

Co-morbid ADHD in community mental health teams

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IT IS UNCOMMON
FOR US TO SEE ADHD
ON ITS OWN

Most evidence-based guidelines would now suggest that:

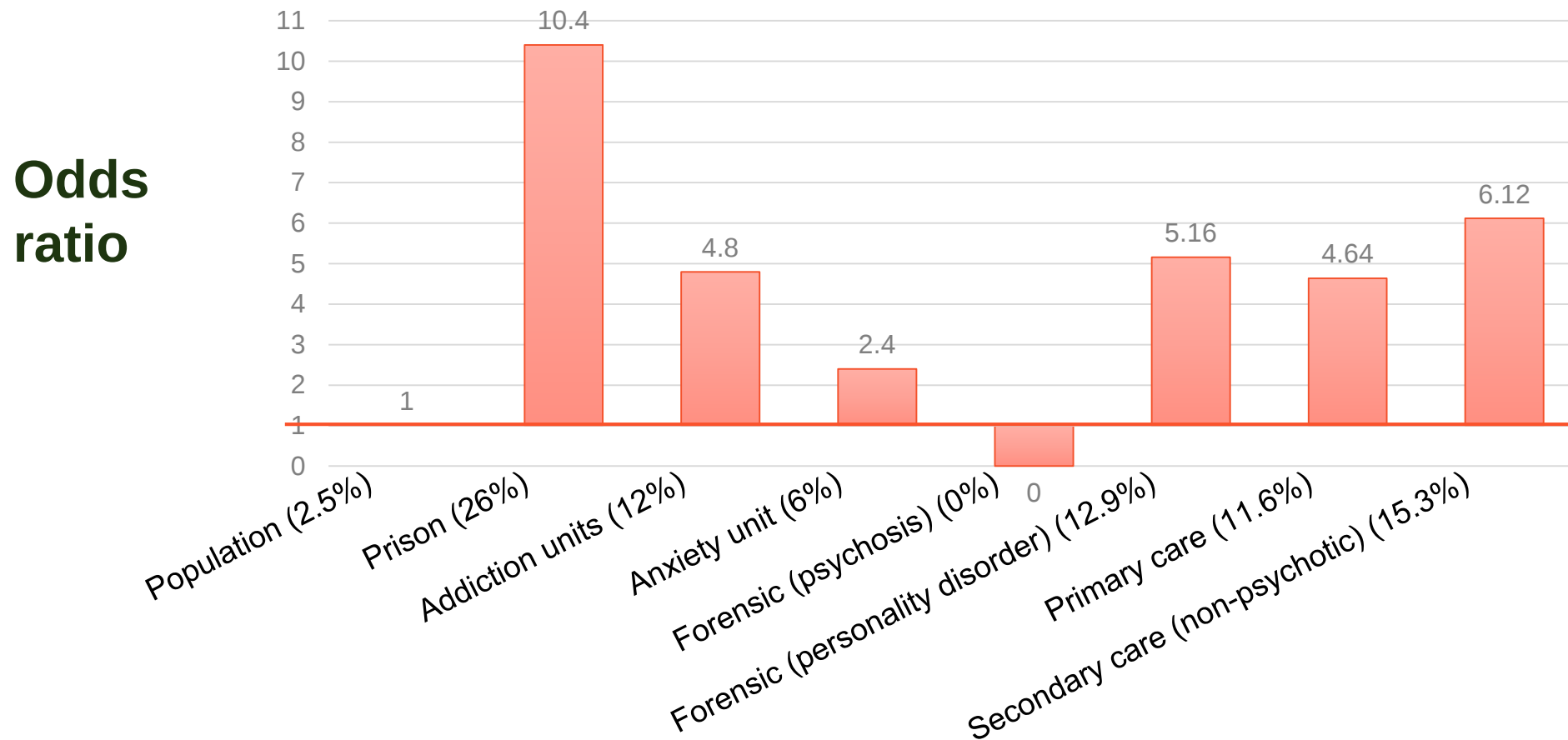
Presence of a diagnosed mental health condition should be seen as a risk factor for ADHD and trigger consideration as to whether ADHD forms part of the clinical picture

Presence of ADHD should be seen as a risk factor for other mental health conditions and trigger consideration as to whether other mental health problems are forming part of the clinical picture

COMORBID SYMPTOMS, SYNDROMES AND DISORDERS

- **Overlapping neurodevelopmental disorders:** autism spectrum disorders and specific learning difficulties
- **Symptoms of ADHD:** symptoms of ADHD that mimic other common mental health disorders:
- **ADHD as a developmental risk factor:** development of comorbid mental health disorder (e.g. substance abuse, personality disorder, anxiety, depression, bipolar disorder)
- A recent systematic review found that
 - around 8% of people with ADHD have bipolar disorder (1 in 13)
 - around 17% of people with bipolar disorder have ADHD (1 in 6)

RATES OF ADHD WITHIN ADULT MENTAL HEALTH AND FORENSIC SETTINGS



I suggest that the question

“Is ADHD contributing to this person’s presentation?”

Should be a standard part of any
mental health assessment

Assessing for ADHD is no more difficult to assessing for any other mental health condition.

The only real difference is that most psychiatrists were never trained to do this

What do we know about the impacts of ADHD over time?

Compared to the general population

- ↑ risk of criminality ⁽¹⁾ ⁽²⁾
 - For both genders; girls have a relatively higher risk
 - Pure ADHD and concurrent CD/ODD (↑ x 4)
- ↑ risk of substance abuse ⁽³⁾
 - for both genders
 - the risk is further increased by comorbidity
- ↑ risk of premature death⁽⁴⁾
 - traffic accidents, drugs, violence (mortality rates 4x higher when diagnosis delayed until after 18 years)
- ↑ risk of attempted and completed suicide⁽⁵⁾
 - 5x higher event when account for other mental health conditions (10x all in)
- ↑ risk of poor academic performance⁽⁶⁾
- ↑ social and personal (economic) costs (\$20 billion/year in Australia)

⁽¹⁾ Dalsgaard et al., 2013, ⁽²⁾ Lichtenstein et al., 2012; ⁽³⁾ Dalsgaard et al., 2014; ⁽⁴⁾ Dalsgaard et al., 2015, ⁽⁵⁾ Ljung et al, 2014, ⁽⁶⁾ Daley et al., 2015, (6) Sciberras et al., 2022

What is the effect of treatment/medication on outcomes?

- Criminality
 - Being on medication reduces the risk of criminality ⁽¹⁾
- Substance abuse
 - Some clinical studies^(2;3) show a reduced risk with medication – others do not
 - Register-based studies ^(4;5): the duration and earlier initiation of stimulant treatment ↓ the risk
- Premature death
 - Reduction in traffic accidents ⁽⁶⁾, reduction in suicidal behaviour ⁽⁷⁾
 - Reduction in death from unnatural causes ⁽¹⁰⁾
- Physical abuse
 - Reduction in physical abuse ⁽¹¹⁾
- Poor academic performance
 - Medication appears to improve learning for children ADHD ^(8;9)

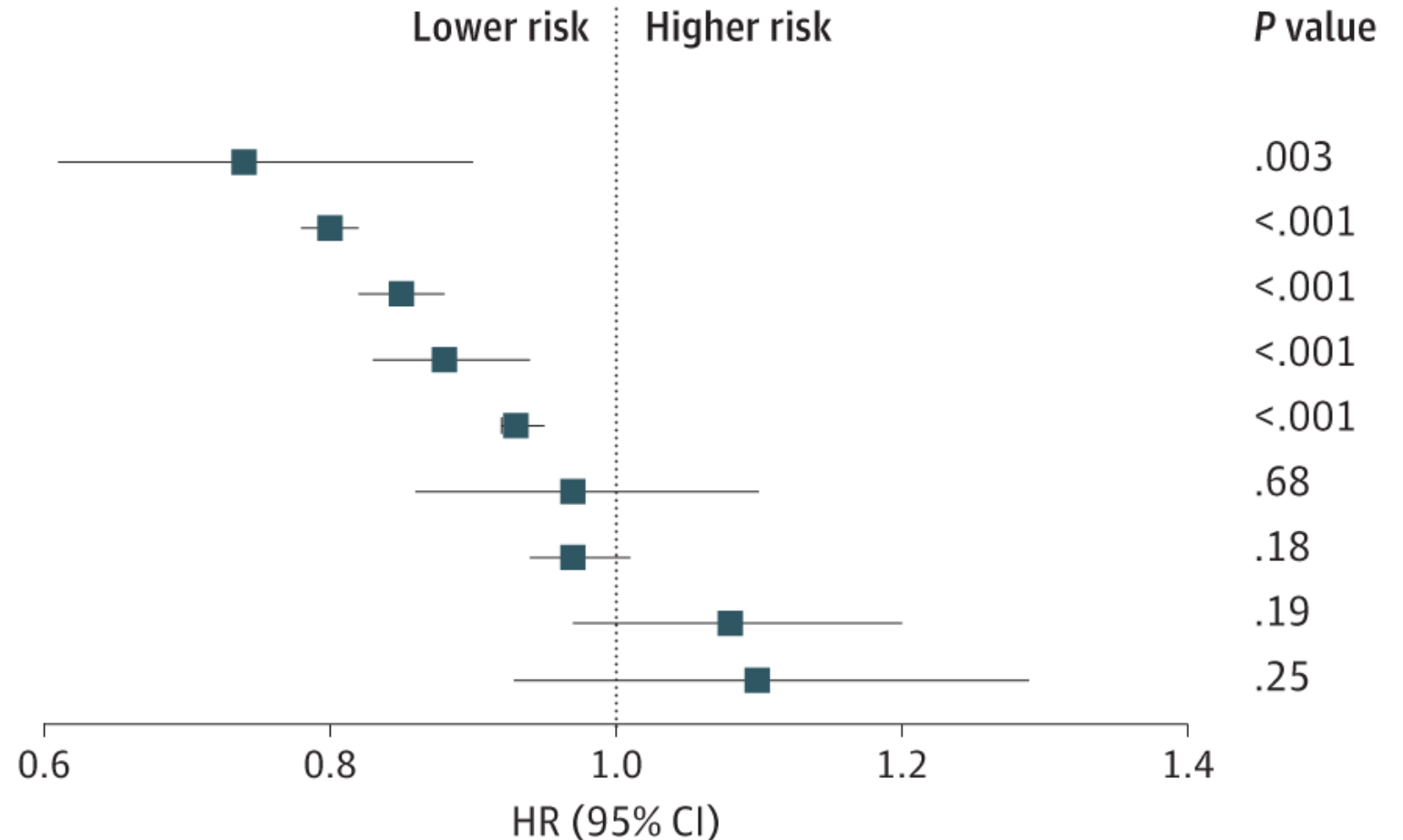
⁽¹⁾ Lichtenstein et al., 2012, ⁽²⁾ Lee et al., 2011; ⁽³⁾ Molina et al., 2013; ⁽⁴⁾ Dalsgaard et al., 2014; ⁽⁵⁾ Steinhausen and Bisgaard, 2014; ⁽⁶⁾ Chang et al., 2014; ⁽⁷⁾ Chen et al., 2014; ⁽⁸⁾ Zoëga et al., 2012; ⁽⁹⁾ Keilow et al., 2014; ⁽¹⁰⁾ Lin Li et al, 2024, ⁽¹¹⁾ Man et al, 2023)

ADHD Medications are associated with lower risk of hospitalisation and suicide attempts

Taipale et al Jama Network Open 2024

Psychiatric Hospitalization

Exposure	HR (95% CI)
Nonuse	1 [Reference]
Amphetamine	0.74 (0.61-0.90)
Lisdexamphetamine	0.80 (0.78-0.82)
Polytherapy	0.85 (0.82-0.88)
Dexamphetamine	0.88 (0.83-0.94)
Methylphenidate	0.93 (0.92-0.95)
Modafinil	0.97 (0.86-1.10)
Atomoxetine	0.97 (0.94-1.01)
Guanfacine	1.08 (0.97-1.20)
Clonidine	1.10 (0.93-1.29)

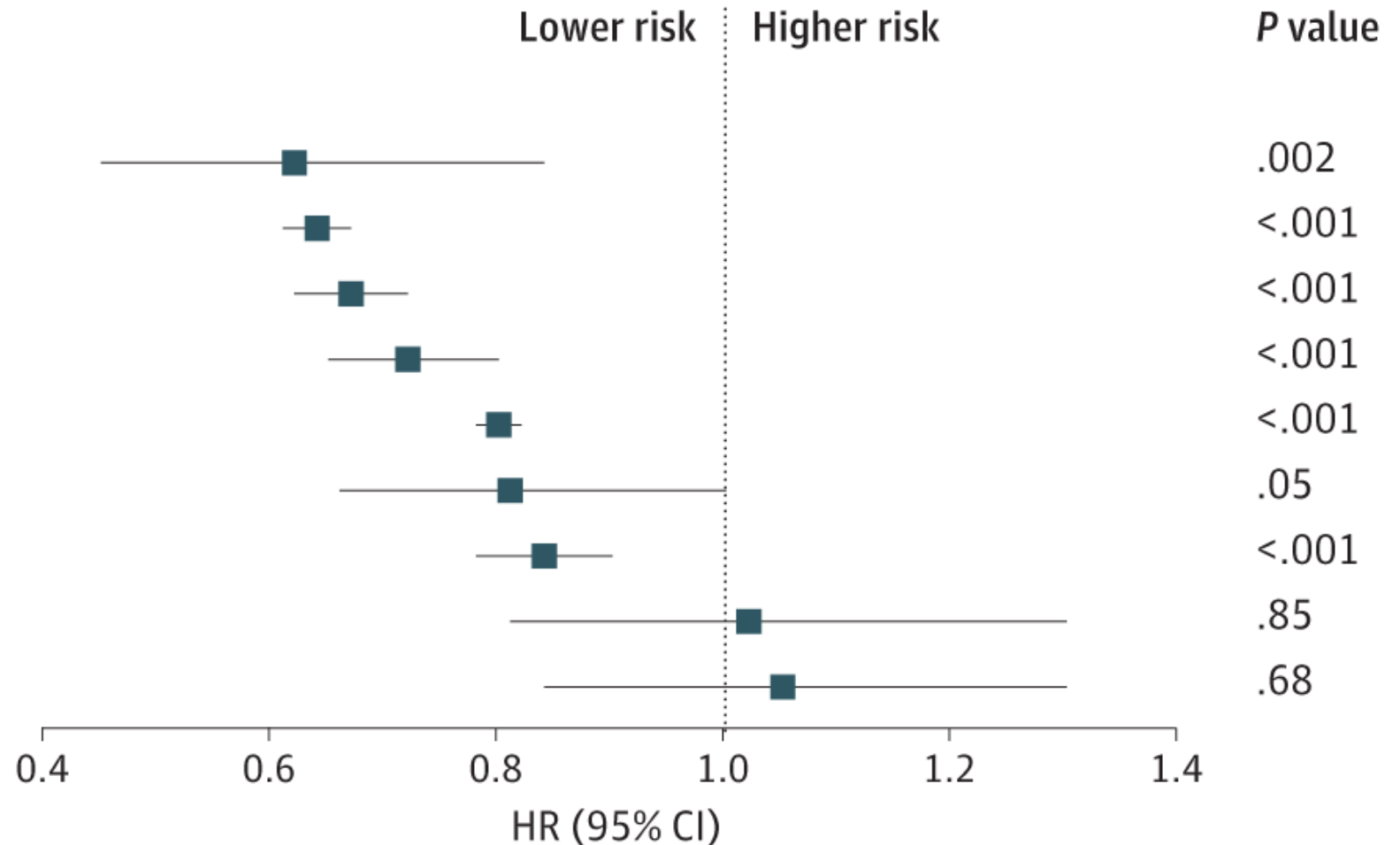


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Taipale et al Jama Network Open 2024

Non-Psychiatric Hospitalisations

Exposure	HR (95% CI)
Nonuse	1 [Reference]
Amphetamine	0.62 (0.45-0.84)
Lisdexamphetamine	0.64 (0.61-0.67)
Polytherapy	0.67 (0.62-0.72)
Dexamphetamine	0.72 (0.65-0.80)
Methylphenidate	0.80 (0.78-0.82)
Modafinil	0.81 (0.66-1.00)
Atomoxetine	0.84 (0.78-0.90)
Guanfacine	1.02 (0.81-1.30)
Clonidine	1.05 (0.84-1.30)

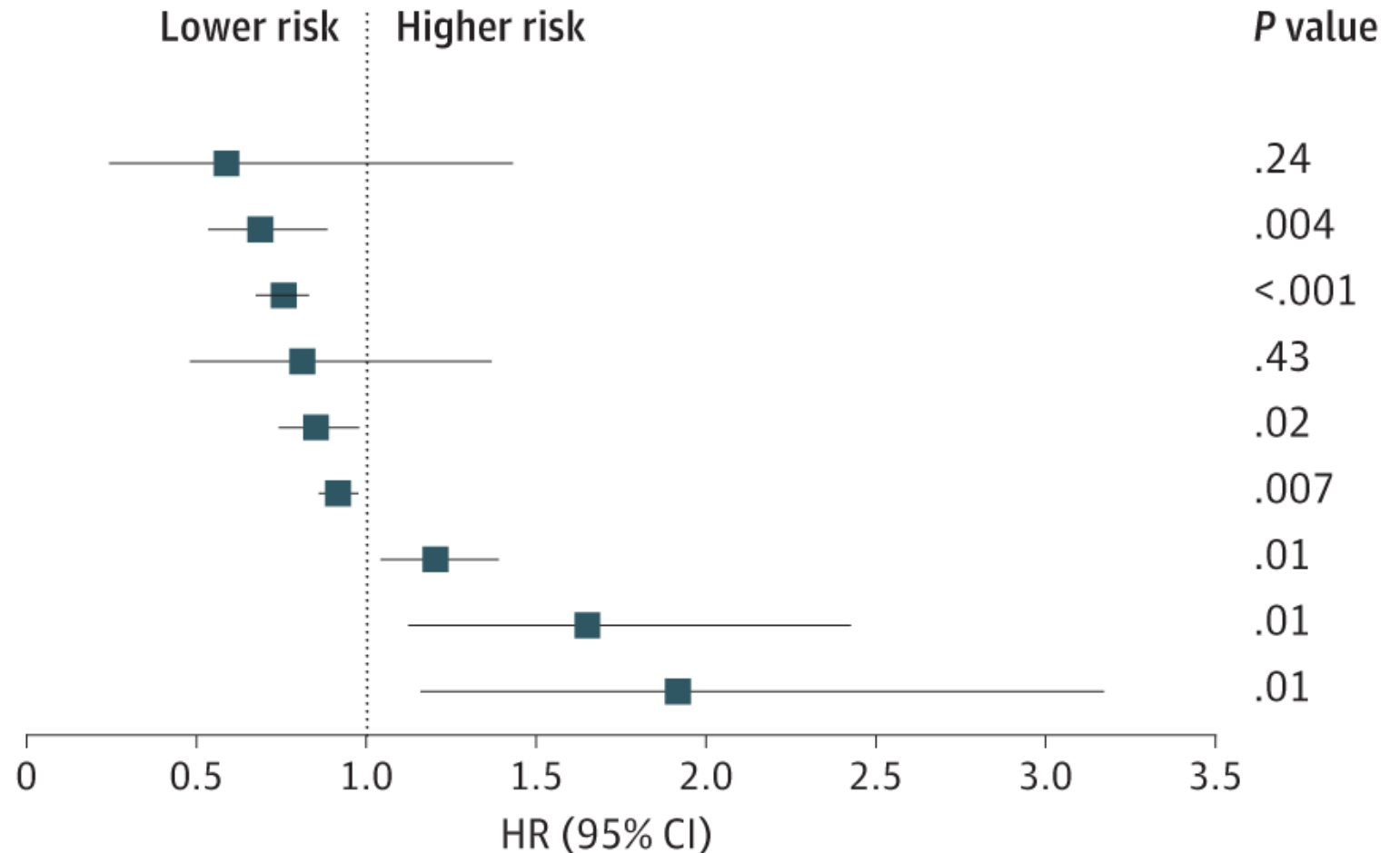


ADHD Medications are associated with lower risk of hospitalisation and suicide attempts

Taipale et al Jama Network Open 2024

Suicide Attempt and/or Death

Exposure	HR (95% CI)
Nonuse	1 [Reference]
Amphetamine	0.59 (0.24-1.43)
Dexamphetamine	0.69 (0.53-0.89)
Lisdexamphetamine	0.76 (0.68-0.84)
Modafinil	0.81 (0.48-1.37)
Polytherapy	0.85 (0.74-0.98)
Methylphenidate	0.92 (0.86-0.98)
Atomoxetine	1.20 (1.04-1.39)
Guanfacine	1.65 (1.12-2.43)
Clonidine	1.92 (1.16-3.18)



Review

Risks and Benefits of Attention-Deficit/Hyperactivity Disorder Medication on Behavioral and Neuropsychiatric Outcomes: A Qualitative Review of Pharmacoepidemiology Studies Using Linked Prescription Databases

Zheng Chang^a, Laura Ghirardi^a, Patrick D. Quinn^b, Philip Asherson^c, Brian M. D'Onofrio^a, Henrik Larsson^{a,*}

Injuries and traumas

Dalsgaard et al., 2015 (39), Denmark

Man et al., 2015 (41), Hong Kong

Mikolajczyk et al., 2015 (43), Germany

Raman et al., 2013 (44), United Kingdom

Motor vehicle accidents

Chang et al., 2014 (49), Sweden. Males

Females

Chang et al., 2017 (50), United States. Males

Females

Criminality

Lichtenstein et al., 2012 (57), Sweden. Males

Females

Suicidality

Chen et al., 2014 (59), Sweden

Man et al., 2017 (63), Hong Kong

Substance use disorder

Chang et al., 2014 (64), Sweden

Quinn et al., 2017 (66), United States. Males

Females

Depression

Chang et al., 2016 (67), Sweden

Bipolar disorder and mania

Viktorin et al., 2017 (69), Sweden. Without mood stabilizers

With mood stabilizers

Psychosis

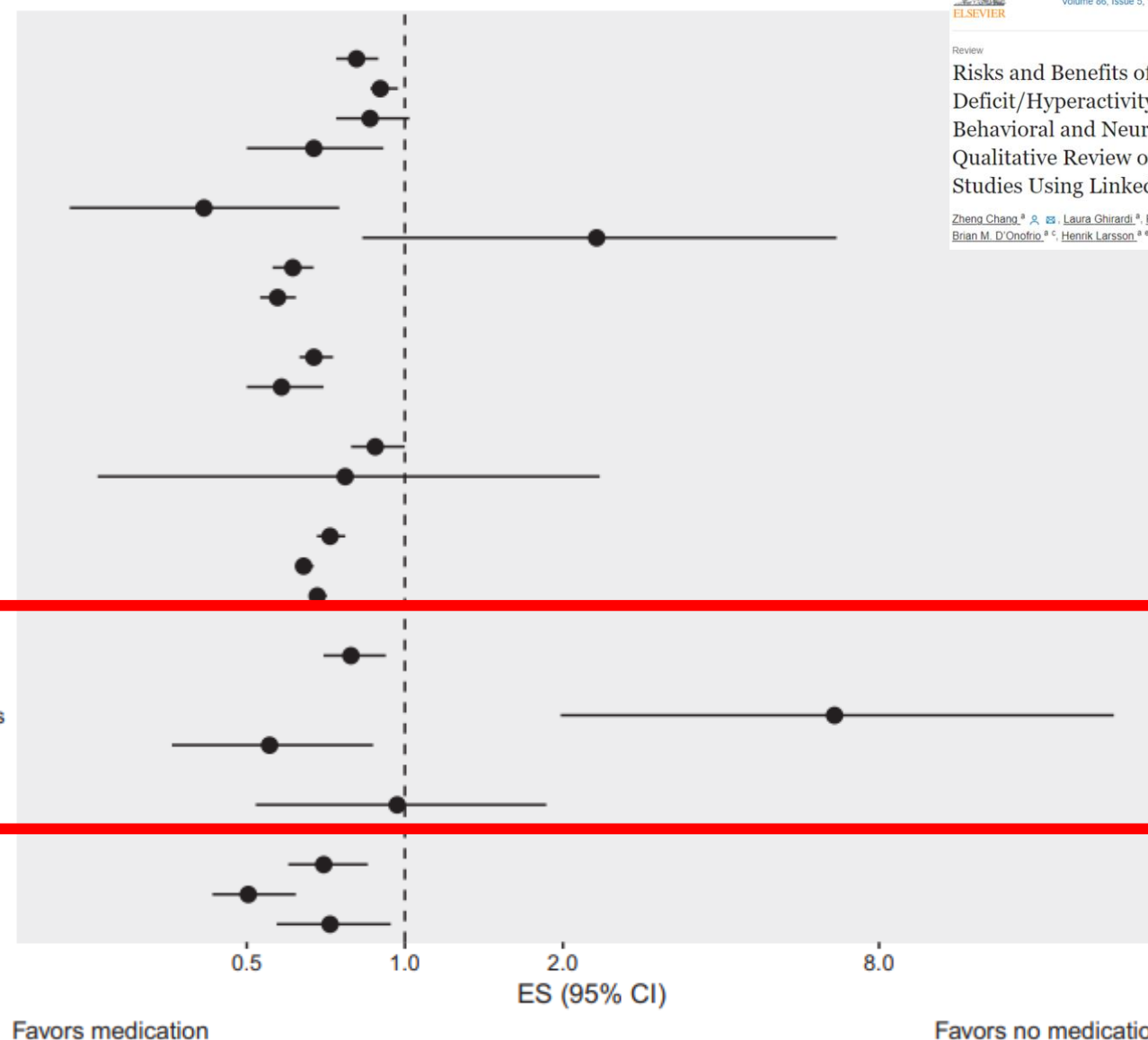
Man et al., 2016 (71), Hong Kong

Seizures

Wiggs et al., 2018 (76), United States. Prior seizure

No prior seizure

Brikell et al., 2019 (77), Sweden



TREATING ADHD IN THE PRESENCE OF A COEXISTING MENTAL HEALTH CONDITION

In most circumstances the process is identical to that for non-comorbid ADHD

General approach to ADHD medication

- Start with a stimulant – either one (MPH or Dex/LDX)
- Titrate up to maximum benefit at minimum dose with least adverse effects
 - General doses
 - Methylphenidate up to 20mg tds IR, 60 mg Ritalin LA or 72 mg Concerta
 - Dexamfetamine up to 10 mg tds
 - Lisdexamfetamine up to 70mg
- If first stimulant is not well tolerated or ineffective then try the other
- If don't tolerate or respond to either stimulant, then try a non-stimulant (Atomoxetine or Guanfacine)

EVIDENCE REVIEW FROM THE AADPA GUIDELINE DEVELOPMENT GROUP (GDG)

Neither the available evidence nor the GDG experience justified a different choice of ADHD medication for people with ADHD and coexisting disorders, but there should be

- Careful baseline assessments
- Consideration of drug interactions
- Slower titration
- More careful monitoring of adverse effects, and regular contact.

GENERAL ADVICE FOR TREATING ADHD IN THE CONTEXT OF BIPOLAR DISORDER

First stabilize the bipolar disorder with mood stabilizer

Then look to add ADHD medications

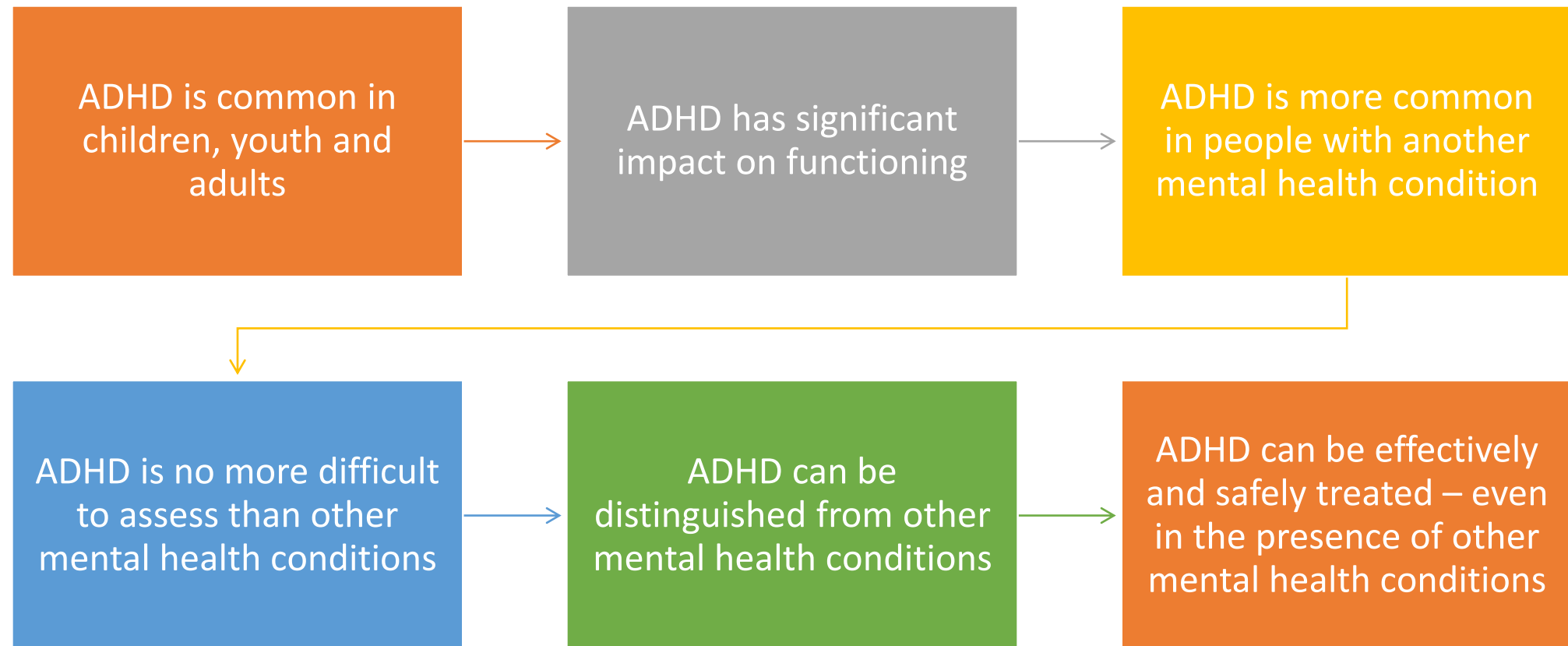
- **Usually, would start with a stimulant as per routine but could start with guanfacine**

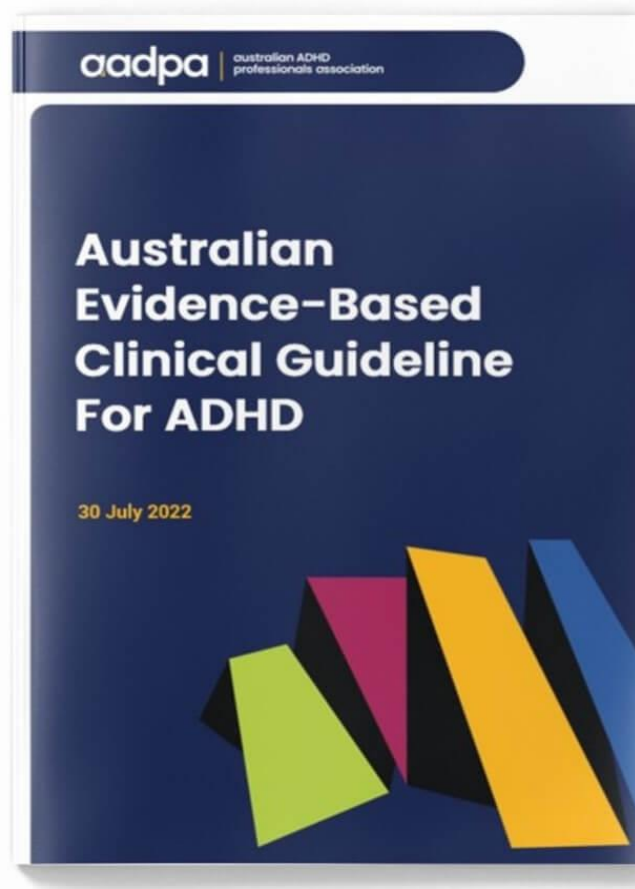
GENERAL ADVICE FOR TREATING ADHD IN THE CONTEXT OF PSYCHOSIS

Stop stimulants and review other medication for ADHD

- **Treat the psychotic or manic episode as necessary**
- **Consider alternate treatment for ADHD after the episode has resolved**
- **Consider costs and benefits of reintroducing stimulant medication. If stimulant medication is to be reintroduced, take extra precautions in monitoring, such as admitting the person to a hospital/clinic for observation.**

Key messages





<https://adhdguideline.aadpa.com.au/>



<https://aadpa.com.au/product/adhd-medication-prescribing-guide/>