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Attention Deficit Disorders

9.3 p.m.

Lord Hodgson of Astley Abbotts rose to ask Her Majesty's Government what plans exist to reduce the impact of attention deficit disorder, attention deficit and hyperactivity disorder, and hypoglycaemia on social behaviour and academic performance.

The noble Lord said: My Lords, I am very pleased to have the chance this evening to draw the Government's attention to the problems faced by children and adults who suffer from attention deficit disorder and attention deficit and hyperactivity disorder, known as ADD and ADHD, and to ask the Government about their plans for tackling these problems.

ADD or ADHD are behavioural disorders characterised by persistent patterns of inattention, hyperactivity, impulsiveness and emotional instability. While the simple words "attention deficit" and "hyperactivity" explain the basic behaviour pattern they do not—indeed cannot—describe how a child with severe ADD/ADHD behaves.

One head teacher asked to describe an ADD child said:

"Short concentration span—and I mean short—seconds rather than minutes; an apparent inability to consider anyone besides himself; a determination to do exactly as he wants and a facility for creating continuous mayhem to draw attention to himself; an idea of what is funny that the other children outgrew in Reception class; there is no point in sanctions, punishment, exclusion because he seems unable to learn any lessons".

I became interested in the subject because I have a son—and boys are 10 times more likely to suffer from ADD/ADHT than girls—who was diagnosed as suffering from a mild form of ADHT. In consequence, he found it difficult to progress academically and to form friendships with his peers. His siblings—and, I fear to say, his parents—found his behaviour

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unpredictable and uncomfortable. When we were told the diagnosis, we were given a piece of paper that described in the gloomiest of terms the prospects for ADD/ADHD children: more likely to leave school without qualifications; to become addicted to drugs; to be unemployed; to commit crime; and so on.

The solution normally proffered by the medical profession is that children should be given the drug Ritalin. Ritalin is a strong stimulant that helps to iron out the child's mood swings and helps him to concentrate. But, as your Lordships can imagine, parents think long and hard before putting their child

on to a permanent daily dose of a stimulant similar to amphetamines. It would be helpful if the Minister could tell us whether there has been any study of the results of prolonged use of that drug.

Families with ADD/ADHD children need help. To get help, they need joined-up government across the Department of Health, the Department for Education and Skills and local social services. The key is early diagnosis, so that families, schools and, where appropriate, social services are aware of the condition. Taking medication can then become the norm. By contrast, children who are diagnosed later have probably already experienced several years of underachievement and failure and are more likely to be oppositional and unprepared to co-operate with medication, thus in many cases condemning themselves and their families to a living hell.

Although medication undoubtedly has an important part to play, it is not the only help for which parents may reach. Indeed, for some children it does not work at all; for others it may lose its effectiveness in their teenage years. Alternative approaches can be tried: for example, homeopathy, specialist exclusion diets, cranial osteopathy, megavitamin therapy, together with behaviour modification therapy, psychotherapy and others. We need to know more about their relative success and to inform parents, teachers and social workers about them.

Every effort needs to be made to destigmatise the condition. Sufferers from ADD/ADHD are not unemployable. Indeed, with the right help and support they are capable of, for example, the sustained, focused effort that characterises many successful entrepreneurs and businessmen.

We need to spread more awareness of the condition among the teaching profession. It is estimated that 90 per cent of teachers have had no special training on how to recognise the symptoms of ADD/ADHD.

Most importantly, we need immediately to begin a programme to build awareness among social workers. For the most part, they do not seem to appreciate the strain on a family living with a severely ADD/ADHD child. There is therefore little or no respite care. Rather, too many social workers have been inclined to see erratic behaviour by a child as evidence of child abuse. No one suggests that there is any malice in that; I am sure that everyone's intentions are good; but there is profound ignorance that we must tackle.

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Some people have suggested that ADD/ADHD results from an inability of sugars to be broken down in certain parts of the brain. The behaviour patterns of an ADD/ADHD child certainly in some cases replicate in an extreme way the condition of a person suffering from hypoglycaemia. He becomes increasingly unreasonable as his sugar levels drop. Other ADD/ADHD children react violently to drinks and food, such as Coca Cola and chocolate, containing high levels of sugar, which make them uncontrollably hyperactive.

A study should therefore be made of ADD/ADHD in connection with hypoglycaemia and sugar levels in the body.

It must be admitted that a cost is involved in taking all the actions that I have mentioned, but a cost is also involved in not taking them—in family breakdown, truancy and erratic behaviour in school, unemployment and, I fear, in some cases, calls on the probation and prison services. In short, if we fail to act, we are condemning a large number of people to a life of chronic underachievement and unhappiness.

Anecdotal evidence suggests that the problem is increasing. I say anecdotal because it is not a notifiable condition; indeed, in many cases, it may never be diagnosed. Further, some of the increase may be precisely because people are more aware that the condition exists, but there has undoubtedly been a dramatic rise in the parallel neurological condition of autism. We know that from Scotland, where census data have enabled an accurate assessment to be made.

So why has there been that increase in those conditions and what can we do to reverse the trend?

It is unlikely that there is any one single cause. Genetics and heredity will probably be found to play a significant part. But what other factors are in play? One matter looks increasingly likely to be a significant contributory cause: the requirement in this country that every baby receives three injections in the first 16 weeks of life as immunisation against diphtheria, tetanus and whole cell pertussis—whooping cough, to laymen—(DTwP). As I understand it, each standard dose of the vaccine used in the UK contains 50 micrograms of a substance called thimerosal. Each dose of thimerosal contains 25 micrograms of ethylmercury. Mercury is a highly toxic substance. That means that, by the 16th week of life, every baby in this country, with an inevitably fragile immune and nervous system, has been injected with 75 micrograms of ethylmercury.

In reply to a Written Question that I submitted on the safety of the practice, the noble Lord, Lord Hunt of King's Heath, replied:

"In 2001, the Committee on Safety of Medicines (CSM) reviewed the available data . . . and advised that there is no evidence of harm caused by doses of thimerosal in vaccines . . . The Institute of Medicine (IOM) in the United States also published a detailed review of the evidence . . . in October 2001. The IOM findings were consistent with CSM conclusions".

That reply was, in the famous phrase, "economical with the actualité". The Institute of Medicine report actually states:

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"The Committee concludes that the evidence is inadequate to accept or reject a causal relationship between exposure to thimerosal from vaccines and the neurodevelopmental disorders of autism, ADHD, and speech or language delay",

but,

"the hypothesis is biologically plausible".

The Written Answer from the noble Lord, Lord Hunt, continued:

"In addition to the above studies, evidence from a recent study by M. Pichichero et al (published in the November 30 2002 Lancet) showed that giving vaccines containing thimerosal does not raise blood levels of mercury. The findings of this paper suggested that ethylmercury is rapidly eliminated from the blood after administration intra-muscularly".—[Official Report, 16/12/02; WA74.]

Again, I am afraid that the Written Answer was less than full-hearted. The department ought to be aware that Dr Pichichero, who, in any case, is an immunologist not a toxicologist, sampled the blood of only 33 children—too small a sample to catch a statistically significant number of children who would be allergic or hypersensitive. Furthermore, the issue is not whether undischarged mercury would be present in the blood but whether it would be retained in the brain. Dr Pichichero failed to check that. He also failed to carry out faecal tests, which is how most mercury would be discharged.

I know that the Government will probably tell us that the mercury in the thimerosal given to infants in this country does not exceed the "safety limits". However, what major studies have been carried out to demonstrate the proper safety limits for exposure to ethylmercury by small infants? What about the reactions in premature babies, whose developmental age is less than that of babies born at full term? What about the reactions of a baby who has suffered trauma at birth? What about those who have an allergic or hypersensitive reaction to mercury? The figure that has been suggested to me is 18 per cent of the whole.

In answer to another Written Question, I asked the noble Lord, Lord Hunt, what research had taken place into allergic reactions to thimerosal/mercury-based vaccines, especially among infants. The Minister's reply related to skin rashes and local swelling at the site of the injection. But what about the unseen reactions? Can the Minister and her department be certain that there is no possibility of neural damage in the brain or to the immune system? For example, studies were carried out on 900 children born in 1987 in the Faroe Islands whose mothers had eaten mercury-contaminated whale meat. They showed that subtle cognitive deficits, detectable by sophisticated neuropsychometric testing, were associated with methylmercury levels previously thought safe.

All of that can be debated, and no doubt the Minister's officials have prepared a polished brief containing an elegant rebuttal. However, it is incontrovertible that in July 1999 thimerosal was removed from all childhood vaccinations in the United States and Australia. Clearly, the authorities there felt uneasy.

I must make it clear that this is not an attack on immunisation. Immunisation is an important part of child healthcare. But it is a question of what goes into

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the vaccines. Thimerosal is not an essential part of a vaccine; its function is as a preservative. There is a mercury-free vaccine licensed in this country under the name Infanrix DTaP. Although it is more expensive, that would be a small price to pay compared to the cost of a child with neurological damage.

Above all, parents have a right to be informed about the choice to be made. At present, parents who know that the more expensive DTaP vaccine exists can demand it from their local GP and be given it. However, it is a hidden choice. Most people know nothing about it and will not be told about it. Inadvertently, they will continue to permit their children to be injected with mercury-based vaccines. Parents are entitled to know the full facts and to be able to prevent their child taking unnecessary risks.

For the future, the only satisfactory answer is for the potential risk to be eliminated. I hope that, in her reply, the Minister will be bold enough to say that the UK will follow a long list of developed countries and remove thimerosal from vaccines forthwith. We owe it to the unhappy individuals who are, or families who have, an ADD, ADHD or autistic child to ensure that in the future children do not have to run this risk.

9.16 p.m.

Lord Astor of Hever: My Lords, I congratulate my noble friend Lord Hodgson of Astley Abbots on introducing this important debate and setting out so clearly the problems faced by ADHD children, their parents and their siblings. My noble friend raised the important issue of mercury-based vaccines, and I look forward to the Minister's response. I declare an interest as the stepfather of a daughter with ADHD, and my wife is patron of ADDISS, the Attention Deficit Disorder Information and Support Service.

Unless one has lived with ADHD and inattentive, overactive and impulsive children, one has no idea of the tornado effect that it has on the entire family. Many families, particularly those with undiagnosed ADHD children, cannot grasp why they suffer. Often, such families are torn apart. That is made worse by the fact that ADHD is a hidden disability. People often judge first what they see as odd or naughty behaviour.

My noble friend rightly said that early diagnosis was the key, but recent surveys suggest that less than a quarter of children with hyperactivity are recognised as such. Barriers exist in recognition in primary care and in the

provision of child and adolescent mental health services. Doctors, psychiatrists, mental health workers, social workers and teachers could prevent many problems from worsening but do not, mainly because they are not properly trained to understand ADHD or the early intervention strategies that could be put into place. In its guidance on ADHD, the National Institute for Clinical Excellence commented:

"Access to child and adolescent mental health services is variable, with long waiting times in some areas".

There are no departmentally endorsed models for diagnosing and treating ADHD. Why not?

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When there is a lack of recognition and diagnosis, we end up with adults with non-productive lives. They suffer from low self-esteem, feel misunderstood or unlovable, think that they are stupid, lack confidence and have a propensity towards needing mental health services. There may also be substance abuse, career failure, costly mental health problems, crime and anti-social behaviour. Our prisons are full of ADHDers—up to 50 per cent, in some cases—at a huge cost to public funds. Many have no education and can never succeed or be re-educated, even in prison, because they still cannot read or write. When they are released, many relapse into crime because they have no skills or training other than a life of crime, drugs and depression.

We must improve our ability to recognise ADHD. We must also have better acknowledgement by doctors and mental health professionals of the growing concerns and problems related to ADHD. Health service provision is provided differently throughout Scotland, Ireland, England and Wales. Providers have in place their own guidelines. Within some authorities, referrals from a family GP to CAMHS will not be considered. How will the children's national service framework take into consideration ADHD and child mental health? Will it contain some guidance of a general nature on referral and assessment?

Many adolescents with ADHD, who receive special educational needs, are being permanently excluded from schools. Inclusion as a concept was a sound idea. However, it is impossible to implement the system without education and training for teachers and staff who have to cope on a realistic basis, day after day, with disruptive pupils. We need to design better institutes of education that offer education to anyone who has a different learning or behavioural style. We need to train our teachers in different teaching styles for people who learn differently. We have a tidal wave of behavioural problems in our classrooms. Disruptive behaviour wears down teachers and interferes with the education of non-ADHD pupils. And still we do not take on board the idea of learning difficulties, which seem to be multiplying.

Those who receive little or no education, due to exclusion, are being lost in the system, especially when involved with the criminal justice system. There, diagnosis of ADHD is not taken into consideration by youth offending teams and within young offenders' institutes. ADHD is not recognised as a disability by youth offending teams. When young people leave such an institute, they are in a very grey area. The transition from child mental health services into adult services is virtually non-existent for those not involved with the criminal justice system. For those who are involved, there is no transition into adult mental health services.

Adolescents with ADHD, who may be sentenced, do not receive the appropriate treatment or education they require. On release from a penal establishment, the special educational provision that they require is not being provided. Also required is some form of provision of health and education for these young persons on release from such establishments.

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There needs to be a departmentally endorsed model in place for those young persons with mental health needs such as ADHD who, for whatever reason, have been sentenced. More training and closer inter-agency working and understanding between youth justice, local education authorities and health services is clearly needed, especially in the light of the health service's increasing involvement in the provision of prison health care services.

I turn finally to the treatment of ADHD. Are the Government satisfied with the implementation of NICE's recommendations on the treatment of ADHD? What do they intend to do to ensure that they are followed?

A new drug may be available as an alternative to Ritalin. Strattera, a non-stimulant, was approved for use in the United States last month. Results found it was as effective as Ritalin, but had fewer side effects. Can the Minister tell the House when Strattera might be available in this country?

9.25 p.m.

Lord Colwyn: My Lords, on behalf of the noble Earl, Lord Baldwin, I apologise for him not being here. I know that he was keen to take part in the debate. I met him briefly yesterday. He is en route to somewhere on the River Nile and regrets not being able to offer his experience to the House. He has spoken on this subject on many occasions and he is sorry to miss the debate.

Hyperactivity, attention deficit, hyperkinesis, minimal brain damage, minimal cerebral dysfunction, Attention Deficit—Hyperactivity Syndrome are all descriptions of one of the biggest growth areas in medicine, particularly in the United States, of the problem child—the child who cannot concentrate, cannot sit still, has difficulty eating and sleeping, cannot adapt to new situations, overacts to new stimuli and, through his unpredictable behaviour, makes life a hell on earth for family, teachers and everyone around him.

As my noble friend Lord Astor said, ADHD is not a true disease but a collection of symptoms and behaviours that are scored, and if a threshold score is reached or surpassed a diagnosis is applied. The popularity and increase in these diagnoses is concomitant to the approval by NICE of methylphenidate hydrochloride as the treatment of choice. These central nervous system stimulants, which are chemically close to cocaine and amphetamine, are potentially addictive and have the paradoxical effect of changing users into a calmed, soporific state.

A study in the New England Journal of Medicine of 8th April 1993 concluded that hyperactive children have something in their make-up—their genes—that causes them to have a generalised resistance to thyroid hormone. As early as 1973, the late American paediatrician and allergist, Ben Feingold, introduced the theory that foods containing salicylates, aspirin like substances such as artificial colours and flavours,

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were mainly responsible for hyperactivity. He found that reducing a child's intake of sugar or artificial additives or locating possible allergies could help.

Although study after study backs Feingold's theories, many standard clinicians still label his approach a fad and are happier to reach for their prescription pad and sentence a small child to many years of stupefying, potentially addictive medication. The makers of Ritalin advise that the drug should be the last resort, but it now tends to be the treatment of choice. In my brief research for this debate, I have become aware of agencies and schools which will withdraw support for these children if drugs are not given. I believe that I am right in saying that, contrary to the principles of evidence-based medicine, the drug has never been tested on children. It should not be used on children under the age of six, but frequently is and is rarely monitored.

I shall be interested to hear whether the Minister has any information about the extent of the use of this drug in the UK. A study undertaken by researchers at Express Scripts Incorporated, a Missouri based pharmacy benefits management company, appearing in this month's issue of Pediatrics, reviewed prescription claims for 178,000 children throughout 1999 and found that about 4 per cent of prescriptions examined for children aged between five and 14 were for stimulants, including Ritalin. The lead researcher, Emily Cox, and her colleagues said that while they did not determine if higher prescription rates represented overuse or if lower rates represented underuse, "both may be occurring".

These variations should be examined,

"to reduce the risk to children from unnecessary drug therapy, as well as the negative health and emotional consequences to children with untreated medical conditions".

It is very important that food sensitivities and the effect of food additives are ruled out before drugs are even considered. A study in the Lancet in 1985 showed that 62 out of 76 overactive children—that is 82 per cent—treated with an elimination diet improved, and the behaviour of 21 became entirely normal. The most common offenders were invariably artificial colours and preservatives. These results have been replicated frequently.

Other foods can also provoke hyperactive symptoms—as can nutritional deficiencies. Dr Melvyn Werbach from the Los Angeles School of Medicine has studied the effect of nutrition on a variety of so-called mental illnesses, including childhood hyperactivity. One such trial suggested that the symptoms of some hyperactive children are due to a deficiency of brain serotonin. Giving such children Vitamin B6, which is required for the conversion of tryptophan to serotonin, has been shown to increase whole blood serotonin. Vitamin B6 can achieve better results than Ritolin without any of the serious side-effects, yet the Government recently tried to ban the nutrient or restrict its dosage to ineffective levels. The EU is now committed to severely restricting natural nutritional supplements, giving more power and control to the pharmaceutical industry to extend synthetic and artificial chemicalisation rather than

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natural, unadulterated nutrients in foods. I know that the noble Lord, Lord Hunt, is sympathetic to concerns on this issue.

Hypoglycaemia is often associated with hyperactivity and ADHD. It is a principal element in pre-menstrual tension and may be a contributing factor in the increasing proportion of offending females. I have been in contact with Peter Bennett, whose work primarily focuses on offenders. He has recently routinely found that children and adults with behavioural problems have hypoglycaemic symptoms arising from mineral deficiencies. These are aggravated by inappropriate diet, eating disorders and substance abuse. For some people, even good foods can be harmful. Intolerance to a number of foods and chemicals is always found in those diagnosed as having ADHD or who are excluded from school and have special educational needs.

I should be interested to hear the Minister explain why there is rejection of most of these findings. The relationship between behaviour, whether at home or in an institution, and nutrition regularly appears in the media. There was an item about this on the "Today" programme on Monday; and my noble friend Lord Baldwin has frequently mentioned it in this House. Yet the obvious is ignored.

The solution to a child's problem or to an offender's behaviour may only be a matter of some careful detective work to locate the culprit.

Peter Bennett, who has wide experience of working with children and offenders both as a senior police officer and as a nutritionist, has repeatedly communicated with statutory agencies over the past 15 years, and has appeared in courts and at educational tribunals. He has invited agencies to

participate in privately funded projects and, even after so-called commitment to partnership working by the agencies, has been routinely ignored and rejected without reason.

The Home Office seems to take this matter seriously. Ten years ago, under the guidance of my noble friend Lord Ferrers, it provided £5,000 for research into the extent of hyperactivity in persistent young offenders. I believe that it is now supporting plans to raise over £2 million for further research into the links between nutrition and behaviour. I should be grateful if the Minister would undertake to follow this latest trial—for 10 years ago the trial, which involved 100 young offenders compared with 100 matched non-offenders, showed that 75 per cent of the young offender population had hyperactivity and associated conditions including intolerance or allergies, mineral deficiencies and excess toxic heavy metals. The findings were published, but were seemingly totally ignored by the Home Office.

The modern medical approach to hyperactivity must realise that it does not stem from a single cause. Dr Sidney Baker, director of the Gesell Institute of Human Development in New Haven, Connecticut, emphasises that short attention spans and impulsive, restless behaviour are indicative of "individual chemical imbalance"—anything from nutritional

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shortages to constant exposure to allergens or food additives, a situation often exacerbated by the typical American or British child's constant consumption of,

"altered, sweetened, fatty and refined foods".

I thank my noble friend Lord Hodgson for introducing this debate. I should apologise to him for not going down the thiomersal route, as a dentist trying hard not to use amalgam fillings but realising that there are some situations where they do have to be used.

I conclude with a brief mention of nutrition and the prison population. Historically there has been a recognised association between deleterious nutritional health of offenders and their offending behaviour. The Minister will be aware of the Aylesbury study, in which a group of 231 prisoners given nutritional supplements committed an average of 26.3 per cent fewer disciplinary offences compared with a placebo-based group.

There is no claim by researchers that malnutrition causes crime. What is being established beyond reasonable doubt is that prisoners have significant nutritional health problems compared with law abiders. Treatment with appropriate nutrients has a beneficial effect on the behavioural health of offenders. There is no harm from such treatment and little cost or resource

implication. Indeed, there is potential for considerable savings in criminal justice and the cost of crime.

9.35 p.m.

Lord Lucas: My Lords, I am very grateful to my noble friend for giving us the opportunity to have this debate. There is no way that my speech will compare with the three previous ones. I have never sat in this House and listened to three opening speeches of such quality. I am totally in awe of them. Doubtless the Minister will surpass them, but I will have to wait for that.

I see something of ADHD in my business of running the Good Schools Guide. It is an extremely difficult condition for a school to deal with. Teachers are just not trained to deal with the level of disruptiveness from someone who has ADHD to any level. It is a quite exceptional school that has the support and understanding that enables it to welcome children with that condition. I can count 5 per cent of the schools that I know, which I would otherwise regard as good, which feel confident in dealing with ADHD.

I have known it in the children of my friends, and it is an extraordinary thing to live with a child who has it, even for a weekend—a human whirlwind who will not be controlled and cannot be directed is, at the same time, an absolutely wonderful and delightful child.

This is a condition that we have to get a grip of. It is difficult, because dealing with it stretches across so many departments of state. At a very early stage of their existence, the Government set out their principles of an evidence-based approach, as in NICE, which is a great progression in terms of its principle, and joined-up government. These are the two things that we need to consider in dealing with ADHD. When you

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look at government as a totality and human beings as a totality, this is an expensive and difficult condition that requires a co-ordinated, long-term and thought-through response.

I think it was my noble friend Lord Astor who mentioned that there is a considerable problem with ADHD being misdiagnosed as child abuse. This is just a matter of training. The people who are making the diagnosis have to understand what ADHD is, but many of them refuse to recognise it as a diagnosis. If you have a kid with this condition and the reputation of the local social services is that it gets picked up as child abuse, you steer a million miles away from anything approaching the sources of help to which you should have access. Once you are in the maw of social services and they think it is child abuse, it is a horrific experience.

I can remember taking my daughter to hospital because she had stuffed a bean up her nose playing with a broken necklace. There was a quarter of an hour of quizzing as to whether she had stuffed the bean up her nose or I had.

It is a frightening experience even at that level. If you have a child who is as clearly behaviourally difficult as an ADHD child, you want to know that if you take them to social services, the first question will be, "Has this child got ADHD?", rather than, "Is this child being abused?". We need that level of understanding in social services if parents are to get access to the help they need early enough.

Schools need to have access to the expertise on how to deal with these children in school, keeping them in school and controlling them. A lot of that is to do with having a resource in school—certainly in a larger school—such as somebody who knows the answer and can sit in class and help the teacher. You cannot teach these things in teacher training college—teachers pick them up with experience. If there is someone in the school who can come and sit with you and show you how little Jimmy can be made into a constructive member of the class, it is much easier for the teacher to deal with a child who otherwise will wind him up extremely fast and will be straight out in the corridor, off to the headmaster and, ideally, out of the school if the master has anything to do with it. That needs to be tackled at a basic level of a school's understanding. That means making sure that the training and understanding are there.

My noble friends have said that we need to look at the causes. They are multiple, but there are certainly common exacerbating factors. I have come across two or three such children in my life and it is clear that diet affected all of them in terms of the intensity of their systems. Different aspects of their diet were involved, but it was important that they kept to a certain pattern and when they did so they were much less uncontrolled than they were when they stepped over the boundary. Sugar is the one that I remember having a particular effect on a child. Just a spoonful of sugar makes the medicine go down, but my goodness it made the child go up like a balloon and it would take half an hour to come down off the high. In a school, with a drinks vending machine and with the sweets being about the

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only edible thing in the tuck shop, it is very difficult to keep children who have even an element of that in their make-up under control.

As my noble friend Lord Colwyn and others have said, many of these kids end up in prison. There is very little understanding in the Prison Service of dyslexia, let alone ADHD. If you can start to tackle these things and get at them, you have an extremely receptive population, because by then they are grown up. They no longer have the uncertainties of being teenagers and having to go through all the changes of life. Underneath it, an awful lot of young offenders really want to become ordinary people. You can provide an enormous amount of motivation if you can show them the way, but you cannot begin to show a kid with dyslexia or ADHD the way unless you have first diagnosed and understood their condition and are tackling and getting at them in a way that they can appreciate and return. There is so much to be done on training and understanding. I hope the Government will set about that.

There is research to be done. As my noble friend Lord Colwyn said, it is expensive. A decent research study is bound to cost £2 million because you are following kids for a longish time. You need a large enough population. A couple of million pounds is about what it takes for a decent study.

There are people out there who have done little studies showing the way. There are people on the Internet making a great deal of money out of parents by selling cures. However, there does not seem to be any support from the Government in just monitoring the people who are doing the work. If the work is being done, you might as well monitor it and start to see whether there are ways of catching these kids early and curing them.

Suppression of the symptoms with a powerful drug cannot be the right answer. It is a wrong turning for medicine to think that you cure something by suppressing those sort of symptoms when you should first be looking to see if you can find a cure. There will be lots of people experimenting, because parents are desperate for it. They do not like the idea of sticking powerful drugs into their children all the time. All the Government need to do is watch what is going on and spend some money monitoring it to see which ones, on analysis, really turn out to be effective.

Curing 25 per cent of the kids is probably the best we are going to do because there is such a wide spectrum of causes. If we can find ways to do that in a pattern of children, we will make a lot of difference and will leave only the really difficult cases on the drugs that are necessary to suppress their symptoms.

I hope we get a positive response from the Minister. Taking a 10 or 20-year view, we can do a lot to make sure that this is much less of a problem for our children, for our schools and for our prisons.

9.44 p.m.

Lord Addington: My Lords, I thank the noble Lord, Lord Hodgson, for initiating this debate. I also congratulate him on providing an occasion when the

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shade of blue on offer has been a very caring and thoughtful one. I should also point out, as my noble friend Lord Roper remarked to me, that we Peers who have lately taken a bit of a battering—those of us here by accident of birth—are in the majority for this debate.

We increasingly talk about a hidden disability or a disability spectrum in which certain similarities are shared. I am glad that the noble Lord, Lord Astor, is in the Chamber. When we last discussed autism, in admiration I teased him for championing the case for placing autism in the fabric of consciousness. Autism has indeed become the sexy and fashionable disability and people are opening their minds to it. However, I doubt whether the spectrum will ever

extend to all such disorders. Someone with mild Asperger's, for example, might simply have a tendency to train spot. People such as the "Rain Man" may have a genius for mathematics or for drawing beautiful buildings. Such people may be regarded as cuddly and friendly. Others may think they are brilliant. Some used to say that all dyslexics were brilliant and geniuses. We have proved them wrong about that.

As the noble Lord, Lord Lucas, rightly said, only a very small number of schools can deal with pupils with attention deficit disorder and still give the other children in the class anything like the education they deserve. When dealing with students with special needs, schools must never forget that those without a disability have rights as well. It is a very difficult teaching and education issue.

As has been rightly said, it is often the prison system that finally deals with many of these problems. I have done a considerable amount of work with the Prison Service in relation to dyslexia and its diagnosis. I suspect that dyslexics stand a better chance of survival in prison than those with attention deficit and hyperactivity disorders because they are less likely to antagonise others. People with these disorders behave as they believe is normal, but such behaviour can antagonise everyone around them.

Children with these disorders may not have caring and supportive parents. As I have said at least a half dozen times in this Chamber, the disabled must choose their parents carefully. Disabled children with parents who are sufficiently informed and have sufficient time and money to support their child will stand an infinitely better chance of getting through life in reasonable shape than those without such a background. It has always been thus. The point is particularly true of children with hidden disabilities. It has to be made clear that these children are not simply being antagonistic. They have a problem that is not self-induced.

I suspect that to identify these children only once they reach the classroom will be too late, and organised, structured teaching and the pressure on them at that point will be far too great. We will have to rely primarily on social workers and the medical professions to identify these children unless it is done in reception classes. Special educational needs co-ordinators could be trained to do identification work.

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However, the identification problem is always worse on the margins. It is just the reverse of battlefield medical techniques, by which the most extreme and difficult cases are dealt with first. We need work on the identification criteria.

This debate has concentrated on the chemical stimulants, whether naturally provided or artificially given, to treat this problem. I cannot help feeling that everyone holds the right opinion on this matter to some extent. However, I sound a note of caution. If Ritalin is the only show in town, let us not refuse it totally. If Ritalin makes someone's life bearable, that person should not refuse

it. However, if a better drug becomes available, I say, "Get it quick". The long-term benefits of prescribing a more effective drug to which more people respond and which has fewer side effects will be massive. If a type of behaviour has been identified that can be treated with drugs, those drugs should be prescribed. Let us not worry whether the treatment comprises vitamin supplements or adapting someone's diet. We only get one shot at the matter.

Prisoners who suffer from the disorders we are discussing have been referred to. Some prisoners become calmer as a result of their problem being identified and treated. However, in my experience prisoners are at least 21 years of age before they calm down and become more accepting of the situation. Young offender institutions comprise the most fear-driven environment that anyone can imagine. When I worked in that field for a brief period, one or two old lags told me that they would rather serve three years in a prison than two years in a young offender institution. Young offender institutions are much more violent and unpleasant than prisons. Some adult prisoners will have had enough of being threatened, stabbed or attacked while they are asleep. I refer to the charming things that occur in prison. They may calm down as adult prisoners and be prepared to accept treatment. However, that is a case of the last chance saloon or of damage limitation. We must try to address the problem at an earlier stage.

Diet affects all of us. Some people discover that they have mild or serious allergies. I believe that there is an interrelation between diet and the disorders we are discussing. But to what extent does diet affect these disorders? I have learnt far more from listening to the debate than from reading the copious briefing notes that I received. I believe that there is a wide range of methods for dealing with these disorders. Some of the disorders may be related to non-tolerance of sugar, wheat or dairy products. Processed white flour does not affect that many people but strong rye bread does.

We must study the effect of chemical stimulants and ensure that people are aware of those studies. Everyone tends to turn to the product with which they are familiar. At present we are rather better informed with regard to psychological problems than we are with regard to physical problems in this field. I am sure that everyone with a disorder will have heard someone else say, "It is due to your background". I was told that I had developed dyslexia because for several years I was a member of a single parent family. I was told that

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in the early 1970s. Everyone tends to "go back to nurse" with this problem. Psychological programming is far more ingrained than we care to admit.

The Government should devote a considerable amount of money to research in this field to get the right answers. However, we should not decree that because there may be a problem with one of the current solutions we should not use that solution. There is no point in starving today in the hope that one

might get a meal tomorrow. We must address the problem now but we must also undertake long-term research. If we do so, we may not pick up such a large bill in the future in terms of the consequences of these disorders.

9.54 p.m.

Earl Howe: My Lords, as the quality of tonight's speeches has shown, my noble friend Lord Hodgson has done us a huge service in raising this seldom debated topic, for which I thank him. In a number of ways, tonight's debate has followed on rather neatly from the excellent one held in this Chamber last week and led by the noble Baroness, Lady Warnock, on the subject of special education. I commend her speech in particular to all noble Lords, because the worries that she voiced have a direct bearing on many of the concerns raised this evening.

If my noble friend has done nothing else today, he has certainly struck a blow for joined-up services. He is right in that the issue of ADD and the children affected by it straddles a host of policy areas, such as health, education and social services, to name the most obvious. He has of course done a great deal more. I do not propose to repeat his extremely interesting line of questioning about the aetiology of ADD and related conditions; I will simply say that from where I sit his ideas and hypotheses merit the most serious study. I hope that the Minister will take it on herself to pursue them through her department.

This week, I read a most persuasive paper recently published in the United States, which concludes that the likelihood of a causal relationship between mercury in vaccines and autism is very great. If that theory is borne out, it has the most profound implications. I wholly agree with my noble friend that a great deal more research is needed. It is interesting to see that, in the United States, the Centers for Disease Control and Prevention have recently commissioned a major epidemiological study into ADD and ADHD, to be carried out by three universities. The aim of the studies is to improve our understanding of ADD in children, why and where it occurs and on what scale, and how best to treat it. All being well, the research should advance public health policy-making considerably. If the Minister would like details of that programme, I should be happy to supply it to her afterwards.

My main concern in the time available to me is to pick up some of the political themes that have emerged this evening. In contrast to my noble friend Lord Astor, I am very fortunate in having four normal, healthy children, none of whom have any sort of

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learning difficulty. To prepare for the debate, I therefore had to do quite a bit of reading up about ADD and what it means. All speakers have emphasised what a devastating condition it is, but let us be clear: we are dealing with a condition, or rather a range of conditions, that can literally lay waste to young lives. Families are pulled apart. Unspeakable disruption is caused in school

classrooms. In the worst cases, of which there are many, ADD and ADHD can lead to crime and mental illness in adult life. They are not conditions to be belittled or in any manner of speaking brushed aside.

Why is it that against that sort of background we in this country seem incapable of giving ADD and ADHD the attention and input that they deserve? Parents or healthcare professionals involved as advocates for the children will tell us that in many areas of the country it is like banging one's head against a brick wall to try to get schools and LEAs to acknowledge that a child who is aloof, unfocused, fidgety and who sometimes causes untold disruption in schools has something wrong with them. To suggest that that "something" not only needs treating, but requires special educational provision to be made is often the subject of huge confrontational argument, sometimes lasting years. Time was when local authorities regarded themselves as being in partnership with the ordinary citizen and the families that they there were to serve. How often does one see that concept articulated nowadays?

As the noble Baroness, Lady Warnock, observed last week, confrontational litigation and appeals tribunals are proliferating in the field of education. As she pointed out, the reason is that the issue rests more on affordability than on need. Appeals by parents of children with special educational needs are now increasing faster than at any time since 1997, a process that ironically is itself a huge consumer of resources. Those resources, it hardly needs me to say, would be much more profitably directed at the care and treatment of children. Sadly, I believe that there is strong resistance in the UK to acknowledging fully those disorders and the impairments that they bring.

That is not true of many professionals, who are leading the way in our understanding of ADD. It is now recognised that what many people previously thought were separate disorders actually interweave in various ways. In Sweden, researchers found that 87 per cent of children with ADHD had at least one other co-existing condition. It would be illuminating to conduct similar research here because the findings from Sweden have profound implications. If a child presents but does not conform totally to the criteria for a particular disorder because he or she displays miscellaneous other behavioural symptoms, one frequently gets confusion and an opportunity for LEAs to use that confusion to say that the child is not suffering from ADHD. In those situations, there is outright resistance to any special provision for the child and there is frequently the suggestion that the behaviour that the child displays is the fault of the parent. I shall return to that rather sinister theme in a moment.

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The notion that a child may have several disorders running alongside one another has been powerfully explained by a British child psychologist, Lisa Blakemore-Brown. She used the metaphor of a tapestry to illustrate that a child may present with various threads of difficulty; for example, ADD combined with Aspergers, or ADHD with a language impairment. Those threads may appear to be the same as those in another child but each

individual will have his own unique weave of problems. The key to helping a child is discovering what threads are there and how they are interwoven. I believe that Lisa Blakemore-Brown's book, *Re-weaving the autistic tapestry*, should be required reading in every LEA—and in the Department of Health. It is very persuasive.

That means that labels such as ADD or ADHD are often unhelpful. Children who straddle diagnostic categories have no single, readily identifiable label, which all too often means that they get no recognition and no help. Those are the children who become exceptionally vulnerable in our system. The kind of disorders that can present alongside ADHD include subtle language and social impairments, motor impairments, obsessive disorders, tics and dyslexia. The more tangled the tapestry, the less likely it is that its constituent parts will be recognised and the more likely it will be that a child will grow older with no support whatever.

Children with unmet needs either have to be coped with in school, as my noble friend Lord Astor said, or they are excluded when their behaviour becomes intolerable. If they stay in school, they are merely controlled and contained during the day. That is like keeping the lid on a pressure cooker. The pressure cooker explodes once the child is in the safe confines of home.

At every step of the way, an LEA can make life a nightmare for families. Parents battle sometimes for years to get recognition and often have to spend large sums of their own money trying to find out what is wrong with the child before being forced by the LEA to go to a tribunal. They spend more money on expensive legal advice. Even if the parents win a tribunal hearing, they may well find the LEA telling them that they need not think that they have won just because the decision has gone their way because it will be taking the whole matter to appeal in the High Court. That sort of bullying by LEAs is commonplace. If I ask the Minister for nothing else this evening, I ask the Government to confront these issues head on and to make it their business to find out the scale of resistance by LEAs and schools to the very idea of special educational needs. Does the Minister accept that if, for instance, a child's ADHD or autism is not understood or accepted, the imposition of punishments and zero-tolerance policies as a tactic to try to improve a child's behaviour is doomed to fail? Yet that kind of discipline is meted out to children whose ADHD has been clearly identified by psychologists but whom the school or the LEA steadfastly refuse to assess.

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Listening to the concerns of parents and taking them seriously at an early stage is fundamental to providing the right type of help for children, but very often that simply does not happen. However, worse still, we are increasingly seeing in schools and local authorities a culture of blame against parents.

Underlying that is one of the most pernicious and ill-founded theories to have gained currency in childcare and social services over the past 10 to 15 years. The theory states that there are parents who induce or fabricate illnesses in

their children in order to gain attention for themselves. The name given to it is Munchausen's syndrome by proxy, or factitious or induced illness—FII, as it is now known. It is a theory without science. There is no body of peer-reviewed research to underpin MSBP or FII. It rests instead on the assertions of its inventor and on a handful of case histories. When challenged to produce his research papers to justify his original findings, the inventor of MSBP stated, if you please, that he had destroyed them.

Yet that theory, which conjures up images of abusing, and potentially even homicidal, parents, is one that has been accepted at the highest levels in government without any caveats whatever. I do not doubt—how could I?—that dreadful and appalling cases of child abuse, and even the attempted murder of children, have been committed by some parents and carers. The case of Victoria Climbié brings home to us that abuse and murder of the most terrible kind is a very real fact of life.

That is not the issue here. My concern is that MSBP, or FII, has so deeply insinuated itself into the language and thinking of social services that it has become an all-purpose label for problem parents and children. A loving but apparently fussy mother, who, on behalf of her sick child, badgers a school or a GP to take her concerns seriously, can suddenly find herself accused of abuse. Once she has a label of MSBP pinned on her, it is very difficult to remove it. That type of case excites what is now an ingrained culture of suspicion in which the normal presumption of innocence disappears.

Last year, the Department of Health issued guidance on FII. Nowhere in that guidance is the possibility of error in diagnosing FII even alluded to. Yet there is a whole range of difficult-to-diagnose conditions in children—ADHD being one; Asperger's being another—where the symptoms are seized upon by adversarially minded social workers as a manifestation of abusive parenting.

Against that background, the official validation of MSBP and FII has come as manna from heaven to local authorities which look for ways to avoid making special educational provision for children. It gives an authority the excuse to say that the child is perfectly normal and that any behaviour he displays is the fault of the mother.

Despite the findings of the Griffiths inquiry, the Government have sadly failed to take that message on board and have instead allowed the proponents of MSBP to hijack the whole system. The Minister would

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earn my eternal gratitude if she were to follow through those concerns in the Department of Health. The situation is a scandal.

As we have heard, much of the solution to these problems lies in better training for teachers, social workers and doctors. But, above all, it lies in listening to parents and in early intervention and treatment—the earlier the

better. I hope that the debate tonight will take us a short way towards that goal.

10.10 p.m.

Baroness Andrews: My Lords, this has been an extraordinary debate. I am grateful to the noble Lord, Lord Hodgson of Astley Abbots, for giving us the opportunity to explore an area of child behaviour which is complex and distressing. I do not think we have had the opportunity for a debate of this kind in your Lordships' House. I have been impressed by the evidence of research that needs to be done, and that research is being questioned and used in evidence in terms of practice. It has been a thoughtful debate, which has demonstrated the cross-disciplinary nature of this issue in terms of both psychiatric practice and policy.

With the leave of the House, I shall speak for 15 minutes rather than the 12 minutes I have been allocated. I shall reply to some of the issues raised but cannot reply to them all. I am well aware that extremely challenging and difficult questions have been raised. I shall do my best to ensure that noble Lords receive a written reply to questions which I am unable to answer tonight, which will be circulated.

The noble Lord, Lord Hodgson, identified the need for support for children with attention deficit and hyperactivity disorder (ADHD) and hypoglycaemia in terms of social behaviour and educational attainment. The language used in tonight's debate ranged from the academic to the intensely personal. We heard the description of children causing a human whirlwind; and of the graphic impact which children who are so disturbed have on their families, schools and ultimately the community, as the noble Lord, Lord Astor, explained in powerful detail, in terms of so many of them ending up in prison and youth offending situations. A range of issues have been debated, covering a range of departments. Most of my remarks will be concentrated on education. As the noble Lord, Lord Addington, stated, we have to start at the earliest stage of development. However, I shall also refer to what we are doing in terms of mental health policy and special needs.

It is extremely difficult for parents, teachers and social workers to deal with a condition which is complex; which traditionally and historically has been misunderstood; which has the confusion of a number of different symptoms and which involves overlapping conditions. It has been extremely easy to confuse the normal boisterous behaviour of children with a condition which is neurologically different, is much more serious and needs a very different prescription. That is part of the problem with which parents and

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everyone involved in the diagnosis and response struggle on a day-to-day basis. We have to face the fact that these are complex situations.

When we admit that, we have to acknowledge that one of the key solutions must be the sharing of information between all the professionals involved. This is hardly a rare disorder. We know that approximately 5 per cent of all school-aged children suffer with some form of ADHD. That is a high figure. The study undertaken by the Office for National Statistics in 1999 estimated that about 1 per cent of children suffer from hyperkinetic disorder at the extreme end of this spectrum. We are conscious of the need to monitor that situation and keep that information up to date. That survey will be repeated in 2004 so that we shall have better evidence of numbers.

The noble Earl, Lord Howe, stressed the importance of parental understanding and referred to the burden of blame that is sometimes laid on parents because of the confusions caused. One optimistic and positive assessment has come from the framework of assessment for children in need, which clearly states that the importance of making a proper diagnosis is partly so that it will release parents from feeling that they are to blame and from other people assuming that they are to blame. At the highest order of policy making that is a statement in which we can take confidence.

The link between hypoglycaemia and children's behaviour has been mentioned. Hypoglycaemia is normally associated with diabetes, but can occur for other, more mundane reasons, related to an inadequate or unbalanced diet. It has been suggested that hypoglycaemia may be a significant factor in the causation of ADD and ADHD.

However, evidence that emerged in the 1980s, which supported the use of elimination diets in the treatment of ADHD, has not been sustained over time, but we know—and noble Lords have referred to many different aspects of the relationship between diet and behaviour—that children seem to react badly to certain types of food. Obviously parents pick that up and respond accordingly by withdrawing the food and so on. But research has discovered that special diets are of limited value. I say that because—having seen some of the weight of research in the field—we can produce research evidence to justify such a statement. I am happy to share it with the House.

I asked the Department of Health to show me some of the research or to list it. That was greeted by a rather loud laugh because one research review that was produced had at least 70 references. Paradoxically, we have so much research in this field—it is one of the most finely researched areas of child development—but we seem to have no universal understanding of its cause, although we now think that at the hyperkinetic end there is a genetic link.

I turn to diagnosis of children with the symptoms of hyperactivity, impulsiveness and inattention to detail and management of the condition. The noble Lord, Lord Lucas, described their impact on the classroom. It is devastating for a teacher with 30 children in the

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class. The diagnosis depends on the symptoms being present before the age of seven, but it is more reliably made when that diagnosis can be tested both in the home and at school, so that one can see the persistent pattern of behaviour. Effective treatment must involve a full specialist assessment, which will form the basis of the treatment plan.

The treatment plan must involve the school. Specialist paediatricians and psychiatrists are increasingly involved. They can go into the school and suggest ways to manage the child in the classroom with, and sometimes without, additional classroom help. It can involve restructuring some of the ways that they are taught. I want to talk more about these ways of teaching that can be used when one is trying to manage—and I have a little experience of this—a difficult child in the classroom. All this can only take place—as the noble Earl, Lord Howe, sincerely said—where there is a genuinely joined-up approach.

These children often not only have attention deficit disorder but associated disorders regarding language, writing and reading ability. So they present a multi-dimensional problem. Parents need as much reliable information as possible. That is an absolute sine qua non. In fact, the Department of Health has helped that process. It has grant-aided the ADHD National Alliance, supported the Royal College of Psychiatrists, and a very helpful and clearly written fact sheet has been produced for general circulation.

In terms of the general treatment of medical needs, the key guidance on procedures and protocols was set out in 1996 in a document by the DfES and the Department of Health entitled Supporting Pupils With Medical Needs In School. That guidance includes advice for teachers on the recognition of the medical condition, the appropriate steps for teachers and school staff and individual healthcare plans. Teachers of pupils with medical needs require information, not only about the nature of the condition but on access to medication and what action to take in cases of emergency. That is obviously critical in the case of ADHD if a child has been prescribed Ritalin because he would be at the severe and specific end of the disorder. But the National Institute for Clinical Excellence states that it is best given as part of a comprehensive treatment. Its study in 2000 found the treatment to be very effective for more extreme cases. However, it also recommended that children receiving Ritalin should be regularly monitored.

Although the noble Lord, Lord Colwyn, did not put it in these terms, by implication he raised the issue of over-medication. NICE also estimated in 2000 that there were approximately 48,000 children in England and Wales who met the criteria for hyperkinetic disorder but who were not receiving treatment. So we may be under-medicating children who could benefit, but some practitioners may be more generous with their treatment. Since the NICE guidance was issued, there has been a modest increase in the number of prescriptions issued.

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I can tell the noble Lord, Lord Astor, that the guidance is scheduled for review by NICE later this year. He asked when Strattera is likely to be available. I have no information about that, but will be happy to find out and write to him. Problems for schools occur when Ritalin is administered during the school day. Slow-release drugs, which are becoming available, will make it easier to treat that condition.

The partnership that must occur at classroom level is supported by the SEN code of practice. Noble Lords will know that we have spent hours debating the SEN code of practice during the past two years. It emphasises the critical role of parents and that there must be a partnership. Paragraph 7.60 of the code makes specific reference to the range of interventions for schools to use to support pupils who are hyperactive and lack concentration. The code of practice is regularly monitored by Ofsted; it represents a major step forward and ADHD will receive the greater profile that it deserves because of the code.

To backtrack to younger children—the noble Lord, Lord Addington, referred to the need for early intervention—the SEN code is underpinned by the £25 million package announced in 2001 to support SEN in the early years and provide additional training for those teachers and trainers who are involved with the youngest children. We are also funding a range of pilots that will test different models of joined-up practice across health and education which will have specific benefit for children who fall into that category. The early support pilot programme deals with children aged zero to two with a range of different abilities. There are 28 new projects that are testing means of getting information to parents, treatment and setting up general arrangements.

Most importantly, the first set of guidance promoting children's mental health in early years in school settings was published in June 2001. It is designed to help teachers working alongside mental health professionals to intervene effectively with children experiencing mental problems. The guidance contains a whole section on ADHD. I should be delighted to give noble Lords further information about that. Accompanying that was guidance on a series of snapshots or specific approaches to help primary school classrooms.

Supporting that, which concerns effective learning management, we have a range of behaviour strategies that fall under the banner of the National Behaviour Strategy under which new training materials and packages are being produced on behaviour and attendance. They will be available from 2003, supported by local best teams in education and training which are located in the areas with the highest street crime. Sixty LEAs will be involved in that. That is all coming together to produce a robust, innovative package of additional targeted help from which children with ADHD behavioural problems will benefit. We are spending £66 million on that.

Teacher training was raised. Young teachers and teachers in training obviously have to be able to manage and implement the SEN code and manage

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behaviour in the classroom. The curriculum reinforces that. Extremely important questions were raised about the nature of social work and how its role will change. In response to the noble Lord, Lord Lucas, the reference to the framework for the assessment of children in need and their families highlights the need for social workers to consider underlying conditions such as ADHD when assessing children's needs. New social work training to be introduced in September 2003 will include elements covering child development, mental health and communication skills. The national service framework for children refers to the range of disabilities, including ADHD. The findings will be published shortly—this month.

Difficult questions on vaccination were raised. I wish to be very careful in what I say to the noble Lord, Lord Hodgson, who warned me of his question. I will say at this point that I have been unable to find any evidence to support his hypothesis. The Committee on Safety of Medicines has reviewed the available data relating to possible neurotoxicity and ethylmercury in vaccines, including attention deficit disorder. It has advised that there is no evidence of adverse neurological effects caused by the ethylmercury content of the vaccines. The view is supported by the World Health Organisation. The noble Lord raised a series of detailed questions following on from earlier parliamentary Questions. I do not want to confuse the

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issue further. I would much prefer to write to him in response to his questions. I wish that I had more time—

Lord Hodgson of Astley Abbots: My Lords, I understand that the questions are detailed, but they are very important. There is a great body of concern out there. In the noble Baroness's response, will her officials address why the United States and Australia have withdrawn thimerosal from the vaccines? Class actions are happening there on a vast scale, not without reason. There is concern there that cannot be brushed aside as was done slightly in some of the Answers that I have received.

Baroness Andrews: My Lords, I can give the noble Lord that assurance.

We are spending much more money. For the first time ever, we have a target for improving the mental health of children and adolescents. We are putting £140 million into that, which will be a great step forward. The grant circular has just gone out to local authorities. Viewed in conjunction with all the other measures that I outlined as regards education and special needs, we are not only giving AHDA a higher profile, we are well on the road to ensuring that we can deal with it more effectively on behalf of parents, children and society.

I am sorry that I do not have time to address the youth offending issues. I will write on behalf of the Home Office.

House adjourned at twenty-eight minutes past ten o'clock.