The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office
Your Health in Mind
Hauora hinengaro Manatuhia

13 June 2023

David Hughes
Chief Medical officer
Pharmac

By email to: david.hughes@pharmac.govt.nz

Tēnā Koe David

Re: The special authority criteria for the class B stimulants

Thanks for your recent email regarding stimulant prescriptions in Aotearoa.

As you will be aware, Attention Deficit and Hyperactivity Disorder (ADHD) has historically been considered a diagnosis of childhood, but in recent years, we have developed improved understanding of the lifelong persistence of symptoms and associated functional impairment through adulthood. Although many individuals are diagnosed by child psychiatrists and paediatricians during childhood, those with more inattentive rather than hyperactive forms of the condition, females and culturally and linguistically diverse individuals tend to be underdiagnosed in childhood and adolescence or diagnosed first during adulthood. The latter group is increasingly presenting for assessment and treatment via adult psychiatric services. Due to the busy nature and scope of public services, assessments for people with mild to moderate symptoms are usually undertaken in private settings.

Current Ministry of Health and PHARMAC regulations require confirmation of ADHD by a paediatrician or psychiatrist prior to commencement of funded stimulant medications (methyl phenidate or dexamfetamine). Following effective treatment, two-yearly specialist approved renewal of the special authorisation is required for continued funded prescription. This is due to concerns about both the need for ongoing treatment and risk of medication diversion.

In recent months, in Aotearoa New Zealand (NZ) and overseas, there has been intense public lobbying by multiple groups and prominent politicians for greater and more equitable access to ADHD assessment and treatment. Suggestions have included diagnosis and treatment in primary care, by Nurse Practitioners and by a wider range of specialist providers in public and private services. In addition, access to prescriptions has been improved by PHARMAC's decision to permit three-monthly prescriptions (soon to be free of charge to everyone). Some of our members, Professor Sarah Romans, Dr Paul Vroegop and Dr David Codyre have already provided feedback on proposed changes via a PHARMAC-organized ADHD working group. Other members Dr David Chinn and Dr Giles Newton Howes may also have provided advice via the Pharmacology and Therapeutics Advisory Committee (PTAC).

The Tu Te Akaaka Roa/NZ College of Psychiatrists views on the prescription of ADHD medication are in keeping with a recently updated RANZCP position statement.[1]

In general, we believe that issues of equity of access to diagnosis and pharmacological treatment should be balanced with risks associated with medication use and misuse.

PO Box 10669 Wellington 6143 New Zealand
T +64 (0)4 472 7247 F +64 (0)4 472 7246
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

1. We support easier and more equitable access to ADHD assessment and treatment, including the availability of free, three-monthly prescriptions.
2. We note that while pharmacotherapy is most effective for core symptoms of ADHD, non-pharmacologic therapies may be more beneficial for improving functioning. As such, we will continue to advocate for improved access to these adjunct therapies, rather than a sole focus on pharmacotherapy for the management of ADHD.
3. We continue to support diagnosis and commencement on stimulant medication for people of all ages by specialists (whether they be paediatricians or psychiatrists), by nurse practitioners working under specialist supervision or by GPs with advanced competencies and the time (David's point).
    a. No matter who is diagnosing ADHD, recommended guidance on multimodal (i.e., information gathered from multiple sources and including formal clinical assessment for symptoms of ADHD) assessment should always be followed. Regular review of the medication regimen also ensures optimal outcomes and is supported by the extensive research now available
    b. Co-morbidity is common and should always be evaluated. If this falls beyond the remit of the assessor, referral to a specialist with sufficient expertise should be undertaken before treatment is commenced.
    c. We draw your attention to recent FDA update on stimulant prescription.[2]
4. We believe that different approaches may be needed for continued stimulant prescription to children (under 18) and adults with ADHD. This is already the case for medications such as melatonin.
5. We recommend two-yearly review of the need for stimulant medication be continued for all children under 18 due to:
    a. provision of consent by parents, rather than children when medication is started at a young age.
    b. developmentally related changes in children's abilities to manage symptoms of ADHD with and without medication; and
    c. adolescent-related increases in risk taking and associated risks of medication diversion during this life stage.
6. Given limitations in access to psychiatrists and paediatricians within public and private parts of the health system, we would be supportive of two-yearly medication reviews for children and young people being undertaken by a general practitioner with acceptable additional training, and nurse practitioners with support from specialist paediatricians or psychiatrists. Telephone or teleconference consultation that includes the following details should be sufficient for this purpose:
    a. confirmation of ongoing clinical symptoms and functional impairment off medication including clinical review to assess mental state.
    b. review of adverse effects, including monitoring of growth.
    c. reviewing comorbid health conditions and their management; and
    d. confirmation of individual consent or parental consent and child assent for continuation of medication.
7. Given the more stable nature of adult ADHD, we are comfortable with the removal of the requirement for two-yearly Specialist review for people with a formally established diagnosis whose symptoms are stable on regular treatment. However:
    a. we note risks of medication diversion are greatest among young adults internationally;[3-5] (albeit that we are not aware of any NZ data on this issue).
    b. we suggest that longer-acting stimulant prescription may reduce this risk, although they may also be more expensive.

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c. we recommend supporting prescribers to follow universal precautions for psychoactive medication as outlined here would be useful.
d. we recommend regular prescriber follow-up to monitor benefits, cardiovascular function including BP, weight and other adverse effects and the risk of diversion; and
e. we recommend monitoring of prescribing trends, given steadily increasing rates of stimulant use over the past couple of decades[6] and the fiscal risk associated with less controlled prescribing; and
f. we recommend monitoring of harms, including poisoning (especially in children and young people), stimulant-related psychosis (probably hard to measure), price on the illicit market (this is currently captured by the NZ Police) and reported use in the drug using population (some work on this is being done by SHORE).

Nga mihi

Dr Hiran Thabrew

Chair Tu Te Akaaka Roa

Dr Tanya Wright

Chair NZ Faculty of Child and Adolescent

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4. Wilens, T. E., Adler, L. A., Adams, J., Sgambati, S., Rotrosen, J., Sawtelle, R., ... & Fusillo, S. (2008). Misuse and diversion of stimulants prescribed for ADHD: a systematic review of the literature. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(1), 21-31.
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