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# ADHD and Crime: The 'school to prison' pipeline

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## Abstract

*This paper is an investigation into what ADHD is, how it is supported in mainstream education, suspensions and exclusions, school behaviour policies, why many are sent to alternative education/pupil referral units, and the factors that can lead young people with ADHD into criminal activity. **Methods:** The paper investigates data drawn from an N=125 online questionnaire of adults with ADHD (diagnosed and undiagnosed), examining their experiences related to diagnosis, school, and criminal involvement. **Results:** Only 10% felt their primary school and 8% felt their secondary school recognised their ADHD. 32% of the sample was spoken to by the police between the ages of 12 and 18 years. Crimes manifested: 32% drugs, 28% stealing, 22% driving under the influence of alcohol/drugs, 14% violence towards property. **Conclusions:** The paper concludes with a discussion of early screening practices for young people, a change of narrative needed in schools by teachers and school leaders, and school behaviour policies. Such a change would aim to educate educators to increase ADHD awareness/training and to reduce crime manifestations in young people with ADHD.*

**Keywords:** ADHD, School, Prison, Crime, Suspensions, Exclusions, Diagnosis, Screening, Treatment, Addiction

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## INTRODUCTION

This study initially came from the author's personal experience as a secondary school 'Special Educational Needs Coordinator (SENDCo)' in a secondary school in London, UK. Following the COVID-19 pandemic, there was a sharp increase in the number of negative behaviours leading to suspensions and exclusions in the school. An investigation found that many students with diagnosed and undiagnosed ADHD (attention deficit hyperactivity disorder) were unsupported, due to a lack of understanding by teachers and senior leaders as to how to support such students. The author saw a lack of provision by the local authority, and that many similar students in other schools were sent to pupil referral units (termed an alternative education provision), as no other options were offered. Such students were often stuck by not getting into another school before leaving at 16 years, gaining minimal qualifications, meaning low educational prospects, and being vulnerable to gangs and crime. This was made difficult by their impulsive actions at their initial school, due to their unsupported ADHD, which meant that often when knives were brought into school, or violence towards staff and peers occurred, many new schools would reject their application for entry. Schools tend to have a very strong knife and violent behaviour policy that can often be misunderstood in relation to those with undiagnosed or diagnosed ADHD.

In collaboration with a national ADHD charity (ADDISS), the author launched an ADHD mentoring project at the school, providing specialist ADHD mentors for one day a week to support students, offering free ADHD parenting courses, a free parent ADHD helpline, and advanced training for teaching staff. This initiative yielded significant results: parents felt listened to, students with diagnosed/undiagnosed ADHD felt heard and were mentored to re-engage in education, and there were waiting lists for the free training courses. The free helpline offered support regarding medication options, and staff felt more informed to support their students. Negative behaviours were reduced, suspensions decreased, and the school felt like a happier and more supportive place to be (as noted by staff and students).

The charity informed the author that this programme was innovative, and that no other schools they knew had a similar support programme. Therefore, they utilised the project to promote what could be possible in schools with the right vision and funding.

## EMPIRICAL STUDY

### What is ADHD?

The DSM-5 (American Psychiatric Association, 2013) updates ADHD to having three subtypes: predominantly inattentive, predominantly hyperactive-impulsive, and a combination of the other two subtypes. This replaces the use of ADHD and ADD (ADD-

attention deficit disorder) as subtypes in earlier use; however, some professionals still prefer the term ADD, being more descriptive (Lanc UK, 2024).

It is estimated that between 3% and 5% of the UK general population has ADHD, which persists into adulthood in more than 65% of cases (Fayyad et al., 2007). Global figures are estimated to be approximately 5%; however, in the US, where diagnosis and treatment rates are higher, the estimate is 5-8% (National Institute for Health and Care Excellence, 2024a). A large 2023 study suggests the global prevalence of ADHD to be between 5% and 7% in children and adolescents, and between 2.5% and 5% in adults (Young et al., 2023).

A male-to-female ratio of 3:1 is common, and in clinics, the ratio can be as high as 10:1 (National Institute for Health and Care Excellence, 2024a). This sex difference may be due to boys presenting with disruptive behaviour that prompts a referral, whereas girls more commonly have the inattentive subtype, which rarely results in a referral.

ADHD is a medical condition best understood to be a biochemical deficit (dopamine), which is known as a pleasure-giving chemical in the body. The lack of it makes the individual crave activities that can naturally stimulate dopamine through adrenaline; it is these activities that are commonly misunderstood as impulsive and disruptive. This is why, until diagnosis, most young people with ADHD are perceived as being naughty and troublesome. Executive processing difficulties are also argued to be part of the ADHD profile; however, this also affects other learning difficulties to a lesser extent.

As a medical condition, a diagnosis is made by a medically trained mental health professional, usually a psychiatrist. A general practitioner doctor would not be viewed as experienced and specialist enough to make such a diagnosis.

The author realises it may be controversial, but he relates this dopamine deficit to an insulin deficit, albeit one that is less life-threatening. Without insulin, a diabetic person goes into shock, and their bodies begin to sweat and shut down, which can cause a coma if not treated quickly. The person with ADHD also goes into shock with low dopamine levels, and like a drowning person, will act without thinking, panicking by splashing and arms swaying without thought, to try to avoid drowning. Many activities naturally release dopamine through adrenaline, such as sports, risk-taking, fighting, or arguing. Like a drug addict, they crave adrenaline/dopamine-producing activities without care for how this may affect others.

Many with ADHD talk about having a racing brain and being constantly bombarded with calls to action: messages, thoughts and feelings. It has been likened to being shouted at by 10 people to do things, not knowing which person to listen to, so doing nothing as they can't cope, and then being blamed for inaction. This is referred to as an executive

processing difficulty and can significantly impede learning, causing a person to struggle to reach their full potential.

### ADHD subtypes

- ◆ **Inattentive:**  
A lack of focus, frequent inattention, and disorganisation. They are very easily pulled away from tasks they are doing due to a noise or movement around them, interrupting their thoughts and concentration
- ◆ **Impulsive/Hyperactive:**  
Restless, fidgety, will act before thinking.
- ◆ **Combined:**  
This is the most common ADHD subtype, in which individuals show symptoms of the other two subtypes.

### Treatment

Treatment is offered in two main forms: biochemical and non-biochemical. Due to a chemical imbalance, biochemical routes are often considered the most effective option; however, many parents prefer non-biochemical options due to concerns about side effects. The National Institute for Health and Care Excellence-NICE (2024b), the UK's medical guidance, suggests that parental support and CBT (Cognitive Behavioural Therapy) should be tried first with primary-aged children (5-10 years old), and if this is not effective, then moving on to biochemical options. Secondary school students and adults (11 years old and above) should proceed directly to biochemical options and utilise CBT where applicable. CBT is a therapy that aims to change how individuals react to events, commonly used to support phobias/fears to reprogram a person's reactions, which may be rational or irrational.

Interestingly, in many countries such as America, South Africa, and Israel, they regularly prescribe ADHD medication (commonly a stimulant) from the age of 7. In America, it is argued by many that ADHD medication is given too quickly for any behavioural concerns, rather than taking time to understand the cause, which may not be ADHD but stressed/overworked teachers lacking consistent teaching strategies.

The internet is full of personal strategies to cope with ADHD, which can range from using daily sports activities to naturally form dopamine to chewing gummy sweets. A person with ADHD may react differently to CBT and medication, so it can take time to identify what works best for them.

## Medications and Self-medication

The two main groups of medication are stimulant and non-stimulant, and if the individual also has autism, then some medications will be effective. Whilst medically prescribed stimulant medications are argued to be more effective (Challman and Lipsky, 2000), there are also non-stimulant options. It is sometimes hard to find the right medication and dose for a person with ADHD, which may be due to other comorbid conditions which can be present: autism, OCD, conduct disorders, anxiety, etc. Medication doses generally start low and are gradually increased until the desired peak performance levels are achieved.

Interestingly, in the UK, only 0.5% of the population are prescribed medication for ADHD, compared to the 4-5% of the population predicted to have ADHD. To date, this has been evenly split between the uptake of medication by adults and children. However, the latest UK data suggests more adults are now taking ADHD medication, and the trend is that this percentage will grow (Connelly, 2023). This is worrying as it suggests many young people lack the medication they need, maybe from being undiagnosed, and therefore being unfairly blamed in school for ADHD manifestations, which are out of their control.

'Concerto' is perceived to be the 'gold standard' ADHD medication; however, many are prescribed generic forms of Ritalin, which was the first ADHD medication on the market, launched in 1944 (Challman and Lipsky, 2000). Many of these generic medications have been found to have negative side effects, such as heightened anxiety, and have led to self-harming and attempted suicide (Challman and Lipsky, 2000) due to other chemical additives.

ADHD medication commonly has general side effects, such as making it hard to sleep and appetite suppression, so many are also prescribed Melatonin, a supplement to support sleep.

ADHD medication aims to offer a slow release of dopamine, which many have remarked has helped to quieten all the shouting voices in their heads, so they can focus and achieve. Those taking the medication have, in my school experience, achieved well, with the ability to study/revise and gain good examination results, attributing this to their ADHD medication. Those who do not take medication (either by choice or by being undiagnosed) tend to struggle at school, struggling to revise, to focus and sit still for examinations; so, they rush to leave as soon as possible and miss out on questions, etc. Their results do not truly reflect their potential, leaving them in a vulnerable position post-school with reduced career/further education options. Many are regularly given detentions, suspensions, and exclusions, as they commonly struggle with school behaviour policies.

Feedback from some taking stimulant medication is that it numbs them, so they can't feel. Some people dislike how it affects them both mentally and physically. Many enjoy the rush ADHD gives them, so may carry on taking the medication to please parents, but supplement it with other medications or drugs to produce the dopamine (feel good) high they crave, e.g. very high caffeinated drinks or recreational drugs. This, of course, defeats the object of their prescribed medication.

Due to the side effects of stimulant medication (loss of appetite, problems sleeping, feeling numb, etc), many with ADHD stop taking their prescribed medication and choose to self-medicate instead. Interviews for the Author (2024, 2025) found teenagers and adults self-medicating with very high-caffeine drinks and recreational drugs. These tend to give very big highs, followed by big lows, so individuals have constant highs and lows throughout their day, rather than the constant safe dose given from prescription medication. Some adults with a good understanding of their ADHD use daily sports to create naturally forming dopamine, but will only medicate if they need to write a report or study for an examination.

In the UK, due to the current medication shortage, students are being advised to save their medication for examinations, without realising they also need it for their revision.

## **Addiction**

Many who self-medicate for ADHD, mostly undiagnosed, have turned to recreational drugs to create the dopamine high they need to feel good. Unfortunately, many of these drugs can create addictions, which then creates additional problems for them. Addictions regarding ADHD have included caffeine (6+ high caffeine drinks a day), cocaine, marijuana, high-risk sex, and high-risk sports. The challenge then comes to how they continue to fund their recreational drug habit, causing many to turn to crime and involvement with gangs.

## **School**

As noted earlier, those with ADHD are commonly perceived as naughty and troublesome by teachers and by their parents, who can't cope. They commonly act before thinking (impulsivity), will have a lack of attention to their schoolwork and in class, and, importantly, will not respond to punishment as a deterrent.

Those with ADHD feel misunderstood in school and like a trapped lion in a cage. Sitting still and paying attention is painful for them, so they find ways to cope, which often gets them into trouble, triggering an adrenaline rush and, consequently, naturally creating dopamine.

Most with ADHD are undiagnosed/unmedicated, so they start each day with a deficit, craving dopamine. Like a drug addict seeking a fix, the young person with ADHD craves activities which will feed their chemical deficit. Whilst an apple or a chocolate bar would bring pleasure to someone without ADHD, those with ADHD gain pleasure through adrenaline-producing activities such as arguing, running, fighting, and high-risk activities. It's common to see such individuals drinking high-caffeine drinks (e.g. Red Bull) before school, and that is the last thing a teacher wants to see first thing in the morning, fights in tutor rooms or lining up to go into school, from a child on an adrenaline/dopamine high/spike!

When this author meets parents, they tend to be reluctant to have their child referred for a possible ADHD diagnosis, and even more reluctant towards possible medication treatment. No parent wishes to give unnecessary medication to their child; however, ADHD is generally misunderstood by parents and teachers alike. They believe ADHD traits are a choice, and punishment will change them. The truth is very different; it's a lifelong medical deficit which can't be cured. It could be argued that, without diagnosis/treatment, parents are preventing their children from reaching their potential and placing them on the 'school-to-prison' pathway, allowing them to come into conflict with strict school behaviour policies which segregate and exclude those who are believed to be rule-breaking and troublesome.

"These numbers show an alarming number of pupils who have not had their disability diagnosed during their school years. This could be due to a lack of resources, class sizes that are too large, or a lack of understanding from teaching staff about the signs and signals to look out for, suggesting inadequate training in this area. Inevitably, this means each child who goes undiagnosed likely did not have the appropriate support and guidance put into place to allow them to reach their potential." Disability Policy Centre (2022).

### **Alternative Provision (AP) and Pupil Referral Units (PRUs)**

When young people in school with undiagnosed ADHD or diagnosed and untreated ADHD without medication fall foul of school behaviour policies, they are commonly suspended and excluded. Many are sent to alternative education provisions (AP) such as 'pupil referral units'. Research (Department of Education, 2023) suggests that these units have high frequencies of students with undiagnosed needs, many of whom have EHCPs (students with severe special needs who receive mandatory funding for special needs support). As a former SENDCO, the author found it interesting that many parents are told these young people can be best served in these units, but as many have undiagnosed special educational needs (SEND), are schools really able to say that when they don't know what the young person's needs are? The terms SEND (Special Educational Needs and Disabilities) and SEN (Special Educational Needs) are often used interchangeably in both UK legislation and educational practice.

The Department for Education (2023) report by the UK government notes '82% of children and young people in state-place funded alternative provision have identified special educational needs [SEN]', however their data notes that a generalised SEND category of 'missing or other difficulty' due to 'persistent disruptive behaviour' can be the reason for more than 60% of those at APs not having an actual diagnosis of need. Until an actual need is identified, the young person cannot be effectively supported to learn to the best of their abilities. This effectively means APs are placements for young people whom schools do not feel they can support. If they enter with a SEND category of 'missing or other difficulty', then their school has failed them by not identifying their learning needs and thus learning barriers. It could be argued that it is the school that has failed them, not the young person failing school. This urgently needs to be highlighted to policymakers.

These units tend to be more nurturing, with smaller classrooms (up to 5 students compared to 30 on average in mainstream education), with targeted specialist support for behaviour and special needs. Diagnosis rarely happens in these provisions, as they are still reliant on the same long waiting lists schools have for diagnostic provisions. In the UK, it is called CAMHS (Child and Adolescent Mental Health Services). The waiting list for an ADHD diagnosis is between 2 and 5 years for an assessment, and during this time, most schools do not provide extra support for possible ADHD needs, nor apply for additional funding for them. This is called an 'Educational Health Care Plan (EHCP)', but most local authorities require a severe diagnosed need before a funding application is approved.

Whilst these units have targeted support, they are full of like-minded young people, failed in mainstream education, who have been suspended and expelled from school for several reasons, such as bringing a knife to school, maybe to show friends (impulsivity), drug use, property damage (impulsivity) or violence (impulsivity). Such groups have a high frequency of drug taking and delinquent behaviour, and as these young people mix inside these classes, they will also likely be after school, leading the young misunderstood and vulnerable person with likely undiagnosed/untreated ADHD to mix with drugs, crime, and gangs (Kaip et al. 2024). They are likely drawn to such high-risk, impulsive behaviour, which gives an adrenaline rush and a dopamine, feel-good sensation.

## **Suspensions and Exclusions**

UK government figures show an increase in all areas. Delving deeper into the data, the figures show that pupils with special educational needs and disabilities (SEND) had suspension rates of over 600 per 10,000 pupils, compared to 144 for pupils with no SEND. Pupils with SEND but without EHCPs also had the highest permanent exclusion rate of 8 per 10,000 pupils (NASEN, 2022).

The most common reason for permanent exclusions remains the same as in previous years, persistent disruptive behaviour (31%), followed by physical assault against a pupil (16%) and verbal abuse or threatening behaviour against an adult (13%). Persistent disruptive behaviour was included as a reason in 41% of all suspensions and 31% of all permanent exclusions in the autumn term 2021/22 (NASEN, 2022).

According to the Department for Education (2023), also see Table 1:

- ◆ There were 787,000 suspensions in the 2022/23 academic year. This is an increase from the previous year, when 578,300 suspensions occurred, and the highest recorded annual number of suspensions. This corresponds to approximately 933 suspensions per 10,000 pupils.
- ◆ There were 9,400 permanent exclusions in the 2022/23 academic year.
- ◆ This is an increase from 6,500 in 2021/22 and the highest recorded annual number of permanent exclusions. This equates to 11 permanent exclusions for every 10,000 pupils.
- ◆ The most common reason for suspensions and permanent exclusions was persistent disruptive behaviour.
- ◆ Persistent disruptive behaviour accounted for 48% of all reasons given for suspension and for 39% of reasons for permanent exclusions. This aligns with previous years, during which this reason was the most frequently reported.

Table1: Suspension and exclusion data (Department for Education, 2024).

<b>Suspensions</b>	<b>786,961,</b> up from 578,280 in 2021/22	<b>9.33%</b> up from 6.91% in 2021/22
<b>Permanent Exclusions</b>	<b>9,376,</b> up from 6,495 in 2021/22	<b>0.11%,</b> up from 0.8% in 2021/22

## Turning to Crime

Unsurprisingly, being blamed in school for misbehaviour that is out of their control, being suspended and excluded, and being sent to a pupil referral unit can lead many young people to feel disillusioned and rejected by the school and society, causing some to become rebellious towards society. Young people with ADHD are easily drawn to high-risk adrenaline-boosting activities such as crime.

The crimes that those with ADHD tend to commit are impulsive acts that get them into trouble, such as mugging, shoplifting, property damage, and physical altercations/harm/violence. They are also drawn to high-risk adrenaline-giving activities such as drugs and armed robbery.

In one interview, the author conducted with a man who had been in prison for multiple armed robberies, he told of how, while inside, he trained in scaffolding, which, upon release, he gained a job doing. He said that within 6 months, he found the work too monotonous and too routine-based for him, and he was again drawn to the excitement of armed robbery. Without a diagnosis and suitable treatment for his undiagnosed ADHD, for example, medication, he was drawn to the huge dopamine high of crime.

## **THE STUDY, METHODOLOGY**

This study was part of a publication by the author (Author, 2024), which is part of a series examining the school-to-prison pipeline.

An online questionnaire, mostly 40 multiple-choice but with some free-text questions (see Appendix 1), was developed to gauge thoughts on the school-to-prison pipeline for those with ADHD, to be completed by those with a diagnosis or awaiting diagnosis, and those who were undiagnosed. Consent was explained and gained on the welcome page of the online questionnaire. The questionnaire investigated: whether they had a private or a government diagnosis (National Health Service or CAMHS), if they were taking ADHD medication, how it made them feel, how they were treated at school, how well schools catered for their needs, whether were they sent to alternative provision (PRU), were they drawn into crime, and lastly if they had been in prison and for what crimes.

Following invitations to various Facebook ADHD Groups and disability forum groups, 124 individuals completed the online questionnaire. Whilst no proof of diagnosis was required, as the project recognised the difficulties in gaining a diagnosis, 70% disclosed they had a formal diagnosis. The questionnaire included questions from known ADHD screeners to indicate that a diagnosis would be likely. All responses to these screener questions fell within normal ranges for individuals with ADHD, as indicated in the ADHD Traits data reported in the results section of this paper. At the end of the online questionnaire, participants had the option to volunteer for an interview for the project. However, this paper only reports on the initial online questionnaire. Data was stored on a password-secure computer.

As the study was conducted outside of a university, no ethics committee approval was required. However, the author, a PhD researcher, implemented measures that a committee would have required.

## RESULTS

### Profile

- ◆ **Participants:**
  - ◇ 55% female
  - ◇ 45% male
- ◆ **Age:**
  - ◇ 57% were 31-50 years old
  - ◇ 25% were 19-30 years old
- ◆ **Location:**
  - ◇ 71% England,
  - ◇ 18% outside of the UK and Europe

### Diagnosis

- ◆ **Diagnosis:**
  - ◇ 78% had a formal ADHD diagnosis
- ◆ **Who diagnosed them:**
  - ◇ 50% privately,
  - ◇ 30% by their country's National Health Service/CAMHS
- ◆ **Age when diagnosed:**
  - ◇ 54% 31-50 years old,
  - ◇ 25% 19-30 years old,
  - ◇ 8% 12-18 years old,
  - ◇ 6% 5-11 years old
- ◆ **Who asked for the diagnosis:**
  - ◇ 30% the individual,
  - ◇ 17% parents,
  - ◇ 14% other family,
  - ◇ 8% the school

### ADHD Traits

- ◇ 76% lack of motivation,
- ◇ 75% disorganisation,
- ◇ 74% forgetfulness,
- ◇ 71% lack of focus,
- ◇ 70% fatigue,
- ◇ 69% anxiety
- ◇ 65% poor time management,
- ◇ 65% poor self-image,
- ◇ 65% impulsivity,
- ◇ 54% relationship issues,
- ◇ 42% fits of rage,

## Medication

- ◆ **Medication:**
  - ◇ 63% had been offered medication for their ADHD
- ◆ **Still taking medication:**
  - ◇ Only 45% of those offered medication still take it
- ◆ **Self-medication:**
  - ◇ 61% self-medicated for their ADHD
- ◆ **Negative effects of their ADHD medication:**
  - ◇ 33% affecting appetite,
  - ◇ 30% affecting sleep,
  - ◇ 20% making them anxious,
  - ◇ 2% feeling numb

## School experiences

- ◆ **School:**
  - ◇ 10% felt their primary school recognised their ADHD,
  - ◇ 8% felt their secondary school recognised their ADHD
- ◆ **Support at school:**
  - ◇ 83% said no help was offered,
  - ◇ 6% gained movement breaks, and
  - ◇ 2% were offered a fidget toy
- ◆ **School:**
  - ◇ 68% felt unfairly blamed for their impulsiveness,
  - ◇ 85% felt they were unfairly blamed for things out of their control
- ◆ **Teachers:**
  - ◇ 60% felt that very few teachers did not understand their ADHD,
  - ◇ 17% had some understanding,
  - ◇ 22% had no understanding of ADHD
- ◆ **School suspension/expulsions:**
  - ◇ 42% had been suspended/expelled from school

## Alternative education

- ◆ **Alternative education/PRUs:**
  - ◇ Only 10% had been sent to such a provision
- ◆ **Alternative education and Drugs:**
  - ◇ 60% felt alternative provisions were unsuitable for vulnerable young people with ADHD
- ◆ **Alternative education/PRUs:**
  - ◇ 55% perceived that such provisions were
  - ◇ 51-75% full of vulnerable young people with ADHD

**Police interaction/types of crime**

- ◆ **Police interaction:**
  - ◇ 32% of the sample was spoken to by the police between the ages of 12-18 years,
  - ◇ 7% between the ages of 5-11 years old, and
  - ◇ 10% between the ages of 19-30 years old.
- ◆ **Involvement with crime:**
  - ◇ 49% of the sample had been involved with crime
- ◆ **Types of crimes:**
  - ◇ 32% drugs,
  - ◇ 28% stealing,
  - ◇ 22% driving under the influence of alcohol/drugs,
  - ◇ 14% violence towards property,
  - ◇ 13% violence towards others
- ◆ **Crime:**
  - ◇ 73% felt there were links between crime and ADHD

**DISCUSSION****Early Screening and Fast Assessment**

54% of this sample were diagnosed when they were between 31 and 50 years old, and another 25% when they were between 19 and 30 years old. This means very few were diagnosed at school, and 50% of this sample were privately diagnosed.

The above is very disappointing, in that they were not diagnosed as young children, and therefore were likely blamed for a medical condition they had. This is extremely unfair and supports the perception that ADHD is misunderstood in schools. The current UK waiting list for the National Health Service/CAMHS is 2-5 years for young people, depending on their location, and should be recognised as a concern requiring urgent action. It also relies on a teacher/school referring them for assessment, suggesting their behaviours at school did not trigger this, which is likely due to a lack of awareness of ADHD traits by teachers.

75% of this sample had gone through school without their needs being recognised and were seen as naughty and lazy. 68% of this sample felt unfairly blamed in school for things beyond their control, such as impulsiveness.

The author's own experience with schools suggests that current teacher awareness remains poor. Historical UK data regarding those in alternative education (APs) with unknown SEND needs and those being suspended/expelled from school suggest that little has changed in schools (Shaw and Audley, 2024).

The author argues that, although the sample may have been predominantly from a 31–50-year-old group and had left mainstream education 15–35 years ago, their views regarding schools are relevant and still reflect current research on the topic. It could be argued that the greater use of behaviour policies at school makes the current experience of young people far more adverse (Shaw and Audley, 2024). The author argues that awareness of ADHD is still very limited in schools, hence the high use of behaviour strategies to control, rather than understand perceived misbehaviour by young people.

A 2017 survey of 803 currently employed UK teachers (ADHD-UK, 2025), equally split between primary and secondary, found that:

- ◆ 24% could not identify a short attention span
- ◆ 26% could not identify hyperactivity
- ◆ 41% could not recognise an impulsive act
- ◆ 74% could not recognise difficulties with organisation
- ◆ 72% did not know how to refer a student suspected of ADHD
- ◆ 34% believe they have undiagnosed ADHD students in their classrooms
- ◆ 42% had not received ADHD training
- ◆ 75% are concerned about the lack of resourcing regarding ADHD in schools

### **A Change of Narrative is Needed**

A change is needed, by teachers and senior school leaders, to question why a child may misbehave and if undiagnosed/unsupported SEND needs are the cause. Rather than punishing the young person, they should be helping them. This does create a dilemma, as it may question a teacher's judgement and what they are doing to offer inclusive learning. However, a change is needed, as school behaviour policies have become harsher in response to increasing demands for results, with lower-attaining students being moved out to avoid affecting their league table scores. Schools are commonly suspending/excluding young people in greater numbers to alternative provisions, often without a diagnosis of learning difficulties.

An innovative programme in Glasgow has closed all but a few alternative provisions, aiming to force schools to offer more inclusive teaching for all students. To question if unmet SEND is the cause of misbehaviour, and what they could do to turn around failing students. It has been very successful, and its innovative leader, Maureen McKenna, has been brought to London by its Mayor to address London's growing youth behaviour problem (Vickers, 2023).

### **School Behaviour Policies**

People laugh when this author remarks that schools and prisons are more similar than people think. All rooms are always locked, and toilets are also always locked in some

schools where the author has taught. Entry/exit gates are locked with guards. Students are always supervised and must abide by strict uniform rules (including clothing, hair, and jewellery); any infractions are severely dealt with. They must sit quietly in classrooms and are unable to talk in some schools, whilst moving from one classroom to the next.

Strict school behaviour policies have been implemented to regulate the behaviour of young people in classrooms and common areas, which could be controversially argued to be similar to herding cattle. A previous secondary school the author taught at had an 'ASAP' policy (Attention, Sit up and look at the teacher, arms laid flat on the table, not moving, and Posture-do not slouch). All students needed to sit up in their chairs, pay attention, put their arms on the table, look at the teacher, and, of course, refrain from talking. Infractions were addressed through a first warning, with the individual's name placed on the board. If non-compliance persists, a final warning is issued, and a second note is added to the board. If they still did not comply, staff needed to call for the 'duty manager' to remove them either to another classroom or the referral room. They would be given an automatic same-day one-hour detention after school, and five detentions a term resulted in a suspension.

At this school, young people with neurodiverse needs (e.g. autism, ADHD, or dyslexia) would struggle with the above policy, especially if their needs were undiagnosed. They were constantly blamed for actions out of their control. A young person with ADHD would be treated harshly for their inability to sit still and pay attention, and would be segregated for long periods of time as a punishment. Again, the analogy of a caged lion comes to mind.

## CONCLUSIONS

This paper offers an investigation of the educational journey of young people with diagnosed/undiagnosed ADHD in mainstream education, and why some are drawn towards crime in various guises. Feeling rejected and misunderstood by adults who were perceived as experts, many turn against society's rules regarding fairness, law, and order.

There is a misconception in school that young people who misbehave are naughty and do so out of choice, so teachers do not ask 'why'. This is likely as teachers commonly lack the time, awareness, and importantly training regarding various commonly found special educational needs in their classrooms, e.g. autism, ADHD and dyslexia. So the response proposed by school leaders is to remove and exclude students who are perceived as 'problematic' rather than asking why they are misbehaving, which is likely to be a result of struggling to access the learning content (they are struggling to understand what is being taught or its seen as not relevant to them) or learning environment (staying in the physical space of a classroom being forced to sit still for hours on end).

Each year, a child is passed from one teacher to another, and neither asks if there are any learning difficulties, as their previous teacher would have identified them and made a referral. Therefore, the misbehaving child in front of them is perceived as naughty, indifferent, and in need of discipline.

There is a need for all class teachers to ask questions of the child in front of them. Why are they disengaged in their lessons? Senior educational leaders should question undiagnosed learning difficulties (SEND) before suspensions are considered, but this would question a teacher's professional judgement. The significant number of undiagnosed young people, from 7 years old, who are being suspended and written off by schools because they have not been screened and supported for their learning barriers, should be a call for action. This is what drives the 'school-to-prison' pipeline, creating disillusioned young people who are vulnerable to drugs and gang culture.

### Ethical Consideration

Online Questionnaire: Informed consent was gained through a cover sheet on the online questionnaire. No quotes were taken from these responses, so no ethical concern was perceived.

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