ADHD AND CANADIAN YOUTH: AN EVALUATION OF THE NEUROCOGNITIVE DISORDER'S IMPACT ON CRIMINAL JUSTICE ASSESSMENT, MANAGEMENT, AND POLICY

by

Adrienne Meredith Forbes Peters
B.A. Criminology, Saint Mary’s University, 2006

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In the
School of Criminology

© Adrienne M. F. Peters 2008

SIMON FRASER UNIVERSITY

Summer 2008

All rights reserved. This work may not be reproduced in whole or in part, by photocopy or other means, without permission of the author.
APPROVAL

Name: Adrienne Peters
Degree: Master of Arts
Title of Thesis: ADHD and Canadian Youth: An Evaluation of the Neurocognitive Disorder’s Impact on Criminal Justice Assessment, Management, and Policy

Examining Committee:
Chair: David MacAlister, LL.M.
Assistant Professor of Criminology

Simon Verdun-Jones, J.S.D.
Senior Supervisor
Professor of Criminology

Margaret Jackson, Ph.D.
Supervisor
Professor of Criminology

Jodi Viljoen, Ph.D.
External Examiner
Assistant Professor of Psychology

Date Defended/Approved: August 1, 2008
Declaration of Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the “Institutional Repository” link of the SFU Library website <www.lib.sfu.ca> at: <http://ir.lib.sfu.ca/handle/1892/112>) and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author’s written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library
Burnaby, BC, Canada

Revised: Fall 2007
STATEMENT OF ETHICS APPROVAL

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

(a) Human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

(b) Advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

(c) as a co-investigator, in a research project approved in advance,

or

(d) as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Bennett Library
Simon Fraser University
Burnaby, BC, Canada
ABSTRACT

Attention-deficit/hyperactivity disorder (ADHD) is the most commonly diagnosed disorder among Canadian youth today. The disorder is particularly visible in young offenders, highlighting the overrepresentation of this disorder in this population. Troublingly, the screening process for ADHD is virtually non-existent within our criminal justice system. In light of these circumstances, is the youth criminal justice system in Canada doing enough to provide care for young offenders who have ADHD? This research presents the findings of an exploratory analysis which included a Canadian youth court case analysis and 14 personal interviews. Results reveal that in order to adequately follow the guidelines of the Youth Criminal Justice Act a new approach to youth with mental health issues is necessary. This research proposes that a potential new approach should be based on a provincial model of funding, consisting of increased education and communication for professionals working in the youth criminal justice system.

Keywords: Attention deficit hyperactivity disorder; ADHD; Youth Criminal Justice Act; youth justice system; assessment; programming; treatment

Subject Terms: Criminology; mental health; attention deficit hyperactivity disorder; youth criminal justice system
DEDICATION

To my family and friends for continually supporting and encouraging me throughout
the research and writing processes

To Max for all of his love and his constant belief in me

For my mother, above all – the woman who taught me to love writing and has
always inspired me to follow my dreams, hopes, and desires.

To you with love
ACKNOWLEDGEMENTS

I would like to thank my supervisory committee for all of their guidance and support during the writing of my thesis and, most of all, for their continuing support following my decision to complete the writing of it abroad.

Vielen Dank to Simon Verdun-Jones for sharing all of your wisdom with me. Thank you for your kindness and for encouraging me to progress, in more ways than one. Thank you, especially, for reinforcing the life lesson – never have regrets.

A special thank you to Margaret Jackson. I remember so well my first weeks at Simon Fraser University as a new graduate student, and feeling so overwhelmed. One day, I finally built up the courage to arrange a visit with you, my designated supervisor. After our initial conversation, I felt a sense of comfort in my surroundings and an overall feeling of relief. I cannot tell you how much that day and your words have meant to me and my experience at SFU. Thank you for your sincere gentleness and valuable advice.

I would also like to thank my external supervisor Professor Jodi Viljoen, for taking time out of her busy summer schedule to attend my defence and to offer many helpful insights and wonderful contributions.

Although they may never see the final product, I would also like to thank all of my willing interview participants who imparted great knowledge, and believe in this research and the support of young people in our youth criminal justice system.

I can no other answer make, but, thanks, and thanks ~ William Shakespeare
TABLE OF CONTENTS

APPROVAL ........................................................................................................................................ ii
ABSTRACT ........................................................................................................................................ iii
DEDICATION...................................................................................................................................... iv
ACKNOWLEDGEMENTS ................................................................................................................... v
TABLE OF CONTENTS ...................................................................................................................... vi
LIST OF TABLES .................................................................................................................................. ix
CHAPTER 1: INTRODUCTION ............................................................................................................ 1
CHAPTER 2: LITERATURE REVIEW .................................................................................................... 4
   Attention-Deficit/Hyperactivity Disorder – Understanding the Disorder ............................................. 4
   The DSM IV-TR ................................................................................................................................ 5
   Disorders Associated with ADHD ..................................................................................................... 5
   Causes of ADHD ............................................................................................................................. 7
      Neurobiology .................................................................................................................................. 7
      Sociology ....................................................................................................................................... 10
   Impulsivity ....................................................................................................................................... 14
   ADHD Aetiology in Criminology ...................................................................................................... 16
      Applying criminological theory to youth with ADHD ................................................................. 17
      Internalization ............................................................................................................................... 19
      Substance abuse ............................................................................................................................ 21
   Conclusion ....................................................................................................................................... 23
CHAPTER 3: METHODOLOGY ............................................................................................................ 25
   Quantitative Element – Case Analysis............................................................................................. 25
      Limitations .................................................................................................................................... 27
   Qualitative Approach – Interviews ................................................................................................. 27
      Why the in-depth personal interview? .......................................................................................... 28
      Study setting .................................................................................................................................. 28
      Sample selection ........................................................................................................................... 29
      Description of interviewees ........................................................................................................... 29
      The instrument ............................................................................................................................... 30
      Procedures ..................................................................................................................................... 30
      The interview and coding processes ............................................................................................. 31
      Limitations ..................................................................................................................................... 31
CHAPTER 4 – LEGAL ANALYSIS ....................................................................................................... 33
   Existing Legislation and Policy ........................................................................................................ 33
      YOA to YCJA ................................................................................................................................. 34
      Medical and psychological reports ............................................................................................... 35
      Sentencing adults in Canada ......................................................................................................... 35
   Cases Analysis – The National Context ........................................................................................... 37
   Results .............................................................................................................................................. 38
      Comorbidity .................................................................................................................................... 38
      Assessments .................................................................................................................................... 39
      Sentencing and final decisions ...................................................................................................... 40
      Youth sentences versus adult sentences ...................................................................................... 41
   Additional points of interest ........................................................................................................... 42
LIST OF TABLES

Table 1: Respondent's Profiles ................................................................. 30
Table 2: Comorbidity in Cases ................................................................. 38
Table 3: Case Breakdown – Assessment Details ........................................ 39
Table 4: Case Breakdown – Sentencing and Final Decisions .................... 40
Table 5: Provincial Breakdown of Cases .................................................. 42
CHAPTER 1: INTRODUCTION

In the academic world, science-based theories are effectively emerging and calling for a new approach to crime and unruly behaviour. In recent years, mental health and its connection to delinquency has gained widespread attention under the spotlight of intense media coverage and the publication of a rapidly increasing body of research literature. This is especially true of fetal alcohol spectrum disorder (FASD). Numerous researchers are undertaking studies evaluating the role of such a condition in young individuals’ lives, with close attention being paid to youths who become entangled with the criminal justice system. FASD is linked to criminality, as characteristics of the disorder include impulsivity and lack of understanding of social cues (Koren, Roifman, & Nulman, 2004). The criminological basis for the examination of neurocognitive disorders, such as FASD, revolves around the high levels of delinquency and aggression associated with them. Individuals suffering from FASD are also found to suffer from internalizing symptoms, such as low self-esteem, social isolation, and depression in childhood, which can all lead to aggression and violence as expressed previously (Green & Gillen, 2002). Regrettably, this is not the only neurocognitive disorder that is linked to these negative outcomes and which, therefore, might benefit from a criminologist’s consideration.

Another perceptible crisis is attention-deficit/hyperactivity disorder, or ADHD. ADHD is a common neurocognitive disorder which today’s youths are combating. In fact, it is currently the most commonly diagnosed developmental disorder affecting young people in Canada and around the world (Bartol, 2002; Currie & Stabile, 2006). As youths diagnosed with attention-deficit/hyperactivity disorder exhibit characteristics, such as lack of self-control, this disorder is linked to a variety of behaviours including impulsivity, acting-out, and violence (Weyandt, 2001). This can have serious implication for the juvenile justice system, as these youths are at a greater risk for conflict and acts of delinquency. Attention-deficit/hyperactivity disorder is undeniably a visible condition affecting a multitude of individuals in our society, directly or indirectly, and especially youths. It is, therefore, the responsibility of the criminal justice system and policy-makers to engage with this issue.

1 "An umbrella term used to encompass all diagnostic categories associated with prenatal alcohol exposure" (Verbrugge, 2004, p. 1).
Schools and communities are collaboratively taking early steps to provide proactive and reactive measures to manage ADHD. This same level of concentration unfortunately cannot be said for the juvenile justice system. The research clearly demonstrates that disabilities, in particular learning disabilities and serious emotional disorders, are far more common among incarcerated youths than among youths in schools (Bartol, 2002; Boland & Buchan, 2005). Data retrieved from court records reveals that people with ADHD are 4 to 5 times more likely to be arrested; they are also more likely to have a history of recidivism with multiple arrests and convictions (Nutt et al., 2007). Additional studies suggest that attention-deficit/hyperactivity disorder is 4 to 5 times more prevalent in youth correctional facilities when compared to in schools; it is also estimated that between 20 and 50 percent of incarcerated youths have ADHD (Mears & Aron, 2003). In Burnaby, British Columbia, a youth corrections facility employee estimated that approximately 30 percent of youths within correctional facilities are suffering from this disorder (Youth corrections employee, personal communication, 2007). Some studies have even suggested that approximately 70 percent of juvenile offenders have ADHD (Brown, 2007). These numbers are alarming when presented alone, but are even more striking when compared to the approximately 3-5 percent of children aged 4-18 who are currently diagnosed with ADHD (American Psychiatric Association, 2000).

In the past few decades, attention-deficit/hyperactivity disorder and its diagnosis in youths has become a widely acknowledged matter. As we can see from the numbers offered above, it is a disorder of immense importance. A noteworthy point regarding these statistics is that they are representative of young offenders with ADHD who are detained; the key being that they are youths who are actually in custody. More commonly, under Canada’s Youth Criminal Justice Act (2002), young people are receiving alternative sentencing. These youths are for this reason receiving reduced care and attention, and the underlying problems at hand are too often swept under the rug. Anchored in the numbers presented, the youth justice system should more closely examine the lives and development of young people in Canada. Before we can understand their behaviour and develop adequate treatment, we must first understand the disorders that are affecting them.

This study aims to identify the existing problems in the criminal justice system’s management of youths with ADHD. More directly, it examines what this population encapsulates, what troubles are encountered by this population, what are the needs of this
population, what is being done by the Canadian youth justice system, and finally what should be done by the youth justice system. The question the researcher has put forth is the following: "is the youth criminal justice system in Canada doing enough to provide care for young people entering it who have attention-deficit/hyperactivity disorder?" To answer this question, this thesis first provides an overview of attention-deficit/hyperactivity disorder, and then proceeds to review the various aetiological underpinnings of the disorder and the potential links it has to delinquency. The methodology for this exploratory research, elaborated upon in chapter 3, uses a primarily qualitative approach while also incorporating a quantitative element. Each of these methods approaches the issue within a Canadian context and includes a review of available Canadian court cases concentrating on ADHD. The qualitative dimension of the thesis is provided by an analysis of data derived from several interviews completed by knowledgeable stakeholders – a psychologist, two psychiatrists, two Crown counsel, three defence lawyers, two probation officers, two juvenile corrections employees, a community health facility employee, and a community organization coordinator. Chapters 4 and 5 provide overviews of the data collected by the researcher.

The concluding chapter includes a presentation of a series of research-based recommendations for decision-makers. This report addresses how the youth justice philosophies and policies underlying the Youth Criminal Justice Act – particularly in relation to youths' mental health – are not complementary to the treatment or programming components offered through Canada's youth justice system. This examination is founded on the existing policies surrounding youths, mental health, and youth court, particularly in reference to the sentencing policies of the Youth Criminal Justice Act, and presents suggestions for the treatment options and programs that should be made available for youths with ADHD. The research focuses on how this disorder fits into the juvenile justice system's sentencing process and the ensuing referral to suitable treatment programs. Furthermore, the researcher recommends that associated policies and special programming for youths with ADHD should be developed in line with the current CRC and Youth Criminal Justice Act's policy to properly serve the needs of this population.
CHAPTER 2: LITERATURE REVIEW

This chapter includes the review of secondary research sources which included empirical studies along with detailed explanatory articles on the disorder. This part of the research examines the causes of attention-deficit/hyperactivity disorder and offers explanations of what the developmental disorder entails. It moves its focus to the role such neurocognitive disorders play in youths' behaviour and day-to-day lives. Such issues comprise attention, impulsivity, peer interaction, delinquency, and aggression. The chapter also includes a discussion of the various links which ADHD can often generate between youths with the disorder and the legal system. The focus in the later section will be on impulsivity, aggression, social relationships and ties, rejection internalization, and substance abuse.

Attention-Deficit/Hyperactivity Disorder – Understanding the Disorder

Attention-deficit/hyperactivity disorder is a lifelong developmental disability characterized by inattentiveness, over-activity, impulsivity, or some combination of these factors (American Psychiatric Association, 2000). For an individual to be diagnosed with ADHD, these characteristics must be greater than that of the normal range for the young person's age and development. Three subtypes of ADHD are currently recognized: predominantly inattentive, predominantly hyperactive-impulsive, and a combined subtype. The combined subtype is the most commonly represented subgroup, accounting for 50 to 75 percent of all individuals with ADHD (Wilens, Biederman, & Spencer, 2002) and is evidently the most complex.

Attention-deficit/hyperactivity disorder affects both genders; however, it is recognized that boys are more commonly diagnosed with the condition (Wilens et al., 2002). A consequence of this is that very little literature on girls with ADHD exists, reflecting a general problem with the forensic mental health literature. The research indicates that disabilities, in particular learning disabilities and serious emotional disorders, are far more common among incarcerated youths than among youths in schools. The U.S. Centre for Disease Control carried out a recent study and found that approximately 7.8 percent of U.S. children aged 4-17 are currently diagnosed with ADHD (Brown, 2007); the number is estimated to be similar among Canadian youths. Studies also suggest that attention-
deficit/hyperactivity disorder is 4 to 5 times more prevalent in correctional facilities than in schools (Mears & Aron, 2003).

**The DSM IV-TR**

The *DSM IV-TR* (2000) criteria for diagnosing ADHD requires six or more indicators from a detailed list composed of symptoms of inattention, hyperactivity, and impulsivity; these symptoms have to be present before the child reaches 7 years of age. Impairment from the symptoms must be present in two or more settings (for example school and home); however, there must be clear evidence of clinically significant impairment in at least the social, academic, or occupational functioning. The symptoms cannot occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder, and cannot be better accounted for by another mental disorder (for example mood, anxiety, dissociative, or personality disorders) (DSM-IV-TR, 2000). These complex criteria define ADHD as a mental health impediment.

The *DSM-IV-TR*, while seemingly valuable, is not the only tool that can be used when screening for ADHD. Psychologists, psychiatrists, and medical practitioners should, therefore, not rely solely on employing the coding system of this manual and should exercise caution when defining the condition.

**Disorders Associated with ADHD**

Depression, sleep deprivation, specific learning disabilities, tic disorders, and aggressive behaviour problems may be confused with – or appear along with – attention-deficit/hyperactivity disorder (Tulman, 2003). This is also true of anxiety disorders, autism, and Tourette’s disorder (Gillberg et al., 2004; Smalley, 1997). A further assortment of conditions that carry with them symptoms analogous to those present in youths with ADHD include giftedness, malnutrition, and alcohol or drug abuse. These often lead to erratic behaviour in young people and adolescents which can be confused with the characteristic symptoms of ADHD. Additional neurocognitive conditions, that display signs similar to those for attention-deficit/hyperactivity disorder, can occur exclusively or can co-exist with ADHD. The most common disorders associated with ADHD are classified as disruptive behaviour disorders; such conditions include conduct disorder (CD) and oppositional defiant disorder (ODD).
Comorbidity – the presence of one or more disorders in addition to a primary disorder – presents a major crisis within juvenile detention facilities (Boesky, 2003). Along with ADHD, young offenders have a tendency to carry another diagnosis coming from a lengthy list of problems: major depression, mania, psychosis, separation anxiety, generalized anxiety, and substance abuse, to name a few; hyperactively disordered youths characteristically have such a litany of disorders. Comorbidity, especially with the presence of conduct disorder, results in an increased likelihood for physical aggression, a greater variety of antisocial behaviour, and, as a result, delinquency (Vermeiren, 2003). Available research has estimated that 3 to 11 percent of jail and prison inmates have co-occurring substance use and mental health disorders (Peters & Matthews, 2003). Professionals questioned in the field of criminal justice and corrections, however, believe this number to be much higher. According to community mental health physician, conduct disorder (CD) and ADHD occur together in approximately 50 percent of all cases (Community mental health physician, personal communication, 2008); learning disabilities and ADHD occur together in approximately 30 percent of all cases (Educational psychologist, personal communication, 2007). These individuals face more personal difficulties in employment, school, social relationships, and mental functioning; they are also the individuals who continually cycle through the criminal justice system. Comorbidity makes it more difficult to make a complete and accurate diagnosis, and, as a consequence, certain disorders are often undetected. As a result, the individuals concerned do not receive proper treatment for any of their many disorders. There are also added problems such as misdiagnosis, neglect of rounded treatment interventions, and ensuing poor outcomes. It is, therefore, important for professionals working with youths with ADHD to have a working knowledge of each of the associated disorders.

Comorbid psychiatric disorders are a major health problem among detained youths. A study coming out of a detention centre for juveniles in Chicago (2003) found that 56.5 percent of females and 45.9 percent of males met the criteria for two or more of the disorders mentioned above (Abram, Teplin, McClelland, & Dulcan, 2003). On top of this, 17.3 percent of females and 20.4 percent of males had one disorder. An earlier study carried out at the same facility discovered that almost two-thirds of males and three-quarters of females could be diagnosed with one or more psychiatric disorders (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Thus it is recommended that further research be
conducted into this situation and that professionals begin to discuss how to improve treatment and reduce health disparities in the juvenile justice and mental health systems.

The identification of young persons with mental health disorders can be very challenging as they are often unwilling to share a diagnosis with corrections staff. If there is no previous assessment or diagnosis made and correctional staff members are not adequately trained to recognize subtle signs or symptoms of a serious disorder, then it is quite possible that they will deem the youth’s negative behaviour as intentional, manipulative, resistant, and so forth (Boesky, 2003). This typically results in “the bad kid” label being applied by staff as a result of the overlooked disorder; thus training staff and corrections personnel in recognizing minor and major symptoms is critical for the improved treatment and rehabilitation of these young persons. Without improved training, it is very possible that unidentified youths will simply be recycled through the system until someone recognizes the underlying cause(s) of their seemingly uncontrollable negative behaviour.

Causes of ADHD

Neurobiology

Specialists are still unsure of the precise neuro and pathophysiological molecule(s) associated with ADHD. There is nonetheless emerging neuropsychological and neuroimaging literature that indicates that the brain structure of youths with ADHD is noticeably different from that of other children. Such scientific studies using advanced neuro-imaging techniques of brain structure and function have scanned the brains of children with ADHD and have indicated abnormalities of the frontal and frontostriatal networks (Wilens et al., 2002). These regions of the brain are central controls for attention and executive functioning; hence such findings can be fundamental in the understanding of what underlies ADHD (Makris et al., 2007).

Researchers have reviewed magnetic resonance imagining studies carried out on children with ADHD that revealed abnormalities in the brain, more specifically of the prefrontal cortex (PFC), basal ganglia, and cerebellum (Serene, Ashtari, Szeszko, & Kumra, 2007). Such abnormalities are believed to trigger symptoms which are prominent in persons with ADHD, such as dysfunction in attention, inhibition, and executive control. A major study coming out of UCLA used magnetic resonance imaging (MRI) to compare the brains of 27 children with ADHD to those of 46 children without the disorder. The researchers
found that the region of the brain associated with attention and impulse control, located on the bottom of the frontal lobes of the brain, was smaller in the ADHD children. On top of this, they discovered that children with ADHD had larger areas of the outer layers of the brain (Sowell et al., 2003). Further studies examining the brain’s structure using the results from MRI studies found that, when compared to healthy control subjects of the same age, children with ADHD have smaller total cerebral volumes in the cerebellum, and greater cortical thinning in the medial and superior prefrontal region (Serene et al., 2007). Additional longitudinal studies (Shaw et al., 2006) showed a normalization of right parietal cortical thickness at the time of follow-up imaging. Encouragingly, this suggests an ongoing maturation of attentional networks during adolescence.

New research and analysis suggests that earlier brain-imaging scans missed a critical phenomenon in understanding the brain and ADHD. It was discovered that crucial parts of the brains of children with attention-deficit/hyperactivity disorder develop more slowly than those of their peers. At the same time, the vital region of the brain that controls movements tends to develop more quickly (Schmid, 2007). This in turn decreases the youth’s ability to focus their attention and suppress inappropriate actions and thoughts.

Further fMRI studies of young persons have been completed employing tests of cognitive and inhibitory control and tests of attention. When comparing youths with ADHD to youths without the disorder, these tests revealed a decreased activation of prefrontal regions and the anterior cingulate cortex of those with ADHD (Serene et al., 2007). These frontostriatal abnormalities have also been observed in other studies using various cohorts and age ranges corroborating the results. Scientific studies also show that children having attention-deficit/hyperactivity disorder process neurotransmitters such as dopamine, serotonin, and adrenalin much differently from their peers; this may lead to obvious difficulties with their behaviour, learning, as well as personality (Tulman, 2003). A study by Durston et al. (2006) predict that an amalgamation of at-risk genotypes (10R allele of the dopamine transporter gene and 4R allele of the dopamine D5 receptor genotype) along with environmental factors and other variables may contribute to abnormalities in brain-tissue volume which lead to the development of ADHD (Durston et al., 2006). Moreover, when utilizing attentional networks in the brain that work in alerting, reorienting, and executive control, persons with ADHD recruit deviant regions of the brain compared to non-ADHD control subjects (Serene et al., 2007).
A probable aetiologic factor in the development of attention-deficit/hyperactivity disorder, which is highlighted in another study, is the role of serotonin 5-hydroxytryptamine (5-HT). Serotonin 5-hydroxytryptamine (5-HT) is a neurotransmitter involved in a variety of functions and behaviours such as attention, sleep, memory and learning, locomotion, control of appetite, anxiety, and drug abuse. Various studies have shown that a reduction in the levels of this transmitter can lead to aggression and impulsivity, both key symptoms associated with ADHD. Based on these detailed studies, it can be deduced that the reduction in serotonergic function linked to ADHD can be traced back to this neurotransmitter and can be used to explain the aetiology of ADHD. Relatively low platelet serotonin levels have been reported in patients with ADHD. It is reasonable to hypothesize that genetic abnormalities in this gene may influence the concentration of brain serotonin levels and contribute to the development of many psychiatric disorders including ADHD (Sheehan et al., 2005).

Increasingly specialists are recognizing that attention-deficit/hyperactivity disorder is not as straightforward as a behaviour disorder. More precisely, it is a “complex syndrome of impairments” in the development of the brain’s cognitive management system, or executive functions (Brown, 2007). The disorder affects an individual’s ability to organize and begin tasks, attend to details and avoid excessive distractibility, and manage emotions appropriately. This is a mere fraction of the catalogue of problems that coincide with this disorder (Moore et al., 2006). From all of these studies, it is obvious that children with attention-deficit/hyperactivity disorder have altered brain pathways. Medication can often reduce such abnormalities in areas that regulate attention and impulsive behaviour. One noteworthy problem, however, that occurs with imaging research, is that it is difficult to control for the effects of medication on brain structure over one’s life-span. Fortunately, more recent studies are able to reduce the possible interference of medications (Bush, Valera, & Seidman, 2005). Although imaging research is evidently not without flaws, it still provides one of the most useful means to study many neurocognitive disorders’ influence on structure.

Understanding the neurobiology underlying attention-deficit/hyperactivity disorder is a fundamental starting point for developing an understanding of why young persons with the disorder behave the way they do. The pivotal trouble for youths with ADHD is their impulsivity – their inability to imagine the future and to forecast reasonable consequences.
for their actions. “The frontal lobe – the last part of the human brain to evolve, the slowest to mature, and the first to deteriorate in old age” – allows us to imagine or experience the future before it happens (Gilbert, 2006, p. 33). According to Gilbert (2006), any damage to the frontal lobe impairs planning and anxiety; which is critical for allowing normal, modern humans to project themselves into the future. Essentially, impairment of the frontal lobe, whether at birth or the result of an accident, results in an inability to think about the future creating a “permanent present” for that person.

**Sociology**

By solely highlighting the possible neurological foundations of attention-deficit/hyperactivity disorder, doctors and ADHD specialists are overlooking a major piece of the ADHD puzzle. The sociology behind ADHD should not be underestimated. Years of empirical research supports the large role environment plays in an individuals’ development and socialization (Einstadter & Henry, 2006; Henslin, 2004; Schmitz, 2003). Family, school, and peers are all intricately intertwined into an individual’s life. Incontrovertibly, family largely influences development (Henslin, 2004). Relationships in the home, school, social, or work settings are the fundamental underpinnings of our quality and experience of life (Gonzalez-Mena, 2005). From these basic principles, it becomes clear that attention-deficit hyperactivity/disorder must be evaluated not only from a biological standpoint, but also from an environmental one.

To emphasize the importance of familial/social support and relationships, a study by Harry Harlow in 1959 examining the attachment behaviour of infant rhesus monkeys, demonstrates the value of an instinctual social drive of seeking to maintain social closeness and social contact (Harlow, 1959). Similar to a lack of food and shelter, a deficiency in social contact often leads to profound grief and distress. In John Bowlby’s attachment theory, attachment is described as a “…lasting psychological connectedness between human beings” (Bowlby, 1982, p. 194) – an emotional relationship that entails the sharing of comfort, care, and pleasure. He promoted the psychoanalytic view that early experiences in childhood, such as weak or insecure relationships, have an important influence on development and behaviour later in life. A paper by Naomi Eisenberger and Matthew Lieberman conceptualizes social pain as being analogous to Bowlby’s description of the separation distress that occurs when an infant is separated from a caregiver and consequently feels
agony. Social pain is described as the distressing experience arising from the perception of psychological distance from others to whom they were close or who were from the same social group (Eisenberger & Lieberman, 2004). Psychological distance includes a series of experiences including rejection, exclusion, non-inclusion, or any socially-relevant cue that causes a person to feel unimportant to, distant from, or not valued by important relationship partners.

Each of the processes discussed in Bowlby's attachment theory, and in Eisenberger and Lieberman's idea of social pain, occurs through the young person's connections to other individuals in their life, including family, friends, classmates, and teachers. Problems, however, may present themselves on this path to self-discovery and acceptance that may offset the proper development of these stages. Two of these "problems" are common psychological disturbances – ADHD and antisocial conduct disorder (Gowdy et. al., 1998). Family, peer and school connectedness are each found to be strongly correlated with concurrent mental health symptoms such as those of ADHD. Results suggest a stronger than previously reported association with the relationships of adolescents' connectedness and depressive symptoms (Dixon, Howie, & Starling, 2004). Understanding mental illness is imperative to the understanding of young people who act against norms or the law. The implications that it can have on society are extremely damaging for the offending youth and the general population.

Attention-deficit/hyperactivity disorder is a disorder that affects not only the individual, but everyone around him or her. As children with ADHD are known to have tremendous trouble listening, are easily distractible, blurt out words or expressions, regularly fidget, run about excessively, and continually interrupt others (Weyandt, 2001), they are evidently very difficult to control. Unfortunately, a consequence of this phenomenon is that, as these youths try to establish and maintain relationships, they begin to irritate and frustrate those individuals with whom they interact. Too commonly, they alienate everyone around them, making it nearly impossible to tolerate their company. Parents and guardians frequently try various techniques to manage the child's behaviour and often resort to harsh punishments when nothing else works. What can be even worse is that, in some instances, parents and guardians make a conscious effort to ignore the child's actions and misconduct in an attempt to calm the child or themselves; ignorance can also be seen as a final resort, but it is not a victorious one. Family dysfunction can be viewed as an outcome of dealing
with a child with the attention disorder. Breakdown within the family, however, can also act as a risk factor in the child’s predisposition to symptoms of ADHD (Bartol, 2002; Hudson & Rapee, 2005). An unstable home environment can aggravate and intensify the appearance of the inattentive, hyperactive, and impulsive behaviours; this setting can, furthermore, cause the conduct to become more recurrent.

There have been numerous cases in which children have had a slight disposition to be identified with attention-deficit/hyperactivity disorder and their home environment served as a tool to exacerbate inattention, impulsivity, and hyperactivity to clinically significant degrees (Hudson & Rapee, 2005). Household settings in which there is little organization, control, consistency, and responsiveness attributed to parental ADHD or other psychopathology can be a major risk for these youths. On a larger scale, in socially disorganized communities, the rates of mental health illnesses are greater when compared with more structured and balanced communities (Silver, Mulvey, & Swanson, 2002). One key feature in dealing with ADHD in young people is creating controlled environments which minimize the outbursts of symptoms such as impulse. The family should provide an accommodating and structured setting, serving as a protective factor in a youth’s upbringing.

To complicate the role that family environment plays in the life of a youth with ADHD, a study carried out in Greece (2007) found that parents consider attention hyperactivity disorder symptoms in their child as less severe than they actually are and, furthermore, that the family environment has fewer negative impacts than it actually does. It also established that parents have a limited knowledge about the clinical meaning of ADHD behaviour (Maniadaki, Sonuga-Barke, Kakouros, & Karaba, 2007). This study, as well as others (Kuo, 2007), exemplify the difficulty of not only recognizing and diagnosing ADHD, but also of understanding the clinical effects of the disorder and appreciating the impact of the youth’s social environment on the symptoms.

The tendency for youths with ADHD to display “difficulty staying on task, remaining cognitively organized, sustaining academic achievement..., and maintaining control over their behaviour” (Bartol, 2002, p. 56) evidently crosses over into the field of learning. Teachers experience similar situations and interactions as parents when dealing with these youths within the class environment. Those who are not familiar with the disorder often believe the children are acting out deliberately; they believe that by punishing
the child, they can modify their behaviour (Tarkan, 2003). Unfortunately, these youths cannot control their own behaviour and the teachers' misguided attempts will inevitably fail.

An added complication in youths with ADHD is serious antisocial behaviour (Bartol, 2002). Young persons with attention-deficit/hyperactivity disorder often endure rejection by their peers, particularly when they are notorious for displaying an aggressive disposition. Sadly, children and adolescents, who demonstrate particularly excessive hyperactive behaviour, experience even greater degrees of exclusion. This rejection seems to persist through the developmental years. On top of home and school-related problems, the added stigmatization and rejection which youths with attention-deficit/hyperactivity disorder receive from peers can be the most damaging. Youths with ADHD are often loners and have trouble relating to people their own age (Hudson & Rapee, 2005). As young individuals look to their friends for the most support and approval, the absence of this close bond is severely unhealthy for social development. The harassment projected onto the child or adolescent with attention-deficit/hyperactivity disorder as a result of their poor social status, further worsens the symptoms and behaviours brought on by ADHD.

Poverty, maltreatment, and other forms of unfavorable conditions for healthy development can also play a role in the development and persistence of ADHD (Kuo, 2007; Steele, Dewa, & Lee, 2007). Various forms of abuse, whether physical, mental, or sexual, may also trigger mental health problems in the form of neurocognitive disorders by releasing high levels of stress hormones. For example, the Dunedin cohort study carried out in New Zealand suggested that childhood maltreatment triggers a genetic disposition of low levels of monoamine oxidase activity which regulates serotonin and dopamine levels (Caspi et al, 2002). As mentioned earlier, these two neurotransmitters are directly associated with ADHD, and as well, abnormal levels increase the risk for aggressive behaviour. Among those individuals who were both maltreated during childhood and had the polymorphism associated with lower MAOA transcription rates, the researchers established increased levels of conduct disorder in adolescence, increased levels of a disposition towards violence, increased convictions for violent offences in early adulthood, and increased antisocial personality disorder symptoms.
Impulsivity

Impulsiveness is one of the principal indicators of ADHD. It is also a central symptom of conduct disorder, oppositional defiant disorder, antisocial personality disorder, FASD, bipolar disorder, and psychopathy (Frick, Bodin, & Barry, 2000; Loeber, Burke, Lahey, Winters, & Zera, 2000; Rentrop et al., 2008). In each of these disorders there appears to be an underlying genetic predisposition towards impulsivity. Interestingly, impulsivity is for the first time being regarded as more than a mere symptom of an assortment of other disorders (Hollander & Stein, 2006) and is instead being approached as a driving force behind disorders such as ADHD and CD. There are two main forms of impulse – functional and dysfunctional, with dysfunctional being the form of impulse correlated with ADHD; nevertheless, each type of impulsivity is described as “the tendency to act without forethought” (Coles, 1997 in Webster & Jackson, 1997, p. 181). A published study by Young and Gudjonsson (2005) constructs impulsiveness as a failure to inhibit or delay a behavioural response, and they put forth that this is the central deficit in ADHD.

The study conducted by Young and Gudjonsson (2005) on youths with ADHD demonstrated that the group of individuals with ADHD were more impaired on neuropsychological measures of attention and impulsivity than the healthy controls. For the ADHD group, they also found a positive correlation between their designated delinquency scale and the test of impulsivity. Furthermore, the result of the self-ratings test of ADHD symptomatology suggested that individuals with ADHD are better able to recognize their attentional problems as compared with their impulse control problems (Young & Gudjonsson, 2005). The lack of awareness of their own impulsivity can undoubtedly make dealing with the attentional disorder more difficult for the persons diagnosed with ADHD.

Impulsivity and its triggers are fundamental in evaluating the aetiology of ADHD as this trait is a central quality of individuals with this diagnosis. On top of this, impulsivity plays a major role in the onset of aggressive tendencies in young people. Studies have confirmed that impulsive aggression is a serious problem for many youths with attention-deficit/hyperactivity disorder (Arehart-Treichel, 2007). Consequently, children with ADHD who are battling extreme impulsivity have severe difficulty controlling inappropriate responses, delaying gratification, and abstaining from inappropriate behaviour. Habitually,

2 Impulsive aggression “takes place in the absence of conscious planning” (McKay & Halperin, 2001, p. 84). It is more spontaneous and occurs when the individual is no longer able to control their feelings of anger.
the outcome of this internal battle is impulsive aggression. Furthermore, cognitive deficits contribute to a greater likelihood of severe violent behaviour, especially as individuals become older (McKay & Halperin, 2001). In order to address the issue of delinquency among youths with ADHD, such factors should certainly be seriously considered.

Aggressive behaviours are often displayed by youths with the presence of a range of inattentive behaviours including attention-deficit/hyperactivity disorder, as well as conduct disorder, and oppositional defiant disorder. The likelihood of aggressive behaviours increases when inattentiveness occurs together with low cognitive ability, or learning disabilities – yet another disorder linked to ADHD (Miller et al., 2006). Although the direct correlation between learning problems and the development of aggressive conduct continues to be enigmatic, many studies have been carried out examining the correlation. Miller et al. (2006) present a study which found that low intelligence and attention problems can be used to predict delinquency in youths.

The association between aggression and delinquency with attention-deficit/hyperactivity disorder is well established. The results of a study by Rey, Sawyer, and Prior (2005) reveal that the impulsive/hyperactive subtype (combined subtype), which is the most common form of ADHD, is specifically associated with aggressive behaviour. This study makes clear the significance of aggressive behaviour in children. Such behaviours should not be undervalued as aggression is related to psychopathology and parental, familial, and social distress (Rey et al., 2005).

Contrary to the impulsive aggression commonly attributed to ADHD, in some circumstances, these young people's displays of poor behaviour and aggression are in fact deliberate. As a type of defense mechanism, antisocial children commonly become fearless. Attached to these feelings of audacity, they in turn become less inhibited (which is typical of many ADHD youths already) and more sensitive to the potential “rewards” of their antisocial behaviour. In response to the lack of attention the youth is receiving in the home and from others, he or she may choose to engage in misconduct, even aggression, as it will warrant some degree of interest from others. The intensity of internal physiological activation accompanying actions centered on aggression is correlated to the expected outcome of the behaviour imagined by the aggressive individual; it is similar to feelings of mastery or control (Vitiello & Stoff, 1997). In the case of youths with ADHD, who rarely receive appropriate or adequate attention, the anticipation of a positive outcome (being any
attention at all), results in a reversal effect of what is sought by the caretaker – inadvertent encouragement of this behaviour.

The major links that can be made between youths with ADHD and delinquency stem from the disorder's overarching symptom of impulsiveness which can be problematic on its own, and in addition to the associated aggression. This leads into the discussion of ADHD and its relation to criminology and criminological theory.

ADHD Aetiology in Criminology

Psychology-based explanations for delinquency have shifted focus from personality traits to an approach that takes an interactive cognitive and developmental focus. It is acknowledged that serious, persistent patterns of delinquency begin early in childhood, and that learning experiences during this time are extremely important. Studies have demonstrated that marked differences in impulsiveness and social skills (both key traits linked to individuals with ADHD) are evident when comparing children who eventually become serious delinquents with non-delinquents (Bartol, 2002). Even during early childhood, aggressive, cantankerous young persons are disliked and avoided by their peers, with aggressiveness being the single most influential reason for exclusion. Highly aggressive and troublesome groups of children are found to have below average interpersonal skills for their age.

Young persons with ADHD come into contact with the criminal justice system at a statistically higher rate than those persons in the general population (Goldstein, 1997). A prominent specialist in the field of ADHD, Russell A. Barkley, predicts that at least one-in-four adolescents with attention-deficit/hyperactivity disorder will drift into antisocial behaviour, and that one-in-five will have substance abuse problems as a teenager (Barkley, 1997). Rosenblatt et al. (2000) published a study demonstrating that, from a sample of arrested youths, 20 percent of youths receiving mental health services had recent arrest records, and 30 percent of youths who were arrested received mental health services. Furthermore, they noted that mental health service users had more arrests than non-mental health service users (Rosenblatt, Rosenblatt, & Biggs, 2000). Bearing this in mind, research regarding the possible aetiologies of ADHD is critical in criminology for the study of youth delinquency.
Attention-deficit/hyperactivity disorder is fundamentally a problem of self-control (Barkley, 1993). Individuals with ADHD are not capable of retaining information at the same level of efficiency as others and their response to events is delayed. This deficiency in working memory makes the individuals more likely to be influenced by the immediate surrounding events and their immediate consequences, than by those events and consequences that are more distant in time. People with ADHD live for the moment; they are not cautious or calculated and they have little regard for the temporally deferred consequences of their conduct. This is further complicated by the fact that information about the past is not as likely to be recalled by persons with ADHD. Their deficit in hindsight and forethought results in a life full of chaos. Individuals with ADHD make impulsive choices that are governed by more temporally proximal outcomes (Barkley, 1993).

Individuals who offend into adolescence and adulthood habitually come into their negative behaviour at a very early age. Characteristically, they have low achievement, are of below average intelligence, have low vocabulary and poor verbal reasoning, which all leads to poor performance in school; these qualities are also associated with later delinquency. The overlap between characteristics attributed to delinquency and those attributed to youths with ADHD is undeniable. For these reasons, the recognition and management of ADHD at an early age helps in the prevention of life-course-persistent (LCP) offenders. A large number of LCP's are found to have shown signs of neurological problems during childhood, such as ADHD, hyperactivity, and learning problems. They, in turn, have judgment and problem-solving deficiencies when older, and commit aggressive and violent crimes over their lifetime. LCP's miss opportunities to acquire and practice pro-social and interpersonal skills because they are rejected and avoided by peers; in addition, parents and teachers give up on them due to frustration. "If social and academic skills are not mastered in childhood, it is very difficult to later recover from lost opportunities" (Moffit, 1993, p. 684).

Applying criminological theory to youth with ADHD

Control theorist, Travis Hirschi, proposes that all humans are antisocial in nature and are thus capable of committing a crime (Einstadter & Henry, 2006). Still, individuals are kept in line by the ties and social bonds that link them to society and its norms. Youths suffering from ADHD, however, do not hold the same bonds as the average individual. The breakdown of bonds, which occurs between these young people and their family, friends,
and school, is very detrimental. As their commitment to the institutions of family and school is waived, they may turn to other youths in similar situations. For youths with ADHD, this simply provides outlets for increased negative conduct and other forms of delinquency.

Hirschi's social control theory and Agnew's strain theory view such social problems as strains on the young individuals (Einstadter & Henry, 2006). Young people experience countless sources of strain from day-to-day living. For youths who are experiencing ADHD, these strains can be augmented drastically. If there is no support system upon which these young people can rely, they may resort to aggressive and/or violent behaviour in an attempt to gain a better sense of themselves or to acquire feelings of worth and recognition, regardless of the fact that the attention received is negative. Agnew's (1996) general strain theory (GST) concludes that strain is felt not only in a failure to obtain socially recognized and valued goals, but is also strongly linked to an individual's basic relationships (Agnew, Cullen, Burton, Evans, & Gregory, 1996). Strain can be felt as an effect of the loss of positively valued stimuli, for example, the connection to members of the family, or as a result of being ignored or chastised (Agnew, 2001).

The rejection sensitivity (RS) model is becoming extensively used in the explanation of youth aggression. As mentioned earlier, their experiences of rejection within the home, among their peers, and in the community, are quite common among youths with ADHD. Influenced by attachment theory, the RS model “proposes that severe, prolonged, rejection leads people to develop defensive (ie. anxious or angry) expectations that others will reject them” (Moretti, Odgers, & Jackson, 2004, p. 9). In such a high state of anxiety and anger, these youths are likely to act in hostile ways, contributing to their increased prevalence of aggression. On top of the neurological predisposition to impulsivity and aggression, this can produce a very volatile combination. A child with poor attachment capacity demonstrates no remorse when harming others and risks developing further anti-social or even aggressive and violent behaviours (Perry, 2006). Again, in combination with impulsive behavioural tendencies, this is extremely problematic for those around an individual suffering from attention-deficit/hyperactivity disorder. Fear of acceptance and feelings of rejection are all too common for these young people and thus this model describes the defense mechanism they employ.
Internalization

It is now clearly established that youths with ADHD experience countless unenthusiastic responses to their behaviour in all social settings. This certainly has severe effects on the young person's psychological and emotional sense of well-being. The many relationships formed during youth are elemental in the development of the many skills that are essential for effective social functioning all through life. Peer relationships, being the most important, are also exceptional because both sides involved in the relationship are of equal status (Hoza, 2007). Consequentially, these peer relationships provide the main source of learning fundamental life skills such as cooperation, negotiation, and conflict resolution.

A group of specialists in social relations and attention-deficit/hyperactivity disorder, lead by Hoza (2007), carried out an extensive study looking into the experiences of youths with ADHD, as compared with other same-age persons, and their perceptions of peer interactions. In their findings, they discovered that children with ADHD report a greater degree of impaired relationships with their peers as compared to the non-ADHD children. On top of this, the study revealed that children with ADHD are less socially preferred and are most often classified as being part of the rejected social status category. Interestingly, the research also suggests that sensitivity to, and perception of, others' attitudes may be impaired for some children with ADHD (Hoza et. al., 2005). These findings support the idea that youths with ADHD have a difficult time relating to other youths. The ADHD group's perceptions of a lack of healthy social relationships can inevitably lead to the development of "outsider" feelings, thereby demonstrating the severity of the negative impact of impaired social relationships on one's mental health.

A crucial point arising from these studies is the tendency for youths, particularly adolescents, to internalize their feelings. The internalizing of problems is a serious concern that can eventually result in more complicated consequences. Young people, who have not become accustomed to certain situations and relationships, a common circumstance for youths with ADHD, tend to internalize these experiences and feelings. This process may result in the expression of atypical behaviour and young people may start displaying even more unruly behaviour in an attempt to regain a sense of worth and belonging. This merely leads to added punishment both at home and in school, and further perpetuates the cycle of rejection (Perry, 2006).
As a result of the relationships which youths with ADHD form with their families, schools, and peers, these young people understand that they are viewed differently than their siblings, classmates, and “friends,” and are also familiar with being treated in a stigmatizing manner. This source of labeling, in turn, leads the young person to act out a type of self-fulfilling prophecy (Einstadter & Henry, 2006). The interpretations by those acquainted or close to youths with ADHD limit their behavioural options based on expected responses; this promotes the antisocial behaviour and the misconduct which constitute the symptoms of ADHD. The result of excessive negative reactions from those associated with the affected youths, leads to an adoption of this identity that has been created for them. Their poor interactions with others give rise to an intangible loss of control over themselves; they can become extremely indignant. Under the labeling theory of deviance, behaviour is not fixed, but rather “open to interpretation...and reformulation” (Einstadter & Henry, 2006, p. 209). This is also the case for children and adolescents with ADHD.

There is yet another noteworthy consequence of labeling. On top of fulfilling society’s expectations of individuals with mental health issues, labeling paves the way for the formation of smaller, like-minded groups of young people, or subcultures. A prevalent criminological theory, aptly known as subcultural theory, stems from the formation of subcultures within society as a result of a discrepancy between society’s norms and values and the norms and values of a specific group of individuals (Einstadter & Henry, 2006). Smaller groups, or gangs, begin to form in response to this strain. The “gang” can serve as “a substitute for what society fails to give, and it provides relief from suppression...” (Thrasher, 1927, p. 33). Criminologist, Albert Cohen (1955), explained subcultures by referring to strain exhibited through rebellion. He posited that young people were taught to strive for social status through academic achievement but, when they failed, this led to frustration and then these persons would strike back at society and the system that had let them down. This can readily be applied to youths with ADHD, who are so often failed by many facets of our society and thus group with others; this process can often result in acting out and deviant behaviour (Cohen, 1955).

Several studies have found that boys, who are found to be diagnosed with ADHD at much higher rates than girls (Quinn, 2004), are more likely to be influenced by their family than are their female counterparts (Henggeler, Edwards, & Borduin, 1997); this would affirm that boys are most likely to act in ways that would satisfy their family. Those boys, who may
have difficulty finding their place in the family realm, may be more likely to turn to each other and the “gang” culture. Problems that often develop once these subgroups are established include drug use, elevated degrees of acting out, and aggression (verbal and/or physical). Individuals of each of the sexes demonstrate noticeably differentiated styles of aggression: “…boys [are] more likely to use direct confrontation…” (Holsinger, 2000, p. 29). Again, as the numbers of boys with ADHD is much higher than females, we can see the correlation between the disorder, the strains, and outward aggression. This prompts the symptoms of ADHD to arise and take charge. Such delinquent behaviours can be especially damaging in combination with their already present symptoms of ADHD. The outcome is too often a strengthening of the harmful symptoms. What is worse is that these youths often become so entangled with subcultures that they are steered even further in the wrong developmental direction. By labeling young people with ADHD and placing them under the heading of “bad,” the attention is naturally drawn to what is wrong, instead of looking at what is right, or even what is wrong with other areas of their lives, for example school and society.

Substance abuse

Youths with attention-deficit/hyperactivity disorder are known to be at higher risk for substance abuse disorder than are other youths (Molina et al., 2007). Often stemming from the antisocial behaviour and the subcultural involvement, these young people turn to drugs and alcohol as a coping mechanism for social and familial problems related to the disorder, or as a means to fit in with other youths. The continual feeling of peer rejection and academic failure associated with young people with ADHD augments their chances for acquiring substance abuse disorders (Szobot et al., 2007). Children with ADHD habitually have trouble developing coping mechanisms by the time they reach adolescence, a circumstance which can further complicate any exposure to drugs.

Studies have supported the view that, having a behavioural disorder such as ADHD, can often predict teen substance abuse. Led by Dr. Kuperman (2001), findings from a team of researchers illustrated that alcohol dependence was remarkably higher in the ADHD group. In the sequence of life events, attention-deficit/hyperactivity disorder typically occurred first, followed by conduct disorder; substance use began with alcohol or tobacco, followed by marijuana and then other street drugs. Given such findings, it is reasonable to
suggest that there is a frequent developmental progression in some teenagers from neurocognitive disorders (above all, ADHD and CD) to use of alcohol, tobacco and marijuana, and finally to alcohol dependence (Kuperman et al., 2001).

Young people with ADHD run an additional risk for potential substance use, abuse and dependence as they often receive ongoing treatment for the disorder with stimulant medications. This can lead to abuse and misuse of the prescribed medication(s), as Ritalin is often exchanged for other street drugs (Evans, Blackburn, Butt, & Dattani, 2004). Although adolescent experimentation with substances may be normative, substance use at an atypically young age is associated with later substance-related problems. ADHD children are found to be at risk for lower age of initial use of alcohol, tobacco, and occasionally illicit drugs; this is especially likely in cases of untreated youths with ADHD (Biederman et al., 1999).

The relationship between youths with ADHD and substance abuse can also be linked to neurobiological sources. Severe impairments of the basal ganglia and frontal cortex associated with the dopaminergic circuit dysfunction make youths with ADHD unable to properly control executive functioning and manage any form of reward-system functioning. Each of these factors has a major influence over one’s propensity to become entangled with persistent drug use. As these youths have a tendency to overrate their capabilities and ignore the possibility or actuality of any negative consequences, drug abuse is a common result (Szobot et al., 2007). Many drugs, particularly stimulants, further act as a means for youths with attention-deficit/hyperactivity disorder to feel a sense of normalcy. Such substances temporarily release and inhibit the reuptake of catecholamines, such as dopamine, thereby allowing youths with ADHD to regain cognitive functioning or at least improve their cognition to some degree (Vaidya et al., 1998). This result can be extremely reinforcing for adolescents. The temporary increase of dopamine concentration in the brain can actually make the individual with ADHD feel – and even perform – better (Volkow et al., 2007). Therefore, the reasons for substance abuse among youths with ADHD are exceptionally multifaceted and, in this case, even comprehensible.

On a final note regarding youths with ADHD and substance abuse is the obvious connection to aggression and deviance. As children and adolescents with attention-deficit/hyperactivity disorder are more inclined to exhibit aggressive tendencies in a wide range of settings and circumstances, it is useful to note the link between aggression and substance abuse. A study published in *Pediatrics* (2006) provides clear evidence that, in
recognizing aggression in individuals, researchers can also anticipate utilization of a greater number of substances, as compared to usage among non-aggressive individuals (Ernst et al., 2006). Further findings of this study included the identification of ties between impulsivity and alcohol use as well as aggression and marijuana and tobacco use. All of these behaviours constitute common symptoms among youths suffering with ADHD. Substance abuse among youths with ADHD may, therefore, be but one manifestation of the underlying impulsivity associated with ADHD.  

Conclusion

ADHD is a developmental problem present very early on in a child’s life. If it remains undiagnosed, the symptoms and their effects only worsen as a result of the lack of treatment and management. Many youths with ADHD are overlooked at school and at home, and these are the individuals who are more likely to come into conflict with the criminal justice system. It should therefore be the responsibility of the various players in this arena to try and recognize the presence of a neurocognitive disorder and proceed with the necessary steps for remediation. The most readily-used and recognized forms of treatment for ADHD include prescription of stimulant medication (such as Ritalin), and intervention at home and at school – through personal and/or family counselling, behaviour modification, and special education (Barkley, 2005). Such procedures should be introduced and upheld in criminal justice settings as well. As attention-deficit/hyperactivity disorder is becoming increasingly recognized and understood among youths, the time has come to turn our attention, as criminologists, to the unique behaviour of these young individuals. This is particularly true for those who find their way into the criminal justice system. Delinquent children and adolescents experience more mental illness than do non-delinquent adolescents (Mullis, Cornille, Mullis, & Huber, 2004). Delinquent youths have few protective factors to offset these risks and are, therefore, at notable risk for subsequent psychopathology and problem behaviours (Sondheimer, 2001). Attention-deficit/hyperactivity disorder and its associated disorders are of serious concern for all members of society.

---

3 The researcher would like to communicate that research in the area of ADHD and substance abuse is varied and thus continuing. Research is also continuing and improving in all areas centered on ADHD.
Although ADHD is too broad an issue to explore exhaustively in this thesis, for an inclusive understanding of ADHD and its link to criminology and the criminal justice system, this exploration of the causal explanations is a helpful starting base. While a great deal of continued research is manifestly necessary, this thesis builds on the present body of knowledge concerning the disorder and identifies the current shortcomings of our justice system's response to youth with ADHD.
CHAPTER 3: METHODOLOGY

This exploratory analysis was largely based upon a qualitative approach. The researcher carried out personal interviews with knowledgeable professionals working with youths with ADHD in the criminal justice system. This approach provided personal insights based on real experiences that bring forward many details and matters that could otherwise be overlooked in quantitative approaches. However, owing in part to the lack of available resources relating specifically to ADHD and youths in court, as well as the extensive scope of this issue, it is important to draw on as many resources as possible. For this reason, a quantitative component was also employed to better illustrate a more rounded picture of this issue. The quantitative feature came from an extensive review of available court cases concentrating on youths with ADHD and, in particular, the trial and sentencing procedures which are applied to such youths in Canada.

In triangulating through the use of both qualitative and quantitative methods, a more universal picture is presented to better facilitate addressing the diverse needs of youths with ADHD, at-risk youths, and young offenders. Triangulation, or multi-methods, is employed in this research as it strengthens the researcher’s interpretations and thus evidence and validity, by drawing on data collected from varied sources – the case analysis and the one-on-one interviews (Johnson & Onwuegbuzie, 2004). In social policy research such as this, the potential advantages provided by triangulation are considerable (Ritchie & Lewis, 2003). Quantitative data can underestimate or neglect dynamics that are non-measurable, but are nevertheless often the most important details to be discovered in a research project. The reality of the social phenomena under study may become ambiguous owing to this underestimation of significant dynamics which are present in the particular set of circumstances which are being investigated by the researcher. Research, therefore, can often be enhanced by using diverse sources (Ritchie & Lewis, 2003). The quantitative element – in this project, the case analysis – provides more defined expressions to qualitative ideas.

Quantitative Element – Case Analysis

Through a comprehensive case analysis using QuickLaw, the researcher examined the current role the courts play in assessing and sentencing youths with attention-deficit/hyperactivity disorder. Included in this analysis were cases in which youths with ADHD
were charged for a range of offences or violations and the researcher investigated how (and if) their diagnosis of ADHD came into play during their case and sentencing. Most importantly, the researcher reviewed cases to see if either the defence or the Crown counsel made any recommendations for the assessment of the young person appearing in youth court with ADHD. Another important case element which was explored concerned the question whether there are existing programs and treatments which are currently available for youths, once they have been diagnosed and sentenced, and if recommendations for the use of such programs were made. The researcher further explored the strategies of various persons involved in the court process as well as the primary suggestions made in terms of therapy, counselling, medication, and so forth. A final issue of concern related to the determination of whether or not there is necessary monitoring taking place to ensure that the treatment goals are being achieved; or at a minimum are currently in progress.

Cases were selected from QuickLaw using various combinations of key words. The final combinations used to exhaust all possible cases were “ADHD and youth,” “Attention Deficit Hyperactivity Disorder and youth,” “ADHD and youth and sentencing,” “Attention Deficit Hyperactivity Disorder and youth and sentencing,” “ADHD and youth and assessment,” “Attention Deficit Hyperactivity Disorder and youth and assessment.” Using the results from each of these arrangements of search terms, the researcher read through each case determining whether or not it was relevant for the purposes of this research. Of the approximately 150 cases found, 39 were suitable for this analysis based on the age of the accused/offender, and the context and nature of the case (see Appendix E). To further break this down, 19 were sentencing cases in youth court, 8 were youth sentencing cases in adult court, 7 were applications to be transferred to adult court, 4 cases were appeals, and finally – 1 case was an application to be tried in youth court.

Once the cases were selected, they were closely reviewed, taking note of details such as the presence of comorbidity, particulars of the assessments, recommendations for medication and other forms of treatment, and resource availability. This information was documented and then organized in a table representing a number and percentage for each of the elected variables (see results, Chapter 4).
Limitations

The major limitation of the case analysis was the use of the QuickLaw database. While very helpful in finding numerous Canadian cases, it is not a portal to all Canadian case documents. As a result, there may have been some Canadian cases that were not available on the database and, therefore, were not included in the analysis. With specific regard to case type, there were many cases decided in appellate court, which provided information on a youth with ADHD; however, the original trial report could not be located in the database or did not include information on the youth's ADHD. It is quite likely that further access to cases could produce increased valuable information and strengthen both reliability and validity.

Another source of restriction was the choice of keywords. The researcher attempted numerous and varied combinations of keywords related to the topic of youths with ADHD. Nonetheless, regardless of the precision used, it is possible that some cases were consequently missed in the search queue.

Qualitative Approach – Interviews

The other step in the analysis of youths with ADHD in the criminal justice system was the implementation of 14 one-on-one interviews. Once the interview questions were compiled and approval was obtained from the Research Ethics Board of Simon Fraser University, the researcher began selection of the interview participants. A range of knowledgeable professionals working in areas that provide services for youths were selected for interviews; these were persons who habitually come into contact with youths with ADHD in the criminal justice system.

Qualitative research conducted by means of an interview constitutes a valuable toolbox uncovering knowledge that is often inadvertently concealed or unreported. In this part of the research process, individuals were purposefully selected for participation in order to fill a desired role. Based on their relationship or connection to the issue at hand, in this case youths with ADHD, these individuals were able to enlighten the researcher, based on the individualistic nature of their responses. This naturalistic approach provided personal insight into particular individuals' knowledge and opinions of the management of youths with ADHD. The qualitative analysis facilitated the acquisition of a first-hand understanding of the nature of young persons with ADHD within the criminal justice system, in addition to
offering a clear personal picture of the phenomenon (Ritchie & Lewis, 2003). Professionals working in the fields of psychology, medicine, law, and corrections all hold distinct impressions of how youths with ADHD are recognized, diagnosed, and treated throughout the various steps of the legal system. Each professional group was able to present their own personal, dynamic perceptions of the realities of these young people.

Why the in-depth personal interview?

On top of the existing research introduced in the literature review, there is additionally a wealth of knowledge to be gained from one-on-one exposure to experts in the field. It is important to gain a sense of the actual experiences undergone by these youths and the people that come into contact with them. By asking questions, researchers can learn so much more and create a deeper meaning and understanding that can resonate with all individuals. This is why in-depth qualitative research on youths and ADHD is so important. Such assessments provide the real-life accounts of authentic experience; not simply lists of problems and suggestions for theoretical solutions. Through personal construal, the interview seeks to describe the meanings of central themes in the world of youths living with attention-deficit/hyperactivity disorder. The interview method is particularly appropriate in light of the researcher’s interest in the opinions and impressions which individuals develop in relation to the question as to what it means to be a youth diagnosed with ADHD and what types of treatment options are, or should be, available.

Study setting

The participants selected for this study are employed primarily in the Lower Mainland area of British Columbia. To make a small comparison between provinces, as well as urban versus rural, two individuals were also interviewed from Newfoundland and Labrador. The bulk of respondents came from Vancouver, Burnaby, Surrey, and Coquitlam/Port Coquitlam. Respondents coming from Newfoundland were located in Whitbourne at the Youth Detention Centre and Clarenville, a neighbouring community. The effort made to contact a probation officer/correctional employee, as well as a psychologist, located in Newfoundland was in order to grasp an idea of the available services on the east coast and in a very rural setting when compared to the much larger metropolis of Vancouver and its surrounding area.
Sample selection

Interviews for this research were carried out with a purposive sample. The participants for this part of the study were chosen with the help from the researcher's graduate committee members and additional SFU criminology staff, who maintain many ties with the mental health and correctional service providers in the area. The researcher also identified some of the participants through her own inquiries and then made initial contact with them personally. In addition, the researcher made contact with some participants through her personal connections with a community youth organization. Once the contacts were made, the snowball effect played out through referrals and suggestions as to other potential participants who could be helpful. The result was 14 respondents. All participants were initially contacted by either an introductory e-mail or a personal phone call. The interviews were then arranged for a later date.

Description of interviewees

Selected individuals included more distinctively, one psychologist, two psychiatrists, two juvenile corrections employees, one community youth mental health treatment centre representative, two Crown prosecutors, three defence counsels, two probation officers, and one community youth program coordinator. The participants had different levels and years of experience in their field. On the subsequent page is a table outlining each participant's profession, date of interview, and their assigned letter representation (for anonymity purposes).
Table 1  Respondent’s Profiles

<table>
<thead>
<tr>
<th>Letter Representation</th>
<th>Profession</th>
<th>Date of Interview</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent A</td>
<td>Psychiatrist</td>
<td>12/07/07</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent B</td>
<td>Crown Counsel</td>
<td>12/10/07</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent C</td>
<td>Adult Defence Lawyer</td>
<td>12/12/07</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent D</td>
<td>Crown Counsel</td>
<td>12/13/07</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent E</td>
<td>Forensic Psychiatrist</td>
<td>01/15/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent F</td>
<td>Youth Probation Officer</td>
<td>01/16/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent G</td>
<td>Defence Lawyer</td>
<td>01/18/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent H</td>
<td>Community Organization</td>
<td>01/21/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent I</td>
<td>Defence Lawyer</td>
<td>01/29/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent J</td>
<td>Youth Probation Officer</td>
<td>01/30/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent K</td>
<td>Community Mental Health</td>
<td>02/08/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent L</td>
<td>Youth Correctional Officer</td>
<td>02/11/08</td>
<td>Lower Mainland</td>
</tr>
<tr>
<td>Respondent M</td>
<td>Educational Psychologist</td>
<td>12/16/07</td>
<td>Newfoundland</td>
</tr>
<tr>
<td>Respondent N</td>
<td>Youth Case Manager</td>
<td>02/13/08</td>
<td>Newfoundland</td>
</tr>
</tbody>
</table>

The instrument

There were 6 sets of interview questions which were compiled by the researcher and developed as open-ended questions geared towards each of the various professionals depending on their specific roles. Questions for the interviews focused on the individual’s personal familiarity with the attentional disorder, their degree and circumstance of contact with youths who have the disorder, their perceived notions of persons with the disorder (for example, its influence on behaviour, risk for delinquency, and so forth), their role in helping young people with the disorder, and any possible recommendations they may have for better managing youths who have been diagnosed with the disorder. The interview questions are located in Appendix A.

Procedures

After obtaining approval from Research Ethics Board of SFU, the introductory e-mails and phone calls were made. Contacts were made through a directory of relevant professionals in the lower mainland received from a professor in the School of Criminology. Further contacts were made with various persons who were identified by means of the snowball sampling technique, by which respondents recommend more appropriate or additional potential interviewees.
Participants were approached by a request to participate in the research and were, in turn, selected based on voluntary agreement. Once interview times were arranged, interviewees were provided with an informed consent document including a synopsis of the research objectives, principles, and goals (see Appendix B). It also stated the low risk of any foreseeable harm occurring during the course of the study. The participants were again briefed on the subject and reminded of the approximate time of the interview before commencing. The participants signed the forms, were ensured of confidentiality and anonymity and then the interviews began.

The interview and coding processes

The interview times ranged from 30 minutes to two hours; each interview was recorded on a personal recording device and, after transcription, was deleted from the apparatus. The dialogues took place in private, quiet settings to avoid any unwanted distractions. In the transcription process, all interviews were transcribed verbatim with informant’s names being replaced by letters. Throughout the research process, the typed transcriptions were protected on the password-enabled personal computer of the researcher.

Once the interview process was complete and all interviews were effectively transcribed, the researcher began her analysis of the transcribed and fundamental data collected. The dominant ideas and common themes that emerged from each interview were pulled from the transcribed document for further examination and analysis.

Limitations

There were some expected shortcomings in carrying out the interviews. The researcher experienced problems obtaining responses from several individuals who had been contacted, even after follow-up attempts. Professionals in these areas are very busy individuals and are not always at the disposal of researchers or interviewers. Furthermore, some professionals seemed disinterested in the research area, and there were those individuals (specifically legal professionals) who did not believe that the disorder actually existed. As a final point, the researcher was unable to obtain a judicial participant. Nevertheless, the researcher believes that the lawyers, particularly Crown counsel, were able to provide information that would be similar to the perspectives of a judge.
On top of problems contacting individuals for an interview, added time constraints did not allow for many follow-ups to individuals who did not initially respond. Although attempts were made, the researcher eventually had to relinquish these potential participants. The time constraints of the respondents also proved to be a major issue as detailed responses were, in some cases, difficult to obtain. Although the main points of the interview questions could be expressed over the period of 20-25 minutes, more descriptive responses were welcomed and required more time; however, for the majority of respondents, these descriptive responses were simply not possible given the respondents’ personal responsibilities.
CHAPTER 4 – LEGAL ANALYSIS

As can be seen from a review of the disorder's causes, symptoms, and effects in Chapter 2, a diagnosis of attention-deficit/hyperactivity disorder does create an involuntarily diminished capacity to deliberate upon the outcome of one's actions. This can have major implications for youths' involvement in crime and their subsequent surfacing in the criminal justice system. Since youths with ADHD are at an increased risk of coming into conflict with negative influences, situations, and hence consequences, the criminal justice system should be aware of this predisposition and develop basic steps to aid the youth during the processing of his or her case. Nevertheless, it must first be noted, that, while it is valuable to incorporate the presence of ADHD into the youth's case for court, the disorder does not warrant any absolution from criminal responsibility for his or her wrongful behaviour. It is argued, however, that lawyers and judges should nevertheless be aware of what a young person incurs as a result of the disorder's presence in their lives.

This chapter reviews the existing policy and legislation relating to mental health and youths in the criminal justice system, explores the differences between youth and adult sentences, and finally presents the researcher's analysis of Canadian court cases putting the current issue into context.

Existing Legislation and Policy

There is no directive manual or specific section in the Youth Criminal Justice Act that delineates a process that should be followed when representing a young person who has received a diagnosis of ADHD. While many legal professionals are moderately familiar with the disorder, they are not trained explicitly for managing the case-work of these young people; nor are they governed by any code that is ADHD specific. There are, however, sections in the YCJA that address mental illness and disorder; these will be explored later in this section.

In 1989, the United Nations signed a Convention on the Rights of the Child (CRC). Founded on various legal systems and cultural traditions, it embodies a universally agreed set of non-negotiable standards and obligations. Also referred to as human rights, these standards represent the dignity and the worth of each individual, irregardless of “race, colour, gender, language, religion, opinions, origins, wealth, birth status or ability and
therefore apply to every human being everywhere” (United Nations, 1989, preamble). In their overarching mission statement, UNICEF promises to support the protection of children’s rights by meeting their basic needs and expanding their opportunities to achieve their full potential (United Nations, 1989). Canada has ratified the CRC and is currently working to support the needs and rights of Canadian youths.

**YOA to YCJA**

In April 2003, the *Young Offenders Act* (YOA) was replaced by the *Youth Criminal Justice Act* (YCJA) with the primary goal of decreasing the use of custody for young offenders⁴. It was believed that there was a manifest overuse of custody for young persons. As a result, under the YCJA, unless the young person has committed a serious offence, the YCJA does not permit a young person to be sentenced to custody (YCJA, 2002). The YCJA directs an increased use of community-based alternatives, which focus on rehabilitation and reintegration into society. In line with this objective, a requirement of the YCJA is that young persons sentenced to custody serve the final one-third of their sentence under community supervision. Section 38 of the YCJA articulates new sentences for young persons which include deferred-custody-and-supervision and intensive-support-and-supervision programs, which are organized in the community. On top of this, the amendments made to the 1984 *Young Offenders Act* in developing the current *Youth Criminal Justice Act* (2002) adhere to the standards of the CRC, as well as the new standards through improved delineation of sentencing and treatment suitable for youths who come into contact with the criminal justice system⁵ (Roberts & Grossman, 2004). In addition, it includes

---

⁴ “In the year following the implementation of the Youth Criminal Justice Act (YCJA), the number of young persons aged 12 to 17 who were admitted into some form of custody declined by nearly one-half. Remands comprised nearly three-quarters (73%) of all admissions to custody in 2003/04” (The Daily, 2006).

⁵ YCJA Preamble - “Whereas members of society share a responsibility to address the developmental challenges and the needs of young persons and to guide them into adulthood; Whereas communities, families, parents and others concerned with the development of young persons should, through multi-disciplinary approaches, take reasonable steps to prevent youth crime by addressing its underlying causes, to respond to the needs of young persons, and to provide guidance and support to those at risk of committing crimes; and Whereas Canadian society should have a youth criminal justice system that commands respect, takes into account the interests of victims, fosters responsibility and ensures accountability through meaningful consequences and effective rehabilitation and reintegration, and that reserves its most serious intervention for the most serious crimes and reduces the over-reliance on incarceration for non-violent young persons” (YCJA, 2002, preamble).
supplementary policy stipulations in its preamble to guarantee a fair set of collective standards.

The above policies are critically important for maintaining impartiality and taking appropriate action when sentencing youths in the justice system. It is imperative that juvenile court participants commit this preamble to memory and take it into account for every case that goes before youth court, especially in trials pertaining to mental illness and disability. The human rights of every individual must be ensured throughout all levels of the justice system.

Medical and psychological reports

As the DSM-IV-TR defines attention deficit hyperactive disorder as a mental health impediment, section 34 of the Youth Criminal Justice Act (2002) (see Appendix C) requires that ADHD be considered a mitigating factor in juvenile court trials. This section relates to youth justice court under the subdivision of Medical and Psychological Reports/Medical or Psychological Assessment. Section 34(1) states that “a youth justice court may, at any stage of proceedings against a young person, by order require that the young person be assessed by a qualified person who is required to report the results in writing to the court” (YCJA, 2002). Furthermore, according to the Youth Criminal Justice Act’s section on Sentencing Purposes and Principles (see Appendix C), lawyers and judges are required to request assessments for any mental health disorders that appear to be present.6

Assuming the conditions of this YCJA policy are implemented during the court process, these sections suggest that, during any youth criminal trial in Canada in which the individual predominantly displays any symptoms of, or asserts that he/she has, attention-deficit/hyperactivity disorder, necessary assessments should be requested by the court; following this, appropriate programming and treatment recommendations should be imposed. This is especially important when sentencing youths, as treatment is most effective and productive the earlier in life it is implemented (Ferguson, 2005).

Sentencing adults in Canada

Canadian sentencing policy is rooted in implementing and upholding fair and effective sanctions for illegal acts as defined in the Canadian Criminal Code. There is an

6 Section 34 of the YCJA also covers the topic of the intensive rehabilitative custody and supervision order.
emphasis on fairness, protection of public safety, individualized approaches to sentencing, and policy based on support for effective methods of reducing crime. Section 718 of the Canadian Criminal Code (1985) outlines the fundamental purpose and principles of sentencing (see Appendix D). On top of crime prevention, sentences are designed to generate public respect for the laws while maintaining a fair and safe society for its members.

The sentencing of adult offenders can be quite different from the sentencing of young offenders. While in both courts there is the underlying principle of proportionality, sentencing in adult court primarily serves to hold individuals accountable and deter the public from committing similar crimes. Sentencing in youth court alternatively focuses on the young age of the individual, holding the belief that he or she can be sentenced in such a way that holds them accountable, but at the same time provides opportunities for rehabilitation and reintegration into society. It is acknowledged that youths lack the same mental capacity as adults and, for this reason, they should be dealt with differently in court. While some members of the public believe that Canada is too lenient on young offenders (Statistics Canada, 2003), it should not be the sole aim of our country and legal system to merely reprimand these young offenders. Children and adolescents are a particularly vulnerable group, therefore under the YCJA they are entitled to special care and protection. These young people are still developing in all areas – physically, mentally, and emotionally. For these reasons, provinces and communities are obligated to offer a range of alternatives to institutionalization. The YCJA proposes that the imprisonment of a child should only be a measure when it becomes the only remaining option; furthermore, in cases where closed custody is sought, it should focus on the young person’s rehabilitation, and he or she should be held for the shortest suitable period of time.

Effective rehabilitation and the teaching of skills for reintegration into the community are especially important for youths with ADHD. These young individuals are still further behind than their peers in all areas of development. To reduce their risk of a future filled with struggle and turmoil, lawyers and judges should take on an active role in facilitating this.
Cases Analysis – The National Context

Based on the secondary literature, it appears as though courts in Canada and the United States do not provide sufficient preventative programs or engage in suitable screening or assessment of attention-deficit/hyperactivity disorder (Goldstein, 1997; Snyder, 2001). In order to better evaluate the current situation in Canada, the researcher carried out a case analysis using several Canadian legal cases that addressed ADHD in youth trials. After hundreds of cases were reviewed, the total sample was 39. Cases were only considered if they were criminal cases involving youths 19 years or younger, who were assessed, diagnosed, or both, with ADHD at some point in their lives. The cases that were included in the analysis were thoroughly examined for various case facts. These details were then organized in tables, the cases being distinguished on the basis of sentencing in youth court (n = 19), sentencing in adult court (n = 8), application for transfer to adult court (n = 7), application for transfer to youth court (n = 1) and appeal (n = 4). From each of these subsections, the specifics that were pulled ranged from the prevalence of comorbidity to assessment procedures to resulting decisions and sentences.
Results

Table 2  Comorbidity in Cases

<table>
<thead>
<tr>
<th>Case details</th>
<th>Youth court</th>
<th>Adult court</th>
<th>Transfer to adult court</th>
<th>Trial in youth court</th>
<th>Appeal</th>
<th>Reduced sentence</th>
<th>Total (diagnoses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comorbidity</td>
<td>11</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>FASD</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>CD</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>ODD</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>APD</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>SAD</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>LD</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Comorbidity

In congruence with existing research, comorbidity was a very visible aspect in many of these youths (see Table 2). Not unexpectedly 56 percent (n = 22) of the young people implicated in these cases were diagnosed with more than one disorder. Oftentimes, they were diagnosed with several disorders on top of ADHD. A further breakdown found that conduct disorder was most common in youths with ADHD at 26 percent (n = 10). Although somewhat smaller than expected, this finding reflects the common overlap of ADHD with CD. As discussed by a community mental health physician, attention-deficit and conduct disorder occur together approximately 50 percent of the time (Community mental health physician, personal communication, 2008).

FASD or fetal alcohol spectrum disorder is another noticeable condition appearing with ADHD. In this analysis, 15 percent (n = 6) of cases had comorbid ADHD with FASD. Again this is not surprising since, like CD, FASD is also closely associated with ADHD. Young people with an alcohol-related disorder are often characterized by symptoms that also pertain to ADHD, for example hyperactivity and impulsivity. According to a psychiatrist in one of the cases, during childhood, approximately 60 percent of children with FASD have ADHD (R. v. W.A.L.D., 2004).
Finally, and also coinciding with previous research, substance-abuse problems and learning disabilities were also uncovered in several of the youths in the cases examined. Each condition was present in 21 percent (n = 8) of the cases.

Table 3 Case Breakdown – Assessment Details

<table>
<thead>
<tr>
<th>Case Details</th>
<th>Sentencing</th>
<th>Special Application</th>
<th>Appeal</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Youth court</td>
<td>Adult court</td>
<td>Transfer to adult court</td>
<td>Trial in youth court</td>
</tr>
<tr>
<td>Assessment – previously made</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assessment – court-ordered</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Assessment – both (one previously made &amp; one court-ordered)</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Complete diagnosis – psychological &amp; psychiatric</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Specific assessment/ diagnosis details unknown</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

**Assessments**

A review of the assessment procedures in these cases (see Table 3) revealed that, in some instances, assessments are being carried out by the courts (51 percent; n = 20) as recommended by lawyers and mental health professionals. Furthermore, the diagnoses carried out appear to be quite thorough involving the professionals necessary for reaching an accurate diagnosis. Both the court-ordered assessments, as well as earlier outside assessments, were most commonly undertaken by more than one mental health expert (64 percent; n = 25), including at least one psychologist and one psychiatrist in the evaluation. This is very important to take into account, as proper screening for ADHD calls on both types of professionals, and often other groups of professionals, to carry out thorough, accurate diagnoses. Unfortunately, however, there are still the remaining 14 cases (46 percent) in which the assessments being carried out for youths with ADHD are not necessarily being completed properly. Furthermore, in 26 percent (n = 10) of cases, the
assessments or diagnoses were not discussed in enough detail to account for any course of action.

### Table 4 Case Breakdown – Sentencing and Final Decisions

<table>
<thead>
<tr>
<th>Case details</th>
<th>Sentencing</th>
<th>Special Application</th>
<th>Appeal</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Youth court</td>
<td>Adult court</td>
<td>Transfer to adult court</td>
<td>Trial in youth court</td>
</tr>
<tr>
<td>Sentence recommendation – medication</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sentence recommendation – counselling</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Sentence condition - unspecified treatment plan</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Probation order – following court imposed conditions</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Order or recommendation for further assessment</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No mention of programming or treatment for diagnosis</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Stay in proceedings due to unavailability of services</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Received an adult sentence to be served in youth facility</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Sentencing and final decisions

Table 4 represents the range of sentences, final decisions, and conditions assigned by the courts in the young offenders’ cases included in this analysis. The numbers of cases found to include specific conditions regarding the use of medication and counselling are not overly encouraging. Medication was recommended by the judge in 10 of the cases (26 percent), while slightly more promising, counseling was suggested in 13 cases (33 percent). Unfortunately, the encouragement felt by the researcher is diminished by the finding that, overall, while 8 cases (21 percent) make mention of the diagnosis of ADHD, they do not,
however, appear to include a consideration of the disorder in the final decision or sentencing. Of the 27 cases (70 percent) that were at the sentencing stage for the youth, 7 cases (26 percent) made no mention of a treatment plan catered to the youth's ADHD (whether medication or counselling). This was the source for major alarm for the researcher.

Youth sentences versus adult sentences

In cases where youths were sentenced as such, most of the assessments were completed by the courts (53 percent; n = 10) (see Table 3). Conversely, the youths who received adult sentences, were more likely to have been previously assessed (50 percent; n = 4) (see Table 3). This is likely due to the fact that they had been in trouble before at school or at home or were even quite possibly involved in the criminal justice system before; therefore, an assessment had previously been made. This could also indicate that the young person likely had more frequent contact with the legal system and/or the severity of the crime was greater. These facts can also account for the more severe sentence.

Both cases in which a youth was sentenced as a youth and in which the youth was sentenced as an adult had thorough assessments—n = 12 (63 percent) and n = 6 (75 percent) respectively (see Table 3). Based on these assessments, it is demonstrated that in the cases where a youth was sentenced as such, there was more attention paid to the disorder and the need for rehabilitation and treatment based on the diagnosis; judges fittingly made more of a direct link between the disorder and the sentence. In 37 percent (n = 7) of youth sentenced cases, there was a recommendation or condition to carry out a set medical régime incorporating the administration of medication for the disorder(s). This is much greater than the 12.5 percent, or one case, in which a medication order was made in a youth case imposing an adult sentence. In terms of recommendations for counselling, again 37 percent (n = 7) of sentenced young persons were ordered to attend some form of counselling; when compared with only 25 percent (n = 2) for youths sentenced as adults, this is notable. In accordance with the YCJA, several of the sentenced offenders were subjected to a probation order to be carried out either on its own or post-custody which involved follow-up assessments and meetings, along with ongoing counselling and treatment. This accounted for 32 percent (n = 6) of the youth cases. There were no mentioned probation orders for youths who were to serve their sentence in an adult facility (0 percent; n = 0). At the time of the initial sentencing, it is immediately unknown what, if any, follow-up and continued
treatment these youth may be recommended to seek upon their release. Oftentimes, they may be adults by the time their sentence is complete, thus there may be no further protective measures in place.

Table 5  Provincial Breakdown of Cases

<table>
<thead>
<tr>
<th>Province</th>
<th>Number of cases</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>13</td>
<td>33.3%</td>
</tr>
<tr>
<td>Alberta</td>
<td>7</td>
<td>17.9%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>5</td>
<td>12.8%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Ontario</td>
<td>8</td>
<td>20.5%</td>
</tr>
<tr>
<td>Quebec</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>4</td>
<td>10.3%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>The Territories</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Additional points of interest

In carrying out the case analysis, there are many characteristics of the cases that are also worth mentioning and considering for further analysis. One point the researcher discovered was that there were far fewer cases in less-densely-populated, rural provinces, than those in more densely populated provinces. Cases came primarily from British Columbia and Ontario, with 33.3 percent (n = 13) and 20.5 percent (n = 8) respectively. Alberta judgments were close behind with 17.9 percent (n = 7). On the other hand, there was a single case (2.6 percent) from both Manitoba and Newfoundland, and Nova Scotia had only 4 cases (10.3 percent) of youths with ADHD. There were no cases coming out of Quebec, Prince Edward Island, New Brunswick, or any of the territories. With the exception of Quebec, the three areas of Canada that did not provide relevant ADHD cases were the smaller and less-densely-populated provinces and territories of the country.

Cases coming from smaller provinces were not only fewer, but the details of the cases were also very vague and deficient when compared to provinces such as British Columbia. The weakest case examined in the case analysis was from the province of Newfoundland. This case mentioned very little regarding the diagnosis of ADHD; there was
no mention of an assessment being done, any further treatment or counselling being carried out, or the conditions of the sentence. In cases such as these, a potential, and sometimes acknowledged, reason for such shortcomings is insufficient support and resources in the area. Another possible reason, and cause for concern, is deficiencies in professional records due to the failure to document existing diagnoses, specific screening details, and so forth. In either scenario, the effects can be severe.

The severity and seriousness of the offences was something that also stood out in the case review. Approximately 56 percent of cases were for more serious offences which included murder, manslaughter, sexual or aggravated assault on their own or in combination with other offences. Whether or not this is the result of the more aggressive, impulsive type of ADHD, it cannot be assumed; however, it may be possible. Such offences are not entirely – and not necessarily – due to the presence of the disorder. Rather it is more likely due to the fact that, until this point in his or her life, the behaviour of the young person was never properly addressed and, therefore, the young person continued to act out and disobey the law. Without receiving proper attention and rehabilitation, the youth eventually ended up in a more serious predicament – charged and in court.

Another interesting point is that many of the cases examined were of older aged youths, or adolescents. This is possibly because these youths were successful in avoiding any serious repercussions for their actions until this stage in their life; also persons in this older age bracket (15-19) are more likely to engage in more serious acts than younger youths. The point that must be made here, however, is that, once a young person has reached this age, he or she is expected to conform to a greater extent. It is at this time that they are thought to be closer to the maturity level and development of an adult. Unfortunately, this is not the case for those struggling with ADHD. Thus, although the courts may wish to punish them more harshly and impose a sense of responsibility, this simply will not work for the benefit of these individuals.

**Discussion**

Research on comorbidity highlights the importance of recognizing multiple diagnoses and catering to each one on their own, as well in combination with the ADHD. To add to this, a notable point about these cases is that they involve youths whose ADHD and accompanying disorders have actually been diagnosed. It is critical to understand the
likelihood that there are also underlying disorders that have not been addressed or recognized in these youths. On top of this, it can be expected that there are many youths who find themselves in the youth justice system who are not diagnosed with any disorder and are being overlooked altogether.

In relation to assessments, both psychologists and psychiatrists are needed to accurately assess individuals for neurocognitive disorders. As can be seen in the assessment analysis, the courts are seemingly aware of this and are making use of all the necessary services. A central limitation of the courts is that they are on schedules based on both time and money; there is not a great deal of room for a careful examination of each and every youth. Although the case analysis in this study has provided positive reinforcement of the good work of the youth criminal justice system, it must be recognized that these were a mere 39 cases out of hundreds from youth courts across Canada. With the high occurrence of mental health disorders in young people, predominantly those who are in conflict with the law, it is quite possible that many youths are slipping through the court system without an identification of a possible disorder being made. This is why more training and education for legal professionals should be made a greater priority. In addition to psychologists and psychiatrists, lawyers and judges can also play a role in the assessment and diagnosis process. As the persons responsible for meeting with the youths and reviewing the files, they too should have at least a basic working knowledge in the area of prevalent mental health conditions in youth, the symptoms, and how they should be best addressed.

A further concern arising from the Canadian case analysis is that the bulk of the cases including a reference to ADHD are emerging from the larger provinces of British Columbia and Ontario. This suggests that the youth criminal justice courts of other Canadian provinces are lagging behind in the recognition of mental health diagnoses. Although increased population size must be accounted for in the larger regions, the numbers still present an ensuing consequence faced by the smaller regions with fewer ADHD and mental health cases – a reduced amount of exposure by professionals to various diagnoses. Based on this finding, other provinces should accordingly be taking supplementary steps to address this disorder and respect the possibility for identification during sentencing. This discrepancy is possibly related to reduced funding and services in the more rural settings; however, it is not a justification for failing to provide the necessary support for the young people of a region.
Furthermore, cases from the east coast and smaller provinces were less detailed and less inclusive. In one case, there was even a stay in proceedings because there were simply no available resources to aid in the rehabilitation of the youth (R. v. W. D., 2001). This is likely the case for many youth cases from smaller regions, as without the essential resources or even a fundamental knowledge of any services or possible treatments, there is very little the courts can offer the young person.

Conclusion

Through the case analysis, the researcher expected that there would be a greater focus on attention-deficit/hyperactivity disorder in youth cases; however, this was not what was seen. As a predominantly youth-afflicted disorder and, in accordance with the YCJA, there should unquestionably be a more powerful spotlight on this disorder. Medication, counselling, and personal training should be seen as fundamental treatments for successful rehabilitation and reintegration back into community. While the adult system is indeed supposedly more punitive, it at least appears to be addressing the condition of ADHD just as much as the youth courts, and in some cases even more.

Based on this analysis, the courts appear to be doing a mediocre job in terms of closely examining and considering this condition during trials in which youths are on the stand for their wrongful acts; if there is more being done, there is little or no record of this. Although several of the youths were assessed for ADHD, few cases discussed the details of their assessment or any potential action taken in relation to sentencing options and programs, or treatments in correctional facilities. It is recommended that more preventative and reactive measures be implemented throughout the court process to reduce the shortcomings concerning the management of youth with ADHD in the Canadian youth justice system.
CHAPTER 5: INTERVIEWS

This chapter features a review of the various interviews carried out by the researcher. One of the aims of the interviews was to provide a rounded picture of the various professionals involved in the assessment, and treatment of, youths with attention-deficit/hyperactivity disorder. The interviews encapsulate the roles played by lawyers, probation officers, correctional employees, mental health service providers, and community-based organizations in working with youths who have been diagnosed with ADHD and have come into conflict with the criminal justice system. These individuals all help these youths gain access to, and support for, treatment and rehabilitation. The overarching goal of the interviews, in line with the research project, was to examine what practices are put in place in order to screen, assess, diagnose, manage, and treat criminalized youths with ADHD. Each of the professionals’ perspectives provides differing – as well as overlapping – ideas as to what is being done and what can, and should, be done.

The researcher begins by examining the first group of professionals involved in the process of the justice system – the Crown prosecutors and defence lawyers. The focus then shifts to probation officers, psychiatrists, psychologists, correctional officers and case managers, and community organizations. Finally, the research briefly includes perspectives from community mental health services. To summarize, the researcher presents overarching themes that appear throughout the interviews and discuss how these themes may be translated into policy and programming recommendations.

Legal Professionals

ADHD familiarity

The interviews carried out with Crown counsel and defence lawyers revealed that lawyers are conscious of the existence of attention-deficit/hyperactivity disorder in some youths who come into contact with the criminal justice system. All of the lawyers interviewed held a working knowledge of ADHD; however, it was made clear by more than one lawyer that the knowledge base about the disorder is not very comprehensive: “[our understanding is] not like psychiatrists” (Respondent B, Crown counsel, 2007). Each legal respondent claimed that his familiarity with ADHD and its symptoms was based on personal experiences over the years in the field and relevant case work he has received during this
time: "basically through that experience we had a lot of kids with special needs who had been apprehended by the Ministry and that's where I first got to know" (Respondent I, defence lawyer, 2008). They all concurred that there is no specific training or information manuals for legal professionals on ADHD or how to manage a case concerning a young person suffering from such a diagnosis. This was the case not only for ADHD, but also for mental health conditions in general.

The legal respondents appeared to be comparatively more familiar with a diagnosis of fetal alcohol spectrum disorder. This reveals that FASD has, in recent years, taken the forefront in terms of awareness and interest in the courts, popping up more often in sentencing options and service recommendations. Such a finding coincides with that of the court case analysis which not only supported the fact that ADHD is often diagnosed in combination with FASD, but also the view that FASD is more often discussed in greater depth during the trial and in sentencing. While a diagnosis of FASD can oftentimes be more expressive and convoluted than ADHD, it should not automatically garner increased weight or importance when determining appropriate treatments for young persons.

To further complicate the issue of how much attention this attentional disorder is attracting in the legal system was the response received from an adult defence lawyer. Although, unlike the other respondents, this lawyer does not specialize in youth cases, Respondent C is a very prominent lawyer and the responses given were startling. To summarize, Respondent C was very adamant in expressing disbelief in the entire arena of mental health diagnoses and the professions involved in these identifications.

I am skeptical about the issues of attention-deficit/hyperactivity disorder...it is a catch all...to explain away social problems and over-medicalize social and class issues...poverty, too little work/educational skills; they are from families with too many children, too many teenage mothers, too many bad life-style examples and too much drugs and/or alcohol (Respondent C, adult defence lawyer, 2007).

Although it is undeniable that these added issues are indeed at play, what this lawyer seems to be missing is that youths can be confronted with a combination of these problems on top of a possible ADHD or mental health diagnosis.

**ADHD cases**

Several of the lawyers stressed that reference to a diagnosis of attention-deficit/hyperactivity disorder is only one fraction of the presentation of a youth’s case. They
recognize that young people with ADHD, who come into conflict with the criminal justice system, often have a variety of added troubles in their lives; "ADHD has never been the central thing that's going on" (Respondent G, defence lawyer, 2008). It's not merely a psychiatric issue; it's a psychiatric issue, plus an economic issue, plus an addiction issue… (Respondent D, Crown counsel, 2007).

Frequently the youth that we encounter are from difficult family backgrounds, people who are in the care of the Ministry, these are people without access to health care, number one, and even more difficult to obtain is mental health care… ADHD alone is not the cause of criminal behaviour; what we see is ADHD plus something else and that plus could include drug or alcohol addiction, chemical addiction, low esteem, family conflicts, sexual abuse, negative peer influence, poverty; so it's these other factors alone or in combination thrown together with ADHD that provides a recipe for a potential trouble maker or young offender (Respondent B, 2007).

These responses are in line with the literature review in Chapter 2 and previous research on youths with ADHD who become involved with the criminal justice system.

**Prevalence in cases**

With the exception of Respondent I, it was articulated in several interviews that there are "not a whole lot of cases of ADHD-specific kids" (Respondent B, 2007). When the researcher compared such comments to the responses provided by a psychiatrist and a correctional officer, it may be more accurate to say that lawyers and the courts do not recognize many cases involving youths with an ADHD or mental health diagnosis. According to a significant amount of current research and the other professionals interviewed in this research, youths with ADHD and other mental health diagnoses constitute a significant proportion of the in-custody population of young offenders. As well, several youths who are on probation and community-based sentences are also found to have one or more psychiatric diagnoses.

One reason that may explain this underestimation in the courts could be that legal professionals follow the *Criminal Code* and the *Youth Criminal Justice Act* which presume all individuals to be of a sound mind: “for example the *Criminal Code* presumes that a person is sane…” (Respondent B, 2007). In light of this assumption, unless there is a previous diagnosis or an obvious manifestation of some condition, youths in the justice system are considered “normal” and tried as such. Furthermore, owing to the lack of specialization of persons working in the legal field, lawyers are not routinely trained to deal with a youth with
ADHD; they are therefore less likely to be able to recognize the disorder. Instead, lawyers rely on reports presented by probation officers that outline any already-made diagnosis, which removes any minor responsibility that the lawyers may have had to look out for these characteristics. Therefore, unless the young person is observably disturbed, there is typically nothing further completed. “You can’t tell, or at least in my experience, you can’t tell from simply talking to the person. It’s difficult to distinguish certain things” (Respondent I, 2008). “However, in cases with extreme schizophrenia... those obvious situations we request an assessment” (Respondent B, 2007).

Respondent D added to the picture a discussion of the Youth Criminal Justice Act which, since 2003, has replaced the YOA. Since the implementation of the YCJA, “more diversion is stressed right from the base – the police; there is a significant drop in the number of youth cases being sent through to the courts and the Crown” (Respondent D, 2007). With this drop in the number of cases referred beyond the police involvement, it is likely that many youths are being released and recommended to community programs without any consideration of underlying problems. This leads to the lack of a diagnosis for many troubled young people.

Court-ordered documents

On the subject of court-related documents and reports, when asked about their role in identifying ADHD in a youth at trial, each of the interview respondents made reference to pre-sentence reports, and less frequently, psychiatric reports. Both Crown counsel and defence lawyers can, and often will, request a pre-sentence report; “if we get a person who seems to have any issues, we will commonly order a pre-sentence report” (Respondent D, 2007). It was noted, however, that it is primarily the defence’s responsibility to introduce to the court the presence of ADHD; “it becomes defence counsel’s responsibility to do that” (Respondent D, 2007); “defence lawyers probably have a more active role in the identification than the Crown” (Respondent I, 2008). This is because the defence lawyer has more familiarity with the youth and the case, and he or she often knows the care provider, social worker, and/or probation officer to some degree. The defence can raise a diagnosis of ADHD as a mitigating factor during the actual trial, whereas Crown can only do so during sentencing (Respondent I, 2008). “We do not look for mental illness within accused persons... they are responsible for their acts, and, if there is a medical, mental, or
psychological or psychiatric issue, it is for the accused or for the defence to raise the issue” (Respondent B, 2007). Lawyers will also at times suggest a psychiatric assessment be carried out; however, this assessment is less common and its completion must first be approved by the court. While psychiatric reports can be very beneficial for certain youths, they often take much longer than a pre-sentence report (Respondent D, 2007). Oftentimes, youths will already have a diagnosis on their files, either from the school or the community (Respondent I, 2008).

These interviews highlighted that it is very rare for the courts to determine that the accused person has ADHD. This finding is reflected in the case analysis described in Chapter 4. This being noted, while lawyers are willing to make requests for screening assessments, it is simply not a common procedure. “The thing is these assessments are costly...time-consuming; we do not order this kind of assessment for every first time offender” (Respondent B, 2007). “Sometimes, it’s not to the client’s advantage to end up getting a psychiatric report” (Respondent D, 2007); “[a diagnosis of ADHD] can be seen by some judges as a mitigating or aggravating factor” (Respondent G, 2008).

Assessments and programs – what the courts know

In conducting the interviews, the researcher discovered that lawyers are not familiar with the types of assessments which may be carried out and the programs available for youths with ADHD. Many lawyers articulated the view that the sentencing and probation terms discussed in court are very general and do not address ADHD treatment specifically. This was also a finding of the case analysis. Lawyers commented that cases generally review the youth’s profile and talk about crafting conditions or a sentence to fit the youth and the offence; however, the suggested provisions are deficient in precision and lack a focus on the ADHD. One lawyer made it sound very idealistic, that the needs of this group were being met: “…so that a treatment plan and a probation order could be decided or crafted to address the unique needs of this kid with ADHD” (Respondent B, 2007). Respondent G said that he would recommend programs to youths with ADHD if he knew they were available to the young person with a diagnosis. When further probed to see if he knew of any, he replied: “I have no idea; that is all done by the probation officer” (Respondent G, 2008). Another defence lawyer, Respondent I, made a similar comment.
It is apparent that lawyers have very minimal familiarity with some of the issues they are encountering in taking on certain cases. Although they are not the persons responsible for several of these procedures, it is troubling that they have no understanding of what, or who, is involved in an medical assessment or which sentencing conditions and programs would best suit a client with ADHD. According to one of the defence lawyers interviewed, this is likely a consequence of the lack of treatment and programs available in that area for ADHD, or the courts lack of awareness of them (Respondent G, 2008).

Undesired help

An additional problem, expressed through the interviews with the lawyers, was that a number of youths who have clinical diagnoses will refuse to believe that they have a particular disorder. The courts are unable to help an individual who is not willing to get treatment, take medication, or partake in counselling. "Most people with illnesses don’t think they are ill; they don’t want to take medication... the courts cannot force them to take treatment or medication" (Respondent B, 2007). The terms that are often given to a young person during sentencing read as follows: "you are to participate in and complete such counselling program as may be directed by your youth worker" (Respondent B, 2007). If the person is rejecting any form of medication, there is nothing the courts can do. The Canadian Charter of Rights and Freedoms protects people from this kind of intrusion; therefore, "you cannot have a term that says you are hereby directed to take Ritalin so many times a day for the rest of your life" (Respondent B, 2007).

There is of course not only a problem of refusing to get help, but there are also instances where the individual lacks the ability to obtain help – either because of the disorder itself or because of their life circumstances. This is especially so for youths with ADHD. "To be able to stop, you have to be able to go through counselling, be able to show up for a counselling appointment; all those things work against them... so the psychiatric problems become worse" (Respondent D, 2007). This lawyer also identified the economic issues that face many of these young people and are a major problem as well. For youths from a low socioeconomic situation, it is more difficult to find treatment and to have a stable residence so that people can reach them and support them in order to work their way through treatment.
What a guilty verdict really means

Upon the decision of a sentence, the lawyer's job is completed and it becomes the responsibility of the probation officer to further aid the young person with regards to treatment for their ADHD. "Once there is a finding of guilt, that's the end of them, I don't see them" (Respondent G, 2008). "Then it's out of the court's hands and it's in the hands of corrections... the difficult duty of putting into action... programs, treatment, and counselling for this young offender" (Respondent B, 2007); "we never deal with that person again... I don't want to say that we don't care... we don't have the time" (Respondent D, 2007). The busy schedules of lawyers compels them to process individuals, in this case youths, through the criminal justice system as expeditiously as possible, so that they can move on to the next issue, the next case, the next offence. There are too many cases in our system requiring the attention of lawyers for any case to be delved into with ample time and care to detail. If youths are overlooked at this stage of the criminal justice system, it is quite possible that they will continue to be unnoticed, undiagnosed, and untreated.

In conclusion, lawyers are not entirely uninformed about ADHD and its presence in youths in the correctional system. There are, however, areas in which improvements can be made. To leave a final thought on the current situation with youths with ADHD in the criminal justice system, a response by one of the legal respondents stood out:

I likely wouldn't be going out on a limb in saying that the resources are not widely available...the more specialized the resources, the more expensive...is it true that everyone gets plugged into the right program? ...I'm thinking not (Respondent I, 2008).

Mental Health Professionals

Mental health professionals are the most important group of people working with youths with ADHD in the criminal justice system regarding assessments and treatment recommendations. Unlike lawyers, they are instrumental in providing accurate evaluations of potentially troubled youths and then offering suggestions for follow-up, based on their analysis. There were two psychiatrists interviewed for this section – one working for youth forensics and the other as a community psychiatrist – as well as one educational psychologist.
ADHD – the reality

In contrast to the blatant skepticism expressed by a defence lawyer, one of the interviewed psychiatrists emphasized that ADHD is one of the most scientifically confirmed mental health disorders; it has the most scientific research and support verifying its appearance in young persons (Respondent A, psychiatrist, 2007). He also went on to express the increased likelihood that youths who suffer from ADHD will find themselves entangled in the justice system: “Youth with ADHD are more susceptible to substance abuse; they most often have family problems, they hang out with the wrong types of peers” (Respondent A, 2007). The interviewed forensic psychiatrist corroborated this link: “It increases their risk… I think their impulsivity plays a huge role in making decisions at the spur of the moment without really thinking them through… the craving for excitement and stimulation” (Respondent E, forensic psychiatrist, 2008).

As 20 percent of all youths today have a psychiatric diagnosis, Respondent A noted that it would be expected that roughly 60 percent of young persons in the criminal justice system have one as well. He further went on to highlight that “comorbidity is the rule, not the exception” (Respondent A, 2007).

ADHD – the reality in correctional institutions

Through the interview with one of the psychiatrists, the problem of undiagnosed conditions in facilities in the Lower Mainland area was also uncovered. When considering the plethora of mental health resources available in British Columbia, in particular the Lower Mainland, this would suggest that such a problem is also present in other regions of the country. Respondent A detailed an experience visiting a Canadian youth facility, where he and a team assessed the youths for ADHD. They found that “fifty percent of the inmates had a diagnosis of ADHD, while only five percent of them had been previously diagnosed and [were] undergoing a treatment régime” (Respondent A, 2007). This shows the seriousness of the problem of overrepresentation in correctional facilities and the overall under-recognition of the disorder in these institutions.

The state of professional assessments and services

Complementing research included in the literature review outlining proper assessment and diagnosis procedures, the psychiatric services available to youths in the
criminal justice system in the Lower Mainland are outstanding. The forensic psychiatrist interviewed enthusiastically agrees – “the assessments are in my opinion the best psychiatric assessments in Vancouver” (Respondent E, 2008). He went on to outline the procedure that is followed upon the intake of a youth for assessment of ADHD, which included a range of exceptionally thorough exams carried out with the help of nurses, psychologists, psychiatrists, probation officers, social workers, and parents/guardians.

When compared to what is done in smaller Canadian provinces, youths in the Lower Mainland are very fortunate with their resources and funding. The assessments and diagnoses carried out in other provincial youth detention facilities, for example in Newfoundland, also appear to be quite inclusive. Assessment deficiencies are most prominent in community assessments carried out by physicians or solely one mental health professional. Respondent A reviewed the procedures he follows during an assessment, which were fairly thorough, though not as detailed as those used by Youth Forensic Services. Unlike youths sent to Youth Forensic Services, those who are assessed in the community fail to receive such comprehensive examinations. There is no 24-hour supervision or any means to gain full insight into the young person’s behavioural problem (Respondent A, 2008). Community physicians make diagnoses based solely on self-reports and reports from the teachers or social workers; they make a general diagnosis in the matter of minutes. This is an extremely important point to take into account because, as indicated by the lawyers’ interviews, it is most often a youth’s prior diagnosis that the courts draw on in their decision-making.

Treatment

In terms of treatment options available for youths with a diagnosis of ADHD, the general psychiatrist said that the only treatment for ADHD was stimulant medication. “Counselling is useless. This is a chemical/brain disorder. ADHD can only be controlled by prescribed...drugs that work with neurotransmitters to regulate their functioning” (Respondent A, 2007). While the youth forensic psychiatrist conferred that stimulants are the most effective treatment, he elaborated that additional, well-accepted approaches to treatment that are of particular benefit to youths in conflict with the law include counselling (Respondent E, 2008). Such therapy would likely be of particular benefit to young offenders in understanding their behaviour and learning how to manage the disorder’s symptoms.
Youths who are being treated in the community appear to only receive one portion of the treatment regime and may therefore miss out on important rehabilitative and coping mechanisms.

A psychologist's perspective

As an educational psychologist, youths were referred to Respondent M from the school system. Her role is to talk to the family and teachers of the young person, obtaining detailed information on personal history and academic performance. Once the young person's file is compiled to the best of her ability, she makes suggestions as to the possible disorders that are present, and then passes the youth's file on to a medical professional – in most cases a local pediatrician (Respondent M, psychologist, 2007). As indicated by the comments of Respondent M, the assessment and diagnoses procedures in Newfoundland appear to be based on multifaceted records and professionals. When compared to the Lower Mainland, however, there is dissimilarity between the degree of specificity and depth in assessments and diagnoses. In British Columbia it was found that more specialized psychiatrists are carrying out the diagnosis. In the correctional setting, psychiatrists are on hand in both provinces; again nevertheless, access to the necessary resources is more readily available in larger areas, such as the Lower Mainland in British Columbia.

Respondent M's interview focused primarily on the most suitable responses to youths with ADHD. In contrast to the "solely stimulant" approach favoured by one of the psychiatrists, the psychologist was of the belief that counselling, life-skills training, and other varied forms of stimulation and exercises are of added benefit on top of prescribed medication (Respondent M, 2007). From this perspective, it is evident that more collaboration between psychiatrists and psychologists is necessary in youth cases involving an ADHD diagnosis.

Comorbidity and early diagnosis

In each of the interviews carried out for this research, comorbidity was raised as an additional problem. This complex phenomenon is best understood by mental health professionals who see the actual affects of comorbidity on a person's functioning. Respondent M highlighted the high degree of comorbidity between ADHD and learning disabilities – which she approximated to be between 30-60 percent, and noted that oftentimes there is the
problem of misdiagnosis between the two (Respondent M, 2007). In any case, the dual or multiple appearances of disorders can, and usually will, further complicate the lives of these young people in all areas. For these reasons, Respondent M stressed the importance of identifying such complex situations before jumping immediately into special treatment. Young people must receive treatment for all of their diagnosed conditions. The earlier such a multiple diagnosis is made, the earlier the young person can begin taking advantage of the interventions which are designed to address his or her problems.

Respondent M was very articulate in stressing the importance of early detection and intervention for youths diagnosed with ADHD alone, and in addition to other disorders: “without early diagnosis and intervention, these youth would begin to embark on a life full of major problems” (Respondent M, 2007). As youths with mental-health-related illnesses become older, they become lost. This can lead to aggression and very defiant behaviour; it is these more blatant expressions that take hold and mask the appearance of an authentic childhood disorder. A further problem is the long waitlists to receive an assessment by a full team and the even longer waiting lists for suitable programs (Respondent M, 2007).

Probation Officers

ADHD familiarity

Probation officers are moderately familiar with the symptoms of ADHD, and even more so with the treatment and services available for this disorder in the community. They receive cursory training which is very brief; however, their knowledge is sufficient to recognize that a youth appears to show signs of ADHD through impulsive action, inability to listen and focus, and so forth. Based on this, they “can make recommendations saying further testing is required for a diagnosis. It is at this time that [the youth] will be sent to youth forensic services” (Respondent F, 2008). The probation officers, like the legal professionals, said that they are also knowledgeable in other mental health disorders that can present themselves in youth in the criminal justice system, such as FASD and Schizophrenia.

The “class” system

It was apparent in several of the interviews conducted - and especially so in the interviews with the probation officers - that there is a totem pole-like structuring taking place by professionals who are working with youths with ADHD. Although inadvertent and
perhaps unnoticeable by the professionals themselves, attention-deficit/hyperactivity disorder is being ranked along with other commonly recognized childhood disorders. This ranking is based on the disorder's perceived level of importance and degree of risk to the person and community. "[We're] more likely to find out about CD, ODD" (Respondent J, 2008). A few of the lawyers also stated that ADHD is not as evident or as pressing as a diagnosis of FASD or schizophrenia: "attention-deficit/hyperactivity disorder is minor compared with schizophrenia and bipolar...ADHD is quite low on the priority list...something like bipolar or schizophrenia poses a greater risk" (Respondent F, 2008).

This type of classing or prioritizing seems to provide a means by which the individuals working with the hundreds of ongoing youth cases can better organize and manage their work load. Where the problems arise, on the other hand, are in cases where the youth's diagnosis of ADHD is in fact a major cause of their aggressive-violent behaviour, or the ADHD is present along with another "more serious," though thus far undiagnosed condition. Or even more problematic is the fact that, according to the latest research, many disorders are being misdiagnosed and confused with other diagnoses. The diagnoses of conduct disorder and oppositional defiant disorder have, oftentimes, been used interchangeably by clinicians, when in reality, they are two very distinct disorders (Biederman, Ball, Monuteaux, Kaiser, & Faraone, 2008); furthermore, CD, ODD, and ADHD are all too commonly misdiagnosed for one another. Finally, as Respondent F put bipolar disorder at a higher ranking level than ADHD, she would likely be surprised to learn that research has found that ADHD is in many cases being misdiagnosed as bipolar disorder; and in some cases, ADHD is an indication of a developing bipolar disorder (Simon, 2007).

Other studies have confirmed this systematic approach to classifying mental illnesses, showing that, in many cases, a young person's mental health condition's symptoms are narrowed down to only one disorder. This simplification is carried out instead of factoring in all of his or her comorbid disorders. More specifically, the disorder that appears to be the most visible and influential on the person's conduct will be the only disorder documented (Abram et al., 2003). This is especially common in quantitative studies. Such a method is exceptionally erroneous and leads to countless errors in treatment and understanding of the youth's behaviour and thoughts. According to this probation officer, it would also lead to different treatment within the justice system and different levels of priority of care or treatment (Respondent F, 2008).
Location, location, location

On top of the low priority ADHD often garners from professionals working in the youth criminal justice system, one of the probation officers focused much of her discussion on the lack of available resources for select youths depending on where they are located and their socioeconomic status:

Well, we [Surrey] are unique...we have more money, so when you divide up Ministry contracts, Surrey has a bigger contract; Langley doesn't get as much, Delta gets nothing, White Rock gets nothing. In all of Langley there are like 50 offenders; just in this part of Surrey we have 145 and the other part of Surrey has another hundred. We get a big chunk of the Ministry money (Respondent J, 2008).

Under the government’s current model of funding – in which money is split between separate municipalities – Surrey is evidently one of the more fortunate regions in the Lower Mainland with regards to service access. For probation officers working out of areas such as Maple Ridge, there is “no ability to actually do something for a kid because you don’t have any programs” (Respondent J, 2008). This creates many problems because the handful of youths in smaller areas, have less access and opportunities to receive training, counselling, and medication for their condition. They, therefore, have less of a chance of learning to manage their problems and successfully rehabilitate themselves.

Taking this further and considering the national context, if one were to examine the situation in other provinces, particularly more rural areas, one would expect to find even fewer government dollars and specialized personnel. These locales are undeniably especially sparse in resource managers/coordinators and related services. “I have friends who work up North who are probation officers and they do their own community work service hours... and the kid doesn’t get even forensics or any kind of personal counselling, anger management...they don’t get anything” (Respondent J, 2008). Such a drawback to the criminal justice system and the mental health system is not one that can be easily resolved. It is expecting a great deal for governments to send professionals into rural areas for the sake of a small number of young people; with this said, nonetheless, it seems more troublesome to expect young people to transform or progress without the necessary help many of them require.
The costs of rehabilitation

As the funding for programs, counselling, and medication from probation services comes primarily from the government, the aforementioned partition of funds is placing many youths at greater risk. There are the few fortunate youths whose families are covered under medical insurance or are capable of disbursing various medical and program expenses; however, the majority of these young people are coming from families and areas of lower socioeconomic status. This circumstance was also pointed out by the legal professionals interviewed: (Respondent B, 2007);

[They’re] not typically covered under insurance. If they’re in jail they get hooked up with whatever medications they may need. Sometimes we can cover the costs and sometimes they are covered through a step-dad or someone who is more stable or whatever and we try to facilitate that. Anything so that we can get the medication started...what I’m getting a lot...they can’t afford it (Respondent J, 2008).

No assurance of help

Matching the discussion with other interview participants, the probation officers discussed their inability to force the administration of medication to youths. As outlined by the lawyers, one probation officer talked about court orders, which will state that: “if a youth refuses or fails to take meds, he/she must report to probation officer daily...[in these cases] the probation officer consults forensic psychiatric services for further advice on alternative means to deal with the youth” (Respondent F, 2008). This is seemingly the best alternative and is made in an attempt to garner a certain degree of control or supervision over the young person. One of the Crown counsel put it as follows:

If you don’t want to take your meds, well, we’re gonna make you report to a probation officer everyday. The theory there is that by reporting everyday, they will know that they are being watched or supervised, and therefore be less likely to reoffend (Respondent B, 2007).

Another problem with the refusal to take medication or receive the recommended help could be less a matter of personal choice and more a matter of actual capacity to do so. As mentioned in the former subsection, many of these youths simply do not have the means to obtain suggested treatment options. Unless the youth is under the care of the Ministry, in a detention centre, or in a city like Surrey where there is an abundance of resource access, there is not much else that can be done. “...you cannot force youth to take medication”
(Respondent J, 2008), especially in the case where the young person has no means to obtain it. Even when provided, there is no assurance of help.

**Corrections**

The interviews carried out with correctional employees delved even further into the complexities of ADHD-diagnosed youths within the justice system. To carry on with a small point of comparison between provinces, the researcher contacted a correctional officer from the Lower Mainland and a case manager from the youth correctional facility in Eastern Newfoundland.

**ADHD familiarity**

After years of experience in the area of youth corrections, correctional employees' repertoire of knowledge has branched into mental health topics, including the existence of attention-deficit/hyperactivity disorder in the youth corrections population. As is the case with the interviewed lawyers and probation officers, this familiarity is the result of experience of working with young people for a number of years and gradually building that knowledge based on personal experience. "[In terms of] symptoms, yes, [we] know what we have to work with here...[from] in-services, professionals, a student worker who did research on signs and interventions" (Respondent N, 2008); “working with the kids...certainly a number of my clients...it's certainly one of the characteristics of a number of our kids in here” (Respondent L, 2008).

**Prevalence**

Each of the respondents was at a loss when asked to make an estimate of how many youths in the facility had ADHD. This was very hard to translate into numbers as the individuals in the in-custody correctional facilities are continually changing (Respondent L, 2008). Respondent L was able to estimate that at least 40 percent of their in-custody youths have a diagnosis of one or more mental health disorders. In comparison to existing research, this number is expected to be in the same range for those youths with ADHD alone (Brown, 2007).
Screening and staff training

Upon intake to any youth correctional facility, there is no screening protocol for neurocognitive disorders such as ADHD. When a young person is sentenced to an incustody sentence, his or her file is forwarded to the facility, where staff can review the given information and use what has already been established in order to formulate a specialized plan for that young person. Unless there are significant differences or there is an obvious justification for extreme measures to be implemented, most youths will receive a similar incustody plan (Respondent L, 2008). As indicated by the respondents, a youth’s record typically includes any pre-disposition report completed by the community social worker; a YLC-risk-needs document; an individual service support program (ISSP) if they have one (one is put in place, if not); school information; and any psychiatric reports, which most often come from a community psychiatrist or psychologist; though very seldom, in some cases they may have been court-ordered. In Newfoundland, the youth facility organizes an intake meeting every week to get together and prepare an initial case plan (Respondent N, 2008).

Based on all of this information, it is expected that a diagnosis or the appearance of ADHD or any other mental health disorder would come to light. It is quite common that a young person will have already received a diagnosis from the school system or, in select cases, the courts will require a psychiatric assessment as part of the sentence (Respondent L, 2008). Nonetheless, if a youth has not been previously assessed and diagnosed with ADHD, the disorder is not inevitably going to be recognized upon entry into the facility. Optimistically, Respondent N noted that, although there are no assessments upon intake, many young people will see a psychiatrist while in custody, especially when something is suspected by staff. She also specified that the professionals on staff are highly qualified to recognize the disorder and implement plans for this type of individual. It would be valuable to further examine this situation as Respondent N’s responses are not consistent with the opinion expressed by Respondent A, who found the incidence of undiagnosed youths with ADHD to be extremely high.

Each interviewee was asked whether or not they thought screening assessments should be carried out upon intake. While Respondent N was extremely confident in the ongoing approach at the facility where she worked, Respondent L responded otherwise:
Yes. It just helps us to...we individually program kids and figure out what their needs are...that's an important thing to know. We don't want to overload a kid or give them something that's just not reachable for them, we want sort of little wins for them so there's positive factors in their life...so obviously if we don't know the kid has that and we're setting all kinds of goals, you may be just setting them up for total failure (Respondent L, 2008).

In addition to this, Respondent N was very secure in saying that no youths in the facility in which she works were undiagnosed or misdiagnosed. She stated that many of them had troubles, although they were not enough to merit a diagnosis. “I'm confident in what's being done on youth. You don't want to over-service them either because that can be overwhelming” (Respondent N, 2008). Respondent L conversely claimed that without a doubt there were young persons in his Lower Mainland facility who have ADHD, but have not been diagnosed. He further articulated that this situation is a result of a simple error in hindsight by professionals who managed the youth over the course of their trial.

Deficiencies in the training provided for correctional staff working in the youth custody centres were also highlighted throughout the interviews conducted on correctional employees. As stated earlier, each respondent claimed that the preponderance of their knowledge-base of ADHD came from personal experience over a defined period. As the two correctional staff members who were interviewed are of higher-ranking status within the institution, it can be assumed that the training is the same for general correctional officers. Respondent L confirmed this:

We're trained in how to deal with youth, more of a general term of how to deal with kids with learning difficulties, mental health issues, things like that. Not specifically that issue...we have a variety of kids with many issues, it's hard to sort of narrow down the training to that specific [in the] month of training. I mean there's many topics (Respondent L, 2008).

As there is not a great deal of topic-specific training taking place for these employees, information on neurocognitive disorders, such as ADHD, is not a part of the initial training. Accordingly, and taking into account their major role with these youths, correctional officers should be receiving more information; if not through direct training, than by means of take-home pamphlets or handbooks.
In-custody services and programs

There is a wide-range of services offered within correctional institutions for youths with various levels of needs. Examples of the programs offered for young people address anger management, criminal behaviour awareness, substance abuse, living on your own, addictions, and adolescent sexuality (Respondent L, 2008). The programs that are best designed for youths with ADHD are those that are developed by the teachers for specific school-related strategies; there are also social development programs and those designed for creating awareness. Finally, although not a program, there is also an information package forwarded to the youth’s living-unit that reviews how to deal with youths with various disorders (Respondent N, 2008).

Possible setbacks in this area, however, are inevitable. The court will sometimes recommend clear conditions for programming, but what is eventually achieved depends entirely on whether the services are actually available. This goes back to the location dilemma – rural versus urban access (introduced by one of the probation officers), as well as unavoidable waitlists; an additional complication is that the lack of ADHD-specific programs, or even proposed beneficial programs, for youth with ADHD in correctional facilities. “Kids need services now, but if they need to go on a wait-list, it can be problematic; [courts are] aware of services in there [(in-custody centre)], but are not always aware of all programs available in province, area, etc” (Respondent N, 2008).

Respondent L also pointed out the troubles that arise as a result of the often short time period youths spend in custody:

We try, but you can’t assess every kid…a number of kids are just floating through for a short period of time…and they’ve got to be willing…and you’ve got to depend on the community to do that once they are back out a lot of the time…contact the community probation officer or a social worker… or the parents even… (Respondent L, 2008).

External relations

Youth in-custody services do hold several ties to other players in the criminal justice system and persons involved in the youth’s case. Unfortunately, the status of these relations is, at the most, mediocre. When asked about the roles lawyers play in all of this, Respondent L was cautious; “well, it’s hard to generalize, I think they could do better, I think some lawyers and some Crown and judges are very knowledgeable about it, but others aren’t”
(Respondent L, 2008). As mentioned previously, Respondent N also discreetly critiqued the courts on their recommendations claiming that they often make recommendations that do not always coincide with what is available.

Respondent N was quick to admit that, while she believed that courts should be aware of the available services in the community, she too was lacking in this knowledge. “I’m not familiar [with services offered in the community]; they are with health and community services, not justice services” (Respondent N, 2008). Respondent L was also unfamiliar with these services stating that it was the responsibility of the community case worker, social worker, or parents. This apparent lack of communication is troubling.

**Time and money**

The central elements that are creating challenges in dealing with youths with ADHD in the criminal justice system, at the level of corrections, are the lack of screening protocols and the shortage of relevant training for correctional staff. Although these detention centres are receiving youths’ files when available, this does not guarantee that there will be an assessment included or that the disorder has previously manifested itself. The hired employees undergo fairly rigorous training; however, it is not of a specific nature. Instead, they are receiving a condensed version of the assortment of skills they require. These shortcomings create many visible gaps in the attempt to identify and then treat youths with ADHD. Respondent L attributes this to a lack of time and money: “But I mean you’ve got to also manage that with what your training time is, what your dollars are...I guess a lot of it’s time and money” (Respondent L, 2008). As exemplified by the probation officers, correctional facilities are doing the best they can with the resources available to them.

**Post-custody**

Respondent L and Respondent N both shed light on the situation for these youths once they are released back into the community. It is anticipated that, during the stay in-custody, youths grasp an understanding of the effects of their actions on top of how they can, as an alternative, choose to advance themselves as members of society. Of course, this is often easier said than done. Youths who are held in custody are typically those who have committed offences of a more serious nature or who demand 24-hour supervision; consequently, these youths require additional time and rehabilitation. Once released into the
community, this should not be the end for their access to support services. Respondent N alleged that, in the case of their youths, “all [support] persons follow the youth back into community.” This includes persons, such as a case or social worker, a psychiatrist, and/or counsellors.

Unfortunately, as expressed by Respondent L and the interviewed legal professionals, there is not as much of a structured follow-up carried out on young persons in the Lower Mainland. Upon release into the community, that is the end of the participation of persons from corrections and the youth must freely make use of the resources in the community. “We don’t follow through and there’s a waitlist at times and you just...whether the kid’s willing to do it and all those things play into it” (Respondent L, 2008). Such circumstances can easily create more problems for the youth.

Community Organization

CHADD, Children and Adults with Attention-Deficit/Hyperactivity Disorder, is a focused non-profit organization operating in the United States and in Canada (CHADD Canada, 2006). Their role is largely played at a community level and does not address youths with ADHD involved with the criminal justice system. Nevertheless, there was an effort made to contact them; however, after a few requests, the researcher was unable to contact an individual from the Chapter in Vancouver for an interview. A coordinator of PLEA Community Services Society of BC, another community-based organization, was available and willing to talk. PLEA is an organization designed to deal with a range of individuals experiencing hardships in life. The PLEA program that this interview focused on was Kidstart, a mentoring program designed for youths who are at-risk and youths on probation.

Familiarity

Respondent H’s knowledge of ADHD is based on personal experience working with youths and families in this program as well as with CHADD. “Over the years, ...in terms of youth, recently, with PLEA, they come in with a whole host of mental health problems...on Ritalin and Dexedrine” (Respondent H, 2008). In addition to ADHD, she was also very familiar with FASD as it is another disorder commonly recognized in youths today. Interestingly, according to this respondent, FASD is under the spotlight right now and there
is more being done in terms of a legal response, as well as, a community response directed at the alcohol-related disorder. The nature of the interviewee's familiarity, and the means by which she came to her understanding of childhood neurocognitive disorders, reflects the responses from other interview respondents. The reappearing discussion of FASD is also a theme that persisted throughout all of the interviews.

ADHD in the criminal justice system and the PLEA program

As a result of her years of experience in the area of community organizations, Respondent H expressed the view that there is undeniably a significant number of youths entering their programs and the criminal justice system who have been diagnosed with ADHD, or who likely have an undiagnosed condition. "If you're not taking meds, or regulating symptoms with special treatment, you're more likely to have impulsive behaviour; this is totally linked to youth crime" (Respondent H, 2008). In terms of youths in the Kidstart program, it is a voluntary support service in the community; youth are referred to the program through their probation officer and the service is paid for by the youth probation officer. Upon entry to the program, volunteers know little about the youths, aside from the details the probation officer has listed on the referral form. Therefore the degree of attention given to various characteristics of the youth is entirely dependent on the probation officer. Also, it should be noted that ADHD and supplementary qualities of the child are not the focus for a referral; the only piece of necessary information is the referring offence (Respondent H, 2008).

As this program is not catered to youths with ADHD or any mental health disorder - nor is any other community youth program in the Lower Mainland - volunteers are not trained in how to mentor or care for a young person with such a diagnosis. Respondent H did add that she "like[s] to prepare them...if impulsive, reckless, cannot sit for periods of time, self-medicating with pot, they need to know; I match the mentor up with specific resources in the community, or a fact sheet...just so you know, here's what happens...[but there is] no training; it's not clinical" (Respondent H, 2008).

Kidstart's nuanced role

The most important idea, which Respondent H presented in her interview, was the unique role Kidstart volunteers play when compared to other professionals working with
youths with a mental health disorder such as ADHD. Although Kidstart is not directed at young people with ADHD, it is a tool that can educate the community on specific disorders, providing an explanation for why youths act in the manner they do. "With Kidstart, it's done with people and say, whether criminal, mental health, whatever the problem is, the kid's a kid first" (Respondent H, 2008). Unlike lawyers, probation officers, doctors, and correctional officers who all focus on the condition first, Kidstart volunteers can help show youths that they can be accepted by a positive adult role model and by their community — regardless of the label they have been branded with; this program can help the young person to no longer see themselves in terms of a diagnosis or what they have. "We offer a sense of normalcy; we're just here to hang out. These kids have a million people in their lives, but we are just there...empower them to accept who they are" (Respondent H, 2008). What is positive is that the volunteers for Kidstart are educated by the young persons concerned, learning what it means to be them. While the psychiatrists and social workers see them for 15 minutes a month, the mentors see the youth for a couple of hours a week, developing a more authentic relationship and, in turn, a better understanding of one another.

**Community Mental Health**

Community mental health services operate using the *Mental Health Act* and do not fall under the jurisdiction of the criminal justice system. The purpose of the interview with an individual from the community mental health perspective was to gain knowledge of what services are available and to whom, at the general public level. Fitting with the research on youths and mental health, the respondent came from a youth facility in the Lower Mainland, British Columbia.

After outlining the various programs provided to youths at the facility, much of the discussion with the community mental health representative was focused on Youth Forensic Services located in the Lower Mainland as it is designed to deal directly with youths in conflict with the criminal justice system and in need of psychiatric assessments. Coming from a community mental health perspective, Respondent K was not familiar with what takes place at the level of the justice system. He referred to Youth Forensics as their neighbour; however, his lack of a clear understanding of what goes on there illustrated that, while they are physical neighbours, they are not coordinating or practicing neighbours. This is understandable, considering the different authorities reigning over each of the services. Still,
it also points to an area that may provide future collaborations that can enhance the services provided to the youth population from either the community or corrections.

Respondent K briefly touched on the nature of mental health disorders and how their incidence can contribute to multiple personal difficulties. Youths with one or more mental-health diagnoses can, therefore, cross both the mental health and the criminal justice systems. “Many have had contact with both” (Respondent K, 2008).

Conclusion

The interviews provided a very comprehensive picture of the issue of youths with ADHD who have come into conflict with the legal system. Each perspective offered deeper insight into what is taking place with young people with mental-health conditions in the Canadian youth criminal justice system. The major themes that emerged throughout all of the interviews were centered around knowledge of, or lack thereof, the disorder; the use of specialized youth reports by the key players in the young persons life; prevalence and issue of comorbidity; screening and assessment protocol used by the courts and corrections; the assortment of services provided, as well as not provided; funding; and the extent of participation and influence of each of the connected professionals.

Aside from the psychiatrists and psychologists whose university studies were centered on mental health, no other group of professionals working with this special group of young people have received focused training in the area of mental health conditions, let alone any training relating specifically to ADHD. The researcher was conscious of the lack of detailed knowledge held by the community in relation to topics, such as ADHD; the paucity of awareness conveyed by these interviews, however, was utterly unanticipated. Education is drastically needed by the general population and, surprisingly, also by the professionals who work with these young persons on a daily basis and in whose hands we place our youths.

This is a more general recommendation that can be relayed to all areas of the criminal justice system that deal with youths with ADHD. Based on the responses received through the interviews, along with the case analysis conducted, there are a number of key recommendations pertaining to various topics and each group of individuals interviewed for this research. These will be covered in the following discussion chapter, Chapter 6.
CHAPTER 6: DISCUSSION and RECOMMENDATIONS

Just as the preceding sections emphasize the diverse needs among the youth ADHD population, they also aim to inform policy discussions among policymakers, practitioners, and researchers. From the case analysis of Chapter 4 and the interviews presented in Chapter 5, many important points emerged. Some issues are specific to one of the two forms of methods used — the case analysis or the interviews — while many topics were reflected by both. Results revealed that, in order to adequately follow the guidelines of the Youth Criminal Justice Act, a new approach to youths with mental health issues is necessary. This can only be achieved through the development of a specific assessment protocol, and treatment recommendations and programs designed exclusively for youths diagnosed with ADHD. Furthermore, a certain degree of pressure should be placed on the courts, correctional institutions, and governments to achieve, and comply with, these recommendations. This chapter sets out a discussion of recommendations, based on the results of the case and interview analyses.

The case analysis produced information on comorbidity, court-used assessment procedures, and sentencing and final decisions. Similarly, the main themes of the interviews included the professionals’ familiarity with the disorder; the pervasiveness of other disorders — alone and comorbidly; assessment procedures at various stages of the criminal justice system; treatment programs and services; relations with other players in the criminal justice system; and the importance of time and money. Derived from these findings, the researcher broke down policy and programming recommendations into 8 categories. They include education and training; communication; communicated follow-up; mental health, including community mental health; specific screening protocol; corrections and programs; government funding; and finally, community-based efforts. This chapter will briefly review the shortcomings of the current task force on youths with ADHD in the youth justice system and, at more length, what should be done to ameliorate the existing situation.

Education and Training

Highlighted in the interviews, there are surprisingly very few individuals working in the youth justice system who are particularly knowledgeable of the condition of attention-deficit/ hyperactivity disorder. The researcher strongly believes that it would be to society's
benefit for legal professionals to gain an improved knowledge-base of the issues they are tackling. The lack of familiarity demonstrated by the lawyers begs the question – how can a lawyer represent his/her client with a disorder or condition when he/she is not cognizant of what the disorder is and what its treatment encompasses? As there is no legitimate excuse for a shortage of understanding, instruction on these conditions should be stressed. There should be more information provided for lawyers, who can draw on the necessary details for their cases, and also distribute the knowledge to the judges. This information should better describe a youth with ADHD and detail what should be done when dealing with these young people.

The screening of ADHD in the courts and in correctional facilities was another area demonstrated as deficient and is yet another reason why there should be increased training for specialized persons working in the criminal justice system. These professionals should acquire a better awareness of what ADHD is, what the symptoms are, and how they and other professionals can straightforwardly begin recognizing the presence, or possible presence, of the developmental disorder. In the correctional setting, there is very little training provided to staff on this topic or any other mental health related topic. These professionals command more training as to how to work with youths diagnosed with ADHD, and other such disorders. Oftentimes, untrained staff members are expected to provide information regarding youths’ daily interactions. Their ability to do so skillfully would be significantly improved by a better understanding of mental disorders’ interactions with everyday functioning. Correctional officers are aware that young people with mental illnesses are entering the facilities and should, therefore, be more prepared to deal with these youths. Consequently, they should have proper ongoing screening, diagnoses, psychiatrists, specially trained employees, and designated programs and facilities. In failing to care for this group upon entry, correctional facilities are inadvertently infringing ethical and legal protocols. It is unethical to care for youths with clinical conditions without providing the necessary resources needed to deal with their disorders. Increased education among correctional employees can aid in the recognition of a possible mental health condition. Ideally, more psychiatric assessments should be carried out and then the necessary treatment can be better administered.

A key problem that was emphasized throughout the interviews was the phenomenon of rating disorders based on expected seriousness. This was described by a probation officer
and a number of the lawyers and also surfaced throughout the case analysis. The researcher found that, in instances where ADHD was present, it was often diagnosed in addition to one or more other disorders. Mistakenly, in many of these cases, the other disorder took precedence over the ADHD diagnosis. This further highlights the lack of understanding professionals have of mental health conditions. It is a significant error to overlook the effects ADHD per se can have on an individual's behaviour and rehabilitation, let alone in combination with another disorder. This further confounds the problem and overall condition of the youth altogether; however, with increased education, such errors can be reduced.

Earlier in this thesis, the researcher presented the definitional problem that exists for individuals with attention-deficit/hyperactivity disorder. Court cases can become highly argumentative and difficult as a result of this setback (Gregg & Scott, 2000). Varying definitions also result in misdiagnosis, over-diagnosis, and even under-diagnosis, which can be particularly problematic for youths. A caveat concerning varying definitions is the consequence that a percentage of young people receive unnecessary medication, while others - those who are not yet diagnosed and/or untreated - face a lifetime of unexplained behavioural problems (Kids need better diagnosis of hyperactivity, 2005). Each side of the spectrum can be very dangerous. Although research is advancing, there should be a move towards building a consensus in relation to a specific definition of this disability and promoting a greater awareness of how to diagnose attention-deficit/hyperactivity disorder. From this base, the juvenile justice system can more accurately set out a rigorous screening protocol and articulate specific criteria for effective treatment for youths diagnosed with ADHD. Haphazard diagnoses of ADHD should be minimized as much as possible through increased research, resources, and education.

Once fixed definitions are established, the evaluation summaries, recommendations, and testimony of experts should be written using the well-established ADHD terminology of the courts. Evaluations and recommendations should not only be clear, but also individualized, compelling the examiner to determine whether the disorder poses any severe limitations for the youth and, in turn, highlighting his or her need for explicit accommodations. Reports should include the expected hardships these youths will encounter while in correctional facilities, or while serving a community sentence, additionally determining whether the youth's diagnosis of ADHD causes behaviour or impairment that
could be problematic in the various settings. Without taking these issues into account, particular youths may be further stigmatized or troubled if they are improperly diagnosed. Finally, clearer definitions would help employees exercise particular caution, when attempting to facilitate services and accommodations for youths with ADHD in order to ensure that fairness and effectiveness can coincide.

The mental health needs of youths should be made a priority so that the courts do not become the last resort for help. Mentally ill youths are extremely vulnerable and frequently go unidentified, especially those with ADHD. Through increased education about the disorder, more legal professionals will be equipped to recognize possible disturbances. As a result, youths referred to the legal system may be screened more frequently for potential mental health problems like ADHD. It is the responsibility of the defence counsel to encourage the judge to order a detailed assessment for mental health disorders by experts when there is reason to believe that a mental health condition is present. Accordingly, judges, defence attorneys, probation officers, and even prosecutors, should be educated on how to advocate for the mentally ill. While this may seem like a weighty task, provinces do offer a variety of continuing education programs and written texts for lawyers and judges on special topics (Respondent D, personal communication, 2007), including mental health disorders. This is a further recommendation for court related policy, in association with cooperation from law schools and law firms.

Education should not be limited to the professionals responsible for caring for these young people. A setback that emerged from the research was that even when the services are available for youth, there is the problem of whether the young person is willing to participate. In British Columbia and other parts of Canada there are many programs for youths with mental health disorders; however, an initial condition determining whether one can partake depends on whether the young person is willing to cooperate and wants to change and seek help. It is a reality that medication cannot be forced on an unwilling youth. There should, therefore, be measures in place to promote programming and help; to create more positive feelings in the youths towards themselves and the condition with which they have been diagnosed. This can be achieved by urging youths diagnosed with ADHD to speak with other youths diagnosed with the disorder. This approach has been proven to work with youths with substance abuse disorders as it is reinforcing for them to see a peer who is dealing with the same issue (Respondent H, personal communication, 2007). Such
tactics can help to improve education, reduce stigmatization, improve self-esteem, and provide support groups for young people. It is very important that society reduces the stigmatization placed on, and felt by, these young people by an effective use of education and communication.

**Communication**

In addition to education, the role of communication can lead to great improvements in the criminal justice system. In this regard, contact should be ongoing between legal professionals, mental health experts, correctional staff, case workers, the community, and parents and guardians. The best long-term solution is that these individuals be equipped and educated; the best means to do this is through integrated communication. Interviews with the correctional employees as well as the psychologists expressed this shortcoming with the current system. Lawyers also expressed that they are not familiar with local services and resources for youths with ADHD. Although this does fall outside of their authority, it is a hindrance in terms of their ability to make explicit sentencing recommendations. Furthermore, more effective communication between lawyers and probation officers could provide knowledge to enable suggestions and solutions for families and youths who do not make it to trial or who are not found guilty. Such support could be of great benefit to the young person’s future and decrease his or her chances for possible recidivism.

Communication should also be opened between criminal justice and community mental health professionals and service providers. While these are distinct services run by separate administrators, they are intricately linked; they are essentially providing the same services, simply under different jurisdictions. The interviewee from the community mental health centre articulated a small degree of knowledge about the forensic mental health centre, and vice versa, but the familiarity was trivial. Rooted in the services they provide young people diagnosed with ADHD and other mental health diagnoses, professionals from these institutions should be working together. This form of open dialogue could promote the sharing of information for improved care plans, potentially reducing a young person’s contact with the criminal justice system.

Not only should communication be improved between professionals handling these young people, the youths themselves should also be included. The importance of clear communication during the trial process is outlined in the *Youth Criminal Justice Act*, section 56
(see Appendix C). As youths diagnosed with ADHD are particularly vulnerable, in these cases the courts should review the fundamental features of a court trial; for example, “this is the judge, this is what they do; this is a lawyer…" and so on. Otherwise, the young persons often fail to understand what is going on (Respondent G, 2008). Youths should also be told, “this is what you did wrong and this is what the judge decided is going to happen to you as a consequence." Communication is an area in which youths with ADHD have many problems. What is extremely important for lawyers and the courts during the trial, as well as in sentencing and treatment recommendations, is maintaining consistency and structure. Ideas should be broken down into small pieces; lawyers and judges should maintain eye contact when speaking to a young person and remain attentive to what they are saying. They can ensure that the young person understands the proceedings by obtaining feedback looking for not only hearing, but most importantly understanding. Courts and other professionals should try to encourage the use of techniques for relaxation and methods to slow the young persons’ thinking processes down; this can help encourage them to be aware of their thinking before they act (Correctional employee, personal communication, 2008).

Communicated Follow-up

The implementation and monitoring of a follow-up procedure is another feature that can be ameliorated in small ways to better serve the offending population of youths with ADHD. This can be accomplished in conjuncture with professionals communicating with one another. Aside from Respondent N, professionals expressed the view that, once a youth with ADHD has been administered through their area of authority, the youth becomes the responsibility of the next group of criminal justice system professionals. Interviewees stated that, once their professional role is complete, they never again see the young person; upon a verdict of guilty, the lawyers can wash their hands; upon the completion of an in-custody sentence (which is typically very short), the youth can walk out the door with little to no guaranteed outside assistance. It appears as though youths with ADHD are being handed down through various stages on a conveyor belt, obtaining added fragments of what is needed for comprehensive support and a more complete rehabilitation as they go.

Accordingly, there should be post-custody measures put into place, especially for those youths who have a mental health diagnosis such as ADHD and who have committed a serious offence. Regrettably, ADHD is not a disorder that someone can learn to manage or
control over a short period; it cannot be completely treated or cured. Therefore, the best measures that can be employed include the review of a youth’s documents during various stages of his/her sentence, as well as education, medication, and counselling over an extended period. These procedures should be ongoing and should not be without some form of supervision, whether in the youth detention facility, at home, at school, or a combination of these.

As touched on in the communication section, for youths who are found not guilty, but have been diagnosed with ADHD, there should be suggestions provided by the legal representatives to the family or care provider as to outside services and resources that can be obtained. In the case of youths who are serving a shorter sentence and have received a diagnosis of ADHD, court recommendations should be made relating to what can be undertaken and accomplished once the young person is released. Even in cases of youths who are sentenced for an extended period of in-custody supervision, they too should be provided with a model for a follow-up regime and follow-up measures to try and ensure their successful rehabilitation and reintegration as outlined in the YCJA and as needed for success in the future and in life. There should be an ongoing continuity of care from the justice system to the community.

Mental Health

Mental health professionals appear to be doing an excellent job in terms of recognizing and responding to youths with ADHD in the youth justice system. Psychologists and psychiatrists are limited in their role as their abilities are restricted to assessing and diagnosing; the importance of this, however, cannot be underestimated. In the Lower Mainland area of British Columbia, forensic assessments are extremely thorough and, according to one of the interviews, largely available when recommended. In more rural areas, such as Canada’s territories, the province of Newfoundland, and possibly other regions in the country, assessments are being carried out by family doctors and general physicians. In these cases, the current state of affairs is not likely to be adequate. One of the interviews revealed that, even in the region of the Lower Mainland, British Columbia, there have been cases in which delays and difficulties with assessments have had severe consequences for the youth justice system and the young persons involved. Such examples of insufficient resources point to the possibility of over- and underdiagnosis, as smaller
communities do not have the resources for a thorough evaluation. There is considerable
need for in-depth research to be carried out on the current conditions of mental health
services in sparsely populated regions of Canada. Possible solutions, that could manage the
existing inadequacies now, include the integration of public health and mental health
services, in addition to offering incentives to mental health professionals for servicing these
areas. In cases where youths have come into serious trouble and are in conflict with the law,
the social worker, probation officer, or physician should recommend that they be sent to a
correctional facility or the mental health unit at a hospital; here, they can be evaluated by an
expert in the area of childhood neurocognitive disorders. At the present time, this is the best
way to ensure a more accurate diagnosis for these youths. Mental health professionals
should also continue to provide information on suitable treatment and programming options
for this group of young people.

There are also important ongoing issues affecting the mental health professionals
and services offered at the community level that should be addressed. These facilities serve
the important function of managing young people and their mental health problems before
they escalate (which can catapult the young person into the rotations of the legal system).
For this reason, their pre-emptive role should be emphasized to the community and to the
justice system. At this level, prevention is fundamental. For those youths who have been
unable to find or utilize help in the community, the youth justice system is very important
for recognizing and dealing with their disorder(s). Even so, it would be wise to take a more
proactive, preventative, approach – as opposed to a reactive one. Although reactive
measures need to be in place, early intervention can help to reduce the incidence of later
problems. This emphasizes the importance of continuing and open-communication
between the justice and the mental health systems in terms of current policies and protocols,
and the most up-to-date practices regarding the management of mental health conditions.

Specific Screening and Assessment Recommendations

In addition to the vital role played by mental health professionals, there are also
specific screening and assessment procedures that should be followed when managing youth
with ADHD in the youth criminal justice system. Ethics play a large role in developing
policy and protocol, particularly when guiding young people. On the subject of mental
health disorders and youths, the main ethical concern is whether ample screening,
assessment, and treatment are being carried out. Without a screening mechanism for disorders, such as ADHD, the answer is no. In actuality, this dismissal, or ignorance, can be viewed as a form of furtive discrimination. Therefore, in order to preserve a firm belief in the ethical care and action in the youth criminal justice system, a mental-health screening should be carried out either during the court trial or upon entry into a correctional facility. In cases in which the results are positive, a more detailed assessment should immediately follow.

Upon entry into youth corrections facilities, youths typically undergo a series of checks – one of these being a review of their medical history. At this time, a mental health screening should also take place. Such a screening can be used to identify any unrecognized mental health conditions in a young person. A mental health screening is more straightforward and cost efficient than a full blown assessment, since it can be carried out by a trained correctional officer. This screening should include a review of the youth’s case, looking for “current use of any medications, service and treatment history, current substance use, and risk of suicidal, self-injurious, and assaultive behaviour” (Wasserman et al., 2003, p. 755). Those youths who screen positive for ADHD, or any other mental health condition, should then be required to obtain a more detailed assessment. If ADHD is detected in the course of a screening, specific programming can be initiated as a part of the youth’s sentence.

When contrasted with the screening process, the assessment of ADHD is a more comprehensive process. The complex nature of ADHD necessitates at least four hours of specialist assessment in order to provide an accurate diagnosis of the developmental disorder. In many circumstances, particularly in smaller communities, children and adolescents are being diagnosed by pediatricians who often only have time to spend 20 to 25 minutes with a young person and typically do not have time to carry out a follow-up. A thorough diagnosis of ADHD requires that children are assessed by pediatricians, psychiatrists, and psychologists; parents and educators should also be included in this process, providing information on their observations of – and experiences with – the youth. More explicitly, accurate attention-deficit/hyperactivity disorder assessments should include a medical assessment, a developmental assessment, a cognitive assessment, an educational assessment, and a behavioural assessment (Respondent E, 2008).
The medical assessment should include a full review of the youth's medical history, together with relevant neurological examinations and family history (Carmichael, Adkins, Gaal, Hutchins, Levy, McCormack et al., 1997); during this evaluation, careful attention should be paid to both the physical and mental health of the youth. In a developmental assessment, the concentration is on determining delays in maturity and difficulties with major motor ability and function, auditory short-term memory, language acquisition and expression, and attention (Carmichael et al., 1997). This assessment can help to detect characteristics that may be contributing to the young person's behaviour.

A cognitive assessment is another critical component of a comprehensive assessment for youth with ADHD; this is carried out by administering various clinical tests. These tests can include, but are not limited to, intelligence/achievement tests and individual neuropsychological measures, such as integrated visual and auditory continuous-performance tests - used to test a youth's executive functioning (Gordon, Barkley, & Lovett, 2005). The results of individual testing, however, can be skewed; therefore, the results should be interpreted with caution.

The educational assessment serves as a tool to monitor the behaviour of the child in the classroom and on the school playground. A review of the youth's academic progress is also included in this assessment drawing on the collective school-based assessments carried out by the teachers. Although the symptoms of ADHD are habitually present in children's early development, it is typically not until the child enters school that the gravity of these symptoms becomes apparent.

Specific behaviour assessment tools that have become popular within the past decade include the Child Behaviour Checklist, the Teacher's Report Form, the ADHD Symptom Checklist, and the Conners' Rating Scale. The Child Behaviour Checklist (CBCL) assesses youths' behaviour and social competency based on parental reports (Crijnen, Achenbach, & Verhulst, 1999; Power, Costigan, Leff, Eiraldi, & Landau, 2001). There are currently two versions of this test, one for youths aged 6-18 and the other for children aged 1 ½ to 5. The checklist contains 113 items concerning social connectedness – peer contact and relationships, relationships with family members, and extracurricular activities and hobbies. Parents are also asked to rate their child or adolescent on diverse issues including academics, inattention, relationships, and behaviours, based on a scale of not true, somewhat true, or true. The Teacher's Report Form (TRF) is a similar 113-item measure designed for
teachers to assess a youth's functioning in the same areas (Power et al., 2001). Knowledge collected using the CBCL and the TRF assists the healthcare provider in determining the correct diagnosis and forming a treatment plan specific to the youth's needs. This test is also instrumental in differentiating diagnoses of CD and ADHD, and other related conditions, as well as differentiating comorbid and non-comorbid cases of ADHD and ODD (Biederman et al., 2008). This is a valuable function, since each of the mentioned disorders requires a different approach to treatment. The CBCL, therefore, provides a broader range of beneficial options for management of the disorders.

The ADHD Symptom Checklist is a 21-item checklist that determines the presence of ADHD symptoms. During an assessment, this checklist is used to establish when the symptoms first began, in what settings the symptoms appear, and whether the symptoms are causing impairment for the young person. The symptom checklist is completed by the youth's parents/guardians and educator. Like the CBCL, this tool can be instrumental in diagnosing young people with ADHD and developing treatment and program options for individual youths (Kelley, Noell, & Reitman, 2003).

The Conners' Rating Scales Revised (CRS-R) were compiled using intensive research on the psychopathology and problem behaviours of young people (Conners, 1997). The revised versions include clearer and more simplistic language, as well as features corresponding with the DSM-IV-TR's outlined symptoms for ADHD. Based on reports made by parents/guardians, teachers, and the youths themselves, these modified scales measure problem behaviours. Comparisons are then made with a set of normative data collected from a large community-based sample of children and adolescents.

The evaluation tools discussed above are instrumental in the diagnosis of youths with ADHD; however, each one lacks the careful assessment by a psychiatrist and/or psychologist. Expert evaluation is imperative to accurately diagnose a young person with ADHD. This step can ensure that any variable symptoms highlighted in the assessment tools are recognized, as they may indicate a comorbid condition or a separate condition all together (Gordon et al., 2005). Finally, during the course of an expert assessment, an examination by a psychiatrist alone is not sufficient to fully assess the presence of cognitive disorders in youths; there is a call for specialized behavioural psychologists to assess additional areas of the child or adolescent's customary routines and behaviour (Respondent
M, 2007). Unlike the case for FASD, however, the inclusion of a neuropsychologist in the assessment process is not essential.

On top of careful initial screening procedures and assessments, youths diagnosed with ADHD, and any comorbid disorders, require regular reassessment. As a result of environmental stressors, youths’ ADHD symptoms may intensify and they may be at an increased risk for developing additional disorders (Wasserman et al., 2003). A screening/assessment protocol should also include an evaluation of the current assessment procedures utilized in smaller communities that have less access to mental health resources. According to the educational psychologist interviewed, physicians are diagnosing youths with ADHD in many of the rural areas in Canada. Although they are knowledgeable of the disorder, a proper diagnosis calls for the involvement of several professionals over an extended period, during which observation and note-taking should be included. Physicians unfortunately cannot offer this level of time; in fact they often talk to the parents and a teacher and then make a diagnosis in the span of a few minutes. A probation officer also discussed colleagues working in Northern Canada who play the role of several professionals because there is simply no one else around to do it. This shows an apparent problem with a lack of proper screening resources, resulting in inadequate diagnoses and persons taking on roles they otherwise should not be doing. Fortunately, for youths in custody, it seems that they have access to the necessary professionals. Nevertheless, many youths do not reach this stage, so there is still some concern about those youths who receive a mediocre diagnosis and begin recommended treatment free from careful supervision and monitoring. Here arises the issue of a possible misdiagnosis which can result in youths receiving services and treatments they do not need and other youths lacking help completely.

Major goals that require attention in this area include: evaluating the effectiveness of prevention, intervention, treatment, and management strategies for reducing delinquency; addressing disability-related needs among this population of youths; and foreseeing possible barriers and facilitators to implementing effective strategies for helping this population.

**Corrections and Programs**

Some policy goals that extend from the screening and assessment components concern the implementation of current and anticipated delinquency/disability-related programming for youths with mental health conditions in the youth justice system. As
outlined in the legal analysis in Chapter 4, the policies and conditions of the *Youth Criminal Justice Act*, sections 34 and 38 (see Appendix C) are well-defined and give the impression that they protect the needs of youths with mental health disorders through recognition and treatment of the disability; they are also supposedly implemented during the court process. Nevertheless, the interviews and case analysis illustrate that the aftercare for youths with ADHD is not as recommended and shortcomings are generated in terms of the availability of appropriate programming. This finding was best articulated by one of the lawyers:

> The YCJA is a fantastic write-up including many recommendations and sets out various measures that need to be taken, from programs to services; but it is written by the Federal government. It is the provincial government that actually provides the services and there are not enough of the actual services recommended or ordered by the YCJA (Respondent G, 2008).

There is a serious disjuncture between the court and the correctional mandates as extrajudicial measures are not adequately and appropriately being implemented. According to the interview data, there are no general programs or services available for youths who enter an in-custody youth facility with ADHD. Even more critical is the fact that correctional staff is not trained in dealing with these young people. Although youths formerly diagnosed with attention-deficit/hyperactivity disorder receive referral to Youth Court Services for intervention, this is no assurance that every child with ADHD will receive such a diagnosis and an appointment. Youths who are sentenced to serve their order in the community are also at a standstill when it comes to finding support for their diagnosis of ADHD.

Several of the interview respondents outlined in-custody programs, confirming that there are no ADHD-specific in-custody programs. Having said this, however, it is not in fact necessary to have attention-deficit-specific programs in place. In fact, many young people with ADHD do well in a correctional setting, as there is already a large degree of structure and discipline in place (Loney & Counts, 2004). What is more essential is for staff to know how to communicate with – and respond to – youths with ADHD; staff members should know how to provide skills training and counselling in order to help youths to better understand their diagnosis and how the disorder can interfere with their daily lives (Respondent M, 2008). Programs should be designed by professionals that are non-discriminatory and based in current ADHD theory and research that can be upheld in the
treatment programming. This approach should promote fair and realistic expectations of what can be accomplished, so that success for youths with ADHD – and other cognitive disorders – can become a reality.

Youths in correctional facilities are commonly affected by learning disabilities and emotional disturbances on top of their ADHD diagnosis; therefore, more specialized programs should be introduced to target such behaviours. Correctional employees, law enforcement agents, and court practitioners, however, should be careful when implementing specific forms of treatment, as the misinterpretation or stigmatization of individuals with ADHD could further contribute to the problem. It is imperative that these stakeholders receive ample education and training as to how to manage youths with the disorder (Mears & Aron, 2003). There should also be more multi-functioning youth programs available to serve youths in the criminal justice system. These programs should not be designed exclusively for substance abuse or exclusively for fetal alcohol spectrum disorder, but for a range of possible conditions and potential risk factors (Respondent I, 2008). Instead of going overboard with ADHD-specific procedures, programs should be developed by specialists in a range of areas that cover an entire spectrum of problems. For example, what is now FASD, was once considered two separate disorders – FAS and FAE. Today, FASD is classified as a spectrum disorder taking in a variety of different problems, from substance abuse disorders to learning disabilities and ADHD. A similar type of approach should be introduced for attention-deficit/hyperactivity disorder. Additionally, a focus on comorbid ADHD should be included in the FASD program. In a similar light, certain disorders should not be replacing or overshadowing other disorders, as seems to be occurring with FASD and bipolar disorder over ADHD. “Kids problems never change. It’s interesting that our focus on them does, but the actual problems do not” (Respondent H, 2008).

Not only should programs be further developed to cater to youths with a variety of conditions including ADHD, the greater number of programs should also then be systematically distributed in some fashion, so that more young people can receive access to those programs that would best service them. Two interviewees from different fields – a lawyer (Respondent G) and a probation officer (Respondent J) – pointed out that this rationing of programs does occur now; however, with the lack of programming, the result is that not everyone is fortunate enough to get connected to a program – let alone one based
on their need-level. The more programs catering to the most needs, the better the chances youths have of receiving a chance of accomplishment.

Another problem with programming, mentioned in several of the interviews, and also highlighted from the case analysis, is that no one can help those who do not want to be helped. There are a number of treatment programs available throughout Canada, but these services are available solely to those persons who are willing to participate. It is often the case that youths refuse to acknowledge their disorder, or if they are aware of it, they choose not to seek help (Respondent B, 2008). Troubled youths are less likely to desire help, yet observably, they are the individuals who need it the most. Amelioration in this area goes back to the idea of better education and awareness of the disorder and how it affects young people. To reiterate from the subsection on education, a recommendation specific for this area is creating information seminars led by youths living with and managing the disorder. These individuals are at an advantage for communicating knowledge to others. At the same time, the public – particularly young people – are especially interested when hearing the experiences of others and, even more so, when the person they are listening to is one of their peers. Young people are more likely to listen to someone their-own age; it can provide a greater feeling of connectedness and, in turn, a sense of security. Knowledge of this illness comes from extensive and intensive counselling, one-on-one preparation, and non-judgemental communication with the youth. Following this, young people are better equipped to attain help.

The enhancement of available programs should not cease at the implementation stage. Based on the literature review and the interviews, there are seemingly no existing tests subjecting the programs or treatment régimes to review, either in-custody or in the community. To considerably improve the current state of the justice system's programs for youths with ADHD, the programs and the participating youths should be assessed periodically. Such reviews should look at matters such as evaluating programs' success and even ensuring that there is consistent and proper administration of care. On top of this, it would be beneficial to know whether enrolled youths are well-matched to the programs and whether they are benefiting from them.

As evidenced from the interviews, there are encouraging measures being implemented for youths afflicted with mental health disorders who become involved in the youth justice system. The YCJA recommendations nonetheless should be written in a
manner that would more accurately correspond to the services and assistance which are actually achievable. Without this, the policy simply looks sound on paper. From a related policy standpoint, there is an apparent gap between the needs and services for these youths. While several policy-makers dismiss it as too theoretical or idealistic, there is a grave necessity for evidence-based policy in this area of youth justice. Correctional facilities require more thorough delinquency intervention programs on top of rigorous policies, as well as disability-related programming efforts that are required by law. This approach was indicated as well because there is relatively little empirical information available on levels and types of programming in juvenile justice systems. The above recommendations, however, could provide more specialized and improved care for youths with ADHD who may otherwise fall victims to the criminal justice system.

**Government Funding**

While these recommendations may sound good in theory, before education, awareness, and communication can be improved, before screening and evaluation protocol can be implemented, and before more specialized programs can be introduced, governments should be becoming more attentive and more involved. A deficiency in money and time was identified as being of crisis proportions throughout all of the interviews. Although respondents noted the current link between youth corrections and youth forensic psychiatric services in the Lower Mainland area of British Columbia, it was also asserted that more government funding would be of tremendous value. More psychiatrists are desperately needed more frequently in youth facilities in order to reduce the problem of underdiagnosis and improve in-custody services. This cannot be realized devoid of increased funding from other areas. “We have a relationship with youth forensic, but I mean that could always be more money to help improve that…” (Respondent L, 2008).

The key rationalization for the absence of ADHD screening in courts, and screening and programs in correctional facilities is a lack of money. Access to mental health services and benefits is becoming a major crisis in Canada and other parts of the world, owing to medical cutbacks, a shortage of trained specialists, and a lack of sufficient resources (Kirby, 2008; World Health Organization [WHO], 2002). Medications such as Ritalin, and particularly newer medications with potentially more benefits, are difficult to access when the persons in need are those who can often least afford it. Hence, Canada and many other
modernized countries require the support and services of government funding for improved mental health resources.

Provincial governments should reevaluate their scheduling and disbursement of funding to the areas of criminal justice and mental health services. From assessments to corrections to community programming, there is not enough to go around. Accordingly, the government of British Columbia should consider the return of the previously used provincial model of funding. Respondent J, a probation officer in the Lower Mainland, expressed her opinion that everybody would be better off under this model. The case analysis also shed light on this dilemma, as one of the cases called for a stay in proceedings because there were simply no services available to help rehabilitate the young person. If such a strategy change were to take place, cities like Surrey, British Columbia would not be the only centres having access to resources; Vancouver, Burnaby, Surrey, and their surrounding communities, could share one resource, allowing more youths the ability to access treatment, support, and programming. It would be a shared pot of money, rather than varying chunks across the region.

The premise of the currently implemented community model is good in its intention; unfortunately, it appears to be too idealistic. It is not serving the purpose or notion of looking after one another; instead it is excluding young people and families who are the most in need. Youths from areas with larger populations are receiving more access to funds and, therefore, are benefiting from a greater opportunity for individualized treatment plans, including medication and counselling. More funding is desperately needed for more rural areas and provinces. It seems indisputable that the government should be using the model that realistically works best, for the benefit of everyone as a whole – not only what works best on paper and in people's minds. This may be a challenging task; still, without it, Canada's youths will continue to suffer and be pushed further through our criminal justice system.

Increased funding can also be realized through more focused, specialized community and non-profit organizations working specifically in support of attention-deficit/hyperactivity disorder and its link to youth delinquency. Currently, there is no single federal agency or advocacy organization whose sole focus is to ensure that the rights and needs of youths with disabilities in the juvenile justice system are addressed. This type of agency could offer support and education sessions with other families; offer mentoring
programs for youths with disorders like ADHD; it could even provide brief training for individuals in non-specific mentoring programs, such as PLEA. Additionally existing organizations, such as CHADD, can assemble charities to raise funds for improvements in areas related to ADHD screening, assessment, and management in the youth criminal justice system.

**Community-Based Efforts**

On top of the reactive approach by courts and in-custody facilities, a more preventative approach is also recommended. The overrepresentation of youths with disabilities, such as ADHD, in the justice system is the result of inadequate community and school-based practices (Slager, 2008; Webster-Stratton & Taylor, 2001). When proper action is taken earlier in life (i.e. neo-natal care, careful assessment and identification, school-based programs and support, behavioural management, use of community mental health services), children are expected to be more likely to abstain from violence and delinquency and be less likely to come into conflict with the juvenile justice system (Wilson, 2000). Earlier diagnosis, programming, and treatment will not only reduce overall costs, but they will also reduce crime and aid youths in becoming happier, healthier, and more positive, contributing members of the community. This is not to divert attention away from the accountability of youths and their actions; it purely offers more constructive methods to better secure their bright futures.

**Conclusion**

On the whole, it appears that, when a diagnosis of attention-deficit/hyperactivity disorder has presented itself, the appropriate criminal justice professionals will include such a diagnosis in their assessment and dealings with the youth. Lawyers and judges will, in some manner, relate the diagnosis to the case; probation officers will search for suitable programming; correctional officers will often fashion more specialized treatment; and so on. Professionals believe they are doing the best they can with the resources and authority bestowed upon them. Having said this, however, professionals working with young people in the youth justice system do not appear to be taking large strides in terms of learning more about – and of recognizing – the disorder; in many cases, without any related training, they
are not in a competent position to do so. A point that was very pronounced through the literature review, the case analysis, and the individual interviews was that attention-deficit/hyperactivity disorder is a very complex disorder; it is "no longer constructed as an all-or-nothing concept. ... Diagnosing ADHD is more like distinguishing clinical depression from normal fluctuations in mood" (Brown, 2007, p. 25).

While there is a range of services and treatments available, particularly in larger areas, for youths who have other mental health diagnoses, such as attention-deficit/hyperactivity disorder, these resources will not be accessed by young persons who cannot afford such services, who are not aware of the services available to them, or whose mental health conditions are being overlooked; the undiagnosed youths are at the greatest risk. These individuals are finding themselves in serious trouble and in the criminal justice system. This becomes a very severe problem not only for the young person, but also for society in general. Youths without access to support services and without a recognized diagnosis are more likely to re-offend, regularly reappearing in the justice system; consequently, they are also more likely to become life-time offenders. All of this, convoluted by the lack of support from family and friends, low self-esteem, and trouble maintaining a job, is a serious recipe for disaster. The more that can be done to identify and diagnose youths who have been unidentified – through intake screening, increased training for staff, and so forth – the more likely it is that youths with ADHD will be rescued in the long-term.

Today's youths are more challenging than those of the past; they can be needy and demanding, and today's youths are much more likely to be afflicted with a mental-health-related illness (Perrin, Bloom, & Gortmaker, 2007; Pytel, 2007). The aims of the UN's Convention on the Rights of the Child and the Youth Criminal Justice Act are for society to offer its young people a sufficient level of services and support in order to help them develop into mature, fulfilled, and contributing adults. In order to uphold these principal goals, we have developed various institutions and relationships that work in tandem with one another during the socialization of youths, be it a family member or mentor, schools, recreational centres, or even mental health facilities, where needed.

There is a sufficient body of existing literature and research to document what is needed for these young people. The present research highlights the key deficits existing in Canada, through the case analysis, and, more explicitly, in the Lower Mainland, British Columbia and Newfoundland, through the interviews. Now it is up to policy-makers to take
the information and begin improving education in relation to mental health disorders in our youth population and coinciding with this, offer more services to deal with them on a more specialized level. Professionals and members of the public should also be talking to the young people themselves and obtaining feedback from those who are living at first-hand the experiences documented in this research; indeed, accounts from youths entangled with the law and trouble-making are the best source of information. In summary, the issue of youths with ADHD in the criminal justice system falls within both the federal and provincial jurisdictions. Areas that should be focused on include better educating the public and professionals involved in the criminal justice system about ADHD, implementing much-needed ADHD screening in the courts and correctional facilities, and developing more specialized programs that are desperately-needed by these youths; such services are also needed to comply with the measures laid out in the *Youth Criminal Justice Act*. 
CHAPTER 7: LIMITATIONS and FUTURE DIRECTIONS

Limitations of the Research

In the first part of this chapter, the limitations of this study are addressed. First, there is a discussion of the sample size used for the interviews, followed by an analysis of the locality of the interview respondents. The chapter concludes by revisiting some of the limitations outlined in the methodology chapter. The limitations of the study will point the way to future research in this area.

The number of cases used for this study, while small, was based on the relevant cases which were available on QuickLaw; there were no fixed measures that could have been implemented by the researcher to enlarge this sample. With regards to the interviews, however, participants were purposively selected, based on their professions and their relationships to youths with ADHD in the criminal justice system. The researcher decided to select a range of professionals to provide a rounded picture of the current issue, but this number was kept to a minimum. Interviews are often unpredictable; it is impossible to determine how many people will agree to participate, or when – and where – these persons will be available. It is also very difficult to foresee individual’s responses or how they will react to questions presented. For all of these reasons and, bearing in mind the time it takes to carry out the necessary steps for an interview, the researcher decided to keep the sample, while diverse, small.

Individuals interviewed for this thesis were primarily professionals working in the Lower Mainland, with the exception of two individuals who are located in Newfoundland. In talking to professionals from these areas, the researcher was able to draw conclusions for the current climate of mental health in youth corrections in the Lower Mainland (British Columbia) and Newfoundland, but not necessarily for other regions or provinces of Canada. While the case analysis was all-inclusive of Canadian provinces and territories, the nature of the qualitative research could not match this geographical breadth.

Even through the interview questions, it is possible that the researcher did not capture all of the respondent’s opinions or knowledge of ADHD in the youth criminal justice system. This is a result of the nature of the researcher’s questions and the time restrictions of the participants. To maintain unity, the questions were designed in such a way
as to enable comparison between groups of professionals, which was readily accomplished by the researcher.

**Future Directions**

This thesis is a valuable pilot study which can lead to several possibilities for future, larger research projects. In relation to the limited number and location of interview respondents, it would be valuable for future research to include a larger sample, conducting more interviews in order to attain further opinions and experiences. These interviews should also span the provinces and territories of Canada, taking in both rural and urban settings and thereby enabling more accurate comparison.

Carrying over from the expansion of the interview participants, future research should also be carried out examining the major inadequacies in our country’s mental health care services. There is considerable need for in-depth research on sparsely populated regions of Canada. Studies should be tailored to examine what facets of care are absent in these areas, what are the perceivable explanations for these absences, and what are possible solutions to remedy them. These studies will not only benefit the rural areas that are under analysis, but the results can also offer important insight into the weaknesses of our mental health care systems in general.

On top of additional research participants from professional fields in Canada, another group of research participants, that can provide rich information about youths with ADHD in the criminal justice system, is the group at the centre of this research – namely, the young people themselves. It would be most prudent to conduct personal or group interviews with youths with ADHD. This approach to research could provide a remarkable degree of insight into the ongoing state of affairs, through discussions with young people with the disorder who have come into contact with the law. The researcher believes it would also be interesting to compare the experiences of these youths to those of youths who have been diagnosed with ADHD, but who have not become involved with the criminal justice system.

Further future research should be carried out on a more longitudinal scale. Although this would prove to be more difficult because of accessibility, locating people, and obtaining permission, long-term follow-up research of youths with ADHD once they are out of treatment or have finished treatment would be significantly beneficial for all individuals.
with ADHD who have, or may, come into contact with the criminal justice system. It would also be important to interview those individuals who are now adults.

Furthermore, researchers could begin taking on projects examining other disorders or the broader topic of youth neurocognitive disorders in general and how these conditions come into play in the criminal justice system. Diagnoses such as fetal alcohol spectrum disorder, bipolar disorder, conduct disorder, and oppositional defiant disorder all presented themselves throughout this study in the cases, and in the interviews. Additional medical and scientific, as well as social-science-based, studies could shed more light on these convoluted issues. Further research into attention-deficit/hyperactivity disorder – its difficulties, causes, symptoms, prevention, and of course treatment – is also indispensable. Today’s youths need examples, guidance, and support during all stages of their development; the presence of this or any impulsivity disorder magnifies this need. The more research which is made available, the better prepared professionals will be to offer the essential services.
REFERENCE LIST


92


CASES REFERENCED


Appendix A: Research Instrument – Interview Questions

Correctional employee

1. Do you consider yourself familiar with the attributes, causes, symptoms, and condition of attention-deficit/hyperactivity disorder?
   a. If yes, how are you so knowledgeable?
   b. If no, why not?
   c. Do you consider it as important?

2. Are you familiar with other neurocognitive disorders in youths? If so, which one(s)?

3. Is there a specific ADHD assessment protocol for youths in the sentencing process that you know of? If so, what does this entail? If not, what do you think it should entail?

4. Do you believe it is necessary? Why or why not?

5. What recommendations, if any, would you offer lawyers and the courts regarding ADHD screening and assessments?

6. Are youths screened for ADHD upon entry into correctional facilities? If yes, how so; if not, why not?

7. a) In your educated judgment, do you feel that there are a significant number of youths within the correctional system that have ADHD? Can you provide an estimate/guesstimate?
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - Over 60%
   b) How severe is the disorder typically perceived?
   c) Is it viewed as a spectrum disorder as is the case with FASD?

8. Are correctional employees sufficiently knowledgeable about this disorder? Explain (how was this knowledge obtained).

9. Do employees receive special training to deal with youths with this disorder? Explain.

10. If a youth who enters the correctional facility has been diagnosed with ADHD, how is this young person cared for or supported? Is it a factor in treatment and programming?
11. Are there special programs or treatment for young person with ADHD within the correctional system?

12. Do you believe a screening process is necessary for youths in correctional centres? Why or why not?

13. What policies, if any, are currently in place to address young people with ADHD in the criminal justice system? Please elaborate as best as possible.

14. Do you believe the current policies are effective? Sufficient?

15. Do you have any personal recommendations based on your experience(s)? (for lawyers, judges, PO's, correctional institutions/employees, the government, parents/guardians, etc.).

Psychologist/psychiatrist

1. Are you specialized in the area of neurocognitive disorders in youths, such as ADHD?

2. How do you believe such disorders could lead young people into the criminal justice system? Do you see this happen frequently?

3. How are you approached to assess youths for any neurocognitive disorders in youth? Who typically calls for this action to be taken?

4. How does the process of assessing a youth with symptoms similar to those of ADHD begin? Please describe this process and the necessary steps included?

5. Which specific tests, instruments, or tools are utilized in the assessment procedure of youths with ADHD?

6. Please list all possible individuals involved in this process; and their roles?

7. Once a diagnosis is made, what takes place next? Ie. Treatment options, programming options, counselling, medication.

8. What is the most common form of treatment?

9. What do you believe to be the most effective? Is this done on a case by case basis?

10. Do you know if youths within the correctional system, whether in detention, community care, probation, and so forth, are receiving adequate care and treatment for neurocognitive disorder like ADHD?
11. Do you have any recommendations that you would make to youth programs, correctional facilities, as well as families with a child with ADHD regarding how to deal with a child or adolescent with a neurocognitive disorder?

**Defence lawyer/Crown prosecutor**

1. Do you consider yourself familiar with the attributes, causes, symptoms, and condition of attention-deficit/hyperactivity disorder?
   a. If yes, how so?
   b. If no, why not?
   c. Do you consider it as important?

2. Are you familiar with other neurocognitive disorders in youths? If so, which one(s)?

3. What are the initial pieces of information you look for when examining a juvenile court case?

4. Have you ever presided over/represented/prosecuted a child or adolescent who had been diagnosed with ADHD?
   a. If so, how was this diagnosis carried out?
   b. What professionals were involved?
   c. When was the youth assessed?

5. Have you or would you ever recommend that the court assess a young person for mental health disorders, ie. neurocognitive disorders such as ADHD?

6. Who do you think should be included in this assessment?

7. When you accept a youth’s case, do you look for the presence of any mental health or neurocognitive disorder(s)?

8. In the sentencing process, are such mitigating factors like ADHD adequately considered and/or reviewed?

9. If such factors were to be considered, do you know if there are adequate programs or treatment options available for these young people? If so, can you please elaborate?

10. In my case analysis, there is little to no mention of a diagnosis of ADHD in sentencing; there is nothing to directly address this condition. Do you have an idea as to why this may be the case? Why would someone mention ADHD in a case, but not attend to it during sentencing?

11. In cases where a youth is found not guilty, are there any recommendations made to them or his/her family in regards to addressing the conditions for which they have been diagnosed?
12. What policies are currently in place to address young people with ADHD in the criminal justice system? Please elaborate as best as possible.

13. Do you believe the current policies are effective? Sufficient?

14. Do you have any personal recommendations based on your experience(s)?

**Probation officer**

1. Do you consider yourself familiar with the attributes, causes, symptoms, and/or condition of attention-deficit/hyperactivity disorder?
   d. If yes, how have you obtained this knowledge?
   e. If no, why not?
   f. Do you consider it as important?

2. What role do you play in working with youths who come into contact with the criminal justice system?

3. What are the initial pieces of information you look for when examining a youth case, if any?

4. Do you see many children coming into conflict with the criminal justice system who have received a diagnosis of ADHD?

5. Have you ever worked with a child or adolescent who had been diagnosed with ADHD?
   a. If so, do you know how this diagnosis was carried out?
   b. What groups of professionals were involved?
   c. When in the youth's life was he/she assessed for ADHD?

6. If yes to question 4, how can you describe this or these experience(s)? How would you describe the youth? How would you compare this youth to other youths you have worked with without a diagnosis of a mental health disorder?

7. Based on your experiences and/or personal knowledge, do you believe that the children who are coming into conflict with the criminal justice system should be screened/assessed for mental health conditions such as ADHD?

8. For your role as a youth worker/probation officer, do you take factors such as ADHD into consideration when managing the youth and his/her case?

9. If you are at all familiar, do you believe that the courts are doing enough for these, whether during the assessment, in after-care, and so forth?
10. For youths in the criminal justice system who have been diagnosed with ADHD, are there adequate programs or treatment options available for them? If so, can you please elaborate? Furthermore, if such services are available, are youths gaining ready access to them?

11. Do you play a role in guaranteeing that youths receive the recommended and necessary treatment and programming for his/her disorder? If yes, please provide details.

12. Based on your experience(s), do you have any personal comments to add that may be beneficial to my research or any recommendations for working with youths with ADHD or any other mental health disorder (at all stages and particularly post-trial)?

**Youth in-custody centre employee**

1. Do you consider yourself familiar with the condition of ADHD - symptoms, causes, treatment, etc.?

2. What role do you play at the Maples? What is the role of the Maples?

3. Are there youths at the Maples who have a diagnosis of ADHD who have come into contact with the CJS? How were they referred to the program? For what reasons were they referred?

4. What kinds of treatment programs are available for youths with mental disorders? More specifically for those with ADHD?

5. Can you please describe the Crossroads program?

6. Are you involved in the rehab of youths with disorders such as ADHD?

7. Do you believe that these young people can be helped/rehabilitated?

8. Where do the Maples receive funding from?

9. Who has access to the program (cities)?

10. Are there adequate funds and resources available?

11. Any recommendations for the management of youths with ADHD who come into conflict with the CJS?
Community youth organization employee (PLEA)

1. Do you consider yourself familiar with the attributes, causes, symptoms, and/or condition of attention-deficit/hyperactivity disorder?
   a. If yes, how have you obtained this knowledge?
   b. If no, why not?
   c. Do you consider it as important?

2. Do you see many children coming into conflict with the criminal justice system who have received a diagnosis of ADHD?

3. As a result of your first-hand experience, do you believe youths in the criminal justice system are not yet diagnosed, but are suffering from the symptoms and effects of ADHD?

4. Based on your experience, do you believe that the children who are coming into conflict with the criminal justice system should be screened/assessed for mental health conditions such as ADHD?

5. Is your organization working with persons with ADHD and/or in line with other groups who work with these individuals? If so, how?

6. When Kidstart receives a young person's file, where do they typically come from/who refers youth to the program?

7. Is there a detailed report summarizing the particulars and diagnosed disorders of the young person?

8. With the information given to you, how do you prepare the mentor who will be working with this youth? Are there training sessions or a one-on-one discussion on how to handle youths with disorder, A, B, C, etc.?

9. Have you ever worked with a young person diagnosed with ADHD? How was this experience? How would you describe them? How would you compare this youth to other youths you have worked with without a diagnosis of a mental health disorder?

10. How do mentors describe their experiences with youths who have neurocognitive disorders such as ADHD?

11. Do you believe Kidstart is beneficial to these youths? How so?

12. What else is in the community for youths diagnosed with ADHD who comes into conflict with the law?

13. Do you have any personal recommendations based on your experience(s)?
Appendix B: Informed Consent by Participants in a Research Study

The University and those conducting this research study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants.

Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at hweinber@sfu.ca or phone at 778-782-6593.

Your signature on this form will signify that you have received a document which describes the procedures, whether there are possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study.

Title: ADHD and Canadian Youth - An Evaluation of Neurocognitive Disorder’s Impact on Criminal Justice Assessment, Management and Policy

Investigator Name: Adrienne Peters

Investigator Department: Criminology

Having been asked to participate in the research study named above, I certify that I have read the procedures specified in the Study Information Document describing the study. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described below:

Purpose and goals of this study: The purpose of this study is to evaluate how youth with ADHD are at greater risk of coming into conflict with the criminal justice system; is an assessment, and then possible diagnosis made for youth believed to be suffering from ADHD; what impact this diagnosis has on various procedures once within the system – sentencing, treatment, and so forth?

What the participants will be required to do: The participants will be asked a series of questions pertaining to youth with ADHD; for example, they will be asked of their knowledge of the disorder and how the disorder affects the behaviour of these individuals; more specifically, legal professionals will be asked about cases in which ADHD can be presented during juvenile court trials; psychologists and psychiatrists will be asked about diagnosis and ensuing treatment; and correctional employees will be focused on the various programs/treatments available, and possibly needed, for these youth.
Risks to the participant, third parties or society: There are no apparent risks for the participants. They are professionals discussing a topic that often permeates their work.

Benefits of study to the development of new knowledge: This study can be very beneficial for youth with ADHD who have come into conflict with the law and often necessitate special consideration in sentencing and treatment as a result of their disorder(s). It can further aid youth who have not yet received adequate resources for a proper assessment receive a more accurate diagnosis and obtain the unique care they warrant. This study will not only benefit these youth; it will also provide information and understanding to professionals working with these young people, ie. doctors, youth care workers, lawyers, judges, researchers, etc.

Statement of confidentiality: The data of this study will maintain confidentiality of your name and the contributions you have made to the extent allowed by the law. I acknowledge my responsibility to protect the confidentiality of all participants in my research study. I am committed to maintaining and protecting the confidentiality of any personal information through the use of various protective measures, ie. informant's names replaced with numbers, collected data protected by lock, no sharing of contact information, and so on. There are situations in which I may be required by law to disclose information without participants consent, although this is highly unlikely considering the nature of my research. If such an issue should arise, I will comply with the situation.

Interview of employees about their company or agency: N/A

Inclusion of names of participants in reports of the study: As previously mentioned, the names of the research participants will not be included in any part of the interview, the transcription of the interviews or the final thesis write-up. After the initial communication and the person's commitment to an interview, I will designate them a representative number that will be matched to their name and protected on my password enabled computer in my home. No one else will have access to this information.

Contact of participants at a future time or use of the data in other studies: No

I understand that I may withdraw my participation at any time. I also understand that I may register any complaint with the Director of the Office of Research Ethics.

Dr. Hal Weinberg
Director, Office of Research Ethics
Office of Research Ethics
Simon Fraser University
8888 University Drive
Multi-Tenant Facility
Burnaby, B.C. V5A 1S6
hal_weinberg@sfu.ca

I may obtain copies of the results of this study, upon its completion by contacting:
Adrienne Peters, from the Criminology department, by contacting Adrienne at 778-846-5157

I understand the risks and contributions of my participation in this study and agree to participate:

The participant and witness shall fill in this area. Please print legibly

Participant Last Name: ___________________________  Participant First Name: ___________________________

Participant Contact Information: ___________________________

Participant Signature (for adults): ___________________________

Date (use format MM/DD/YYYY): ___________________________
Appendix C: Youth Criminal Justice Act (2002)

DECLARATION OF PRINCIPLE

3. (1) Policy for Canada with respect to young persons - The following principles apply in this Act:

(a) the youth criminal justice system is intended to

   (i) prevent crime by addressing the circumstances underlying a young person’s offending behaviour,

   (ii) rehabilitate young persons who commit offences and reintegrate them into society, and

   (iii) ensure that a young person is subject to meaningful consequences for his or her offence in order to promote the long-term protection of the public;

(b) the criminal justice system for young persons must be separate from that of adults and emphasize the following:

   (i) rehabilitation and reintegration,

   (ii) fair and proportionate accountability that is consistent with the greater dependency of young persons and their reduced level of maturity,

   (iii) enhanced procedural protection to ensure that young persons are treated fairly and that their rights, including their right to privacy, are protected,

   (iv) timely intervention that reinforces the link between the offending behaviour and its consequences, and

   (v) the promptness and speed with which persons responsible for enforcing this Act must act, given young persons’ perception of time;

(c) within the limits of fair and proportionate accountability, the measures taken against young persons who commit offences should

   (i) reinforce respect for societal values,

   (ii) encourage the repair of harm done to victims and the community,

   (iii) be meaningful for the individual young person given his or her needs and level of development and, where appropriate, involve the parents, the extended family, the community and social or other agencies in the young person’s rehabilitation and reintegration, and
(iv) respect gender, ethnic, cultural and linguistic differences and respond to the needs of aboriginal young persons and of young persons with special requirements; and

(d) special considerations apply in respect of proceedings against young persons and, in particular,

(i) young persons have rights and freedoms in their own right, such as a right to be heard in the course of and to participate in the processes, other than the decision to prosecute, that lead to decisions that affect them, and young persons have special guarantees of their rights and freedoms,

(ii) victims should be treated with courtesy, compassion and respect for their dignity and privacy and should suffer the minimum degree of inconvenience as a result of their involvement with the youth criminal justice system,

(iii) victims should be provided with information about the proceedings and given an opportunity to participate and be heard, and

(iv) parents should be informed of measures or proceedings involving their children and encouraged to support them in addressing their offending behaviour.

(2) Act to be liberally construed - This Act shall be liberally construed so as to ensure that young persons are dealt with in accordance with the principles set out in subsection (1).

PART 3 - JUDICIAL MEASURES

Medical and Psychological Reports

34. (1) Medical or psychological assessment - A youth justice court may, at any stage of proceedings against a young person, by order require that the young person be assessed by a qualified person who is required to report the results in writing to the court,

(a) with the consent of the young person and the prosecutor; or

(b) on its own motion or on application of the young person or the prosecutor, if the court believes a medical, psychological or psychiatric report in respect of the young person is necessary for a purpose mentioned in paragraphs (2)(a) to (g) and

(i) the court has reasonable grounds to believe that the young person may be suffering from a physical or mental illness or disorder, a psychological disorder, an emotional disturbance, a learning disability or a mental disability,
(ii) the young person's history indicates a pattern of repeated findings of guilt under this Act or the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, or
(iii) the young person is alleged to have committed a serious violent offence.

(2) Purpose of assessment - A youth justice court may make an order under subsection (1) in respect of a young person for the purpose of

(a) considering an application under section 33 (release from or detention in custody);

(b) making its decision on an application heard under section 71 (hearing - adult sentences);

(c) making or reviewing a youth sentence;

(d) considering an application under subsection 104(1) (continuation of custody);

(e) setting conditions under subsection 105(1) (conditional supervision);

(f) making an order under subsection 109(2) (conditional supervision); or

(g) authorizing disclosure under subsection 127(1) (information about a young person).

(3) Custody for assessment - Subject to subsections (4) and (6), for the purpose of an assessment under this section, a youth justice court may remand a young person to any custody that it directs for a period not exceeding thirty days.

(4) Presumption against custodial remand - A young person shall not be remanded in custody in accordance with an order made under subsection (1) unless

(a) the youth justice court is satisfied that

(i) on the evidence custody is necessary to conduct an assessment of the young person, or

(ii) on the evidence of a qualified person detention of the young person in custody is desirable to conduct the assessment of the young person, and the young person consents to custody; or

(b) the young person is required to be detained in custody in respect of any other matter or by virtue of any provision of the Criminal Code.

(5) Report of qualified person in writing - For the purposes of paragraph (4)(a), if the prosecutor and the young person agree, evidence of a qualified person may be received in the form of a report in writing.
(6) Application to vary assessment order if circumstances change - A youth justice court may, at any time while an order made under subsection (1) is in force, on cause being shown, vary the terms and conditions specified in the order in any manner that the court considers appropriate in the circumstances.

(7) Disclosure of report - When a youth justice court receives a report made in respect of a young person under subsection (1),

(a) the court shall, subject to subsection (9), cause a copy of the report to be given to

(i) the young person,

(ii) any parent of the young person who is in attendance at the proceedings against the young person,

(iii) any counsel representing the young person, and

(iv) the prosecutor; and

(b) the court may cause a copy of the report to be given to

(i) a parent of the young person who is not in attendance at the proceedings if the parent is, in the opinion of the court, taking an active interest in the proceedings, or

(ii) despite subsection 119(6) (restrictions respecting access to certain records), the provincial director, or the director of the provincial correctional facility for adults or the penitentiary at which the young person is serving a youth sentence, if, in the opinion of the court, withholding the report would jeopardize the safety of any person.

PART 4 – SENTENCING

Purpose and Principles

38. (1) Purpose - The purpose of sentencing under section 42 (youth sentences) is to hold a young person accountable for an offence through the imposition of just sanctions that have meaningful consequences for the young person and that promote his or her rehabilitation and reintegration into society, thereby contributing to the long-term protection of the public.

(2) Sentencing principles - A youth justice court that imposes a youth sentence on a young person shall determine the sentence in accordance with the principles set out in section 3 and the following principles:
(a) the sentence must not result in a punishment that is greater than the punishment that would be appropriate for an adult who has been convicted of the same offence committed in similar circumstances;

(b) the sentence must be similar to the sentences imposed in the region on similar young persons found guilty of the same offence committed in similar circumstances;

(c) the sentence must be proportionate to the seriousness of the offence and the degree of responsibility of the young person for that offence;

(d) all available sanctions other than custody that are reasonable in the circumstances should be considered for all young persons, with particular attention to the circumstances of aboriginal young persons; and

(e) subject to paragraph (c), the sentence must

(i) be the least restrictive sentence that is capable of achieving the purpose set out in subsection (1),

(ii) be the one that is most likely to rehabilitate the young person and reintegrate him or her into society, and

(iii) promote a sense of responsibility in the young person, and an acknowledgement of the harm done to victims and the community.

(3) Factors to be considered - In determining a youth sentence, the youth justice court shall take into account

(a) the degree of participation by the young person in the commission of the offence;

(b) the harm done to victims and whether it was intentional or reasonably foreseeable;

(c) any reparation made by the young person to the victim or the community;

(d) the time spent in detention by the young person as a result of the offence;

(e) the previous findings of guilt of the young person; and

(f) any other aggravating and mitigating circumstances related to the young person or the offence that are relevant to the purpose and principles set out in this section.

39. (1) Committal to custody - A youth justice court shall not commit a young person to custody under section 42 (youth sentences) unless

(a) the young person has committed a violent offence;

(b) the young person has failed to comply with non-custodial sentences;
(c) the young person has committed an indictable offence for which an adult would be liable to imprisonment for a term of more than two years and has a history that indicates a pattern of findings of guilt under this Act or the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985; or

(d) in exceptional cases where the young person has committed an indictable offence, the aggravating circumstances of the offence are such that the imposition of a non-custodial sentence would be inconsistent with the purpose and principles set out in section 38.

(2) Alternatives to custody - If any of paragraphs (1)(a) to (c) apply, a youth justice court shall not impose a custodial sentence under section 42 (youth sentences) unless the court has considered all alternatives to custody raised at the sentencing hearing that are reasonable in the circumstances, and determined that there is not a reasonable alternative, or combination of alternatives, that is in accordance with the purpose and principles set out in section 38.

(3) Factors to be considered - In determining whether there is a reasonable alternative to custody, a youth justice court shall consider submissions relating to

(a) the alternatives to custody that are available;

(b) the likelihood that the young person will comply with a non-custodial sentence, taking into account his or her compliance with previous non-custodial sentences; and

(c) the alternatives to custody that have been used in respect of young persons for similar offences committed in similar circumstances.

(4) Imposition of same sentence - The previous imposition of a particular non-custodial sentence on a young person does not preclude a youth justice court from imposing the same or any other non-custodial sentence for another offence.

(5) Custody as social measure prohibited - A youth justice court shall not use custody as a substitute for appropriate child protection, mental health or other social measures.

(6) Pre-sentence report - Before imposing a custodial sentence under section 42 (youth sentences), a youth justice court shall consider a pre-sentence report and any sentencing proposal made by the young person or his or her counsel.

(7) Report dispensed with - A youth justice court may, with the consent of the prosecutor and the young person or his or her counsel, dispense with a pre-sentence report if the court is satisfied that the report is not necessary.

(8) Length of custody - In determining the length of a youth sentence that includes a custodial portion, a youth justice court shall be guided by the purpose and principles set out in section 38, and shall not take into consideration the fact that the supervision portion of the sentence may not be served in custody and that the sentence may be reviewed by the court under section 94.
(9) Reasons - If a youth justice court imposes a youth sentence that includes a custodial portion, the court shall state the reasons why it has determined that a non-custodial sentence is not adequate to achieve the purpose set out in subsection 38(1), including, if applicable, the reasons why the case is an exceptional case under paragraph (1)(d). 

Pre-sentence Report 

40. (1) Pre-sentence report - Before imposing sentence on a young person found guilty of an offence, a youth justice court 

(a) shall, if it is required under this Act to consider a pre-sentence report before making an order or a sentence in respect of a young person, and 

(b) may, if it considers it advisable, require the provincial director to cause to be prepared a pre-sentence report in respect of the young person and to submit the report to the court. 

(2) Contents of report - A pre-sentence report made in respect of a young person shall, subject to subsection (3), be in writing and shall include the following, to the extent that it is relevant to the purpose and principles of sentencing set out in section 38 and to the restrictions on custody set out in section 39: 

(a) the results of an interview with the young person and, if reasonably possible, the parents of the young person and, if appropriate and reasonably possible, members of the young person’s extended family; 

(b) the results of an interview with the victim in the case, if applicable and reasonably possible; 

(c) the recommendations resulting from any conference referred to in section 41; 

(d) any information that is applicable to the case, including 

(i) the age, maturity, character, behaviour and attitude of the young person and his or her willingness to make amends, 

(ii) any plans put forward by the young person to change his or her conduct or to participate in activities or undertake measures to improve himself or herself, 

(iii) subject to subsection 119(2) (period of access to records), the history of previous findings of delinquency under the Juvenile Delinquents Act, chapter J-3 of the Revised Statutes of Canada, 1970, or previous findings of guilt for offences under the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, or under this or any other Act of Parliament or any regulation made under it, the history of community or other services rendered to the young person with respect to those findings and the response of the young person to previous sentences or dispositions and to services rendered to him or her,
(iv) subject to subsection 119(2) (period of access to records), the history of alternative measures under the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, or extrajudicial sanctions used to deal with the young person and the response of the young person to those measures or sanctions,

(v) the availability and appropriateness of community services and facilities for young persons and the willingness of the young person to avail himself or herself of those services or facilities,

(vi) the relationship between the young person and the young person’s parents and the degree of control and influence of the parents over the young person and, if appropriate and reasonably possible, the relationship between the young person and the young person’s extended family and the degree of control and influence of the young person’s extended family over the young person, and

(vii) the school attendance and performance record and the employment record of the young person;

(e) any information that may assist the court in determining under subsection 39(2) whether there is an alternative to custody; and

(f) any information that the provincial director considers relevant, including any recommendation that the provincial director considers appropriate.

42. (1) Considerations as to youth sentence - A youth justice court shall, before imposing a youth sentence, consider any recommendations submitted under section 41, any pre-sentence report, any representations made by the parties to the proceedings or their counsel or agents and by the parents of the young person, and any other relevant information before the court.

(2) Youth sentence - When a youth justice court finds a young person guilty of an offence and is imposing a youth sentence, the court shall, subject to this section, impose any one of the following sanctions or any number of them that are not inconsistent with each other and, if the offence is first degree murder or second degree murder within the meaning of section 231 of the Criminal Code, the court shall impose a sanction set out in paragraph (q) or subparagraph (r)(ii) or (iii) and may impose any other of the sanctions set out in this subsection that the court considers appropriate:

(a) reprimand the young person;

(b) by order direct that the young person be discharged absolutely, if the court considers it to be in the best interests of the young person and not contrary to the public interest;
(c) by order direct that the young person be discharged on any conditions that the court considers appropriate and may require the young person to report to and be supervised by the provincial director;

(d) impose on the young person a fine not exceeding $1,000 to be paid at the time and on the terms that the court may fix;

(e) order the young person to pay to any other person at the times and on the terms that the court may fix an amount by way of compensation for loss of or damage to property or for loss of income or support, or an amount for, in the Province of Quebec, pre-trial pecuniary loss or, in any other province, special damages, for personal injury arising from the commission of the offence if the value is readily ascertainable, but no order shall be made for other damages in the Province of Quebec or for general damages in any other province;

(f) order the young person to make restitution to any other person of any property obtained by the young person as a result of the commission of the offence within the time that the court may fix, if the property is owned by the other person or was, at the time of the offence, in his or her lawful possession;

(g) if property obtained as a result of the commission of the offence has been sold to an innocent purchaser, where restitution of the property to its owner or any other person has been made or ordered, order the young person to pay the purchaser, at the time and on the terms that the court may fix, an amount not exceeding the amount paid by the purchaser for the property;

(h) subject to section 54, order the young person to compensate any person in kind or by way of personal services at the time and on the terms that the court may fix for any loss, damage or injury suffered by that person in respect of which an order may be made under paragraph (e) or (g);

(i) subject to section 54, order the young person to perform a community service at the time and on the terms that the court may fix, and to report to and be supervised by the provincial director or a person designated by the youth justice court;

(j) subject to section 51 (mandatory prohibition order), make any order of prohibition, seizure or forfeiture that may be imposed under any Act of Parliament or any regulation made under it if an accused is found guilty or convicted of that offence, other than an order under section 161 of the Criminal Code;

(k) place the young person on probation in accordance with sections 55 and 56 (conditions and other matters related to probation orders) for a specified period not exceeding two years;

(l) subject to subsection (3) (agreement of provincial director), order the young person into an intensive support and supervision program approved by the provincial director;
(m) subject to subsection (3) (agreement of provincial director) and section 54, order the young person to attend a non-residential program approved by the provincial director, at the times and on the terms that the court may fix, for a maximum of two hundred and forty hours, over a period not exceeding six months;

(n) make a custody and supervision order with respect to the young person, ordering that a period be served in custody and that a second period — which is one half as long as the first — be served, subject to sections 97 (conditions to be included) and 98 (continuation of custody), under supervision in the community subject to conditions, the total of the periods not to exceed two years from the date of the coming into force of the order or, if the young person is found guilty of an offence for which the punishment provided by the Criminal Code or any other Act of Parliament is imprisonment for life, three years from the date of coming into force of the order;

(o) in the case of an offence set out in subparagraph (a)(ii), (iii) or (iv) of the definition “presumptive offence” in subsection 2(1), make a custody and supervision order in respect of the young person for a specified period not exceeding three years from the date of committal that orders the young person to be committed into a continuous period of custody for the first portion of the sentence and, subject to subsection 104(1) (continuation of custody), to serve the remainder of the sentence under conditional supervision in the community in accordance with section 105;

(p) subject to subsection (5), make a deferred custody and supervision order that is for a specified period not exceeding six months, subject to the conditions set out in subsection 105(2), and to any conditions set out in subsection 105(3) that the court considers appropriate;

(q) order the young person to serve a sentence not to exceed

   (i) in the case of first degree murder, ten years comprised of

       (A) a committal to custody, to be served continuously, for a period that must not, subject to subsection 104(1) (continuation of custody), exceed six years from the date of committal, and

       (B) a placement under conditional supervision to be served in the community in accordance with section 105, and

   (ii) in the case of second degree murder, seven years comprised of

       (A) a committal to custody, to be served continuously, for a period that must not, subject to subsection 104(1) (continuation of custody), exceed four years from the date of committal, and

       (B) a placement under conditional supervision to be served in the community in accordance with section 105;
(r) subject to subsection (7), make an intensive rehabilitative custody and supervision order in respect of the young person

(i) that is for a specified period that must not exceed

(A) two years from the date of committal, or

(B) if the young person is found guilty of an offence for which the punishment provided by the Criminal Code or any other Act of Parliament is imprisonment for life, three years from the date of committal, and that orders the young person to be committed into a continuous period of intensive rehabilitative custody for the first portion of the sentence and, subject to subsection 104(1) (continuation of custody), to serve the remainder under conditional supervision in the community in accordance with section 105,

(ii) that is for a specified period that must not exceed, in the case of first degree murder, ten years from the date of committal, comprising

(A) a committal to intensive rehabilitative custody, to be served continuously, for a period that must not exceed six years from the date of committal, and

(B) subject to subsection 104(1) (continuation of custody), a placement under conditional supervision to be served in the community in accordance with section 105, and

(iii) that is for a specified period that must not exceed, in the case of second degree murder, seven years from the date of committal, comprising

(A) a committal to intensive rehabilitative custody, to be served continuously, for a period that must not exceed four years from the date of committal, and

(B) subject to subsection 104(1) (continuation of custody), a placement under conditional supervision to be served in the community in accordance with section 105; and

(s) impose on the young person any other reasonable and ancillary conditions that the court considers advisable and in the best interests of the young person and the public.

(5) Deferred custody and supervision order - The court may make a deferred custody and supervision order under paragraph (2)(p) if

(a) the young person is found guilty of an offence that is not a serious violent offence; and
(b) it is consistent with the purpose and principles set out in section 38 and the restrictions on custody set out in section 39.

(6) Application of sections 106 to 109 - Sections 106 to 109 (suspension of conditional supervision) apply to a breach of a deferred custody and supervision order made under paragraph (2)(p) as if the breach were a breach of an order for conditional supervision made under subsection 105(1) and, for the purposes of sections 106 to 109, supervision under a deferred custody and supervision order is deemed to be conditional supervision.

(7) Intensive rehabilitative custody and supervision order - A youth justice court may make an intensive rehabilitative custody and supervision order under paragraph (2)(r) in respect of a young person only if

(a) either

(i) the young person has been found guilty of an offence under one of the following provisions of the Criminal Code, namely, section 231 or 235 (first degree murder or second degree murder within the meaning of section 231), section 239 (attempt to commit murder), section 232, 234 or 236 (manslaughter) or section 273 (aggravated sexual assault), or

(ii) the young person has been found guilty of a serious violent offence for which an adult is liable to imprisonment for a term of more than two years, and the young person had previously been found guilty at least twice of a serious violent offence;

(b) the young person is suffering from a mental illness or disorder, a psychological disorder or an emotional disturbance;

(c) a plan of treatment and intensive supervision has been developed for the young person, and there are reasonable grounds to believe that the plan might reduce the risk of the young person repeating the offence or committing a serious violent offence; and

(d) the provincial director has determined that an intensive rehabilitative custody and supervision program is available and that the young person’s participation in the program is appropriate.

48. Reasons for the sentence - When a youth justice court imposes a youth sentence, it shall state its reasons for the sentence in the record of the case and shall, on request, give or cause to be given a copy of the sentence and the reasons for the sentence to

(a) the young person, the young person’s counsel, a parent of the young person, the provincial director and the prosecutor; and

(b) in the case of a committal to custody under paragraph 42(2)(n), (o), (q) or (r), the review board.
56. (1) Communication of order - A youth justice court that makes an order under paragraph 42(2)(k) or (l) shall

(a) cause the order to be read by or to the young person bound by it;

(b) explain or cause to be explained to the young person the purpose and effect of the order, and confirm that the young person understands it; and

(c) cause a copy of the order to be given to the young person, and to any parent of the young person who is in attendance at the sentencing hearing.

62. Imposition of adult sentence - An adult sentence shall be imposed on a young person who is found guilty of an indictable offence for which an adult is liable to imprisonment for a term of more than two years in the following cases:

(a) in the case of a presumptive offence, if the youth justice court makes an order under subsection 70(2) or paragraph 72(1)(b); or

(b) in any other case, if the youth justice court makes an order under subsection 64(5) or paragraph 72(1)(b) in relation to an offence committed after the young person attained the age of fourteen years.
Appendix D: Canadian Criminal Code (1985)

PURPOSE AND PRINCIPLES OF SENTENCING

Section 718 of the Criminal Code deals with the purpose and principles of sentencing. The section is intended to provide direction to the courts in making sentencing decisions. The following is the text of the purpose of sentencing:

718. The fundamental purpose of sentencing is to contribute, along with crime prevention initiatives, to respect for the law and the maintenance of a just, peaceful and safe society by imposing just sanctions that have one or more of the following objectives:

(a) to denounce unlawful conduct;
(b) to deter the offender and other persons from committing offences;
(c) to separate offenders from society, where necessary;
(d) to assist in rehabilitating offenders;
(e) to provide reparations for harm done to victims or to the community; and
(f) to promote a sense of responsibility in offenders, and acknowledgment of the harm done to victims and to the community.

The fundamental principle of sentencing is as follows:

718.1 A sentence must be proportionate to the gravity of the offence and the degree of responsibility of the offender.

Other sentencing principles include the following:

718.2 A court that imposes a sentence shall also take into consideration the following principles:

(a) a sentence should be increased or reduced to account for any relevant aggravating or mitigating circumstances relating to the offence or the offender, and, without limiting the generality of the foregoing,

(i) evidence that the offence was motivated by bias, prejudice or hate based on the race, nationality, colour, religion, sex, age, mental or physical disability or sexual orientation of the victim, or

(ii) evidence that the offender, in committing the offence, abused a position of trust or authority in relation to the victim

shall be deemed to be aggravating circumstances;
(b) a sentence should be similar to sentences imposed on similar offenders for similar offences committed in similar circumstances;

(c) where consecutive sentences are imposed, the combined sentence should not be unduly long or harsh;

(d) an offender should not be deprived of liberty, if less restrictive sanctions may be appropriate in the circumstances; and

(e) all available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of aboriginal offenders.
Appendix E: ADHD Cases Used

R. v. M.D.D., [2004], No. 595 (SKPC) (QL)
R. v. S.J.L., [2005], No. 273 (BCSC) (QL)