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Medication

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1. Medication - Medication for ADHD

So medications for ADHD. Ritalin is by far and away the most commonly used type of medicine. There are various forms of that. So there's a short-acting form of Ritalin and then there's a long-acting form which lasts for six to eight hours. We used to have access to another form of Ritalin called SR, but now there's a generic called Rubirthin. So there's Rubirthin SR and there's also immediate release Rubirthin. And within the methylphenidates, so they're all methylphenidate preparations, and there are a couple of other ones. There's Concerta which has an even longer duration of action, usually 10 or so hours, and I often feel that that's best for teenagers who need longer periods of time.

Duration or adults who have ADHD. And Pharmac have introduced a generic called Teva ER, which is supposed to be relatively close to Concerta, but a seventh the cost. So there's quite a range of methylphenidates and there are short-acting forms and intermediate acting forms and long-acting forms. And why would you choose short-acting initially? So I tend to use, short-acting initially with much younger kids, where you don't want the medicine in the system for too long and you can use much smaller doses. So you can use five milligrams or even less than that, whereas the long-acting preparations, the minimum dose is 10 milligrams, or Ritalin long-acting or Concerta is 18 or Teva 18.

So it just allows you to use lower doses in people that might be vulnerable, where there's concerns about other things that you want to do. But in adolescence I usually prefer to start with a longer acting medicine. And so Teva's been quite useful for that because we can still use the same special authority that we do when we apply for the short-acting form. So I think that's going to be a helpful medicine. So the methylphenidates, they have about a 70 percent chance of being moderately helpful, but they don't suit everybody. And there are two other forms of ADHD medicines.

There's Dexamphetamine, amphetamine which is another stimulant so it's like ritalin methylphenidate but different i called it like a cousin similar and for some people they have a better response to that so about a third of people methylphenidate um methylphenidate tends to be a bit better tolerated so if people haven't responded to methylphenidate they possibly should have a trial of dex dexamphetamine and there's another medicine called atomoxetine which isn't a stimulant um and it was developed as an antidepressant so it has a 24 action takes a while to build up in the system and takes a while to start working um and it tends to be a

little better tolerated than the stimulant preparations overall but sometimes causes much the same side effects but can cause sedation at times and there's some rare difficulties with atomoxetine that can it can lead to a hypermanic or manic episode and people very rare chances can if you deliver quite badly so it's kind of third line it would be the number three treatment generally it's also tick neutral so if kids have bad Tourette's and they get worse on stimulants then atomoxetine would be a good trial and in the states there are two other medicines which have the tick for a year and they started out life as an anti-high blood pressure and it has quite good evidence don't do well enough and you add it to a stimulant but New Zealand hasn't funded clonidine xr we have a short-acting form so we can use that off-label and it's not used that much but it's used a bit and then there's another medicine in the states called guanfacine extended release and it's helpful and it would be good for us to have that and it's under consideration at the most sort of five options really there's one other medicine that's under consideration by pharma called lisdexamphetamine so it's a long-acting form of dexamphetamine and has the big advantage of being so dexamphetamine has got some street value and can be diverted and lisdexamphetamine gets around a lot of those issues and we're hopeful they may fund that next year I'm fascinated because I know that for example Australia's got different stuff yeah they've got lisdex and they've got guanfacine xr so they've got they've got better tools than us so if this is just an off to um if a person in New Zealand wanted to trial one of those and they're not funded in New Zealand can they be prescribed it by you and imported themselves or yeah I've prescribed lisdexamphetamine a couple of times yeah very helpful for one person who and I have used guanfacine uh a little so three or four times and people can pay for it but lisdexamphetamine is about a hundred dollars a month and uh extended release guanfacines depends on the preparation but so it's not that these medications are unavailable in New Zealand it's that they aren't yeah you know and often too much for we've got some families can afford this

2. Medication - Medication and psychosocial approaches

ADHD is interesting. There was a massive study called the MTA trial 20 years ago where they looked at 580 kids with ADHD, and they were really trying to look at how did medication compare to a really very, very good intervention involving parents doing a lot of parent behaviour management work, children getting access to social skills on a holiday camp for six weeks, two-weekly teacher consultation, 50 days of teacher aid over a year for the kids, so a really good psychosocial approach. And that really, the results of that study showed that the medication approach and the medication combined with the psychosocial approach were much better than just the psychosocial approach for ADHD symptoms themselves.

Okay. And that really changed how we prescribed for ADHD. So back when I qualified, there were very few people taking ADHD medicines, and we would encourage parents to go through quite a lot of parent management work before trialling medicine. And the MTA trial turned that around really where if people have very significant ADHD symptoms, we will use medication much earlier than we used to in the old days. So it sounds like it's quite a pragmatic approach given the constraints around the funding. Does it change your outlook on mental health in New Zealand and the research is backing it up anyway?

Yeah. The current situation is difficult. Our waitlist within our service is around 11 months, 12 months for people with non-acute injuries where risk is not a concern or there isn't psychosis or those sorts of things. It's just resourcing is a massive issue. So what's happening in New Zealand?

3. Medication - Zombie effect

So I asked before, if my child's going to lose their personality, become a zombie if they start on these medications, is that your experience? Yeah, so the kind of zombie effect is one of parents' main concerns around medicines for ADHD. And there's a lot in the media around that, and I think it's kind of, I think it's overblown to some extent. So the psychiatrist's view on it is that at high doses, children can become over-focused and become flat. And that's not a helpful place to be. But parents and psychiatrists and paediatricians are very conscious of that. And if people do lose their personality and become zombie-like or those sorts of things, they're very bad.

And that really means the dose is too high, and the dose can be reduced. And those things are completely reversible. If you stop the medicine, the next day, your kid's no longer in their state. So I think it, I think there's a lot of hype around it and a lot of fear for parents because of that. But for psychiatrists, it's not really a concern. You know, we just think some people metabolize these things, but slowly, and they will accumulate. These adverse effects are quite low dose. We're other people won't get them until very high doses, but it's just, it's just basically a dose of it. So there isn't a KG to dose kind of chart you can follow with kids with this?

There's general guidelines for dose, but about four or 5% of the population metabolize methylphenidate very slowly. And just the enzyme system within their liver. And you don't know who that is. Increasingly, they might become available because you can do blood tests. You can do blood tests. You can test for these things and test for various enzyme action. But at the moment, we don't have that.

We have to go on how people respond. Similarly, dexamphetamine is metabolized by different enzymes. And about 20% of the population metabolize very, very quickly and they'll burn through it. And most people just average range.

And then you get some people who are extremely sensitive to that and will get adverse effects. It's really low doses. And so it's just, it's just quite variable. It's something that psychiatrists are very aware of. And do you have maximum doses that you must not exceed? So, yeah, there are guidelines around maximum dose. So for methylphenidate, the Ritalin-type medicines, it's usually 60 milligrams for children. And for adults, maximum doses is around 72 milligrams. But sometimes that will be exceeded. And dexamphetamine is 40 milligrams. Milligrams, I haven't had a kid on more than 60 milligrams.

All right. Remember that. Alright. This video, I did not mean to daxe sub it all in, but I just wanted you guys to know that at least I want to give you all a good idea of how it's going to be in the next three weeks' time.

4. Medication - Natural remedies

So are there other natural alternatives that we could be using if we're not using CBD, because it's clearly not evidence-based yet? Yeah, so a lot of interest in natural remedies, and I think that's reasonable. I think overall there's still a lack of research, and we need a lot more research to explore that area. Unfortunately, it's difficult to get funding, it's difficult to do those trials without funding, so that's a bit of a double-edged sword. Best evidence is probably in the ADHD area. So omega-3, there's a lot of interest in omega-3 for ADHD, and there have been 10 or 15 randomised controlled trials of omegas.

And the evidence base, it's a little bit hard to interpret some of the evidence, and the trials aren't massively accurate, and they're not massively robust. But omega-3s may have a mild positive impact on ADHD symptoms, and they're pretty benign, and so I wouldn't discourage people from trying those. I often ask people, what have you tried when they come into the service, and frequently people have. And it's kind of a mixed report, some people have found it helpful and other people not. Locally, micronutrients is an area of interest, which is a group out of Canterbury Uni. So she's done a trial in adult ADHD, and another trial with ADHD in young people looking at 25 vitamins and minerals in quite high doses.

And those trials are interesting, a little bit variable, but the psychologist who meets with the relevant person, overall found about 50% had a positive response to the micronutrients, like looked better overall, compared to about 20%, sometimes a little bit higher, on the placebo medicine, or placebo arm. But for ADHD symptoms themselves, there are probably some fairly modest benefits, possibly for an attention, but more evidence in the adult trial. But teachers and parents weren't really rating ADHD symptoms as being, hugely different. There did seem to be some benefit for things like emotional regulation, and possibly some aspects of other behaviour.

So interestingly enough, Julia and I did an application to Pharmac, a year ago, and Pharmac have considered micronutrients as a possible intervention for ADHD, and they've said that they will give that low priority, which is Pharmac speak for, yes, there's some evidence for that, and it could have a role, but it's low priority for funding at this stage, and so it's a little bit of a wait and see, but it's a start. When people ask me about micronutrients, I always suggest they try medicines first, because the evidence base, I think, is stronger. But if people don't have a good response, and they can afford it, it may be a reasonable option.

Can they be used concurrently? The micronutrient people say it shouldn't be, but I have had a few people, anecdotally, where they've used it concurrently, and there haven't been a lot of adverse effects, you know, interactive adverse effects. So, yeah, I don't know. It's a bit of a tricky one. I think you probably need more evidence, but I think it would be worth a go if people had a suboptimal response, and it was something you wanted to have a look at. And again, I'd encourage people to get a rating scale from relevant people before and do it after, and just see what has it done after three, four months, rather than committing to it for a very long time if it's not useful.

So if you've got an option of supplementing micronutrients, are there vulnerable groups of people in the community that may already have malabsorption or malnutrition? Yeah, there probably are. So there are studies of kids with ADHD where their omega-3 markers are kind of lower, certainly in some people. ADHD, similarly, sometimes vitamin D deficiency, sometimes iron deficiency, and if people have a deficiency, remediating that's probably helpful. But we looked at that with the trial with Julia, with the ADHD kids, and nutrient level before the study didn't predict who responded and who didn't.

5. Medication - Growth and behaviour

So one of my children has been on Ritalin and one of the concerns that was raised to me when he first started on it is that he would potentially not grow as tall if he took this throughout his childhood. He's tall. It was unfounded in our case but what are some of the adverse effects that we can, that we need to consider when these children are, these young people are being put on these medications? Yeah so with medicines what we would normally do would be to start at a low dose and see that it's well enough tolerated before gradually increasing the dose to a level that might be helpful and we're always aiming to get to something that's called the

minimum effective dose and it's sometimes trial and error and sometimes you overshoot and you have to come back but adverse effects with the ADHD medicines, it's very common for people to have an appetite.

And sleep issues. So two or three people out of ten, that will be significant. If you're not getting enough calories it does potentially have an impact on growth and we used to think that that was transient and people would catch up but the MTA trial I mentioned earlier suggested that by adulthood those that were regularly medicated throughout compared to those who weren't by adulthood were on average two and a half seconds. Then they're usually about six centimeters smaller and somewhat lighter so there can be a growth effect and boys won't thank you for that. Girls will be a little less concerned about it on the whole but it still could be a concern if you want to play sport.

So those are issues and then there's a raft of other things so for the most part people's mood will be better if they have ADHD. They'll be less reactive, have more time to think. More even with their mood when the medicine starts to work. In their system, but about five kids out of 100, it really doesn't suit them, and they might become much more reactive, or more highly anxious, or miserable, those sorts of things. And again, those would stop. If you stop the medicine, they go away quite quickly, but it's important to be aware of that. Psychiatrists worry about tics. So tics are repetitive, abrupt movements, blinking, twitching, that you get with Tourette's, and stimulants can uncover those, a tendency to tics, and usually if you stop the medicine, they reduce again over time, but just occasionally they don't, and you've got to...

And then there are things like headaches and tummy aches, which you might get with anything. We monitor pulse and blood pressure. And then atomoxetine, I mentioned a little bit before. The adverse effects are pretty similar, but usually more mild than with stimulants for ADHD, but there's a risk of some other things, a risk of a very rare chance of liver issue. So that's the ADHD medicine.