

# The Rise and Fall of Child ADHD Prescribing in Perth Western Australia - Lessons Learned in Isolation

*A Teacher, Politician, Author, Activist and Researcher's reflections on the competition that led to the rise (1989-2002) and fall (2003-2010) in Attention Deficit Hyperactivity Disorder child prescribing rates in Western Australia.*

Preventing Overdiagnosis Conference

Barcelona 22 September 2016

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*“Psychiatry is more like a two-party political system with the biological and environmental parties constantly vying for power. Biological psychiatry is now the party in power.”*

American psychiatrist **Peter R. Breggin M.D.** (1998),  
*Talking back to Ritalin*, Common Courage Press

# Three perspectives on ADHD

## The Enthusiasts

Proponents believe ADHD is a common genetically determined neurobiological disorder, that is, a biochemical brain imbalance, which is under-diagnosed and under-medicated.

## The Critics

**Concerned Critics** - some critics take a centrist view, that ADHD is a rare but real condition, that is overdiagnosed and over prescribed.

**Convinced Critics** - Some critics argue ADHD is a dumbed down label that robs understanding of a child's individual circumstances and that the use of amphetamines and other psychotropic drugs to 'treat' ADHD creates far more ongoing harm than benefit.

## ADHD - Under-Diagnosed, Over-Diagnosed or Unscientific Harmful Label?

Attention Deficit Hyperactivity Disorder (ADHD) is the most commonly diagnosed and medicated childhood psychiatric disorder in the world.[1,2]

There are large variations in international, state and localised ADHD medication prescribing rates.[3]

Both the diagnosis and treatment of ADHD are controversial and the subject of considerable debate within the psychiatric, paediatric and general medical professions, the media, and the public.

**The controversy centres around three issues:**

- 1. The validity of the diagnosis**
- 2. The safety and efficacy of ADHD medications**
- 3. The relationship between ADHD and drug abuse.**

**Western Australia's ADHD history offers insights into all three.**

[1] Inyang Takon (2011), 'Clinical use of a modified release methylphenidate in the treatment of childhood attention deficit hyperactivity disorder', *Annals of General Psychiatry*,10:25. Available at <http://www.annals-general-psychiatry.com/content/10/1/25>; and US National Library of Medicine, 'Attention Deficit Hyperactivity Disorder', *Medline Plus*, 11 April 2011. Available at <http://www.nlm.nih.gov/medlineplus/ency/article/001551.htm> (accessed 13 December 2011).

[2] Sung V, Hiscock H, Sciberras E, Efron D. (2008), 'Sleep problems in children with attention-deficit/hyperactivity disorder: Prevalence and the effect on the child and family', *Archives of Pediatrics and Adolescent Medicine*, 162(4): pp. 336-342.

[3] Philip Hazell (1995), 'Stimulant treatment for attention deficit hyperactivity disorder', *Australian Prescriber: an independent review*, 18:60-3; Available: <http://www.australianprescriber.com/magazine/18/3/60/3/> (accessed 13 December 2011); I McKenzie, C Wurr (2004), 'Diagnosing and treating attentional difficulties: a nationwide survey', *Archives of Disease in Childhood*, Vol 89;10 :pp. 913-916.

## Perth, Western Australia (arguably) the most isolated city in the world

One daily newspaper *The West Australian* and until recently one medical school

Western Australia  
is 3.5 times the  
size of Texas!



Population of Western  
Australia: 2.6 million

Population of Perth: 2.0  
million

Distance to nearest city Adelaide: 2,131 kilometres

Distance to Sydney: 3,294 kilometres



## About Martin Whitely PhD

1959: Born active, inattentive and impulsive

1995-2001: A teacher at a wealthy all boys high school in an area with very high rates of ADHD prescribing

2001-2013: A member of the Western Australian Parliament representing an economically disadvantaged electorate, also with very high rates of ADHD prescribing

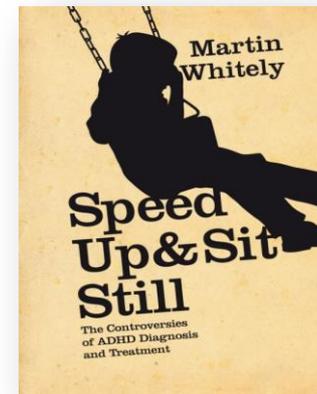
2013- 2016: A mental health advocate and researcher

Author of

***Speed Up & Sit Still, the controversies of ADHD diagnosis and treatment*** (UWA Publishing 2010)  
book chapters, several journal articles a website  
and blog on ADHD: [www.speedupsitstill.com](http://www.speedupsitstill.com)

PhD Thesis

***Attention Deficit Hyperactivity Disorder Policy, Practice and Regulatory Capture in Australia 1992–2012***  
Available at [www.speedupsitstill.com](http://www.speedupsitstill.com)



## Western Australia's ADHD Story – Key Facts

1. Childhood ADHD – Perth Western Australia (WA) is the world's first ADHD prescribing hot spot to see a large and sustained decline in per capita child prescribing rates. (50% between 2002 and 2010).
2. Adult ADHD - WA has consistently had the highest adult prescribing rates in Australia. In 2002 WA adults were prescribed government subsidised ADHD medications at 7.1 times the national rate (excluding WA). By 2011 there had been a closing of the gap but WA's rate was still 3.3 times the national rate.
3. Individual heavy prescribers have contributed to localised (postcode specific) ADHD epidemics. In 2003-2004 a single paediatrician prescribed to 2,077 children in 17 months and in 2014 a single psychiatrist prescribed to 1,812 adults in 12 months.
4. There has been a strong correlation between ADHD prescribing rates and amphetamine and other drug abuse rates for both adults and teenagers in WA.
5. The Raine Study provided a unique long term data source which associates long term ADHD stimulant use with school failure and permanently raised blood pressure (when comparing 'medicated' with 'never medicated' ADHD diagnosed children).
6. Like children in the USA, Canada and Taiwan - WA children also demonstrate a strong "ADHD late birthdate effect".
7. In Australia 'regulatory capture' of ADHD policy by the ADHD Industry is the 'norm'.

# 17 lessons learned in isolation – Campaigning to stop ADHD over-diagnosis

1. **Be persistent**, be a nuisance, be the squeaky wheel that demands oiling.
2. **Beware the superficial appeal of the “reasonable middle ground”**. Very often the truth lies in the middle but sometimes the truth is at the extreme. Some conditions are legitimate but over-diagnosed (e.g. autism) others like ADHD are unhelpful “un-explanatory” labels.
3. **Identify and repeat your core messages**. In the case of ADHD
  - **Make the diagnostic criteria central to any discussion**. i.e. often fidgets, often loses things, often has difficulty playing quietly, often dislikes homework, often forgetful, often easily distracted etc.
  - Point out the near universal focus narrowing effects of low dose oral amphetamines and concede that *“if you want to alter behaviour nothing alters behaviour faster than amphetamines... but in the long term amphetamines are harmful to developing brains and bodies”*.
  - Acknowledge that some children diagnosed with ADHD do have real problems, and point out that *“each child needs to have support that matches their individual circumstances – they don’t need a dumbed down one size fits all label and amphetamines”*. (Don’t fall into the trap of competing to offer an alternative universal answer.)

## 17 Lessons learned in isolation – Campaigning to stop ADHD over-diagnosis

4. **Don't let the “experts” get away with stating hypothesis as fact.** When they claim “*ADHD is a neurobiological disorder,*” point out that they are claiming without evidence that ADHD is a chemical imbalance in the brain even though DSM-5 states “*no biological marker is diagnostic for ADHD*”.

5. **Mock the ADHD Industry's outrageous claims,** such as, “*denying medication to an ADHD child is like denying insulin to a diabetic child*”. Point out that the pancreas produces insulin but drug labs produce amphetamine. Ask to see the evidence that any child is suffering from a deficit of amphetamine. Similarly poke fun at the ADHD Industry's absurd claim that un-medicated ADHD causes drug abuse and that giving “*ADHD children*” medication (amphetamines) stops them growing up to be drug addicts.

6. **Use the ADHD Industry's own words against them.** For example, when they claim ADHD medications are not addictive or that they prevent drug abuse later in life, quote the manufacturers of DEXEDRINE® (a brand of dexamphetamine) Product Information Leaflet:

**WARNING AMPHETAMINES HAVE A HIGH POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DRUG DEPENDENCE AND MUST BE AVOIDED. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILITY OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS, AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY. MISUSE OF AMPHETAMINES MAY CAUSE SUDDEN DEATH AND SERIOUS CARDIOVASCULAR ADVERSE EVENTS.**

## 17 Lessons learned in isolation – Campaigning to stop ADHD over-diagnosis

7. **Don't allow the ADHD Industry to choose the language of debate** – amphetamine is a more precise description than stimulant medication. (They are not giving children a cup of coffee.)
8. **Fight the 'So Big it Must be Real' effect that reverses of the onus of proof.** It is for the ADHD industry's task to prove their hypothesis that ADHD is caused by a "*chemical imbalance in the brain*". However, they substitute 'consensus of the like-minded' for scientific evidence and act as if hypothesis is established fact.
9. **Prevalence rates for 'disorders' with subjective diagnostic criteria are meaningless,** but a favourite trick of the ADHD Industry is claiming treatment rates are lower than the prevalence rate and therefore ADHD is underdiagnosed.
10. **Point out the circularity of the ADHD Industry argument that ADHD causes ADHD,** i.e. ADHD (diagnosed by observing inattentive, impulsive behaviour) causes inattentive, impulsive behaviour.
11. **Don't allow the ADHD industry to get away with retrospectively diagnosing ADHD in dysfunctional populations,** such as prisoners and drug addicts, and claiming that ADHD caused the dysfunction.
12. **Stories about individuals are at least as powerful as statistics.** The ADHD Industry understands this and are masterful at promoting industry friendly consumer voices.

## 17 Lessons learned in isolation – Campaigning to stop ADHD over-diagnosis

13. **Follow the money trail that flows to the “experts”.** It is almost always there and often not hard to find.
14. **Fight on every level:** scientific, political, traditional media, social media and popular culture.
15. **Governments and health insurers are potential allies.** They are increasingly concerned about wasteful health expenditure and are potentially great beneficiaries from tackling over-diagnosis.
16. **Accept that it is not a fair fight.** You can't make a living out of being a critic but you can make lots of money out of being a proponent. This is why the “experts” are almost always proponents of ADHD.
17. **Be prepared to be disliked, criticised and ridiculed** by “experts” who claim fidgeting, disliking homework and playing loudly are compelling evidence of a debilitating brain disease best treated with amphetamines.

**Persist**

## DSM-5 **Diagnostic Criteria** for Attention Deficit/Hyperactivity Disorder.

Either six or more (at least 5 for those aged 17+) 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 behavior 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 (e.g., toys, school assignments, pencils, books, or tools)
- h. is often easily **distracted by extraneous stimuli**
- i. is often **forgetful** in daily activities

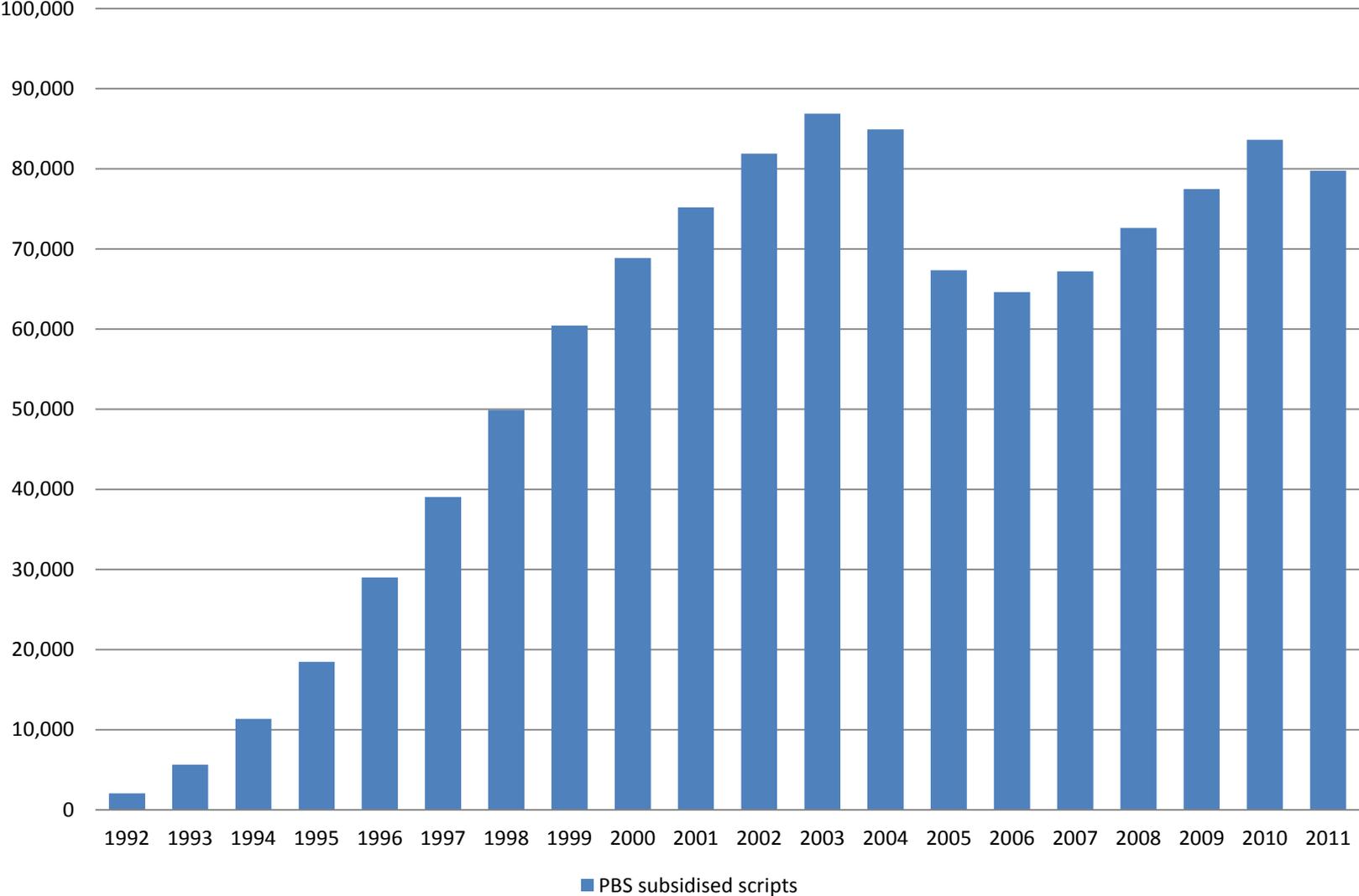
## DSM-5 Diagnostic Criteria for ADHD (continued)

Or six or more (five for those aged 17+) 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/Impulsivity*

- 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**
- g. often **blurts out answers** before questions have been completed
- h. often **has difficulty awaiting turn**
- i. often **interrupts** or intrudes on others (e.g., butts into conversations or games)

# Total WA (all age) government subsidised ADHD prescriptions



## The Rise - WA's ADHD child prescribing from 1989 to 2002

- WA Health Department estimated the total number of (all age) Western Australians prescribed psycho-stimulants for all purposes grew by over twenty-one-fold between 1989 (880 patients) and 2002 (18,715 patients).[1]
- *“From 1994 to 2000, the total licit psychostimulant consumption in the US, Canada and WA did not differ significantly”*. In 2000 the Western Australian all-age per-capita rate was marginally higher than the USA and Canadian national rates and nearly twice that in New South Wales which had the second highest rate of Australian states.[2]
- In 2002 WA's child per-capita prescribing rate of dexamphetamine (at the time the only government subsidised ADHD drug) was approximately 2.8 times the rate of other Australian states.[3]

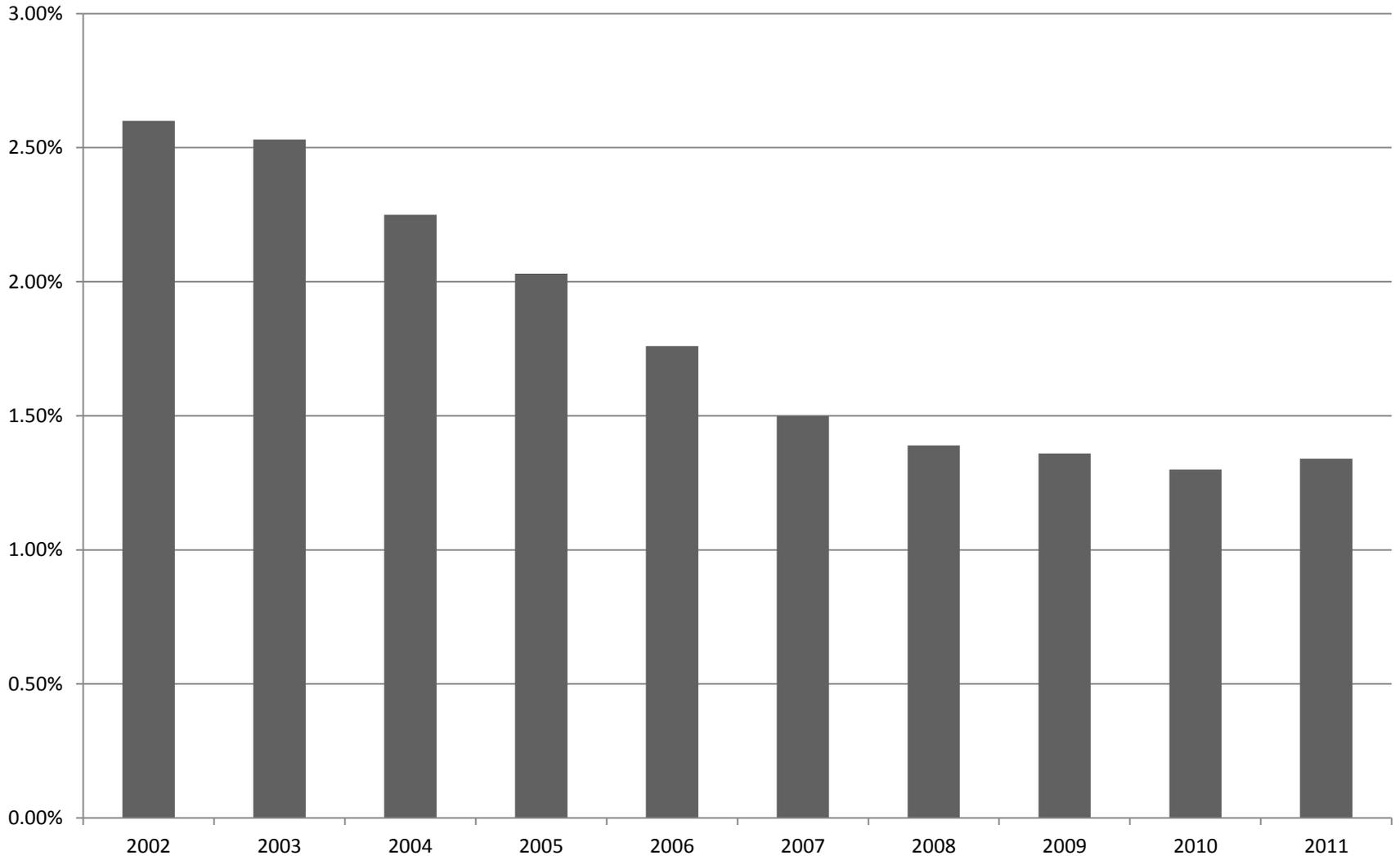
[1] Government of Western Australia (2002), Department of Health, *Attentional Problems in Children: Diagnosis and Management of Attention Deficit Hyperactivity Disorder (ADHD) and Associated Disorders*, Office of Mental Health, Department of Health, Perth, p.21.

[2] Constantine G Berbatis, V Bruce Sunderland and Max Bulsara, *Licit psychostimulant consumption in Australia, 1984–2000: international and jurisdictional comparison*, Medical Journal of Australia Vol 177 18 November 2002 [https://www.mja.com.au/system/files/issues/177\\_10\\_181102/ber10505\\_fm.pdf](https://www.mja.com.au/system/files/issues/177_10_181102/ber10505_fm.pdf)

[3] Department of Health and Ageing, *Letter to Martin Whitely dated 21 April 2012*.

# The Fall

2002- 2011 Percentage of WA children 4-17 prescribed ADHD drugs



## The fall in **child** prescribing rates - What changed in WA?

1. ADHD policy and regulation had been dominated by ADHD industry insiders. However, beginning with my election to the WA State Parliament in 2001, **ADHD sceptics became prominent in determining policy.**
2. In 2003-2004 there was a **Parliamentary Inquiry** into ADHD.
3. **Media coverage gradually moved from disease awareness and treatment promotion to a contested debate** about the validity of the diagnosis, the safety and efficacy of “amphetamine like drugs” and stories about their diversion and abuse.

# The Rise - ADHD Policy and Regulation

## 1994 - 2002 (Proponent Dominated)

As a result of some early concerns about the growth in ADHD prescribing a Stimulants Committee was formed to ensure appropriate prescribing practices. BUT a club of ADHD experts (all heavy prescribers) dominated the committee membership.

- The committee decided to grant “Block Authorisation” to paediatricians and psychiatrists considered “familiar” with ADHD and the medications (i.e. themselves and their close colleagues) so that the heaviest prescribers become the least accountable.
- Only prescribing outside guidelines (extremely high doses) was reported to the Committee, which took no action except to propose that “Block Authorisation” be extended to “off label” use.
- There was no external reporting of patient or prescriber numbers. (Concerns about over-diagnosis were dismissed as anecdotal).
- Prescribing rates soared.

# The Fall - ADHD Policy and Regulation

**2003- 2008 (Critic Dominated)**

In late 2002, following lobbying by me, the Western Australian Minister for Health (a former senior policeman who had seen the problem of dexamphetamine diversion) announced the following changes which came into effect in August 2003:

- The Stimulants Committee was replaced by a Stimulants Panel comprised of different personnel (most of the heavy prescribers were removed).
- Block Authorisation was abolished in August 2003.
- Public (de-identified) reporting of patient numbers, prescriber numbers and dosages commenced. (One paediatrician who had been a member of the Stimulants Committee prescribed stimulants to 2,077 children in 17 months. His early 'encouraged' retirement from prescribing followed.)
- Between 2002 and 2010 the child per-capita prescribing rates fell 50% (from 2.6% to 1.3%). Most change occurred between 2002 and 2008, when rates fell 47%.

# What Changed – A Parliamentary Inquiry into ADHD

- A Parliamentary Inquiry was established in 2003 and reported in 2004. I was co-opted to the cross-party committee.
- The starting point for most committee members (4 of 6) was that “ADHD is so Big it must be Real”. These members argued the emphasis of the Inquiry should be on how best to treat it.
- I and another member (also a former teacher sceptical about ADHD) persuaded the other members to start with the fundamental question “What is ADHD?”
- The final unanimous report was critical of frequent misdiagnosis and over-prescription and raised concerns about the misuse of dexamphetamine. The report attracted considerable media interest and helped to turn the debate.

The Rise - Media coverage included lots of disease mongering like this...

### **‘Quiet Children Slip ADHD Net’**

Dawn Gibson, *The West Australian*, 16 April 2003.

Children with attention deficit disorders who are not naughty and disruptive are falling through the medical net, resulting in learning difficulties and social problems, according to a WA expert. Curtin University psychology professor, David Hay, who specialises in attention deficit hyperactivity disorder, said children with a form of the disorder that makes them dreamy and inattentive were often not diagnosed until their teens if at all. Girls were most likely to slip through the net. The form of ADHD most widely known – when children are noisy and difficult – was more common in boys but both boys and girls were equally likely to have ‘quiet’ ADHD.

‘ADHD is meant to be diagnosed by the age of seven but with a lot of girls, it only comes to the fore when they get to high school,’ Professor Hay said. ‘It becomes obvious in high school because they are no longer in just one class, they have to move classes all the time and be organised, so all the organisational problems with ADHD suddenly come to the fore. **When we did surveys in schools, about 4 per cent to 5 per cent of kids have this inattentive type (of ADHD) but because they are quiet kids no one really picks it.....**

# The Fall – Media coverage changed to a more critical approach...

## **Doubt over ADHD drugs**

CATHY O'LEARY MEDICAL EDITOR - The West Australian on February 17, 2010.

The use of stimulant medication to treat children with attention deficit hyperactivity disorder faces new scrutiny in the wake of a world-first study by Perth researchers linking it to poor school performance and raised blood pressure.

The study, which tracked 131 children from the age of five to 14, found those taking drugs such as Ritalin and dexamphetamine had significantly higher diastolic blood pressure - the pressure between heartbeats - than children with ADHD who were not medicated.

They were also 10 times more likely to be rated by their teachers as performing below average compared with non-medicated children...

Overall, medication did not necessarily improve children's social and emotional wellbeing or academic performance.

Significantly, children on medication had diastolic blood pressure readings higher than those never medicated...

Researcher Lou Landau said the findings suggested a child's heart function could be affected by long-term stimulant use and might remain affected even after stopping medication.

"While these differences were small, the results suggest that doctors should look at a child's cardiovascular risk symptoms before starting treatment with stimulant medication," he said.

Medication critic and Labor MP Martin Whitely said the findings debunked the claim that medication improved school performance but of greater concern was its link with raised blood pressure...

# The Raine Study - Unique WA long term data

The Western Australian Pregnancy Birth Cohort (Raine) Study is a large scale longitudinal health and wellbeing study.

- It began in 1989 as a cohort of 2,868 pregnant Perth women.
- The children in the Raine Study were part of Western Australia's ADHD generation. (They were 13 years old in 2002 when child prescribing rates were at their peak).
- Data on child health, development and wellbeing have been collected from the participants (both the mother and her child) pre and post birth and when the child turned 1, 2, 3, 5, 8, 10, 14, 17, 20, 23 and 26.

# The Raine Study ADHD Cohort

By age 14 of the 1785 adolescents remaining in the sample, 131 (7.3%) had received a diagnosis of ADHD. Of the 131:

- 61 were taking ADHD stimulants.
- 41 had previously used stimulants but were not currently using them.
- 29 had never used stimulant medication.

For full details see

[https://www.health.wa.gov.au/publications/documents/MICADHD\\_Raine\\_ADHD\\_Study\\_report\\_022010.pdf](https://www.health.wa.gov.au/publications/documents/MICADHD_Raine_ADHD_Study_report_022010.pdf)

## Significant findings: Long-term cardiovascular Effects

“The most noteworthy finding in the study was the association between stimulant medication and diastolic blood pressure. Compared to not receiving medication, the consistent use of stimulant medication was associated with a significantly higher diastolic blood pressure (of over 10mmHg)...

When comparing groups who were currently receiving medication, it was found that those who had consistently received medication at all time points had a significantly higher mean diastolic blood pressure than those who had not consistently received medication in the past (difference of 7mmHg).

In addition **children who ceased using stimulant medication had a higher diastolic blood pressure than those never medicated.** These findings indicate there may be a lasting longer term effect of stimulant medication on diastolic blood pressure above and beyond the immediate short-term side effects.”

For full details see

[https://www.health.wa.gov.au/publications/documents/MICADHD\\_Raine\\_ADHD\\_Study\\_report\\_022010.pdf](https://www.health.wa.gov.au/publications/documents/MICADHD_Raine_ADHD_Study_report_022010.pdf)

## Significant finding: school failure

In children (diagnosed) with ADHD, ever receiving stimulant medication was found to increase the odds of being identified as performing below age-level by a classroom teacher, by a factor of 10.5 times.

For full details see

[https://www.health.wa.gov.au/publications/documents/MICADHD\\_Raine\\_ADHD\\_Study\\_report\\_022010.pdf](https://www.health.wa.gov.au/publications/documents/MICADHD_Raine_ADHD_Study_report_022010.pdf)

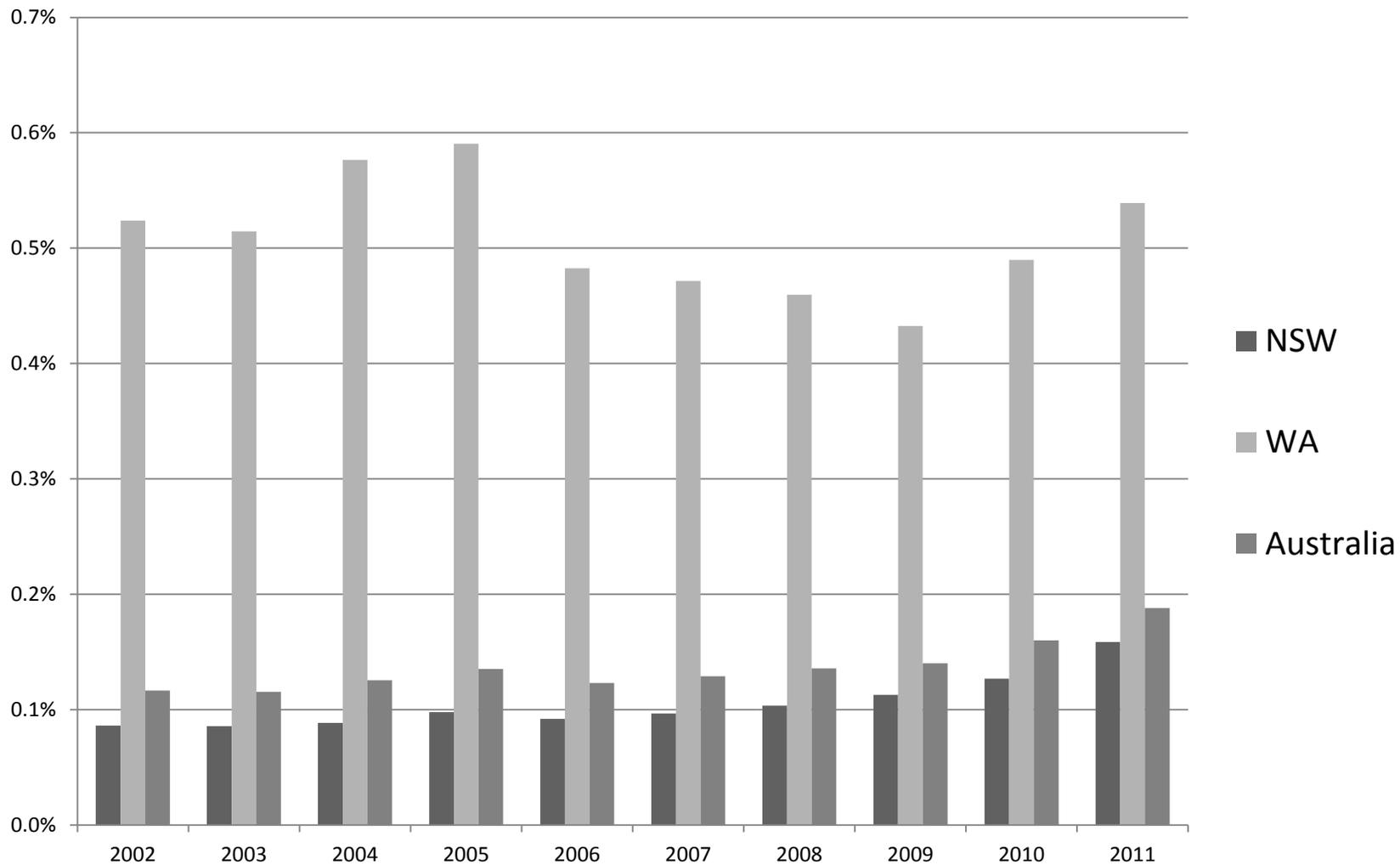
## Were the children with 'severe ADHD' more likely to be medicated?

- The comparison of the groups at age 5 (before any child was 'medicated') showed no statistically significant differences in symptom severity or health measures.
- The statistically significant differences that existed at age 14 occurred between age 5 and 14, after some of the children were medicated.
- To the extent that (non statistically significant differences) existed at age 5, these were controlled for by using the 'propensity for medication' score, the symptom severity before commencement of medication treatment, and a number of socio-demographic measures.

For full details see

[https://www.health.wa.gov.au/publications/documents/MICADHD\\_Raine\\_ADHD\\_Study\\_report\\_022010.pdf](https://www.health.wa.gov.au/publications/documents/MICADHD_Raine_ADHD_Study_report_022010.pdf)

# PBS Adult (18+) per capita prescribing rate



# The relationship between ADHD prescribing and drug misuse.

## The Controversy

**Proponents contend** that the 'under-recognition' of ADHD is a cause of illicit drug abuse. They argue that early identification of ADHD and subsequent **medication prevents undiagnosed individuals using illicit drugs to self-medicate.**<sup>[1]</sup>

**Critics counter** that the **amphetamine and amphetamine-like drugs most commonly used to treat ADHD are often diverted for illicit use or abused.** Critics also contend that the effects of ADHD stimulants are similar to illicit amphetamines.

[1] Dave Coghill (2005), 'Attention-deficit hyperactivity disorder: should we believe the mass media or peer-reviewed literature?', *The Psychiatrist*, 29, pp.288–91

## Western Australia

### A chance to test the ADHD proponents drug abuse hypothesis

All other things being equal, **if ADHD proponents are correct**, the prescription of ADHD medications to 'patients' diagnosed with ADHD should prevent drug abuse.

Therefore **jurisdictions with high per-capita prescribing rates should have decreased rates of drug abuse including abuse rates of amphetamine.**

Western Australia offers a chance to test the hypothesis because, compared to other Australian states, WA has been an outlier for both child and adult ADHD prescribing rates (with different trends since 2002).

## **Western Australia – ADHD and drug misuse the short story**

**Adults** – From the 1990s until now WA has had the highest per-capita adult prescribing rates in Australia (between 3 and 7 times the national average) and the highest rates of amphetamine abuse and the highest rates of illicit drug use of all Australian states.

**Children** – Between 2002 and 2008 Western Australia's child prescribing per-capita rate fell by about a half (47%) and self-reporting of amphetamine abuse by WA secondary school age children also fell by about half (48%).

## WA adult amphetamine and misuse rates

- 2004 WA 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 %. [1]
- 2005/6 the Australian average was 11% of all treatment episodes for which amphetamines was identified as the principal drug of concern, while WA reported the highest rate of 24.6 %. [2]
- The 2013 National Drug Strategy household survey found that, among Australian's older than 14 'Meth/Amphetamine use was higher in WA (3.8%) than any other jurisdiction (national average 2.1%)'. [3]

[1] Australian Institute of Health and Welfare (2005), *2004 National Drug Strategy Household Survey: State and territory supplement*, AIHW cat. No. PHE 61, Canberra, AIHW, p.7.

[2] Australian Institute of Health and Welfare (2007), *Alcohol and other drug treatment services in Australia, 2005-06*, p.14.

[3] Australian Institute of Health and Welfare (2014), *National Drug Strategy Household Survey detailed report: 2013. Drug statistics*, series no. 28. Cat. no. PHE 183. Canberra: AIHW : pp.11-12

## WA adult all illicit drug abuse rates

- The 2001, 2004, 2007, 2010 and 2013 National Drug Strategy Household Survey all found WA had higher rates of 'illicit use of [all] drugs' than all Australian states.
- The 2013 National Drug Strategy Household Survey also stated "*Western Australians were more likely to misuse pharmaceuticals (5.6%) than any other state or territory*".

Australian Institute of Health and Welfare (2014), *National Drug Strategy*, pp.79-80

<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549848>

## Teenage (12-17) amphetamine misuse in Western Australia 2002-2008

The 2008 Australian Secondary School Alcohol and Drug Survey (ASSAD) indicated that:

- In 2002 10.1% of Western Australian 12-17 year olds self reported having abused amphetamines in the last 12 months.
- In the 2005 ASSAD this figure had fallen to 6.5%.
- In the 2008 ASSAD this figure had fallen further to 5.3%. [1]

In **between 2002 and 2008:**

- **There was a 48% decline in teenage (last 12 months) self-reported amphetamine abuse rates.**
- **The proportion of WA children prescribed ADHD medications fell from 2.6% to 1.39% - a drop of 47%.**

Note: Prescribing rates continued to fall until 2010 bottoming out at 1.3% before rising marginally to 1.34 percent in 2011. Comparisons with the 2011 ASSAD report data are slightly problematic as the definition of amphetamine-type stimulants used was expanded to include ecstasy. Nonetheless the reported WA rate of abuse (in the last 12 months) of amphetamine-type stimulants by WA Secondary Schools children fell to 3.4% 2011. [4]

[1] Drug and Alcohol Office WA, *ASSAD Drug Survey: illicit Drug Report 2008 WA results Surveillance Report No 3 p.43*  
<http://www.dao.health.wa.gov.au/portals/0/DAO/Info%20and%20resources/Research%20and%20statistics/Statistics/ASSAD/2008%20ASSAD%20illicit%20drugs%20report.pdf>

[2] Miller, J, Bridle, R & Christou, A (2012). Illicit Drug Use in Western Australia: Australian School Students Alcohol and Drug Survey 2011. Brief communication no.9. Drug and Alcohol Office, Perth.  
<http://www.dao.health.wa.gov.au/vsu/resources/www.dao.health.wa.gov.au/2011%20ASSAD%20illicit%20drug%20bulletin.pdf>

## A snapshot - Teenage prescription amphetamine abuse in Western Australia 2005

Throughout the 1990s and early 2000's there had been considerable media reporting of the diversion of ADHD amphetamines amongst teenagers and young adults. When data on teenage abuse rates first became available through the 2005 Australian Secondary Students' Alcohol and Drug Survey (ASSAD) it showed that:

- It estimated 9,492 (being 5.5% of) WA secondary school students had abused prescription amphetamines in the last 12 months. This represented 84% of the total number of students (6.5% of all 12-17 year-olds) who had self-reported abusing amphetamines in the previous 12 months.
- **27% of 12-17 year-olds who had been prescribed stimulant medication either gave it away or sold it.** Of these, 67% had done so in the last year and 30% percent in the last week.
- **45% of WA high school students who had ever taken dexamphetamine or methylphenidate were not prescribed the drugs by a doctor.**

Note: Unfortunately similar data has not been published for the 2008 or 2011 ASSAD surveys or for other states.

Drug and Alcohol Office WA, *ASSAD Drug Report 2005*, pp 30–32.

<http://www.dao.health.wa.gov.au/portals/0/DAO/Info%20and%20resources/Research%20and%20statistics/Statistics/ASSAD/2005%20ASSAD%20Illicits%20report.pdf>

## Conclusion: does WA's experience support the ADHD proponents' drug abuse hypothesis?

Children: Tighter prescribing accountability measures introduced in 2003 for ADHD stimulants were followed by reduced child prescribing rates but also by significantly reduced teenage amphetamine abuse rates.

Adults: WA has consistently had the highest rates of adult ADHD prescribing and the highest national rate of amphetamine and other illicit drug misuse of all Australian states.

Far from supporting the ADHD proponent hypothesis that medicating for ADHD prevents illicit amphetamine misuse by self-medicating untreated ADHD sufferers, **WA's experience supports the assertion that prescribing amphetamines facilitates their abuse and is associated with increased levels of generalised substance misuse.**

# The ADHD Late Birthdate Effect

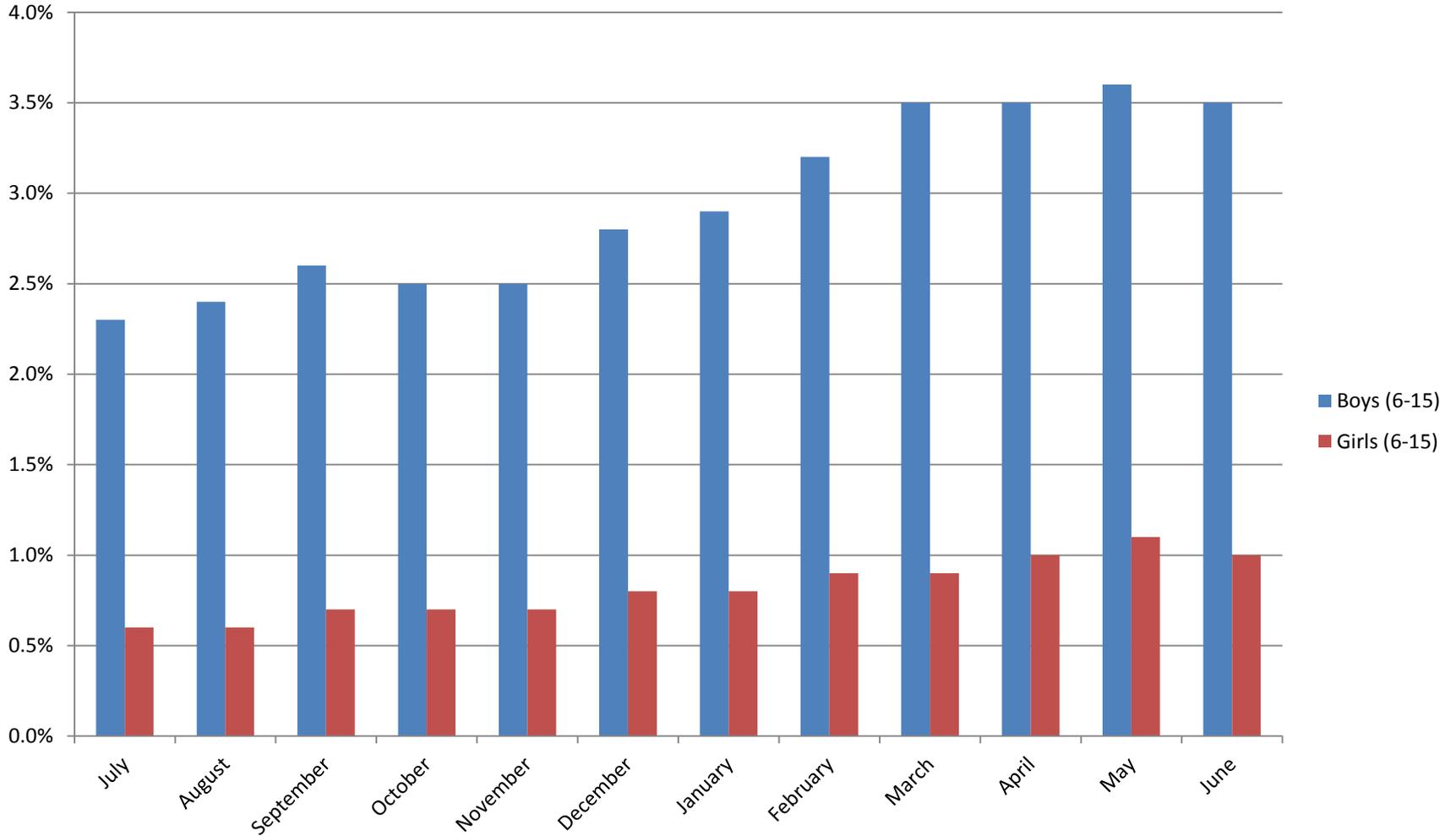
**Four international studies (3 North American and 1 Taiwanese) have found that the youngest children in a class are more likely than their classmates to be medicated for ADHD.**

Allen Frances, who led the American Psychiatric Association's DSM-IV development taskforce, has argued that North American studies demonstrating this effect indicates that developmental immaturity is being mislabelled as a mental disorder and treated with unnecessary stimulant medication. He has also asserted that while he considers ADHD to be a legitimate diagnosis, it is being over-diagnosed and over-medicated and has guessed that a 'diagnostic rate of around 2%... would best balance harms and benefits'

In the Taiwanese study, the rate of prescribing was 1.6%.<sup>4</sup> The measured late birthdate effect in the Taiwanese was of similar strength to that displayed in the three earlier North American studies, where the reported prescribing rates for the periods analysed were much higher (3.6%<sup>3</sup>, 4.5%<sup>1</sup> and 5.8%<sup>2</sup>).

**The Taiwanese study indicates that even at relatively low rates of prescribing there are significant concerns about the validity of ADHD as a diagnosis.**

## Percentage of WA Children (aged 6-15) by month of birth receiving at least one government subsidised ADHD medication prescription in 2013



# WA evidence of the ADHD late birthdate effect

- **For children aged 6-10, those born in June, the last month of any recommended school year intake, were approximately twice as likely (boys +93%, girls +111%) to have received medication than those born in the first month (the previous July).**
- For **children aged 11-15** the effect was less but still significant (**boys +26%, girls +43%**). The combined group (6-15) effect was +52% for boys and +73% for girls.
- Similar trends were demonstrated when comparing children born in the first three (or six) months and the last three (or six) months of the school year intake. These results are consistent with the earlier international studies.
- The rate of ADHD prescribing in the cohort was 1.9%. **Like the Taiwanese study the Western Australian evidence indicates that, even at relatively low rates of prescribing, there are significant concerns about the validity of ADHD as a diagnosis.**

**Western Australia's ADHD history offers insights into all of the three central ADHD controversies:**

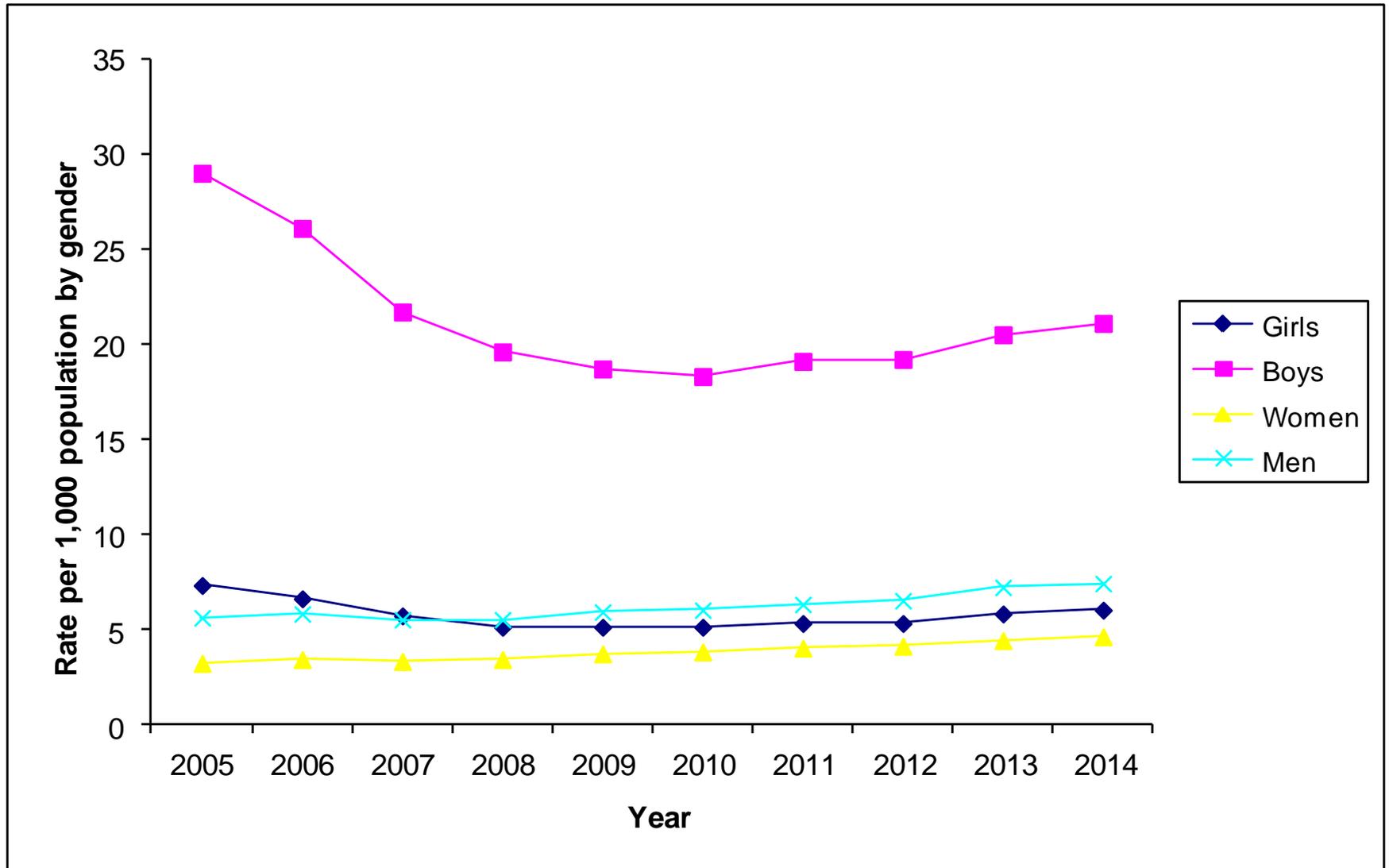
- 1. The validity of the diagnosis** - WA's ADHD late birthdate effect evidence indicates the diagnosis lacks validity.
- 2. The safety and efficacy of ADHD medications** - The Raine Study indicates that in the long term ADHD diagnosed medicated children have significantly worse cardiovascular and education outcomes than ADHD diagnosed un-medicated children.
- 3. The relationship between ADHD and drug abuse** - High ADHD prescribing rates were associated with higher rates of amphetamine and other drug misuse rates.

**Put plainly, Western Australia's experience supports the contention that ADHD is a unscientific harmful label and that in the long term the prescription of medicinal amphetamines is bad for developing brains and bodies and increases the likelihood of illicit drug use.**

# Number of Western Australian ADHD patients taking ADHD stimulant by age and gender (2004-2014)

WA Department of Health *Western Australian Stimulant Regulatory Scheme 2014 Annual Report* Pharmaceutical Services Branch

[https://www.google.ie/?gws\\_rd=cr&ei=tErVV6XSntWugAabl4TACQ#q=western+australia+stimulants+monitoring+annual+report+2014](https://www.google.ie/?gws_rd=cr&ei=tErVV6XSntWugAabl4TACQ#q=western+australia+stimulants+monitoring+annual+report+2014)



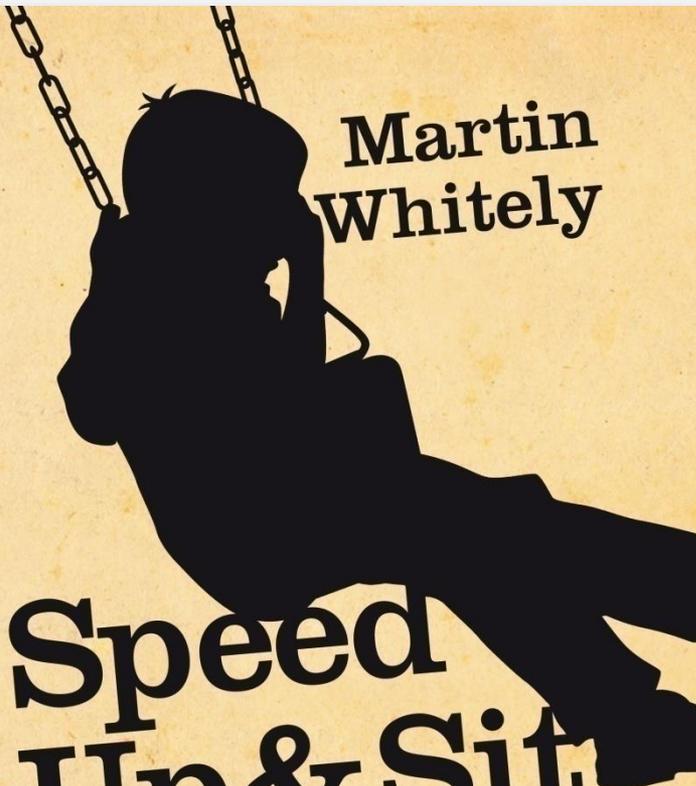
## **Proposed joint statement on ADHD - Will you please consider signing it?**

We the undersigned contend the independent, robust, long term evidence in regards to Attention Deficit Hyperactivity Disorder (ADHD) demonstrates that:

- ADHD is a subjective, unscientific, imprecise label that fuels a cycle of low expectations and achievement.
- The use of addictive amphetamines and other psychotropic drugs to 'treat' ADHD creates far more ongoing harm than benefit.

We acknowledge that some children diagnosed with ADHD have problems and need help but believe that the label hinders the adults responsible for their care - particularly parents, teachers and doctors - from identifying the cause of their individual problems and taking appropriate action.

If you are interested in signing this statement please contact [martinwhitely59@gmail.com](mailto:martinwhitely59@gmail.com)

A black silhouette of a person sitting on a swing, viewed from the side. The swing's chains are visible at the top of the frame. The person is leaning back, and their legs are extended downwards.

**Martin  
Whitely**

**Speed  
Up & Sit  
Still**

The Controversies  
of ADHD Diagnosis  
and Treatment