FEDERAL INVOLVEMENT IN THE USE OF BEHAVIOR MODIFICATION DRUGS ON GRAMMAR SCHOOL CHILDREN OF THE RIGHT TO PRIVACY INQUIRY

HEARING

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

SECOND SESSION

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FEDERAL INVOLVEMENT IN THE USE OF BEHAVIOR MODIFICATION DRUGS ON GRAMMAR SCHOOL CHILDREN OF THE RIGHT OF PRIVACY INQUIRY

TUESDAY, SEPTEMBER 29, 1970

HOUSE OF REPRESENTATIVES,
SPECIAL STUDIES SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10 a.m. in room 2154, Rayburn House Office Building, Hon. Cornelius E. Gallagher, presiding.

Present: Representatives Cornelius E. Gallagher, Benjamin S. Rosenthal, John W. Wydler, and John T. Myers.

Staff member present: Charles Witter, professional staff member; Louis Freed, staff administrator; and Thomas H. Saunders, minority staff.

Mr. GALLAGHER. The subcommittee will come to order.

I want to welcome you here today to our hearing into Federal responsibility in promoting the use of amphetamines to modify the behavior of grammar school children. The indications are that these drugs are now being widely employed to ameliorate the effects of what is called minimal brain dysfunction (MBD) in children. One of our witnesses today has been quoted as saying that the use of this type of therapy will "zoom" from its current usage in approximately 200,000 to 300,000 American children today.

These amphetamines, such as Dexedrine and Ritalin, apparently do not act the same in children as they do in young adults, according to some authorities. Instead of being "speed" and accelerating the individual's activity pattern, proponents of the program claim that amphetamines slow down the child and make him controllable both in the classroom and at home. This use of stimulants to calm children termed hyperactive is called the "paradoxical effect" and it is but one of the many paradoxes which this hearing is designed to explore. Let me list a few contradictory implications.

First, and a distressingly obvious paradox, is the effect of accelerating this use of amphetamines on our extensive national campaign against drug abuse. From the time of puberty onward, each and every child is told that "speed kills" and that amphetamines are to be avoided. Yet, this same child has learned that Ritalin, for example, is the only thing which makes him a functioning member of the school environment and both his family and his doctor have urged the pills on him.

I am frankly very curious about the kind of credibility his parents have when they try to guide him away from amphetamines after encouraging him to take them.

If for no other reason than this paradoxical effect, every possible alternative method of therapy should be exhausted before an amphetamine is given to the young child.

I do want to make it very clear at this point, however, that we are not trying to interfere in any way with the doctor-patient relationship. Nor is it our intention, at this point in our investigation, to counsel any parent against allowing this medication to be used. Our purpose is to probe, not pontificate; we desire to discuss, not damn.

Second, I am very concerned about the fact that the child who has been undergoing drug therapy becomes a permanent part of the child's school record, to be recalled and available to anyone who wishes to see it. We may well break the child's MBD induced hyperactive behavior pattern, but by freezing on the record the fact that it took drugs to do it, we cast a cloud of suspicion over that child's future. I hope that one result of these hearings will be to remove a cloud of doubt from the public's mind about any child who has to undergo any special training or therapy. It would indeed be a paradoxical effect to help a child, but to damn him at the same time.

A third paradoxical effect is directly related to the jurisdiction of this subcommittee of the Committee on Government Operations. We are charged with the responsibility of determining whether Federal funds are spent in an economical manner and whether the operations of Federal agencies are conducted efficiently. We have learned that Federal funds have been used to support various experimental programs and studies concerning the use of drugs to treat learning disabilities in children. Assisted by this infusion of tax dollars, it has become apparent that biochemical mediation and alteration of the learning environment is considered as part of a "new wave" approach to public education in the United States by many persons both in and out of the Government.

Not only has this issue never been subjected to full public discussion and understanding, but I am deeply concerned about the possibility that an overreliance on drug therapy could spread far beyond its apparently valid applications and thus denigrate the novel learning methods which have also been explored by the use of Federal funds. In so many areas which the Privacy Subcommittee has explored, we have seen a dependence on quick and inexpensive solutions offered by the new technology without adequate attention being paid to the slower and perhaps more costly methods which would preserve the sanctity of human values and the precious resources of the human spirit.

This point is made well in a telegram I received recently from a parent who lists 10 drugs given his child in one year. He says, "Testing proved child creatively gifted, no classroom available. My State has hundreds of gifted and creative children on prescribed drugs as result of refusal to provide proper educational facilities."

And here we come to what is perhaps the greatest paradox in this entire program and why I am convinced that public discussion must take place before the use of behavior modification drugs "zooms." As the father of four, I am well aware of the occasional frustrations which come from the fact that children do not simply sit quietly and perform assigned tasks. Based on my personal experience, I believe

that children learn with all their senses, not just with their eyes and ears. For childhood is an exploratory time and the great energy of children propels them into situations which may look frivolous or counterproductive to more restrained adults, but which are the sum and substance of the child's learning experience. I do not think I am overstating the case when I say that the learning environment for the young child is the total environment and every experience is a learning experience.

Obviously, this unstructured passion for all the events in a child's world is regarded as unruly and disruptive, particularly in overcrowded classrooms. I fear that there is a very great temptation to diagnose the bored but bright child as hyperactive, prescribe drugs, and thus deny him full learning during his most creative years.

While we intend to hear from the Food and Drug Administration about the legal guidelines for the use of such drugs in children and the warnings they require to be printed on the packages, I am deeply concerned about the mislabeling of the child and packaging an ill-conceived program as an answer to our ills in the education of our children.

In addition, are there reliable medical guidelines which can be universally and absolutely applied to separate the normally active child from a clinically diagnosed hyperactive child?

These then are what I regard as some of the paradoxes inherent in the nationwide program of prescribing speed for children. Our attempt in these hearings will be to assemble a quantity of expert opinion and evidence, and to raise questions and implications about the program's effect on the quality of America's future. For as we have learned in previous hearings and investigations of the Privacy Subcommittee, all too often the tools of the new technology are employed solely in the environment of anticipated short-term success, with little or no attention being paid to the long range effect on the shared values of Americans.

Public men must investigate the uses of science and research and decisions must not be made solely on the expertise of those connected with a new technology. In the past we have tried to excise the potentially toxic elements from the beneficial tonic of technology; that is the purpose of this hearing today.

Before calling our first witness, I want to place in the hearing a portion of the preliminary report I received last Friday, September 25, from the General Accounting Office. This shows almost $3 million in Federal funds have been expended solely by the National Institute of Mental Health in grants in the conduct of research of learning disabilities and, as part of each study, behavior modification through the use of drugs.

This document, focusing only on grant awards by the NIMH of the Department of HEW shows nine grants totaling nearly $3 million. Of that figure, the General Accounting Office reports $965,000 has been granted since the beginning of 1970.

While the first reported grant in this subject was made in 1961, a total of almost $3 million was granted so far this year.

Without objection, I will place this in the record.

(The information referred to follows:)

GRANTS AWARDED BY THE NATIONAL INSTITUTE OF MENTAL HEALTH

R01 MH 18180—David M. Engelhardt, M.D., Outpatient Pediatric Psychopharmacology, State University of New York, Downstate Medical Center, Brooklyn, N.Y.

Testing the full range of FDA-approved psychotropic drugs for their effects on children, to establish guidelines for safe and effective use of psychotropic drugs in the treatment of emotional disorders in the young. The subjects are autistic and hyperactive children between 4 and 12 years old who are treated on an outpatient basis at the Psychopharmacology Treatment Research Unit at the Downstate Medical Center.

June 1, 1970 ..... $102,076

R01 MH 17039—James H. Satterfield, M.D., Psychophysiological Studies in Hyperkinetic Children, Gateways Hospital, Los Angeles, Calif.

A study of the neurophysiological mechanisms underlying this disorder and the development of improved diagnostic and treatment methods. Subjects: school children in the first six grades, obtained through a clinic for hyperkinetic children.

June 20, 1969 ..... $84,704
June 1, 1970 63,592

R01 MH 18579—Donald F. Klein, M.D., Comparative Drug Effects in Hyperkinetic Children, Hillside Hospital, Glen Oaks, N.Y.

Evaluation of the relative efficacy of thioridazine, methylphenidate, thioridazine-methylphenidate combination and placebo in hyperkinetic children.

Subjects: Hyperkinetic children between ages 6 and 12 and group of nonhyperkinetic children at least 2 years below grade level in reading and arithmetic. Assessment through number of rating scales and EEG evaluations.

September 1, 1970 ..... $60,185

R01 MH 15134—Lawrence M. Greenberg, M.D., Pharmacotherapy of Hyperactive Children, Research Foundation, Children's Hospital of the District of Columbia, Washington, D.C.

A study of the clinical effect of selected major tranquilizers and stimulant drugs on children characterized by poor impulse control and hyperactivity. An examination of the influence of these drugs on certain selected parameters of the learning process.

Subjects: children 6 to 16 years of age referred with basic complaint of hyperactivity, with I.Q.'s above 60, with or without minimal or gross chronic brain syndromes, few psychotic children if show hyperactivity.

Six treatment conditions: dextroamphetamine, methylphenidate, chlorpromazine, thioridazine, placebo, no pills. Patients randomly assigned to one of these conditions.

Predrug evaluation: pediatric examination, psychological evaluation, historical material obtained by social worker and visiting nurse, child rating scale by mother, classroom behavior inventory, psychiatric examination.

	Dollars
January 1, 1968	108,316
January 1, 1969	113,312
February 1, 1970	98,221

R01 MH 14432—C. Keith Conners, Ph. D., Drug and Cognition Studies in Disturbed Children, Massachusetts General Hospital, Boston, Mass.

This project continues the systematic series of drug studies with children previously conducted by Leon Eisenberg, M.D., at the Johns Hopkins University, Baltimore, Md. This research focuses on further elucidation of the action of the stimulant drugs (dextroamphetamine and methylphenidate) on behavior, cortical processes, and cognitive functioning. The subjects are children with conduct problems, minimal brain damage, and/or learning disabilities. The project also includes an investigation of the effectiveness of diphenylhydantoin in treating patients with a primary complaint of temper tantrums, violent and aggressive behavior.

	Dollars
September 1, 1967	101, 022
September 1, 1968	117, 456
September 1, 1969	104, 127
September 1, 1970	120, 189

R10 MH 4665—Barbara Fish, M.D., Children's Psychopharmacology Unit, New York University Medical Center, New York, N.Y.

An evalutaion of various forms of drug therapy in disturbed children to determine how children's responses to psychotropic drugs differ from those of adults and to develop improved drug therapy for disturbed youngsters. This is a comprehensive research program with the subjects, aged two to 12, having diagnoses ranging from the neuroses to the most severe forms of schizophrenic disorder.

	Dollars
January 1, 1961	32, 580
March 1, 1962	43, 114
March 1, 1963	47, 037
May 1, 1963 (supplemental)	9. 082
March 1, 1964	87, 010
April 1, 1965	89, 143
April 1, 1966	94, 189
April 1, 1967	96, 523
April 1, 1968	99, 657
April 1, 1969	102, 824
April 1, 1970	94, 632

R03 MH 15771—Grace G. Steinberg, M.D., Dextroamphetamine Treatment of Hyperactive Children, District of Columbia Department of Public Health, Washington, D.C.

A study to test methods for identifying first- and second-grade children with hyperkinetic impulse disorders and to test methods of treatment. Subjects: 40 children in the District of Columbia.

January 1, 1968	$4, 200

PO1 MH 07346—Robert L. Sprague, Ph. D., Remediation of Disturbed and Retarded Children, University of Illinois, Urbana, Ill.

This comprehensive research program is designed to improve the detection and treatment of mentally retarded, emotionally disturbed, and brain-damaged children. Portions of this program are on the effects of psychotropic drugs on learning and behavior. Principal subjects are retarded and emotionally disturbed children residing at the University of Illinois Children's Center, some normal children from surrounding community.

September 1, 1964	$78, 154
September 1, 1965	239, 892
September 1, 1966	299, 971
September 1, 1966 (supplemental)	10, 800
September 1, 1967	329, 989
September 1, 1968	346, 822
September 1, 1969	362, 074
September 1, 1970	323, 153

PO1 MH 18909—Robert L. Sprague, Ph. D., Pediatric Psychopharmacology, University of Illinois, Urbana, Ill.

An investigation of the efforts of methylphenidate and thioridazine in a variety of pediatric populations and over a wide range of cognitive and behavioral situations. The focus will be both on methodological and substantive issues in drug use with children 6–12 years of age. Some examples of studies to be conducted are: (1) Dissociation effects of methylphenidate and thioridazine. Fifteen children will be selected from the patient population at Lincoln State School (State institution for the mentally retarded); (2) Effect of dosage level of methylphenidate on physiological measures. Twelve children from the special education classes for emotionally disturbed children; (3) Effect on methylphenidate on activity level. Twelve hyperactive-aggressive children presently in three special classes for emotionally disturbed children; (4) Effects of chronic drug administration on myelinogenesis in cortical-associative areas of rat brain.

September 1, 1970	$103, 171

Mr. GALLAGHER. The first testimony we will hear this morning will be from the Department of HEW. Dr. Thomas Points is Deputy Assistant for Health Services and will be accompanied by those in the Department who can perhaps address themselves to some of the specific details in these areas in which public knowledge is at present rather incomplete.

I want to welcome you and your associates this morning.

Could you kindly identify the gentlemen and the lady for the record? Please proceed.

STATEMENT OF DR. THOMAS C. POINTS, DEPUTY ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. DOROTHY DOBBS, DIRECTOR, DIVISION OF NEUROPHARMACOLOGICAL DRUG PRODUCTS, FDA; DR. JEROME LEVINE, CHIEF, DIVISION OF PSYCHOPHARMACOLOGY RESEARCH BRANCH, NATIONAL INSTITUTE OF MENTAL HEALTH; DR. RONALD LIPMAN, CHIEF, CLINICAL STUDIES SECTION; AND ALVIN GOTTLIEB, COUNSEL, FDA

Dr. POINTS. Thank you, Mr. Chairman and members of the subcommittee.

I would like to introduce on my right Dr. Dorothy Dobbs from the Food and Drug Administration and Mr. Alvin Gottlieb from the Food and Drug Administration; Dr. Levine from the NIMH, and also Dr. Lipman from the NIMH.

I am pleased to appear before you today to discuss the treatment for children with hyperkinesis and the proposed regulations for the use of amphetamines.

Hyperkinesis is recognized by the medical community as one of the more common behavior disorders of childhood which, when diagnosed by a competent physician or medical team, lends itself to safe and effective drug treatment, given, of course, adequate medical supervision. While this treatment should not be "forced" upon the parent, neither should it be denied to those children whose parents willingly give permission for such treatment. In most cases, proper drug treatment will provide symptomatic relief and will reduce the personal unhappiness of the child while enabling him to profit from the educational experience and from other forms of therapy such as psychotherapy, family counseling, and remedial reading.

While it seems clear that there is some diagnostic heterogeneity in children labeled as hyperkinetic, this syndrome, in addition to the key symptom of overactivity, usually includes many of the following symptoms: short attention span, low frustration tolerance, aggressive-hostile behavior, and hyperexcitability. The syndrome is frequently accompanied by impairment in perception, conceptualization, language, and memory. A neurological examination typically reveals minimal signs of neurological impairment.

Most clinicians feel that the hyperactivity per se is outgrown by adolescence. However, the few followup studies that have been reported suggest that hyperkinetic children who have not received treatment and/or whose treatment has been limited to either individual

or group psychotherapy show as adults, a disporportionately high incidence of diagnosed psychoses, and sociopathic personality. Conversely the percentage of hyperkinetic children whose adjustment was characterized as evidencing "no psychiatric disease" (21 percent) was quite low relative to a matched control group (60 percent). It should be noted that the hyperkinetic children comprising this sample of roughly 250 children were not mentally retarded, nor were they psychotic at the time of the original diagnosis.

The few controlled studies of the therapeutic efficacy of psychotherapy in the treatment of hyperkinetic children show it to be minimally effective, especially compared to the results of psychotherapy of children with neurotic symptomatology.

The pharmacotherapy of hyperkinetic children started with the use of the stimulant drug Benzedrine. The amphetamines were introduced for the treatment of children with hyperkinesis more than 30 years ago. Since that time, there has been extensive use of the "stimulant" drugs (Benzedrene, Dexedrine, Ritalin) for the treatment of the hyperkinetic child. Both clinical reports and the extensive literature of controlled studies indicate a highly favorable clinical response.

The present concensus of expert opinion regarding the treatment of hyperkinetic children is that Ritalin (methylphenidate) and Dexedrine (dextroamphetamine) are the drugs of choice. Although Ritalin and Dexedrine are considered stimulant, they have a calming and quieting effect in hyperkinetic children in striking contrast to their exciting, stimulating effect in adults. Given under competent medical supervision, these drugs are regarded as safe and clinically effective in a very high percentage of hyperkinetic children. While children report that they feel better when receiving these drugs, we are aware of no evidence to suggest any feeling of euphoria and no evidence to suggest that these drugs are addicting in children.

The therapeutic efficacy of the stimulant drugs is evidenced both behaviorally (there is reduced overactivity, impulsiveness, temper outbursts, aggressiveness) and on such cognitive tasks as arithmetic, spelling, paired-associate learning, recognition, maze learning, etc. This improvement is obvious to the physician, parents, teachers, peers and to the child himself. Moreover, there is evidence to suggest that the stimulant drugs do not "dull" the child or decrease his activity level in appropriate situations such as free play; rather these drugs enable the child to sit still and attend in those situations, such as in the classroom, where this behavior is both appropriate and, indeed, necessary if the child is to profit from the educational experience and not become a school dropout.

The side effects of the stimulant drugs, loss of appetite and sleep difficulty, occur in approximately 12–14 percent of treated children. These side effects diminish over time and can be adequately controlled with adequate medical supervision by adjusting the prescribed dosage and the time during the day when the drugs are given.

It should be noted that both methylphenidate (Ritalin) and dextroamphetamine (Dexedrine) are approved by the FDA for the treatment of hyperkinetic children and that the efficacy of these drugs is supported by an editorial which appeared in the Journal of the American Medical Association in 1967.

A long-term followup study of hyperkinetic children who received stimulant drugs (up to 20 years previously) is presently being carried out at Harvard Medical School by Dr. Keith Conners. His preliminary findings suggest that there was a favorable outcome.

In addition to the treatment of hyperkinetic children with stimulant drugs, drugs of other classes ranging from the tranquilizers, antidepressants, and antihistamines have also been employed. While the phenothiazine drugs, introduced in the early 1950's, have proven effective in controlling the behavioral symptoms associated with the hyperkinetic syndrome there is little evidence to suggest that the phenothizines improve attentional and cognitive processes and some evidence to suggest that this class of drugs may actually interfere with efficient cognitive functioning.

The use of the antidepressant drugs have only recently been studied and while promising, there is not sufficient data available to make a firm judgment about their efficacy at this time.

Mr. Chairman, I would now like to direct my remarks to another related topic you expressed interest in—new regulations in the use of amphetamines.

The administration published in the Federal Register of August 8, 1970, a statement of policy on the use of amphetamine, dextroamphetamine, their salts, and levamfetamine and its salts. We are submitting copies of this statement for the record. The principle underlying concern in this regard is with use of these drugs in the treatment of obesity and with the problems of abuse.

This action was taken after the National Academy of Sciences/National Research Council Panel on Psychiatric Drugs concluded that these drugs have been shown to have a generally short-term anorectic, or appetite suppressing, action. The Food and Drug Administration agreed that they are not a treatment for obesity in themselves, but should be used only as an adjunct to a total program of weight reduction. Further, the anorectic effect often plateaus or diminishes after a few weeks.

Clinical opinion as to the contribution of the amphetamines, in a weight-reduction program varies widely. Most studies of these preparations are for short periods. The NAS/NRC Panel suggested that controlled studies of long-term effects of sympothomimetic stimulants in a weight reduction program be conducted.

Amphetamines were regarded by this Panel as being of value in the treatment of narcolepsy and in minimal brain dysfunction in children.

The statement of policy published is intended to deal with the amphetamines which did not go through the new drug procedures. The policy statement directs that the labeling of amphetamine and dextroamphetamine be revised since the present labeling neither adequately reflects the knowledge we now have concerning their limited medical usefulness nor emphasizes necessary warning information regarding their potential for use and abuse.

As relabeled, the amphetamines are regarded as new drugs. The new drug approach was taken in an attempt to obtain the information needed to reach a scientifically sound conclusion concerning their proper indications. Also, we believe that patient welfare would be best served if the amphetamines are also subject to the controls and experience monitoring facilitated by the new drug procedures.

The policy statement sets forth labeling for single ingredient amphetamine or dextroamphetamine preparations providing for their use in narcolepsy, hyperkinetic behavior disorders in children, and in exogenous obesity as a short-term adjunct in a regimen of weight reduction based on caloric restriction. The statement requires revision of the labeling for the many preparations presently marketed containing amphetamine and dextroamphetamine in combination with various other drugs, to be consistent with the labeling of the single component drugs. As relabeled the combinations are also regarded as new drugs.

In addition to amphetamine and dextroamphetamine preparations, there are on the market a few levamfetamine products. As far as we are aware, these are labeled only for obesity. We have at present no basis for prescribing labeling revision for these drugs because there is very little information available concerning their safety and effectiveness. The policy statement regards them as new drugs requiring approved new drug applications. Any of these which claim a "grandfather" exemption from the efficacy provisions of the law will be considered individually.

The net effect of the policy statement will be to require that the manufacturer of amphetamines and combinations revise their labeling within 60 days in accordance with the labeling prepared by Food and Drug Administration. Further, manufacturers will be required to submit within 1 year, proof of effectiveness for all claims made for these drugs. In the absence of such proof, manufacturers will be required to delete unsupported claims from the labeling. In addition to proof of effectiveness, manufacturers of levamfetamine preparations must furnish proof of safety before marketing of this product may continue.

The ultimate impact of this policy may be substantial since the equivalent of over 3 billion dosage units of amphetamines were produced for domestic use in 1968. As stated earlier, the extent of use in narcolepsy and hyperkinesis is believed to be quite insignificant as compared with use and misuse for obesity and gross abuse of such drugs on the illicit market. The Department of Justice was unable to account for the sale of 38 percent of the supply manufactured in this country. This Department and the Department of Justice are eager to work closely with manufacturers to stop the unnecessary production and sale of the drug.

Mr. Chairman, I will be glad to answer any questions you or the committee members may have.

Mr. GALLAGHER. Thank you.

Dr. POINTS. You are welcome.

Mr. GALLAGHER. In your statement on page 3, you say that children report they feel better when they receive drugs, whereas no evidence suggests any feeling of euphoria. Is that statement 100 percent correct? Is there is no addicting effect in children?

Dr. POINTS. I wouldn't say anything is 100 percent effective when it comes to medicine.

As far as any of the reports we have, we have not been able to find addictiveness coming from the use of these drugs for hyperkinesis in children.

Mr. GALLAGHER. It appears to be on a collision course with the fact that amphetamines are the leading cause of drug abuse in the United States.

I wonder whether or not we are involved in something here which may be misleading to the public. On the one hand we are advocating the use of amphetamines. On the other hand, it seems that the most common problem in every school throughout the country is the abuse of amphetamines by children.

I am wondering too about the followup program. Just what kind of followup programs have there been over the past years on these programs? What are the effects?

Dr. LIPMAN. I will answer that.

Mr. GALLAGHER. I might ask, while you are doing that, since this program obviously has been going forward for 30 years now—do we know what the effect is on what number of children involved, say for the past 20 years?

Are there any results at all?

Dr. LIPMAN. Let me talk to your question about followup studies. First, there are three studies that have been reported in the literature with regard to long-term followup studies of children diagnosed as having hyperkinesis. There is a study by Menkes, Rowe and Menkes, that has been published in 1967; a study by Morris, Eskol and Wexler published in 1966; a study by Patricia O'Neal and Robbins in 1958.

The combined sample of these studies involved roughly 250 hyperactive children, hyperkinetic children, and they were followed as adults and the results of that followup suggested a very high incidence of psychiatric disease in these children who had been exposed to treatment modalities other than drugs. Drugs weren't involved in the original diagnosis and treatment of these children.

The study that is currently being conducted by Dr. Connors at Harvard is in a preliminary data generating phase, and he has currently examined long-term followup on something like 67 children out of 100 who were originally treated by Doctors Denfoff, Bradley, and Laufer, and his preliminary findings are positive in the sense that these children who have been diagnosed as hyperkinetic and who had received Benzedrene, or dextroamphetamine as part of their treatment showed as adults a very low incidence of psychiatric disorder.

Mr. WYDLER. Before we get to Dr. Connors' study, would you tell me who funded those first three studies that you referred to?

Dr. LIPMAN. Those studies were done individually. Federal funds weren't involved to the best of my knowledge.

Mr. WYDLER. If we know it wasn't Federal funds, where did the funds come from that funded those studies? Who paid for them?

Dr. LIPMAN. I don't know. I would assume they were probably done by research people in universities. The salaries were being paid by the university and they were engaged in this activity as part of their academic function.

Mr. WYDLER. That is an assumption.

Could we find out who ultimately paid the cost of the studies?

To me that is significant, and I would like to know who that was, if we could find out.

Dr. LIPMAN. Yes.

(The information referred to follows:)

The information on the funding of these studies is as follows:

1. The study by O'Neal and Robbins on the "Relation of Childhood Behavior Problems to Adult Psychiatric Status: A Thirty Year Follow-up Study of 150 Subjects" was financed by the foundation's fund for research and psychiatry and by an NIMH grant (No. M–1400) awarded in 1956.

2. The Morris, Escoll, and Wexler study entitled "Aggressive Behavior Disorders of Childhood—A Follow-up Study" was financed by the Donner Foundation and by Hall Mercer Hospital, Pennsylvania Hospital Division, Pennsylvania Hospital, Department for Mental and Nervous Diseases.

3. The Menkes, Rome, and Menkes Study "A Twenty Year Follow-up of Children with Minimum Brain Damage" was financed by the United Cerebral Palsy Research and Education Foundation and by two grants (No. NB–05212 and No. 5–PI–NB–5359–04) from the National Institute of Neurological Disease and Blindness, NIH.

Mr. GALLAGHER. Dr. Connors is a recipient of considerable grants from the U.S. Government.

Dr. LIPMAN. Yes.

Dr. Connors and Dr. Leon Eisenberg have been granted funds since approximately 1958 and they are considered to be two of the leading experts in this area.

Mr. GALLAGHER. How can they judge their own——

Dr. LIPMAN. This is not their work. This is a followup study of children who have been treated much earlier by Drs. Laufer, Denhoff, and Bradley.

Mr. GALLAGHER. Is not Dr. Connor doing this work at Johns Hopkins?

Dr. LIPMAN. Yes; he has done that kind of work at Johns Hopkins since the early sixties. Dr. Leon Eisenberg initiated the studies of the program at Johns Hopkins starting roughly in 1958.

Mr. GALLAGHER. Isn't he defending his own case?

Are there any objective studies that go back any period of years on the use of amphetamines?

Dr. LIPMAN. Other than the study that Dr. Connors is currently engaged in, I am not aware of any others.

Mr. WYDLER. Can I ask you this:

The Federal Government has been funding Dr. Connors' studies for 4 years. Do we have any reports from him on the studies?

Dr. LIPMAN. Yes.

Those have been incorporated into some of the references that could be entered into the record of the hearings.

Mr. WYDLER. I assume we arrived at no conclusions as a result of these reports, however. Would that be a fair statement?

Dr. LIPMAN. No, sir. I don't think so.

I think prior to the work of Eisenberg and Connors there were many uncontrolled studies in the literature which consisted mainly of clinical reports, and supported on the basis of clinical observation, the efficacy of some of the drugs we are discussing today.

Mr. WYDLER. You are continuing his studies. I assume there is something else you are looking for.

Dr. LIPMAN. We are looking for neurological mechanisms underlying response to these drugs. We are trying to understand more fully what it is that is involved in hyperkinesis and we are also trying to

zero in a little more closely on selecting the right drug for the right hyperkinetic child, developing subtypes within the general diagnostic syndrome of hyperkinesis.

Dr. Connors is currently completing a study comparing the relative efficacy of dextroamphetamine, Ritalin and placebo in hyperkinetic children and he has evolved a typology based on teachers' reports of the behavior of the child, the parents' reports of the behavior of the child, and in this effort he is hoping to develop constellations of children who respond better to either amphetamine, Ritalin, or placebo, which is also included.

When I said uncontrolled studies, I think it is primarily the work of Eisenberg and Connors that provided the scientific support for the efficacy of these drugs which had been mainly based on clinician's observations pretty much up until about 1956.

I don't know if that answers your question or not, sir.

Mr. GALLAGHER. Could you answer this: Are there dissenting studies going on, funded by Federal money?

Dr. LIPMAN. Are there what?

Mr. GALLAGHER. Dissenting.

Dr. LIPMAN. Dissenting?

Mr. GALLAGHER. Yes.

Dr. LIPMAN. We are supporting a number of grants. We don't know what their findings will be until the studies are completed.

Mr. GALLAGHER. Nobody knows what the number of grants are?

Dr. LIPMAN. We know that.

Mr. GALLAGHER. How many grants are involved in this? What funding is involved?

Dr. LIPMAN. I would like to make a distinction between grant studies in the area of pediatric psychopharmacology and grant studies in this area, that are focusing on hyperkinesis.

Mr. GALLAGHER. We are focusing today on the use of drugs in behavioral modification programs.

I would be interested in that.

Dr. LIPMAN. I will just take this list in the order of it.

Dr. David Engelhardt is a psychiatrist at Downstate Medical Center in Brooklyn, who has recently received a grant in which the focus of the study would be both on autistic schizophrenic children and on children diagnosed as having hyperkinesis.

This study has only recently been reviewed and approved and was started, I guess, in June of 1970, so that there are really no findings at this time.

Mr. WYDLER. Is there something different between what he is supposed to do and what Dr. Connors is doing?

Dr. LIPMAN. Yes, sir.

Mr. WYDLER. All right.

Dr. LIPMAN. Dr. James H. Satterfield, a pediatric neurologist, Gateways Hospital in Los Angeles, is receiving funds to study the neurological mechanisms underlying hyperkinesis and as part of his procedure, he will give a single dose of Ritalin so that it is not really a clinical trial of Ritalin.

Donald F. Klein, director of research at Hillside Hospital, Glen Oaks, N.Y., has recently been funded and that study will compare the efficacy of Ritalin alone, Ritalin in combination with a tranquilizer, and placebo in children diagnosed as having hyperkinesis.

Mr. WYDLER. Is Ritalin an amphetamine?

Dr. LIPMAN. It is a stimulant drug like amphetamine, but it is not an amphetamine.

Mr. WYDLER. It is not?

Dr. LIPMAN. No.

The generic name is methylphenidate.

That study has just recently been funded, so thereare no results at this time.

Dr. Lawrence Greenberg, a psychiatrist at Children's Hospital in the District, has been funded for approximately 2 years now to study the relative efficacy of drugs of different classes in the treatment of children with hyperkinesis and he is comparing two tranquilizers, amphetamine and placebo, in children diagnosed with hyperkinesis. He is currently in the data analysis phase of that study, and his preliminary results suggest an overall superiority for dextroamphetamine in comparison with the two tranquilizers and with placebo, although he also feels clinically there are subtypes of children with hyperkinesis that respond better to one drug or another of these classes. But his data is still being analyzed at this time and he would not like to make a firm conclusion at this time.

Mr. GALLAGHER. Who makes a decision in these programs as to whether a child has hyperkinesis or is just a bored, bright, creative, pain-in-the-neck kid?

Dr. LIPMAN. In most of the studies there is a medical team involved in the screening process.

In Dr. Greenberg's study, for example, there is a child psychiatrist, Dr. Greenberg, a pediatrician, Dr. Shirley McMahon, and——

Mr. GALLAGHER. In this clinical study, where is that conducted?

Dr. LIPMAN. At Children's Hospital in the District of Columbia.

Mr. GALLAGHER. Let me clarify a point of our inquiry.

We are not really aiming at clinical privileged confidential, patient-doctor relationships. That is an area that we are not involved in at all.

What I am concerned about is when children are in the public schools and these children are involved in the experiments. The children are, in effect, getting involved in a psychological game of chance that may or may not affect their future. That is what we are concerned about.

How many public schools do you know and in what areas are these studies conducted?

Dr. LIPMAN. I don't think it would be fair to say that the studies are conducted in the school.

Mr. GALLAGHER. How do you select the children?

Dr. LIPMAN. Children are typically referred either from the report of the parent seeking help for the child, from the child's physician or pediatrician, or on the recommendation of a teacher and then the child may go through the route of seeing the school psychologist and then being referred on.

None of these studies are done directly in the school system.

Mr. GALLAGHER. What qualifications would a teacher have to make this kind of diagnosis to nominate a child for this kind of study?

Dr. LIPMAN. I think typically what may happen is the teacher will see that the child is extremely inattentive in class, extremely restless. The child is not performing up to the level of intellectual ability that the child has.

The child seems personally unhappy, unable to get along with his or her peers. The child is continually in motion, continually getting into things, and in general their academic performance does not come up to what their intellectual abilities would suggest it should.

Mr. GALLAGHER. Couldn't it also be similarly a result of a poor teacher, or a bright child who is beyond the point of concentration because the class is dull?

Dr. LIPMAN. I would say that the role of the teacher is not to diagnose the medical syndrome.

Mr. GALLAGHER. But that is where the child begins the treatment, diagnosed by some teacher, isn't that a fact? It comes from the public school system, as opposed to a parent who may take a child to a doctor?

Dr. LIPMAN. I think the role of the teacher is really a referral function. That the diagnosis should be properly made by a skilled medical person or a medical team.

Mr. WYDLER. I would think that what you describe as a problem is practically almost the average child that go to school. They have all of these kinds of problems. All you are dealing with is the question of degree. Don't most children have a problem of attention span and things of this nature? This is almost normal. I would think that is a normal problem. I have that problem myself.

Dr. LIPMAN. I think we all do.

Mr. GALLAGHER. To try to follow your testimony, we would need a quick fix on this. We are veering off the subject.

Dr. LIPMAN. All I am saying is that hyperkinesis is frequently something that brings the child into conflict with his parents, peers, and teachers, and that the teacher observes behavior and has a referral role to play, but, as you know, hyperkinesis is a medical syndrome. It should be properly diagnosed by a medical doctor.

Mr. MYERS. Is there a procedure that is used in every State, or does every State allow the use of drugs on students? My question is does your department set out guidelines to the State in the use of these drugs?

Dr. POINTS. The department does not send out guidelines to the school systems, but they do send out the regulations of FDA on the use of these drugs, however, not to the individual school systems.

Mr. MYERS. Are there any States which prohibit the use of drugs to your knowledge?

Dr. POINTS. Not that I know of, if they are prescribed by their physician.

Mr. MYERS. Can it be used on a student without the parent's permission?

Dr. POINTS. No, sir, it is not supposed to be.

Mr. WYDLER. I didn't hear the answer?

Dr. POINTS. It is not supposed to be by ethics, law. A physician cannot treat a minor child without the parent's permission.

Mr. MYERS. At this time, in your judgment, is this still to be considered as a pilot program, the use of these drugs, or would you say it is an on-going program?

Dr. POINTS. I would say these are on-going programs to find out all the ramifications, even the long-term ones we hadn't looked at until just recently.

Mr. WYDLER. In reference to the project that you just funded at Glen Oaks, N.Y., where are they going to get the children from?

Dr. LIPMAN. There are a number of referral sources. Some come from the family physician of the child, some come by way of other clinics for emotionally disturbed children, some come through the route of the school teacher, the child psychologist then to the clinic. There are many different referral sources.

Mr. WYDLER. I realize how many there could be, but I am wondering in this particular case, where did the proposal say they were going to get the children? That is what I am asking you. There are unlimited possibilities. I am saying where are these children going to come from? You talked about them as being between the age of 6 and 12, at least 2 years below grade level in reading and arithmetic. It would seem to me that more or less they would have to come from the school, wouldn't it?

Dr. LIPMAN. I think to a large extent they would be referred from the school. I would have to check the original grant application. I don't have that detail at my fiingertips.

Mr. WYDLER. Are there certain drugs approved by the FDA for use by children?

Dr. LIPMAN. Yes, sir.

Mr. WYDLER. Would you list them for me?

Dr. LIPMAN. I think perhaps Dr. Dobbs could answer that.

Mr. WYDLER. Would you list them for me so I know which ones they are when I hear them discussed?

Dr. DOBBS. Confining this to the hyperkinetic child, ritalin and the amphetamines. Certain of the tranquilizers are approved for use in children, but not specifically in the type of child we are talking about now.

Mr. WYDLER. Now, the second question is, are some drugs which are not approved by the FDA for use in children used by these experiments that we are discussing here?

Dr. DOBBS. In these particular experiments, not that I recall.

Mr. WYDLER. Not that you recall?

Dr. DOBBS. I could recheck this review quickly. I believe the drugs covered are the amphetamines, mellaril is one, and ritalin. All of those would be approved.

Mr. WYDLER. What is your answer to that question?

Dr. DOBBS. I believe all of the drugs included are approved for such use by FDA.

Mr. WYDLER. Thank you, Mr. Chairman.

Mr. MYERS. Could I ask another question?

Mr. GALLAGHER. Yes, sir.

Mr. MYERS. You all were introduced as doctors. Does this mean doctor of medicine?

Dr. POINTS. I have a doctor of medicine and doctor of philosophy.

Mr. MYERS. The rest of you, are you doctors of medicine?

Dr. DOBBS. I am a psychiatrist and doctor of medicine.

Dr. LEVINE. Doctor of medicine, psychiatrist.

Dr. LIPMAN. Psychologist with clinical training.

Mr. MYERS. Thank you.

Mr. GALLAGHER. Doctor, we have a study done on minimal brain-damaged children. Much of this type of research with drugs was

involved. A letter was sent to all parents on studies. This letter was sent to parents telling them; not asking them. When you say there is supposed to be consent, I would ask what kind of consent? Implied consent? Coerced consent? Explicit consent?

Dr. LIPMAN. I have one letter of informed consent from an investigator whose grant was recently reviewed. I would be happy to read it.

Mr. GALLAGHER. No; I am sure in some cases that is correct. We found in other areas there may be an implied consent.

Dr. LIPMAN. No; this takes the form of a written consent.

Mr. GALLAGHER. The one you are speaking of?

Dr. LIPMAN. Yes.

Mr. GALLAGHER. Are there any children involved in this that may not be covered by a written explicit consent?

Dr. LIPMAN. I don't know, sir, but the regulation——

Mr. GALLAGHER. I am not asking that. I know what the regulations are. The thing in these programs that troubles me is the number of children involved. How many children would you say today are being treated—we have seen quoted a figure of some 200,000 to 300,000 children. Would that be correct? More? Less?

Dr. LIPMAN. Well, if you restrict it to amphetamine and to Ritalin, I would say that figure is probably high. It would probably be closer to about 150,000 to 200,000. That is just a rough estimate, Mr. Gallagher.

Mr. GALLAGHER. Now, further, the man who gives that figure, Dr. Lipman, who we are speaking to here, you said that perhaps 300,000 children are now on the——

Dr. LIPMAN. That is incorrect. The figure I presented had 200,000 as an upper limit.

Mr. GALLAGHER. Then further you state, "I think the results of the last few years of research will soon reach the Nation's doctors. The pediatricians will begin using them." In effect, what will happen is it will zoom as word of its success spreads throughout the Nation's medical community.

Where do you think it will zoom to 5 years from now?

Dr. LIPMAN. I didn't use the term "zoom." I said it would probably increase.

Mr. GALLAGHER. I think your enthusiasm led to the word "zoom."

Dr. LIPMAN. I guess really some evidence that we have indicates that child psychiatrists tend to be using more of the stimulant drugs than pediatricians. I think the more recent studies that are well controlled and meet scientific standards have strengthened the earlier clinical reports and I think as the scientific validity of the treatment of children with hyperkinesis with the stimulant drugs as part of their total treatment program becomes better known and better accepted by the medical community, that there probably will be some increase. Now, where it will go, I don't know.

Mr. GALLAGHER. Do you think that it should be allowed to increase or zoom or whatever word we want to use, on the basis of the followup studies which involve, as I recall, some 250 children out of 200,000 or 150,000 or 300,000, whatever is the correct figure? Are we justified at this point in further funding the use of amphetamines for children?

Dr. LIPMAN. Well, I think there are many gaps in our present knowledge. I don't think we know as much about the neurological mechanisms underlying the action of these drugs as we might. Many studies are being supported, such as Dr. Satterfield's, to look into that area

more closely. I think also we are trying to develop a more refined approach to the treatment of children with hyperkinesis with drugs and we are now looking more at selecting the right drug for the right children when drug treatment is indicated.

I think we need more knowledge in these areas and I think the studies that we are currently supporting are directed to developing that knowledge.

Mr. GALLAGHER. If we need more knowledge, wouldn't it be better at the present time to control the clinical studies to those children whose parents request it, whose doctors recommend it, rather than have these programs reaching into our public school system?

Dr. LIPMAN. I don't think under any circumstances a parent should be coerced into giving permission for a child to receive drugs.

Mr. GALLAGHER. What does coercion really mean in that context?

Dr. LIPMAN. By coercion, I would mean strong recommendation to the parent without adequately explaining why the treatment is being given, what the possible side-effects of the treatment are, and what alternative treatments are available.

Mr. GALLAGHER. We have some evidence, I might say, Dr. Lipman, that some parents have been coerced into this. One who is here today, who was subjected to tremendous harassment and had to leave the city because she questioned the validity of the program when the technique was imposed upon that particular city.

Dr. LIPMAN. It is very difficult to talk about an individual case. I think none of us could testify——

Mr. GALLAGHER. This is one of the problems. We are talking about individual cases. The thing that troubles the committee is that when we start talking about treating the masses, what is the effect on the individuals? Why, for instance, did these followup studies appear to begin now when we have been involved for so many years?

Dr. LIPMAN. Well, I think this is an important area where further work certainly needs to be done. I think one of the reasons why there have been so few followup studies is because they are so difficult to do. They involve going back into medical records that are very difficult to come by. They involve tracking down people after a period of 20 years. This is very difficult logistically. It requires a certain kind of scientific dedication that you just don't find too many people have.

Mr. GALLAGHER. If we don't have it, then should the program be allowed to grow? This is one of the points of our inquiry. If there is not this amount of scientific dedication around at this time, why are we allowing this to grow in the proportion that it appears—to use your own words here, whatever they indicate—if we don't have any real followup studies in light of all of the evidence that we do have of the effect of the drug culture on American children today?

Dr. LIPMAN. Well, the followup study by Conners, which is the only one I can really talk to with any——

Mr. GALLAGHER. Yes; but Dr. Conners has been involved in this for some time. He is obviously a dedicated scientist to his thing. Where do we have some other dedicated scientist who may question this? This is the point. An adversary development may well produce a more valid opinion, no matter how dedicated the people may be. Are we doing any of that before we begin to zoom?

Dr. LEVINE. The adversary procedure is one procedure.

The procedures that Dr. Conners follows in the design of the experiments and in the conduct of them attempt to identify and to guard against biases that would creep in, so that his followup is an objective kind of followup stating what has happened to the particular individuals.

I don't think that an adversary procedure is the only way in which this kind of information can be gathered.

Mr. GALLAGHER. I am not saying it is the only way, but certainly there must be some other way than merely having a proponent of a program view it "objectively," as you tell me Dr. Conners is doing.

That is not the only way to proceed either, I would think. But that is the only way we are proceeding now.

We have hundreds of thousands of children, millions of dollars of taxpayers' money involved in this, and we are going on the basis of one or two opinions that are being formed now.

Dr. LEVINE. The use of the word "program," I wonder if we could clarify that. We don't indicate that there is an organized program being centrally run and conducted.

There are a number of studies in this area going on, individual studies, but the large number that is referred to, the 200,000 or 150,000 predominantly is being given—those drugs are being given in the context of private medical practice and the one to one relationship to which you referred previously.

They are not being given, to our knowledge, in terms of any large monolithic organized program.

Mr. GALLAGHER. In these studies that you have concluded and Dr. Conners' study, what is the addiction percentage of children in these programs, or the dependency percentage? Say out of 150,000 children?

Dr. LIPMAN. As I mentioned, Mr. Gallagher, the results of Dr. Conners' study is still preliminary, in the first 67 cases he examined, there have been no instances of diagnosed alcoholism or drug addiction.

Mr. GALLAGHER. Sixty-seven out of 150,000. That is all we have looked at? That is not a real basis to give additional millions of dollars to these programs, if all we know is 67, and when the whole bulk of the medical industry is trying to tell us, and all parents are trying to say, that amphetamines are so widely used they become the basis of addiction.

Dr. LIPMAN. With all due respect, the basis of addiction seems to be the euphorian quality that amphetamines have with adults.

All of the evidence that is available, indicates that there is no euphorian effect to taking amphetamines when given to hyperkinetic children.

Mr. GALLAGHER. Are you telling me there is no euphoria addiction or euphoric stage induced in children by Ritalin or amphetamines?

Dr. LIPMAN. To the best of my knowledge, there is not.

Mr. GALLAGHER. What is the point of——

Dr. LIPMAN. In hyperkinetic children.

Mr. GALLAGHER. Are all children involved in this certified hyperkinetic?

Dr. LIPMAN. You mean in the studies that we are supporting? Yes, sir.

Mr. GALLAGHER. At what age does the effect of amphetamines reverse itself and get the paradoxical effect?

Dr. LIPMAN. I would say after the age of 12 these drugs should be given with extreme caution, if at all.

Mr. GALLAGHER. What happens to the hyperkinetic child when he is 12?

Dr. LIPMAN. Well, many hyperkinetic children, when they reach adolescence, outgrow the hyperactivity.

Mr. GALLAGHER. But they do that without amphetamines?

Dr. LIPMAN. Yes, sir; they probably would.

But the followup studies where drugs weren't employed show that their total adjustment as adults is very poor.

Mr. ROSENTHAL. How many children are involved in the followup studies?

Dr. LIPMAN. Roughly 250.

Mr. GALLAGHER. I thought you told me 67 cases.

Dr. LIPMAN. There are four studies that I am referring to. Three of these studies followed up children who were diagnosed as having hyperkinesis who didn't receive drug treatment. The number of children involved in those three studies is approximately 250.

The fourth study I referred to is the preliminary results of Dr. Connors' study in which 67 out of 100 cases that are available to him have been looked at and as I indicated to this point, his preliminary results are quite positive.

Now, admittedly, these numbers are small, but that is the information available at this time.

Mr. MYERS. Has anyone approached this from the drug addiction point of view?

We have so many young people who are in their early twenties, who are drug addicts now. Have we ever approached this from the reverse position of looking into their background and seeing if any of them were hyperactive as children and might have received drugs?

Dr. LIPMAN. I don't know of any study.

Mr. MYERS. It looks to me like this would be the way to approach it instead of going the reverse way and looking at 250. Let's look at the end product who already became a drug addict and see why.

To your knowledge—none of the four of you here—this approach has never been taken.

Dr. DOBBS. I have heard the possibility discussed, but apparently it was never tried.

Mr. GALLAGHER. Could you repeat that?

Dr. DOBBS. I also heard this interesting possibility discussed, but as far as I know, it has never been tried.

Dr. LEVINE. There may very well be studies of amphetamine abusers underway now in which they are looking into their backgrounds and histories in which this evidence would be developed, but in this particular program the things that we are talking about today, we know of no study that has been conducted in that particular way.

Mr. MYERS. The bad thing about that is that we have to wait until after the fact. Are we creating more drug addicts? If we are, and I am not saying we are, but, it looks to me like someone should investigate this possibility.

Dr. LEVINE. The evidence we have to date is to the contrary. That it is not true.

It is a possibility. I don't think we would argue with that. However, I would like to differentiate between the careful medically supervised, medically dosed treatment of properly diagnosed individuals who have the hyperkinetic syndrome from the typical picture of drug abuse which is nonmedically supervised, drugs being obtained from illegal sources, primarily in people who don't have a medical diagnosis—that is a very different kind of situation.

Mr. MYERS. On the evidence that you have knowledge of, you say there is no indication of addiction.

To your knowledge, does everyone completely agree with this, or do you know of any of the professionals that might disagree with this assumption, and this conclusion you have drawn?

Is there anyone who says there may be a possibility of addiction that you know of?

Any professional doctor or——

Dr. LEVINE. I don't presume to know everyone.

Mr. MYERS. But to your knowledge?

Dr. LEVINE. I don't know anyone who has published or put forth data, scientific data, that would indicate that this is a possibility.

Mr. MYERS. Then to your knowledge, all four of you who testified, there is no controversial position here taken by anyone else differing from your views?

Dr. POINTS. I don't know of any personally.

Mr. GALLAGHER. May I follow up that.

Are you a medical doctor?

Dr. LIPMAN. I am a psychologist.

Mr. GALLAGHER. Are there any medical doctors on your staff?

Dr. LIPMAN. Numerous.

Mr. GALLAGHER. How many?

Dr. LEVINE. I am a medical doctor, chief of the psychopharmacology research branch, of which Dr. Lipman is head of the clinical section. There are two other physicians with us in this particular branch.

Mr. GALLAGHER. What is their opinion medically of the side effects? Do they concur with your observations?

Dr. LEVINE. They are not involved——

Mr. GALLAGHER. I guess they are. They are still working. [Laughter.]

Dr. LEVINE. They are not involved in this particular program and they haven't addressed themselves in the depth that Dr. Lipman has to this particular program.

I would also emphasize that the program of the psychopharmacology research branch, not the program that you were referring to earlier, is one in which we give grants for support of research and that research is conducted primarily by people in universities, both medical people and nonmedical people.

We are primarily a reviewing and funding agency.

Mr. WYDLER. I want to go back to something more fundamental here so I can get a point clear in my mind.

We are giving some school children these drugs. What is the purpose of it?

Is it to make that child learn better or more?

Is it to make it easier for his classmates to learn more because he becomes more amenable to the learning process and less disruptive, or is it to help the teacher possibly control the class?

For what purpose are we giving these drugs to children in school? That is really my question. I would like to hear somebody address themselves to that question.

Dr. POINTS. I will address myself to that, Mr. Wydler.

It is mainly to improve their learning.

Mr. WYDLER. Of the children that are suffering?

Dr. POINTS. Sir?

Mr. WYDLER. Of the children that are suffering, improve their learning?

Dr. POINTS. Yes, sir.

Mr. WYDLER. What evidence do we have that that has worked?

Dr. POINTS. There are several reports over the years that in these true hyperkinetic children, their arthmetic improves, and so forth.

These true hyperkinetic diagnosed children treated with these drugs, have increased their learning capacities and improved their social adjustment.

Mr. WYDLER. What reports?

Dr. POINTS. There is one, again by Dr. Eisenberg, "Role of Drugs in Treating Disturbed Children."

Mr. WYDLER. Those are the three we heard of before?

Dr. POINTS. Yes; but there are many references.

I can give you about 26—38 different references to the use of these in the hyperkinetic children.

Mr. WYDLER. They all concluded they help the learning process?

Dr. POINTS. Yes, sir.

Mr. WYDLER. And there were 38 reports?

Dr. POINTS. Yes, sir.

Mr. WYDLER. We have them in the testimony here somewhere?

Dr. POINTS. We have the reference for them. We don't have all the articles, but we have the reference for those.

If you would like, we will——

Mr. WYDLER. I wish you would supply it for the record, if you would. I would like to have that available to the committee and to the public.

Dr. POINTS. All right.

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Mr. WYDLER. Thank you, Mr. Chairman.

Mr. GALLAGHER. Dr. Dobbs, how does your agency classify amphetamines?

Dr. DOBBS. Pharmacologically or in some other way?

Pharmacologically, the amphetamines are central nervous system stimulant drugs.

Mr. GALLAGHER. What guidelines have you prescribed or established for prescribing these drugs?

I would preface this by saying: Is it not true you recently changed the authorized description of these drugs and the description of purpose for which they were described?

I would ask why the change was made?

Dr. DOBBS. The statement resulted from a number of different factors. It resulted from a very large scale review process of several thousand drugs that were marketed between 1938 and 1962, which were evaluated by the National Academy of Science/National Research Council Panels.

It resulted also, of course, from a concern with the problem of abuse.

It resulted from a concern that the amphetamines and some other drugs are used in the treatment of obesity, perhaps not always appropriately, and with less than excellent results in many cases.

The amphetamines present a difficult legal problem because they were marketed prior to 1938 and fall into what is termed the "grandfather" drugs.

Neverthless, we published recently, August 8, 1970, our statement which would require, among other things, that the amphetamines be relabeled. Currently they are labeled for a variety of indications, including the appropriate ones, and also they include fatigue and mild depression and a number of other things.

The labeling that we have outlined in the Federal Register statement includes as indications narcolepsy, minimal brain dysfunction in children, such as hyperkinetic behavior disorders, as an aid to general management, and, finally, exogenous obesity as a short term, that is a few weeks, adjunct to a regimen of weight reduction based on caloric restrictions.

Mr. GALLAGHER. Were the guidelines that were established—did they prescribe the use of amphetamines in the cases that you have just mentioned for rare usage?

Dr. DOBBS. For rare use?

Mr. GALLAGHER. Yes.

Dr. DOBBS. No, sir.

Our labeling doesn't ordinarily go to the frequency of use. It simply attempts to set out the appropriate conditions for use.

Mr. GALLAGHER. The appropriate conditions would be general, limited, or rare in the use of amphetamines in hyperactivity?

Dr. DOBBS. I am not sure I understand the question as to the rarity of the entity. The statement doesn't address itself to that.

Mr. GALLAGHER. Do you recommend they be widely used, or rarely used or limited to a doctor-patient relationship?

Dr. DOBBS. The drugs, of course, are prescription drugs, and therefore have to be prescribed by a physician. That has always been true and remains true, of course.

Mr. GALLAGHER. Doctor, a former FDA Administrator, Dr. Goddard, stated in an interview that amphetamines may be as dangerous or even more dangerous than so-called hard narcotics.

Do you agree with his judgment?

Dr. DOBBS. They are certainly both dangerous drugs. It is difficult to decide which is the more dangerous.

Mr. GALLAGHER. Would you agree at best that we don't have a great deal of information on the effects of amphetamines?

Dr. DOBBS. No, sir. I feel that we do have, relative to a number of other drugs, a good deal of information on the use of amphetamines in the children's entity that we are talking about today.

Perhaps less so in its use in narcolepsy. That is an uncommon illness.

The data on amphetamines in obesity are limited to a small number of actually good studies, and these would indicate only very minimal weight reduction.

Mr. GALLAGHER. Then, are they dangerous?

You are limiting your judgment of the use of the drug to children under 12; is that right?

Since most people seem to think that amphetamines are the highest cause of drug abuse in the country today——

Dr. DOBBS. Certainly one of the leading.

Mr. GALLAGHER. Yet we are prescribing it for children in what you describe as controlled circumstances.

I am wondering whether or not we do have sufficient information to say that the average child who suffers from hyperactivity should be used as a guinea pig in pilot programs?

Dr. DOBBS. It is our position that only the properly diagnosed child should receive amphetamines under adequate medical supervision. We certainly don't endorse the inappropriate prescription of amphetamines for a child who is merely restless or bored.

However, that would be a matter for the individual physician, the individual patient, and it is, of course, ordinarily out of our province.

Mr. GALLAGHER. You see no danger at all then in the use of amphetamines among hyperactive children?

Dr. DOBBS. No, sir; I couldn't agree with that statement. There is at least a theoretical possibility of abuse. But as my colleagues have stated, we are not aware of any evidence of amphetamines leading to addiction in later life. Amphetamines; that is, used in this context.

Mr. GALLAGHER. And you assume opposite studies to see whether there is any evidence, since that would have to be properly funded too?

Dr. DOBBS. Long-term studies are certainly needed in this area as they are in many medical areas.

Mr. GALLAGHER. Would you fund a study from those who may be in a position different from the proponents of the program?

Dr. DOBBS. FDA probably would not. FDA only funds a very limited number of studies. That is much more the province of NIMH.

Mr. GALLAGHER. Are you familiar with the drug program in Omaha?

Dr. DOBBS. I have some limited knowledge of the drug program in Omaha.

The newspaper article, of course, came to our attention and I made a telephone inquiry at the request of the bureau director to the physician named in that article.

Mr. GALLAGHER. Are you satisfied that all conditions were met in Omaha, Nebr.?

Dr. DOBBS. I was satisfied, sir that Dr. Oberst, and the program with which he is affiliated, the STARR program, was not a wide scale drug administration program. I was informed by Dr. Oberst that individual physicians were prescribing drugs for individual patients.

Mr. GALLAGHER. And it was limited to that as far as your knowledge is concerned?

Dr. DOBBS. To my knowledge; yes, sir.

Mr. GALLAGHER. Did you go beyond that to determine whether or not that knowledge was sufficient to continue on with the program?

Dr. DOBBS. We didn't. We were convinced that the situation was other than had been described and in any event was not a matter for Food and Drug Administration.

Mr. GALLAGHER. This was on the basis of your conversation with Dr. Oberst; is that correct?

Dr. DOBBS. Yes.

Mr. GALLAGHER. You didn't feel compelled to go beyond Dr. Oberst—this is an area where we do have limited knowledge to see whether or not there were any other effects or whether or not all the children involved were properly diagnosed as hyperactive?

Dr. DOBBS. We at FDA didn't see the necessity for further inquiry; no, sir.

Mr. GALLAGHER. Who would observe that necessity in the Government?

We are funding to the tune of $3 million. Is there anybody who oversees this type of thing?

Dr. DOBBS. To my knowledge we are not funding any program in Omaha. Certainly FDA isn't. I should not intrude on my colleagues.

Mr. GALLAGHER. The United States, in which we all play some small part, is involved according to the General Accounting Office to the tune of $3 million at the present time just for NIMH. Where there was a problem such as Omaha, wouldn't it be advisable to seek out the information, you or Dr. Lipman or somebody, and see what went on there?

Dr. POINTS. I made one or two calls just on a cursory basis, and the information I could gather, indicated there was no Federal program involved, and no mass program in the school. The patients under the program that we learned of from my cursory inquiry were on an individual patient-doctor relationship. Many of them could have been referred by the school to the physician for diagnosis. But there was no program as such involved in the Omaha program.

Mr. GALLAGHER. My point is, since we are searching for some evidence as to the validity of these programs, using children as guinea pigs for good purposes certainly, would it not be in the interest of the U.S. Government, your office and all of us, to follow up exactly what did happen in these programs? More than a telephone conversation or a personal basis of a cursory examination. What troubles me is that we are plunging ahead in this field with hundreds of thousands of children involved now, regardless of what the precise figure is, with the justification that narrows down to some 250 ideally situated children are involved and that becomes a justification to allow a program to zoom, to use one word, or increase, to use your word.

Are we really carrying out our responsibility by allowing this to proliferate to the degree it appears to be? If you are not watching it, who does?

Dr. POINTS. Up to this point, Mr. Gallagher, the funding, as I understand it, from the Federal Government has been to try to find a method of treatment of these children who are diagnosed as having hyperkinesis. There have been followup studies started now.

In answer to your earlier question, we would be willing to fund somebody who wasn't bent toward this way. I am sure the National Institute of Mental Health would look very kindly on such an application.

Mr. GALLAGHER. Did your office also do the study on Dr. Hutchnecker's proposal?

Dr. POINTS. Doctor who?

Mr. GALLAGHER. Dr. Hutchnecker. He had a proposal of open rehabilitation camps for 6-year-olds.

Dr. POINTS. I am not familiar with that, so I couldn't answer.

Mr. ROSENTHAL. Could anyone tell us what is the professional estimate, as to the number of children in the United States that may be affected by MBD disorders?

Dr. LIPMAN. Based on the percentage figures that we have seen, which have ranged from roughly 3 to 10 percent of the school age population, we would estimate somewhere between about 1½ to 3 or 4 million children. Based on surveys.

Mr. ROSENTHAL. I don't think you answered my question. Maybe I didn't phrase it correctly.

What percentage of our children suffer from MBD?

Dr. LIPMAN. The estimates we have are from 3 to 10 percent of those up to 12 years of age.

Dr. POINTS. Three to ten percent of the children from 3 to 12.

Mr. ROSENTHAL. Somewhere between 3 and 10 percent of the youngsters below 12 years of age are potential recipients of this drug program.

Dr. POINTS. Yes, sir.

Mr. ROSENTHAL. It seems to me a rather shocking figure.

How many companies make the drugs that have been involved in this experimental program?

Dr. DOBBS. First of all, sir, let me reiterate something that Dr. Levine said earlier. It seems to me the word "program" is being used in two different ways. At one moment to refer to several studies and at another moment to refer to a large number of children who may be

receiving the drugs from individual physicians. We are not aware of any large-scale program involving thousands and thousands of children consisting of drug administration——

Mr. ROSENTHAL. If this kind of treatment is successful, then substantial numbers of youngsters are potential patients of the program; isn't that correct?

Dr. DOBBS. I don't think we could give a very precise number. One of the problems is the terminology involved in the diagnosis. Incidentally, this is an area that I claim very little expertise in. Someone counted up approximately 38 different overlapping and similar terms that have been used for this entity. I don't think we know at all yet that every child who might be diagnosed as having minimal brain dysfunction would be a proper candidate for drugs.

Mr. ROSENTHAL. I was looking in the CIBA catalog. It says by one estimate that this disorder affects 5 percent or more of our child population. We are talking in terms of millions of young people, aren't we, as potentially programed into this therapeutic method? The most successful program would reach millions of youngsters.

Dr. DOBBS. We are probably talking about a very large number of children who have some form of learning disability. It may be that only a small fraction of those are proper candidates for treatment with one of the drugs that we are talking about. I don't believe that we have any good estimates of the number of children who should receive drugs.

Mr. ROSENTHAL. I am curious as to your professional opinion. I am shocked by some of the pictures in the catalog. I am surprised they were used.

Do you think these are legitimate pictures or posed pictures?

Dr. DOBBS. As no more than a guess, posed, but it is just a guess.

Mr. ROSENTHAL. Does that offend your professional sensibilities that they use that kind of posed picture in a catalog for professional men?

Dr. DOBBS. I don't think I could comment without really reviewing the piece as a whole.

Mr. ROSENTHAL. They say here that potential candidates for referral to physicians should be viewed by teachers, counselors, nurses, school psychologists, and so forth.

Do you folks consider that these people should be the ones who handle the patient initially?

Dr. DOBBS. Going to the question of the teacher, it seems to me it is very comparable to the teacher who feels that a child may have a visual impairment or hearing impairment. The teacher doesn't make the diagnosis or prescribe the glasses but she might very properly suggest that the child be evaluated by the proper professional person. I think the same thing might hold true for this entity.

Mr. WYDLER. I am particularly interested in this statement concerning the feeling of euphoria.

Is that something that is generally felt by an adult who takes these amphetamines?

Dr. DOBBS. Some adults do and some don't. I can't give you a better estimate than that. Some people are made uncomfortably nervous and jittery and tense by relatively low doses of amphetamines. Others feel a euphoria or so-called high.

Mr. WYDLER. But children don't get this feeling.

Dr. DOBBS. As far as we know, that is true.

Mr. WYDLER. What is the medical basis for that distinction? Could you suggest any to us?

Dr. DOBBS. No, sir; I cannot.

Mr. WYDLER. Could it possibly be that the children don't know they are having that feeling or maybe they haven't had enough experience with the way they should feel, being children, to describe it or know it? The only way you would probably be able to tell is to ask them how they feel. I wonder if—if the only evidence you get is their own statements, whether they know their feelings enough to describe them to you, the doctor, or whoever is asking the question. It seems to me there is no medical basis for the distinction you are drawing between a child and an adult and the physical reaction to a drug.

If there isn't any I would question that statement seriously unless somebody can suggest some reason why a child's body would react differently to the taking of an amphetamine than an adult's body.

Dr. POINTS. The reason is in the nature of development. In other words, the child's brain is not as mature, and synapses between the end of one nerve and the beginning of another are immature. These synapses are affected by the drugs in that they don't get stimulated as easily, thus slowing down the crossing of nerve impulses. The child is thus toned down without having a feeling of euphoria.

Mr. WYDLER. Why is this stressed so much in your statement? I don't understand that either. You underline the word "no" particularly, in page 3 of the statement, you say there is no evidence, underlined, to suggest any feeling of euphoria.

Dr. POINTS. Because all of the reports——

Mr. WYDLER. If there was evidence to suggest a feeling of euphoria, what would that mean to you?

Dr. POINTS. It would mean that these drugs were going farther than what they have been shown to up to this point and probably the child was maybe a little more mature mentally or brainwise than would show from the diagnosis.

Mr. WYDLER. But let's say that every child that you gave these drugs to indicated evidence of euphoria. What would you then decide to do with the drugs? What would that mean?

I am trying to find out why this is so important.

Dr. POINTS. I think the main importance of that is that one of the bases for the use of amphetamines by adults is the euphoria that the adults get from it. The children don't have this result so they don't have the desire to keep taking it so they will feel so good. This is the reason for that.

Mr. WYDLER. Maybe I am not making this clear. Let's say we had clear evidence that every child given these drugs had the feeling of euphoria. Would you then determine that possibly there was danger in their use?

Dr. LEVINE. To go to the first question, it is not unique that children or older people have paradoxical reactions to different types of drugs. For example, older patients over 65 commonly react paradoxically to drugs like phenobarbital and barbiturates. That is, instead of being calmed down by them they become more excited by them and confused, which again is a paradoxical reaction to the drug.

Mr. WYDLER. Is there a medical or physical reason for that?

Dr. LEVINE. The exact reason that this occurs is not known. However, there might very well be differences in the way the immature organism metabolizes the drug. That is, the way the body degrades it and eliminates it, that could account for these kinds of differences. There is the explanation also suggested by Dr. Points: It also may be that the neurochemistry of the central nervous system not being fully developed, not having the different hormonal controls that the adult has, leads to a difference in response.

At this time this is an empirical observation that has been made. The mechanism by which it occurs is unknown.

Mr. WYDLER. You are satisfied that the children don't have any feeling of euphoria. That is a universal statement but nevertheless what is stated in the testimony.

Dr. LEVINE. In medicine there are no universal truths.

Mr. WYDLER. But there is no evidence. That means you never had a case of it. I presume that is what it means.

Dr. LEVINE. To my knowledge there is no evidence that the feelings of euphoria are induced in hyperkinetic children when properly treated with amphetamines. Now, the reason that this is important is that if there were feelings of euphoria induced, as you suggested, we would be more concerned about the possibility of the child wanting to take the drug and going on to abuse.

Mr. GALLAGHER. What troubles me more now than before I started is the inexactitude of all of these programs. There is no evidence that they are all hyperkinetic children and you say that everything is perfect in all of this. I listen to mothers and teachers calling and screaming. You might say you can't address yourself to individual cases, but a 6-year-old with a dosage up to 50 milligrams, are you telling me there is no dependency? Where it does create a dependency? I am talking about individual cases and you are basically talking about 250 individuals.

We are talking in broad context of hundreds of thousands of children. The thing that really troubles me in this is a certain glibness about the experimentation on young children in this country, used as guinea pigs. In one case I know of, a dosage went up to 150 milligrams. Another case where a child, 6 years old, in effect, goes cold turkey every 3 months. There is nothing wrong with that, you say? Here we are acting in a way that rather assumes that the drug problem doesn't exist in America. I think the most torturous problem in our country today is drug abuse. The biggest part of drug abuse is amphetamines.

Even if you were absolutely right, are we not really on a dangerous course when our Government which you speak for—is encouraging growth in this area? This is the thing that troubles me, because we talk about credibility gaps and generation gaps. The U.S. Government says they cannot get off those drugs, but on the other hand they can take it until they are up to 12 years old. I just wonder whether or not we are justified in proceeding in any direction until we have more certain knowledge of the total broad effect.

I admire your presentation. It is great. If everything were exactly the way you say it is, perhaps that is the justification. It is, however, at odds with some of the people who are involved in the experimentation, parents who are concerned, and children who are involved. What about

the reliance, the dependency, created on the basis of a child being on Ritalin or amphetamines up to 12 years of age and then thinking that that dependency is no longer going to exist? This is the thing that troubles me. You made your case this morning, but you leave me more concerned than when we began.

Mr. MYERS. What is the alternative? We talked about the use of drugs. Would you consider this a drug program or a program to help hyperactive children to learn?

My second question is, what happens to children who would not receive this drug? We have many adults in this room. Maybe some of them were hyperactive as children. What type of individual, what type of citizen are they today? This isn't something new, is it? We had it for a long, long time.

Mr. GALLAGHER. Einstein and Jack Kennedy were probably the same way.

Dr. POINTS. I think this is one of our adjuncts in the treatment of this. We are also worried very much about the drug-abuse problem. We are very much aware of this. But we also don't like to feel that we deny these children that are diagnosed as hyperkinetic children treatment that we have felt was good treatment, that can help them become better students and learn better. Some have alluded to the fact that these children that are not treated have a higher dropout rate. I can't give you a reference on this but this has been said. There are other methods used, special education, to a great extent for some of these. I am sure that not all of these children are diagnosed yet.

Mr. GALLAGHER. Special education—you are referring to a slow-down curriculum where these are all together in one group?

Dr. POINTS. I cannot get into all these because I don't know them specifically, but many of the school systems do have special education classes, special ways for these children—I don't know them all. I never had looked into them, but I have had some knowledge of these in years past. But even with that, we find that these children that are diagnosed by hyperkinetic with this drug became better students.

Mr. GALLAGHER. Now, do you feel that the average country doctor, who is doing a very fine job, would be able to diagnose a hyperactive child?

Dr. POINTS. Having been a country doctor; yes, sir.

Mr. GALLAGHER. Have you ever prescribed drugs for children?

Dr. POINTS. Yes, sir.

Mr. GALLAGHER. Have any of you prescribed them for your own children?

Dr. POINTS. No.

Mr. GALLAGHER. Would you hesitate?

Dr. POINTS. No; not if my child's physician indicated, I wouldn't. I wouldn't make the diagnosis. But if my child's physician made the diagnosis, I would not hestitate.

Mr. GALLAGHER. Have any of you specialized in pediatrics?

Dr. POINTS. No.

Mr. GALLAGHER. Then you are considering this possible drug effect with the child as a trade-off. I don't think you ever did answer my question a while ago. You are thinking about a trade-off of balancing some ill effects, as Dr. Dobbs said there might possibly be, with the success

of the program for helping the children. Is that what you are saying?

Dr. POINTS. Yes. I think you do this in the practice of medicine in many diseases and many entities.

Mr. GALLAGHER. Being a parent myself, I hate to admit my children might have problems. Is there a tendency for parents not wanting to admit or recognize or accept the fact that their children are hyperactive? Should there be any stigma with the hyperactive child?

Dr. POINTS. No. I don't think there should be too much. As an illustration I used to use, there is a difference in horses. The race horse is a different makeup than the plow horse. You have to take the individual. I wouldn't think there would be any stigma at all to hyperactivity. Many of these people are average or above average intelligence.

Mr. MYERS. You say you have no guidelines now. Do you think that guidelines will be or should be necessary sometime in the future, either from FDA? I would assume that is where they probably should come from rather than from HEW. Do you feel there should be guidelines in the use of these drugs prescribed in the future?

Dr. POINTS. Yes; I think there will be. I think we have some now. We say that they can be used in those diagnosed as hyperkinetics. These are guidelines. Or do you think they should be more definitive? Is that what you mean?

Mr. MYERS. Yes, sir; that is my question.

Dr. POINTS. As to the definity, I hesitate for us to get into definitive guidelines for the treatment of most diseases because people are individuals and I think that the physician has to decide which one of these fits into the general broad guidelines of the drug users.

Mr. MYERS. One last question. In your judgment, how far should a school administrator go in trying to encourage—I don't say coerce—I say encourage a family to allow their child to have the opportunity to use drugs, this type of drug? I never taught school, but all my family has and I heard stories all my life about children being denied glasses because the parents didn't want them to have glasses. They didn't wear glasses and their kids weren't going to wear glasses either. Parents are inclined to want their children to be pretty much like they are and don't want to accept facts which might indicate otherwise, How far should a school administrator go in encouraging proper drug use?

Dr. POINTS. I don't know how far they should go, but they should be knowledgeable and know some of the things that they can call to their attention in these children. They can be referred for further diagnosis or further investigation.

Mr. MYERS. Refer them to their family doctors?

Dr. POINTS. Yes, sir.

Mr. MYERS. Thank you.

Mr. GALLAGHER. We will have some additional questions that we would like to submit to you, Doctor, if you would respond.

Dr. POINTS. I would be happy to.

Mr. GALLAGHER. Thank you very much.

The next testimony we will hear will be that of Mr. John Holt. He is a former grade school teacher. He has been, in fact, where the action is. He is also the author of several widely printed books, among them, "How Children Learn," "How Children Fail," and he is now an educational consultant and lecturer at Harvard University.

His testimony will be presented by his associate, Mr. Paul Curtis.

I want to thank Mr. Holt for taking time to prepare his testimony and I want to thank you also, Mr. Curtis, for coming here this morning on such short notice to present testimony I am sure will be very helpful to the subcommittee's inquiry in putting the subject under discussion in its proper perspective. That is, the perspective of the child.

Mr. Curtis?

STATEMENT OF PAUL CURTIS AND ROGER SMITH, ASSOCIATES OF JOHN HOLT, EDUCATIONAL CONSULTANT AND LECTURER AT HARVARD UNIVERSITY

Mr. CURTIS. John Holt is presently lecturing in Indiana, but due to his deep interest and concern about the indiscriminate use of drugs on highly active children, I, as an associate of Holt Associates, am representing him. Mr. Holt and I have prepared a statement, which is a synopsis of his recent printed statements.

STATEMENT OF JOHN HOLT AS READ BY PAUL CURTIS

Mr. CURTIS [reading]:

One of my concerns has been the lack of real knowledge as to the nature and effects of the use of these drugs. What actually happens when a child is given these drugs? A mother brings a child to a doctor and says, "Doctor, my child is doing this or that, he won't sit still at meals, he fights with other children, he doesn't pay attention to me when I talk, et cetera, et cetera." Does the doctor himself observe any of this behavior? He does not. Does he have any way of knowing the history of the child and the mother, whether there is anything in her way of dealing with the child that might cause the child's behavior? He does not.

Does he fulfill his minimum responsibility as a physician by giving the child a thorough enough physical examination to be reasonably sure that there is not some other somatic cause for the child's behavior—bad hearing or sight, other body malfunctions, muscular or nervous injury, tension, pain, hypoglycemia, protein or vitamin deficiency, allergies, gladular disturbances? In the cases I have heard of, he does not. Does he test in any way the hypothesis that it might be something other than brain damage in the child that is causing the mother to describe him as she does? For the most part, he does not.

Might not one of the causes be the fact that we take lively, curious, energetic children, eager to make contact with the world and to learn about it, stick them in barren classrooms with teachers who on the whole neither like nor respect nor understand nor trust them, restrict their freedom of speech and movement to a degree that would be judged excessive and inhuman even in a maximum security prison, and that their teachers themselves could not and would not tolerate? Then, when the children resist this brutalizing and stupefying treatment and retreat from it in anger, bewilderment, and terror, we say that they are sick with "complex and little-understood" disorders, and proceed to dose them with powerful drugs that are indeed complex and of whose long-run effects we know little or nothing, so that they may be more ready to do the asinine things the schools ask them to do.

We hear Dr. James H. Satterfield, a Los Angeles psychiatrist and director of Gateway Hospital's Hyperactive Children's Clinic, saying "The school system is usually the best place to identify hyperkinesis. The teachers are usually the first to recognize that the child has something wrong with him." He adds that he sees no problem of abuse in drug therapy.

Suppose I were to order Dr. Satterfield under the threat of heavy penalties to sit absolutely still, without even changing his position, and neither speaking nor making any sound without my permission, for many hours of the day, not just 1 day but about 180 days out of the year. How would he react to this demand? He would surely resist in whatever way he could.

Suppose I then announced that his reluctance or refusal to obey my orders showed that he was suffering from a malady called "hyperkinesis," and that for his own good, and whether he liked it or not, I was going to dose him with some powerful new drug to make him more compliant. What then? As soon as he could, he would probably have me arrested and locked up as some kind of dangerous and criminal lunatic. And most reasonable men would think him quite right to do so.

Children have a great deal of energy; they like to move about; they live and learn with their bodies and muscles, not just their eyes and ears; when adults try to compel them to remain still and silent for long periods of time they resent and resist it; most of them can be cowed and silenced by various bribes and threats; 5 to 15 percent cannot. These we diagnose as suffering from a "learning malady called hyperkinesis."

We ought to ask ourselves how do children behave during those years of their lives, when, according to almost everyone who has studied their learning, they learn more rapidly and permanently than at any other time. Do they sit still and quiet, and wait for people to tell or show them things? They do not. They constantly move about, investigating at first hand, and with all their senses and in all possible ways, every part that they can reach of the world around them.

Do we say that the baby or infant, busily exploring and experimenting, hardly ever still except when asleep, is suffering from hyperkinesis? We do not. We recognize that he is an extraordinarily able learner and that his learning grows out of his activity. Indeed, we have much evidence to show that a child who in babyhood and infancy is deprived of the chance to move about and explore on his own may later have a great deal of trouble in learning. How then and why do we decide that the energy and activity that in a 3-year-old is appropriate, necessary, and valuable, must in a 6-year-old be considered a disease?

The answer is very simple. We consider it a disease because it makes it difficult to run our schools as we do, like maximum security prisons, for the comfort and convenience of the teachers and administrators who work in them. The energy of children is "bad" because it is a nuisance to the exhausted and overburdened adults who do not want to or know how to and are not able to keep up with it.

Given the fact that some children are more energetic and active than others, might it not be easier, more healthy, and more humane to deal with this fact by giving them more time and scope to make use of and work off their energy?

In addition to the educational questions, there are two other areas that we must consider. First, the social response of the child, and second, the kinds of pressure that the parents are subjected to.

In the first instance, what I think we can say, and with great certainty, is that if we think a child is strange, treat him as if he were strange, and tell him he is strange, he will begin to think of himself as strange and will act more and more strangely. I have known some such children myself. They often talked and acted as if they had a license to act crazy, to do what other children were embarrassed or ashamed or forbidden to do. This, in turn, added to their reputation of strangeness, and so around in a vicious circle.

Further, in a community where parents are under enormous pressure to have their children look well and do well, in school and everywhere else, where people justify their lives through their children's accomplishments, the parents of these children are out of the rat race, off the hook. Other people might have to agonize—"What have I done? What must I do?"—when their son or daughter has failed in school, misbehaved, and broken windows. But not these other parents, for they have the perfect answer—their child has a medical label, so it is not their fault, there is nothing for them to do about it, and how lucky it is that there are these experts here to look after their poor darlings. Everyone is taken care of, except, of course, the child himself, who wears a label which to him reads clearly enough "freak," and who is denied from those closest to him, however much sympathy he may get, what he and all children most need—respect, faith, hope and trust.

Mr. GALLAGHER. Thank you very much, Mr. Curtis. That was an excellent statement.

The thing that troubled me with the previous witnesses, I might say, is that respect, hope and trust did not seem to be very much a part of the problem in the closely contained situation they were describing.

Everything seemed to be perfect and would be the perfect substitute for faith, hope and trust in children.

We sat through that testimony. It was really aimed at a very limited number of children. Some 250, is what it boils down to. Then it was further reduced to 67. What we are really talking about, however, is in this year of 1970 some 300,000 children and, as most of the people who have written on this subject say, this figure will zoom. That was the word actually used. We are probably talking about millions of children and proceeding on the justification of several people in the U.S. Government.

It appears that the full power of the U.S. Government is behind this program in these terrible times of drug abuse. I am wondering what your response would be to the presentation just made.

Mr. CURTIS. My personal opinion, because I feel to make reference to John after having read his statement would not be valid, but in my personal view——

Mr. GALLAGHER. I am interested in your personal views since you are associated with him doing work with children.

Mr. CURTIS. I myself have taught in public schools, both in America, and in England, and have had the fortunate opportunity of working in progressive education over here and have worked with children, a large percentage I feel would have been labeled as hyperkinetic children with the criteria I heard this morning.

It disturbed me that I heard some very vague statements in terms of real research into why and how these drugs were being applied and being used. Very little real understanding, I felt, was shown on the nature of how a child behaves and how a child learns, which I think is very relevant in this case because the children that came to me from public school as problem children because the teacher could not control them because they were a misfit in the classroom, these children when put and allowed into a less restricting environment where the child was allowed to develop as an individual, he was considered as an individual, the child became comfortable, not only in the school with other children but in his home with his parents.

I think what I would like to see is more looking at the children themselves before a wide use of drugs is applied for highly active children. I am not saying that I do not believe that there are not children who may need drugs. We are talking about a different problem. We are talking about brain damage. This is something that does not need tremendous medical research before you can apply this. But I don't think for the children that I have worked with, other teachers have been working with in many parts of this country, and it must apply to other countries as well, I think it would be a big mistake to apply this kind of strategy to most active children.

Mr. GALLAGHER. Thank you. This was the part of the problem with the testimony of other experts here this morning. They were addressing their responses to a limited number of children who may well have brain damage and, therefore, all the answers came out right.

The problem is broader. The problem is going to children who in no way are related to brain-damaged children, who fit under the term of hyperkinetics. This is the problem of what we are going to do in the future. Should we really proceed with this program?

I think what we are doing is substituting medical diagnosis for a code word that will now be part of the public school system. Hyperkinesis. Therefore justifying this on a wide scale.

I wonder, too, based on your experience and discussions with Mr. Holt and others, would you say we may be trying to alter the child to fit an uncomfortable situation rather than trying to alter the child's uncomfortable situation?

Mr. CURTIS. What I hear you saying, or what I think you are asking me is, are we trying to restrain the child because of the child's behavior rather than considering the child's behavior and then taking it from there; is that right?

Mr. GALLAGHER. Precisely.

Mr. CURTIS. I think that is a very easy thing to do. It is the very easy way out. Unfortunately, as educators, we tend to look for the solution before we really considered the problem.

I am not really too sure what you are asking me to say about that apart from that I——

Mr. GALLAGHER. On the basis of your experience, if the child does not have a brain dysfunction, if the child is hyperactive, not a child that we described who may be bored and bright but restless——

Mr. CURTIS. I think a child is a highly active human being. I have no desire to repress children. I believe there is a certain kind of discipline that is important, but what I feel is the question here is that this is not an unnatural function of a young human being to behave in this way and we cannot label as I have read from John's statement, we cannot label children. We should not want to label children with some easy way out that is going to solve the school's problems, the teacher's problems, the parents' problems. When it has such an important—it can have a very destructive effect on the nature of our educational system which is what I am very much concerned about.

Mr. GALLAGHER. That is part of my concern. The problem is in terms of groups rather than individual children. The problems of individual children wearing the scars of this kind of labeling. I am afraid we will move into a situation where if we put the label hyperkinesis on a child, it is as the old song, "Anything Goes."

But it was hard to find out how you get to wear the label. Whether or not the symptoms of brain damage are similar to a bright, active child who may be bored. But the label is sufficiently broad enough and if you buy the label, as the Government witnesses did this morning, then you apply the clinical results of children who are actually suffering from brain dysfunction. This is the problem.

The problem of labeling so many hundreds of thousands of our children where there has in fact been no medical diagnosis of that child, other than to make the child's attention span a little broader than it has been. If this is the trend, we may be supporting it by Federal grants. It would seem to me we are about to do a great disservice to a great number of children.

I have been informed that children with high IQ's who are not achieving up to their capacity in the classrooms like many of these children, or because of behavior problems, exhibited dramatic improvement when placed in groups with children of equal intelligence. Has that been part of your experience?

A child might be in a classroom with children not up to his level of intelligence, or might have a boring teacher, or a dull teacher, and that child does become hyperactive. But if placed in a class with a teacher of competence, and his peers have high IQ's, that child does improve considerably.

Mr. CURTIS. I think there can be many reasons for a child becoming hyperactive, and that is becoming a label which I myself do not like to use, all of which you have given examples of.

If a child is—as we know of our educational system, there is a program that is presented and a child can accept that or reject it. Now, the child who goes beyond that isn't getting any stimulation to be able to develop it any further. That child will become bored and may become a problem child in the class.

There is the other child who sees it to the other degree. Can't understand what is going on. His immediate needs are not met by the school's program. Therefore he becomes a problem child. He becomes bored and disinterested because he can't understand. To both extremes.

Going back to your point of brain damage, if a child has brain damage then there is definite need for medical assistance and I don't think that that particular child would be in the public schools that we are discussing that would be advocating the use of these drugs. He needs to be somewhere else. He needs to be somewhere where he can be given supervision and assistance, whether it is medical or social, psychological or whatever the assistance is.

Mr. GALLAGHER. I think you are absolutely right. What we are really talking about are apples and oranges. The justification for the apples may be valid but it is applied to oranges. That is another problem of those children who are bearing this label.

The other trouble is that in the educational societies themselves they are becoming aware of the uses of behavior modification programs. For instance, the master plan in Hawaii. I also point to an article in the January edition of the National Education Journal entitled "Forecast of the 1970's." It was projected that classrooms in the 1970's will become learning clinics with learning clinicians and behavioral input analysts rather than teachers as we know them today. I think this is all part of the developing pattern which gets away from the personal attention that children need.

It may well be helpful to some children in our schools. The question we must come to grips with is whether or not we are really prepared to now substitute drug modification programs on our children to bring them to a common norm and whether or not we are about to, in the 1970's as the National Education Journal indicates, turn classrooms into learning clinics and teachers into learning clinicians and input analysts and further depersonalizing our public schools system.

Drugs obviously can be very helpful in this area. Do you see this trend——

Mr. CURTIS. I do not feel qualified or experienced enough or sufficiently versed in the particular area to make any comments on that.

Mr. Smith, also a member of John Holt's associates, perhaps he could answer this.

Roger?

Mr. SMITH. Roger Smith I am also an associate of John Holt. I have been working on the same thing with John. One thing I would say is that you must understand clearly, and I think John Holt explains this

in his books and he is very much against the trends that public schools are taking and everybody taking for some considerable time in dehumanizing in successive steps.

This particular drug thing is an example of it. I do not know which gentleman it was who brought up three points I think about why the drugs were being used. Was it to help the teacher, the children, or whatever? The previous testimony here, which was essentially medical and limited to medical kinds of things, obviously opted for helping children to learn. The question that John Holt raises is that there are other things that are brought into this—the question of abuse. It is used by teachers and administrators to make themselves feel more comfortable and have the children adapt to the situation.

Now, this is what John Holt is against. This is what we are against. Not so much the use of the drugs in the carefully diagnosed and known situations but the indiscriminate use, and just by having a situation of no control but continued abuse, indiscriminate use of these drugs by anybody, reaching lower and lower into the levels and into the areas where there are people not obviously qualified to prescribe these drugs.

For instance, you could say a teacher is not qualified to prescribe amphetamines to a child, nor yet a doctor who has not made a proper diagnosis.

Mr. MYERS. How can you assume this when the M.D.'s thought they were capable of making the proper diagnosis? You are making an assumption here of no basis.

Mr. CURTIS. I don't think it is an assumption. I listened clearly to the testimony as to the kind of research that went in.

Mr. MYERS. Are either one of you medical doctors?

Mr. CURTIS. No; my qualifications are in education and I am not—I am giving you my personal opinion, as I said before, which you can accept or reject, but, you know, continuing this, of the medical introduction into schools, for many, many years now there has been questions as to the direction of public education, the direction of what is happening in schools of children being repressed, not allowed to be human beings, to develop as a personality. I see this as another step of avoiding the issue once again.

I would like to know where that is going to lead to.

Mr. MYERS. Are you suggesting a "Spock theory" of let the child do his thing? Is that what you are suggesting?

Mr. CURTIS. You are interpreting what I am saying and labeling it. If you are interested in my philosophy of education I would be only too pleased to tell you but I am sure it wouldn't be relevant to the hearing today. I am not advocating any particular kind of behavior education. I believe very much in a child being an individual, being a person, being allowed to be a person, and I don't see this consideration going into it in the advocating of the use of this kind of drug in school.

I see it as an avoidance of other problems existing in schools and I wonder where that is going to lead. Therefore, I really feel very strongly that tremendous research should go into this particular problem before we find ourselves in another situation in 5 years' time saying where do we take this from here and finding very little back up from where we started. It is real information that I think is important, whether it is educational, medical or——

Mr. MYERS. Do you have any experience in your background—I think both of you said you had been grammar school teachers—have

you ever had experience with the use of this drug? Have you seen it used?

Mr. SMITH. I have seen it used with children by a doctor, properly medically prescribed. I haven't bothered to question its use.

Mr. MYERS. You haven't bothered?

Mr. SMITH. I haven't bothered to question its use at the time since in the particular situations I walked into the situation and the child was already under it and I was unable to, you know, find out exactly how he behaved without it.

Mr. MYERS. What was the result of the use in your experience? Did the child lose his individuality as is being suggested by your associate?

Mr. SMITH. No; I think that is a little overdramatic. What I feel perhaps was that the child wasn't able to realize his full potential and I had no means of knowing what that was because in the case of the three children that I am thinking of, they really didn't get into anything. They had a very uncommitted approach to——

Mr. MYERS. Who is "they"?

Mr. SMITH. The three children I am talking about. It was a very vague—there was an attitude of vagueness about them. It wasn't anything somnambulic. It was just vague.

Mr. GALLAGHER. Euphoria?

Mr. SMITH. No; I really don't know what euphoria is in that respect.

Mr. CURTIS. The children I referred to before came from public schools where medical treatment had been advised for the children because of their inability to adjust to the school situation and the parents decided that they wanted to send their child to a different kind of school to see whether or not it was behavioral or what the needs were, so the three children came into my group. I can think of the three specifically. I had very little information at that time about the use of drugs, although even then I would have had the same feeling that without real information——

Mr. MYERS. They left your school?

Mr. CURTIS. They came to the school from the public schools. There was a certain amount of adjustment that was necessary. They established these preconceived ideas of the role of the teacher, the role of themselves with other children. One particular boy who was always told by the teacher that everybody in the class couldn't work because of Andrew, because Andrew made so much noise nobody could work. Andrew believed he couldn't work with anybody. He used to go home from school every day and cried and used to go to school the next day and misbehave and be a nuisance because that was the only way he knew to get attention.

When he came to the school I was working at he had no way of understanding how to behave. He was given the responsibility to do certain things. He couldn't take the responsibility. He couldn't understand that there were other ways of relating to children. It took him quite some time. There was no medical introduction into this child's case. He was given love and affection and perhaps a little understanding not only by the teachers, but by children as well, and he began to realize and he came around and——

Mr. MYERS. How old was he?

Mr. CURTIS. He was 7. He had had 2 whole years where he had been pushed in this direction. This was similar with other children. They were boys. They were lively. They were energetic. They wanted to move, build, explore and experiment, which is what learning is about.

Mr. MYERS. Somehow I didn't get the same idea from the testimony that they were wanting to have little machines sitting at desks. These were children that weren't learning that they were trying to give assistance to, to let them learn. Frankly, from the paper, you haven't offered any alternative to solving problem—that hyperactive children can't learn.

Mr. CURTIS. I haven't been asked to offer alternatives. I was asked to give my feelings.

Mr. MYERS. Would you be the one to ban the use of drugs entirely?

Mr. CURTIS. I think that is a carte blanche statement that nobody can really apply. I would like to see some real research and then I would be prepared to consider it and discuss it in terms of what I know of it now. Yes, I would.

Mr. MYERS. How would we get research? You have to have some type of, as has been suggested here, guinea pig. I don't think that is a very good word to use, a very good definition of students who have been given the opportunity to learn, but how would you get the experience?

Mr. CURTIS. Once again, I am not so sure I am here to suggest any forms of research. I would be very interested in suggesting some ideas to people if they were interested but I don't think it is the time and the place. I think this is something that could be considered as some kind of extensive followup. Even though I would wholeheartedly stand behind John Holt's statements, otherwise I wouldn't have read them——

Mr. MYERS. Dr. Holt, on his last page, called these children freaks. Do you think that is a fair definition? Do you think it is fair to call them freaks? No one called them freaks this morning. Yes; he referred to them as freaks.

Mr. SMITH. Because from his experience, and indeed my own, he is not labeling the children as freaks. He is taking from them what they said they felt they are.

Mr. CURTIS. Andrew was a freak. This child Andrew was a freak. He considered himself as not a typical child.

Mr. MYERS. Don't you think it is fair to him if he considered himself a freak to be given some kind of assistance, medical or mental assistance, psychiatric assistance or something some place along the line to help this child grow up to be a normal, productive individual in society?

Mr. CURTIS. No one is denying Andrew needed assistance. What I am questioning, or what I feel I am here to testify in terms of questioning, is how do we go about this? I don't see the advocating of these kinds of drugs, the indiscriminate use of drugs that is being used now.

Mr. MYERS. But you say that without any real experience in the use of them, don't you? You have nothing to base that assumption on.

That is what we are here for, we are trying to get concrete facts. You really have nothing to base that assumption on except a belief of your own.

Mr. SMITH. Except perhaps the issue might be there are no real concrete facts, not sufficient enough to make a——

Mr. MYERS. Either way. You would have to agree either way.

Mr. SMITH. That is the issue. So I suppose the thing here is that we must be very careful about promoting something that might have harmful effects about which, again, we know very little.

Mr. MYERS. I think everyone would agree with that statement.

Mr. GALLAGHER. It would seem to me that these gentlemen, perhaps, have more facts on how children react than the people who are authorizing the grants who never really have contact with the children. This is really what we are trying to get at, as to what is the best approach. Perhaps the nondrug remedial program encouraged by research grants may come up with some answers as to what we are going to do with creative, bright, intelligent children rather than to modify their behavior. This is the name of the game. Behavioral modification drug programs. Maybe the government should not be involved in this kind of thing.

I say again that the thing that troubles me is that we are about to embark on a program placing millions of children on drugs which we know so little about. I think that some of you people better put together some requests for grants for nondrug remedial behavioral programs, since we are worried about this. I might ask too: What is the effect on the child? How is he considered among his peers when they know each day he must take his little blue pill? What does that do to him?

One teacher I might say called me, and she was quite irate over the fact that I was involved with questioning this program. She said she couldn't teach little Johnny unless he had his dexe in the morning. I was wondering who really should have the dexe in the morning.

What is the effect of children to the degree you know of? How do their friends consider them when they know they have to take a dexe in the morning?

Mr. SMITH. That is where I got the word freak from. It is as simple as that.

Mr. CURTIS. Freak is ideology. It is another label.

Mr. SMITH. It is in children's language and in this particularly group's language, these children were apart from us. They weren't normal. They weren't the same as us. In difficult moments, they were the kind of children you ridiculed.

Mr. GALLAGHER. Then at the point where he begins to learn, in effect he then develops other problems in his personality. He may be then a better learner but obviously considered as strange by those that he is attempting to join.

Mr. SMITH. I think you have to question what he learns.

Mr. MYERS. Psychologically the word "freak" isn't very complimentary and encouraging to a child. I would use the word "exceptional" child. Every child is exceptional in some way or another. To me education is a matter of the teaching process being able to complement these exceptional children and draw them out. I have never taught, except practice teaching, but if I were a teacher I would try to

draw these things out and I can recognize, even though I haven't been a teacher, I see hundreds of kids in my traveling about and I see exceptional children and I know they are the superactive but I can also recognize the problem of the teacher who has 30 children in a large classroom trying to get the maximum out of each child.

If one child isn't playing ball with the other 29 something has to be done. Either the child doesn't fit in the class and then the child will be the loser; some way you have to bring the 30th child back into line with the 29 others. That is what we are speaking about. How will be accomplish this? Is it the responsibility of government to do this? You speak about a program of drugs. I don't believe there is any Federal program encouraging drugs, is there?

Mr. GALLAGHER. Yes; $3 million worth.

Mr. MYERS. It is not encouraging massive use of——

Mr. GALLAGHER. It involves itself with behavior modification programs which use drugs. Just for the record I might say it was not these gentlemen calling those children "freaks." It is what the children called themselves; is that correct?

Mr. SMITH. There are two languages in operation here and I completely agree, you and I wouldn't use the word freak for the obvious connotations. The language I used was drawn as an example here. It is the language that the children within the group use. Not what I would use or what you would use or other people.

Mr. GALLAGHER. How do you view the encouragement of these programs in context of the overall drug abuse within the school system? Is it related at all? Does it create a credibility issue?

Mr. SMITH. Only with suspicion based on the premise that as teachers, and we regard ourselves as people who practice, not theorists, we know just how little we know about children. We also are very aware of the periphery inputs. How little is known about that in terms of understanding a child psychologically. Too many gray areas. So we are unwilling to back any other kind of program other than one that is done very carefully, that is very carefully controlled, and very carefully watched and very carefully employed. Strictly so. There is really no chance of abuse. Children are much too precious to take chances with.

Mr. GALLAGHER. I want to thank you very much for pointing out an essential area: that is, the practice of teaching. You have pointed up the experience of the human relationships as opposed to the clear theory, and how this works out in practice. I think you have demonstrated that the problem concerns human beings who can't be viewed merely from the one dimensional or clinical aspect.

I am afraid some of the programs we are funding today reflect merely one side without taking into account the overall effect on the children involved and the overall effect on children who are associated with those children.

Do you have anything further?

Mr. MYERS. One final question.

Would either of you gentlemen feel that further research, as is being suggested here, as being already authorized, to investigate the use of drugs to assist children in learning, is ill-advised?

Mr. SMITH. No.

Mr. MYERS. Neither of you feel it is ill-advised?

Mr. SMITH. As long as at this point it is research and not widespread indiscriminate application.

Mr. MYERS. If doctors are prescribing drugs that are legal drugs, I don't know if this committee can do anything about that.

Mr. CURTIS. I suppose what I feel very strongly about is that I feel that there should be more information about the nature of children and learning. I think this is relevant to whether or not it is necessary to apply any kind of drug program to—I am getting fed up with labels. I feel it is very important, and I didn't hear anything here, of some real finding out with children about people working with children, from all levels, to find out what is going on.

Mr. MYERS. But you would not discard the possibilities of using——

Mr. CURTIS. I feel the research is very important.

Mr. GALLAGHER. This afternoon we will hear some people who are intimately involved with the research as well as several of the parents of children who have been involved in this program, what some of the results have been.

The committee will stand adjourned until 1:30.

(Whereupon, at 12:30 p.m., the subcommittee was recessed, to reconvene at 1:30 p.m., this same day.)

AFTERNOON SESSION

Mr. GALLAGHER. The subcommittee will come to order.

Our next witness will be Mr. Theodore Johnson.

Mr. Johnson is a chemist with the Veterans' Administration in Omaha, Nebr.; father of five children; someone who is quite familiar with the program of medication to alter behavior of children as being conducted in the Omaha school system.

We are not focusing exclusively on the Omaha situation, but since it was there that the program was first uncovered and was subjected to nationwide attention, we felt it was important to hear first-hand from someone familiar with the ramifications of the program in the Omaha community. It was not our intention to become involved in a wide-ranging criticism of educational procedures that may occur or that may be occurring in Omaha or any other city or State. Our concerns are to find out about the giving of amphetamines to children, and I want to welcome you to the hearing for that purpose this afternoon.

Please proceed.

STATEMENT OF THEODORE J. JOHNSON, CHEMIST, VETERANS' ADMINISTRATION, OMAHA, NEBR.

Mr. JOHNSON. Gentlemen, the series of events which caused us to be here today have seemingly resulted from issues, false issues and non-issues over what I perceive to be a basically simple problem. We have to determine whether or not a behavioral modification program exists, for one thing, in violation of some very basic individual rights. Second, whether legal drug abuse is a part of this plan. Third, whether the conduct of such a program meets ethical and scientific criteria for continuance.

I have submitted a prepared statement which I don't think I will read at this time unless you so desire, but there are some areas in that statement that I do feel need underscoring.

Mr. GALLAGHER. We will include the entire statement in the record at this time.

(The prepared statement follows:)

PREPARED STATEMENT OF THEODORE J. JOHNSON, CHEMIST, VETERANS' ADMINISTRATION, OMAHA, NEBR.

In July of this year, I submitted a statement to Congressman Cornelius Gallagher entitled "The Three R's: Readin', 'Ritin', and Ritalin." This was an attempt to demonstrate in a logical manner, the very real danger to which a whole generation of our children is being exposed. Since that time, there has been an overwhelming national response, asking the general question, "Is 1984 a product of an imaginative novelist, or the profound revelation of a prophet?"

Messrs. Ernest Chambers (Omaha, Nebr.) and Robert Maynard (Washington Post), raised the questions; I will attempt to furnish some answers and perhaps pose other questions.

WHAT ARE THE QUESTIONS?

Minimal cerebral dysfunction, hyperkinesis, learning disability, brain damage, hyperactivity, and problem child, are descriptive terms very loosely and interchangeably used, in any statements seen to date concerning this drug problem. The unstated danger lies in the fact that many, if not most, medical doctors believe that these terms are indeed interchangeable, attested to by the many statements submitted by them in support of the drug program—including Dr. Byron B. Oberst, the sponsor of the program in Omaha, Nebr.

Minimal cerebral dysfunction occurs in prepuberty children (usually disappearing without any treatment by age 14) who have borderline, average, or above-average intelligence. It is not associated with a pathological (cellular damage) condition of the brain cells. It is not detectible by electroencephalograph or by microscopic examination, as many physicians indicate. This condition, unexplainable, manifests itself by compulsive activity, peer-group frustration, short interest span, and bizarre behavior patterns; but it can rarely be accurately diagnosed by other than a neurologist. This would exclude any broad participation of the general practitioners, including pediatricians.

Hyperactivity, learning disability, etc., can and do occur from a variety of other causes which generally include: boredom, poor teaching, inadequate facilities, lack of parental guidance, watered-down curriculum, and inappropriate administrative policies and procedures. A smaller percentage may be the emotionally mental retarded (EMR) child. None of these causes are changed or "modified" by pills.

Question 1. Who is involved in the program?

Question 2. Why are the terms "behavior-modification" and "control" equated?

Question 3. Should there be a drug-therapy program for problem children in public schools?

Question 4. Is there sufficient justification to launch a full-fledged, intensive investigation into this type of program?

ANSWERS

Question 1. Who is involved in the program?

In Omaha, Nebr., the drug program, under the umbrella of the STAAR (skills, technique, academic, accomplishment, and remediation) includes medical clinics, private physicians, the Omaha public schools, some parents, and most important, children. The Omaha Board of Education and its administrative head, Superintendent Owen A. Knutzen, have denied an active role in the program. Dr. Dyron B. Oberst states in the August 10, 1970, issue of *American Medical News* that, "We have no formal program in Omaha." A position paper, written from the basis as president of the medical staff at Children's Memorial Hospital and the Omaha-Douglas County Medical Society representative, was presented June 1970, at a forum sponsored by the Omaha Board of Education, at the University of Nebraska at Omaha.

The first paragraph of this paper includes the following statement: "There are a number of existing examples of close communication and cooperation between the medical and educational community as evidenced by the STAAR program, which in part has been fostered and co-sponsored by the Omaha

Public School District with the approval of Dr. Owen Knutzen, the superintendent of schools. This has been a joint endeavor to try to reach about 10 percent of the total school population faced with school learning disabilities."

This document was signed by Byron B. Oberst, M.D., and stamped received June 10, 1970, by the superintendent of schools.

Designation as a program dictates that some organized structure exists, if only to accumulate data and to evaluate the results obtained. There must also exist an identification and referral system, which must involve the school system—as the classroom misbehavior occurs in the schools.

Question 2. Why are the terms "Behavior-Modification" and "Control" equated?

From preschool to postdoctoral programs, much concern has been demonstrated nationally, on the quality of education being offered to today's students. In all cases, it has been found to be much less than desirable, although this fact has often been obscured by overreaction to some forms of protest. Consequently, there have been innumerable programs and proposals studied and submitted to federally funded structures, in an attempt to resolve these problems.

Common to some of the more recent proposals, is the drastic departure from the notion of achieving academic excellence, and relating the educational experience to the daily needs and life styles of the consumer—today's child. This noble concept has been replaced by the attempts to control whole populations, by edifying conformity to a system already adjudged to inadequately serve 75 percent of the population. The obvious result of this course of action is to mass-produce mediocrity. Perhaps Senator Roman Hruska was merely exhibiting his clairvoyance, when he was making his now famous remarks about "mediocrity."

I offer these general observations:

(1) The "Master Plan for Public Education in Hawaii" introduced April 1969, by the superintendent of schools—directly related to a drug-therapy program.

(2) California, not to be outdone, has its "Grand Design."

(3) The most grotesque of proposals reached President Nixon, December 1969, by memorandum from Dr. Arnold Hutschnecker, a psychiatrist and consultant to the National Commission on the Causes and Prevention of Violence. He suggested that all 6- to 8-year-old U.S. children be required to take psychological tests to determine whether they had a predeliction for criminal behavior, and to weed out the potentially dangerous. This program would have been implemented by the construction of "rehabilitation camps," day-care centers and afterschool centers, where the children could be treated.

I have been informed that Dr. Hutschnecker was educated in Berlin, Germany, in 1939. This may explain the insight he shared with the President, "There are Pavlovian methods which I have seen effectively used in the Soviet Union." Perhaps even more alarming, is the fact that the President sent this ludicrous thing to HEW for advice on setting up pilot projects.

What noble, or even practical attribute can be assigned to these endeavors? Quite clearly, these programs are disguised under the banners of law and order, and the preservation of freedom of choice—how ironic.

Question 3. Should there be a drug-therapy program for problem children in public schools?

Extreme caution and control would obviously be prerequisites to conduct such a program. How professional are the professionals?

(1) Byron B. Oberst, M.D., describes himself as the primary architect of the program. He justifies this position by proclaiming himself an authority. He claims active association with this type of program since 1962, and referred to several articles published and/or spoken from over the years, on the subject of drugs and learning disabilities.

(2) Correspondence from HEW (FDA), dated August 6, 1970, received by Ernest Chambers, indicated that, "It was explained to Dr. Oberst that any use of drugs outside the parameters of the approved labeling is regarded as investigational and we recommend that the studies be performed in accordance with the investigational drug regulations under the Federal Food, Drug, and Cosmetic Act. This would entail, among other things. the submission of a notice of claimed investigational exemption for a new drug (IND)."

"It was pointed out to him, in relation to two drugs named in the article, that the Tofranil labeling does not carry any indications for use in children; in fact, there is in the warning section a statement not recommending its use in children. The labeling for a second drug, Aventyl, has recently been revised to delete any indication for use in children, and now specifically warns against notice of claimed investigational exemption for a new drug (IND).

Dr. Oberst stated that he was unaware of these facts and we agreed to forward the necessary forms and full information on requirements to him. These were mailed on July 8, 1970.

The closing paragraphs imply that by August 6, 1970, the date of this letter, there had been no response from Oberst. Remember, the forms were mailed to him July 8, 1970. The letter was signed, M. J. Ryan, Director, Office of Legislative Services.

The additional question raised is, "How many of the doctors currently prescribing these drugs are even more ignorant of the status and the effects of them?"

I refer now to the 2-day meeting of 16 scientists (October 30–November 2, 1969) held in Los Angeles, Calif., at the request of the National Institute of Mental Health Council and the National Advisory Mental Health Council. They were charged with considering the nonpsychiatric hazards of drugs such as LSD, amphetamines, barbituates, narcotics, and marihuana. Dr. Joshua Lederberg, a council member and Nobel Prize winning Stanford genetecist, and Dr. Samuel S. Epstein, a toxicologist from Children's Cancer Research Foundation in Boston, and the meeting chairman, repeatedly pointed out that many drugs on the market have never been tested to see whether they have the same hazards to genetic material that LSD may have. Dr. Lederberg said, "We are beginning to think that every agent has some teratogenic, mutagenic, or carcinogenic effect on some system at some time."

The method of recruitment and referral is the issue which brought the situation in Omaha to focus.

(1) Coercion of parents by harassing techniques used by teachers and administrators, along with threats of expulsion of children from the public schools.

(2) Rejection of any diagnosis that did not result in a prescription for some medication, those nonproductive pawns would be referred to other doctors until one was found who would make the "right" prescription.

I can only conclude that under these circumstances, no program of this nature should be permitted in any school system.

Question 4. Is there sufficient justification to launch a full-fledged, intensive investigation into this type of program?

This is the question that you gentlemen must answer. I am prepared to amplify this statement with oral testimony, and to answer whatever additional questions you may have, within my ability.

The Three R's: Readin', 'Ritin', and Ritalin

A statement on the school-drug issue in Omaha

(By Theodore J. Johnson)

"We are, in fact, in the midst of a drug culture that threatens the future of our society if we do not act swiftly, forcefully and intelligently to bring it under control . . . The alarming fact is that we may be just in the first stages of this collective national trip . . . It is expected that the use of all forms of drugs in the next decade will increase a hundredfold . . . We as a country have hardly noticed this remarkable phenomenon of legal drug use, but it is new, it is increasing and the individual and social costs have yet to be calculated."

—Vice President Spiro T. Agnew, June 1970.

WHAT PROGRAM?

When is a program not a program? That seems to be the question raised in Omaha, Nebr.—resulting from the dialog about STAAR: Skills, technique, academic, accomplishment, and remediation. STAAR is a program concerned with behavior modification, by the use of drugs, introduced to the Omaha public schools over 1 year ago—according to Dr. Byron B. Oberst, a local pediatrician. The public schools, through the superintendent, denied an accessory role to the program. Board of education members expressed a variety of responses, from "I don't know anything about the program", to, ". . . the schools are only a passive instrument in the administration of drugs."

STAAR is an undeniable reality, and by definition of program, a reality with stated goals and objectives. If classroom "behavior modification" and extended interest spans are the immediate goals, and improved education the objective; then the following conditions must also be present:

I. Endorsement and cooperation from the school system

Any program which involves the physical facilities, personnel, or the student population of the public schools, must be evaluated and approved in terms of cost, maintenance, and supervision. Contingent to this decision, is the subsequent assignment of space, facilities, personnel, and students, or a structure whereby this can be accomplished.

II. Monitoring and collection of data

Any program, experiment, or study, which expects change, must have programed into it, some observation or monitoring agent, within the environment where the change is expected to occur—how else can the "change" be noted? If these observations are to be used to verify or disprove a hypothesis, then there must also be within the experimental design a means of collecting and correlating these data.

III. Selection of experimental population and the establishment of statistically significant numbers

Defined in the objectives and goals are the types of groups of the population to be studied (in this case, classroom behavior problems). These have to be located and identified—even the Greenleigh Associates didn't have that kind of access to the schools. To be of any significance in the evaluation of the experiment or study, the population under observation must be able to meet certain statistical criteria. The number required in the sample depends on the variability of the specimens and on the degree of error that will be tolerated in the result.

IV. Establishment of controls over the experiment

Assuming that a specific result is sought in a given experiment or program, the subject(s) under study must be in a continuously controlled environment; where all possible parameters are either controlled or observable. That is, any change must be able to be correlated with the experimentally introduced agent. Introduction of other nonmeasurable or noncontrollable variables, makes any experiment insignificant, or, at best, coincidental—in any case, of no value in an evaluation.

Francis Bacon said, "Read not to contradict and refute, nor to believe and take for granted . . . but to weight and consider."

There are some rules and guidelines which should be followed if there is a sincere desire to conduct a meaningful study or program:

1. What investigations have already been done? Has the relevant literature been critically reviewed?
2. Define the problem in terms of its manifestations to distinguish it from other conditions with which it may be confused.
3. Information obtained is marshaled and correlated and the problem is defined, broken down into specific questions.
4. Intelligent guesses are made to answer questions, and as many hypotheses as possible are considered.
5. Experiments are devised to test first the likeliest hypotheses bearing on the most crucial question.

LET US EXAMINE A FEW FACTS

As many as 12 different drugs have been, or are being used in the STAAR program. Of these, five have been identified by Dr. Oberst as: Ritalin, dexedrine, deaner, aventyl and tofranil. It is most interesting to inventory the side effects of these drugs, which include: nervousness, nausea, overt psychotic behavior, psychic dependence, sodium and potassium depletion, vomiting and/or mental confusion, possible suicide attempts in depressed patients, agranulocytosis, hypotension, overstimulation, epileptiform seizures, insomnia, dizziness, angina, jaundice, paralytic ileus, impotence, anorexia, palpitation, cardiac arrhythmia, tremor, hostility, and high blood pressure.

There are many others, equally undesirable. Consideration of the contraindications and the warnings will help to place the observations in their proper perspective: hyperthyroidism, restlessness, and prepsychotic states—patients may become agitated during therapy.

NOTE.—Pending evaluation of results from clinical trials in children, the drug is not recommended at the present time for use in patients under 12 years of age.

On this basis alone, there is clearly indicated, the need for strong prohibitive legislation—especially when we consider that 8 percent of the total prescriptions written in this country are for the administration of amphetamines (H. Res. 17,

91st Congress, first session, Nov. 18, 1969). Unfortunately, there are other considerations which must be dealt with. One of these considerations is the investigated subject—the child, age range 6–18. At this point, I refer back to the location, identification, and selection of experimental subjects.

If we are to believe the statistics furnished by our schools, our hospitals and our State and Federal governmental agencies, then we must accept that:

1. The underachiever, the slow learner, the nonreader, the class disrupter, and the discipline problem, is the kind of student considered typical or, at least, common to minority groups—ethnic, economic, and cultural (in public school jargon, title I kids).

2. This position is supported by the facts, that these are also the schools where corporal punishment is part of the curriculum; where security guards are posted and patrol the halls; where 90 percent of the remedial programs are instituted; and where teacher-training programs can be justified when applying for Federal grants.

3. The existing educational system is not serving the needs of the majority of the population (if only 25 percent succeed, then 75 percent must fail, or fall somewhere short of success).

The inference that can be drawn from these statements is that minority groups are, in fact, the targets, or objectives of the STAAR program. Literally tons of reports and studies resulting from continuous research and investigation, supports the notion that poor educational achievement among the socioeconoculturally deprived (where behavior problems are greatest), more often than not, is attributable to racist attitudes among teaching faculties and administrators, inferior or outdated textbooks, watered down curriculum, inadequate facilities, incompetent teachers, and all the ills generally associated with the "poverty cycle." Second, the introduction of behavioral modification drugs is perceived to be another step in the process of controlling specific groups of people.

A SIMPLE MATTER OF ARITHMETIC

Residents of deprived areas exhibit a variety of physical, mental, emotional, and environmental conditions, symptomatic of our current social disease. Among these conditions can be found: malnutrition, broken rest patterns, anxiety, depression, tension, inadequate housing, hyperexcitability, unstable homes, and physical fatigue.

These are also some of the causes of the "behavioral problems" which are encountered in the classrooms. How many are so naive as to believe that a pill is going to place shoes on bare feet in December; or make the rats leave the premises; or make a bowl of cereal equivalent to ham and eggs with orange juice and toast? No pill is going to make the Dick and Jane stories relevant to the child who oftentimes must match wits with the hustler in the "streets" just to survive until the next day. It would indeed be the miracle drug that could cause any child to regard the wooden board that punishes his flesh, or the teacher that wields it, as an educational tool which has his best interests at heart.

Equally important is the underlying fact that these conditions, where found, contraindicate the use of nearly all of these drugs, and are included in special warnings accompanying them.

To cite a few of these special warnings:

Ritalin

May mask normal fatigue states induced by overexertion.

For severe depression. * * * used only in the hospital under careful supervision.

Aventyl

The possibility of a suicidal attempt in a depressed patient should always be considered.

Troublesome patient hostility may be aroused by the use of Aventyl hydrochloride.

This drug, like members of its group, has a tendency to produce sinus tachycardia.

Dexedrine

Excessive use of amphetamines by unstable individuals may result in psychological dependence.

Use with caution in patients with severe hypertension.

Tofranil

Possibility of suicide in seriously depressed patients.

Pending evaluation of results from clinical trials in children, the drug is not recommended at the present time for use in patients under 12 years of age.

When considering the type of child most prone to be identified as a behavior problem, we find that usually this is also the child who should not be given drugs—of any kind.

Lesson: 1+1=2, even in the ghetto.

CAN A LAYMAN EVALUATE THIS PROGRAM?

Yes, given the total picture:

1. Dr. Byron B. Oberst, initiator, of STAAR, has stated that no one really knows how these amphetamines work.

Compare that statement with the facts surrounding Chlormycetin. This is an antibiotic about which much is known; yet it didn't prevent the lady in Ohio from developing a beard, acquiring heavy muscles and a deep voice, et cetera.

Aside from the immediate organic effects, it is entirely possible that genetic effects, which may not show up for a generation or more, may be occurring.

Within the past 3 weeks, at an international convention, in St. Louis, Tolbutamine (Orinase), a drug used to substitute for Insulin in diabetics, has been charged with increasing the incidence of heart disease in diabetics—along with supporting statistics.

What could we be doing to our children who are still in their formative years?

2. A critical search through the literature will very likely reveal that 90 percent or more of the research, evaluation and presentation of these drugs was conducted by the drug companies, or through investigations underwritten by the companies.

Self evaluation is a noble endeavor, but realistically, we do live in a profit-motivated society.

3. Crime in America—Why 8 billion amphetamines?

Familiar? This question entitled the Hearings before the Select Committee on Crime, House of Representatives, 91st Congress, first session, pursuant to House Resolution 17, Nov. 18, 1969, Washington, D.C. Perhaps recalling some of the testimony given before the committee will best establish the basic premises leading to the ultimate conclusions.

Dr. Sydney Cohen, Director, Division of Narcotic Addiction and Drug Abuse, National Institute of Mental Health.—"I would like to clear up one point, namely, that the large doses of methamphetamines can produce all the hallucinations and all of the strange illusions and delusions that LSD can do, even though they are two different groups of chemicals".

Dr. John D. Griffith, assistant professor of psychiatry, Vanderbilt University School of Medicine.—"I would first like to point out that every drug, however innocuous, has some degree of toxicity. A drug, therefore, is a type of poison and its poisonous qualities must be carefully weighed against its therapeutic usefulness. A problem now being considered in most of the capitals of the free world is whether the benefits derived from amphetamines outweigh their toxicity. It is the consensus of the world scientific literature that the amphetamines are of very little benefit to mankind. They are, however, quite toxic."

Responding to the question: Are they used in mental hospitals where there is a serious mental disturbance?

"Very rarely by competent physicians. After many years of clinical trials, it is now evident that this antidepressant effect of amphetamines is very brief—on the order of days. If the patient attempts to overcome this tolerance to the drug, he runs the risk of becoming addicted and even more depressed."

"Dr. Cohen has said, and I support him, that amphetamines are used in the treatment of hyperkinetic impulse disorders. Children who manifest this condition are frequently brain damaged and exhibit such a high degree of pathological hyperactivity that they cannot learn, be disciplined, or allowed to play with normal children."

(How many children fit that category?)

"Approximately 8 percent of the prescriptions written in this country are written for amphetamine drugs. That is a lot of prescriptions."

"* * * there is a need for research in the field of drug addiction and alcoholism. It may come as a surprise to some of you that we do not know how drugs and alcohol act; where they act (except somewhere in the brain); or how to treat addiction to these substances."

Dr. Benjamin J. Shepard (M.D. and attorney), executive director of the Catholic Services Welfare Bureau for the Archdioceses of Florida.—"Dexedrine does help the hyperkinetic * * * But the duration of Dexedrine is never very long * * * I ersonally can see no use for amhetamine whatsover. I would be in favor, very definitely, of banning it completely, or giving the few people who need the Dexedrine in this type of school some supervision."

"The FDA has determined that in 1962 over 100,000 pounds of amphetamines and methamphetamine products were available in the United States. The amount in this 1-year inventory is enough to supply 25 milligrams of these substances (stimulants) or 25 to 50 doses to every person in this country."

Dr. David C. Lewis, associate in medicine at Beth Israel Hospital and Harvard Medical School, Boston, Mass.—"They (amphetamines) are now recognized to be a group of drugs with a very high potential for producing psychological dependence * * * The behavioral toxicity with high doses often reaches the proportions of what has been described as the "amphetamine psychosis," a condition characterized by distortion of reality, impairment of judgment, and a hyperactive paranoid state with hallucinations."

"Virtually no other drug currently being abused has this wide a spectrum of hazards, and I would include here the opiates, the hallucinogens, and marihuana. Amphetamine abuse is the major drug abuse problem in the United States outside of the large cities where heroin addiction is so prevalant."

"We continue to insist that they are good drugs when used under medical supervision but their greatest use turns out to be frivolous, illegal, and highly destructive to the user."

"It turns out that amphetamines really do not conform, in my opinion, to the standards that we attempt to apply to every drug. That is, we need to show that there is a need for the drug, that the drug is effective, and that it is safe. On all three counts, I really do not feel that they qualify."

"I frankly feel that if amphetamines remain legal, you almost have to legalize also heroin, LSD, and marihuana in order to remain consistent, because they also have therapeutic potentials and amphetamines just are not that much different from these apparently terrifying dangerous drugs."

Dr. George R. Edison, director of Student Health Service, University of Utah, and chairman of the Board of Trustees of the Community Drug Crisis Center in Salt Lake City.—"I think the Food and Drug Administration now has sufficient evidence of the ineffectiveness as well as the danger of these drugs to remove them from the pharmacopoeia without resort to legislation. If FDA action or voluntary curtailment by the pharmaceutical industry does not develop, legislation will be necessary."

CONCLUSION

The conclusion is obvious. The STAAR program, as it is practiced in the Omaha public schools, should be immediately discontinued, condemned, and revealed as another ploy to hide and cover up the real reasons that our children are receiving an inferior education. This type of response and action is all too consistent with the mentality and rationale displayed by our school board and its administration.

How great it would be if we could get this much energy and resources directed toward the improvement of course content, teaching development, and curriculum revision.

Mr. MYERS. I have two statements.

Mr. JOHNSON. Both statements were submitted.

Mr. GALLAGHER. We will include both statements.

Mr. JOHNSON. The first thing that comes up, is there a program? First of all, there has been a great denial that any kind of organized effort exists, whether or not it exists only to assess whatever information is gathered for purposes of evaluating the program.

Now, if such a thing does not exist, then we are all here on a wild goose chase. There exists in Omaha a program called STAAR under

which they at least gather together people who are connected with the prescribing of these drugs and since we are talking about the drugs being a help-meet for students, we must have some way of identifying the problem students. We must have some mechanism devised, whereby we can refer these to M.D.'s, or what have you, who are responsible for prescribing for these students. On the way back, there has to be someone to monitor the behavior of any of the children that are placed on these drugs. They have to collect this data; they have to weigh it in terms of its good and bad effects, and it has to be reportable. Else, those who purport that all these beautiful statistics that say this, * * * "helps in 85 percent of the cases," * * * where are they getting their figures?

So, whether there is a program in existence or not, and how well knit or how loosely the organization is formed is really of no value for purposes of this investigation.

Now, the schools, particularly in Omaha, deny that there is such a program. They have to make, at least, the personnel of their schools available to take part in the program. It has to be the teachers who identify the students in the classrooms as being the behavior problems. The schools have to make the referrals, whether they be to the parents or whether they be to the educational psychologist, which is hired by the school system and where the ultimate referral should be made, to those pediatric-neulogists or whatever.

Since the primary issue of this committee seems to be whether privacy is being invaded, we have to consider whether in the recruitment or referral process there is indeed coercion and/or harassment involved. These are questions that have answers. There can be gotten more concrete answers and proof only if a committee of this nature or some other arm of the Government is willing to hold a full-fledged investigation, and is then able to provide certain protection for those who feel intimidated by the program.

At this time, parents are quite unwilling to identify themselves because of whatever reprisals may come back to them, on their children or themselves personally. So, that brings the whole referral system under question and it causes one to wonder how a teacher or an administrator can continually call and harass a parent, indicating to that parent that their child will not be admitted to the school unless they are involved in some kind of program which will modify their child's behavior.

Now, oftentimes this has been to the extent of a teacher recommending certain drugs. Whether they identify the drug by its name, such as Ritalin, or whether they say this child needs to be placed on a tranquilizer before I will teach him again, this amounts to coercion, when you consider the relationship of the average parent to such an authoritative person as a teacher. You can relate this to your own experiences with the PTA meetings or to your own childhood.

Mr. MYERS. Do you know instances where teachers refused to teach if the child was not on a drug?

Mr. JOHNSON. I know of instances where this has been stated to parents. Now, if you are willing to provide certain protection for these parents, I am sure that I can get them to talk to you personally about it, or before a committee.

Mr. GALLAGHER. I may say that we do have such a parent here today who will testify.

Mr. MYERS. That is from a different area. I was concerned about the Omaha area, if that was prevalent there.

Mr. JOHNSON. There are several. There were a couple who were identified in the original Post article. There are at least three others who were not identified in that article who have volunteered in private this information, but have indicated that they feel too personally intimidated——

Mr. MYERS. What happened? The result was that the families allowed the drugs to be used rather than——

Mr. JOHNSON. In one case, the parent went to the pediatrician who prescribed the drug and just didn't give it to the child, just told the teacher that they got it. For example, with Ritalin, they can prescribe that in such doses that if they give the first dose at about 9 o'clock, they won't require another one until toward the end of the school day, about 2:30 or perhaps 3 o'clock, so that this could occur without them being in school. Under a situation like this one in particular, the teacher would have no way of knowing whether that child was on the drug or not.

The interesting thing to relate to that, is that while the child was not on the drug, but the teacher thought the child was on the drug, he started getting better grades and started being treated differently and being regarded differently by the teacher. That is the point that I am trying to bring out here today as one of the alternatives to drugs. Better programing. So, we talk a bit about the organization and implementation and the controls.

Now, let's assume for the sake of argument that you have this kind of investigational program. Anytime you start examining an unknown quantity, you want to exert the kind of controls over the total environment so that any changes that you know as a result of this program can be directly related to whatever external agents you introduce in the project. In this case, the drugs.

Now, you don't have that kind of control over a schoolchild in a school year, and that is what makes this program so much different than other cases where special drugs are used, say, in university hospitals and service hospitals, or VA hospitals. Here you have 24-hour environmental control. You have emergency equipment available, you have personnel available on the spot all the time to care for the patient, you have control over diet, over exercise, over sleep, which if it doesn't come naturally can be induced. You have periodic checking of the so-called vital signs, so this is a proper manner in which to conduct this kind of experimentation, in the hospitals, where you have this kind of control.

Where you are talking about an everyday school situation, it is impossible to maintain the kind of control that would be required. For example, in the original Post article, it points out the fact that, at the time they were having problems controlling the distribution of the drugs on the school ground, for example, children were exchanging drugs. "You take my yellow one and I will take your blue one." This is a quotation from one of the assistant superintendents who I see is on the agenda today.

I can almost assure you that doesn't exist right now in Omaha, but it is after the fact, and it is after the fact that all the controversy has come about over the program itself.

The problems that we see involved here are, one, a very loose use of terminology in terms of the very definitions of minimal brain dysfunction. A good deal of that which has been written about minimal brain dysfunction, at least in the Omaha papers, is a result of this original Post article, has been discredited by many M.D.'s within the city of Omaha to the extent that one of the things that they tried to palliate parents with is the idea that all these kids are given EEG's, electroencephalograms, when minimal brain dysfunction does not really involve pathological conditions of the brain itself.

They are talking about something they can't explain except in terms of its manifestations. There are no—there is nothing that would show up in a microscopic examination of tissue, for example, so it is not just a clear case of there being actual cellular damage, but then when you use this term together with other terms like "learning disability," "hyperactivity," "hyperkinesis," we are speaking as though these are all one and the same thing and can all be treated in the same manner, and this, I think, is where much of the confusion arises and this is where the possibility for the abuse of drugs exists, in this very fuzzy mixture of definitions.

Now, according to a pediatric-neurologist whom I talked to at length about this, he indicates that perhaps there are very few M.D.'s who are really competent to make this particular diagnosis, that this does require a good battery of neurological examinations and because they don't show up on a little quick diagnostic test that you can run in a clinical lab, it takes a bit of knowledge that is not generally had by general practitioners, whether they be pediatricians or not.

This, then, brings about the situation that exists among the medical profession, itself, that there are two positions that are being taken on the use of amphetamines, particularly on children.

Now, there is a tremendous amount of information which you have available to you which was gained through a committee hearing that was held here in November of 1969. That was the hearing before Chairman Claude Pepper's Select Committee on Crime, House of Representatives, 91st Congress, pursuant to House Resolution 17.

If you had to make a decision on whether or not to ban the drug, there is more than enough condemning information in that alone, and these are quotations from people who are indeed experts in this particular field.

Now, it has been pointed out that this is, in Omaha at least, a special program, and this has been denied in Omaha by both the school board, and by Dr. Byron B. Oberst, the head of the STAAR program.

Now, in a letter from the Food and Drug Administration—let's see if I can find it here—this is dated August 6, 1970, and this is signed by M. J. Ryan, Director of the Office of Legislative Services, and this is on the letterhead of the Department of HEW, Public Health Service, Food and Drug Administration, Rockville, Md.

This is in response to a letter from Mr. Ernest Chambers who was asking about this program.

Now, if you will indulge me, I will read here:

It was explained to Dr. Oberst that any use of drugs outside the parameters of the approved labeling is regarded as investigational and we recommended that the studies be performed in accordance with the investigational drug regulations under the Federal Food, Drug, and Cosmetic Act. This would entail, among other things, the submission of a notice of claimed investigational exemption for a new drug.

It was pointed out to him, in relation to two drugs named in the article that the Tofranil labeling does not carry any indications for use in children; in fact, there is in the warning section a statement not recommending its use in children. The labeling for a second drug, Aventyl, has recently been revised to delete any indication for use in children and now specifically warns against such use. We informed him that he should submit an IND.

Dr. Oberst stated that he was unaware of these facts and we agreed to forward the necessary forms and full information on requirements to him. These were mailed on July 8, 1970, which implies that at least by August 6, there had been no response.

Mr. GALLAGHER. I might say, Mr. Johnson, I am very disappointed because the Government's witness didn't make any reference whatsoever to this point this morning. In fact they stated just the opposite, that investigation showed full compliance within the prescribed guidelines.

Mr. JOHNSON. In fact, they offered testimony contrary to this that indicated all the amphetamines were acceptable for this use.

Now, it took several letters to get this kind of response also, but the value of this kind of response, I think, should make it rather clear to you that this man is considered an expert in this area. He has claimed to have been active in this area since 1962. He is president of the Children's Memorial Hospital. He has very impressive credentials.

Mr. MYERS. Is that letter in the record?

Mr. GALLAGHER. No, but if there is no objection we will include it in the record at this time and ask for a resubmission from the FDA in light of their testimony exactly opposite to what is in this letter.

(The information referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
FOOD AND DRUG ADMINISTRATION,
Rockville, Md., August 6, 1970.

Mr. ERNIE CHAMBERS,
Omaha, Nebr.

DEAR MR. CHAMBERS: This is in response to your July 23, 1970 letter concerning the drug administration program involving schoolchildren in Omaha, Nebr.

As you indicated on June 22, 1970, this was the subject of a rather lengthy article in the Washington Post. On July 1, 1970, the Food and Drug Administration contacted Dr. Byron Oberst, the physician named in the Washington Post article.

Dr. Oberst is certified by the American Board of Pediatrics and is a member of the American Academy of Pediatrics. He holds an associate professorship in pediatrics at the University of Nebraska and is also in private practice of pediatrics.

Dr. Oberst said the Washington Post statement that 5 percent to 10 percent of the 62,000 schoolchildren in Omaha are taking "behavior modification" drugs is completely distorted; rather, 5 percent to 10 percent of the children, in his opinion, have "learning disabilities." (According to an FDA psychiatrist, depending upon one's definition, this fingure does not appear unreasonable.)

He stated that the STAAR program (skills, technique, academic accomplishment, and remediation) is not experimental. It is a community education project, primarily a parents' organization concerned with learning problems in children. He states they hold seminars and named a number of expert guest speakers who have met with the group.

With respect to the number of children on drugs, he emphasized there is no way of knowing this since the children who receive drugs do so on the prescription of individual physicians. There is no systematic drug administration program and there is no drug research. There is no pooling of data and there is no direct involvement with manufacturers.

It was explained to Dr. Oberst that any use of drugs outside the parameters of the approved labeling is regarded as investigational and we recommended that the studies be performed in accordance with the investigational drug regulations under the Federal Food, Drug, and Cosmetic Act. This would entail, among other things, the submission of a notice of claimed investigational exemption for a new drug (IND).

It was pointed out to him, in relation to two drugs named in the newspaper article, that the Tofranil labeling does not carry any indications for use in children; in fact, there is in the warning section a statement not recommending its use in children. The labeling for a second drug, Aventyl, has recently been revised to delete any indication for use in children and now specifically warns against such use. We informed him that he should submit an IND.

Dr. Oberst stated that he was unaware of these facts and we agreed to forward the necessary forms and full information on requirements to him. These were mailed on July 8, 1970.

In reference to use in children of the five drugs named in the Washington Post article, the following may be of interest:

Ritalin (methylphenidate hydrochloride), Ciba Pharmaceutical Co., Summit, N.J.: The current indication for use in children reads: "Ritalin is indicated as an aid to general management in the treatment of minimal brain dysfunction in children, which often manifests itself in the form of hyperkinetic behavior."

Dexedrine (dextroamphetamine sulfate), Smith Kline & French Laboratories, Philadelphia, Pa.: This is an amphetamine which predates the 1938 requirements to the Federal Food, Drug, and Cosmetic Act. The labeling provides for its use in childhood neurotic behavior disorders, particularly in the hyperkinetic syndrome.

There is a fair amount of evidence to back up its efficacy and the amphetamines are generally accepted drugs for this purpose. The National Academy of Sciences-National Research Council panel reviewing the efficacy of drugs approved between 1938 and 1962 has not considered Dexedrine because it is pre-1938. However, the panel has regarded amphetamine products as effective for this purpose.

Deaner (deanol acetamidobenzoate), Riker Laboratories, Northridge, Calif.: This drug is offered for use in children with hyperkinetic behavior problems and learning disorders. In May 1970, we published in the Federal Register NAS–NRC findings stating that the drug was found possibly effective for this use.

Aventyl (nortriptyline hydrochloride), Eli Lilly & Co., Indianapolis, Ind.: The labeling for Aventyl formerly stated ". . . symptomatic reaction in childhood (for example, enuresis) have responded to treatment with Aventyl HCl." However, the new labeling being placed into use for this drug includes no indication for use in children and the warning section states "This drug is not recommended for use in children since safety and effectiveness in the pediatric age group have not been established." According to our medical staff, this change does not reflect new information on toxicity, but that there was a lack of substantial evidence of effectiveness in children. It was never systematically studied for hyperkinetic behavior disorders in children.

Tofranil (imipramine hydrochloride), Geigy Pharmaceuticals, Ardsley, N.Y.: The labeling carries the following statement under the warning section: "Pending evaluation of results from clinical trials in children, the drug is not recommended for use in patients under 12 years of age." We do not have information that it has been systematically studied in hyperkinetic behavior disorders in children.

If and when Dr. Oberst submits his IND, review will be expedited to determine to what extent a problem exists here. Of course, if Dr. Oberst (or any other physician) decides on his own volition to experiment with a drug that he can obtain locally under labeling for some other purpose, he does not violate the Federal law by administering or prescribing the drug for the experimental

purpose. By the same token, the physician does have the usual responsibility for determining that the drug prescribed and the manner in which it is prescribed constitute proper treatment for his patient. Whether it is or not would be a matter for consideration by State or local medical authorities.

We hope this information is helpful. If there is any additional assistance we can furnish, please let us know.

Sincerely yours,

M. J. RYAN,
Director, Office of Legislative Services.

Mr. JOHNSON. If a man of his credentials and obvious interest in the program is unaware of these kinds of things, then I think this does raise a very serious question as to how many M.D.'s are truly qualified to prescribe these kinds of drugs, whether it be for minimal brain dysfunction or not.

I am not about to argue the validity of the use of that drug for minimal brain dysfunction so long as it fits certain very narrow definitions.

Mr. GALLAGHER. I think the letter itself——

Mr. MYERS. I do not understand. I thought a moment ago you said you believe it should be outlawed, that there was enough evidence in the material in the crime hearing there to outlaw the use of the drug.

Mr. JOHNSON. That is not what I stated. A few moments ago I said if you are looking for the kind of information that would permit you to condemn the drug or ban the drug, then you have all you need out of these hearings.

Mr. MYERS. You have read the hearings. If you had the power to do so, would you outlaw the drugs today?

Mr. JOHNSON. Yes; I would.

Mr. MYERS. That is not what you said a few sentences ago. You confuse me here. I am lost.

Mr. JOHNSON. Do not misquote me.

Mr. MYERS. I will try not to.

Mr. JOHNSON. What I said a few moments ago was that I was not going to argue specifically the validity of using these drugs in minimal brain dysfunction. I have other things that I would like to discredit this drug program on and its use in the schools without attacking the use of it on grounds of it not being a useful drug in minimal brain dysfunction.

Mr. MYERS. Maybe it will be clear in the rest of your testimony what you mean by that.

Mr. JOHNSON. Once we give the permissiveness to explore this kind of program we get the abuse we are seeing right now because of lack of controls, because of lack of knowledge. I think that what would be very germane to an investigating body would be perhaps to get some scientific people who are non-M.D.'s, who are not necessarily pharmacologists even, but who have scientific training to evaluate the nature of the research that is being done.

I do have something I can refer to that is somewhat typical of the kind of research that is being done, or being called research, and what I am getting at, is that there is normally a very naive kind of research where the results are very selective and it is very superficial.

They make very quick transitions from animals to humans. Only to a point can you do this sort of thing.

Mr. MYERS. Then you would not agree with the cyclamate decision made a year ago because it was made solely on animal research; is that what you are saying?

Mr. JOHNSON. That existed over a possibility. They pointed out here it was a possibility of this being a carcinogenic material. Just the existence of the possibility was sufficient to deny the use of it, and you can certainly do that sort of thing on animals, and it would be a very safe thing. They are not definitely stating that this——

Mr. MYERS. How would you test the use of drugs? What would you prescribe as a logical and legitimate use or a test to see if the drugs would really work or if they are safe? How would you do it?

Mr. JOHNSON. One thing you want to do before you start administering drugs to humans or anything else is to exclude the possibility of harm, and here is where we have not had any kinds of tests to see if they have any genetic effects.

Mr. MYERS. The pharmaceutical producers of these drugs have not either?

Mr. JOHNSON. There is nothing in the literature that indicates this. This came out of an NIMH sponsored meeting, which again occurred last year, and which I am amazed that FDA testimony were not able to refer to, in which——

Mr. GALLAGHER. We intend, in view of the documents you have submitted, to call them back and reexamine them on these points.

Mr. JOHNSON. This is in the particular that I referred to: Dr. Lederberg, who is a Nobel Prize winning geneticist, and Dr. Samuel Epstein, a toxicologist from Children's Cancer Research Center in Boston, repeatedly pointed out that many drugs on the market have never been tested to see whether they have the same hazards to genetic material that LSD may have.

This, then, would include LSD, amphetamines, barbiturates, narcotics and marihuana. Now they are talking about the LSD not being the only agent suspected of breaking chromosomes. Dr. Lederberg said:

> We are beginning to think that every agent has some teratogenic, mutagenic or carcinogenic effect on some system at some time.

Teratogenic means it is capable of causing birth defects; mutagenic means it is capable of producing a change in chromosomes; carcinogenic means cancer causing.

Now, these drugs then have not been tested in these areas. Now, there is an illusion given in the testimony earlier by the people from the FDA, I suppose that is who they were, that everything is just kind of hunky-dory, that they had all these kinds of things, and they totally overlooked this.

This particular meeting was of 16 of your top scientists in the country who gathered in Los Angeles at the specific request of the National Institutes of Mental Health. I am sure that they were made aware of the dialog and the testimony that came out of it.

But this points to the whole weakness of the program. There is a tremendous selectivity in the kind of information that is presented. If the extent of your research is going to be to take only those findings that tend to support your position, then your research is invalid. These are the kinds of things that you have to take into consideration when you start evaluating these programs, to evaluate the kind of research.

I have nothing further prepared to state and I will answer any questions that you might direct at this time.

Mr. GALLAGHER. Would you please identify the document?

Mr. JOHNSON. This is an article called Psycho-active Drugs in the Immature Organism. It is by Cahn and Kornetsky, Division of Psychiatry, Boston University School of Medicine, Boston, Mass., received for publication February 9, 1970. It appeared in the Psychopharmacologia, Berlin, 17th edition, pages 105 to 136.

Mr. GALLAGHER. Thank you.

Mr. Johnson, you sat through the testimony this morning. As a scientist, what was your professional opinion of the description of what was really going on?

Mr. JOHNSON. First of all, I was amazed that in light of the overwhelming supportive evidence that FDA claims to have presented such a very feeble case for themselves. I felt it was a very superficial presentation. It comes to what I think is a part of the program, of the problem which brings us together today. There seems to be an attempt to bring in this clinical evaluation that is being under fire by a few "hot-headed" people like myself. This isn't true at all. We are talking about the use of the drug as we perceive it to be occurring in the public schools.

Mr. GALLAGHER. Mr. Johnson, the thing that troubled me was they saw no relationship to the terrible problem of drug abuse in our schools. Therefore, they treated it as if it didn't exist or was unrelated.

If we are telling older children, high school and junior high school students, not to go the drug route, what about the validity of their parents or our Government when they know their younger brothers or sisters may be on the same drug that we are telling them to stay away from.

Mr. JOHNSON. This should be very distressing to you. It should be distressing to perhaps every committee in Congress, both the House and the Senate. But when you start talking about creating a psychological dependence on a drug, and this is precisely what you are doing, you are taking a child and associating every good thing that happens to him to the taking of a pill. You associate the change in attitude that his teachers regard him in. The improved conditions that he now enjoys at home and with his peer group. You are associating that with the taking of a pill.

Now you could take a piece of sugar, a sugar cube, and do the same thing without the drug and this is a very real danger. It was implied this morning that these amphetamines don't have the same kind of hopping up effect on children. I would ask you, as just rational individuals, if that is not true, why do kids take them illegally? Why are we finding it necessary to have drug abuse programs?

Mr. MYERS. I can remember as a kid in school something like that in the physics class. We used something, I don't remember what it was now because I am not a chemist like you are, but we tasted something and were told, some of us, that it was alcohol and some that it was something we didn't know. The ones who thought they were taking alcohol began to feel the effects of alcohol. Perhaps a great part of the problem—and cure—is psychological. Would you disagree with this?

Mr. JOHNSON. That is very much a part of this problem. Whether the drug is doing the job or not, you are making psychological associations; you are forming that in the child's mind. This becomes of peculiar interest to ethnic minority groups, to those who are a little lower on the socioeconomic scale, who normally find themselves in communities in statistical groupings which label them as the underachievers, the slow learners, et cetera. These are also situations where you find children who generally are not getting good physical care, who oftentimes suffer from malnutrition, who suffer from broken rest patterns, who have no regularity in their everyday life styles. All are things which may very well produce irritability in class, tiredness and short attention span. The whole thing that they are trying to lump into learning disability and treat with drugs. I say that you have to correct that part of the problem that the school has to do with and exclude it from one of the precipitating causes before you start going into modifying the behavior of the child to fit that existing situation, which is already perceived to be bad.

I think if any of you are aware of the recent report that came out from the Carnegie Institute, you will see that this is exactly what is going on in the school. Seventy-five percent of the school population is not being adequately served. You can find this out from, oh, the U.S. Office of Education, which has several large programs which have made many evaluations the same kinds of data come out of them. That even predates the Carnegie effort.

So you have a bad situation which I see you fitting the child to, rather than making the situation fit the child's needs. I see that the utilization of drugs in this matter is another kind of a crutch that enables a teacher and administrator to justify the programs that they have in the schools and justify whatever they chose to do at the time.

Mr. GALLAGHER. We see the same side effects and the same sort of effects as on adults. We produce a situation where you have put the discipline inside the child rather than the teacher doing it. What you really do is induce stress, is that right, by the use of amphetamines?

Mr. JOHNSON. About all that is actually known about the mechanics, the workings, the physiological or biochemical reaction that goes along with this, no one knows. They know it affects the central nervous system. Beyond that, there is not much you can say. This is the reason you have such long confusing terms associated with it. You always find that when there is very little known about it. But they can observe that if we give you this, we get this kind of effect. How it works, no one knows.

Mr. GALLAGHER. In effect, doesn't it really work the same way as it does on adults? I mean some of the same patterns.

Mr. JOHNSON. If you are considering the normal child, I would say "Yes." This would be at variance with what was stated this morning. They intended to imply, I think, that none of the children, say, 12 years or under, would respond to these amphetamines in the same manner that an adult would. Well, that is totally untrue and you can just look at the kids they pick up on speed and determine that very easily. That precisely is what speed is.

Now there are particular warnings against using these amphetamines in conjuction with tranquilizers. These are what are commonly

called goof balls. These apparently have a worse effect than taking either the tranquilizer or the amphetamine alone. This came out again in the House Select Committee on Crime hearings.

Mr. GALLAGHER. There would be some effect if, say, the child was on speed and took cough medicine for a cold. You have a mixture of chemicals creating a third effect.

Mr. JOHNSON. Restate that. I think I missed something.

Mr. GALLAGHER. What I am trying to say is we know of people who are on tranquilizers taking alcohol and this produces death in some cases.

Therefore, the prescribed Ritalin or amphetamine taken by a child who may be given cough sirup or codeine in the cough medicine, are we not now generating something that we really have no idea what the outcome will be?

Mr. JOHNSON. From the mere point that there is so little known about what is going on, these are considerations that anyone would have to make. These would indicate extreme caution.

Mr. GALLAGHER. This is why I think it's so important, what you were saying about the 24-hour clinical supervision period. In the VA hospital, for instance.

Mr. JOHNSON. Let me amplify that. This is a rather normal common accepted procedure. There are a good number of new medicines which are experimented with on people. There are a lot of social workers who are not very happy about this because these kinds of experiments usually take place at the free clinics, the county hospitals, the VA hospitals, the service hospitals, that kind of thing.

However, the conduct of this type of investigation requires, No. 1, that the patients involved are made aware that this is a special program. They are included in the experimental designing normally, and then, because it's conducted in a very controlled atmosphere environment, you are less concerned about things that can happen which might—in this case, with a child you could have something happen to him at home or off in a playground and who would know what to do?

Just because of the variables that are associated with this kind of experimentation——

Mr. MYERS. By your testimony we find you have more information and knowledge about drugs and associated problems than a layman would have. I see by our fact sheet that you are a chemist with the VA.

What is a chemist with the VA in Omaha?

What are your responsibilities and functions?

Mr. JOHNSON. I am classified as a research chemist. I have been there for 10 years with that classification. I work in the department of medical research there.

Mr. MYERS. In the veteran's hospital?

Mr. JOHNSON. Yes. A rather large research facility. It's not quite as large as it once was. To jump ahead of you a bit, the majority of my research has not been associated with drugs necessarily.

In fact, only one real project that involved the evaluation of a drug I had any direct relationship with, was a diagnostic drug they were using with diabetics and it was a matter of comparing that to glucose tolerance tests in terms of discerning the diabetic and following along.

But my criticism as a scientist is purely on the basis of the experimental design. The way you conduct the experimentation. This transcends all disciplines.

These are things you just do when you construct an experiment. You arrange to be able to control all the parameters that are relevant to one another and where possible the only variable is the object under investigation.

So this is a general concept. This is not something that you need to have specific knowledge of to evaluate a program.

No more than you would have to have a specific knowledge to evaluate one of these articles.

Mr. MYERS. Then I take it you are not objecting now anyway so much to the possibility of using drugs but the fashion and the manner of the way they have gone about it. Is that what you are saying?

Mr. JOHNSON. Partly.

Mr. MYERS. In Omaha, specifically.

Mr. JOHNSON. Partly. Partly I am very concerned about what it permits. The other part of that is what it permits to occur if it continues. That is the other path of abuses.

Mr. MYERS. Something no one really knows today, do we? We can only speculate what might happen here. We have no clinical information, at least it hasn't been presented yet to this committee.

Mr. JOHNSON. You mean in terms of physical harm to the individual? Is this what you are talking about?

Mr. MYERS. Isn't that what you are speaking about?

Mr. JOHNSON. I was thinking in terms of other abuses of the drugs.

Mr. MYERS. By the taker of the drugs or the administration?

Mr. JOHNSON. By the administrators.

Mr. MYERS. Abuse of who receives them, then.

Mr. JOHNSON. Yes. See, because this goes over and spills over into the use of transquilizers, which certainly could be used in almost any kind of situation where a child was acting at variance with whatever a teacher or administrator felt he should act—once you have established a permissive atmosphere in the school.

Mr. MYERS. Then you are taking issue here with the diagnostic procedure used by the school administrators and/or the medical profession.

Mr. JOHNSON. Their referral system; yes, I am.

Mr. MYERS. You referred to STAAR in Omaha. Who and how and why did STAAR come about? You said it has been several years. Who makes up the organization of STAAR and what promotes it and how is it kept alive?

Mr. JOHNSON. That you would have to get that information from STAAR officials. I do know two M.D.'s who are a part of STAAR and it may come as a great surprise to you but at least at a couple of school meetings I have spoken to groups in support of certain aspects of the STAAR Program.

Mr. GALLAGHER. I want to say, Mr. Johnson, for the purpose of the testimony, we will have some officials of the STAAR program.

Mr. MYERS. We have somebody coming up from STAAR?

Mr. GALLAGHER. Yes.

Mr. JOHNSON. As far as the organization of it, I know very little.

Mr. GALLAGHER. Thank you very much.

Mr. MYERS. I had one more question. Do you favor further research into this area?

Mr. JOHNSON. I would like to change that question. Do I favor research being done in the area? I feel the quality of the research done thus far is not the quality that I would like to see.

So, yes; I would like to see a lot of research done in this area.

Mr. MYERS. Thank you.

Mr. GALLAGHER. Thank you very much.

Our next testimony will be a joint appearance by Dr. Sam Clements and Dr. John Peters.

We welcome you here this afternoon, gentlemen.

Dr. Clements and Dr. Peters are in charge of the Child Study Center, University of Arkansas Medical Center at Little Rock and are leaders in developing the techniques of modifying behavior by the use of drugs.

You have a prepared statement but Dr. Clements, before we go to your testimony, I would like to ask one or two questions for purposes of the record in connection with Federal involvement. The subcommittee has been able to obtain two documents. The National Project on Minimum Brain Dysfunction in Children, volumes 1 and 2 of a series issued by the Public Health Service Department of HEW.

Doctor, you are identified as the Project Director in phase 1, printed in 1966 and second phase, 1969. You are that Dr. Clements?

STATEMENTS OF JOHN E. PETERS, M.D., AND SAM D. CLEMENTS, PH. D., CONNECTED WITH THE CHILD STUDY CENTER, UNIVERSITY OF ARKANSAS MEDICAL CENTER

Dr. CLEMENTS. Yes; I am.

Mr. GALLAGHER. Both of these documents say they are part of a three phase project. May I inquire about the final phase? Is it completed?

Dr. CLEMENTS. It is completed and available.

Mr. GALLAGHER. We would appreciate it if you would make that available to the subcommittee.

Dr. CLEMENTS. Absolutely.

Mr. GALLAGHER. I certainly don't want to invade your privacy but this does not include the funds. Your project was not included in the figures I received earlier from the General Accounting Office.

I also notice the Easter Seal Research Foundation assisted sponsorship of your project along with the Health Services and Mental Health Administration of HEW, the National Institutes of Health and the U.S. Office of Education. However, in order to lay the additional record of Federal funding would you give us your estimate of the amount of tax dollars which have gone into your project so far and what you expect the total amount to be?

Dr. CLEMENTS. I would not have those figures available. This was a shoestring project. None of the members serving received any pay whatsoever. I was given a leave of absence from my home university to spend 3 months at NIH to produce the first document you have in your hand. This involved mainly the review of all the American literature in this area and then to present it to the committee, which was a multidisciplinary committee, heavily loaded with educators, physicians, language pathologists and other child specialists. I prepared the document from my investigation and review of literature and

presented it to the committee. Transportation was paid to the committee people to come to the meetings which were very few and far between. Most of it was done by correspondence, sending documents back and forth with criticisms, suggestions for rewrite, suggestions for inclusions, omissions, et cetera, and the final document which was approved by Dr. Richard Masland, who was then Director of the National Institutes of Neurological Diseases and Blindness, now referred to as the National Institute of Neurologic Diseases and Stroke.

Mr. GALLAGHER. The point I was trying to make is if you could submit what Federal involvement, Federal funding was involved in the projects at some later date we would like to include that in the record. I ask that because in a statement referring to the Child Center you have in Arkansas, construction is financed in part by matching grant from the Federal Government. When was this grant made and did the grant specify the type of work which could be done or would be undertaken?

I think the figure was that the general assembly there appropriated some $75,000 and there was to be a matching Federal fund for construction. We would like to know the extent.

Dr. CLEMENTS. Construction of the Child Study Center, which is the name given to unit 2 of the Greater Little Rock Community Mental Health Center, was part of the Community Mental Health Centers Act. Funds were secured through that funding resource.

Mr. GALLAGHER. Yes.

What we are trying to get is the amount. That amount was not included in the GAO figure this morning that we presented. If you would submit that for the record we would appreciate that.

(See app. I, p. 109.)

Now would you please proceed?

Dr. CLEMENTS. As indicated, I am Sam D. Clements, a clinical child psychologist, and associate professor in the departments of psychiatry and pediatrics, and executive director of the Child Study Center, University of Arkansas Medical Center.

To my left is Dr. John E. Peters, a physician and child psychiatrist, professor, department of psychiatry and head of the division of child and adolescent psychiatry of the University of Arkansas Medical Center.

Before proceeding, I would wish to correct an error which is contained in the descriptive statement about me which appears in the mimeographed witness list. I am not now nor have I ever been a "major investigator in the usefulness of behavior modification drugs for grammar school children." I am sure it was intended as a compliment but I can't claim the distinction. I am a clinician. I am a child psychologist. I am not a research scientist.

Mr. GALLAGHER. The record will stand corrected.

You are the project director, is that right?

Dr. CLEMENTS. This is not a drug study. I am Project Director of the National Project on Minimal Brain Dysfunction and/or Learning Disabilities in Children.

Mr. GALLAGHER. Yes. Thank you.

Dr. CLEMENTS. The operational base of the division of child and adolescent psychiatry within the School of Medicine of the University

of Arkansas Medical Center is the Child Study Center, a separate building located on the campus of the medical center in Little Rock.

The primary functions of the division of child and adolescent psychiatry are twofold: (1) to teach, and (2) to serve.

The teaching activities of the multidisciplinary staff of the Child Study Center are directed to medical students, nursing students, residents in psychiatry, residents in pediatrics, interns in clinical psychology, trainees in social work, and special educators.

The service activities of the center are provided, in the main, through a variety of outpatient diagnostic and treatment programs. The recipients of direct clinical services are children and adolescents up to age 18 years, and their parents, who come from all sections of the State of Arkansas and include all socioeconomic levels.

The decision to seek professional help through the services of the Child Study Center is made by the parents, who may first consult with their family physician, school personnel, or other community resources.

These parent-initiated requests for service may be made by telephone, by letter, or by a direct walk-in visit to the center.

The problem areas which concern parents about their children, and which culminate in a referral, are many and varied, but generally revolve around observed deviations in behavior, development, emotions, learning, and/or general adjustment.

The 20th century has been referred to as the "century of the child," for it was not until the early 1900's that the historical antecedents which led to the insight that the human being was a legitimate object of scientific investigation became expanded to include children as a group worthy of special attention and consideration.

Highlights of this new focus on the child during the early decades of this century included the development of techniques for assessing individual differences, the establishment of juvenile courts, compulsory education, special education, and the founding of child guidance clinics.

As knowledge, methods, and techniques accumulated and were refined, the specialty areas of child psychology and child psychiatry matured into recognized professions and added to man's efforts to study and help his fellow men.

As we have come to better understand the diversity of problems which surround the developing child, workers in these fields have been able to delineate certain deviations and deficiencies which compromise the youngster in his adjustment to home, school, and society; and which often result in personal tragedy and economic loss to the Nation.

Dr. PETERS. May I take up here?

Mr. GALLAGHER. Oh, yes.

Dr. PETERS. To evaluate such factors, the initial step in our center is to carry out a careful clinical assessment of the referred child. A family and personal history is obtained from the parents with particular emphasis on information regarding the pregnancy of the mother and the early development of the child. In addition, the interpersonal patterns of family life are discussed. The child receives a series of psychological and educational measurements which cover cognitive, perceptual, visual motor, and language skills, and his level of achievement in basic academic subjects such as reading, spelling and arithmetic. A special neurological examination is administered to the child

to determine possible deficits in complex motor integration. Also, a personal interview is conducted with the child. On the basis of these data, a decision can be made as to whether medication and/or other recommendations may be of help in ameliorating the chief complaints and concerns about the child.

The disruptive symptoms which have been most successfully alleviated by medications are those of hyperactivity, impulsivity, short attention span, and disordered learning.

Over 30 years ago, Dr. Charles Bradley first reported the successful medical treatment of hyperactivity and resulting disorders of learning through the use of an amphetamine. Although for many years this highly specific treatment was known to but a few pediatricians and psychiatrists, it has, over the last decade, been widely acknowledged and utilized for this purpose by the medical profession.

Dr. Bradley continued to do research in this area all through the years and was very productive and the results very elucidating.

Over the years, other medications have become available which achieve similar results or are beneficial in modifying other aspects of handicapping deviations and emotional disorders in children. Examples of such medications are methylphenidate, thioridazine, and imipramine.

Beginning in 1955, our child psychiatry clinic began to use some of these medications to help alleviate the conditions mentioned above with a small number of selected children. This was always done with the full agreement and cooperation of the parents. With children of school age, the parents obtained regular reports from the teacher as to the effect of the medication on the symptoms of the child. These feedback reports assisted us in the appraisal of changes in behavior and guided in decisionmaking as to dosage or medication change.

Continuous followup of medication cases cannot be overemphasized. In our center, the practice is to have the child and his parents return periodically for checkup to determine the progress of the child, and for further parent counseling as to management. In some cases, and with the permission of the parents, we write a letter to the school principal or counselor regarding our findings on the child and with suggestions as to methods of management and remediation. In some cases, we visit the school, observe the child's behavior, and assist the teacher in developing an individualized program. For this purpose, we have education specialists on the regular staff of the center.

Over a period of many years, we obtained laboratory blood studies on all children placed on medication as part of their treatment program. A report of these findings was published in the Southern Medical Journal in 1968. The results indicated that 40 percent of the children showed an initial transient leukopenia (a drop in white cell count), which returned to normal within a few weeks as the medication was continued. We uncovered no serious complications.

We have had the infrequent experience of a particular child whose symptomotology was heightened by one of these medications. In such cases, medication was stopped completely, or a trial on a different medication was prescribed.

The experiences of these children prior to medication are distressing—inability to attend to what the teacher is saying, or to concentrate on the page in front of them; inability to resist talking out in class or

answering constantly whether called upon or not; inability to tolerate waiting their turn in the classroom or on the playground; a feeling of restlessness and out-of-control driveness.

When medication is instituted, the typical response is a decrease in unfocused and unproductive activity; and an increase in ability to concentrate to the degree that the child is able to achieve at a higher level in school, is less impulsive and disruptive in the classroom and on the playground, and is better accepted by his peers.

We have always maintained that medication alone is rarely sufficient in cases of learning disability. Many of such children require special teaching methods in a highly structured small group program.

To summarize, a combined program of special teaching, parent counseling, and medication is effective in the majority of children with hyperkinesis, short attention span, impulsivity, and learning disabilities. By modifying a symptom complex which is distressing to parents, teachers, peers, and the child himself, the judicious use of medications as part of a total treatment program enables a child, frequently expelled from school or deeply perplexed by his continual defeat, to achieve a more nearly normal role in his own world, and to effectively utilize the abilities he possesses.

We believe such intervention in the critical early school years may serve to prevent the development of malignant personal and social consequences later in life.

May I add a few comments?

Mr. GALLAGHER. Yes; please do.

Dr. PETERS. About the record of the child's being on medication in the school, any material that we send to the school, to the teacher, to the principal, is only with the signed permission of the parents.

We wouldn't consider it otherwise. We used no Federal money to pay for drugs or for research on drugs. Our research efforts have been to better define the group of children who fall into this category.

These are not just bright, bored children. These are deviant children. I think those of you who have not seen children of this kind don't know what we are talking about. These are children diagnosed by specialists in my category of child psychiatry.

Mr. GALLAGHER. I don't believe the inquiry is directed to properly diagnosed children who fall into that category. There is no argument at all with them. The argument is that the label is applied to other children who are not examined as minutely as you examine them at the child center and treat them as medical cases.

That is the difference in our approach—thank you—go ahead.

Dr. PETERS. Our greatest effort is helping the schools develop educational program for each child who has a problem.

Specifically about use of the drug, of, say, amphetamines or Ritalin, when we had a child on one of these drugs for say a year or even 3 years we had no problem about removing the drug. There is no problem as far as we are able to tell in terms of habituation and addiction.

We had no child cry out for it afterward. I know of no cases of addiction resulting from our use of the drugs.

Mr. GALLAGHER. Do you know of addiction resulting from the use of these drugs under uncontrolled circumstances?

Dr. PETERS. I don't know of any but I certainly can imagine that it could happen. Yes, sir.

Mr. GALLAGHER. Why could it not happen under your conditions, but could happen under other conditions?

Dr. PETERS. We are very anxious to stop the drugs. For many years I have been aware of this problem. I feel very anxious to stop the drugs at around age 12 or 13 just because when you get into the area of adolescence, children know about these as speed and goof balls and these various names that are attached to them.

For that reason, even though it might be useful, I prefer not to use these drugs at that age.

Mr. GALLAGHER. Is it practical to believe that all of these children will stay away from the drugs they have been on for years when they reach 14 or 15? Or will they not fall back into the pattern in non-controlled——

Dr. PETERS. It's surprising how delighted they are to get off of it.

Mr. GALLAGHER. But there are so many delighted to get on it.

Dr. PETERS. This is true when they get to be adolescents and hear about it.

Mr. GALLAGHER. These children are quite aware of it in the formative years.

Dr. PETERS. Quite aware of what the drug is that they are taking in relation to what the adolescent knows?

I don't think so. This may change with the changing picture.

Mr. GALLAGHER. You see no danger at all of the child relying on Ritalin or an amphetamine for 2 or 3 years and then cutting him off at 12 or 13? You see no temptation at all that child now leaving your supervision and going into the normal drug pattern that so many of our children are in?

Dr. PETERS. I couldn't say that. Of course, I thought of this possibility and danger. I haven't had it happen. Theoretically, this could be true. Even the possibility of it bothers me.

But I haven't had it happen. That is not to say I may not have it happen tomorrow.

Mr. MYERS. Do these young people really realize they are on drugs? Are they congnizant that they are one of the hard drugs?

Dr. PETERS. No. They don't understand its relationship to the drug abuse problem among adolescents and adults.

Our young children don't know this connection.

Mr. GALLAGHER. Is there any clinical evidence of the response of a child who does suffer from hyperactivity differing from the normal child who doesn't suffer?

Is there any relative difference in the way they respond?

Dr. PETERS. Nobody has done research on normal children with amphetamines. Who would do it? This is something you wouldn't do.

Mr. GALLAGHER. Does every child respond properly to the use of drugs?

Dr. PETERS. No. There are at least 12 percent as a rule who respond unfavorably and we have to take them off or change them.

Mr. WYDLER. Would the gentleman yield?

The thing that bothers me here is the fact whenever you describe the problems that these children are having they sound like perfectly normal problems to me. They sound like the typical child rather than the abnormal child.

The way you describe it, this was true in the prior testimony, too, you describe the problem as being inability to attend to what the teacher is saying.

That is practically a normal problem with a young child. They have a great deal of trouble concentrating for any period of time; concentrating on the page in front of them; inability to resist talking out in class; answering constantly whether called upon or not; inability to tolerate waiting their turn in the classroom or the playground; a feeling of restlessness and out of control diffidence. That almost sounds to me like the children I have seen and known all my life, that sounds like the average young boy, for example.

I realize this is a degree.

Dr. PETERS. Exactly.

Mr. WYDLER. I understand that. But my problem is here, in the matter of degree. If you have ones with the problem on one extreme and the good ones or the ones without the problem on the other extreme some you give the drugs to and some you don't.

But what about the child with a degree of the problem?

If you read all the good results of giving these children drugs you wonder, maybe if you gave every child a little bit of it, they might be all better off.

They might all become more docile or more cooperative or something of this nature.

This would almost seem to follow logically from what you are driving at here.

Dr. PETERS. Well, of course, I wouldn't be a party to any such thing. What you say about the degree——.

Mr. WYDLER. What harm would it do?

Dr. PETERS. In any judgment of a degree we can only rely on those experts who have had the experience to say when a degree is too much.

For instance, everybody today dreams, but when it is too much, we use the term "schizophrenia."

Mr. WYDLER. But everything I heard here today says that giving these drugs to children is absolutely harmless—nothing wrong with it. Yet we have a great tendency to want to get them off as quickly as we can.

Apparently, nothing happens to them adversely. If nothing happens adversely and it helps them to concentrate, why not give small doses to those that have a little bit of a problem?

It would help them be more attentive in school. This seems to be almost the logic of where you will go once you start down this road.

Dr. PETERS. If you take that kind of position, this would be true of almost any psychiatric symptom and everybody would be on tranquilizers, following your line of argument, which I don't accept.

Mr. WYDLER. How do you draw the line?

Dr. PETERS. By having years of experience in this work. That is all I can answer. I have known enough psychiatric cases and enough who have deviations and enough children who are hyperactive to be able to make a judgment about it.

Mr. WYDLER. Let me ask you this. As I understand the program that you have, somebody sends the children to you. I presume the teacher.

Dr. PETERS. Just as often the parent calls us and ultimately it has to come through the family physician. This is a requirement at our particular center.

Mr. WYDLER. In other words, if the teacher or parent thinks there is a problem, they must send them to a physician first and he refers them to you?

Dr. PETERS. Correct.

Mr. WYDER. How would he know that you are there.

Dr. PETERS. Well, everybody in Little Rock knows we are there. Many of the doctors in Arkansas know we are there.

Mr. MYERS. Do you advertise.

Dr. PETERS. Not in the least.

Mr. MYERS. How does a parent who has a child having problems, find you?

Dr. PETERS. I would say usually if they don't know about us, then this comes from the family physician who does know about us.

Mr. WYDLER. How many of the people referred to you, children referred to you in the last year, did you decide didn't need any treatment?

Dr. PETERS. Well, I could give you some figures. We see about 600 cases, new cases, a year.

Mr. WYDER. Referrals? Six hundred new referrals?

Dr. PETERS. No; these are children worked up. We may not see all those that are referred for one or another reason. We work up about 600 new cases a year. In the course—at the present time we have 77 children on either Dexedrine, Ritalin or Mellaril, 77 children out of 65,000 children of school age in our county.

As you can see, that is a small fraction of 1 percent. If you estimate—I think I know the medical community there pretty well—if you estimate that the private doctors, pediatricians, and so on, may be treating an equal number as to ourselves, this is still much less than 1 percent. It is a very small percent of the number of children.

As you can see, that is a fraction of the 600 new cases that we see.

Mr. WYDLER. Just to make sure I understand, last year or within the last year or the last recorded year, you had 600 referrals; is that right?

Dr. PETERS. For all psychiatric conditions, not just hyperactivity.

Mr. WYDLER. Well, that is what I want to be careful of now.

How many of these 600 were referred to you for drug treatment or possible drug treatment?

Dr. PETERS. Nobody is referred for drug treatment.

Mr. WYDLER. So, you had 600 cases referred to you. Of those 600, how many did you put on the drug treatment?

Dr. PETERS. Well, as I say, we have 77 on now. I don't have the exact figure of those 600, but it would be less than the 77, because some of those 77 have been with us for a couple of years or 3 years.

Mr. WYDLER. What did you do with the rest of the children?

Dr. PETERS. We make recommendations back to the school for handling. We may treat them with psychotherapy, with group therapy, with play therapy. There are other ways to treat children who have other symptoms. Not all children who are hyperactive do we deem as suitable for this medication. It depends on the degree of the hyperactivity.

As you pointed out before, if there is a lesser degree of it, we don't use medication. We try to use other methods.

Mr. MYERS. Do any doctors in the Little Rock area, to your knowledge, prescribe without going through your clinic? Would some doctors have some students on drugs right now and you wouldn't have knowledge of it?

Dr. PETERS. Yes, That is why I say that our number of 77, I would estimate that there is another 77 at least that the private doctors have.

Mr. MYERS. The local physician.

Do the local schools have it in their ability to prescribe drugs without the doctor?

Dr. PETERS. Absolutely not. Nor do they ever recommend it.

Mr. MYERS. You have absolute knowledge they don't do this?

Dr. PETERS. They don't do this.

Mr. MYERS. All right.

Mr. GALLAGHER. I notice on page 4 of your statement examples of such medications. These names——

Dr. PETERS. Methylphenidate is Ritalin.

Mr. GALLAGHER. What is the pronunciation of your next one?

Dr. PETERS. Thioridazine. That is Mellaril.

Mr. GALLAGHER. You use these medications in your treatment?

Dr. PETERS. Yes.

Mr. GALLAGHER. The thing that troubles me among other things that have troubled me in this hearing is that a letter quoted by Mr. Johnson, which I don't believe you have it in front of you, dated August 6, 1970, from the Health, Education, and Welfare, signed by Mr. M. J. Ryan, Director of the Office of Education Services. He states that Tofranil which is included in Imipramine and hydrochloride, states:

The labeling carries the following statement under the warning:

And I quote now:

Pending evaluation of results from clinical trials in children, the drug is not recommended for use to patients under 12 years of age. We don't have information that has been systematically studied in hyperkinetic behavior for these children.

How does that square?

Dr. PETERS. The use of Imipramine or Mellaril?

Mr. GALLAGHER. Imipramine, which, according to this statement, shouldn't be used on children under 12.

Dr. PETERS. I don't think it is a question of not using it. It should be used only under careful medical supervision.

Mr. GALLAGHER. The warning says, "Pending evaluation of results with clinical trials in children, the drug is not recommended for use in patients under 12 years of age" until we have information that it has been systematically studied.

Dr. PETERS. Well, I think that this implies——

Mr. GALLAGHER. Is imipramine-hydrochloride a different drug than imipramine?

Dr. PETERS. Imipramine is the scientific name for Tofranil, which is the trade name.

Mr. GALLAGHER. This is exactly what it says. It shouldn't be used in children under 12. You are saying you do use it for children under 12.

Dr. PETERS. We have used Imipramine; we use Mellaril, a good bit of it, which has been approved for children.

Mr. GALLAGHER. In your statement, you give equal weight to the three drugs that you are using. One here is on a list that states it shouldn't be used. This is part of the thing that troubles the subcommittee and when we get into some of the——

Dr. PETERS. We use very little of Imipramine, very little of it. And I quite agree with you that this should be done only with careful supervision of the child.

Mr. GALLAGHER. Well, I again point out for whatever it is worth that is not what the warning states. The warning states it shouldn't be used for children under 12. Yet you are telling me you do use this for children under 12 in the program. I am just wondering whether or not the use of these drugs on children shouldn't be suspended until we have sufficient knowledge of where these drugs are taking us.

Dr. PETERS. You mean this particular drug should be suspended?

Mr. GALLAGHER. All right, this particular drug, and then extend it to the use of amphetamines and Ritalin, because obviously, while they can be used under prescribed conditions, there is a wide difference of opinion as to what the side-effects are.

Dr. PETERS. As to the possibilities of suspending the others, that is another thing entirely.

Mr. GALLAGHER. I am wondering whether or not you shouldn't suspend the use of this drug in your clinic.

Dr. PETERS. Until this is clarified, I can assure you we will suspend the use of Tofranil until this becomes further clarified.

Mr. GALLAGHER. I would appreciate it if you would advise the committee, after you have made your own request of HEW on this particular——

Dr. PETERS. I will.

Mr. GALLAGHER. If this is being used as part of the program around the country, obviously it is——

Dr. PETERS. It has been used a great deal for enuresis in children, stopping bed wetting.

Mr. GALLAGHER. This is part of what troubles me. Our Government puts out these warnings and yet is also supporting programs using them.

Dr. PETERS. I might point out to you that there is no way by which, for instance, once a drug is cleared in toxicology experiments on animals and then is used with volunteers and then cleared for adults, as you go in each one of these steps there is no way by which knowledge can be expanded in the use of drugs than by doing it. Of course, with all the proper safeguards.

Mr. GALLAGHER. I agree with you. The only thing we are directing this investigation toward is the use of behavioral modifying drugs on children. Obviously, here we have a direct warning not to use these drugs on children and yet it is part of the program. The purpose of the hearing is to clear the air as to what we are doing to our children.

Mr. MYERS. You heard the witness, Dr. Dobbs, from the FDA?

Dr. PETERS. Yes.

Mr. MYERS. Did you find any exception to any of her testimony?

Dr. PETERS. No; I did not.

Mr. MYERS. You agreed with what she said in your analysis?

Dr. PETERS. Yes.

Mr. GALLAGHER. Then evidently Dr. Dobbs does not pay much attention to Mr. Ryan in the FDA.

Dr. PETERS. I think this has to be put into historical perspective. It is only in recent years that the medical profession has had to be so concerned with ramifications and effects of drugs. The big emphasis on this began in the early 1960's with the use of thalidomide, in Germany, where these deformed babies came about. From then on we have all been terribly concerned.

Mr. GALLAGHER. I was wondering whether or not we might be creating some sort of mental thalidomide condition.

Dr. PETERS. These are investigations that will have to be made. Now, the scientific tools are becoming available for that kind of investigation.

Mr. MYERS. In the reports you periodically make on some of the drugs, is there any such reporting procedure now used?

Dr. PETERS. No; unless it is a clearly trial experimental drug. In that case there has to be very stringent safeguards.

Mr. MYERS. The drugs you think are beyond that stage. They have been clinically tested by the pharmaceutical companies as well as FDA and everybody concerned?

Dr. PETERS. Yes.

Mr. MYERS. They are absolutely cleared drugs for the use that you are intending?

Dr. PETERS. For instance, the one Mr. Gallagher was mentioning, imipramine, it is not stated that one should not use it with children, only that the conditions for using it with children are not clearly established.

Mr. GALLAGHER. I would like to repeat. It does say on the warning "pending evaluation of clinical results the drug is not recommended for use in patients under 12."

Dr. PETERS. In my pharmaceutical books this has not yet appeared. Maybe this is a more recent development.

Mr. GALLAGHER. This is August 6, 1970.

Dr. PETERS. May I make one other comment germane to this problem about the use in schools and so on? Though there may have been a rare instance of a teacher or a principal exerting pressure—who can be absolutely sure—to my knowledge, this has not been done in Little Rock. The school officials in Little Rock would soon hear about it, and knowing them as we do, we know they would not tolerate this for long. It might happen as a temporary thing, but it will not be tolerated for long.

Naturally we have an interest in not wanting the school systems of Little Rock to be dragged across the papers and maligned in any way. I am sure in this forum this would not be the case. But if this has happened it has been a rare incident, and as I say, the whole community would be up in arms against it if this were so.

Mr. GALLAGHER. We happen to have——

Dr. PETERS. I am sure there is always that one exception, and I would be the first one to condemn any kind of pressure by the school.

Mr. GALLAGHER. It is very rare that you get people to come forth. What we are really doing is looking at the total effect on our children.

Dr. PETERS. My concern is not the generality of our children but these particular children that these parents bring to me. This is my concern.

Mr. GALLAGHER. We have a broader responsibility to the children of our country. What a doctor recommends is the doctor's business, but not when our Government is sponsoring it.

Thank you very much.

Mr. MYERS. I have a few more questions.

It has been discussed here, kicked back and forth today, that MBD can be physiological as well as psychological; is this true?

Dr. PETERS. It is not known exactly the underlying organic condition or psychological condition behind MBD. We feel it has to do with some dysfunction of the brain, and we have to go mainly by analogy between children who have known brain damage and their behavior and children who do not have known brain damage, but do have identical behavior, so by deduction we assume that there has to be some dysfunction in the brain.

There are certainly other causes for this. For instance, there can be psychogenic emotional causes and cultural deprivation. In our investigation of each case we have to be careful about this because we do not want to say that these children have dysfunction who may simply be showing the results of being culturally disadvantaged. We look at this very seriously.

Mr. GALLAGHER. Do you feel the diagnostic procedure used today is sufficient and adequate?

Dr. PETERS. I think it is clear to us, particularly in, say, the middle-class home where the nutrition and the psychological environs have been what we might call healthy. I think it sometimes is not clear in the culturally deprived. We do not know which it is.

Mr. GALLAGHER. But you feel that you can at least detect it and properly diagnose it as this, as MBD. Can a country doctor do this?

Dr. PETERS. If I had the chance to teach him, yes. [Laughter.]

Mr. GALLAGHER. Are they being taught in medical school today?

Dr. PETERS. Definitely. If the country doctor read the literature that is available to him, yes, I think he could, as the testimony was given this morning.

Mr. GALLAGHER. Then you feel in your judgment drugs are adequate to treat this and to——

Dr. PETERS. I think they are a minor part of the treatment.

Mr. GALLAGHER. What procedures do you use deciding whether you use drugs or other type of psychiatric treatment? Briefly, if you can, what system? How do you make this decision?

Dr. PETERS. We try to help the schools work out an individualized program for the child who is hyperactive or who has this learning condition, and where a school has a special class we try to have the child included in this special class or to receive the help of a resource teacher. If they do not have one we encourage them to develop such a class.

If the child is to a degree hyperactive, that he cannot function in the class he is in, whether it is the regular or a special one, then we will use medication.

Mr. GALLAGHER. In your judgment then, is more research required in this area or do you feel we have adequate knowledge now to properly train and carry out the treatment?

Dr. PETERS. Well, I think we have adequate knowledge to treat as we are now, but I think we need much more research because we need to know much more about what is going on in the brain what is happening in these children, what is different about them, how the medication is affecting them, and more than anything we need other educational approaches as ways of handling them too.

Mr. GALLAGHER. Have you ever prescribed to one of your own children——

Dr. PETERS. It so happens I have.

Mr. MYERS. Drugs?

Dr. PETERS. Yes.

Mr. MYERS. One last question. Where was your mimeographing done?

Dr. PETERS. We did not do the mimeographing. I suppose it was done here.

Mr. MYERS. Thank you.

Mr. WYDLER. I do not want to pry unnecessarily, but I do not think we can leave that answer quite that way. Have you prescribed these types of drugs for your own children?

Dr. PETERS. Excuse me?

Mr. WYDLER. You say you prescribed drugs for your children Are you speaking of the type we are discussing now?

Dr. PETERS. I am speaking of Ritalin.

Mr. GALLAGHER. I might ask you, Dr. Peters, about what came in this morning from a Dr. McMahon of the Tulane University School of Medicine, a professor of medicine. He says:

> Dear Mr. Gallagher, the American Medical Association News of August 10 made me aware that you and others are interested in the use of the drug Ritalin in children and childhood diseases. If you have not already been aware you might be interested to know an injectable form of this drug was taken off the Swedish market about 4 years ago because of widespread misuse of teenagers in sex orgies. At this time I was vice president in charge of medical research in the United States and recall vividly the affair in Sweden.

I inquire again where we are leading our children who are not minimally brain dysfunction children by advocating the use of Ritalin. Are we not really advocating it and making the atmosphere far more permissive for children who do not need Ritalin to use it for other purposes?

Dr. PETERS. First of all, I agree with your concern. I like that. I agree with it. But secondly, I think we have to distinguish between what is medically useful and what is abuse and because a given treatment is abused, I do not think it is reason to throw it out of existence.

Mr. GALLAGHER. I am not saying throw it out of existence. What I am really saying is whether or not the advantages to those children who are on amphetamines and Ritalin, whether or not the advantages of those programs so widely advertised that these drugs are useful are not creating great disadvantages to millions of other children who might be tempted to go the drug route.

Dr. PETERS. Well, I——

Mr. GALLAGHER. Especially an older brother or sister of a child who might be taking Ritalin and the sole source of success is that young child——

Dr. PETERS. That may be correct.

Dr. CLEMENTS. I feel it is a medical problem. In this instance I would defer to Dr. Peters. It is strictly speculative as far as I am concerned.

Mr. GALLAGHER. Do you think we are creating new problems for far more children who are not in need of stimulant drugs in their education by advocating these behavioral programs for other children?

Dr. CLEMENTS. I would sincerely hope not.

Mr. GALLAGHER. This is one of our great concerns here.

Dr. CLEMENTS. It is one of mine, also.

Dr. PETERS. May I add there that of course I am no expert in this area, but it seems to me that other causes of the spread of drugs other than those legitimately prescribed for these children are much more important.

Mr. GALLAGHER. It is really a problem of psychology, I guess.

Dr. CLEMENTS. I would like to respond to some things I heard this morning and this afternoon and which appear blatantly in Holt's testimony.

Mr. GALLAGHER. All right.

Dr. CLEMENTS. It is an indictment against the public school system in America and the teachers. I would like to defend them. I think they labor under great odds, a great deal of pressure, and I know no school system and its personnel who would not fight to upgrade the programs for the children who sit in those classrooms and I resent the kinds of statements that were made in Mr. Holt's testimony because it was an indictment of the American public school system, and I came out of the American public school system and I am quite proud of it, and I am proud of the teachers.

Mr. GALLAGHER. One of the agonies of the American school system is the terrible drug problem. Every teacher, every parent, every principal is worried about it. Now we are also saying out of the other side of our mouth that perhaps we can solve many of our problems with the use of drugs. I think this is significant.

Dr. CLEMENTS. I do not know who said that. We talk about——

Mr. GALLAGHER. Mr. Holt himself is a great schoolteacher.

Dr. CLEMENTS. I am quite aware of his work. He runs a private school. I suppose one of the alternatives is to send every child to his school. That would be marvelous, I suppose.

Mr. MYERS. Would it be?

Dr. CLEMENTS. I doubt it seriously. It would be quite expensive, too, I believe, and probably out of the range of most families. Alternatives, yes, we are all interested in that, and we all mentioned learning disabilities and there are reports of reading disorders in the United States and the great amount of learning disabilities that do exist in our public school systems.

It is a topic of one of the forums of the White House conference on children coming up in December. There are many concerned people, and we are all looking for alternatives.

Mr. GALLAGHER. I hope we find them, other than the use of more drugs in our schools.

Dr. CLEMENTS. We are talking about, I believe, as has been implied by many people, that if we improve the public school system, that many—or if we train teachers better of if we could train teachers

to have better attitudes and be more tolerant of certain behaviors, et cetera, I think most teachers are trying very hard to do these things.

Mr. GALLAGHER. Yes. Thank you very much.

Our next witness is Mrs. Daniel Youngs. I want to welcome you to the subcommittee hearings, Mrs. Youngs. I want to thank you for coming to present your testimony.

Mrs. Youngs lived in Little Rock, Ark., for 3 years. She has two children, both of whom were singled out as possible recipients of the behavioral modification drugs which are under discussion this morning. Mrs. Youngs vigorously resisted the placing of her children in such a position, the story she will tell today.

It is not our intention to criticize general school administrations in any locality. This is outside the jurisdiction of this subcommittee. We are not prepared to become involved in a personal dispute between parents, doctors, and school administrators. Our purpose in inviting Mrs. Youngs here is to present another side of this question that we are so concerned with today.

Again, Mrs. Youngs, I am delighted that you could be with us, and we would now appreciate the opportunity to know what one family in one locality endured when its children were thought to suffer from MBD.

The testimony is indicative of many other experiences of parents in the rest of the country and it is in that context I welcome you here this morning.

One of the problems that was pointed out earlier was that you cannot consider individual cases. Yet, in the whole history of our country it boils down to the effect of programs on individual people. Unless one talks about helping individual people, obviously one cannot talk skillfully about the masses.

We are delighted to hear from an individual person with two children involved with the problem we are here discussing.

Mr. MYERS. I might also, as a fellow Hoosier, welcome you to this committee. I see you are a Hoosier now. I was born that way and you selected it, so we welcome you not only to this committee, but to Indiana also.

STATEMENT OF MRS. DANIEL YOUNGS, INDIANAPOLIS, IND.

Mrs. YOUNGS. Mr. Chairman, distinguished members of the committee, I am Mrs. Daniel Youngs, residing at 3651 Dubarry Road, Indianapolis, Ind., with my husband and two children. Before moving to Indiana we lived in Little Rock, Ark.

We moved to Little Rock, Ark., in the fall of 1963 from a small town in Ohio. We had no way of knowing, at the time, that the next 3 years were going to be a nightmare.

One of the first things we had to take care of after arriving in Little Rock was the enrollment of our third-grade daughter and first-grade son in Hardin Bale Public School. We took our children's report cards into the principal's office at Hardin Bale. The meeting we encountered with the principal lasted 4 unbelievable hours.

The principal, Mrs. LeMay, took our children's report cards and studied them for a few minutes, and then made an astonishing diagnosis: "Your daughter, Mr. and Mrs. Youngs, has minimal brain dysfunction."

This diagnosis by the principal was made solely on a report card. She had never laid eyes on our daughter. We protested strongly, but to no avail. She went on to explain that the public schools and the University of Arkansas Medical Center were involved in an experimental program set up by Dr. Clements to help children with learning disabilities.

Mrs. LeMay told us that her own daughter had minimal brain dysfunction and was put on drugs to stimulate her to learn.

Before we left Mrs. LeMay's office she gave us some literature that Dr. Clements had written on the subject of minimal brain dysfunction and asked us to read it.

After spending a week studying the literature and going to the library, my husband and I came to one conclusion: It was absolutely insane to give children with average- and above-average intelligence amphetamines and other drugs to stimulate their learning capacity.

The principal called me a few weeks later and told me they would like to put my daughter back in second grade as she was having difficulty in reading. After much thought we consented.

Again the principal called and told me my daughter was still having difficulty with reading and would I come in to discuss this. At this meeting I told the principal we would like to hire a tutor to bring my daughter up with the rest of the class. I was informed that the only type of tutor that could help my daughter was a teacher that had training in Dr. Clements' program and, furthermore, that my daughter should be sent to the medical center for testing by Dr. Clements' staff.

I told her under no circumstances would I or my husband allow our daughter to be tested by Dr. Clements' staff. The other alternative she proposed was for me to follow her instructions on tutoring my own daughter. The instructions were to strip a room of all objects, wear a black dress with no buttons and to put in the room only one table and two chairs.

She went on to say that in helping her to achieve more in school to have no salt and pepper shakers on the table during meals, turn her bed down every night exactly the same way, lay out her clothes in the morning at the exact same spot and many, many more such suggestions. At this meeting I was told that my daughter was underactive and a daydreamer. During the school year of 1963–64, I was called constantly and went down for conference after conference about my daughter, always about the same thing—minimal brain dysfunction—and always with the same result. We would not cooperate with their program.

At the end of the school year, Mrs. LeMay called and said Dr. Clements was going to speak at the school and would I please come. The meeting was very informative to me because during his whole speech the word drugs was not mentioned.

This is when a very deceptive pattern became clear to me for the first time. There was a question and answer period and I took the opportunity to ask Dr. Clements about the usage of drugs in his program. This was his answer, verbatim: "If you are going to worry about the use of drugs, I suggest you don't give your children aspirin." The subject was closed.

Dr. Clements and his staff held their first convention in the spring of 1964 on learning disabilities. This was the first time we became aware of the extent of their experimental program. Many school administrators, teachers, lawyers, Catholic priests, parents of children with so-called minimal brain dysfunction, newspaper reporters, doctors, radio, and television personnel were involved with this program and some of the literature that Dr. Clements had written was an Easter seal publication.

The public was being exposed to this program by coverage on radio, television, and in newspapers, we never heard the words amphetamines and drugs used in any of this coverage.

Step by step they were plotting a well-laid plan for soliciting children with average and above average intelligence to be used as guinea pigs.

During the school year of 1964–65 I was called down to the school at least once a week about my daughter and son. I was told my son was overactive and my daughter underactive.

We noticed during the year that the school curriculum was heavily supplemented by the principal and teachers, the children were tested constantly and that the workload was becoming too much.

My husband and I made many trips to the school administration offices. We tried to tell them what was going on. They just didn't care and showed one reaction—total apathy.

One of the meetings I had was with Mr. Floyd Parsons, superintendent of schools. I told Mr. Parsons of the harassment and unfair treatment of my children, the pressure exerted upon us because we would not cooperate with their program and the fact that my children were going to a diagnostic clinic with clinical classrooms instead of a public school.

Mr. Parsons told me in this meeting that although Dr. Clements stated publicly that 17 percent of all schoolage children had minimal brain dysfunction, privately Dr. Clements was stating 30 percent.

Mr. Parsons said he did not agree with the program and it was really a thorn in his side. He went on to say he didn't care what they did because he wasn't from Arkansas, anyway. In a gesture of dismissal, he stood up, and with slow deliberation informed me that if I repeated anything he had said he would deny it and call me a liar. After leaving his office I felt only one thing: fear, fear for my children and the children in the State of Arkansas.

During this 2-year span my children had made B's and C's on their report cards.

The next school year, 1965–1966, started off well. The month of September we didn't hear from the school. We felt nothing but relief for our children and ourselves. It was shortlived. October of 1965 was the month when we began to feel that our own private family life would become the property of the State, involved in a bizarre program of drugs and unethical medical and educational practices that would be unbelievable to most people of the United States of America.

Within the same week in October 1965, I was asked to come to the school for a conference with my son's teacher, Mrs. Fincher, and my daughter's teacher, Mrs. Nelson. My daughter's teacher was saying the same thing I had heard for 2 years: have your daughter tested for minimal brain dysfunction.

At the conference with my son's teacher I heard these words for the first time: "Mrs. Youngs, I think your son has minimal brain dysfunction and we would like to test him." No sooner had she spoken the words and I was down the hall and in Mrs. Le May's office. Mrs. Le May told me they were considering testing both children with or without our permission.

I told her that if my children were tested without our permission we would take legal action. The next day I received a call from the school officials asking me to write a statement to the effect that the children could not be tested. The statement follows:

OCTOBER 28, 1965

To the principal and staff, Hardin Bale Elementary school, Little Rock, Ark.

My daughter or son (blank) is not allowed to participate in any special testing involved with any experimental medical research program without my written permission in advance.

This note is written in accordance with the request of the Little Rock Public School authorities who assured this will be done in accord with my request.

(Signed) MR. AND MRS. DANIEL H. YOUNGS.

The next few months the pressure was extreme. We received almost daily notes from the children's teachers and calls from the school. We were told our children had completely quit trying and were failing every subject. We knew what they were trying to accomplish by this because we knew parents in the neighborhood that submitted their children to the program because they couldn't take the pressure. Believe me, it wasn't a pretty sight to see little children's personalities changed with the use of drugs.

The pressure kept building. My son was not allowed to have recess with the other children because it was too stimulating. The final blow was the day my son came home crying hysterically. After I calmed him down I found out the problem. He had been put in a cardboard box for 2 weeks. I went down to the school in a rage. The box was gone. Mrs. Le May said the box was removed because some of the parents were going to build wooden partitions to replace the box. They did not deny that the cardboard box had been used for him. He was easily distracted. I was told this way he could learn without distractions.

My husband and I had no one to turn to. We knew that the school officials would do nothing. At this point we felt we had two alternatives: leave Arkansas or stay and fight. We chose to stay and fight. We knew there were hundreds of children on drugs and someone, somewhere would listen and help us put a stop to this program. We were wrong.

Two weeks later the teacher had my son call me on the telephone from school. He was crying and said he wanted me to come down to the school. The teacher took the telephone and told me the only way she knew for him to get his work done was for me to come down and sit beside him. I told her I would be down.

After 2½ hours in the classroom, two men came to the door and asked for me. They were school officials from the administration office. They asked me to leave the building and escorted me to the door. They told me not to come back in the school again. I left the school with the full knowledge that the whole episode had been prearranged.

Early in 1966 I took my son into the office of my family physician for a routine examination for a sore throat and slight fever. During the examination Dr. Flack asked my son how he was doing in school. My son answered, "I get C's and D's."

Dr. Flack asked my son how he would like it if he could get A's and B's. My son said he would like that.

Dr. Flack proceeded to write out a prescription for drugs and told my son this would help him to do better in school. I was in the room at the time, but the conversation by Dr. Flack was directed completely to my son. I refused the prescription and, needless to say, Dr. Flack was no longer my family physician.

We attended the "Third Annual Convention of the Arkansas Association of Children with Learning Disabilities," held in the spring of 1966 to obtain additional information. We were asked what we were doing there. We were watched and followed throughout the day. In succeeding weeks our home was periodically watched.

Following is a list of people and organizations we contacted in an effort to expose to the general public the use of various drugs on elementary school children.

Winthrop Rockefeller, candidate for Governor of Arkansas. We saw his campaign manager. He took our names, heard our story and said he would give our information to Mr. Rockefeller. I also sent information to Mr. Rockefeller by mail.

Robert E. Hall, U.S. Department of Health, Education, and Welfare, Office of Education. We informed him of the drugs used in this program. He said that each State involved was running its programs differently.

Federal Bureau of Investigation agent. He was nice to us, sympathized with us, but said no crime was indicated.

U.S. attorney. He said there was no way he could do anything; that we should see the superintendent of schools or the district attorney.

Federal Drug Administration agent. He talked to us almost an hour and told us he was definitely going to report it and see if they couldn't do something with it or about it.

Staff medical officer. The agent from the Federal Drug Administration office sat in on this meeting. The State medical officer told us he already knew about the program and he saw no reason to be so concerned; they—the program—had done nothing that he could find fault with and more or less dismissed us.

Three Little Rock attorneys. They all refused to give us legal advice or take a retainer.

David Brinkley, NBC News. The information was sent back.

Mike Wallace, CBS News. He wrote and said he turned the information over to the producer of the CBS Morning News, Phil Lewis.

Charles Mangel, Look magazine senior editor. He wrote a seven-page article on brain-damaged children called "Bobby Joins His World." Only one sentence in seven pages spoke of the use of drugs. We sent him our information on the Little Rock program.

Mr. Spencer, Post magazine. We sent them some specific information. There was no reply.

Phil Lewis, producer of the CBS Morning News. Mr. Lewis showed the most interest and corresponded with us, and took time to talk to us on the telephone. He said there was no public interest in minimal

brain dysfunction at that time. I knew our story was hard to believe and we thanked him for his understanding and kindness toward us personally, through telephone conversations and letters.

Mr. Lewis asked us if we could get any information on the drug clinic the children were assigned to in Little Rock.

I placed a call to the University of Arkansas Medical Center and spoke to Dr. John E. Peters. I told him I was very interested in his program and asked him how many children were in the program and how many were assigned to the drug clinic.

He said, "Is this Mrs. Youngs?" He went on to say I was the most dangerous, detrimental, destructive person he had ever heard of and that AMA was well aware of what I was trying to do and they could put a halt to it.

Near the end of the school year I received the final and decisive call from the school principal. At the meeting, Mrs. Le May said my children were failing and since we wouldn't do anything about it, the school officials were very seriously considering taking it out of our hands. When I found out how they hoped to accomplish this, I was panic-stricken. Mrs. Le May went on to tell me that the school officials were contemplating using our children in a trial court case, to see if children could be put in this program without the parents' consent. At this point the mental agony I felt was extreme.

When I arrived home I immediately placed a call to my husband. He came right home and the same night he found a new job in Indiana, and we made preparations to get the children out of the State of Arkansas. The next day he gave his place of employment a 2-week notice.

We told the school principal we were moving and asked for our children's report cards. With only 2 weeks of school left, Mrs. Le May said the children would not be promoted nor would she release their report cards to us. She also informed us she would make sure that minimal brain dysfunction was on our children's permanent school records.

We went down to the school officials and after a much-heated discussion they assured us that no mention of minimal brain dysfunction would appear on any records and that they would call Mrs. Le May to release our children's report cards. We were told it would be up to the State to which we moved whether the children were promoted to the next grade level. That weekend my husband took our children to safety in Ohio.

The next week Mr. James Stover, my husband's employer in Little Rock, Ark., asked if I would come into the office with my husband for a meeting. At the meeting he said he wanted us to stay in Little Rock and for my husband to continue working for him.

Mr. Stover said that he had talked to the school officials and they were willing to let us transfer our children to another school in town, and guaranteed our children would be left alone—on one condition—I was to keep my mouth shut, never interfere and never mention the program to anyone again.

The price I would have had to pay for what every American takes for granted was too great. The price: Elementary school children put on dangerous drugs, and now my freedom of speech.

Mr. GALLAGHER. Thank you very much, Mrs. Youngs.

Mr. WYDLER. Could I just ask one or two preliminary questions?

How old are your children now?

Mrs. YOUNGS. Fifteen and a half and 13½.

Mr. WYDLER. And they are still obviously in school?

Mrs. YOUNGS. Absolutely.

Mr. WYDLER. What are their names? We haven't heard that yet. It would be helpful to identify them.

Mrs. YOUNGS. My daughter is Mickey and my son is Ross.

Mr. WYDLER. How are their grades in school now?

Mrs. YOUNGS. Wonderful. They have been ever since they left Little Rock.

Mr. WYDLER. When you say wonderful, I don't know how they grade in Indiana. Probably my colleagues here could inform me. Is it A, B, C, D?

Mrs. YOUNGS. My daughter is an A and B student and my son is a B and C student.

Mr. WYDLER. Has this been consistently so since they went to Indiana?

Mrs. YOUNGS. With my daughter, yes. With my son, it has been a progressive thing. When we first moved to Indiana, he was getting mostly C's and D's and then he progressively made better grades every year.

In fact, I talked to the principal last week and she said if anybody on the subcommittee wishes to question them on my children's grades since they left Little Rock, they would be available to answer any questions.

I might add that my daughter last year won six awards in the eighth grade. She won a science award. She received the highest honors in her class—in the school for science. She won the Gold Key Award. Altogether she won six awards.

Mr. WYDLER. One last question. Do you have any memorandums, notes, letters, anything in writing at all from any of the teachers or other persons we described here complaining about your children's conditions or attitudes in school or anything relating to this at all?

Do you have anything that would be written? Any notes that they sent you to come in to see them, anything of this sort?

Mrs. YOUNGS. Yes, I have notes.

Mr. WYDLER. During the period of this statement that you have given us today?

Mrs. YOUNGS. I saved only one part of the notes. The rest I tore up but I did save some notes, yes.

Mr. WYDLER. Mr. Chairman, I would like to see those. I think they would be helpful to me in understanding this statement.

Mr. GALLAGHER. Yes.

Mr. WYDLER. I am not suggesting we make them part of the record; I don't want to intrude on your privacy but it would be helpful to me.

Mr. GALLAGHER. Is that what you have there?

Mrs. YOUNGS. Yes.

Mr. WYDLER. Oh, you have them with you.

Mrs. YOUNGS. Yes.

Mr. WYDLER. Could I look at them?

Mrs. YOUNGS. Yes.

Mr. WYDLER. All right, Mr. Chairman, that is all, thank you.

Mr. GALLAGHER. It's rather difficult to accept all that has happened in the case. I know, Mrs. Youngs, that you were reluctant to testify here today.

Mrs. YOUNGS. Absolutely.

Mr. GALLAGHER. I want to tell you this, Mrs. Youngs. We have stacks of letters that are available that demonstrate or tell of similar experiences. I might say none are like what you have been through with regard to drug programs in various schools throughout our country. Why were you reluctant to come here today to testify at this hearing?

Mrs. YOUNGS. As I say, I was never sure whether minimal brain dysfunction was put on my children's records after we moved to Indiana and I wanted to check with the principal first to make sure what Indiana would do if this was exposed. I still in my own mind was so afraid that somebody was going to try to put my children in this program that I wanted to know the stand of the Indiana school system before I felt safe in testifying.

Believe me, their stand was quite a bit different than Little Rock's.

Mr. GALLAGHER. Did you ever discuss your reservations about the Little Rock program personally with Dr. Clements?

Mrs. YOUNGS. No, I haven't. The only time that I have ever talked to Dr. Clements was on the question about drugs in his program.

Mr. GALLAGHER. We know that from your statement you made many attempts to bring the Little Rock situation to the attention of various people.

Mrs. Youngs, could you tell us in more depth as to why you didn't want to follow the recommendations of the Little Rock officials?

Mrs. YOUNGS. Well, I think any parent, anybody that is in this room, if they had a principal look at their children's report cards and make this statement, they immediately would become suspicious.

Mr. GALLAGHER. This was the first point that this subject of minimal brain dysfunction——

Mrs. YOUNGS. It was the first time I ever heard the words. I never heard the term before.

Mr. GALLAGHER. We have been led to understand that all these programs are volunteer programs on the recommendation of a personal physician. Is that the case here?

Mrs. YOUNGS. As far as my personal knowledge of that 3 years, any parents I have talked to, which have been many, have been pressured—and I mean extreme pressure.

Many of them would have come forth except they are still afraid. There is a couple right now in Little Rock that wrote me a letter and said if we weren't afraid of the repercussions we would love to be able to help you.

So there is still this fear.

Mr. GALLAGHER. I would like to ask you, not for the record but I would like to ask you if you could submit to us the names of the people who might cooperate.

I don't want this for the record. This would be off the record. privately.

Mrs. YOUNGS. Yes.

Mr. GALLAGHER. Mrs. Youngs, I am not sure really what to say. You have performed a valuable service in bringing your personal experience here today. I want to commend you for your courage and your love of children.

Mrs. YOUNGS. They are loved.

Mr. MYERS. I would like to ask some questions. Mrs. Youngs, this astounds me, too. I can't help but be puzzled a little bit, being a parent myself, and frankly 4 or 5 years ago we had a problem with our youngest daughter, who wasn't learning and we were called to school like you.

Frankly, I didn't fight it because I knew she wasn't learning. I could tell. We went to the clinic and they didn't prescribe drugs but tutoring and other help because our daughter hadn't had the proper attention at home, frankly.

I was out on my first campaign and I was out working and who could explain it. But why did you fight it?

Mrs. YOUNGS. As I say, because of the way I was approached on it. I thank God I was approached on it that way because from what I have seen and what I have studied, it's a very deceptive program and I wouldn't want my children to be a part of it.

My children weren't problem children. They didn't have behavior problems whatsoever. They had a learning disability because my daughter hadn't been taught phonetics in the first and second grade.

There was a good reason for this learning disability.

Mr. MYERS. You spoke about the doctor, who is still in the room, commenting about aspirin. Do your children take aspirin and cough medicine and things like that?

Mrs. YOUNGS. I am not opposed to giving children medication when it's called for. Absolutely not.

Mr. MYERS. But do you voluntarily give them aspirin when they have a headache or a little cold or something?

Mrs. YOUNGS. Not voluntarily.

Mr. MYERS. Without a doctor's prescription, do you give them——

Mrs. YOUNGS. Aspirin? Yes. If they have a fever, the doctor usually says give them aspirin every 4 hours.

Mr. MYERS. In some cities, I believe I am correct in this, the city of Indianapolis adds an additive to the water to prevent tooth decay. Do you oppose that or do you agree with that? Fluoride.

Mrs. YOUNGS. I didn't know they had fluoride in the water.

Mr. MYERS. I am not sure. Don't go back and get on the mayor and say I told you.

Mrs. YOUNGS. I don't think they do.

Mr. MYERS. A number of cities do have. What is your position on that?

Mrs. YOUNGS. I am not sure. I would have to look into it.

Mr. MYERS. If you learned that they were adding fluoride to the water to prevent your child's tooth decay, would you look into it or accept the fact?

Mrs. YOUNGS. I don't know. I would probably look into it.

Mr. MYERS. You have never taken a position on that?

Mrs. YOUNGS. No.

Mr. MYERS. I have one or two other questions.

You say that the episode where you were down to the school classroom sitting with your son was prestaged, prearranged and was a setup. What would be the purpose of this setup? I don't follow you here.

Mrs. YOUNGS. I have no idea. I was called at 8 o'clock in the morning. Mrs. Fincher asked me to come down to the school and I was there approximately two and a half hours and two men from the administration building came in and asked me to leave the school and don't come back in this school.

Mr. MYERS. But you believe it was prearranged but you couldn't know why.

Mrs. YOUNGS. I would say that since the teacher and the principal were in the office at the time my son called me, and then somebody had to call the administration office, it might be an assumption on my part but it's a pretty good one that it wasn't somebody unconcerned that called.

It probably came from the principal. She called the administration office and told them I was at the school.

Mr. MYERS. Now, your family physician in Little Rock also prescribed for your son, is that right?

Mrs. YOUNGS. This is another assumption on my part but I feel very strongly that the school officials called my family physician.

Mr. MYERS. Did your physician ever tell you this?

Mrs. YOUNGS. No. I said this was an assumption on my part.

Mr. MYERS. Did you go to another doctor to have your children examined or another clinic?

Mrs. YOUNGS. Absolutely not. There was no need for it.

Mr. MYERS. You never had your children really examined?

Mrs. YOUNGS. I was told by many doctors back home not to have it done.

Mr. MYERS. Not to have your child examined.

Mrs. YOUNGS. I add since I am a mother, I raised these children I knew quite well how to handle my children. I knew what caused my daughter's learning disability, she didn't have phonetic training. I also knew why my son was overactive and I am a parent who really thanks God my son is overactive. He had a severe medical problem and if he hadn't been able to overcome it with his being so energetic and full of life, he would have been a very stifled individual.

He has been in hospital after hospital. So I think his ability to overcome and being overactive was really great in his instance.

Mr. MYERS. Now, in your judgment do you believe that the Federal Government should research this further, the possibility of using drugs or any other therapy to improve children's learning?

Mrs. YOUNGS. I feel that anybody that has been at this hearing today, if they don't feel it should be done, it's sad.

Mr. MYERS. You say yes or no?

Mrs. YOUNGS. I think it's sad if you personally can't say after this hearing, Yes, there should be more investigation.

Mr. MYERS. I am asking your opinion.

Mrs. YOUNGS. In my opinion, absolutely. Anybody that is in this room, if they have listened—there has to be more investigation to know what has been going on.

Mr. MYERS. You would approve of more research.

Mrs. YOUNGS. On research. The way Dr. Clements and these other doctors have run the program? Absolutely not. There should be research but it should be controlled.

Mr. WYDLER. Dr. Clements, I am sure would tell you that is exactly what they are trying to do. Whether they are or not, that is quite another story.

Mr. GALLAGHER. I would like to say that perhaps things have changed considerably since the time of Mrs. Youngs——

Mr. WYDLER. I am sure that is what they try to do.

Mrs. YOUNGS. They might try to do it but they were wanting my children.

Mr. WYDLER. They are human. They can make mistakes. Even I make mistakes once in a while.

Mrs. YOUNGS. But it is a high price to pay, with the children.

Mr. WYDLER. Could I ask a question or two?

I notice these notes you gave me were about your son. Do you have any about your daughter?

Mrs. YOUNGS. No. Most all of the notes concerning my daughter, I threw away. Most of it was done by telephone calls. In fact the principal at the school called me on holidays and she called me during the summer for 3 years.

Mr. WYDLER. The answer is that you destroyed the ones for your son and daughter but there were some——

Mrs. YOUNGS. My son was in the last year and this was when we decided to fight it so I saved more material during the last year than the first 2 years.

Mr. WYDLER. I wonder if I can ask Dr. Clements, Doctor, the only thing I can see in this statement where you would really have some personal knowledge was this meeting where you addressed a group that has been described here.

Do you remember that? Did you hear that part of the testimony we heard?

Dr. CLEMENTS. Yes, I read it.

Mr. WYDLER. Apparently you gave a talk on your program from what I understand and then at the conclusion you were answering questions and you were asked a question about the use of drugs. Is that so—in accordance with your recollection?

Dr. CLEMENTS. No, because——

Mr. WYDLER. Do you remember the meeting?

Dr. CLEMENTS. Frankly I don't. There are many years when I speak once or twice a week at various places in and out of State and out of the country. To recall the specific meeting is very difficult for me.

Mr. WYDLER. Is it normal for you, when you make a tour to describe the program, to mention the fact that you use amphetamines and other types of drugs as part of the program?

Dr. CLEMENTS. What bothered me most is——

Mr. WYDLER. Do you avoid it so as not to scare off parents? What is your policy? Do you have one?

Dr. CLEMENTS. No, I have no set policy. I try to respond to questions that parents might have. If it happens to be a parents' meeting. I think everyone who knows me knows I am not a physician, that I

don't have the training about prescriptions of medications. Yes, I understand since all my professional life I have worked in a medical school and helped train physicians, future physicians, yes, I am aware of these things. Through the experience and my collaboration with Dr. Peters, we have collaborated in writing about such things. I am not ashamed to relate some things we have written in response to a question from a parent or a professional or anyone.

Mr. WYDLER. But you still haven't answered my question.

Is it normal for you when you describe this program to mention the fact that drugs are used in the program?

Dr. CLEMENTS. I don't know what the program is. This is always—the reference to my program or the program. I simply don't understand what that means. It is as if—I would like to point out very quickly the Arkansas Association for Children with Learning Disabilities is a parent organization. It is not my organization as indicated in that very flattering——

Mr. WYDLER. You don't ever remember seeing Mrs. Youngs before?

Dr. CLEMENTS. Yes, I do recall seeing Mrs. Youngs and I do recall the convention that she spoke about in her testimony. I do recall that.

Mr. WYDLER. Did she see you at the convention, talk to you?

Dr. CLEMENTS. I am sure she did. I was in and out constantly helping speakers get up to the auditorium and running the projector——

Mr. WYDLER. Where did you see her at the convention?

Mrs. YOUNGS. May I say he followed me? At the convention, and there are two other witnesses that watched this go on all day long. If I would go out to the telephone, no matter where I went, Dr. Clements followed me.

Mr. MYERS. Did he watch your house, too?

Mrs. YOUNGS. I don't know who those cars were but another couple had their house watched by the same car.

Mr. MYERS. You say publicly 17 percent of all schoolchildren suffer from MBD and yet privately you say 30 percent. Why would you give——

Dr. CLEMENTS. That is another quote that I—I don't know. I think that was attributed to Mr. Parsons, who is the superintendent of schools in Little Rock.

Mr. MYERS. He is quoting you.

Dr. CLEMENTS. I say yes, supposedly in this testimony he is quoting me. I don't know where these figures or——

Mr. WYDLER. Have you said privately that it is 30 percent?

Dr. CLEMENTS. No, sir.

Mrs. YOUNGS. May I say something?

Mr. WYDLER. Excuse me a minute now. I still didn't get an answer to my question.

You say you saw Mrs. Youngs at the convention. Where did you see her?

Dr. CLEMENTS. Well, I presume she was in the lobby. We used the University of Arkansas Medical Center Auditorium which is on the campus at the Medical Center.

Mr. WYDLER. I asked you where you saw her.

Dr. CLEMENTS. In the lobby.

Mr. WYDLER. How did you know who she was?

Dr. CLEMENTS. How did I know who she was? I think she was pointed out to me probably. I have no actual recollection—certainly by somebody. It may have been the principal of the school. She may have come up and introduced herself. I don't really recall.

Mr. WYDLER. All right.

Dr. PETERS. Could I make one comment?

Mr. GALLAGHER. As soon as Mrs. Youngs finishes.

Mrs. YOUNGS. He said he didn't know where the figure 30 percent came from. This was Mr. Parson's figure but one of their associates, Dr. Stevens, quoted on Allan Rothman's Talk of the Town Show in Little Rock, Ark., that 25 percent of the school population had minimal brain dysfunction and this was on a radio program and it was Dr. Stevens, one of their colleagues.

Dr. CLEMENTS. I think the reference is not to minimal brain dysfunction at all, but to learning disabilities.

Mr. GALLAGHER. Did either of you know of the recruiting methods that got the people to the center as described? There was a rather strong recruiting going on?

Dr. PETERS. As I indicated before, there could be some individual teacher or some principal who abused the system. I don't know in this particular case. But it is certainly not the policy of the school that there be any recruiting under pressure. We would all be against it.

Mr. GALLAGHER. Would you be against what went on?

Dr. PETERS. I certainly would. If she was pressured I think this is terrible. May I make a comment where Mrs. Youngs' testimony coalesced with me and where she quoted me on the phone as saying I consider her a dangerous destructive person, the most I ever heard of and the AMA was well aware?

I can only say categorically this cannot be true. I wouldn't say such a thing. As I recollect the conversation I advised her nobody could make her come to the clinic, which was what she asked me. Can I be made to come to the clinic? Do my children have to come there? She asked me questions about how many children were on medications and this sort of thing. I didn't feel I should answer this over the phone and I didn't.

Mr. GALLAGHER. How many conversations did you have?

Dr. PETERS. One.

Mr. GALLAGHER. Thank you very much, Mrs. Youngs.

I would like to say that the presentation was made in Omaha in the same way. The drugs are rarely alluded to, or vaguely, if at all, in the presentations of the STAAR program. That is very much the same.

Our next witness is Sally R. Williams. Mrs. Williams is president of the Department of School Nurses of the National Education Association. Mrs. Williams is a registered nurse, bachelor of science and has a masters degree. She has been a school nurse in elementary and secondary schools for 18 years.

I had the opportunity to look over your testimony, Mrs. Willliams, and I am very pleased you have come forward with positive recommendations. If this program of behavior modification by drugs in grammer school is to continue or zoom as predictions say and as some suggest, it is obvious that the school nurse will play a crucial role in preventing abuse.

Your testimony is quite valuable to us and we would be pleased to hear from you now. In view of the hour, we do have your statement and would like to put it into the record if you would like to summarize it, or whichever is more comfortable for you.

STATEMENT OF SALLY R. WILLIAMS, PRESIDENT, DEPARTMENT OF SCHOOL NURSES, NATIONAL EDUCATION ASSOCIATION

Mrs. WILLIAMS. I think many of the points that I have included have been covered by other people earlier in the day, so to speed up things, I would like to make a point that as a school nurse, I have to react to the constant use of the word "drug." This is quite important to us in education.

With our boys and girls that are in need of drugs as you say, we always use the word "medication." This is to differentiate between the abuse of drugs. We can't change the Nation on that terminology, but the individual children that we work with are taught they are on medication and they are taught the reaons why they are on medication and the fact that medication is not new in the school system, that we have lots of epileptics, asthmatics, et cetera, that have always been on medication over the years so that I personally don't feel that there is the danger of this particular child who happens to be on behavior modification medication abusing it.

The other point I would like to highlight is those who are abusing drugs are, according to Dr. Ottinger, using at least 10 times the medical recommendation. I think it is crucial that we have a school nurse with a surcase load so that she can be the liaison between the doctor and the family and the education community.

I have plenty of case studies, as I talked with nurses across the country; for instance, one that comes to mind is when the parent deliberately didn't tell anyone at the school that this child who had had severe learning disabilities had been put on the drug. I am not sure which one (drug) that was. I think it was Ritalin. They were actually then put on medication. It was not required to be given in school. As has been stated, it can be given just before school and just after school is dismissed. The teacher did notice a dramatic change in this particular child's behavior in the classroom.

Now, he became attentive and it was such a dramatic change that in talking with the school nurse they found there was nothing in the record that said anything had happened to this child in the recent past. They called the parent and the parent then admitted very joyfully that the child had been put on this kind of medication and they were very pleased with the results of it.

My point in bringing this out is they didn't want the teacher to get the halo effect and this is an argument that goes both ways; but how can we work intelligently with our boys and girls in the school systems if we don't understand what kind of treatment they are receiving outside of the 5 hours that they are under our jurisdiction? So that the problem of changing drugs—I know that as I talked with nurses across the country that some of the children bring their medication in their lunchboxes.

I think there should be, as I recommended, some regulation that does not allow this to happen. We, as the Department of School Nurses, feel that it is very important.

Mr. GALLAGHER. Are we talking now about medication for all sorts of things or are we talking about medication of drugs used in behavioral modification?

Mrs. WILLIAMS. I would talk about all medications. For instance, the sharing of dilantin, which is not one of the behavior modification—which is not one of the drugs commonly prescribed for the hyperactive child also can be very detrimental if it is shared.

I would like to recall when I worked in elementary school, we had a charming little boy who had an infection and at that time his mother was using good old potassium pemangamate. He was so intrigued with the change of color that he brought the box to school unbeknownst, of course, to mother, and in a typical third-grader manner shared with his friends.

After you have participated in getting 30 stomachs pumped in a school setting, one closes down the campus to all medication and I include the high school level, also.

I know your concern is only with elementary. This is the only way we are ever going to be able to control the abuse of drugs actually on the school campus. Anyone who needs to take any kind of medication then must have the parents' permission, the doctor's prescription and have it locked in a central office and the initial dose given by the school nurse so that she can be assured that all the proper forms and permissions are filled out and that the teacher is informed as to what this child is taking and the need for it and there can be then the communication back to the doctor. I think this is a stopgap. For instance, nurses are prepared not to oversee the physician but we also are the doublecheck on the medication dosage and should a child come to my attention where the dosage on Ritalin, for instance, was more than 30 milligrams per day, I would feel that my professional responsibility is to call the doctor and verify that that is really the amount he meant to prescribe and set up the channels of communication.

Mr. GALLAGHER. If the child was on any dosage of Ritalin, wouldn't you feel compelled to check with the doctor? Or any amphetamine? You said you would check if it went over 30.

Mrs. WILLIAMS. Yes, because—I would doublecheck back again to verify the written order. I think we should know all of these children, so we can then implement these special teaching techniques that they may have to have. For instance, we give it the broad title of learning disabilities, perceptual handicap; in calling around the various States, it is hard to tell who is what in this ball game, because they have so many different games.

I am from California, and I like our title, educationally handicapped. In California you are only allowed to have 2 percent of the total population of the pupils, including secondary, in any special education class for the educationally handicapped.

So, I question some of these other figures that go much higher. This does not mean these children are medicated that are in this class. We also will have children who are under behavior modification medication that would be in a regular class.

It was not necessary for them to be placed in the special education class, but I think they have an education handicap. If it is severe enough, they warrant the special help, but it also must be guaranteed that they can get out of that class.

I am very much against labeling children.

Mr. GALLAGHER. As a nurse do you think it would be preferable for a child with a problem to be in a special class or on a behavioral modification program?

Mrs. WILLIAMS. I don't think it is an either/or. There has to be the definitive diagnosis by the physician and it is in his judgment whether this child may or may not be helped by the drug.

Mr. GALLAGHER. Suppose the principal makes the kind of diagnosis that was made in Mrs. Young's case?

Mrs. WILLIAMS. He would hear from his school nurse. He has no right to make that kind of a judgment. He may be the chief administrator but this has to be an assessment that involves the school nurse with the medical records, the schoolteacher that is serving that particular child.

Mr. GALLAGHER. How involved are school nurses in the behavioral modification programs?

Mrs. WILLIAMS. It varies from very intricately involved, required by State law to serve on the admission and discharge committees, to no involvement. It varies. I was deeply disturbed when I talked with one of the nurses up in Washington to find they have no special education program for these children so in desperation——

Mr. GALLAGHER. Here in Washington?

Mrs. WILLIAMS. The State of Washington. So in desperation to try to get the child some special help in their learning disability areas they have been putting them in with the educationally mentally retarded. What does that do to that child's self-image? I think we really need some kind of recommendation that will force all States to supply this kind of special education to the children who do need it with the safeguard of an active admission and discharge committee that is not a paper procedure, that all of these records have been turned in, have been interpreted, and that it is a real committee discussion. It is not a rubber stamp with one member, for instance a psychologist, or worse yet the school nurse, dominating this particular discussion. It must be an intelligent discussion with placement recommended to the parent with the exception—with the understanding that the parent may reject this recommended placement and that the child will remain where he is with the best help that we can provide in that regular classroom so that we will have the cooperation of the home and the school.

If the home does not agree with the placement and if they are coerced in any way to place the child in the program you have already lost the child's education because when the home and the school are in conflict it is the child that loses.

Mr. GALLAGHER. What are the admitting and discharge committees? Are school boards involved in diagnosing drugs?

Mrs. WILLIAMS. Well, the admission and discharge committee, as I recommended, at the minimum should be a school nurse who has already, with parents' permission, gotten the doctor's records, the report of the physician, including the diagnosis and treatment if there is any.

Mr. GALLAGHER. This is on the behavioral modification program?

Mrs. WILLIAMS. Well, specifically that is our concern today, but this is the procedure for all placement in all special education, be it trainable, educationally handicapped, mentally——

Mr. GALLAGHER. I would like to restrict it to behavior modification.

Mrs. WILLIAMS. My recommendations are the same. You still need the medical diagnosis and treatment if there is one recommended. You also need the developmental history so that if there is anything that happened from the birth of the child on, actually from gestation on, this might give you added knowledge. This is gained from the parent by interviewing the parent.

Then we need to have the battery of test results that the psychologist either has given or the psychologist has done the interpretation, the classroom teacher with her report of academic records, with anecdotal records rather than "Jerry is a disruptive boy. What did he do? He took a bat and knocked a kid's"—I say there are dangers. If you have ever seen one in a school setting, they really are a danger to themselves and others because they can't control the impulses.

Mr. WYDLER. What do you do when you have a case where a teacher, you or somebody in the school system thinks that a child is either not learning or is disruptive or is a problem and wants to send the child for some special guidance to one of these programs and you have parents who say "We don't want this for our child"? What happens?

Mrs. WILLIAMS. Before this referral should be made there should be a meeting of the classroom teacher and the school nurse to discuss the child. The administrator may be involved in this.

Mr. WYDLER. Say that takes place.

Mrs. WILLIAMS. Then depending on what the teacher actually reports and proves with concrete evidence, then there should be the interview with the parent, usually the school nurse, to see if there is the same kind of behavior at home. If the parent does not see this same kind of disruptive behavior at home, then we better look closely at what is going on in that particular classroom with that particular child.

I would still then feel that we should observe the child more closely and once again check back with the home and if the situation has not changed in the classroom—this is provided the teacher changed some of the teaching techniques and really tried to involve the child more in the curriculum—then permission should be sought to have the school personnel do additional testing.

The problem is the generalized tests that we give that give us a rough IQ score don't help us with those children.

Mr. WYDLER. I am afraid you do not get the problem in my question. The problem in my question is that assuming whatever procedures you started with, you come to a point where the school authorities say a child should go into some program other than the normal program becuase they think the child needs it but the parents say no. What should happen at this point?

Mrs. WILLIAMS. We should accept the parents' answer.

Mr. WYDLER. The child should continue in the normal classroom?

Mrs. WILLIAMS. Yes, with the consultant help that the district is able to provide. We would, in our hearts, feel that this was less than the best educational opportunity we had to offer, but if the parents did not agree with us then we would put the child in conflict between the home and the school and this would be much more detrimental than having the child in the special classroom.

Mr. WYDLER. I am glad to hear that answer. I agree with you, but I wanted to know what you really did do. You are affecting other people as well. You have to remember that in the final analysis the whole class will be affected somewhat by a disruptive child. This should be taken into account. You have a very, very difficult problem on your hands. I am not minimizing it.

Mr. MYERS. Did I understand the answer was you stay in the class, you don't put him off in a special classroom for special education if there is one available?

Mrs. WILLIAMS. If the parent refuses this placement then the child has to remain in the regular classroom.

Mr. MYERS. Disrupting all the other students all the time? Is it fair to the remainder of the class?

Mrs. WILLIAMS. No, it is not fair to the remainder of the class but we would continue to study and work with the parent without pressure so that they perhaps could understand——

Mr. MYERS. Which could be construed by the parents as pressure as long as you kept calling them and asking have you given this a second thought? Your child is not doing well. This could be considered harassment. Just to get a call from the teacher might be harassment.

Mrs. WILLIAMS. Yes, but I would have to be honest——

Mr. MYERS. Be considered as harassment I meant to say.

Mrs. WILLIAMS. I would have to be honest to say in protection to the other pupils in the classroom it could happen that Johnny is not allowed to go out to recess because we can't have him near a baseball bat. You know, in danger to the other children.

Mr. GALLAGHER. He should not be put in a box, though.

Mrs. WILLIAMS. Study carrols are a very popular teaching technique.

Mr. GALLAGHER. What is that?

Mrs. WILLIAMS. Study carrol is the term for the box.

Mr. GALLAGHER. Putting a child in a box?

Mrs. WILLIAMS. We would take a table like this and with the amount of money we had to use in the school we would probably use cardboard and make six stations here at this table.

Mr. GALLAGHER. Behavioral modification, rather a remedial tiger cage. [Laughter.]

Mrs. WILLIAMS. Part of it is they think they are unduly distractable and this helps to control the distraction from the others and actually they do react to any kind of say grunt or whatever noise goes on in the classroom. These children sincerely want help. The ones—I realize this is not your concern. The ones that are properly diagnosed——

Mr. GALLAGHER. No, it is not. Mrs. Williams, I have a clipping here that says about what Mrs. Youngs said. There is an emerging national pattern of using tranquilizing drugs to help overactive pupils sit still long enough to learn. You said that the drug aid programs are most highly developed in New York, California and Michigan. The medication is often used to help children who might learn nothing because they have "springs" in them. The use of drugs makes it possible for children to contain themselves so they would be amenable to learning. How extensive are the programs in New York, California and Michigan? Are these basically local programs funded by the State, or city, or Federal Government?

Mrs. WILLIAMS. They are funded—it is a State reimbursement program.

Mr. GALLAGHER. By whom, by the Federal Government?

Mrs. WILLIAMS. By the State education moneys. They fund the special education programs. Maryland has a very extensive program and the children are carefully selected to be placed in here.

Mr. GALLAGHER. What exactly do you mean by program?

Mrs. WILLIAMS. The special classes.

Mr. GALLAGHER. Special classes that concern themselves with, as the statement says, an emerging national pattern using tranquilizing drugs. The drug program, is that what we are talking about?

Mrs. WILLIAMS. That is a misquote because I don't believe in the use of drugs unless it is prescribed——

Mr. GALLAGHER. I might say they didn't say that you specifically said that. But from your speech, it is implied that there is an emerging national pattern of using tranquilizing drugs to help overactive pupils.

Would you say that there is an emerging national pattern of using drugs?

Mrs. WILLIAMS. I think our physicians across the country are becoming aware of this new therapy that can help the properly diagnosed child. I have been around for 18 years and I worked with Dr. Ottinger in the elementary school system. At that time he was the only doctor that was using that kind of treatment 18 years ago.

Now we find that people are more aware, the physicians are more aware of this particular therapy and are prescribing it. We also are having more children with the medical care that they are able to receive who are not quite as healthy as we have in the past because they have lived longer.

Mr. GALLAGHER. As a person dedicated to helping children, as you are by spending all those years in your profession, do you think we are justified at this point to have programs using drugs? To use imipramine which was written off this afternoon like that? Yet these drugs are employed that we know so little about whether or not they should be used on children, before we know what the drugs do. This is the thing that troubles me. As we get into these modification programs——

Mrs. WILLIAMS. I wish medical science could be more definitive. I would dearly love personally to know what is the matter with each of these children who the drug is prescribed for and does work.

Mr. GALLAGHER. How about the children it doesn't work with? Have you ever seen any children where the drug does not work or any side effects or bad effects other than a stomach pumping?

Mrs. WILLIAMS. Yes, I have had children who presented the symptoms of a hyperactivity, et cetera, that the family physician has prescribed—at that time it was the amphetamines—which just excited them even more; so they were immediately removed from the drug and felt that they didn't qualify for that kind of therapy.

Mr. GALLAGHER. That was the thing this morning. We have some evidence of this. I am glad you corroborated that.

HEW was never able to find it. They are rather clear cut it never happens in children under 12.

Mrs. WILLIAMS. Part of this probably is that their work is done with controlled studies and they are carefully selected. We are dealing

with the family physician out in the local community and I would not be critical at all of the family physician. He is trying desperately to help this child.

Mr. GALLAGHER. We are on his side. What we are talking about is whether or not there should be an emerging national pattern in the use of drugs in this way.

Mrs. WILLIAMS. Though we don't know exactly how the drug does modify this behavior and what exactly is wrong with this child, we do know behavioral symptoms and diagnose on the behavior of the child rather than on medical findings. They use the words "soft neurological signs" to describe what are the medical findings on this child.

Mr. GALLAGHER. Until we get to those findings do you feel this committee should try and deaccelerate the zoom of the seventies?

Mrs. WILLIAMS. I don't think there is going to be a zoom. I think there will be a gradual increase.

Mr. GALLAGHER. I might say that your position in the NEA, in their forecast of the seventies, it is predicted there will be wide usage and reliance on drugs.

Mrs. WILLIAMS. I would like to clarify that. That article in today's education was a flight of fancy on the part of two professors at Indiana University.

Mr. GALLAGHER. That is what starts the trouble.

Mrs. WILLIAMS. I happen to be a working staff person so we have the kids and we have the families and they are the ones that we have to report to.

Mr. GALLAGHER. I would rather listen to you when we get into these areas. If you were on this committee what would you recommend?

Mrs. WILLIAMS. I would certainly recommend further study to try and define what is the mechanism of the drug that changes the behavior and what is the definitive diagnosis of these children who respond favorably to the drug. I would also then urge the special education for those children who have perceptual learning disabilities, whatever name you want to put to it.

Mr. GALLAGHER. Have you treated children who are not in programs but who are on drugs?

Mrs. WILLIAMS. I have administered medication prescribed by the doctor——

Mr. GALLAGHER. A child on speed, ritalin, amphetamines.

Mrs. WILLIAMS. You mean overdosing himself?

Mr. GALLAGHER. Who shouldn't be on it?

Mrs. WILLIAMS. I am currently a high school nurse. Yes; it happens fairly often. One has to decide whether you have to get them to the emergency center——

Mr. GALLAGHER. Are the reactions similar in the younger children?

Mrs. WILLIAMS. No; absolutely not.

This is a comparison so you have to be aware of what the child was before the medication was started and then you compare—after all, if he is out of his seat like 15 times in 5 minutes and on the medication is out 20 times in 5 minutes—you have to keep concrete records. It isn't just judgment. You are busy and you have got the other 30 kids in the classroom so if you don't keep records all of a sudden you got

to bed late that night and Johnny is irritating you today and unless you mark down the number of times he hops out of the seat and runs around the room you are making very subjective judgments and I don't think that is fair to children.

Mr. GALLAGHER. Thank you very much. We appreciate your coming here.

Mr. MYERS. You say you have treated some students who have been drug addicts or at least taking drugs illegally. Have you ever found any dependence has been developed because they have been on drugs, whether it be for learning purposes or for some other disease? Has there ever been in your judgment any of these students who have been dependent upon drugs and thusly become addicts?

Mrs. WILLIAMS. No, I have not.

Mr. MYERS. Do you feel that they might become dependent, that a child might move from drugs for therapy purposes to taking drugs for kicks and become addicted?

Mrs. WILLIAMS. First, one would have to put in some qualifications. If this child has already developed emotional problems as a result of his complete frustration in the classroom because he could not perform adequately before he began to be medicated, there is possibly the chance that this emotional problem would continue, which then might lead him into drug abuse at a later date. But I would say that these children who are given the correct medical dosage and are taught the respect for medication would almost never go to abuse of drugs.

I would like to make the remarks that we talk about drug abuse education. What we need to teach in this society is the wise use of medication or drugs. So we start that in kindergarten. Unless one develops their own individual philosophy—of course it is worse to be high on "speed" but what about the one taking the aspirin every 2 hours, too? He is dependent. It is not a criminal act but he has become dependent on aspirin.

Mr. MYERS. Possibly you can't answer this, but how much more powerful are the drugs that we are speaking about here, whatever they might be, than a common dosage of aspirin for a toothache? Isn't aspirin also a drug?

Mrs. WILLIAMS. Yes.

Mr. MYERS. How much more powerful—do you have any idea? Maybe you can't answer this——

Mrs. WILLIAMS. I don't think you can compare them. They are for two different purposes.

Mr. MYERS. But they are both drugs.

Mrs. WILLIAMS. We still don't know the mechanism of how aspirin works on the human body either and we have had that over a hundred years.

Mr. MYERS. I have never taken one of these hallucinatory drugs but I have taken aspirin and that doesn't do anything so I don't know, maybe some people aren't always under the effect one way or the other.

Mrs. WILLIAMS. I have students at the high school level now who are on Ritalin at their own discretion. That is, they have been under treatment and they were unable to come completely off of the medication.

Mr. MYERS. Unable to——

Mrs. WILLIAMS. They were taken off of the medication and they still came back to the springs inside, the inability to control their behavior. So that the doctor has put it on a PRN, which means when necessary, so because these are senior high school students they come up to the health office and come to me and say "I think I need my Ritalin now," so we talk a little bit about what went on in the classroom. Obviously they need it but all I can say is I had five children on PRN medication and I think a total of 10 visits from the five children so I would say that they are not abusing it.

Mr. MYERS. It doesn't happen frequently then. You wouldn't consider them habituals.

Mrs. WILLIAMS. No. It was there every day of the school year. Out of the five, there were 10 visits.

Mr. GALLAGHER. What about the paradoxical effect alleged to be different in children under 12?

Mrs. WILLIAMS. Well, because they can't give us a definitive diagnosis, I would like to state historically in California they have been working on this and we start with the title brain damaged child. We changed it to minimal brain damaged child. Then we changed it to the neurologically handicapped child. Then they started calling them perceptually handicapped children. Finally they quit and said they are educationally handicapped. So that I am putting all of these in the same category.

Mr. GALLAGHER. I think that is a splendid point.

Mrs. WILLIAMS. But the thing is they have something wrong. We can't say exactly what is wrong with the nervous system or the brain but there is a defect somewhere that we can't identify and it is these children who respond so dramatically to the amphetamines. A normal child, in my experience, will respond as you and I would to Dexedrine.

Mr. GALLAGHER. Regardless of age?

Mrs. WILLIAMS. Yes.

Mr. GALLAGHER. Thank you very much.

Mr. MYERS. Thank you.

(The prepared statement of Mrs. Williams follows:)

PREPARED STATEMENT OF SALLY R. WILLIAMS, PRESIDENT, DEPARTMENT OF SCHOOL NURSES, NATIONAL EDUCATION ASSOCIATION

Thank you for giving me, the President of the National Education Association Department of School Nurses, the opportunity to present testimony regarding the use of various behavior modification drugs on elementary school pupils. The need for medication by pupils during school hours is not new. School nurses have always supervised administration of medication for children who would otherwise be unable to attend school. These children have in the past years usually been diabetic, epileptic, asthmatic or have other chronic diseases. There has been a gradual increase of identification of these handicapped children as better medical supervision during the prenatal, neonatal and early childhood period has become available in this country.

It was parental concern about their apparently healthy child who was completely unmanageable and unable to succeed academically that forced the physician and school personnel to collaborate and create conditions which would make it possible for this type child to learn. Our of this collaboration a more definitive diagnostic procedure evolved.

Referrals were made by parents, teachers, and school nurses to pediatricians. The children were given an extensive examination to determine the specific nature of the learning disabilities. A careful gestation and developmental history was taken. Children diseases and other illnesses were located as to age. The children

were interviewed with the parent(s) in order to determine specific interpersonal dynamics, particularly emotional stresses and traumata, et cetera. In addition, behavioral and academic observations by the children's teachers were studied and these proved especially valuable in the overall assessment. A neurological examination was done to determine the presence of clear unequivocal signs, but it is now oriented to the value of "equivocal signs." Such an examination generally included a test of postural reflexes and coordination, selected items from "routine" neurological examination, miscellaneous tests, and observation. The latter includes:

1. Reading test: A different form than the one used in the psychological evaluation.
2. Right-left confusion (this knowledge normally established by age 7 or 8): (a) Place right hand on left ear, (b) a diversional test such as finger agnosia, (c) place left hand on right knee.
3. Mixed laterality: Hand, foot, eye preference (use peep-hole card-note which eye winks more easily): ambidexterity (by observation and questions regarding writing, throwing, batting, combing, wiping, etc.)
4. Finger agnosia: Hands placed palms up (doctor touches various fingers and asks patient to name or indicate which one).
5. Unusual anatomical proportions, asymmetry, or other stigmata as noted.
6. Electroencephalagrams are obtained when abnormal neurologic signs or symtoms are found. According to Dr. Mary McDermott, pediatric neurologist in Detroit, "It was generally noted (95 percent of cases) that there was more 'slow activity' in the electrocephalagrams than should be present for their chronological age in these children."

School personnel became concerned that about 2 percent of their pupils with normal and above normal intelligence quotient, as demonstrated by the standard tests, were unable to achieve up to their expectancy in reading, spelling and mathematics. The parent, teacher, and school nurse agreed that this child was extremely hyperactive, as though he had "springs inside;" he had a very short attention span, could not write his full name on the paper; was excessively distractible, and responded actively to every motion, grunt, sigh or shuffle of the other 29 children in the classroom; he had no impulse control and upon impulse acted immediately, thus placing himself in frequent situations where he is in danger to himself and other pupils.

Descriptions of these handicapped pupils' behavior and learning problems were related to the education psychologists. Their research began to point out defects in intellectual functioning in the areas of memory, comprehension and practical judgment of those children whose standard I.Q. test scores have always been normal or above but who were so disruptive at home and school. In the last 10 years education psychologists have developed tests that determine precisely the area of distortion in this type of child's response to perceptual motor tests, comprehension and judgment.

With the comprehensive psychological and medical evaluation it became apparent that a disruption in cortical integrative processes was the basic factor operating in most learning defects and disorders. Experience and medical research has proven that behavior modification drugs are of distinct value for children with these learning disorders.

In many States these children are identified for special education purposes as: Minimal brain dysfunction; minimal brain damaged; perceptually handicapped; dyslexia handicapped; learning disabilities; neurologically handicapped; maturational lag; developmental lag; or simply educationally handicapped.

The use of medication to moderate this pupil's behavior, once he is properly diagnosed is very dramatic. The literature is filled with documented case studies such as the following: A 7-year-old boy was extremely hyperactive, always out of his seat in class, kicking, fighting, biting, and unable to complete any assignment given by the teacher. He was failing to make any academic progress in the first grade. The teacher conferred with the school nurse and together they talked with his parents. It was confirmed that the boy behaved in the same manner at home and the parent's were unable to find any method of improving his behavior. They had tried "every method of child management" as had the teacher. A comprehensive developmental-medical history was taken by the school nurse and the child was tested by the school psychologist. These procedures demonstrated that the child was of above normal intelligence; that he had no physical disability; vision and hearing tests were normal, but still the boy was unable to learn. The school nurse conferred with the parents again and suggested that they permit the school to send copies of their records to their physician. She urged the parents to make an

appointement for comprehensive medical evaluation of their son. The physician conducted an extensive examination and decided that this boy could probably be helped by the use of Ritalin, 10mgm, three times a day. The doctor talked with the school nurse and sent the medication order to the school. The parents signed the parent permission form for the administration of medication to their son and bought a supply of the medication and took it to the health office.

The medication was placed in a locked cabinet and the child was instructed in the school procedure for coming to the health office for his medicine before lunchtime. The nurse talked with the child's teacher explaining to him anticipated results, possible side effects of the medication, and asked him to keep anecdotal records on the pupil as time permitted. The physician had also recommended that the pupil be placed in a special education class. The special education admission and discharge committee composed of the school nurse, the classroom teacher, the psychologist, the special education teacher, all met and studied the developmental-medical history report, the physician's report, the anecdotal records of classroom behavior and academic progress and the psychological report. It was the decision of the committee, based on the above reports, that the child be placed in the educationally handicapped class. The parents agreed on the placement. The regular classroom teacher had reported that within 2 weeks after the start of the medication the child began to read, but without comprehension, the child was able to participate in class activities without explosive actions and that his attention span had increased markedly. The school nurse conferred again with the parents and they also reported a dramatic change in their son's behavior pattern at home. As one mother of an EH child described her home: "It was like living with the air-raid sirens on for months at a time". This boy began to gradually develop reading comprehension in the special education class. After 4 years on medication, the boy has been placed in regular class this year, and is a very adequate student. The physician has indicated that he will be able to discontinue the medication at the end of this school year. This is a classic example; the diagnosis is difficult, but the behavioral symptoms are unmistakable.

To protect our schoolchildren who are educationally handicapped/learning disabled, the Department of School Nurses, NEA, makes the following recommendations:

1. All State departments of education should be required to establish a division os special education including programs for the educationally handicapped/learning disabled, staffed by an adequate number of consultants in the various fields, including school nursing.
2. All school districts should be required to offer special education classes for the educationally handicapped/learning disabled pupils.
3. All school districts should be required to have a fully operating admission and discharge committee for all special education programs, including the educationally handicapped/learning disabled programs.
4. All pupils considered for placement in any special education class must have a comprehensive developmental-medical history taken by the school nurse; physicians report to the school from the child's physician including his diagnosis and treatment if prescribed; a psychological report from the school psychologist and community agencies if deemed appropriate; a complete summary of the pupil's academic achievement by the classroom teacher; and an evaluation of the home environment by the school nurse submitted to the committee before a decision of possible placement or removal is made.
5. The admission and discharge committee should be composed of at least the school nurse, the psychologist who did the testing, the pupil's classroom teacher, and the special education teacher.
6. The committee's decision must be submitted to the pupil's parents and their permission must be granted before placement can be made.
7. All pupils in special education classes for the educationally/handicapped/learning disabled must have an annual report from the phsyicain or health agency submitted to the school nurse each year.

With the safeguards given above, I do not feel that the use of behavior modification drugs for children in special classes will be abused.

It is important for school districts to be more accurate in the figures given on the number of pupils on medication and the positive results. These figures are not now available. A school nurse from Washington gave the following case study: A sixth-grade boy had been in a residential school for disturbed children for 2 years. After further consideration and evaluation, the doctor prescribed Ritalin. In a few weeks the boy was judged to have improved enough to be

placed in public school class. With the cooperation of the school nurse, physician, parents, and classroom teacher, the sharing of information and suggestions from the school psychologist of techniques for working with the boy, he was placed in a regular fifth-grade class. The teacher and the school nurse reported very fine progress and adjustment. He is now attending his second year in public school with every indication that he will progress normally, with special consideration within the regular classroom. This child most likely would have been lost to society had not the action presented above been taken, to say nothing of the heartbreak of the parents and the cost of residential care.

We school nurses have seen the value of this type treatment for selected pupils. We realize that the general public has recently become alerted to the possible abuse of this treatment. Any medical regimen could be abused, not only the prescriptions for behavior modification medications, but others. We do have a serious problem of drug abuse among our children and youth, but we must not allow those problems to jeopardize the effective treatment of one segment of our pupil population. The following article deals with some of these concerns: "Amphetamines, Hyperkinesis and Learning," written by Leon Oettinger, Jr., M.D., a physician on the west coast who has studied and treated children with these kinds of learning problems for many years:

"The relationship between hyperactivity and school difficulties has recently been brought into sharp focus by the lay press. * * * This unfortunate state seems to have occurred because of several factors, the primary of which is fear of what side effects may occur with drugs and an inability to comprehend their value.

* * * the use of amphetamines is not new. Bradley and others began experimental work in 1935, and the first article was published in 1937 in the American Journal of Psychiatry. * * * This means that this drug antedates penicillin and other antibiotics, and was contemporaneous with the use of sulfa drugs. Since this original article, several hundred have been published by scientists all over the world * * *.

Recently Ritalin has been widely used and has been found to be as effective as the amphetamines—all felt that there was less appetite suppresion and less insomnia with Ritalin than with the amphetamines but otherwise they are quite comparable. How the amphetamines improve the behavior of the child who is hyperkinetic and has learning problems is not clear. The answers are not simple. These drugs do not simply slow the patient down. They, in some manner which is still in dispute, make the brain function better, and as the brain functions better, the child behaves in a more normal pattern; and therefore, hyperactive children become less hyperactive, yet learn faster, are more able to think and to solve problems, can write better and perform various tasks more accurately and successfully.

Double blind studies; that is, studies in which neither the doctor nor the patient knows whether the patient is getting active medicine or placebo (an inactive substance), have repeatedly confirmed these findings.

One of the most important of these studies, and the one which convinced many, of those who had been dubious was that done at Johns Hopkins by Dr. Conner Eisenberg, and others. This prolonged, well-designed study conclusively proved that hyperactive children who received amphetamines did better socially and scholastically than did those who received placebos. Acute double blind studies by Wherry at Chicago showed that both amphetamines and another group of drugs, the phenothiazines, improved distractability and thus aided hyperactive children. There are no major studies which disagree with the major premises of these articles.

How dangerous are those drugs? Probably among the safest ever discovered by man, when used in medical dosages they have essentially no major toxic effects. There is some loss of appetite associated with weight loss and occasional insomnia and at times hyperactivity is increased. There are no reports of liver damage, kidney damage. Schizophrenics may be made worse. All of these side effects stop when the drug is discontinued, however, and permanent residuals are essentially unknown. Speed freaks, those who misuse methedrine, and other amphetamines, use 10 times the medical amounts usually given. In some ways water is more toxic than the amphetamines. If a person were forced to consume 20 to 30 times the normal amount of water used in a day, they would be dead in less than a week. Amphetamines, however, are used in this quantity for weeks and months, and even then seldom prove to be fatal.

The other major worry is habituation and addiction. These, again, do not occur in normal medical dosage. The author has personally, over the last 23 years, given amphetamines to more than 2,000 patients, and has never had a problem with abuse. One of the major problems arising in adolescents who as children have been hyperactive or have had a learning problem with no treatment, is the development of emotional problems which make them particularly prone to drug abuse.

The maintenance of achievement and a healthy outlook goes far to prevent this type of problem so that the use of drugs to stabilize an individual may in fact prevent the abuse of drugs in later life. The author's experience verifies this finding. Of the more than 2,000 treated, a very few have gone on to drug abuse, but this number was minimal considering the fact that all of the children had major social or scholastic difficulties early in life. Amphetamines and similar drugs, as well as other drugs affecting the brain, are useful tools which are the most valuable yet found medically to aid in stabilizing the brain of children with learning disorders and hyperactivity. These drugs are unusually safe—much more so than aspirin or penicillin, and when used properly, do not lead to habituation, addiction, or abuse, but rather, help control the underlying psychological and physiological problems which lead to such abuse.

Not all children who may benefit from behavior modification drugs need special education classes. To prevent abuse of this useful medical treatment, adequate school nursing services should be required in all school districts. When the specially prepared, state certified school nurse has a reasonable pupil load (one school nurse to 1,500 pupils), she is able to confer with the teachers, parents, physicians and be informed about the pupils who are on daily medication for any reason. She serves as the bridge between the medical community and the education community. She is trained to speak both languages. She can interpret to the parent, physician, and the classroom teacher the symptoms and behavior of the pupil in the school setting. She then can interpret to the classroom teacher the findings of the doctor and his recommendations. The physician does not have the time to educate each teacher in the medical care of his patients; that is the function of the school nurse, as she can do it most effectively and efficiently. The school nurse knows the teacher, the physician, and the parents. She is able to supervise the care of the child in school and she does the followup with the parent and physician to be assured that the child remains under medical supervision while on medication. She is available during the school day so that the parent and physician can easily contact her when necessary. All nurses, wherever employed, must observe the law that requires them to have a doctor's written order before the administration of any medication.

As a further safeguard for school pupils the NEA Department of School Nurses recommends that State regulations be enacted that require all medication administered in the school setting must have the *initial* dose given by the school nurse. This regulation would thus insure that a pupil's condition had been diagnosed by a physician, a written order for the medication would be on file in the school records, the medication would be kept in a locked cabinet and the school personnel, including the pupil, would be properly instructed. The school nurse would thus *have* to be notified of any student placed on medication. She would then be able to follow through to see that the student remained under medical care, and the classroom teacher would also be made aware of the disability and treatment.

Mr. GALLAGHER. We have one more witness. The hour is late.

Mr. Warner, if you would like to submit your statement for the record and briefly sum up. Our next witness is Mr. Don Warner, formerly assistant superintendent of schools in charge of special services, Omaha public schools.

Mr. Warner, could you please identify the gentleman with you?

Mr. WARNER. Mr. B. R. Gyger, who is with the Omaha public schools in the capacity of public relations.

Mr. GALLAGHER. You are presently in the public school system or are you no longer there?

Mr. GYGER. I retired as of September 1.

Mr. GALLAGHER. Please proceed.

STATEMENT OF DON WARNER, FORMERLY ASSISTANT SUPERINTENDENT OF SCHOOLS IN CHARGE OF SPECIAL SERVICES, OMAHA PUBLIC SCHOOLS, OMAHA, NEBR.

Mr. WARNER. For 25 years as superintendent I was in charge of the psychological services, special education, visiting the teachers, school of social work and the health services; and I am here because of the Omaha, Nebr., public schools being drawn into this subject matter through national publicity.

We welcome this hearing and I wish to thank you and the committee on behalf of the schools for this opportunity to clarify a number of points.

Some of these misunderstandings were due to differences—inferences drawn from data that had no relationships.

Point one, no member of the Omaha public school staff has given or may give any medication to children. No testimony nor any facts have been given to refute this. This regulation of the board of education has existed to my knowledge for 25 years and no violations of this rule have been proved.

Not even aspirin tablets are allowed to be given by teachers, nurses, or any other staff members.

No. 2, no school staff member could obtain a prescription——

Mr. GALLAGHER. What would a school nurse do there? What is the nurse's function?

Mr. WARNER. The nurse's function is to screen for hearing, for vision, to keep the records of height and weight, to urge parents to have the immunization vaccination and dental care at the routine times that we would ask for. In case of dental it is every 6 months. In the case of physical exams it is at kindergarten entrance. At the sixth grade level and the eighth grade level and the 11th grade level.

Mr. GALLAGHER. You say a nurse cannot prescribe aspirin?

Mr. WARNER. The nurse cannot give—cannot prescribe but cannot even give an aspirin.

Point two, no school staff member could obtain a prescription for a drug for a student. No one ever has to my knowledge. Only the child's parents may do this. Through inference there has been the statement that schools have given drugs.

No. 3, the medical profession is not an entity or nonentity in this matter. Prescriptions for patients is done on an individual basis. The physician, by ethics of his profession, is sworn not to discuss the patient with anyone other than the patient or the parent of the child. Any discussion of the child with the school would be with the parents' knowledge and consent. This would rule out any program of mass medication.

No. 4, the ethics of the teaching profession likewise rule out the discussion of the progress and behavior of the child with other than the parent without the parents' consent. No facts or evidence has been presented to show that this ethical consideration has been violated in connection with the alleged conspiracy to experiment on schoolchildren in Omaha.

Point five, no one in the Omaha Public School staff has defended the use of medications. This defense must come from a physician who wrote the prescription for the individual child. His judgment and

training are the concern of the parent who asks for his help. I can say to this committee and to the public at large that we have several young children in schools in Omaha who would either not be alive or not be in school if it were not for medications known today that were not known or not available 15-years ago. Asthmatic, diabetic, epileptic, allergic, cardiac children who are on drug therapy and successful in school are alive and are not handicapped. One of the most dramatic of these is the control of epilepsy. Certainly if I want to use the term "knowledge of behavior motivation" this is definitely that. I think of the children now who are in school. We used to have to send teachers to the home in many of these cases.

I am not talking now about the Ritalin or other drugs that this hearing is about, but I think of the similarity of what we have gone through to reach this point.

Concerning the STAAR program and I was a member of the STAAR group that met and discussed children with educational problems and learning disabilities, it is interesting to me that last year brought in by the parents and by the educational services in the community was Dr. Byron Croudy from the University of California, Los Angeles, who is an educator and who spoke to physicians, parents and teachers about procedures for working educationally with children with learning disabilities.

His particular line of discussion was movement therapy in the field of education. Following Dr. Croudy, we brought to Omaha Dr. Frank Taylor, who was also an educator from Santa Monica who has a school of his own and he spoke to physicians and parents and teachers about curriculum, teaching methods and teaching teacher training in working with children who were failing to be successful in school.

During the past year no discussion of medication as an answer took place in the STAAR program. The critics of STAAR have apparently not attended the meetings. I might add at this point that I received, even though I have retired and do live outside of Omaha at the present time, I received a communication from the STAAR group and today it is entirely a parent group.

The parents of children who have learning problems have taken the lead and they are now STAAR. No educators, no physicians are involved in it.

In conclusion, students in the Omaha Public Schools have taken medications prescribed by their own physicians as they have in every other community in this country. Their parents sought help and accepted the advice of their doctor. There have been no programs for the administration of drugs to students in the Omaha Public Schools by public school staff.

Thank you.

Mr. GALLAGHER. Thank you Mr. Warner. I am afraid however your testimony is really not directed exactly to what we are discussing here today. I appreciate, however, your concern with the broad scope of medication for various diseases that fortunately have been cured or kept correctible.

Are you saying there have been no referrals from physicians to the school system?

Mr. WARNER. I am saying to you that if we were to ask a parent to go to their physician, it would not be for the purpose of having a

drug prescribed. It would be for the purpose of the physician to determine whether or not a drug was the prescription in that case.

Mr. GALLAGHER. Where did the school system itself first become aware of the drug behavior modification program? Did they discuss this with physicians or did it come through the literature? Did you discuss it with physicians?

Mr. WARNER. Obviously we have read the literaure. Obviously physicians who have had children on medication, the parents who know this asked us how the children are doing, but as far as a concerted program for us to place children on medication, there has been none.

Mr. GALLAGHER. Where does the money come from for these programs?

Mr. WARNER. For what?

Mr. GALLAGHER. For the programs of remedial help sponsored by doctors?

Mr. WARNER. I truly cannot—I do not understand your question, Mr. Gallagher.

Mr. GALLAGHER. For instance there were two projects, one project in the Omaha, Nebr. school system, which seems to provide the base for the activities that received the attention. This project No. DPSC 661123, funded 1966. The name given for further information is Vaughn Phelps.

Mr. WARNER. That is district 66, a suburban school district near Omaha.

Mr. GALLAGHER. They provided funds for comprehensive mental health service that would be established to provide early identification, referral and treatment for students with emotional problems. Would minimal brain dysfunction come under that, in your view?

Mr. WARNER. This is not the Omaha public school system you are discussing.

Mr. GALLAGHER. I am discussing something else that is close to Omaha, and I must ask you: Is the Omaha school system in any way related to this?

Mr. WARNER. No.

Mr. GALLAGHER. Close by, they say, 10 percent of the students of the county need such services.

Mr. WARNER. No.

Mr. GALLAGHER. You are not in that county?

Mr. WARNER. We are in Douglas County, but no one discussed this program with the Omaha public school staff.

Mr. GALLAGHER. This is a countywide grant. Would you participate in such a grant?

Mr. WARNER. No; we did not.

Mr. GALLAGHER. The grant states that school staff members will be trained to understand the medical means essential to favorable mental health climate in the classroom and recognize when behavioral problems should be referred to the mental health service. Parents will be assigned assistance dealing with such problems in the home environment. The prevention program will also be included.

Do you have any such program such as this?

Mr. WARNER. No.

Mr. GALLAGHER. What is the STAAR program?

Mr. WARNER. The STAAR program was a name given to a voluntary group of people who tried to understand each other's problems as physicians, teachers, and parents met together and listened to each other in an attempt to understand the learning problems of the children involved.

Mr. GALLAGHER. Have you ever made any investigation or attempt to verify complaints of parents in Omaha?

Mr. WARNER. Yes.

Mr. GALLAGHER. What were your findings?

Mr. WARNER. None came forward.

Mr. GALLAGHER. Well, if a person were making a complaint, wouldn't that be a step forward?

Mr. WARNER. Say that again.

Mr. GALLAGHER. If a person made a complaint, would not that complaint be a step forward?

Mr. WARNER. Yes. There was one question raised at a school board meeting, but it was not by the parent of the child, and later it turned out that the parent of the child was not truly complaining. He said later the doctor prescribed the drugs; the school had nothing to do with it.

Mr. GALLAGHER. Did you ever tell a reporter that kids in Omaha were trading pills?

Mr. WARNER. Yes.

Mr. GALLAGHER. But those pills were not part of any Omaha school program?

Mr. WARNER. No.

Mr. GALLAGHER. How would you know that?

Mr. WARNER. Say that again.

Mr. GALLAGHER. How would you know the trading in pills among students in the schools was not part of a program?

Mr. WARNER. We have no program. They could not be.

Mr. GALLAGHER. How did it come to your attention?

Mr. WARNER. It came to our attention because the teachers heard the kids discussing it at the noon lunch.

Mr. GALLAGHER. Then you would say that——

Mr. WARNER. They carried them in their lunch pails.

Mr. GALLAGHER. How old were these kids?

Mr. WARNER. What?

Mr. GALLAGHER. How old were these kids?

Mr. WARNER. They were in the 8-, 9-, 10-year-old range.

Mr. GALLAGHER. Where would they get the drugs?

Mr. WARNER. From their parents. They brought them to school to take at noon.

Mr. GALLAGHER. Then there must have been some program sponsored by doctors if kids knew enough to trade their pills around, whether or not it was sponsored by the Omaha school——

Mr. WARNER. If a youngster was on medication and had the pill with him at lunch, and if he offered to trade with another youngster, this is not a program. This is an individual youngster having his problem, and if he is in fact either disturbed or retarded, he might not be wholly responsible for his act.

Mr. GALLAGHER. Well, trading would indicate it is rather widespread. Is there a widespread drug problem in Omaha?

Mr. WARNER. No.

Mr. GALLAGHER. That appears to be somewhat contradictory. Would you agree with Mrs. Williams about tighter procedures in the system?

Mr. WARNER. Yes.

Mr. GALLAGHER. Tighter procedures?

Mr. WARNER. Yes. The very thing—I approved very much of the testimony Mrs. Williams gave. The very rules which she set down for the bringing of medication to school and the way in which they were given was what in fact we have made a part of the regulations of the Omaha public schools. If children do bring medications to school, we are aware of it, and we know that they are not in fact abusing them.

Mr. GALLAGHER. I would ask you of the letter to Mr. Ernie Chambers that referred to Dr. Oberst who was supervising a drug program.

Mr. WARNER. Dr. Oberst?

Mr. GALLAGHER. Yes.

Mr. WARNER. I am not aware there was a drug program.

Mr. GALLAGHER. The FDA did, in fact, send this letter to——

Mr. WARNER. Dr. Oberst is a physician in private practice, Mr. Gallagher.

Mr. GALLAGHER. Then there is no relationship at all to the school system, is that right?

Mr. WARNER. No, there is not.

Mr. GALLAGHER. Would you consider that the doctors in Omaha are perhaps more aware of behavior modifying thoughts than in other areas?

Mr. WARNER. I would say compared to what?

Mr. GALLAGHER. Compared to the district next to you. It appears that there is some activity of some scope in Omaha with behavioral drugs, and you tell us they are not part of the school. That is now part of the record; that it is not sponsored in any way. Then it would appear to be that some doctors are more alert to the advancement of drug programs in Omaha than in other places.

Mr. WARNER. This I don't concur with.

Mr. GALLAGHER. Do you have any questions?

Mr. MYERS. Yes.

Mr Warner, you had been active in STAAR, I believe; you are no longer, am I correct?

Mr. WARNER. I am not in the city of Omaha any longer.

Mr. MYERS. Did I understand you to say educators were no longer active in STAAR? It was parents only?

Mr. WARNER. This was the notice which I was sent. I now live in Kimberly City, Mo. This was a notice I received last week.

Mr. MYERS. Your associates are still in the Omaha schools, is that right?

Mr. WARNER. Yes.

Mr. MYERS. This is an accurate statement, that parents now are entirely——

Mr. WARNER. In charge of the STAAR program.

Mr. MYERS. Now, STAAR has been a success, is that true or false?

Mr. WARNER. Considering the national publicity——

Mr. MYERS. Disregarding all that. I want the facts. I have seen publicity before.

Mr. WARNER. I would say that in the giving of information of parents to teachers and of physicians to teachers and parents—in other words, getting a line of communication extablished in which we could talk to each other more intelligently, yes.

Mr. MYERS. Was it ever the purpose of STAAR to diagnose student's problems?

Mr. WARNER. No.

Mr. MYERS. They were a catalyst in trying to bring all the efforts of the community in solving learning problems?

Mr. WARNER. That is correct.

Mr. MYERS. In that direction, did they suggest a certain agency or a certain clinic or anything like that?

Mr. WARNER. No; definitely not. For example, in our own rules and regulations, if a parent said to whom should I go, our answer would be your own physician. "But I don't have a physician." Our rules say to give them the names of three or more physicians in a rotating order, or to ask them to call the medical society for an answer to that.

Mr. MYERS. How long has STAAR been in operation?

Mr. WARNER. Two years.

Mr. MYERS. One of the witnesses, Mr. Johnson—his recommendation was that STAAR be discontinued. If it was to continue, it should redirect its efforts toward "improvement of course content, teaching development, and curriculum revision."

If you spent all your time on these three areas, could you solve the directed problem of some students not being able to learn?

Mr. WARNER. I doubt it. It would help, undoubtedly. Of course, this is one reason for the testimony here, is that Dr. Crowdy and Dr. Tailor did focus that attention during this past year on those very things.

Mr. MYERS. Does STAAR have as one of its goals to do these things? Improve course content and teaching development and curriculum revision? Do they get in this area at all?

Mr. WARNER. Yes.

Mr. MYERS. Then the use of drugs really is not pushed by STAAR at all?

Mr. WARNER. Definitely not.

Mr. MYERS. It may be one of the end results of their efforts and work.

Mr. WARNER. It is obviously from the testimony that has been given a possibility in correction of a learning disability or an educational handicap, but this has not been a major part of the discussion. Psychological, psychiatric, educational change and improvement have been more discussed by STAAR than certainly has medication.

Mr. MYERS. Then the sole and only goal of STAAR is to increase the learning capacity of all students or just those——

Mr. WARNER. No; it isn't even that. It was to increase the knowledge of the parents and the physicians and the teachers about what was available or could be done. In other words, what work is going on in the field of education about children with learning problems.

Mr. MYERS. Just for children with learning problems?

Mr. WARNER. Right.

Mr. MYERS. Then it is correct to say you would not favor discontinuing STAAR?

Mr. WARNER. That is correct.

Mr. MYERS. One last question, do you believe there should be greater research in the area of using drugs to help some children who have difficulties?

Mr. WARNER. I certainly do.

Mr. MYERS. In the medication area?

Mr. WARNER. Right.

Mr. MYERS. That is all, Mr. Chairman.

Thank you very much.

Mr. GALLAGHER. We have some figures of 5 to 10 percent of children having learning disabilities in Omaha. Would that be correct?

Mr. WARNER. You say. Is that correct?

Mr. GALLAGHER. Yes, is it?

Mr. WARNER. I don't think so.

Mr. GALLAGHER. What would you say the correct figure would be?

Mr. WARNER. My impression would be that in terms—I think we would have to first get a definition of what we mean by learning disabilities.

Mr. GALLAGHER. Let me say that a learning disabilities would be where someone would suggest to a doctor in Omaha to prescribe a remedial drug?

Mr. WARNER. I would certainly not concur with that 5 to 10 percent on that basis. Of course, I would not make any personal—I don't think as the school system we ever had a feeling that the drug is the answer. The question is: What is wrong with this child? What is the problem? It turns out to be psychological; if it turns out to be a vision, hearing; then we have accomplished our purpose if the doctor finds that, in fact, there is a vision problem and corrects it. We got the job done to get that block out of the way.

Mr. GALLAGHER. Thank you very much.

The committee is now adjourned, subject to call of the Chair.

(Whereupon, at 5:40 p.m., the hearing in the above-entitled matter was adjourned, subject to the call of the Chair.)

APPENDIXES

APPENDIX I.—SUPPLEMENTAL STATEMENTS AND CORRESPONDENCE RECEIVED BY THE SUBCOMMITTEE SUBSEQUENT TO THE HEARING

HOUSE OF REPRESENTATIVES,
SPECIAL STUDIES SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C., October 12, 1970.

Hon. ELLIOT RICHARDSON,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: As you may know, my Right to Privacy Inquiry of the House Committee on Government Operations held a hearing on September 29, 1970, into the question of Federal involvement in promoting the use of behavior modification medication for grammar school children. During the hearing, we heard a number of specific criticisms of the manner in which the Federal Government controlled the activities of those who were administering such drugs and the way in which your grantees were conducting their research. Further, the Food and Drug Administration's investigation of the program in Omaha, Nebr. was shown to be, in my judgment, woefully inadequate.

I certainly do not want this letter to be taken as critical of any of your Department's witnesses, for I believe that what was truly disclosed at our hearing was a significant weakness in structure, which existed before this administration, as did these programs.

First, two HEW witnesses testified that they had conducted separate and "cursory" investigations of the Omaha situation, and we were reassured that all requirements for the use of these drugs had been met. Yet, later in the hearings, it was revealed that the Food and Drug Administration had, on August 6, 1970, sent a letter to the chief advocate of the program in Omaha, Dr. Bryon Oberst, pointing out that one drug he was using was "not recommended for use in children under 12," and strongly urging him to submit additional documents to the FDA. Shortly after this disclosure, testimony was received that the same drug was being used in a behavior modification program in Little Rock, Ark., and that the doctors in charge there were equally unaware of FDA warnings and requirements.

Second, we learned from the National Institute of Mental Health that only this year had research been funded which would show the long-term effect on children who had taken this medication. A preliminary General Accounting Office report showed that the NIMH had granted at least $3 million for studies in this area, and a NIMH witness testified that at least 150,000 children around the Nation were receiving drugs. Yet, only in 1970, had funding been provided for a study of the children who had themselves received the drugs.

Third, both before and after the hearing, I have received letters from people employed by, and copies of studies which were funded by, the Office of Education at HEW. They are highly critical of the focus on the medical side of minimal brain dysfunction, which is, incidentally, one of at least 38 names attached to this condition. They confirmed testimony we received that the medically oriented studies did not adhere to high scientific standards. In addition, representatives of other disciplines have indicated to me that MBD may not be an abnormality. Such a high incidence in the population—as high as 30 percent in ghetto areas according to some authorities—may well be a selective advantage genetically and may not be pathological at all.

Fourth, new regulations of August 8, 1970 by the Food and Drug Administration limit the valid uses of amphetamines to three specific areas: weight reduction, narcolepsy, and hyperkinetic children. Evidence presented elsewhere states that it is minimally effective in obesity and that narcolepsy is extremely rare. Testimony presented to our hearing conceded amphetamines' effectiveness in children

whose behavior was truly MBD inspired, but suggested nonmedical procedures as well as drugs other than amphetamines which could control hyperactive behavior.

I would, therefore, make three recommendations for your consideration:

1. The entire funding and reviewing procedure at HEW should be subjected to a multidisciplinary evaluation to permit all sides of this question to enter the decision making process.

2. Control over these grants and followup studies should be centralized in one office so that should a situation like that in Omaha again arise, responsibility for an adequate in-depth investigation would be firmly fixed.

3. In view of the fact that amphetamines now rival and perhaps exceed hard drugs as a source of abuse, I recommend studies focusing on other medication to control the behavior of hyperactive children, should it be determined that Federal funding should continue to be involved.

For, Mr. Secretary, it is the future of young Americans that is at stake. Evidence at the hearing and correspondence to me suggest quite strongly the value of behavioral medication in some cases, and I would not presume to criticize administering these drugs on the grounds of their efficacy. I do, however, believe our mutual concern over the spiraling rate of drug abuse, specifically the abuse of amphetamines, demands a prompt and complete review of the Federal role of legitamizing and accelerating the use of such dangerous drugs on grammar school children.

I would appreciate a reply at your earliest convenience.

With continued best wishes,

Sincerely,

CORNELIUS E. GALLAGHER,
Chairman, Right to Privacy Inquiry, Special Studies Subcommittee.

[From the Washington Post, Monday, Oct. 12, 1970]

PANEL TO EXAMINE CHILD 'SPEED' DRUG

The Nixon administration soon will convene a "blue ribbon" panel to warn pediatricians and educators against the overuse of "behavior modification" drugs to calm overactive school children.

Dr. Edward F. Ziegler, director of the new Office of Child Development, told a panel of United Press International reporters that he is very much afraid that many teachers in this Nation are utilizing (amphetamine drugs) as a way out of the difficulties of a classroom."

Dr. Ziegler said he is bringing together "a blue ribbon panel of scientists and pediatricians to issue a statement to the Nation on this problem."

He said the panel would "inform educators that perhaps it is as much a problem of the kind of schoolroom children have to adjust to rather than what is wrong" with the nervous systems of the children.

The widespread use of amphetamines—known in street parlance as "speed"—to control overactive children was reported in The Washington Post on June 29 in a story from Omaha, Nebr.

Dr. Ziegler's disclosure of the creation of a special scientific panel on the subject followed by a week the convening of hearings on the problem of Capital Hill, chaired by Rep. Cornelius Gallagher (D-N.J.).

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., November 3, 1970.

Hon. CORNELIUS E. GALLAGHER,
Chairman, Right to Privacy Inquiry, Special Studies Subcommittee of the Committee on Government Operations, House of Representatives, Washington, D.C.

DEAR MR. GALLAGHER: This is in further response to your letter of October 12, 1970, which contained a number of recommendtions regarding the Federal role in the drug treatment of grammer school children.

I strongly share your concern regarding the growing problem of drug abuse in this country and your interest in the use of stimulant drugs in the treatment of hyperkinetic children. As you know, the stimulant drug treatment of children with this disorder began in the late 1930's and has been widely accepted as safe and effective by the medical community. We would agree, however, that hyperkinesis in children is a multifaceted problem which should be treated by all effective treat-

ment modalities that are at our disposal. These would include remedial education, family counseling, many forms of psychotherapy and drug treatment when indicated. We have no vested interest in the use of any one treatment modality and are continuing to look for the most effective treatments and treatment combinations for this disorder. We will continue to employ the highest standards of scientific excellence in evaluating the results of investigations.

With respect to research dealing with this problem there apparently is some misunderstanding regarding the nature and level of the grants supported by the National Institute of Mental Health. The $3 million figure for NIMH grant support in this area represents the total expenditure of funds by NIMH in the children's area since 1958 and includes a wide range of research which was not limited to drug studies nor to drug studies on hyperkinesis in children. The level of support for fiscal year 1970 amounts to approximately $885,000 for the support of eight grants, one of which is specifically limited to the evaluation of the stimulant drugs.

By contrast, four grants are focused on evaluating the efficacy of drugs of the major tranquilizer, minor tranquilizer, and stimulant drug class for the treatment of hyperkinesis. Other grants have their primary focus on the study of childhood schizophrenia and autism. In addition, many of the studies are not limited to just the question of drug efficacy but are also attempting to learn more about the neurological mechanisms and the deficits associated with hyperkinesis.

All grants supported by the NIMH receive a dual review by a scientific peer group as well as by the National Advisory Mental Health Council which as you know consists of eminent scientists drawn from many disciplines as well as citizens drawn from nonscientific fields. In addition, all grant supported drug research by the NIMH requires that individual grantees obtain informed consent of the parent in writing for such treatment, and the grantee must comply with the regulations of the Food and Drug Administration vis a vis the use of drugs in a research project.

There also seems to be some misunderstanding regarding the legal responsibility of the Food and Drug Administration and the procedures they followed in response to the Omaha situation. With regard to Dr. Bryon B. Oberst, the physician identified as involved in treating hyperkinetic children in Omaha, the FDA ascertained that (1) there was no school program of drug therapy in Omaha, (2) whatever drug treatment of hyperkinetic children taking place was being conducted within the framework of the individual doctor-patient relationship, and (3) no research project or other systematic data collection efforts existed.

It is not the role of the FDA to regulate the practice of medicine by the private practitioner, nor is the private practitioner legally required to file information with the FDA when he prescribes medication for a condition other than those approved. In this regard, it should be noted that the statement "not recommended for use in children under 12" only implies that not enough information is available to vouch for its safety and effectiveness, but this does not imply any particular hazard if used in the pediatric age group.

I have given careful thought to your recommendations. Since nearly all of the Department's support for research involving the drug treatment of hyperkinetic children is located at NIMH and since their review process, as described earlier, is very broadly based, it is my feeling that multidisciplinary inputs are already in existence. Thus, to the extent possible, all sides of the question are examined prior to a decision to support a research activity. With respect to your second recommendation it is my feeling that the grant and evaluation activities associated with research into the drug treatment of hyperkinetic children are appropriately centralized within the National Institute of Mental Health and that the review and regulation of drug studies located in the Bureau of Drugs of the FDA is required by their legal responsibility and mission. I do not believe that the current organizational relationships in any way preclude this Department's ability to mount responsible and adequate investigations of reported incidents involving drugs.

I am in total agrrement with your last recommendation that studies focusing on other medications to control the behavior of hyperactive children should be mounted. As indicated earlier, NIMH is currently supporting a number of studies which involve other drugs, attempting to compare their efficacy with the stimulant drugs which are presently considered the standard reference drugs for the treatment of hyperkinesis.

Since an informed profession and public is a goal which we both share, the Department's Office of Child Development will shortly convene a blue ribbon panel of Federal and non-Federal participants to set forth recommendations for the conditions under which these drugs are harmful or beneficial in the treatment of hyperkinetic children and the auspices under which they should or should not be administered.

I want to thank you for your interest in these issues, for your recommendations, and for sharing your deep concerns with us.

With best regards,

Sincerely,

ELLIOT L. RICHARDSON, *Secretary.*

THE JOHNS HOPKINS UNIVERSITY,
DEPARTMENT OF SOCIAL RELATIONS,
Baltimore, Md., September 28, 1970.

Hon. CORNELIUS GALLAGHER,
House of Representatives,
Washington, D.C.

DEAR MR. GALLAGHER: As an anthropologist with a background in genetics and biology who is also the parent of a hyperactive son, I have been very concerned—both personally and professionally—about the druging of hyperactive children. I am, therefore, delighted to see that you will be investigating the matter.

Though hyperactivity is described as minimal brain disfunction, there are strong indications that certain forms of hyperactivity are inherited and occur in at least 4 percent of boys. (This hereditary hyperactivity is often associated with reading and spelling problems, sometimes termed dyslexia.)

To be present in the population at such a high frequency, a genetic trait cannot be an "abnormality"—rather it must now have or have had in the fairly recent past some selective advantage. And the population is said to be polymorphic for that trait.

In the case of hyperactivity, the selective advantage must be quite large, in order to counterbalance the fact that hyperactive children almost certainly have a higher mortality rate. It is impossible to know, with the limited knowledge we have at present, what this advantage might be; but it makes it entirely wrong to think of hyperactivity as a pathology, as medical doctors seem to do.

Fortunately my son's hyperactivity was not medically diagnosed until after he completed fifth grade—and by that time he had learned to control it in the school situation. Also, he went to a rural school where the pressures are much less, and his teachers were very tolerant and patient when he fiddled, dropped his crayons, and was unable to sit still.

Long before the diagnosis, we realized that our family could not survive in the city, so we choose to live on a farm. Where there are important, tiring, and responsible physical jobs to do, a hyperactive child is a joy to have around.

Money is now being spent (and rightly so) for training retarded children, whose capabilities, even with the very best training, are so very limited. It is sad that school programs cannot also be designed for hyperactive children—because if they are not destroyed by the school system, their potentialities are so tremendous.

I have over the past year been gathering information on dyslexia and also on hyperactivity (for a book I am writing). If this material would be of use to you, I would be glad to give you a list of references.

Yours sincerely,

(DR.) RADA DYSON-HUDSON.

SONOMA STATE HOSPITAL,
Eldridge, Calif., September 30, 1970

Representative CORNELIUS E. GALLAGHER,
Chairman, Congressional Committee on the Invasion of Privacy, House of Representatives Office Building, Washington, D.C.

DEAR CONGRESSMAN: I have read with considerable interest of the recent hearing on the use of drugs in controlling children with so-called minimal brain dysfunction. As a psychologist rather than physician, I cannot address myself to the medical efficacy or ethics of this practice. I do wish to note that it has been my experience in dealing with children who have been treated with either methyl-

phenidate or dextroamphetamine that behavior changes occur in some cases, mostly in a positive direction. I am less than impressed with the effects of the so-called tranquilizers. Nevertheless, I am not an advocate of the continued indiscriminate use of any of these agents with children, guided only by blind empiricism. If they are truly effective in some cases, we should look for more specific indices for their utilization. The diagnosis of "minimal brain dysfunction" (MBD) is by no means a substitute for this specificity. As you may note on pages 34 and 35 of the enclosed report, "the likelihood of a child being given this (by now meaningless) label is positively accelerating. In a sense, it has become one of our most fashionable forms of consensual ignorance."

I include a complete copy of my own study because it is the most comprehensive attempt to get at the problem of MBD that I know of—nothing exists in the current literature to better illustrate the fallacy of using such a term. I include in this indictment the two publications of the Clements-directed task force (Public Health Service Publications Nos. 1415 and 2015). These individuals should spend less time in libraries and meetings and more time in looking at the kids they are talking about!

Much of the enclosed material is perhaps too technical for you or your staff to be concerned with, but I include the whole of it because I don't know fully which parts would be of interest to you. The following conclusions are worth noting for anyone who is interested in individual rights:

(1) A number of syndromes of neuropsychological dysfunction were identified, all of which might be termed "MBD" although the behaviors are quite different. The prescriptions for remediation of members of each cluster (graphically depicted in fig. 4 A–H) would be quite different. Perhaps for only two of the eight syndromes identified would there be justification for psychopharmacological intervention on even a trial basis. Perhaps none.

(2) Some of our so-called MBD children had very high behavioral communalities with children known to be brain lesioned; others had few communalities, especially those in clusters A and D, where I had to stretch a point to hypothesize a specific neurophysiologic substrate (table 9). These particular groups were characterized behaviorally by specific learning disabilities and aggressive behavior disorders—often considered candidates for treatment with drugs.

(3) In retrospect, and from my ongoing work with severely neurologically handicapped children, I would say that individuals in those two syndrome clusters are most often not the victims of brain trauma or aberrant brain chemistry. Their brains are no doubt dysfunctioning in the sense that this intricate network of neurons is involved in mediating behavior which is academically and/or socially dysfunctional. Now, what causes the brain to do this?

I think parental dysfunction, teacher dysfunction, and educational system dysfunction, including textbooks, architecture, and school board politics as well as teacher training is responsible for much dysfunctional behavior.

When we analyze the behavior of hospitalized retarded children who are given a relatively more enriched learning schedule, fewer numbers, and a daily opportunity to freely explore their environment, we find: (1) less stereotyped and self-destructive behavior; (2) less hyperactivity and aggression toward others and property; and, (3) even fewer seizures! Brain dysfunction indeed!

In closing, I would like to say that I think there is a need for more systematic investigation of true brain dysfunction and the usefulness of psychopharmacological intervention for specific syndromes identified. On the other hand, dextroamphetamines and the like should not be used as a shoehorn to cram bored, mismanaged, and disillusioned children into an irrelevant educational experience.

Incidentally, I read with delight your committee's prior work with the psychological test issue, the bulk of which we were fortunate to have published in the American Psychologist. I still use some standardized tests as experiments which stand for themselves in demonstrating brain function. I reject their normative or acturial interpretation and thank you for clarifying for me a longstanding concern.

I hope this material may be of use to you in your continuing efforts to protect our rights. Thank you.

Sincerely,

FRANCIS M. CRINELLA, Ph. D.,
Staff Psychologist, Growth and Development Program.

AMERICAN ACADEMY OF PEDIATRICS,
Evanston, Ill., October 12, 1970.

Hon. CORNELIUS GALLAGHER,
Government Operations Committee,
House of Representatives, Washington, D.C.

DEAR MR. GALLAGHER: Mr. George K. Degnon, who serves as the Government liaison representative for the American Academy of Pediatrics, has asked that I mail you a copy of a recent statement prepared by the academy's committee on drugs entitled "Pharmacologic Approaches to Learning Impediments", published in our journal Pediatrics, July 1970.

The present controversy over the use of certain drugs to reduce hyperactivity in children and promote their ability to learn will be a very important subject on the agenda for this committee, meeting in San Francisco on October 22–23. If the academy or its committee on drugs can be of further assistance to you and the Government Operations Committee, please do not hesitate to call on us.

Very sincerely yours,

STANLEY L. HARRISON, M.D.,
Secretary.

AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON DRUGS

AN EVALUATION OF THE PHARMACOLOGIC APPROACHES TO LEARNING IMPEDIMENTS

The administration of pharmacologic agents to children with learning impediments or disabilities is not a new method of treatment. Publications of related investigations date back more than 30 years. An accurate assessment of the effectiveness of the chemotherapeutic approach poses enumerable difficulties. These stem from factors such as (1) the lack of uniform terminology, (2) marked variability in methodology for evaluation, (3) the absence of standardized requirements for precise diagnosis and classification of the symptomatology constituting learning impediments, and (4) the paucity of long-term, properly controlled studies. As a result, a valid evaluation of response and objective comparison of the effectiveness of drugs administered in an attempt to mitigate or lessen learning impediments becomes impossible.

The clinical manifestations that collectively constitute learning disabilities are grouped as general classifications; or, in attempts to be specific, they are classified into etiologic and/or descriptive terminology. For instance, the symptomatology referred to by the broad term "minimal brain dysfunction syndrome" consists of learning and behavioral impediments "associated with impairment in perception, conception, language, memory, and control of attention, impulse or motor function." [1] A subcategory of this syndrome includes the slightly more specific hyperkinetic syndrome, which is the term most generally used and the behavior impediment most commonly investigated in the studies reviewed. The use of general terms which allude to varied conditions makes the specificity of diagnosis imperative prior to the administration of any drug, especially in evaluating efficacy.

The more specific vocabulary used in the classification of learning impediments includes cortical brain dysfunctions, lethargy, fluctuations in mood and thought, stuttering, speech-voice disorders, 14–6 c.p.s. EEG patterns, and learning deficits which consist of "poor attention span; reading, spelling, audio-verbal receptivity impairment, poor performance in arithmetic and/or English." [2] Although not as generalized as "minimal brain dysfunctions," these terms still lack clarity and distinction between the organic and/or psychogenic etiological factors either before or after the administration of the drug under evaluation.

The methods used in evaluating the drugs consisted of varied techniques dependent on the behavioral manifestations under assessment. Standardized objective tests used to determine changes in such areas as intelligence and personality included Bender-Gestalt, Goodenough Draw-A-Person, WISC, Wechsler-Bellevue forms, Hundleby and Cattell (personal function), Rorscharch inkblot, Raven Progressive Matrices, and others. An actometer was used to measure the motor activity of some children. EEG patterns provided another criteria of evaluating changes in the subjects as well as criteria for participation in some studies. Other

[1] Millichap, J., and Fowler, G. W.: Treatment of "minimal brain dysfunction" syndromes. Pediat. Clinics N. Amer., 14 : 767, 1967.

[2] Smith, W. L., and Weyl, T. C.: The effects of ethosuximide (Zarontin) on intellectual functions of children with learning deficits and cortical brain dysfunction. Curr. Ther. Res., 10 : 265, 1968.

methods consisted of investigator devised and/or standardized tests for coordination and perception; personality and behavioral-rating forms; and written or oral personal observations by parents, teachers, physicians, interviewers, and others.

In arriving at conclusions, most investigators appeared to be in agreement about the achievement of some beneficial results from the administration of certain drugs as an aid in alleviating learning impediments. However, discrepancies exist in reference to which drug produces the most beneficial results with a minimum of adverse side-effects. The few (controlled) studies appeared to be limited to two drugs and a placebo. The investigators seemed vague and inconclusive in respect to the actual influences of the drug in specific areas which should receive consideration; they often came to feeble but encouraging conclusions on the basis of certain positive results, disregarding or attempting to explain away inconsistencies. Generally, investigators based their promising conclusions on either a broad spectrum of positive and negative results or on an individual and a specific encouraging effect.

Numerous variables affect the validity of the conclusions reached in the articles reviewed and in turn the validity of the evaluation of the drugs employed.

1. Well controlled studies employing a double-blind, crossover design and/or placebo drug were too few in number. The absolute necessity of using a placebo receives reinforcement from study results, especially since the effects of one of the drugs under evaluation differed only slightly from the placebo.

2. The number of patients involved in a study ranged from 10 to over 100, but they averaged anywhere from 14 to 40, which is too sparse a sampling for definite conclusions.

3. The psychologic effect of being in a study (Hawthorne effect) must receive consideration. The stimulation produced by participation and the general effect of increased personal attention can result in an improvement unrelated to the effects of the drug. This would be accounted for in controlled studies. Position in the treatment schedule has shown its effect, even in controlled studies.

4. Test situations which remove a patient from his general environment provide for a variable often resulting in improvement.

5. Utilization of more sensitive and precise diagnostic criteria would eliminate the possibility of undetected, underlying organic disease unknowingly affecting test results.

6. Discrimination between the organic and/or psychogenic effects produced by the drugs is lacking. The administration of appropriate or effective antiepileptic agents to patients with abnormal EEG patterns may result in some improvement.

TABLE I.—*Drugs Used to Lessen Learning Impediments*

Generic name	*Trade name*
Central nervous system Stimulants:	
Methylphenidate	Ritalin.
Amphetamines	Dexedrine and Benzedrine.
Deanol	Deaner.
Cylert	
Tranquilizing agents:	
Chlordiazepoxide	Librium.
Chlorpromazine	Thorazine.
Reserpine	Serpasil.
Hydroxyzine	Atarax.
Meprobamate	Miltown.
Fluphenazine	Prolixin.
Chlorprothixene	Taractan.
Promazine	Sparine.
Antihistaminics	
Phenothiazines	
Anticonvulsants:	
Primidone	Mysoline.
Diphenylhydantoin	Dilantin.
Ethosuximide	Zarontin.

7. Well controlled investigations evaluating the influences of drug on epileptic children, nonepileptic children, and children with normal and abnormal but not diagnostic EEG patterns need to be implemented.

8. There is need for focus on specific learning problems, with a corresponding identification of the influence of a drug on the specific symptom. As an example, one study detected an improvement reflecting a motivational factor but not a change in intellectual ability. Specifically, does the drug affect personality, behavior, motivation, and/or intelligence, and in what aspects?

9. The potential adverse side effects of the drugs warrant more attention.

10. The variations in observational methodology and lack of continuity in the observers result in incomparable data.

The drugs evaluated in the publications reviewed are listed in table I.

Chemotherapy provides no panacea for the physician confronted with the varied manifestations of learning impediments. In most instances, chemotherapy should support and be compatible with the therapeutic approaches of the parents, the school, and other allied health professionals, and then only after a specific and detailed diagnosis. Ideally, when administered, the drug should produce none or only the minimal adverse side effects and should reduce the major learning impediment, i.e., reduction of motor hyperactivity and improvement of such factors as memory, attention span, visual and auditory perception, coordination, and general behavior. Until a valid interpretation of the beneficial and adverse effects of the individual drugs is available, physicians should proceed with caution in the use of pharmacologic agents to alleviate learning impediments.

SUMMARY

Studies indicate that certain drugs have a promising effect in the treatment of children with learning impediments. The valid assessment of the true pharmacologic effect necessitates an accumulation of comparable, long-term, properly controlled studies and a careful evaluation of these data compared alone and with adjunctive therapy.

CHARLES F. WEISS, M.D.,
Acting Chairman.
SUMNER J. YAFFE, M.D.,
Chairman.
HOWARD M. CANN, M.D.
ARNOLD P. GOLD, M.D.
FREDERIC M. KENNY, M.D.
HARRIS D. RILEY, Jr., M.D.
IRWIN SCHAFER, M.D.
LEO STERN, M.D.
HARRY C. SHIRKEY, M.D.,
Consultant.

UNIVERSITY OF ARKANSAS MEDICAL CENTER,
Little Rock, Ark., October 20, 1970

Hon. CORNELIUS E. GALLAGHER,
U.S. Representative,
Washington, D.C.

DEAR MR. GALLAGHER: During our testimony on September 29, 1970, before the Committee on Invasion of Privacy, you requested that Dr. Sam D. Clements and I provide you with the amount of Federal matching money which went into the building of the child study center which is unit II of the Greater Little Rock Community Mental Health Center and the teaching and service component of the Division of Child-Adolescent Psychiatry of the University of Arkansas Medical Center. The Federal portion spent or committed was $456,731 and the local matching was $224,183. Additional local money to the amount of $41,553 went into the center.

As we attempted to make clear during the testimony, this structure is part of a community mental health center and it is not a "drug program" by any stretch of the meaning of words. Any implication that the above amount of Federal money is for a "drug program" is patently false and misleading. Likewise our federally supported research on minimal brain dysfunctions and learning disabilities in children is not a "drug program." Within our facility we operate a large child and adolescent outpatient diagnostic and treatment service as well as a therapeutic day school which serves children who are emotionally disturbed and/or have severe learning disabilities. The staff also serves as consultants to various child agencies and to the schools. We use the usual child psychiatric methods in treating children and among these is the use of medications in selected cases.

During the hearing you raised the question of our use of the drug imipramine on children under 12. At that time I did not have an age analysis for that particular drug; I mentioned its well known use in enuresis in children, and more recently, reports of its beneficient effects in cases of hyperkinesis. At the present time we have no children under 12 on this drug, and I have issued a memorandum to the doctors working in this clinic that it cannot be used, pending further research in that age group.

We are in agreement with the spirit of the questions put by Representative John Myers to the effect that research relative to medicines for hyperkinesis in children is very much needed. I feel sure that the majority of experts in child psychiatry, child psychology and child development are in agreement with that position. And that position in no way conflicts with the great need for research in improved ways of teaching and managing learning disabled and hyperkinetic children. Such children constitute a sizable portion of the future adult population. What educators and doctors do for them now should have a significant effect on the mental and economic health of these future adult citizens and their families. The upsurge of a completely separate drug abuse problem should not be allowed to negate and overwhelm a legitimate and reasonable treatment modality.

To keep the matter in perspective, it is necessary to emphasize that only in a small percentage of cases is the use of medications indicated. The major treatment for children with learning disabilities should be based on an individualized instruction program which allows each child to progress at his own success rate and which takes cognizance of his particular deficits, be they in scanning and decoding spoken language, short-term memory for written symbols, visual-motor coordination, or ability to focus and modulate attention.

Yours very sincerely,

JOHN E. PETERS, M.D., *Director.*

ST. PAUL, MINN., *October 3, 1970.*

CORNELIUS GALLAGHER,
Chairman, Office of Subcommittee Investigating Behavior-modifying Drugs, U.S. House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE GALLAGHER: May I commend your willingness to hear testimony from laymen skeptical of the use of drugs for behavior-modification in the classroom.

I am writing to you because I doubt that you will find many members of the educational establishment willing to testify in support of that parental concern.

I would like to volunteer my services in that role when you meet for further testimony later.

After 7 years of working with children with "special learning disabilities" I came to the conclusion that the behavior dysfunctions known as dyslexia and hyperkinesis had an instructional cause and could be instructionally cured. After a year of research in the neurological journals I also became convinced of the falsity of the hypothesis of neurological causation.

After being told that I could not publish my findings in education journals or speak on the subject without losing my job I dropped out, earned a Ph. D. in education at the University of Minnesota, and am now working on a book intended for popular consumption the tentative title of which is "Why Johnny's On Speed."

Enclosed is a stamped self-addressed envelope. I look forward to hearing from you if you are interested.

Very truly yours,

JANE RACHNER.

THE READING STUDIO,
Fort Myers, Fla., October 2, 1970.

Congressman CORNELIUS GALLAGHER,
U.S. Congress,
Washington, D.C.

DEAR MR. GALLAGHER: I am greatly concerned with the controversy about drugs for "hyperactive" children in the elementary schools. I am the director of the Reading Studio, a private service for children with reading disabilities.

In my work in this small institution, I have had two children sent to me labeled "hyperactive." One of these was being given drugs—Ritalin, I believe. In my unmedical opinion, this was a truly hyperkinetic child, but our experience with him was confusing, to say the least. He often forgot to take his pill, and during some brief periods his mother tried to withdraw him from its use. In either case

with or without the drug, the boy was totally unteachable. He was unable to profit even from one-to-one instruction. The second child has not been taking drugs. After 3 years of kindergarten and first grade experience, he is not learning to read. His problem is probably neurological, but he is not, again in my own opinion, hyperkinetic. I recently sent to his pediatrician a report showing that when Mike is engaged in work that satisfies him and gives him some feeling of success, he can remain perfectly quiet. But when he is asked to read—the very word frightens him—he becomes fidgety and overactive. The remedy for this boy lies not in drugs, but in a revised program for learning.

It is my deepest conviction that the giving of drugs must not be decided by the schools, but only after a careful examination and diagnosis by a private family physician or specialist. I have been in a position to observe at first hand the examinations given by school doctors, who, pressured by the limitations of time and the great numbers of children, give these physicals en masse. It can be disillusioning. Since I was once a public school teacher, I remain loyal to these people, but I am aware that there are good teachers and mediocre teachers, flexible teachers and rigid teachers. There are teachers who care about the kids, and there are methodical teachers whose greater concern is with uniform standards of achievement.

I sincerely hope that your commission will find a definitive answer to this problem, one which recognizes that medical judgment should not be delegated to, or even expected of, teachers. The responsibility is too solemn, the dangers too great, the desire for orderly classrooms too tempting.

May I close with a true story that is not really as irrelevant as it may seem. When my son was quite young we bought a very tiny and very beautiful puppy. She contracted distemper, and took an agonizingly long time to die. One day I called the veterinarian and asked if it would help to give her a dose of whiskey. Kindly and most sympathetically he replied, "I think it would help more, Mrs. Heppe, if you took it yourself."

Very truly yours,

MARGARET W. HEPPE.

POMPANO BEACH, FLA,
September 30, 1970.

Re Hearing on use of tranquilizers and amphetamines for schoolchildren.
Representative CORNELIUS GALLAGHER,
Democrat, New Jersey, House of Representatives, Washington, D.C.

DEAR SIR: I am sure you have done much painstaking research on the drug "Ritalin" and its effects and side effects; its uses and abuses. I agree wholeheartedly with your efforts and your concern. Ritalin and its counterpart, the tranquilizer "Melleril", are potent and potentially dangerous drugs and thought of giving these powerful drugs to little children is a very frightening thing. I know—I had to face the decision of using these drugs on my own 8-year-old. I am not entirely satisfied that I have done the best thing for my child, but there were no alternatives.

The point of this letter, Mr. Gallagher, is to ask that while your committee is investigating the use of these drugs, would it be possible for you to investigate the alternatives. There are very few if any, for the truly hyperkinetic child. God knows how I wish there were. I am not referring to the overactive child. The truly hyperkinetic or hyperactive child is something else entirely and defies description.

I read in the local paper this morning that a witness, Theodore Johnson, a Veterans' Administration chemist, stated that "there is no real medical problem connected with hyperkinetic children." I would like to challenge Mr. Johnson to spend 1 day with my Tommy and repeat this statement. I agree that Ritalin is not the best solution, and should be used with caution, if at all, but I disagree vehemently with his statement that there is "no real medical problem." If he had a hyperactive child, he too would be grasping at straws. Does he know what it is like to have to spend hours literally training yourself to sit still? I do. Does he know how it feels to be able to "out think" your classmates only to be frustrated by not being able to get it down on paper? I do. Has he ever felt the frustration and confusion of knowing that people could not tolerate your presence, when you want so badly to be liked? I have. Oh yes, I have, and I have a child who is experiencing the same pain. When I was a child, I was called stupid, uncontrollable, and many other unprintable names. I will not have my child go through this if it is in my power to prevent it.

Mr. Gallagher, would you please take the time to read my story? It may give you some idea of the desperation facing the parents of these children. We do not have an easy task—that of trying to guide an uncontrollable child, when the medical profession in general and our friends and neighbors refuse to admit that such a child exists. We know he exists. We know how many methods we have tried. We also know how hard that child has tried. We know how that child can be hurt, because we hear him when he wakes up in the middle of the night, screaming with pain, either physical or mental. These children are prone to ulcers, you know—possibly because of the constant frustration, or possibly because they hurt more deeply than other children.

My own story began on October 10, 1962. At age 32, I gave birth to my second son—10 years and two miscarriages after my first son. What a delightful, fascinating baby he was. Not beautiful by any stretch of the imagination, but bright, happy, and as I said, fascinating. For instance, he said his first word at 4½ months. That's right—4½ months. The word was very clear—"Shew-Shew" for "Chew-Chew," our poodle. At first I thought it was an accident, but when he repeated it each time the dog walked by, I realized that he was really calling the dog as he had heard us do. This word was followed in a few days by "boy" for Mike, his brother. He was coached on this one. Mike spent about one-half hour trying to get Tommy to say the word by repeating the word then pointing to himself. When Mike finally gave up and walked away—Tommy yelled "boy" and laughed when Mike came back. From then on, whenever Tommy wanted Mike's attention, he yelled "boy." I am relating this, not to brag about my "brain child," but as an indication of the brightness and the actual thinking process of this child.

Granted, every mother is proud of her child, but Tommy was a "special" child, and I would have had to be blind not to see it. He actually thought things out, and it was obvious. You could almost watch the wheels turning. I have three boys of my own. I raised my younger sister and also my older sister's children, plus being in demand as a baby sitter most of my life. I taught handicapped, or as they are now called, "exceptional" children, and also studied child development psychology, as well as abnormal psychology. I have been closely involved with a multitude of children—active, passive, bright and dull. When I say Tommy was "special," I think I can speak with some experience. He was different.

When Tommy was 5½ months old, he underwent an overnight change. My happy, bright, red-headed baby became a "red-eyed demon." The change was so abrupt, so unexpected, it left me stunned. He could not be interested nor entertained. Before, he would play for hours "talking" to the dog, trying to catch the sunbeams or laughing at the drapes blowing in the breeze. Suddenly, he raged at the slightest provocation, forgot how to crawl, roll over, sit up, pull up, all of the little accomplishments that once kept him occupied. His appetite dropped to almost nothing and sleep became virtually nonexistent.

This behavior lasted about 1 week. Then one morning when I had about given up, he woke up with a smile on his face, a twinkle in his eye and a shiny new tooth in his mouth. My Tommy was back again and that other "monster" was nowhere to be found.

I won't bore you with the details of each and every "change," but it happened frequently. Every tooth brought about Mr. Hyde. The day the tooth popped through, Kindly Dr. Jeckyl reappeared. It reached a point that the neighbors would say, "Oh, I see Tommy is cutting a tooth.", or "Hey, Tommy's tooth came through." The change in personality became almost standard and very predictable, starting with crankiness, loss of appetite, frustration, extreme perspiration, speed-up of motion and loss of coordination, plus the wild, wide-eyed look that disappeared the very minute a tooth popped through. The older he got, the longer the periods of stepped up activity became and the periods of normal behavior were shorter.

I might inject at this point, the fact that I had a pediatrician who did not believe in drugs and who also refused to believe that Tommy's behavior was unusual. His diagnosis was that Tommy was unusually bright, extremely well co-oriented and very large for his age—a combination that would naturally be frustrating to any "nervous" mother.

Now, I ask you, Mr. Gallagher—picture yourself the parent of a 7½-month-old baby. You have put him in his crib for a nap. You hear noises and open the door. There is your "normal" 7½-month-old son, standing on the window ledge, making like Tarzen with the drapes. He has bounced his crib across the room to the window—the window being about 2½ feet above the top of the crib, and somehow he has climbed up and is standing on the windowsill. Would you agree with

your pediatrician that there is nothing unusual about his behavior? When you find it necessary to remove all furniture from the room to keep him from climbing on it, even having to take the pictures off the wall and curtains off the windows, would you agree with the doctor that you are "overly nervous?" When this same child reverses himself, almost in the blink of an eye with the popping of each tooth, would you agree that there is "no real medical problem" involved? After awhile you begin to believe that you are cracking up because your head has begun to hurt from contact with that brick wall.

By the time Tommy was 2 years old, I knew he was not only bright, but almost brilliant. He could "read" a story by looking at pictures. He recognized letters of the alphabet and knew their sounds by comparing his favorite cereal boxes, etc. In other words, he knew the word "Jelly" and knew that "Jello" and "Jelly" must sound alike because they started with the same letter. He could count to 10 and add simple numbers. For example, he knew two cookies and two cookies made four cookies. If I gave him four cookies and took one back, he knew he had three left. He talked a blue streak and invented beautiful stories about the sun, how the grass grows, what makes the moon shine at night, and could recite the Pledge of allegiance from watching Romper Room school on television. I did not coach him on these things, he taught himself by observing others.

When Tommy was 3, he had begun cutting his last molars, which lasted until he was 4-4½. All that he had taught himself was lost—gone as though it had never existed. He could not sit still, he screamed over nothing, threw things, was awake till all hours of the night and was generally about as obnoxious as a child could be. Still my pediatrician was unconcerned and refused to acknowledge anything out of the ordinary. I was beginning to worry about school—how I would be able to settle him down long enough to sit in a class room. As he grew older, he became wilder and the teeth took longer coming through. To make matters worse, his permanent teeth were coming in early. He had four permanent teeth before he was 6—the first one shortly before his fifth birthday. His antics became more and more destructive and my temper became shorter. I am not what you might call a "permissive parent" but short of standing over him with a baseball bat, there was no way to keep him settled down. I was neglecting my house as well as my other two children. I had a 24-hour job just trying to keep up with Tommy to keep him out of serious trouble. He had no friends. One Tommy was a demon who pushed, poked, prodded, and screamed. The other Tommy suffered the consequences and still his doctor was completely unconcerned.

In September of 1968, Tommy started first grade. Would you believe this "brilliant" child could not recognize numbers and letters he had known for 3 years? He could not begin to make simple circles on paper. He could not recognize colors that he had known for years and he could not remember from 1 minute to the next what had been said in class, much less from one day to the next. In school, he was a model child, behaviorwise. The minute the bell rang, he was once more a monster. You see—he wanted to learn, he wanted the teacher to like him, he wanted to be like the other children, and he concentrated all his energies into sitting still and being a "good boy." At home, he woke up screaming four or five times a night, and developed an ulcer. This child who was so well coordinated at two that he could hit a baseball three out of five times, could not walk the "line" nor pass other simple coordination skill tests at school.

In November of 1968, I reached the end of my patience, stormed into my pediatrician's office and let go. He finally made an appointment with a neurologist, not because he believed that there was any "medical problem" involved, but more to get me off his back. It took the neurologist about 15 minutes of conversation and observation to recognize the classic hyperkinetic symptoms. After a thorough examination and an EEG, he suggested that we start Tommy on 10 mg. Melleril twice a day. I was not enthusiastic over this plan, as I had a basic revulsion toward feeding my child tranquilizers, but I was desperate enought to try most anything. Life in our house was becoming a nightmare.

The EEG showed very minute brain damage, but apparently in the sensory or stimuli center of the brain. Why it only affects Tommy when he is cutting teeth is still a big mystery. However, the neurologist agreed with my theory of a glandular or possibly a nerve involvement. He suggested that we take steps to check this out, but I ran into what might be considered "insurmountable conditions" on the part of other doctors. I will discuss that later, but for now, I would like you to know the effects of the drug, Melleril.

Remember, Tommy had been in first grade for 3 months before starting the medication. The rest of his class had finished three or four primer readers, were printing quite well, and were beginning to work with numbers. Tommy was still

unable to "read" the picture book which he could do on his own at 2 years of age. He was totally unable to make letters or draw simple pictures, and so forth. I had discussed the situation with his teacher, who, incidentally, had never heard of hyperkinetic children, nor Melleril, nor Ritalin, but who was very cooperative and very, very interested in helping Tommy. We had decided that we would leave Tommy in first grade, but treat it as his kindergarten year, as Florida does not provide kindergarten in public schools. I had fully intended having him repeat first grade.

Even now, it is a bit difficult for me to believe, but within 3 weeks after starting the Melleril (which had to be increased to 50 milligrams twice a day), Tommy had caught up with the lower reading group, was printing—not well, but legibly and was comprehending numbers satisfactorily. He was definitely not at the head of his class, but he was doing first grade work. He was still a study in perpetual motion at home, but was somewhat less destructive, more constructive, and easier to control.

Tommy went on to complete first grade with the rest of his class. His teacher strongly urged me not to hold him back because he had worked so hard and was keeping up with his class even though he had a 3-month delayed start! His printing had improved although it still had a long way to go. He had some trouble with arithmetic, as he had a tendency to reverse numbers. (This is a problem I have had all my life, even though I am a cost accountant—I cannot add. I am told that this phenomenom is called discalculus. I grew up thinking it was called stupidity.)

In July of 1969, the Melleril was no longer doing the job. Tommy had two upper teeth coming through and was really in orbit. I could not control him. He was going through the familiar Jekyll-Hyde transformation and I was becoming a screaming banshee. Once again, I consulted the neurologist and he suggested that we switch to Ritalin. We started with 5 milligrams which just made matters worse. We then switched to 10 milligrams twice a day. It is impossible to describe the change. The stomach pains subsided and he slowed down and became more constructive. He would work at cleaning his room instead of throwing toys, writing, reading, and other things, as though he wanted to catch up and make up for the time he had lost. When he started second grade, he was able to keep up with his class and his writing improved to a point that his printing was one of the best in his class. He did work slowly, however. If he worked fast, he made mistakes and his printing was messy—a problem he still has. He finished second grade in the top group. The dosage of Ritalin had been gradually increased to 60 milligrams three times a day, or a total of 180 milligrams per day.

To wind up my story—I am not entirely satisfied with the course of treatment. I feel that I am only treating symptoms rather than getting at the cause. I feel that there must be something amiss in this child's system, and the Ritalin is only serving as a substitute or possibly a coverup. The Ritalin, it seems to me, is only masking the true medical problem. It may keep him calmed down, but no one has ever given me an acceptable explanation as to why he goes into orbit in the first place.

I am disappointed that I have been unable to get any doctor interested in finding the true cause of Tommy's problem. The Ritalin has been a tremendous help in settling him down and also in allowing him to channel all that energy into constructive outlets, but I cannot help feeling that it is basically wrong to feed a child the quantity of amphetamine that I feed my child every day. At present, I have to wake him at 6 a.m. in order to give him his pills, so that he will calm down enough to get dressed and leave for school at 7:45 a.m. The first one-half hour is sheer hell. He runs—he throws things, he yells—well, I can't describe it. You have to see him in action and still it is hard to comprehend. However, once the pills take effect, he settles down to the work at hand.

Right now, he is receiving 180 milligrams of Ritalin a day. It should be increased, as it is not doing the job it should, but I am trying to hold out. In August, I had 2 days of relative calm. He cut one of the upper teeth, and for 2 days, received no medication. He was a delight to live with for those 2 days. Then off he went, back in orbit, and the other tooth still hasn't come through. At least I can take some measure of encouragement from that 2-day interval. I had been worried about the effects of withdrawing the drug. Apparently in Tommy's case, there are none. Also—I can hope that within a few weeks, I will be able to drop the medication for a while, provided we don't start cutting eye and stomach teeth immediately.

Tommy's dentist is at a loss to explain why his teeth should set off such a reaction. They are strong, healthy teeth. When he X-rayed Tommy's teeth last March, he could not understand why the two teeth that have been causing so much trouble were not coming through. They should have popped long ago.

Since January 1, 1970, I have spent in excess of $250 on Ritalin alone. That's quite a sum of money to spend for a nonmedical problem which doesn't exist. We are not wealthy people and cannot afford the luxury of spending $250 on a status symbol, nor on our imagination. None of my boys are what you would consider quiet boys. I'm used to the problems and the antics of overactive children. I certainly would not spend the amount of money I have spent on diagnosis and treatment unless I were faced with a problem completely beyond my control.

I hope I haven't bored you with my lengthy epistle. I realize your committee is primarily interested in the abuses of these drugs when they are given to normal children. Still, isn't it equally abusive to pounce upon a drug to treat symptoms, leaving the cause unknown? To me, it is much the same as giving large doses of aspirin to a child with a high fever. Sure, the aspirin keeps the fever down, but does it help in locating the underlying illness? Children used to be given aspirin to alleviate the discomfort of common growing pains, until it was discovered that these growing pains sometimes were the body's way of turning on a red light, signaling rheumatic fever.

Please don't misunderstand. I will be eternally grateful to the neurologist who took the time to examine Tommy and prescribe the Ritalin. Without it, one of us would not have survived. I am not a violent person, but it is virtually impossible to be patient, kind, and loving when you are faced with the frustrating day-to-day antics of the hyperactive child. The drug, Ritalin, has been a Godsend to Tommy and our entire family. Still, it is not easy to live with oneself, knowing that you are pumping huge quantities of potent drugs into a child, just for the sake of peace and quiet.

I have written this letter in the hope that during the course of your hearings, you might be able to question some of the experts as to further research into the cause of hyperkinesis. It is not enough to label it minimal brain dysfunction and stop there. Not when there is even one child like Tommy, whose hyperactivity is triggered by a specific cause. If brain damage is the villian, why isn't it consistent? Why does it come and go, running a definite pattern?

I have tried to get a satisfactory answer from several doctors. However, their attitude seems to be "you have a drug that is keeping him quiet—why push it further?" I went to an endocrinologist who was far more interested in labeling Tommy manic-depressive than in examining him. (A 6-month-old baby—manic-depressive?) He refused even to give him a glucose tolerance test for hypoglycemia stating that this was the pediatrician's department. The pediatrician felt it was too long and involved to bother with. (I suffer with hypoglycemia, so my request wasn't really that far-fetched.) My pediatrician has yet to give Tommy a simple thyroid or other glandular test. In other words, most doctors are far too inclined to say, "Why worry, the problem really doesn't exist, but if it did, he would out grow it. They all do." Sure they do! One day, when they are 12 or 13, all symptoms magically disappear. (Twelve—thirteen being the age of puberty, bringing glandular not brain changes.) What happens to all the years of frustration, friendlessness, being yelled at, being confused and very, very much alone. Do the effects of all these years disappear too? I think not. At least, they didn't for me. I overcame a great deal, but I was in my twenties before I realized I was not stupid, that I could use my mind if I trained myself to do so. I still have an ulcer which flares up periodically. I still get nervous and actually shake at times when I have to talk to a stranger in unfamiliar surroundings, because I am afraid I will goof or in the child's vernicular, be yelled at or laughed at.

I have watched Tommy in those periods of normalcy between teeth. This child hurts and he hurts deeply. He doesn't know why the other kids turn their backs when he is trying so hard to make friends and to be liked. You bet he hurts and so do I! If Ritalin helps relieve even one part of that hurt, then I'll keep feeding it to him. I don't like it, but as I said in the beginning—Is there an alternative?

If, in the course of your hearings, you ferret out any information on research being done into the alternatives, would I be out of order in asking for this information? Is it possible to receive a transcript of these hearings?

Tommy is just one little boy out of hundreds of thousands of children in this country. But Tommy has an inventive, creative mind. He is bright and possibly brilliant. Can we afford to ignore even one creative mind? Can we, when the need is so great and the supply so small? Consider also the fact that most hyperactive children are bright, inventive, and creative, which is one of the reasons they are capable of thinking of so many ways to be destructive. They are literally taking their own little world apart in order to find out what makes it tick. Can we, as a Nation, afford to lose the productivity of these minds? Are we so well supplied with brilliance that we can afford to write them off? These children have so much to

offer to the future of our Nation if we can find a way to help them utilize their minds and to channel all this activity into productive means. Ritalin is the only solution now, but there must be a better way. There must be!

My Tommy is a special child. Someday he will overcome his handicap because he wants to overcome it, and because he has parents who recognize his problem and want to help him overcome it. When he does, he will carve a special place in this world for himself. I know this. I am very, very sure of it. There are thousands of other children who have his drive, his ability, and his handicap. Can you, Mr. Gallagher, afford to let your committee do a halfway job as the medical profession seems to have done? Can you afford to lose the vast potential of these children?

Yes, Mr. Gallagher, there is a real hyperkinetic child. He may not have a real medical problem, but he does have a problem. You are in a position to help him now. Will you try?

My Tommy will thank you.

Thousands of other children and their parents will thank you.

Your country will thank you.

And I thank you for listening.

Very truly yours,

Mrs. Frederick N. Kelly.

San Francisco, Calif.,
October 1, 1970.

Hon. Cornelius Gallagher,
Chairman, House Privacy Subcommittee,
House of Representatives, Washington, D.C.

Sir: I am on active duty with the U.S. Army in Vietnam.

I refer to the hearings your subcommittee is conducting into school-sponsored use of drugs. Apparently, another socio-psychologists field-day is to be unleashed on the public. Once again the sociologists in their usual guise of the saviors of the masses from themselves, and dogged by failure after failure in their efforts to correctly diagnose the ills of society, let alone the cures, now seize upon a new fad which will lead our children to a "Brave New World."

It does not surprise me in the least to read that there are individuals in the program who would coerce parents, or try to, in their efforts to justify their own ideas. It is not for nothing that we have witnessed the Spokian philosophy reduce our educational system to a shambles and undermine the core ideology of the Nation. Now there is a new scientific toy in the bag of tricks. Unfortunately, the "system" is going to depend on someone deciding which children are normal and which are not. Is it not a fact that among psychologists and psychiatrists there is an "abnormally" high rate of suicide? How "normal" are they?

In the attached article I see that an Ohio osteopath states,

> "No representative of Congress should have the audacity to state that children are being drugged just to keep them quiet."

Danger! Super intellectual at work! Ordinary people are stupid, or at best just plain ignorant. We do not know what is good for ourselves, and fantastic as it may seem, some of us actually think we are happy and know quite a bit more about children than the average pseudo-scientific hack making a name for himself at our expense and at the expense of our children.

I strongly urge you to recommend legislation to halt this unwarranted invasion of privacy of individuals, and to halt all drug experiments on children except under the most stringent controls at fully approved and federally inspected hospitals. Otherwise this kind of thing could spread from careless application to so-called abnormal children to "normal" children to "improve" them. Where would such monstrosity end?

Respectfully yours,

John D. Whitehouse.

The University of Wisconsin,
Madison, Wis., October 1, 1970.

Hon. Cornelius Gallagher,
Representative from New Jersey,
U.S. House of Representatives, Washington, D.C.

Dear Representative Gallagher: As a former citizen of Hudson County, N.J. and one who still has a family and many relatives in your area of representation, I am very pleased to see that you are conducting a special House subcommittee investigation of the use and possible misuse of pharmacological agents in the treatment of children's behavior and learning disorders.

As a trained professional in the area of clinical psychology with a special interest in the treatment of childhood disorders, I have become increasingly concerned with the use of drugs to treat children who are considered to be "minimally brain damaged". This syndrome is ill-defined and many professionals in the medical, educational, and psychological areas hold that the diagnosis of "minimal brain damage" is of dubious usefulness in the treatment of children. Furthermore, irrespective of the diagnostic label used, there is little evidence, if any, to indicate that the use of amphetamines is the treatment of choice in the areas of behavior disorders and learning disabilities of children or adolescents.

In fact, it is my strong opinion that the individuals prescribing this form of treatment are ignoring alternative approaches, such as reinforcement therapy, which do not rely on the use of drugs and have been found to be effective in treating both behavior and learning disorders. More importantly, the advocates of pharmacological treatment are using chemical agents of dubious value and of unknown impact on the future functioning and behavior of individuals, particularly children. This latter point is of special significance, considering the concern in our society with the frightening increase in drug abuse among the youth of our country. The use of medication of any form should be closely scrutinized, and confirming data collected before decisions are made about the worth of a treatment regime and its concomitant widespread use. This has not been done at present with the prescription of amphetamines and other drugs for the treatment of childhood disorders.

I truly hope that your committee will provide the time and opportunity for concerned individuals to speak out and present alternatives to the use of drugs in the treatment of behavior and learning disorders of children.

If I could be of any assistance to your committee in the gathering of this information please feel free to call on me.

Sincerely,

WALLACE L. MEALIEA, Jr., Ph. D.,
Assistant Professor Educational Psychology.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., August 25, 1970.

Mr. ROBERT C. MAYNARD,
Washington Post Staff Writer,
The Washington Post, Washington, D.C.

DEAR MR. MAYNARD: I was delighted to read in Sunday's August 23 paper, your article, regarding the utilization of drugs for troubled, hyperactive children. I feel that you are contributing tremendously in providing the public with information on the treatment of such children. I was disappointed, however, that you neglected to be advised by nationally known and reputable educators. This appears to me as noteworthy and consistent with most copy on the problem in reporting on the treatment and rehabilitation needs of disturbed and troubled children. There is no doubt that the reporting theme of the article is clinically and medically oriented. Somehow a curve was pitched as you reported on Dr. Sidney Adler's observation that "this is an educational problem that has been dumped into the lap of medicine." Dr. Adler's observation is disconcerting and inaccurate. It is typical of the priest-medicine man who, ages ago, assumed responsibility and knowledge regarding the many aspects of human endeavor. Today, that phenomenon often recurs. Too many medical personnel feel duty bound to enter in vast areas of activities other than medicine and advise about education, sociology, criminology, and so on. This situation may be reflected by the activities in Omaha where up to 10 percent of the school population was drugged to reduce apparent unacceptable behavior. Dr. Arnold Hutschnecker's plan for prevention of violent crime is another case in point.

Your article also dramatically illustrates the medical preoccupation with causation, etiology, definition, and labeling handicapped children. This is a luxury as educators need to and do plan immediate practical programs to educate children.

In summary, your article is informative and commendable. Too bad you didn't obtain information on this issue from educators about the educational implications in utilizing drugs for troubled children.

Sincerely yours,

JAMES R. TOMPKINS,
Coordinator, Unit on Education of the Emotionally Disturbed.

SOUTH WEYMOUTH, MASS.

Mr. CHARLES WITTER,
Cannon House Office Building, Washington, D.C.

DEAR MR. WITTER: A few days ago, I called Representative Gallagher's office, to give my opinion on his investigation concerning drugs for hyperactive children.

Let me tell you now, that I have two medically diagnosed hyperactive children, that are on medication. This was not done through the school, but my children's school is aware of the treatment they are getting.

My husband and I were aware of their special problem, long before either one of them started school, and we have been through many long days at a Boston hospital, seeing our children put through many very important tests, before they were put on the drug. I must also tell you, this has also been very expensive.

I am very much against this sort of treatment on such a large scale, such as in Little Rock and other areas, and I will try to give you my reasons.

One of the reasons we took our children for treatment is the fact that our children were so very active, that they spent so much time at the hospital getting stitches. They never walked, they always ran with such speed that they couldn't see where they were going and would trip and fall. They couldn't sit still long enough to have a story read to them, eat a meal, or be allowed to play in another child's yard, as the other parents thought it was contagious. Needless to say, they were very unhappy children.

We have tried all kinds of discipline, except beating them, but it was to no avail as it was just something they couldn't help. Even though they were always jumping all over the place and causing so much trouble they were never rude, and always kind and loving children.

The fact that they are on this medication, does not change their personality, it just allows them to be like other normal children. They would be in great danger of physiological problems later on in life, if they were not on this drug, and being treated now.

My youngest daughter is not hyperactive, and if she was in school now, and was slow in math or spelling, I would not want her on any drug.

If the Government is allowing this drug to be passed to so many children, who really don't need it, I think it is a disastrous thing.

When my two children reach a certain age, they will grow out of this and will no longer need the drug, but now they are being taught to have respect for this drug, just as an epileptic child is taught. I have no fears that they will become drug addicts because of this.

If this mass medication is not stopped though, I can not dare to think of what might happen to all those children, who are taking drugs just to bring home a straight A report card.

There must be strict guidelines, and this has got to be something between parent, child, and doctor. If a child has a real hyperactive medical problem, the parents will know, believe me, they don't need any school to tell them.

Sometimes a school classroom is and can be very dull. We need good teachers, well paid teachers that can give challenge to these children who have trouble learning, not drugs.

Not every child can excel in everything, and that is just the way it is.

There is so much more I can say, but it would turn out to be a book, but I feel we have been through so much that I wanted to give you some idea of how important this is.

Sincerely yours,

Mr. & Mrs. LESTER C. JONES.

P.S. I felt very sorry to hear about what Mrs. Daniel Youngs has had to go through. But I am glad she was willing to help bring this to light. I also thank you.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
FOOD AND DRUG ADMINISTRATION,
Washington, D.C.

For release: Immediate—Wednesday, August 5, 1970

Dr. Charles C. Edwards, Commissioner of the Food and Drug Administration, said today he has moved to limit sharply the use of amphetamine drugs, now, being widely sold as stimulants and appetite suppressants in this country, and he appealed to manufacturers to reduce the production and sale of the drug.

He said an FDA order, to be issued this week, will seek to confine the use of amphetamines to three specific medical uses: uncontrollable sleepiness (narcolepsy), hyperkinetic bahavior disorders in children, and short-term treatment of obesity.

Citing the widely documented abuse and misuse of amphetamines, the FDA Commissioner said he believed that along with this new order the amphetamines problem must be attacked by a nationwide effort involving close cooperation between Government, the drug manufacturers, and practicing physicians.

"Industry has not faced its responsibility with these drugs," he said. "It is time for the manufacturers to accept the challenge of working closely with the FDA and the Department of Justice to stop the unnecessary production of amphetamines."

He said last year 3½ billion amphetamine doseage units were made in this country, many more than medical need required.

Such tremendous production makes easy the diversion of large supplies into improper channels of trade, Dr. Edwards said, and noted that last year the Justice Department's Bureau of Narcotics and Dangerous Drugs was unable to account for the sale of 38 percent of the supply produced in this country.

Dr. Edwards emphasized that use of amphetamines against obesity, mentioned in this week's order, should be short term because a report by the National Academy of Sciences-National Research Council has stated that in obesity the effectiveness of amphetamines often begins to diminish within a short period of time.

The FDA order will also require revised labeling on all amphetamines. Some present labeling, Dr. Edwards said, lacks the specific directions to the physician which reflect the limited medical uses of amphetamines or sufficient warning about their potential for misuses and abuses.

By terms of the FDA order, manufacturers of amphetamines and methamphetamines will have 60 days to revise labeling on these drugs to match the FDA's model labeling. Within 1 year all manufacturers will be required to submit proof of effectiveness for all the claims made for amphetamines.

Manufacturers of combination drugs containing amphetamines must also relabel their products concerning their amphetamine components.

A related class of drugs, levoamfetamine preparations, was found not to have substantial evidence of safety and effectiveness, the order says, and FDA will now require proof of safety and effectiveness from manufacturers who want to retain these drugs on the market.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., November 19, 1970.

Hon. CORNELIUS E. GALLAGHER,
Chairman, Subcommittee on Invasion of Privacy,
Cannon Building, Washington, D.C.

DEAR CORNELIUS: Although I realize that technically the record is closed on testimony before your Subcommittee on Invasion of Privacy concerning the use of certain drugs in treating children with learning disabilities, I am enclosing a statement from Mrs. Roy S. LeMay, principal of Hardin Bale School in Little Rock, in answer to the statement made available to your subcommittee on September 29, 1970, by Mrs. Daniel Youngs. Mrs. LeMay made this information available to me while we were in Arkansas for the recess.

A great deal of misunderstanding has been generated over treatment of these particular children and, since it is our understanding that the galley proofs have not been returned for final printing, it would be greatly appreciated if you would consider making Mrs. LeMay's statement a part of the record.

With kindest personal regards, I am

Sincerely yours,

WILBUR D. MILLS.

Enclosure.

ANSWER TO THE PREPARED TESTIMONY OF MRS. DANIEL YOUNGS

To Whom It May Concern:

This is an answer to the testimony of Mrs. Daniel Youngs, 3651 Dubarry Road, Indianapolis, Ind., which she read before the Right to Privacy Inquiry on September 29, 1970. In behalf of myself and the dedicated teachers who taught the Youngs' children, I feel that it is my professional responsibility to refute her highly inaccurate, libelous statements given in her prepared remarks.

This answer is taken from documented summaries of parent-teacher conferences held with Mr. and Mrs. Youngs from October 1963 through May 1966, from recent interviews with the teachers concerning confrontations with the family, from my personal experiences involving the administrative staff, and from other original school records at my disposal.

Mr. and Mrs. Daniel H. Youngs moved to Little Rock, Ark., in October 1963. They enrolled their son, Ross Owen Youngs, and their daughter, Michele Hazel Youngs, in Hardin Bale School on October 25, 1963. The family came from Loveland, Ohio, where their children attended the Loveland Miami Elementary School. They expressed their dissatisfaction with their former school situation. The son enrolled in the first grade, and the daughter enrolled in the third grade. During my absence, my secretary listened to their story and answered the Youngs' inquiries concerning the teaching of phonics, reading, new math, and the school program in general.

It was not until November that Mr. and Mrs. Young held a meeting in the principal's office. (It was lengthy; however, it did not last "four unbelievable hours"; neither was it held on the day that they enrolled their children, as stated in Mrs. Youngs' testimony.)

Throughout Mrs. Youngs' testimony there are a few grains of truth, but for the most part, it is untrue. At no time during the 3-year period that the Youngs' children were enrolled in Hardin Bale School did the teachers, the administrative staff, or the principal diagnose the son or daughter of the Daniel Youngs as having "Minimal Brain Dysfunction", neither did we suggest or prescribe drugs for them. As professional educators we were well-qualified to diagnose educational strengths and weaknesses and to prescribe materials, aids, and techniques—which we did as the need arose, however, we left the diagnosis of Minimal Brain Dysfunction and the prescribing of medication to the medical and psychological experts.

On November 15, 1963, Dr. Sam Clements, director of the Child Guidance Study Unit, University of Arkansas Medical Center, Little Rock, Ark., was the guest speaker at a PTA Study Club held in the activity room at the school. His topic was "Learning Difficulties Among Children with Average and Above Average Intelligence." Invitation to attend was in the form of the usual mimeographed notices sent home by school children. (This meeting was not held at the end of the school year as stated by Mrs. Youngs, and the principal did not call to ask Mrs. Youngs to "please come.") The lady who spoke out at the meeting was unknown at the time—but not for long.

At the November meeting with the principal, Mr. and Mrs. Youngs entered in a cordial mood and expressed much interest in learning disabilities and showed great concern for their daughter's reading difficulties. Due to the principal's limited knowledge of Dr. Clement's new program on learning disabilities at the medical center, and the underlying causes of their daughter's reading problems, the principal centered her discussion around first-hand information which she had acquired at St. Louis Children's Hospital, where her daughter was a patient for 1 week. At this time the principal was introduced to the term minimal cerebral dysfunction—not minimal brain dysfunction. (Mrs. Youngs' entire discourse concerning this meeting is filled with inaccuracies from its timing to what was said.) The principal did tell the Youngs what she knew about the program at St. Louis and about her own daughter's reading problems which had been diagnosed as a visual perceptual disability; also, about her poor hand-eye coordination, her allergies, and how the prescribed medication had helped her to experience more academic success. She also discussed a structured learning environment which helped to improve her daughter's reading comprehension and ability to concentrate. The principal did not say, however, that her daughter had minimal brain dysfunction or that she was put on drugs "to stimulate her to learn" as was reported in Mrs. Youngs' testimony. Mrs. Youngs inquired about literature on learning disabilities, and the principal gave her a copy of a reprint by Dr. Clements and Dr. Peters, which had been made available at the time of the PTA Study Club.

At one time we did discuss the possibility of a remedial reading tutor to work with the Youngs' daughter; however, there was no mention of tutors being trained in Dr. Clements' program or the daughter's being sent to the medical center for testing by Dr. Clements' staff. The alternate proposal (as stated by Mrs. Youngs) was quite amusing, since it was so ridiculous and grossly distorted. The principal can't take credit for this imaginative story, so it will have to be attributed to Mrs. Youngs' creative ability.

Because of the daughter's lack of success at the third-grade level, the Youngs agreed to the reassignment of their daughter to the second grade, which was nearer her level of reading achievement. This move was made on November 19, 1963.

The receiving teacher held conferences with Mrs. Youngs on the following dates: November 27, 1963; February 18, 1964; and April 9, 1964. In November the mother was furnished a set of phonics records for home use. In February the mother questioned the grades on the daughter's report card and asked the teacher to send a series of notes home to indicate whether or not the child was completing her work. The teacher told the mother, "Mickey is having trouble finishing her work. She dreams and seems to be in another world." At the April conference, the teacher recommended summer school.

The son's first grade teacher held a routine conference with Mrs. Youngs on December 10, 1963. In February 1964, she discussed the "C" grades on his report card. The mother called the teachers frequently at school and at home.

During the 1963–64 school year, Mrs. Youngs made herself known to the school administrative personnel by protesting Dr. Clements' appearance as a guest speaker at the Bale School PTA Study Club. In late November, Mrs. Youngs came to the principal's office in a huff and demanded the return of her daughter's report cards before we received records from Loveland, Ohio. She accused the principal of diagnosing her daughter as "Minimal brain dysfunction" sight unseen, on the basis of a report card. She went on to say that she had made long-distance calls (amounting to $60, something) concerning the use of drugs to stimulate children to learn. She mentioned the number of references which she had in her home library and the personal research which she was doing on minimal brain dysfunction. The school secretary was startled at this emotion-packed dissertation. The principal denied her accusations, which the secretary knew to be untrue. Mrs. Youngs left the office after receiving the report cards.

Mrs. Youngs made many contacts in the school community. She discussed her extensive research on learning disabilities and the use of drugs with anybody and everybody who would listen. She was tireless in her efforts to fight the cause of learning disabilities. Most people were polite but ignored her pitch; however, she found a few sympathizers. She spoke of a story which she and her husband had written and about the contacts she had made. There was talk of Mrs. Youngs circulating a petition and of getting the teachers fired. Her activities and remarks were encroachments upon both the medical and educational professions; however, no one panicked at her threats or her ceaseless efforts.

We had a good school and an active PTA. Parents resented the unfavorable verbal attacks directed toward the school's operation—from the administrative level to the PTA. It was rumored that Mrs. Youngs would like to become a member of the Bale PTA Executive Board. After weighing the good against the bad, the nominating committee felt that this would be an excellent way for Mrs. Youngs to become knowledgeable of the good about the school and the school system as a whole. In the spring of 1964, Mrs. Youngs was invited to become parliamentarian of Hardin Bale JTA. She accepted, was nominated, and elected to this office. At the general meeting held on May 23, 1964, the officers were installed. Mrs. Youngs was absent but did not notify anyone that she would not be present. A good lady "stood in" for her at the installation. During the summer (without having officially served) Mrs. Youngs resigned. No reason was given for her actions. She was replaced on August 20, 1964, at the preschool PTA executive board meeting (verified by PTA minutes).

During the 1964–65 school year, Mrs. Youngs was not called to the school at least once a week for conferences; neither were her children tested constantly as she stated in her testimony. The following conferences were held with her daughter's teacher: October 14, 1964 (mother wanted to review past school records and the Metropolitan Achievement Test scores); April 28, 1965 (teacher and mother studied daughter's grades and decided on summer tutoring in the area of reading). On May 17, 1965, Mrs. Youngs requested a conference. Upon arriving, the teacher invited Mrs. Youngs to have the conference in the principal's office; the mother refused and left without a conference. (The administration had requested that the teachers of the Youngs' children hold future conferences in the principal's office.) The father requested a conference on the morning of May 21, 1965, to be held in the principal's office with administrative personnel, the teacher, and the principal. Due to her mother's surgery, the principal was unable to be present. At this conference, the teacher was accused of hiding some of the daughter's tablets and disposing of some of her papers. There were other nebulous remarks. This conference amounted to little more than humiliation of a fine dedicated teacher who had taught in this community for 10 years.

Upon the request of Mrs. Youngs, and at the direction of the administration, each teacher of the Youngs' children was asked to give written results of the Metropolitan Achievement Tests to the parents. This report was prepared by the school secretary on May 21, 1965.

On May 3, 1965, the superintendent conferred with the principal concerning complaints filed with him by Mrs. Youngs. It was absolutely astonishing how she had the audacity to bend anybody's ear who would listen—always with the same end results—unsubstantiated evidence and false accusations.

During the 1964–65 school year, the son's teacher held the following conferences with Mrs. Youngs: October 14, 1964 (discussed Metropolitan Test results; phonetic aids to improve his reading; and his reading grade); March 15, 1965 (discussed reading and the lowering of his grade to "D").

In the spring of 1965, Mrs. Youngs' son announced to the children at school that his mother and another mother were going to have the teacher fired. A patron, who was also a teacher in the school system, called the principal and later called the teacher to see if there was any basis to the rumor spread by Mrs. Youngs' son. Needless to say, the teacher was "bowled over" to think that she had been coming to school a half hour early each morning to tutor the son in phonics and reading, and this was her unjust reward from the parents.

In Mrs. Youngs' testimony, she states that the school curriculum was heavily supplemented by the principal and teachers. A more accurate description of our school's curriculum would have been "extra help for the underachiever and enrichment for the accelerated pupils." Our goal is, and always has been, to help each child work to his potential.

Mrs. Youngs states that she and her husband made many trips to the school administration office (during 1964–65). There is no reason to doubt this fact; however, there is reason to question her statement concerning total apathy on the part of the administration.

Our superintendent of schools is a very capable, well-qualified administrator, whose integrity is respected by both educators and the community; therefore, he needs no defense against Mrs. Youngs' defamatory remarks attributed to him. He is able to speak for himself. The same is true for Dr. Sam Clements and Dr. John Peters.

Mrs. Youngs stated that during this 2-year span (1963–65) her children made B's and C's on their report cards. This statement becomes authentic only after adding D's to the B's and C's (as verified by office copies of their report cards).

During the Youngs' final year at Bale School (1965–66) her son's teacher, Mrs. Fincher, held a conference on October 12, 1965, to discuss standardized test results and his weak areas of learning. (The mother refused to sign the conference summary.) On October 18, 1965, the teacher sent home a routine interim report to give the son's grades in spelling and reading for the first 6 weeks of a 9 weeks' period. (The mother signed and returned.) Another interim report was sent home on December 1, 1965, to let the parents know that their son had quit trying and was almost failing in spelling, reading, language, and math. On December 3, 1965, Mr. Youngs came for a conference concerning his son's lack of interest and poor work. The father discussed buying extra books to have at home as needed when his son forgot to bring his books home. The teacher told the father that the son was still playing and not finishing his work. The father requested that the son not be kept in at recess to complete unfinished work. (The father refused to sign the conference summary.) In January 1966, Mrs. Youngs called Mrs. Fincher to tell her that her son had decided to do better but that no matter how much better he did, the teacher would not raise his grades and that the parents couldn't convince him that the teacher would. (This was 2 weeks before report cards.) Mrs. Fincher sent home a written request for a conference on February 2, 1966. The mother sent a written reply stating that February 2 was not convenient for her, but she could come at a later date. Mrs. Fincher also helped the son before school in the mornings, sent notes when requested by the mother, and went far beyond the call of duty to help the son; she lacked parental cooperation.

In Mrs. Fincher's classroom was a little wooden screen, 4 by 4 feet, behind which was a pupil's desk and chair. The pupils called this their private office where they could go to work quietly; they loved to occupy the center. A colorful "No vacancy" sign indicated when it was in use. This was a very popular station, and every pupil was eager to have his turn behind the screen. (Sitting at this study center was strictly on a voluntary basis.) Then one day Ross sat at the station; the mother heard about it and called the teacher. The mother was very rude and abusive. An attempt was made to explain the use of the station behind the screen—but to no avail. The principal did not say (as stated by Mrs. Youngs)

that the box had been removed because some of the parents were going to build wooden partitions. As a matter of fact, the little wooden screens had been in use for 2 years and were originally constructed by a father.

Mrs. Youngs' story about her son being placed in a cardboard box for 2 weeks is absolute fiction. There is not an ounce of truth in it. There was never a cardboard box.

I do remember that Mrs. Youngs came to school and sat in her son's classroom taking notes, but I was unaware that she was removed by two administrative officials. Neither does the teacher nor the administrative personnel remember such a "prearranged episode" as stated by Mrs. Youngs in her testimony.

Mrs. Nelsen, the daughter's fourth grade teacher, sent home an interim report on October 12, 1965, to request a parent-teacher conference on October 14, 1965. The mother refused to sign the report and return it, but she sent word she would come. The daughter was quite upset—torn between home and school. At the conference on October 14, 1965, Mrs. Nelsen discussed 16 points with the mother. (The teacher's preconference notes are on file as well as the conference summaries.) This is the date that Mrs. Youngs went into a rage—not about the cardboard box as stated in her testimony. The mother refused to sign the conference; she was using very abusive language—making threats and promises. The teacher invited the mother to go with her to the office where she related what had happened. In a fit of anger, the mother threatened "to slap a lawsuit on anyone who instigated special testing for her daughter." She said that this was not a threat, but a promise. She stated that she would love to exploit "this" in court and bring unfavorable publicity to Bale School and the Little Rock school system. This vociferous tirade was not only witnessed by the principal and teacher, but also by another teacher and sixth grade student in the adjoining healthroom. The principal demanded that the mother leave if she could not use proper language and act like a lady. Shaking and crying, she stated that she couldn't take more and departed.

A followup conference was called the next day to include the assistant superintendent, Mr. and Mrs. Youngs, the teacher, and the principal. Mrs. Youngs did not attend; the father said that the mother was too emotionally upset to come. Mr. Youngs knew only what the mother had told him, so the teacher reviewed all the facts leading up to the mother's tirade. The assistant superintendent let it be known that school personnel did not have to tolerate such intimidation. He pointed out that the children were in a good school and had good teachers who were trying to help them.

On April 13, 1966, a telephone conference was held with Mrs. Youngs. The teacher made suggestions for summer study and discussed the daughter's weaknesses. She suggested that the parents use a more positive approach to home study and grades and to use less depriving methods. Mrs. Nelsen also sent notes home at the request of Mrs. Youngs. The teacher was most willing to do whatever she could, but she felt that a part of the daughter's problems stemmed from the home. On May 20, 1966, the teacher prepared a written evaluation of the daughter's weaknesses and her needs; she included suggestions for helping the daughter during the summer even though Michele would not be returning to Bale School.

When Mr. Youngs came to check his daughter out of school, he thanked the teacher for her help, and the daughter embraced her teacher in departing.

The draft of the letter on page 3 of Mrs. Youngs' testimony was not sent to the principal or teachers at Bale School; however, the school administration agreed to honor the mother's request about special testing, even though parental permission is not required for such a test. The request for a special test is initiated by the teacher when she feels a need for such an evaluation in planning a child's program of study. The teacher fills in the request form and sends it to the principal, who approves the request by signing. The tests are scheduled through the Special Services Department of the Little Rock School System, and a psychometrist is sent to the school where the individual evaluation is administered. On at least one of Mr. Youngs' trips to the administration office, a psychometrist explained to him the difference between an individual evaluation and standardized group testing.

Never did the principal or other school officials contemplate using the Youngs' children (or any other children) in a trial court case to see if children could be put in any kind of program without parents' consent. Neither was there ever a threat by the principal to record "minimal brain dysfunction" on the children's permanent record cards. However, we were instructed by the administration to

base the grades for the last reporting period on 7 weeks of the last 9 weeks' reporting period, and to indicate what the classification for the next year would have been had the children remained in Bale School until the end of the school year.

Over the 3-year period, the mother initiated the majority of the telephone calls. She felt free to call the teachers at home as well as at school, concerning her son's and daughter's progress—or to call the school administration. The daily notes, of which the mother spoke, were requested by her. Even though time consuming, the teachers tried to work with Mrs. Youngs in every way possible.

As we read Mrs. Youngs' testimony, we asked ourselves if she really believed what she had written. Also, it gave some insight into her thinking, her suspicions, her obsessions, and her activities—and most of all, why her children might have had problems. The whole testimony was sickening!

It is indeed unbelievable that Mrs. Youngs could have made so many contacts during her stay in Little Rock, Ark., yet could get no one to pursue her story; then more than 4 years after leaving the State, she finally located someone naive enough to exploit her defamatory statements in a sensational hearing. It is not only incredible, but appalling to think that any Government official in a position of trust and leadership would permit such libelous, erroneous information to become a matter of public record when he could have affirmed the validity of the facts presented in her testimony upon receiving her prepared remarks prior to the hearing. It should have never happened!

If this testimony cannot be expunged from the record, it is requested by the teachers and principal that this answer be filed with the document, containing her statements, to refute her testimony.

Mrs. ROY S. LEMAY,
Principal, Hardin Bale School, Little Rock, Ark.
Mrs. ROBERT L. FINCHER,
Mrs. JUANITA E. NELSEN,
Miss GLORIA A. SUITT,
Mrs. HATTIE BELLE CARUTH.

PROVIDENCE, R.I., *October 6, 1970.*

Hon. CORNELIUS C. GALLAGHER,
Chairman, Subcommittee on the Right to Privacy, Cannon Office Building, Washington, D.C.

DEAR MR. GALLAGHER: I was very glad to read a news item in the Providence Evening Bulletin of September 20, 1970, regarding your committee's investigation in the area of cortical stimulant drugs for problem children.

As former director of the Providence Child Guildance Clinic, as consultant in child psychiatry at the Child Development Center of Rhode Island Hospital, supervisor of trainees in child psychiatry at the Emma Pendleton Bradley Hospital and my private practice, this has been a matter of great personal concern for over 10 years.

I am very aware that a great deal of abuse in the utilization of these drugs has existed and that in an increasing number of cases, teachers and other nonmedical professionals, as well as parents of children with learning problems, exert considerable pressure on physicians to prescribe these drugs, sometimes with rather cursory evaluation of the circumstances.

Physicians themselves have been oversold on the appropriate use of and indications for these medications, which, of course, are very specific and definite in a percentage of these children when they have been thoroughly evaluated.

It is important to single out two drugs in the category of cortical stimulants which are most frequently used and abused. One of them is dextro-amphetamine (more commonly known as "Speed") and the other, methylphenidate hydrochloride. Recently, one of the drug companies which produces the second drug mentioned has been on a low key campaign of promotion of drugs in the management of the problem child and the hyperkinetic child aimed at teachers (by means of films) and at clinical psychologists (by means of exhibits at psychological association meetings (not medical meetings). This is directed at increasing the frequency of requests for the use of medication in the handling of these children.

As a result of this, a delegate of the Rhode Island district branch of the American Psychiatric Association to the assembly of district branches of the national association, I am planning to introduce a resolution strongly opposing the sort of promotion previously mentioned.

The next meeting of the assembly of district branches will be held the latter part of November in Washington, D.C., and at that time I shall be very pleased to meet with you for further discussion of this very important matter if you so desire.

Sincerely yours,

HECTOR JASO, M.D.

AUGMENTATION RESEARCH CENTER,
STANFORD RESEARCH CENTER,
Menlo Park, Calif., July 2, 1970.

Hon. CORNELIUS GALLAGHER,
House Office Building,
Washington, D.C.

DEAR MR. GALLAGHER: I was shocked to read in the paper yesterday of the monstrous experiments which have been going on in Omaha, involving the administration of personality distorting drugs to large numbers of young children. And today's paper carried reports showing that this travesty is being carried out on a large scale in California as well, indicating that there is likely to be a nationwide trend toward this very sinister kind of drug abuse.

I see very little wrong in the practice of an adult administering mind-affecting drugs such as coffee, nicotine, alcohol, marihuana, LSD, mild amphetamines and barbituates, et cetera, to himself on a voluntary basis—we have to assume that he has weighed the risks and benefits for himself and that he has the final, ultimate responsibility for determining how he wants to shape his own personality.

But to administer such drugs to vulnerable children in the absence of knowledgeable will is, to me, a crime of enormous magnitude. Particularly, when the excuse used for giving such drugs is to improve the childrens' ability to learn.

Every educator with the slightest knowledge of children as they really are knows that most of the problems children encounter in school have little to do with supposed deficiencies in their ability to learn, but are, rather, a product of the school environment itself. To cow little children into servility and silence by the administration of mind-dulling drugs is an unspeakable obscenity and a perversion of every value that most Americans hold sacred. To attempt to mold our young people—and children are people—into automatons which can be docilely processed by our educational system, rather than working to make the educational system more responsible and relevant to the needs of children, is a major step on the way to a police state of the kind envisioned by Orwell and Huxley.

I am pleased to see that you are also upset by this sad state of affairs, and I want you to know that you have my full support in carrying out the investigations which you have initiated. Thank you for your dedication to the basic principles of democracy and human decency which have been so badly neglected in recent times.

Sincerely yours,

WALTER L. BASS, *Research Engineer.*

[Reprinted from Federal Register of Aug. 8, 1970; 35 F.R. 12652, 12678]

TITLE 21—FOOD AND DRUGS

CHAPTER I—FOOD AND DRUG ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER C—DRUGS

PART 130—NEW DRUGS

SUBPART A—PROCEDURAL AND INTERPRETATIVE REGULATIONS

AMPHETAMINES (AMPHETAMINE, DEXTROAMPHETAMINE, AND THEIR SALTS, AND LEVAMFETAMINE AND ITS SALTS) FOR HUMAN USE; STATEMENT OF POLICY

Pursuant to provisions of the Federal Food, Drug, and Cosmetic Act (Secs. 502(f), (j), 505, 701(a), 52 Stat. 1051–53, as amended, 1055; 21 U.S.C. 352(f), (j), 355, 371(a)) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 2.120), Part 130 is amended by adding to subpart A the following new section:

§ *130.46 Amphetamines (amphetamine, dextroamphetamine, and their salts and levamfetamine and its salts) for human use; statement of policy*

(a) *Amphetamine and dextroamphetamine and their salts.*—(1) Pursuant to the drug efficacy requirements of the Federal Food, Drug, and Cosmetic Act, the National Academy of Sciences-National Research Council, Drug Efficacy Study Group, has evaluated certain dosage forms of amphetamines and other sympathomimetic stimulant drugs intended for use in the treatment of obesity and for other uses. The academy found that such drugs as a class have been shown to have a generally short-term anorectic action. They further commented that clinical opinion on the contribution of the sympathomimetic stimulants in a weight reduction program varies widely, the anorectic effect of these drugs often pleateaus or diminishes after a few weeks, most studies of them are for short periods, no available evidence shows that use of anorectics alters the natural history of obesity, some evidence indicates that anorectic effects may be strongly influenced by the suggestibility of the patient, and reservations exist about the adequacy of the controls in some of the clinical studies. Their significant potential for drug abuse was also cited.

(2) In addition to those dosage forms that were reviewed for efficacy by the academy, other dosage forms of amphetamine drugs are on the market that were not cleared through the new drug procedures. While certain amphetamines were marketed prior to enactment of the Federal Food, Drug, and Cosmetic Act in 1938, some of the conditions of use now prescribed, recommended, or suggested in their labeling (for example, for the treatment of obesity) differ from uses claimed for the amphetamines before said enactment. Such uses have not been cleared through the effectiveness provisions of the Drug Amendments of 1962 (Public Law 87–781 which amended the Federal Food, Drug, and Cosmetic Act). These drugs are very extensively used in the treatment of obesity. The extent of use for such purposes as narcolepsy and minimal brain dysfunction in children is believed to be insignificant as compared with the total usage of these drugs. Because of their stimulant effect on the central nervious system, they have a potential for misuse by those to whom they are available through a physician's prescription, and their abuse by those who obtain them through illicit channels is well documented. Production data indicate that amphetamines are produced and prescribed in quantities greatly in excess of demonstrated medical needs.

(3) On the basis of the foregoing, the Food and Drug Administration finds that the current labeling of amphetamine or dextroamphetamine or their salts neither adequately reflects the present state of knowledge concerning their limited medical usefulness nor emphasizes the necessary warning information regarding their potential for misuse and abuse. Such drugs must be relabeled in accord with the information shown below. Amphetamines labeled as required by this section are regarded as new drugs and must be subjects of new drug applications.

(4) Pending conclusions reached pursuant to information that may become available through new-drug applications or other sources, the labeling of orally administered amphetamine and dextroamphetamine and their salts should be substantially as follows:

AMPHETAMINE AND DEXTROAMPHETAMINE—AMPHETAMINES HAVE A SIGNIFICANT POTENTIAL FOR ABUSE. IN VIEW OF THEIR LIMITED SHORT TERM ANORECTIC EFFECT AND RAPID DEVELOPMENT OF TOLERANCE, THEY SHOULD BE USED WITH EXTREME CAUTION AND ONLY FOR LIMITED PERIODS OF TIME IN WEIGHT REDUCTION PROGRAMS

DESCRIPTION

(To be confined to a statement of the physical and chemical properties of the drug.)

ACTIONS

Amphetamines are sympathomimetic amines with CNS stimulant activity. Peripheral actions include elevation of systolic and diastolic blood pressures and weak bronchodilator and respiratory stimulant action. The anorectic effect diminishes after a few weeks.

INDICATIONS

Narcolepsy.

Minimal brain dysfunction in children (hyperkinetic behavior disorders) as an aid to general management.

Exogenous obesity, as a short term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction.

CONTRAINDICATIONS

Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines.

Agitated states.

Patients with a history of drug abuse.

During or within 14 days following the administration of monoamine oxidase inhibitors, hypertensive crises may result.

WARNINGS

Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued.

Amphetamines may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug dependence: Amphetamines have a significant potential for abuse. Tolerance and extreme psychological dependence have occurred. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with amphetamines include severe dermatoses, marked insomnia, irritability, hyper-activity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

Usage in pregnancy: Safe use in pregnancy has not been established. Reproduction studies in mammals at high multiples of the human dose have suggested both an embryotoxic and a teratogenic potential. Use of amphetamines by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and infant.

Usage in children: Amphetamines are not recommended for use as anorectic agents in children under 12 years of age.

PRECAUTIONS

Caution is to be exercised in prescribing amphetamines for pateints with even mild hypertension.

Insulin requirements in diabetes mellitus may be altered in association with the use of amphetamines and the concomitant dietary regimen.

Amphetamines may decrease the hypotensive effect of guanethidine.

The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS

Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central nervous system: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely, psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, other gastrointestinal disturbances. Anorexia and weight loss may occurr as undesirable effects when amphetamines are used for other than the anorectic effect.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

DOSAGE AND ADMINISTRATION

Regardless of indication, amphetamines should be administered at the lowest effective dosage and dosage should be individually adjusted. Late evening medica tion should be avoided because of the resulting insomnia.

1. Narcolepsy: Usual dose 5 to 60 milligrams per day in divided doses.
2. Minimal brain dysfunction:

a. Not recommended for children under 3 years of age.

b. Children from 3 to 5 years of age: 2.5 milligrams daily, raised in increments of 2.5 milligrams at weekly intervals until optimal response is obtained.

c. Children 6 years of age and older: 5 milligrams once or twice daily, increased in increments of 5 milligrams at weekly intervals. Only in rare cases will it be necessary to exceed a total of 40 milligrams per day.

3. Obesity: Usual adult dose 5 to 30 milligrams per day in divided doses.

OVERDOSAGE

Manifestations of acute overdosage with amphetamines include restlessness, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management of acute amphetamine intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

(5) Distribution of any such preparation currently on the market without an approved new-drug application may be contiued provided that all the following conditions are met:

(i) Within 60 days following the date of publication of this section in the Federal Register, the labeling of any such preparation shipped within the jurisdiction of the act is in accord with the labeling conditions described in this section. After said 60 days any such preparation labeled or advertised contrary to this section will be regarded as misbranded within the meaning of section 502 (f) (1) and (2) and (j) of the act, and will be subject to regulatory proceedings. New drug charges will be included in appropriate cases.

(ii) The manufacturer, packer, or distributor of such drug submits to the Food and Drug Administration, within 1 year after the date of publication of this section in the Federal Register, a new-drug application providing substantial evidence derived from adequate and well-controlled clinical investigations that the drug is effective for each of its labeled indications. Since the treatment of obesity necessarily requires a prolonged period of time, data in support of the drug's long-range effectiveness in this condition must be based on studies conducted over periods exceeding a few weeks; intermittent administration of the drug may be required. Such studies should also include data on long-term toxicity; for example, cardiovascular and central nervous system. Such information is essential for an evaluation of the benefit-to-risk ratio.

(iii) The applicant submits within a reasonable time additional information required for the approval of the application as specified in a written communication from the Food and Drug Administration or in a notice published in the Federal Register.

(iv) The application has not been ruled incomplete or unapprovable.

(v) The Food and Drug Administration has not, by publication in the Federal Register, announced further conclusions concerning amphetamines based upon information submitted in new-drug applications or other information available.

(6) The labeling of any combination drug containing amphetamine or dextroamphetamine or their salts which includes any of the same indications for use as are listed in the labeling in this section should be revised to reflect the substance of those parts of the labeling set forth in this section that are applicable to the amphetamine component. Combination products labeled as required by this section are regarded as new drugs and must be subjects of approved new-drug applications.

(b) *Levamfetamine and its salts.* (1) Levamfetamine preparations currently on the market are represented to be useful in the treatment of obesity. The Food and Drug Administration finds there is neither substantial evidence of effectiveness nor a general recognition among qualified experts that these drugs are safe and effective for such use. Accordingly, these preparations are regarded as new drugs requiring approved new-drug applications.

(2) Regulatory proceedings based on section 505 of the act may be initiated with regard to any such drug shipped within the jurisdiction of the act for which an approved new-drug application is not in effect. Those products claiming exemption from the efficacy provisions of the Drug Amendments of 1962 (Public Law 87-781; 76 Stat. 780 et seq.) under the "grandfather" provisions (sec. 107(c)(4) of that act; 76 Stat. 789) will be considered on an individual basis.

(Secs. 502 (f), (j), 505, 701(a), 52 Stat. 1051-53, as amended, 1055; 21 U.S.C 352 (f), (j), 355, 371(a))

Dated: July 30, 1970.

CHARLES C. EDWARDS,
Commissioner of Food and Drugs.

SPEECH OF CONGRESSMAN CORNELIUS E. GALLAGHER, CHAIRMAN, RIGHT TO PRIVACY INQUIRY, BEFORE NEW JERSEY STATE AFL–CIO AT TRAYMORE HOTEL IN ATLANTIC CITY, N.J., JUNE 4, 1970

I deeply appreciate the opportunity to address again the New Jersey State Convention of the AFL–CIO. In the past, we have met together in happier times and a particularly sorrowful note today is the tragic death of that great man of labor and America, Walter Reuther. It is hard to think of a time in our Nation's history when men of such compassion and wisdom are more necessary. Walter Reuther was a great leader of organized labor, but perhaps more important, he exercised a powerful moral leadership in our Nation.

I think it is entirely appropriate to consider the direction in which organized labor is going to move in the last third of the 20th century. I propose to discuss with you today a source of particular concern to me and why I believe it is of especially vital importance to labor's future. I will direct my remarks today to invasion of privacy and the very real threat posed to union members, collective bargaining, and the union movement by the new technology.

Let me illustrate this by a description of the actions of the Federal Government in dealing with F. Lee Bailey's leadership of the recent air controller's "sick out." One does not have to approve or disapprove of Mr. Bailey's conduct to be appalled at the weapons of the new technology which were used against labor by the Government.

The Federal Aviation Agency assembled records of Mr. Bailey's past public appearances, including news and television film, and requested Government psychiatrists and psychologists to create a personality profile on him. In addition, they collected Mr. Bailey's records of his dealings with Federal agencies in the past, specifically his school reports and the evaluations of teachers and counseling personnel. Armed with this collection of fact and fiction, of hard data and loose opinion, the Government's management people concluded that Mr. Bailey's major strengths and weaknesses could be played to, or manipulated by, the Government's bargainers.

It may have been a "sick out" by the controllers, but it was a "sick in" at the FAA.

This was the first formal recognition, to the best of my knowledge, that such traditional issues as wages and working conditions were less important than the personality and psychological makeup of a union's chief negotiator. Since the Federal Government sets the policy for private industry in so many areas, I regard it as perhaps one of the most significant turning points in the history of American labor relations.

With the approval of the Federal Government now given to such tactics, with the world's largest employer now endorsing the worst possible uses of the new technology in its relations with its employees, it is not at all hard to predict that virtually every labor negotiation will now have a "wild card" in it.

What is that "wild card?" It is the personal background and private characteristics of labor's representatives. It is the easy incursion into the allegedly secret planning sessions of the union's leaders. Ultimately, it is the destruction of the effectiveness of those who speak for the union.

And, naturally, if your elected representatives are stripped of their power to move aggressively and creatively in your own best interests, what will happen to the individual labor union member?

I say that he will be left defenseless against a united front of management which will be free to probe and pry into every part of his life. I think we may well see the return of a peephole in the wall of every latrine and a great increase in the use of such things as lie detector tests for even maintenance employees.

Truly, I suspect that the dawning of the Age of Aquarius will really be the dawning of the Age of Aquariums, in which everybody has to live most of his life in a fish bowl. And most American citizens will be entirely naked as their thoughts will be open to psychological testers, their beliefs open to lie detectors, and where even their blood can damn them forever.

"Come on, Gallagher," you may say at that point. Even their blood?

Unfortunately, I am telling you the truth, $300,000 in Federal funds are being used in a Maryland study to determine which young men have a XYY chromosome in their blood. There is a faint suspicion that type of blood is bad blood and that it leads to aggressive and anti-social behavior. Led on by the flimsiest possible evidence, your tax dollars are now being expended to take blood tests which may possibly show young men who someday may commit a crime.

Now, let us be very sober about this. We all know that some criminal behavior is not explained by the personal surroundings in which a young man may grow up. Some of our richest children turn to crime and delinquency and so if the bad blood could be identified as a trigger to such behavior, it might disclose young men who could be helped at any early age and diverted from future violence.

All well and good. But how has this program been administered? It seems that those now in the research phase, who may be identified as having the XYY, are not to be protected from the release of their names into the criminal justice system. It may be eventually conceivable that such a prediction of behavior, based on bad blood, may be reliable, but at this point in the study even the chief investigators in the program have told me that results of previous tests have shown nothing.

So based upon absolutely no solid fact, a cloud of suspicion is going to be spread over the future of any young man who has the XYY. In addition, the parents or guardians of these children were not informed of the purpose of the tests. It was only after my Privacy Subcommittee had expressed outrage that a consent form was employed.

But the misapplications of advanced research can always be usesd by unscrupulous men and their allegations that they base their opinions on science can dispel most traditions based on law and humanity. I would only ask you to consider how much more powerful the Government could have been in its negotiations with the air controllers, had it been able to whisper around the information that the aggressive F. Lee Bailey had the bad blood.

After all, based upon the opinions of doctors who had never even seen him in the flesh, the FAA did whisper around the fact that the guiding force of his career was "to destroy authority." How much more powerful such a description would have been if they could have added the fact that he had the XYY.

Surely here we can find one answer to that old question: "If you have nothing to hide, why be concerned about invasion of privacy?" You may not know it, but you or your children may have the XYY chromosome to hide. And I regret to say that the dangers of dictating an American's future by a drop of his blood are rivaled by what you or your child might see in an inkblot.

Again, I can hear many of you saying, "Come on, Gallagher." What possibly could be the danger to me or my children in what we see in an inkblot?

And once again, I regret to tell you that I am telling the truth. Yes, my friends you have another real and personal reason to become friends of privacy, for the most recent success of my Privacy Subcommittee has been to put the finishing touches on discrediting a proposal to psychologically test every single 6-year-old child in the Nation for possible criminal potential.

Every 6-year-old in the country was to be tested and, should he flunk, he would be subjected to massive psychological manipulation and, should he continue to be suspected of some sort of deviation, he would be sent off to a special camp for close order drill in conformity.

The greatest single difficulty we had in scuttling this bizarre thought was that most people regarded it as a joke. But it was forwarded, on White House stationary, to the Secretary of Health, Education, and Welfare. I am sure you will agree with me that you just cannot get any more serious than that in America.

I could go into great detail on this plan and about its proud parent, Dr. Arnold Hutschnecker. I could point out that the tests upon which he would have relied, including the inkblot, have been shown to be accurate only slightly more than 50 percent of the time. I could refer to the 1965 investigation of my Privacy Subcommittee and our discovery that certain tests would have concluded that Sonny Liston was effeminate and any leader of the Jewish faith was irreligious. I could point out that Dr. Hutschnecker has no children of his own and does not treat children in his practice.

But what I want to emphasize is that those were your own children Dr. Hutschnecker was proposing to rip from your wife's arms and send to "a romantic setting out West," as he describes it. It sounds more like an American Dachau to me.

By testing tots, the good herr doktor was really going to mop up moppets. He was seriously proposing to use an allegedly objective application of science to make very sure that only a certain kind of man, with a certain kind of outlook and background, could have any kind of influence in America.

This cast of his mind was revealed when he endorsed the concept that every man who holds or seeks a position of power—such as a Congressman or a union leader—in America should first get a mental health certificate. This would weed out anyone who deviated from somebody's norm and would assure that only one kind of person could ever be chosen by his fellow men to lead them.

I objected most strongly to that proposal because it would directly deny the diversity which is America's strength and also because I rather suspect that no one worthwhile could get such a Government stamp of approval. With all the troubles which holding public office brings, you have to be slightly unbalanced these days even to offer your name for a position of leadership.

When the Federal Aviation Agency's personality profile on Mr. Bailey was first uncovered, I immediately thought of those hospital and doctor movies we have all seen. I imagined the following phrase coming over the administration's intercom: "Calling Dr. Hutschnecker—Dr. Hutschnecker, report to the FAA, please."

For here was living proof that while his specific proposal may have been abandoned, the basis for its eventual widespread application already existed and a significant part of it was already in practice.

And so another specific answer is suggested to the question: "If I have nothing to hide, why should I be concerned about invasion of privacy?" You or your child may have had bad dreams the night before you faced the inkblot and without vigorous and effective concern over privacy, your family might have learned whether Dr. Hutschnecker was right in calling the camp "a romantic setting out West," or if I was right in describing it as "an American Dachau."

In fairness to the Doctor, I must mention that he is not the only man in America working on plans to freeze out the sense of personal freedom and achievement which is so precious in our society. For example, several years ago, I attended a seminar in which some of the most respected social scientists in our Nation seriously proposed to bug every single room in a federally sponsored low rent housing project. I strongly objected to that massive invasion of citizen's privacy and it was not done.

There is another point which must be made before this group and that is the broad range of threats against collective bargaining and the very existence of strong, effective labor unions. Every individual American and every union member has a real and vital stake in the preservation of his own privacy, but I contend that this is equally true for organizations as well.

As I have shown, the effectiveness of your leaders can be fatally damaged by invasions of their personal privacy, but there is also the question of the privacy of the discussions which must take place before the bargaining session begins. We all know that the first offer is not the final offer and the original demand may only hint at the direction in which a union's demands will go. These eventual positions must be secret for if they are known by the other side, you may be engaging in collective bargaining but the industry will destroy it by knowing everything in advance.

And the new technology can penetrate anything, anywhere, anytime.

The dawning of the age of aquariums means that rooms are really fishbowls and that something far more deadly than the Beatles' "Yellow Submarine" can surface and put its periscope into a supposedly private meeting. Wiretapping, eavesdropping, electronic surveillance, bugs, parabolic microphones, closed circuit TV cameras, remote control miniature satellites, the infinity transmitter—the range of the intrusive devices spawned by the new technology is immense, and powerful organizations can and have employed them to learn what they feel they must know.

It is interesting to recall that most of these devices have been developed for military and foreign intelligence-gathering operations. I am sure that most of you remember the not-too-far-distant days when the labor movement was considered an internal enemy. It is not at all far fetched to imagine a domestic version of the *Liberty* or the *Pueblo* cruising in those fishbowls I have mentioned.

Indeed, the whole thrust of the surveillance mentality which is now so powerful in Government and industry circles, seems to be to regard the American people as the enemy. Pointing to a fuzzily defined version of national security and playing upon popular fears, they push toward finding the criminal tendency in every American, just as Dr. Hutschnecker said he was "focusing on the criminal mind of the child."

This is not based on mere conjecture on my part. I was truly appalled to notice the other day that an Administration witness testified before a House committee that the total amount spent on foreign and military intelligence was $2.8 billion. Especially chilling was that this incredible figure did not include the budget of the CIA and the Department of State.

Let me repeat that amount: $2.8 billion, excluding the CIA and the Department of State. You don't have to be a radical or a militant to be outraged at that figure. All you have to be is an American concerned about the future of democracy and free government.

Let me expand further on what seems to be the war on our children and try to put invasion of privacy into a little broader frame. All of us who are parents have probably followed a very similar procedure as our own children matured. When our child was very small, he either slept in the same room with us or the door to his own room was always wide open. As he became older, we permitted more and more privacy until he would finally regard another room as his own and, in most families, had the right to firmly shut the door against even his own parents at certain times.

But the surveillance mentality thinks that that door must always be open and regards that room as always subject to spying eyes and all-hearing ears.

A compassionate mother and father have become a vindictive big brother. And big brother treats the rest of us exactly like babies.

So, if we want to be men and have the right to associate with other men in organizations such as labor unions, we are going to have to insist upon the right to close that door against the increasingly nosey, demanding, and dictatorial big brothers in our society.

This, then, suggests the final answer to the question: "If I have nothing to hide, why should I be concerned about invasion of privacy?"

We can only assure our hard won status as functioning adults and the victories won by organizations working for us, by slamming shut that door against the privacy invaders.

And I have succeeded in slamming shut that door against some of the privacy invaders in the past and I have been warning against these threats for many years. I was especially pleased to note that organized labor has commissioned a privacy study. The results from your work, so far, have reinforced my feelings about the lie detector and confirmed the facts disclosed by another investigation of my privacy inquiry: the incredible mass of records on the financial, social, and moral life of Americans now in the hands of the credit reporting industry.

So some people are listening to the often solo cry I have been raising for 8 years. But far too few share our concerns, my friends, and so I would appeal to you to communicate with your own representatives in the legislature and in the Congress.

For of all the many threats which face America, I continue to believe that invasion of privacy will affect each of us to a greater degree than any of the other great issues of our times.

If we are going to survive as a nation of free, mature, and independent men and not become a nursery of helpless, wailing babies, we must fight for our own privacy and for the privacy of our own organizations.

Let me remind you once again that it is your's and your children's beliefs that will allegedly be discovered by lie detectors; it will be your's and your children's future that will be destroyed by allegations of the XYY and bad blood; it will be your's and your children's opinions and thoughts allegedly uncovered by psychological testing.

And it will be your own leaders and your own unions which will be rendered powerless by a Government or a business firm which does not care for privacy. Let me again point out that the new technology allows them to listen in on a whole office, a whole factory, and even a whole city.

And our old friend, the computer, has now developed the capacity to weed a single conversation among thousands, a single voice among millions, and to make public a hushed, supposedly private conversation.

And so I appeal to you today to care for privacy—it is yours, and if you lose it, you will have lost everything. And all of us will have lost a great Nation.

Thank you.

[From the Congressional Record, Apr. 16, 1970]

GALLAGHER HAILS REJECTION OF PROPOSAL TO TEST EVERY AMERICAN CHILD FOR CRIMINAL POTENTIALITY

Mr. GALLAGHER. Mr. Speaker, I rise today to make what I fervently hope will be the final comments on the proposal to test all the Nation's 6-year-olds for criminal potential. The very fact that such a proposal was taken seriously by those in the highest levels of our Government is a source of great concern to me.

Yet, of course, it is easy to understand how men so burdened with the worries of our nuclear world could consider something allegedly based on sophisticated science. Perhaps the most serious damage done to our Nation by this now discredited proposal will be to cast doubt upon the valid use of the psychological knowledge.

I would urge those who see the absurdity in the specific proposal advanced by Dr. Arnold Hutschnecker not to transfer that feeling to the soundly based applications of advanced research. Our Nation needs every tool it can muster in the ongoing struggle against the ills which so obviously afflict our society.

But in this case, Mr. Speaker, the cure was more dangerous than the disease. I commend the Secretary of Health, Education, and Welfare for recognizing that fact and for reporting unfavorably on the proposal.

Mr. Speaker, I shall insert several news articles which describe the plan and the actions which have taken place since my privacy subcommittee began its investigation. I would call special attention to the fine article by Miss Judith Randall, prize-winning reporter for the Washington Star. She makes the point that conformity is as deadly as any of the pollutions now undergoing scrutiny at all levels of government. I am delighted that she says substantially the same thing I have said during the 6 years I have been concerned with invasion of privacy.

Privacy permits diversity. Privacy encourages the many different ethnic and intellectual traditions in America and privacy is really what stirs the "melting pot."

And privacy is now under massive attack. This is why I also insert an editorial from the Washington Daily News on the subject of testing young men for an XYY chromosome. I would merely comment that while HEW was rejecting a proposal which could result in preordained doom because of what a child saw in an ink blot, it is funding many studies which may do the same thing over a drop of blood.

I also insert an article from the Washington Star which describes a proposal recently made by Commissioner of Education James E. Allen. Commissioner Allen apparently approves of having local centers in school systems which "would know just about everything there is to know about the child."

It may well be, Mr. Speaker, that both of these thoughts have a great deal of merit and will not lead to the disaster which so clearly would have been the result of implementing Dr. Hutschnecker's proposal. I have, therefore, directed my subcommittee staff to study them both.

However, Mr. Speaker, I am reasonably confident that tomorrow's newspapers will bring to light proposals of equal complexity and containing similar dangers for a free society. I have proposed the creation of a Select Committee on Technology, Human Values, and Democratic Institutions for precisely this reason. I believe the Congress must have a fully funded committee whose sole purpose is to look beneath the surface of plans such as I have described and to assemble a sophisticated body of evidence in opposition to what appears to me to be the present campaign against the human spirit here in America. In light of the three proposals described herein, I would urge my colleagues in the House to look with favor upon the creation of a Select Committee on Technology, Human Values, and Democratic Institutions.

The quick and, hopefully, final disposition of Dr. Hutschnecker's plan should not blind us to similar and more modest ones which are going forward. It is relevant to recall that while my privacy subcommittee was able to halt the national data bank, hundreds of smaller versions are now operating with little or no privacy protection or procedures guaranteeing due process to the citizens whose dossiers have been automated.

Mr. Speaker, I again commend those who courageously resisted the seemingly inexpensive way to solve the Nation's ills offered by Dr. Hutschnecker and I insert the articles referred to at this point in the Record:

[From the Washington Post, Apr. 16, 1970]

CRIME TEST FOR TOTS REJECTED BY HEW

(By Robert C. Maynard)

A proposal made to the White House that all of this country's 6-year-old children be psychologically tested for their criminal potential has been deemed unfeasible by the Department of Health, Education, and Welfare.

HEW said its view of the proposal, made to President Nixon last December by Dr. Arnold Hutschnecker of New York, is "most unfavorable."

Representative Cornelius Gallagher, Democrat, of New Jersey, was informed of the HEW rejection by a White House official last night. Gallagher informed HEW and the White House yesterday of his intention to hold hearings on the Hutschnecker proposal.

White House staff members would only confirm the report that HEW has rejected the proposal. It was sent to HEW on December 30 by John Ehrlichman, the President's assistant for domestic affairs.

Details of the rejection were also unavailable from HEW, which was asked by Ehrlichman to advise the White House on the "advisability of setting up pilot projects embodying some of these approaches."

The approaches of Dr. Hutschnecker to the problem of urban crime are tests for all children between the ages of 6 and 8. Those children found by the tests to have a potential for criminal behavior would be treated through a massive psychological and psychiatric program.

"The hard core," Dr. Hutschnecker said, "should be confined to camps where they would learn more socially acceptable behavior patterns."

Psychiatrists and psychologists have denounced the plan as "ridiculous," ignorant," and "Frankenstein fiction." HEW has remained silent for the 10 days since Dr. Hutschnecker's memorandum to President Nixon came to light.

Gallagher, chairman of the House Special Subcommittee on Invasion of Privacy, said last night that his staff notified the administration that hearings on the Hutschnecker proposal were being scheduled for April 24 and that eminent psychiatrists and psychologists were being invited.

Gallagher said he asked the administration if it wished to be represented, noting that he also invited Dr. Hutschnecker to testify.

The White House staff, in a conversation early last night, informed Gallagher that HEW had given the plan a failing grade.

But there was no official word from the White House that the plan is dead. In an interview Monday, Dr. Hutschnecker said that while HEW has been studying his proposal, he has been having discussions with members of the White House staff on the question of what kind of test to select for use.

[From the Washington Star, Apr. 16, 1970]

CRIME-TENDENCY TESTING AT 6 REJECTED BY HEW

A proposal by President Nixon's former physician that 6- to 8-year-olds should be tested to determine whether they have "violent and homicidal" tendancies has received an unfavorable report from the Department of Health, Education, and Welfare.

The department had been asked by the President's counsel, John D. Ehrlichman, for its opinion on setting up pilot projects suggested by Dr. Arnold Hutschnecker, an internist who treated Nixon in the 1950's.

Hutschnecker had urged mass psychological testing and a variety of treatment facilities, including residential camps for "the young hard-core criminal."

Last night, Representative Cornelius E. Gallagher, Democrat, of New Jersey, whose Subcommittee on the Right to Privacy planned a hearing on the Hutschnecker proposal, said he had been informed by the White House of HEW's negative recommendation.

"I have tonight urged the President to accept the HEW report," Gallagher said. "If he does so, I see no need to hold the hearing."

The White House today indicated that HEW's opposition to the Hutschnecker proposal probably would end any further consideration.

Last week, three leading professional organizations criticized Hutschnecker's proposal, saying psychological tests for young children are of doubtful predictive value and that Hutschnecker is not a certified specialist in psychiatry.

[From the Washington Post, Apr. 14, 1970]

Doctor Pushes Crime Tests for Tots

(By Robert S. Maynard)

The New York physician who has proposed to President Nixon the testing of all 6-year-old children for future criminal tendencies said last night that he has been discussing with members of the President's staff specific tests that could be used to carry out the proposal.

Dr. Arnold Hutschnecker said he could not reveal the names of the White House staff members with whom he talked. But he added:

"There are a variety of tests and we are now in the process of narrowing it down to the most reliable and the one that will cost the least."

The White House sent Dr. Hutschnecker's suggestion to the Department of Health, Education, and Welfare on December 30. Secretary Robert H. Finch's office has said the Department is still considering what response it will make to the White House.

Dr. Hutschnecker, whose proposal first came to light 10 days ago, has been roundly condemned by the scientific community for advocating "Frankenstein fiction" and "the problem of crime."

Reacting to that last night, Dr. Hutschnecker said in a telephone interview from his New York office:

"It's a shame to see your labor of love turned into a sinister plot."

He said his proposal for confining hard-core youth in camps had been misunderstood. "I had children's camps in mind," he said, "a romantic setting like in the West, and with proper psychologists."

Dr. Hutschnecker said the President asked him last December to write a memorandum suggesting ideas for implementing the report of the National Commission on the Causes and Prevention of Violence.

Dr. Hutschnecker said he noted that the commission had concluded that the answer to urban crime is urban reconstruction. He said he supported that idea but felt that "urban reconstruction takes a long time. I felt testing would be a quicker way to determine who the future delinquents are."

In any case, Dr. Hutschnecker said, he feels that all children should be psychologically tested because he believes such tests will turn up emotional disturbance soon enough for therapy to be useful and effective.

"All children should be tested," Dr. Hutschnecker said. "The younger the better."

He said he does not treat children in his own practice and has no children of his own.

He was asked what he thought the public policy ought to be in cases where the parents of a child object to the universal testing he proposes.

"It is to the benefit of the child, his parents and the Nation," Dr. Hutschnecker responded. "It should be handled with delicacy. The voluntary approach is the most desirable. If there is resistance, then we have a problem that needs legislation."

Dr. Hutschnecker said his idea is that those children found to be disturbed be placed in group therapy because, "you couldn't afford individual therapy for children. And they conform better in a group."

He said he has been discussing several tests with the White House staff, but he said he is particularly impressed with a test developed at the University of Mexico by Dr. Robert Hartman. He said the Mexican Government is employing the Hartman test.

He said the Hartman test actually tests the values of the subjects by asking them to state a variety of preferences along a sliding scale from great appreciation to great dislike.

Several professional associations in the field of social science have condemned Dr. Hutschnecker's work because predictive tests are thought to be highly unreliable, depending as they must, on the judgment of the person administering the test.

Furthermore, the American Psychiatric Association has said that Dr. Hutschnecker, although he has identified himself as a psychotherapist, is not qualified by the American Board of Psychiatry and Neurology.

Dr. Walker E. Barton, medical director of APA, also said there is no evidence that Dr. Hutschnecker's "proposal for the nationwide psychological testing of youngsters * * * has any support whatsoever from the profession of psychiatry."

[From the Washington Star, Apr. 16, 1970]

DANGERS IN "TENDENCIES" TESTS

(By Judith Randal)

Dr. Arnold Hutschnecker President Nixon's physician while he lived in New York, is not a psychiatrist and is well past middle age, so he may perhaps be forgiven for not being abreast of modern behavioral research.

The unfortunate thing is that his proposal to have the Government test all 6- to 8-year-olds for their "delinquent tendencies" was taken sufficiently seriously to be sent by John D. Ehrlichman, Nixon's chief domestic policy adviser, to the Department of Health, Education, and Welfare for further study.

The fortunate thing is that HEW opposed the idea and the White House indicated that would end any further consideration.

Hutschnecker seemingly is no Fascist—despite that fact that this is suggested by his recommendation of special camps for incorrigible teenagers and the general tenor of "strength through joy" that runs just under the surface of his memorandum, sent to HEW in December.

The text suggests quite sensibly that "many intellectually superior young people with ideals and enthusiasm * * * would be eager to serve a great cause and their country" as counselors in remedial programs. What Hutschnecker apparently is unaware of is that this sort of domestic Peace Corps activity already exists under the aegis of the VISTA volunteers fielded by the Office of Economic Opportunity, and merely needs expansion.

Less benign is his suggestion that tendencies can be spotted in 6- to 8-year-olds that will reliably predict their behavior as teenagers or adults and his assumption that manipulating people without altering their circumstances—the filth, the hunger, the underemployment, the illness and degradation that typify our crime-breeding slums—will bring law and order in its wake.

Who knows what will be criminal behavior a decade hence? Some things, to be sure, are always crimes—theft, for example. But the criminal status of others comes and goes. The group practice of medicine is regarded as the coming thing, for example, but it still is illegal in 22 States. Abortion has been regarded as murder since the 19th century; that judgment is changing now.

With the preponderance of blacks in our inner-city slums, furthermore, Hutschnecker's thinking, as a psychiatrist has pointed out, is racist in consequence, if not in intention. The failure to recognize that criminal behavior is an interaction between the individual's idiosyncrasies and the particulars of his environment is incredibly naive.

Hutschnecker implies that his plan is a "direct, immediate and * * * effective" alternative to "urban reconstruction." Given what is known about personality development, this just isn't so.

Which brings us to the predictive value of psychological tests. In the 1890's, an Italian physician, Dr. Cesare Lombroso, after a survey of prisoners, listed physical traits which he considered stigmata of degeneration and therefore conducive to criminal behavior.

He did not, however, look at the population at large for the frequency of such traits and then follow through to learn what percentage of them became lawbreakers. Although Hutschnecker would focus more on psychological than physical variables, the same falacy can be detected in the mass-screening measures he suggests.

The Sheldon-Glueck test he refers to, for example, which was devised in the late 1940's and early 1950's and is Lombroso brought up to date, has proved to be predictive no more than 50 percent of the time.

Much the same is true of the Rorschach test, which, in any case, was designed to be diagnostic rather than prognostic. It depends for its interpretation on what the subject sees in a standardized set of ink-blot shapes.

In the absence of continued observation of a child's actual behavior, such one-shot examinations deal with probabilities rather than certainties. To label a youngster as having criminal tendencies on this basis is to expose him to the risk of reactions from others that will make his test scores a self-fulfilling prophecy. Many children who are low achievers at school, for example, remain so because they sense that that is what is expected of them.

In his first public statement of the decade, President Nixon proclaimed the 1970's as the "now or never" years for recouping the quality of the environment.

Certainly, no one can quarrel with this aim. But if we fail to recognize that an insistence on conformity is every bit as much a threat to the ecology—to use that suddenly fashionable term—as pollution and overpopulation, we shall be, if anything, worse off in 1980 than we are today. One era's deviant is often the social visionary of the next.

[From the Washington Daily News, Feb. 3, 1970]

BOYS, BLOOD, AND BEHAVIOR

There is a new theory in some scientific circles that males whose blood cells carry an extra Y chromosome—producing the relatively rare "supermasculine" XYY pattern—may, for some as yet unfathomed reason be predisposed to violent criminal behavior.

Spooky, isn't it?

But worth investigating, particularly since the traditional explanations of delinquency—the broken home, the lack of discipline, love, and security, various other deprivations—fails to justify ALL of people who, despite having what would appear to be adequate advantages, simply seem to be "born bad."

All right. Someone having raised the XYY chromosome theory, why not try to prove it out, or lay it to rest? This is what Johns Hopkins University, with financial help from the National Institutes of Mental Health is about to do.

This is where it gets really creepy.

The blood of 6,000 delinquent boys confined to Maryland's correctional institutions will be tested for the extra chromosome in the next 3 years as well as the blood of 7,500 boys, age 2 to 18, from underprivileged Negro families in East Baltimore who are now enrolled, or will enroll later, in a free Johns Hopkins medical program.

Now as long as there remains any doubt as to whether or not an extra Y chromosome may be, in some sinister a fashion, a factor in telling a lad to scrag his sister or feed his employer into the sausage machine, it would seem incumbent upon any research team to take extraordinary precautions to safeguard the identities of the children it puts to the chromosome test.

Instead, Robert C. Hillson, director of the Maryland Department of Juvenile Services blandly confirms that names of these kids found to have the XYY thing will "probably be passed on to the courts for whatever use they can make of it."

We can see a judge, or a jury, trying to be impartial when informed that the wretched youngster in the dock has got the bad blood. And we picture the parents of a 2-year-old (parents' permission for the tests, by the way, has been largely overlooked) eyeing the potential little monster as he eats his cornflakes at breakfast. Good grief.

Two congressional committees, having read stories in the Washington Daily News about this study, are going to look into what Representative Cornelius E. Gallagher, Democrat, of New Jersey, chairman of one of them, calls "a terrible question of preordained doom for these guys."

Good. Someone should take a hard look.

[From the Washington Star, Apr. 15, 1970]

SET UP DATA BANKS, ALLEN URGES SCHOOLS

(By John Mathews)

U.S. Commissioner of Education James E. Allen, Jr. has outlined a plan for restructuring local schools that would include computerized data systems designed to help professionals "prescribe" programs for helping pupils and their families.

The closely structured and controlled approach he suggested calls for major evaluations of a child's problems and potential before he is 6 years old, then again at 11 and 15.

In his proposal, made yesterday in a speech to the National School Boards Association convention in San Francisco, Allen suggested each local school system should have a central diagnostic center "to find out everything possible about the child and his background" to plan an individualized program for him.

"FULLY INFORMED"

After test and home visits, Allen said, the center "would know just about everything there is to know about the child—his home and family background, his cultural and language deficiencies, his health and nutrition needs and his general potential as an individual."

The information would be fed into a computer for use by a team of trained professionals who would write a "prescription" for the child "and if necessary, for his home and family as well," Allen said. "If the home is contributing negatively to the child's development, it too should receive attention and aid."

Prescriptions for dealing with the child's problems and those of his family would be made by local health and welfare departments as well as the schools, Allen said.

At the high school level, the professional team, after consulting with the student and his parents, would prescribe a course of specialized study for him. The high school course would lead to college or other post-high-school training or employment.

OPPOSITION LIKELY

Allen's proposal, which he said was made to challenge school board members to think of innovative approaches, is likely to be challenged on several fronts.

Much concern has been voiced in recent years about the use of computerized data banks by governmental agencies. Some educators also say that predictive techniques, such as the one suggested by the commissioner, are dangerous in that they categorize a student too early in life.

Some critics may also see in Allen's scheme some of the elements of a plan proposed by Dr. Arnold Hutschnecker, President Nixon's former physician.

In a memorandum sent by the White House to the Department of Health, Education, and Welfare for comment, Hutschnecker suggested testing of 6-to-8-year-olds to determine their "delinquent tendencies." Professional organizations have condemned the Hutschnecker plan as scientifically unsupportable.

STATEMENT BY MARILYN P. DESAULNIERS FOR THE SPECIAL STUDIES SUBCOMMITTEE, HOUSE COMMITTEE ON GOVERNMENT OPERATIONS

Following Congressman Gallagher's statement in the Congressional Record concerning the reported use of amphetamines on schoolchildren in Omaha, I contacted his office and made available to Mr. Mark Belnik the attached report, as well as other materials and sources indicating Federal involvement in promoting and funding the experimental use of drugs on schoolchildren through education-mental health agencies.

The attached report, titled "The Functional Abuse of the Public Schools," describes the historical background for this activity, the philosophy in education which accepts it, and the nature of one "preventive mental health" activity—that is, family life education, which is designed to shape the attitudes and values systems of children in the public schools through the use of behavior-modification tools such as role-playing and sensitivity training in its varied forms—and to directly intervene in the parent-child relationship.

The methods by which this activity was introduced to the Virgin Islands, including the deceptive publicity techniques and use of Federal agencies, behind a "front" of volunteer or community activities, has been detailed in my "Report on the Functional Abuse of the Public Schools".

The tactics are not reassuring—and are identical with the introduction and promotion of the "overactive child" programs which use dangerous drugs on children in a climate of irresponsible professional harassment.

In fact, it is the common source, funding and philosophy of both these programs that made it possible for me to provide Mr. Gallagher's office with relevant materials on short notice—materials developed in my investigation of the organization and activity behind 7 years of personal encounters with unbelievable and shocking activities in public schools in Kansas, Maryland, Texas, and Virginia. One major area of concern involved "drug education" to which my child had been exposed.

My own background in advertising and public relations alerted me to the common promotional techniques present in each area of my own personal concern. A closer analysis revealed a multilayer campaign to "sell" these activities through every possible channel, including the news media. Moreover, the sell was always accompanied by an advance smear technique to label any opposition as peculiar members of odd ball religious groups holding extremist political beliefs.

An effective gag, gentlemen, in the mouths of anyone who opposes this abuse of the public schools—and the 50 million children compelled by law to attend them.

It is in the interest of identifying the common source, organization, and tactics by which such programs are imposed that I have prepared this statement, since it seems impossible to investigate a single activity—the "minimal brain dysfunction" programs—without a closer examination of the umbrella under which it operates. Moreover, the inability of individuals or groups outside this activity to protect themselves or their children makes an examination of the structure involved an imperative.

In the interests of brevity, I will refrain from more than an outline of these activities which have created, in effect, a second government in the Nation, blurring or eliminating the constitutional safeguards against interference in personal beliefs, attitudes, and activities where these do not violate the law through overt action.

I urge the committee to examine this structure and its activities in the interest of protecting the citizen and his rights of privacy and due process. And, I further ask that the committee include in its considerations the use of dangerous nonchemical behavior modification techniques which are currently being applied to entire school populations without the knowledge or consent of guardians—or, indeed, even against the expressed will of the guardian—through those same agencies involved in Omaha, Little Rock, and the family life-sex education material covered in my attached report. And, I emphasize again that family life education is a "mental health" activity in the schools.

A single example of dangerous, nonchemical behavior modification is "closed loop, video tape replay," a confrontation form of sensitivity training which will be required in the fourth to sixth grades of Fairfax County schools as a part of the new "family life" curriculum.

Concerning this form of psychiatric therapy, Dr. Ronald S. Reivich, Department of Psychiatry, University of Kansas School of Medicine, Kansas City, Kans., states that, despite the new availability of low-cost video tape hardware for this new technique, serious reservations must be considered. In the Journal of the Kansas Medical Society, 70(3) :101–104, 1969, he writes, "Although some clinicians have begun to employ video tape playback as an aid to treatment, there is neither impressive theoretical reason nor empirical data to justify this use except as an experimental procedure * * * cautionary observations on the adverse effects of carelessly or thoughtlessly programed self-confrontational experiences have been made." His article further describes the "stun" effect such techniques have produced in student doctors of psychiatry in environments under professional, medical control.

The effect of such powerful tools on the children in Fairfax County schools when implemented in the classroom by the teacher can be left to the imagination of the committee's members.

The methods by which these activities are introduced to a community stem from a series of Federal laws and the interest of Federal agencies in exploiting them. By regrouping existing governmental and local nongovernmental services into new forms, the education-mental health philosophy has acquired fantastic control over communities throughout the country. A brief demonstration of some of the forms such control takes should be helpful.

From the Federal level, title V of the 1965 Elementary and Secondary Eduation Act provides "grants to stimulate and assist States in strengthening the leadership resources of their education agencies and to assist these agencies in establishing and improving programs to identify and meet educational needs."

In addition to emphasizing State rather than local control of public education (see later reference to H.R. 11764) the consistent policy in the title III and title IV areas of this act indicate that the leadership development in title V would be directed to coordinate with and serve the title III mental-health approach. (See attached "Report on the Functional Abuse of the Public Schools.")

Again, the Federal Office of Education controls the Education Professions Development Act funds—and the report, "The People Who Serve Education," prepared by Harold Howe II, indicates the same philosophy and direction in the use of these funds. An example is the "high priority program" described as

well as through new terms added to existing legislation—an example being the inclusion of persons with personality disorders under those subject to treatment by the terms of the Narcotics Rehabilitation Act of 1966. And, what is a personality disorder? Who could be rehabilitated under this vague term? Children who are bored in school? Or their parents who feel the problem may lay in other than a psychological defect of the family? Who will define the limits of personality disorder? * * * And what sort of Orwellian society has been created with massive appropriations deceptively labeled "education" and "mental health"?

The faith of the National Institute of Mental Health in public reaction to its activities is best illustrated by the difficulty in obtaining information about their specific programs. An order still stands requiring all information officers to report weekly on any contact with the press.

Moreover, to fill the gap created by a "no information" policy, degrees in mental health journalism are federally created and funded, such as that given by the Kansas State University in Manhattan, Kansas under project director, Deryl R. Leaning. According to NIMH, "The 2-year program is geared to preparing the trainees for jobs as newspaper reporters, magazine writers, and information officers specializing in mental health, social problems, and human behavior. * * * The core of the program consists of two seminars that will focus on such issues as public attitudes toward mental illness, the role of the mass media in mental health reporting, and reporting techniques."

Since accuracy and truth have been the accepted role of the mass media in any area of reporting, one is forced to wonder what special approaches to mental health items are taught in these degree courses. The protection of the press under the first amendment is based on the need for full, factual news coverage. What sort of approaches are urged on young journalism students—perhaps with the explanation that the public would be unnecessarily alarmed by certain activities—which the student newsmen now understand to be in the public interest? Are these young people encouraged to use their positions for the sort of slanted treatment of health and mental health materials that we have all grown used to in commercial advertising? Is there a propaganda machine operating in behalf of this "thought control"?

And what of efforts to control from the top the varied social and civic organizations such as evidenced by the National Conference on Continuing Education in Mental Health (October 25 to 27, 1967) arranged by the National Institute of Mental Health Continuing Education Branch.

Enjoying the prestige of the Federal Government and control of billions of tax dollars, the education-mental health philosophy gained entree to individuals from a wide range of backgrounds (representatives of industry, universities, community mental health centers, continuing education programs, mental health administrators, and program planners, and agencies of local State and Federal Governments). That seems to be just about everybody who counts, right?

And, with this audience assembled by the prestige and power available to this Federal agency, the following policy was described: Emphasis was placed on the need for expanded and intensified effort in continuing education and the nationwide mental health program, especially the community mental health concept which requires vastly increased reservoirs on mental health manpower. Describing the changes in education wherein educators have abandoned formal education in favor of lifetime learning, this Federal agency urged these representatives to take part in this induced expansion—and made special note of the fact that a lot more money was available for it now.

(The complete description of the conference from which this excerpt is taken can be found on p. 7 of the March 1968 Mental Health Digest, published by the National Institute of Mental Health.)

This is money, power, and influence talking—all unaccountable to the citizen or taxpayer except through a proceeding such as this committee's hearings—and all grinding out propaganda with education and health money to discredit in advance any attempt to control these activities.

The power and influence of the allies thus acquired can only be hinted at in the recent Financial News item, by UPI Staff Writer Dean C. Miller, in the Evening Star, July 6, 1970. He writes, under the headline "Business Gearing To Profit From Boom in Education," the following paragraphs:

"New York—American business is preparing for an education revolution which will 'reshape the economy as well as the individual' in the next 30 years, according to the U.S. Chamber of Commerce.

"Salaries, construction, and other educational expenditures are expected to account for $1 out of every $4 spent in the year 2000. The U.S. Office of Education sees the educational sector generating 25 percent of the $2.4 trillion gross national product expected at the turn of the century.

"That figure today is only about 6 percent of a GNP of less than $1 trillion. So it's logical that big business is rushing toward the "super growth" sector of education-information.

"Seven major firms—RCA, CBS, General Learning Corp., Xerox, Litton, ITT and Raytheon—already entered the 'learning' industry by acquiring textbook publishing houses. Others are preparing to enter the educational arena."

Although this item does not mention them, two other giants of American industry are already committed to the course mapped out by Office of Education and the psychological education activities: IBM (through their Science Research Associates as well as the many computers involved in the programs cited in my attached report), and 3M, which is producing transparencies, and so forth, for sex education—among other "educational products."

And again, the involvement of such powerful segments of the private sector would make it difficult for individuals to affect a course so effectively tied to the health and well-being of GNP.

But perhaps the most frightening example of the restructuring of government at all levels in the interests of these single-minded activities is the lobbying of the bureaucratic agencies in favor of H.R. 11764, the State and Local Government Modernization Act of 1969.

The bill would provide $50 million and Presidential power (all of these agencies are branches of the executive) to grant program planning funds to the Governors of States in the interest of "modern government programs." Specifically, provision for State control of health, education, and welfare and the sort of regional governments best corresponding to HEW regional offices.

In selling the new Virginia Constitution, which includes these two provisions in articles V and VII, Governor Holton has let it be known that acceptance of this document by the voters in November is necessary if the State is to receive Federal funds for its problems.

The fact that the entire constitution, with the exception of three minor bond issues, is listed as a "yes" or "no" choice on the ballot is unfortunate. The repeated plea for the people of the State to endorse it "on faith," since there is not time to explain it fully, reminds one of the tactic called railroading.

Add the endorsement of NIMH, taken from materials prepared by the Legislative Services Branch, Office of Program Planning and Evaluation, NIMH, and the direction of these "modernizations"—which will, among other things eliminate local control of schools—becomes chillingly clear.

"To the extent that the bill would increase direct State support of such local activities as health, education, and welfare," states NIMH, "the mental health programs might fare appreciably better."

And, indeed, although education and health funds have been ingeniously used to create an organized control down through layer after layer of local communities, it would be more efficient if the major controlling efforts could be exercised at the State level—thus requiring only 50 focal points for the leverage, influence, and down-right coercion often exhibited in these activities listed as health—and as education—and as welfare.

Moreover, the creation of regional decisionmaking in a formal structure would effectively place these activities outside the influence of any normal, representative government such as State or county or township, and thus completely beyond control by the citizens of the area. A completely new form of governmental unit will have been created which owes its allegiance to no citizen, community or State, but only to its bureaucratic masters.

If this is the new federalism of which we hear so much, it needs much more public examination and explanation—but, whatever its name, it needs investigation and control by the only agency left to act for the people—the Congress.

This statement represents only an outline of the methods and organization through which activities such as those in Little Rock can take place. The normal channels have all been blocked against any attempt by parent or citizen to turn back the dangerous philosophy of mental health which now controls our education process. In defining what it is healthy to think and feel, the concept is arrogant. In imposing involuntary or coercive treatment through chemical or nonchemical behavior modification, it is totalitarian. In the use of education and

health funds to create machinery responsive only to its own philosophy, it expresses organized contempt for the American people and their elected representatives. The power of the vote has been devalued, since real power lies outside its influence.

In an attempt to deal with the situation in Omaha, I urge the chairman and the committee to consider how it was possible for such a problem to exist—waiting on a chance news item to offer the opportunity these hearings represent to so many for redress.

How many other situations like it have been buried by the combined activities of the organization outlined in this statement? And consider how long troubled citizens have looked in vain for help against a single philosophy that dominates nearly every area of their private lives.

The need for a committee, such as that proposed by Congressman Gallagher, to exercise legislative oversight in the areas of technology, human values, and democratic institutions is clearly demonstrated by the materials submitted to this committee in respect to the Omaha reports.

Further, a full-scale investigation of the activities of executive branch agencies, by the full Committee on Government Operations would seem a logical outcome of this hearing. Although these activities appear to have begun under President Kennedy, and grown under President Johnson, they continue to operate and gain impetus under President Nixon—indicating, perhaps, their nearly total independence of all elected officials including the Chief Executive himself, under whose supervision and control they are directly placed.

But, however the situation has developed, something must be done to remedy it. The supragovernmental apparatus itself could be retained by placing the regional offices of HEW at the disposal and control of the host States, retaining the core of expertise at the Federal level for its proper purposes of research and information, rather than the making and implementing of policies in which it has been actively engaged.

It should be further possible for legislation to be enacted specifically prohibiting the use of the nonchemical forms of behavior modification in any setting—clinical research, institutional or otherwise—without the express, voluntary consent of the individual toward whom it is directed or the legal guardian of that person if incompetent or a minor.

Additionally, it becomes imperative, in view of the techniques used in the changing of attitudes throughout State, local, and Federal agencies, that this legislation provide for loss of Federal funds to any community acting in violation of such a law, as well as criminal penalties for individuals violating it.

It is a difficult and complex situation—and one made more difficult to explain because of the massive propaganda campaign to label any criticism or opposition in terms designed to silence and isolate the critic. However, I give you my word that I am not a rightwing, radical reactionary * * * although I have often been called a loudmouthed liberal.

And, in defense of liberals, let me add that this is far from a liberal activity—in fact, the advent of a thought-control mechanism such as "mental health," no matter how humane or well intended, presents the greatest political prize in this country's history for whoever is ruthless and powerful enough to gain control of it. And the direction of such a mechanism by any single philosophy, no matter how benevolent, represents the death of diversity * * * and liberalism.

Thank you for your time and your consideration.

Appendix II.—Supplemental Newspaper and Magazine Articles Pertaining to Federal Involvement in the Use of Behavior Modification Drugs on Grammar School Children

[From the Scientific American, April 1970]

Hyperactive Children—Certain Children Are More Than Usually Restless, Noisy, Destructive, and Distractible—Their Behavior Appears To Be a Distinct Disease Syndrome That May Well Be Innate

(By Mark A. Stewart)

Parents and teachers have long been aware of a youthful syndrome that is succintly described in a short story in verse for children written a century ago (and here translated) by a German physician, Heinrich Hoffmann:

Fidgety Phil,
He won't sit still;
He wriggles,
And giggles . . .

at the dinner table, and when his father admonishes him, it only results in

The naughty restless child
Growing still more rude and wild.

Fidgeting in itself is hardly an unusual or alarming behavior in children, but it is a matter for concern when it is accompanied by a cluster of other symptoms that characterize what is known as the hyperactive-child syndrome. Typically a child with this syndrome is continually in motion, cannot concentrate for more than a moment, acts and speaks on impulse, is impatient and easily upset. At home he is constantly in trouble because of his restlessness, noisiness, and disobedience. In school he is readily distracted, rarely finishes his work, tends to clown and talk out of turn in class, and becomes labeled a discipline problem.

Clinicians developed an active interest in the syndrome during the 1918 epidemic of encephalitis in the United States. Among the children who were stricken and recovered from the acute phase of the attack, many later showed a catastrophic change in personality: they became hyperactive, distractible, irritable, unruly, destructive, and antisocial. It then began to be noted that the same cluster of behavior problems commonly occurred in children who had suffered brain damage from other causes, particularly from head injury or oxygen lack during or shortly after delivery. Hyperactivity therefore came to be called the "brain damage" syndrome. It has been found, however, that most children diagnosed as hyperactive do not have a history suggesting brain injury. An early history, for instance, of prenatal or birth complications that might have caused brain damage is no more common among hyperactive children than among normal children. Some clinicians still hold to the brain-damage theory, noting that many hyperactive children show suggestive signs such as clumsiness, squinting, and speech difficulties, but these symptoms might well arise from functional disorders of the brain rather than from structural damage.

The hyperactivity syndrome is not confined to children. Many adults exhibit the same cluster of symptoms. In adult life, however, certain of the basic characteristics—high energy, aggressiveness, lack of inhibitions—may be helpful in one's work, whereas in childhood, when one is *required* to sit still at a desk and concentrate on studies for long periods, the restlessness associated with the syndrome may be a great handicap and give rise to severe problems.

Many years ago Charles Bradley of the Emma Pendleton Bradley Home made the paradoxical discovery that stimulating drugs, such as amphetamine (benzedrine), tend to calm hyperactive children and improve their behavior. The drug enable such children to sit still, concentrate and get their work done. On the other hand, barbiturate sedatives, it has been found, tend to increase the restlessness of a hyperactive child.

My own interest in the syndrome developed from a more general interest in the chemical basis of psychiatric disorders. In the psychiatry clinic of the St. Louis Children's Hospital we had seen many hyperactive patients, and we estimated that about 4 percent of suburban grade school children were afflicted with this disorder. The syndrome suggested intriguing questions in basic biology. Is the hyperactive temperament hereditary? Does it have a basis in disordered metabolism? How early does it show itself in a child? Do children outgrow the troublesome behavior or do the problems persist through adolescence and into adulthood? As an approach to clarification of these questions I decided to study the natural history of the syndrome in children. With the help of associates at the Washington University School of Medicine and with support from the National Institute of Mental Health we undertook a program of investigations.

Our first project was to establish a systematic description of the nature and incidence of the symptoms as a base for follow-up studies of patients. For this purpose we selected a sample of hyperactive children and compared them with a control group of normal children. The patients were 37 schoolchildren (32 boys and five girls) aged 5 through 11 who were being treated in the psychiatry clinic of Children's Hospital; all showed pronounced symptoms of overactivity and inability to maintain concentration but had no chronic disease or special sensory defect. The controls were first-grade children who generally matched the patient group except for their younger average age. This age difference could be disregarded in comparing the two groups for symptoms of hyperactivity, because the hyperactive children had developed most of their symptoms before they entered the first grade.

Using a questionnaire that covered the child's present and past symptoms, his medical and developmental history, his school record and the family history, we interviewed the mother of each child in the patient group and the control group. The interview took between 1 hour and 2 hours, and as far as possible the replies to the questions were recorded verbatim. The answer for each symptom was later scored positive or negative according to predetermined criteria. For example, the answer to the question "Has he worn out furniture and toys?" was scored positive if the child had worn out a new bicycle in less than a year or if he had used his baby crib so badly that it could not be handed on to the next child. On questions that did not provide such objective criteria we looked for other forms of confirmatory evidence. For instance, to the question "Does he rock, jiggle, fidget?" the answer was scored positive only if the mother thought the child's behavior in these respects was very different from that of her other children and if other observers had remarked on the behavior. In most cases a symptom was scored positive only if the behavior had persisted over a period of years.

The results showed that the hyperactive patients were strikingly different from the controls. The differences were most marked on symptoms that have been accepted as particularly characteristic of the syndrome. For example, 81 percent of the patients were described as unable to sit still at meals, as against only 8 percent of the controls; 84 percent of the patients were said by their mothers to be unable to finish projects, whereas among the controls none was found to be lacking in this ability. Substantial percentages of the children in the control group were reported to be overactive, fidgety, overtalkative or given to teasing, but even in these necessarily subjective answers the control children had a much lower positive score as a group than the patients did. All in all the catalog of symptons indicated clearly that the patients were distinctly different in temperament from normal children.

Along with their fidgetiness and inability to concentrate the hyperactive children showed many forms of antisocial behavior. They were given to fighting with other children, irritability, defiance, lying, and destructiveness, and nearly half were said to be unpopular with other children. About one in four of the patients had been caught stealing (usually money from members of their family), and about one in ten had been guilty of vandalism, setting fires, cruelty to animals and truancy. Consulting their teachers, we found that half of the patients had had to be disciplined in school, more than a third had had to repeat grades and the same proportion had histories of repeated fighting in school.

The hyperactive children's troubles had generally started at a very early age. About half of the mothers had begun to notice that their child was unusual before he was 2 years old. We found no indication that the behavioral disorder was significantly related to complications in the mother's pregnancy or delivery, to a family history of mental disease or to absence of the child's parents from home; there was no statistical difference between the patients' family back-

grounds and the control children's in these respects. The patients did tend, however, to have a history of feeding problems, disturbed sleep and generally poor health in the first year of life, and many had been handicapped by delayed development of speech and poor coordination. All of this suggested the possibility of inborn difficulties.

We followed up this study of young children with a similar survey of teenagers who had previously been seen in our clinic for the same disorder. This sample consisted of 45 youngsters (41 boys and four girls) between the ages of 12 and 16. On the average they had first come to the clinic about 5 years previously, and all had definitely been diagnosed at that time as hyperactive on the basis of several symptoms. For the followup study we used a questionnaire for interviewing the mothers that was much like the one we had employed in the survey of the sample of younger children. In this case we added interviews with the teenagers themselves, asking them about their symptoms, their general behavior at home and in school, their attitudes toward school, and their self-evaluation.

Our interviews with the mothers indicated that these children had not changed much since we first saw them. Of the 45 teenagers 14 had deteriorated or at least not improved in behavior, 26 had improved somewhat and only five were said to be more or less free of their original symptoms. Most of the youngsters were still notably restless, unable to concentrate or finish jobs, overtalkative, and poor in school performance. A large majority were described by their mothers as being low in self-esteem and tending to feel picked on (questions that we had unfortunately neglected to include in the earlier study of young children). It turned out that the teenagers showed a distinct increase (over the younger sample) in impatience, resistance to discipline, irritability, and lying. Substantial proportions of them engaged in fighting and stealing, and deviant behavior such as running away from home, going with a "bad crowd" and playing hooky; drinking was not uncommon. In our interviews with the teenagers themselves, many said they found it hard to study and were not interested in school. A third of the mothers said their child was so hard to handle that they had seriously considered sending him away to a boarding school or an institution. Four out of 10 of the mothers could think of no career for which their child would be suited.

These youngsters were clearly abnormal, but not seriously so in the usual psychiatric terms. Three of the 45 have a record of antisocial behavior so extensive that they might be called sociopaths. The others are best described as individuals with personality problems.

We have not yet compared these teenagers with a control group. That their problems are not typical of teenagers' problems in general has already been indicated, however, by the results of a study by Jean W. Macfarlane and her associates at the University of California at Berkeley. They found that in a large sample of normal teenage boys from roughly the same socioeconomic background as our group the frequency of overactivity was only 17 percent; of irritability, 12 percent; of quarrelsome, 4 percent; of lying, 8 percent; of stealing, zero.

We have found evidence of another kind that hyperactive children start life with a temperament that is distinctly abnormal. In clinical practice I have been impressed by the frequency with which hyperactive children turn out to have had a history of an accidental poisoning early in life—usually before the age of three. This might be expected, because the medicine cabinet is a prime target for children's curiosity, and a hyperactive child is more likely than a normal one to get into such things as soon as he can toddle and climb. The question has considerable practical importance; if active children do indeed run a higher than normal danger of accidental poisoning, extra precautions to prevent access to drugs and toxins should be taken in such households. We decided to look into the facts concerning the extent of this hazard for hyperactive children.

Two medical students at Washington University followed up 90 young children who had been treated at Children's Hospital for accidental poisoning 6 years earlier. They interviewed the mothers and teachers of the children with our standard questionnaire for eliciting symptoms of the hyperactivity syndrome. At the time of the interviews these children were 8 or 9 years old. It turned out that a third of the 58 boys could be diagnosed as hyperactive, using fairly rigorous criteria, an incidence considerably higher than the 7-percent figure we have found in a control population of boys. We also sent questionnaires to the mothers of 80 hyperactive children visiting our clinic and to the mothers of an equal number of normal second grade children. Again the returns showed that 22 percent of the hyperactive children, as against only 8 percent of the controls, had had an accidental poisoning.

This finding, it seems to me, strongly supports the thesis that the syndrome manifests itself at an early age and that hyperactive children may be innately different from other children. It is consistent with the fact that 80 percent of the responding parents in our first study of young children in the early grades and 60 percent of those in our study of teenagers reported they knew their children were unusual before they reached school age. Alexander Thomas, Stella Chess and Herbert G. Birch of the New York University School of Medicine, who have made an extensive study of the behavioral development of children from birth, have found that certain patterns observable at a very early age foreshadow later disorders of behavior. The investigators conclude that many disorders may be traceable to inborn temperament.

In our own experience with hyperactive children in the clinic we have commonly found that the child's father had been troublesome as a youngster, that he may have dropped out of school and that as an adult he is characteristically restless and short tempered. Our interviews with the mothers in our first study did not disclose any significant difference between the patient group and the control group in this aspect of the family history, but the interviews did not actually yield much information on the subject. We plan to explore the question directly and in detail in further studies. An investigation at the genetic level is already in progress: A medical geneticist at Washington University is analyzing the chromosomes of a group of children from our clinic. This inquiry was prompted by the recent discovery of an association of aggressive antisocial behavior with a peculiarity of the XYY karyotype. This is a chromosomal abnormality in which a male is born with two Y chromosomes instead of one.

It seems highly significant that the hyperactivity syndrome is much more common in boys than in girls (the ratio in the various groups studied is six to one or more) and that boys are also afflicted more frequently with other behavioral problems such an infantile autism, reading disability and delayed speech development. There is every reason to believe these are inborn differences and not the result of biased treatment of boys by parents and teachers. Moreover, difficulties in reading and speech are often familial. It appears that some inherited eccentricities of behavior or learning may be sex-linked or that the male nervous system may be peculiarly prone to certain failures in early development; conceivably both of these hypotheses are true.

The idea that hyperactivity has a biological basis is further strengthened by the dramatic change in behavior produced in many of these children by a stimulating drug (such as amphetamine or methylphenidate). Under the influence of the drug the hyperactive child (in at least half of all cases) becomes quieter, exhibits a longer attention span and greater perserverance with assigned work, performs better in school and is generally easier to get along with. It has been found that amphetamine has a somewhat similar effect on the performance of normal adults who are assigned a boring or complex task. Russell Davis of the University of Cambridge reported, for example, that in an experiment along these lines men who were given the drug became absorbed in the task, apparently as a result of the focusing of all their attention on it. The stimulating drug, in short, seems to bring about a more acute and better-organized responsiveness to the environment.

It is known that the amphetamines act on the reticular formation in the brain stem, a key area controlling consciousness and attention. When amphetamine is administered to a subject, one can usually tell he is aroused simply by observing his behavior: he becomes more attentive, alert, and frequently more talkative. Objective evidence of "arousal" can also be seen in changes that occur in his brain waves as shown by an electronencephalogram. It is also known that amphetamine produces specific effects on the metabolism of norepinephrine, or noradrenalin, in the brain cells. Norepinephrine probably controls the transmission of nerve impulses by some key nerve cells; it is highly concentrated in areas such as the hypothalamus and brain stem, which have much to do with mood and awareness. In recent experiments Sebastian P. Grossman of the University of Chicago found that the injection of a minute amount of norepinephrine in the reticular formation of a rat lowers the animal's activity level and responsiveness; injection of acetylcholine has the opposite effect. Since amphetamine is known to stimulate the release of norepinephrine from nerve endings, it seems entirely possible that the drug's effect on the behavior of hyperactive children may be due to its action at this critical juncture. It may repair a deficit in the activity of norepinephrine or in some other way restore the normal balance of activity between norepinephrine and acetylcholine.

This idea gains credence from the fact that hyperactive children often behave very differently from their usual selves when they are under tension. A child who has been described by his mother as a demon may be an angel when he comes to the psychiatrist's office. Most hyperactive children tend to be subdued in a strange situation and to display their bad behavior only when they feel at home. The explanation may lie in a stress-induced release of norepinephrine in the brain cells. Thus a state of anxiety may produce the same effect as a dose of amphetamine—through exactly the same mechanism.

It has been known for many years that removal of the frontal lobes of the brain produces hyperactivity in monkeys. Harry F. Harlow and his associates at the University of Wisconsin narrowed down the critical area: hyperactivity and apparent distractibility could be produced in monkeys by removing a section of granular cortex toward the rear of the frontal lobe. In a related series of experiments George D. Davis of the Louisiana State University School of Medicine has found that the effects of lobectomy in monkeys can be reversed with a stimulating drug; it reduces the animals' overactivity and improves their concentration.

As a practicing child psychiatrist I am of course concerned primarily with treatment of the hyperactivity syndrome. Amphetamine and other stimulants produce such good results that it is tempting to base treatment on use of a drug. Its effect is only temporary, however; when the drug wears off, the child reverts to his usual behavior. Furthermore, continuance of the drug into the teens runs the danger that the child may overuse it or become a habitual drug user. We therefore employ the drugs only to enable a hyperactive child to make a good start in school and prevent him from becoming resentful and insecure. My colleagues and I devote ourselves principally to adjusting the environment to the needs of the handicapped child.

This approach entails giving practical advice to the parents and helping them to apply techniques of behavioral therapy. We also assist the child's teachers in planning ways to work around his difficulties in learning. Educating the parents and teachers in what the problems of hyperactive children are and how to handle them appears to offer the best hope for enabling the patients to grow up to be confident and happy in spite of the limitations of their temperament.

[From the Christian Science Monitor, Oct. 31, 1970]

SCHOOL STORM: DRUGS FOR CHILDREN

(By Susan Hunsinger)

WASHINGTON.—Are public schools "pushing" drugs to control the behavior of so-called hyperactive children?

"We've been harassed and pressured by the school for 4 years now to put our 9-year-old on medication—for hyperactivity—" says a southern California mother, "and we've refused for 4 years. Two family doctors have backed up our decision * * *."

At least 150,000 to 300,000 grammar-school-age children now get legal amphetamines from their doctors to curb "hyperkinesis." This term is one of 38 medical names for such symptoms as unruly behavior, short attention span, and "learning disability."

The National Institute of Mental Health estimates that there are up to 4 million "hyperactive" children in the United States who could benefit from these drugs, including Dexedrine and Ritalin.

"NO" NOT ACCEPTED

But Representative Cornelius E. Gallagher (D) of New Jersey, chairman of a House subcommittee which is investigating the situation, wonders if the definition of "hyperactive" has been stretched to "include merely overactive children who are bright but bored in the classroom."

Many parents, such as the one quoted above, have written the committee to complain of school pressure to get the medication for their children:

A Colorado mother says she reluctantly "caved in to the combined requests of the school nurse, the school psychologist, principal, and teachers" that she get medication for 6-year-old son's "learning disability."

The school will not accept a "no" from a family physician, complains a California mother. "Most every parent who has an overactive child in the school is told to go see the same pediatrician because that doctor knows what the school wants."

Several concerned parents said they had transferred their children to other schools. "My son's temperament and attitude toward school improved in 5 days," said an Oakland, Calif., mother who enrolled her "hyperactive" child in a private school.

Some parents, however, have written the committee to praise the effects of the drugs on their children's home and classroom behavior.

"Please don't be swayed," wrote a Washington state couple, "by those people who have denied their children treatment for a serious and 'treatable' problem."

Those parents who complain of school pressure may already have the law on their side, according to subcommittee aide Charles Witter. A few parents in Omaha, Nebr.—where the complaints first surfaced last July—may press lawsuits.

The Harvard Center for Law and Education in Cambridge, Mass., and the American Civil Liberties Union in Seattle are investigating grounds for possible suits on behalf of parents. "The purpose would not be so much to win these individual cases as to publicize the whole issue," says ACLU lawyer Edmund J. Wood. "The schools would probably be very embarrassed, and retreat."

The Gallagher subcommittee, which conducted hearings last September, is also considering a number of recommendations to regulate the prescription of amphetamines for "hyperactivity."

One possibility would be to require physicians to list all prescriptions for amphetamines with a Federal agency. Another would be to ban amphetamines completely and look for alternative medications and methods to curb "hyperactivity" in children.

GUIDELINE DIFFICULTIES

Meanwhile, acting on one of the subcommitee's recommendations, the Nixon administration has appointed a panel of scientists and pediatricians to advise parents and other pediatricians on the use of the drugs for children.

The panel's role will be to warn, not regulate. "Guidelines are difficult in this case"—which involves the doctor-patient relationship, explains Dr. Edward Ziegler, the Office of Child Development director in charge of appointing the panel.

Depending upon the panel's findings, the Gallagher subcommittee may hold more hearings in January.

The medical profession itself is divided on the suitability of prescribing amphetamines to calm "hyperactive" children. Some doctors stress that the condition is difficult to diagnose.

"These drugs have been greatly oversold and overutilized for children," says Dr. Hector Jaso, consultant in child psychiatry at the Child Development Center at Rhode Island Hospital.

PROMOTIONAL CAMPAIGN?

He says the center has found that "only one out of 20 children who come in have been correctly diagnosed as 'hyperactive.' For the other 19, we find other kinds of emotional problems."

Dr. Jaso charges that the pharmaceutical companies are promoting the overuse of drugs on "hyperactive" children. He says that CIBA, which manufactures Ritalin, "has recently been conducting a low-key campaign of promotion * * * aimed at teachers (by means of films) and at clinical psychologists (by means of exhibits at psychological association meetings)."

One such promotional film, he says, will soon be shown by the Greater Providence Chamber of Commerce.

Some medical experts, however, do not think the drugs have been overused for "hyperactive" children. These physicians suggest that the best indication of an accurate diagnosis is a child's positive response to the medication.

Dr. Leon Eisenberg, chief of psychiatry at Massachusetts General Hospital, says that two-thirds of the nearly 500 children he has treated for "hyperactivity" in the last 10 years seem "to learn better on medication."

In addition to the medical controversy, the use of drugs to curb "hyperactivity" raise questions of principle:

1. Does it promote drug addiction?

Amphetamines now rival narcotics as a drug of abuse among adults in the United States. But most medical experts assert that amphetamines are not physiologically addictive when used by preadolescent children.

"But regardless of whether these drugs are physiologically addictive," says John Holt, author of "How Children Fail" and specialist in learning problems, "the children will get psychologically dependent on drugs. To put this kind of label on a kid, telling him that he's a little bit crazy * * * unless he takes this pill * * * is psychologically harmful."

2. Does it cover up a child's real problems?

Mr. Holt is concerned that the drugs will allow overcrowded schools to continue to "put down" a child's natural curiosity and creative energy. School officials consider "hyperactivity" a disease, he says, "because it makes it difficult to run schools as we now do—like maximum-security prisons." Mr. Holt suggests that perhaps the teachers, not the kids, "are the ones who need the drugs."

Dr. Eisenberg responds that "some children in the school system really are hyperactive and need special medical help." But he adds that drugs are no panacea for children's problems.

In ghetto areas, where some medical experts estimate a 30 percent rate of "hyperactivity" among children, Dr. Eisenberg says "what we really need is food, health care, housing—not drugs after the fact to quiet the victims."

3. Is it the first step toward "1984"?

A number of educators think that the use of drugs to curb "learning disabilities" in "hyperactive" children may be only the first step toward an Orwellian world where drugs are used to affect everyone's learning and personality.

"If I could be sure it would stop here—that our experiments in behavior control would go no further, I might not be so disturbed," says Mr. Holt. "But could anybody who reads our behavioral experts today believe that it will? Why not wire everybody up so when he does something wrong, he gets a jolt of pain, and when he does something good, he gets a pleasant feeling?"

Those who advocate drugs for medically diagnosed "hyperactive" children do not deny the potential for drug overuse. But "the fact that a drug has a potential for abuse," says Dr. Eisenberg, "is not reason to deny it to people it can help."

[From the Evening Sun, Baltimore, Oct. 2, 1970]

USE OF TRANQUILIZERS BY CITY PUPILS REPORTED INCREASING

(By Sue Miller)

The use of amphetamines and tranquilizers to treat hyperactive children in the Baltimore city school system is increasing, Dr. James Ryhne, director of school health services for the City Health Department, said today.

And, Dr. Harrie M. Selznick the school system's superintendent of special education, acknowledged that there are no formal guidelines that spell out controls as to who should be responsible for administering these drugs.

GROWING RATE

In some cases, according to Dr. Selznick, teachers are dispensing the pills. In others, youngsters are carrying their bottles of pills to school and taking them or counting on their teacher to remind them when they should.

Dr. Ryhne said the drugs are being prescribed at a growing rate for city schoolchildren because private physicians and clinic officials are finding that more and more children have learning disabilities. These disabilities sometimes manifest themselves by hyperactivity.

CALMING EFFECT

"We need guidelines," Dr. Ryhne declares. "And we're working on them. We've had several meetings (city educators and health officials), but we have not been able to reach a concensus because of the complexity of the problem."

Dr. Selznick agrees that guidelines are needed and says representatives of the legal profession and teachers who are confronted with the problem should have a say in what is drawn up.

Although amphetamines stimulate adults, they have proved calming when used by children between the ages of 6 and 10, Dr. Rhyme says.

Pupils with learning disabilities are those who have behavioral or emotional disturbances or organic damage to the brain or some parts of it. They are not mentally retarded and often have a high I.Q.

WANTS IT STATEWIDE

The amphetamines, Dr. Ryhne said, do not work for all of these children, but when they do they allow them to fit into the classroom and even get better grades.

Dr. Selznick feels the guidelines are not only needed in the city system but throughout the State because the rules governing the use of drugs and these pupils vary from county to county.

But, last week, members of the State board of education turned a deaf ear to similar concerns and fears voiced by a former social worker who is serving as a member of the State advisory committee on the problems surrounding drug use and abuse in the State's public schools.

Mrs. Genevieve Fleury, wife of a Towson attorney, called for guidelines "to make sure the use of drugs is controlled and not indiscriminate."

WON'T REGULATE DOCTORS

The State board indicated it has little knowledge of drugs being used to tranquilize problem children in county schools, that, when given, the drugs are prescribed by doctors and that it has no intention of regulating doctors.

Mrs. Fleury wants a uniform policy that would not allow teachers or pupils to administed pills. She feels they should be dispensed by school nurses, following a doctor's prescription and with a parent's written consent.

WALL CLIMBERS

The former social worker says that normal, bright children could mistakenly be given pills when actually "they may need a gifted child's program rather than a drug that slows them down to get along better with a group."

"We do not want teachers administering the drugs since they are not medically trained," Dr. Selznick said. "But, it is our suspicion that some teachers who have had 'wall climbers' do assume this responsibility" ex officials.

"They may send notes to parents telling if they will leave a supply of pills with them they will keep them in their drawer and give them out when needed.

"But, this is not done with our sanction or approval."

BEFORE THEY LEAVE

He added, "It has been suggested that parents give their children pills just before they leave for school and enough to maintain them throughout the school day."

A problem, however, arises when some children require a pill at midday or else get completely unmanageable.

"At a time like this," Dr. Rhyne says, "it may be necessary for a child to take his own pill which has been prescribed by a doctor or for the teacher or principal to be responsible for administering it."

"To keep children in school, you have to make exceptions," he added.

NURSES FORBIDDEN

The city health department has directed school nurses not to give out the pills because they are not in the schools on a daily basis.

Dr. Selznick describes drug therapy as "a newly evolving field about which there are many questions."

One that has never been resolved, he said is: What is the relationship of extended drug therapy and addiction in later years?

[From Newsweek, July 13, 1970]

PEP PILLS FOR PUPILS

"I am horrified and extremely angered," thundered New Jersey Democrat Cornelius E. Gallagher on the floor of the House of Representatives last week. Gallagher heads the "right-to-privacy" inquiry of the House Government Operations Committee, and what had roused his rage was a Washington Post report that

3,000 to 6,000 youngsters in Omaha public schools were receiving "behavior modification" drugs to improve deportment and learning ability. "In Omaha, through drugs," the Congressman contended, "physicians are attempting to induce conformity."

Not everyone, however, felt the situation to be quite so big brotherly as all that. At issue was the use of stimulants (including amphetamines such as Dexedrine, and two newer drugs, Ritalin and Tofranil) to treat children diagnosed as suffering from hyperkinesis—the so-called "hyperactive child" syndrome. Typically, such children are restless, overactive, and have short attention spans. They not only do poorly in their own studies but also tend to disrupt the work of their schoolmates. The cause of the trouble—which afflicts roughly 4 percent of the Nation's school kids, according to one researcher—isn't known. But many psychologists and neurologists suspect that hyperkinesis involves failure of certain parts of the central nervous system to mature. Often, the disorder is accompanied by difficulties in reading and spelling, as well as other perceptual learning problems.

Calming.—The use of amphetamines to control hyperkinesis began in the 1930's, and many child specialists claim that drugs prove beneficial to at least half the children with this condition. "The drugs produce a significant increase in the degree of attention, learning, and perceptual functions," says Dr. C. Keith Conners, who, along with Dr. Leon Eisenberg, has directed a study of the drugs effects on Boston schoolchildren through the Massachusetts General Hospital's Child Development Laboratory. In this connection, he notes that stimulants have the reverse effect on children that they do on adults, calming them down rather than pepping them up. Moreover, Conners points out, the drugs do not produce dependence in children as they do in adults. Dr. Barbara Fish of New York's Bellevue Hospital doesn't believe the effect of stimulants on children is really as paradoxical as it seems. Many hyperkinetic children, she believes, are restless because they are bored and tired. "Amphetamines," she says, "seem to help simply by increasing alertness and relieving fatigue."

The widespread use of stimulants to treat Omaha schoolchildren is traceable to the proselytizing of Dr. Byron B. Oberst, a 47-year-old local pediatrician who learned of the benefits of such therapy at a Syracuse University symposium in December 1968. He passed the word among fellow physicians and school officials, and not long afterward a local organization called STAAR (skills, technique, academic accomplishment, and remediation) was established to spread information about drug relief for hyperkinesis. According to Owen Knutzen, superintendent of schools, there has been no formal program in the public-school system to urge the pills upon families with unruly children. But when a teacher observes a child who may be hyperkinctic, he may suggest that the parents consult the family doctor.

Suspicion.—The new vogue for drug treatment has been a source of alarm for a number of Omaha's parents. Mrs. Mack Thornton, for example, whose 10-year-old son started taking the pills last year, fears that the experience may lead to a ready acceptance of other drugs later in life. "I don't want my child to grow up," she says, "believing that as soon as things aren't going right, he can take a pill to make them better." Some children, too, have apparently been swapping their pills at school, leading the Omaha Medical Society to recommend that doctors administer long-acting drugs that could be taken in the morning before the child goes off to classes. And, almost inevitably, members of Omaha's black community have voiced the suspicion that the program is intended to reduce Negro children to a state of passive submission; one black mother complained that her son's teacher "badgered us for a month and a half" until she obtained a pill prescription.

School officials, of course, deny any racist intent, And while some teachers may have been overly zealous about recommending treatment, it is reportedly often the parents who are keenest on obtaining pills for their children.

Diagnosis.—Representative Gallagher has demanded to know whether Federal funds are being used in the Omaha program. And the Food and Drug Administration has promised to check on whether any U.S. drug laws have been violated. But central issues in Omaha seem to turn on the extent of the children's drug program and its degree of discrimination.

For the moment at least, the answers to both those questions lie buried in the records of Omaha's private physicians. But Oberst, for his part, denies that as many as 3,000 to 6,000 Omaha children are taking the stimulants; that figure, he says, is his estimate of the total number of youngsters in the city's schools with

learning disability. "If the drugs are being used on a wholesale scale," concludes one FDA physician, "for children who are not appropriately diagnosed or who might be just active boys, then I view it with alarm. But if they are being used with appropriate diagnosis and supervision—marvelous. They should be a help to a great many children."

[From the Reader's Digest, April 1970]

MIND RESEARCH: THE PROMISE AND THE PERIL

(By Fred Warshofsky)

(Exciting discoveries in the fields of learning and memory indicate that science is about to lay bare that most precious of man's possessions—his mind)

In a Baltimore elementary school, 52 fifth and sixth graders, all of them poor learners with behavioral problems, were presented each day with what the students called "smart pills." In reality, half the youngsters were receiving a potent stimulant known to have an "exciting" effect on the central nervous system. The other half received a placebo (a sugar pill) as a control measure. After a month, the two groups were switched.

In each test, the group receiving the drug always showed a significant improvement in their behavior, while the placebo-treated group showed no change. More significant, reports Keith Conners, who headed the experiment, the youngsters receiving the drug showed increased ability to concentrate and more motivation toward learning.

In another experiment, far removed from the classroom, a goldfish swam in one compartment of a tank that was divided in two by a plastic barrier that reached to within 1 inch of the water's surface. A light flashed on in the fish's compartment, and the goldfish immediately swam over the barrier into the other compartment. The fish was exhibiting learned behavior; it had been taught to swim away from the light by a University of Michigan biochemist named Bernard Agranoff.

Next Dr. Agranoff injected an antibiotic around the brain of the trained goldfish. The drug, puromycin, is known to prevent the manufacture of protein. After several days, the fish was returned to the tank and the light flashed again. The goldfish did not respond. From this experiment and many others, most brain researchers conclude that protein synthesis in the brain contributes importantly to learning and memory.

Indeed, the exact mechanism of the mind has become the target of a vast amount of research in laboratories around the world. Just where this research is leading, and how it will affect us and our children, no one really knows. "But I am convinced," says David Krech, professor of psychology at the University of California at Berkeley, "that in the relatively near future we will have chemical aids to brain functioning—'Get Smart' pills."

Such speculation, once labeled wild-eyed, is now considered logical by virtually every scientist working in learning and memory research. Thus they are eagerly seeking out the evanescent trail of memories, to learn how, where and in what form memories are deposited within the brain. In a short time, they have made remarkable progress.

Protein storehouses.—We have known for most of this century that brains give off an electrical current. In 1924, with the first use of the electroencephalograph, to record human brain waves, scientists began to learn a great deal about this electrical activity. They also came to suspect that memory itself functions electrically—that messages from the eyes, ears, and other sensory organs flow into the nerve cells, or neurons, of the brain, where they are noted and either stored as memories, dropped into some limbo and immediately forgotten, or sent back out to various parts of the body as signals for action. Repetition of an act or idea is assumed to produce a specific pattern of electrical activity in a given circuit of neurons—much as a path is worn through a forest by constant traffic.

Then, in the 1950's, brain researchers began subjecting trained animals to electric shocks to the brain that were expected to destroy memory. Surprisingly, the animals did not forget their training. Clearly, something other than electrical patterns was implicated in memory storage. It was at this point that the scientific discipline called molecular biology was turned to brain research.

At the University of Gothenburg, Sweden, biologist Holger Hydén trained rats to perform a variety of tasks. Then the animals were sacrificed and individual neurons that made up their brains were isolated and compared with neurons from the brains of untrained rats. It was quickly apparent that stimulation of any sort increased the production in the neurons of a chemical called ribonucleic acid, RNA. A less complex nucleic acid than DNA, the primary deposit vault of all genetic information, RNA acts as a messenger, carrying instructions from the DNA molecule in the nucleus of the cell to another part of the cell where protein is made. The RNA provides the instructions on just what sort of protein to build. After hundreds of trials and analysis. Heydén put forth the theory that sensory inputs cause both an increase and a change in RNA production, which in turn lead to the formation of specific proteins that serve in the storage and retrieval of information.

Some memory is strictly for short-term use, some for a lifetime, and researchers are learning that the mechanisms for the two are different. Dr. Samuel Barondes, of the University of California at San Diego, has been testing the idea that protein synthesis is essential to long-term memory. He injects a memory eraser, known to inhibit protein synthesis, into a group of mice and then trains them to run a maze. A second group is trained but doesn't get the drug. Both groups learn at about the same rate; 3 hours later they perform equally well. But after that the drug-injected group quickly begins to forget its training, while the control group, even 6 weeks later, remembers a great deal of it.

Counting cells.—Chemistry also seems to play a major role in the actual assembly and organization of brain cells early in their development. "While the fetus is young," explains Prof. Roger Sperry of Cal Tech, "the brain cells acquire and retain thereafter individual identification tags, chemical in nature, by which they can be recognized and distinguished from one another."

This theory was supported by a set of intricate experiments in which Sperry and his colleagues, working with living fish, severed and then scrambled the nerve fibers that connected their eyes to the brain. Unlike mammals, fish can regrow nerve-fiber connections. The scientists microscopically photographed successive stages in the regeneration process—and found that in each instance the scrambled fibers unscrambled themselves and regrew along their own particular original channels until they regained their original hookups.

It is now becoming apparent that a great many of the most complex components of behavior are built in, ready to function without benefit of experience. Just last year, Richard F. Thompson, a psychobiologist at the University of California at Irvine, found cells in the brains of cats and monkeys that could actually count!

This discovery came while Thompson and his colleagues were examining the response of certain cat brain cells to specific stimuli. A series of clicks would be sounded, and the cell under examination would fire off an electrochemical signal. At first there seemed to be no particular rhyme or reason to the timing of the response. Then Thompson noticed that a particular cell fired only after a series of seven clicks. If the series added up to five or six, the cell did not respond. If there were more than seven clicks in the series, the cell would fire at seven.

Eventually, Thompson found other cells in the cat brain that responded similarly to the numbers 2, 5, and 6. In monkeys, cells were found that would count from 2 to 9.

Do "counting" cells, and perhaps other specific learning function or "gnostic" cells, exist in man? Probably. "Children," Thompson points out, "seem to know a great deal without being taught. For example, infants will spontaneously sort objects into color categories."

Memory molecules.—The view that protein synthesis is at the seat of memory storage is not held universally. A persistent minority of brain researchers cling fiercely to a theory called chemical transfer. They believe that when two animals learn a task the chemical changes that occur in their brains are almost identical. Thus it should be possible to take the "memory molecules" from one brain and inject them into another, actually transferring the memory of one organism to another. Eventually they hope that these chemicals can be identified and synthesized, for then, says James McConnell, professor of psychology at the University of Michigan, "scientists might even be able to implant artificial memories in human beings. Obviously, education would be quite a different matter indeed if students could be injected with algebra memories or Spanish memories rather than having to read books or attend lectures."

In 1962 McConnell reported on experiments that he had performed with primitive flatworms called planarians. First, he conditioned the flatworms to curl up whenever a light flashed. He then ground up these trained worms and fed them to untrained planarians. The cannibalistic, but untrained worms, he reported, learned to curl up in response to the light far more quickly than did a similar, but less exotically fed, group of untrained worms.

The chemical that McConnell believes to be the carrier of memory is RNA, and in this he is fairly close to the mainstream of researchers. Still, his experiments aroused a storm of controversy which persists to this day. Some scientists claim not to have been able to duplicate the results; others say they can, not merely in worms, but in mammals such as rats and mice, and have spent years in seeking the elusive memory molecule.

Staggering implications.—Most psychobiologists do not share McConnell's views. But few of them will deny that something is going on. "One possibility among many," explains Prof. James McGaugh, of the School of Biological Sciences at the University of California at Irvine, "is that there are several effects of brain extracts on behavior. The extracts would conceivably contain biochemical substances which facilitate learning by stimulating the central nervous system of recipient animals." McGaugh and other researchers have found that in rats and mice the learning rate can be substantially improved by low doses of central-nervous-system stimulants such as pentylenetetrazol.

The implications are staggering "In the future," says McGaugh, "drug treatment of memory defects could become as common as drug treatment of allergies and emotional disorders."

"Who decides?"—At present, drugs to treat human learning deficiencies are being used only by psychiatrists and psychologists confronted with learning and memory problems in their patients that defy all conventional treatment. Meanwhile, science is beginning to close in on that most elusive of man's possessions—memory. Eventually researchers hope to understand the process well enough to duplicate or aid it. Some scientists also foresee the use of agents to stimulate specific learning areas. Explains Berkeley's David Krech, "Through a combination of psychology and chemistry we may be able to raise verbal abilities in some, arithmetical reasoning in others, artistic abilities in still others."

This raises awesome thoughts. "Who gets what raised?" asks Dr. Krech. "He who has the price of a pill? And who decides for whom? The parent, the huckster, the school board? On what basis do we make the decisions?"

Obviously, these are not simple questions. Just as obviously, they must be anticipated and solved before man gets to the point of providing intelligence in a pill.

[From Case Reports, March 1965]

A Specific Placebo Effect Encountered in the Use of Dexedrine in a Hyperactive Child

(By John F. McDermott, M.D.)[1]

The amphetamines have been found to be of value in the therapy of behavior disorders in children when problems center around hyperactive, distractible, impulsive behavior. While investigation continues toward better defining the exact pharmacological action of these drugs on the central nervous system, it is no less important to consider carefully "placebo effect" as another factor in determining the patient's response to the drug. Since children so frequently attribute magical powers to medicine, the understanding of this factor is of crucial importance.

After the physician has placed a child patient on drugs, he can usually determine how the child views the medicine simply by asking, during followup visits, how and why he felt the drug worked. Often, the mentally disturbed patient has already forgotten or distorted the doctor's initial explanation to him, and has developed his own personal theory. The answer not only gives the physician an idea of how important the placebo effect is in the response of this particular

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child to the drug, but also may provide additional insight into the child's specific areas of mental conflict. It is felt that the rather unusual circumstances seen in the following case report serve to emphasize this point.

Dick, an 8-year-old third grader, was referred to the Guidance Clinic because the school felt that his failing grades were caused by his hyperactivity, short attention span, and poor impulse control. At home he was described as disobedient, prone to temper tantrums and destructive outbursts. His parents related that he had been nervous and excitable since infancy. They felt that in many ways he reflected their own stormy personalities and chronically unsettled domestic life. Dick and his mother tended to pair off against the father, who in turn, was quite jealous of the "attention" his wife gave to his son.

Early history: Although there was a significant amount of bleeding during pregnancy, birth and delivery were uncomplicated and developmental milestones were all within normal limits. Dick suffered the usual childhood illnesses without sequelae.

Psychiatric examination: During the interview Dick was constantly in motion, sucked his thumb and related in a very immature fashion. He mentioned that he often got so angry at his parents that he felt unable to control himself. Much of his discussion centered around concerns he had about his adequacy in school work, baseball, etc., as well as general worries about growing up. Neurological examination was unremarkable except for some questionable difficulty with fine motor coordination.

The initial step in Dick's treatment consisted of placing him on Dexedrine 10 mgs. b.i.d. for symptomatic improvement of his hyperkinesis, to be followed by outpatient psychotherapy for Dick and casework for his parents. Unfortunately, however, after accepting the prescription, the family did not return to the clinic until 6 months later. At that time they reported that Dick's school performance had improved dramatically, both academically and behaviorally, and that he was much more relaxed and cooperative at home, in spite of the fact that their marital difficulties continued essentially unchanged. They attributed his improvement to the Dexedrine.

When asked about this, it quickly became apparent that they had misinterpreted the instructions at the time the medication was started. Instead of returning to the clinic for refill of the prescription, and other follow-up measures, they had chosen to believe that Dick had simply needed a "course of treatment," and so when the bottle was empty after several weeks they felt that therapy was completed. They related how eagerly Dick had counted the days until his treatment would be finished, and how, following discontinuation of the drug, his adjustment had continued to improve at the same rate as before.

When Dick was asked about the medicine, he said the pills had given him the dose of "strength" he needed—he could lift things easily, run farther, and hold his breath under water longer. He added that he was more confident of himself now and no longer had to worry about whether he was going to do well in spelling or at baseball.

Beyond the actual chemical effect of the drug, then, it appeared that Dick had made important psychological use of the medication in the service of his own emotional needs. It had, for the time being at least, made him feel stronger, more secure about himself in relation to others, and more adequate as a boy.

[From the Washington Post, Sept. 30, 1970]

FDA Warns Against Uses Of "Behavior" Amphetamines

(By Robert C. Maynard)

Federal Food and Drug Administration officials have warned physicians in Omaha, Nebr., against the use of two drugs that had been commonly prescribed there for the "behavior modification" of school children.

The revelation was among several that emerged in a long day of testimony in Congress yesterday on the use of amphetamine-type drugs to curb the behavior of "hyperactive" children.

Minutes after the FDA warning was introduced to the Right to Privacy Inquiry of the House Government Operations Committee, a Little Rock, Ark., physician testified that one of the drugs was among those used in his behavior modification program.

"That's one of the great concerns about the use of these drugs," said Representative Cornelius Gallagher (Democrat, New Jersey), chairman of the inquiry. "You are using drugs that FDA says are dangerous and you didn't even know the drugs were dangerous. We should suspend the use of these drugs for this purpose until more is known."

His remarks were addressed to Dr. John E. Peters of Little Rock, who said he uses one of the drugs, Tofranil, for children with learning disabilities.

Neither Tofranil nor the other drug, Aventyl, should be used in children, and the FDA said it "now specifically warns against such use." The agency advised Dr. Byron B. Oberst of Omaha of this in a letter on August 6. Dr. Oberst had been quoted in an article earlier in the Washington Post as saying that Tofranil and Aventyl were among several drugs he prescribed for modifying the behavior of children. The most common drug in Ritalin.

The FDA in its letter to Dr. Oberst emphasized that Tofranil's labeling specifically warns against its use in children. Its side effects include constipation, difficulty in focusing the eyes, precipitation of glaucoma, nausea, vomiting and mild symptoms of Parkinsonism, among others.

Aventyl, the agency reminded Dr. Oberst, had been relabeled to warn against its use in the treatment of children. Its known side effects include fall of blood pressure, tremors and bleeding into organs.

The FDA said in its letter that if Dr. Oberst wished to use these drugs in children, it would constitute an experiment and he would have to apply for a special permit.

Dr. Peters, head of the division of child and adolescent psychiatry at the University of Arkansas Medical Center, said he would suspend the use of Tofranil "until this is cleared up."

The discovery that the FDA had warned a doctor against the use of Tofranil in children came late in the day's testimony and after representatives of the agency had testified.

Dr. Dorothy Dobbs, the agency's Director of the Division of Neuro-Pharmacological Drug Products, was asked whether she had investigated the use of drugs for behavior modification in Omaha. She said she had telephoned Dr. Oberst and determined that nothing irregular was taking place.

Dr. Oberst is one of several physicians in Omaha involved in a program for children with behavior and learning disabilities. Many of the children had been placed on amphetamines.

It was well after the testimony of Dr. Dobbs and several other FDA witnesses that the existence of the letter from the agency's legislative liaison, M. J. Ryan was introduced by Theodore J. Johnson, a black chemist and Omaha resident. The letter had been addressed to Ernie Chambers, an opponent of the drug treatment approach to hyperactive children and an Omaha candidate for the Nebraska Legislature.

"I am very disturbed," Gallagher said after Johnson introduced the FDA's letter. He charged that the agency had said that "everything is hunk dory" about using amphetamine-type drugs in children, only for the committee to discover later that two common drugs in such treatment are declared dangerous for children.

FDA officials could not be reached last night for comment, but Gallagher said before the hearing recessed that the agency would be recalled later.

Sally R. Williams, preseident of the Department of School Nurses of the National Education Association, was among those witnesses who said she felt stimulant drugs were safe if given to children under careful condition.

But Gallagher hammered away throughout the day's testimony at the fact that amphetamines, commonly known as speed, are a common cause of drug abuse in the United States.

The FDA witnesses had said there was no evidence of a link between drug abuse and the administration of such drugs to children.

Don Warner, retired assistant superintendent of schools in Omaha, said he was concerned that the national attention had made it appear that the school system was dispensing drugs. He said only private physicians prescribe the drugs.

[From the Washington Post, July 22, 1970]

Student Pep Talk

(By Nicholas von Hoffman)

Look what they done to my brain, ma
Look what they done to my brain
Well they picked it like a chicken bone
And I think I'm half insane, ma

(from Melanie, Buddah Record BDS 5060).

Washington Post reporter Bob Maynard has discovered that between 5 and 10 percent of the first to sixth graders in the Omaha, Nebr., public school system are on speed. Speed being the generic name in the dope culture for all the amphetamines like pep pills or uppers as the druggies call them. The dope pushers in this instance are pediatricians and educational specialists who prescribe what they chillingly call behavior modification drugs for children whom they find difficult to deal with in the classroom.

Don't protest this development. It's too late. The awesome combination of organized medicine and organized education had decided that it's not phonetics, or the wink and blink system or any of that which will get Johnnie to read, it's dope that'll do it. In the January 1969, issue of Today's Education, the National Education Association's journal, you can read, "Biochemical and psychological mediation of learning is likely to increase. New drama will play on the education stage as drugs are introduced experimentally to improve in the learner such qualities as personality, concentration and memory."

They're right about "speed." It can increase concentration, not only in the "hyperactive child" but in everyone: "Perhaps the most curious effect of amphetamines is its capacity to induce behavior which is persisted in or repeated for prolonged periods. If the user is not too disorganized, the activity may, on the surface at least, be useful. Dwellings may be cleaned, automobiles polished, or items arranged to an inhuman degree of perfection," writes Dr. John C. Kramer, chief of medical research, California Rehabilitation Center, Corona, Calif. (Journal of Psychedelic Drugs, vol. II, issue II.)

Dr. Kramer continues by noting, "These activities may be partially complete when another compulsively pursued task intervenes. The behavior may be bizarre as in the elaborate but nonfunctional reconstruction of mechanical or electrical devices. * * *"

Dr. Kramer made his observations by studying "speed" freaks, amphetamine addicts who are loose on the streets, but what looks bizarre to Dr. Kramer and other sane people is grade A deportment in many grammar schools. For many a school authority the model student is one who persists in apparently useful behavior over prolonged periods but who may be interrupted and set compulsively to work on new, nonfunctional tasks. This is called concentration.

"Biochemical mediation of learning" may not be introduced without a few objections, however. The NEA Journal cautions us that, "The application of biochemical research findings, heretofore centered in infrahuman subjects, such as fish, could be a source of conspicuous controversy when children become the objects of experimentation."

This has already happened. A number of people around the country are commencing to object to their children being treated like halibuts, flounders, and walleyed pikes. One is a New Jersey Congressman named Gallagher (Cornielius E., a Democrat). Fot his pains he gets letters from doctors upbraiding him for not knowing his place as an ignorant layman. Here is a portion of one from a Columbus (Ohio) physician with many intimidating titles following his name:

"What do you know about the hyperactive child and about the problems that they have incurred in school? What do you know about the family that is besieged with phone calls from irate teachers that the child is destructive, uncooperative, has a short attention span, won't learn? * * * Problems of taking care of children, their medical needs, should rightfully be left in the hands of pediatricians. No representative of Congress should have the audacity to publicly state that children are being drugged just to quiet them down."

These "speed" merchants always say they never put little kids on amphetamines without the parents' permission. A great deal is made of this, but here is a letter from the father of a little girl in grammar school. Read this and you'll see how permission is obtained:

"The teacher started complaining about our little girl being too active, and soon the school nurse called me and suggested that I put her on tranquilizers. We objected as we do not believe in handing drugs out so freely. Soon the school started calling us up and complaining about her behavior. They said she was restless and overactive, but not bad or disrespectful.

"Finally the school psychologist made an appointment with me and told me to put my daughter on Ritalin (an amphetamine-like drug manufactured by Ciba). I told her I didn't like the idea. She was so annoyed with me and told me that soon my little girl would start to masturbate as a result of all this extra energy. She made me feel as though I was a stupid, neglectful parent who was only doing my child harm by not giving her this Ritalin. Of course, the school was upset and kept bothering us. They even went as far as to tell me to keep her home from school if she was the least bit sick because the teacher could not handle her. By the way, four other children in her class are on drugs."

If anybody needs a mind-bending, personality-changing drug in this situation, it's the teacher; she's the one having the trouble getting bright, active children to sit through her dull, painful classes. However, dope is pushed onto the kids with the excuse that they're the ones who're at fault and must submit to treatment. Often the official line is that the child suffers from "marginal brain damage"; that is, conjectured damage which shows on no tests and for which there are no clear symptoms.

In Russia they do the same thing with the scientists and artists who get out of line. They diagnose them as crazy and put them in the "loony bin." Here we say of a kid who won't go along with some soporific program, that he's got marginal brain damage and we dope him up.

It's a therapeutic procedure with enormous social and political promise. Not only can we withdraw all police and disciplinary authorities from our schools, we can forget about the President's internist's idea of putting all the kids suspected of having criminal tencencies in concentration camps. "Biochemical medication" puts the cop and the concentration camp inside the pill and we put the pill inside the kid.

[From the Village Voice, Dec. 3, 1970]

Order in the Classroom!

Isaiah E. Robinson, vice president of the board of education, says he is concerned about the use of behavior-modification drugs on New York City schoolchildren. He specifically mentioned (Times, Nov. 22) the use of Ritalin and Dexedrine. "I found out recently," Robinson said, "that we are * * * using one of these drugs in the New York City schools. I don't know to what extent it's being used, but I intend to investigate and find out."

If Mr. Robinson is serious in his concern, I would suggest he contact Nathan Weber of the Chelsea Clinton News. In the November 19 issue of that weekly, Weber wrote about "the dispensation of tranquilizing pills by Roosevelt Hospital 'hyperkinetic' or highly active pupils at Public School 51." Two sons, 12 and 11, of Mr. and Mrs. Rafael Valentin, were given Ritalin. According to their parents. the boys "were never any trouble until they got into her (a teacher's) class."

Nathan Weber writes: "Lengthy discussions with, and observations of the youths, both in and out of their apartment, confirmed to an observer the impression that they are neither overactive nor deficient in ability to learn, as indicated in their report cards."

After the school had recommended a medical examination, consented to by the parents, Ritalin was first prescribed to the boys by a psychiatrist at Roosevelt Hospital in March 1970. The parents again consented. The two boys took the drug, Weber continues, "and became drowsy and headachy. * * * The parents finally decided to take the children off the drug even though they had been notified by the school's guidance counselor by letter that 'we find it very hard to do any work with the boys when they don't have the medicine.'

"The two brothers and the parents indicated displeasure with the teacher, implying that she did not treat the Spanish-speaking children as nicely as she did the others, becomes angry and screams often, throws books, and uses words like 'moron' and 'idiot' when a child does not do well on a particular lesson."

How about drugging the teacher instead of the children?

As for Ritalin, Dr. Richard Burack, author of "The New Handbook of Prescription Durgs," has noted that "it begins to appear that Ritalin might not achieve a full sparation of amphetamines' desirable and undesirable effects; amphetamine abusers are beginning to ask for it. Sweden has banned its sale."

In the November 26 Chelsea Clinton News, moreover, veteran science writer Irma Hunt quotes from a recent article by Dr. Morton S. Rapp in the Canadian Medical Journal: "The chemical structure and reported behavioral effects of methylphenidate (Ritalin) make it clear that the drug is a direct stimulant of the central nervous system with actions indistinguishable from those of the amphetamines. It is generally accepted that amphetamines have few genuine medical uses; that they are over-prescribed and that they have a high potential for habituation. The same thinking should apply to methylphenidate * * *."

Now—dig this—the same Times story about Isaiah Robinson's anxiety quotes Eliott Levinson, assistant to Chancellor Harvey Scribner. Asked about behavior-modification drugs in schools, Levinson said "that such drugs were 'being used in many school systems across the country on an experimental basis.' He understood that these drugs were 'nonaddictive and not harmful when given to young children.' "

Wow!

Scribner, in the same story, said he was not familiar with any program in the New York City public schools "in which behavior-modification drugs were used." He ought to start finding out.

In the August 31 issue of New City Free Press, Charles Isaacs writes: "Four mothers who live in Queens * * * explained that their children had always seemed normal and healthy until entering first grade, when they were told by school officials that 'something was wrong.' In order to correct this, they said, the children were 'drugged' by an agency operating through the school. Because of the drugs, the children often fell asleep in class; in one case, the principal, unable to wake the child, carried him out to the school bus at the end of the day. When the first parent refused to permit this treatment to continue, she encountered repeated harassment by the authorities * * *. Not all programs are run in this way. Dr. Stanley Lamm, a noted pediatric neurologist, treats 'hyperactive' and other children at long Island College Hospital in Brooklyn. He realizes the limited potential of durg therapy, and questions why the board of education insists on putting many of these children in a 'brain-injured program' when they are not brain-injured at all. His course of treatment, limited to a small scale, involves the entire family in therapy, recognizing that it is not enough just to keep the child quiet. Even this program, though, assumes that the disorder is in the student and not in the school."

Does the board of education put these children in a brain-injured program? How extensive is the use of Ritalin and other drugs on allegedly "hyperactive" children in this city's schools? I would greatly appreciate any information on this subject (and on allied uses of drugs in the schools). You can write to me at 25 Fifth Avenue, New York.

With regard to the drugging of children in classrooms throughout the country, there follows an extract from a letter to Elliot Richardson, head of HEW, dated October 12, by Congressman Cornelius Gallagher, chairman of the right-to-privacy inquiry: "* * * We learned from the National Institute of Mental Health that only this year had research been funded which would show the long-term effect on children who had taken this medication. A preliminary General Accounting Office report showed that NIMH had granted at least $3 million for studies in this area, and a NIMH witness testified that at least 150,000 children around the nation were receiving drugs. Yet, only in 1970 had funding been provided for a study of the children who had themselves received the drugs."

Gallagher also noted that minimal brain dysfunction, "one of at least 38 names attached to this condition" (hyperkinesis being another), is supposed to have an incidence as high as 30 percent in "ghetto areas." Who says? The "experts" say. However, Gallagher emphasizes, "both before and after the hearing (on the use of drugs in schools), I have received letters from people employed by, and copies of studies which were funded by, the Office of Education at HEW. They are highly critical of the focus on the medical side of minimal brain dysfunction * * *. They confirmed testimony we received that the medically oriented studies did not adhere to high scientific standards."

As a result of Gallagher's hearing and his persistent exposure of this situation on the House floor and in whatever media would give him space and time (all too few), the administration is going to convene a "blue ribbon" panel (Washington Post, October 12) "to warn pediatricians and educators against the overuse of 'behavior modification' drugs to calm overactive schoolchildren."

Did the Times run that story? If so, I didn't see it.

According to the Washington Post (which has become necessary reading as the Times' Washington staff continues to slumber during a number of important stories), "Dr. Edward F. Ziegler, director of the new Office of Child Development,

told a panel of United Press International reporters that he is very much afraid that many teachers in this Nation are utilizing (amphetamine drugs) as a way out of the difficulties of a classroom." Ziegler added that "perhaps it is as much a problem of the kind of schoolroom children have to adjust to rather than what is wrong" with the nervous systems of children.

Since I, spurred by John Holt, started writing about the use of drugs on schoolchildren, I've received many requests for additional data. I can now recommend the best single, concise survey of the problem I've yet seen: "A Report on the Use of Behavior Modification Drugs on Elementary School Children" by M. Yanow. It's included in one of the periodic issues of Observations from the Treadmill (which he edits) and can be obtained from him at 357 Hidden River Road, Narberth, Pa.

In addition to a careful survey of the background of the subject and of present practices involved in using drugs on children, Yanow appends a useful bibliography, much of it consisting of citations from medical literature.

In answer to doctors and others (including several angry readers of this column) who ask: "Are you saying there is no such thing as minimal brain dysfunction or hyperkinesis?" Yanow writes, "Psychiatrists who have worked with the disorder are firm and unanimous on this point: While parent and teacher observations and questionnaires are helpful, an accurate diagnosis is completely dependent upon a series of complex psychiatric and neurologic examinations. Many psychiatrists with whom I talked had never personally diagnosed a case of hyperkinesis and some could not recall ever having seen one. Information disclosed in the Gallagher hearings revealed that in many cases the diagnosis was being made by school doctors and family physicians * * *. The line between a normally energetic and undisciplined youngster and an abnormally hyperactive one is too fine for someone unqualified to draw. The category of unqualified 'experts' would include parents, teachers, school nurses, school doctors, school administrators, family physicians, and most pediatricians."

I would add a good many psychiatrists.

Yanow continues: "Parents must be made aware that the diagnosis is a complex one which requires psychiatric and neurologic examinations, and that anything less constitutes a serious threat to the physical and mental well-being of their child. As to the use of amphetamines of the treatment of hyperkinetic children, there is sufficient confusion among the medical researchers regarding the merits of this treatment as to suggest that all concerned proceed with the utmost caution."

To say the least. And I repeat Dr. Edward Ziegler's point that it may be as much a problem of the kind of schoolroom children have to adjust to rather than what is wrong with the nervous systems of children.

The term "as much" is far too mild. Let this blue ribbon panel examine those learning situations in which there is space for each child to be, to move, to talk, to pursue what interests him. Let the panel contrast these children with those in most schools in this country, and then let us see how high an incidence of "hyperkinesis" exists in the more open classrooms.

Meanwhile, what the hell is going on—with regard to the drugging of children—in New York City schools? And do you suppose that what is "wrong" with the students and parents at George Washington High School (Albert Shanker's Ocean Hill-Brownsville of 1970) is that they were not given Ritalin when they were in elementary school?

NAT HENTOFF.

[From the NEA Journal, January 1969]

FORECAST FOR THE 1970'S

(By Harold G. Shane, university professor of education, and June Grant Shane, professor of education, School of Education, Indiana University, Bloomington)

During the last 5 years, there has been a marked increase in long- and short-range speculation regarding possible educational futures that may lie before us in the remaining years of the 20th century. For the past 3 years, we have studied approximately 400 published and unpublished articles and books in which such conjectures and projections occur.

These current writings clearly indicate that education and schools, as they exist today, will change drastically during the 1970's and will be modified almost

beyond recognition by the end of the century. The paragraphs that follow summarize some of the more important developments that could occur in the next decade and propose some of the new roles in which the teacher is likely to be cast. In conclusion, we give thought to the question: For what kind of world should children who will live most of their lives in the 21st century be prepared? Here, then, as many scholars see it, are some of the possible designs of educational futures in the seventies.

Education will reverse its traditional pattern of expenditure. From the beginning, more money has been spent per student in higher education, with secondary education coming in a strong second and elementary education, a poor third. Preschool and kindergarten programs have not been in the race for funds. But now, major support for early childhood education seems highly probable because of our belated recognition that we have spent literally billions at the upper age ranges to compensate for what we did not do at the 2- to 7-year age levels.

Now priorities for education of the youngest will bring to public education nonschool preschools, mini-schools, and a preprimary continuum. As nonschool preschool programs begin to operate, educators will assume a formal responsibility for children when they reach the age of 2. We will work with parents of young children both directly and through educational TV programs for young mothers. And we will offer such services as medical-dental examinations and followup, early identification of the handicapped and deprived, attacks on nutritional needs, and—of major importance—early referral to cooperating social agencies for treatment of psychobehavioral problems.

New programs for 2-year-olds will involve the coordination of community resources, under school auspices, to equalize educational opportunity for these children before cultural deprivation makes inroads on their social and mental health.

The minischool, as envisioned here, is one that provides a program of carefully designed experiences for the 3-year-old—experiences deliberately devised to increase the sensory input from which the children derive their intelligence. Each minischool presumably would enroll six or eight children under a qualified paraprofessional. A professionally prepared childhood environmental specialist would directly supervise clusters of approximately six minischools.

We will probably build these small schools into housing projects, make them part of new schoolhouse construction, or open them in improvised space in convenient buildings.

The preprimary continuum is a new creation intended to replace contemporary kindergartens for the 4- and 5-year-old. This program presupposes that the young learner will spend from 1 year to 4 years preparing himself to perform effectively in a subsequent primary continuum, the segment of education now usually labeled grades one through three. The preprimary interval should sharply reduce the problems of widely varied experience and social adjustment encountered by children who are arbitrarily enrolled in grade one at age 6 regardless of their previous cultural environment.

Major environmental mediation for 2- to 6-year-olds, as described above, will permit schools to abandon the current transitional concept of nongrading. In the coming decade, a seamless primary, middle-school, and secondary continuum of coordinated learning experiences will begin to replace the nongraded programs of the sixties.

Here, progress and the time spent on a given topic will become completely individual matters, as one emergent design for learning serves all ages. The intellectually advantaged child, for instance, might spend only 2 years in the primary or intermediate continuum, accomplishing what most children would accomplish in 3 or 4 years.

In this personalized educational continuum, the question of how to group children will no longer be relevant. The child will simply work with others in ephemeral groupings during whatever time certain shared learning experiences happen to coincide.

Admission age quibbles, too, will become irrelevant after several years of minischool and preprimary experience. There is no need to group children for first grade at the magic age of 6, since they would be phased into their primary school year at any time from age 4 at one extreme to age 8 at the other.

Promotion problems will also vanish, since in a continuum of learning there are no specific points at which a student passes or fails; he merely moves ahead at his own pace. Grade cards are likewise destined to disappear: Evaluation of progress will be continuous, and a progress report can be made in a parent conference whenever pupil performance analysis is in order.

The school will provide more learning experiences that parallel or accompany conventional academic content. The creative and enjoyable will begin to vie strongly with the utilitarian and academic dimensions of education. Such paracurricular ventures as educational travel, school camping, informal dramatics (including sociodrama), enlarged intramural sports programs that stress mass participation, and engaging youth in useful service to the community are due to increase in frequency and extent.

Biochemical and psychological mediation of learning is likely to increase. New drama will play on the educational stage as drugs are introduced experimentally to improve in the learner such qualities as personality, concentration, and memory. The application of biochemical research findings, heretofore centered in infrahuman subjects, such as fish, could be a source of conspicuous controversy when children become the objects of experimentation.

Enrichment of the school environment in the seventies—especially in the ghetto—to "create" what we now measure as intelligence by improving experiential input also will become more accepted. Few are likely to make an issue of efforts to improve educational opportunities for the deprived child. However, there could be a tinderbox quality to the introduction of mandatory foster homes and "boarding schools" for children between the ages of 2 and 3 whose home environment was felt to have a malignant influence. Decisions of the 1970's in these areas could have far-reaching social consequences. Although it is repugnant to permit a child's surroundings to harm him, there is no clear social precedent for removing a child from his home because it lacks the sensory input needed to build normal intelligence and, therefore, in effect condemns him to a lifetime of unskilled labor.

The next decade will see new approaches to educational disaster areas. Most of America's large cities, and some suburban and rural sections, contain a central core that can only be described in this way. Damage surrounding this core decreases from severe, to extensive, to moderate, to negligible.

Up to now, perhaps, we may have spent too much energy and money on just the worst schools of these central cores. In such neighborhoods, we cannot create a decent educational opportunity until the total social setting is rehabilitated. In the early 1970's, we may find it both more efficient and more educationally sound to direct our attention initially to improving those areas and schools where educational damage is moderate to extensive rather than drastic. For such areas, immediate attention may prevent their deteriorating in the near future into severe disaster areas. Once the deterioration in these outer ring schools is reversed, greater educational resources will become available to help us close in on the ghetto schools where damage is severe or total.

It would be unthinkable to ignore the children who live in our worst educational disaster areas until we can mobilize the greater forces needed to bring these schools up to necessary standards of excellence. Therefore, until inner cities regain their socioeconomic and educational health, we often will transport their children to outlying areas. In the next decade, this will involve a rapid buildup of facilities in these areas both in terms of enlarging existing schools and of creating new types of learning environments. Removing children from inner-city problem areas has the added merit of stimulating them through contacts with children from other social groups.

Later in the seventies, the elementary school changes will cause the junior and senior high schools to modify their programs. Their curriculums will preseumably become more challenging and interesting. Wider age ranges, increased pupil interchange within and between schools, and individualized programs built around new instructional media will inevitably influence emerging secondary school organization.

In the late 1970's or early 1980's, it is not unlikely that students will graduate from high school with knowledge and social insight equal or superior to that of the person who carried a bachelor's degree in the 1960's.

On entering college, these students will be ready to begin postbaccalaureate studies, and our undergraduate college programs in their present forms will be unnecessary.

If this seems farfetched, bear in mind that the young person pictured here will have had the benefit of carefully developed learning opportunities in a skillfully mediated milieu since he was 2 or 3 years old.

During the next 10 years, business will participate in education to a greater extent. Although many of their activities are neither widely known nor generally understood, major corporations are already contracting to tackle pollution, teach marketable skills to the deprived, administer police protection, reclaim slums, and manage civic governments.

John Kenneth Galbraith has noted that the modern corporation already has the power to shape society. Frank Keppel commented recently that the revival of U.S. metropolitan schools depends as much in the action of leaders of finance and commerce as it does on educators. And Hazel Henderson commented last summer in the "Harvard Business Review" that industry's expansion into such areas as housing, education, and dropout training is probably the best way to handle our central needs if suitable performance standards and general specifications are properly controlled.

The growth of a cooperative business-and-education relationship will be of great portent in the seventies as corporations both expand the production activities of the education industry and assume more management and control responsibilities.

The roles and responsibilities of teachers will alter throughout the next decade. Future-think suggests that between 1970 and 1980 a number of new assignments and specialties will materialize if present trends continue.

For one thing, the basic role of the teacher will change noticeably. Ten years hence it should be more accurate to term him a learning clinician. This title is intended to convey the idea that schools are becoming clinics whose purpose is to provide individualized psychosocial treatment for the student, thus increasing his value both to himself and to society.

In the school of the future, senior learning clinicians will be responsible for coordinating the services needed for approximately 200 to 300 children. In different instructional units (an evolution of the team concept) we will find paraprofessionals, teaching interns, and other learning clinicians with complementary backgrounds. Some will be well-informed in counseling, others in media, engineering, languages, evaluation, systems analysis, simulation, game theory, and individual-need analysis.

But on the whole, the learning clinician will probably not be appreciably more specialized in subject matter disciplines than he was in the 1960's except for being more skilled in using educational technology. He will do more coordinating and directing of individual inquiry and will engage in less 1968-style group instruction. He will be highly concerned with providing and maintaining an effective environment, skilled in interpersonal transactions, and able to work with persons of different ages and learning styles.

Ten years from now, faculties will include:

Culture analysts, who make use of our growing insights into how a subculture shapes the learning style and behavior of its members.

Media specialists, who tailor-make local educational aids, who evaluate hardware and software and their use, and who are adept in the information sciences of automated-information storage and retrieval, and computer programing.

Information-input specialists, who make a career of keeping faculty and administration aware of implications for education in broad social, economic, and political trends.

Curriculum-input specialists, who from day to day make necessary corrections and additions to memory bank tapes on which individualized instructional materials are stored.

Biochemical therapist/pharmacists, whose services increase as biochemical therapy and memory improvement chemicals are introduced more widely.

Early childhood specialists, who work in the nonschool preschool and minischool programs and in the preprimary continuum.

Developmental specialists, who determine the groups in which children and youth work and who make recommendations regarding ways of improving pupil learning.

Community contact personnel, who specialize in maintaining good communication, in reducing misunderstanding or abrasions, and in placing into the life of the community the increased contributions that the schools of the 1970's will be making.

As educators turn a speculative eye on the next decade, they must seek to answer a question that most of them have hesitated to face. For what kind of world should we strive to prepare children and youth who will spend most of their lives in the next century? We say this question is crucial because educational policy decisions in the 1970's will not only anticipate tomorrow, they probably will help to create it.

Recent publications in the physical, natural, and social sciences suggest emerging changes in society that seem likely to characterize the world of A.D. 2000. A number of future-think writers agree that unless unforeseen catastrophes intervene, such developments as the following are probable:

The individual's personal freedom and responsibility will be greater.

The IQ of the average child will be 125, perhaps 135.

Cultures throughout the world will be more standardized because of the impact of mass media and increased mobility.

Access to more information will carry us toward an international consensus as to what is desirable in family life, art, recreation, education, diet, economic policies, and government.

Cruelty will be more vigorously rejected and methodically eliminated.

Leaders will be those who are the most able, regardless of their racial origins, religious beliefs, family backgrounds, or lack of great wealth.

The worldwide status and influence of the female will greatly increase.

Differences in wealth and ownership between haves and have-nots will narrow.

Through the mediation of trends, society will begin to design or give direction to the future so that the years ahead will better serve human welfare.

The changes described above will open many more doors for educational leadership. During the coming decade, however, education must do more than just lengthen its stride to keep pace with trends and innovations. We must bring social perception and long-range vision to the task of designing and planning schools that can help bring about the best of many possible tomorrows.

[From the New York, July 21, 1969]

The Amphetamine Explosison

(By Gail Sheehy)

"Anyplace where young people gather—where worship of the eureka experience runs high and faith in America runs low—amphetamine is becoming a god. Cops have Mace, kids have speed."

"Savages. Look at 'em. They've turned into savages."

The cabbie, driving through the East Village, is talking about a group of our young New Yorkers who used to be cursed for their interest in love, peace, and flowers.

"Buncha savages, these kids today."

Where have all the flowers gone? Whatever happened to hippies. Yippies and the marshmallow-eyed mystics? What changed them is not politics. It is not the military-industrial complex, too much money or the long, hot summer—though it's a silent partner to all these. It is beyond pot, LSD and alcohol. It is a change of drug.

Amphetamines—or speed, ups, stimulants, diet pills—are science's latest contribution to the turn-on generation. These little pills are quietly building toward the next major drug explosion in America.

In communal enclaves like the East Village, amphetamine is already the No. 1 drug. It has left LSD in the dust. A restaurant on Second Avenue once known as The Eatery is now fondly called The Speedery. Hell's Angels grew up on speed. It is a staple of motorcycle gangs now in residence in the East Village.

Speed has a paradoxical effect. In a peaceful country, like Sweden, it brings out the hedonism. In a violent country (or city, like this one) it activates the violence. Metropolitan-area doctors find that during withdrawal, for instance, users are just likely to be homicidal as suicidal.

But the appeal of amphetamine extends beyond the young and beyond the Village. Eight billion amphetamine tablets are officially produced in the United States annually, enought to supply 40 doses to every man, woman, and child. The drug is distributed to widely diverse groups of people. With little publicity, often by doctor's prescription, amphetamine is spreading like a new flouride in the national water supply. On college campuses the promise of excitement and sexual prowess is spreading the mystique of methamphetamine, taken by injection. Other enthusiasts range from ambitious business executives, tired housewives, artists, and writers who order a year's supply at a time so that they can work through the nights, to infantrymen in Vietnam who are issued it for long patrols, to football players who are alternated on ups (amphetamine) and downs (bartiturates), depending on which reaction is called for by the score. Couples often live through a divorce on it. General practitioners rely increasingly on amphetamine to treat overweight and mildly depressed patients, as well as alcoholics and drug addicts. The general practitioner can keep his patients moving through his office fast and returning for more. The patient may need referral to a psychiatrist, but a happy

pill will placate him. Amphetamines are helpful to all these people: the do lift the mood, curb the appetite and energize the body. The problem is control. The communications media and the courts devote much time to settling the problem of marihuana. Yet marihuana use is a peccadillo compared to the known dangers and frightening potential of mass stimulant abuse. Psychologically, amphetamines are the most dangerous of all the ill-used drugs—including herion.

This is the gist of concern being expressed, here and in England, by doctors. The great debate is: does the medical value of amphetamine outweigh the dangers of abuse and dependency? Sweden has already banned all amphetamines; they cannot even be used therapeutically. West Germany, Switzerland, and Austria have withdrawn a series of slimming drugs, derived from amphetamines, after describing a link between them and disturbances in heart rhythm as "the most serious affair since the Thalidomide tragedy." In Japan the amphetamine epidemic spread in the wake of World War II. By 1954 an estimated 500,000 to 600,000 Japanese—almost all under 30—were habituated to amphetamine. The authorities took dramatic action.

While controversy flares behind doors of national medical meetings and in board rooms of drug companies, parents try to cope.

Parents hear speed kills. Like the parents in the story which follows, they think this means that a very dangerous drug named speed causes the criminal user to die of overdose, convulsions, etc., which it often does. But speed is not a clean bomb. Speed maims. It disorganizes the personality. An average person has a minor weakenss of character. At most, under normal stresses of life, it would be called a neurosis. But under amphetamine it balloons into a major phsychosis. On top of this, the usual requirements for satisfaction in life are completely replaced by artificial stimulation. Eventually the energizing effect of amphetamine goes into reverse. Life becomes more disorderly surroundings more squalid, but the user loses the ability to recognize this. Not only does he stop trying to return to reality, he believes he is in contract intellectually—in fact, more in contact with life than anyone else. These people are the silent victims among whom amphetamine dealers do their highest volume of business.

Parents are generally unaware of how often young people use the stimulant drugs now: intravenously, by injection. Beginning with diet pills they may find in their parents' medicine cabinet, or with the standard prescription of 15 milligrams of Dexamyl handed out liberally by college health services for "mild depression," they find that by taking more than the prescribed three pills daily, they feel even mor than euphoric. They have eureka experiences:

"Prolonged periods of thinking about the meaning of life * * * intense religiosity * * * later degenerating into delusions and the compulsion to analyze a variety of details to find meaning," describes the British Journal of Nervous and Mental Disease. Sensitivity to what others think or feel is lost.

Moving on to injection, users shoot melted pills or liquid "Meth" [Methedrine]. The veins constrict. The body's metabolism is jolted into high gear, blood forces through the tightened vessels, and euphoria hits the brain almost immediately.

In New York one shot of Methedrine sells for about the same street price as heroin—$5 a bag. Penalties for amphetamine abuse are much lighter than those for heroin; many heroin addicts have, in fact, gradually switched. This is due to the game of semantics:

Amphetamine is legally classified a "dangerous drug" but not a narcotic. Abusers are called "habitués" rather than addicts. Amphetamines are not physically addicting, but tolerance does occur, requiring a user to increase his dose. Semantics. As medical research indicates and every user knows, the big problem shared by all pleasure-giving drugs is the same: dependency. Or, as a rehabilitated speed user says: "It's OK until you shoot. Then it might as well be heroin."

Dr. Donald B. Louria at Cornell University Medical College in New York is a widely published authority on drug abuse. Amphetamines are being introduced at such young ages that Dr. Louria writes about the subject in pediatrics journals. Speaking at Boston Children's Hospital, he traced the correlation between amphetamines and the demise of the hippie movement:

"This (phychic and physical) energizer could not be rationalized as consistent with the hippie ethic of peace and expansion of the individual's inner world. Instead, it represents a drug taken solely for kicks by a subculture increasingly populated by thrill seekers, psychopaths, angry sociopaths and young persons who find themselves incapable of functioning in our society."

The results of amphetamine abuse around the world are almost standardized by now: bizarre behavior, elaborate sexual fantasies, striking changes in females who were frigid, sudden marked increase in sexual deviations and extreme mas-

ochism, fear and terror reactions (more common than depression), hepatitis, weight loss—and, finally, paranoid psychosis. Or simply, paranoia. Speed makes people behave as though they are crazy. And, in fact, antisocial and schizoid personalities are attracted to amphetamine more than they are to other dangerous drugs.

Sweden had an experience with amphetamine that has something to say to New York. In 1965 Stockholm alone had an estimated 3,000 users. Medical authorities decided stimulant abuse was a medical disease, rather than a psychiatric problem, as it is considered in the United States. They would treat it by maintenance therapy. Habitues were given virtually unlimited amounts of the drug. They supplemented this with their old blackmarket supplies, increased their own dosages and sold the rest to new users. Paranoid psychois among the maintained users increased enormously. Two years later, Stockholm's amphetamine habitues doubled to 6,000. The experiment was declared an "unmitigated disaster." Sweden banned amphetamines.

The paradoxical effect of amphetamine makes it even more dangerous to New York. Here, as on campuses in revolt or any place young people gather where worship of the eureka experience runs high and faith in America runs low, amphetamine is becoming a god. It has no Leary; it makes no pretense of having a high priest. Cops have Mace. Kids have speed.

Parents find amphetamine abuse very difficult to spot. They can be easily conned. Doctors have difficulty with the diagnosis. It takes months for an amphetamine "addiction" to show its ravages.

Amphetamine is like a Christmas package with a time bomb inside.

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