

Medication for Mental Health

Full transcript · 12 video clips · generated 22 September 2026

About this transcript. This transcript was produced automatically from the video audio. It has not been checked by a person, so names, place names, te reo Māori and medical terms may be wrong in places. The video is the record. If something here reads oddly, please check it against the video.

Watch the series: listeningtofamilies.co.nz/medication-for-mental-health

IN THIS TRANSCRIPT

1. Medication - How does medication help children
2. Medication - Special Authority
3. Medication - Clinician interaction with pharmaceutical companies
4. Medication - Information about medications for families
5. Medication - Pros and cons of medicating children
6. Medication - Impact of medication
7. Medication - Are adolescents and children being over medicated
8. Medication - Risk of addiction
9. Medication - Long term medication
10. Medication - Is there a role for CBD
11. Medication - Multiple meds
12. Medication - Key messages

1. Medication - How does medication help children

Hi my name is Shelley and I am neurodivergent and I have neurodivergent children. Hi I'm Matt Eggleston, I'm a psychiatrist at CAF North in Christchurch and yeah I've got an interest in autism, ADHD, learning difficulties but also just the general range of child and adolescent mental health conditions. Matt it's so lovely to talk to you today, we're going to cover off some stuff about mental health conditions and neurodiversity and medicating children today. Yes, how does medication help children? So medication has a role in helping children and adolescents with mental health conditions and it varies a little bit according to what we're treating.

So sometimes medication has a very important role, so for things like bipolar disorder or psychotic disorders and with ADHD has a kind of like a leading role and then for some other conditions it has a support role so for moderate to severe anxiety or depression or OCD it's not usually a leading treatment it's often used after other therapies but it has a support role and can facilitate therapy being more effective and it has a bit of a role with things like bulimia and with Tourette's and then there are some other conditions where it has really not much of a role and that would be conditions where there aren't associated conditions that you can treat so just single conditions which isn't that common.

Things like anorexia nervosa medications are usually something else. Behavioural disorders like conduct disorder or oppositional defiant disorder. Autism, so autism by itself as you'll know is often associated with other things that may benefit from treating those conditions. So you can't go to a GP to get medication for your kids for these? Yeah for some things medication can be prescribed by

GPs but they're often a little bit reluctant because it's a specialty area and they often have comfort with treating adults but at least comfort but in spaces a little bit more and where young people often have a different response to medications than adults.

So getting the medication at the right dose can be quite hard? Yeah and even choosing the right medicine so an example might be the vaccine for depression is very commonly used. It's really extremely rarely used with multiple trials of other things have failed because the evidence base is different. But GPs yeah they they can initiate often for adolescence they'll initiate medication where people have had treatment and things like you know depression and adolescence we do see some GPs prescribing for that. Other GPs will contain medication but yeah some things like ADHD to get a special authority number you need to see so GPs won't initiate.

2. Medication - Special Authority

Tell me about special authority numbers. Yeah. Oh, you want to know a bit about that? Yeah, please. So, special authority numbers are just a mechanism whereby doctors can apply to Pharmac for a subsidy, essentially. So, those medicines can be used without a subsidy, but they're sometimes quite expensive. But, generally, things like ADHD, either a paediatrician or a psychiatrist will review a person and then recommend treatment. And, in our case, we would initiate and titrate the medicine. So, that's working out what the dose is? Yeah, working out whether the medicine is tolerated, whether it's beneficial, and then trying to find the dose that's going to be helpful.

Awesome. And so, you get a special authority number? And it's forever? No, unfortunately, it's variable. So, for melatonin, it's about a year. Really? So, melatonin for sleep, yeah. So, would you need to go to a specialist to get that? No, GPs can apply for melatonin. So, different special authorities issue for different conditions, and different people are authorised to do that. Yeah. So, stimulants for ADHD, methylphenidate, yeah, they require rec. And they last for? They last for two years. Two years. Yeah. But there are also a gate to try and control access to, or to make sure that the right people are getting them, so that GPs just aren't issuing very expensive drugs willy-nilly, where there's the benefits not as, you know, different.

Yeah, they're used for different reasons. So, sometimes it is an expense situation, so new drugs particularly, and Pharmac, won't be restricted to people that have failed other medicines. But, yeah, sometimes, you know, control doesn't work. It's specialist only because they have had previous issues back in the day when we didn't have special authority. ADHD medicines, one or two GPs, we're prescribing really quite large amounts to quite a lot of people. Those processes are reviewed periodically. For example, Atomoxetine went from requiring a special authority number to not requiring one. Exactly.

When Pharmac negotiated a generic. Yeah. It was a generic cell. Yeah. Yeah. When you have a specific, you know, certain type of condition, but you don't have the required, you know, to be the, to be the same person, but, yeah, I don't know, that's it. Yeah. Yeah. Yeah. Yeah. Yeah. Okay. Yeah. Okay. Okay. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah.

3. Medication - Clinician interaction with pharmaceutical companies

So there's a lot in the news about Big Pharma, you know, particularly since we've been through the pandemic and a lot of social media content. And recently there was the Netflix drama about Oxycontin at the moment. So this is something that's on the mind of parents. What's the situation in New Zealand? Can doctors get a kickback if they prescribe certain medications? Not in mental health. I think that would be extremely rare. So we used to have drug reps come to meet with us on some basis and they would sometimes bring in morning tea or something like that. That practice, I hadn't seen that practice for some time now, perhaps five or ten years.

And yeah, psychiatry, mental health in New Zealand, most psychiatrists work within the public system and Pharmac's a protective factor because there aren't these new medicines that have a lot of hype. It may or may not be better than current treatments with drug companies wanting to get their use increased. So there's a bit less pressure, I think, because of those things. And then most doctors within the public system where a good number of these medicines are initiated have a medical education allowance, which is pretty generous. So back in the day, big pharmaceutical companies would sponsor people to go to a conference or pay accommodation, but actually there's not any need for that with public sector doctors.

And so, yeah, I don't think there's much, yeah, I don't think there's much sort of risk of that. And if you present at a conference, you have to present the disclosures, what you've done, you know, money you've got out of pharmaceutical companies. So, yeah, I don't think there's much risk of that. Increasingly, pharmaceutical companies in New Zealand are reporting on what they're paying out to doctors, you know, as another safeguard. So I think the risks are relatively low. And, you know, we haven't had an opioid difficulty in New Zealand, for instance.

4. Medication – Information about medications for families

And if I was a parent wanting to get information about medication, is there reputable sources that I can go to where I can find out the research that you're talking about, the solid evidence base, the decisions that Pharmac's making, those kinds of things? Oh, that's quite complicated, the Pharmac decisions. But, yeah, I mean, there is good information around. Most doctors will have their preferred sources, and I don't know, it would be quite good if there was a bit more uniformity with that, perhaps. So there's some brochures that we hand out fairly routinely when we initiate medicines within our service, but they're not public.

But there's some good publicly available sources. So Kids Health in New Zealand has some good information. There's something called the New Zealand Formulary for Children. And the New Zealand Formulary is really good. It's quite succinct. It's a little bit technical, but most people would be able to get to grips with it and just provide. It provides really good information. And particularly about the interactions between medications. It has an interaction checker as well. But, yeah, it just has good information on the main medicines as well, usually a page or two, so they're not massive. And then MedSafe have data sheets, so they're massive, about 20 pages of technical information.

But some people will want to read some of that, so that can be useful. And then there are practice guidelines, like Autism Guideline of New Zealand has some good information around autism and is kept up to date. The NICE guidelines are very good. And then we use practice parameters, which are guidelines developed to guide doctors. And with some parents, I will give them a practice guideline, particularly parents who are very cautious around a medicine that we think is likely to be very helpful for information. That's very fair. So it's kind of a little bit horseradish, of course. There is a wide range out there.

The NHS has some good information for young, so adolescents, the NHS UK has some really good fact sheets and side effects. So, Shelly, there'll be some links to those sites I've mentioned on the website. Thank you.

5. Medication – Pros and cons of medicating children

Can we talk about the pros and cons of medicating children or young people with these kinds of conditions? Are they going to turn into zombies? They're going to two different questions Why would we choose medication over what else is available? And what are the pros and cons if we do?

Yeah, so the pros and cons, weighing that up is really critical And It's difficult in child and adolescent psychiatry because often there's less research going on to drive clinical practice compared to the adult area But yeah Where we see children and adolescents with those conditions I mentioned a bit earlier ADHD, bipolar disorder, psychotic disorders, medication Can be very helpful and will be used quite early in the treatment plan For other conditions, you know, anxiety, moderate to severe anxiety, depression, OCD, that group of conditions Usually medicine would be used After therapy has been attempted or in most of their cases concurrently with therapy And it's really looking at Is there Significant impairment and significant symptomatology Would that respond well to a medicine?

How does that medicine compare to other treatment approaches? And if you have all those things together then Benefits tend to be things like reduction in symptoms, reduction in impairment, more functionality, better able to use therapy techniques Reducing stress in people's general lives, those sorts of things The cons?

And there are a few of them notably adverse effects So, you know, that's often a very significant limiting step some people feel that taking medicines is a very very big step and have a natural tendency not to want to use medicines and That can be difficult, you know for them to adjust to the idea that a medicine could be helpful And we don't tend to rush that process that process so if people are needing some time to consider that then you know that's time well spent but some people yeah feel that it's you know an affront on their functioning and um you know it can have some impacts on on people's feelings about themselves another con is that sometimes if you use a medicine people can become keen on the medicine and they de-emphasize a little bit too medication oriented and i think just broadly there's a bit of a risk with you know wait lists um being as they are that you know we have pressure to get people through the system and i think sometimes the medication is used earlier than it would have been in the past where it's another con another risk so what how do the outcomes compare when medication's been initiated earlier in the absence of therapy versus therapy and so there's some good evidence in some disorders um or conditions around early use of medicine so there's um particularly depression so there's this a key study looking at um therapy cbt cognitive versus a medication approach versus the combination approach showing that medicine plus cbt resulted in a faster response although many people would eventually get there with therapy down the track so um medication for depression and the evidence base for depression uh for medicines and children and adolescents is moderate it's not that great so yeah in that case it can lead to people getting a much quicker response time to response hasn't been studied that well in other areas but i'd expect that you'd get a fairly similar result with ocd and with anxiety conditions

6. Medication – Impact of medication

The antidepressant type medicines, SSRIs, so they generally are fairly well tolerated and we would almost always use fluoxetine first because it has the best evidence base and it has the best safety profile, in children at least. And again we start off at a low dose and gradually increase and yeah fluoxetine tends to be pretty well tolerated. Adverse effects that are common include tummy issues, diarrhoea or nausea, difficulty getting off to sleep, sometimes you get an increase in anxiety initially which can reduce usually over time. Again there's a risk of mood becoming elevated. And there's a black box warning from the FDA, so there was a lot of concern around SSRIs use in adolescents 10 or 15 years ago and when you start these medicines with young people they're at higher risk of having more feelings of hopelessness and an increased chance of having suicidal thoughts.

And so the FDA says basically you should be monitoring for that and you need to warn people. Our monitoring of people on SSRIs is probably more stringent than it used to be. I mean sometimes the SSRIs can affect sexual drive and that is often unwanted and sometimes they're not keen to talk about those things so it's good to outline that at the outset. And is there any evidence that that can be long term? It tends to be a dose related thing and some medicines are more likely to cause it. Sometimes you might give an adjunct of medicine which can actually improve it. And then the next most commonly used medicine after the ADHD medicines and the SSRIs, the fluoxetine type, anti-psychotic medicines.

More concerns from psychiatrists, about those not as good a safety profile as the ADHD medicines or SSRIs. So they're reserved usually for severe bipolar disorder, extreme self-injury or aggression and autism, sometimes tics. And they can be very sedating. The biggest concern around them is possibly people develop a bigger appetite on them and can gain significant amounts of weight. And increasingly we need to monitor for metabolic syndrome where people put on a lot of weight and have abnormalities of their blood sugars and cholesterol goes up and their blood pressure goes up and it's not a healthy place to be.

So it's a constant balance and some of them are least likely to cause those things to be resolved but some people think it doesn't work quite as well. And then anti-psychotics can also cause some movement disorders which are of concern. So early on people can get some cramping in their muscles called dystonia which is pretty rare actually if you start at a low dose and particularly develop something called tardive dyskinesia. One of the larger worries for psychiatrists where they develop some mouth movements usually after big doses for long periods but some mouth movements kind of like a chewing which which is quite resistant sometimes doesn't go away if you reduce and stop the medicine and can be a difficult thing benign.

But anti-psychotics we would usually you know we usually reserve them for those more significant presentations. There is one issue with quetiapine. So quetiapine is a second generation anti-psychotic and it's very sedating at low doses and there's increasing use of quetiapine for people with very significant pharma and some other bodies that have had concerns that it's been overused and it potentially is but it can be a very helpful medicine in situations where it's sleep and you've tried everything out. I was going to say about whether or not the side effects reduce over time. Whether you know do we take them off because of the side effects or do we keep them on then?

Yeah, adverse effects can improve over time and there's a guy Steven Stahl who's written a number of textbooks for psychiatrists and in the adverse effect column it always says wait, wait, wait. Like many things do improve but equally some things don't and some things like tics you need to respond to quite early. Can you tell parents the list of side effects that are deal breakers? Yeah I tend to let people know you know which things I'm most concerned about and which things are my least concerned. You know monitoring is important and just discussion over time but I mean you do get kids who get referred back to service who haven't grown for two years you know that kind of thing so it doesn't always things don't always improve but frequently they do.

7. Medication – Are adolescents and children being over medicated

We hear a lot about kids being over-medicated and we've been talking today about how the rates of medication has increased significantly since for example the study that you mentioned earlier. Are kids being over-medicated or how do we account for the increased rate of medication in young people? Yeah so there are two types of over-medication. One is that large groups of people are increasingly prescribed medicines and then there's individuals who are prescribed too much medicine but we'll talk mainly about the first one. Medication rates are gradually increasing year by year and the last data from Pharmac in 2016 suggested that percentages of increase particularly for adolescent girls with ADHD has taken off and you'd expect that because they've been underdiagnosed for years.

But also SSRI use is increasing. By international standards we're still very low in terms of how frequently we prescribe overall. So the figures were about 2.5 percent of young people who prescribed mental health medication. About one percent, a little over one percent now probably for ADHD which is actually internationally extremely low, maybe under-treating. And the SSRI rate, the antidepressant rate, was around 1.5 percent which again is pretty low. We've got anxiety disorders with a prevalence of about five to seven percent

and mood disorder with a prevalence of... So it's something to be aware of but yeah I think New Zealand tend to be pretty cautious and we haven't got caught up with excess prescribing for people with so-called bipolar disorder that we have in the States.

So yeah I don't think there's widespread over-prescribing. I think there will be some kids who are prescribed for where some people would think they shouldn't be prescribed for. There'd be many many more people where a medicine could be helpful where they haven't accessed it. There's a much bigger issue. And then occasionally yeah medication can be used in too high doses for some people and it's often a very difficult balance. You've got someone who's on the verge of getting excluded from school and they're not growing that well but it's reduced. They may well get excluded. There's a lot of people who are on the verge of getting excluded from school and they're not growing that well but it's reduced.

There's a lot of people who are on the verge of getting excluded

8. Medication - Risk of addiction

And does putting kids on medication when they're young people increase their risk of addiction long term, or them becoming reliant or addicted to the medication or other addictive elements? Yeah, so it's a tricky one that has been studied, but kids with mental health conditions may be at greater risk of substance use in adulthood anyway, and we know that young people with ADHD, Conduct Disorder, Oppositional Defiant Disorder, or three behaviour difficulties are at increased risk, and they tend to be more impulsive, they tend often to hang around with other people who are getting into substance use things, and they often have more novelty seeking, they like doing new things and experimentation.

So you have to account for that, and a number of studies have with ADHD in particular, and in particular, has been controversial, because you're giving a medicine which, if not used appropriately, can be abused or diverted, and it makes sense that it could increase the chance of substance use difficulties in adulthood, but there are probably ten or eleven good studies looking at that, a number of reviews where it consistently reports that there isn't an increase. Yeah.

So that's quite good to know, and there's some concerns, apart from ADHD, there's some concerns around SSRIs, so some people are worried that SSRIs may be addictive, and there's something called discontinuation syndrome, so short-acting SSRIs, like Esotolopram, and paroxetine, citalopram, can be hard to stop, but people don't seek them out, they don't pay money for those things, it's not a drug of abuse, but people can have difficulty stopping it when they try and reduce, they get irritable, and can get shocked, things through their body, and not sleep, and feel terrible, and generally, when we suggest people come off SSRIs, we're using longer-acting medicines, so fluoxetine, it's very risky, it's very rare that people would get those symptoms with fluoxetine, quite uncommon with sertraline that can occasionally happen in some vulnerable people, but we would always suggest that people come off quite slowly anyway, and that if there are issues, people go even slower, and sometimes if you're on a short-acting one, you need to be transferred to a longer-acting one to kind of reduce the medicine over time if you want to come off it, but most people don't have too many difficulties, but some people have massive difficulties, and then occasionally people...

I started on a benzodiazepine, so in child and adolescent psychiatry, that's pretty rare, and we would use them for people with bipolar disorder, or so if you use short-acting benzodiazepines for longer than three weeks or so, you can get difficulties with stopping it, and dependence with some people, and that could conceivably increase your chance of substance use later in life. There is some concern. There is some concern about lots of things, and then when I said that there are some other reasons for me to have had that condition, I'm not talking about anything else, but helping children. All of the things that are happening to children.

There is a significant amount of transmission around benzodiazepines, so that's disepam, lorazepam, clonazepam, that group, particularly the short-acting ones like lorazepam.

9. Medication - Long term medication

And do you have very clear guidelines around the medications that are potentially for life and the medications that are to treat a current situation that they're likely to come off at some point? Yeah, some medicines are for the long term. So that would be particularly bipolar disorder, which has been recurrent, and lithium carbonate. So stopping and starting lithium we don't think is very useful for people. And so if you're committed to that, usually it's for a longer term. Other medicines, so ADHD medicines, we would usually say it's a year-by-year prospect. So by adulthood, about half of people will have developed out of ADHD, but the other half will have still significant issues, and you don't know who's going to develop out when.

Often it's pretty obvious whether the medicine's still required or not because people have an onset effect. If it starts working, you can see that, and if it stops working, you're at 4pm or 5pm or whatever. And it's obvious, but if it's not obvious, it can be useful to have a trial off each year, usually term two or term three, when schools know what the young person's like and they can see if there's a

deterioration, but most parents wouldn't know anything. And then SSRIs, we would usually say continue them for six to 12 months after an episode of depression and then have a trial off. And then recurrent depression, that people are on for the medium to long term.

Similarly with anxiety we'd say much the same thing. So it kind of varies a little bit. Most medicines we will attempt to try and get people off and then if they have recurrent issues then it's quite likely for the medium. But nothing's forever. Sometimes we'll go off there quite successfully and life's more settled and there's less stresses and things.

10. Medication - Is there a role for CBD

What role does cannabis or CBD products play in treating mental health in young people? Yes there's quite a bit of interest in cannabis and CBD for whole rafting conditions and you have to be a little bit concerned when people are using something for everything or it's recommended for a whole lot of things because there's not usually a panacea that does everything but in child and adolescent psychiatry we usually go based on randomised controlled evidence, preferably double blind where people don't know what they're getting, and there isn't. There just isn't evidence in our area for CBD or cannabis for any condition so it's not something that we would recommend on the whole. I have had a couple of parents of young people with really severe autism where they had a couple of methods called hi-fat pills while a child was taking a pill which actually, and the other pandemic, was provoking kids to do this and they were having problems with it. But they were have accessed CBD, those young people have had really severe aggression or tantrums, those sorts of things. Young people with really significant issues and it hasn't been useful for either of those kids but you know again that's anecdotal. Just more trials are needed you know I think when there's more research if it shows that it's helpful people will start to consider it but at this stage it's preliminary. We're not jumping at it.

11. Medication - Multiple meds

How many kids would be on more than one mental health condition medication? Yep, so psychiatrists tend to try to avoid using more than one medicine because we just don't know often how combinations of medicines work. There are some exceptions to that, so combinations that have been tried a little bit with OCD, adult depression, ADHD. So there are some combinations which can be used, but most psychiatrists will try and avoid that and they'll do single medication approaches in the first instance. Then if people don't respond to a single medicines, you do start to think about combinations and whether that could be worthwhile having a look at. The other area of difficulty, though, is that people often have more than one condition. So particularly neurodivergent people, like people with autism, for instance, very, very frequently have anxiety conditions and they're often quite severe and they're very, very difficult to deal with. Very frequently have ADHD. And so in those situations, you know, sometimes medicines are used in combination. And some medicines are better in combination than others. So fluoxetine, I mentioned earlier, is our first SSRI, but fluoxetine slows down the metabolism of a number of other medicines that we use and so there are interactions with it which need to be watched, which don't occur so much with some others like esitalopram. So, yeah, it's just tricky. We try and avoid it.

12. Medication - Key messages

Key messages. Medication can have an important role, particularly for those disorders I mentioned, bipolar disorder, psychotic disorders, ADHD. A little less so for anxiety, depression, OCD, tic disorders. Not much of a role for other disorders by themselves. Just to encourage people to keep an open mind about medicines, that psychiatrists aren't over-prescribing, I don't think, in New Zealand. We're very cautious by nature, and are really acting in the best interests of kids. We try very hard to take parenting and young persons' views into account, and just present them with the best options for them at the time. That would be the key bits.