“VAADA Elevate 21 September 2023”

Working with People with ADHD & SUD

Dr Dianne Grocott MBBS (UWA 1983), FRANZCP (1989)

RANZCP Faculties of Addiction Psychiatry & of Adult Psychiatry with the ADHD Network

Co-founder Victorian Adult ADHD Interest Group (VAADHDIG), 2015

Foundation Member of Australian ADHD Professionals Association (AADPA), 2017

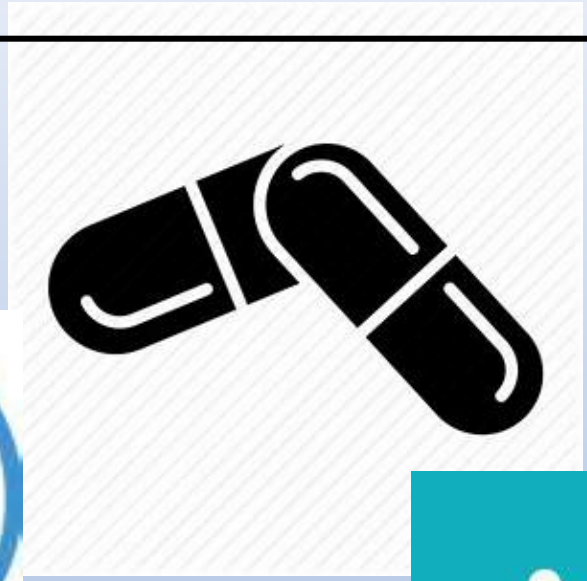
How can we make a difference?

- We screen our kids in school for Vision and Hearing so they can function well.
- So why not for Attention?
- If a large number of people with SUD had dysregulation of their attention, movements, impulses and emotions (ie have ADHD) before onset of SUD, why don't we screen and treat them?

People with Diabetes shouldn’t be expected to just “try harder” to regulate their blood sugar levels.

They are given Education, Medication and Coaching for Lifestyle Change

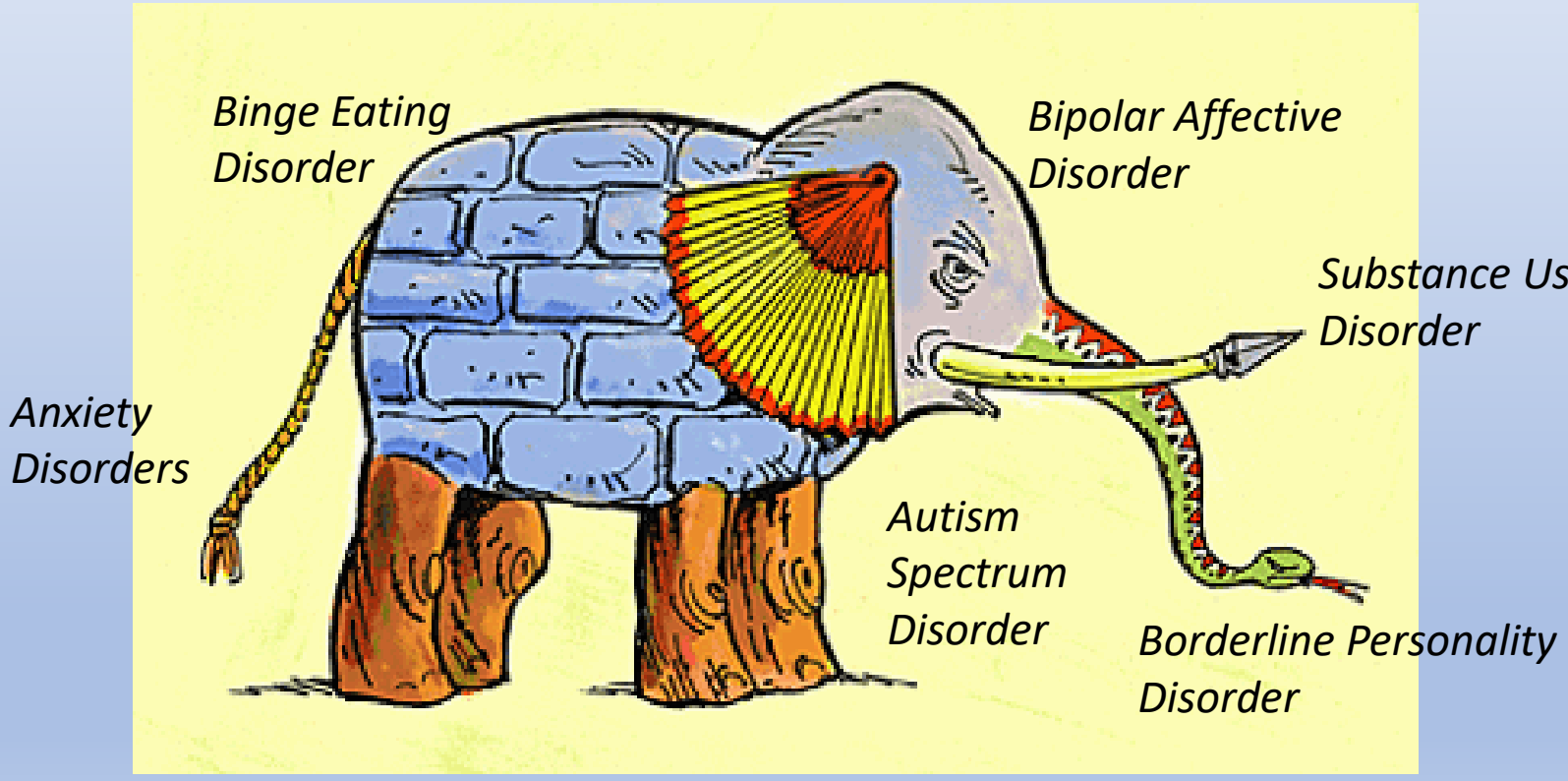
People with ADHD shouldn't be expected to just "try harder" to regulate their dopamine levels.



They should be given Education, Medication and Coaching for Lifestyle Change

Why is the diagnosis of ADHD so often missed in Adults?

Because it is the Elephant in the Room, camouflaged in plain sight



Six blind men who had never met an Elephant described a Rope, a Wall, a Tree trunk, a Spear, a Fan and a Snake.

Coexisting Condition	Adults with ADHD	Adults without ADHD
Any mood disorder	**38.3%**	**11.1%**
Major depressive disorder	18.6%	7.8%
Dysthymia (mild, chronic depression)	12.3%	1.9%
Bipolar disorder	19.4%	3.1%
Any anxiety disorder	**47.1%**	**19.5%**
Generalized anxiety disorder	8.0%	2.6%
PTSD	11.9%	3.3%
Panic disorder	8.9%	3.1%
Agoraphobia	4.0%	0.7%
Specific phobia	22.7%	9.5%
Social phobia	29.3%	7.8%
Obsessive-compulsive disorder (OCD)	2.7%	1.3%
Any substance abuse disorder	**15.2%**	**5.6%**
Alcohol abuse	5.9%	2.4%
Alcohol dependence	5.8%	2.0%
Drug abuse	2.4%	1.4%
Drug dependence	4.4%	0.6%
Intermittent explosive disorder	**19.6%**	**6.1%**
Overweight	**33.0%**	**28.8%**
Obese	29.4%	21.6%

Cortese, Samuele et al. (2015). Association Between ADHD and Obesity: A Systematic Review and Meta-Analysis. *American Journal of Psychiatry* (Kessler et al. (April 2006). The Prevalence and Correlates of Adult ADHD in the United States: Results From the National Comorbidity Survey Replication, *American Journal of Psychiatry* 163(5):71. **National Comorbidity Survey Replication (NCS-R)** in 3,199 adults with ADHD (ages 18-44)

What if having an ADHD brain is actually an asset?

A growing number of innovators, entrepreneurs, CEO's, Olympic athletes, and award-winning artists have gone public about their diagnosis, saying that their ADHD, managed effectively, has played a vital role in their success.

The Disruptors hears from many of those game-changing people speaking candidly about their ADHD, and intimately takes viewers inside a number of families as they navigate the challenges, and the surprising triumphs, of living with ADHD.

https://www.imdb.com/title/tt14854294

Inattention actually “Dysregulation of Attention”

- ***Your brain is so busy***
  - easily distracted,
  - Can’t concentrate
  - Can’t pay attention
  - Can’t listen or remember
  - Disorganised and overwhelmed
- ***But you can hyperfocus***
  - When the topic is exciting, frightening, urgent or emotional, with a deadline you hyperfocus
- ***So sometimes you feel really bright***
  - and other times, for no reason, you feel ***lazy or stupid***?

Hyperactivity actually “Dysregulation of Movement”

- ***You always feel restless***
  - Fidgety
  - Can’t easily sit still
  - Driven by a motor
  - Always talking
- ***And this irritates others***
  - but you can’t stop it
- ***But you feel really normal when you are moving***

Impulsivity actually "Dysregulation of Impulses"

- ***You can't wait your turn***
- ***You often interrupt***
  - Because you care
  - You'd forget the first idea if you waited for the next one
  - And you knew what they were going to say
- ***You blurt out things***
  - that you regret later
- ***You make impulsive decisions***
  - that you regret later
- ***You are accident-prone***
  - And you regret that too

Emotional dysregulation

- ***Not on the diagnostic list***
  - Because occurs in other disorders
  - But causes much grief
- ***Your emotions are***
  - Hypersensitive
  - Out of proportion to the trigger
  - Are harder to manage
- ***Examples are extreme***
  - Anger, impatience, rage
  - Embarrassment
  - Rejection Sensitivity Dysphoria
  - Social anxiety, panic
  - Insensitivity

What is Diagnosis?

- Differentiating one condition from all others

- Only a Lion has a Mane
- Only a Tiger has Stripes
- Doesn't mention the teeth, claws, legs or tail

- And doesn't indicate how to tame them.

The DSM-5 Diagnostic criteria for ADHD requires the following:

- The symptoms to have been present before you were 12 years old
- The symptoms lead to significant functional impairment in different spheres of life
- (For Adults), diagnosis requires at least 5 of 9 symptoms from either or both of the two lists below:

List 1: Inattention Symptoms	List 2: Hyperactivity/Impulsivity
1. *Often misses details or makes careless mistakes*	1. *Often fidgets/taps/squirms*
2. *Unsustained attention*	2. *Leaves seat*
3. *Fails to listen*	3. *Restless feeling*
4. *Poor follow-up or finishing*	4. *Not quiet*
5. *Poor organisation*	5. *Always on the go as if driven by a motor*
6. *Avoidance of difficult tasks*	6. *Talkative*
7. *Losing items*	7. *Blurts answers*
8. *Easily distracted*	8. *Can't wait*
9. *Forgetful*	9. *Interrupts*

- Presentation (symptoms over past 6 months)can be Inattentive, Hyperactive/Impulsive or Combined

Is there a quick Screening questionnaire?

Adult ADHD Self-Report Screening Scale for DSM-5 (ASRS-5) © NYU & Harvard. More than 14/24 is suggestive of ADHD	Tick the box for You in the past 6 months				
	Never (0)	Rarely (1)	Sometimes (2)	Often (3)	Very Often (4)
1. How often do you have difficulty concentrating on what people are directly saying to you?					
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
3. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
4. When you are in a conversation, how often do you finish people's sentences before they can finish them themselves?					
5. How often do you put things off until the last minute? (avoidance and procrastination?)					
6. How often do you depend on others to keep your life in order and attend to details?					

My Score

Max = 24

More than 14 out of 24 = maybe ADHD

WHAT IS ADHD?

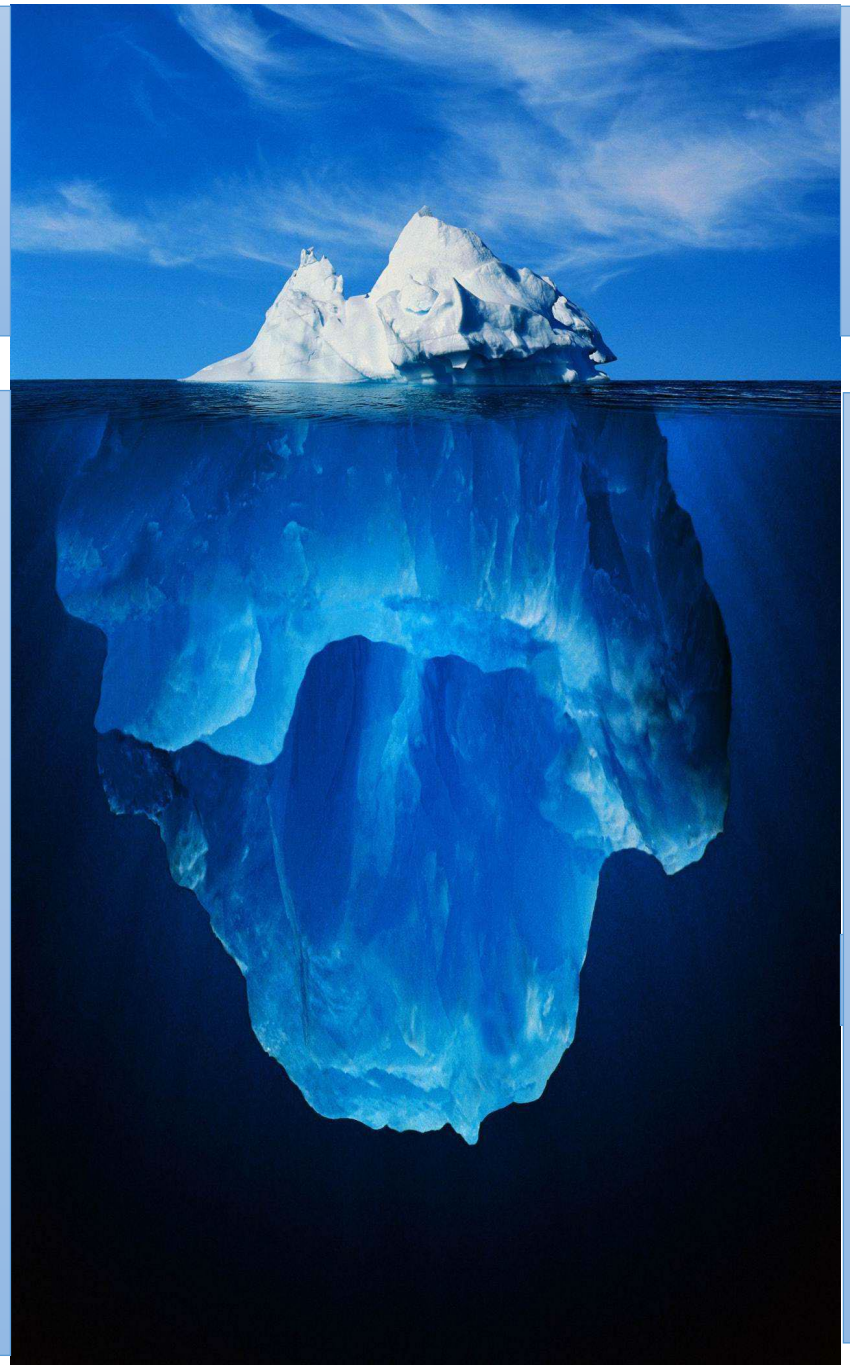
Diagnostic criteria only differentiates between disorders. eg Lion = mane, Tiger = stripes.

Doesn't mention the teeth, claws, four legs & tail

And doesn't indicate how to tame them.

DIAGNOSIS
Observable
Measurable
Differentiates

LIVED EXPERIENCE
Symptoms
Comorbidities
Supports
Compensations
Consequences

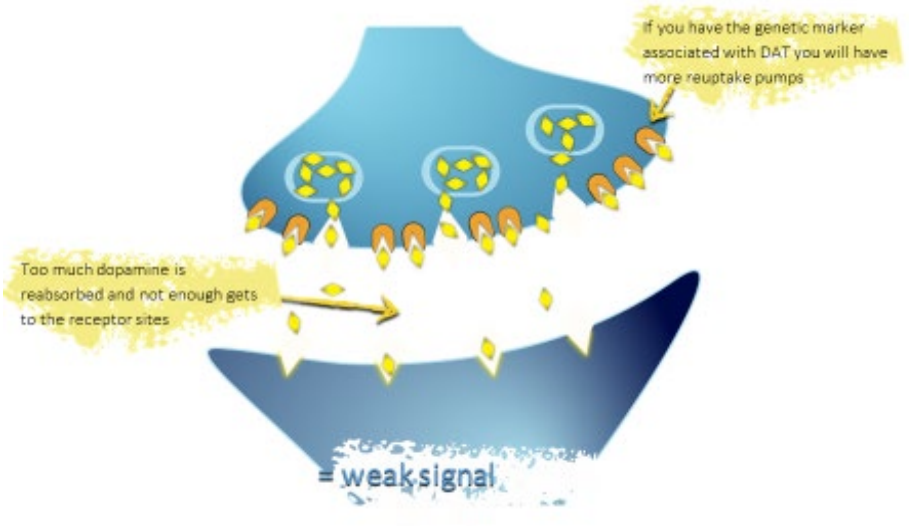


Inattention
+/-
Hyperactivity
& Impulsivity

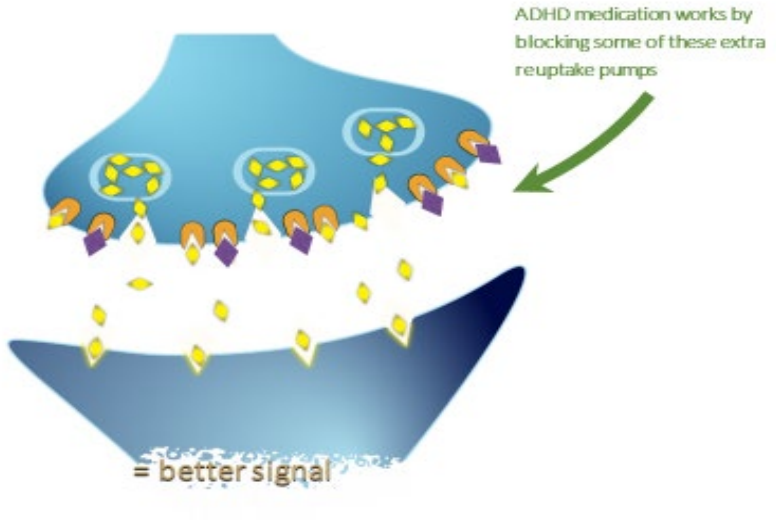
Emotional - dysregulation
Busy brain
Anxiety
Addictions
Avoidance
Losses
Shame
Skills
Nutrition
Environment
Genetics

What's happening in the ADHD Brain with and without Medication?

ADHD = Too many "Vacuum cleaners" gives intermittent weak signals.
Can "try harder" and increase signal.
Or produce more NT's by natural means - exercise, goals, thoughts, situations
ADHD Medication plugs the excess vacuum cleaners - feel normal



ADHD – Weak signals

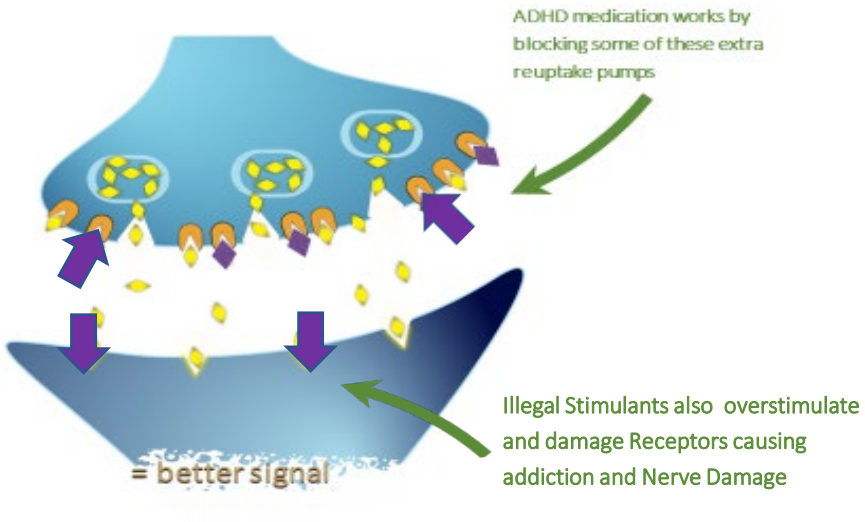


ADHD + medication – Better signals

Appreciation to Jon Hassall, www.ConnectADHD.com

The difference between Illegal and Legal Stimulants

Cocaine & Meth (ice, speed) plug vacuum cleaners which helps ADHD
But also stimulate then damage Receptors.
With less receptors, "need" drugs to get signal = Addiction
ADHD (Ritalin, Dex, Lisdex) meds don't plug Receptors so No Addiction.



Cocaine ↓ and Methamphetamine (speed, ice) ↓ plug Vacuum cleaners and Receptors and cause addiction

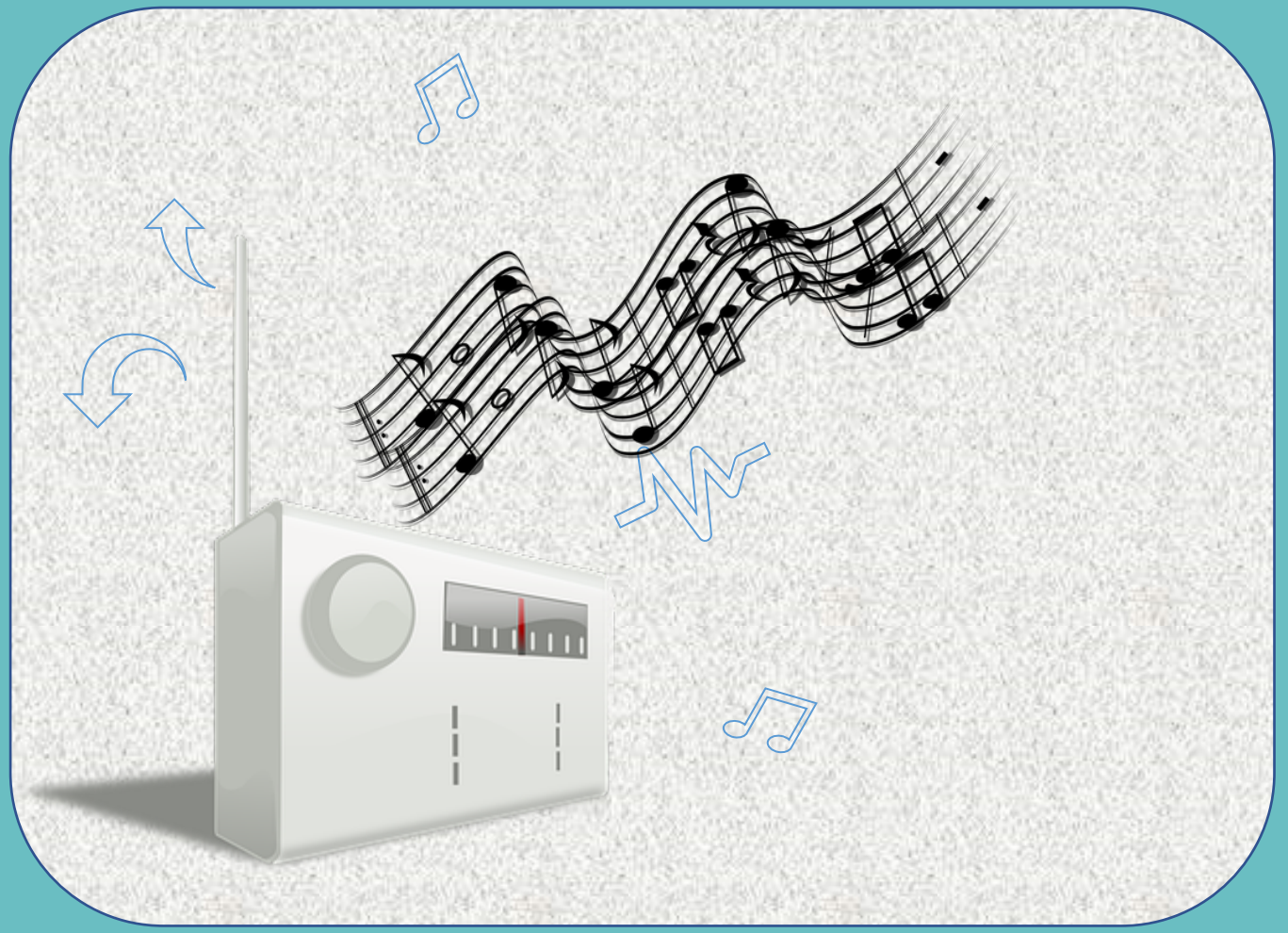
Ritalin ◆ and Dex ◆ don't affect Receptors so don't cause addiction

Appreciation to Jon Hassall, www.ConnectADHD.com

ADHD Brain is like a radio that is not tuned to the station, so you hear song and static noises

Noradrenaline is like the Volume knob: the song is louder but so is everything else

Serotonin is like a mute button, so you may not feel much at all, and not care

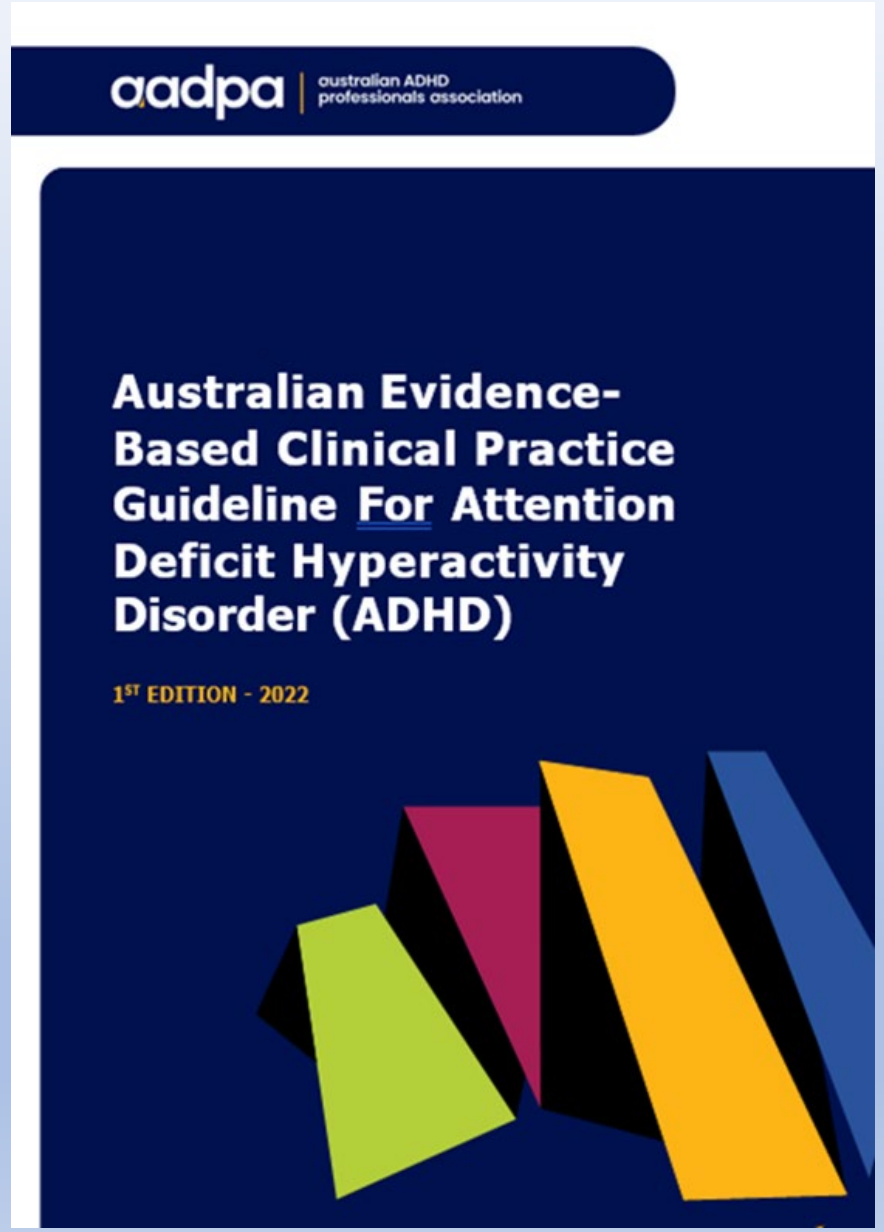


Dopamine is like the tuning knob:
The song is heard clearly

So Why Do I Sometimes Function Normally?

Because All These Increase Dopamine And Noradrenaline In My Synapses

Tasks I am good at, Hyperfocusing	Exciting thoughts, Loud music	Being busy Deadlines	Achieving goals, or Expecting to
Spending, Shopping, Speeding,	Video Games, Internet "Rabbit-holing"	Exercise, Extreme Sports, Competition, Dancing	Danger, Fear, Crisis, Conflict, Drama
Risk taking, Gambling, Porn	Negative, critical or controlling thoughts,	Stimulant chemicals (caffeine, nicotine, ice, cocaine),	Stimulant medication (MPH, DEX, LDX, ATX, GUF)



6.3 People with substance use disorders

6.3.1 - Screen ADHD patients for SUD
6.3.2 - Screen SUD patients for ADHD
6.3.3 - Screen early in SUD treatment
6.3.4 - treat ADHD & SUD in parallel
6.3.5 - Usually stabilise SUD, but don't delay ADHD Rx
6.3.6 - Multimodal therapies
6.3.7 - Be mindful of misuse. Consider long-acting psychostimulants
6.3.8 - Consider non-stimulant if active SUD
6.3.9 - Titrate psychostimulants, maybe higher doses

6.3 People with substance use disorders

6.3.1 Those working in public and mental health settings should be aware of the high co-occurrence of substance use disorders in those with ADHD.
Clinicians treating ADHD in these settings should routinely screen for problematic substance use or substance use disorders using best- practice screening questionnaires for substance use disorders.
Formal diagnosis of substance use disorders in an individual with ADHD should follow recommended guidelines for substance use disorders and include a structured diagnostic interview

6.3.2 Those working in drug and alcohol settings should be aware of the high co-occurrence of ADHD and substance use disorders.
Clinicians treating substance use disorders in these settings should routinely screen for ADHD using appropriate screening questionnaires for ADHD.
Formal diagnosis of ADHD in an individual with substance use disorders should follow recommended guidelines (see 2. Diagnosis).

6.3.3 Screening and diagnostic assessment should take place when the person's substance use is sufficiently stabilised. Only in case of acute intoxication or severe withdrawal symptoms should these assessments be postponed.

6.3.4 Treatment for people with ADHD and substance use disorders should focus on both disorders concurrently, should consider their interrelationship, and should follow the guidelines for each separate disorder and the general guidelines about treatment of people with co- occurring disorders.

6.3 People with substance use disorders

6.3.5 In most cases of concurrent ADHD and substance use disorders, clinicians should start treatment aimed at abstaining from or reducing/ stabilising the use of substances first, since current substance use disorders may complicate diagnosis and treatment of ADHD. However, start of pharmacological or non-pharmacological treatment of ADHD should not unnecessarily be delayed.

6.3.6 Treatment of substance use disorders in patients with ADHD should follow a multimodal treatment approach comprising both pharmacological and cognitive behavioural based interventions.

6.3.7 Clinicians treating ADHD with substance use disorders should be aware of, and monitor for, the risk of misuse and diversion of psychostimulant medication. To minimise risk of diversion and misuse, use of long- acting, rather than short-acting, psychostimulants should be considered.

6.3.8 Before starting stimulant pharmacotherapy in people with concurrent ADHD and substance use disorders, it is important that the person is abstinent or has reduced/stabilised their substance use. If this is not the case, the clinician should consider non-stimulant pharmacotherapy (e.g. atomoxetine, guanfacine, or bupropion)

6.3.9 Pharmacological treatment of ADHD requires careful titration and monitoring of its effect and possible adverse effects. Higher doses of stimulants may be required in people with ADHD and concurrent substance use disorders than in those without substance use disorders to achieve a favourable effect on both the ADHD symptoms and reduction of substance use.

Clinical considerations for implementation of the recommendations p164

- Given the high co-occurrence of substance use disorders and ADHD, clinicians working in addiction settings require expertise and training in ADHD.
- Those in mental health settings or settings including people with high risk of ADHD, need to have experience in the identification of people with ADHD who have substance use disorders.
- Legitimate concerns exist regarding the diversion or misuse potential of stimulant medications in those with ADHD and substance use disorders.
- If urine screening for illicit substances is used, clinicians should be aware of the limits of such screening tests and the potential for false positives/negatives and interactions with other medications. They should contextualise the interpretation of results with detailed patient histories.
- Greater awareness that stimulant medications are rigorously controlled, safe medications and that long-acting formulations, in particular, are associated with no increased risk of future substance use disorders should help to reduce any fear or stigma around their use in alcohol and drug services, and will ensure those with ADHD receive access to vital treatment.
- Greater interaction between addiction specialists and ADHD-specialists is urgently needed.

ICASA - IASP Study 2010-11

International ADHD in Substance use disorders Prevalence study

- **11 countries - 3,588 Treatment seeking-SUD Patients worldwide**
- **Australia - 489 SUD Patients in 16 settings – 215 had ADHD** **Australian prevalence = 44%**
- **ADHD complicates the course of SUD**
  - earlier onset, greater severity of substance use, more difficult to treat, more relapses.
- **Increased harms in ADHD/SUD vs Non-ADHD/SUD populations**
  - inattention, carelessness, and impulsive risk-taking associated with ADHD.
  - high-risk behaviours - injecting, non-sterilising,
  - Early onset (<15yo) nicotine use
  - Current and past amphetamine use, Heavy alcohol use
  - Long duration (≥5 years) of alcohol, opiates other than heroin or methadone, and amphetamine
  - Comorbid depression, anxiety or personality disorder
  - Driving offences, licence suspensions, at-risk MVA's

https://ndarc.med.unsw.edu.au/project/examining-prevalence-adhd-among-those-sud

ICASA - Guidelines 2018 (1)

International Consensus Statement on Screening, Diagnosis and Treatment of SUD Patients with Comorbid ADHD

Crunelle, C and ICASA Consensus Group *Eur Addict Res 2018;24:43–51*

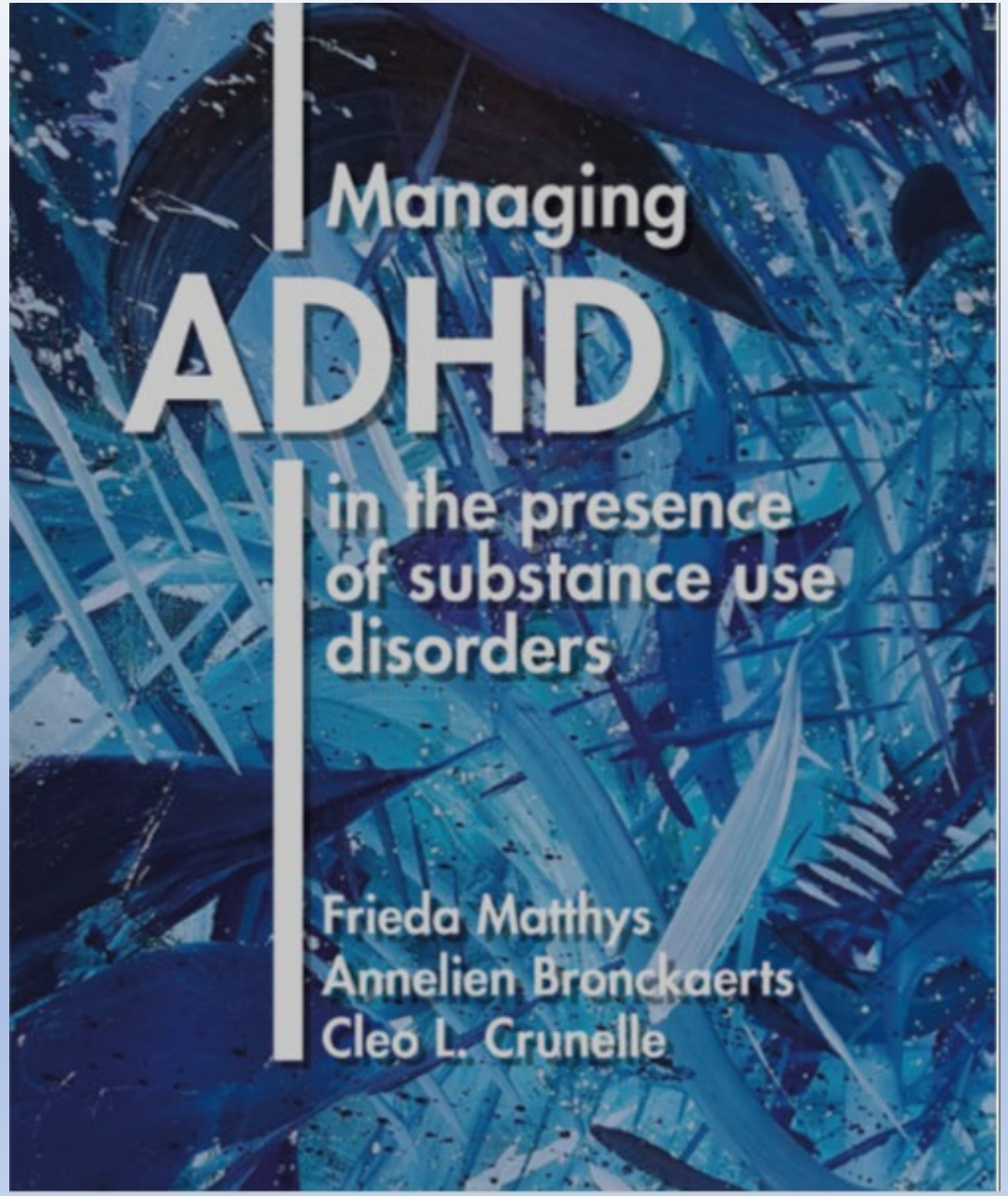
- Screen all SUD patients for ADHD
- ASRS, Wender Utah Rating Scale and Conners' Adult ADHD Rating Scale have been sufficiently validated as screeners.
- Diagnosis by a physician or psychologist trained in ADHD/SUD - questionnaires, semi-structured interviews, collateral history from family and school reports, longitudinal observation by staff to reduce the risk of over- or under-diagnosis.
- Anticipate other psychiatric comorbidities

ICASA - Guidelines 2018 (2)

International Consensus Statement on Screening, Diagnosis and Treatment of SUD Patients with Comorbid ADHD

Crunelle, C and ICASA Consensus Group *Eur Addict Res 2018;24:43–51*

- Integrated multimodal therapies for ADHD and SUD
- Medication
  - Psychostimulants - long acting, +/- high doses, limited supply
    - Methylphenidate, Lisdexamfetamine
    - Atomoxetine - alcohol, delayed onset
  - Treat SUD - anticraving, ORT etc
  - Treat other comorbidities – eg antidepressants
- Psychotherapy
  - Integrated CBT

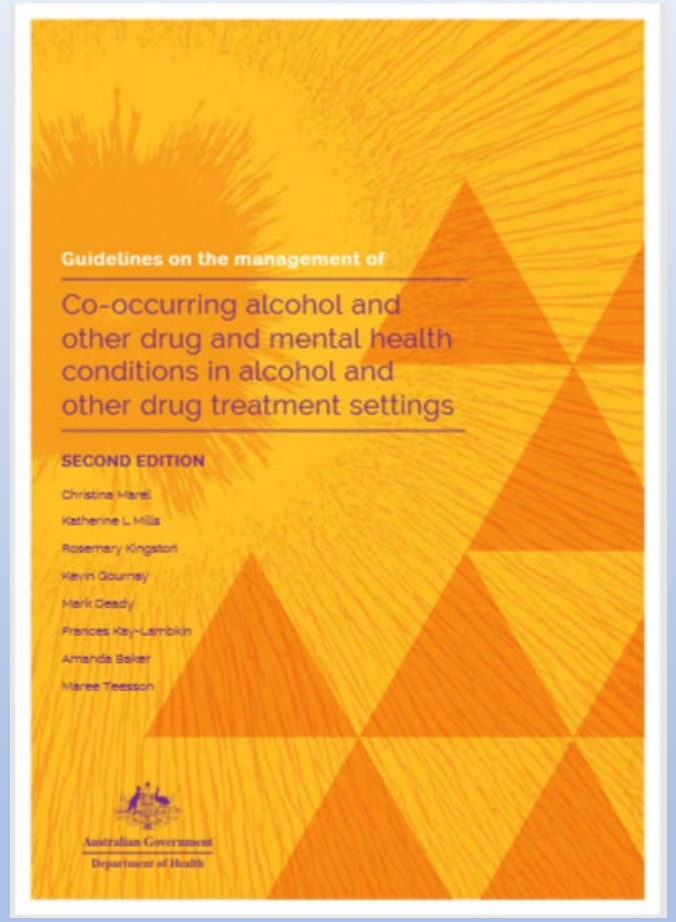


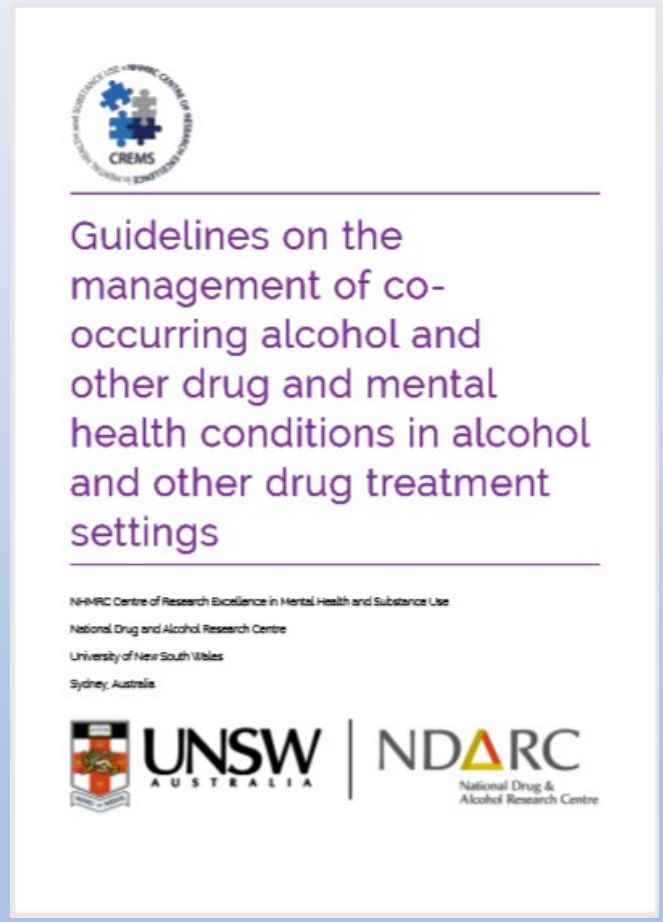
ICASA Textbook 2018

Table of Contents

- Guidelines ADHD/SUD
- Principles of treatment
- Modules
  - Psychoeducation
  - Planning/Organisation
  - Better Sense of Time
  - Reducing distractions
  - Managing SUD
  - Emotional Regulation
  - Negative Thoughts
  - Reducing Impulsivity
  - Social skills
  - Relapse Prevention
- Worksheets

Australian Comorbidity Guidelines AOD & ADHD (2014)



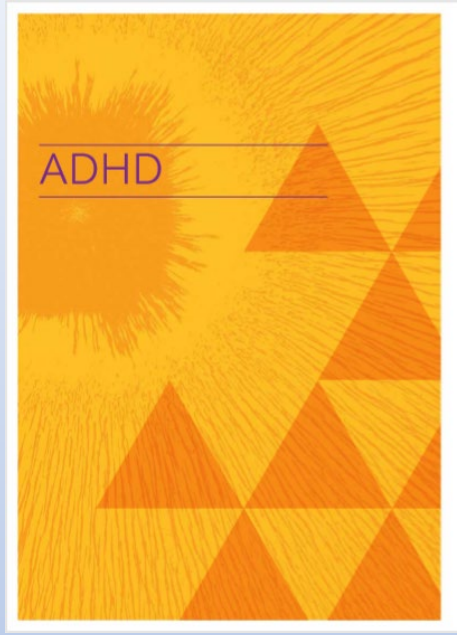


These are excellent guidelines, but there is no training on ADHD for addiction psychiatrists

https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf

Australian Comorbidity Guidelines AOD & ADHD (2014)

Integrated multimodal approach



- Psychoeducation
- Psychotherapy – individual, group
- Peer & Family Support
- Pharmacotherapy
  - Methylphenidate, Dexamphetamine, Lisdexamfetamine, Atomoxetine,
- e-health interventions, smartphone Apps
- physical activity
- complementary and alternative therapies (e.g., dietary supplements).

Excellent guidelines but unfortunately ignored. The curriculum for training addiction psychiatrists does not mention ADHD

European Addiction Research

Research Article

Eur Addict Res 2020;26:223–232
DOI: 10.1159/000508385

Received: April 8, 2020
Accepted: May 4, 2020
Published online: July 7, 2020

International Consensus Statement for the Screening, Diagnosis, and Treatment of Adolescents with Concurrent Attention-Deficit/Hyperactivity Disorder and Substance Use Disorder

Heval Özgen[a, ξ] Renske Spijkerman[a] Moritz Noack[b] Martin Holtmann[b] Arnt S.A. Schellekens[c, d] Geurt van de Glind[d, e] Tobias Banaschewski[f] Csaba Barta[g, h] Alex Begeman[i] Miguel Casas[j] Cleo L. Crunelle[k] Constanza Daigre Blanco[l–n] Søren Dalsgaard[o] Zsolt Demetrovics[P] Jacomine den Boer[i] Geert Dom[q] Valsamma Eapen[r] Stephen V. Faraone[s] Johan Franck[t] Rafael A. González[u, v] Lara Grau-López[l–n, T] Annabeth P. Groenman[w, x] Malin Hemphälä[t] Romain Icick[y, z, A] Brian Johnson[s] Michael Kaess[B, C] Máté Kapitány-Fövény[D, E] John G. Kasinathan[F] Sharlene S. Kaye[G] Falk Kiefer[H] Maija Konstenius[t] Frances R. Levin[I] Mathias Luderer[J] Giovanni Martinotti[K] Frieda I.A. Matthys[L] Gergely Meszaros[M] Franz Moggi[N] Ashmita P. Munasur-Naidoo[O, P] Marianne Post[Q] Sharon Rabinovitz[R] J. Antoni Ramos-Quiroga[m, n, S, T] Regina Sala[U] Abu Shafi[V] Ortal Slobodin[W] Wouter G. Staal[X, Y] Rainer Thomasius[Z] Ilse Truter[α] Michiel W. van Kernebeek[β] Maria C. Velez-Pastrana[γ] Sabine Vollstädt-Klein[H] Florence Vorspan[z, δ, ε, ζ] Jesse T. Young[θ, η, ι, κ] Amy Yule[λ] Wim van den Brink[e, μ] Vincent Hendriks[a, ξ]

Summary of International Consensus Statement for the Screening, Diagnosis, and Treatment of Adolescents with Concurrent ADHD and Substance Use Disorder (2020)

- **Risk of developing SUD**

ADHD increases risk of SUD - Childhood ADHD is a serious risk factor for developing SUD in adolescence

ADHD + CD/ODD even greater risk for SUD - ADHD + conduct disorder (CD) or oppositional defiant disorder (ODD) pose greater risks for developing SUD in adolescence

Stimulant medication DOESN'T lead to SUD - There is strong evidence that stimulant treatment of childhood ADHD does not increase the risk of developing SUD in adolescence

Stimulant medication protects against SUD - Stimulant treatment of childhood ADHD reduces risk of developing SUD in adolescence

- **Screening and diagnosis of ADHD and SUD**

Heavy substance use predicts worse treatment outcomes for both ADHD and SUD.

Early detection and treatment improves outcomes

High co-morbidity of ADHD+SUD

Screen everyone - all primary care and mental health patients for SUD and all SUD patients for ADHD

Diagnosis by trained professional using standardized structured diagnostic instruments and diagnostic procedures for each separate disorder

Summary of International Consensus Statement for the Screening, Diagnosis, and Treatment of Adolescents with Concurrent ADHD & Substance Use Disorder (2020)

Treat both ADHD and SUD in parallel.

Stabilise SUD first but don't delay ADHD treatment unnecessarily

Clinical judgement in individual cases is needed regarding which medication and whether to wait until abstinence or not.

Psychological treatment should include psychoeducation and motivational interviewing to enhance treatment engagement and retention and CBT for either SUD or both conditions

Consider family-based treatment

First-line pharmacotherapy of ADHD in adolescents with concurrent ADHD and SUD consists of long-acting psychostimulants (e.g., methylphenidate, lisdexamfetamine, dexamphetamine, and mixed amphetamine salts). As second-line pharmacological treatments atomoxetine, guanfacine XR or bupropion can be considered

Carefully titrate medication, monitoring effect and possible adverse effects.

Higher doses of psychostimulants may be required in patients with ADHD+SUD

Minimise risk of psychostimulant medication misuse or diversion, with careful clinical monitoring, therapeutic contract, long-acting instead of short-acting psychostimulants, limited dispensing

Monitor growth, weight, BP. Cardiac assessment if indicated

Healthy lifestyle - balanced diet, good nutrition, regular exercise, scheduled bed and wakening hours is recommenced

Complementary treatments - Insufficient research in adolescent ADHD+SUD populations to recommend Neurofeedback, dietary interventions, meditation/mindfulness- based therapies , physical exercise interventions or herbal medicine as primary treatments

FIRST STEP SUD+ADHD DIAGNOSIS AND TREATMENT Protocol (July 2019)

STEP 1: SCREEN ALL SUD PATIENTS FOR ADHD

Current ADHD Sx, Childhood ADHD Sx, Prior ADHD Dx, Effect of Simulants, FAMILY Hx ADHD,

Screening Questionnaires (ASRS-18, Jasper-Goldberg)

Not ADHD:

Maybe ADHD:

Get more information

Probably ADHD

Reconsider Dx
PTSD? BPAD?

STEP 2: LINK WITH CASE COORDINATOR and DECIDE IF NEED MORE INFO and WHO WILL TREAT

Who will treat? Afford Private Psychiatrist? Current Private Psychiatrist?
Current Public Psychiatrist? External GP?
Need more Information? DIVA, School Reports, Collateral Family Hx, Past Psych Hx

Co-Manage

Private Psychiatrist

First Step

STEP 3a: GP MEDICAL REVIEW
CASE COORDINATOR Liaises

Organic causes that Mimic/Aggravate ADHD Sx: Anaemia
Sleep apnoea, Hyperthyroidism,

Conditions worsened by Stimulants: Unstable SUD, Psychosis, BPAD, Anxiety, Anorexia

Contraindications to Stimulants: Cardiac, Epilepsy, Tics, Glaucoma

Work-up for Stimulants: BP, Physical ECG >40 or FHx heart disease. +/- Echo FBE, U&E, glucose, lipids, TSH, T4, T3, Iron studies, Vit D, B12, Serum Copper, Plasma Zinc, CRP, Ceruloplasmin. Consider UDS.

Refer to Psychiatrist if indicated

STEP 3b: PATIENT AND FAMILY INFO
CASE COORDINATOR Liaises

Watch videos
HowToADHD
The Disruptors

Complete First Step ADHD Questionnaire with Significant Other

School Reports, Collateral Family Hx if not already obtained

Past Psych Hx if not already obtained

STEP 4: PSYCHIATRIST ASSESSMENT

Assessment of ADHD, SUD, other Comorbidities and Past Treatments, Strengths and Supports, Stage of Change

Education about ADHD and Treatment options – medication, lifestyle, diet, sleep, exercise, skills, assistance, psychotherapy, skills coaching, family therapy

If Lisdexamfetamine is indicated, Support Letter for GP Schedule 8 Permit

STEP 5: BACK TO CASE COORDINATOR

Organise Schedule 8 Permit for GP to prescribe Lisdexamfetamine
Organise First Step ADHD Medication Contract

Organise GP appointment for medication, education, sign contract and prescribe

First Step ADHD+SUD Medication Protocol (still in DRAFT) – liaise with Patient, Prescriber, Family, Pharmacy

STEP 6: FIRST STEP MEDICATION PROTOCOL

First Step ADHD Medication Contract between Patient, Prescriber and Pharmacist

Lisdexamfetamine Dose: start 30mg, titrate cautiously to max 70mg

Weekly review by First Step Staff then OK to Pharmacy for next week's collection
If on ORT, align LDX collection+ 1 day in advance so can take with breakfast

Consider purpose of UDS

Costs to Patient: Appts Bulk Billed, UDS:GCMS for Meth $75

LESSONS LEARNED SO FAR

Good communication with outside Treatment Team & Involve Family if at all possible

Regular monitoring and Limited supply of ADHD Medication

First Stabilise Homelessness, Crises, other Medical conditions, Psychosis, Hypomania

Stabilise SUD – maybe Inpatient Detox or Rehab first

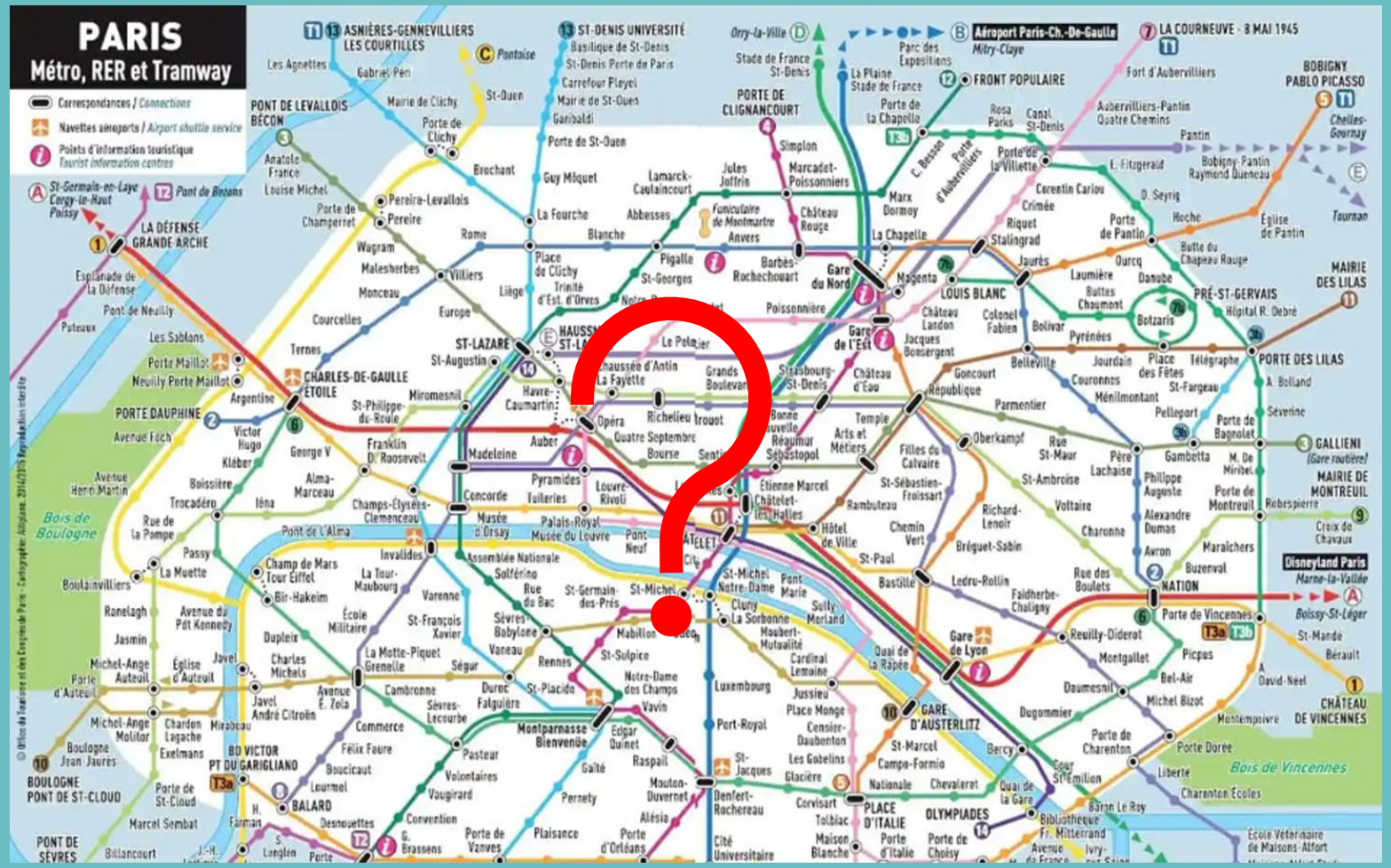
Be prepared to reassess diagnosis ?PTSD ?Psychosis

SUD Stage of Change often predicts ADHD treatment success, but not always

Warn patients to be prepared for emotional destabilisation

Therapists be prepared to be surprised or proved wrong (Murphy had ADHD)

New ADHD Diagnosis?
Like landing in a new City



- Overwhelming?
- Why so few Tour Guides?
- Why a psychiatrist not a GP?
- Why such a long wait?
- Why such a detailed assessment?
- Why no public clinics?
- Why not Coaches subsidised?

If diabetics waited 6 months to see an Endocrinologist to start insulin, there would be an outcry.

M.A.P = My ADHD Plan

If you had an ABOVEGROUND MAP
you could participate more.
And find your way back to the Hotel
if you lost your Tour Guide

A.B.O.V.E G.R.O.U.N.D

MAP = My ADHD PLAN

A = ADHD education
B = Be aware of my ADHD
O = Optimise medications
V = Various comorbidities
E = Executive function
G = Get a healthy lifestyle
R = Rollercoaster
O = Other people
U = Untangle messes
N = Numbers
D = *Delight in your Life*

A

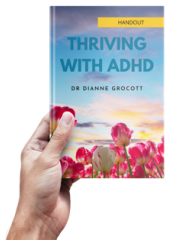
= ADHD Education

Patient and significant others know where to find ADHD information.

A.B.O.V.E G.R.O.U.N.D

Websites, YouTube, Support Groups

Reflect Health Resources Library
adhd@reflecthealth.com.au



YouTube

Dr Grocott's seminar

B

= Be aware of my ADHD

Patient and significant others understand the impact of their ADHD symptoms, positives, compensatory strategies, "dopamine menu"

A.B.O.V.E. G.R.O.U.N.D.

My compensatory behaviours

My "dopamine menu"

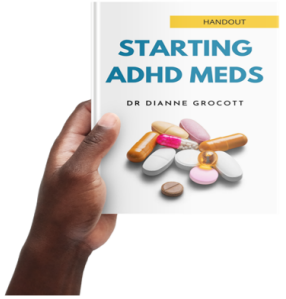
O

= Optimise medication.

- Titrate and stabilise medications for insomnia, mood instability, ADHD and other co-morbidities.
- 'Stimulant' meds don't stimulate ADHD brains but calm and focus them.

A.B.O.V.E. G.R.O.U.N.D.

- Start LOW, Go SLOW.
- TARGET = "Goldilocks" dose
- Often combine short + long acting.



V

= Various co-morbidities

Psychiatric, Addiction, Medical

- Some need to be stabilised before using ADHD meds
- Some are from untreated ADHD and may 'melt away'
- Some need to be treated in parallel

A.B.O.V.E. G.R.O.U.N.D.

Prioritise what to tackle first

E

= Executive function skills

Five questions for Getting Started

- Q#1 What am I avoiding?
- Q#2 What would it look like when it's done?
- Q#3 What's the First Step?
- Q#4 What help do I need with the First Step?
- Q#5 How can we make this Fun?

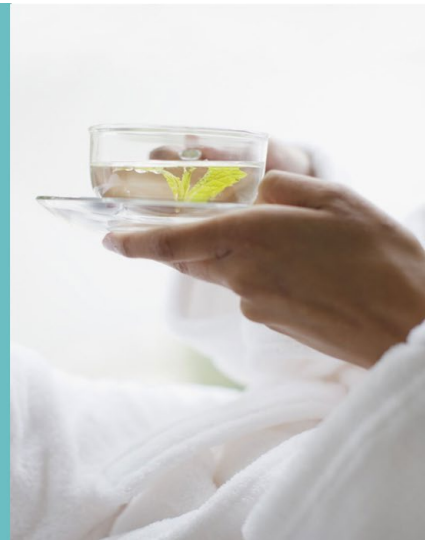
A.B.O.V.E. G.R.O.U.N.D.

G

= Get a healthy lifestyle

- Get to bed
- Get up
- Get exercise
- Get your vegies
- Get daily goals

A.B.O.V.E G.R.O.U.N.D.

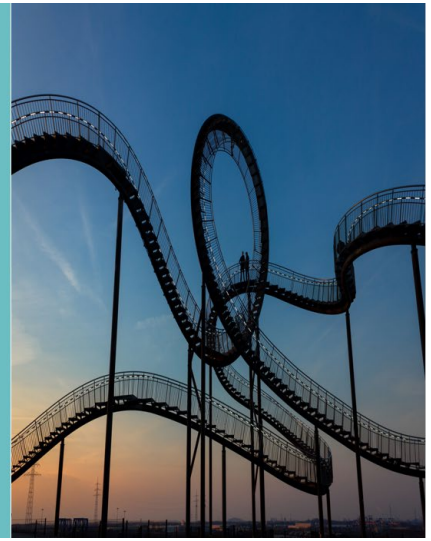


R

= Rollercoaster of emotions

- Emotional destabilisation of diagnosis
- Memories, regrets, traumas
- Say Hello; then keep, toss, repurpose
- Hear and see yourself as you were

A.B.O.V.E G.R.O.U.N.D.



O

= Other people

- Restore relationships
- Support groups
- Interpersonal therapies
- ADHD Coaching
- Relationship counselling

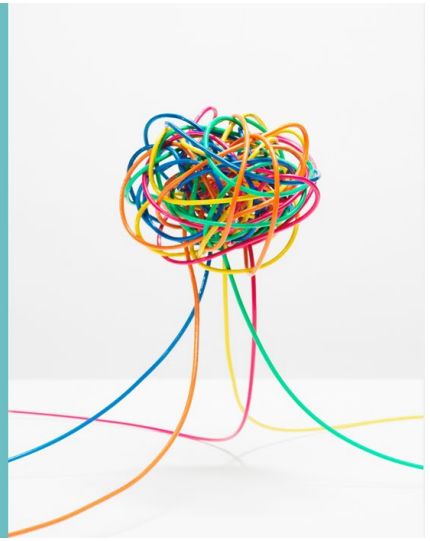
A.B.O.V.E G.R.O.U.N.D.

U

= Untangle messes

- Get organised – Declutter
- Academic /Occupational Advocacy
- Paperwork/Tax returns
- Traffic fines/Legal problems

A.B.O.V.E G.R.O.U.N.D.



N

= **Numbers** Rating Scales

- Identify goals of therapy
- Measure
- Celebrate your progress
- Research

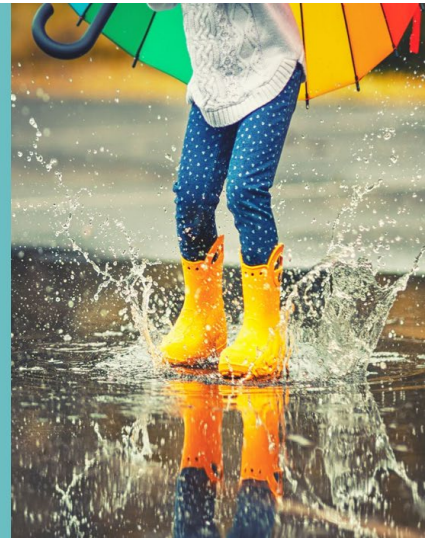
A.B.O.V.E G.R.O.U.N.D.

D

= Delight in being you

- What's your passion, purpose, legacy?
- Restore relationships
  - with yourself
  - with others
  - with your future

A.B.O.V.E G.R.O.U.N.D.



Would this instrument be useful to inform treatment decisions?

Integrated Motivational Assessment Tool (IMAT-ADHD)*

Stage of Change regarding ADHD & SUD

Motivation regarding SUD Treatment

Motivation regarding ADHD Treatment

	Pre-contemplation	Contemplation	Preparation / Determination	Action	Maintenance
Pre-contemplation					
Contemplation					
Preparation / Determination					
Action					
Maintenance					

*Adapted from NSW Department of Health IMAT (2007). Mental health reference resource for drug and alcohol workers.

TAKE HOME MESSAGES

There are great opportunities to significantly impact many lives by treating ADHD+SUD+

Screen “Everyone with ADHD for SUD” & “Everyone with SUD for ADHD”

Comprehensive Management Plan for ADHD+SUD+

Don’t re-invent the wheel – The knowledge is available

“What difference can I make?”