FINAL REPORT OF THE

HJR 660 Joint Subcommittee to Investigate the Improper Prescription and Illegal Use and Diversion of Ritalin and Oxycontin and to Study the Effects of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder on Student Performance

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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EXECUTIVE SUMMARY

HJR 660 JOINT SUBCOMMITTEE TO INVESTIGATE THE IMPROPER PRESCRIPTION AND ILLEGAL USE AND DIVERSION OF RITALIN AND OXYCONTIN AND TO STUDY THE EFFECTS OF ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER ON STUDENT PERFORMANCE

AUTHORITY AND STUDY OBJECTIVES

Adopted by the 2001 Session of the General Assembly, HJR 660 created a 10-member joint subcommittee to study the effects of attention deficit disorder and attention deficit hyperactivity disorder (ADHD) on student performance and to investigate the improper prescription and illegal use and diversion of Ritalin and OxyContin. The General Assembly assigned the HJR 660 joint subcommittee a number of responsibilities, specifically, to:

"(i) determine the number of students diagnosed as having ADD/ADHD in Virginia's public schools, and whether such children receive treatment;

(ii) ascertain whether such students also have dual exceptionalities or chronic and acute health problems, and the demand created by these conditions for certain school services;

(iii) determine the academic performance levels of such children;

(iv) identify other educational, social, and health factors that may compromise their academic performance and educational outcomes;

(v) identify school practices to manage, the methods used to treat, and the medications prescribed for and dispensed to ADD/ADHD students in the school setting for their disorder;

(vi) evaluate the special education programs and related services provided or which may be provided to meet the needs of such students;

(vii) assess the demand for and effectiveness of existing education programs and related services, including school health services, by ADD/ADHD students;

(viii) evaluate the effect of ADD/ADHD on grade retention, absenteeism, school suspension and expulsion, and disciplinary action taken by public schools;

(ix) and make appropriate recommendations that address identified problems and allow public schools to serve such children efficiently and effectively;

(x) determine the health conditions for which Ritalin and OxyContin are lawfully prescribed in Virginia;

(xi) ascertain the number of such prescriptions for the last five years to determine the rate of increase or decrease, and the cause of any increase in the number of such prescriptions;

(xii) determine if Ritalin and OxyContin have been diverted to the street drug trade, and if so, assess the demand for Ritalin and OxyContin as street drugs in Virginia;

(xiii) establish whether the use of Ritalin or OxyContin for non-medical purposes is a problem among school-aged children and college students in the Commonwealth;

(xiv) consider and explore such other issues as the joint subcommittee may determine pertinent; and

(xv) recommend ways to correct problems associated with the over-prescription and the illegal use, possession, and distribution of Ritalin and OxyContin, as appropriate."

The joint subcommittee met three times in 2001 and was to submit its findings and recommendations to the Governor and the 2002 Session of the General Assembly.

ATTENTION DEFICIT HYPERACTIVITY DISORDER AND RITALIN USE

One of the most common mental disorders among children, Attention Deficit Hyperactivity Disorder (ADHD), affects an estimated three to five percent of all children in the United States. Other estimates place ADHD in two to 9.5 percent of school-age children worldwide. The condition typically presents in childhood, often between the ages of three and five, and may persist throughout adulthood. Today, specialists agree that Attention Deficit Hyperactivity Disorder is not a single condition but may be classified in subtypes reflecting the behaviors typically associated with the condition: inattentiveness, impulsivity, and hyperactivity. While these behaviors are certainly not necessarily indicative of ADHD, experts generally assess whether these behaviors are excessive, pervasive, and long-term. Distinguishable from ADHD are certain classroom behaviors that may be addressed through adjustments in instruction, recognition of learning style, or acknowledgement of individual student emotional or social needs.

The causes of ADHD remain under scientific investigation. Theories being explored today focus on brain development and processes as well as possible genetic influences. Recent brain imaging studies and other research indicate the involvement of specific brain areas that regulate attention; one theory focuses on genetic mutations--specifically, defects in those genes responsible for the regulation of the brain's use of the neurotransmitter dopamine.

Three medications--all classified as stimulants--have been used over the years to treat ADHD: Ritalin, Dexedrine or Dextrostat, and Cylert. Although considered safe when administered under medical supervision, the stimulant drugs can be addictive if misused by adolescents and adults. Used since the 1960s, Ritalin is found to assist 70 to 90 percent of children over age five for whom it is prescribed.

The National Institute of Mental Health has recognized concern regarding cases in which children who do not suffer from ADHD, but whose disruptive behavior prompted by other conditions or causes may be classified as impulsive or inattentive, are medicated unnecessarily. Expressing similar concerns are some physicians and educators who question describing ADHD as a disease or disability and who urge increased focus on the talents and skills of these children. Prompting much of this debate are escalating Ritalin prescriptions. Differing attitudes toward medications, insurance coverage, physician preferences, and other factors are generally viewed as contributing to the range of prescribing frequencies.

Abuse of Ritalin remains a national concern. While there is little hard data regarding specific Ritalin-related crimes, anecdotal information reveals incidences of abuse, theft, and diversion by dispensing school officials, sales among students, and threats against students on the medication to sell their pills. A September 2001 report of the U.S. General Accounting Office indicated that there are no data directly indicating either the degree of drug diversion or abuse in American public schools or the effect of state laws and regulations guiding schools in the administration of these medications. Concluding that the diversion of attention deficit disorder medications is not "a major problem at middle or high schools," the report noted that the development of nonstimulant medications and increased use of once-a-day attention deficit disorder medications may ameliorate the possibility of abuse or diversion in schools.

Dispensing of student medications during school hours also warranted committee consideration. The Code of Virginia does not prohibit student possession and administration of their own prescription medications at school. School board policies have typically governed possession and administration of student medications; this is not, however, clearly delineated in statute. School boards may prohibit student possession of their own prescription medications, and anecdotal evidence suggests that many do.

Virginia ranks in the highest quartile in the nation for Ritalin prescription; within the Commonwealth, higher concentrations are seen in Tidewater, Richmond, and Northern Virginia. In response to a Virginia Department of Education survey conducted in September 2001, 129 school divisions (95.5 percent response rate), indicated that 16,521 students--or 1.52 percent of the student population--received ADHD medication at school in 2000-2001. Of these students, 55 percent receive Ritalin; 45 percent are receiving other ADHD medication. These numbers are not indicative of the numbers of public school children with ADHD, as some children may not receiving medication or may be taking medication at home. The highest rates were noted in grades four and five; the lowest in kindergarten and in grade 12. Boys comprised 76 percent of students receiving ADHD medication at school; students with disabilities accounted for 59 percent of pupils receiving ADHD medication at school. The survey found no significant statistical differences among racial/ethnic groups receiving ADHD medication at school.

OxyContin Use and Diversion

In addition to exploring Ritalin abuse, the resolution also directs the joint subcommittee to examine the abuse and diversion of OxyContin in the Commonwealth. Abuse of OxyContin may be facilitated in part by its potency, effectiveness, and available dosages. According to the Virginia State Police, OxyContin diversion is primarily achieved through "doctor shopping" and physician over-prescribing. In addition, instances of importing from Mexico or Canada, forged or altered prescriptions, and travel to neighboring North Carolina or from West Virginia and Kentucky to Virginia to obtain prescriptions have been reported.

The Attorney General's Task Force on Prescription Drug Abuse is also examining the rising problem of abuse of OxyContin in Southwest Virginia. Comprised of doctors,

health care consumers, a pain management specialist, pharmacists and pharmaceutical companies, rehabilitation experts, and state and local law-enforcement officials, the task force is expected to issue its report in fall 2001.

A plan released in May 2001 by Purdue Pharma, the manufacturer of OxyContin, and the DEA targets the dissemination of educational brochures to physicians and pharmacists; the distribution of tamper-resistant prescription pads; and support for a study of "best practices in state prescription monitoring programs" with the goal of developing a national model. In addition, Purdue Pharma is working with the Virginia Attorney General to co-sponsor continuing medical education regarding OxyContin abuse for physicians in southwest Virginia.

Increased diagnoses of anxiety, depression, and ADHD among college students may potentially bring more antidepressants and other medications to campuses, with greater opportunities for nonmedical use. While Ritalin and OxyContin abuse do not appear to be a problem at Virginia institutions of higher education, continued drug education and appropriate interventions are necessary to reduce high-risk behaviors. The Virginia State Police reported that while Ritalin and OxyContin abuse remain problematic among school- and college-aged students in Virginia, these drugs are more often diverted and abused by other age groups. Campus police at three Virginia universities have reported no campus arrests involving either of these drugs.

CONCLUSIONS AND RECOMMENDATIONS

The joint subcommittee makes the following recommendations:

Recommendation 1: *That § 22.1-279.3:1 of the Code of Virginia be amended to require reporting of theft of student prescription medications from students during school hours, on school property, or at school-sponsored activities, or from school storage.*

Recommendation 2: *That reimbursement for pediatric specialists at pediatric medical centers through Medicaid and FAMIS be increased.*

Recommendation 3: *That the Joint Subcommittee endorse the efforts of the Attorney General's Task Force on Prescription Drug Abuse regarding the implementation of an appropriate prescription monitoring system for the Commonwealth.*

Recommendation 4: *That the Special Advisory Commission on Mandated Health Insurance Benefits examine and encourage continuing education of third party payers regarding adequate reimbursement for behavioral evaluations and ADHD and study the feasibility and appropriateness of expanding reimbursement for child evaluations to address an appropriate range of mental health services, including comprehensive assessment by clinical psychologists, without tying such reimbursement to a specific, final diagnosis.*

Recommendation 5: *That the Department of Health, in collaboration with the Departments of Education, Health Professions, and Mental Health, Mental Retardation, and Substance Abuse Services, with the assistance of researchers with public health and education expertise, conduct a statewide epidemiological study examining the prevalence of methylphenidate use and ADHD diagnoses in the Commonwealth; that such study incorporate, among other things, consideration of (i) contributing factors to any such prevalences; (ii) any relevant nutritional and educational issues; and (iii) the identification of age-appropriate behaviors by education and health professionals; and that such study include the input of psychologists, physicians, and other health professionals.*

Recommendation 6: *That the governing bodies of the Commonwealth's public and private institutions of higher education support increased student prescription drug abuse prevention and education programs on their respective campuses.*

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Recognizing that "although children with this disorder present significant challenges to public schools and the educational system, ...it is important that the educational, health, and social needs of these children be addressed, and the impact on public schools and the ability of the educational system to meet their needs be evaluated," the General Assembly also included within this study examination of abuse of Ritalin, a psychostimulant often prescribed to address ADHD. In addition, the resolution incorporated the directives of SJR 327, to embrace exploration of misdirection and abuse of OxyContin, a pain medication.

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II. Attention Deficit Hyperactivity Disorder

Definitions and Diagnosis

Hyperactive or excessively inattentive behavior in children has elicited a number of labels from psychiatric professionals over the years. For more than six decades, these behaviors have prompted diagnoses of "minimal brain dysfunction," "brain-injured child syndrome," "hyperkinetic reaction of childhood," "hyperactive child syndrome," and

"attention-deficit disorder."[1] Other appellations include organic driveness, "fidgety Phils," post-encephalitic behavior disorder, minimal brain damage, minimal dysfunction, hyperkinesis, hyperactivity, and ADD or ADD with or without hyperactivity. While the anagrams "ADD" and ADHD" are now used somewhat interchangeably,[2] today, the official clinical diagnosis is "ADHD"--a designation established by the American Psychiatric Association in 1994. References to "ADD" arise from the clinical designation made in 1980.[3] More recently, ADHD has been referred to as a "critical neurobehavioral condition,"[4] and "a persistent and troubling developmental disorder."[5] One nationally-recognized specialist notes that the "frequent changes reflect how uncertain researchers have been about the underlying causes of, and even the precise diagnostic criteria for, the disorder."[6]

One of the most common mental disorders among children, Attention Deficit Hyperactivity Disorder (ADHD) affects an estimated three to five percent of all children in the United States.[7] Other estimates place ADHD in two to 9.5 percent of school-age children worldwide. The condition more frequently affects boys than girls, with ratios estimated from 3:1 to one to as disparate as 9:1.[8] Estimates of the prevalence of ADHD vary based on the particular ADHD definition, the examined population and geographic location, and the level of agreement among the relevant educators and specialists making the diagnosis.[9] The condition typically presents in childhood, often between the ages of three and five, and may persist throughout adulthood.[10]

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[1]Barkley, R., "Attention-Deficit Hyperactivity Disorder," *Scientific American* (September 1998) <http://add.about.com/health/add/gi/dynamic/offsite.htm?site=ttp%3 A%2F%2Fwww.scientificamerican.com%2F1998%2F0998issue%2F0998barkley.html>[hereinafter referred to as Barkley].

[2]Thompson, Anna M., "Attention Deficit Hyperactivity Disorder," *Phi Delta Kappan* 433 (February 1996)[hereinafter referred to as Thompson]; *see also*, National Institute of Mental Health, National Institutes of Health, *Attention Deficit Hyperactivity Disorder* (1994; reprinted 1996)[hereinafter referred to as *ADHD*].

[3]National Information Center for Children and Youth with Disabilities (NICHCY), *Briefing Paper: Attention Deficit Disorder* <http://www.add-adhd.org/ADHD_attention-deficit.html>[hereinafter referred to as NICHCY].

[4]National Attention Deficit Disorder Association, *Guiding Principles for the Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder* (2000) <http://www.add.org/gp98.htm>[hereinafter referred to as ADDA].

[5]Barkley, *supra* note 1.

[6]Barkley, *supra* note 1.

[7]*ADHD*, *supra* note 2, at 1; *see also*, ADDA, *supra* note 4; Thompson, *supra* note 2, at 434; American Academy of Pediatrics, Committee on Quality Improvement, Subcommittee on Attention-Deficit/Hyperactivity Disorder, "Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder," *Pediatrics* 1158 (May 2000)[hereinafter referred to as *Pediatrics*].

[8]Barkley, *supra* note 1.

[9]Armstrong, T., "ADD: Does It Really Exist?" *Phi Delta Kappan* 424 at 425 (February 1996)[hereinafter referred to as Armstrong]. Armstrong cites Barkley's *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. See also*, *Pediatrics*, *supra* note 7, at 1158.

[10]*Pediatrics*, *supra* note 7, at 1158; Barkley, *supra* note 1; ADDA, *supra* note 4; National Attention Deficit Disorder Association, *Fact Sheet on Attention Deficit Hyperactivity Disorder (ADHD/ADD)* (1998) <http://www.add.org/content/abc/factsheet.htm>[hereinafter referred to as *Fact Sheet*].

Today, specialists agree that Attention Deficit Hyperactivity Disorder is not a single condition but may be classified in subtypes: ADHD Combined Type; ADHD Predominantly Inattentive Type; and ADHD Predominantly Hyperactive-Impulsive Type.[11] These subtypes reflect the behaviors typically associated with the condition: inattentiveness, impulsivity, and hyperactivity.[12] While these behaviors are certainly not necessarily indicative of ADHD, experts generally assess whether these behaviors are excessive, pervasive, and long-term. Guidelines for determining whether these seemingly common behaviors are consistent with a diagnosis of ADHD are set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Specialists concur that an ADHD diagnosis may be appropriate when these behaviors appeared early in life (before age seven), and continue for at least six months. The behaviors must "create a real handicap in at least two areas of a person's life, such as school, home, work, or social settings."[13]

DIAGNOSING ADHD

REPRINTED FROM: Barkley, Russell A., "Attention-Deficit Hyperactivity Disorder," *Scientific American* (September 1998) <http://add.about.com/health/add/gi/dynamic/offsite.htm?site=ttp%3A%2F%2Fwww.scientificamerican.com%2F1998%2F0998issue%2F0998barkley.html>

Psychiatrists diagnose attention-deficit hyperactivity disorder (ADHD) if the individual displays six or more of the following symptoms of inattention or six or more symptoms of hyperactivity and impulsivity. The signs must occur often and be present for at least six months to a degree that is maladaptive and inconsistent with the person's developmental level. In addition, some of the symptoms must have caused impairment before the age of seven and must now be causing impairment in two or more settings. Some must also be leading to significant impairment in social, academic or occupational functioning; none should occur exclusively as part of another disorder. (Adapted with permission from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders. ©1994 American Psychiatric Association.)

INATTENTION	HYPERACTIVITY AND IMPULSIVITY
• Fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities	• Fidgets with hands or feet or squirms in seat
• Has difficulty sustaining attention in tasks or play activities	• Leaves seat in classroom or in other situations in which remaining seated is expected
• Does not seem to listen when spoken to directly	• Runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, subjective feelings of restlessness)
• Does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace	• Has difficulty playing or engaging in leisure activities quietly
• Has difficulty organizing tasks and activities	• Is "on the go" or acts as if "driven by a motor"
• Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork)	• Talks excessively
• Loses things necessary for tasks or activities (such as toys, school assignments, pencils, books or tools)	• Blurts out answers before questions have been completed
• Is easily distracted by extraneous stimuli	• Has difficulty awaiting turns
• Is forgetful in daily activities	• Interrupts or intrudes on others

[11]NICHCY, *supra* note 3; *Fact Sheet, supra.*

[12]NICHCY, *supra* note 3; *Fact Sheet, supra* note 10; *Pediatrics, supra* note 7, at 1158; *ADHD, supra* note 2, at 4-5; Thompson, *supra* note 2, at 433-434.

[13]*ADHD, supra* note 2, at 5-6.

The DSM IV categorizes symptoms in two subsets: one for inattention and the other grouping hyperactivity and impulsivity together. Six or more of the various symptoms within each subset must be "maladaptive and inconsistent with developmental level" and have persisted for six months.

DSM-IV Criteria for Attention-Deficit/Hyperactivity Disorder

Source: *Mental Health: A Report of the Surgeon General* <http://www.mentalhealth.com/fr20.html>

A. Either (1) or (2):

(1) six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that cause impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).

Distinguishable from ADHD are certain classroom behaviors that may be addressed through adjustments in instruction, recognition of learning style, or acknowledgement of individual student emotional or social needs. Further complicating an ADHD diagnosis may be other conditions, such as a specific learning disability; Tourette's Syndrome; oppositional defiant disorder, a condition affecting nearly half of all children diagnosed with ADHD and characterized by, among other things, temper outbursts or belligerent behavior; or various emotional disorders such as anxiety or depression. [14]

That the condition may affect academic and other achievement has been documented in recent years. According to a 1993 study, boys with ADHD achieved "significantly lower social class rankings, completed 2.5 years less schooling and had lower occupational rankings." One-third of the boys studied was diagnosed with a mental disorder at adult follow-up--most commonly antisocial personality or substance abuse. Treatment of the disorder is critical; a 1999 study indicated that children with ADHD who received treatment were at an 85 percent lower risk of substance abuse than untreated children.[15]

New Recommendations for ADHD Diagnoses

Testifying before the subcommittee, Dr. Thomas J. Sullivan, President, Virginia Chapter, The American Academy of Pediatrics/Virginia Pediatrics Society (AAP), cited new guidelines issued by the American Academy of Pediatrics to assist primary care physicians in diagnosing ADHD in children aged six to 12. The primary care clinician should initiate the ADHD evaluation for children exhibiting signs of academic underachievement, difficult family and school relationships, and other behavioral problems. In addition, the AAP recommended using the diagnostic guidelines set forth in the DSM-IV, requiring that ADHD symptoms be manifested in two settings and that these symptoms negatively affect "academic or social functioning for at least six months." An assessment of ADHD should also "include information obtained directly from parents or caregivers, as well as a classroom teacher or other school professional, regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms and degree of functional impairment." Positive reinforcement, time-out, response cost (withdrawing rewards or privileges for undesirable behavior), and token economy (earning "tokens" for rewards for good behaviors) were cited as effective behavioral techniques for students with ADHD.

Noting that better educated clinicians will reduce the risk of over-diagnosis of ADHD, Dr. Sullivan also indicated that under the DSM III diagnostic criteria, seven percent of students ages six through 12 were diagnosed with ADHD. Under the DSM IV criteria, that percentage increases to 10. Microsystems may prompt variations in the application of recommendations in chronic disease. Citing mental health parity and insurance coverage concerns, he noted that ADHD is a "pediatric diagnosis insurers down code" and that some insurers do not accept this diagnosis from pediatricians and family

[14] *Id.* at 8-9.
[15] October 30, 2001, Meeting Summary.

practitioners. Also noted was the need for evaluation of the child for any coexisting conditions.[16]

American Academy of Pediatrics
Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder: Abstract, October 2001
<http://www.aap.org/policy/s0120.html

- Primary care clinicians should establish a treatment program that recognizes ADHD as a chronic condition.
- The treating clinician, parents, and child, in collaboration with school personnel, should specify appropriate target outcomes to guide management.
- The clinician should recommend stimulant medication and/or behavior therapy as appropriate to improve target outcomes in children with ADHD.
- When the selected management for a child with ADHD has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions.
- The clinician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects, with information gathered from parents, teachers, and the child.

Potential Causes and Treatment

The causes of ADHD remain under scientific investigation. Now largely debunked by scientists are previous theories targeting environmental rather than biological causes, minor brain injuries or birth complications, or refined sugar and food additives in diets. Theories being explored today focus on brain development and processes as well as possible genetic influences.[17] Research indicates that ADHD is "very likely caused by biological factors which influence neurotransmitter activity in certain parts of the brain, and which have a strong genetic basis." Supporting these findings are NIMH studies with a positron emission tomography (PET) scanner of the brain, which have detected a correlation between brain activity and attentiveness.[18] Bolstering further exploration of genetic factors is evidence that persons diagnosed with ADHD have 25 to 35 percent probability of having another family member diagnosed, in contrast to the four to six percent of others in the general population.[19] More specifically, research has detected a link between ADHD and the DRD4 repeater gene in a significant number of ADHD diagnoses. In addition, identical twins appear to have higher

[16]October 30, 2001, Meeting Summary.
[17]*ADHD*, *supra* note 2, at 10-12; *see also*, *Fact Sheet*, *supra* note 10; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, *Mental Health: A Report of the Surgeon General* at 145 (1999) <http://www.mentalhealth.com/fr20.html>[hereinafter referred to as *Surgeon General*].
[18]*Fact Sheet*, *supra* note 10.
[19]*Id*; *see also*, Barkley, supra note 1.

concordance rates for ADHD than fraternal twins--by rates of 81 percent and 29 percent, respectively, in one study, and 67 percent and zero percent in another.[20]

While clearly noting that "[n]o one knows the direct and immediate causes of the difficulties experienced by children with ADHD," Dr. Russell Barkley, director of psychology and professor of psychiatry and neurology at the University of Massachusetts Medical Center in Worcester, states that recent brain imaging studies and other research indicate the involvement of specific brain areas that regulate attention. Studies indicate that these areas are smaller in children diagnosed with ADHD; one theory for this difference focuses on genetic mutations--specifically, defects in those genes responsible for the regulation of the brain's use of the neurotransmitter dopamine.[21] Dr. Barkley's theory contends that "ADHD is not a disorder of attention per se...[r]ather, it arises as a developmental failure in brain circuitry that underlies inhibition and self-control. This loss of self-control in turn impairs other important brain functions crucial for maintaining attention, including the ability to defer immediate rewards for later, greater gain."[22]

Practice parameters published in 1991 by the American Academy of Child and Adolescent Psychiatry contend that "the cornerstones of treatment are support and education of parents, appropriate school placement, and pharmacology."[23] Similarly, the National Institute of Mental Health has stated that more lasting improvement is achieved when medication is combined with behavioral therapy, counseling, and "practical support," while the National Attention Deficit Disorder Association (ADDA) cites medication as the "cornerstone of an effective overall treatment regimen"--but only if prescribed following a patient comprehensive evaluation.[24]

Medications for ADHD. A brand name for methylphenidate hydrochloride, Ritalin is only one of many medications used to treat ADHD. The drug is a "mild central nervous system stimulant" for the treatment of ADHD as well as narcolepsy. Methylphenidate is also produced as Concerta, Metadate, Methylin, and several generics. Amphetamines such as Adderall, Dexedrine, and other generics may treat the disorder, as well as Cylert and certain antidepressants.[25]

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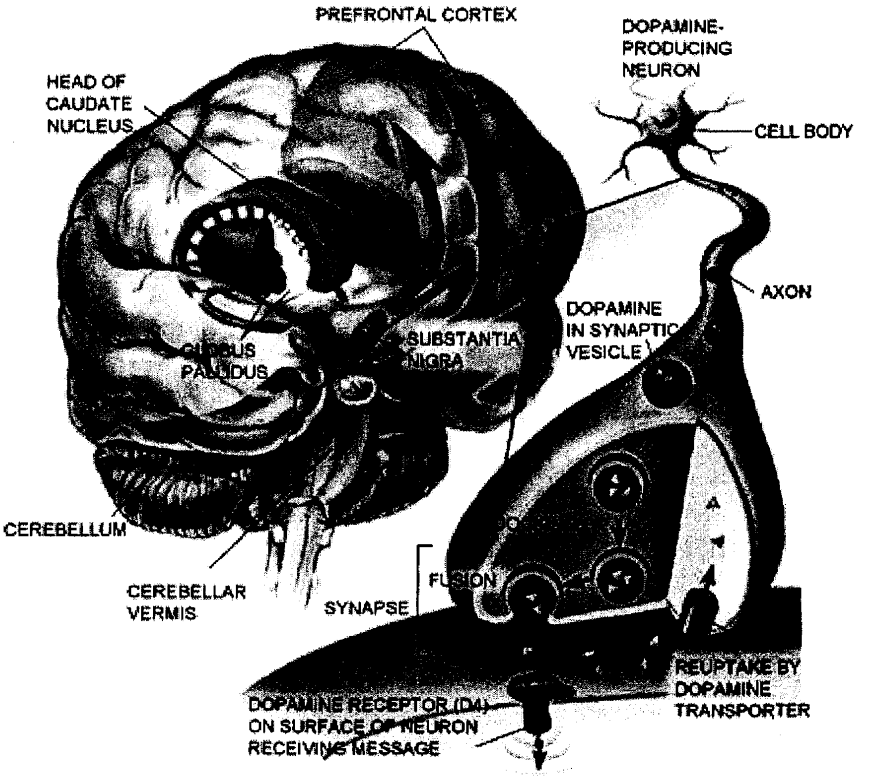
[20]Robin, Arthur L., "Research Update on ADHD," National ADDA <http://www.add.org/content /research.update.html>
[21]Barkley, *supra* note 1.
[22]*Id.*
[23]*Surgeon General, supra* note 17, at 146.
[24]*ADHD, supra* note 2, at 23.
[25]October 30, 2001, Meeting Summary.

BRAIN STRUCTURES



BRAIN STRUCTURES affected in ADHD use dopamine to communicate with one another (green arrows). Genetic studies suggest that people with ADHD might have alterations in genes encoding either the D4 dopamine receptor, which receives incoming signals, or the dopamine transporter, which scavenges released dopamine for reuse. The substantia nigra, where the death of dopamine-producing neurons causes Parkinson's disease, is not affected in ADHD.

Source: Barkley, Russell A., "Attention-Deficit Hyperactivity Disorder," *Scientific American* (September 1998) <http://add.about.com/health/add/gi/dynamic/offsite.htm?site=ttp%3A%2F%2Fwww.scientificamerican.com%2F1998%2F0998issue %2F0998barkley.html>

Three medications--all classified as stimulants--have typically been used over the years to treat ADHD: methylphenidate (Ritalin); dextroamphetamine (Dexedrine, Dextrostat); and pemoline (Cylert). Although considered safe when administered under medical supervision, the stimulant drugs can be addictive if misused by adolescents and adults. Interestingly, the medications are not addictive in children.[26] Used since the 1960s, Ritalin is found to assist 70 to 90 percent of children over age five for whom it is prescribed; also recommended are parent and teacher training in "specific and more effective methods for managing the behavioral problems" of children diagnosed with ADHD.[27] Methylphenidate is classified as a Schedule II drug under the state and federal law; for purposes of federal statute, Schedule II substances are those with a "high potential for abuse."[28]

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[26]*ADHD*, *supra* note 2, at 22-23.

[27]Barkley, *supra* note 1; Thompson, *supra* note 2, at 434.

[28]Va. Code § 54.1-3448 (2001 Supp.); Drug Enforcement Administration, U.S. Department of Justice, Diversion Control Program, 21 U.S.C. § 812 <http://www.deadiversion.usdoj.gov/21cfr/21usc/812.htm>

Ritalin blocks the re-uptake of dopamine and norepinephrine, the neurotransmitters believed linked to ADHD. Off patent since 1964, Ritalin is the most extensively researched treatment for ADHD, with more than 200 studies of the drug having been completed, addressing more than 6,000 children. The medication is no longer the leading prescription for the treatment of ADHD, but rather comprises 10 percent of the analeptic market and 20 percent of the methylphenidate market.[29]

Additional treatment methods. Recommended behavior modification treatment methods include more immediate consequences for the child's actions as well as increased reminders about rules and time constraints. These efforts will "aid children with ADHD by anticipating events for them, breaking future tasks down into smaller and more immediate steps, and using artificial immediate rewards. All these steps serve to externalize time, rules and consequences as a replacement for the weak internal forms of information, rules and motivation of children with ADHD."[30]

In citing other treatments "that have not been scientifically shown to be effective in treating the majority of children or adults with ADHD, the National Institute of Mental Health identified biofeedback, diets, allergy treatments, medication for inner ear conditions, megavitamins, chiropractic treatments, eye training, and special colored glasses."[31]

A self-described "consumer advocacy organization," the National ADDA developed guiding principles to serve as "organizational framework" to aid consumers in dealing with ADHD diagnosis and treatment issues. Culled from the research, expertise, and experiences of professionals and laypersons, the 11 guiding principles address, among other things, evaluation and treatment of the "whole person"; consideration of ADHD symptoms along a spectrum, while acknowledging the need to assess any coexisting conditions; comprehensive assessments, with evaluation and treatment by a qualified professional; diagnoses based primarily on ADHD criteria as stated in the DSM, rather than relying on patient reaction to medication; and the use of multiple avenues of treatment.[32]

The National Institute of Mental Health and the U.S. Department of Education are currently conducting a five-year national study of the most effective treatments.[33]

Controversy in Diagnosis, Treatment, and Prescription Abuse

The National ADDA has expressed concern that, "paradoxically, ADHD is both incorrectly diagnosed when it is not present and under diagnosed when it is present;

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[29]October 30, 2001, Meeting Summary.
[30]Barkley, *supra* note 1.
[31]*ADHD*, *supra* note 2, at 31.
[32]ADDA, *supra* note 4.
[33]*ADHD*, *supra* note 2, at 34.

ADHD is both incorrectly treated and under treated."[34] The National Institute of Mental Health has recognized concern regarding cases in which children who do not suffer from ADHD, but whose disruptive behavior prompted by other conditions or causes may be classified as impulsive or inattentive, are medicated unnecessarily.[35]

Expressing similar concerns--indeed, even vehement doubts as to the validity of ADHD as a diagnosis at all--are some physicians and educators who decry ADHD as "the label du jour in America education," cite the "myth" of ADD as a disease or disability, and who urge increased focus on the talents and skills of these children.[36] The debate has captured congressional attention, as the House Committee on Education and the Workforce, Subcommittee on Oversight and Investigations, conducted a hearing on the use of behavioral drugs on schools on September 29, 2000. Testifying were representatives of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, describing the diagnosis and treatment of ADHD[37] and encouraging the involvement of parents and physicians, rather than teachers, in making decisions regarding prescriptions for ADHD.[38] Also testifying, however, were physicians and educators criticizing the acceptance and "reconceptualizing" of ADHD as a "disease";[39] suggesting special education funding incentives for schools to label various students with an ADHD diagnosis;[40] and urging parents and educators to reject "the use of stimulants for the treatment of attention deficit hyperactivity disorder or for the control of behavior in the classroom or home."[41]

Experts questioning the "rush to label schoolchildren as suffering from...ADHD" suggest that some parents and educators may welcome an ADHD diagnosis for a child, as it may somehow absolve them from responsibility for the child's inappropriate

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[34]ADDA, *supra* note 4.
[35]*ADHD*, *supra* note 2, at 25-26.
[36]Armstrong, *supra* note 9, at 428, 427.
[37]Fassler, David, M.D., Statement before the House Committee on Education and the Workforce, Subcommittee on Oversight and Investigations, Hearing on "Behavioral drugs in Schools" Questions and Concerns" (September 29, 2000)< http://edworkforce.house.gov/hearings/106th/oi/ ritalin92900/fassler.htm>
[38]Heumann, Judith E., Testimony before the House Committee on Education and the Workforce, Subcommittee on Oversight and Investigations, Hearing on "Behavioral drugs in Schools" Questions and Concerns" (September 29, 2000)<http://edworkforce.house.gov/hearings/106th/oi/ritalin92900/heumann.htm>
[39]Baughman, Fred A., Jr., M.D., "The Rise and Fall of ADD/ADHD," Testimony before the House Committee on Education and the Workforce, Subcommittee on Oversight and Investigations, Hearing on "Behavioral drugs in Schools" Questions and Concerns" (September 29, 2000)< http://edworkforce.house.gov/hearings/106th/oi/ritalin92900/baughman.htm>
[40]Johnson, Patti, Testimony before the House Committee on Education and the Workforce, Subcommittee on Oversight and Investigations, Hearing on "Behavioral drugs in Schools" Questions and Concerns" (September 29, 2000)< http://edworkforce.house.gov/hearings/106th/oi/ritalin92900/johnson.htm>
[41]Breggin, Peter R., M.D., Testimony before the House Committee on Education and the Workforce, Subcommittee on Oversight and Investigations, Hearing on "Behavioral Drugs in Schools" Questions and Concerns" (September 29, 2000)< http://edworkforce.house.gov/hearings/106th/oi/ritalin92900/breggin.htm>[hereinafter referred to as Breggin].

behavior.[42] Others criticize diagnostic tools that may rely on teacher's subjective judgment, particularly when the evaluative process may ask a teacher to determine, for example, a "normal" level of fidgeting for children.[43] Specialists caution that "[p]hysicians, psychologists, school officials, and teachers have an obligation to the child and the child's parents to explain that the classification ... is not a license to get away with anything, but rather an explanation that may lead to legitimate help for the child in question."[44]

Offering committee testimony consistent with these perspectives was David B. Stein, Ph.D., professor of psychology, Longwood College, and author of *Ritalin Is Not the Answer: A Drug-Free, Practical Program for Children Diagnosed with ADD or ADHD*, noted that there are no diagnostic or laboratory tests for ADHD. Questioning whether ADHD is "a disease of the body or modern society," he cited concerns regarding addiction and possible as well as unknown short- and long-term side effects of psychotropic medications addressing ADHD. Studies have indicated that Cylert, used to manage ADHD, may suppress growth hormones and adversely affect the liver. He noted the Lovaas behavioral intervention method, and also described the success of the Caregivers Skills Program, which also uses behavior modification in handling noncompliance, oppositionalism, and temper tantrums. He concluded by stating that he is "not convinced" that there is a physical component to ADHD.[45]

Prompting much of this debate are escalating Ritalin prescriptions. In 1995, the International Narcotics Control Board (World Health Organization) reported that 10 to 12 percent of American boys between the ages of six and 14 have been diagnosed with ADHD and are receiving Ritalin. In Virginia, an estimated 20 percent of white male fifth graders received a stimulant medication from school officials; in North Carolina, another study indicated 10 percent of all children were taking these medications either at home or at school.[46] According to the DEA, production of Ritalin increased 450 percent over a four-year period in the mid-1990s.[47]

Ritalin use varies across the United States, with children in parts of the Northeast and Midwest three times as likely to be on the medication than children in the Southwest. Youngsters in Hawaii and New Mexico are prescribed Ritalin the least frequently. Differing attitudes toward medications, insurance coverage, physician preferences, and other factors are generally viewed as contributing to the range of prescribing frequencies.[48]

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[42]Smelter, R., Rasch, B., Fleming, J.; Nazos, P., and Baranowski, S., "Is Attention Deficit Disorder Becoming A Desired Diagnosis?" *Phi Delta Kappan* 429 at 430 (February 1996)[hereinafter referred to as Smelter].

[43]Armstrong, *supra* note 9, at 426.

[44]Smelter, *supra* note 42, at 432.

[45]October 30, 2001, Meeting Summary.

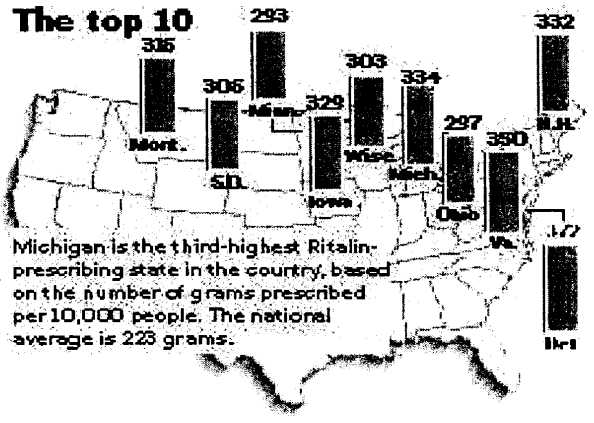
[46]Breggin, *supra* note 41.

[47]Armstrong, *supra* note 9, at 425.

[48]"Location might play role in Ritalin prescriptions," NewsFlash (May 6, 2001) <wysiwyg://96/http;//www.cleveland...H--RitalinUse&&&newsnews&newsflash-ohio>

Ritalin Prescriptions: Top 10 States (1998)

Source: Hurt, C., "Michigan ranks third in nation in prescribing the drug Ritalin-Some say schools turn to medication to control students," *The Detroit News* (detnews.com)(March 8, 1998) <http://detnews.com/1998/metrox/ritalin/11ead/11ead.htm>



Ritalin and other prescribed stimulant medications may also prompt weight loss, decreased appetite, slowed physical growth, and difficulty falling asleep in some children.[49] Although a recent National Institute of Mental Health study found no "safety issues" in these prescriptions over a 14-month period, the U.S. Surgeon General has suggested that "research is needed to examine the long-term safety of treatment and to investigate whether other forms of treatment may be combined with psychostimulants to lower their dose as well as to reduce other problem behaviors found with ADHD."[50] While noting that children with ADHD are at increased risk for substance abuse, however, the Surgeon General also indicated that "the rate of lifetime nonmedical methylphenidate use has not increased..., suggesting that abuse is not a major problem."[51]

Yet abuse of Ritalin remains a national concern. One of the top prescriptions stolen in the United States, Ritalin has been misused to experience a "euphoric" high, to counter the effects of alcohol, and to assist in studying. The drug may be prepared for injection or crushed and inhaled.[52] The DEA includes methylphenidate among its listed "drugs of concern" and has reported that filler materials in Ritalin prompt complications when injected, as "these materials block small blood vessels, causing serious damage to the lungs and retina of the eye. MPH [methylphenidate] also produces dose-related increases in heart rate and blood pressure and is capable of producing severe psychological dependence."[53]

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[49] *ADHD, supra* note 2, at 24 *see also, Surgeon General, supra* note 17, at 146.
[50] *Surgeon General, supra* note 17, at 150.
[51] *Id.*
[52] Ziegler, N., "Recreational Ritalin--Kids Using Prescription Drug for Fun"; Vogel, S., "How Ritalin Is Abused," *ABCnews.com.* (May 5, 2000) <http://www.abcnews.go.com/sections/living/DailyNews/ritalin0505.html#sidebar>; Drug Enforcement Administration, U.S. Department of Justice, "Methylphenidate (Ritalin)," *Drugs of Concern* <http://www.usdoj.gov/dea/concern/ritalin.htm> [hereinafter referred to as *Drugs of Concern*].
[53] *Drugs of Concern, supra.*

Available in five, 10, and 20 milligram tablets as well as a timed-released formula, Ritalin has been reported to sell on a "street market" at three dollars to $15 per tablet, compared to the prescription cost of 25 to 50 cents per tablet. More recent data indicate street prices of five to six dollars per tablet. Because the medication targets dopamine neurotransmitters, it "resembles the stimulant characteristics of cocaine."[54] When taken appropriately, Ritalin's stimulant effects are typically "mild to moderate"; snorting or injecting the drug intensifies its effect.[55]

1999 Rankings: States with Highest Use of Methylphenidate per 100,000

1999 U.S. Methylphenidate Average: 3,082 grams per 100,000 population

Rank	State	Grams per 100K
1	New Hampshire	5,525
2	Vermont	5,005
3	Michigan	4,848
4	Iowa	4,638
5	Delaware	4,439
6	Massachusetts	4,318
7	South Dakota	4,235
8	Virginia	4,207
9	Minnesota	3,941
10	Maryland	3,935

Source: DEA Congressional Testimony, Statement by Terrance Woodworth, Deputy Director, Office of Diversion Control, Drug Enforcement Administration Before the Committee on Education and the Workforce: Subcommittee on Early Childhood, Youth and Families (May 16, 2000) <http://www.usdoj.gov/dea/pubs/cngrtest/ct051600.htm>

Detailing Incidents of Ritalin Diversion and Abuse in Public Schools

Testifying before the Committee on Education and the Workforce: Subcommittee on Early Childhood, Youth and Families on May 16, 2000, Terrance Woodworth, deputy director, Office of Diversion Control, Drug Enforcement Administration, noted that methods of dispensing of medications in schools may facilitate diversion of drugs; a 1996 DEA study indicated that many schools did not have nurses dispensing medications, and that a variety of individuals--and, at the middle and high school levels, sometimes the students themselves--administered the medication.[56] Finally, the testimony noted that:

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[54]Bailey, W., *Factline on Non-Medical Use of Ritalin (methylphenidate)*, Indiana Prevention Resource Center (November 1995)<http://www.drugs.indiana.edu/publications/iprc/factline/ritalin.html#pattern>; DeWeese, T., "Ritalin is Poison," The DeWeese Report, DeWeeseOnline (April 2000)<http://www.deweeseonline.com/article_pushing_pills.html>

[55]*Id.*

[56]DEA Congressional Testimony, Statement by Terrance Woodworth, Deputy Director, Office of Diversion Control, Drug Enforcement Administration Before the Committee on Education and the Workforce: Subcommittee on Early Childhood, Youth and Families (May 16, 2000)<http://www.usdoj.gov/dea/pubs/cngrtest/ct051600.htm>

"[t]here is little doubt that Schedule II controls and the lack of clandestine production have limited the illegal use of this drug. However, reports of methylphenidate misuse/abuse among adolescents and young adults are particularly disturbing since this is the group that has the greatest access to this drug. Adolescents don't have to rob a pharmacy, forge a prescription or visit the local drug dealer to acquire methylphenidate - they have little difficulty obtaining it from a friend or classmate at school."[57]

The Drug Enforcement Administration (DEA) reports that youths abusing stimulant medications typically purchase, receive freely, or steal the drugs from youths for whom it has been appropriately prescribed. In October 2001, the Canadian Medical Association Journal reported a small percentage of students gave away or sold their medication, or were robbed or experienced coercion for their medications. [58] While there is little hard data regarding specific Ritalin-related crimes, anecdotal information reveals incidences of abuse, theft, and diversion by dispensing school officials, sales among students, and threats against students on the medication to sell their pills. To unearth more specific information, in November 2000, the General Accounting Office initiated a study of the diversion of Ritalin and other medications in public schools.[59]

In response to the September 14, 2000, request of Congressman Henry J. Hyde (R-IL), the GAO examined "(1) the diversion and abuse of attention deficit disorder drugs in public schools, (2) the school environment in which drugs are administered to students, and (3) the state laws or regulations addressing the administration of prescription drugs in schools."[60] In its report released exactly one year later, the GAO indicated that there are no data directly indicating either the degree of drug diversion or abuse in American public schools or the effect of state laws and regulations guiding schools in the administration of these medications. Citing the use of Ritalin, Adderall, and other prescription stimulants targeting attention deficit disorders, the report noted rising concern that the administration of these controlled substances during the school day may facilitate diversion and abuse. The study incorporates a survey of middle and high school principals, as well as of representatives of every state department of education.[61]

Concluding that the diversion of attention deficit disorder medications is not "a major problem at middle or high schools," the report noted that the development of nonstimulant medications and increased use of once-a-day attention deficit disorder medications may ameliorate the possibility of abuse or diversion in schools. Also noted

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[57]*Id.*

[58]October 30, 2001, Meeting Summary.

[59]Thomas, K., "Stealing, dealing and Ritalin," *USAToday.com* (November 27, 2000) <http://www.usatoday.com/life.health/child/lhchi215.htm>

[60]*See generally*, Division of Legislative Services, Memorandum, "GAO Report: Attention Disorder Drugs--Few Incidents of Diversion or Abuse Identified by Schools" (September 25, 2001); U.S. General Accounting Office, Report to Congressional Requesters, *Attention Disorder Drugs--Few Incidents of Diversion or Abuse Identified by Schools* at 1 (September 2001)[hereinafter referred to as GAO].

[61]*Id.*

were numerous state policies designed to curb diversion and abuse of medications in schools.[62]

The report offered a number of interesting statistical results:

- Only eight percent of the surveyed school principals reported at least one incident of diversion or abuse of these drugs for the 2000-2001 school year, and of this percentage, most indicated knowledge of only a single incident. Another three percent of surveyed principals cited a "possible" incident of drug abuse or diversion, without certainty of the drugs involved.[63]

- Of the eight percent of schools reporting incidents involving attention disorder drugs, 73 percent of incidents involved methylphenidate (Ritalin); amphetamines (such as Adderall) accounted for 20 percent.[64]

- School officials typically administer these medications; nurses handle drug dispensing in 60 percent of schools, with non-health professionals (including secretaries) undertaking this duty in the remaining schools.[65]

School Personnel Dispensing Attention Disorder Medication

U.S. General Accounting Office, Report to Congressional Requesters, *Attention Disorder Drugs--Few Incidents of Diversion or Abuse Identified by Schools* at 13 (September 2001)

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

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

- While 90 percent of schools reported staff administering attention deficit disorder medications, only about two percent of students receive these medications during the school day.[66]

- More middle school (96 percent) than high school officials (83 percent) administer attention deficit disorder medications.[67]

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[62] *Id.* at 19.
[63] *Id.* at 2, 6.
[64] *Id.* at 7.
[65] *Id.* at 2, 12.
[66] *Id.* at 2, 10.

- Of schools administering these medications, approximately half (48 percent) indicated parents only were bringing the medications to school; 34 percent permit parents or students to bring the medications. Another 12 percent indicated students bring medications; these schools indicated various policies precluding opportunities for diversion, such as requiring taped medication bottles, parental note, and indication of pills contained.[68]

- Medications are locked at 96 percent of schools, and students are observed while ingesting the drugs.[69]

- Of schools indicating attention deficit disorder medications are secured by lock, 93 percent reported that fewer than six people have access; the average number of persons with access was three.[70]

- About 72 percent of dispensing schools store the medications in a locked cabinet and in a locked room or office.[71]

Low rates of diversion and abuse and other variations prohibited the sure finding of a number of conclusions. The report specifically stated that a number of conclusions could not be drawn from the survey data:

- Due to low rates of diversion and abuse and high levels of medication security at most schools, no clear nexus could be assumed between incidences of diversion, type of school (urban, small town, etc.) and security measures.[72]

- No conclusions could be drawn regarding personnel administering medications, numbers of students on these medications, storage procedures, or transport of medication.[73]

Statutes, regulations, or policies address school administration of these medications in 37 states and in the District of Columbia. Of these states, 29 require or permit schools to adopt medication policies, typically following state requirements. The District of Columbia and remaining eight states regulate school dispensing of these prescriptions through state or division requirements.[74]

- The District of Columbia and 28 states require parental authorization--typically written--for school administration of medication.

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[67] *Id.* at 10.
[68] *Id.* at 15.
[69] *Id.* at 2, 13, 15.
[70] *Id.*
[71] *Id.* at 13.
[72] *Id.* at 7-8; 13.
[73] *Id.* at 2, 7, 13, 15.
[74] *Id.* at 15-16.

- The District of Columbia and 19 states require physician orders or instructions for school dispensing.[75]

- Schools must obtain the prescriptions in the original container in 22 states and in the District of Columbia.

- Various security and storage requirements are set forth in 18 states.

- Documentation in a medication log or similar record for dispensing of medication to students is required in 16 states.[76]
- Maryland requires regular "pill counts."
- Connecticut documents skipped doses and the reasons therefor.
- Massachusetts records the return of unused medication to parents.

Discretionary policy "guidelines," rather than legal requirements, regarding dispensing of medication in schools are set forth in 22 states, including Virginia, and the District of Columbia.[77]

Additional Controversy

Further fueling the Ritalin debate is the revelation that Ciba/Novartis, Ritalin's manufacturer, has silently supported the national organization Children and Adults with ADD in recent years with more than $1 million in grants and services.[78] In May 2000, a class action lawsuit was filed against Ciba/Novartis and CHADD, alleging that Ciba/Novartis "planned, conspired, and colluded to create, develop and promote the diagnosis of ... ADHD... in a highly successful effort to increase the market for its product Ritalin." Also alleged in the suit were the efforts of Ciba/Novartis "to promote and dramatically increase the sales of Ritalin" by supporting CHADD, disseminating misleading promotional materials, and promoting Ritalin as the "drug of choice." The suit also alleges that, while receiving funds from Ciba, CHADD "deliberately made efforts to increase the sales of Ritalin, and to increase the supply of methylphenidate ... available in the United States, and to reduce or eliminate laws and restrictions concerning the use of Ritalin and methylphenidate ...,

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[75]*Id.* at 16.
[76]*Id.* at 17.
[77]*Id.* at 18.
[78]PBS Report and the Merrow Report, "ADD, Ritalin, CHADD (CH.A.D.D.) and Ciba-Geigy: Attention Deficit Disorder: A Dubious Diagnosis?" (October 20, 1995),http:www.add-adhd.org/ritalin_CHADD_A.D.D.html>

all to the financial benefit of Ciba/Novartis."[79] The year 2000 witnessed the filing of five such class action lawsuits against Novartis in California, Texas, Florida, Puerto Rico, and New Jersey. Four have been dismissed, and another motion to dismiss is pending in New Jersey.[80]

Manufacturer Perspectives

Representing Novartis Pharmaceuticals Corporation, manufacturer of Ritalin, Rama Seshamani, M.D., executive director, Product Information, and Ron Califre, senior vice president, Research & Development, and head, U.S. Operations, addressed the joint subcommittee regarding the use of Ritalin in other countries; pilot Ritalin studies providing compensation for participation; Ritalin patent information; and primary sources for Ritalin abuse and diversion.

Novartis has not participated in a direct-to-consumer advertising campaign for Ritalin. In addition, Novartis does not support payment to individuals participating in clinical trials. Patient benefits for participation may, however, include a comprehensive medical evaluation and free treatment as well as a high level of personal attention and monitoring. Nominal reimbursement may sometimes be provided for travel and time; an independent ethics committee must approve these. The amount cannot be calculated to serve as an inducement to participation; a review of reimbursement of Ritalin studies indicated an average of less than $20 per visit, with most participants receiving no funding.

Increased treatment of ADHD in the last decade has been attributed to increased awareness of the condition, better diagnostic criteria and treatment guidelines, more diagnoses among adults and girls, and increased compliance with one-a-day treatments. A 1996 study indicated that students typically remain on methylphenidate into mid- and later secondary school grades. A 1998 study released by the Journal of the American Medical Association indicated "little evidence" of over-diagnosis or prescribing for ADHD; corroborating this finding was a 1999 report in the *New England Journal of Medicine*, indicating that ADHD may be "under-treated." The U.S. Surgeon General's National Action Agenda, released in early 2001, estimated that fewer than one in five children receive the treatment needed for mental illness (including ADHD).

The worldwide prevalence of ADHD is fairly consistent at four to five percent; this figure has not changed considerably over time. However, higher numbers are indicated for school-aged children in the United States, Germany and New Zealand. An estimated 70 percent of American children with ADHD are actually diagnosed, with 75 percent of these treated with medication. In contrast, only 26 percent of European children with ADHD are diagnosed, with 46 percent of these receiving medication.

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[79]Waters and Krauss, LLP, "Ritalin Fraud," *Hernandez, Plaintiff, Individually and on Behalf of all Others Similarly Situated v. Ciba Geigy Corporation, U.S.A., Novartis Pharmaceuticals Corporation, Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD), and the American Psychiatric Association* <http://ritalinfraud.com/>

[80]October 30, 2001, Meeting Summary.

These different prevalences may be attributed to differing medical practice guidelines, availability of care, and reimbursement issues.

Ritalin Usage and Sales Outside the U.S.--A View of 8 Countries (1997-2000)

Netherlands	573% increase
German	292% increase
Mexico	200% increase
Brazil	127% increase
United Kingdom	123% increase
South Africa	31% increase
Canada	24% increase*
Australia	0% increase**

*Two generics launched in Canada.

** From 1991-1998, Ritalin Rxs in Australia increased 620% in 1991-1998; Rxs for dexamphetamine increased 2,400%.

To reduce Ritalin diversion and abuse, Novartis reconciles batch yields and conducts annual inventories. Cameras, sealed trucks, and full-time controlled substance officers are also used. The development of new one-a-day treatments will reduce the need for mid-day dosing at school, and educational programs targeting youths, such as Be SMART (Safe Medication And Responsible Treatment) and the 3 R's of Ritalin--Read, Respect, Responsibility--were designed to reduce abuse and diversion.[81]

IDEA and ADHD

Public school students diagnosed with ADHD are eligible for special education under the Individuals with Disabilities Education Act (IDEA). During the 1991 reauthorization of the Act, Congress considered adding ADHD as a specific disability, but declined to do so. The effect of the statute, however, as interpreted by a 1991 Department of Education memorandum, nonetheless was to permit children with ADHD--under the category of "other health impaired"--to obtain special education if the particular student's impairment was consistent with "chronic or acute impairments that results in limited alertness which adversely affects educational performance."[82] In addition, children with ADHD who were not necessarily eligible for special education under IDEA might be entitled to services under Section 504 of the Rehabilitation Act of 1973.[83]

Revisions to the Act in 1997 and subsequent corresponding regulations clarified the Department's 1991 interpretation. Regulations were amended to specifically name ADD and ADHD as conditions that might render a child eligible for special education

[81]October 30, 2001, Meeting Summary.

[82]*ADHD*, supra note 2, at 20; U.S. Department of Education, Office of Special Education and Rehabilitative Service, Assistant Secretary Memorandum, Clarification of Policy to Address the Needs of Children with Attention Deficit Disorders within General and/or Special Education (September 16, 1991)<http://www.add.org/content/legal/memo/htm>[hereinafter referred to as *DOE Memo*].

[83]*DOE Memo, supra.*

under "other health impairment" within the definition of "child with a disability" who, by reason of such disability, requires special education and related services. The regulations now provide that "other health impairment" means "having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that—

> (i) Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and
>
> (ii) Adversely affects a child's educational performance."[84]

Special education services are recommended for certain severe cases, as it may "provide a smaller, less competitive and more supportive environment in which the child can receive individual instruction."[85] Recommended accommodations may include providing a low-distraction work area, allowing space and mobility for the hyperactive student, preparing the student for daily shifts in activities, providing assignments and instructions in brief steps, offering alternative testing formats, and providing weekly course syllabi and lesson outlines.[86] Experts suggest that special services be designed to promote self-sufficiency and to facilitate functioning outside a special program.[87]

ADHD and Public Education in Virginia

Focus on attention deficit hyperactivity disorder as a major educational and developmental concern for Virginia students has been evidenced in various legislative and executive branch actions in recent years. Recognizing "the need to ensure that children with ADD receive a quality education appropriate to their learning styles and developmental levels" and growing concerns about the use of Ritalin to treat these children, the 1990 Session of the General Assembly adopted HJR 146, requesting the Departments of Health Professions, Mental Health, Mental Retardation, and Substance Abuse Services, and Education to "study jointly the effects of the use of methylphenidate."[88] The Departments' 1991 report found "no evidence of widespread abuse or diversion of methylphenidate in the Commonwealth, but dramatic increases in distribution of the drug to retail outlets over the last decade, and isolated incidents of

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[84]U.S. Department of Education, Office of Special Education and Rehabilitative Service, IDEA '97 Regulations, IDEAs that Work, "Children with ADD/ADHD" (March 1999)<http://www.ed.gov/offices/OSERS/IDEA/Brief-6.html; 34 C.F.R. § 300.7 <http://www.ideapractices.org/regs/definitionsmain.htm>

[85]Barkley, *supra* note 1.

[86]Booth, R., *List of Appropriate School-based Accommodations and Interventions for a 504 Plan or for Adaptations and Modifications of an IEP* (1998) <http://add. org/content/school/list.htm>[hereinafter referred to as Booth].

[87]Barkley, *supra* note 1; Booth, *supra*.

[88]1990 Acts of Assembly, HJR 146 (1990).

abuse or diversion create cause for some concern."[89] A task force appointed by the Departments to conduct the study recommended "best practices" to enhance educational services for children with ADHD; among these practices were a requested Department of Education survey to "determine the prevalence of ADHD among school children and the use of methylphenidate, the availability of medical personnel in each school to administer and track information regarding ADHD medication, improved communication between physicians and educators regarding Ritalin use by students, and school nurse "leadership in coordinating health and related services for ADHD students, including the administration of medications."[90]

Although the Commonwealth currently does not specifically track the numbers of public school students diagnosed with ADHD, Department of Education data for the 1998-1999 school year indicate that a total of 9,414 students were designated as "other health impaired," a categorization that embraces some children diagnosed with ADHD. It is important to note, however, that this figure includes children who have been diagnosed with a range of other impairments, and does not include those children with ADHD whose condition does not warrant special education services.

H. Douglas Cox, assistant superintendent, Instructional Support Services, Virginia Department of Education, stated that while medication for ADHD does not "cure the disorder," it removes barriers to learning. Noting that medication for ADHD may be seen as part of a comprehensive management plan, he emphasized family, school, and physician communication in addressing the disorder.[91]

STATE SUMMARY - AS OF DECEMBER 1, 1998:
Students Reported as "Other Health Impaired"

(8VAC20-80-10: "Other health impairment" means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that (i) is due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, arthritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, **attention deficit disorder or attention deficit hyperactivity disorder**, and diabetes; and (ii) adversely affects a child's educational performance.")

Age 3	**Age 4**	**Age 5**	**Age 6**	**Age 7**	**Age 8**	**Age 9**
17	21	71	198	383	751	1,009
Age 10	**Age 11**	**Age 12**	**Age 13**	**Age 14**	**Age 15**	**Age 16**
1,134	1,125	1,001	968	814	645	571
Age 17	**Age 18**	**Age 19**	**Age 20**	**Age 21**	**Age 22+**	**Total**
429	219	42	13	2	1	9,414

Source: Virginia Department of Education, Report of Children and Youth with Disabilities Receiving Special Education, Part B, Individuals with Disabilities Education Act, 1998-1999 School Year, Totals--as of December 1, 1998 (July 20, 1999) <http://www.pen.k12.va.us/VDOE/Publications/SPED_child_count/total98.html>

[89]Final Report of the Virginia Departments of Education, Health Professions, Mental Health, Mental Retardation and Substance Abuse Services on the Effects and Use of Methylphenidate, *House Document No. 28* at iv (1991)[hereinafter referred to as *HD 28*].
[90]*HD 28*, *supra*, at v, vi.
[91]August 28, 2001, Meeting Summary.

Teacher Training. Training in attention deficit disorder is a requirement for teacher licensure in the Commonwealth, pursuant to legislation adopted in 1996.[92] Board of Education licensure regulations include within professional studies requirements for early/primary education, elementary education, and middle education a total of three semester hours in "human growth and development (birth through adolescence), which is to embrace "skills contributing to an understanding of developmental disabilities and developmental issues related to but not limited to attention deficit disorders, substance abuse, child abuse, and family disruptions." Similar requirements are set forth for professional studies for adult education, preK-12 endorsements, special education, and secondary grades six through 12 endorsements and for special education endorsement in learning disabilities.[93]

Dispensing of Medications in the Commonwealth's Public Schools. The Standards of Quality require school divisions to provide student attendance and health services as among "those support services which are necessary for the efficient and cost-effective operation and maintenance of its public schools...."[94] Schools are authorized, but are not required, to employ school nurses, physicians, physical therapists, occupational therapists and speech therapists. The Code of Virginia provides aspirational ratios for the employment of school nurses: "at least one nurse (i) per 2,500 students by July 1, 1996; (ii) per 2,000 students by July 1, 1997; (iii) per 1,500 students by July 1, 1998; and (iv) per 1,000 students by July 1, 1999."[95]

Statute further provides that, with the exception of school administrative personnel and persons employed by school boards who have the specific duty to deliver health-related services--those services that, if performed in a health facility, would have to be delivered by licensed or certified personnel--licensed instructional employees, instructional aides, and clerical employees cannot be disciplined, placed on probation or dismissed for refusal to perform nonemergency health-related services for students. The Code clearly states, however, that instructional aides and clerical employees may not refuse to dispense oral medications.[96] While school nurses and other school personnel may administer medications; however, four school divisions--Rockbridge, Mecklenburg, Lee, and Buena Vista--do not have school nurses. Statewide, 970 school nurses serve 1.2 million public school students. [97]

The Code of Virginia does not prohibit student possession and administration of their own prescription medications at school. School board policies have typically governed possession and administration of student medications; this is not, however, clearly delineated in statute. School boards may prohibit student possession of their own prescription medications, and anecdotal evidence suggests that many do. The *Virginia*

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[92]Va. Code § 22.1-298 (2000); 1996 Acts of Assembly, c. 197.
[93]8VAC20-21-120 < http://legl.state.va.us/cgi-bin/legp504.exe?000+reg+8VAC20-21-120>; 8VAC20-21-170, <http://legl.state.va.us/cgi-bin/legp504.exe?000+reg+8VAC20-21-170>; 8VAC20-21-434<http://legl.state.va.us/cgi-bin/legp504.exe?000+reg+8VAC20-21-434> (updated through February 12, 2001).
[94]Va. Code § 22.1-253.13:2 (2000).
[95]Va. Code § 22.1-274 (2000).
[96]Va. Code § 22.1-274 D (2000).
[97]October 30, 2001, Meeting Summary.

School Health Guidelines, promulgated by the Department of Health in collaboration with the Department of Education, corroborate this authority, noting that "many school divisions do not allow self-administration of medication except under special circumstances with a physician's order and under the supervision of the school nurse, principal or the principal's designee."[98]

The *Guidelines for Specialized Health Care Procedures*, issued in 1996 by the Virginia Department of Health in collaboration with the Department of Education, address administration of medications in Virginia public schools. More specifically, legislation adopted by the 2000 Session of the General Assembly provided that the Drug Control Act allows persons to administer drugs to students in Virginia public schools in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security, and record keeping, when the drugs would normally be self-administered by the student. Training for such persons must be accomplished through a program approved by the local school boards, in consultation with local departments of health. Recent statutory provisions require school board policies permitting self-administration of inhaled asthma medications and also address administration of glucagon to diabetic students.[99]

A training manual developed by the Department of Education, in collaboration with the Department of Health, offers guidelines for this training of unlicensed assistive personnel, such as health assistants, instructional assistants, secretaries, teachers, and principals' designees. The guidelines address training of personnel by a registered school nurse; encourage medication administration at home, especially the first dose; urge written authorization of prescription medication with detailed patient, dispensing, and handling instructions; provide for obtaining and renewing parental consent; detail medication container requirements; and provide for counting, securing, storing, retrieving, and destroying medications.[100] The *Virginia School Health Guidelines* recommend that a two-week supply or less (unless administered daily throughout the year) should be kept in "an appropriately labeled container which is locked and secured in a designated space (e.g. a locked box stored within a locked cabinet)."[101]

Testimony of Department of Education representatives indicated that most school divisions have policies requesting parents to bring student prescription and non-prescription medicines to school. If the student brings the medication, it must be delivered to school personnel upon the student's arrival. The student then reports to school personnel for the medication to be administered.

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[98]Virginia Department of Education, *Virginia School Health Guidelines*, "General Guidelines for Administering Medications in School" at 259 (May 1999)[hereinafter referred to as *School Health Guidelines*].

[99]Va. Code §§ 54.1-3408 (2001 Supp.); 22.1-274.2; 22.1-274 E (2000).

[100]August 28, 2001, Meeting Summary.

[101]*School Health Guidelines*, *supra* note 98, at 258.

Testimony from Hanover Public Schools nursing staff detailed the division's "double-locked system"; medications are counted weekly, with the total noted on the student's record. Parents must sign permission forms and transport the medication to school; high school students may bring their own medications. Ideally, the parent and the nurse count the pills together upon arrival. Unlicensed personnel are dispensing medications, but these individuals have had medical training. Department of Education dispensing guidelines are posted in the clinic.[102]

The School's Role in Diagnosis and Evaluation Procedures. Department of Education testimony confirmed that diagnosis of the need for medication for the management of ADHD can only be made by licensed physicians or nurse practitioners; school personnel are not licensed to make this judgement. Assessment of ADHD is best conducted by a multidisciplinary team that includes the student's physician, neurologist, psychologist, educators, nurses, and other specialists.

A 1990 Department of Education Task Force Report on ADHD and public schools noted controversy in public schools nationwide regarding parent perceptions of being forced by school personnel to obtain medication for their children. The report clearly stated that "it is critical that personnel in schools recognize that the medical diagnosis of ADHD, and the prescription of drugs such as Ritalin, are appropriately to be left in the hands of trained physicians." Should educators perceive behavior that impairs a student's learning, in the case of special education, the school might request a medical examination for the particular student. The student's IEP team, which includes the parent, determines the course of action for the child.[103]

Also noted by the joint subcommittee were recent statutes in other states addressing the involvement of educators and public schools in prescribing psychotropic medications for students. Minnesota has recently adopted a statute prohibiting conditioning readmission to school conditioned on use of these medications. The Connecticut legislature has enacted a bill calling for local school board policies to prohibit personnel from recommending treatment by psychotropic drugs. Similar legislation has been considered in Arizona, New Jersey, New Jersey, and Oregon.[104]

Survey: Students Receiving ADHD Medications in Public School. In response to a Department of Education survey conducted in September 2001 regarding numbers of students receiving medication at school for ADHD, 129 school divisions, representing 94.5 percent of Virginia's public school population and a 95.5 percent survey response rate, indicated that 16,521 students--or 1.52 percent of the student population--received ADHD medication at school in 2000-2001. Of these students, 55 percent receive Ritalin; 45 percent are receiving other ADHD medication, such as Adderall, Catapres, Cylert, Desedrine, Norpramine, Pamelor, Tofranil, Wellbutrin, or other drugs. These numbers are not indicative of the numbers of public school children with ADHD, as some children may not be receiving medication or may be taking medication at home.

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[102]October 30, 2001, Meeting Summary.
[103]October 30, 2001, Meeting Summary.
[104]August 28, 2001, Meeting Summary.

While the survey indicated that children throughout grades K-12 receive ADHD medication at school, grades four and five had the highest rates. The lowest rates were in kindergarten and in grade 12. Boys comprised 76 percent of students receiving ADHD medication at school; students with disabilities accounted for 59 percent of pupils receiving ADHD medication at school. The survey found no significant statistical differences among racial/ethnic groups receiving ADHD medication at school.

Students Receiving ADHD Medication at School
Department of Education Survey--September 2001

	Number	Racial/Ethnic Group Receiving Medication as Percentage of Racial/Ethnic Group as Whole
White	12, 043	1.74%
Black	4,018	1.36%
Hispanic	298	0.56%
Asian	114	0.25%
American Indian/Alaska Native	48	1.57%
All Students	**16,521**	**1.52%**

Reporting of Prescription Thefts at School. Testimony from one school division indicated only two incidents of medications stolen from the division's locked system; the principal decides whether to report a medication theft to law enforcement. These incidents are treated as property thefts.

School principals are statutorily required to report criminal conduct involving alcohol and controlled substances--such as theft of prescription medications--to law-enforcement agencies.[105] The Department's September 2001 survey indicated thefts of medications had occurred at school; about half of the responding school divisions indicated they have no policy or procedure regarding stolen medications.

Superintendent's Memorandum No. 158, dated October 26, 2001, encouraged school divisions to "review their current policies and procedures regarding the storage, maintenance, and administration of medications." Citing the work of the HJR 660 joint subcommittee, the Memorandum noted as helpful resources the *Virginia School Health Guidelines* as well as *The Manual for the Training of Public School Employees in the Administration of Medication* (Virginia Department of Education, September 2000). The Memorandum cited drug infraction reporting requirements and statutory immunity for school personnel "investigating or reporting alcohol or drug use or disclosure of related activities."[106] Finally, the Memorandum recommended that "school and law enforcement officials work together to determine the best procedures for referrals."

[105]Va. Code § 22.1-279.3:1 (2001 Supp.).
[106]Va. Code § 8.01-47 (2001 Supp.).

The Department of Education does not collect data regarding the ages of students most likely to be threatened for their ADHD prescriptions. Virginia crime and violence data for 1999-2000 indicate that middle school students are most likely to be threatened; it is perhaps likely then that threats for medication might also be higher in these grades.[107]

Prevalence of ADHD Diagnoses in Southeast Virginia. Gretchen B. LeFever, Ph.D., associate professor, Pediatrics and Psychiatry, Center for Pediatric Research, Norfolk, addressed the subcommittee regarding the prevalence and impact of ADHD in Southeast Virginia; intervention and prevention initiatives to reduce severity of ADHD in public school setting; and medical management of children with ADHD, as well as perspectives regarding other committee study directives. Dr. LeFever noted that some school personnel fail to honor the Department of Education policy regarding the impropriety of school officials proffering ADHD diagnoses. Noting that Ritalin is no longer the drug of choice for the treatment of ADHD, she noted that more pharmaceuticals dispensed in schools target mental health disorders; half of these medications are for ADHD.

Virginia ranks in the highest quartile in the nation for Ritalin prescription; within the Commonwealth, higher concentrations are seen in Tidewater, Richmond, and Northern Virginia. The Center for Pediatric Research has examined Portsmouth and Virginia Beach students receiving Ritalin in public schools. The Center's study indicates that eight to 10 percent of elementary school students in these divisions are getting Ritalin at school--a rate two to three times higher than national estimates. Black girls are least likely to be diagnosed and treated, and white boys are most likely to be diagnosed and treated. Contending that ADHD is over-diagnosed and over-treated in the region and perhaps in 36 states, Dr. LeFever noted that the treated students continue to struggle academically.

ADHD Treatment Effectiveness Questions

	Students Without ADHD	Students With ADHD
% More than 5 days absent	12	30
% Repeat grades	14	35
% Special education	13	43
% Expelled or suspended	15	56

Evidencing possible premature diagnoses is the fact that more than half of students were diagnosed by the first grade; 28 percent of the Portsmouth and Virginia Beach elementary school students receive two or more psychotropic drugs. Also cited were the efforts of the School Health Initiative for Education (SHINE) in facilitating understanding of ADHD issues in Southeastern Virginia. Dr. LeFever recommended a statewide epidemiological study be conducted by researchers with public health expertise to examine Ritalin use and ADHD diagnosis in the Commonwealth.[108]

[107]October 30, 2001, Meeting Summary.
[108]October 30, 2001, Meeting Summary.

III. OxyContin Use and Diversion

In addition to exploring Ritalin abuse, the resolution also directs the joint subcommittee to examine the abuse and diversion of OxyContin in the Commonwealth. Specifically, the joint subcommittee is to "ascertain the number of such prescriptions [for OxyContin and Ritalin] for the last five years to determine the rate of increase or decrease, and the cause of any increase in the number of such prescriptions; (xii) determine if Ritalin and OxyContin have been diverted to the street drug trade, and if so, assess the demand for Ritalin and OxyContin as street drugs in Virginia; (xiii) establish whether the use of Ritalin or OxyContin for non-medical purposes is a problem among school-aged children and college students in the Commonwealth; (xiv) consider and explore such other issues as the joint subcommittee may determine pertinent; and (xv) recommend ways to correct problems associated with the over-prescription and the illegal use, possession, and distribution of Ritalin and OxyContin, as appropriate."

A prescription pain reliever, oycodone hydrochloride is derived through an alkaloid found in opium. Typically prescribed to alleviate pain associated with injuries, cancer, arthritis, and other conditions, oxycodone products include not only OxyContin but also Percocet, Percodan, and Tylox. Oxycodone products act as a central nervous system depressant, yielding responses ranging from simple pain relief to respiratory depression and euphoria. Patients repeatedly using OxyContin may develop a tolerance for the drug, and may be able to consume dosages that would be fatal to other individuals. Patented in 1996, OxyContin boasts a long-lasting effect of 12 hours, clearly surpassing the four- to six-hour relief afforded by Percocet. The medication is usually prescribed in amounts of two to four tablets a day and is available in 10, 20, 40, 80, and 160 milligrams.[109]

Representing Purdue Pharma, LP, manufacturer of OxyContin, Sidney H. Schnoll, M.D., Ph.D., medical director, Health Policy, reported to the joint subcommittee that about eight million OxyContin prescriptions were dispensed last year; the drug is Purdue Pharma's top-selling medication. Citing recent headlines regarding illegal use of prescription drugs, Dr. Schnoll differentiated addiction, physical dependence, and drug tolerance. Defined as a "primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations," addiction is characterized by behaviors such as compulsive or impaired control of drug use, craving, and continued use despite harm. Physical dependence is a "state of adaptation that is manifested by a drug class specific withdrawal syndrome...produced by

[109]National Drug Intelligence Center, Information Bulletin, *OxyContin Diversion and Abuse* (January 2001) <http://www.usdoj.gov/ndic/pubs/651/index.htm#Contents>[hereinafter referred to as NDIC]; see also, Kalb, C., "Playing with Pain Killers," *Newsweek* 45 at 46 (April 9, 2001)[hereinafter referred to as Kalb].

abrupt cessation, rapid dose reduction, decreasing blood levels of the drug, and/or administration of an antagonist." In contrast, tolerance is a state of adaptation in which "exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time."

Oxycodone, contained in OxyContin, is an oral opioid painkiller that has better bioavailability--a better absorption rate in the body--than does morphine. In treating pain, physicians strive to prescribe the minimum effective analgesic concentration (MEAC) for the patient, to ensure a sustained level of pain reliever in the bloodstream. The MEAC is influenced by the drug itself, the patient, and the pain intensity.[110]

Illegal Use of Oxycodone Products

With increased emphasis on legitimate pain management within the medical profession, sales of painkillers rose to $1.8 billion in 2000, having tripled since 1996. Studies indicate a corresponding painkiller abuse over the same period. Although specific data is admittedly scarce, a 1999 estimate reported that four million Americans used painkillers in the last month for "nonmedical" purposes. The statistic divides first-time and repeated abusers in nearly equal portions. The Drug Enforcement Administration (DEA) places oxycodone and similar drugs among those most frequently abused.[111] While an April 2000 report of the Journal of the American Medical Association (JAMA) indicated a 23 percent increase in "the medical use of oxycodone with no corresponding increase in the illicit abuse of the drug," 1998 data from the Drug Abuse Warning Network (DAWN) Medical Examiner (ME) showed a 93 percent increase in oxycodone "mentions" between 1997 and 1998.[112] Consistent with these findings are DEA Diversion Control Program resources indicating that the "estimated number of emergency department episodes involving oxycodone were stable from 1990 through 1996. However, the number of ED episodes doubled from 1996 to 1999: 3,190 episodes in 1996 to 6,429 in 1999."[113] These numbers increased again from 3,369 in the first half of 1999 to 5,261 in the first half of 2000, according to DAWN statistics presented by the President's Office of National Drug Control Policy.[114]

Rural communities--primarily in Maine, Massachusetts, Kentucky, Ohio, Virginia, and West Virginia--were the first to witness marked abuse of OxyContin.[115]

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[110]October 30, 2001, Meeting Summary.
[111]Kalb, *supra*, at 45, 46.
[112]NDIC, *supra* note 109.
[113]U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Program, *Drugs and Chemicals of Concern: Oxycodone* <http://www.deadiversion.usdoj.gov/drugs_concern/oxycodone.htm>
[114]Executive Office of the President, Office of National Drug Control Policy, *Drug Policy Information Clearinghouse Fact Sheet--OxyContin* < http://www.whitehousedrugpolicy.gov/drugfact/oxycontin/index.html>
[115]Media Awareness Project, "OxyContin--Bad Medicine?" (March 25, 2001) <http://www.mapinc.org/drugnews/v01/n525/a06.html?136>; *see also*, Diversion Control Program, Drug Enforcement Administration, U.S. Department of Justice, "Drugs and Chemicals of Concern--Oxycodone" <http://www.deadiversion.usdoj.gov:80/drugs_concern/oxycodone.htm>; Executive Office of the President, Office of National Drug Control Policy, *Pulse Check: Trends in Drug Abuse Mid-Year 2000* at 2 (March 2001).

Deaths from OxyContin overdoses have been reported in the past three years across the country; Pike County, Kentucky, reported 19 such deaths in the year 2000 alone. Similarly, four fatal OxyContin overdoses have occurred in Pulaski, Virginia, since 1998, and five since May 2000 in southwestern West Virginia. In April 2001, Virginia officials were reported as attributing estimate at least 28 deaths due to OxyContin abuse in the past two years.

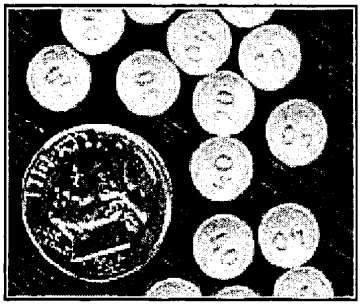
OxyContin Tablet Prices

Cincinnati Police Department Pharmaceutical Diversion Squad, November 2000

Strength	Licit Retail Price per Tablet	Illicit Retail Price per Tablet
10 mg	$1.25	$5 to $10
20 mg	$2.30	$10 to $20
40 mg	$4.00	$25 to $40
80 mg	$6.00	$65 to $80
160	$14.00	unknown

Source: National Drug Intelligence Center, Information Bulletin, *OxyContin Diversion and Abuse* (January 2001) <http://www.usdoj.gov/ ndic/pubs/651/index.htm#Contents>; *see also*, U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Program, *Drugs and Chemicals of Concern: Oxycodone* <http://www.deadiversion.usdoj.gov/drugs_concern/oxycodone.htm>

Also associated with OxyContin abuse are crimes such as pharmacy thefts, shoplifting, and health care fraud. The Pulaski County, Virginia, police chief noted in October 2000 that 90 percent of all thefts and shoplifting were related to OxyContin diversion; that same month, Tazewell County prosecutors reported OxyContin-related felony charges against 150 individuals.[116]



Abuse of OxyContin may be facilitated in part by its potency, effectiveness, and available dosages.[117] Abusers may practice "doctor shopping" or obtain drugs through a street market; physicians may fraudulently prescribe.[118] OxyContin pills may be crushed and snorted, or dissolved in water and injected, with either method hastening absorption and offering the user a "heroin-like" high.[119] Testimony before the joint subcommittee cited the chilling effect of OxyContin on legitimate prescribing of the medication, and the insufficient availability of methadone treatment centers for opioid abusers. The unique geographic distribution of OxyContin abuse--Maine, Southwest Virginia, and Kentucky--has been attributed to high rates of poverty, higher concentrations of persons on Medicaid, and use by persons with prior history of drug abuse.[120]

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[116]NDIC, *supra* note 109; "Second teen faces OxyContin count," *Richmond Times-Dispatch* (April 10, 2001).

[117]NDIC, *supra* note 109.

[118]Kalb, *supra* note 109, at 47; NDIC, *supra* note 109.

[119]*Id.* at 46; Rosenberg, D., How One Town Got Hooked," *Newsweek* 48 (April 9, 2001)[hereinafter referred to as Rosenberg]; NDIC, *supra* note 109; Kalb, C., "Painkiller Crackdown," *Newsweek* 38 (May 14, 2001) [hereinafter referred to as *Crackdown*].

[120]October 30, 2001, Meeting Summary.

Regulation of OxyContin

The Federal Comprehensive Drug Abuse Prevention and Control Act designates OxyContin as a "Schedule II drug"--indicating a "high potential for abuse." Interestingly, because penalties for diversion of Schedule II drugs are linked to tablet weight rather than potency, persons illegally distributing less powerful but heavier weight painkillers such as Percocet may receive harsher penalties.[121] According to an April 2001 *Newsweek* report, 17 states now monitor prescriptions.[122]

Prescribing Practices. Prescriptive authority remains a primary mode of regulating medication dispensing in the Commonwealth. Professions licensed by the Board of Medicine and having prescriptive authority include doctors of medicine and surgery, doctors of osteopathy and surgery, doctors of podiatry, and physician assistants. Nurse practitioners, regulated by the Boards of Nursing and Medicine, also possess prescriptive authority. Dentists, veterinarians, and some optometrists also have this authority. Prescriptive authority is not unfettered among these professionals; nurse practitioners and physician assistants cannot prescribe Schedule II drugs, such as Ritalin and OxyContin. Only doctors of medicine, osteopathy, and podiatry, dentists, and veterinarians may prescribe Schedule II drugs.

Statutes govern prescribing procedures, requiring a bona fide practitioner-patient relationship and setting forth prescription formats. Statutes and regulations address unprofessional conduct. Prescriptions for Schedule II drugs cannot be refilled; rather, a new prescription must be obtained. These prescriptions cannot be filled more than six months beyond the date of issue. Partial filling is permissible only if a full supply is not available; further filling may occur upon the passage of 72 hours and the issuance of a new prescription. Pharmacists may dispense a small amount of a Schedule II in an emergency, upon the practitioner's oral authorization. A written prescription must be provided in seven days.

The Board of Medicine receives complaints about its licensees, some involving excessive or inappropriate prescribing practices. Ritalin and OxyContin have been named in such complaints, typically in combination with other medications. In addition to criminal penalties, professionals abusing prescriptive authority may also be subject to license revocation.[123]

Virginia Law-Enforcement Initiatives. Testimony before the joint subcommittee confirmed the Commonwealth's efforts to curb prescription drug diversion and abuse. Col. W. Gerald Massengill, superintendent, Virginia State Police, described the work of the Drug Diversion Unit (DDU), initially created with state and federal funds in 1987 as the Pharmaceutical Diversion Investigative Unit within the Virginia State Police. The unit's mission has been the statewide investigation of criminal diversion of

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[121]Kalb, *supra* note 109, at 47; NDIC, *supra* note 109.
[122]Kalb, *supra* note 109, at 47.
[123]October 30, 2001, Meeting Summary.

drugs; the establishment of a database to assist in identifying the breadth of diversion activities; and the education of health care professionals, law-enforcement personnel, and the public regarding illegal drugs. The State Police now fund the unit.

Citing the regulatory role of the Department of Health Professions addressing excessive prescribing practices as well as the law-enforcement responsibilities of the State Police regarding illegal prescribing, Col. Massengill noted that the diversion of Ritalin and OxyContin continue to be "a problem in Virginia." Diversion of Ritalin, however, is far less prevalent than diversion of OxyContin. Noting increased Ritalin production and numbers of ADHD diagnoses, he reported that the DDU received three complaints of Ritalin diversion in 1998. These complaints increased to nine in 1999 and fell to seven in 2000. To date, the DDU has received eight such complaints in 2001. Diversion is primarily accomplished by "doctor shopping" to obtain multiple prescriptions for subsequent use or sale to others, or by adult patients obtaining an ADHD diagnosis through deception.[124]

According to the Virginia State Police, OxyContin diversion is primarily achieved through "doctor shopping" and physician over-prescribing. In addition, instances of importing from Mexico or Canada, forged or altered prescriptions, and travel to neighboring North Carolina or from West Virginia and Kentucky to Virginia to obtain prescriptions have been reported.

Like the Task Force on Prescription Drug Abuse, the State Police cited the value of a prescription drug-monitoring program. Already in effect in 17 states, these initiatives can protect patient privacy and ensure legitimate access to prescription medications while tracking physician, pharmacy, and patient information and providing information access to doctors as well as law-enforcement personnel.

Also recommended was increasing the penalty for distribution of Schedule III and IV substances from misdemeanor to felony. While fraudulently obtaining these drugs is a felony, distribution remains a misdemeanor. Additional recommendations included requiring photo identification for obtaining Schedule II drugs (such as Ritalin or OxyContin); ensuring that any legislation addresses a class or Schedule of drugs, rather than particular product names; and enhancing resources for the DDU, which currently employs only 16 agents statewide.

Briefly cited were existing consequences for drug diversion and abuse in Virginia. In addition to a range of criminal penalties for possession and distribution of Schedule II drugs such as OxyContin and Ritalin, the Code of Virginia also contemplates license revocation for inappropriate prescribing or dispensing practices by physicians and pharmacists, respectively. Students adjudicated delinquent or guilty of a crime for which a report of adjudication must be forwarded to the division superintendent--crimes including the manufacture, sale, distribution or possession of a Schedule II controlled substance (such as OxyContin)--may be suspended or expelled. Reports must be made to school principals regarding any conduct involving controlled substances on a school bus,

[124]August 28, 2001, Meeting Summary.

on school property, or at a school-sponsored activity. In addition, principals are to report to local law-enforcement officials those incidents that would constitute a criminal offense. Students committing these "reportable incidents" may be required to participate in prevention and intervention initiatives.[125]

Virginia State Police Superintendent Col. W. Gerald Massengill, describing drug diversion awareness and prevention issues in the Commonwealth generally, reported that the State Police Drug Diversion Unit makes one arrest every 2.1 days; increased funding is needed to support additional law-enforcement personnel. Identified as key components of abuse prevention were education of health professionals, patients, and communities; public awareness and support for accessible addiction treatment; and law enforcement. Briefly reviewed were the efforts of Operation Octagon, involving eight agencies, including the Office of the Attorney General, the FBI, DEA, IRS, and Virginia State Police; the initiative investigates various drug, insurance, Medicaid fraud, and other violations.[126]

Virginia Attorney General's Task Force on Prescription Drug Abuse. Created in March 2001 by then-Attorney General Mark Earley, the 35-member Task Force on Prescription Drug Abuse was to address the rising problem of abuse of OxyContin in Southwest Virginia. Comprised of doctors, health care consumers, a pain management specialist, pharmacists and pharmaceutical companies, rehabilitation experts, and state and local law-enforcement officials, the task force met in Abingdon in May and August in Roanoke. The task force is expected to issue its report in fall 2001.

The task force is exploring the implementation of a prescription monitoring program (PMP) to curb "doctor shopping" and diversion of controlled substances; the feasibility and appropriateness of requiring the use of tamper-resistant pads for these prescriptions; various sentencing recommendations; and education, prevention, and rehabilitation initiatives. In addition, Purdue Pharma and the Office of the Attorney General will work collaboratively in a "Class Action" initiative to educate parents and students regarding the dangers of "designer" drugs.

Representatives of the Office of the Attorney General reported 55 oxycodone-related deaths in Virginia; many of these deaths are attributed to suicide, and that the victims are most often middle-aged, white females. Victims also typically present alcohol or other drugs in the system, in addition to the oxycodone. Consistent with national trends, OxyContin abuse in Virginia is clustered in rural, mountainous areas. However, while Southwest Virginia has witnessed much of the abuse, there is increasing evidence that the problem may be waning in that region--perhaps due to arrests and convictions--and escalating in Northern Virginia.[127]

Manufacturer Initiatives. A March 2001 meeting between Purdue Pharma, the manufacturer of OxyContin, and the DEA yielded a *10-Point Plan to Reduce*

[125]August 28, 2001, Meeting Summary.
[126]October 30, 01 Meeting Summary.
[127]August 28, 2001, Meeting Summary.

Prescription Drug Abuse released in May 2001. Targeted within the Plan are the dissemination of educational brochures to physicians and pharmacists; the distribution of "tamper-resistant prescription pads" to Alabama, Maine, and Virginia doctors, with ultimate expansion to "all states where the diversion of OxyContin is a public health problem"; and support for a study of "best practices in state prescription monitoring programs" with the goal of developing a national model.[128] In addition, Purdue Pharma is working with the Virginia Attorney General to co-sponsor continuing medical education regarding OxyContin abuse for physicians in southwest Virginia. The DEA also designed an initiative specifically designed to reduce OxyContin abuse.[129]

In addressing the potential diversion and abuse of OxyContin, Purdue Pharma has also developed non-promotional continuing medical education programs addressing pain assessment and treatment. Drug abuse and diversion information has been disseminated to 500,000 physicians and 60,000 pharmacists; drug education and prevention programs target youth. In addition, Purdue Pharma is involved in a study of prescription monitoring programs and is also coordinating with state Attorneys General. Tamper-resistant prescription pads have also been developed; an "Rx," printed on the reverse of each sheet, "disappears" when rubbed briskly. The word "VOID" will appear on photocopied or scanned sheets.

From Purdue Pharma Statement on DEA Program to Reduce Diversion of OxyContin® Tablets
(May 4, 2001)<http://www.cocensys.com/news/docs/DEA_Statement_050401.htm>

"Purdue Pharma and the DEA agree that:

1. *OxyContin® should only be prescribed to patients where use of an opioid is appropriate for moderate to severe pain lasting more than a few days.*

2. *OxyContin® should only be prescribed by physicians who are knowledgeable about the use of opioids in the treatment of pain.*

3. *None of the efforts to reduce abuse and diversion should interfere with the ability of patients in pain to receive OxyContin® Tablets for appropriate medical uses."*

Abuse-resistant medications are also being explored. Ideally, the addition of any abuse antagonists to opioid medications should not interfere with drug efficacy and should be designed to block all routes of abuse. The antagonists should not prompt withdrawal symptoms in patients legitimately taking the medication, must be stable in preparation, and, ultimately, approvable by the Food and Drug Administration.[130]

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[128]Purdue Pharma, *Purdue Pharma Statement on DEA Program to Reduce Diversion of OxyContin® Tablets* (May 4, 2001)<http://www.cocensys.com/news/docs/DEA_Statement_050401.htm>; *see also, Crackdown, supra* note 119.

[129]Purdue Pharma, *Frequently Asked Questions About the Illegal Abuse and Diversion of OxyContin® Tablets*(March 26, 2001)< http://www.cocensys.com/news/docs/Oxy_faqs.htm>; Purdue Pharma, *Purdue Pharma Announces Programs to Curb Prescription Drug Abuse in Virginia* (March 1, 2001)<http://www.cocensys.com/news/docs/PurduePharma_Statement_010301.htm

[130]October 30, 2001, Meeting Summary.

Additional Efforts. The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) is involved in coordinating with community service boards (CSBs) in Southwest Virginia to enhance substance abuse treatment--particularly for OxyContin abuse--in the region. Ages of region's addicted population vary widely. The area's CSBs have indicated that these individuals have not necessarily had a previous drug addiction. Methadone replacement therapy is seen as the treatment of choice for the region; DMHMRSAS will support a new opioid treatment center in Galax, providing 90-180 days of detoxification to persons referred by a CSB. The center is expected to serve 50-80 persons. While addiction is a marked problem for Southwest Virginia, the region has recently witnessed a reduction in incidents of new abuse.[131]

Regulation of drugs and drug use continues to receive congressional scrutiny as well, as the Drug Abuse Education, Prevention and Treatment Act of 2001 (SB 304) currently resides in the Senate Judiciary Committee. The measure is designed to "reduce illegal drug use and trafficking and to help provide appropriate drug education, prevention, and treatment programs."[132]

Other recent developments include enhanced drug warnings by the Food and Drug Administration and Purdue Pharma; and a request by U.S. Senator John Warner of Virginia for Congressional inquiry into OxyContin abuse.[133]

Penalties for OxyContin Abuse in Virginia

Consistent with the federal model, Virginia's Drug Control Act classifies oxycodone as a Schedule II drug. Abuse of these substances "may lead to severe psychic or physical dependence."[134] Unauthorized transport of Schedule II drugs into the Commonwealth constitutes a felony, punishable by a five- to 40-year sentence, with a minimum of a three-year imprisonment and a fine not to exceed $1,000,000. Subsequent convictions carry a minimum, mandatory term of imprisonment of 10 years "which shall not be suspended in whole or in part and shall be served consecutively with any other sentence."[135]

Other penalties are similarly severe: unauthorized possession of a Schedule I or II drug is classified as a Class 5 felony, punishable by a term of imprisonment of not less than one year and no more than 10 years, or, in the discretion of the jury or the court, a jail term of not more than 12 months and a fine not exceeding $2,500, or both.[136] Unauthorized manufacture, sale, gift, distribution, or possession with intent to manufacture, sell, give or distribute Schedule I or II drugs is punishable by imprisonment for not less than five nor more than 40 years and a fine not exceeding $500,000. Subsequent convictions may result in life imprisonment.[137] Persons convicted of

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[131]October 30, 2001, Meeting Summary.
[132]S. 304, 107th Congress <http://thomas.loc.gov/cgi-bin/query/D?c107:1:./temp/~c107jRKM1i:b0:>
[133]August 28, 2001, Meeting Summary.
[134]Va. Code §§ 54.1-3447; 54.1-3448 (1998 and 2001 Supp.).
[135]Va. Code § 18.2-248.01 (2001 Supp.).
[136]Va. Code §§ 18.2-10; 18.2-250 (2001 Supp.).
[137]Va. Code § 18.2-248 (2001 Supp.).

manufacturing, selling, giving, distributing or possessing with the intent to manufacture, sell, give or distribute a Schedule I or Schedule II controlled substance are not eligible for Virginia's home/electronic incarceration program.[138] Obtaining controlled substances by "fraud, deceit, misrepresentation, embezzlement, or subterfuge; or ... by the forgery or alteration of a prescription or of any written order...[;] the concealment of a material fact; or ... by the use of a false name or the giving of a false address" is punishable as a Class 6 felony, carrying a term of imprisonment from one to five years, or a 12-month jail term and a fine of no more than $2,500.[139]

Additional penalties may include license revocation for inappropriate prescribing or dispensing practices by physicians and pharmacists, respectively.[140] Insurance fraud provisions may also be called into question in cases in which insurance companies have been duped in providing coverage for falsified prescriptions.[141]

Students adjudicated delinquent or guilty of a crime for which a report of adjudication must be forwarded to the division superintendent--crimes including the manufacture, sale, distribution or possession of a Schedule II controlled substance (such as OxyContin)--may be suspended or expelled.[142]

Further aiding in tracking drug infractions--whether involving OxyContin or Ritalin or other substances--is the statutory requirement that reports be made to school principals or designees regarding certain incidents of crime or violence; specifically required to be reported is "any conduct involving alcohol, marijuana, a controlled substance, imitation controlled substance, or an anabolic steroid on a school bus, on school property, or at a school-sponsored activity...."[143] The principal, in turn, must relay all such incidents to the division superintendent, who submits an annual report to the Department of Education. Local school boards may penalize, demote, or dismiss principals who fail to report these incidents. In addition, principals are to "immediately report" to local law-enforcement officials those incidents that would constitute a criminal offense. Students committing these "reportable incidents" may be required to participate in prevention and intervention initiatives included in the division's drug and violence prevention plan as deemed appropriate by the division superintendent.[144]

Finally, monitoring the prescribing of oxycodone products is currently being contemplated, as state law-enforcement officials nationwide are exploring the creation of a database to identify abusers.[145]

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[138]Va. Code § 53.1-131.2 (2001 Supp.).
[139]Va. Code §§ 18.2-10; 18.2-258.1 (2001 Supp.).
[140]Va. Code §§ 54.1-2915; 54.1-2926 (1998).
[141]NDIC, *supra* note 109.
[142]Va. Code § 22.1-277 (2001 Supp.).
[143]Va. Code § 22.1-279.3:1 (2001 Supp.).
[144]*Id.*
[145]NewsChannel 10 (Roanoke, Virginia), "Database may help cut OxyContin abuse" (March 13, 2001) <http://www.wsls.com/news/MGBE7QDR9KC.html>; "OxyContin abuse targeted--Use of database is considered," *Richmond Times-Dispatch* B-4 (May 15, 2001).

IV. ADDITIONAL ISSUES

Prescription Drug Abuse in Virginia Colleges and Universities

Examining whether "the use of Ritalin or OxyContin for non-medical purposes is a problem among school-aged children and college students in the Commonwealth" (Study Directive xiii), the joint subcommittee received testimony from Dr. Sherilyn W. Poole, student affairs director, State Council of Higher Education for Virginia (SCHEV), who commented on the experimentation and exploration that often marks adolescence. Citing increasing alcohol and drug arrests among college students and increased tobacco smoking on campuses, she also noted the mixing of prescription drugs with alcohol. Increased diagnoses of anxiety, depression, and ADHD among college students potentially bring more antidepressants and other medications to campuses. While data regarding abuse is largely anecdotal, one recent study has indicated that 13 percent of high school students have used Ritalin without a prescription. While Ritalin and OxyContin abuse do not appear to be a problem at Virginia institutions of higher education, continued drug education and appropriate interventions are necessary to reduce high-risk behaviors. Two recent deaths on college campuses--one in Florida and one in Connecticut--were attributed to a dangerous mix of drugs and alcohol. Briefly cited was the federal Campus Security Act, which addresses issues concerning substance abuse and confidential treatment.[146]

Representatives of the Virginia State Police reported that while Ritalin and OxyContin abuse remain problematic among school- and college-aged students in Virginia, these drugs are more often diverted and abused by other age groups. Campus police at Virginia Tech, Virginia Commonwealth University, and Radford University have reported no campus arrests involving either of these drugs. State Police statistics indicate that prescription drug arrests typically involve individuals between the ages of 31 and 40.[147]

V. CONCLUSIONS AND RECOMMENDATIONS

In addition to addressing the specific study directives of HJR 660, the joint subcommittee examined a variety of complex issues. The joint subcommittee recognizes that prescription medication may be only one part of an effective treatment program for managing ADHD. It is critical to a child's continued success in school that a medical doctor supervise carefully the use of these medications; ongoing communication between the physician and parents and--upon parental approval--school personnel, is essential.

Other concerns noted by the joint subcommittee are the need for appropriate insurance reimbursement mechanisms to ensure access to effective evaluation and treatment for children with ADHD and continuing educational efforts targeting college students. Also worthy of further exploration are recent data indicating the Commonwealth's potentially alarming rates of ADHD diagnoses and methylphenidate

[146]October 30, 2001, Meeting Summary.
[147]August 28, 2001, Meeting Summary.

prescriptions; additional study, seeking the expertise and resources of public health and education specialists, is needed to determine actual prevalence of the disorder among Virginia students.

Among potential recommendations explored by the joint subcommittee were (i) amending the Code of Virginia to clarify current law regarding possession and administration of prescription medications in public schools and directing school boards to implement policies regulating student possession of their own prescription and nonprescription medications; (ii) directing school boards to adopt policies consistent with the Virginia School Health Guidelines promulgated by the Virginia Department of Health, in collaboration with the Virginia Department of Education, addressing the dispensing and storage of student prescriptions in the public schools; (iii) amending the Code to prohibit school personnel (or through school board policy) from suggesting that parents seek psychotropic medication for their child; (iv) increasing funding for the Virginia State Police Drug Diversion Unit and for methadone treatment centers; and (v) continuing the joint subcommittee for an additional year.[148]

The joint subcommittee therefore makes the following recommendations:

Recommendation 1: *That § 22.1-279.3:1 of the Code of Virginia be amended to require reporting of theft of student prescription medications from students during school hours, on school property, or at school-sponsored activities, or from school storage.*

Testimony before the committee indicated that, at least in some school divisions, the principal decides whether to report a medication theft to law-enforcement. These incidents are treated as property thefts. The Department of Education's September 2001 survey indicated thefts of medications had occurred at school; about half of the responding school divisions indicated they have no policy or procedure regarding stolen medications. The Code of Virginia already directs school principals to report criminal conduct involving alcohol and controlled substances to law-enforcement agencies; however, clarifying this provision to include thefts of student prescriptions held by the school may assist in detailing incidents of diversion and abuse.

Recommendation 2: *That reimbursement for pediatric specialists at pediatric medical centers through Medicaid and FAMIS be increased.*

Recommendation 3: *That the Joint Subcommittee endorse the efforts of the Attorney General's Task Force on Prescription Drug Abuse regarding the implementation of an appropriate prescription monitoring system for the Commonwealth.*

The Virginia Attorney General's Task Force on Prescription Drug Abuse has noted that prescription monitoring systems in Nevada and Kentucky have received particular praise among the various systems currently in place in 18 states. Under Task Force consideration is a recommendation for the creation of a prescription monitoring system for Virginia; the system will provide a central data center for data from

[148]December 3, 2001, Meeting Summary.

pharmacies on all controlled substance prescriptions. Data collected would be identical to that already submitted for Medicaid and insurance purposes. This data would be available to law-enforcement for open, ongoing investigations; the system would not be used to identify aberrations or possible infractions. The anticipated start-up cost for such an initiative is over $1 million, with the Department of Health Professions the likely repository for this data. Also under consideration by the Prescription Drug Abuse Task Force is increasing the penalties for distribution of Schedule III and IV drugs from misdemeanor to a Class 6 felony.[149]

The Joint Subcommittee applauds the efforts of the Attorney General's Task Force regarding the feasibility and appropriateness of implementing a prescription monitoring system for controlled substances in the Commonwealth. As the Task Force expects to develop recommendations at its December 18 meeting, the Joint Subcommittee could not make a more specific recommendation at this time regarding this issue.

Recommendation 4: *That the Special Advisory Commission on Mandated Health Insurance Benefits examine and encourage continuing education of third party payers regarding adequate reimbursement for behavioral evaluations and ADHD and study the feasibility and appropriateness of expanding reimbursement for child evaluations to address an appropriate range of mental health services, including comprehensive assessment by clinical psychologists, without tying such reimbursement to a specific, final diagnosis.*

Recommendation 5: *That the Department of Health, in collaboration with the Departments of Education, Health Professions, and Mental Health, Mental Retardation, and Substance Abuse Services, with the assistance of researchers with public health and education expertise, conduct a statewide epidemiological study examining the prevalence of methylphenidate use and ADHD diagnoses in the Commonwealth; that such study incorporate, among other things, consideration of (i) contributing factors to any such prevalences; (ii) any relevant nutritional and educational issues; and (iii) the identification of age-appropriate behaviors by education and health professionals; and that such study include the input of psychologists, physicians, and other health professionals.*

Recommendation 6: *That the governing bodies of the Commonwealth's public and private institutions of higher education support increased student prescription drug abuse prevention and education programs on their respective campuses.*

Respectfully submitted,

HJR 660 Joint Subcommittee to Investigate the Improper Prescription and Illegal Use and Diversion of Ritalin and OxyContin and to Study the Effects of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder on Student Performance

[149]December 3, 2001, Meeting Summary.

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HOUSE JOINT RESOLUTION NO. 660

Establishing a joint subcommittee to study the effects of attention deficit disorder and attention deficit hyperactivity disorder on student performance and to investigate the improper prescription and illegal use and diversion of Ritalin and OxyContin.

Agreed to by the House of Delegates, February 22, 2001
Agreed to by the Senate, February 22, 2001

WHEREAS, Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD), the most commonly diagnosed behavioral disorder of childhood, is a neurobiological disability characterized by developmentally inappropriate levels of attention, concentration, activity, distractibility, and impulsivity, and in some cases, hyperactivity, that affects three to five percent of school-age children, or 1.35 to 2.25 million children, and approximately two to four percent of adults; and

WHEREAS, children with ADD/ADHD generally have functional impairment across multiple settings, including home, school, and peer relationships, and ADD/ADHD may have long-term adverse effects on the academic performance, vocational success, and social-emotional development of children; and

WHEREAS, diagnosis and treatment of the disorder have generated considerable controversy, and parents, clinicians, researchers, educators, and policymakers have diverse and conflicting opinions concerning this disability, including disagreement as to the use of psychostimulants such as Ritalin to treat the condition; and

WHEREAS, regular and special education teachers and other school personnel must be trained to identify children with ADD/ADHD, as certain characteristics are shared between children with ADD/ADHD and children who are gifted, making it very difficult for the untrained eye to distinguish between the exceptionalities; and

WHEREAS, teachers must use different instructional methodologies and provide certain adaptations in the classroom to meet the educational needs of children with ADD/ADHD, and providing for their unique educational needs becomes more difficult when these children have dual exceptionalities, such as other chronic or acute health problems, a learning disability, or giftedness; and

WHEREAS, although children with this disorder present significant challenges to public schools and the educational system, including the delivery of required health services, it is important that the educational, health, and social needs of these children be addressed, and the impact on public schools and the ability of the educational system to meet their needs be evaluated; and

WHEREAS, methylphenidate, commonly known as Ritalin, is prescribed in the treatment of narcolepsy, and most often for children diagnosed with attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD), a neurobiological disability characterized by developmentally inappropriate impulsiveness, inattention, and in some cases, hyperactivity, that affects three to five percent of school-aged children and approximately two to four percent of adults; and

WHEREAS, it is estimated that Ritalin has been prescribed for at least four million American children who have been diagnosed as having ADD/ADHD, of whom 80 percent are males; and

WHEREAS, Ritalin, when properly prescribed, enables children with ADD/ADHD to become more focused and increases their attention span, but Ritalin causes different results in adults, many of them harmful; and

WHEREAS, Ritalin, when taken as prescribed, has mild to moderate stimulant properties, but when snorted or injected produces cocaine-like stimulant effects; and

WHEREAS, according to the United States Drug Enforcement Administration, prescriptions for Ritalin have increased more than 600 percent over the past five years, and according to federal law-enforcement agencies involved in drug interdiction, 90 percent of the world's supply of Ritalin is prescribed in the United States; and

WHEREAS, a significant portion of these prescriptions are diverted for illicit nonmedical use, as Ritalin ranks among the top 10 most frequently reported stolen controlled pharmaceuticals; and

WHEREAS, due to the substantial increase in ADD/ADHD diagnoses over the past several years, the manufacturing quotas have not increased sufficiently to meet the increased demand, resulting in sporadic and regional shortages of Ritalin, which have been further exacerbated by the diversion of the drug to the illicit street drug trade; and

WHEREAS, the National Institute on Drug Abuse described Ritalin abuse over the last two decades as "sporadic but persistent," and there is concern that an upsurge in illicit street use of Ritalin reported on the West Coast and in the Midwest is spreading across the country, with reports of increasing use, experimentation, and illegal distribution and possession among young children, teens, and college-aged students; and

WHEREAS, the adverse consequences of the abuse of Ritalin is of paramount concern as more and more college students are self-prescribing Ritalin to help them concentrate, stay awake, and focus, and many college students are using Ritalin as an inexpensive recreational drug; and

WHEREAS, OxyContin has been approved by the Federal Drug Administration for the treatment of moderate to severe pain caused by terminal cancer or musculoskeletal conditions; and

WHEREAS, OxyContin's chief advantage is its time-release formula that enables patients to maintain pain relief for up to 12 hours without having to take repeated doses; and

WHEREAS, like morphine and heroin, OxyContin is an opiate that eases suffering, and creates a euphoric effect similar to a heroin high; and

WHEREAS, meant for those suffering from chronic pain, OxyContin has also become a drug used for recreational purposes and is often obtained by fraudulent means or through illegal sale or theft; and

WHEREAS, federal investigators have identified five pockets of heavy OxyContin abuse in the United States: Southwest Virginia, rural Maine, Cincinnati, Baltimore, and Charleston, and do not understand why the drug is so popular in these areas; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study the effects of attention deficit disorder and attention deficit hyperactivity disorder on student performance and to investigate the improper prescription and illegal use and diversion of Ritalin and OxyContin. The joint subcommittee shall consist of 10 legislative members to be appointed as follows: 6 members of the House of Delegates, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates and 4 members of the Senate to be appointed by the Senate Committee on Privileges and Elections.

In conducting the study, the joint subcommittee shall (i) determine the number of students diagnosed as having ADD/ADHD in Virginia's public schools, and whether such children receive treatment; (ii) ascertain whether such students also have dual exceptionalities or chronic and acute health problems, and the demand created by these conditions for certain school services; (iii) determine the academic performance levels of such children; (iv) identify other educational, social, and health factors that may compromise their academic performance and educational outcomes; (v) identify school practices to manage, the methods used to treat, and the medications prescribed for and dispensed to ADD/ADHD students in the school setting for their disorder; (vi) evaluate the special education programs and related

services provided or which may be provided to meet the needs of such students; (vii) assess the demand for and effectiveness of existing education programs and related services, including school health services, by ADD/ADHD students; (viii) evaluate the effect of ADD/ADHD on grade retention, absenteeism, school suspension and expulsion, and disciplinary action taken by public schools; (ix) and make appropriate recommendations that address identified problems and allow public schools to serve such children efficiently and effectively; (x) determine the health conditions for which Ritalin and OxyContin are lawfully prescribed in Virginia; (xi) ascertain the number of such prescriptions for the last five years to determine the rate of increase or decrease, and the cause of any increase in the number of such prescriptions; (xii) determine if Ritalin and OxyContin have been diverted to the street drug trade, and if so, assess the demand for Ritalin and OxyContin as street drugs in Virginia; (xiii) establish whether the use of Ritalin or OxyContin for non-medical purposes is a problem among school-aged children and college students in the Commonwealth; (xiv) consider and explore such other issues as the joint subcommittee may determine pertinent; and (xv) recommend ways to correct problems associated with the over-prescription and the illegal use, possession, and distribution of Ritalin and OxyContin, as appropriate.

The direct costs of this study shall not exceed $8,500. An estimated $1,000 of the direct costs is allocated for materials and resources. Such expenses shall be funded from the operational budget of the Clerk of the House.

The Division of Legislative Services shall provide staff support for the study. Technical assistance shall be provided by the Department of State Police, the Board of Medicine, the Board of Pharmacy, the Department of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Education, and the State Council of Higher Education. All agencies of the Commonwealth shall provide assistance as requested by the joint subcommittee for this study.

The joint subcommittee shall complete its work in time to submit its written findings and recommendations by November 30, 2001, to the Governor and the 2002 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Meetings of the HJR 660 Joint Subcommittee

First Meeting -- August 28, 2001
General Assembly Building, Richmond, Virginia

Election of Chairman, Vice-Chairman; Review of background report: Kathleen G. Harris, senior attorney, Division of Legislative Services; H. Douglas Cox, assistant superintendent, Instructional Support Services, Virginia Department of Education ~ Information and Perspectives regarding Study Directives i-ix; Brad Cavedo, deputy attorney general: Activities with Purdue Pharma, OxyContin manufacturer; criminal penalties in Virginia; Col. W. Gerald Massengill, superintendent, Virginia State Police; Lt. Col. Darrel Stilwell, and Special Agent Landon Gibbs: Study Directives xii, xiii, and xv.

Second Meeting -- Double session ~ Tuesday, Oct. 30, 2001
General Assembly Building, Richmond, Virginia

Dr. Lissa Power-deFur, associate director, Student Services, Special Education and Student Services, and Gwen Smith, R.N., school health specialist, Special Education and Student Services, Virginia Department of Education, responding to committee inquiries from initial meeting, including plans for additional guidance to schools regarding required reporting of irregularities or thefts in the management and administration of student medications, diagnostic and evaluation processes, demographic data regarding students with ADHD in the public schools, data regarding the ages of students most likely to be threatened for their Ritalin, and the number of private school students with ADHD who transfer to public schools; Sidney H. Schnoll, M.D., Ph.D., medical director, Health Policy, Purdue Pharma, LP, manufacturer of OxyContin; Rama Seshamani, M.D., executive director, Product Information, and Ron Califre, senior vice president, Research & Development, and head, U.S. Operations, Novartis Pharmaceuticals Corporation, manufacturer of Ritalin, including information regarding use of Ritalin in other countries, pilot Ritalin studies providing compensation for participation, Ritalin patent information, and primary sources for Ritalin abuse and diversion; Dr. William Harp, executive director, Board of Medicine, and Mike Ayotte, R.Ph., immediate past president of the Virginia Board of Pharmacy, Prescribing practices; James Evans, M.D., medical director, and Robert Johnson, director, Substance Abuse Services Division, Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) regarding 1991 Study, services for ADHD students, AG Task Force on Prescription Drug Abuse (activities regarding OxyContin); Perspectives from State Council of Higher Education for Virginia, Dr. Sherilyn W. Poole, student affairs director, regarding Study Directive xiii: "establish whether the use of Ritalin or OxyContin for non-medical purposes is a problem among school-aged children and college students in the Commonwealth"; PowerPoint presentation by Virginia State Police, Col. W. Gerald Massengill, superintendent, accompanied by Lt. Col. Donald R. Martin; First Sgt. J.C. Lewis; Lt. Rod Best, Pharmaceutical Unit; and Maj. Terry A. Bowes, deputy director of the Bureau of Criminal Investigation (BCI); Gretchen B. LeFever, Ph.D., associate professor, Pediatrics and Psychiatry, Center for Pediatric Research, Norfolk, VA, regarding prevalence and impact of ADHD in Southeast Virginia, intervention and prevention initiatives to reduce severity of ADHD in public school setting, medical management of children with ADHD, and perspectives regarding Study Directives i-viii; David B. Stein, Ph.D., professor of psychology, Longwood College; author, *Ritalin Is Not the Answer: A Drug-Free, Practical Program for Children Diagnosed with ADD or ADHD*; Dr. Tom Sullivan, president, Virginia Chapter, The American Academy of Pediatrics/Virginia Pediatrics Society; Dr. John Russell, M.D., adolescent psychiatry, Richmond; clinical professor, MCV; Elizabeth Morris, nurse practitioner, Hanover Public Schools; Dr. John Russell, M.D., adolescent psychiatry, Richmond; clinical professor, MCV; Laura DiCarlo, executive director of the Citizens Commission on Human Rights; Ashby Watson, Virginia Cancer Pain Initiative; and Tricia Baggett-Phelps, clinical director, the National Alliance for the Mentally Ill, Virginia.

Third Meeting-- Monday, December 3, 2001
General Assembly Building, Richmond, Virginia

Presentation by Bradley Cavedo, Deputy Attorney General, Office of the Attorney General: Status Report on Activities of the Task Force on Prescription Drug Abuse; Discussion and development of final recommendations.

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SENATE BILL NO. _____ HOUSE BILL NO. _____

A BILL to amend and reenact § 22.1-279.3:1 of the Code of Virginia, relating to reporting of certain acts to school authorities.

Be it enacted by the General Assembly of Virginia:

1. That § 22.1-279.3:1 of the Code of Virginia is amended and reenacted as follows:

§ 22.1-279.3:1. Reports of certain acts to school authorities.

A. Reports shall be made to the principal or his designee on all incidents involving (i) the assault, assault and battery, sexual assault, death, shooting, stabbing, cutting, or wounding of any person on a school bus, on school property, or at a school-sponsored activity; (ii) any conduct involving alcohol, marijuana, a controlled substance, imitation controlled substance, or an anabolic steroid on a school bus, on school property, or at a school-sponsored activity, including the theft or threatened theft of student prescription medications; (iii) any threats against school personnel while on a school bus, on school property or at a school-sponsored activity; (iv) the illegal carrying of a firearm onto school property; (v) any illegal conduct involving firebombs, explosive materials or devices, or hoax explosive devices, as defined in § 18.2-85, or explosive or incendiary devices, as defined in § 18.2-433.1, or chemical bombs, as described in § 18.2-87.1, on a school bus, on school property, or at a school-sponsored activity; or (vi) any threats or false threats to bomb, as described in § 18.2-83, made against school personnel or involving school property or school buses.

B. Notwithstanding the provisions of Article 12 (§ 16.1-299 et seq.) of Chapter 11 of Title 16.1, local law-enforcement authorities may report, and the principal or his designee may receive such reports, on offenses, wherever committed, by students enrolled at the school if the offense would be a felony if committed by an adult or would be a violation of the Drug Control Act (§ 54.1-3400 et seq.) and occurred on a school bus, on school property, or at a

school-sponsored activity, or would be an adult misdemeanor involving any incidents described in clauses (i) through (v) of subsection A.

C. The principal or his designee shall submit a report of all incidents required or authorized to be reported pursuant to this section to the superintendent of the school division. The division superintendent shall annually report all such incidents to the Department of Education for the purpose of recording the frequency of such incidents on forms that shall be provided by the Department and shall make such information available to the public. A division superintendent who knowingly fails to comply or secure compliance with the reporting requirements of this subsection shall be subject to the sanctions authorized in § 22.1-65. A principal who knowingly fails to comply or secure compliance with the reporting requirements of this section shall be subject to sanctions prescribed by the local school board, which may include, but need not be limited to, demotion or dismissal.

The principal or his designee shall also notify the parent of any student involved in an incident required by subsection A or authorized by subsection B to be reported, regardless of whether disciplinary action is taken against such student or the nature of the disciplinary action. Such notice shall relate to only the relevant student's involvement and shall not include information concerning other students.

Whenever any student commits any reportable incident as set forth in this section, such student shall be required to participate in such prevention and intervention activities as deemed appropriate by the superintendent or his designee. Prevention and intervention activities shall be identified in the local school division's drug and violence prevention plans developed pursuant to the federal Improving America's Schools Act of 1994 (Title IV - Safe and Drug-Free Schools and Communities Act).

D. The principal shall immediately report to the local law-enforcement agency any act enumerated in subsection A that may constitute a criminal offense.

E. A statement providing a procedure and the purpose for the requirements of this section shall be included in the policy manual of all school divisions.

The Board of Education shall promulgate regulations to implement this section, including, but not limited to, establishing reporting dates and report formats.

F. For the purposes of this section, "parent" or "parents" means any parent, guardian or other person having control or charge of a child.

G. This section shall not be construed to diminish the authority of the Board of Education or the Governor concerning decisions on whether, or the extent to which, Virginia shall participate in the federal Improving America's Schools Act of 1994, or to diminish the Governor's authority to coordinate and provide policy direction on official communications between the Commonwealth and the United States government.

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SUMMARY

Reporting of certain acts to school authorities. Adds theft or threatened theft of student prescription medications to those incidents required to be reported to school authorities, that, in turn, are to be reported to the division superintendent for annual reporting to the Department of Education. In addition, these incidents are added to those events principals are required to report to law enforcement if constituting a criminal offense.

Current law limits these various reporting requirements to actions involving weapons, violence, and conduct involving alcohol, marijuana, a controlled substance, imitation controlled substance, or an anabolic steroid on a school bus, on school property, or at a school-sponsored activity.

This bill is a recommendation of the HJR 660 Joint Subcommittee to Investigate the Improper Prescription and Illegal Use and Diversion of Ritalin and OxyContin and to Study the Effects of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder on Student Performance.

HOUSE JOINT RESOLUTION NO. _____

Requesting the Department of Health, in collaboration with the Departments of Education, Health Professions, and Mental Health, Mental Retardation, and Substance Abuse Services, to conduct a statewide epidemiological study examining the prevalence of methylphenidate use and ADHD diagnoses in the Commonwealth.

WHEREAS, the U.S. Surgeon General's National Action Agenda, released in early 2001, estimated that fewer than one in five children receive the treatment needed for mental illness, including Attention Deficit Hyperactivity Disorder (ADHD); and

WHEREAS, a brand name for methylphenidate hydrochloride, Ritalin is only one of many medications used to treat ADHD; and

WHEREAS, methylphenidate is also produced as Concerta, Metadate, Methylin, and several generic drugs, and amphetamines such as Adderall, Dexedrine, and other generics may treat ADHD, as well as Cylert and certain antidepressants; and

WHEREAS, Ritalin use varies throughout the United States, with children in parts of the Northeast and Midwest three times as likely to use the medication than children in the Southwest, and experts have attributed these variations in prescribing frequencies to differing attitudes toward medications, insurance coverage, physician preferences, and other factors; and

WHEREAS, Virginia ranks in the highest quartile in the nation for Ritalin prescription; within the Commonwealth, higher concentrations are seen in Tidewater, Richmond, and Northern Virginia; and

WHEREAS, according to a 2001 study conducted by the Center for Pediatric Research in Norfolk, eight to 10 percent of elementary school students in the Portsmouth and Virginia Beach school divisions are receiving Ritalin at school--a rate two to three times higher than

national estimates--and that black girls are least likely to be diagnosed and treated, and white boys are most likely to be diagnosed and treated; and

WHEREAS, while most pharmaceuticals dispensed in public schools target mental health disorders, with half of these medications prescribed for ADHD; and

WHEREAS, in response to inquiries by the HJR 660 (2001) Joint Subcommittee to Investigate the Improper Prescription and Illegal Use and Diversion of Ritalin and OxyContin and to Study the Effects of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder on Student Performance, the Virginia Department of Education surveyed Virginia school divisions in September 2001 to determine numbers of students receiving medication at school for ADHD; and

WHEREAS, responses from 129 school divisions, representing 94.5 percent of Virginia's public school population and a 95.5 percent survey response rate, indicated that 16,521 students--or 1.52 percent of the student population--received ADHD medication at school in 2000-2001, and that, of these students, 55 percent receive Ritalin; and 45 percent are receiving other ADHD medication, such as Adderall, Catapres, Cylert, Desedrine, Norpramine, Pamelor, Tofranil, Wellbutrin, or other drugs; and

WHEREAS, although these data are helpful in estimating methylphenidate use in Virginia public schools, they are not clearly indicative of the numbers of public school children who may be taking Ritalin at home or other psychotropic medications at school or at home; and

WHEREAS, some experts contend that ADHD is over-diagnosed and over-treated in parts of Virginia and perhaps in 36 states; and

WHEREAS, also evidencing possible premature diagnoses is the fact that more than half of the students in the Center for Pediatric Research study were diagnosed by the first grade, and that 28 percent of the Portsmouth and Virginia Beach elementary school students receive two or more psychotropic drugs; and

WHEREAS, a comprehensive examination of the prescription and use of methylphenidate and other psychotropic medications among school-aged children is necessary to supplement the work of the HJR 660 joint subcommittee and to more accurately determine the prevalence of such prescriptions and use among Virginia's children; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health, in collaboration with the Departments of Education, Health Professions, and Mental Health, Mental Retardation, and Substance Abuse Services, conduct a statewide epidemiological study examining the prevalence of methylphenidate use and ADHD diagnoses in the Commonwealth.

In conducting the study, the Department may contract for services with appropriate private research organizations with public health and education expertise and shall seek the input of psychologists, physicians, and other health professionals. The study shall incorporate, among other things, consideration of (i) contributing factors to any such prevalence; (ii) any relevant nutritional and educational issues; and (iii) the identification of age-appropriate behaviors by education and health professionals.

All agencies of the Commonwealth shall provide assistance to the Department for this study, upon request.

The Department shall complete its work in time to submit its findings and recommendations to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

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SUMMARY

Study; prevalence of ADHD diagnoses and methylphenidate prescriptions. That the Department of Health, in collaboration with the Departments of Education, Health Professions, and Mental Health, Mental Retardation, and Substance Abuse Services, conduct a statewide epidemiological study examining the prevalence of methylphenidate use and ADHD diagnoses in the Commonwealth. In conducting the study, the Department may contract for services with appropriate private research organizations with public health and education expertise and shall seek the input of psychologists, physicians, and other health professionals. The study shall incorporate, among other things, consideration of (i) contributing factors to any such prevalence; (ii) any relevant nutritional and educational issues; and (iii) the identification of age-appropriate behaviors by education and health professionals. The Department shall complete its work in time to submit its findings and recommendations to the Governor and the 2003 Session of the General Assembly.

This measure is a recommendation of the HJR 660 Joint Subcommittee to Investigate the Improper Prescription and Illegal Use and Diversion of Ritalin and OxyContin and to Study the Effects of Attention Deficit Hyperactivity Disorder on Student Performance.

HOUSE JOINT RESOLUTION NO. _____

Requesting the Special Advisory Commission on Mandated Health Insurance Benefits to examine and encourage continuing education of third party payers regarding adequate reimbursement for behavioral evaluations and ADHD and study the feasibility and appropriateness of expanding reimbursement for child evaluations to address an appropriate range of mental health services, including comprehensive assessment by clinical psychologists.

WHEREAS, increased treatment of attention deficit hyperactivity disorder (ADHD) during the past decade has been attributed to increased awareness of the condition, better diagnostic criteria and treatment guidelines, more diagnoses among adults and girls, and increased compliance with one-a-day treatments; and

WHEREAS, the U.S. Surgeon General's National Action Agenda, released in early 2001, estimated that fewer than one in five children receive the treatment needed for mental illness, including ADHD; and

WHEREAS, the complexities of reimbursement and co-payment requirements may deter some parents from seeking the appropriate medical and psychiatric evaluation for their children; and

WHEREAS, adequate insurance coverage for child behavioral evaluations is essential to help ensure that the children of the Commonwealth have access to the care and services needed for good mental and physical health; and

WHEREAS, a recent study by the Center for Pediatric Research in Norfolk indicates not only that Virginia ranks in the highest quartile in the nation for Ritalin prescriptions, but that ADHD is over-diagnosed and over-treated in the Tidewater region, and perhaps in 36 states; and

WHEREAS, such findings may suggest a need for improved access to appropriate child behavioral evaluations to more accurately determine those behaviors that might be better treated without medication; and

WHEREAS, pursuant to § 2.2-2504, the Special Advisory Commission on Mandated Health Insurance Benefits is directed to provide "assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the General Assembly" and to provide "additional information and recommendations, relating to any system of mandated health insurance benefits and providers, to the Governor and the General Assembly upon request"; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Special Advisory Commission on Mandated Health Insurance Benefits examine and encourage continuing education of third party payers regarding adequate reimbursement for behavioral evaluations and ADHD and study the feasibility and appropriateness of expanding reimbursement for child evaluations to address an appropriate range of mental health services, including comprehensive assessment by clinical psychologists. In conducting the study, the Commission shall seek the input and expertise of child health and psychology professionals and shall address, among other things, the feasibility of providing reimbursements for child evaluative services without tying such reimbursement to a specific, final diagnosis.

All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Commission shall complete its work by November 30, 2002, and submit its findings and recommendations to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

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SUMMARY

Study; reimbursement for behavioral evaluations. Requests the Special Advisory Commission on Mandated Health Insurance Benefits to examine and encourage continuing education of third party payers regarding adequate reimbursement for behavioral evaluations and ADHD and study the feasibility and appropriateness of expanding reimbursement for child evaluations to address an appropriate range of mental health services, including comprehensive assessment by clinical psychologists. In conducting the study, the Commission shall seek the input and expertise of child health and psychology professionals and shall address, among other things, the feasibility of providing reimbursements for child evaluative services without tying such reimbursement to a specific, final diagnosis.

The Commission shall complete its work by November 30, 2002, and submit its findings and recommendations to the Governor and the 2003 Session of the General Assembly.

This measure is a recommendation of HJR 660 Joint Subcommittee to Investigate the Improper Prescription and Illegal Use and Diversion of Ritalin and OxyContin and to Study the Effects of Attention Deficit Hyperactivity Disorder on Student Performance.