

CHILDREN'S HEALTH

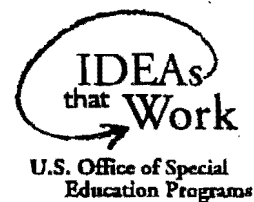
PHOTOCOPY
PRESERVATION

Ruby
as requested,
press releases
from Mondays
evening. Barbara



B. Donovan
fr: Remy

FAX



**U.S. DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES
OFFICE OF SPECIAL EDUCATION PROGRAMS
OFFICE OF THE DIRECTOR**

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DATE:

TO
<i>Ann O'Leary</i>

FROM
<i>Patty Guad</i>

Warlick, Kenneth

From: Warlick, Kenneth
Sent: Friday, March 17, 2000 2:33 PM
To: Guard, Patty
Subject: ADHD

Q: How should I work with my child's school to ensure that the teacher and other staff understand the importance of my child's treatment?

A: First you should meet and share information about your child and his/her needs with a professional staff member with whom you feel comfortable talking. This may be the principal, your child's teacher, the school nurse, a guidance counselor, social worker or school psychologist.

Each child's needs are different. The person you talk with should be able to tell you which other people in the school need to be informed and can help to arrange a meeting with those individuals if needed. In most cases the child's teacher, principal, and school nurse need to be informed. However, children who are eligible for services under IDEA or 504 should have a plan developed by their individual education program (IEP) team or 504 team.

If your child is receiving medication, be sure to ask for any policies or rules your school or district has about either the use of medication or who can administer medication.

Be sure to ask questions about how your school will monitor the effects of your child's treatment and/or medication on school performance and how they will provide you and your child's doctor information (feedback) on those effects.

Ann

F4F

*Here is a Q & A. I thought the question would
love it.*

*Also attached is an updated "commitment list".
I have sent it to Diane Rasi to see if there is anything
else she wants added.*

*Judy would like the NICHY phone # on any fact sheet
the First Lady may hand out (see attached info on NICHY).*

Patty 205-5507

Department of Education Response to ADHD/Ritalin Initiative

1. **The Department is disseminating a document for parents of children with ADHD developed recently by one of our grantees, the National Information Center for Children and Youth with Disabilities. The document is available by calling 1-800-695-0285 or accessing the NICHY web site at www.nichcy.org**
2. **The Department will update and disseminate a research based ADHD information kit for parents and teachers. We will collaborate with our partners in other agencies to incorporate relevant information from their work. We will collaborate with parent, teacher and advocacy organizations in the design of the materials to ensure that the materials will be in a usable format.**
3. **We would like to collaborate with NIMH on research that incorporates behavioral interventions as part of a comprehensive treatment approach.**

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Mrs. Clinton Joins Fray Over Police Shooting

By DAVID BARSTOW and ADAM NAGOURNEY

In unusually harsh language, Hillary Rodham Clinton accused Mayor Rudolph W. Giuliani last night of intentionally polarizing New York City by leading "a rush to judgment" over the disputed circumstances of last week's fatal police shooting of an unarmed black man.

"Last week, the mayor and I both said that New Yorkers should wait and reserve judgment on this latest case until all the facts come out," Mrs. Clinton, who is running against Mr. Giuliani for the United States Senate, said during an appearance at Bethel A.M.E. Church in Harlem. "I am still waiting for a full and fair investigation. Unfortunately, the mayor has not, and that is just wrong."

Specifically, Mrs. Clinton criticized Mr. Giuliani for portraying the dead man, Patrick Dorismond, as a violent, hot-tempered criminal while extolling Anthony Vasquez, the detective who shot Mr. Dorismond, as a dedicated and courageous undercover narcotics officer.

"Everyone, whether he is a police officer or a civilian, is entitled to equal protection under the law and a fair investigation before any judgment is rendered," she said. "That should be the rule and all of us should abide by it. It is wrong to attack either the character of Patrick Dorismond or the police officer."

The mayor did not immediately respond to Mrs. Clinton's remarks, but his campaign manager, Bruce Teitelbaum, said, "Once again, Mrs. Clinton is shamelessly doing her best to exploit this for political purposes, just like she did when she rushed to judgment and called the police officers involved in the Diallo case 'murderers' during her visit with her pal Al Sharpton."

Since the shooting last Thursday, many of the city's elected officials have accused Mr. Giuliani of demonizing Mr. Dorismond to deflect criticism from the Police Department, which is the subject of a broad civil rights inquiry by Loretta Lynch, the United States attorney in Brooklyn.

In particular, they have expressed anger over Mr. Giuliani's decision during his first news briefing about 15 hours after the shooting to have Police Commissioner Howard Safir release details of Mr. Dorismond's arrest history, but not information about Detective Vasquez's disciplinary record, although it was later available at Police Headquarters.

Mr. Giuliani's aides explained yesterday that the mayor and the police commissioner had failed to reveal the detective's disciplinary history because they had not known about his troubled record.

"The reason we didn't put that information out," said Sunny Mindel, the mayor's spokeswoman, "is that we were revealing information as it became available. As we got information, we put it out."

The city's corporation counsel, Michael D. Hess, said yesterday, "The full histories of both parties were probably not yet totally researched." He noted that police officials subsequently briefed reporters about some aspects of Detective Vasquez's disciplinary history.

The release has prompted a fury of condemnation from many of Mr. Giuliani's political opponents. Yesterday, there were demands for investigations, for resignations, for apologies.

"These are serious matters," said C. Virginia Fields, the Manhattan borough president, "and the mayor and the police commissioner cannot simply use the laws for personal gain and expect other people to follow the letter of the law." Ms. Fields called on Jonathan Lippman, New York City's chief administrative judge, to investigate the mayor's release of Mr. Dorismond's juvenile record.

Others, including Mr. Dorismond's family, the Legal Aid Society

and Haitian community groups, urged Attorney General Eliot L. Spitzer to investigate what they called the mayor's "illegal release" of Mr. Dorismond's juvenile arrest history.

But Mr. Hess said yesterday that Mr. Giuliani and Mr. Safir did nothing wrong in releasing Mr. Dorismond's arrest information.

Juvenile records are kept confidential to protect defendants from suffering the consequences of youthful indiscretions with, for example, prospective employers. But Mr. Dorismond's death ended the need for confidentiality, he said. "An individual's right of privacy protection is limited to being a living person and is extinguished upon death," he said, noting, for example, that libel laws do not apply to dead people.

Saying the mayor wanted to be "evenhanded" in his release of information, Mr. Hess said new background information would be released about Detective Vasquez and Mr. Dorismond as it was learned.

In that spirit, Mr. Hess revealed a new allegation yesterday against Mr. Dorismond. He said police records showed that on March 7, Mr. Dorismond's girlfriend, Karen Sturkey, filed a complaint against him alleging that he had struck her head and cursed at her during an argument about their 1-year-old daughter.

The next day, she told the police, Mr. Dorismond made harassing phone calls to her.

According to Mr. Hess, the police took no action in the case, which was closed.

Law enforcement officials also disclosed details of an incident four years ago in which Mr. Dorismond had been approached by an undercover narcotics officer.

That incident, on April 9, 1996, led to Mr. Dorismond's fourth and most recent arrest, on a charge of possession of marijuana. But the following day, the case was adjourned in contemplation of dismissal, a form of probation in which the criminal charge is dismissed if the person is not involved in any trouble for a set period, usually six months.

In the incident, Mr. Dorismond was approached in the Flatbush section of Brooklyn by an undercover officer looking to buy crack cocaine, the officials said. The undercover officer reported that Mr. Dorismond told him, "My man will hook you up," but Mr. Dorismond's companion never returned, the officials said. Eventually, the undercover officer's backup team moved in, searched Mr. Dorismond and found a small amount of marijuana in his pocket.

END

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 30 and saying, 'I have chest pains, I'd like to have coronary artery bypass 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

Gore With More In Bank Than Bush

McCain's Bid Sapped GOP Leader's Funds

By MIKE ALLEN
Washington Post Staff Writer

Vice President Gore began the month with \$1.5 million more to spend than Texas Gov. George W. Bush, the first time Gore has achieved financial superiority over his Republican opponent.

Bush, who is free from spending limits because he is not accepting federal funds for his nomination race, still has raised far more than Gore—\$74 million to \$37 million. But reports filed with the Federal Election Commission yesterday showed Gore began March with \$9.3 million to spend, while Bush had just \$7.8 million, taking into account cash on hand as well as the debt the candidates reported.

A significant chunk of Gore's available cash was in the form of \$6.2 million in federal matching funds that he is owed by the U.S. Treasury, and his campaign said it expects to eventually receive \$1.1 million more.

The report does not include spending for the week before Super Tuesday, when Gore and Bush essentially locked up their nominations.

The new figures reflect the unexpectedly vigorous challenge Bush faced from Arizona Sen. John McCain and the lighter spending Gore needed before Super Tuesday because of the fading threat from Bill Bradley, the former New Jersey senator.

Gore officials also attributed their financial advantage to the aggressive economizing that began in September with the campaign's move from Washington to Nashville. The campaign had drawn up three potential budgets for television advertising and was able to stick with the lowest, a Gore aide said.

In February, Gore raised \$2 million and spent \$6 million, while Bush raised \$3 million and—for the second month in a row—spent \$13 million. A Washington Post computer analysis showed that Bush spent \$7.5 million last month on advertising. That was about twice as much as Gore's \$3.9 million in media spending, although each candidate spent about 60 percent of his total last month on advertising.

Gore's campaign chairman, Tony Coelho, issued a statement saying the campaign is "in a strong position today because we allocated our resources wisely during the primary season."

Coelho continued, "We have the financial capacity to continue to strategically deploy our resources to get out Al Gore's message and to campaign vigorously until the con-

vention" in August.

Bush is scrambling to replenish his bank account with a series of fund-raisers that he hopes will bring in \$5 million to \$10 million before April 30.

The Bush campaign used the opportunity of releasing its financial report to needle Gore on the topic of campaign finance reform. Bush's Web site (georgewbush.com) includes a Donor Database that allows visitors to search his contributions by name, date and amount.

"Complete and rapid disclosure of all campaign contributions is a healthy campaign finance reform that can begin today, and I am proud that my campaign is taking the lead," Bush said in the statement. "It doesn't take a new law for a candidate to post campaign contributors on the Internet every day—it just takes a commitment to public disclosure."

Gore's spokesman, Doug Hattaway, said the information about the campaign's contributors is available at the FEC site (www.fec.gov), where monthly reports are instantly posted.

"We could make two important reforms today if only George W. Bush would agree to ban soft money and drop radio and TV ads," Hattaway added, echoing a Gore challenge to Bush.

Patrick J. Buchanan, who is seeking the Reform Party nomination, reported raising \$559,000 during February. He spent \$646,000 and had \$202,000 left at the end of the month.

Database editor Sarah Cohen contributed to this report.

Buchanan, Reform Party Seeking Part In Debates

Associated Press

The Reform Party and Patrick J. Buchanan are demanding to be included in the presidential debates, saying the major political parties are conspiring to rob the third party of any chance to win the White House.

"Our political opponents are the ones deciding our fate," Buchanan said yesterday after filing a formal complaint with the Federal Election Commission. "Without the debates, there really is no chance, I believe, that the Reform Party can win the presidency of the United States, and that is grossly unjust."

In the complaint, Buchanan and the Reform Party take issue with a ruling Jan. 6 by the Commission on Presidential Debates that only candidates with 15 percent standing in five national public opinion surveys may participate in the events. Buchanan, who has not yet won the Reform Party nomination, stands in single digits.

Buchanan and Reform Party Chairman Pat Choate said the threshold is arbitrary and skewed by the major party memberships of the commission leaders. "There's not a single member of the Reform Party on the commission itself," Buchanan said.

The FEC has 90 days to respond. If it does not allow Buchanan and the Reform Party to participate, the conservative commentator says he will take the case to court.

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.

Clinton and Blair Shouldn't Destroy Our Research

By J. CRAIG VENTER

When President Clinton and British Prime Minister Tony Blair recently encouraged all genomics researchers to make their raw genetic data freely available immediately, their timing and intent puzzled us. On the face of it, they seemed to be simply restating the existing National Institutes of Health policy that requires publicly funded genome labs to release their findings nightly.

Yet if there is not much new here, why have we witnessed some of the biggest losses in the history of Nasdaq Stock Market, with more than \$30 billion lost by 10 companies in the genomics sector alone? And why was the president encouraged to issue a statement that would have such a negative impact on the promising industries of biotechnology and genomics?

I think the simple answer is confusion. Confusion in part about Celera's business model, confusion about why the U.S. government is competing with a small company on decoding the human genome and confusion about how the public will best benefit from the genomics revolution. Here's a clarification of these issues:

In May 1998 we founded Celera Genomics, a company whose goal was to become the definitive source of genomic and related biological information. To accomplish this goal, we are using new methods and technology to complete the sequencing of the human genome this year, years ahead of the scheduled completion of the publicly funded Human Genome Project.

This Friday one of Celera's first milestones will be met when we publish the sequence of the fruit-fly genome—the largest genome published to date—in *Science* magazine. This project took less than 10 months to complete and has demonstrated that Celera's strategy works. It was undertaken in collaboration with public researchers at Berkeley Drosophila Genome Project and has been a wonderful success.

Celera stated from its formation that it would publish the human genome sequence when it was complete. We still intend to do so.

How does Celera make money if it gives the human genome sequence away free? Celera's business model, unlike other genomic firms, is not based on se-

crecy and patents. Rather, as an information company, we aim to disseminate scientific information broadly in a user-friendly form. Celera is developing state-of-the-art software tools that make analyzing this enormous volume of genomic data easier for our subscribers. This is not a new business model; Bloomberg, Dow Jones Interactive and Lexis-Nexis are existing

examples. Much of the information in these databases is in the public domain, but subscribers choose to pay for the software and data-mining capabilities.

Celera has created one of the largest civilian computing facilities in the world and has brought together some of the greatest minds to develop ways to interpret this vast amount of genomic information. Celera's database of 60 trillion bytes represents more than five times the information content of the Library of Congress. This is why large pharmaceutical and biotechnology companies have chosen to subscribe to our databases.

We are now entering the next phase of our business model, with upcoming an-

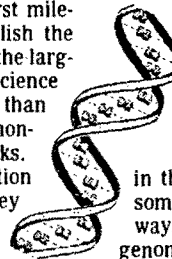
nouncements of database subscriptions with academic institutions and biotechnology companies. After that phase, our hope is to offer services to physicians and eventually to the public.

Celera has always been willing to collaborate with public researchers, but this can't mean sacrificing the investment of our shareholders. This is why in our negotiations with the public Human Genome Project we have insisted on protection from other genomic information companies that would repackage and sell our data. We think this is a fair proposal, since we have invested hundreds of millions of dollars to create Celera and sequence the genome. There is nothing sinister about this notion. It is plain entrepreneurship coupled with good corporate citizenry.

It would be wonderful to think that by simply putting the human genome sequence data on the Internet, diseases would become immediately treatable. The reality is that advances in medicine will be possible only with substantial investment from pharmaceutical and biotechnology companies. The first step in this process is the investment Celera has made, putting this huge amount of genomic data into usable form. The next step is in the creation of new therapeutics. It should be clear that new pharmaceuticals won't be developed without patent protection. Our belief is that patents on genes as targets for pharmaceutical development need to be broadly and *nonexclusively* licensed to encourage development.

Investors and the public were beginning to recognize the potential that genomics holds. If I were a pessimist I would say that with one short statement this research could be delayed for all of us. But I don't think that will happen. Celera is already moving beyond the sequence to understand that information through our initiatives in proteomics, functional genomics and individualized medicine.

The only race that Celera has ever been engaged in is the race to the starting line so that the real research and discovery can begin. There are still centuries of work to be done in this field, and Celera intends to be at the forefront.



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.

Waco Simulation Is Held to Determine F.B.I. Role

By JIM YARDLEY

A1

KILLEEN, Tex., March 19 -- Gathered deep inside the nation's largest military base, a group of government officials, special investigators and private lawyers watched an unusual and controversial simulation today that was intended to help determine whether the Federal Bureau of Investigation had been truthful about its role in the fatal Branch Davidian standoff in 1993.

The exercise, which was ordered by a federal judge and carried out at Fort Hood, was designed to examine unproven allegations that F.B.I. agents fired into the Branch Davidian's Mount Carmel compound before it burned to the ground on April 19, 1993. About 80 men, women and children died that day, including the leader of the religious sect, David Koresh.

Initially, the special infrared video taken of today's simulation was supposed to have been released to the public. But this morning United States District Judge Walter S. Smith, presiding over a wrongful death lawsuit brought against the government by survivors and descendants of the Branch Davidians, sealed the videos, precluding any public viewing. The simulation was supervised by former Senator John C. Danforth, who was appointed by United States Attorney General Janet Reno to lead an investigation into the F.B.I.'s role in the standoff.

Early this evening, F.B.I. officials said that agency experts had conducted a preliminary review of the videos, and said they vindicated their position that agents had never fired on April 19. Michael Caddell, the lead lawyer for the plaintiffs in the wrongful death lawsuit, was scheduled to hold a news conference on Monday morning in Houston after his experts had concluded reviewing the videos.

The lack of public access has created the possibility that both sides in the case would offer conflicting opinions without any public review of the videos. An independent analysis of the videos by the British company that conducted today's simulation could be turned over to the court within 30 days and then possibly released to the public.

At a news conference after the simulation, Mr. Caddell and one of the lead lawyers for the government relayed Judge Smith's action to reporters, saying they had not anticipated the judge's action. "That was the court's decision," said United States Attorney Mike Bradford, one of the main lawyers for the government in the civil case. "I don't think either side really solicited it."

For years, controversy has surrounded aerial infrared videos taken by the F.B.I. on the day of the fire that showed unexplained "flashes." Mr. Caddell and other government critics have contended that the flashes were from F.B.I. agents firing into the compound. He has argued that the gunfire trapped Davidians inside when the fire broke out. Government officials have presented evidence that Mr. Koresh ordered that the fires be started as part of a suicide pact.

Today's simulation was designed to capture gunfire on a similar infrared video and then determine if the shots created similar flashes.

The exercise began at about 11 a.m. and lasted about three hours. In addition to Mr. Danforth and Judge Smith, the group of about 20 observers included representatives from the Department of Justice, the F.B.I., the Texas Rangers and private lawyers representing the plaintiffs. They watched a series of drills performed by six postal inspectors and two Army soldiers dressed in uniforms similar to those worn by F.B.I. agents on the day of the fire.

First, the eight participants fired different weapons from prone and kneeling positions. Then, they slowly advanced to a prescribed firing line where they fired a series of single shots followed by shorts bursts and long bursts of automatic gunfire. They repeated the exercise four times as the F.B.I. Nightstalker airplane and a

British Navy helicopter took turns filming from different altitudes.

In addition, an armored vehicle was driven beside a field littered with debris like twisted aluminum, broken glass and pools of water. Each aspect of the exercise -- the gunfire and the armored vehicle -- was intended to test the conflicting theories about the flashes. Mr. Caddell said he thought the staged gunfire would create identical flashes on the infrared tape put forth by the plaintiffs and by the government. Mr. Caddell has contended that the flashes were gunfire while the government had said the flashes, or "glints," were merely reflections from debris scattered around the Mount Carmel compound.

Mr. Caddell said secrecy and security was at a premium. The observers were driven by bus for nearly an hour to a location within Fort Hood. For security, he said, several military vehicles were positioned nearby. Judge Smith denied a motion by several news media organizations, including The New York Times, to witness the test. There had been concerns that cold weather might force a postponement or possibly skew today's results. But the temperatures eventually pushed above the agreed upon minimum of 65 degrees. On the day of the fire at Mount Carmel, temperatures reached 85 degrees.

Last December, Judge Smith granted a plaintiffs' motion to hold the demonstration and ordered that Mr. Danforth's staff supervise the exercise. Initially, government lawyers had fought against the motion, contending that similar Forward Looking Infrared, or FLIR, technology no longer existed. But Mr. Danforth's staff located such a device in Britain.

When it became clear that both the judge and Mr. Danforth favored the exercise, the government reversed itself and consented.

Regardless of the results of the exercise, the Waco controversy seems likely to rage on, particularly for those who believe the Davidians were innocent victims. Clive Doyle, a surviving Branch Davidian not represented by Mr. Caddell, criticized Mr. Caddell as not taking a hard enough line against the government. Mr. Doyle and other survivors are represented by Ramsey Clark, the former United States Attorney General, while Mr. Caddell represents many descendants of those who died in the fire. Judge Smith appointed Mr. Caddell as the lead lawyer for the plaintiffs in the civil case.

Mr. Doyle said he had "no confidence in the test because I believe the test is being done to try to justify and prove the government line rather than the plaintiffs'."

Early this morning, before the test, Mr. Caddell signaled his likely approach to the civil trial when he told reporters that he did not believe the deaths of the Branch Davidians resulted from an overarching government conspiracy but rather from the improper actions of supervisory agents at the scene.

"I know that may disappoint some people," he said. "But this is not a big conspiracy, it's a small conspiracy. There were a handful of people on April 19 who took matters into their own hands and disobeyed the orders of the Attorney General and the F.B.I. leadership. Those people have to be held accountable."

END

Curbing Use of Psychiatric Drugs for Children

By ROBERT PEAR

WASHINGTON, March 19 -- The White House will announce a major effort on Monday to reverse a sharp increase in the number of preschool children using Ritalin, Prozac and other powerful psychiatric drugs, administration officials said today.

As part of the initiative, they said, the government will inform parents and teachers about the risks of such drugs, the Food and Drug Administration will develop new drug labels, the National Institutes of Health will begin a huge nationwide study of Ritalin use in children under the age of 6, and the White House will hold a conference this fall on the diagnosis and treatment of mental illness in very young children.

Hillary Rodham Clinton and federal health officials plan to meet on Monday with parents, psychiatrists, pediatricians, psychologists, nurses and social workers to discuss the issue.

Then the administration plans to issue a statement declaring that "the use of medication is not generally the first option for a preschool child with a psychiatric disorder."

In a study last month in the Journal of the American Medical Association, researchers reported that there had apparently been an acute increase in the number of preschoolers taking psychotropic drugs, particularly stimulants like Ritalin and antidepressants like Prozac.

Ritalin is called a stimulant because it belongs to a family of drugs that stimulate the central nervous system and increase a person's alertness and ability to pay attention. Researchers say 20 percent of white boys are taking the drug in some suburban school districts.

The study caused concern among parents and medical experts alike, and the administration is now trying to address that concern.

In an interview, Dr. Steven E. Hyman, director of the National Institute of Mental Health, said, "As a rule of thumb, doctors, psychologists and social workers should attempt to modify the behavior of a child and deal with family crises before drugs are prescribed."

The government has prepared a new guide for parents on the treatment of young children with mental disorders. "When medication is used, it should not be the only strategy," but should be part of an overall treatment plan, the guide says. Parents and doctors may want to consider behavioral therapy for the child, family therapy and other techniques to help manage the child's symptoms, the document says.

Administration officials said the initiative was inspired mainly by Mrs. Clinton, who they said wanted to announce some immediate steps after seeing the immense public concern about the use of powerful pills to treat toddlers with emotional and behavioral disorders.

Mrs. Clinton is running for the United States Senate in New York, but White House officials said it would be cynical to believe that her motives were only political. They noted that for years she has been interested in children's issues, including the testing and labeling of drugs for children. Health officials and medical experts said the government's concern was well founded.

"Everything Mrs. Clinton does is related to her campaign, but this initiative has substance too," a federal health official said. "We want doctors and parents to think about these issues."

In an editorial in the Journal of the American Medical Association last month, Dr. Joseph T. Coyle, chairman of the psychiatry department at Harvard Medical School, said children with behavioral disorders were "increasingly subjected to quick and inexpensive pharmacologic fixes," even though "there is no empirical evidence to support psychotropic drug treatment in very

young children."

Indeed, Ritalin carries a warning that says, "Ritalin should not be used in children under 6 years, since safety and efficacy in this age group have not been established."

Dr. Hyman said the National Institute of Mental Health would spend \$6 million in the next five years to study whether Ritalin is safe and effective in treating preschoolers with the impulsive, aggressive behavior traits known as attention deficit hyperactivity disorder -- the most commonly diagnosed psychiatric disorder in children.

In the study, Dr. Hyman said, hundreds of girls and boys at research centers around the country will receive Ritalin, behavior therapy or some combination of the two.

Dr. Hyman said the problem was not simply that children were being overmedicated, but that they were not being appropriately evaluated and treated. "In some communities," he said, "too few children are receiving medications, just as in other communities, too many are getting medications."

Government scientists said they recognized that drug therapy could sometimes provide relief to young children. "If a kid is engaged in aggressive behavior, self-mutilation, head banging, and is otherwise uncontrollable, you should try medication," Dr. Hyman said.

Certain drugs are widely prescribed for young children even though they have not been studied, approved or labeled for such use. The Food and Drug Administration does not regulate the practice of medicine; after a drug is approved for one purpose, doctors often prescribe it for other purposes.

The White House said, for example, that some medications used to treat depression and anxiety disorders in children, like Paxil, Prozac and Wellbutrin, were not labeled for pediatric use.

In addition, the White House said, Zoloft has been approved to treat obsessive-compulsive disorder in children 6 and older, while Luvox has been approved for the same condition in children 8 and older. But both drugs are used in younger children.

Drug labels often do not specify the proper doses for children. The White House said the food and drug agency would soon specify how drug companies should conduct the research needed to develop "pediatric dosage information" that can be included on the labels of Ritalin, clonidine and other drugs used to treat hyperactivity and other attention deficit disorders in young children.

Dr. Jane E. Henney, the commissioner of food and drugs, said that in the last year her agency had sent letters to seven companies asking them to study the effects of antidepressants in children 7 to 18 years old. The government, she said, is analyzing ways in which research on younger children can be scientifically and ethically conducted.

Dr. Hyman said: "Lots of mood disorders and anxiety disorders begin in childhood. But the younger a child is, the more difficult it is to make a diagnosis of mental disorder with certainty. It is quite difficult to diagnose attention deficit hyperactivity disorder in children under 6 because they are usually not articulate, their brains and behavior are changing rapidly, and they are very reactive to their environment."

END

The New York Times
March 20, 2000

TAIWAN

Violent Protests in Taiwan Follow Election Defeat

By MARK LANDLER

AI

TAIPEI, Taiwan, March 19 -- A day after Taiwan's Nationalist Party was swept from power after more than 50 years, the fury of the losers erupted tonight, forcing President Lee Teng-hui to barricade himself inside his party headquarters as thousands of disaffected supporters battled with the police for hours.

While the worst street clashes in a decade raged outside the building -- sealed like a fortress with cordons of riot policemen and powerful water cannons -- Mr. Lee bowed somewhat to the intense anger and calls for his immediate resignation, agreeing to step down as party chairman in September, a year earlier than planned. Three senior party leaders submitted their resignations, but in the turmoil, Mr. Lee refused to accept them.

The unraveling of the Nationalist Party after its candidate finished last in a bitter three-way presidential race poses huge potential dangers for Taiwan at a time of delicate transition.

The country's newly elected president, the opposition leader Chen Shui-bian (pronounced chen shway-bien), is viewed with deep suspicion by China for his past advocacy of Taiwan independence. So far, official reaction to his election from Beijing has been noncommittal, but Washington is so concerned that senior administration officials have been sent to China to keep tensions from escalating.

After a half-century of iron rule, the Nationalists are being replaced by Mr. Chen and his Democratic Progressive Party, which with the legislature still under Nationalist control will preside over a divided government.

In addition, James Soong, the former Nationalist who ran as an independent and finished a close second in the election on Saturday, announced the formation of a new party, in effect splitting the Nationalist movement.

If Mr. Lee is forced out as the Nationalists' chairman, it is unclear how effectively he could govern Taiwan until May 20, when Mr. Chen is inaugurated.

Mr. Chen sought to cool tempers, saying: "With the end of the election, fervor should also become a thing of the past. We hope everyone will calm down so things can slowly return to normal."

But as the magnitude of their defeat became clear to the Nationalists, the tensions long simmering in their ranks exploded into the streets of this normally tranquil capital.

Protesters, a vast majority of them supporters of Mr. Soong, cried "Lee Teng-hui is a traitor!" and pelted the Nationalists' headquarters with eggs and stones. One adviser to Mr. Lee was dragged out of his car and beaten; another fled in panic.

"The K.M.T. is very weak now," said Lee Ching-ping, who attended an emergency meeting today of the Kuomintang, as the Nationalists are known here.

"The question is: Who will be the next leader of the party?"

For the party, Mr. Lee's departure would leave a major vacuum. The charismatic, 79-year-old president has utterly dominated the Nationalists for more than decade, since he succeeded Chiang Ching-kuo in 1988.

But Mr. Lee's leadership has been more divisive than is commonly thought in the outside world, where he is viewed as the man who brought democracy to Taiwan. In recent years, the party has become split between native-born Taiwanese like Mr. Lee who favor a strong line toward China, and mainland-born people like Mr. Soong who take a more conciliatory approach.

Mr. Lee ignited a firestorm in July when he announced that and China could negotiate reunification only on a "special state-to-state" basis. China, which views Taiwan as a renegade province, denounced Mr. Lee for taking the first steps toward Taiwan independence.

The party split was aggravated when Mr. Lee clashed with Mr. Soong, who had become one of the country's most popular politicians as the provincial governor of Taiwan. After Mr. Lee picked the more reserved Lien Chan instead of Mr. Soong to be his designated successor, Mr. Soong declared that he would run as an independent and was expelled from the party.

The feud between Mr. Lee and Mr. Soong was so bitter that supporters of Mr. Soong believe that the president would have done anything to defeat his candidacy -- even if it meant throwing the election to Mr. Chen. Moreover, Mr. Chen's past support for independence is seen by many as closer to Mr. Lee's position.

In the end, Mr. Chen drew 39 percent of the vote, while Mr. Soong won 36 percent and Mr. Lien 23 percent. Some political analysts said Mr. Lien's weakness played to Mr. Chen's advantage. And that, to the protesters, was proof that Mr. Lee orchestrated his own party's defeat.

"This party has a 100-year history, and he sold it out in a single election," said Jerry Ho, 31, a businessman. "His strategy was to pull down Lien's vote, so Chen would win the election."

Mr. Ho said he believed that 95 percent of the protesters accepted the result of the election. But he said they wanted to hold Mr. Lee accountable for his role.

Another demonstrator who gave his name as Chen called Mr. Lee a traitor. "It's not enough for him to step down in a few months," said Mr. Chen. "We want him to resign immediately."

For his part, Mr. Soong sought to channel the anger of his supporters. He announced that he would create a new party to challenge the primacy of the Nationalists. The party, which does not yet have a name, would be similar to the Nationalists in ideology, he said, but would be cleaner, breaking with the corruption that long characterized Nationalist rule.

"The K.M.T. has gone against the wishes of the people and against the democratic process," Mr. Soong said, as hundreds of cheering supporters mobbed the streets outside his campaign headquarters.

Mindful of the mayhem across town, Mr. Soong urged his supporters to be "calm and rational" and avoid "bloodshed."

Mr. Soong left the door open to a reconciliation with the Nationalists, saying he would pursue talks with other parties. It was not clear whether he could bridge the gap with his former colleagues, though some officials of the Nationalist Party are reportedly eager to see him return.

Whatever happens, it was clear today that President Lee was losing support, even among Nationalist officials who had not defected to Mr. Soong's camp. Tonight, Ma Ying-jeou, the popular mayor of Taipei, tried to calm the protesters by telling them that he would pass on to Mr. Lee their demand for his resignation.

Mr. Ma, who is one of Nationalists' rising stars, earlier faxed in his resignation from the party's standing committee. Vice President Lien, humbled by his poor showing in the election, also submitted his resignation as deputy chairman of the party. But neither Mr. Lien and Mr. Ma were able to attend the emergency party meeting because the building's entrance was blocked by dozens of howling protesters.

Those people who got close wound up being attacked. Witnesses said Hsu Li-teh, a top adviser to Mr. Lee, was pulled out of his car and beaten.

President Lee managed to get into the building. But after the meeting, protesters trapped him inside for several hours by crowding around the exits. He finally escaped after 5:30 p.m. when

"All the News
That's Fit to Print"

The New York Times

MONDAY, MAY 16, 1988

NEW YORK, MONDAY, MAY 16, 1988

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WHITE HOUSE SEEKS TO QUIET PLOTS USED TO CALM THE YOUNG

RIGHTS GROUPS REEVALUATED

Michael Stipe is featured in
book of Paul D. Miller's
Crises of the American

By MICHAEL STIPE
WASHINGTON, May 15 — The White House has been accused of trying to silence a group of young people who are known for their activism in the civil rights movement. The group, known as the Young People's Socialist Alliance, has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union. The group has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union.



A person in a suit and hat is seen in a crowd of people in front of a building in Washington, D.C.

Waco Simulation Is Held, and Judge Seals Videos

By JIM HAMILTON

WACO, Tex., May 15 — A simulation of the Waco siege was held today by the Federal Bureau of Investigation (FBI) and the Texas State Police. The simulation was held in a wooded area near Waco, Texas. The FBI and the Texas State Police were the main participants in the simulation. The simulation was held in a wooded area near Waco, Texas. The FBI and the Texas State Police were the main participants in the simulation.

Plaintiffs Review Tapes

— F.B.I. Said That
a Backing Appear

The plaintiffs in the Waco case are reviewing tapes of the simulation. The FBI has said that the simulation was a success. The plaintiffs are reviewing the tapes to see if they can find any evidence of wrongdoing. The FBI has said that the simulation was a success. The plaintiffs are reviewing the tapes to see if they can find any evidence of wrongdoing.

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The Target Old Favorite

For Mr. Kennedy,
Savior of Ireland

By JIM HAMILTON

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Violent Protests in Taiwan Follow Election Defeat

DEMOCRATIC GROUPS

Long-term members of the
Democratic Group in Taiwan

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Top Team United

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Baseball Ratings Hit a Slump at NBC And That Is Crazy

By JIM HAMILTON

NEW YORK, May 15 — The White House has been accused of trying to silence a group of young people who are known for their activism in the civil rights movement. The group, known as the Young People's Socialist Alliance, has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union. The group has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union.

Shards of Misery, Not Far From Clinton Stop in Bangladesh

By JIM HAMILTON

DHAKA, Bangladesh, May 15 — The White House has been accused of trying to silence a group of young people who are known for their activism in the civil rights movement. The group, known as the Young People's Socialist Alliance, has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union. The group has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union.



A train is seen passing through a landscape in Bangladesh.

Rival to New Jersey Emerges in Business Of Living Business

By JIM HAMILTON

NEW JERSEY, May 15 — A group of young people in New Jersey are known for their activism in the civil rights movement. The group, known as the Young People's Socialist Alliance, has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union. The group has been accused of being a front for the Soviet Union. The White House has been accused of trying to silence the group by labeling it as a front for the Soviet Union.

More Weather, and in Color

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Agenda of the Week

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Richard Nixon's Memoirs

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Clinton praises Bangladeshi bank's battle against poverty

By Susan Page
USA TODAY

DHAKA, Bangladesh — Zalimon Nessa is scrupulous about paying back 24 Bangladeshi takas every week (about 50 cents) to her local banker for the loans that enabled her to buy a milking cow and a husking machine she uses to make rice cakes to sell.

"When there is no Grameen Bank, we have hardship," the mother of six says. "But by using this loan I am having a little bit better life."

Nessa was one of dozens of women from Joypura who made the 20-mile journey to Dhaka on Monday to listen to President Clinton extol the virtues of the microcredit initiative that has

made such a difference in their tiny village. Clinton's planned visit to the village was relocated because of a security scare.

The theory of microcredit is that loans of as little as \$100 can provide the toehold for the poor to become economically self-sufficient.

"If you look only at the Grameen Bank, it has 2.4 million borrowers in 39,000 villages; 94% of the borrowers are women, 98% of the loans are repaid," Clinton said.

"Now, with loans for people to buy cell phones, entire villages are being brought into the Information Age. I want people throughout the world to know this story."

Muhammad Yunus, a Bangladeshi who founded the Grameen Bank and

is credited with creating the microcredit movement in the developing world, sat to one side in the audience and smiled.

Clinton, the first U.S. president to visit Bangladesh, was supposed to travel to Joypura by helicopter, but what one official called a "credible" threat prompted the White House to cancel the stop just hours before Clinton arrived. Secret Service agents were said to be concerned about flying Marine One over a stretch of dense tropical forest.

"We had specific information that led us to the conclusion that traveling to the village was inadvisable," national security adviser Samuel Berger told reporters. He and other officials refused to elaborate.

Security during the visit to the small Muslim nation that has become a symbol of Third World poverty was very tight. Clinton arrived not on the distinctive blue-and-silver 747 that usually serves as Air Force One but on a smaller C-20 Gulfstream.

An estimated 12,000 police officers, soldiers and paramilitary troops in camouflage garb lined the streets where his motorcade passed. U.S. and Bangladeshi military jets practicing over the capital on Sunday generated sonic booms and public alarm.

Even more dismayed were the people of Joypura, who had watched with growing anticipation as a landing pad was constructed for Clinton's helicopter at the edge of the village

and a stage erected near a 100-year-old banyan tree for his speech.

In the end, about 200 villagers were bused to Dhaka to meet with Clinton in the sweltering courtyard of the U.S. Embassy. "I regret that I cannot go to the village," Clinton told them, "and I'm delighted the village will come and see me."

During his 10-hour visit here, he also met privately with Bangladeshi officials, including Prime Minister Hasina Wazed, and was honored at a state dinner held in the Bangladeshi president's official residence, called Bangabhaban, or House of Bengal.

Earlier, Clinton told Joypura villagers that their ability to overcome obstacles was proof that no one should believe "that poverty is destiny, that

people have to remain poor, that their children cannot learn and do better."

He announced a series of modest aid pledges: \$97 million in food aid; \$6 million to reduce Bangladesh's debt in exchange for tropical forest conservation; \$14 million to help keep children out of factories and in school; \$84 million over four years for clean-energy initiatives in Bangladesh, India and Nepal.

President to meet with Syrian leader

By Susan Page
USA TODAY

DHAKA, Bangladesh — President Clinton will meet with Syrian President Hafez Assad in Geneva on Sunday to try to revive Syrian-Israeli peace talks, a process Clinton hopes will bear fruit before he leaves office.

"I don't want to unduly raise expectations," Clinton said Monday in a joint news conference with Bangladeshi Prime Minister Hasina Wazed. "But I think that this is an appropriate thing for me to do to try to get this

back on track so that our objective of having a comprehensive peace can go forward."

Clinton downplayed expectations of a breakthrough, but White House officials say the time might be ripe to conclude in relatively short order an elusive Israeli-Syrian peace agreement that would bring about greater security for Israel and the return of the Golan Heights to Syria.

Clinton has spent considerable effort cultivating Assad through telephone calls and other consultations. The two men last met in person six

years ago in a session also held in Geneva.

Israel and Syria agreed to open U.S.-sponsored peace talks last December after four years of standoff, but the negotiations in Shepherdstown, W.Va., broke down in January in a dispute over what issues to consider first.

Syria demanded focusing first on Israel's withdrawal from the Golan Heights, the strategic plateau seized by Israel in the 1967 Mideast war. Israel refused to commit itself in advance to a full withdrawal before security and other issues were discussed.

First lady takes lead in child mental health project

By Karen S. Peterson
and Kathy Kleiy
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



By Joe Marquette, AP

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

ways just a matter of decreasing the adult dosage."

Experts nationwide worry about over-medicating the

The White House quotes recent studies published in *The Journal of the American Medical Association* that show

► 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 Ad-

"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 applaud the first lady's initiative.

"We know that the use of medication in children has increased dramatically," said

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

White students are not the only ones who are affected by the transfer policies. Officials in urban districts say parents of Asian, Latino and black children have complained when their sons and daughters are turned down by magnet schools. Sometimes, those schools say they have too many minority students and not enough white students.

The recent rulings come as no surprise to Terence J. Pell, a lawyer for the Washington-based conservative Center for Individual Rights. He has represented parents and college students who have challenged affirmative action policies.

"The courts have been quite consistent in saying you can't use race just to get a racial mix of students," he said. "The exception is that you can use race as part of a court-ordered desegregation program."

In other action, the court:

Agreed to decide whether arbitrators can overrule a company and reinstate a worker who tested positive for drug use. (Eastern Associated Coal Corp. vs. United Mine Workers).

Agreed to review Washington state's policy of locking up sexually violent predators after they have served their prison terms.

Three years ago, the high court upheld such a policy in Kansas, but the 9th U.S. Circuit Court of Appeals said Washington failed to provide treatment for the inmates. In *Seling vs. Young*, the justices will hear the state's appeal.

Gun Maker Glock Weighs Liabilities Pact

By Eric Lichtblau
Los Angeles Times

WASHINGTON Faced with mounting political pressure, the United States' biggest supplier of police firearms said Monday that it is considering entering into a settlement that would free it of legal liabilities in exchange for placing severe restrictions on its manufacturing and marketing operations.

If it agrees to a settlement in the next few days, Glock Inc. would be the first gun maker to follow Smith & Wesson, the nation's biggest manufacturer of handguns, which entered into a ground-breaking agreement Friday with federal, state and local officials.

Under the terms of that pact, Smith & Wesson pledged to make dozens of concessions aimed at keeping guns out of the hands of children and criminals, including placing mandatory trigger locks on all guns, developing "smart" gun technology to prevent unauthorized use and toughening the code of conduct for gun dealers to deter felons from buying firearms at gun shows. In exchange, the company was released from liability in lawsuits brought by more than 15 cities and other groups seeking to hold manufacturers legally responsible for violence caused by their weapons.

The settlement, brokered by the Clinton administration, drew harsh reaction Monday from the National Rifle Association, the powerful industry lobby. The NRA, unusually silent when the Smith & Wesson pact was announced, condemned the agreement in a statement as a "futile act of self-interest" by the Massachusetts gun maker.

"Smith & Wesson has promised away not only its own rights but those of licensed gun dealers and law-abiding gun owners," NRA chief lobbyist James Jay Baker said Monday. The group urged gun owners to oppose the plan.

But the industry split caused by Smith & Wesson's move threatens to grow even wider if Glock agrees to similar terms.

"We're carefully reviewing the proposal that Smith & Wesson agreed to, and we're trying to see what our position needs to be," Jim Pledger, national sales manager for Georgia-based Glock, said in an interview. "What we need to do is make a good business decision and a good decision related to public policy."

Glock is under particular pressure in the industry because federal and local officials say they may try to organize government boycotts of gun suppliers who do not abide by the restrictions established by Smith & Wesson.

Glock has built its reputation as a leading supplier of police firearms. The company has contracts authorizing it to supply firearms to about 60 percent of the nation's 15,000 law-enforcement agencies, plus military weaponry, Pledger said.

Pledger said Glock wants to talk with government officials about "some real concerns" regarding elements of the Smith & Wesson agreement.

He would not spell out those concerns. But he noted in a straw poll of about 100 callers to the company Monday, all of whom opposed the Smith & Wesson deal, gun owners voiced concerns about how the government would impose "smart" gun technology and mandatory safety training for firearms purchasers, he said.

Glock officials want to "take a real close look" at some 80 provisions to which Smith & Wesson agreed, Pledger said. "We're trying to be open to this. ... My hope is we can find something in the middle," he said.

Pledger said he expects a decision by the end of this week. "We may be very, very close. We just need some more time," he said.

EPA to Impose Ban on Gasoline Additive MTBE

By Marla Cone
Los Angeles Times

The U.S. Environmental Protection Agency announced Monday that it will impose a nationwide ban on a clean-burning gasoline additive that has contaminated water supplies.

Methyl tertiary butyl ether, or MTBE, has been added to gasoline across much of the nation to boost its oxygen content and help clean up air pollution. But it has leaked from underground tanks, spread quickly and polluted drinking-water wells in some cities, most notably in Santa Monica, Calif.

"If we delay too long, the problem will become worse," EPA Administrator Carol Browner said at a news conference Monday. "The time has come to take action. Americans deserve both clean air and clean water and never one at the expense of the other."

In addition to the proposed phase-out, which could take up to three years to implement, the Clinton administration announced that it is asking Congress to amend the Clean Air Act. The amendment is aimed at eliminating MTBE and requiring fuels to include a small amount of ethanol or other renewable products, Browner said.

California's regulation bans MTBE by the end of 2002. But for that ban to take effect without worsening air quality, Congress must first remove a provision of the Clean Air Act that requires gasoline to contain a certain amount of oxygenates such as MTBE or ethanol.

On Monday, Browner said she is asking Congress to eliminate the oxygenate requirement and replace it with a national requirement for use of some renewable fuels. If Congress does not act, the EPA is considering granting California a waiver.

Most oil companies will use ethanol instead of MTBE to boost oxygenates in gasoline. Ethanol, made largely from corn, is not as clean-burning as MTBE, but experts say it poses a far lower threat to water supplies because it biodegrades in water.

Because Congress has not acted to ban MTBE, Browner said the EPA will take action on its own under a law that allows the agency to phase out any substance that poses a public threat. "This action is the best tool legally available for eliminating the use of MTBE," Browner said. The full proposed rule will be issued in about six months. But, Browner said, the ban could take several years to implement because of long reviews the EPA must conduct under law. As a result, she said it is still important for Congress to act soon.

Banning MTBE has been controversial in Congress because members representing Midwestern states fear that if the law's oxygenate standard is removed, corn growers and renewable fuel producers will lose business.

Sen. Charles E. Grassley, R-Iowa, said Monday that the EPA action does not go far enough and will not provide economic protection for farmers. He called for an immediate ban on MTBE and a requirement for ethanol.

The EPA "wants farmers to give up a \$1-billion-per-year bird in the hand today for the slight chance legislation can be passed to provide a \$1-billion-per-year market nine years from now," Grassley said.

But U.S. Agriculture Secretary Dan Glickman said the market for ethanol will grow if Congress approves the renewable-fuels legislation recommended by the Clinton administration.

The legislation faces a rocky time in Congress. Rep. Tom Bliley, R-Virginia, chairman of the Commerce Committee, said he is "disappointed that the best Browner can do is present the American public with only a vague half-page proposal that offers

"The price you put on 150 lives is incalculable," said Hecht, a pilot with Southwest Airlines.

"We do owe it to our passengers to be in the best health we can be; we owe it to our crew," added Savoie, who flies the Oakland-to-Dallas route for American Airlines.

Not to mention the fact that becoming incapacitated in any way could jeopardize the Gulf War veterans' careers in the lucrative commercial field, where pilots are not even allowed to take cold medicine for fear it will dull their senses.

Savoie had one more reason for concern: She was in a fertility program, trying to get pregnant. Now, at 45, she is expecting twins.

So the two became unlikely leaders of an unlikely group of protesters: Air Force Reserve pilots who make their living flying commercial jets.

Monday they joined 15 other pilots at a Davis news conference calling for an immediate cessation of the anthrax vaccination program. Most have shunned their weekend warrior duty for months to avoid having to disobey a direct vaccination order.

"There is a time for blind obedience; we know that," said Lt. Col. Rick Morris, a Delta Airlines pilot who transferred to a reserve desk job to avoid the inoculations. "But this is not wartime, (and) everybody's being told to close those eyes."

The news conference was organized by Washington, D.C., attorney Mark Zaid, who has been civilian counsel in many of the courts martial involving anthrax vaccine refusals. He was an attorney in the nation's first such case, that of an active-duty airman from Travis.

Even before it was ordered for all troops in 1998, the vaccination stirred controversy because of questions about efficacy and possible connections to illness among Gulf War veterans.

The military maintains that the vaccine is perfectly safe, pointing out that more than 400,000 service members have taken it and only 620 have reported adverse effects. Of those, only 70 took time off work, said Army medical representative Virginia Stephanakis.

Zaid said that number is meaningless because many problems are never reported. Pilots, in particular, do not want to jeopardize their flying status by acknowledging less than perfect health, he said.

At Travis, about half of the 3,000 reservists have started the series of shots. Base spokesman Lt. Tom Crosson said he had taken three and had "no reactions" at all. He would not comment further on the reservists' actions.

Nationwide, more than 10,000 Air Force reservists and 22,000 Air National Guard members have been inoculated, Stephanakis said.

Airline companies have not taken a position on the anthrax vaccine, though many of their pilots are in the reserves. At Southwest Airlines, spokeswoman Linda Rutherford said, about one in 10 pilots is a reservist.

Airlines have a somewhat symbiotic relationship with the military. The service pays the millions that it costs to train a pilot. When that pilot is ready to move on, the airlines provide flexibility for them to continue to serve their country with as little as 24 hours' notice.

That was how Savoie ended up at American and Hecht with Southwest while still piloting gigantic military transport planes on both war and relief missions to Kosovo, Bosnia, Somalia and elsewhere.

Travis continued to be a big part of their social lives, too. It was, Savoie said, "like the lodge without the hats."

When they heard last spring that anthrax vaccines would soon be required of reservists who enter war zones, the two automatically figured they would comply. Their medical records show they have taken dozens of shots in the past three years from flu to typhoid to meet reserve requirements.

But reports of protests and problems elsewhere caused them to seek more information. The Internet led them to conflicting government reports and to Zaid, who had testified before Congress on the subject.

WASHINGTON The Supreme Court on Monday cast doubt on the future of voluntary moves to integrate the nation's public schools, as it let stand a ruling that bars "racial balancing" by school officials.

Under this decision, which arose in a Maryland case, officials may not consider a student's race as a factor in transfers between schools.

Since 1980, many large school districts have tried to bring about racial integration through magnet schools and other programs that encourage students to look outside their neighborhoods.

Typically, more students apply to magnet schools than can be accommodated, and race usually figures into deciding who is admitted.

Those integration policies recently have come under attack by parents upset that their child's rejection was based on race.

The high court, in a series of rulings, has said that the Constitution bars public officials from using race as a decision-making factor, whether in awarding government contracts, drawing electoral boundaries or awarding state scholarships.

Relying on those decisions, federal judges across the country have said that school officials cannot use a student's race or ethnicity as a factor in admissions or transfers.

By turning down an appeal Monday in the Maryland case, the high court did not make an official ruling and school officials elsewhere are free to ignore it. But the consistent pattern of decisions leaves most school districts' integration policies in legal jeopardy.

The first major ruling on the use of racial preferences in public schools came two years ago. The U.S. Court of Appeals in Boston ruled that the "good intentions" of school officials were not enough to save a race-based admissions policy at the prestigious Latin School.

The parents of Sarah Wessman, a white student, had sued when she was turned down by the Latin School. Boston school officials admitted they considered race in deciding who was accepted but said they did so only to maintain an integrated student body.

Unswayed, the 1st U.S. Circuit Court of Appeals ruled this "policy of racial balancing" was unconstitutional.

Civil rights lawyers helped persuade Boston officials not to appeal to the Supreme Court, fearing they would lose and that a ruling from the high court would affect public schools across the country.

Then, in October, the U.S. Court of Appeals in Richmond, Va., handed down a nearly identical decision rejecting racial balancing.

This case arose when Jacob Eisenberg, a first-grader in suburban Washington, D.C., was blocked from enrolling in a math and science magnet school. The Montgomery County, Md., school board used the magnet schools to encourage integration and transfer requests were judged based on their "impact on diversity."

Jacob, who is white, wanted to transfer from a neighborhood school that had a majority of black and Latino students. School officials said he could not transfer because his move would cause "racial isolation" in his neighborhood school.

His parents sued, contending their son was discriminated against because of his race.

The appeals court agreed and ruled the race-based transfer policy violated the Constitution's guarantee of equal protection of the laws.

The Maryland school board appealed to the Supreme Court, and it was joined by national education groups, including the National School Boards Association, the American Association of School Administrators and the California School Boards Association. They maintained officials should be permitted to consider the race of students to maintain integration. They also said school boards will be vulnerable to lawsuits from parents if these lower court decisions are allowed to stand.

Nonetheless, without comment or dissent, the high court turned down the appeal Monday in Montgomery County vs. Eisenberg.

Education officials said they were disappointed.

"We encourage the schools to achieve diversity, and it is a very common practice to use race to achieve some kind of balance. We don't want all-white academies," said Julie Underwood, general counsel for the National School Boards Association.

High Court Casts Doubt on Schools' 'Racial Balancing'

By David G. Savage
Los Angeles Times

Top of page:

Col 1: Foreign newsfeature. Moving later with art.

Cols 2-5: Pope John Paul II begins a long-awaited pilgrimage to the Holy Land with a panoramic gaze across its arid landscape from the mountain where Moses is said to have died, and appeals for an end to the region's ancient conflicts. (with art) (POPE-TIMES, moved).

Col 6: Fueling Mexico's longest period of growth since the 1970s, direct foreign investment is expected to rise 24 percent this year in the clearest sign yet that the nation's global trade alliances have begun to pay off. (MEXICO, moved).

Above fold:

Col 1: The Supreme Court casts doubt on the future of voluntary moves to integrate the nation's public schools as it lets stand a ruling that bars "racial balancing" by school officials. (SCOTUS-TIMES, moved).

Cols 3-4: In what could be the first crack in a 2 1/2-month freeze in talks between Syria and Israel, President Clinton and Syrian President Hafez Assad plan to meet in Switzerland to discuss how to revive the stalled U.S.-sponsored negotiations. (MIDEAST-TIMES, moved).

Below fold:

Cols 3-4: The theft and recovery of the entertainment industry's most highly coveted awards the Oscar statuettes, appears to have ended with all the drama, mystery and wackiness of a Hollywood made-for-TV movie. (OSCARS, moved).

Bottom of page:

Cols 1-2: Scientists uncover what they believe to be glaring errors in a patent issued last month to Human Genome Sciences Inc. for a human gene that plays a crucial role in AIDS. (PATENT, moved).

Cols 4-6: He may have entered political life "by accident," as an acquaintance once described it, but he didn't pursue it that way; Chen Shui-bian's victory in Taiwan's second presidential election capped 20 years of ceaseless campaigning, workaholic habits and a dogged rise through the ranks. (TAIWAN-CHEN, moving Tuesday).

During Day Trip, Clinton Praises Bangladesh, Announces Aid
By Edwin Chen

Los Angeles Times

DHAKA, Bangladesh President Clinton on Monday became the first American head of state to visit Bangladesh, and he praised the political and economic progress that this impoverished nation has made since winning its war of independence from Pakistan 29 years ago.

"You have come together to build a nation that has won the respect of the world," Clinton declared during a daylong visit filled with pageantry.

After meeting with Prime Minister Sheikh Hasina, the president participated in a series of events to highlight not only Bangladesh's achievements but also its growing ties with the United States.

"Our nations grow closer every day through expanding trade, through the Internet revolution, and through our shared interest in building a world more peaceful, more tolerant, more prosperous and more free," Clinton said. "Today marks only the beginning of a stronger partnership."

The president's trip here came at the start of a weeklong visit to South Asia, during which peace is on his mind, especially because of escalating tensions between India and Pakistan over Kashmir.

Clinton arrived in New Delhi on Sunday night, and he flew here early Monday morning. After a state dinner in Dhaka, he returned to New Delhi and will remain in India until Saturday.

On his way home, Clinton will stop in Islamabad, Pakistan, to meet with Gen. Pervez Musharaff, who took power from a democratically elected government in a coup last October.

A central mission of Clinton's visit to the region is to promote contacts between Islamabad and New Delhi in hopes of easing tensions.

Clinton also announced on Monday that he will fly to Geneva and meet with Syrian President Hafez Assad on Sunday to encourage Syria to enter into direct peace negotiations with Israel.

In remarks to the media after a bilateral meeting with Hasina, Clinton evoked memories of Bangladesh's war of independence in 1971, and said Bangladesh "did not receive the support it deserved from many countries around the world."

A nation of about 120 million people, Bangladesh has made great strides since the early 1970s. The literacy rate is up to 65 percent now and the country once described by a senior U.S. official as an international "basket case" is self-sufficient in food production.

Bilateral trade between the United States and Bangladesh has risen from \$653 million in 1991 to \$2.2 billion last year. With vast reserves of natural gas, Bangladesh is playing host to an ever-growing number of international energy companies.

In the diplomatic arena, Bangladesh has played increasingly visible peacekeeping roles around the world. It recently became the first in troubled South Asia to ratify the Comprehensive Nuclear Test Ban Treaty action that Clinton hopes India and Pakistan will emulate.

During his visit, Clinton announced that the U.S. Agency for International Development will provide \$50 million to Bangladesh and other nations in South Asia to harness clean energy resources. AID also will provide another \$97 million in food assistance.

The president committed the United States to give \$8.6 million to help 30,000 children move from work, often in hazardous industries, to schools. And he said several more million dollars will be given to help develop solar-energy programs.

Clinton, Assad to Meet on Reviving Syria-Israel Talks

By John Daniszewski and Edwin Chen

Los Angeles Times

CAIRO, Egypt In what could be the first crack in a 2 1/2-month freeze in talks between Syria and Israel, President Clinton and Syrian President Hafez Assad plan to meet Sunday in Switzerland to discuss how to revive the stalled U.S.-sponsored negotiations.

Clinton announced the surprise summit with the Syrian head of state during a news conference in Bangladesh, during the first leg of the president's six-day journey to South Asia. He said the meeting with Assad would take place on his way home.

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 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 lived in Syria. 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?

New York Times
March 23, 2000

ESSAY / By WILLIAM SAFIRE Saddam's Sudan?

What do you do with a disturbing national security tip from a usually reliable source? You check it out, of course, with intelligence operatives who have no ax to grind.

But what do you do when those analysts say that they pondered the report at interagency meetings and doubt its accuracy -- but it could be true and bears watching? All I can do is pass along the disputed report with appropriate caveats.

It was first hinted at six months ago in a paragraph by the well-connected Bill Gertz of The Washington Times: "A Pentagon intelligence agency reported earlier this month that North Korea offered to sell the government of Sudan an entire factory for assembling Scud missiles."

That didn't seem to add up, because Sudan is nearly broke and doesn't need long-range missiles to fight its civil war. Where would the money be found to finance the missile factory, and who in that area wants the Scuds?

Enter Amir Rashid, Iraq's oil minister and Saddam Hussein's chief procurer of ballistic missiles.

Two years ago, I'm told, Rashid paid a secret visit to Pyongyang and saw North Korea's missile marketer, Chon Byong-Ho. Saddam's man also visited the Chang Gwang Sinyong Corporation, a key world source of illicit arms.

Topic A was Scuds, many of which were secreted by Iraq in Sudan to escape U.N. detection. A year later, Iraq's chief engineer, Ra'ad Ismail Jamil, received a North Korean delegation in Baghdad.

Only five weeks ago, says my informant, two delegations arrived in Khartoum, capital of Sudan. One was a group of North Korean technical experts; the other was a military research mission from Baghdad.

Their project? The Koreans are said to be working on building a ballistic-missile plant near Khartoum, with Iraqi financing of \$475 million. Pyongyang gets a big chunk of that for turnkey construction and expert staffing; Khartoum a smaller percentage for acting as cutout, site protector and smuggler; and Baghdad gets its old missiles refurbished and new, longer-range missiles built.

If true, such conspiracy among three rogue nations would spell big trouble. So I rattled some American intelligence cages; had they heard of this three-pariah missile deal?

All had. The story (without the recent Khartoum meeting) has been bruited about for months, including the \$475 million figure. It was the subject of two interagency meetings; the White House was briefed.

The current U.S. assessment is that any Iraqi-financed missile factory "cannot be confirmed," although there is no doubt that North Korea has been peddling arms in Sudan. "The report is impossible to stamp out," says a frustrated doubter. Another derogates the story that won't go away as "rumint" -- merely rumored intelligence.

Their logical reason for skepticism is that Sudan is heavily infiltrated by Iranian operatives, who might sabotage or publicize any Iraqi plant. Another is that newly secure Pyongyang is now in the midst of a charm offensive, which will soon include the first visit to Washington by a high-level diplomat since the end of the Korean War. This huge weapons deal would run counter to that opening.

On the other hand, there is reason for skepticism about the spookery's skepticism. Eighteen months ago, on indirect evidence later questioned, President Clinton ordered a cruise missile attack at

the Al Shifa pharmaceutical plant. Our spies may now be super-cautious.

On the third hand, I am inclined to take the rumint seriously because this method of outsourcing his secret weapons development to a rogue-state neighbor so neatly fits Saddam Hussein's interest. Also, if true, a secret Sudanese missile plant financed by Iraqi oil sales would argue cogently against efforts to appease Saddam by lifting economic sanctions, so avidly desired by the Jiang-Putin-Chirac cabal at the U.N.

Wait -- this just in. Porter Goss, chairman of the Permanent House Select Committee on Intelligence, is willing to go on the record: "We have been concerned with the development of weapons of mass destruction and their delivery systems in Sudan, as well as Sudan's ties with North Korea. The matter is receiving our attention."

END

Blunt Talk in India

President Clinton has paid his hosts in India the ultimate compliment this week. He has spoken to them candidly. Precisely because of the uneasy state of Indian-American relations, there was little to be gained from platitudes. In private meetings, public statements and a speech to Parliament yesterday, the president instead cut to the main point, emphasizing the vital importance of India's and Pakistan's turning back from their nuclear arms race and trying to resolve their differences peacefully. Indian leaders politely disagreed with much of what Mr. Clinton said. That was to be expected. But the exchange was healthy, and it could open the way toward progress in the future.

The contrast between the promise and perils of South Asian civilization has been on dramatic display during Mr. Clinton's visit, the first by an American president in 22 years. It was moving to see him scattering petals at the cremation site of Mohandas Gandhi, the apostle of nonviolence. Yet violence was also close by, with the shock of a horrific mass murder of Sikhs in Kashmir and the abrupt cancellation of Mr. Clinton's trip to a Bangladeshi village because of fears of a terrorist attack. A region of such deep faith and deep hatreds does not easily take to lectures on good behavior by outsiders, especially the leader of a superpower.

Mr. Clinton's comments in India have been adroit. He appropriately acknowledged that no foreigner can assess India's defense needs. But he also challenged conventional wisdom in India that building a nuclear arsenal and using military force in the disputed Indian state of Kashmir are the way to achieve security. In a welcome promise, Mr. Clinton said he would tell Gen. Pervez Musharraf of Pakistan the same thing when he stops in Islamabad later in the week. This pledge should help assuage India's resentment over Mr. Clinton's planned stop in Pakistan.

Prime Minister Atal Behari Vajpayee was said to be pleased with Mr. Clinton's declaration that the Kashmir boundary with Pakistan, known as the Line of Control, must be respected. With this comment, Mr. Clinton signaled American opposition to Pakistani intervention in Kashmir, including the infiltration of fighters from Pakistani territory.

But Indian leaders did not hesitate to provide tough talk of their own. Mr. Vajpayee made clear that India had "the means and the will to eliminate this menace" in Kashmir. The Indian president, K. R. Narayanan, even disagreed with the American analysis that tensions with Pakistan have made South Asia into the world's most dangerous region. In effect, he was warning the United States not to reward Pakistani troublemaking in Kashmir by exaggerating the dangers of war and putting unfair pressure on India.

Because India fears such pressure, it does not welcome the United States as a mediator on Kashmir. Mr. Clinton, for his part, has made clear that he would like to get involved in his waning months in office. It was a good sign that Mr. Vajpayee agreed to a joint "vision statement," pledging to work with the United States to curb nuclear weapons and delivery systems, and to visit America before Mr. Clinton leaves office. If Mr. Clinton can coax India and Pakistan to consider reciprocal steps to ease tensions -- a reduction in Indian forces in Kashmir in return for a cutoff of Pakistani aid to the rebels -- the visit this week will have been valuable indeed.

END

Drug Therapy for Preschoolers

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.

END

NEWS RELEASE

FOR IMMEDIATE RELEASE

March 20, 2000

Contact: Darriek Nicholas
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AACAP Supports White House Plans for Medication Research and Education Fall Conference Scheduled

American Academy of Child and Adolescent Psychiatry (AACAP) President Clarice Kestenbaum, M.D., joined other national leaders from physician, parent, consumer and practitioner associations to support a White House plan, initiated by Hillary Clinton, to assure appropriate prescribing of psychotropic medications for pre-school children. The First Lady emphasized that this call to action is not to "bash medications, which have been a godsend to many children," but to look further into reported increases in prescribing psychotropic medications for young children and into the barriers that prevent appropriate diagnosis and treatment.

Meeting participants discussed several points of agreement: that prescriptions should be accompanied by therapy, that the best information must be available to everyone, that the ongoing clinical trials for use of medications by children must be expedited, and that the stigma carried by mental illnesses is often worse in children than in adults. The current health care system also contributes to the number of questions about the pattern of prescribing. Dr. Kestenbaum reinforced the problem of treatment limitations under a managed care system. She noted that, "Children need comprehensive evaluations to reach an accurate diagnosis, and time constraints on patient care can threaten the treatment process."

The AACAP supports the White House commitment to expedited pediatric labeling, enhanced research resources, and updated teacher-parent information. The association is prepared to share its extensive scientific data and consumer information with the federal agencies that administer programs for children and their families who have mental illnesses. Child and adolescent psychiatrists look forward to participating in a national conference on the issues related to using psychotropic medications as part of a treatment plan.

The December 1999 *Surgeon General's Report on Mental Health* stated that there are approximately six to nine million children and adolescents in the U.S. with serious emotional disturbances. The utilization of psychiatric services has rapidly outgrown the supply of specialists, specifically child and adolescent psychiatrists. Utilization rate projections for the next two decades show a 100 percent increase.

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The Report also noted that there is a dearth of child psychiatrists, which places a burden on other physicians to identify children for referral and treatment decisions. The AACAP welcomes the attention that this meeting and its announced federal actions will give to the need for increased training support.

With nearly 7,000 members, the AACAP is the leading national medical association dedicated to improving the quality of life for youth under 18 years of age who are affected by mental illnesses. The AACAP promotes child and adolescent psychiatry research, prevention and early intervention, continuing medical education, and access to quality care for all children and families. AACAP members are physicians with five years of training to evaluate, diagnose and treat children and adolescents with mental illnesses.

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The American Academy of Child and Adolescent Psychiatry represents over 6,900 child and adolescent psychiatrists with at least five years of additional training beyond medical school in adult, child, and adolescent psychiatry. AACAP members actively research, diagnose, and treat psychiatric disorders affecting children, adolescents, and their families. *Your Child and Your Adolescent*, the AACAP's new books on parenting, give us an in-depth look at child development from infancy to adulthood; discussing what's normal, what's not, and when to seek help. The AACAP actively refers the media to expert spokespeople on child and adolescent issues.

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NEWS

1021 Prince Street, Alexandria, VA 22314

www.NMHA.org

Embargoed until March 20, 2000

Contact: Patrick Cody (703) 838-7528

Children's Mental Health, Long Neglected, Wins White House Attention

ALEXANDRIA, VA (March 20, 2000) "By helping to determine which children need psychotropic medications and which don't, the Clinton Administration will improve mental healthcare for millions of children in America," said Michael M. Faenza, president and CEO of the National Mental Health Association (NMHA).

Faenza will participate in a high-level meeting at the White House today in which Mrs. Hillary Clinton, Mrs. Tipper Gore, and the heads of federal health agencies are expected to discuss how more and more young children are being prescribed psychotropic medications.

"Mental healthcare for children is a growing crisis in America," Faenza said. "Federal statistics show one in ten children has a *serious* mental health problem, but only a third of them get any care, let alone the right care. There is plenty of evidence that millions of children who need mental healthcare do not get it. Anecdotal evidence suggests, however, that many children – some very young – who get psychotropic medications may not need them, but instead would benefit from psychotherapeutic work."

Faenza said the Administration can help support new research to determine:

- Which children with serious mental health problems could benefit from medications,
- How long they should remain on the medications and at what dosages,
- How these medications affect children over the long term.

Such research will support much-needed labeling information from the Food and Drug Administration on treatment and dosage for youth, he said.

NMHA founded National Childhood Depression Awareness Day in 1997, and also works to heighten public understanding that untreated mental health problems in children can lead to a host of negative outcomes, including school failure, substance abuse, and contact with the juvenile justice system.

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PRESS RELEASE

Washington DC 3/20/00

School psychologists announce national survey of treatment services for children with serious mental, emotional and behavior disorders.

The National Association of School Psychologists (NASP) has initiated a national survey of its over 21,000 members to determine the numbers of preschool and school children and their families who are receiving treatment by school psychologists for mental and behavioral problems. This information will be provided to Surgeon General Satcher within the year. It is hoped that funding will allow this "phase one" service count of kinds and amounts of service to be followed by a more in depth analysis of treatment effects.

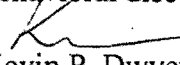
The second NASP study is proposed to survey evaluation measures of these services including combination of treatments, and community coordinated services. Unmet mental health treatment needs of children and youth in school communities will also be examined.

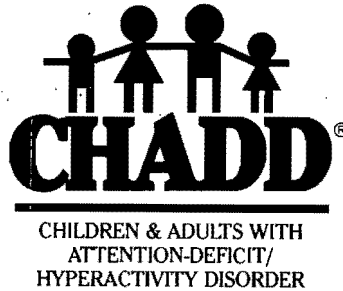
Background:

The Surgeon General's report on mental health (1999) indicated that schools are a primary treatment agent for children with serious emotional disorders but that most children needing treatment still go unserved. Others may receive inadequate services.

The report also showed that school psychologists and counselors provide the majority (possibly as much as 80%) of the mental health services that school age children receive. Research has shown that when school based services are measured they reduce symptoms and help these children improve academically. Furthermore, children are more likely to consistently attend services in school than in other settings.

Little is known about the numbers of children being served in schools by these and other professionals. No national survey has been made of the numbers of treatment contacts over time and the kinds of treatment services provided. This initial NASP survey will begin that analysis for school psychologists. NASP hopes to cooperate with other professions in broadening the survey. NASP also hopes to address questions about unmet needs and how effectively school staffs are evaluating these treatment services for children with mental emotional and behavioral disorders.


Kevin P. Dwyer, MA, NCSP



EMBARGOED UNTIL 11:00 AM, MONDAY, MARCH 20, 2000

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CHADD CALLS FOR MORE ACTION BY NIMH AND THE FDA

LANDOVER, MARYLAND (March 20, 2000) - At a press conference held earlier today CHADD, the nation's leading association for children and adults with attention-deficit/hyperactivity disorder (ADHD), praised the Clinton administration for bringing attention to the need for support for more research dollars in the area of childhood mental health and for working toward connecting providers, parents and teachers in a comprehensive approach to treating ADHD.

"Too little attention has been given and too few resources have been allocated to developing better diagnostic standards and treatment for ADHD," said Beth Kaplanek, president-elect of CHADD. "We applaud the efforts of the Clinton administration for taking this bold step to assist in providing additional funding to support campaigns designed to provide missing information about the diagnosis and treatment of children and adults with ADHD. This approach has long been recommended by CHADD."

While three to five percent of children in the United States are believed to have ADHD, according to current diagnostic standards, CHADD shares the public's concern over reports that

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CHADD

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increasing numbers of very young children are being prescribed psychotropic medications.

Although progress has been made in diagnosing mental disorders that begin in childhood, children's brains are in a state of rapid change and growth, and diagnosis and treatment of those disorders must be viewed with this in mind.

"The use of psychotropic medications in very young children has not been sufficiently researched," Kaplanek said. "The substantial increase in prescriptions for these medications in children under the age of five demands that the FDA, NIMH and manufacturers pay immediate attention to this situation. While the short-term use of psychotropic medications has been found to be safe and effective in older children, it is imperative that we have the same level of assurance about the safety of these medication in younger children."

While some mental health problems are short-lived, others are persistent and very serious, and parents should seek help for their children. Untreated ADHD can affect the developing brain and impede learning and social development. Although individuals with ADHD can be successful in life, without early identification, diagnosis and proper treatment ADHD may lead to serious consequences, including academic failure, depression, conduct disorder, failed relationships, substance abuse, and possible risk for antisocial and criminal behavior.

Treatment of ADHD, following appropriate diagnosis, is crucial if youth affected by this disorder are to be given a chance of succeeding. The largest childhood psychiatric study ever performed by the NIMH reaffirmed that the most appropriate treatment of this disorder is a

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CHADD
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multimodal approach. This multimodal approach includes: parental training, appropriate educational interventions, family counseling, and medication when required. CHADD has strongly recommended this approach for years for the treatment of ADHD.

Changes in children's behavior can be of concern to parents. It's important to recognize behavior changes, but also to differentiate them from signs of serious problems. CHADD defines ADHD as a disorder with at least six of the following characteristics: failing to give close attention to details or makes careless mistakes; difficulty sustaining attention; does not appear to listen; struggles to follow through on instructions; difficulty with organization; avoids or dislikes requiring sustained mental effort; often losses things necessary for tasks; easily distracted; forgetful in daily activities.

"While the multimodal approach is CHADD's recommended form of treatment for ADHD, medications are not usually the first option for a child with a mental disorder," said Kaplanak.

"When medication is used, it should not be the only strategy and all medication should be monitored and evaluated closely and regularly."

Ms. Kaplanek said, "CHADD calls on the NIMH, the FDA and pharmaceutical companies to begin immediate research on the efficacy of giving stimulant medication to children younger than five and to begin a study on the long-term safety of psychotropic medications. CHADD realizes that with the increased awareness of ADHD more and more children are being identified at an earlier age. As a result parents are looking for answers."

"CHADD further urges the federal government to investigate whether the current increase

CHADD
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in the number of diagnoses of ADHD is valid; to begin studies on the efficacy of alternative treatment modalities; to look at the prevalence of ADHD in minority groups; and to work with managed care to ensure that mental health coverage is available under all policies.”

CHADD is a not-for-profit organization dedicated to improving the quality of life for the nine million plus children and adults with attention deficit hyperactivity disorder through education, advocacy and support.

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News Release

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Release No. 00-08
March 20, 2000

MENTAL HEALTH CARE FOR CHILDREN

Statement by Allan Tasman, M.D., President, American Psychiatric Association

The American Psychiatric Association is pleased to join Mrs. Hillary Rodam Clinton in calling for a national consensus and strategy to improve the mental health care of our nation's children. As the Surgeon General reported last December, 20% of children will experience a mental disorder this year, and 5% will suffer extreme functional impairment. Of those, half will receive no treatment at all, only 20% will be evaluated by a child psychiatrist, and some will end up in jails and juvenile detention centers. There are several reasons for lack of treatment access. Funding is sorely lacking for needed services for our most troubled children and adolescents—and for research to better understand the causes of mental illness and develop more effective treatments. And, there are not nearly enough child and adolescent psychiatrists, according to government assessments.

We know that the use of medication in children has increased dramatically. 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—and frequently the only choice—treatment for complicated problems that often require sophisticated psychosocial interventions.

We reject the trend to view medications as the lone cure-all without attention to the antecedents, developmental concerns, and the psychological and social aspects of emotional disturbances in children and adolescents—and adults.

The national debate has under-emphasized the substantial positive impact of programs to prevent mental illness in children, and there is a critical need to put vastly increased resources into these efforts. We hope that the summit meeting called today by Mrs. Clinton will launch a broad-reaching public discussion of the essential role of parents in influencing early child development, so crucial to modulating aggressive and other maladaptive behavior, and to promote healthy mental development.

More



Tasman Statement -- 2

We must empower parents to better fulfill their commitment to healthy child development through greatly expanded parenting education opportunities, school-based programs, and through adequately funded and accessible community services.

Although problems of violence and serious emotional disturbances in children may never completely disappear, we can make a significant change in the nature and prevalence of these problems with appropriate preventive and therapeutic interventions throughout childhood. Members of the American Psychiatric Association join Mrs. Clinton in making this the highest priority for our country.

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The American Psychiatric Association is the national medical specialty society representing 40,000 psychiatric physicians specializing in the diagnosis, treatment and prevention of mental illnesses and substance abuse disorders.

*Fact*SHEET

American Psychiatric Association, 1400 K St. NW, Washington, DC 20005

CHILDREN, MENTAL ILLNESS AND MEDICINES

It is unfortunate that childhood offers no protection against mental illness. In the US, one in five children and adolescents suffer from mental health problems at any given time. The key to ideally handling these childhood disorders is for parents to recognize the problem and seek appropriate treatment. The causes of mental illness in children are complex and never due to a single factor. As with other types of illnesses, mental disorders have specific diagnostic criteria and treatments, and a complete evaluation by a child psychiatrist is imperative to determine whether a child needs help.

DIAGNOSIS

Diagnosis is based on a collaborative process that should involve psychiatric and other physicians, the child, and the child's family, and school-based or other health care clinicians as appropriate. They are involved in an assessment designed to reach a comprehensive diagnosis and the creation of a treatment plan. When deciding what treatment will best benefit the child, it is essential to apply a careful diagnostic assessment after a thorough evaluation of psychiatric, social, cognitive, educational, and medical/neurological factors.

TREATMENT

Psychiatrists develop a comprehensive treatment plan that encompasses all aspects of a child's life. After a comprehensive diagnostic evaluation, an individual treatment approach based on any coexisting mental and physical conditions should be selected according to the child's needs and family and child preferences. Psychotherapy, family and school consultation, and medication are all potential elements of comprehensive treatment. Medications should not be used alone due to the need to deal with ongoing developmental processes. The benefits of psychotropic medications along with various forms of therapy (e.g. cognitive-behavior therapy, psychotherapy, parental and family therapy, social skills training, group therapy) should be carefully examined and accounted for when determining the next steps. Medications should not automatically be considered to be the first choice in treatment, and should be used as part of a comprehensive treatment plan only when their benefits outweigh the risk.

Many clinical research studies have reported beneficial effects of antidepressant medications as part of a comprehensive treatment plan in children and adolescents. It must be remembered that medications are only part of a comprehensive treatment plan and a psychiatrist or other well-trained physician must prescribe them. There are three major classes of antidepressants:

Selective serotonin reuptake inhibitors (SSRIs) – fluoxetine, sertraline, paroxetine, fluvoxamine and citalopram – are the second most prescribed psychotropic medications, after stimulants, for children. They appear safe and effective for the treatment of severe and persistent depression and anxiety disorders, such as obsessive-compulsive disorders (OCD) and panic attacks, in children and adolescents.

Heterocyclic antidepressants – imipramine, desipramine, amitriptyline, nortriptyline, clomipramine. This type of antidepressant also may be prescribed to treat depression in children. However, despite the fact that HCAs are the third most frequently prescribed psychotropic medications for children, available studies do not support the efficacy of HCAs for depression in this age group.

Imipramine is also used to treat enuresis (bed-wetting) in children after the age at which urinary control should have been achieved. Clomipramine is used to treat obsessive-compulsive disorder (OCD). Nortriptyline and imipramine are also prescribed for ADHD, particularly if a child is prone to tics.

Monoamine oxidase inhibitors (MAOIs) - MAOIs are known to be helpful in the treatment of depressive disorders with prominent anxiety features but are not recommended for use in children. The major limitations associated with the use of MAOIs are significant dietary restrictions, including most cheeses, tomato sauces, and other foods popular with children, and interactions with over-the-counter medications such as cold treatments and diet pills.

Antianxiety Medications

Anxiety is the most common mental health problem that occurs in children and adolescents. Studies report that children can also experience panic disorder and agoraphobia (Biederman, 1987). Children with anxiety disorders are often treated with a group of antianxiety medications called benzodiazepines: clonazepam, diazepam and alprazolam, and beta blockers. These medications work quickly to even out a child's anxiety.

Antipsychotics

Antipsychotic medications have been used to treat childhood psychotic disorders but also to control symptoms of agitation, aggression, and self-injurious behaviors in children with severe developmental disorders (including mental retardation) and pervasive developmental disorder (autistic and autistic-like disorders).

The principal categories of psychotic illness that affect children are schizophrenia and bipolar disorder, both chronic and disabling disorders. Typically, the illness emerges in

REVIEW OF MEDICATIONS

(This document only reviews treatment with medications. Extensive information regarding the complete range of treatment options is available from the American Psychiatric Association)

Stimulants

Attention deficit and hyperactivity disorder (ADHD) affects 3-5% of children, and some adults. It is characterized by distractibility, impulsiveness and disorganization. Stimulants, including methylphenidate, amphetamine and pemoline, are by far the most widely researched and commonly prescribed treatments for children with ADHD. They diminish motor overactivity and impulsive behaviors seen in ADHD and allow the child to sustain attention and improve physical coordination (e.g. handwriting, sports).

Methylphenidate helps a child focus by preventing the reuptake of dopamine and norepinephrine--two chemicals involved in normal brain function. It should be prescribed carefully and only by a medical expert. D-amphetamine (Dexadrine) and adderall may also be prescribed for ADHD. All stimulants can have mild side effects including insomnia, weight loss, decreased appetite, abdominal pain and headaches. Most side effects of stimulants are short-term, dose-related and subject to individual differences.

Use of stimulants can result in an immediate and often dramatic improvement in behavior both at school and at home. The benefits and the risks associated with stimulant treatment must be weighed carefully, and evaluated and monitored continually for every child. In general, stimulants are regarded as an effective ADHD therapy with high safety and relatively few side effects.

There has been some public concern about whether exposure to stimulant medication in children with ADHD increases the risk for substance abuse in later life. A recent study by Biederman et. al. (1999) suggests that rather than inducing substance use in youth with ADHD, such medications may protect children with ADHD from future substance abuse.

Antidepressants

Depression tends to run in families. While a predisposition does not automatically mean that a child will get the disease at least one study shows that more than one in four depressed children have a close relative with the disease. Evidence shows that early onset may predict more severe illness in adult life, unless otherwise recognized and treated early in life. Depression in children often comes hand in hand with school performance and other problems. It is an often underlying factor in eating disorders, headaches, sleep problems and other physical problems affecting children and teens.

mid to late adolescence or early adulthood. However, research studies are revealing that cognitive and social impairments may be evident earlier in children who later develop schizophrenia.

There are a number of antipsychotic medications available. They generally yield comparable results; the main differences are in the potency, the dosage (amount) prescribed to produce beneficial effects, and the side effects.

Other Medications

Clonidine, a medication used primarily in the treatment of adult hypertension, has become more prominent in pediatric psychopharmacology because of its wide range of indications. In addition to being used to treat ADHD and sleep disturbances, clonidine is now considered the first line of treatment in Tourette's syndrome and other tic disorders (Leckman et al 1991). It is the fourth widely used psychotropic medication in children and has been increasingly accepted because of its relative safety.

Guanfacine, as with clonidine, appears to have beneficial effects on hyperactive behaviors, attention abilities, and tic disorders (Chappell et al. 1995). Compared to clonidine, guanfacine appears to be less sedating.

OFF LABEL USE

Physicians are allowed by law to prescribe medications in ways not specifically approved by the Food & Drug Administration, such as prescribing psychotropic medications for children younger than five years old. New research findings, clinical experience, and the child's and parent's personal preferences are factors considered by physicians when deciding the appropriate medications to prescribe. Prescription for "off-label" purposes of any medication should be made only after a comprehensive evaluation has been made, other forms of therapy (or combination of) have been considered, and must be monitored closely.

SUMMARY

In a study published by The Journal of the American Medical Association (February 2000), researchers reported the use of certain psychotropic medications in two-to-four-year-olds rose up to three-fold between 1991 and 1995. One of the reasons for this increase may be attributed to a growing acceptance of psychotropic medications. The mounting pressure for children to conform to social standards of good behavior may also contribute to this increase. School administrators play a critical role in determining which kids may need help as they are often the first to notice the symptoms of behavioral disorders. However, it is not their responsibility, nor do they have the training, to recommend or mandate the use of medications as a solution to behavior problems.

Another reason for this increase may be that more physicians are diagnosing behavior disorders at an early age. However, in a consensus conference by the NIH on ADHD in 1999, it was found that family doctors, the ones with the least expertise in ADHD, diagnose more quickly and prescribe medications more frequently. Experts worry that

some doctors are making diagnoses based on symptom checklists rather than on thorough evaluation of a child's life both in and out of the home. The current managed care approach to reimbursement has compounded this problem because it makes it extremely difficult for multidisciplinary clinics-- that in the past brought together pediatric, psychiatric, behavioral and family dynamic expertise--to obtain adequate reimbursement for their services. As a result, children with mental illnesses now are increasingly subjected to quick and inexpensive pharmacological fixes. For optimal outcomes, an informed, multi-modal therapy specifically designed by a pediatric psychiatrist for a specific child's condition is highly necessary.

According to David Fassler, M.D., chairman of the American Psychiatric Association's Council on Children, Adolescents and their Families, "The real tragedy is that most children and adolescents with psychiatric disorders still do not get the help they need. It is easy to overlook the seriousness of childhood mental disorders. If left untreated, the physical, emotional, social and intellectual development of children with mental disorders will be severely stunted, if not crippled. These children are at a heightened risk for school failure and dropout, drug abuse, and many other difficulties - all of which can be prevented by timely evaluation and appropriate treatment."

For parents who have recognized symptoms of childhood mental disorders in their children, sought medical help, and have embarked upon a treatment plan that includes medications, child and adolescent psychiatrists recommend:

- Medications should be closely monitored for efficacy, adverse effects and ongoing needs. Careful observation will ensure that the child is getting the appropriate dosage. Talk to your psychiatrist about all medications your child is taking, including non-prescription medicines, to learn of possible contraindications.
- Talk regularly with your child's teachers, caregivers and physician(s) about how your child is doing, especially when medication is first started, re-started or when the dose is changed.
- Applaud your child for improvements in behavior (better grades, developed social skills, more friends, etc.). The therapy and medications are not responsible for these improvements - they simply make it possible for your child's own assets and natural skills to shine through.
- Find a school or classroom setting that can provide structure and organization beneficial to your child. A child with mental health problems does not need unnecessary pressure and inappropriate expectations.
- Help children feel comfortable with their therapy and medication. They need to know the value of their treatment program and that being a part of it does not make them different from the rest of their peers.

The American Psychiatric Association shares the concerns of the National Institute of Mental Health regarding the need to ensure the appropriate use of medications to treat

mental illnesses in children. Medications must be prescribed in the most judicious manner as part of a comprehensive treatment plan and only after a thorough evaluation by qualified medical personnel. There is at present inadequate funding for both mental health services for children, and for further research aimed at understanding the causes of illness and the development of effective treatments for children.

Bibliography to be added.



CHILDREN & ADULTS WITH
ATTENTION-DEFICIT/
HYPERACTIVITY DISORDER

EMBARGOED UNTIL 11:00 AM, MONDAY, MARCH 20, 2000

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CHADD CALLS FOR MORE ACTION BY NIMH AND THE FDA

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While three to five percent of children in the United States are believed to have ADHD, according to current diagnostic standards, CHADD shares the public's concern over reports that

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increasing numbers of very young children are being prescribed psychotropic medications.

Although progress has been made in diagnosing mental disorders that begin in childhood, children's brains are in a state of rapid change and growth, and diagnosis and treatment of those disorders must be viewed with this in mind.

"The use of psychotropic medications in very young children has not been sufficiently researched," Kaplanek said. "The substantial increase in prescriptions for these medications in children under the age of five demands that the FDA, NIMH and manufacturers pay immediate attention to this situation. While the short-term use of psychotropic medications has been found to be safe and effective in older children, it is imperative that we have the same level of assurance about the safety of these medication in younger children."

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"While the multimodal approach is CHADD's recommended form of treatment for ADHD, medications are not usually the first option for a child with a mental disorder," said Kaplanek. "When medication is used, it should not be the only strategy and all medication should be monitored and evaluated closely and regularly."

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CHADD is a not-for-profit organization dedicated to improving the quality of life for the nine million plus children and adults with attention deficit hyperactivity disorder through education, advocacy and support.

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First Lady Hillary Rodham Clinton
Meeting on the Safe Use of Medications for Young
Children with Emotional and Behavioral Conditions
March 20, 2000

List of Attendees

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

First Lady Hillary Rodham Clinton
Meeting on the Safe Use of Medications for Young
Children with Emotional and Behavioral Conditions
March 20, 2000

Dr. Hyman

List of Attendees

MaryLee Allen, Director, Child Welfare & Mental Health Division, Children's Defense Fund
Lanny R. Copeland, MD, Chairman of the Board, American Academy of Family Physicians
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MaryLee Allen, Director Child Welfare and Mental Health Division, Children's Defense Fund

Satcher
Hymson
Hymson
Chris
Henry
Sec. Foster



Devorah R. Adler
03/20/2000 08:15:55 AM

Record Type: Record

To: Ruby Shamir/OPD/EOP@EOP, Sarah A. Bianchi/OPD/EOP@EOP, Trooper Sanders/OVP@OVP, Ann O'Leary/OPD/EOP@EOP

cc:

Subject: here are the q&a for this morning -- can you send to your press office

Q: Aren't you politicizing an issue to benefit the First Lady in her Senate race?

A: Absolutely not. The First Lady's history and support for children's health issues is well known and documented. She, like many other parents and children's advocates, have been concerned about the potential inappropriate use of medications, particularly in preschoolers. She feels that the recent medical journal articles on this issue need to be highlighted further, but more importantly, addressed, and has been working with the Administration to see what interventions could be considered. She hopes, as does the rest of the Administration, that the information we are providing to parents, the diagnostic and treatment protocols that the AAP is announcing it will release, and our ongoing pediatric research and labeling initiatives, will make significant headway in this regard.

Q: What has Hillary Clinton's involvement been in the past on this issue?

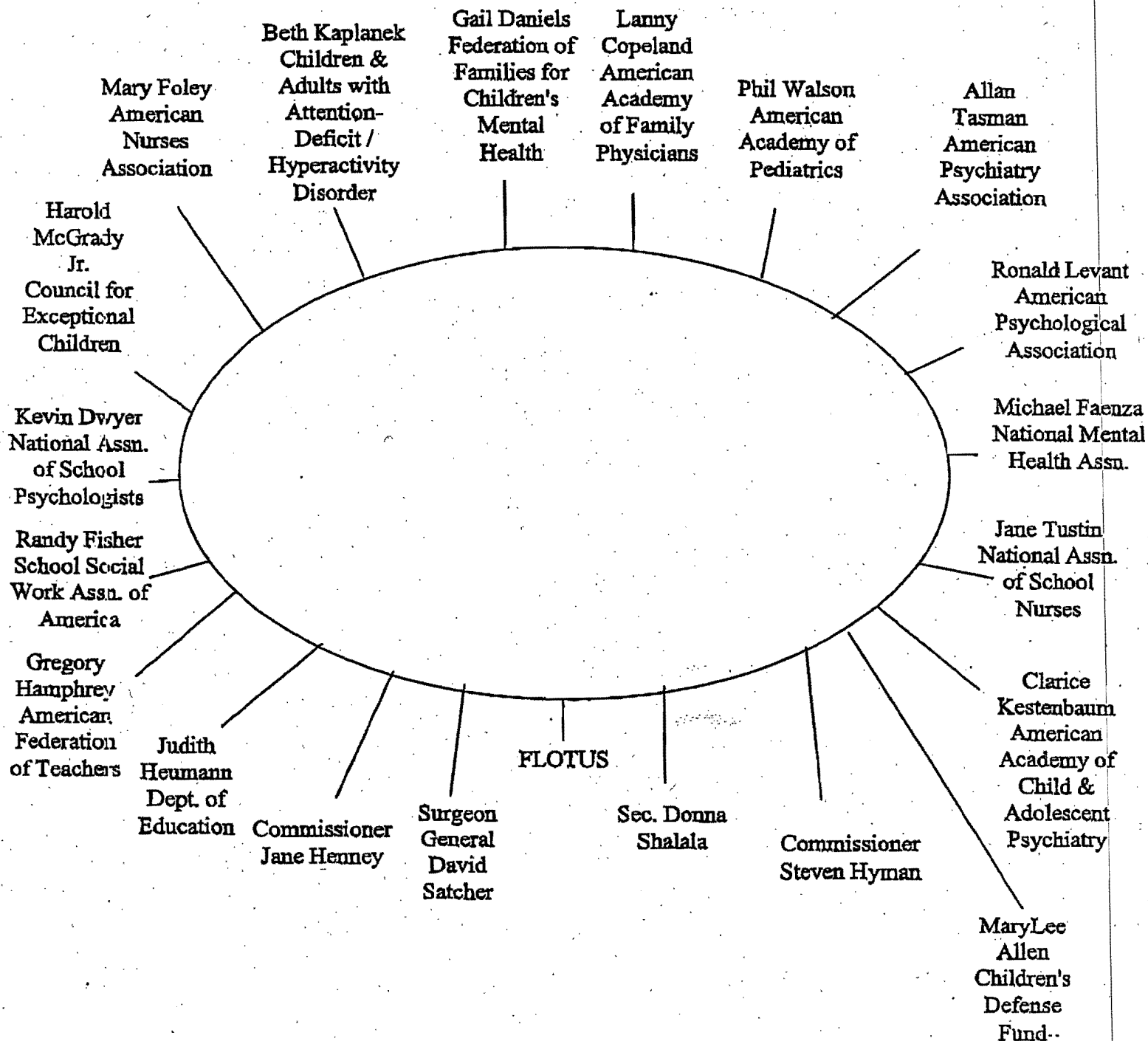
A: Throughout her professional lifetime, the First Lady has been involved in children's issues. In 1997, she was a strong advocate within the Administration for the development and release of regulations as well as subsequent legislation to significantly increase pediatric labeling information developed by FDA for physicians and parents. The First Lady's record on children's health care, child care, and education, speaks for itself. She was a strong advocate for: the passage of the Children's Health Insurance Program, the Family and Medical Leave Act; new regulatory and statutory authority for pediatric labeling; administration efforts to improve child care.

Q: Is Tipper Gore part of this announcement? Is she supportive of this?

A: Tipper Gore is pleased to see attention focused on this important issue. She has played an unprecedented leadership role on mental health issues and has encouraged this next step focusing on mental health issues and children. As the First Lady's remarks point out, Tipper Gore's leadership on this issue is unparalleled. All of the actions being taken today build on the landmark work resulting from the first ever White House Conference on Mental Health and the release of the unprecedented Surgeon General's Report on Mental Health last year, both of which were spearheaded by Tipper Gore in her role as the President's Mental Health

Advisor.

First Lady
Meeting on the Safe Use of Medications for
Young Children with Emotional & Behavioral Conditions
March 20, 2000
Map Room
10:00 a.m.



Staff:

Mary Crosby, Deputy Executive Director, American Academy of Child & Adolescent Psychiatry

Jay Cutler, American Psychiatry Association

Elaine Holland, Assistant Director, American Academy of Pediatrics

Jeffery Human, Director of Government Relations, American Academy of Family Physicians

Jacqueline Pomfret, Associate Director, American Nurses Association

Paula Trubisky, Senior Legislative Affairs and Federal Affairs Officer of Science Policy, American Physiological Association

Joni J. Ketter, Staff, Federation of Families for Children of Mental Health

Deborah Ann Ziegler, council for Exceptional Children

Jeanine M. Becker, National Assn of School Nurses

John Heavener, CHADD

Alfonso V. Guida, Jr., national Mental Health Association

TREATMENT OF YOUNG CHILDREN WITH MENTAL CONDITIONS

When to Get Help • People to Talk To • Learning About Medications

A NOTE TO PARENTS

There has been recent public concern over reports that increasing numbers of very young children are being prescribed psychotropic medications. Some parents are criticized for giving their children these medications, while others are criticized for not doing so. New studies are needed to tell us what the best treatments are for children with emotional and behavioral disturbances.

Although progress has been made in diagnosing the mental illnesses that begin in childhood, children's brains are in a state of rapid change and growth, and diagnosis and treatment of mental disorders must be viewed with this in mind. While some problems are short lived, others are persistent and very serious, and parents should seek help for their children. Treatment decisions should be weighed for risks and benefits, and each child should be viewed individually.

WHEN TO GET HELP

Changes in behavior can be of real concern to parents. It's important to recognize behavior changes, but also to differentiate them from signs of more serious problems. All children act out at times as part of typical development. Some children, however, experience significant changes that may indicate a more serious problem. But in some cases, children need help. Problems deserve attention when they are severe, persistent, and impact daily activities. Seek help for your child if you observe persistent problems such as sleep disturbances, changes in appetite, social withdrawal, or fearfulness; behavior that slips back to an earlier phase such as bedwetting; signs of depression; erratic and aggressive behavior, a tendency to be easily distracted or forgetful, or an inability to sustain attention; self-destructive behavior such as head banging; or a tendency to have frequent injuries. It's important to address concerns early – mental, behavioral, or emotional disorders affect the way your child grows up.

PEOPLE TO TALK TO IF YOU ARE CONCERNED ABOUT YOUR CHILD

Remember that every child is different, and even normal development varies from child to child. If your child is in daycare or preschool, ask the teacher if your child has shown any troubling changes in behavior, and discuss this with your doctor. Ask your doctor questions and find out everything you can about the behavior or symptoms that worry you. Be sure to tell your doctor about extreme symptoms, such as self-injury, impulsive or aggressive behavior, hyperactivity, or social withdrawal.

Ask your doctor whether your child needs further evaluation by a specialist in child behavioral problems. A variety of specialists, including psychiatrists, neurologists, psychologists, behavioral therapists, social workers and educators may be needed to help your child. Consistent follow-up is critical to successful treatment.

LEARNING ABOUT MEDICATIONS

The use of medication is not generally the first option for a preschool child with a psychiatric disorder. When medication is used, it should not be the only strategy. Family support services, educational classes on parenting strategies, behavior management techniques, and other approaches should be considered. If medication is prescribed, it should be monitored and evaluated closely and regularly. There are several categories of medications used for emotional and behavioral disorders: stimulants, anti-depressants, anti-anxiety agents, anti-psychotics, and mood stabilizers.

Stimulants

There are four stimulant medications that are approved for use in the treatment of attention deficit hyperactivity disorder (ADHD), the most common behavioral disorder of childhood. Children with ADHD exhibit symptoms such as short attention span, excessive activity, and impulsivity that cause substantial impairment in functioning. If the child attends school, collaboration with teachers is essential. These medications are labeled for pediatric use.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Adderal	amphetamines	3 and older
Cyclert	pemoline	6 and older
Dexedrine	dextro-amphetamine	3 and older
Ritalin	methylphenidate	6 and older

Anti-Depressant and Anti-Anxiety Medications

These medications are used for depression and for anxiety disorders, including obsessive compulsive disorder.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Anafranil	clomipramine	10 and older (OCD)
Luvox	fluvoxamine	8 and older (OCD)
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older (bedwetting)
Zoloft	sertranline	6 and older (OCD)

Other medications that are used to treat these disorders in children include Effexor (venlafaxine), Paxil (paroxetine), Prozac (fluoxetine), Serzone (nefazodone), and Wellbutrin (bupropion). They are not labeled for pediatric use.

Anti Psychotics

These medications are used to treat schizophrenia, bipolar disorder, autism, Tourette's syndrome, and conduct disorders.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Haldol	Haloperidol	3 and older
generic only	Thioridazine	2 and older
Orap	Pimozide	12 and older

There are other medications used to treat these disorders in children, including clozaril (clozapine), Risperidal (risperidone), seroquel (quetiapine), Zyprexa (olanzapine). These drugs are newer (atypical) antipsychotics, and have fewer side effects. These medications are not labeled for pediatric use.

Mood Stabilizers

These medications are used to treat bipolar disorder (manic depressive illness).

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Cibalith-S	lithium citrate	12 and older
Depakote	divalproex sodium	2 and older (for seizures)
Eskalith	lithium carbonate	12 and older
Lamictal	lamotrigine	16 and older (for seizures)
Lithobid	lithium carbonate	12 and older
Neurontin	gabapentin	12 and older (for seizures)
Tegretol	carbamazepine	any age (for seizures)

Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder are ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

**FOR MORE INFORMATION ON MENTAL DISORDERS IN CHILDREN
CONTACT THE NATIONAL INSTITUTES OF MENTAL HEALTH 301 443 4513 / www.nimh.nih.gov**

March 17, 2000

R. Blin Aug: ToDo

press

- name ext

- ① press paper
- ② finalize stakeout room
- ③ leak on Sunday

Logistics Speech

- ① get room for press avail
- cord on off area for presidents
podium
standing ext
- ② talk to Shale's scheduler
- ③ h/c speech

Movement

- ① how to move presidents (3 rolls?)
- ② can Carol sit in strategy
- ③ clear

Strategy

- ① move everyone into tents
put her in hold (over)
- ② get her questions / Shale (DA)
gms

 Devorah R. Adler
03/16/2000 02:55:10 PM

Record Type: Record

To: Ruby Shamir/OPD/EOP@EOP, Ann O'Leary/OPD/EOP@EOP, Heather H. Howard/OPD/EOP@EOP

CC:

Subject: fact sheet

This is what I have prepared to go back to HHS. I will send it as soon as Chris signs off. It will probably come back to us again -- but the window for changes is shrinking.

If Education has additional information they would like to have included, they need to get it to us ASAP.

Thanks, Devorah



ritalin fact sheet 3-16.d

DRAFT FOR PARENTS

Questions and Answers: Treatment of Children with Mental Disorders

A Note to Parents

There has been recent public concern over reports that very young children are being prescribed psychotropic medications. Some parents are criticized for giving their children these medications, while others are criticized for not doing so. The studies to date are incomplete, and much more needs to be learned about young children who are treated with medications for all kinds of illnesses. In the field of mental health, new studies are needed to tell us what the best treatments are for children with emotional and behavioral disturbances. For medications, we must also make sure that there are no negative consequences for the developing brain.

While there has been progress made in diagnosing the mental illnesses that begin in childhood, children are in a state of rapid change and growth, and diagnosis and treatment of mental disorders must be viewed with this in mind. While some problems are short lived, others are persistent and very serious, and parents should seek ways to help their children.

Not long ago, it was thought that many brain disorders such as anxiety disorders, depression, and bipolar disorder began only later in life. We now know they can begin in childhood. An estimated 6 to 9 million children and adolescents in the United States suffer from a serious

behavioral or emotional disturbance. Perhaps the most studied, diagnosed, and treated childhood-onset mental disorder is attention deficit hyperactivity disorder (ADHD), but even with this disorder there is a need for further research in very young children. Every decision about treatment should be weighed for risk and benefit, and each child should be viewed individually.

Questions and Answers

Q: What should I do if I am concerned about mental, behavioral, or emotional symptoms in my young child?

A: Talk to your child's doctor. Ask questions and find out everything you can about the behavior or symptoms that worry you. Every child is different and even normal development varies from child to child. Sensory processing, language, and motor skills are developing during early childhood, as well as the ability to relate to parents and to socialize with caregivers and other children. If your child is in daycare or preschool, ask the caretaker or teacher if your child has been showing any worrisome changes in behavior, and discuss this with the doctor. Always bring extreme symptoms, such as self-injury, impulsive or aggressive behavior, persistent sadness,

hyperactivity, or social withdrawal, to the attention of the doctor.

Q: How do I know if my child's problems are serious?

A: Many everyday stresses cause changes in behavior. The birth of a sibling may cause a child to temporarily act much younger. It is important to recognize such behavior changes, but also to differentiate them from signs of more serious problems. Problems deserve attention when they are severe, persistent, and impact on daily activities. Seek help for your child if you observe persistent problems such as sleep disturbances, changes in appetite, social withdrawal, or fearfulness; behavior that slips back to an earlier phase such as bed wetting; signs of distress such as sadness or tearfulness; self-destructive behavior such as head banging; or a tendency to have frequent injuries. In addition, it is essential to review the development of your child, any important medical problem he/she might have had, family history of mental disorders, physical and psychological traumas or situations that may cause stress.

Q: Whom should I consult to help my child?

A: First, consult your child's pediatrician. Ask for a complete health examination of

DRAFT FOR PARENTS

your child. Describe the behaviors that worry you. Ask whether your child needs further evaluation by a specialist in child behavioral problems. Parents may be faced with a patchwork of providers. Ultimately, a variety of specialists including physicians, behavioral therapists, and educators may be needed to help your child.

Q: How are mental disorders diagnosed in young children?

A: Most disorders are diagnosed by observing signs and symptoms. A skilled clinician will consider these signs and symptoms in the context of the child's developmental level, social and physical environment, and reports from parents and other caretakers or teachers. Very young children often cannot express their thoughts and feelings, which makes diagnosis a challenging task. The signs of a mental disorder in a young child may be quite different from those of an older child or an adult.

Q: Won't my child just grow out of such problems?

A: Sometimes yes, but in other cases children need help. Problems that are severe, persistent, and impact on daily activities should be brought to the attention of the child's doctor. Great care should be taken to help a child who is suffering, because mental, behavioral, or emotional disorders can affect the way the child grows up.

Q: Are there situations in which it is advisable to use psychotropic medications in young children?

A: Psychotropic medications may be prescribed for young children with mental,

behavioral, or emotional symptoms when the potential benefits of treatment outweigh the risks. Some problems are so severe and persistent that they would have serious negative consequences for the child if untreated, and psychosocial interventions may not always be effective by themselves. The more extreme the problems, the more likely it is that medication will be prescribed. However, the safety and efficacy of most psychotropic medications have not yet been studied in young children. As a parent, you will want to ask many questions and evaluate with your doctor the risks of starting and continuing your child on these medications. Learn everything you can about the medications prescribed for your child, including potential side effects. Learn which side effects are bothersome but tolerable, and which ones are threatening. In addition, learn and keep in mind the goals of treatment (e.g., change in specific behaviors). Although it has become common practice, combining multiple psychotropic medications should be avoided in very young children unless absolutely necessary. Any medication treatment should proceed with careful monitoring of benefits and adverse effects.

Q: Does medication affect young children differently from older children or adults?

A: Yes. Young children's bodies handle medications differently than older individuals and this has implications for dosage. The brains of young children are in a state of very rapid development, and animal studies have shown that the developing neurotransmitter systems can be very sensitive to medications. A great

deal of research is needed to determine the effects and benefits of medications in children of all ages. It is important to remember that serious untreated mental disorders themselves negatively impact brain development.

Q: If my preschool child receives a diagnosis of a psychiatric disorder, does this mean that medications have to be used?

A: No. Psychotropic medications are not generally the first option for a preschool child with a psychiatric disorder. The first goal is to understand (and if possible, to remediate) the factors that may be contributing to the condition. The child's own physical and emotional state is key, but many other factors such as parental stress or a changing family environment may influence the child's symptoms.

Q: How should medication be included in an overall treatment plan?

A: When medication is used, it should not be the only strategy. There are many services that you may want to investigate to develop a complete treatment plan for your child. Family support services, educational classes on parenting strategies, behavior management techniques, as well as family therapy and other approaches should be considered. If medication is prescribed, it should be monitored and evaluated closely and regularly.

Q: Which mental disorders are seen in children?

A: Mental disorders with possible onset in childhood include: anxiety disorders;

DRAFT FOR PARENTS

attention deficit and disruptive behavior disorders; autism and other pervasive developmental disorders; eating disorders (e.g., anorexia nervosa); mood disorders (e.g., major depression, bipolar disorder); schizophrenia; and tic disorders. Enuresis and encopresis may be symptoms of a mental disorder.

Q: Can family events such as a death in the family, illness in a parent, onset of poverty, or divorce cause symptoms?

A: Yes. When a tragedy occurs or some extreme stress hits, every member of a family is affected, even the youngest ones. This should also be considered when evaluating mental, emotional, or behavioral symptoms in a child.

Q: What difference does it make if a medication is specifically approved for use in children or not?

A: The approval of a medication by the U.S. Food and Drug Administration (FDA) allows for doctors to prescribe the medication as they feel appropriate. In some cases there is extensive clinical experience in using medications for children or adolescents. However, everyone agrees that studies in children would be valuable for finding appropriate dosages and learning the effects of medications.

Q: What does "off-label" use of a medication mean?

A: Based on clinical experience and medication knowledge, a physician may prescribe to children a medication that has been FDA-approved for use only in adults. This use of the medication is called "off

label." Most medications prescribed for child mental disorders, including many of the newer medications that are proving helpful, are prescribed off label, because only a few of them have been systematically studied for safety and efficacy in children. Medications that have not undergone such testing are dispensed with the statement that "safety and efficacy have not been established in children."

Q: Why haven't many medications been tested in children?

A: In the past, medications were not studied in children because of ethical concerns about involving children in clinical trials. However, this created a new ethical problem: lack of knowledge about the best treatments for children. But in clinical settings, medications are being prescribed for children at increasingly early ages. The NIH and the FDA have begun examining the issue of research on medications in young children. New research approaches are being considered, and progress is being made to require such studies when a medication is undergoing FDA approval.

Q: Does the FDA approve medications for different age groups among children?

A: Yes. For example, Ritalin® is approved for children age 6 and older, whereas Dexedrine® is approved for children as young as 3. The lowest age for which the FDA approves a given medication is a function of the policies in effect at the time of initial approval and the specific requests of the drug manufacturer. Dexedrine® is an older medication than Ritalin®. When Ritalin®

was tested for efficacy by the pharmaceutical company that developed it, only children age 6 and above were involved; therefore, age 6 was established as the lower age limit for Ritalin®. There is no reason to believe that one medication is safer than the other based on differences in FDA approval.

Q: What medications are used for which kinds of childhood mental disorders?

A: There are several major categories of psychotropic medications: stimulants, antidepressants, and anxiety agents, antipsychotics, and mood stabilizers. For medications approved by the FDA for use in children, dosages depend on body weight and age.

■ *Stimulant Medications:* There are four stimulant medications that are approved for use in the treatment of attention deficit hyperactivity disorder (ADHD), the most common behavioral disorder of childhood. These medications have all been extensively studied and are specifically labeled for pediatric use. Children with ADHD exhibit such symptoms as short attention span, excessive activity, and impulsivity that cause substantial impairment in functioning. Stimulant medication should be prescribed only after a careful evaluation to establish the diagnosis of ADHD and to rule out other disorders or conditions. Medication treatment should be administered and monitored in the context of the overall needs of the child and family, and consideration should be given to combining it with behavioral therapy. If the child is of school age, collaboration with teachers is essential.

DRAFT FOR PARENTS

Stimulant Medications

Brand Name	Generic Name	Approved Age (children)
Adderal	amphetamines	3 and older
Cylert	pemoline	6 and older
Dexedrine	dextro-amphetamine	3 and older
Ritalin	methylphenidate	6 and older

▪ *Antidepressant and Antianxiety Medications:* These medications follow the stimulant medications in prevalence among children and adolescents. They are used for depression, a disorder recognized only in the last twenty years as a problem for children, and for the anxiety disorders, including obsessive-compulsive disorder (OCD). The

medications most widely prescribed for these disorders are the selective serotonin reuptake inhibitors (the SSRIs).

In the human brain, there are many "neurotransmitters" that affect the way we think, feel, and act. Three of these neurotransmitters that antidepressants influence are serotonin, dopamine, and

norepinephrine. SSRIs affect mainly serotonin and have been found to be effective in treating depression and anxiety without as many side effects as some older antidepressants. The following are the most commonly prescribed medications for children with depression or anxiety disorders (including OCD).

Antidepressant and Antianxiety Medications

Brand Name	Generic Name	Approved Age (children)
Anafranil	clomipramine	10 and older (for OCD)
Effexor	venlafaxine	
Luvox (SSRI)	fluvoxamine	8 and older (for OCD)
Paxil (SSRI)	paroxetine	
Prozac (SSRI)	fluoxetine	
Serzone (SSRI)	nefazodone	
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older (for bedwetting)
Wellbutrin	bupropion	
Zoloft (SSRI)	sertraline	6 and older (for OCD)

■ **Antipsychotic Medications:** These medications are used to treat children with schizophrenia, bipolar disorder, autism, Tourette's syndrome, and severe

conduct disorders. Some of the older antipsychotic medications have specific indications and dose guidelines for children. Some of the newer "atypical"

antipsychotics, which have fewer side effects, are also being used for children. Such use requires close monitoring for side effects.

Antipsychotic Medications

Brand Name	Generic Name	Approved Age (children)
Clozaril (atypical)	clozapine	3 and older
Haldol	haloperidol	
Risperdal (atypical)	risperidone	2 and older
Seroquel (atypical)	quetiapine	
(generic only)	thioridazine	
Zyprexa (atypical)	olanzapine	12 and older (for Tourette's syndrome). Data for age 2 and older indicate similar safety profile.
Orap	pimozide	

■ **Mood Stabilizing Medications:** These medications are used to treat bipolar disorder (manic depressive illness). However, because there is very limited data on the safety and efficacy of most mood stabilizers in youth, treatment of children and adolescents is based mainly on experience with adults. The most typically used mood stabilizers are lithium and valproate (Depakote®), which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes in adults. Research on the effectiveness of these and other medications in children and adolescents

with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using

stimulant medications to treat co-occurring ADHD or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

DRAFT FOR PARENTS

Mood Stabilizing Medications

Brand Name	Generic Name	Approved Age (children)
Cibalith-S	lithium citrate	12 and older
Depakote	divalproex sodium	2 and older (for seizures)
Eskalith	lithium carbonate	12 and older
Lamictal*	lamotrigine	16 and older (for seizures)
Lithobid	lithium carbonate	12 and older
Neurontin*	gabapentin	12 and older (for seizures)
Tegretol	carbamazepine	any age (for seizures)

* Putative mood stabilizers

References

Coyle JT, 2000. Psychotropic drug use in very young children [editorial]. *Journal of the American Medical Association*, 283: 1059-1060.

Physician's Desk Reference (PDR), 1999. Medical Economics Company, Montvale, NJ.

Zito JM, et al., 2000. Trends in the prescribing of psychotropic medications to preschoolers. *Journal of the American Medical Association*, 283: 1025-1030.

For More Information on Mental Disorders in Children, Contact:

Office of Communications and Public
Liaison, NIMH
Information Resources and Inquiries
Branch
6001 Executive Blvd., Room 8184, MSC
9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
TTY: 301-443-8431
FAX: 301-443-4279
Mental Health FAX 4U: 301-443-5158
E-mail: nimhinfo@nih.gov
NIMH home page address:
www.nimh.nih.gov

TREATMENT OF YOUNG CHILDREN WITH MENTAL DISORDERS

When to Get Help • People to Talk To • Learning About Medications

A NOTE TO PARENTS

There has been recent public concern over reports that very young children are being prescribed psychotropic medications. Some parents are criticized for giving their children these medications, while others are criticized for not doing so. New studies are needed to tell us what the best treatments are for children with emotional and behavioral disturbances.

Although progress has been made in diagnosing the mental illnesses that begin in childhood, ^{we know that} children's brains are in a state of rapid change and growth, and diagnosis and treatment of mental disorders must be viewed with this in mind. While some problems are short lived, others are persistent and very serious, and parents should seek ways to help their children. Treatment decisions should be weighed for risks and benefits, and each child should be viewed individually.

WHEN TO GET HELP

It's important to recognize behavior changes, but also to differentiate them from signs of more serious problems. Sometimes, changes in behavior that you find worrisome may be a normal part of your child's development, and do not need medical attention. But in some cases, children need help. ^{which of} Problems deserve attention when they are severe, persistent, and impact daily activities. ^{Talk to your pediatrician} Seek help for your child if you observe persistent problems such as sleep disturbances, changes in appetite, social withdrawal, or fearfulness; behavior that slips back to an earlier phase such as bedwetting; signs of depression; erratic and aggressive behavior, a tendency to be easily distracted or forgetful, or an inability to sustain attention; self-destructive behavior such as head banging; or a tendency to have frequent injuries. It's important to address concerns early – mental, behavioral, or emotional disorders affect the way your child grows up.

PEOPLE TO TALK TO IF YOU ARE CONCERNED ABOUT YOUR CHILD

If you are concerned about your child's behavior, talk to your doctor. Ask questions and find out everything you can about the behavior or symptoms that worry you. Remember that every child is different, and even normal development varies from child to child. If your child is in daycare or preschool, ask the teacher if your child has shown any troubling changes in behavior, and discuss this with your doctor. Be sure to tell your doctor about extreme symptoms, such as self-injury, impulsive or aggressive behavior, persistent sadness, hyperactivity, or social withdrawal.

Ask your doctor whether your child needs further evaluation by a specialist in child behavioral problems. A variety of specialists, including psychiatrists, neurologists, psychologists, and behavioral therapists, and educators may be needed to help your child. Consistent follow-up is critical to successful treatment.

LEARNING ABOUT MEDICATIONS

The use of medication is not generally the first option for a preschool child with a psychiatric disorder. When medication is used, it should not be the only strategy. Family support services, educational classes on parenting strategies, behavior management techniques, and other approaches should be considered. If medication is prescribed, it should be monitored and evaluated closely and regularly. There are several categories of medications used for emotional and behavioral disorders: stimulants, anti-depressants, anti-anxiety agents, anti-psychotics, and mood stabilizers.

Stimulants

There are four stimulant medications that are approved for use in the treatment of attention deficit hyperactivity disorder (ADHD), the most common behavioral disorder of childhood. Children with ADHD exhibit symptoms such as short attention span, excessive activity, and impulsivity that cause substantial impairment in functioning. If the child attends school, collaboration with teachers is essential. These medications are labeled for pediatric use.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Adderal	amphetamines	3 and older
Cyclert	pemoline	6 and older
Dexedrine	dextro-amphetamine	3 and older
Ritalin	methylphenidate	6 and older

Anti-Depressant and Anti-Anxiety Medications

These medications are used for depression and for anxiety disorders, including obsessive compulsive disorder.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Anafranil	clomipramine	10 and older (OCD)
Luvox	fluvoxamine	8 and older (OCD)
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older (bedwetting)
Zoloft	sertranline	6 and older (OCD)

Other medications that are used to treat these disorders in children include Effexor (venlafaxine), Paxil (paroxetine), Prozac (fluoxetine), Serzone (nefazodone), and Wellbutrin (bupropion). They are not labeled for pediatric use.

Anti Psychotics

These medications are used to treat children with schizophrenia, bipolar disorder, autism, Tourette's syndrome, and severe conduct disorders.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Haldol	Haloperidol	3 and older
generic only	Thioridazine	2 and older
Orap	Pimozide	12 and older

There are other medications used to treat these disorders in children, including clozaril (clozapine), Risperidal (risperidone), seroquel (quetiapine), Zyprexa (olanzapine). These drugs are newer (atypical) antipsychotics, and have fewer side effects. These medications are not labeled for pediatric use.

Mood Stabilizers

These medications are used to treat bipolar disorder (manic depressive illness).

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Cibalith-S	lithium citrate	12 and older
Depakote	divalproex sodium	2 and older (for seizures)
Eskalith	lithium carbonate	12 and older
Lamictal	lamotrigine	16 and older (for seizures)
Lithobid	lithium carbonate	12 and older
Neurontin	gabapentin	12 and older (for seizures)
Tegretol	carbamazepine	any age (for seizures)

Research on the effectiveness of these another medications in children and adolescents with bipolar disorder are ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

FOR MORE INFORMATION ON MENTAL DISORDERS IN CHILDREN
CONTACT THE NATIONAL INSTITUTES OF MENTAL HEALTH 301 443 4513 / www.nimh.nih.gov



American Psychiatric Association
1400 K Street, NW
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FAX COVER

TO: Ruby

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FR: Jay Cutler

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

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

Message:

Ruby —

How the diagnosis comes into being
by the medical profession.

— Jay

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DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

DSM-IVTM



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AMERICAN PSYCHIATRIC ASSOCIATION
WASHINGTON, DC

Attention-Deficit/Hyperactivity Disorder

Diagnostic Features

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

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

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

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

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

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

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

Subtypes

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

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

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

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

Recording Procedures

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

Associated Features and Disorders

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

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

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

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

Specific Culture, Age, and Gender Features

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

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

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

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

Prevalence

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

Course

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

Familial Pattern

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

Differential Diagnosis

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

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

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

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

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

■ Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2):

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

Inattention

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- (b) often has difficulty sustaining attention in tasks or play activities

(continued)

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

- (c) often does not seem to listen when spoken to directly
 - (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
 - (e) often has difficulty organizing tasks and activities
 - (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
 - (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
 - (h) is often easily distracted by extraneous stimuli
 - (i) is often forgetful in daily activities
- (2) six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

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

Impulsivity

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

- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
- C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

(*continued*) •

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

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

Code based on type:

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

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

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

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

314.9 Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified

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

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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.

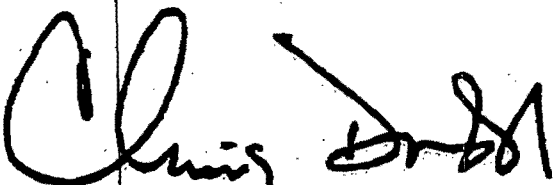
But, while progress has been made, we still have a long way to go to make sure that children are not an afterthought when it comes to drug research -- as the *JAMA* article so clearly highlights. As reported in *JAMA*, doctors are prescribing powerful psychiatric drugs like Ritalin and Prozac for preschoolers 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.

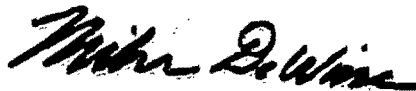
Therefore, we urge you to make the pediatric testing of psychiatric drugs a high priority for your agency. We strongly encourage you to work with pharmaceutical manufacturers to complete the pediatric research they have begun and to initiate research for those products not yet being studied. We also 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