# Senate Inquiry: Barriers to consistent, timely and best practice assessment of attention deficit hyperactivity disorder (ADHD) and support services for people with ADHD

## Submission by Critical Psychiatry Network Australasia (CPNA).

CPNA is an Australia-wide coalition of psychiatrists and other mental health experts, seeking to promote mental health policy and practice based on robust evidence. CPNA is under the auspices of the Robinson Research Institute at the University of Adelaide.

The focus of this submission is on children in relation to four of the terms of reference of the Inquiry.

### Adequacy of access to ADHD diagnosis

There is a history of over medicalising mental distress in Australia; for example we are now among the highest in the world per capita for antidepressant prescriptions[1] without evidence that this is improving mental health.[2] This over medicalisation causes numerous difficulties including harms from medication and other treatments and disempowering non-medical practitioners in their endeavours to provide appropriate help. Labelling people with what sounds like a medical condition for which there is no underlying cause or pathology can inadvertently cause serious harm. Although initially appealing as an explanation for distress with a clear pathway forward it can leave people feeling as though they have some sort of broken brain or disability.

Not every child with the symptoms of ADHD is the same. Despite substantial research efforts, there are no convincing brain changes in children diagnosed with ADHD.[3] Furthermore, the claimed genetic basis to ADHD symptoms[3] is often cited as implying that ADHD is a disease, but many physical and emotional properties have genetic causes without being thought of as diseases (eg short stature, temperament). Similarly, ADHD symptoms can be caused by developmental traumas such as foetal alcohol syndrome, birth anoxia, and head injuries. They can also manifest when individuals predisposed by temperament (a temperament that might be adaptive in a hunter-gatherer society) are placed under pressure by their environment.

As explained below, expanding services to facilitate the earlier diagnosis and treatment of ADHD could result in significant harms, particularly to children. Diagnosing ADHD does not identify underlying problems, instead locating the problem in the child's neurobiology with a disingenuous disregard of social determinants such as poverty, housing insecurity, poor schooling and unemployment. This in turn invites biochemical interventions that modify behaviours in the short-term but carry significant long-term risks. What is needed is services that respond to the needs of each individual child.

As a descriptive diagnosis ADHD has no explanatory power.[4] ADHD does not cause symptoms such as inattention and hyperactivity, ADHD *is* such symptoms. What causes them is another matter entirely and one of great importance. To deny that ADHD is an explanation for the symptoms that define it is not to deny the degree of disturbance in people along the three dimensions subsumed by the ADHD concept (inattention, overactivity and impulsivity), or the longitudinal stability of such symptoms.

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[1] https://www.statista.com/statistics/283072/antidepressant-consumption-in-selected-countries/

[2] Jorm AF, Patten SB, Brugha TS, Mojtabai R. Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry*. 2017 Feb;16(1):90-99.

[3] Faraone SV et al. The World Federation of ADHD International Consensus Statement: 208 Evidence-based conclusions about the disorder. Neurosci Biobehav Rev. 2021 Sep;128:789-818.

[4] Jureidini J. Explanations and unexplanations: Restoring meaning to psychiatry. Australian & New Zealand Journal of Psychiatry. 2012;46(3):188-191.

Further discussion of the role of language choice, logical fallacies, genetic reductionism, and textual silence in medicalising discourse about inattentive and restless behaviours can be found in: te Meerman S, Freedman J, Batstra L. ADHD and Reification: Four Ways a Psychiatric Construct Is Portrayed as a Disease. *Front Psychiatry*. 2022;13:1055328.

There are many well-designed studies to show that this symptom cluster can be reliably identified.[5] Such disturbance clearly occurs, but there are many other important dimensions that need to be considered in formulating causes for such disturbance: dimensions such as learning disability, language disorder, grief, trauma, abuse, family dysfunction, parenting style, bullying, sleep deprivation, hunger, poor eyesight or hearing, the structure of the classroom environment, incompetent teaching or poverty.

Another challenge to the management of attention and emotions is the high level of distraction through social media and multiple screens. Those old enough to have had a boring childhood might remember how boredom facilitates reverie, in turn generating creativity. That world cannot be recreated, but young people can be helped to accept that they need not fill every empty moment with relatively meaningless activities and encouraged to make the time required for less immediately engaging activities and possibly the emergence of strong feelings.

While our primary concern is ADHD diagnosis and treatment in children, we note that convincing adults to take amphetamines is not difficult. Taken in moderate doses, amphetamines make most people feel alert, focused and on top of their game in the short term. While adults who have been fully informed have the right to choose to self identify as having ADHD and to seek medication this does NOT legitimise framing ADHD as a 'neurodevelopmental disorder' or drugs as safe and effective for either children or adults in the long term.

*Recommendation*: The ADHD label should not be conceptualised as an explanation for children's distress and/or dysfunction. The presence of symptoms of overactivity and/or inattention and/or impulsivity should signal the need for careful evaluation of the child and family and their social circumstances as discussed below.

### Adequacy of access to supports after an ADHD assessment

It is essential energetically to seek more robust explanations for the symptoms of inattention, overactivity and impulsivity because management will be more effective when there is a true understanding of the cause of the symptoms. It is therefore useful to think of a patient with ADHD as having a cluster of associated symptoms to be further understood and explained, rather like a patient who presents with nausea, anorexia and abdominal pain. In this way, ADHD is more a diagnostic question than a conclusion. As a result, what is conceptualized by ADHD adherents as specific treatment for ADHD is in fact adjunctive treatment of symptoms. Such symptoms can be caused by other pathologies or by non-pathological experiences that are understandable in the context of the child's relative immaturity and/or classroom circumstances.

Nevertheless many health professionals are attracted by reasoning such as:

> *Whatever else is going on, it is probable that I can help this child (by taking away some of their overactivity, enhancing their attention etc.) by giving drugs. That must be for the better, whatever else (within limits) I am missing.*

But, just as opiates should never be given to a child with undiagnosed abdominal pain because of the risk of masking dangerous pathology, a child with ADHD should never be treated with stimulants until there is an explanation for overactivity/inattentiveness, or at least until all major pathology has been excluded. A child who is overactive at school in the context of an incapacity to understand the tasks because of a specific learning disability might well be temporarily more narrowly focussed and compliant with instructions when taking psychostimulants, but long-term improvement will not come until any learning disability is recognized and addressed. The risk is that the non-specific, temporary

[5] Notwithstanding claims for 'descriptive validity', description does not amount to explanation and reliability of identification does not entail validity as disease. Yet the presence of reliable descriptions of ADHD in diagnostic manuals seems to elevate the condition to the status of disease in the eyes of many clinicians and researchers.

behaviour-altering, focus-narrowing effects of stimulants create the illusion that the cause of problematic behaviour has been identified and addressed. In turn, when withdrawal effects occur on halting use of psychostimulants, this can be mistakenly interpreted as evidence that a biochemical problem has re-emerged.

Long-term studies either fail to demonstrate benefit from ADHD diagnosis and treatment or suggest that harms outweigh benefits. For example, two Australian cohort studies comparing children with similar baseline levels of ADHD symptoms found that those diagnosed with and/or treated for ADHD showed worse outcomes in those who were not: firstly, in a Western Australian birth cohort, continuous high doses of stimulants over 8 years produced a worse educational outcome[6]; secondly, comparison between diagnosed children and matched controls in the Longitudinal Study of Australian Children showed no improvement or worse outcomes for those diagnosed[7]. Similarly, where antipsychotics are prescribed for behavioural control[8], the research shows some benefit in calmer behaviour in the short term, but these medications can cause serious metabolic and neurological harms.[9]

The label of ADHD can be applied so broadly that it could overwhelm the NDIS system and people with severe physical and intellectual disabilities may miss out. The Senate committee might consider the New Zealand schools model that assesses level of functional impairment and allocating resources accordingly, agnostic to diagnosis.[10]

Australia has the highest per capita use of cocaine and methamphetamine in the world.[11] The current escalation in prescribed amphetamines risks making us the highest per capita users of these as well.

*Recommendation*: In the absence of evidence for long-term benefits with significant evidence of harms, no steps should be taken that risk increased prescribing of psychostimulant and other potentially dangerous medications to children.[12]

### The availability, training and attitudes of treating practitioners, including workforce development options for increasing access to ADHD assessment and support services

It is understandable that we are concerned when children are distressed. But children can be distraught without it meaning they are sick. Because complex problems rarely have simple solutions, it is often difficult to know how best to respond to children with 'behaviour problems'. Rather than seek diagnoses, we would do better to trust children's capacity to survive and benefit from strong uncomfortable feelings; be more respectful of the time and space that is required to do so; and tolerate and manage the anxiety we experience through not intervening. Prescribing medication to

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[6] https://www.health.wa.gov.au/~/media/Files/Corporate/Reports-and-publications/PDF/MICADHD_Raine_ADHD_Study_report_022010.pdf

[7] Kazda L, et al. Association of Attention-Deficit/Hyperactivity Disorder Diagnosis with Adolescent Quality of Life. *JAMA Netw Open*. 2022;5(10):e2236364.
An Irish study produced similar findings. (O'Connor C, McNicholas F. What Differentiates Children with ADHD Symptoms Who Do and Do Not Receive a Formal Diagnosis? Results from a Prospective Longitudinal Cohort Study. *Child Psychiatry Hum Dev*. 2020;51(1):138-150).

[8] Sultan RS, et al. Antipsychotic Treatment Among Youths With Attention-Deficit/Hyperactivity Disorder. *JAMA Netw Open*. 2019;2(7):e197850.

[9] Bastiampillai T, Parry P, Allison S. Can antipsychotic medication administered for paediatric emotional and behavioural disorders lead to brain atrophy? Australian & New Zealand Journal of Psychiatry 2019, Vol. 53(6) 499–500

[10] https://www.education.govt.nz/school/student-support/special-education/ors/criteria-for-ors/

[11] https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports/report-18-national-wastewater-drug-monitoring-program

[12] Although only a small increase in pregnancy risk has been demonstrated, increased ADHD diagnosis in young women also increases the risk of harm to unborn infants (Cohen JM e al. Placental Complications Associated with Psychostimulant Use in Pregnancy. Obstet Gynecol. 2017;130(6):1192-1201).

lessen mental pain potentially creates a reduced state in which children are not fully themselves and are less able to get on with the task of growing up. We need to help them to be *good at feelings*, of being able to make sense of uncomfortable but healthy emotions, rather than *feeling good*, which is shallow and evaporates in the face of adversity.[13]

Taking a different approach to ADHD has important training implications – anyone responding to children's behaviour problems need to be rigorously attentive to whatever social risks faced by the child and family and the primary task must be to make meaning of the behaviour that has raised concerns rather than focusing on whether it meets diagnostic criteria.

*Recommendation*: Training programmes that encourage a reflective approach to children's challenges, mindful of social determinants of mental health, should be sought and developed for health professionals, educators and other members of the community.

### The viability of recommendations from the Australian ADHD Professionals Association's [AADPA] Australian evidence-based clinical practice guideline for ADHD [Guidelines]

Although these Guidelines have been approved by NHMRC, they have serious shortcomings. First, there is a misleading implication that each of the 113 clinical recommendations is evidence based. In fact all but 12 are designated 'Clinical Consensus Recommendations' because 'there was insufficient evidence to inform' an evidence-based recommendation or were 'based on expert opinion and clinical experience' of the Guideline Development Group.

Second, the quality of evidence supporting those 12 evidence-based recommendations was mostly low and, according to the Guideline authors' own guideline development process, did not justify the rating of 'strong' attached to nine of the recommendations.

Table: Evidence-Based Recommendations in ADHD Guideline

| | Recommendation | Strength | Certainty |
|---|---|---|---|
| 1.1.1 | Clinicians should be aware that the following groups of children, adolescents, and adults, have an increased prevalence of ADHD, compared with the general population … | **** (strong) | Low to High |
| 4.2.1 | Parent/family training should be offered to parents/families of young children with ADHD. | **** (strong) | Low to Moderate |
| 4.2.2 | Parent/family training should be offered to parents/families of children with ADHD. | *** 'conditional' | Low |
| 4.2.3 | More intensive parent/family training programs should be offered to parents/families of children with ADHD who have co-occurring oppositional defiant disorder or conduct disorder. | **** (strong) | Moderate |
| 4.2.8 | Cognitive-behavioural interventions could be offered to children with ADHD. | *** 'conditional' | Low |
| 4.2.9 | Cognitive-behavioural interventions should be offered to adolescents with ADHD. | *** 'conditional' | Low |
| 4.2.11 | Cognitive-behavioural interventions should be offered to adults with ADHD. | **** (strong) | Low |
| 5.3.1 | Methylphenidate or dexamfetamine or lisdexamfetamine should be offered as the first-line pharmacological treatment for people with ADHD, where ADHD symptoms are causing significant impairment. | **** (strong) | Low |
| 5.3.4 | Atomoxetine or guanfacine or clonidine should be offered to children and adolescents if any of the following apply: … Due consideration of risks and safety is required, especially if medications are used in combination. | **** (strong) | Low |
| 5.4.1 | Methylphenidate or dexamfetamine or lisdexamfetamine should be offered as the first-line pharmacological treatment for people with ADHD, where ADHD symptoms are causing significant impairment. | **** (strong) | Low |

[13] Jureidini J. Let children cry. *Med J Aust* 2014; 201 (10)

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|---|---|---|---|
| 5.4.4 | Atomoxetine or guanfacine should be offered to adults with ADHD if any of the following apply: … Due consideration of risks and safety is required, especially if medications are used in combination. | **** (strong) | Very Low |
| 5.5.1 | The following could be offered to adults with ADHD, in no particular order: • bupropion • clonidine • modafinil • reboxetine • venlafaxine. Careful monitoring of adverse side effects is required. | **** (strong) | Very Low |

Third, important and robust evidence is ignored, including: relative-age effect, whereby younger children in a classroom are more likely to be diagnosed with, and medicated for, ADHD than their older classmates[14]; serious adverse effects, such as the increased risk of suicidality associated with atomoxetine; and the lack of long-term and substantial benefits from treatment.

Fourth, there are significant conflicts of interest. The Guideline primarily reflects the collective opinions and biases of the AADPA, a guild group invested in the ADHD concept and its treatment. AADPA and its executive have significant engagement with the pharmaceutical industry and should not have been regarded as independent or suitable to develop guidelines, a task that should have been entrusted to an independent body.

A more detailed critique of the Guideline has been prepared for submission to an academic journal and can be made available to the Inquiry.

*Recommendation*: The Inquiry should take a critical stance towards these Guidelines.
The Inquiry should call on the NHMRC to withdraw approval of the Guideline.

I would be grateful for the opportunity to take oral evidence to the Inquiry Committee on behalf of CPNA.

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[14] This is no accidental omission: relative age was deliberately excluded from the literature search, without any stated justification. For a review of the birthdate effect, see: Whitely M et al. Attention deficit hyperactivity disorder late birthdate effect common in both high and low prescribing international jurisdictions: systematic review, *J Child Psychol Psychiatry*, 2019, 60(4), 380-391.