



December 2008

**Re: 2008 Screening, Referral and Treatment for Adult Attention Deficit and Hyperactivity Disorder (ADHD)**

Dear Health Care Provider:

Enclosed you will find the updated 2008 UW Health Screening, Referral and Treatment guideline for Adult Attention Deficit and Hyperactivity Disorder (ADHD). This guideline along with the child and adolescent version were developed by a consortium of regional health care interests - the Department of Family Medicine, the University of Wisconsin Medical Foundation, the University of Wisconsin Hospital and Clinics, Unity Health Insurance, Physicians Plus Insurance Corporation, chaired by Jennifer Eddy, MD from the Department of Family Medicine.

The goal of these clinical guidelines is to provide health care professionals with evidence-based screening and assessment tools and effective treatment methods along with referral recommendations. The guideline is also available on U Connect under guidelines at: <https://uconnect.wisc.edu> under clinical guidelines and then other guidelines and programs.

We are pleased to share the results of this effort with you. Please feel free to contact us if you have any questions or would like additional information.

Respectfully,

The UW Health ADHD Guideline Work Group

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**2008 SCREENING, REFERRAL AND TREATMENT FOR ADULT  
ATTENTION DEFICIT AND HYPERACTIVITY DISORDER (ADHD)  
IN A PRIMARY CARE SETTING**

Guidelines are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This guideline outlines the preferred approach for most patients. It is not intended to replace a clinician’s judgement or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

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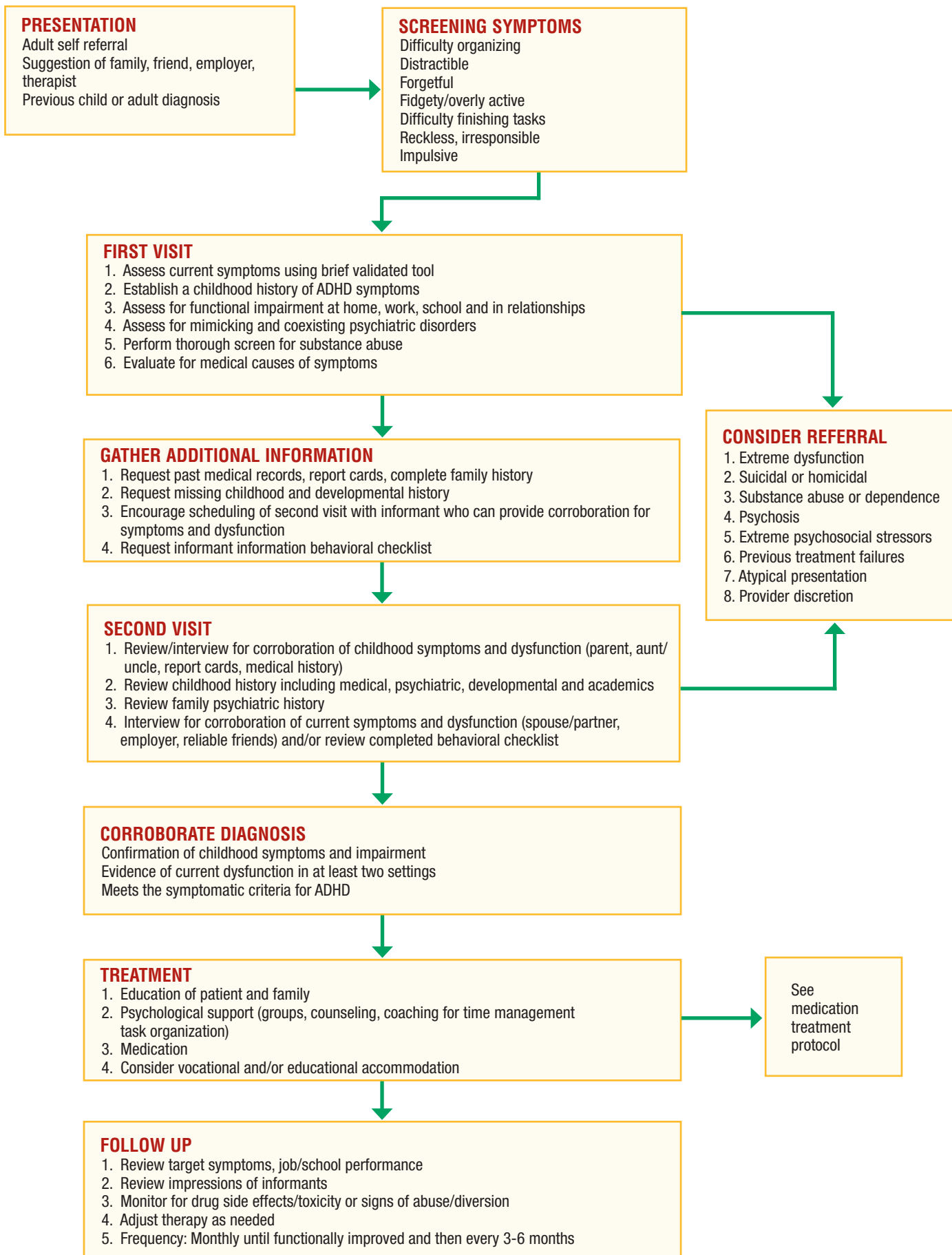
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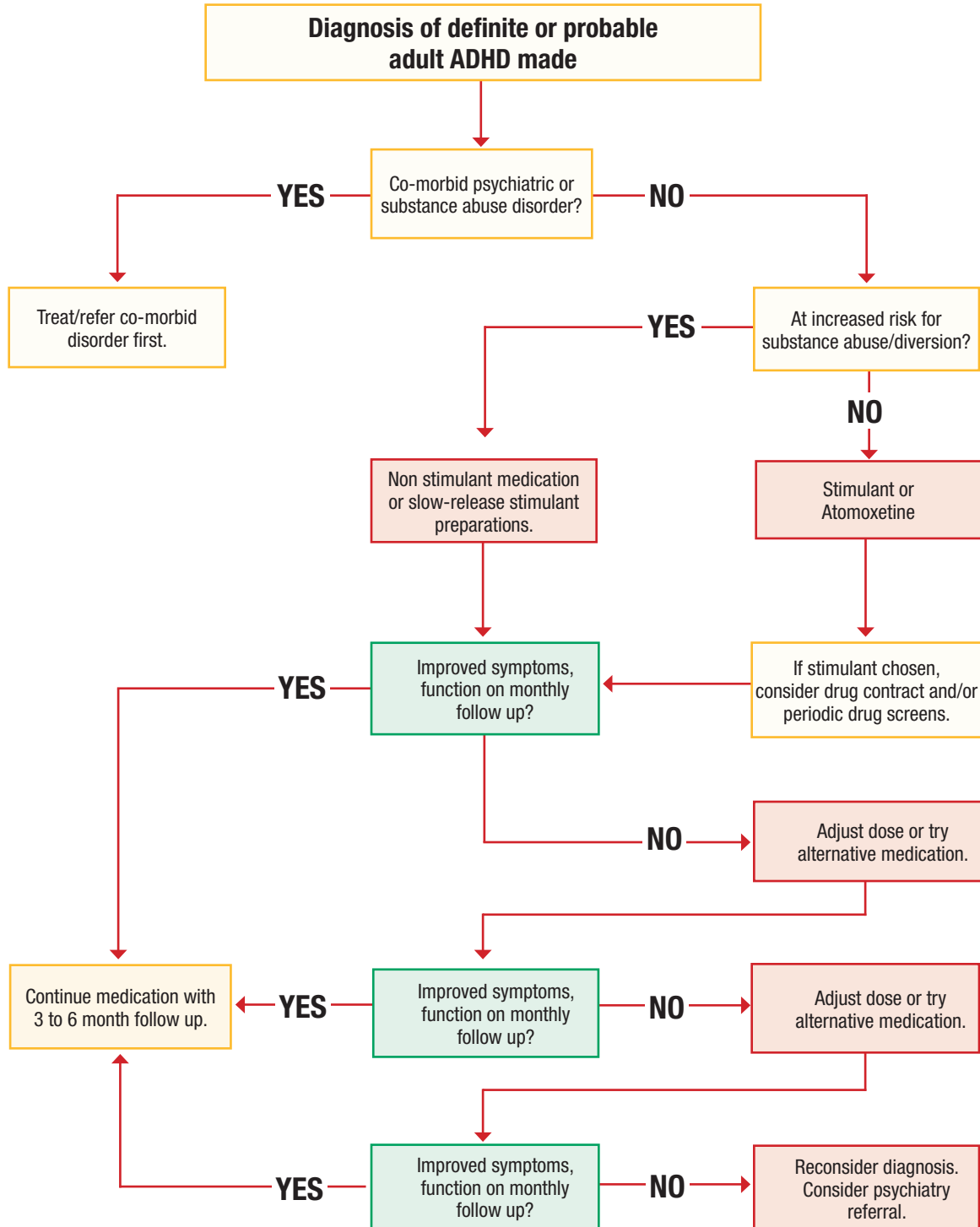
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# Adult ADHD Protocol (Ages 18 +)



# Adult ADHD Medication Protocol



## Adult ADHD Introduction

Attention Deficit Hyperactivity Disorder, originally thought to occur just in childhood, is now widely understood as persisting into adulthood. Between 50 to 65 percent of adults diagnosed with childhood ADHD will continue to have symptoms of inattention, distractibility and impulsivity causing functional impairment as adults. In addition, adults who were never diagnosed as children may present with a complicated array of behavioral, legal and functional problems requesting diagnosis and treatment. The DSM childhood criteria have not been validated for adults and the symptom lists are questionably appropriate in terms of adult development and thresholds. Without clear consensus for diagnosis and with the high prevalence of comorbid psychiatric disorders, the primary care clinician is often unsure of the best approach for initial assessment.

This guideline is designed to provide primary care clinicians with a structure, tools and referral criteria for diagnosis and treatment of adults 18 and over with symptoms typical of ADHD.

## Presentation and Screening

Adults with potential ADHD may present with a self-diagnosis, at the suggestion of a family member, friend, employer or therapist or with other behavioral or psychological problems. There may or may not be a previous childhood or adult diagnosis of ADHD.

Adult ADHD is characterized by chaotic lifestyle. Indicators of ADHD and screening symptoms include:

- Inattention
- Restlessness
- Forgetfulness
- Poor executive functioning
- Disorganization
- Impulsive behaviors
- Poor planning
- Difficulty parenting

High risk behaviors, failed relationships, legal difficulties, substance abuse and recurrent job loss are common. Physical hyperactivity diminishes in severity with age, but inattentive symptoms become more prominent and may be perceived as incompetence. Some adults compensate by finding a spouse / partner who organizes them or a job which is very active, highly absorbing or stimulating.

## Structure of the Assessment Process

Evaluation of adults presenting with ADHD symptoms requires at least 2 visits. As well as allowing for a thorough evaluation, 2 visits allows the clinician to assess motivation for follow up, persistence of symptoms and dysfunction and likelihood for alternative diagnoses. The following components of a complete evaluation are considered during both visits:

- review and corroboration of current symptoms and dysfunction
- determination of a childhood onset
- evaluation for comorbid and /or mimicking psychiatric problems, medical disorders or substance abuse.

## First Visit

### 1. REVIEW CURRENT SYMPTOMS AND FUNCTIONAL IMPAIRMENT

- A. Current symptoms should be reviewed through use of a validated adult tool. There are several forms in use. Attached to this Guideline is the Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist and Screening tool.
- B. Patients may not connect their symptoms to functional impairment so it may be necessary to inquire why they have been recurrently fired (disorganization, couldn't complete tasks), relationships (insensitivity, couldn't listen, interrupting), legal problems (MVA, speeding, impulsive stealing or fighting).

### 2. ESTABLISH ONSET

- A. ADHD does not have an adult onset. If the patient does not remember difficulties in school or at home in childhood then the clinician should investigate an alternative diagnosis.

### **3. PERFORM MEDICAL EVALUATION**

- A. Screen for medical, psychiatric or substance abuse issues which could explain or exacerbate symptoms of ADHD (neonatal anoxia or exposure to drugs / alcohol, lead poisoning, seizures, head trauma, hyperthyroidism, atrial fibrillations).
- B. Screen for medical conditions which would influence choice of medication (cardiac compromise, arrhythmias, liver damage, glaucoma)
- C. Establish baseline vital signs: height, weight, blood pressure, pulse.
- D. Laboratory testing should be limited to areas of concern, such as TSH.

## **Gather Additional Information**

### **1. HISTORICAL INFORMATION**

Most patients with adult ADHD will not know their complete family or personal history and are unlikely to come with old records. It is important to seek corroboration of childhood symptoms and impairment. Old medical records, report cards or interviews with parents or close family members are the main sources for childhood medical and academic history. A complete family history, including psychiatric disorders or other familial family disorders (sudden death, cardiac disorders) which could influence consideration of diagnosis or choice of medications should be sought.

### **2. CURRENT SYMPTOM CORROBORATION**

It is also important to have corroboration of current symptoms and dysfunction. Scheduling the second visit with an informant, such as a spouse, partner, friend or parent, can be very helpful in obtaining more detail about patient concerns. Phone interviews or completion of adult symptom scales by a close observer can be used as an alternative to attending a patient visit.

## **Second Visit and Evaluation**

The second visit is spent primarily on reviewing records and corroborative information. If these materials and the patient's presentation are consistent with adult ADHD, the clinician can begin forming a treatment and follow up plan as well.

### **1. CORROBORATE CHILDHOOD ONSET AND IMPAIRMENT**

Childhood history can be gathered by review of medical records, review of report cards or other academic materials, and interview with parents or close family member either in person or via phone call. High activity patterns, difficult temperament, and frequent accidents or risk taking behavior are common childhood characteristics. Review of academic background should reveal areas of impairment or concern. Look for drop outs, failures, learning disability, special evaluations or classes, suspensions / expulsions, and focused problems in areas such as reading, writing, penmanship or math. Review of report cards often indicates behavior problems, lack of expected achievement, incomplete work, or inadequate effort. If there is no objective evidence of childhood symptoms and impairment, the diagnosis of adult ADHD should be reconsidered.

### **2. REVIEW FAMILY PSYCHIATRIC HISTORY**

It is common to have a positive family psychiatric history. Inquire particularly about learning disabilities, behavior problems, legal difficulties, ADHD, and substance abuse.

### **3. CONSIDER PSYCHIATRIC DIAGNOSIS**

Psychiatric disorders can cause inattentive symptoms or can influence the course of treatment. Presence of another psychiatric diagnosis does not preclude a diagnosis of adult ADHD but it does make diagnosis and treatment more confusing. Significant physical, verbal or emotional abuse / neglect can contribute to symptoms characteristic of ADHD. Depression, bipolar disorder, anxiety, personality disorders, substance abuse and other psychiatric disorders should be considered as a part of the evaluation. Patients whose psychiatric status is unclear should be referred to mental health. Patients with active substance abuse should be referred to an AODA program.

## Referral

Referral to psychiatrists and additional providers is always at the discretion of the provider.

There are several presentations and co-conditions for which referral is recommended:

1. Extreme dysfunction
2. Suicidal or homicidal
3. Substance abuse or dependence
4. Psychosis
5. Extreme psychosocial stressors
6. Previous treatment failures
7. Atypical presentation – if presentation as brand new symptoms this is not ADHD, even if not diagnosed as a child the symptoms must concur
8. Provider discretion

A list of suggested referral sources are provided near the end of this document.

## Establish Diagnosis

1. There are no adult criteria in the DSM IV TR; however, patients with fewer than four of the listed symptoms should not be diagnosed with ADHD. DSM child symptom lists must be interpreted in terms of adult expectations and functions. The DSM child symptom lists are provided as attachments to this guideline.
2. An alternative to using the child symptom lists in DSM IV TR is to use a positive score on a validated adult screening tool for symptom definition.
3. All patients require evidence of current dysfunction in multiple settings, and a history of childhood onset in addition to a current positive symptom score.
4. It is important to establish comorbid disorders because:
  - a. psychiatric conditions should be addressed prior to starting treatment for ADHD.
  - b. certain medical conditions (liver disease, seizures, hypertension, glaucoma) are relative contraindications to certain ADHD medications. See medication section.
  - c. they may change the expected outcome of treatment.

## Treatment

1. Provide or offer referral for full education regarding ADHD symptom management and coping strategies for both the patient and family.
2. Offer psychological support as needed through group therapy or counseling. Some patients may have grief and anger issues due to lost opportunities when diagnosis is made in adulthood.
3. Adults with ADHD who are also parents may benefit from cognitive behavior therapy to assist them with parenting skills.
4. Provide or offer referral for skills training in the areas of finances, communication, time management and task organization. Some adults benefit from finding a coach or mentor who provides encouragement and problem solving for difficult situations.
5. Consider vocational and/or educational accommodation.
6. Follow medication treatment protocol. Adults are better able to adhere to regimens with long acting formulations. Side effects tend to decrease in severity over the first 3 months of use. Data is unavailable regarding pros and cons of drug holidays or intermittent use.
7. In situations where there is increased risk of substance abuse or diversion, non stimulant preparations or slow release stimulants are strongly preferred. Slow release stimulant preparations should be used with some caution as they still offer some risk of abuse or diversion. When crushed, they more closely resemble immediate release preparations in terms of onset and effect.

## Referral Sources

The following groups can assist those in the UW Health system with resources and referral options outside of the primary care setting.

If you are unsure of where to direct a patient or need additional assistance determining referral options for your patient, UW Health Patient Relations/Social Services is the internal department that can help you and the patient determine options.

### **Patient Resources**

7974 UW Health Court  
Middleton, WI 53562  
608.821.4819

Additionally The UW Health Behavioral Health Consultation Systems provides referral management, prior authorization, and concurrent case review for Physicians Plus Insurance Corporation HMO members and Unity Health Insurance members. Gateway Recovery provides the management for alcohol and other drug abuse (AODA) services for Unity and GHC members.

### **Behavioral Health Consultation Systems**

UW Health-BHCS  
780 Regent Street, Suite 300  
Madison, WI 53715  
800.683.2300  
608.282.8960 (local in Madison)

### **Gateway Recovery**

25 Kessel Court, Suite 200  
Madison, WI 53711  
608.278.8200 (local in Madison)

## Follow-up Care

Adults with a new diagnosis, uncontrolled symptoms or change in medication should be seen within 30 days by a clinician who can assess for side effects and adjust medication if needed. Monthly contacts or visits should be routine until functionality is significantly improved. Once functionality is improved, follow-up appointments every 3 to 6 months are recommended. Informants should be included, as available, in follow-up sessions.

At each follow-up visit:

1. Review target symptoms, job/school performance, relationship issues
2. Monitor for adherence to therapy, drug side effects/toxicity or signs of abuse/diversion
3. Review impressions of informants
4. Adjust therapy as needed

## Screening Tools

Both the Adult ADHD Self-Report scale (ASRS v1.1) Symptom Checklist and Screening tool and the Wender Utah Rating Scale can be used without copyright permission or cost. The Adult ADHD Self-Report Scale is attached to this document.

The Copeland Symptom Checklist for Adult Attention Deficit Disorders, Brown Adult Attention Deficit Disorder Scales and the Connors Adult Attention Rating Scales are all proprietary and must be obtained from their publishers.

## Attachment

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

## Acknowledgement

This guideline was initially developed in 2006 by a collaborative UW Health work group. Members of the work group included staff from the Departments of Family Medicine and Internal Medicine, UW Medical Foundation, UW Hospital and Clinics, Behavioral Health Consultation Systems, Unity Health Insurance, Physicians Plus Insurance Corporation and Group Health Cooperative. Questions, comments or requests for additional information should be directed to Jennifer Eddy, MD, or Susan Hanauer, Care and Quality Innovations, University of Wisconsin Medical Foundation at [susan.hanauer@uwmf.wisc.edu](mailto:susan.hanauer@uwmf.wisc.edu) or 608.821.4210.

## Evidence and References

1. Greenhill, Laurence, Pliszka, Steven, et al., Practice Parameter for the Use of Stimulant Medications in the Treatment of Children, Adolescents, and Adults; *J Am Acad of Child Adoles Psychiatry*. 2002; 41 (2 Supplement): 26S – 49S.
2. Kessler, Ronald; Adler, Lenard; et al, Patterns and Predictors of Attention-Deficit/Hyperactivity Disorder Persistence into Adulthood: Results from the National Comorbidity Survey Replication. *Biol Psychiatry* 2005; 57: 1442-1451.
3. Kessler, Ronald; Adler, Lenard; et al, The World Health Organization Adult ADHD Self-Report Scale (ASRS): a Short Screening Scale for Use in the General Population. *Psychological Medicine*, 2005; 35: 245-256.
4. McGough, James J and Russell Barkley, Diagnostic Controversies in Adult Attention Deficit Hyperactivity Disorder. *Am J Psychiatry* 2004; 161: 1948-1956.
5. Montano, Brendan, Diagnosis and Treatment of ADHD in Adults in Primary Care. *J Clin Psychiatry* 2004; 65: (suppl 3): 18-21.
6. Searight, Russell, Burke, John and Fred Rottnek, Adult ADHD: Evaluation and Treatment in Family Medicine. *Am Fam Physician* 2000; 62: 2077-86.
7. Weiss, Margaret and Candice Murray, Assessment and Management of Attention-Deficit Hyperactivity Disorder in Adults. *SMAJ*; 168: 715-22.

# Medications used in the Treatment of Attention-Deficit/Hyperactivity Disorder

## GENERAL CONSIDERATIONS FOR STIMULANTS

- Use cautiously if history of tics
- Longer-acting stimulants may have greater problematic effects on evening appetite and sleep
- Use cautiously if history of substance abuse or diversion concern
- Monitor patient growth and weight gain
- Give with/after food and swallow whole with liquids
- Pellet/beaded capsule formulations may be opened & sprinkled on soft food
- Nonabsorbable tablet shell may be seen in stool
- Perform full cardiovascular evaluation before starting therapy

## METHYLPHENIDATE PRODUCTS

	Product Names	Duration of Action	Strengths Available (in mg)	Usual Dosing
Short acting	methylphenidate methylin (equivalent to Ritalin)	4 hours or less	5, 10, 20 2.5, 5, 10, 20	5-20mg 2-3 times daily
Intermediate acting	methylphenidate SR methylin ER (equivalent to Ritalin SR) Metadate ER dexmethylphenidate tabs (Focalin)	4 – 6 hours	20 10, 20 10, 20 2.5, 5, 10	20-40mg in morning and 20mg in early afternoon  5mg 2 times daily
Long acting	Metadate CD caps Concerta tabs Ritalin LA caps dexmethylphenidate caps (Focalin XR) Daytrana patch	6 – 8 hours 10 hours 6 – 8 hours 10 – 12 hours 12 hours (with 2 -3 hour delay)	10, 20, 30 18, 27, 36, 54 10, 20, 30, 40 5, 10, 20 10, 15, 20, 30	10-60mg once daily 18-54mg once daily 20-60mg once daily 5-20mg once daily 10-30mg patch daily

## AMPHETAMINE PRODUCTS\*

	Product Names	Strengths Available (in mg)	Usual Dosing
Short acting	dextroamphetamine sulfate Dexedrine Dextrostat	5, 10 5 5, 10	5-15mg 2 times daily or 5-10mg 3 times daily
Intermediate acting	dextroamphetamine SR Dexedrine spansules methamphetamine (Desoxyn) amphetamine salt combo (equivalent to Adderall) Adderall	5, 10, 15 5, 10, 15 5 5, 7.5, 10, 12.5, 15, 20, 30 5, 7.5, 10, 12.5, 15, 20, 30	5-30mg daily OR 5-15mg 2 times daily 5mg 1-2 times daily 5-30mg 1-2 times daily 5-30mg 1-2 times daily
Long acting	amphetamine salt combo / Adderall XR lisdexamfetamine (Vyvanse)	5, 10, 15, 20, 25, 30 20, 30, 40, 50, 60, 70	10-30mg once daily 20-70mg once daily

## GENERAL CONSIDERATIONS FOR NON-STIMULANTS

- Safety/effectiveness not studied in patients < 6 yrs
- May be used in cases if history of tics worsening from stimulants
- Perform cardiovascular evaluation for clonidine, guanfacine, imipramine or atomoxetine
- Medication of choice if concern about abuse or diversion
- Monitor patient growth and weight gain
- Give with/after food and swallow whole with liquids
- Also effective for sleep disturbances
- Taper off to avoid rebound hypertension for clonidine or guanfacine
- Avoid bupropion if history of seizure disorders
- Monitor closely for suicidal ideation with atomoxetine or imipramine use
- Atomoxetine (Strattera) can cause liver damage in rare cases

## NON-STIMULANT PRODUCTS

	Product Names	Strengths Available (in mg)	Usual Dosing
Anti-depressants	imipramine desipramine bupropion (equivalent to Wellbutrin)  bupropion SR (equivalent to Wellbutrin SR)  bupropion XL (Wellbutrin XL)	10, 25, 50 10, 25, 50, 75, 100, 150  75, 100, 150  150, 300	Doses vary: 2-3 times daily Doses vary: 2-3 times daily  50-100mg 3 times daily 100-150mg 2 times daily 150 – 300 mg once daily
Other	atomoxetine (Strattera) clonidine guanfacine (equivalent to Tenex)	10, 18, 25, 40, 60 100mcg, 200mcg, 300mcg 1 or 2 milligram	40mg starting dose, 40-100mg daily 100mcg 2-4 times daily 500mcg-1mg 4 times daily

# 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?							
<b>Part A</b>							
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?							
<b>Part B</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.<sup>1-4</sup> 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.<sup>4</sup>

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

### References:

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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.