

On the television soap opera "Saints and Sinners," the characters talk about AIDS. In newspapers and on the radio, the new government has launched an ad campaign that talks about it, too. The ads say: "Three people die every five minutes from AIDS in Kenya. What are you doing about it?"

Kenyan doctors now hand out condoms in bars and talk about prevention over warm Tusker beer. Even the national museum is addressing the issue, running an exhibit this month on how treatment and prevention improve the lives of patients.

"All of my friends say using condoms is like eating a banana with the skin on," said Walter Koga, 22, a jobless man who was hanging out with his friends at a barbershop in Kiangemi. "Men just won't wear them because of stubbornness. People say it's not manly. But attitudes are changing. People don't want to be diseased, suffer horribly and die. I actually thought I would never wear one and now I do. I've changed."

As a group of Koga's friends gathered to joke about how they still don't want to use condoms, Lucy Wanjiku hovered nearby, listening. She folded her arms over her chest and rolled her eyes. She told a group of women standing nearby about a friend of hers who had asked a man to use a condom and ended up getting beaten.

She wanted to tell Koga's friends to stop joking, but she didn't. Instead she went inside her dark metal shack to rest. She was too sick and weak to fight with them.

Mr. LANTOS. Mr. Speaker, I yield back the balance of my time.

Mr. HYDE. Mr. Speaker, I want to thank my friend, the gentleman from California (Mr. LANTOS), for his generosity. Believe me, he is indispensable to this effort, too.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LAHOOD). All time for debate has expired.

Pursuant to the order of the House of Tuesday, May 20, 2003, the previous question is ordered.

The question is on the motion offered by the gentleman from Illinois (Mr. HYDE).

The motion was agreed to.

A motion to reconsider was laid on the table.

CORRECTING THE ENROLLMENT OF H.R. 1298, UNITED STATES LEADERSHIP AGAINST HIV/AIDS, TUBERCULOSIS, AND MALARIA ACT OF 2003

Mr. HYDE. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate concurrent resolution (S. Con. Res. 46) to correct the enrollment of H.R. 1298, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate concurrent resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

The Clerk read the Senate concurrent resolution, as follows:

S. CON. RES. 46

Resolved by the Senate (the House of Representatives concurring). That the Secretary of the Senate, in the enrollment of the bill (H.R. 1298) to provide assistance to foreign

countries to combat HIV/AIDS, tuberculosis, and malaria, and for other purposes, shall make the following correction: In section 202(d)(4)(A)(i), strike "from all other sources" and insert "from all sources".

The Senate concurrent resolution was concurred in.

A motion to reconsider was laid on table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote is objected to under clause 6 of rule XX.

Record votes on postponed questions will be taken later today.

CHILD MEDICATION SAFETY ACT OF 2003

Mr. BURNS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1170) to protect children and their parents from being coerced into administering psychotropic medication in order to attend school, and for other purposes, as amended.

The Clerk read as follows:

H.R. 1170

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Child Medication Safety Act of 2003".

SEC. 2. REQUIRED POLICIES AND PROCEDURES.

(a) IN GENERAL.—As a condition of receiving funds under any program or activity administered by the Secretary of Education, not later than 1 year after the date of the enactment of this Act, each State shall develop and implement policies and procedures prohibiting school personnel from requiring a child to obtain a prescription for substances covered by section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) as a condition of attending school or receiving services.

(b) RULE OF CONSTRUCTION.—Nothing in subsection (a) shall be construed to create a Federal prohibition against teachers and other school personnel consulting or sharing classroom-based observations with parents or guardians regarding a student's academic performance or behavior in the classroom or school, or regarding the need for evaluation for special education or related services under section 612(a)(3) of the Individuals with Disabilities Education Act (20 U.S.C. 1412(a)(3)).

SEC. 3. DEFINITIONS.

In this Act:

(1) CHILD.—The term "child" means any person within the age limits for which the State provides free public education.

(2) STATE.—The term "State" means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 4. GAO STUDY AND REVIEW.

(a) REVIEW.—The Comptroller General of the United States shall conduct a review of—

(1) the variation among States in definitions of psychotropic medication as used in regard to State jurisdiction over public education;

(2) the prescription rates of medications used in public schools to treat children diagnosed with attention deficit disorder, attention deficit hyperactivity disorder, and other disorders or illnesses;

(3) which medications used to treat such children in public schools are listed under the Controlled Substances Act; and

(4) which medications used to treat such children in public schools are not listed under the Controlled Substances Act, including the properties and effects of any such medications and whether such medications have been considered for listing under the Controlled Substances Act.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit a report that contains the results of the review under subsection (a).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Georgia (Mr. BURNS) and the gentleman from California (Ms. WOOLSEY) each will control 20 minutes.

The Chair recognizes the gentleman from Georgia (Mr. BURNS).

GENERAL LEAVE

Mr. BURNS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 1170.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

Mr. BURNS. Mr. Speaker, I yield myself such time as I may consume.

Today we are considering H.R. 1170, the Child Medication Safety Act, which will prevent school personnel from requiring a child to obtain a prescription for a controlled substance in order to remain in the classroom. I would first like to thank Chairman BOEHNER and Speaker HASTERT for their support of this legislation and Subcommittee Chairman CASTLE for conducting an important hearing on this bipartisan bill.

In recent decades there has been a growing number of children diagnosed with attention deficit disorder and attention deficit hyperactivity disorder and then treated with medications such as Ritalin and Adderall. When a licensed medical professional properly diagnoses a child as needing these drugs, the administration of the drugs may be entirely appropriate and very beneficial. While these medications can be helpful, they also have the potential for serious harm and abuse, especially for children who do not need these medications. In many instances, school personnel freely offer diagnosis for ADD and ADHD disorders and urge parents to obtain drug treatment for the child.

Sometimes officials even attempt to force parents into choosing between medicating their child and remaining in the classroom. This is unconscionable. School personnel may have good intentions, but parents should never be required to decide between their child's education and keeping them off potentially harmful drugs. School personnel

should never presume to know the medication needs of a child. Only medical doctors have the authority to determine if a prescription for a medication is physically appropriate.

□ 1115

The bill before us today, the Child Medication Safety Act of 2003, is straightforward, sensible legislation that aims to remedy this problem facing parents across the Nation. It requires States to establish policies and procedures prohibiting school personnel from requiring a child to take medication in order to attend school. This bill has been carefully crafted to preserve communication between the school personnel and the parent, but it also protects parents from being coerced into placing their child on a drug in order to receive educational services. Parents would no longer be forced into making decisions about their child's health under duress from school officials.

The language as amended in committee makes some important clarifications to the bill. While the bill as introduced only included drugs listed in schedule II of the Controlled Substances Act, we learned that there are replacement drugs for Ritalin and Adderall in other schedules. For this reason and to answer concerns among the mental health community, the list of covered drugs was expanded to cover those listed in all five schedules of the Controlled Substances Act.

The bill before the House today also includes an important clarification to ensure that parents and teachers are able to have an open dialogue about any academic or behavior-related needs of the child. This legislation is intended only to prevent school personnel from requiring children to be medicated. It is not intended to stifle appropriate dialogue between parents and teachers. Teachers spend so much time with the students and observe a wide variety of situations and parents often ask their child's teachers to share their observations about their child's behavior in school. We certainly do not want to infringe on these important conversations. The Child Medication Safety Act of 2003 makes clear that appropriate conversations can still take place. This is an important change that was brought to my attention by a number of my colleagues, and I would like to particularly thank the gentleman from Rhode Island (Mr. KENNEDY), the gentlewoman from California (Mrs. DAVIS), and the gentlewoman from California (Ms. WOOLSEY) for their help in this area.

This bill is not antischool, antiteacher, or antimedication. This bill is pro-children and pro-parent. The Child Medication Safety Act of 2003 is essential to protecting both parents and children. I urge my colleagues to support this bill that restores power to the parents.

Mr. Speaker, I reserve the balance of my time.

Ms. WOOLSEY. Mr. Speaker, I yield myself such time as I may consume.

When I asked the Marin County superintendent of public schools what she thought about H.R. 1170, she replied that it was a bill that would affect the many to solve the possible problem of just a few, and I think that describes it perfectly. Of course no one wants a school to force parents to medicate their children. In fact, we would not stand for that. But neither do we want teachers and other school personnel to be afraid to talk to parents about children's behavior or to suggest that a child should be evaluated by a medical health practitioner. That is why we worked with the gentleman from Georgia (Mr. BURNS) to add a provision to H.R. 1170 that specifically protects a teacher's right to have these discussions with parents and to identify a child for evaluation just as they can do now under IDEA. While I do think this bill creates more paperwork than good public policy, I do understand the gentleman from Georgia's (Mr. BURNS) intentions, and I appreciate his willingness to work with us.

This bill was unanimously voted out of the Committee on Education and the Workforce, and I know of no objection to it passing under suspension this morning.

Mr. Speaker, I reserve the balance of my time.

Mr. BURNS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from South Carolina (Mr. WILSON), a member of the committee.

Mr. WILSON of South Carolina. Mr. Speaker, it is an honor for me to be here today to speak on behalf of the Child Medication Safety Act of 2003. I want to particularly commend the author of this bill, the gentleman from Georgia (Mr. BURNS). He himself is a professional educator and knows firsthand how significant that law can be. I have the perspective of being the father of four children, and I know how important this can be to their ability to do well in school. And it is a big day for us. My ninth grader completes his final day today. I know he is a happy creature at home on his way to the tenth grade. Additionally, my wife is a teacher, and I am really proud of her service. She just concluded her first grade class yesterday; so she is out for the summer.

But as a parent and a spouse of a teacher, I appreciate this legislation. The Child Medication Safety Act of 2003 requires States, as a condition of receiving Federal education funds, to establish policies and procedures prohibiting school personnel from requiring a child to take a controlled substance in order to attend school. Parents have felt pressured to place their child on drugs like Ritalin or Adderall. These are potentially dangerous drugs and only licensed medical practitioners should recommend these drugs and then carefully monitor the child for harmful side effects. School districts and teachers should not presume to

know what medication a child needs or if the child even needs medication. Only medical personnel have the ability to determine if a prescription for a controlled substance is appropriate for a child.

The input and advice from schools and teachers carry weight with most parents. Parents should not be forced to decide between getting their child into school and keeping their child off mind-altering drugs. Parents are in the best position to determine what is best for the child. After listening to licensed medical personnel, a parent is the one who should determine whether their child should be medicated, not school personnel. Schools should respect a parent's choice and not use coercive measures that might be harmful to children merely to avoid dealing with behavioral problems. Most importantly, the bill ensures that there is open communication between the school personnel and parents.

I urge my colleagues to support H.R. 1170.

Ms. WOOLSEY. Mr. Speaker, I yield 3 minutes to the gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Speaker, I want to commend both sides for working out a good bill that passed unanimously from the committee. I want to commend the gentleman from Georgia (Mr. BURNS), my good friend and colleague, and his office for working very closely with all of us in trying to ensure that we were able to address the needs of families and children in school.

When I travel around my district in Rhode Island, I find school teachers telling me that the biggest single problem they have is addressing the emotional and social development of the kids in their classrooms. These kids come to school often from broken families, family violence, situations that none of us can even begin to imagine, and to think that these children are going to learn and not be able to shut out these things from their mind about what is going on at home is just not being realistic. These kids need assistance, they need help, and they need counseling. That is why I think we have done so well by trying to ensure that there are more school counselors, but we still need to do more.

In terms of the mental health part, I think this is an important part of development. I think this bill does a lot to ensure that we do not tie the hands of teachers and principals and administrators insofar as their consulting with parents. In many respects teachers have a window into what is going on in that child's life, and they are best equipped to be able to talk to those parents and be able to consult with those parents about what those children might need. Obviously, none of us wants to see a situation where instead of getting these kids the necessary emotional and social support, all they give to these kids is medication. We do not need to do that, but we do need to

ensure that for those kids who do need medication who do have those kinds of chemical imbalances that make it very difficult for them to learn that they can get the needed support.

I think overall the biggest challenge that we have in this area is ending the stigma of mental health. Somehow, having any kind of range of mental illness is a stigma. I myself suffer from depression. I take medications for it. It is nothing I feel ashamed of. I also have asthma. I take medications for that. And yet in this country we still have this pervasive view that somehow if one has kind of an emotional problem that that is their problem, that is of their own making, that it is not some part of their brain chemistry. Just as diabetes or asthma or any other chronic disease would not be their fault, neither is any mental illness.

So that is why I think this bill is important in that it does not stigmatize those families and children that may be suffering from emotional and social challenges. So with that I ask for support for this legislation and commend the gentlewoman from California (Ms. WOOLSEY) for her good work.

Mr. BURNS. Mr. Speaker, I yield 6 minutes to the distinguished gentleman from Pennsylvania (Mr. MURPHY), a professional in the health care field.

Mr. MURPHY. Mr. Speaker, I thank the gentleman from Georgia (Mr. BURNS) for putting together this legislation which actually is extremely important. I know I have seen in my own practice as a psychologist the importance of helping to make sure that children get to the right professionals and that there is not coercion or threat that goes to the families.

I want to take a few moments, first of all, to lay out with regard to this bill the issues involved with attention deficit hyperactivity disorder, an often misunderstood and often maligned diagnosis that because of that lends itself to prejudicial comments as certainly the gentleman from Rhode Island (Mr. KENNEDY) was also alluding to. Attention deficit disorder has a number of diagnostic criteria which are laid out in what is called the "Diagnostic and Statistical Manual." They include categories of inattention, hyperactivity and impulsiveness. Because psychiatric and psychological symptoms are described in behavioral terms they oftentimes seem vague and only behavioral. For example, under the inattention category, it might mean a person who fails to give close attention to details or has difficulty sustaining attention in tasks or often does not seem to listen when spoken to directly or does not follow through on instructions to finish school work, et cetera; often has difficulty organizing tasks and activities or avoids or is reluctant to engage in tasks that require sustained mental effort.

When one just hears some of those symptoms, one may think that those could cover a wide range of behaviors

that may not necessarily reach a diagnosis that requires medication, and there is something to that. That is why it is so very important when there is a concern raised about a child's symptom picture perhaps fitting the diagnosis of attention deficit disorder that that child be thoroughly evaluated by perhaps a team of professionals psychiatrists, psychologists, people who are trained to do this, but not simply referred on the basis of this child is difficult in the classroom.

And let me lay out why. In terms of attention behaviors, we look upon this as a primary, secondary, and tertiary diagnosis. A primary attention deficit disorder is one where a child actually has the symptom pictures of attention disorder related to the biological and in some cases some inherited factors for that, but it is pretty clearly in that category. They meet the diagnostic criteria.

Secondary attention deficit disorder is when the child may have the same problems with concentration and attention and getting their work done, but it is secondary to some other problems. For example, a child may have an anxiety disorder. They may be suffering from depression. They may have sensory problems. I have known children who were referred to me for attention disorder only to find out they needed glasses or they had a subtle hearing loss. They may be having social problems, cultural problems, as they are moving from one school district to another and have a great deal of difficulty. They may have speech and communication problems where they have trouble understanding the teacher. And yet those children's symptom picture can look similar. They are not paying attention, not concentrating, they are not getting their work done, they are agitated and hyperactive. It is important that those other problems are diagnosed clearly and those are treated and those are not the children who should be given medication.

A third type is a tertiary problem, and this is not the problem with the child so much as it is a problem with expectations. That is, people may expect a pre-school child to sit still. People may expect a teenager to concentrate and not daydream. We know anybody with any rudimentary knowledge of having children knows that those are not realistic expectations, and yet there are those sometimes who feel that children who are out of sync with their expectations will somehow require medication, and that is inappropriate.

These diagnostic criteria, I should also add, in the testimony that was given to the Committee on Education and the Workforce, there were some who raised the question of whether or not this was biological. I draw some attention to some research that was done, I believe, in 1990 where they did Positron Emission Tomography. That is, they could look at the activity in

the brains of people who were identified with attention disorder and those who were not and found in those who had a diagnosis of attention disorder, their brain activity was somewhat lower.

That is not to mean that they had brain damage. It simply meant by looking at levels of brain activity, they found that those parts of the brain that generally control impulses and thought, that is, the frontal lobe, et cetera, were not as active as those in people who did not have attention disorder. That lent a great deal to the science of understanding attention disorder because all along before that we thought that the brains were overstimulated and it may actually be they were undercontrolled in some regions.

This of course also lends credence to why sometimes one may use medication. The medications used, such as Ritalin or Adderall or Dexedrine, are stimulant medications; and we for many years wondered about this paradoxical effect of why would you give a stimulant medication to actually slow someone down. And the point is that it appears to stimulate those portions of the brain. Basically, sometimes a layman can understand that if they feel tired and groggy and overwhelmed and they are having trouble staying alert and staying focused, sometimes a person, as they are driving down the road, will be overactive.

□ 1130

But the point is this: What I am trying to lay out here is the complexity of this.

Let me end with this one anecdote. When I was practicing as a psychologist, I received a call to evaluate a child, and did so. Then, calling back to the school district, said this child does not appear to have primary attention disorder. I think there were some other issues here, but not that.

I was told then by the referring source in the school district, put this child on Ritalin, or we will never refer another child to your practice again. I challenged that person on that immediately and said I need to go by what I believe an appropriate diagnostic criteria is and suggested they withdraw that threat.

But that is the very reason why we need legislation like this, to say this is not something that should be done to control children. This should be something that is done to help do the best thing in the child's best interest with the best people involved using the appropriate diagnostic criteria.

This is a positive thing for children and ultimately a positive thing for families, and I certainly implore my colleagues vote yes on this bill.

Ms. WOOLSEY. Mr. Speaker, I yield 5½ minutes to the gentlewoman from California (Mrs. DAVIS).

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Mrs. DAVIS of California. Mr. Speaker, I thank the gentlewoman for yielding me time.

Mr. Speaker, I rise today to oppose H.R. 1170 on very simple grounds: It is a solution without a problem. The bill is based on the assumption that a substantial number of educators require students to take medication in order to attend school.

At a hearing 2 weeks ago, I asked all of the witnesses if they had any statistical evidence of the frequency with which this happens. Mr. Speaker, not a single one did. All they offered were anecdotes, often anonymous ones. I believe it is irresponsible to rush to legislative judgment without facts; and, indeed, I am requesting that the Government Accounting Office report, based on its ongoing research, whether there are verified instances of this being a cause for due process hearings.

Let us be clear: If parents believe that a school has pressured them to seek a medical evaluation for their child due to the child's behavior, and if a physician evaluates the child and prescribes appropriate medication, and if the parent nonetheless does not want to give the medication to the child, there may be a conflict about the child's placement in a regular classroom. Should that happen, the parent has clear due process rights to seek an evaluation through the special education process whether or not the child will ultimately qualify for special education services. If the parent is dissatisfied with those results, an appeal to a due process hearing officer is available.

Please note: Teachers educate. They cannot medicate; and physicians, as we know, must do that.

What happens in real life if a parent is unhappy with a school's placement of their child? As a former school board member, I can tell you that they pick up the phone and they call their school board representative. And that is exactly what they should do. Where a problem may indeed exist, the problem needs to be addressed specifically with the involved personnel and known circumstances.

Are there bad apples in the world of education who may have put inappropriate pressure on a parent to seek a pharmaceutical solution to a behavior problem? Well, yes, there possibly are. Bad apples do exist. But if we think of every one of tens of thousands of schools in our country as having a barrel of apples, the teachers of our children, is it fair to castigate all of those barrels of apples as being rotten because across the country there is one bad apple in a barrel here or there? I think we discredit the tens of thousands of wonderful teachers in our country when we legislate based on this false assumption.

But I want to thank, Mr. Speaker, the gentleman from Georgia (Mr. BURNS) for having accepted changes to his original bill that mitigate the most alarming issue contained in the original language. He has accepted a provision that clearly states that it is the right and responsibility of teachers to counsel parents about the educational,

physical and emotional attributes of their child as compared to the norm of children and to recommend professional evaluation, if warranted.

If a child is having trouble seeing the blackboard, the teacher must advise the parent to seek professional help. Teachers cannot prescribe glasses, but they certainly must identify the need. It is the same if a child with diabetes or asthma is having trouble regulating the medications he takes, and this affects the child's ability to learn. It is the same if the child's mental health needs require evaluation so that that child and the class can function beneficially.

The reason that this section is so important is that it appeared that the measure as originally proposed had provided an opportunity for groups who openly oppose all mental health evaluation to seek to affect the teacher-parent counseling relationship by chilling the teacher's right to speak of these matters to parents.

While the measure before us today contains some mitigating language, what is so alarming is that when the Individuals with Disabilities in Education Act came before the committee, this bill's original language was offered without notification and was voice-voted without the benefit of hearings or study. It is thus part of the House-passed IDEA bill; and it is critical that, should that language be included in the conference bill, that the mitigating paragraph contained in today's separate bill be included in that language as well.

Although today's bill has been improved, I would still ask Members as legislators to consider the process of this legislation. I believe that legislation should be based on the documented existence of a problem, not on hearsay and innuendo; and I believe that all of the wonderful, caring teachers in our country should be celebrated for their compassion for children's needs and not tarnished by the stated assumption of this measure.

Mr. BURNS. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, I thank the gentleman for yielding me time, and I want to congratulate the gentleman from Georgia (Mr. BURNS) on this legislation, H.R. 1170, and would like to encourage strongly all of our colleagues to support this bill.

Mr. Speaker, the Child Medication Safety Act of 2003 requires States, as a condition of receiving Federal education funds, to establish policies and procedures prohibiting school personnel from requiring a child to take a controlled substance in order to attend school. I could not agree with that more.

The problem is, parents feel the pressure from school officials to put their child on drugs like Ritalin or Adderall. Basically, these can be potentially dangerous drugs, and the underlying part here is that only licensed medical prac-

tioners should recommend these drugs and then carefully be able to monitor the child for harmful side effects.

The very idea that the pressure can be brought to bear on a parent to force them to put a child on any of these drugs, and particularly Adderall and Ritalin, just goes against the principles of good common sense.

School districts and teachers ought not to presume to know medications that a child needs. If a child in fact needs medication, only medical personnel have the ability to determine that.

I am very pleased that this bill will hopefully begin to rein in some of the consequences of leaving it up simply to the school to determine if a child needs to be put on a medication and, more importantly, to put the pressure on the parents. This does not keep the school officials and the parents from having good conversations about a child. Obviously, we all want that. I am absolutely satisfied that the bill offered by the gentleman from Georgia (Mr. BURNS) does not keep that from happening.

Mr. Speaker, let us support this common sense legislation and move on.

Ms. WOOLSEY. Mr. Speaker, I yield 4 minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Speaker, I rise in support of H.R. 1170, the Child Medication Safety Act, and commend the gentleman from Georgia (Mr. BURNS) for taking the initiative to introduce this resolution.

I also would like to most directly associate my remarks with those of the gentleman from Massachusetts (Mr. KENNEDY), who made what I think to be some real points relative to medication, the utilization of it, and really the relationship of the whole question of mental health.

Mr. Speaker, there are several studies over the last decade pointing out the fact that prescription drug abuse is on the rise in America. In 1999, an estimated 4 million people, 2 percent of the population, aged 12 and older were currently using certain prescription drugs nonmedically. The data from the National Institute on Drug Abuse demonstrates that the most dramatic increase in new users of prescription drugs for nonmedical purposes occurs in the ages 12 to 17 and 18 to 25. This resolution will hopefully help this growing problem of addiction by giving parents a voice in whether their child should be medicated or not without the consequence of having their child removed from school.

Teachers and other school personnel will still be able to recommend to parents if they feel there is a medical problem with the child, be it a need for a hearing or vision test, or if there is concern that maybe the child should be seen by a physician for diabetes, epilepsy or attention deficit disorder.

Of course, our teachers and school personnel are with our children for a

longer period of time during the day and, of course, many may witness problems that parents may not see before or after school. But no parent or child should be forced to use prescription drugs to obtain an education. There is still something called patients' rights, parents' rights, children's rights; and certainly the parents of children should have the right to determine when and if their children should be medicated or not.

I think this legislation provides the opportunity for the kind of interaction between parents and teachers so that parents get the best information. They then can make a determination, and jointly the child's education can always be the first order of concern.

Mr. Speaker, I think this is an excellent piece of legislation.

Mr. BURNS. Mr. Speaker, I reserve the balance of my time.

Ms. WOOLSEY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I appreciate all of the remarks we have heard on the floor today. I said before when the subject of Ritalin come up, I raised four children, and I am absolutely certain that Ritalin or some other psychotropic drug would have been suggested for each and every one of them sometime during their school career. In fact, when I was a kid, my grandfather used to offer to pay me 5 cents for every minute that I could sit still. Well, I never earned a nickel. So my kids came with this hyperactive behavior through the genes, and we all learned through behavior modification and through growing up that, indeed, moving around all the time was not going to get us anywhere. So they learned to be calm, before I did, actually.

But that is why I have concerns about blurring the line between the behavior of an active, high-spirited child and a child with a disability.

This is not to suggest, however, that attention deficit hyperactivity disorder, ADHD, is not a very real disability for many children. ADHD robs so many children and their parents of the pleasures of childhood and family. The children are labeled as "bad" for things that they actually cannot control. The parents find themselves frustrated and often angry at their child.

However, the growing increase in the manufacture and prescription of psychotropic drugs, like Ritalin, is a cause for concern. The decision to treat a child with any drug, but certainly a stimulant, should be made very, very carefully and only after comprehensive evaluation and diagnosis. It is crucial that parents be very well informed about these drugs, both the possible successes of the drug and the possible side effects of a drug, if it is being considered for their child.

It goes without saying, parents must have the final word in deciding whether or not their child takes any psychotropic drug.

□ 1145

Mr. Speaker, I am pleased to have been part of these negotiations with

the gentleman from Georgia (Mr. BURNS) and with the other side of the aisle in our committee so we could come up with a bill that we totally support and feel will be good for the child, for the parent, and for the education system for that child.

Mr. Speaker, I yield back the balance of my time.

Mr. BURNS. Mr. Speaker, I yield myself such time as I may consume.

I would like to thank my colleagues on the other side of the aisle for working closely with us on this bill. I appreciate the gentleman from California (Mr. GEORGE MILLER), the gentlewoman from California (Ms. WOOLSEY), and the gentlewoman from California (Mrs. DAVIS), in particular, for their contributions to this important legislation.

I also would like to thank the Speaker of the House, the gentleman from Illinois (Mr. HASTERT), for his support and guidance in this effort and also the leadership as we sought to bring this bill to the floor this day.

This is a straightforward, sensible bill. It just makes common sense. It is a bipartisan bill that has been worked out to ensure the appropriate and effective protection of our children. This bill protects children. It puts the power back in the hands of the parents so they can make an informed choice in the best interests of their family. It ensures that teachers and administrators are involved in the decision process, actively involved in the child's development.

In conversations with the National Association of Education, they in their review saw no problems and are supportive of this legislation.

The most important thing about this bill is it protects children and it keeps them from being inappropriately medicated. This bill is not antischool or antiteacher; it is not antimedication. There are appropriate and reasonable ways in which we should use medication in the best interests of our children. But this bill is prochild, it is prohealth, it is proparents. It ensures that America's children are protected.

Mr. Speaker, this is good legislation, it is reasonable legislation, and it is legislation that is good for America. I urge my colleagues to support H.R. 1170.

Mr. HASTERT. Mr. Speaker, I rise today in support of H.R. 1170, the Child Medication Safety Act, which prohibits school personnel from requiring a child be medicated in order to receive an education and stay in the classroom.

There have been reports that schools have forced parents to put their children on medication, such as Ritalin, in order to allow them to continue attending school. Some have gone so far as to keep children out of the classroom until the parents relent and agree to put their kids on these drugs. In one specific case, a child was removed from their home because the parents refused to put them on medication as mandated by the school. This is outrageous. School personnel should never presume to know the medication needs of a child.

Only medical doctors have the ability to determine if a prescription for a psychotropic drug is appropriate for a child.

As a former school teacher, I am sympathetic to need to have order in a classroom with as few disruptions as possible. However, it has been my experience that kids will be kids and there will always be children in the classroom who are overactive or inattentive.

It's important to note that nothing in this legislation prevents a school or school personnel from recommending a parent seek medical review of their child's physical or mental health. This legislation just keeps them from requiring medication in order to receive education services. The prescribing of medication should be left to parents and medical professionals not school officials.

Psychotropic drugs are serious medications and have an altering effect on the mind. These drugs have potential for serious harm, addiction and abuse that is why they are listed on Schedule II and IV of the Controlled Substances Act. Therefore, it is critical that they only be prescribed by licensed medical practitioners who have seen the child and made a medical evaluation to determine a diagnosis and the proper needs of a child.

H.R. 1170, the Child Medication Safety Act, is important legislation that protects children and parents. I would like to thank Congressman BURNS and Chairman BOEHNER for their hard work on this bill. I strongly support their efforts to move this legislation forward.

Mrs. BLACKBURN. Mr. Speaker, no parent should feel forced to put their child on a psychotropic drug like Ritalin or Adderall. But that is just what is happening every day in schools across America. Currently, teachers can coerce parents by demanding that their child be medicated to attend their class.

This is wrong. Parents should not feel pressured to make a choice for their child because a teacher or school administrator—individuals who do not have a medical background to make these suggestions—tells them their child must be medicated. That is why House Resolution 1170, the Child Medication Safety Act of 2003, is such an important piece of legislation. It gives parents the ultimate power in deciding whether or not their child should be on medication.

This bill requires states that receive Federal education funds to establish policies and procedures that prohibit school officials and teachers from requiring a child to be on a psychotropic drug to attend school.

Of course, parents often seek the advice and input of their child's teacher. But this bill calls for open communication between parents and teachers. Once a teacher or other school official meets with the parent and makes a suggestion that medication may be needed for a child to learn in the best way possible, the parent can then go to their family doctor to discuss both the risks and the benefits of these psychotropic drugs and make the choice themselves after weighing all of the options.

Parents are the only ones who should make the ultimate decision whether their child needs to be on medication. They should never be told that their child cannot attend school without being on a drug like Ritalin. H.R. 1170 gives the power to the parent when it comes to these choices.

Mr. BOEHNER. Mr. Speaker, I rise today in support of H.R. 1170, the Child Medication

Safety Act, which will prevent school personnel from requiring a child to obtain a prescription for a medication in order to remain in the classroom.

I would first like to thank my colleague from Georgia, Representative MAX BURNS, for his leadership in introducing this legislation to address this significant issue. I would also like to thank LYNN WOOLSEY for her help to improve this legislation. I am please to support this bipartisan legislation and am thankful for their efforts.

We have heard from numerous parents and grandparents that have been coerced or pressured by school districts into placing their child on medication in order for the child to attend school or receive services. I recognize the difficulty that children with attention or behavior problems bring to school, but no one should react by automatically assuming that the child should be on drugs. And certainly an individual without a medical license should not presume to understand the severity of a problem and simply assume that the child would be better off with drugs.

I'm sure that in these situations school personnel think they are doing the child, and the parents, a favor. But they are not. Instead they create new problems, unintended problems, and add to the culture where a pill should magically solve all of the child's problems. Worse, the quick fix of a pill fails to account for the potentially harmful effects of these drugs when not properly administered.

The diagnosis of a disability or emotional or behavioral problem requires the careful examination and discussion with a licensed medical practitioner. This bill protects that dialogue and ensures that parents are not forced to decide between their own preferences and a school official who is acting inappropriately.

I think it is also important to point out that we have provided strong safeguards to protect appropriate communication between the parent and the teacher. Teachers will still be able to share their observations with parents about the child's behavior in the classroom and the school. Teachers and parents will still be able to discuss the child's academic performance. This bill does not stifle appropriate communication.

This bill has the clear and simple goal of preventing school officials from requiring children to be medicated with a controlled substance in order to attend school. This is a goal we can and should all support.

H.R. 1170 is an important bill that will provide security and comfort to both teachers and parents to ensure that our children are protected. I urge my colleagues to support this bill.

Mr. BURTON of Indiana. Mr. Speaker, I rise to express my support for the "Child Medication Safety Act of 2003 (H.R. 1170)," which would prohibit the required administration of psychotropic medications in order for children to attend school.

Like many Members, I believe that our children are our future. We need to do our best to protect and improve the health and well-being of our Nation's children, including protecting them from medications that can potentially harm them.

While I was the Chairman of the Full Committee on Government Reform, I held a hearing on September 26, 2002, to examine allegations that too many children are being medicated for Attention Deficit Disorder (ADD) and

Attention Deficit/Hyperactivity Disorder (ADHD) at increasingly younger ages, and to discuss the health implications of these drugs.

Our investigation found that disorders, such as ADD and ADHD, are diagnosed by a checklist of behaviors, not medical science. According to the National Institutes of Health, the behaviors, or "symptoms" used to diagnose these disorders are inattention, hyperactivity, and impulsivity. Based on these descriptions, almost every child in the United States would be considered afflicted, and under current law, be required to take psychotropic medication to attend school.

Ritalin is perhaps the most prescribed psychotropic drug used to control children with behavioral problems. It is estimated that four to six million children are taking this drug daily in the United States, a 500 percent increase since 1990.

Ritalin is classified as a Schedule II stimulant. This means that it has met three criteria: (1) it has a high potential for abuse; (2) it has a currently accepted medical use in the treatment; and (3) it is shown that abuse may lead to severe psychological or physical dependence. According to research published in the Journal of the American Medical Association, Ritalin was shown to be a more potent transport inhibitor than cocaine. In addition, the chronic use of Ritalin can lead to: aggression, agitation, disruption of food intake, weight loss, and even death.

Schools should not be able to force parents to administer these psychotropic drugs to their children—not only are these disorders diagnosed without physiological testing, but they can also lead these children to further drug-use and dependence, or even the worst of all scenarios . . . death.

Mr. Speaker, H.R. 1170 would protect our children from being required by schools to become subject to psychotropic medications that can lead to detrimental health effects as well as drug addiction based on unscientific diagnoses. I urge continued support from my colleagues on this important legislation.

The SPEAKER pro tempore (Mr. LAHOOD). The question is on the motion offered by the gentleman from Georgia (Mr. BURNS) that the House suspend the rules and pass the bill, H.R. 1170, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. BURNS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

PROVIDING FOR CONSIDERATION OF H.R. 1588, NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mrs. MYRICK. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 245 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 245

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 1588) to authorize appropriations for fiscal year 2004 for military activities of the Department of Defense, to prescribe military personnel strengths for fiscal year 2004, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and the amendments made in order by this resolution and shall not exceed two hours equally divided and controlled by the chairman and ranking minority member of the Committee on Armed Services. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute recommended by the Committee on Armed Services now printed in the bill. The committee amendment in the nature of a substitute shall be considered as read. All points of order against the committee amendment in the nature of a substitute are waived. No amendment to the committee amendment in the nature of a substitute shall be in order except those printed in the report of the Committee on Rules accompanying this resolution and those made in order by a subsequent order of the House. Each amendment printed in the report of the Committee on Rules may be offered only in the order printed in the report (except as specified in section 2 of this resolution), may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment (except that the chairman and ranking minority member of the Committee on Armed Services each may offer one pro forma amendment for the purpose of further debate on any pending amendment), and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. All points of order against amendments printed in the report are waived. After disposition of the amendments printed in the report, the Committee of the Whole shall rise without motion. No further consideration of the bill shall be in order except by a subsequent order of the House.

SEC. 2. The Chairman of the Committee of the Whole may recognize for consideration of any amendment printed in the report of the Committee on Rules out of the order printed, but not sooner than one hour after the chairman of the Committee on Armed Services or a designee announces from the floor a request to that effect.

SEC. 3. During consideration of the bill under this resolution or by a subsequent order of the House—

(1) after a motion that the Committee rise has been rejected on a legislative day, the Chairman of the Committee of the Whole may entertain another such motion on that day only if offered by the chairman of the Committee on Armed Services or the Majority Leader or a designee; and

(2) after a motion to strike out the enacting words of the bill (as described in clause 9 of rule XVIII) has been rejected, the Chairman may not entertain another such motion.

The SPEAKER pro tempore. The gentleman from North Carolina (Mrs. MYRICK) is recognized for 1 hour.

Mrs. MYRICK. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman