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ADHD Meets Public Policy

SCIENTIFIC VALIDITY OF ADHD AND ITS TREATMENT

Our presidential election is only days away. Forty eight million people in America are uninsured and healthcare costs are rising 2-3 times faster than our nation's GDP. Where will America's healthcare system be in 5 years? Welcome to ReachMD's monthly series, Focus on Public Health Policy. This month we explore the many questions facing healthcare today.

I am highly impressed to think of a diagnosis more controversial than pediatric ADHD. Everybody has an opinion on Ritalin. Our guest today reminds us that this ongoing dialogue doesn't really reflect the scientific validity of ADHD and its treatment, but rather gives us a window in to what happens when science is translated into public policy, rules, and even the law.

Welcome to our special segment on Healthcare Policy. I am Dr. Leslie Lundt, your host and with me today is Dr. Rick Mayes. Dr. Mayes is an associate professor of public policy at the University of Richmond Department of Political Science and a faculty research fellow at the Petris Center on Healthcare Markets and Consumer Welfare at the University of California at Berkley. His newest book is called Medicating Children, ADHD and Pediatric Health.

DR. LESLIE LUNDT:

Welcome to ReachMD, Rick.

DR. RICK MAYES:

Thank you. Happy to be here.

DR. LESLIE LUNDT:

How did you become interested in this topic?

DR. RICK MAYES:

Great question. I remember how I became interested very clearly even though it was like 10 years ago that it all began. I was teaching my first ever college class in the summer of 1998. I was just a Lowe graduate student and this was my first stint as an instructor and at the end of, I think it was either the second or the third day of class, 2 students approached to me at the end of my lesson after all the other students had left and these 2 students had already been noticeably active in class in a great way and they were already valuable contributors to our discussion. They were really sharp students. When they approached to me, they looked a little uncomfortable and they quickly handed me 2 separate letters from my dean, the dean of the college, which stated that they had a diagnosis of ADHD and

therefore they were entitled to a variety of academic accommodation like a separate room for them to take the midterm and final exam, extra time in both of those tests, etc. The exact details of the accommodation, the letter said to be hammered up between me and the students as long as we were both satisfied, for the relatively flexible in terms of how these accommodations were made, but I confess that in 1998, I had literally had never heard of ADHD. This was my first time also even been in charge of a class as a teacher and I remember trying not to look as confused as I felt and I had actually been an intern in the George Bush, Sr, White House and always why I mentioned that was that his administration that pushed for an ultimately achieved passage of a landmark disability policy in 1995, I was kind of <____> but I was completely clueless. Moreover, when I thought of disability, my first image back then was always something physical, wheelchair access, ramps, Braille on ATMs, etc. In addition, I was looking at to what initially seemed to be my better, may be not even by best students in my class and they were asking for special arrangements that would probably require me to write separate tests, make other separate arrangements, which would actually impinge on whatever I wanted to do. One more thing I worried, what would the other students say when they found out. Would they feel like ever being disadvantaged against, or I playing favors, and lastly all graduate students like all teachers were taught and drilled into them. In general, you trust most of your students but they always cultivate a certain healthy sense of skepticism about students' special requests. We are always told to announce in fact on the first day of class that there will be no special arrangements or accommodations except in extraordinary and pre-approved circumstances. So, all that just to say that my first initiation into how a medical diagnosis could have massive, and for me very personal significant legal and policy issues, I was totally unprepared and may be think well, this is one of those rare incidences, may be not as rare I understand now, but back then I thought how often does this kind of thing happen that the medical world completely eclipses, overlaps, and interconnects with policy and educational legal world in a way that affects me and that began to make me think why is that happening and to what extent is this appropriate and what is the history of these areas that otherwise people tend to think it as separate in the medical world and there is diagnosis, there is educational world and those do not overlap. What now as we all know more and more, they have huge amounts of overlap that have very serious consequences, but back then I thought I should look into this more. My initial desire to write to any of this, which is just like I could be less clueless.

DR. LESLIE LUNDT:

Now, you briefly mentioned your time in the George Bush, Sr, White House, but in your book you talk about the 3 seemingly minor policy changes in the 90s, which changes whole landscape. What were they?

DR. RICK MAYES:

<____> massive cases of unintended consequences. Back in the early 1990s, 3 really small policy changes happened that had nothing intrinsically or explicitly to do with ADHD at all but in the end had a huge effect on the diagnosis and the use of the drugs. In 1990, the Supreme Court modified the Supplemental Security Income Program to include for the first time, children diagnosed with ADHD. So, for children and adults who received monthly checks from the government to supplement their income, meaning they had a disability and their family was relatively poor enough to qualify. After 1990, for the first time, if your child had ADHD, they could receive Supplemental Security Income. One year later, in 1991, Congress adjusted the individuals with Disabilities Education Act to expressively include ADHD as a protected disability. This ties into the discussion we just had about special test, accommodation, study buddies, separate rooms, extra time on tests. After 1991, if you had ADHD, you work for the first time and entitled for all these special educational accommodations and finally the last one that actually is only now coming to light. In the early 1990s, Congress expanded dramatically, the number of children who qualify for Medicaid. In other words, they increased their income threshold, meaning a lot more people who were poor, where they were poorest as they had to be previously to qualify, now qualified for Medicaid. So whereas before these expansions, there were about 19 to 20% of all US children who could qualify for Medicaid, by the early 1990, more than 30% of American children could qualify for Medicaid and that had an enormous effect on the amount of psychotropics in general and specifically stimulants that were used in this country. The numbers are amazing between 1991 and 2001; Medicaid spending on psychotropic drugs, all of them went some less than half a billion dollars to 7 billion dollars by 2001 and specifically on stimulants for children. Over that same 10-year period, real inflation adjusted spending on stimulants increased 9 fold and the number of stimulant prescriptions increased 6 fold. In short, you had these 3 minor policy changes that were not specifically intended to have a huge effect of ADHD that when they all came together just were a massive spark for unprecedented increase in ADHD diagnoses and stimulant use.

DR. LESLIE LUNDT:

Rick, why has the use of other medicines like antidepressants and antipsychotics lag behind the stimulants in the pediatric population.

DR. RICK MAYES:

Good question. There are two basic reasons that explain this difference. The first one is that the newer atypical second generation antipsychotics did not really become available until the early to mid 1990s and they were not studied very much for use by children until after 1997 when major drug legislation was passed that provided a financial incentive for drug companies to do more research on pediatric psychopharmacology, and second, depression and bipolar disorder have traditionally been seen as adult disorders, not for kids. The prevailing wisdom until the last 10 years is that these were very, very, very rare to almost not existent in children. In the last 10 years that has changed significantly and now it is becoming more and more seen as something that children can have conversely, interesting to give you a comparison, if you look at where the big increase in ADHD diagnosis and stimulant prescriptions have been over the last 10 years, it has not been in children and adolescents. It has been in adults. That is where the real growth market for both of those has been. Why might that be? Well exact opposite reason. ADHD has traditionally been seen as a child and adolescent disorder and only in the last 10 years has ADHD been seen as something that adults can have. So, they provide good mirror images of one another.

DR. LESLIE LUNDT:

Do you see the pendulum swinging back at all?

DR. RICK MAYES:

That is a great question. I hope that I would have an answer for it when I started writing this book. It is a genuine frustration that I have that at the end of this book, I understand more of the complexities and the frustrations and the dilemmas and I think the audience might be aware of this as well. There is a growing backlash against the increase in bipolar diagnosis among children and adolescents and there is empirical evidence that the black box warnings on SSRI antidepressants have led to many physicians curtailing the use of these drugs among the pediatric patients. But I don't see anything quite like that with ADHD and stimulants. I would share with your audience on a personal level, the two ways in which I personally as a professor and someone who works in this field to see ADHD and stimulants as that these 2 realities more or less fight for my primary attention. I teach a class on mental healthcare and policy at my University, which kind of makes me the de facto mental health guy in our institution. I get lots of calls and e-mails and requests to talk with a struggling student or his/her parents or get out to participate in a forum discussion on college mental health issues, and on top of that my wife and I have for the last 6 years lived as dorm parents with 120 other guys in our college dorm. So, we have gotten both from the classroom and on a personal level, I have really gotten to know a lot of students really well and what is continually impressed upon me is how many students I need who after they know I am, the area I work in, and mental health is one I am interested in well after a while <____> reality for them is that they are at this college and our college is relatively competitive. They are at college primarily because of stimulants. It is not because they cannot do the work and the stimulants provides them everything to get the work done, but that in all honesty that it is the critical factor in their lives that allows them to actually get into the college and to stay in the college and actually try and these are enough for those you think and a lot of them say very candidly, I do not know if I have full-blown clinical threshold quality ADHD. I do not know if I do have and I do not know if I would ever know that. I do know that I have one person without medication and I really struggle and I have another person with medication and even I, to this point now, as a professor and a teacher who lives among them, I can tell. When they come into my room, I say, Oops, I do not think they are on medication today and that is apart from what I actually do think in my heart of heart they have ADHD or not, because in the end, this is the great diagnostic struggle with mental disorders is that there is no blood, urine, or radiological exam that can definitively tell you and I do not know when we are going to have that. At the same time, I have done formal and informal surveys in focus groups among my students that were intended to try to get some measure of the black market that exists for stimulants among college students and the findings that have from the surveys is the other reality, a very sobering reality in that after we have that massive surge in the number of ADHD diagnosis and the prescriptions that were with them in the 1990s, that is a whole cohered of kids who are now coming to college and they are bringing their prescriptions with them. So, every tenth room on the floor has a child or is now not a child is now an adult, who has a legitimate prescription for stimulants. They have stimulants and those stimulants go for sale from between \$1 to \$5 depending the dosage level, depending on the time of the semester, and depending on the law of supply and demand, and that reality exists as well and depending on how you ask the question in your surveys and focus groups about do you use drugs, do you use these stimulants illicitly, depending on how you asked it, you get between 10% and 30% of college students at schools like mine, they acknowledge using stimulants illicitly and that raises a whole variety of really. This isn't like rub your chin kind of deep question, this is a kind of question that the roommate is saying, wait a minute; I am not using these drugs with my roommate, as he or she could be getting on the edge. At one point, my other <____> don't

use.

DR. LESLIE LUNDT:

Thank you so much for sharing your experience with us today.

DR. RICK MAYES:

Thank you for having me.

DR. LESLIE LUNDT:

We have been talking about the very complicated world of ADHD and public policy with our guests, Dr. Rick Mayes. I am Dr. Leslie Lundt. You are listening to ReachMD XM 157, The Channel for Medical Professionals. For a complete program guide and downloadable pod casts , visit our web site at www.reachmd.com. For comments and questions, give us a ring at 888-MDXM-157. Thank you for listening.

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