

Response to The Global Market For ADHD Medications
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Scheffler and colleagues focus on the global use and cost of ADHD drugs; their paper raises a profound question of perception about the nature of ADHD.

If their recommendation "to adjust overuse or underuse" based on careful consideration of "potential benefits versus potential liabilities" is to be a balanced assessment, then setting diagnostic criteria based on the DSM -- the U.S. standard -- raises questions about the validity of that instrument in clinical use.

The standard of "diagnostic prevalence" (cases actually diagnosed by clinicians) varies both according to country and according to the training of clinicians. Pediatricians, child psychiatrists, and general physicians differ in their judgment of causes of childhood symptoms of ADHD. Some reify the symptoms as a "disease entity," which it is not. Others insist that the symptoms should first be assessed for "causes" before starting to medicate.

"Cultural differences" among countries should include the medical diagnostic culture as well. In this case, the claim that the rest of the world was found to "lag well behind" the true prevalence could be interpreted as the U.S. overusing the medication option.

Response to The Global Market For ADHD Medications
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In response to the letter (Dr. George Halasz, 21 March 2007) that was commenting on our article "The Global Market for ADHD Medications," several points are salient. First, it has been known for some years that a number of other nations have rates of ADHD diagnoses that are similar to those in the U.S. -- e.g., Taiwan, Australia, Sweden, India, Germany, Japan, and New Zealand (ADHD Report 6:1-6, 4/98, J Am Ac Ch and Adol Psychiatry 40:1410-1417, 2001, J Child Psychol Psychiatry 42: 487-492, 2001, J Formos Med Assoc 92:133-138, 1993). Second, recent data suggest that when similar parallel diagnostic criteria are used to evaluate patients in North America, Europe, Africa, and Australia, the severity of ADHD symptoms is actually worse in the non- North American group. (Eur Ch Adol Psychiatry 15:177-181, 2006).

Third, there are problems associated with the failure to receive an accurate diagnosis. A Norwegian study found that among adults with diagnosable ADHD, many had received some form of psychiatric services as youth but failed to receive an ADHD diagnosis. Their rates of impairment and comorbidity here high (Nord J Psychiatry 60: 38-43). Fourth, in the U.S., ADHD in adolescence and adulthood, ascertained via DSM criteria, yields high rates of school failure, relationship problems and divorce, substance use disorders, criminality, and psychiatric comorbidity. (J Am Ac Ch Adol Psychiatry 36:1222-1227, 1997, J Am Ac Ch Adol Psychiatry 23:261-269, 1984, J Am Ac Ch Adol Psychiatry 45:192-202, 2/06; Journal of Consulting and Clinical Psychology, 74, 489-499).

Overall, ADHD is not a benign condition, and rates of diagnosis and impairment appear similar in and outside North America.