Ontario College of Family Physicians

Family & Community Medicine UNIVERSITY OF TORONTO | Mental Health and Addictions

Practising Well Community of Practice

September 18, 2024: Best practices for treating and diagnosing ADHD in primary care

Panelists: Dr. Kyle Lee and Dr. Devon Shewfelt
Host: Dr. Carrie Bernard; Co-host: Dr. Stephanie Zhou

Curated answers from CoP guests, panelists, Practising Well Community of Practice planning team to in-session questions posed by participants.

- **How much could we charge (lump sum or per session) for treating ADHD to compensate for non-OHIP portions of the assessments like questionnaires?**

My understanding is that non-physicians are charging for non-OHIP assessments. Not sure how physician treatments can be billed privately in these cases but curious of others' thoughts.

I would tend to bill these patients fee for service and spend visit times going over questionnaires etc. so still quite lucrative.

- **I had a patient experience Raynaud phenomenon in fingers. Is this common?**

Yes, I have experience with patients who have noticed this side effect. Often this may improve over time or may minimize with conservative management. If needed, a dose reduction or medication switch is helpful.

- **Do you need to do bloodwork and EKG prior to non-stimulant meds?**

Not routinely required but may depend on patient risk factors such as personal and/or a family history of cardiac events, comorbidities, or side effects.

- **How do you dispense stimulants (monthly, q3 months dispensed monthly, or 3 months at a time)?**

This is quite variable, and will depends on the time course of the treatment - is this their first trial? Have they been stable for many years? How is their function? If stable, I lengthen their course similar to other stable chronic medications like SSRIs.

- **Is there ever a case to prescribe Adderall. I have someone who was started by psych years ago. I am reluctant to change. Is this ok, or should I force them to change?**

Adderall XR is still first-line treatment on CADDRA guide to treatment. If patients are stable and functioning well, I am not routinely switching them all to another medication.

- **What are your top online patient resources for adults with ADHD?**

I like CADDAC and ADDitude online magazine.

- **How do you manage patient expectations to have medication at the first visit?**

Great question. I set expectations early and discuss how long other assessments are compared to ours in primary care. I also focus on how seeing them over a long time can ensure safety and accurate diagnosis and emphasize how we are able to treat their ADHD more comprehensively over a lifetime alongside other medical issues.

- **How do you appropriately manage your time for these multiple assessments? In particular, how do you manage in a FHO model where shadow billing for mental health or similar is so low?**

Honestly, they aren't significantly different than any other mental health visit, with 1-3 visits up front. I find these patients to be easy visits after that vs the chronic anxiety/depression patients.

- **It is frustrating and challenging when patients go for assessment privately and return with a recommendation to start medications; some sound legitimate, but others are murky. Explaining to patients that we are uncomfortable and want to delve more into ddx, etc. is usually not accepted to patients. Any tips on what to do here or navigate these scenarios?**

It might be helpful to understand which parts are murky. At the end of the day learning and understanding the clinical picture can help with comfort. Again, their response to medication is often diagnostic and so sometimes diving in is the best way to build comfort. Just like have done with all over aspects of our practice.

- **How do you do the coffee test?**

Just ask, "how much coffee do you drink?" "Do you have to cut off coffee at a certain time or you can't sleep, or could you have one at 10pm and go to bed half an hour later".

- **I struggle with patients who are incredibly high performing and working long hours who are convinced they have ADHD and need stimulants to focus, and I feel weary/resentment that they are trying to do more than would be expected of a normal human. They might have some mild ADHD-like symptoms, but they also aren't sleeping enough due to work etc., that could also explain it. I feel uncomfortable with a trial of meds because wouldn't a stimulant help everyone, including me?!**

This is where getting to know the true ADHD symptoms will be helpful with this. If this person can maintain focus through the day and just work long hours, then they likely don't have ADHD. VS. someone who is working long hours because they are disorganized, can't maintain attention, task switching constantly because they can't maintain focus ect. If they are the latter, you may get them managed so they regain time in their life with their family/friends.

- **I use the Wender Utah questionnaire. Is the scale mentioned by speakers the better one?**

Wender Utah looks great and highly detailed. I would get someone to do it at home before a visit. The ASRS is MUCH shorter, and I find useful as a history taking guide.

- **What about ADHD in a bipolar individual?**

These tend to be the patients I refer more often, largely for managing their bipolar disorder, especially if complex. If comfortable, an option is to start them and stabilize them on a mood stabilizer, and once stable you can safely use first line stimulants for these patients.

- **Having worked in university student health, I found a lot of students claiming ADHD, well researched into S&S, wanting stimulants. Is there any info about this?**

That can be challenging certainly. Again, this doesn't have to be done on visit #1 and so take a few visits. Some may not come back once they don't get it first visit. Getting a sense of them in high school, how the transition to university went.

- **Has anyone ever noticed patients with worse symptoms with (low dose) stimulants?**

Depends on what symptoms we're talking about, but if their anxiety, focus etc. is worse with a low dose, then they DON'T have ADHD.

- **What is going on that multiple perimenopausal patients are deciding they have ADHD suddenly?**

Yes, I find inattention and difficultly focusing is a common complaint for perimenopausal women. I try to explain that this is unlikely to be new onset ADHD at this stage in life.

This is where the history taking is helpful for the patient to at least feel you took it seriously, clarifying it will have always been there, and how did they manage "boring adulting things".

- **The real challenge is getting parents to agree. The other issue I find it they take them off medication for weekends and summer break.**

I tend to manage more adults generally but will take over care of their kids. With the hesitant parent they fear the meds, so your job is to ensure they are adequately "scared" of untreated ADHD, i.e. substance use, car accidents, crime, failure/low performance in school. I tend to advocate for staying on weekends and frame it as avoiding the roller coaster of withdrawal and restart, but its ok for them to take a break over the summer.

- **What are your thoughts with pts with ADHD, who have a history of alcohol abuse, and stimulants?**

Often the question is WHY? Why are they drinking, and what are they getting out of it. There are tons of untreated individuals with ADHD out there using substances because they don't have access to treatment. As you build confidence these cases won't be so daunting, and just

dispense weekly or less often. Come at them compassionately and nonjudgmentally so they keep coming back.

- **Is it a medication for life? Should we engage more with patients about termination of therapy at some stage of life?**

It's a medication for context I think, so an adult may not need it when their kids get older, empty nesters, retirement or job change.

- **When you suggested small afternoon dose, would this be same formulation as AM dose, or short acting Ritalin for example?**

No same med, so ex. Vyvanse 50mg in AM, 20mg at noon.

- **How high can you go on the medications?**

I would make sure people are deliberate about what evidence they need to know they have "arrived", over treatment can make concentration worse. Avg Vyvanse/Foquest is <70mg, but the odd up to 100mg, rare but with a history of meth use it may need higher.

- **I have heard that if you are getting "wearing off" in the later half of the day then you should just increase the long-acting dose vs adding in a booster dose - which approach is best and why?**

If they are well in the morning and you increase, you'll overflow the cup and they'll get stimulated, so we're trying to stay below the overflow line.

- **As patients get older (60s-70s) should we stop this medication due to increased CV risk/ contraindicated?**

If they do not have cardiac risk factors, I would have a discussion with this around this, but age alone is not necessarily a contraindication.

- **Marijuana use is almost universal now in teenagers. Any impact on increase in ADHD?**

I tend to require 4-6 weeks of no cannabis use to then re-evaluate symptoms, i.e. focus on the substance use disorder before the ADHD eval. I may add an SNRI/Trintellix if they are managing anxiety with cannabis.

- **How much marijuana days per week or alcohol drinks recreationally can a person have when on Vyvanse for example. Do they need to eliminate 100%?**

I review that other substances including EtOH and cannabis have NOT been studied with psychostimulants in the clinical trials. Like how people address medications like SSRIs and other medications etc. with substances, I advise on caution and lowest amounts possible at the end of day.It may negatively impact their treatment and we may need to explore why they may be using substances.

- **Any resources for behaviour therapy, how effective it is?**

Have a look on the slides, but in short, very effective.

- **My patient was diagnosed with OCD AND ADHD - is this also very common?**

I wouldn't say very common, but long-term untreated ADHD can lead to other stuff for sure. Treating the ADHD is easy with the meds I admit, and then can focus on the OCD, vs. starting one of the SNRI/Trintellix/viladozone meds toimprove the OCD sx first.