Submission to Childrens Commissioner

This submission is made by a group currently developing a new model for the assessment, diagnosis, and treatment of ADHD and co-occurring conditions, based on a multidisciplinary team-based care approach (ADHD collaborative care model). The group is planning to launch the ADHD collaborative care model this year.

Key members of the group are:

- **Dr Geoff Kewley**, Neurodevelopmental Paediatrician. Geoff has written 3 books on ADHD and worked in the UK for 23 years, developing and running a nationally recognised ADHD service where he was at the forefront of increasing ADHD awareness and services. He chaired the ADHD special interest group [The George Still Forum] within the Royal College of Paediatrics and Child Health for many years. He now runs a practice for children and youth with ADHD and related conditions in Sydney.

- **Dr Peter Heffernan**, Consultant Psychiatrist & Psychoanalytic Psychotherapist MBBS MPM FRANZC Founder and previous Chair RANZCP ADHD Network Committee.

- **Professor T Ewais**, Consultant Child & Adolescent Psychiatrist whose current research interests include anti-inflammatory therapies for youth chronic illness and their psychosocial co-morbidities, depression, anxiety, fatigue, stress and pain. Additional areas of research include resilience in medical students, doctors and health professionals, the role of social determinants of health and health and justice partnerships in youth with chronic illness and development and appraisal of integrated care pathways and mental health guidelines.

- **Scott Beachley,** Lawyer and governance advisor to the health, tech and not for profit sectors. Scott is Head of Legal, Governance and Risk for the Australian National Committee for UNICEF and on the National and International Boards of Smart Recovery, a support organisation for those with Substance Misuse and Addictive Behaviour. He is former chair of a youth mental health charity and the founder and former CEO of a digital mental health social enterprise.

- **Chris Brideson,** Business Consultant. Chris has over 30 years' experience in consulting on strategy, governance and risk, primarily in the Financial Services industry. He has lived experience of ADHD.

- **Brooke Fogarty**, • Brooke Fogarty, ADHD coach, accredited through ADDCA, a member of ADHD Coaches Australasia, ICF and AADPA. Brooke is a single parent of two primary school aged children who have ADHD. Over the last 25 years she has built a strong foundation in the corporate world starting in advertising in Sydney, and then incentive marketing. She established a successful brand development and digital marketing studio where she honed her business and workplace culture skills. In her spare time she pursued a B. Psych. Science and completed comprehensive training with ADDCA, enhancing her understanding of ADHD and its management. Brooke has lived experience of ADHD.

- **Corey Lane,** Clinical Psychologist and an Adjunct Lecturer in Criminology and Criminal Justice Studies at James Cook University, Australia.

The following sets out the group's perspectives on relevant issues for the Inquiry to consider, as well as recommendations on how to address these issues. The perspectives and recommendations are based on over 2 years research into the many roadblocks to the effective assessment and management of people with ADHD in the Youth Justice System, the discrepancy between capacity and demand for ADHD services in Australia, as well as research into ADHD care models, clinical guidelines and leading practices in the UK, Canada and the USA.

The submission addresses each of the Inquiry's terms of reference, unless indicated otherwise.

Introduction:

We consider the that both the **Queensland Youth Justice Strategy 2019-2023** and the **Healthcare Standards for Children & Young People in Secure Settings** from the UK …to be an excellent documents, and should be used as a basis for change. Our comments below use those documents as the basis for action.

1. **What factors contribute to children's and young people's involvement in youth justice systems in Australia?**

We consider that much higher priority must be given to the underlying causes of youth crime, and in particular the vulnerability caused by untreated or partially treated ADHD, even where there are significant social challenges. For example, recent **Practice Guidelines from the Australian ADHD Professionals Association** clearly points out the link between ADHD and youth crime [P155]. The report noted that:

- 'Attention deficit hyperactivity disorder (ADHD) rates are higher in custodial settings than in the general population, estimated to be 5 times higher among youth prisoners and 10 times higher among adult prisoners. There may likely be higher rates among Aboriginal prisoners, and this is likely associated with Foetal Alcohol Syndrome. Many prisoners positively screened for ADHD were never previously diagnosed. Among people in prison, ADHD is often complicated by substance misuse and co-occurring mental health disorders.

- ADHD, its identification, treatment &/or prevention has received limited specific attention in most major recent reviews & inquiries into youth & criminal justice populations in Australia.

- ADHD symptoms increase the risk of institutional aggressive disturbances/critical incidents in prison. ADHD is also associated with conduct disorder in children and later anti-social behaviour, multiple socio-economic disadvantages, and other criminogenic factors. If left untreated, symptoms create unnecessary challenges in our jails and juvenile facilities. There are therefore advantages in managing ADHD in custodial settings. However, managing ADHD in custodial settings is difficult because many prison health systems are already

overstretched and tend to focus their resources on acute mental illness and suicidal ideation. Many prisons are unable to offer mental health services to community standards.

- Many people in prison experience socioeconomic disadvantage, and co-occurring conditions (particularly substance use disorders), meaning that complexity is the norm. However, in prison there may an opportunity to provide interventions which may be lacking or not be readily accessed in community settings.

- There are potential benefits of addressing ADHD in prison. Treatment may reduce symptoms, reduce the rate of critical incidents in prison and make them safer places for both staff and those in custody, reduce the rate of recidivism after release, assist in the treatment of other disorders (such as personality disorders, substance use disorders, anxiety disorders).'

Lane and Chong have reviewed studies on the incidence of ADHD in Australian prisons:

Study	Setting	Prevalence
Moore, Sunjic Kaye, Archer & Indig, (2013).	4 x Selected NSW Prisons	• 17% of adults met full ADHD criteria • 35% subclinical ADHD.
2009 NSW Inmate Health Survey (Indig, et al., 2010)	Self-Reported ADHD	• 10.8% total • 11.8% men • 6% women
2015 Young People in Custody Health Survey (Justice Health & Forensic Mental Health Network and Juvenile Justice New South Wales, 2017)	Self-reports and clinical interviews of young people in custody during survey period in 2015 (classifies ADHD as attentional/ behavioural disorder)	<u>Self-Report</u> • 40.3 % <u>Clinical Interview</u> • 22.3% males • 27.3 % females • 24% ATSI young people <u>Conduct Disorder (ADHD is precursor)</u> • 45.3%

The Deloitte Report on the criminal costs of ADHD in Australia:

- The Deloitte report estimated that total cost of crime due to ADHD, including the cost to the justice system, was $307 million in 2019.

- People with ADHD are more vulnerable to engage in antisocial and criminal behaviour, likely due to their impulsive actions and behaviours, disengagement from education and comorbidities that develop in adolescence such as conduct disorder and substance use disorders.

- Australian and international research suggests that a disproportionately high number of individuals with ADHD are involved in criminal activity and within the criminal justice system. An Australian study conducted in NSW found that 17% of inmates screened positive for a full ADHD diagnosis (DSM-IV), which is considerably higher than the prevalence in the general population.

- Not only are people with ADHD overrepresented in prisons both domestically and internationally, there is evidence to suggest that the cost of incarceration for people with ADHD is significantly higher than those without ADHD. One UK based study estimated that the annual incremental cost of inmates with ADHD was £590 more than inmates without ADHD. This cost comprises both medical treatment costs within the correctional facility, and behavioural related prison costs.

2. **What needs to be changed so that youth justice and related systems protect the rights and wellbeing of children and young people? What are the barriers to change, and how can these be overcome?**

The most important reform is better recognition of the mental health predisposition to youth offending in general and ADHD in particular. Whilst ADHD comes under the broad umbrella of Mental Health, it is in fact a neurodevelopmental disorder. A high degree with impulsiveness, [i.e. lack of self-control] is one of the core symptoms, correlates well with criminology studies. There is no robust international evidence of the much higher incidence of ADHD in the prison population and the vulnerability it creates to other adverse coexisting conditions. An informed understanding of the condition creates several challenges. It is often part of the foetal alcohol syndrome complex particularly in the indigenous population.

Historically the overriding professional view has been that a lack of self-control or excessive impulsiveness has been due to poor parenting and/or environmental issues as postulated in the 'Theory of Crime'. This still very much pervades current thinking of those working in the justice system, society in general and particularly politicians.

More recently, Criminologists have recognised, as did Pratt that:' the cause low self-control has clearly been shown to be an important causative factor in the genesis of crime, previous criminology theories may be wrong or at least substantially incorrect.'

The incidence of ADHD in the Youth Justice population has been shown by authors such as Young et al. to be between 30 and 40%. It is only the last 10 years that the lifespan importance of ADHD is fully recognised. Thus, it is likely that many youth and young adults with ADHD have progressed through school, there problems of the last by their learning difficulties and/or environmental factors.

People with ADHD are more likely to be:

i) Misread by behaviour as defiance, evasiveness, or evidence of guilt.

ii) 2.5 times more likely to be arrested.

iii) As high as 3.5 times as likely to receive a court conviction.

iv) As high as 3 times as likely to be imprisoned.

2.a. The prevention of entry and diversion all youth offenders from the justice system with specific consideration of risk the factors that reduce crime.

As a starting point the Recommendations of the Australian ADHD Guidelines regarding good practice should be considered and incorporated into a national Youth Justice Strategy:

i. Screening and assessment processes should be established to identify the presence of ADHD and co-occurring conditions among people entering the criminal justice system.

Comment: very early on in the process, evidence of the characteristics of those involved in youth crime, be identified. We consider that the most appropriate screening tool is CHAT – The Comprehensive Assessment Tool for young offenders.
https://www.uominnovationfactory.com/expressip/expressip-healthcare/chat/

By doing this, appropriate decisions re subsequent strategies can be made. International evidence strongly suggests that not only are environmental and economic issues important in this field, that additionally the person having learning difficulties, the early onset of conduct disorder or hyperactivity, and having inherently low self-control also important factors. {see Moffitt in the Dunedin Study and Farrington.]

ii. Custodial staff and those within the criminal justice system (e.g. police, magistrates) should receive ADHD awareness training. Essential training in ADHD and related neurodevelopment and mental health issues for staff must be made available. Our group is currently developing an appropriate training program specifically for criminal justice staff.

iii. Treatment in custodial settings should include pharmacological and non-pharmacological approaches, equivalent to the treatment available in the community.

iv. Prisons should include ADHD tailored educational and occupational programs to increase engagement and skills development.

v. Prisons should establish safe processes of administering long acting stimulant medication to those with ADHD (similar to ways of administering other controlled drugs and ensuring the safety of the person in prison receiving stimulant medication). Specific screening for comorbid substance use disorders should be undertaken before administering stimulant medication

vi. Prisoners with ADHD should have a comprehensive multi-agency integrated and coordinated care plan, with particularly close coordination between criminal justice, mental health agencies and disability services, and at all transition points, with appropriate identified care pathways into the community.

vii. Prisons should be resourced to enable identification and treatment of offenders with ADHD, to improve clinical and criminal justice outcomes.

RE costings, Lane and Chong further emphasised that one significant motivation towards addressing the overrepresentation of those with ADHD is cost. The total cost of ADHD to

Australia was estimated to be nearly US$13 billion for the period 2018 to 2019. The annual ADHD-related service costs in the UK were estimated to be £670 million. ADHD-related criminal justice annual costs in Australia have been estimated to be A$ 215 million annually, whereas annual youth justice costs in the United States has been estimated to be between US$2 billion and US$4 billion. Young and Cocallis have also suggested that the motivation for redressing the issue of ADHD over-representation in criminal justice populations could lie in reducing the cost associated with ADHD in prison populations. In a relevant 2018 study, Young, Gonzalez, Fridman, Hodgkins and Gudjonsson discovered that costs associated with behaviour-related problems and medical treatment in the Scottish prison system appeared to amount to £590 greater per annum for individual prisoners with ADHD when compared to those individuals without ADHD. Furthermore, when taking into account ADHD prison prevalence rates, they estimated that the annual medical and behaviour-related cost for the Scottish prison systems would amount to £11.7 million.

Additionally, Young and Cocallis stress that the appropriate provision of treatment for prisoners with ADHD would likely result in a highly beneficial rate of return for wider society. The same argument may be made for those with ADHD who are considered offenders within youth and criminal justice systems as a whole. As might be assumed, Young and Cocallis' base this proposition on the observed efficacy of ADHD treatments outside and inside prison populations. Support for the reduced costs associated with treating ADHD in criminal justice populations is provided in a 2019 study by Freriks and colleagues. Stimulant treatment appeared to be cost-effective for the treatment of ADHD in children and adolescents.

Silvia and colleagues in Western Australia in 2014 conducted the study of almost 10,000 boys and almost 3000 girls diagnosed with ADHD, compared to a control group. They found ADHD was 2.5 times more likely to be present in boys and three times more likely in girls who had Community Corrections Contact Records. In boys the first contact occurred at a younger age. They found that girls were seven times and boys 2.5 times more likely to have a juvenile detention record if they had ADHD. Burglaries and break-and-enters were more common in ADHD youths.

Effective ways to stop recidivism and protect the community from offending and the opportunity for community-controlled organisations with specific reference to the role of First Nations peoples to provide support solutions and services.

Screening for ADHD as part of an overall metal health and neurodevelopmental screen, both at entry to, and at certain key points in the system, including exit from, redirection to drug and alcohol programs, and reoffending are essential.

Anything said in this document applies equally to First Nations peoples, as a number of studies have shown that ADHD is a significant issue in this population, in addition to all the other more often addressed issues. It is essential that the concept that the first nations people may have ADHD, in addition, or instead of other environmental or cultural issues is addressed by policymakers

In addition, anything said in this document also likely applies to the perpetrators of Intimate Partner violence.

Studies show that effective identification and management of ADHD and related conditions can significantly reduce recidivism. This is really what one might have expected given the high degree of impulsiveness in this population. By treating the impulsiveness medically in combination with appropriate additional supports, recidivism can be reduced. One study showed that it could be reduced from 62% down to 12%.

The ADHD Guidelines comment re indigenous people that:

'Clinicians should conduct a culturally appropriate screening assessment of ADHD in Aboriginal and Torres Strait Islander peoples. A strengths-based focus should be employed wherever possible.

Clinicians should be aware that ADHD symptom questionnaires and other tools used for screening and assessing ADHD may not be valid in Aboriginal and Torres Strait Islander peoples and should be used with caution. Clinicians should seek the assistance of a cultural interpreter or Aboriginal and Torres Strait Islander health worker.

Culturally and psychometrically validated symptom questionnaires should be developed for ADHD presenting in Indigenous children, adolescents and adults.

Clinicians should conduct a culturally appropriate assessment of ADHD in Aboriginal and Torres Strait Islander peoples. This should include a cultural and social assessment of the meaning and significance of symptoms. A strengths-based focus should be employed wherever possible. The assistance of a cultural interpreter or Aboriginal and Torres Strait Islander health worker should be sought if needed.

Interventions should include input from parents, families, community, and Elders, as appropriate, to maximise treatment effectiveness given strong family values in Aboriginal and Torres Strait Islander cultures. The wishes of parents, families and individuals with ADHD regarding treatment options (e.g. cultural, pharmacological versus nonpharmacological treatments and their combination) should be prioritised.

Non-pharmacological interventions need to be culturally sensitive and appropriately tailored for Aboriginal and Torres Strait Islander peoples with consideration for the local cultural context.

Pharmacological interventions should be explained carefully with an awareness of potential cultural issues. Pharmacological options may be more acceptable if offered as part of a broad package aimed at helping a person reach their potential'

3. Can you identify reforms that show evidence of positive outcomes, including reductions in children's and young people's involvement in youth justice and child protection systems, either in Australia or internationally?

Building on Youth Justice strategies from an ADHD perspective, is essential. For example, a robust psychological treatment developed for youth offenders is Reasoning and Rehabilitation 2 AHDH (R&R2ADHD). There is RCT support for R&R2ADHD multimodal treatment for antisocial behaviour in community and impatient male samples (Young et al., 2017) The R & R2 program developed by Dr Susan Young is an evidence-based and well-

recognised program for early intervention and prevention. This is done in association with medication were appropriate. https://www.psychology-services.uk.com/R-and-R2-2.

We would be interested to develop a Restorative Justice program where the nature of the perpetrators underlying neurodevelopmental and/or mental health difficulties was explained to the victim. Associated other community understanding supports. group support etc, with a provider contract in place with targets to increase housing, education, employment etc.

In custodial settings ADHD has been found to be disproportionately associated with incidents involving verbal aggression, damage to property, violence, non-compliance and behavioural disturbances, such assessment and management programs would include largely telehealth support as well as 'on ground' support coming from an understanding of ADHD and related coexisting conditions. There would need to be support for the often associated, learning difficulties, ASD, substance misuse, and psychosocial issues. Such supports need come from an ADHD perspective, rather than from just a psychosocial perspective. Our group is developing essential ADHD awareness and support training for those working in social and community sectors.

Systems based on Multisystemic therapy have some basis, provided they are linked in with the possibility of additional use of medication to minimise impulsiveness, help with concentration and reduce hyperactivity. There is usually a flow on effect to self-esteem, social skills and mood swings but occasionally additional medications are required. Medication alone in this sort of situation is rarely sufficient without additional Psychological, ADHD coaching or other supports. Such supports are available through various organisations providing and offering multisystemic therapy including https://www.ozchild.org.au/service/multisystemic-therapy-mst/.

RCTs demonstrated robust treatment effect for osmotic-release methylphenidate (OROS-MPH) including overall minimal use in custodial settings likely due to perceived potential for misuse, malingering, drug seeking behaviour.

In 2021 it was suggested that the incidence of ADHD among youth and adult offenders across police custody, prison, probation and forensic mental health settings falls at around one in four (25%). Given the phenomenology of ADHD involving disinhibition, impulsivity and impaired executive functioning, this is not surprising.

We consider that this would be an ideal population to screen for ADHD in addition to other mental health problems, as noted above.

v. Alternatives to detention.

Alternatives to detention must include facilities that come from understanding of the difficulties that have made the individual more vulnerable to entering the justice system, rather than just considering them to be 'a bad lot'. By understanding the factors that have likely predispose them to difficulty, including understanding the nature of ADHD, of

associated learning difficulties, of the vulnerability to substance misuse, and the progression of ADHD with low self-esteem, underachievement, and social skills problems, appropriate rehabilitation and community alternatives to detention can be put in place. One of our directors, Scott Beachley, was the Executive Chair of such an operation spanning the NSW Northern Rivers and Southeast Queensland. Whilst this approach likely contrasts with some of the current approaches, it must be continually emphasise that this is not an excuse, rather an explanation, and that attempts to treat the underlying neurodevelopmental and mental health difficulties are not only to help the individual and society, but to minimise reoffending.

At the moment it is largely the case that if a person with ADHD is detained, there appears to be little consideration to the high incidence of violence in those with ADHD, the difficulty in putting someone who is hyperactive into solitary confinement, into minimising their impulsiveness, and into the whole court and justice system. They are more likely to tell mistruths, to say the first thing that comes into their mind to get out of the situation, and many other issues. There is a need for the ADHD to be properly understood and managed throughout the whole process of the judicial system including requisite specialised training.

Mental health and associated issues, especially the needs of a person with complex ADHD should be considered.

Consideration of a restorative justice system that includes sharing with the victim, the likely antecedents of that person performing the crime. For example, if the victim understands that the perpetrator has ADHD, coexisting with ASD, with learning difficulties and came from a poor environment, there may be some basis for understanding. That is not to say that any of this as an excuse, but rather it is an explanation.

The whole issue of neurodevelopmental difficulty in the context of youth justice creates very significant societal, political, and personal undertones and annoyance. In carefully managing an approach to ADHD in the context of other mental health issues, this needs to be very much born in mind and handled carefully.

4**. From your perspective, are there benefits in taking a national approach to youth justice and youth wellbeing in Australia? If so, what are the next steps?**

Although Youth Justice management is largely a State matter, the current situation really demands that there be National Standards and Policy with provision of clear Guidelines for States to follow. Below are some suggestions:

1) A thorough understanding of ADHD with appropriate training of those making policy in the youth justice system and also those working within the system. There is an overwhelming need to put what is known and what has been researched, into real world practice , for the benefit of the individual and for society.
   A system of coping with the recognition that the very nature of ADHD - particularly because of there being a biological lack of impulse control or self-

control – will challenge many existing societal and professional beliefs regarding the perpetrators being an 'bad lot' needs to be addressed by training and appropriate restorative justice support. By having this understanding, emphasis can then be given to helping with the underlying conditions and vulnerabilities, rather than purely punishing, and hoping that as a result the issues will disappear.

2) A mechanism of effective screening is an essential first step. This particularly applies to those at the earlier stages of the justice system, those on community orders, and re-offenders, assessment and management of those with ADHD can make an enormous difference to their lives, to society generally, and to the costs of the youth justice system.

3) Prepare a detailed costing analysis. For example, The Deloitte report on the costs of ADHD to Australia, and to the Australian ADHD Professionals Association's recent guidelines. We also referred to the voluminous international literature on the subject. We would emphasise that ADHD is an internationally recognised condition of brain function that is very treatable but that it creates a vulnerability to many other conditions particularly substance misuse.

4) Work on instigating the appropriate strategies as outlined in ADHD guidelines.

5) Consider funding a pilot proof of concept trial of screening in a local Primary Health network. Our group is applying for a Queensland Youth Justice Crime Prevention Grant for this purpose.

For example, our group has been developed to take a lead role in facilitating this type of operation. We are a Social Enterprise specialising in the Collaborative Care model of management of ADHD and related conditions. One component of our service is education and training such as to all of those involved in the youth justice system including police, care workers and others. Another component of our organisation will be clinical management. There will be a range of professionals skilled in the assessment and management/treatment of people with ADHD and related conditions. This will also include management of substance misuse, links to educational providers, psychologists, and other supports.

The third component of our service will be able to provide screening and other appropriate supports, prior to and after full assessment. We are keen to come to an arrangement with a Primary Health Trust or similar specialised organisation, for an initial trial. This could be done either with those on Community Care orders, repeat offenders to try minimise and assess reoffending, and/or with those on probation.

6) Identify staff suitable for training and place them on an appropriate course.

7) Form a high-level committee to activate the committee's recommendations.

8) Consider implementing the relevant Australian items from: Healthcare Standards for Children & Young People in Secure Settings. This is a really important document that could be used as a basis for Australian policy.

9) Include awareness of Foetal Alcohol Syndrome within the broad concept of ADHD when screening and general management are involved.

In the context of social policy and Youth Justice reform, ADHD is much more than just another mental health or neurodevelopmental condition. The vulnerability it creates, in large part by virtue of the inherent associated lack of self-control, but also by its complications, opens doors for a complete rethink to all the questions posed by this Committee. We would encourage the Committee to use this opportunity to become informed regarding the information in this submission, incorporate it much more into the Queensland Youth Justice Strategy, so that a new era of much more effective and cost-effective management of offenders can be enabled.

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