Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	re: Meeting (13 pages)	03/20	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Heather Howard (Subject Files)
OA/Box Number: 21197

FOLDER TITLE:
[Meetings on Ritalin] [Loose]

2012-0254-S
rc685

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

5/16 House Education + Workforce Cmte

chris krock - cmte majority staff — hearing on Ritalin

schaeffer — Colorado State Bd. of Ed passed resolution discouraging use of Ritalin + encouraging use of std. classroom mgt - so dist get another Blythe Shelburne

Castle just wants to do something

- out of cmte's jurisdiction
- TV station in Castle's district did investigative report

alex
fax 225-3614 -
phone 226-2068

Beverly Malone
~~fax~~ 690-7694
(Betty)
fax 690-6960

witnesses: Pryce
Kucinich
Lawrence Diller - behavioral psychiatrist has written articles testifying a little negative
special ed teacher - pro-Ritalin
parent - past-president CHADD
DEA - abuse - kids in college

not proposing any legislation

3 hour hearing w/ nothing to come out of it
-"no hook"

(cntd.) Chris Ann Pirie - fax 226 1010 phone . 225-4527
Kara - Castle personal office 225 2221 (fax)
225-4165 (phone)

Education + Workforce

Subc. on Early Childhood
Youth & Families
Castle / Kildee

witnesses -
Deborah Pryce
Dennis Kucinic 690-7694
[3339] - ecclectic
5700 - ma - library
martha
behavioral pediatrician

Dept. Director - DEA
- ask for alex knock
226-2068

SG's Conferenca

4/17 Conference Call -Ritchie

Chris + Deborah
Liz Sumaya
Beverly Marlene

prep for more formal mtg - pre-planning mtg.

Chris - asks Beverly what their thoughts are, who they are involving

mtg of selected as chair - invite those who want to be involved - ask them to submit something in writing
- talk about universe of issues
May or June - 1½ - 2 hours

Then follow up smaller planning group - Core group working group
mostly internal folks

Sept - Late Aug.

Chris - ask for written comments 2 weeks before the mtg, need to give them 2 weeks to prepare something

Chris - come up w/ a list before you send a letter inviting ~~to~~ input + share w/ us.

Beverly will get Chris the list + he'll circulate around WH

BMalone@osophs.dhhs.gov (Beverly Malone)
04/07/2000 04:15:30 PM

Record Type: Record

To: Heather H. Howard/OPD/EOP

cc: BJames@osophs.dhhs.gov (Betty James)
Subject: Re: Conference

Heather, it's 202 690-6960. Thanks. BEV

_____ Reply Separator _____
Subject: Conference
Author: Heather_H._Howard@opd.eop.gov at INTERNET
Date: 4/6/00 8:10 PM

Beverly -- I want to send you several letters the First Lady has received from people interested in the conference. What is your fax number?

Thanks!
Heather Howard

3/28 Surgeon General's Office -

Dr. Beverly Malone - heavy on internal mtg
SG's deputy
Bernie Arons - has a big effort for kids - big #
Steve Hyman
/

- want to bring in new people - incl. NAMI

See a big mtg w/ all the groups that want to be involved
followed by smaller mtgs for planning

HRC + TG will be invited to conference

First mtg - May 8th? or June?
will include Dr. Satcher - set the agenda + the
"SG's workshop"
- will invite HRC + TG.

- told her we'd like to be involved.

Bmalone@osophs.dhhs.gov
690-7694 fax: 690-6960

3/28 Dr. Arons will send me info on what he's doing,
including NY program

4/5 called Beverly - she will call Dr. Bellanti

4/5 Dr. Bellanti

very happy to hear from me
HRC was very supportive

I will tell SG to include him in planning
The event

wants Conference to recommend Most research ~~$~~ —
cutes looking at research be broad —
not just child psychiatrists — gastroenterologists,
immunologists, environmental health, etc —
need interdisciplinary approach

finding some interesting gut lesions in kids w ADHD

look at nutrition, allergy, vitamin supplementation

4/5 — called Beverly Malone at SG's office
asked her to include Dr. Bellanti —
She will call him + ask him to submit a
statement of interest as she is doing w everyone
who is expressing interest.

Event 3/20/00

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	re: Meeting (13 pages)	03/20	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Heather Howard (Subject Files)
OA/Box Number: 21197

FOLDER TITLE:
[Meetings on Ritalin] [Loose]

2012-0254-S
rc685

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

March 18, 2000

MEETING ON THE SAFE USE OF MEDICATION FOR YOUNG CHILDREN WITH EMOTIONAL AND BEHAVIORAL CONDITIONS

Date:	**Monday, March 20, 2000**
Time:	**10:00 AM – 11:00 AM**
Location:	**Map Room, Roosevelt Room**
From:	**Ann O'Leary, Heather Howard and Ruby Shamir**

I. PURPOSE

To demonstrate your commitment to children's health by convening health and education experts to discuss the appropriate treatment of young children with emotional and behavioral conditions with a particular focus on the use of medication in treatment.

II. BACKGROUND

Overview

This event focuses on the controversy surrounding the recent increase in the prescription of stimulants and antidepressants to preschoolers despite a lack of information about the safety and efficacy of these drugs for young children.

While progress has been made in diagnosing and treating children with emotional and behavioral conditions, justifiable concerns have been raised about the inappropriate over- and under-utilization of medications such as Ritalin, clonidine, and antidepressants in the very young. Just as important, there is a lack of understanding among parents, teachers and health professionals about the best diagnostic, pharmacological, and behavioral interventions now available.

Several themes have emerged from our discussions with health professionals: 1) parents need more information on how to deal with children who are experiencing behavior changes – signs to look for, how to get help, when and what medication is appropriate; 2) the importance of proper diagnosis, and the collaboration between parents, educators, and mental health professionals that is necessary for such a diagnosis; 3) when psychotropic drugs may be appropriate, in combination with other therapies, and 4) the importance of careful monitoring and management of treatment.

At the event, along with Secretary Shalala and representatives of parents and a broad range of health and education professionals, you will announce a public-private effort to develop strategies to ensure that children with emotional and behavioral conditions are appropriately diagnosed, treated, monitored, and managed by qualified professionals.

Policy Deliverables

1. *Information for Parents*: One major theme of the event will be the importance of giving parents the information they need to help insure their children receive appropriate care. To that end, NIMH has developed an easy to understand Q&A fact sheet on treating children with mental and behavioral conditions. This fact sheet will be available on the Internet, and the groups participating in the event have agreed to distribute the fact sheet through their membership. In addition, the Department of Education will commit to distributing an information kit to parents and teachers on strategies for the many things that can do to help children with ADHD.

2. *Announcement of Federal Conference on the Treatment of Children with Behavioral and Mental Disorders*: The Surgeon General will coordinate a conference with HHS, FDA, the Department of Education and representatives of the provider, research, consumer advocacy, and education communities. Topics of discussion will include: developing a research strategy to develop interventions that can be used by providers nationwide; how best to ethically determine the efficacy and safety of medications in young children; and strategies to address the difficulty of accurate diagnosis in preschoolers.

3. *NIMH Research*: NIMH will announce that it is dedicating $X in research to determine the efficacy of medications used to treat behavioral and emotional conditions in very young children. This research, conducted in concert with FDA, will assemble the latest information on the use of these drugs, determine safety and efficacy, and identify discrepancies between clinical practice and scientific evidence.

4. *Additional Pediatric Labeling Efforts*: FDA will announce that it will work with its Pediatric Advisory Commission to design research protocols that will be used to develop new pediatric dosage information to be included on the labels of drugs such as methylphenidate (generic name for Ritalin), clonidine, and other drugs commonly used in children. These studies will be designed to address the ethical issues associated with the study of these drugs in this vulnerable population.

5. *Private Sector Efforts*: You will praise private sector efforts to improve diagnosis and treatment protocols for young children under the age of six.

JAMA Report

On February 23, 2000, JAMA published a report, "Trends in the Prescribing of Psychotropic Medications to Preschoolers," which found that the prescription of psychotropic medications for preschoolers increased dramatically between 1991 and 1995. Attached please find the abstract from this report. There were numerous press reports on this issue in response to the study; several are attached.

The studies published in JAMA, reviewing selected provider data, found that:

- The number of children aged two through four taking stimulants such as Ritalin more than doubled. Ninety percent of preschoolers on medication were on Ritalin or a similar stimulant to treat attention deficit disorders, and the number of these children increased 169 percent

over the five-year period.

- In this five-year period, the number of children under the age of five on clonidine, which is used to treat insomnia in children with attention deficit disorders, tripled.
- *Many children are inappropriately treated.* Studies indicate wide geographic variation in the numbers of children receiving psychotropic drugs such as Ritalin. One study indicated that in some suburban areas, as many as 40 percent of children were on Ritalin. Other research indicates racial variations as well: a study of one Maryland HMO indicated that African-Americans children were 2.5 times less likely to receive Ritalin as white children. This wide variation in treatment patterns supports the need for more research to determine appropriate treatment protocols for children with behavioral disorders.
- *Failure to treat emotional and behavioral disorders has severe life-long consequences.* Studies suggest that many children with untreated emotional and behavioral disorders fail to reach their full potential. Brain damage causing lifelong psychological or social damage may stem from an on-going cycle of punishment and ostracism for behaviors that the child cannot control without help. Children with these types of problems are at significantly higher risk for anti-social activities later in their life than those without behavioral problems. Accurate, early diagnosis, with education, support, and if necessary and appropriate, medication, can overcome many early problems and help prevent long-term negative behavior.
- *More research is necessary to ensure informed treatment decisions.* Many drugs of the being prescribed to very young children have not been tested in children under the age of 16; none have been tested for children under the age of six. More research is necessary to ensure that providers and parents have the information they need, especially information about the impact of medication on brain development, to make appropriate treatment decisions.

In December, the Surgeon General published the first-ever Surgeon General's Report on Mental Health, stemming from the White House Conference on Mental Health led last June by Tipper Gore. Several important messages on children and mental health came out of the conference and subsequent report: 1) children are not just small adults – their brains are very different and are continually developing, and thus what we know about the impact of medication on adults does not necessarily translate to children; 2) there is a lack of training among pediatricians and family practitioners about how to handle mental health issues in children; 3) the stigma of mental illness is often worse for children than adults; and 4) it is important to raise public awareness of the mental health problems children face.

Success of Pediatric Labeling Efforts

In 1997, you led efforts to improve the safety of pediatric drugs, championing the passage of the Better Pharmaceuticals for Children Act, enacted as part of the FDA Modernization Act. The new law provides financial incentives for pharmaceutical companies to conduct studies on the effects of their medications on children. The new financial incentives for companies, as well as new regulatory authority for pediatric labeling, have significantly improved the information available to both parents and physicians about the appropriate use of medications for children. In the 18 months since these initiatives have been implemented, research has been completed on 19 drugs, resulting in new safety information being added to six drugs with changes expected for the other 13. Studies of an additional 125 drugs are already underway. In contrast, in the five years preceding the legislation, only 11 studies to gather additional safety information about drugs

already on the market were conducted. Of course, much more still needs to be learned about young children with emotional and behavioral disorders.

III. PARTICIPANTS

Open Press Session
Secretary Shalala
Surgeon General Satcher
NIMH Director Dr. Steve Hyman
FDA Commissioner Dr. Jane Henney

Closed Strategy Session
Participants from Open Press Session plus:
Judith Heumann, Assistant Secretary, Special Education and Rehabilitative Services, Dept of Ed.
MaryLee Allen, Director, Child Welfare & Mental Health Division, Children's Defense Fund
Lanny R. Copeland, MD, Chairman of the Board, American Academy of Family Physicians
Gail Daniels, President, Board of Directors, Federation of Families for Children's Mental Health
Kevin P. Dwyer, MA, NCSP, President, National Association of School Psychologists
Michael M. Faenza, MSSW, President & CEO, National Mental Health Association
Randy A. Fisher, President, School Social Work Association of America
Mary E. Foley, MS, RN, President, American Nurses Association
Gregory A. Humphrey, Special Assistant to the President, American Federation of Teachers
Beth A. Kaplanek, RN, President Elect, Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clarice Kestenbaum, MD, President, American Academy of Child & Adolescent Psychiatry
Ronald F. Levant, Ph.D., Board of Directors, American Psychological Association
Harold James McGrady, Jr., MD, Council for Exceptional Children
Allan Tasman, MD, President, American Psychiatry Association
Jane Tustin, RN, MSN, CSN, President, National Association of School Nurses
Phil Walson, Member, MD, AAP Committee on Drugs, American Academy of Pediatrics

IV. SEQUENCE OF EVENTS

The event will have two parts: closed strategy meeting in the Map Room, and then press announcement in the Roosevelt Room.

9:30- 10:30 am	**STRATEGY MEETING** Map Room
10:00am	**THE FIRST LADY** will arrive in the Map Room
10:02- 10:20am	Each group will have 2 minutes to present their accomplishments

10:20-10:35am **THE FIRST LADY** will do a photo receiving line with group leaders.

10:35am Group leaders will be escorted to the Roosevelt Room

10:37am **THE FIRST LADY** proceeds to the Roosevelt Room joined by Shalala

10:40-10:57am **ANNOUNCEMENTS**

- Secretary Shalala will introduce the issue and you, highlighting your leadership.
- You will speak for approximately five minutes.

10:58am **THE FIRST LADY** departs

V. PRESS PLAN

- Open Press for the opening session, closed for strategy session.

VI. REMARKS

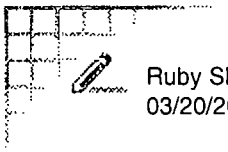
- Provided by Laura Schiller

ATTACHMENTS

- Press articles
- JAMA abstracts

To be provided with talking points:

- Press paper and NIMH Fact Sheet/Q&As for parents



Ruby Shamir
03/20/2000 08:59:54 AM

Record Type: Record

To: Jennifer H. Smith/WHO/EOP@EOP, Lissa Muscatine/WHO/EOP@EOP, Heather H. Howard/OPD/EOP@EOP, Katharine Button/WHO/EOP@EOP

cc:
Subject: ped drug mtg

List of attendees from outside administration

First Lady Hillary Rodham Clinton

Meeting on the Safe Use of Medications for Young

Children with Emotional and Behavioral Conditions

March 20, 2000

List of Attendees

Lanny R. Copeland, MD, Chairman of the Board, American Academy of Family Physicians

Gail Daniels, President, Board of Directors, Federation of Families for Children's Mental Health

Kevin P. Dwyer, MA, NCSP, President, National Association of School Psychologists

Michael M. Faenza, MSSW, President & CEO, National Mental Health Association

Randy A. Fisher, President, School Social Work Association of America

Mary E. Foley, MS, RN, President, American Nurses Association

Gregory A. Humphrey, Special Assistant to the President, American Federation of Teachers

Beth A. Kaplanek, RN, President Elect, Children and Adults with Attention-Deficit/Hyperactivity Disorder

Clarice Kestenbaum, MD, President, American Academy of Child & Adolescent Psychiatry

Ronald F. Levant, Ph.D., Board of Directors, American Psychological Association

Harold James McGrady, Jr., MD, Council for Exceptional Children

Allan Tasman, MD, President, American Psychiatry Association

Jane Tustin, RN, MSN, CSN, President, National Association of School Nurses

Phil Walson, Member, MD, AAP Committee on Drugs, American Academy of Pediatrics

MaryLee Allen, Director Child Welfare and Mental Health Division, Children's Defense Fund

Dr Brady?

Eddie Davis, NEA (did not attend closed mtg.)

4:31 pm Bdy
Chris's office: 216
or x62565, # 4421

Barbara D. Woolley
03/15/2000 12:13:52 PM

Record Type: Record

To: Ruby Shamir/OPD/EOP@EOP, Ann O'Leary/OPD/EOP@EOP, Devorah R. Adler/OPD/EOP@EOP

cc:
Subject: ritlin call today

Here's who will be on call.

Elaine Holland and possible pediatrician, American Academy of Pediatrics
Rosie Sweeney and her national president, American Academy of Family Physicians
Marj Vanderbilt, American Nurses Assn
David Dempsey, National Ass of Social Workers
Jay Cutler, American Psychiatric Assn
Al Guida, National Mental Health Assn (NMHA)

From my phone conversations today with the above folks here's what they tell me. Clearly, the 2 major groups that have been working on this issue are the pediatricians and the NMHA. The other groups have not been as engaged. I'm also getting a copy of the Dodd/Dewine letter to FDA that asks FDA to determine if their is more the FDA can within their stature to provide more information on labels.

AAP would say they hope that we would not do anything class by class but rather consider all pediatric drugs. AAP's principle concern is that fought with the Administration on the 97 FDA Reauthorization bill for the existing statutory provision. They also backed the Administration on the rule when it came out. Now, they are concerned in 2001 that Congress will say "this isn't working" and dump the language. For having supported the Administration on this effort, would not make them happy if the Adm then supported any efforts to dump it.

The NMHA, on the other had, says what they want is to seek better labeling to make the dosage info clearer. They say 70% of all children's prescriptions are prescripted by pediatricans. A vast number of the pediatric drugs haven't been tested. So they would like to have us take a closer look at what more can be done in the existing regulations to have more info..

6264

American Psychiatric Association
1400 K Street, NW
Washington, DC 20005

Division of Government Relations
Telephone: (202) 682-6060
DGR Fax : (202) 682-6287

FAX COVER

TO: Ruby

FAX: 2/ 456-2878

FR: Jay Cutler

Please contact me at (202) 682-6060 if there are any questions.

Number of pages transmitted including cover: 9 **Date:** 3/15/00

Message:

Ruby —

How the diagnosis comes into being by the medical profession.

— Jay

Important Notice:

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

DSM-IV™

PUBLISHED BY THE
AMERICAN PSYCHIATRIC ASSOCIATION
WASHINGTON, DC

Attention-Deficit/Hyperactivity Disorder

Diagnostic Features

The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development (Criterion A). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder) (Criterion E).

Inattention may be manifest in academic, occupational, or social situations. Individuals with this disorder may fail to give close attention to details or may make careless mistakes in schoolwork or other tasks (Criterion A1a). Work is often messy and performed carelessly and without considered thought. Individuals often have difficulty sustaining attention in tasks or play activities and find it hard to persist with tasks until completion (Criterion A1b). They often appear as if their mind is elsewhere or as if they are not listening or did not hear what has just been said (Criterion A1c). There may be frequent shifts from one uncompleted activity to another. Individuals diagnosed with this disorder may begin a task, move on to another, then turn to yet something else, prior to completing any one task. They often do not follow through on requests or instructions and fail to complete schoolwork, chores, or other duties (Criterion A1d). Failure to complete tasks should be considered in making this diagnosis only if it is due to inattention as opposed to other possible reasons (e.g., a failure to understand instructions). These individuals often have difficulties organizing tasks and activities (Criterion A1e). Tasks that require sustained mental effort are experienced as unpleasant and markedly aversive. As a result, these individuals typically avoid or have a strong dislike for activities that demand sustained self-application and mental effort or that require organizational demands or close concentration (e.g., homework or paperwork) (Criterion A1f). This avoidance must be due to the person's difficulties with attention and not due to a primary oppositional attitude, although secondary oppositionalism may also occur. Work habits are often disorganized and the materials necessary for doing

the task are often scattered, lost, or carelessly handled and damaged (Criterion A1g). Individuals with this disorder are easily distracted by irrelevant stimuli and frequently interrupt ongoing tasks to attend to trivial noises or events that are usually and easily ignored by others (e.g., a car honking, a background conversation) (Criterion A1h). They are often forgetful in daily activities (e.g., missing appointments, forgetting to bring lunch) (Criterion A1i). In social situations, inattention may be expressed as frequent shifts in conversation, not listening to others, not keeping one's mind on conversations, and not following details or rules of games or activities.

Hyperactivity may be manifested by fidgetiness or squirming in one's seat (Criterion A2a), by not remaining seated when expected to do so (Criterion A2b), by excessive running or climbing in situations where it is inappropriate (Criterion A2c), by having difficulty playing or engaging quietly in leisure activities (Criterion A2d), by appearing to be often "on the go" or as if "driven by a motor" (Criterion A2e), or by talking excessively (Criterion A2f). Hyperactivity may vary with the individual's age and developmental level, and the diagnosis should be made cautiously in young children. Toddlers and preschoolers with this disorder differ from normally active young children by being constantly on the go and into everything; they dart back and forth, are "out of the door before their coat is on," jump or climb on furniture, run through the house, and have difficulty participating in sedentary group activities in preschool classes (e.g., listening to a story). School-age children display similar behaviors but usually with less frequency or intensity than toddlers and preschoolers. They have difficulty remaining seated, get up frequently, and squirm in, or hang on to the edge of, their seat. They fidget with objects, tap their hands, and shake their feet or legs excessively. They often get up from the table during meals, while watching television, or while doing homework; they talk excessively; and they make excessive noise during quiet activities. In adolescents and adults, symptoms of hyperactivity take the form of feelings of restlessness and difficulty engaging in quiet sedentary activities.

Impulsivity manifests itself as impatience, difficulty in delaying responses, blurting out answers before questions have been completed (Criterion A2g), difficulty awaiting one's turn (Criterion A2h), and frequently interrupting or intruding on others to the point of causing difficulties in social, academic, or occupational settings (Criterion A2i). Others may complain that they cannot get a word in edgewise. Individuals with this disorder typically make comments out of turn, fail to listen to directions, initiate conversations at inappropriate times, interrupt others excessively, intrude on others, grab objects from others, touch things they are not supposed to touch, and clown around. Impulsivity may lead to accidents (e.g., knocking over objects, banging into people, grabbing a hot pan) and to engagement in potentially dangerous activities without consideration of possible consequences (e.g., riding a skateboard over extremely rough terrain).

Behavioral manifestations usually appear in multiple contexts, including home, school, work, and social situations. To make the diagnosis, some impairment must be present in at least two settings (Criterion C). It is very unusual for an individual to display the same level of dysfunction in all settings or within the same setting at all times. Symptoms typically worsen in situations that require sustained attention or mental effort or that lack intrinsic appeal or novelty (e.g., listening to classroom teachers, doing class assignments, listening to or reading lengthy materials, or working on monotonous, repetitive tasks). Signs of the disorder may be minimal or absent when the person is under very strict control, is in a novel setting, is engaged in especially interesting activities, is in a one-to-one situation (e.g., the clinician's office), or while the person experiences frequent rewards for appropriate behavior. The symptoms are more likely

to occur in group situations (e.g., in playgroups, classrooms, or work environments). The clinician should therefore inquire about the individual's behavior in a variety of situations within each setting.

Subtypes

Although most individuals have symptoms of both inattention and hyperactivity-impulsivity, there are some individuals in whom one or the other pattern is predominant. The appropriate subtype (for a current diagnosis) should be indicated based on the predominant symptom pattern for the past 6 months.

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type. This subtype should be used if six (or more) symptoms of inattention and six (or more) symptoms of hyperactivity-impulsivity have persisted for at least 6 months. Most children and adolescents with the disorder have the Combined Type. It is not known whether the same is true of adults with the disorder.

314.00 Attention Deficit/Hyperactivity Disorder, Predominantly Inattentive Type. This subtype should be used if six (or more) symptoms of inattention (but fewer than six symptoms of hyperactivity-impulsivity) have persisted for at least 6 months.

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type. This subtype should be used if six (or more) symptoms of hyperactivity-impulsivity (but fewer than six symptoms of inattention) have persisted for at least 6 months. Inattention may often still be a significant clinical feature in such cases.

Recording Procedures

Individuals who at an earlier stage of the disorder had the Predominantly Inattentive Type or the Predominantly Hyperactive-Impulsive Type may go on to develop the Combined Type and vice versa. The appropriate subtype (for a current diagnosis) should be indicated based on the predominant symptom pattern for the past 6 months. If clinically significant symptoms remain but criteria are no longer met for any of the subtypes, the appropriate diagnosis is Attention-Deficit/Hyperactivity Disorder, In Partial Remission. When an individual's symptoms do not currently meet full criteria for the disorder and it is unclear whether criteria for the disorder have previously been met, Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified should be diagnosed.

Associated Features and Disorders

Associated descriptive features and mental disorders. Associated features vary depending on age and developmental stage and may include low frustration tolerance, temper outbursts, bossiness, stubbornness, excessive and frequent insistence that requests be met, mood lability, demoralization, dysphoria, rejection by peers, and poor self-esteem. Academic achievement is often impaired and devalued, typically leading to conflict with the family and school authorities. Inadequate self-application to tasks that require sustained effort is often interpreted by others as indicating laziness, a poor sense of responsibility, and oppositional behavior. Family relationships are often characterized by resentment and antagonism, especially because variability in the individual's symp-

tomatic status often leads parents to believe that all the troublesome behavior is willful. Individuals with Attention-Deficit/Hyperactivity Disorder may obtain less schooling than their peers and have poorer vocational achievement. Intellectual development, as assessed by individual IQ tests, appears to be somewhat lower in children with this disorder. In its severe form, the disorder is very impairing, affecting social, familial, and scholastic adjustment. A substantial proportion of children referred to clinics with Attention-Deficit/Hyperactivity Disorder also have Oppositional Defiant Disorder or Conduct Disorder. There may be a higher prevalence of Mood Disorders, Anxiety Disorders, Learning Disorders, and Communication Disorders in children with Attention-Deficit/Hyperactivity Disorder. This disorder is not infrequent among individuals with Tourette's Disorder; when the two disorders coexist, the onset of Attention-Deficit/Hyperactivity Disorder often precedes the onset of the Tourette's Disorder. There may be a history of child abuse or neglect, multiple foster placements, neurotoxin exposure (e.g., lead poisoning), infections (e.g., encephalitis), drug exposure in utero, low birth weight, and Mental Retardation.

Associated laboratory findings. There are no laboratory tests that have been established as diagnostic in the clinical assessment of Attention-Deficit/Hyperactivity Disorder. Tests that require effortful mental processing have been noted to be abnormal in groups of individuals with Attention-Deficit/Hyperactivity Disorder compared with control subjects, but it is not yet entirely clear what fundamental cognitive deficit is responsible for this.

Associated physical examination findings and general medical conditions. There are no specific physical features associated with Attention-Deficit/Hyperactivity Disorder, although minor physical anomalies (e.g., hypertelorism, highly arched palate, low-set ears) may occur at a higher rate than in the general population. There may also be a higher rate of physical injury.

Specific Culture, Age, and Gender Features

Attention-Deficit/Hyperactivity Disorder is known to occur in various cultures, with variations in reported prevalence among Western countries probably arising more from different diagnostic practices than from differences in clinical presentation.

It is especially difficult to establish this diagnosis in children younger than age 4 or 5 years, because their characteristic behavior is much more variable than that of older children and may include features that are similar to symptoms of Attention-Deficit/Hyperactivity Disorder. Furthermore, symptoms of inattention in toddlers or preschool children are often not readily observed because young children typically experience few demands for sustained attention. However, even the attention of toddlers can be held in a variety of situations (e.g., the average 2- or 3-year-old child can typically sit with an adult looking through picture books). In contrast, young children with Attention-Deficit/Hyperactivity Disorder move excessively and typically are difficult to contain. Inquiring about a wide variety of behaviors in a young child may be helpful in ensuring that a full clinical picture has been obtained. As children mature, symptoms usually become less conspicuous. By late childhood and early adolescence, signs of excessive gross motor activity (e.g., excessive running and climbing, not remaining seated) are less common, and hyperactivity symptoms may be confined to fidgetiness or an inner

feeling of jitteriness or restlessness. In school-age children, symptoms of inattention affect classroom work and academic performance. Impulsive symptoms may also lead to the breaking of familial, interpersonal, and educational rules, especially in adolescence. In adulthood, restlessness may lead to difficulty in participating in sedentary activities and to avoiding pastimes or occupations that provide limited opportunity for spontaneous movement (e.g., desk jobs).

The disorder is much more frequent in males than in females, with male-to-female ratios ranging from 4:1 to 9:1, depending on the setting (i.e., general population or clinics).

Prevalence

The prevalence of Attention-Deficit/Hyperactivity Disorder is estimated at 3%–5% in school-age children. Data on prevalence in adolescence and adulthood are limited.

Course

Most parents first observe excessive motor activity when the children are toddlers, frequently coinciding with the development of independent locomotion. However, because many overactive toddlers will not go on to develop Attention-Deficit/Hyperactivity Disorder, caution should be exercised in making this diagnosis in early years. Usually, the disorder is first diagnosed during elementary school years, when school adjustment is compromised. In the majority of cases seen in clinical settings, the disorder is relatively stable through early adolescence. In most individuals, symptoms attenuate during late adolescence and adulthood, although a minority experience the full complement of symptoms of Attention-Deficit/Hyperactivity Disorder into mid-adulthood. Other adults may retain only some of the symptoms, in which case the diagnosis of Attention-Deficit/Hyperactivity Disorder, In Partial Remission, should be used. This diagnosis applies to individuals who no longer have the full disorder but still retain some symptoms that cause functional impairment.

Familial Pattern

Attention-Deficit/Hyperactivity Disorder has been found to be more common in the first-degree biological relatives of children with Attention-Deficit/Hyperactivity Disorder. Studies also suggest that there is a higher prevalence of Mood and Anxiety Disorders, Learning Disorders, Substance-Related Disorders, and Antisocial Personality Disorder in family members of individuals with Attention-Deficit/Hyperactivity Disorder.

Differential Diagnosis

In early childhood, it may be difficult to distinguish symptoms of Attention-Deficit/Hyperactivity Disorder from **age-appropriate behaviors in active children** (e.g., running around or being noisy).

Symptoms of inattention are common among children with low IQ who are placed in academic settings that are inappropriate to their intellectual ability. These behaviors must be distinguished from similar signs in children with Attention-Deficit/Hyperactivity Disorder. In children with **Mental Retardation,** an additional diagnosis of Attention-

Deficit/Hyperactivity Disorder should be made only if the symptoms of inattention or hyperactivity are excessive for the child's mental age. Inattention in the classroom may also occur when children with high intelligence are placed in academically **understimulating environments.** Attention-Deficit/Hyperactivity Disorder must also be distinguished from difficulty in goal-directed behavior in children from inadequate, disorganized, or chaotic environments. Reports from multiple informants (e.g., babysitters, grandparents, or parents of playmates) are helpful in providing a confluence of observations concerning the child's inattention, hyperactivity, and capacity for developmentally appropriate self-regulation in various settings.

Individuals with **oppositional behavior** may resist work or school tasks that require self-application because of an unwillingness to conform to others' demands. These symptoms must be differentiated from the avoidance of school tasks seen in individuals with Attention-Deficit/Hyperactivity Disorder. Complicating the differential diagnosis is the fact that some individuals with Attention-Deficit/Hyperactivity Disorder develop secondary oppositional attitudes toward such tasks and devalue their importance, often as a rationalization for their failure.

Attention-Deficit/Hyperactivity Disorder is not diagnosed if the symptoms are better accounted for by **another mental disorder** (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, Personality Disorder, Personality Change Due to a General Medical Condition, or a Substance-Related Disorder). In all these disorders, the symptoms of inattention typically have an onset after age 7 years, and the childhood history of school adjustment generally is not characterized by disruptive behavior or teacher complaints concerning inattentive, hyperactive, or impulsive behavior. When a Mood Disorder or Anxiety Disorder co-occurs with Attention-Deficit/Hyperactivity Disorder, each should be diagnosed. Attention-Deficit/Hyperactivity Disorder is not diagnosed if the symptoms of inattention and hyperactivity occur exclusively during the course of a **Pervasive Developmental Disorder** or a **Psychotic Disorder.** Symptoms of inattention, hyperactivity, or impulsivity related to the use of medication (e.g., bronchodilators, isoniazid, akathisia from neuroleptics) in children before age 7 years are not diagnosed as Attention-Deficit/Hyperactivity Disorder but instead are diagnosed as **Other Substance-Related Disorder Not Otherwise Specified.**

Diagnostic criteria for Attention-Deficit/ Hyperactivity Disorder

A. Either (1) or (2):

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

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

(b) often has difficulty sustaining attention in tasks or play activities

(continued)

☐ **Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder** (*continued*)

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

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

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

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

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

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

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

(continued)

☐ **Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder** (*continued*)

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

314.9 Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified

This category is for disorders with prominent symptoms of inattention or hyperactivity-impulsivity that do not meet criteria for Attention-Deficit/Hyperactivity Disorder.

Press Paper

FIRST LADY HILLARY RODHAM CLINTON LAUNCHES NEW PUBLIC-PRIVATE EFFORT TO IMPROVE THE DIAGNOSIS AND TREATMENT OF CHILDREN WITH EMOTIONAL AND BEHAVIORAL CONDITIONS
March 20, 2000

Today, First Lady Hillary Rodham Clinton, together with Secretary Shalala and representatives of parents and a broad range of health professionals, launched an unprecedented public-private effort to ensure that children with emotional and behavioral conditions are appropriately diagnosed, treated, monitored, and managed by qualified health care professionals, parents, and educators. Federal actions she will outline include: (1) the release of a new, easy to understand fact sheet about treatment of children with emotional and behavioral conditions for parents; (2) a new $5 million funding commitment by the National Institute of Mental Health (NIMH) to conduct additional research on the impact of psychotropic medication on children under the age of seven; (3) the initiation of a process at the Food and Drug Administration (FDA) to improve pediatric labeling information for young children; and (4) a national conference on Treatment of Children with Behavioral and Mental Disorders to take place this fall. The First Lady will also highlight actions taken by the private sector to ensure appropriate diagnosis and effective treatment of these children. All of these actions build on the landmark work resulting from the first ever White House Conference on Mental Health and the release of the unprecedented Surgeon General's Report on Mental Health last year, both of which were spearheaded by Tipper Gore, the President's Mental Health Advisor.

INAPPROPRIATE DIAGNOSIS AND TREATMENT OF BEHAVIORAL AND EMOTIONAL CONDITIONS HAVE ADVERSE CONSEQUENCES. While progress has been made in diagnosing and treating these conditions, justifiable concerns have been raised about the inappropriate (both over and under) utilization of medications such as Ritalin, clonidine, and Prozac in very young children. Just as important, there is a lack of understanding amongst parents, teachers, and health professionals about the best diagnostic, pharmacological, and behavioral interventions now available. Recent studies published in the *Journal of the American Medical Association* reviewing selected provider data over a five year period found that:

- **Failure to treat emotional and behavioral disorders can have severe life-long consequences.** Studies suggest that many children with untreated emotional and behavioral conditions fail to reach their full potential. Untreated mental illness has a negative impact on the developing brain, causing lifelong emotional and social damage. Children with these types of problems are at significantly higher risk for anti-social activities later on than those without behavioral problems. It is evident that an accurate early diagnosis, education, support, and medication, if necessary, can overcome many early problems and help prevent long-term negative behavior.

- **The number of preschoolers on anti-depressants increased by over 200 percent.** The number of children on tri-cyclic anti-depressants, often used to control bedwetting, increased 220 percent over five years. Given the difficulty of diagnosing depression in children this young and the relative normalcy of bedwetting in children this young, the increase in the use of this drug in preschoolers is troubling.

- **The number of children under the age of five on clonidine increased exponentially.** The 28-fold increase in children using clonidine, used in children with attention deficit disorders or children exhibiting disruptive behaviors, is notable, as the increase in its use occurred without research ensuring that it is safe and effective. Adverse effects, including rapid or irregular heartbeat and fainting, have been reported in children using the drug with other medications for attention-deficit disorder.

- **The number of children aged two through four taking stimulants such as Ritalin more than doubled.** The vast majority of preschoolers taking stimulants were on Ritalin to treat attention deficit disorders – as many as ninety percent in one study – and the number of these children increased by 150 percent over a five year period. Although there are a disproportionate number of boys taking medication for attention deficit disorders as opposed to girls (a ratio of 4:1), the number of girls being diagnosed and treated with attention deficit disorders increased over this time period; in one study, the proportion of girls taking stimulants increased by 60 percent.

- **Many children are inappropriately diagnosed and treated.** Studies indicate wide geographic and ethnic variation in the numbers of children receiving psychotropic drugs such as Ritalin. In one study, the percentage of children receiving Ritalin was as high as 10 percent – 2 to 3 times as high as the expected rate of attention deficit disorder. The percentage of boys receiving medication for attention deficit disorder in the fifth grade was as high as 20 percent. Other research indicates racial variations as well; a study of one Maryland HMO indicated that African-Americans children were 2.5 times less likely to receive Ritalin as white children. This wide variation in treatment patterns supports the need for more research to determine appropriate treatment protocols for children with emotional and behavioral disorders. Although little is known about the effects of over medication on children, unnecessary use of these medications can have adverse effects on the developing brain and the emotional and social development of young children.

- **More research is necessary to ensure informed treatment decisions.** Many of the drugs being prescribed for very young children have not been tested in children under the age of 16; few have been tested for children under the age of six. More research is necessary to ensure that providers and parents have necessary information, especially about the impact of medication on brain development, to make appropriate treatment decisions.

NEW ACTION TO ENSURE BETTER DIAGNOSIS, TREATMENT, AND MANAGEMENT OF CHILDREN WITH EMOTIONAL AND BEHAVIORAL CONDITIONS. At today's meeting, the First Lady will announce a series of public and private actions designed to address the challenges posed by children with emotional and behavioral conditions. Federal actions she will outline include:

- **Initiation of a process for the development of pediatric labeling information for psychotropic drugs used in young children.** Today, FDA will announce that it will work with its Pediatric Advisory Committee to design research protocols that will be used to develop new pediatric dosage information to be included on the labels of drugs such as methylphenidate, clonidine, and other drugs increasingly used in young children. These studies, which will begin after national research goals have been identified, will be designed to address ethical and scientific issues associated with the studies on this population.

- **Announcement that NIMH will dedicate more than $5 million to research on attention deficit disorder and Ritalin use in preschoolers.** Today, the National Institute of Mental Health announced that it plans to invest more than $5 million in research on the use of medication to treat attention deficit disorder in preschool children. This research will assemble the latest information on the use of these drugs and identify discrepancies between clinical practice and current scientific evidence.

- **New efforts to provide parents with up-to-date information on the appropriate diagnosis and treatment of children with emotional and behavioral conditions.** This week, NIMH will release a new fact sheet to help parents of children with behavioral and emotional conditions understand the treatment options available and guide them in their decision-making process. This fact sheet includes easy to understand information on when to include medication in an overall treatment plan; how to help determine if a child's problems are serious; and when and how to get help. The Department of Education will also release an information kit on ways for teachers and parents of children with attention deficit disorders.

- **A national Conference on the Diagnosis and Treatment of Children with Behavioral and Mental Disorders.** This fall, the Office of the Surgeon General, together with NIMH and FDA, will coordinate a Conference on Treatment of Children with Behavioral and Mental Conditions. This national conference, which will build on the success of the recent White House Conference on Mental Health chaired by Tipper Gore, and the Surgeon General's Report on Mental Health, will include representatives of provider, consumer advocacy, and education communities. Topics of discussion include: developing research on treatments and services that can be used by providers nationwide; how best to determine the efficacy and safety of medications in young children; and ways to address the difficulty of accurate diagnosis in preschoolers. The Surgeon General will also release a report on children's mental health by the end of the year.

NEW PRIVATE SECTOR COMMITMENT TO ENSURING APPROPRIATE DIAGNOSIS OF EMOTIONAL AND BEHAVIORAL CONDITIONS IN YOUNG CHILDREN. Today, the First Lady will praise and highlight the new efforts of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) to ensure appropriate diagnosis and effective treatment of children with emotional and behavioral conditions. This spring, the AAP will distribute new clinical practice guidelines on the diagnosis and evaluation of children with attention deficit disorders. to every one of their 55,000 members. In addition, as part of their focus on mental health in the year 2000, the AAFP will sponsor education courses nationwide for their over 89,000 members on how to address the problems of young children with emotional and behavioral conditions.

HILLARY ROHDAM CLINTON'S LONGSTANDING COMMITMENT TO CHILDREN. For over 25 years, Hillary Clinton has fought to raise awareness and support policies that protect children. She was a strong advocate for: the passage of the Children's Health Insurance Program, the Family and Medical Leave Act; new regulatory and statutory authority for pediatric labeling; administration efforts to improve child care. The new pediatric labeling regulations and the FDA Modernization Act enacted by the Clinton Administration have improved the information available to both parents and physicians about the appropriate use of medications for children. In the 18 months since these initiatives have been implemented, research has been completed on 19 drugs,

resulting in new safety information being added to six drugs with changes expected for the other 13. Studies of an additional 125 drugs are already underway.

Launch of New Public-Private Effort to Improve the Diagnosis and Treatment of Children with Emotional and Behavioral Conditions

Remarks by First Lady Hillary Rodham Clinton
Roosevelt Room
March 20, 2000

Thank you all for joining us here this morning. I want to thank Secretary Shalala for her leadership, and I'm also pleased she refuses to sit still. Because whenever our children's health is at stake, she's out there working very hard to make sure we all pay attention.

Also, I'm pleased to be joined not only by Secretary Shalala, but by Surgeon General David Satcher, and FDA Director Jane Henney, and NMIH Commissioner Dr. Steve Hyman, and Dr. Judith Heumann, and representatives from many of the groups who are on the frontlines working on behalf of all of our children, particularly children with behavioral and emotional challenges.

We just came from a meeting where we talked about what more we can do to ensure that children with emotional and behavioral problems get the diagnosis and treatment they need, and when they need it. Today's meeting and the announcements around it are important steps, but they are certainly not the last step we need to take in ensuring that all of our children get the health and support and treatment that they deserve.

You know, when a child comes to us who is hurt or sick, there is nothing more terrifying for any of us, especially parents, when we don't know how to make it better. If they have a broken arm, we want to fix it; if they have a deadly disease, we want to do everything we possibly can to cure it. And it's no different if the problem they bring to us lies in their head or their heart.

Thanks in large part to the leadership of Tipper Gore, the President's mental health adviser, we've come a long way in our battle to bring mental illness out of the shadows and make sure it is treated just as seriously as physical illness. More and more often, those treatments include drugs, even for young children. That is the issue we're here today to discuss.

As many of you know, the Journal of the American Medical Association recently reported that the number of preschoolers who are taking psychotropic drugs increased dramatically from 1991 to 1995. We know that the increase for Ritalin alone was 150 percent, and the use of anti-depressants increased over 200 percent. Now I am no doctor, as is obvious, but I am a parent and I have been a longtime children's advocate. And these findings concern me. I know they concern Dr. Hyman, Secretary Shalala and countless other experts.

But let me be very clear: We are not here to bash the use of these medications. They have literally been a Godsend for countless adults and young people with behavioral and emotional problems. We know that when children with such problems are left untreated, they may fail to

reach their God-given potential later in their lives. That's why we are here. We want the best information for every parent, every doctor, every teacher—every single person who cares for our children.

But we do have to ask some serious questions about the use of prescription drugs in all children. We have to ask, for example, how are we diagnosing, treating and caring for children with behavioral and emotional conditions? Do we have the best tools to make the most accurate diagnoses? When it comes to drug treatments for children, why are we seeing such great variations by community and race? And what effects do overuse and underuse of these medications have on our children?

We need to ask also, why aren't we doing a better job of combining drugs, when necessary, with family therapy and other behavior modifications? And what about the effects on our very youngest children who haven't been tested for these prescription drugs and whose brains are in their most critical stage of development?

These are tough questions, and none of us have all of the answers. But as we made clear in the meeting this morning, we are building on a record, not starting from scratch. We have already taken critical steps over the past few years to ensure that drugs are being tested and labeled specifically for children. Some of you may remember that was a long, drawn out struggle, that we were finally able to make progress and we were able to make an announcement at the White House last year. In so doing, we have learned that finding the right prescription for a child is not always just a matter of decreasing the dosage.

You know, I think it's important that all of us adults recognize that children are not just miniature adults; that their systems, their developmental needs, are different from that of an adult. We also learned quite a bit from the first ever Surgeon General's report on mental illness, which came out in December. It grew out of the White House Conference on Mental Illness, led by Tipper Gore. It taught us that the stigma of mental illness is worse for children; that too many health care professionals lack training in the area of children's mental, emotional and behavioral needs; and that we have a long way to go to increase awareness about children's mental health.

So clearly, we must do more. We know that the questions being raised are very difficult and they cannot be answered overnight. And they certainly won't be answered by the government, or health care professionals or educators or parents acting alone. Every single person with a stake in our children's health has an important role to play.

So I'm very pleased today to announce some of the immediate steps we are taking to make sure that children with mental illness, with behavioral and emotional problems, get the right care at the right time.

As our meeting made clear, we already know a lot about the proper diagnosis and treatment of emotional and behavioral problems in children. But that critical information has not reached many of the people who need it most—many of the parents, many of the teachers, many of the school nurses, many of the school social workers, many of the family physicians, many of

the pediatricians—so there are a few things we are going to try to do to change that.

Today, the NMIH is releasing a new, easy to understand fact sheet that parents can use to make the right decisions about their children's treatment for these conditions. The Education Department will soon release an information kit to help parents and teachers better care for children with ADHD. And I want to thank both the American Academy of Pediatrics and the American Academy of Family Physicians for all they are doing on this issue. This spring and fall, the American Academy of Pediatrics will give all of their 55,000 members up-to-date guidelines for diagnosing and treating children with emotional and behavioral problems. And as part of their yearlong focus on mental health, the American Academy of Family Physicians is sponsoring continuing education courses about these conditions for their 90,000 members.

But now we also have to admit, honestly, that there are some areas where we still just don't know enough, and that's especially true when it comes to giving prescription drugs to our very youngest children. I am pleased that NIMH will dedicate over $5 million to conduct a landmark study examining ADHD and Ritalin use in preschoolers. This study will look at the gap between what we are finding out in the science labs and what is happening in clinical practice, so we can ensure that our children get the care they need. In addition, the FDA will look at some common psychotropic drugs and begin a process to find out what dosage levels are appropriate for very young children. This information will then be included on the labels of these medications, and the studies on them will address the obvious ethical issues that arise when you examine the use of prescription drugs in such a vulnerable group.

Finally, I'm delighted that this fall, the office of the Surgeon General will coordinate a national conference on the treatment of children with behavioral and mental disorders. It will bring together experts from the administration, parents, advocates, educators, researchers, healthcare professionals and consumers. It will look at the challenges we are all still facing in caring for children with mental illnesses. It will help us develop long term strategies that each of us can use to help young people get the childhood and chance in life that we all deserve.

I remember, as we were talking today, that I was fortunate, more than 30 years ago, to work at the Yale Child Study Center, one of the premier research institutions in our country when it comes to treating our young children. And I was exposed to some of the greatest minds and experts in the country about how to treat very young children. And there was nothing more challenging and, in many ways, heartbreaking, than a preschooler with obvious mental, emotional and behavioral problems. That child cannot speak for him or herself. So it's often difficult to find out what kind of conditions in the child's life led to—if there is a cause and effect—the kind of behavior that is being observed. So I know firsthand—from 30 years of work on my own behalf, and watching experts who are really on the frontlines of this—that this is a very big challenge we are taking on today.

But I am also concerned that we are seeing increasing numbers of children who are both being diagnosed with certain disorders and whose behaviors are crying out for helpful intervention. We spoke earlier today in our meeting about the increasing number of very young children in foster care. The fastest growing group of children being put into foster care are

children under 5. They come into foster care because of abuse or neglect and they therefore have more than the kinds of problems that one would expect in the population at large. We talked about the increasing numbers of children who are in the juvenile justice and criminal justice systems. We are not doing what we need to do to help intervene and treat those children, just as we are not providing adequate medical and mental health services in our adult prisons. These are problems that affect all of society, not just the individual with the specific problem or that individual's family or those teachers and others that come into contact with that young person. This has ramifications for all of us.

All we need to do is look back a few weeks and think about the 6-year-old that brought the gun to school to kill the other 6-year-old. That is a problem that did not just occur the morning the child picked that gun up off of the bed in that terrible condition in which he was living. So all of us have a stake in the research, the diagnosis and the treatment. And I would also add that we need some other people at the table, and we're going to try to do that through Dr. Satcher's efforts and the efforts of the associations represented here. We need to be sure that the insurance industry, the HMO industry, the pharmaceutical industry—as well as decision-makers at all levels of government—are also at the table. We do have a lot of information about what works, but we need more. And that's what this meeting and these announcements are about. But we should at least be trying to implement what we do know works while we look for more answers, and follow up on the efforts that will be underway.

You know, when a child is sad or misbehaving, it is never easy for even the most well-intentioned, best-meaning parent to figure out what is happening. Anyone who has ever had a child who is pre-verbal with any kind of illness, or a toddler, or a preschooler, knows how difficult it is. Some of these young people have problems that are symptoms of nothing more than childhood or adolescence. Some of them need a parent to love them, or a person simply to listen to them talk about their pain. And yet some do have severe emotional and mental problems that can be greatly helped by prescription drugs. These children are waiting for our help—every one of them—and today we are taking important steps to provide it.

It is my great hope that this meeting will move us closer to the day that we will be able, number one, to remove the stigma from these problems so that no parent or no community has to wonder whether this is something that should be talked about, or help should be sought for. And number two, that we will treat the problems of the body and the mind the very same.

I hope that all of us will see this as a beginning and that we will be even more committed to doing whatever it takes to make sure that our children get the help, support and love that they need to have.

Thank you all very much.

Handout