

# Australian Evidence-Based Clinical Practice Guideline For ADHD FACTSHEET: ADHD WITH CO-OCCURRING SUBSTANCE USE DISORDERS

## ADHD Risk Factors

ADHD is a risk factor for the development of substance use disorders (SUDs), particularly if ADHD is untreated and, people presenting with SUDs have increased risk of having ADHD (Groenman et al., 2013; van Emmerik-van Oortmerssen et al., 2012)(see also (Faraone et al., 2021; Ozgen et al., 2020). People with ADHD are almost three times more likely to be nicotine-dependent and 50% more likely to develop a drug or alcohol use disorder than individuals without ADHD (Lee, Humphreys, Flory, Liu, & Glass, 2011). Evidence also shows there is an increased prevalence of ADHD in those presenting with primary SUDs compared with the prevalence of ADHD in the population (van Emmerik-van Oortmerssen et al., 2012). It is important for clinicians working in addiction settings and those working with people with ADHD, to be aware of the overlap including how to identify, diagnose and provide treatment and support to people who have both conditions.

## Screening

Early screening is important to allow for early treatment to reduce the increased risk of morbidity and other negative health outcomes in people with ADHD and co-occurring SUDs. People with SUDs can be screened for ADHD using the 6 item Adult ADHD Rating Scale (ASRS) Part A (Daigre & Ramos-Quiroga, 2009; Van de Glind et al., 2013). People with ADHD can be screened for problematic drug and alcohol use using the DAST (Drug Abuse Screening Test) and AUDIT (Alcohol Use Disorders Identification Test) (McCann, Simpson, Ries, & Roy-Byrne, 2000). If a person screens positive for either, they should be provided with access to a diagnostic assessment.

## Diagnosis

Diagnosis for ADHD in SUDs; or SUDs in ADHD should follow best practice guidelines by an appropriately qualified clinician. This may involve referring to another service for a diagnostic assessment.

## Treatment of ADHD and substance use disorders (SUDs)

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

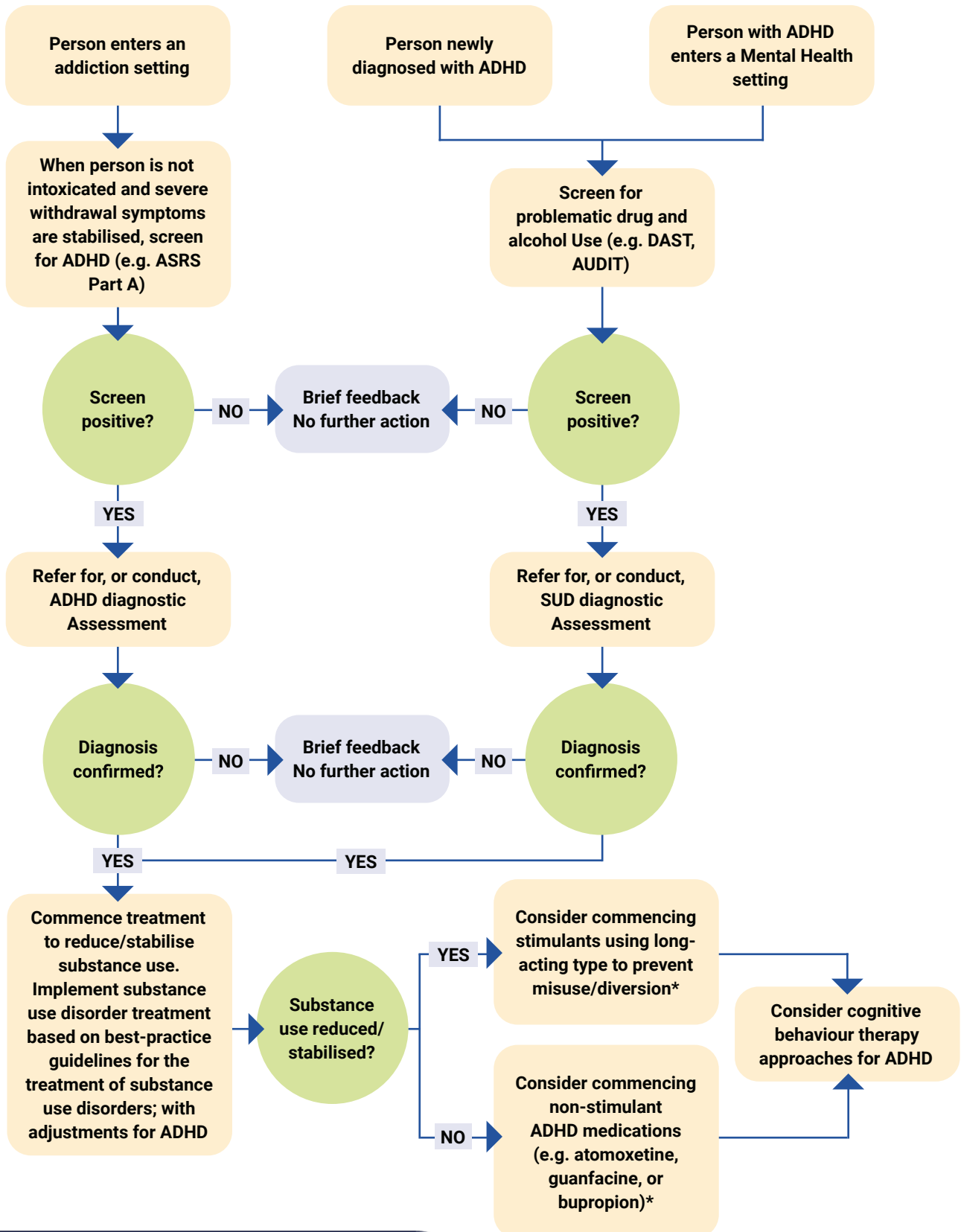
In most cases of concurrent ADHD and SUDs, clinicians should start treatment aimed at abstaining from or reducing/stabilising the use of substances first, since current SUDs may complicate diagnosis and treatment of ADHD. However, start of pharmacological or non-pharmacological treatment of ADHD should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

A multi-modal approach combining medication (particularly stimulants) and cognitive-behavioural intervention approaches is needed to treat ADHD in people with SUDs. Before starting stimulant pharmacotherapy in people with concurrent ADHD and SUDs, 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). Where misuse or diversion is suspected, there should be consideration of non-stimulant treatment. To minimise the risk of misuse and diversion, use of long-acting, rather than short-acting, stimulants, is recommended (Ozgen et al., 2020).

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 SUDs than in those without SUDs to achieve a favourable effect on both the ADHD symptoms and reduction of substance use (Ozgen et al., 2020).

Treatment for SUDs in people with ADHD should follow best-practice guidelines for the treatment of SUDs, but with treatment delivery methods adjusted to account for ADHD symptoms.

# Decision Flow Chart: ADHD and Substance Abuse Disorders



## Importance of dispelling myths around ADHD and substance use disorder (SUD)

There are a number of myths regarding ADHD, SUDs and stimulant medication. One is that use of stimulant medication to treat ADHD causes or increases the risk of later developing SUDs. There is robust evidence that providing stimulant treatment for ADHD does not increase the risk of SUDs, compared with people with ADHD who do not access stimulant medication (Boland et al., 2020; Humphreys, Eng, & Lee, 2013). Stimulant treatment in people with ADHD can result in many positive outcomes for those with co-occurring SUDs including reduced substance use (Boland et al., 2020; Fluyau, Revadigar, & Pierre, 2021). Other positive outcomes from the use of stimulant medication in people with ADHD include a protective effect against mood disorders, suicidality, criminality, accidents and injuries, traumatic brain injuries, motor vehicle crashes, and improved educational outcomes (Boland et al., 2020).

It is critical that myths about ADHD and stimulant use are addressed by clinicians through accurate education, as they cause stigma which can negatively impact on the self-esteem and self-worth of people with ADHD. Further, some state-wide regulations regarding the prescription of controlled drugs (which include stimulants) preclude or limit their use in people with ADHD and substance use disorders, and may not reflect the evidence above. These myths and regulations can result in people with ADHD and their families not accessing the first line and most effective treatment for ADHD, resulting in poor long-term outcomes.

## Resources for clinicians

The guideline has several resources for clinicians to support clinical quality improvement in ADHD identification, diagnosis, treatment and care. You can access these resources here: <https://adhdguideline.aadpa.com.au>

## References

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## Disclaimer

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