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PSYCHOTROPIC MEDICATION IN SCHOOLS

House Bill 4025 (Substitute H-2)
First Analysis (3-27-03)

Sponsor: Rep. Sue Tabor
Committee: Education

THE APPARENT PROBLEM:

Recently, two policy institutes have released reports about Ritalin abuse: The Heritage Foundation published "Why Ritalin Rules" in *Policy Review* (April/May 1999); and, the Mackinaw Center for Public Policy issued a *Viewpoint on Public Issues* entitled "A Mixed Message to Children: Say "No" to Drugs, but "Yes" to Ritalin?" (January 8, 2000).

According to these and other reports, in the year 2000 approximately six million children in the United States—roughly one child in every eight, or 12½ percent—were taking a medication called Ritalin. This was an increase of millions over 1975 when the Food and Drug Administration first approved the drug for behavior problems. Then only 150,000 children took Ritalin. Ritalin use among schoolchildren seems to be a cultural practice that is prevalent mostly in the United States, although Canada and Australia also report a significant increase in the incidence of prescription and use. Indeed, five percent of the world's population now accounts for 85 percent of the world's consumption of the drug. Among the fifty states, Michigan ranks third in per capita use of Ritalin, and one report indicates that five percent of pediatricians in this state prescribe 50 percent of the drug.

Ritalin, or methylphenidate, is one of a wide array of psychotropic drugs generally categorized in seven categories and used to treat many different diseases and conditions. Generally, the drug Ritalin is prescribed for children who have an abnormally high level of activity, or what has come to be called attention-deficit hyperactivity disorder (ADHD). According to the National Institute of Mental Health, about three to five percent (some say six percent) of the general population has the disorder, which is characterized by agitated behavior and an inability to focus on tasks, and it is diagnosed eight times more often in boys than girls.

Ritalin is a central nervous system stimulant. It has effects similar to, but more potent than, caffeine and less potent than amphetamines. Despite the fact that it is categorized as a stimulant, it has a notably calming effect on hyperactive children, and also a focusing effect on those with ADHD. Increasingly there are reports that those without ADHD use the drug, as well, including college students whose aim it is to sharpen their memory during study sessions, and also reduce their desire for sleep and food.

The increased levels of use and abuse of Ritalin nationwide prompted major plaintiffs' attorneys in the tobacco and asbestos suits to charge Ritalin's manufacturer, Novartis (formerly Ciba Geigy) with fraud and conspiracy in five class action suits, although all the lawsuits that were filed during 2000 and 2001 were either dismissed by the courts, or withdrawn by plaintiffs between April 2001 and February 2002. See *BACKGROUND INFORMATION* below.

Some have speculated that the market-driven restructuring of the health care industry has contributed to the increase in Ritalin use, since it is much cheaper for a health maintenance organization to treat ADHD with drugs rather than psychiatric analysis and other behavioral therapies. (A typical month-long prescription of Ritalin is $30 to $60, while a typical psychiatric analysis is $1,500, or at least twice as much as the coast of Ritalin for a year.) Further, physicians are pressured to spend less time with patients, and evaluation of those whose diagnosis may be ADHA takes time. Yet others have speculated that Ritalin use has increased because school environments require more order and self-control as the students there focus more carefully on academic achievement to meet higher subject matter standards and pass high stakes tests. Those who suspect a school-based cause for the increase in Ritalin use say teachers customarily recommend that parents have their children evaluated for attention disorders, if their behavior in school seems to warrant doing so.

Ideally diagnosis of a child involves a visit with the child, reports on his or her schoolwork, examination of his or her home life, and discussions with parent and teachers to develop a profile of the child and his or her situation. The disorder is complex, based on behavior that is to one degree or another present in all children. Deciding when a child is affected is a matter, then, of judging degrees. The diagnosis is even more difficult because ADHD frequently appears with other disorders, including Tourette Syndrome, lead poisoning, fetal alcohol syndrome and retardation. In addition, many other conditions—depression, manic depressive illness, substance abuse, anxiety and personality disorder—share similar symptoms.

In order to ensure that the diagnosis of ADHD is carefully undertaken only by physicians, and to define the role that educators have in making evaluations and referrals as they counsel students' parents based upon behaviors they see within their classrooms, legislation has been introduced.

THE CONTENT OF THE BILL:

House Bill 4025 would amend the Revised School Code to require that not later than 90 days after the effective date of this legislation, the Department of Education develop and distribute to all school districts, intermediate school districts, and public school academies, a state model policy concerning chronic behavioral issues and psychotropic medication for pupils. Under the bill, the state model policy would be required to include all of the following:

• that, if school personnel suspect a child has a chronic behavioral condition, or if requested by a child's parent, school personnel would be permitted to do any of the following:

i) discuss the child's behavior with the child's parent;

ii) if appropriate and with parental consent, refer the child for an educational evaluation by appropriate educational evaluators;

iii) if appropriate, recommend to the child's parent that the child be evaluated by an appropriate health care provider;

iv) refer the parent to appropriate health professionals affiliated with the school district, intermediate school district, or public school academy for possible evaluation of the child; and,

v) if behavior issues persist after taking the steps under subparagraphs i) to iv), follow local procedures to provide specialized educational services as appropriate for the child.

• that, unless he or she is licensed, certified, or registered to do so, a teacher would not be permitted to:

i) make a psychological or medical diagnosis of a behavioral condition or disorder in a child; or,

ii) recommend a psychotropic drug for any child.

Further, House Bill 4025 specifies that not later than the beginning of the 2003-2004 school year, the board of a school district, a local act school district, or intermediate school district, or the board of directors of a public school academy, would be required to adopt and implement a local policy concerning chronic behavioral issues and psychotropic medication for pupils that was consistent with the state model policy.

Under the bill, if a school district or an intermediate school district operated or provided educational services for students in a residential care facility for court-placed children, then the local policy could exclude or exempt that facility, and children and teachers in that facility.

Further and under the bill, a board or board of directors would be required to notify parents of the local policy, and the bill specifies that the notification could be made by including the policy in a student handbook that was distributed to students and parents at the beginning of each school year.

Definitions. Under the bill, "parent" is defined to mean a child's parent or legal guardian. In addition, "education evaluator" is defined to mean appropriate school personnel, including certified school psychologists, approved school social workers, approved or certified speech pathologists, school nurses, and school counselors.

MCL 380.1180

BACKGROUND INFORMATION:

Ritalin abuse. Because of its stimulant properties, there have been reports of methylphenidate abuse by people for whom it is not a medication. Some individuals abuse it for its stimulant effects: appetite suppression, wakefulness, increased focus/attentiveness, and euphoria. When abused, the

tablets are taken either orally, or crushed and snorted. Some abusers dissolve the tablets in water and inject the mixture. Because the medicine has the potential for abuse, the U.S. Drug Enforcement Administration (DEA) has placed stringent Schedule II controls on its manufacture, distribution, and prescription. For example, DEA requires special licenses for these production and distribution activities, and prescription refills are not allowed. In addition, states may impose further regulations, such as limiting the number of dosage units per prescription.

Class action suits. The first lawsuits related to the use of Ritalin were brought during the late 1980s and early 1990s, coincident with the campaign against ADHD and stimulant medication for children that was spearheaded by the citizens Commission on Human Rights, a nonprofit anti-psychiatry organization founded by the Church of Scientology. The first case was filed in Atlanta, Georgia, and similar cases followed in Massachusetts, Minnesota, and California. Most alleged adverse side effects, and defendants included school districts, doctors, and the American Psychiatric Association. Ten years after filing the first case in Georgia, attorney John Coale (a part of the national tobacco litigation in 1998) was involved in a new series of class action lawsuits.

Beginning in 2000, class action suits for fraud and conspiracy to over-promote the stimulant medication Ritalin (methylphenidate) were filed in four states and Puerto Rico by leading tobacco and asbestos trial attorneys, including Coale. The first suit was brought on May 1, 2000, in a Texas court, the District Court for Cameron County, by the law firm of Waters and Kraus, and later moved to federal court in Dallas. Attorneys from the Waters and Kraus law firm were leaders in major asbestos cases. In September, 2000, two additional suits were filed in California (with the U. S. District Court in San Diego on behalf of all Californians who had used or bought Ritalin), and in New Jersey (with the Bergen County Superior Court where the plaintiff class is described as "all individuals in the State of New Jersey who have taken the drug Ritalin"). A plaintiffs' attorney best known for his work in the tobacco litigation, Richard Scruggs of Pascogoula, Mississippi (and according to reports, a friend of John Coale's), was leading the group of attorneys bringing the suits. In November 2000, a fourth case was filed in federal court in Orlando, Florida, brought by the law firm Stanley, Dehlinger, and Rasher, accompanied by a San Juan attorney, Peter Porrata. Then in February 2001, Porrata filed a fifth case in Puerto Rico District Court. The new suits tracked the allegations filed in the California, New Jersey, and Texas suits very closely.

However, all suits have subsequently been dismissed by the courts, or withdrawn. On April 23, 2001, U.S. District Judge Rudi Brewster dismissed the California suit under California's so-called anti-SLAPP statute (an acronym for Strategic Lawsuits Against Public Participation), a statute designed to weed out of the court system at their inception, lawsuits which are in reality political actions designed to intimidate defendants from exercising their First Amendment rights. In addition to dismissing the suit, the court also ordered that the plaintiffs pay the legal fees of the defendants. On May 18, 2001 a Texas judge dismissed the similar Texas case, finding that the plaintiffs had failed to state their claims of fraud and conspiracy with sufficient particularity. On July 5, 2001, the plaintiffs in Florida alerted the court of their intent to dismiss the class action that had been filed in Orlando, and then on August 16, 2001, attorneys for the plaintiffs in the Puerto Rico case also notified the court that they intended to dismiss their case. Finally, on February 5, 2002, the suit filed in federal court in New Jersey was withdrawn by the plaintiffs.

The initial class action suit, filed in Texas, alleged that the manufacturer of the drug Ritalin, the American Psychiatric Association, and an association of people with attention deficit problems called CHADD (an acronym for Children and Adults with Attention-Deficit/Hyperactivity Disorder) have "planned, conspired, and colluded to create, develop and promote the diagnosis of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) in a highly successful effort to increase the market for the drug Ritalin." The law firm Waters & Kraus, which specialized in cases related to toxic exposure and cancer, has filed the suit entitled *Hernandez, Plaintiff, Individually and on Behalf of all Others Similarly Situated v. Ciba Geigy Corporation, USA, Novartis Pharmaceuticals Corporation, Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), and the American Psychiatric Association.* The suit stated allegations based on fraud and conspiracy from approximately 1955 through 1995.

Further information is available at several web sites, including
http://www.pbs.org/wgbh/pages/frontline/shows/medicating/backlash/lawsuits.html

FISCAL IMPLICATIONS:

The House Fiscal Agency notes that House Bill 4025 would have no fiscal impact. (3-24-03)

ARGUMENTS:

For:

Proponents of this legislation note that the frequency of Ritalin use among Michigan school children is alarming, and they suggest the amount of medication prescribed suggests a problem of epidemic proportions. They note that a sharp rise in diagnoses of attention deficit disorder (ADD) is directly tied to a 700 percent increase in the amount of Ritalin produced in the United States, and that an increase of this magnitude in the use of a single medication is unprecedented for a drug that is categorized and regulated as a controlled substance. During committee deliberations, proponents reported that Dr. Lawrence Diller, M.D., a behavioral pediatrician who practices in California, recently compiled the following information from the National Disease and Therapeutic Index of IMS Health (a drug company rating organization): In a recent survey of doctors to determine changes in their use of psychotropic drugs for children between 1995 and 1999, stimulant drug use was up 23 percent; the use of Prozac-like drugs for children under 18 was up 74 percent, for those between seven and 12 it was up 151 percent, and for youngsters under six, it was up 580 percent. For young people under 18, the use of mood stabilizers other than lithium was up 40 fold, and the use of new anti-psychotic medications such as Risperdal had grown nearly 300 percent.

Proponents of these bills note that increases in drug use by young people of this kind and magnitude warrant the attention of policymakers. That is especially true in Michigan, they argue, because the state ranks third in the nation for psychotropic drug use by children.

Supporters of the legislation report they "are hearing from many parents" who say "some teachers are not only implying that a child is ADD or ADHD, based on their own observations and comparison to other students, but are actually suggesting and even recommending that a particular child be put on Ritalin." These parents feel pressured "and in some cases threatened by the teacher or school official to put their child on Ritalin, or else…"

The increase in psychotropic drug use among school children, the fact that nationally Michigan ranks third in use, and the reports of real (or even perceived) threats by school personnel, indicate that each school needs to adopt a policy to guide use of psychotropic medication.

Against:

Opponents of this legislation note that the actual decision to place a child on psychotropic drugs is already by law a medical decision. Only physicians can write prescriptions. During testimony on a similar bill during the last legislative session, opponents of the bill noted that while reports indicate that Kalamazoo County is in the top 1.4 percent of counties in the nation in the number of prescriptions for ADHD per capita, and that 4.53 percent of children in that county take medication for ADHD, this rate is within the guidelines set by the United States Surgeon General since the overall prevalence of ADHD nationwide is between three and five (some say six) percent. Some opponents of the bills pointed out that Kalamazoo County "could be doing it right" and that other counties could be denying much-needed benefits to children with behavior disorders. Or, opponents said, there could well be other explanations for the relatively high incidence in Kalamazoo County, explanations that would illuminate the reasons for differences in use among various regions of the state. For example, there could be a concentration of certain specialists in medical care in certain areas; or it could be that many families travel from a surrounding rural area to a population center in order to receive specialized medical care at a centrally located state-of-the-art facility; or, the socio-economic status of the population may generate more frequent medical evaluations; or, the region may be one in which parents have higher than average expectations for academic performance among children.

Opponents of the legislation also note that there seems to be a persistent misunderstanding about the evaluation services provided by school personnel for children with behavior problems. They note that "most schools do not have *medical* personnel on staff. They do have psychologists, social workers and/or licensed professional counselors, and state certified special education teachers available, who work together as a team to assess the special needs of children and develop intervention strategies so that each child can experience learning success to the best of his or her ability." Often these teams are based in the intermediate school district office, and they serve individual school districts as consultants. The team's

school-based assessments save poor families money, since a psychological assessment customarily takes between three and five hours and can cost (in west Michigan, according to testimony) between $315 to $550 if performed in the private sector.

Others who oppose the bill emphasize the importance of early identification in the prevention and treatment of mental illnesses and disorders in children and adolescents, and they fear that this bill may direct attention to the early detection of just one 'chronic behavioral condition or disorder,' at the expense of many others. These critics say that 20 percent of U.S. children and adolescents ages 9 to 17 have diagnosable psychiatric disorders, and that one in 10 children and adolescents suffer from a mental illness severe enough to cause some impairment, although fewer than one in five receive needed treatment in any given year. They also report that seven- to 14 percent of all children will experience an episode of major depression before the age of 15. What is more, they say that researchers have observed that prevalence of mental disorders in children is on the rise, and is appearing at earlier ages. Further, they are discovering genetic markers for most mental illnesses. They warn that ADHD is not the only disorder students suffer, and that sometimes its symptoms can be confused with others.

Opponents also expressed concern that the bill could stigmatize those who need the services of school-based clinics. They point out that "teachers have a very real role in the evaluation of a child for potential ADHD. Like many mental disorders and many chronic disorders, the diagnostic criteria for ADHD involves patient history and behavioral assessment without the benefit of laboratory or radiologic confirmation. The criteria require the physician to confirm the existence and persistence of symptoms and behaviors in both the home and the school (or work) environment." However, before a referral to a physician is contemplated and medication prescribed, the National Association of School Psychologists recommends a series of nine effective interventions, each tailored to the unique strengths and needs of every student. These interventions require classroom modifications, behavior management systems, direct instruction, collaboration and consultation with families, monitoring by a case manager, education of school staff, access to special education services, collaboration with community agencies, and interventions to develop self esteem.

The National Association of School Psychologists observes that "research indicates that medication can be an effective treatment for many students with attention problems, and can enhance the efficacy of other interventions. The NASP believes that a decision to use medication rests with parents, and is not an appropriate contingency for school placements and interventions." The organization's "Position Statement on Students with Attention Problems" (adopted in July 1998) continues "A thorough, differential assessment is essential prior to pharmacological intervention to assure that the most appropriate medication (if any) is prescribed. Furthermore, medication should be considered only after attempting or ruling out alternative, less invasive treatments. When medication is considered, NASP strongly recommends: 1) that behavioral and academic data be collected before and during blind medication trials to assess baseline conditions and the efficacy of medication; and 2) that communication between school, home, and medical personnel emphasize mutual problem solving and collaborative teamwork; and 3) that the student's health, behavior, and academic progress while on medication are carefully monitored and communicated to appropriate medical providers."

Finally, some opponents of the legislation note that Ritalin, and other similar products used to treat ADHD, have earned the approval of the Federal Drug Administration for use in pediatric populations. Indeed, these products "may be among the most thoroughly researched medications on the market today," according to the spokesperson for the Michigan Psychiatric Society. However, "the persistent controversy and what might be termed a 'climate of fear' prompted the Council of Scientific Affairs of the American Medical Association to conduct an exhaustive review of the research, which was reported in the Journal of the American Medical Association in 1998. The investigators discovered that the condition is more likely to be under-diagnosed than over-diagnosed. The evidence suggests that stimulants in ADHD populations are simply being used more broadly, for longer periods, and without interruptions in recent years than was done previously. The disorder is now being recognized to be persistent into the adolescent and adult years." Further, "another significant recent study found that medications are the single most effective way to treat ADHD. The study emphasized careful evaluation and did recommend that medications be used in conjunction with other therapeutic behavioral approaches, but these approaches alone are not effective."

Those who raise these issues seek a positive approach to evaluation and treatment that fosters understanding and cooperation. They fear this legislation singles

out a mental disorder, casts it negatively, and could well stifle the important conversation between parents and teachers about the well-being of children.

POSITIONS:

The Michigan Counseling Association and its Division, the Michigan School Counselors' Association, support the bill. (3-25-03)

The Michigan Association of School Social Workers supports the bill. (3-25-03)

The Michigan Education Association supports the bill. (3-26-03)

Analyst: J. Hunault

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.