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The United States leads the world in understanding the importance of overall health and well-being to the strength of a Nation and its people. What we are coming to realize is that mental health is absolutely essential to achieving prosperity. According to the landmark "Global Burden of Disease" study, commissioned by the World Health Organization and the World Bank, 4 of the 10 leading causes of disability for persons age 5 and older are mental disorders. Among developed nations, including the United States, major depression is the leading cause of disability. Also near the top of these rankings are manic-depressive illness, schizophrenia, and obsessive-compulsive disorder. Mental disorders also are tragic contributors to mortality, with suicide perennially representing one of the leading preventable causes of death in the United States and worldwide.

The U.S. Congress declared the 1990s the Decade of the Brain. In this decade we have learned much through research—in basic neuroscience, behavioral science, and genetics—about the complex workings of the brain. Research can help us gain a further understanding of the fundamental mechanisms underlying thought, emotion, and behavior—and an understanding of what goes wrong in the brain in mental illness. It can also lead to better treatments and improved services for our diverse population.

Now, with the publication of this first Surgeon General's Report on Mental Health, we are poised to take what we know and to advance the state of mental health in the Nation. We can with great confidence encourage individuals to seek treatment when they find themselves experiencing the signs and symptoms of mental distress. Research has given us effective treatments and service delivery strategies for many mental disorders. An array of safe and potent medications and psychosocial interventions, typically used in combination, allow us to effectively treat most mental disorders.

This seminal report provides us with an opportunity to dispel the myths and stigma surrounding mental illness. For too long the fear of mental illness has been profoundly destructive to people's lives. In fact mental illnesses are just as real as other illnesses, and they are like other illnesses in most ways. Yet fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover.

In this Administration, a persistent, courageous advocate of affordable, quality mental health services for all Americans is Mrs. Tipper Gore, wife of the Vice President. We salute her for her historic leadership and for her enthusiastic support of the initiative by the Surgeon General, Dr. David Satcher, to issue this groundbreaking Report on Mental Health.

The 1999 White House Conference on Mental Health called for a national antistigma campaign. The Surgeon General issued a Call to Action on Suicide Prevention in 1999 as well. This Surgeon General's Report on Mental Health takes the next step in advancing the important notion that mental health is fundamental health.

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Foreword

Since the turn of this century, thanks in large measure to research-based public health innovations, the lifespan of the average American has nearly doubled. Today, our Nation's physical health—as a whole—has never been better. Moreover, illnesses of the body once shrouded in fear—such as cancer, epilepsy, and HIV/AIDS to name just a few—increasingly are seen as treatable, survivable, even curable ailments. Yet, despite unprecedented knowledge gained in just the past three decades about the brain and human behavior, mental health is often an afterthought and illnesses of the mind remain shrouded in fear and misunderstanding.

This Report of the Surgeon General on Mental Health is the product of an invigorating collaboration between two Federal agencies. The Substance Abuse and Mental Health Services Administration (SAMHSA), which provides national leadership and funding to the states and many

professional and citizen organizations that are striving to improve the availability, accessibility, and quality of mental health services, was assigned lead responsibility for coordinating the development of the report. The National Institutes of Health (NIH), which supports and conducts research on mental illness and mental health through its National Institute of Mental Health (NIMH), was pleased to be a partner in this effort. The agencies we respectively head were able to rely on the enthusiastic participation of hundreds of people who played a role in researching, writing, reviewing, and disseminating this report. We wish to express our appreciation and that of a mental health constituency, millions of Americans strong, to Surgeon General David Satcher, M.D., Ph.D., for inviting us to participate in this landmark report.

The year 1999 witnessed the first White House Conference on Mental Health and the first Secretarial Initiative on Mental Health prepared under the aegis of the Department of Health and Human Services. These activities set an optimistic tone for progress that will be realized in the years ahead. Looking ahead, we take special pride in the remarkable record of accomplishment, in the spheres of both science and services, to which our agencies have contributed over past decades. With the impetus that the Surgeon General's report provides, we intend to expand that record of accomplishment. This report recognizes the inextricably intertwined relationship between our mental health and our physical health and well-being. The report emphasizes that mental health and mental illnesses are important concerns at all ages. Accordingly, we will continue to attend to needs that occur across the life span, from the youngest child to the oldest among us.

The report lays down a challenge to the Nation—to our communities, our health and social service agencies, our policymakers, employers, and citizens—to take action. SAMHSA and NIH look forward to continuing our collaboration to generate needed knowledge about the brain and behavior and to translate that knowledge to the service systems, providers, and citizens.

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Preface

*from the Surgeon General
U.S. Public Health Service*

The past century has witnessed extraordinary progress in our improvement of the public health through medical science and ambitious, often innovative, approaches to health care services. Previous Surgeons General reports have saluted our gains while continuing to set ever higher benchmarks for the public health. Through much of this era of great challenge and greater achievement, however, concerns regarding mental illness and mental health too often were relegated to the rear of our national consciousness. Tragic and devastating disorders such as schizophrenia, depression and bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year, yet continue too frequently to be spoken of in whispers and shame. Fortunately, leaders in the mental health field—fiercely dedicated advocates, scientists, government officials, and consumers—have been insistent that mental health flow in the mainstream of health. I agree and issue this report in that spirit.

This report makes evident that the neuroscience of mental health—a term that encompasses studies extending from molecular events to psychological, behavioral, and societal phenomena—has emerged as one of the most exciting arenas of scientific activity and human inquiry. We recognize that the brain is the integrator of thought, emotion, behavior, and health. Indeed, one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between “mental” and “physical” health.

We know more today about how to treat mental illness effectively and appropriately than we know with certainty about how to prevent mental illness and promote mental health. Common sense and

respect for our fellow humans tells us that a focus on the positive aspects of mental health demands our immediate attention.

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down.

Promoting mental health for all Americans will require scientific know-how but, even more importantly, a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fear, and misunderstanding that remain as barriers before us. It is my intent that this report will usher in a healthy era of mind and body for the Nation.

David Satcher, M.D., Ph.D.
Surgeon General

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Chapter Conclusions

Chapter 2: The Fundamentals of Mental Health and Mental Illness

The past 25 years have been marked by several discrete, defining trends in the mental health field. These have included:

1. The extraordinary pace and productivity of scientific research on the brain and behavior;
2. The introduction of a range of effective treatments for most mental disorders;
3. A dramatic transformation of our society's approaches to the organization and financing of mental health care; and
4. The emergence of powerful consumer and family movements.

Scientific Research. The brain has emerged as the central focus for studies of mental health and mental illness. New scientific disciplines, technologies, and insights have begun to weave a seamless picture of the way in which the brain mediates the influence of biological, psychological, and social factors on human thought, behavior, and emotion in health and in illness. Molecular and cellular biology and molecular genetics, which are complemented by sophisticated cognitive and behavioral sciences, are preeminent research disciplines in the contemporary neuroscience of mental health. These disciplines are affording unprecedented opportunities for "bottom-up" studies of the brain. This term refers to research that is examining the workings of the brain at the most fundamental levels. Studies focus, for example, on the complex neurochemical activity that occurs within individual nerve cells, or neurons, to process information; on the properties and roles of proteins that are expressed, or produced, by a person's genes; and on the interaction of genes with diverse environmental influences. All of these activities now are understood, with increasing clarity, to underlie learning, memory, the experience of emotion, and, when these processes go awry, the occurrence of mental illness or a mental health problem.

Equally important to the mental health field is "top-down" research: here, as the term suggests,

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the aim is to understand the broader behavioral context of the brain's cellular and molecular activity and to learn how individual neurons work together in well-delineated neural circuits to perform mental functions.

Effective Treatments. As information accumulates about the basic workings of the brain, it is the task of translational research to transfer new knowledge into clinically relevant questions and targets of research opportunity—to discover, for example, what specific properties of a neural circuit might make it receptive to safer, more effective medications. To elaborate on this example, theories derived from knowledge about basic brain mechanisms are being wedded more closely to brain imaging tools such as functional Magnetic Resonance Imaging (MRI) that can observe actual brain activity. Such a collaboration would permit investigators to monitor the specific protein molecules intended as the “targets” of a new medication to treat a mental illness or, indeed, to determine how to optimize the effect on the brain of the learning achieved through psychotherapy.

In its entirety, the new “integrative neuroscience” of mental health offers a way to circumvent the antiquated split between the mind and the body that historically has hampered mental health research. It also makes it possible to examine scientifically many of the important psychological and behavioral theories regarding normal development and mental illness that have been developed in years past. The unswerving goal of mental health research is to develop and refine clinical treatments as well as preventive interventions that are based on an understanding of specific mechanisms that can contribute to or lead to illness but also can protect and enhance mental health.

Mental health clinical research encompasses studies that involve human participants, conducted, for example, to test the efficacy of a new treatment. A noteworthy feature of contemporary clinical research is the new emphasis being placed on studying the effectiveness of interventions in actual practice settings. Information obtained from such studies increasingly provides the foundation for services research concerned with the cost, cost-effectiveness, and “deliverability” of interventions and the design—including economic considerations—of service delivery systems.

Organization and Financing of Mental Health Care. Another of the defining trends has been the

transformation of the mental illness treatment and mental health services landscapes, including increased reliance on primary health care and other human service providers. Today, the U.S. mental health system is multifaceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and educational agencies. These agencies do not always function in a coordinated manner. Its configuration reflects necessary responses to a broad array of factors including reform movements, financial incentives based on who pays for what kind of services, and advances in care and treatment technology. Although the hybrid system that exists today serves diverse functions well for many people, individuals with the most complex needs and the fewest financial resources often find the system fragmented and difficult to use. A challenge for the Nation in the near-term future is to speed the transfer of new evidence-based treatments and prevention interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems.

Consumer and Family Movements. The emergence of vital consumer and family movements promises to shape the direction and complexion of mental health programs for many years to come. Although divergent in their historical origins and philosophy, organizations representing consumers and family members have promoted important, often overlapping goals and have invigorated the fields of research as well as treatment and service delivery design. Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability, as well as by age or gender or by the racial and cultural identity of those who have mental illness.

Chapter 2 of the report was written to provide background information that would help persons from outside the mental health field better understand topics addressed in subsequent chapters of the report. Although the chapter is meant to serve as a mental health primer, its depth of discussion supports a range of conclusions:

1. The multifaceted complexity of the brain is fully consistent with the fact that it supports all behavior and mental life. Proceeding from an acknowledgment that all psychological

experiences are recorded ultimately in the brain and that all psychological phenomena reflect biological processes, the modern neuroscience of mental health offers an enriched understanding of the inseparability of human experience, brain, and mind.

2. Mental functions, which are disturbed in mental disorders, are mediated by the brain. In the process of transforming human experience into physical events, the brain undergoes changes in its cellular structure and function.
3. Few lesions or physiologic abnormalities define the mental disorders, and for the most part their causes remain unknown. Mental disorders, instead, are defined by signs, symptoms, and functional impairments.
4. Diagnoses of mental disorders made using specific criteria are as reliable as those for general medical disorders.
5. About one in five Americans experiences a mental disorder in the course of a year. Approximately 15 percent of all adults who have a mental disorder in one year also experiences a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.
6. A range of treatments of well-documented efficacy exists for most mental disorders. Two broad types of intervention include psychosocial treatments—for example, psychotherapy or counseling—and psychopharmacologic treatments; these often are most effective when combined.
7. In the mental health field, progress in developing preventive interventions has been slow because, for most major mental disorders, there is insufficient understanding about etiology (or causes of illness) and/or there is an inability to alter the *known* etiology of a particular disorder. Still, some successful strategies have emerged in the absence of a full understanding of etiology.
8. About 10 percent of the U.S. adult population use mental health services in the health sector in any year, with another 5 percent seeking such services from social service agencies, schools, or religious or self-help groups. Yet critical gaps exist between those who need service and those who receive service.
9. Gaps also exist between optimally effective

treatment and what many individuals receive in actual practice settings.

10. Mental illness and less severe mental health problems must be understood in a social and cultural context, and mental health services must be designed and delivered in a manner that is sensitive to the perspectives and needs of racial and ethnic minorities.
11. The consumer movement has increased the involvement of individuals with mental disorders and their families in mutual support services, consumer-run services, and advocacy. They are powerful agents for changes in service programs and policy.
12. The notion of recovery reflects renewed optimism about the outcomes of mental illness, including that achieved through an individual's own self-care efforts, and the opportunities open to persons with mental illness to participate to the full extent of their interests in the community of their choice.

Mental Health and Mental Illness Across the Lifespan

The Surgeon General's report takes a lifespan approach to its consideration of mental health and mental illness. Three chapters that address, respectively, the periods of childhood and adolescence, adulthood, and later adult life beginning somewhere between ages 55 and 65, capture the contributions of research to the breadth, depth, and vibrancy that characterize all facets of the contemporary mental health field.

The disorders featured in depth in Chapters 3, 4, and 5 were selected on the basis of the frequency with which they occur in our society, and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how gender and culture, in addition to age, influence the diagnosis, course, and treatment of mental illness. The chapters also note the changing role of consumers and families, with attention to informal support services (i.e., unpaid services), with which many consumers are comfortable and upon which they depend for information. Persons with mental illness and, often, their families welcome a proliferating array of support services—such as self-help programs, family self-help, crisis services, and advocacy—that help them cope with the isolation, family disruption, and possible loss of employment and housing that may accompany mental disorders.

Support services can help to dissipate stigma and to guide patients into formal care as well.

Mental health and mental illness are dynamic, ever-changing phenomena. At any given moment, a person's mental status reflects the sum total of that individual's genetic inheritance and life experiences. The brain interacts with and responds—both in its function and in its very structure—to multiple influences continuously, across every stage of life. At different stages, variability in expression of mental health and mental illness can be very subtle or very pronounced. As an example, the symptoms of separation anxiety are normal in early childhood but are signs of distress in later childhood and beyond. It is all too common for people to appreciate the impact of developmental processes in children, yet not to extend that conceptual understanding to older people. In fact, people continue to develop and change throughout life. Different stages of life are associated with vulnerability to distinct forms of mental and behavioral disorders but also with distinctive capacities for mental health.

Even more than is true for adults, children must be seen in the context of their social environments—that is, family and peer group, as well as that of their larger physical and cultural surroundings. Childhood mental health is expressed in this context, as children proceed along the arc of development. A great deal of contemporary research focuses on developmental processes, with the aim of understanding and predicting the forces that will keep children and adolescents mentally healthy and maintain them on course to become mentally healthy adults. Research also focuses on identifying what factors place some at risk for mental illness and, yet again, what protects some children but not others despite exposure to the *same* risk factors. In addition to studies of normal development and of risk factors, much research focuses on mental disorders in childhood and adolescence and what can be done to prevent or treat these conditions and on the design and operation of service settings best suited to the needs experienced by children.

For about one in five Americans, adulthood—a time for achieving productive vocations and for sustaining close relationships at home and in the community—is interrupted by mental illness. Understanding why and how mental disorders occur in adulthood, often with no apparent portents of illness in earlier years, draws heavily on the full panoply of research conducted under the aegis of

the mental health field. In years past, the onset, or occurrence, of mental illness in the adult years, was attributed principally to observable phenomena—for example, the burden of stresses associated with career or family, or the inheritance of a disease viewed to run in a particular family. Such explanations now may appear naive at best. Contemporary studies of the brain and behavior are racing to fill in the picture by elucidating specific neurobiological and genetic mechanisms that are the platform upon which a person's life experiences can either strengthen mental health or lead to mental illness. It now is recognized that factors that influence brain development prenatally may set the stage for a vulnerability to illness that may lie dormant throughout childhood and adolescence. Similarly, no single gene has been found to be responsible for any specific mental disorder; rather, variations in multiple genes contribute to a disruption in healthy brain function that, under certain environmental conditions, results in a mental illness. Moreover, it is now recognized that socioeconomic factors affect individuals' vulnerability to mental illness and mental health problems. Certain demographic and economic groups are more likely than others to experience mental health problems and some mental disorders. Vulnerability alone may not be sufficient to cause a mental disorder; rather, the causes of most mental disorders lie in some combination of genetic and environmental factors, which may be biological or psychosocial.

The fact that many, if not most, people have experienced mental health problems that mimic or even match some of the symptoms of a diagnosable mental disorder tends, ironically, to prompt many people to underestimate the painful, disabling nature of severe mental illness. In fact, schizophrenia, mood disorders such as major depression and bipolar illness, and anxiety often are devastating conditions. Yet relatively few mental illnesses have an unremitting course marked by the most acute manifestations of illness; rather, for reasons that are not yet understood, the symptoms associated with mental illness tend to wax and wane. These patterns pose special challenges to the implementation of treatment plans and the design of service systems that are optimally responsive to an individual's needs during every phase of illness. As this report concludes, enormous strides are being made in diagnosis, treatment, and service delivery, placing the productive and creative possibilities of adulthood within the reach of persons who are encumbered by mental disorders.

Late adulthood is when changes in health status may become more noticeable and the ability to compensate for decrements may become limited. As the brain ages, a person's capacity for certain mental tasks tends to diminish, even as changes in other mental activities prove to be positive and rewarding. Well into late life, the ability to solve novel problems can be enhanced through training in cognitive skills and problem-solving strategies.

The promise of research on mental health promotion notwithstanding, a substantial minority of older people are disabled, often severely, by mental disorders including Alzheimer's disease, major depression, substance abuse, anxiety, and other conditions. In the United States today, the highest rate of suicide—an all-too-common consequence of unrecognized or inappropriately treated depression—is found in older males. This fact underscores the urgency of ensuring that health care provider training properly emphasizes skills required to differentiate accurately the causes of cognitive, emotional, and behavioral symptoms that may, in some instances, rise to the level of mental disorders, and in other instances be expressions of unmet general medical needs.

As the life expectancy of Americans continues to extend, the sheer number—although not necessarily the proportion—of persons experiencing mental disorders of late life will expand, confronting our society with unprecedented challenges in organizing, financing, and delivering effective mental health services for this population. An essential part of the needed societal response will include recognizing and devising innovative ways of supporting the increasingly more prominent role that families are assuming in caring for older, mentally impaired and mentally ill family members.

Chapter 3: Children and Mental Health

1. Childhood is characterized by periods of transition and reorganization, making it critical to assess the mental health of children and adolescents in the context of familial, social, and cultural expectations about age-appropriate thoughts, emotions, and behavior.
2. The range of what is considered “normal” is wide; still, children and adolescents can and do develop mental disorders that are more severe than the “ups and downs” in the usual course of development.
3. Approximately one in five children and

adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, but only about 5 percent of all children experience what professionals term “extreme functional impairment.

4. Mental disorders and mental health problems appear in families of all social classes and of all backgrounds. No one is immune. Yet there are children who are at greatest risk by virtue of a broad array of factors. These include physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.
5. Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and emotional development by providing, for example, educational programs for young children, parent-education programs, and nurse home visits.
6. A range of efficacious psychosocial and pharmacologic treatments exists for many mental disorders in children, including attention-deficit/hyperactive disorder, depression, and the disruptive disorders.
7. Research is under way to demonstrate the effectiveness of most treatments for children in actual practice settings (as opposed to evidence of “efficacy” in controlled research settings), and significant barriers exist to receipt of treatment.
8. Primary care and the schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff are limited, as are options for referral to specialty care.
9. The multiple problems associated with “serious emotional disturbance” in children and adolescents are best addressed with a “systems” approach in which multiple service sectors work in an organized, collaborative way. Research on the effectiveness of systems of care shows positive results for system outcomes and functional outcomes for children; however, the relationship between changes at the system level and clinical outcomes is still unclear.
10. Families have become essential partners in the delivery of mental health services for children and adolescents.

11. Cultural differences exacerbate the general problems of access to appropriate mental health services. Culturally appropriate services have been designed but are not widely available.

Chapter 4: Adults and Mental Health

1. As individuals move into adulthood, developmental goals focus on productivity and intimacy including pursuit of education, work, leisure, creativity, and personal relationships. Good mental health enables individuals to cope with adversity while pursuing these goals.
2. Untreated, mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.
3. Stressful life events or the manifestation of mental illness can disrupt the balance adults seek in life and result in distress and dysfunction. Severe or life-threatening trauma experienced either in childhood or adulthood can further provoke emotional and behavioral reactions that jeopardize mental health.
4. Research has improved our understanding of mental disorders in the adult stage of the life cycle. Anxiety, depression, and schizophrenia, particularly, present special problems in this age group. Anxiety and depression contribute to the high rates of suicide in this population. Schizophrenia is the most persistently disabling condition, especially for young adults, in spite of recovery of function by some individuals in mid to late life.
5. Research has contributed to our ability to recognize, diagnose, and treat each of these conditions effectively in terms of symptom control and behavior management. Medication and other therapies can be independent, combined, or sequenced depending on the individual's diagnosis and personal preference.
6. A new recovery perspective is supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers.
7. Certain common events of midlife (e.g., divorce or other stressful life events) create mental health problems (not necessarily disorders) that may be addressed through a range of interventions.

8. Care and treatment in the real world of practice do not conform to what research determines is best. For many reasons, at times care is inadequate, but there are models for improving treatment.
9. Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, although there are substantial gaps between what research recommends and what typically is available in communities.
10. Sensitivity to culture, race, gender, disability, poverty, and the need for consumer involvement are important considerations for care and treatment.
11. Barriers of access exist in the organization and financing of services for adults. There are specific problems with Medicare, Medicaid, income supports, housing, and managed care.

Chapter 5: Older Adults and Mental Health

1. Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems.
2. Continued intellectual, social, and physical activity throughout the life cycle are important for the maintenance of mental health in late life.
3. Stressful life events, such as declining health and/or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not “normal” and should be treated.
4. Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or co-occur should be recognized and treated as illnesses.
5. Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group:
 1. Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life;

2. Depression contributes to the high rates of suicide among males in this population; and
3. Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.
6. There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety), and many mental health problems, such as bereavement.
7. Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status.
8. Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications.
9. Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is underrecognized and undertreated in primary care settings.
10. Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

Chapter 6: Organization and Financing of Mental Health Services

In the United States in the late 20th century, research-based capabilities to identify, treat, and, in some instances, prevent mental disorders is outpacing the capacities of the service system the Nation has in place to deliver mental health care to all who would benefit from it. Approximately 10 percent of children and adults receive mental health services from mental health specialists or general medical providers in a given year. Approximately one in six adults, and one in five children, obtain mental health services either from health care providers, the clergy, social service agencies, or schools in a given year.

Chapter 6 discusses the organization and financing of mental health services. The chapter provides an overview of the current system of mental health services, describing where people get care and how they use services. The chapter then presents information on the costs of care and trends in spending. Only within recent decades, in the face of concerns about discriminatory policies in mental health financing, have the dynamics of insurance financing become a significant issue in the mental health field. In particular, policies that have emphasized cost containment have ushered in managed care. Intensive research currently is addressing both positive and adverse effects of managed care on access and quality, generating information that will guard against untoward consequences of aggressive cost-containment policies. Inequities in insurance coverage for mental health and general medical care—the product of decades of stigma and discrimination—have prompted efforts to correct them through legislation designed to produce financing changes and create parity. Parity calls for equality between mental health and other health coverage.

1. Epidemiologic surveys indicate that one in five Americans has a mental disorder in any one year.
2. Fifteen percent of the adult population use some form of mental health service during the year. Eight percent have a mental disorder; 7 percent have a mental health problem.
3. Twenty-one percent of children ages 9 to 17 receive mental health services in a year.
4. The U.S. mental health service system is complex and connects many sectors (public–private, specialty–general health, health–social welfare, housing, criminal justice, and education). As a result, care may become organizationally fragmented, creating barriers to access. The system is also financed from many funding streams, adding to the complexity, given sometimes competing incentives between funding sources.
5. In 1996, the direct treatment of mental disorders, substance abuse, and Alzheimer's disease cost the Nation \$99 billion; direct costs for mental disorders alone totaled \$69 billion. In 1990, indirect costs for mental disorders alone totaled \$79 billion.
6. Historically, financial barriers to mental health services have been attributable to a variety of

economic forces and concerns (e.g., market failure, adverse selection, moral hazard, and public provision). This has accounted for differential resource allocation rules for financing mental health services.

1. "Parity" legislation has been a partial solution to this set of problems.
2. Implementing parity has resulted in negligible cost increases where the care has been managed.
3. In recent years, managed care has begun to introduce dramatic changes into the organization and financing of health and mental health services.
7. Trends indicate that in some segments of the private sector per capita mental health expenditures have declined much faster than they have for other conditions.
8. There is little direct evidence of problems with quality in well-implemented managed care programs. The risk for more impaired populations and children remains a serious concern.
9. An array of quality monitoring and quality improvement mechanisms has been developed, although incentives for their full implementation has yet to emerge. In addition, competition on the basis of quality is only beginning in the managed care industry.
10. There is increasing concern about consumer satisfaction and consumers' rights. A Consumers Bill of Rights has been developed and implemented in Federal Employee Health Benefit Plans, with broader legislation currently pending in the Congress.

Chapter 7: Confidentiality of Mental Health Information: Ethical, Legal, and Policy Issues

In an era in which the confidentiality of all health care information, its accessibility, and its uses are of concern to all Americans, privacy issues are particularly keenly felt in the mental health field. An assurance of confidentiality is understandably critical in individual decisions to seek mental health treatment. Although an extensive legal framework governs confidentiality of consumer-provider interactions, potential problems exist and loom ever larger.

1. People's willingness to seek help is contingent on their confidence that personal revelations of

mental distress will not be disclosed without their consent.

2. The U.S. Supreme Court recently has upheld the right to the privacy of these records and the therapist-client relationship.
3. Although confidentiality issues are common to health care in general, there are special concerns for mental health care and mental health care records because of the extremely personal nature of the material shared in treatment.
4. State and Federal laws protect the confidentiality of health care information but are often incomplete because of numerous exceptions which often vary from state to state. Several states have implemented or proposed models for protecting privacy that may serve as a guide to others.
5. States, consumers, and family advocates take differing positions on disclosure of mental health information without consent to family caregivers. In states that allow such disclosure, information provided is usually limited to diagnosis, prognosis, and information regarding treatment, specifically medication.
6. When conducting mental health research, it is in the interest of both the researcher and the individual participant to address informed consent and to obtain certificates of confidentiality before proceeding. Federal regulations require informed consent for research being conducted with Federal funds.
7. New approaches to managing care and information technology threaten to further erode the confidentiality and trust deemed so essential between the direct provider of mental health services and the individual receiving those services. It is important to monitor advances so that confidentiality of records is enhanced, instead of impinged upon, by technology.
8. Until the stigma associated with mental illnesses is addressed, confidentiality of mental health information will continue to be a critical point of concern for payers, providers, and consumers.

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Pediatric Labeling

First Lady Seeks Curb Of Drug Use to Treat Behavioral Problems

By a WALL STREET JOURNAL Staff Reporter

WASHINGTON—Hillary Rodham Clinton announced an effort to rein in the rapid growth of drug use to treat behavioral and emotional problems in children.

After meeting with national health leaders, the first lady and Senate candidate from New York said further research is needed to improve the diagnosis and treatment of children with conditions such as

attention deficit disorder. She announced a study of Ritalin use by preschoolers with ADD that will cost the National Institute of Mental Health an estimated \$6 million over five years. Also, the Food and Drug Administration will study appropriate pediatric dosage information that will eventually appear on labels of drugs such as Ritalin and clonidine, prescribed to children with attention disorders to help them sleep.

Meanwhile, the National Institute of Mental Health released a fact sheet for parents who are considering medicines to treat their children, and the Office of the Surgeon General is planning a national conference on the issue in the fall.

Mrs. Clinton said she is concerned about a February report in the Journal of the American Medical Association that showed

the number of preschoolers taking Ritalin jumped 150% between 1991 and 1995, and those taking antidepressants had skyrocketed 200%. "Some of these young people have problems that are symptoms of nothing more than childhood or adolescence," she said.

Comptroller's Office Rules on CD Auction By Bank on the Web

Dow Jones Newswires

WASHINGTON — The Office of the Comptroller of the Currency said a Pennsylvania law regulating auctioneers would be pre-empted by federal law if it was applied to a bank that uses an auction format to market and sell certificates of deposit over the Internet.

When it launched a review of the question and invited public comments early this year, the OCC cited the novelty of the question of the applicability of state law to national banks that provide traditional financial services through electronic means.

In a notice published yesterday, the OCC said the activities in question—receiving deposits, marketing and using electronic means to engage in permissible activities—are authorized by federal law and that the state law, if applied to the bank's online auction program, would be pre-empted.

The bank's Web site permits visitors to link to a site on which the bank offers potential customers the opportunity to purchase certificates of deposit that it issues and that are priced through an online auction process.

The bank asked the OCC's opinion on whether federal law pre-empted a Pennsylvania law requiring auctioneers to obtain state licenses and subjecting them to examination and inspection. The bank, which is based in Pennsylvania, isn't named in the notice and the OCC has declined to identify the institution.

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First Lady Urges Ritalin Caution

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Filed at 12:27 p.m. EST

By The Associated Press

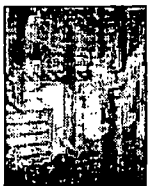
WASHINGTON (AP) -- Parents should use caution in giving their preschool children Ritalin and other mind-altering drugs, meant to treat attention deficit disorders, Senate candidate Hillary Rodham Clinton said today, making use of her position as first lady to highlight a matter that troubles many families.

The drugs are intended to treat attention deficit disorders, but "some of these young people have problems that are symptoms of nothing more than childhood or adolescence," Clinton said at a White House meeting she called with national health and education officials and experts.

The plan she outlined proposes new government warning labels for the drugs, a national study of their use and a fall conference on children's mental health.

But she insisted the efforts are not an attack on medical treatments for children's emotional well-being, some 125 of which are in the pipeline. "Some children do have severe emotional behavioral problems that can be helped by prescription drugs. These children are waiting for our help and today we are taking important steps to provide it," she said.

Clinton said, however, that rapid increases in the drugs' use bears watching. Recent studies show a doubling to tripling of the number of children under age 4 taking Ritalin, a common brand name for the stimulant methylphenidate, which is believed to increase a child's alertness by stimulating the central nervous system.



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Attention deficit disorder, or ADD, usually is diagnosed in school-age children based on interviews and observed behavior.

Symptoms of ADD include the restless inability to sit still to read, study or even watch television. Often a child cannot play in group games, and a common symptom is the inability to control impulses. Some mild forms of these symptoms are common in many children, leading experts to worry that ADD is diagnosed too often.

Some authorities worry that the drugs supplant behavior therapy, which in many cases might be more helpful.

In addition to Ritalin, more young children are also taking clonidine, a blood pressure drug used to treat sleep problems stemming from attention disorders, and antidepressants such as Prozac. In the federal Medicaid program, prescriptions for antidepressants have doubled.

The National Institute of Mental Health is about to start a nationwide study of Ritalin use in children under the age of 6, said Clarissa Wittenberg, communication director of the mental health arm of the National Institutes of Health.

Children at selected sites around the nation will be observed. Previous study, Wittenberg said, shows that drugs alone are not the answer to treating children with such disorders.

“While behavioral therapy can be very effective and medication was most effective, probably the wisest course to go for treating children is both,” she said.

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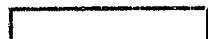
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P is for Prozac

How a government corrupted by special interests is spawning a generation of medicated preschoolers.

By Arianna Huffington

March 21, 2000 | At a White House meeting with health and education officials Monday, Hillary Clinton tapped into a growing national concern and outlined proposals for warning labels and a wide-ranging study on the use of Ritalin. "Some of these young people," she said, "have problems that are symptoms of nothing more than childhood or adolescence." This is good news indeed, coming at a time when those promoting the legal drugging of America's children score fresh triumphs every day.

A recent study published in the Journal of the American Medical Association found a dramatic increase in the number of 2- to 4-year-olds on Prozac, Ritalin and other mood-altering drugs. But the same legislators who talk tough about their commitment to fighting illegal drugs seem oblivious to the dangers of pushing powerful prescription drugs on preschoolers. Even though Prozac hasn't been approved by the Food and Drug Administration for children under 18, and methylphenidate -- the generic name for Ritalin -- carries a warning against its use by children younger than 6, doctors everywhere are prescribing these drugs to children.

In a particularly stunning development, the drug industry has even enlisted the cuddly characters from Sesame Street as unwitting, but no doubt highly effective, soldiers in the fight for our children's hearts and minds. By purchasing 15-second "enhanced underwriter acknowledgments" -- PBS-speak for commercials -- Pfizer has linked its antibiotic Zithromax with Elmo, Big Bird and Oscar the Grouch. How long before Eli Lilly decides to get in on the act and change Sesame Street's traditional sign-off: "Today's show was brought to you by the letter 'P,' which stands for Prozac, and the number

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you by the letter 'P,' which stands for Prozac, and the number '2,' which is how many of the little green pills you should take each morning to make sure you have another 'sunny day, chasing the clouds away!'"

And if you think that time will never come, you probably also thought that there would never come a time when the chairman of the House's health subcommittee, engaged in drafting legislation affecting prescription-drug costs, would be holding a \$2,000-per-person fund-raiser hosted by Eli Lilly, Johnson & Johnson and Bristol-Myers. But that's precisely what Rep. Bill Thomas, R-Calif., did just last week -- as well, of course, as failing to exercise any oversight while the drug industry pushes its chemical crutches to our nation's children.

It was the U.N.-sponsored International Narcotics Control Board that recently lambasted the United States for overprescribing stimulants such as Ritalin -- pointing out that America consumes more than 90 percent of all the methylphenidate taken worldwide.

The official psychiatric diagnostic manual describes as symptoms of attention deficit hyperactivity disorder "squirms in seat," "interrupts or intrudes on others" and "is often on the go." Sounds a lot like childhood, a condition that -- when left untreated -- tends to cure itself over time. As Dr. Julie Magno Zito, the lead author of the journal study, put it: "It is not really clear that children this young could meet the diagnostic criteria for either attention deficit hyperactivity disorder or depression."

 **Next page | Kip Kinkel and Eric Harris' meds of choice**



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P IS FOR PROZAC | PAGE 1, 2

Despite these warning signs from the medical profession, the mainstreaming of legal drugs for kids continues unabated. The latest battlefield is our nation's schools, where teachers and administrators increasingly demand that parents of rambunctious children -- known in bureaucratese as hyperactive and attention-deficient -- either put them on drugs or face expulsion. Dr. Peter Breggin, author of "Reclaiming Our Children," says that his practice has been "flooded" with families at the end of their rope over these threats and demands.

One of Breggin's patients is Michael Weathers, a fourth-grader at the Alden Place Elementary School in Millbrook, N.Y., who was given a succession of psychiatric drugs, including Ritalin and Paxil, starting in the second grade. When his parents, disturbed by the manic side effects, took him off the drugs, the school reported them to Child Protective Services, charging them with, among other things, medical neglect.

Michael's father, Roman, explains that although their case is an extreme example, it's far from an isolated one. He says that half of the students in his son's school were on Ritalin, and that the school nurse had to go along on field trips to administer the kids' medicine. Yet the school's principal, Fred Merz, refused to answer even a general question about what percentage of his students were on mood-altering drugs.

Despite the fact that the number of children on Ritalin has skyrocketed from 1 million in 1990 to 4 million today, and that we now have more than a million children on Prozac, there are no signs of deceleration. "In America today," Breggin told me, "if you can toddle along, your pediatrician can give you a psychoactive drug."

Perversely, the only good news on the legal drug front, other than the first lady's warning, stems from a drug-fueled crime spree that culminated in a bank robbery. The robber was

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spree that culminated in a bank robbery: The robber was acquitted by a Connecticut judge because he was under the influence of Prozac when he committed the crime. This is the first time the so-called "Prozac defense" has worked, after at least 77 previous attempts in courtrooms across the country. It's also the first legal opening for what now must become an ongoing investigation into the connection between outbreaks of violence and drugs such as Prozac and Luvox -- the meds of choice for school shooters Kip Kinkel and [Eric Harris](#).

So is there any chance that members of the FDA Oversight Committee -- which should be renamed the FDA Blind-Eye Committee -- will wake up from their donor-induced stupor? It would certainly be nice if they did it before our kids are turned into a troop of drugged-out zombies, while we grown-ups fight a \$40 billion-a-year drug war in their name.
salon.com | March 21, 2000

About the writer
[Arianna Huffington](#) is a nationally syndicated columnist and author of seven books. Her eighth book, "How to Overthrow Your Government," was published in February by Regan Books (HarperCollins).

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March 23, 2000

Drug Therapy for Preschoolers

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The increase in the number of preschool children being prescribed Ritalin, Prozac and other psychiatric drugs in the last decade is troubling and cries out for closer scrutiny. Thus it was heartening that the Clinton administration said this week that it would conduct two research projects to address questions related to the use of such powerful drugs by the very young.

Concerns were raised by a study recently published in the Journal of the American Medical Association that examined the medical records of more than 200,000 preschoolers, ages 2 through 4, from 1991 to 1995. It found that the use of Ritalin to treat attention deficit hyperactivity disorder doubled over that period, as did the number of preschoolers on anti-depressants. Although that was still a relatively small number of children taking the drugs -- less than 1.5 percent of the children in the study -- the upward trend is alarming because it may suggest an overuse of medication to solve behavior problems that do not require it. Diagnoses of mental disturbances that might require drug therapy are difficult to make with any certainty in very young children.

In some cases medication can help a youngster with severe and persistent behavioral and emotional disorders.

Medical science long believed that mental illnesses such as depression and bipolar disorder began after childhood. Now it is known that such disorders can begin in early childhood, with an estimated six to nine million children and adolescents currently suffering from serious conditions. Failure to treat mental illness in young children can have serious, lifelong consequences. But the difficulty lies in accurately diagnosing disorders in the very young and determining when medication is appropriate, along with counseling and other non-drug therapies, and when drug therapy is unnecessary.

There are also many unanswered questions about the drugs themselves. Many psychiatric drugs, though approved by the Food and Drug Administration for use by adults, have not been specifically tested or had their doses calibrated for children. Prozac, for example, is officially approved only for people 18 and older, and Ritalin is officially approved only for use in children 6 years and older. It is legal and common for doctors to prescribe drugs approved for adults to children and teenagers, but for very young children that practice could pose risks. There is scant information about the appropriate dosage, effectiveness and long-term effects of psychiatric drugs on the physical and brain development of preschoolers.

The F.D.A. has announced that it will begin designing studies to develop pediatric dosage information for labeling on drugs that are increasingly used on young children. The National Institute of Mental Health will dedicate more than \$5 million over the next five years to study whether Ritalin is safe and effective for preschoolers who have been diagnosed with attention deficit disorders. These steps rightly focus on the need for more research in a rapidly changing field. But neither study will clarify how often the drugs are being dispensed indiscriminately to young children for whom they are inappropriate. That problem will require vigilance on the part of doctors and parents.

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United States Senate

WASHINGTON, DC 20510

March 3, 2000.

Jane B. Henney, M.D.
Commissioner, Food and Drug Administration
5600 Fishers Lane, Room 14-71
Rockville, MD 20857

Dear Dr. Henney:

We were troubled to learn of a study recently published in the *Journal of the American Medical Association (JAMA)* which found a rapidly increasing use of stimulants and anti-depressants by preschoolers, despite a lack of information about the safety of these products for young children. As you know, the dangerous shortage of medicines labeled for children has been a long-standing concern of ours. That is why we authored the Better Pharmaceuticals for Children Act, which was enacted into law as part of the Food and Drug Administration Modernization Act (FDAMA) of 1997.

The Better Pharmaceuticals for Children Act provides a market incentive for drug companies to make the extra effort needed to test their products for children. By all accounts, this incentive approach is beginning to close the dangerous gap in knowledge about how drugs work in children. In just the 18 months since the initiation of the incentive program, research has been completed on 19 drugs that were previously used for children without adequate information about safety. These studies have already resulted in new safety information being added to six drugs, with labeling changes expected for the other 13 in the near future. In addition, pediatric studies of more than 125 additional drugs are currently underway. In contrast, in the five years prior to enactment of the legislation, only 11 studies to gather additional safety information about drugs already on the market were conducted.

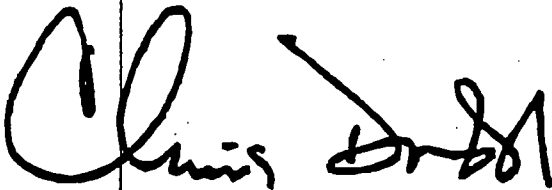
But, while progress has been made, we still have a long way to go to make sure that children are not an afterthought when it comes to drug research — as the *JAMA* article so clearly highlights. As reported in *JAMA*, doctors are prescribing powerful psychiatric drugs like Ritalin and Prozac for preschoolers at rates that have doubled or even tripled from 1991 to 1995. Given all that we know about the astonishing pace of brain development in young children, it is extremely troubling that the effect of the drugs on children's long-term cognitive, social, and emotional development are largely unknown.

We are pleased with the progress you have made in implementing the Better Pharmaceuticals for Children legislation. However, major work remains to be done, particularly with regard to psychiatric drugs. We understand that Clonidine, an adult blood pressure medication that is being used for attention deficit disorder in children, is on the list of products that your agency has identified as needing better pediatric information, but that no request for studies has yet been made of the manufacturer. We also understand that Prozac is now being

studied under our incentive program for children aged seven and older, but even when these studies are completed, we will still lack information about its safety in pre-school age children.

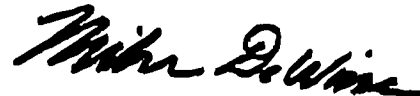
Therefore, we urge you to make the pediatric testing of psychiatric drugs a high priority for your agency. We strongly encourage you to work with pharmaceutical manufacturers to complete the pediatric research they have begun and to initiate research for those products not yet being studied. We also urge you to work with the National Institute of Child Health and Human Development to facilitate research on off-patent drugs such as Ritalin, for which the market exclusivity incentive is not appropriate.

Thank you again for your continued support of our efforts to secure better information about the safety and effectiveness of prescription drugs for children. In the absence of this much-needed information, the continuation of current prescribing practices holds too dear a price: the safety of our children.



CHRISTOPHER J. DODD
United States Senator

Sincerely,



MIKE DEWINE
United States Senator

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—online edition—

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Hil Unveils Drug Study

Feds eye psychiatric meds for kids under 6

By KENNETH R. BAZINET
Daily News Washington Bureau

WASHINGTON

Hillary Rodham Clinton yesterday announced a major government effort to determine whether a growing number of preschoolers are being wrongly prescribed mind-altering drugs.

"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," Clinton said after a White House meeting with top children's health experts.

The First Lady, who is running for Senate in New York, announced a \$5 million nationwide study examining the use of Ritalin in children under age 6.

In addition, the Food and Drug Administration will study the proper dosages for various types of psychiatric drugs in preschoolers and require manufacturers to use warning labels.

Ritalin is the leading medication prescribed to calm children diagnosed with attention deficit hyperactivity disorder. Its use in preschoolers soared 150% from 1991 to 1995, while the use of anti-depressants increased by more than 200%, according to a study published last month in the Journal of the American Medical Association.

"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," Clinton said.

Noting she wasn't out to "bash" the use of all psychiatric drugs, Clinton said some of them have "literally been a godsend for countless adults and young people with behavioral and emotional problems."

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NEWS

PRESCHOOLERS ON PSYCH DRUGS
By LEAH GINSBERG, HALLIE LEVINE, and MARILYN RAUBER



GETTING THE PICTURE: Dr. Edgardo Zengotita, a colleague of Dr. Leon Zacharowicz, gathers neurofeedback information, similar to biofeedback, on a patient at the Manhattan office the doctors share. - N.Y. Post: Joey Newfield

ALARMED by reports of a dramatic rise in the use of psychiatric drugs for preschoolers, First Lady Hillary Rodham Clinton yesterday weighed into the debate about the use of the stimulant Ritalin.

She announced the development by the Food and Drug Administration of new kiddie-dosage warning labels for the drugs and a \$5 million federal study into the use of Ritalin by preschoolers.

"We just don't know enough" about the effect of mind-altering drugs on young children, the first lady said.

"I am no doctor, but I am a parent and I have been a longtime children's advocate, and these findings concern me."

Clinton -- who briefly left the New York campaign trail to seize the White House bully pulpit -- also announced a White House conference next fall on child mental-health and said Uncle Sam will start distributing information kits to doctors, parents and schools about Attention Deficit Disorder.

MANY doctors welcomed Clinton's concern, although some questioned her motives.

"I think if Hillary Clinton was not running for

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Congress in New York, this would be dealt with [differently]," said Mitchell Clionsky, the director of Neuropsychology Associates and the ADD Center in Springfield, Mass.

While Clionsky agreed with the American Medical Association study that there's been an acute increase (150 percent between 1990 and 1995) in the number of preschoolers taking psychotropic drugs -- particularly Ritalin--he said Washington has overreacted.

"[Ritalin] is not a great public health hazard, and it is very helpful for many," he said. "If you want my opinion, it's turning it into something of a cause celebre."

DOCTORS are divided on the subject.

Dr. Leon Zacharowicz, a child neurologist at Nassau County Medical Center in East Meadow, L.I., said Ritalin is overprescribed and children are often misdiagnosed with ADD.

"I've had parents tell me they were prescribed Ritalin within 30 minutes of coming to their family doctor's office," he said.

Zacharowicz blamed a "fast-food approach" to medicine.

"The family's primary-care practitioner may be so harried with 30 screaming patients with ear infections in the waiting room that he doesn't have time to properly evaluate the child," he said.

Zacharowicz said doctors often prescribe Ritalin without delving into other emotional issues that can affect a child's behavior.

"I saw a child recently who was being abused by a neighbor," he says.

"His teacher recommended he see me for Ritalin -- but the child was irritable only at home, when his neighbor was around. If we hadn't [talked] to him, that never would have gotten sorted out."

EVEN if a child is eventually diagnosed with ADD, Zacharowicz and other doctors say there are other treatments that should be tried before drug

therapies.

Dr. Daniel Kuhn, a Manhattan neuropsychiatrist with St. Luke's-Roosevelt Hospital, says he's had success with a technique known as neurofeedback, similar to biofeedback.

Kuhn said studies have shown the treatment has a 70 percent success rate -- and none of the side effects of Ritalin.

"I'll put a child on Ritalin while starting him on neurobiofeedback. After a while, we reduce the medicines and then stop them entirely. If the child's ADD isn't severe, we don't need medicines at all."

ZACHAROWICZ added that Ritalin has many potent side effects --including seizures -- which can be deadly and that its use on the young hasn't been fully investigated.

"I've seen some kids turn into, almost, little zombies, or suffer mood changes," he said.

"There are also milder side effects ... headaches, lethargy, the child becoming more withdrawn or experiencing a decreased appetite, dizziness, and dry mouth."

Zacharowicz said he's concerned that doctors aren't running enough diagnostic tests before prescribing Ritalin.

"Kids in New York have been treated for ADD when what they really had was lead poisoning," he explains. "That's dangerous, because if lead poisoning is left untreated, children can get very sick."Ÿ8>

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Steps Taken To Curb Use Of Drugs To Calm Young

First Lady Starts White House Effort

By JOHN F. HARRIS
Washington Post Staff Writer

First lady Hillary Rodham Clinton yesterday added her voice to a rising chorus of medical experts who fear that physicians are too quick to prescribe drugs such as Ritalin to young children possibly suffering from attention deficit hyperactivity disorder or other behavioral problems.

Making a cameo appearance at the White House from her new home on the Senate campaign trail in New York, Clinton joined federal health officials in announcing a series of steps designed to prompt parents and doctors alike to think twice before medicating difficult children or teenagers.

The steps included the release of a federal "fact sheet" for parents about treatment of children with behavioral problems and a \$5 million study by the National Institute of Mental Health to conduct further research on the effects of "psychotropic medication" on children under age 7. She also touted a conference scheduled for the fall on "Treatment of Children with Behavioral and Mental Disorders." The Food and Drug Administration also has begun a process aimed at devising cautionary labels on the use of psychiatric drugs for children.

"Some of these young people

have problems that are symptoms of nothing more than childhood or adolescence," Clinton said. "Some of them need a parent to love them, or a person simply to listen to them talk about their pain."

But the first lady, and White House aides afterward, emphasized that she was not challenging the usefulness of drugs for some young people. "Some children do have severe emotional behavioral problems that can be helped by prescription drugs. These children are waiting for our help and today we are taking important steps to provide it," she said.

The point of the government campaign, a White House official said, is to encourage a more methodical approach by the health community in deciding who is genuinely suffering from behavior malady and might be helped by drugs.

Long-standing concerns about possible over-medication received new impetus last month when a study published in the *Journal of*

the American Medical Association documented soaring use of psychiatric drugs for children under five.

The number of preschoolers on antidepressants jumped 200 percent over five years; the number of children on "tricyclic antidepressants," often prescribed for bed-wetters, jumped 220 percent. The number of children ages 2 through 4 taking the stimulant methylphenidate, marketed under the brand name Ritalin, to control attention-deficit disorder doubled.

A White House fact sheet cited studies suggesting that prescriptions of these drugs—in some school districts 20 percent of fifth graders are being medicated for attention deficit disorder—are many times higher than the normal rate of incidence.

There are risks, health officials warn. Clonidine, a drug that in recent years has soared in use for children exhibiting disruptive behavior, can cause rapid or irregular heartbeats and fainting spells.

The Washington Post

TUESDAY, MARCH 21, 2000

First lady takes lead in child mental health project

By Karen S. Peterson
and Kathy Kiely
USA TODAY

The White House is drawing attention to an issue of rising concern to parents and experts: the growing use of mind-altering drugs to treat emotional and behavioral disorders in very young children.

The psychotropic (mind-changing) medications are intended to treat behavioral problems, but some youngsters who get the drugs display behaviors that are merely typical of childhood, first lady Hillary Rodham Clinton said. She addressed a White House meeting of experts in the private sector and government.

Clinton outlined a plan Monday that includes more government money to research the effects of using drugs on preschoolers, new labels on drugs for pediatric use, and a fall White House conference on children's mental health.

She is not, she stressed, attacking the use of medications to deal with children's emotional problems. "We are not here to bash the use of these medications," Clinton said. When properly prescribed, they can be a "godsend."



Minds on the matter: Before experts including Surgeon General David Satcher, Hillary Rodham Clinton announces a plan to research the rising use of mind-altering drugs to control young children's behavior.

But Clinton is concerned because many drugs prescribed for children have not been tested for them. "Finding the right prescription for a child is not al-

ways just a matter of decreasing the adult dosage."

Experts nationwide worry about over-medicating the brains of the very young.

The White House quotes recent studies published in *The Journal of the American Medical Association* that show, from 1991 to 1995:

► The number of preschoolers on antidepressants increased 200%.

► The number of children ages 2 to 4 taking stimulants such as Ritalin more than doubled. Ritalin is used in part to treat attention deficit disorders, conditions that prevent children from staying on task.

Failure to treat emotional and behavioral disorders can have lifelong consequences. Untreated mental illness hampers the developing brain, causing emotional and social damage.

Additionally:

► Many children are inappropriately diagnosed and treated. Although little is known about the effects of over-medicating children, unnecessary use of drugs can have adverse effects on children's brains and emotional and social development.

► More research is necessary to ensure informed treatment. Many of the drugs prescribed for very young children have not been tested in children under 16; few have been tested on those under age 6.

The first lady's plan includes several points of attack:

► The Food and Drug Administration will research new

"Finding the right prescription for a child is not always just a matter of decreasing the adult dosage."

— First lady Hillary Rodham Clinton

pediatric dosage information to be included on drug labels.

► The National Institute of Mental Health (NIMH) will budget more than \$5 million to research attention deficit disorders and Ritalin use in preschoolers.

► NIMH will release a fact sheet this week to help parents understand treatment options. The Department of Education will release an information kit for teachers and parents.

Many mental-health-care experts applauded the first lady's initiative.

"We know that the use of medication in children has increased dramatically," said a statement from Allan Tasman,

president of the American Psychiatric Association. "Some of the increase may be due to improved case finding and evaluation. However, the influence of managed care, which has emphasized medications as a quick fix for many problems, has pervaded all of medicine and has inappropriately tilted the system, including the schools, toward medication as a first choice."

Psychologist Mark Stein, with the Children's National Medical Center in Washington, said: "It is a disturbing trend that more and more young children are being treated with medication. And we don't know how effective it is in that age range."

Younger children, he noted, are naturally active and impulsive.

The White House event was billed by Clinton's staff as a natural continuation of her work as a children's advocate. Clinton harked back to work she did 30 years ago at the Yale Child Study Center. But her appearance also comes in the midst of her U.S. Senate campaign in New York, where polls show that she needs to shore up her image among suburban women.

Manufacturers, Doctors and Teachers Back White House Effort

By ROBERT PEAR

WASHINGTON, March 20 -- Teachers, psychiatrists, family doctors and drug companies reacted favorably today to the Clinton administration's plan to reduce the large numbers of preschoolers who are getting Ritalin, Prozac and other powerful medications without being properly evaluated by doctors.

At the White House, Hillary Rodham Clinton said: "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."

But in announcing a White House initiative to reverse a sharp increase in the use of such drugs by children younger than 6 years old, Mrs. Clinton expressed concern that "some of these young people have problems that are symptoms of nothing more than childhood or adolescence."

Jerald L. Newberry, director of the health information program at the National Education Association, welcomed the comments by Mrs. Clinton.

Too often, Mr. Newberry said, teachers come under pressure to recommend a medical solution to a child's learning or behavioral problems because school districts do not have enough counselors, nurses, social workers and school psychologists.

Ritalin is used to treat attention deficit hyperactivity disorder, the most commonly diagnosed psychiatric disorder in children.

An article last month in the Journal of the American Medical Association reported an apparently sharp rise in the number of preschoolers taking psychotropic drugs. The report prompted widespread public concern; Mrs. Clinton asked administration officials to devise a response.

Nat LaCour, executive vice president of the American Federation of Teachers, said: "There's a big difference between a child with a serious psychiatric disorder requiring drugs and a child who acts out occasionally. Pushing psychiatric drugs on a child with behavioral problems may be a quick fix, but could prove problematic later on."

Dr. Laurence L. Greenhill, professor of clinical psychiatry at Columbia University, said: "Doctors are sometimes too quick to prescribe medications for preschool children. The behavior of an enthusiastic, ebullient 3-year-old with lots of energy can be misinterpreted as attention deficit disorder when it's just a variant of normal behavior."

Dr. Greenhill has proposed a large study to see whether Ritalin is safe and effective for the treatment of behavioral problems in preschool children, and the National Institute of Mental Health said today that it wanted to finance such a study. Before a doctor prescribes Ritalin for a preschooler with problems, Dr. Greenhill said, the parents should be trained in behavior modification techniques to help the child.

Dr. Lanny R. Copeland of Albany, Ga., chairman of the American Academy of Family Physicians, said many parents arrived in his office and announced, "I am here to start the child on Ritalin." Typically, Dr. Copeland added, the parents say: "I talked to the teachers at school. They think the child would benefit from the medication."

Dr. Copeland said that many parents appeared to believe that "this is a cure-all for their children's problems." In some cases, he said, academic performance seemed to improve after children began taking Ritalin.

But Dr. Copeland said he was concerned because parents wanted the prescriptions before their children had been fully evaluated by a

doctor. "It would be like somebody coming in at the age of 50 saying, 'I have chest pains, I'd like to have coronary artery surgery,'" he said.

Dr. Allan Tasman, president of the American Psychiatric Association, said that managed care organizations had "emphasized medications as a quick fix for many problems," and he said that this view had influenced schools as well.

Novartis, the manufacturer of the brand-name version of Ritalin, acknowledged that the drug had not been approved for use by children younger than 6. But it said that "Ritalin has been used safely and effectively" in the treatment of millions of older children for four decades.

Gina Moran, a spokeswoman for Novartis, said the company supported the government's plan for a large-scale study of Ritalin's safety and effectiveness in children under 6.

Eli Lilly & Company, which makes Prozac, said it agreed "that the rapid increase in use of psychiatric medications in young children is a cause for concern." Ed West, a company spokesman, said behavioral therapy was "often the most appropriate and effective first-line treatment."

Prozac is approved for use in patients 18 and older who suffer from depression, obsessive-compulsive disorder or bulimia. Lilly said it did not promote the drug for use by other patients. But federal officials said that doctors had often prescribed Prozac for children.

END

The rare trip abroad by the deliberate and cautious 69-year-old Syrian leader could be portentous, coming amid hints in the Israeli media and by some Arab commentators that the two sides are closer to resuming talks than their harsh public rhetoric would suggest.

Although there have been repeated rumors about the failing health of Assad, who has ruled since 1970 and is the only surviving Arab leader to have attacked Israel, the proposed meeting would seem to indicate he is still on top of the peace process and capable of making decisions.

Clinton speaks with Assad regularly by telephone and has met the Syrian leader three times, most recently a year ago at the funeral of King Hussein of Jordan. They also met twice in 1994, in Geneva and Damascus.

It was not immediately clear what inducements Clinton could use this time to jump-start the talks with Israel, since Syria has said it will not return to the table until Israel has agreed in principle to Syria's "sovereign" demand for full restitution of its territory. Syria defines that as a pullback to the line that existed on June 4, 1967, the eve of that year's Arab-Israeli war.

"We'll just have to see what comes out of the talks," said Clinton, speaking at a joint news conference in Dhaka with Bangladeshi Prime Minister Sheikh Hasina Wajed.

Noting that Israeli-Palestinian talks already have been put back on course they are scheduled to resume Tuesday Clinton called giving a push to the Syrian-Israeli track "the next logical step."

"I don't want to unduly raise expectations, but I think that this is an appropriate thing for me to do, to try to get this back on track, so that our objectives of having a comprehensive peace can go forward."

U.S. national security adviser Sandy Berger, traveling with Clinton, said that the president has been "in ongoing contact" with Assad and with Israeli Prime Minister Ehud Barak ever since the last round of talks in Shepherdstown, W. Va., ended.

Meeting directly with Assad now makes sense for Clinton, said Berger, because Clinton has "had many direct, face-to-face conversations with Prime Minister Barak. And there are some things that are best discussed face-to-face, leader-to-leader." The adviser said that Clinton would not be carrying "a specific American proposal," but would present Assad "his impressions of how the process of negotiations can be resumed."

For its part, Israel said it hoped the Geneva discussions would break the logjam and allow the negotiating teams to meet again. But a statement from Barak's office warned: "Such talks will take place only if the appropriate conditions are created."

Each side has accused the other of causing the impasse. Israel has said repeatedly it is ready to go back into talks with Syria. Syria has said it wants talks, too. However, it said it must be sure that Israel is serious and is prepared to meet its demand for the return of territory before the Syrians can go back to discussing other topics of mutual concern, which include as water-sharing, normalization of relations and security. A leaked negotiating document in January suggested that the two sides were close to agreement on most of these issues.

Clinton, who is believed to badly want to achieve peace in the Middle East before his term ends next year, managed to bring the two sides together in December after a four-year hiatus.

But after just two brief rounds, the negotiations broke off in January, with the Syrians expressing frustration at what they considered the unwillingness of the Israeli side to discuss the territorial issue. Syria said that for talks to resume, Israel now must agree to demarcate the border.

According to news accounts published in Israel, Barak recently revealed to his Cabinet that past Israeli leaders, including the late Prime Minister Yitzhak Rabin, in fact had acceded years ago to Syria's demand that Israel agree to pull back from all of the Golan if other issues were settled. However, Barak stopped short of saying that he would be willing to do the same.

For the Syrians, the admission was significant because Barak's predecessors had always denied that Israel ever conceded that it was willing to give back the Golan in full. However, Syria expressed disappointment that Barak made the admission only in a closed Cabinet meeting and not to the Israeli public.

The Syrians say they are willing to establish normal, peaceful relations with Israel after more than half a century of war, if Israel gives back all of the Golan it seized in 1967, chasing

from their homes more than 100,000 Syrian Arabs who live in Syria argues that by making peace with its oldest and most implacable foe, Israel would gain peace with all other states in the Arab world as well.

U.S. to Look at Behavioral Drugs Prescribed for Preschoolers

By Nick Anderson

Los Angeles Times

WASHINGTON The White House said Monday that the federal government will intensify research on medications used to treat preschoolers for behavioral disorders, responding to growing concerns about the high number of youngsters who take prescription drugs such as Ritalin and Prozac.

The government said it will launch a \$5-million research project over five years to study children who take Ritalin to treat attention-deficit disorder; redouble efforts to study labeling and dosage of psychiatric drugs for youngsters; and convene a conference on the issue to be held in the fall.

Monday's announcement was orchestrated by first lady Hillary Rodham Clinton, who is running for the U.S. Senate in New York and who has crusaded on children's issues during her husband's presidency.

Some details about her initiative such as the scope and launch date of the Ritalin studies remained unavailable Monday. Other parts seemed to repackage policies that are already in place.

But Clinton administration officials insisted that fresh answers are needed on a topic that affects millions of American children and parents. One recent study found that the usage of stimulants or anti-depressants among certain groups of children ages 2 to 4 had more than doubled from 1991 to 1995.

"We must unlock the mysteries of children's mental health which treatments are the most successful; whether some children are being systematically misdiagnosed," said Donna Shalala, secretary of health and human services.

Despite the potential political overtones, some health experts said the event served a useful purpose.

"I think it's significant that they're calling attention to this problem and saying we really need to figure out what's going on," said Dr. Mark Stein, an expert on attention deficit disorders at Children's National Medical Center in Washington. "Giving medications to children is a very controversial topic particularly for very young children. But we really need to go beyond the headlines and try to understand what is happening and why."

Ritalin, a stimulant known generically as methylphenidate, has been available for decades. It is one of a number of drugs that have been used increasingly in recent years to treat hyperactivity and attention-deficit problems. Its label warns that the drug should only be used by children at least 6 years old. But many children younger than that are given the drug by doctors who prescribe it "off-label," an entirely legal but sometimes controversial practice.

Federal officials and health experts said that problems surrounding dosage and prescription are complex. They cautioned that some children may not be getting medication who actually need it, while others are getting too much medication.

But experts like Stein say they are spotting a disturbing trend among their pediatric patients. "More and more younger children are coming in on multiple medications. That's a cause of great concern," he said.

Air Force Reservists Break Ranks on Vaccination

By Amy Pyle

Los Angeles Times

DAVIS, Calif. Maj. Ramona Savoie and Maj. James Hechtel were not the type to question authority. They were patriots first, Air Force Reserve pilots second and commercial pilots third.

But facing a military requirement that they be vaccinated against germ warfare specifically the deadly anthrax virus the Travis Air Force Base reservists found themselves caught between military duty and civilian responsibility.

If the anthrax vaccine is safe, why did the couple know people who had suffered rashes, immune system disorders and seizures after taking just a few of the required six shots in the anthrax series? Even if the chances of a bad reaction were slight, how could they in good conscience take any risk with the lives of their commercial passengers?

Hillary calls for study on use of mood-altering drugs by children

By Andrea Billups
THE WASHINGTON TIMES

A1

Democratic Senate candidate Hillary Rodham Clinton called for more research on the effects of mood-altering medications like Ritalin and Prozac on children younger than 7.

While some children may benefit from drug therapy for behavioral problems like attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), Mrs. Clinton questioned whether too many young children were being prescribed those medications without adequate research on whether they are appropriate or effective.

"Some children do have severe emotional behavioral problems that can be helped by prescription drugs," she said. But she noted that

"some of these young people have problems that are symptoms of nothing more than childhood or adolescence."

The first lady, who is seeking a Senate seat from New York, met with a group of health and education experts at the White House yesterday, announcing a \$5 million National Institute of Mental Health study on the impact of psychotropic drugs on children.

Those drugs include stimulants, depressants, sedatives and antipsychotics, which act chemically on the brain. She also called for new government warning labels for the drugs and a fall conference on children's mental health.

Mrs. Clinton's announcement comes less than a month after the Journal of the American Medical Association reported that the number of preschool children on anti-

depressants had increased by more than 200 percent between 1991 and 1995. The number of children aged 2 to 4 taking stimulants such as Ritalin also more than doubled, the JAMA study found.

Only about 25 percent of prescription medications are labeled for use on children, according to the American Academy of Pediatrics.

rics.

More research is needed, said Salvatore Cullari, chairman of the psychology department at Lebanon Valley College in Annville, Pa.

"We don't have any good scientific studies with kids under age 6," Mr. Cullari said. "Even if it does work with these kids, I'm not sure we should be using it anyway until we've done these studies."

Ritalin, which is used to treat hyperactivity, has not been approved for use under the age of 6, but off-label usage for those patients is widespread among physicians, he said.

"I think medications really should be the last resort, especially with young kids. We should try everything else first unless we are talking about a kid who is in danger of hurting himself or attempting suicide."

"The problem is that I think it's easier for a physician to just prescribe a medication," he said. "I think some of the managed care companies would just prefer the physicians to prescribe the medication because it's cheaper to treat than through therapy or behavior modification and other psychological techniques, which would take longer."

Critics call Ritalin a "poison" and compare its effects on the brain to cocaine.

Dr. Leslie Walker, an associate professor of pediatrics at Georgetown University, says stimulants like Ritalin or Adderall, commonly

prescribed to adolescents, are rarely addictive because they slow down most patients rather than hype them. She agrees that more research is important.

"In certain populations and in certain areas they are overprescribed, but then there are some people who would benefit greatly from them," she said.

Of ADD and ADHA, she adds: "It's clearly something that is going on... that starts in childhood and extends through adulthood that some medicines can help."

Tom DeWeese, president of the American Policy Center in Herndon, Va., buys none of those arguments.

While more than 7 million children have been diagnosed with ADD or ADHD, "there has never been issued a single peer-reviewed scientific paper officially claiming to prove ADD/ADHD exists," he says.

He blames the psychiatric industry for creating a problem to make money. Preschoolers, he adds, are simply the latest targets of "the pill brigade."

"As education restructuring grew into a full-blown behavior-modification assault designed to change the attitudes, values and beliefs of the children, a key element to the process was to turn healthy children into 'patients,'" he said.

Mrs. Clinton and her "village" need to get out of the brains of America's children, Mr. DeWeese said.

"When in the history of this country do we have the White House looking at the brain development of children? What she means is the government knows best how to raise a child, not a parent. What Hillary needs to do is stay out of the family and let the parents raise the children."

China would be
the United

familiar with the air alarms."

And a local newspaper reported that the city plans to invest an additional \$7.3 million to complete a huge downtown air raid shelter so that "70-to-80 percent of Fuzhou citizens will find places to hide during the war."

White House launches bid to curb use of psychiatric drugs on children

By Mary Otto

Knight Ridder Newspapers

WASHINGTON Alarmed at research that suggests an increase in the prescription of mood-altering medications for children as young as 2 years old, first lady Hillary Rodham Clinton on Monday announced efforts to ensure that the very young are being properly diagnosed and treated.

Shifting from her role as a U.S. Senate candidate to her position as the president's spouse, Clinton drew attention to a child-care topic that affects millions of American families.

An estimated 6-to-9 million American children and adolescents suffer from serious behavioral and emotional disturbances, according to the National Institute of Mental Health. Many young people diagnosed with attention-deficit hyperactivity disorder or ADHD are prescribed stimulants such as Ritalin to alleviate their problems with inattention, restlessness and impulsivity.

"We are not here to bash the use of these medications," Clinton said. "They have literally been a godsend to countless adults and young people with behavioral and emotional problems." If left untreated, such conditions as ADHD prevent children from living their full potential in life, Clinton said.

However, she noted, research recently published in the Journal of the American Medical Association found that the number of children from ages 2 to 4 taking stimulants such as Ritalin has more than doubled over five years. The number of preschoolers on anti-depressants, which are often used to control bedwetting, was up over 200 percent during the same period.

The findings left even researchers wondering how the doctors prescribing these drugs might be reaching diagnoses such as hyperactivity in toddlers.

"How can you distinguish between appropriate and inappropriate hyperactivity in 2-year-olds?" asked University of Maryland researcher Julie Magno Zito, who co-authored the JAMA study, in a recent interview. As for the prescription of anti-depressants, she said "we didn't really think children as young as 2 and 3 could meet the criteria for depression."

The findings were based on the prescription records of children aged 2 to 4 enrolled in two Medicaid programs and a Health Maintenance Organization. The researchers analyzed data from 1991, 1993, and 1995 involving more than 200,000 patients.

Other studies have reached similar findings. One examination of Michigan Medicaid claims found that of children aged 3 or below who are diagnosed with ADHD, only one-quarter received psychological services, but nearly 60 percent received mood-altering medications. In an interview Dr. Joseph T. Coyle of Harvard Medical School, who wrote an editorial on the subject in JAMA, said he worried that the medications may be being

perceived as a quick fix.

"Primary care physicians may be prescribing these drugs to avoid the cost of a referral," Coyle said. "People who are poor are much more vulnerable to these practices."

On Monday Clinton also expressed concern about the way different populations of children may be treated for mental conditions. Overall, she insisted, not enough is yet known about the impact of medications on the developing minds of toddlers and preschoolers. Ritalin, for example, has not been tested or approved for use on children under the age of 6, according to the National Institute of Mental Health.

"What effects do the overuse and underuse of these medications have on our children?" Clinton asked. "Why aren't we doing a better job of combining drugs, if 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 entering their most critical development?" she asked. "These are tough questions and none of us have the answers."

Clinton announced that to better understand the issues, the Food and Drug Administration will begin developing research

protocols necessary to provide dosage information and pediatric labeling for mood-altering medications.

She also said the National Institute of Mental Health will dedicate more than \$5 million to research ADHD and Ritalin use in preschoolers. At the news, Ritalin manufacturer Novartis Pharmaceuticals Corp. issued a brief statement welcoming the study.

On Monday, the National Institute of Mental Health also released a fact sheet to help parents of children with emotional and behavioral conditions understand their options. Entitled "Treatment of Young Children with Mental Conditions," it counsels parents to seek help for children who display severe or persistent problems such as sleep disturbance, appetite change, fearfulness, regression to bedwetting, self-injury, or erratic or aggressive behavior.

Clinton entourage faces 'Delhi Belly' in world's 'most dangerous place'

By Christopher Marquis

Knight Ridder Newspapers

NEW DELHI, India Urgent Memo to the President:

On the eve of your historic state visit to India this week you noted that South Asia has become the world's "most dangerous place." Something about nukes and borders and terrorists. Well, you don't know the half of it. You forgot about "Delhi Belly," cancer-causing festivals and street monkeys with attitude.

It's all there in briefing papers, doled out by nervous U.S. and Indian officials who are determined to keep you, your staff and the White House press corps out of trouble.

On the flight over, you voiced hopes to arrive in time for dinner, declaring "I love Indian food." Not so fast. By now, you've received your shots for yellow fever and hepatitis and are well into your five-week regime of anti-malaria medicine.

But here's a friendly tip: Look before you leap. If you didn't peel it yourself, drop that kiwi. Brush your teeth with bottled water; spurn ice cubes unless you made them yourself. It was wise of you to bring your own kitchenware.

Your best bet is to eat food that is still steaming. If anything looks dubious, just tell people you're fasting. "Indians understand fasts," the U.S. Embassy here advises. With luck, you'll avoid the tourist's curse known as "Delhi Belly."

It may seem odd in urban streets, but beware of wildlife. A press advance man nearly crashed into a camel while running in the darkened alleys of Jaipur, and another runner in Delhi merged with a herd of goats.

Whatever you do, the advance man warns, avoid the vacant lot across the street from your five-star Sheraton Hotel room. "It's inhabited by wild monkeys that bite first and ask questions later." And you thought Washington was a tough town.

Your arrival coincides with the Festival of Color and the national holiday known as Holi. Holi is a time for letting one's hair down and forgetting one's place in society. This can be problematic in a nation with a billion people.

A big part of the Holi celebration involves smearing colored powders and dyes on others. That includes strangers in the street. Local youth love drenching the well-dressed with liquid-filled balloons. "Please bear this in mind if you choose to leave the hotel area," your staffers warned in big black letters.

The Hindustan Times offers another reason to stay inside. Lab tests show the dyes being flung about have enough mercury, asbestos and other toxins in them to "constitute a major health hazard ... (including) skin disorders, impairment of vision, respiratory problems and even cancer."

Many Indians opt to celebrate Holi with private parties and a mysterious greenish beverage called bhang. Careful here: bhang is made in the blender, with lots of milk, spices and sugar to kill the taste of that other ingredient, the stuff you didn't inhale. Most guests fall asleep by mid-afternoon.

When you do finally venture out, it's best to keep your hands to yourself. For all their crowding, Indians have a thing about personal space, the U.S. Embassy warns. "Strangers avoid touching each other," one memo says. "Cross-gender touching is especially offensive."

Brace yourself, however. "You will see same-sex friends walking around holding hands or hugging," warns the memo, entitled "Some Cultural Guidelines for Visitors to India."

While we're on the subject of body language, Indians are head-bobbers. In conversations, locals tend to tilt their heads to the



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Facsimile

(If this transmission is incomplete or illegible,
please call the number above)

DATE: May 11, 2000

TO: OFFICE OF THE FIRST LADY
Attn: Mickie Mailey
FX: 202-456-5340

FROM: Dr. Enid Haller
Behavioral Arts & Research
Ph: 212-799-9388
Fx: 212-799-4403

RE: Information you requested

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: BLR DATE: 021 27112
2012-0254-5

~~PERSONAL & CONFIDENTIAL~~

Neera see no problem with the message that they are in sync. They support restricting use for preschool age children, same as HRC. HRC also believes in family therapy as they support. We can make it clear in her remarks her viewpoints. She see no problem! Neera said to contact her if you have any questions.



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OFFICE OF THE FIRST LADY

Attn: Mickie Mailey

5/11/00

Dear Ms. Mailey:

Enclosed you will find the information you requested about Behavioral Arts & Research. As you know, we are a non-profit outpatient mental health facility specializing in the treatment of Attention Deficit/ Hyperactivity Disorder (AD/HD). We have designed a multidisciplinary approach, which includes both conventional and alternative therapies including: behavior management, nutritional modifications, parent training, neurofeedback, and individual/family/group therapy. Behavioral Arts & Research is committed to bridging traditional and alternative treatments and integrating both worlds in the treatment of Attention Deficit Disorder.

We would be thrilled to have the First Lady's support and join in her concern for the safety and well-being of our Nation's children.

Please feel free to contact me at 212-799-9388 if you need any additional information or if I can be of further assistance. Thank you.

A handwritten signature in cursive script, appearing to read 'Enid Haller', written over a horizontal line.

Enid Haller, ACSW, Ph.D.



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Announcing the first center for the comprehensive treatment of **Attention Deficit Disorder (AD/HD)**

Behavioral Arts & Research is a new treatment concept for children and adults suffering with Attention Deficit Disorder (AD/HD) and other coexisting problems that may be interfering with healthy relationships and effective life functioning.

The Center recognizes that AD/HD is often accompanied by other disorders, and it offers the necessary treatment options all under one roof. Staff psychologists and therapists are on hand with years of experience in handling anxiety, depression, co-dependency, substance abuse, alcoholism, chronic illness, learning disabilities and self-esteem issues. The Center offers both holistic and traditional therapies.

List of Services

- Neuropsychological Evaluations
- Treatment of Learning Disabilities
- ADD Testing and Assessment
- Career Goals, Management and Assessment
- Crisis Intervention
- Diet and Nutrition Therapy
- Dual-Diagnosis Treatment (addictive behaviors & AD/HD)
- Psychopharmacological Consultations
- Groups for families, adult children, and spouses of troubled ones
- Psychotherapy (individual, group, and family)
- Drama Therapy
- Art Therapy
- Sand Tray Therapy
- Play Therapy
- Academic Remediation
- School and Legal Issues
- Stress Management
- Neurofeedback
- Relaxation Techniques
- Massage & Therapeutic Touch
- Integrative Yoga and Meditation Therapy
- Adolescent Substance Abuse Treatment
- Educational Kinesiology/Brain Gym
- Hypnosis
- Creative Arts Summer Program for Children with AD/HD

The Center frequently arranges for its professional staff to address groups and organizations on clinical and personal approaches to handling AD/HD and learning difficulties. Call us directly to arrange a speaker for your community at no fee.

Behavioral Arts & Research is committed to being the single most comprehensive source for the treatment of AD/HD in the New York area. If you have questions, or would like to share your experience, please feel free to contact us at (212) 799-9388 or (888) 497-3722.



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Neurofeedback and ADD

Neurofeedback is a remarkable treatment protocol that has slowly been gaining momentum in the mental health field over the last twenty years. Neurofeedback refers specifically to a type of biofeedback training that gives us information about our brainwaves. Each of us has a variety of brainwaves. They include: alpha waves, which occur at around 8 to 12 cycles per second, or hertz (hz), and are associated with deep relaxation; theta waves, which occur at 4 to 8 hz, and are connected with the daydreamy state some of us are most familiar with just before we drop off to sleep; and beta, 12 – 32 hz, which predominate when we are alert and focused. Research has shown that brainwave patterns can be used to identify certain disorders. Alcoholics, for example, produce less alpha than normal. It is thought that they drink in an effort to increase their alpha waves, which helps them relax. People with ADD/ADHD have been shown to have more theta and less beta than normal, whereas people with anxiety disorders tend to have higher beta and less theta.

Neurofeedback can be utilized to teach the brain to alter these pathological wave patterns. So, for example, alcoholics can learn to increase their alpha waves, and people with ADD/ADHD can be taught to increase beta and decrease theta. People with anxiety disorders, including panic disorder, can resolve their fears by learning to increase their theta waves.

Controlled studies of patients suffering from both ADD/ADHD and alcoholism have shown that 80 to 90 percent of alcoholics treated with neurofeedback have been able to stop drinking entirely, with follow-up studies over a ten year period; and that 80 to 90 percent of people with ADD/ADHD have been able to reduce their levels of medication significantly, with half of those able to go off medication entirely.

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Nutritional Influences on AD/HD

Nutrition clearly has a role in the management of many children and adults with AD/HD. From a dietary standpoint, the two most important factors to address are hypoglycemia or weak blood sugar regulation and food allergies or sensitivities. Many studies have shown a significant relationship between sugar and carbohydrate intake, and behavior in children. Evidence also suggests that smaller changes in blood sugar can produce specific adverse functional effects in the nervous system of children in comparison to adults. With regard to food allergy, several studies have shown that behavioral effects are observed in a minor but significant proportion of children with AD/HD. Blinded research has shown further that these children with food-induced Ad/HD also have documentable changes in brain electrical activity as indicated by EEG techniques.

Nutritional status and nutritional supplementation constitute a second important area to evaluate and address. While vitamin levels in children with AD/HD have infrequently been found to be deficient, mineral deficiency is not uncommon, especially for magnesium and zinc, and to a lesser extent iron and calcium. Some studies have shown beneficial effects with nutritional supplementation; however, more studies are clearly required to substantiate benefits and to identify the specific circumstances for the optimal use of nutritional supplement protocols.

A final area that can influence behavior and function of AD/HD children that is usually covered within 'nutrition' is exposure to and accumulation of toxic minerals such as lead. Interestingly, studies have shown even 'normal' levels of lead can influence learning and other functions in children. Further research has suggested that this may be promoted by subclinical or clinical deficiency of minerals described above.

While there are many other nutritional factors and nutritional supplements that may be important in AD/HD, what emerges from the previous discussion of these nutritional factors is the assertion that nutrition may have a significant role in most cases of AD/HD. Also, this is a multi-factorial disorder; the challenge is to determine which children are most affected by which nutritional factors and then to implement the most beneficial therapeutic regimen. In order to most effectively accomplish this, sensitive nutritional evaluation and counseling is required for each individual. At the same time significant clinical research is necessary to further clarify these relationships. Therefore, we at *Behavioral Arts* will continue to refine our nutritional and holistic therapies for AD/HD to provide the best possible treatment for those involved. In addition, we hope to contribute to the further understanding of this disorder and to the development of even more effective therapies.

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The Eidetic Image Approach to ADD

The Problem

Children with Attention Deficit Disorder and learning disabilities are often bright, sensitive individuals. Despite their potential, they either do poorly in school or have to struggle to keep up. If a child is also hyperactive, the problem is compounded.

How We Learn

As children, we learned about the world around us by interacting with objects physically and mentally. We explored our world in an imaginative way, creating countless play scenes in ever more complex variations as we developed. This early imaginative interaction is a natural, informal stage of learning and is the basis for all future learning. In the child with attentional problems or learning disabilities, this early learning process has been hindered or interrupted and needs to be rekindled if the child is to regain his or her full potential.

The Image Approach

The Image Approach to learning disability and Attention Deficit Disorder was created by Akhter Ahsen, a renowned researcher and clinician on imagery and its therapeutic applications. Ahsen's Image Approach works directly with the child's early learning process, encouraging his innate ability to create mental images and explore them in imagination, which is the basis of learning. The Image Approach creates a natural, non-threatening learning situation, which allows the child to resume his learning process where he left off. Any resemblance to the more formal school setting is carefully avoided at first. The therapist uses specially designed stories and pictures to spark the child's interest and imagination and to resolve emotional blocks to learning and social interaction through imaginative expression. The pictures are used as a steady focal point for the child to build imaginative, ongoing stories from week to week, enlisting the child's memory and ability to focus and creatively interact with the learning materials.

Improved Focus

Once this process is underway, the child's ability to focus improves and he or she can begin to successfully engage in the more formal learning process at school. The process also enriches the child's social interactions. For the hyperactive child, as he improves his ability to establish satisfying relationships at home and at school, his behavior and the behavior of others toward him begin to normalize.

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Behavioral Arts
in association with
The Center for Meditation and Healing
of Columbia Presbyterian Medical Center

Presents

MEDITATION FOR ADD

Meditation is the practiced observation of thoughts, feelings, impulses and sensations that can produce a sense of mental and physical calm. It is not about doing something or getting somewhere else, but about allowing yourself to be where you already are. Meditation is practiced in a non-threatening, supportive, safe environment.

Meditation may be useful to help school-aged children and adults cope more effectively with the symptoms of Attention Deficit Disorder (ADD) (Le Page, 1999). Research has indicated that meditation can facilitate improved concentration, reduced anxiety and stress, improved memory and general intelligence, and increased empathy for people (Benson, 1982; Kabat-Zinn & Santorelli, 1995; Le Page, 1997; and Murphy, Donovan & Livingston, 1995). Children became more "aware of when others pushed their buttons" and "take more responsibility for their behavior" after practicing meditation (Hall & Olness, 1993).

Behavioral Arts provides a comprehensive program focusing on meditative methods for treating ADD. This program is available for individuals and groups of school-aged children and their parents or caregivers. The program's goal is to help participants cope and manage symptoms of ADD more effectively. It is expected that:

- Meditation will help participants to attend to the present moment.
- Meditation participants will become more aware of the clutter in their minds.
- Meditation will enable participants to become calm, focused, and balanced.
- Meditation participants will gain insight into what drives them to distraction, how they react impulsively, and how they solve their social dilemmas.
- Meditation will provide participants an opportunity to improve their self-esteem and overall personal, school, and family adjustment.



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MINDFUL PLAY/MINDFUL LEARNING

BEHAVIORAL ARTS PRESENTS

Mindful Play/Mindful Learning — An integrative approach developed to improve school-aged children and adolescents' abilities to focus, attend, and concentrate more effectively in school and social situations. This approach combines traditional and alternative methods in psychology, education, meditation, and yoga. The program is a comprehensive method that is based on the individual needs of the client. Individual and group sessions are scheduled.

Mindful Play/Mindful Learning promotes change through:

1. Assessing an individual's ability to attend, concentrate, and focus;
2. Identifying specific mindfulness skill/s to improve;
3. The development of a program which includes yoga, meditation, psycho-educational instruction, guided imagery, visualization, and relaxation techniques; and
4. At the conclusion of the program, parents are invited to participate and receive feedback about their child's improvement. Parents will receive recommendations for maintenance of mindfulness skills.

Children and adolescents will find this program especially beneficial to cope and manage symptoms associated with *Attention Deficit Disorders and Learning Problems*.

INTEGRATIVE YOGA THERAPY

BEHAVIORAL ARTS PRESENTS

Contact:

Mercedes A. McCormick, Ph.D.
and Tami Farber

Trained & Experienced in the
fields of psychology, yoga, and
meditation.

Location:

58 West 88th Street
New York, New York 10024
212-799-9388, ext. 31
Fax: 212-799-4403

Behavioral Arts & Research

Psychotherapy and Alternative Treatments

Enid Haller, ASCW, Ph.D.

Executive Director

Dr. Haller has been a practicing mental health professional for eight years in New York City with a specialty in Attention Deficit Disorder (ADD) and addictive behavior. Holding a masters degree in social work and a doctorate in clinical psychology, Dr. Haller has worked in a variety of challenging settings: as counselor to crack-addicted mothers and children in the OBS/GYN unit of Metropolitan Hospital NYC; counselor for chemically-dependent patients in the Dual-Diagnosis Unit of Regent Hospital NYC; counselor at the Training Institute for Mental Health NYC and for dual-diagnosis patients at Parallax Center NYC. She has also worked in couples and family counseling at the Ackerman Institute for Family Therapy NYC, and provided psychotherapy counseling for chemically dependent patients at Robinson Institute NYC.

Dr. Haller is leading the national dialogue on treatment for ADD in adults and children by bridging alternative and traditional therapies. Her book on the subject is due this year, and she is seen and heard frequently on television and radio. Dr. Haller is the founder of *Behavioral Arts & Research*.

Mary Alice Askew, MS

Certified Hypnotherapist

Ms. Askew received her Masters of Science degree in Counseling Education from North Carolina Agricultural and Technical State. In May 1977, she was licensed for school counseling by the North Carolina State Board of Education/Department of Public Instruction, and received "Board Eligible" status with the Nation Board for Certified Counselors, having passed their National Counselor's Exam. In her capacity as a school counselor, Ms. Askew provided individual and group counseling services, taught classroom guidance lessons, and provided consultations to parents and children. She is registered as a Certified Hypnotherapist with the American Board of Hypnotherapy. Ms. Askew has been trained in Brain Gym, a system of movement designed to help individuals overcome learning blocks. She incorporates NeuroLinguistic Programming (NLP) and self hypnosis into her practice, both of which are effective in treating AD/HD.

Ina Becker, M.D.

Psychiatrist, Psychopharmacologist

Dr. Ina Becker received her medical degree in 1987 in Hamburg Germany. She obtained additional training at Albert Einstein College of Medicine, where she had a residency in Child and Adolescent Psychiatry. She went on to become the Associate Unit Chief of the Acute Adolescent Unit and the Unit Chief of the Young Adult Services Division of Bronx Children's Psychiatric Center in 1993. Currently, Dr. Becker is the Assistant Psychiatrist at Columbia Presbyterian Medical Center. Additionally, she is in private practice with a focus on psychopharmacology. *Behavioral Arts & Research* is happy to welcome her as its resident psychiatrist.

Joel Edman, D.Sc., FACN

Director of Nutritional Counseling

Dr. Edman is a clinical nutritionist and nutritional consultant with a specialization in neuro-psychological disorders and hypoglycemia. In addition to nutritional practice in New York City and Westchester County, Dr. Edman is a part-time nutritionist at Canyon Ranch in the Berkshires and the former Director of Nutrition at the Atkins Center for Complementary Medicine, where he worked for over nine years.

Behavioral Arts & Research

Psychotherapy and Alternative Treatments

Dr. Edman received a Master's Degree in Clinical Nutrition from Drexel University and a Doctoral Degree in Nutritional Sciences from Boston University. He is also a Fellow of the American College of Nutrition. Dr. Edman is an author or co-author of 17 peer-reviewed articles and abstracts examining disorders such as depression, impaired cognition, seizures, hypoglycemia, diabetes and colitis. These have been published in the journals Biological Psychiatry, Acta Psychiatrica Scandinavica, The Journal of the American College of Nutrition and Alternative Therapies in Health and Medicine, among others.

Sandra Greenbaum, ACSW

Psychotherapist

Ms. Greenbaum received a Masters degree in social work from Hunter College School of Social Work and has been in practice for more than 20 years. Her career has included work with children of all ages in the context of adoption, foster care and educational settings, as well as a private practice on Manhattan's Upper West Side. Mrs. Greenbaum has lectured at professional organizations and conducted workshops at Manhattan private schools. Her practice focuses on children and families. She provides individual and family treatment and runs groups for children experiencing socialization difficulties.

Jennifer Healey, CSW, MBA

Psychotherapist

Ms. Healey is a psychotherapist and New York State Certified Social Worker who provides individual, couples and family therapy to adolescents and adults. Her experience involves a variety of clinical settings and treatment modalities including brief, crisis oriented individual and group psychotherapy at NYU Counseling Services, individual and group psychotherapy for mandated substance abusing clients at Phonix House, and individual, couples, and group psychotherapy for dual diagnosis clients at Parallax Center NYC. Currently, Ms. Healey is an advance training candidate at the Psychoanalytic Psychotherapy Study Center and is in private practice in Manhattan. She provides individual, couples and family therapy at *Behavioral Arts & Research*.

Julie Iannone, CSW

Psychotherapist

Ms. Iannone is a New York State Certified Clinical Social Worker and Psychotherapist. She provides individual psychotherapy to adults and couples therapy. Her experience includes depression and anxiety disorders, AD/HD, substance abuse and women's issues. Ms. Iannone has over five years clinical experience working with clients at the Center for Marital and Family Therapy in Manhattan. She serves as a supervisor to MSW student interns at *Behavioral Arts & Research*. Ms. Iannone has received additional post-graduate training in clinical social work and psychodynamic theory from New York University. She currently offers a psychotherapy group for women with AD/HD at *Behavioral Arts & Research*.

Janice Lyons Jacobs, Ph.D.

Director of Assessment Services

Licensed Psychologist

Dr. Jacobs is a licensed clinical psychologist with extensive experience evaluating and treating children with a variety of emotional, behavioral and educational problems. She was a Court Psychologist for the Juvenile and Domestic Relations District Court in Fairfax County, VA. She has also worked as a clinical psychologist in special education settings focusing on children with severe learning disabilities and emotional disturbance. Dr. Jacobs obtained her doctorate from the Pennsylvania State University and received her training at the Children's Hospital National Medical Center in Washington, D.C. Dr. Jacobs is the Director of Assessment Services at *Behavioral Arts & Research*.

Behavioral Arts & Research

Psychotherapy and Alternative Treatments

Babette Lefrak, CSW

Psychotherapist

Ms. Lefrak is a Clinical Social Worker and Psychotherapist who provides individual psychotherapy to adolescents and adults as well as family and couples therapy. In addition to her work at Behavioral Arts & Research, she is on staff at The Fifth Avenue Center for Counseling and Psychotherapy, where her experience includes psychodynamic and cognitive-behavioral treatment of patients from a variety of economic, ethnic and cultural backgrounds, with a broad range of psychiatric diagnoses. She has also worked extensively with geriatric patients and their families. Ms. Lefrak is an advanced training candidate at the Psychoanalytic Psychotherapy Study Center in New York City. She provides individual, couples and family therapy at *Behavioral Arts & Research*.

Mercedes A. McCormick, Ph.D.

School Psychologist and Specialist in Yoga and Meditation

Dr. McCormick has a significant background working with children, adolescents, and their families dealing with behavioral, developmental, emotional and learning challenges. Dr. McCormick earned the doctorate degree in philosophy with specialization in family therapy at Seton Hall University, South Orange, New Jersey. She received pre-doctoral training at Kessler Rehabilitation Hospital, West Orange, New Jersey in the evaluation and treatment of the physically challenged, particularly traumatic brain injuries. During the past two decades she has worked as an Urban School Psychologist, where she has provided evaluation and treatment for children, adolescents, and their families from diversified ethnic and economic backgrounds. She is trained to work with clients who are experiencing personal and professional challenges due to attention difficulties. Dr. McCormick is also trained in Mindfulness Meditation, Integrative Yoga Therapy, and Prana Yoga. She will be offering a Meditation Group for children with ADD at *Behavioral Arts & Research* in the fall.

Rene O'Neill, MA

Marriage, Family and Child Therapist

Ms. O'Neill completed her graduate work in California, where she worked at Stanford University on a project focusing on treatment of eating disorders. She also worked in a Stanford clinic as a therapist to families, children and adults in single parent families, or families in transition. Over the last several years Ms. O'Neill has worked as a clinician at New York State Psychiatric Institute working with individuals and children with depression and other comorbid disorders. She has extensive training in assessment, diagnostic methods, play and sandtray therapies for children and treatment of adults in recovery. Ms. O'Neill works from an eclectic framework, utilizing various theoretical methods for the best treatment possible. She will provide individual and family therapy, as well as sand tray therapy at *Behavioral Arts & Research*.

Deborah Pines, CSW

Psychotherapist - Neurofeedback Specialist

Ms. Pines is a New York State Certified Social Worker who has trained with the leading experts in the field of neurofeedback, a method of treatment that has been shown to be highly effective with ADD/ADHD and substance abuse as well as a number of other psychological issues. Recognizing the effects on marriages in which children or members of couples suffer from these disorders, Ms. Pines is currently in a certificate program with the Imago Institute for Relationship Therapy. Ms. Pines provides neurofeedback, as well as individual and couples therapy at *Behavioral Arts & Research*.

Behavioral Arts & Research**Psychotherapy and Alternative Treatments****Dawn Volkart, CSW Candidate*****Psychotherapist, AD/HD & Organizational Coach***

Ms. Volkart is completing her Masters Degree in Social Work at Fordham University School of Social Service and has already passed the New York State Licensing Exam. In addition to her work at Behavioral Arts & Research, she is on the staff at Maria Droste Services, an outpatient mental health facility, where she provides individual psychotherapy to a wide variety of clientele. Ms. Volkart's experience includes working with individuals suffering from depression, anxiety, Attention Deficit Hyperactivity Disorder (AD/HD), and mild traumatic brain injury, as well as with adult survivors of physical and sexual abuse. Prior to graduate school, she worked for seven years with neuropsychologists specializing in AD/HD. Ms. Volkart provides individual psychotherapy and AD/HD/organizational coaching at *Behavioral Arts & Research*.

Amy Wiest, CSW***Psychotherapist***

Ms. Wiest is a psychotherapist and clinical social worker specializing in anxiety and depression; the psychological aspects of chronic illness and disability; mind body psychotherapy; and stress reduction. Her experience involves a variety of clinical settings and treatment modalities including intensive psychotherapy for adults at Blanton-Peale Counseling Center and in private practice; group and individual therapy with high-risk adolescents at Dewitt Clinton High School; counseling the elderly and their families through the Department of Human Services and the Office for the Aging; and crisis counseling at a walk-in center at the Department of Human Services. Ms. Wiest received additional post-graduate training through the Training Institute for Mental Health. She is an active member of the New York Society for Clinical Social Work and the National Association of Social Workers. Ms. Wiest provides psychotherapeutic services and supervises student interns at *Behavioral Arts & Research*.

Behavioral Arts

Evaluation and Assessment

Janice Lyons Jacobs, Ph.D.

Director of Assessment Services

Licensed Psychologist

Dr. Jacobs is a licensed clinical psychologist with extensive experience evaluating and treating children with a variety of emotional, behavioral and educational problems. She was a Court Psychologist for the Juvenile and Domestic Relations District Court in Fairfax County, VA. She has also worked as a clinical psychologist in special education settings focusing on children with severe learning disabilities and emotional disturbance. Dr. Jacobs obtained her doctorate from the Pennsylvania State University and received her training at the Children's Hospital National Medical Center in Washington, D.C. Dr. Jacobs is the Director of Assessment Services at *Behavioral Arts*.

Joseph Hirsch, Ph.D., Psy.D., FPPR

Licensed Psychologist

Dr. Hirsch is a neuropsychologist with an extensive background in clinical practice and research. He began his career with a doctorate in Pharmacology in 1979 from the Downstate Medical Center, State University of New York, Brooklyn, specializing in Neuropharmacology. In 1989 Dr. Hirsch received his Certificate in Counseling from the Post Graduate Center for Mental Health, NYC. He received his doctorate in School/Community Psychology in 1995 from Pace University. Currently Dr. Hirsch is a Neuropsychologist and Psychotherapist in private practice and works as a Consulting Neuropsychologist and Psychodiagnostician. He is an Adjunct Associate Professor for the Department of Psychology and Biology at Pace University, an Adjunct Assistant Professor for the Department of Pharmacology for the New York University College of Dentistry, and a Professor for Fielding Institute/Prescribing Psychologists' Register where he also is a workshop and seminar presenter. Dr. Hirsch has obtained a diplomate from the American Board of Forensic Examiners. He has published extensively. Dr. Hirsch will be providing neuropsychological evaluations for *Behavioral Arts*.

Gabriela Hohn, Ph.D.

Licensed Psychologist

Dr. Hohn is a clinical psychologist with specialized training and experience in child and family treatment, neuropsychological and psychological assessment, and crisis intervention with clients from diverse cultural backgrounds. She has worked in the forensic setting, as well as teaching college classes in Forensic Psychological and Adolescent Development. Dr. Hohn administers neuropsychological evaluations at *Behavioral Arts*.

Mercedes A. McCormick, Ph.D.

School Psychologist

Dr. McCormick has a significant background working with children, adolescents, and their families dealing with behavioral, developmental, emotional and learning challenges. Dr. McCormick earned the doctorate degree in philosophy with specialization in family therapy at Seton Hall University, South Orange, New Jersey. She received pre-doctoral training at Kessler Rehabilitation Hospital, West Orange, New Jersey in the evaluation and treatment of the physically challenged, particularly traumatic brain injuries. During the past two decades she has worked as an Urban School Psychologist, where she has provided evaluation and treatment for children, adolescents, and their families from diversified ethnic and economic backgrounds. She is trained to work with clients who are experiencing personal and professional challenges due to attention difficulties. Dr. McCormick is also trained in Mindfulness Meditation, Integrative Yoga Therapy, and Prana Yoga. She will be offering a Meditation Group for children with ADD at *Behavioral Arts* in the fall.

Behavioral Arts

Evaluation and Assessment

Lana Morrow, Ph.D.

Neuroscientist and Neuropsychology Evaluator

Since 1985, Dr. Morrow has worked as a licensed neuropsychologist in Italy, leading neuropsychological and psychophysiological research with Parkinsonian and Alzheimer's patients. In 1990, Dr. Morrow began her involvement with research in neuropsychology and psychophysiology of attention. Her interests evolved into clinical research and practice with children, adolescents, and adults. Presently, in private practice in Manhattan, she specializes in neuropsychological assessment and treatment of children and adolescents with Attention Deficit Disorder and learning difficulties. Dr. Morrow is a consultant to Behavioral Arts and numerous private school of Manhattan, and is a president of Spark Therapeutic Interfaces Incorporated, a company specializing in design and invention of software interfaces to help children with learning and attentional difficulties. She holds a Suma Cum Lauda doctorate from University of Rome, Italy, a fellowship in Sorbonne, Paris; a post doctorate from Mount Sinai; and has completed courses in experimental cognition at City University of New York. Dr. Morrow has presented at numerous conferences and seminars both in Europe and the USA.

Stacy Berrin Wasserman, Ph.D.

Licensed Psychologist

Dr. Wasserman obtained her doctorate in Psychology in 1997 from the City University of New York, Queens College, specializing in Neuropsychology. Her experience is in clinical neuropsychological evaluations of children and adults, including patients with neurologic, psychiatric and developmental disabilities. She spent her 1983-84 academic year at the Bar Ilan University in Ramat Gan, Israel. Dr. Wasserman provides neuropsychological evaluations at *Behavioral Arts*.

Tutors/Remediators

Nelson Dorta, Ph.D.

Neuropsychologist and Remediator

Dr. Dorta received his doctorate from the State University of New York at Buffalo and subsequently completed two fellowships at Harvard Medical School. He is the supervising Neuropsychologist at St. Luke's Hospital Department of Child Psychiatry and Psychology where he coordinates the neuropsychological and learning evaluation clinic. Dr. Dorta is also the Director of the Learning Disorder Program and a Staff Neuropsychologist at Andrus Children's Center and Orchard School. He was previously the Chief Psychologist and Coordinator of Training at North Shore Child and Family Guidance Center. Dr. Dorta provides remediation of severe math and perceptual difficulties at *Behavioral Arts*.

Genata Carol, Ph.D.

Clinical Psychologist and Remediator

Dr. Carol is a clinical psychologist with a Masters in School Psychology, as well as a Masters in Drama Therapy. She earned her doctorate in Clinical Psychology from Adelphi University. She currently provides psychological and neuropsychological assessments in private practice. Previously, she worked at Young Adult Institute (YAI) as a group facilitator for adolescents with vocational, socialization and interpersonal difficulties. Dr. Carol provides individual tutoring and remediation at *Behavioral Arts*.

Meredith Englander, CSW

Clinical Social Worker

Ms. Englander is a clinical social worker who is currently obtaining an additional Masters in Special Education. She earned her MSW at Columbia University School of Social Work and is finishing up her Masters in Special Education at Bank Street College of Education. Ms. Englander has provided tutoring for a wide variety of children over the past five years. She has experience with AD/HD, and in tutoring math, English, Hebrew and Judaic studies. She is providing these services at *Behavioral Arts*.

Marcia Massih, MA

Tutor

Ms. Massih obtained her Masters degree at Columbia University School of International and Public Affairs. She was an English teacher at Centro Colombo-Americano School and was a French teacher and Guidance counselor to junior high and high school students in Putney, Vermont. Additionally, she taught conversation and writing to professional engineers in Cali, Columbia. Privately, she has assisted urban high school students with organizational strategies and has taught English as a second language. Ms. Massih provides tutoring in English, French and organizational skills at *Behavioral Arts*.

Carol Ramsey, MS

Tutor

Ms. Ramsey holds a Masters in Education from Bank Street College of Education and is currently completing an additional Masters in Special Education. Ms. Ramsey has taught at Abraham OJoshua Heschel School, where she implemented the Orton Gillingham Multisensory program, Corlears, The Walden Lincoln School, and The New Lincoln School. She provides tutoring for young children at *Behavioral Arts*.

Merry Regenstreich, MA, M.Ed.

Learning Disability Specialist

Ms. Regenstrich obtained her Masters in Special Education from Bank Street College of Education and an additional Masters in Recreational Therapy from New York University. She is currently a private tutor specializing in study skills, organizational strategies, writing and language

Tutors/Remediators

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Neuropsychologist and Remediator

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ADELPHI UNIVERSITY

**SCHOOL OF SOCIAL WORK
&
SCHOOL OF EDUCATION**

PRESENT

ENID HALLER, ACSW, Ph.D.

ON

A COMPREHENSIVE VIEW OF ADD: TREATMENT & DIAGNOSIS

An in-depth survey of Attention Deficit Disorder: Definition, History, Symptoms, Diagnosis, ADD and Comorbid Disorders, and traditional and alternative treatment methods. Dr. Haller is the Executive Director of Behavioral Arts, a NYC center which provides comprehensive services to individuals with ADD.

**ADELPHI SOHO 75 VARICK ST., 2ND FLOOR, NEW YORK, NY
WEDNESDAYS, MARCH 15, 2000 – MAY 10, 2000**

6:00 PM – 8:00 PM

\$275.00

*15% discount for Adelphi Alumni
25% discount for Senior Citizens (60+)*

TO REGISTER OR FOR MORE INFORMATION CALL:

(212) 965-8383

(212) 965-8388



From the TelePort of: Ceslie J. Armstrong

Date: Thursday, May 11, 2000

Number of Pages: 4

To: Mickie Mailey, Office of the First Lady

Fax Number: 202 456-5340

Memo: Hi Mickie! Following is some information regarding Behavioral Arts and The Aqua Ball. The Clinic is going to fax you the detailed information including credentials, programs, etc. as well as information on The Caedman School. Please phone me at 813-2011 or after 3:00 at 212-683-5222 if you need to.
Regards! Ceslie

ARMSTRONG & ASSOCIATES, INC.

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Dr. Enid Haller and Julianne Moore proudly announce
Hillary Rodham Clinton and The Caedman School
as honorees at Aqua Ball 2000 to benefit Behavioral Arts & Research

- What:** Aqua Ball 2000 supporting Behavioral Arts & Research's complimentary treatments for Attention Deficit Hyperactivity Disorder
- When:** Wednesday, 24 May 2000
7:00 to 10:00 pm Cocktails/Dance/Hors d'ouvres/Live and Silent Auction
6:30-8:00 V.I.P. Cocktail Lounge
8:00 Announcements/Honoree Program
8:30-9:15 Live auction
9:30 Silent auction results
- Where:** Spa Nightclub, 76 East 13th Street (betw Broadway and 4th Ave)
- Honorary Chairwoman:** Julianne Moore
- Celebrity Host Committee:** Brooke Adams, Craig Bierko, Finn Carter, Kim Cattrall, Catherine Curtin, Karen Duffy, Peter Gallagher, Grainger Hines, Tom O'Leary, Mary-Louise Parker, Sandra Santiago, Forrest Sawyer, Tony Shaloub, Stanley Tucci
- Event Chairwoman:** Dr. Enid Haller
- Event Committee:** Ceslie J. Armstrong, Nicholas Barnes, Tom Bradley, Mr. & Mrs. Richard Burns, Greg Calejo, Mr. & Mrs. Paul Carroll, Mr. & Mrs. Charles Cecil, Mr. & Mrs. Dylan Doherty, Michael Gilberto, Samuel W. Hiser, Marc Henry Johnson, James Kaufman, Phyllis Keitlen, Andrew LePera, John Larkin, Patrick McMullan, Dawn Palo, Camilla Rees, John Reid, Jr., Christopher Scinto, Kevin Sharpe
- Medical Committee:** Dr. Ina Becker; Joel Edman, D.Sc., FACN; Sandra Greenbaum, ACSW; Julie Iannone, CSW; Janice Lyons Jacobs, Ph.D.; Babs Lefrak, CSW; Dr. Donald Salmon; Rene O'Neill, MA; Deborah Pines, CSW; Amy Wiest, CSW; Barbara Richert, CSW; Mary Alice Askew, MS; Stacy Berrin Wasserman, Ph.D.; Jenny Healey, CSW; Dawn Volkart; Tammy Farber; Dr. Joseph Loizzo; Dr. Ned Hallowell; Dr. John Ratey; Thomas Hartmann; Dr. Lana Morrow
- Honorees:** Hillary Rodham Clinton (via videotape presentation) & The Caedman School
- Auction Highlights:** Autographed scripts, costumes, gowns, and memorabilia from major motion pictures and television shows.
- Sponsors:** COACH, Marc Bouwer Fashion, Natural Nylon Films, Noli's Restaurant
- Tickets:** Individual tkts \$250; \$3500 Table of 10 includes VIP Room
Business check, VISA, MasterCard, American Express,
Discover, or Diners Club payable to Behavioral Arts.
R.S.V.P. to John Lakin, Armstrong & Associates, Inc.
340 E. 52nd Street, 7th floor, suite D, NYC 10022
tel: 212-813-2011, fax: 212-752-3197, email: ArmstrongMedia@aol.com
Payment must be received by 5/22/00 for confirmation
- Press:** Credentials necessary, fax request to: John Larkin, Armstrong & Associates, Inc.
fax: 212-752-3197 tel: 212-813-2011

Enid Haller, ACSW, PhD

Biography

Distinctions in Assessment and Treatment

Dr. Haller is Executive Director of Behavioral Arts & Research, Inc., a non-profit outpatient treatment and research facility specializing in Attention Deficit/Hyperactivity Disorder (AD/HD). Dr. Haller's clinical approach offers both long- and short-term treatment with an emphasis on the social and biological roots of behavior problems. In working with AD/HD cases, she draws from broad experience with issues of co-dependency, substance abuse and cognitive psychology. And being a skilled diagnostician and psychotherapist in a variety of individual and group settings, Dr. Haller is frequently called upon for her expertise with the difficult cases involving dual diagnosis and for second-opinion assessments.

Dr. Haller is well known to New York patients and professionals for her accomplishments in several sub-specializations of psychology. She is most noted for her pioneering work with AD/HD and related problems, though her range of experience and past professional appointments permit her to work with a host of psychological dysfunctions with both individuals and families. She is a much sought-after consultant, guest lecturer and author, and currently teaches a Masters level course at Adelphi University, Assessment and Treatment of AD/HD.

Dr. Haller holds certification and advanced workshop credits from the noted Ackerman Institute and The Training Institute for Mental Health, both in New York City. Her challenging work at Metropolitan Hospital, Regent Hospital and Parallax Center in Manhattan involved extreme cases -- including crack-addicted pregnant teens -- in which she performed counseling and advanced treatment planning. And through her many clinical appointments, Dr. Haller has worked with patients under the tutelage of some of the community's most prominent professors and researchers.

Dr. Haller is an active member in numerous influential organizations in the field including the American Psychological Association; the Academy of Certified Social Workers; the Association for Children with Learning Disability; Children and Adults with Attention Deficit Disorders; the National Institute of Drug Abuse. As her clinical work involves (adult) children of alcoholic parents, she maintains association with The National Association of Alcoholism and Drug Counselors and The New York Federation of Alcoholism Counselors.

Dr. Haller holds a BA in fine arts from Emerson College (Boston), an MSW from Fordham University (New York), and a PhD in Clinical Psychology from the Union Institute (Cincinnati). She lives with her husband, their daughter and Great Dane in Manhattan.

Behavioral Arts & Research, Inc.

Description of Clinical Services & Research Activities

Behavioral Arts & Research is a pioneer in applying complementary treatments for people suffering from Attention Deficit/Hyperactivity Disorder (AD/HD). Established in 1996, the center -- the first of its kind -- uses a multi-model approach that integrates a variety of treatment methods (with or without medication) toward building customized solutions for individuals, families, children and adults.

Clinical approaches that are successful at Behavioral Arts for AD/HD patients include:

Nutritional Assessment & Programs

Neurofeedback Training

Meditation & Yoga

Organizational Skills Workshop

Socialization Group

Support Group

Family Therapy

Medication is prescribed only as a last resort, or in extreme cases, and it is always accompanied by complementary treatment along with close monitoring for side-effects and proper dosage. Medication is never prescribed for pre-school children. The addictive potential of the AD/HD brain makes medicating the disorder an acute risk. Consequently, a proper and thorough diagnosis becomes essential.

Diagnosis of AD/HD is the most important element of the Behavior Arts clinical model. The center's expertise in diagnosis, and its emphasis on the importance of the diagnostic process, sets Behavioral Arts apart. AD/HD cases undergo a thorough intake process in which important background health and family information is collected. Then, a thorough neuropsychological evaluation is made in order to distinguish any possible neurological dysfunction from the presenting attentional or learning difficulty. The center has found that superficial diagnoses of AD/HD by non-qualified sources is one of the primary causes of the alarming trends in the use of medication.

Research activities at the center are designed to advance the understanding of the nexus of brain function and behavior in cases of AD/HD. Studies are currently underway that will gauge the efficacy of certain complementary treatments both with and without the accompanying use of medication. And quantitative studies are planned to illuminate the basis of the co-morbidity of AD/HD with accompanying addictions and other common related behavioral dysfunctions.

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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001. fax	re: political (3 pages)	05/09/2000	Personal Misfile
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Clinton Presidential Records
Domestic Policy Council
Heather Howard (Subject Files)
OA/Box Number: 21197

FOLDER TITLE:

Ritalin [Binder] [2]

2012-0254-S

rc670

RESTRICTION CODES

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

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

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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]

FAX

DATE: Wednesday, May 10, 2000

TO: Mickie Mailey, Office of the First Lady

FAX: 202 456-5340

FROM: Ceslie J. Armstrong

PAGES: 3

MEMO

ARMSTRONG & ASSOCIATES, INC.

media • marketing • entertainment

10 May 2000

Ms. Mickie Mailey
Office of the First Lady
The White House
1600 Pennsylvania Avenue, N.W.
Washington D.C.

Dear Mickie,

I was great to speak with you this morning! As I said, we are all big Hillary supporters! Per your request, following is a suggested speech for the upcoming video taping. I can include any other information you need as necessary. I can be reached between 2 and 6 p.m. today at my film company, 212-683-5222, or, you may always leave a message for me at 212-813-2011. Feel free to phone anytime!

The billing contact is:

Dr. Enid Haller
Behavioral Arts & Research
58 West 88th
New York, NY 10024
tel: 212-799-9388

Please make the format BETA

Delivery address is:

Ceslie Armstrong/John Larkin
340 East 52nd no. 7-D
New York, NY 10022
tel: 212-813-2011

Sincerely,



Ceslie J. Armstrong

ARMSTRONG & ASSOCIATES, INC.

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Thank you so much for this wonderful honor. I am sorry I am not able to attend Aqua Ball 2000, but I am with you in spirit and message! You should all be commended for your participation in raising awareness and research dollars for Attention Deficit Hyperactivity Disorder. As you know the overuse of Ritalin, especially in children between the ages of 2 and 5, is rampant in our society and school systems.

{insert information from Mrs. Clinton's recent press release regarding the overuse of ritalin HERE; she may also refer to the New York Times article, attached}

This is an alarming problem that all of us here tonight, as parents, teachers, mentors, and New Yorkers must address to ensure the positive health and well-being of our Nation's youth--our future leaders. A lot of heat has been generated in the recent publicity about these alarming trends of our medication of children, but, we need answers and solutions! I'm so honored to be recognized by Behavioral Arts & Research because it is the one institution that for the past three years has focused on the solution to these trends associated with AD/HD. I want to recognize Dr. Enid Haller and her respected staff who have shown a commitment to the real well-being of their patients, who bring their commitment, dedication and creativity to the task of helping people enhance their own lives. And also, to Julianne Moore for co-chairing this event and lending her name and support to this very important evening. And of course, the teachers and administrators at The Caedman School for embracing and practicing alternative treatments to AD/HD. You certainly set an example for other private schools to follow. By participating as committee members and guests supporting tonight's auction and event, you are helping to further much needed research and making the innovative programs at Behavioral Arts available to more families. I urge you to have fun this evening, but more importantly, keep the children and their families in mind when bidding on the memorabilia in tonight's auction. In fact, Janis, Sharon, may I enter a bid for.....

{it might be light hearted to mention an auction item that either Hillary, Bill, or Chelsea might be interested in. ie. Peter Gallagher's hand signed script from American Beauty, or, Julianne Moore's Oscar Sweatshirt; script from Magnolia; Golden Globe gown; or, Kim Cattrall's Golden Globe gown; or, Stanley Tucci's autographed cook books.}

Bill Gates launching Windows 95, before his antitrust troubles began.

Associated Press

prime minister.

By Stephanie Strom

adultery.

By Nicholas Wade

young boy.

By Lizette Alvarez



7

NYT 4/9/00
Sec. 4, P. 1

Reading, Writing and Ritalin

Fury, Not Facts, in the Battle Over Childhood Behavior

By ERICA GOODE

ARE toddlers being plied with Prozac, Ritalin and other powerful drugs for behavior problems no more severe than sticking pennies into the VCR, throwing peas at the dinner table or refusing to go to bed on time?

The hand-wringing in recent weeks over a study that documented an acute increase in the prescription of psychiatric medications — primarily stimulants and antidepressants — for preschoolers over a five-year period would suggest just that.

Some mental health professionals have painted young children as the latest victims of a culture obsessed with syndromes and disorders. And politicians have seized the opportunity to condemn the "overmedicating" of the nation's youngest citizens. On March 20, Hillary Rodham Clinton announced a major federal initiative to reverse the trend.

Yet, as often happens when science goes to Washington, the complexities that underlie the study's findings have been slighted in the public debate.

And while concern over the rise in prescriptions is warranted, outrage may be premature. In fact, scientists know almost nothing about the children who are receiving such drugs, or the circumstances under which the medications are being prescribed. The study in question, for example, published in the *Journal of the American Medical Association*, did not analyze information about the children's diagnoses or the specialties of

the physicians who wrote the prescriptions.

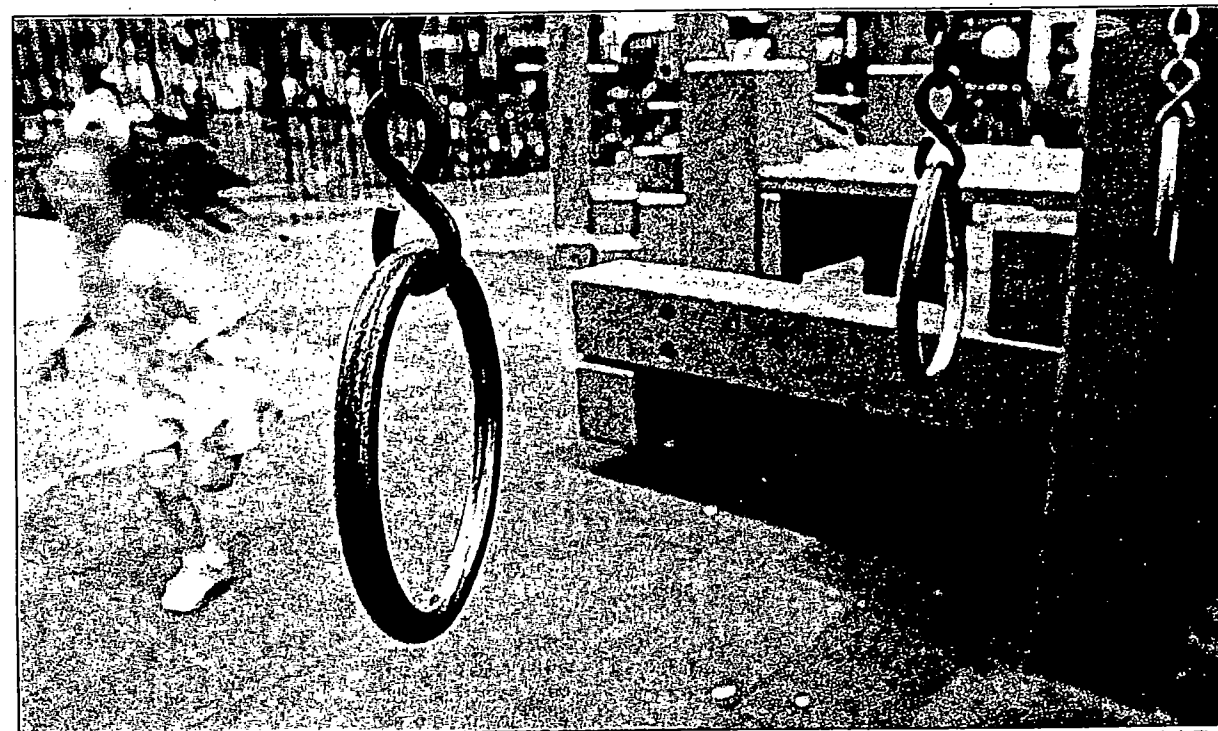
What little researchers and clinicians do know suggests that the increases cannot be solely attributed to reckless prescribing by doctors hell-bent on tagging a psychiatric label on every child who walks into the consulting room.

While pressure on parents and the current popularity of diagnoses like attention deficit hyperactivity disorder and depression undoubtedly play a role, it is also clear that at least some proportion of very young children taking psychiatric drugs have severe troubles. And in many cases, the drugs are given as a last resort, prescribed in the hope of protecting the child's safety, ensuring the safety of others or offering relief to a toddler whose life is being swallowed up by symptoms.

"I think the general public doesn't understand that we're not talking about kids who won't stay in the grocery cart," said Dr. Marsha D. Rappley, an associate professor in pediatrics and human medicine at Michigan State University and the lead investigator in a smaller 15-month study of medication use in preschoolers with attention disorders.

"We are talking about very disturbed behavior," Dr. Rappley said. "And these children need help."

Dr. Rappley's study, which tracked 223 children under the age of 3 who were enrolled in a Michigan Medicaid program, has been cited in the public debate as one more indication that very young children are being drugged unnecessarily. Yet a closer look at the



Ruby Washington/The New York Times

Continued on Page 5

The line between normal behavior and clinical mental illness in young children is seldom clearly defined.

THE NEWS

ANCHOR: EXCUSE ME, MR. MAJOR. ELIAN'S FATHER IS. EXCUSE ME. DOCTOR. JUST A MIN. NOW, LET'S GO TO BEIJING WHERE TWO PANDAS ARE...

REPORTER 1: EXCUSE ME, JULIE. WE'VE GOT A BREAKING STORY. LITTLE ELIAN GONZALEZ HAS JUST COME OUT OF HOUSE. MIAMI'S MAJOR IS...

REPORTER 2: AM I ON?

REPORTER 3: AM I ON? (SHUT UP, DOCTOR.)

REPORTER 4: AM I ON?

ANCHOR: HE WAS LOST AT SEA AND UH... MR. MAJOR, CAN YOU HEAR ME?

REPORTER 1: LITTLE ELIAN SPEAKS! WE HATE FIDEL!

REPORTER 2: WE HATE FIDEL!

REPORTER 3: I BLAME JANET. RENO BE...

REPORTER 4: EXCUSE ME, MR. MAJOR. WE HAVE TO PAUSE FOR THIS COMMERCIAL MESSAGE...

ANCHOR: MILLIONS PERISH BUT IT'S JUST BANGLADESH OR SOMEWHERE ELSE. LATER: DID YOU KILL JON BENET? PSYCHOLOGISTS DISAGREE.

OTHER NEWS: THANKS SO MUCH FOR THAT REPORT. WE'LL BE RIGHT BACK WITH A REPORT ON TEEN-AGE SEX. THE ANGUISH, THE SEARING BITTER... EH... STUFF... PANDAS... SOCKS... STOCKS...

REPORTER 1: AM I ON?

REPORTER 2: BUT FIRST A WORD FROM...

REPORTER 3: AM I ON?

REPORTER 4: AM I ON?

ANCHOR: ALL, CHRISTIE, STATE DEPARTMENT OFFICIALS DON'T KNOW...

The Battle Over Child Behavior

Outrage is easy; it is harder, and more expensive, to find real answers.

*'To injure no man,
but to bless all mankind'*

BOSTON • TUESDAY
MARCH 21, 2000

THE CHRISTIAN SCIENCE MONITOR

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Hillary meets the press *As Senate campaign heats up, the first lady is warming to reporters.* 3

China's high-tech compromise *Lobbying by businesses results in a modified encryption law.* 7

Learning *Is rudeness rampant on campus? A recent conflict at Dartmouth spotlights the issue.* 16

75¢

COURTESY CORPS

Colombia's curbside course in Manners 101

By Howard LaFranchi
Staff writer of The Christian Science Monitor

MY ATTENTION fixes on the headlines of the morning paper. I hardly notice the young woman in the kelly-green jumpsuit (and matching cap) who runs up and plants her right in front of

BOGOTA, COLOMBIA

Backlash to pills in preschool

■ The White House weighs in on pill dependence with a move to curb use of Ritalin and other psychiatric drugs.

By Linda Feldmann
Staff writer of The Christian Science Monitor

WASHINGTON - When a recent study reported a sharp increase in the number of preschool children taking psychiatric drugs, parents and medical experts took notice.

So did first lady Hillary Rodham Clinton. In short order, the White House has an-

nounced an initiative aimed at getting the word out that powerful behavioral drugs such as Ritalin and Prozac carry risks and that not enough is known about their effects in young children.

"I think what we have here is a national outcry at a grass-roots level that is finally reaching the government," says Peter Breg-

gin, a psychiatrist in Bethesda, Md., and a longtime crusader against what he calls the overmedicating of children.

The Clinton administration's effort, while limited to younger children, sharpens questions about how much children of all ages are being medicated for disruptive behaviors. Recently, a United Nations panel criticized doctors in the United States for overprescribing psychiatric drugs. The panel reports that 80 percent of the world's Ritalin

See **CHILDREN** page 5

political PROLOGUE

XX 7: J .

PHOTOCOPY
PRESERVATION

U.S.A.

Clinton plan hints at backlash to preschooler pill use

CHILDREN from page 1

is consumed in the US.

The government initiative, announced yesterday, includes:

- Preparation of a guide for parents on how to treat young children with emotional and behavioral disorders.

- New labeling by the Food and Drug Administration that will instruct physicians on proper dosages of psychiatric drugs for young children. The FDA will soon instruct drug companies on how to conduct research into uses of hyperactivity and attention-deficit medications.

- A nationwide study by the National Institute of Mental Health on the safety and effectiveness of Ritalin use among preschoolers diagnosed with attention deficit hyperactivity disorder (ADHD).

- A White House conference this fall on the treatment of mental disorders among very young children.

Advocates for the rights of people diagnosed with ADHD agree with the need for more research on the use of psychostimulant medication among the young.

"The substantial increase in prescriptions to children ages 2 to 4 demands that we pay immediate attention to this situation," says a statement from Matthew Cohen, president of Children & Adults with Attention-Deficit/Hy-

peractivity Disorder (CHADD), a group based in Landover, Md.

"While psychostimulant medication has been found to be safe and effective in older populations, it's imperative that we have the same level of assurance about its safety in young children before this trend continues."

THE study that triggered this flurry of attention to children and psychiatric drugs was published last month in the *Journal of the American Medical Association*. It found Ritalin use for preschoolers had either doubled or tripled between

1991 and 1995, depending on the group being examined. The research was done by the University of Maryland and looked at two Medicaid programs and one HMO.

The use of antidepressants was up by 30 percent in the HMO and about doubled in the other two groups. Overall, researchers found that between 1 and 1.5 percent of children aged 2 to 4 were medicated for mental, emotional, and behavioral problems.

A backlash has been brewing for some time over the use of psychiatric drugs with children of all ages. Some opponents of such drugs note that several of the chil-

dren involved in recent school shootings were taking such drugs. Some teens also use Ritalin and other psychiatric drugs recreationally.

While no one condones the unprescribed use of Ritalin, some physicians maintain that there is definitely a place for medication in the treatment of some very young children with severe behavioral problems. In a recent opinion piece in the *New York Times*, Dr. Harold Koplewicz cited the case of a patient he treated in the early 1980s named Christopher. The boy, then 3 1/2, had a very limited attention span - he played with 61 toys during one five-minute period - and could not enroll in preschool.

When Dr. Koplewicz gave him Ritalin, the boy was able to sit still and function normally. He is now 20, and a high-school graduate who describes himself as happy. He is still taking Ritalin.

Koplewicz calls psychiatric illnesses in children "no-fault brain disorders," not examples of "inadequate parenting and bad childhood traumas."

The question for some parents is how to distinguish between wild behavior that a toddler will outgrow and a serious illness. Some doctors believe it is never appropriate to prescribe Ritalin and other psychological drugs to children under age six. Indeed, the label on Ritalin reads, "Ritalin

should not be used in children under 6 years, since safety and efficacy in this age group have not been established."

But once the FDA approves a drug, it cannot limit how a physician prescribes it.

Still, some physicians never use drugs with young children, preferring instead to focus on family behavioral issues.

"I never recommend for any of my clients, and that's 100 percent, ... medication for kids under 6 years old," says Michael Gurian, a family therapist in Spokane, Wash., and author of several books on boys.

"It is not the appropriate choice because we don't fully know to what extent the child has an actual psychiatric disorder under about 6 to 7 years old."

"Just altering behavior and improving bonding - in other words; getting a mom and a dad and some other people more deeply involved with a kid in an everyday way - is a far more humane approach to taking care of a small child," says Mr. Gurian.

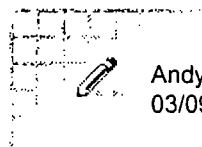
The fundamental problem, adds Gurian, is "not providing children - especially male children - with the love they need and being too busy to do it."

■ Staff writer Gail Russell Chadock and special correspondent Brad Knickerbocker contributed to this report.



WHOSE DECISION? Paula and Steve Johnson say schools in Lawrence, Mass., want to keep their son, Christian, on Ritalin.

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from Salon.com

Kids on drugs

A behavioral pediatrician questions the wisdom of medicating our children.

BY LAWRENCE H. DILLER, M.D.

I've practiced behavioral pediatrics since 1978 in Walnut Creek, Calif., an affluent suburb of San Francisco. I have evaluated and treated more than 2,000 children who struggle with behavior and performance at home or at school. Last year alone, I wrote more than 700 prescriptions for Ritalin or a similar stimulant. I am not against prescribing psychiatric medication to children.

But I've become increasingly uneasy with the role I play and the readiness of families and doctors to medicate children.

I recently obtained some information from the National Disease and Therapeutic Index of IMS Health that adds to my uneasiness about the number of children taking psychiatric drugs in the United States.

IMS Health is to drug companies what the A.C. Nielsen company is to television networks. The pharmaceutical industry relies on it to report on the latest trends in medication usage. The company recently surveyed changes in doctors' use of psychiatric drugs on children between 1995 and 1999 and found stimulant drug use is up 23 percent; the use of Prozac-like drugs for children under 18 is up 74 percent; in the 7-12 age group it's up 151 percent; for kids 6 and under it's up a surprising 580 percent. For children under 18, the use of mood stabilizers other than lithium is up 40-fold, or 4,000 percent and the use of new antipsychotic medications such as Risperdal has grown nearly 300 percent.

Approximately 5 million American children take a psychiatric drug today. Based on production/use quotas maintained by the Drug Enforcement Administration and national physician practice surveys, it's possible to say with confidence that nearly 4 million children took the stimulant drug Ritalin, or its equivalent, in 1998.

Stimulants such as Ritalin have been used for more than 60 years to treat hyperactivity and inattentiveness in children. Over the past 10 years, however, psychiatric drug use for children has broadened considerably. There are more drugs and they are being used for more purposes. Ritalin is now prescribed for children as young as 2 and 3. A recent Michigan survey of Medicaid children found a few hundred toddlers taking stimulants and other psychiatric drugs. A study released two weeks ago in the Journal of the American Medical Association confirmed this trend in children of privately insured families.

Medicines originally developed and tested to treat depression in adults, such as the well-known Prozac (now in liquid form for easy pediatric administration), Paxil and Zoloft, but also Wellbutrin, Effexor and Serzone, are now being employed for a wide range of children's behavioral problems. Medications originally developed to treat blood pressure, such as clonidine (Catapres) and its longer-acting relative, Tenex, are also being used for behavioral management.

Pierre, 8-year-old Bobby's father, pleaded with me to evaluate his son. Bobby was on three different psychiatric medications. Pierre and Bobby's mother, Carol, had bitterly divorced and had been fighting since Bobby was 2. Bobby had had problems at school since kindergarten. Teachers described him as distractible, hyperactive, slow to learn and with few friends.

But his behavior at home, especially with his mother, posed the biggest headaches. He defied Carol and flew into violent rages, hitting and trying to bite her. Time outs were ineffective because he would either escape from his room or completely trash it.

Pierre admitted that he had seen this kind of behavior from Bobby only three or four times over the past three years. But at Carol's, Bobby had major temper tantrums at least weekly. Carol took Bobby to a child therapist when he was 4. The therapist thought Bobby might have "ADD" -- attention deficit disorder or, properly, ADHD (H for hyperactivity). She also thought he was depressed because of the divorce. Weekly play-therapy sessions for Bobby continued for three years and Carol sometimes got advice from the therapist on how to handle Bobby.

Pierre only met the therapist once. He acknowledged he'd never been a big fan of therapy and questioned its value. Carol had been a psychiatric patient for much of their 17-year marriage. She suffered from serious bouts of depression and took Prozac, the well-known antidepressant, and Ativan, a medication for anxiety much like Valium.

Bobby's pediatrician started him at age 5 on Ritalin, the best-known stimulant for ADHD, because the boy kept getting up from circle time and twice ran out of the classroom at school. Later he was switched to a very similar stimulant medication, Dexedrine. Bobby's acting out and impulsiveness continued, so Carol took him to a child psychiatrist who added the drug Wellbutrin to his regimen, thinking that Bobby's irritability might be a sign of depression. (Wellbutrin has been used primarily to treat depression in adults, but has also been employed for a variety of other problems from anorexia nervosa to stopping smoking.) The Wellbutrin did not make much of a difference and

after two months was stopped.

Bobby's problem persisted. At Carol's his bedtime would begin at 8:30 and at 11 Bobby was still up, getting out of bed, pestering his mother for water or food and driving her "crazy." Another medication, Anafranil, was prescribed to help him fall asleep. (Anafranil was originally used in adult depression and obsessive-compulsive disorder, a condition of unwanted recurrent thoughts and compulsive behaviors like repetitive hand washing. But it often was too sedating for most people to tolerate.) Bobby fell asleep faster when he took this pill. Pierre, who in general had fewer problems with Bobby, only occasionally gave him this medication.

Bobby was 7 when Carol took him to a private psychiatric clinic well known for its controversial use of brain scans for psychiatric diagnosis and its liberal use of psychoactive medications. Bobby, now getting bigger, had stabbed another child with a pencil. No brain scan was done but the psychiatrist said that Bobby suffered from bipolar disorder, the current name for manic depression, and should take yet another drug. This fifth medication, Neurontin, originally approved as an anticonvulsant, more recently had been categorized felicitously as a "mood stabilizer." The psychiatrist said this medication would help Bobby control his episodes of rage and prevent a further worsening of his symptoms.

When I first met Bobby he took Dexedrine in the morning, Neurontin three times a day and Anafranil at night only before bedtime. He took 12 pills a day when he stayed with his mother. At his father's, he usually skipped the Dexedrine and Anafranil, especially on weekends. Pierre was afraid to stop the Neurontin because he had been told that Bobby might experience headache and irritability if that medication were abruptly discontinued.

Bobby was a very unhappy, angry boy caught in a web of strained emotions and loyalties between his parents. He was not an easy child to raise, especially for his mother, who had her own problems with depression. Bobby's story is disturbing not for its uniqueness but for how it represents a growing trend in the U.S. -- young children are being given essentially untested and potentially dangerous psychotropic drugs alone and in combination in greater volume than ever before.

Diagnosing bipolar disorder in children as young as 3 has become the latest rage. It justifies using a host of meds to treat very difficult-to-manage, unhappy children. The old-line drug, lithium, has been replaced by newer, untested (in children) mood stabilizers like Neurontin or Depakote as a first-choice intervention for pediatric "manic depression." Finally, a new class of anti-psychotic medications -- the most popular these days is Risperdal -- is heralded as the ultimately effective treatment for a number of diagnoses whose common features are not hallucinations or psychosis, but severe acting-out behaviors.

No one knows precisely how many children are taking these non-stimulant medications. The most recent survey of physicians' practices had 1.5 million children taking an anti-depressant in 1996. Most were teenagers (girls are the majority), but more than 200,000 children under 12 are also prescribed an

antidepressant. Other data tells us that rates of antidepressant use since 1996 continue to rise. For example, 150,000 prescriptions for clonidine were written for children in 1996. More than 100,000 children take "mood-stabilizing" drugs for purported bipolar disorder. Again, most are teens (here boys predominate) but it's being advised that children as young as 3 take these drugs. More than 200,000 children receive anti-psychotic medications, mostly to control unruly behavior rather than to treat hallucinations or other symptoms of schizophrenia.

The number of children combining two or more psychoactive drugs is unknown. Combined pharmacotherapy (known pejoratively as polypharmacy) has been strongly endorsed by leading research groups as the sensible approach to treating the co-morbid, or multiple occurring, diagnoses common in "high problem resistant behavior" children. Some doctors call it prescribing by "symptom chasing."

No other society prescribes psychoactive medications to children the way we do. We use 80 percent of the world's stimulants such as Ritalin. Only Canada comes close to our rates, using half, per capita, the amounts we do. Europe and industrialized Asia use one-tenth of what we do. Psychiatrists in those countries are perplexed and worried about trends in America. The use of psychoactive drugs other than Ritalin for preteen children is virtually unheard of outside this country.

In my practice of behavioral pediatrics I regularly meet children under 13 on two psychiatric medications. A 5-year-old girl troubled by fears had tried eight different psychoactive drugs over the year before she saw me. I met the mother of a 29-month-old boy who wanted me to prescribe medication. I didn't, but later I learned the boy was getting lithium, Zoloft and Risperdal from another doctor.

Is this cutting-edge treatment or an outrage? I'm not sure. But with three or four exceptions, none of these drugs, alone or in combination, has been shown to be effective for a specific psychiatric condition in children. Outside of the stimulants and old-line anti-psychotic group, only two of the most frequently prescribed medications, Luvox and Zoloft, have been studied sufficiently to obtain the Food and Drug Administration's approval for psychiatric use in children. Only a handful more have been examined systematically to eliminate the placebo effect, which has a particularly powerful influence in psychiatric conditions and in children. None of the newer medications has been studied beyond a few months for efficacy or side effects, and no one has looked at their effects on children's growth and development.

Until recently the recondite and rarified worlds of academic child psychiatry and psychology have largely supported the increased use of these medications. Joseph Biederman, chief of Harvard's pediatric psychopharmacology clinic, hails the increased use of psychiatric drugs in children as evidence "that child psychiatry is finally catching up to adult psychiatry" in psychopharmacological practice.

Other leaders in the field of child psychiatry are not as sanguine. Michael Jellinek, who as the head of child psychiatry at Harvard is effectively Biederman's boss, and Peter Jensen, who recently stepped down as director of child and adolescent research of the National Institutes of Mental Health,

have both publicly worried whether physicians' prescribing practices for children have outstripped their scientific substantiation. They are also concerned that not enough is being done about the world these troubled children live in.

It's Johnny's Brain: The Triumph of Biological Psychiatry in America

What makes America so different from the rest of the world in how it views and treats children's emotional and behavioral problems? Perhaps no other profession fell so completely under the sway of Freudian ideas as American psychiatry and psychology did in the first 60 years of the 20th century. Yet by the late 1960s critics both within and outside of American psychiatry had doubts about psychoanalysis as a science and as an effective treatment. In the 1950s drugs like lithium, Thorazine and Elavil, found to be useful in alleviating psychiatric symptoms, further challenged the Freudian hegemony on psychiatric thinking and practice in this country.

By the 1970s research and academic psychiatrists fomented an internal revolution culminating in 1980 with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The DSM III replaced the old Freudian diagnoses, which were based on traumatic childhood experience, with etiologically neutral lists of symptoms collected into supposedly definable syndromes. DSM III was meant only to be descriptive and used primarily for research. Few outside of an inner circle of research psychiatrists knew of a paragraph in the introduction, deleted at the last moment (ostensibly to maintain etiological neutrality), that said the presumptive cause of most of the disorders listed was biological, that is, the result of heredity or a chemical imbalance.

It really didn't matter what was written, because over the next 10 years American academic psychiatry shifted 180 degrees from blaming Johnny's mother for all his problems to blaming Johnny's brain and genes.

The introduction of Prozac in the late 1980s cemented America's belief in the biological basis for abnormal behavior. Prozac was no more effective than earlier antidepressants but had less severe side effects, which allowed greater numbers of less severely disabled people to continue to take the drug. A logic developed that if a drug improved behavior, the problems must be biologically based. No one speaks of headache as an "aspirin deficiency" even though the drug relieves the symptoms. Nevertheless terms like "chemical imbalance" became increasingly fashionable in explaining problem behavior.

Media exaggeration of scientific findings contributed to the revolution. The acceptance of Prozac made taking a psychotropic drug no longer taboo; it became the topic of dinner-party conversation. Nearly one in 10 Americans has taken Prozac or one of its close drug relatives. With so many adults taking a drug for mood, it didn't take long for the primary drug for children's behavior, Ritalin, to zoom in use.

Ritalin production and use for the treatment of ADHD rose by more than 700 percent between 1991 and 1998. Amphetamine production also used for ADHD initially lagged but has tripled in use since 1996. Trade amphetamine (primarily Adderall) surpassed trade Ritalin prescriptions in 1998, a testament primarily to the marketing success of the manufacturers of Adderall.

✱ As Prozac opened the door for Ritalin use in children, Ritalin itself ushered in a new "better children through chemistry" age in our country. At least Ritalin had been the most studied of pediatric drugs, though only a handful of the thousands of studies look at patients other than boys or monitor the children beyond a couple of weeks. Meanwhile research on other psychotropic drugs for use in children has been limited. Until recently, funding for studies of psychiatric medication in children was meager by adult comparisons. Questions about children's rights and consent to participate in studies raised thorny ethical issues, and the pharmaceutical industry did not believe there was much of a market for these drugs in children and so it did not fund studies.

Ironically, the new belief in a robust market for psychotropics in children has fueled a host of pending studies of different drugs for different child psychiatric conditions.

The community of pediatric psychopharmacology researchers is rather small; Biederman's Harvard program has been arguably the most productive and influential. His work stands as prototypic of children's psychiatric research under the DSM (now in its fourth edition) and demonstrates how a drug becomes established in the pediatric psychiatric pharmacopea. His research has won awards and his professional publications are prolific.

Biederman's group demonstrated in the late 1980s that the tricyclic antidepressants (their chemical structure contains three "rings") imipramine and desipramine, abandoned as a treatment for childhood depression because studies had shown them to be ineffective, could be used in high doses to successfully treat children with ADHD who had failed to respond to stimulants. In 1996, the Harvard clinic published a paper that said that 23 percent of their ADHD children also "had" bipolar disorder. (Most child psychiatrists believed manic depression to be a rare disorder in children.)

The Harvard group had always found higher rates of co-occurrence or "co-morbidity" of other disorders in their ADHD patients, but this rate of bipolar disease in children astonished the world of academic child psychiatry.

Biederman further claimed he could diagnose manic depression in children as young as 3. Few of these children demonstrated the classic signs of mania, euphoria or grandiosity. They did not have distinct periods of several weeks or months between their highs and lows. These children could cycle on a daily basis. They were very angry, very irritable kids.

Few of these kids were crazy. They could distinguish reality as long as they weren't enraged. They were very unhappy and very difficult to control. But Biederman felt that children diagnosed as bipolar could be saved from a lifetime of antisocial behavior and substance abuse by aggressively treating them with medication.

The presumed hereditary and biochemical nature of bipolar disorder would justify the use of a new class of drugs known as mood stabilizers: lithium, Depakote, Neurontin -- all drugs with far more serious short- and long-term side effects than Ritalin.

The response from other academic researchers was mixed. Debate goes on in

the professional journals over the definition and frequency of bipolar disorder in children. One psychiatrist commented cynically that "Ritalin is for irritable and irritating children while lithium is for very irritable and very irritating children." The practical effect, though, of the announcement of this new interpretation of pediatric bipolar disorder, was that these medications began to be used in very young children without even short-term evidence of their effectiveness and safety.

Of late, the new anti-psychotic drug, Risperdal, has been touted by the Biederman group as more effective than mood stabilizers in controlling the symptoms of bipolar children. Risperdal's ascendancy as the drug of choice has not been slowed by a different set of more serious disabling side effects.

How should drugs properly be studied for use in children? Only two of the newer psychotropic drugs have been approved by the FDA for the treatment of a psychiatric condition in children. Paxil and Luvox, both variations of Prozac, have proved effective in clinical trials required by the FDA for the treatment of pediatric obsessive compulsive disorder (OCD). No other medication, as yet, has met FDA approval. Several drug trials in children, actively supported by the pharmaceutical industry, are under way.

Once a drug is approved for use by the FDA for the treatment of a specific medical condition, a doctor can legally prescribe it "off label" for any purpose. Virtually every other med used to treat children's behavior is prescribed this way. Off-label use of medicines in pediatrics is common, but nowhere more so than in psychiatric medications. Physicians are constrained only by their own judgment and ethics. Local hospital and medical boards usually do little to interfere with doctors' preferences for treatment.

Most of the drugs used to treat children's emotional problems first became available after they met the FDA's standards for approval in psychiatric clinical trials in adults. A few were initially approved for use in adults for other medical conditions: Depakote and Neurontin for control of seizures, clonidine for blood pressure.

The typical path to the widespread use of any of these drugs for children begins with a report of a single child's response to a drug, usually as a letter in one of the professional journals. Journal editors explicitly state their openness to these kinds of "case" reports and more critical peer review scrutiny is omitted. The report will generate other letters until a series of cases are reported in which everyone -- the kids, parents and doctors -- knows what drug the child is taking.

Such studies are notorious for creating expectations of both positive and unwanted placebo effects. In the only study demonstrating the effectiveness of Prozac in children when the patients and doctors didn't know which pill was taken, 60 percent of the improvement in depressive symptoms was attributed to the placebo effect.

The Super Bowl of drug testing, which supposedly can distinguish between the actual effects of the active ingredients of a medication and placebo, is called the double-blind randomized control study (DBRCS). In a DBRCS neither the family nor doctor knows whether the child is getting the medication or an identical capsule filled with an inert ingredient. Only the pharmacist who

prepares the medication knows which capsule contains the drug to be tested.

Patients are carefully screened for the psychiatric condition to be treated and then are randomly selected to receive either the real drug or the placebo. The children are monitored by their parents and doctors for improvements and side effects; along with benefits coming from placebo, many children complain of unwanted effects like headache and stomachache while taking placebos. After a pre-determined period it is revealed who took the drug and who took the placebo. Only then does one learn the "real" vs. "believed" effects of the drug.

Such DBRCS are expensive; until recently, pediatric psychopharmacology researchers have been limited by low funds for their studies. Those few DBRCSs that had been run usually included only enough children, usually fewer than 100, to generate the likelihood of a statistically significant difference between drug and placebo required for scientific journal publication, but not enough for FDA approval.

But with only scores of children assessed, drugs like Prozac, imipramine, clonidine and Wellbutrin have come to be prescribed for hundreds of thousands of children. Research with imipramine demonstrated that adult drug studies do not necessarily correspond to effects in children. Nonetheless, adult medication trials are regularly invoked to justify the use of those same agents in children.

Calls for increased funding for pediatric psychopharmacology research are ubiquitous within the child mental-health community. The pharmaceutical industry, which now sees a children's market large enough to justify the expense, is funding several large studies, hoping to obtain FDA approval for the tested drugs.

On the other hand, studies on psychosocial interventions provide no similar profit-driven initiative for investigation. The much lower funding for this kind of research comes primarily from government. However, with the profit-motive incentive to develop new drugs and the real-life pressures to medicate children these days, there is ever-increasing pressure to medicate.

When all you've got is a hammer, everything starts to look like a nail.
salon.com | March 9, 2000

 About the writer

Dr. Lawrence H. Diller practices behavioral pediatrics in Walnut Creek, Calif. He is the author of "Running on Ritalin: A Physician Reflects on Children, Society, and Performance in a Pill."

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The Role For Pills in Preschool

By Harold S. Koplewicz

The outcry over a recent report showing a dramatic increase in the use of medications like Ritalin for preschoolers reminded me of a patient of mine named Christopher.

In the early 1980's, when I was researching the efficacy of Ritalin in young children, Christopher was 3½. He still slept in a crib to discourage his getting up in the middle of the night and wandering around the house. It didn't work: he often escaped, going to the kitchen and playing with the stove. Babysitters came only once. Nursery schools kept him for just a few days.

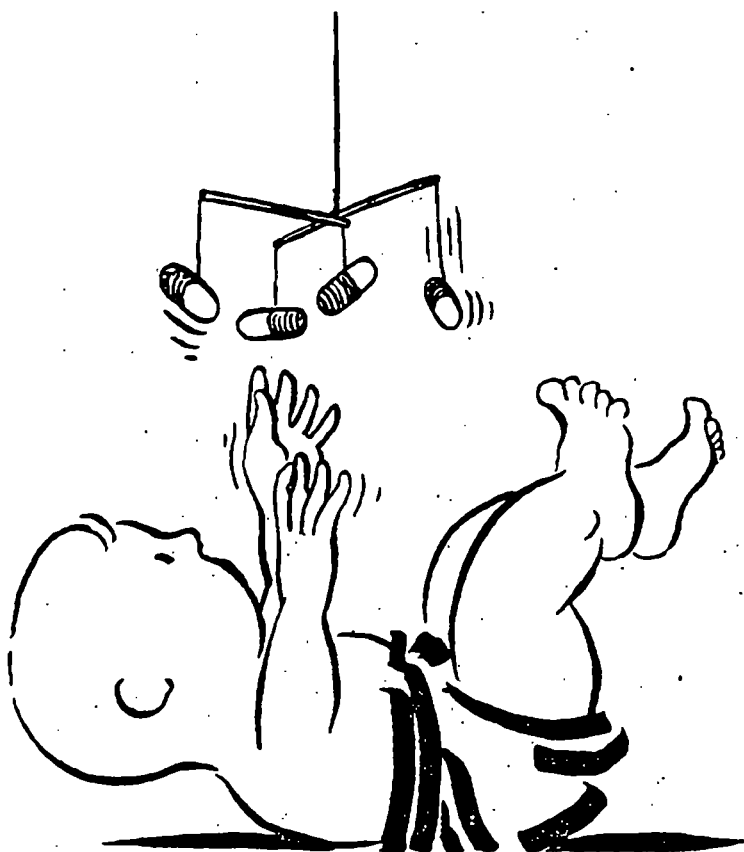
We observed Christopher and his mother in our clinic. She kept running after him to catch his attention; he played with 61 toys in one five-minute span. Then we put Christopher on Ritalin. In his mother's words: "He became a different child. He will sit and let me read a book to him. I can take him to a puppet show. We now can enjoy each other."

Christopher is now 20, a high school graduate who describes himself as well adjusted and happy. He also still takes Ritalin twice a day.

I guess I shouldn't be surprised that attention deficit hyperactivity disorder is still so frequently dismissed as childhood exuberance or "just a phase." Most adults do not realize how it differs from behavior that is simply on the active end of normal. Children with the disorder are 10 times as likely as the average child to drop out of high school. They have a higher incidence of drug abuse. This is a real psychiatric disorder and requires treatment.

The latest study, published in the *Journal of the American Medical Association*, found that between 1991 and 1995, there was a twofold to threefold

Harold S. Koplewicz, a physician, is the author of "It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents."



Matthew Martin

increase in the use of Ritalin and similar drugs in children aged 2 to 4. About 1 in 100 children received Ritalin in 1995. Is 1 percent of children taking such medications too high?

Unfortunately, we have no information about the percentage of very young children who meet the criteria

When a diagnosis calls for it, Ritalin can be a godsend.

for an accurate diagnosis of A.D.H.D. For those who do, medications like Ritalin are the best treatment we have.

Understandably, there is concern that medications may affect brain development. Encouragingly, the evidence we have, although limited and crude, does not suggest that development is compromised by Ritalin.

Critics are also concerned that some medications for psychiatric illness are prescribed for preschoolers without approval by the Food and Drug Administration for use in that age group. But this practice holds true in other areas of medical care. One asthma medication, for example, is frequently given to young kids even though the F.D.A. has not approved it for children. There is ample evidence of Ritalin's effectiveness for school-aged children with A.D.H.D., and some evidence that it helps younger children.

What should be at issue is not the clinical wisdom of giving Ritalin to young children, but who gives it and how the decision is made. Unfortunately, pediatricians and general practitioners are usually not trained to undertake the necessary clinical evaluations to make psychiatric diagnoses and monitor treatment.

Increasing use of Ritalin is not necessarily cause for alarm. The real outrage is that an estimated 20 percent of the nearly 10 million American children and teenagers who suffer from diagnosable psychiatric illnesses ever receive help.

February 23, 2000, Wednesday

SECTION: WIRE; Pg. A03

LENGTH: 772 words

HEADLINE: Troubling trend: tots on Ritalin

BYLINE: Associated Press

CHICAGO -- The number of 2- to 4-year-olds taking psychiatric drugs like Ritalin and Prozac soared 50 percent between 1991 and 1995, according to a new study that experts said reveals a troubling and growing trend.

Doctors said the effects of such drugs are largely unknown in children so young, and they worry the drugs could affect the development of young minds. More than 200,000 preschool-aged children around the country were studied for the report in Wednesday's Journal of the American Medical Association.

"These are substantial increases with little or no data supporting their use. I think that's the message that should go out," said Julie Magno Zito, lead author and assistant professor of pharmacy and medicine at the University of Maryland.

The researchers suggest the increase is due to a growing acceptance of such drugs and because more and more children are attending day-care and are being pressured to conform to school standards of good behavior.

Michele Barker, a Hot Springs, Ark., mother of three, learned firsthand about psychiatric drug use in small children before her son, Heath, started kindergarten.

Nicknamed "the red tornado" for his auburn hair and wild ways, Heath's penchant for tearing things up and plunging off furniture worried his parents, so they had him tested. A pediatrician diagnosed an attention deficit disorder and prescribed the stimulant Ritalin in the 1990s. Heath was 4 years old.

Heath's mother has anecdotal evidence suggesting -- as the authors do -- that the increases are continuing. Through her involvement in several Web support groups for parents of children with behavior problems, she said she's hearing of "more and more 3- and 4-year-olds" being put on drugs like Prozac.

"It's become a quick fix," said Barker, 39.

Dr. Joseph Coyle of Harvard Medical School's psychiatry department said the study reveals a troubling trend. He said "there is no empirical evidence to support psychotropic drug treatment in very young children" -- and there are valid concerns that such treatment could harm brain development.

"These disturbing prescription practices suggest a growing crisis in mental health services to children and demand more thorough investigation," Coyle wrote in a JAMA editorial.

The authors reviewed Medicaid prescription records from 1991, 1993 and 1995 for preschoolers from a midwestern state and a mid-Atlantic state; and for those in an HMO in the Northwest. The states were not identified.

Use of stimulants, anti-depressants, anti-psychotics and clonidine -- a drug used in adults to treat high blood pressure and increasingly for insomnia in hyperactive children -- were examined. Substantial increases were seen in every category except anti-psychotics, though in some cases the actual number of prescriptions was quite small.

The number of children getting any of the drugs totaled about 100,000 in 1991

and jumped to 150,000 in 1995. That year, 60 percent of the youngsters on drugs were age 4, 30 percent were 3 and 10 percent were 2-year-olds.

The use of clonidine skyrocketed in all three groups. Although the numbers were small, the researchers said the clonidine increases were particularly remarkable because its use for attention disorders is "new and largely uncharted." They noted that slowed heart beat and fainting have been reported in children who use clonidine with other medications for attention disorders.

Dr. David Fassler, chairman of the American Psychiatric Association's council on adolescents and their families, said the medications studied "can be extremely helpful for some children, even quite young children. " But he said they should be prescribed only after a comprehensive evaluation and in conjunction with other therapy.

Their use is increasing in part because doctors are getting better at diagnosing behavior disorders at an early age, Fassler said.

However, because their effects on younger children and their development aren't known, Fassler said, the Food and Drug Administration has recently instructed pharmaceutical companies to study the connection.

Barker said Ritalin calmed her son and helped him do well in school. But it also stole his bubbly personality, so she took him off it after four years.

"He started becoming the so-called zombie," she said. The family altered his diet and tried nutritional supplements instead.

Now almost 12 and drug-free for nearly four years, Heath is repeating fifth grade and has some learning difficulties. But his mother said he seems happier, and so is she.

"I don't care if he's not an honor roll student," she said, "because he's healthy."

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February 23, 2000, Wednesday, CITY EDITION

SECTION: FRONT, Pg. 1A

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HEADLINE: Prescriptions for Prozac, Ritalin rising sharply for preschoolers; study finds doctors are giving the drugs despite little knowledge of the effects on children so young.

BYLINE: SUSAN OKIE The Washington Post

Doctors are prescribing stimulants like Ritalin and antidepressants like Prozac for preschoolers at rates that are rising rapidly, according to a new study released Tuesday.

The study, which examined the use of such medicines in children between ages of 2 and 4 in three large health systems in different parts of the United States, found the use of such drugs had doubled or even tripled between 1991 and 1995.

The rapid increase in the use of these drugs in such young children occurred despite the fact that none of the most-commonly used drugs has been approved for children under 6 and little research has been done on the medicines' effects on children so young.

"The knowledge base that we have to support the effectiveness and safety of these medicines in preschool-age children is certainly insufficient," said Julie Magno Zito of the University of Maryland School of Pharmacy, the study's principal author. "There's no dosing information for these children. . . . Are we satisfied that it's appropriate?"

Although previous studies have documented a rapid increase in Ritalin among older children in recent years, the new study is the most comprehensive effort so far to examine the use of such drugs in preschoolers. Experts said Tuesday that they believe the findings -- published in today's issue of the Journal of the American Medical Association -- reflect a national trend.

The study analyzed data from two state Medicaid programs and a health maintenance organization and found that as many as 1.5 percent of children between 2 and 4 years old were receiving stimulants, antidepressants or anti-psychotic drugs -- a group that includes "major tranquilizers" such as thiorazine. The findings suggest that, nationally, as many as 150,000 children in this age group were taking such medicines in 1995, up from about 100,000 in 1990, said Zito.

The study does not describe what conditions the children were being treated for, nor whether the drugs were prescribed by pediatricians, family practitioners or psychiatrists.

Zito and other experts said, however, that the growing use of stimulants and antidepressants in preschoolers is undoubtedly related to a recent national increase in the use of such drugs to treat attention deficit hyperactivity disorder (ADHD) in older children. As many as 2 million elementary schoolchildren in the United States are thought to have ADHD, and during the 1990s the number receiving Ritalin, amphetamines and other stimulants has almost tripled.

Doctors' increasing use of stimulants and antidepressants in very young children may also reflect the inadequacy of mental health services available to many children with severe psychiatric or developmental problems, several experts said Tuesday.

"Many insurance companies will not pay for a physician and a psychologist on the same day," said Marsha D. Rappley of Michigan State University's College of Human Medicine. "As a profession, we need to do more about finding better ways to help these families."

The study examined data on more than 200,000 children between the ages of 2 and 4 who were enrolled in one of three health care systems -- a Medicaid program in a mid-Atlantic state, a Medicaid program in the Midwest, and an HMO in the Pacific Northwest. It found that between 1991 and 1995, the use of stimulants, antidepressants and clonidine in this age group increased substantially, while the use of major tranquilizers increased only slightly.

Stimulants (primarily Ritalin) were the category of drugs most commonly prescribed, but there was considerable geographic variation. For instance, in 1995, about 11 of every 1,000 children between 2 and 4 years old in the Midwestern Medicaid program received Ritalin, vs. about four of every 1,000 in the HMO. When antidepressants were used, an older family of drugs called tricyclic antidepressants was most often chosen, but use of the newer class that includes Prozac increased dramatically between 1991 and 1995 at the two Medicaid programs.

In an editorial accompanying the study, Joseph T. Coyle of the Harvard Medical School in Boston sharply criticized the growing use of stimulant and antidepressant drugs in preschool-age children.

This age "is a time of extraordinary, unprecedented changes in the brain," Coyle said in a telephone interview. "We have very little information about the long-term impact of treatment with these drugs early in development."

Stimulants such as Ritalin have been tested in preschoolers and are considered safe, but they don't work as well in this age group as in older children and are also more likely to produce side effects such as sleeplessness and loss of appetite, said Judith Rapoport of the National Institute of Mental Health. She said antidepressants such as Prozac have not been studied in preschoolers.

Rapley expressed concern about the use of clonidine, a blood pressure medicine with sedative effects that some doctors have prescribed for ADHD in older children.

AP Source: Journal of the American Medical Association DRUGGING TH;

YOUNG A study found that the number of 2- to 4-year-olds on psychiatric drugs, including stimulants such as Ritalin and anti-depressants such as Prozac, jumped between 1991 and 1995.; 14 per 1,000 preschoolers; 1991; 1993; 1995 Total stimulants; Ritalin Total anti-depressants;

Note: Results shown are for 151,675 preschoolers in one Midwestern Medicaid group.; (Figures in chart were imprecise, SEE microfilm for graphic.)

SHOW: WORLD NEWS TONIGHT (6:30 PM ET)

February 22, 2000, Tuesday

TYPE: Profile

LENGTH: 450 words

HEADLINE: MORE RITALIN PRESCRIBED TO CHILDREN AGED TWO TO FOUR

ANCHORS: PETER JENNINGS

REPORTERS: JOHN McKENZIE

PETER JENNINGS, anchor:

There is a study in tomorrow's issue of the Journal of the American Medical Association which finds a significant rise in the use of prescription stimulants and anti-depressants among the young. With the growing aware of mental illness that shouldn't come as a great surprise, until you hear that these new users are approximately ages two through four. The biggest increase is in the use of Ritalin. Here is ABC's John McKenzie.

JOHN McKENZIE reporting:

(VO) Ritalin is used to treat attention deficit hyperactivity disorder. The study found that between 1991 and 1995, Ritalin prescriptions for preschoolers jumped by as much as 300 percent, to as many as one out of every 100 children between the ages of two and four.

Dr. JOSEPH COYLE (Harvard Medical School): The use of medications in this age group clearly appears to be inappropriate when used at--on such a widespread basis.

McKENZIE: (VO) Dr. Joseph Coyle, head of the Harvard psychiatry department, says there are extreme cases where Ritalin is appropriate for preschoolers. But he says this rapid increase in the number of prescriptions raises a number of troubling questions. For example, are these children getting proper diagnosis? The typical symptoms of attention deficit hyperactivity can easily be misleading in preschoolers.

Dr. LAWRENCE GREENHILL (Columbia University): High levels of impulsivity, hyperactivity and inattention can be found from time to time in normal three-year-olds. And this makes it more difficult.

McKENZIE: (VO) Even if the diagnosis is correct, is Ritalin the proper treatment? Many doctors are enthusiastic about Ritalin because it can be so effective in treating older children. But in younger children, there have been only a few studies with mixed results. While it is not illegal to prescribe Ritalin to preschoolers, the warning label clearly states, "Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established" and safety is of particular concern. From birth to four years of age, the brain is undergoing dynamic, unparalleled development. And no one knows the long-term impact of starting on Ritalin this early.

Dr. GREENHILL: The earlier you introduce these psychiatric drugs, in the treatment of a very young child, the more you may influence the development of motor skills, language skills and personality.

McKENZIE: Some researchers say this study is further evidence that when it comes to very young children and psychiatric disorders, many doctors may be too quick to diagnose, and too willing to prescribe medications. John McKenzie, ABC News, New York.

February 23, 2000, Wednesday , CITY FINAL EDITION

SECTION: NEWS; Pg. A10

LENGTH: 340 words

HEADLINE: Physician urges time, not medicine, for tots' behavioral problems

BYLINE: KATHLEEN SCHUCKEL; STAFF WRITER

Preschoolers are receiving anti-depressants and other psychiatric drugs at skyrocketing rates to substitute for the lack of time and care that parents, doctors, educators and others have for them, say two Indianapolis doctors.

Psychiatric drugs should not be used with preschoolers, because studies haven't proven them safe for young children, said Dr. Morris Green, the Perry W. Lesh professor of pediatrics at the Indiana University School of Medicine.

Even so, Green said he has no doubt the drugs are being used widely in the United States -- including in Indiana.

In 1994, Indiana had the fifth-highest level of Ritalin use in the country, according to the federal Drug Enforcement Administration. Ritalin is mostly prescribed to children to help stem hyperactivity or attention problems.

In the past decade, Green, the former chief physician at Riley Hospital for Children, said he has seen an increasing number of out-of-control toddlers: They bite, hit, scream, destroy things and don't sleep much.

These children can, and should, be treated with behavioral methods, Green said. But it takes an investment of time on the part of the physician, who often isn't paid by insurance for the time needed to help the child, he said.

Dr. Shardha K. Sabesan, a psychiatrist who treats children and adolescents at Midtown Community Mental Health Center, turns to drugs for children as young as 4 or 5 as a last resort, because few other supports exist.

There are many ill-prepared teen-age parents and too few community programs to rely on behavioral methods alone, she said.

Sabesan said psychotropic medicines have become safer with fewer side effects in recent years, making them an option for some emotionally disturbed children.

Green isn't swayed. He thinks most parents can help their child's behavior by providing structure, predictability and time.

He urges parents and others in the community to come together to meet children's needs. "This is not just a medical or psychiatric problem. It's a community problem."

February 24, 2000

SECTION: Guardian Home Pages; Pg. 3

LENGTH: 754 words

HEADLINE: The pre-school pill poppers

BYLINE: Julian Borger in Washington

Julian Borger in Washington

Americans are renowned for their pill-popping tendencies, but a study suggests the habit has even spread to the kindergarten. Toddlers between the age of two and four are being prescribed stimulants, anti-depressants and other drugs in dramatically increasing numbers for perceived psychiatric problems.

The use of stimulants such as Ritalin to treat hyperactivity is increasingly common in the United States among school-age children. The study discovered a three-fold rise in prescriptions of medical drugs for children under five.

Paediatricians expressed shock yesterday that the drug-dependent culture was afflicting pre-school children before any conclusive research had been carried out on the effect of psychiatric drugs on brain development. Nor are there clear guidelines on how to tell whether a two-year-old has attention deficit disorder or is just a lively toddler.

The study, published in *Jama*, the Journal of the American Medical Association, analysed prescriptions to 200,000 toddlers under the national Medicaid and private health systems. Doctors' prescriptions of stimulants (mainly Ritalin) increased from 4.1 to 12.3 per 1,000 pre-school children between 1991 and 1995. The use of anti-depressants increased from 1.4 to 3.2 toddlers per 1,000.

Although psychiatric drugs of all kinds were prescribed to only 1.5% of the toddlers in the study, the trend was sharply upwards and the *Jama* researchers said they suspected it had continued on its steep trajectory in the five years since the study was conducted.

The recent explosion in the use of 'lifestyle' drugs such as the anti-depressant Prozac has generated fears that a significant part of the population is becoming dependent on prescription medicines to solve its problems. Increasingly drugs such as Ritalin have been used to address the problems of 'difficult' children.

Nearly 3% of all Americans between the ages of five and 18 are on Ritalin - almost 3m children. The *Jama* study confirms evidence that surfaced in a smaller survey in Michigan in 1998, that children were being put on medication for supposed psychiatric problems even before they were old enough to go to school.

US experts have suggested that the growing trend towards treating 'problem' children with drugs may be a consequence of a health system in which both wholly private and subsidised systems are reluctant to pay for counselling or other non-drug treatments, which are harder to quantify. Paediatricians also point to growing pressure from parents and schools to diagnose troublesome children as having medical problems such as attention deficit disorder.

Steven Hyman, director of the US national institute of mental health, told the *New York Times* he was 'more than shocked' by the findings, adding that the use of psychiatric drugs in young children was 'an area of enormous concern'.

Reasons given by American doctors for prescribing these medicines include pain relief (analgesics and sedatives/hypnotics), anxiety associated with medical or dental procedures (hydroxyine), bed-wetting in children

over six years old (tricyclic antidepressants), and attention deficit hyperactivity disorder in children of three years and older, for which they are given a variety of drugs. There are concerns that some drugs may affect children's growth.

Few of the psychiatric drugs mentioned in the Jama study are approved for treating children of preschool age, and packets of methylphenidate (the generic name for Ritalin) carry warnings against prescribing the drug to children under six.

Most psychiatric drugs work by neutralising or enhancing chemicals in the brain, but animal studies suggest that those chemicals play a critical role in the growth of nerve cells in the brain.

Joseph Coyle, chairman of psychiatry at Harvard Medical School, said: 'These interventions are occurring at a critical time in brain development and we don't know what the consequences are.'

He argued that the normal behaviour of many two- or three-year-olds is hard to distinguish from hyperactivity.

Julie Zito, an associate professor of pharmacy and medicine at the University of Maryland and the study's lead author, said: 'It is not really clear that children this young could meet the diagnostic criteria for either attention deficit hyperactivity disorder or depression.'

Ritalin, being given to more and more hyperactive children, has caused enormous controversy in the US and now the UK.

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The Associated Press State & Local Wire

January 9, 2000, Sunday, PM cycle

SECTION: State and Regional

LENGTH: 170 words

HEADLINE: Ritalin manufacturer sued over death of Canton couple's daughter

DATELINE: CANTON, Ohio

A couple is seeking more than \$50,000 from the makers of Ritalin, claiming the drug caused their daughter's death of a rapid heartbeat.

Janet and Michael Hall filed the suit against Novartis Pharmaceuticals Corp. in Stark County Common Pleas Court on Thursday.

The couple's 11-year-old daughter, Stephanie Marie Hall, took Ritalin to treat an attention-deficit hyperactivity disorder.

She died in January 1996, a day after her physician doubled her Ritalin dosage, said Steven Okey, the Halls' attorney.

The lawsuit accuses the East Hanover, N.J., company of producing a defective product and concealing adverse reactions and Ritalin -related deaths.

Novartis officials said they could not comment on the lawsuit, but they did issue a statement that said Ritalin is a safe and effective therapy for attention-deficit hyperactivity disorder.

About 2 million to 3 million patients in the United States take Ritalin or its generic equivalent to help treat the disorder, according to the company.

January 2, 2000, Sunday ALL EDITIONS

HEADLINE: Daydreaming of everyone on Ritalin; Don't hook your kids on drugs

BYLINE: LAWRENCE DILLER

Pippi Longstocking just left my office on Ritalin. Of course, that's not her real name. Her name could be Kayley, Anna, Natalie or that of a half-dozen other girls I see in a week at my behavioral pediatrics practice in an affluent suburb east of San Francisco.

Eleven-year-old Pippi was not performing "up to her potential" at her private school, according to her teacher. She daydreamed and, when called upon, was often not prepared to answer. She could be silly in the classroom. This girl in my office demonstrated academic skills two grade levels above average. She spoke to me cogently and thoughtfully about her life. She dreamed about living on a ranch with many animals. She did act a bit nervous and giggly with her parents and more serious younger brother. But she did not seem to me like a serious case of attention deficit hyperactivity disorder, or ADHD, and I told her parents so.

I didn't think she needed medication at this time. I suggested that we work on making consequences more immediate for Pippi at home and at school, and if she still was struggling a few months from now, perhaps Ritalin could be tried then.

Pippi's mom asked me if there was really anything bad about taking Ritalin and if not, why not do it now so that Pippi could do better in school immediately. I said that most children and adults have little problem taking Ritalin and that it was probably pretty safe. It works, ADHD or not, to improve focus and attention on tasks found boring or difficult. Pippi's dad, uneasy about using a drug that also had abuse potential, thought they should wait.

The family came back to see me a week later. Dad had changed his mind. Another doctor felt Pippi had mild ADHD and gave them a prescription. Pippi apparently felt OK about taking it. The prescribing doctor had only left the instructions on the bottle, "1 to 3 tablets per day." They asked me to tell them more about using the medication. I internally shrugged and started to tell them how to determine the optimal dose and frequency using a teacher-feedback sheet. They left happy. I felt strange.

I find myself evaluating and prescribing medication for more and more Pippis and Tom Sawyers. These seemingly normal children are inattentive or disinterested in school and a bit slow to finish their chores at home. Concerned and loving parents bring them in because the children aren't performing "up to their potential" or are disruptive in their classrooms.

Ritalin production is up 700 percent this decade. Production of Dexedrine and Adderall, the other two stimulants used for ADHD, has tripled in the past three years. America uses 85 percent of the world's Ritalin. While school-age boys remain the largest users of Ritalin, girls and adults are the most rapidly increasing groups taking the drug.

In some rural areas, virtually no children get Ritalin. Yet in Virginia Beach, one in five white fifth-grade boys receives Ritalin at school.

I wish to offer a Swiftian "Modest Proposal" of my own. With classroom sizes now averaging 30 kids per class and about 4 million children taking Ritalin, I propose that we increase the number of children taking Ritalin to 7 million. We then could probably increase class size to 45 children and save a lot of money.

Ritalin "works," but I don't see it as the moral equivalent or substitute for better parenting and schools. Currently, our country has an intolerance for temperamental diversity in our children. I worry about an America where there's no place for an unmedicated Pippi Longstocking.

Lawrence Diller, who practices in Walnut Creek, Calif., is the author of "Running on Ritalin: a Physician Reflects on Children, Society and Performance in a Pill."

The Scary Truth About Stock Options

U.S. News & WORLD REPORT

MARCH 6, 2000

www.usnews.com

Paxil, Prozac, Ritalin...
Are These
Drugs Safe
for Kids?

Many parents are
using powerful pills
to control behavior

Amy Coburn
Former Paxil user

\$3.50





The Perils Of Pills

The psychiatric medication of children is dangerously haphazard

BY NANCY SHUTE, TONI LOCY,
AND DOUGLAS PASTERNAK

Before Joshua Andrews turned 1 year old, he was leaping out of his crib and tearing through the house. By 2, he was darting out the front door and bolting straight into traffic. By 3, he was endangering the life of the family hamster with well-aimed pencil pokes through the cage wires. He'd kick his friends, say he was sorry, then kick them again. He'd cuddle in his mother's arms for a moment, then elbow her aside to dart around wildly. By the age of 4, he had been asked to leave his Norwood, Mass., preschool, told never to return to summer camp, and sent to a special residential school three times—each time for about a month—for impulsive, aggressive behavior. "That was my little son," Joshua's mother, Susan, recalls. "Dr. Jekyll and Mr. Hyde."

About nine months ago, Susan and Joshua's psychiatrist decided to treat the boy with Wellbutrin, an antidepressant, to calm him down and help him focus. "At first I was afraid. I didn't want to medicate him," Susan

recalls. "But I was at my wit's end."

Although most people picture the toddler years as a time of peekaboo and *Pat the Bunny*, more and more preschoolers like Joshua are being treated with powerful psychiatric drugs. Last week, researchers reported in the *Journal of the American Medical Association* that the number of 2-to-4-year-old children on Ritalin, antidepressants, and other psychoactive drugs increased dramatically from 1991 through 1995. Startling as it is, the news about toddlers merely underscores the rise in the use of powerful psychiatric drugs in kids of all ages—despite the fact that these drugs are largely untested for use in the young. According to the surgeon general, almost 21 percent of children age 9 and up have a mental disorder, including depression, attention deficit hyperactivity disorder, and bipolar disorder.

A little knowledge. But the treatment children get is often dangerously haphazard. Some are heedlessly medicated, with no follow-up; other children don't get the treatment they desperately need to be able to play and learn and grow. The problem is exacerbated by the fact that the majority of psychiatric prescriptions written for children and adolescents are handled by general practitioners and pediatricians who lack mental health training. Of nearly 600 family physicians and pediatricians who responded to a 1999 University of North Carolina survey, 72

A nurse dispenses medications to students at a middle school.

● "How are these children qualifying for the use of these medications?"

MICHELE McDONALD FOR US&WR



percent said they had prescribed antidepressants to children under 18. But only 16 percent of the doctors said they felt "comfortable" doing so, and just 8 percent said they have adequate training to treat childhood depression. Peter Jensen, a professor of child psychiatry at Columbia University, says bluntly: "Pediatricians and family practitioners should not be prescribing these drugs for children under 18.

Susan Andrews gives Joshua, 4, his medication in their Norwood, Mass., home.

● *He was "Dr. Jekyll and Mr. Hyde."*

They don't have the time or the skills. This is a complicated area of medicine."

Kathy Hale of Lexington, Ky., knows this scenario all too well. When her daughter Katie saw the pediatrician at age 7, the doctor quickly diagnosed ADHD and pre-

scribed Ritalin. But Katie's temper and aggression only intensified. The grade schooler pulled a butcher knife on her older sister and gave her stepfather a black eye. Kathy called the pediatrician several times and begged to have her daughter sent to a hospital, but he refused. Last October, Kathy decided to take Katie, now 13, to a psychiatrist at the University of Kentucky, who diagnosed bipolar disorder. Katie is

Behavior in a pill

These are some of the most common psychiatric medications.

NAME OF DRUG	USED TO TREAT	TOTAL PRESCRIPTIONS IN 1999 (ALL AGES)	INTENDED EFFECT	SIDE EFFECTS
Methylphenidate (Ritalin)	Attention deficit hyperactivity disorder	11.4 million	Mildly stimulate the central nervous system	Addiction, nervousness, insomnia, loss of appetite
Amphetamines (Dexedrine, Biphedamine, Desoxyn)	Hyperactivity in children, narcolepsy, obesity	6.5 million	Stimulate the central nervous system	Addiction, nervousness, insomnia, loss of appetite
Tricyclic antidepressants (Tofranil, Norpramin, Aventyl)	Major depression. In children, Tofranil is used to treat bed-wetting	31.5 million	Restore the brain's normal level of neurotransmitters	Dry mouth, constipation, blurry vision, difficulty urinating
SSRI antidepressants (Prozac, Zoloft, Paxil)	All types of depression and several anxiety disorders	84.0 million	Influence the brain chemical serotonin	Insomnia, nausea, diarrhea, headache, nervousness

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now on lithium and Risperdal, and her mother says she's on the right track.

Psychiatric drugs can help youngsters, but they have not been tested even in older children, and most are not approved by the Food and Drug Administration for pediatric use. Almost nothing is known about how antidepressants and other psychoactive drugs affect a child's developing brain.

The increased use of psychiatric drugs in children also raises larger questions on how our society deals with difficult behavior. Last week, a United Nations panel lambasted the United States for overprescribing psychiatric drugs, particularly stimulants; according to the panel, the United States consumes 80 percent of the world's methylphenidate (the generic name for Ritalin). Are American youngsters indeed suffering more behavioral illnesses, or have we as a society become less tolerant of disruptive behavior? Mental health officials say they don't know. Much of the official psychiatric diagnostic manual's entry on ADHD reads like a catalog of a typical young child's behavior: "squirms in seat"; "is often 'on the go'"; "interrupts or intrudes on others." Child psychiatrists uniformly report that diagnosing mental disorders in children is a difficult, delicate task—and the younger the child, the tougher the call. "How are these children qualifying for the use of these medications?" asks Julie Magno Zito, an associate professor of pharmacy and medicine at the University of Maryland-Baltimore and lead author of the *JAMA* study. "The fact that there are such dramatic increases means that something's changing. Why?"

Raising questions. Zito's report is the first large-scale look at psychiatric drug use among the very young. The data show that the use of Ritalin and other stimulants, which are used to treat attention disorders, increased almost threefold in the early 1990s. By 1995, 12 of every 1,000 children in the Midwestern Medicaid group were on a stimulant. The children's use of antidepressants doubled, to 3 out of every 1,000 at Midwestern Medicaid. In other research, Zito has found increased medication use among older children, too.

Given that 3 percent to 5 percent of school-age children are affected by ADHD and 2.5 percent by depression (the number rises to 8 percent in teens), psychiatrists say it's not surprising to see 1.2 percent of children being treated for ADHD and 0.3 percent for depression. What does upset the doctors is the paucity of research on how the drugs work in children and how the drugs affect future growth and development.

Until very recently, the FDA didn't require drug companies to test the safety and



Amy Coburn, 16, plays outside her Perry, Utah, home with nephews and a niece.

● On *Paxil*, "I thought the world was watching me. There were cameras everywhere."

effectiveness of drugs on children, because of ethical and safety concerns. Prozac is not FDA approved for children under 18; Ritalin, which has been much more extensively studied in children than the antidepressants, is not approved for children under 6. But doctors can still legally prescribe those drugs to children, and frequently do, for whatever therapeutic use they decide is appropriate. The situation is changing; the FDA has made testing of drugs intended for children mandatory starting in December. But for now, doctors have almost no data to turn to in deciding how to use psychiatric drugs on kids.

Children are not miniature adults. Their bodies metabolize medications differently. Their brains are in the midst of rapid development. Animal studies suggest that the brain's developing neurotransmitter

system can be exquisitely sensitive to drugs, leading to permanent changes in adult life. Thus doctors who prescribe psychiatric drugs to children, even with the best intentions, are experimenting on their patients. Says Robert Johnson, director of adolescent medicine for the University of Medicine and Dentistry of New Jersey: "We know more about the effects of marijuana on kids than Prozac."

For their part, practitioners say that they're often pressured by managed-care companies and insurers to avoid referring their patients to mental health specialists and to reduce the time they spend with families. Time is money in health care today, and it takes a lot of time to properly assess a child's behavior, emotions, and family situation. "You need at least four 45-minute sessions, observing the

JIM LO SCALZO FOR USNEWS



child, with the family, taking a family history," says Stanley Greenspan, a child psychiatrist in Bethesda, Md., and author of *Building Healthy Minds*. "But in many situations a child is being prescribed and diagnosed in one half-hour meeting. Insurance coverage doesn't support the kind of assessment you need."

Two wrongs. The push to diagnose quickly and simply creates a paradoxical result: Children are both undermedicated and overmedicated. "Twenty percent or less of kids with major depression get treatment," says Neal Ryan, a professor of child psychiatry at the University of Pittsburgh. Many of the children who are diagnosed are massively undertreated, Ryan says, in part because of parents' fears of stigmatizing their children.

Martin Teicher, an associate professor of psychiatry at Harvard Medical School, estimates that as many as half of the children diagnosed with depression actually have bipolar disorder and that many are mistakenly placed on antidepressants or stimulants. "That is a bad cocktail," he says.

Kelly Bagwell of Silver Creek, Miss., saw her 2-year-old daughter, Tori, flail and thrash for hours, uncontrollably, after her pediatrician put her on Ritalin. After Tori

Eydie Alguadich continues to give 8-year-old Danielle extra tutoring and help.

● "She wasn't learning in class."

tried to jump out a second-story window, the Bagwells took her off the medication. It took four more years before Tori was diagnosed with bipolar disorder. Tori is now doing well on Zyprexa, an antipsychotic, and Topamax and Depakote, mood

stabilizers. "Without this diagnosis, she'd be in an institution," her mother says.

Because there are no treatment guidelines and dosage standards, the prevalence of psychotropic drugs for children varies wildly, from doctor to doctor, school to school, and county to county. Ritalin use, for instance, ranges from 7 percent among children in inner-city Baltimore to 1 percent in Salt Lake City. Psychiatrists were particularly alarmed at the evidence in last week's *JAMA* study that doctors are increasingly prescribing tricyclic antidepressants for children, as well as more clonidine. Tricyclics such as Elavil have never been proven to work in children, and they can cause fatal overdoses, unlike newer antidepressants such as Prozac and Paxil. Clonidine, a blood-pressure medication prescribed for children as a tranquilizer, also has dangerous side effects. "There's all risk and very little benefit for these two drugs," says Steven Hyman, director of the National Institute of Mental Health.

All too often, children get drugs with none of the behavior modification, counseling, and long-term follow-up that mental health experts say are essential. "The quickest and easiest thing is to write a pre-

WHAT TO ASK

Queries for a doctor or a therapist:

- **How will you make a diagnosis?** At a minimum, the provider should interview you for at least an hour about the child's medical and family history, observe the child for a similar amount of time, and talk to teachers or baby sitters.
- **If medication is called for, how long should my child take it to know if it works?** Since psychotropic medications are untested on children, it will be a process of trial and error. If a drug causes any troubling side effect, talk to your doctor immediately about stopping it.

scription," says Paul Lipkin, a pediatrician and head of clinical programs at the Kennedy Krieger Institute in Baltimore. "It's harder to convince parents to go in for weeks of psychotherapy." A cost-conscious health care environment encourages the use of medication—about \$20 a week for selective serotonin reuptake inhibitor (SSRI) antidepressants like Prozac—over therapy, which runs \$150 for a 45-minute session. But even the pharmaceutical companies say it is inappropriate to prescribe antidepressants for children without exploring other methods of treatment, particularly behavioral therapy. Rajinder Judge, director of neuroscience at Eli Lilly, the maker of Prozac, says these antidepressants should not be used as "the first line of treatment."

Judy Coburn has seen a system where psychotropic medications were handed out to children indiscriminately. Three years ago, a few months after Judy's husband committed suicide, her 13-year-old daughter, Amy, was admitted to a hospital near their Perry, Utah, home. She was contemplating suicide. When her mother picked her up a week later, the discharge nurse said that Amy had been placed on 20 mg a day of Paxil, an SSRI antidepressant—the same drug her father had been taking when he killed himself. He had been taking just 10 mg a day. "I remember I asked the counselor at the hospital, 'Am I supposed to bring her back for a follow-up?'" recalls Judy. "And he said, 'No, the medication will keep her calmed down.' And he did not say anything about any side effects at all." The drug insert for Paxil lists paranoid reactions, antisocial behavior, trouble concentrating, and hostility as some of the rare, but serious, behavioral side effects of the drug. Amy experienced all of these reactions. She stopped taking Paxil because of the side effects, and counseling helped her deal with the grief over her father's death. Today Amy, 16, is a girl with a broad smile who enjoys acting in school plays.

Many parents say that without medication, their children would not have been able to learn in school, play with friends,

and do all the little things that are essential to the business of growing up. Eydie Alguadich will never forget the day her 5-year-old daughter, Danielle, started to say, "Mommy, I wish I was dead." It went on for two years. "I had a major, major prejudice against using drugs on children," says Alguadich, an interior designer and stay-at-home mom in Herndon, Va. When a pediatrician recommended that her older daughter, Samanthe, take Ritalin at age 2, Alguadich enrolled her in a gym class instead. But as she watched Danielle founder despite intensive tutoring from her mother, she decided it was time to seek help and brought her in for an assessment by psychologists and pediatricians. Danielle, 8, now takes Ritalin, as do her two older sisters. Their mother says they're no longer struggling in school, and the drug appears to have no side effects. "Kids know when there's something wrong," Alguadich says. "It's the parents who are the last to know."

National experiment. The vast pharmacological experiment on America's children raises larger questions of whether behavior is a medical or social issue. Two hundred years ago, the mentally ill were considered cursed or evil. Only in this cen-



Haley Francis, 4, is being treated for bipolar disorder.
● "It's no different than cancer or diabetes."

A PARENT'S GUIDE

Tools to treat a troubled child

When a child under age 5 is constantly fighting, flitting, running, biting, bouncing off the walls, and otherwise annoying grown-ups, he or she could have a serious behavioral problem. Or maybe the kid's just a typical toddler. Prescribing drugs for these children is the final treatment tool, child psychiatrists stress, and should come only after child and family have been evaluated and other approaches have been tried.

Behavioral therapy can help when a child, even a preschooler, has attention deficit hyperactivity disorder, says Enrico Mezzacappa, child psychiatrist at Children's Hospital in Boston. The therapy is a consistent system of rewards and consequences. "You catch them being good, you praise them and give lots of rewards," said Bruce Black, a child psychiatrist in Wellesley, Mass. If they're bad, a parent gives them a timeout or takes away a toy.

Children with obsessive-compulsive disorder can benefit from behavioral therapy as well as exposure therapy. If a girl feels a need to constantly wash after touching a toy that she fears is dirty, or just plain yucky, she might be led to touch the toy and taught relaxation techniques to ease anxiety.

When such therapies fail to provide relief, they may begin to work with medication. Parents should be advised that little is known about immediate or long-term effects of psychotropic drugs; virtually all are untested on children younger than 6.

Severe depression in a very young child is almost always caused by a major upheaval. "In kids under 5, it's marital discord, divorce, witnessing violence," says Glen Elliott, director of child and adolescent psychiatry at the University of California-San Francisco. A pill won't help. The daunting solution is to change family life or move from a dangerous neighborhood. —Susan Brink

tury have doctors come to understand that depression, schizophrenia, and other disorders arise from the genes and cells, not from the Devil. Even 20 years ago, children were thought to be incapable of becoming depressed, a holdover from the Freudian belief that it took an adult superego to suffer angst. By recognizing the biological basis of mental disorders, medicine has offered millions of people the possibility of a real life. But in elevating the biological causes of mental disorders,

society risks ignoring other key factors: family, environment, culture. If a child behaves badly because the parents' marriage is in turmoil, is the problem with the child or with the family? Are today's parents too busy to give difficult children the one-on-one attention and patience they need? Do teachers demand that children be drugged rather than accept a rambunctious classroom?

Lawrence Diller, a behavioral pediatrician in Walnut Creek, Calif., and author

of *Running on Ritalin*, says that society's increased demands on children make it harder for them to cope and force teachers and parents to consider drugs for troubled children. "The expectations of children are going down in age and up in standards. More and more is asked of kids, with less and less support." ●

With Susan Brink, Mary Lord, John S. MacNeil, Mark E. Madden, Stacey Schultz, and Rachel Sobel

CAUSE AND EFFECT

Can drugs spark acts of violence?

By any measure, Jarred Viktor was a troubled kid. The 16-year-old was experimenting with illegal drugs, drinking heavily, and talking about suicide. In 1995, Brenda Viktor brought her son to their family physician, David Borecky, near the Viktors' Escondido, Calif., home. After a brief visit, Borecky handed Jarred a three-week supply of the antidepressant Paxil. He said the drug would take time to kick in and told Jarred that he wouldn't need to see him for two to three weeks. Ten days later, Jarred stabbed his grandmother 61 times. He was convicted of first-degree murder and is doing life without parole.

No one will ever know what role Paxil played in Jarred's actions. Borecky believes it played none and that his treatment of Jarred was appropriate. In 1991 the Food and Drug Administration found no link between Prozac, a cousin to Paxil, and suicide or violence in adults. But the FDA has not examined the drug's effect on kids. And none of this class of drugs is approved for use in kids with depression.

Doctors are divided on the issue of antidepressants



Jarred Viktor, 17, at graduation with his parents, Brenda and Jurgen, following his murder conviction. Below, Matt Miller.

● "There was a pill that we were told could fix Matt."

and violence. Many experts say it's impossible to know whether violent acts are linked to the drug or to the disease itself. But others find the anecdotal evidence convincing. "What jumped out at me," says psychiatrist Alan Abrams, who testified for the defense at Jarred's trial, "was this very withdrawn kid who started acting as though he was primed to explode" days after he started taking Paxil. Abrams believes the drug caused Jarred to become violent.

Known risks. SmithKline Beecham, the maker of Paxil, and other drug companies say their medications play no role in violent behavior or suicide. Still, the companies do warn in pack-

age inserts that a small number of patients, fewer than 1 percent, may experience side effects, including abnormal dreams, agitation, hostility, suicidal thoughts, and delusions. But with an estimated 1.5 million young-



sters receiving these antidepressants in 1996 alone, that's about 15,000 who could be vulnerable.

Matt Miller's parents believe their child was among the vulnerable. Miller, a 13-year-old from Overland Park, Kan., was given free samples of Zoloft in 1997 by his psychiatrist. There was no printed information; the Millers say they were told Matt might get a bellyache and have trouble sleeping. "We were ecstatic that there was a pill that we were told could fix Matt," his father says. Seven days later, Matt's mother went to collect laundry from her son's room and found him hanging inside his closet. The Millers have filed suit against Pfizer, the manufacturer of Zoloft. The company believes the drug is not linked to violence.

Even experts who believe these drugs can cause violent behavior blame not the drugs themselves but the way in which physicians diagnose and monitor their patients. Psychiatrist Frederick Goodwin, a former head of the National Institute of Mental Health, contends that kids who get violent may have been misdiagnosed and placed on the wrong drug in the first place. That is why it is critical to see a doctor with expertise in mental health care, experts say. Unless things change, says Goodwin, "then the likelihood of these negative events happening goes way up." —D.P. and T.L.

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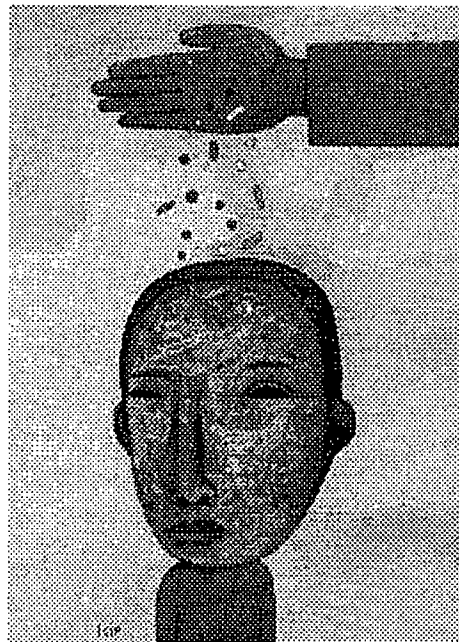
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Kids on drugs

A behavioral pediatrician questions the wisdom of medicating our children.

By Lawrence H. Diller, M.D.

March 9, 2000 | I've practiced behavioral pediatrics since 1978 in Walnut Creek, Calif., an affluent suburb of San Francisco. I have evaluated and treated

more than 2,000 children who struggle with behavior and performance at home or at school. Last year alone, I wrote more than 700 prescriptions for Ritalin or a similar stimulant. I am not against prescribing psychiatric medication to children.

But I've become increasingly uneasy with the role I play and the readiness of families and doctors to medicate children.

I recently obtained some information from the National Disease and Therapeutic Index of IMS Health that adds to my uneasiness about the number of children taking psychiatric drugs in the United States.

IMS Health is to drug companies what the A.C. Nielsen company is to television networks. The pharmaceutical industry relies on it to report on the latest trends in medication usage. The company recently surveyed changes in doctors' use of psychiatric drugs on children between 1995 and 1999 and found stimulant drug use is up 23 percent; the use of Prozac-like drugs for children under 18 is up 74 percent; in the 7-12 age group it's up 151 percent; for kids 6

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percent; in the 7-12 age group it's up 151 percent; for kids 6 and under it's up a surprising 580 percent. For children under 18, the use of mood stabilizers other than lithium is up 40-fold, or 4,000 percent and the use of new antipsychotic medications such as Risperdal has grown nearly 300 percent.

Approximately 5 million American children take a psychiatric drug today. Based on production/use quotas maintained by the Drug Enforcement Administration and national physician practice surveys, it's possible to say with confidence that nearly 4 million children took the stimulant drug Ritalin, or its equivalent, in 1998.

Stimulants such as Ritalin have been used for more than 60 years to treat hyperactivity and inattentiveness in children. Over the past 10 years, however, psychiatric drug use for children has broadened considerably. There are more drugs and they are being used for more purposes. Ritalin is now prescribed for children as young as 2 and 3. A recent Michigan survey of Medicaid children found a few hundred toddlers taking stimulants and other psychiatric drugs. A study released two weeks ago in the Journal of the American Medical Association confirmed this trend in children of privately insured families.

Medicines originally developed and tested to treat depression in adults, such as the well-known Prozac (now in liquid form for easy pediatric administration), Paxil and Zoloft, but also Wellbutrin, Effexor and Serzone, are now being employed for a wide range of children's behavioral problems. Medications originally developed to treat blood pressure, such as clonidine (Catapress) and its longer-acting relative, Tenex, are also being used for behavioral management.

Pierre, 8-year-old Bobby's father, pleaded with me to evaluate his son. Bobby was on three different psychiatric medications. Pierre and Bobby's mother, Carol, had bitterly divorced and had been fighting since Bobby was 2. Bobby had had problems at school since kindergarten. Teachers described him as distractible, hyperactive, slow to learn and with few friends.

But his behavior at home, especially with his mother, posed the biggest headaches. He defied Carol and flew into violent rages, hitting and trying to bite her. Time outs were ineffective because he would either escape from his room or completely trash it.

Pierre admitted that he had seen this kind of behavior from Bobby only three or four times over the past three years. But

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Bobby only three or four times over the past three years. But at Carol's, Bobby had major temper tantrums at least weekly. Carol took Bobby to a child therapist when he was 4. The therapist thought Bobby might have "ADD" -- attention deficit disorder or, properly, ADHD (H for hyperactivity). She also thought he was depressed because of the divorce. Weekly play-therapy sessions for Bobby continued for three years and Carol sometimes got advice from the therapist on how to handle Bobby.

Pierre only met the therapist once. He acknowledged he'd never been a big fan of therapy and questioned its value. Carol had been a psychiatric patient for much of their 17-year marriage. She suffered from serious bouts of depression and took Prozac, the well-known antidepressant, and Ativan, a medication for anxiety much like Valium.

Bobby's pediatrician started him at age 5 on Ritalin, the best-known stimulant for ADHD, because the boy kept getting up from circle time and twice ran out of the classroom at school. Later he was switched to a very similar stimulant medication, Dexedrine. Bobby's acting out and impulsiveness continued, so Carol took him to a child psychiatrist who added the drug Wellbutrin to his regimen, thinking that Bobby's irritability might be a sign of depression. (Wellbutrin has been used primarily to treat depression in adults, but has also been employed for a variety of other problems from anorexia nervosa to stopping smoking.) The Wellbutrin did not make much of a difference and after two months was stopped.

Bobby's problem persisted. At Carol's his bedtime would begin at 8:30 and at 11 Bobby was still up, getting out of bed, pestering his mother for water or food and driving her "crazy." Another medication, Anafranil, was prescribed to help him fall asleep. (Anafranil was originally used in adult depression and obsessive-compulsive disorder, a condition of unwanted recurrent thoughts and compulsive behaviors like repetitive hand washing. But it often was too sedating for most people to tolerate.) Bobby fell asleep faster when he took this pill. Pierre, who in general had fewer problems with Bobby, only occasionally gave him this medication.

Bobby was 7 when Carol took him to a private psychiatric clinic well known for its controversial use of brain scans for psychiatric diagnosis and its liberal use of psychoactive medications. Bobby, now getting bigger, had stabbed another child with a pencil. No brain scan was done but the psychiatrist said that Bobby suffered from bipolar disorder, the current name for manic depression, and should take yet

another drug. This fifth medication, Neurontin, originally approved as an anticonvulsant, more recently had been categorized felicitously as a "mood stabilizer." The psychiatrist said this medication would help Bobby control his episodes of rage and prevent a further worsening of his symptoms.

When I first met Bobby he took Dexedrine in the morning, Neurontin three times a day and Anafranil at night only before bedtime. He took 12 pills a day when he stayed with his mother. At his father's, he usually skipped the Dexedrine and Anafranil, especially on weekends. Pierre was afraid to stop the Neurontin because he had been told that Bobby might experience headache and irritability if that medication were abruptly discontinued.

Bobby was a very unhappy, angry boy caught in a web of strained emotions and loyalties between his parents. He was not an easy child to raise, especially for his mother, who had her own problems with depression. Bobby's story is disturbing not for its uniqueness but for how it represents a growing trend in the U.S. -- young children are being given essentially untested and potentially dangerous psychotropic drugs alone and in combination in greater volume than ever before.

Diagnosing bipolar disorder in children as young as 3 has become the latest rage. It justifies using a host of meds to treat very difficult-to-manage, unhappy children. The old-line drug, lithium, has been replaced by newer, untested (in children) mood stabilizers like Neurontin or Depakote as a first-choice intervention for pediatric "manic depression." Finally, a new class of anti-psychotic medications -- the most popular these days is Risperdal -- is heralded as the ultimately effective treatment for a number of diagnoses whose common features are not hallucinations or psychosis, but severe acting-out behaviors.

No one knows precisely how many children are taking these non-stimulant medications. The most recent survey of physicians' practices had 1.5 million children taking an anti-depressant in 1996. Most were teenagers (girls are the majority), but more than 200,000 children under 12 are also prescribed an antidepressant. Other data tells us that rates of antidepressant use since 1996 continue to rise. For example, 150,000 prescriptions for clonidine were written for children in 1996. More than 100,000 children take "mood-stabilizing" drugs for purported bipolar disorder. Again, most are teens (here boys predominate) but it's being advised that children as young as 3 take these drugs. More than 200,000 children

receive anti-psychotic medications, mostly to control unruly behavior rather than to treat hallucinations or other symptoms of schizophrenia.

The number of children combining two or more psychoactive drugs is unknown. Combined pharmacotherapy (known pejoratively as polypharmacy) has been strongly endorsed by leading research groups as the sensible approach to treating the co-morbid, or multiple occurring, diagnoses common in "high problem resistant behavior" children. Some doctors call it prescribing by "symptom chasing."

No other society prescribes psychoactive medications to children the way we do. We use 80 percent of the world's stimulants such as Ritalin. Only Canada comes close to our rates, using half, per capita, the amounts we do. Europe and industrialized Asia use one-10th of what we do. Psychiatrists in those countries are perplexed and worried about trends in America. The use of psychoactive drugs other than Ritalin for preteen children is virtually unheard of outside this country.

 **Next page | Instead of blaming Johnny's mother, now we blame his brain and genes**

Illustration by Jordin Isip

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Kids on drugs | page 1, 2, 3

In my practice of behavioral pediatrics I regularly meet children under 13 on two psychiatric medications. A 5-year-old girl troubled by fears had tried eight different psychoactive drugs over the year before she saw me. I met the mother of a 29-month-old boy who wanted me to prescribe medication. I didn't, but later I learned the boy was getting lithium, Zoloft and Risperdal from another doctor.



Is this cutting-edge treatment or an outrage? I'm not sure. But with three or four exceptions, none of these drugs, alone or in combination, has been shown to be effective for a specific psychiatric condition in children. Outside of the stimulants and old-line anti-psychotic group, only two of the most frequently prescribed medications, Luvox and Zoloft, have been studied sufficiently to obtain the Food and Drug Administration's approval for psychiatric use in children. Only a handful more have been examined systematically to eliminate the placebo effect, which has a particularly powerful influence in psychiatric conditions and in children. None of the newer medications has been studied beyond a few months for efficacy or side effects, and no one has looked at their effects on children's growth and development.

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Until recently the recondite and rarified worlds of academic child psychiatry and psychology have largely supported the increased use of these medications. Joseph Biederman, chief of Harvard's pediatric psychopharmacology clinic, hails the increased use of psychiatric drugs in children as evidence "that child psychiatry is finally catching up to adult psychiatry" in psychopharmacological practice.

Other leaders in the field of child psychiatry are not as sanguine. Michael Jellinek, who as the head of child psychiatry at Harvard is effectively Biederman's boss, and Peter Jensen, who recently stepped down as director of child and adolescent research of the National Institutes of Mental Health, have both publicly worried whether physicians' prescribing practices for children have outstripped their

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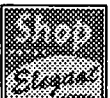
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prescribing practices for children have outstripped their scientific substantiation. They are also concerned that not enough is being done about the world these troubled children live in.

It's Johnny's Brain: The Triumph of Biological Psychiatry in America

What makes America so different from the rest of the world in how it views and treats children's emotional and behavioral problems? Perhaps no other profession fell so completely under the sway of Freudian ideas as American psychiatry and psychology did in the first 60 years of the 20th century. Yet by the late 1960s critics both within and outside of American psychiatry had doubts about psychoanalysis as a science and as an effective treatment. In the 1950s drugs like lithium, Thorazine and Elavil, found to be useful in alleviating psychiatric symptoms, further challenged the Freudian hegemony on psychiatric thinking and practice in this country.

By the 1970s research and academic psychiatrists fomented an internal revolution culminating in 1980 with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The DSM III replaced the old Freudian diagnoses, which were based on traumatic childhood experience, with etiologically neutral lists of symptoms collected into supposedly definable syndromes. DSM III was meant only to be descriptive and used primarily for research. Few outside of an inner circle of research psychiatrists knew of a paragraph in the introduction, deleted at the last moment (ostensibly to maintain etiological neutrality), that said the presumptive cause of most of the disorders listed was biological, that is, the result of heredity or a chemical imbalance.

It really didn't matter what was written, because over the next 10 years American academic psychiatry shifted 180 degrees from blaming Johnny's mother for all his problems to blaming Johnny's brain and genes.

The introduction of Prozac in the late 1980s cemented America's belief in the biological basis for abnormal behavior. Prozac was no more effective than earlier antidepressants but had less severe side effects, which allowed greater numbers of less severely disabled people to continue to take the drug. A logic developed that if a drug improved behavior, the problems must be biologically based. No one speaks of headache as an "aspirin deficiency" even though the drug relieves the symptoms. Nevertheless terms like "chemical imbalance" became increasingly fashionable in explaining problem behavior.

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problem behavior.

Media exaggeration of scientific findings contributed to the revolution. The acceptance of Prozac made taking a psychotropic drug no longer taboo; it became the topic of dinner-party conversation. Nearly one in 10 Americans has taken Prozac or one of its close drug relatives. With so many adults taking a drug for mood, it didn't take long for the primary drug for children's behavior, Ritalin, to zoom in use.

Ritalin production and use for the treatment of ADHD rose by more than 700 percent between 1991 and 1998. Amphetamine production also used for ADHD initially lagged but has tripled in use since 1996. Trade amphetamine (primarily Adderall) surpassed trade Ritalin prescriptions in 1998, a testament primarily to the marketing success of the manufacturers of Adderall.

As Prozac opened the door for Ritalin use in children, Ritalin itself ushered in a new "better children through chemistry" age in our country. At least Ritalin had been the most studied of pediatric drugs, though only a handful of the thousands of studies look at patients other than boys or monitor the children beyond a couple of weeks. Meanwhile research on other psychotropic drugs for use in children has been limited. Until recently, funding for studies of psychiatric medication in children was meager by adult comparisons. Questions about children's rights and consent to participate in studies raised thorny ethical issues, and the pharmaceutical industry did not believe there was much of a market for these drugs in children and so it did not fund studies.

Ironically, the new belief in a robust market for psychotropics in children has fueled a host of pending studies of different drugs for different child psychiatric conditions.

The community of pediatric psychopharmacology researchers is rather small; Biederman's Harvard program has been arguably the most productive and influential. His work stands as prototypic of children's psychiatric research under the DSM (now in its fourth edition) and demonstrates how a drug becomes established in the pediatric psychiatric pharmacopea. His research has won awards and his professional publications are prolific.

Biederman's group demonstrated in the late 1980s that the tricyclic antidepressants (their chemical structure contains three "rings") imipramine and desipramine, abandoned as a treatment for childhood depression because studies had shown them to be ineffective, could be used in high doses to

successfully treat children with ADHD who had failed to respond to stimulants. In 1996, the Harvard clinic published a paper that said that 23 percent of their ADHD children also "had" bipolar disorder. (Most child psychiatrists believed manic depression to be a rare disorder in children.)

The Harvard group had always found higher rates of co-occurrence or "co-morbidity" of other disorders in their ADHD patients, but this rate of bipolar disease in children astonished the world of academic child psychiatry.

Biederman further claimed he could diagnose manic depression in children as young as 3. Few of these children demonstrated the classic signs of mania, euphoria or grandiosity. They did not have distinct periods of several weeks or months between their highs and lows. These children could cycle on a daily basis. They were very angry, very irritable kids.

Few of these kids were crazy. They could distinguish reality as long as they weren't enraged. They were very unhappy and very difficult to control. But Biederman felt that children diagnosed as bipolar could be saved from a lifetime of antisocial behavior and substance abuse by aggressively treating them with medication.

The presumed hereditary and biochemical nature of bipolar disorder would justify the use of a new class of drugs known as mood stabilizers: lithium, Depakote, Neurontin -- all drugs with far more serious short- and long-term side effects than Ritalin.

The response from other academic researchers was mixed. Debate goes on in the professional journals over the definition and frequency of bipolar disorder in children. One psychiatrist commented cynically that "Ritalin is for irritable and irritating children while lithium is for very irritable and very irritating children." The practical effect, though, of the announcement of this new interpretation of pediatric bipolar disorder, was that these medications began to be used in very young children without even short-term evidence of their effectiveness and safety.

Of late, the new anti-psychotic drug, Risperdal, has been touted by the Biederman group as more effective than mood stabilizers in controlling the symptoms of bipolar children. Risperdal's ascendancy as the drug of choice has not been slowed by a different set of more serious disabling side effects.

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How should drugs properly be studied for use in children? Only two of the newer psychotropic drugs have been approved by the FDA for the treatment of a psychiatric condition in children. Paxil and Luvox, both variations of Prozac, have proved effective in clinical trials required by the FDA for the treatment of pediatric obsessive compulsive disorder (OCD). No other medication, as yet, has met FDA approval. Several drug trials in children, actively supported by the pharmaceutical industry, are under way.



Once a drug is approved for use by the FDA for the treatment of a specific medical condition, a doctor can legally prescribed it "off label" for any purpose. Virtually every other med used to treat children's behavior is prescribed this way. Off-label use of medicines in pediatrics is common, but nowhere more so than in psychiatric medications. Physicians are constrained only by their own judgment and ethics. Local hospital and medical boards usually do little to interfere with doctors' preferences for treatment.

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Most of the drugs used to treat children's emotional problems first became available after they met the FDA's standards for approval in psychiatric clinical trials in adults. A few were initially approved for use in adults for other medical conditions: Depakote and Neurontin for control of seizures, clonidine for blood pressure.

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The typical path to the widespread use of any of these drugs for children begins with a report of a single child's response to a drug, usually as a letter in one of the professional journals. Journal editors explicitly state their openness to these kinds of "case" reports and more critical peer review scrutiny is omitted. The report will generate other letters until a series of cases are reported in which everyone -- the kids, parents and doctors -- knows what drug the child is taking.

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positive and unwanted placebo effects. In the only study demonstrating the effectiveness of Prozac in children when the patients and doctors didn't know which pill was taken, 60 percent of the improvement in depressive symptoms was attributed to the placebo effect.

The Super Bowl of drug testing, which supposedly can distinguish between the actual effects of the active ingredients of a medication and placebo, is called the double-blind randomized control study (DBRCS). In a DBRCS neither the family nor doctor knows whether the child is getting the medication or an identical capsule filled with an inert ingredient. Only the pharmacist who prepares the medication knows which capsule contains the drug to be tested.

Patients are carefully screened for the psychiatric condition to be treated and then are randomly selected to receive either the real drug or the placebo. The children are monitored by their parents and doctors for improvements and side effects; along with benefits coming from placebo, many children complain of unwanted effects like headache and stomachache while taking placebos. After a pre-determined period it is revealed who took the drug and who took the the placebo. Only then does one learn the "real" vs. "believed" effects of the drug.

Such DBRCS are expensive; until recently, pediatric psychopharmacology researchers have been limited by low funds for their studies. Those few DBRCSs that had been run usually included only enough children, usually fewer than 100, to generate the likelihood of a statistically significant difference between drug and placebo required for scientific journal publication, but not enough for FDA approval.

But with only scores of children assessed, drugs like Prozac, imipramine, clonidine and Wellbutrin have come to be prescribed for hundreds of thousands of children. Research with imipramine demonstrated that adult drug studies do not necessarily correspond to effects in children. Nonetheless, adult medication trials are regularly invoked to justify the use of those same agents in children.

Calls for increased funding for pediatric psychopharmacology research are ubiquitous within the child mental-health community. The pharmaceutical industry, which now sees a children's market large enough to justify the expense, is funding several large studies, hoping to obtain FDA approval for the tested drugs.

On the other hand, studies on psychosocial interventions provide no similar profit-driven initiative for investigation. The much lower funding for this kind of research comes

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The much lower funding for this kind of research comes primarily from government. However, with the profit-motive incentive to develop new drugs and the real-life pressures to medicate children these days, there is ever-increasing pressure to medicate.

When all you've got is a hammer, everything starts to look like a nail.

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Tomorrow: A view from the front lines and Bobby's story, continued

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