

## Expert Panel Discussion and Recommendations

### Selected clinical issues – ADHD

ADHD is the most common diagnosis for which clinicians request consent for psychotropic medications. This disorder is often associated with co-morbid mood disorders and PTSD. Consequently, many cases of ADHD are quite challenging to treat. Treatment is not uncommonly associated with symptoms of psychosis. Furthermore, there are many agents used in the treatment of ADHD including long and short acting stimulants, antidepressants, alpha2 agonists such as clonidine and guanfacine, atomoxetine and modafinil. This break-out group will address the following issues:

- 1) Is there data to suggest a first line of treatment for uncomplicated ADHD with hyperactivity, e.g., methylphenidate or amphetamine vs atomoxetine?
- 2) For patients initially started on atomoxetine is it appropriate to treat partial responders by adding a stimulant or is a trial of stimulant monotherapy more justifiable given the data available?
- 3) If a patient requires both a short-term stimulant and a sustained release preparation, is it appropriate to use different chemicals (i.e., Concerta and d-amphetamine or Adderall SR and methylphenidate)?
- 4) If a patient develops new onset symptoms of psychosis on stimulants what is the appropriate course of action? Discontinue the stimulant? Discontinue the stimulant and add an antipsychotic? Keep the patient on a stimulant and add an antipsychotic? Increase a stimulant if the patient remains inattentive and add an antipsychotic?
- 5) Given available data, at what point would modafinil be considered? Is it a first line drug in place of the stimulants? A second line drug before atomoxetine? A third line drug before clonidine, guanfacine or bupropion?

### Panel Report

The panel disagreed with the statement that “Treatment is not uncommonly associated with symptoms of psychosis”. They believed it was more accurate to say that there are rare instances of hallucinatory experiences but not full psychosis.

- 1) Assuming that the diagnosis of “uncomplicated ADHD” is accurate the panel thought that the Texas Medication Algorithm for Children for ADHD<sup>1</sup> was an appropriate approach. They felt that FDA approved medications should be tried first. They recommended starting with a stimulant, then a secondary stimulant if the primary one fails and a tertiary stimulant if the second one fails. No one supported the use of atomoxetine as a first line treatment for ADHD, reserving instead for other issues such as loss of appetite, sleep problems, or refusal of stimulants.

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<sup>1</sup> Pliszka SR., et al, Texas Consensus Conference Panel on Pharmacotherapy of Childhood Attention Deficit Hyperactivity Disorder. The Texas Children's Medication Algorithm Project: revision of the algorithm for pharmacotherapy of attention-deficit/hyperactivity disorder. Journal of the American Academy of Child & Adolescent Psychiatry. 45(6):642-57, 2006.

- 2) The panel felt that if monotherapy of children with stimulant-naïve ADHD with atomoxetine was ineffective or partially effective that the atomoxetine be discontinued and a stimulant tried before considering co-pharmacy with atomoxetine and a stimulant.
- 3) The panel recommended that if a long and short acting preparation of a stimulant is necessary for adequate symptom control that both preparations be of the same parent chemical; i.e., methylphenidate and Concerta, or d-amphetamine and Adderall.
- 4) The panel that recommended if a patient develops new onset symptoms of psychosis after starting or increasing the dose of a stimulant that the stimulant be discontinued. Furthermore, they recommend holding off on starting pharmacotherapy with an antipsychotic, recommending instead that the patient's condition be re-evaluated after 2 days to determine if an antipsychotic was indicated. The panel recommends the same approach in the case of treatment-induced aggression.
- 5) The panel recommended modafinil as a third line drug with clonidine, guanfacine, or bupropion. The choice of these medications should be made on symptoms or co-morbid conditions. The panel further recommended that if a pediatrician is treating a youngster who has failed stimulant and atomoxetine pharmacotherapy that he or she obtain a psychiatric consultation. If you get to 3<sup>rd</sup> line, then reevaluate and get a child psychiatry consult

The panel made two recommendations related to treating youth with ADHD, first that a list of medications be developed for which no DCFS consent was required. Upon further discussion with the large group it was clear that this would violate the Illinois Mental Health Code and DCFS Rule 325. They also recommended that DCFS bring treating physicians medication releases for the school and copies of previous evaluations to initial diagnostic session to facilitate history gathering.