The Reaction Against Ritalin

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Executive Summary

During the 1990s, the U.S experienced an enormous increase in the prescribing of Ritalin and other psychotropic drugs to treat U.S. schoolchildren, primarily boys, diagnosed with attention deficit disorders. The United Nations reported that that the U.S. was manufacturing and consuming 90 percent of the world's supply of Ritalin, a powerful stimulant that's been on Schedule II of the Controlled Substances Act since 1971. Between 1991 and 1999, domestic sales of Ritalin increased 500 percent. Some critics believe a 1991 federal Department of Education decision to classify attention deficit (hyperactivity) disorder (ADHD or ADD) as a learning disability for which schools could receive reimbursement under the Individuals With Disabilities Education Act (IDEA) contributed to this questionable Ritalin boom.

A movement is rapidly spreading among state legislatures to prevent public-school personnel from pressuring parents to accept medication of their children with psychotropic drugs. Connecticut, Minnesota, New Jersey, New York, Oregon and Virginia have passed laws with that intent, and Arizona, Kentucky, Utah, and Vermont are among states currently considering such legislation.

The forthcoming congressional reauthorization of the IDEA presents an opportunity for policy-makers to encourage solutions to school disciplinary problems that do not entail the over-medication of students.

Details follow.

The Reaction Against Ritalin

Ritalin ruled the 1990s but in the first years of the new century a reaction has set in at the grassroots level. Could it be that King Ritalin will be de-throned?

State legislatures have begun to consider carefully laws to ensure that schools aren't a party to the over-prescribing of this drug to children who may be exhibiting symptoms of nothing more serious than restless childhood.

Ritalin is the brand name for methylphenidate, one of two controlled substances American physicians widely prescribe to treat children diagnosed as having attention deficit (hyperactivity) disorder, interchangeably referred to as ADHD or ADD.

The other such substance is amphetamine, primarily marketed as Adderall and Dexedrine. Ritalin and amphetamine are powerful stimulants that have been on Schedule II of the Controlled Substances Act since 1971. According to a top official of the U.S. Drug Enforcement Administration (DEA), Schedule II "contains those substances that have the highest abuse potential and dependence profile of all drugs that have medical utility."[1]

The DEA also notes that in clinical studies, Ritalin produces "behavioral, psychological, subjective, and reinforcing effects similar to cocaine." Clinically addicted rodents and monkeys crave Ritalin just as intensely as they do cocaine.[2]

In 1991, the U. S. Department of Education ruled that children with ADD or ADHD diagnoses qualified for special education services provided under the Individuals with Disabilities Education Act (IDEA). Critics charged that the federal government thereby created a financial incentive for schools to label children as disabled and to encourage their treatment with Ritalin or other psychotropic drugs.[3]

Whether a cause-and-effect relationship can be proven or not, no reasonable doubt exists that the use of Ritalin and amphetamine with American children skyrocketed during the 1990s. In congressional testimony in May, 2000, the DEA reported that "the number of prescriptions written for ADHD has increased by a factor of five since 1991."[4]

Furthermore, the records show that boys are four times more likely than girls to be diagnosed with ADHD and be prescribed Ritalin or another stimulant. In 1998, the prescription auditing company IMS Health found that 40 percent of all prescriptions for ADHD were being written for children between the ages of 3 and 9 – and 4,000 Ritalin prescriptions were written for children 2 years of age or younger![5]

United Nations data indicate that the United States produces and consumes 90 percent of the world's supply of Ritalin. The DEA has reported that from 1991 to 1999, domestic sales of Ritalin increased by almost 500 percent.[6]

Ritalin and other stimulants are considered effective in treating the symptoms of ADHD; they help children settle down and concentrate on their schoolwork. However, concerns abound about possible long-term effects, abuses of the drug, and over-prescribing, as suggested by regional disparities in rates of usage. In addition, considerable debate rages as to the scientific basis for the widespread diagnoses of attention deficit disorders. There is no laboratory test for the malady and some critics charge that ADHD is nothing more than a lucrative marketing tool for drug companies. However, many medical professionals counter that there is evidence that ADHD is a neurological disorder that, if left untreated, could have long-time ill effects on a child's prospects for success in school and later life.

Hyperactivity, impulsivity, and inattention are the three classifications of ADHD symptoms listed in the American Psychiatric Association's (APA)1994 *Diagnostic and Statistical Manual of Mental Disorders*. Addressing the congressional subcommittee, Bethesda, Maryland physician Peter Breggin, the director of the International Center for the Study of Psychiatry and Psychology, remarked that, "Under hyperactivity, the first two, and most powerful criteria are

'often fidgets with hands or feet or squirms in seat' and 'often leaves seat in classroom or in other situations in which remaining seated is expected.' Clearly, these two 'symptoms' are nothing more or less than the behaviors most likely to cause disruptions in a large, structured classroom.

"Under impulsivity, the first criterion is 'often blurts out answers before questions have been completed,' and under inattention, the first criterion is 'often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.' Once again, the diagnosis itself, formulated over several decades, leaves no question concerning its purpose: to redefine disruptive classroom behavior into a disease. The ultimate aim is to justify the use of medication to suppress or control the behaviors."[7]

However, in response, David Fassler, a child and adolescent psychiatrist from Burlington, Vermont, testified that APA guidelines are more rigorous than the critics claim. "The diagnosis of ADHD requires a comprehensive assessment by a trained clinician. In addition to direct observation, the evaluation includes a review of the child's developmental, social, academic, and medical history. It should also include input from the child's parents and teachers and a review of the child's records." Major damaging consequences can occur, he continued, if the disorder is ignored: "Without proper treatment, a child with ADHD may fall behind in schoolwork and have problems at home or with friends. It can also have long-term effects on a child's self-esteem and lead to other problems in adolescence, including an increased risk of substance abuse."[8]

Legislative debate and action are spreading across the country.

In the aftermath of the massacre at Columbine High School in Littleton, Colorado, which brought to the fore concerns about schoolhouse violence being committed by young persons who were taking psychotropic drugs, the Colorado Board of Education became (on November 11, 1999) the first public body to officially discourage teachers from recommending Ritalin. (One of the Columbine shooters, Eric Harris, had been taking Luvox, an anti-depressant, though there is no proof that had anything to do with his actions.) The resolution sponsored by board member Patti Johnson had no legal force, but it has inspired action around the country to curb the use of Ritalin and other potent behavioral drugs used for children.[9]

In Vermont, Democratic Senator Richard Sears, the Chairman of the Judiciary Committee, is currently sponsoring a bill intended to make clear that parents have the ultimate say over whether their child goes on the drug, and that schools must not pressure them to put the child on the powerful psychotropic drugs.

"There are two things I've learned that bother me," said Sears, after reviewing testimony on this issue last year. "One is there seems to be a lot of abuse of Ritalin going on among 12- and 13-year-olds who smash it and snort it. And two, Vermont is second in the nation in its rate of prescribing the drug."[10]

DEA data for 1999 indeed ranked Vermont second in the nation with usage of 5,005 grams of Ritalin per 100,000 population. New Hampshire was first with a rate of 5,525 grams. Others among the top five were Michigan, Iowa, and Delaware.

1999 Ritalin and Amphetamine Distribution: Top Ten Users

RANK	*RITALIN*		*AMPHETAMINE*	
	STATE	*GRAMS PER 100K*	*STATE*	*GRAMS PER 100K*
1	New Hampshire	5,525	Delaware	2,538
2	Vermont	5,005	Rhode Island	1,903
3	Michigan	4,848	South Carolina	1,830
4	Iowa	4,638	Wisconsin	1,686
5	Delaware	4,439	Alaska	1,614
6	Massachusetts	4,318	Missouri	1,482
7	South Dakota	4,235	Arkansas	1,472
8	Virginia	4,207	Montana	1,431
9	Minnesota	3,941	Maryland	1,425
10	Maryland	3,935	Virginia	1,404

1999 Methylphenidate U.S. average = 3,082 grams per 100,000 population
1999 Amphetamine U.S. average = 1,060 grams per 100,000 population

Source: U.S. Drug Enforcement Administration

Delaware, Virginia, and Maryland were the only three states to rank among the top 10 in usage of both Ritalin and amphetamine.

In the current session of the Virginia General Assembly, Delegate John J. Welch III, R-Virginia Beach, sponsored a bill intended to prevent teachers and other school personnel from recommending that children be put on Ritalin. School officials still would be able to recommend that a child be evaluated by a doctor. The measure, HB90, passed the House of Delegates on February 1.[11]

In November 2001, *The Virginian-Pilot* of Norfolk quoted Gretchen LeFever, a psychologist and assistant professor of pediatrics at Norfolk's Center for Pediatric Research, as stating that 15 to

18 percent of elementary pupils in Virginia are taking Ritalin. “That’s astronomically high,” she said. She has compiled a national database using DEA data that pinpoints pockets of population around the country with unusually high rates of Ritalin use. In addition to Hampton Roads, areas of the Old Dominion with high rates of usage are Northern Virginia, Richmond, Charlottesville, and Roanoke.[12]

Connecticut, Minnesota, New Jersey, New York, Oregon and now Virginia are states that already have passed laws that are designed to ensure that parents do not encounter pressure from schools to put little Johnny (or Janie) on Ritalin.

In Vermont lawmakers related anecdotal evidence of school officials urging parents to have their children medically evaluated and then pressuring them to put their children on Ritalin if it is recommended. Sometimes parents face threats that their children will be barred from returning to school unless they accede to the Ritalin, the lawmakers said.[13]

In Kentucky, State Representative Mike Cherry, a Democrat, recently introduced a bill that would forbid school personnel from recommending to parents that they put their children on psychotropic drugs when they are diagnosed with ADD or ADHD. Under his measure, the state could not punish parents who decide against keeping their children on stimulants like Ritalin.[14]

According to *Education Daily*, Kentucky has seen its numbers of children diagnosed with attention disorders increase since 1992 from 408 to 6,872. Many of those students wound up on Ritalin or amphetamine.

“It is worth the little bit of effort to make sure the teaching profession knows it’s not their job to recommend a particular drug for a particular kid,” Cherry told the *Lexington Herald-Leader*. However, some educators – in Kentucky and elsewhere – are concerned that such laws will force them to keep mum about observations that might be important to a child’s well-being.[15]

“If we were in the position not to tell parents of the resources, then I think that would be negligent,” said Diann Shuffett, an assessment specialist in Fayette County, Kentucky.[16]

In Utah, a blaze of controversy erupted after a Republican legislator’s introduction of a bill that would make it a misdemeanor for a teacher to imply or require that a child must take a psychotropic drug in order to stay in school. A teacher could recommend in a letter that a child be considered for professional treatment for a possible behavioral disorder – but the letter could go only to the parent.[17]

“The greatest concern of a parent is to have a child labeled,” said the bill’s sponsor, Representative Katherine Bryson. “We’re talking about psychotropic drugs as a condition of attending school.”[18]

In opposition, Phyllis Sorensen of the Utah Education Association said, “The way it’s written, teachers can’t even sit down with parents and tell what they observe. It’s really restrictive and hampers the kind of teamwork needed for the sake of the kid.”[19]

The efficiency of schools in handling Ritalin appears to be questionable, judging from DEA reports. Schools have more Ritalin on hand for daytime dosing than many pharmacies have available, yet typically schools do not have licensed handlers for these controlled substances as all other institutions must. According to the DEA, supplies often are kept in unlocked desks, and a variety of people dispense the pills to students – not just nurses, but secretaries, parent aides, teachers, and even, in at least one instance, the janitor.[20] However, the General Accounting Office (GAO) subsequently reported a more reassuring picture to Congress after surveying middle and high school principals. During the school year 2000-01, only 8 percent of the public-school principals reported knowing about attention-deficit drugs being diverted or abused at their schools, and most said they were aware of no more than one incident. The GAO also said the principals reported that medications were kept locked up "in almost all" (96 percent) of the schools. (Of course if drugs were "only" left unlocked in 4 percent of schools, that still could pose a threat to public health and safety.)[21]

The DEA has reported that the magnitude of Ritalin diversion and trafficking is comparable to that for similarly potent pharmaceutical drugs, such as morphine sulfate. However, Ritalin abuse is particularly worrisome because it occurs primarily among adolescents and young adults, many of whom have the wrong-headed notion that the drug is not dangerous. They don't have to forge a prescription or visit a drug pusher to obtain it. Frequently they can just obtain it from a classmate.[22]

Problems with Ritalin may arise as an issue during the coming congressional reauthorization of the mammoth Individuals with Disabilities Education Act (IDEA). State legislatures or state/local education boards are bringing important questions to the fore by exerting clout to ensure that parents are not coerced or cajoled into accepting drug therapy in inappropriate cases.

The IDEA process could encourage a process of treatment of children with behavioral disorders that does not depend so heavily on medication. In a recent paper for the Progressive Policy Institute and the Thomas B. Fordham Foundation, Wade F. Horn and Douglas Tynan cited a long-term treatment study of students with ADHD wherein the "best outcomes" came for children "who received a combination of relatively low doses of medication, a classroom behavior modification program and behavioral family therapy to help parents better manage their child's home behavior."[23]

Continued Horn and Tynan:

"Rather than being taught to rely on medication to manage their symptoms, the children in the combination treatment were systematically taught, both at home and in school, the skills necessary to maintain behavioral control even in the absence of medication. These results suggest that students with ADD and ADHD would benefit more if schools would structure their environments more clearly, with obvious rules and boundaries and clear consequences for good and bad behavior, rather than relying on medication alone to enhance educational outcomes."[24]

It is impossible to look at the explosive increase in Ritalin use in the USA over the past decade without concluding that something more than student behavior is out of control. Coming

hearings on the revising and reauthorizing of IDEA offer an opportunity to examine ways American schools and homes can restore discipline without seeking it excessively in pill form.

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ENDNOTES

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5. *Ibid*.
6. "Dramatic Increase in Methylphenidate Consumption in U.S.: Marketing Methods Questioned," United Nations Information Service release, UN International Narcotics Board annual report, February 28, 1995.
7. "House Hearing Highlights Extremes of Ritalin Controversy," *Special Education News*, October 8, 2000, *www.specialednews.com/disabilities/disabnews/ADHDritalinhearing100800.html*
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14. Ted Gotsch, "Ky. Bill Would Bar Schools From Discussing Kids' Medication," *Education Daily*, January 23, 2002.
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18. *Ibid*.
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20. Woodworth, *op. cit.*
21. "Attention Disorder Drugs" Few Incidents of Diversion or Abuse Identified by Schools," United States General Accounting Office, GAO-01-1011, September 2001.
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