ADHD and the Irish Criminal Justice System: The Question of Inertia

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Summary: Studies report ADHD rates of 26% for incarcerated adults and 30% for young people, highlighting an overrepresentation of this cohort within the prison/detention systems. There has been some progress internationally in terms of developing guidelines and protocols for criminal justice practitioners when presented with diagnosed and/or suspected cases of ADHD within the adult and youth justice fields. Further, there is a growing body of literature supporting better outcomes, in terms of reoffending and general life course progression, for those who are identified as having the condition and treated accordingly. However, the Irish system has been slow to make progress in this space. This paper presents international research, discusses why the Irish system has failed to develop a strategy to explore the potential for approaches currently being adopted elsewhere, and makes suggestions for next steps.

Keywords: Attention deficit hyperactivity disorder, diagnosis, treatment, mental health, criminal justice, youth justice.

Introduction

Attention deficit hyperactivity disorder (ADHD) is a common developmental disorder with early onset of symptom presentation (Polanczyk *et al.*, 2007). While it has traditionally been associated with children and young people, there is a growing body of literature directed at the adult population (Ginsberg *et al.*, 2010). The primary symptoms are hyperactivity, inattention and impulsivity, but deficits in executive functioning, such as planning, organisation, self-control, affect regulation and working memory, are also common (Sayal *et al.*, 2018). These variables combined can impact on educational and occupational performance, social skills

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and psychological functioning, thus impairing an individual's life course development and progression (Kessler *et al.*, 2005; Torgersen *et al.*, 2006).

ADHD occurs in 3–5% of school-aged children (Polanczyk, 2007) and 2-4% of adults (Ginsberg *et al.*, 2010). ADHD symptomology presents as pervasive and impairing levels of over-activity, inattention and impulsivity in excess of typical developmental progression (Ginsberg *et al.*, 2010; Sayal *et al.*, 2018). Moreover, deficits in executive functioning, such as planning, organisation, self-control, affect regulation and working memory, are common (Ginsberg *et al.*, 2010). The majority of children with ADHD continue to experience symptoms into teenage years (Barkley *et al.*, 2006), with lifespan persistence evident in approximately 2–4% of adults (Ginsberg *et al.*, 2010). Early onset of ADHD-type presentation is an indicator for this continuation (Wright *et al.*, 2015), with some studies suggesting that obvious ADHD impairment at a young age is associated with higher risk for persistence into adulthood (Ginsberg *et al.*, 2010). Research in the area of adult ADHD has found increased levels of sick leave and unemployment and an increased risk of experiencing abuse, presenting with coexisting conditions and involvement with antisocial behaviour leading to conviction (Kessler *et al.*, 2005; Torgersen *et al.*, 2006). Moreover, children and young people with ADHD are at an increased risk of developing other mental health problems in adulthood (Sayal *et al.*, 2018), with reports suggesting that nearly 80% of adults with ADHD present with at least one other coexisting psychiatric disorder (Sobanski *et al.*, 2007; Torgersen *et al.*, 2006).

A diagnosis of ADHD requires a level of impairment in at least two areas of life to be evident for a duration of at least six months (Young *et al.*, 2015). As a prevalent psychiatric disorder of childhood, ADHD and ADHD-type presentation is the single most frequent reason for attendance at Child and Adolescent Mental Health Services (CAMHS) in Ireland (CAMHS, 2014). Furthermore in Ireland, a large, nationally representative study of 8568 nine-year-olds (Growing Up in Ireland Study) revealed that ADHD diagnosis rates are five times lower than established prevalence rates (Nixon, 2012), highlighting a potential under-diagnosis of children with ADHD in Ireland and thus a failure to provide timely targeted therapeutic input. Even when children are correctly diagnosed, resource limitations within CAMHS mean that they receive very little therapeutic input and support despite the known effectiveness of treatment (Sayal *et al.*, 2018; Sonuga-Barke *et al.*, 2013; Storebo *et al.*, 2015). With ADHD, just as in almost all medical conditions, early detection promotes positive

outcomes (McGorry and Killackey, 2002; Sayal *et al.*, 2018). Similarly, early intervention with ADHD-type presentation is key to preventing behaviour deterioration and problematic outcomes in terms of life course progressions (Fletcher and Wolfe, 2009).

One of the most impairing aspects of ADHD and ADHD-type presentation is its negative impact on academic functioning, which has been consistently and robustly demonstrated across both primary and secondary schooling and is therefore likely to impair educational outcomes of children and employment prospects in adult life (Frazier *et al.*, 2007; Watts, 2018). Further, the lack of supports and expertise among practitioners who work with children on a daily basis in terms of how to effectively manage ADHD-type presentation results in a high percentage of young people disengaging with the education system as a result of problematic behaviour (Fletcher and Wolfe, 2008).

The majority of young people with ADHD within the general population who are receiving treatment at the service boundary age of 18 will require adult services, yet most adult services do not treat ADHD, representing a cliff-edge in treatment and a profound discontinuity in mental health service structure and provision (McNicholas *et al.*, 2015; Ogundele 2013; Sayal *et al.*, 2018). Adults with ADHD in Ireland have also faced problems whereby the adult psychiatric services tend to have a higher threshold than CAMHS, and this often results in referral letters from CAMHS to the adult services being returned with a recommendation to engage with a general practitioner or another medication management expert (Murry *et al.*, 2017). This problem has also been reported in other jurisdictions (Coghill, 2017).

Those who present with ADHD may be doubly disadvantaged within the criminal justice system whereby difficulties around remaining focused and attentive during, for example, probation interviewing/work can prove problematic and, for those undiagnosed, may result in incorrect interpretations in terms of engagement and attitude, making them more vulnerable within the system (Usher *et al.*, 2013). For example, functional impairments can impact on the individual's ability to follow the basic rules of the court and probation (Colwell *et al.*, 2012). There is limited Irish research within this space and therefore it is difficult to determine whether these findings are applicable in an Irish context. The aim of this paper is to raise these issues and encourage debate and research in this area going forward, with a view to optimising outcomes for young people and indeed adults who are experiencing these problems within the system without appropriate supports.

Prevalence rates

The *Diagnostic and Statistical Manual of Mental Disorder*, fifth edition (DSM-V; American Psychiatric Association, 2013) outlines the diagnostic criteria for ADHD as six or more symptoms of inattention and/or six or more symptoms of hyperactivity–impulsivity, which must be present for at least six months prior to assessment (over 17 years of age it reduces to five or more symptoms). The symptom presentation should be observed more frequently and be more severe than for children at a similar stage of development. The hyperactivity–impulsivity and/or inattentiveness symptoms typically occur prior to the age of seven years; the impairment should be evident in at least two settings, e.g. home and school; and there should be evidence of clinically significant impairment in social, academic and/or occupational settings. DSM-V also distinguishes between mild, moderate and severe presentation – mild relates to no or few symptoms beyond those required to make the diagnosis; moderate relates to where symptoms present as being mild to severe; and severe relates to presentation where symptoms are in excess of those required to make a diagnosis and impact the social, academic and/or occupational functioning of the individual. Prevalence rates are typically reported as 5–8% of the general population (WHO, 2012). However, statistics on ADHD from the Centers for Disease Control and Prevention suggest that some parts of the US far exceed what would be expected (9.4% in 2016),[1] thus suggesting over-diagnosis, whereas in the EU some commentators argue that there has been under-diagnosis, particularly among girls and older children (Sayal *et al.*, 2018). While figures are not available in an Irish context, figures for 2004 from the UK suggest that less than half of children with ADHD have been diagnosed and thus the others have received no treatment (Sayal *et al.*, 2010). It is important that potential over-diagnosis in other jurisdictions should not mask the under-diagnosis evident in countries such as Ireland.

Why would under-diagnosis persist? As outlined below, this condition remains controversial in terms of acceptance as a concrete condition. Further, the medicalisation of children has proved difficult for society to accept (we will return to this below).

While the World Health Organisation estimates prevalence rates at 5–8% (WHO, 2010), this figure rises for those who are incarcerated in prisons. For example, studies point to ADHD being common among

[1] See https://www.cdc.gov/ncbddd/adhd/data.html (accessed 11 April 2018).

adult prison inmates (Edvinsson *et al.*, 2010; Eme, 2009; Rasmussen *et al.*, 2001; Rösler *et al.*, 2004, 2009), with one Swedish study reporting prevalence rates as high as 40% among adult inmates (Ginsberg *et al.*, 2010), and 30% reported for young people (Young *et al.*, 2015). However, studies that used screening for diagnosis for adults had a significantly higher prevalence rate (43.3%) than those that used clinical interview (25.5%), thus recommendations for best practice suggest screening followed by clinical interview (Young *et al.*, 2015).

Even taking the figure of 25.5% of adult inmates, this is approximately an eight-fold increase when compared to the general population of adults (2–4%). These figures therefore highlight a clear over-representation of people with ADHD within the prison system. However, there is a dearth of research exploring prevalence among individuals involved with the criminal justice system but not incarcerated. In Ireland no data are available on the number of young people who are involved with Young Persons' Probation, the Garda Diversion Programme and/or the Garda Diversion Projects who may meet the criteria for a diagnosis of ADHD. Similarly, no data are available on the number of adults who have ADHD and are working with the Probation Service and other Probation-supported services.

A brief discussion on assessment, treatment and management

Guidelines related to assessment, treatment and management have been developed internationally and yet reports suggest that clinicians often discuss guidelines as being vague, particularly in the area of assessment and diagnosis (Kovshoff *et al.*, 2012). Treatment and diagnosis is time consuming and complicated due to requiring process steps of gathering and then piecing together information related to the individual (Kovshoff *et al.*, 2012). While guidelines for diagnosis and treatment are broadly similar across the EU and the US, there is variation in terms of the order of the treatment. For example, in the US medication is the first-line treatment whereas in the EU medication is acceptable for first-line in more severe cases, while in mild to moderate cases behavioural management is recommended for first-line treatment with medication the second-line treatment approach (Sayal *et al.*, 2018). Data from a randomised control trial – Multimodal Treatment of ADHD (MTA) – suggest that medication was superior to behavioural treatment for more severe ADHD, but differences were less evident among less severe cases (Santosh *et al.*,

2005). Meta-analyses have reported behavioural treatments as improving conduct and parental coping skills but as not improving ADHD symptoms, whereas pharmacological treatment shows moderate to large effects in terms of symptom improvements (Sayal *et al.*, 2018). Therefore it is suggested that behavioural treatments will benefit people with ADHD but are less likely to reduce symptoms (Sayal *et al.*, 2018).

The UK National Institute for Health and Care Excellence (NICE) has published guidelines for treatment. For parents of children with moderate impairment, parent training programmes are recommended with cognitive behavioural and/or social skills training recommended for the children themselves (NICE, 2008). For those with severe impairment, drug treatment is recommended as a first-line treatment, with psychological and family therapy as part of the treatment plan (NICE, 2008). While the evidence for the effectiveness of social skills training programmes has been mixed, some studies have noted cognitive behavioural therapy (CBT) interventions, combined with parent training and classroom accommodations as well as medication, as beneficial (Hannesdottir *et al.*, 2017). More complex cases have been discussed as being best managed through multidisciplinary teams consisting of psychologists, occupational therapists, social workers and specialist nurses, with the most important member being a family therapist (Coghill, 2017).

Working with the young person and their family also requires the gathering of information from multiple sources such as teachers and, in the case of the Irish criminal justice system, it is suggested, juvenile liaison and Probation Officers. This makes ADHD a labour-intensive and multi-modal approach which requires multidisciplinary teams to work together. In practice this can prove problematic due to historical silos across the multiple agencies that interact with children and young people. Indeed, a previous study which explored welfare provision in probation practice in Ireland reported difficulties in inter-agency working and information sharing between professionals across key agencies who deal with young people (Quigley, 2014). The same study found that Probation Officers often struggled to engage child protection and welfare agencies due to high thresholds of risk/need required for such engagement, and this resulted in Probation Officers attempting to address those gaps as part of Probation assessment and supervision. This problem is not peculiar to Ireland: similar issues have been raised in other jurisdictions (Pakes and Winstone, 2010).

The pathologisation of behaviour?

It would be inappropriate for this paper not to address the elephant in the room. ADHD has had a controversial history, although diagnosis of other neurodevelopmental disorders such as autism has been less contentious (Sayal *et al.*, 2018). This may be a result of the less obvious symptomology presentation, which is typically a more extreme version of the norm. However, this does not mean that it does not have a debilitating effect on an individual's life. The contentiousness has led to diverging schools of thought, the most obvious being (1) those who recognise ADHD as a condition which seriously impairs individuals' lives; (2) those who do not recognise the condition and feel that it is a modern construct and pathologisation of problematic behaviours (Sayal *et al.*, 2018). The latter is an important argument in terms of an over-pathologisation of behaviour generally. This is not new to the criminal justice space; one need only look to the father of criminology, Cesare Lombroso, and the evolution of the positivist school of thought that emerged from his ideas to recognise the link to positive criminology (Mannheim, 1972). Whether or not bringing a condition such as ADHD into the criminal justice space could result in problematic welfare-based sanctions – such as indeterminate sentences, which still operate in the US juvenile system – requires more attention, and certainly the authors of this paper are not suggesting anything of the sort. Rather, we are suggesting that some young people and adults may be criminalised for behaviours that require a health service rather than a criminal justice service intervention. It is beyond the scope of this paper to discuss the problematic history associated with welfare provisions within the criminal justice space, and indeed it has been discussed at length by scholars in the area (see Garland, 2001). The aim of this paper is to better understand the shift that has already occurred within the system in terms of the diagnosis being presented to criminal justice practitioners, with limited service provision and supports being put in place to meet these changes.

The contentious nature of the condition alongside the problematic nature of providing welfare services through the criminal justice system may be the reasoning behind the underdeveloped symptom identification, diagnosis, referral and treatment/management systems in place within the Irish criminal justice system. It may also be the reason why there has been limited progress in the area of training for criminal justice practitioners (An

Garda Síochána, Probation Officers, lawyers, Judges, detention school staff/prison officers) who interact with individuals potentially presenting with such symptoms. Further, it may explain why there are no Irish-specific protocols and guidelines in terms of 'next steps' or long-term management when there is a suspicion of the condition.

The controversial nature of the diagnosis can lead to stigma for the young person and their family. This stigma can be compounded by a lack of acceptance, recognition and support by key professionals who interact with the young person and their family, such as teachers, primary care practitioners and criminal justice practitioners (Bell *et al.*, 2011). Commentators have recommended increasing the knowledge base around ADHD of these groups of practitioners to reduce ADHD-related stigma (Sayal *et al.*, 2018). Moreover, it was suggested that systems and interventions aimed at streamlining care pathways between key stakeholders (primary care, specialist healthcare services, education and youth justice) be put in place to allow these groups to interact and communicate, thus facilitating improved access to care (Wright *et al.*, 2015).

Even in jurisdictions where the condition is broadly accepted, ADHD remains somewhat controversial within wider society but also within professional fields, such as clinicians, teachers, social care workers and youth justice workers (Sayal *et al.*, 2018). Commentators have suggested that this may be a result of diagnostic controversies and difficulties. Recurring themes within these debates are: the lack of a specific diagnostic test to diagnose ADHD; the fact that symptoms are an extreme version of typical behaviours; the perception of a cut off-point where normal behaviours move into the realm of abnormal behaviours based on subjective evaluation; the broadening of diagnostic criteria over time; reports of variation in diagnostic rates across clinicians and the use of medication (Sayal *et al.*, 2018). And yet these same issues can be raised for other psychiatric disorders and physical conditions such as hypertension and asthma without the conditions being invalidated (Coghill and Sonuga–Barke, 2012). Indeed, when ADHD was compared with other psychiatric disorders in the DSM-V field trials,[2] its value was

[2] 'The DSM-5 Field Trials were designed to obtain precise (standard error <0.1) estimates of the intraclass kappa as a measure of the degree to which two clinicians could independently agree on the presence or absence of selected DSM-5 diagnoses when the same patient was interviewed on separate occasions, in clinical settings, and evaluated with usual clinical interview methods' (Regier *et al.*, 2013: 59).

one of the most reliable (0.61), exceeded by autism (0.69) while being higher than bipolar disorder (0.56), schizophrenia (0.46), major depressive disorder (0.28), and generalised anxiety disorder (0.20) (Sayal *et al.*, 2018). Moreover, concerns regarding false-positives have been challenged through research findings which report higher rates of false-negatives (Foreman and Ford, 2008). Foreman and Ford (2008) conducted a study in the UK involving a sample of 502 patients and while a small number of false-negatives were reported, only one false-positive was. Findings from this study suggest that while there certainly seems to be an issue with over-reporting in some parts of the US, as outlined above, it has been reported that appropriate and carefully standardised assessment can accurately and reliably diagnose ADHD (Sayal *et al.*, 2018).

Medication has been another bone of contention. For example, there has been widespread concern about the increased prescribing of methylphenidate, e.g. Ritalin, for the condition across the UK and other jurisdictions (Boffey, 2015). Indeed, in 2011 the Dutch Ministry for Health declared an intention to 'demedicate' its youth (Foundation Nederlands Comité voor de Rechten van de Mens, 2014). Concerns around medication and its diversion for recreational use have also played a role in the negative reporting on the use of medication within the media and society generally (Wilens *et al.*, 2008). This continues despite new methods of dispensation that operate through slow release, reducing or eliminating its use for a quick-release 'high' (Sikes *et al.*, 2017). Further concerns around the use of stimulant medication leading to adolescent substance use have been raised (Wilens *et al.*, 2003). However, studies have shown either that ADHD medication is a protective factor against substance use in adolescence or that it neither increases nor decreases the risk of substance abuse among this cohort (Hogue *et al.*, 2017). In fact, while there was a spike in prescribing over the past twenty years, this has slowed considerably more recently (Holden *et al.*, 2013), perhaps suggesting a catch-up phenomenon (Sayal *et al.*, 2018).

ADHD and the criminal justice system

ADHD, like other mental health issues, can cause considerable difficulties for frontline criminal justice staff such as Probation Officers (McCormick *et al.*, 2017). Moreover, providing care to people with mental health difficulties as they move through the criminal justice

system has been described as being fraught with difficulty (Pakes and Winstone, 2010). These difficulties can raise concerns regarding the ability of the offender to engage with rehabilitative interventions. Moreover, such needs often take precedence over reoffending work and can require Probation Officers, and other criminal justice practitioners, to attempt to manage the gap of mental health service provision (Haqanee *et al.*, 2015; Quigley, 2014). Individuals with untreated ADHD have been reported to have greater contact with the criminal justice system, have an earlier age of first contact with the system, have higher recidivism rates and display more institutional behavioural disturbance (Young *et al.*, 2015). Other symptoms, such as being more likely to get easily frustrated, having greater difficulty dealing with the frustration and being more likely to inappropriately express their anger (Connor *et al.*, 2012; Ginsberg *et al.*, 2015), are all contrary to behavioural expectations within the criminal justice system, with studies reporting this cohort being treated more harshly in the system than offenders without such symptoms (Colwell *et al.*, 2012).

Inmates with ADHD have been reported to be involved in up to eight times more incidents of aggression, this being associated with underlying deficits in executive function (Young *et al.*, 2009). Within the prison system adult prisoners were found to have more acute ADHD when compared to psychiatric outpatients and controls (Ginsberg *et al.*, 2010), leading Ginsberg *et al.* (2010) to suggest that this group present as severely affected by their ADHD and that the common view that ADHD symptoms reduce with age may not hold true for inmates.

There is a dearth of such information on offenders engaging with criminal justice practitioners in the community. Related to mental health in general, Probation Officers reported filling the gap where mental health services have failed and outlined struggling to engage appropriate services (Quigley, 2014). This small study highlights a gap in resources in terms of accessing required supports for the type of presentation (Quigley, 2014). Approximately 26% of adults and 30% of young people (with some studies reporting rates as high as 75%) involved in the prison system are likely to meet criteria for ADHD. It follows that if the care and treatment of ADHD were to be enhanced through identifying and implementing efficiencies and delivering services in line with international mental healthcare standards, these changes would represent a very significant enhancement of mental health care within the criminal justice system (Young *et al.*, 2015).

How are other jurisdictions dealing with this?

It would be impossible to discuss all services and initiatives in other jurisdictions; below we outline key programmes in England and the US – the Youth Justice Liaison and Diversion (YJLD) teams and the Diversion and Liaison Scheme (D&L) in England; and specialised supervision, the Front End Diversion Initiative (FEDI) and the mental health courts in the US. These may provide points of interest in terms of models that might be developed for the Irish system.

England

YJLD

The aim of the YJLD was to divert vulnerable young people (first arrest) away from the criminal justice system and direct them towards mental health, emotional support and welfare services. The service was originally set up across six areas and operated by screening and identifying vulnerabilities, delivery of brief interventions and liaison with specialist services. They were separate from, but worked closely with, Youth Offending Teams (YOTs), CAMHS and other appropriate professional groups. The primary aim of the teams was to identify needs and make appropriate referrals. An evaluation reported beneficial effects in terms of mental health improvements (Whittington *et al.*, 2015) but no effect in terms of reoffending rates (Haines *et al.*, 2015). However, there was an effect in terms of the average time to reoffending (Haines *et al.*, 2015), meaning that those who engaged with the YJLD took longer to reoffend. This suggests that follow-up interventions may decrease reoffending rates (Haines *et al.*, 2015) – further research is required in this area.

D&L

The Bradley Report (Lord Bradley's 2009 review of people with mental health problems or learning difficulties in the criminal justice system) recommended the establishment of a national model of Criminal Justice Mental Health Teams (CJMHTs) that focused on the adult system. Their primary aims would be screening, assessment, liaison and information management – with the objective of managing continuity of care for an individual as they move through the criminal justice system. Indeed, the report recommended a National Diversion Programme with the roll-out of liaison and diversion services in all custody suites and courts by 2014. In 2014 the Liaison and Diversion Programme, as it is

now called, was implemented and by 2016 it covered 53% of the population of England, with the aim being to cover 75% of the population by April 2018.[3] Evaluations found that there has been an increase in the total number of people being identified with vulnerabilities such as mental health issues and that those who were part of the Liaison and Diversion (police station) had significantly less contact with the police as either victim or perpetrator than prior to their engagement with the programme (Earl *et al.*, 2017). However, there are limited data to show whether this model reduces reoffending and/or improves mental health (Kane *et al.*, 2017). Further research is required in this area.

United States

Specialised supervision

Specialised supervision is a form of probation supervision focused on adult offenders with mental health difficulties. It operates less as a monitoring and enforcement approach, typical in the US probation model, and more as a case management approach (Colwell *et al.*, 2012), with small caseloads, specialised trained officers, internal and external service co-ordination, and active problem-solving (Skeem *et al.*, 2006). On review, the departments that adopted this model experienced reduced recidivism rates and improved mental health related to the offenders who came under the scheme (Skeem *et al.*, 2006).

FEDI

Arising from specialised supervision, the FEDI operated for young offenders out of four Texas probation departments. The model operated specialised supervision and low caseloads (no more than 15). The officers were trained in motivational interviewing, family engagement, crisis intervention and behavioural health management (Colwell *et al.*, 2012). This approach differed from the traditional probation approach in the US and fostered a more holistic multidisciplinary model that led to multiagency relationships and relationships between the Probation Officer, the young person and their family. Young people who received the specialised supervision had improved school attendance and fewer disciplinary referrals compared to the three months prior to engagement (Colwell *et al.*, 2012).

[3] See https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/news/ (accessed 19 April 2018).

While Irish Probation Officers already adopt this style of practice whereby they have maintained a strong social work practice ethos and approach (Bracken, 2010; Quigley 2014), their caseloads, along with minimal access to mental health supports and in particular support with potential ADHD cases, may hamper their ability to achieve more positive and sustained change for this cohort of offenders.

Mental health courts

Mental health courts are a form of diversion out of the traditional court system and therefore do not operate at police level as some of the diversion programmes discussed above do. There are currently over 250 in the US (Schneider, 2010).

Mental health courts are a form of therapeutic jurisprudence, a philosophical approach or paradigm which is often discussed in terms of the law and practice being therapeutic for those they affect (Wexler and Winick, 1991). The overall aim of therapeutic jurisprudence is to explore the therapeutic and anti-therapeutic nature of the law and to outline more therapeutic approaches: importantly, without breaching due process and/or constitutional rights (Wexler, 2018). The retention of due process and constitutional rights is key to a rights-based therapeutic jurisprudence which is not overly paternalistic, autonomy-depriving and punitive.

The mental health court operates a multidisciplinary model which incorporates psychiatrists, psychologists, case workers and social workers who work collaboratively to meet the particular mental health needs of the individual (Schneider, 2010). The accused elects to participate in either a mental health treatment programme tailored to their needs or a fixed programme, the former being seen as preferable and incorporating psychological therapies, educational training, occupational therapy, housing, social services, counselling, budgetary counselling and so on (Schneider, 2010). Evaluations have found: high levels of satisfaction and a feeling of fairness on the part of participants and low levels of coercion (Poythress *et al.*, 2002); reduced recidivism after participation (McNiel and Binder, 2007); reduced violent crime after participation (Frailing, 2010); less time spent in prison than for those who travelled the traditional criminal justice pathway (Boothroyd *et al.*, 2003); and reduced homelessness and reduced psychiatric hospitalisation after participation (O'Keefe, 2006). Interestingly, mental health court participation was not the driver to beneficial outcomes; rather completion of the course was necessary (Frailing, 2010).

Juvenile mental health courts

Juvenile mental health courts were introduced in 1998, with the first one set up in York County, PA (Heretick *et al.*, 2013). As with the adult system, they adopt a therapeutic jurisprudence philosophy promoting a non-adversarial, treatment-oriented approach when adjudicating juvenile offenders, while still upholding their due process rights. Similarly to adult mental health courts, they adopted a multidisciplinary approach with the added family support/therapy layer (Heretick and Russell, 2013). The goal of the juvenile strand is to decrease recidivism and increase engagement with appropriate treatment (McNiel and Binder, 2007). Evaluations of the juvenile mental health courts are limited. However, what work has been done in the area highlights efficacy in terms of both aims of the system, namely reduced recidivism and increased engagement with treatment, with graduates showing significant post-release reductions in offences, including violence offences (Heretick and Russell, 2013). Again, further research is required in this area.

All of these initiatives relate to mental health generally and, while they are important in their own right, ADHD can be overlooked if not lost within these models. As a result, recommendations have been made in England outlining the need to build on these services so as to incorporate specific screening and assessment for ADHD across the various agencies – police, courts, probation, court and detention facilities– with a view to appropriate referrals for assessment and to ensure that offenders are managed in a manner that meets their particular needs (Young *et al.*, 2011).

Suggested next steps

The aim of this paper was not to provide concrete recommendations but rather to review the issue of ADHD within the criminal justice system, and to point to developments in other jurisdictions that might inform current and future thinking in this jurisdiction. In an ideal world, screening would take place at each contact point of the criminal justice system – Garda, court, Probation Service, incarceration/detention – with a view to referring those identified for clinical assessment, and ensuring that case notes follow the client to prevent duplication and screening fatigue.

Screening training can be provided to the Gardaí and Probation Officers as a first point of identification with a view to referring those

deemed in need of clinical assessment on to clinicians with expertise in ADHD. What might this look like? A brief outline of a possible model is given below and, while each agency/phase of the criminal justice system is discussed separately, it is suggested that a cross-agency and multi-layered strategy be considered.

Community

Pre-court

A national roll-out of mental health screening with an explicit ADHD component operationalised at Garda level and providing a pathway to assessment, treatment and management. This screening should facilitate early and first-line identification with a view to referral/diversion for both youth and adult offenders.

Court system

The Mental Health Commission and An Garda Síochána (2009) recommended the introduction of a pilot mental health court system at district court level. To date this has not occurred. Ryan and Whelan (2012) have provided a comprehensive analysis of mental health courts in other jurisdictions and argued that the Irish system would benefit from such a model, alongside other diversionary methods. They suggest that the best model would not depend on a guilty plea for participation, that charges should be dropped upon graduation, that prison should not be used as punishment for non-compliance, that a clear protocol should be in place to ensure participation is voluntary, and that due process should be respected. It is hoped that many individuals would be identified at an earlier stage, namely first contact with the police, and diverted for treatment at that point. For those who slip through that net and for those who repeatedly present to criminal justice agencies resulting in a court appearance, the evidence of the effectiveness of mental health courts, as outlined above, provides some empirical basis to move forward in this direction. Therefore, it is suggested that the recommendation of the above 2009 Report be explored further.

Probation Service

It is suggested that the Probation Service have a role in carrying out the screening for the mental health courts and that this screening for mental health difficulties (inclusive of ADHD) could be carried out alongside the usual risk assessments that are currently conducted. Those identified

could be diverted for assessment, treatment and management with a view to establishing a form of specialised supervision as outlined above to meet the particular needs of this cohort of offender. This would require additional training on the part of the Probation Officers and a reduced case load as a result of the additional burden in terms of time and resources required for this type of work.

Custodial

Adult imprisonment and youth detention

There is currently mental health screening and assessment at youth detention and prison phases of the system. Furthermore, there is currently a robust and effective in-reach and liaison service for mental health (McInerney *et al.*, 2013; O'Neill *et al.*, 2016), albeit with a primary focus on more acute mental health conditions such as psychosis rather than ADHD. Thus, it is likely that limited attention is being paid to ADHD despite the high prevalence rates identified in other jurisdictions among those incarcerated. It is suggested, as was recommended by Harpin and Young (2012), that ADHD screening, assessment and care pathways be developed, and this can easily be integrated in to the current system.

It is accepted that the suggestions above would require a major overhaul of the criminal justice system, would be time- and resource-intensive, and would require collaboration across agencies. However, working towards such an approach is not an impossible task, as is evidenced by other jurisdictions.

Conclusion

Individuals involved with the criminal justice system, both young people and adults, have been shown to have higher rates of ADHD than the general population. Symptoms associated with ADHD can be mis-interpreted as intentional non-compliance and purposeful defiance, leaving those within the criminal justice system additionally disadvantaged compared to their peers.

The increasing attention paid to mental health issues within criminal justice practice of late, with reference to key interventions that have emerged in other jurisdictions and, to a more limited extent, in this jurisdiction, have been explored in this paper. In an Irish context these interventions are primarily focused on the prison and detention phase of

the system, and what interventions do exist primarily focus on more acute episodes of mental health problems such as psychosis. As a result, those with ADHD or ADHD-type presentation are currently being overlooked within the system. The authors of this paper recommend a comprehensive review of current interventions with a view to incorporating ADHD screening and assessment into prison and youth detention, and developing an Irish-appropriate community mental health diversion model specifically incorporating ADHD into screening, diversion, assessment and treatment.

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