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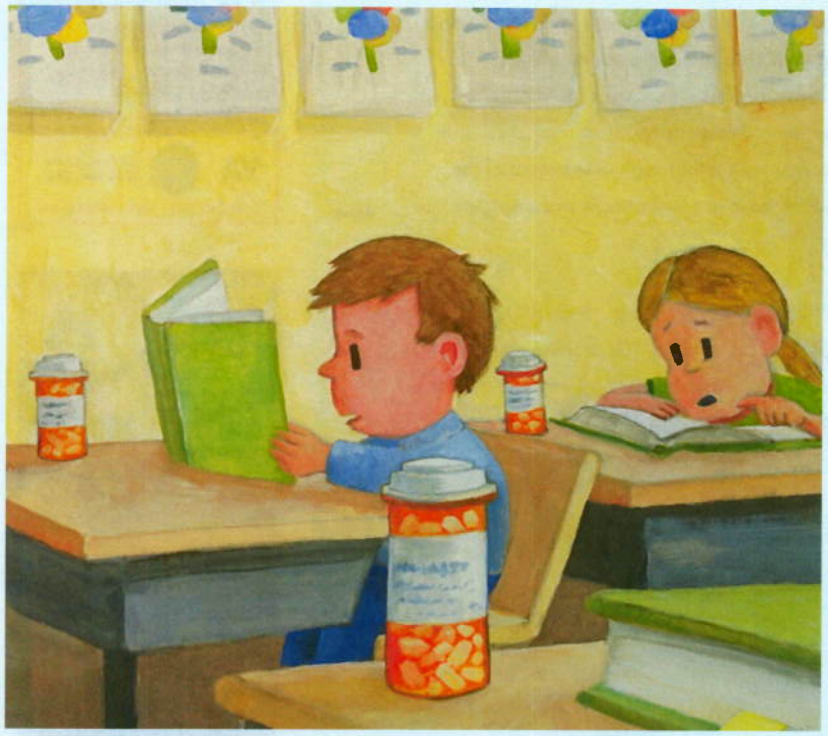

COVER STORY ONE

Labeling and medicating children

A new epidemic

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Part One: a legislator's perspective

Prior to my election to the Minnesota House of Representatives in 2010, I served on my local school board for 16 years. During that time, I developed an interest in the increasing practice of labeling and medicating children who showed signs of Attention Deficit Hyperactivity Disorder (ADHD). I learned that the procedure used to diagnose these children was primarily based on a series of

Let me stress that I do not want to hurt any special education students. I have relatives who were in special education programs, but I am committed to finding factual answers to the above concerns.

Part Two: a physician's concerns

As a general internist with a special interest in pharmacology, nutritional and botanical medicine, and complex illness, I have grown especially concerned with the misapplication of drugs—often many in the same patient. The rapid evolution of the physician (and other provider) workplaces with computerized medical records and the compulsion to practice medicine by "drop down menu" has added to the propensity to overprescribe. Nowhere is this more apparent than in the inappropriate overprescribing of psychotropic drugs for children—often by physicians who have not adequately examined the child.

Questions about effectiveness

Many drugs used to manage mood and behavior in children either have very little scientific basis (never tested thoroughly in youth under 18) or have a very undesirable risk-to-benefit ratio. This latter item is rarely, if ever, fully disclosed to the patients or their legal guardians in the spirit of informed consent. Examples include medications like Risperidone, a drug now in relatively common use for schizophrenia and other related thought disorders that has profound implications when given long term. It can actually cause permanent brain damage, resulting in irremediable tardive dyskinesia (an involuntary movement disorder that is both humiliating and disabling).

The so-called "serotonin reuptake inhibitors," long in use for the management of depression and anxiety (Prozac, Zoloft, etc.) in fact have very little scientific basis for their action. They are routinely given for anxiety and depression, particularly in children who suffer various types of posttraumatic stress disorder from abusive homes, injuries, medical conditions, and other factors. There is very little validated evidence that they are safe or effective in children. In fact, there is a boxed warning regarding both homicidal and suicidal ideations on several of these drugs that are commonly used. A recent expose disclosed that a majority of mass shootings have been perpetrated by individuals taking these drugs. The breathtaking element here is the utter lack of scientific scrutiny for safety and efficacy, particularly when given on a long-term basis (longer than six months).

Trends in diagnoses

Another overriding concern is the growing number of individuals using these medications. Much of this goes back to the publication of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in 1994. When this now-revised fourth version came out, reported rates of ADHD, autism, and childhood bipolar disorder increased dramatically, largely because of the then-new DSM definitions. Some have called this "diagnostic inflation," a phenomenon that is strongly