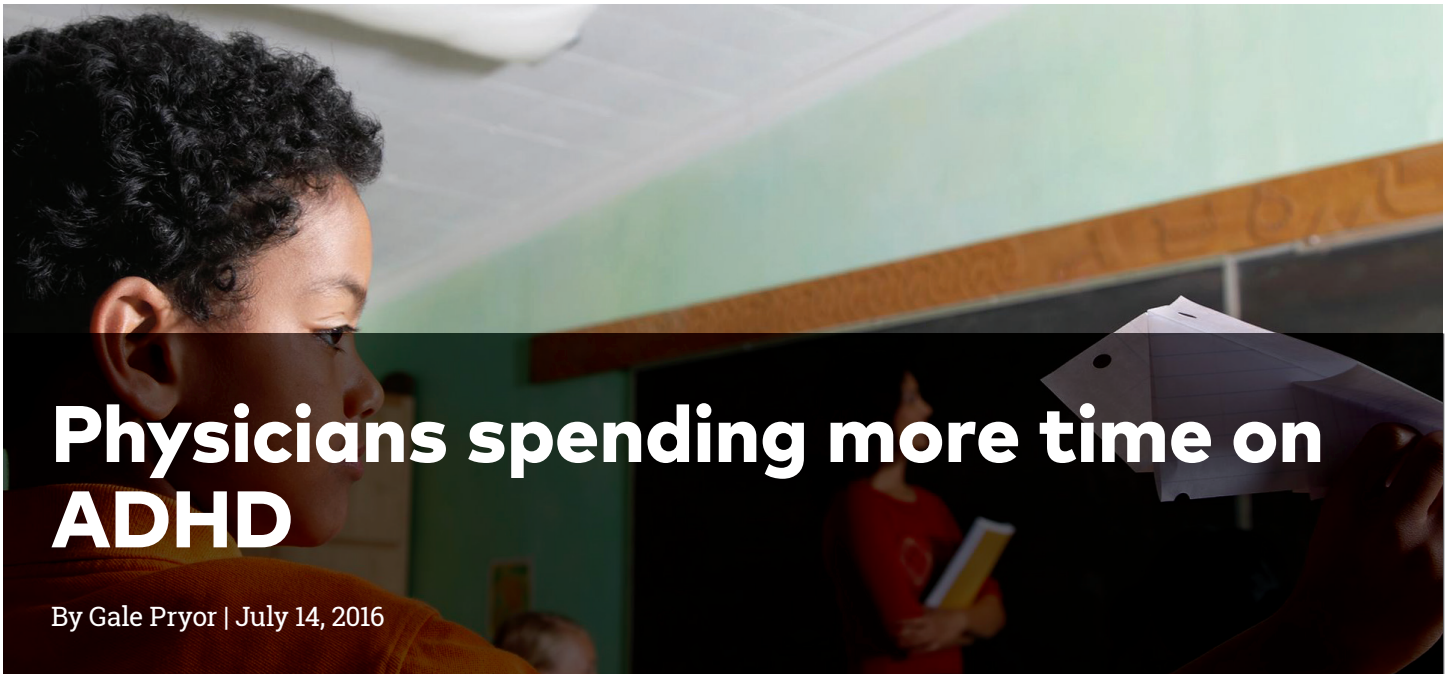
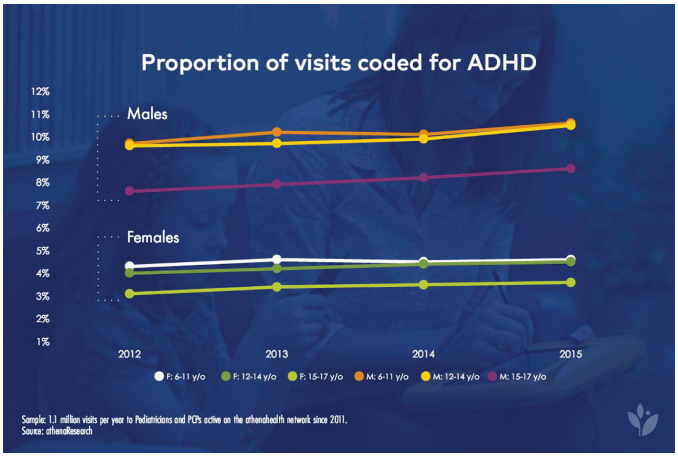


Physicians spending more time on ADHD

By Gale Pryor | July 14, 2016

In the past four years, doctors have been spending more and more time treating children — especially boys — with ADHD. That's the conclusion of a study of visits to primary care providers on athenahealth's national network.

Researchers examined claim codes in 1.1 million visits per year over a four year period, and found that the numbers are especially striking when broken down by gender and age: ADHD treatment accounts for more than 10 percent of visits with 6-to-14-year-old boys.



These figures, though consistent with CDC data, don't measure the rates of ADHD in the population at large. Instead, they show how much time doctors are spending diagnosing, managing, and monitoring the condition. So the data could indicate an influx of new ADHD patients, an increase in care for the same number of children, or some combination of the two.

athenaInsight asked some experts for their theories and reactions. Here are their thoughts, edited and condensed:

Thomas Mohr, M.D.

Chair of the Department of Pediatrics at Southwest Healthcare Hospitals and CEO of Pediatric Partners, in San Diego, California

Previously, if a child was on medication and stable, his pediatrician may have seen him every six months. New federal standards set in 2012, however, require three visits in every ten months for kids on ADHD medication. That guideline alone increases ADHD visits by one to two visits per patient per year — and it fits the timeframe of the data and the uptick it shows.

A blend of factors, however, could contribute to the increase in these visits. New, long-acting drugs

can be taken with in a single daily dose at home, with less stigma and better compliance. So there is an increased willingness among pediatricians to prescribe them, leading to more visits.

Physicians may also be spending more time on ADHD visits due to the changing nature of education. Children now spend more time on repetitive tasks with bigger class sizes — both especially challenging for kids with ADHD. If kids are borderline and may not have needed medication in the past, they may be pushed to the point of needing now. Medicaid and CHIP expansion could also be a factor. With better access to more providers, kids with untreated ADHD are now coming in for care. It all adds up to the spike in time spent treating ADHD.

George DuPaul, Ph.D.

Professor of School Psychology, Lehigh University, Pennsylvania

ADHD is a complex phenomenon. It is a highly heritable disorder: Twin studies and other studies suggest as high as 80 percent in the heritability index. It is a disorder that lies at the interface between biology and environment: The environment can worsen or dampen the severity of the symptoms. And the environment has become more demanding.

Kids with symptoms of ADHD struggle with standardized testing, with waiting their turn, taking their time. So there is a push by schools to address their issues either within the school setting or by encouraging families to seek outside help. Districts with lower socioeconomic populations are especially stressed by high-stakes testing and may be pressing even more for any disability a child may have to be addressed.

There is good evidence to suggest that the symptomatic behaviors of ADHD occur on a [spectrum]. Most people display occasional attention problems or impulsivity, while some people at the tail of the distribution in the positive direction are highly focused and very reflective at all times. The other tail is those individuals who are highly likely to be inattentive, impulsive and hyperactive.

And so we make a decision that at some point — let's say, two standard deviations above the mean — that everybody who is at that point or above has ADHD. And everybody who is below that cut point doesn't. It is a somewhat arbitrary decision. What this data indicates is that we are capturing more people to the right of that mean, especially as their environment changes.

Claudia Gold, M.D.

Pediatrician, author of The Silenced Child: From Labels, Medications, and Quick-fix Solutions to Listening, Growth, and Life-long Resilience

What we call ADHD is not a known biological entity in the way, for example, diabetes is. It is a collection of behaviors that represent difficulties with regulation of emotion, behavior and attention. Children develop these capacities in the setting of caregiving relationships. While a child might have a genetic vulnerability to inattention and hyperactivity, the environment he grows up in has a significant impact on the way that vulnerability is expressed.

Yet pediatricians' daily schedules do not allow sufficient time to listen for the story of the father who lost his job and is now severely depressed, the mother with her own history of abuse who lashes out and hits her child, the marital conflict, and other stressors all too common in the lives of families. Instead, behavioral concerns are addressed through ADHD management. When we diagnose a child based on their behavior — or "symptoms" — and then eliminate those behaviors with medication — or "management"— the child's communication is silenced and these stories become buried.

These unheard stories may continue to exert their harmful effects, likely accounting for the poor long-term outcome of ADHD, with emergence of comorbidities. The Adverse Childhood Experiences Study offers ample evidence that these experiences account for a range of negative long-term outcomes in both mental and physical health.

Children who exhibit these behaviors, and their families, definitely need help. But the ever-increasing trend to apply ADHD treatment protocols

to them leads us to place the problem in the child without opportunity to address the full historical and relational context of their behavior.

What's your theory about the uptick in ADHD treatment? Join the conversation in the comments or on Twitter @athena_insight.

Gale Pryor is a staff writer for athenaInsight