Examining AD/HD's Role in Incarceration

By Stanley Kapuchinski, M.D.

Anyone who has had the experience of a child with Attention-Deficit/Hyperactivity Disorder (AD/HD) knows that there can be tornado-like energy crammed into a small body. He, and it more often is a "he," acts or speaks without thinking, cannot sit still or wait his turn. He may have trouble with his temper, have tantrums or exhibit aggressive behavior by pushing, shoving or biting anyone who gets in his way. He is constantly on the move.

The hyperactive child can frequently be into "mischief." He can be the daredevil who walks on the roof of the house, climbs to the top of the highest tree and has more than his share of skinned knees, cuts and broken bones. He does not surprise his parents if he gets into frequent trouble with neighbors, friends or classmates. He can be the child for whom the many books on dealing with your AD/HD child have that special chapter entitled, "What to do When Nothing Seems to Work."

The hyperactive child can be easily bored. At times, play like video games, fast biking or downhill skiing (never repetitive cross country) Ñ things that have constant motion and change built into them and are not repetitive, can hold his interest. To be successful, his fun must be new, challenging and ever-changing. It would be ideal if it were made of the stuff that parents approved of Ñ e.g., sports, reading, hobbies or pursuits needing imagination and creativity. But unfortunately, new, exciting and challenging pastimes can also contain the more troublesome side of behaviors such as starting fires with lighter fluid or gasoline, taking the car out for a drive (at age 7), vandalism, stealing, assaults, drugs or alcohol. School problems can go from frequent detentions and calls home to parents, to suspensions and expulsions, even from elementary school.

The hyperactive child can also be impulsive with his rashness, easily leading to doing "dumb" things and not necessarily knowing why. It is acting before thinking, even though the child can get immediately into trouble. When the "NIKE" ad proclaims "just do it!" Ñ the hyperactive/impulsive child does!

There is a convincing amount of research suggesting that children with AD/HD are at a significantly higher risk to have involvement with the law and substance-related disorders (Manuzza et al., 1998; Forehand et al., 1991). It is estimated that 30-50 percent of AD/HD children, mostly boys, also acquire the psychiatric diagnosis of conduct disorder (Biederman et al., 1991, Newcorn & Halperin, 1994) exhibiting behaviors which include stealing, lying, fighting, trespassing, truancy, low grades and

sometimes drug and/or alcohol abuse. Psychiatry defines conduct disorder as "a persistent pattern of behavior in which the basic rights of others or major, societal norms or rules are violated" (DSM-IV-R, 1994.) It is here where his actions start to go beyond just family and school problems and involve the legal system. Early on, sentences can be court stipulations (e.g., to do community service) or probationary periods. However, since a person with AD/HD does not hold following rules and doing repetitive tasks high on the list of favorite pastimes, further infractions can occur with incarceration, at some point, becoming an outcome.

Although substantial data points to the fact that AD/HD/conduct disorder children grow into the anti-social personality disorder (the adult lawbreaker), there is scant information on the prevalence of AD/HD adults who are incarcerated. One article (Eyestone & Howell, 1994) found that 25 percent of 100 inmates in a prison had an AD/HD diagnosis. This amount far exceeds the prevalence of AD/HD in the general population, where 6-9 percent of children have the diagnosis and only 30 percent carry it into adulthood.

What this may mean is that there may very well be a significant number of incarcerated men with AD/HD who continue to go undiagnosed and treated. In the prison setting, they are more frequently labeled as troublemakers, guys with "attitudes," people out of control and needing to be closely guarded or men who are just plain hopeless and do not want to help themselves. Their impulsive behavior continues to keep them in a revolving door of release and return to prison. Purely from a financial viewpoint, this undoubtedly increases manpower hours and general costs to prison systems (and ultimately the taxpayer) throughout the country. What is the most concern, however, is that many of these men feel like "losers" with no hope of changing. The reality is that there is much hope for them to change themselves and their lives. The tragedy is that they continue to go undiagnosed and untreated.

Working as a consultant psychiatrist to a prison system, my experience with AD/HD in inmates began with serendipity. A few years ago, an inmate in the prison where I consult saw a TV program on AD/HD and sought out an appointment by my department. As he sat in the waiting room, he certainly seemed "hyper" with his ever moving "dancing feet" and tapping fingers. When finally seen, he proclaimed to me that his life and behavior was exactly like the person with AD/HD described in the television program.

A review of his past and present medical histories (to eliminate other problems that could look like AD/HD, e.g., bipolar illness, conduct disorder, schizophrenia and Tourette's), his childhood records, completed AD/HD questionnaires, as well as

communication with his parents, indicated that this man was, indeed, correct. He had adult AD/HD.

As we uncovered more and more individuals with this diagnosis, it became clear that this inmate's history was one that was frequently repeated in others. He had been a "very active boy" for as long as he could remember. Because of his behavior, he had been expelled from three grammar schools (two public, one private) by the time he was eight years old. He began using alcohol at age 10 and marijuana by age 11. The stealing started earlier and progressed to cars by age 12. Despite being very bright, he had dropped out of school at an early age. He began using various hard drugs (cocaine, heroin and crack) in his teens, but found alcohol to be his drug of choice. Harassing his ex-wife over the phone (he had had a restraining order against him after previously assaulting her) had led to his incarceration. Once in prison, he was labeled an "attitude problem" because of his outspoken behavior, and received many disciplinary citations.

It has been three years since this man brought himself to my attention and began receiving treatment. Today, he is a different individual. He has returned to school and is taking college courses; he holds a steady prison job, has had no more disciplinary problems and is very focused on his future.

The recurring pattern that we found in numerous cases was of extreme behavioral problems at an early age. (One man remembered being put into a chicken-wire cage when he was five because he was so out of control) and severe school difficulties (grades and behavior). There were problems with the law by at least age 10 Ñ early marijuana and/or alcohol abuse going to hard drugs in the teens, as well as various forms of aggressiveness including fighting, assaults, rapes, breach of peace charges and vandalism. (One man had been convicted of two counts of attempted murder at age 12.)

If these men had relationships, they were always in conflict. Many of the men were not only divorced, but also abandoned by their families. Not surprisingly, those who had children frequently identified their kids as "following in my footsteps" with legal problems. Some of the children had already been diagnosed with AD/HD and were receiving treatment.

Many of the older men (over 40) expressed futility and despair in trying to change or better control what they said and did. They stated that they had reached a point of not caring anymore about changing, accepted their being out of control and had the attitude that "Whatever happens,. happens."

The prison program has now had about 75 men who have been or are being treated for AD/HD. The vast majority of these people have the combined type with their hyperactivity and impulsiveness quite apparent. Their ages run from late teens to late fifties. With a rare exception, they all have had a serious drug abuse problem. These are people who would say, "If it was out there, I'd abuse it!" This includes sniffing airplane glue or gasoline, smoking marijuana laced with embalming fluid or injecting "speedballs" (a combination of heroin and cocaine) into their veins. Very often and despite their severe drug use, they had "K-sign." This was (despite a tendency to abuse everything) a dislike for stimulants. They would not get the usual "high" from a stimulant (such as amphetamines or cocaine) so they stopped using it. They had the same paradoxical response to psychostimulants as those with AD/HD do. Instead of being "hyped-up," they were calmed down. One man said, "There I was with everyone jumping around the place high on coke and I wanted to sit down and have a conversation!" Another man said he loved cocaine, not for the high, but "because it just kept me from running in circles. It got me to relax better, focus on everything. When I'm high (on cocaine), I'm like a normal person." This man was self-medicating. Unfortunately, it was with an illegal substance. Because of the extremes of their aggressive and assaultive behaviors, they frequently have had disciplinary actions against them.

The treatment of incarcerated individuals with AD/HD encompasses various approaches. These include one-on-one sessions to educate them about AD/HD (why he acts the way he does) and to teach better skills in dealing with life. There is also group therapy and medication management. Other members of the mental health staff who screen inmates new to the system have been educated as to the signs and symptoms of AD/HD and often refer the men for treatment. As the program grew, referrals came from inmates in the program who recognized their symptoms in others.

Each man's past history, family history and previous treatments are gathered and confirmed, if possible. He is given a detailed questionnaire to elicit symptoms of AD/HD and is then interviewed individually. Most of the men have had continued behavioral problems after being incarcerated.

Medication to treat AD/HD (and the less frequently seen inattentive type of ADD) is often used. If this is not helpful or cannot be used, we try other remedies in hopes of giving the man any resource to help him experience a better sense of control in behavior and attention span. We also use non-stimulant medicines such as buproprion, doxepin, clonidine, imipramine and others as adjuncts or by themselves.

The results, thus far, are very hopeful. Men who had not read a magazine article (let

alone a book) in many years because of their severe distractibility, are reading and going back to school. Men with creative skills such as writing or drawing but who could never finish anything, are now following through and discovering their talent and maybe, some confidence for the first time in their lives.

They are also finding those few extra seconds to think before they act. They feel in control of themselves. Because of this, there are less rule infractions, less fighting and less agitation that requires less of staff time. This allows prison manpower to be used elsewhere in more productive ways and reduces costs.

The group therapy sessions are held (an accomplishment in itself just getting 10 or 12 men with hyperactivity to sit still, wait their turn and talk with each other) to discuss how to handle relationships better, how to deal with anger and volatility, how to put their past in the context of AD/HD, and how medication works. The group is also used to cultivate cohesiveness among the men to preserve the integrity of the program.

The biggest problem encountered so far has occurred when it is time for a man to leave prison. If he is to be released on parole, many times there is a stipulation that he go to a halfway house geared for substance abusers. Very often, these places refuse to take men on medication. If a man is released directly 'into the street,' we always set up an appointment with a mental health clinic for follow-up care. More often than not, the clinic contacted is extremely cautious about accepting a person with a substance abuse problem. Usually, there is much paperwork and reassurance on our part before the appointment is given and medication continued.

To date, little information is available about how these men fare once out of the prison structure and on their own. Despite their improved way of acting and thinking, the education they have received about AD/HD and the ways it can affect them, many who leave prison with a firm resolve can still wind up going back to old habits.

What we do know, however, is that the likelihood of individuals with AD/HD who are in prison is high and that treatment for them can be extremely effective. We are very hopeful that with treatment, especially at an early age, we can help break their cycle of recurrent drug abuse and re-incarceration. A recent article supports our hope (Biederman et al., 1999). It stresses that, as with adults, "untreated AD/HD was a significant risk factor in substance use disorder (SUD) in adolescents. In contrast, pharmacotherapy was associated with an 85 percent reduction in risk for SUD in AD/HD youth."

We have seen that these men can attain a better sense of control in their lives, resume

their schooling or work on other skills and find a new sense of self-confidence and pride. They can become productive (for some for the first time in their lives). They have gone from hopeless individuals to ones with a positive future.

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