

# Assessment of attention-deficit hyperactivity disorder in people with substance use disorder: Another case of what gets measured gets done

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*'Accountability means counting. What gets measured gets done.'*

–Dr Margaret Chan, 7th Director-General of the World Health Organization (2006–2017)

International guidelines recommend that attention-deficit hyperactivity disorder (ADHD) be identified and treated in all age groups, with increased focus on subpopulations with a high prevalence of ADHD. One such group is people who seek treatment for substance use disorder (SUD). ADHD doubles the risk of SUD and approximately one in four people with SUD have co-occurring ADHD. Although often complex and challenging, ADHD can be reliably diagnosed during active substance use and is often important for effective treatment of concurrent SUD (Van Emmerik-Van Oortmerssen et al., 2017). Despite this, ADHD is underdiagnosed among adults with SUD.

ADHD often complicates the clinical profile and treatment of SUD. ADHD has been associated with increased complexity and chronicity of SUD and decreased SUD treatment efficacy and retention. Furthermore, ADHD among those with SUD can result in high rates of costly substance use-related acute care contacts, poor physical and mental health outcomes, increased contact with the criminal justice system, reduced quality of life, suicidal behaviour and

premature mortality (Sciberras et al., in press).

Without addressing the underlying impaired executive functioning and impulsivity – both central characteristics of ADHD – those with unidentified ADHD may engage in risk-taking behaviour increasing their risk of poor health and social outcomes, despite receiving treatment for SUD and other mental health disorders. Accordingly, a randomised controlled trial found that treating ADHD symptoms decreased substance use and criminal justice involvement (Konstenius et al., 2014).

## Identifying co-occurring ADHD is necessary for effective SUD treatment

The World Health Organization acknowledges that generating information, which establishes a gap between the prevalence of a problem and the resources required to address it, is fundamental for achieving an effective and sustainable response (USAID et al., 2015). A lack of a systematic approach to identifying ADHD among people seeking SUD treatment is an example of where insufficient evidence precludes our ability to respond effectively.

For people with SUD, a missed diagnosis of co-occurring ADHD is detrimental to recovery from both disorders. Like many other co-morbidities, ADHD and SUD typically have a bi-directional

relationship, with symptoms of each disorder compounding and maintaining the other. However, unlike many other co-morbidities, identification of ADHD does not occur routinely within SUD treatment.

Symptom overlap makes establishing a clinical diagnosis of ADHD challenging and resource intensive (Lin et al., 2016). Furthermore, diagnosing ADHD among those with SUD is often ad hoc in nature, dependent on self-disclosure or historical information from family members or other

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close informants (i.e. teachers). However, access to collateral information is often severely limited in SUD treatment settings.

Siloed, parallel systems which promote brief, episodic care over longitudinal assessment and continuity is another barrier to establishing a diagnosis of ADHD in SUD treatment settings. Limited resourcing and capacity for adult ADHD management – both pharmacological and psychological – within the broader mental health and primary care sectors compounds this issue. As a result, clinicians are often reluctant to undertake diagnostic assessment because they are unable to provide realistic and accessible treatment recommendations.

Without efforts to overcome these barriers, those with co-occurring ADHD and SUD will remain largely invisible and untreated. Thus, where establishing a clinical diagnosis of ADHD is not feasible, routine screening for ADHD should be implemented. Several valid ADHD screening instruments, such as the ADHD Self-Report Scale, are freely available for use in those with SUD. These tools take little time and training to administer and analyse effectively.

Often necessary to trigger a formal diagnosis, ADHD screening is an essential step towards developing a comprehensive care pathway for people with ADHD and SUD. Without screening, we cannot initiate a commensurate response and ensure equitable treatment. However, routine ADHD screening is not conducted in Australian or New Zealand SUD treatment settings.

### **Without identifying ADHD among adults with SUD our health system will not change**

A lack of screening and identification of ADHD in SUD treatment settings reinforces several system-level factors which impede an effective response. Unless this changes, we will have a

limited understanding of the scale of the problem, the resources required to respond to it, the potential benefits of addressing it, and importantly, the consequences of doing nothing. These are foundational building blocks of health system change.

### **Workforce capability**

Although adult ADHD is underdiagnosed, there is a long-standing gap between those diagnosed with ADHD and trained professionals required to treat them. Exacerbated by underinvestment, a similar deficit of ADHD-specific knowledge and capability exists among specialists in the SUD treatment sector.

Inadequate training, capacity and resourcing of our workforce are avoidable system-level barriers to treating ADHD among those with SUD. This can place clinicians in role conflict, whereby they are asked to investigate the presence of a condition which they are ill-equipped to manage effectively. As such, workforce training and education in evidence-based treatment for people with ADHD and SUD is urgently needed to ameliorate these barriers. However, inadequate workforce capability is as much a consequence of our lack of identifying co-occurring ADHD and SUD, as it is a cause. We cannot expect to upskill or resource our workforce to address a problem which is unidentified. Therefore, the importance and impact of ADHD among people with SUD remains ill-defined and subject to uninformed debate.

### **Achieving value for money**

Limited efforts to identify co-occurring ADHD hinder our ability to evaluate SUD treatment effectiveness for this group. Thus, we know little about the comparative efficacy of different treatment modalities provided for co-occurring ADHD. Although routine evaluation is essential for optimising care, a lack of identification of ADHD in SUD treatment settings precludes

measurement of outcomes. This compromises our ability to evaluate treatment outcomes and guideline concordance, establish benchmarks for accountability and embed mechanisms for continuous quality improvement for those with ADHD in SUD treatment settings. These are essential components of achieving value for money in our health system and inherently determine our ability to do more with less.

### **Stakeholder and policymaker engagement**

For any given health condition, identification and documentation of the condition is necessary, but admittedly not sufficient, to secure stakeholder/policymaker engagement and support to direct scarce resources to address it. A rationale for stakeholders and policymakers to allocate resources to improving workforce capability cannot be made effectively without evidence on co-occurring ADHD and SUD. Without this evidence, individuals with co-occurring ADHD and SUD remain invisible, omitted from clinical guidelines and policy change alike. If we accept that evidence-based policy is effective policy, then we must accept that we will not achieve effective policy or treatment without evidence. Inevitably, this pursuit begins with screening for ADHD in SUD treatment settings.

Without evidence to elicit stakeholder/policymaker engagement and support, developing and implementing ADHD-specific educational programmes, workforce capacity building and commensurate resourcing of treatment services will remain aspirational. If we do not actively identify ADHD in those with SUD, we run the risk of perpetuating the inverse care law, a well-established determinant of health inequality whereby those in greatest need of good medical care are the least likely to receive it. Essentially, we will fail to achieve equivalent outcomes for adults with ADHD and SUD.

## Conclusion

Parallel efforts to screen for ADHD in SUD treatment settings and train and resource our SUD treatment workforce are essential to respond effectively to this common dual diagnosis. Routine screening of co-occurring ADHD is an essential first step towards addressing system-level inequities and achieving equitable outcomes for adults with ADHD and SUD. Therefore, co-occurring ADHD among people with SUD is simply another case of 'what gets measured gets done'.

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