SB
48

Memorandum

To: Senator Fred Dyson, Chair
Senate HESS Committee

From: Senator Bettye Davis *BD.*

Date: March 9, 2006

RE: Addressing Concerns for Senate Bill 48

I wanted to reiterate to you some of the changes I have incorporated into the proposed CS for SB 48 as they pertain your memo of April 29, 2003 on SB 5. I'm not certain you've had the opportunity to note the changes since your memo. Therefore I will address your concerns from that memo.

Here are the responses to your major questions:

I would also like to know the status of this issue in Alaskan schools. How large of a problem is this issue?

Most information of this nature is antidotal, as most teachers and schools wouldn't necessarily admit to this. Here are excerpts of testimony from SB 230 (the bill's designation when originally introduced during the 22nd Legislature) and two other comments.

March 4, 2002 Senate Health, Education and Social Services Committee Meeting

"...However at times, teachers also may make suggestions regarding medication out of an attempt to be helpful because they are trying to help a parent come up with options that may be useful. Again, this points out the need for training in that area because while the suggestion maybe from good intentions, it may not have the intended consequences."
(Greg Maloney, Director of Special Education, DEED)

"The North Star Borough School District has brought in psychiatrists from other states on two different occasions to give teachers a pep talk on how to identify children with ADHD in the classroom. During the seminar, the psychiatrist supported the use of Ritalin and another drug as part of the treatment plan. Also the school district has had a long time relationship with Dr. Ferguson who is a leader in prescribing Ritalin in Fairbanks. I asked the school board to have Dr. Ferguson come in and give an opinion on evaluating a child for ADHD and psychotropic drugs but they declined."
(Frank Turney, Fairbanks Resident)

May 11, 2002 Senate Judiciary Committee Meeting

Chairman Taylor thanked Senator Davis and said he has heard of situations in his district in which children were placed on psychotropic drugs but once the children were removed from the drugs and the school setting, they did very well.
(Robin Taylor, Chair, Senate Judiciary Committee)

Other Statements

May 1, 2005

"After talking about the issue with several parents of school aged children (K-12), my own experiences and that of my immediate and distant family, I've formed the opinion that those people who do not believe this happens and those of us to whom this has happened, view education as though we were from entirely different planets. Why do we have to "convince" an education board that we are telling the truth?"
"...However the fact remains that the parents I have recently spoken to, 15 separate families, in my research of this subject have all had this recommendation form teachers for their children. Here in Fairbanks. So, we have at least 15 individual teachers who have used this 'medically concerned' tactic."
(Email from BJ Williams, concerned grandparent in Fairbanks)

March 11, 2006

"I had four different teachers and one academic counselor tell me my son probably needed some kind of drugs because he was very active and was not engaged. I finally had to put him in a school outside that didn't do that, that kept him engaged. He's graduating with good grades."
(Statement by Rick Henderson to legislative staff, Richard Benavides)

It seems that current law already addresses these concerns. Schools are already prohibited from linking admission to treatment/medication. In addition there are currently mechanisms in place to investigate and discipline school personnel who make unethical choices.

Currently, AS 14.30.045 currently states the Grounds for suspension or denial of admission and it seems that the directives of this bill are already implied in that section. It would appear that school personnel who deny admission for failure to receive treatment/medication are already breaking the law.

The Professional Teaching Practices Commission, made up of nine members appointed by the Governor, works to ensure Alaska educators follow the Code of Ethics of the Education Profession. It has the authority to discipline educator misconduct. Anyone can submit a complaint to the Commission. Commission staff investigates complaints, and the Commission, acting like a jury, decides whether an educator will be disciplined. More info can be found at http://www.eed.state.ak.us/ptpc/. It seems that their duties already include dealing with issues like this. This commission is established in AS 14.20.380–14.20.510.

The statute you reference above (AS 14.30.045) along with AS 14.30.047[1] seems designed to cover areas concerning physical and mental disorders that render the child either incapable of benefiting from school or being a danger to themselves or others. The statute does not directly relate to a linkage between treatment/medication. It would seem difficult to bring an action against a teacher for recommending the use of a psychotropic drug using this statute.

In relation to AS14.30.045 and AS14.30.047, there is no violations section for those statutes.

While there are mechanisms in place to investigate those who make unethical choices, the Code of Ethics and Teaching Standards does not contain any language on this subject.[2]

While the standards allow for an investigation if a teacher commits a crime, the present statutes concerning discipline (AS 14.20.030. Causes For Revocation and Suspension.)[3] would not cover psychotropic drugs. If the bill passes, then a law would have been broken allowing for an investigation by the Professional Teaching Practices Commission.

Regarding AS 14.30.171 (5) (C), I believe schools do have the right to recommend a child be evaluated by a doctor.

The proposed CS on page 1, line 7 contains the words, "*unless otherwise authorized by law*," which was purposely added to allow those within a school district or individual school who has the training and whose position has as one of their authorized duties to make such a recommendation, to continue to do so.

Regarding AS 14.30.172, it seems that this section is unnecessary to again state what school personnel are already allowed to do.

This was a drafting choice by legislative legal to make clear what is allowed after the section stating what is not allowed.

Regarding AS 14.30.174, items (1), (2), and (3) seem redundant in lieu of earlier material in the bill.

Regarding AS 14.30.179 (1), what does this mean? What does the federal education law state?

I will combine the answers to both questions, as they are related. In the CS, this is moved to page 3, line 8 as section 14.30.174(b)(1). This definition cites the federal laws that apply to any state that receives federal funding for children from these programs. Portions of this law covers assessments of children to determine eligibility for services, hence the inclusion of this section to allow those acting within the scope of the federal law to recommend these actions.

Regarding AS 14.30.177, will a teacher be fired? Is this appropriate in light of the authority of the P.T.P.C.?

As stated above in an earlier question, if the bill passes, and a teacher is alleged to have broken this law, the Professional Teaching Practices Commission would undertake an investigation. If the teacher were found to have broken this law, the punishment would still be up to the commission. Whether it rises to the level of dismissal is up to the commission. There would have to be substantial noncompliance as cited in AS 14.20.170(3)[4]

Regarding AS 14.30.179 (3), where is this definition from?

In the proposed CS, this definition is moved to page 3, line29 and listed simply as AS 14.30.179. It is taken from AS 14.25.220(33)

Regarding AS 14.30.171 (3), how will this affect current practice?

These evaluations would still be allowed. As stated in a prior question, the proposed CS allows school personnel who are trained and authorized by their school or district to perform these evaluations, can continue to do so. I don't believe we want individuals without the knowledge to perform these tasks doing those types of important evaluations.

Notes

[1]**AS 14.30.045. Grounds For Suspension or Denial of Admission.**
A school age child may be suspended from or denied admission to the public school that the child is otherwise entitled to attend only for the following causes:
(1) continued wilful disobedience or open and persistent defiance of reasonable school authority;
(2) behavior that is inimicable to the welfare, safety, or morals of other pupils or a person employed or volunteering at the school;
(3) a physical or mental condition that in the opinion of a competent medical authority will render the child unable to reasonably benefit from the programs available;
(4) a physical or mental condition that in the opinion of a competent medical authority will cause the attendance of the child to be inimicable to the welfare of other pupils;
(5) conviction of a felony that the governing body of the district determines will cause the attendance of the child to be inimicable to the welfare or education of other pupils.

AS 14.30.047. Admission or Readmission When Cause No Longer Exists.
(a) A child who has been suspended from or denied admittance to a school under AS 14.30.045 (3) or (4) shall be permitted to attend school when the child is obviously recovered or presents to the governing body a statement in writing from a competent medical authority that the child is no longer afflicted with, or suffering from, the physical or mental condition to the extent that it is a cause for suspension or denial of admission under AS 14.30.045 (3) or (4).

[2]**20 AAC 10.020. CODE OF ETHICS AND TEACHING STANDARDS.** (a) The following code of ethical and professional standards governs all members of the teaching profession. A violation of this section is grounds for discipline as provided in **AS 14.20.030**.
(b) In fulfilling obligations to students, an educator:
(1) repealed 10/25/2000;
(2) may not deliberately distort suppress, or deny access to curricular materials or educational information in order to promote the personal view, interest, or goal of the educator;
(3) shall make reasonable effort to protect students from conditions harmful to learning or to health and safety;
(4) may not engage in physical abuse of a student or sexual conduct with a student and shall report to the commission knowledge of such an act by an educator;
(5) may not expose a student to unnecessary embarrassment or disparagement;
(6) may not harass, discriminate against, or grant a discriminatory advantage to a student on the grounds of race, color, creed, sex, national origin, marital status, political or religious beliefs, physical or mental conditions, family, social, or cultural background, or sexual orientation; shall make reasonable effort to assure that a student is protected from harassment or discrimination on these grounds; and may not engage in a course of conduct that would encourage a reasonable student to develop a prejudice on these grounds;
(7) may not use professional relationships with students for private advantage or gain;
(8) shall keep in confidence information that has been obtained in the course of providing professional service, unless disclosure serves a compelling professional purpose or is required by law;
(9) shall accord just and equitable treatment to all students as they exercise their educational rights and responsibilities.
(c) In fulfilling obligations to the public, an educator:
(1) repealed 10/25/2000;
(2) shall take reasonable precautions to distinguish between the educator's personal views and those of any educational institution or organization with which the educator is affiliated;
(3) shall cooperate in the statewide student assessment system established under 4AAC 06.710-4 ACC 06.790 by safeguarding and maintaining the confidentiality of test materials and information;
(4) repealed 10/25/2000;
(5) may not use institutional privileges for private gain, to promote political candidates, or for partisan political activities;
(6) may not accept a gratuity, gift, or favor that might influence or appear to influence professional judgment, and may not offer a gratuity, gift, or favor to obtain special advantage;

(7) may not knowingly withhold or misrepresent material information in communicating with the school board regarding a matter before the board for its decision; and
(8) may not use or allow the use of district resources for private purposes not related to the district programs and operation.
(d) In fulfilling obligations to the profession, an educator:
(1) may not, on the basis of race, color, creed, sex, age, national origin, marital status, political or religious beliefs, physical condition, family, social or cultural background, or sexual orientation, deny to a colleague a professional benefit, advantage, or participation in any professional organization, and may not discriminate in employment practice, assignment, or personnel evaluation;
(2) shall accord just and equitable treatment of all members of the profession in the exercise of their professional rights and responsibilities;
(3) may not use coercive means or promise special treatment in order to influence professional decisions of colleagues;
(4) may not sexually harass a fellow employee;
(5) shall withhold and safeguard information acquired about colleagues in the course of employment, unless disclosure serves a compelling professional purpose;
(6) shall provide, upon the request of the affected party, a written statement of specific reasons for recommendations that led to the denial of increments, significant changes in employment, or termination of employment;
(7) may not deliberately misrepresent the educator's or another's professional qualifications;
(8) repealed 10/25/2000;
(9) may not falsify a document, or make a misrepresentation on a matter related to licensure, employment evaluation, test results, or professional duties;
(10) may not intentionally make a false or malicious statement about a colleague's professional performance or conduct;
(11) may not intentionally file a false or malicious complaint with the commission;
(12) may not seek reprisal against any individual who has filed a complaint, provided testimony or given other assistance in support of a complaint filed with the commission;
(13) shall cooperate fully and honestly in investigations and hearings of the commission;
(14) repealed 10/25/2000;
(15) may not unlawfully breach a professional employment contract;
(16) shall conduct professional business through appropriate channels;
(17) may not assign tasks to unqualified personnel;
(18) may not continue in or seek professional employment while unfit due to (A) use of drugs or alcohol that impairs the educator's competence or the safety of students or colleagues; (B) physical or mental disability that impairs the educator's competence or the safety of students or colleagues;
(19) may not interfere with a colleague's exercise of political or citizenship rights and responsibilities

[3]**AS 14.20.030. Causes For Revocation and Suspension.**
(a) The commissioner or the Professional Teaching Practices Commission may revoke or suspend a certificate only for the following reasons:
(1) incompetency, which is defined as the inability or the unintentional or intentional failure to perform the teacher's customary teaching duties in a satisfactory manner;
(2) immorality, which is defined as the commission of an act which, under the laws of the state, constitutes a crime involving moral turpitude;
(3) substantial noncompliance with the school laws of the state or the regulations of the department; or
(4) upon a determination by the Professional Teaching Practices Commission that there has been a violation of ethical or professional standards or contractual obligations.
(b) The commissioner or the Professional Teaching Practices Commission shall revoke for life the certificate of a person who has been convicted of a crime, or an attempt, solicitation, or conspiracy to commit a crime, involving a minor under AS 11.41.410 - 11.41.460 or a law or ordinance in another jurisdiction with elements similar to an offense described in this subsection.
(c) The commissioner or the Professional Teaching Practices Commission shall request the chief administrative law judge (AS 44.64.020), to appoint an administrative law judge employed by the office of administrative hearings to preside at a hearing conducted under this section. AS 44.64.060 and 44.64.070 do not apply to the hearing.

[4] **AS 14.20.170. Dismissal.**
(a) A teacher, including a teacher who has acquired tenure rights, may be dismissed at any time only for the following causes:
(1) incompetency, which is defined as the inability or the unintentional or intentional failure to perform the teacher's customary teaching duties in a satisfactory manner;
(2) immorality, which is defined as the commission of an act that, under the laws of the state, constitutes a crime involving moral turpitude; or

(3) substantial noncompliance with the school laws of the state, the regulations or bylaws of the department, the bylaws of the district, or the written rules of the superintendent.

(b) A teacher may be suspended temporarily with regular compensation during a period of investigation to determine whether or not cause exists for the issuance of a notification of dismissal according to AS 14.20.180.

(c) A teacher who is dismissed under this section is not entitled to a plan of improvement under AS 14.20.149 .

ALASKA STATE LEGISLATURE

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Senate
State Affairs
Committee

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Fax: (907) 465-3756
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While in Anchorage
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SENATOR BETTYE DAVIS

Senator_Bettye_Davis@legis.state.ak.us
www.akdemocrats.org

Memorandum

To: Senator Fred Dyson, Chair
Senate HESS Committee

From: Senator Bettye Davis

Date: April 27, 2005

RE: Request for Hearing, SB 48

I respectfully request a hearing for Senate Bill 48, Psychological Evaluation/Treatment For Students.

I have attached a newer CS that I feel covers the concerns of those I have spoken to over the course of the interim and the beginning of this year.

24-LS0208\F
Mischel
4/18/05

CS FOR SENATE BILL NO. 48( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to recommending or refusing psychotropic drugs or certain types of**
2 **evaluations or treatments for children."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 14.30 is amended by adding new sections to read:
5 **Article 2A. Psychiatric and Behavioral Evaluations and Treatments.**
6 **Sec. 14.30.171. Prohibited actions.** Except as provided in AS 14.30.172 -
7 14.30.176, school personnel may not, unless otherwise authorized by law,
8 (1) recommend to a parent or guardian that a child take or continue to
9 take a psychotropic drug as a condition for attending a public school;
10 (2) require that a child take or continue to take a psychotropic drug as a
11 condition for attending a public school;
12 (3) conduct a psychiatric or behavioral health evaluation of a child;
13 (4) recommend a specific licensed physician, psychologist, or other
14 health specialist to a parent or guardian for a child;

1 (5) recommend that a parent or guardian seek or use any of the
2 following:
3 (A) the administration of a psychotropic medication to a child;
4 (B) a psychiatric or psychological treatment for a child; or
5 (C) a psychiatric evaluation of a child; or
6 (6) make a report of suspected child abuse or neglect to authorities,
7 including the Department of Health and Social Services, based solely on the fact that a
8 parent or guardian refuses to consent to
9 (A) the administration of a psychotropic drug to a child;
10 (B) a psychiatric, psychological, or behavioral treatment of a
11 child; or
12 (C) a psychiatric or behavioral health evaluation of a child.
13 **Sec. 14.30.172. Communication not prohibited.** Nothing in AS 14.30.171
14 may be construed to prohibit school personnel from
15 (1) communicating information to other school personnel about a
16 child;
17 (2) exercising their authority relating to the placement within the
18 school or readmission of a child who may be or has been suspended or expelled for a
19 violation of a school disciplinary and safety program adopted under AS 14.33.110 -
20 14.33.140; or
21 (3) informing a child's parent or guardian of a perceived behavioral
22 problem of the child as long as the school personnel do not
23 (A) make an assertion or recommendation that violates
24 AS 14.30.171; or
25 (B) attempt to denigrate, criticize, or punish a parent, guardian,
26 or child for a decision made by the parent or guardian for the child to take, not
27 take, or discontinue to take a psychotropic drug.
28 **Sec. 14.30.174. Compliance with federal education law.** (a)
29 Notwithstanding AS 14.30.171(3) and (5), a mental health professional working
30 within a public school system may, for the sole purpose of complying with federal
31 education law,

1 (1) recommend, but not require, a psychiatric or behavioral health
2 evaluation of a child;
3 (2) recommend, but not require, psychiatric, psychological, or
4 behavioral treatment for a child; and
5 (3) conduct a psychiatric or behavioral health evaluation of a child
6 with the consent of the child's parent or guardian.
7 (b) In this section,
8 (1) "federal education law" means 20 U.S.C. 1400 - 1487 (Individuals
9 with Disabilities Education Act), 20 U.S.C. 7101 - 7143 (Safe and Drug-Free Schools
10 and Communities Act of 1994), 29 U.S.C. 794 (nondiscrimination under federal grants
11 and programs), and 42 U.S.C. 12101 - 12213 (equal opportunity for individuals with
12 disabilities);
13 (2) "mental health professional" has the meaning given in
14 AS 47.30.915.
15 **Sec. 14.30.176. List of community resources.** Notwithstanding
16 AS 14.30.171(4), a school district may make available to an interested parent or
17 guardian a list of community resources, including mental health services if the list
18 conspicuously states the following: "This list is provided as a resource to you. The
19 school neither recommends nor requires that you use this list or any of the services
20 provided by individuals or entities on the list. It is for you to decide what services, if
21 any, to use and from whom you wish to obtain them."
22 **Sec. 14.30.177. Violations.** (a) A violation of AS 14.30.171 - 14.30.176
23 constitutes substantial noncompliance with a school law of the state for purposes of
24 dismissal of a teacher under AS 14.20.170 or nondetention of a teacher under
25 AS 14.20.175.
26 (b) Each school board shall adopt a bylaw under AS 14.14.100 that provides
27 that violation of AS 14.30.171 - 14.30.176 is grounds for disciplinary action against a
28 person employed by the school district.
29 **Sec. 14.30.179. Definition.** AS 14.30.171 - 14.30.179, "public school"
30 means a school operated by publicly elected or appointed school officials in which the
31 program and activities are under the control of those officials and that is supported by

1 public funds.

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SENATOR BETTYE DAVIS

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Senate Bill SB 48

"An Act relating to recommending or refusing psychotropic drugs as a treatment for children and to the evaluation and treatment of children with behavioral or psychological problems."

Sponsor Statement

The use of psychiatric drugs in our nation's schools has more than doubled in the first half of the last decade and continues to escalate. There are documented incidences of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline, which may be related to a variety of causation. There is also parental concern regarding the issue of diagnosis and medication and their impact on student achievement.

In recognition of the importance that only physicians should make psychiatric diagnoses of behavioral problems, recommend psychiatric screening for specific behavioral problems, and suggest the use of psychiatric medication for a student, this bill would insure that:

No one but a licensed physician in consultation with the parents or guardian can recommend or prescribe the use of psychotropic drugs.

No public educational facility or employee thereof may deny enrollment in the school or facility for the refusal of his or her parents to place that child on psychotropic drugs.

No parent would be threatened with a formal action or proceeding of neglect for refusal to place a child on psychotropic drugs.

Provisions to allow behavioral, psychological or psychiatric screening by those qualified to do so, with parental consent are preserved.

Communication between school employees on behavioral and learning issues concerning the child are preserved.

24-LS0208\G
Mischel
4/15/05

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY SENATOR DAVIS

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

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14 health specialist to a parent or guardian for a child;

(5) recommend that a parent or guardian seek or use any of the following:

(A) the administration of a psychotropic medication to a child;

(B) a psychiatric or psychological treatment for a child; or

(C) a psychiatric evaluation of a child; or

(6) make a report of suspected child abuse or neglect to authorities, including the Department of Health and Social Services, based solely on the fact that a parent or guardian refuses to consent to

(A) the administration of a psychotropic drug to a child;

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Sec. 14.30.172. Communication not prohibited. Nothing in AS 14.30.171 may be construed to prohibit school personnel from

(1) communicating information to other school personnel about a child;

(2) exercising their authority relating to the placement within the school or readmission of a child who may be or has been suspended or expelled for a violation of a school disciplinary and safety program adopted under AS 14.33.110 - 14.33.140; or

(3) informing a child's parent or guardian of a perceived behavioral problem of the child as long as the school personnel do not

(A) make an assertion or recommendation that violates AS 14.30.171; or

(B) attempt to denigrate, criticize, or punish a parent, guardian, or child for a decision made by the parent or guardian for the child to take, not take, or discontinue to take a psychotropic drug.

Sec. 14.30.174. Compliance with federal education law. (a) Notwithstanding AS 14.30.171(3) and (5), a mental health professional working within a public school system may, for the sole purpose of complying with federal education law,

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2 evaluation of a child;
3 (2) recommend, but not require, psychiatric, psychological, or
4 behavioral treatment for a child; and
5 (3) conduct a psychiatric or behavioral health evaluation of a child
6 with the consent of the child's parent or guardian.
7 (b) In this section,
8 (1) "federal education law" means 20 U.S.C. 1400 - 1487 (Individuals
9 with Disabilities Education Act), 20 U.S.C. 7101 - 7143 (Safe and Drug-Free Schools
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30 means a school operated by publicly elected or appointed school officials in which the
31 program and activities are under the control of those officials and that is supported by

1 public funds.

Legislation Enacted in States 2002-2004

2002 Legislative Session

State legislatures enacted legislation primarily on Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) and psychotropic medications at schools for ADD/ADHD. The following is a sample of legislation that passed:

- **Georgia** House Resolution 946 created the Commission on Psychiatric Medication of School-Age children to study and investigate the use of psychiatric medications and their effects on school-age children and provided recommendations for improved oversight of narcotic prescriptions for the state's youth.
- **Illinois** House Bill 3744 (Public Act 02-0663) defined psychotropic and psychostimulant medication and required each school board to adopt and implement a policy that prohibits disciplinary action for the refusal of a student's parent or guardian to administer or consent to administration of psychotropic or psychostimulant medication. The bill does not prohibit school medical staff or professional from recommending that a student be evaluated by an appropriate medical practitioner or school personnel from consulting with the medical practitioner with the consent of the student's parent or guardian.
- **Virginia** House Bill 90 (Chapter 314) required the state Board of Education to develop and implement policies prohibiting school personnel from recommending the use of psychotropic medications for any student. The policies may not prohibit school health staff, teachers or other school professionals from recommending that a student be evaluated by appropriate medical practitioners or from consulting with such with the written consent of the student's parent.
- **Virginia** House Joint Resolution 122 requested that the state Department of Public Health collect data to determine the prevalence of methylphenidate and amphetamine prescriptions used to treat ADD/ADHD in the Commonwealth

2003 Legislative Session

Enacted legislation included bills on student use of psychotropic medications and school-based mental health programs. The following is a sample of legislation that passed:

- **Colorado** House Bill 1172 required each school board to adopt a policy prohibiting school personnel from recommending or requiring a student use a psychotropic drug or to test or require a test for a child's behavior without prior written permission from the parent, guardian or child. School personnel are encouraged to discuss the child's behavior with the parent or guardian which may include a suggestion that the the parent or guardian speak to an appropriate health care professional.
- **Oregon** Senate Bill 456 (Chapter 485) prohibited K through 12 public school administrators, teachers, counselors, or nurses from recommending that a student seek a prescription for a medication that is prescribed with the intent of affecting or altering the thought processes, mood or behavior of a student.
- **Texas** Senate Bill 491 required the Texas Education Agency, the Texas Department of Mental Health and Mental Retardation, the Texas Department of Health, and the Texas Commission on Alcohol and Drug Abuse to conduct a joint assessment, including recommendations for further development of school-based mental health and substance abuse programs.

2004 **Legislative Session**

The following is a sample of legislation that passed:

- **New Hampshire** House Bill 551 (Chapter 237) established a committee to study the prescription and use of psychotropic drugs, including Ritalin, in childcare centers, preschools and public schools.
- **Illinois** House Bill 307 (Public Act 98-0892) counties may adopt a $5 mandatory fee where a teen court, peer court, peer jury, youth court or other youth diversion program has been created to pay for the administration and operation of such programs.
- **New Hampshire** House Bill 1397 (Chapter 34) requires the Health Education Review Committee to review the efforts of the New Hampshire Youth Suicide Prevention Advisory Assembly in developing a statewide comprehensive plan for youth suicide prevention.

Psychotropic Medications at Schools

Current as of January 3, 2005

States that passed legislation in the 2004 session

New Hampshire passed legislation establishing a committee to study the prescription and use of psychotropic drugs, including Ritalin, in childcare centers, preschools, and public schools, grades K through 12. **Delaware's** House of Representatives adopted Resolution 83 creating a task force to study the patterns of treatment of ADD and ADHD in school-aged children and the role of school personnel in the recommendation process for the use of psychotropic and sympathomimetic medications on school aged children.

Approximately 15 states considered legislation related to psychotropic and sympathomimetic medications and psychiatric treatment for school-age children. Psychotropic medications are drugs that have an altering effect on perception, emotion or behavior. Sympathomimetic drugs produce physiological effects resembling those caused by the activity or stimulation of the sympathetic nervous system. Examples of these drugs include Ritalin, Adderall, Cylert and Dexedrine. These drugs are generally used in the treatment of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD).

Below is a list of states that have laws related to psychotropic medications at schools and a chart of states that introduced legislation in the 2004 session. These laws and bills primarily focus on school personnel recommending psychotropic medications for students and recommending medical evaluations for students for suspected behavioral disorders.

States that passed laws prior to the 2004 legislative session

Georgia adopted a resolution to investigate the use of psychotropic medications and their effects on school aged children in the state.

Colorado enacted legislation regarding school board policies covering when personnel may address health care treatment for student behavior issues; requires each school board to adopt a policy prohibiting school personnel from recommending or requiring the use of a psychotropic drug by any student.

Connecticut prohibits school personnel from recommending the use of psychotropic drugs for any child, but does not prohibit recommending a child be evaluated by a medical practitioner or school personnel from consulting with one.

Hawaii adopted two resolutions requesting the departments of health and education research and examine the use and effectiveness of medication for children with behavioral problems.

Illinois requires training of school personnel on the use of psychotropic medications and does not prohibit school medical staff from recommending that a student be evaluated or from consulting with a medical practitioner about a student.

Oregon prohibits K through 12 public school administrators, teachers, counselors or nurses from recommending that a student

seek a prescription for a medication that is prescribed with the intent of affecting or altering the thought processes, mood or behavior of the student.

Texas prohibits school personnel from recommending that a student use a psychotropic drug or suggest any particular diagnosis or use the refusal by a parent to consent to the administration of a psychotropic drug to or psychiatric evaluation or examination of a student as grounds, by itself, for prohibiting the child from attending a class or participating in a school-related activity. Does not prohibit a school district employee from recommending that a child be evaluated by an appropriate medical practitioner.

Virginia directed the Board of Education to develop and implement policies prohibiting school personnel from recommending the use of psychotropic medications for any student.

State's that have introduced legislation in 2004 (includes carryover 2003-2004)

State	Bill Number
Alaska	**AK SB 5** Would prohibit school personnel from recommending or requiring a child take or continue to take a psychotropic drug as a condition for attending a public school, conducting or recommending a parent or guardian seek psychiatric or behavioral health evaluation of a child, recommending a health specialist to a parent or guardian, recommending the administration of psychotropic medication, or recommending psychological or psychiatric treatment of a child. School personnel may communicate information to other school personnel about a child and may inform a parent or guardian of a perceived behavioral problem.
California	**CA AB 1424** Specifies that refusal of a parent or guardian of a child to administer or consent to the administration of any psychotropic drug or psychological or psychiatric evaluations or treatments would not constitute a basis for finding that the child should be removed from the custody of the parent or guardian.
Delaware	**DE HR 83 (Adopted by the House of Representatives on June 30, 2004)** Creates a task force to study the patterns of treatment of ADD and ADHD in school-aged children and the role of school personnel in the recommendation process for the use of psychotropic and sympathomimetic medications on school aged children.
Florida	**FL HB 1275 and a section of SB 1578e1** Would require that public school district boards prohibit personnel from requiring a student to take any psychotropic or similar mind altering medication as a condition of attending school or receiving educational services. School district personnel would be able to consult or share observations with parents regarding a student's academic performance or behavior or the need for evaluation for special education or related services provided the evaluation is strictly academic and not psychologically or psychiatrically based. **FL SB 1140 and HB 223** Specifies that parental refusal to administer psychotropic medication to a child shall not constitute grounds for Children and Family Services Department to take a child into custody; would require district school board policies to prohibit personnel working in child care facilities from administering medications to a child without written authorization of the child's parent or guardian except in the event of a medical emergency; and directs school boards to adopt rules prohibiting school board personnel from recommending psychotropic medication for a student, however it would not prohibit school board medical personnel from recommending that a student

	be evaluated or consulting with a medical practitioner with the consent of the student's parent.
Kentucky	**KY HJR 58** Would request that the Kentucky Department of Education provide education and training to school personnel regarding the use of psychotropic drugs; provide guidelines for school personnel and procedures to follow when recommending a child be evaluated; urges the Cabinet for Families and Children to ensure that a parent's refusal to allow a child to receive psychotropic drugs as part of treatment not be used as sole grounds for taking a child into custody; and requests a study of the issues related to psychotropic drugs.
Massachusetts	**MA HB 2227** Would prohibit the school committee, any teacher, any counselor or any other agent from requiring a student be placed on a psychotropic drug in order to attend or remain in school. Prohibits the right to recommend or suggest the use of a psychotropic drug for any child.
Michigan	**MI HB 4025** Would direct the Department of Education to develop and distribute model policy concerning chronic behavior issues and psychotropic medications for pupils. This policy should include, allowing school personnel to discuss a child's behavior with the parent or with parental consent, refer the child for an educational evaluation or appropriate health care provider. Would prohibit a teacher from making a psychological or medical diagnosis of a behavioral condition or disorder or recommending a psychotropic drug.
Mississippi	**MS HB 40** Would require physicians and psychiatrists who diagnose any child with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) to report the total number of those children to the respective school districts where the children attend school.
New Hampshire	**NH HB 551 (Signed by governor June 15, 2004. Chapter 237)** Establishes a committee to study the prescription and use of psychotropic drugs, including Ritalin, in childcare centers, preschools, and public schools, grades K through 12.
New York	**NY AB 3563** Would prohibit school personnel and school districts from suggesting or recommending the use of psychotropic drugs for students. **NY AB 5760 and SB 3458** Would direct the commissioner of education to establish rules and regulations prohibiting school personnel from recommending psychotropic drugs for children.
Oklahoma	**OK HB 2272** Would require the board of education to develop and implement policy prohibiting school personnel from recommending the use of psychotropic medication for any student. Would prohibit disciplinary action against the student and prohibit school personnel from making child abuse or neglect report to authorities based solely on the parent or guardian's refusal to administer or consent to the administration of such medications to the student. Would not prohibit teachers or other school personnel from consulting or sharing observations with parents or guardians regarding the

	academic performance or behavior of the student, or regarding the need for evaluation for special education. Would not prohibit a school district from making available to an interested parent or guardian a list of resources and services.
Pennsylvania	**PA HB 996** Would direct each board of school directors to adopt and implement a policy prohibiting any school personnel from recommending the use of psychotropic drugs for any child. Would not prohibit any staff from recommending that a child be evaluated by appropriate medical practitioner or consulting with a medical practitioner with the consent of the parent's or guardian of the child. **PA HB 1016** Would prohibit a school official or employee from recommending that a student use any psychotropic or sympathomimetic drugs. Would not prohibit staff from recommending an evaluation of a child by an appropriate medical practitioner or school personnel from consulting with the medical practitioner with the consent of the student's parents.
Tennessee	**TN HB 663 and SB 547** Would prohibit administration of any psychotropic drug to a student in public elementary or secondary school unless the school has obtained authorization and direction from the student's physician. Would require that the departments of health and education adopt rules and regulations to govern the administration of psychotropic drugs to pupils in public schools. **TN HB 708 and SB 635** Supports the creation of a statewide task force to discuss and resolve matters relative to the usage of ritalin in schools. Would prohibit a local education agency from recommending the use of psychotropic drugs to treat children in elementary or secondary schools until said task force has been formed and issued a repot regarding the use of psychotropic drugs to treat students with behavioral disorders. Would allow a school's medical staff to recommend medical evaluation of a student with the parent's or legal guardian's consent. **TN SB 636 and HB 707** Would prohibit an employee or person under contract with a local board of education from recommending the use of psychotropic drugs to treat children enrolled in elementary or secondary schools. Would allow a school's medical staff to recommend appropriate medical evaluation of a student with the parent's or legal guardian's consent.
Vermont	**VT HB 706** Would prohibit public schools from requiring a child to take psychotropic drugs as a condition of attending school; creates an informed consent process for parents or guardians regarding the use of psychotropic drugs prescribed to children; prohibits social and rehabilitation services from taking custody of a child because a parent or guardian refuses to administer such drug to the child; directs the commissioner of health to conduct an annual assessment of the prescribing patterns of psychotropic medications to school-age children and to study the feasibility of creating a statewide pharmacy database. **VT SB 30**

	Would prohibit schools from requiring that a child take a sympathomimetic medication, such as Ritalin, as a condition of attending school. Would allow a medical inspector or a teacher to recommend that a child be evaluated by an appropriate medical practitioner; however, a parent or guardian may agree or disagree to allow the child to take the medication.
Washington	**WA HB 2571 and SB 6289** Would direct public and private schools to implement a policy that prohibits school personnel from recommending the use of psychotropic drugs for any child. They may recommend an evaluation be conducted by a licensed physician if they perceive the child may have a behavioral or psychological problem.

If there are any errors or omissions, please feel free to contact the Adolescent and School Health Project.

Return to Adolescent and School Health Menu Page

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California Initiative

SA2005RF0055

American Family Rights Association

Fair Oaks, Ca | William O. Tower California Director | Sacramento
(916) 342-1700 P.O. Box 1582 Fair Oaks, California. 95628 (916) 966-8578
Www.familyrightsassociation.com wm.tower@sbcglobal.net

Promoting the Fundamental Liberty Rights & Privileges of Families

January 25, 2005

Honorable Bill Lockyer
Attorney General of California
1300 I Street, Suite 125
Sacramento, CA 94244

Attention: Trisha Knight
Initiative Coordinator
HAND DELIVERED

Dear Attorney General Lockyer:

This is a formal request to your office for a title and summary of the attached proposed initiative, which is supported by the American Family Rights Association.

It is our intention to place the initiative on the first available ballot – hopefully for a general election to be called in November of this year.

This proposed initiative would:

- Re-establish and affirm basic rights to the family unit – the parent and child.
- Provide parents the authority to object to and prevent mental health screening and evaluation of their children in public schools without informed consent.
- Prohibit Child Welfare Services or judicial officers from removing a child from the custody of their parent or guardian by virtue of a refusal of the parent to permit psychiatric drugging or treatment of their child.

There are no financial implications of this proposed initiative. It will not require any State funds to administer or implement. Rather, it affirms parental rights and prohibits the exercise of unlawful authority by state authorities.

Thank you for your prompt attention to this request.

Sincerely,

RECEIVED
JAN 25 2005
INITIATIVE COORDINATOR
ATTORNEY GENERAL'S OFFICE

William Tower
California Director,
American Family Rights Association
Proponent

SA2005RF0055

PARENT AND CHILD RIGHTS ACT

Section 1. Title

This Act shall be known and may be cited as the "Parent and Child Rights Act."

Section 2. Findings and Declarations

The People of the State of California hereby find and declare all of the following:

1. The Universal Declaration of Human Rights, the United Nations Convention on the Rights of the Child, the United States Constitution and the California Constitution, each establish and acknowledge the existence of basic human rights and civil rights guaranteed to all persons in our society. Among these are, as stated in the Convention on the Rights of the Child, that:

> Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.

2. However, the State of California, through acts by state school officials in screening and evaluating children for purported "mental disorders," by state and local Child Welfare Services employees by evaluating children for purported "mental disorders," and by state and local family courts, has stripped away and denied basic rights to many citizens. Worse, through the pretense of "protection" of children with psychological and psychiatric evaluation and treatment, these entities have denied basic rights to the most vulnerable persons in our society – our children.

3. Violations of the civil rights and human rights of children and their parents in California have caused considerable destruction to the basic building block of our society, illegally removing children from their parents' homes and their parents' care and nurturing, destroying families, and destroying futures of our children. Children removed to foster care or institutions are many times more likely to be abused and assaulted than those in the care of their own parents. Many children removed to foster care and institutional care are automatically labeled with purported psychiatric disorders and treated with psychiatric drugs.

4. Yet, the practice of psychiatry concedes that it is theoretical, that the purported "mental disorders" listed in psychiatric texts and manuals are purely subjective

evaluations. Psychiatric texts such as the Diagnostic and Statistical Manual of Mental Disorders, and purported psychiatric experts creating the parameters for mental disorders, concede that the existence of any actual mental illness cannot be proven with any medical or objective test. Thus, the designation of hundreds of supposed mental illnesses, including and especially those describing supposed conditions of children such as Attention Deficit Hyperactivity Disorder, are essentially a matter of belief and theory, but are not genuine science. Yet, psychiatric belief and theory has been adopted by California Child Welfare Service agencies, their employees and some courts as the only appropriate philosophy for child rearing. As a result, many parents with philosophical, ethical, religious and common-sense views of life and child rearing which conflict with the beliefs of psychiatry with its emphasis upon psychotropic drugs, have been targeted and they and their children punished for asserting beliefs disparate from psychiatric treatment and psychiatric drugging of our children.

5. However, the psychiatric model may be detrimental and dangerous to the welfare and even the life of the child. Many psychiatric drugs have been shown not only to be ineffective, but, according to the U.S. Food and Drug Administration and numerous studies and reports, a source of a host of deleterious physical and mental side effects including violence, hostility, suicidal and homicidal thoughts and aggressive behavior, drug dependence, and many physical illnesses.

6. Acting outside of any legitimate governmental authority, and in direct contravention of the Bill of Rights guaranteed by the United States Constitution, and international treaties, child protection services and social services employees in California, acting independently and in some cases, in concert with family courts, have removed thousands of children from their homes because their parents disagreed with the provision of dangerous psychiatric drugs to their children. California authorities, viewing parents' beliefs of child rearing antagonistic to psychiatric theory and to constitute a "threat" to the child, have removed thousands of children from the loving care of their parents and siblings solely because of their parents' disagreement with psychiatric practice and the mental illness model theorized by psychiatry.

7. Acting outside of any legitimate governmental authority, and in direct contravention of the Bill of Rights guaranteed by the United States Constitution, and international treaties, employees of public school have implemented psychological and psychiatric screening and evaluation, often without parental consent and typically without genuine informed consent. Such subjective screening and evaluation of children has caused many children to acquire denigrating and damaging labels of mental illness they carry with them for a lifetime, and causing them to receive unnecessary and dangerous psychiatric drugs and treatments.

Section 3. <u>Purpose and Intent</u>.

Section 304.8 of the Welfare and Institutions Code is added as follows:

Parent and Child Rights Act

The People of the State of California hereby declare their purpose and intent in enacting this Act to be as follows:

1. To preserve for children and parents of California, basic human rights, and civil rights guaranteed t_ all persons in our society.

2. To proclaim that the theory and philosophy of modern psychiatry is not senior to the rights of parents to have and rear children and to do so within the context of their own peaceful philosophic, religious and common-sense mores.

3. To provide full and complete due process of law for parents and children within our state.

Section 4. <u>Definitions</u>

Section 304.9 of the Welfare and Institutions Code is added as follows:

For the purposes of Parent and Child Rights Act:

"Due process" includes all rights, privileges, immunities and procedures guaranteed to all citizens in accordance with the United States Constitution, the California Constitution, the California Code of Civil Procedure and the California Code of Criminal Procedure, including, but not limited to, a full and fair noticed hearing, cross-examination of witnesses, discovery, habeas corpus, rights against warrantless search and seizure and expedited appeal.

"Child Welfare Services" means all agencies and employees of California state or county or local agencies that perform child protective services or child welfare service, whether designated as that name or not, and social welfare agencies with child protection functions.

"Psychiatric drugs" is defined as any prescription medication intended to affect mental, rather than physical functioning. The definition includes any prescription substance employed to control, manage or in any way affect a

purported mental health condition, disorder and/or syndrome as defined in the Diagnostic and Statistical Manual of Mental Disorders and/or the Mental Health Disorders section of the International Classification of Diseases. This specifically includes but is not limited to the drug classes known as Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants, neuroleptic or anti-psychotic drugs and psychiatric stimulants.

Section 5. <u>Limitations of Child Welfare Services and Other Social Welfare Agencies' Activities</u>

1. Section 300 of the Welfare and Institutions Code describes the several categories of children who fall within the jurisdiction of the juvenile court for the purpose of being adjudged to be a dependant of the Court. One such category, set forth in Section 300(c) of the Welfare and Institutions Code, now states:

> "The child is suffering serious emotional damage, or is at substantial risk of suffering serious emotional damage, evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, as a result of the conduct of the parent or guardian or who has no parent or guardian capable of providing appropriate care. No child shall be found to be a person described by this subdivision if the willful failure of the parent or guardian to provide adequate mental health treatment is based on a sincerely held religious belief and if a less intrusive judicial intervention is available"

Section 300(c) is amended to delete the first sentence, and to amend the second sentence as follows:

> No child shall be found to be a person described by this subdivision if the alleged willful failure of the parent or guardian to provide adequate mental health treatment is based upon the refusal of the parent or guardian to give the child psychiatric medication, or to permit mental health treatment of the child.

2. Section 300(l) of the Welfare and Institutions Code, is added as follows:

> No Child Welfare Services employee may institute any formal action or proceeding against a parent and/or guardian as defined in Section 300 of the Welfare and Institutions Code for the refusal of the parent or guardian to give the child psychiatric medication or refusal to permit psychological or psychiatric screening, evaluation or treatment.

2. Section 300(m) of the Welfare and Institutions Code, is added as follows:

> Violation of Section 300(l) by any Child Welfare Service official or employee shall be a misdemeanor, conviction of which shall be subject to a fine for each violation of no less than $500 and no more than $5,000, and imprisonment for a period of 15 to 30 days.

Section 6. Limitations of Public Educational Facilities and Employees

Section 285 is added to Article 12, Chapter 2, Part 1, Division 1 of Title 1 of the Education Code as follows:

> 285(a). No public educational facility or employee thereof may require any child enrolled in the school or facility to receive mental health, psychological or psychiatric screening, evaluation or treatment, without informed written consent of both parents or guardians of the child.
>
> 285(b) "Informed written consent" for mental health screening, evaluation or treatment, means written consent only after full written disclosure including, but limited to the nature, details, scope and purpose of any screening, evaluation or treatment, including identification of the person or persons who would perform such screening or evaluation, the proponent of the screening or evaluation procedure, to whom the child could be referred as a result of the screening, and the sources of funds for the screening or evaluation.
>
> 285(c) Violation of Section 285(a) or (b) by any public school official or employee shall be a misdemeanor, conviction of which shall be subject to a fine for each violation of no less than $500 and no more than $5,000, and imprisonment for a period of 15 to 30 days.

Section 7. Limitations of Orders by Judicial Authorities

Section 304.7 (d) is added to the Welfare and Institutions Code as follows:

> (1) No court or judicial officer may order the removal of a parent or legal guardian from custody and control of a child based upon a refusal of the parent or guardian to give psychiatric drugs to the child.
>
> (2) No court or judicial officer may remove a parent or legal guardian from custody and control of a child based upon a refusal of the

parent or guardian to permit psychological or psychiatric screening, evaluation or treatment.

(3) No court or judicial officer may remove a parent or legal guardian from custody and control of a child without full and fair due process of law, including, if the parent chooses, a public proceeding.

Section 8. Conflicts of Law

To the extent any part of this Act contravenes or conflicts with any other law respecting the rights of parents to control upbringing of their child, the purported need for psychiatric treatment or medication, the authority of Child Welfare Services, or involuntary commitment laws affecting children, this Act controls.

Section 9. Amendment or Supplementation

This Act shall be broadly construed to accomplish its purposes. The provisions of this Act may be amended by a two- thirds vote of the Legislature so long as such amendments are consistent with and further the intent of this Act. The Legislature may by majority vote add provisions to clarify procedures and terms including the procedures herein, location of the statutes in the California Code, and pass specific statutes to effectuate the purposes stated herein.

Section 10. Constitutionality

If any provision of this Act is held to be unconstitutional or invalid for any reason, such unconstitutionality or invalidity shall not affect the validity of any other provision.

Section 11. Retroactivity

The rights guaranteed herein shall be retroactive with respect to any pending action or proceeding. The penalties for violations of this Act shall not be retroactive.

Section 12. Effective date

The provisions of this Act shall be effective immediately upon passage thereof by the people.

Medical Research

The Center for Health and Health Care in Schools
The School of Public Health & Health Services
THE GEORGE WASHINGTON UNIVERSITY

Psychotropic Drugs and Children
Use, Trends, and Implications for Schools

Revised December 2004

What the research tells us

Background

The safe and effective use of medications for the treatment of certain medical conditions and illnesses has enabled many children to attend school and achieve academic success.[1] In medical practice, widespread acceptance of drug therapy for behavioral disorders has facilitated diagnosis and treatment of these conditions in ambulatory care.[2]

Recent increases in the use of psychotropic medications by children and adolescents, limited information on the benefits of these therapies for children, and concerns about the adverse consequences of certain drugs have prompted the U.S. Food and Drug Administration to revise their guidance for prescribers and patients. Because some of these drugs will be brought to school for administration during the school day, the Center has developed this fact sheet to summarize key information on the topic.

Please see details of new FDA safeguards on the next page of this Fact Sheet.

Emotional and Behavioral Health Problems Among Children

- Of the population ages 9 – 17, an estimated 21 percent experience the signs and symptoms of a *DSM-IV* disorder in the course of the year, 11 percent experience significant impairment, and 5 percent experience extreme emotional impairment.[3]
- Results of a national survey of pediatricians showed that 19 percent of pediatric visits involved a psychosocial problem requiring attention or intervention. Psychosocial problems are the most common chronic condition for pediatric visits, eclipsing asthma and heart disease.[2]
- Almost 5 million children 3 – 17 years of age (8%) have been identified as having a learning disability (such as dyslexia). An estimated 4 million children (6%) have been identified as having attention deficit hyperactivity disorder (ADHD). Ten percent of boys had a learning disability, compared with 6 percent of girls; 10 percent of boys had ADHD compared with 4 percent of girls.[4]
- The combined prevalence of anxiety disorders is higher than that of all other mental disorders of childhood and adolescence. The 1-year prevalence in children ages 9 – 17 is 13 percent.[3]
- Depression estimates vary but a recent report indicates that depression is present in 1 percent of children and 5 percent of adolescents at any given time. Before puberty, boys and girls are at equal risk for depression, after puberty onset the rate of depression is twice as high for girls.[5]
- Conduct disorder, or oppositional defiant disorder, affects 1 to 4 percent of 9- to 17-year-olds. Children with conduct disorder act out their feelings or impulses in destructive ways, including aggression, lying, theft, setting fires, and vandalism, the degree of offense growing more serious over time.[6]

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FDA Launches a Strategy to Strengthen Safeguards for Children Treated with Antidepressant Medications[7]

Treatment: What we know

- The effectiveness of stimulants for short-term treatment of attention deficit-hyperactivity disorder is well documented. A smaller number of studies demonstrates that stimulants or stimulants in combination with behavioral treatments produce long-term improvements when the drug continues to be taken.[8]

- The effectiveness of selective serotonin reuptake inhibitors (SSRIs) and clomipramine [Anafranil] for obsessive-compulsive disorder (OCD) has been indicated by a number of studies. In 1999, the US Food and Drug Administration approved the use of two SSRIs, fluvoxamine [Luvox] and sertraline [Zoloft], for use in pediatric OCD. Fluoxetine [Prozac] also is approved for use in pediatric OCD.[8]

- The use of antidepressants to treat major depression in children and adolescents has been controversial. Many studies of antidepressant treatment of major depression among adolescents have shown these agents to be only modestly effective.[9] Additional concerns have focused on possible associations between antidepressant drug use and increases in serious depression and suicide attempts. However, a recent large study by the National Institute of Mental Health concluded that Prozac, which is approved for treatment of depression in pediatric patients, paired with cognitive behavioral therapy (a form of talk therapy) was most successful in helping 71 percent of the study's teenagers overcome depression. The Treatment for Adolescents with Depression Study also showed that Prozac alone was effective in 61 percent of subjects, while talk therapy alone worked with 43 percent. Thirty-five percent of those who received a placebo also improved. Researchers found that patients became significantly less suicidal, no matter which treatment they were given.[10]

- FDA Safeguards. On October 4, 2004, the FDA issued a public health advisory announcing that a "black box" warning and expanded cautionary statements will be required on the labels of all antidepressants, to alert prescribers to an increased risk of suicidal thinking and behavior in pediatric patients treated with antidepressant medication. In addition, the FDA cautions that pediatric patients should be "closely observed" for signs of worsening illness, or agitation, irritability, suicidality, and unusual changes in behavior, especially during the initial few months of a course of medication, or at times of dose changes. Patients will also receive a MedGuide with their prescription, informing them of the risks associated with taking antidepressant medication.[11]

- An NIMH-funded study to test the efficacy and safety of medications commonly used by practitioners to treat children and adolescents (in off-label applications), found that fluvoxamine [Luvox], an SSRI antidepressant approved for treating OCD in children, was both safe and effective in treating social phobia, separation anxiety disorder, and generalized anxiety disorder in children 6 to 17 years of age.[12]

- Data reported by a pharmacy benefits manager indicated that, among children and youth taking at least one medication overall, the percentage taking one or more prescription drugs to treat behavioral and emotional health problems reached nearly 9%.[13] Another study documented rapid growth in the use of antidepressants.[9] See table below.

Antidepressant Prescriptions Among Commercially Insured School-Age Children and Youth[9]

	Percent of children & youth prescribed antidepressants		
	1998	2000	2002
Preschool (<5 years)			
Girls	.08	.12	.16
Boys	.14	.14	.23
Elementary (6-10 years)			
Girls	.57	.72	.84
Boys	1.21	1.18	1.60
Middle school (11-14 years)			
Girls	1.44	1.63	2.36
Boys	2.56	2.64	3.12
High school (15-18 years)			
Girls	3.74	4.73	6.36
Boys	3.00	3.49	4.23

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Definition

Psychotropic drugs are those that affect the function, behavior, or experience of the mind.[14] While their exact mechanism of action is not known, psychotropic drugs are thought to act upon the biochemistry of the brain and positively affect thinking mechanisms, emotional control, mood, and other behavioral processes. Included are neuroleptics (such as Haldol), antipsychotics (such as Zyprexa), antidepressants (such as Prozac), stimulants (such as Ritalin), and antianxiety agents (such as BuSpar).[14]

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26 Paxil [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 2003.

27 Zoloft [package insert]. New York, NY: Roerig, Division of Pfizer, Inc; 2002.

28 Celexa [package insert]. St. Louis, MO: Forest Pharmaceuticals, Inc; 2002.

29 Luvox [package insert]. Marietta, GA; Solvay Pharmaceuticals, Inc; 2000.

30 Anafranil [package insert]. St. Louis, MO: Mallinckrodt Inc; 2004.

Psychotropic Drugs That May Be Encountered in the Health Suite

* Symptoms associated with diagnosis.

** Observed effects of medication (side effects), improper dosing, medication conflicts, missed doses, discontinued medication, or individual adverse reactions.

Drug	Symptoms *	What To Watch For **
Drugs used for ADD and ADHD, including stimulants and non-stimulants		
STIMULANTS Ritalin, Methylin, Focalin, Concerta, Metadate, (methylphenidate in various forms for administration) Adderall, Dexedrine (amphetamine and dextroamphetamine in various forms) Cylert (pemoline)	Inattention, distractibility, agitation, behavior problems Impulsiveness; hyperactivity[19] Symptoms of **inattention** include making careless mistakes, lack of sustained attention, not listening, failing to finish tasks, poor organization, failing to follow directions, avoiding tasks requiring sustained mental effort, forgetting, losing things, and being easily distracted.[19,20] Symptoms of **hyperactivity** and **impulsiveness** include at least six of the following: fidgeting or squirming, leaving the seat, talking excessively, running or climbing at inappropriate times, difficulty with quiet activities, inability to wait for a turn, blurting out answers, and interrupting others.[19,20] Some patients have more symptoms of hyperactivity and impulsiveness while others have more symptoms of inattentiveness. Some patients have all 3 types of symptoms.[19,20]	Nervousness, insomnia, decreased appetite, weight loss, headaches, stomachaches, skin rash, jitteriness, and social withdrawal.[21] Rare adverse events can include tachycardia, blood pressure changes, nausea, dizziness, and palpitations.[22] Overdose is characterized by vomiting, agitation, tremors, muscle twitching, convulsions, hallucinations, delirium, sweating, and cardiac arrhythmias. Contact a poison control center.[20]
NON-STIMULANT Strattera (atomoxetine)	Symptoms of ADD and ADHD, above	Headache, nasal symptoms; nausea, vomiting, and stomach pain, dizziness, tiredness; mood swings.[21] Irritability insomnia, sedation; blood pressure effects.[21] Weight loss may occur early, followed by weight gain.[21]
SSRI Antidepressants for depression, mood disorders, obsessive-compulsive disorder		
Prozac (fluoxetine) This is the only SSRI currently FDA-approved for use with depression in pediatric populations. Prozac also is approved for pediatric OCD[25] Paxil (paroxetine), Zoloft (sertraline), Celexa (citalopram), Luvox (fluvoxamine maleate, generic), approved for pediatric OCD[29] Anafranil (clomipramine), approved for pediatric OCD[30]	**Depression**—Prominent and relatively persistent depressed mood that usually interferes with daily functioning, and includes at least five of the following nine symptoms: depressed mood; loss of interest in usual activities; significant change in weight and/or appetite; insomnia or hypersomnia; psychomotor agitation or retardation; increased fatigue; feelings of guilt or worthlessness; slowed thinking or impaired concentration; a suicide attempt or suicidal ideation.[24] **Obsessive-compulsive disorder**—Recurrent and persistent ideas, thoughts, impulses, or images (obsessions) that are ego-dystonic and/or repetitive, purposeful, and intentional behaviors (compulsions) that are recognized by the person as excessive or unreasonable.[24] **Panic disorder**—Occurrence of unexpected panic attacks, and associated concern about having additional attacks, worry about the implications or consequences of the attacks, and/or a significant change in behavior related to the attacks.[24]	Anxiety, nervousness, insomnia. Mania, agitation, decreased appetite. Rash or hives; thoughts of suicide, attempted suicide, or actual suicide; in rare cases, seizure.[21,25,26,27,28,29,30] A recent public health advisory from the FDA cautions that patients beginning treatment with antidepressant medication—or having their dose adjusted up or down—should be closely observed for any worsening of the illness, as well as agitation, irritability, suicidality (suicidal thinking or behavior), and any unusual changes in behavior.[11]

References, cont.

[31] BuSpar [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; 2000.
[32] Wellbutrin [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 2002.
[33] National Library of Medicine Medline Plus. Propranolol (Inderal) Drug Information. 2003. Accessed at http://www.nlm.nih.gov/medlineplus/druginfo/medmaster/a682607.html
[34] Effexor [package insert]. Philadelphia, PA: Wyeth Laboratories, Inc; 2001.
[35] Risperdal [package insert]. Titusville, NJ: Janssen Pharmaceutica Products, Inc. 2003.
[36] National Institute of Mental Health: *Child and Adolescent Bipolar Disorder.* Bethesda, MD: NIMH; 2000. Pub. #00-4778.
[37] Depakote [package insert] North Chicago, IL: Abbott Laboratories; 2003.
[38] Spearing M. National Institute of Mental Health. *Eating Disorders.* Bethesda, MD: NIMH; 2001. Pub. #01-4901.

Drug	Symptoms *	What To Watch For **
Other psychotropic drugs used to manage ADD/ADHD, anxiety, or depression		
BuSpar (buspirone)	Symptoms of anxiety: shakiness, jumpiness, trembling, tension, muscle aches, fatigability; inability to relax, twitching, fidgeting, restlessness, easy to startle. Also sweating, heart pounding; apprehensiveness; vigilance; Generalized Anxiety Disorder (GAD).[31]	Dizziness, nausea, headache, nervousness, lightheadedness, and excitement; slowness or sedative effect.[31]
Wellbutrin, Zyban (buproprion)	Depression, as defined above[32]	Agitation, anxiety, insomnia; hypertension; possible hallucinations or delusions. Weight loss. Dose-related risk of seizure.[32]
Inderal (propranolol)	Anxiety, nervous tension; panic attacks. Aggressive behavior	Dizziness, insomnia, excessive tiredness, upset stomach, vomiting, rash, diarrhea; difficulty breathing, sore throat, unusual bleeding, swelling of feet or hands, slow heartbeat, chest pain.[33]
Effexor (venlafaxine)	Depression, as defined above	Dizziness, drowsiness; trouble with sleep, difficulty breathing, cold hands / feet, hallucinations, irregular heartbeat; hypertension. In rare cases, fever, depression.[21,34]
Atypical Antipsychotics used in psychotic disorders and dementia		
Risperdal (risperidone), Clozaril (clozapine), Zyprexa (olanzapine), Seroquel (quetiapine)	Indicated for schizophrenia, bipolar disorder, mania; the drugs have not been tested in children but may be prescribed off-label for certain cases with multiple conditions occurring together.	Hyperglycemia, diabetes mellitus; hypotension; cognitive and motor impairments. Rare: serious cardiac and neuromuscular effects.[35]
Mood Stabilizers used for bipolar disorder and mania		
Lithobid, Lithostat (lithium carbonate); Depakote, Depakene (valproate)	Severe changes in mood—extremely irritable to overly silly—overly inflated self-esteem; increased energy, decreased need for sleep; talkativeness, distractibility; hypersexuality; increased goal-directed activity or agitation.[36]	Nausea, drowsiness, dizziness, vomiting, abdominal pain; headache; tremor. Severe abdominal pain, nausea, and vomiting may be symptomatic of rare but severe pancreatitis and liver disease.[37] Do not take aspirin with Depakote.
Drugs used with eating disorders, specifically bulimia nervosa and binge-eating disorder; occasionally in anorexia nervosa, after weight regain		
Prozac (fluoxetine) Other SSRIs or SNRIs may be used	**Bulimia nervosa**—Recurrent episodes of binge eating, followed by forced purging through self-induced vomiting, or use of laxatives, diuretics, enemas, or other medications; fasting; excessive exercise.[38] **Binge-eating disorder**—Uncontrolled eating (often rapidly and in great quantities) without forced purging or compensating behavior.[38] **Anorexia nervosa**—Abnormal restriction of eating due to intense fear of gaining weight or becoming fat; resistance to maintaining weight at or above a minimally normal weight for the age and height.[38]	Denial of illness, refusal to maintain treatment; may require hospitalization.[38] Side effects: Impaired judgment, thinking, motor skills; anxiety, nervousness, insomnia; mania; agitation; decreased appetite; rash or hives; seizure; thoughts of suicide, attempted suicide, or actual suicide.[11,25] In anorexia, psychotropic medication used only after weight regain established.[38]

References, cont.

14 Ayd F. *Lexicon of Psychiatry, Neurology, and the Neurosciences.* 1995. Baltimore: Williams & Wilkins.

15 US General Accounting Office. *Attention Disorder Drugs: Few incidents of diversion or abuse by schools.* 2001. GAO Report 01-1011. Accessed at http://www.gpoaccess.gov/gaoreports/search.html

16 Brener ND, Burstein GR, DuShaw ML, Vernon ME, Wheeler L, Robinson J. Health Services: Results from the School Health Policies and Programs Study 2000. *J Sch Health.* 2001;71(7):294-303.

17 Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE. *Ecstasy use falls for second year in a row, overall teen drug use drops* [press release]. Ann Arbor: University of Michigan News and Information Services; December 19, 2003. Accessed at http://www.monitoringthefuture.org, June 4, 2004.

18 AAP Policy Statement—Guidelines for the Administration of Medication in School. *Pediatrics.* 2003;112(3):697-699.

Schools and Medication Administration

- 37 states and the District of Columbia have statutes, regulations, and/or mandatory or recommended policies addressing medication administration at school.[15]

- A US General Accounting Office survey reported that 90% of the schools it had surveyed received district regulations or policies regarding the administration of prescription medications.[15]

- Most schools report keeping medications in a locked space.[15] 74% of schools report having a medical supply cabinet with a lock.[16] A recent study found that 96% of schools report that students are observed when ADHD medications are administered.[15] In 2003, the annual prevalence of illegal use of Ritalin was reported as 2.6% among 8th graders, 4.1% among 10th graders, and 4.0% among 12th graders.[17]

- In response to Congressional concerns regarding the diversion or abuse of stimulant medications (e.g., Ritalin) in school, a federal agency conducted a study and concluded that schools had identified few incidents of abuse or diversion.[15]

Who Dispenses Medications at School?[15]

Personnel	Percent approved to administer attention disorder medication*	Percent most often administering attention disorder medications**
Nurse	75	59
Other health care personnel	13	7
Principal	32	2
Teacher	12	2
Other, non-health care personnel	51	28
Students self-administer	6	1

* The column does not total 100% because more than one person may be approved to dispense medication
** The column total does not equal 100% because of rounding.

Role of Schools: What parents and school staff need to know[1, 18]

- Know the policies of your state and local governments as well as school board regarding the administration of medications in school, whether psychotropic medication or other.

- Learn about the drugs being administered to students—at home and at school—whether school staff are doing the dosing or not.

- Get to know the resources on pediatric antidepressants offered by the US FDA, especially those available on the FDA Web site, and be aware of public health advisories issued by the agency. This information is available at http://www.fda.gov/cder/drug/antidepressants/default.htm.

- Make yourself aware of the possible side effects of the drugs being administered; learn to recognize symptoms of missed doses or overdosage.

- Have an emergency plan for each student taking psychotropic medications, in case there is ever a need to use one.

The Five Rights
of medication administration

- **The right patient**
- **Receives the right drug**
- **In the right dose**
- **By the right route**
- **At the right time.**

References, cont.

[39] US Food and Drug Administration. FDA Proposed Medication Guide: About using antidepressants in children or teenagers. October 21, 2004. Accessed at http://www.fda.gov/cder/drug/antidepressants/SSRIMedicationGuide.htm, November 10, 2004.

Role of Schools: What school staff needs to do [1, 11, 18, 39]

- Keep medications in a locked cabinet (or a locked refrigerator) in a secure place.
- Require that medications be delivered to school in the original prescription container, bearing the student's name, the dosing and frequency, the physician's name, a copy of the package insert, and a copy of the MedGuide, now to be included with all prescriptions for antidepressants.
- Ask parents to notify the school when dosing begins, when any changes or adjustments are made to dosing, or when medication is changed or discontinued. These are the times when the child or adolescent is most likely to experience changes or additional effects of the medication.
- Whenever possible, talk with the prescribing physician directly, to maximize accuracy. If you observe any of the behavioral warning signs—worsening illness, or agitation, irritability, suicidality, and unusual changes in behavior—contact the physician or parent immediately.
- Keep careful records of all administration of medication. Some schools use a signature and log form, others track administration with a computer program.
- Safeguard the privacy of students and protect them from any stigma that may be associated with the administration of medications during school hours.

Resources

The American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
202-966-7300
www.aacap.org

Bright Futures
The American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
847-434-4000
http://brightfutures.aap.org/web/

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22207-3901
703-907-7300
www.psych.org/

The American Psychiatric Nurses Association
1555 Wilson Blvd., Suite 515
Arlington, VA 22209
703-243-2443
www.apna.org

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
800-374-2721
800-964-2000
www.apa.org

Attention Deficit Information Network
475 Hillside Avenue
Needham, MA 02194
781-455-9895
www.addinfonetwork.org

Center for Health and Health Care in Schools
The George Washington University
School of Public Health and Health Services
1350 Connecticut Ave., NW, Suite 505
Washington, DC 20036
202-466-3396
www.healthinschools.org

Healthy Youth Program
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, Georgia 30333
800-311-3435
404-639-3534
http://www.cdc.gov/HealthyYouth/index.htm

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 201
Landover, MD 20785
800-233-4050
www.chadd.org

Learning Disabilities Association of America
4156 Library Road
Pittsburgh, PA 15234
412-341-1515
www.ldaamerica.org

National Association of School Nurses
1416 Park Street, Suite A
Castle Rock, CO 80109
866-627-6767
303-663-2329
www.nasn.org

National Attention Deficit Disorder Association (ADDA)
1788 Second Street, Suite 200
Highland Park, IL 60035
847-432-2332
www.add.org

National Center for Learning Disabilities
381 Park Avenue South, Suite 1401
New York, NY 10016
888-575-7373
212-545-7510
www.ld.org

National Information Center and Youth with Disabilities (NICHCY)
P.O. Box 1492
Washington, DC 20013
800-695-0285
www.nichcy.org

National Institute of Mental Health (NIMH)
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
301-443-4513
www.nimh.nih.gov

US Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-0498
800-872-5327
www.ed.gov

US Food and Drug Administration
Center for Drug Evaluation and Research
5600 Fishers Lane
Rockville MD 20857-0001
888-INFO-FDA (888-463-6332)
http://www.fda.gov/cder/drug/antidepressants/default.htm

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December 2004

Federal Legislation

News from the
Committee on Education and the Workforce
John Boehner, Chair an

FOR IMMEDIATE RELEASE
May 21, 2003

CONTACTS: Alexa Marrero or
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House Overwhelmingly Votes to Protect the Rights of Parents and Children, Ensure Medication is not Forced on Students

WASHINGTON, D.C. – In an overwhelmingly bipartisan vote to protect the rights of parents and students, the U.S. House of Representatives today approved the Child Medication Safety Act (H.R. 1170), legislation that will ensure no parent is coerced into medicating a child in order for that child to attend school. The legislation, authored by Rep. Max Burns (R-GA), was approved by a vote of 425-1.

The bill requires states, as a condition of receiving federal education funds, to establish policies and procedures prohibiting school personnel from requiring a child to take medication in order to attend school. The legislation aims to ensure that no parent is forced to choose between their child receiving educational services, and being forced to medicate their child against their own judgment.

While the legislation protects the rights of parents and students, and prevents inappropriate medicating of children that can have a devastating effect on student health and well-being, it also carefully protects appropriate communication between parents and school personnel. The bill includes strong safeguards to preserve the parent-teacher communication that plays an important role in fostering strong academic achievement for children.

"The Child Medication Safety Act is straightforward, sensible legislation that aims to remedy this problem facing parents across the nation. This bipartisan bill is carefully crafted to preserve communication between school personnel and parent, but also protect parents from being coerced into placing their child on a drug in order to receive educational services," said Burns. "The goal is simple: empowering parents and protecting our children."

A measure similar to the Burns legislation was included as a non-controversial amendment to the reauthorization of the nation's special education law, the Individuals with Disabilities Education Act (IDEA), legislation approved by the House on April 30.

"As a former school teacher, I am sympathetic to need to have order in a classroom with as few disruptions as possible. However, it has been my experience that kids will be kids and there will always be children in the classroom who are overactive or inattentive," noted Speaker of the House J. Dennis Hastert (R-IL). "School personnel should never presume to know the medication needs of a child. Only medical doctors have the ability to determine if a prescription for a psychotropic drug is appropriate for a

child."

"We have heard from numerous parents and grandparents who have been coerced or pressured by school districts into placing their children on medication in order for those children to attend school or receive services," said Rep. John Boehner (R-OH), chairman of the Education & the Workforce Committee. "I recognize the difficulty that children with attention or behavior problems bring to a school, but no one should react by automatically assuming that the child should be on drugs. And certainly an individual without a medical license should not presume to understand the severity of a problem and simply assume that the child would be better off with drugs."

"The diagnosis of a disability or emotional or behavioral problem requires the careful examination by, and discussion with, a licensed medical practitioner," continued Boehner. "This bill protects that dialogue and ensures that parents are not forced to decide between their own preferences and a school official who is acting inappropriately."

A number of states have passed laws preventing school personnel from requiring that parents medicate their child in order to attend school. Connecticut, Minnesota, Illinois, and Virginia have passed such laws, and Georgia, Hawaii, North Carolina, Utah, and Texas have established Commissions or enacted resolutions to investigate this issue or encourage schools to use proven methods of addressing behavior problems instead of relying on medication.

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Press Releases

19-006

108TH CONGRESS

REPORT

HOUSE OF REPRESENTATIVES

1st Session

108-121
CHILD MEDICATION SAFETY ACT OF 2003

MAY 21, 2003- Committed to the Committee of the Whole House on the State of the Union and ordered to be printed
Mr. BOEHNER, from the Committee on Education and the Workforce, submitted the following
R E P O R T
[To accompany H.R. 1170]
[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 1170) to protect children and their parents from being coerced into administering psychotropic medication in order to attend school, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the `Child Medication Safety Act of 2003'.

SEC. 2. REQUIRED POLICIES AND PROCEDURES.

(a) IN GENERAL- As a condition of receiving funds under any program or activity administered by the Secretary of Education, not later than 1 year after the date of the enactment of this Act, each State shall develop and implement policies and procedures prohibiting school personnel from requiring a child to obtain a prescription for substances covered by section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) as a condition of attending school or receiving services.

(b) RULE OF CONSTRUCTION- Nothing in subsection (a) shall be construed to create a Federal prohibition against teachers and other school personnel consulting or sharing classroom-based observations with parents or guardians regarding a student's academic performance or behavior in the classroom or school, or regarding the need for evaluation for special education or related services under section 612(a)(3) of the Individuals with Disabilities Education Act (20 U.S.C. 1412(a)(3)).

SEC. 3. DEFINITIONS.

In this Act:

(1) CHILD- The term `child' means any person within the age limits for which the State provides free public education.

(2) STATE- The term `State' means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 4. GAO STUDY AND REVIEW.

(a) REVIEW- The Comptroller General of the United States shall conduct a review of--

(1) the variation among States in definitions of psychotropic medication as used in regard to State jurisdiction over public education;

(2) the prescription rates of medications used in public schools to treat children diagnosed with attention deficit disorder, attention deficit hyperactivity disorder, and other disorders or illnesses;

(3) which medications used to treat such children in public schools are listed under the Controlled Substances Act; and

(4) which medications used to treat such children in public schools are not listed under the Controlled Substances Act, including the properties and effects of any such medications and whether such medications have been considered for listing under the Controlled Substances Act.

(b) REPORT- Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit a report that contains the results of the review under subsection (a).

PURPOSE

H.R. 1170, the Child Medication Safety Act of 2003, addresses the significant concern that parents are being required to obtain a prescription for psychotropic medication for their child in order for the child to attend school or receive services. The bill protects parents from being forced by school personnel into medicating their child's under duress.

COMMITTEE ACTION

Subcommittee hearing

On Tuesday, May 6, 2003, the Committee on Education and the Workforce, Subcommittee on Education Reform, held a hearing in Washington, D.C. on `Protecting Children: The Use of Medication in Our Nation's Schools and H.R. 1170, the Child Medication Safety Act of 2003'. The purpose of this hearing was to gather information exploring the prevalence of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD), the appropriate role of prescription medication, and the concern that some school officials are coercing parents to place their child on a prescription for psychotropic medication in order to attend school. Testifying before the Subcommittee were the Honorable Katherine Bryson, State Representative in the Utah House of Representatives from Orem, Utah; Dr. William Carey, MD, Director of Behavioral Pediatrics at

The Children's Hospital of Philadelphia, Philadelphia, PA; and Dr. Lance Clawson, MD, Private Psychiatrist from Cabin John, Maryland.

Legislative action

On March 11, 2003, Representative Max Burns (R-GA) introduced H.R. 1170, the Child Medication Safety Act. This legislation would require States receiving federal education funds to set up policies and procedures prohibiting school personnel from requiring children to take drugs listed on Schedule II of the Controlled Substances Act in order to attend school or receive services.

On May 15, 2003, the Committee on Education and the Workforce considered H.R. 1170 in legislative session and reported it favorably, as amended, to the House of Representatives, by voice vote. The Committee considered three amendments and adopted the following two amendments.

The Committee adopted by voice vote an amendment in the nature of a substitute offered by Mr. Burns. The substitute expands the list of drugs covered by the bill to include all drugs covered under the Controlled Substances Act. The substitute also added a provision that allows

school personnel to consult with parents regarding classroom-based observations about the child's academic performance and behavior in the classroom while confirming that teachers and other school personnel continue to be able to refer children for evaluation as provided under the Individuals with Disabilities Education Act.

The Committee adopted by voice vote an amendment offered by Mrs. Musgrave requiring a GAO study to examine the use of psychotropic medication in schools and to report on whether such medications are listed under the Controlled Substances Act and the effect of non-scheduled medications. The study will provide a current review of all definitions States are using for psychotropic medications, what medications are being used in schools, and the prevalence of their use.

SUMMARY

H.R. 1170, the Child Medication Safety Act, requires States that receive any federal education funds to develop and implement policies and procedures that would prohibit school personnel from requiring a child to obtain a prescription for a controlled substance in ord to attend school.

COMMITTEE VIEWS

The Child Medication Safety Act of 2003 requires States, as a condition of receiving Federal education funds, to establish policies and procedures prohibiting school personnel from requiring a child to take medication in order to attend school. Only medical personnel have the ability to determine if a prescription for a psychotropic drug is appropriate for a child.

Testifying before the Subcommittee on Education Reform on May 6, 2003, Dr. William Carey stated that:

In the last two decades the United States has experienced a great increase in the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and its treatment with stimulants. Not only child health professionals but now also a wide variety of unqualified persons, such as preschool teachers and acquaintances, are freely offering the diagnosis and confidently urging parents to accept their judgment and obtain drug treatment, such as methylphenidate (Ritalin), for the child. . . . This chaotic situation urgently requires intervention at several levels, including the Federal government.

The Committee has been made aware of situations where parents have voiced concern that local educational agency officials have required them to place children on psychotropic medication in order to attend school or receive services. The Committee feels that school officials should not presume to know what medication a child needs, or if the child even needs medication. Representative Katherine Bryson testified to the Subcommittee on Education Reform that:

[S]chool personnel faced with children who often have not been properly taught to read, who may be coming to school on a breakfast of sugar or no breakfast at all, who could be affected by lead, mercury or other toxic substances--a plethora of explainable reasons--are assessing them in the classroom as having a `learning disorder' or Attention Deficit Hyperactivity Disorder (ADHD). From here, parents are being coerced into drugging their child with threats of the child's expulsion or charges of medical neglect by Child Protective Services against the parents who refuse to give or take their child off a psychiatric drug.

The Committee believes that only medical personnel have the ability to determine if a prescription for a psychotropic drug is appropriate for a child or if medication is appropriate at all.

Accordingly the bill requires States, as a condition of receiving any Federal education funds, to establish policies and procedures prohibiting school personnel from requiring a parent to obtain a prescription for their child for drugs listed under the Controlled Substances Act in order to attend school or receive services. The Controlled Substances Act regulates the manufacture and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the illicit production of controlled substances. The Controlled Substances Act places all regulated substances into one of five schedules. This placement is based upon a substance's medicinal value, harmfulness, and potential for abuse or addiction. Ritalin is listed on Schedule II of the Controlled Substances Act, and drugs are placed on that Schedule when: (A) The drug or other substance has a high potential for abuse; (B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; or (C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

Psychotropic drugs, such as Ritalin, can be beneficial to some individuals when properly diagnosed and the medication is properly administered and monitored. In testifying to the Subcommittee on Education Reform, Dr. Lawrence Clawson stated `research clearly demonstrates that medication can be an effective part of treatment for ADHD.' The Committee recognizes the validity of that research, but is concerned that too often the easy answer of medication is utilized as a response for too many children. As Dr. Carey noted, treatment is improved by educational as well as medical interventions.

The Committee also wants to stress the importance of open and effective communication between the parent and school officials (including teachers) regarding the needs of the child as a whole. In no way does the Committee intend for this legislation to stifle appropriate conversation between school officials and parents about the behavior and academic achievement of the child. School personnel spend many hours a day with a child and are able to observe a variety of situations and behaviors. When parents seek to discuss their child with a teacher or school official, school personnel should continue to be free to discuss their observations with the parent to ensure that the parent has sufficient information to make appropriate decisions about their child's medical needs. However, the Committee cautions that such discussion should be mutual consulting conversations that describe and identify areas of concern, but which are not followed by recommendations of school personnel that would be construed as a medical diagnosis or condition of attending school

The Committee has heard from many parents, teachers, and national organizations that feel that there must continue to be open lines of communication between school personnel and parents about the academic, behavioral, and health related needs of children. The Committee shares the concern of those organizations, but feels that this legislation walks a clear and carefully crafted line of ensuring that such communication can take place, while protecting parents from being coerced by school officials to place their child on a psychotropic drug in order for

the child to attend school or receive services.

The Committee recognizes that there is a need for greater information on this topic, and includes in the bill a requirement that the GAO issue a report examining the use of psychotropic medication in schools and to report on whether such medications are listed under the Controlled Substances Act and the effect of any non-scheduled medications. The study will provide a current review of all definitions States are using for psychotropic medications, what medications are being used in schools, and the prevalence of their use.

This is an important study that will help provide greater information to Congress and State and local educational agencies, as well as medical professionals, to improve the understanding of the types of medications that exist to treat children with attention deficit disorder, attention deficit-hyperactivity disorder, and other disorders or illnesses.

Summary

In recent decades, there has been a growing number of children diagnosed with attention deficit disorder (ADD) or attention deficit-hyperactivity disorder (ADHD) and then treated with medications such as Ritalin or Adderall. In many of these cases, school personnel freely offer diagnoses for these disorders and urge parents to obtain drug treatment for the child. Sometimes officials attempt to force parents into medicating their child in order for the child to continue going to school.

H.R. 1170 aims to remedy this significant problem. The goal of this Act is straightforward. It would require States to establish policies and procedures prohibiting school personnel from requiring a child to take medication in order to attend school. At the same time, this bill carefully preserves the teacher-parent communication that is essential to fostering strong academic achievement for children. The Committee believes that this bill takes important steps to protect children, and their parents, and sets up a good standard for States to follow.

SECTION-BY-SECTION ANALYSIS

Section 1. Short Title. Establishes the short title of the act to be the `Child Medication Safety Act of 2003.'

Section 2. Required Policies and Procedures. Establishes required policies and procedures prohibiting the requirement of a prescription, and includes a rule of construction regarding consulting on classroom-based observations.

Section 3. Definitions. Establishes definitions for the terms `child' and `state.'

Section 4. GAO Study and Review. Requires the Comptroller General of the United States to review definitions and usage of psychotropic medications.

EXPLANATION OF AMENDMENTS

The Amendment in the Nature of a Substitute is explained in the body of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104-1 requires a description of the application of this bill to the legislative branch. H.R. 1170, the Child Medication Safety Act, requires States that receive any federal education funds to develop

and implement policies and procedures that would prohibit school personnel from requiring a child to obtain a prescription for a controlled substance in order to attend school. The bill does not prevent legislative branch employees coverage under this legislation.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104-4) requires a statement of whether the provisions of the reported bill include unfunded mandates. H.R. 1170 requires States that receive any federal education funds to develop and implement policies and procedures that would prohibit school personnel from requiring a child to obtain a prescription for a controlled substance in order to attend school. As such, the bill does not contain any unfunded mandates.

CORRESPONDENCE

House of Representatives,

Committee on Education and the Workforce,

Washington, DC, May 20, 2003.

Hon. W.J. (BILLY) TAUZIN,
Chairman, Committee on Energy and Commerce,
Rayburn HOB, Washington, DC.

DEAR CHAIRMAN TAUZIN: I thank you for your May 20, 2003 letter, regarding H.R. 1170, the `Child Medication Safety Act of 2003', which was referred to the Committee on Education and the Workforce. The Education and the Workforce Committee ordered the bill favorably reported on May 15, 2003. I intend to file the report this week. I thank you for working with me regarding an amendment adopted in Committee, offered by Rep. Musgrave, which creates a new Section 4, GAO Study and Review, and requires the General Accounting Office to study various aspects of students on medication in our nation's schools. While the Energy and Commerce Committee holds a jurisdictional interest in Section 4, I appreciate your willingness to work with me in moving H.R. 1170 forward without the need for additional legislative consideration by your Committee.

I agree that this procedural route should not be construed to prejudice the jurisdictional interest and prerogatives of the Committee on Energy and Commerce over these provisions or any other similar legislation and will not be considered as precedent for consideration of matters of jurisdictional interest to your Committee in the future.

I thank you for working with me regarding this matter and look forward to continuing our work and cooperation on this bill and similar legislation. This letter and your response will be included in the Committee Report to accompany this bill. If you have questions regarding this matter, please do not hesitate to call me.

Sincerely,

John A. Boehner,

Chairman.

House of Representatives,

Committee on Energy and Commerce,

Washington, DC, May 20, 2003.

Hon. JOHN A. BOEHNER,
Chairman, Committee on Education and the Workforce,
Rayburn House Office Building, Washington, DC.

DEAR CHAIRMAN BOEHNER: On May 15, 2003, the Committee on Education and the Workforce ordered reported H.R. 1170, the Child Medication Safety Act of 2003. As ordered reported by your Committee, the legislation contains a requirement for a General Accounting Office study that falls within the jurisdiction of the Committee on Energy and Commerce.

Recognizing your interest in bringing this legislation before the House expeditiously, the Committee on Energy and Commerce agrees not to seek a sequential referral of the bill. By agreeing not to seek a sequential referral, the Committee on Energy and Commerce does not waive its jurisdiction over these provisions or any other provisions of the bill that may fall within its jurisdiction. In addition, the Committee on Energy and Commerce reserves its right to seek conferees on any provisions within its jurisdiction which are considered in the House-Senate conference, and asks for your support in being accorded such conferees.

I request that you include this letter as part of the report on H.R. 1170 and as part of the Congressional Record during consideration of this bill by the House.

Sincerely,

W.J. 'Billy' Tauzin,

Chairman.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause (2)(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

NEW BUDGET AUTHORITY AND CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of 3(c)(3) of rule XIII of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee has received the following cost estimate for H.R. 1170 from the Director of the Congressional Budget Office:

U.S. Congress,

Congressional Budget Office,

Washington, DC, May 16, 2003.

Hon. JOHN A. BOEHNER,
Chairman, Committee on Education and the Workforce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1170, the Child Medication Safety Act of 2003.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Donna Wong.

Sincerely,

Barry B. Anderson

(For Douglas Holtz-Eakin, Director).

Enclosure.

H.R. 1170--Child Medication Safety Act of 2003

H.R. 1170 would require states, as a condition of receiving funds, to develop and implement policies and procedures prohibiting school personnel from requiring a child to receive or take controlled substances as a condition of attending school or receiving services.

The bill would result in no significant cost to the federal government and would not affect direct spending or receipts. The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

The CBO staff contact for this estimate is Donna Wong. This estimate was approved by Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House rule XIII, the goal of H.R. 1170 is to require States that receive any federal education funds to develop and implement policies and procedures that would prohibit school personnel from requiring a child to obtain a prescription for a controlled substance in order to attend school. The Committee expects the Department of Education to comply with H.R. 1170 and implement the changes to the law in accordance with the changes.

CONSTITUTIONAL AUTHORITY STATEMENT

Under clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee must include a statement citing the specific powers granted to Congress in the Constitution to enact the law proposed by H.R. 1170. The Committee believes that the amendments made by this bill, which authorize appropriations for

education assistance, are within Congress' authority under Article I, section 8, clause 1 of the Constitution.

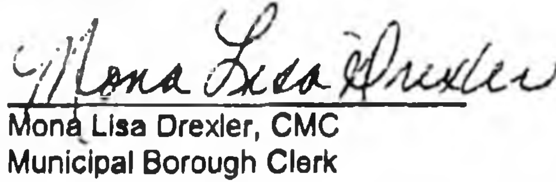
COMMITTEE ESTIMATE

Clause 3(d)(2) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison by the Committee of the costs that would be incurred in carrying out H.R. 1170. However, clause 3(d)(3)(B) of that rule provides that this requirement does not apply when the Committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act.

Fairbanks Borough Resolution

1 By: Bonnie Williams
2 Introduced: 04/14/05
3 Adopted: 04/14/05
4
5
6 FAIRBANKS NORTH STAR BOROUGH
7
8 RESOLUTION NO. 2005 - 23
9
10 A RESOLUTION OF SUPPORT ON PSYCHOTROPIC DRUGS AND CHILDREN
11
12
13 WHEREAS, the use of drugs to address behavioral problems in children
14 has become alarmingly prevalent; and
15
16 WHEREAS, some public schools have endorsed and enforced such
17 usage through recommendations, suggestions and other actions; and
18
19 WHEREAS, parents may be coerced into taking actions which are not in
20 the best interest of their child through untrained referrals; and
21
22 WHEREAS, recommendations, referrals and suggestions involving
23 behavioral problems should only involve trained personnel, parents and legal guardians,
24 and licensed physicians and psychiatrists; and
25
26 WHEREAS, the use of psychotropic drugs may be appropriate to help
27 some children; and
28
29 WHEREAS, there are no prohibitions in current state statutes prohibiting
30 coercion by school officials on parents and children involving psychotropic drugs; and
31
32 WHEREAS, proactive statutory limitations can prevent before a triggering
33 event and tragedy actually occurs.
34
35 NOW THEREFORE BE IT RESOLVED, that the Fairbanks North Star
36 Borough Assembly supports legislation, which addresses this issue in a manner that
37 leaves open the provision of informational resources, leaves untouched school authority
38 to maintain discipline, but which prohibits coercive actions by schools involving
39 psychotropic drugs.
40
41 BE IT FURTHER RESOLVED, that copies of this resolution be forwarded
42 to the Governor of the State of Alaska, and members of the Interior Delegation of the
43 Alaska State Legislature.
44
45
46

47 PASSED AND APPROVED THIS 14th DAY OF APRIL 2005.
48
49
50

51 Garry Hutchison
52 Presiding Officer
53
54 ATTEST:
55
56
57


58 Mona Lisa Drexler, CMC
59 Municipal Borough Clerk
60
61 Ayes: Romans, Bartos, Sattley, Rex, Williams, Hopkins, Aldridge, Frank, Hutchison
62 Noes: None

Proposed
Fairbanks School District Resolution

FAIRBANKS NORTH STAR BOROUGH BOARD OF EDUCATION
RESOLUTION 2005-?

A Resolution Concerning Use of Psychotropic Drugs

Draft

WHEREAS, the Fairbanks North Star Borough Board of Education is aware the use of drugs to address behavioral problems in children has become alarmingly prevalent; and

WHEREAS, there are documented incidents of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline which may be related to lack of academic success; and

WHEREAS, some public schools have endorsed and enforced such usage th[illegible]gh recommendations, suggestions and other actions; and

WHEREAS, recommendations, referrals and suggestions involving [illegible] oble[illegible] should only involve trained personnel, parents and legal guardia[illegible] [illegible] phys[illegible] and psychiatrists; and

WHEREAS, programs such as tutorin[illegible] ng [illegible]nics [illegible] guidance, medical examinations, allergy testing, standar[illegible] ciplir[illegible] pr[illegible]dures [illegible] other proven academic and/or classroom management soluti[illegible] o res[illegible] b[illegible]vior, attention, and learning difficulties known to be effective and h[illegible]less [illegible]ould [illegible] recommended to parents as their options; and

WHEREAS, at times, the use of psych[illegible]pic drugs may be appropriate to help some children; and

WHEREAS, there are no prohibitions in current state statutes prohibiting coercion by school officials on parents and children involving psychotropic drugs; and

WHEREAS, proactive statutory limitations can prevent before a triggering event and tragedy actually occurs;

NOW THEREFORE BE IT RESOLVED that the Fairbanks North Star Borough Board of Education supports legislation, which prohibits coercive actions by schools involving psychotropic drugs

PASSED AND APPROVED: _______________.

____
Bill Burrows, President
Board of Education

ATTEST:

____
Susan Bessette
Secretary to the Board

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB048-DHSS-OCS-03-31-06
(   ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: REFUSING PSYCHOTROPIC DRUGS AND TREATMENTS FOR CHILDREN

RDU: Children's Services

Component: Front Line Social Workers

Sponsor: DAVIS

Requester: SENATE (HES)

Component No. 2305

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

SB 48 proposes to accomplish three major things: 1) prohibit public schools from recommending mental health services and/or psychotropic medication for students; 2) prohibit public schools from reporting suspected abuse or neglect if the only concern is that a parent or guardian refuses to consent to proper mental health treatment for a child; and, 3) prohibit the DHSS from taking custody based solely on a parent or guardian's refusal to consent to proper mental health treatment for a child. There would be no fiscal impact to the department.

Prepared by: Tammy Sandoval, Deputy Commissioner — Phone 465-3191
Division: Office of Children's Services — Date/Time 03/31/2006

Approved by: Karleen Jackson, Commissioner — Date 03/31/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 48
() Publish Date:

Revision Date/Time (Note if correction):

Title: "An Act relating to recommending or refusing psychotropic drugs . . .
Sponsor: Davis
Requester: HESS

Dept. Affected: Education & Early Development
RDU: Teaching & Learning Support
Component: Student and School Achievement
Component No. 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	*	*	*	*	*	*
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF	*	*	*	*	*	*
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

POSITIONS	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 48 describes specific actions and communications in which school personnel may or may not engage related to psychiatric and behavioral evaluations and treatments. School personnel are prohibited from recommending or requiring that a child take or continue to take a psychotropic drug as a condition for attending school; conducting a psychiatric or behavioral evaluation of a child; recommending a specific physician, psychologist or other health specialist to a parent or guardian; recommending that the parent take a specific course of medical or psychiatric action; and reporting suspected child abuse or neglect based solely on whether a parent or guardian refuses to consent to a course of medical, psychiatric, psychological, or behavioral treatment or evaluation.

Costs for school districts to implement provisions of this bill are indeterminate.

Prepared by: Barbara Thompson, Director — Phone 465-8727
Division: Teaching & Learning Support — Date/Time 3/31/06 12:30 p.m.
Approved by: Karen Rehfeld, Deputy Commissioner — Date 03/31/2006
Agency: Education & Early Development

24-LS0208\Y
Mischel
4/11/06

CS FOR SENATE BILL NO. 48( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): **SENATOR DAVIS**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to recommending or refusing psychotropic drugs or certain types of**
2 **evaluations or treatments for children."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 14.30 is amended by adding new sections to read:
5 **Article 2A. Psychiatric and Behavioral Evaluations and Treatments.**
6 **Sec. 14.30.171. Prohibited actions.** Except as provided in AS 14.30.172 -
7 14.30.176, school personnel may not, unless otherwise authorized by law,
8 (1) recommend to a parent or guardian that a child take or continue to
9 take a psychotropic drug as a condition for attending a public school;
10 (2) require that a child take or continue to take a psychotropic drug as a
11 condition for attending a public school;
12 (3) conduct a psychiatric or behavioral health evaluation of a child;
13 (4) recommend a specific licensed physician, psychologist, or other
14 health specialist to a parent or guardian for a child,

1 (5) recommend that a parent or guardian seek or use for a child
2 (A) a psychotropic medication; or
3 (B) a psychiatric or psychological treatment; or
4 (6) make a report of suspected child abuse or neglect to authorities,
5 including the Department of Health and Social Services, based solely on the fact that a
6 parent or guardian refuses to give signed consent for
7 (A) the administration of a psychotropic drug to a child;
8 (B) a psychiatric, psychological, or behavioral treatment of a
9 child; or
10 (C) a psychiatric or behavioral health evaluation of a child.
11 **Sec. 14.30.172. Communication not prohibited.** (a) Nothing in AS 14.30.171
12 may be construed to prohibit school personnel from
13 (1) consulting or sharing classroom-based observations with parents or
14 guardians regarding a student's academic and functional performance, behavior in the
15 classroom or school, or regarding the need for evaluation for special education or
16 related services as long as school personnel do not
17 (A) make an assertion or recommendation that violates
18 AS 14.30.171; or
19 (B) denigrate, criticize, punish, or attempt to denigrate,
20 criticize, or punish, a parent, guardian, or child for a decision made by the
21 parent or guardian pertaining to whether the child takes, does not take, or
22 discontinues taking a psychotropic medication; or
23 (2) exercising their authority relating to the placement within the
24 school or readmission of a child who may be or has been suspended or expelled for a
25 violation of a school disciplinary and safety program adopted under AS 14.33.110 -
26 14.33.140.
27 (b) Nothing in AS 14.30.171 may be construed to prevent teachers or other
28 school personnel from complying with the requirements of AS 47.17.020.
29 **Sec. 14.30.174. Compliance with federal education law.** (a) Notwithstanding
30 AS 14.30.171(3) and (5), a behavioral or mental health professional working within a
31 public school system may, for the sole purpose of complying with federal education

1 law,

2 (1) recommend, but not require, a psychiatric or behavioral health
3 evaluation of a child;

4 (2) recommend, but not require, psychiatric, psychological, or
5 behavioral treatment for a child; and

6 (3) conduct a psychiatric or behavioral health evaluation of a child
7 with the consent of the child's parent or guardian.

8 (b) In this section,

9 (1) "behavioral health professional" means a person who has a master's
10 degree in psychology, social work, counseling, or a related field with specialization or
11 experience in working with children experiencing behavioral, physical, and emotional
12 disabilities, and is working within the scope of the person's training and experience;
13 "behavioral health professional" does not include a person employed as a teacher;

14 (2) "federal education law" means 20 U.S.C. 1400 - 1487 (Individuals
15 with Disabilities Education Act), 20 U.S.C. 7101 - 7143 (Safe and Drug-Free Schools
16 and Communities Act of 1994), 29 U.S.C. 794 (nondiscrimination under federal grants
17 and programs), and 42 U.S.C. 12101 - 12213 (equal opportunity for individuals with
18 disabilities);

19 (3) "mental health professional" has the meaning given in
20 AS 47.30.915.

21 **Sec. 14.30.176. List of community resources.** Notwithstanding
22 AS 14.30.171(4), a school district may make available to an interested parent or
23 guardian a list of community resources, including mental health services if the list
24 conspicuously states the following: "This list is provided as a resource to you. The
25 school neither recommends nor requires that you use this list or any of the services
26 provided by individuals or entities on the list. It is for you to decide what services, if
27 any, to use and from whom you wish to obtain them."

28 **Sec. 14.30.177. Violations.** (a) A violation of AS 14.30.171 - 14.30.176
29 constitutes substantial noncompliance with a school law of the state for purposes of
30 dismissal of a teacher under AS 14.20.170 or nonretention of a teacher under
31 AS 14.20.175.

1 (b) Each school board shall adopt a bylaw under AS 14.14.100 that provides
2 that violation of AS 14.30.171 - 14.30.176 is grounds for disciplinary action against a
3 person employed by the school district.
4 **Sec. 14.30.179. Definition.** In AS 14.30.171 - 14.30.179, "public school"
5 means a school operated by publicly elected or appointed school officials in which the
6 program and activities are under the control of those officials and that is supported by
7 public funds.

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PRINTTHIS

Uncle Sam wants you – well, not everyone in prime recruiting age group

By Pauline Jelinek
ASSOCIATED PRESS

9:33 a.m. March 12, 2006

WASHINGTON – Uncle Sam wants YOU, that famous Army recruiting poster says. But does he really?

Not if you're a Ritalin-taking, overweight, Generation Y couch potato – or some combination of the above.

As for that fashionable "body art" that the military still calls a tattoo, having one is grounds for rejection, too.

With U.S. casualties rising in wars overseas and more opportunities in the civilian work force from an improved U.S. economy, many young people are shunning a career in the armed forces. But recruiting is still a two-way street – and the military, too, doesn't want most people in this prime recruiting age group of 17 to 24.

Of some 32 million Americans now in this group, the Army deems the vast majority too obese, too uneducated, too flawed in some way, according to its estimates for the current budget year.

"As you look at overall population and you start factoring out people, many are not eligible in the first place to apply," said Doug Smith, spokesman for the Army Recruiting Command.

Some experts are skeptical.

Previous Defense Department studies have found that 75 percent of young people are ineligible for military service, noted Charles Moskos of Northwestern University. While the professor emeritus who specializes in military sociology says it is "a baloney number," he acknowledges he has no figures to counter it.

"Recruiters are looking for reasons other than themselves," said David R. Segal, director of the Center for Research on Military Organization at the University of Maryland. "So they blame the pool."

The military's figures are estimates, based partly on census numbers. They are part of an elaborate analysis the military does as it struggles each year to compete with colleges and companies for the nation's best and brightest, plan for future needs and maintain diversity.

The Census Bureau estimates that the overall pool of people who would be in the military's prime target age has shrunk as American society ages. There were 1 million fewer 18- to 24-year olds in 2004 than in 2000, the agency says.

The pool shrinks to 13.6 million when only high school graduates and those who score in the upper half on a military service aptitude test are considered. The 30 percent who are high school dropouts are not the top choice of today's professional, all-volunteer and increasingly high-tech military force.

Other factors include:

- the rising rate of obesity; some 30 percent of U.S. adults are now considered obese.

- a decline in physical fitness; one-third of teenagers are now believed to be incapable of passing a treadmill test.

- a near-epidemic rise in the use of Ritalin and other stimulants to treat attention deficit hyperactivity disorder. Potential recruits are ineligible for military service if they have taken such a drug in the previous year.

- Doctors prescribe these drugs to about 2 million children and 1 million adults a month, according to a federal survey. Many more are believed to be using such stimulants recreationally and to stay awake longer to boost academic and physical performance."

Other potential recruits are rejected because they have criminal histories and too many dependents. Subtract 4.4 million from the pool for these people and for the overweight.

Others can be rejected for medical problems, from blindness to asthma. The Army estimate has subtracted 2.6 million for this group.

That leaves 4.3 million fully qualified potential recruits and an estimated 2.3 million more who might qualify if given waivers on some of their problems.

The bottom line: a total 6.6 million potential recruits from all men and women in the 32 million-person age group.

In the budget year that ended last September, 15 percent of recruits required a waiver in order to be accepted for active duty services – or about 11,000 people of some 73,000 recruited.

Most waivers were for medical problems. Some were for misdemeanors such as public drunkenness, resisting arrest or misdemeanor assault – prompting criticism that the Army is lowering its standards.

This year the Army is trying to recruit 80,000 people; all the services are recruiting about 180,000.

And about the tattoos: They are not supposed to be on your neck, refer to gang membership, be offensive, or in any way conflict with military standards on integrity, respect and team work. The military is increasingly giving waivers for some types of tattoos, officials said.

- On the Net:
Defense Department career and aptitude exploration site: **www.asvabprogram.com**

Find this article at:
http://www.signonsandiego.com/news/military/20060312-0933-unclesamwantsyou.html

☐ Check the box to include the list of links referenced in the article.

Fairbanks Daily News-Miner

FYI

Councilman backs bill affecting psychotropic drugs in schools
By CHRIS ESHLEMAN
Staff Writer

Monday, April 10, 2006 - A Fairbanks City Council member is asking the council to support a bill in Juneau that seeks to bar employees in public schools in Alaska from recommending the use of psychotropic drugs by students.

While he thinks it is rare that schools would require children to take drugs like Ritalin or Adderall as a prerequisite of attending, Councilman Lloyd Hilling said he is concerned that school employees in Alaska can recommend parents put their children on the drugs without enough understanding of the possible and proven side effects psychotropics can have.

"Let's let scientific research prove these psychotropic drugs," Hilling said. "Meanwhile, let's not be pushing them."

Hilling has put forward a resolution to the council that, if approved, would support a bill introduced last year in the Alaska Legislature. The bill, sponsored by state Sen. Bettye Davis, D-Anchorage, would, in part, prohibit school employees from recommending that a child take a psychotropic drug as a condition for attending a public school.

The bill has not moved from the Senate since it was introduced over a year ago, but a Senate committee plans to hold a public hearing on it Wednesday.

In a sponsor statement on her bill, Davis said it is important that only physicians suggest the use of psychiatric medication. Davis said the use of the drugs in schools has increased rapidly in recent years, and points to parents' concern regarding the issue of diagnosis.

"There are documented incidences of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline," Davis' statement reads.

Hilling said the roles of schools in the prescription of psychiatric drugs has been a concern of his for years. A teacher at the University of Alaska Fairbanks and former teacher's aide, Hilling said he supports Davis' bill in part because it would help require parents around the state to go to doctors for advice without being biased through conversations with school employees.

Chris Eshleman can be reached at [illegible]59-7582 or ceshleman@newsminer.com .

Introduced by: Council Member Hilling
Date: April 10, 2006

RESOLUTION NO. 4208

A RESOLUTION IN SUPPORT OF SENATE BILL 48, WHICH WOULD PROHIBIT SCHOOL PERSONNEL FROM RECOMMENDING OR REQUIRING PRECRIPTIONS OF PSYCHOTROPIC DRUGS FOR SCHOOL CHILDREN

WHEREAS, the family of psychotropic drugs, such as the Amphetamine-type Ritalin and Adderall, are often prescribed for school age children in Alaska; and

WHEREAS, school personnel often require or recommend to parents that these drugs be prescribed to ameliorate their children's behavior; and

WHEREAS, such drugs pose significant risk for a multitude of proven negative side effects, including negative transformations of personality and even death; and

WHEREAS, Alaska Senate Bill No. 48, "An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children," is currently being debated in the Alaska State Legislature; and

WHEREAS, the SB 48 would amend the Alaska Statutes by adding 14.30.171, which reads in part "school personnel may not recommend..." [or require that a parent or guardian obtain a prescription for] "...a child to take or continue to take a psychotropic drug..." (a full copy of the Bill is attached);

NOW, THEREFORE, BE IT RESOLVED that the City Council of the City of Fairbanks supports adoption of SB 48 and encourages the public to review the Bill and provide input to the legislature.

Passed and Approved this 10th day of April, 2006.

____
STEVE M. THOMPSON, MAYOR

ATTEST:

____
Carol L. Colp CMC, City Clerk

APPROVED AS TO FORM

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Herbert P. Kuss, City Attorney

LISA MURKOWSKI
ALASKA
MAJORITY DEPUTY WHIP

COMMITTEES:
ENERGY AND NATURAL RESOURCES
ENVIRONMENT AND PUBLIC WORKS
VETERANS' AFFAIRS
INDIAN AFFAIRS

United States Senate

WASHINGTON, DC 20510-0203
(202) 224-9301 FAX

April 18, 2005

Mr. Frank Turney
Post Office Box 70392
Fairbanks, Alaska 99707

Dear Frank:

I appreciate hearing from you regarding S. 1390, the Child Medication Safety Act, that was pending in the 108th Congress and would have prohibited school personnel from coercing children to receive, or their parents to administer, psychotropic medication. I understand your concerns.

The reason S. 1390 has not been reintroduced this year is that the language it contained was included in another bill that passed last year. The reauthorization of the Individuals with Disabilities Act reauthorization bill, H.R. 1350, included the following language:

SEC. 612. STATE ELIGIBILITY.

(a) IN GENERAL.--A State is eligible for assistance under this part for a fiscal year if the State submits a plan that provides assurances to the Secretary that the State has in effect policies and procedures to ensure that the State meets each of the following conditions:

(25) PROHIBITION ON MANDATORY MEDICATION.--
(A) IN GENERAL.--The State educational agency shall prohibit State and local educational agency personnel from requiring a child to obtain a prescription for a substance covered by the Controlled Substances Act (21 U.S.C. 801 et seq.) as a condition of attending school, receiving an evaluation under subsection (a) or (c) of section 614, or receiving services under this title.

(B) RULE OF CONSTRUCTION.--Nothing in subparagraph (A) shall be construed to create a Federal prohibition against teachers and other school personnel consulting or sharing classroom-based observations with parents or guardians regarding a student's academic and functional performance, or behavior in the classroom or school, or regarding the need for evaluation for special education or related services under paragraph (3).

H.R. 1350 was signed into law (Public Law 108-446) by the President on December 3, 2004. Again, thank you for sharing your thoughts with me.

Sincerely,

Lisa Murkowski
United States Senator

HOME PAGE AND WEB MAIL
MURKOWSKI.SENATE.GOV

Introduced by: Council Member Hilling
Date: April 10, 2006

RESOLUTION NO. 4208, As Amended

A RESOLUTION IN SUPPORT OF SENATE BILL 48, WHICH WOULD PROHIBIT SCHOOL PERSONNEL FROM RECOMMENDING OR REQUIRING PRECRIPTIONS OF PSYCHOTROPIC DRUGS FOR SCHOOL CHILDREN

WHEREAS, the family of psychotropic drugs, such as the Amphetamine-type Ritalin and Adderall, are often prescribed for school age children in Alaska; and

WHEREAS, school personnel often require or recommend to parents that these drugs be prescribed to ameliorate their children's behavior; and

WHEREAS, potential recruits are ineligible for military service if they have taken such a drug in the previous year and such recruits may be ineligible due to childhood use; and

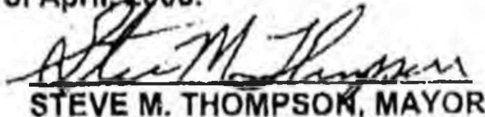
WHEREAS, such drugs pose significant risk for a multitude of proven negative side effects, including negative transformations of personality and even death, and

WHEREAS, Alaska Senate Bill No. 48, "An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children," is currently being debated in the Alaska State Legislature; and

WHEREAS, the SB 48 would amend the Alaska Statutes by adding Section 14.30.171, which reads in part "school personnel may not recommend..." [or require that a parent or guardian obtain a prescription for] "...a child to take or continue to take a psychotropic drug..." (a full copy of the Bill is attached);

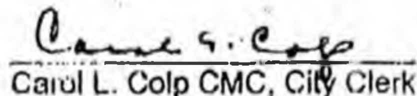
NOW, THEREFORE, BE IT RESOLVED that the City Council of the City of Fairbanks supports adoption of SB 48 and encourages the public to review the Bill and provide input to the legislature.

Passed and Approved this 10th day of April, 2006.



STEVE M. THOMPSON, MAYOR

ATTEST:



Carol L. Colp CMC, City Clerk

APPROVED AS TO FORM

Herbert P. Kuss, City Attorney

By: Bonnie Williams
Introduced: 04/14/05
Adopted: 04/14/05

FAIRBANKS NORTH STAR BOROUGH

RESOLUTION NO. 2005 - 23

A RESOLUTION OF SUPPORT ON PSYCHOTROPIC DRUGS AND CHILDREN

WHEREAS, the use of drugs to address behavioral problems in children has become alarmingly prevalent; and

WHEREAS, some public schools have endorsed and enforced such usage through recommendations, suggestions and other actions; and

WHEREAS, parents may be coerced into taking actions which are not in the best interest of their child through untrained referrals; and

WHEREAS, recommendations, referrals and suggestions involving behavioral problems should only involve trained personnel, parents and legal guardians, and licensed physicians and psychiatrists; and

WHEREAS, the use of psychotropic drugs may be appropriate to help some children; and

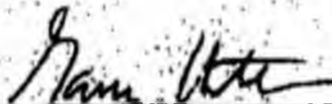
WHEREAS, there are no prohibitions in current state statutes prohibiting coercion by school officials on parents and children involving psychotropic drugs; and

WHEREAS, proactive statutory limitations can prevent before a triggering event and tragedy actually occurs.

NOW THEREFORE BE IT RESOLVED, that the Fairbanks North Star Borough Assembly supports legislation, which addresses this issue in a manner that leaves open the provision of informational resources, leaves untouched school authority to maintain discipline, but which prohibits coercive actions by schools involving psychotropic drugs.

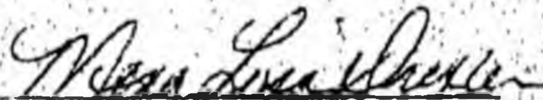
BE IT FURTHER RESOLVED, that copies of this resolution be forwarded to the Governor of the State of Alaska, and members of the Interior Delegation of the Alaska State Legislature.

47 PASSED AND APPROVED THIS 14th DAY OF APRIL 2005.
48



Garry Hutchison
Presiding Officer

ATTEST:



Mona Lisa Drexler, CMC
Municipal Borough Clerk

49
50 Ayes: Romans, Bartos, Sattley, Rex, Williams, Hopkins, Aldridge, Frank, Hutchison
51 Noes: None

From Sen. Davis

Available Bills

Category	Bill #	Summary	Status
Children	AK SB 0048	PSYCH. EVALUATION/TREATMENT FOR STUDENTS	introduced
Children	FL HB 0209	Contains the following provisions: 1) A recipient of state funds shall not require a student to be prescribed or administered any psychotropic medication as a condition of such student receiving educational or school-based services; 2) A psychotropic medication shall not be administered to a student on school premises except by a licensed health care professional and in compliance with HIPPA; and 3) A school or school district personnel shall not initiate, or make a referral for, diagnosis or treatment of a student for any disorder listed in the Diagnostic and Statistical Manual of Mental Disorders or in ICD-10.	passed house committee
Children	FL SB 1090	Minors/Psychotropic Medication	passed senate committee
Children	FL SB 1766	School Students/Psychotropic Med	introduced
Children	GA SR 0128	Mental Health Screening; urge GA Congressional Delegation to oppose	introduced
Children	NH HB 0240	relative to psychotropic drugs and child protection.	passed house committee
Children	NM SJM 0052	STUDY PRESCRIPTION DRUGS FOR CHILD BEHAVIOR	enacted
Children	NY AB 1132	Directs the commissioner of education to establish rules and regulations prohibiting school personnel from recommending psychotropic drugs for children.	introduced
Children	NY AB 5043	Restricts recommendations for psychotropic drugs.	introduced
Children	NY SB 2900	Directs the commissioner of education to establish rules and regulations prohibiting school personnel from recommending psychotropic drugs for children.	introduced
Children	PA HB 0591	An Act amending the act of March 10 1949 (P.L.30 No.14) known as the Public School Code of 1949 prohibiting school officials or employees from recommending that a child use psychotropic or sympathomimetic drugs.	introduced
Children	TN HB 0580	Students - Prohibits school personnel from recommending psychotropic drugs such as Ritalin to treat elementary and secondary school students for behavioral concerns. - Amends TCA Title 49 Chapter 6 Part 50.	hearing held
Children	UT HB 0042	Prohibits school personnel from making certain medical recommendations for a minor, including the use of psychotropic drugs; prohibits consideration of a petition for removal of a n[illegible] and removal of a minor from parental custody based on a parent's refusal to consent to the administration of psychotropic drugs.	passed house & senate
Children	VT HB 0074	PSYCHOTROPIC DRUGS AND SPECIAL NEEDS SERVICES FOR CHILDREN	introduced
Children, Medications Access, Mental Health	NY AB 5885	Authorizes and directs the department of health to conduct a study on drugs prescribed for school-age children with ADD.	introduced

Testimony on Senate Bill 48, "An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children."

Presented by Richard Warner, President, Seattle Chapter, Citizens Commission on Human Rights, Seattle, Washington, 1-877-448-8517.

Legislation similar to SB 48 has been passed by a number of states, including Connecticut, Minnesota, Illinois, Virginia, Colorado, Arizona, New Hampshire, and Florida.

Such legislation is meant to address the problem of the intrusion of psychiatry into the lives of families by means of the powers granted to schools and state agencies.

There is no question that children face enormous difficulties growing up in today's society and there are dozens of root causes that we can point to which influence their development and behavior. They include such things as divorce and broken homes, hours spent in front of television sets, constant exposure from a very young age to sexual images, poor nutrition and poor overall health, poverty, drug abuse, exposure to environmental toxins, and a lack of adult guidance in their lives.

The psychiatric and drug industries have a marketing plan to use the problems of children and families to sell their services and drugs. That plan is to pitch the message that the real problem is a chemical imbalance in the brains of children and that children need to be tested to see if they are mentally ill and provide them treatment.

This plan is dangerous and destructive to the welfare of children and families for two basic reasons: The unscientific and arbitrary nature of psychiatric diagnosis and the ineffectiveness and dangerous effects of psychiatric drugs. Time does not permit going into this subject in detail here but let me briefly point to two issues. Attached you will find a brief but more detailed presentation on psychiatric drugging and diagnosis.

According to psychiatry's own diagnostic manual, "In DSM-IV [the latest edition] there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or no mental disorder." Thus psychiatry's own manual admits it can't distinguish a mental disorder or no mental disorder.

Moreover, there is no biological or physiological basis to psychiatric diagnosis. The Surgeon General's 1999 report on mental health stated, "...there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify the illness," and referred to the "lack of objective, physical symptoms."

Harvard psychiatrist Joseph Glenmullen has written, "In recent decades, we have had no shortage of alleged biochemical imbalances for psychiatric conditions. Diligent though these attempts have been, not one has been proven. Quite the contrary. In every instance where such an imbalance was thought to have been found, it was later proven false."

And as Elliot Valenstein, Professor Emeritus of Psychology and Neuroscience at the University of Michigan stated, "There are no tests available for assessing the chemical status of a living person's brain."

Most children who are psychiatrically labeled end up on psychiatric drugs. That's why the psychiatric drugging of children is skyrocketing.

A January 2006 study in *Psychiatric Services* reported that the prescription of stimulants and antidepressants to teens has increased over 200% since 1994. The use of other psychiatric drugs, such as antipsychotics, has increased 385%.

Lawrence Diller, M.D., a well-known behavioral pediatrician at the University of California, San Francisco, and author of the book *Running on Ritalin,* cites IMS Health, a company that compiles prescribing statistics for the pharmaceutical industry, for his finding that between 1995 and 1999 the use of Prozac-like drugs for children under 6 increased 580% and the use of new antipsychotic drugs for children under 18 grew by nearly 300%.

The FDA has recently issued an unprecedented series of warnings about psychiatric drugs. Here are just a few of their findings.

September 15, 2004: The (FDA) reports that a causal role for antidepressants in inducing suicidality has been established in pediatric patients, and children given such drugs are twice as likely to commit suicide as those given a placebo. The FDA orders drug manufacturers to place a Black-Box warning on all antidepressants. The warning came 13 years after a panel composed mostly of psychiatrists with extensive financial ties to the pharmaceutical industry, rejected the evidence of published studies, testimony from victims, and the FDA's own adverse reaction reporting system and told the FDA there was no credible evidence linking antidepressants to suicidality.

June 28, 2005: The FDA issues a statement saying that it would make labeling changes to methylphenidate products such as Ritalin and Concerta describing "psychiatric events" such as suicidal ideation, hallucinations, aggression and violent and psychotic behavior.

September 29, 2005: The FDA orders new Black Box warnings for the ADHD drug Strattera, which was linked in clinical trials to suicidal thinking, suicidal behaviors, as well as agitation and irritability.

February 8, 2006: An FDA advisory panel warns ADHD drugs increase the risk of sudden death and serious cardiovascular problems. Dr. Steven Nissen, a cardiologist at the Cleveland Clinic and a panel member said, "I must say that I have grave concerns about the use of these drugs and grave concerns about the harm they may cause."
Dr. David Graham, a medical officer in the FDA's Office of Drug Safety, described the agency's preliminary analysis of millions of medical records that suggested an increased risk of strokes and arrhythmias. "The number of arrhythmia hospitalizations really struck us as surprising," Dr. Graham said. "Arrhythmia is believed to be the pathway for sudden unexplained death."

March 23, 2006: Another FDA panel reports that 2 – 5% of children who take stimulants for over a year "will suffer serious psychotic episodes like hallucinations." With an estimated six million children taking stimulants that translates into as many as 300,000 psychotic children.

The other problem with the drugs is their lack of effectiveness.

For example, in April 18, 2004 the *Washington Post* reported,

> Of 15 trials conducted among depressed children, 10 failed to show antidepressants were better than dummy pills. Two were inconclusive, and three showed positive results. The negative results have mostly been withheld from public scrutiny by the pharmaceutical companies that paid for the trials, which say that the data are proprietary.

Regarding two Prozac studies that appeared to demonstrate the drug worked better than dummy pills, the Post noted. "But an FDA internal analysis of the trials found Prozac failed on the statistical measure that researchers had originally chosen as their primary benchmark: 'The evidence for efficacy based on the pre-specified endpoint is not convincing.'"

The inefficacy of antidepressants has been known for some time. A 1996 study published in the *Journal of Nervous and Mental Diseases* referred to the "unanimous literature of double-blind studies indicating that antidepressants are no more effective than placebos in treating depression in children and adolescents…."

Conclusion

There is absolutely no justification for the state being involved in forcing a parent to give their child a drug which has been proven to be ineffective and can cause such serious health consequences. A parent's decision not to submit their child to an unscientific labeling procedure which is regularly ridiculed by psychiatrists themselves, or a parent's decision not to play psychiatric Russian roulette with the brain of their child should never be grounds for any action by the state. Over the course of its entire history the psychiatric industry has proven continually that it cannot be trusted to tell the public the actual effects of its drugs and treatments.

Sections 2 and 3 of this bill, which deal with the circumstances under which the state may intervene in the lives of families, should therefore be strengthened. It should state that the refusal of a parent to consent to the psychiatric evaluation and/or psychiatric drugging of a child shall never be considered grounds or evidence for a finding that a child is in need of aid.

Attachment #1

Psychiatric Diagnosis and Psychiatric Drugs

Psychiatry's diagnostic manual is the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Herb Kutchins, a professor of social work at California State University and Stuart A. Kirk, the Marjorie Crump Endowed Chair in Social Welfare in the School of Public Policy and Social Research at UCLA, have written two books on the DSM. In *Making Us Crazy*, they reported,

Mental health clinicians independently interviewing the same person in the community are as likely to agree as disagree that the person has a mental disorder and are as likely to agree as disagree on which of the over 300 DSM is present.[1]

Psychiatric disorders are simply lists of human traits fashioned together by committees that allow a clinician to label virtually anyone, particularly any child, mentally ill if they so choose. Paula Caplan, a psychologist who attended one DSM committee meeting, said, "The low level of intellectual effort was shocking. Diagnoses were developed by majority vote on the level we would use to choose a restaurant."[2]

The DSM itself admits, "In DSM-IV [the latest edition] there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or no mental disorder."[3]

Imagine a doctor saying there are no absolute boundaries dividing cancer from diabetes, an infection, or perfect health and you begin to understand the problem. Psychiatry's own diagnostic manual admits it can't distinguish a mental disorder from no mental disorder! This is one of many reasons why the DSM has become the laughingstock of its own profession, regularly criticized by psychiatrists themselves. In the April 2003 issue of *Psychiatric Times*, psychiatrist Paul Genova wrote that the DSM "is so intellectually incoherent as to raise eyebrows among the well-educated, critical thinkers in our own psychotherapy clientele."[4] In a January 2006 column in the *Los Angeles Times*, UCLA psychiatrist Irwin Savodnik accused the American Psychiatric Association of "inventing mental illnesses for the past 50 years" by "turning ordinary human frailty into disease."[5] Loren Mosher, the former Chief of the Center for Studies of Schizophrenia at The National Institute of Mental Health, called the DSM-IV a "fabrication upon which psychiatry seeks acceptance by medicine in general."[6]

Making matters worse, there is no biological or physiological basis to psychiatric diagnosis. The Surgeon General's 1999 report on mental health stated, "…there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify the illness,"[7] and referred to the "lack of objective, physical symptoms."[8] Dr. Harold Pincus, the vice chairman of the DSM-IV task force, writing in the January 2000 issue of *Clinical Psychiatry News*, stated, "There has never been any criterion that psychiatric diagnoses require a demonstrated biological etiology. In fact, virtually no mental disorder except those that are substance induced or due to a general medical condition, has one."

Then why do "experts" claim that mental illnesses are the result of a chemical imbalance? Short of greed, expedience, or ignorance, there is no good explanation. Harvard psychiatrist Joseph Glenmullen has written, "In recent decades, we have had no shortage of alleged biochemical imbalances for psychiatric conditions. Diligent though these attempts have been, not one has been proven. Quite the contrary. In every instance where such an imbalance was thought to have been found, it was later proven false."[9]

Moreover, as Elliot Valenstein, Professor Emeritus of Psychology and Neuroscience at the University of Michigan stated, "There are no tests available for assessing the chemical status of a living person's brain."[10] Last year the President of the American Psychiatric Association (APA), Steven Sharfstein, confirmed Valenstein's statement. He said,"We do not have a clean-cut lab test" to detect chemical imbalances.[11] Dr. Mark Graff, Chair of the Committee of Public Affairs for the APA, confessed, "Chemical imbalance … it's a shorthand term, really, it's probably drug industry derived."[12]

Psychiatry's diagnostic manual is called a manual of "disorders," not diseases. But even the term "disorder" is misleading. The diagnostic criteria for these "disorders" are normal human behaviors and emotions. The disorders are literally voted into existence at conventions, with arbitrary criteria and arbitrary cutoff points (e.g., requiring someone to meet 5 of 9 diagnostic criteria). According to psychiatrist Nancy Andreasen, the Editor-in-Chief of the *American Journal of Psychiatry*, the boundaries of duration (diagnostic criteria requiring that symptoms last a certain period of time) and severity used in psychiatric diagnosis are "boundaries of convenience … not boundaries with any inherent biological meaning."[13]

Thus, psychiatric diagnosis is not diagnosis at all. It is simply the employment of medical jargon for the purpose of promoting the notion that individuals experiencing difficulty in life are sick and need "medication."

Attention deficit hyperactivity disorder is a perfect example this. In 1998 the National Institutes of Health held a "Consensus Development Conference on Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder." The final Consensus Statement of the conference, presented to the press on Nov. 18, 1998, stated, "...we do not have an independent, valid test for ADHD, and there are no data to indicate that ADHD is due to a brain malfunction." (Actual video from this conference can be viewed at www.cchr.org. Just click on the link, "Video of psychiatrists and doctors admitting that ADHD has no science," to view the shocking ineptitude of the panel of "experts" the NIH assembled. It must be seen to be believed.)

Though psychiatrists use medical terms it is clear that this is primarily a marketing facade. How else could millions of children have been "diagnosed" and "medicated" for an "illness" that, without a valid test or evidence of pathology, has not and, more importantly, *cannot* be shown to exist?

Psychiatric Drugs

The most common treatment for children who are given psychiatric labels is psychiatric drugs. A survey of early-career child and adolescent psychiatrists published in the *Journal of the American Academy of Child and Adolescent Psychiatry* found that 91% prescribed psychiatric drugs.[14] The skyrocketing number of children being prescribed psychiatric drugs indicates that pediatricians and primary care doctors are following psychiatry's lead.

A January 2006 study in *Psychiatric Services* reported that the prescription of stimulants and antidepressants to teens has increased over 200% since 1994. The use of other psychiatric drugs, such as antipsychotics, has increased 385%.[15]

Lawrence Diller, M.D., a well-known behavioral pediatrician at the University of California, San Francisco, and author of the book *Running on Ritalin*, cites IMS Health, a company that compiles prescribing statistics for the pharmaceutical industry, for his finding that between 1995 and 1999 the use of Prozac-like drugs for children under 6 increased 580% and the use of new antipsychotic drugs for children under 18 grew by nearly 300%.[16]

But while the psychiatric and pharmaceutical industries have been relentless in selling their drugs to children, they have been much less eager to reveal the truth about the drugs' effects. It is simply an historical fact that the truth about psychiatric drugs comes only after years, and in many cases decades, of lawsuits, Freedom of Information Act requests, and pressure put on the Food and Drug Administration.

The demand for the truth has recently resulted in an unprecedented series of warnings about psychiatric drugs from the FDA. Here are just a few of their findings.

September 15, 2004: The (FDA) reports that a causal role for antidepressants in inducing suicidality has been established in pediatric patients, and children given such drugs are twice as likely to commit suicide as those given a placebo. The FDA orders drug manufacturers to place a Black-Box warning on all antidepressants. The warning came 13 years after a panel composed mostly of psychiatrists with extensive financial ties to the pharmaceutical industry, rejected the evidence of published studies, testimony from victims, and the FDA's own adverse reaction reporting system and told the FDA there was no credible evidence linking antidepressants to suicidality.

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March 23, 2006: Another FDA panel reports that 2 – 5% of children who take stimulants for over a year "will suffer serious psychotic episodes like hallucinations."[18] With an estimated six million children taking stimulants that translates into as many as 300,000 psychotic children.

These warnings only touch the surface of what has been revealed about these drugs over the past few months and more dangers appear every day. A recent study in *Cancer Letters*, for example, found that treatment with Ritalin (methylphenidate) produced significant chromosome aberrations and called for further investigations "in view of the well-documented relationship between elevated frequencies of chromosome aberrations and increased cancer risk."[19] Duke University researchers recently presented the results of a study which "found heart patients taking antidepressants had a 55 percent higher risk of dying than those not taking antidepressants."[20]

A February 9, 2006 study published in the *New England Journal of Medicine* found an association between maternal exposure to SSRI antidepressants during late pregnancy and persistent pulmonary hypertension (PPHN) in newborns. PPHN is a life-threatening condition in which babies do not receive enough oxygen in the blood and require intensive-care treatment to survive.[21] An April 2006 study in the *American Journal of Obstetrics and Gynecology* has reported, "The use of selective serotonin reuptake inhibitors in pregnancy may increase the risks of low birth weight, preterm birth, fetal death, and seizures."[22]

The other problem with the drugs is their lack of effectiveness.

On April 18, 2004 the *Washington Post* reported,

Of 15 trials conducted among depressed children, 10 failed to show antidepressants were better than dummy pills. Two were inconclusive, and three showed positive results. The negative results have mostly been withheld from public scrutiny by the pharmaceutical companies that paid for the trials, which say that the data are proprietary.[23]

Regarding two Prozac studies that appeared to demonstrate the drug worked better than dummy pills, the Post noted, "But an FDA internal analysis of the trials found Prozac failed on the statistical measure that researchers had originally chosen as their primary benchmark: 'The evidence for efficacy based on the pre-specified endpoint is not convincing.'"[24]

The inefficacy of antidepressants has been known for some time. A 1996 study published in the *Journal of Nervous and Mental Diseases* referred to the "unanimous literature of double-

blind studies indicating that antidepressants are no more effective than placebos in treating depression in children and adolescents...."[25]

A study published in the *British Medical Journal* last year found,

Recent meta-analyses show selective serotonin reuptake inhibitors have no clinically meaningful advantage over placebo.
Evidence that antidepressants are more effective in more severe conditions is not strong, and data on long term outcome of depression and suicide do not provide convincing evidence of benefit.[26]

Stimulants and antipsychotics are equally ineffective. According to psychiatrist Peter Breggin, "Ritalin's lack of effectiveness has been proven by hundreds of studies but has not been revealed to doctors, teachers or parents."[27] Instead, the dubious results of flawed studies are trumpeted to the public while the authors keep quiet about their negative findings. The 1999 Multimodal Treatment Study for Attention-Deficit Hyperactivity Disorder is a classic case of this. Widely touted, it was neither placebo controlled nor double blind (parents and teachers knew which children were on stimulants), although one group of blind classroom observers found no superiority of drugs over behavioral approaches.[28] Moreover the children themselves did not feel benefited and 64% experienced adverse drug reactions.

Increasing numbers of children are being prescribed antipsychotics, arguably the most powerful and dangerous psychiatric drugs. A recent study in *The New England Journal of Medicine* that compared a conventional antipsychotic with four newer "atypical" antipsychotics found, "...74 percent of patients discontinued the study medication before 18 months.... The majority of patients in each group discontinued their assigned treatment owing to inefficacy or intolerable side effects or for other reasons.[29]

The vast majority of patients in this study discontinued treatment within 3 – 5 months. The "Duration of successful treatment" was 3 months for one drug and 1 month for all the others.

It is impossible to convey in a few pages the amount of damage these drugs have produced. But we should mention that many of the teen school shooters had been prescribed these drugs, which are known to cause violent, psychotic states. In 1999 Dr. Malcolm Bowers of Yale University reported in *Clinical Psychiatry News* that psychosis induced by the newer antidepressants (known as selective serotonin reuptake inhibitors or SSRIs) accounted for 8% of all general psychiatric hospital admissions over one 14-month period.[30]

Here is a partial list of teen shooters over the past few years:

Jeff Weise, Red Lake, MN, **Prozac**
Eric Harris, Columbine High School, Littleton, CO, **Luvox**
Jason Hoffman, Granite Hills High School, CA, **Effexor, Celexa**
Thomas Soloman, Conyers, GA, **Ritalin**
Kip Kinkle, Springfield, OR, **Prozac, Ritalin**

Cory Baadsgaard, Mattawa, WA, **Paxil, Effexor**. Held 23 students hostage with rifle. No one killed.
Michael Carneal, West Padukah, KY. Reportedly on **Ritalin**.
Luke Woodham, Pearl, MI, reportedly on **Prozac**
Elizabeth Bush, Williamsport, PA, **antidepressants**
Dominick Maldonado, Tacoma, WA, **Ritalin**
Andrew Golden, Jonesboro, AK, **Ritalin**
Unnamed 13 year-old killer of Louise Frazier, Seattle, WA, **Prozac**

1. Herb Kutchins and Stuart A. Kirk, *Making Us Crazy*, The Free Press, 1997, p. 52.
2. Paula Caplan, *They Say You're Crazy*, Addison Wesley, New York, 1995, p. 90.
3. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, DSM-IV, p. xxii.
4. Paul Genova, "Dump the DSM!" *Psychiatric Times*, April 1, 2003, p. 72.
5. Irwin Savodnik, "Psychiatry's Sick Compulsion: turning weaknesses into diseases," *Los Angeles Times*, January 1, 2006.
6. Loren Mosher, Letter of Resignation from the American Psychiatric Association, 4 Dec. 1998, available at: http://www.moshersoteria.com/resig.htm.
7. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999, p. 44.
8. Ibid., p. 48.
9. Joseph Glenmullen, *Prozac Backlash*, 2000, p. 196.
10. Elliot Valenstein, *Blaming the Brain*, 1998.
11. Steven Sharfstein, "All Fired Up," *People*, 11 July 2005, p. 87.
12. Mark Graff, CBS 2 News Interview, July 10, 2005.
13. Marcia Andreasen, "Linking Mind and Brain in the Study of Mental Illnesses: A Project for a Scientific Psychopathology," *Science*, 14 March 1997: 1586-1593.
14. Dorothy Stubbe and W. John Thomas, "A Survey of Early-Career Child and Adolescent Psychiatrists: Professional Activities and Perceptions," *Journal of the American Academy of Child and Adolescent Psychiatry*, 41:2, February 2002, pp. 123- 130.
15. Cindy Thomas, Peter Conrad, Rosemary Casler, et al., "Trends in the Use of Psychotropic Medications Among Adolescents, 1994 to 2001," *Psychiatric Services*, January 2006, Vol. 57, No. 1, pp. 63-69.
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17. Gardiner Harris, "Warning Urged on Stimulants Like Ritalin," *New York Times*, February 8, 2006.
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24-LS0208\L
Mischel
4/11/06

CS FOR SENATE BILL NO. 48( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to recommending or refusing psychotropic drugs or certain types of
2 evaluations or treatments for children."

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

4 * Section 1. AS 14.30 is amended by adding new sections to read:
5 Article 2A. Psychiatric and Behavioral Evaluations and Treatments.
6 Sec. 14.30.171. Prohibited actions. Except as provided in AS 14.30.172 -
7 14.30.176, school personnel may not, unless otherwise authorized by law,
8 (1) recommend to a parent or guardian that a child take or continue to
9 take a psychotropic drug as a condition for attending a public school;
10 (2) require that a child take or continue to take a psychotropic drug as a
11 condition for attending a public school;
12 (3) conduct a psychiatric or behavioral health evaluation of a child;
13 (4) recommend a specific licensed physician, psychologist, or other
14 health specialist to a parent or guardian for a child;

1 (5) recommend that a parent or guardian seek or use for a child
2 (A) a psychotropic medication; or
3 (B) a psychiatric or psychological treatment; or
4 (6) except when refusal of consent causes a child to suffer mental
5 injury or neglect, as defined in AS 47.17.290, make a report of suspected child abuse
6 or neglect to authorities, including the Department of Health and Social Services,
7 based solely on the fact that a parent or guardian refuses to give signed consent for
8 (A) the administration of a psychotropic drug to a child;
9 (B) a psychiatric, psychological, or behavioral treatment of a
10 child; or
11 (C) a psychiatric or behavioral health evaluation of a child.
12 **Sec. 14.30.172. Communication not prohibited.** (a) Nothing in AS 14.30.171
13 may be construed to prohibit school personnel from
14 (1) consulting or sharing classroom-based observations with parents or
15 guardians regarding a student's academic and functional performance, behavior in the
16 classroom or school, or regarding the need for evaluation for special education or
17 related services as long as school personnel do not
18 (A) make an assertion or recommendation that violates
19 AS 14.30.171; or
20 (B) denigrate, criticize, punish, or attempt to denigrate,
21 criticize, or punish, a parent, guardian, or child for a decision made by the
22 parent or guardian pertaining to whether the child takes, does not take, or
23 discontinues taking a psychotropic medication; or
24 (2) exercising their authority relating to the placement within the
25 school or readmission of a child who may be or has been suspended or expelled for a
26 violation of a school disciplinary and safety program adopted under AS 14.33.110 -
27 14.33.140.
28 (b) Nothing in AS 14.30.171 may be construed to prevent teachers or other
29 school personnel from complying with the requirements of AS 47.17.020.
30 **Sec. 14.30.174. Compliance with federal education law.** (a) Notwithstanding
31 AS 14.30.171(3) and (5), a behavioral or mental health professional working within a

1 public school system may, for the sole purpose of complying with federal education
2 law,
3 (1) recommend, but not require, a psychiatric or behavioral health
4 evaluation of a child;
5 (2) recommend, but not require, psychiatric, psychological, or
6 behavioral treatment for a child; and
7 (3) conduct a psychiatric or behavioral health evaluation of a child
8 with the consent of the child's parent or guardian.
9 (b) In this section,
10 (1) "behavioral health professional" means a person who has a master's
11 degree in psychology, social work, counseling, or a related field with specialization or
12 experience in working with children experiencing behavioral, physical, and emotional
13 disabilities, and is working within the scope of the person's training and experience;
14 "behavioral health professional" does not include a person employed as a teacher;
15 (2) "federal education law" means 20 U.S.C. 1400 - 1487 (Individuals
16 with Disabilities Education Act), 20 U.S.C. 7101 - 7143 (Safe and Drug-Free Schools
17 and Communities Act of 1994), 29 U.S.C. 794 (nondiscrimination under federal grants
18 and programs), and 42 U.S.C. 12101 - 12213 (equal opportunity for individuals with
19 disabilities);
20 (3) "mental health professional" has the meaning given in
21 AS 47.30.915.
22 **Sec. 14.30.176. List of community resources.** Notwithstanding
23 AS 14.30.171(4), a school district may make available to an interested parent or
24 guardian a list of community resources, including mental health services if the list
25 conspicuously states the following: "This list is provided as a resource to you. The
26 school neither recommends nor requires that you use this list or any of the services
27 provided by individuals or entities on the list. It is for you to decide what services, if
28 any, to use and from whom you wish to obtain them."
29 **Sec. 14.30.177. Violations.** (a) A violation of AS 14.30.171 - 14.30.176
30 constitutes substantial noncompliance with a school law of the state for purposes of
31 dismissal of a teacher under AS 14.20.170 or nonretention of a teacher under

1 AS 14.20.175.

2 (b) Each school board shall adopt a bylaw under AS 14.14.100 that provides
3 that violation of AS 14.30.171 - 14.30.176 is grounds for disciplinary action against a
4 person employed by the school district.

5 **Sec. 14.30.179. Definition.** In AS 14.30.171 - 14.30.179, "public school"
6 means a school operated by publicly elected or appointed school officials in which the
7 program and activities are under the control of those officials and that is supported by
8 public funds.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/12/05

FURTHER: Judiciary

Date of 5-Day Notice: ____________
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 4.12.06

Health, Education and Social Services Committee considered

SENATE BILL NO. 48

SB 48 PSYCH. EVALUATION/TREATMENT FOR STUDENTS

"An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children."

and recommends:

[X] be replaced with ______ CS for SB 48 (HES)

[ ] adopt previous ______ CS ____________ (______)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ____________ Committee

[ ] further referral to ____________ Committee

Senate Bill:
[x] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
EED	3/31		x		
HSS	3/31			x	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
~~EED~~			~~x~~		

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	Do Pass	Do Not Pass	No Rec	Amend
[signature]	✓			
Gary Wilken [signature]			✓	
[signature]			✓	
CHAIR: [signature]	✓			