# ADHD in adults

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ABSTRACT

The diagnosis and management of adult ADHD in general practice based on 317 patients is discussed. The personal and social cost of adult ADHD in terms of accidents, suicide, crime, substance abuse, unemployment, psychological and family damage is huge but largely unacknowledged. Recognition, education and a management plan belong primarily in general practice because this is a problem which is common, lifelong, straightforward to diagnose and affects the whole family. Treatment requires a long-term, team-orientated continuity. If medication is needed it is safe, effective and not complicated to monitor. General practice excels in all these dimensions.

**Key words**

ADHD, adults, ritalin

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Whatever happened to the restless fidgety kids who caused havoc in our surgeries when they were preschoolers or in primary school, and havoc in our communities as they rocketed through teenage years? The answer is very simple. They grew up to struggle their way through marriages, businesses and society creating more havoc for themselves and those around them. Attention Deficit Hyperactivity Disorder (ADHD) is not just about children who are hyperactive, it is just as much about underachieving dreamers. It does not stop at the end of teens. It is a common, life-long problem with a major impact on a wide array of social statistics.[1] It should be a huge concern for general practice, yet it passes largely unidentified and untreated.

What we now know as ADHD was first described by Dr Still of Still's disease fame in 1902, exactly one hundred years ago. It went through a series of name changes until it was defined in modern terms in the early 80s as excessive distractibility manifest as poor concentration and impulsivity. From the mid 80s some overseas experts began to look beyond childhood.[2,3] Finally in 1994 it found its way into the DSM IV criteria[4] as a genuine adult problem, but it sits there largely unacknowledged despite our history being littered with rich and colourful characters who almost certainly had ADHD, Leonardo Da Vinci, Beethoven, Einstein and Churchill being among the more obvious as judged by their biographies.

When I first became involved in treating ADHD kids around 1990 I would often ask parents, *'Is there any one else in the family with similar problems?'* Over time my question has changed to *'Which of you did he or she inherit it from?'*[5] Often a few months after the child starts on medication that parent will quietly turn up alone and ask if there was anything that could be done for him or her. That first trickle gradually became a flood so that I currently have over 300 adults, 20 years and older, with ADHD. Coming to know them has been a fascinating and sometimes very moving experience from which I would like to draw some thoughts for other GPs.

ADHD is a common problem. Surveys overseas and in New Zealand estimate about 5% of the population affected, varying slightly according to how tightly the DSM IV criteria are applied.[1] That translates into 200 000 out of four million in this country. According to Pharmac, figures about 5 000 people are currently on ritalin or dexamphetamine, hardly justifying a claim of over-prescribing. Overseas experts consider that about two-thirds of adults are well enough compensated to their ADHD.[6,7] The other third would benefit from help. A practice population of 2 000 patients will contain about 100 with ADHD, 25 children and teenagers, and 75 adults.

This represents about twice the likely number of diabetics in the same practice. We pride ourselves on having screened our populations well enough to have identified most diabetics, whether they need medication or not. Should we not do the same for ADHD?

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The mortality and morbidity from untreated diabetes motivates us to search hard. Just as strong a case can be made for screening for ADHD. Let us look at some disturbing secondary consequences of untreated ADHD.

1. In the USA, surveys have show that about 25% of the huge prison population have ADHD.[8,9] No-one has asked the question in NZ. Around 1% of New Zealanders will do a prison sentence at some time. At least 50 of my 317 ADHD adults have been in prison, and another 50 have faced criminal charges other than traffic offences,

but avoided incarceration. The great majority have one thing in common – impulsivity. Typical of many would be the two friends who had been on a hunting trip. One was driving; the one with ADHD was asleep. The driver woke his friend by swearing at the behaviour of the car in front so my patient grabbed a shotgun off the back seat and fired a couple of rounds out of the window. To his surprise a police roadblock was waiting a few miles down the road.

2. Evidence again from overseas suggests that the rate of road accidents for ADHD patients is four times that for the rest of the population and that the ADHD driver is nearly eight times more likely to be the cause.[10] Translated into the NZ rate of about 500 road fatalities per year it is highly likely that ADHD is a major factor. The ADHD driver is at risk in two ways, both from loss of concentration and from impulsivity expressed in risk taking by speed, overtaking and substance abuse. The literature from overseas suggests that on medication the accident rate is halved.[10] My patients confirm this. One lady describes how on ritalin she now looks at the road rather than the shops when driving.
3. The adrenalin surge of risk taking behaviour is marked in ADHD adults in several ways, including their choice of occupation and their preference for extreme sport. Many choose the armed services, the police or the fire service. The attraction lies in the combination of structure, which they need to function effectively, and risk. One man described how after joining the army he volunteered for bomb disposal and felt the most fulfilled of his life standing in the middle of a mine field in Cambodia. Another patient who is an amateur military historian suggested from his research that most VC holders had ADHD because they won their medals through impulsive acts which they probably survived.
4. Among my patient group there is a high preference for being self-employed because many cannot handle the restrictive demands of an employer who expects them to concentrate and keep to a timetable. Impulsivity can make for successful entrepreneurial behaviour because they do not foresee rejection, but the demands of record keeping, paying taxes and keeping to the regulations become their undoing and there are a high proportion of business failures. Those with ADHD are far more likely than others to have needed at some point an unemployment benefit, a sickness benefit or a domestic purposes benefit. Financial management is a major modern area of difficulty for those with ADHD. Easy credit and readily accessible gambling put them at great risk of impulsive spending. Among my patients this would account for a few wealthy people and a lot of bankrupts.

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5. Alcohol and drug abuse is said in the literature to be twice as common in those with ADHD as the average for the population.[11] The biggest trap for NZ ADHD patients is in the ready availability of marijuana which appears to be especially difficult in that it calms them but then damages memory and concentration thus aggravating their existing problems. Substance abusers with ADHD are a real challenge. Their contact with the drug scene makes the prescription of stimulants highly tempting, but at the same time, for many, the use of appropriate rather than inappropriate medication offers the best hope of moving out of the cycle of destructive behaviour.[12] This is just the kind of situation where GPs are in a better position to manage treatment than specialist clinics because we are close to the whole family and have ears in the community.[13] The secret of success with this tricky group lies in the combination of strong motivation to succeed in leaving the past behind and committed support from family and friends.
6. Clinical depression affects about 20% of adults at some time. In my adult ADHD patients a history of depression and usually ineffective antidepressant use is present in more than 50%.[14,15,16] The 'depression' of ADHD adults is born of frustration. Potential and dreams remain unrealised. A therapeutic combination of a stimulant and an antidepressant is safe but frequently after a period on ritalin the need for the antidepressant disappears. Another disturbing aspect of depression in ADHD is high suicide risk. I now always ask ADHD patients about a history of suicide attempts. About one third admit to one or more attempts. Among those I have assessed for ADHD I am aware of three completed suicides, all in young adults, two while off medication.

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7. ADHD patients love to move. If they were physically hyperactive as young kids that may have gone

by adulthood but they are still restless and quickly bored. They move house, job and partner. Some ADHD adults by the age of 30 have had 100 jobs. Some were fired for poor performance or outrageous behaviour. Most times they just left seeking new stimulation. They are likely to be performing below their true ability because of a lack of qualifications. Many change partners as easily as they change jobs. It may be the result of impulsive reaction in conflict or an unplanned affair but often again they just got bored. A string of temporary relationships frequently leave behind a string of children whose chances of a functional life are remote given unstable parenting and the ADHD genes.[5]

8. Beyond the drinkers, the gamblers, the risk takers, the criminals and the wanderers there are still a substantial number of ADHD patients who have avoided all these paths but in their way are struggling just as much. They are intelligent, workaholics, cautious by personality and products of protective home environments. With awesome determination they have achieved, conformed and persevered. They have stayed in the same house, job and marriage. Some describe living as if in a fog. One day they 'hit the wall', and can continue no longer. A common age in my patient group is about 40. Anything can happen including breaking down, breaking up and breaking out. They will often have been our patients for years, presenting occasionally with the usual variety of complaints. If we ever once took the time to have them tell their life stories the clues to ADHD would be there. I normally spend one hour initially with new ADHD patients letting them tell me their stories in their own words and way. Quite often people of 40 have said after doing so, *'I have told you things I have never told anyone. No-one has ever let me describe my life without interruption before.'* One of the great advantages of family practice is that we have often been part of much of that story.[17]
9. A fascinating observation in my particular patient group is how different the gender ratio is among adults compared with children. The ratio of M/F in 543 patients under 20 is 5:1, but in the 317 who are 20+ it changes to 3:2. This suggests that a diagnosis of ADHD is not considered in a huge number of female children and adolescents.

The effective management of adult ADHD is essentially the same as in children. Because so much has happened in life in the way of failure, rejection and hurt, results take longer to be apparent. At the same time successful treatment is immensely satisfying. Rarely in general practice do we have the opportunity to make such a difference.

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There are five elements in management, all of which require the kind of long-term involvement which we are so good at in general practice.

1. Lifestyle management is critical. Structure and routine greatly reduce the stress involved with poor short-term memory. Developing checks against impulsivity so that the mental 'committee meeting' takes place before the word or action, rather than the inquest afterwards, is effective damage control. Books on adult ADHD and soundly-based websites are useful resources.[18,19]
2. Drug avoidance is vital. In childhood the problems are coke and chocolate. In adult life they are alcohol and marijuana especially. When patients realise they have been self-medicating and there is now a better way they are often prepared to change. I offer people a choice, my medicine or theirs but not both.
3. Education is exciting. I have patients with IQs of 140 who emerged from school with few or no qualifications and have never completed any tertiary course because of major problems with concentration, particularly in lectures. A large number of my 300+ adult ADHD patients on ritalin have entered university and begun or completed diplomas and degrees, including masters and, in several cases, doctorates.
4. Support is necessary. Helping them look for someone who will care, encourage and persevere but not dominate or gossip is a challenge. Support organisations like the ADHD Association or ADDvocate do a great job and will often lead people to mutually supporting friendships. As general practice teams we can be a vital component in support in ways that specialist practices rarely offer.[13] I find myself frequently in the role of advocate for ADHD adults with the justice system, WINZ, partners, employers and universities.
5. Medication may be life-changing. Ritalin and Dexamphetamine each suit about 80% of adults just as they do children.[20] The dose and timing need to be adjusted to suit the individual. Most adults do well on Ritalin 20–60mg daily usually in the SR form but there are a few who do better on 80mg daily. Of 300 patients only about 15 have turned out to be abusers and been discontinued or very strictly supervised. My approach has been first to be sure of the diagnosis by careful history with corroboration from others, supported by

a Test Of Variable Attention (TOVA) computer test which can be performed in a visual or auditory mode and has high sensitivity and specificity for ADHD.[21] Potential for abuse and the presence of other psychiatric conditions need to be weighed carefully. If, despite being well motivated to take measures 1–4 above, people are still struggling significantly, a trial of Ritalin is worthwhile. The Pharmac restrictions imposed three years ago without significant GP consultation make life difficult. Once approved, long-term management will nearly always need to be back in our hands.

Adult ADHD is a challenge for family practice. My experience has been that there are few times in general practice that we have the opportunity to see such profound and lasting change in a struggling individual and family. To have a part in this is deeply satisfying.

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