

Attention Deficit Hyperactivity Disorder in Prison: A Treatment Protocol

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Prescribing controlled substances in correctional settings can create challenges for security, nursing, and psychiatric staff. Some inmates, including those with functionally significant attention deficit hyperactivity disorder (ADHD), however, can benefit from such treatment. This article describes the development of a protocol for the treatment of prison inmates with ADHD that attempted to address a broad range of concerns including disparate diagnostic and treatment standards among prison psychiatrists, conflicts between stakeholders, and medication misuse and substance abuse among inmates. The protocol provides criteria in four main areas: diagnosis, current functional impairment, treatment in general, and treatment with stimulants. Stakeholders had mixed reactions to the protocol.

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Few aspects of correctional psychiatry engender the degree of controversy and vexing challenges that arise with the use of controlled substances. Treating attention deficit hyperactivity disorder (ADHD) in correctional settings can create significant problems. As with the prescription of any controlled substance, potentially serious consequences arise when inmates have access to stimulant medications. Some inmates feign symptoms in an attempt to get medications that can be abused or bartered. The high prevalence of substance dependence and abuse among inmates adds to this concern.¹ Differentiating malingerers from truly impaired patients can consume staff time and lead to contentious interactions with drug-seeking inmates. Security problems also arise when medications are diverted and traded within a facility, either because of successful deceptions or when legitimate patients conceal and surrender their medications under duress from predatory inmates. For nursing staff, handling controlled medications involves special storage, monitoring, administration, and documentation that can strain time and resources. Concerns about malingering, security risks,

and demands on time and resources have led some commentators to discourage strongly the availability of sympathomimetics on the formularies of adult correctional facilities.²

Despite legitimate concerns about treating inmates with controlled substances, ADHD remains a significant disorder with potentially serious consequences that often persist into adulthood.^{3–7} Some data suggest that the rate of ADHD among prison inmates significantly exceeds the prevalence in community settings.^{8–14} Untreated inmates can experience functional impairments that interfere with their ability to participate in work, programming, and educational activities. In addition, impulsivity can contribute to behavioral problems and disciplinary infractions. Effective treatment, which often requires stimulant medications, improves functioning and relieves distress for many patients,^{5,6,15,16} including inmates.¹⁷ A complete prohibition of such treatment would deprive appropriate inmates of beneficial treatment and result in preventable individual dysfunction and institutional disruptions.

Unmonitored prescribing of controlled substances, however, creates its own problems. Inconsistent standards and prescriber variability in use of diagnostic and treatment criteria can result in disorganization and discord. Inmates may pressure conservative prescribers to behave more like their liberal colleagues, while security and nursing staff may pressure liberal prescribers to be-

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come more conservative. When inmates transfer between facilities, conservative practitioners might inherit patients who are already on stimulants and are resistant to coming off them. The lack of explicit guidelines for medication use or an independent approval process leaves the individual psychiatrist with little support for difficult decisions on whether to prescribe stimulants.

Unless stimulants are to be entirely restricted, correctional systems must develop approaches to their use that address the risks and concerns. In 2004, the University of Massachusetts Correctional Health (UMCH) program sought to do this by developing a protocol for the treatment of ADHD in the Massachusetts prison system. In addition to addressing the concerns already noted, the purpose of this initiative included two major goals. The first was to foster greater diagnostic and treatment consistency in a multi-prescriber environment. The second was to support reasonable and appropriate prescription practices by implementing more consistent standards and a prior approval process that could shield practitioners from excessive pressure about their treatment decisions. For example, a protocol with explicit diagnostic and treatment guidelines could support individual practitioners in their decisions not to prescribe stimulant medications when inmates file grievances, complaints, or litigation for failure to treat. Alternatively, the approval process could diffuse some of the pressures against practitioners who prescribe stimulants.

Developing the Protocol

The core group tasked with designing the protocol included the author of this article, who served at that time as director of the overall correctional mental health program provided by UMCH to the Massachusetts Department of Correction (DOC); and the program's discipline chiefs from psychiatry, psychology, and social work. The process of developing the protocol involved literature review, expert consultation, and discussions with and feedback from stakeholders. The literature review focused both on the extensive publications about ADHD diagnosis and treatment in general and on the more limited literature on ADHD in correctional settings. We also had informal contacts with local and national experts in psychopharmacology and ADHD treatment and in correctional mental health care.

Considerable effort went into consultations with key stakeholders. At the start of the project, we re-

viewed the underlying concerns with all clinical and administrative staff; we informed them that a protocol would be developed; and we solicited their initial suggestions and comments. Special outreach was made to our psychiatry staff, prison site-based mental health clinical administrators, nursing administrators, nonpsychiatric physicians, and statewide DOC administrators. During the year that it took to complete the final draft, the developing policy was discussed at multiple meetings, especially with psychiatry staff and site-based mental health clinical administrators. These groups, along with nursing, medical, and DOC leadership, received early drafts of the protocol for their feedback. In addition to group meetings, we received written feedback and we met individually or in small groups with concerned stakeholders.

Although a broad spectrum of clinical and security staff had opportunities to comment on the development of the protocol, some potentially noteworthy groups of stakeholders did not. We did not solicit input from inmates or from community organizations or advocates. None of these groups typically plays a direct role in policy development within the DOC in general, and the ADHD protocol was no exception. Perhaps not surprisingly, many of the most vocal objections to the policy after its implementation came from these groups, as described later.

Reactions from stakeholders during the development of the protocol ranged from enthusiastic support to dismay and irritation. On one extreme, some individuals opined that controlled substances should simply have no place in a correctional setting and that a protocol that allowed and sanctioned their use was misguided at best. On the other end of the spectrum, some of the more liberal prescribers felt personally targeted by the development of the protocol and viewed it as an unjustified infringement on their clinical independence and discretion. The more common reaction, however, consisted of cautious optimism. Although some stakeholders indicated that they would reserve judgment until seeing the final product and its effects, many expressed hope that a protocol would have the desired results, including increased consistency of practice and decreased medication misuse.

Provisions of the Protocol

The protocol addresses four main areas: diagnosis, current functioning, treatment in general, and treat-

ment with stimulants. Thresholds and requirements have been set for each of these areas, but the protocol allows the psychiatrist serving as mental health program director to authorize exceptions to any of the provisions of the protocol on a case-by-case basis. The protocol requires treating psychiatrists to obtain prior approval from a supervising psychiatrist or from the mental health program director before commencing any treatment for ADHD.

As part of the diagnostic assessment, the inmate must provide evidence consistent with the diagnosis of ADHD before the age of 12. In general, this evidence should be more than just self-report. It can consist of written or oral documentation from parents, teachers, treatment providers, or other sources. Although current diagnostic criteria as specified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)¹⁸ require evidence of symptoms causing impairment before age seven, we believed that this would set too high a threshold for documentation by adult inmates and that age 12 was more reasonable. This loosening of the age requirement seemed justified by findings that a significant number of children who likely have ADHD fail to show impairment before age seven,¹⁹ a finding that has led some commentators to call for raising the age of onset criterion to age 12.²⁰ The difficulty that adults in general have in recalling or providing evidence of symptoms and impairments during childhood²¹ and the limited empirical support for using age seven as a threshold have also led some experts to call for setting evidence before age 12 or the onset of puberty as a more appropriate criterion when diagnosing ADHD in adults.²² The evidence and support for loosening the age criterion has continued to mount since the development of our protocol.^{23,24} After implementation of the protocol, we allowed this criterion to be met with a relatively low threshold of documentation and the most frequent use of the provision for exceptions by the program director because of the understandable difficulty that some inmates have in providing childhood data.

The protocol also requires psychological testing by a doctoral psychologist as part of the diagnostic work-up. Testing includes a diagnostic interview, a self-report instrument, assessment of cognition and attention, and assessment for malingering. We recognized that such tests might have limited diagnostic validity for ADHD, but they could still aid in the accuracy of the diagnosis and in delineating the

extent of functional impairments. For these reasons, the test results must be reviewed by the treatment providers, but no threshold test findings are required before making the diagnosis or commencing treatment.

Along with establishing diagnostic requirements, the protocol emphasizes that an assessment of current functioning should generally precede the more labor-intensive interventions such as testing. To qualify for treatment, the inmate must have clinically significant impairment in areas such as ability to function in the general prison population, ability to participate in programming, or ability to perform work assignments. Data on functioning obtained from the diagnostic process and the inmate's self-report generally must be corroborated by collateral sources, such as corrections officers, administrators, teachers, work supervisors, program officers, and health care staff. The key to this part of the assessment is the focus on current environmental demands and activities rather than on past functional difficulties in other community or correctional settings.

Patients who meet the protocol's assessment requirements must cooperate on an ongoing basis with nonpharmacological treatment recommendations, such as individual or group therapies, to be eligible for pharmacologic interventions. Group interventions may focus on areas such as organizational skills, self-esteem, and education about the disorder.^{25,26} Meaningful participation can improve functioning and confirm the inmate's investment in the treatment process. Initial pharmacologic treatment is with nonstimulant medications (e.g., tricyclic antidepressants, bupropion, and venlafaxine), unless the inmate has clear contraindications or well-documented lack of response to adequate past trials of nonstimulants. When we developed the protocol, atomoxetine had not been added to the statewide formulary, which applied to all state agencies, largely because of questions about whether it had superior efficacy compared with other less costly nonstimulants.

Treatment with stimulants can occur only after a failure of a complete trial of one or more nonstimulant agents, or when such trials are contraindicated. The decision to treat with stimulants also requires a review of the patient's substance abuse history for potential contraindications to stimulants. The pharmacy must receive prior approval from a senior supervising psychiatrist and annual reapprovals before beginning or continuing to dispense stimulants. The

approval process is initiated through submission, by the treating psychiatrist, of a one-page form that includes prompts for diagnostic, functional, past treatment, and nonpharmacologic treatment information.

Additional constraints on treatment with stimulant medications include use of crushable, immediate-release medications, which lessens the risk of medication diversion and misuse, unless there is documentation of the functional necessity for use of sustained-release medications. Ongoing treatment requires documentation of objective improvement in functioning, including corroborating information from collateral sources. Stimulant use also must be discontinued if the inmate diverts or otherwise misuses the medication.

Reactions to the Protocol

The protocol went into effect in early 2005 and underwent minor revisions in late 2005. Reactions, both formal and informal, from stakeholders were mixed. Psychiatrists and other mental health professionals were especially ambivalent. On the positive end, some of them noticed a decrease in inappropriate medication-seeking presumably related to the protocol's requirements for childhood information, objective functional impairment, participation in nonpharmacological treatments, and preference for nonstimulant medications. The protocol also deflected some conflicts away from the patient-psychiatrist dyad because denial of stimulants could be attributed to the protocol or to supervisor review. Some conflicts with nursing and security staff were similarly attenuated because they perceived that treatment had been vetted through the standards and approval process established by the protocol. Negative responses from psychiatrists typically involved perceptions that the protocol was too restrictive, and dissatisfaction with the impingement on clinical autonomy and the documentation requirements. In contrast, some practitioners opined that the protocol was not restrictive enough or that any availability of stimulants perpetuated demands on their time and ongoing conflicts from drug-seeking inmates. Even some psychiatrists who prescribe stimulants and otherwise support their availability expressed the opinion that their jobs would be easier with a complete ban.

The response from nursing and correctional staff was generally positive. Many appeared to view the protocol as responsive to their concerns, especially in

that it limits stimulant use to inmates with demonstrable needs and provides effective mechanisms to discontinue medications if they are abused. Concerns expressed by these groups about unbridled or inappropriate medication use diminished significantly after implementation of the protocol. Nevertheless, some negative responses continued, often based on opposition to use of controlled substances in prison for any reason.

Responses from inmates included several formal grievances from some who did not meet treatment criteria under the protocol. Most of these grievances, and at least four cases of threatened or actual litigation, involved inmates who were denied stimulants due to confirmed misuse or abuse of their medications (e.g., hoarding) or contemporaneous misuse or abuse of other medications or illicit substances.

Responses by external reviewers from the community also were primarily critical. Their criticisms involved three main contentions: the diagnostic criteria, such as diagnostic data before age 12, were too restrictive; the protocol would exclude many inmates who would benefit from treatment resulting in unnecessary discomfort or behavioral problems; and several psychiatrists in the system told the reviewers that they objected to the protocol's restrictions and the manner in which it was implemented. Although we had chosen a less restrictive age threshold than the one specified in the DSM-IV, some reviewers argued that diagnostic criteria in general and testing do not necessarily predict who will benefit from treatment, and therefore they should not be used to restrict treatment. The repeated opportunities for feedback during the development of the protocol also apparently did not mollify some of the dissatisfaction with its final provisions or the fundamental objection by some psychiatrists to oversight of their practice.

The range of reactions from stakeholders persisted during the first two years of the protocol. Although some individuals remained dissatisfied for the reasons previously mentioned, much of the pre-protocol discord over the use of stimulants for inmates with ADHD disappeared. The new procedures appeared to address many of the prior concerns about treatment of inmates with ADHD.

Conclusion

Whether and when to prescribe stimulant medications for inmates with ADHD are questions that evoke strong, and sometimes passionate, reactions.

At the extremes, the options include either *de facto* bans or unmonitored use. Our experience demonstrates that adopting an approach between these two extremes can involve clinical, administrative, political, and even legal challenges. Nevertheless, correctional systems need to find ways to balance the legitimate functional needs of inmates with ADHD against the risks of introducing controlled substances into their institutions. The protocol described in this article represents one attempt to do that.

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