

SUMMARY

This paper by long-term ADHD medication critic, Labor State Politician and former teacher Martin Whitely highlights Western Australia's history as the world's only ADHD hot spot to have experienced a significant and sustained downturn in child medication rates.

From 1989-2003 Western Australia had an unprecedented increase in the prescription of dexamphetamine and to a lesser extent methylphenidate (Ritalin) to young people as a treatment for Attention Deficit Hyperactivity Disorder (ADHD). By 2002 Western Australian prescription rates were amongst the highest in the world, exceeding the US national average. In 1989, 880 people in WA were prescribed stimulant medication. By the year 2000 this had increased to 20,648 with an estimated 85-90% being children. In 2000 an estimated 4.2% to 4.5% of all West Australian children aged between 4-17 years were on ADHD stimulants.

Child drugging rates continued to grow until the introduction of tighter ADHD amphetamine prescribing accountability measures in late 2003. Since then child prescribing rates in WA have fallen by an estimated 65%, with 6188 children on stimulants in 2007. Simultaneously amphetamine abuse rates by West Australian teenagers fell approximately 40%. Whilst WA adult ADHD prescription rates remain the highest in the nation, WA is the only state where total prescribing rates are trending downwards and Sydney has now replaced Perth as Australia's ADHD child drugging capital.

Whitely participated in a WA parliamentary inquiry into ADHD in 2004 which added to an intense local debate around the validity of the diagnosis and the safety of the drugs. The prime recommendation of the inquiry was to establish multidisciplinary clinics that ensure drugs are not the first line treatment for children with concentration and behavioural problems. A needs analysis determined that four clinics with over 50 full time staff would be needed to fill unmet need. Funding for two of the four clinics was announced by the then Premier Hon Alan Carpenter in late 2007. The change of government in September 2008 and the 3% funding cuts saw plans for the proposed clinics in danger of being shelved. However, the Barnett Government Mental Health Minister the Hon Graham Jacobs intervened to make sure the first two clinics were funded.

In this paper Whitely acknowledges that if Labor had remained in government his strategy was to pressure the Commonwealth Government to divert some funds from the PBS subsidisation of ADHD drugs to funding the extra two clinics required. Whilst praising the Gallop, Carpenter and Barnett Governments' interventionist approach to ADHD, Whitely is highly critical of the Howard and Rudd Government's response. He accuses both of delegating their response to concerns about ADHD misdiagnosis and

over-prescription to 'ADHD experts' which have financial ties to the pharmaceutical companies that manufacture ADHD drugs.

Whitely believes that the explosion in ADHD drugging rates was in part due to inadequate time for comprehensive assessments that identify children's real problems. He argues that the Barnett Government should press the Rudd Government to fund the clinics and resist the temptation to try and service all unmet need from the two clinics. He also argues that access to the clinics should be restricted, if necessary by post code, to ensure that assessment times are not cut, so that every child assessed in the clinic receives a full assessment.

Whitely concludes that without a cautious, diagnose slowly - drug as a last resort philosophy, and adequate time for a full assessment, the pressure for a quick diagnosis could exacerbate the very problems that the clinics were set up to address.

The following paper is an extract from “Speed Up and Sit Still” a book about the politics and marketing of ADHD by Martin Whitely MLA to be published early 2010. For more information see www.adhdspeedupsitstill.com

How Childhood became a Disorder

Attention Deficit Hyperactivity Disorder (ADHD) and its predecessor Attention Deficit Disorder (ADD) were not discovered by science. They were voted into existence by committees of the American Psychiatric Association, and included in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the handbook of American psychiatry. The vote determined that childhood behaviours such as losing toys, forgetting, fidgeting, butting in, disliking homework, and playing loudly were not simply normal or even naughty childhood behaviours, but rather the diagnostic criteria of a “psychiatric disorder”. This wholly unscientific process was one step in a series of drug company influenced medico-political processes that have resulted in ADHD’s widespread recognition. Medicine and psychiatry should be driven by hard science. ADHD has snowballed internationally because the results of drug company sponsored pseudo-scientific research have been largely accepted without question by the medical profession, governments, regulators and the public.

As a result, across the globe millions of responsible, loving yet ill-informed parents have accepted at face value the advice of an “expert” clinician and “medicated” their child for ADHD. Typically these parents have been told their child has a biochemical imbalance in the brain best treated with safe effective stimulant medication. Most are never told the truth. Most are never told that there is no direct evidence of a biochemical imbalance in their child’s brain. None are ever shown a blood test or any scientific proof of their child’s supposed biochemical brain imbalance. They are not shown these because they don’t exist. Few are ever told that the diagnosis of ADHD is entirely based on parent and teacher observations that a child avoids homework, interrupts, fidgets, squirms in their seat, loses pens and pencils and is forgetful and disorganised. Few are ever told that the amphetamines used to treat ADHD are drugs of addiction with a range of serious adverse side effects and unknown long-term effects on developing minds and bodies.

These parents are denied their right to informed consent about their child’s treatment. In many cases there is nothing to “treat”. Many children are naturally inattentive, impulsive and hyperactive. In these cases normal childhood behaviour is pathologised and healthy children are drugged. Some children however do have a range of real problems that cause disruptive behaviour. For example, children who can’t hear or see properly may be inattentive or impulsive because they are frustrated with not being able to keep up with the rest of the class. It is hardly surprising that drugging these children with behaviour altering amphetamines alters their behaviour, masking the symptoms, but doing nothing to deal with the underlying cause.

Perth boy Brandon’s story is disturbing but typical of too many children worldwide. Brandon was first medicated for behavioural problems when he was 4. By early 2004 Brandon (then 12) was on Dexamphetamine for ADHD, Sodium Valproate for mood stabilisation, and tranquilizers to calm him down. Brandon suffered mood swings, migraines, insomnia, he sleepwalked, had chronic stomach-aches, and was unnaturally thin. The Bentley Clinic ADHD team, a residential intensive intervention program, turned around Brandon and his family’s lives. Brandon was initially detoxified and his mother Katherine participated in effective parenting sessions. Brandon’s real problems of hearing and learning difficulties

were identified. Brandon is now drug free, happy, well behaved (for a 16 year old), and has just begun full time work.

Although many tiny pre-schoolers are diagnosed and drugged, most of the symptoms of ADHD relate to classroom behaviour. School children who are disorganised and have difficulty concentrating are assumed to have a biochemical imbalance in their brain. These children can be difficult to control in a classroom and in many cases are more compliant when drugged. However, there is absolutely no scientifically valid evidence that compliant drugged students learn better in the long term. If there are educational benefits from drugging so called ADHD students, they are for other students who may get a quieter learning environment and more of the teacher's time. There may be an argument for drugging psychotic adults who represent a danger to others, but there is absolutely no justification for drugging children to keep them quiet. Surely it is a basic right of every child to grow free from unnecessary biochemical interference.

Dodgy Diagnosis

Every claim about the science of ADHD should be viewed in the light of its diagnostic criteria. In layman's terms, the diagnostic criteria for ADHD in all its forms results in the ADHD labelling of children who are too active (hyperactivity), not active enough (hypoactivity), or too day-dreamy (inattentive). The diagnosis of ADHD is entirely based on observations of a child's behaviour, as "*there are no laboratory tests, neurobiological assessments, or attentional assessments that have been established as diagnostic in the clinical assessment of Attention Deficit/Hyperactivity Disorder*".¹ If a child "often" shows at least 6 out of 9 of the following inattentive or impulsive/hyperactive behaviours for at least six months, to an extent that is considered dysfunctional at home and school, then they meet the diagnostic criteria for ADHD.

Inattention

- 1- *fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.*
- 2- *has difficulty sustaining attention in tasks or play activities*
- 3- *does not seem to listen when spoken to directly*
- 4- *does not follow through on instructions and fails to finish school work or chores*
- 5- *has difficulty organizing tasks and activities*
- 6- *avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort such as schoolwork or homework*
- 7- *loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books or tools)*
- 8- *easily distracted by extraneous stimuli*

¹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition, Text Revised (DSM-IV)*, (American Psychiatric Association: Washington, D.C., 2000): pp86-88

9- *forgetful in daily activities.*

Impulsivity/Hyperactivity

- 1- *fidgets with hands or feet or squirms in seat*
- 2- *leaves seat in classroom or in other situations in which remaining seated is expected*
- 3- *runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness*
- 4- *has difficulty playing or engaging in leisure activities quietly*
- 5- *“on the go” or often acts as if “driven by a motor”*
- 6- *talks excessively*
- 7- *blurts out answers before questions have been completed*
- 8- *has difficulty awaiting turn*
- 9- *interrupts or intrudes on others (e.g., butts into conversations or games)*

These 18 behaviours are, depending on your view, either compelling evidence of a biochemical brain imbalance or, within the normal range of childhood behaviour. However many people, children as well as adults (including this author) display them to varying degrees in homes, schools and workplaces every day. As we mature most people become less impulsive and distracted, however, children are naturally impulsive/inquisitive and active/playful and often inattentive. The diagnostic criteria reflect absurd expectations of what constitutes normality in young children. They also require that *“some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years”*.² Yet how many six year olds give close attention to details, follow through on instructions and finish school work, chores, like or even have homework, don't run about or climb excessively, play quietly and await their turn patiently? Childhood was never meant to be that constrained, controlled, predictable and boring.

What is supposed to distinguish ADHD sufferers from the rest of the population is the level of impairment or dysfunction. Specifically, *“There must be clear evidence of clinically significant impairment in social, academic or occupational functioning”* and *“Some impairment from the symptoms is present in two or more settings (e.g. at school {or work} and at home)”*.³ How *“often”* a child *“fidgets or squirms in their seat”*, or *“interrupts”* or *“avoids homework”* or *“fails to remain seated when remaining seated is expected”* or *“is*

² American Psychiatric Association op cit p85

³ American Psychiatric Association op cit pp92-93

distracted by external stimuli” so that they exhibit “*some impairment*” is not defined in DSM-IV. Like beauty, “*impairment*” is in the eye of the beholder.

DSMIV says “*Signs of the disorder may be minimal or absent when the person is receiving frequent rewards for appropriate behaviour, is under close supervision, is in a novel setting, is engaged in especially interesting activities, or is in a one-to-one situation (e.g., the clinician’s office.)*”⁴ In other words, ADHD children will behave appropriately (not display ADHD), when they are rewarded, people pay attention to them (close supervision), and are having new experiences (novel situations), and are not bored (especially interesting activities). Conversely ADHD children will be inattentive and easily distracted (have ADHD) when their good behaviour goes unrewarded, no one pays any attention to them, or they are in a boring, routine, situation. The absurdity of this proposition is self-evident.

It is of great concern that the diagnostic criteria are all behavioural, however, it should be of even greater concern that the diagnosing clinician doesn’t have to observe any of the symptoms, let alone any impairment. The clinician may simply base their diagnosis on third party accounts of a child’s behaviour. The child’s parents and teachers usually provide these third party accounts. Parents and teachers are typically asked to fill in a questionnaire detailing if a child always, often, sometimes or never display behaviour like avoiding homework and chores, losing toys, not listening, fidgeting, butting in, talking excessively or being easily distracted or forgetful⁵ supporting scientific evidence.

The ADHD industry counters this argument by stating that all psychiatric disorders, most of which are ultimately treated with medications, are diagnosed using similar behavioural criteria. Pointing out inadequacies in the diagnosis of other psychiatric conditions is hardly a valid defence for the inadequacies of the ADHD diagnostic criteria. Whilst the criticism is valid for a range of other psychiatric disorders, conditions like Schizophrenia involve extreme behaviours like hallucinations and delusions, rather than normal childhood behaviours like avoiding homework and losing toys.

Whilst there is no doubt that biochemical interventions are the most immediate method of altering behaviour and that ADHD type behaviours can be problematic, medication simply masks symptoms and does nothing to address underlying causes. The prevailing conceptualisation of ADHD as a disorder, with a neurobiological basis, is flawed. Dysfunctional inattention, impulsivity and hyperactivity occur for a multitude of reasons. Poor diet, sight, hearing, parenting, teaching, physical, sexual or psychological abuse or trauma, sedentary lifestyle, neurotoxin exposure, underlying medical conditions and even boredom can lead to a child failing to pay attention and/or acting in a impulsive or hyperactive manner. Most of these causes have nothing to do with “brain chemistry”; however, occasionally neurotoxins may cause a biochemical imbalance in the brain. Environmental or dietary neurotoxins should be removed from the child’s environment or diet. Drugging to address an environmentally created biochemical brain imbalance simply introduces another toxin to the child’s brain and body.

⁴ American Psychiatric Association op cit p86

Dangerous Drugs

The most commonly used drugs to treat ADHD are the amphetamine based psycho-stimulants, dexamphetamine and methylphenidate (brand name Ritalin). Responses to psycho-stimulants are highly variable, however, when taken orally in low doses psycho-stimulants will temporarily sharpen focus in most people and the majority of children become more compliant. However, in the minds of many parents their newly compliant, medicated, ADHD child's biochemical imbalance has been balanced. Some parents however, become concerned about the loss of spontaneity and creativity in their child. Whatever the attitude of parents, the reality is that in allowing their children to be chemically altered with amphetamines they risk a host of side effects. These range from the common and relatively mild side effects like insomnia and headaches to less common, life threatening side effects such as psychosis, strokes and suicide. Often the 'upper' side effects of stimulant amphetamines are balanced by prescribed 'downer' psychotropic drugs like Clonidine. With sustained prescription amphetamine use, children also risk long term cardio-vascular damage and physical and psychological amphetamine dependence. The other less commonly prescribed ADHD drug Strattera is not amphetamine based and has the advantage that it has little potential for illicit abuse. However, Strattera carries the highest possible black box warning for suicidal ideation as well as a warning for potentially fatal liver damage.

Sometimes parents feel apprehensive and a little guilty about their decision to medicate their child, and it is only human to look for evidence that validates important decisions. Stimulants provide the evidence parents concerned about their decision to medicate their child are looking for. Put simply, amphetamine based stimulants stimulate virtually anyone. However in the minds of parents their medicated ADHD child's biochemical imbalance has been balanced. Even within the organisation that invented ADHD, the American Psychiatric Association, the indiscriminate effect of amphetamines has long been understood. In 1996 Dr. Debra Zarin, representing the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, testified to a US Congressional committee that, "*It is a commonly held misconception that if a stimulant calms a child, that he must have ADHD; if he didn't have the disorder, the thinking goes, the medication would not have any effect. That is not true. Stimulants increase attention span in normal children as well as those with ADHD.*"⁶ Whilst there are exceptions, usually after a newly diagnosed ADHD child receives their first dose parents and teachers see a more focused and compliant child. However, when the short-term stimulant effects of the drugs wear off there are often "bounce" or withdrawal effects that worsen ADHD type behaviours. This reinforces the parent's and the teacher's belief that the child is chemically imbalanced without the drug. These parents are given false comfort by the short-term improved attentiveness of their "stimulated" child.

Many parents take at face value the advice that ADHD is inheritable and become suspicious that they may share the "lifelong affliction" with their child. Their subsequent diagnosis of

⁶ Fred A. Baughman Jr., MD & Craig Hovey, *The ADHD Fraud: How Psychiatry Makes "Patients" of Normal Children*, Victoria BC, Trafford Publishing (2006): p6 Footnote 17 Fred A. Baughman Jr., MD & Craig Hovey, *The ADHD Fraud: How Psychiatry Makes "Patients" of Normal Children*, (Victoria BC, Trafford Publishing, 2006): p9

adult ADHD is in their minds confirmed when they become temporarily more focussed after taking stimulants. Some of these newly medicated families then become public advocates through drug company sponsored consumer organisations like LADS in Western Australia and CHADD in the USA.

Whilst there is no doubt biochemical interventions are the most immediate method of altering behaviour and that ADHD type behaviours can be problematic, medication simply masks symptoms and does nothing to address underlying causes. In short term research trials pharmacological interventions invariably appear more effective than non-drug treatments for ADHD, for two flawed reasons. First, drugs are much faster at altering behaviour than non-drug treatments and trials most often measure improvements by short-term symptom management often for no longer than a few weeks. Second, whilst the behaviour altering effects of stimulants are almost universal, other treatments will only improve attention and behaviour for a narrow range of the spectrum of those diagnosed ADHD. For example family counselling will be of little or no benefit if the underlying cause of behavioural problems is an undiagnosed hearing impairment. Stimulants seduce both parents and adult patients into believing they are ‘chemically unbalanced’ without amphetamines in their system. The temporary effects of stimulants create the illusion of a permanent solution to challenging and inconvenient behaviours.

Rather than inventing a drug to match a disease the pharmaceutical industry profited by helping invent a disease, i.e. ADHD, to match their drugs. None were developed specifically for ADHD, or address the causes of ADHD type behaviours. At best they temporarily inhibit unwelcome behaviours, at worse they kill.

Pseudoscience

When asked for proof of ADHD validity, ADHD “experts” will often respond that there are thousands of scientific papers that support their claims. However, when asked which one of these scientific papers has robust methodology, they cannot identify a single, long term, research paper that stands scrutiny. Good science is not about quantity of research it, is about quality. None of the thousands of papers cited by the ADHD industry prove that ADHD is a biochemical imbalance or that amphetamines or Strattera are safe and effective treatments. The ADHD industry makes up for a lack of quality research, supporting their arguments, by producing a mass of short term, poor quality research. To back up this dodgy research ADHD industry insiders produce consensus statements, where like-minded, self appointed ‘experts’ agree that ADHD is real and amphetamines are a safe and effective treatment.

Compelling evidence of the poor quality of this research was demonstrated in 2005 through the Oregon Health and Science University ADHD Drug Effectiveness Review Project. The review was commissioned by fifteen U.S. states in order to determine which ADHD drugs

were the safest and the most cost effective.⁷ The 731-page report analysed “*virtually every investigation ever done on ADHD drugs anywhere in the world.*”⁸ Of the 2,287 studies analysed “*The group rejected 2,107 investigations as being unreliable, and reviewed the remaining 180 to find superior drugs.*”⁹ The review concluded there is, “*No evidence on long-term safety of drugs used to treat ADHD in young children or adolescents.*” The review also found that “*Good quality evidence . . . is lacking,*” that ADHD drugs improve “*global academic performance, consequences of risky behaviours, social achievements and other measures.*” Safety evidence is of “*poor quality,*” including research into the possibility that some ADHD drugs could stunt growth. The evidence that ADHD drugs help adults “*is not compelling,*” nor is the evidence that one drug “*is more tolerable than another.*” “*The way the drugs work is, in most cases, not well understood*”. Instead of being able to make objective comparisons of the safety and effectiveness of different ADHD drugs the review was “*severely limited*” by a lack of studies measuring “*functional or long-term outcomes.*”¹⁰ The ADHD industry’s response to this independent report was characteristically dismissive. The Senior Vice President of the Pharmaceutical Research and Manufacturers of America, Ken Johnson, refused to comment directly on the Oregon Report, but offered the standard ADHD industry response, that the benefits of ADHD drugs “*clearly outweigh the risks.*”¹¹

Until the 3 year follow up data was published in 2007 the Multimodal Treatment Study for Attention-Deficit Hyperactivity Disorder (The MTA Study) was frequently quoted by the ADHD industry as supporting the use of stimulants for ADHD. Early results of the MTA Study found that 14 months of medication worked better than behavioural therapy. The 3-year follow up to the MTA Study however concluded that while drugs such as Ritalin and Dexamphetamine worked in the short term, after three years of medication ‘that there were no beneficial effects – none’. The MTA study results were entirely in keeping with the joint propositions that nothing affects behaviour as fast as behaviour altering medications and that ADHD medications simply mask symptoms and do nothing to address the causes of dysfunctional behaviours. Since the publication of the three year data the MTA is rarely mentioned by the ADHD industry. Many other studies unfavourable to the pharmaceutical companies are never publicised. This ability to bury unfavourable results is an essential tool in the ADHD industry’s quest to show that amphetamines are good for children.

⁷ McDonagh MS, Peterson K, Dana T, Thakurta S. *Drug Class Review on Pharmacologic Treatments for ADHD: Final Report Update #2, Evidence Tables.* (Oregon Health & Science University, Portland, Oregon, 2007)
http://www.ohsu.edu/ohsuedu/research/policycenter/customcf/derp/product/ADHD_Final%20Report%20Update%20Evidence%20Tables.pdf (accessed 13 February 2009)

⁸ Alexander Otto, “Are ADHD drugs safe? Report finds little proof.” *The News Tribune*, 13 September 2005

⁹ *ibid*

¹⁰ *ibid*

¹¹ McDonagh MS, Peterson K, Dana T, Thakurta S. *Drug Class Review on Pharmacologic Treatments for ADHD: Final Report Update #2, Evidence Tables.* (Oregon Health & Science University, Portland, Oregon, 2007)
http://www.ohsu.edu/ohsuedu/research/policycenter/customcf/derp/product/ADHD_Final%20Report%20Update%20Evidence%20Tables.pdf (accessed 13 February 2009)

The Australian public and even the Australian drug safety regulator the Therapeutic Goods Administration (TGA) are not allowed to know the whole truth about the results of drug trials. Pharmaceuticals are usually licensed first in the U.S. by the Food and Drug Administration (FDA) and soon after in Australia by the TGA. In America, pharmaceutical companies are free to determine who conducts their studies and which studies they publish and which they keep quiet.¹² Obviously the pharmaceutical companies do not choose researchers or set research parameters designed to show their products in a bad light. When that happens it is also obvious their response is to turn off the lights. Another favourite trick of the ADHD industry is confusing cause and effect by arguing that when left un-medicated ADHD causes criminal behaviour or drug abuse. Identifying dysfunctional populations like criminals and drug addicts as having dysfunctional behaviours (i.e. ADHD) is the equivalent of being able to bet on a horse after the race has finished.

Yet another tactic of the ADHD industry is to defend claims that ADHD is over-diagnosed and over-medicated by claiming prevalence rates exceed diagnosis and drugging rates, and therefore claim ADHD is under-diagnosed/under-medicated. Prevalence rates are estimates of the percentage of a population with a disease or disorder. A prevalence rate is different from a diagnosis rate, which is the percentage of the population diagnosed with a condition. Not surprisingly estimates of the prevalence vary widely. A study conducted in 1998 found that prevalence estimates within vary between 1.7% and 16%.¹³ The huge range is a consequence of relying on subjective and ill defined diagnostic criteria.

The School System – Drugging Square Pegs to Fit Round Holes

The diagnostic criteria of ADHD like making careless mistakes, not “seeming to” listen, failing to finish school work, being disorganised, disliking schoolwork or homework and leaving a seat when remaining seated is expected, blurting out answers, are all evidence of the failure of a child to comply in a school environment. As most symptoms relate to failure to comply in a school setting the obvious question is; which is the problem, the child or the environment (i.e. school)? Despite the rhetoric of student focussed education the vast majority of classrooms still operate in the traditional manner where the teacher sets common tasks and students of varying ability and disposition are expected to complete them. The emphasis on mainstreaming an increasingly diverse range of students with a ‘one size fits all’ approach to education means there are an increasing number of ‘square peg’ students in ‘round hole’ classrooms. A diagnosis of ADHD removes responsibility from the school and shifts “*the focus away from what might be wrong with schooling to centre only on what is ‘wrong’ with the child.*”¹⁴ The environment is not modified to fit the child; instead the child is modified (drugged) to fit the environment.

¹² David Armstrong and Keith J Winstein, ‘Antidepressants Under Scrutiny Over Efficacy’, *The Wall Street Journal Online*, 17 January 2008

¹³ Goldman, L.S., Genel, M., Bezman, R.J., & Slanetz, P.J. (1998) Diagnosis and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Journal of the American Medical Association*, 279(14), 1100-1107.

¹⁴ Linda J. Graham, ‘Drugs, labels and (p)ill-fitting boxes: ADHD and children who are hard to teach’ in *Discourse: Studies in the Cultural Politics of Education*, Vol. 29, 1: (March 2008): p94

These are not new concerns. In 1970 in response to the then new practice of drugging for hyperactivity, American author and educator John Holt testifying about the US education system before a US House of Representatives committee said: *“We consider it (hyperactivity) a disease because it makes it difficult to run our schools as we do, like maximum security prisons, for the comfort and the convenience of the teachers and administrators who work in them. The energy of children is “bad” because it is a nuisance to the exhausted and overburdened adults who do not want to or know how to and are not able to keep up with it. Given the fact that some children are more energetic and active than others, might it not be easier, more healthy, and more humane to deal with this fact by giving them more time and scope to make use of and work off their energy?...Everyone is taken care of, except, of course, the child himself, who wears a label which to him reads clearly enough “freak,” and who is denied from those closest to him, however much sympathy he may get, what he and all children most need – respect, faith, hope, and trust.”*¹⁵ In 1970 America, as in current Australia, too often the one size fits all inadequacies of the school system are backed up with medication to make children fit the system. A truly inclusive education system would recognise and cater for difference. Philosophies of inclusion must be supported with the resources needed to cater for individual needs.

The Politics of ADHD

ADHD is a “disorder” manufactured to match our times. It is a quick catch all diagnosis with a magic bullet treatment. The contrived ADHD epidemic started in the United States and has been adopted around the globe with varying degrees of enthusiasm. ADHD drugging works well for cynical, populist, governments. At a relatively low cost it gives the appearance of addressing children’s mental health needs. Even governments, which believe there is something not quite right with giving amphetamines to inattentive children, become fearful that if they go too hard they will alienate parents who have come to depend on subsidised drugs as their chief means of behaviour control. This is entirely understandable. There are votes to be lost telling parents that the “magic bullet” they are giving their “improved” child is in fact sometimes a crutch propping up their inadequate parenting or simply masks a host of other more complex problems.

This is part of the reason we have independent regulators like the Food and Drug Administration (FDA) in the US and the Therapeutic Goods Administration (TGA) in Australia whose task it is, without fear or favour, to protect the public from unsafe treatments. However over the last 20 years, Australian Government agencies charged with protecting patients, including the TGA and the National Health and Medical Research Council (NHMRC), have allowed drug companies to hype the benefits and distort the risks of ADHD drugs. Eli Lilly (Strattera), Novartis (Ritalin), Janssen-Cilag (Concerta) and Glaxo Smith

¹⁵ Ronald Lipman, “Federal involvement in the use of behaviour modification drugs on grammar school children of the right to privacy inquiry. Hearing before a Subcommittee of the Committee on Government Operations House of Representatives, Ninety-First Congress, Second Session, (29 September 1970): p33 <http://www.fredsworld02.com/pdf/federal%20involvement.pdf> (accessed 9 April 2008)

Kline (dexamphetamine) benefit enormously from having their drugs sponsored, by Australian taxpayers through the Pharmaceutical Benefits Scheme. The TGA has accepted drug-company funded research to determine drug safety approvals and has relied on the same companies to collect and evaluate adverse side effect incidents, virtually without scrutiny. Instead of forcing drug companies to prove their products are safe, regulators pay lip service to public safety and effectively force the public to prove beyond a doubt the drugs are unsafe. This is well after any damage has been done and profits have been distributed to directors and shareholders. In addition the medical practice standard setters, the NHMRC, have a history of producing influential ADHD industry friendly reports.

ADHD is a clear example of market failure, in that the private interests of profit maximising drug companies and public wellbeing are divergent. There is a clear need for government intervention, via regulations, in order to borrow an old Australian political slogan "*keep the bastards honest*". However Australian Government regulators and to a lesser extent in U.S. Government regulators have failed abysmally. Typically the U.S. FDA and its tag along little brother the Australian TGA accept the results of drug-company sponsored research and only react when the overwhelming weight of evidence from "adverse events" compels action. Far from applying the precautionary principle regulators adopt hands off approach and usually intervene as a last resort and then only timidly.

Most governments leave the issue in the too hard basket. Typical of this timid approach was former West Australian Health Minister Kevin Prince's response in 1997 to a parliamentary question regarding the State Government's attitude to ADHD. Despite Western Australia then having 4 times the national rate of ADHD prescriptions Minister Prince said, "*(ADHD) is a matter that should be addressed on a nationwide basis and it should not be taken up by one State to the exclusion of all others, because it clearly affects the totality of Australian people.*"¹⁶ Minister Prince's almost comical desire to pass the buck to another level of government reflects in 'Yes Minister' terms how 'courageous' it is to express a view on this issue. When responsible governments rise to this challenge they, naturally, have one eye on the public good and the other on the ballot box. Good governments express concern about misdiagnosis and over-prescription. None are ever brave enough to say ADHD is a fraud.

Even my advocacy on ADHD has until recently been tempered by the reality that parents with children on ADHD medication vote, and if I tell the whole brutal truth, they may not vote for me. In truth, I consider parents at best desperate, vulnerable and gullible, and at worst reckless, in regard to the long term wellbeing of their child. When lobbying both my own government and other governments it has been my tactic to try and position the government as concerned about prescription rates and supporting other strategies so that medications are not the first and only line of treatment. This pragmatic approach shifts government policy to a less pro-drugging position, however, it leaves the door open for drugging children with amphetamines and implicitly recognises the validity of ADHD, even if as a diagnosis of last resort.

¹⁶ Western Australia Hansard, Hon Kevin Prince, Minister for Health, *Health – Attention Deficit Disorder*, 22 October 1997

Perhaps the strongest statement ever to be backed up by action by a significant political leader was made in September 2007 by the then Western Australian Premier Alan Carpenter. Premier Carpenter while announcing the funding for the new multidisciplinary clinics, told state parliament that, *“Although medication may still be required for severe cases of ADHD, this new approach will ensure that stimulant medication is not the first line of treatment....The aim is to reduce the prescription rates for young people suffering ADHD. If our recent history is any guide, reducing ADHD prescription rates will reduce amphetamine abuse rates, and we all know that the abuse and misuse of amphetamines is a major issue in our society broadly.”*¹⁷ The West Australian Government has been as interventionist to protect the rights of children as any government. Whilst some U.S. states have taken action to protect children, they have only done so to protect parents and their children from state enforced drugging. None have acted to protect children from parental enforced drugging. In 1999, Colorado legislated to prevent school personnel from recommending psychotropic drugs to students. Other states followed, however, the legislation does not stop teachers and other school employees recommending to parents that their child should be assessed by a doctor.¹⁸

In the next 5 to 10 years ADHD child drugging will be seen for what it is; a tragic abuse of child rights and society will collectively wonder how it all happened. However, democratically elected governments rarely get ahead of public opinion and for the moment getting governments to support strategies aimed at making ADHD medications a last order treatment is a good result. No Government will ban the use of amphetamines in children until it is no longer brave to do so.

The Howard and Rudd Governments Response to ADHD

Currently the Australian Government spends tens of millions of dollars annually subsidising ADHD medications through the Pharmaceutical Benefits Scheme (PBS) much of which is diverted for illicit use. Unwittingly the Commonwealth Government is a major sponsor of illicit amphetamine abuse. Commonwealth Government financial resources that are currently allocated to pharmacological interventions, to achieve short-term symptom management, would be better directed to assisting state governments to develop multi-disciplinary services to identify accurately the causes of behavioural problems in children.

In May 2007 media exposure of the pharmaceutical company ties for the chairperson of the Royal Australian College of Physicians (RACP) committee that had been tasked by the Commonwealth Government to review the national ADHD treatment guidelines prompted the then Health Minister Tony Abbott’s intervention. Abbott said he *“instinctively questioned”*

¹⁷ Hansard, Hon Alan Carpenter , Thursday, 27 September 2007 p5946c-5948a

¹⁸ Linda J. Graham, “Drugs, labels and (p)ill-fitting boxes: ADHD and children who are hard to teach”, *Discourse: Studies in the Cultural Politics of Education*, Vol 29, 1 (March 2008): p95

the long-term use of drugs for non-life threatening conditions.¹⁹ This followed up comments the previous week by then Prime Minister John Howard who said *"I am very worried about reports of the over-prescription of Ritalin."*²⁰ However, the fatal flaw in the Howard Government's approach was revealed in Minister Abbott's statement *"I want to see new clinical guidelines but I stress it is up to the experts to carefully weigh all the issues."*²¹ The problem being, apart from a few determined and isolated skeptics, the 'experts' in ADHD are almost exclusively fervent believers in the validity of the diagnosis and the safety and effectiveness of the drugs. No skeptics made it onto the RACP guidelines review, only ADHD true believers, therefore Abbott had delegated the solution to the problem of reckless prescribing to the very people who had created the problem.

Then Opposition Health spokesperson, current Rudd Government Health Minister Nicola Roxon, roared about protecting kids from unnecessary prescribing.²² Roxon demanded transparency and called for the names and drug company connections of members of the guidelines review committee to be made public saying, *"These guidelines are incredibly important and it is important there is public confidence in them. Given the controversy surrounding ADHD, releasing the names is the sensible option to help restore public confidence in the process."*²³ When in November 2007 she became Health Minister, Nicola Roxon failed to disclose the names of the committee and their drug company connections.

If it were not for FOI's we wouldn't know about the commercial ties members of the committee have to drug companies. In November 2008 the Adelaide Advertiser revealed that *"Seven of the original 10 (guidelines committee) group members, including doctors, have declared receiving grants and air fares, hotels and overseas trips from companies making drugs to treat the disorder. One non-medical member, former teacher Geraldine Moore, had the bill for her Sydney book launch picked up by Eli Lilly, manufacturer of one of the two major ADHD drugs, Stattera.....The newspaper has obtained the conflict of interest declarations made by nine of the 10 original working group members. The 10th has demanded details remain secret. Two of the nine since have quit. Among replacements is educational consultant Michelle Pearce, who helped write a booklet "Teenagers with ADHD" for drug company, Novartis."*²⁴

¹⁹ ADHD guru quits over Ritalin link Daily Telegraph by Janet Fife-Yeomans, May 05, 2007

²⁰ "Call for ADHD drug inquiry" Daily Telegraph By Janet Fife-Yeomans and Bruce McDougall <http://www.news.com.au/dailytelegraph/story/0,22049,21628621-5001021,00.html> April 27, 2007

²¹ ADHD guru quits over Ritalin link Daily Telegraph by Janet Fife-Yeomans, May 05, 2007

²² "Call for policy on ADHD drugs" Brisbane Courier Mail April 26, 2007 [Increase](#)

²³ "Secrecy for ADHD doctors" Daily Telegraph By Janet Fife-Yeomans June 30, 2007 <http://www.news.com.au/dailytelegraph/story/0,22049,21989550-5001021,00.html>

²⁴ Guidelines panel linked to drug firms, From Adelaide advertiser Janet Fife-Yeomans November 17, 2008 12:01am <http://www.news.com.au/adelaidenow/story/0,22606,24660999-5006301,00.html>

In addition to calling for full committee disclosure, when in opposition Roxon also called for an inquiry into ADHD child drugging “*along the lines of one into ADHD in Western Australia three years ago.*” Roxon wanted the inquiry to address the community's "clear" concern that Australia has one of the world's highest rates of attention deficit hyperactivity disorder stating, “*we don't want children being medicated if they don't need to be and we want to make sure children who need support and assistance can get it, so we must get the balance right.*” The Western Australian Inquiry Roxon referred to was conducted in 2004 by six parliamentarians, three from the Labor (including me as a co-opted member), one Liberal and one from the National Party, none of whom had any commercial interest in ADHD. In contrast the RACP guidelines review was conducted by a group of drug company allies, with a clear commercial and professional investment in the continued drugging of children for ADHD.

The Australian Medical Association's, response to Roxon's call for an independent inquiry was to protect the interests of their membership by defending prescribing practices and rejecting a “*full-blown inquiry*” and insisting the RACP committee complete its work.²⁵ Despite her calls in opposition, since she became the Minister for Health Nicola Roxon has ignored the lessons that can be learned from WA and has taken the powerful AMA's advice and relied on the conflicted RACP group. The Howard and Rudd Government's have both made the same mistake in seeking to address concerns about ADHD reckless prescription. They have kept going back to the ADHD industry for advice and the ADHD industry inevitably promotes further prescribing. The Western Australian Government only made progress on tackling WA's out of control child prescribing rates when it stopped listening to the ADHD industry. It is a pity Canberra is not prepared to learn from Perth's experience.

Western Australia's Public Policy

The ADHD story in Perth Western Australia, the world's most isolated capital city, contains the key disturbing elements of the global debate. Played out at the top by the pharmaceutical companies and the American Psychiatric Association and, lower down, in terms of thousands of schools and doctors surgeries across the globe and in towns and cities like Perth. Across the globe millions of parents have been fooled and scared into ‘medicating’ their children with amphetamines in order to prevent imagined disastrous educational and life outcomes. But Perth's story offers hope that with common sense and leadership children can have a future where difference is regarded as a strength, not a disorder, and those with problems have their real needs met.

Until recently Perth had the highest prescription rate of amphetamines in Australia. Throughout the 1990's, and until 2003, Western Australian children were roughly 4 times more likely than other Australian children to be diagnosed with ADHD and drugged with amphetamines. There was no evidence that Perth children had different brain chemistry or behaviour from children in Melbourne, Adelaide, Sydney or anywhere else in the world. The real difference was in the clinical practice of the paediatricians and child psychiatrists who treated them. Until 2005 Perth had one medical school and has a cliquy medical community

²⁵ “Call for ADHD drug inquiry” Daily Telegraph By Janet Fife-Yeomans and Bruce McDougall <http://www.news.com.au/dailytelegraph/story/0,22049,21628621-5001021,00.html> April 27, 2007

who, at least publicly, are reluctant to criticise each other. This lack of a critical culture allowed a handful of irresponsible clinicians to diagnose and drug without proper scrutiny. In the meantime, fuelled by diverted prescription dexamphetamine, Perth became the illicit amphetamine capital of Australia with rates twice the Australian average.

All sides of the ADHD debate acknowledge that differences in the demographic, socio-economic and environmental characteristics between states are not the major explanation of differential drugging rates. There is little argument that WA prescription rates throughout the 1990's and until 2003 were many times the rates in other states because of differing diagnostic and prescribing practices, however, opinions as to the appropriateness of WA diagnosing and prescribing practices vary. Perth's ADHD enthusiasts argued WA rates are higher because WA clinicians (i.e. they) are better at recognising and diagnosing ADHD than other states. Their position is that other states were missing the diagnosis of ADHD and rather than W.A. misdiagnosing and over prescribing, other states were yet to catch up with "best practice" W.A.

In Perth child psychiatrists are in short supply, and whilst there are a number of exceptions most rarely prescribe for ADHD. Perth's shortage of appropriately trained psychiatrists to perform time intensive diagnosis and treatment left a vacuum which was filled by a relatively small number of inadequately trained paediatricians who diagnosed and prescribed quickly; creating the illusion that children's mental health needs were being met. The absence of appropriate services may be a significant reason that the situation developed but it does not exempt these paediatricians from their Hippocratic obligation to "first do no harm". It was their careless application of subjective and overly broad ADHD diagnostic criteria and routine prescription of psycho-stimulants that created Perth's ADHD epidemic.

Psychiatrists in Western Australia have exclusive authority to prescribe stimulants for ADHD to adults. Children, however, are frequently prescribed stimulants for ADHD, by paediatricians and even co-prescribing G.P.'s who are not as well trained as psychiatrists in diagnosing and treating mental health disorders²⁶²⁷ The diagnosis of mental health disorders in children should be at least as thorough for children as it is for adults. Children have neither the authority nor capacity to make informed judgements about their treatment. In order to give children at least as much protection as adults, only child psychiatrists should be able to diagnose and prescribe medications for the treatment of psychiatric disorders.

Whilst there is a tendency for paediatricians to diagnose and prescribe stimulants more often than psychiatrists there are many exceptions to the rule. The attitudes and practices of individual paediatricians and psychiatrists are wildly divergent. When statistics about individual prescribing patterns become available it confirmed anecdotal evidence that prescribing patterns were skewed with a tiny minority of authorised prescribers responsible

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²⁷ WA 36th Parliament Education and Health Standing Committee Report No. 8 "ADHD in WA" report finding 4 p.24. Page 24, Finding 4 - *"During their training, paediatricians have not been adequately informed about the extent of alternative diagnoses and treatment methods, and are therefore more likely to use drug therapy in the first instance in the management of ADHD."*

for the vast majority of prescriptions. The first annual report of the stimulants monitoring regime revealed a single Perth paediatrician was responsible for prescribing to 2077 children in 17 months, or 13.2% of all ADHD patients prescribed in WA over that period. This is clearly an absurd number for a single practitioner who must have been doing little more than meeting, diagnosing, prescribing and forgetting. Perth's heaviest prescriber was no lone ranger. In the same 17 month period in W.A. 15 of the 172 authorised prescribers were responsible for prescribing to over 7300 (nearly half) of patients who received stimulants. Also less than 1/4 of the 172 authorised prescribers were responsible for prescribing to over 3/4 of patients who received stimulants.

ADHD has become one of the most commonly medicated childhood disorders, even though in Western Australia at least, a small minority of potential prescribers do the vast majority of prescribing. In a 2006 survey of 245 West Australian general practitioners, three and a half times as many GPs agreed (56%) with the statement that dexamphetamine was over-prescribed than disagreed (16%).²⁸ In effect, an ADHD ideologue fringe, who believe that amphetamines are good for children who play too loudly, fidget, interrupt and don't like doing their homework, dominated clinical practice.

In recent years ADHD prescription rates in all Australian states except Western Australia have continued to grow. However, since the introduction of tighter prescribing accountability measures in 2003, and a Western Australian parliamentary inquiry in 2004 which was part of an intense local debate around the validity of the diagnosis and the safety of the drugs, there has been a significant and unprecedented downturn in Western Australia's child drugging rates.²⁹

From 1989-2003 Western Australia had an massive increase in the prescription of dexamphetamine and to a lesser extent methylphenidate (Ritalin) to young people as a treatment for Attention Deficit Hyperactivity Disorder (ADHD). In 1989, 880 people in WA were prescribed stimulant medication. By the year 2000 this had increased to 20,648 with an estimated 85-90% (17,551 to 18,583) being children. In 2000 an estimated 4.2% to 4.5% of all West Australian children aged between 4-17 years were on ADHD stimulants.³⁰

Until August 2005 dexamphetamine was the only drug for ADHD subsidised through the Pharmaceutical Benefits Scheme (PBS). From 1993 until 2003 according to PBS data WA was consistently the highest prescribing state (or territory) of dexamphetamine. In 2003 the number of prescriptions dispensed for dexamphetamine in WA was around three and a half

²⁸ Medical WA Forum 28 April 2006 http://www.medicalhub.com.au/index.php?option=com_content&task=view&id=2700&Itemid=229 accessed 30/6/2009

²⁹ Whilst West Australian adult prescription rates have continued to grow, Western Australia is the only state where total prescribing rates are trending downwards.

³⁰ Office of Mental Health, *Attentional Problems in Children: Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder(ADHD) and Associated Disorders*, November 2002, Government of Western Australia: p21

times higher per 1000 population than the Australian average (including WA) and was comparable to the highest prescribing rates in the world.³¹

Concerns about West Australian rates of prescription of Dexamphetamine and to a lesser degree Methylphenidate emerged in the mid 1990's. In 1995 the Court Liberal WA State Government set up a Technical Working Party *"to report to government on the incidence of ADHD in Western Australia and to seek expert opinion on the appropriate diagnosis and treatment for the condition"*³² The Working Party's report highlighted that in 1994 the rates of prescription per child in WA were about two and a half times the national average and the 43 – fold growth in the prescription of dexamphetamine to five to 14-year-olds in Western Australia between 1989 and 1994. It also highlighted rates of prescription per child in WA were about two and a half times the national average. Furthermore, the report identified that prescription patterns varied greatly across the Perth metropolitan area.

The report identified concerns with the diagnostic practices of some unnamed Perth paediatricians stating, *"The parent is frequently the sole source of information and often educational and behavioural information is not sought. When information is sought from the school, the questions asked are frequently inappropriate. Behavioural observations are rarely obtained."*³³ Furthermore, the report identified that prescription patterns varied greatly across the Perth Metropolitan Area. It concluded that it is *"the view of the working party that the differential rate of prescriptions may be more reflective of the prescribing patterns of paediatricians servicing the various areas than it is of social or other factors associated with ADHD in those areas"*.³⁴ To address the inconsistency in prescribing rates the report recommended, *"that the stimulants committee of the Department of Health be authorised to carry out random audits into the use of block authorisations, and that paediatricians and psychiatrists found to be failing to abide by the appropriate criteria have their bloc authorisation capacity removed."*³⁵ However, no action was taken.

Under Block Authorisation *"a practitioner was able to apply to the (West Australian) Department of Health and be granted blanket approval to treat any number of patients with stimulant medication, without further notifying of changes to individual patient details or*

³¹ In 2003, WA dispensed 86,980 prescriptions for dexamphetamine (WA pop = 1,969, 046) compared to 61,390 in NSW (pop = 6,716,277) which was 44.2 prescriptions per 1000 pop in WA compared to NSW at 9.1/1000 and the Australian average 12.5/1000. Department of Parliamentary Services, *Medication for Attention Deficit/Hyperactivity Disorder (ADHD): an Analysis by Federal Electorate (2001-03)*, Current Issues Brief 16 November 2004, No. 8 2004-2005, Parliament of Australia: p7

³² *The Report of the Technical Working Party on Attention Deficit Disorder to the Cabinet Sub-Committee* (1997); Parliament House Western Australia: p2

³³ Parliament House Western Australia op cit p8

³⁴ Parliament House Western Australia op cit p6

³⁵ Parliament House Western Australia op cit p20

dosage,” provided the dose was within the manufacturers prescribing guidelines.³⁶ Bloc Authorisation granted an exemption from normal accountability requirements to frequently prescribing clinicians considered to be “*familiar with the prescribing guidelines.*”³⁷ In effect Bloc Authorisation meant that frequent prescribers were the least accountable. In contrast, a clinician who prescribed infrequently as a last resort was accountable for every individual script. Presumably the rationale for the policy of “bloc authorisation” was the assumption that those who prescribe frequently were familiar with, and therefore competent in, the prescription of dexamphetamine and methylphenidate.

Some isolated and ineffective efforts to rein in the ADHD prescribing rates took place between 1997 and 2000. In 1996 when the concerns about prescribing rates first lead to suggestions to curtail bloc authorisation the rate of prescription of stimulant medication in Western Australia was less than 1 per cent (1.6 per cent of boys and 0.15 per cent of girls).³⁸ Four years later in September 2000, “*Over 3.7 per cent of Western Australian children under 18 years are on stimulant medication with most of these young people being treated for ADHD*”.³⁹ Inaction had seen rates quadruple in 4 years.

In February 2001 the Western Australian State Election resulted in the replacement of the Court Liberal Government with the Gallop Labor Government. I was elected as the Labor Member for Roleystone and I raised the issue of bloc authorisation in my inaugural speech stating; “*The problem of bloc authorisation continues. I believe making doctors accountable on a case-by-case basis for the prescription of stimulant medication is essential to dealing with the problem of over prescription.*”⁴⁰ The change of government, my election and the appointment as W.A. Health Minister of the Honourable Bob Kucera, a former policeman who had seen the problems of ADHD prescription amphetamine diversion, provided the opportunity for the direction of policy to be reversed.

In 2002 the report “Attentional Problems in Children and Young People” was published by the Western Australian Mental Health Division. An earlier draft of the report emphasised developing a tiered approach with teachers and child-care workers spotting potential ADHD children and referring them up the chain for diagnosis by specialist clinicians. The draft

³⁶ Dr Rowan Davidson, Chief Psychiatrist with the DoH, Education and Health Standing Committee Hansard Evidence transcript 15 Sept 2004

³⁷ *The Report of the Technical Working Party on Attention Deficit Disorder to the Cabinet Sub-Committee* (1997); Parliament House Western Australia: p20

³⁸ *The Report of the Technical Working Party on Attention Deficit Disorder to the Cabinet Sub-Committee* (1997); Parliament House Western Australia

³⁹ Department of Mental Health, ‘Attentional Problems in Children and Young People: Diagnosis and Management of ADHD and Associated Disorders, *Draft Report*, August 2001, Mental Health Division of the Western Australian Department of Health, Western Australia.

⁴⁰ Western Australian Legislative Assembly Hansard, Martin Whitely MLA, Inaugural speech, Thursday, 3 May 2001, p152b-179a

report was, with my input, significantly altered by Kucera's ministerial office. The final draft abandoned the tiered spotters approach, recommended the abolition of bloc authorisation and the establishment of multidisciplinary clinics to diagnose and treat children with behavioural and learning problems, often characterised as ADHD. Minister Kucera announced the decision to end bloc authorisation in December 2002 and the practice was stopped in August 2003 so that every authorised prescriber was equally accountable for every individual prescription. After bloc authorisation was abolished every practitioner was compelled to "apply to the (West Australian) Department of Health and obtain a unique Stimulant Prescriber Number (SPN) to initiate stimulant treatment in any patient. The practitioner must provide individual patient details, including age, gender and dose required, thus enabling the collection of data for future analysis of stimulant use in WA."⁴¹

Prior to the abolition of bloc authorisation and the introduction of the new stimulants monitoring system information about ADHD prescribing rates was limited to total script numbers provided through the PBS. It was difficult to know the numbers of children and adults who were on ADHD medications or the doses they received. As previously stated the West Australian Department of Health estimated there were 20648 people on ADHD stimulants in WA in 2000.⁴² Based on available information from NSW it was estimated between (85%) 17551 and (90%) 18583 were children (0-17) (Office of Mental Health, 2002). By 2005 the number of children on ADHD stimulants had fallen dramatically to 8057, a fall of approximately 55%.⁴³ Even if the initial estimates of children as a proportion of the ADHD cohort was an overestimate and the proportion of the ADHD cohort in 2000 was only 70% (14597) this represents a fall in child ADHD drugging rates of over 44%. Subsequent to the initial fall, child prescribing rates have continued to decline with the number of children prescribed stimulants in 2007 totalling 6188 (Department of Health 2008).⁴⁴

Prescription Amphetamine Abuse

The 2005 Australian Secondary Students' Alcohol and Drug Survey (ASSAD) data indicated a reduction in 'last 12 month amphetamine abuse' by school children 12 - 17 year olds from 10.3% in 2002 to 6.5% in 2005 (ASSAD 2007).⁴⁵ This 38% reduction occurred over a

⁴¹ Education and Health Standing Committee, *Attention Deficit Hyperactivity Disorder in Western Australia*, Report No. 8, 36th Parliament of Western Australia (October 2004): p27

⁴² Office of Mental Health, *Attentional Problems in Children: Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD) and Associated Disorders*, November 2002, Government of Western Australia: p21

⁴³ Department of Health, *Western Australian Stimulant Regulatory Scheme 2005 Annual Report*, Pharmaceutical Services Branch, Environmental Health Directorate, Department of Health, Western Australia (2006): pIII

⁴⁴ Department of Health, *Western Australian Stimulant Regulatory Scheme 2007 Annual Report*, Pharmaceutical Services Branch, Health Protection Group, Department of Health, Western Australia (2008): p41

⁴⁵ *Australian Secondary Students' Alcohol & Drug Survey 2005, Summary of Western Australian Results*, Statistical Bulletin Number 37, June 2007, Drug and Alcohol Office, Government of Western

similar time period as the (50-60%) fall in ADHD child stimulant prescribing rates. This evidence supports the contention that excessive legal prescribing rates link with dexamphetamine diversion and amphetamine abuse. Interstate comparisons of dexamphetamine prescription rates and amphetamine abuse rates confirm that high prescribing rates are associated with high amphetamine abuse rates. In the 2003 Commonwealth Department of Health and Aged Care Survey the National average of dexamphetamine prescriptions was 11.3 per 1000 population, Victoria reported the lowest rate of 6.7, while Western Australia was clearly the highest with a rate of 43.2.⁴⁶ In 2004 Western Australia had the highest level of amphetamine abuse of all states, with a rate of 4.5% of the population aged 14 years and over having abused amphetamines in the past year. This was well above the national average of 3.2%. Victoria had one of the lowest rates of just 2.8%.⁴⁷ The proportion of people presenting for treatment with amphetamine abuse as the principal drug of concern in 2005/6 also confirms this trend. The Australian average was 11% of all treatment episodes with amphetamines identified as the principal drug of concern, while Western Australia reported the highest rate of 24.6% and Victoria the lowest with a rate of 6.3%.⁴⁸

Far from supporting the assertion that medicating for ADHD prevents illicit drug abuse by self-medicating untreated ADHD sufferers, the West Australian experience is there is a positive correlation between amphetamine abuse rates and the legal prescribing rates for amphetamines for the treatment of ADHD. This experience makes a mockery of the ADHD industry claims that amphetamines, when prescribed to ADHD children, prevents drug abuse. The evidence is unequivocal, it clearly supports the common sense proposition that prescribing amphetamines facilitates the abuse of amphetamines. This view was accepted by the Western Australian Government with the then Premier Alan Carpenter telling the W.A. Parliament on 27 September 2007 *“The evidence shows that if amphetamine prescribing rates are decreased, abuse rates are decreased.”*⁴⁹ Whilst the positive correlation between prescribing rates and abuse rates seems obvious the Premier’s statement was very significant and made necessary by the failure of senior figures including Health Minister Hon Jim McGinty to recognise the damage created by the diversion of illicit amphetamines.

In 2003 Jim McGinty replaced Bob Kucera as Health Minister. McGinty did not share Kucera’s concern or understanding of ADHD amphetamine diversion. Whilst McGinty’s public statements on ADHD have supported my position, he was not prepared to work

⁴⁶ Commonwealth Department of Health and Aged Care; Australian Bureau of Statistics, *Population by Age and Sex*, June 2000 (ABS 3201.0).

⁴⁷ Australian Institute of Health and Welfare, 2004 *National Drug Strategy Household Survey, First Results*, Australian Institute of Health and Welfare Drug Statistic Series Number 13, April 2005, Australian Government, Canberra, <http://www.aihw.gov.au/publications/index.cfm/title/10133> accessed 30/6/2009

⁴⁸ Treatment Episodes Principle Drug of Concern 2005/2006, Alcohol and other Drug Treatment Services in Australia: Report

⁴⁹ Western Australian Hansard Hon. Alan Carpenter Thursday, 27 September 2007 p5946c-5948a

cooperatively with me on this issue. The difficult relationship between McGinty and I meant that after Kucera's active cooperation any progress achieved on ADHD policy was because of the intervention of Premiers Gallop and particularly Carpenter. Whilst Gallop was sympathetic, he was also loathe to undermine the jurisdiction of a senior minister. Fortunately Kucera's decision to abolish bloc authorisation and introduce a new stimulants monitoring regime was in place before McGinty took over as Health Minister.

Like Gallop before him Alan Carpenter was heavily reliant on McGinty to fulfil the demanding dual roles of Minister for Health and Attorney General and was understandably reluctant to override McGinty. However, Carpenter was eventually convinced of the need to rein in prescribing practices and address the real needs of West Australian children. Although progress on the issue was much faster under Kucera, Carpenter's eventual preparedness to override McGinty made further progress possible.

In 2007 the State Government called an "Ice Summit" to create community generated solutions to the problem of amphetamine abuse. In media coverage and throughout the summit the terms 'amphetamine' and 'Ice' were used as if they were interchangeable and amphetamine abuse statistics were misrepresented as ice abuse rates. Professor Bruce Maycock of Curtin University and I attended the summit as uninvited delegates. We conducted a series of interviews and I wrote to invited summit participants highlighting the illicit diversion data and the fact that the Government had missed the elephant in the school yard by focusing the summit on Ice/Methamphetamine and not recognizing that diverted prescription amphetamines represented a very significant proportion of illicit amphetamine use.⁵⁰

The Ice Summit, as it was almost being exclusively called in both the media and within government, had narrowed public debate about amphetamines abuse to Ice. The aim of the letter to delegates and subsequent lobbying was to emphasise the importance of the nexus between amphetamine prescribing and abusing that had been briefly acknowledged and then virtually ignored at the summit and to build support for state run multidisciplinary clinics designed to reduce ADHD prescribing rates. Within 6 weeks of the Ice Summit the Premier Carpenter issued a press release stating, "*Studies show that dexamphetamine accounts for a substantial amount of amphetamine use by young people in WA*" and announcing funding of \$9million over 4 years "*to establish two 14-member specialist teams for ADHD, co-located with existing community-based mental health services. The teams will include professionals from a range of disciplines including psychiatrists, paediatricians, clinical psychologists, clinical nurses, speech pathologists, occupational therapists and social workers.*"⁵¹ The Premier was persuaded by the statistics 'that giving amphetamines to teenagers lead to amphetamine abuse by teenagers'. The clinics that were first recommended to the Court WA state government in July 1996, and that had been key recommendation of the 2004 parliamentary inquiry into ADHD, finally received funding.

⁵⁰ Elephant in the Schoolyard unpublished paper 2009 by Professor Bruce Maycock and Martin Whitely MLA

⁵¹ Carpenter, A. (2007). State Government invests \$16 million in 'ice' fight. *Media Release*, 19 August.

In September 2008 the Carpenter Labor Government lost office to the Barnett Liberal/National Government. I was however re-elected as an opposition backbencher to the West Australian Parliament. In order to fund election commitments a general 3% cut to all departmental budgets, including Mental Health was instituted. Mental Health bureaucrats identified halting the roll out of the clinics as a means of helping to achieve the desired cuts. After a discussion between myself and the new Minister for Mental Health, the Honourable Graham Jacobs, the Minister directed his department to fully fund and continue to establish the clinics. As a consequence of this bi-partisan commitment the first of two multidisciplinary clinics will open in 2009 with the second to follow in 2010.

Another policy change that was recommended in the 2004 WA Parliamentary Inquiry into ADHD designed to address the problem of diversion of prescription amphetamines was implemented in 2006 (Carpenter, McGinty 2006).⁵² This recommendation was made in response to evidence of a teenager receiving 175 days worth of repeat scripts in 13 days and an adult patient receiving 125 days worth of repeat scripts in 40 days. The recommendation was that Western Australia copy the New South Wales restrictions on the frequency with which schedule 8 prescriptions can be dispensed by ensuring all repeat scripts for a patients psycho-stimulants were held by one pharmacist and could only be filled as required for prescribed dose usage. Implementation of this initiative post-dated the fall in teenage amphetamine in W.A. teenage abuse rates between 2002 and 2005. Therefore, unlike the end to bloc authorisation, it cannot be viewed as a likely cause of this decline.

The experience in Western Australia of a huge (approximately 50- 60%) downturn in ADHD child prescribing rates coinciding with large (approximately 38%) decrease in amphetamine abuse rate amongst 12 to 17 year olds, supports the hypothesis that prescribing amphetamines for ADHD leads to higher rates of amphetamine abuse amongst secondary students. Whether this relationship also exists for younger children and adults is unknown as the research undertaken in the 2005 ASSAD survey has not been replicated for other age groups. It would however seem intuitively obvious (the elephant in the school yard) that providing amphetamines to a “behaviourally dysfunctional” cohort, regardless of age, will result in increased amphetamine abuse rates. The emotional vulnerability of adolescents and young adults may exhibiting ADHD type behaviours may predispose them to providing amphetamines to their peers in order to increase their social status and acceptance.

Implications for Other Governments

The policy implications of the correlation between amphetamine prescribing and abuse rates for government are significant. The Commonwealth Government spends tens of millions of dollars annually subsidising ADHD medications through the Pharmaceutical Benefits Scheme (PBS), much of which is diverted for illicit use. Unwittingly the Commonwealth Government is a major sponsor of illicit amphetamine abuse.

⁵² WA 36th Parliament Education and Health Standing Committee Report No. 8 “ADHD in WA”

State Governments seeking to replicate WA's downturn in ADHD prescribing rates and subsequent fall in amphetamine abuse rates experienced in Western Australia should consider replicating Western Australia's stimulant monitoring system and measures put in place requiring repeat stimulant prescription to be held by a single pharmacist and dispensed when due. In addition resources should be dedicated to strategies designed to decrease ADHD amphetamine prescription rates including establishing multidisciplinary clinics to help children with behavioural and learning difficulties. Such measures, if implemented by those who genuinely oppose the use of drugs as a first line treatment, should have the dual benefit of providing more comprehensive non medication treatment services for children with behavioural and learning difficulties, and reducing ADHD amphetamine prescription and abuse rates.

The future of ADHD policy in Western Australia

The prime recommendation of the 2004 Parliamentary Inquiry was to establish multidisciplinary clinics that ensure drugs are not the first line treatment for children with concentration and behavioural problems. A needs analysis determined that four clinics with over 50 full time equivalent staff including occupational therapists, speech therapists, social workers etc, would be needed to satisfy unmet demand. Funding for two of the four clinics was announced by the then Premier Hon Alan Carpenter in late 2007. The change of government in September 2008 and the 3% funding cuts saw plans for the proposed clinics in danger of being shelved. However, the Barnett Government Mental Health Minister Hon Graham Jacobs intervened to make sure the first two clinics were funded. I applaud the Barnett Government's bi-partisan approach to the funding of the clinics. If Labor had remained in government my strategy was to encourage the Premier to pressure the Commonwealth Government to divert some funds from the PBS subsidisation of ADHD drugs to funding the extra two clinics required.

The explosion in ADHD drugging rates was in part due to inadequate time for comprehensive assessments that identify children's real problems. Medicare pays paediatricians a set fee for untimed consultations when ADHD is diagnosed. This along with the PBS subsidisation of ADHD drugs creates economic incentives for a quick diagnosis and prescription. The Barnett Government should press the Rudd Government to fund the two additional clinics and resist the temptation to try and service all unmet need from the two clinics that are being established. If necessary access to the clinics should be restricted by post code to ensure that assessment times are not cut, so that every child visiting the clinic gets a full assessment. Without the cautious diagnose slowly, drug as a last resort philosophy, and adequate time for a full assessment, the pressure for a quick diagnosis could exacerbate the very problems that the clinics were set up to address.

Conclusion

Western Australia is the only jurisdiction in the world to have experienced such a massive turn around in ADHD child drugging rates. This has been achievable because senior figures in the Western Australian Government primarily, Kucera and Carpenter and now Mental Health Minister Jacobs have been prepared to intervene. In contrast the Howard and Rudd

Government's have delegated their concerns about ADHD misdiagnosis and over-prescription to the very industry, the ADHD industry, that has created the problem. They have failed to learn from Western Australia's experience. This is a great pity because WA's ADHD story offers hope that we can do more for children with behavioural and learning difficulties than give them amphetamines so that they "Speed Up and Sit Still".