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Adult ADHD Resource Guide

Introduction

In the Fall of 2017, in response to requests from our CCNC Primary Care Providers, a Community Care of North Carolina (CCNC) workgroup formed to create a resource guide designed to assist primary care practitioners in screening and treating adult Attention-Deficit/Hyperactivity Disorder (ADHD) in the primary care setting. This workgroup was comprised of Network Psychiatrists, Network Pharmacists, Network Behavioral Health Coordinators, the CCNC Central Office Behavioral Health Team, and physician representatives from area medical practices.

This resource guide is designed to assist busy primary care practitioners in accessing practical, evidence-based tools to help them successfully treat ADHD in adults. It includes an algorithm to aid in the initial assessment and corresponding treatment approach (of adult ADHD), screening tools, a medication guide, and billing and coding guidance. In addition, the resource guide highlights multimodal interventions for adult ADHD based on available evidence, and gives providers suggestions on the screening, treatment, and monitoring for/of comorbid adult ADHD and substance abuse and/or substance use disorder.

Our hope is that this resource guide proves useful, and we greatly look forward to continuing to work together on achieving the highest attainable levels of patient care across our wonderful state of North Carolina.

If you have any questions, or would like assistance in connecting with your local CCNC Network and its resources, please contact a member of the Central Office Behavioral Health Team:
(Current as of Summer 2018)

Andrew Clendenin, MSW	Director aclendenin@communitycarenc.org
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Treatment Algorithms

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Adult (>18 Years) ADHD Flow Chart:

Past ADHD Diagnosis | **Patient Complaint** | **Suspicion of ADHD**

Does patient have established diagnosis of ADHD with sufficient documentation?*

yes → Does patient have active substance use disorder?

no → Does patient have active substance use disorder?

Does patient have active substance use disorder?

yes → Refer for substance abuse treatment
(if refuses, contact CCNC Network for assistance as/if needed)

no → Does patient currently meet criteria for a Major Depressive Episode?**
Other Considerations: Trauma, Bipolar Disorder, Anxiety, Etc.

yes → Treat depression***

no → Does patient have history of substance abuse?

Does patient have history of substance abuse?

no → Start evidence-based treatment, consider stimulant medications

yes → Start evidence-based treatment but avoid stimulant medications

Does patient meet criteria for ADHD?

yes → Does patient have active substance use disorder?

no → Refer for further evaluation
OR
Consider differential diagnosis
OR
Refer for psychotherapy/counseling

NEED ASSISTANCE?

Reach Out To/Consult With Your Network Behavioral Health Team to Create Practice and/or Patient-Specific Strategies

ADHD Diagnostic Evaluation

(*Note: May take several visits to complete)

Patient	School or Work	Family or Friends
Complete clinical history***	Academic or work records	Childhood history; Current concerns
Validated ADHD rating scales (see corresponding section within this resource guide)		Validated ADHD rating scales
Computer or neuropsychological testing (optional)		

*Documentation should include evidence of past diagnostic workup, including: Elements of standardized rating scales; clinical interview; collateral reports from school, work, or home; computer testing; or neuropsychological testing

** Please review the CCNC Adult Depression Resource Guide; Contact CCNC Network for assistance as/if needed related to major depressive episode(s)/disorder, trauma, bipolar disorder, anxiety, or any other potentially coexisting disorder(s)/differential diagnosis(es)

*** This should include: Chief concerns, history of symptoms (e.g. age of onset and course over time), family history, past medical history, psychosocial history, review of systems, evaluation of coexisting conditions, report of function, as well as both strengths and weaknesses

Screening/Evaluation

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.

2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.

3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.

2. Consider work/school, social and family settings.

3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

The Value of Screening for Adults With ADHD

Research suggests that the symptoms of ADHD can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it.[1-4] Because this disorder is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers:

- **Lenard Adler, MD**
  Associate Professor of Psychiatry and Neurology
  New York University Medical School

- **Ronald C. Kessler, PhD**
  Professor, Department of Health Care Policy
  Harvard Medical School

- **Thomas Spencer, MD**
  Associate Professor of Psychiatry
  Harvard Medical School

As a healthcare professional, you can use the ASRS v1.1 as a tool to help screen for ADHD in adult patients. Insights gained through this screening may suggest the need for a more in-depth clinician interview. The questions in the ASRS v1.1 are consistent with DSM-IV criteria and address the manifestations of ADHD symptoms in adults. Content of the questionnaire also reflects the importance that DSM-IV places on symptoms, impairments, and history for a correct diagnosis.[4]

The checklist takes about 5 minutes to complete and can provide information that is critical to supplement the diagnostic process.

References:
1. Schweitzer JB, et al. Med Clin North Am. 2001;85(3):10-11, 757-777.
2. Barkley RA. Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. 2nd ed. 1998.
3. Biederman J, et al. Am J Psychiatry.1993;150:1792-1798.
4. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. 2000: 85-93.

Multilingual ASRS-v1.1 & Other Alternative ADHD Rating Scales

Adult ADHD Self-Report Scale (ASRS-v1.1) Multilingual:
https://www.hcp.med.harvard.edu/ncs/asrs.php

Note:** The above link provides ***translations of the ASRS-v1.1 screening tool. Please note that these translations may **NOT** be validated, and that translation without validation can lead to false test results due to poor interpretability [translation ≠ interpretation]. As such, an interpreter/interpretation services is/are always recommended over translated materials. For more information on validation and translation of the ASRS, an email for inquiries is provided on the linked web page above.

In addition to the Adult ADHD Self-Report Scale (ASRS-v1.1) provided above, other adult self-report measures to aid in the clinical assessment of potential adult ADHD include the following:

Barkley and Murphy Adult ADHD Rating Scale:

- Current Symptoms Scale, Executive Functioning Assessment [*BDEFS*]:
  - BDEFS Adult: https://www.guilford.com/books/Barkley-Deficits-Executive-Functioning- Scale-BDEFS-Adults/Russell-Barkley/9781606239346
    - *Note: Comprises both a self-assessment to be filled out by the patient, as well as an "other" assessment to be filled out by someone with a close relationship to the patient (familial; spouse/partner; friend; etc.)

Wender Utah Rating Scale (WURS):

- To Give Patients: http://www.attentiondeficit-info.com/pdf/wender-utah-rating-scale.pdf

- For Providers: http://psycheducation.org/wp-content/uploads/2014/12/wender.pdf
  - *Note: Contains interpretation/scoring instruction

Medication Information

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Medication Table: Attention Deficit Hyperactivity Disorder (ADHD)

Products listed in the following chart are FDA approved for the management of ADULT ADHD.[1] Many of these medications, as well as additional medications, are approved for the treatment of child/adolescent ADHD for a listing of these medications, along with their dosing, titration, max dose, duration of action, and other information, please see the child/adolescent ADHD resource guide.

Medication	Initial Dose (mg)	Titration Schedule	Maximum Dose (mg)	Duration of Action	Pregnancy Category	Dosage Forms & Additional Information
Immediate-release (IR) methylphenidate						
RITALIN™ Generics Available	5 BID-QID, or 10 qam and noon	5-10mg every 7 days	60	3 to 5 h	C	-5, 10, 20mg tabs (10 and 20mg tabs – scored) -Administer 30-45min. before meals. -Effective in 70% of patients. -If no observed improvement after 1-month, with appropriate dosage adjustment, discontinue drug.
METHYLIN™	5 BID-QID, or 10 qam and noon	5-10mg every 7 days	60	3 to 5 h	C	-2.5, 5, 10 mg chewable tabs -5 mg/5 mL, 10 mg/5 mL oral solution -Administer chewable tabs with at least 240ml of water/fluid. -Administer 30-45min before meals.
Extended-release (IR) methylphenidate						
RITALIN LA™ Generics Available	10-20 every morning	10mg every 7 days	60	6 to 9 h	C	-10, 20, 30, 40, 60mg bead-filled capsules (½ IR and ½ enteric coated, delayed release) -May be taken whole or sprinkled on applesauce. Use immediately if sprinkled on applesauce. -Do not crush or chew capsule or contents.
METADATE ER™	20 every morning (for those tolerating 10 IR morning and noon) May be given daily or BID if 2nd dose is needed	20mg every 7 days	60	6 to 8 h	C	-20mg wax matrix tabs -Must be swallowed whole.
METADATE CD™ Generics Available	20 every morning without regard to meals	10-20mg every 7 days	60	6 to 10 h	C	-10, 20, 30, 40, 50, 60mg bead-filled capsules (30% IR and 70% ER) -May be taken whole or sprinkled on applesauce. Use immediately if sprinkled on applesauce. -Do not crush or chew capsule or contents.

SUD = Substance Use Disorder BID = Twice Daily CD = Controlled or Continuous Delivery H = Hour IR = Immediate Release LA = Long Acting ODT = Orally Disintegrated Tablet
OROS = Osmotic (Controlled) Release Oral System TID = Three Times Daily QID = Four Times Daily XR or ER = Extended-Release Yr. = Year

Medication	Initial Dose (mg)	Titration Schedule	Maximum Dose (mg)	Duration of Action	Pregnancy Category	Dosage Forms & Additional Information
Extended-release (IR) methylphenidate						
CONCERTA™ Generics Available	18-36 every morning	18mg every 7 days	72	10 to 12 h	C	-18, 27, 36, 54mg ER tabs (OROS with IR overcoat) -Must be swallowed whole -Do not crush or chew capsule or contents.
DAYTRANA™ (Transdermal Patch)	10 (apply 2 hours before desired effect) Change application site daily in the mornings	Next highest patch strength	30	12 h (with 9-h wear time)	C	-1.1mg/hr. (10mg/9hr.), 1.6mg/hr. (15mg/9hr.), 2.2mg/hr. (20mg/9hr.), 3.3mg/hr. (30mg/9hr.) -Worn daily for 9hr. Apply to hip area. -Can be worn up to 16hr. -Remove at least 3hr. before bedtime.
QUILLICHEW ER™	20 every morning without regard to meals	10, 15, or 20mg every 7 days	60	8 h	C	-20, 30, 40mg chewable ER tabs (30% IR and 70% ER) -20mg and 30mg tabs (scored)
QUILLIVANT XR™	20 every morning without regard to meals	10-20mg every 7 days	60	12 h	C	-5mg/ml oral suspension (20% IR and 80% ER) -Pharmacist must reconstitute.
APTENSIO XR™	10 every morning at a consistent time in regard to meals	10mg every 7 days	60	6 to 10 h	C	-10, 15, 20, 30, 40, 50, 60mg caps filled with multi-layered beads (40% IR and 60% ER) -May be taken whole or sprinkled on applesauce. Use immediately if sprinkled on applesauce. -Do not crush or chew capsule or contents.
Immediate-release (IR) dexmethylphenidate						
FOCALIN™	2.5 BID, at least 4 hr. apart, without regard to meals	2.5mg with morning and/or noon dose every 7 days	20	3 to 5 h	C	-2.5, 5, 10 mg tabs (un-scored) -If no observed improvement after 1-month, with appropriate dosage adjustment, discontinue drug.
Extended-release (ER) dexmethylphenidate						
FOCALIN XR™ Generics Available	10 once daily in the morning	10mg every 7 days	40	8 to 12 h	C	-5, 10, 15, 20, 25, 30, 35, 40 mg caps -May be taken whole or sprinkled on applesauce. Use immediately if sprinkled on applesauce. -Do not crush or chew capsule or contents.

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Medication	Initial Dose (mg)	Titration Schedule	Maximum Dose (mg)	Duration of Action	Pregnancy Category	Dosage Forms & Additional Information
Amphetamines						
Mixed amphetamine salts *(brand Adderall™ discontinued)* Generics Available	10 qam and noon	10 BID every 7 days	40	4 to 6 h	C	-5, 7.5, 10, 12.5, 15, 20, 30 mg tabs -Usually given once or twice daily at four- to six-hour intervals.
MIXED AMPHETAMINE SALTS, ER CAPS *ADDERALL XR™* Generics Available	20 once daily without regard to meals	5-10 every 7 days	30	10 to 12 h	C	-5, 10, 15, 20, 25, 30 mg ER caps -May be taken whole or sprinkled on applesauce. Use immediately if sprinkled on applesauce. -Do not crush or chew capsule or contents.
AMPHETAMINE SALTS, ER CAPS *ADZENYS XR-ODT™* Generics Available	12.5 once daily without regard to meals	3.1-6.3 every 7 days	Not well established for adults	10 to 12 h	C	-3.1, 6.3, 9.4, 12.5, 15.7, 18.8 mg -Tablet strengths reflect amount of amphetamine base. -Placed on tongue and allowed to disintegrate. -Do not crush or chew tablet or swallow whole.
AMPHETAMINE DYANAVEL XR™	2.5 -5 once daily in the morning without regard to meals	2.5-10 every 7 days	20	> 12 h	C	-2.5mg/ml oral ER suspension -Administer directly into the mouth from oral dispenser; do not add to food or mix with liquid.
Dextroamphetamine *(brand Dextrostat™ discontinued)* Generics Available	2.5-5 every morning and noon	2.5-5 / week	40	4 to 6 h	C	-5, 10mg tabs -First dose upon awakening, with additional doses at 4 to 6 hour intervals.
LISDEXAMFETAMINE *VYVANSE™*	30 once daily in the morning without regard to meals	10-20 every 7 days	70	up to 14 h	C	-10, 20, 30, 40, 50, 60, 70 mg caps -May be taken whole or contents dissolved in water, yogurt or orange juice and taken immediately. A film of inactive ingredients may remain on the container. -Do not crush or chew capsule.
AMPHETAMINE/ DEXTROAMPHETAMINE *MYDAYIS™*	12.5-25 once daily	12.5 / week	50	≤ 16 h	C	-12.5, 25, 37.5, 50 mg caps -Do NOT substitute mg-for-mg if converting from other mixed formulation (discontinue previous, then titrate as directed). -Administer consistently WITH or WITHOUT food. -May be taken whole or sprinkled on applesauce. Use immediately if sprinkled on applesauce.
Non-stimulants						
ATOMOXETINE *STRATTERA™*	40 mg/day (patients > 70 kg) Once daily or BID without regard to meals	Increase to 80mg/day, then up to 100mg/day after 2-4 more weeks (patients > 70 kg)	Patients > 70 kg and adults 100mg	10 to 12 h	C	-10, 18, 25, 40, 60, 80,100 mg caps -Response rate lower compared with methylphenidate. -Efficacy may take up to 4 weeks. -Consider for patients with co-morbid anxiety, tics, insomnia or SUD.

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**PLEASE NOTE: For all questions outside the realm of this grid, please contact your CCNC Network Pharmacist.

Practical Points:

If a patient does not respond to one stimulant at therapeutic doses, a trial of a medication in another stimulant class is recommended before switching to other therapeutic options.

Base the choice of medication on the severity of patient symptoms and the time of day when symptoms are most problematic.
Therapy is evaluated at least monthly initially until symptoms have stabilized, with changes in the frequency of follow-up based upon adherence of the patient and caregivers to the drug regimen, drug response, appearance of side effects, and the need for education and/or psychosocial intervention.

**Dose conversion between medications and formulations is available via website or smartphone application here: http://www.adhdmedcalc.com/
**A secondary resource for dose conversion information is the March 2016 "Pharmacist's Letter/Prescriber's Letter", which can be found in the references section of this document (see below; pp 12).

References:

1. **(Adapted From)** - Therapeutic Research Center. *Pharmacist's Letter/Prescriber's Letter: Comparison of ADHD Medications*.; 2016. http://rw.therapeuticresearch.com/pl/ArticlePDF.aspx?cs=&s=PRL&DocumentFileID=0&DetailID=271221&SegmentID=0.
2. National Association for Continuing Education (NACE). Medications for ADHD; n.d. National Association for Continuing Education (NACE). http://naceonline.com/article-medications-for-adhd.php. Accessed May 4, 2018.
3. United States Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). *Stimulant and related medications: U.S. Food and Drug Administration-Approved indications and dosages for use in adults*.; 2015. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/Downloads/stim-adult-dosingchart11-14.pdf. Accessed May 4, 2018.

Billing Information

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Billing/Diagnostic Codes and Other Guidance: ADHD Visits (Adults)

Coding and Description:

	Initial Assessment:	Follow-Up:
Time:	45-60 minutes	25-40 minutes (minimum Q3 months)
Rating Scales:	Social-Emotional Screening Code: 96127 *Limit 2 units per visit* *Recommended Rating Scale: Adult ADHD Self-Report Scale (ASRS-v1.1)	Social-Emotional Screening Code: 96127 *Limit 2 units per visit* *Recommended Rating Scale: Adult ADHD Self-Report Scale (ASRS-v1.1)
Pre-Visit:	Review records and rating scales.	Review rating scales. Review records as needed.
CPT:	Consult Code: 99244/99245 Appropriate if requested by school/teacher/colleague.[1] Must send report. *See sample report form for school.* **Otherwise wellness visit E&M code: 99214/99215** **Use prolonged visit code if needed based on time beyond E&M: 99354-99355[2]**	Wellness Visit Code: 99214/99215 **Use prolonged visit code if needed based on time beyond E&M: 99354-99355[2]**
ICD-10:	F90.0 ADHD, inattentive type F90.1 ADHD, hyperactive/impulsive type F90.2 ADHD, combined type F90.8 ADHD with developmental delay R45.87 Hyperactive/impulsive behavior problem R41.840 Inattention problem F81.9 Learning Problem R27.8 Graphomotor problems/dysgraphia Z55.3 Academic underachievement Z55.9 Education/academic problem	F90.0 ADHD, inattentive type F90.1 ADHD, hyperactive/impulsive type F90.2 ADHD, combined type F90.8 ADHD with developmental delay R45.87 Hyperactive/impulsive behavior problem R41.840 Inattention problem F81.9 Learning Problem R27.8 Graphomotor problems/dysgraphia Z55.3 Academic underachievement Z55.9 Education/academic problem

Coding and Payment:

Code Type:	Code:	Payment (Medicaid 2018):
Rating Scales:	96127	$4.25
Consults:	99244/99245	$148.40/$182.39
E&M:	99214/99215	$81.76/$110.58
Prolonged Visit	99354/99355	$82.03/$81.21

To access the most up-to-date information on North Carolina Medicaid CPT codes, please view the most recent Physician Fee Schedule:
https://medicaid.ncdhhs.gov/providers/fee-schedule/physician-services-fee-schedule

For North Carolina Division of Medical Assistance support, contact the Medical Assistance Operations Section at (919) 855-4050.
If you have a billing or credentialing concern, you may contact CSRA (NCTracks) at (800) 688-6696

[1] Referral from school or colleague: ***Must*** indicate referral source and send a report only usable for initial visit
[2] **99354:** 31-75 minutes beyond E&M; **99355:** 16-30 minutes beyond 99354

Other ADHD Care Support Resources

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ADHD Multimodal Intervention Grid

__Please Note__: While the management of ADHD often requires a multimodal approach, the ***__evidence-base__* for specific non-pharmacological, and therefore multimodal, Adult ADHD interventions is minimal

Treatment:	▪ Simulant Medication[1,2] ▪ Non-Stimulant Medication[1,2] ▪ Sleep/Hygiene[3] ▪ Physical Activity[4-7] ▪ Cognitive Behavioral Therapy (CBT) for ADHD[1,8,9] ▪ ADHD Coaching[10] ▪ Cognitive Training[11,12] ▪ Neurofeedback[13] ▪ Chronotherapy ▪ Mindfulness[1]
School/Work:	▪ Time Management Skill Building (i.e. "Chunking" of Tasks)[14] ▪ Minimized Environmental Distraction(s) ▪ Employer Support; Peer Support
Home:	▪ Sleep/Hygiene[3] ▪ Physical Activity[4-7] ▪ Mindfulness[1] ▪ Time Management ▪ Prioritization of Tasks ▪ Visual Cues ▪ Familial Support

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1. De Crescenzo F, Cortese S, Adamo N, Janiri L. Pharmacological and non-pharmacological treatment of adults with ADHD: A meta-review. *Evid Based Ment Health*. 2017;20(1):4-11. doi:10.1136/eb-2016-102415.
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3. Hvolby A. Associations of sleep disturbance with ADHD: implications for treatment. *Atten Defic Hyperact Disord*. 2015;7(1):1-18. doi:10.1007/s12402-014-0151-0.
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12. Dentz A, Guay M-C, Parent V, Romo L. Working Memory Training for Adults With ADHD. *J Atten Disord*. August 2017:108705471772398. doi:10.1177/1087054717723987.
13. Schönenberg M, Wiedemann E, Schneidt A, et al. Neurofeedback, sham neurofeedback, and cognitive-behavioural group therapy in adults with attention-deficit hyperactivity disorder: a triple-blind, randomised, controlled trial. *The Lancet Psychiatry*. 2017;4(9):673-684. doi:10.1016/S2215-0366(17)30291-2.
14. LaCount PA, Hartung CM, Shelton CR, Stevens AE. Efficacy of an Organizational Skills Intervention for College Students With ADHD Symptomatology and Academic Difficulties. *J Atten Disord*. 2018;22(4):356-367. doi:10.1177/1087054715594423.

Adult ADHD and Substance Use Disorders: Tips of the Trade

If you are treating patients with Adult ADHD, you are likely treating patients with Substance Use Disorders (SUDs). Comorbidity rates between the two conditions are as follows:

- 15% of patients with Adult ADHD have a history of SUD[1]
- 7-25% of adult patients with a SUD have ADHD[1]

Tip #1: Screening

Screen Adult ADHD patients for SUD
Screen patients with SUD for Adult ADHD

If a patient has a **history of SUD** and Adult ADHD, try behavioral interventions, psychotherapy, and non-stimulant medications before prescribing a stimulant medication. If these do not work, document the failed trials in the patient's chart and carefully consider the risks and benefits of starting a stimulant medication. If patient has **active SUD**, refer for treatment and **do not start** a stimulant until patient is successfully engaged in treatment and showing improvement, and all other interventions have failed (proceed with caution, monitoring frequently; ongoing assessment of benefit(s) versus risk(s) recommended).

Tip #2: Weigh the Risks of Stimulant Use

Possible risks of stimulants for patients with ADHD and history of SUD:
- *potential for misuse and addictive behaviors*

Possible benefits of stimulants for patients with ADHD and history of SUD:
- *reduce impulsivity making it easier to treat SUD*
- *less self-medicating with other substances*
- *improved performance at work and at home*

If you prescribe stimulants for Adult ADHD, your practice must have standardized protocols for dealing with this class of controlled substances. Implementation of these protocols must be clear to all clinical staff, administrative staff, and the patient before stimulants are prescribed.

Tip #3: PROTOCOLS

- *maximum # days that stimulant will be prescribed*
- *refill / call-in policy*
- *controlled substances database checks*
- *lost or stolen medication*
- *ran out of medication early*
- *requests for early fill on medication*
- *urine toxicology*

In most cases, urine toxicology will be an important part of monitoring stimulant adherence and abuse. Think carefully about your protocols for UTOX and what you will do in all possible scenarios. Consider the referral pathways you will use if patients are found to be abusing or misusing their stimulant medications.

Tip #4: UTOX

Establish a good relationship with a lab that routinely handles UTOX for substance use disorders. Depending on volume, some labs will embed a lab tech at no cost to the practice to help you with your UTOX protocol.

Tip #5: REFERRAL PATHWAYS

Before prescribing stimulants, make sure you have a solid referral pathway to treatment for SUDs. Ideally, your referral should have experience with patients with comorbid Adult ADHD and SUD.

Useful Resource (SBIRT): https://www.integration.samhsa.gov/clinical-practice/sbirt

References:

1. Kessler et al., The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. Am J Psychiatry. 2006 Apr; 163(4): 716-723.