Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton [partial] (1 page)	09/23/1999	b(6)
002. schedule	Schedule for Hillary Rodham Clinton [partial] (3 pages)	10/13/1999	b(6)
003. schedule	Schedule for Hillary Rodham Clinton [partial] (3 pages)	10/14/1999	b(6)
004. schedule	Schedule for Hillary Rodham Clinton [partial] (1 page)	03/20/2000	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 18538

FOLDER TITLE:
HRC Healthcare Book #13: Health Reform [3]

2013-0534-S
rc1789

RESTRICTION CODES

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

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

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

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

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

Clinton Presidential Records
Digital Records Marker

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

9/8/99: AIDS

Divider Title:_____

TALKING IT OVER

HILLARY RODHAM CLINTON

September 8, 1999

Twenty years ago, no one had ever heard of the human immunodeficiency virus. Yet, today, it is the fourth leading cause of death worldwide. In sub-Saharan Africa, AIDS is the leading cause of death, killing 5,500 people and infecting 11,000 new victims each day. In our own country, we learned just last week that the rate of HIV infections is no longer declining. Despite these grim statistics, though, there is cause for optimism.

Last year, on World AIDS Day, my husband spoke about the growing tragedy of children orphaned by AIDS, and directed his Office of National AIDS Policy to lead a fact-finding mission to Africa. What they found is a human, economic, political and social catastrophe that touches each and every one of us. If we don't take steps to stop it today, what we are witnessing in Africa will most likely be repeated in India, Southeast Asia and the Newly Independent States of the former Soviet Union.

Although AIDS kills indiscriminately, the disease is stalking women and young people in Africa disproportionately. More than half of all new HIV infections are among women, shattering families and placing extraordinary burdens on the villages that have been the backbone of the child-rearing tradition.
In addition to isolation and stigma, the destruction of families threatens child welfare in unprecedented ways. In many places, one-quarter of the children are living with an HIV-positive parent, and are destined to be orphaned by the end of this year. Over the course of the next decade, more than 40 million children will lose one or both parents to AIDS.

An entire generation of Africa's children is in

Talking It Over: 1999

- December 15, 1999
- December 8, 1999
- December 1, 1999
- November 24, 1999
- November 17, 1999
- November 10, 1999
- November 3, 1999
- October 27, 1999
- October 20, 1999
- October 13, 1999
- October 6, 1999
- September 29, 1999
- September 22, 1999
- September 15, 1999
- **September 8, 1999**
- September 1, 1999
- August 25, 1999
- August 18, 1999
- August 11, 1999
- August 4, 1999
- July 28, 1999
- July 21, 1999
- July 14, 1999
- July 7, 1999
- June 30, 1999
- June 23, 1999
- June 16, 1999

An entire generation of Africa's children is in jeopardy.

AIDS is not only causing unfathomable human suffering, it is also wiping out decades of progress on a host of development objectives. Life expectancy in Zimbabwe has dropped by an unbelievable 25 years. In the coming decade, child mortality will triple. In the Ivory Coast, one teacher per day dies of HIV/AIDS. And despite steady advances in access to education, a rapidly increasing number of children, particularly girls, is dropping out of school to work or care for dying parents. Far too few are finding their way back. In Zambia, 100,000 children, most orphaned by AIDS, are living on the streets of Lusaka. In an effort to survive, many are forced into crime, sex and drug operations, and we can only assume that HIV is spreading rapidly among them.

Not surprisingly, this extraordinary level of human devastation is jeopardizing economic growth and threatening political stability. Over the course of the next 20 years, it is predicted that AIDS will reduce the economies of sub-Saharan Africa by as much as 25 percent.

AIDS is not just an African problem. It is a worldwide problem, and it is time to act. Our efforts in this area must be part of our overall development policy. Leadership, combined with sustained investment, has made, and can continue to make, an extraordinary difference. Uganda's President Yoweri Museveni demonstrated bold leadership early in the epidemic by developing a plan to reduce the stigma and transmission as well as to support those who became sick. As a result, infection rates in urban Uganda have been cut in half.

Over the past decade, the United States has invested with the Ugandan government, other donors and non-governmental organizations to provide HIV prevention, care and support. When I was in Uganda, I saw the results at the AIDS Information Center I visited and on billboards exhorting Ugandans to protect themselves against the disease. Now, momentum is building, and other African leaders are speaking out as well.

In July, the Vice President, calling AIDS in Africa the "worst infectious disease catastrophe in the history of modern medicine," announced that the administration would seek the largest-ever budget increase in the global battle against AIDS, an increase that would allow us to more than double our efforts in sub-Saharan Africa. In addition, several new initiatives, including a UN Conference

June 9, 1999
June 2, 1999
May 26, 1999
May 19, 1999
May 12, 1999
May 5, 1999
April 28, 1999
April 21, 1999
April 14, 1999
April 7, 1999
March 31, 1999
March 24, 1999
March 17, 1999
March 10, 1999
March 3, 1999
February 24, 1999
February 17, 1999
February 10, 1999
February 3, 1999
January 27, 1999
January 20, 1999
January 13, 1999
January 6, 1999

on Children Orphaned by AIDS and a G-7 debt-relief agreement that will allow countries to target new resources for combating the disease, will encourage public and private groups around the world to become involved.

As part of this initiative, this week at the White House, I convened a meeting of senior government officials, corporate CEOs, representatives of the World Bank, the United Nations, international foundations and community groups to discuss how best to enhance and coordinate our AIDS efforts in Africa and around the world.

The global battle against AIDS has just begun, and we know the worst is yet to come. But the faces of the world's children beckon us -- especially members of Congress -- to act now. It is time to develop the capacity and partnerships we lack, not only to seek a vaccine, but also to care for those who are suffering from this dreadful disease today.

To find out more about Hillary Rodham Clinton and read her past columns, visit the Creators Syndicate web page at www.creators.com.

White House Weekly

September 13, 1999

SECTION: Vol.20, No.36

LENGTH: 844 words

HEADLINE: Talking It Over: **AIDS:** Act Now, Or Expect Even Worse

BYLINE: HILLARY RODHAM **CLINTON**

BODY:

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Although **AIDS** kills indiscriminately, the disease is stalking women and young people in Africa disproportionately. More than half of all new HIV infections are among women, shattering families and placing extraordinary burdens on the villages that have been the backbone of the child- rearing tradition.

In addition to isolation and stigma, the destruction of families threatens child welfare in unprecedented ways. In many places, one-quarter of the children are living with an HIV-positive parent, and are destined to be orphaned by the end of this year. Over the course of the next decade, more than 40 million children will lose one or both parents to **AIDS.**

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First lady **Hillary** Rodham **Clinton's** column is distributed by Creators Syndicate, Inc.

LOAD-DATE: November 5, 1999

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Divider Title: **9/23/99 Video: Women's Health**

SCHEDULE FOR HILLARY RODHAM CLINTON
THURSDAY, SEPTEMBER 23, 1999

FINAL

NEW YORK, NEW YORK / WASHINGTON, DC

NEW YORK

LEAD ADVANCE:	KEVIN PARKER	
	518/339-0550	CELL PHONE
NDI LEAD ADVANCE:	ERIC WOODARD	
	202/456-5708	PHONE
SCHEDULER:	EVAN RYAN	
	202/456-6751	PHONE
	202/456-5340	FAX
	202/483-0383	HOME
	WHCA PAGER	#4223

PREV RON — Private Residence
New York, New York

8:00 am — **DEPART** Private Residence
EN ROUTE 1345 Avenue of the Americas
[drive time: 5 minutes]

8:05 am — **ARRIVE** 1345 Avenue of the Americas

GREETERS:
Margo Alexander
Frank Savage

8:10 am-
9:35 am — **BREAKFAST FUNDRAISER**
Conference Room
41st Floor
Alliance Capital
1345 Avenue of the Americas
New York, New York
Hold: small conference room
Phone: 212/969-6876
Fax: 212/969-2118
CLOSED PRESS

FORMAT:
-HRC does a receiving line.

-HRC is seated.

-Breakfast is served.

-Margo Alexander makes remarks and introduces Fred Savage.

-Fred Savage makes remarks and introduces HRC.

-HRC makes remarks and departs.

PARTICIPANTS: 60-70 guests

CONTACT: John Loan 212/969-2331

9:40 am **DEPART** 1345 Avenue of the Americas
EN ROUTE Fun Quest
[drive time: 30 minutes]

10:10 am **ARRIVE** Fun Quest

GREETERS:
Fernando Ferrer, Bronx Borough President
Roberto Ramirez, Member of Assembly, Bronx County Chair

10:15 am- **MEET & GREET**
10:50 am Fun Quest
CLOSED PRESS

FORMAT:
-Receiving line.

-Fernando Ferrer makes brief remarks.

-Roberto Ramirez makes brief remarks and introduces HRC.

-HRC makes remarks and departs.

PARTICIPANTS: 50 guests

11:00 am **DEPART** Fun Quest
EN ROUTE Cleaner King
[walk time: 10 minutes]

11:10 am **ARRIVE** Cleaner King

11:15 am- **PRESS CONFERENCE**
11:45 am Outside Cleaner King
OPEN PRESS

FORMAT:
-Roberto Ramirez makes remarks and introduces Joey Aguiar.

-Joey Aguiar, Owner, Cleaner King, makes remarks.

-Miguel Cerda, plant manager, makes remarks.

-Fernando Ferrer makes remarks.

-HRC makes remarks.

11:50 am **DEPART** Cleaner King
EN ROUTE Ramirez Law Offices
[drive time: 5 minutes]

11:55 am **ARRIVE** Ramirez Law Offices

12:00 pm- **MEET & GREET**
12:15 pm Ramirez Law Offices
CLOSED PRESS

PARTICIPANTS: 10 local elected officials

12:20 pm **DEPART** Ramirez Law Offices
EN ROUTE 216 West 14th Street
[drive time: 40 minutes]

1:00 pm **ARRIVE** 216 West 14th Street

GREETERS:
Denny Farrell

1:05 pm-
1:45 pm

MEET & GREET
Union Hall
Union Offices
216 West 14th Street
New York, New York
Hold: Executive Conference Room
Phone: 212/242-2000 x291
Fax: 212/242-7772
CLOSED PRESS

PARTICIPANTS: 60-70 guests

1:45 pm-
2:15 pm

PRIVATE MEETING
Office
Union Offices
216 West 14th Street
New York, New York
Hold: Executive Conference Room
Phone: 212/242-2000 x291
Fax: 212/242-7772
CLOSED PRESS

PARTICIPANTS:
HRC
C. Virginia Fields, Manhattan Borough President

2:15 pm

DEPART 216 West 14th Street
EN ROUTE LaGuardia International Airport
[drive time: 35 minutes]

2:50 pm

ARRIVE LaGuardia International Airport

3:00 pm

WHEELS UP LaGuardia International Airport
EN ROUTE Andrews Air Force Base
[flight time: 50 minutes]

3:50 pm

WHEELS DOWN Andrews Air Force Base

4:00 pm

DEPART Andrews Air Force Base
EN ROUTE The White House
[drive time: 20 minutes]

4:20 pm

ARRIVE North Portico

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton [partial] (1 page)	09/23/1999	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 18538

FOLDER TITLE:
HRC Healthcare Book #13: Health Reform [3]

2013-0534-S
rc1789

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4:25 pm- 4:30 pm **PHOTO WITH** (b)(6) [001]
Foyer
The White House
CLOSED PRESS/WH PHOTO

CONTACT: Ann McCoy 202/456-2957

4:30 pm- 5:00 pm **DOWN TIME**

5:00 pm- 5:30 pm **PRIVATE MEETING**
Map Room
CLOSED PRESS/WH PHOTO

PARTICIPANTS:
HRC
President Vike-Frieberga of Latvia
Melanne Verveer
Steve Flanagan, NSC
Dick Norland, NSC
Latvian staff tbd

5:30 pm **PROCEED** to the OEOB

5:35 pm- 5:40 pm **MAMMOGRAPHY PSA TAPING**
Room 450
Old Executive Office Building
TAPING FOR BROADCAST/WH PHOTO

CONTACT: Brenda Anders 202/456-5654

5:45 pm- 6:15 pm **VIDEO TAPINGS**
Studio
Old Executive Office Building
CLOSED PRESS/WH PHOTO

TAPING:
- Vital Voices Trinidad
- A Family Celebration Gala
- Recognizing Leaders in Women's Health Awards
- Ralph Lauren Birthday Greetings

CONTACT: Brenda Anders 202/456-5654

6:20 pm **PROCEED** to the White House

6:25 pm- 6:50 pm **DOWN TIME**

6:50 pm **DEPART** North Portico
EN ROUTE The Washington Hilton
[drive time: 5 minutes]

6:55 pm **ARRIVE** The Washington Hilton

GREETERS:
Paul Kirk, Chairman, NDI
Kenneth Wollack, President, NDI
Jean Dunn, Vice President, NDI

7:00 pm- 7:30 pm **RECEIVING LINE**
Cabinet Room
Washington Hilton
Hold: Presidential Hold
Attire: Business
CLOSED PRESS/WH PHOTO

PARTICIPANTS: 70-80 guests

7:30 pm- 7:40 pm **HOLD**
Presidential Hold

7:40 pm- 9:40 pm **THE NATIONAL DEMOCRATIC INSTITUTE FOR INTERNATIONAL AFFAIRS' 1999 W. AVERELL HARRIMAN DEMOCRACY AWARD**
Ballroom
Washington Hilton
Hold: Presidential Hold
Attire: Business
OPEN PRESS

FORMAT:
-Kenneth Wollack introduces the President and the First Lady and President Eduard Shevardnadze and Mrs. Shevardnadze into the room, accompanied by Paul Kirk.

-Kenneth Wollack, President, NDI, makes welcoming remarks.

7:45 pm -Dinner is served.

8:30 pm -Paul Kirk, Chairman, NDI, makes remarks and introduces Senator Ted Kennedy.

-Senator Ted Kennedy makes remarks and presents award to President Eduard Shevardnadze.

-President Eduard Shevardnadze makes remarks.

-Paul Kirk introduces Monica McWilliams.

-Monica McWilliams presents award to the First Lady.

-The First Lady makes remarks.

-Kenneth Wollack introduces the President.

-The President makes remarks.

-Kenneth Wollack closes program.

-The President and the First Lady depart.

-The First Lady proceeds to the Cabinet Room and the President proceeds to Hold.

PARTICIPANTS: 650 guests

CONTACT: Erin Carper 202/797-4968

9:45 pm-
9:50 pm **INTERVIEW WITH ICELANDIC STATE TV**
Cabinet Room
The Washington Hilton
ICELANDIC STATE TV/WH PHOTO

PARTICIPANTS:
HRC
Johanna Vigdis Hjaltadottir, interviewer

9:55 pm **DEPART** The Washington Hilton
VIA Presidential Motorcade
EN ROUTE The White House
[drive time: 5 minutes]

10:00 pm **ARRIVE** South Portico

RON The White House

WEATHER FORECAST FOR NEW YORK, NEW YORK: Sunny, breezy and pleasant. High 78. Low 60.

WEATHER FORECAST FOR WASHINGTON, DC: Sunny and pleasant. High 74. Low 58.

VIDEOS

Date:	**September 23, 1999**
Time:	**5:30 PM**
Location:	**459 OEOB**
From:	**Eric Massey**

I. PURPOSE

To record 3 videos.

II. BACKGROUND

Vital Voices Trinidad

At the roundtable you hosted in Palermo, you met a woman from Haiti, who talked about how energized women from her country and region had been after Montevideo. In the aftermath of the Vital Voices conference in Montevideo, women from the Caribbean decided to host their own conference focusing on the common and unique challenges they face in their region. It is being put on jointly by the respective U.S. Embassies and the UN Information Agency. It will take place in Trinidad from September 29- October 1-- and will be attended by approximately 100 women from Haiti, Barbados, Belize, Dominican Republic, Trinidad and Tobago, Suriname, St. Lucia and other nations of the Caribbean. Your video greeting will be introduced by Ambassador Shumaker (SHOE-MAKE-ER) and played during the opening session at 9:00 am on the first morning of the conference. The conference will include sessions ranging from economic opportunity to legal reform to political participation.

A Family Celebration

The Director of the Children's United Nations, Daphna Edwards Ziman has asked you, to record a video for the first annual "A Family Celebration" fundraising and awards gala in Los Angeles on September 26, 1999. The proceeds of the event will go to the Child Welfare League of America, Associates for Breast & Prostrate Cancer Studies, We Care About Kids, the American Diabetes Association and the Elizabeth Knight Fund. The gala is divided into two parts. The first half will pay tribute to Gladys Knight and the ABC TV drama "The Practice". The second part will be the Child Welfare League of America Awards presentation to Shuki Levy (SHOE-KEY LEE-VEE), David Liederman, Bradley O'Leary, Shannon Reed and Daphna Edwards Ziman. You have been asked to congratulate the awardees and pay tribute to the organizations benefiting from the dinner.

The Gala is being held at the Century Plaza Hotel. Your video will be played at the beginning of the evening program to an audience of 2000.

Ralph Lauren Birthday Greetings

You have been asked to record a short birthday greeting for Ralph Lauren. The video will be part of a larger montage and is a surprise gift from his wife Ricky Lauren.

Women Legislators' Lobby's Recognizing Leaders in Women's Health Awards Dinner

You have been asked to record a video for the Women's Legislators' Lobby annual leaders in women's health award dinner. This year they will be recognizing Sen. Patti Murray (WA), Rep. Anna Eshoo (CA), Rep. John Porter (IL), State Representative Bessie Moody-Lawrence (SC), State Representative Nan Grogan Orrock (GA) and First Lady Sue Ann Thompson (WS). The dinner is underwritten by Wyeth-Ayerst (WHY-ETH AIR-EST) Laboratories and will take place at the Hotel Washington in Washington, DC. Your video will be shown at the beginning of the program to an audience of 300 state legislators and leaders in the women's health community.

Medicare Mammography PSA

You have been asked by the Office of Public Liason to re-record a PSA promoting the Medicare Mammography program. Your video segment will be rolled into a larger PSA featuring Jimmy Smitts and Whitney Houston. This is the third PSA you have taped.

You will be recording this video in OEOB # 450 when you have finished taping the ones above.

TALKING IT OVER

HILLARY RODHAM CLINTON

December 1, 1999

Ask any young parent whom they turn to first with questions and concerns about their children, and they're likely to answer, "The pediatrician." When our children are young, many of us call the pediatrician at the first sign of a sniffle. We rely on them to calm our anxieties about the full range of complaints -- from colic to chicken pox, bronchitis to boyfriends.

Last month, with overwhelming bipartisan support, Congress passed the Children's Hospitals Education and Research Act. Introduced by Congresswoman Nancy Johnson of Connecticut, and Senator Bob Kerrey of Nebraska, the bill will provide long overdue financial support to the very institutions -- the children's medical centers and teaching hospitals -- that are the most important training facilities for our children's doctors.

In an increasingly competitive health-care market, dominated by managed care, teaching hospitals struggle to cover the significant costs associated with training and research. While other teaching hospitals receive support for these costs through Medicare, children's hospitals receive virtually no federal funds, even though they train 30 percent of the nation's pediatricians and nearly 50 percent of all pediatric specialists. In many cases, they provide the regional safety net for children, regardless of medical or economic need, and they are the major centers of research on children's health problems.

Millions of American children each year are treated by physicians affiliated with or trained in one of 60 independent children's hospitals across the country. As I have traveled around the country over the past 25 years, I have had the opportunity to become acquainted with the valuable services many of them provide.

When Bill and I lived in Arkansas, one of Chelsea's pediatricians was Dr. Betty Lowe, the medical director of the Arkansas Children's Hospital, a facility dedicated exclusively to the care of children and the training of children's doctors. I was proud to have played a part in the development and expansion of this important regional facility, serving as a member of its board of directors for many years. I saw firsthand the miracles that happened there every day -- miracles that would have been impossible without the commitment of both its dedicated senior staff and its roster of talented medical residents.

Here in Washington, one of my favorite Christmas traditions is a visit to the Children's National Medical Center, widely considered one of the best pediatric hospitals in the nation, and the largest private provider of pediatric primary care in the Washington, D.C., region. The annual trip to Children's is also a favorite outing for Socks, who typically sits in my lap as I read holiday stories and answer questions from the young patients -- many of whom will spend their holidays in the hospital.

In recent years, I have made several trips to Children's Hospital in Boston, the nation's oldest children's hospital. In addition to treating young patients suffering from complex medical conditions, Children's runs the largest

pediatric training program in the country, and the largest pediatric research program in the world.

I have also spent time visiting the patients at Children's Mercy Hospital in Kansas City, Mo. There, I read to the youngsters as part of the hospital's Reach Out and Read program, which provides books for hospitalized children. Like Children's Mercy, pediatric hospitals around the country are dedicated to treating not only the immediate condition that brings sick or disabled children to the hospital, but also to improving their overall health and well-being.

Earlier this year, I invited a group of senior children's hospital administrators to the White House to discuss the burdensome costs of graduate medical education. A typical independent children's teaching hospital receives less than 1/200th, or .005 percent, of the Medicare graduate medical education support that other teaching hospitals receive. This inequity is only exacerbated by the fact that these centers face the additional costs of serving the poorest, sickest and most vulnerable children, as well as conducting research that benefits all children.

That day, I was pleased to announce that, in order to address this issue, the President would earmark $40 million in his FY2000 budget plan to provide federal financing of graduate medical education for freestanding children's hospitals. On average, hospitals could receive nearly $10,000 per resident, or almost $700,000 for each facility. We worked tirelessly to win these funds, and were extremely pleased that Congress authorized them in the budget agreement.

When the President signs the Children's Hospitals Education and Research Act, we will have taken an important first step toward putting children's teaching hospitals on an even footing with other medical education centers -- a critical investment in a healthy future for all our children.

To find out more about Hillary Rodham Clinton and read her past columns, visit the Creators Syndicate web page at www.creators.com.

Talking it Over

Read our Privacy Policy

White House Weekly

December 6, 1999

SECTION: Vol.20, No.48

LENGTH: 849 words

HEADLINE: Talking It Over: Bill Improves Health Of Children's Hospitals

BYLINE: HILLARY RODHAM **CLINTON**

BODY:

Ask any young parent whom they turn to first with questions and concerns about their children, and they're likely to answer, "The pediatrician." When our children are young, many of us call the pediatrician at the first sign of a sniffle. We rely on them to calm our anxieties about the full range of complaints-from colic to chicken pox, bronchitis to boyfriends.

Last month, with overwhelming bipartisan support, Congress passed the **Children's Hospitals Education and Research Act.** Introduced by Rep. Nancy Johnson of Connecticut, and Sen. Bob Kerrey of Nebraska, the bill will provide long overdue financial support to the very institutions- the children's medical centers and teaching hospitals-that are the most important training facilities for our children's doctors.

In an increasingly competitive health-care market, dominated by managed care, teaching hospitals struggle to cover the significant costs associated with training and research. While other teaching hospitals receive support for these costs through Medicare, children's hospitals receive virtually no federal funds, even though they train 30 percent of the nation's pediatricians and nearly 50 percent of all pediatric specialists. In many cases, they provide the regional safety net for children, regardless of medical or economic need, and they are the major centers of research on children's health problems.

Millions of American children each year are treated by physicians affiliated with or trained in one of 60 independent children's hospitals across the country. As I have traveled around the country over the past 25 years, I have had the opportunity to become acquainted with the valuable services many of them provide.

When Bill and I lived in Arkansas, one of Chelsea's pediatricians was Dr. Betty Lowe, the medical director of the Arkansas Children's Hospital, a facility dedicated exclusively to the care of children and the training of children's doctors. I was proud to have played a part in the development and expansion of this important regional facility, serving as a member of its board of directors for many years. I saw firsthand the miracles that happened there every day-miracles that would have been impossible without the commitment of both its dedicated senior staff and its roster of talented medical residents.

Here in Washington, one of my favorite Christmas traditions is a visit to the Children's National Medical Center, widely considered one of the best pediatric hospitals in the nation, and the largest private provider of pediatric primary care in the Washington, D.C., region. The annual trip to Children's is also a favorite outing for Socks, who typically sits in my lap as I read holiday stories and answer questions from the young patients-many of whom will spend their holidays in the hospital.

In recent years, I have made several trips to Children's Hospital in Boston, the nation's oldest children's hospital. In addition to treating young patients suffering from complex medical conditions, Children's runs the largest pediatric training program in the country, and the largest pediatric research program in the world.

I have also spent time visiting the patients at Children's Mercy Hospital in Kansas City, Mo. There, I read to the youngsters as part of the hospital's Reach Out and Read program, which provides books for hospitalized children. Like Children's Mercy, pediatric hospitals around the country are dedicated to treating not only the immediate condition that brings sick or disabled children to the hospital, but also to improving their overall health and well-being.

Earlier this year, I invited a group of senior children's hospital administrators to the White House to discuss the burdensome costs of graduate medical education. A typical independent children's teaching hospital receives less than 1/200th, or .005 percent, of the Medicare graduate medical education support that other teaching hospitals receive. This inequity is only exacerbated by the fact that these centers face the additional costs of serving the poorest, sickest and most vulnerable children, as well as conducting research that benefits all children.

That day, I was pleased to announce that, in order to address this issue, the president would earmark $40 million in his FY2000 budget plan to provide federal financing of graduate medical education for freestanding children's hospitals. On average, hospitals could receive nearly $10,000 per resident, or almost $700,000 for each facility. We worked tirelessly to win these funds, and were extremely pleased that Congress authorized them in the budget agreement.

When the president signs the **Children's Hospitals Education and Research Act,** we will have taken an important first step toward putting children's teaching hospitals on an even footing with other medical education centers-a critical investment in a healthy future for all our children.

First lady **Hillary** Rodham **Clinton's** column is distributed by Creators Syndicate, Inc.

LOAD-DATE: December 8, 1999

SCHEDULE FOR HILLARY RODHAM CLINTON
WEDNESDAY, OCTOBER 13, 1999

FINAL

WASHINGTON, DC / NEW YORK, NY / CHAPPAQUA, NY / NEW YORK, NY

LEAD ADVANCE:	MWITU NDUGU	
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	917-328-9499	CELL PHONE
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SITE ADVANCE:	JUSTIN KRONHOLM	
	212-246-7912	WORK
	917-532-5056	CELL PHONE
SITE ADVANCE:	DIANA REINHARDT	
	718-817-2187	HOME
SCHEDULER:	EVAN RYAN	
	202/456-6751	PHONE
	202/456-5340	FAX
	202/483-0383	HOME
	WHCA PAGER	#4223

PREV RON The White House

6:00 am **DEPART** South Portico
EN ROUTE Andrews Air Force Base
[drive time: 20 minutes]

6:20 am **ARRIVE** Andrews Air Force Base

6:30 am **WHEELS UP** Andrews Air Force Base
EN ROUTE LaGuardia International Airport
[flight time: 50 minutes]

7:20 am **WHEELS DOWN** LaGuardia International Airport

7:30 am **DEPART** LaGuardia International Airport
EN ROUTE 11 Madison Aveune
[drive time: 45 minutes]

8:15 am **ARRIVE** 11 Madison Avenue

27TH FLOOR GREETERS:
Ken Miller

8:20 am-
9:30 am **HRC EXPLORATORY COMMITTEE FUNDRAISING BREAKFAST**
The Great Hall
27th Floor
Credit Suisse
11 Madison Avenue
New York, New York 10010
Hold: Canadian Room
Phone: 212/325-6042
Fax: tbd
Staff Hold: Italian Room
Phone: 212/325-6046
CLOSED PRESS

FORMAT:
-HRC greets guests at tables.

-HRC is seated at the head table.

-Breakfast is served.

-Ken Miller makes remarks and introduces HRC.

-HRC makes brief remarks and has the option of taking q&a.

-HRC departs.

PARTICIPANTS: 35 guests

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. schedule	Schedule for Hillary Rodham Clinton [partial] (3 pages)	10/13/1999	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 18538

FOLDER TITLE:
HRC Healthcare Book #13: Health Reform [3]

2013-0534-S
rc1789

RESTRICTION CODES

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

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

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

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

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

9:35 am — **DEPART** 11 Madison Avenue
EN ROUTE (b)(6) [0021]
[drive time: 20 minutes]

9:55 am — **ARRIVE** (b)(6)

10:00 am-
11:45 am — **DOWN TIME**

11:45 am — **DEPART** (b)(6)
EN ROUTE 375 Park Avenue
[drive time: 10 minutes]

11:55 am — **ARRIVE** 375 Park Avenue

NOTE: (b)(6)

5TH FLOOR GREETER:
(b)(6)

12:00 pm-
12:45 pm — **PRIVATE MEETING**
5th Floor
Seagram's Executive Offices
375 Park Avenue
New York, New York 10022

(b)(6)

CLOSED PRESS

PARTICIPANTS:
HRC
(b)(6)

12:50 pm — **DEPART** 375 Park Avenue
EN ROUTE 90 Park Avenue
[drive time: 10 minutes]

1:00 pm — **ARRIVE** 90 Park Avenue

26TH FLOOR GREETERS:
(b)(6)

1:05 pm-
1:35 pm **PRIVATE MEETING**
(b)(6)
26th Floor
Warnaco, Inc.
90 Park Avenue
26th Floor
New York, New York 10016
Hold: tbd
Phone: tbd
Fax: tbd
CLOSED PRESS

PARTICIPANTS:
HRC
(b)(6)

1:40 pm **DEPART** 90 Park Avenue
EN ROUTE Louis Calder Center Biological Station
[drive time: 1 hour]

2:45 pm **ARRIVE** Louis Calder Center Biological Station

GREETERS: tbd

3:00 pm-
3:40 pm **PRESS CONFERENCE ON PUBLIC HEALTH ISSUES**
Louis Calder Center Biological Station
53 Whippoorwill Road
Armonk, New York
OPEN PRESS

FORMAT:
-Dr. James Wehr makes welcoming remarks and introduces Andy Spano.

-Andy Spano makes remarks and introduces Dr. Doug Aspros.

-Dr. Doug Aspros makes remarks and introduces HRC.

-HRC makes remarks and departs.

3:45 pm **DEPART** Louis Calder Center Biological Station
EN ROUTE 959 8th Avenue
[drive time: 1 hour, 15 minutes]

5:00 pm **ARRIVE** 959 8th Avenue

5:05 pm- **DROP-BY** with (b)(6)
5:10 pm Ellen Levine's Office
5th Floor
959 8th Avenue
New York, New York
Phone: 212/649-2477
Fax: 212/247-3248
CLOSED PRESS

PARTICIPANTS:
HRC
(b)(6)

5:15 pm- **GOOD HOUSEKEEPING MAGAZINE RECEPTION**
5:45 pm Dining Room
6th Floor
959 8th Avenue
New York, New York
Hold: Ellen Levine's Office
Phone: 212/649-2477
Fax: 212/247-3248
GOOD HOUSEKEEPING PHOTO

FORMAT:
-Ellen Levine, editor-in-chief of Good Housekeeping magazine, makes welcoming remarks.

-Amy Langer, National Alliance of Breast Cancer Organizations, makes remarks and introduces Dr. Deborah Axelrod.

-Dr. Deborah Axelrod makes remarks and introduces HRC.

-HRC makes remarks and departs.

PARTICIPANTS: 65 guests

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. schedule	Schedule for Hillary Rodham Clinton [partial] (3 pages)	10/14/1999	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 18538

FOLDER TITLE:
HRC Healthcare Book #13: Health Reform [3]

2013-0534-S
rc1789

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SCHEDULE FOR HILLARY RODHAM CLINTON
THURSDAY, OCTOBER 14, 1999

FINAL

NEW YORK, BOLTON LANDING, LAKE PLACID, NEW YORK / NEW YORK

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	1-888-434-7935	PAGER
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SITE ADVANCE:	PETE SELFRIDGE	
	212-669-7623	WORK
	212-255-3770	HOME
SITE ADVANCE:	KEVIN PARKER	
	718-859-9280	HOME
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	212-289-6185	HOME
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	212-246-7912	WORK
	917-532-5056	CELL PHONE
SITE ADVANCE:	DIANA REINHARDT	
	718-817-2187	HOME
BOLTON LANDING		
LAKE PLACID		
LEAD ADVANCE:	STEVE FEDER	
	LAKE PLACID HILTON	ROOM 727
	518/523-4411	PHONE
	518/523-1120	FAX
	917/576-1780	CELL PHONE
SCHEDULER:	EVAN RYAN	
	202/456-6751	PHONE
	202/456-5340	FAX
	202/483-0383	HOME
	WHCA PAGER	#4223

PREV RON

(b)(6)

C003)

8:00 am **DEPART** (b)(6)
EN ROUTE 540 Park Avenue
[drive time: 5 minutes]

8:05 am **ARRIVE** 540 Park Avenue

GREETER: Christopher Kinable

8:05 am-
9:05 am **HRC EXPLORATORY COMMITTEE FUNDRAISING BREAKFAST**
The Regency
540 Park Avenue
New York, New York
Hold: Mirror Room
Phone: 212/339-4184
Fax: 212/339-4004
CLOSED PRESS

FORMAT:
-HRC works the tables.

-Wendy Paulsen makes remarks and introduces HRC.

-HRC makes remarks and departs.

PARTICIPANTS: 40 guests

9:10 am **DEPART** 540 Park Avenue
EN ROUTE LaGuardia International Airport
[drive time: 40 minutes]

9:50 am **ARRIVE** LaGuardia International Airport

9:55 am **WHEELS UP** LaGuardia International Airport
EN ROUTE Floyd Bennett Airport, Glen Falls, NY
[flight time: 40 minutes]

10:35 am **WHEELS DOWN** Floyd Bennett Airport, Glen Falls, NY
FBO: Empire East Aviation Inc.
Phone: 518/798-3091
Fax: 518/798-3152

10:40 am **DEPART** Floyd Bennett Airport, Glen Falls, NY
EN ROUTE Sagamore Resort
[drive time: 35 minutes]

11:15 am **ARRIVE** Sagamore Resort

GREETERS:
Robert and Jane McIntosh, President of Sagamore Resort and wife
Laura Curtis, Director of Rooms
Hal Powell, Residential Manager
Dan Sisto, President, Healthcare Association of NY State
Michael Bragman, Majority Leader

11:25 am-
11:55 am **HEALTHCARE ASSOCIATION OF NEW YORK STATE**
Belleview Room
Sagamore Resorts
Sagamore Road
Bolton Landing, NY
Hold: Abenia Room
Phone: 518/743-6451
Fax: 518/743-6452
OPEN PRESS

FORMAT:
-Dan Sisto, President, Healthcare Association of NY State makes remarks and introduces HRC.

-HRC makes remarks.

-HRC works a ropeline and departs.

PARTICIPANTS: 500 guests

12:00 pm-
12:20 pm **MEET & GREET** with local electeds
Evelley Room
Sagamore Resorts
Sagamore Road
Bolton Landing, NY
Hold: Abenia Room
Phone: 518/743-6451
Fax: 518/743-6452
CLOSED PRESS

PARTICIPANTS: 35-40 local electeds

12:25 pm **DEPART** Sagamore Resort, Bolton Landing, NY
EN ROUTE Olympic Center, Lake Placid, NY
[drive time: 90 minutes]

1:55 pm **ARRIVE** Olympic Center, Lake Placid

GREETERS:
Stu Brody, Essex County Chair
Shirley O'Connell, Clinton County Chair
Joseph Pickreign, Franklin County Chair
Gerald Morrow, Dean of the Democratic Supervisors
Clifford Donaldson, County Manager
Barbara Joyce, President NY Nurses Association
Phyllis Collins, President-elect, NY Nurses Assoc.
Martha Orr, Executive Director, NY Nurses Assoc.
Arlene Day, Convention Sales, Olympic Center

2:00 pm- **MEET & GREET** with local electeds
2:20 pm Haystack & Skylight Rooms
Olympic Center
Lake Placid, New York
Hold: Whiteface Room
Phone: tbd
Fax: 518/523-2605 (convention offices)
CLOSED PRESS

PARTICIPANTS: 40 local electeds

2:25 pm- **NEW YORK NURSES ASSOCIATION**
2:55 pm Lussi Rink
Olympic Center
Lake Placid, New York
Hold: Whiteface Room
Phone: tbd
Fax: 518/523-2605 (convention offices)
OPEN PRESS

FORMAT:
-Barbara Joyce, President, New York Nurses Association, makes remarks and introduces HRC.

-HRC makes remarks.

-HRC works a ropeline and departs.

PARTICIPANTS: 500 guests

3:05 pm **DEPART** Olympic Center
EN ROUTE Adirondack Regional Airport
[drive time: 25 minutes]

3:30 pm **ARRIVE** Adirondack Regional Airport
Phone: 518/891-4600
Fax: 518/891-6330

3:40 pm **WHEELS UP** Lake Placid Airport
EN ROUTE LaGuardia International Airport
[flight time: 45 minutes]

4:25 pm **WHEELS DOWN** LaGuardia International Airport

4:30 pm **DEPART** LaGuardia International Airport
EN ROUTE Corzine Showroom, 979 Third Avenue
[drive time: 45 minutes]

5:15 pm **ARRIVE** Corzine Showroom

GREETERS:
Nancy Corzine
Andrea Stark

5:20 pm-
6:50 pm **HILLARY 2000 EXPLORATORY COMMITTEE FUNDRAISER**
Corzine Showroom
979 Third Avenue
#804
New York, New York
CLOSED PRESS

FORMAT:
-HRC does a receiving line with guests.

-Andrea Stark makes remarks and introduces Nancy Corzine.

-Nancy Corzine introduces HRC.

-HRC makes remarks and departs.

PARTICIPANTS: 65 guests

6:55 pm **DEPART** 979 Third Avenue
EN ROUTE (b)(6)
[drive time: 40 minutes]

7:35 pm **ARRIVE** (b)(6)

GREETERS:
(b)(6)

7:40 pm- **HOUSE PARTY**
9:10 pm
(b)(6)

CLOSED PRESS

FORMAT:
-HRC does a receiving line with guests.

-HRC makes remarks.

-HRC departs.

PARTICIPANTS: 65 guests

9:15 pm **DEPART** (b)(6)
EN ROUTE (b)(6)
[drive time: 30 minutes]

9:45 pm **ARRIVE** (b)(6)

RON
(b)(6)

WEATHER FORECAST FOR NEW YORK, NEW YORK: Mostly sunny. Very windy. High 63. Low 52.

WEATHER FORECAST FOR GLEN FALLS AND LAKE PLACID, NEW YORK: Sunny. High 48. Low 29.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

11/30/99 AIDS

Divider Title:_____

November 30, 1999

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: **Brenda Costello**
SUBJECT: **Briefings for Wednesday, December 1**

World AIDS Day Symposium: *The Children Left Behind*
-Briefing
-Program
-VIPs
-Background on children orphaned by AIDS
-"Call to Action for 'Children Left Behind' by AIDS," 12/1/99
-Background on Compulsory Licensing
-Memo from Sandy Thurman re: Need for Enhanced Response to AIDS crisis in Africa/World
-Press Release, "Vice President Gore Announces Administration Will Seek $100 million Initiative," 7/19/99
-"AIDS Epidemic Update": December 1999, *UNAIDS/WHO*

Massachusetts Background
-Political Briefing
-Administration Accomplishments

Drop-by Dick Friedman Book Party
-Guest List
-Background on Henrietta, by David Mamet

Remarks
-World AIDS Day Symposium

November 30, 1999

WORLD AIDS DAY SYMPOSIUM

DATE:	**Wednesday, December 1**
TIME:	**10:35am – 11:35am**
LOCATION:	**United Nations Headquarters**
	New York, NY
FROM:	**Brenda Costello**

I. PURPOSE

To deliver the keynote address at the United Nations World AIDS Day International Symposium, "The Children Left Behind."

II. BACKGROUND

As you know, December 1st is World AIDS Day. The United Nations and the National Black Leadership Commission on AIDS (BLCA) are holding a one-day international symposium to address issues affecting children orphaned by the loss of their parents to AIDS. The United Nations has designated this symposium, entitled "The Children Left Behind," as the official UN event in observance of World AIDS Day 1999.

The symposium is an outgrowth of one of the recommendations submitted to the President following the presidential fact-finding mission to sub-Saharan Africa by Sandy Thurman, White House Office of National AIDS Policy Director. You were invited to deliver the keynote address by BLCA Board of Directors Chairman David N. Dinkens. Event co-sponsors include the Magic Johnson Foundation, the White House Office of National AIDS Policy, the United National Department of Public Information, the Joint United Programme on HIV/AIDS (UNAIDS) and UNICEF.

"The Children Left Behind" Symposium
Wednesday's symposium will consist of a morning and afternoon session, each beginning with welcoming remarks followed by panels/presentations on *Child Care, Child Welfare and Clinical Issues* and *Finance and Funding Issues*. The closing segment begins with a film screening of Epidemic Africa, introduced by Sandy Thurman, followed by remarks from UN Secretary General Kofi Annan Queen Noor and Peter Piot, Executive Director, UNAIDS.

An audience of 800 representatives of the international AIDS community is expected to attend, including program participants Geri Benoit-Preval, First Lady of Haiti, Cong. Charles Rangel Magic Johnson and Rev. Jesse Jackson.

The FY 2000 Budget includes an additional $100 million to address the global AIDS crisis, more than doubling our efforts to fight AIDS in Africa ($65 million for USAID and $35 million for HHS).

Format

You will deliver you remarks in the first of two session of the symposium. The morning session will include an opening segment, followed by presentations from three children orphaned by AIDS and your keynote address (children's background attached).

You will meet briefly with VIPs just prior to your remarks (list attached).

III. PARTICIPANTS

-The First Lady
-Alexandra Burke, *Childrens' Express* reporter (age 15)
-Paris Lane, USA, 17 years old
-Khomsan Sang-sue-moon, Thailand, 13 yrs old
-Andrew Jackson Okurut, Uganda, 13 years old
-Kensaku Hogen, Under-Secretary General for Communications and Public Information

IV. SEQUENCE OF EVENTS

- The First Lady enters Conference Room #4 and takes seat in front row.
- Alexandra Burke, a 15 year-old reporter for *Children's Express*, makes remarks and introduces three children who will each give short remarks (speaking order tbd):
  -Paris Lane, USA, 17 years old
  -Khomsan Sang-sue-moon, Thailand, 13 yrs old
  -Andrew Jackson Okurut, Uganda, 13 years old
- At conclusion of children's' remarks, Kensaku Hogen will make an off-stage announce for The First Lady to join the children on-stage.
- The First Lady proceeds on-stage and takes seat between the children.

NOTE: The First Lady and children are seated behind a table and remarks are delivered from a seated position at the table.

- The First Lady delivers keynote address.
- The First Lady departs

V. PRESS

Open press.

VI. REMARKS

Provided by June Shih.

WORLD AIDS DAY

Wednesday, 1 December 1999
Conference Room 4

The Children Left Behind:
A symposium on children orphaned by AIDS
in observance of World AIDS Day

Morning Session

WELCOMING REMARKS

Kensaku Hogen, Under-Secretary-General for Communications and Public Information

OPENING SEGMENT 10:00 a.m. - 11:15 a.m.

Theo-Ben Gurirab, President of the fifty-fourth session
of the United Nations General Assembly
Louise Fréchette, Deputy Secretary-General of the United Nations
Peter Piot, Executive Director, UNAIDS

Children orphaned by AIDS:
[illegible] (U.S.A.)
Khomsan Sang-sue-moon (Thailand)
Andrew Jackson Okurut (Uganda)
*Moderated by **Alexandra Burke,** Reporter, Children's Express*

Hillary Rodham Clinton, First Lady of the United States

FIRST PANEL 11:15 a.m. - 1:00 p.m.
CHILD CARE, CHILD WELFARE and CLINICAL ISSUES

Andrew Billingsley, Professor, University of South Carolina
Urban Johnsson, Regional Director, Eastern and Southern Africa, UNICEF
Mechai Viravaidya, Chairman, Population & Community Development Association, Thailand
and UNAIDS Ambassador
Geri Benoît-Préval; First Lady of Haiti
Beatrice Were, Coordinator, National Community of Women Living with HIV/AIDS, Uganda

LUNCHEON 1:15 - 2:45 p.m.
Delegates Dining Room

Hosted by **Debra Fraser-Howze**, President and CEO,
National Black Leadership Commission on AIDS, Inc.,
Earvin "Magic" Johnson, UN Messenger of Peace and
Cookie Johnson

Keynote address by **Rev. Jesse Jackson**
Remarks by **US Cong. Rep. Charles B. Rangel** (D, NY)

Sponsored by **Bristol-Myers Squibb**

Afternoon Session

WELCOMING REMARKS

David Dinkins, Chairman of the Board of Directors, BLCA
Nils Daulaire, President, Global Health Council

SECOND PANEL 3:00 p.m. - 4:30 p.m.
FINANCE and FUNDING ISSUES

Kenneth E. Weg, Vice-Chairman, Bristol-Myers Squibb
Elmi Watanabe, Assistant Administrator and Director,
Bureau for Development Policy, UNDP
Hirofumi Ando, Deputy Executive Director, Policy and Administration, UNFPA
Callisto E. Madavo, Vice-President for the Africa Region, World Bank
Eka Esu-Williams, President, Society of Women and AIDS in Africa

CLOSING SEGMENT 4:30 p.m. - 6:00 p.m.

Film screening of EPIDEMIC AFRICA
*with Introduction by **Sandra L. Thurman**, Director,*
White House Office of National AIDS Policy

Introductions by **Harry Belafonte**, Goodwill Ambassador, UNICEF

Kofi Annan, Secretary-General of the United Nations
Her Majesty Queen Noor Al Hussein of Jordan
Peter Piot, Executive Director, UNAIDS: "A Call to Action"

RECEPTION 6:30 - 8:30 p.m.
Waldorf Astoria Starlight Room

Hosted by the **Magic Johnson Foundation**
Mpule Kwelagobe, Miss Universe 1999, will accept a donation of toys from the Magic Johnson Foundation for children from countries featured in the programme

WORLD AIDS DAY SYMPOSIUM 12/1/99

LIST OF VIPs

Theo-Ben Gurirab, President of the 54th session of the
General Assembly and Foreign Minister of Namibia
Louis Fréchette, Deputy Secretary-General
Geri Benoît-Préval, First Lady of Haiti
Her Majesty Queen Noor Al Hussein of Jordan
Harry Belafonte, Goodwill Ambassador, UNICEF
Mpule Kwelagobe, UNFPA Goodwill Ambassador and Miss Universe 1999
Mrs. Nane Annan
Jeanne Moutoussamy Ashe
Earvin "Magic" Johnson, UN Messenger of Peace

Hello my name is Paris Lane I live in Harlem. I am here to talk to you today to talk about what it's like after losing both parents to the AIDS virus.

1. Dealing with feelings after my parents passed away
    a. felt like life was over
    b. reacted to situation, not thinking about consequences
2. Dealing with family after my parents passed away
    a. Separated from brother and sisters
    b. never found out how they felt about parents' death
    c. other family members did not want to get involved
3. Problems I faced and situations I got myself into
    a. stayed out all night
    b. never really cared about anybody else's feelings
    c. did illegal things and got locked up

4. Even though your parents are gone your life is not over
    a. you still have family and friends
    b. thinking about future of sisters and brother made him think twice about illegal activity
    c. live on and do something to make my parents proud

5. Live with family -
attending private School - Honor student

Future Goals

KHOMSAN SANG-SUE-MOON

Age: 14 years

Address: 7/1 Baan Mae Kee, Moo 3, Pa Sang Sub-District
Mae Chan District, Chiang Rai Province 57110, Thailand

Both parents died of AIDS. Khomsan now lives with his uncle and is in Grade 8 (the second year of secondary school). Khomsan represents not only a case of AIDS orphan but also of a child from broken family. He, however, has a very good support from his uncle. He is supported by UNICEF through their district-based project for caring for children affected by AIDS.

Khomsan Sang Sue Moon's Statement
1 December, *The Children Left Behind*
United Nations, New York

My name is Khomson Sang Sue Moon. I'm 14 years old. I live in the northern part of Thailand. My family lives in Maechan District Chiang rai Thailand. My parents died of AIDS. My mother died when I was 11 months old. I can't remember my mother. I lived with my father until I was 12 years old. My father was sick -- he lost a lot of weight and looked very weak before he died. I remember him well. I don't want to believe that he died of AIDS. Now I live with my uncle. He is a good parent. He supports me a lot.

I don't think AIDS is a dangerous disease because it can be prevented easily. I want everybody in the world to offer care and support for people living with HIV/AIDS. It is not good to isolate and discriminate against people living with HIV/AIDS.

I think children affected by AIDS in my country can live in the society and community because they can receive help from my government and non-governmental organizations.

I lost both of my parents to AIDS. I cannot explain my feelings. If the community isolates children who are affected by AIDS, then they become more vulnerable to HIV infection.

I think that if people living with AIDS in today's world are not isolated and discriminated against, then the problem of AIDS would be easy to solve.

I thank everyone for helping me and my friend. I will help other children who are orphaned by AIDS and hope they will have a good future.

Thank you.

Children left behind: Children Orphaned by AIDS

A presentation made in observance of World AIDS Day

Wednesday, 1, December 1999, New York, USA

By Andrew Jackson Okurut, Uganda

Contact Address: National Community of Women living with HIV/AIDS in Uganda - NACWOLA
P.o.Box 4485 Kampala, Uganda
Tel/fax 256 41 269694
E-mail; nacwola@infocom.co.ug

My name is Andrew Jackson Okurut. I am 13 years old and the last child in my family. I am one of the million orphans from Africa who have lost parents due to AIDS.

Due to AIDS I have lived a fatherless life having lost my father when I was five months old. I have no idea of what my father looked like, what his voice or footsteps sounded like! People tell me I resembled my late father - I just have to believe them anyway.

I lived with my mother, a brother and sister for thirteen years. I painfully knew that my mother had AIDS but I did not believe she would die.

For two years I witnessed my mother go through pain and helplessness.
On the 24th. September this year the dark day struck my life! My mother died leaving us helpless.

My greatest fears since then have been:

- I live without that love of my parents which most children are fond of.
- I feel very lonely most of the time as I miss my mother and father.
- I am uncertain about continuation in school and my future.
- I am uncertain about our home, as we have to leave the government house where our parents left us.
- My mother's plan to build us a house could not mature as she died before completing the structure.

I have had some sources of support during the hard time of my life.
I need to mention the support I have received from The AIDS Support Organisation-TASO. They have paid my school fees for the last 5 years till the end of my primary school.

The National Community of Women living with HIV/AIDS -NACWOLA who offered my mother moral and emotional support. They guided me to compile a Memory book. This book contains important family history and information about my family values. It helps to grow up without a parental hand.
My mother was guided to write a will, which she left behind, for our security.

We have a kind auntie who watches over us two times in a week.

I wish to make this important call today: -
The governments of the world, donors and the U.N must recognise the special needs of AIDS orphans. These needs include our education, food, shelter and clothing.

- AIDS orphans should have full participation in planning and running programmes that target them.

- Conflict situations and wars must come to an end as they worsen our situation.

We are tomorrow's world and future. Our voices are small so please help us to blow the whistle and please listen to it!

Embargoed until
1 December 1999 - 5:30 a.m. EST

grandparents

Call to Action for 'Children Left Behind' by AIDS

A plea for communities, governments, civil society, the private sector and international partners to vigorously address the plight of children who are affected by the AIDS epidemic.

Issued by the Joint United Nations Programme on HIV/AIDS (UNAIDS), The United Nations Children's Fund (UNICEF) and the National Black Leadership Commission on AIDS, Inc. (BLCA)

Background

The new millennium dawns on a world facing an unprecedented human tragedy - the loss of millions of people to the AIDS epidemic. More than 16 3 million people have died. By the end of the year 2000, a cumulative total of 13 million children will have lost their mother or both parents to AIDS, and 10 4 million of them will still be under the age of 15.

More than 90 per cent of children orphaned by AIDS are in sub-Saharan Africa, and the numbers are increasing daily. In the next decade, the numbers of orphans are also expected to increase in Asia, the Americas, Central and Eastern Europe and the countries of the Commonwealth of Independent States. In industrialized countries, deaths have declined significantly, but AIDS remains a deadly menace in the absence of an effective cure.

The onslaught of AIDS on people of reproductive age is increasing the numbers of orphans at such a rate that communities cannot rely on traditional means of caring for these children. This is particularly true in many sub-Saharan African countries lacking adequate basic social welfare services. The inability of communities to respond adequately and appropriately to the situation has resulted in social, psychological and economic deprivation for the children, and this is likely to continue for the long term. Such deprivation is worse for girls whose parents have died, as these girls often have to care for their siblings and take on extra work, thereby reducing their opportunities for schooling.

Of course, AIDS affects children long before their parents die. The toll taken by the disease begins during the period of illness, continues through death and bereavement and will likely persist into adulthood if adequate support and protection are lacking. These extremely vulnerable children can suffer myriad problems and human rights abuses: the terrible stress of watching parents fall ill and die, grief for lost family members, a decline in nutritional status; loss of health care; increased demands for their labour; reduced opportunities for education; loss of inheritance; homelessness; discrimination; physical abuse, and sexual abuse, which in turn exposes them to HIV infection.

The absence of parental protection and care, combined with HIV-related illnesses, has contributed significantly to the increase in deaths of children under five in the countries most affected. AIDS has undermined the capacity of communities and households to cope and is hindering efforts to achieve goals for the survival and development of children, including the year 2000 goals agreed to by world leaders at the 1990 World Summit for Children.

Specific needs of children and families affected by HIV/AIDS

The onset of AIDS, in many developing countries, marks the beginning of a transition from poverty to complete destitution. The reality is most bleak in the worst-affected areas of sub-Saharan Africa, where over 50 per cent of the population lives below the poverty line.

Despite many obstacles, however, threatened communities around the world are struggling to support orphans and families affected by HIV and AIDS. However, among the constraints are the sheer numbers of orphans, which have the potential to overwhelm these efforts, the urban focus of many programmes, which therefore reach relatively few people, and limited coordination with government These constraints have prevented the needs and rights of many children and families from being addressed.

With the relentless toll of AIDS reducing the ability of families and communities to support and care for children, we now face troubling scenarios: grandmothers struggling to care for orphans; households headed by children, many of them primary-school age, who are caring for younger siblings; and worse, children with nowhere at all to turn. Often compounding the devastation caused by AIDS is armed conflict, which poses the additional challenges of forced migration, displaced populations and further violations of rights.

These multiple crises surrounding AIDS call for the urgent and full engagement of all levels of society, which have a guide for action in two key international conventions: the Convention on the Rights of the Child (CRC), ratified by 191 countries, and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), ratified by 165 countries as of November 1999. By ratifying, countries have made themselves accountable for addressing the rights and needs of children and women, including those affected by HIV or AIDS.

Call to Action

This call is a plea for communities, governments, civil society, the private sector and international partners to vigorously address the plight of children who are affected by AIDS epidemic. Urgent action to meet their needs and ensure the realization of their rights is needed at three levels: family and community, government and global.

I. Family and community level

'Keep families and communities at the front line' **by empowering and supporting them to care for orphans.** Lessons from community initiatives over the past 15 years point to the following actions as essential:

- **Foster active participation of the community,** including people living with HIV or AIDS, in identifying and implementing actions to strengthen community-based care and support for orphans.
- **Increase women's access to credit, income-generating activities and property, including land,** because the burden of care tends to fall on poor women with few resources. In many cases, such action will require changing laws and policies regarding inheritance and property ownership.
- **Establish widespread confidential counselling and voluntary testing** for HIV. The benefits of such counselling include prevention of mother-to-child-transmission, promotion of the rights of girls and women to make informed decisions and realization of people's right to know their HIV status.
- **Target social assistance to all families in need, not just those grappling with AIDS,** as a way of ensuring equity and discouraging discrimination against orphans and others affected by AIDS.
- **Reduce demands on the labour of girls and women:** In many parts of Africa, for example, improving access to water and fuel for heating and cooking would free up more time for girls and women, allowing more girls to obtain a basic education, as is their right
- **Respond to the psychosocial needs of orphans** through counselling services for children and families in need. School and home-based care and services should ensure in particular that children develop emotionally and intellectually through play and other activities and that they feel a sense of belonging to their communities
- **Encourage community leaders to protect the legal rights of children and women,** especially those of widows and orphans. This will involve changing harmful practices and customary laws that are discriminatory or exploitative.

II. Government level

'Break the conspiracy of silence'**: The success of governments will be measured by their ability to prevent HIV and to enable families and communities to cope with the effects of the epidemic.** Governments need to take action in three key areas:

Advocacy and social mobilization

- **Actively combat discrimination.** Raise the visibility of AIDS while combating the shame and stigma associated with the disease
- **Raise public awareness** of the nature of the crisis and mobilize resources locally and internationally
- **Encourage the full participation of communities in all aspects of the response to AIDS.** Ensure that people living with HIV or AIDS and those caring for them are involved at every step — including planning, implementation, monitoring and evaluation

Priorities and reform

- **Develop priority national policies in support of HIV prevention and mitigation of the impact of AIDS.** Focus on protecting younger children and girls and on providing young people with *effective* education on HIV and AIDS and on related reproductive health issues. Encourage prevention programmes involving peer educators.

- **Mobilize widespread support for the fight against AIDS** and establish frameworks linking efforts of government, civil society, including religious organizations, non-governmental organizations, the private sector and communities to use resources most efficiently

- **Ensure access to education, especially for girls,** by introducing specific measures such as subsidies, scholarships and the provision of alternative avenues for high-quality education, such as community schools.

- **Reform the education sector to respond better to the needs of orphans and their communities.** The traditional approach to education needs to be overhauled to make schools more participatory and responsive to the everyday needs of students and more relevant to their lives. It is essential that schools help students acquire skills that can enable them to make informed decisions and avoid risks. Teacher training and support is pivotal to this effort.

- **Reform the health sector to emphasize HIV prevention and the provision of quality health care services** that can address the needs of children and communities affected by AIDS.

- **Introduce and enforce laws that realize the rights of children and women,** emphasizing social welfare and the best interests of the child. Focus on protection issues such as child abuse and rape, children in commercial sex work, exploitative child labour, juvenile justice, and children and women who lack secure tenure and are denied property ownership.

Monitoring and evaluation

- **Identify, assess and document successful community-based initiatives** with a view to expanding them into effective national or intercountry programmes.

- **Monitor the impact of HIV and AIDS on children and families at all levels** and use the information gathered to take targeted action.

- **Equip communities to monitor the local impact of the epidemic, facilitate action and evaluate interventions.**

III. Global level

'Keep children orphaned by AIDS high on the global agenda': Governments, donors, the private sector and international organizations have a moral obligation to act comprehensively and quickly in addressing the rights and needs of AIDS orphans. Their efforts can focus on these actions:

- **Make AIDS central to development assistance,** especially for the most affected countries in Africa **Ensure that resources are allocated in such a way that countries can do** more than merely stave off increased poverty and the deterioration of social services.

- **Make AIDS orphans a priority in plans to accelerate debt relief** and also in sector-wide lending initiatives.

- **Provide financial support for long-term human development projects.**

- **Promote and advocate for the rights of children and women** as articulated in CRC and CEDAW.

- **Encourage the development of resource networks** to facilitate the sharing of human, technical and financial resources regionally and globally.

Conclusion

This Call for Action is a clarion call for a new vision of solidarity and partnership at all levels. The facts are self-evident: The human suffering brought on by AIDS will only continue to multiply. Even if the rate of new infections declines in the near future, the suffering will remain, and the proportion of children orphaned by the epidemic will continue to increase for decades. The recommended action to address problems and protect the rights of children and women must therefore be sustained over a very long time. Such action is not only morally imperative but economically sound.

The experiences of severely affected countries have made it clear that no single action can make a meaningful and lasting impact on the AIDS crisis. Nor can the governments of these countries, working on their own, ensure the well-being of their populations. Partnerships are key, as are increased resources, policy development, review and reform of laws, social mobilization and coordination among the various sectors of government, the private sector and civil society.

Equally crucial, there needs to be very close involvement of those most affected by the epidemic – children, families and communities – whose role in tackling this still unfolding tragedy will continue to be indispensable. Efforts must focus strongly on supporting families. When solutions are weighed against the best interests of the child, it will become ever more apparent that the family remains the primary cradle of care for children and their most cherished and valuable safety net.

Compulsory Licensing

In September, USTR announced that we had reached a common understanding with South Africa which resulted in the setting aside of long-held differences related to patent protections for intellectual properties as they pertain to pharmaceuticals. At the center of the debate was South Africa's intent to implement compulsory licensing and parallel importation of pharmaceuticals to expand access to affordable medicines. USTR has generally opposed these practices believing they infringe on the rights of patent holders and undercut economic incentives for the development of new drugs.

South Africa reaffirmed that any future use of these practices would be in full compliance with its obligations under the WTO's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). In light of South Africa's unique circumstances, including the immediate dire impact of the HIV/AIDS crisis, USTR agreed to voice no further objections to South Africa's intent to implement these practices.

Public health organizations and activist groups seized upon this issue and are currently demanding that USTR lift its opposition to these practices for all nations. Until now, USTR recognized the South Africa solution as a special case, which required special measures. Yet in conjunction with the framing of the resolution of our difference with South Africa, USTR sought to develop a cooperative approach with HHS concerning health-related intellectual property matters to ensure that the application of U.S. trade law and policies remain sufficiently flexible to respond to legitimate public health crises.

On December 1st, USTR and HHS will jointly announce the results of their efforts. The agreement reached between the agencies calls for USTR to consult with HHS, when a foreign government expresses concern that U.S. trade law or policy related to intellectual property significantly impedes its ability to address a health crisis. USTR pledges to seek and give full weight to the advice of HHS regarding the international health considerations involved. While this approach was developed specifically with the global HIV/AIDS crisis in mind, it is not limited solely to addressing that crisis.

Compulsory Licensing – refers to the use of a patent without the authorization of the patent holder, including use by government or third parties authorized by government. TRIPS imposes a number of specific and restrictive obligations related to compulsory licensing.

Parallel Importing – refers to the importing of genuine products without the authorization of the patent holder. Parallel importing permits the importation of a good from any authorized distributor worldwide, rather than limiting transactions solely through a single authorized distribution channel.

THE WHITE HOUSE

WASHINGTON

September 3, 1999

MEMORANDUM TO THE FIRST LADY

FROM: Sandra Thurman, Director, Office of National AIDS Policy

SUBJECT: Need for an Enhanced Response to the AIDS Crisis in Africa and Around the World

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Summary

- In the next decade, 40 million children will be orphaned as a result of losing one or both parents to AIDS.
- AIDS is not just taking lives, it is threatening economics, stability, and civil society.
- AIDS is wiping out decades of progress on a variety of development fronts, including per capita GNP, infant mortality, and life expectancy.
- Leadership and investment can help, and has helped, to turn the tide.
- Political support for a more aggressive United States response is building.
- As goes Africa, so will go India, Asia, and the new Soviet states, and by 2005, more than 100 million people worldwide will have been infected with HIV.

Background

On World AIDS Day last year, the President highlighted the growing global tragedy of children orphaned by AIDS in sub-Saharan Africa. At that time, he directed me to lead a fact-finding mission to the region and to report back to you with recommendations for productive action. From March 27 through April 5, I led a Presidential Delegation to Zambia, Uganda, and South Africa. I was accompanied by Representatives Jackson-Lee, Kilpatrick, and Lee, and assorted senior staff. We were also joined by a select group of individuals from outside of government including Mayor Dinkins, Bishop Felton May, and William Harris. [Attachment A: Manifest]

The goals of the trip were: to heighten awareness, promote leadership, and identify promising interventions. In Zambia and Uganda, we met with the Presidents and a variety of government ministers (health, welfare, community development, finance, etc.). In each country we visited a host of community-based programs serving children and families affected by AIDS, and talked with donors, experts, providers, and consumers about actions taken, lessons learned, and barriers to further progress.

On July 19, 1999 the White House released the subsequent report to the President on the mission and our proposed plan of action (press release attached). The new initiative includes a request to the Congress for an additional $100 million to combat AIDS primarily in Africa. This is the largest-ever budget increase in the global battle against AIDS and more than doubles the United States efforts.

In addition to the $100 million, the initiative includes a variety of strategic opportunities for challenging other partners to join in an enhanced effort starting with your meeting with key stakeholders on Tuesday. Others include:

- Business Leaders Meeting - The Department of Commerce will facilitate a meeting of business leaders active in Africa to encourage them to increase their efforts in the battle against AIDS. This is tentatively scheduled for early November and the Vice President has expressed interest in participating.

- Labor Leaders Meeting – The Department of Labor, led by Secretary Herman, and the AFL-CIO will co-host a meeting of US and African labor leaders to determine ways to expand existing programs which use trade unions to provide outreach and HIV/AIDS education (Note: In many parts of South Africa one in four mine workers in HIV-positive).

- Religious Leaders Summit – The Office of National AIDS Policy will facilitate a meeting of African, American and other religious leaders to discuss ways to more effectively engage communities of faith in the fight against AIDS. Several prominent religious leaders have tentatively committed to participate including Reverends Jesse Jackson, Leon Sullivan, Andrew Young and Archbishop Desmond Tutu.

- UN Conference on Children Orphaned by AIDS – On December 1,1999 (World AIDS Day), the United Nations in conjunction with the National Black Leadership Commission on AIDS (chaired by David Dinkins), The White House Office of National AIDS Policy, The Magic Johnson Foundation and a variety of NGO's will hold a conference to focus attention on the growing number of children orphaned by AIDS. You have been asked to deliver a keynote address.

Attached please find the Memoranda to the President on this issue for your review.

I welcome the opportunity to discuss this with you further, and greatly appreciate your continued support and leadership on behalf of people living with HIV/AIDS both at home and abroad.

THE WHITE HOUSE

Office of the Vice President

For Immediate Release
Monday, July 19, 1999

Contact:
(202) 456-7035

VICE PRESIDENT GORE ANNOUNCES ADMINISTRATION WILL SEEK $100 MILLION INITIATIVE – A RECORD INCREASE -- IN FUNDS TO FIGHT AIDS AROUND THE WORLD

Washington, DC -- Vice President Al Gore today joined Archbishop Tutu, Director of the Office of National AIDS Policy Sandra Thurman, Members of Congress, and leaders of the African-American, religious, children's, and AIDS communities to announce that the Administration will seek the largest-ever budget increase in the global battle against AIDS – a new investment of $100 million. The Vice President also unveiled a new report from the Office of National AIDS Policy that assesses the AIDS crisis in Africa and recommends this investment. In addition, the Vice President announced new efforts to encourage other public and private entities across the world to address AIDS across the world.

"AIDS in Africa is the worst infectious disease catastrophe in the history of modern medicine," Vice President Gore said. "More than twenty million people are now infected and nearly 500 more become infected each hour. We hope this initiative will not only provide much-needed relief but will inspire decisive action by other countries and institutions – and bring hope to the millions of children and families trapped in this horror." Today, the Vice President:

RELEASED A NEW REPORT ON THE PRESIDENTIAL MISSION ON CHILDREN ORPHANED BY AIDS IN SUB-SAHARAN AFRICA. Last December, President Clinton directed the Director of the Office of National AIDS Policy to go on a fact-finding mission to assess the problem of HIV/AIDS in Africa. Today, the Vice President is releasing the report that includes new findings and a plan of action resulting from this mission. The report finds that:

AIDS in sub-Saharan Africa is one of the largest health crises in the history of the world. In the past decade, twelve million people in sub-Saharan Africa have died of AIDS -- one quarter of them children -- and each day AIDS buries another 5,500 women and children. Over the next decade, AIDS will kill more people in sub-Saharan Africa than the total number of casualties in all of the wars of the 20th century combined. By 2005, the daily death toll will reach 13,000 people per day.

Millions of children will be orphaned by this epidemic. In some areas up to one-quarter of all children already live with an HIV-positive parent. In the next decade, more than forty million children in sub-Saharan Africa will lose a parent to HIV/AIDS.

This epidemic has a devastating impact on many aspects of life in sub-Saharan Africa. AIDS is undermining much of the progress in development that has been made in Africa. AIDS is reducing life expectancy by more than 20 years in some countries. Many children are dropping out of school to care for dying parents undermining improvements in education, and AIDS will continue to have a major negative impact on the economy, hitting a range of professionals, from teachers to military to business leaders and therefore undermine its current trade with other nations throughout the world.

UNVEILED NEW $100 MILLION INITIATIVE TO COMBAT HIV/AIDS ACROSS THE GLOBE. The Vice President also unveiled a new initiative to double the existing efforts to prevent and treat AIDS. This initiative will be targeted to Africa in addition to other parts of the world where this epidemic is growing. It will help move forward on four critically important and interconnected fronts including:

Containing the AIDS Pandemic. A new $48 million initiative will be used to implement a variety of prevention and stigma reduction strategies including: HIV education; engagement of political, religious and other leaders; voluntary counseling and testing; blood supply screening, and, interventions to reduce mother-to-child transmission (MTCT). In addition, the Department of Defense (DoD) will begin new efforts to work with African militaries to provide educational material and training on AIDS prevention.

Providing Home and Community-Based Care. This $23 million investment will be used to deliver counseling, support palliative and basic medical care including treatment for sexually transmitted diseases, opportunistic infections, and tuberculosis (TB) through community-based clinics and home-based care workers and enhance training and technical assistance efforts.

Caring for Children Orphaned by AIDS. This new $10 million initiative will be used to assist families, extended families, and communities in caring for their children through nutrition, education, health and counseling support, in coordination with micro-finance programs.

Strengthening Prevention and Treatment by Augmenting Planning, Infrastructure, and Capacity Development. This $19 million initiative will help strengthen host country ability to plan and implement effective interventions. It will also strengthen the capacity for effective partnerships between local government and community-based organizations. Strengthen local surveillance systems to track the spread of HIV infection, AIDS, and the effects of interventions to enable the best targeting of HIV/AIDS prevention programs.

This United States Government investment would be provided through AID ($55 million), HHS ($35 million) and DOD ($10 million) and will be fully offset.

ENGAGING OTHER PARTNERS TO ADDRESS THIS CRISIS. Addressing the crisis of AIDS worldwide will require a broad-based commitment from public and private partners across

the globe. The Vice President also unveiled a series of new initiatives to enhance efforts to address this problem including:

Multi-lateral Partners Meeting to Enhance Coordination Around the World. On September 7, 1999, First Lady Hillary Rodham Clinton will convene a meeting of donors, The World Bank, UNAIDS, international foundations, CEOs and others to discuss how we can best enhance and coordinate our AIDS efforts in Africa and around the world.

A United Nations Conference on Children Orphaned by AIDS. The United Nations, in conjunction with the National Black Leadership Commission on AIDS, The White House Office of National AIDS Policy, The Magic Johnson Foundation and a variety of NGOs, will organize a conference on World AIDS Day to focus attention on the growing number of children orphaned by AIDS worldwide, with a special emphasis on sub-Saharan Africa.

New Partnerships with Private Sector Leaders to Address This Crisis, Such As the Religious, Business and Labor Communities.

-- Given the impact of AIDS on businesses active in Africa as well as the overall economic-impact on African countries, the White House will facilitate a meeting of business leaders to encourage commitment and involvement in AIDS programs, such as workplace education, outreach to communities, and increased funding support for AIDS efforts.

-- The White House will host a meeting of US and African labor leaders, co-chaired by the AFL-CIO, to build on successes in working with the Council of South African Trade Unions to address AIDS.

-- The White House will also facilitate a religious summit of African, American, and other religious leaders to discuss the important role of communities of faith in the fight against AIDS. In Uganda and Senegal it is very clear that the involvement of religious communities and leaders had a dramatic impact on the ability of these two countries to reduce HIV prevalence or to maintain it at low levels over time.

UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

AIDS epidemic update:

December 1999

UNDER EMBARGO UNTIL 14.00 GMT, 23 November 1999

Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

World Health Organization

Global summary of the HIV/AIDS epidemic, December 1999

People newly infected with HIV in 1999	**Total**	**5.6 million**
	Adults	5 million
	Women	2.3 million
	Children <15 years	570 000
Number of people living with HIV/AIDS	**Total**	**33.6 million**
	Adults	32.4 million
	Women	14.8 million
	Children <15 years	1.2 million
AIDS deaths in 1999	**Total**	**2.6 million**
	Adults	2.1 million
	Women	1.1 million
	Children <15 years	470 000
Total number of AIDS deaths since the beginning of the epidemic	**Total**	**16.3 million**
	Adults	12.7 million
	Women	6.2 million
	Children <15 years	3.6 million

The AIDS epidemic in the 21st century – a widening gap

As the 20th century draws to a close, some 33.6 million men, women and children face a future dominated by a fatal disease unknown just a few decades ago. According to new estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), 32.4 million adults and 1.2 million children will be living with HIV by the end of 1999.*

- Over the course of the year, some 5.6 million people became infected with the human immunodeficiency virus (HIV), which causes AIDS.

- The year also saw 2.6 million deaths from HIV/AIDS – a higher global total than in any year since the beginning of the epidemic, despite antiretroviral therapy which staved off AIDS and AIDS deaths in the richer countries. Deaths among those already infected would continue mounting for some years even if prevention programmes managed to cut the number of new infections to zero. However, with the HIV-positive population still expanding – there were 5.6 million new infections this year alone – the annual number of AIDS deaths can be expected to increase for many years before peaking.

- Around half of all people who acquire HIV become infected before they turn 25 and typically die of the life-threatening illnesses called "AIDS" before their 35th birthday. This age factor makes AIDS uniquely threatening to children. By the end of 1999, the epidemic had left behind a cumulative total of 11.2 million AIDS orphans, defined as those having lost their mother before reaching the age of 15. Many of these maternal orphans have also lost their father.

- The overwhelming majority of people with HIV – some 95% of the global total – live in the developing world. That proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.

- HIV is still a challenge in industrialized countries. There is evidence that safe sexual behaviour is being eroded among gay men in some Western countries, perhaps because of complacency now that life-prolonging therapy is available. If this is the case, the complacency is misplaced. The disease remains fatal, and information from North America and Europe suggests that the decline in number of deaths due to antiretroviral therapy is tapering off.

- HIV infections in the former Soviet Union have doubled in just two years. Injecting drug use gave the Eastern European and Central Asian region the world's steepest HIV curve in 1999. Drug-injecting is also a major concern in the industrialized countries, as it is in the Middle East, where total AIDS cases are still relatively low but drug-injecting accounted for two-thirds of cases in Bahrain, half in the Islamic Republic of Iran and over a third in Tunisia.

- Some Latin American countries are managing to expand efforts to provide treatment to those infected. However, there is evidence that infections are on the rise in Central America and in the Caribbean

* This appears to be a relatively small rise over the global HIV totals at the end of 1998. The real rise is larger, however. Improved surveillance now suggests that national infections in a few populous countries of Latin America and Asia were overestimated in 1998.

basin – which has some of the worst HIV epidemics outside Africa.

- Strong prevention programmes seem to have reduced HIV risk and lowered or stabilized HIV rates in some countries of Asia, such as Thailand and the Philippines. Other Asian countries have raised warning flags after collecting new information showing that injecting drug use is spreading and that condom use is uncommon, including among clients of prostitutes and men who have sex with men. In many places prevention efforts are hampered by the shame and stigma attached to AIDS.

- Sub-Saharan Africa continues to bear the brunt of HIV and AIDS, with close to 70% of the global total of HIV-positive people. Most will die in the next 10 years, joining the 13.7 million Africans already claimed by the epidemic and leaving behind shattered families and crippled prospects for development.

- Because of AIDS, companies doing business in Africa are hurting and are bracing themselves for far worse as their workers sicken and die. According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service. Retirement accounted for just 2% of employee drop-out by 1997.

- Life expectancy at birth in southern Africa, which rose from 44 years in the early 1950s to 59 in the early 1990s, is set to drop to just 45 between 2005 and 2010 because of AIDS. In contrast, South Asians, who could barely reach their 40th birthday in 1950, can expect by 2005 to be living 22 years longer than their counterparts in AIDS-ravaged southern Africa.

- New information suggests that between 12 and 13 African women are currently infected for every 10 African men. There are a number of reasons why female prevalence is higher than male in this region, including the greater efficiency of male-to-female HIV transmission through sex and the younger age at initial infection for women.

- In 1999, an estimated 570 000 children aged 14 or younger became infected with HIV. Over 90% were babies born to HIV-positive women, who acquired the virus at birth or through their mother's breastmilk. Of these, almost nine-tenths were in sub-Saharan Africa. Africa's lead in mother-to-child transmission of HIV was firmer than ever despite new evidence that HIV ultimately impairs women's fertility: once infected, a woman can be expected to bear 20% fewer children than she otherwise would.

In short, the huge gap in HIV infection rates and AIDS deaths between rich and poor countries, and more particularly between Africa and the rest of the world, is likely to grow even larger in the next century. Likely, but not certain. Massive national and international efforts may yet help to end the stifling silence that continues to surround HIV in many countries, to explode myths and misconceptions that translate into dangerous sexual practices, to expand prevention initiatives such as condom promotion that can reduce sexual transmission, to create conditions in which young children have the knowledge and the emotional and financial support to grow up free of HIV, and to devote real money to providing care for those infected with HIV and support to their families. A trail of successful responses has already been blazed by a small number of dedicated communities and governments. The challenge for the leaders of Africa and their partners in development is to adapt and massively expand successful approaches that make it harder for the virus to spread, and that make it easier for those affected to live full and rewarding lives.

Regional HIV/AIDS statistics and features, December 1999

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate (*)	Percent of HIV-positive adults who are women	Main mode(s) of transmission (#) for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s-early '80s	23.3 million	3.8 million	8.0%	55%	Hetero
North Africa & Middle East	late '80s	220 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6 million	1.3 million	0.69%	30%	Hetero
East Asia & Pacific	late '80s	530 000	120 000	0.068%	15%	IDU, Hetero MSM
Latin America	late '70s - early '80s	1.3 million	150 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	360 000	57 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	360 000	95 000	0.14%	20%	IDU, MSM
Western Europe	late '70s - early '80s	520 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s - early '80s	920 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	500	0.1%	10%	MSM, IDU
TOTAL		**33.6 million**	**5.6 million**	**1.1%**	**46%**	

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.
# MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

The world's splintered epidemic

Contrary to expectations when AIDS was first identified, the epidemic has taken different forms in different parts of the world. In some areas HIV rapidly became common among men and women throughout the population. In others it became entrenched in certain sub-populations whose sexual or drug-injecting behaviour carries an especially high risk of contracting or passing on the virus – particularly sex workers and their customers, men who have sex with men, and drug injectors.

The extent to which HIV spreads between groups with high-risk behaviour and any larger population depends on whether members of those groups have sex with people who do not share their high-risk behaviour, and whether condoms are used in those sexual encounters. For an HIV epidemic to take off in a country's general population, there also has to be a substantial amount of sexual mixing among adults. To sustain a heterosexual epidemic, on average each infected person must have unprotected sex with a minimum of two partners, becoming infected by one and passing on the infection to at least one other. Indeed, since not every encounter between an HIV-positive and an HIV-negative partner will result in a new infection, a sustained heterosexual epidemic suggests that a substantial proportion of the population, both male and female, have a number of sex partners over their lifetimes.

Note about UNAIDS/WHO estimates

The estimates concerning HIV and AIDS in this document are based on the information available to UNAIDS and WHO at the current time. They are provisional. WHO and UNAIDS, together with experts from national AIDS programmes and research institutions, keep these estimates under constant review with a view to updating them as improved knowledge about the epidemic becomes available and as advances are made in the methods for deriving estimates.

For example, knowledge about the epidemic improves not only as better information becomes available about HIV spread (for example, through more representative sentinel surveillance), but also as more is learnt about the factors that help or hinder the spread of the virus (for example, the natural history of HIV infection in different parts of the world, the impact of HIV infection on fertility, and the effects of improved treatment). This improved knowledge together with methodological advances together provide the basis for updated estimates of HIV incidence, prevalence and mortality. Because of these factors, the current estimates cannot be directly compared with those for earlier years, nor with those that may be published subsequently.

The purpose of publishing these estimates is to help governments, nongovernmental organizations and others who have a stake in bringing AIDS under control to gauge the status of the epidemic in their country and to monitor the effectiveness of the considerable efforts at prevention and care being made by all partners.

For more information, please contact Anne Winter, UNAIDS, Geneva, (+41) 22 791 4577, mobile (+41) 79 213 4312, Lisa Jacobs, UNAIDS, Geneva, (+41) 22 791 3387 or Andrew Shih, UNAIDS, New York, (+1) 212 584 5024. You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org).

THE CLINTON-GORE ADMINISTRATION: A RECORD OF PROGRESS ON HIV AND AIDS

"How can we be one America if a ravaging disease like this is being brought under control in part of our population, but not in another?"

-- President Clinton, November 2, 1998

"We are united in the fight for research, care, and prevention. And we will not stop until all who need it have access to the treatment they need. We will not rest until we have a vaccine -- and a cure."

-- Vice President Gore, September 19, 1998

Providing National Leadership. President Clinton has worked hard to invigorate the response to HIV and AIDS, providing new national leadership, substantially greater resources and a closer working relationship with affected communities. During his administration, funding for AIDS research has increased by over 89 percent at the Department of Health and Human Services (HHS), while funding for HIV prevention has increased 47 percent. Funding for the Ryan White CARE Act has increased by over 338 percent.

Although much work remains to find a cure, progress has been made. In 1996, for the first time in the history of the AIDS epidemic, the number of Americans diagnosed with AIDS declined. And between 1996 and 1997, HIV/AIDS mortality declined 42 percent, falling from the leading cause of death among 25-44 year olds in 1995 to the fifth leading cause of death in that age group. There has been a decline in the number of AIDS cases overall and a sharp decline in new AIDS cases in infants and children.

Leading the Global Fight Against HIV/AIDS. In July, 1999, the Administration announced a new global AIDS initiative entitled LIFE (Leadership and Investment in Fighting an Epidemic). The cornerstone of the initiative is a $100 million increase in US support for global AIDS efforts, with a particular focus on sub-Saharan Africa. The United States has invested over $1 billion in international AIDS relief since the start of the epidemic and funds 25% of UNAIDS. NIH represents the largest single public investment in AIDS research in the world. More than $62 million of NIH's international AIDS research in FY1999 is being conducted overseas in partnership with the global scientific community.

Historic Effort to Address HIV/AIDS in Communities of Color. While racial and ethnic groups account only for about 25 percent of the U.S. population, they account for more than 50 percent of all AIDS cases. On October 28, 1998, President Clinton declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities and announced a comprehensive new initiative that invests an unprecedented $156 million to improve the nation's effectiveness in preventing and treating HIV/AIDS in the African-American, Hispanic, and other minority communities. Funding levels for Fiscal Year 2000 were increased to over $245 million.

This funding is spread across three broad categories: technical assistance and infrastructure support; increasing access to prevention and care, and building stronger linkages to address the needs of specific populations.

Fighting to Pass a Strong, Enforceable Patients' Bill of Rights. President Clinton has called on the Congress to pass a strong, enforceable patients' bill of rights that assures Americans the quality health care they need. The bill should include important patient protections such as: assuring direct access to specialists; real emergency room protections; continuity of care provisions that protect patients from abrupt changes in treatment; a fair, timely, and independent appeals process for patient grievances; and enforcement provisions to make these rights real.

Protecting Medicaid and Social Security Coverage. The President fought for and won the preservation of the Medicaid guarantee of coverage which serves more than 50 percent of people living with AIDS -- and 92 percent of children with AIDS -- who rely on Medicaid for health coverage. He also revised eligibility rules for Social Security Disability Insurance to increase the number persons living with HIV who qualify for benefits.

Focusing National Efforts on an AIDS Vaccine. On May 18, 1997, the President challenged the nation to develop an AIDS vaccine within the next ten years. He announced a number of initiatives to help fulfill this goal, including: dedicating an AIDS vaccine research center at the National Institutes of Health and encouraging domestic and international collaboration among governments, medical communities and service organizations. On June 9, 1999, President Clinton dedicated the new Dale and Betty Bumpers Vaccine Research Center at the National Institutes of Health and announced that the primary work of this new Center will be HIV vaccine research.

Dramatically Increasing Overall AIDS Funding. The Clinton Administration has responded aggressively to the significant threat posed by HIV/AIDS with increased attention to research, prevention and treatment. President Clinton has increased overall funding for major HIV/AIDS programs by 121 percent (primarily within HHS), funding for the Ryan White CARE programs has increased 338 percent and support for AIDS-related research has increased by over 89 percent.

Increasing AIDS Drug Assistance and Accelerating AIDS Drug Approvals. Funding for AIDS drug assistance has increased from $52 million per year to $528 million per year during the Clinton Administration. This program provides new life-prolonging drugs to people with HIV and AIDS. In addition, President Clinton convened the National Task Force on AIDS Drug Development, and removed dozens of bureaucratic obstacles to the effective and decent treatment of people with AIDS. Since 1993, the Food and Drug Administration has approved dozens of new AIDS drugs for AIDS-related conditions and new diagnostic tests.

Making Research a Priority. In one of his first acts in office, President Clinton signed the National Institutes of Health Revitalization Act of 1993, placing full responsibility for planning, budgeting and evaluation of the AIDS research program at NIH in the Office of AIDS Research. The Administration has increased NIH AIDS research funds by 89% in five years.

Building Partnerships to Optimize HIV Care. In March, 1997 Vice-President Gore approved the creation of the Forum for Collaborative HIV Research, a unique coalition of federal government agencies, health care providers, pharmaceutical companies, HIV researchers, and patient advocates. The Forum builds collaboration between these stakeholders to address emerging issues in HIV clinical research and care. In its first two years, the Forum has focused issues such as adherence to HIV therapy, side effects of HIV drugs, HIV treatment education, and the development of new methods to treat HIV.

Focusing on Prevention: Supporting the Centers for Disease Control and Prevention. The Administration has increased funds for HIV prevention at the CDC by 47%. Under the leadership of the Clinton/Gore Administration, the CDC reorganized its AIDS prevention efforts to foster greater overall coordination and enhance efforts to reduce sexually transmitted diseases and tuberculosis.

Educating Young People about the Dangers of AIDS. The Clinton/Gore Administration launched the Prevention Marketing Initiative, focusing on the risk to young adults (18-25) with frank public service announcements recommending the correct and consistent use of latex condoms for those who are sexually active.

Requiring the Federal Workforce to Understand AIDS. The Administration issued a directive on September 30, 1993 that requires every Federal employee to receive comprehensive education on HIV/AIDS.

Established a White House AIDS Office and Created a Presidential Advisory Council. President Clinton created a White House Office of National AIDS Policy to bring greater direction and visibility to the war on AIDS. Sandy Thurman, the current director of the office, has broad experience in both domestic and international AIDS services. At the same time, the Administration has sharpened the focus of its AIDS programs. The President also created the Presidential Advisory Council on HIV and AIDS to provide him and his Administration with expert outside advice on the ways in which the Federal government should respond to the HIV/AIDS epidemic. Dr. R. Scott Hitt, a California physician specializing in HIV/AIDS care, chairs the panel.

Convened the First Ever White House Conference on HIV and AIDS. On December 6, 1995, the President convened the first White House Conference on HIV and AIDS in the history of the epidemic, bringing together more than 300 experts, activists and citizens from across the country for a discussion of key issues.

SELECTED HIV/AIDS INVESTMENTS	FY2000	Increase from FY99	Increase from FY93
Ryan White CARE Act *AIDS Drug Assistance*	**$1.6 billion** *$528 million*	**13%** *61%*	**338%**
HIV Prevention (CDC)	**$730 million**	**11%**	**47%**
AIDS Research (NIH) *Vaccine Research (FY99)*	**$2.0 billion**** *$200 million*	**13%** *33%*	**89%** *145%*
Housing (HUD)	**$232 million**	**3%**	**132%**
International (USAID)	**$200 million****	**48%**	**75%**

*since FY96, when separate program established
** estimated

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Divider Title: **2/5/00: PRESCRIPTION DRUG PLAN BENEFIT**

White House Weekly

February 14, 2000

SECTION: Vol.21, No.7

LENGTH: 845 words

HEADLINE: Talking It Over: President's Prescription Drug Benefit Plan Throws Lifeline To Seniors

BYLINE: HILLARY RODHAM **CLINTON**

BODY:

In recent years, lifesaving drugs have become an indispensable part of modern medicine. Yet, 13 million senior citizens in this country-three out of five of our elderly population-lack dependable drug coverage. Furthermore, millions of older Americans, the ones who need prescription drugs the most, pay the highest prices for them.

Pat Brown, a senior citizen from Johnson City, Tenn., knows firsthand just how hard life can be without insurance to help pay for prescription drugs. Pat, who suffers from five chronic illnesses, used to have drug coverage under her Medigap policy. But her premiums increased to the point that she had to buy a less expensive policy, one that did not cover her medicine.

Today, Pat pays approximately **$4,200 a year for her prescriptions drugs, and not surprisingly, she is worried about spending her life's savings and depleting the money she has put aside for her retirement. Unfortunately, Pat is not alone.**

The price of prescription drugs is rising 12 percent each year, more than any other segment of the health care industry. Coupled with the fact that seniors lack the collective power to negotiate discounts, our elderly citizens pay twice as much for their medicines as those in large groups that command steep discounts.

The high cost of today's prescriptions forces too many seniors to choose between paying for food and utilities, or paying for medicine. Some opt for the medically risky route of taking smaller doses of their medications than their doctors recommend-sacrificing their health and well-being in order to make their drugs last longer. And everyday, groups of senior citizens climb aboard buses to Canada, where they can purchase their medicines at a fraction of the cost they would pay in this country.

Medicare, created 35 years ago to protect the health of Americans as they grow older, is a success story. Before Medicare, nearly half of our seniors had no health coverage at all, and families were left to bear the financial burden of caring for their loved ones.

Medicare changed all that. In the past 35 years, though, the medical landscape has changed. Today, new medicines play an increasingly important role in providing quality health care to all our citizens, but especially to our senior citizens.

Prescription drugs can accomplish what once could be done only through surgery, at less pain and lower cost. And the number of new drugs is rising every day. In 1998, pharmacists filled 2.8 billion prescriptions-a number that is expected to grow to 4 billion in the next five years.

Despite all this, and although Medicare covers doctor and hospital benefits, we let our seniors go without the very prescription drugs that could keep them healthy. It doesn't make sense. If we were crafting the Medicare program today, we would never consider proposing a program

without a prescription drug benefit. It's time to do what we know is right.

Last week, the president submitted his budget to Congress. In addition to making Medicare more efficient, competitive and fiscally sound-extending its solvency until at least the year 2025-his plan creates a long-overdue, voluntary prescription drug benefit that offers high-quality medicines to senior citizens at affordable prices.

Furthermore, the president's budget includes a reserve fund to protect those who are confronted with catastrophic drug costs. Beneficiaries who opt for the prescription drug coverage would pay $26 a month in the first year, an amount that would rise to $51 a month in later years. Premiums would drop-in some cases to zero-for low-income recipients. There would be no deductible, and the plan would cover half of each beneficiary's drug cost, from the first prescription filled each year up to an annual limit of $5,000.

Let me reiterate: Despite what some television ads would have you believe, the president's plan is entirely voluntary. No senior would be required to participate.

Medicare is truly at a crossroads. When the baby boom generation retires, it will be called on to care for twice as many Americans as it does today. Yet, this important program, which, for 35 years, has played such a vital role in preserving and improving the health of our senior citizens, will not be up to the task, unless we act now.

If we are to protect our children from shouldering the burden of caring for us as we age, we must strengthen and reform Medicare. We must make it fiscally sound, and we must offer a prescription drug benefit to those who feel they need it.

In his State of the Union speech last month, the president had this to say: "In good conscience, we cannot let another year pass without extending to all our seniors this lifeline of affordable drugs." He has taken the first step. Now, it is up to members of Congress to do their part. Pat Brown and 13 million of her fellow citizens-this country's parents and grandparents-are counting on.

First lady Hillary Rodham Clinton's column is distributed by Creators Syndicate, Inc.

LOAD-DATE: February 14, 2000

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TALKING IT OVER

HILLARY RODHAM CLINTON

February 9, 2000

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To find out more about Hillary Rodham Clinton and read her past columns, visit the Creators Syndicate web page at www.creators.com.

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Divider Title: **3/20/00 Children / Mental Conditions**

FINAL REVISED

WASHINGTON, DC/ HARLEM, NY/ CHAPPAQUA, NY

NYC LEAD ADVANCE:	BASIL SMIKLE	
	917/270-6598	CELL
	212/289-6185	HOME
SCHEDULER:	JANNA PASCHAL	
	202/456-5373	PHONE
	202/456-5340	FAX
	202/939-0504	HOME
	WHCA PAGER	#4939
SCHEDULER:	DINO MILANESE	
	202/456-6751	PHONE
	202/395-2106	CELL
	202/456-5340	FAX
	703/418-0170	HOME
	WHCA PAGER	#4289

PREV RON — The White House

10:00 am-
10:35 am — **RITALIN STRATEGY MEETING**
Map Room
CLOSED PRESS/WH PHOTO

FORMAT:

-Upon arrival, HRC is seated.

-Leaders of National Mental Health Organizations each present their accomplishments in two minute segments per organization.

-Upon completion of the presentations, HRC participates in a photo receiving line with group leaders.

-Upon the conclusion of the photo receiving line, HRC proceeds to the Roosevelt Room, escorted by Secretary Shalala.

PARTICIPANTS: 18 guests.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. schedule	Schedule for Hillary Rodham Clinton [partial] (1 page)	03/20/2000	b(6)

COLLECTION:
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First Lady's Office
Melanne Verveer
OA/Box Number: 18538

FOLDER TITLE:
HRC Healthcare Book #13: Health Reform [3]

2013-0534-S
rc1789

RESTRICTION CODES

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

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

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

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

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

10:40 am-
11:00 am

MEETING ON THE SAFE USE OF MEDICATION TO TREAT YOUNG CHILDREN
Roosevelt Room
OPEN PRESS/WH PHOTO

FORMAT:

-Secretary Shalala makes brief welcoming remarks and introduce HRC.

-HRC makes remarks.

-Upon the conclusion of her remarks, HRC departs to the library.

PARTICIPANTS: 45 Guests.

11:05 am-
11:15 am

PRESENTATION OF LETTER FROM SENAGOLIAN WOMEN
Library
CNN/TAPING

11:20 am-
11:30 am

DROP BY
Map Room

PARTICIPANTS: (b)(6)

11:50 am

DEPART The White House
EN ROUTE The Hyatt Regency on Capitol Hill
[Drive time: 10 minutes]

12:00 pm

ARRIVE The Hyatt Regency on Capitol Hill

GREETERS:

Alfred Whitehead, General President
Vincent Bolland, Board Member
David Kelly, Board Member
Dick Hyatt, Board Member

12:00 pm-
12:40 pm

INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS
ANNUAL LEGISLATIVE CONFERENCE
The Regency Ballroom
The Hyatt Regency on Capitol Hill
400 New Jersey Avenue (NW)
Hold: Kitchen Corridor
Phone: 202/942-1571
Phone: 202/737-1234 Main
Fax: 202/393-7927
CLOSED PRESS

FORMAT:

-Upon arrival, HRC proceeds to hold.

-HRC is announced off stage.

-HRC proceeds onto stage, led by Alfred Whitehead and Vincent Bolland.

-Harold Schaitberger, Executive Assistant to the General President, makes welcoming remarks and introduces HRC.

-HRC makes remarks.

-Upon the conclusion of her remarks, HRC departs to hold or works and optional ropeline.

-Before departing, HRC proceeds to a meet and greet with 11 participants.

PARTICIPANTS: 750 guests.

12:45 pm

DEPART The Hyatt Regency on Capitol Hill
EN ROUTE Andrews
[Drive time: 25 minutes]

1:10 pm

ARRIVE Andrews

1:15 pm

WHEELS UP Andrews
EN ROUTE LaGuardia
[Flight time: 50 minutes]

2:05 pm	**WHEELS DOWN** LaGuardia **CLOSED PRESS**
2:10 pm	**DEPART** LaGuardia **EN ROUTE** 775 Washington Street [Drive time: 40 minutes]
2:50 pm	**ARRIVE** 775 Washington Street
2:55 pm- 3:15 pm	**PHOTO SHOOT WITH NEW YORK MAGAZINE** 775 Washington Street Hold: tbd Phone: tbd Fax: tbd **CLOSED PRESS** **PHOTOGRAPHER:** Mary Ellen Mark
3:20 pm- 3:30 pm	**CAMPAIGN PHOTO SHOOT** 775 Washington Street **PHOTOGRAPHER:** Lisa Berg
3:35 pm	**DEPART** 775 Washington Street **EN ROUTE** 125 Barclay Street [Drive time: 15 minutes]
3:50 pm	**ARRIVE** 125 Barclay Street
3:55 pm- 4:10 pm	**MEETING WITH PETER VALLONE** Room: tbd **PARTICIPANT:** Peter Vallone, New York City Council Speaker
4:15 pm- 4:25 pm	**LEADERSHIP MEETING** Room:
4:30 pm- 4:40 pm	**PHOTO RECEIVING LINE**

4:45 pm-
5:30 pm

MAIN MEETING/Q & A SESSION
Conference Room, 6th floor
DC37
125 Barclay Street
Hold: Room 634
Phone: 212/815-1478
Fax: tbd
CLOSED PRESS

PARTICIPANTS: 35 guests.

5:35 pm

DEPART 125 Barclay Street
EN ROUTE Bethel AME Church
[Drive time: 40 minutes]

6:15 pm

ARRIVE Bethel AME Church

GREETERS:

C. Virginia Fields, Manhattan Borough Pres.
Reverend O'Neil Mackey, Bethel AME Church
Rep. Charles Rangel

6:20 pm-
6:30 pm

MEET AND GREET
Bethel AME Church

PARTICIPANTS: 15 guests.

6:35 pm-
8:05 pm

HARLEM LEADERSHIP TOWN HALL
Bethel AME Church
52 West 132nd Street
Between Lenox and 5th
Hold: Dressing Room
Phone: 212/862-0100
Fax: 212/694-1323
OPEN PRESS

FORMAT:

-Upon the conclusion of the meet and greet, HRC proceeds upstairs.

-Upon entering the church, HRC greets guests as she proceeds up the aisle en route the pulpit.

-Upon reaching the pulpit, HRC takes a seat.

-Reverend Mackey makes welcoming remarks and introduces Bill Perkins.

-Councilmember Bill Perkins makes remarks and introduces Rep. Charles Rangel.

-Rep. Charles Rangel makes remarks and introduces C. Virginia Fields.

-C. Virginia Fields, Manhattan Borough President, makes remarks and introduces HRC.

-HRC makes remarks.

-Upon the conclusion of her remarks, HRC opens to Q & A from panelists.

Panelist Participants:
Eleanor Tatum, Amsterdam News
Saran Atkinson, Rheedlan Center
Mark Riley, WLID Radio
Dr. Megan McLaughlin

-Upon the conclusion of Q & A with panelists, HRC opens to Q & A with audience members.

-Upon the conclusion of Q & A with audience members, C. Virginia Fields makes brief concluding remarks.

-Upon the conclusion of those remarks, HRC works a ropeline as she exits, and departs.

PARTICIPANTS: 600 guests.

8:10 pm	**DEPART** Bethel AME Church **EN ROUTE** 260 Park Avenue South [Drive time: 30 minutes]
8:40 pm	**ARRIVE** 260 Park Avenue South
8:45 pm- 9:15 pm	**PRIVATE MEETING** Office Of Randi Weingarten, 4th Floor 260 Park Avenue South & 21st Phone: 212/598-9215 Fax: 212/598-7788 **PARTICIPANT:** Randi Weingarten, President of UFT
9:20 pm	**DEPART** 260 Park Avenue South **EN ROUTE** Chappaqua [Drive time: 45 minutes]
10:05 pm	**ARRIVE** Residence, Chappaqua
RON	Chappaqua, New York

THE WHITE HOUSE

WASHINGTON

March 18, 2000

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

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

I. PURPOSE

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

II. BACKGROUND

Overview

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

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

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

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

Policy Deliverables

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

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

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

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

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

JAMA Report

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

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

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

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

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

Success of Pediatric Labeling Efforts

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

III. PARTICIPANTS

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

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

IV. SEQUENCE OF EVENTS

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

9:30- 10:30 am	**STRATEGY MEETING** Map Room
10:00am	**THE FIRST LADY** will arrive in the Map Room
10:02- 10:20am	Each group will have 2 minutes to present their accomplishments
10:20- 10:35am	**THE FIRST LADY** will do a photo receiving line with group leaders.

10:35am	Group leaders will be escorted to the Roosevelt Room
10:37am	**THE FIRST LADY** proceeds to the Roosevelt Room joined by Shalala
10:40-10:57am	**ANNOUNCEMENTS** • Secretary Shalala will introduce the issue and you, highlighting your leadership. • You will speak for approximately five minutes.
10:58am	**THE FIRST LADY** departs

V. PRESS PLAN

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

VI. REMARKS

- Provided by Laura Schiller

ATTACHMENTS

- Press articles
- JAMA abstracts

To be provided with talking points:

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

The Scary Truth About Stock Options

U.S.News & WORLD REPORT

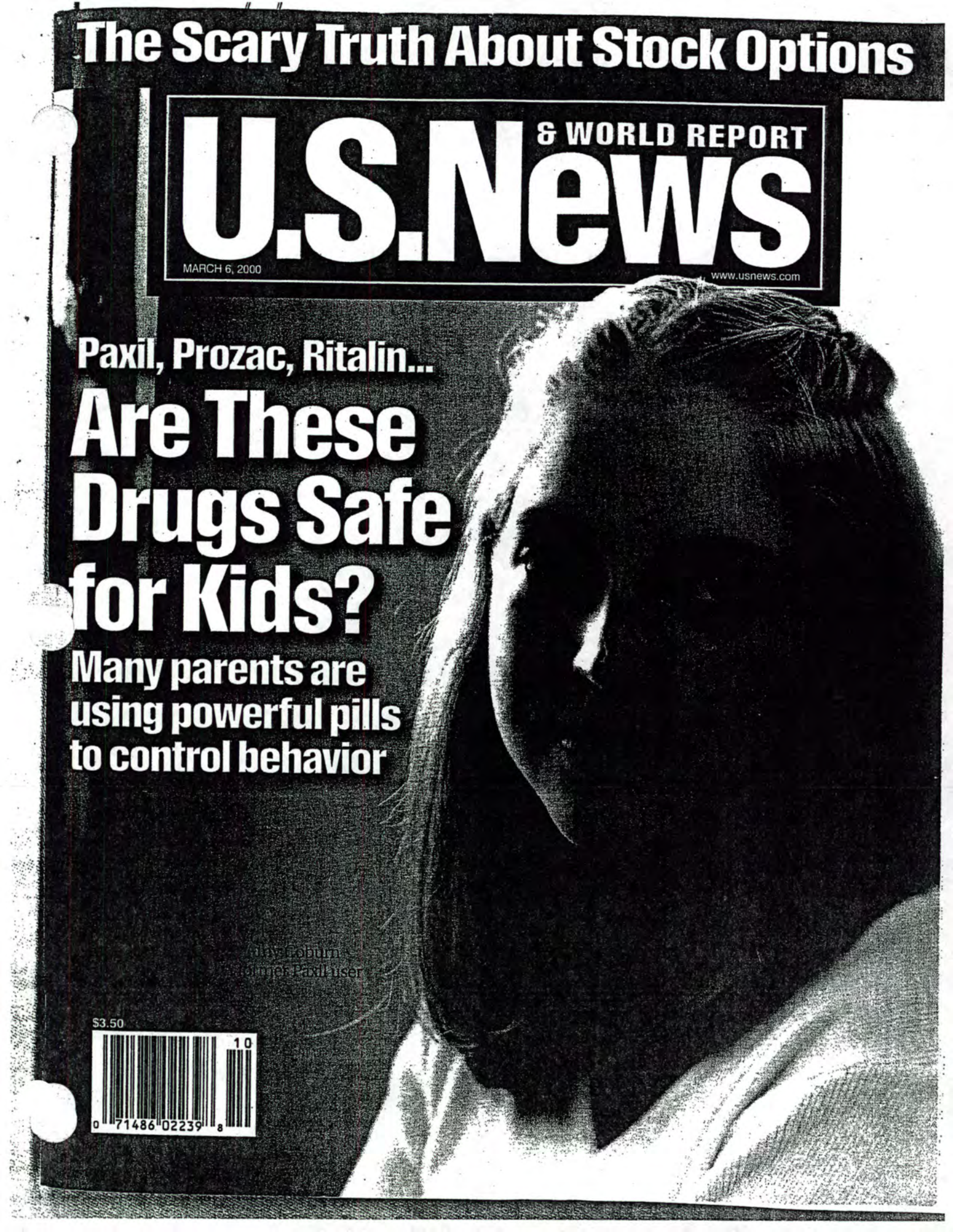
MARCH 6, 2000

www.usnews.com

Paxil, Prozac, Ritalin...

Are These Drugs Safe for Kids?

Many parents are using powerful pills to control behavior



Tony Coburn
former Paxil user

$3.50

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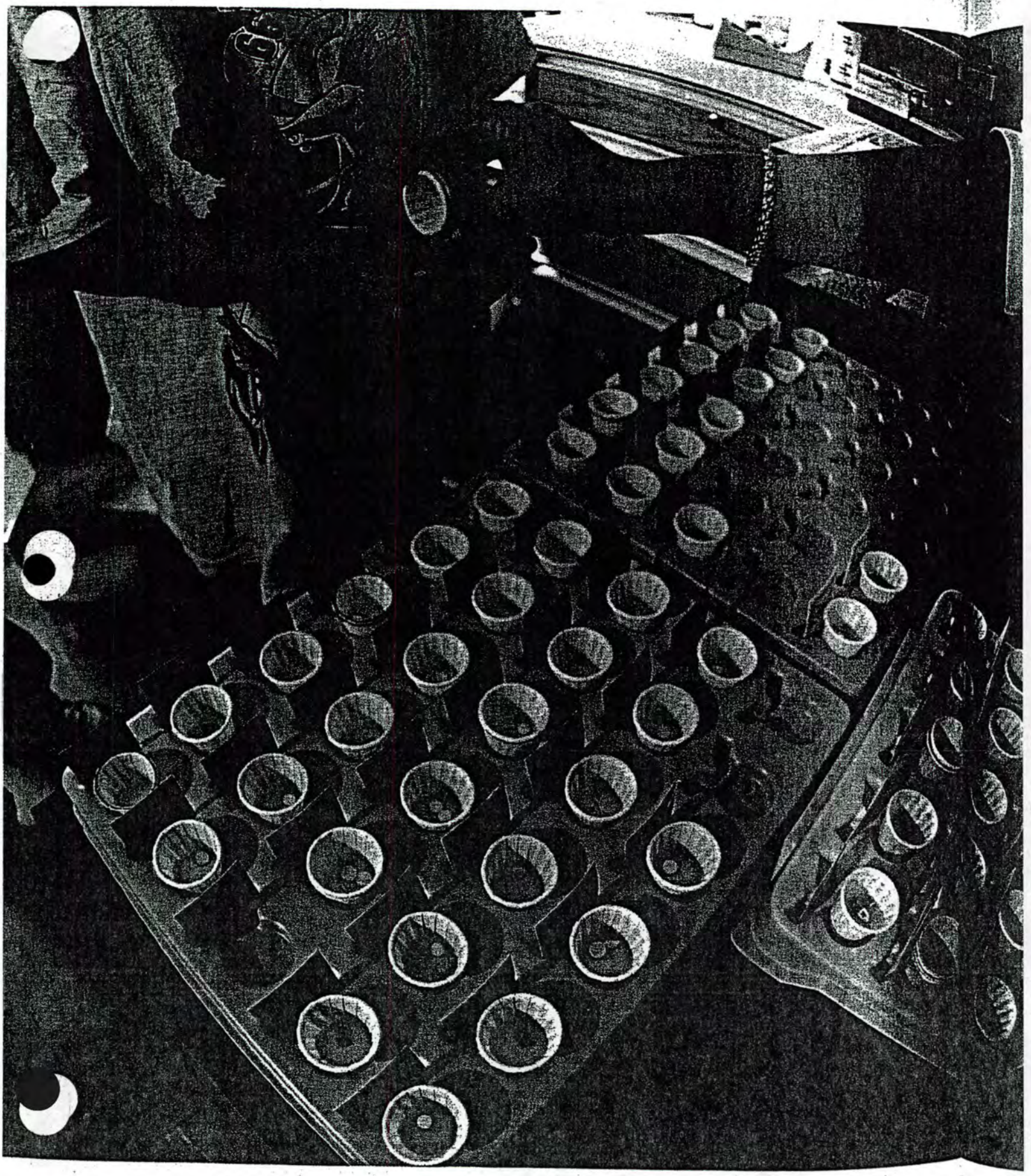
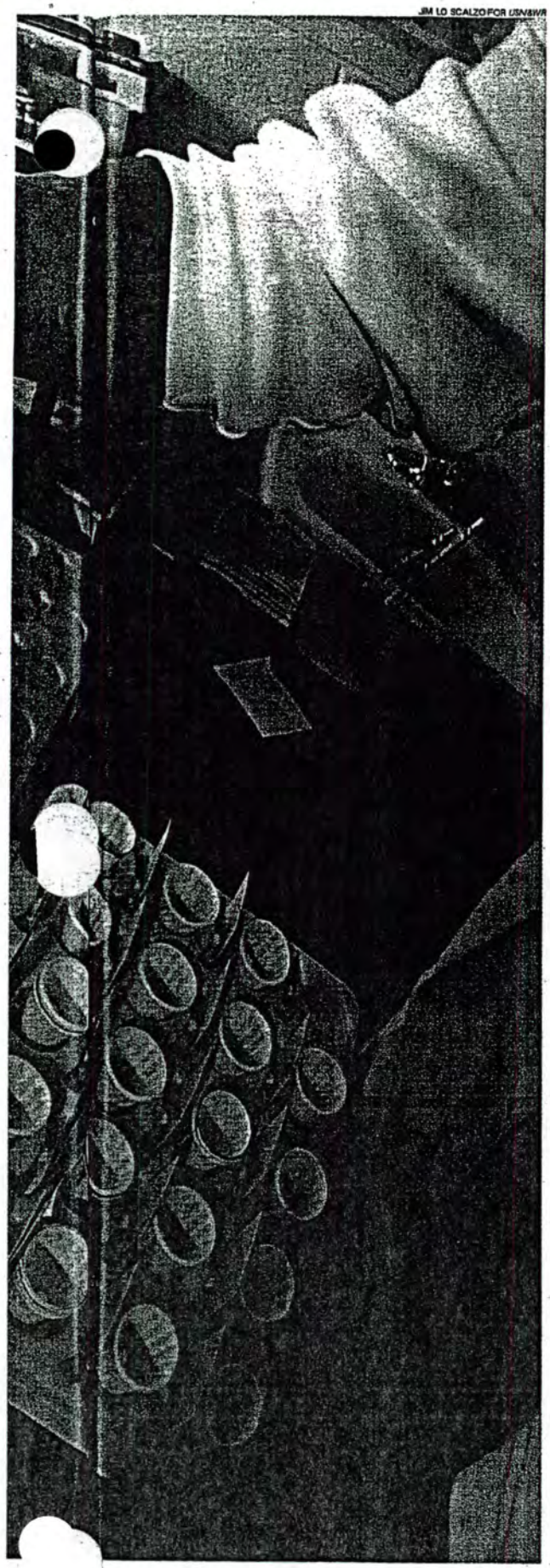



JIM LO SCALZO FOR *USN&WR*

A nurse dispenses medications to students at a middle school.

The Perils Of Pills

The psychiatric medication of children is dangerously haphazard

BY NANCY SHUTE, TONI LOCY, AND DOUGLAS PASTERNAK

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

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

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

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

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

MICHELE MCDONALD FOR USN&WR

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

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

● *He was "Dr. Jekyll and Mr. Hyde."*

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

Kathy Hale of Lexington, Ky., knows this scenario all too well. When her daughter Katie saw the pediatrician at age 7, the doctor quickly diagnosed ADHD and prescribed Ritalin. But Katie's temper and aggression only intensified. The grade schooler pulled a butcher knife on her older sister and gave her stepfather a black eye. Kathy called the pediatrician several times and begged to have her daughter sent to a hospital, but he refused. Last October, Kathy decided to take Katie, now 13, to a psychiatrist at the University of Kentucky, who diagnosed bipolar disorder. Katie is

Behavior in a pill

These are some of the most common psychiatric medications.

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

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

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

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

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

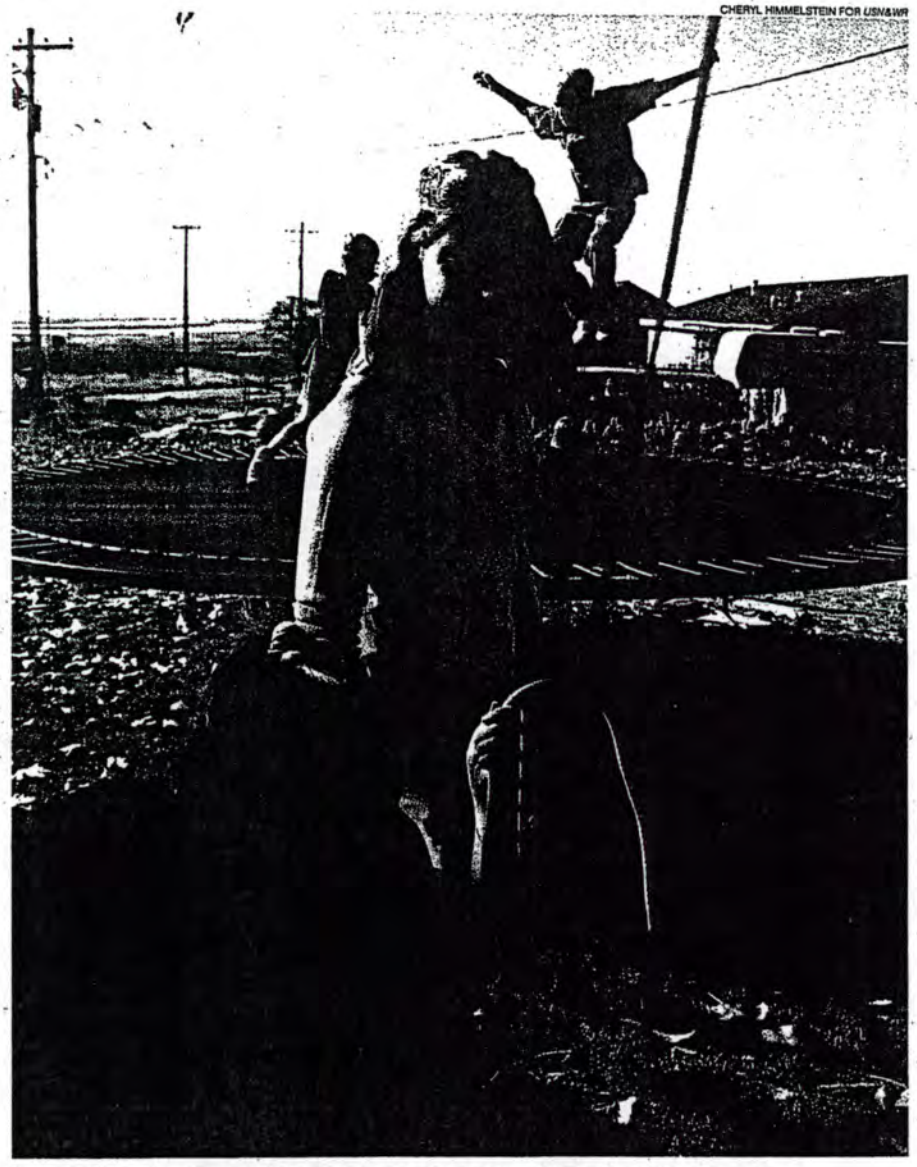
Given that 3 percent to 5 percent of school-age children are affected by ADHD and 2.5 percent by depression (the number rises to 8 percent in teens), psychiatrists say it's not surprising to see 1.2 percent of children being treated for ADHD and 0.3 percent for depression. What does upset the doctors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

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

Children are not miniature adults. Their bodies metabolize medications differently. Their brains are in the midst of rapid development. Animal studies suggest that the brain's developing neurotransmitter system can be exquisitely sensitive to drugs, leading to permanent changes in adult life. Thus doctors who prescribe psychiatric drugs to children, even with the best intentions, are experimenting on their patients. Says Robert Johnson, director of adolescent medicine for the University of Medicine and Dentistry of New Jersey: "We know more about the effects of marijuana on kids than Prozac."

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

CHERYL HIMMELSTEIN FOR *USN&WR*



Amy Coburn, 16, plays outside her Perry, Utah, home with nephews and a niece.
● *On Paxil, "I thought the world was watching me. There were cameras everywhere."*

JIM LO SCALZO FOR *USN&WR*

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

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

Martin Teicher, an associate professor of psychiatry at Harvard Medical School, estimates that as many as half of the children diagnosed with depression actually have bipolar disorder and that many are mistakenly placed on antidepressants or ...ulants. "That is a bad cocktail," he says. ...elly Bagwell of Silver Creek, Miss., saw ... 2-year-old daughter, Tori, flail and thrash for hours, uncontrollably, after her pediatrician put her on Ritalin. After Tori tried to jump out a second-story window, the Bagwells took her off the medication. It took four more years before Tori was diagnosed with bipolar disorder. Tori is now doing well on Zyprexa, an antipsychotic, and Topamax and Depakote, mood stabilizers. "Without this diagnosis, she'd be in an institution," her mother says.

Eydie Alguadich continues to give 8-year-old Danielle extra tutoring and help.
● *"She wasn't learning in class."*

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

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

WHAT TO ASK

Queries for a doctor or a therapist:

● **How will you make a diagnosis?** At a minimum, the provider should interview you for at least an hour about the child's medical and family history, observe the child for a similar amount of time, and talk to teachers or baby sitters.

● **If medication is called for, how long should my child take it to know if it works?** Since psychotropic medications are untested on children, it will be a process of trial and error. If a drug causes any troubling side effect, talk to your doctor immediately about stopping it.

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

JIM WEST—IMPACT VISUALS FOR USN&WR

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

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

Many parents say that without medication, their children would not have been able to learn in school, play with friends, and do all the little things that are essential to the business of growing up. Eydie Alguadich will never forget the day her 5-year-old daughter, Danielle, started to say, "Mommy, I wish I was dead." It went on for two years. "I had a major, major prejudice against using drugs on children," says Alguadich, an interior designer and stay-at-home mom in Herndon, Va. When a pediatrician recommended that her older daughter, Samanthe, take Ritalin at age 2, Alguadich enrolled her in a gym class instead. But as she watched Danielle founder despite intensive tutoring from her mother, she decided it was time to seek help and brought her in for an assessment by psychologists and pediatricians. Danielle, 8, now takes Ritalin, as do her two older sisters. Their mother says they're no longer struggling in school, and the drug appears to have no side effects. "Kids know when there's something wrong," Alguadich says. "It's the parents who are the last to know."

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

A PARENT'S GUIDE

Tools to treat a troubled child

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

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

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

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

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

tury have doctors come to understand that depression, schizophrenia, and other disorders arise from the genes and cells, not from the Devil. Even 20 years ago, children were thought to be incapable of becoming depressed, a holdover from the Freudian belief that it took an adult superego to suffer angst. By recognizing the biological basis of mental disorders, medicine has offered millions of people the possibility of a real life. But in elevating the biological causes of mental disorders, society risks ignoring other key factors: family, environment, culture. If a child behaves badly because the parents' marriage is in turmoil, is the problem with the child or with the family? Are today's parents too busy to give difficult children the one-on-one attention and patience they need? Do teachers demand that children be drugged rather than accept a rambunctious classroom?

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

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

CAUSE AND EFFECT

Can drugs spark acts of violence?

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

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

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

COURTESY OF VIKTOR FAMILY

Jarred Viktor, 17, at graduation with his parents, Brenda and Jurgen, following his murder conviction. Below, Matt Miller. ● *"There was a pill that we were told could fix Matt."*

Known risks. SmithKline Beecham, the maker of Paxil, and other drug companies say their medications play no role in violent behavior or suicide. Still, the companies do warn in package inserts that a small number of patients, fewer than 1 percent, may experience side effects, including abnormal dreams, agitation, hostility, suicidal thoughts, and delusions. But with an estimated 1.5 million youngsters receiving these antidepressants in 1996 alone, that's about 15,000 who could be vulnerable.

COURTESY OF MILLER FAMILY

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

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

February 23, 2000, Wednesday

SECTION: WIRE; Pg. A03

LENGTH: 772 words

HEADLINE: Troubling trend: tots on Ritalin

BYLINE: Associated Press

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

February 23, 2000, Wednesday, CITY EDITION

SECTION: FRONT, Pg. 1A

LENGTH: 836 words

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

BYLINE: SUSAN OKIE The Washington Post

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

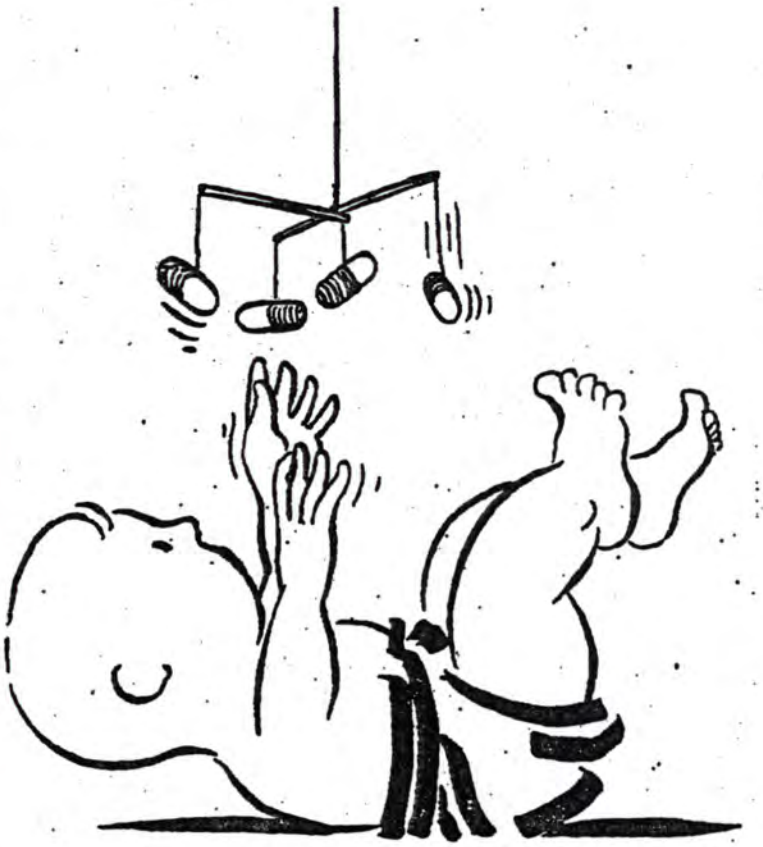
YOUNG A study found that the number of 2- to 4-year-olds on psychiatric drugs, including stimulants such as Ritalin and anti-depressants such as Prozac, jumped between 1991 and 1995.; 14 per 1,000 preschoolers; 1991; 1993; 1995 Total stimulants; Ritalin Total anti-depressants;

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

NY Times
3/1/00

The Role For Pills in Preschool

By Harold S. Koplewicz



Matthew Martin

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

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

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

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

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

The latest study, published in the Journal of the American Medical Association, found that between 1991 and 1995, there was a twofold to threefold increase in the use of Ritalin and similar drugs in children aged 2 to 4. About 1 in 100 children received Ritalin in 1995. Is 1 percent of children taking such medications too high?

Unfortunately, we have no information about the percentage of very young children who meet the criteria for an accurate diagnosis of A.D.H.D. For those who do, medications like Ritalin are the best treatment we have.

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

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

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

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

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

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

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Trends in the Prescribing of Psychotropic Medications to Preschoolers

Julie Magno Zito, PhD; Daniel J. Safer, MD; Susan dosReis, PhD; James F. Gardner, ScM; Myde Boles, PhD; Frances Lynch, PhD

Context Recent reports on the use of psychotropic medications for preschool-aged children with behavioral and emotional disorders warrant further examination of trends in the type and extent of drug therapy and sociodemographic correlates.

Objectives To determine the prevalence of psychotropic medication use in preschool-aged youths and to show utilization trends across a 5-year span.

Design Ambulatory care prescription records from 2 state Medicaid programs and a salaried group-model health maintenance organization (HMO) were used to perform a population-based analysis of three 1-year cross-sectional data sets (for the years 1991, 1993, and 1995).

Setting and Participants From 1991 to 1995, the number of enrollees aged 2 through 4 years in a Midwestern state Medicaid (MWM) program ranged from 146,369 to 158,060; in a mid-Atlantic state Medicaid (MAM) program, from 34,842 to 54,237; and in an HMO setting in the Northwest, from 19,107 to 19,322.

Main Outcome Measures Total, age-specific, and gender-specific utilization prevalences per 1000 enrollees for 3 major psychotropic drug classes (stimulants, antidepressants, and neuroleptics) and 2 leading psychotherapeutic medications (methylphenidate and clonidine); rates of increased use of these drugs from 1991 to 1995, compared across the 3 sites.

Results The 1995 rank order of total prevalence in preschoolers (per 1000) in the MWM program was: stimulants (12.3), 90% of which represents methylphenidate (11.1); antidepressants (3.2); clonidine (2.3); and neuroleptics (0.9). A similar rank order was observed for the MAM program, while the HMO had nearly 3 times more clonidine than antidepressant use (1.9 vs 0.7). Sizable increases in prevalence were noted between 1991 and 1995 across the 3 sites for clonidine, stimulants, and antidepressants, while neuroleptic use increased only slightly. Methylphenidate prevalence in 2 through 4-year-olds increased at each site: MWM, 3-fold; MAM, 1.7-fold; and HMO, 3.1-fold. Decreases occurred in the relative proportions of previously dominant psychotherapeutic agents in the stimulant and antidepressant classes, while increases occurred for newer, less established agents.

Conclusions In all 3 data sources, psychotropic medications prescribed for preschoolers increased dramatically between 1991 and 1995. The predominance of medications with off-label

(unlabeled) indications calls for prospective community-based, multidimensional outcome studies.

JAMA. 2000;283:1025-1030

The prevalence of psychotropic medication treatment for children and adolescents with emotional and behavioral disorders has significantly increased in the United States during the last few decades, particularly in the last 15 years. Specifically, the 5 through 14-year-old age group has experienced a great increase in stimulant treatment for attention-deficit/hyperactivity disorder (ADHD), and the 15 through 19-year-old age group has had sizable increases in the use of antidepressant medications.[1,2]

Approved and unapproved indications for psychotropic medications in young children are not extensive. These include: short-term use of analgesics and sedatives/hypnotics for pain relief; hydroxyzine for situational anxiety associated with medical, presurgical, and dental procedures; tricyclic antidepressants for nocturnal enuresis (6-year-olds and older); and amphetamines for ADHD in those 3 years old and older.[3] Accordingly, the prevalence of psychotropic medication treatment for children younger than 5 years old has not received much professional attention until recently.[4-6]

Concern about this age group relates to off-label (unlabeled) use, ie, for treatment indications with little or no proven efficacy and lacking product package insert labeling information approved by the US Food and Drug Administration (FDA).[7] One psychiatric newsletter, citing FDA-compiled marketing data, reported that 3000 prescriptions for fluoxetine hydrochloride were written for children aged younger than 1 year in 1994.[8] In a 1998 professional meeting report,[5] pediatric researchers noted that 57% of 223 Michigan Medicaid enrollees aged younger than 4 years with a diagnosis of ADHD received at least 1 psychotropic medication to treat this condition during a 15-month period in 1995-1996. Of the treatments, methylphenidate and clonidine were prescribed most often.

Although the use of psychotropic medication in preschool-aged children compared with older youths is relatively small, the reports cited argue for additional assessment to more systematically estimate its use. Consequently, 3 large, computerized data sources were used to estimate total, age-specific, and gender-specific psychotropic medication prevalence for 2 through 4-year-olds; to compare prevalence in the youngest age group with that in older children and adolescents; and to show utilization trends in the 5-year span from 1991-1995.

METHODS

Data Sources

Three large data sets were assembled from 2 types of health care systems. The first 2 are outpatient data sets from 2 geographically distinct Medicaid populations, 1 in a Midwestern state and 1 in a mid-Atlantic state. The third set of data comes from a group-model health maintenance organization (HMO) serving a predominantly employed population in the northwest region of the United States

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employed population in the northwest region of the United States. The total enrollments for those younger than age 20 years in 1991 and 1995, respectively, are as follows: Midwestern Medicaid (MWM), 669,164 and 687,722; mid-Atlantic Medicaid (MAM), 165,502 and 248,466; and group-model HMO (HMO), 131,038 and 131,860. These populations included both continuous and noncontinuous enrollees for each study year. The Medicaid youth populations were almost entirely eligible under Aid to Families with Dependent Children, and a small proportion qualified because of disability status (Supplemental Security Income) or foster care status. Nonwhites were overrepresented in the Medicaid populations and were underrepresented among HMO enrollees according to general statistical profiles of the settings.[9]

Study Measures

Psychotropic medication prevalence was defined for each study year as the frequency of persons with 1 or more HMO pharmacy records or Medicaid prescription claims for a psychotropic medication class, subclass, or specific medication per 1000 enrolled youths. Time trends were assessed across the 5-year span with data from 3 cross-sectional annual analyses (1991, 1993, and 1995).

For age-specific prevalence, children were grouped into 4 age strata (aged 2-4, 5-9, 10-14, and 15-19 years) according to US census categories. Data analyses focused on children aged 2 through 4 years. We were unable to investigate psychotropic medication use in infants 1 year old or younger in the 2 Medicaid populations because year of birth is recorded in a 2-digit field. Thus, "95" could refer to someone born in 1895 or 1995. We were unable, therefore, to distinguish those 1 year old and younger from 100- and 101-year-olds. We do present data on methylphenidate use in infants 1 year old or younger from the HMO program, as 4-digit years of birth were available. From 1991-1995, the number of enrollees aged 2 through 4 years ranged from 146,369 to 158,060 in the MWM program; from 34,842 to 54,237 in the MAM program, and from 19,107 to 19,322 in the HMO.

A separate analysis was performed to examine medication use among preschool-aged children by year of age. Gender-specific prevalence provided separate prevalence rates for boys and for girls.

Psychotropic Medications

Three psychotropic medication classes were examined: stimulants (methylphenidate, other stimulants), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], and other antidepressants), and neuroleptics. Selection was based on the frequent use of stimulants and antidepressants and the public health significance of the use of neuroleptics in the very young. In addition, 2 specific medications (methylphenidate and clonidine) were examined because their use alone or as a combined treatment has increased substantially since the early 1990s. All the drugs were identified using a data dictionary encompassing the national drug codes for each of the 3 study years. The study was given an exempt classification by the institutional review board–expedited review.

RESULTS

Total Psychotropic Medication Prevalence

The rank order of psychotropic medication prevalence in 1995 for the MWM program shows that, per 1000 enrollees, stimulants (12.3) were the leading treatment among those 2 through 4 years old, followed by antidepressants (3.2), clonidine (2.3), and neuroleptics (0.9) (Table 1). Within classes, methylphenidate prevalence (11.1 per 1000 enrollees) represented 90% of the stimulant treatment, while TCA prevalence (2.4 per 1000 enrollees) led the antidepressant class. A similar ranking of medication prevalence in 1995 was observed for the MAM program, while preschool-aged children in the HMO had nearly 3 times more clonidine use than antidepressant use (Table 1).

Pronounced differences in psychotropic prevalence across the 3 sites are apparent from Table 1. Stimulant and antidepressant use in 1995 was considerably less among preschoolers in the MAM program and HMO than among those in the MWM program. Enrollees in the MWM program and in the HMO led in the use of clonidine, whereas its use in the MAM program was one-half to two-thirds that of the other sites. Neuroleptic use per 1000 enrollees in either Medicaid program (0.9 in the MWM program, and 0.5 in the MAM program) was more common than in the HMO (0.2).

Time Trends in Psychotropic Medication Prevalence Across a 5-Year Span

The rate of psychotropic medication prescribed for preschoolers in the MWM program increased substantially from 1991-1995. The increase was greatest for clonidine (28.2-fold), stimulants (3.0-fold), and antidepressants (2.2-fold). By contrast, neuroleptic use did not increase substantially during this time. Comparisons of psychotropic medication between sites showed that trends were similar in all 3 sites, with minor deviations for neuroleptics and antidepressants in the population enrolled in the HMO (Table 1). Specifically, the methylphenidate prevalence increase by site was: MWM, 3-fold; MAM, 1.7-fold; and HMO, 3.1-fold. Increases were more dramatic when the base prevalence was low. For example, methylphenidate use in the HMO was the lowest of the 3 sites, but its rise from 1.3 per 1000 enrollees in 1991 to 4.0 per 1000 in 1995 represented the largest methylphenidate increase (3.1-fold) across the 3 sites (Table 1).

Age-Specific Methylphenidate Medication Prevalence

Methylphenidate use according to age group in children and adolescents in the MWM program was most prominent for those aged 5 through 14 years (Figure 1). By comparison, children 2 through 4 years old were treated at approximately one tenth the rate of their 5 through 14-year-old counterparts. The time trend analysis revealed that those in all 4 age groups experienced increases in the use of methylphenidate during the 5-year period. The largest methylphenidate increase (311%) was among 15 through 19-year-olds, whereas the 2 through 4-year-olds, like the 5- through 14-year-olds, had a smaller but still substantial increase (169% to 176%). The increase in prevalence within the preschool-aged group was greater for older children in the MWM program (from 6.9 to 20.8 per 1000 4-year-olds vs 1.1 to 3.5 per 1000 2-year-olds). The age-specific trends by year of age for those in the MAM program and HMO were consistent with those in the MWM program (Figure

1). There was no methylphenidate use in infants 1 year old or younger in the HMO population.

Gender-Specific Methylphenidate Medication Prevalence

There was a greater proportional increase in preschool-aged girls receiving methylphenidate from 1991 through 1995; in the HMO, the male-to-female ratio decreased from 7:1 to 4:1 during this time. A similar but less dramatic trend was evident in the MAM program (4:1 in 1991 to 3:1 in 1995). By contrast, the gender ratio for methylphenidate treatment in the MWM program was stable over these years (3:1 in 1991 and in 1995).

Changes in Drug Utilization and Off-Label Use

Changes in the use of older agents with a well-established efficacy profile were observed. For example, despite a general increase in total stimulant use, methylphenidate use in the MAM program decreased proportionally by 7% from 1991 to 1995, while the use of other stimulant medications rose from 15% to 27% of total stimulant use among preschoolers. In all 3 sites, TCAs were the mainstay of the antidepressant category in 1991, and their prevalence remained relatively stable through 1995. By contrast, the use of SSRI antidepressants increased dramatically at the Medicaid sites, although by 1995 these drugs comprised only a small proportion of antidepressants used in the HMO (Figure 2). Thus, antidepressant use increased, particularly through off-label use, in the preschool-aged group.

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COMMENT

Several prominent trends characterized the use of psychotropic medications in preschoolers during the early to mid 1990s. Overall, there were large increases for all study medications (except the neuroleptics) and considerable variation according to gender, age, geographic region, and health care system. These findings are remarkable in light of the limited knowledge base that underlies psychotropic medication use in very young children.[10] Controlled clinical studies to evaluate the efficacy and safety of psychotropic medications for preschoolers are rare.[3] Efficacy data are essentially lacking for clonidine and the SSRIs and methylphenidate's adverse effects for preschool children are more pronounced than for older youths.[11] Consequently, the vast majority of psychotropic medications prescribed for preschoolers are being used off-label.[7] Specific study findings are discussed below according to 3 major outcomes: prevalence findings for specific medications; age- and gender-specific data; and geographic and health care system variations.

Prevalence Findings

Stimulant treatment in preschoolers increased approximately 3-fold during the early 1990s. The prominence of stimulant and clonidine use is consistent with Michigan Medicaid use patterns for children younger than 4 years with an ADHD diagnosis.[5] The data show greater US methylphenidate prevalence for children younger than age 5 years than was reported in a prevalence study in Western

Australia (0.26% to 0.64% vs approximately 0.1%).[14] Hypothesized reasons for the overall increased stimulant use include: (1) a larger pool of eligible youths because of expanded diagnostic criteria for ADHD since 1980[13]; (2) more girls being treated for ADHD as evidenced by the narrowing of the gender ratio even among preschoolers; (3) greater acceptance of biological treatments for a behavioral disorder; and (4) the expanded role of school and preschool health personnel in identifying medical needs.[14]

Methylphenidate accounted for the vast majority of stimulant use (eg, 90% of the 1995 stimulant use in the MWM program). There was a modest but consistent decrease in the proportion of methylphenidate use relative to other stimulants across the 3 time periods. Generalizing from the efficacy and adverse effect experience of stimulants in older youths to preschoolers is often not valid,[11] at least partly because of preschoolers' developmental immaturity.

Clonidine had the most dramatic increases, although its use in 1995 was only 15% to 35% of the prevalence rate of stimulants. Clonidine use is particularly notable because its increased prescribing is occurring without the benefit of rigorous data to support it as a safe and effective treatment for attentional disorders. Cardiovascular adverse effects including bradycardia, atrioventricular block, and syncope with exercise have been reported in children treated with clonidine in combination with other medications for the treatment of ADHD and its comorbidities.[15, 16] Problems with abrupt withdrawal producing noradrenergic overdrive have been reported. Its use to combat the insomnia associated either with ADHD itself or secondary to the stimulant treatment of ADHD is new and largely uncharted,[17, 18] and its increased use for ADHD since 1991 helps explain the increased clonidine poisonings in children taking either their own medications or that of siblings.[19, 20]

The combined use of clonidine and methylphenidate has been associated with questions of safety[16, 21] and has been debated.[22] Unfortunately, the present data do not distinguish single vs concomitant medication use, information vital to understanding how these agents are being used in children. Such an analysis is better undertaken in a continuously enrolled cohort so that censored data do not create artifactual findings. We are currently conducting a continuously enrolled retrospective cohort study.

Antidepressants were the second most commonly prescribed psychotropic class of drugs for preschoolers, and their use increased substantially from 1991-1995. Tricyclic antidepressants still represent the bulk of early childhood antidepressant use, although the growth in use of SSRIs was strong in those enrolled in both Medicaid programs but very modest in those in the HMO. The proportional decrease in use of TCAs was largely explained by the recent increase in use of SSRIs, a trend we have previously shown for older youths[2] and one that has been documented in adults.[23] The use of TCAs for enuresis is common among 5 through 13-year-olds,[24] but its use in the preschool group is puzzling. It is also likely that some use of imipramine and desipramine was related to the treatment of ADHD in preschoolers.[25]

Neuroleptic use was infrequent and relatively stable across the study period. The neuroleptic prevalence rate in this preschool data showed rates one-tenth to one-half the annual prevalence among 5 through 19-year-olds in Rome from 1986 through 1991.[26] Both the neuroleptic and antidepressant findings bring new information on

population-based prevalence and provide some benchmarks to chart the use of these agents in ambulatory settings. Additional clinical interpretation, however, awaits prospective outcome studies.

Age- and Gender-Specific Prevalence Findings

Preschoolers' use of methylphenidate showed increases similar to those of 5 through 14-year-olds, suggesting that the expanded use of this medication for attentional disorders in US youths extends even to the very young. It is notable that the largest gains in use occurred among high school–aged students (15 through 19-year-olds), a trend that has been documented from county school survey data.[13]

Geographic and Health Care System Variations

Disparities in psychotropic medication prevalence data between the 2 state Medicaid program populations are provocative and suggest numerous hypotheses. These include differences between the states in (1) policies for eligibility or access to continuing care; (2) the proportion of individuals with emotional or mental disorders that may be related to the proportion of youths receiving Supplemental Security Income and foster care in each state; (3) preschool health assessment and referral programs; (4) physician specialty training, particularly among psychiatrists and primary care providers, with resultant referral or practice differences; (5) the cultural values that underlie families' decisions to accept or reject medication for behavioral or mental disorders; and (6) racial/ethnic population differences that may affect cultural orientations and beliefs. Also notable is the finding that the HMO prevalence rates, collectively, were substantially lower than those of the Medicaid programs. In this instance, geography and clinical population factors confound the prevalence findings related to HMO vs Medicaid systems. The presence of less severely disabled youths in the HMO population is likely to explain a large part of the differences, but geographic and patient cultural factors need to be considered as well. Also, the rapid expansion of Supplemental Security Income benefits since 1990 resulted in more youths with ADHD being eligible for Medicaid coverage than in previous years.[27]

Limitations

The study is limited in several ways. First, the findings may be generalizable to comparable Medicaid programs and to group-model HMO enrollees, but the extent to which they may apply to other treatment settings is unknown. Second, the cross-sectional nature of the data from the 3 study years do not permit a follow-up of the natural course of treatment. Until a continuously enrolled cohort is assembled, descriptive data on the natural course of treatment and prescription changes over time cannot be adequately assessed. However, noncontinuously enrolled individuals make up the bulk of the Medicaid membership. Thus, capturing these annual data snapshots of both noncontinuous and continuous enrollees is useful for clinical description. Third, no diagnostic codes were linked to the medications in this analysis, thus limiting information about why certain medications were selected. Fourth, computerized data sources use a limited number of variables to describe the clinical patterns in the usual practice settings. However, they have the advantage of describing the usual practice setting without the artificiality and the interference that prospective studies impose on physicians' decisions about medication and patients' decisions about treatment. Compared with data from specialty clinic samples, data from community treatment settings provide a far more accurate

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from community treatment settings provide a far more accurate assessment of medication practices, therapy variations, and treatment. Adding outcome assessments would allow the effectiveness of the treatments to be evaluated.

Clinical Research Recommendations

Because children's responses to medications are not necessarily similar to those of adults, systematic and careful outcome research specifically needs to be done for them.[7] Two types of studies would help provide more systematic information on psychotropic drug therapy in children. First, epidemiologic (naturalistic) studies could describe youth treatment in major medical settings (eg, traditional preferred provider organizations, Medicaid, salaried medical group-model HMOs, and other managed care organizations) to document types of treatments, diagnosis, severity, and time in treatment and to evaluate clinical outcomes. Outcome measures could include symptom control; social, day care, and preschool functioning; parent satisfaction; reasons for initiation and discontinuation; and adverse drug events.[28] Second, randomized, double-blind, controlled clinical trials are needed for off-label indications to evaluate dosages, efficacy, and safety of single and multiple agents shown to be commonly used or widely recommended. For disorders that occur very infrequently or questionable combinations of drug therapy with unknown risks, a case registry approach may be useful.

Future studies using large databases for clinical descriptive information should require that the year of birth be stored as a 4-digit number to avoid misclassification of elders as youths. Finally, youths in Medicaid programs should be subdivided by type of eligibility (eg, low income [formerly Aid to Families with Dependent Children, now called Temporary Assistance for Needy Families], Supplemental Security Income, or foster care) so that the total treatment prevalence, which includes children with known disabilities and major social stressors, will not be unfairly compared with that of less impaired youths in non-Medicaid populations.[27]

Unresolved questions involve the long-term safety of psychotropic medications, particularly in light of earlier ages of initiation and longer durations of treatment. While it is reassuring that anecdotal reports have rarely documented these problems, the possibility of adverse effects on the developing brain cannot be ruled out.[29] Active surveillance mechanisms for ascertaining subtle changes that the developing personality may undergo as a result of a psychotropic drug's impact on brain neurotransmitters should be developed.

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Trends in the Prescribing of Psychotropic Medications to Preschoolers

Julie Magno Zito, PhD; Daniel J. Safer, MD; Susan dosReis, PhD; James F. Gardner, ScM; Myde Boles, PhD; Frances Lynch, PhD

Context Recent reports on the use of psychotropic medications for preschool-aged children with behavioral and emotional disorders warrant further examination of trends in the type and extent of drug therapy and sociodemographic correlates.

Objectives To determine the prevalence of psychotropic medication use in preschool-aged youths and to show utilization trends across a 5-year span.

Design Ambulatory care prescription records from 2 state Medicaid programs and a salaried group-model health maintenance organization (HMO) were used to perform a population-based analysis of three 1-year cross-sectional data sets (for the years 1991, 1993, and 1995).

Setting and Participants From 1991 to 1995, the number of enrollees aged 2 through 4 years in a Midwestern state Medicaid (MWM) program ranged from 146,369 to 158,060; in a mid-Atlantic state Medicaid (MAM) program, from 34,842 to 54,237; and in an HMO setting in the Northwest, from 19,107 to 19,322.

Main Outcome Measures Total, age-specific, and gender-specific utilization prevalences per 1000 enrollees for 3 major psychotropic drug classes (stimulants, antidepressants, and neuroleptics) and 2 leading psychotherapeutic medications (methylphenidate and clonidine); rates of increased use of these drugs from 1991 to 1995, compared across the 3 sites.

Results The 1995 rank order of total prevalence in preschoolers (per 1000) in the MWM program was: stimulants (12.3), 90% of which represents methylphenidate (11.1); antidepressants (3.2); clonidine (2.3); and neuroleptics (0.9). A similar rank order was observed for the MAM program, while the HMO had nearly 3 times more clonidine than antidepressant use (1.9 vs 0.7). Sizable increases in prevalence were noted between 1991 and 1995 across the 3 sites for clonidine, stimulants, and antidepressants, while neuroleptic use increased only slightly. Methylphenidate prevalence in 2 through 4-year-olds increased at each site: MWM, 3-fold; MAM, 1.7-fold; and HMO, 3.1-fold. Decreases occurred in the relative proportions of previously dominant psychotherapeutic agents in the stimulant and antidepressant classes, while increases occurred for newer, less established agents.

Conclusions In all 3 data sources, psychotropic medications prescribed for preschoolers increased dramatically between 1991 and 1995. The predominance of medications with off-label

(unlabeled) indications calls for prospective community-based, multidimensional outcome studies.

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Launch of New Public-Private Effort to Improve the Diagnosis and Treatment of Children with Emotional and Behavioral Conditions Remarks by First Lady Hillary Rodham Clinton

Indian Treaty Room
Roosevelt Room
March 20, 2000

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

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

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

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

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

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

But let me be very clear: We are not here to bash the use of these medications. They have literally been a Godsend for countless adults and young people with behavioral and emotional problems. We know that when children with such problems are left untreated, they may fail to reach their God-given potential later in their lives. That's why we are here. We want the best information for every parent, every doctor, every teacher—every single person who cares for our children.

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

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

development?

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

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

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

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

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

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

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

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

childhood and chance in life that we all deserve.

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

But I am also concerned that we are seeing increasing numbers of children who are both being diagnosed with certain disorders and whose behaviors are crying out for helpful intervention. We spoke earlier today in our meeting about the increasing number of very young children in foster care. The fastest growing group of children being put into foster care are children under 5. They come into foster care because of abuse or neglect and they therefore have more than the kinds of problems that one would expect in the population at large. We talked about the increasing numbers of children who are in the juvenile justice and criminal justice systems. We are not doing what we need to do to help intervene and treat those children, just as we are not providing adequate medical and mental health services in our adult prisons. These are problems that affect all of society, not just the individual with the specific problem or that individual's family or those teachers and others that come into contact with that young person. This has ramifications for all of us.

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

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

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

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

Thank you all very much.

TALKING IT OVER

HILLARY RODHAM CLINTON

March 22, 2000

When our children come to us hurt or sick -- whether it's with a simple cold or a life-threatening illness -- there is nothing more frightening than not knowing how to make them better. It's no different for the parent of a child who is sad or misbehaving.

Sometimes, these children have problems that are simply typical of childhood or adolescence. Some need only a parent to love them, or a person to listen. But others have severe behavioral or emotional problems -- problems for which there are now a number of treatments, including therapy, behavior modification and prescription drugs.

Recently, the Journal of the American Medical Association reported that the number of preschoolers taking prescription drugs increased dramatically between 1991 and 1995. The increase for Ritalin alone -- the drug most widely used to treat attention-deficit/hyperactivity disorder -- was 150 percent. The use of antidepressants grew 200 percent.

When I read these results, I was alarmed -- and I was not alone.

I know that prescription drugs have been a godsend for countless young people suffering with emotional and behavioral disorders. And research tells us that, if left untreated, many would fail to reach their full potential later in life.

But despite this good news, it is time to look carefully at some important unanswered questions: How are we diagnosing, treating and caring for children with behavioral and emotional conditions? Do we have the best tools to make the most accurate diagnoses? Why are there dramatic variations in treatment among different communities and races? And what effects do overuse -- and underuse -- of medications have on children?

Further, we need to ask: Why aren't we doing a better job of combining drugs, when necessary, with therapy and other treatments? And what about the fact that these drugs have never been tested on our very youngest children, whose brains are at their most critical stage of development.

These are tough questions, but over the past few years, we have begun to tackle the answers. We have taken critical steps to ensure that drugs are tested and labeled specifically for children. In the process, we have learned that finding the right prescription for a child is not always as simple as decreasing an adult's dose.

And thanks in large part to the leadership of the President's Mental Health Policy Advisor, Tipper Gore, we have come a long way in our effort to bring these problems out of the shadows. In the wake of last summer's White House Conference on Mental Illness, which she led, and the subsequent Surgeon General's Report on Mental Illness, we learned that children suffer the stigma of these conditions more than adults; too many professionals lack training in this area; and it is time to increase public awareness of children's mental health

issues.

This week, at the White House, along with the Secretary of Health and Human Services, Donna Shalala, I hosted a meeting of health professionals, educators and parents to take steps toward increasing awareness and improving the diagnosis and treatment of children with emotional and behavioral conditions. By the end of the meeting, it was clear that, although there is much we already know, critical information has never reached the people who need it most.

In order to change that, we have now launched an unprecedented effort to ensure that children are appropriately diagnosed, treated, monitored and managed by their parents, their teachers, their doctors, and other professionals.

To that end, the National Institute of Mental Health is releasing an easy-to-understand fact sheet that parents can use to make treatment decisions for their children. The Education Department will issue an information kit for parents and teachers helping youngsters with ADHD.

The American Academy of Pediatrics will give each of their 55,000 members up-to-date guidelines for diagnosing and treating patients with emotional and behavioral problems. And as part of a year-long focus on mental health, the American Academy of Family Physicians will sponsor continuing education courses for their 90,000 members.

The NIMH will undertake a study of ADHD and Ritalin use in preschoolers. The FDA will investigate appropriate doses of some common drugs prescribed for very small children. And the Surgeon General's office will coordinate a National Conference for the Treatment of Children with Behavioral and Mental Disorders.

I hope that this week's meeting will move us closer to the day when the stigma surrounding these issues disappears, and we treat problems of the mind with the same care and understanding that we bring to problems of the body. And I hope that we will be even more committed to making sure that our children get the help, support and love they need.

To find out more about Hillary Rodham Clinton and read her past columns, visit the Creators Syndicate web page at www.creators.com.

Talking it Over

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