THE DEVELOPMENT OF THE ADHD PATHWAY AT HMYOI FELTHAM

MANAGEMENT OF ADHD IN MALE PRISONERS AGED 15-21YRS

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ADHD

- **Impaired attention:**
  - Easily distracted, making careless mistakes, appearing forgetful/losing things, unable to complete tasks, unable to carry out instructions, difficulty organizing tasks, changing from one task to another without completion
- **Hyperactivity:**
  - Difficulty sitting still, fidgeting, difficulty waiting their turn, interrupting conversations, talking excessively, impatience, excessive physical movement
- **Impulsivity**
  - Impatience, acting without thinking, little or no sense of danger, inability to deal with stress

EPIDEMIOLOGY

- UK survey 5-15yr olds: **3.62% boys** & 0.85% girls had ADHD (Ford et al, 2003)
- Summary rate of **5.3%** worldwide (Polanczyk & colleagues, 2007)
- Prevalence in adults declines with age
  - 15% retained full ADHD diagnosis by age 25yrs
  - 65% fulfilled criteria for ADHD or ADHD in partial remission- i.e. persistence of some symptoms, with impairment, in **two thirds of cases** (Faraone et al, 2006)
- Estimated prevalence of ADHD in adults **3-4%** (Faraone & Biederman, 2005; Kessler et al., 2006)

GUIDELINES

- **NICE**
  - New guideline March 2018
- RCPsych
- ADHD Institute
- European Network ADHD guidelines

- Increased prevalence of ADHD in:
  - Preterm birth
  - **Looked after children and young people**
  - **Children with oppositional defiant disorder or conduct disorder**
  - Children with mood disorders (e.g. anxiety, depression)
  - Family history ADHD
  - Those with epilepsy
  - **Those with Neurodevelopmental disorders (ASD, tic disorders, LD)**
  - Adults with a mental health condition (e.g. psychosis)
  - **Those with a history of substance abuse**
  - **Those within the secure estate**
  - Those with acquired brain injury

DIAGNOSIS

- Specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD
- Not to be made solely on basis of rating scales or observational data
  - Conners' rating scales and the Strengths & Difficulties questionnaire are valuable adjuncts
- Observations (e.g. at school) useful

MANAGEMENT OF ADHD

- Ensure continuity of care
- Comprehensive, holistic shared treatment plan to address
  - Psychological
  - Behavioural
  - Occupational/educational needs
- Severity of symptoms, goals, level of impairment, resilience & protective factors, impact of ND or MH conditions

TREATMENT

- Non-pharmacological and pharmacological treatments
- Healthy lifestyle & exercise
- Personal preferences and concerns
- Effect of other ND or MH conditions on treatment choice
- Importance of adherence to treatment and factors affecting this (e.g. short vs long acting preparations)

- Offer medication if ADHD symptoms having persistent significant impact in at least 1 domain of everyday life after environmental modifications
- Consider non-pharmacological treatment (CBT) for those who have:
  - Made an informed choice not to have medication
  - Difficulty adhering to medication
  - Found medication ineffective/cannot tolerate it
- Consider course of CBT in those who have benefitted from medication but symptoms continue to significantly impact at least one domain of everyday life, addressing:
  - social skills with peers
  - Problem-solving
  - Self-control
  - Active listening skills
  - Dealing with & expressing feelings

MEDICATION CHOICE FOR YOUNG PEOPLE

- **Methylphenidate** first line
- **Lisdexamfetamine** for those who do not respond adequately to methylphenidate
- Dexamfetamine for those who respond to lisdexamfetamine but cannot tolerate the longer effect profile
- Atomoxetine or guanfacine if methylphenidate & lisdexamfetamine cannot be tolerated or they have not responded to separate 6 week trials of each in adequate doses

MEDICATION CHOICE FOR ADULTS

- **Lisdexamfetamine** as first line
- **Methylphenidate** for those whose symptoms are not responding adequately to lisdexamfetamine
- Dexamfetamine for those who respond to lisdexamfetamine but cannot tolerate the longer effect profile
- Atomoxetine if they cannot tolerate lisdexamfetamine or methylphenidate or they have not responded to a 6 week trial of each at adequate doses

- Those with anxiety, tic disorder or autism spectrum disorder to be offered the same medication as others with ADHD
- Consider an atypical antipsychotic (e.g. risperidone) in addition to stimulants if there is co-existing pervasive aggression, rages or irritability causing severe impairment and inadequately responsive to behavioural interventions
- Titrate more slowly & monitor more frequently if there is a ND disorder (ASD, tic disorder LD) or MH disorder (e.g. anxiety, OCD, schizophrenia, BAD, depression, PD, eating disorder, PTSD, substance misuse) or physical health condition (e.g. epilepsy, ABI)

HMYOI FELTHAM

- Originally built in 1854 as an industrial school
- Taken over by the Prison Commissioners in 1910 as their second Borstal institution
- Existing building opened as a Remand Centre in March 1988
- Current HM Prison and Young Offender Institution Feltham formed by the amalgamation of Ashford Remand Centre & Feltham Borstal in 1990/91
- Currently one of 4 establishments in the Youth Justice Board (YJB) commission from the National Offender Management Service (NOMS) to provide specialist custodial places for young people aged 15-18yrs

- Current Roll: 497
  - A-side (age 15+): 157
  - B-side (age 18+): 340

- Current no. on ADHD caseload: 18
  - A-side: 9 (5.7%)
  - B-side: 9 (2.6%)

MANAGEMENT OF ADHD CASELOAD

- 1 x full time Psychiatrist (Specialty Doctor) = assessment, diagnosis, prescribing, monitoring
- 3 x Community Psychiatric Nurses = monitoring of compliance and effect, psychoeducation, liaison with unit staff and educational staff

- Role of the MDT:
  - Occupational Therapists = sleep disorder interventions, stress management, sensory interventions
  - Psychologists = management of co-morbidities (e.g. Anxiety, Depression)
  - LD & SLCT = assessment and interventions re Learning Disability, Social Communication Difficulties, Autism
  - Consultant Forensic Psychiatrist = management of comorbidities

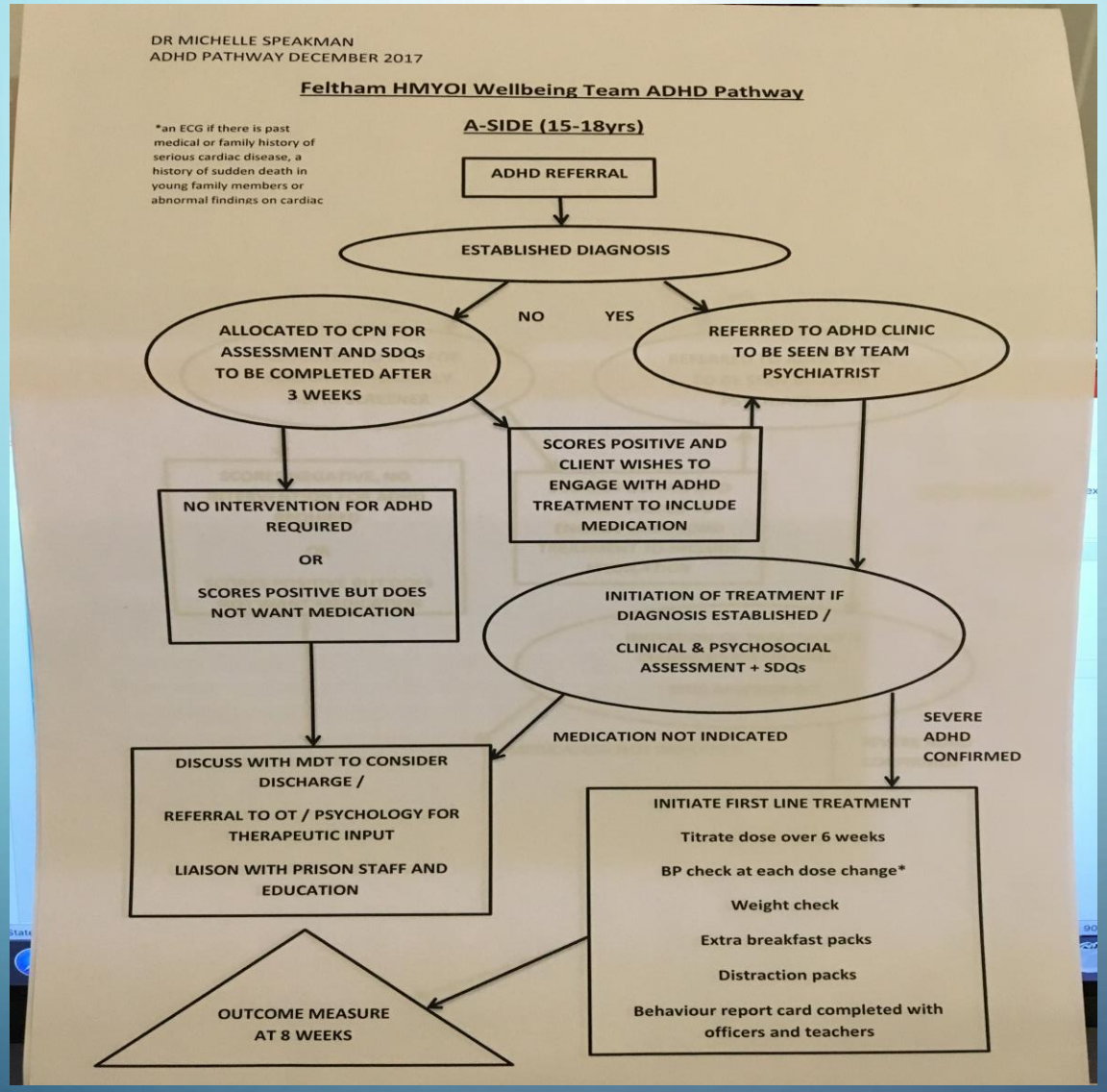
- Current no. on prescribed medication for ADHD: 16
  - Concerta XL: 7
  - Equasym XL: 5
  - Lisdexamfetamine: 2
  - Atomoxetine: 2
- Psychoeducation: 1 (+ referred for CBT for social anxiety)
- Inadequate response & intolerable S.E.s: 1 (lisdexamfetamine switched to methylphenidate)

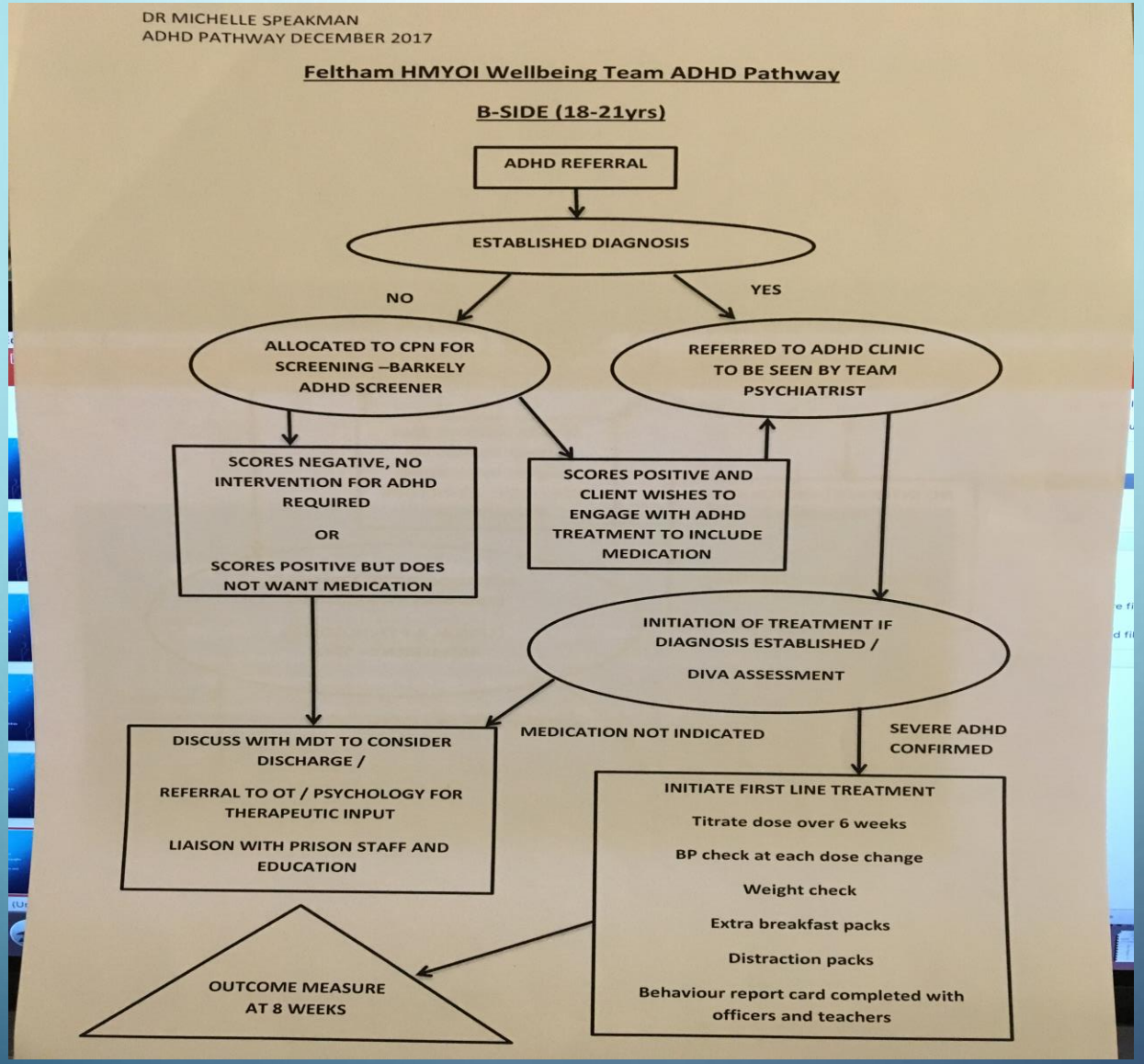
ASSESSMENT

- **Strengths & difficulties questionnaires x 3 on A-side**
- **Adult Self Report Scale (ASRS) on B-side**

- Conners'
- Diagnostic Interview for ADHD in Adults (DIVA 2.0)
- Barkley Adult ADHD Rating Scale–IV (BAARS-IV)

- Conners' & DIVA are lengthy assessments that can take up to 1hr to complete. Is this feasible in the prison setting?


DR MICHELLE SPEAKMAN
ADHD PATHWAY DECEMBER 2017
Feltham HMYOI Wellbeing Team ADHD Pathway
*an ECG if there is past medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac
A-SIDE (15-18yrs)
ADHD REFERRAL
ESTABLISHED DIAGNOSIS
NO
YES
ALLOCATED TO CPN FOR ASSESSMENT AND SDQs TO BE COMPLETED AFTER 3 WEEKS
REFERRED TO ADHD CLINIC TO BE SEEN BY TEAM PSYCHIATRIST
SCORES POSITIVE AND CLIENT WISHES TO ENGAGE WITH ADHD TREATMENT TO INCLUDE MEDICATION
NO INTERVENTION FOR ADHD REQUIRED
OR
SCORES POSITIVE BUT DOES NOT WANT MEDICATION
INITIATION OF TREATMENT IF DIAGNOSIS ESTABLISHED /
CLINICAL & PSYCHOSOCIAL ASSESSMENT + SDQs
MEDICATION NOT INDICATED
SEVERE ADHD CONFIRMED
DISCUSS WITH MDT TO CONSIDER DISCHARGE /
REFERRAL TO OT / PSYCHOLOGY FOR THERAPEUTIC INPUT
LIAISON WITH PRISON STAFF AND EDUCATION
INITIATE FIRST LINE TREATMENT
Titrate dose over 6 weeks
BP check at each dose change*
Weight check
Extra breakfast packs
Distraction packs
Behaviour report card completed with officers and teachers
OUTCOME MEASURE AT 8 WEEKS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Feltham HMYOI Wellbeing Team ADHD Pathway
B-SIDE (18-21yrs)
ADHD REFERRAL
ESTABLISHED DIAGNOSIS
NO
YES
ALLOCATED TO CPN FOR SCREENING –BARKELY ADHD SCREENER
REFERRED TO ADHD CLINIC TO BE SEEN BY TEAM PSYCHIATRIST
SCORES NEGATIVE, NO INTERVENTION FOR ADHD REQUIRED
OR
SCORES POSITIVE BUT DOES NOT WANT MEDICATION
SCORES POSITIVE AND CLIENT WISHES TO ENGAGE WITH ADHD TREATMENT TO INCLUDE MEDICATION
INITIATION OF TREATMENT IF DIAGNOSIS ESTABLISHED /
DIVA ASSESSMENT
MEDICATION NOT INDICATED
SEVERE ADHD CONFIRMED
DISCUSS WITH MDT TO CONSIDER DISCHARGE /
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OUTCOME MEASURE AT 8 WEEKS

AT RELEASE……

- GP follow up
- Referral to local mental health services
- Compliance poor
  - Substance misuse
  - Stigma
  - Already preoccupied with license conditions and probation appointments
  - Lifestyle compatible with feeling ‘energetic’
  - Don’t want to feel ‘unlike themselves’