BEHAVIORAL DRUGS IN SCHOOLS:

QUESTIONS AND CONCERNS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON EDUCATION AND

THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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September 29, 2000

U. S. House of Representatives

Subcommittee on Oversight and Investigations

Committee on Education and the Workforce

Washington, D.C.

The Subcommittee met, pursuant to call, at 9:00 a.m., in Room 2175, Rayburn House Office Building, Hon. Peter Hoekstra, Chairman of the Subcommittee, presiding.

Present: Representatives Hoekstra and Schaffer.

Staff Present: Christie Wolfe, Professional Staff Member; Whitney Rhoades, Staff Assistant; Kent Talbert, Education Policy Counsel; Krisann Pearce, Professional Staff Member; Patrick Lyden, Professional Staff Member; and Deborah Samantar, Office Manager;

Chairman Hoekstra. A quorum being present, the Subcommittee on Oversight and Investigations will come to order.

The Subcommittee is meeting today to hear testimony on the use of behavioral drugs in schools. I am eager to get to the testimony today, so I am going to limit opening statements to 5 minutes. Since there is no one here from the Minority, you will have the opportunity to hear from the Majority for 5 minutes this morning. Any other statements that Members wish to put into the record at a later date will be entered into the record.

With that, I also ask unanimous consent for the hearing record to remain open for 14 days to allow Members statements, witnesses written testimony and other material to be submitted for the record. Without objection, so ordered.

I am looking forward to the hearing today. My colleague from Colorado has taken the lead in putting the hearing together. I will yield to Mr. Schaffer from Colorado to deliver an Opening Statement and to introduce the witnesses that we have with us today.

Mr. Schaffer.

OPENING STATEMENT OF CONGRESSMAN BOB SCHAFFER, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Mr. Schaffer. Thank you, Mr. Chairman. I am grateful for your indulgence in holding this hearing. This is one that I think is important and have wanted to see the Congress conduct for some time now.

I guess for me that time started when the State Board of Education in my home state of Colorado passed a resolution that urged further review and study of the use of various psychotropic drugs where schools are concerned. In addition it also asked that the State in an official capacity urge parents to be more involved in making these kinds of decisions by becoming knowledgeable about various motivations, as well as the medical implications of these drugs and what is to be accomplished by use of them.

However, that is not the only resolution we have received. We received others from State legislators across the country that have been concerned about a number of Federal incentives. Let me speak to a few of them.

In 1990, Supplemental Security Income, SSI, a Federal Government welfare program, was opened to allow low-income parents whose children were labeled with ADHD to be eligible for a cash benefit under the SSI program. This allowed some families to receive more than $450 per month per child from the Federal Government. In 1989, children citing mental impairments including ADHD but not retardation made up only 5 percent of disabled kids on SSI; and that figure rose to nearly 25 percent by 1995.

Then, in 1991, the Department of Education made hundreds of special education dollars available every year for children labeled with ADHD and also those in need of special education. After that, modification schools could receive more than $400 per student under IDEA for each child diagnosed with ADHD and in need of special education.

Now both SSI and ADHD changes coincide with a dramatic rise in the number of children said to have ADHD. Between 1990 and 1992, the number of ADHD diagnoses jumped from approximately one million to over three million and the production of one drug, Ritalin, increased from 2,000 kilos to over 8,000 kilos in that time period.

So these are correlations that certainly exist and can be documented. As to whether there is a cause and effect that is the question that remains to be explored, and from my perspective I view this hearing as somewhat of an introduction to the Congress. We have held, to my knowledge, just one hearing on this topic previously. I see this as just another step in that introduction.

I have not prepared legislation or even intend to at this point in time. This is one of those rare occasions when Congress actually wants to learn something before it starts putting a proposal down on paper. So with regard to this issue, as far as I am concerned Congress is somewhat of an open book. We are thrilled today, Mr. Chairman, to have a number of expert panelists who are here to join us and lead us in this discussion, which I hope is just one of many more to come.

I might parenthetically add that I know Chairman Hyde over in the Judiciary Committee has also indicated he would like to hold similar hearings regarding law enforcement issues and these psychotropic drugs that are within the jurisdiction of the Judiciary Committee. Other Members on the Commerce Committee who deal more in the medical end of things, health care and so on, have indicated that they may perhaps be willing to pursue similar hearings. I think that underscores the magnitude of the issue. I think this is a topic that spans several Committee jurisdictions where schools and the extent to which they are affected by so many children who are medicated with these powerful drugs are concerned. It is fitting for this Committee to perhaps play the lead role in initiating these kinds of hearings.

Let me introduce the witnesses that we have before us. They are not seated in order. Let me start with Patricia Weathers. Ms. Weathers is a parent from Mill Brook, New York. Her son reacted so severely to being taken off his psychotropic medication that the school called Child Protective Services. I am grateful for you being here.

Also, Dr. Fred Baughman is here. He is a fellow with the American Academy of Neurology. I will let the witnesses introduce themselves a little further. I have lengthy introductions that would take a long time to go through. Let me just say that Dr. Baughman is very knowledgeable, an expert in this area and has been an adult and child neurologist in private practice for 35 years.

Dr. David Fassler is testifying on behalf of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. He is a child and adolescent psychiatrist practicing in Burlington, Vermont.

Ms. Patty Johnson is a good friend of mine from Colorado who I have known for quite a long time and whose work in Colorado education I greatly admire. She is a member of the Colorado State Board of Education, and lives in Broomfield, Colorado. She is the author of a Colorado State School Board of Education resolution promoting the use of academic solutions to resolve problems with behavior attention and learning which passed our State Board of Education earlier in the year.

Ms. Judy Heumann, is Assistant Secretary for Special Education and Rehabilitative Services, U. S. Department of Education here in Washington. We appreciate you being here.

Our final witness is Dr. Peter Breggin. He is the Director, International Center for the Study of Psychiatry and Psychology in Bethesda, Maryland.

We have a distinguished panel, and we are anxious to sit back and let you take it from here.

Mr. Chairman, I yield back.

Chairman Hoekstra. I thank the gentleman.

I have just a couple of notes before we get started. We have some new technology. The microphones are rather sensitive, but it does mean that you have to pull them close. Bob and I will be able to hear you whether you are speaking into the microphone or not, but the people sitting behind you will not be able to hear you if the microphone is not pulled close.

With that, we will begin. Ms. Weathers, welcome.

STATEMENT OF PATRICIA WEATHERS, PARENT, MILL BROOK, NEW YORK

Ms. Weathers. My name is Patricia Weathers. I am here today to tell you about the ordeal my family has been through and particularly that of my son Michael.

When Michael was in kindergarten, we began getting reports that Michael was having behavior problems. Michael was talking out of turn, clowning around in class and apparently being disruptive. Then when Michael was in the first grade his teacher told me that his learning development was not normal, and that he would not be able to learn unless he was put on medication. Then near the end of the first grade the school principal took me into her office and said that unless I agreed to put Michael on psychiatric drugs the school would transfer him to a special education center for children with behavior problems. As a parent I felt extremely pressured by the school's staff at this point. The teacher, school psychologist and principal were all telling me that putting my son on drugs was the right thing to do.

At this point, Michael's first grade teacher filled out an ADHD checklist on Michael and sent it to his pediatrician. Based on this ADHD checklist and a short evaluation by the pediatrician, Michael was given the diagnosis of ADHD and put on the drug Ritalin. According to his teacher Michael was much better, meaning that he was quiet and doing his work.

I didn't notice any difference at first, but eventually I began getting reports that Michael was not socializing with other kids, and that he was withdrawn. This was completely out of character for Michael who was normally very social and outgoing. It got worse. When Michael was in the third grade, my grandmother saw Michael just standing by himself at the far corner of the playground staring at his feet. I also began receiving reports that Michael had started chewing on things, pencils, erasers, and paper, even his clothing. His behavior was getting more and more bizarre.

Instead of recognizing the effects the drugs were having on my son, the school's psychologist claimed Michael now had a, "social anxiety disorder and needed to see a psychiatrist." She immediately produced the name and the number of the psychiatrist I was to call. The psychiatrist talked to Michael for 15 minutes and, again, with the aid of the school reports, diagnosed him with social anxiety disorder. She handed me a prescription for an antidepressant and told me it was a wonder drug for kids.

On October 5th, 1999, Michael started taking the antidepressant. Shortly afterwards, he told his teacher he was hearing a male voice in his head telling him to do bad things. I watched as my son began to have wild mood swings and would see him just flip out over the smallest things. One night I tried to get him to just sit down for dinner, and he ran at me in the hallway and attacked me. I could no longer recognize my own son, and I realized it was the drugs that had changed him.

At this point, I did what I knew I had to do. I took him off the drugs. It took him a full month before he stopped hallucinating. The psychiatrist meanwhile, not recognizing that my son was in withdrawal from a powerful drug, tried to get me to hospitalize him and try different sedatives until I found, "the right one."

The school's psychologist tried to convince me it was, "trial and error" in finding the right drug. By now, I was furious and frustrated. I remember that I had seen a doctor on TV discussing the drugging of children and how she believed

in finding underlying physical causes that could affect a child's behavior. I began doing my own research on these mental disorders, the drugs and their side effects.

On January 3rd of this year I brought my research to the school's psychologist to show her what I believe were the side effects of the medications. The next day I had a meeting with the school staff and the principal. The principal produced my research, threw it on the desk and said I take serious offense over this biased literature. He then told me they had nothing left there to offer my son, and Michael was dismissed from school.

Essentially, this led to a downward chain of events, which culminated in the school calling Child Protective Services on my husband and I, and charging us with medical neglect. The charge was for failing to give Michael the necessary medication and failure to follow the psychiatrist's advice of hospitalization. The only reason my son was not removed from my custody that day was that I had obtained an independent psychological evaluation in which the psychologist stated that Michael did not require hospitalization. If it were not for this, he would have been taken from our home.

What concerns me is the intimidation tactics that a school can use to coerce a parent to drug their child. The question is raised, what will happen to the parent without the financial means to combat these tactics? If I didn't have family members who were willing to financially back my son and I in my son's cause, it is entirely possible that my son would have ended up in a psychiatric ward.

Today, Michael is doing fine. He has been off drugs for 9 months and is once again a social, happy, outgoing boy. He is in private school, and I also home school him.

What really disturbs me now is that the public school that dismissed my son has just sent me a letter saying that they have now reclassified him as learning disabled, based solely on their old records.

The question I leave you with is this: Is the school district still collecting funds on behalf of my child even though he is attending private school? I can tell you that he is not receiving any services from them or any educational assistance. I hope that this Committee will seriously look into this matter and the documents that I will provide to you so that some safeguard will be enacted to prevent this flagrant disregard of parental rights.

Thank you for listening to my story.

WRITTEN STATEMENT OF PATRICIA WEATHERS, PARENT, MILL BROOK, NY – SEE APPENDIX A

Chairman Hoekstra. Thank you very much.

I was looking through some of the other documents provided and the letter that you are talking about is here at the end dated 9/6/2000?

Ms. Weathers. Yes.

Chairman Hoekstra. Okay. Good, thank you. We will have questions after we go through the entire panel. Thank you for being here.

Dr. Baughman.

STATEMENT OF FRED A. BAUGHMAN, JR., M.D., EL CAJON, CALIFORNIA

Dr. Baughman. Good morning. It is a pleasure and a privilege to be here this morning, Congressmen.

I am a neurologist and pediatric neurologist. I have been in private practice for 33 years, making disease versus no disease determinations daily; and I have discovered and authored descriptions of several real diseases.

In April 1998, I wrote Attorney General Reno, "The biggest health care fraud in U.S. history is the representation of ADHD to be a disease and the drugging of millions of normal children." Every physician knows disease equals physical abnormality. Nowhere in the brains or bodies of these children has psychiatry found an abnormality.

In 1996, Congressman Christopher Shays observed, " in ADHD we are trying to draw the line between personality and pathology. We should do so only with the greatest care and with particular reticence to make our children medical patients."

In 1970, Congressman Cornelius Gallagher wrote to HEW Secretary Elliot Richardson, "I have received letters highly critical of the focus of the medical side of minimal brain dysfunction, which is, incidentally, one of at least 38 names attached to this condition. Such a high incidence in the population, as high as 30 percent in ghetto areas, may not be pathological at all."

In 1948, neuropsychiatry was divided into neurology, dealing with organic diseases of the brain, and psychiatry, dealing with psychological conditions in normal human beings. But psychiatric drugs appeared in the 1950s, and in the 1960s psychiatry and the pharmaceutical industry authored a joint market strategy. They would call emotional problems brain diseases due to chemical imbalances needing chemical balancers, pills. In 1980, they invented ADD, and in 1987, ADHD. Eight of 14 behaviors were diagnostic. In 1994 ADHD was changed yet again; six of nine behaviors diagnosed three subtypes.

In 1996, Schiller, of the Department of Education, and, Jensen and Swanson, of the NIMH and CHADD, wrote, "Once parents and teachers recognize that children with ADD are not lazy or bad but have a biologic disorder they can stop blaming themselves."

Diller wrote, "The reason you have been unable to obtain articles presenting clear evidence of a physical or chemical abnormality is there are none. The search for a biological marker is doomed from the outset because of the contradictions and ambiguities of the current construct of ADHD." In 1993 I testified at NIH hearings, " if, as I am convinced, these entities are not diseases, it would be unethical to initiate research to evaluate biological interventions; unethical and fatally flawed scientifically."

In 1994, Pearlman wrote, "I take issue with the APA assertion that elimination of the term *organic* in the DSM-IV has served a useful purpose for psychiatry. Elimination of the term *organic* conveys the impression that psychiatry wishes to conceal the *non-organic* character of many behavioral disorders." In 1998, Castellanos of the NIMH confessed, "we have not yet met the burden of demonstrating the specific pathophysiology that we believe underlie this is condition."

Opening the 1998 Consensus Conference, Hyman of the NIMH posited, "ADHD affects 0 to 3 percent in some school districts, up to 40 percent in others. This cannot be right." Carey then asserted, "What is described as ADHD in the United States appears to be a set of normal behavioral variations."

Degrandpre observed, "It appears that you define disease as a maladaptive cluster of characteristics. In the history of science and medicine, this would not be a valid definition of disease." Failing to prove a disease, psychiatry sought to redefine what a disease is.

I testified at the Consensus Conference, "without an iota of proof, the NIMH has proclaimed the children brain diseased, abnormal. CHADD, funded by Ciba-Geigy, has spread the neurobiological lie. The U.S. Department of Education, absolving itself of controlling the children and rendering them literate, coerces the labeling and drugging. ADHD is a total, 100 percent fraud." The final statement of the panel was "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." That was November 18, 1998.

In 1999, I challenged the American Medical Association, which had concluded that ADHD was not being over diagnosed. I stated, "Once children are labeled with ADHD, they are no longer treated as normal. Once Ritalin or any psychotropic drug courses through their brain and body, they are, for the first time, physically, neurologically and biologically abnormal."

In December 1999, Surgeon General Satcher announced, "Mental illness is no different than diabetes, asthma, or other physical ailments. Mental illnesses are physical diseases. We know the chemical disorders we are treating." I responded, "All physicians know that the presence of disease is confirmed by an objective or physical or chemical abnormality. You know there is no abnormality in life, or at autopsy, in depression, bipolar disorder or other mental illnesses. Your role in this deception is clear. You should resign."

In January, 20 years after the start of the ADHD epidemic, Castellanos observed, "Incontrovertible evidence is still lacking. I am confident we will confirm the case for organic causes."

On May 1, 2000, Waters and Kraus of Dallas filed the first of several class action lawsuits charging the APA, CHADD and Ciba-Giegy/Novartis, "planned, conspired and colluded to create, develop, promote and confirm the diagnoses of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder in a highly successful effort to increase the market for its product Ritalin."

The government should not be validating diseases that science cannot validate. The only question that you, sirs, have to ask of experts appearing before you, if you want to know if a real disease is being dealt with or not, is simply is it a disease, yes or no? If yes, give the citation from the scientific literature. Additionally, sirs, I have some slides, transparencies that I can't present but I will duplicate and share with you, that lay forth the essential "are these diseases or aren't they diseases" question. That is the fundamental linchpin of the fraud with which we are confronted.

Thank you.

WRITTEN STATEMENT OF FRED A. BAUGHMAN, JR., M.D., EL CAJON, CA – SEE APPENDIX B

Chairman Hoekstra. Thank you very much.

Dr. Fassler.

STATEMENT OF DAVID FASSLER, M.D., TESTIFYING ON BEHALF OF, AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, D.C., AND AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, WASHINGTON, D.C.

Dr. Fassler. Good morning. My name is David Fassler. I am a board certified child and adolescent Psychiatrist practicing in Burlington, Vermont. I am the President of the Vermont Association of Child and Adolescent Psychiatry, and I serve as Chair of the Council on Children, Adolescents and Families for the American Psychiatric Association.

First of all, let me thank you for the opportunity to appear before this Subcommittee. My testimony today is on behalf of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry.

Before I begin my remarks, I just want to respond to my colleague, Dr. Baughman, who asked for a specific citation from the scientific literature. I have with me the AMA Council on Scientific Affairs report, and I will just read you two sentences of their conclusion.

Attention Deficit Hyperactivity Disorder is a childhood neuropsychiatric syndrome that has been studied extremely thoroughly over the past 40 years. Available diagnostic criteria for ADHD are based on extensive empirical research and if applied appropriately lead to the diagnosis of a syndrome with high interrater reliability, good face validity and high predictability of course and medication responsiveness. ADHD is one of the best-researched disorders in psychiatry, and the overall data on its validity are far more compelling than for most mental disorders and even for many medical conditions.

Now, as a psychiatrist when I think of ADHD I think first of the faces of children and families that I have seen over the years. In particular, I think of the 7-year-old boy who was about to be left back in second grade due to his disruptive behavior. The teachers have labeled him difficult to control; the other kids just call him weird. He has few friends, and he is already convinced that he is bad and different. I think of a 12-year-old girl with an IQ of 130. She is not disruptive, but she is failing seventh grade. I also think of a 16-year-old boy who lost his driver's license and place in the high school football team due to a growing substance abuse problem. In part, he was trying to self-medicate the restlessness associated with his illness. Finally, I think of a 28-year-old administrative assistant who was appreciative when he received an accurate diagnosis and appropriate treatment for his long-standing condition. But I also remember his anger and frustration because, in his words, he had missed out on 20 years of his life.

According to the National Institute of Mental Health, ADHD is the most commonly diagnosed psychiatric disorder of childhood. It is estimated it affects between 3 and 5 percent of school age children, and it occurs three times more often in boys than in girls.

I have with me for the Committee, the Diagnostic Statistic Manual of Mental Disorders and the DSM-IV, which is central to understanding the formal diagnosis of ADHD. The key features of the diagnosis include inattention, hyperactivity and impulsivity. The symptoms must also be interfering with the child's life at home, at school, at work or with their friends. So just having the symptoms aren't enough.

The diagnostic criteria are specific and well established within the field. They are the product of extensive research conducted at academic centers and clinical facilities throughout the country.

Let me be very clear, ADHD is not an easy diagnosis to make; and it is not a diagnosis that can be made in a 5- or 10-minute office visit. Many other problems, including anxiety disorders, depression and learning disabilities can present with signs and symptoms, which look similar to ADHD. There is also a high degree of

comorbidity, meaning that over half of the kids who have ADHD also have a second significant psychiatric problem.

The diagnosis of ADHD requires a comprehensive assessment by a trained clinician. In addition to direct observation, the evaluation includes a review of the child's developmental, social, academic and medical history. It should also include input from the child's parents and teachers and a review of the child's records. Schools play a critical role in identifying kids who have having problems, but schools should not make diagnoses or dictate treatment.

ADHD is also a condition, which should not be taken lightly. Without proper treatment, a child with ADHD may fall behind in schoolwork and have problems at home or with friends. It can also have long-term effects on a child's self-esteem and lead to other problems in adolescence, including an increased risk of substance abuse.

The treatment of ADHD should be comprehensive and individualized to the needs of the child and family. Medication, including methylphenidate of Ritalin, can be extremely helpful for many children, but medication alone is rarely the appropriate treatment for complex child psychiatric disorders such as ADHD. Medication should only be used as part of a comprehensive treatment plan, which will usually include individual therapy, family support, counseling and work with the schools.

In terms of methylphenidate, we have literally hundreds of studies clearly demonstrating the effectiveness of this medication on many of the target symptoms of ADHD. It is also generally well tolerated by children with minimal side effects. Nonetheless, I share the concern that some children may be placed on medication without a comprehensive evaluation, accurate and specific diagnosis or an individualized treatment plan.

Let me also be very clear that I am similarly concerned about the many children with ADHD and other psychiatric disorders, who would benefit from treatment, including treatment with medication, but who go unrecognized and undiagnosed and who are not receiving the help that they need.

The American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry would like to offer the following specific recommendations for the Subcommittee's consideration:

First, we fully support the importance of accurate diagnosis and treatment. This requires access to clinicians with appropriate training and expertise and sufficient time to permit a comprehensive assessment.

Next, we fully support the increased emphasis of the FDA and the NIMH on research on the appropriate use of medication in the psychiatric treatment of children and adolescents, and we welcome the commitment to expanded clinical trials and longitudinal studies for all medications prescribed for children.

We also fully support the passage of comprehensive parity legislation at both the State and the Federal level so there are fewer barriers to keep kids from getting the kind of comprehensive evaluations and individualized treatment that they need.

We fully support and welcome all efforts to sustain and expand training programs for all child mental health professionals, including programs for child and adolescent psychiatrists.

Finally, we fully support and appreciate the efforts of Surgeon General David Satcher to focus increased attention on the diagnosis and treatment of all psychiatric conditions, including those that affect children and adolescents.

In summary let me emphasize that child psychiatric disorders, including ADHD, are very real and diagnosable illnesses that affect lots of kids. The good news is they are also highly treatable. We can't cure all the kids that we see, but with comprehensive, individualized intervention we can significantly reduce the extent to which their conditions interfere with their lives. The key for parents and teachers is to identify kids with problems as early as possible and make sure that they get the help that they need.

Thank you for the opportunity to appear before the Subcommittee, and I will be happy to respond to any questions.

WRITTEN STATEMENT OF DAVID FASSLER, M.D., TESTIFYING ON BEHALF OF, AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, D.C., AND AMERICAN ADACEMY OF CHILD AND ADOLESCENT PSYCHIATRY, WASHINGTON, D.C.

SEE APPENDIX C

Chairman Hoekstra. Thank you very much.

Ms. Johnson.

STATEMENT OF PATTI JOHNSON, MEMBER, COLORADO STATE BOARD OF EDUCATION, 2ND CONGRESSIONAL DISTRICT, DENVER, CO

Ms. Johnson. Good morning. My name is Patti Johnson, and I have been an elected Member of the Colorado State Board of Education for the past 6 years. Thank you for holding this hearing.

Over the years I was contacted by a number of parents who had been pressured to put their children on various psychotropic drugs for a variety of so-called learning disorders, the most common of which was Attention Deficit Hyperactivity Disorder, ADHD. In some cases, they were told their children would not be allowed the attend school if they did not begin taking these drugs.

One parent who was given the option of placing her son on a stimulant drug or removing him from school elected to home school. She told me that it just didn't make sense that a straight "A" student would be labeled "learning disabled." A Douglas County parent I spoke with said she was told her son had ADHD. What she was being told about the behavior her son supposedly exhibited and what she observed were not consistent. She looked into the matter and the school's special education director admitted she had coaxed the teacher to answer the ADHD checklist in a certain manner. A Jefferson County parent told me that he had first complied with the school's direction to place his son on a stimulant drug. The drug caused his son to become violent. He began taking steak knives out of the kitchen and stabbing his stuffed animals and mattress. When the parent took him off the drug the principal began pressuring him to resume the stimulant, so much pressure that the matter is now in court and the parent could possibly lose his parental rights. More examples exist.

When I looked into this matter I realized that many of the learning disorders are an effort to "medicalize" what are actually failures in proper instruction and discipline. Some of the learning disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual illustrate this point. For example, the fourth edition lists mathematical disorder and disorder of written expression. A child can be diagnosed with one of these illnesses simply because he scores low on math or writing tests. The fact that this may be due to a failure to instruct properly is not taken into consideration.

In December of 1999, the Los Angeles Times reported that tens of thousands of California's special education students were placed there not because they have a serious emotional or mental handicap but because they were never taught to read properly. Reid Lyon, head of the Federal Government's research efforts into reading and writing, told the Times, "it is where children who weren't taught well go in many cases". This fact is also documented in two articles that I have enclosed in your documents.

Though teachers are not allowed by law to practice medicine, a team at school generally does the adjudication that a child has one of these disorders and should be placed on medication and into special education. At one I had attended at the request of the parent, two teachers, the principal, a social worker and the special education instructor determined that the child had five different mental illnesses and should be placed on Ritalin.

The label of ADHD is assigned if the child exhibits such symptoms as not listening when spoken to, is forgetful, fails to finish homework, fidgets, talks excessively. Parents of children said to have these disorders are generally told it is a neurological disorder or a chemical imbalance in the brain. Yet at a Consensus Development Panel conducted by the National Institutes of Health on ADHD in November of 1998, it was reported that, "we do not have an independent, valid test for ADHD, and there are no data to indicate that ADHD is due to brain malfunction. Further research to establish the validity of the disorder continues to be a problem."

The above factors led me to introduce a resolution before the Colorado State Board of Education entitled "Promoting the use of academic solutions to resolve problems with behavior, attention and learning." It was passed by a vote of six to one in November of 1999 and was strongly supported by the citizens of Colorado. In fact, in a 2-week period we received over 1,000 letters of support. Also, a poll done by the Rocky Mountain News gave it a 95 percent approval rating.

I have been asked to research whether financial incentives exist for schools to label children with ADHD. The full history of this is too long to cover in this limited time available. More information is included in my written statement, and I have just begun to investigate this area. It needs further investigation.

What I do know is that the legislation, which is now the Individuals With Disabilities Education Act, was originally the Education for All Handicapped Children Act of 1975, and the change they made was they changed handicapped to disabilities. Then, in 1991, the Department of Education said schools could get $400 extra dollars in special education money for each child with ADHD, and I believe the number is now over $600 per child. According to the Drug Enforcement Agency, after this, Ritalin consumption increased six fold by 1995.

There is also a "child find" provision which requires States to actively seek out any children who may qualify for special education in order to receive Federal special education funds, and in Colorado this child find program starts at birth.

This, of course, serves to push up the numbers of children labeled with ADHD; and I have read in many cases they never get rid of this label. They say the purpose is to help these children, but by the time they get into first grade they are still in special education, and they never get out.

In many States schools have become authorized Medicaid providers and collect funds for children labeled with one of the learning or behavior disorders. This can be such a lucrative cash cow that in a letter dated October 8, 1996 the Illinois State Board of Education strongly encouraged one of its districts to participate in Medicaid. The letter stated that Illinois had received $72,500,000 in Federal Medicaid money in 1996 and that Medicaid dollars had been used for a wide variety of purposes and "the potential for the dollars are limitless."

To the degree educators are expected to diagnose children, they are being distracted from their main duty, which is to provide our children with a quality education. Our schools are the only institution entrusted to attend to the academic needs of our children, and their mission must not be diluted. I urge this Committee to do everything in its power to get schools out of the business of labeling children and back to the job of teaching.

Thank you.

WRITTEN STATEMENT OF PATTI JOHNSON, MEMBER, COLORADO STATE BOARD OF EDUCATION, 2ND CONGRESSIONAL DISTRICT, DENVER, CO – SEE APPENDIX D

Chairman Hoekstra. Thank you very much.

Dr. Breggin.

STATEMENT OF PETER R. BREGGIN, M.D., DIRECTOR, CENTER FOR THE STUDY OF PSYCHIATRY AND PSYCHOLOGY, BETHESDA, MARYLAND

Dr. Breggin. I am Peter Breggin. I am here as the Director of the Center for the Study of Psychiatry and Psychology, also as a parent and also as a psychiatrist in practice since 1968.

Let me begin by showing you what we are up against in terms of billion dollar industries with multimillion-dollar ad campaigns. This is now an ad that is in magazines throughout the United States.

Chairman Hoekstra. We have the reply card, is that correct?

Dr. Breggin. I think you may have the reply card.

Chairman Hoekstra. This one is actually out of Better Homes and Gardens, I believe.

Dr. Breggin. This is out of Good Housekeeping, but I hear it is also in People magazine.

What this ad is doing is basically advertising Concerta, which is an ALZA/McNeil product. It is the addictive drug Ritalin in a long-acting form. It is illegal by international law to advertise addictive drugs to the public directly. One way that the manufacturers are getting around it is by not mentioning the drug, simply pointing out that this is about ADHD and giving you a number to call.

Another document that has been around for a while but is still in use is this ADHD manual. It is called ADHD, Attention Definite Hyperactivity Disorder Booklet for the Classroom Teacher, by a Washington, D.C. psychiatrist. It is put out by Ciba-Geigy. Right here on the back, the manufacturer of Ritalin going into the schools to propagandize teachers.

It is because of this kind of multimillion-dollar campaign to push addictive drugs on our kids that we need the class-action suits that have been mentioned. There are four of them now. I am very proud that they are based on my book Actually Talking Back to Ritalin and that I am the medical expert in the suits. I think that we need this kind of enormous legal confrontation with this kind of power.

Earlier, Dr. Baughman challenged my colleague, Dr. Fassler, to produce a scientific document to show that ADHD is a disease; and he quoted the AMA Council report, which is a political document, as he probably knows, and rather slipshod scientifically. There are no scientific studies to show that in any ordinary sense ADHD is a disease.

Dr. Fassler also mentioned the pleasure that people have when they are told they have ADHD. It is not my experience at all. When I tell a young child there is nothing the matter with you, you just need some help with your learning, and some help with your discipline, and we are going to get your parents and teachers together to help you adjust better to your life and your family and your school, the kids really, really smile because they don't have a disease. Kids don't want to have biochemical imbalances and crossed wires.

I want to talk about the dangers of stimulant medication, which has been rather ignored so far. Table one in my report describes the multiple adverse effects from stimulant drugs; everything from cardiac problems to the suppression of growth to zombie-like effects. Depression is very, very common, as is agitation, anxiety and impaired learning. After all, this is speed. Ritalin is an amphetamine-like drug. Adderall, which is almost replacing it, now, is an amphetamine. We are basically giving our kids amphetamines.

Animals cross-addict to methylphenidate, or Ritalin, amphetamine, methamphetamine and cocaine. The same neurotransmitter systems are affected. Pet scan shows the same part of the brain is affected by cocaine and Ritalin and drugs like Adderall and, in fact, human beings cross-addict to these drugs. That is why they are all, including cocaine and the opiates and Ritalin, in Schedule II of the DEA, the highest schedule there is for abuse potential and addiction potential. Incidentally, CHADD one of the organizations being sued in the class action suits lobbied on behalf of the drug companies to try to get the DEA to drop Ritalin from Schedule II.

The stimulants impair growth. They can actually stunt growth. They do it not just by suppressing appetite but also by disrupting growth hormone, the very substance that controls how our brain develops, how our liver develops, how our whole body develops. And while it is disrupting growth hormone, these drugs are bathing the brain and disrupting at least three major neurotransmitter systems during the growth period.

Stimulants become gateway drugs. We have studies by Nadine Lambert where she has followed children at the University of California. Children prescribed stimulants by doctors become cocaine addiction prone as young adults. We finally have the data to back up what should have been obvious from early studies.

But, more important, these are gateway drugs to all psychiatric drugs. In my practice I am now commonly seeing a child started on Ritalin get over stimulated, put on an addictive drug like Klonopin or Xanex to calm them down. Then he gets depressed from the combination of drugs, so the child is put on an antidepressant, then on a mood stabilizer, then on a neuroleptic. I am taking 10-year olds off five psychiatric drugs. Thank goodness, they come out better when they are off the drugs. If parents are cooperative, their schools are cooperative, it is not so difficult to get the kids off drugs, because children respond to changes in their lives and the adults and the teachers around them.

The diagnosis itself has already been dealt with, but what I want to point out is what the diagnosis is, and this hasn't been made absolutely clear. It is nothing more than a list of behaviors that disrupt classrooms. Number one under hyperactivity is "often fidgets with hands or feet or squirms in seat." The next one is "often leaves seat in classroom." Another one is "blurts out answers before the questions have been completed by the teacher." These are behaviors that have been identified by professionals working in the classroom that disturb and stress teachers and justify the use of drugs. That is the ultimate aim. It is to make it easier to take care of kids in structured classrooms.

I want to reemphasize that the American Academy of Pediatrics and other organizations have said there is no biological basis to this.

We also know how the drugs work, and that has not been addressed. From animal studies and human studies we know that stimulants crush spontaneous behavior. It can be measured in an animal or a child. Exploration is reduced, and inquisitiveness is reduced, as well as the desire to socialize, or to play. Basically, you take the spirit or the spunk out of the child; and probably because of effects on a particular part of the brain, the basal ganglia, you enforce obsessive behavior.

So if you can crush the spontaneity of a child, however slightly, all the way up to robotic, obsessive, compulsive, it looks good in a classroom. The child sits down and shuts up. That is the only reason they get better grades. There is no evidence from all the studies of any improvement in academic performance, in the emotional life of a child, or in the sociability of the child.

What is really going on here is that we are taking conflicts between our kids and ourselves in the home and in the classroom, and we are drugging the weakest member of the conflict. So when we have a child who is in conflict in the classroom standing up, walking around, and not paying attention, instead of asking what do we as adults do to help this child meet our expectations, what do we as parents do, we end the conflict by crushing the spontaneity of the child with a drug.

When we do this, we not only injure our children, we set back any hope of reform in our schools. Because, after all, if you can take 10 percent of your kids or 20 percent of white males in some studies in our public schools on these drugs, you can take the kids that are protesting the most, that are upset the most, that don't fit in the most, maybe, in many ways, our best, brightest, most energetic. If you can put those kids out of commission, basically, then you are in a situation where you don't have to reform the classrooms.

That is one of the big social disasters here. For a generation we have been drugging kids instead of making the classrooms better for teachers, better for students, better for education, and more interesting. You know better than I what the schools need. What you may not realize and what I want to get across to you is that the ADHD diagnosis and the drugging of the kids substitutes for educational reform. That is absolutely key.

I hope that my presentation today, my books, my scientific articles will empower the Committee and parents to reject the solution of diagnosing and drugging children instead of meeting their genuine needs. We have a national tragedy now with up to five million or more children on these drugs. The parents who oppose the drugging are heroes, in my opinion; and I hope they will take heart from this hearing and continue to stand up on this issue.

Thank you.

WRITTEN STATEMENT OF PETER R. BREGGIN, M.D., DIRECTOR, INTERNATIONAL CENTER FOR THE STUDY OF PSYCHIATRY AND PSYCHOLOGY, BETHESDA, MD – SEE APPENDIX E

Chairman Hoekstra. Thank you.

Ms. Heumann.

STATEMENT OF JUDITH E. HEUMANN, ASSISTANT SECRETARY FOR SPECIAL EDUCATION AND REHABILITATIVE SERVICES, U.S. DEPARTMENT OF EDUCATION, WASHINGTON, D.C.

Ms. Heumann. I would like to make a couple of statements before I read my statement.

IDEA does not encourage the use of Ritalin or any other medications. And I also want to, for the record, in relationship to the discussion that has been going on around the funding of IDEA, make a couple of points.

Increasing the number of children who take behavioral drugs will not increase the size of a school district's IDEA grant. IDEA funds are distributed to States and school districts based on the size of the jurisdiction's population of school age children and the relative number of those children who live in poverty. Funds are not distributed based on the number of children identified as disabled and in need of special education. There was a formula change that, in fact, took place in 1997 when we reauthorized the IDEA so that incentive would be removed.

I am also a former schoolteacher, and so many of the issues, which have been discussed here this morning, are issues that I faced as a classroom teacher in New York. I understand that the focus of this hearing is the use of behavioral drugs among children and the effect this is having on their education. I always welcome the opportunity to discuss the ways that disabled children are being educated and what we can do to improve educational experiences for these children and all children.

As you know, the Office of Special Education and Rehabilitative Services has responsibility for administering the Individuals With Disabilities Education Act. We work with States, school district s and schools in their efforts to comply with the IDEA and to ensure that all children with disabilities receive the free and appropriate public education guaranteed under the Act. Our mission is to provide leadership to achieve full integration and participation in society of people with disabilities by helping to ensure equal opportunity and access to and excellence in education, employment and community living.

I think one of the significant changes that we made in the reauthorization in 1997 was really trying to focus that special education should not be a place but rather a service and that if we look at special education as a service as opposed to a place it can also help us provide more appropriate services to children.

When discussing the use of prescription drugs in this context, we have been articulating since 1993 that families and physicians, not educators, must make such decisions. We reemphasized our position on this at the behavioral summit we sponsored here on the Hill last year. Of course, it is not inappropriate for families to consult with educators in their decision making process, but the diagnostic responses and decisions must be left to qualified physicians. Families and educators can often provide input about the student's behavior that may aid in the diagnosis, but it is not the role of the school or the educator to make recommendations for treatment.

The school has to make the educational environment one that supports learning for all children. In our Office of Special Education Programs we support research and projects that make schools more effective places of learning for all students. Effective learning takes place in an environment where all children are given the tools that they need to succeed. In order to do that, schools need to establish specific and well-understood expectations that can be followed by all students, faculty and staff.

If students do not adhere to the standards, a clear system of redress must be in place. We feel strongly that addressing behavioral problems should be a school-wide effort. There should be mutually understood behavioral expectations for all students. That is very important to ensuring that inappropriate behavior is responded to appropriately and effectively.

The Office of Special Education Programs supports research and technical assistance projects that provide models for implementing positive behavioral support in schools. There is a need for not only more research in this area but a need to be able to more effectively disseminate the research that we have been conducting.

Because educators are frequently the ones to notice manifestations of behaviors that can impede learning, it is appropriate that teachers communicate with parents about their children's progress and classroom behaviors. This does not differ from a case where a teacher observes a child who may have a visual impairment or sees a child who is reading at a higher level and becoming bored in class. I think it is important for teachers to have open lines of communication with the parents to increase their involvement in their child's education. I would stress that this communication is not diagnostic but, rather, informative.

We all know the importance of parental involvement in education for all children. In fact, in 1997, when we reauthorized the IDEA, we strengthened the rights of parents under the IDEA to participate not only in the typical portions of the individualized educational program but also to be involved in placement decisions for their children which we believe is critical to ensuring that children are placed in the least restrictive environment.

We all know that education is a partnership between children, families and educators. We need to be sure that children are getting the support that they need to succeed in school in order to be able to go on to earn a diploma and hopefully attend college and move into the world of work.

Under IDEA, we work tirelessly to give disabled students the support they need to succeed in school. All findings indicate that if children drop out of school they are less likely to return and are far more likely to become involved in the justice system. I think we all have a vested interest in making sure that children are getting the kinds of support they need to remain in school, to improve their academic achievements and to develop an enthusiasm about learning that will carry them through their entire lives.

IDEA deals with education and civil rights issues, not medical issues. All children have potential, and we want to make sure that they are allowed to reach their full potential. For some students, reaching their potential will include the need for supports to encourage behaviors that will allow them to succeed in school.

I would like to reiterate that it is not the role of teachers to diagnosis medical conditions nor to prescribe medications. It is the role of teachers to involve parents in the educational process for their children. When they work together, they significantly improve the results for their children. I believe that both of the Members present today are in support of the current discussions that are going on pertaining to the appropriations of I believe, as much as a $2 billion increase in the support of IDEA.

I think the bipartisan support, which is being given for these increased funds, is not because we believe that children are being over identified, but because we believe that children need to receive appropriate services. And that children with appropriate identification needing special education and related services cost more money than not-disabled children, and so there is an appropriate role for the Federal Government to intercede and provide appropriate support. So I think that the Congress has grappled with this issue, and I think we are moving in the direction there.

But I also want to say that I have, in the last 8 years since I have been in this position, met regularly with parents who had legitimate concerns with the types of services that they have been receiving under the IDEA. It is one of the reasons that I believe very strongly that effective monitoring by the Federal Government and the State government and local school districts is critically important, because issues like parents have presented here today are ones that should be able to be identified and corrective action should be able to be put in place.

It is the responsibility of State school boards and local school boards to make sure that the IDEA is being appropriately implemented, that children are not being over identified and that children are not being forced to take medications against the will of their parents. There are provisions in the IDEA as it pertains to due process protections which allow parents, who believe that their children are being inappropriately served, to file a complaint with the State; the State then has 60 days in which to investigate that complaint. Parents also have a right to request mediation, they have a right to request due process.

Parents are certainly encouraged to call my office and we have brought a number of staff people up here today to be able to talk with parents so that we could help them further investigate some of the issues. I want to say that we believe fervently that one of the problems that is going on in schools today is that teachers and administrators need better training on how to utilize appropriate behavioral supports. That where teachers and administrators are not being provided with this training, one of the other problems that we are finding is that children are dropping out of school, they are inappropriately being suspended and expelled from school.

That is one of the other big conflicts that I think we need to address when looking at the use of medication. I think that if, in fact, you look at the research, which is being done as it pertains to positive behavioral interventions it is research not predicated on the use of medication, but rather the identification of children early, the ability to provide appropriate services for parents, and appropriate training for children. In those cases where active behavioral interventions are being utilized, and I think Dr. Breggin was referring to this very specifically, we are seeing that children are performing better in school, they are behaving better at home, and they are performing more effectively in the community.

I think that is really what this is all about; trying to make sure that children are not being overmedicated and trying to make sure that children are receiving appropriate services from well-trained personnel. We are also doing a better job of coordinating services so that children who need mental health services are able to get those appropriate mental health services in a timely and appropriate way.

WRITTEN STATEMENT OF JUDITH E. HEUMANN, ASSISTANT SECRETARY FOR SPECIAL EDUCATION AND REHABILITATIVE SERVICES, U.S. DEPARTMENT OF EDUCATION, WASHINGTON, D.C. – SEE APPENDIX F

Mr. Hoekstra. You are good. I think you just committed Bob and myself to voting for higher spending. That is not bad. As some of our leadership would tell you, that is not always the easiest thing to get all of us to do. Maybe they will call you next time and ask you to help them work with Mr. Schaffer and myself.

Thank you all very much for being here. As a parent, it has been fascinating testimony. I am not sure one knows exactly where to begin. I would like the witnesses to understand that Bob and I are going to be more informal today in the questioning. If you have been in front of Congress before, you know about the green, yellow and red lights up there. We have been very generous and let all of you finish your statements, even though you got to the red. That was not a problem. Bob and I are not going to abide by what we call the 5-minute rule; we will just follow up on each other's questions or whatever. It is not going to be the typical type of format.

Dr. Fassler, I am interested in a comment that you made because I am interested in understanding exactly what these drugs do and how they may affect our kids. Ms. Weathers talked about how drugs impacted her son Michael. Dr. Breggin talked a little bit about that. On page 6 of your statement the sentences that caught my attention at the bottom of the page say that it is also generally well tolerated by children with minimal side effects. What exactly does that mean?

And, you know, Drs. Breggin or Baughman or Ms. Weathers, if you want to answer that after Dr. Fassler, I would be interested in how the drug works, and what it does. What happens when the child, or young adult actually moves off of the drugs? What does the drug(s) actually do?

Dr. Fassler. The drug affects the neurotransmitter pathways, both the dopamine and the neurepinephrine. It appears to increase the amount of those neurotransmitters. And we do actually have some research evidence that in children and adults with ADHD, there are reduced functioning in certain parts of the brain. We have some early pediatric scan data responding to some of the comments of my colleagues, and we also have very good genetic data.

In fact, we know, for example, that with identical twins versus non identical twins, there is at least a five times increase in the likelihood that both twins will have ADHD. So there is a clear genetic component and there is also a biological component. In terms of the side effects, the most common side effects are things like insomnia, decreased appetite, stomachache, headache and jitteriness that can often usually be handled by adjusting the dosage or the time that the child takes the medication.

A key in your question is the importance of monitoring these medications closely with the child's physician. It is not appropriate and it is not okay just to give medication and then not see a child for a long period of time. If there are side effects or more serious side effects or a child having a particular reaction, then the parents need to be in close contact with the physician, and the child needs to be managed and monitored closely. The medication either needs to be stopped or changed.

So I would completely agree with my colleagues, both that we need a comprehensive assessment and ongoing monitoring for kids who are taking medication as well as kids who are receiving other interventions. In terms of the medication, the AMA summary report summarizes medications that have been unequivocally shown by double blind placebo controlled studies to reduce the core symptoms of hyperactivity, impulsivity and inattentiveness. They help classroom behavior and academic performance, diminish oppositional and aggressive behaviors, promote increased interaction with others and increased participation in leisure time activities. I don't think medication is the answer, or the only answer for kids with ADHD. But it is clearly something that works for a lot of kids. And kids who are going to benefit from it should have access to it. But it should also be used carefully and monitored closely.

Mr. Hoekstra. I am going to go to Ms. Weathers. She is pulling the microphone out of there.

Ms. Weathers. I am jumping out of my seat at this point. In my son's case, it severely impaired his growth development. My son, while he was taking the stimulant Ritalin, did not grow for probably 3 years. He remained the same size. And when I took him off all the drugs, he grew three sizes in three weeks. That is a size a week. I don't think parents are aware of this. It should be made very clear. I know Dr. Breggin could back me on this too. The growth issue is a major issue here. I will never know if my son would be the same size. I will never know what kind of permanent damage it has done to my son.

Mr. Hoekstra. May I follow up with a question? Dr. Fassler has talked about the need for parental consultation and also for monitoring. If you are going to put a child on these drugs, there has to be close monitoring probably by a specialist, by the parents and by the teachers. How closely were others monitoring your son's behavior once he was put on the drugs?

Ms. Weathers. Basically the teacher just reported rave reviews that he was sitting behind his desk and doing his work and how wonderful it was.

Mr. Hoekstra. I mean, monitoring by outside experts because we know that the teachers were.

Ms. Weathers. There was only a pediatrician following him. In addition, I think New York State law says that in order to refill the Ritalin, the other doctors could intervene at this point, I believe you get three refills and then your child has to be seen for a checkup to make another refill, or to another prescription.

And that is basically the extent of the monitoring. I didn't have any phone calls from a pediatrician to see how he was reacting. She didn't tell me about any other side effects when she gave me the prescription other than it might curb his appetite and possible insomnia. She never let me know that my son would never be able to go into the military, for one thing.

Parents around the country should be made aware of this fact, and it is not addressed. I don't think anybody in the school district has said if you put your son or daughter on this medication, they will never be allowed to go into the military. What are we saying? We are making the decisions for our children. What happens when they get older and they want to join the military? This is just wrong. It is wrong. And something has to be done.

You know, another thing Dr. Fassler said is that kids are less likely to commit crimes and go to jail. I just want to tell you something; in our local school district Ritalin tablets were stolen from the nurse's office at one point. This was about 5 years back. We are giving children legalized drugs and in some cases they are stealing the drugs and marketing them. What are we saying to our children? We are telling them no drugs and yet we are orally giving it to them.

Mr. Hoekstra. Thank you.

Ms. Weathers. I think it is wrong.

Mr. Hoekstra. Dr. Breggin and Ms. Heumann, I didn't think it would be too hard to generate some dialogue on these questions today.

Dr. Breggin. Let me address what the drugs actually do.

Mr. Hoekstra. Thanks.

Dr. Breggin. Dr. Fassler mentioned dopamine and neurepinephrine, two of the major neurotransmitter systems we have studied. He left out serotonin, which is a third system they all impair. They cause significant drastic impairments that have been studied for four decades in animals. They over stimulate these systems by blocking the removal of these substances from the synapses, the connections between the cells and by also causing an excess production and release of these substances. The system treats this as a toxic invasion, not a nutrient. Toxic invasion begins to kill off its own responsiveness, so that over a period of weeks, the serotonin, the neurepinephrine, the dopamine systems are no longer as responsive as they used to be.

Animal studies have clearly shown that drugs like Adderall; the amphetamines kill brain cells at routine clinical doses. I cite these studies in detail in my peer reviewed scientific article that I have given to you. This is just an elaboration of the testimony I was asked to give by NIH at the consensus conference. In regard to Ritalin, we don't have quite as many studies as with the amphetamine drugs which are Adderall and Dexedrine. But we do know permanent changes are caused in the brain. If you give Ritalin to an animal in just a few doses, 45 days later that animal is more sensitive than ever to the Ritalin. That is how addictions are developed. These are very serious.

Mr. Hoekstra. The drugs are addictive?

Dr. Breggin. They are not only addictive; they are the most addictive drugs known in medicine today. They are in Schedule II of the DEA, which is Ritalin or methylphenindate, amphetamine, which is Dexedrine and Adderall, and methamphetamine, which is also given to children, is in that group. Cocaine is in the group, and so are so some of the more powerful opiates and narcotics. It is Schedule II. This is the DEA; this is the international narcotics control board of the World Health Organization, to which every single nation belongs.

Almost all the Nations belonging to this system put methylphenindate in Schedule II. The disruption of the growth hormone by these drugs takes place by the over stimulation of dopamine, which goes to the pituitary glands, and eventually controls the growth hormone production. It is so diagnostic that if a child's growth hormone isn't disrupted, the child is probably not taking their medication.

Dr. Fassler mentioned genetics claiming this is a genetic disorder. First of all, common sense says it is not genetic because it is just a list of behaviors that upset teachers in classrooms that make it hard to teach kids. It is a collection of every single behavior you can think of in the list. In fact, there are no genetic studies that he is citing. I defy him to hand me a paper on what has ever been shown to be genetic. You find a text book that makes this claim that he has made here, that there is hard science. There are always things running in families, but speaking English runs in families, and naturally certain kinds of way of behaving may run in families.

The Department of Defense issue is brought up, so let me again clarify. I didn't mean to give you as many facts as I can. There is a Department of Defense controlled substances regulation, which specifically states that if a prospective recruit has had stimulant medication after the age of 12, they are ineligible for service in the Armed Forces. I know of one or two exceptions where military officers have gotten their children into the Armed Forces, but they had lower clearances. I know it has to do with the fact that these are addictive drugs because that is in the regulations.

Finally, with regard to the issue of close monitoring, close monitoring is not as helpful as you might hope it would be. The doctors who tend to closely monitor these children are advocates of these drugs, and are often are ignorant about the effects. So what we see with close monitoring in general clinical practice is when the child gets depressed, the parent isn't told that it is common. We have studies showing that 20 percent of children get depressed on these drugs. And I do cite these studies.

So 20 to 30 percent of kids get apathetic and lethargic, but the doctor doesn't know this, and is simply not paying attention. Close monitoring means giving an antidepressant. When you combine the antidepressant and the stimulant, you are likely to get mania or psychosis, which is the kind of tragedy that Ms. Weathers talks about, and then the doctor will give a neuroleptic drug. So some of the kids I have seen on the most drugs have been monitored.

What we need to do is to come to the conclusion that controlling the behavior of children by literally curbing their spontaneity with these drugs is simply not the answer. We need to improve our educational system. We need schools that teachers want to teach in. We need schools kids want to go to. We need kids that are full of technologies that fascinate and interest children. We are doing the opposite. We are blunting their imaginations, blunting their spontaneity and blunting their liveliness in order to fit them into the same old situation.

Mr. Hoekstra. Thank you. We are going to Ms. Heumann, and then we will go to Mr. Schaffer.

Ms. Heumann. I would like to make two comments: One is that there has been much discussion going on here in the Congress around issues of discipline in schools. I really encourage the Members to think about this issue. Many of the children that we may be talking about now are children who may exhibit behavioral problems in schools. There may be an encouragement for these children to be suspended or expelled from school because teachers have not been appropriately trained on how to work with these children. I really want to make this point very strongly because it has been an issue that we have been fighting for within the Department for many years now. And I would say it is one of the areas where we have had some significant disagreements between some of the Members.

So I think I am not in the middle of the discussion about the appropriate use of medications, et cetera, but I am in the middle of the discussion about our concern that children who are not receiving appropriate services frequently are the ones who are becoming the victims. Sometimes there is encouragement from those of new policy positions, to remove these children from school and put them on the street without any services.

I would be interested in knowing whether or not Ms. Weather's child had an IEP? Was there ever any discussion about doing a behavioral evaluation to determine if a behavioral plan needed to be in place and what kinds of support the child was given, what kinds of training the child was given, whether the child received any additional support in the classroom from a special ed teacher or an aid, or whether any mental health services were being provided? Bottom line, was there a behavior or plan for your child put in place?

Ms. Weathers. Yes. He had an IEP, the results of which you can view later on. There was program modifications or supports listed on it for him. But basically what I found was they labeled him, and not only did he feel worse about himself, but he felt additionally worse and additionally abnormal, because he had to take his medication to go to school. He did not feel better about himself. He felt more like a freak. He had to be drugged to go to school. That is what it comes down to, and that is pretty sad.

Mr. Hoekstra. I am going to go to Mr. Schaffer and I am sure we will have an opportunity to hear from all of you a few more times today.

Mr. Schaffer.

Mr. Schaffer. Thank you, Mr. Chairman. This is a Subcommittee of the Education Committee, and our main objective and purpose is along the lines of what Dr. Breggin has mentioned on a couple of occasions. What kinds of things can we do in the Congress to improve the quality of education throughout the country?

Ms. Heumann, you are right. You are looking at two of the more conservative Members of Congress and spending more money is not something we came to Washington to do. Yet there are some priorities that are under funded, and many, many more that are over funded and others that are not priorities that gets lots of cash anyway. I mention all that because you are looking at two Members of Congress who have probably spent more time than anyone else in this body visiting schools across the country and trying to learn what works, what doesn't work, what we do right, and where waste occurs.

I can tell you from my perspective; I hear lots of stories like Ms. Weathers. I have heard lots of them in my State. I have heard them from others around the country. I have read stories and accounts in all kinds of newspapers, magazines and books. You have to understand that as a conservative, I like the concept of Federalism that our founders created 224 years ago, and the notion that when it comes to creating schools the authority is local, not Federal.

I generally view the U.S. Department of Education and the Federal Government as more of an impediment to learning in this country than an institution that helps. Many of the things that ail public schools in America really come down to strips of red tape, barriers that the Federal Government presents, or incentives that are perverse when it comes to how dollars are spent as well. And so, I have what I think is a healthy suspicion especially when it comes to spending billions of dollars as we do with the Individuals with Disabilities and Education Act.

You are correct. Pete and I have been the most vocal in trying to fully fund the IDEA program. The reason is because it is the largest Federal mandate that the U.S. Government hands down to local schools. We only fund 12 percent of it; closer to 13 percent this year. However, this is my partisan shot. I disagree that there has been bipartisan support to try increase IDEA funding. We have offered amendment after amendment to try to move money from lesser priorities to IDEA funding and we got no support from the White House, and no support from our friends on the other side of the aisle.

Now that is significant for a number of reasons, because when the Federal Government hands down rules and regulations, in this case under a civil rights decree from the court, we hand down these rules to States and we don't fund them. That means that every school in the country has to come up with the money to pay for the mandate and replace the dollars that the Federal Government didn't have the courage to support. So we have supported IDEA full funding for that reason, because it frees up money at the local level to spend more flexibly on things that local school board members and people like Patty Johnson believe to be real priorities in their State rather than things that we think are important here.

We are for more funding, but I don't want to confuse more funding with blanket approval of the IDEA program. At the same time we are advocating funding this mandate.

Ms. Heumann. But I think you are saying at the hearing today that the children that you are concerned about are supposed to be everyone's real priorities.

Mr. Schaffer. Absolutely.

Ms. Heumann. We are supposed to be making sure that these children are receiving services. I think whether or not you know what your politics are almost doesn't matter, the bottom line is there is an agreement that these children are not getting appropriately served and that we have to make sure that they are getting appropriate services. I think the Federal role, if we look narrowly just at this population of children, is very important, because this problem is occurring all across the United States in many of our schools. The ability to not only identify the problem but also be able to do effective research helps us look at the best way of providing services in schools such as positive behavioral interventions. I think it is a very appropriate role for the Federal Government to play, then implemented by the State and local communities.

The issue I was raising earlier is that what has disturbed me since I have been in this office is that in many cases, the State and local education authorities are not taking responsibility for these children. The parents are raising some very legitimate concerns. And many cases these parents are being identified as problem parents.

Mr. Schaffer. Where we disagree is I think determining what is in the best interest of children. The needs of public education are something to be determined from the bottom up, not from the top down. That is why Republicans and Democrats differ and liberals and conservatives differ. We can agree all day long about the importance of getting resources to children, but it doesn't translate into unanimity when it comes to actually voting for these funds here in Washington. We have seen a clear difference. That is not what I want to get into at the moment.

I will concede on the point that we both care about getting resources to children, and in fact, underscore it myself. But where I differ with your conclusion that IDEA does nothing to provide any incentives is really borne out in the statement Ms. Weathers made, and it comes down to this child find policy. Ms. Weather's son was taken out of the public schools and put into a private school and home schooled as well, and yet the public school still continues to pursue her son, Michael.

We have gone back and looked through the records and although Michael is in another setting by other education service deliverers, the public school is still digging through the records changing and modifying their interpretation of what those records say, and going through the formal process of providing the legal cover for themselves of sending the letter to the parents. Her question is does this have some impact on the money the government school receives for diagnosing my child or coming up with this determination? The answer is yes. It is under this child find.

Ms. Heumann. Wait, wait, let us understand what child find is.

Mr. Schaffer. This child find provision, does not relate specifically to ADHD or ADD, but it relates to the effort, the process that all states must go through in school districts in order to maintain their eligibility to receive IDEA funds even under that formula that you mentioned. It essentially says that all States that want to receive special needs Federal funding must create a system that locates all special needs students within the State. Upon finding these students, IDEA requires that not only do States offer the special needs services, but also States are required to evaluate these children if they obtain the consent of parents.

So even if these kids leave the government school setting, the school district still has to show some effort that they are trying to identify these children, whether they are in the schools or not, whether it is ADD, or ADHD.

Ms. Heumann. The child find provision also identifies children with blindness or mental retardation or emotional disability. One of the reasons why we needed the IDEA in 1975 was that parents and professionals were complaining significantly that children in States who had disabilities were not receiving educations. We knew in 1975 that there were at least 1 million disabled children that were receiving no services at all and this resulted in the child find provision. I know for myself, because I was denied the right to an education through the middle of the fourth grade for the sole reason that I was in a wheelchair.

So the purpose of child find, I think is a good and appropriate purpose. It is not to over find. It is to appropriately identify. It is to listen to parents who, in many cases, come forward and say we believe our child needs additional services and may need special education related services. There are all types of procedures that are built into this law to ensure that children are not being over identified.

But in the case of the child that we are discussing now, no, for two reasons: Under the old formula, the State would not be drawing down any dollars because the child is currently not being served under the IDEA, unless the child was placed by the public school setting into the private school, in which case they would be receiving funding. I don't believe that is the situation here. But because of the formula change that occurred in 1997, as I said earlier, the formula is no longer operating in the same way.

Mr. Schaffer. The law goes so far as to say that if parents of the child that is in question refuse consent for evaluation, the agency may continue to pursue evaluation by utilizing the medication and due process procedures under these other sections, except to the extent inconsistent with State laws relating to parental consent. But the parents don't even have to agree.

Ms. Heumann. That is not right. The parent has to agree to it for the assessment to go forward. If the parent doesn't want the assessment to go forward, that is, saying if the school district believes strongly that the child needs special ed-related services, they can follow other procedures to try to get the parents to have to make that determination. The bottom line is this provision was put in to protect parents. It was one of the additional protections that were put into the 1997 law.

Mr. Schaffer. Let me ask Ms. Weathers how much comfort she found under those protections.

Ms. Weathers. I found no comfort.

Ms. Heumann. I don't know what year your child was identified.

Ms. Weathers. Many years ago. They are taking his old records from 2 years ago and using that to reclassify him as a special education student. They know that he is in private school and he is doing well. And I don't know why they would go to all this trouble sending me all these letters if they are not receiving some type of funding for him. If they aren't, I would like to know. If they are, I would like to know too, because I don't feel that this is right.

Mr. Schaffer. My next question is for Ms. Johnson. I know you want to comment on this, but this letter you included from the Illinois State Board of Education is just astounding! For those who have not seen it, this is a most outrageous document. The letter is written to the Superintendents of the Barrington CU School District from a State Board of Education Medicaid consultant. This doesn't deal with IDEA. This is about another government motivation and incentive. It is just mind-boggling.

The State bureaucrat is writing to the local superintendent saying our records reflect that you are not participating in Medicaid initiatives. It says recent data indicate that there are more than 78 Medicaid eligible students with disabilities receiving services in the Barrington CU School District # 220. And it goes on to describe the law and talks about all the services that you can purchase with these funds. "Medicaid dollars have been used for purchases ranging from audiometers to mini buses, from a closed caption TV for a classroom to an entire computer system from contracting with substitutes to employment of a new special education staff from expanding existing special education programs to implementing totally new programs. The potential for dollars is limitless."

It sounds like an investment brochure. The State spells it all out in writing and sends it to the local district. I don't know how it made its way here, but I am glad it did because for those who deny that there is no government-sponsored financial incentive, it couldn't be laid out more clearly that there is.

I would like you to comment not only on the Medicaid provision, but also perhaps on IDEA and other things that you have noticed in our State in Colorado.

Ms. Johnson. Thank you. Colorado has implemented the Medicaid provision in the schools also. I believe when Pennsylvania implemented it, the spending went up 1700 percent in one year, but I would have to document that. I just remember reading that somewhere.

What I want to address along with this issue are two things, that if you fund more, they may just identify more. Or, unless you are more specific where it can go, the more money you put in will just feed more children into the system.

The intent of the original law, which was the Education for All Handicapped Children Act of 1975, was to ensure that those with actual physical disabilities received a free and appropriate public education like Ms. Heumann. These children are now being shortchanged because such a large percentage of special education funds are being diverted for vague psychiatric diagnoses. In 1998, 51.1 percent of special education children were in the category of specific learning disabilities, which would be the mathematical disorder, the disorder of written expression, the ADHD.

One other point I want to make is about child find. In Colorado one of the programs for child find is parents as teachers. That is strongly encouraged as the system to use in the Federal school; in Goals 2000 program they mentioned Parents as Teachers programs. That is where you can help us get rid of some of these programs.

In Parents as Teachers and I don't have it with me, but I can send you the document, the identification system is so broad that just about anyone in any family would have qualified; three children under the age of 3, death in the family. Our grandfather lived with us and died. Allergies. I had allergies. Parents smoke. My parents smoked. Too many toys, too few toys. How do you decide? Too much stimulation, too little stimulation.

And then at the very end of this, the most amazing feature of this document says "other." In their own words they use that wonderful catchall. I didn't make that up. I can document that. That is one of the programs that actively seek to identify children starting at birth to qualify for these programs. I think that is where you can help us to get rid of some of these programs that would try to put everybody in this category. The actual physically handicapped people are not getting the help that was meant for them.

Ms. Heumann. Just for the record, this law was never intended to assist only physically disabled individuals. We would be glad to give a briefing on that.

Mr. Schaffer. Dr. Breggin.

Dr. Breggin. I would like to amplify what Ms. Johnson is saying. It is not just the physically disabled children who lose out when we define this category of ADHD or learning disabilities. It is all children, not just the physically handicapped. If you look at what the child who is diagnosed ADHD needs, or what the child who is diagnosed LD needs, they need what every child needs. They need a smaller classroom; they need more interesting and engaging techniques of teaching. They need specially trained teachers who are more able to involve kids with emotional problems.

So you end up in the ironic situation where by funding programs for special needs children that include kids with learning and behavior problems, you end up giving that group what all children need. And it really throws the whole system out of kilter. So some parents are trying to get their kids diagnosed so that they can get into smaller classrooms so that they can have more computers, so they can have a teacher with special training in how to deal with difficult kids.

I think that we should get rid of the idea that children diagnosed ADHD or LD, "have special needs." The kids who are disruptive in class and hate their homework need exactly what every other kid needs. We need to get to work on providing better schools.

Ms. Heumann. It is one of the reasons why we have been fighting for smaller class size.

Mr. Hoekstra. Let's not get into the appropriations on these things. We know what debates are going on. We will have an opportunity to have that discussion.

Ms. Heumann. I just want to say, I think the point that is being made is when children are in smaller classes, and when children have well-trained teachers, many of these children are getting the services they require and they may well not have to be identified as needing special ed services.

Dr. Breggin. All children need this.

Ms. Heumann. I agree with you.

Mr. Hoekstra. I didn't think we were going there today, but if we are going to make a political statement, this is why Republicans are fighting for smaller class size, for more technology, and for educational investment. What we want to do is recognize that individual school districts have individual problems, and we would like them to be empowered to make decisions for what their kids need in their school district not what we in Washington believe is this program or that program or that program.

We are going to get back to the focus of the hearing, and Dr. Baughman.

Dr. Baughman. In this hearing, that deals not just with ADHD and Ritalin, but also with psychiatric intervention and drugs in general, I think we have to go back to the 1996 caveat of Congressman Christopher Shays. He said in ADHD we are trying to draw the line between personality and pathology. We should do so only with the greatest care and with particular reticence to make our children medical patients. That gets us back to the essential nature of psychiatry and psychology. None of these children have diseases of the brain. They are all entirely physically normal children until the moment they are given brain-altering medication.

That is the first actual disease. Dr. Fassler of the APA stated the key features of ADHD are inattentiveness, hyperactivity and impulsiveness. I submit these are the key features of childhood, particularly of schoolchildren who are not being adequately disciplined or adequately being instructed in basic literacy with which to stand up and read, with which to progress from one grade to another. What is happening here is they are being "medicalized" for profit.

In medicine, as in any treatment situation we have what is called a risk benefit equation or a risk benefit balance that we must compute with the patient or with parents of minor patients. On the risk side there is in medicine usually a disease and on the benefit side there are drugs and there are surgeries and such things. What people don't realize is that there are risks in every single drug, and there are risks in every single kind of therapy. In the risk benefit situation or risk benefit equation in psychiatry, there is simply no disease on the risk side of the risk benefit equation. These are normal if troubled children. The only physical risk that they are put at is the risk that comes from the drugs they are being put on.

For example, with diabetes on the risk side, and insulin on the benefit side, we don't begin insulin until we have demonstrated the physical abnormality in diabetes, the elevated blood sugar, and the diminished insulin levels. We don't begin radiotherapy or chemotherapy in cancer until we have identified the malignant cells. However, in ADHD and in all of psychiatry, they begin treatment with dangerous, frequently addictive, sometimes deadly drugs never having demonstrated a physical abnormality in a single patient. For anyone from the APA or psychiatry to come here and say these are diseases is a fraud.

Mr. Hoekstra. Okay. I think, Dr. Fassler, we are going to get to the area we want to move into.

Dr. Fassler. Can I respond briefly?

Mr. Hoekstra. You'll get a chance to respond. You will get your time. We have talked about the characteristics of the drug; we have talked a little bit about the incentives or lack of incentives from the Federal Government for the diagnosing of or the categorization of our kids. I think where Bob is going to take us is have you talk us through how kids are diagnosed with this.

Mr. Schaffer. Well, you just stated the question. That is where I wanted to go next. Why don't you go ahead and use this opportunity to respond. Most parents I have spoken with tell me that their family doctor, their pediatrician is the physician that made the diagnosis and prescribed the drug. Having a psychiatrist who specializes in psychiatric medicine here with us gives us another perspective. What kinds of doctors are dispensing these drugs?

Dr. Fassler. I think something that we here on the panel all share is we all want to do right by kids. We want to figure out the best way to help kids. We may have different ideas and different beliefs and different approaches to that.

I want to give my colleague, Dr. Baughman, a citation from JAMA entitled "Dopamine Defect and ADHD", which is a report from the NIH of some of the early research on changes in a certain enzyme, dopadecarboxylase, in patients with

ADHD. He can take a look at that.

I want to go back to my colleague, Dr. Breggin, and take him up on his challenge. We have done this back and forth before. I want to give him a citation to the International Journal of Neuropsychopharmocology on the genetics of the attention deficit hyperactivity disorder. So clearly, there are differences of opinion. And there is no one right or wrong answer. And there is no magic solution.

In terms of your point about family physicians, it is true most of the kids with ADHD are certainly not seeing psychiatrists. They are not seeing child and adolescent psychiatrists. Most of them are not even seeing mental health professionals. A pediatrician may diagnose them. They may be diagnosed by a family practitioner. Many of the family practitioners are good at doing this work, but many of them don't have time. We work in close collaboration to the extent that we can with our pediatric and family practitioner colleagues.

But there is a significant problem in the country in terms of access to mental health services. There is both a problem with having enough mental health professionals working in the field, enough funding for training of mental health professionals, and there is a huge problem with funding for mental health services.

One of the concerns that I have is, as we have increased managed care over recent years, has that made it more difficult for kids to get the mental health services that they need? In terms of IDEA funding and some of these services coming into the schools, I believe some of that is happening because it is harder to get those services outside of the schools. And clearly, there are kids who are in trouble and need help.

In terms of how kids get evaluated, often either a parent or a teacher will recognize a problem and they will usually talk first with the child's pediatrician or primary care physician. Then the pediatric or primary care doctors may make the diagnosis themselves, and they may start treatment themselves. My preference would be a referral to a mental health professional for a more comprehensive evaluation.

These evaluations, in my opinion, and according to the Academy on Child and Adolescent Psychiatry take between 1 and 2 hours. You can't do it in a typical pediatric office visit. It is a comprehensive evaluation. You need to look at the child's early developmental history, the family history, what's happening in school, what is happening socially with his or her friends, and what the child's behavior is like at home. You need to spend time with the child and with the parents. You just can't do that in a brief visit. And then there are also other problems that can present with symptoms that look like ADHD, including anxiety problems, other learning problems, reactions to certain medications. So it really needs a comprehensive evaluation.

Based on the evaluation, then you make a diagnosis and then you develop a treatment plan, which really needs to be individualized to that particular child and family. The treatment plan may include medication, but it should also include individual counseling or support, working with the family and ongoing interaction with the school. I would agree with my colleagues that there are many kids in the country who aren't getting that kind of comprehensive evaluation and treatment planning and programming.

And that is part of where we need your help, to make sure that kids really are getting the intensive comprehensive services that they need. I am listening to a lot of the discussion here, and what I am not hearing about is really looking at the level of impairment. I think we would all agree that there are kids who are having problems in school or problems at home, and we need to find those kids, and on an individual basis, we need to figure out what is going to work and what can help those kids.

I think that is what we all share. We all want to help kids. We may have a different approach to it. We need to look at all the tools available and we need to figure out what is going to work best for each child and family.

Mr. Schaffer. I just had dinner with some friends Sunday night, and one of them happened to be a schoolteacher from Pennsylvania. I asked her about the hearing this week and asked her if she knew anything about psychotropic drugs. It turns out she had personal experience because her child was diagnosed with ADD and given the drug Ritalin.

I went to a CHADD-sponsored session with parents on how to cope with children who are on the drugs. Somebody asked, well, did you ever get an eye test? So sure enough she went and got an eye test and found out that the child was seeing double, and didn't want to tell the parents because she thought only nerds wore glasses. Turned out she went through the eye therapy with an ophthalmologist. A few months later she was able to read. This girl had gone from kindergarten through fourth grade without the ability to read well, and somehow she met all of the diagnostic check offs for ADD. The school managed to get through to the doctor to get the drug into her body before somebody asked about getting her eyes tested.

I checked the American Optometric Association Web site. The symptoms listed for learning related vision problems are short attention span for a child's age, frequent daydreaming, trouble finishing written timed assignments, difficulty remembering what is read, omitting or repeating or miscalling words or confusing similar words, difficulty remembering identifying and reproducing basic shapes, difficulty with sequential concepts, poor hand/eye coordination, and displaying evidence of developmental immaturity. It goes on and on, and is remarkably similar to what teachers are asked to look for by the Department of Education information that is provided for teachers when identifying ADD.

Now, I guess the issue I would like Dr. Fassler, or anyone else to address regards this phenomenon that we just heard about of how schools put such pressure on the families of these children to get them on the drug. I hear this all the time. Parents are telling me that they were told by their school district either get them on this drug or he is not going to be in this classroom.

Dr. Fassler. You are making my point exactly, and it is exactly the reason why these kids need a comprehensive evaluation. Let me just briefly read you the differential diagnosis for ADHD; includes sensory disorder, including deafness visual impairment, medication-induced problems, seizure disorder, thyroid disorder, learning disability, retardation, substance abuse, lead intoxication, oppositional defined disorder, number of psychiatric disorders, age-appropriate over activity, inappropriate school placement, family and social disruption, or child abuse.

So clearly, part of the evaluation is reviewing the child's medical history. It can't be done in 5- or 10 minutes.

Mr. Schaffer. My point is even though we may agree there needs to be more research and there needs to be more knowledge about these things, the fact is schools, it appears to me, by default are not going to these parents saying go buy the kid glasses. Instead they are saying go put the kid on the drug.

Dr. Fassler. I don't support that at all. I think what we need to do is help parents to become the best advocates possible for their kids and we need your help to do this. I support what Ms. Weathers did. If she sees things happening with her child, and she knows it is not right for her child, she has to do something different. We need to give parents the tools to get the kind of evaluations and the kind of resources that they need.

In some areas there is a knee jerk reaction to this behavior, and the answer should be Ritalin. I am sure that it happens. But it is not the way that we want to practice. It is not the way that we should be practicing. It also, doesn't happen across the country? So I think we need to be careful by taking examples from particular areas or data from particular areas and then automatically extrapolating to the entire country, because it is not necessarily the case.

But I would completely agree we need to help parents advocate for comprehensive evaluations and individualized treatment. Teachers and schools should not be making diagnoses and they should not be prescribing any treatment or medication certainly before a comprehensive evaluation and a diagnosis is made.

Mr. Hoekstra. I think we have got a full lineup of people who want to speak. I think we also want to recognize that for Ms. Weathers to make the decisions that she made it had to be awfully painful for her, including the principal telling her if she didn't put her son on these drugs they were going to expel him.

We will go to Ms. Johnson. Dr. Baughman, Dr. Breggin and Ms. Heumann did you also have comments?

Bob, did you want to interject more right here, or do we want to take some more testimony?

Mr. Schaffer. I will save it for the end.

Mr. Hoekstra. Ms. Johnson.

Ms. Johnson. What I don't want to see come out of these hearings is the push for more psychologists, and more counselors in the schools. First, I think we have overanalyzed these children and we have gotten away from common sense. A lot of it is just common sense. We have to get back to what we are supposed to be doing, and that is teaching. These problems escalated when we brought more psychology programs into the schools.

Second, just to give you a few examples, one young man was bright and intelligent, but the teacher was saying he was ADHD and needed to be put on Ritalin. When I looked at this child, I thought they would have put Einstein on Ritalin. What he needed was just more challenge and to be bumped up a grade or two, and the problem would have been alleviated. Also, some of the schools are taking away recess. These are the very children that need recess, and need to run around. It is just common sense.

Third, now they are diagnosing preschoolers with ADHD. Are preschoolers supposed to sit still and pay attention? Do we want them to sit there like little adults and not be children? This is just common sense. They don't need to be analyzed and psychoanalyzed.

A single mom called me and she was desperate. She said Patty, please come to this IEP, they are ganging up on me and they are pressuring me to put my son on Ritalin. She told me her story. Within 5 minutes I saw the problem. The dad had left for another woman and moved out of State. The mom had a full-time job, had gone back to college and wasn't around for her child. He had a problem in reading. They were doing whole language in the school. This child was psychoanalyzed to death. He was uptight thinking something was wrong with him, and he was just missing his dad, and his mom. He needed some discipline, and to be taught to read properly. He didn't need a psychologist and hours of psychoanalysis.

So my point is we don't need more of that. We have to get back to the job of teaching and using a little common sense in the schools.

Thank you.

Chairman Hoekstra. Dr. Breggin.

Dr. Breggin. I want to affirm everything that Ms. Johnson is saying. We don't need more psychiatrists in the schools or counselors or psychologists. We need more attention to giving every child what every child needs and that is going to take care of a good portion of what we are calling ADHD and learning disabilities.

What we don't need is this persistence in taking a group of behaviors and calling it a disease. Dr. Fassler purported to give me a study of genetics that was going to show this was a genetic disorder, and it is not even a published study. What it shows is that he was surfing the Web on September 15th.

Chairman Hoekstra. I think you two are going to have an opportunity to talk about this more often in the future, aren't you?

Dr. Breggin. I want to emphasize the lack of scientific evidence. This is literally an unpublished thing pulled off the Web.

The idea of a comprehensive evaluation simply doesn't make it because as long as we find impulsivity or hyperactivity or inattention, it is ADHD and the cause is lost. It doesn't matter how many doctors or psychologists evaluate. So long as they believe that this collection of behaviors is a disorder, the child is lost, and we are going to stand by as parents and teachers while the child gets drugged.

We have to give up this idea that the answer is medical when it is just behaviors. Sure, if it is hypothyroid, it is medical; if it is diabetes, it is medical. But when it is a bored or angry or upset child, as long as we even allow the possibility that the diagnosis is medical we have lost the child.

In conclusion, I want to bring up something that I don't think has been mentioned yet. The situation is getting so bad that we now have increased drugging of preschoolers.

An article by Zito from Maryland that came out in the Journal of the American Medical Association a few months ago showed that we now have a three times increase in the diagnosing and drugging of preschoolers aged 2- to 4-years-old. It is measured in terms of an increase in giving out Ritalin and stimulant drugs to them. As long as we believe that we can take a group of behaviors and handle it by drugging the child rather than improving the child's family, improving the child's school and improving the child's community, we are not going to solve the problems with our kids.

Chairman Hoekstra. That is the fundamental question isn't it?

Dr. Breggin. Yes.

Chairman Hoekstra. Dr. Baughman.

Dr. Baughman. Thank you, Mr. Hoekstra. Likewise Dr. Fassler passed me the abstract of an article that appeared in the Journal of the American Medical Association in August of 1998. I think he is as aware as I am that as of January 2000, and as of this present moment, as summarized by Xavier Castellanos of the NIMH, the status of ADHD scientifically was "incontrovertible". Evidence is still lacking. I am confident we will confirm the case for organic causes.

So it was invented in 1980, and here we are 20 years later. It has never been confirmed to be a disease. The children have never been proven to be other than normal to begin with, but, again, the very moment that they are put on these brain-altering drugs such as and Ritalin, and the amphetamines are especially dangerous and addictive as well, then they are for the first time definitely physically abnormal.

I would like to emphasize this point citing NIMH research and NIMH-sponsored research, which, as early as 1986, showed that ADHD children have brain scans that show brain shrinkage or brain atrophy. The only problem with that first 1986 study was that all the kids were on these drugs, and the authors appropriately said it may be the drugs that are doing this. And from 1986 to the present time, some seven or eight brain-scanning studies have affirmed that the brains of ADHD children, all of them on these drugs, are on average 10 percent shrunken or atrophic. No conclusion can be drawn other than the drugs are doing it. So we start with a normal child, or we have started with 5 million normal children, and put them on drugs that clearly damage the brain in ways too numerous to mention and far beyond our knowledge.

ADHD is a multimillion-dollar industry that embodies all in mental health. It has been adapted for use in pediatrics, general medicine and family practice because they are the ones now prescribing the lion's share of these drugs. There is an endless supply of patients because they don't have to have an objective abnormality. And all of them are busily exhorting teachers to make these diagnoses and append these labels, to fuel the industry, and to create fodder for this industry. Teachers are in a veritable diagnosing ecstasy. Suddenly they are brain diagnosticians; no longer any need to be satisfied with things so mundane as conferring literacy on children or truly parenting them for the 6 hours a day that they are in school.

So we have a parasitic enterprise industry that has appended itself to the public schools of this country. It is doing untold damage to our youth and to the country. Thank you.

Chairman Hoekstra. Ms. Heumann.

Ms. Heumann. I just want to say that I think some of these statements are very unfortunate and very misleading, but first, as I said earlier, IDEA does not encourage the use of Ritalin or any medications.

We assume that when States are implementing this law appropriately, if they are finding that these types of problems are occurring, that the State, through their monitoring systems, will be addressing these issues with local school districts. If they are finding that parents allegations are, in fact, true, that parents are being told their children will not be able to attend school unless they take medication, this is a violation and needs to be dealt with. I encourage you as Members of your sates to determine whether your states are effectively monitoring the system.

Let me also say that increases of children with disabilities served under the IDEA who have ADHD have been primarily in the category of other health-impaired. Even if half of all other health-impaired students were children with attention deficit hyperactivity disorder, it would only be 90,000 out of 5.4 million children, or 1.7 percent of the total population of children receiving services under the IDEA.

Now let me get back to some of the discussions that have been going on here. I always like to relate back to my days as a classroom teacher because I had 36 children in my classroom. I was fortunate, because I was in a wheelchair, I had an aide in my classroom, which most of my colleagues did not. So they had large classrooms without any support in the classroom and very limited mental health services. I had six to eight children in my classroom that clearly had mental health needs. I had a great deal of difficulty getting them any support because the number of school psychologists that we had in a very large school were incredibly limited.

Teachers do not want to diagnose mental health or any other kinds of disorders. Teachers want to teach, and you know that because you have teachers who come into your offices complaining about the children that we are talking about today.

We are talking about a medication, but the reality is we are talking about children who, when they are in classrooms, are not exhibiting appropriate behavioral interactions. We are hearing on a regular basis that these children are making it more difficult for other children to learn, and therefore we argue to take these children out of the classroom.

We have to really grapple with these issues in a sincere way. We need additional school psychologists. It is not the Federal Government's statement. This is what we hear from local people. We need the ability to help identify the needs of children. We need the support for these children and for the teachers. Teachers should not have to be diagnosing conditions of children. That is not what they are supposed to be doing. They need training to be able to understand how to teach children how to read. Teachers need to be able to teach the children who are having difficulty learning how to read.

Much of what is going on is at the State and local level. As you know, the Federal Government does not prescribe what teachers are being trained to teach. Many of the teachers are still not being appropriately taught how to work with these kids and to help them learn how to read. These kids are becoming behavioral problems in schools when they are not able to appropriately read.

We have to deal with this issue in a way that is responsible to all, to teachers to parents and to children, because I do agree that everyone up here wants to make sure these children are being appropriately served. Believe me, I had one of my kids put on medication when I was teaching. It disturbed me because I didn't believe that the medication in the long run was ultimately helping him. What it did was to make him a more passive child in the classroom because he was one of the more aggressive acting-out children. We weren't getting appropriate supports for those working with this child.

So I implore you that at the end of this discussion we also deal with some of the critical and real issues that parents and teachers are talking about. These issues are kids who are failing in school, kids who do not fit the norm, and the ability to make sure that we are appropriately meeting the individual needs of these children.

Chairman Hoekstra. Thank you.

Mr. Schaffer, do you have any questions?

Mr. Schaffer. I want to thank all the panelists for coming here today and for the willingness to share their expertise and knowledge of the topic with Congress. I think it is an important gesture and one that in the end leads us, and the other Members who are not here but rely on the work this Committee does, to make better decisions and have a better idea of what is really needed to make schools in America better.

Ms. Huemann, on a philosophical basis, there is not much you say that I can find myself in agreement with, but I do deeply appreciate your candor with us here today. Some of the things you have said I find do need immediate attention by Congress. The notion that overcrowded classrooms with insufficient resources leads to children being labeled with special need is something I find an abhorrent thought and one that needs to be prevented to the greatest extent possible. In no case should insufficient resources, under prepared teachers, or inability to deliver curriculum be the basis for children being labeled and diagnosed with ailments and disabilities that in some cases lead to drug therapies being recommended.

Ms. Heumann. Mr. Schaffer, the law does not support that. The law does not support over identification, and we can go over the provisions and protections in the law with you.

What I am saying, and I think what everybody else here has also been saying, is that what we do see is schools do not have appropriate support teams, and they are not identifying kids who are having difficulty learning to read early enough. They are not providing appropriate reading interventions, and they are not providing individual evaluations to work with children who have behavioral problems. These children in many cases, as everyone has been discussing, are becoming bored in school, having more problems in school, and acting out in school. In some cases where there are not appropriate services, not with the intent of the law, these children may be receiving special ed services, or after 3 to 5 years of not receiving appropriate services, their needs may legitimately rise to the level of needing special ed services not in a separate place, but in a regular classroom setting.

Mr. Schaffer. I understand that. This phenomenon, though, of what New York teacher of the year John Taylor Gotto described as the exhausted school is a very real concept, and you described it accurately, as others have.

Pete and I have gone across the country and met many teachers. They are expected to be guidance counselors, substitute parents, pregnancy counselors, suicide counselors, disciplinarians, and eventually they get around to teaching. Having one more child in a classroom that requires an inordinate amount of attention is something most teachers are too exhausted to deal with, and finding some drug to pacify them, I can understand, just as you do.

Ms. Heumann. I think you minimize this issue by putting it onto drugs. We are only talking about ADHD children here.

Mr. Schaffer. You sat here and described your education experience as a teacher yourself and described how a drug pacified a student, and made him a little more docile.

Ms. Heumann. But I was also saying that had I had appropriate support, had we had appropriate school psychologists in the school, had I had the training that I needed, this child might well have never been referred to additional services.

Mr. Schaffer. That is the point of the hearing today and exactly why we are here. We are trying to maintain the stature of our public schools as places where children are nurtured and cared for by responsible professionals. Never under any circumstances should a lack of resources or lack of preparedness by a teacher become the basis for drugging children. Never.

Ms. Heumann. I agree with you.

Mr. Schaffer. You have said time and time again that it does.

Ms. Heumann. No, sir, I said over and over again that IDEA does not encourage medication of disabled children.

Mr. Schaffer. I heard you say that, and I don't agree with that either. Let me finish my point by telling you why. That is because between SSI, Medicaid and IDEA, we have turned schools into aggressive identifiers of disabled children. It is in your own documentation.

Ms. Heumann. If we had no IDEA, if we had no SSI, if we had no medications, these children in these schools would still be exhibiting problems that we would need to address.

Mr. Schaffer. That may be, but the point of this hearing is over identification, over diagnosis, and over medication of children, which corresponds directly to political decisions that were made here in Washington about funding.

Now, the reason teachers and school boards and school administrators are not tracking down kids after they have left to find out if they have double vision is because there is no money in eyeglasses. There is money in drugs, and it comes from your child find provision in IDEA. It comes from the increased reimbursement under SSI for poor families. It comes under the Medicaid reimbursement that is as virtual a gravy train as you can find in the State of Illinois.

You say teachers have not been diagnosing kids, and it is not their responsibility. On May 15th of this year in the State of Rhode Island, the chief legal counsel had to send a letter to all the superintendents saying, we are getting reports of teachers helping diagnose kids.

Ms. Heumann. The State acted appropriately by intervening.

Mr. Schaffer. The point is the State had to write the letter to the teacher saying, stop diagnosing kids.

Ms. Heumann. It is the State's responsibility when these problems happen. The State acted appropriately in this case by hearing from parents, by using procedures, and by directing the schools not to do something inappropriately.

Mr. Schaffer. You say it the State's responsibility, but when the Federal Government provides billions of dollar in incentives, it is reasonable to expect superintendents, school board members and teachers to follow the money. It works that way in virtually every single enterprise this Federal Government is involved in. If you want more of something, subsidize it. If you want less of something, tax it.

Without a doubt we are subsidizing the aggressive pursuit of children with disabilities. It is not resulting in accurate diagnosis. It is resulting in an over diagnosis, and that point has been abundantly proven and established not only in this Committee, but in plenty of the other documents that the Committee had received prior to the hearing, and, I suspect, even afterwards.

Ms. Heumann. But, sir, I think one thing we are all agreeing with today is that we need more training of educators. Educators need to know how to work more appropriately with these children.

Mr. Schaffer. Last week the education Committee held a hearing on the need for more literacy training. The week before that it was more science training. We know that we need more training for a lot of things in schools. I am inclined to agree with Ms. Johnson, though, that we ought to focus on literacy and science first, and once we can pat ourselves on the back and see our test scores higher than being 19 out of 21 in the third international math /science comparison, then maybe we can focus on diagnosing kids.

Chairman Hoekstra. All right. We are going to take a time out here with Mr. Schaffer and Ms. Heumann, and we are going to go to Ms. Weathers and then Dr. Baughman. I thought you were wrapping up.

Mr. Schaffer. I did say that. I thought I was wrapping up.

Chairman Hoekstra. You did a fine job, I can say that.

Mr. Schaffer. I pledge to stop now.

Chairman Hoekstra. Ms. Weathers.

Ms. Weathers. I just want to say that I do not think for one minute that schools need additional psychologists. In my son's case, the psychologist is the one that is pushing all these disorders, and sending me pamphlets in the mail about bipolar disorder. I don't think that we need funding going to psychologists who push disorders and push medication in schools. That is not the answer. We need smaller classrooms. We need more individualized teaching per child.

Chairman Hoekstra. Dr. Baughman, and then we are going to wrap it up.

Dr. Baughman. Nothing has been said about the invariably deleterious effect of false disease labels on children. And nothing has been said about the role of educators, or "mis-educators", shall we say, in rendering these children disturbed and not literate and not prepared.

In the State of California in 1987, the State superintendent of education adopted the whole language, psycholinguistic methodology to the exclusion of phonics to teach reading and swept the phonics materials from the schools of California. By 1992, California fourth-graders were the worst readers in the country, at that point tied on the NAPE test with fourth-graders from Mississippi. By 1994, California readers had sole possession of last place.

Fifty-nine percent of our fourth-graders as of 1994 read at a less than basic level, which meant they were at a first-grade level as fourth-graders; 86 percent of them were less than proficient. How happy a lot do you expect that these fourth-graders were when asked to stand and read or when presented with each subsequent semester's materials to read?

So there was nothing wrong with the children. There was something radically wrong with the schools, and our schools in California have been loath to turn loose their whole language ideology to this day, and the rates at which we produce rank illiterates is disgraceful.

Chairman Hoekstra. Thank you. Mr. Schaffer has a unanimous request for submitting documents for the record. Without objection, so ordered.

Let me thank the panel for being here. I think there is universal agreement that, number one, we all are focused on doing what is best for all of our kids. We cannot afford to leave any child behind. I think as a parent observing Ms. Weathers this morning, I have got to believe it is a tough position to be in, recognizing that the experts in the field have such a divergent opinion as to whether or not there really is a medical disorder. I would guess maybe a few years ago Ms. Weathers didn't have the opportunity to view both sides of this issue, and there may be three or four or five sides. It seems disappointing that we have got this kind of a discrepancy.

Let me just tell you a few things that I think are going to happen in Congress. Henry Hyde is going to have additional hearings on this issue. The Committee on Education and the Workforce will have additional hearings to more fully gauge the issues surrounding this. Are there incentives for labeling through the Federal Government programs, or are there not? Let us get a full understanding of exactly how the funding mechanisms and those types of things work and try to get a better understanding of some of the issues in the classroom.

As Bob has indicated, he and I have gone to over 20 states and met with parents and teachers and school board members and experts around the country, and we have seen some great things working. We have also seen some things that haven't worked as well as we would have hoped.

I hope that from a professional standpoint, we recognize that there could be more agreement as to exactly how we treat some of the behaviors that we are seeing. This is an issue that Bob brought to my attention. But as I talked to some