Managing ADHD in Adults on the inpatient Unit Fact Sheet [G]

Introduction:

Adult ADHD can become a contentious issue on the inpatient unit, primarily because the treatment of choice, psychostimulants, is a substance of abuse for some people. Some units have a blanket policy of not prescribing stimulants. In other cases, it is a doctor-specific issue, with some making withholding stimulants a part of their own practice. There are rationales for both points of view.

The case for continuing stimulants:

- Discontinuing stimulants will often cause a mild withdrawal syndrome of fatigue and depression, both of which can exacerbate the presenting psychiatric disorder.
- People who have severe inattention symptoms will concentrate poorly off stimulants, and this will diminish their ability to benefit from therapeutic programs.
- Discontinuing stimulants implicitly communicates a mistrust of the judgment of the outpatient provider who has been prescribing the medication.

The case for discontinuing stimulants:

- Stimulants are likely to destabilize major psychiatric syndromes that led to admission, such as bipolar disorder, psychosis, agitation.
- Since ADHD is easily malingered, patients may claim they have ADHD just to get a prescribed a stimulant to get high while they are admitted.

Recommended approach

Attempt to establish the diagnosis:

- Recall that the key points for an adult ADHD diagnosis are:
    - Initial onset of symptoms by age 12
    - Symptoms include either or both of the following 2 categories:
        - Inattentiveness and disorganization (eg., easily distracted, can't finish projects, can't concentrate on tasks)
        - Impulsivity and hyperactivity (eg., can't keep still, talks impulsively, makes rash decisions)
- You can ask about these symptoms in a reliable patient and establish a diagnosis—but inpatients often have comorbid conditions, such as psychosis, bipolar disorder, substance use disorder, that make it hard to make a valid diagnosis based on interview.
- Contact collaterals, such as outpatient providers and family members/significant others, who have known the patient for years and can usually provide more reliable information.

Keep an open mind on prescribing stimulants—but don't be a pushover either:

- If the outpatient provider has consistently prescribed stimulants, you should generally continue the same medication at the same dose during the inpatient stay.
- Exceptions to this rule include the following:
    - The symptoms prompting admission may have been worsened by stimulants—eg., symptoms such as psychosis, agitation, anxiety, mania.
    - There are clear signs of substance use disorder, either by history or by results of urine drug screening.
- If the patient is requesting stimulants but there is no track record of an outpatient ADHD diagnosis or consistent refills of stimulants, then we don't generally recommend starting stimulants. Instead, offer a non-addictive alternative, such as atomoxetine or bupropion.
    - Some patients get angry or irritated, insisting that stimulants are the only things that really help them. Here are some ways to respond to this.
        - "Diagnosing ADHD is difficult, and the best way to do it is in the outpatient setting where your doctor can do a full evaluation that may take a several appointments. We can't do that here on the inpatient unit."
        - "Stimulants can be helpful but they are also highly addictive—for that reason, we don't prescribe them unless we can talk to an outpatient prescriber who can assure us that you have the diagnosis and that you have used these meds responsibly."