

# Child Medication Fact Book *for* Psychiatric Practice

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—FRED R. VOLKMAR, MD

*Child Study Center, Yale University School of Medicine*

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# Child Medication Fact Book *for* Psychiatric Practice

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## **Child Medication Fact Book For Psychiatric Practice**

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# General Tips on Child and Adolescent Psychopharmacology

Over the course of a career, most of us realize that pediatric psychopharmacology is more art than science, and that much of the knowledge we've acquired over the years has come from our work with patients after completing residency and fellowship. Here are some hard-won tips and pearls that you might find useful in your practice.

## ASSESSMENT, DIAGNOSIS, AND CASE CONCEPTUALIZATION

- **Target symptoms are king.** Most patients come to us with mixed symptoms from several diagnostic categories. Depression, for example, takes on myriad shapes in different patients, with the result that this one diagnosis can seem like many. While formal diagnosis is helpful for insurance and school advocacy, for treatment it is usually more practical to list and prioritize target symptoms. During the workup and ongoing follow-up, it is very helpful to have a running list of all the presenting and ongoing target symptoms, circling the ones that are the current focus. For instance, in one patient you might be targeting substance use, mood instability, and impulsivity, circling all three, while leaving issues of poor grades, tics, and peer relationships on the list but uncircled—intending to focus on them a bit down the line. Another patient with the same set of symptoms might have different issues to target.
- **Meds are the tail, not the dog.** Medications can be very helpful at times, even life-saving, but they cannot make up for an inadequate overall plan or placement. If a child is laboring under challenging or outright abusive situations at home or school, pills do not fix that. For instance, a teen with moderate autism spectrum disorder was brought in for a medication evaluation for irritability and “acting out.” On evaluation, his treatment plan included “training for pre-vocational skills”—and his acting out turned out to be in part a rebellion from years of being subjugated to tasks such as sorting silverware. The answer in this case was to rethink the goals that had been imposed on the patient as part of the treatment plan, and not to provide chemical restraint.
- **Informed consent is your friend.** Use informed consent—diagnosis, target symptoms, discussion of options, etc—to guide rational treatment. See the appendices for additional tips on this process.
- **Good care demands time.** You know this, and you are probably fighting for time—time to see the patient; talk to family, therapists, and teachers; review records; call labs; and whatever else you need to do to care for your patient. When we are taken to task about care, we are asked such things as “Did you call the lab?” “We need time to do these things, and we don’t have it.” We need to be clear about the elements of patient care.
- **Keep development in mind.** Developmental changes that occur during childhood, such as the onset of puberty, can have a profound impact on the course of illness. For example, an active child who becomes more sedentary may experience changes in mood and behavior.
- **Be patient.** Medication trials often take time to see results. It is important to be patient and to communicate this to families.

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## MEDICATION TIPS

- **One change at a time.** Try to make only one medication change at once, for example, to see which medication can make it hard to tell which one is easing symptoms and which one is causing side effects. There will be exceptions, particularly in more urgent situations; however, it is best to try to be parsimonious and patient.
- **Start low and go slow.** While making small changes may take patience and reassurance, rapid or large changes in medications often lead to untoward side effects and aborted medication trials. It is helpful to tell families, especially if they are hesitant about medication, that we want to use the lowest dose that is effective; therefore, the best first result is to see no change in symptoms and no side effects, because we've used so little medication. From here, we bring up the dose gradually so we can see the results.
- **Take it down (slowly) if it doesn't work.** There is little point in keeping a medication at a robust dose if it is not having a clear positive impact. We often see people who have stayed on medications more out of habit than anything else. Get



# ADHD Medications

Generally, in treating kids with ADHD, you should start with psychostimulants, since they are the most effective options. Second-line agents include atomoxetine, bupropion, and alpha agonists.

## STIMULANT RECOMMENDATIONS

When choosing a stimulant, the first decision is between an amphetamine or methylphenidate preparation. Methylphenidates are often the go-to as they tend to be more easily tolerated and are as effective as amphetamines for most patients. The second decision is choosing between a long-acting or short-acting stimulant.

For kids who don't like swallowing pills, there are various options. Some long-acting stimulants can be opened and sprinkled on food. There are also short- and long-acting liquid, chewable, and disintegrating brand-name options—though they are expensive and often require pre-authorization. Finally, another option for the pill-phobics is the Daytrana patch.

### The case for long-acting stimulants

- More practical: It's easier to take a single dose that lasts through the duration of a school day.
- Addresses acute tachyphylaxis: Response to stimulants diminishes rapidly, but most newer long-acting stimulants release an increasing amount of drug over the 6–12 hour course of the dose, which most people need for the medication to be effective. This avoids the need for multiple short-acting dosage bursts to maintain continued response.
- Decreased stimulant rebound: People sensitive to rebound irritability or worsening of ADHD symptoms often report a more attenuated rebound with long-acting stimulants.

### The case for short-acting stimulants

- For situations where a child only requires a few hours of effect, such as a half day of school, an afternoon of completing homework, or a weekend activity.
- Minimizes appetite suppression during meals.
- May be less likely to interfere with sleep.

## DOSE EQUIVALENTS

Some kids may not respond to the first medication they try. In these cases, it's best for them. The

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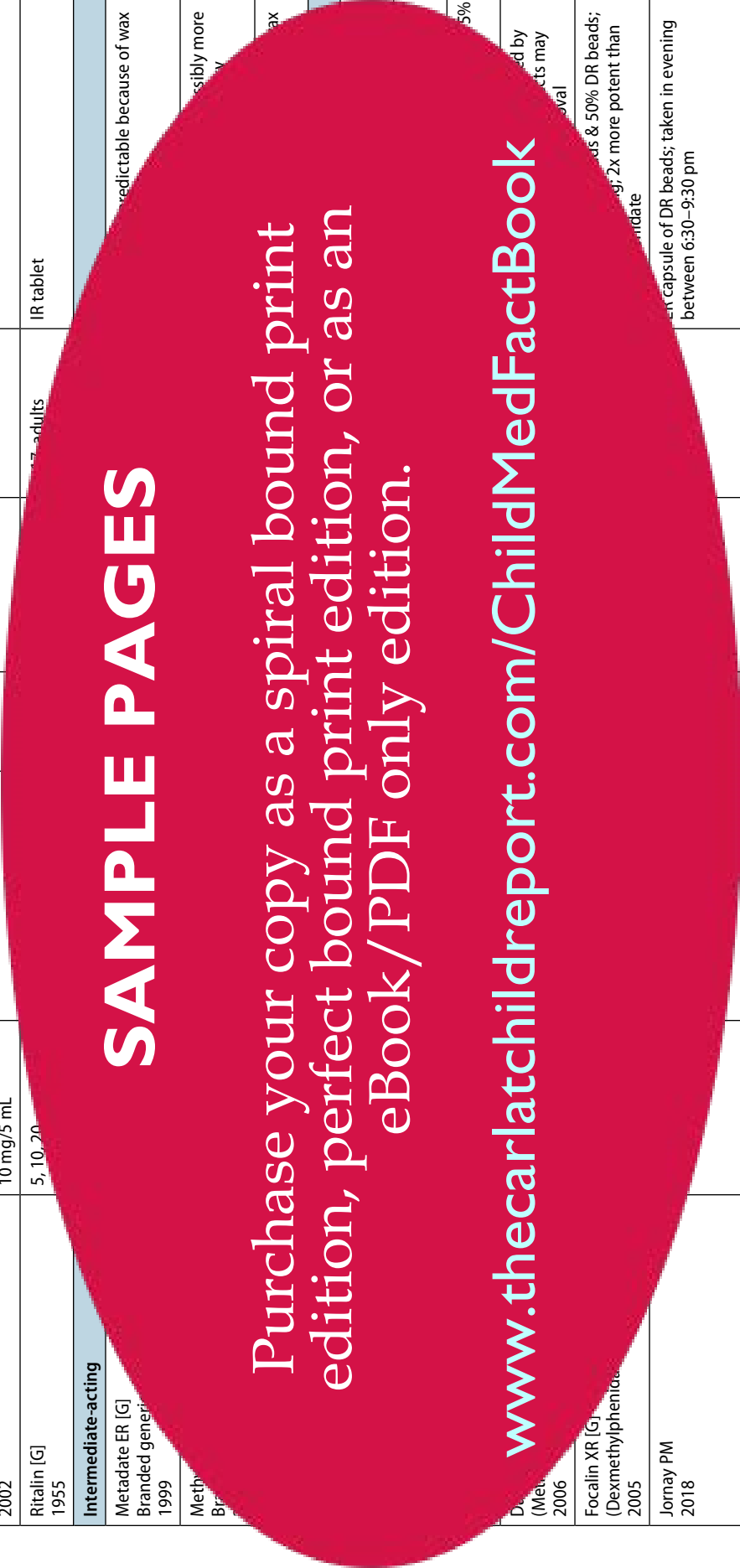
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1. **From amphetamine to methylphenidate (or vice versa)**
  - With amphetamine, the usual dose is 5–15 mg, 2–3 times a day.
  - Concerta, being a long-acting amphetamine, is dosed at 18–36 mg once a day. The usual dose of Concerta is 36 mg, which is equivalent to 30 mg of methylphenidate equivalents. Thus, Concerta 36 mg is equivalent to 30 mg of methylphenidate 15 mg, 36 mg is equivalent to 30 mg, and so on.
  - Focalin is the dextro-isomer of methylphenidate, which is twice as potent as methylphenidate. Thus, use about half the dose when using Focalin.
2. **From methylphenidate to amphetamine (or vice versa)**
  - With amphetamine, the usual dose is 5–15 mg, 2–3 times a day.
  - Concerta, being a long-acting amphetamine, is dosed at 18–36 mg once a day. The usual dose of Concerta is 36 mg, which is equivalent to 30 mg of methylphenidate equivalents. Thus, Concerta 36 mg is equivalent to 30 mg of methylphenidate 15 mg, 36 mg is equivalent to 30 mg, and so on.
  - Focalin is the dextro-isomer of methylphenidate, which is twice as potent as methylphenidate. Thus, use about half the dose when using Focalin.
3. **From methylphenidate to an amphetamine (or vice versa)**
  - Methylphenidate is roughly half as potent as amphetamine, so Ritalin 10 mg = Dexedrine 5 mg, etc. Consistent with this equivalency, child psychiatrists often dose methylphenidate at 1 mg/kg, whereas they dose amphetamine at 0.5 mg/kg. Conversely, if you're switching from Dexedrine to Ritalin, you would need to double the dosage.

**TABLE 1: ADHD Medications**

Brand Name (Generic Name, if different than heading) Year FDA Approved [G] denotes generic availability	Available Strengths (mg except where noted)	Usual Pediatric Dosage Range (starting–max) (mg)	Duration of Action (hours)	Can It Be Split?	Ages Approved for ADHD	Delivery System/Notes (IR = immediate release, CR = controlled release, DR = delayed release, ER = extended release)
<b>Methylphenidates</b>						
<b>Short-acting</b>						
Focalin [G] (Dexmethylphenidate) 2001	2.5, 5, 10	2.5 BID–10 BID	3–4	Yes (not scored)	6–17	Tablet; D-enantiomer of Ritalin; 2x more potent than methylphenidate
Methylin CT [G] 2003	2.5, 5, 10	2.5 BID–20 TID	3–4	Yes	6–17, adults	Chewable, grape-flavored tablet
Methylin oral solution [G] 2002	5 mg/5 mL, 10 mg/5 mL	2.5 BID–20 TID	3–4	NA	6–17, adults	Clear, grape-flavored liquid
Ritalin [G] 1955	5, 10, 20				6–17, adults	IR tablet
<b>Intermediate-acting</b>						
Metadate ER [G] Branded generic 1999						Unpredictable because of wax
Methylphenidate ER [G] Branded generic 2006						Possibly more predictable than Metadate ER
Focalin XR [G] (Dexmethylphenidate) 2005						DR beads & 50% DR beads; 2x more potent than methylphenidate
Jornay PM 2018						DR capsule of DR beads; taken in evening between 6:30–9:30 pm



## AMPHETAMINE (Adzenys XR-ODT, Dyanavel XR, Evekeo) Fact Sheet

### PEDIATRIC FDA INDICATIONS:

**ADHD** (Adzenys XR-ODT and Dyanavel XR: children >6; Evekeo: children >3).

### ADULT FDA INDICATIONS:

ADHD (Adzenys XR-ODT); narcolepsy (Evekeo); obesity (Evekeo).

### OFF-LABEL USES:

Treatment-resistant depression.

### DOSAGE FORMS:

**Tablets (Evekeo):** 5 mg, 10 mg (scored).

**ER orally disintegrating tablets (Adzenys XR-ODT):** 3.1 mg, 6.3 mg, 9.4 mg, 12.5 mg, 15.7 mg, 18.8 mg.

**ER oral suspension (Dyanavel XR):** 2.5 mg/mL.

### PEDIATRIC DOSAGE GUIDANCE:

- Tablets (Evekeo):
  - Children 3–5: Start 2.5 mg QAM, increase in 2.5 mg/day increments weekly to maximum of 40 mg/day in divided doses.
  - Children 6–17: Start 5 mg QAM, increase in 5 mg/day increments weekly to maximum of 40 mg/day in divided doses.
- ER ODT (Adzenys XR-ODT):
  - Start 6.3 mg QAM, increase in 3.1–6.3 mg/day increments weekly. Maximum of 18.8 mg/day (ages 6–12) or 12.5 mg/day (ages 13–17).
- ER oral suspension (Dyanavel XR):
  - Start 2.5 mg–5 mg QAM, increase in 2.5–10 mg/day increments every 4–7 days. Maximum 20 mg/day.

**MONITORING:** Weight, height

**COST:** \$\$\$\$

**SIDE**

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- Divide
- Approximate equivalencies: 3.1 mg = 5 mg, 6.3 mg = 10 mg, 9.4 mg = 15 mg
- Shake Dyanavel XR oral suspension for extended release formulation of mixed amphetamine salts.
- Amphetamines are not interchangeable on a mg:mg basis. When switching, use a lowered dose and adjust.

### FUN FACT:

The term “amphetamine” is the contracted form of the chemical “alpha-methylphenethylamine.” Its first pharmacologic use was when pharmaceutical company Smith, Kline and French sold amphetamine under the trade name Benzedrine as a decongestant inhaler.

### BOTTOM LINE:

Newer formulations of an old drug come with a high price tag. Stick to the usual amphetamine products like mixed amphetamine salts unless liquid or ODT dosing is absolutely necessary.

# Antidepressants

In contrast to the data available for adults, the evidence for efficacy and safety of antidepressants in children is less robust. Nonetheless, some studies, specifically the TADS (The Treatment for Adolescents With Depression Study) and TORDIA (Treatment of Resistant Depression in Adolescents), have shown that SSRIs can work for depression in adolescents, especially when combined with cognitive behavioral therapy.

In general, when faced with a child or adolescent with depression who has not responded to psychotherapy, we recommend starting with fluoxetine, because it has the most evidence for efficacy and safety. Other first-line options include sertraline and escitalopram. Paroxetine has fallen out of favor due to concerns about suicidality as a possible side effect and significant withdrawal symptoms.

If the first SSRI trial fails, rotate to a different SSRI. An SNRI trial (either venlafaxine or duloxetine) is reasonable after 2 failed SSRIs. SNRIs tend to have more side effects than SSRIs and potentially severe discontinuation symptoms.

Try bupropion for patients that have comorbid depression and ADHD, but remember that in patients with eating disorders, this drug causes a lowered seizure threshold. Mirtazapine and trazodone can be helpful for depressed and anxious patients with insomnia—but mirtazapine can cause substantial weight gain.

When antidepressants are not working well enough on their own, you can use augmenting agents, including atypical antipsychotics, lithium, and thyroid supplementation. However, there is very little research evidence supporting this practice in the pediatric population.

We rarely use tricyclics in kids, because of possible cardiac toxicity and other side effects. Nonetheless, consider them for particularly severe and unresponsive cases, or for patients with comorbid OCD, enuresis, insomnia, migraines, or poorly controlled headaches.

## SIDE EFFECTS AND CLASS WARNINGS

- **Black box warning of suicidality:** All antidepressant medications come with a black box warning based off of a meta-analysis that demonstrated a 2-fold increase in suicidal thinking or behaviors in patients under 25 years of age. No completed suicides were demonstrated, and the suicidal parameters encompassed a broad range of definitions, including parasuicidal thoughts and behaviors. While the black box warning is a significant consideration, the pros of antidepressant treatment outweigh the cons in the majority of patients. Prior to the black box warning in 2004, the rate of suicide in the adolescent and young adult population was rising. After the warning, the rate of suicide rate increased. That the rate of SSRI prescriptions was rising. That the rate of antidepressant

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- Gradual tapers are also required, in light of SNRIs' significant withdrawal symptoms, which can be extremely uncomfortable and may include dizziness, fatigue, and irritability, to name a few symptoms.
- SNRIs:
  - Given their potential to increase blood pressure, closer blood pressure monitoring is required.
  - Gradual tapers are also required, in light of SNRIs' significant withdrawal symptoms.
- Other side effect considerations:
  - Serotonin syndrome can occur, particularly when using multiple serotonergic agents or serotonergic supplements such as St. John's wort or SAME; if it occurs, it will require discontinuation of offending medications or supplements. Symptoms often present within a day of starting medication and can include sweating, GI symptoms, hyperthermia, tachycardia, increased blood pressure, confusion, and tremors, and can be life threatening; they will require immediate assessment and supportive care.
  - Risks of hypomania and mania need to be considered.
  - Sexual side effects can occur, including delayed orgasm/ejaculation and decreased sexual drive, which may be of concern to some adolescents—bupropion and mirtazapine are less likely to cause these problems.

**TABLE 2: Antidepressants**

Generic Name (Brand Name) Year FDA Approved <i>[G] denotes generic availability</i>	Relevant FDA Indication(s) (Pediatric indications in bold)	Available Strengths (mg)	Usual Dosage Range (starting–max) (mg) Pediatric unless specified
<b>Selective serotonin reuptake inhibitor (SSRI)</b>			
Citalopram [G] (Celexa) 1998	MDD	10, 20, 40, 10/5 mL	10–40
Escitalopram [G] (Lexapro) 2002	<b>MDD (12+ yrs)</b> , GAD	5, 10, 20, 5/5 mL	5–20
Fluoxetine [G] (Prozac) 1987	<b>MDD (8+ yrs)</b> , <b>OCD (7+ yrs)</b> , panic disorder, bulimia, PMDD (as Sarafem)	10, 20, 40, 60, 20/5 mL 10, 20 (Sarafem)	10–60
Fluoxetine DR [G] (Prozac Weekly) 2001	MDD maintenance	90 DR	90 Qweek (adults)
Fluvoxamine [G] Luvox brand discontinued 1994			200
Fluvoxamine [G] (Luvox) 1994			
Desvenlafaxine [G] (Khevea) 2008			
Duloxetine [G] (Cymbalta) 2004			
Venlafaxine [G] 1993 Effexor brand discontinued; generic only		25, 50, 75, 100	37.5–75
Venlafaxine ER [G] (Effexor XR) 1997	MDD, GAD, social anxiety disorder, panic disorder	37.5, 75, 150, 225 ER	37.5–225
<b>Tricyclic antidepressant (TCA)</b>			
Amitriptyline [G] Elavil brand discontinued; generic only 1961	MDD	10, 25, 50, 75, 100, 150	25–200
Clomipramine [G] (Anafranil) 1989	<b>OCD (10+ yrs)</b>	25, 50, 75	25–200
Desipramine [G] (Norpramin) 1964	MDD	10, 25, 50, 75, 100, 150	25–150

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