Submission in Response to the

Mental Health Productivity Commission Draft Report

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Executive Summary

My submission in response to the *Mental Health Productivity Commission Draft Report* addresses four issues.

1. The statement on Page 2 of the *Draft Report* that *"The **cost to the Australian economy** of mental ill-health and suicide is, conservatively, in the order of $43 to $51 billion per year. Additional to this is an approximately $130 billion cost associated with diminished health and reduced life expectancy for those living with mental ill-health."* (Pages 3 – 9)
2. **Suicide and suicide prevention** – particularly among young Australians. (Pages 10 – 18)
3. **Recommendation 24.2** (p.106): *In the short term (in the next 2 years) the Department of Health should cease directing PHNs [Primary Health Networks] to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit. In the medium term (over 2–5 years) there should be no requirements that commissioning agencies (RCAs or PHNs) have to fund particular service providers.* (Pages 19 – 24)
4. **ADHD** – its aetiology, prevalence and the role of teachers the role of schools and teachers. (Pages 25 - 30)

The quality of the analysis and recommendations in the *Draft Report* is highly variable. On the positive side **Recommendation 24.2 (p. 106)** at last offers the opportunity for *headspace* and *headspace Youth Early Psychosis Program* to be subject rigorous scrutiny where continued funding is contingent on performance, rather than political lobbying and influence. The evidence base for both programs is at best weak, and subjecting these programs to open competition is likely to result in funding being directed to programs that will achieve improved outcomes.

On the negative side, the implication that there are potential **economic benefits of up to $181billion per annum** (approximately 10% of Australia's GDP) is not credible. The claim appears to be based on outrageously optimistic assumptions about the capacity of government and mental health interventions to deliver improved outcomes. It ignores the incidence and impact of iatrogenic harm resulting from misdiagnosis, overtreatment, and the questionable diagnostic validity of many of the psychiatric disorders defined in DSM-5.

In addition, the analysis of **suicide prevention** fails to examine the relationship between antidepressant use and youth suicide. This submission details relevant information not included in the *Draft Report*. In 2004 the US FDA issued a black box warning that using antidepressants was associated with a roughly doubled risk of suicidal thinking and behaviour in people aged under 25 diagnosed with depression and other psychiatric disorders. Following the FDA warning there was a large fall (-31% from 2004 to 2008) in PBS antidepressant prescribing rates for young Australians and a marginal fall (-5%) in suicide rates.

However, several prominent Australian organisations and key opinion leaders contested the FDA warning and argued antidepressants decrease the risk of suicide. Since 2009 it appears we have followed their advice and there has been a large increase in both young Australian suicide (+49%) and antidepressant prescribing (+66% estimated) rates. There has also been an alarming increase in self-harm rates among Australian children and adolescents, with many using their own prescription drugs, particularly antidepressants, to self-harm.

This is just one example of how increasing treatment rates have be associated with worsening outcomes. If the *Productivity Commission* is interested I am happy to provide further detail of other

examples that further undermine the assumption that more treatment necessarily results in better outcomes.

There are a number of statements in regards to **Attention Deficit Hyperactivity Disorder (ADHD**) in the *Draft Report* that are also of concern. Page 158 states *"major depressive disorders are less transparent compared to other mental illnesses, such as ADHD or conduct disorders".* I challenge the authors of the Draft Report to reconcile this statement with the ADHD Birthday Lottery (detailed on page 27 of this submission). Please explain if ADHD is so easy to identify, why does the relative age of a child compared to their classmates strongly dictate the probability of that child being diagnosed with, and 'medicated' for, ADHD? It appears that many schools are failing these children by misinterpreting perfectly normal age related immaturity for ADHD, and yet the Draft Report appears (on page 668) to be encouraging an increased role for schools in spotting potential ADHD cases.

The other statement of great concern is on page 157 of the Draft Report - *"ADHD is the most common mental illness for young males with a prevalence rate of 10.4%".* As discussed at page 7 these sorts of estimates are fundamentally flawed, but are frequently used to justify increased the drugging of children, by providing the spurious rationale that the prevalence rate exceeds the diagnosis and treatment rate for ADHD.

The text of this submissions also details why ADHD is not a valid diagnostic label. However, it is important to understand that arguing that ADHD is not a valid diagnostic entity, is different from claiming that all children diagnosed with ADHD are well. Some clearly do have problems and need support that matches their individual circumstances. However, they do not benefit from a dumbed-down, catch-all label, and addictive drugs, that temporarily mask problematic behaviours but are potentially damaging to developing brains and bodies. It is unacceptable that the *Productivity Commission* effectively validates increased child ADHD diagnosis and medication, without examining the validity of the diagnostic label, and the safety and efficacy of the drugs used to treat it.

If the authors of the *Draft Report* require further detail I would be happy to provide it either verbally or in written form.

Issue 1 – Economic Impact

Page 2 of the *Productivity Commission Draft Report* states that *"The cost to the Australian economy of mental ill-health and suicide is, conservatively, in the order of $43 to $51 billion per year. Additional to this is an approximately $130 billion cost associated with diminished health and reduced life expectancy for those living with mental ill-health."*

The clear implication of this claim is that the Australian economy has the potential to benefit by up to $181billion per annum (adding nearly 10% to Australia's GDP) if we address mental health needs. The lack of detailed supporting evidence for the figures in Table 1 on page 9 limits my capacity to bury down into the details of the estimated costs and therefore potential benefits from improved outcomes, however it is obvious that this assertion is based on heroically optimistic (i.e. fanciful) assumptions about the capacity of mental health interventions to deliver positive outcomes.

This claim massively overestimates of the potential for mental health interventions to deliver economic benefits and seriously diminishes the credibility of the *Draft Report*. The analysis and other similar claims are based on two flawed assumptions. The first being that we can accurately identify (without massive false positives) who needs help, and the second that the treatments available fix the problem, without creating iatrogenic harm.

It is surprising that the entire 1,238 page report doesn't not include the word iatrogenic, despite significant concerns that many mental health interventions are known to cause significant harms and therefore cause economic loss. For example, there is compelling evidence that antipsychotic use can cause cardiovascular and metabolic damage and shorten life expectancy.[1] However, there is absolutely no reference to this or any other form of iatrogenic harm and subsequent economic loss anywhere in the report. It is also notable that despite antidepressant medications (primarily SSRI's prescribed by GPs) being by far the most common (in fact dominant) mental health intervention in Australia the word antidepressant appears twice (pages 205 and 1,019) and there is no discussion of their safety and/or efficacy.

Relevant Information overlooked in the *Productivity Commission Draft Report* economic analysis.

This year over 1 in 6 Australians will take at least one mental health-related drug[2], with roughly 1 in 8 taking an antidepressant.[3] There is no doubt that for some Australians, mental illness can be debilitating, and for some psychotropic drugs when use judiciously are helpful. Nonetheless, Australia's high and rising rates of antidepressant and other mental health drug use, appears to be a result of slick salesmanship, questionable medical practice (overlooked by our timid 'captured' regulators) and cultural, commercial, and political drivers.

According to reputable sources, including the Australian Bureau of Statistics, right now more than four million Australians are suffering from a mental illness. So if you assume the drugs work, and you accept the official estimates of the prevalence of mental illness, it makes perfect sense that over four million Australians take psychiatric medication. However, the estimates of prevalence of mental illness are based on dodgy DSM-5 definitions of psychiatric disorders, and for many patients pills hurt far more than they help.

The reality for most Australians seeking mental health help, is a visit to the GP, a script of antidepressants, and a bit of a chat if you are lucky. Many of these patients will received multiple medications. For example, many elderly Australians are prescribed antidepressants for anxiety or depression, along with antipsychotics to control agitation. Similarly children prescribed amphetamines (uppers) for Attention Deficit Hyperactivity Disorder (ADHD) are sometimes prescribed Clonidine, or other downers to help them sleep.

Resources are spread too thinly and there is far too much reliance on quick diagnosis backed up by the indiscriminate prescribing of drugs that messily interfere with a patient's biochemistry without addressing their underlying problems. Diagnostic labels and drugs are used as a poor substitute for individualised person-centred support. Currently the balance of mental health responses is 80% drugs and 20% psychosocial/housing/employment/education support. This ratio needs to be reversed if we want to see sustained improvements in outcomes.

Much of this prescribing is 'off label', i.e. for conditions and/or populations that it has not been approved for even if this contravenes to the manufacturer's recommendations or product warnings. Off label prescribing occurs so regularly that it has, in many cases, become the norm. It does not necessarily result in adverse outcomes, sometimes patients benefit. But off label prescribing is unregulated and outside safety parameters established through licencing process. This should not be acceptable. Psychiatric practice should be based on robust independent evidence.

DSM5 - A Flawed Diagnostic System that promotes over-diagnosis and over-treatment.

A huge part of Australia's problem is that we have outsourced our definitions of mental illness to the country that spends the most per-capita on mental health interventions, use the most psychotropic drugs[4], has the highest rates of diagnosed psychiatric disorders[5] but achieves appalling outcomes.[6] America remains the home of ADHD child drugging, with about 1 in 10 children (aged 2-17) ever having been diagnosed with ADHD[7] and millions of children prescribed antidepressants and/or antipsychotics.[8] None of this appears to be working. American teenagers perform very poorly on numeracy and literacy tests.[9] The USA is tumbling down global happiness rankings[10], and the life expectancy of Americans is shortening[11].

The USA should hardly provide the model for enhancing the mental health of Australians. However, the domination of Australian psychiatric practice by the American Psychiatric Association (APA), through the Diagnostic and Statistical manual of Mental Disorders (DSM), ensures that is exactly what happens. On key measures - psychiatric drug use, diagnosis rates, measures of national happiness[12] and suicide rates[13] - Australia is following America's lead. Our rates of child prescribing are considerably lower than the US, but we are catching up. More than 100,000 Australian children are taking off label antidepressants[14] and even more are on ADHD drugs, primarily amphetamines. This is despite the fact that the long-term evidence supporting these aggressive chemical interventions in developing brains and bodies is worse than weak.

Viewed from the perspective of patient and child wellbeing, this makes absolutely no sense. But if you accept the fundamental principle of economics - that self-interest drives most human and corporate behaviour - it makes perfect sense. The APA, Big Pharma, and their allies in the USA, Australia and around the globe are acting in a totally rational way. Defining more people as psychiatrically disordered and exaggerating the benefits and understating the risks of drugs, expands markets and grows profits. What could be more economically rational?

The evolution of the DSM reflects the long-term economic realities of American psychiatry. Psychologists, counsellors and social workers are all able to offer professional talking therapies as alternatives to psychiatry. Even friends and family can offer informal chats and advice. The licence to medically intervene either pharmacologically or through surgery is psychiatry's major marketing edge. It makes perfect sense for the American Psychiatric Association to coalesce with Big Pharma. Both benefit from promoting medical interventions (primarily drugs) rather than less invasive talking therapies.

It is disturbing is that this corrosive Americanisation of Australian psychiatric practice is officially endorsed by our governments. In 2017 the Council of Australian Governments agreed mental illness is a "*clinically diagnosable disorder"* that significantly interferes with a person's cognitive, emotional

or social abilities.[15] Of course 'clinically diagnosable disorders' are typically defined in American Psychiatric Association's DSM-5.

Each successive version of the DSM has involved 'diagnostic creep' - the loosening of diagnostic criteria for existing disorders or addition of new disorders. One notable exception to this pattern of diagnostic creep was the removal of the classification of homosexuality as a mental illness in the early 1970s. In 1952 the original DSM classified homosexuality as a "*sexual deviation disorder*", as did the second edition, DSM-II, published in 1968. In December 1973 DSM-II was modified by the Board of Trustees of the APA. The Board voted to eliminate the general category of homosexuality, and replace it with *"sexual orientation disturbance".* After this change, only individuals who were in conflict with their sexual orientation had a psychiatric disorder.[16]

This hard fought victory over medicalised bigotry resulted from changing social norms and coordinated protest and lobbying. It is clear evidence that the development of the DSM has been driven by social, cultural and political considerations, rather than science.

DSM-5's publication in May 2013 was a huge and controversial event within the psychiatric profession. There was significant international dissent in the lead up to its publication. Professor Allen Frances, the Chairman of the Task Force that developed the previous version, DSM-IV (published in 1994), was the unofficial leader of this backlash.

Early drafts of DSM-5 included many reckless proposals that went beyond just proposing diagnostic creep, and offered a diagnostic explosion, that would have seen many millions of previously 'normal' people made potential psychiatric patients. The backlash caused the American Psychiatric Association to abandon, or tone down some of its more controversial DSM-5 proposals, however many made it into the final published version. I encourage you to read a *Huff Post* opinion piece *DSM-5 Is a Guide, Not a Bible: Simply Ignore Its 10 Worst Changes* written by Professor Frances that details concerns with the DSM-5 development process and its outcomes.[17]

From an Australian perspective a disappointing aspect of DSM-5 was the limp reaction of health authorities and the relevant the professional bodies including the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP), and especially the Royal Australian and New Zealand College of Psychiatry (RANZCP).

I believe yhe RANZCP as the organisation representing specialists in psychiatry failed in its obligation to patients to properly scrutinise DSM-5. By keeping their critical analysis of the DSM-5 to a bare minimum[18] and then embracing DSM-5 as the definitive diagnostic guide for psychiatric disorders[19], the RANZCP has smoothed the transition from DSM-IV to DSM-5 and endorsed the psychiatric disease-mongering embedded in the DSM-5. As a consequence hundreds of thousands, possibly millions, of ordinary Australian who under DSM-IV where 'sane' now meet the criteria for at least one of the DSM5's 312 disorders.

ICD is a preferable (though far from perfect) alternative to the DSM - There is a ready-made alternative to the APA's DSM. The World Health Organization *International Clarification of Diseases* 10 (ICD-10) has been the criterion for mental health disorders predominantly used in Europe. Despite the fact that Australia is a member of the World Health Organization and obviously not a member of the American Psychiatric Association, DSM is the predominant criteria used in Australia.

Chapter Five of the ICD details the diagnostic criteria of psychiatric disorders and provides codes that can be used to identify a disorder when clinicians claim payment from health insurers and government authorities. The ICD-10 numerical coding system is often used in the Australian health system by clinicians and hospitals to obtain Medicare co-payment entitlements, however DSM-5 is the most commonly used diagnostic system.[20]

The development of the ICD has tended to lag the DSM in reflecting the shift within psychiatry from a psychoanalytic approach (emphasising personal historical circumstances and later consequences), to a system that defines behavioural symptoms of an increasing number of discreet, although often comorbid (co-existing), disorders. Despite a gradual convergence, significant but subtle differences exist remain. While many of the criticisms of subjectivity of assessment of behaviours are common to both systems, the DSM generally contains looser, less rigorous diagnostic criteria than the ICD. A 2005 study compared diagnosis rates for a range of childhood psychiatric disorders using the diagnostic criteria in DSM-IV and the equivalent disorder in ICD-10. For the majority of disorders rates of diagnosis were higher using DSM-IV.[21]

DSM-5's publication in 2013 further widened the gap between the two systems. ICD11 is due for publication in 2022. Perhaps the gap will close up a little again then, however, the DSM has always promoted more extreme disease mongering than he ICD. Although it is far from perfect if we as a nation chose to use the WHO's ICD rather than the APA's DSM this would instantaneously mean hundreds thousands of Aussies are no longer officially mentally ill. A shift from the DSM to the ICD would likely be very good for patients, but it would not be good for drug company sales. Not surprisingly since the publication of DSM-5 Australian rates of psychotropic medication use have grown rapidly.

Growth in Australian psychotropic prescribing rates since DSM-5 was published in 2013

Antidepressants - the number of Australians on antidepressants was already high. In the period July 2012 to June 2013, 2,490,793 Australians (about 10.9%) were prescribed an antidepressant. For the period July 2017 to June 2018, this figure rose to 3,042,922 (12.2%). The fastest growth was for children (aged 0-17) with the number rising from 69,973 (1.3%) to 101,174 (1.8%).[22]

Antipsychotics - According to SANE Australia "in 2011, nearly 350,000 Australians had at least one prescription filled for antipsychotic medication. That's 1.6% of the population".[23] In the period July 2017 until June 2018, the number of 406,999 Australians prescribed at least one script had risen to 406,999 (roughly 1.7%).[24] The vast majority (73%) of this prescribing was done by GPs. The fastest growth appears to be for children. According to News Corp "Federal health department data…show[s] the number of children aged 17 or under prescribed antipsychotics increased by 24 per cent between 2013-14 [from 19,934] and 2017-18 [to 24,700], far outstripping the age group's 5 per cent population growth".[25]

ADHD medications (primarily amphetamines) - In 2013, 75,386 Australian children (approximately 1.9% of those aged 4 to 17) were prescribed an ADHD drug. By 2017, this number grew to 107,345. Since 2017 rates of prescribing have grown about 11% per annum. In 2019 it is estimated that approximately 130,000 children (3.0% of those aged 4-17) were prescribed an ADHD drug. From 2013 to 2019 the number of Australian adults prescribed an ADHD drug grew from 37,159 to approximate 70,000.[26]

Science not faith should guide psychiatric practice - Much of modern psychiatric practice, specifically pharmaceutical psychiatry, is based on the belief (faith) that the underlying cause of mental illness are undetectable chemical imbalances in the brain. In the absence of objective evidence assuming that biological factors create chemical imbalances that cause aberrant behaviours (i.e. psychiatric disorders) is a leap of faith more characteristic of religion than science.[27] [28]

It is a leap of faith that the Royal Australia and New Zealand College of Psychiatry (RANZCP) promotes and the Australian Government endorses. The RANZCP website states that medications treat mental illness by rebalancing the chemicals in the brain.[29] The Australian Government goes even further. In 2007 it produced a series of brochures on anxiety, bipolar, depression, eating

disorders, personality disorders and schizophrenia that are still available on the Australian Government Department of Health website.[30] All these brochures declare that these conditions are believed to be caused by a chemical imbalance.

For example the brochure *What is a depressive disorder?* states:

> *Depressive disorders are thought to be due, in part, to a chemical imbalance in the brain. Anti-depressant medication treats this imbalance… anti-depressant medications are not addictive. They slowly return the balance of neurotransmitters in the brain, taking one to four weeks to achieve their positive effects.*[31]

The government's claim that antidepressants are not addictive is grossly misleading. Many who take antidepressants later regret it. They find they are very difficult - sometimes impossible - to withdraw from.[32] [33] After a prolonged argument the UK Royal College of Psychiatry reluctantly conceded that what many patients were claiming is true – i.e. withdrawing from antidepressants is often a strange, frightening and torturous experience.[34] In contrast, the Australian Government's continues to declare that antidepressants are not addictive and declare its faith in the ability of medications, to rebalance brain chemistry. Any drug company that claimed that antidepressants '*slowly return the balance of neurotransmitters in the brain*' would be guilty of misleading promotion, but our government continues to promote this highly speculative hypothesis as if it is proven fact.

False claims that Mental Illness is massively underdiagnosed and undertreated based on dodgy DSM based estimates of the prevalence of mental illness - A very common claim is that prevalence rates of many psychiatric disorders exceed diagnosis and treatment rates so rather than being over-diagnosed and over-medicated, mental illness is massively under-diagnosed and under-treated.

For diseases like asthma, haemochromatosis, or leukaemia - with science-based diagnosis, real and indisputable negative consequences, and medically valid treatments - we need to be concerned if prevalence rates exceed diagnosis rates. This means that real treatable disease is going undiagnosed. However, for subjective, ill-defined diagnosis (i.e. many DSM-5 defined psychiatric disorders) estimating the prevalence rate is like answering the question - How long is a piece of string? The answer depends entirely on how you cut it.

For example estimates of the prevalence of ADHD have varied between 1.7%[35] and 29%[36] of children. This huge range is an inevitable consequence of relying second hand reports of children fidgeting, interrupting, loosing things etc. to diagnose a hypothesised neurodevelopmental psychiatric disorder.

Most estimates of the prevalence of a psychiatric disorder involve surveying a sample of the population (or in the case of children their parents) to identify to what extent (never, sometimes often, always) they display 'disordered' behaviours. These behaviours are then overlayed upon the diagnostic criteria of all psychiatric disorders to identify what proportion of the population would qualify for a diagnosis. Sometimes, more rigorous researchers make an effort is made to determine if the degree of perceived dysfunction or impairment reaches the diagnostic threshold. Occasionally, they may ask question about external factors, like recent trauma, that may contribute to behaviour.

Irrespective of how thorough a prevalence rate estimate is, it invariably exceeds the current rate of diagnosis rates, particularly for the more controversial psychiatric disorders. This happens for one simple reason. Most potential patients (or parents who have children who would qualify for a diagnosis) are too sensible to allow themselves (or their child) to be given a dumbed down label. For example if properly informed about the subjective behavioural basis of the diagnosis, and the nature of the 'medications' used to treat it, few competent parents allow their child to be labelled ADHD, and given a daily amphetamine habit.

Nonetheless, very high estimates of the prevalence of mental illness are widely quoted - **including in the *Productivity Commission Draft Report*** – and most who hear these alarming figures fail to understand the significant limitations of these estimates. Even the Australian Parliamentary website contains a page titled, *Mental Health in Australia: a quick guide* that contains the following examples of alarmingly high estimates of the prevalence of mental illness.[37]

- The Australian Bureau of Statistics (ABS) National Survey of Mental Health and Wellbeing (NSMHWB) [conducted in 2007] provides the most comprehensive (albeit dated) estimates for mental disorders in Australian adults both over their lifetime and in the preceding 12 months. The survey estimated that 45 per cent of Australians had experienced a mental disorder in their lifetime, with 20 per cent experiencing a mental disorder in the previous year.
- The most recent ABS National Health Survey estimated there were 4.8 million Australians (20.1%) [who identify as having] a mental or behavioural condition in 2017–18. This was an increase of 2.6 percentage points from 2014–15, mainly due to an increase in the number of people reporting anxiety-related conditions, depression, or feelings of depression.
- The Australian Child and Adolescent Survey of Mental Health and Wellbeing, conducted between June 2013 and April 2014 by the Department of Health, estimated that almost 14 per cent of young people aged 4 to 17 years (or 560,000 children) experienced a mental disorder in the 12 months before the survey.

These inflated figures are used to argue that mental illness is being left unrecognised and untreated with disastrous consequences, and that governments must support universal mental health screening in schools and in the workplace.

More treatment can lead to worse outcomes - In Australia we have come to believe as an article of faith that spending more on mental health interventions improves outcomes and has economic benefits. This belief is obvious throughout the *Draft Report*. However, in the USA since 1987, rapidly rising rates of mental health interventions have been associated with massive increases in the proportion of American's receiving government disability support payments for mental illness. This comes with an obvious opportunity cost to both the individual and the economy.[38]

Sometimes the 'medications' that 'treat' psychiatric disorders create new disorders that are managed with other drugs. For example, disruptive children, some as young as four, prescribed amphetamines to control their ADHD, are sometimes prescribed depressants to manage the stimulants side effects. In addition, the withdrawal effects from psychiatric drugs are often worse than the initial problems they were supposed to treat. This iatrogenic suffering (harm caused by treatment) is often blamed on the 'patients' re-emerging mental illness and doses are increased and/or new medications (toxins) are added. The end result is the patient gets locked into a vicious cycle of drugs creating harm with more drugs added to address that harm; meanwhile 'medication' sales soar and Big Pharma rakes in iatrogenic profits (profits caused by creating harm).[39]

There is mounting evidence of harms caused by psychiatric drugs, particularly antipsychotics (diabetes, metabolic syndrome**,** heart attacks**,** brain atrophy) antidepressants (suicidality, falls and injuries**,** birth abnormalities) and stimulants (addiction, psychiatric disorders, growth retardation, cardiovascular disorders etc.) that increases the demands on non-psychiatric health and welfare services.

This suffering is avoidable if governments, doctors, patients and their families need to resist the sugar rush temptation of relying on pharmaceutical quick fixes for complex mental health and social problems. Governments must recognise the harms caused by the over-prescription of the

psychotropic drugs that they often subsidise. Otherwise they will continue to misallocate resources to options that superficial appear to address mental health need at minimal cost.

Too many non-experts General Practitioners prescribe psychotropics - The vast majority of the prescribing of mental health drugs in Australia is done by non-psychiatrists, especially general practitioners.[40] In 2017/18 according to the Australian Productivity Commission *"about 15% of the population [3.9 million people] received a mental-health-related prescription from their GP".*[41] Sadly, non-expert, DSM-5 based pharmaceutical psychiatry has become the dominant model of psychiatric care in Australia, yet the *Productivity Commission Draft Report* does not address the issue.

Issue 2 - Antidepressants and Youth Suicide and Self-Harm - the depressing facts

As previously mentioned despite antidepressants being by far the dominant mental health intervention in Australia there is no discussion of their safety and/or efficacy in the Draft Report. The only two relevant references occur on Page 843 *"Almost two-thirds of people who die by suicide had a diagnosed mental illness, including depression, substance use disorders and anxiety"* and page 853 "*Mental health services can be effective at reducing suicidal behaviour (Ougrin et al. 2015; Zalsman et al. 2016). This includes medications and psychological treatment*". These statement imply that treating depression with antidepressants reduces the incidence of suicide.

However, as is detailed below recent Australian evidence indicates the use of antidepressants is associated with an increased risk of suicide, particularly for young people. In Australia, no antidepressant is approved for the treatment of depression in people aged under 18 and only two SSRIs (fluvoxamine and sertraline) are approved in Australia for children and adolescents with obsessive compulsive disorder.[42] Despite this, and increasing evidence that antidepressants have very little benefit in treating depression in young people,[43] [44] from July 2017 to June 2018 approximately 1.8% (101,174) of Australians aged 0-17 were prescribed an antidepressant.

FDA + TGA Suicidality Warnings - In October 2004, the US Food and Drug Administration (FDA) issued the highest level a 'Black Box' warning that using antidepressants was associated with a roughly doubled risk of suicidal thinking and behaviour in people aged under 25 diagnosed with depression and other psychiatric disorders.[45] The warning was a result of an FDA analysis[46] of short-term trials of antidepressants in children and adolescents that showed *"a relative risk for suicidal behaviour or ideation of 1.95 (95% confidence interval 1.28 to 2.98) for those treated with antidepressants compared with those given placebo"*[47].

Ten months later, in August 2005, Australia's medical product regulator, the Therapeutic Goods Administration (TGA), stopped short of issuing the equivalent Boxed Warning. Instead the TGA required the rewording of Product Information and Consumer Information leaflets made available to doctors and consumers to inform them of the need to monitor for signs of suicidality.[48]

Local 'experts' contest the FDA suicidality warning

Subsequent to the FDA's black box warning, and the TGA's lower-level warning, prominent Australian mental health organisations, including Suicide Prevention Australia, Orygen and headspace, along with psychiatric thought leaders, Professor Patrick McGorry and Professor Ian Hickie, minimised the significance of the warning, arguing that antidepressants reduce the risk of youth suicide.

Suicide Prevention Australia (SPA) describes itself as the *"national peak body for the suicide prevention sector"*.[49] In 2010, SPA published a *Youth Suicide Prevention* position statement, which concluded that, *"balanced against the risk of not treating youth depression, SSRIs offer some potential to reduce youth suicide"*.[50] SPA's position paper cited a single source (Gould et al. 2003[51]) and wrongly claimed it had *"shown [SSRIs] to be an effective treatment for youth depression and suicidality"*.[52] Instead Gould et al reported that there was no evidence from *"psychopharmacological studies that have specifically targeted suicidal adolescents"* but it was *"plausible"* that increased antidepressant prescribing might have decreased youth suicide rates in the US.[53]

SPA's position statement also claimed that *"the decreased use of SSRIs in Australia has recently been linked to increased youth suicides"*, but identified no evidence of an Australian decrease in use of SSRIs and no basis for the alleged link with youth suicide.[54] In fact, as detailed later in this submission, in the period between the FDA warning and SPA producing its position statement, for young Australians a substantial fall in antidepressant prescribing rates was associated with a small fall in the suicide rate.

The next sentence in the SPA position statement cited a Cochrane review[55] of SSRI antidepressant use by children and adolescents as supporting fluoxetine (common brand Prozac) as the *"most effective SSRI"*.[56] However, the Cochrane review reported that even for fluoxetine *"the reduction seen in symptoms was modest"* and the limited evidence came from trials of *"young people not representative of those presenting for treatment in clinics"*.[57] The SPA position statement did not report that the Cochrane review found *"an increased risk of suicidal ideation and behaviour"* and higher rates of adverse events among children and adolescents prescribed SSRIs.[58]

In March 2019, nearly a decade after publication, SPA removed the position statement from its website.[59]

Orygen, headspace and Professor Patrick McGorry - SPA's position statement also cited a paper *Evidence Summary: Using SSRI Antidepressants to Treat Depression in Young People* produced by influential Australian mental health service providers, Orygen and headspace.[60] Professor Patrick McGorry is the Executive Director of Orygen and is on the board of headspace. He was also listed as one of three Clinical Consultants that contributed to the *Evidence Summary.*

That *Evidence Summary* noted that no antidepressant was approved for used by under-18 year-olds, and acknowledged the FDA warning, but it concluded that there were *"even greater risks of not treating depression with any type of intervention (e.g. pharmacological or psychological intervention)"*.[61] Drugs and talking therapies have very different risk/benefit profiles. Conflating the two types of treatment, providing no evidence for either, but simply asserting that treatment, any treatment, reduces suicide risk, is not appropriate for an "*Evidence Summary*".

The Evidence Summary also stated that fluoxetine is superior to all SSRI antidepressants, but even it is only *"modestly effective for reducing symptoms of depression in young people"*. Nonetheless it recommended that SSRIs may be used to treat moderate to severe depression *"within the context of comprehensive management of the patient, which includes regular careful monitoring for the emergence of suicidal ideation or behaviour"*.[62]

Despite these words of caution about the need for "*regular careful monitoring"* an audit of the prescribing practices at Orygen's own clinic demonstrated Orygen hasn't always done this. In 2007 at Orygen *"the majority of young people (74.5%) were prescribed an antidepressant before an adequate trial of psychotherapy was undertaken and that less than 50% were monitored for depression symptom improvement and antidepressant treatment emergent suicide related behaviours (35% and 30% respectively)"*.[63] Results of this audit were not published until 2012[64] and I have not been able to locate any publicly available evidence of subsequent prescribing audits. So I cannot assess if Orygen has improved its practices since 2007.

We do know that in February 2009, the same year that Orygen produced the original Evidence Summary, it also published a document Medications for Depression that made no reference to suicidality risks, and contradicted the Evidence Summary by overstating the evidence for the effectiveness of antidepressants. Medications for Depression states: *"Antidepressants also work well for less severe types of depression"*, whereas the Orygen/headspace Evidence Summary states that, of all SSRI antidepressants, only *"fluoxetine is modestly effective for reducing symptoms of depression in young people"*.[65] Despite this inaccuracy, Medications for Depression is still available on Orygen's website (as at 18 November 2019).[66]

Professor Ian Hickie - In 2003, the year before the FDA issued its warning, Hickie was a co-author of a study (Hall et al. 2003), that is frequently cited as supporting the use of SSRI antidepressants. The abstract implies that antidepressants decrease the risk of suicide, however in my view the results, detailed in the body of Hall et al. 2003, are inconsistent with the abstract's positive conclusions. The abstract states:

Changes in suicide rates and exposure to antidepressants in Australia for 1991-2000 are significantly associated. This effect is most apparent in older age groups, in which rates of suicide decreased substantially in association with exposure to antidepressants. The increase in antidepressant prescribing may be a proxy marker for improved overall management of depression. If so, increased prescribing of selective serotonin reuptake inhibitors in general practice may have produced a quantifiable benefit in population mental health.[67]

Hall et al. 2003 demonstrated there were massive increases in antidepressant prescribing to all Australians, particularly younger Australians, from 1990-1991 through to 1998-2001. The suicide rate data was examined in three different time-bands: 1986-1990, 1991-1995 and 1996-2000. Between the base period 1986-90 and the end period 1996-2000, the per-capita suicide rate rose by approximately 16% for Australians aged 15 to 45 (no data were available for children aged 14 or younger). There was a 15% fall in the per-capita suicide rate for Australians aged 45 or older. When combined, the per-capita suicide rate for all Australians (aged 15 or older) rose by 3%.

Because of the growth in suicides among Australians aged 15 to 44 (who made up 59% of the population of Australia aged 15 or older), the life-years lost to suicide will have risen by significantly more than 3% from 1986-90 to 1996-2000.

Hall et al. 2003 has been an influential paper. The TGA's initial response (in 2005) to the FDA 2004 suicidality warning was outlined in *Suicidality with SSRIs: adults and children.* This document cited Hall + Hickie et al. 2003 as evidence that *"increased prescribing of antidepressants in Australia during 1991-2000 was associated with decreasing suicide rates"*.[68] In *Suicidality with SSRIs: adults and children*, the TGA identified that there was a decrease in the suicide rate among older Australians, but did not acknowledge the more than offsetting increase in suicide by younger Australians. While it stated that Hall et al. 2003 did *"not demonstrate a causal relationship",* it reinforced their suggestion that increasing SSRI prescribing rates may be *"indicative of improved overall management of depression"*.[69]

General Practitioners - While they are clearly influential it would be inaccurate to attribute sole responsibility for the rise in Australia's youth antidepressant prescribing rates to a few individual key opinion leaders and organisations, or even the psychiatric profession alone. Most antidepressant are prescribed by GPs. For example, in 2014/15, General Practitioners prescribed 90.4% of antidepressants. Psychiatrists were directly responsible for only 6.5%.[70]

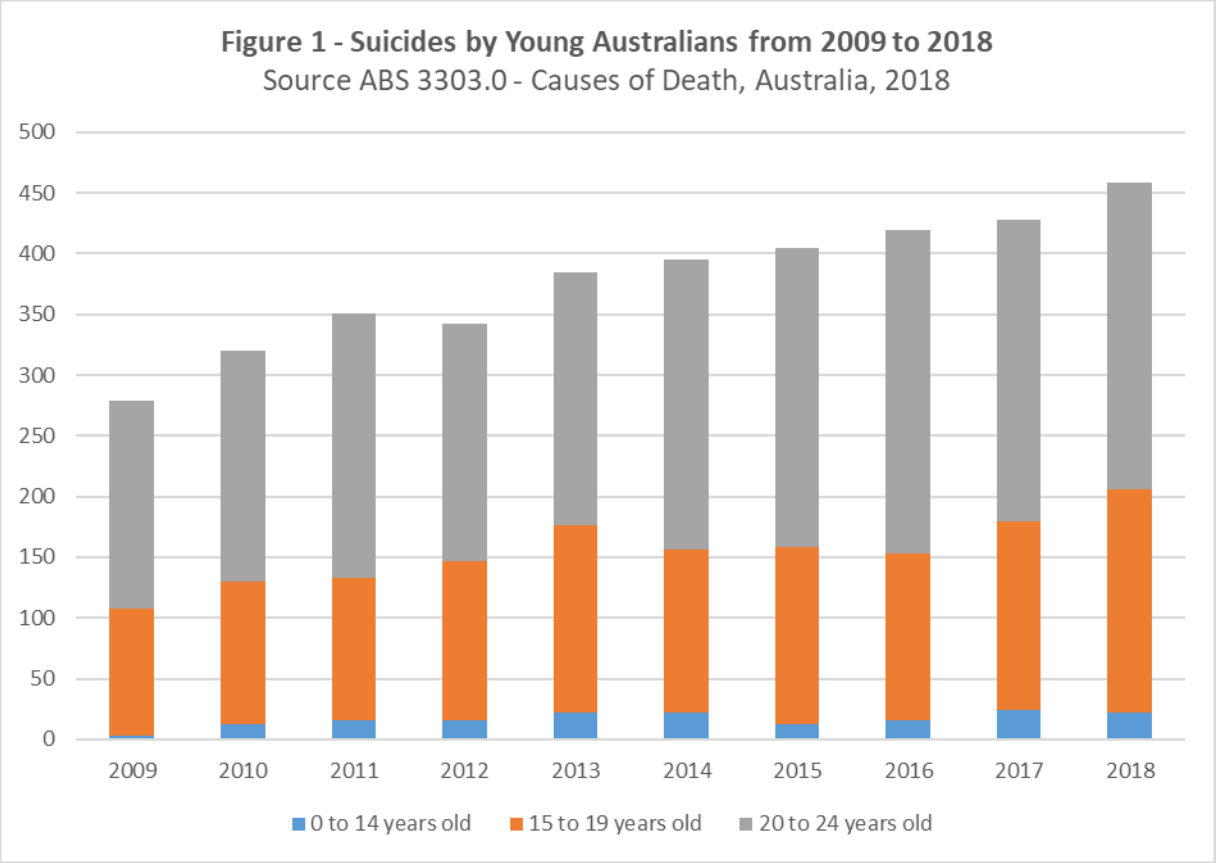
Whether GPs have the time or the skills needed to treat individuals distressed by grief, family breakup, unemployment or any other of life's inevitable trials is a relevant question. How many patients (or in the case of children parents), are informed of the risks of antidepressants by their GP, and whether their GP explores other options, and monitors their response to medication, are also important unresolved questions. GPs can refer patients to a psychologists for up to ten visits a year to a psychologist under the *Better Access* program. But clearly with over 1 in 8 Australians prescribed an antidepressant and the vast majority of prescribing done by GPs; drugs not *Better Access* psychological services are the front line service.

A decade on: What does Australian 'real world' evidence tell us?

There is now nearly a decade of real-world Australian data since the Orygen/headspace Evidence Summary and the SPA position statement were published and Professor Ian Hickie made his unequivocal assertion that the *"real harm, as evidenced by the suicide statistics, comes from not receiving a diagnosis or treatment".* Multiple sources, including Orygen[71], have identified rising child, adolescent and young adult antidepressant prescribing rates[72] [73] and/or increasing rates of suicide[74]

and self-harm[75] by young Australians over the last decade, however there appears to have been little effort to investigate the possibility of a link.

Suicide - As demonstrated in Figure 1 below, 279 Australians aged under 25 died by suicide in 2009. Over the next decade the number trended upwards, reaching 458 in 2018.[76] This represented an increase of 49.2% from 3.87 to 5.78 deaths by suicide per 100,000 Australians aged 0 to 24 years over this period. If the per-capita rate of under-25-year-old suicide had remained at the average rate for 2008 and 2009 levels, 741 fewer young Australians would have killed themselves between 2010 and 2018.



Antidepressant Use - In Australia, most commonly used prescription medications, including antidepressants, are subsidised for patients by the Commonwealth Government through the Pharmaceutical Benefits Scheme (PBS), which generates detailed data on prescribing patterns. Analysing shifts in PBS data is the best available method for identifying trends in antidepressant.

After the 2004 FDA warning - PBS data shows that the number, and the proportion, of young Australians (aged 0-27 years) receiving government subsidised antidepressant fell significantly after the FDA issued its warning. From the year ending 30 June 2004 (2003-04), until the year ending 30 June 2008 (2007-08), the number and proportion of Australians aged under 28 years receiving PBS subsidised antidepressants fell from 203,929 (2.7%) in 2003-04 to 147,052 (1.8%) in 2007-08 – a 32% decrease.

After Australia's depression experts offer their contradictory advice - The data the Australian Government provided for the period 2003-04 to 2010-11 were collected on a different basis from the data for the period 2012-13 to 2017-18. The data from 2011-12 are a hybrid of both methods. Because of these changes, care needs to be taken interpreting the data.

Despite this limitation, there is a clear trend of increasing prescribing. Following the 2007-08 low point in prescribing rates for young Australians (aged 0-27), the rates rose marginally (1%) in 2008-09, but have increased rapidly thereafter.

- From 2008-9 until 2010-11, there was there was a 17% increase in the likelihood of a young Australian taking PBS subsidised antidepressants.
- From 2012-13 until 2017-18, there was there was a 25% increase in the likelihood of a young Australian taking PBS subsidised antidepressants.
- In 2017-18 approximately 1.8% of Australian children (aged 0 to 17 years) and 9.4% of young adults (aged 18 to 27 years) were prescribed an antidepressant.

As a result of the change in method in 2011-12, it is not possible to calculate the exact per-capita growth in antidepressant use by young Australians, since the upswing began in 2008-09. However, assuming the growth rate between July 2010 and June 2012 was the same as average growth rates for the two years before and after this period, then over the decade from 2008-09 to 2017-18, the proportion of Australians aged 0 to 27 years, using antidepressants grew from 2.9% to 4.8%. As demonstrated in Figure 3 below, and, bearing in mind the limitations arising from the changing data collection basis, the pattern of growth in prescriptions was relatively consistent.

In summary, there was a marginal fall (-5%) in suicide rates associated with a large fall (-31%) in PBS antidepressant prescribing rates for young Australians in the wake of the FDA warning. **In contrast, following the contrary advice from Australian experts, there was a large increase in both young Australian suicide (+49%) and antidepressant prescribing (+66% estimated) rates.**

Many factors are likely to impact suicide and self-harm rates, and correlation does not prove causation. However, the evidence from falling young Australian antidepressant use and suicide rates, followed by rising young Australian antidepressant prescribing and suicide rates (after 2009) suggests that the advice offered by Australia's leading suicide prevention experts may have contributed to rising antidepressant use rates and suicide rates among young Australians.

This is a possibility that many suicide prevention experts seem reluctant to consider. Instead, they hypothesise alternative explanations for rising youth suicide rates. For example, in 2016, *Orygen*, in collaboration with eleven other organisations (including *beyondblue*, the *Black Dog Institute* and *headspace*), produced a report titled *Raising the bar for youth suicide prevention*.[77] The report unambiguously identified that youth and child suicide and self-harm rates were rising, stating:

> *Over the past 10 years, rather than making inroads into reducing the number of young lives lost to suicide in Australia, there have instead been small but gradual increases in suicide rates… This has mirrored high rates of self-harm among young people. (p. 7)*

The report hypothesised multiple possible causes (e.g. increased use of social media, homophobia and untreated mental illness). In the entire 57-page report, the word 'medication' was mentioned once, and antidepressants and SSRIs were not mentioned at all. The highly plausible hypothesis, that, in line with the FDA warning, rising antidepressant prescribing rates are at least in part responsible for rising youth and child suicide rates, was completely ignored.

Self-Harm - There is also strong evidence that antidepressants are commonly used in self-poisoning (overdose). Australian research, Cairns et al 2019, found *"a concerning increase in child/adolescent [aged 5 to 19 years] self-poisoning in Australia"* that corresponded to an increase in psychotropic prescribing rates, particularly SSRI antidepressants. It also found that there was *"substantial overlap between the most dispensed psychotropics and medicines most commonly used in self-poisoning episodes"*.[78]

Cairns et al. presented evidence of increasing antidepressant prescribing rates from 2009 to 2016 in two time-frames. They cited prior research79 showing that, from 2009 to 2012, antidepressant use by Australians under the age of 25 increased by 25%, and among this group grew fastest in children aged 10-14 (35.5%). They also found that, from July 2012 to June 2016, the number of individuals dispensed SSRIs increased 40% and 35% in those aged 5-14 and 15-19, respectively.

Cairns et al. then reviewed data from 2006 to 2016 for New South Wales and Victorian self-poisonings and found, in the under-20 age group, an increase in intentional annual poisonings of 98% from 2006 to 2016, with most of the growth occurring after 2011.

These results are consistent with the hypothesis that antidepressants increase the risk of suicidality and self-harm in young people. Furthermore, they provide compelling evidence that the antidepressants prescribed to children and adolescents are frequently the means of self-harm.

Given that the FDA warned that antidepressants were associated with an approximately doubled risk of suicidality relative to placebo, I am not surprised that rising prescribing rates have been associated with increasing youth suicide rates. In fact it is exactly what I predicted would happen. In the lead-up to the August 2010 Federal election, political activist group *GetUp* had organised candle-light vigils to highlight concerns about youth suicide. Professor McGorry had addressed these vigils.[80] A year later I told the Western Australian Parliament that if we followed his *Orygen's*, *headspace's* and Professor McGorry's advice we should expect an *"increase in the number of candles"* at the next vigil. [81]

Most worryingly little seems to have changed. On 24 June 2019, *The West Australian*, published series of articles including a front page article about a seven year old girl who became suicidal on a cocktail of psychotropic drugs including antidepressants. An article titled *It's time to rethink kids pills*[82] that quoted the following excerpt from a letter I wrote to Prime Minister Scott Morrison:

> *Over the last decade Australian psychiatric practice, much of which is conducted by GPs with little training, has substantially ignored the FDA and TGA's warnings and followed advice of local 'experts'. The results are that over the last decade the 0 to 27-year-old prescribing rate per capita has risen about 60 per cent, (while) 0 to 24-year-old per capita suicide rates have risen 40 per cent.*[83] [Note: an extra year of data has become available since then, demonstrating a 66% increase in antidepressant use and a 49% increase in the suicide rate]

In response Professor Patrick McGorry said that the association made between increased antidepressant use and suicide rates simply did *"not hold up…Antidepressants don't increase suicide. Evidence shows there can be a temporary increase in suicidal ideation . . . (but) they reduce suicide risk in most"*. Ironically on the same day *The West Australian* published the story, a study that reviewed the information held by the FDA, found that *"the rate of suicide [attempts and completed suicides] was about 2.5 times higher in antidepressant arms relative to placebo"*.[84]

Professor Hickie was also quoted in *The West Australian* article: *"They (critics) are acting like there's something wrong with increasing treatment…As treatment goes up, we have to be careful, we do run the danger as we increase access…that the trade-off is low-quality care. But what's the alternative? No care?"* My response to Professor Hickie is that, when 'increasing treatment' is clearly associated with increasing death by suicide of young Australians, 'there's something wrong'.

In summary, over the last decade, the dominant message in the public discourse has been that depression is very common and is serious but easily treated if only troubled young people seek help.[85] Very often it has simply been assumed that treatment, any treatment, reduces the risk of suicide. Many who propagate this message are undoubtedly well-meaning, but the reality for too

many young people is that 'help' is nothing more than a short consultation with a GP, a script for an SSRI antidepressant, and perhaps a few words of caution about possible side-effects.

In 2016 - eleven years after the TGA issued in original inept response to the FDA warning - the TGA issued a *Medicines Safety Update* highlighting concerns about SSRIs and suicidality in children and adolescents.[86] It discussed research that found patients and carers were very often not informed about potential risks of antidepressants, including suicidality risks. Had the TGA responded competently and publicly when the FDA issued its warning in 2004, it is very likely that more patients and parents would have been aware of the risk and some would have avoided to taking antidepressants. Of course we can never know for sure, but it may be that some young Australians who suicided while using or withdrawing from antidepressants would be alive today if the TGA did it job.

Regardless of who is responsible, it is obvious that the current drug dominant approach to youth depression has failed. **More young Australians are taking antidepressants, and more young Australians are killing themselves and self-harming, often by intentionally overdosing on the very substances that are supposed to help them.**

Issue 3 – The future of headspace and Early Psychosis Services

Recommendation 24.2 on page 106 states:

> ***In the short term (in the next 2 years) the Department of Health should cease directing PHNs [Primary Health Networks] to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit. In the medium term (over 2–5 years) there should be no requirements that commissioning agencies (RCAs or PHNs) have to fund particular service providers.***

This recommendation threatens the monopoly that headspace has on Commonwealth Government funds for youth (aged 12 to 25 years) mental health services. It is a sensible recommendation as there is very little independent, robust, evidence supporting the effectiveness of either headspace[87] or its Youth Early Psychosis Program.

Since it was established in 2006, headspace has been scaled up with enormous fanfare. However at a population level, most measures of the mental health of young Australians, particularly rates of youth self-harm and suicide, have got considerably worse. Despite its failure to deliver demonstrable benefits, expanding headspace is frequently marketed as the recipe for better outcomes, including reducing the per-capita rate of youth suicide. Nonetheless, the Morrison Government's mental health 2019 election policy - Our Plan for youth mental health and suicide prevention - committed an *"additional $375 million to expand and improve the headspace network".*[88]

headspace's Youth Early Psychosis Program, previously known as EPPICS (Early Psychosis Prevention Intervention Centres), is a particularly worrying innovation. Again, despite the lack of a supporting evidence base, the Morrison Government's has committed *"$110 million to continue the Early Psychosis Youth Services [EPYS] program at six headspace centres nationally"*.[89]

One of the driving force behind EPYS is the belief that young people at 'Ultra High Risk' of psychosis can be identified and treated, and thereby prevented from developing psychosis and schizophrenia. Intuitively, it seems like a reasonable 'stitch in time' theory. However, the independent evidence indicates that there are three problems with the theory:

1. The rate of false positives is extremely high. Proponents of the Ultra High Risk diagnosis claim a false positive rate of 64%[90], critics assert it is 92%[91]. Either way the vast majority of young people diagnosed as being at 'Ultra High Risk' of psychosis, never become psychotic.
2. Even in those cases where the predictions are accurate, there is little to no independent evidence that the interventions that are on offer, help, in the long term.
3. Labelling young people as being at Ultra High Risk of becoming psychotic is stigmatising, and may encourage the unwarranted use of antipsychotic medications, with substantial risks of life-shortening metabolic and cardiovascular damage.

Early Psychosis Services have survived two prior crisis that should have seen them starved of Commonwealth Government funding. In May 2011 the Gillard Government made the first serious commitment of money; $222.4 million, half the cost, for the rollout of 16 EPPICS across Australia. These clinics were proposed with the dual purpose of diagnosing and treating young people at Ultra High Risk of Psychosis and treating those who have become psychotic.

Shortly after (in May 2011), the *American Psychiatric Association* abandoned plans to include an Ultra High Psychosis Risk Disorder (otherwise called Attenuated Psychosis Syndrome or Psychosis Risk Disorder) in DSM5. This was done in response to widespread criticisms of the proposal. In effect, this meant one of the services two key functions - diagnosing and treating Psychosis Risk Disorder -

was discredited internationally, at about the same time Commonwealth Government funding was secured for this very purpose.

Following this Professor McGorry who has championed the EPPIC rollout responded by claiming that "EPPICs do not treat people with psychosis risk but only patients who have had their first psychotic episode".[92] However, identifying and treating those considered to be at Ultra High Risk of Psychosis always was, and still is still, core business for EPPICS and EPYS.[93] [94] EPPICs survived that obstacle but hit a road block when individual state governments, sensibly in my view, declined to kick in half the funding. Nonetheless, the Gillard Government delivered some of the promised clinics.

The second survival crisis for EPPICs (later renamed Early Psychosis Services - EPYS) occurred in June 2016, when the Turnbull Government Health Minister Sussan Ley announced the staged closure of the seven EPYS located at headspaces. It was planned that the money saved would be redistributed to Primary Health Networks to spend on a broader range of youth focused services. Minister Ley told the ABC the changes were part of a bank of recommendations made by some of the country's top mental health experts and the money would be allocated more effectively.

Orygen Youth Health's (headed up by Patrick McGorry) website describes his successful political lobbying response to this threat to in his own words:

> *That's when it really started to go pear-shaped," Professor McGorry says. "At that point, a decision was made by senior bureaucrats and supported by the Minister [Sussan Ley] to wind this program up and hand over the funds to be used in a diffuse and "flexible" manner by the new and untested Primary Health Networks on completely non-evidence-based programs. Naturally, that caused huge problems for the patients that were already being treated, created serious risks and widespread distress, including for the dedicated staff that were trying to make those programs work.*
>
> *"It was a completely outrageous decision, which flew in the face of arguably the best-quality evidence ever assembled for any model of mental health care. We tried everything politically to get it reversed in the lead-up to the 2016 election, but even with a fair bit of support with the coalition, we couldn't get it reversed."*
>
> *In a last-ditch effort to save the programs, Professor McGorry addressed the National Press Club, accompanied by a young person from the program. The following Sunday, the Sunday Telegraph hit Sydney streets with the headline, "Mal, Can We Talk? Funding cuts prompt fears of youth suicide rise", blazoned across the front. "Within hours of that article being released, the Prime Minister was on the phone to me saying, "What do we need to do to fix this?" And within two hours, they organised a personal meeting with Sussan Ley, her adviser, Kerryn Pennell, myself — with Treasurer Scott Morrison and Malcolm Turnbull joining on the phone," Professor McGorry remembers.*

In my opinion this story demonstrates that the survival of EPPICs/EPYSis has depended on political lobbying rather than robust evidence of positive outcomes.

However Professor McGorry has frequently claimed EPICCs/EPYS are supported by robust scientific evidence. In 2011 he co-authored a Blueprint to Transform Mental Health and Social Participation in Australia. This document stated Early Psychosis Services have *"the largest international evidence base of any mental health model of care, demonstrating not only their clinical effectiveness but also their financial and social return on investment. This is a mature model simply requiring*

implementation in Australia".[95] In 2012 I detailed to the Western Australian Parliament why I thought this claim "simply doesn't stack up". I still believe this is the case.

Of course the *Draft Report* does not recommend defunding EPYS or headspace. Rather it seeks to encourage competition, and ensure money is well spent. So headspace would have an equal opportunity to convince the Primary Health Networks, and we taxpayers who ultimately pay the bill, that it is the interests of young Australians to fund headspace and Early Psychosis Services, rather than other youth programs.

For both headspace and Early Psychosis Services there are a number of unanswered questions that must be addressed in this process:

- How does *headspace* reconcile its past advice regarding antidepressant prescribing, with the real world Australian experience over the last decade of soaring rates of antidepressant use and suicide by young Australians?
- Will *headspace* commit to allowing a robust, independent and public audit and evaluation of headspace and EPYS diagnosis, prescribing and other treatment practices?

These are crucial questions that demand independent scrutiny and the attention of decision makers. I believe a robust, arm's length assessment would recommend Early Psychosis Services are defunded. I have argued, and continue to believe that EPPICs/EPYS were supported by a flimsy evidence base, that never should have been funded in the first place.

While I am highly critical of the overselling of *headspace*, the concept of a one-stop shop supporting troubled young people has merit. A reconfigured *headspace*, better integrated into other services, with a 'personalised, listen and support' focus, and not a 'medicalised, diagnose and treat' approach, could prove valuable. To achieve this an honest admission that the headspace rhetoric has never matched the reality is required. Professor Ian Hickie recently tweeted that headspace CEO Jason Threthowan had acknowledged that *'the brand is way ahead of the substance'.*[96] This gives me reason to hope that change may be possible. However, in my view there would need to be an ongoing commitment (tied to funding), for full public independent, audits and evaluations of diagnosis and treatment practices (including prescribing) at all headspace clinics.

headspace - the hype doesn't match reality - Two evaluations conducted with headspace's cooperation both provided very weak evidence to support the effectiveness of headspace, let alone its cost-effectiveness. The first evaluation, Muir et al (2009), found "there was little tangible evidence of the extent to which services were evidence-based".[97] The more recent evaluation, Hilferty et al. (2015), showed high levels of client attrition and raised concerns about poor engagement with Indigenous young people.[98] Media reports have also raised similar concerns.

Furthermore, even the weak evidence of positive outcomes in these two reviews is questionable, because both evaluations had significant methodological limitations. The Muir 2009 evaluation had no control group for comparison.[99] Hilferty et al.'s 2015 evaluation used two comparison groups.[100] The 18-25-year-old comparison group was recruited online from commercial access panels, with a very low response rate (p. 175), and was poorly-matched (p. 16). In addition, the headspace client survey group excluded clients who only attended once (p. 180), and girls/women were over-represented (p. 179).

The independent assessment conducted in 2015 by Professor Anthony Jorm, without headspace's involvement, found "improvements seen in headspace clients are similar to those seen in untreated cases, and it would seem that the services provided may have had little or no effect".[101] Apart from

the weak evidence base, other concerns associated with the rollout of headspace include problems with workforce shortages and its failure to service those most at risk and respond to local conditions.

More information on Early Psychosis Services - The national website for headspace states headspace Early Psychosis Services are,

> *in a unique position to identify and treat those at risk. Based on evidence developed by Orygen; the National Centre of Excellence in Youth Mental Health, the program focuses on early intervention, providing young people and their families with timely access to specialist support. headspace centres delivering the early psychosis program are equipped with specially trained staff to help young people and their families.*[102]

An example of the guidance offered by *Orygen* to the *"specially trained staff"* is a *Comprehensive Assessment of At Risk Mental State (CAARMS) Training DVD.*[103] It trains staff on how to diagnose youth considered to be at Ultra high Risk of becoming psychotic. It begins,

> *The CAARMS has two functions; First, to assess whether the person meets the ultra-high risk criteria for psychosis or not and second, to assess the range of psycho-pathology which we see typically in people in the prodrome preceding a first episode of psychosis. For this training video we'll just focus on the first function, that of assessing the ultra high-risk criteria… We're going to show you four interviews of typical people who present to the Pace clinic. Also in the DVD there will be slides showing the ratings for each of these people. By viewing the DVD you'll see both how the interviewer asks the questions and the responses that we commonly encounter at the clinic.*

The interviewees in the training video were played by actors. An excerpt of the DVD showing a mock interview between a psychiatrist and an 18 year old apprentice electrician Nick is available online.[104] In the excerpt Nick explains how he feels pressured by his father to complete his apprenticeship and eventually take over the family business. Nick is anxious that he is not a good apprentice and it is obvious he feels bullied into following his father's plans for him.

At the end of the interview it is explained why Nick meets the diagnostic criteria for being at Ultra High Risk of Psychosis (i.e. having Attenuated Psychosis Syndrome or Psychosis Risk Disorder). In my non-clinical opinion the evidence used to diagnose Nick is incredibly flimsy and demonstrates that the process is dangerously devoid of credibility. Professor of Psychiatry at Flinders University Jon Jureidini agrees with my assessment. In a commentary accompanying my video blog Professor Jureidini wrote that rather than being a credible learning tool, the Orygen DVD "provides a potential teaching tool for medical students in how not to carry out a psychiatric interview and interact with young people".[105]

I encourage all to watch the excerpt (available at https://www.psychwatchaustralia.com/mcgorry-video-fails-commonsense-tes), and apply common sense and decide; Is Nick sick with attenuated psychosis? Or is Nick simply very unhappy because he feels forced into a job he hates by his Dad and perhaps he smokes a bit too much dope?

Since this DVD was released in 2009 successive Australian Governments have committed hundreds of millions of taxpayer's dollars to a service built on this model that diagnose children as young as twelve as being pre-psychotic. I wonder if the Ministers and Prime Ministers responsible would have done this if they took the twenty minutes required to watch the excerpt of this DVD? I think not.

I also doubt our political leaders considered the independent evidence regarding EPPICs. In June 2012 a systematic review assessing the cost of early intervention in psychosis conducted by Brisbane psychiatrist and economist Dr Andrew Amos was published in the Australia New Zealand Journal of Psychiatry. The abstract states:

Results: Eleven articles were included in the review. The more rigorous research (two randomized control trials and two quasi-experimental studies) suggested no difference in resource utilization or costs between early-intervention and treatment-as-usual groups. One small case-control study [co-authored by McGorry] with evidence of significant bias concluded annual early-intervention costs were one-third of treatment-as-usual costs. Conclusion: The published literature does not support the contention that early intervention for psychosis reduces costs or achieves cost-effectiveness. Past failed attempts to reduce health costs by reducing hospitalization, and increased outpatient costs in early-intervention programmes suggest such programmes may increase costs.[106]

Note: To read more about the reasons for my concerns with EPYS, refer to Time Magazine 2006 - Drugs before Diagnosis and The Australian and New Zealand Journal of Psychiatry 2012 - 'Prodromal' diagnosis of psychosis: Ethical problems in research and clinical practice and the PsychWatch Australia pages Guruisation of Australian Mental Health Policy and Orygen Prepsychosis Training Flawed.

Issue 4 - ADHD its diagnosis, aetiology, prevalence, drug abuse and the role of schools.

The behavioural diagnostic criteria outlined in DSM-5 are the sole basis for a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). Every claim about ADHD must be viewed in that light.

Extract from the Diagnostic and Statistical Manual of Mental Disorders 5th Edition DSM- 5 ADHD Diagnostic Criteria.[107]

To meet the DSM5 diagnostic criteria a child should display either:

- six of the behavioural criteria below at 1 (Predominantly Inattentive Subtype - sometimes referred to as passive ADHD or ADD)
- six of the behavioural criteria below at 2 (Predominantly Hyperactive/Impulsive Subtype)
- or six of both 1 and 2 (Combined Subtype)

for at least six months to an extent that is inconsistent with their age and significantly impairs their social and academic functioning. For adolescents 17+ and adults five are sufficient.

1. Inattention

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

2. Hyperactivity and 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
d) often unable to play or engage 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)

DSM5 also recognizes two additional categories of ADHD where children “do not meet the full criteria for ADHD”.

- Other Specified ADHD – when clinician “chooses to communicate the specific reason that the presentation does not meet the criteria for ADHD”.
- Unspecified ADHD – when the clinician “chooses not to communicate the specific reason that the presentation does not -meet” these criteria.

These criteria fall way short of what constitutes a valid, science based, psychiatric diagnosis. The idea that reports of children behaving like children - playing, climbing, running, talking, not waiting their turn, interrupting and avoiding homework etc. - is evidence of a psychiatric disorder caused by neurodevelopmental factors is just absurd. It is even more absurd that the first line treatment for this 'disorder' is to give children - sometimes even toddlers - a daily amphetamine habit. But this precisely what we do to vast numbers of Australian children and regrettably the *Draft Report* will only encourage further damage from indiscriminate prescribing.

130,000+ Aussie kids will take drugs for ADHD in 2019

In 2009, according to the Australian Government data 60,931 children were dispensed at least one prescription of an ADHD medication (primarily amphetamines).[108] In 2017 the latest year for which age specific data is available this number had risen to 107,345.[109] Since then (from January 2018 until September 2019) the total number of Australian PBS subsidised prescriptions has risen at 11% per annum.[110] Based on this rate of growth, it is estimated that more than 130,000 Australian children were dispensed an ADHD medication in 2019. In summary, from 2009 until 2019, the percentage of Australian children aged 4-17 years dispensed ADHD drugs has grown from 1.6% to an estimated 3.0%.

The massive explosion in prescribing rates in Australia, and across the globe, is evidence of the incredible marketing skills of the ADHD Industry. This marketing triumph has been so complete that my view - i.e. annoying, disruptive childhood behaviours are not evidence of a disease, and that amphetamines are bad for developing brains and bodies - is now a radical position.

It is important to understand that arguing that ADHD is a fraud, is different from claiming that all children diagnosed with ADHD are well. Some clearly do have problems and need support that matches their individual circumstances. Many non-biological factors have been associated with higher rates of ADHD diagnosis and medication use. These include gender, ethnicity of students and teachers[111], divorce[112], poverty[113], parenting styles[114], low maternal education, lone parenthood and the receipt of social welfare[115], sexual abuse[116], sleep deprivation[117], perinatal issues[118], artificial food additives[119], mobile phone use[120], clinician speciality[121], postcode and regulatory capture[122]. Children with behavioural problems need to have the causes of their individual circumstances identified and responded to. They do not need a daily amphetamine habit.

The attraction of amphetamines is that, while responses vary between individuals, there is no doubt that in most cases low dose psychostimulants narrow focus, and make disruptive children more compliant and easier to manage. This occurs in most people regardless of whether they are diagnosed ADHD or not.[123]

These immediate behavioural changes are often welcomed by parents, teachers, and in some cases other students who benefit from not having to put up with annoying behaviour. The losers in this process are the 'medicated children', especially those with real problems that, because they are covered over with drugs, are never identified and addressed. Too often ADHD drugs mask the signs of serious problems such as sexual, emotional or physical abuse, bullying or trauma.[124] Some children are doubly abused when the original abuse is compounded by the harmful administration of amphetamines. It's obvious that children who have been sexually or physically abused are highly likely to be inattentive and behave inappropriately. These blameless, voiceless, victims deserve the very best of care. Instead children who have been bashed or raped are told their brain is broken and the get a daily drug habit.

Many of the criticisms of the disorder (lack of objective diagnostic tests, diagnostic creep, overselling of the benefits of medications) apply to other psychiatric disorders. It is the medicalisation of normal

(if annoying) childhood behaviours that sets ADHD apart. The symptoms of severe depression, schizophrenia and bipolar disorder are extreme behaviours, but even many ADHD proponents acknowledge there is nothing unusual about children fidgeting, running, playing loudly and disliking homework.

ADHD Birthday Lottery - The clearest evidence of how irredeemably flawed the ADHD label is (and how poorly schools cope with relative age related immaturity) comes from research by eight international authors that I led. We used data for over 15 million children in 13 countries that demonstrated that across the globe the youngest children in a classroom are much more likely than their oldest classmates (up to a year older) to be 'medicated' for ADHD.[125] In effect, perfectly normal age related immaturity among relatively young children is being treated as if it is a brain disorder. This ADHD late birthdate effect occurs in countries with high prescribing rates, like the USA and Canada, and low prescribing rates like Finland and Sweden. Our global research built on our earlier award winning[126] research I led that showed the youngest children in a Western Australian primary school classrooms (born in June) are about twice as likely to be given ADHD drugs as their oldest classmates born the previous July.[127] (Copies of these two studies are sent as separate attachments)

Not surprisingly, in our Western Australian study and in most of the international studies we later examined, the effect was stronger in the early years of school, when as a proportion of time lived, the age difference between the youngest and oldest in class was greatest. Since our global study was first published in October 2018 multiple other studies have found the same effect.[128] [129]

Prior to the publication of our global analysis Professor Allen Frances, cited studies from the USA[130], Canada[131], and Iceland[132], as providing conclusive proof ADHD is over-diagnosed.[133] Professor Frances has repeatedly been critical of US prescribing rates and has argued that a diagnostic rate of around 2% to 3% would best balance harms and benefits.[134] However, the data from the large Swedish[135], Finnish[136], Taiwanese[137] and Western Australian[138] studies, and a much smaller Spanish[139] study, all showed strong late birthdate effects at rates of prescribing below Frances' estimated ideal target range. The fact that this happens in both high and low prescribing jurisdictions does not support Professor Frances' assertion that there is an ideal target range. Instead this indicates that misdiagnosis is an inevitable consequence of ADHD's extremely vague and broad diagnostic criteria, and that there is no safe level of diagnosis and prescribing.

Lack of long term evidence on safety and efficacy of ADHD 'medications' - If asked for proof of the medications' effectiveness, 'experts' will often respond that there are thousands of scientific papers that support their claims. When asked which one of these scientific papers has robust methodology, they cannot identify a single long-term research paper that withstands scrutiny. Compelling evidence for 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 US states in order to determine which drugs were the safest and most cost effective.[140] The 731-page review analysed 2287 studies, *"virtually every investigation ever done on ADHD drugs anywhere in the world"*.[141] Of the studies analysed, *"The group rejected 2,107 investigations as being unreliable, and reviewed the remaining 180 to find superior drugs"*.[142] Instead of being able to make objective comparisons of the safety and effectiveness of the different drugs, the review was "*severely limited*" by a lack of studies measuring *"functional or long-term outcomes"*.[143]

The review concluded that *"evidence on the effectiveness of pharmacotherapy for ADHD in young children is seriously lacking"*[144] and that there was *"no evidence on long-term safety of drugs used to treat ADHD in adolescents"*[145]. The review also found that *"good quality evidence on the use of drugs to affect outcomes relating to global academic performance, consequences of risky behaviours, social achievements, etc. is lacking"*.[146] It was also critical of the lack of research into the possibility that some ADHD drugs could stunt growth and found that the evidence that ADHD drugs help adults was *"not compelling"*.[147] Overall, the review ascertained that the body of evidence was of *"poor quality"*.

Predictably these findings were either ignored, or dismissed with the ADHD Industry mantra that the benefits of drugs *"clearly outweigh the risks".*[148]

Little has changed in the fifteen years since the *Oregon Health and Science University ADHD Drug Effectiveness Review* was published. Despite this paucity of evidence on the long term effects of psycho-stimulants on children, parents are commonly reassured that stimulants have been used to control ADHD-like behaviour since the 1930s. This begs the obvious question: why haven't the pharmaceutical companies set up credible long-term analysis of the effects of their products? The answer is even more obvious, why kill the goose that lays the golden eggs.

Stimulants invariably appear more effective than non-drug treatments in short-term trials for two reasons. First, low dose amphetamines alter behaviour much faster than non-drug treatments, and improvement is usually measured by short-term symptom management, with drug trials often lasting for no longer than a few weeks. In addition, while the behaviour-altering effects of low dose psychostimulants are almost universal - narrowing focus in most people regardless of their 'ADHD status'- the effects of other forms of treatment are not. Diet modification, for example, may be of little or no benefit if the underlying cause of behavioural problems is severe family dysfunction.

The thousands of short-term studies confirming the behavior altering effects of stimulants are in that sense valid. However, the many claims of new research purporting to prove biological differences, have all been shown to be false, or gross exaggerations of differences applying to only a small subset of children labelled ADHD. Many of these studies claimed to show differences between ADHD and non-ADHD brains, compared ADHD brains that had never been medicated, to ADHD brains that had been exposed to psychostimulants that have been shown to cause brain atrophy and retard growth.[149]

ADHD and Drug Abuse - A common focus for ADHD Industry research is to show that left undiagnosed and untreated ADHD causes horrific life outcomes. Even criminality and drug abuse are attributed to undiagnosed, and therefore un-medicated, ADHD.[150]

The effect of this association with extreme dysfunctional behaviour is to create a sense of crisis that extreme consequences will result from ADHD going untreated - which really means un-medicated. Criminal and drug-taking behaviour are in themselves dysfunctional and most often impulsive acts. How many drug addicts aren't forgetful, distracted or disorganised? It is self-evident that many criminals and drug addicts tend to demonstrate ADHD behaviours and certainly live dysfunctional lives, therefore qualifying for a diagnosis of adult ADHD. Yet to argue that ADHD, when left un-medicated, causes criminal behaviour or drug abuse is to confuse cause and effect. It involves identifying dysfunction in what is already identified as a dysfunctional population. This is the equivalent of being able to bet on a horse after the race has finished.

The claims the ADHD Industry makes about treating the disorder and drug use are particularly absurd. Fundamentally they argue that unless we give children with challenging behaviours a daily amphetamine habit they will go onto become drug addicts. All ADHD stimulants are addictive and carry similar warnings for abuse to that for Dexedrine a brand of dexamphetamine.[151]

Extract from Prescribing Information for Dexedrine

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 CARDIO-VASCULAR ADVERSE EVENTS.

Even the American Psychiatric Association recognise that amphetamines, methylphenidate and cocaine are "*neuro-pharmacologically alike*".[152] The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* recognises the abuse and addiction of these drugs in a common class of 'Amphetamine or Amphetamine-Like – Related Disorders'. It states: "*Prescribed stimulants have sometimes been diverted into the illegal market…Most of the effects of amphetamines and amphetamine-like drugs are similar to those of cocaine*".[153] Furthermore, the diagnostic criteria for *"Amphetamine Intoxication"* include "*recent use of amphetamine or a related substance (e.g. methylphenidate)*" and many of their potential side effects such as "*impaired social or occupational functioning, tachycardia, elevated blood pressure, nausea or vomiting, weight loss dyskinesias and dystonia*".[154]

Western Australia's Unique ADHD History - Western Australia (WA) has a unique history as the world's first ADHD hotspot to see a massive decrease in ADHD child prescribing rates (50% drop between 2002 and 2008).[155] However, over the last decade there has been a significant rebound. So it is a history in three parts: a period of rapidly rising prescribing rates, followed by a massive decline, and then a strong rebound.

The Rise 1993-2002: Throughout the 1990s the proportion of children and adolescents (aged 0 to 17) prescribed ATS grew more rapidly in WA than elsewhere in Australia. By 2000 prescribing rates were approximately 2.8 times the average of other Australian states and were among the highest in the world. They grew a further 15% between 2000 and 2002.156

The Fall 2003-10: Following significant regulatory reforms prescribing rates for 0 to 17 year olds declined and by 2010 were approximately halved.[157] [158] During this period child and adolescent prescribing rates rose rapidly in all other states. By 2011 WA rates were approximately 11% below the national average.

The Rebound 2011 onwards: There was a rebound from 1.05% (in 2010) to 1.62% in 2017. Most of the growth occurred between 2014 and 2017, when there was a jump from 6,971 to 9,587 (a 37.5% rise) in the number of 0 o 17 year olds receiving prescribed ATS despite the WA population only increasing by 4%.[159]

Throughout the 1990's and early 2000's in Western Australia there was considerable anecdotal reporting of the diversion of ADHD amphetamines amongst WA teenagers and young adults. When data became available through the *Australian Secondary Students' Alcohol and Drug Survey (*ASSAD) these suspicions were confirmed. ASSAD surveys indicated a reduction in 'last 12 month amphetamine abuse' by 12-17 year-olds from 10.3% in 2002 to 5.1% in 2008.[160] This 51% reduction in self-reported abuse occurred over a similar time period as the 50% fall in ADHD child stimulant prescribing rates.

Even though prescription rates had begun to drop by 2005, the ASSAD survey estimated that 9,492 (5.5%) of Western Australia's secondary school students had abused prescription ADHD amphetamines in the last year. The same survey found that amongst 12-17 year-olds, 84% of those who had abused amphetamines in the last year had abused diverted stimulants, and that 27% of those who had been prescribed stimulant medication either gave it away or sold it. It also showed that 45% of Western Australian high school students who had ever taken dexamphetamine or methylphenidate were not prescribed the drugs by a doctor.[161]

Despite the clear evidence of significant abuse of prescription amphetamines in the 2005 ASSAD survey, it wasn't until 2017 that secondary school students were surveyed again. Even then it was only about dexamphetamine abuse, and only in WA. The 2017 ASSAD surveyed 3,361 WA secondary students about their non-medical use of dexamphetamine - 3% reported non-medical use in the last 12 months.[162] In comparison, approximately 1.2% were prescribed dexamphetamine. This indicates

that for every WA secondary school student prescribed dexamphetamine approximately 2.5 used it non-medically.

The 3% figure does not include those students who had non-medically used Ritalin or other brands of methylphenidate. In 2017 dexamphetamine was only prescribed to about 40% of WA children who took an ADHD drug.[163] It is therefore likely that the rate of last 12-month non-medical use of all forms of prescribed ADHD drugs was much higher than 3%. It is clear that Claire Murray was not an isolated case. Over the last twenty years unknown tens of thousands of WA adolescents have abused prescription ADHD amphetamines.

WA adults have long been prescribed ADHD stimulants at many times the rates of adults in other states. In 2002 they were prescribed PBS dexamphetamine (until 2005 the only PBS-subsidised ATS) at over seven times the rate of other Australian adults.[164] By 2008, all stimulant medications were PBS-sponsored and there was a narrowing of the gap. However, in 2017 WA adults were still over 2.6 times more likely than other Australian adults to receive PBS-subsidised Amphetamine Type Stimulant for ADHD.[165] WA has also consistently reported high rates of meth/amphetamine use compared to other Australian states and there is evidence from multiple sources that indicates dexamphetamine abuse is a significant part of WA's amphetamine abuse culture.

Far from supporting the ADHD Industry assertion that medication use prevents illicit drug abuse by self-medicating untreated ADHD sufferers, the WA experience is that there is a positive correlation between amphetamine abuse rates and the legal prescribing rates for amphetamines for the treatment of ADHD. This supports the common sense proposition that prescribing amphetamines facilitates the abuse of amphetamines. Nonetheless, ADHD proponents continue to push children towards ADHD amphetamines using the rationale that in doing so they prevent future drug abuse.

The Emperor's New Disorder - Proponents of ADHD deserve ridicule for this and so many of their other absurd claims. Ultimately they are arguing that losing your toys, playing too loudly, interrupting etc. are evidence of a biochemical brain imbalance, and that amphetamines are good for children and prevent drug abuse. It is nonsense propped up by lies and faulty analysis.

In summary, the lies told about ADHD and the effects of ADHD 'medications' combine to produce a self-fulfilling prophecy of failure, dysfunction and drug abuse. The addictive properties of amphetamines, and the likely long term adverse effects of 'medications', combined with the short term cycle of temporary compliant behaviour and withdrawal symptoms, are all mistakenly attributed to the 'patient's' ADHD rather than the label and the drugs. This reinforces the ongoing need for the same label and drugs that have created, or at best exacerbated, existing problems.

ENDNOTES

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