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ADHD Update

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In this episode, Dr. Simone Moody leads a discussion focusing on ADHD, and the recent advancements in diagnosing, as well as management and treatment options.

Featured Speaker:
Simone Moody, PhD
Simone Moody, PhD is a Clinical Psychologist and Director of Psychological Services for the ADHD Specialty Clinic at Children's Mercy Kansas City.

Transcription:
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Rob Steele, MD (Host): Welcome to Pediatrics in Practice, a CME podcast. I'm your host, Dr. Rob Steele, Executive Vice President and Chief Strategy and Innovation Officer at Children's Mercy, Kansas City. Before we introduce our guest, I wanted to remind you to claim your CME credits after listening to today's episode, and you can do so by visiting CMKClink/CMEpodcast.

And then just click the claim CME button. Today, we are joined by Dr. Simone Moody for an ADHD update. Dr. Moody is a Clinical Psychologist and Director of Psychological Services for the ADHD Specialty Clinic at Children's Mercy Kansas City and Associate Professor of Pediatrics at the University of Missouri Kansas School of Medicine.

She received her PhD in Clinical Psychology from Texas Tech University and completed her internship and postdoctoral fellowship at Children's Mercy Kansas City. Dr. Moody provides targeted assessment and treatment for youth with ADHD in an interdisciplinary setting to improve functioning in their everyday lives at home, school, and social settings.

In addition to clinical care, Dr. Moody is actively engaged in program development, community outreach, research, and education and training. Her professional interests include early intervention and dissemination of evidence based practice to improve access to quality behavioral health care. Thank you for joining us today, Dr. Moody.

Simone Moody, PhD: Thank you for having me.

Host: So, I have to ask you, as the oldest child that you are, you know, oldest children are often described as high achievers, conscientious, responsible. I think I've already covered the high achiever with your intro, because you've clearly achieved quite a bit, but does that resonate with you? Are you conscientious and responsible?

Simone Moody, PhD: I would say so, very much.

Host: Very good. All right. Well, you've heard it here first, folks. My unfunded, non blinded, non random trial of N of 1 confirms what we have all heard about firstborn. I am, firstborn myself. Let's jump right on into it and we'll talk a bit about ADHD. Can you give the audience, a sense of the prevalence of ADHD now in 2024?

Simone Moody, PhD: So we know that ADHD is one of the most prevalent, if not the most prevalent, pediatric behavioral health conditions, with about 11 percent of kids diagnosed with ADHD.

Host: And has that seemed to have increased? I mean, from my perspective, when I was in practice, it seemed like that prevalence was ever increasing year over year. I don't know if that was just better diagnosis or whether there was really an increasing prevalence. Can you give our listeners a sense of whether that is increasing in prevalence and maybe the reasons why?

Simone Moody, PhD: So the prevalence has increased, whether it's a true increase or just a matter of differences in how we assess and our awareness to behavioral health conditions is to be determined. But I would say there is some good rationale suggesting that overall, there's more increased awareness and surveillance of behavioral health conditions as a whole.

Also there's been some changes to our diagnostic and statistical manual that provides criteria to evaluate behavioral health conditions like ADHD. And in 2013, there was some pretty significant changes from the DSM-4 to the DSM-5 for ADHD. So, one of them being, the criteria for the age in which symptoms needed to first present, it was initially seven and that moved up to 12, and then for adolescents, 17, and then obviously adults the number of symptoms required went down from six to five.

So those are a couple of changes within our diagnostic criteria. Also, there's been more guidance on how to evaluate and manage ADHD. The American Academy of Pediatrics, in particular, started with recommendations in 2000, and then over time, clinical practice guidelines that have increased the age range in which they capture from preschoolers through adolescents.

And then lastly, there's also different policies now that really support more behavioral health services integrated into primary care.

Host: Yeah. And I'm going to assume that the prevalence is not, you know, universal across all demographics. Can you give a sense of are there populations in which there's a disproportionate increase in that prevalence and maybe reasons why, if we know them?

Simone Moody, PhD: So, one of the differences in just boys and girls, right? So, boys are twice as more likely than girls to have a diagnosis of ADHD. But what we've seen over time is that gap has actually gotten smaller. And I think a lot of that has to do with the increased awareness and more tools and guidance.

But if you think about it, girls are more likely to have the inattentive presentation versus boys. And it's easier to capture hyperactive impulsive symptoms. It's very easy to see a kid who's bouncing off the walls driven by a motor versus maybe a child who is able to sit in their seat, but just having trouble paying attention.

So that's one difference that we see in terms of diagnosis between boys and girls. There's also some, disparities in terms of race and ethnicity and, and diagnosis in our country. We know that ADHD is present across most cultures, but in our country in particular, we see children who are Asian, Hawaiian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and children identified as Hispanic or Latine are being less likely to be diagnosed or identified as having ADHD, compared to Black and white children and those who are non Hispanic or non Latine.

Host: As we become more sophisticated and more aware of the symptomatology that might lead to that diagnosis, the times that children spend in school is very significant as compared to home. There's always this sort of dance between what a teacher thinks is going on versus what the parents think versus what you actually look for, for symptomatology.

Can you give a sense of are we seeing more concerns on the teacher side, in which they're bringing it up and then how do you navigate that dance really?

Simone Moody, PhD: When it comes to disparities in particular, especially across different cultures, I think we have a couple of things at play. So one is just the cultural acceptability of that diagnosis and understanding on the caregiver side. So that can play into it as well as biases that we see among individuals and also within our systems that might make it harder to identify ADHD.

Host: Okay. So we've talked a little bit about the prevalence. Why don't we move a little bit toward how we assess, screen and ultimately diagnose. What tools are out there for the primary care physician to use and best ways in which those are brought up with parents and how we implement those.

Simone Moody, PhD: And this is really great timing because, we just published at Children's Mercy our ADHD Clinical Pathway, that anyone can access through the Children's Mercy website if they click the link for healthcare providers and then under clinical pathways, evidence based practice, they can see our ADHD Clinical Pathway there and that is an algorithm that provides a step by step process for evaluating ADHD and then also managing ADHD.

So I'd highly recommend that tool and it links out to different assessment rating scale tools on there as well that directly evaluate ADHD, but then also screen for other co occurring conditions. We linked as many free versions as we could to that. The NICHQ, the National Institute for Children's Health Quality has a free ADHD toolkit that was published in 2002.

And then the American Academy of Pediatrics also has one available, for purchase. And they're very similar, so, you can get really good information, from both. Both are easily accessible through our ADHD Clinical Pathway. And for providers who work at Children's Mercy, we actually have an institutional license for the AAP ADHD toolkit that I worked hard to get. It took a long time, but we got it. And, if you work at Children's Mercy, you can search ADHD on the scope and it'll pull up the toolkit and the Clinical Pathway pretty easily.

Host: That's great and you've given the directions on how to get to it, those resources on the website. Sounds like it is a bit of a one stop shop. So I encourage our, listeners, those who are taking care of those patients that potentially have or do have the diagnosis of ADHD and looking at that clinical pathway.

I think that's fantastic. Let's move a little bit further on, now past diagnosis and maybe into therapy. Can you give us a sense of just the common medications with ADHD, why some are recommended and why and maybe even some of the controversies with regard to those medications?

Simone Moody, PhD: So I think there's a lot of misinformation out there about ADHD medications. They've gotten a bad rap over the years. But our two main groups or how they're commonly classified is our stimulant medications and then our non stimulant medication. So I want to preface this as I'm not a prescribing provider.

I'm not a physician. But I do know a good amount about medications for ADHD. So our stimulant medications are first line treatment because they're way more likely to be effective. We know that through lots and lots of research. We know that some children will respond equally well to different stimulant groups, and there are two main groups, our amphetamine group and our methylphenidate group, but there are some that might respond better to one group versus the other, and so it does take a little bit of trial and error to try to find a medicine that will optimize symptom management while having minimal side effects, so that can be a tricky balance.

One thing that I did want to highlight is, more recently, we've heard a lot about pharmacogenomic testing, and it's actually become more readily available, and more cost effective for families, so we hear a lot about this, and it's important to know that for stimulant medications in particular, the information that we receive from that testing is not clinically meaningful for stimulant medication. So, really it's hard to know which child's going to respond best to which medication.

Host: No, and I appreciate the shout out to our research colleagues that are looking into the pharmacogenomic aspects of that. I know there's a lot of work going on here on the non stimulant medications and, how we might be able to predict those that will respond and the dosage at which that might occur.

There's a lot to learn there, but I appreciate you bringing that up. With respect to those children that now have been diagnosed with ADHD, there's often a lot of comorbidities, other diagnoses that come with that. Could you talk a little bit about the prevalence of having some other diagnosis with ADHD and maybe some of the challenges that might have in addressing ADHD itself.

Simone Moody, PhD: The most recent estimates suggest that about 77, 78 percent of children and adolescents with ADHD have another coexisting condition. Most of the time, like one of the more common ones are other additional behavioral challenges like oppositional defiant disorder. But we also see ADHD co occur with other neurodevelopmental disorders, like learning disorders, and Autism. We see more anxiety and depression, and so really it's more common than not that we are gonna see children with ADHD with a coexisting condition.

Host: You know, that always makes that a challenge in being able to, not just identify, but also then treat those comorbid conditions with that. So, moving along that line, at what point, we have a lot of our listeners are primary care pediatricians, and they certainly see a lot of children with ADHD, and I'm sure that there's a lot that they are taking care of that we never see here at Children's Mercy.

But, can you give some advice to those primary care pediatricians with regard to which patients should be referred in for more specialty care as compared to ones that are maybe being treated there in the primary care office.

Simone Moody, PhD: When I started here at Children's Mercy, I kind of had that same question. I'm like, who should be with the PCP versus who should be with us? I mean, I know, I offer more of the behavioral therapy arm, which pediatricians don't have as much access to, but in particular for things like medication, like when does that make the most sense?

And I was really pleased to see in 2020, the Society for Developmental and Behavioral Pediatrics develop a clinical guideline on complex ADHD. And fun fact, one of our developmental pediatricians here at Children's Mercy was on that committee, Dr. Lisa Campbell. And they really identified when to refer for specialty care, when the primary care clinician should consider that.

I can go over that recommendation. So for children who are less than four years old, for those older than 12 when their symptoms first presented, if there is a coexisting condition like a developmental or learning issue, potentially medical complexity or psychiatric diagnosis, then for those children and adolescents with what we would call like moderate to severe functional impairment. So these are kids who are having a lot of difficulties, maybe behaviorally or academically at school. Maybe they're having some social challenges getting along with their peers. Or they're having some stress at home, some trouble with compliance and doing the tasks that they need to complete at home. Another consideration for specialty care would be if the diagnosis is unclear to the primary care clinician. So, the AAP guideline recommends that pediatricians initiate that diagnosis, but sometimes it's hard to know. And so those are really good referrals for specialty care where we can dive a little bit deeper and have more time, to investigate the concerns.

And then lastly, if you are treating a child who their response to your treatment is not optimal. So a good example of this is thinking about medication management and maybe a kiddo or teen who's failed a trial of each one of those stimulant groups from the amphetamine group and the methylphenidate category.

Host: That's really great information, particularly for the primary care physician to help guide them on when those children need to be referred in for specialty care. You had gone over, Dr. Moody, with the resources that we have on our website with regard to the care pathways and some of the other information.

Those are largely for the physicians, I'm going to presume, to be able to work through diagnosis and treatment. But, what about for families and for schools? What resources can you recommend for them?

Simone Moody, PhD: There are a lot of resources out there, and it's really hard to know which ones are best or which ones provide the most information or the best guidance. So I would highly recommend guiding families toward the organization called CHAD, or Children and Adults with ADHD. And their website is chadd.org, so c-h-a-d-d.org, and they are a national resource center for ADHD. So they have information about parenting a child with ADHD, adults with ADHD, information for schools, or how to advocate for school based resources at school. We are lucky to have a local chapter of CHADD here in Kansas City, called ADHD KC, and you can find more information at ADHDKC.org. Another recommendation for families in particular, I really like Russell Barkley's book called Taking Charge of ADHD for Parents of Children with ADHD, and he also has an adult version of that book as well, and we know that ADHD is one of the most heritable behavioral health conditions and so it's really common for us to see a caregiver also with ADHD in our clinic.

He also has a YouTube channel for visual learners that I think can be really helpful as well. For schools, there is information on our clinical pathway on CHADD in the book I just suggested on how to recommend evidence based tools in those settings. Two things that I'll highlight is, children with ADHD have educational rights and they might qualify for an individualized education program or an IEP or a 504 accommodation plan to help them be successful at school.

And we know that the AAP recommends this sort of behavioral classroom intervention, and most of the kids that I see are not getting that when I see them, and so really guiding families toward the links in the resources that I suggested on how to establish, for example, a daily school to home report card, to set goals for kids, to help them build their skills in a classroom setting.

Host: Very good. Well, thank you again, Dr. Moody, for joining us today. Before I let you go, I got to circle back to how we started this. As a firstborn child, you are too. Does birth order, is there there any prevalence or any connection with birth order and ADHD? Inquiring minds want to know, really. My mind wants to know.

Simone Moody, PhD: Yeah, not that I am aware of. However, I will say having kids of my own, I do see these sort of patterns in birth order information that has been sent my way that I'm like, huh, that's interesting. I see that. But I wonder if it's more just like that social, interaction and just the time we have to spend with one child versus once you add other kids to the mix and things like that, that might make a difference.

Host: Well, maybe there's a research opportunity in all that. Well, Dr. Moody, thank you again for joining us. As a reminder, claim your CME credit for listening to our show today. Visit cmkc.link/CMEpodcast, and then click the claim CME button. This has been another episode of Pediatrics in Practice, a CME podcast.

I'm Dr. Rob Steele. See you next time.