Pathways to social failure within the ADHD community - it's criminal how much we get wrong.

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Abstract

People with ADHD are much more likely to encounter difficulties at school, at work and socially. They are more liable than the general population to misuse drugs and to commit criminal acts. Management of ADHD involves far more than simply decreasing the scores on behavioural scales. Because the consequences of the impairment of executive function can be so profound, attention needs to be paid to ways in which these deficits can be overcome by adopting a broader approach to assessment and management.

Introduction

Whilst watching my 14 year old daughter play competitive hockey last weekend I was drawn to a parallel of life that relates strongly to the subject under discussion in this paper.
One of her team mates was struck in the face by the ball, never a pleasant experience. Naturally people flocked to assist her and make sure she was all right. Whilst this was going on, and throughout the morning, a young lad had been climbing up the railings, running round and shouting at his parents. No-one was flocking to his or their assistance or setting out to see if he was OK. In fact they were avoiding them as a family. He was not OK. He was bored. He had no one to mix with and play with and he was frustrated. Knowing him, and his parents, I suspect to this day he has a behavioural disorder such as ADHD. That is the issue. I knew the girl had been hit in the face, and needed help. I could only suspect the lad was poorly, and most people around had no clue as to what could have been wrong and what to do. They shunned him. ADHD is an unseen disability. Yes, we see the manifestations of the disorder, but we do not see the cause. That affects how we react.

In this paper I seek to outline a number of entry pathways that are frequently 'taken' by the young person with ADHD into what I label 'negative social outcomes'. Often seen as failures for the individual, I argue that it is the professionals working with these young people that have failed them if this is the outcome. Low self-esteem, unlawful drug taking, acquisitive crime, road deaths and injuries are all discussed with an over-riding message that in clinical settings more can be done to reduce these risks if the clinician is sensitised to the issues above and beyond their understanding of rating scales and behavioural measurement charts.

My thesis is that the unseen nature of the disorder, ADHD in conjunction with, but not reliant on, co-occurring conditions, gives rise to a heightened risk of criminal behaviour in adolescents and adults. We have a low tolerance for 'abnormal behaviours' and the law sets tolerances about what is acceptable often, if not at all times, regardless of the causes of errant behaviour. Those facts alone heighten the risk of young people with ADHD coming into contact with the legal system.

Pathways to Success or Failure

ADHD is commonly referred to as 'a neuropsychiatric disorder that becomes apparent when the child's functioning is negatively impacted upon by inattention, hyperactivity and impulsivity' (1). I find that definition to be stifling, and by using three words that have become the common language, we do little to assist in people's understanding of what ADHD really is. This therefore constrains what we do about it.

To be able to see forward into the predictable outcomes for a person with ADHD, which are more often

than not negative outcomes, a more meaningful definition is necessary. I find that defining ADHD in terms of executive function impairments assists practitioners to recognise the impact on life and the scale of the issues more readily. Executive functioning is described as 'neurocognitive processes that maintain an appropriate problem-solving set to attain a later goal: in particular responses to inhibition, vigilance, working memory, and planning' (2). Barkley (3) and other commentators are clear on the link.

ADHD is a deficit in self-control – what some professionals call the executive functions, critical to carrying out human behaviour over time.

Brown breaks down executive functioning into 6 key areas, all of which operate in unison in the human brain, a fact that he states separates us out from other animals on the planet (4). When these key areas are drawn to the attention of professionals I have found that they begin to observe and grasp how deficits in these areas can lead to a social crisis for the person with ADHD. Their understanding is far greater through this analytical route than by merely discussing inattention, hyperactivity and impulsivity. Brown has summarised the areas of executive functioning as follows.

- Organising, prioritising and activating work
- Focusing, sustaining and shifting attention to tasks
- Regulating alertness, sustaining effort and processing speed
- Managing frustration and modulating emotions
- Utilising working memory and assessing recall
- Monitoring and self regulating action

A lengthy analysis of executive functioning is not possible in a brief paper. My aim is to stimulate debate on how awareness of this functioning capability and its deficits can lead to a more appropriate care regime, one that aims at improving social outcomes rather than only reducing symptoms. This care regime commences within the medical provision and clinical setting. In real-life terms and by way of an example, consider the following.

Imagine crossing a road alone for the first time. The difficulties that this may pose for any youngster are many fold. Now imagine you have ADHD and your ability to function executively is greatly reduced. This is now not a frustrating task, it is a dangerous one. Judging traffic speeds, regulating action to a point where you will stop on the pavement long enough to cross safely, recalling what went on from your left whilst looking to your right, organising your thoughts to block out distractions and to focus on the road width, approaching cars speed, etc, staying alert and thinking to act expediently when safe... It is all too obvious where this exercise can and does go wrong. In 1998 DiScala concluded that those with ADHD, in particular boys, were significantly more likely to be injured as pedestrians and severely injured (12.5% v 5.4%), as measured by the Injury Severity Score (5).

This is a fundamental point relating ADHD to life outcomes; it is not just about distracted children in the classroom – it is real everyday life that can and should be the focus of management by all professionals charged with responsibility.

However, the school setting is very important. Within the school setting, executive functioning is a major contributor to success, or often for those with ADHD, lack of it. Practitioners recognise, for ICD 10 or DSM IV and other current assessment criteria, that the school setting is a primary source of evidence for impairment. Studies found that students with ADHD, compared to students without ADHD, had persistent academic difficulties that resulted in lower average marks, more failed grades, more expulsions, increased dropout rates, and a lower rate of college undergraduate completion (6). In 2004 the UK Audit commission reported that children excluded from school are twice as likely to commit crime. Biederman reported in 2006 that the suspension rate for school aged children with ADHD was significantly higher than those without (21% v 71%) (7). Research in both the UK and US

(8) found that children with ADHD are noticeably shunned by their peers from the age of 6 years as a consequence of school behaviour. They are no longer invited to play in the playground, go on after school outings or attend sleep-overs and parties.

This exclusion from friendships and the subsequent drop in self-esteem was said by one young interviewee to be 'the most impactive and upsetting time in my life' (9). The constant lowering of self-esteem leads inevitably to inappropriate friendships, and for boys this is frequently with older boys. Many case studies report the typical escalation of actions that arise from such friendships: feeling a sense of belonging for the first time, proving ability by currying favour, stealing when challenged from a parent, drinking / drug-taking to be part of the [older] group.

Substance abuse is a common co-occurring condition that occurs in the adolescent or adult (10). Molina (11) found that ADHD is a predictor of substance abuse in young people by the age of 16 years. The relationship between illicit substances and ADHD is worthy of further examination (see elsewhere in this issue). Avoidance of this harmful social outcome should be a fundamental concern of medical staff in clinical settings. The taking of unlawful drugs by a person with ADHD has been described as 'a way of stopping the tumble drier in my head' (12) and is very common. However, in contrast to prescribed medications for ADHD, which are approved, titrated, measured and controlled, unlawful self-medication regimes are not, and the heightened risk that results is often life threatening. For over half of the community abusing unlawful drugs, such as heroin, the primary form of income is acquisitive crime (13), such as burglary and vehicle-related theft.

Qualitative research in Newcastle, England undertaken by the University of Central Lancashire (14) on behalf of the author found that the success of treatment regimes for people with ADHD and substance abuse issues is often directly related to the environment and conduct of the clinical setting and its sensitivity to the primary disorder of ADHD: in short, people with ADHD do not perform well in traditional clinical / care settings, with their ADHD becoming a frustration to success.

This is perhaps easily explained by imagining sitting a group down to discuss their unlawful drug taking habits, with say 2 of the 10 attendees having ADHD. The disruptive nature of the disorder to such settings and formalities can and often does cause withdrawal from the programme, and the nature of the rehabilitation processes underway. The almost complete nationwide absence of such clinical sensitivities and awareness can be argued as part of the problem when discussing the high recidivism figures for substance abusers that can be as high as 60% (15). What is clear that completing treatment programmes has a significant effect on substance abusers returning to their unlawful behaviours (16).

The Challenge for Professionals

I therefore challenge professionals, particularly but not exclusively clinical practitioners, to begin to analyse ADHD differently.

1. Ask yourself and the patient about lifestyle in terms of self-esteem; challenge parents to be aware of the need to manage this from the beginning, especially if the child is shunned by peers.

2. Be aware of the increased dangers of road use for young people with ADHD, whether on a bicycle, driving a car or as a pedestrian. Advise parents and carers of these risks at the time of diagnosis and remind them on repeat clinical visits.

3. Coach young people with ADHD (and their carers) on their life skills, particularly with regard to executive functioning as a set of areas for individual plans and coping strategies.

4. See success not as reduced behavioural patterns on rating scales, but as improved social outcomes for the patient and those around them. This is a harder but more rewarding outcome for which to strive.

These are four straightforward areas that, when managed well, can assist a person with ADHD to avoid following pathways to failure. People with ADHD will challenge us in public, on the sports field, in class or in the clinic. The task facing parents, clinicians and other professionals is not only to understand the condition better but also to have a more positive attitude to the individual with ADHD, knowing that sound management can lead to a much better outcome.

Conclusion

Clinical practitioners should adopt treatment regimes that seek to do more than reduce the symptomatology in well-documented rating scales. By assessing the impact of the condition, particularly of the executive function deficits, on the individual's life, treatment should seek to improve longer-term outcomes. As a result, it should be possible for medical teams to reduce the propensity for people with ADHD to fall into a life of crime.

But we should be clear about ADHD and criminal behaviour. ADHD is an explanation and can never be an excuse for errant and disruptive, unlawful behaviour. I have often been held to account for allegedly trying to make excuses for young people's behaviour to let them 'off the hook'. We have a set of laws in the country that we should all seek to abide by. However, the legal process should not be used as an excuse for failing to assess, manage and treat the individual with ADHD in an appropriately professional way.

We have a judicial system that seeks to rehabilitate offenders to prevent laws being broken again. My observation is that with disorders such as ADHD not enough is understood about the drivers that allow lawlessness to manifest, and we can all, whatever the setting, learn and do more for these poorly people. It is especially important, if not vital, for clinicians to push for transition services into adulthood for people with ADHD; how can we allow a system to prevail that treats young people for a period determined by biological age, and just at the time of academic challenge, hormonal development removes the very regime that allows them to executively function because they reach the age of 16. It's a very clear 'welcome card' to the criminal justice system for most, and this is inexcusable.

It is not inevitable that the individual with ADHD will follow a pathway to failure and poor social outcomes, but, in many cases, avoiding this and assuring success will depend on sensitive, skilled management by a multi-discipline team working in harmony.

GP comment.

What have I learned from this paper?

1. Because ADHD is an "unseen" condition, it may go undiagnosed and untreated for long periods.

2. Formal definitions of ADHD are in terms of hyperactivity, inattention and impulsivity but the deficits in the executive function can lead to a much broader range of issues that need to be addressed by the individual, the family and professionals.

3. The deficits in executive function in ADHD imply that there can be problems in organising, sustaining or shifting attention appropriately, sustaining effort and processing speed, managing frustration/emotions, using working memory appropriately, planning, and monitoring with self-regulation of action.

4. The individual with ADHD may not only follow a pathway of social failure but may also encounter the legal system or even be imprisoned. Understanding of the implications of the condition and providing appropriate, timely professional management might lead to a very different pathway.

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