D-FADS

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Senate Select Committee on Mental Health
Department of the Senate
Parliament House Canberra
ACT 2600

Dear Committee Members

Re: Attention Deficit/Hyperactivity Disorder (ADHD)

Thank you for the opportunity to present to the committee regarding ADHD on 1 September 2005. I would like to provide supplementary information on two issues on behalf of D-FADS and some additional information requested during the hearing.

Issue 1: P.B.S. listing of Dexamphetamine and Ritalin

During the hearing Senators Humphries and Scullion asked a number of questions on the continued use and PBS subsidisation of Dexamphetamine and Ritalin for ADHD. On reflection I believe my answers were inadequate and I would like to provide additional information.

As outlined at the hearing both Dexamphetamine and Ritalin have severe side effects. Drugs with dangerous side effects should only ever be used as a last resort to treat/manage conditions of sufficient severity to warrant risking these adverse consequences.

The diagnostic criteria for ADHD set by the American Psychiatric Association in DSM-IV are basically “normal behaviours” which on their own do not warrant treatment with potentially dangerous drugs.

Risking symptoms such as depression, severe headaches, insomnia, nausea, hallucinations and worse, to control a tendency to interrupt, fidget, be forgetful or disorganised, is not justifiable. It is a violation of the primary rule of medicine “first do no harm” and particularly when done without informed consent is a violation of the rights of a patient.

A diagnosis of ADHD should therefore not be sufficient to justify the prescription and subsidisation of either Dexamphetamine or Ritalin via the Pharmaceutical Benefit Scheme.

The 18 diagnostic criteria for Hyperkinetic Disorder outlined in ICD-10 are virtually identical to those for ADHD in DSM-IV. There are, however, two important distinctions. Firstly, for a diagnosis of Hyperkinetic Disorder an individual is required to display at least 6 of 9 of the inattentive **and** 3 of 5 of the hyperactive **and** 1 of 4of the impulsive behaviours. Secondly, Hyperkinetic Disorder is not diagnosed if another condition that may explain inattentive, hyperactive and impulsive is diagnosed.

The standard for diagnosing ADHD (as outlined in DSM-IV) is considerably lower. An individual need only display 6 of 9 inattentive **or** 6 of 9 impulsive behaviours and the diagnosis of many other (so called co-morbid) condition/s which could explain inattentive or impulsive/hyperactive behaviours does not preclude an ADHD diagnosis.

ICD-10 is the criteria published by the World Health Organisation and used in Europe. DSM-IV is the criteria used in North America and regrettably, in Australia.

Prescription rates in countries using ICD-10 are considerably lower than those using DSM-IV. The rate of psycho-stimulant use per head in the U.S. and Western Australia (using DSM-IV) are approximately ten times the U.K. rate (predominantly using ICD-10)[1].

Whilst many of the problems of subjectivity of assessment of behaviours are common to both DSM-IV and ICD-10, in practice fewer 'normal' children, or children with other problems, are diagnosed using the more rigorous ICD-10 criteria.

Recommendation 1: Dexamphetamine and Ritalin should be subsidised via the PBS for a diagnosis of Hyperkinetic Disorder as set out in ICD-10. A diagnosis of ADHD using DSM-IV should be insufficient to warrant PBS subsidisation of either drug.

Issue 2: The Diagnosis of Mental Health Disorders by Paediatricians

The diagnosis of mental health disorders in children should be at least as thorough for children as it is for adults as children have neither the authority nor capacity to make informed judgements about their treatment.

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[1] WA 36th Parliament Education and Health Standing Committee Report No. 8 "ADHD in WA" Report p.24, Finding 1 - ***"The use of different diagnostic tools may explain the variation in ADHD prevalence rates between Australia (DSM-IV) and the United Kingdom (ICD-10"*** and page 19 finding 2 *"Broadening the diagnostic criteria in the DSM-IV (from DSM-III) to include 2 subtypes, ADHD Hyperactive-Impulsive Type and ADHD Inattentive Type, is likely to have contributed to the growth in diagnosis of ADHD in Australia."*

Psychiatrists exclusively diagnose adult mental health disorders. Children, however, are frequently diagnosed with mental health disorders, including ADHD, by paediatricians who are not as well trained as psychiatrists in diagnosing and treating mental health disorders[2].

In order to give children at least as much protection from insufficiently trained diagnosticians and prescribers only child psychiatrists should be able to diagnose and prescribe medications for the treatment of childhood mental health disorders.

Recommendation 2: Only prescriptions written by a child psychiatrist for the treatment of mental health disorders in children should be subsidised via the Pharmaceutical Benefits Scheme.

Adult ADHD

At the hearing Senator Troeth requested more information on Adult ADHD.

Despite ADHD diagnostic criteria being defined in terms most applicable to children in a classroom setting, in recent years considerable energy has been put into marketing "Adult ADHD".

An ADHD DSM-IV diagnosis normally requires that *"Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years."* However, the broadening of ADHD diagnostic criteria (from DSMII to DSMIV) to recognise the undefined category *"Attention Deficit Hyperactivity Disorder - Not Otherwise Specified"* enables virtually anybody to be diagnosed despite them not meeting the normal criteria.

Whilst some adults seek a diagnosis of ADHD in order to obtain government sponsored recreational drugs (for personal abuse or sale) many are genuinely seeking help. They have a right to informed consent about how mental health conditions are diagnosed and treated (including potential dangers of medications).

Very often both adult patients and parents of children are told things like "ADHD is a neurobiological disorder (i.e.; caused by a biochemical brain imbalance) best treated with safe, effective (psycho-stimulant) medication." This denies the opportunity to both adult patients and parents of children for informed consent.

[2]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."*

Michelle Toner's verbal evidence (on behalf of LADS) that:

1- *"ADHD is a neurobiological disorder and there are grave consequences if it is left untreated"*

2- *"…the most effective treatment for ADHD is a multimodal approach involving both pharmacological and non- pharmacological interventions"*.

3- *"It (stimulant medication) is regarded as a safe medication by clinicians"*

is typical of the hyped rhetoric that (however well meaning) misinforms and denies patients (and parents for children) the capacity to informed consent.

In the absence of scientific proof the ADHD industry relies on "International Consensus Statements", where "ADHD experts" (read enthusiasts) agree a consensus position and offer this as evidence of their claims[3].

The facts (derived primarily from DSM-IV and the drug manufacturers published information) are:

1- The diagnosis of ADHD relies exclusively on reports of inattentive and/or hyperactive/impulsive behaviour.

2- Stimulants when taken orally in low doses stimulate attention in the vast majority of people regardless of their ADHD status.

3- Dexamphetamine and Methylphenidate (Ritalin) have a range of severe potential adverse short and long term and side effects that frequently require balancing medications.

4- Psycho-stimulants are potentially addictive and are frequently abused.

This factual information must be provided to all potential adult patients and the parents of children undergoing diagnosis and treatment, otherwise they have been denied their right to informed consent.

Canadian Withdrawal from sale of Adderall

During the hearing I made reference to the removal from sale of ADHD drug Adderall (a brand of dexamphetamine) from the market by Health Canada as a result of 20 deaths from cardiovascular events. I gave an undertaking to provide additional information.

[3] For an opposing international consensus statement to the one presented by LADS at the hearing see http://www.giulemanidaibambini.org/consensus/consensus_en.html

Health Canada's 9 February 2005 statement on the suspension from sale of Adderall read *"Health Canada's decision comes as a result of a thorough review of safety information provided by the manufacturer, which indicated there were 20 international reports of sudden death in patients taking either ADDERALL® (sold in the United States, not in Canada) or ADDERALL XR® (sold in Canada). These deaths were not associated with overdose, misuse or abuse. Fourteen deaths occurred in children, and six deaths in adults. There were 12 reports of stroke, two of which occurred in children."*[4]

I thank you for the opportunity to present this supplementary information and trust that in your deliberations you will value the rights of vulnerable children (like Brandon Frances) above all else.

Yours sincerely

Martin Whitely
Chairperson DFADS

13 September 2005

P.S. Please find attached the diagnostic criteria for both ADHD (from DSM-IV) and Hyperkinetic Disorder (from ICD-10)

[4] Details are available from the Canadian Health Department website http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/2005/2005_01_e.html

DIAGNOSTIC CRITERIA FOR ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

(from DSM-IV, American Psychiatric Association, 2000, pp.92-93.)

A. Either (1) or (2):

(1) six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

a) often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities

b) often has difficulty sustaining attention in tasks or play activities

c) often does not seem to listen when spoken to directly

d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)

e) often has difficulty organizing tasks and activities

f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

g) often loses things necessary for tasks or activities (eg. toys, school assignments, pencils, books, or tools)

h) is often easily distracted by extraneous stimuli

i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

a) often fidgets with hands or feet or squirms in seat

b) often leaves seat in classroom or in other situations in which remaining seated is expected

c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

d) often has difficulty playing or engaging in leisure activities quietly

e) is often “on the go” or often acts as if “driven by a motor”

f) often talks excessively

Impulsivity

a) often blurts out answers before questions have been completed

b) often has difficulty awaiting turn

c) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a personality Disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type:
if both criteria A1 and A2 are met for the past 6 months

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly
Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly
Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

314.9
ATTENTION-DEFICIT HYPERACTIVITY DISORDER NOT OTHERWISE SPECIFIED
This category is for disorder with prominent symptoms of inattention or hyperactivity-impulsivity that do not meet the criteria for Attention-Deficit/Hyperactivity Disorder.

Examples include:

1. Individuals whose symptoms and impairment meet the criteria for Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type but whose age at onset is 7 years or after

2. Individuals with clinically significant impairment who present with inattention whose symptom pattern does not meet the full criteria for the disorder but have a behavioural pattern marked by sluggishness, daydreaming, and hypoactivity.

DIAGNOSTIC CRITERIA FOR HYPERKINETIC DISORDERS

(from ICD-10, World Health Organisation, Geneva, 1993)

The research diagnosis of hyperkinetic disorder requires the definite presence of abnormal levels of inattention, hyperactivity and impulsivity that are pervasive across situations and persistent over time, and which are not caused by other disorders such as autism or affective disorders.

G1 Inattention

At least six of the following symptoms of inattention have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

1) often fails to give close attention to details, or makes careless errors in school work, work or other activities;

2) often fails to sustain attention in tasks or play activities;

3) often appears not to listen to what is being said to him or her;

4) often fails to follow through on instructions or to finish school work, chores or duties in the workplace (not because of oppositional behaviour or failure to understand instructions);

5) is often impaired in organising tasks and activities;

6) often avoids or strongly dislikes tasks, such as homework that require sustained mental effort;

7) often loses things necessary for certain tasks or activities, such as school assignments, pencils, books, toys or tools;

8) is often easily distracted by external stimuli;

9) is often forgetful in the course of daily activities.

G2 Hyperactivity

At least three of the following symptoms of hyperactivity have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

1) often fidgets with hands or feet or squirms on seat;

2) leaves seat in classroom or in other situations in which remaining seated is expected.

3) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, only feelings of restlessness may be present);

4) is often unduly noisy in playing, or has difficulty in engaging quietly in leisure activities;

5) exhibits a persistent pattern of excessive motor activity that is not substantially modified by social context or demands;

G3 Impulsivity

At least one of the following symptoms of impulsivity has persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

1) often blurts out answers before questions have been completed;

2) often fails to wait in lines or await turns in games or group situations;

3) often interrupts or intrudes on others (eg butts into others' conversations or games);

4) often talks excessively without appropriate response to social constraints;

G4 Onset of the disorder is no later than the age of 7 years;

G5 Pervasiveness The criteria should be met for more than a single situation, eg the combination of inattention and hyperactivity should be present both at home and at school, or at both school and another setting where children are observed, such as a clinic (evidence for cross situationality will ordinarily require information from more than one source; parental reports about classroom behaviour for instance, are unlikely to be sufficient).

G6 The symptoms in G I & G3 cause clinically significant impairment in social, academic or occupational functioning distress or

G7 The disorder does not meet the criteria for pervasive developmental disorders (F84,-) manic episode (F30,-), depressive episode (F32,-) or anxiety disorders (F41,-).