ECHO IDAHO

Counseling Techniques for Substance Use Disorders

Differential Diagnosis of ADHD During SUD Treatment

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Cloeie Hood, LCSW, AADC

Tegmentum Counseling Services

University of Idaho
School of Health and Medical Professions

Project ECHO

Learning Objectives

- Recognize the challenges in diagnosing ADHD in people with substance use disorders (SUD)
- Understand how ADHD affects SUD treatment and relapse risk
- Learn how to differentiate ADHD from other conditions in SUD clients using case examples

Why does this matter?

- High prevalence of ADHD among individuals with SUD
- ADHD can increase vulnerability to substance use
- Misdiagnosis can lead to ineffective treatment

ADHD Criteria: Two symptom Categories

1. **Inattention** (at least 6 symptoms for children up to age 16, or 5 symptoms for adolescents 17+ and adults)
2. **Hyperactivity and Impulsivity** (at least 6 symptoms for children up to age 16, or 5 symptoms for adolescents 17+ and adults)

Inattention:

- Difficulty sustaining attention & following instructions
- Disorganized, forgetful, frequently losing things
- Easily distracted, avoids tasks requiring focus

Hyperactivity and Impulsivity:

- Fidgets, restless, excessive talking
- Interrupts, blurts out answers, difficulty waiting turn
- Acts as if "driven by a motor"

Additional Criteria:
Symptoms present for 6+ months, start before age 12
Must appear in 2+ settings (home, school, work)
Must impair daily life and not be better explained by another disorder

- ADHD Types: Inattentive | Hyperactive-Impulsive | Combined

Reasons why diagnosing ADHD in SUD clients is sometimes difficult…

Overlapping symptoms: impulsivity, inattention, restlessness

Substance use masking or mimicking ADHD symptoms

Withdrawal effects complicating diagnosis

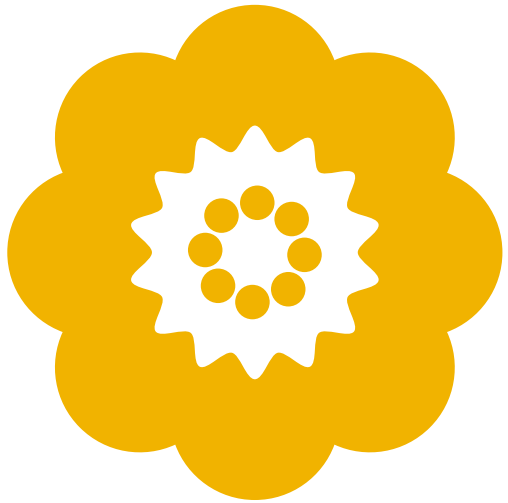
Differential Diagnosis vs. Comorbidity

Differential Diagnosis: Distinguishing between ADHD and symptoms caused by substance use or other mental health conditions

Comorbidity: Co-occurrence of both disorders in the same individual

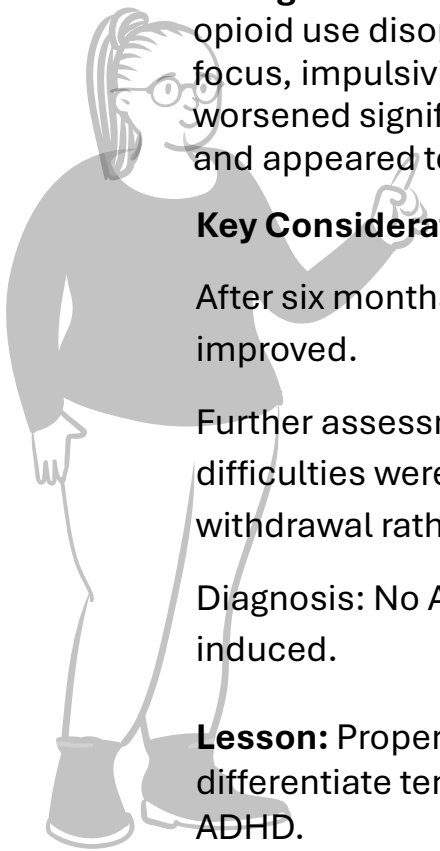
Distinguishing Factors of ADHD

- Developmental History
- Symptom Consistency
- Differentiation from other disorders



- Onset of symptoms
- Abstinence Assessment
- Use of Structured diagnostic tools:
  - Adult ADHD self-report scale (ASRS-SV)
  - Wender Utah Rating Scale (WURS)
  - Conners' Adult ADHD Rating Scales (CAARS)
  - Adult ADHD Diagnosis Assessment (ADSA)

Case Examples of Differential Diagnosis



Case 1: Lisa – Substance-Induced Symptoms vs. ADHD

Background: Lisa, a 27-year-old woman, entered treatment for opioid use disorder. She reported long-standing difficulties with focus, impulsivity, and disorganization. However, her symptoms worsened significantly during periods of heavy substance use and appeared to fluctuate with withdrawal cycles.

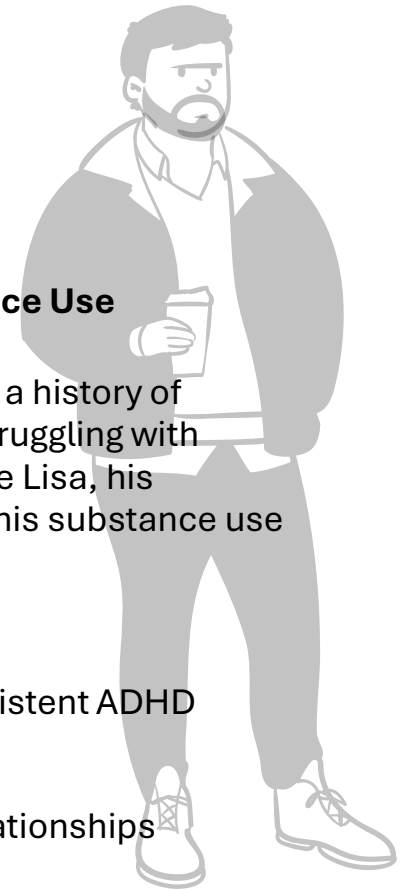
Key Considerations:

After six months of sobriety, Lisa's symptoms significantly improved.

Further assessment suggested that her concentration difficulties were more likely related to opioid use and withdrawal rather than ADHD.

Diagnosis: No ADHD; symptoms were substance-induced.

Lesson: Proper assessment over time is crucial to differentiate temporary cognitive impairment from true ADHD.



Case 2: James – ADHD Masked by Substance Use

Background: James, a 35-year-old man with a history of methamphetamine use disorder, reported struggling with focus and impulsivity since childhood. Unlike Lisa, his symptoms remained constant regardless of his substance use patterns.

Key Considerations:

Review of his childhood history showed persistent ADHD symptoms before substance use began.

He struggled with work performance and relationships due to his impulsiveness and inattention.

After six months in recovery, his difficulties persisted, supporting an ADHD diagnosis.

Lesson: ADHD symptoms present before substance use began suggest a true diagnosis rather than substance-induced symptoms.

Case 3: Mike – Misdiagnosis Leading to Treatment Challenges

Background: Mike, a 42-year-old man with alcohol use disorder, was diagnosed with ADHD and prescribed stimulant medication. However, he experienced increased cravings and a relapse after starting the medication.

Key Considerations:

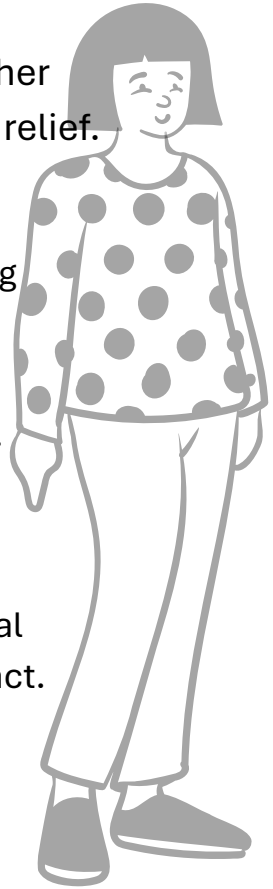
A reassessment suggested his attention issues were more related to untreated anxiety rather than ADHD.

Switching to a non-stimulant treatment approach (e.g., therapy and non-stimulant ADHD medications) improved his focus without triggering substance cravings.

Lesson: Careful differential diagnosis is essential to prevent misdiagnosis and ensure appropriate treatment, especially when prescribing stimulants to clients with SUD.

Case 4: Sarah – Trauma Mimicking ADHD

Background: Sarah, a 29-year-old woman with a history of alcohol use disorder, sought treatment for ongoing difficulties with focus, emotional regulation, and impulsivity. She had been diagnosed with ADHD in her early 20s, but stimulant medications provided little relief.



Key Considerations:

Sarah had a history of early childhood trauma, including neglect and exposure to domestic violence.

Her symptoms, such as hypervigilance, emotional dysregulation, and difficulty concentrating, were better explained by PTSD rather than ADHD.

Trauma therapy (e.g., EMDR, CBT for PTSD) led to significant improvements in her attention and emotional regulation, while ADHD medications had minimal impact.

Lesson: Trauma symptoms—such as hyperarousal, dissociation, and emotional instability—can mimic ADHD, leading to misdiagnosis. A thorough history is essential to differentiate between ADHD and trauma-related responses.

Challenges in Treating ADHD and SUD together

- Stimulant medications and concerns of misuse
- Cognitive-behavioral challenges: executive dysfunction/ impulsivity
- Overlapping and Masking Symptoms
- Difficulty with adherence to treatment plans
- Lack of integrated Treatment Approaches

Medication Management Complications

- **Stimulant Medications:** The most effective treatments for ADHD (e.g., methylphenidate, amphetamines) have a high potential for misuse in individuals with SUD.
    - Neurobiological Similarities- both prescribed medications and illicit stimulants act within the brains dopamine system which can potentially trigger cravings or relapse in individuals recovering from stimulant use disorders.
- **Risk of Diversion:** Patients may misuse or sell prescribed medications, leading to ethical and clinical concerns.
    - Individuals with a history of substance misuse may be at an increased risk of misusing prescribed medications, either by taking higher doses than prescribed or using them through non-prescribed routes of administrations
- **Alternative Treatments:** Non-stimulant medications (e.g., atomoxetine, guanfacine) may be safer and help to mitigate above risks but are often less effective for ADHD symptoms.
- **Monitoring and Support:** If stimulant medications are deemed necessary, closing monitoring, regular counseling, and comprehensive relapse prevention plans are essential to support the individual's recovery

Medication Management Complications: Jake

Background:

Jake, a 34-year-old man in early recovery from methamphetamine use disorder, struggled with severe inattention, impulsivity, and disorganization. He had been diagnosed with ADHD as a child but never received consistent treatment. When he sought ADHD medication as part of his recovery, he encountered multiple challenges due to his past substance use and substance related criminal charges

Key Considerations:

Jake's providers were hesitant to prescribe stimulant medications due to his history of substance misuse, leading to multiple treatment delays.

He initially tried a non-stimulant medication (atomoxetine), but he found it ineffective and became frustrated with the lack of improvement.

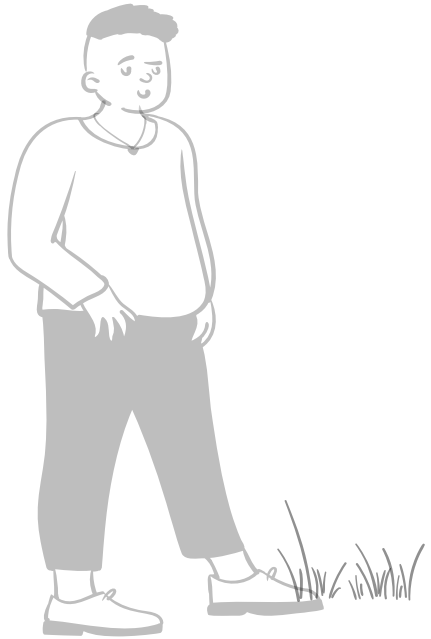
After extensive advocacy, he was prescribed an extended-release stimulant, but he began misusing it, increasing his dose without medical guidance, which ultimately led to relapse.

Following relapse treatment, Jake was placed on a structured medication management plan with monitored dispensing, which helped him use his medication appropriately.

Lesson:

ADHD medication management in individuals with SUD requires a careful balance. Clinicians must consider both relapse risks and treatment barriers, using non-stimulant options, when possible, extended-release formulations when stimulants are necessary, and structured oversight to support recovery.

Stigma and systemic barriers often prevent individuals with SUD from accessing appropriate ADHD treatment. Education and advocacy are necessary to ensure equitable care.



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Cognitive and Behavioral Challenges

- Executive Dysfunction: ADHD contributes to difficulties with impulse control, organization, and delayed gratification, making sustained sobriety harder.
- Impulsivity and Cravings: ADHD-related impulsivity can increase the likelihood of relapse
- Emotional Dysregulation: Both ADHD and SUD are linked to mood instability complicating treatment engagement.

Cognitive and Behavioral Challenges- Maria

Background:

Maria, a 27-year-old woman in treatment for opioid use disorder, struggled with impulsivity, emotional reactivity, and difficulty maintaining focus in daily tasks. She suspected she had ADHD and sought medication to help manage her symptoms.

Key Considerations:

- Maria had a long history of emotional dysregulation, difficulty following through on tasks, and engaging in high-risk behaviors, which worsened during active substance use.
- Cognitive testing revealed deficits in executive functioning, but her history of heavy opioid and benzodiazepine use also contributed to cognitive impairment.
- After six months of sobriety, her cognitive abilities improved slightly, but she still struggled with attention, organization, and impulse control, confirming an ADHD diagnosis.
- A combination of behavioral therapy (CBT) and structured routines helped Maria develop coping strategies, but she required additional support to maintain consistent progress.

Lesson:

ADHD and SUD both contribute to executive functioning deficits, requiring targeted behavioral interventions alongside medication. Long-term substance use can compound cognitive challenges, making it essential to reassess symptoms after a period of sobriety.

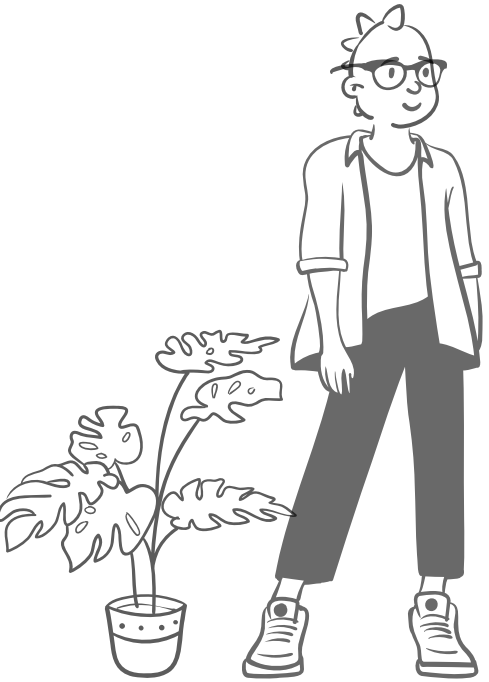
Overlapping and Masking Symptoms

- Withdrawal Symptoms Mimic ADHD: Restlessness, inattention, and mood swings can appear during detox, leading to misdiagnosis
- Substance Use can Temporarily Mask ADHD: Some individuals report using stimulants or depressants to self-medicate ADHD symptoms, making it difficult to determine the true underlying condition

Overlapping and Masking Symptoms: Kevin

Background:

Kevin, a 30-year-old man with cannabis use disorder, sought treatment for persistent difficulties with focus, emotional instability, and impulsivity. He was unsure if his symptoms were due to ADHD, substance use, or another underlying issue.



Key Considerations:

- Kevin displayed core symptoms of ADHD, but chronic cannabis use had also contributed to motivational deficits, mood swings, and inattention.
- His symptoms were exacerbated by anxiety and sleep disturbances, making it difficult to determine the root cause.
- After a period of abstinence, his motivation and emotional stability improved, but he continued to struggle with distractibility and impulsivity, leading to an ADHD diagnosis.
- A structured treatment plan incorporating ADHD medication, therapy, and relapse prevention strategies helped him better manage both conditions.

Lesson:

ADHD and SUD symptoms often overlap, making differential diagnosis challenging. Careful assessment over time, including observation during abstinence, is essential to accurately distinguish between ADHD, substance-induced effects, and other comorbid conditions.

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Treatment Adherence and Engagement

- Difficulty with Routine and Follow-Through: ADHD clients often struggle with consistent appointment attendance and medication adherence
- Lower Treatment Retention Rates: Individuals with co-occurring ADHD and SUD are more likely to drop out of treatment.

Lisa- Treatment Adherence and Engagement Issues

Background: Lisa, a 38-year-old woman with co-occurring ADHD and cocaine use disorder, frequently missed therapy appointments, struggled with medication compliance, and had difficulty maintaining structured routines in her recovery.

Key Considerations:

- Lisa's ADHD symptoms contributed to forgetfulness, poor planning, and difficulty following through with treatment recommendations.
- She often felt overwhelmed by structured treatment requirements, leading to inconsistent attendance in both addiction counseling and ADHD therapy.
- Her lack of engagement made it challenging for providers to adjust her treatment plan effectively.
- Implementing external supports, such as appointment reminders, accountability partners, and simplified treatment goals, improved her adherence and engagement over time.

Lesson:
ADHD-related executive dysfunction can impact treatment engagement and adherence. Providers should implement strategies that accommodate attention and organizational challenges, such as structured reminders, simplified interventions, and external accountability systems.

Lack of Integrated Treatment Approaches

- Many SUD treatment programs do not adequately assess or treat for ADHD
- Standard SUD treatments may not account for cognitive and attentional difficulties in ADHD clients
- Need for specialized, integrated care that address both ADHD and SUD simultaneously

Darren- Lack of Integrated Treatment Response

Background: Darren, a 42-year-old man with a history of alcohol use disorder and ADHD, faced significant barriers in receiving coordinated treatment for both conditions.

Key Considerations:

- Darren's addiction treatment providers discouraged ADHD medication use, while his psychiatrist emphasized its necessity, leading to conflicting recommendations.
- His SUD providers focused on abstinence-based strategies but lacked ADHD-specific interventions, leaving his symptoms largely unmanaged.
- Without effective ADHD treatment, Darren struggled with impulsivity and disorganization, increasing his risk for relapse.
- He eventually found a program integrating SUD and ADHD care, where medication management was combined with behavioral therapy and relapse prevention strategies.

Lesson:
Many treatment programs are not equipped to address ADHD and SUD together, leading to fragmented care. Integrated treatment approaches that coordinate psychiatric and addiction services are essential for long-term success.

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Key Points

- **Improve Screening & Differential Diagnosis** – Utilize validated tools to differentiate ADHD from substance-induced symptoms, trauma, or other comorbid conditions. Conduct assessments over time, especially after a period of sobriety, to ensure accuracy.

- **Address Treatment Barriers & Medication Management** – Balance the risks and benefits of stimulant medications in clients with a history of substance misuse. When appropriate, use extended-release or non-stimulant options alongside structured medication monitoring.

- **Integrated & Individualized Treatment Approaches** – Adopt an approach that combines behavioral therapy, medication management, and relapse prevention strategies. Ensure coordination between SUD and ADHD treatment providers for a seamless treatment plan.

- **Enhance Client Engagement & Adherence** – Implement structured support systems such as appointment reminders, accountability measures, and simplified treatment plans to accommodate executive dysfunction and improve adherence.

- **Educate Clinicians & Reduce Stigma** – Train healthcare providers to recognize the complexities of co-occurring ADHD and SUD, avoiding both overdiagnosis and underdiagnosis. Encourage a nuanced understanding of ADHD treatment in recovery rather than a one-size-fits-all approach.

By addressing these key areas, clinicians can improve outcomes for individuals struggling with both ADHD and substance use disorders, ultimately fostering more effective and sustainable recovery.

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