Improving the Screening and Referral Process for ADHD Evaluation in Adults: A Quality Improvement Project

Doctorate of Nursing Practice Report

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Abstract

Attention-deficit hyperactivity disorder (ADHD) is a challenging diagnosis to make in adults for a variety of reasons. Among these are the significant symptom overlap between ADHD and other common psychiatric disorders, as well as the high abuse potential of first line medications used to treat it. An ADHD-specific outpatient clinic was recently created within a local Veteran's Health Administration mental health clinic in order to improve the diagnostic process for veterans displaying ADHD-related symptoms. The purpose of this quality improvement project was to work with providers in both the referring and ADHD clinics in order to develop a new screening and referral tool that could be efficiently utilized by referring providers and would provide valuable screening data to the ADHD clinic. Utilizing the Institute for Healthcare Improvement's Plan, Do, Study, Act framework for creating change, this project was able to develop a usable tool that incorporated an existing, validated ADHD screening instrument prior to its early termination due to Covid-19. While measures aimed at assessing the benefits and potential drawbacks of the implemented tool were not able to be carried out, these considerations are still discussed here.

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Introduction

Problem Description

Accurate diagnosis and appropriate treatment of attention-deficit hyperactivity disorder (ADHD) in adults is challenging for a number of reasons, including the frequent presence of comorbid mental health disorders and symptom overlap, dependence upon self-reported symptoms with lack of collateral or potentially unreliable historical information (Kouros, Horberg, Ekslius, & Ramklint, 2018), and the potential for malingering. Psychiatric prescribers within the Portland Veteran's Affairs mental health clinic (PVAMHC) report varying degrees of discomfort with making the diagnosis of ADHD, and there is currently no formal guideline within this health care system to guide diagnosis of ADHD. In an attempt to improve the process of evaluating and treating ADHD in this setting, an ADHD-specific clinic was created that provides in-depth evaluations and group sessions for veterans to learn to cope with ADHD symptoms. At the outset of this project, the referral process to this clinic was strictly informal and the criteria for inclusion or exclusion were vaguely defined, causing inappropriate referrals to be placed, veterans to have unrealistic expectations of what would be available to them, and leaving open the possibility that referrals could slip through the cracks. The absence of a formal screening and referral tool led to discussions with involved clinicians around developing and implementing one as a quality improvement project.

Available Knowledge

An important step in assessing ADHD is utilizing screening tools that help to quantify symptom severity and potentially identify additional contributing mental or physical health issues. A number of potentially useful validated tools are available, but informal assessment of their use indicated that they are likely underutilized by PVAMHC providers, due to lack of familiarity with available tools, time constraints, and the fact that some of the tools are not freely available. Incorporating the use of validated screening tools thus represented a potential area for practice improvement that could improve diagnostic and treatment accuracy, improve the efficiency of the process by which clients are referred to the new ADHD clinic, and ultimately improve clinical outcomes for veterans.

Studies based on the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM)-IV estimate the prevalence of ADHD in adults to be between 3-5%, while newer studies using the DSM-5 criteria which require the presence of fewer symptoms, suggest an even greater prevalence (Asherton & Agnew-Blais, 2019). Between 1994 and 2009, stimulant prescribing for adults by psychiatric providers increased 6-fold (Olfson, Blanco, Wang, & Greenhill, 2013), raising concern for overdiagnosis and overprescribing of stimulants for ADHD. Despite this valid concern, a large study in 2006 found that only 11% of adults with ADHD were receiving treatment for it (Katzman, Bilkey, Chokka, Fallu, & Klassen, 2013). These findings, when considered together, suggest that there is valid cause for concern that stimulants are being inappropriately prescribed to those who may not have an indicated condition, and that many people who could benefit from appropriate treatment are not receiving it.

Current recommendations suggest a multimodal approach to ADHD diagnosis that includes a thorough clinical interview and history supplemented by self-rated and informant-rated scales (Bukstein, 2019). Validated instruments such as the Wender Utah Rating Scale (WURS), the World Health Organization Adult ADHD Self Report Scale (ASRS), the Conners' Adult ADHD Rating Scale (CAARS), and the structured Diagnostic Interview for ADHD in Adults (DIVA 2.0) are just a few of the available tools for assessing ADHD in adults. While they are all designed to aid in diagnosing ADHD in adults, they also vary significantly, and have different strengths and weaknesses. These tools may yield frequent false positives if relied upon as the sole sources of diagnostic information (Paris, Bhat, & Thombs, 2015), which underscores the importance of collecting information from multiple sources and with multiple tools when able.

Rationale

There are two elements that created a clear avenue for a quality improvement project in this practice setting. These were the desire to develop a standardized referral process between the general outpatient clinic to the new ADHD clinic, along with the current gap between common practice and recommended best practice for ADHD workup.

The VA has developed a quality improvement framework through it's Quality Enhancement Research Initiative (QUERI), thus the QUERI Implementation Guide was referenced in order to understand the process of implementing a quality improvement in this setting. While the QUERI guide is designed as a four-phase framework for guiding large scale institutional change, the scope of this project was limited to phase 1. Phase 1

projects are limited in time and scale, but can provide important initial information about intervention feasibility and address systematic barriers and facilitators to implementation (Department of Veterans health Administration, 2013), as this project was intended to do. The other framework that was utilized to guide the iterative process of change related to this project was the Institute for Healthcare Improvement (IHI) Model for Improvement utilizing its Plan, Do, Study, Act (PDSA) cycle process. The IHI model is, "a simple yet powerful tool for accelerating improvement (that has been used) to improve many different healthcare processes and outcomes" (Institute for Healthcare Improvement, 2020).

Specific Aims

The goals of the project were to determine which tool or tools could be integrated into the work flow, address existing barriers such as time limitations and lack of familiarity with tools, and work toward developing a screening and referral template that included a validated screening tool. Once the template was developed and refined to a finished product, an additional goal was to have it incorporated into the Computerized Patient Record System (CPRS), which is the electronic health record (EHR) currently utilized within the VA. Accomplishing these goals had the potential to increase the number of appropriate referrals to the ADHD clinic, improve veteran access to appropriate care, and more efficiently screen out those who do not meet criteria for assessment in the ADHD clinic.

Methods

Context

As stated previously, this project took place within the outpatient PVAMHC. The ADHD clinic is technically a part of the PVAMHC, but for the sake of clarity in this report, is distinguished as its own clinic. Five PMHNPs within the PVAMHC participated in the project. An additional three PMHNPs who work in other local VA mental health programs clinic participated in an information gathering meeting. These additional PMHNPs, despite not working in the same clinic where the project was taking place, can also refer clients to the ADHD clinic, thus their participation was warranted. Additional participants in the project were the lead psychologist within the ADHD clinic and one of the current psychology fellows. One member of the PMHNP group and the lead psychologist were considered key stakeholders and were primary points of contact. Had it not been for the limitations placed on the project by the Covid-19 pandemic, this project would have also involved the information technology department (IT) to get the tool formatted properly and embedded within CPRS. As a result of the aforementioned Covid-19 limitations, the descriptions of this project's methods, results, and discussion contain details on what was actually accomplished in addition to planned elements that were not.

Interventions

Informal discussions with the key PMHNP stakeholder prior to implementation of this project suggested that barriers to utilization of ADHD screening tools among providers at the PVAMHC included a perceived lack of time to administer them and the fact that some tools must be purchased in order to be used. Knowing that additional institutional costs could be prohibitive with regard to this project, a literature review was

conducted in order to identify validated ADHD screening tools that could be quickly administered, were freely available, and were specific to the adult population. Two commonly used and validated tools which met the above criteria were the 61-question Wender Utah Rating Scale (WURS), which can also be used in a 25-question format, and the 18-question Adult ADHD Self-Report Scale (ASRS).

These scales were brought to the larger group of participating PMHNPs at an hour-long monthly meeting for PMHNPs. The providers' familiarity with these and other tools was assessed, and ultimately the providers present stated with consensus that the WURS, despite being longer, would be preferable to use in a screening tool. The rationale for this preference being that the questions in the ASRS are so specific to ADHD that the results are too easy to feign if a client desires an ADHD diagnosis. In addition to an introduction to these tools and a brief educational presentation on ADHD prevalence, diagnosis, and treatment in adults, the group was also asked a series of semi-structured questions in order to assess current practices and perceptions. These questions are presented in Table 1 below.

Table 1

Semi-Structured Questions for PMHNPs

1. What are the challenges do you see in making ADHD diagnoses in veterans?
2. How often do you use a screening tool when trying to rule in/out ADHD?
3. Which screening tool(s) do you use and why?
4. How often do you refer veterans to the ADHD clinic?
5. What do you think could be done to improve this process?

Following the meeting with the PMHNP group, an email was sent out to the group with follow-up data on questions that went unanswered during the meeting. A meeting with the key psychologist stakeholder indicated that there was agreement between the two groups that the WURS scale would be an acceptable screening tool to incorporate into the referral template. As the person responsible for making the determination of whether veterans were appropriate for evaluation in the clinic, additional questions were added in order to understand aspects of the clients' histories and current presentations not accounted for in the screening tool. These additional items are presented in Table 2 below.

Table 2

Additional Suggested Screening Tool Items

1. Is the veteran older than 65?
2. Is the veteran already taking a stimulant medication or other medication for ADHD? (If yes, list)
3. Is the patient actively suicidal?
4. Does the veteran have a history of a learning disability? (if yes, please describe)
5. Does the veteran have a diagnosis of any other severe mental illness? (If yes, list)
6. Does the veteran have a history of a substance use disorder? (If yes, describe)
7. Has the veteran sustained a serious head or other neurologic injury?
8. Please list active medical problems

Of these questions, answers of "yes" to the first three would have likely led to an automatic screen-out from evaluation in the ADHD clinic. The remaining questions could

also lead to veterans being screened out, but would have been discretionary and dependent on the relevance of the details provided. Combining these items with the 61-question version of the WURS resulted in the first working template that could be trialed by involved PMHNPs and then evaluated for its usability and utility in the referral process prior to being incorporated into CPRS.

Study of the Intervention

The primary means of data collection and information dissemination over the course of this project were informal discussions, email, and scheduled monthly PMHNP meetings. The information obtained from these channels, however, was meant to provide context and guidance for the intervention, which was implementation of the referral tool. The process of studying the impacts of this intervention was not completed due to Covid-19, thus, considered within the framework of the IHI's Model for Improvement, this represents an incomplete PDSA cycle. After the PMHNP group had a period of two weeks to trial the referral tool in a paper format, an anonymous, brief survey was to be sent out via email utilizing an online survey generator asking if they had attempted to use the tool to generate a referral. If yes, they would be asked to approximate how long the form took to complete and if there were any specific recommendations on how to improve it. This information would have been used to inform any changes to the template prior to formatting it for CPRS. Review of de-identified completed forms to assess the percentage of veterans being accepted for ADHD assessment was considered, but the previously informal referral and screening process would have made collecting baseline comparator data difficult and potentially inaccurate.

Measures

The primary process measure for this project was to assess whether the new referral tool could be completed in ten minutes or less by surveying providers who had utilized it. This detail was deemed important because most of the involved providers stated that the time spent filling out an additional form would take away valuable time spent discussing other clinically relevant details with clients. A secondary process measure would have been to assess the providers' levels of comfort in utilizing the tool. The initial primary outcome measure for this project was to assess the total number of referrals being generated with an expectation that the new tool would increase the total number of referrals. This proved to be an unnecessary and likely unattainable goal, as the dynamics of the interface between the two groups evolved between the time of this project's conception and its implementation.

When the ADHD clinic was new, then number of referrals received was lower than its capacity to provide evaluations, but as time progressed and providers grew more familiar with it, this issue naturally resolved. The clinic now has a waiting list for evaluations. An appropriate balancing measure for this project would have been to understand whether the time spent in using the referral tool had a negative impact on provider time to deliver care. This is an important measure because while intake appointments are typically 90 minutes long in this setting, follow up appointments are typically only 30 minutes. Even a tool that takes between five and ten minutes would utilize a significant portion of a follow up appointment, thus it would be important to understand how providers felt this impacted their appointments.

Analysis

Given the small number of participants in this project and because the obtained information was primarily descriptive, no advanced statistical analysis was required. Had the project continued to its projected endpoint, advanced statistical analysis would not likely have been necessary, as the study of the interventions would have relied on comparisons of average pre- and post-intervention data that could have been adequately displayed in bar and run charts or tables. The formal meeting with PMHNPs was not recorded, but thorough notes taken during the meeting allow for some descriptive analysis to understand patterns in opinion and practice within the group.

Ethical Considerations

Since there was no direct patient participation in this project, it did not carry any significant risk to patients and did not limit their ability to obtain care. The risk of taking up providers' time to deliver care was mitigated by utilizing email and already scheduled team meetings to communicate about the project. Identifying patient data was not needed, nor was it collected, thus there was no discernable risk toward patient privacy. Furthermore, communications with providers associated with this project and information collected from them was considered private and was not shared outside of the context of this project. Data collected from providers is de-identified in this report and will be in any future presentations on the project. IRB approval was obtained through necessary channels within the OHSU and VA systems, and the individual responsible for quality improvement management at the PVAMHC was consulted to ensure it was conducted in an acceptable manner. There are no conflicting interests to report.

Results

Had this project been seen to completion, it would likely have consisted of two PDSA cycles aimed at developing, refining, and understanding the effects of the referral tool for the ADHD clinic. Since the project was cut short by unforeseen circumstances, the second PDSA cycle was not completed, and thus the proposed process, outcome, and balancing measures could not be studied. The first PDSA cycle, which led to the creation of the referral template is outlined below in Figure 1.

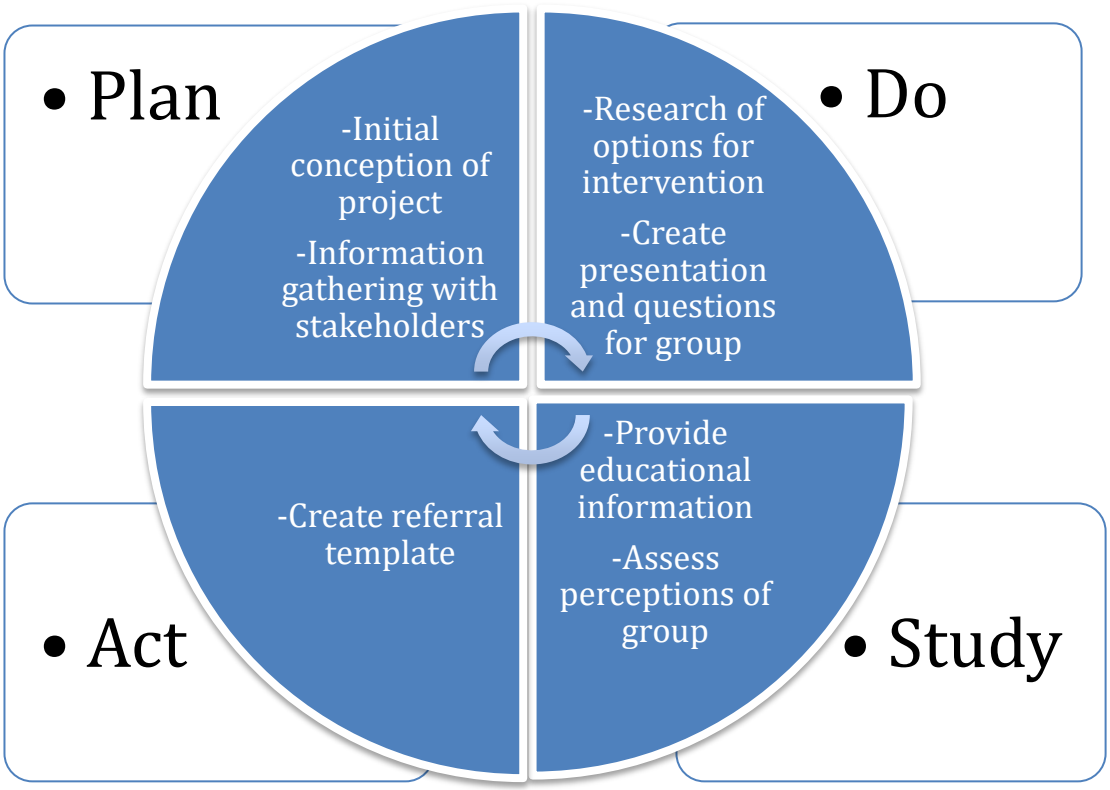

Figure1. First PDSA Cycle.

While the details of the PMHNP group meeting were ultimately not all relevant to the progression of the project, there were some important elements that were. The risks associated with potential substance use disorders (SUDs), not uncommon among

veterans, and prescribing stimulants was of a significant concern to the providers in this group. Additionally, all of the participants felt that drug seeking behavior was a significant concern and believed that it made clients more likely to misreport symptoms. This is important because it was expected that the providers would prefer the ASRS over the WURS when considering options to incorporate into the template, but this was not the case. Two of the eight providers present reported that they had previously utilized the ASRS in practice, but had stopped because they found the questions to be too easily feigned, causing enough likely false positive results to be of value. An additional three providers agreed that they found minimal value in the tool for this reason. None of the providers present expressed familiarity with the WURS scale; however, there was a strong, although not quantified, interest in it. This was specifically due to the fact that it contains 25 questions that pertain specifically to the symptoms of ADHD, while the remaining questions could aid in assessing additional mental health symptoms, patterns of behavior, and physical symptoms the individual experienced as a child. The perceived value of this tool persisted despite the observation that it contains three times as many required responses as the ASRS. It was felt that by distributing ADHD-related questions among less specific questions, it would be easier to ascertain if results were being feigned and potentially better understand other persistent mental health symptoms contributing to the current presentation.

When asked about experiences with referring to the ADHD clinic, the responses were somewhat unexpected. None of the four providers who stated they frequently refer patients to the ADHD clinic reported any issues with the process, despite it being informal. Importantly though, this sentiment was not echoed by the psychologist who

manages the ADHD clinic. This individual reported that referrals had come from other providers through a variety of communication channels, making keeping track of them difficult. It was also reported that a significant number of the referrals he had received likely would have been screened out more efficiently had a more formal tool been in place to aid in the process.

Ideally, the second PDSA cycle would have helped to understand the usability of the tool, specifically by assessing how long it took to administer. It was expected that it would take 10 minutes or less; however, given the complexity of many clients in this clinic and with an embedded screening tool containing more than 60 questions, it is possible this process could have taken longer. Without any data based on clinical utilization of the tool, it is difficult to say if any subsequent actions to improve it would have been necessary. Had action been needed to shorten the tool, one option would have been to abbreviate the WURS from the 61-question format to the 25-question format that includes only the questions related specifically to ADHD presentation. While providing only the 25-question form to clients may have decreased the perceived value of the questionnaire to clinicians, it may have been possible to provide clients with the long form version to complete in the waiting room prior to their appointments and then transcribe only the 25 ADHD-specific questions into the referral template. Even barring unforeseen circumstances, the additional proposed measures would have likely still fallen outside of the scope allowed by the limited timeframe of this project.

The most important contextual element to discuss in considering the unforeseen obstacles this project encountered is the Covid-19 pandemic. In order to prevent avoidable transmission of this new disease, clinical rotations for all students in the School

of Nursing at Oregon Health & Science University were suspended two months prior to the expected completion of this project, severely limiting its progress. Fortunately, this did not mean that the project was forced to cease. A psychology fellow who had already been identified as a potential collaborator based on her plans to work on an overlapping project was able to take over some aspects of the downstream implementation of this project. As such, it remains a strong possibility that the tool developed over the course of this project, or some version of it, will still be incorporated into CPRS by September, 2020. Another projected obstacle for this project was that the VA is planning to transition to a new EHR within the coming year. This detail may have made formatting and incorporating new tools into a soon-to-be retired EHR a low priority. Even if the new tool is not ultimately incorporated into the old EHR, it should still be possible to incorporate it into the new EHR once it is introduced.

Discussion

Summary

While this project did not achieve all of its intended goals, there were notable accomplishments which made it nonetheless relevant to its rationale. At the outset, there was no formal process for making referrals to the ADHD clinic. To this end, significant steps were made in identifying a useful screening tool that the involved providers were previously unaware of. Combing this tool with a set of relevant questions suggested by the psychologist in charge of the ADHD clinic yielded a tool that may not yet be refined enough to represent a finished product, but likely represents a step in the right direction. While not an issue addressed specifically by this project, it was discovered that SUDs potentially co-occurring with ADHD represent an area of significant concern for

prescribing clinicians. Unexpectedly, it was found that referring PMHNPs actually preferred a longer screening instrument, despite the fact that it takes longer to utilize. Also unexpected was that the PMHNP groups did not report any concerns with the existing referral process, despite its informal nature. This was countered by the report of the psychologist who leads the ADHD clinic who found the informal process to be difficult to navigate and negatively impactful on the clinic's ability to efficiently screen referrals and provide assessments.

The primary strength of this project is that it was aimed at improving a clinical process in a way that was in line with institutional policies and evidence-based practice. These should be the goals of any quality improvement project, but this project was able to obtain a significant amount of interest and buy-in from both of the involved groups. From the PMHNP group, this interest was largely born out of the ubiquitous feeling that diagnosing ADHD in adults is challenging and that additional tools to accomplish this goal were welcome. From the ADHD clinic, this interest was primarily related to the desire to have a more formal and efficient referral process.

Obtaining and maintaining engagement of stakeholders in quality improvement projects is considered a core tenet of quality improvement. Specifically, finding key stakeholders who are also in positions to enact change is paramount (Silver et al., 2016). Given that a lack of investment in change initiatives can hinder their progress, this project may have been more likely to meet its goals than similar projects without the same level of investment. A large part of this was due to the fact that key stakeholders in both of the involved departments were also in positions where they were in charge of clinical coordination within their departments. Another benefit was that the key PMHNP

stakeholder also had a background in quality improvement science prior to her current position.

Interpretation

It is difficult to concretely interpret the effects of this project's interventions on outcomes, as the measures meant to accomplish this were not ultimately assessed, but inferences can still be made that are worth discussing. Additionally, there were findings from the meetings and information gathering process of the project that warrant discussion and comparison with existing literature.

The fact that a validated and, among the involved PMHNPs, previously unutilized tool was brought to the attention of clinicians who expressed significant interest in it may itself represent a notable accomplishment. If a new tool gives providers more confidence and ability to make accurate diagnoses, possibly without the necessity of a referral to the ADHD clinic, clients might obtain appropriate diagnosis treatment in a timelier manner. This could also theoretically reduce the wait time for ADHD evaluations for those who are ultimately referred to the ADHD clinic.

While finding that PMHNPs preferred the WURS over the ASRS despite it likely creating more work for them was unexpected, there is evidence in literature to support this opinion. A recent study comparing the two scales found that while both scales had good psychometric and screening properties, the specificity of the WURS was significantly better than the ASRS at diagnostic thresholds that maintained adequate sensitivity. This study's discussion suggests that this difference may be due to the retrospective nature and wider symptom range of the WURS (Brevik, Lundervold, Haavik, & Posserud, 2020). It did not specifically take into consideration that the broader

array of symptoms assessed could decrease the respondent's bias toward answering questions in a particular way, but nonetheless, supported the idea that it would yield fewer false positive results than the ASRS.

The difference in perception of the current referral process was another interesting observation that is likely explained by contextual factors. The PMHNP group does not lose productivity in any appreciable way by having an informal referral process and may also perceive the formalization of this process as likely to increase their time spent in placing a referral. The workload of the ADHD clinic psychologist who receives the referrals, on the other hand, appears to be much more tangibly increased by the inefficiencies of the informal process. It therefore makes sense that the ADHD clinic would have a stronger interest in changing the existing process. Fortunately, the potential for increased time spent in generating more formal referrals appeared to be offset by the PMHNP group's interest in the project and the new tool, at least up to the point the project was completed to at the time of this report.

The finding that PMHNPs had a significant amount of concern around prescribing stimulants for ADHD in a population where SUDs commonly occur, while not surprising, is important, despite it not being a specific focus of this project. While a literature search did not reveal any prevalence data specific to the veteran population, a meta-analysis aimed at better understanding the link between ADHD and SUDs found that among the 29 included studies an average of 23.1% of those diagnosed with an SUD also met criteria for ADHD (van Emmerik-van Oortmerssen et al., 2012). With these potentially mutually predisposing conditions, where the first-line treatments for ADHD have the potential to worsen SUDs and related outcomes, it is therefore reasonable that prescribing

clinicians would approach treatment decisions cautiously. Unfortunately, the data looking at SUD and ADHD-related outcomes in the setting of ADHD treatment with stimulants is mixed and sparse.

A 2017 meta-analysis found that four out of eight included studies showed significant improvement in ADHD-related outcomes in stimulant treatment groups compared to controls. Of note, both groups combined CBT or other psychosocial interventions with the stimulant or placebo, so the additional benefit of these interventions may have decreased the observable impact of the medication. This same meta-analysis found that only two of the six studies that addressed substance use related outcomes showed significant reductions in substance use in those who took stimulants over placebo. Notably, the studies that used higher stimulant doses tended to have better results in both measures, but the results weren't robust enough to make a definitive treatment recommendation around stimulant use (Cook, Lloyd-Jones, Arunogiri, Ogden, Bonomo, 2017).

Limitations

The generalizability of this project is likely limited by the fact that a dedicated ADHD evaluation group is not standard among VHA mental health clinics. Due to the uniqueness of this clinic, the tool developed to streamline its referrals is likely of little value to most other facilities at this time. Aside from the limitations placed on the project by Covid-19, the timeframe for the project was likely still too short to fully assess the impacts of the interventions. Additionally, given the informal nature of the referral process prior to this project, it may have been difficult to compare intervention data to

baseline data, as the informal process did not generate data within the EHR that could be easily collected for analysis via chart review.

Conclusions

Beginning in December of 2019 after obtaining IRB approval and ending unexpectedly in March of 2020, a small-scale quality improvement project was undertaken in order to formalize and improve the referral process to a relatively new ADHD-specific clinic within the PVAMHC. Though ultimately unfinished, there was a promising level of enthusiasm around the proposed change from the involved parties. Based on what was discovered during this project, there are potential avenues for future projects. Assuming that the referral template is ultimately incorporated into standard practice- an outcome that appears likely, although not certain- a future project could be developed to better understand its impacts, particularly if questions remain as to the utility of the tool. Additionally, if the backlog of patients waiting to be evaluated by the ADHD clinic continues to grow, a project aimed specifically at improving providers' skills and confidence around conducting ADHD-specific evaluations without requiring a referral to the ADHD clinic could be justifiable.

Since this project ended prior to its expected endpoint, there remains room for future PDSA cycles specifically related to the goals outlined in this report. The next obvious step would be to evaluate how long the tool takes to use and whether or not the providers using it find it helpful or have any specific feedback on how it could be further refined. Lack of time to incorporate a proposed change and/or excessive time needed in order to learn how to incorporate a proposed change are consistently considered barriers to success in quality improvement (McHugh, Brown, Liss, Walunas, & Persell, 2018).

This is critical, because the interest expressed by the involved PMHNPs was based on discussions about the change and its hypothetical relevance to their practices. It is, therefore, possible that if an implemented tool was not adequately studied after implementation and created a serious impediment to clinical workflow, it may not ultimately be as accepted or utilized.

Another important next step would be to examine how veterans are screened after utilizing the tool. For instance, if the screening criteria are too strict or if not enough information is provided, it could lead to an excess of people who could benefit from additional ADHD evaluation from being screened out of it. A major reason why this is important ties back into the previously expressed concern of the involved providers regarding SUDs and ADHD. While there may be a paucity of evidence regarding some aspects of this comorbidity, there is likely enough literature available to create an educational project around how to deal with this common and complicated scenario. While it is not widely accepted within the field at this time, there is even a growing body of evidence and support for the idea that a harm-reduction strategy utilizing pharmaceutical psychostimulants in treatment of stimulant use disorders could be beneficial (Mariani, Khantzian, & Levin, 2014) in a manner akin to the use of buprenorphine or methadone for opioid addiction. For individuals who previously used illicit stimulants in an attempt to manage ADHD-related symptoms, a strategy like this could theoretically have positive outcomes related to both ADHD and the SUD. There is currently a study underway investigating the efficacy and safety of lisdexamfetamine as an agonist therapy for methamphetamine dependence (Ezard et al., 2018). While this study is not related specifically to ADHD outcomes, if the results are positive, it could

help to shift the paradigm around how clinicians approach stimulants in treating SUDs. In theory, a project, or even a series of projects and PDSA cycles could be undertaken to provide education on the issue and work toward creating a policy or clinical guideline for dealing with comorbid SUD and ADHD.

Within the context of the project that led to this report, future success will be contingent on maintaining interest. One aspect of this could be providing education on emerging research. Another avenue could be to highlight the importance of having an official referral process as a matter of institutional policy-related necessity. Ultimately though, the long-term sustainability of this project or other projects related to it will require reiteration and analysis of the fact that these projects are aimed at improving the lives and care of the veterans seen in this setting.

As seen in this report, ADHD evaluation and treatment in adults present interesting challenges and are realms where there is currently exciting research underway. In the years to come, there will surely be room for growth in the ways ADHD is approached by clinicians, and this growth has the potential to benefit patients, mental healthcare systems, and providers alike.

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