CEP | Providers

Attention Deficit Hyperactivity Disorder in Adults

This tool is designed to support primary care providers in screening, diagnosing and implementing treatment for adult patients (≥ 18 years) with attention deficit hyperactivity disorder (ADHD). ADHD in adulthood can be associated with significant impairment in occupational, academic, social and emotional functioning.[1,2] The treatment of ADHD involves pharmacological and non-pharmacological interventions.

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SECTION A: Screening and diagnosis

Consider screening for ADHD in primary care in adults who present with executive function difficulties, including those who do not have a childhood diagnosis of ADHD. Recent studies have shown that a substantial proportion of individuals with adult ADHD were not diagnosed or recognized in childhood.[3]

Some opportunities for screening

Consider screening your patient who has:[2]

- A hard time adjusting to structure and transitions in their life
- Binge eating issues/fluctuating weight
- Emotional dysregulation
- Family dysfunction
- Occupational instability
- Persistent perceived underachievement
- Poor adherence to healthy lifestyle
- Risk taking behaviour
- Treatment resistant anxiety and/or depression

Screening

Use the Adult ADHD self-report scale (ASRS-V1.1) symptom checklist to screen patients for ADHD.[6] The ASRS-V1.1 is designed to encourage dialogue between you and your patient to identify if they have symptoms of ADHD.[3] If the patient has symptoms highly consistent with ADHD in adults, then investigation is warranted using the diagnostic criteria below.[6]

Due to the barriers to accessing specialty care, this tool aims to empower and guide primary care providers to manage adult ADHD within the primary care setting. For additional support consult specialists across the province at OTN eConsult[4] and find mentors at the Ontario College of Family Physician's (OCFP) Collaborative Mental Health Network.[5]

Diagnosis

In order to diagnose for ADHD, symptom manifestations of hyperactivity/impulsivity and/or inattention should:[7]

☐	Meet the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) for ADHD[8,9]
☐	Be pervasive, occurring in two or more of the categories in the **Categories of impairment** table below
☐	Cause at least moderate impairment in one category in the **Categories of impairment** table below as identified in the initial assessment

If possible, ask the patient for permission to consult a third-party (a friend or family member) who is close to the patient and can offer further insight into their symptoms.

Talking Points

Look for signs of ADHD and address it with your patient
"Were you diagnosed with ADHD as a child? You seem to have some symptoms of ADHD. Let's do an assessment to check."

Talk to your patient without judgment, stigma or bias
"Many people don't know that they have been living with ADHD until adulthood. It is a treatable and common condition, affecting 3.4% of adults worldwide."[3]

Categories of impairment

The following are examples of impairment that patients with ADHD may experience.

Educational	Family	Life skills	Occupational	Self-concept	Social	Risk
Problems with:	Problems with:	Problems with:	Problems with:	Feels:	Problems with:	Problems with:
• Focusing • Completing assignments • Meeting deadlines	• Family members • Parenting • Balancing their needs against those of their family	• Weight control • Sleeping • Perceived underachievement • Time management	• Performing required duties • Keeping a job • Supervisors	• Bad about themselves • Frustrated with themselves • Discouraged	• Avoiding arguments • Getting along with people • Regulating emotions	• Aggressive driving • Substance use • Physical aggression

Table adapted from the Weiss functional impairment rating scale (WFIRS-S)[10]

SECTION B: Initiating treatment

Develop a treatment plan with your patient that addresses their psychological, behavioural, occupational and educational needs.[7]

Take into account:[7]

- how symptoms and impairments affect the patient's daily life activities, including sleep[7]
- the patient's resilience and protective factors (positive self-esteem, success at school, steady employment, supportive family)[7,11]

Discuss the following with your patient:[7]

- how to use the Specific, Measurable, Achievable, Realistic, and Timely (S.M.A.R.T.) goals framework to create S.M.A.R.T. methods for monitoring treatment effect (e.g. if a patient wants to focus more on their studies, be more financially responsible, manage their time better)[12]
- how other diagnosed mental health or neurodevelopmental conditions might affect their treatment decisions
- the benefits and risks of non-pharmacological and pharmacological treatments
- the importance of adherence to their treatment plan

Talking Point

Reassure patients that their treatment plan can be changed

"Nothing is set in stone. Your treatment options are negotiable, and we can always revisit at the next appointment."

SECTION C: Pharmacological management

If a patient has a diagnosis of ADHD, pharmacological and non-pharmacological treatment should be used in parallel.

Considerations when prescribing

- Revisit the patient's S.M.A.R.T. goal methods to determine when their medication needs to be effective over an extended period of time (this can help determine if medication is losing effect during the day)[2]
- Rule out contraindications to medication (e.g. uncontrolled hypertension, cardiovascular disease, uncontrolled epilepsy)[2]
- When prescribing stimulants for ADHD, use extended-release once-daily preparations (see SECTION C: First-line treatment options)[7]
- Prescribe medication for no more than three months and have patient come back for review of medication (see SECTION F: Maintenance and monitoring)[2]
- Document the patient's blood pressure, pulse rate, BMI/weight and ASRS-V1.1 score at baseline and all subsequent visits to measure the effect of treatment for monitoring purposes[2,4]

PT NAME	DATE	BLOOD PRESSURE	PULSE RATE	BMI/WEIGHT	ASRS-V1.1 SCORE

Talking Points

Discuss the following when starting pharmacological treatment

"When starting at a low dose it's not uncommon to feel like the same dose is no longer supportive. This is normal and expected and we can increase the dose based on your needs."

"It is important to maintain a routine and to take your medications at the same time every day."

"Avoid drinking excessive alcohol and caffeinated beverages while taking stimulants."

- Choose extended-release stimulants because of the higher risk of diversion and misuse affiliated with immediate-release medications[2]
- Be aware of possible diversion by some patients who may request these medications for cognitive enhancement or appetite suppression[2]

SECTION C: Pharmacological management (Continued)

The medication list below is recommended for adult patients ≥ 18 years. It does not address patient populations <18 years of age. For a more comprehensive list of medication information such as adverse effects, consult each individual product monograph.

First-line treatment options

Evidence supports the efficacy of the stimulants lisdexamfetamine or methylphenidate as first-line pharmacological treatment for adult patients living with ADHD.[2,15]

- If one stimulant doesn't work consider conducting a trial with another stimulant in the table[2]

Medication	Formulation	Dosage	Duration of action	Adverse effects[16, 35]	ODB coverage	Cost*
Lisdexamfetamine (Vyvanse ®)[16,17,18]	10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg and 70 mg capsules[18] 10 mg, 20 mg, 30 mg, 40 mg, 50 mg and 60 mg tablets[18]	Initial: 20-30 mg[19] once daily in the morning; may increase in increments of 10 mg or 20 mg at weekly intervals until optimal response is obtained Maximum: 60 mg/day[19,20]	13–14 hours[16]	**Common adverse effects:** Restlessness, irritability, anxiety, insomnia or anorexia, worsening of aggressive behaviour or hostility at the start of treatment • Paradoxical psychiatric effects such as rebound, restlessness, irritability, and increased aggression may be observed • Somatic effects such as insomnia, decreased appetite, tics, stomach ache, and headache are all common, especially at the beginning of therapy • The slower the rate of titration, the less severe the initial side effects • Many of these psychiatric and somatic side effects will endure throughout treatment, making drug holidays useful to assess impact of relative risk vs. benefit, and necessitating the regular monitoring of growth **Discontinuation syndrome:** Abrupt withdrawal after prolonged use may result in dysphoria, irritability or rebound in symptoms of ADHD, increase in sleep and appetite reported. Consider tapering over several weeks in patients who poorly tolerate discontinuation or have been on medication for longer than 3 months. If stimulants are taken in conjunction with an antipsychotic, sudden discontinuation may result in the emergence of extrapyramidal symptoms previously masked by the stimulant. **Note:** Monitor patient for suicidal thoughts/ideation; consider a change in treatment if concerns arise.	Yes	$$$$$
Methylphenidate controlled-release capsules (Biphentin®)[16,21,22]	10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg and 80 mg capsules[22]	Initial: 10–20 mg QAM PO; may increase by 5–10 mg Q 7 days[16] Maximum: 80 mg/day[16]	10–12 hours[16]		Yes	$$$$
Methylphenidate controlled-release capsules (Foquest ®)[16,21,23]	25 mg, 35 mg, 45 mg, 55 mg, 70 mg, 85 mg and 100 mg capsules[23]	Initial: 25 QAM PO; may increase by 10–15 mg Q 5 days[16] Maximum: 100 mg/day[16] Patients who are already taking methylphenidate can convert to the next lower strength of Foquest® based on the total methylphenidate daily dose[16]	16 hours[16]		No	$$$$$
Methylphenidate bilayer controlled-release tablets (Concerta ®)[16,21,24]	18 mg, 27 mg, 36 mg, and 54 mg tablets[24]	Initial: 18 mg QAM PO; may increase by 9–18 mg Q 7 days[16] Maximum: 72 mg/day[16,19] Consult product monograph for dose conversion from other methylphenidate formulations[16] Note: When possible, use the brand name product of this medication as the generic brand version does not have the same bioequivalence and does not work the same[2]	12 hours[16]		Partially covered	$$

Cost of 30-day supply of mean dosage: $< $30 $$=$30–60 $$$=$60–90 $$$$=$90–120 $$$$$=$120–150

*Please note that dispensing fees have not been included

Note: reference to brand names does not imply endorsement of any of these products

SECTION C: Pharmacological management (Continued)

Second-line treatment options

Offer atomoxetine to adults if:[7]

• they cannot tolerate lisdexamfetamine or methylphenidate or

• their symptoms have not responded to separate six-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses

Medication	Formulation	Dosage	Duration of action	Adverse effects	ODB coverage	Cost*
Atomoxetine (Strattera ®)[16,25,26]	10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg and 100 mg capsules[26]	Initial: 60 mg then 80 mg/day Maintain dose for a minimum of 7-14 days before adjusting Maximum: 100 mg/day[19,27] Note: Generic versions of this medication work well[2]	24 hours[19]	**Common adverse effects:** Rhinitis, upper abdominal pain, nausea, vomiting, decreased appetite, weight loss (seen initially, especially if dose titrated too rapidly but levels off with time), dizziness, headache, fatigue, emotional liability, insomnia (more common in adults), sexual dysfunction. **Discontinuation syndrome:** No evidence to date that suggests a drug discontinuation or withdrawal syndrome exists. Note: Monitor patient for suicidal thoughts/ideation; consider a change in treatment if concerns arise.	Partially covered	$$$$$

Cost of 30-day supply of mean dosage: $< $30 $$=$30–60 $$$=$60–90 $$$$=$90–120 $$$$$=$120–150

*Please note that dispensing fees have not been included

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Titration

Titrate starting at the lowest appropriate dose according to the product monograph, the patient's symptoms and adverse effects until dose optimisation is achieved (i.e. the patient experiences reduced symptoms; a positive behaviour change; or, improvements in education, employment and relationships, while reporting potential tolerable adverse effects).

- Most patients will notice initial improvement but it may also take a number of months to get the choice of medication and dosage into the range where the patient has the optimum benefit[2]
- Progress should be reviewed regularly - initially at one month and then less frequently as the patient stabilizes
- Review of ADHD symptoms, impairments and side effects should be discussed. The ASRS-V1.1 can also be used as a scale to follow changes in the patient's executive function. Inquiry as to how patients are managing with their S.M.A.R.T. methods are also important[2,7]
- Dose titration must be slower and monitored more carefully in patients with co-morbid conditions, neurodevelopment disorders and medical conditions as outlined in SECTION E: Treatment for patients with comorbid conditions and differential diagnosis

SECTION D: Non-pharmacological treatment options

Non-pharmacological treatment should always be discussed when prescribing medication for ADHD in order to optimize the effects of the patients treatment.[2] When available, the following maybe helpful:

Consider a structured, supportive psychological intervention focused on ADHD, such as cognitive behavioural therapy (CBT)[7]

Consider offering a print out of the Patient resources section for more information on ADHD coaches, counselling, food and nutrition, healthy lifestyle modifications, vocational advice, financial resources and other tips

For additional support consider consulting the Canadian ADHD Resource Alliance (CADDRA) Guide to ADHD psychoeducation for tips on engaging in pyschosocial treatment with your patient.[28]

SECTION E: Treatment for patients with comorbid conditions and differential diagnosis

About 75% of adults with ADHD will have at least one other mental health condition (e.g. anxiety, a mood disorder, personality disorder or substance use disorder) or a comorbid neurodevelopmental condition (e.g. autism spectrum disorder or a learning/intellectual disability).[7,29] Consultation with a psychiatrist or psychologist may be required for complex cases (see Provider resources).[2] The comorbid conditions in this section are common in adults with ADHD, but it is not an exhaustive list.

Talking Point

"We will need to treat your other conditions for you to start feeling better. In order to do this, we will address the most important issues first."

Acute psychotic or manic episodes

- For adults with ADHD experiencing an acute psychotic (e.g. hallucinations, delusions and disorganized thinking) or manic episode (e.g. abnormally upbeat, jumpy or wired, increased activity, energy or agitation, decreased need for sleep)[7,30,34]
  - stop stimulant medication for ADHD[7]
  - consider resuming or starting new ADHD medication after the episode has been treated[2,7]

Anxiety disorders

- Consider the same medication choices to patients who have ADHD comorbid to an anxiety disorder as offered to patients who have ADHD without a comorbid condition[7]
- In situations where anxiety is exacerbated by the ADHD, treat the anxiety first[2]
  - *Note: anxiety is often secondary to unsupported ADHD*[2]

Bipolar disorder

- Patients with co-occurring bipolar disorder and ADHD should be stabilized on a therapeutic dose of a mood-stabilizing medication before treating ADHD with a stimulant[1]

Cardiovascular disease

- All patients should be monitored with regular blood pressure and pulse rate checks
  - *If a patient has significant cardiovascular disease or a family history of sudden cardiac death in young family members, referral to a cardiologist should be undertaken prior to treatment*[2]

Depression

- For patients with ADHD and co-occurring depression, consider combining ADHD treatment with an antidepressant
- If a patient has treatment-resistant depression, then the primary concern may be the undiagnosed ADHD. When the ADHD is treated, the continued use of antidepressants may not be required[1,2]

Substance use disorder (SUD)

- In adults with ADHD and an active SUD, the SUD is to be acknowledged and ideally stabilized before starting pharmacotherapy for ADHD[1]
  - Treatment with atomoxetine may be recommended as it has limited abuse potential[1]
  - Lisdexamfetamine is also recommended because of its unique chemical properties that makes it difficult to abuse[2]
- Patients with SUD benefit from additional structure in dispensation and monitoring for their safety:
  - Consider daily observed doses at the pharmacy[2]

SECTION F: Maintenance and monitoring

Guidance for conducting follow-up visits with patients

The recommended time frame after initiating treatment should be at three months, unless clinical indicators warrant the need for an earlier visit. See below on considerations to address during the follow-up visit.

- Ongoing maintenance of the following is recommended: appetite, weight, sleep, cardiovascular, and wellness, including sexual performance[2]
- Revisit the patient's S.M.A.R.T goal methods for monitoring treatment effect from before treatment onset to assess the patient's areas of improvement and change[2]
- Ask patient if they notice the medication wearing off during the day (avoid adding a top-up medication)
- Monitor and record the effectiveness of the patient's medication for ADHD by conducting the ASRS-V1.1 at each visit to monitor for improvement[7]
- Encourage the patient to monitor and record the effects associated with their medication, both positive and negative[7,31]

Review of medication and discontinuation

- Review ADHD medication at least once a year and discuss with the patient whether medication should be continued[7]
- Atomoxetine can be stopped at anytime without tapering[2,20,35]
- When tapering is warranted for lisdexamfetamine or methylphenidate, please decide based on patient's medical history and needs (i.e. if they have prolonged use of a stimulant and/or they are taking another medication in conjunction such as antipsychotics)[35]
- Continue to document patient factors to monitor treatment effects at follow-up visits

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Resources

Provider resources

[I] Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions: https://add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf
[II] Canadian ADHD Resource Alliance (CADDRA): https://www.caddra.ca/
[III] Canadian ADHD Resource Alliance (CADDRA) guide to ADHD psychosocial interventions: https://caddra.ca/pdfs/Psychosocial_October2016.pdf
[IV] Centre for ADHD awareness Canada (CADDAC): https://caddac.ca/adhd/
[V] DSM-5 diagnostic criteria for ADHD: https://images.pearsonclinical.com/images/assets/basc-3/basc3resources/DSM5_DiagnosticCriteria_ADHD.pdf
[VI] OTN eConsult: https://otn.ca/providers/

Patient resources

Cognitive behavioural therapy, oaches, counselling and support groups

- Big White Wall: https://www.bigwhitewall.com/
- ADHD coaches: https://caddac.ca/adhd/resources/clinicsagencies/
- MindShift™ CBT app: https://www.anxietycanada.com/resources/mindshift-cbt/
- Occupational therapy: https://www.caot.ca/site/findot
- Support groups: https://caddac.ca/adhd/resources/support-groups/

Financial aid, managing money and scholarships

- Financial aid and scholarships: https://caddac.ca/adhd/resources/scholarships/
- Managing money & ADHD: https://chadd.org/wp-content/uploads/2019/08/ManageMoneyInfographic.pdf
- Mint app: https://www.mint.com/
- Spending Tracker app: https://apps.apple.com/ca/app/spending-tracker/id548615579

General information, fact sheets, and recommended reading

- CADDRA recommended reading list: https://www.caddra.ca/public-information/adults/recommended-reading/
- Fact sheets for patients: https://chadd.org/understanding-adhd/adhd-fact-sheets/
- Red flags for adult ADHD: https://caddac.ca/adhd/wp-content/uploads/2016/10/Red-Flags-for-Adult-ADHD.pdf
- What you need to know about ADHD: https://caddac.ca/adhd/wp-content/uploads/2019/02/What-You-Need-to-Know-About-ADHD_Final.pdf

Food and nutrition

- Canada's food guide:
  - https://food-guide.canada.ca/en/
  - https://food-guide.canada.ca/static/assets/pdf/CDG-EN-2018.pdf
- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) resource for nutrition and ADHD: https://chadd.org/about-adhd/nutrition-and-adhd/

Mental health

- Canadian Mental Health Association (CMHA) resources: https://cmha.ca/

Managing social media

- Freedom app:* https://freedom.to/
- Screen Time (Apple products): https://support.apple.com/en-ca/HT208982
- Quality Time (Android products): https://play.google.com/store/apps/details?id=com.zerodesktop.appdetox.qualitytime&hl=en_CA

Organization and task management

- Evernote app:* https://evernote.com/
- OmniFocus:* https://www.omnigroup.com/omnifocus/
- Todoist:* https://todoist.com/
- Engross app:* https://engrossapp.com/

Podcasts

- CADDAC Club ADHD the Podcast: https://caddac.ca/adhd/resources/podcast/

Recreation programs, tutors, schools, and camps

- Recreation programs, tutors, schools, and camps: https://caddac.ca/adhd/resources/tutoring/

Setting routines and reminders

- Routinist app:* http://morningroutineapp.com/
- Remember the Milk:* https://www.rememberthemilk.com/
- EpicWin app:* https://apps.apple.com/ca/app/epicwin/id372927221

YouTube Videos

- Videos from CADDAC: https://www.youtube.com/user/adhdvid/featured

*Costs may be associated

References

[1] UpToDate. Approach to treating attention deficit hyperactivity disorder in adults. 2019. [cited 2019 November 13].

[2] Expert opinion

[3] UpToDate. Attention deficit hyperactivity disorder in adults: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis. 2018. [cited 2020 March 4].

[4] Ontario Telemedicine Network. eConsult. [cited 2020 January 13]. Available from: https://otn.ca/providers/

[5] Ontario College of Family Physicians. Collaborative Mental Health Network. [cited 2020 January 13]. Available from: https://www.ontariofamilyphysicians.ca/education/collaborative-mentoring-networks/collaborative-mental-health-network

[6] Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions. [cited 2019 November 15]. Available from: https://add.org/wp-content/uploads/2015/03/adhdquestionnaire-ASRS111.pdf

[7] National Institute for Health and Care Excellence (NICE). Attention deficit hyperactivity disorder: diagnosis and management. 2018. [cited 2019 November 1]. Available from https://www.nice.org.uk/guidance/ng87

[8] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 5th ed. Washington: American Psychiatric Publishing; 2013. Section II: Attention-Deficit/HyperactivityDisorder; p.59-66. [cited 2019 December 1].

[9] Attention-Deficit/Hyperactivity Disorder (ADHD). [cited 2019 December 1]. Available from https://images.pearsonclinical.com/images/assets/basc-3/basc3resources/DSM5_DiagnosticCriteria_ADHD.pdf

[10] Weiss functional impairment rating scale-self report (WFIRS-S). [cited 2020 January 18]. Available from https://www.caddra.ca/wp-content/uploads/WFIRS-S.pdf

[11] Government of Canada. Risk and protective factors. 2015. [cited 2020 February 20]. Available from https://www.publicsafety.gc.ca/cnt/cntrng-crm/crm-prvntn/fndng-prgrms/rsk-fctrs-en.aspx

[12] SMART goal worksheet. [cited 2020 January 18]. Available from https://www.mcckc.edu/counseling/goal-setting/docs/SMARTGoalWorksheet.pdf

[13] Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). Nutrition and ADHD. [cited 2020 February 28]. Available from https://chadd.org/about-adhd/nutritionand-adhd/

[14] Sample Patient Agreement Forms. [cited 2019 December 3]. Available from https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf

[15] UpToDate. Pharmacotherapy for attention deficit hyperactivity disorder in adults. 2019. [cited 2020 February 19].

[16] RxTx. Attention-Deficit Hyperactivity Disorder. 2019. [cited 2019 November 12].

[17] Ontario Drug Benefit Formulary/Comparative Drug Index. Lisdexamfetamine. [cited 2019 December 4]. Available from https://www.formulary.health.gov.on.ca/formulary/results.xhtml?q=Lisdexamfetamine%2B&type=1

[18] Shire Pharma Canada ULC. Vyvanse®. [cited 2019 December 4]. Available from https://pdf.hres.ca/dpd_pm/00052075.PDF

[19] Canadian ADHD Resource Alliance (CADDRA). CADDRA Guide to ADHD Pharmacological Treatments in Canada - January 2020. 2020. [cited 2020 February 14]. Available from https://www.caddra.ca/wp-content/uploads/Medication_Chart_English_CANADA-1.pdf

[20] Lexicomp. Lisdexamfetamine (Lexi-Drugs). [cited 2019 December 3].

[21] Ontario Drug Benefit Formulary/Comparative Drug Index. Methylphenidate. [cited 2019 December 4]. Available from https://www.formulary.health.gov.on.ca/formulary/results.xhtml?q=methylphenidate%2B&type=1

[22] Purdue Pharma. Biphentin®. [cited 2019 December 4]. Available from https://pdf.hres.ca/dpd_pm/00049365.PDF

[23] Purdue Pharma. Foquest®. [cited 2019 December 3]. Available from https://pdf.hres.ca/dpd_pm/00049955.PDF

[24] Janssen Inc. Concerta®. [cited 2019 December 4]. Available from https://pdf.hres.ca/dpd_pm/00050777.PDF

[25] Ontario Drug Benefit Formulary/Comparative Drug Index. Atomoxetine. [cited 2019 December 3]. Available from https://www.formulary.health.gov.on.ca/formulary/results.xhtml?q=atomoxetine&type=1

[26] Eli Lilly Canada Inc. Strattera®. [cited 2019 December 3]. Available from https://pdf.hres.ca/dpd_pm/00032230.PDF

[27] Lexicomp. AtoMOXetine (Lexi-Drugs). [cited 2019 December 4].

[28] Canadian ADHD Resource Alliance. CADDRA Guide to ADHD Psychosocial Interventions.2016. [cited 2020 February 19]. Available from https://caddra.ca/pdfs/Psychosocial_October2016.pdf

[29] BMJ Best Practice. Attention deficit hyperactivity disorder in adults. 2018. [cited 2019 December 4].

[30] Centre for Addiction and Mental Health (CAMH). First episode psychosis An information guide. 2015. [cited 2020 February 20]. Available from https://www.camh.ca/-/media/files/guides-and-publications/first-episode-psychosis-guide-en.pdf?la=en&hash=E217B7A693F6AE0E4242A6535F922C50A1E24F78

[31] Canadian ADHD Resource Alliance (CADDRA). CADDRA Patient ADHD Medication Form. [cited 2020 February 28]. Available from https://www.caddra.ca/wp-content/uploads/CADDRA-Patient-ADHD-Medication-Form.pdf

[32] ConnexOntario. Intensive Case Management Program. [cited 2020 February 27]. Available from https://www.connexontario.ca/

[33] National Sleep Foundation. Sleep Diary. [cited 2020 February 27]. Available from https://www.sleepfoundation.org/sites/default/files/inline-files/SleepDiaryv6.pdf

[34] Mayo Clinic. Bipolar disorder. 2018. [cited 2020 February 21]. Available from https://www.mayoclinic.org/diseasesconditions/bipolar-disorder/symptoms-causes/syc-20355955

[35] Virani AS, Bezchlibnyk-Butler KZ, Jeffries JJ, Procyshyn RM, editors. Clinical Handbook of Psychotropic Drugs. 19th ed. Boston: Hogrefe Publishing Corp; 2012.

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