



ASSUMPTIONS FOR TODAY

- Most of us don't work 2 W's without seeing a person with ADHD
- You are familiar with the DSM-5 criteria
- You are prescribing (mostly) stimulants for adults with ADHD
- We understand that ADHD has genetic and neurobehavioral roots
- There is no pathognomonic sign or symptom

GOALS FOR THIS PRESENTATION

- Review an algorithm for medical treatment of adult ADHD
- Acknowledge controversies and perhaps stir up some new ones
- Diagnostic helpers beyond the formal DSM criteria
- Drug choice and dosing issues
- ADHD and SUDs: if/when are stimulants appropriate

SOME KEY TAKEAWAYS

- Prior diagnostic evaluations range from awesomely good to awesomely bad
- Never assume childhood 'focus' problems had to be caused by ADHD
- "I can't focus" should be the start, not the end, of the conversation
- Past "benefit" from stimulants proves nothing
- There is no test for ADHD that is definitive
- Anticipate comorbidity

MORE KEY TAKEAWAYS

- Medication algorithms are of limited help, so let that free you
- Matching meds' neurotransmitter effects to symptoms is still aspirational only
- Follow-up visits should incorporate some objective rating scales or similar
- Have a clear policy for lost/stolen/ruined pills
- Monitoring improvement should include functional assessment

ADHD Symptom Manifestation by Age

CHILDHOOD	ADOLESCENCE	ADULTHOOD
Hyperactivity	Easily distracted, inattentive	Inattentiveness
Low frustration tolerance	Easily bored	Poor organization of time/money
Aggression	Impatient	Missing deadlines or appointments
Easily distracted	Emotionally immature compared to peers	Poor bill tracking
Difficulty developing routines	Shifts activities	Restlessness
Impulsiveness	Poor driving	Emotional reactivity

Wasserstein. JCLP 2005. Wilens et al. Ann Rev Psychiatry 1999. Millstein et al. J Atten Disord 1997.

CLUES TO THE DIAGNOSIS

- I'm always losing cellphones, keys, glasses, wallets...
- I've never read a book all the way through
- Paperwork, bedroom, office a shambles
 - Bills, projects at work or school
- Lateness
- 4-shot espressos, Monsters, Red Bulls

Alexander SJ J Atten Disorders 2013,17 (1):29-37
Harrison AG. Canadian J School Psych 2013, 28(3):243-260

TESTING IS NOT DIAGNOSTIC

- ADHD may be more or less likely based on screening
- Many other possible explanations for the patient's 'lack of focus' or other complaints
- History is key
 - *No childhood onset= NO ADHD*
 - *Frequently not recognized in childhood, but impairment was present*

McGough JJ. Am J Psych 2016;173(10), 960-6

DOSING STIMULANTS

- Traditional dosing – MPH 1 mg/kg. AMF 0.5 mg/kg
- Folklore says rarely go >60 mg for MPH and >40 mg for AMF
- Some evidence exists that higher doses are safe and, for some, more effective
- At what point is it time for a switch?
- Careful monitoring of what we mean by response is key

Cortese S et al. Lancet Psychiatry. 2018 Sep;5(9):727-738.
CADTH Rapid Response Reports, 2016.
Katzman MA et al. BMC Psychiatry. 2017 Aug 22;17:302-16.
McGough JJ. Am J Psych. 2016;173(10), 960-6.

DOSING SCHEDULES

- Educate your patient as to how to gauge response
- Encourage reasonable experimentation and flexibility when patients are engaged and responsible
- No reason why a fixed daily schedule is necessary
- Think of the meds as tools to do a job

ADHD, SUBSTANCE USE, AND SUBSTANCE ABUSE

- Hard to get reliable data on benefits of ADHD rx in this population
- No reason to think that conclusions can be drawn across different substances
- Distinguishing between use and abuse isn't so easy
- Paradoxically, there is some evidence that ADHD rx protects against SUD
- Even worse, some evidence says you need higher stimulant doses for benefit!

Katzman MA et al. BMC Psychiatry. 2017 Aug 22;17:302-16
McGough JJ. Am J Psych. 2016;173(10): 960-6
Quinn PD et al. Am J Psych. 2017;174(9):877-85

WHAT'S YOUR STANCE REGARDING PRESCRIBING FOR ADHD IN THE PRESENCE OF SU OR SUD?

- No way no how?
- Does it depend on the substance(s)?
- You have to stop using completely first?
- You have to be clean for X number of days/weeks/months/years/decades?
- I'm OK with it even in the presence of some SU?
- I'm OK with it even in the presence of some SUD?

OTHER APPROACHES TO ADHD

- Patient education is at the core
- Psychotherapy
- Mindfulness
- Bibliotherapy
- Websites
- Addressing comorbid conditions

Janssen L et al. Psychol Med. 2018 Feb;28:1-11.

SOME ASPECTS OF ADHD WE DIDN'T GET TO

- Does ADHD NEVER have an adult onset?
- Is it ethical to prescribe stimulants for cognitive enhancement in the absence of ADHD?
- Faking
- Should all college students with ADHD have accommodations, and should they all have the same ones?
- How useful is the testing we do in KPSC?
- What would it take to get PCPs to treat uncomplicated ADHD?

REFERENCES

1. Alexander SJ, Harrison AG. Cognitive responses to stress, depression, and anxiety and their relationship to ADHD symptoms in first year psychology students. *J Atten Disorders*. 2013 Jan,;17(1):29-37.
2. Carpentier P-J. Pharmacological treatment of adhd in addicted patients: what does the literature tell us? *Harv Rev Psych*. 2017;25(2): 50-64.
3. Cortese S et al. Comparative efficacy and tolerability of medications for ADHD in children, adolescents, and adults: a systematic review and network meta-analysis. *Lancet Psychiatry*, 2018 Sep;5(9):727-738. Epub 2018 August 7. doi: 10.1016/S2215-0366(18)30269-4.
4. Harrison AG et al. Higher reported levels of depression, stress, and anxiety are associated with increased endorsement of ADHD symptoms by postsecondary students. *Canadian J School Psych*. 2013;28(3):243-260.
5. CADTH Rapid Response Reports. *High-dose stimulants for attention-deficit/hyperactivity disorder: A review of the clinical effectiveness, safety and guidelines*. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health, 2016. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27077166>
6. Jansen L et al. Mindfulness-based cognitive therapy v treatment as usual in adults with ADHD: a multicentre, single-blind, randomized controlled trial. *Psychol Med*. 2018 Feb;28:1-11.
7. Katzman MA et al, Adult ADHD and comorbid disorders: clinical implications of a dimensional approach. *BMC Psychiatry* 2017 Aug 22;17:302-16.
8. McGough JJ. Treatment controversies in adult ADHD. *Am J Psych*. 2016;173(10):960-6
9. Quinn PD et al. ADHD medication and substance-related problems. *Am J Psych*. 2017;174(9):877-85.

ADDITIONAL RESOURCES

- Magomedov A. "How to Convince Your Shrink You've Got ADHD." 2006. Available at: <http://tinyurl.com/crc4ldn>
- Video: "Take Your Pills." Netflix documentary, 2018. Available at: <https://www.netflix.com/title/80117831>

SELF-ASSESSMENT QUESTIONS

SA-Q#1. Neuropsychological testing alone is sufficient to confirm the diagnosis of ADHD.

- A. True
- B. False
- C. Sometimes

SA-Q#2. A past history of patient-reported benefit from stimulants strongly suggests the presence of ADHD

- A. True
- B. False

SA-Q#3. Which of the following best describes findings of Cortese et al. in their recent meta-analysis comparing ADHD meds for adults?

- A. Amphetamines somewhat more effective than methylphenidate
- B. Methylphenidate somewhat more effective than amphetamines
- C. No difference in effectiveness
- D. Modafanil should be considered a first-line medication

SA-Q#4. Which of the following is the most accurate regarding amphetamine salt doses above 40 mg and methylphenidate doses above 60 mg?

- A. Present a major cardiovascular risk and must be avoided
- B. Have been shown to be safe and effective in selected patients
- C. Won't provide any additional benefit beyond that of lower doses
- D. Are contraindicated in patients with a history of substance abuse

SA-Q#5. Which of the following is most accurate regarding ADHD medications in the presence of a substance abuse disorder and ADHD?

- A. May have a positive impact on the course of the substance abuse disorder
- B. Are always contraindicated
- C. Can make the treatment of the substance abuse disorder unnecessary
- D. Should be limited to atomoxetine

TABLETOP DISCUSSION

TABLETOP DISCUSSION #1

Your new patient is 24 and has no history of treatment for any psychiatric or substance abuse problem. S/he wonders if s/he has ADHD. The intake was inconclusive for any diagnosis. You go through the DSM5 criteria, and though the patient doesn't meet enough criteria, you still think this could be ADHD.

What are 3 non-DSM-criteria questions might you ask to try to sort this out?

TABLETOP DISCUSSION #2

Your 45-year-old patient has recently completed treatment for alcohol use disorder, and you are convinced s/he has been sober for 6 weeks. S/he presents a persuasive history of childhood-onset ADHD, with past successful treatment with amphetamine salts during middle and high school. S/he is back to work, engaged in alcohol treatment aftercare, including naltrexone, and reports recurring and troubling work problems strongly suggestive of ADHD. S/he fears for her/his job.

1. Does this patient get an amphetamine-salt prescription today from you?
2. Is there any other information you'd like before you decide?

TABLETOP DISCUSSION #3

You've recently started a new-to-Kaiser patient on methylphenidate IR 10 mg bid for ADHD, inattentive type. You're pretty confident of your diagnosis and there is no history of substance abuse or other known psychiatric problems. Three days after starting the drug, the patient is calling to say "it's not working, can I double the dose?" You ask your nurse to get more specifics. The nurse calls the patient back, and tells you the patient was irritated by the call, that "I already told you it's not working!"

What is your next step?