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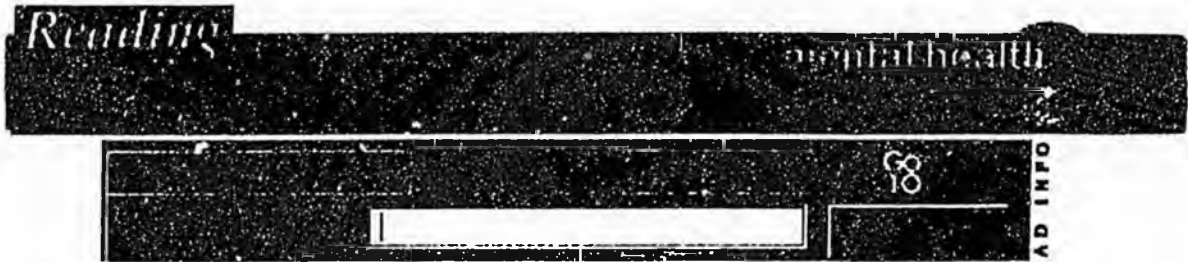
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**Attachment F**

**"Researchers Find Potential for Ritalin Abuse in Schools," *Mental Health Net*, June 15, 1998**



## Researchers Find Potential For Ritalin Abuse In Schools

June 15, 1998

WASHINGTON, MD -- Researchers have discovered wide variations in rules and enforcement procedures in schools that they say pose a potential for abuse of Ritalin (methylphenidate) and other prescribed stimulant medication taken by children with attention deficit hyperactivity disorder (ADHD).

Want to learn more about ADHD? Browse through our comprehensive listing of [Attention Deficit/Hyperactivity Disorder](#) resources.

Cynthia Musser and colleagues at the Marshfield Clinic's Medical Research Foundation in Wisconsin, surveyed 53 school principals in rural areas and small towns in central Wisconsin, then anonymously surveyed 73 schoolchildren in rural sections of central Wisconsin and northern Michigan who had been prescribed Ritalin for at least five years.

They found that some schools store the medications unlocked. Some students carry their medication with them. Sixteen percent of the children said they had been asked to sell, give, or trade their medication to others. Yet, both school principals and students said they saw no problems of medication abuse.

Study findings are published in this month's issue of the Journal of Developmental and Behavioral Pediatrics.

"The potential for abuse exists with 16 percent [of the students] having been asked to either sell, give or trade their stimulant medication," the researchers write. "Although the survey did not address whether the children had actually given, sold, or traded their medication, it is possible that some of them did, given the significance of peer pressure. The potential for unauthorized access or theft also exists at all grade levels."

Most schools, they report, keep medication in a locked cabinet in a central location. Most students either carry their own medication or store it in a school office, nurse's office or principal's office.

The researchers recommend that states and schools adopt and enforce policies regarding the use and dispensing of medication, and that school administrators, teachers, health care providers and affected families all be consulted to develop such policies.

"It is incumbent on the physician to educate parent and child regarding the appropriate use, as well as the potential for abuse of these drugs," the researchers write. "Monitoring prescription usage, periodic follow-up and continuing education of parents, teaching staff and child should all be part of a multimodal treatment plan for [ADHD]."

Findings are limited because the students completed their surveys at home and may have been influenced by parents. The researchers also note that results from a largely rural population might not be the same as for other geographic areas where diagnosis and treatment approaches might differ.

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**Attachment G**

**"New Research Helps Explain Ritalin's Low Abuse Potential When Taken as Prescribed," National Institute on Drug Abuse Advisory, September 29, 1998**



## NIDA Media Advisory

Contact: Beverly Jackson or Sheryl  
Massaro

FOR RELEASE, Tuesday, September 29, 1998, 12:00 p.m. E.S.T.

301-443-6245

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### New Research Helps Explain Ritalins Low Abuse Potential When Taken As Prescribed

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New research sheds light on why individuals taking therapeutic doses of methylphenidate rarely abuse it or become addicted, even though it is a stimulant with properties similar to those of cocaine and amphetamines. Ritalin, an oral form of methylphenidate, is the drug prescribed most frequently for children, adolescents, and adults diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

Findings reported in the October 1, 1998, issue of the *American Journal of Psychiatry* confirm that oral doses of methylphenidate do not reach peak concentrations in the brain until 60 minutes after ingestion, compared to 5 minutes for cocaine or 9 minutes for methylphenidate taken intravenously. The fact that Ritalin taken orally is drawn so slowly into the brain is a likely reason why patients do not experience a high from this means of use. In general, if brain concentrations of a substance peak quickly, the potential for abuse and addiction increases, as an individual experiences the drug more dramatically and, thus, is more likely to try to repeat the experience more frequently.

"This research is important for a number of reasons", said Dr. Alan I. Leshner, director of the National Institute on Drug Abuse (NIDA), National Institutes of Health, which contributed funding for the research. "First, it helps clarify why Ritalin rarely leads to abuse and addiction when taken properly as a treatment for ADHD. Second, it helps explain why non-ADHD individuals might abuse methylphenidate or become addicted to it when they take the drug intravenously or when they crush and inhale the pills. It is extremely important to clarify that different methods of taking a medication can alter its medicinal effects and can make it more or less dangerous in ways totally unrelated to its clinical indications."

Ritalin is not a new medication - for about 30 years it has been prescribed, increasingly, to treat ADHD. Estimates indicate that about 5 to 10 percent of the general population have the disorder. Exactly how methylphenidate works to calm ADHD individuals is not completely understood, but the drug has long been thought to block reuptake of dopamine in the brain. The current research, conducted by Dr. Nora Volkow and colleagues at the Department of Energy's Brookhaven National Laboratory and the State University of New York at Stony Brook, is the first to measure the drug's actual effectiveness in blocking the molecular gatekeepers to dopamine uptake, known as dopamine transporters (DATs). Since DATs are target sites for the action of cocaine and other stimulating drugs of abuse as well, the researchers also evaluated methylphenidate for its abuse potential.

Using positron emission tomography (PET) scanning, which enables researchers to measure levels of DAT blockage in the brain, the Brookhaven researchers studied the effects of oral methylphenidate in seven healthy young adults who did not have ADHD. These individuals also were asked to rate the subjective effects of methylphenidate by verbally rating their feelings of "drug effects", "restlessness", or being "high". Calibrated for subject weight, a range of oral doses was tested that included doses commonly used therapeutically.

The researchers found that, taken orally at the levels currently prescribed for ADHD (0.25 mg/kg to 1.0 mg/kg), methylphenidate is very effective at blocking DATs and is likely to occupy more than 50 percent of them in the brain. It is believed that this level of occupancy may be necessary for therapeutic efficacy.

The oral doses of methylphenidate, however, did not produce a "high" in all but one of the subjects in this study, in contrast with cocaine which, in previous Brookhaven research, was shown to produce a "high" when the drug reached a level blocking 60 percent of the DATs. The researchers believe the explanation for the lack of experienced "high" has to do with the amount of time it takes orally administered methylphenidate to reach peak concentration in the brain. In a parallel PET study using a baboon, the scientists found that it took a full 60 minutes for peak concentrations to be reached after oral administration of methylphenidate.

Importantly, previous research has shown that the more quickly a drug works, the greater the perceived "high". Hence, the route of administration may make a difference in the kind of "high" produced by methylphenidate. "When the drug is abused", Dr. Volkow notes, "it tends to be snorted or used intravenously. That causes brain concentrations to rise and spike very rapidly, and this likely accounts for the 'high' the abuser experiences".

NIDA supports more than 85 percent of the world's research on the health aspects of drug abuse and addiction. The Institute also carries out a large variety of programs to ensure the rapid dissemination of research information and its implementation in policy and practice. Fact sheets on health effects of drugs of abuse and other topics can be ordered free of charge in English and Spanish by calling NIDA Infobox at 1-888-NIH-NIDA (-644-6432) or 1-888-TTY-NIDA (-889-6432) for the deaf. These fact sheets and information on other research funded by NIDA can be found on the NIDA home page at <http://www.nida.nih.gov>.

On November 16-18, 1998, the National Institutes of Health will sponsor a *Consensus Development Conference on the Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder*. Primary sponsors of the meeting are NIDA, the National Institute of Mental Health, and the NIH Office of Medical Applications of Research. For information about the conference, call 301-592-3320.

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**Attachment H**

**"NIDA Infobox on Ritalin," National Institute on Drug Abuse,  
February 1998**

# NIDA Infobox

National Institute on Drug Abuse  
National Institutes of Health

Call toll-free: 1-888-NIH-NIDA (1-888-644-6432)  
Hearing impaired: 1-888-TTY-NIDA (1-888-889-6432)  
NIDA's Home Page: <http://www.nida.nih.gov/>

## Ritalin

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Ritalin, the trade name for methylphenidate, is a medication prescribed for children with an abnormally high level of activity or with attention-deficit hyperactivity disorder (ADHD) and is also occasionally prescribed for treating narcolepsy. It stimulates the central nervous system, with effects similar to but less potent than amphetamines and more potent than caffeine.

Although we do not understand fully how it works, Ritalin has a notably calming effect on hyperactive children and a "focusing" effect on those with ADHD. When taken as prescribed, Ritalin is a valuable medicine. Further, research funded by the National Institute of Mental Health has shown that people with ADHD do not get addicted to their stimulant medications at treatment dosages.

Because of its stimulant properties, however, in recent years there have been reports of its abuse by people for whom it is not a medication. At their December 1996 meeting, members of NIDA's Community Epidemiology Work Group (CEWG)\* noted that:

- Illicit methylphenidate appears to be more available in Texas and Michigan than elsewhere in the country, with Michigan historically having one of the highest per capita levels of distribution.
- In Chicago, some stimulant users mix Ritalin (or "West Coast") with heroin, or with both cocaine and heroin for a more potent effect.
- In Detroit and Minneapolis/St. Paul, middle and high school students crush and inhale the drug or take the pill orally.
- In Phoenix, some adults have been admitted to treatment programs for abusing the drug from their children's prescriptions.
- In Boston, according to reports by youth treatment providers, adolescents continue to abuse the drug, which is most easily available through diverted prescriptions. Drug abuse treatment staffs in Boston also report an increase in abuse among adults.

Because stimulant medicines such as Ritalin do have potential for abuse, the U.S. Drug Enforcement Administration (DEA) has placed stringent controls on their manufacture, distribution, and prescription. For example, DEA requires special licenses for these activities, and prescription refills are not allowed. States may impose further regulations, such as limiting the number of dosage units per prescription.

In January 1996, the U.S. Food and Drug Administration (FDA) announced that in studies of rodents given methylphenidate (Ritalin), the drug produced a "weak signal" for the potential to cause liver cancer. The cancer occurred in male mice, but not in female mice or rats. FDA continues to regard Ritalin as a safe and effective drug, but says the potential risk needs to be considered and further studied because of the increasing and often long-term use of Ritalin in

children. The FDA also noted that the kind of liver tumor found in mice is extremely rare in people, and its occurrence in recent years has not increased despite an increase in the use of Ritalin.

For more information on treating ADHD, please call the National Institute of Mental Health, National Institutes of Health, at 301-443-4513 or visit their internet address at <http://www.nimh.nih.gov>.

\* CEWG is a NIDA-sponsored network of researchers from 20 major U.S. metropolitan areas and selected foreign countries who meet semi-annually to discuss the current epidemiology of drug abuse.

CEWG's most recent report is *Epidemiologic Trends in Drug Abuse, Volumes I and II, December 1996*.

For additional information about NIDA send e-mail to [Information@lists.nida.nih.gov](mailto:Information@lists.nida.nih.gov)

*This page last updated Friday, February 27, 1998.*

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**Attachment I**

**Susan Brink, "Doing Ritalin Right," *U.S. News & World Report*,  
November 23, 1998**

# Doing Ritalin right

*Sure, it works—but there are big flaws in the way it's being given*

BY SUSAN BRINK

In schools across America, as many as 1 million children line up every day for a glass of water and a little yellow pill called Ritalin. Doctors prescribe it, parents hesitantly agree to it, and school nurses supervise the ritual of handing it out because they believe the pill will calm children down and stop them from clowning around or goofing off. The ultimate reward, they hope, will be academic and social success.

A long-awaited study by the National Institute of Mental Health shows that drugs like Ritalin calm kids down even better than previously thought—as long as the children continue taking them. But there's no proof that in the long run the drugs help kids get better grades or build better lives. Children with what is now called attention deficit hyperactivity disorder, or ADHD—the most common rea-

son for taking Ritalin and similar stimulants—are at higher risk than their peers of dropping out, of becoming smokers, of abusing alcohol or drugs, even of spending time in prison. This study provides stronger evidence than ever that medication can shift troubled kids to a better track. But it echoes the frustrating finding of earlier studies that a little yellow pill is not enough, by itself, to keep them there.

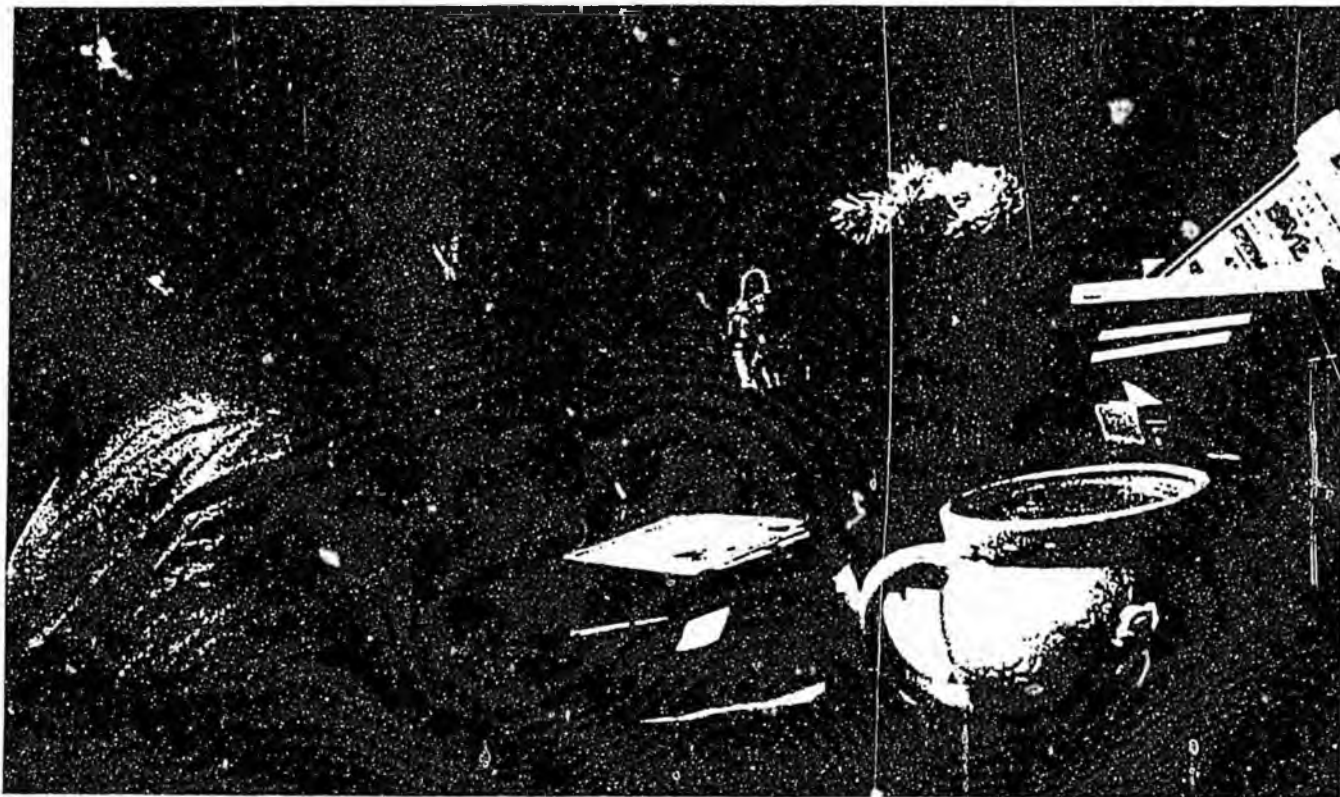
**Lost potential.** The study also suggests that society could do much better by the children diagnosed with ADHD. One way to interpret its findings is this: Assuming a million kids have ADHD, 690,000 of them will get better the way they're typically treated, though many will still have symptoms of the disorder. But if those 1 million kids were treated in the most effective way science has devised, 850,000 of them could get better.

The study, as yet unpublished, was presented last month at the annual meeting

of the American Academy of Child and Adolescent Psychiatry in Anaheim, Calif. It is based on the largest clinical trial ever conducted by the National Institute of Mental Health, or NIMH. It is NIMH's first clinical trial involving children and the longest active treatment study of ADHD.

Its strongest finding is that drugs work. Closely monitored treatment with stimulant drugs (Ritalin is one of four commonly prescribed, and its use has increased 700 percent in this decade) can erase enough symptoms of ADHD to eliminate the diagnosis for 82 to 85 percent of children. That may reassure parents who are giving their children the typical twice-daily dose, but the study also suggests that three times a day works better, with a nighttime dose about half the size of the first two. Researchers monitored the ef-

PHOTOGRAPHY BY  
MARC ASNIN-SABA FOR USN&WR



**WHIRLWIND.** It doesn't take much to distract Faith Harris, 7, from her homework. Her mother's job is to keep her on track.



**DAYDREAMER.** At school and play, Jimmy Reinicke, 11 (standing), can get engrossed in one subject to the exclusion of everything else.

fect of the drug closely, through talks with both parents and teachers—first weekly, then monthly—altering the dose or changing drugs as necessary.

How often does that happen in everyday cases? Hardly ever, says William Pelham, one of the principal investigators of the NIMH study and director of the Attention Deficit Hyperactivity Disorder Program and Summer Treatment Program at SUNY-Buffalo. (There are 16 such state-of-the-art summer treatment camps; for information, call 716-833-2143.) "That kind of prescribing is an extreme rarity," says Pelham. "If one tenth of 1 percent of kids are getting medicated like this, I'd be astonished. It should be 100 percent."

**Straight A's.** Doctors also got a daily behavioral report card from teachers to help them decide whether a drug was working and the dosage was right. That kind of communication rarely happens in the real world. But "without that report card, it's like asking a physician to manage a diabetic without data on blood sugar," says Mark Wolraich, director of Vanderbilt University's child development center.

Few things are clear about this disorder—not even what to call it, despite the

fact that it's the most commonly diagnosed behavioral disorder in children. One early term was minimal brain dysfunction; another was hyperkinesis. Then it was called attention deficit disorder, or ADD—a term that still has wide currency. The behavior associated with it seemed essentially disruptive and impulsive; kids with the disorder, it was thought, would jump from Legos to Matchbox cars, from a hula hoop to a Superman doll, shoving their best friends to the ground in the process. Many children with the disorder are disruptive and impulsive. But others are more quietly distracted, their attention diverted by something as innocuous as a blowing leaf, which they then lose interest in if a bird flies by.

Two New York children illustrate the difference between the hyperactive and the inattentive. Faith Harris, now 7, was a whirlwind even as a baby. She'd shake a rattle once, throw it down, then grab a ball. She'd push the ball, but before it stopped, she'd pick up her teddy bear. And she'd forget about that if she saw a shadow move across the wall. "She was the busiest baby I ever saw," says her mother, Jean.

By the time Faith was 4 years old, she

had been diagnosed with ADHD. A doctor recommended Ritalin, and before she was 5, Faith was taking the drug twice a day. But after six months, Harris and the child's doctor agreed the drugs were having no effect. Faith is one of a minority of children for whom such drugs don't work. She struggles mightily to sit still, pay attention, and get her schoolwork done.

Jimmy Reinicke, 11, is primarily inattentive (actually, boys are more often hyperactive than inattentive, whereas most girls with ADHD are primarily inattentive). When Jimmy was in first grade, the bell rang for lunch and the teacher asked the class to line up. The noisy 6-year-olds scrambled out of their desks and marched out into the hall; the teacher slammed the door shut behind her. But Jimmy didn't notice. His mother doesn't know exactly what he was doing—maybe examining his new crayons. Suddenly, he looked up and realized the class had left without him. "His classmates called him Jimmy from Outer Space," says his mother. Jimmy started on Ritalin and switched to a newer drug, Adderall, after showing side effects like anxiety and insomnia. (Other stimulants prescribed are Dexedrine and Cy-

lert.) Jimmy has just started junior high school, a point at which many ADHD children run into trouble because of added academic pressure and personal responsibility. He's doing well so far.

A scientific debate over whether this is one disease with subtypes or two entirely different diseases will take place this week as the National Institutes of Health hosts a consensus conference on ADHD. (A consensus conference draws together the best minds in a field to hash out medical disagreements among them.) The NIMH study looked only at children who were both hyperactive and inattentive, because researchers reasoned they should study children with the most severe form of the disorder. It's not yet clear if the positive findings about the benefit of medication for these children will also apply to children like Jimmy. But children like Faith, if prescribed drugs under such close scrutiny, could increase their odds of getting better.

**Zero absolutes.** What is clear, from studies of twins and of patterns within families, is that children inherit a tendency toward ADHD. In fact, multiple genetic components contribute to an array of symptoms; so do a child's surroundings. But there's no biological marker, no brain scan, no blood test, no definitive psychological test that absolutely diagnoses ADHD. Some doctors and teachers see it in every child who misbehaves; others don't even believe it exists.

Scientists think ADHD occurs in part because certain receptors in the brain involved in focusing attention and reining in impulsiveness fail to respond to the brain's natural chemicals, dopamine and norepinephrine. The interactions between the chemicals and the receptors help most of us stick with tedious chores like balancing the checkbook (they also prevent most of us from blurting out spontaneous observations about the boss's ideas). Medications like Ritalin are thought to increase those chemicals and to stimulate the inhibitory receptors, producing the odd result of a stimulant drug's acting to increase inhibition. The drugs enter the body quickly and leave just as quickly, curing nothing but letting a child focus on the important work of learning.

The NIMH study, which lasted 14 months, looked at 576 children in six cities, sorting them into four groups. One received drugs. One got "psychosocial therapy," which meant parent training, teacher counseling, and intensive work on the children's social skills, and a third got

both drugs and therapy. A fourth group, used as a control, received whatever treatment happened to be available. Drugs alone worked; slightly better were drugs in combination with other therapy. Both approaches worked far better than psychosocial treatment alone or standard outside treatment.

Researchers fear the results will be misinterpreted as evidence that all ADHD children need is a good, mind-altering drug. But it's not that simple. The chil-

study's finding that medication alone has no long-term benefit on how children do academically is frustrating. And an observation that the children receiving combination therapy (drugs plus behavior modification taught at school, at home, and with other kids their age) did slightly better than those on drugs alone was also inconclusive: It remains to be seen how each group of children, 7 to 9 years old when the study began, fares in adolescence.

Meanwhile, about 25 percent of parents

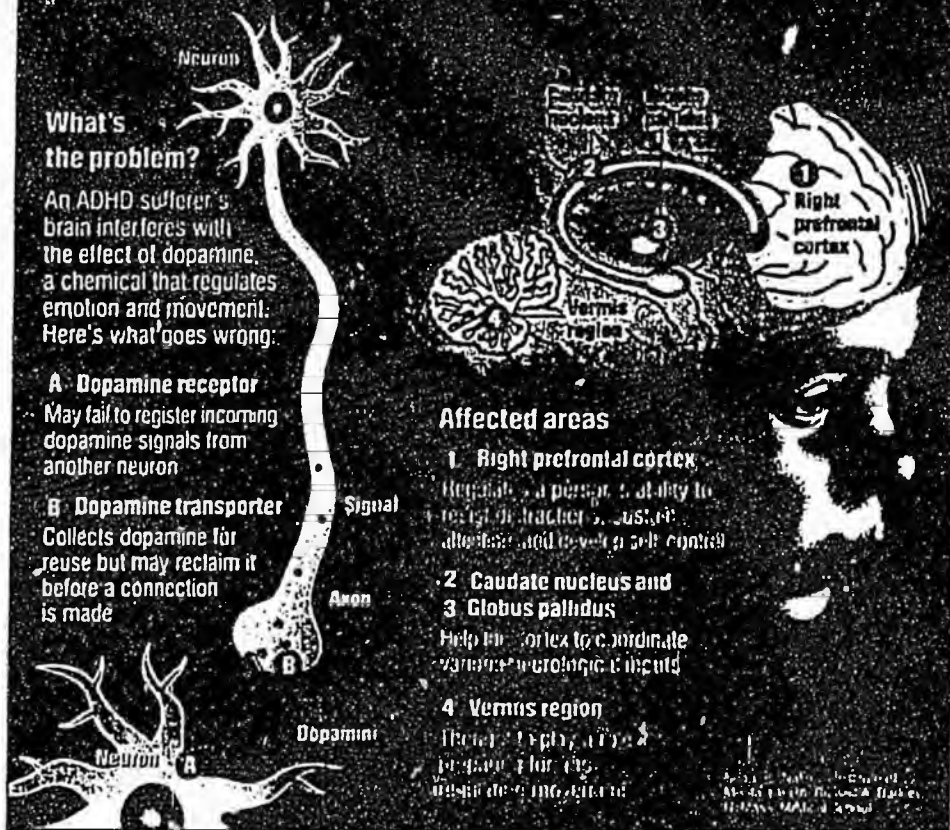
## Missed connections

Attention deficit hyperactivity disorder (ADHD) may result from the brain's inability to catch up on cues.

### What's the problem?

An ADHD sufferer's brain interferes with the effect of dopamine, a chemical that regulates emotion and movement. Here's what goes wrong:

- A Dopamine receptor**  
May fail to register incoming dopamine signals from another neuron
- B Dopamine transporter**  
Collects dopamine for reuse but may reclaim it before a connection is made



### Affected areas

- 1 Right prefrontal cortex**  
Regulates a person's ability to resist distraction, control attention and to exert self-control
- 2 Caudate nucleus and Globus pallidus**  
Help the cortex to coordinate various neurologic functions
- 3 Vermis region**  
Helps regulate posture and balance

dren getting nondrug therapy received intensive treatment for nine months, including eight weeks at a special summer camp, but then treatment leveled off. The children on drugs, by contrast, got their doses like clockwork for the full period of the study, three times a day, seven days a week. "There are few, if any, psychosocial researchers who would say that five months after you stop treatment, children would do as well as those children still taking drugs," says Pelham. "Everybody knows that, in the short run, medication has a whopping effect."

It's the long run that's uncertain. The

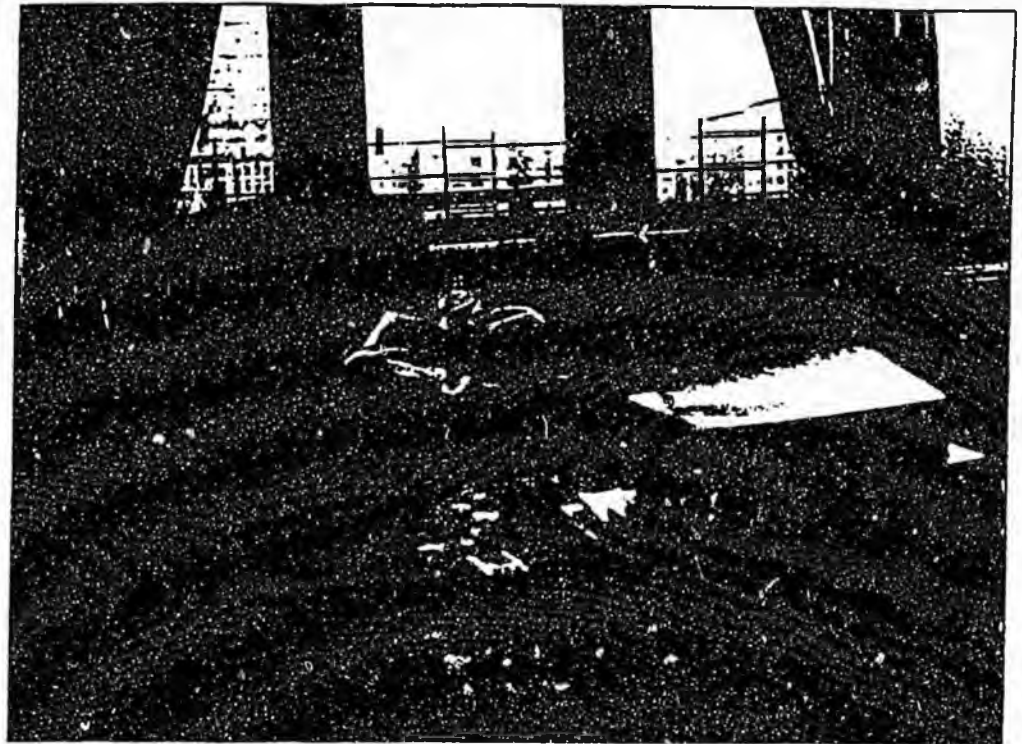
adamantly refuse to give their children drugs for the disorder, says Peter Jensen, associate director for child and adolescent research at NIMH and one of the lead investigators on the study. "Probably about 1 in 3 children with ADHD is getting treated with a drug," says Jensen. "There is probably dramatic *undertreatment* with drugs."

But some experts think there is overtreatment as well. "What's maddening is that I see it in both directions," says Glen Elliott, director of child and adolescent psychiatry at the University of California-San Francisco. He sees children who could benefit from drugs but whose fam-

ilies refuse medication. He also sees families for whom an ADHD diagnosis is "getting them off the hook. They've got a kid who's a pain in the rear and they want a drug."

**Problem child.** The pressure doesn't always come from parents; sometimes the school system insists on a brain-disorder label. A Midwestern professor, for example, who wants to protect his daughter's privacy by not using his name, talks about endless phone calls from teachers about his child, who as a preschooler liked to play by herself. Now 7, she grew up the only child in a quiet, academic household, and when she went to school she had trouble getting along with kids her age. She'd play alone, quietly working a puzzle, say, and her teachers were alarmed. Boys would bully her, and she'd retreat.

"First it was the teacher. Then the school counselor. Then the heavies in the school, the principal, start to show up. You go to meetings, and everybody thinks your child has a problem," he said. Doctors and therapists each had a different diagnosis—ADHD, anxiety disorder, obsessive-compulsive disorder, depression—and each diagnosis called for a different drug. But at home, his daughter did well; her grades and reading skills were so good that she was able to advance directly from kindergarten to second grade. The professor continues to refuse drug treatment, and his greatest concern is that his daughter has been labeled "abnormal." "Social conformity and mental health are becoming the same terms," he says. "The person with a different perspective is seen



**FOCUSED DOSE.** Ann Collin gives her 9-year-old son, Willie (above), Ritalin before he studies.

as a candidate for medication."

Lawrence Diller, a San Francisco pediatrician who specializes in ADHD, often prescribes stimulant drugs for children but believes that treating a disorder has become confused with enhancing performance in an increasingly competitive society. Diller wrote *Running on Ritalin: A Physician Reflects on Children, Society, and Performance in a Pill* (Bantam, 1998, \$26), and he lays the blame for a lot of children's behavioral problems on social conditions: Parents are away from home too much, large classes demand conventional behavior, and quirky kids get labeled and lost. "I just don't believe a pill is

the moral equivalent of good parenting and good schooling," says Diller. "I prescribe it because I recognize I can't change the larger social and cultural factors. My job is to relieve suffering, and Ritalin, in the short term, will ease suffering."

It may ease suffering, but Ritalin will never cure in the way an antibiotic cures an ear infection. The symptoms of ADHD retreat only for as long as those diagnosed with it keep gulping down the little yellow pills. Parents of 1 million children are pinning their hopes on the theory, as yet unproven, that the respite their children get through Ritalin will buy them the attention span they need to develop. ■

#### QUESTIONS TO ASK

### To drug or not to drug

**T**esting a child for attention deficit hyperactivity disorder (ADHD) means working with a pediatrician, a child psychiatrist, a child psychologist, or a pediatric neurologist. The specialty matters less than does experience. Beware of therapists

who either push drugs immediately or dismiss drugs completely.

About two thirds of children don't outgrow the disorder, so be wary of advice to wait and see. Most experts agree that medication can help, but it isn't the only solution—parents and teachers need to learn new ways (through rewards and consequences, for example) to teach their kids how to follow rules and sit still. And don't

go to the doctor and accept a prescription after a 15-minute office visit; an evaluation should include medical, psychological, behavioral, and educational assessments. The doctor or therapist should talk both to parents and the child, and get information from teachers before coming to a conclusion.

Once your child is diagnosed, beware of unproven therapies. Sugar doesn't cause ADHD, and a special

diet won't cure it. Many children are still treated with traditional one-on-one therapy, with play therapy in a therapist's office, or with biofeedback, none of which has been proven effective in treating ADHD. Previous studies have proven only three approaches to be effective: medication, behavior therapy (in which parents and teachers are taught how to work with children), and a combination of both. —S.B.

**Attachment J**

**"Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder," NIH Consensus Statement Online, November 16-18, 1998**

**DRAFT - - DRAFT - - DRAFT**

## **110. Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder**

National Institutes of Health  
Consensus Development Conference Statement  
November 16-18, 1998

This statement will be published as:

Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder. NIH Consensus Statement 1998 Nov 16-18; 16(2): In press.

For making bibliographic reference to consensus statement no. 110 in the electronic form displayed here, it is recommended that the following format be used:

Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder. NIH Consensus Statement Online 1998 Nov 16-18; In press. [cited year, month, day]; 16(2): In press.

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NIH Consensus Statements are prepared by a nonadvocate, non-Federal panel of experts, based on (1) presentations by investigators working in areas relevant to the consensus questions during a 2-day public session; (2) questions and statements from conference attendees during open discussion periods that are part of the public session; and (3) closed deliberations by the panel during the remainder of the second day and morning of the third. This statement is an independent report of the consensus panel and is not a policy statement of the NIH or the Federal Government.

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### **Introduction**

Attention deficit hyperactivity disorder (ADHD) is the most commonly diagnosed behavioral disorder of childhood, estimated to affect 3 to 5 percent of school-age children. Its core symptoms include a developmentally inappropriate level of attention and concentration, developmentally inappropriate levels of activity, distractibility, and impulsivity. Children with ADHD usually have pronounced difficulties and impairment resulting from the disorder across multiple settings—in home, at school, and with peers—as well as resultant long-term adverse effects on later academic, vocational, social-emotional, and psychiatric outcomes.

Despite the progress in the assessment, diagnosis, and treatment of children and adults with ADHD, the disorder has remained controversial in many public and private sectors. The confusion resulting from diverse, frequently expressed opinions has made many families, health care providers, educators, and policymakers uncertain about the status of the disorder and its long-term consequences, whether it should be treated, and, if so, how. One of the major controversies regarding ADHD concerns the use of psychostimulants to treat the condition. Psychostimulants, including amphetamine, methylphenidate, and pemoline, are by far the most widely researched and commonly prescribed treatments for ADHD. The use of methylphenidate and amphetamine nationwide has increased significantly in recent years. The increased production and use of psychostimulants have intensified the concerns about use, overuse, and abuse. This 2½-day conference brought together national and international experts in the fields of relevant medical research and health care as well as representatives from the public.

After 1½ days of presentations and audience discussion, an independent, non-Federal consensus panel chaired by Dr. David J. Kupfer, Thomas Detre Professor and Chair, Department of Psychiatry, University of Pittsburgh, weighed the scientific evidence and wrote a draft statement that was presented to the audience on the third day. The consensus statement addressed the following key questions:

- What is the scientific evidence to support ADHD as a disorder?
- What is the impact of ADHD on individuals, families, and society?
- What are the effective treatments for ADHD?
- What are the risks of the use of stimulant medication and other treatments?
- What are the existing diagnostic and treatment practices, and what are the barriers to appropriate identification, evaluation, and intervention?
- What are the directions for future research?

The primary sponsors of this conference were the National Institute on Drug Abuse, the National Institute of Mental Health, and the NIH Office of Medical Applications of Research. The conference was cosponsored by the National Institute of Environmental Health Sciences, the National Institute of Child Health and Human Development, the U.S. Food and Drug Administration, and the Office of Special Education Programs, U.S. Department of Education.

### **1. What Is the Scientific Evidence To Support ADHD as a Disorder?**

The diagnosis of ADHD can be made reliably using well-tested diagnostic interview methods. However, 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. Further research to establish the validity of the disorder continues to be a problem. This is not unique to ADHD, but applies as well to most psychiatric disorders, including disabling diseases such as schizophrenia. Evidence supporting the validity of ADHD includes the predictable course of ADHD over time, cross-national studies revealing similar risk factors, familial aggregation of ADHD (which may be genetic or environmental), and heritability. Further efforts to validate the disorder are needed: careful description of the cases, use of specific diagnostic criteria, repeated followup studies, family studies (including twin and adoption studies), epidemiologic studies, and treatment studies. To the maximum extent possible, such studies should include various controls, including normal subjects and those with other

clinical disorders.

Such studies may provide suggestions about subgrouping of patients that will turn out to be associated with different outcomes, responses to different treatment, and varying patterns of familial characteristics and illnesses. As homogeneous subgroups become identified, they can facilitate efforts to delineate alterations in structure and function.

Certain issues about the diagnosis of ADHD have been raised that indicate the need for further research to validate diagnostic methods.

1. Clinicians who diagnose this disorder have been criticized for merely taking a percentage of the normal population who have the most evidence of inattention and continuous activity and labeling them as having a disease. In fact, it is unclear whether the signs of ADHD represent a bimodal distribution in the population or one end of a continuum of characteristics. This is not unique to ADHD as other medical diagnoses, such as essential hypertension and hyperlipidemia, are continuous with the normal population, yet the utility of diagnosis and treatment have been proven. Nevertheless, related problems of diagnosis include differentiating this entity from other behavioral problems and determining the appropriate boundary between the normal population and those with ADHD.
2. ADHD often does not present as an isolated disorder, and comorbidities (coexisting conditions) may act as confounders in any research studies. This may account for some of the inconsistencies in research findings.
3. Although the prevalence of ADHD in the United States has been estimated at about 3 to 5 percent, it is clear that wider ranges of prevalence have been reported. The reported rate in some other countries is much lower. This indicates a need for better study of ADHD in different populations and better definition of the disorder.
4. All formal diagnostic criteria for ADHD were designed for diagnosing young children and have not been adjusted for older children and adults. Therefore, appropriate revision of these criteria to aid in the diagnosis of these individuals is encouraged.
5. In summary, there is validity in the diagnosis of ADHD, defining a maladjustive cluster of characteristics.

## **2. What Is the Impact of ADHD on Individuals, Families, and Society?**

Children with ADHD experience an inability to sit still and pay attention in class and the negative consequences of such behavior. They experience peer rejection and engage in a broad array of disruptive behaviors. Their academic and social difficulties have far-reaching and long-term consequences. These children have higher accident rates, and later in life, children with ADHD in combination with conduct disorders experience drug abuse, antisocial behavior, and accidents of all sorts. For many individuals, the impact of ADHD continues into adulthood.

Families who have children with ADHD, as with other behavioral disorders and chronic diseases, experience increased levels of parental frustration, marital discord, and divorce. In addition, the direct costs of medical care for children and youth with ADHD are substantial. These costs represent a serious

burden for many families because they frequently are not covered by health insurance.

In the larger world, these individuals consume a disproportionate share of resources and attention from the health care system, criminal justice system, schools, and other social service agencies. Methodologic problems preclude precise estimates of the cost of ADHD to society. However, these costs are large. For example, additional national public school expenditures on behalf of students with ADHD may have exceeded \$3 billion in 1995. Moreover, ADHD, often in conjunction with coexisting conduct disorders, contributes to societal problems such as violent crime and teenage pregnancy.

Families of children impaired by the symptoms of ADHD are in a very difficult position. An already painful decision-making process is often made substantially worse by the media war between those who overstate the benefits of treatment and those who overstate the dangers of treatment.

### **3. What Are the Effective Treatments for ADHD?**

A wide variety of treatments have been used for ADHD including, but not limited to, various psychotropic medications, psychosocial treatment, dietary management, herbal and homeopathic treatments, biofeedback, meditation, and perceptual stimulation/training. Of these treatment strategies, medications and psychosocial interventions have been the major focus of research. Studies on the efficacy of medication and psychosocial treatments for ADHD have focused primarily on a condition equivalent to DSM-IV combined type, meeting criteria for Inattention and Hyperactivity/Impulsivity. Until recently, most randomized clinical trials have been short term, up to approximately 3 months. Overall, these studies support the efficacy of stimulants and psychosocial treatments for ADHD. However, there are no long-term studies testing stimulants or psychosocial treatments lasting several years. There is no information on the long-term outcomes of medication-treated ADHD individuals in terms of educational and occupational achievements, involvement with the police, or other areas of social functioning.

Short-term trials of stimulants have supported the efficacy of methylphenidate (MPH) dextroamphetamine, and pemoline in children with ADHD. Few, if any, differences have been found among these stimulants on average. However, MPH is the most studied and the most often used of the stimulants. These short-term trials have found beneficial effects on the defining symptoms of ADHD and associated aggressiveness as long as medication is taken. However, stimulant treatments do not "normalize" the entire range of behavior problems, and children under treatment still manifest a higher level of some behavior problems than normal children. Of concern are the consistent findings that despite the improvement in core symptoms, there is little improvement in academic achievement or social skills.

Several short-term studies of antidepressants show that desipramine produces improvements over placebo in parent and teacher ratings of ADHD symptoms. Results from studies examining the efficacy of imipramine are inconsistent. Although a number of other psychotropic medications have been used to treat ADHD, the extant outcome data from these studies do not allow for conclusions regarding their efficacy.

Psychosocial treatment of ADHD has included a number of behavioral strategies such as contingency management (e.g., point/token reward systems, timeout, response cost) that typically is conducted in the classroom, parent

training (where the parent is taught child management skills), clinical behavior therapy (parent, teacher, or both are taught to use contingency management procedures), and cognitive-behavioral treatment (e.g., self-monitoring, verbal self-instruction, problem-solving strategies, self-reinforcement).

Cognitive-behavioral treatment has not been found to yield beneficial effects in children with ADHD. In contrast, clinical behavior therapy, parent training, and contingency management have produced beneficial effects. Intensive direct interventions in children with ADHD, such as summer camp programs, have produced improvements in key areas of functioning. However, no randomized control trials have been conducted on the summer camp intervention alone or in combination with medication.

Emerging data suggest that medication using systematic intensive monitoring methods over a period of approximately 1 year may be superior to an intensive set of behavioral treatments on core ADHD symptoms (inattention, hyperactivity/impulsivity, aggression). Combined medication and behavioral treatment added little advantage overall, but combined treatment did result in more improved social skills, and parents and teachers judged this treatment more favorably. Both systematically applied medication and combined treatment were superior to routine community care, which often involved the use of stimulants. An important potential advantage for behavioral treatment is the possibility of improving functioning with reduced dose of stimulants. This possibility was not tested.

There is a long history of a number of other interventions for ADHD. These include dietary replacement, herbal exclusion or supplementation, various vitamin or mineral regimens, biofeedback, perceptual stimulation, and a host of others. Although these interventions have generated considerable interest and there are some controlled and uncontrolled studies using various strategies, the state of the empirical evidence regarding these interventions is uneven, ranging from no data to well-controlled trials. Some of the dietary elimination strategies showed intriguing results suggesting future research.

The current state of the empirical literature regarding the treatment of ADHD is such that at least five important questions cannot be answered. First, it cannot be determined if the combination of stimulants and psychosocial treatments can improve functioning with reduced dose of stimulants. Second, there are no data on the treatment of ADHD, Inattentive type, which might comprise a high percentage of girls. Third, there are no conclusive data on treatment in adolescents and adults with ADHD. Fourth, there is no information on long-term treatment (treatment lasting more than 1 year), which is indicated in this persistent disorder. Finally, given the evidence about the cognitive problems associated with ADHD, such as deficiencies in working memory and language processing deficits, and the demonstrated ineffectiveness of current treatments in enhancing academic achievement, there is a need for application and development of methods targeted to these weaknesses.

#### **4. What Are the Risks of the Use of Stimulant Medication and Other Treatments?**

Although little information exists concerning the long-term effects of psychostimulants, there is no conclusive evidence that careful therapeutic use is harmful. When adverse drug reactions do occur, they are usually related to dose. Effects associated with moderate doses may include decreased appetite and insomnia. These effects occur early in treatment and may decrease with continued dosing. There may be negative effects on growth rate, but ultimate height appears not to be affected.

It is well known that psychostimulants have abuse potential. Very high doses of psychostimulants, particularly of amphetamines, may cause central nervous system damage, cardiovascular damage, and hypertension. In addition, higher doses have been associated with compulsive behaviors and, in certain vulnerable individuals, movement disorders. There is a very small percentage of children and adults treated at high doses who have hallucinogenic responses. Drugs used for ADHD other than psychostimulants have their own adverse reactions: tricyclic antidepressants may induce cardiac arrhythmias, bupropion at high doses can cause seizures, and pemoline is associated with liver damage.

The degree of assessment and followup by primary care physicians varies significantly. This variance may contribute to the marked differences in appropriate prescribing practices. Adequate followup is required for any prescribed medications, especially for higher doses of psycho-stimulants. Although an increased risk of drug abuse and cigarette smoking is associated with childhood ADHD (see Question 2), existing studies come to conflicting conclusions as to whether use of psychostimulants increases or decreases the risk of abuse. A major limitation of inferences from observational databases is that the diagnosis of ADHD is confounded with the use of stimulant medication; additional confounders include severity of ADHD and coexisting conditions.

The increased availability of stimulant medications may pose risks for society. The threshold of drug availability that can lead to oversupply and consequent illicit use is unknown. There is little evidence that current levels of production have had a substantial effect on abuse. However, there is a need to be vigilant in monitoring the national indices of use and abuse among high school seniors and Drug Abuse Warning Network (DAWN) emergency room reports.

##### **5. What Are the Existing Diagnostic and Treatment Practices, and What Are the Barriers to Appropriate Identification, Evaluation, and Intervention?**

The American Academy of Child and Adolescent Psychiatry has published practice parameters for the assessment and treatment of ADHD. The American Academy of Pediatrics has formed a subcommittee to establish parameters for pediatricians, but those guidelines are not available at this time. Primary care and developmental pediatricians, family practitioners, (child) neurologists, psychologists, and psychiatrists are the providers responsible for assessment, diagnosis, and treatment for most children with ADHD. There exists wide variation among type of practitioner with respect to frequency of diagnosis of ADHD. The type of practitioner also determines the frequency of stimulant prescription management; data indicate that family practitioners prescribe medication more frequently than psychiatrists or pediatricians. This may be due in part to the limited time spent making the diagnosis. This propensity for prescribing medications may remove incentives for establishing educationally relevant interventions. Some practitioners invalidly use response to medication as a diagnostic criterion. Primary care practitioners are less likely to recognize comorbid (coexisting) disorders.

Diagnoses are often made in an inconsistent manner with children sometimes being overdiagnosed and sometimes being underdiagnosed. Some practitioners do not use structured parent questionnaires or rating scales or teacher or school input. Pediatricians, family practitioners, and psychiatrists tend to rely on parent rather than teacher input. There appears to be a "disconnect" between developmental or educational (school-based) assessments and health-related

(medical practice-based) services. There is often poor communication between diagnosticians and those who implement and monitor treatment in schools. In addition, followup may be inadequate and fragmented. This is particularly important to ensure monitoring and early detection of any adverse effect of therapy. School-based clinics with a team approach that includes parents, teachers, school psychologists, and other mental health specialists may be a means to remove these barriers and improve access to assessment and treatment. Ideally, primary care practitioners with adequate time for consultation with such school teams should be able to make an appropriate assessment and diagnosis, but they should also be able to refer to mental health and other specialists when deemed necessary.

*What are the barriers to appropriate identification, evaluation, and intervention?*

Studies identify a number of barriers to appropriate identification, evaluation, and treatment. Barriers to identification and evaluation arise when central screening programs limit access to mental health services. The lack of insurance coverage of neuropsychological evaluations, behavior modification programs, school consultation, parent management training, and other specialized programs presents a major barrier to accurate classification, diagnosis, and management of ADHD. Substantial cost barriers exist in that diagnosis results in out-of-pocket costs to families for services not covered by managed care or other health insurance. Mental health benefits are carved out of many policies offered to families, and thus access to treatment other than medication might be severely limited. Parity for mental health conditions in insurance plans is essential. Another cost implication lies in the fact that there is no funded special education category for ADHD, which leaves these students underserved. This results in educational and mental health service sources disputing responsibility for coverage of special educational services.

Barriers exist in relationship to gender, race, socioeconomic factors, and geographical distribution of patients seeking identification and evaluation. Other important barriers include those perceived by patients, families, and clinicians. These include lack of information, concerns about risks of medications, loss of parental rights, fear of professionals, social stigma, negative pressures from families and friends against seeking treatment, and jeopardizing jobs and military service. For health care providers, the lack of specialists and difficulties obtaining insurance coverage as outlined above present significant obstacles to care.

## **6. What Are the Directions for Future Research?**

Basic research is needed to better define ADHD. This research includes the following: (1) studies of cognitive development and cognitive processing in ADHD and (2) brain imaging studies before the initiation of medication and following the individual through young adulthood and middle age.

Further research should be conducted with respect to the dimensional aspects of this disorder, as well as the comorbid (coexisting) conditions present in both childhood and adult ADHD. Therefore, an important research need is the investigation of standardized age- and gender-specific diagnostic criteria.

The impact of ADHD should be determined. Studies in this regard include (1) the nature and severity of the impact on individuals, families, and society of adults with ADHD beyond the age of 20 and (2) determination of the financial costs related to diagnosis and care of children with ADHD.

Additional studies are needed to develop a more systematized treatment strategy. These include:

- Studies of the inattentive type of ADHD, especially since it might comprise a higher proportion of girls than the other subtypes.
- Studies of long-term treatment (treatment lasting longer than 1 year), which are needed because of the persistence of the disorder.
- Prospective controlled studies, up to adulthood, of the risks and benefits associated with childhood treatment with psychostimulants.
- Studies to determine the effects of psychotropic therapy on cognitive function and school performance.
- Studies of the effects of instructional treatments on the academic achievement of children with ADHD.
- Studies to determine whether the combination of stimulants and psychosocial treatments can improve functioning with a reduced dose of stimulants.
- Studies to determine the risks and benefits associated with treating children younger than age 5 with stimulants.

Greater attention should be given to developing integrated programs for diagnosis and treatment. These include:

- Model projects to demonstrate methods of training teachers to recognize and provide appropriate special programs for children with ADHD.
- Incorporation of classroom strategies to effectively serve a greater variety of students and thereby reduce the prevalence of ADHD referral and diagnosis.
- Determination of the extent to which individuals with ADHD are being served in postsecondary education and, if so, where they are being served, with what types of accommodations, and with what level of success.

## Conclusions

Attention deficit hyperactivity disorder or ADHD is a commonly diagnosed behavioral disorder of childhood that represents a major public health problem. Children with ADHD usually have pronounced difficulties and impairments resulting from the disorder across multiple settings. They also can experience long-term adverse effects on later academic, psychosocial, and psychiatric outcomes.

Despite progress in the assessment, diagnosis, and treatment of ADHD, this disorder and its treatment have remained controversial in many public and private sectors. The major controversy regarding ADHD continues to be the use of psychostimulants both for short-term and long-term treatment.

Although a consistent diagnostic test for ADHD does not exist, evidence supporting the validity of the disorder can be found. Further research will need

to be conducted with respect to the dimensional aspects of ADHD, as well as the comorbid (coexisting) conditions present in both childhood and adult ADHD. Therefore, an important research need is the investigation of standardized age-and gender-specific diagnostic criteria.

The impact of ADHD on individuals, families, schools, and society is profound and necessitates immediate attention because a considerable share of resources from the health care system and various social service agencies is currently devoted to ADHD, often in a nonintegrated manner. Resource allocation based on better cost data leading to integrated care models needs to be developed for individuals with ADHD.

Effective treatments for ADHD have been evaluated primarily for the short term (approximately 3 months). These studies have included randomized clinical trials that have established the efficacy of stimulants and behavioral treatments for positive effects on the defining symptoms of ADHD and associated aggressiveness. Lack of consistent improvement beyond the core symptoms leads to the need for treatment strategies that utilize combined approaches. At the present time, there is a paucity of data providing information on long-term treatment beyond 14 months. Although trials combining drugs and behavioral modalities are underway, conclusive recommendations concerning treatment for the long term cannot be made easily.

The risks of treatment, particularly the use of stimulant medication, are of considerable interest. Substantial evidence exists of wide variations in the use of psychostimulants across communities and physicians, suggesting no consensus among practitioners regarding which ADHD patients should be treated with psychostimulants. As measured by attention/activity indices, patients with varying levels and types of problems (and even possibly unaffected individuals) may benefit from stimulant therapy. However, there is no evidence regarding the appropriate ADHD diagnostic threshold above which the benefits of psychostimulant therapy outweigh the risks.

Existing diagnostic and treatment practices, in combination with the potential risks associated with medication, point to the need for improved awareness by the health service sector concerning an appropriate assessment, treatment, and followup. A more consistent set of diagnostic procedures and practice guidelines is of utmost importance. Current barriers to evaluation and intervention exist across the health and education sectors. The cost barriers and lack of coverage preventing the appropriate diagnosis and treatment of ADHD and the lack of integration with special educational services represent considerable long-term cost for society. The lack of information and education about accessibility and affordability of services must be remedied.

Finally, after years of clinical research and experience with ADHD, our knowledge about the cause or causes of ADHD remains speculative. Consequently, we have no strategies for the prevention of ADHD.

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## Psychotropic Drugs

Imagine a society where children are all on psychotropic drugs. Imagine it is the teacher's fault, because they referred all the kids. A society where the drugs are doing more bad than good. That could happen if someone doesn't take the power away from teachers to put kids on psychotropic drugs. This could be a serious problem in the near future.

I believe you should pass Senate Bill No. 230 and save our society's children. Senate Bill 230 is trying to limit teachers influence on putting kids on psychotropic drugs. Psychotropic drugs are drugs to calm children down like Ritalin or to treat mental disabilities like Depression. Teachers sometimes recommend these drugs to parents of disobedient kids for behavior problems. According to the *Journal of the American Medical Association*, from 1991 to 1995, the number of preschoolers on antidepressants increased 200 percent, and the number of children ages 2 to 4 taking stimulants more than doubled. Chemically treating our children at the rate we are now, may lead to problems in our society that will require emotional and financial costs, to correct. These medications are being prescribed to children at increasingly younger ages, and I believe this is because of the school influence.

There are some children for whom Ritalin may be their best option. However, there are countless others that are being drugged unnecessarily. There are some downsides to Ritalin like:

Ritalin is derived from the same family as cocaine.

Ritalin lasts only four hours.

Ritalin treats only some of the symptoms of ADD.

Ritalin provides superficial healing, does not treat the root of the problem.

Ritalin can cause side effects such as appetite loss, anxiety, insomnia, lies, headaches, stomach aches.

Ritalin use is responsible for causing children to begin a habit of taking drugs.

Ritalin may need to be taken over entire life span.

Stimulant drugs were found to have a short-term effectiveness of 60 to 80 percent in reducing the hyperactivity, distractibility, and impulsiveness of school-age children. Studies beginning in the 1960s showed that children who took stimulants for hyperactivity over several years did just as poorly in later life as the group of hyperactive children who took no medication. Doctors sharply criticized the lack of a uniform system for diagnosing and treating ADHD, saying the Health Department had largely ignored National Health and Medical Research Council recommendations published in 1997. Dr. Florence Levy, from the Sydney Children's Hospital, has expressed concern at the frequency of incorrect diagnosis before.

The facts are stark. The numbers of kids on psychotropic drugs is rising. School influence is forcing parents to put their kids on psychotropic drugs by threatening to take it to Social Services and even reporting them. Most teachers probably have never been to medical school and can't diagnose that kind of disorder. If there is I'd like to meet them. But for now we need to limit what schools can do.

Ritalin is commonly used psychotropic drug.

**Subject: Comment on SB 230**

**Date:** Sat, 27 Apr 2002 18:53:27 -0800

**From:** "Christina T. Zafren" <czafren@alaska.com>

**To:** Randy Phillips <Senator\_Randy\_Phillips@legis.state.ak.us>,  
Jerry Ward <Senator\_Jerry\_Ward@legis.state.ak.us>,  
Robin Taylor <Senator\_Robin\_Taylor@legis.state.ak.us>,  
Loren Leman <Senator\_Loren\_Leman@legis.state.ak.us>,  
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Johnny Ellis <Senator\_Johnny\_Ellis@legis.state.ak.us>,  
Lyda Green <Senator\_Lyda\_Green@legis.state.ak.us>,  
John Cowdery <Senator\_John\_Cowdery@legis.state.ak.us>

**CC:** theo lexmond <tlex@kpbsd.k12.ak.us>

Alaska School Psychologists Association  
10181 Curvi Street  
Anchorage, AK 99507  
March 24, 2002

Dear Senators,

The Alaska School Psychologists Association would like to register concern with Senate Bill No. 230.3 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<sup>2</sup>. Our specific concerns are with AMENDMENT AS47.33120 (A) SUBSECTION 9 - creating policies prohibiting school personnel from discussion of the possible use and benefits of psychotropic drugs for students with behavioral and/or emotional problems.

As professionals, we believe that legislation, such as SUBSECTION 9, is **unnecessary** and **ill-advised** for the following reasons:

SUBSECTION 9 is **unnecessary** because school psychologists' ethical standards already prohibit us from acting outside our areas of professional expertise and knowledge. School psychologists who deviate from these ethical standards will be dealt with administratively and/or through the Professional Teaching Practices Commission. State regulation of this administrative function is therefore unnecessary.

SUBSECTION 9 is **ill-advised** because:

It may be interpreted as prohibiting any discussion by knowledgeable school personnel (e.g. school psychologists) of the options available for families in addressing a variety of emotional and/or behavioral disorders which are manifested by their children, our students. School psychologists are frequently asked by families to help them decide when to seek outside referrals. The information provided to parents by school psychologists is based on the most reliable and current professional recommendations. Additionally, outside referring agencies and mental health professionals frequently rely upon the observations and feedback of school psychologists regarding the efficacy of various psychotropic medications when this is prescribed to our students. This subsections could be interpreted as preventing a school psychologist from performing such a vital role for our families and students.

It could be interpreted as making school districts responsible for the cost of obtaining medical evaluations if these referrals were made as part of a Special Education evaluation.

It currently delineates the only appropriate referral as one to a licensed physician when an appropriate initial referral for a student with behavioral and or emotional problems may be to a licensed mental health provider such as an outpatient psychologist, social worker, rather than only to a licensed physician.

Please take under consideration our concerns as you evaluate this bill. If you have any questions, please do not hesitate to contact us. We would be available for further consultation and/or testimony before a subcommittee.

Sincerely,

Chris Tower Zafren,  
Nationally Certified School Psychologist

cc: Theo Lexmond, President ASPA

**Subject: Please hold a hearing on the amended S.B. 230**

**Date: Wed, 17 Apr 2002 10:19:55 -0400**

**From: "john breeding" <wildcolt@flash.net>**

**To: <Senator\_Lyda\_Green@legis.state.ak.us>**

**CC: <Senator\_Bettye\_Davis@legis.state.ak.us>**

TEXAS

Dear Senator Green,

I am aware that the amended version of Senate Bill 230, relating to the use of psychotropic drugs in the schools, is pending another hearing in your committee. As you know, my organization strongly supports this bill as an important step in protecting parents from pressure and coercion to use psychotropic drugs on their children, and in helping to refocus educators on the very real and important practices of teaching children.

Variations of this bill have been passed in Minnesota, Connecticut and Utah. They are being heard just now in several states, including California, Arizona and Missouri. It is crucial that this issue be fully confronted as the national trends continue toward more and younger children being placed on these dangerous drugs.

As I mentioned in an earlier message to you, it is most often our women legislators who are championing this cause on behalf of our children and families. I beg you to give this amended bill a full hearing as soon as possible. The lives of our children, the integrity of our families, and the safety and effectiveness of our schools are all at stake.

Please use your leadership to ensure a full hearing on this bill, for the good of all our children.

Sincerely,

John Breeding, PhD  
Texans For Safe Education

# FISCAL NOTE

**STATE OF ALASKA**  
**2002 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: SB 230  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): 1/16/2002 9:11 am Dept. Affected: Health & Social Services  
 Title: PSYCHOTROPIC DRUGS FOR TREATMENT OF CHILDREN IN BRU: Purchased Services  
NEED OF AID Component: Foster Care Special Need  
 Sponsor: DAVIS  
 Requestor: SENATE (HES) Component Number: 2238

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( 0 )</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2002) cost: \_\_\_\_\_

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

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

Section 1 of this bill does not impact this department. Sections 2 and 3 amend CINA statute AS 47.10.019. This statute places limits on the court's determinations in finding a minor to be a child in need of aid. This amendment adds a subsection which prohibits the court from finding a minor to be a child in need of aid and prohibits the department from taking custody of a child solely on the basis of an allegation or finding that the child's parent or legal custodian refuses to administer or consent to the administration of psychotropic medication.

Should this bill become law, the department does not anticipate any fiscal impact. The bill has impact on practice only.

Prepared by: Debbie Loveid Phone \_\_\_\_\_  
 Division: Family & Youth Services Date/Time \_\_\_\_\_  
 Approved by: Elmer A. Lindstrom, Deputy Commissioner Date 01/24/2002  
 Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

*Chief find*

*School Psychologist*

22-LS1162VA

*SB 230 provides guidance to teachers  
Teachers may make suggestions, intending  
to be helpful, however they may not be right*

**SENATE BILL NO. 230**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**TWENTY-SECOND LEGISLATURE - SECOND SESSION**

**BY SENATOR DAVIS**

**Introduced: 1/14/02**

**Referred: Health, Education and Social Services, Judiciary**

**A BILL**

**FOR AN ACT ENTITLED**

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

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

5 \* **Section 1.** AS 14.33.120(a) is amended to read:

6 (a) Each governing body shall adopt a written school disciplinary and safety  
7 program. The program required under this subsection must include written

8 (1) standards for student behavior and safety that reflect community  
9 standards and that include, at a minimum, basic requirements for respect and honesty;  
10 standards required under this paragraph must be developed and periodically reviewed  
11 with the collaboration of members of each school, parents, teachers, and other persons  
12 responsible for the students at a school; a governing body may require that standards  
13 developed under this paragraph be consistent for all schools in an attendance area or  
14 the district;

1 (2) standards relating to when a teacher is authorized to remove a  
2 student from the classroom for

3 (A) failure to follow student behavior and safety standards; or

4 (B) behavior described under AS 14.30.045(1) or (2);

5 (3) procedures for notifying teachers of dangerous students consistent  
6 with AS 47.12.310(b);

7 (4) standards relating to when a teacher, teacher's assistant, or other  
8 person responsible for students is authorized to use reasonable and appropriate force to  
9 maintain classroom safety and discipline as described under AS 14.81.430(a)(2);

10 (5) policies necessary to comply with provisions of state and federal  
11 law, including 20 U.S.C. 1400 - 1485 (Individuals with Disabilities Education Act);

12 (6) standards to address needs of students for whom mental health or  
13 substance abuse may be a contributing factor to noncompliance with the school  
14 disciplinary and safety program;

15 (7) policies for implementing a student conflict resolution strategy,  
16 including the nonviolent resolution or mediation of conflicts and procedures for  
17 reporting and resolving conflicts;

18 (8) procedures for periodic review and revision of the school  
19 disciplinary and safety program;

20 (9) policies prohibiting school personnel from recommending the  
21 use of psychotropic drugs for a student and requiring that, if school personnel  
22 perceive that a student may have a behavioral or psychological problem, a letter  
23 be sent to the parent or other person having care and custody of the child  
24 recommending that an appropriate medical or behavioral health evaluation be  
25 conducted by a licensed physician.

*accurate info  
free choice*

*A home call  
intervention  
team meeting*

*other  
intervening  
steps  
pos. behavior  
post-req.*

*FD&A-97  
Dist's  
to pay if in  
reference  
made*

26 \* Sec. 2. AS 47.10.019 is amended to read:

27 **Sec. 47.10.019. Limitations on determinations. (a)** Notwithstanding other  
28 provisions of this chapter, the court may not find a minor to be a child in need of aid  
29 under this chapter solely on the basis that the child's family is poor, lacks adequate  
30 housing, or exhibits a lifestyle that is different from the generally accepted lifestyle  
31 standard of the community where the family lives. However, this subsection

1 [SECTION] may not be construed to prevent a court from finding that a child is in  
2 need of aid if the child has been subjected to conduct or conditions described in  
3 AS 47.10.011 - 47.10.015.

4 \* **Sec. 3.** AS 47.10.019 is amended by adding a new subsection to read:

5 (b) Notwithstanding other provisions of this chapter, a court may not find a  
6 minor to be a child in need of aid and the department may not take custody of a child,  
7 including emergency custody, solely based on an allegation or finding that the child's  
8 parent or other person having the care and custody of the child has refused to  
9 administer or consent to the administration of a psychotropic drug to the child.

*allegation of medical neglect*

## SUMMARY OF LEGISLATIVE ACTIONS

### Legislation Restricting Physician Practice, 2002

**California, SB 119:** This legislation would criminalize decision-making by physicians if statutory procedures were not followed when a physician prescribes a psychiatric medication to a legal minor. The legislation makes it a crime for a physician to prescribe a psychiatric medication to a legal minor until the physician has received a physical exam from a pediatrician and had all physical conditions treated prior to prescribing the medication; the physician has fully explained all possible side effects to the parents; and has obtained written informed consent from the parents. There are additional physician reporting requirements to the pharmacist and state Board of Pharmacy.

**Mississippi, HB 221:** Any physician or pharmacist that prescribes Ritalin or fills a prescription for Ritalin shall be subject to suspension of their license to practice and may be fined up to \$5000.

**Wisconsin, AB 672:** Any physician who diagnoses a child with AD/HD must provide the parents with an explanation of the method used to diagnose, including the results of tests and evaluations; information on alternative treatments; and any potential risks of any medication prescribed for AD/HD. The state is required to prepare materials which all physicians must give parents of children with AD/HD including how using medication may affect health insurance costs and how use of medication may affect a person's future eligibility to serve in the U.S. armed forces. The state must also distribute such information to school officials.

### Legislation Restricting Teachers Giving Advice, 2002

**Michigan, HB 5085:** The legislation would prohibit teachers from diagnosing AD/HD and recommending the use of medication, but teachers could discuss with parents optional treatments for AD/HD, which could include medication. Teachers could discuss behavioral, learning, or emotional problems of children with the parents and could recommend professional assessments.

**Utah, HB 123:** This bill would make teachers criminally liable for referring a student's behavioral problems to anyone outside the school other than the parent. Any statement to the parent must be in writing. The school would continue to serve the child even if the parent refused to have a psychiatric, psychological, or behavioral assessment of the child's behavioral problems. Unless conveyed in a letter, teachers would be prohibited from recommending a professional behavioral assessment or recommending that the parents contact physicians, psychologists, or any other health specialist.

**Vermont:** Legislation would stipulate that schools might not require students with behavioral problems to take psychiatric medication as a condition of staying in schools.

### Related Legislative Actions of 2000-2001

**California, SB 2098:** Requires the state to adopt standards for the administration of psychotropic medications for children under the jurisdiction of the State Department of Youth. This legislation was enacted.

**Connecticut, H 5701:** Requires that each local and regional board of education shall adopt and implement policies prohibiting any school personnel from recommending the use of psychotropic drugs for any child. The provisions of this section shall not prohibit school medical staff from recommending that an appropriate medical practitioner evaluate a child, or prohibit school personnel from consulting with a practitioner with the consent of the parents or guardian of the child.

States that the refusal of a parent or other person having control of a child to administer or consent to the administration of any psychotropic drug to the child shall not, in and of itself, constitute grounds for the Department of Children and Families to take the child into custody or for any court of competent jurisdiction to order that the child be taken into custody by the department, unless the refusal causes the child to be neglected or abused, as defined in section 46b-120 of the general statutes. Enacted 6/28/01.

*CHADD Concerned with Legislative Efforts*

**Florida, S 682:** Requires the state to adopt standards for the use of psychotropic medications for children under the jurisdiction of the State Department of Children and Family Services. This legislation was enacted.

**Georgia, HR 1079:** Creates a Commission on Psychiatric Medication of School-Age Children and requires the commission to investigate the use of such medications. This legislation was signed into law by the governor.

**Hawaii, SCR 92 and SR 70:** Both contain the same provisions: Provides that the Department of Health and the Department of Education are jointly requested to increase efforts to educate parents, the school community, and other interested parties with regard to the diagnosis and treatment of children with "attention deficit disorder" or "attention-deficit/hyperactivity disorder" and to study the use and effectiveness of medication utilized to improve the child's educational opportunities, as well as research, examine, and recommend non-medication and other appropriate alternatives.

Requires that the departments submit a report of their findings and recommendations to the Governor and the Legislature no later than twenty days prior to the convening of the Regular Session of 2002. Adopted 4/23/01.

**Idaho, H 213:** Requires that any pharmacy licensed by the Board of Pharmacists that dispenses the stimulant methylphenidate, commonly known as Ritalin, shall disclose, at the least, the following information:

- (a) Known side effects of prescriptive use of the drug include tachycardia, dizziness, insomnia, depression, abdominal pain, anorexia, loss of appetite, dry mouth and suppression of growth associated with long-term use;
- (b) Ingesting the tablet by any means other than swallowing can result in severe reactions or complications such as blood clots, skin and circulatory problems, and even death;
- (c) No person who takes Ritalin after the age of twelve (12) years is eligible for military service; and
- (d) Distribution of the medication to any other person is a felony offense in Idaho and is also a federal offense.

Specifies that the board is authorized and directed to promulgate rules to ensure that the information in this section is provided by the licensed dispensing pharmacy to each person who takes possession of a Ritalin prescription. Passed House 3/5/01. Regular session adjourned, no carry over to 2002.

**Indiana, S 471:** Requires that the controlled substances advisory committee shall review the records maintained by the central repository for controlled substances designated by the state police department regarding the prescribing of psychotropic medications to children. Requires that no later than December 1, 2001, the advisory committee shall submit a report to the legislative council, the governor, and the medical licensing board regarding this review. The report required must include the following:

- (1) A comparison of the number of prescriptions written for psychotropic medications for children (A) participating in Medicaid or the children's health insurance program; and (B) not participating in a program described in clause (A).
- (2) A statement by the advisory committee regarding whether the information provided indicates that psychotropic medications are being disproportionately prescribed for children described in subdivision (1)(A).
- (3) Identification of any pattern of prescribing of psychotropic medications for children contrary to the most recent guidelines adopted by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. Vetoed by governor 5/11/01.

**Maryland, S 742:** Creates an advisory council on AD/HD to facilitate communication between educators, families, and physicians and to promote needed reform and training to better serve children with AD/HD, including research into the relationship between AD/HD and learning disabilities. This legislation was enacted.

**Minnesota, S 750:** A bill for an act relating to education; raising awareness of issues related to student use of sympathomimetic medication; clarifying neglect to indicate that a parent's refusal to provide sympathomimetic medications does not constitute educational neglect; and providing for a study to examine student's Ritalin use.

*CHADD Concerned with Legislative Efforts*

**North Carolina, S 542:** Requires that the Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention shall review the feasibility of establishing and maintaining a statewide database containing information on the prescription and administration of psychotropic medications to children who receive state services. Enacted 5/25/01.

**New York, A 3162:** Amends the mental hygiene law, the social services law and the education law by adding to each, new sections which establish the rights of children in residential care. Included in these enumerated rights is the right to safe medication prescribing practices, including provisions for information about medications and consent for psychotropic medications from the parent or guardian and the right to be free from physical restraint and seclusion, except as otherwise authorized by law or regulation, provided, however, no mechanical restraint or seclusion may be used if the child is under twelve years of age. Passed Assembly 4/2/01.

**Oklahoma, H 1965:** Authorized the state's courts to order children under court order to take medication as prescribed by the court. This legislation was enacted.

**Utah, H 170:** Amends the definition of substantiated child abuse to exclude the failure to administer prescribed medication or course of treatment if the parent or legal guardian has not been notified of the opportunity to obtain a physical examination of the minor by a health care professional.

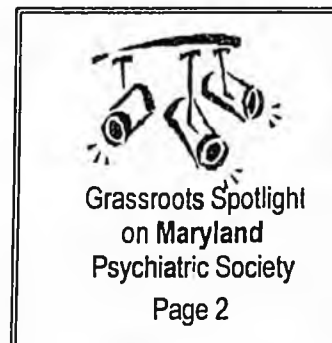
The bill does not specify or define what types of medication. It is intended to be broader than the introduced version of the bill, which specified and defined "psychiatric medication." Enacted 3/15/01.

**Virginia, HJR 660:** That a joint subcommittee be established to study the effects of attention deficit disorder and attention-deficit/hyperactivity disorder on student academic performance and on public education programs and services. Adopted 2/24/01.

**Washington, H 2912:** Requires the state to report on children in out-of-home care for longer than 90 days who take psychotropic medication. This legislation was enacted.

June/July 2001

- **CHILDREN / ADOLESCENTS**
- **NONPHYSICIAN PRESCRIBING BILLS**
- **GAY AND LESBIAN ISSUES**
- **GRASSROOTS SPOTLIGHT**
- **OTHER STATE LEGISLATION**



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### CHILDREN/ADOLESCENTS

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**CONNECTICUT:** Governor John Rowland June 6 signed HB 5701\*, now Public Act No. 01-124, related to recommendations for and refusals of the use of psychotropic medications by children. The legislation requires school boards to adopt and implement policies prohibiting school personnel from recommending that a child use psychotropic drugs. It allows (1) school medical staff to recommend appropriate evaluation of a student by a medical practitioner and (2) school personnel to consult with the medical practitioner with the consent of the child's parents or guardian.

The new law also specifies that a parent's refusal to administer or consent to administration of psychotropic medication to a child does not, by itself, constitute grounds for the Department of Children and Families to take the child into custody, or for a court to order that the child be taken into custody, unless that refusal results in the child's abuse or neglect.

Finally, the law requires utilization review companies, when making determinations related to "mental or nervous conditions," to report them separately from all other reported determinations. By law, utilization review companies must annually file with the Insurance Commissioner the number of determinations not to certify an admission, service, procedure, or stay extension and the outcome of appealed determinations.

**UTAH:** H 170\*, signed by Governor Michael Leavitt, excludes from the definition of substantiated child abuse the failure to administer prescribed medication or course of treatment if the parent or legal guardian has not been notified of the opportunity to obtain a physical examination of the minor by a health care professional. The Act authorizes the Division of Child and Family Services to report an individual to the appropriate licensing authority if the division has reason to believe the individual exceeded his/her scope of practice by recommending medication for a minor.

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**OREGON:** HB 2682\* grants criminal and civil immunity to a school administrator, teacher or other school employee who administers prescription medication to a student if certain conditions are met. The school employee must

administer the medicine, pursuant to written permission and instructions of the pupil's parents or guardian, and must act in compliance with the instructions of a physician, physician assistant or nurse practitioner. Governor John Kitzhaber has signed HB 2682.



### GRASSROOTS SPOTLIGHT

#### MARYLAND PSYCHIATRIC SOCIETY

A Political Action Committee (PAC) is one component of a successful grassroots program in a state district branch. Maryland Psychiatric Society (MPS), with 760 members, this past year raised \$20,000 for its PAC treasury. How did they raise that much money? By implementing a methodical annual strategy to raise funds and politically involve psychiatrists in Maryland.

Maryland Psychiatric PAC (MPPAC) fundraising consists of a systematic approach relying on a combination of an energetic PAC Chair, Mayer Liebman, M.D., an active PAC Board of Trustees, and assistance from district branch staff. An annual letter to MPS members requesting PAC contributions raises approximately 30% of their funds. Biannual phone-a-thons, scheduled at the end of the state legislative session in April and in the Fall to prepare for the upcoming legislative session, raise 60% of their money. MPPAC board members play a crucial role in the phone-a-thons, individually calling fellow psychiatrists and asking for contributions. In some cases, they call psychiatrists who are not members of MPS, but who do contribute to the PAC.

The MPPAC distributes a semi-annual newsletter to keep PAC contributors and MPS members current and raises approximately 10% of their contributions. The newsletter, *Political Action*, prints articles about lobbying legislators, along with information about the MPS's and the state medical society's legislative agenda. Each winter *Political Action* features an insert with the current contact information for each legislator in the Maryland General Assembly, just in time for members to make their calls about specific bills introduced in Annapolis. Written by MPPAC members, it is a valuable tool of communication for the membership on state legislative issues.

PAC checks are hand delivered by MPPAC members to state legislators, whenever possible. Only when unavoidable are PAC checks mailed into a candidate. In addition to direct contributions to campaigns, early this year the PAC financed a legislative reception in Annapolis. MPPAC held the event on a weekday evening, during the legislative session and walking distance from the legislative office buildings. The event was a culmination of the great efforts by MPPAC as thirty-one legislators mingled with the twenty-four psychiatrists who attended!

The MPPAC has consistently grown since its inception eleven years ago. A successful grassroots advocacy program includes contributing to a PAC to educate legislative candidates, thus bringing greater attention to the priorities of psychiatry. If you are interested in creating or enhancing your district branch PAC and would like to talk over strategies, please contact either Jennifer Gajewski, 410-625-0232, MPS Executive Director, or the Division of Government Relations. APA. 202-682-6060.

**NORTH CAROLINA:** Session Law 2001-124\*, formerly SB 542, directs the Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention to review the need for establishment of a statewide database on the administration of psychotropic medications to children who receive state services. The Departments are to make recommendations to several legislative committees on the costs and feasibility of setting up and maintaining the database in a manner that provides data for the analysis of prescription medication usage by and effects on children. The report is also to provide detailed information on how the database will be maintained to protect medical records and other privacy interests.

**DELAWARE:** HB 29\* states that "No psychotropic drug may be prescribed to any minor unless, prior to prescribing the drug, the practitioner; (i) has had the minor's parent, guardian, or other caregiver read, from the "Physician's Desk Reference Family Guide to Prescription Drugs," the full information on any psychotropic drug being prescribed, and (ii) has obtained a written attestation from the parent, guardian, or caregiver that he or she has read and understood the information provided by the practitioner, including any information on known drug side effects. If the parent, guardian, or caregiver is unable to read the psychotropic drug information, or indicates that he or she does not understand any part of all of the information, the practitioner shall fully explain the information, including side effects, before obtaining the written attestation. The attestation is to be kept on file as part of the child's medical record."

The bill also requires the Department of Health and Social Services, working with "pediatric health care practitioners," and local chapters of the American Academy of Pediatrics and Family Physicians, to develop a brochure in English, and in any other language that is endemic to the area it will be servicing. The brochure should inform parents and guardians about potential drug side effects, as well as general information relating to psychotropic medications prescribed for children.

HB 28\*, since withdrawn, would have prohibited any law, regulation, or policy from being established in any school district or public school that requires a student to be placed on a psychotropic drug as a condition of enrollment, or attendance in any class.

**NEW JERSEY:** AB 3471\* prohibits the Superior Court, in proceedings involving alleged cases of child abuse or neglect, from ordering the parent or guardian of a child to administer methylphenidate hydrochloride to the child. Proponents cited a case in New York, in which parents faced child abuse charges when they tried to discontinue the administration of medication to their child and a judge ordered that the child continue to be given the medication.

Citing a "deep concern over the increased use of medication to control behavior in school children," A 2170\* would prohibit school personnel from recommending, encouraging, or discussing medication for school pupils without either the pupil or the pupil's parents. In addition, the measure provides that school personnel shall respect the parents' right to refuse psychiatric medication for their children, and shall not suggest nor insist that medication be required for a child's participation in any aspect of school.

**VIRGINIA:** HJ 660\* is a study resolution establishing a joint subcommittee to study the effects of attention deficit disorder and attention deficit hyperactivity disorder on student performance. The subcommittee will also investigate "the improper prescription and illegal use and diversion of Ritalin and OxyContin." Among other things, the legislative subcommittee is to determine the number of students diagnosed as having ADD/ADHD in the public schools, whether they receive treatment and whether the conditions have an effect on absenteeism or disciplinary action; and determine the health conditions for which Ritalin and OxyContin are lawfully prescribed. The study group is also to recommend ways to correct problems associated with the over-prescription and illegal use of the medications.

**MINNESOTA:** HB 478\* clarifies the definition of educational neglect to indicate that a parent's refusal to provide sympathomimetic medications does not constitute educational neglect. The measure also appropriates funds for the Department of Children, Families, and Learning for a study to determine the number and overall incidence rate of Minnesota children diagnosed with ADD or ADHD currently taking sympathomimetic medications. The contractor would be encourage to examine the number of children who take medications at home and not at school, previous interventions tried with the children, types of practitioners who prescribe the medications and "what pressures families have experienced in terms of providing their children with sympathomimetic medications."

**HAWAII:** The legislature adopted SCR 92\*, which requests the Departments of Health and Education to research and examine non-medication alternatives to dealing with children who have difficulty paying attention, have difficulty learning, and display hyperactive behavior. Alternatives would include reallocation of resources to non-medication programs of social, recreational, educational, athletic, artistic, and cultural activities.

Enacted with SCR 92, SR 70\* requests the departments to determine whether the diagnosis of children with ADD or ADHD in Hawaii has been excessive, "whether the state's children are being subjected to excessive use of psychiatric drugs to modify their behavior," and to research and recommend non-medication alternatives.

**NEW YORK:** A 3162\* establishes a bill of rights for children in residential care facilities operated by various state agencies, including mental health. Its purpose is to assure that all children will receive appropriate care and treatment, including the right to be free from abuse, to have an individualized treatment plan, to receive safe medication and communication with family members, to recreation, religious freedom, and to an appropriate education. A 3162 passed the Assembly and was referred to the Senate Mental Health and Developmental Disabilities Committee.

**CALIFORNIA:** Existing law requires court approval to give psychotropic medication to a child in foster care unless the guardian or caregiver has obtained a court order authorizing the caregiver to obtain the medication. AB 225\* would impose penalties on physicians for prescribing psychiatric medications for foster children, pharmacists for filling the prescriptions, and foster parents for administering medications to the children. Opponents, including the California Psychiatric Association, have charged the bill would likely decrease the number of physicians willing to see foster children, thereby decreasing access to all medications and other medical treatment for them. The legislation would also force pharmacists to inquire whether a child receiving a prescription is a foster child, a breach of the child's privacy.

AB 681\*, as introduced, called for a study of the use of psychotropic medications, especially Ritalin, on foster children. As amended, the bill calls for the Department of Health Services to report on prescription medication of children in foster care and to develop a study of the use of psychotropic medications in foster care in comparison to the pattern of use of psychotropic medications among children in the general population. The study would include the number of foster youth receiving mental health assessments and treatment services, and the number of those children with a diagnosis that meets criteria for which there is a clinical consensus that medication treatment is an acceptable component of care.

**ILLINOIS:** HB 548\* directs the Director of Public Health to appoint an Advisory Council on Psychotropic Drug Therapy for Children and Adolescents. The council is to include child psychiatrists, pharmacologists, child behavioral specialists, educators, and parents of children taking psychotropic medications, child advocates, and representatives of the Department of Children and Family Services. It is to study and analyze mental illness and serious emotional disturbances affecting children and adolescents and the psychotropic medications used to treat those illnesses. It is directed to address the potential impact of psychotropic drugs on children and adolescents, "including the relationship between the use of such drugs and tendencies toward violence or suicide."

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## NONPHYSICIAN PRESCRIBING

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Legislators in two key Louisiana health committees defeated measures (HB 414\* and SB 312\*) during hearings in Baton Rouge to permit psychologists to prescribe psychotropic medications. With assistance from the APA, the Louisiana District Branch mounted a strong "constituent call-in" and fax message effort to members of the House Health and Welfare Committee.

## Psychotropic Drugs

Imagine a society where children are all on psychotropic drugs. Imagine it is the teacher's fault, because they referred all the kids. A society where the drugs are doing more bad than good. That could happen if someone doesn't take the power away from teachers to put kids on psychotropic drugs. This could be a serious problem in the near future.

I believe you should pass Senate Bill No. 230 and save our society's children. Senate Bill 230 is trying to limit teachers influence on putting kids on psychotropic drugs. Psychotropic drugs are drugs to calm children down like Ritalin or to treat mental disabilities like Depression. Teachers sometimes recommend these drugs to parents of disobedient kids for behavior problems. According to the Journal of the American Medical Association, from 1991 to 1995, the number of preschoolers on antidepressants increased 200 percent, and the number of children ages 2 to 4 taking stimulants more than doubled. Chemically treating our children at the rate we are now, may lead to problems in our society that will require emotional and financial costs, to correct. These medications are being prescribed to children at increasingly younger ages, and I believe this is because of the school influence.

There are some children for whom Ritalin may be their best option. However, there are countless others that are being drugged unnecessarily. There are some downsides to Ritalin like:

Ritalin is  
commonly  
used  
psychotropic  
drug.

Ritalin is derived from the same family as cocaine.

Ritalin lasts only four hours.

Ritalin treats only some of the symptoms of ADD.

Ritalin provides superficial healing, does not treat the root of the problem.

Ritalin can cause side effects such as appetite loss, anxiety, insomnia, tics, headaches, stomach aches.

Ritalin use is responsible for causing children to begin a habit of taking drugs.

Ritalin may need to be taken over entire life span.

Stimulant drugs were found to have a short-term effectiveness of 60 to 80 percent in reducing the hyperactivity, distractibility, and impulsiveness of school-age children. Studies beginning in the 1960s showed that children who took stimulants for hyperactivity over several years did just as poorly in later life as the group of hyperactive children who took no medication. Doctors sharply criticized the lack of a uniform system for diagnosing and treating ADHD, saying the Health Department had largely ignored National Health and Medical Research Council recommendations published in 1997. Dr Florence Levy, from the Sydney Children's Hospital, has expressed concern at the frequency of incorrect diagnosis before.

The facts are strait. The numbers of kids on psychotropic drugs is rising. School influence is forcing parents to put their kids on psychotropic drugs by threatening to take it to Social Services and even reporting them. Most teachers probably have never been to medical school and can't diagnose that kind of disorder. If there is I'd like to meet them. But for now we need to limit what schools can do.

With the adjournment of legislatures in Illinois, Tennessee and Texas, this means that bills that would have granted psychologists prescribing authority have been defeated in nine states in the 2001 sessions.

# Senate Bill 230

*Psychotropic Drugs For Children*

## *Similar Legislation*

NFWL Resolution

**NFWL Special Education Sub-Committee**  
**Representative Aisha Abdullah-Odiase, Chairwoman**  
**Passed unanimously on September 28, 2001**

**Resolution**

**Whereas:**

- 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;
- Production of these drugs has increased by more than 700% since 1990.
- The number of schoolchildren taking these drugs is approaching the 4 million mark.
- Recent media stories have brought increased scrutiny to this uniquely American large-scale use of psychotropic drugs in our schools.
- Recent books such as No more ADHD by Dr. Mary Ann Block; Ritalin Nation: Rapid-Fire Culture and the Transformation of Human Consciousness; and Lawrence H. Diller's Running on Ritalin: A Physician Reflects on Children, Society and Performance in a Pill; that has provided important viewpoints and information to the public debate on the dangers of the drugging of our children.
- Public health issues such as lead poisoning, thyroid deficiencies and malnutrition are known to decrease student academic performance.
- Advances in medicine offer additional opportunities to identify and treat underlying physiological abnormalities and deficiencies that may contribute to decreases in student performance. Such abnormalities and deficiencies have been shown to place students at risk of being identified as slow learners or behavioral problems.
- The state of Connecticut has recently passed legislation prohibiting non-medical personnel from suggesting behavioral problems are the result of ADD or ADHD.
- Public officials are frequently asked to provide policy guidance on this issue without a clear understanding of the medical and scientific issues attending the use of psychotropic on our school children.

**Be it resolved that the NFWL Special Education Sub-Committee supports:**

- A review by scientific, educational and medical professional of the physiological risk factors associated with decreases in academic performance and behavior.
- Recommendations on screening procedures to identify children at risk due to physiological abnormalities and deficiencies.
- Recommendations of non-drug treatment options or model legislation to decrease the occurrence of these risk factors in our school-age population.

# Senate Bill 230

*Psychotropic Drugs For Children*

## *Similar Legislation*

Connecticut

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# EDUCATION REPORTER

NUMBER 186

THE NEWSPAPER OF EDUCATION RIGHTS

JULY 2001

## Connecticut Curbs Promotion of Ritalin

HARTFORD, CT - The Connecticut General Assembly has approved a bill prohibiting educators from recommending psychotropic drugs such as Ritalin for use on school children. (See text below.) The House of Representatives on May 22 approved **H.B. 5701** by a vote of 141-0. The bill has also passed the Senate and is awaiting the Governor's signature.



*Lenny Winkler*

State Rep. Lenny Winkler (R-Groton) introduced the legislation, citing "the dramatic increase in the amount of psychotropic drugs, such as Ritalin and Prozac, being prescribed for children in recent years." In announcing the bill's passage, she stated that "these drugs are too often prescribed without a thorough medical and psychological evaluation. This bill will go a long way toward preventing unnecessary use of psychotropic drugs in Connecticut."

An emergency room nurse herself, Winkler expressed horror at the list of mind-altering drugs that are taken by some of the children admitted to the hospital. She pointed out that strong "anecdotal evidence" indicates that recommendations of these drugs to parents by school personnel have contributed to the increase in prescriptions. "Because teachers are held in such high esteem," Winkler noted, "their opinions regarding a student's health are taken seriously."

H.B. 5701 also prohibits a parent's refusal to place a child on psychotropic drugs from becoming grounds for the Connecticut Department of Children and Families to take the child into custody.

The law *does* allow schools to recommend that a student undergo a thorough medical examination. With the parents' permission, school officials may still consult with doctors about a child's case. "The school system will always play a vital role in a child's well being," Rep. Winkler affirmed. "But it's extremely important that the diagnosis of any medical condition be performed by a medical professional."

Partial Text of H.B. 5701

## An Act Concerning Recommendations For And Refusals Of The Use Of Psychotropic Drugs By Children. . . .

Be it enacted by the Senate and House of Representatives in General Assembly convened:

**Section 1.** Each local and regional board of education shall adopt and implement policies prohibiting any school personnel from recommending the use of psychotropic drugs for any child. The provisions of this section shall not prohibit school medical staff from recommending that a child be evaluated by an appropriate medical practitioner, or prohibit school personnel from consulting with such practitioner with the consent of the parents or guardian of such child.

**Section 2.** The refusal of a parent or other person having control of a child to administer or consent to the administration of any psychotropic drug to such child shall not, in and of itself, constitute grounds for the Department of Children and Families to take such child into custody or for any court of competent jurisdiction to order that such child be taken into custody by the department, unless such refusal causes such child to be neglected or abused, as defined in section 46b-120 of the general statutes.

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General Assembly  
January Session,  
2001

## **Substitute Bill No. 5701**

### **AN ACT CONCERNING RECOMMENDATIONS FOR AND REFUSALS OF THE USE OF PSYCHOTROPIC DRUGS BY CHILDREN.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) Each local and regional board of education shall adopt and implement policies (1) prohibiting any school personnel from recommending the use of psychotropic drugs for any child, and (2) requiring that if school personnel perceive that a child may have a behavioral or psychological problem, a letter shall be sent to the parent or other person having control of the child recommending that an appropriate medical or behavioral health evaluation be conducted by a licensed physician.

Sec. 2. (NEW) Notwithstanding any provision of the general statutes or the regulations of Connecticut state agencies, the refusal of a parent or other person having control of a child to administer or consent to the administration of any psychotropic drug to such child shall not, in and of itself, constitute grounds for the Department of Children and Families to take such child into custody or for any court of competent jurisdiction to order that such child be taken into custody by the department.

<b>PH</b>	<i>Joint Favorable Subst.</i>
<b>JUD</b>	<i>Joint Favorable</i>
<b>HS</b>	<i>Joint Favorable</i>
<b>ED</b>	<i>Joint Favorable</i>

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**OLR Bill Analysis**

sHB 5701

***AN ACT CONCERNING RECOMMENDATIONS FOR AND REFUSALS OF THE USE OF PSYCHOTROPIC DRUGS BY CHILDREN.***

**SUMMARY:**

This bill requires each local and regional board of education to implement policies (1) prohibiting school personnel from recommending that a child use psychotropic drugs and (2) requiring that a letter be sent to the child's parent or other person in control recommending an appropriate medical or behavioral health evaluation by a physician if school personnel perceive a child has behavioral or psychological problems.

The bill also specifies that a parent's refusal to administer or consent to administration of psychotropic drugs to a child does not, by itself, constitute grounds for (1) the Department of Children and Families (DCF) to take the child into custody or (2) a court to order the child be taken into DCF custody.

EFFECTIVE DATE: October 1, 2001

**COMMITTEE ACTION**

Public Health Committee

Joint Favorable Substitute

Yea 25      Nay 0

# Senate Bill 230

*Psychotropic Drugs For Children*

## *Similar Legislation*

Arizona

1 Be it enacted by the Legislature of the State of Arizona:  
2 Section 1. Title 8, Arizona Revised Statutes, is amended by adding  
3 chapter 12. to read:

4 CHAPTER 12

5 ADMINISTRATION OF PSYCHIATRIC DRUGS TO CHILDREN

6 ARTICLE 1. GENERAL PROVISIONS

7 8-1101. Administration of psychiatric drug or medication;  
8 parental consent; tracking system; violation;  
9 classification; definition

10 A. A PHYSICIAN WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17  
11 AND WHO WISHES TO PLACE A CHILD ON A PSYCHIATRIC DRUG OR MEDICATION SHALL  
12 FIRST:

13 1. OBTAIN THE SIGNED INFORMED CONSENT OF THE CHILD S PARENT OR LEGAL  
14 GUARDIAN. IF THE CHILD IS A WARD OF THE STATE, THE PHYSICIAN SHALL OBTAIN  
15 THE CONSENT OF THE CHILD S GUARDIAN.

16 2. ALLOW A PEDIATRICIAN CHOSEN BY THE CHILD S PARENT OR LEGAL GUARDIAN  
17 TO CONDUCT A PHYSICAL EXAMINATION OF THE CHILD. THE EXAMINATION SHALL TEST  
18 FOR ALLERGIES, THYROID FUNCTION, ENDOCRINE FUNCTION, NUTRITIONAL PROBLEMS,  
19 COMMON MEDICATION SENSITIVITIES AND ADVERSE REACTIONS TO ENVIRONMENTAL  
20 FACTORS.

21 3. ADDRESS ANY MEDICAL CONDITIONS THAT ARE DISCOVERED PURSUANT TO  
22 PARAGRAPH 2 OF THIS SUBSECTION.

23 B. THE DEPARTMENT OF HEALTH SERVICES SHALL TRACK ANNUALLY THE NUMBER  
24 OF PSYCHIATRIC DRUGS OR MEDICATIONS PRESCRIBED FOR CHILDREN IN THIS STATE.  
25 THE DEPARTMENT SHALL SUBMIT A REPORT OF ITS FINDINGS TO THE GOVERNOR, THE  
26 PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES ON OR  
27 BEFORE NOVEMBER 15 EACH YEAR. THE DEPARTMENT SHALL PROVIDE A COPY OF THIS  
28 REPORT TO THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE  
29 LIBRARY, ARCHIVES AND PUBLIC RECORDS. THE REPORT SHALL NOT CONTAIN THE NAMES  
30 OF ANY CHILD OR ANY CHILD S PARENT OR LEGAL GUARDIAN. A PHYSICIAN SHALL  
31 COOPERATE WITH DEPARTMENT REQUESTS FOR INFORMATION.

32 C. A PHYSICIAN WHO VIOLATES THIS SECTION IS GUILTY OF A CLASS 3  
33 MISDEMEANOR AND COMMITS AN ACT OF UNPROFESSIONAL CONDUCT.

34 D. FOR THE PURPOSES OF THIS SECTION, "PSYCHIATRIC DRUG OR MEDICATION"  
35 MEANS:

- 36 1. ANTICONVULSANTS.  
37 2. ANTIDEPRESSANTS.  
38 3. BEZADIAZEPINES.  
39 4. NEUROLEPTICS.

# Senate Bill 230

*Psychotropic Drugs For Children*

## *Similar Legislation*

California

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**Introduced by Senators Haynes and Oller**

January 24, 2001

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An act to add Section 725.5 to the Business and Professions Code, relating to the healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 119, as introduced, Haynes. Healing arts: prescribing psychiatric medications for minors.

Existing law regulates the practices of healing arts licentiates and designates as unprofessional conduct certain acts committed by these licentiates, including those related to the violation of laws and regulations pertaining to prescription drugs. Under existing law, unprofessional conduct by licentiates is subject both to disciplinary action by the board that licensed the practitioner and to punishment as a crime in certain instances.

This bill would require a physician and surgeon, dentist, optometrist, or podiatrist before prescribing a psychiatric medication, as defined, for a minor to obtain informed consent, as specified, from the minor's parent or legal guardian and confirm that the minor has been examined by a pediatrician to eliminate the possibility that the minor's condition is the result of a physical condition. The bill would additionally require these licentiates to provide the minor's parent or legal guardian with a list of all of the minor's medications to submit when the prescription is dispensed. The bill would make the licentiate's failure to comply with any of these requirements unprofessional conduct.

Because the violation by a physician and surgeon or by a podiatrist of any law regulating dangerous drugs constitutes a crime, this bill would expand the scope of an existing crime by proscribing additional

conduct pertaining to dangerous drugs, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 725.5 is added to the Business and  
2 Professions Code, to read:

3 725.5. (a) The following definitions apply for the purposes of  
4 this section:

5 (1) "Legal guardian" means a person who has been appointed  
6 the minor's guardian by a court of competent jurisdiction.

7 (2) "Licentiate" means a physician and surgeon, dentist,  
8 optometrist, or podiatrist.

9 (3) "Minor" means a person under the age of 18 years who is  
10 not married and has not been declared emancipated by a court of  
11 law.

12 (4) "Parent" means the natural or adoptive parent of the minor.

13 (5) "Psychiatric medication" means any of the following types  
14 of drugs:

15 (A) Anticonvulsants, including, but not limited to,  
16 carbamazepine and divalproex sodium.

17 (B) Antidepressants, including, but not limited to, doxepin,  
18 lithium, floxetine, fluvoxamine, paroxetine, sertraline,  
19 venlafaxine, nefazodone, clomipramine, bupropion,  
20 amitriptyline, protriptyline, imipramine, and buspirone.

21 (C) Benzodiazepines, including, but not limited to,  
22 methylphenidate, dextroamphetamine, and pemoline.

23 (D) Neuroleptics, including, but not limited to,  
24 chlorpromazine, triflupromazine, thioridazine, perphenazine,  
25 prochlorperazine, fluphenazine, thiothixene, haloperidol,  
26 loxapine, clozapine, and resperadone.

1 (b) Before prescribing a psychiatric medication for a minor, a  
2 licentiate shall complete each of the following acts:

3 (1) Confirm that the minor has received a physical examination  
4 by a pediatrician chosen by the minor's parent or legal guardian to  
5 eliminate the possibility that the minor's current condition is the  
6 result of an adverse or untreated physical condition.

7 (2) Confirm that any adverse or untreated physical condition  
8 detected by the physical examination has been treated.

9 (3) Fully explain to the minor's parent or legal guardian the  
10 nature of any psychiatric medication that the licentiate intends to  
11 prescribe for the minor, including all possible side effects caused  
12 by the psychiatric medication.

13 (4) Obtain written, informed consent signed by the minor's  
14 parent or legal guardian, acknowledging that the parent or legal  
15 guardian has given consent for the prescription of the psychiatric  
16 medication for the minor and that the requirements of paragraphs  
17 (1) to (3), inclusive, have been satisfied.

18 (c) A licentiate who prescribes a psychiatric medication for a  
19 minor shall provide the minor's parent or legal guardian a list of  
20 all medications the minor is currently taking to submit when the  
21 prescription is submitted for dispensing.

22 (d) The licentiate shall submit to the California State Board of  
23 Pharmacy a list of all psychiatric medications he or she has  
24 prescribed for each minor. The board shall track the number and  
25 kind of psychiatric medications prescribed for minors in the state  
26 to ensure that reliable figures are available on an ongoing basis for  
27 use by the Legislature and other state entities.

28 (e) The failure of a licentiate to comply with any of the  
29 requirements of subdivisions (b) and (c) constitutes  
30 unprofessional conduct and grounds for disciplinary action against  
31 the licentiate by his or her licensing board.

32 SEC. 2. No reimbursement is required by this act pursuant to  
33 Section 6 of Article XIII B of the California Constitution because  
34 the only costs that may be incurred by a local agency or school  
35 district will be incurred because this act creates a new crime or  
36 infraction, eliminates a crime or infraction, or changes the penalty  
37 for a crime or infraction, within the meaning of Section 17556 of  
38 the Government Code, or changes the definition of a crime within

SB 119

— 4 —

- 1 the meaning of Section 6 of Article XIII B of the California
- 2 Constitution.

# Senate Bill 230

*Psychotropic Drugs For Children*

## *Similar Legislation*

Texas



# TEXAS EDUCATION AGENCY

1701 North Congress Ave. ★ Austin, Texas 78701-1494 ★ 512/463-9734 ★ FAX: 512/463-9838 ★ <http://www.tea.state.tx.us>

Jim Nelson  
Commissioner of Education

August 2, 2001

John Breeding, Ph.D., Director  
Texans for Safe Education  
2503 Douglas Street  
Austin, Texas 78741

Dear Dr. Breeding:

This purpose of this letter is to respond to your request for clarification regarding the legal position of the Texas Education Agency (TEA) on the issue of whether public school personnel can require a child to take a psychoactive medication as a condition of attending school. You also inquire about TEA's position on the related issue of whether a public school can threaten to expel a child who is not put or continued on a psychoactive medication.

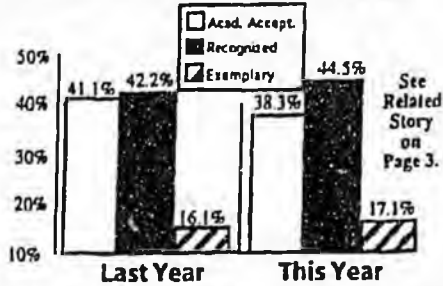
A public school's attempt to require a child to take a psychoactive medication as a condition of enrolling or attending school is unlawful. Threats to expel from public school a child who is not put or continued on a psychoactive medication are also unlawful. Such requirements violate rights guaranteed by both federal and state law, including a parent's rights to independently make decisions related to child rearing and education and to consent a child's medical treatment.

If you have additional concerns regarding these issues, please contact me at (512) 463-9720.

Sincerely,

David A. Anderson  
General Counsel  
Office of Legal Services

## Texas School Quick Fact School District Accountability Ratings\*



\* Academically Unacceptable — 5 districts last year / 1 district this year.



Volume 18

Sept. 10, 2001

Issue 27

### In This Week's Texas Education News:

- Ritalin-related warning. *Page 1.*
- Health insurance crisis. *Page 1.*
- School-finance news. *Page 2.*
- UIL panel to examine athletes' health issues. *Page 2.*
- Accountability ratings/dropouts. *Page 3.*

- *The courts:* Court denies Plano ISD's immunity claim in math lawsuit. *Page 3.*
- *News briefs:* Commissioner's master-appointment powers challenged, Houston ISD stops corporal punishment, San Antonio ISD sets minimum wages, "DROP." *Page 4.*
- *Attorney general:* County school land authority, school board elections. *Page 4.*

### TEA Lawyer Issues Anti-Ritalin Warning

School district's can't legally require students to take "psychoactive" drugs as a condition of school enrollment, according to a letter by TEA legal counsel David Anderson.

Anderson's letter was written to the head of Texans for Safe Education (TFSE), a group opposed to the widespread prescribed use of Ritalin and other similar drugs by children who have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) conditions.

The letter was released by the group during an Aug. 24 news conference at the Capitol.

The pertinent portion of Anderson's Aug. 2 letter to TFSE leader John Breeding says:

"A public school's attempt to require a child to take a psychoactive medication as a condition of enrolling or attending school is unlawful. Threats to expel from public school a child who is not put or continued on a psychoactive medication are also unlawful.

"Such requirements violate rights guaranteed by both federal and state law, including a parent's rights to independently make decisions related to child rearing and education and to consent a child's medical treatment."

#### Threatened With Expulsion

Breeding said he asked for Anderson's legal opinion because his group has heard from Texas parents whose children were threatened with expulsion from school if they refused to accept psychiatric evaluation and/or drugs.

Among those on hand to support the group's position were an Austin mother who spoke about her experience with her child's school trying to force her to put her son on drugs and SBOE member Judy Strickland of Plainview.

Strickland said that she was pleased that Anderson reinforced an SBOE resolution that passed in November 2000 that keeps teachers and administrators in the academic arena and leaves educational issues to parents and their preferred professionals.

The resolution, which was passed by an 8-6 SBOE vote, urges districts to respect the exclusive authority of physicians in determining the need for students to take Ritalin and similar

drugs. *The SBOE's resolution is available at:*

[www.tea.state.tx.us/sboe/minutes/0011resolve.html#health](http://www.tea.state.tx.us/sboe/minutes/0011resolve.html#health)

See also: *TEN*, Nov. 13, 2000, *Page 1*, and Dec. 4, 2000, for Texas-specific Ritalin-related articles.

### School Health Insurance Problems Mushroom

The new state-backed school employee health insurance program won't begin actually offering coverage until 2002, but its effect is already being felt in a big way for districts and their employees.

*The major controversies:*

- **Draft plan** — Teacher groups in particular are complaining about the bottom line of a *draft health plan* under consideration by the TRS.

The major problem — according to a two-week media campaign being conducted by the Texas State Teachers Association — is that what the TRS is looking at could wind up costing many school employees more than they are paying for coverage right now.

But state Rep. Paul Sadler, who authored the state health plan bill, cautioned critics not to be too harsh on the TRS.

After all, Sadler reminded critics, insurance rates are going up, and it's unfair to compare this year's rates with what the TRS might be faced with charging for the new state plan next year.

- **Hit by Increases** — A large number of ISDs are being hit by moderate to large increases in the amounts they pay for health insurance coverage this year when compared to last year, and many are passing on some or all of the increases to their employees.

- **No Bids** — Small districts, in particular, are finding it difficult to get any health insurance bids this school year. And those that they do get, are high.

The *Austin American-Statesman* recently reported that insurance companies are saying that they are not handling schools any more because they aren't making any money on them.

Continued, Page 2

OK TO REPRODUCE  
T-EN/CC

# Senate Bill 230

*Psychotropic Drugs For Children*

## *Similar Legislation*

Utah

**PRESCRIBING PSYCHIATRIC DRUGS OR MEDICATION**

2001 GENERAL SESSION

STATE OF UTAH

**Sponsor: Matt Throckmorton**

**This act modifies the Human Services Code. The act amends the definition of substantiated child abuse to exclude the failure to administer prescribed medication or course of treatment if the parent or legal guardian has not been notified of the opportunity to obtain a physical examination of the minor by a health care professional. The act authorizes the Division of Child and Family Services to report an individual to the appropriate licensing authority if the division has reason to believe the individual exceeded the individual's scope of practice by recommending medication for a minor.**

This act affects sections of Utah Code Annotated 1953 as follows:

**AMENDS:**

**62A-4a-116**, as last amended by Chapters 304 and 321, Laws of Utah 2000

*Be it enacted by the Legislature of the state of Utah:*

Section 1. Section **62A-4a-116** is amended to read:

**62A-4a-116. Management information system -- Requirements.**

(1) The division shall develop and implement a management information system that meets the requirements of this section and the requirements of federal law and regulation.

(2) With regard to all child welfare cases, the management information system shall:

(a) provide each caseworker with a complete history of each child in his caseload, including:

(i) all past action taken by the division with regard to that child and his siblings, the complete case history and all reports and information in the control or keeping of the division regarding that child and his siblings;

(ii) the number of times the child has been in foster care;

(iii) the cumulative period of time the child has been in foster care;

(iv) all reports of abuse or neglect received by the division with regard to that child's parent or parents, including documentation regarding whether each report was substantiated,

# Senate Bill 230

*Psychotropic Drugs For Children*

## *Similar Legislation*

Minnesota

K-12 Education Omnibus Bill

Minnesota Special Session

H.F. 2 / S.F. 6

Signed June 30, 2001 by Governor

### ARTICLE 3

#### SPECIAL PROGRAMS

Section 1. Minnesota Statutes 2000, section 121A.41, subdivision 10, is amended to read:

Subd. 10. [SUSPENSION.] "Suspension" means an action by the school administration, under rules promulgated by the school board, prohibiting a pupil from attending school for a period of no more than ten school days. If a suspension is longer than five days, the suspending administrator must provide the superintendent with a reason for the longer suspension. This definition does not apply to dismissal from school for one school day or less, except as provided in federal law for a student with a disability. Each suspension action may include a readmission plan. The readmission plan shall include, where appropriate, a provision for implementing alternative educational services upon readmission and may not be used to extend the current suspension. **Consistent with section 125A.09, subdivision 3, the readmission plan must not obligate a parent to provide a sympathomimetic medication for the parent's child as a condition of readmission.** The school administration may not impose consecutive suspensions against the same pupil for the same course of conduct, or incident of misconduct, except where the pupil will create an immediate and substantial danger to self or to surrounding persons or property, or where the district is in the process of initiating an expulsion, in which case the school administration may extend the suspension to a total of 15 days. In the case of a student with a disability, the student's individual education plan team must meet immediately but not more than ten school days after the date on which the decision to remove the student from the student's current education placement is made. The individual education plan team shall at that meeting: conduct a review of the relationship between the child's disability and the behavior subject to disciplinary action; and determine the appropriateness of the child's education plan.

The requirements of the individual education plan team meeting apply when:

- (1) the parent requests a meeting;
- (2) the student is removed from the student's current placement for five or more consecutive days; or
- (3) the student's total days of removal from the student's placement during the school year

exceed ten cumulative days in a school year. The school administration shall implement alternative educational services when the suspension exceeds five days. A separate administrative conference is required for each period of suspension.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

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Sec. 8. Minnesota Statutes 2000, section 125A.09, subdivision 3, is amended to read:

Subd. 3. [INITIAL ACTION; PARENT CONSENT.] (a) The district must not proceed with the initial formal assessment of a child, the initial placement of a child in a special education program, or the initial provision of special education services for a child without the prior written consent of the child's parent or guardian. The refusal of a parent or guardian to consent may be overridden by the decision in a hearing held pursuant to subdivision 6 at the district's initiative.

**(b) A parent, after consulting with health care, education, or other professional providers, may agree or disagree to provide the parent's child with sympathomimetic medications unless section 144.344 applies.**

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260A.01 [TRUANCY PROGRAMS AND SERVICES.]

(a) The programs in this chapter are designed to provide a continuum of intervention and services to support families and children in keeping children in school and combating truancy and educational neglect. School districts, county attorneys, and law enforcement may establish the programs and coordinate them with other community-based truancy services in order to provide the necessary and most effective intervention for children and their families. This continuum of intervention and services involves progressively intrusive intervention, beginning with strong service-oriented efforts at the school and community level and involving the court's authority only when necessary.

**(b) Consistent with section 125A.09, subdivision 3, a parent's refusal to provide the parent's child with sympathomimetic medications does not constitute educational neglect.**

[EFFECTIVE DATE.] This section is effective the day following final enactment.

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Sec. 15. Minnesota Statutes 2000, section 260C.163, subdivision 11, is amended to read:

Subd. 11. [PRESUMPTIONS REGARDING TRUANCY OR EDUCATIONAL NEGLECT.] (a) A child's absence from school is presumed to be due to the parent's, guardian's, or custodian's failure to comply with compulsory instruction laws if the child is under 12 years old and the school has made appropriate efforts to resolve the child's

125A.08 [SCHOOL DISTRICT OBLIGATIONS.]

(a) As defined in this section, every district must ensure the following:

(1) All students with disabilities are provided the special instruction and services which are appropriate to their needs. Where the individual education plan team has determined appropriate goals and objectives based on the student's needs, including the extent to which the student can be included in the least restrictive environment, and where there are essentially equivalent and effective instruction, related services, or assistive technology devices available to meet the student's needs, cost to the district may be among the factors considered by the team in choosing how to provide the appropriate services, instruction, or devices that are to be made part of the student's individual education plan. The individual education plan team shall consider and may authorize services covered by medical assistance according to section 256B.0625, subdivision 26. The student's needs and the special education instruction and services to be provided must be agreed upon through the development of an individual education plan. The plan must address the student's need to develop skills to live and work as independently as possible within the community. **The individual education plan team must consider positive behavioral interventions, strategies, and supports that address behavior for children with attention deficit disorder or attention deficit hyperactivity disorder.** By grade 9 or age 14, the plan must address the student's needs for transition from secondary services to post-secondary education and training, employment, community participation, recreation, and leisure and home living. In developing the plan, districts must inform parents of the full range of transitional goals and related services that should be considered. The plan must include a statement of the needed transition services, including a statement of the interagency responsibilities or linkages or both before secondary services are concluded;

Senate Bill 230

*Psychotropic Drugs For Children*

*Articles Against Use of Psychotropic Drugs*

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**WorldNetDaily**

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## ADHD: Another Doctor Handing-out Drugs

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By Dr. Mary Ann Block

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The American Academy of Pediatrics is now on record for recommending drugs for Attention Deficit Hyperactivity Disorder (ADHD). This is nothing new. It has obviously been the common practice for years or else there would not be five million children in the United States taking psychiatric drugs. This rubber stamp of approval from the American Academy of Pediatrics may shoot those numbers even higher. While this should make the drug companies happy, I don't think it is a very safe or effective way to help our children. Here are some compelling facts which support my position on this controversial subject.

1. ADHD is a psychiatric diagnosis with no valid test to prove it exists.
2. ADHD was voted into existence by a show of hands.
3. Side-effects of the drugs used for ADHD include psychosis, paranoia, aggression, heart attack, cardiac arrhythmias and high blood pressure.
4. Ritalin has the same dependency profile as cocaine.
5. Ritalin treatment predisposes takers to cocaine's reinforcing effects.
6. The United States uses 90 percent of the world's Ritalin supply.
7. There are underlying health and learning issues which can cause attention and behavior problems.

### ADHD is a subjective label

Attention Deficit Hyperactivity Disorder (ADHD) is officially a psychiatric label. In 1987, ADHD was literally voted into existence by the American Psychiatric Association and inserted into the Diagnostic and Statistical Manual of Mental Disorders (DSM). Psychiatrists write the book and decide what behaviors or groups of behaviors are psychiatric disorders.

Within one year of deciding to insert ADHD in the DSM, 500,000 children in the United States were diagnosed with the disorder. A common denominator of these psychiatric disorders is that

there is no objective way to define or to diagnose them. If you have high blood pressure, your doctor can objectively measure and diagnose the problem. If you have diabetes, your doctor can objectively measure your blood sugar and give you a diagnosis. There is no way to measure for a psychiatric diagnosis. It is this subjective standard that the American Academy of Pediatrics is recommending for pediatricians to use when deciding to give a child a mind-altering drug which carries many serious risks.

### Drug risks

In addition to the most commonly prescribed drug, Ritalin, other drugs used for ADHD symptoms include Adderall, Dexedrine and Metadate (long-acting Ritalin), which are amphetamines or "speed" type drugs. Amphetamines are classified as controlled substances because they have a high likelihood of abuse. Ritalin is similar to cocaine, affects the same receptor sites in the brain and triggers the same effect on the body when taken in the same manner. In medical research, Ritalin and cocaine are used interchangeably. Ritalin is being sold and used by teenagers and college students as a street drug.

Adderall and Dexedrine are straight amphetamines. Another drug prescribed for children is Clonidine or Catapres, which is an adult high blood pressure medication. This "adult" drug has never been tested on children under the age of 18 and is not indicated for use for anyone under age 18.

The SSRI drugs, including Prozac, Paxil, Zoloft, Luvox and others are also used on children. These drugs list as possible side-effects heart problems, paranoia, suicide and aggressive behaviors. I have seen many patients who were prescribed these drugs by other doctors who have become extremely aggressive and suicidal while taking them.

There are many other side effects to the drugs prescribed for ADHD symptoms. I recommend to all my patients that they get a drug insert from the pharmacist or purchase a Physician's Desk Reference (PDR) for themselves. If the side effects sound worse than the problem, they might not choose to take the drug. The reason the PDR lists side effects is because they can and do occur. Everyone should decide individually if the benefit of taking the drug is worth the risk of the potential side effect.

### Causes of attention and behavior problems

Every child deserves a complete medical work-up by a physician who understands that allergies, blood-sugar problems, learning problems, diet and nutrition can affect how a child feels, thinks and acts. When a child has attention and behavior problems, it is not ADHD. These children don't have psychiatric problems. They often have medical conditions or academic problems interfering with their attention and behavior.

In my practice, I see thousands of children from all over the world who have been damaged both physically and psychologically by the ADHD label and the drugs prescribed to them. Prior to seeing me, most of these children have never had a medical exam to rule out any health problems causing the symptoms. In fact, countless children have suffered frightening side-effects to the drugs before seeing me. After a comprehensive history and medical exam, I

have uncovered a variety of underlying health problems in my patients that are overlooked by other doctors. I have seen time and time again how the attention and behavior problems resolve after treating the identified health issues.

Drugs and behavior modification have no place in the treatment of these children, and doctors who use them are not taking the time to do the appropriate medical and educational work-ups. So if the American Academy of Pediatrics thinks we should be drugging these children, then ADHD might as well stand for Another Doctor Handing-out Drugs. Our children deserve better.

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*Dr. Mary Ann Block is an international expert and author on the treatment of ADHD without drugs. She has served as a peer reviewer for the Agency for Health-care Policy and Research and the American Academy of Pediatrics for the diagnosis and treatment of ear problems. Additionally, Dr. Block has been a guest on The Montel Williams Show and interviewed on CNN News, NBC's Home Page, Fox Network News, Extra, TBN, and The Today Show in New York as well as such magazines as Better Homes and Gardens and radio and newspapers across the country. She is scheduled to be a guest on this week's edition of CBS' "48 Hours" television program.*

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Baughman letter re ADHD and the drugs given to children.

In its ADHD treatment guideline, just released, the American Academy of Pediatrics (AAP) states (1) "The initiation of treatment requires the accurate establishment of a diagnosis of ADHD," and (2), that "the American Academy of Pediatrics' clinical practice guideline on diagnosis of children with ADHD [1] provides direction in appropriately diagnosing this disorder. Does their diagnosis guideline do any such thing?

In my letter to the editor of PEDIATRICS (journal of the AAP) regarding their previously published diagnosis guideline, I [2] wrote:

Clinical Practice Guideline opens: "Attention-deficit/hyperactivity disorder is the most common neurobehavioral disorder of childhood." "Neurobehavioral," implies an abnormality of the brain; a disease. And yet, no confirmatory, diagnostic, abnormality has been found. With six million children said to have it, most of them on addictive, dangerous, stimulants, ambiguity as to the scientific status of ADHD is not acceptable.

In medicine, physicians are responsible for determining whether a disease is present or not, i.e., whether or not an abnormality has been detected. If not, there is no medical/biological abnormality to treat; to make normal or more nearly normal. And yet many, throughout medicine, persist in referring to ADHD as a disease, hoping, it will justify medical/pharmacological interventions, and billing for them. In a recent article in—of all places--the Journal of the American Medical Association, Vastag [3]

proclaimed:

In 1999, Darin Dougherty, MD, and colleagues [4]...reported that people with ADHD have many more dopamine transporters than those without the condition.

Dougherty, et al, proved no such thing. They provided so little information about the drugs their subjects were on that their research could not be replicated, even if someone wished to try to do so. This was just another in a long line of false research claims and press releases, asserting that ADHD was an actual disease, when it is not—when, given it's wholly subjective nature—it never can be. The never-replicated claims of Zametkin et al [5], in 1990, sustained the epidemic-without-a-disease, through the nineties.

Nor does the lack of scientific proof stop those at the AAP from referring to ADHD as a disease, and urging that it be treated, as if it were, with methylphenidate (Ritalin) and other, addictive, dangerous, sometimes deadly, Schedule II, amphetamines.

In April [6] Stein, a co-chairperson on the APA Subcommittee on ADHD, wrote:

Factors that impact compliance (with prescription medication) include their belief that the treatment will be effective, the parents' understanding of the disease and how treatment will alter or ameliorate symptoms, and the quality of the therapeutic alliance between the clinician, child, and parent.

Here, without a doubt, and, without a shred of scientific proof, Stein, of the AAP, conveys that ADHD is a disease. Can there be any doubt the parent of a normal child, led to believe that

their child is "diseased"/ "abnormal," will have a different view of their child and of their child's corrective needs, than of the parent told honestly that ADHD is nothing but a set of normal behaviors in a wholly normal child.

If the AAP has proof that ADHD is a disease; that the children are abnormal, diseased, why don't they say so. Instead, they too, seem intent on conveying to the to patients and the public, albeit with no proof, that ADHD, a propaganda construct, is a disease, that children with it are "diseased"/ "abnormal."

At the November 16-18, 1998, National Institutes of Health Consensus Conference on ADHD, Carey [7], an invited speaker, made the following statements:

What is now most often described as ADHD in the United States appears to be a set of normal behavioral variations... This discrepancy leaves the validity of the construct in doubt.

ADHD behaviors are assumed to be largely or entirely due to abnormal brain function. The DSM-IV [the Diagnostic and Statistical Manual of Mental Disorders, which lists the diagnostic criteria of mental disorders] does not say so, but textbooks and journals do.

We see...that the causes of these behaviors called ADHD are entirely speculative. And yet... parents and children are being told that these behaviors are due to a brain malfunction. Can you not please strengthen the statement to discourage practitioners from making this statement when there is not adequate proof to support that at this time?"

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We see...that the causes of these behaviors called ADHD are entirely speculative. And yet... parents and children are being told that these behaviors are due to a brain malfunction. Can you not please strengthen the statement to discourage practitioners from making this statement when there is not adequate proof to support that at this time?"

Nor is there the least bit of proof today, that ADHD is a bona fide disease, that the millions of children said to have it are diseased/abnormal and in need of such medical/biological/pharmacological treatment as is invariably urged upon them.

As I urged previously [3]:

It is apparent that virtually all professionals of the extended ADHD 'industry' convey to parents, and to the public-at-large, that ADHD is a 'disease' and that children said to have it are 'diseased'-'abnormal.' This is a perversion of the scientific record and a violation of the informed consent rights of all patients and of the public-at-large.

The wording of the AAP Guideline should be changed, forthwith, to reflect the scientific and medical facts of the matter.

In publishing this letter to the editor in the May issue of their journal, PEDIATRICS, no one from the APA or their Subcommittee on ADHD responded in the least to the questions I raised, nor did they stop referring to ADHD as a "neurobehavioral disorder" implying something neurologically (brain) abnormal/diseased within children thus labeled.

Their intentions seems clear: to continue to call normal children "abnormal"/"diseased," and to continue to "treat" them with methylphenidate (Ritalin) and other amphetamines of the Schedule II, controlled, designation, as if they were.

The first, abnormality/disease/chemical imbalance such children have, is that due to the drugs they are given.

This is not the legitimate, ethical, practice of medicine.

Sincerely,

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