Ontario College of Family Physicians

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

Practising Well Community of Practice

May 28, 2025: Supporting patients with ADHD and comorbidities

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Host: Dr. Stephanie Zhou; Co-host: Dr. Nikki Bozinoff

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

1. **How might a family doctor find a specialist that can help with managing patients who have SUD as well as ADHD? Are there any specific doctors on eConsult or elsewhere that can help?**

It depends where along recovery they are. I have patients being managed elsewhere for their suboxone, methadone etc. and I manage their ADHD, with long-acting medication with short dispensing windows, even daily if they already do this for their addiction medications. I've been able to get patients off methamphetamine and cocaine by myself, with a strong rapport and greater fear of the SUD than the ADHD medication.

You could seek a second opinion from another addictions MD via your local RAAM? Or try to understand why addiction MD feels it is not appropriate? Diagnosis of ADHD can be difficult in the setting of active stimulant use. If there is a clear childhood hx that is easier. My personal experience is that treating ADHD doesn't necessarily reduce or eliminate unregulated stimulant use. There are first-line medications and psychosocial treatments for stimulant use disorder that should also be pursued.

2. **How many visits does it typically take you to make a diagnosis of ADHD in an adult without a prior childhood dx? And do you have a standard approach including use of specific forms etc. How do you gather collaborating information from when they were young?**

Two 30min visits typically, I use the ASRS/GAD/PHQ and then using those to ask questions. Collaborative information is helpful and builds a case, but not an absolute necessity. Histories from others can be rife with misattribution as well or not recognizing their inattention.

Sitting down with the CEP detailers can help build your confidence and approach.

3. **What about stimulant use in pregnancy? Is that a concern to the fetus?**

eConsult to a clinical pharmacologist can be very helpful. But it depends on the degree of distress/dysfunction, if mild then highlighting skills and coping is key, but if you have someone with debilitating mental health disorder then the risk of not treating their ADHD is likely higher than the risk of the medication.

4. **I've found that severe untreated anxiety presents itself as symptoms like ADHD, especially inattentiveness. I've seen that ADHD can be difficult to treat with Vyvanse and Concerta when they have severe anxiety and are not on appropriate pharmacotherapy for that. Would optimizing anxiety treatment first be beneficial for making future ADHD treatment more successful?**

I would have said the same, until I optimized my patient on their ADHD medication. I was advised that titrating them until a dose makes them worse, instead of better, then go back to the last dose. ie 55mg Foquest helps, 70mg feels vibrating, like 10x coffees then you go back to 55mg.

I find it much easier to optimize ADHD meds than many others, and so if there are symptoms left over then can SSRIs etc.

Much of the time their anxiety is rooted in their negative experiences from their untreated ADHD.

5. **What are your thoughts on the DIVA questionnaire?**

I'm not incredibly familiar with it, but I remember seeing it, and just looked again, and it feels like too much. However, may be worth trying and see if this helps guide you. Eventually if you do this enough, you may get comfortable enough that you can get the history on your own.
I don't use the McIsaac score for strep anymore because I know it so well already.

I really like the DIVA for adult ADHD diagnoses in combination with clinical assessment and collateral information from external resources.

6. **In individuals without ADHD, do we know what percentage would benefit (if any) from stimulant medication? Just wondering if most people would report a benefit from stimulant medication even if the diagnosis is incorrect?**

I'm not sure if there is data around people with depression and significant negative symptoms which you might see. However, from experience, people without ADHD, with anxiety, distinctly get worse on ADHD meds. Even small doses speed their brains up more and make it even harder for them to manage their anxiety and panic.

Temporary benefit is very common for 1-2 weeks as would be seen in anyone with stimulant's motivation and mood lifting qualities but for patients with ADHD the benefit persists but for those that do not have ADHD the benefits will wear off after 1-2 weeks on any dose.

7. **For a patient diagnosed with 'anxiety' and on an SSRI and not optimized, then improves on Concerta, how do I address the SSRI? Reduce / stop?**

I would treat it like how you would an adjunct. Optimize their Concerta, get them stable and doing well for 6-12 months, then try down titrating their SSRI and see how they do. Keep it going if they need it.

8. **I wasn't aware the dosing was dependent on patient weight - but each speaker has mentioned not using "low doses in an individual of x kg". Can you explain how weight plays into your dosing choice?**

ADHD meds are some of the rare ones we use in in 50lbs 5 year and in a 280lbs adult. Certainly, adult doses tend to be higher than kids, but its highly individualized. Titrate until either their distress/dysfunction is improved or resolved, OR the next dose up feels stimulating and makes things worse.

It is not dosed according to weight - but a 10 mg starting dose of Vyvanse for an adult will never touch them.

9. I find diagnosis the greatest barrier. Very involved, getting old teachers and parents to fill out questionnaires. Any tips to decrease barrier to diagnosis?

As adults, getting coordinating histories can help but isn't a complete necessity. I'll look for 5-10min through old report cards to get a feel of themes that come up, or parents will be in the visit with them, but largely gotten to the point where 2x 30min visits, and how easy it is afterwards, is so much easier than the untreated ADHD, treatment resistant depression/anxiety alternative.

10. How does trauma/ACE impact ADHD diagnosis? Specifically referring to female patients who often endure much more early childhood trauma events — it can often be hard to tease out whether the symptoms are due to trauma or true ADHD from birth?

In short that traumatic history drastically increases their cognitive and emotional load as an adult which brings ADHD symptoms out. As well those kids in traumatic environments as kids will disproportionately not go for evaluation and not get treated.

11. Why do u think there is such a high rate of medication discontinuation after 1 year especially after most patients' initial response can be life altering?

I think patients need more education about what ADHD is - we give them resources, but they don't always follow up. I also think it is important to see them every 3 - 6 months and reinforce the need to treat.

12. Do you have any guidance around prescribing for older adults with ADHD who have not previously been diagnosed and treated? For older adults with established diagnosis and already treated, when would you consider de-prescribing?

I have started to treat more and more seniors quite successfully. I do an EKG and make sure their BP is controlled and insist they check their BP regularly. If they have hypertension, I have them get it under control first. There are studies that are popping up that suggest treatment of ADHD reduces dementia- more to follow over time on that issue.

13. Approach to diagnosing ADHD in the pediatric population in primary care? Would you be comfortable with making this dx in clinic without referral?

It evolves over time as you get experience and confidence. I have started diagnosing and treating 14-15yo and older. However, I have diagnosed a couple of 10-11yo with a sibling/genetic history there already, but I also lean on audiology/optometry clearance first and be ready to refer if optimizing their med doesn't resolve much of their struggle and distress. Peds referral won't be a wrong answer for kiddos.

14. Wondering if you can speak to non-pharmacologic strategies? Are there resources for patients to develop better tools for executive functioning, address impact of technology on attention etc.?

CADDAC is great, the patient resources in the CEP ADHD in Adults tool are great as well. For myself, magnet fridge to do lists/calendars, pomodoro timers and fidget tools are very helpful. “How to ADHD” series on YouTube is great.

There are virtual groups via CADDAC that many of my clients find helpful. You can also find private therapists if patient has coverage.

15. Can you discuss the risk of cardiovascular disease with the use of stimulant medication? Seeing more older patients with suspected mild to moderate disease presenting for assessment and treatment?

Generally, the risk is low but monitor their BP/HR. Don’t treat with doses of meds beyond upper recommended limits. I have refused treatment to patient with unstable BP, history of CV/CNS complications.

16. How does alcohol use affect ADHD symptoms? Do these kids experience more executive dysfunction?

They should still take their stimulants it they’re out ’partying’ - they get into far more trouble off their meds - I’ve seen many who have been sexually abused, assaulted, when impaired. Cannabis is not a good med with ADHD - it impairs EF.

17. Given what’s been said about short acting stimulants. If I have prescribed short acting stimulants for folks already who are not getting an effect throughout the day, should I work on deprescribing?

I would work through this like deprescribing or shifting prescribing for benzos or others.
I would shift them over to long-acting treatment, can do it quite directly, but an eConsult with clin pharm can help. Generally, it’s with a dose reduction and CADDRA tables can give you a sense of the relative doses. Also being clear with the patient about SMART goals or what their treatment goals are and ensuring they have reasonable expectations.

18. I find considering ADHD in folks I meet as adults with a diagnosis of PTSD difficult given their memory lapses and the overlap of the ways executive dysfunction factors in. Any tips about teasing that apart? Executive dysfunction in an adult patient with PTSD to be expected or more likely to be ADHD?

I think getting to know both diagnoses well is the answer, to help teasing this apart. The “why” to their distress or dysfunction is the key for sure. Whichever you feel is the dominant diagnosis can treat first and see how they do, but don’t be afraid to trial stimulant medications.

19. How do you manage with insomnia as a side effect of Adderall?

I rarely use Adderall - Vyvanse seems better tolerated in most. Make sure they are taking it early enough in the day - and that they are taking it every day. On and off meds cause more insomnia.