Forced Drugging of Children in Foster Care: Turning Child Abuse Victims into Involuntary Psychiatric Patients

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Abstract

The use of psychotropic medication by children and youth within the child welfare system is examined. The increasing use of these medications by this population is presented as problematic through a case study and by identifying general aspects of the social systems that have contributed to its development and entrenchment. The needs of children and youth in the child welfare system, the influence of the pharmaceutical industry and historical trends in child psychiatry supplement a narrative of a child who was misdiagnosed as severely mentally disturbed and subjected to intense psychotropic medication. The article concludes by stating that resisting the forces that attempt to enforce the use of psychotropic medication by these children and youth is possible through self-education and assertive advocacy for non-chemical alternatives.

Introduction

Imagine getting ready for bed each night, your feet feeling as if they were made of lead. You worry that you might not make it to the bathroom in time. Imagine getting the same persistent ideas every night that there are spiders under your pillow and in your chest of drawers. You try to think, but your thoughts escape and you can't recapture them. Imagine that you have nightmares when you fall into a hazy, dizzy sleep and that some of those nightmares you know are real-someone groping at you and violating you but no one listens or believes you. Imagine waking up each morning with a dry mouth, aching bones, pains in your stomach, and blood in your underwear. Another day of taking a fistful of pills, your "happy vitamins" which are neither vitamins nor do they make you happy. You also must take your other medicines to relieve your constipation, to relieve your acid indigestion, to treat your skin rashes. You have a poor appetite and your muscles are wasting. Your complexion has a grey pallor to it. You are a weakling and there is no one around who loves you. The people who love you are also weak. They cannot help you and they are kept from you as much as possible.

This startling description is of a nine-year old boy in the custody of child welfare services who, like many other children, was diagnosed with non-existent multiple mental disorders and then prescribed mind-numbing, physically debilitating psychiatric medications known as psychotropics. These children are housed in dormitories where other abused and neglected children of varying ages can perpetuate the same abuse that they have experienced onto other younger, more vulnerable children. This is what happened to one boy named Jay[2] and, unless something is done to stop it, it will continue to happen to other children.[3]

How This Situation Arose

The vulnerability of these children and the extreme harm that psychotropic abuse inflicts on children demand an answer as to how this situation came to be. Without first considering this question, it will be impossible to fix the problems that endanger foster children. Of course, cause is multifactoral: flaws in the child

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welfare system; in the medical system; in the legal system. For all the good that is done by child protection services, it would be profoundly irresponsible not also to recognize that these organizations have many problems. It has often been the experience of this author that many frontline workers have little or no understanding of child psychology or psychopharmacology.[4] Often these workers have large case-loads and are unable to devote sustained attention to any particular child. In fact, once a child has been placed into a group home his/her worker may only visit once a month, or less. Yet these workers are legally empowered to make all medical decisions for the children in their care. Moreover, these workers can enforce compliance with these medical decisions through a variety of means – all without actually consulting the child or really understanding his/her needs and the effects that these drugs may be having on him or her.[5]

For the sake of focus, the following will concentrate primarily on medical abuse occurring within our society and how we can judge the level of this medical abuse by the way in which the most vulnerable members of our society are treated within the child welfare system. What happened to Jay, and is continuing to happen to other children, was made possible, in part, by our collective neglect of taking responsibility for our own health and the health of our children. At the same time, the profit-driven and power-hungry medical system and the even more profit-driven and power-hungry Big Pharma[6] have stepped into this breach. Although both groups provide many benefits to some of their clients, their motivations are often self-interested and so, because children in child protection cannot adequately self-advocate, the medical profession and Big Pharma can exercise undue and even harmful influence on the care that these children receive.

When I first began working in the child welfare system, children who were brought into care were seen as the abused and neglected children that they were. Now, they are often seen as mentally disordered children.[7] Over time, child psychiatrists and the exotic diagnoses they bring with them, have become institutionally entrenched, and with them the drugs – the stimulants, neuroleptics, anti-convulsants, etc. These drugs are dispensed with such frequency and with such matter-of-factness, that the reality of their dangerous toxicity becomes trivialized. A self-validating process takes place. "They must not be dangerous–look how routinely they are given," goes the reasoning.

There are now many new players, tellingly referred to as "stakeholders", and there is a lot of money being made from these abused and neglected children. In fact, in some jurisdictions the obscurity of a child's diagnosis is directly related to the fee that is paid to the group home or foster parent and is also related to the fees that the practitioner is allowed to charge, the latter fee ostensibly being based on the assumption that these obscure diagnoses take extra time to assess, greater caution and the need to rule out more commonplace conditions. In reality, however, these diagnoses are frequently made without any medical examination of the child, no blood or other laboratory tests, and on the basis of checklists filled out by third parties who have their own vested interests.[8] This does not necessarily mean that these parties purposely misdiagnose in order to maximize their income, although the implications of this end result must be considered in general and in specific cases. For instance, research demonstrates that financial relationships with pharmaceutical companies have strong correlations to diagnostic and prescribing behaviour of physicians, even when the practitioner is unaware of

this linkage.[9] Sadly for the child, when he or she is administered a drug based on a misdiagnosis the drugs will not have the expected effect and, when the drugs do not work, more diagnoses are likely to follow with more drugs prescribed, often in higher dosages. A vicious circle can arise where no one stops to question whether the diagnoses could be wrong-though they are almost always wrong, in my experience.

These are abused and neglected children, which means that they have been deprived of proper care prior to becoming wards of child welfare services. It is most likely that they are deprived and undernourished and that they have been subjected to acute and/or prolonged stresses. It is well known that stress is a destructive and depletive factor on the body.[10] These children need to be free from immediate dangers and after this they need proper nutrition, proper rest, sunlight and exercise. In general, these children need to be in surroundings in which they are being respected and cared for. It is a matter of their human dignity and their human rights that they be allowed to develop naturally, and this means being free of the coercive use of chemical restraints.[11] Children in welfare services need and deserve to be free from drug-induced sleep patterns, from drugs which alter their brain chemistry and cause organ damage and to be free to play with other "normal" children.[12] They deserve not to be stigmatized, not to be seen as permanently damaged and disordered in the eyes of their community and, ultimately, in their own eyes.

What I am proposing for these children is the normalization of their lives instead of the abnormalization of their lives. This is exactly the opposite of what is actually happening to them in many foster care group homes. Rather than chemically-oriented psychiatrists, they would be served better by nutritionists and other health-oriented professionals alongside professionals skilled in social and personality-based interventions. When we abandon these vulnerable children as beyond rehabilitation and adopt the system of "management" we make them worse, and this is exactly what resigning them to a lifetime of psychotropic use involves. A paradigm shift is needed to make them better. Rather than labelling them as abnormal they should be understood as having very normal reactions to stressful situations: it is not a disorder to react to abuse or neglect with anxiety and confusion. Consider the opposite – that to behave blithely in the face of unavoidable stress would be a much clearer symptom of a possible mental disorder.[13] Definitive animal studies show that if you subject an animal to stress, and that stress is unavoidable, there are predictable physiological and deteriorative changes that take place.[14] Humans are no different in this way. It is also useful to note that psychotropics, as a result of both their desired effects (changing brain chemistry) and their undesired effects (immediate and short-term adverse reactions and long-term organ damage) constitute further stressors on the individual taking these powerful drugs.

Children's Mental Health

Turning briefly to the history of child psychiatry, it is apparent that it is a new field that essentially did not exist before the 1960s.[15] However, to judge by the influence that it now exerts within our society, it seems reasonable to ask how society managed to survive without child psychiatrists. From stimulants to antidepressants to antipsychotics, the use of these drugs has been increasing at a speed[16] which would lead an uninformed observer to conclude that a gaping, unaddressed need is finally being met. On the contrary, it may actually be the case that children were safer before child psychiatry. When

this author has posed the question of why we need child psychiatrists the usual reply is: to deal with children's mental health. This, though, prompts yet another question: what is children's mental health? And here we come to a central issue. That is, that the notion of "children's mental health" is, in itself, a relative new term which comes with its own assumptive "baggage". These assumptions require one to conceptualize childhood as a perilous journey, fraught with danger, in which mental disorders lurk around every bend in the developmental road and in every corner of the child's experience. The concept of "children's mental health" implies that children are uniquely susceptible to dire psychological harm because they are children.[17] The public, uninformed of the history or the interests underlying the concept of children's mental health, are told that one in five children suffer from a serious mental health disorder[18] but not that these mental disorders are, by and large, the creations of conventional psychiatry itself. It is not surprising that each new edition of the psychiatric diagnostic manual has yet more disorders.[19]

Direct-to-consumer advertising of psychotropic medications is the most blatant form of manipulating the public's understanding of psychological health and well-being.[20] Having found an effect of a drug, the initial phenomena that it affects is presented in television and billboard advertisements as a mental disorder needing treatments. Potential consumers are saturated with messages listing so-called symptoms that are, in fact, so readily recognizable that the market is generated as people begin to believe that they exhibit the features of such-and-such condition. This process is akin to a first-year medical student reading a Merck's manual and thinking that the symptoms of each disease encountered apply to them. One is also reminded of studies in which a person reading his or her horoscope personalizes information that is universal and/or vague enough to apply to almost anyone.[21] The process then becomes complete when these newly created hypochondriacs approach their physicians, who have already been informed by helpful pharmaceutical sales representatives of the importance of treating "undetected" disorder X and who have provided the physicians with research studies demonstrating the efficacy of drugs as well as free samples so that they can see for themselves with their patients.[22] Industry-supported public awareness campaigns are only more diffuse versions of this same strategy. Like all advertising campaigns, we are filled with anxiety about a perceived risk and then provided with a product to buy to deal with that newly discovered risk. Child psychiatry presents itself as an ever-vigilant sentinel alerting us to new and increasingly dangerous disorders that must be detected and then early intervention provided-in the form of drugs. When child psychiatry and child protection mix, for instance through industry-sponsored continuing education of agency staff, the mixture of misguided good intentions, self-interest and child-clients' inability to self-advocate creates untenable potential for harm.

Children's mental health is, for the vast majority of children, a matter of being loved and cared for and protected from harm and provided with an environment in which they can thrive. This is primarily the job of parents and extended family, and that of child welfare services only secondarily. On occasion, society does have to protect children from their parents. This puts social agencies in the position of "loco parentis," in the place of a parent. This should be considered a sacred trust, but in child welfare agencies, where over-worked and under-skilled frontline workers struggle to meet impossible deadlines, it is too often the case that this parental responsibility is relegated

to child psychiatry and other profit-motivated forces, such as group homes. In these group homes the staff, often even more limited in relevant education than the child welfare workers, become the enforcers of the drugs' administration and, through ignorance, their practices and records reinforce the notion that the child is fundamentally abnormal and beyond rehabilitation.

Children with fears and phobias benefit from psychologists, play therapists and art therapists, for instance, and do not, in my considered view, need child psychiatrists.[23] Despite the fact that there are probably some very nice people who are child psychiatrists, on the whole, it is my position that child psychiatrists have created more child harm than child benefit. While this does not necessarily have to be the case, as long as the child psychiatry machine runs on the powerful engine of Big Pharma, acting as sales agent for its products and extending the bounds of its market, it will continue to be one of the biggest threats to children's physical and mental health.

Jay's Case

Referring back to Jay again, this boy came out of a dysfunctional situation. Starting at age four, he had seen over five dozen physicians, and he was diagnosed with dozens of disorders and conditions, ranging from mental retardation to ADHD, Tourette Syndrome to bipolar. His conditions were treated with psychotropics, and there is little evidence that there were any genuine efforts to provide him with non-drug interventions. By the time that he came into the care of the child welfare services, he was heavily drugged and diagnosed as having ADHD, Tourette Syndrome, Oppositional Defiant Disorder, Obsessive-Compulsive Disorder, Conduct Disorder and Childhood Onset Bipolar Mood Disorder. In care of the child welfare system, Jay was given, among other drugs, a steadily increasing regimen of Ritalin, Divalproex and Seroquel, the latter two being prescribed on an "off-label" basis.[24]

Once extended family came forward to offer a plan to be his guardians, the full nature of his predicament became apparent. As a result of concerns about the child, a letter was sent to the province's Attorney General alerting him to the fact that there were specific individuals who were administering noxious substances to Jay, which is contrary to Canada's Criminal Code. The assertion was made to the Attorney General that this should be seen as a criminal offense, as it was forced drugging, that is, it was clearly against the express wishes of Jay and that the effects on the child were of a toxic nature.[25] The response of the Attorney General's office did not assist Jay in ending his ordeal or in holding those accountable for his involuntary drugging. The response of government, of course, varies. A recent case in Boston in which a child died did lead to criminal charges–but against the parents for not administering the drug properly. This child too was only four years old, known to child welfare services and was taking a drug cocktail, of which two of the three drugs were the same as those taken by Jay, the two that were experimental for children. However, the psychiatrist has been subject to some scrutiny and has had her license to practice suspended pending investigation into her prescribing practices, a significant difference from the reaction in Ontario. Still, it is a far cry from Texas where the state Comptroller released a damning report in December of 2006 raising blistering concerns about the use of psychotropics by children in foster care.[26]

In all three jurisdictions there are some steps being made to save children who fall through the cracks of child welfare and child psychiatry, although they differ significantly in their forcefulness

and their follow-through. Concerned independent professionals, government workers and journalists can make a difference, but ultimately need the public's support, which, of course requires their awareness. The people who are prescribing these poisons to our children need to be held accountable and the industries that profit from them must be scrutinized and meaningfully regulated. Unfortunately, it takes a death of a child for there to be any real notice of the problem, and only time will tell if this public concern is maintained. These drugs are toxins which can have long-lasting effects and so it might be expected that people would care. These substances lead to increased risks for diseases such as diabetes, thyroid dysfunctions; neurological diseases, such as Parkinsonism; liver, kidney and pancreatic disease; heart disease; brain atrophy; and reproductive organ damage. Even more outrageous, these poisons do not cure anything, which is readily admitted by drug companies and psychiatrists. Instead, they are used to "manage" these "diseases," which is far more profitable as management entails perpetual use, while cures have a start and a finish. Consequently, children are commodities in this situation, or perhaps markets to be tapped. In some instances this is a self-reinforcing process as the psychotropics produce their own side-effects (iatrogenic conditions) which are misdiagnosed as additional diseases which then require further tests, treatment and rack up greater profits. This is what happened to Jay. It is a cruel and abusive cycle that benefits everyone involved, except the child. When side-effects become disorders requiring their own treatment they are no longer side-effects, they are problems and, in my view, malpractice. We must demand that children not be labelled with implausible disorders, subjected to drug experimentation, or exposed to life-long harm. However, the problem with needing public support in this mission is that apathy is not defined as an absence of caring or of awareness, but of action.

What We Can Learn

There are lessons to be learned and ways to move forward. One is that the patient's interests and the doctor's interests are not identical. One way to look at the problem is to see that the pharmaceutical manufacturers of psychotropic drugs use doctors as distributors.[27] Teachers and psychologists often serve as the intermediaries, funnelling "problem children" into prescribers' offices.[28] Then, social workers, group home workers and others act as enforcers, ensuring that the drug abuse goes on and that alternative health measures are not available to the child.[29] Along the way, the prescriber makes a profit, as does the pharmacy and the pharmaceutical corporation; the child welfare agency and the group home, which are usually funded according to the volume of their clients and the complexity of their needs, make a profit; the teachers experience fewer demands for individualized programming for children who fall outside the learning or behavioural norms which means that they can work less for the same pay, essentially a profit, and the school board may receive additional funding because they have a "special needs" student; even the abusive parent may benefit by being able to claim that they were not a problem--instead responsibility lies with their child-he has one or more disorders. Child psychiatry, as it is practiced in these types of settings, amounts to an unconscionable blaming of the victim.

A second lesson is the need for parents, or whoever is looking out for the interests of a child, to empower themselves. In general, approach the medical model of mental health with extreme scepticism and do not be afraid to advocate for a more holistic health model.[30] Attend conferences where these issues are

discussed by credible experts and where you can meet other people with similar experiences–knowledge is power, community is power. Search the internet and then read books to follow up on what you have learned. Write to people who seem knowledgeable, and if they don't write back, keep trying to find the help that you need. Consult with health professionals who have knowledge in nutritional medicine and brain allergies.

In specific situations, people need to question and be prepared to reject any psychiatric diagnosis applied to their child-whether it is suggested by teachers that a child has ADHD, child protection workers who have just attended a faddish, corporate sponsored continuing education seminar or a doctor who tags the child as oppositional-defiant, bipolar, obsessive-compulsive, or any other psychodiagnosis that happens to be current. The questions would be: What are the criteria which are being used to make this diagnosis? What are other possibilities besides this diagnosis? It is important to note that these "disorders" are not ones which have objective findings like blood analysis or the presence of pathogens. These are disorders which are susceptible to subjective opinions. The next question that a parent should ask is if there is a cure for a proposed condition. The answer is no, and a doctor will have to tell you that there is no cure, only management, which is another way of saying that it can be a life-sentence of drugs. A life-sentence of drugs is a shortened life and one in which the quality of life is significantly decreased. No parent or loved one need accept this kind of pronouncement unquestioningly.

This type of enquiry will tell a physician that one is not simply going to accept the drugging of a child. It is the expected awe that people have of doctors which makes the misdiagnosing and drugging of children possible. But, a child's health is a collaborative effort between care-giver and physician and there is no reason to relinquish this responsibility to authority figures. In fact, authority comes from being able to attain results, not from training alone. If there is a problem with your child, you need a cure, not just management. This may require changes in lifestyle, such as diet, or his/her care-givers making changes in their working hours so that they can provide the child with the opportunities for learning self-regulation. Big Pharma relies on people's wish to find an easy solution to a problem without having to look at the bigger picture and modify priorities and lifestyle.

A third lesson is that one has to be prepared to fight and that there may be consequences. The nature of authority it that it assumes itself to be correct. Of course there are many child psychiatrists who will be pleased to have an informed client, and of these there are some who will readily accept a client's direction even if it is in contrast to their own opinion. However, this should not be expected and when child welfare services are also involved the difficulty in disagreeing with a misdiagnosis compounds and the powers to coerce are very much real. In Jay's case, child welfare took the view that his misdiagnosis was definitive since it had come from a child psychiatrist.The absence of a psychological assessment, discrepancies in the diagnoses and observable side-effects did not have any discernable impact upon the agency's conduct. As a result, the agency vigorously pursued legal remedies in order, initially, to keep the child in a group home rather than in his family's care and then, once the family was granted his custody, to force them to try to continue his psychotropic use and to try to dictate their choice of medical professionals. Eventually, the family, or more accurately, Jay was successful. The courts ruled that the involvement of child welfare services was no longer war-

ranted and so had no more jurisdiction, the media picked up his story and the government investigated his treatment, but it is not always this way. For many families the end result is a sad one, the child is taken away forever, raised in a drug-induced stupor with grave impacts for their development and education and, in some case, the family members face prosecution for abuse or neglect if they attempt to intervene to stop the medical abuse of their child.

This last stage of using the Courts to enforce the drugging of children is disturbing in terms of its oppressive and authoritarian implications and should concern every citizen of a democratic society. The final lesson is that what you do matters, and it is only through individual and collective efforts that this systemic medical abuse and psychiatric dictatorship will be halted.

Notes

1. The author wishes to thank Jay's grandparents for their perseverance, Michele Cheung, Kamala Rao and CBC Toronto for taking a story that three other journalists were prevented from covering and Jay, for making it through and being himself. The author also wishes to thank Sean McKay for his research and writing assistance during preparation of this article.
2. Not his/her real name.
3. In this case, when concerns were voiced to child protection services that children in the same group home as Jay may be subject to the same medical abuses, an expert was retained to review the files of four child residents. This expert found only a single problem with the psychotropic regimen of these children: one child had one of his/her psychotropics replaced for an alternative. Later, the relevant regulatory body retained another expert to review the psychotropic regimen and general treatment of Jay. This expert found that despite there being no assessment of his condition and needs, the criteria for making his diagnoses were unaccounted for and seemingly contradictory, off-label medications and research protocols were being employed and there was insufficient proof of consent and monitoring, the prescribing psychiatrist's practice was deemed to be acceptable. Later, a government appointed investigation found serious errors in the care given to Jay. These contradictory findings raise the strong possibility that this is a systemic problem across child protection and perhaps child psychiatry in general. Florida, Massachusetts and Texas are only three examples of other jurisdictions in which child welfare services and child psychiatry practices have raised compelling concerns regarding the forced drugging of children in state care. Carol Marbin Miller, "Mind-Altering Drugs Given to Some Babies in DCF's Care", in Miami Herald Sept 17, 2002; Patricia Wen, "Girl's Death Puts Doctor at Center of Controversy - Questions Raised on Prescriptions", in Boston Globe February 19, 2007; and Carole Keeton Strayhorn, Foster Children: Texas Health Care Claims Study - Special Report, Texas Comptroller 2006.
4. Despite the heavy recruitment of child welfare workers of employees with social work degrees, there appears to be no requirement in colleges or by child welfare agencies that these people have this knowledge base. In general, social work, a traditionally valuable field, interprets the predicaments of its clients through a paradigm that positions them as directed by forces external to them, "social forces". Without debating the merits of this approach, the point is that it is therefore not surprising that focus on the individual is not stressed. Recently, there has been some recognition that traditional social work is not fully adequate for child welfare work and some colleges have begun offering "child and youth worker" programs, often with formal or informal links to child welfare agencies. However, even a cursory review of the required and optional courses of these programs revealed a disproportionate requirement for administratively-oriented courses and none devoted to psychopharmacology.
5. Legally, in Ontario children have the right to make decisions regarding their health care, if deemed capable. In fact, they are presumed to be capable, but unless they know of their rights, and the psychiatrist and child welfare worker also know and respect this, it is a right on paper alone.
6. In 2002, for example, the top 10 drug companies in the United States had a median profit margin of 17%, compared with only 3.1% for all the other industries on the Fortune 500 list. Indeed, subtracting losses from gains, those 10 companies made more in profits that year

than the other 490 companies put together." Marcia Angell, "Excess in the pharmaceutical industry", in Canadian Medical Association Journal December 2004; for profit incentive of health professionals see also Nicholas A. Cummings, "Expanding the Shrinking Economic Base: the Right Way, the Wrong Way and the Mental Health Way", in Destructive Trends in Mental Health - The Well-Intentioned Path to Harm (New York: Routledge, 2005); for a useful synthesis see Carl Elliot, "The Drug Pushers", in The Atlantic Monthly, April 2006.

7. One study of youths within the child welfare system claims a "substantial need for mental health treatment among youths who were the subjects of investigations of maltreatment. Despite an estimate that one half of the population had clinically significant emotional or behavioral problems, only one fourth of this group (or one sixth of the study population older than age 2) received any mental health care during the year before the study interview. The gap between need for and receipt of services is significant. Although this gap parallels a similar proportion of unmet need (60%-80%) for the general population of U.S. children, the magnitude is much greater due to an estimated prevalence that is 2.5 times greater in the child welfare population." The authors surmise that this "constitutes a truly missed opportunity. The data presented underscore the necessity to implement fully the existing policies about screening, evaluation, and referral. Assessment of mental health need and access to mental health professionals for evaluation and treatment should be a priority for youths early in their exposure to the child welfare system; universal screening is clearly indicated ... In conclusion, the need for serious attention to the mental health needs of these youths ... can become a reality when *a true partnership is established between the child mental health and child welfare service systems."* [emphasis added] B. Burns, S. Phillips, H. Wagner, R. Barth, D. Kolko, Y. Campbell, & J. Yandsverk, Mental health need and access to mental health services by youths involved with child welfare: A national survey. Journal of the American Academy of Child and Adolescent Psychiatry, 2004.
8. The increasing move to the use by psychiatrists and paediatricians of checklists, filled out by teachers, parents (even, at times, abusive parents), is troubling because it represents an "off-loading" of the diagnostic process to non-professionals. The checklists include a variety of criteria that must be subjectively interpreted, and the checklist items arguably provide a cueing of responses that funnel the results toward the identification of a disorder, such as ADHD. Those filling out the forms--parents, teachers, social workers or group home staff, may have explicit or unconscious rationale for interpreting the child's behaviour as deviant while also decreasing their own responsibility.
9. Ashley Wazana, "Physicians and the Pharmaceutical Industry: Is a Gift Ever Just a Gift?" in Journal of the American Medical Association, 2000; Carl Elliot, "The Drug Pushers", in The Atlantic Monthly, April 2006.
10. Harrison Wein, "Stress and Disease: New Perspectives:, in NIH Word on Health, 2000. (http://www.nih.gov/news/WordonHealth/oct2000/story01.htm, accessed May, 2007).
11. Yolanda Lambe, Chemical Management of Canadian Systems Youth, National Youth in Care Network, 2006.
12. "Dr. Andrew McCulloch, chief executive of Britain's Mental Health Foundation has stated 'There is a growing body of evidence, and a number of significant voices are championing the role of diet in the care and treatment of people with mental health problems. The potential of dietary interventions in treating depression and Attention Deficit Hyperactivity Disorder, for example, are being increasingly recognized. We would be foolish to underestimate their importance ...'" in Carole Keeton Strayhorn, Foster Children: Texas Health Care Claims Study - Special Report, Texas Comptroller 2006.
13. For instance, shallow emotional responses are seen in psychopaths, R. Hare, Psychopathy: Theory and Research, 1970
14. Harlow performed a number of experiments on monkeys that demonstrated that an absence of affective bonding, conditions of loneliness and the experience of sexual violence led to the development of severe dysfunctions. Most famously, he raised monkey babies without access to a mother and found that they were unable to adjust socially. Later, when some of these subject animals were forcibly impregnated they were found to have serious deficits in their parenting abilities. See Lauren Slater Opening Skinner's Box - Great Psychological Experiments of the Twentieth Century (W.W. Norton & Co., 2004).
15. In 1960 the first certification exams and residencies in child psychiatry took place and in 1962 The Journal of the American Academy of

Child Psychiatry was launched: "The stipulation that child psychiatry residencies must be linked to psychiatry residencies and that these must be linked to medical centers was an occurrence of extreme importance. It forced child psychiatry, sometimes kicking and screaming, from community child guidance centers to hospitals and medical schools. In my opinion, this saved child psychiatry from being marginalized. If it had not been pulled into medicine, it would have been replaced by a new iteration born in medicine." John E. Schowalter, "A History of Child and Adolescent Psychiatry in the United States", in Psychiatric Times, September 1, 2003.

16. The rate of stimulant use with children increased 600% from 1987 to 2002, antipsychotic use rose 600% between 1993 and 2002 and, from 1998 to 2002 antidepressant use by children and youth increased by 49%, though an unpublished study presented at the American Psychiatric Association showed the rate to have increased by 260%. S.H. Zuyekas, B. Vitiello, and G. S. Norquist, "Recent Trends in Stimulant Medication Use Among U.S. Children," in American Journal of Psychiatry, 2006; M. Olfson, C. Blanco, L. Liu, C. Moreno and G. Laje, "National Trends in the Outpatient Treatment of Children and Adolescents with Antipsychotic Drugs," in Archives of General Psychiatry, 2006; T. Delate, A. J. Gelenberg, V. A. Simmons and B. R. Motheral, "Trends in the Use of Antidepressants in a National Sample of Commercially Insured Paediatric Patients, 1998-2002," in Psychiatric Services, 2004; and R. McGough, "More Kids Given Antidepressants as Number of Diagnoses Rockets," in Wall Street Journal, May 5, 2004.
17. While it is true that children may be more vulnerable to emotional difficulties when subjected to certain conditions, this is different than asserting that childhood itself is the cause of disorders. In the former, the child's under-developed coping skills may create heightened vulnerability. Consequently, in this model environment is the crucial variable in the development of a disorder. In the latter, pathology arises from the child him/herself and environment is, at the most, a trigger. Additionally, studies in resilience in children indicate that not only is resilience a factor in mitigating environmental stressors, but that children can learn resilience and so avoid such reactions as depression and apathy. Conventional psychiatry focuses on risk management and defect assumptions rather than resilience assumptions and coping skills. J. Gillham, K. Reivich, D. Freres, T. Chaplin, A. Shatté, Samuels, E. Barbra, A. Elkon, S. Litzinger, M. Lascher, R. Gallop and M. Seligman, "School-Based Prevention of Depressive Symptoms: A Randomized Controlled Study of the Effectiveness and Specificity of the Penn Resiliency Program", in Journal of Consulting and Clinical Psychology, 2007.
18. Rachel Masi and Janice Cooper, Children's Mental Health: Facts for Policymakers, National Center for Children in Poverty, Columbia University (http://www.nccp.org/pub_ucr06b.html, accessed May 2007).
19. Following the redefinition of attention deficit disorders there was a marked increase in the numbers of children prone to such diagnoses by teachers. Likewise, the same trend has been identified in psychiatrists and pediatricians regarding Autism. M.L. Woltraich, J.N. Hannah T.Y. Pinnock, A. Baumgaertel and J. Brown, "Comparison of Diagnostic Criteria for Attention-Deficit Hyperactivity Disorder in a County-Wide Sample", in Journal of the American Academy of Child and Adolescent Psychiatry, 1996; and Catherine Skellern, Philip Schluter and Michael McDowell, "From Complexity to Category: Responding to Diagnostic Uncertainties of Autistic Spectrum Disorders", in Journal of Paediatrics and Child Health 2005.
20. Semih Semin, Sahbal Aras and Dilek Guldal, "Direct-to-Consumer Advertising of Pharmaceuticals: Developed Countries Experiences and Turkey", in Health Expectations, 2007; N. Cummings, "Expanding the Economic Base"; Roger McGann, "Pharmaceuticals Target Direct-to-Consumer Marketing in '05", in Click Z Stats - Trends & Statistics: The Web's Richest Source (http://www.clickz.com/showPage.html?page=3451121, accessed May 2007).
21. R. Glick, "Stars in Our Eyes," Psychology Today, August 1987.
22. See note 9.
23. Paquette et al. "Change the Mind and You Change the Brain": Effects of Cognitive Behavioural Therapy on the Neural Correlates of Spider Phobia", in NeuroImage, 2003; and Eve Bender, "Brain Data Reveal Why Psychotherapy Works", in Psychiatric News 2004.
24. Off-label refers to the practice of prescribing medications in ways for which they have not been granted regulatory approval. In this case Divalproex, an anti-convulsant, whose authorized use in children was limited to those 6 and over with a diagnosed seizure disorder,

was given to treat a "children's mental health" condition. Given that this drug is an anti-convulsant and that this drug is being used as a "mood stabilizer" with children, the logical inference is that this drug is both figuratively and literally a chemical restraint or "chemical straight-jacket" for the thousands of children in foster care who receive it on a daily basis. Likewise, Seroquel, which has not been approved for use by children for any condition, was also prescribed off-label. The practice of off-label prescribing is wide-spread. It is seen as a cost-effective means of making drugs available to the public. However, there are important ethical issues raised by this practice. For instance, a regulatory body's approval of Divalproex for epilepsy does not mean that it is equally safe for use with bipolar, as the risk-benefit analysis is substantially different as are often the drugs it is used in conjunction with. Also, the profit incentive that exists for pharmaceutical corporations to have their drugs approved for the condition that is most likely to meet the regulatory criteria, even if this is not what will be the most prevalent use of the drug, is a skirting of the spirit, if not the letter of regulation. Moreover, because a corporation can extend its patent based on new uses of its drug, there is an incentive for corporations to look for new ways in which it may have a clinical effect. The end result is that drugs may be used extensively, even primarily, in ways that have never been scrutinized for patient safety (or efficacy). In general, however, there is an even larger problem with the regulation of psychotropic medications: even when they are scrutinized, it is only for their effect on physical health, not psychological health; so whether a drug diminishes capacity to learn, feel emotions or process information is not considered or made known to practitioners or the public.

Regarding Divalproex, a 2004 study sponsored by the National Institute of Mental Health sought test subjects in order to "assess whether adding a mood stabilizer, divalproex sodium, to stimulant treatment is more effective than stimulant treatment alone in reducing aggressive behavior among children with attention deficit hyperactivity disorder (ADHD)." The rationale was that "ADHD is one of the most common childhood mental disorders ... children with ADHD often develop aggressive behavior, which is not usually adequately suppressed by standard stimulant treatments for ADHD. In order to address this problem, many physicians prescribe multiple medications at once. There is no clinical evidence, however, proving that this method is safe and effective. This study will assess whether adding a mood stabilizer, divalproex sodium, to stimulant treatment is more effective than stimulant treatment alone in reducing aggressive behaviour among children with ADHD." At the time of writing the results of this study and its primary funders were not yet published.

A recent study of 151 Scottish hospital based paediatricians found that "Over 90% of responders were familiar with the concept of, and knowingly prescribed, off label drugs; 55% of responders stated that such prescribing disadvantaged children, and 47% expressed concerns about the efficacy of off label medicines. Although 70% of responders expressed concerns about safety, only 17% had observed an adverse event, and 47% a treatment failure, while 69% did not obtain informed consent or tell parents they were prescribing off label, and 67% did not inform the family's general practitioner. Many respondents did not believe it was necessary to carry out clinical trials in children for new (46%) or generic (64%) medicines. However, 52% of respondents stated that they would be willing to undertake clinical studies and recruit their own patients (61%) or children (73%) to take part in such studies." J.S. McLay, M. Tanaka, S. Ekins-Daukes, and P.J. Helms, "A Prospective Questionnaire Assessment of Attitudes and Experiences of Off Label Prescribing Among Hospital Based Paediatricians", in Archives of Disease in Childhood, 2006.

25. Not only were his medications being prescribed on an off-label basis, he exhibited signs of serious side-effects: thyroid dysfunction, problems in temperature regulation, digestive disturbances, right-sided pain, skeletal pain and changes in consciousness.
26. Carole Keeton Strayhorn, Foster Children: Texas Health Care Claims Study - Special Report, Texas Comptroller 2006.
27. Physicians are not only serve a gate-keeper function in accessing a drug, through the prescription process, but they also operate as outreach personnel through such activities as screening for mental health problems - or more recently, "risk" of mental health problems.
28. D.N. Hartnett, J.M. Nelson and A.N. Rinn, "Gifted or ADHD? The Possibilities of Misdiagnosis", in Roeper Review, 2004; D.N. Hartnett, J.M. Nelson and A.N. Rinn, "The Possibility of Misdiagnosis of Giftedness and ADHD Still Exists: A Response to Mika" in Roeper Review, 2006;

and M.L. Woltraich, J.N. Hannah T.Y. Pinnock, A. Baumgaertel and J. Brown, "Comparison of Diagnostic Criteria for Attention-Deficit Hyperactivity Disorder in a County-Wide Sample", in Journal of the American Academy of Child and Adolescent Psychiatry, 1996.
29. It is often an explicit requirement that these care-givers ensure that the child maintains their regimen of psychotropic medications, and to do otherwise could constitute professional failure leading to discipline and possible dismissal.
30. However, failure to comply with a psychiatric medication regimen can be seen as child abuse and/or neglect constituting sufficient reason for a child to be apprehended and parental rights terminated.