Variability in the prevalence of adult ADHD in treatment seeking substance use disorder patients: Results from an international multi-center study exploring DSM-IV and DSM-5 criteria☆☆

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Contributors
GvdG and MK wrote the proposal, coordinated the study, were involved in the data management and data analyses, drafted the manuscript and wrote the final version of the manuscript.

GVDG, FRL, WvdB, MWJK, PJC, JAR-Q, AS contributed to the design of the study.

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Conflict of interest
All the authors declare, apart from the funding resources, no other conflicts of interest.
Abstract

Background—Available studies vary in their estimated prevalence of attention deficit/hyperactivity disorder (ADHD) in substance use disorder (SUD) patients, ranging from 2 to 83%. A better understanding of the possible reasons for this variability and the effect of the change from DSM-IV to DSM-5 is needed.

Methods—A two stage international multi-center, cross-sectional study in 10 countries, among patients form inpatient and outpatient addiction treatment centers for alcohol and/or drug use disorder patients. A total of 3558 treatment seeking SUD patients were screened for adult ADHD. A subsample of 1276 subjects, both screen positive and screen negative patients, participated in a structured diagnostic interview.

Results—Prevalence of DSM-IV and DSM-5 adult ADHD varied for DSM-IV from 5.4% (CI 95%: 2.4–8.3) for Hungary to 31.3% (CI 95%:25.2–37.5) for Norway and for DSM-5 from 7.6% (CI 95%: 4.1–11.1) for Hungary to 32.6% (CI 95%: 26.4–38.8) for Norway. Using the same assessment procedures in all countries and centers resulted in substantial reduction of the variability in the prevalence of adult ADHD reported in previous studies among SUD patients (2–83% → 5.4–31.3%). The remaining variability was partly explained by primary substance of abuse and by country (Nordic versus non-Nordic countries). Prevalence estimates for DSM-5 were slightly higher than for DSM-IV.

Conclusions—Given the generally high prevalence of adult ADHD, all treatment seeking SUD patients should be screened and, after a confirmed diagnosis, treated for ADHD since the literature indicates poor prognoses of SUD in treatment seeking SUD patients with ADHD.

Keywords
Prevalence; Substance use disorder; Attention deficit hyperactivity disorder; DSM-5; Adults
1. Introduction

Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most common mental health disorders affecting children and adolescents (Polanczyk and Rohde, 2007). The prevalence of childhood ADHD in general population surveys varies from 6 to 9% (Kessler et al., 2005a), whereas for adult ADHD a pooled estimated prevalence of 2.5% was reported (Simon et al., 2009). A meta-analysis of longitudinal data suggests that in two-thirds of the cases childhood ADHD persists into adulthood (Faraone et al., 2006).

Studies in adults with substance use disorders (SUD) show a higher prevalence of adult ADHD compared to the general population (Rounsaville and Carroll, 1991; Levin et al., 1998; King et al., 1999; Wilens, 2007; Ohlmeier et al., 2008; Arias et al., 2008; Huntley et al., 2012). This is important since research suggests that co-occurring ADHD and SUD are associated with a more severe course of substance use and poorer treatment outcome (Wilens and Fusillo, 2007; Carroll and Rounsaville, 1993). Moreover, patients with these co-occurring disorders have higher rates of other psychiatric disorders (Kessler et al., 2005a; Wilens et al., 2005).

Prevalence rates of ADHD in SUD patients show an enormous variation ranging from 2% in substance abusing Icelandic adolescents (Hannesdottir et al., 2001) to 83% in Japanese methamphetamine and inhalant abusers (Matsumoto et al., 2005). In a recent meta-analysis by Van Emmerik-van Oortmerssen et al. (2013), reporting on 12 studies in adult treatment seeking SUD patients, the pooled ADHD prevalence rate was 23.3%, ranging from 10.0 to 54.1% in individual studies. Possible explanations for this huge variability include differences in diagnostic criteria, primary drug of abuse, country specific factors (treatment offer, service structure), treatment setting (e.g., inpatient vs. outpatient treatment), clinical biases and demographic factors. However, the relative effect of these factors has not been studied, because the studies so far vary considerably in the definition of adult ADHD and the diagnostic procedures and assessment instruments. Hence, although there is increasing recognition of the importance of adult ADHD in treatment seeking SUD subjects, there is considerable uncertainty about the magnitude of the problem in this population, and the factors that affect variability of the prevalence.

In addition, changes in criteria for adult ADHD in the newest edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5 (American Psychological Association, 2013) may affect the prevalence of adult ADHD in SUD patients. First, the increase in the age threshold for the onset of ADHD symptoms from ‘prior to the age of 7 years’ to ‘prior to the age of 12 years’, may increase the prevalence of ADHD. Second, the reduction in the minimum number of symptoms needed for a diagnosis of adult ADHD from 6 to 5 out of 9 symptoms for either inattention and/or hyperactivity/impulsivity may increase the prevalence of adult ADHD. These changes have been criticized because they may inflate the prevalence of ADHD with serious consequences for practice, policy and research (Batstra and Frances, 2012; Frances and Widiger, 2012). Nonetheless there has been no empirical examination of this issue in clinical samples of SUD patients so far.
The IASP study represents the first cross-national study of ADHD among treatment seeking SUD patients. Data was collected from participating addiction treatment centers all using the same diagnostic criteria and conducting the same sampling design and assessment procedures and instruments. In 10 countries across the globe, this study examines the effect of changes in the diagnostic system (DSM-IV vs. DSM-5) and the effects of country, age, gender, setting (inpatient vs. outpatient) and primary substance of abuse (alcohol vs. drugs) on the variation in the prevalence of childhood and adult ADHD in treatment seeking SUD patients.

2. Method

2.1. Design and procedure

Data was collected in the context of the International ADHD in Substance Use Disorders Prevalence study (IASP), completed within the framework of the International Collaboration on ADHD and Substance Abuse (ICASA). The IASP is an international, multi-center, cross-sectional study consisting of a screening stage and a full assessment stage. Australia, Belgium, France, Hungary, the Netherlands, Norway, Spain, Sweden, Switzerland and the United States participated in the screening stage. France, Hungary, the Netherlands, Norway, Spain, Sweden, and Switzerland also participated in the full assessment stage. For a detailed description of the methodology (including choice of instruments, translation and training procedures), study population and screening results the reader is referred to Van de Glind et al. (2013a). The IASP study is a large study with many different aspects, and data on other research topics have been and will be published. For example, results on the psychometric quality of the Adult ADHD Self-Report Scale (ASRS V 1.1.; Kessler et al., 2005a) were published in Van de Glind et al. (2013b) and a paper on the psychiatric comorbidity of SUD patients with and without ADHD is currently under revision (Van Emmerik-van Oortmerssen et al., 2013).

2.2. Participants

A random sample of 3558 patients, 18–65 years, seeking treatment for SUD for a new treatment episode, were asked to participate in the study in each participating center/ward. Patients with insufficient language skills or unwilling to sign informed consent were excluded from the study. Patients who were intoxicated or currently suffering from severe physical or mental problems were asked to join the study when their clinical condition improved. All participants gave signed informed consent after receiving verbal and written information about the study. They did not receive financial compensation, except for Australia, where patients received AUD $20 reimbursement for associated costs. The study was approved by the local Ethical Review Board in each participating country.

2.3. Assessments

In the first stage, all participants filled out a questionnaire on demographics and substance use. In addition, the ASRS V 1.1 (Kessler et al., 2005b) was administered assessing ADHD symptoms in adulthood (American Psychological Association, 1994). ADHD symptoms in the ASRS are rated from “never” to “very often” and scored from 0 to 4. Items 1–3 are positively endorsed with scores ≥2, items 4–6 with scores ≥3. The first six items have been
found most predictive of ADHD diagnosis, and were used as a screener with a cut off of four positively endorsed items for a positive screening result.

Three countries (Belgium, Australia, United States of America) with 963 subjects participated in the screening stage only. All patients from the other 7 countries, regardless of their ASRS result, were referred to the second stage, resulting in 1276 subjects from seven countries. In this stage, a psychiatric interview was administered to assess the presence of SUD, ADHD and other commonly occurring psychiatric disorders in SUD patients.

For the diagnosis of ADHD, we applied the Conners’ Adult ADHD Diagnostic Interview for DSM-IV (CAADID; Epstein et al., 2001), a valid semi-structured interview. CAADID-Part I was filled out by the patient before the interview, collecting information on demographics, developmental course, ADHD risk factors, and psychopathology. CAADID-Part II was administered by trained clinicians and is designed to evaluate the presence of DSM-IV ADHD criteria in childhood and in adulthood, as follows: (A) presence of symptoms (six out of nine symptoms of inattention and/or hyper-activity/impulsivity), (B) age of onset before the age of seven, (C) pervasiveness of the symptoms, (D) impairment caused by the symptoms, and (E) the symptoms are not better explained by another disorder.

To evaluate Criterion E, further information was collected using two additional semi-structured interviews: the Mini International Neuropsychiatric Interview (M.I.N.I.) Plus version 5.0.0 (Sheehan et al, 1998) to assess prior and current episodes of mood disorders, bipolar disorder and antisocial personality disorder (APD); and the borderline module of the Structured Clinical Interview for DSM-IV personality disorders (SCID II) (Williams et al., 1992) to assess borderline personality disorder (BPD).

The DSM-IV also includes a code ADHD-Not Otherwise Specified (ADHD-NOS) for individuals not meeting the age criteria (symptoms present before the age of 12 instead of before the age of 7) and/or symptom criteria for ADHD but showing ADHD symptoms (≥4 instead of ≥6 out of 9) and who do fulfill criteria of pervasiveness and impairment. In addition, the American Psychiatric Association (APA) presented the main changes in criteria for ADHD in childhood and adulthood for DSM-5 (APA, 2013).

To assess ADHD diagnosis according to the ADHD-NOS criteria and DSM-5 criteria, we adapted the diagnostic algorithm of the CAADID using a different cut off for the age of onset criterion of <12 and different cut offs for the number of symptom criterion of 4 (DSM-IV ADHD-NOS) and 5 (DSM-5) respectively.

There is debate on whether or not a retrospectively obtained diagnosis of childhood ADHD should be mandatory for the diagnosis of adult ADHD (Faraone and Antshel, 2008). For this paper we used the CAADID algorithm for the diagnosis of adult ADHD, including a retrospectively obtained diagnosis of childhood ADHD meeting all of the 5 criteria. This procedure results in conservative prevalence rates of adult ADHD as it is stricter than the DSM criteria that does not expressly demand meeting full childhood ADHD criteria.
SUD was assessed via self-report measures related to the current primary substance of abuse, and it included only current use of either alcohol or illicit drugs, assuming that all of those coming for treatment to an addiction treatment center has a SUD.

For more detailed information on validation of the ASRS and CAADID, the reader is referred to Van de Glind et al. (2013a,b).

2.4. Statistical analyses

Although all of the participants were referred to the second stage, the proportion of ASRS positives (40.0%) participating in the second stage slightly differed from the proportion of ASRS positives (36.3%) in those who dropped out after stage one (in those countries participating in stage 2; Van de Glind et al. (2013a,b). Because this effect was different for the different countries, we constructed weights based on the percentage of ASRS positives, CAADID cases, and country. To prevent biased standard errors, these weights were constructed in such a way that the overall number of participants did not change. All tests, estimates and confidence intervals are based on weighted data. SPSS 20 was used for analyzing the data.

3. Results

3.1. Preliminary analyses

Of the 2595 patients screened in the seven countries participating in stage two, 1276 patients completed the CAADID. There were no significant differences between the patients who completed the CAADID and the drop-outs, with two exceptions: the mean age in Norway and Spain was significantly higher for participants than for drop outs, and the above mentioned difference in ASRS score. The latter was taken into account as described in the methods section. Of 1276 included subjects with completed CAADID interviews, 511 had a positive score and the remaining 765 had a negative score on the ASRS.

3.2. Demographics (Table 1)

Table 1 describes the demographic and substance use characteristics of the 1276 participants. Mean age varied between 37 years in France to 43 years in Hungary, approximately one in four were women, fewer than one third were employed, almost one in ten were homeless and only one in four were currently married or had a partner. The primary substance of abuse varied considerably between the countries. Alcohol was the most frequent primary substance of abuse in the total sample (54.6%), followed by stimulants (15.1%), cannabis (10.8%), opiates (10.8%) and other drugs (8.6%). With the exception of housing status, there was a significant country effect for all demographic and clinical characteristics ($p < .001$; adjusted for multiple testing). The number of ASRS positives varied between countries ranging from 20.8% in Hungary to 65.9% in Norway.

3.3. Ranges of ADHD prevalence rates (Table 2)

Table 2 presents the ranges of weighted prevalence rates of childhood and adult ADHD according to DSM-IV and DSM-5 and for adult ADHD-NOS according to DSM-IV. The prevalence of adult ADHD-DSM-IV differed markedly across countries with Hungary
having the lowest and Norway having the highest rate: 5.4% (CI 95%: 2.4–8.3) and 31.3% (CI 95%: 25.2–37.5), respectively. Based on DSM-5 criteria the prevalence for adult ADHD were slightly higher, ranging from 7.6% (CI 95%: 4.1–11.1) in Hungary to 32.6% (CI 95%: 26.4–38.8) in Norway. However the DSM-5 rates were within the range of rates observed for adult ADHD-NOS (DSM-IV): 8.2% (CI 95%: 3.9–12.5) in Switzerland to 34.5% (CI 95%: 28.2–40.7) in Norway.

The percentage of patients with DSM-IV childhood ADHD also meeting criteria for DSM-IV adult ADHD (ADHD persistence into adulthood) varied considerably between countries, ranging from 38% in Hungary to 90% in Spain.

3.4. Stratified analyses: setting and primary substance of abuse (Tables 3 and 4)

We were unable to statistically control for country, because country was confounded with setting (inpatient vs. outpatient) and/or by primary substance of abuse (alcohol vs. drugs) with only one country (Norway) including both inpatients and outpatients and one country (Switzerland) including almost only patients with alcohol use disorders (see Table S13). Therefore, we performed analyses stratified by setting and primary substance of abuse (see Table 3). In these results the exact binomial confidence intervals were calculated using a method proposed by Morisette and Khorram (1998).

Using DSM-IV criteria for adult ADHD based on the CAADID algorithm (including the mandatory presence of full childhood ADHD diagnosis), the prevalence is lower among treatment seeking SUD patients whose primary substance of abuse was alcohol, compared to those whose primary substance of abuse was illicit drugs. Similarly, the prevalence of adult ADHD was lower among outpatients than among the inpatients.

However, even within these strata, there was a large country effect, with prevalence rates ranging from 5 to 22% in inpatients with alcohol use disorders (AUD) and 4 to 14% in AUD outpatients. Among inpatients with drug use disorders (DUD), prevalence rates ranged from 5 to 52% and, among DUD outpatients, from 10 to 33%. These large country differences were mainly due to the relatively high prevalence rates for all subgroups in the Nordic countries (Norway and Sweden). After adjustment for age, gender, occupational status, housing and marital status there was still a large and statistically significant effect of Nordic versus non-Nordic countries on the prevalence estimates, After post hoc stratification on Nordic versus non-Nordic countries the difference in prevalence of ADHD within Nordic and within non-Nordic countries was no longer significant (see Tables 3 and 4).

4. Discussion

The present study is, to our knowledge, the first multinational study on the prevalence of ADHD in adult treatment seeking SUD patients. Based on DSM-IV criteria, the reported rates of adult ADHD were much higher in our sample of treatment seeking SUD patients than in the general population (6–9% childhood ADHD; 2.5% adult ADHD; Kessler et al., 2005c; Simon et al, 2009). The prevalence of DSM-IV adult ADHD varied between

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3Supplementary material can be found by accessing the online version of this paper. Please see Appendix A for more information.
countries from 5.4% (CI 95%: 2.4–8.3) in Hungary to 31.3% (CI 95%: 25.2–37.5) in Norway. Although this is a broad range of prevalence rates, the range is much smaller than the ranges reported on ADHD in SUD patients in the literature so far (2–85%; Hannesdottir et al., 2001; Matsumoto et al., 2005) and the range reported in a recent meta-analysis in treatment seeking SUD patients (10–54%; Van Emmerik-van Oortmerssen et al, 2012); a finding that is probably related to the fact that in the current study the same classification and the same diagnostic procedures and instruments were used. Furthermore, post hoc analyses showed that the remaining variation in prevalence of adult ADHD between the various countries was mainly caused by the high prevalence in the Nordic countries (Norway and Sweden). Moreover, these differences between the Nordic and non-Nordic countries were independent of gender, age, occupational status, housing and marital status. One explanation may be latitude which may affect circadian rhythm (Suren et al, 2012) and circadian rhythm may be related to the incidence and prevalence of ADHD (Friborg et al., 2012). An important indication for such an influence of region related to solar intensity on the prevalence of ADHD has recently been reported (Arns et al, 2013), indicating high solar intensity as a protective factor, possibly via improving circadian clock disturbances. However, the prevalence rates of childhood ADHD in Scandinavian countries lie well within the range as found in other countries as reported by Faraone et al. (2003). In Sweden two independent studies found childhood ADHD prevalence of 4.0% (Landgren et al., 1996) and 3.7% (Kadesjö and Gillberg, 2001) using DSM-III-R resp. DSM-IV. A Norwegian study recently reported childhood ADHD prevalence of 5.2% (Ullebø et al, 2012). Thus, other explanations are likely to be of more importance. These other explanations may be found in country specific reasons, leading to more or less subjects with ADHD within addiction treatment centers, e.g., differences in the public awareness of ADHD frequently coexisting with SUD resulting in differences in recognition and referral, and differences in treatment availability and treatment approach for patients with co-occurring ADHD and SUD. Unfortunately, no data is currently available to support these explanations. Moreover, selection of treatment centers within the various countries was not random and thus the observed differences in prevalence may also be a result of selection bias at the center level. However, all participating centers indicated that their center was representative for the national situation. Moreover, national non-representativeness does not directly explain the Nordic vs. non-Nordic gradient and it is thus rejected as a plausible explanation.

The observed range of adult ADHD prevalence rates among inpatients (AUD: 5–22%; DUD: 5–52%) is difficult to interpret as these reflect participating sites from 3 countries with inpatient AUD sites and 2 countries with inpatient DUD sites only (see Table 3). The AUD outpatient adult ADHD prevalence rates ranged from 4 to 14% and the DUD outpatient adult ADHD prevalence rates ranged from 10 to 33%. These results show that ADHD is more prevalent in patients with illicit drug use than in patients with alcohol use as their primary addiction. This is consistent with the finding that ADHD and DUDs are familial/genetically related, whereas ADHD and AUDs are not (Biederman et al, 2008). However, this finding is inconsistent with the meta-regression analysis of Van Emmerik-van Oortmerssen et al. (2012) reporting a lower prevalence of adult ADHD in treatment seeking cocaine dependent patients compared to treatment seeking alcohol and opioid dependent patients.
Although it is possible to calculate overall prevalence rates for ADHD for the total sample, we resisted this temptation. In presenting overall rates we would overrule the important finding of the large variability in prevalence rates due to Nordic-non-Nordic country effects, primary substance of abuse and probably other unknown factors influencing referral and access of subjects with adult ADHD and SUD to addiction treatment centers.

The use of DSM-5 criteria resulted in a modest increase in prevalence rates: 7.6% (CI 95%: 4.1–11.1) in Hungary to 32.6% (CI 95%: 26.4–38.8) in Norway. The observed DSM-5 prevalence rates were all within the rates based on ADHD-NOS criteria in DSM-IV, indicating that DSM-5 may reduce the use of the NOS category without increasing the prevalence of clinical relevant ADHD syndromes in treatment seeking SUD patients. Therefore the fear that DSM-5 would inflate the prevalence of ADHD (Batstra and Frances, 2012) seems not justified and the change from DSM-IV to DSM-5 will have, if any, minimal implications for clinical practice in addiction treatment centers.

4.1. Limitations

Although our study included a large sample based on a similar recruitment strategy and assessed with identical instruments for the diagnosis of adult ADHD, there are several limitations to consider.

Because of the lack of information about the initial number of referred patients and the dropout rates in some countries, it remains unclear to what extent the current sample is representative of all service attendees, let alone all people affected by a SUD in the various countries. Although the participants dropping out from the full assessment stage of the study were very similar to those who participated (Van de Glind et al. 2013a,b), the possibility that there were ADHD related differences that could have biased the estimates of ADHD cannot be fully discounted. In addition, requiring sustained abstinence as a criterion for inclusion might have resulted in more reliable information, but would have potentially excluded some of the more severely dependent participants, thereby leading to a possible underestimation of the prevalence of ADHD (Wilens, 2004).

The diagnostic accuracy of adult ADHD can be enhanced by obtaining additional information from parents or other individuals who knew the patient well during childhood. In this study, patients were approximately 40 years old and often came from dissolved families; hence it would be difficult if not impossible to track down parents or other key informants. When requiring attainment of collateral information to include SUD patients for this study, many would have been excluded. This decision however may have lowered (Barkley et al., 2002) the prevalence rates based on the CAADID.

Furthermore, we obtained information on the primary substance of abuse via self-report measures during the screening procedure (stage one), and it included only current use of either alcohol or illicit drugs. This is a simplification of reality, as many patients use multiple substances and no clear distinction between primary and non-primary substance of abuse can be made. It is unclear how this may have had a specific impact on the prevalence rates.
In addition, we have no measures of severity of SUD in our sample. Since severity of substance use may be related to treatment type with inpatients using more substances, this in turn may have an effect on the prevalence rates.

Finally, we had limited data on the reliability of the interviews in the various study locations (Polanczyk and Rohde, 2007). This may have influenced the prevalence rates in some of the countries. However, all sites were trained in the use of the MINI and the CAADID by the same clinical researcher (GvdG) and all interviewers at all sites were extensively trained using the same training manual for all assessment instruments.

### 4.2. Conclusions

Using the same definitions and diagnostic instruments in all countries and centers resulted in substantial reduction of the variability in the prevalence of adult ADHD reported in previous studies among SUD patients (2–83%) and treatment seeking SUD patients (10.0–54.1%) to 5.4–31.3%. The remaining variability was partly explained by primary substance of abuse and country. Prevalence estimates for DSM-5 were slightly higher than for DSM-IV and all within the rates based on ADHD-NOS criteria in DSM-IV. Therefore, the change from DSM-IV to DSM-5 will hardly have any effect on the clinical practice in addiction treatment centers. However, given the generally high prevalence of adult ADHD in treatment seeking SUD patients and given the fact that efficacious pharmacologic (Faraone and Glatt, 2010) and cognitive behavioral (Safren, 2006) interventions exist for the treatment of adult ADHD and its potential impact upon the outcomes of SUD treatment, all treatment seeking SUD patients should be screened and, after confirmed diagnosis, treated for ADHD since the current literature indicates poor prognoses of SUD in treatment seeking SUD patients with ADHD (Wilens, 2004).

### Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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**Role of funding source**

The ICASA Foundation ([www.adhdandsubstanceabuse.org](http://www.adhdandsubstanceabuse.org)) developed the IASP study, and arranged with its participating institutes that each of these institutes would seek funding for their regional process and data sampling efforts. The ICASA Network sought funding for the central organization costs. These central costs included:

- Organizing meetings for the network;
- Site visits for training and monitoring (The first author (VdG G) visited all of the institutes at least once, the European institutes were visited twice);
- Building a data base fit for remote data storage at the University of Amsterdam;
- Obtaining the right for use of the CAADID interview;
- Translating the instruments in the necessary languages;
- Cleaning the data;
Analysing the study results and coordinating publishing:

In the period of development of the study the ICASA network received unrestricted grants from the following pharmaceutical companies: Janssen Cilag, Eli Lilly and Company, Shire. Since the ICASA Network is a formal foundation (September 2010) it operates independent from pharmaceutical funding. Since then funding was obtained via the following sources:

Participating institutes:

The Noaber Foundation; The Waterloo Foundation, The Augeo Foundation.

The local institutes report the following funding sources:

The Netherlands, Amsterdam: no external funding was obtained. The participating institute, Arkin, paid for the costs involved, and used funding from Fonds NutsOhra for this project.

Norway, Bergen Clinics Foundation: Main external funding has been the Regional research council for addiction in West Norway (Regionalt kompetansesenter for rusmiddelforskning i Helse Vest (KORFOR)), funding a 50% position. The remaining resources, with staff and infrastructure, has been from the Bergen Clinics Foundation.

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The funding companies, institutes and foundations did not have and will not have influence on any aspect of the study, including research questions, data sampling, data management, data analyses and publishing results. Since September 2010 the IASP study functions independent from pharmaceutical companies.

G. Van de Glind was on one occasion consultant for Shire, for which he refused payment. In 2013 he received an unrestricted travel grant from Neunotech and he is (unpaid) member of the advisory board of Neurotech.

P.-J. Carpentier received in 2011 fee for speaking at a conference organized by Eli Lilly.

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from the National Institutes of Health (NIH). His institution is seeking a patent for the use of sodium-hydrogen exchange inhibitors in the treatment of ADHD. In previous years, he received consulting fees or was on Advisory Boards or participated in continuing medical education programs sponsored by: Shire, Alcobra, Otsuka, McNeil, Janssen, Novartis, Pfizer and Eli Lilly. He receives royalties from books published by Guilford Press: Straight Talk About Your Child’s Mental Health and Oxford University Press: Schizophrenia: The Facts.

J.A. Ramos-Quiroga was on the speakers’ bureau and/or acted as consultant for Eli-Lilly, Janssen-Cilag, Novartis, Shire and Rubió in the last 3 years. He also received travel awards (air tickets + hotel) for taking part in psychiatric meetings from Janssen-Cilag, Shire, and Eli-Lilly. The ADHD Program chaired by him received unrestricted educational and research support from the following pharmaceutical companies in the last 3 years: Eli-Lilly, Janssen-Cilag, Shire, and Eli-Lilly.

M. Casas was on the speakers’ bureau and/or acted as consultant for Eli-Lilly, Janssen-Cilag and Shire in the last 3 years. He also received travel awards (air tickets + hotel) for taking part in psychiatric meetings from Janssen-Cilag, Shire, and Eli-Lilly.

Z. Demetrovics received reimbursement for participating at a symposia organized by Lundbeck (2011).

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.drugalcdep.2013.09.026.

References

American Psychological Association. Diagnostic and Statistical Manual of Mental Diseases (DSM-IV). 4th ed. Washington, DC: American Psychological Association; 1994.

American Psychological Association. Highlights of Changes from DSM-IV-TR to DSM-5. 2013. http://www.psych.org/practice/dsm/dsm5 [accessed 21.04.13]

Arias AJ, Gelernter J, Chan G, Weiss RD, Brady KT, Farrer L, Kranzler HR. Correlates of co-occurring ADHD in drug-dependent subjects: prevalence and features of substance dependence and psychiatric disorders. Addict. Behav. 2008; 33:1199–1207. [PubMed: 18558465]

Arns M, van der Heijden KB, Arnold LE, Kenemans JL. Geographic variation in the prevalence of attention-deficit/hyperactivity disorder: the sunny perspective. Biol. Psychiatry. 2013; 74(8):585–590. [PubMed: 23523340]

Barkley RA, Fischer M, Smallish L, Fletcher K. The persistence of attention deficit/hyperactivity disorder into young adulthood as a function of reporting source and definition of disorder. J. Abnorm. Psychol. 2002; 111:279–289. [PubMed: 12003449]

Batstra L, Frances A. DSM-5 further inflates attention deficit hyperactivity disorder. J. Nerv. Ment. Dis. 2012; 200:486–488. [PubMed: 22652611]
Biederman J, Petty CR, Wilens TE, Fraire MG, Purcell CA, Mick E, Monuteaux MC, Faraone SV. Familial risk analyses of attention deficit hyperactivity disorder and substance use disorders. Am. J. Psychiatry. 2008; 165:107–115. [PubMed: 18006872]

Carroll KM, Rounsaville BJ. History and significance of childhood attention deficit disorder in treatment-seeking cocaine abusers. Compr. Psychiatry. 1993; 34:75–82. [PubMed: 8485984]

Epstein, JE.; Johnson, DE.; Conners, CK. Conners’ Adult ADHD Diagnostic Interview for DSM-IV (CAADDI). Toronto: Technical Manual, MHS; 2001.

Faraone SV, Antshel KM. Diagnosing and treating attention-deficit/hyperactivity disorder in adults. World Psychiatry. 2008; 7:131–136. [PubMed: 18836579]

Faraone SV, Glatt SJ. A comparison of the efficacy of medications for adult attention-deficit/ hyperactivity disorder using meta-analysis of effect sizes. J. Clin. Psychiatry. 2010; 71:754–763. [PubMed: 20051220]

Faraone SV, Sergeant J, Gillberg C, Biederman J. The worldwide prevalence of ADHD: is it an American condition? World Psychiatry. 2003; 2:104–113. [PubMed: 16946911]

Faraone SV, Biederman J, Mick E. The age-dependent decline of attention deficit hyperactivity disorder: a meta-analysis of follow-up studies. Psychol. Med. 2006; 36:159–165. [PubMed: 16420712]

Frances AJ, Widiger T. Psychiatric diagnosis: lessons from the DSM-IV past and cautions for the DSM-5 future. Annu. Rev. Clin. Psychol. 2012; 8:109–130. [PubMed: 22035240]

Friborg O, Bjorvatn B, Amponsah B, Pallesen S. Associations between seasonal variations in day length (photoperiod), sleep timing, sleep quality and mood: a comparison between Ghana (5 degrees) and Norway (69 degrees). J. Sleep Res. 2012; 21:176–184. [PubMed: 22074243]

Hannestad H, Tyrningsson T, Piha J. Psychosocial functioning and psychiatric comorbidity among substance-abusing Icelandic adolescents. Nord. J. Psychiatry. 2001; 55:43–48. [PubMed: 11827606]

Huntley Z, Maltezos S, Williams C, Morinan A, Hammon A, Ball D, Marshall EJ, Keaney F, Young S, Bolton P, Glaser K, Howe-Forbes R, Kuntsi J, Xen-tidis K, Murphy D, Asherson PJ. Rates of undiagnosed attention deficit hyperactivity disorder in London drug and alcohol detoxification units. BMC Psychiatry. 2012; 12:223. [PubMed: 23216993]

Kadesjö B, Gillberg C. The comorbidity of ADHD in the general population of Swedish school-age children. J. Child Psychol. Psychiatr. 2001; 42:487–492.

Kessler RC, Adler LA, Barkley R, Biederman J, Conners CK, Faraone SV, Green-hill LL, Jaeger S, Secnik K, Spencer T, Ustün TB, Zaslavsky AM. Patterns and predictors of attention-deficit/ hyperactivity disorder persistence into adulthood: results from the national comorbidity survey replication. Biol. Psychiatry. 2005a; 57:1442–1451. [PubMed: 15950019]

Kessler RC, Adler L, Ames M, Demler O, Faraone S, Hiripi E, Howes MJ, Jin R, Secnik K, Spencer T, Ustün TB, Walters EE. The World Health Organization Adult ADHD Self-Report Scale (ASRS): a short screening scale for use in the general population. Psychol. Med. 2005b; 35:245–256. [PubMed: 15841682]

Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch. Gen. Psychiatry. 2005c; 62:593–602. [PubMed: 15939837]

King VL, Brooner RK, Kidorl MS, Stoller KB, Mirsky AF. Attention deficit hyperactivity disorder and treatment outcome in opioid abusers entering treatment. J. Nerv. Ment. Dis. 1999; 187:487–495. [PubMed: 10463066]

Landgren M, Pettersson R, Kjellman B, Gillberg C. ADHD, DAMP and other neurodevelopmental/ psychiatric disorders in 6-year-old children: epidemiology and co-morbidity. Dev. Med. Child Neurol. 1996; 38:891–906. [PubMed: 8870611]

Levin FR, Evans SM, Kleber HD. Prevalence of adult attention-deficit hyperactivity disorder among cocaine abusers seeking treatment. Drug Alcohol Depend. 1998; 52:15–25. [PubMed: 9788002]

Matsumoto T, Kamijo A, Yamaguchi A, Iseki E, Hirayasu Y. Childhood histories of attention-deficit hyperactivity disorders in Japanese metham-phetamine and inhalant abusers: preliminary report. Psychiatry Clin. Neurosci. 2005; 59:102–105. [PubMed: 15679548]
Morisette JT, Khorram S. Exact binomial confidence interval for proportions. Photogramm. Eng. Remote Sensing. 1998; 64:281–283.

Ohlmeier MD, Peters K, Te Wildt BT, Zedler M, Ziegenbein M, Wiese B, Emrich HM, Schneider U. Comorbidity of alcohol and substance dependence with attention-deficit/hyperactivity disorder (ADHD). Alcohol Alcohol. 2008; 43:300–304. [PubMed: 18326548]

Polanczyk G, Rohde LA. Epidemiology of attention-deficit/hyperactivity disorder across the lifespan. Curr. Opin. Psychiatry. 2007; 20:386–392. [PubMed: 17551354]

Rounsaville B, Carroll K. Psychiatric disorders in treatment-entering cocaine abusers. NIDA Res. Monogr. 1991; 110:227–251. [PubMed: 1944500]

Safren SA. Cognitive-behavioral approaches to ADHD treatment in adulthood. J. Clin. Psychiatry. 2006; 67:46–50. [PubMed: 16961430]

Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavs J, Weiller E, Her-gueta T, Baker R, Dunbar GC. The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. J. Clin. Psychiatry. 1998; 59:22–33. [PubMed: 9881538]

Simon V, Czobar P, Bálint S, Mészáros A, Bitter I. Prevalence and correlates of adult attention-deficit hyperactivity disorder: meta-analysis. Br. J. Psychiatry. 2009; 194:204–211. [PubMed: 19252145]

Suren P, Bakken JJ, Aase H, Chin R, Gunnes N, Lie KK, Magnus P, Reichborn-Kjennerud T, Schjølberg Øyen AS, Stoltenberg C. Autism spectrum disorder, ADHD, epilepsy, and cerebral palsy in Norwegian children. Pediatrics. 2012; 130:152–158.

Ullebø AK, Posserud AB, Heiervang E, Obel C, Gillberg C. Prevalence of the ADHD phenotype in 7-to 9-year-old children: effects of informant, gender and non-participation. Soc. Psychiatry Psychiatr. Epidemiol. 2012; 47:763–769. [PubMed: 21499807]

Van de Glind G, Van Emmerik-van Oortmerssen K, Carpentier PJ, Levin FR, Koeter MW, Kaye S, Skutle A, Franck J, Konstenius M, Bu E-TH, Moggi F, Dom G, Demetrovic Z, Fatséas M, Auriacombe M, Schilling A, Kapitány-Fövény M, Verspreet S, Seitz A, Johnson B, Faraone SV, Casas M, Ramos-Quiroga JA, Allsop S, Carruthers S, Barta C, Schoevers RA, van den Brink W. IASP Research Group. The International ADHD in Substance use disorders Prevalence (IASP) study: background, methods and study population. Int. J. Methods Psychiatr. Res. 2013a; 22:232–244.

Van de Glind G, van den Brink W, Koeter MW, Carpentier PJ, van Emmerik-van Oortmerssen K, Kaye S, Skutle A, Bu ET, Franck J, Konstenius M, Moggi F, Dom G, Verspreet S, Demetrovic Z, Kapitány-Fövény M, Fatséas M, Auriacombe M, Schilling A, Seitz A, Johnson B, Faraone SV, Ramos-Quiroga JA, Casas M, Allsop S, Carruthers S, Barta C, Schoevers RA, van den Brink W. IASP Research Group. Validity of the Adult ADHD Self-Report Scale (ASRS) as a screener for adult ADHD in treatment seeking substance use disorder patients. Drug Alcohol Depend. 2013b; 132:587–596. [PubMed: 23660242]

Van Emmerik-van Oortmerssen K, van de Glind G, van den Brink W, Smit F, Crunelle CL, Swets M, Schoevers RA. Prevalence of attention-deficit hyperactivity disorder in substance use disorder patients: a meta-analysis and meta-regression analysis. Drug Alcohol Depend. 2012; 122:11–19. [PubMed: 22209385]

Van Emmerik-van Oortmerssen K, van de Glind G, Koeter MWJ, Allsop S, Auriacombe M, Barta C, Bu ETH, Burren Y, Carpentier PJ, Carruthers S, Casas M, Demetrovic Z, Dom G, Faraone SV, Fatsés M, Franck J, Johnson B, Kapitány-Fövény M, Kaye S, Konstenius M, Levin FR, Moggi F, Ramos-Quiroga A, Schilling A, Møller M, Skutle A, Verspreet S, research group IASP, van den Brink W, Schoevers RA. Psychiatric comorbidity in treatment seeking substance use disorder patients with and without ADHD. results of the IASP study. 2013 Addiction, in press.

Wilens TE. Impact of ADHD and its treatment on substance abuse in adults. J. Clin. Psychiatry. 2004; 65:38–45. [PubMed: 15046534]

Wilens TE. ADHD: prevalence, diagnosis, and issues of comorbidity. CNS Spectrosc. 2007; 12:1–5.

Wilens TE, Fusillo S. When ADHD and substance use disorders intersect: relationship and treatment implications. Curr. Psychiatry Rep. 2007; 9:408–414. [PubMed: 17915081]
Wilens TE, Kwon A, Tanguay S, Chase R, Moore H, Faraone SV, Biederman J. Characteristics of adults with attention deficit hyperactivity disorder plus substance use disorder: the role of psychiatric comorbidity. Am. J. Addict. 2005; 14:319–327. [PubMed: 16188712]

Williams JB, Gibbon M, First MB, Spitzer RL, Davies M, Borus J, Howes MJ, Kane J, Pope HG Jr, Rounsaville B, Wittchen H. The structured clinical interview for DSM-III-R (SCID). II. Multisite test-retest reliability. Arch. Gen. Psychiatry. 1992; 49:630–636. [PubMed: 1637253]
Table 1

Main characteristics of the study population (N= 1276).

|                     | France (n = 157) | Hungary (n = 226) | Netherlands (n = 129) | Norway (n = 220) | Spain (n = 222) | Sweden (n = 168) | Switzerland (n = 154) | Total (N = 1276) | p       |
|---------------------|------------------|-------------------|-----------------------|-----------------|-----------------|------------------|-----------------------|-----------------|---------|
| Age M (SD)          | 36.8 (10.6)      | 43.1 (12.1)       | 40.4 (10.3)           | 38.1 (10.7)     | 37.9 (9.8)      | 42.6 (11.6)      | 42.5 (10.8)           | 40.0 (11.2)     | χ²(6, 1265)= 11.55 <.001 |
| ASRS screen positive (%) | 40.1             | 20.8              | 53.5                  | 65.9            | 35.6            | 37.5             | 28.6                  | 40.0            | Wald(6)= 89.01 <.001 |
| Female (%)          | 44 (28.0)        | 55 (24.3)         | 23 (17.8)             | 69 (31.3)       | 46 (20.7)       | 52 (31.0)        | 51 (33.6)             | 340 (26.7)      | Wald(6)= 16.64 .010 |
| Employed (%)        | 51 (32.5)        | 53 (24.0)         | 68 (53.1)             | 55 (26.4)       | 81 (36.7)       | 56 (35.9)        | 20 (13.4)             | 384 (31.0)      | Wald(6)= 54.80 <.001 |
| Homeless/shelter (%) | 9 (5.7)          | 27 (13.2)         | 10 (7.8)              | 14 (6.9)        | 19 (8.6)        | 18 (5.9)         | 9 (11.0)              | 106 (8.6)       | Wald(6)= 11.56 .073 |
| Married/partner (%) | 35 (22.3)        | 71 (31.7)         | 30 (23.3)             | 39 (18.4)       | 58 (26.4)       | 47 (28.7)        | 47 (30.9)             | 327 (25.9)      | Wald(6)= 14.57 .024 |
| Main substance (missing): | 0               | 0                 | 0                     | 6               | 1               | 3               | 2                     | 12              |         |
| –Alcohol (%)        | 79 (50.3)        | 169 (74.8)        | 79 (61.2)             | 68 (31.8)       | 57 (25.8)       | 92 (55.8)        | 146 (69.6)            | 690 (54.6)      | Wald(6)= 189.31 <.001 |
| –Stimulants (%)     | 10 (6.4)         | 13 (5.8)          | 12 (9.3)              | 57 (26.6)       | 81 (36.7)       | 16 (9.7)         | 2 (1.3)               | 191 (15.1)      | Wald(6)= 171.16 <.001 |
| –Opiates (%)        | 15 (9.6)         | 8 (3.5)           | 1 (0.8)               | 37 (17.3)       | 39 (17.6)       | 35 (21.2)        | 2 (1.3)               | 137 (10.8)      | Wald(6)= 51.79 <.001 |
| –Cannabis (%)       | 32 (20.4)        | 4 (1.8)           | 31 (24.0)             | 30 (14.0)       | 30 (13.6)       | 10 (6.1)         | 0 (0.0)               | 137 (10.8)      | Wald(6)= 39.25 <.001 |
| –Other drugs (%)    | 21 (13.4)        | 32 (14.2)         | 6 (4.7)               | 22 (10.3)       | 14 (6.3)        | 12 (7.3)         | 2 (1.3)               | 109 (8.6)       | Wald(6)= 24.77 <.001 |
|                  | France (n = 157) | Hungary (n = 226) | Netherlands (n = 129) | Norway (n = 220) | Spain (n = 222) | Sweden (n = 168) | Switzerland (n = 154) | Range (N = 1276) |
|------------------|------------------|-------------------|----------------------|------------------|----------------|------------------|----------------------|------------------|
| **Childhood ADHD** |                  |                   |                      |                  |                |                  |                      |                  |
| **DSM-IV %**     | 21.3             | 12.9              | 15.0                 | 41.0             | 10.6          | 27.7             | 15.1                 | 10.6–41.0        |
| (CI 95%)         | (14.9–27.7)      | (8.6–17.3)        | (8.9–21.2)           | (34.5–47.5)      | (6.5–14.6)    | (20.9–34.5)      | (9.4–20.8)          |
| **DSM-5**        | 23.2             | 12.9              | 15.0                 | 42.3             | 13.0          | 29.1             | 15.6                 | 12.9–42.3        |
| **Age of onset <12% (CI 95%)** | 16.6–29.8 | 8.6–17.3 | 8.9–21.2 | 35.7–48.8 | 8.5–17.4 | 22.2–36.0 | 9.8–21.3 |
| **Adult ADHD DSM-IV % (CI 95%)** | 11.2 | 5.4 | 10.1 | 31.3 | 9.2 | 19.7 | 6.1 | 5.4–31.3 |
| **DSM-5**        | 16.2             | 7.6               | 11.8                 | 32.6             | 10.6          | 22.4             | 7.7                  | 7.6–32.6         |
| **Age of onset <12 and # symptoms ≥5% (CI 95%)** | 10.5–22.0 | 4.1–11.1 | 6.2–17.3 | 26.4–38.8 | 6.6–14.7 | 16.1–28.7 | 3.5–12.0 |
| **Combined: age of onset <12 and # symptoms 4/9% (CI 95%)** | 11.0–22.7 | 5.2–12.7 | 6.7–18.0 | 28.2–40.7 | 6.6–14.7 | 16.1–28.7 | 3.9–12.5 |

*a Prerequisite: Diagnosed Childhood ADHD based on CAADID retrospective diagnosis; DSM-IV criteria for Childhood ADHD.

b Prerequisite: Diagnosed Childhood ADHD based on CAADID retrospective diagnosis; DSM-5: adjusted age of onset <12 criterion for childhood.
Table 3

Prevalence of ADHD (DSM-IV).

| Inpatients alcohol (n=339)<sup>a</sup>, weighted data | Inpatients drugs (n = 109)<sup>f</sup>, weighted data |
|------------------------------------------------------|----------------------------------------------------|
| **Childhood DSM-IV** | **Adult ADHD DSM-IV** | **Childhood DSM-IV** | **Adult ADHD DSM-IV** |
| Prevalence | 95% ci<sup>b</sup> | Prevalence | 95% ci<sup>b</sup> | Prevalence | 95% ci<sup>b</sup> | Prevalence | 95% ci<sup>b</sup> |
| Hungary (169<sup>a</sup>) | 12% | 7–18 | 5% | 02–10 | Hungary (57<sup>a</sup>) | 16% | 8–28 | 5% | 1–15 |
| Norway (24<sup>a</sup>) | 43% | 23–64 | 22% | 02–10 | Norway (52<sup>a</sup>) | 57% | 42–71 | 52% | 37–66 |
| Switzerland (146<sup>a</sup>) | 15% | 09–21 | 5% | 02–10 | – All countries<sup>f</sup> | 35% | 26–44 | 27% | 19–36 |
| – All countries<sup>f</sup> | 15% | 12–20 | 6% | 4–10 | – All countries<sup>f</sup> | 35% | 26–44 | 27% | 19–36 |
| – Without Nordic<sup>c</sup> | 13% | 10–17 | 5% | 3–8 |
| – Only Nordic | 43% | 23–64 | 22% | 8–44 |
| **Observed range** | | | | | | | | |
| – All countries | 12–43% | 5–22% | | | – All countries | 16–57% | 5–52% |
| – Without Nordic | 12–15% | 5.1–5.4% | | | – Only Nordic | n.a.<sup>d</sup> | n.a.<sup>d</sup> |
| **Effect country<sup>c</sup>** | | | | | | | | |
| – All countries Wald(2); (p) | 16.67 (<.001) | 8.00 (.018) | | | – All countries Wald(1); (p) | 10.58 (.001) | 14.13 (<.001) |
| – Without Nordic Wald(1); (p) | .024 (.878) | .585 (.444) | | | – Only Nordic | n.a.<sup>d</sup> | n.a.<sup>d</sup> |

Inpatients alcohol (n=339) and inpatients drugs (n=109), weighted data.

<sup>a</sup>Presented is the non-weighted n.

<sup>b</sup>Exact binomial confidence interval using the approach by Morisette and Khorram (1998).

<sup>c</sup>Effect of country on prevalence adjusted for age, sex, occupational status, housing and marital status.

<sup>d</sup>Not applicable.

<sup>e</sup>Nordic countries: Norway and Sweden.

<sup>f</sup>All countries: meaning all countries with subjects in this setting.
### Table 4

Prevalence of ADHD (DSM-IV).

| Childhood DSM-IV | Adult ADHD DSM-IV | Childhood DSM-IV | Adult ADHD DSM-IV |
|------------------|-------------------|------------------|-------------------|
| **Outpatients alcohol (n = 351<sup>a</sup>)**, weighted data | **Outpatients drugs (n = 454<sup>b</sup>)**, weighted data |
| Prevalence | 95% ci<sup>b</sup> | Prevalence | 95% ci<sup>b</sup> |
| France (79<sup>a</sup>) | 12% | 6–22 | France (78<sup>a</sup>) | 30% | 20–42 |
| Netherlands (79<sup>a</sup>) | 14% | 7–23 | Netherlands (50<sup>a</sup>) | 17% | 7–32 |
| Norway (44<sup>a</sup>) | 25% | 14–40 | Norway (50<sup>a</sup>) | 41% | 30–52 |
| Spain (57<sup>a</sup>) | 4% | 0.5–13 | Spain (16<sup>a</sup>) | 12% | 8–19 |
| Sweden (92<sup>a</sup>) | 17% | 10–27 | Sweden (50<sup>a</sup>) | 37% | 26–49 |
| **–All countries**<sup>f</sup> | 14% | 11–18 | **–All countries**<sup>f</sup> | 26% | 21–30 |
| **–Without Nordic**<sup>e</sup> | 11% | 7–16 | **–Without Nordic**<sup>e</sup> | 14% | 14–23 |
| **Observed range** | **Observed range** | **Observed range** | **Observed range** |
| –All countries<sup>e</sup> | 4–25% | 4–14% | –All countries<sup>f</sup> | 12–41% | 10–33% |
| –Without Nordic<sup>e</sup> | 4–12% | 4–10% | –Without Nordic<sup>e</sup> | 12–30% | 10–16% |
| **–Only Nordic** | 17.25% | 13–14% | **–Only Nordic** | 37–41% | 26–33% |
| **Effect country**<sup>e</sup> | **Effect country**<sup>f</sup> | **Effect country**<sup>f</sup> | **Effect country**<sup>f</sup> |
| –All countries Wald(4); (p) | 10.23 (.037) | 7.06 (.133) | –All countries Wald(4); (p) | 30.54 (<.001) | 18.47 (.001) |
| –Without Nordic Wald(2); (p) | 4.62 (.099) | 2.79 (.248) | –Without Nordic Wald(2); (p) | 9.33 (.009) | 1.60 (.449) |
| –Only Nordic Wald(1); (p) | .003 (.957) | .60 (.440) | –Only Nordic Wald(1); (p) | .15 (.699) | .016 (.889) |

Outpatients alcohol (n = 351) and outpatients drugs (n = 454), weighted data.

<sup>a</sup>Presented is the non–weighted n.

<sup>b</sup>Exact binomial confidence interval using the approach by Morisette and Khorr (1998).
Effect of country on prevalence adjusted for age, sex, occupational status, housing and marital status.

Not applicable.

Nordic countries: Norway and Sweden.

All countries: meaning all countries with subjects in this setting.
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