



Medication Update

Antidepressant Medications for Children and Adolescents: Information for Parents

Reprinted from the National Institute of Mental Health

Recently, concerns have been raised that the use of antidepressant medications themselves may induce suicidal behavior in youths. In fact, following a thorough and comprehensive review of all the available published and unpublished controlled clinical trials of antidepressants in children and adolescents, the FDA has warned the public about an increased risk of suicidal thoughts or behavior (“suicidality”) in children and adolescents treated with SSRI antidepressant medications.

Studies show that there are substantial benefits from medication treatment for adolescents with moderate and severe depression, including many with suicidal ideation.

FDA Review of Clinical Trials

In the FDA review, no completed suicides occurred among nearly 2,200 children treated with SSRI medications; however, the rate of suicidal thinking or behavior, including actual suicidal attempts, was 4 percent for those on SSRI medications, twice the rate of those on inert placebo pills (2 percent).

The FDA adopted a “black box” label warning (PDF file) that antidepressants were found to increase the risk of suicidal thinking and behavior in children and adolescents with major depressive disorder. A black-box warning is the most serious type of warning in prescription drug labeling.

The warning also emphasizes that children and adolescents started on SSRI medications should be closely monitored for any worsening in depression, emergence of suicidal thinking or behavior, and in general for any unusual changes in behavior — such as sleeplessness, agitation, withdraw from normal social situations. This monitoring is especially important during the first four weeks of treatment. SSRI medications usually have few side effects in children and adolescents, but for unknown reasons, can trigger agitation and abnormal behavior in certain individuals.

What Do We Know About Antidepressant Medications?

The SSRIs (serotonin reuptake inhibitors) include: fluoxetine (Prozac); sertraline (Zoloft); paroxetine (Paxil); citalopram (Celexa); escitalopram (Lexapro); fluvoxamine (Luvox); venlafaxine (Effexor)—another antidepressant closely related to the SSRIs.

SSRI medications are considered an improvement over older antidepressant medications because they have fewer side effects and are safer if taken in an overdose (which is an issue for patients at risk for suicide). They have been extensively tested in adult populations and have been proven to be safe and effective for adults. Use of SSRI medications has risen dramatically in the past several years in children and adolescents age 10-19. Some studies show that this increase has coincided with a significant decrease in suicide rates in this age group, but it is not known if SSRI medications are directly responsible for this improvement.

Fluoxetine (also known as Prozac) is the only medication approved by the FDA for use to treat depression in children age 8 and older. The other SSRI medications, such as sertraline, citalopram,

From the Co-Presidents

Dear Members,

It is with great sadness that we inform you of the loss of an invaluable member of our NAMI-CCNS community. Board member Jim Walsh succumbed to pancreatic cancer on October 1st after a very short but brave battle against this ruthless illness. He and his wife, Deb, have served on our board for the past two years. As treasurer, Jim helped us with budget planning and the other financial responsibilities required to run a nonprofit, membership-based organization. Deb has enthusiastically served as our fundraising chair with wonderful creativity and energy. We sincerely hope that Deb will continue to remain in our NAMI-CCNS community and on our board.

On a more positive note, we are very happy to announce that our own Barb Maier, longtime board member and coordinator of the statewide Visions for Tomorrow program, was awarded the NAMI Illinois Katie Petray Excellence in Education award at the recent state conference in Springfield, Illinois. In 2002, Barb responded to an identified need for NAMI to sponsor programs for parents of children and adolescent with mental illness by obtaining a three-year statewide grant to launch the Visions for Tomorrow program. Three years later, over 80 Illinois teachers have been trained; over 500 parents and caretakers have participated in this program as students. Congratulations Barb on all the energy and effort you have contributed to make this program happen in Illinois!

Co-president Ann George and I were pleased to attend the NAMI Illinois conference in October. We attended many inspiring presentations and gathered practical information that will be useful for NAMI-CCNS operations. We hope to work with other board members and committee chairs to bring these ideas into fruition during the next year. To do so, however, will require new board and committee members.

Now is the time for you to decide if you want to become more involved in NAMI-CCNS. The increased calls to NAMI-CCNS from individuals with mental illness, family members, and professionals show our organization has gained credibility as a worthwhile source of assistance, knowledge, and support. In order to respond effectively to the many calls that we receive, we need more people to volunteer. You can either e-mail or call either one of us to let us know of your interest.

Ann George 847-989-8012 anngeorge@comcast.net
Candice Hughes 847-920-9380 Chughesnamiccns@aol.com

Board meetings are open to all members. We encourage you to attend. This is a good way to learn about what NAMI-CCNS is doing. The next meetings will be held at Wilpower, 444 Frontage Road, Northfield, November 2nd and December 7th at 7:30 p.m.

Respectfully yours,

Candice Hughes & Ann George

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Visit our website: www.namiccns.org
Website maintained by Tom Maier

**November 2005 –
January 2006**



Medication Update/ *continued*

and paroxetine, and the SSRI-related antidepressant venlafaxine, have not been approved for treatment of depression in children or adolescents, though they have been prescribed to children by physicians in “off-label use”—a use other than the FDA approved use. In June 2003, the FDA recommended that paroxetine not be used in children and adolescents for the treatment of major depressive disorder.

Fluoxetine has been shown to be helpful for treating childhood depression in three different clinical trials—two supported by NIMH and the other supported by the manufacturer of the drug. The trials found that fluoxetine by itself, and even more so when combined with cognitive behavioral therapy, reduced depression for many children better than an inert placebo pill. However, fluoxetine failed to improve depression in at least one third of patients. Also, about one in 10 children experienced adverse side effects such as agitation and mania.

In the recently completed Treatment for Adolescents with Depression Study (TADS) funded by NIMH, suicidal thinking generally decreased during treatment with fluoxetine, but 15 of the 216 youths on fluoxetine (6.94 percent) had a suicide-related event, such as a suicidal attempt or threats, as compared with 9 of the 223 on the inert placebo pill (4.04 percent).

Fluoxetine leads to significant improvement of depression overall. The drug, however, may increase the risk for suicidal behaviors *in a small subset of adolescents*. As with all medical decisions, doctors and families have to weigh risks and benefits of treatment for each individual patient.

What Remains Unknown

Currently, there is no way of telling who may be sensitive to an SSRI’s positive or adverse effects. Results thus far are based on populations—some individuals may show marked improvement, some may see no change, and some may be vulnerable to adverse effects. The response to medication of an individual patient cannot be predicted with certainty from the kind of studies that have been done so far.

It is extremely difficult to determine whether SSRI medications do or do not increase the risk of completed suicide, especially since depression itself increases the risk for suicide and because completed suicide is a rare event. Controlled trials typically include only hundreds of patients, not the thousands needed to detect effects for rare events. In addition, controlled trials typically exclude patients

considered at high risk for suicide, such as those with a history of suicide attempts.

What Should You Do for a Child With Depression?

Major depression in children and adolescents is a serious condition that should be adequately treated, which includes careful follow-up and monitoring.

Each child should be carefully and thoroughly evaluated by a physician to determine if medication is appropriate. Those who are prescribed an SSRI medication should receive ongoing medical monitoring, with particular care paid in the first four weeks of taking the drug.

Psychotherapy is often used as an initial treatment for milder forms of depression. Many times, psychotherapy accompanied by an early follow-up appointment may help to establish the persistence of depression before a decision is made to try antidepressant medications. Psychotherapies include “cognitive behavioral therapy” and “interpersonal therapy.” For moderate to severe forms of depression, especially if persistent, the current evidence supports the use of fluoxetine alone or in combination with cognitive-behavioral therapy (CBT). See results for the recently completed Treatment for Adolescents with Depression Study (TADS).

Should suicidal thinking or behavior, nervousness, agitation, irritability, mood instability, or sleeplessness emerge or worsen during treatment with SSRI medications, parents should obtain a prompt evaluation by a clinician with expertise in these medications.

Children already on any of the SSRI medications should remain on the drug if it has been helpful but they should also be carefully monitored by a physician for evidence of side effects. Once started, treatment with these medications should not be abruptly stopped, because of potential side effects. Families should not discontinue treatment without consulting with their physician.

All treatments can be associated with side effects. A careful weighing of risks and benefits, with appropriate follow-up to help reduce risks, is the best that can be currently recommended. ■

For more information on this topic, see Antidepressant Medications in Children, Vitiello, B, Swedo, S. National Institute of Mental Health, Bethesda, MD. *New England Journal of Medicine* Apr 8;350(15):1489-91; For more information on FDA labeling, go to <http://www.fda.gov/cder/drug/antidepressants/labelTemplate.pdf>

A Guide to... Treatment of Children with Mental Disorders

Reprinted from the National Institute of Mental Health

There has been public concern over reports that very young children are being prescribed psychotropic medications. The studies to date are incomplete, and much more needs to be learned about young children who are treated with medications for all kinds of illnesses. In the field of mental health, new studies are needed to tell us what the best treatments are for children with emotional and behavioral disturbances.

Children are in a state of rapid change and growth during their developmental years. Diagnosis and treatment of mental disorders must be viewed with these changes in mind. While some problems are short-lived and don't need treatment, others are persistent and very serious, and parents should seek professional help for their children.

Not long ago, it was thought that many brain disorders such as anxiety disorders, depression, and bipolar disorder began only after childhood. We now know they can begin in early childhood. An estimated 1 in 10 children and adolescents in the United States suffers from mental illness severe enough to cause some level of impairment. Fewer than one in five of these ill children receives treatment. Perhaps the most studied, diagnosed, and treated childhood-onset mental disorder is attention deficit hyperactivity disorder (ADHD), but even with this disorder there is a need for further research in very young children.

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

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

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

Many everyday stresses cause changes in behavior. The birth of a sibling may cause a child to temporarily act much younger. It

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

Whom should I consult to help my child?

First, consult your child's doctor. Ask for a complete health examination of your child. Describe the behaviors that worry you. Ask whether your child needs further evaluation by a specialist in child behavioral problems. Such specialists may include psychiatrists, psychologists, social workers, and behavioral therapists. Educators may also be needed to help your child.

How are mental disorders diagnosed in young children?

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

Won't my child get better with time?

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

Which mental disorders are seen in children?

Mental disorders with possible onset in childhood include: anxiety disorders; attention deficit and disruptive behavior disorders; autism and other pervasive developmental disorders; eating disorders (e.g., anorexia nervosa); mood disorders (e.g., major depression, bipolar disorder); schizophrenia; and tic

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Legislative Update

By Sally Mann

National

Action Needed on Housing

The Senate is expected to take up the FY 2006 funding bill for the U.S. Department of Housing and Urban Development (HUD). The bill (HR 3058) includes funding for critically important housing programs serving low-income people with mental illness including Section 811, permanent housing under the McKinney-Vento Homeless Assistance Act and the Section 8 rental voucher program.

A bipartisan coalition led by Senators Norm Coleman (R-MN) and Patrick Leahy (D-VT) is planning to offer an amendment to supplement funding for a range of HUD programs, including the Section 8 rental voucher program. The amendment would add an additional \$200 million for Section 8 and ensure that the \$70 million needed to renew all expiring Section 811 tenant-based rent subsidies is fully funded as part of the overall Section 8 account. This additional funding for Section 8 will also ensure that all current rental vouchers in use are renewed for FY 2006.

Advocates are strongly encouraged to contact their Senators to urge them to support the Coleman-Leahy Amendment to HR 3058, the FY 2006 Treasury-Transportation-HUD Appropriations bill. *[To contact your legislator, see below, next article]*

Action Needed to Halt Medicaid Cuts

Help Protect Beneficiaries from Harm and Assist Katrina Survivors

During the next week, the Senate Finance Committee is expected to act on proposals to cut Medicaid by approximately \$10 billion over five years. The House will act on similar legislation later this month that could include a much larger cut to Medicaid. These bills may allow states to increase cost-sharing and limit benefits for Medicaid beneficiaries and could cause severe reductions in Medicaid funding for rehabilitative services and targeted case management. While the catastrophic consequences of Hurricane Katrina had caused Congress to delay action on proposed cuts to Medicaid, conservatives are now insisting that the disaster relief funding that Congress has provided must be paid for by additional cuts to Medicaid and other government programs that aid the poor.

Meanwhile, the Bush Administration and several Republican Senators continue to block the Emergency

Medicaid Hurricane Katrina Relief bill sponsored by Senators Chuck Grassley (IA-R) and Max Baucus (MT-D) and as a result over half of the applicants for medical assistance in Louisiana have been denied coverage. To top it off, leaders in both houses of Congress still intend to cut taxes this year by at least \$70 billion over the next five years.

A tremendous public outcry of opposition is our only hope of stopping harmful cuts in medical assistance for the very low-income people who rely on Medicaid.

Message: *I am outraged that Congress is even considering cutting federal support for Medicaid while moving forward with plans to cut taxes. I urge Senator/Representative _____ to oppose proposals that will harm Medicaid beneficiaries by allowing higher cost-sharing and more limited benefits. The Administration's proposals to limit Medicaid coverage for rehabilitative services and targeted case management will have a devastating impact of community-based mental health services. I urge Senator/Representative _____ to oppose those proposals. The recent natural disasters have caused many more people to need assistance accessing health care than was previously expected. Congress must enact the Grassley-Baucus bill to provide emergency Medicaid relief for Katrina survivors.*

- **Call:** Telephone the U.S Capitol Switchboard at 202-224-3121 and ask for the office number of your Senator or find their phone numbers as www.senate.gov or www.house.gov.
- **E-mail:** Go to the Internet site <http://www.congress.org>, enter your ZIP code, select the appropriate Senator, click on the e-mail address, and a message form will appear that you can fill out (including by cutting and pasting the messages above) and e-mail to his or her office.
- **Fax:** Call the office of your Senators to request the fax number or visit their Web sites, where a fax number is usually listed.

Illinois

Illinois Restricting Psych Drugs: Doctors Fume Over Cuts

Mental health providers and advocates are fighting a rule that will make doctors get a nod from the state before putting Medicaid patients on certain brand-name drugs over cheaper alternatives. The change will save more than \$7 million in the first year, state officials said. About 30,000 Medicaid patients who suffer from illnesses such as

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schizophrenia and bipolar disorder are taking the drugs, known by the brand names Zyprexa and Seroquel.

Opponents of the rule say the two drugs aren't interchangeable with others that treat the same disorders with similar success rates. They fear patients who end up on the wrong drug - one that doesn't work as well or has worse side effects - will ditch medication altogether, ending up in hospitals, homeless or in the criminal justice system.

"It has taken years for some of us to stabilize our patients on these medications," said Dr. Surinder Nand, president of the Illinois Psychiatric Society. "No two patients who suffer from psychosis or schizophrenia have the same kinds of symptoms, and they don't respond to the same atypical antipsychotics," Nand said, referring to the class of drugs. "These drugs are very different."

The state will allow a transition period for patients already taking the drugs. Their doctors will have four months to try the cheaper alternatives or document that those drugs have already failed. State officials promise to provide a fax number to receive the forms seeking approval, which they say will be turned around within 24 hours, along with waivers for co-payments on all antipsychotic drugs.

Mark Heyrman, director of a coalition of Illinois mental health patients and their families called the Mental Health

Summit, isn't comforted by such assurances. "What they are doing is allowing you four months to be cut off and switched to a medication that may not work for you," he said. The state doesn't pay doctors to argue for premium drugs, and most won't go through the trouble, Heyrman said. "They won't do it because they don't have the time." ■

Source: Excerpted from an article in the *Daily Southtown* by Gregg Sherrard Blesch

Clinical Study

The University of Chicago is conducting a genetic study of bipolar disorder funded by the NIMH.

We are seeking:

- Individuals with (or having) all symptoms of bipolar disorder

OR

- Individuals diagnosed with (or having) all symptoms of bipolar disorder AND
- Immediate family members with depression, mania, or mood swings

Participants will be reimbursed \$75 for their time and a blood sample. No travel required.

Please call our study line at 866 51-GENES or e-mail: Family@yoda.bsd.uchicago.edu

NAMI CCNS News Update

Barb Maier Receives Education Award

The National Alliance on Mental Illness, Illinois, presented NAMI CCNS Board member Barb Maier with the "Katie Petray Excellence in Education" award on October 15th in Springfield, Illinois, at the annual NAMI Illinois Conference. The "Katie Petray Excellence in Education" award is for a NAMI Illinois member who has made an outstanding contribution to further education in serious mental illness, providing education through one or more of NAMI Illinois' education programs.

Barb successfully co-wrote a grant to NAMI Illinois to implement the "Visions For Tomorrow" psychoeducational course for parents of children and adolescents throughout the state. NAMI Illinois now has more than 80 Visions For Tomorrow teachers across the state; nearly 500 parents of children and adolescents with serious mental illnesses have taken the 12-week course. NAMI Illinois has been selected

as one of three states to pilot the updated Visions For Tomorrow curriculum.

Barb has a Masters in Marriage and Family Counseling; has completed Advanced Clinician Training in Collaborative Problem Solving Therapy; is a past Board Member of NAMI Illinois; a current Board member of NAMI Cook County North Suburban; Program Coordinator/NAMI Illinois Visions For Tomorrow program; has facilitated a support group for parents of children and adolescents with serious mental illnesses for 5 years at Kenilworth Union Church; and mentors a group of young adults who created "Sundays At One," a social group for young adults, sponsored by NAMI CCNS.

Death Notice

Jim Walsh, NAMI CCNS treasurer and board member for two years, has died of cancer. Our condolences go out to his family. ■

disorders. Under some circumstances, bed-wetting and soiling may be symptoms of a mental disorder.

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

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

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

Yes. Young children's bodies handle medications differently than older individuals and this has implications for dosage. The brains of young children are in a state of very rapid development, and animal studies have shown that the developing neurotransmitter systems can be very sensitive to medications. A great deal of research is still needed to determine the effects and benefits of medications in children of all ages. Yet it is important to remember that serious untreated mental disorders themselves negatively impact brain development.

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

No. Psychotropic medications are not generally the first option for a preschool child with a mental disorder. The first goal is to understand the factors that may be contributing to the condition. The child's own physical and emotional state is key, but many other factors such as parental stress or a changing family environment may influence the child's symptoms. Certain psychosocial treatments may be as effective as medication.

How should medication be included in an overall treatment plan?

When medication is used, it should not be the only strategy. There are other services that you may want to investigate for your child. Family support services, educational classes, behavior management techniques, as well as family therapy and other approaches should be considered. If medication is prescribed, it should be monitored and evaluated regularly.

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

There are several major categories of psychotropic medications: stimulants, antidepressants, antianxiety agents, antipsychotics, and mood stabilizers. For medications approved by the FDA for use in children, dosages depend on body weight and age. The Medications Chart in this booklet shows the most commonly prescribed medications for children with mood or anxiety disorders (including OCD).

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

Antidepressant and Antianxiety Medications: These medications follow the stimulant medications in prevalence among children and adolescents. They are used for depression, a disorder recognized only in the last 20 years as a problem for children, and for anxiety disorders, including obsessive-compulsive disorder (OCD). The medications most widely prescribed for these disorders are the selective serotonin reuptake inhibitors (the SSRIs).

In the human brain, there are many "neurotransmitters" that affect the way we think, feel, and act. Three of these neurotransmitters that antidepressants influence are serotonin, dopamine, and norepinephrine. SSRIs affect mainly serotonin and have been found to be effective in treating depression and anxiety without as many side effects as some older antidepressants.

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Antipsychotic Medications: These medications are used to treat children with schizophrenia, bipolar disorder, autism, Tourette's syndrome, and severe conduct disorders. Some of the older antipsychotic medications have specific indications and dose guidelines for children. Some of the newer "atypical" antipsychotics, which have fewer side effects, are also being used for children. Such use requires close monitoring for side effects.

Mood Stabilizing Medications: These medications are used to treat bipolar disorder (manic-depressive illness). However, because there is very limited data on the safety and efficacy of most mood stabilizers in youth, treatment of children and adolescents is based mainly on experience with adults. The most typically used mood stabilizers are lithium and valproate (Depakote®), which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes in adults. Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using stimulant medications to treat co-occurring ADHD or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

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

Approval of a medication by the FDA means that adequate data have been provided to the FDA by the drug manufacturer to show safety and efficacy for a particular therapy in a particular population. Based on the data, a label indication for the drug is established that includes proper dosage, potential side effects, and approved age. Doctors prescribe medications as they feel appropriate even if those uses are not included in the labeling. Although in some cases there is extensive clinical experience in

using medications for children or adolescents, in many cases there is not. Everyone agrees that more studies in children are needed if we are to know the appropriate dosages, how a drug works in children, and what effects there are on learning and development.

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

Many medications that are on the market have not been officially approved by the FDA for use in children. Treatment of children with these medications is called "off-label" use. For some medications, the off-label use is supported by data from well-conducted studies in children. For instance, some antidepressant medications have been shown to be effective in children and adolescents with depression. For other medications, there are no controlled studies in children, but only isolated clinical reports. In particular, the use of psychotropic medications in preschoolers has not been adequately studied and must be considered very carefully by balancing severity of symptoms, degree of impairment, and potential benefits and risks of treatment.

Why haven't many medications been tested in children?

In the past, medications were not studied in children because of ethical concerns about involving children in clinical trials. However, this created a new problem: lack of knowledge about the best treatments for children. In clinical settings where children are suffering from mental or behavioral disorders, medications are being prescribed at increasingly early ages. The FDA has been urging that products be appropriately studied in children and has offered incentives to drug manufacturers to carry out such testing. The NIH and the FDA are examining the issue of medication research in children and are developing new research approaches.

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

Yes. However, this is based on the data provided to the FDA by the drug manufacturer and the policies in effect at the time of approval. For example, Ritalin® is approved for children age 6 and older, whereas Dexedrine® is approved for children as young as 3. When Ritalin® was tested for efficacy by its manufacturer, only children age 6 and above were involved; therefore, age 6 was approved as the lower age limit for Ritalin®.

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

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

Calendar

New sessions of NAMI CCNS psychoeducation classes beginning!

“Family To Family” A 12-week class for parents and caregivers with children or family members with mental disorders aged 24 and over. Course covers a wide range of topics, including information on mental disorders, coping skills, advocacy, and problem solving. For information or to enroll, call Joyce Schladweiler at 847 853-6191 or Diane Thurnblad at 847 904-7894.

“Visions For Tomorrow” An 8-week course for parents and primary caregivers of children and adolescents with brain disorders such as ADHD, bipolar disorder, anxiety and eating disorders, depression and obsessive compulsive disorder. Starts February 7, 7:00 pm. to 9:00 pm. at New Trier West in Northfield. For more information and to register contact Barb Maier at 847 446-8416.

November 2 Board of Directors meeting at Wilpower, 444 Frontage Road, Northfield, 7:30 pm.

November 8 “Care and Share” is a support group for people with mental disorders and their families and friends. 2 South Conference Room at Rush North Shore Hospital, 9600 Gross Point Road, Skokie, 7:30-9:00 pm.

November 10 “Visions for Tomorrow” Support and discussion group for parents of children, adolescents, and young adults with mental disorders. 7:30 pm. Kenilworth Union Church, 211 Kenilworth Ave., Kenilworth. Call Barb Maier for information at 847 446-8416.

November 12 “Power of the Brain” The program will explore what new research is revealing about the brain and the implications for raising emotionally healthy children. Evanston Civic Center, 2100 Ridge Ave., Evanston, 8:00 am-1:00 pm. To receive program registration materials or additional information, call Harvey Saver at 847 448-8053 or Hsaver@cityofevanston.org

November 27 “Sundays at One” is a support group for young adults with mental disorders who want to do things together. 1:00-3:00 pm at Borders Bookstore, 49 S. Waukegan Road, Northbrook (corner of Waukegan

and Lake Cook Roads). For information and registration, call Nate Maier 847 446-8416 or Alan Carlile 847 736-4587. *(Please note: There will be no “Sundays at One” in December)*

December 7 Board of Directors meeting (*see November 2*)

December 8 “Visions for Tomorrow” support group (*see November 10*)

December 13 Possible program or “Care and Share” at 7:30 pm in the Sharfstein Center at Rush North Shore Medical Center, 9600 Gross Point Road, Skokie. Details to be posted on the NAMI CCNS web site: www.namiccns.org

January 10 NAMI CCNS Annual Meeting 7:30 pm. in the Sharfstein Center at Rush North Shore Hospital. Program details will follow in a separate mailing to the membership.

January 12 “Visions for Tomorrow” support group (*see November 10*)

January 29 “Sundays at One” (*see November 27*)



NAMI CCNS
Box 612
Winnetka, IL 60093

Place
Stamp
Here

NAMI CCNS EDUCATION CLASSES, SUPPORT GROUPS AND OTHER SERVICES

**NAMI CCNS' two psychoeducational classes*

***Visions for Tomorrow** An 8-week course designed for primary care givers of children with mental disorders. The class covers bipolar disorder, schizophrenia, anxiety disorders, eating disorders, ADHD, as well as brain biology, treatments, medications, communication and coping skills. Class is free of charge. Call Barb Maier for information at 847-446-8416. (*New classes starting, see Calendar*)

***Family to Family** A 12-week class designed for family members and close friends of individuals with mental illnesses. The course covers schizophrenia, depression, bipolar disorder, borderline personality disorder, panic disorder, obsessive compulsive disorder, co-occurring addictive disorders, as well as medications, coping skills, and advocacy. Class is free of charge. To register, call Joyce at 847-853-6191. (*New classes starting, see Calendar*)

General Meeting is an educational program featuring speakers with expertise in the mental health field. (*See Calendar for details*)

Care and Share is a support group for people with mental disorders, as well as their friends and families. (*See Calendar for details*)

Visions for Tomorrow Support Group is for parents of children, adolescents, and young adults with mental disorders. Call Barb Maier for information at 847-446-8416. (*See Calendar for details*)

Response Team A "warm line" (not a crisis hot line) for anyone looking for resources, referrals (or just a chance to connect to others) about dealing with mental disorders. Call the NAMI CCNS office and leave a message at 847-724-1460.

Sundays at One is a social meeting group for young adults (ages 18 to 35) coping with mental disorders. Run by Alan Carlile, Candice Savastio, and Nathan Maier (who struggle with chemical imbalances). Call Nate at 847-446-8416. (*See Calendar for details*)

Other Organizations

Anorexia Nervosa and Associated Disorders offers information on referrals, and local support groups for eating disorders. Call Dawn at 847-831-3438.

Child and Adolescent Bipolar Foundation is a national, parent-led organization of families raising children diagnosed with bipolar disorder. For information on support groups, visit www.bpkids.org or call 847-256-8525.

Depression and Bipolar Support Alliance of Greater Chicago meets the second and fourth Monday of each month at the Devon Bank, 6445 N. Western Ave., Chicago. 7:30 pm. Call Chet for details at 773-465-3280.

Depression Support Group meets the fourth Monday of every month at the Kenilworth Union Church, 211 Kenilworth Avenue, Kenilworth, 7:00-9:00 pm. Individuals and families interested in learning more about depression and bipolar disorder are invited to attend. Call 847-251-4272 for information.

Obsessive Compulsive Disorder Support Group meets Thursday evenings at Resurrection Hospital, 7435 W. Talcott, Chicago. 7:30-9:00 pm. Call Carol Miller for information at 773-774-3019.

Obsessive Compulsive Disorder Support Group meets the first Monday evening of each month at the Anxiety and Agoraphobia Treatment Center in Northbrook. \$20 fee. Call Mona Berman for information at 847-559-0001, ext. 4.

Obsessive Compulsive Foundation of Metropolitan Chicago Call for information 773-880-1635.

Panic Disorder Support Group meets Wednesday evenings at the Anxiety and Agoraphobia Treatment Center in Northbrook. \$15 fee. Call Marleen Lorenz for information at 847-559-0001, ext. 6.

Recovery, Inc. is a self-help group for people with mental disorders. Call 312-337-5661 for meeting places and times.

TARA Chicago Personality Disorder/Emotion Dysregulation Support Group Professionally-led group for family members of persons with BPD or other emotional dysregulation issues. Meets the third Wednesday of each month at the Northwestern Memorial Hospital conference facility in Chicago. 6:30-9:00 pm. \$5 per session donation. Please email: rh5mail-tara@yahoo.com before attending for information. Web: www.tara4bpd.org ■