EXPERT PANEL
Specific Topics

Selected clinical issues - bipolar disorder

There has been a large increase in the rate of diagnosis of bipolar disorder in children and adolescents over the past eight years. With the increased rate of diagnosis of bipolar disorder has come an increase in polypharmacy and the use of anticonvulsant medications as mood stabilizers. Many of the common practices do not have good data to support their efficacy and some have potentially dangerous adverse effects. This break-out group will address the following issues:

1) What is the appropriate first line of treatment for mania?, mixed mania?
2) What is the role of antidepressants in the management of bipolar disorder? At what point in the treatment are antidepressants introduced?
3) What is the role of stimulants in the management of co-morbid bipolar disorder and ADHD? At which point should stimulants introduced?
4) What is the role of atomoxetine, a selective norepinephrine reuptake inhibitor with antidepressant properties in the treatment of ADHD in patients with bipolar disorder?
5) What are the indications for lamotrigine?
6) Are the AACAP Practice Guidelines appropriate for the treatment of bipolar disorder in this population?
7) Under what circumstances is it warranted to deviate from the AACAP Practice Guidelines?

Selected clinical issues – major depression

Major depression and related disorders, such as mood disorder NOS, depression NOS, and dysthymia, are among the most common diagnoses in this population. Many of these youth have severe affective dysregulation complicating their diagnosis and treatment. The data guiding treatment of depression in this age group is sparse. This break-out group will address the following issues:

1) Is there enough data to support the use of one antidepressant over others in previously untreated youngsters with depression?
2) What changes in practice have clinicians had to make and what precautions have clinicians had to take to use the SSRIs?
3) Is the Texas Children's Medication Algorithm Project appropriate for the treatment of major depression in this population?
4) Under what circumstances is it warranted to deviate from the Texas Children's Medication Algorithm Project?
5) Insomnia and sleep disorders often accompany depression and there is evidence to suggest that the depression will not improve until the sleep disturbance remits. What is an appropriate treatment intervention for insomnia and sleep disturbances in depressed adolescents? What is an appropriate duration of treatment?

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?

Selected clinical issues – sleep disorders, enuresis

Sleep disorders are commonly seen in youngsters with psychiatric disorders and emotional and behavioral disturbances. These sleep disturbances can be primary (obstructive sleep apnea, parasomnias such as night terrors, and sleep schedule disturbances), secondary to psychotropic medications (such as stimulants in youth with ADHD), or due to the underlying psychiatric disorder (impaired sleep due to mania or depression). This break-out group will address the following issues:

1) What is an appropriate level of evaluation for youngsters with sleep disturbance?
2) What is the appropriate level of diagnostic specificity to warrant ongoing pharmacological treatment? For example, 'insomnia' is a symptom of initiating and maintaining sleep and may be a primary (pathophysiological insomnia), secondary (due to the alerting effects of stimulant medications), or due to the underlying illness (insomnia due to major depression).
3) What are treatments of choice for due to primary or secondary insomnia or sleep disturbance due to a psychiatric disorder?
4) What is the role of nonpharmacological treatments such as chronotherapy, light therapy, and progressive relaxation and self-hypnosis? What is the role of melatonin?
5) Under what conditions would a benzodiazepine be considered for long term treatment?

6) What is the role of behavioral therapy techniques, such as the bell-and-pad, overlearning and dry-bed training, in the treatment of enuresis?

Selected clinical issues – psychosis and antipsychotic medications

Atypical antipsychotic medications are among the most frequently prescribed medications for this population. Common uses are to treat psychosis, aggression, bipolar disorder and affective instability due to PTSD. The second generation antipsychotic medications have several advantages over the first generation antipsychotic medications (neuroleptics). They are less likely to cause neuroleptic malignant malignant syndrome, extrapyramidal symptoms and tardive dyskinesia. Despite these advantages, second generation medications are associated with various adverse effects. Some are associated with hyperprolactinemia. Others cause severe weight gain, hyperlipidemia, insulin resistance, and hyperglycemia. In addition, many clinicians seem to be more likely to use co-pharmacy with two antipsychotic medications than one. This break-out group will address the following issues:

1) What monitoring is needed for children and adolescents on antipsychotic medications? How frequent? Should monitoring be mandated? Should these data be monitored by the DCFS consent unit?
2) Should DCFS recommend/mandate loss or weight maintenance programs for youth on second generation antipsychotic medications? Exercise programs? What would such a weight program entail?
3) What are the indications for co-pharmacy with antipsychotics? Should co-pharmacy with antipsychotic medications be tried before or after clozapine?

Monitoring effectiveness and safety of treatment

The use of psychotropic medications is based on a thorough diagnostic assessment, identification of specific target symptoms responsive to psychotropic medications, and the development of a comprehensive treatment plan that includes psychotropic medications as one of the treatment interventions. The effectiveness of a medication is determined by monitoring symptom severity over time. Adequacy of treatment is in part measured by blood levels of certain medications. The safety of a medication is established by monitoring adverse effects and by obtaining appropriate medical tests and laboratories. This break-out group will address the following issues:

1) What is standard practice for diagnostic assessments in outpatient settings? Residential Treatment settings? Inpatient hospitalizations? Is adequate time allotted for assessment and treatment planning?
2) How are target symptoms being identified in routine clinical practice? Are standardized symptom severity being utilized to measure baseline symptom severity and to assess treatment effectiveness?
3) How are treatment emergent side effects being managed in routine clinical practice? Are standardized scales being used to evaluate side effects of medicine?
4) How feasible is it to obtain standardized symptom severity and treatment emergent scales in outpatient settings? Residential treatment settings? Inpatient hospitalizations?

5) What symptom severity scales and side effect scales are routinely used in outpatient care? Residential treatment settings? Inpatient hospitalizations?
6) Are there barriers to getting necessary laboratory tests and medical studies in outpatient and residential settings? How does this affect clinical care?
7) Should treatment guidelines regarding monitoring of care be established? Should these guidelines function as suggestions to clinicians or should they be mandated? Should response data and side effect data be collected by the DCFS Consent Program?

<u>Evidence-based medicine, algorithms, practice guidelines</u>

There has been a phenomenal growth in evidence-based medicine since 2000. Evidence-based medicine is a set of easily taught tools that integrate individual clinical expertise, the best available external clinical evidence from systematic research, and the patient's values and expectations. Despite the growth of evidence-based medicine, there is a great deal of resistance to its incorporation into day-to-day practice. This resistance includes the adherence to the "art" of medicine as opposed to the science, very busy schedules, lack of incentives, institutional settings that make utilization of evidence-based medicine difficult, and the large number of solo practitioners in psychiatry leading to decreased contact with colleagues. Medication algorithms are defined as a step-by-step protocol for the management of health care problems. Based on available evidence, they are testable approaches to the pharmacological management of patients with psychiatric illnesses. The goals of algorithms are to decrease variation in patient care, provide a framework for clinical decision-making, deliver consistent treatment across clinicians and environments, improve patient outcomes, and improve provide metric for evaluating new treatments. In contrast, a practice guideline is a systematically developed statement designed to assist practitioners and patients in making decisions about appropriate health care for specific clinical circumstances. Practice guidelines list the preferred drug and nondrug treatments for common health problems. Several practice guidelines and medication algorithms exist to help child psychiatrists in their treatment planning, including the Texas Children's Medication Algorithm and the AACAP Practice Parameters. The DCFS Psychopharmacology Consultation Program often relies upon principals of evidence-based medicine, medication algorithms, and practice guidelines to advise DCFS regarding whether or not to recommend that DCFS consent for a medication. This break-out group will address the following issues:

1) Should consultants refer to treatment algorithms and practice guidelines when evaluating the appropriateness of a medication consent request?
2) How should the DCFS Psychopharmacology Consultation Program choose which algorithms to utilize in their independent medication reviews?
3) How should decisions regarding consent be made in areas where available treatment algorithms and practice guidelines are outdated or do not exist?
4) How closely should guidelines and algorithms be adhered to? What information should be used when the decision is made to disregard the guidance of existing algorithms and guidelines?
5) What are the pros and cons to consulting existing guidelines and algorithms when making a determination about the appropriateness of a medication request?

6) How should a clinician's personal experience be used in making determinations about the appropriateness of a consent request? For example, "in my experience paroxetine is better for depression than fluoxetine when the patient has sleep problems and anxiety?"
7) How should information regarding algorithms and guidelines used in the consent process be relayed to clinicians?

Polypharmacy and co-pharmacy

There has been a marked increase in the rate of polypharmacy (the prescription of more than one psychotropic medication) and co-pharmacy (the prescription of more than one psychotropic medication from the same class of medications such as two antidepressants or two antipsychotics) in children and adolescents with psychiatric illnesses over the past decade. The use of polypharmacy in children and adolescents draws intense attention from the lay press, fuels anti-psychiatry sentiment and is a major motivating factor behind the push for greater oversight of pharmacotherapy in children by regulatory and government agencies. Unfortunately, many of the of polypharmacy and co-pharmacy practices are not supported by research in either the pediatric or the adult medical literature. This break-out group will address the following issues:

1) What are the stated reasons for the use of polypharmacy and co-pharmacy in children and adolescents? What reasons are supported by the literature?
2) At what point in the treatment of a youngster with severe emotional or behavioral disturbances should polypharmacy be considered? Co-pharmacy?
3) At what point should the use of concomitant psychotropic medications be considered as being excessive? Is there an absolute number of medications that should be considered as being too many? Does this determination vary by age or diagnosis? At what point should polypharmacy prompt a clinical review of a child's or adolescent's management?
4) What Clinical data should the consent unit and the DCFS Psychopharmacology Consultation Program use to determine the appropriateness of a polypharmacy regimen? What research data? How should these determinations be made?
5) Many instances of polypharmacy are not warranted by clinical circumstances or research data to support the intervention. What can the DCFS Consent Unit and the DCFS Psychopharmacology Consultation Program do to decrease the inappropriate use of polypharmacy?

Communication

As mental health professionals we strive to provide timely, effective care for our patients and clients. While the consent program aspires to facilitate the care of wards, various forces, seen and unseen, can affect the consent process. For example, new research findings may change accepted treatment strategies, medications are added to and removed from the HFS Preferred Medication List with little notification, DCFS consent procedures change (for a positive example the centralized consent process for youths in foster care and residential treatment), DCFS rules governing pharmacotherapy and behavioral management are subject to change, and unforeseen developments alter the short-term functioning of the consent program (witness the urgent evacuation of the consent unit from the 310 S. Michigan building). At times changes in the community standard of care will affect the consent process. Effective bi-directional

communication is necessary to optimize the efficiency of the consent procedure the quality of care wards receive and to optimize the. This break-out group will address the following issues:

1) Who are the stakeholders in the consent program and what are their needs regarding education about medications? Changes in the HFS Preferred Drug List? DCFS policies and procedures? Back-up plans in the event of infrastructure disruption?
2) What are the most effective ways of communicating new policies, procedures, and medication information to providers, foster parents, and clinicians?
3) Should there be separate mechanisms to communicate with DCFS caseworkers, prescribing clinicians, hospitals, residential treatment facilities, and foster parents?
4) What materials should available to the stakeholders at all times? In what media format? What information should be included in, and even prompt, updates? What format should updates take?

Additional services

The scope of services offered by the DCFS Psychopharmacology Consultation Program is fairly broad. The unit was initially established to provide an independent review of all medication consent requests with regards to their safety and appropriateness. Other services provided include offering educational programs to foster parents and residential treatment providers, reviewing specific wards' pharmacotherapy regimens at DCFS' request; reviewing prescribing patterns by clinician, placement, region of the state, and treatment setting should disturbing trends arise; providing data at DCFS' request to various governmental agencies re: the use of psychotropic medications for youth in state care, including the Cook County Off ice of the Public Guardian, and the Office of the Inspector General; providing input into the development of policies and procedures regulating the prescription of medications to state wards; providing in-depth assessments of specific wards at the request of DCFS; and providing clinicians with phone consultations on particularly problematic cases. This break-out group will address the following issues:

1) What other services would be useful to various stakeholders (i.e., foster parents, care providers, and clinicians)? Educational opportunities? CME activities? Conferences? Limited clinical consultations? Literature searches?
2) Would you be willing to pay for such services?