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 to get me to hospitalize him and try different sedatives until I found, “the right one.”

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 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

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 chewing on things, pencils, erasers, and paper, even his clothing. His behavior was getting more and more bizarre.

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 $430 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 those 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 Weatheres. 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 accommodations 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.

Ms. Weatheres. My name is Patricia Weatheres. 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 standing himself at the far censer 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 prescribed them 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 would be accomplished by use of them.

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 was a wonder drug for kids.
in finding underlying physical causes that could affect a child's behavior. I began doing my own research on those 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 case, 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.
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. Faessler. Good morning. My name is David Faessler. 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 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 neurodevelopmental 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 girl who was about to be left back in second grade due to her disruptive behavior. The teachers had labeled her difficult to control; the other kids just called her weird. She had few friends, and she was already convinced that she was bad and different. I think of a 12-year-old boy with an IQ of 130. She is not disruptive, but she is failing seventh grade. I also think of a 26-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 common 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 isn'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 development, 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. School 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 that 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 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 ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, WASHINGTON, D.C.

SEE APPENDIX C

Chairman Hoekstra. Thank you very much.

Ms. Johnson. Thank you very much.
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 to 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 coerced 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 stock knives out of the kitchen and stabbing his stuffed animals and mattresses. 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 those 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 complete homework, daydreams, 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 facts 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 and 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 number 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 those 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 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.

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 fear 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 Deficit 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 is going to the schools to propagandize to parents.

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. Fauser, 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 alphabetic and Accessiliphem. There are no scientific studies to show that in any ordinary sense ADHD is a disease.

Dr. Fauser also mentioned the pleasure that people have when they are told they have ADHD. It is not my expertise 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 be given a label that they really don't have.
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 changed 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 or in order 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 support that encourages behaviors that will allow them to succeed in school.

I would like to reiterate that it is not the role of teachers to diagnose 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 the child.

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 those 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 6 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 stuff 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 parents are one of the people that is going on in schools today that teachers and administrators need better training on how to utilize behaviorally supportive behaviors. 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 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 early 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. Schiffer 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 stick to what we call the minute rule. We will just follow up on each other’s questions or whatever. It is not going to be this typical type of format.

Dr. Faseler. 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 sentence that caught my attention at the bottom of the page says that it is also generally well tolerated by children with minimal side effects. What exactly does that mean?

And, you know, Drs. Breggin or Beagman or Mr. Weathers, if you want to answer that after Dr. Faseler, 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 actually do?

Dr. Faseler. The drug affects the neurotransmitter pathways, both the dopamine and the neuropeptidime. 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 brain data responding to some of the comments of my colleagues, and we also have very good genetic data.

In fact, we know that children with ADHD have 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 so 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 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.

Mr. Hoekstra. Thank you.

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

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

Mr. Hoekstra. Thanks.

Mr. Breggin. Dr. Fassler mentioned dopamine and neurobehavioral. One of the major neurotransmitter systems we have studied has left out serotonin, which is a third system they all impair. They cause significant dramatic 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 excessive 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 neurobehavioural dopamine systems are no longer as responsive as they were before.

Animal studies have clearly shown that drugs like Adderall, the amphetamines kill brain cells at routinely 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 have occurred in animals. 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?

Mr. Breggin. They are not only additive, they are also all addictive drugs known in medicine today. They are in Schedule II of the DEA, which is Ritalin or methylphenidate, amphetamine, which is Dexedrine and Adderall, and methamphetamine, which is also known to children, is in that group. Cocaine is in the group, and so are 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 belong to this system put methylphenidate in Schedule II. The disruption of the growth hormones 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 studies 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, let me again clarify. I don't mean to give you more data than 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 clearance. 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 it might be. It is the doctors who tend to closely monitor these children are advocates of these drugs, and are often 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 visit schools across the country and try to learn what works, what doesn't work, what we do right, and what works across.

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 antipsychotic. When you combine the antidepressant and the stimulant, you are likely to get mania or psychosis, which is the kind of tragedy that Ms. Weather 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.

We talk to you about the issue of the appropriate use of medications, etc. in schools, but I am in the middle of the discussion about our concerns that children who are not receiving appropriate services frequently are the ones who are being 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 education teacher or on an IEP, or whether any mental health services were being provided? Bottom line, was there a behavior plan or for your child put in place?

Ms. Weather. 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 Committeee, 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. 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 concerns that we have in that area are particularly about the intervention that can be made in schools for children who are suspended or expelled from school because teachers have not been appropriately trained to make these point by point. I really feel that what we need to look at strongly 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 it is 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 concerns that children who are not receiving appropriate services frequently are the ones who are being 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.

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?

Mr. Hoekstra. Ms. Heumann, 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.

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Ms. Heumann. I would like to think about that, as a representative 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.

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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.
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 know in 1975 that there were at least 1 million disabled children who were not receiving 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.

Ms. Schaffer. The law goes as 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 those 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, if 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.

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

Ms. Weatherhead. I found no comfort.

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

Ms. Weatherhead. 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.

Ms. 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 Burlington School System 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 bureaucrats are writing to the local superintendents saying our records reflect that you are not participating in Medicaid initiatives. It says recent data indicate that there are more than 76 Medicaid eligible students with disabilities receiving services in the Burlington School System. It says 76 percent of special education funds are being diverted for vague psychiatric diagnoses. In 1996, 51 percent of special education children were in the category of special learning disabilities, which would be the medical 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 program. That is one of the areas 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 "either." 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 actually seek to identify children starting at birth to qualify for those programs. I think that is where you can help us get rid of some of those 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.

Ms. Schaffer. I agree. But there is a whole other issue here.

Ms. Johnson. 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 those children are getting the services they require and they may well not have to be identified as needing special ed services.

Mr. Schaffer. 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 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 sizes.

Ms. Hoekstra. Let's not get into the appropriations on those 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 those children are getting the services they require and they may well not have to be identified as needing special ed services.

Mr. Schaffer. Dr. Breggin. All children need this.

Ms. Heumann. I agree with you.

Mr. Schaffer. 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 the program or that program that program.

Mr. Schaffer. Can I respond briefly?

Ms. Heumann. 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 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. Faesser. I think something that we have on the panel all the way is we want to do a lot right for kids. We want to figure out how to help kids. We may have different ideas and different beliefs and different approaches to that. I want to give my colleagues, Dr. Breggin, a citation from JAMA entitled "Dysphonia Deficit and ADH BIEF", which is a report out of 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. Beeglin, 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 Neuropsychopharmacology 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 that 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 same 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 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 those 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.

Those 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 pediactric 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 colleague 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 unemployment, 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 these 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 Friday 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 ADHD and given the drug Ritalin.

I went to a CHADD-sponsored session with parents on how to cope with children who are on these 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 or kids were through. 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 or her before somebody asked about getting her 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 tasks assignments, difficulty remembering what is read, omitting or repeating or recalling or confusing similar words, difficulty remembering identifying and reproducing basic shapes, difficulty with sequential concepts, poor hand-eye coordination, and displaying evidence of sensory problems in the environment. 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. Fauster, 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 otherwise get them on this drug or he is not going to be in this classroom.

Dr. Fauster. You are making your 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 disorders, including visual and visual impairment, medication-induced problems, seizure disorder, thyroid disorder, learning disability, retardation, substance abuse, lead intoxication, oppositional defiant 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 kids glasses. Instead they are saying go take the kid on the drug.

Dr. Fauster. I don't support that at all. I think when 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. Weatherby did. If she sees things happening with her child, and she knows it is not right for her child, she has to give parents the tools to get the kind of evaluations and the kind of knowledge 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 he has got a full lineup of people who want to speak. I think we also want to recognize that for Ms. Weatherby 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. Beeglin, Dr. Beeglin and Ms. Heumann did you also have comments?

ros. 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 these kids who are being identified as ADHD are kids who are supposed to be doing well, and second, what we are supposed to be doing, is starting to take in a group of behaviors and calling it a disease. Dr. Fauster 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. Beeglin. I want to emphasize the lack of scientific evidence. This is literally an unpulled thing which is pulling 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 to the 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. Beeglin. Yes.
Chairman Hokenstra. Ms. Heumann.

Ms. Heumann. 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 reports of teachers helping diagnose kids. 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 any circumstances should a lack of resources or lack of preparedness by a teacher become the basis for drugging children. Never.

We are talking about a medication, but the reality is we are talking about children who, when they are not in the classroom, 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.

Mr. Schaffer. 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 Hokenstra. Thank you.

Mr. Schaffer. 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 importantgesture 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. Heumann, 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 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 having adequate class sizes, 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 years of not getting adequate special 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 Gatto described as the exhausted school is a very real concept, and you described it accurately, as others.

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 therefore we argue to take these children out of the classroom.

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

Mr. Schaffer. If I may, I would like to emphasize this point citing NIH research and NIH-sponsored research, which, as early as 1996, showed that ADHD children have brain scans that show brain shrinkage or brain atrophy. The only problem with that first 1996 study was that all the kids were on those drugs, and the authors appropriately said it may be the drugs that are doing this. And from 1996 to the present time, some seven or eight brain-scanning studies have affirmed that the brains of ADHD children, all of them on those drugs, are on average 10 percent smaller or shrunken. No conclusion can be drawn on the other 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.

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. I do not have IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA. Dr. Baughman, you have said time and time again that IDEA does not encourage medicalization of disabled children.

Ms. Heumann. I agree with you.

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Ms. Heumann. If we had no IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA, if we had no IDEA. 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 be the basis for children being labeled and diagnosed with ailments and disabilities that in some cases lead to drug therapies being recommended.

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Ms. Heumann. No, sir, I say over and over again that IDEA does not encourage medicalization 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.
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 lax to turn lose 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