

The Challenge of ADHD and Youth Offending

Val Harpin¹ and Susan Young^{2*}

1 Consultant Paediatrician, Sheffield Children's NHS Foundation Trust

2 Senior Lecturer in Forensic Clinical Psychology, King's College London, Institute of Psychiatry, UK

Email address:

VH: val.harpin@sch.nhs.uk

SY: susan.young@kcl.ac.uk

* Corresponding Author

Abstract

Research suggests that ADHD youths are vulnerable to committing crimes and that there is a disproportionately high proportion of individuals with ADHD involved with the criminal justice system. UK studies of offenders have indicated around 45% of youths and 24% of male adults screen positive for a childhood history of ADHD, 14% of whom have persisting symptoms in adulthood. Young people with persisting ADHD symptoms begin offending at a significantly younger age and more commonly re-offend. They find it difficult to control their behaviour in institutions and are therefore less likely to be eligible for early release. Although there are international guidelines available for the treatment of ADHD in young people and adults, these do not take into account the more complex and comprehensive interventions serious offenders with ADHD require, such as psychological interventions containing a prosocial competence component. Diagnosis and ongoing intervention should be offered to young people with ADHD who are excluded from school and/or come into contact with the criminal justice system, to try to reduce the risk of offending.

Keywords: ADHD, youth offending, recidivism, intervention, crime, prison.

The relationship between ADHD and offending

Growing evidence is confirming an association between ADHD and offending. Studies published in the 1980s and 1990s reported that ADHD youths were more likely to be arrested, to receive convictions (1-5) and to begin criminal activity at a younger age (6-8).

When comprehensive clinical assessments using DSM-IV criteria are conducted in prison settings, rates of inmates with persistent ADHD symptoms are around 45% for youth offenders (6,7,9) falling to 30% for male adults (8) and 10% for female adults (10). It is likely that reported rates overestimate the real picture, with a high number of false positives being obtained from self-rated checklists for childhood/adulthood symptoms. Nevertheless the rates are undoubtedly considerably higher than community prevalence rates in children of 5% (11) and adults 2.5% (12).

The most comprehensive study to date of the characteristics of male offenders with ADHD was carried out in Aberdeen Prison, Scotland (13-15). This study identified that the group with current ADHD symptoms were significantly younger than the non-ADHD group at the time of first conviction, had more total previous convictions (particularly for property and violent offences) and were more likely to re-offend. Drug and alcohol misuse featured strongly in the sample.

The authors investigated the relationship between childhood ADHD, symptom persistence into adulthood and drug and alcohol use, with the motivation for offending. Offences were categorized into total offences, violent offences, drug offences, property offences and 'other' offences (e.g. breach of bail, criminal damage, arson and sexual offending). When predictors of offending for each category were analysed, the most powerful predictor of total offending was regular heroin use, followed by childhood ADHD. The most striking finding was that the most powerful predictor of violent offending was childhood ADHD, followed by alcohol dependence. Drug offences were predicted by crack

cocaine use, and 'other' offences by heroin use. There were no significant predictors of property offending. A similar pattern of results was found in the model when replacing a childhood history of ADHD with persistent symptoms.

Within the institution, the ADHD prisoners were involved in eight times more aggressive incidents than other prisoners, and six times more incidents when controlling for antisocial personality disorder. An evaluation of the highest frequency (10%) of critical incidents showed a clear relationship between participation in critical incidents and persistence of ADHD symptoms. Thus ADHD inmates are likely to be seen as challenging individuals who are difficult and expensive to manage. Behavioural disturbance within prisons, especially staff assaults and prisoner-on-prisoner assaults, are of major concern and many such aggressive incidents lead to formal adjudications which, in turn, reduce the possibility of early release.

Why are young people with ADHD vulnerable to involvement with the criminal justice system?

1. Engagement in antisocial activities.

Young people with ADHD tend to commit offences that are reactive and opportunistic rather than well planned and organized. They are therefore more easily apprehended. They are more impulsive and less likely to appreciate the seriousness of their actions; 40-60% of children and adolescents with ADHD develop conduct disorder or oppositional defiant disorder (16). Young people with ADHD and these comorbid disruptive disorders appear to have clinically and genetically more severe variants of their independent disorders (17).

2. Coping within the Criminal Justice System.

ADHD youths may be less able to cope with arrest, the police interview and court process. They may struggle to sustain attention during lengthy questioning under pressure or focus on questions whilst involved in other tasks such as looking at exhibits or sketching maps of locations. Young people are more susceptible to interrogative pressure than adults (irrespective of whether they have ADHD or not) and, to avoid this, they are more likely to accept or comply with the suggestions of authority figures (18,19). When adults with ADHD are put under interrogative pressure they may appear evasive by engaging in a strategy of responding "I don't know" even to questions that they should be able to answer. This may be because they do not trust their memory in these circumstances of stress and pressure (20). They may also be motivated to comply with requests and avoid conflict and confrontation (21,22). All of these factors may contribute to the reported increase in false confession by people with ADHD (21,23).

3. In offender Institutions

Once incarcerated, individuals with untreated ADHD, even those in partial remission, seem to have great difficulty tolerating the stress of prison life, resulting in high rates of aggressive incidents in secure settings (24,13,25). Several factors associated with ADHD may contribute to this, including impulsive responding (26), mood instability, low frustration tolerance (27,28) and a chaotic/disorganised personality style (29). Conversely some young offenders may find the structure and security of the institution beneficial, especially when they are provided with education at an appropriate level (30).

4. Re-offending.

Once released, young offenders with ADHD often have little family or community support and they may not have the resources to obtain and hold down a job. They may also have substance misuse disorders and for those who are untreated, substance use may be an attempt to self-medicate (31). Re-offending is frequent and the cycle continues.

Can we reduce the likelihood of young people with ADHD becoming offenders?

ADHD in young people is increasingly being recognised, leading to treatment with psychological and pharmacological methods. There is, however, no robust research into whether current ADHD management strategies will reduce the risk of offending in ADHD youth. Taylor et al. (32) reviewed the current status of young people aged over 14 years in a UK paediatric service and suggested that outcomes could be better than suggested in previous literature. Future research needs to include long-term outcomes for children with ADHD and comorbid conduct disorder. We need much more long-term follow-up data.

Interventions for ADHD offenders

As a neurodevelopmental disorder that crosses the lifespan, the window for intervention is not a one-off opportunity and appropriate interventions can be offered at any age (33). Nevertheless the most effective intervention is prevention. For example, by offering assessment for ADHD at the point of second fixed-term exclusion from school it would be possible to identify some children at risk and ensure they are treated at an earlier stage.

In the UK, the National Institute for Health and Clinical Excellence guidelines (34) recommend treatment with medication as the first-line for children and adults with severe ADHD, and psychological treatment as first-line for those with less severe symptoms. The guidelines state that drug treatment for ADHD should always include a comprehensive treatment programme addressing psychological, behavioural, educational or occupational needs. However, when treating serious offenders with ADHD, even more complex and comprehensive interventions are likely to be needed. The aims of 'treatment' in such cases must be the following.

- (1) Conferring health gain to the individual by reducing ADHD symptoms and associated impairment, improving function and quality of life.
- (2) Rehabilitating the individual by providing targeted treatments, e.g. to address antisocial attitudes and thinking styles, to develop insight into offending and victim empathy.
- (3) Considering public protection issues and reducing risk to society.
- (4) Delivering justice in a fair and reasonable way.

Medication alone is unlikely to achieve these aims fully. There is growing evidence from studies in children suggesting that multimodal treatments (involving psychological and drug treatments) lead to greater effects on comorbidity and greater long-term effects. Indeed, most psychosocial treatments have evolved from interventions designed for children with disruptive behavioural problems (33). By contrast, psychosocial treatments developed for non-offending ADHD adults specifically target the reduction of ADHD symptoms and the improvement of executive function skills, e.g. time-management, planning and organization skills (35,36). If these are provided to offenders with ADHD, the outcome may not be the acquisition of prosocial competence (defined as competence in behaving in a way that benefits others, such as helping, sharing, co-operating and volunteering), but antisocial competence. Thus it is essential that the psychosocial treatments that are delivered to ADHD offenders (and given the high rates of comorbidity with conduct disorder, perhaps also ADHD non-offenders) include a prosocial competence component. One such programme is the R&R2 for ADHD Youths and Adults (37) which is a manualised 15 session CBT group programme. R&R2 is a revision of the earlier R&R programme which has demonstrated high efficacy with a 14% reduction in re-offending when delivered in institutional settings and a 21% reduction when delivered in community settings (38). R&R2 has been evaluated in a randomized controlled trial in a sample of non-offending clinically referred ADHD patients (39). Results suggested medium to large treatment effects for ADHD symptoms, which increased further at three month follow-up. Comorbid problems (anxiety, depression, antisocial behaviour, social functioning) also improved at follow-up, with large effect sizes. Thus antisocial behaviour significantly decreased even though participants were not

specifically referred for this reason. A controlled pilot study of the R&R2 intervention delivered to offenders with severe personality disorder and ADHD symptoms has also reported significant improvements at outcome with medium effect for social problem solving and emotional stability, while reducing ADHD symptoms, violent attitudes and reactive anger (40).

Conclusions

It is now well established that there is a disproportionately high prevalence of ADHD within the prison population. Those who commit non-indictable offences e.g. drunk and disorderly behaviour and less severe acts of public order or criminal damage are also more likely to have ADHD. Individuals with ADHD enter the criminal justice system at a younger age, often as a result of being apprehended for impulsive and violent crimes. They often become 'revolving door' recidivists and their aggressive behaviour within institutions means that they are ineligible for early release. Yet ADHD in young offenders is all too often being missed, misdiagnosed or inadequately treated. Appropriate treatment and support is likely to reduce symptoms, improve behavioural and emotional control, and improve prosocial skills. Moreover, with early recognition and a goal-directed intervention, there is the potential to divert youths away from a criminal trajectory, offering a better future for both the individual and the community. We know the solutions; we just have to start to implement them. Is this so challenging?

GP Comment

What have I learned from this paper?

1. The rate of ADHD in both teenage and adult offenders is high but the condition is often untreated.
2. Early recognition of the ADHD, for example screening for ADHD after a second school exclusion, followed by effective treatment, might prevent some offending behaviour.
3. Management of ADHD should include not only medication but teaching of prosocial skills to prevent offending/re-offending.
4. This paper emphasises two point in particular.
 - First, the need for early recognition of ADHD. This implies that there should be appropriate training and systems for identification in primary care, schools, children's services, social care and young offenders services.
 - Second, the need for access to psychological assessment and treatment for those diagnosed with ADHD.

Dr Morgan Walters, GP, Bedford.

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