Attention-deficit/hyperactivity disorder

Terry Brugha | Philip Asherson | André Strydom | Zoe Morgan | Shanna Christie

ADULT PSYCHIATRIC MORBIDITY SURVEY 2014 CHAPTER 8
Summary

- Attention-deficit/hyperactivity disorder (ADHD) is a complex neurodevelopmental disorder which starts in childhood and often persists into adulthood. Adult ADHD is often unrecognised or misdiagnosed by professionals. It is associated with significant impairment and adverse outcomes, including premature mortality.

- APMS provides the only general population data on ADHD in adults in England. The 2007 and 2014 surveys both included the six-item Adult ADHD Self-Report Scale (ASRS). The screen assesses ADHD characteristics of inattention, hyperactivity and impulsivity during the six months prior to interview. A score of 4 or more constitutes a positive screen for ADHD.

- Screening positive for ADHD indicates that someone warrants a fuller assessment. While the actual prevalence of ADHD will be lower, APMS provides key information on the distribution of ADHD characteristics in the general adult population.

- One in ten (9.7%) adults screened positive for ADHD, with similar rates for men and women. This rate was slightly higher than that found in 2007 using the same measure (8.2%).

- Screening for ADHD was more common among: younger adults; those living alone; people without educational qualifications; the unemployed and those who are economically inactive, especially those in receipt of disability-related out-of-work benefits.

- Very few adults screening positive for ADHD believed that they had the disorder (3.7%) or had been diagnosed with ADHD by a professional (2.3%). 0.5% of adults screening positive for ADHD were currently taking medications specifically indicated for ADHD.

- However, adults screening positive for ADHD were three times more likely to be in receipt of psychotropic medication or psychological therapy than those who did not (34.3% compared with 10.8%). They were also more likely to make use of health or community care services, and to have requested particular treatment which they did not subsequently get.
These findings suggest that ADHD characteristics are widespread in the adult population in England. While no definitive assessments of ADHD are reported on here, the findings are consistent with the view that ADHD may often go unrecognised, misdiagnosed and undertreated.

8.1 Introduction

Attention-deficit/hyperactivity disorder (ADHD) is widely recognised as a complex neurodevelopmental disorder in childhood. Prevalence estimates for childhood ADHD range between 3% and 9%, depending on the diagnostic criteria applied (NICE 2008). The persistence of ADHD into adulthood is also well established, but has only gained significant recognition – and become a focus for research and clinical management – over the past decade (Nutt et al. 2007).

The National Institute for Health and Clinical Excellence (NICE) reviewed the diagnostic construct of ADHD across the lifespan and concluded that when ADHD persists into adulthood it is often associated with significant impairment (2008). It remains uncertain what level of ADHD symptoms and impairment in adults should be considered grounds for intervention.

Worldwide prevalence estimates for ADHD in adults from survey studies range from 2.5% to 3.4% (Simon et al. 2009; Fayyad et al. 2007). Survey estimates of reporting both childhood ADHD and persistence into adulthood vary widely within and between countries, with US general population surveys suggesting a prevalence of between 3% and 5% (Fayyad et al. 2007; Faraone and Biederman 2005; Kessler et al. 2006). Analysis of multiple follow-up studies of children diagnosed with ADHD has indicated that about 15% of children diagnosed with ADHD retained the diagnosis at age 25. A further 50% of children with ADHD were in partial remission by age 25, meaning they still experienced some impairing symptoms (Nutt et al. 2007). More recent follow-up studies in the UK and the Netherlands of children with ADHD attending child mental health services found far higher persistence rates into adulthood (in the order of 80%) (Van Lieshout et al. 2016; Cheung et al. 2015). This may reflect the severity of the cases in these studies.
APMS 2007 provided the first epidemiological data on the prevalence of ADHD characteristics in the adult population in England. Findings from that survey indicated that prevalence was higher among particular population subgroups: most notably unemployed people, those with substance misuse disorders, and previously married individuals (McManus et al. 2009). APMS 2014 has the same screening tool as that used in 2007, and presents the first opportunity to look at trends in ADHD characteristics.

ADHD in adults may go unrecognised or be misdiagnosed by mental health professionals (Asherson 2005). A recent survey using diagnostic interview assessments with non-psychotic patients attending adult mental health services in European countries found an ADHD rate of 15.8% (DSM-IV) (APA 1994) to 17.4% (DSM-5) (APA 2013). Their ADHD was often undiagnosed and untreated (Deberdt et al. 2015). One difficulty with diagnosis is that some of the characteristic features of ADHD may also be seen in other psychiatric conditions. These include personality disorders (particularly those characterised by emotional instability such as antisocial personality disorder and borderline personality disorder), while poor attention and distractibility are also common in depression, anxiety and bipolar disorder. ADHD symptoms also overlap or co-occur with other neurodevelopmental disorders such as autism and intellectual disability, and specific learning difficulties. This may result in additional or alternative diagnoses (Nutt et al. 2007). Furthermore, behavioural problems such as substance misuse disorders and antisocial behaviour occur at increased rates in adults with ADHD. If ADHD in adulthood is unrecognised as a result of comorbidity, service provision and treatment may be ineffective.

Untreated, the presence of ADHD may lead to educational and occupational disadvantage, and significant social impairments. Adults with ADHD tend to have fewer academic qualifications, probably because of difficulties with distractibility and restlessness, as well as problems with organising time, prioritising tasks and meeting deadlines (Nutt et al. 2007). ADHD is found in 26% of prisoners (Young et al. 2014; Ginsberg et al. 2010) and 12% of treatment-seeking patients with substance abuse disorders (van de Glind et al. 2014). It is associated with increased rates of criminal convictions (Lichtenstein et al. 2012), transport accidents (Chang et al. 2014) and mortality (Dalsgaard et al. 2015). Additional costs to society are incurred through absenteeism, reduced productivity and
poor work performance (Kessler et al. 2005b). The social consequences of the adult form of ADHD are equally marked, with dysfunctional patterns of behaviour leading to poor interpersonal relationships and marital failure (Nutt et al. 2007).

Service provision and treatment for ADHD in childhood is now well established, but is much less available for adults diagnosed with the condition. Many ADHD medications considered effective for children and adolescents are not licensed for use in adults (Nutt et al. 2007), although this is changing with licensed indications for the first time in the UK for use of atomoxetine and lisdexamfetamine in adults with ADHD. Mental health services for adults with ADHD remain relatively uncommon or greatly under-resourced in the UK and across much of Europe, resulting in high levels of untreated disorder even when it is identified (Van Lieshout et al. 2016).

Information about the prevalence of ADHD and the use of mental health services by adults presenting with the characteristic features of ADHD in the English population is essential for planning improvements in diagnosis and service provision. This chapter describes the general population distribution of characteristic behavioural symptoms associated with ADHD, examines their association with age, sex, and certain sociodemographic characteristics, and profiles the use of mental health treatment and services. Comorbidity involving ADHD is addressed in Chapter 13.

8.2 Definition and assessment

Attention-deficit/hyperactivity disorder (ADHD)

ADHD is a neurodevelopmental disorder defined by the core dimensions of inattention, hyperactivity and impulsiveness. Characteristic symptoms and behaviours include significant and enduring difficulties with organisation and planning, distractibility, forgetfulness, over-activity, restlessness and impulsiveness, to an extent that causes significant distress or significantly interferes with everyday functioning (Weiss et al. 2002). The role of ancillary characteristics has been highlighted in recent years; these include emotional dysregulation, sleep onset insomnia and problems with the self-regulation of behaviour (Asherson et al. 2016).
While these are not used to define ADHD, they are commonly seen in the condition and often lead to impairment. They are also seen in other mental disorders.

Two official sets of diagnostic criteria are in current use; the International Classification of Diseases 10th Revision (ICD-10) (WHO 1992) and the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) (APA 2013). The ICD-10 uses a more restricted set of criteria, whereby ADHD symptoms are classified as hyperkinetic disorder when all three characteristics of inattention, hyperactivity and impulsivity are present and lead to impairment. This stricter classification excludes cases comorbid with conditions such as anxiety, personality disorder and pervasive developmental disorder, although such comorbidity is common. The narrowness of this definition can be seen as a limitation, as it will not identify people with all the features of adult ADHD if the criteria for other conditions are also met, and will only detect the most severe cases. On the other hand, given the severity of ICD-10 hyperkinetic disorder, people meeting these criteria represent a clear priority.

DSM-5 in contrast sets out a broader definition of the disorder and allows the presence both of comorbid disorders and of impairing symptoms in the inattentive or hyperactive-impulsive domains. This approach might therefore be seen as over-identifying ADHD in individuals who are primarily suffering from other disorders (Nutt et al. 2007).

**Adult ADHD Self-Report Scale-v1.1 (ASRS)**

The Adult ADHD Self-Report Scale (ASRS), developed in collaboration with the World Health Organisation (WHO), was used in both the 2007 and 2014 APMS to estimate the prevalence of possible ADHD (WHO 2003). The scale is referred to in this chapter as a screening test for reasons of convention, although it is not currently recommended as part of an official screening programme in England.

The six-item ASRS is a shortened version of the 18-item Symptom Checklist scale, which measures the frequency of recent symptoms of adult ADHD listed in the DSM-IV. This short screen appears to out-perform the full 18-question ASRS in terms of sensitivity (68.7% versus 56.3%), specificity (99.5% versus 98.3%).

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1 DSM-IV Criterion A symptoms are categorised as a clinical diagnosis of adult ADHD requiring a respondent to have at least six symptoms of either inattention or hyperactivity-impulsivity during the six months before the interview.
and total classification accuracy (97.9% versus 96.2%) (Kessler et al. 2007). Its use and validity have been established predominantly in community samples, although it has been suggested that the scale could also prove to be a useful complement to more accurate clinical diagnostic assessments (Kessler 2005a). However, it may lack sufficient predictive validity in some populations, such as those with substance use disorders (van de Glind et al. 2013).

The ASRS screen was administered face-to-face to all participants. The six questions assess the ADHD characteristics of inattention, hyperactivity and impulsivity during the six months prior to interview. Participants were asked to rate the frequency of these characteristics using a five-point response scale: ‘never’, ‘rarely’, ‘sometimes’, ‘often’ and ‘very often’. In this chapter we report 1) the proportion of adults reporting four or more characteristics at or above the specified frequency threshold, and 2) the proportion reporting all six characteristics. The four-item threshold is that recommended for indicating the need for a clinical assessment for ADHD (Fayyad et al. 2007). However, the developers of the scale also emphasise that the higher the score the more likely it is that ADHD is present, and for this reason we also show the proportion of the sample meeting the threshold frequency for all six items. This reveals subgroups with the greatest likelihood of a positive diagnosis at clinical assessment.

While it has been established that the ASRS identifies a group with a greater chance of meeting the full criteria, the rate will not be accurate because some participants may lack significant impairment or another defining characteristic of ADHD symptoms. To address this problem, additional work using a short clinical assessment format was introduced to phase two during the 2014 fieldwork and will be described and reported on separately.2 In the meantime, the validity of self-evaluation of ADHD characteristics described in the present report should be regarded with some caution.

The questions in the ASRS scale used to screen for possible adult ADHD and the threshold frequencies are displayed below.

2 The phase two data on ADHD will be analysed in subsequent publications.
## Adult Self-Report Scale-v1.1 (ASRS-V1.1) Screen

<table>
<thead>
<tr>
<th>Thinking about now and the past six months…</th>
<th>Responses indicating symptom is significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>… how often do you have trouble wrapping up the fine details of a project, once the challenging parts have been done?</td>
<td>Sometimes, often, very often</td>
</tr>
<tr>
<td>… how often do you have difficulty getting things in order when you have to do a task that requires organisation?</td>
<td>Sometimes, often, very often</td>
</tr>
<tr>
<td>… how often do you have problems remembering appointments or things you have agreed to do?</td>
<td>Sometimes, often, very often</td>
</tr>
<tr>
<td>… when you have a task that requires a lot of thought, how often do you avoid or delay getting started?</td>
<td>Often, very often</td>
</tr>
<tr>
<td>… how often do you fidget or squirm with your hands or your feet when you have to sit down for a long time?</td>
<td>Often, very often</td>
</tr>
<tr>
<td>… how often do you feel overly active and compelled to do things, like you were driven by a motor?</td>
<td>Often, very often</td>
</tr>
</tbody>
</table>

Although the ASRS screen shows strong concordance with clinical diagnosis in US population surveys, caution is required in interpreting ASRS-based findings. First, self-reported information is always subject to some social desirability biases (Greenfield et al. 2001). Second, adults may under-report their ADHD symptoms in comparison to informant observations (Cheung et al. 2015; Moffitt et al. 2015). Third, the childhood age of onset, the level of impairment resulting from the symptoms of hyperactivity and inattention, and the degree of pervasiveness across situations such as home and work are key criteria for the diagnosis of ADHD, and the ASRS does not include an overall assessment of these requirements.

It is important to note that for the purposes of this chapter, scoring four or more on the ASRS is counted as a ‘positive screen for ADHD’. Occasionally a rate is also presented for those who endorsed all six items on the ASRS. Screening positive for ADHD (with a score of 4 or more) indicates that an individual has sufficient symptoms to warrant a further and more detailed ADHD assessment. The actual ADHD rate is likely to be lower than the rate screening positive for ADHD.
8.3 Results

Screening positive for ADHD in 2007 and 2014, by age and sex
One in ten (9.7%) adults scored four or more (the threshold at which clinical assessment for ADHD may be warranted) on the ASRS. If all adults in the household population had been screened it is likely (95% confidence) that the proportion who screened positive would be between 8.9% and 10.6%. The proportion endorsing all six characteristics on the ASRS screen was much lower (0.7%).

Overall, men and women were equally likely to screen positive (at either threshold); 10.0% of men and 9.5% of women scored four or more on the ASRS, and 0.7% of men and 0.6% of women scored six. The lack of association with sex is consistent with findings from APMS 2007. However, some studies have found ADHD to be two to four times more prevalent in men than women (Faraone and Biederman 2005).

The proportion of adults screening positive for ADHD broadly decreased with age. This pattern was observed in both women and men. The proportion with scores of four or more was highest in adults aged 16–24 (14.6%), and lowest in adults aged 75 and over (3.4%). Table 8.1

Figure 8A: Screen positive for ADHD (score of 4 or more on the ASRS), by age and sex
Base: all adults
The proportion of adults screening positive for ADHD was somewhat higher in 2014 (9.7%) than in 2007 (8.2%). This upward trend was evident in both men (8.8% in 2007; 10.0% in 2014) and women (7.7% in 2007; 9.5% in 2014).

**Table 8.2**

**Figure 8B: Screen positive for ADHD in 2007 and 2014, by sex**

*Base: all adults*

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Women</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>All</td>
<td>8</td>
<td>10</td>
</tr>
</tbody>
</table>

**Self diagnosis and professional diagnosis of ADHD**

Table 8.3 presents ASRS scores in relation to whether or not people considered themselves to have had ADHD, and whether or not a professional had diagnosed them with ADHD.

There was some concordance between the survey test for ADHD and people’s own perceptions. People who screened positive on the ASRS were also more likely to think that they had ADHD than those who did not screen positive. Even so, a small minority of those who screened positive for ADHD believed that they had ADHD (3.7% of those endorsing four or more ADHD characteristics, and 7.7% who endorsed all six).
Men were more likely than women to think that they had had ADHD. 5.4% of men reporting four or more ADHD characteristics thought that they had had the disorder, compared with 1.9% of women.

People who screened positive on the ASRS were also more likely than those who did not to have had the disorder diagnosed by a professional. 2.3% of people with four or more ADHD characteristics reported having had a diagnosis. Men screening positive for ADHD were more likely than screen-positive women to have been diagnosed. Of those with a score of four or more, 3.9% of men had been diagnosed with ADHD at some point, compared with 0.7% of women. Table 8.3

**Variation in screening positive for ADHD by other characteristics**

**Ethnic group**
No significant association was found between ethnic group and screening positive for ADHD. While this is consistent with findings from the 2007 survey, the small number of minority ethnic participants in the sample should be noted. Table 8.4

**Household type**
People screening positive for ADHD were more likely to live in some types of household than in others. In particular, people living in households with one adult aged under 60 had the highest prevalence of ADHD characteristics (17.7%), while the prevalence was lowest (4.4%) in those living in households consisting of two older adults (aged 60 or over). It should be noted that analysis by household type could not be age-standardised, and it is likely that the association is partly explained by the younger age profile of people screening positive. Table 8.5
Figure 8C: Screen positive for ADHD, by household type

Base: all adults

Region
The prevalence of ADHD characteristics did not vary with region. **Table 8.6**

Educational qualifications
Screening positive for ADHD varied somewhat by highest educational qualification achieved, although this was less pronounced than the association with employment status. People without qualifications were the most likely to score four or more on the ASRS (14.5%). This compares with 11.0% of people whose highest qualifications were GCSE (or equivalent), and 7.7% of those with a degree. A similar pattern was also observed in the 2007 survey data. **Table 8.7**

Employment status
Employment status was strongly associated with screening positive for ADHD. Unemployed people (14.6% of unemployed men and 14.5% of unemployed women) were about twice as likely as those in employment (7.3% of men and 6.7%
of women) to screen positive for ADHD. The employment status associated with the highest rates however, particularly among men, was the ‘economically inactive’ group. This heterogeneous category included students, people looking after the home, those who were long-term sick or disabled, and those taking early retirement (the analysis was run on adults aged 16–64). One in four economically inactive men (23.8%) and one in seven economically inactive women (15.0%) screened positive for ADHD. (See the Glossary for a definition of economic inactivity). Table 8.8

Figure 8D: Screen positive for ADHD, by employment status and sex (age-standardised)
Base: all adults aged 16–64

Benefit status
Benefit status was looked at in relation to three groupings: being in receipt of any out-of-work benefit (including Jobseeker’s Allowance and Employment and Support Allowance (ESA)), receiving an out-of-work benefit specifically related to disability (specifically ESA), and living in a household that received housing benefit support with rent. Analysis by out-of-work benefits were based on those aged 16 to 64 years. These categories are further described in the Glossary.
Screening positive for ADHD was higher in each of these groups than in people not in receipt of the benefits. The strength of association was greatest among those receiving ESA. One in three people in this group (35.1% of men and 35.5% of women) screened positive for ADHD, compared with one in eleven (9.0% of men and 8.6% of women) not receiving an out-of-work disability benefit.

Table 8.9

Table 8E: Screen positive for ADHD, by receipt of Employment and Support Allowance and sex

Base: all adults aged 16–64

<table>
<thead>
<tr>
<th>Recipient of Employment and Support Allowance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

Treatment and service use

Participants were asked about a range of types of treatment and services. These included current use of psychotropic medication or psychological therapy for a mental or emotional problem, together with the use of a range of health, community and day care services over the last year. Two of the most commonly prescribed ADHD medications were asked about: methylphenidate (e.g. Ritalin,
Concerta, Equasym) and atomoxetine (Strattera). The treatment and service use variables are described in more detail, including variation in their reference periods, in the Glossary.

One in three adults (34.3%) screening positive for ADHD was currently in receipt of medication, counselling or therapy for a mental or emotional problem. This compares with 10.8% of those with ASRS scores of less than four. Adults screening positive for ADHD were five times more likely than those below the threshold to be having counselling or other psychological therapy (10.1%, compared with 2.2%), and three times more likely to be on medication (31.5% of those with a score of four or more were taking psychotropic medication, compared with 9.4% of those scoring less).

More than one in three adults who screened positive (37.4%) reported using health care services for a mental or emotional reason, compared with one in ten of those below the threshold (10.0%). There was a similar pattern in the use of community care and day care services. **Table 8.10**

Among those screening positive, the types of psychotropic medication most likely to be taken were drugs for treating anxiety (27.2%) and depression (27.2%). Only 0.5% of adults who screened positive for ADHD were currently taking medication specifically indicated for ADHD (methylphenidate or atomoxetine). However, it is possible that some participants may have been taking an ADHD preparation not asked about, may have taken an ADHD medication preparation in the past, or could be currently taking methylphenidate or atomoxetine and not reported it (either because they chose to withhold this information or because they were unaware). Adults who scored four or more on the ASRS were more likely to have used every type of service asked about than those who screened negative. **Table 8.11**

7.8% of people screening positive for ADHD reported that they had requested a particular mental health treatment in the past 12 months (not necessarily for ADHD), but had not received the requested treatment. In comparison, 1.0% of people without a positive ADHD screen had requested, but not got, a particular mental health treatment. **Table 8.12**
8.4 Discussion

There is a lack of survey data describing the presence of possible ADHD in the general adult population in England. The circumstances of adults with ADHD are also poorly understood. This chapter presents data on the prevalence of possible ADHD as measured by the six-item ASRS screen previously used in the 2007 survey.

In 2014, 9.7% of the population were identified as having sufficient ADHD characteristics in the last six months to warrant clinical assessment for ADHD. This was slightly higher than the rate found (8.2%) when the survey was last carried out, in 2007. Comparable data have been collected in the US using the same screening tool, with similar population patterns found. Studies that include a fuller assessment of ADHD tend to find a lower prevalence of ADHD (Fayyad et al. 2007; Faraone and Biederman 2005; Kessler et al. 2006), as these studies often factor in reporting of childhood ADHD and adult persistence (Kessler et al. 2006). ADHD-like symptoms in some participants screening positive on the ASRS may have first occurred in adulthood, and perhaps are related to a different adult-onset condition (Faraone and Biederman 2016). They may also reflect adult onset forms of ADHD, perhaps secondary to acquired factors. While these have been identified in recent studies, they have not yet been validated (Moffit et al. 2015). The ASRS does not take account of whether symptoms persist across different aspects of a person’s life, nor how impairing symptoms are. Despite these limitations, the APMS findings are valuable in identifying the population distribution of characteristics associated with possible ADHD that warrant recognition and assessment.

Previous research has identified variations in rates of ADHD by particular socio-demographic factors. Only some of these factors were consistent with the APMS 2014 data (Faraone and Biederman 2005). For example, although no significant variation by sex and ethnic origin was observed, positive screens for the disorder were found to be concentrated in younger age groups, among the unemployed and in those in receipt of benefits. The APMS 2007 survey also highlighted associations with educational attainment and marital status.
The great majority of people screening positive for ADHD did not access treatment for ADHD. However, they were more likely than those screening negative to seek – and not get – treatment and services for mental or emotional reasons. They were also more likely than those screening negative to get other types of mental health treatment. This may reflect the fact that adults screening positive for ADHD often have comorbid diagnoses of other psychiatric conditions (such as depression, anxiety and personality disorders). Alternatively, their ADHD characteristics may be misdiagnosed by doctors not trained to recognise and treat adult ADHD. This interpretation is supported by the very low levels of ADHD medication currently being taken by participants screening positive for ADHD, together with their high levels of anxiolytic and antidepressant use. It is worth noting, however, that the APMS cannot be used to estimate how many adults would be likely to benefit from treatment.

Progress is being made with the development of best practice advice and guidelines on care for adults with ADHD, which identifies key priorities for treatment and management of the disorder (Nutt et al 2007). These APMS findings have clearly identified the need for further work in improving the diagnosis and treatment of adult ADHD, both at the population level where precise screening tools need to be developed in relation to clinical assessments of the general population, and in clinical practice. Further analyses of the APMS 2014 data are underway in this area.

8.5 Tables

**Prevalence and trends**

Table 8.1  Number of ADHD characteristics present in the past six months, by age and sex

Table 8.2  Screen positive for ADHD in past six months in 2007 and 2014, by age and sex

Table 8.3  Screen positive for ADHD in past six months, by self-diagnosis and professional diagnosis of ADHD
Characteristics
Table 8.4 Screen positive for ADHD in the past six months (observed and age-standardised), by ethnic group and sex
Table 8.5 Screen positive for ADHD in the past six months, by household type and sex
Table 8.6 Screen positive for ADHD in the past six months (observed and age-standardised), by region and sex
Table 8.7 Screen positive for ADHD in the past six months (age-standardised), by highest educational qualification and sex
Table 8.8 Screen positive for ADHD in the past six months (age-standardised), by employment status and sex
Table 8.9 Screen positive for ADHD in the past six months (age-standardised), by benefit status and sex

Treatment and service use
Table 8.10 Treatment and service use, by ASRS score
Table 8.11 Psychotropic medication currently taken, by ASRS score
Table 8.12 Requested but not received a particular mental health treatment in the past 12 months, by ASRS score

8.6 References


This chapter should be cited as: