



youth affairs network qld

USE OF PSYCHOTROPIC DRUGS ON CHILDREN IN STATE CARE

2012

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Youth Affairs Network of Queensland

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INTRODUCTION

The Youth Affairs Network of Queensland Inc (YANQ) is one of many groups, practitioners, politicians parents and individuals concerned about the alleged increase in cases of 'attention deficit hyperactivity disorder' ('ADHD') amongst young people in Australia. Of current, particular concern is the growing percentage of children in the Queensland state care system that are being diagnosed with and treated for the 'disorder'. A wealth of medical and psycho-social evidence points to the deficits of the 'diagnostic criteria' presently used to diagnose 'ADHD' and the damaging side-effects of the stimulants prescribed to manage the 'disorder'. The state care system appears resistant to acknowledging the existence of such evidence and the associated need for a thorough review of departmental practices which may be endangering the health of many young Queenslanders.

We have been raising our concern with the State Government since 2002. The inaction of government over this time has seen a massive jump in the number of Queensland children who are being medicated. We hope that the current Commission of Inquiry will use all its powers to shed light on this issue and recommend appropriate protection from these very dangerous drugs.

OVERVIEW OF THE QUEENSLAND STATE CARE SYSTEM

The CCYPCG was established to “promote and protect the rights, interests and wellbeing of children and young people in Queensland, particularly those who: are in care or detention; have no one to act on their behalf; are not able to protect themselves, or are disadvantaged because of a disability, geographic isolation, homelessness or poverty”.¹ The Commission has a representative, administrative and protective function to uphold the standards and legal requirements set out in its enabling legislation, the *Commission for Children and Young People and Child Guardian Act 2000* (Qld).

The wellbeing of children under the state’s guardianship historically has a troubled past. The abuses that occurred during the last century orphanages, church and state run state homes, institutions, detention centres and goals have been well documented. The 1999 Commission of Inquiry into Abuse of Children in Queensland Institutions (‘the Forde Inquiry’), set out a number of key recommendations to target areas of the child protection system in long need of reform. The Inquiry’s Chairperson, Leneen Forde, then poignantly urged consideration for “how it came to pass that many of them (children in Queensland institutions) were abused and mistreated, and why it has taken so long for their stories to be told”.² It is pertinent to reflect here on evidence that practices, procedures and standards that were once deemed acceptable/tolerable in the past, in relation to the care of these children, were later found to be gross violations of human rights and offences to children’s vulnerability.

The Forde Inquiry uncovered shortcomings within the then ‘modern’ “legislative provisions for care and protection of children in institutions”.³ The continuing demand for legal reform in all areas of public life, at both a state and federal level, is evidence that decisions and standards once believed to be adequate and effective are not always enduring. History provides a multitude of examples of where the status quo has been proved to be dangerous and destructive, despite ‘good intentions’ at its outset. Consequently, it is hoped that the same reassessment will be applied in relation to ‘ADHD’s recognition in the community and specifically the Child Guardian’s allowance of continually high rates of the ‘disorder’s’ diagnosis and treatment through stimulant medication amongst children in state care.

¹ The Commission for Children and Young People and Child Guardian – *Our Role*, 2010:1

² *Commission of Inquiry into Abuse of Children in Queensland Institutions*, 1999: Foreword.

³ *Commission of Inquiry into Abuse of Children in Queensland Institutions*, 1999: x.

HISTORY OF 'ADHD'

The symptoms and 'diagnosis'

The American Psychiatric Association's Diagnostic and Statistical Manual IV (DSM) is borrowed from heavily in Australian medical practitioners' diagnoses and treatment of 'ADHD'. The alleged reliability of the disorder's identification in this authority rests on professionals' ability to subjectively match the broad categories of symptoms with the behaviour presented by the patient. 'Distractibility', 'impulsivity' and 'hyperactivity' are some of the disorder's alleged behavioural signifiers.⁴ The diagnosis cannot be confirmed or complemented by physical examination or the use of a diagnostic instrument as "there is nothing to look for".⁵ Dr Peter Breggi argues that "there are no objective diagnostic criteria for 'ADHD' – no physical symptoms, no neurological signs and no blood tests" and, despite contrary allegations, no biochemical imbalances.⁶ The prescription of powerful stimulants to young children and rapidly developing young people is the result of a process that entirely lacks objective validity.⁷ The American National Institutes of Health ADHD Consensus Panel concedes, "we do not have an independent valid test for ADHD, and there is no data to indicate that ADHD is due to brain malfunction".⁸

Following a 'diagnosis' of ADHD, many medical practitioners then order pharmacological treatment – most often in the form of stimulant prescriptions. Methylphenidate, commonly referred to as Ritalin, and dexamphetamine are some of the most commonly prescribed drugs. There is research to indicate strong similarities between pharmacological and behavioural effects of these drugs and cocaine with long term use resulting in brain damage to cell structure and function⁹ (CMC, 2002: 2). The prescribed medication and its illicit counterpart produce similar immediate, long term and withdrawal effects.¹⁰ Ritalin and other amphetamines are 'Schedule II Drugs' in the United States and both 'special condition drugs'¹¹ and 'dangerous drugs'¹² in Australia, classifications indicating significant risk of abuse.¹³ Whilst such psycho-stimulant medication appears to be readily prescribed by health practitioners, there is a comparative barrier to accessing appropriate alternative health services and treatment options.¹⁴

Current trends in 'ADHD' medication

Recent studies suggest that stimulant medication is being more frequently used to treat young people, children and young children throughout Australia diagnosed with 'ADHD'. Between 2002 and 2009, "ADHD' targeted stimulants" prescription rates increased by 87%.¹⁵ Methylphenidate, which has previously been the second most frequently prescribed stimulant after dexamphetamine, had prescription rates which increased alarmingly by 300% in the study period – a rate which was attributed to the drug's inclusion in the Pharmaceutical Benefits Scheme.¹⁶

Hollingworth, Nissen, Stathis, Siskind, Varghese and Scott's study,¹⁷ described as "the most comprehensive report to date of Australian national trends of stimulant dispensing", additionally highlighted the disparities in stimulant use between the genders with 'ADHD'. Records show 'ADHD' diagnoses are 2.45 times higher in

4 Jaksa 1998, cited in Queensland Crime and Misconduct Commission, *The Illicit Market for ADHD Prescription Drugs in Queensland*, 2002:2.

5 Jacobs, *Queensland Children at Risk*, 2002: 12.

6 Breggin, Peter (1998), cited in above no. 4.

7 Joe Kosterich (Federal Chairman of the General Practitioners branch of the Australian Medical Association) (2002), cited in Jacobs, *Queensland Children at Risk*, 2002: 12.

8 John Breeding and Fred Baughman Jnr, *Informed Consent and the Psychiatric Drugging of Children*, 2003:61.

9 Above no. 4, 2.

10 Ibid.

11 Section 78, *Health (Drugs and Poisons) Regulation 1996* (Qld).

12 Schedules 2 and 5, *Drugs Misuse Regulation 1987* (Qld).

13 Above no. 8.

14 Luke Buckmaster, *Medication for Attention Deficit/Hyperactivity Disorder (ADHD): An Analysis by Federal Electorate (200103)* Social Policy Section APH, 2004: 7-8.

15 Samantha Hollingworth, Lisa Nissen, Stephen Stathis, Dan Siskind, John Varghese, and James Scott, *Australian National Trends in Stimulant Dispensing: 2002 – 2009*, 2010: 4.

16 Ibid.

17 Ibid.

males than females.¹⁸ Whereas, stimulant use is *five times greater* in males than females.¹⁹ Over-prescription, illegal prescription and illicit use are all potential contributors to this diagnosis-prescription disparity.

This recent report indicated that treatment of the 'disorder' through pharmacological means should only occur in relation to patients with more serious symptoms or cases where 'psychosocial intervention' has failed.²⁰ Hollingsworth et al similarly recommended that patients and carers are provided with treatment options that involve both. It was similarly recommended that practitioners provide patients and carers with both pharmacological and non-pharmacological options for the management of 'ADHD', tailored to the specific needs and situation of each patient.²¹ The need for non-pharmacological treatment options for the patient in addition to their carers and/or family has been highlighted by both medical practitioners and social therapists.²²

18 Ibid, 2

19 Ibid.

20 Ibid.

21 Ibid.

22 Dr James Scott, *Medications for children in care with emotional and behavioural problems*, 2010:24.

CURRENT TRENDS IN 'ADHD' DIAGNOSIS AND PHARMACOLOGICAL TREATMENT IN THE QUEENSLAND STATE CARE SYSTEM

For the past several years the CCYPCG has conducted a state wide survey in relation to the wellbeing of children and young people in the Queensland foster care system. The *Views of Young People in Foster/Residential Care* survey results show rates of 'ADHD' diagnosis and associated stimulant use at levels significantly higher than the state average. In 2009, one in four of the respondents identified as having a disability; of these 12% labelled their disability as 'ADHD' or 'attention deficit disorder', whilst 21% of all young people reported taking medication for 'ADHD'.²³

In 2010, 18% of young people, 17% of children and 23% of young children in foster care identified as having a disability.²⁴ Of these, 16.4% of young people and 15.2% of children were being medicated for 'ADHD'.²⁵ These statistics indicate a significant disparity between medication levels of children in care and the 6.7% of those medicated in the general population.²⁶

The 2010 results worryingly indicate that of the medicated group of children, 30% are under the age of six.²⁷ This evidence contradicts strong recommendations by the Royal Australasian College of Physicians that pharmacological treatment of the alleged 'disorder' is not appropriate for children under the age of six.²⁸ The recommendation confirms the need for caution in the prescription of stimulant medication amongst moderate 'ADHD' supporters.

The following information and statistics are from reports by the Queensland Commission for Children and Young People and Child Guardian:

Age	2006 ²⁹	2007 ³⁰	2008 ³¹	2009 ³²
Young children (0-4 years)	6% (RC/FC)	6% (FC)	n/a	7% (FC)
Children (5-8 years)	14% (RC/FC)	18% (FC)	n/a	15.2% (FC)
Young people Foster Care (9-18 years)	16% (RC/FC)	17% (FC)	n/a	16.4% (FC)
Young people Residential Care (9-18 years)	16% (RC/FC)	n/a	21.3% (RC)	n/a

% take medication for ADHD—young children, children and young people

RC = Residential Care FC = Foster Care

The 2009 figure in the table above shows that 16.4% of young people and 15.2% of children reported taking medication for ADHD. These figures remain largely consistent with those of previous years and are

23 Commission for Children and Young People and Child Guardian, *Views of Young People in Residential Care Queensland*, 2009: ix.

24 Commission for Children and Young People and Child Guardian, *Views of Young People in Foster Care Queensland*, 2010: 18.

25 Ibid.

26 Ibid.

27 Ibid.

28 Ibid, 19.

29 Commission for Children and Young People and Child Guardian. 2006. *Child Guardian : Views of Children and Young People in Care : Queensland 2006*. Brisbane, Australia.

30 Commission for Children and Young People and Child Guardian. 2008. *Child Guardian : Views of Children and Young People in Foster Care : Queensland 2008*. Brisbane, Australia.

31 Commission for Children and Young People and Child Guardian. 2008. *Child Guardian : Views of Children and Young People in Residential Care : Queensland 2008*. Brisbane, Australia.

32 Commission for Children and Young People and Child Guardian. 2010. *Views of Children and Young People in Residential Care : Queensland 2010*. Brisbane, Australia.

well above the rate of 6.7% for the general population of children and young people in Australia (Royal Australasian College of Physicians, 2009). Of particular note is that medication rates of young children have risen over the same period from 6% to 7%.

In relation to the 2009 figures, two-thirds of respondents who reported taking ADHD medication specified the type(s) of medication they were taking. Less than half (39%) reported taking medications currently licensed for the treatment of ADHD: 21% indicated taking methylphenidate (for example, Ritalin) and 18% dextroamphetamine (for example, Dexedrine). Fifty-four per cent indicated taking antipsychotic preparations (such as Risperidone) for ADHD, 25% said they were taking antidepressants and 11% said they were taking clonidine (Catapres).

The most commonly prescribed medications are methylphenidates such as Ritalin and Concerta and dextroamphetamines, including Dexedrine and Vyvanse, Antipsychotic medications such as Risperdal and Zyprexa are also noted, as are antidepressants, including Prozac, Zoloft and Paxil. In a number of cases, more than one medication is prescribed.

Of the carers, 7.0% reported that the child in their care is currently taking ADHD medication. While this is similar to the rate for the general Australian population, further analyses of survey data reveal that round **30% of these children are less than 6 years of age.**

Given the prevalence of attention and conduct disorders among children and young people in care, it is not surprising that they are frequently diagnosed as having attention deficit hyperactivity disorder (ADHD). Children exposed to domestic violence, child abuse or other trauma can indeed develop behaviours symptomatic of ADHD (Royal Australasian College of Physicians, 2009) and an emerging body of research points to ADHD medication being prescribed to those in statutory care at rates well above those in the general community (CCYPCG, 2006, 2008, and 2010; Simmel, Brookes, Bath & Hinshaw, 2001).

However, as the latest guidelines from the Royal Australasian College of Physicians (2009) caution, ADHD medication should only be prescribed after a comprehensive medical, developmental and psychosocial assessment, preferably by a suitably trained paediatrician or child and adolescent psychiatrist, *and only to those aged 6 years and older.*

THE FUTURE

This report provides an overview of 'ADHDs' prevalence and treatment amongst children and young people in the Queensland state care system. It is one of many publications calling for an end to and an independent objective review of the dangerously high rates of stimulant prescriptions, amounting to well over double those of the general population,³³ being given to this group in order to treat a 'disorder' that is lacking in scientific validation in a manner that is often legally unauthorised and ethically irresponsible.

We urge the Commission to use all its powers to ensure that lack of investment in appropriate therapies for traumatised children and young people in the Child Safety system does not result in the continuation of abuse against children and young people under the guardianship of the state.

³³ Above no. 23.