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## Research Project Bar Examination Accommodations for ADHD Graduates

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# RESEARCH PROJECT: BAR EXAMINATION ACCOMMODATIONS FOR ADHD GRADUATES

## BEGIN TRANSCRIPT\*

**NEHA SAMPAT:** Thank you so much for sticking around. It's been a really wonderful and full, informative day. We've done some research on ADHD accommodations on the bar exam that we'd like to share with you.

In assessing ADHD accommodations requests, a number of state bars take what we think is a rigid approach to ADHD diagnosis, denying ADHD accommodations due to a lack of a well-documented childhood history of ADHD symptoms from the bar applicant.

We became concerned by the denial on such a basis when we saw students with a practical inability to obtain childhood history documentation based on a range of factors. Our concern was heightened in realizing that many of the factors making it impractical or impossible to obtain childhood history documentation are disproportionately experienced by people of minority backgrounds and protected classes or populations woefully underrepresented in our profession. In other words, we believe that the common state bar practice of requiring documented childhood history of ADHD for provision of ADHD accommodations on the bar exam has a discriminatory impact on applicants who are female, members of a racial or ethnic minority, people from lower socioeconomic strata, and those who are relatively older when applying for bar membership.

We know that this is a controversial assertion and we're not at all implying that any of this is intentional on the part of state bars. On the contrary, we really feel that we're all in this together, state bars included, so we think it's important for all of us to examine the realities of many diverse bar applicants with ADHD and to all work together to increase overall diversity in the profession.

With that in mind, we are going to focus our presentation today on

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\* Panel: Neha Sampat, Associate Dean for Student Services, Golden Gate University School of Law; and Esmé Grant, Disability Service Coordinator, Golden Gate University School of Law.

discussing, first, the professional context of the need for diversity and increased access in the legal profession. We're then going to describe the state bars' policies and procedures relating to bar exam accommodations, and specifically ADHD accommodations. And then we'll go on to explain the legal framework applicable to bar examiner agencies. We'll then provide a basic introduction to ADHD and its diagnostic criteria and then discuss the discrepancies in diagnosis. We'll conclude by setting forth specific recommendations to mitigate, if not address, the issues faced by these bar applicants.

**ESMÉ GRANT:** Thank you. The real issue of what our research is aimed at is how the diversity of the legal profession is affected by standards such as the childhood history requirement for receiving bar accommodations. Although this might be a small group of students, when you are discussing minority inclusion in the legal profession, every student counts and can make a significant difference on the diversity of the profession.

In presenting my part of the research, I am going to refer to both national issues in diversification of the legal profession, and at times focus in on California, where the students that Neha and I worked with mostly applied for these bar accommodations.

Now, beginning with the national perspective, the ABA has expressed that it believes that a legal profession must be more inclusive and states that one of its goals is to promote full and equal participation of lawyers with disabilities.<sup>1</sup>

Although I imagine the audience here has a good idea of why the legal profession needs to be diverse, I want to list the four arguments made by the ABA's Presidential Initiative Commission Report from 2010, which are the democracy, business, leadership, and demographic arguments. Rather than focus on why we need to diversify this profession, because I think we have a good understanding, I'm going to shift the conversation to where we are not seeing these goals being met.<sup>2</sup>

What you see before you, and I'll draw some of these numbers for you, is a table gathered by the California Bar Association's Council on Access and Fairness, comparing census data and state-by-diversity data.<sup>3</sup>

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1. AM. BAR ASS'N PRESIDENTIAL INITIATIVE COMM'N ON DISABILITY, DIVERSITY IN THE LEGAL PROFESSION: THE NEXT STEPS 3 (2010), [hereinafter ABA, THE NEXT STEPS], available at <http://mldc.whs.mil/download/documents/Readings/Next%20Steps%20Final-Virtual%20Accessible%20042010.pdf>.

2. Slide (listing the democracy, business, leadership, and demographic arguments for why the legal field should be diverse) (on file with author); see also ABA, THE NEXT STEPS, *supra* note 1, at 5.

3. Slide: *Diversity Statistics* (on file with author) (citing Rodney Fong, State Bar

Some aspects of this to note are that the representation of African Americans in the profession in California has actually decreased since 2001 and never neared the levels reflected by the Census. So to give you an example, in the bar profession of California, African Americans in 2001 represented 2.4 percent of the profession and they're now at 1.7 percent in 2006. In the Census, African Americans represented six percent of the population, so you can see that this is a significant difference.

Also, other minorities, like Asian/Pacific Islanders and Hispanic/Latinos continue to grow in representation of California residents, but they do not grow, at least significantly, in representation of attorneys.

In California, Caucasians represent over eighty percent of a profession in a state where they are represented by less than half of the population. This is not much different on a national level. The 2010 ABA report cites that Caucasians constitute seventy percent of working people over age sixteen, but are overrepresented among lawyers.<sup>4</sup> So to give you an idea of that, eighty-nine percent of attorneys nationwide are Caucasian, and ninety percent of judges nationwide are Caucasian. Caucasians also dominate other areas of leadership in the legal profession, like law firm partnerships and so forth.

Now that we have touched upon the lack of racial diversity in the legal profession. I want to talk a little about lawyers with disabilities. Lawyers with disabilities are much more difficult to survey and track due to a number of reasons. But, a 2010 survey done by the California Bar reported that there are four percent of attorneys with disabilities, compared to a 2004 Census report, which represented 17.4 percent people with disabilities.<sup>5</sup>

There are likely countless reasons why the legal profession has not diversified itself as much as other professions, but our contention is that one of these reasons is due to the unreasonable standards required by bar associations to qualify for testing accommodations that, in particular, impede the access of minorities with ADHD from entering the legal profession. Again, this is likely a smaller group of people, but every lawyer counts.

Now, I want to put this diversity information in context of what we are precisely discussing, which is the unfairness of the childhood history requirement standard held by many state bars. I want to start off with a discussion of the accommodations process in state bars, which many of you are probably familiar with.

As a former disability services provider at GGU, I will draw from the

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of California Council on Access & Fairness (presentation) (Fall 2010)).

4. See ABA, *THE NEXT STEPS*, *supra* note 1, at 12.

5. Slide: *Diversity Statistics*, *supra* note 3 (citing Rodney Fong, State Bar of California Council on Access & Fairness (Fall 2010) (presentation)).

experiences of my former students to give some examples of where this childhood history requirement has been an injustice to them.

As the window on what students are facing, I want to draw from a survey of Florida attorneys conducted in 2006, where one-third of attorneys with disabilities indicated that they thought the Florida State Bar's testing accommodation documentation requirements and the application for admission were unfair. Nineteen percent of these lawyers reported having difficulty in the bar accommodation process, and twenty one percent reported that policies and practices created barriers in the bar exam process.<sup>6</sup>

I know that a lot of you are probably familiar with the application process for the bar, but I'm going to briefly go over the accommodations process for applying for ADHD accommodations and really center in on this childhood history requirement.

What we're looking at here, and many of you are probably familiar with, is a state bar's—in this case California's—website, which posts the forms for applying for bar accommodations.<sup>7</sup> In California, the process is form-based. Students with ADHD must complete Form A, which is the general request form. Then they have their psychologist and evaluator who gave their diagnosis, fill out Form D to give additional insight into their evaluation. Finally, the law school disability services provider fills out Form F, confirming what accommodations the student received.

The California Bar has very recently gone through some modifications, and in mid-February added the option of having a student's diagnostician speak with the bar committee. We see this as a move in the right direction, particularly because state bars and evaluators have shown distrust for many clinical psychologists who provide the diagnoses.

So this is the form process in a nutshell; however, there is a further documentation component. Students with ADHD also submit their testing. And where there's not a childhood diagnosis, students may and are encouraged to send along anything from their childhood that may have indicated that the ADHD symptoms were present but were going undiagnosed. In my past experience, this has included report cards with faded pencil markings of "John Doe talks a lot," to report cards in later years exhibiting academic struggle, to disturbing letters from parents who have admitted to the state bar committee that cultural beliefs or lack of information prevented them from getting their child the help they needed.

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6. Slide (on file with author) (citing THE DISABILITY INDEPENDENCE GRP., FLORIDA LAWYERS WITH DISABILITIES: A SURVEY REPORT 8 (2007)).

7. Slide (on file with author) (citing The State Bar of California, *Testing Accommodations*, <http://admissions.calbar.ca.gov/Examinations/TestingAccommodations.aspx> (last visited Feb. 1, 2011)).

In one particular instance, a student with an adult ADHD diagnosis brought me a heartfelt letter written from her father, who believed he failed his daughter and felt tremendously guilty that she did not receive the services she needed earlier in her academic career, thus causing her struggles throughout it. The student had me read the letter, as many of my students did with their applications and additional materials submitted to the bar. It was a great letter, tough to read, but it seemed that this level of personal information was really surpassing the bar of reasonableness.

Along with the forms I discussed, the California State Bar also used to post a three-page document reviewing guidelines for applicants with learning disabilities and ADHD. Only very recently did they remove these forms, but I'm going to post some of the language from a version that was posted as recently as mid-February and has since been removed.

I want to point out that the standard that really projected our research into the childhood history requirement can be found in part two of the requirements: that applicants warranting an ADHD diagnosis must meet basic DSM-IV-required criteria, including evidence that symptoms of inattention, and/or hyperactivity-impulsivity were present during childhood.<sup>8</sup>

I want to also draw your attention to guidelines consideration number two, and I'm going to read it in its entirety to exemplify the standard being asked, so bear with me:

AD/HD evaluation is primarily based on in-depth history consistent with a chronic and pervasive history or AD/HD symptoms beginning during childhood and persisting to the present day. The evaluation should provide a broad, comprehensive understanding of the applicant's relevant background including family, academic, social, vocational, medical, and psychiatric history. There should be a focus on how AD/HD symptoms have been manifested across various settings over time, how the applicant has coped with the problems, and what success the applicant has had in coping efforts. There should be a clear attempt to rule out a variety of other potential explanations for the applicant's self-reported AD/HD difficulties.<sup>9</sup>

Neha will further delve into the process of diagnosing and evaluating someone for ADHD, but I want to make a few points here. Unless well versed in state bar processes, evaluators will not usually be aware of these standards in advance of their evaluation, thus making the standard impossible to meet.

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8. See The State Bar of California, *Guidelines for Evaluating Petitions for Testing Accommodations Based on Attention Deficit/Hyperactivity Disorder*, [http://admissions.calbar.ca.gov/LinkClick.aspx?fileticket=0cNK\\_373Kuc%3D&tabid=267](http://admissions.calbar.ca.gov/LinkClick.aspx?fileticket=0cNK_373Kuc%3D&tabid=267) (last visited June 24, 2011).

9. *Id.* at 2.

And although cognitive evaluations like the type that diagnose ADHD typically include a background history portion, they primarily are more focused on how to adjust the subject's future learning potential and not looking at the history of the person as a main component of their objectives.

Furthermore, someone who has a later diagnosis may not recognize their coping strategies at the time of their diagnosis. In fact, what happened in reality with some of our students who received a late diagnosis is they did not realize why they were having struggles, only to later get diagnosed.

In sum, these guidelines make it clear that students have a high hill to climb in order to qualify for accommodations because they are required to heavily document their childhood. In requiring such unreasonable documentation, bar associations are also asking students to compromise areas of their privacy that may have not been required to receive previous academic support. In one instance, I had a student who had actually been diagnosed with ADHD as a child and had a clear history of that diagnosis, but he had not updated his testing in a while. So he went to a tester who was familiar with bar exam requirements, and as a result, she issued a pretty thorough biography and history of the student into his report.

The student had asked the evaluator to submit to me—his disability services provider—an edited version. Why? Because the full report gave a history on his adoption, something that nobody beyond his family knew about. Fortunately, we reached a point where he could confide in me about this part of his life, but I understood his hesitation to reveal something so personal and not necessarily related to his receiving academic accommodations.

Now, as I mentioned, these guidelines were posted until just recently, so Neha and I are hoping that removing them from this California State Bar website means we're moving in the direction of changing the childhood requirement, and the unreasonable nature of this standard. Unfortunately, this is something we have yet to see evidence of and furthermore, it is not just a California issue, but it affects state bars across the country.

Returning to the accommodations process: in most if not all states, once a student has completed an application for accommodations they then submit it for evaluation by the state bar admissions committee and a group of evaluators. Students await a determination, which in California can be up to four months. If denied, they may petition depending on how close to the bar exam they are. Typically, I've seen petitions that allow ten days, one day, or are not permitted given the timing. Denials from California State Bar Admissions include reasoning and quotes from consultants used in the evaluation process.

This slide shows one example of the response we received in the report

denying accommodations. Essentially, it is saying that without the childhood history requirement, or without meeting the childhood history documentation, the diagnosis is inappropriate.<sup>10</sup>

I have had many students receive denials, and one in particular was given ten days from the time the denial letter was sent to gather childhood history to prove his adult ADHD diagnosis. So he actually planned a trip to his junior high school hoping to find the teacher who had mentioned something about his undiagnosed behavior as a child. He was well over 30 at this point, and she of course was no longer working there, and so he was empty-handed in that regard. Beyond an appeal letter from me and his cognitive testing, he was on his own to prove the existence of his condition to the bar.

The evaluators from the bar have indicated and acknowledge that there is an issue with the lack of childhood history documentation, but unfortunately, they do not give us a path for what people should do.<sup>11</sup>

Now that we have established how these standards play out, I want to be sure and touch upon how pervasive this issue is. These are some examples of states that have childhood history requirements for receiving bar accommodations, and these are just a few that we picked out: Arizona, Florida, Louisiana, Massachusetts, and Michigan.<sup>12</sup> Our fantastic research assistant, Kerry Lafferty, actually sought this information from all fifty state bars, and I'm pulling just a few here as I mentioned.

**AUDIENCE MEMBER:** Can we get this?

**ESMÉ GRANT:** You can actually contact us and I'll give you information at the end.

Michigan and Massachusetts, with highlighted language, give specific examples of what records are sought to “prove” the childhood prevalence, including kindergarten through high school report cards, teacher comments, disciplinary records, job assessments, and so forth. So ultimately, state bars are sending a message to bar applicants with ADHD that they need to have very thorough histories to prove their disability if they hope to get

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10. Slide (on file with author) (quoting a consultant in letter denying bar accommodations for ADHD diagnosis, “The diagnosis of ADHD hinges on evidence of clinically significant impairment that has a childhood onset . . . . Without compelling evidence of early-appearing and chronic impairment across settings, the diagnosis is regarded as inappropriate”).

11. See John D. Ranseen, *Lawyers with ADHD: The Special Test Accommodation Controversy*, 29 PROF. PSYCHOL. RES. & PRAC. 450, 455 (1998).

12. Slide: *Chart of State Bar ADHD Childhood History Requirements by State* (on file with author) (showing requirements from Arizona, Florida, Louisiana, Massachusetts, and Michigan).



accommodations for the bar.

These standards unfortunately are so unreasonable, particularly for those whose families do not save report cards from elementary school, teacher comments from middle school, or disciplinary records from high school. My point being, these standards are discouraging some of the most important future members of the legal profession, even with testing, all because they do not have these documents that they could not have known were going to play such an important role in their future.

Now that we have a vision of what applicants are facing in terms of applying for accommodations to enter this profession, I want to shift the discussion to disability accommodations and how they work in context with the Americans with Disabilities Act of 1990 and how they are now changed with the Amendments Act of 2008. I'm going to first jump right into the purpose of the Americans with Disabilities Act, which I think was put quite well in this quote from the *Price* case stating that the "ADA is not designed to allow individuals to advance to professional positions through a back door. Rather, it is aimed at rebuilding the threshold of a profession's front door so that capable people with unrelated disabilities are not barred by that threshold alone from entering the front door."<sup>13</sup>

It can go without being said that the Americans with Disabilities Act of 1990 was a huge movement in the direction of federal civil rights legislation to protect people with disabilities and ensure their equal access to engaging in American society. Unfortunately, the implementation of this legislation has not been easy and litigation has delivered itself as the enforcement mechanism to achieve full integration of people with disabilities.

The ADA requires that one prove their establishment into the protected class. So in order to qualify as a person with a disability a person must have a physical or mental impairment that substantially limits a major life activity.<sup>14</sup> A lot of us here know this definition well.

Students with ADHD have faced pervasive issues, however, with being qualified into this class. What began to happen in many cases where students have been denied accommodation was that courts were struggling with definitions of major life activities or substantial limitations. Courts have tended to borrow interpretive regulations from Title I of the employment provisions of the ADA. Interestingly though, a figure from 2004 shows that plaintiffs lost ninety-seven percent of the ADA employment discrimination claims that actually made it to trial, often due

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13. *Price v. Nat'l Bd. of Med. Exam'rs*, 966 F. Supp 419, 421-22 (S.D.W. Va. 1997).

14. Americans with Disabilities Act, 42 U.S.C. § 12102 (2006).

to the definition of disability.<sup>15</sup> As we'll see, the ADA Amendments Act broadens the definition of disability and opens this front door for students with ADHD.

Neha will expand on how ADHD significantly limits people, but what I really want to draw on here in discussing definition is that most students with an ADHD diagnosis should be able to meet this definition of disability under ADA coverage without having to prove a childhood history.

Once someone is verified as a person with a disability, then the question becomes what does the law require of a licensing agency such as the state bar in order to provide equal access to exams for people with disabilities? Well, there are specific laws under the ADA that protect this access, and what I think is of particular mention is that the ADA is the first federal civil rights statute to unequivocally apply to state occupational licensing tests. So whether this indicates past wrongdoing or not, it suggests that policymakers understood the need to regulate licensing exams in order to ensure equal access.

As for the laws themselves, there is still somewhat of a debate of what title of the ADA to apply. There has been some indication by courts that have leaned towards the Title II interpretation, which applies to public entities, while DOJ might lean towards Title III approach because they consider state bars as private entities. Both do, however, indicate discrimination is not permitted in the administration of bar exams.<sup>16</sup>

For purposes of this presentation, I am going to skip defenses to the ADA and Amendments Act and leave this discussion for the article that Neha and I are working on. But, just to touch on this discussion, the ultimate concern and what we hope is not happening is that students with ADHD are being denied accommodations based on lack of childhood history documentation to avoid providing extra time for these students who are viewed as a fundamental alteration to the administration of bar exams.

Moving on to the new era, the ADAAA. As I previously mentioned, there was tremendous confusion in the courts about even the most basic application of the ADA, including the definition of disability. As policymakers and disability advocates followed the implementation of this legislation, many were not satisfied with how it was playing out in the legal system. As a result, the Amendments Act was signed by President George W. Bush in 2008—eighteen years after his father signed the original act.

The ADAAA did a few things to guarantee better implementation of the original civil rights act, particularly for students and applicants with

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15. See Sandra B. Reiss & J. Trent Scofield, *The New and Expanded Americans with Disabilities Act*, 78 ALA. LAW. 38, 39 (2009).

16. Slide (on file with author) (excerpting language from 42 U.S.C. §§ 12132, 12189 (2006)).

ADHD. For one, it broadened the protected class, or rather clarified the definition to explain the broad range of the protected class. So for instance, it added reading, concentrating, communicating, and thinking to the list of major life activities.<sup>17</sup> This is of particular importance for applicants with ADHD who struggle in all of these areas.

Bar evaluators have also argued that ADHD must impact multiple major life activities when the ADAAA made it clear that an impairment that substantially limits one major life activity need not limit other major life activities to qualify as a disability.<sup>18</sup>

Also, as many of you know, the ADAAA removed the mitigating measures requirement whereby someone receiving medication for ADHD does not get pulled out of the definition of disabled.<sup>19</sup>

What I specifically want to touch upon is that the new interpretation of the definition of disability has lowered the threshold for individuals with respect to the amount of proof or evidence they must offer to establish they have a disability. This very point was made by a disability advocate and consultant, Salome Heyward, who noted in her blog that the previous restrictive interpretation of the definition has been replaced by more inclusive presumption of coverage that shifts the focus of responsibility of institutions to provide meaningful access.<sup>20</sup>

Looking at the upcoming changes in regulations for licensing exams under Title III—effective next week, March 15—we can see there is more attention being paid to make sure these requests are limited and reasonable.<sup>21</sup> Courts have now held that the larger effect of the ADAAA on boards of bar examiners is that the focus will shift to the consideration of whether an applicant has a disability within the meaning of the Amendments Act to whether an applicant with a qualifying disability is entitled to accommodations, and if so, which ones are reasonable.

Other cases have noted as early as 2009 that although implementation is at its beginnings, courts are already seeing a more broad understanding of disability in higher education.<sup>22</sup> In 2009, we started to really see the

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17. § 12102 (2)(A).

18. § 12102 (4)(C).

19. § 12102 (4)(E)(i)(I).

20. Salome Heyward, BLOG (July 2010), [http://www.salomeheyward.info/index.php?view=article&id=34&tmpl=component&print=1&task=printblog&option=com\\_myblog&Itemid=3](http://www.salomeheyward.info/index.php?view=article&id=34&tmpl=component&print=1&task=printblog&option=com_myblog&Itemid=3) (last visited Feb. 1, 2010).

21. See 28 C.F.R. 36.309(b)(1)(iv) (2010) (“Any request for documentation, if such documentation is required, is reasonable and limited to the need for the modification, accommodation, or auxiliary aid or service requested.”).

22. See generally *Jenkins v. Nat’l Bd. Med. Exam’rs*, 2009 WL 331638 (6th Cir. Feb. 11, 2009).

ADAAA take effect. And courts have held in both academic cases and elsewhere that while individuals must still present something more than a diagnosis, the failure to present an exhaustive listing of the manifestations of a condition will no longer defeat a disability claim.<sup>23</sup>

In sum, we are seeing what we hope to be a big change with the ADAAA in terms of disability rights. As far as it relates to our project, we see the changes in the law, or as I said before, the clarification of the law with the Amendments Act showing that the ADA's intention was to apply to a broad class, that people with ADHD should qualify for protection, and should not be held to unreasonable documentation standards such as proving childhood manifestation of a condition to receive reasonable accommodations.

With that, I'll turn things over to Neha, who will continue our presentation with a description of ADHD, describe discrepancies in diagnosis, and then we will both touch upon recommendations for how to break down the barriers students with ADHD face in applying for bar accommodations.

**NEHA SAMPAT:** So, where do the state bars get this childhood history requirement from? Well, they actually got it from the *Diagnostic and Statistical Manual of Mental Disorders*—the clinical definition of ADHD. But many clinicians acknowledge that this definition is in flux and the state bars need to gain a better understanding of ADHD, the development of the diagnostic criteria, and the ways that clinicians address the limitations of the diagnostic framework.

I'm going to start by giving you a very brief understanding of the development of ADHD as a recognized cognitive disorder before launching into the controversy surrounding adult ADHD and its diagnosis, focusing in on the childhood history requirement. Then I'm going to move into a discussion of the discrepancies in diagnosis; in other words, how certain populations, mostly minority or nontraditional students in our schools, have an unjustly harder time meeting this childhood history requirement.

Let's start with ADHD, and I know most of us in this room have some basic understanding of what it is. In a nutshell, it is a brain pathway disorder that can impair a person's ability to stay focused and may cause restlessness. For adults, it can impair reading comprehension, speed, and focus, as well as mathematical problem-solving. But it does not impair logical problem-solving,<sup>24</sup> which, as we all know, is at the crux of the

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23. See *Brodsky v. New England Sch. of Law*, 617 F. Supp. 2d 1 (D. Mass. 2009); see also *Rohr v. Salt River Project Agric. Improvement and Power Dist.*, 555 F.3d 850 (9th Cir. 2009).

24. Lenard A. Adler, *Managing ADHD in an Adult with Psychiatric Comorbidity*,

practice of law.

ADHD-like behaviors in children were clinically labeled starting in the 1950s, with medication treatment starting in the 1960s.<sup>25</sup> In the 1970s, ADHD symptoms in adults started to gain some very limited recognition,<sup>26</sup> but diagnosis still required childhood symptoms.<sup>27</sup> In 1980, the DSM-III was published, naming the disorder “attention deficit disorder,” or “ADD,” and providing a vague description of adult symptoms.<sup>28</sup> With the advent of the DSM-III-R in 1987, the name changed to what it is now, “attention deficit hyperactivity disorder.” This is when a formal classification was added for adult ADHD, stating that one-third of children experienced symptoms into adulthood, but it still required the childhood onset of symptoms.<sup>29</sup>

In 1994, the DSM-IV was published, stating definitively that ADHD persists into adulthood.<sup>30</sup> That said, the criteria were never validated in adults and contained some serious limitations for adult diagnosis that persist today.<sup>31</sup> In 2000, the currently used DSM-IV-TR, or text revision, was published, which does not make significant changes to the DSM-IV definition of ADHD. Please note that the DSM-IV-TR is the current version, even though it’s already eleven years outdated, and we expect the DSM-V to be published in May 2013.

So as you can see, the understanding of ADHD has been, and continues to, develop and evolve, and with it the rates of diagnosis have changed, which we’ll discuss in a bit.

The main framework for diagnosis of ADHD is still the DSM. However, it’s important that we distinguish the psychology world’s view of the DSM diagnostic criteria from how we in the legal world, view legal rules with elements that must all be met strictly. Psychologists look to the DSM to understand a disorder, but their view is that these criteria cannot always strictly be met due to the constant advances in medical research and the

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MEDSCAPE EDUC. (July 30, 2008), <http://www.medscape.org/viewarticle/578010>.

25. Gretchen B. LeFever & Andrea P. Arcona, *ADHD Among American Schoolchildren Evidence of Overdiagnosis and Overuse of Medication*, 2 SCI. REV. MENTAL HEALTH PRAC. 1, 1 (2003).

26. Lenard A. Adler & Julie Cohen, *ADHD: Recent Advances in Diagnosis and Treatment*, MEDSCAPE EDUC. (Oct. 16, 2002), <http://www.medscape.org/viewarticle/443113>.

27. See LeFever & Arcona, *supra* note 25, at 5.

28. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III (American Psychiatric Association ed., 3d. ed. 1980) (1952).

29. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III-R (American Psychiatric Association ed., rev. 3d ed. 1987).

30. See Adler & Cohen, *supra* note 26.

31. James McGough & Russell Barkley, *Diagnostic Controversies in Adult Attention Deficit Hyperactivity Disorder*, 161 AM. J. PSYCHIATRY 1948, 1948 (2004).

inability of the DSM to keep up with that medical research.

As we just discussed, one area under more recent development is adult ADHD, and we all are seeing students come in with adult ADHD diagnoses. Studies have indicated that four to five percent of adults in this country have ADHD, but only fifteen to twenty percent of them know they have it.<sup>32</sup> One obvious reason why adults are under-diagnosed is that it was only recently confirmed that ADHD persists into adulthood for the majority of children who have it.<sup>33</sup> However, without a diagnosis from childhood a person often remains undiagnosed in adulthood.<sup>34</sup>

Well, how has an adult made it this far without being diagnosed or receiving accommodations? This is a question that bar examiners often ask when they're skeptical about applicants who received a more recent ADHD diagnosis, often during law school. There are a number of reasons why an adult may not have recognized the symptoms or sought treatment.<sup>35</sup> Many undiagnosed adults made it all the way through college by relying on their coping mechanisms, such as working harder or longer, their social support network, organization, and time management.<sup>36</sup> Maybe most of their classes were graded by take-home papers instead of timed exams. Changes in an adult's life, including added responsibilities or more pressure, such as our students entering law school, may make the symptoms worsen or may render previously effective coping mechanisms useless.<sup>37</sup>

Sometimes even when an adult sees a specialist about their symptoms, the specialist fails to identify the symptoms of ADHD or misattributes the symptoms to another disorder. Studies show that primary care doctors may lack the appropriate training and experience to recognize adult ADHD and that almost half of all primary care doctors do not feel comfortable diagnosing adults with ADHD, sometimes because they still inappropriately view it as a childhood disorder.<sup>38</sup> The flawed tools for diagnosing adults with ADHD is another reason why clinicians are not diagnosing adults who should be diagnosed with it.

Let's take a look at the DSM-IV-TR's diagnostic framework.<sup>39</sup>

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32. See Rita Rubin, *ADHD Focuses on Adults*, USA TODAY, Dec. 3, 2003, at D1.

33. S.L. Able et al., *Functional and Psychosocial Impairment in Adults with Undiagnosed ADHD*, 37 PSYCHOL. MED. 97, 97 (2007).

34. *Id.* at 98.

35. *Id.* at 97-98.

36. Patricia Kaminski et al., *Predictors of Academic Success Among College Students with Attention Disorders*, 9 J. C. COUNSELING 60, 61 (2006); see also Lenard A. Adler, *Clinical Presentations of Adult Patients with ADHD*, 65 J. CLINICAL PSYCHIATRY 8, 8 (2004).

37. See Adler, *supra* note 24.

38. Able et al., *supra* note 33.

39. Slide: *DSM-IV-TR Criteria for ADHD Listed* (on file with author).

Although many argue that this is the most widely-used criteria for adults,<sup>40</sup> it actually has never been validated in adults. In fact, DSM field trials included only school-aged children,<sup>41</sup> so it is not surprising that it is inappropriate for adult diagnosis on a number of fronts.

For example, the diagnostic symptoms themselves are not age-appropriate for adults.<sup>42</sup> Adult ADHD is commonly indicated by distractibility, impulsive decision-making and poor executive functioning, but not hyperactivity.<sup>43</sup> The DSM symptoms “runs and climbs excessively” and “has difficulty playing quietly” are obviously not appropriate for adults.<sup>44</sup>

Now let’s hone in on the childhood history criterion, which requires that “[s]ome hyperactive-impulsive or inattentive symptoms that cause impairment were present before age seven years.”<sup>45</sup> The specific age-of-onset was introduced in the DSM-III, and even then it wasn’t based on reliable scientific evidence. Field trials for DSM-IV showed that a significant percentage of kids believed to have ADHD, particularly those with the inattentive type, were not able to meet this age of onset requirement.<sup>46</sup> In fact, ADHD symptoms often do not create impairment until several symptoms have emerged, and that often doesn’t take place until a child faces a particularly demanding academic or social situation.<sup>47</sup> In some less-resourced schools, the demands triggering evidence of symptoms may not appear until higher grade levels due to a less demanding curriculum.

Even if an adult had childhood symptoms and impairment by age seven, they may not realize it or be able to prove it sufficiently to get bar accommodations. First, most adults find it difficult to recall much from age seven. Add to that the evidence that indicates that people who have ADHD are less self-aware of behaviors that have been present since

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40. John Ranseen, *Lawyers with ADHD: The Special Test Accommodation Controversy*, 29 PROF. PSYCHOL. RES. & PRAC. 450, 452-54 (1998).

41. McGough & Barkley, *supra* note 31, at 1948-56; James McCracken & James McGough, *Adult Attention Deficit Hyperactivity Disorder: Moving Beyond DSM-IV*, 10 AM. J. PSYCHIATRY 1673, 1673-75 (2006); *see also* Russell A. Barkley & Kevin Murphy, *Identifying New Symptoms for Diagnosing ADHD in Adulthood*, 14 ADHD REPORT 7 (2006), available at <http://www.naceonline.com/article-identifying-new.php>.

42. McCracken & McGough, *supra* note 41.

43. Barkley & Murphy, *supra* note 41.

44. McGough & Barkley, *supra* note 31, at 1950.

45. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR (American Psychiatric Association ed., 4th ed. 2009) (1952).

46. McGough & Barkley, *supra* note 31, at 1951.

47. Andrew S. Rowland et al., *The Epidemiology of Attention-Deficit/Hyperactivity Disorder (ADHD): A Public Health View*, 8 MENTAL RETARDATION DEVELOPMENTAL DISABILITIES RES. REVS. 162, 163 (2002).

childhood.<sup>48</sup>

Even if adults are able to recall their own childhood symptoms accurately, many aren't able to provide the corroborating evidence of the disorder, either via retrospective parental reports or childhood academic records such as report cards, and as Esmé mentioned, this corroborating evidence is often what bar examiners are looking for in order to provide bar accommodations. How many of you have reasonable access to your elementary school report cards? I certainly don't know where mine are. Even if I were to find them, I'm not sure they would include many comments that would be helpful for providing this childhood history documentation.

The DSM language itself acknowledges that supporting documentation may not always be available, but that corroborating information from other informants, including prior school records, is helpful for improving the accuracy of the diagnosis.<sup>49</sup> In fact, the DSM actually provides an out; it actually has a catch-all category for ADHD diagnosis called ADHD Not Otherwise Specified ("ADHD-NOS") and that's for instances where someone obviously has ADHD impairment, but does not meet the symptom threshold. Some view the NOS category as intended in part to address the limitations of the current DSM diagnostic criteria for adults with ADHD. So ADHD-NOS has been used in certain instances where an adult may not have, for instance, all the childhood symptoms required under the DSM's traditional ADHD definition.

Although childhood history may be helpful for improving diagnosis accuracy, many adults, particularly older people, minorities, people from poor families and females, are unlikely to have the requisite childhood history, which brings us to our discussion of the discrepancies in diagnosis.

Treatment rates for ADHD are highest for affluent, male, nonminority children, under age ten.<sup>50</sup> One study compared ADHD identification and treatment in three-eighteen-year-olds in the years 1987 to ten years later in 1997.<sup>51</sup> During this ten-year period they found a significant increase in treatment rates for ADHD across almost all groups, with the largest increases among those who had historically low treatment rates; in other words, those from lower income families, children aged twelve to eighteen,

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48. Marla Zucker et al., *Concordance of Self and Informant Ratings of Adults' Current and Childhood Attention-Deficit/Hyperactivity Disorder Symptoms*, 14 PSYCHOL. ASSESSMENT 379, 379-80 (2002).

49. AM. PSYCHIATRIC ASS'N, *supra* note 45, at 89.

50. LeFever & Arcona, *supra* note 24, at 8; Craig Lerner, *Accommodations for the Learning Disabled: A Level Playing Field or Affirmative Action for Elites?*, 57 VAND. L. REV. 1041, 1107 (2004).

51. Mark Olfson et al., *National Trends in the Treatment of Attention Deficit Hyperactivity Disorder*, 160 AM. J. PSYCHIATRY 1071, 1071 (2003).



and children from racial and ethnic minorities.<sup>52</sup>

Seeing the large difference in ADHD treatment between 1987 and 1997 it becomes apparent that the age of a person has a direct impact on whether they're likely to have or be able to get a by-the-book diagnosis of ADHD. This slide indicates the number of children diagnosed with ADHD has risen substantially since the 1970s, when it was around one percent.<sup>53</sup> What the slide doesn't indicate is that the current prevalence in school-aged kids is approaching ten percent.<sup>54</sup> As long as the age-of-onset criterion exists, older students are going to be less likely to receive a diagnosis and thus receive ADHD accommodations on the bar exam, because they were age seven or under at a time when awareness and understanding of ADHD was very low and, thus, the disorder was under-diagnosed.<sup>55</sup> And let's be clear that when we say "older people," we're actually including relatively young people. I mean people born before the early 1980s. Additionally, the older the person is, the less likely they are to themselves remember childhood symptoms or be able to track down a primary school or junior high school teacher, as Esmé mentioned in the example she mentioned earlier, and the less likely their parents are to be around or to be able to even find their school report cards.

For Golden Gate University School of Law's 2008 full-time matriculated class, so those likely to be applying for ADHD accommodations on this upcoming July 2011 bar exam, the average age of matriculation was twenty-six. That means that the average aged student was age seven years or under in 1989, at a time when schools remained unequipped to properly identify students with ADHD and when minority, female, and poor students were extremely under-identified. As one study indicates, some of these under-identified populations started to become better identified, but limitations still remain.

Let's look at a breakdown of our current JD students by birth year.<sup>56</sup>

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52. *Id.*

53. Slide (on file with author) (citing U.S. Dept. of Health and Human Services, *Diagnosed Attention Deficit Hyperactivity Disorder and Learning Disability: United States, 2004-2006*, 237 VITAL AND HEALTH STAT. 1, 2-3 (July 2008)) (showing line graph of the prevalence of ADHD among American school children from the 1970s to the late 1990s).

54. See U.S. Department of Health and Human Services, *Diagnosed Attention Deficit Hyperactivity Disorder and Learning Disability: United States, 2004-2006*, 237 VITAL AND HEALTH STAT. 1, 3 (July 2008).

55. Jane D. McLeod et al., *Public Knowledge, Beliefs, and Treatment Preferences Concerning Attention-Deficit Hyperactivity Disorder*, 58 PSYCHIATRIC SERVS. 626, 630 (2007).

56. Slide (on file with author) (citing Kimberly Dustman & Phil Handwerk, *LSAC Analysis of Law School Applicants by Age Group, ABA Applicants 2005-2009*, Oct. 2010, <http://www.lsac.org/LSACResources/Data/PDFs/Analysis-Applicants-by-Age-Group.pdf> (showing percentage of ABA and Golden Gate University School of Law students by birth year).

This is looking at Golden Gate University Law's current students and all 2009-2010 ABA matriculants. As this chart indicates, for Golden Gate Law, over twenty-six percent were born in 1980 or before and over seventy-five percent were born in 1985 or before, which means that most of our current students have a large hill to climb to get their bar accommodations.<sup>57</sup>

You can also see that the vast majority of 2009-2010 matriculants in ABA schools were born in 1988 or before. The further we go back in birth year, the harder it becomes for many of these people to meet the childhood history requirement.

Thus, we're already talking about a vast number of our current students having difficulty providing childhood history evidence. Now, add to that, even greater obstacles for racial and ethnic minorities, people from poor families, and females.

Research indicates that a number of race, cultural, and ethnic minority groups are less likely to be identified in childhood as having symptoms of ADHD. Between 1987 and 1997, large numbers of children from race and ethnic minorities were brought into treatment, so their under-diagnosis was significantly more severe in the late 1980s,<sup>58</sup> which unfortunately, was when a number of our current students were children needing to be recognized as having ADHD impairment so they could get accommodations on a bar exam they didn't know they would be taking twenty years later. Even with the increase over that 10-year period, white children are still two times as likely to receive ADHD treatment as minority children, so there is still a ways to go.<sup>59</sup>

We know there are some links between race/ethnicity and socio-economic level, but even when controlled for income and other characteristics, non-white children and children of immigrants are diagnosed with ADHD at relatively lower rates than other elementary school students.<sup>60</sup>

The lack of childhood recognition of ADHD can be explained in part by intrinsic factors; in other words, the experiences and perspectives of the people in these groups. Before launching into this section, I just want to remind you that when we make observations through studies about particular groups of people, these conclusions do not define any particular individuals within that group, but rather reflect trends.

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57. See Dustman & Handwerk, *supra* note 56.

58. Olfson et al., *supra* note 51, at 1071-73.

59. *Id.* at 1073-74.

60. Helen Schneider & Daniel Eisenberg, *Who Receives a Diagnosis of Attention-Deficit/Hyperactivity Disorder in the United States Elementary School Population?*, 117 PEDIATRICS, 601, 607 (2006).

With that in mind, studies have found that minority parents themselves have a lesser likelihood of identifying ADHD in their child than white parents.<sup>61</sup> Case studies show a lack of trust and effective communication between minority patients and white medical providers, which may prevent the best ADHD care and treatment for minority patients.<sup>62</sup>

Parental and cultural recognition and comfort with clinical issues in general also negatively impact the likelihood of recognition of symptoms. Studies indicate that ethnic minority parents are less likely to recognize their child's clinical problems than white parents.<sup>63</sup> White parents have been found to be more effective at advocating for care for their child than, say, African-American parents, who are more likely to indicate lack of knowledge of appropriate treatment for their child and less likely to request medication treatment,<sup>64</sup> sometimes out of fear of over-diagnosis or misdiagnosis.<sup>65</sup>

Parental and cultural beliefs and knowledge specifically about ADHD impact the likelihood of a child being recognized as having ADHD symptoms. Non-white racial and ethnic groups are less likely to have heard of ADHD.<sup>66</sup> African-Americans familiar with ADHD are more likely to view it as a social construct and less likely to view it as having a biological cause than their white counterparts.<sup>67</sup> Studies have found that they might instead, for instance, attribute it to too much sugar in the diet.<sup>68</sup> Research has also found that African-American parents believe that their child will outgrow the symptoms of ADHD.<sup>69</sup> Their view of treatment as almost

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61. Heather Hervey-Jumper et al., *Deficits in Diagnosis, Treatment and Continuity of Care in African-American Children and Adolescents with ADHD*, 98 J. NAT'L MED. ASS'N, 233, 235 (2006).

62. Rahn K. Bailey, *Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in African-American and Hispanic Patients*, 97 SUPP. TO J. NAT'L MED. ASS'N 3S, 3S-4S (2005).

63. Mery J. Macaluso, *The Role of Culture in Parental Perceptions of Psychological Disorders in Children and Help-Seeking Behaviors* 57 (1999) (unpublished Ph.D. dissertation, Uni. of Kansas) (No. 3185188), *microformed on ProQuest Information and Learning Company* (Ann Arbor, Mich.).

64. Regina Bussing et al., *Parental Explanatory Models of ADHD: Gender and Cultural Variations*, 38 SOC. PSYCHIATRY AND PSYCHIATRIC EPIDEMIOLOGY 563, 569 (2003).

65. Rahn K. Bailey & Dion L. Owens, *Overcoming Challenges in the Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder in African-Americans*, 97 SUPP. TO J. NAT'L MED. ASS'N 5S, 6S-7S (2005).

66. McLeod et al., *supra* note 55, at 630.

67. Charmayne Maddox, *Race Matters: Disparities in African-American Children with Attention Deficit Hyperactivity Disorder*, 10 PENN ST. MCNAIR J. 145, 159 (2003), available at <http://forms.gradsch.psu.edu/diversity/mcnair/2003/maddox.pdf>.

68. Regina Bussing et al., *Knowledge and Information About ADHD: Evidence of Cultural Differences Among African-American and White Parents*, 46 SOC. SCI. MED. 919, 923 (1998); McLeod et al., *supra* note 55, at 629.

69. Bailey & Owens, *supra* note 65, at 6S.

certainly medication also prevents them from seeking a diagnosis.

One of my students, who happens to be African-American, came to meet with me after being academically disqualified. He confided in me that one of his high school teachers had repeatedly recommended that he get tested for ADHD, but he and his family did not want him to get tested. One reason was because they had a history of addiction in their family, and they were very worried that if he was diagnosed with ADHD that he would be required to take medication. He also reported that they didn't get what ADHD was and that it was culturally frowned upon to seek treatment for it. We discussed the scenario, the student met with Esmé, and Esmé provided him with more information about ADHD and he subsequently got tested. Sure enough, he did have ADHD, as was suspected, and he was reinstated to school with accommodations. He subsequently did very well in school and later reported to me what a huge difference his diagnosis made not only in his academics but in his life. In fact, after the student got diagnosed, his parent recognized ADHD symptoms within himself and eventually got diagnosed despite the stigma associated with ADHD diagnosis in their community.

The fear of social stigma with ADHD plays a significant role in under-diagnosis of ADHD in race and ethnic minorities.<sup>70</sup> Minority parents feel that their kids are already disadvantaged due to race and ethnic discrimination and fear that ADHD is just another way their child is going to be discriminated against.<sup>71</sup> Specific research on this issue has found that African-American parents are concerned that their child's future employment or military service options may be limited by ADHD diagnosis and thus don't seek treatment for their child's symptoms.<sup>72</sup> Many minority parents also feel significant pressure from their social networks to refrain from seeking treatment for symptoms, and they worry that their parenting skills may be viewed in a negative light.<sup>73</sup>

Many parts of Asian culture emphasize societal reputation, viewing disability as a taboo and treating people with disabilities as social outcasts, so many Asian parents don't want their kids tested for or labeled as having any sort of disability, including a cognitive disability. Immigrants in general feel pressure to fit in at any cost and they don't want to stand out in any way, including by being labeled as having a disability.

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70. Paul Ruffins, *Creating an Atmosphere of Acceptance*, DIVERSE ISSUES IN EDUCATION (June 12, 2008), <http://diverseeducation.com/article/11268/>.

71. Bailey & Owens, *supra* note 65, at 7S; Rashmi Goel, *Delinquent or Distracted? Attention Deficit Disorder and the Construction of the Juvenile Offender*, 27 L. & INEQUALITY 1, 33 (2009).

72. Bailey & Owens, *supra* note 65, at 7S.

73. *Id.*

Prevalence of ADHD has also been found to be significantly lower among primarily non-English-speaking children.<sup>74</sup> Some have specifically argued that the lower prevalence of childhood diagnosis of ADHD among Hispanic as compared to non-Hispanic children is due in part to the language barriers.<sup>75</sup> Specifically, language barriers for ethnic minorities and children of foreign-born parents may also cause clinician dismissal of ADHD symptom concerns or parental difficulty sufficiently explaining their kid's symptoms to medical providers or schools.<sup>76</sup>

There are also a number of ways that race and ethnic minorities' engagement with schools may impact recognition of ADHD symptoms. For instance, one study indicated a disconnect between African-American parents and the schools, which could help explain why African-American students appear to have more limited access to support services specifically regarding ADHD.<sup>77</sup> This same study found that African-American parents are less likely to request school interventions.<sup>78</sup> Immigrant parents do not have as much personal knowledge of how the American school system works, so they may not realize the special education and other resources available through the schools to help with their child's difficulties.

Even when minority parents seek school and medical support for their child's impairment, discrimination, and inequality . . . in other words, extrinsic factors among medical providers in schools, whether conscious or unconscious, may prevent recognition of ADHD symptoms. With regard to medical providers, such discrimination can be in the minority's actual access to healthcare or in the medical treatment that they eventually receive.

Minority children have been found to be less likely to have a regular source of healthcare,<sup>79</sup> such as a primary care physician, and primary care physicians are often the first people to diagnose or recognize ADHD symptoms in kids. One large factor in access to healthcare is, obviously, insurance, and African-American and Hispanic children are less likely to have insurance than white children.<sup>80</sup> Given that healthcare insurance is so

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74. S. Marshall Williams et al., *The Role of Public Health in Mental Health Promotion*, 54 MORBIDITY & MORTALITY WKLY. REP. 842, 844 (2005).

75. Cynthia E. Perry et al., *Latino Parents' Accounts of Attention Deficit Hyperactivity Disorder*, 16 J. TRANSCULTURAL NURSING 312, 319-20 (2005).

76. Bailey, *supra* note 62, at 3S-4S (2005); Schneider & Eisenberg, *supra* note 60, at 608.

77. Regina Bussing et al., *Parental Explanatory Models of ADHD: Gender and Cultural Variations*, 38 SOC. PSYCHIATRY AND PSYCHIATRIC EPIDEMIOLOGY 563, 571-72 (2003).

78. *Id.* at 571.

79. Maddox, *supra* note 67, at 152.

80. *Id.* at 151-52.

closely tied to socioeconomic factors, I'm going to defer that discussion to when we get to socio-economic disparities in diagnosis.

Racial discrepancies in access to basic healthcare<sup>81</sup> may be tied to discrimination issues among healthcare providers.<sup>82</sup> Medical providers may dismiss concerns regarding ADHD symptoms due to the language barriers we just discussed and medical provider bias.<sup>83</sup> Clinicians having different expectations for different ethnicities may play a role, as some researchers have found that clinicians may view African American children's behavior as more related to environment and white children's behavior as more related to a biological cause, which may lead to more disruptive disorder diagnosis for African American children and more ADHD diagnosis among white children, when they all display the same symptoms.<sup>84</sup>

Discrimination and unequal access in school resources is another reason race and ethnic minority children are under-diagnosed. According to the U.S. Department of Education in 2005, African American and Latino students underuse school-based services.<sup>85</sup> Teacher bias, whether unconscious or conscious, plays a very large role in if and how a student is identified as having symptoms of a disability, as they serve as the primary referral point to special education, and their opinions are viewed by the assessment teams as very relevant. In fact, assessors usually confirm the teacher's recommendation, even in the face of contrary evidence.<sup>86</sup>

I'll now move from race and ethnicity to describe how a person's socioeconomic background has an impact on whether their ADHD symptoms are identified. Studies have found that students requesting and receiving a cognitive disability diagnosis are disproportionately from affluent communities.<sup>87</sup> In 1987, kids from medium or high income families were more than twice as likely to receive ADHD treatment than those from low income families.<sup>88</sup> Although this disparity narrowed by 1997,<sup>89</sup> it was too late for our current students, who were likely age seven or under when the disparity was fairly large.

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81. *Id.* at 152.

82. *Id.* at 151.

83. Bailey, *supra* note 62, at 3S.

84. David S. Mandell et al., *Ethnic Disparities in Special Education Labeling Among Children With Attention-Deficit/Hyperactivity Disorder*, 16 J. EMOTIONAL & BEHAV. DISORDERS 42, 49 (2008).

85. Laurel Leslie et al., *School-Based Service Use by Youth with ADHD in Public-Sector Settings*, 16 J. EMOTIONAL BEHAVIORAL DISORDERS 163, 165 (2008).

86. Mandell, *supra* note 84, at 43.

87. Lerner, *supra* note 50, 1106-07.

88. Olfson, *supra* note 51, at 1073.

89. *Id.*

Obviously there are socioeconomic disparities in access to basic healthcare.<sup>90</sup> As with children from minority backgrounds, children from poor families are less likely to have “the usual sources of care,” which translates into barriers to their access to primary care,<sup>91</sup> which is where ADHD is often identified. Many people just cannot afford healthcare, unfortunately, and many families do not have any type of insurance.<sup>92</sup>

Children with health insurance, as you might be able to predict, have a higher prevalence of ADHD diagnosis and are more likely to be diagnosed than those without insurance.<sup>93</sup> Even though the disparity between low income and high income diagnosis is narrowed, Olfson and his colleagues found that the rate of treatment for uninsured children remained less than half of the rate of treatment for those with insurance.<sup>94</sup> Even in the law school stage, a number of our students lacked the resources to get recent testing as is required by the bar examiners.

The education level of parents is also a factor in whether a child is identified with ADHD symptoms. People with higher education are more likely to have heard of ADHD<sup>95</sup> and seek assistance for ADHD symptoms in their children than parents with lower levels of education.<sup>96</sup> In addition, the social stigma associated with the diagnosis and treatment of a mental health issue is likely more prevalent in populations with less education and lower socioeconomic status.<sup>97</sup>

When schools are under-resourced, they may not be able to identify ADHD symptoms in students as effectively as schools that are properly resourced. While it’s true that education accountability laws have meant greater likelihood of diagnosis, due to the increased pressure for student performance,<sup>98</sup> these pressures are relatively recent, earlier in this decade. So the underprivileged, underperforming schools that many of our current students attended were not subject to such pressures. In fact, a 1999 study indicated that the existence of ADHD had been recognized only relatively recently and that many K-12 schools still did not have comprehensive and

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90. Slide (on file with author) (quoting Jo Anne Simon, American University Washington College of Law, *Assisting Law Students with Disabilities in the 21st Century: Brass Tacks*, Mar. 8, 2007) (“Now it is very clear under the law that it is your obligation to produce documentation that is necessary. On the other hand, there is a very distinct problem with it not being very equal in terms of economic justice.”).

91. Maddox, *supra* note 84, at 152.

92. *Id.* at 152; Heather Hervey-Jumper et al., *Identifying, Evaluating, Diagnosing, and Treating ADHD in Minority Youth*, 5 J. ATTENTION DISORDERS 1, 4 (2008).

93. U.S. Department of Health and Human Services, *supra* note 54, at 4-6.

94. Olfson, *supra* note 51, at 1073.

95. McLeod, *supra* note 55, at 628-29.

96. Macaluso, *supra* note 63, at 61-62; Hervey-Jumper et al., *supra* note 92, at 2.

97. Able et al., *supra* note 33, at 105.

98. Schneider & Eisenberg, *supra* note 60, at 602.

effective screening programs, often leaving students unidentified as having ADHD until college or law school.<sup>99</sup>

Let's move on to sex and gender disparities in diagnosis. Female children are less likely to be diagnosed with ADHD than male children.<sup>100</sup> In fact, the prevalence of ADHD is reported to be anywhere between two-four times higher in males than in females. This disparity unfortunately has not changed much over the years, as the Olfson and colleagues study found that in both 1987 and 1997 boys were about three times as likely to receive ADHD treatment as girls.<sup>101</sup> Some suggest there is some biological basis for this,<sup>102</sup> but many attribute the discrepancy and diagnosis at least in part, to how the behaviors of girls versus boys are viewed and understood.

The view that ADHD is a male disorder is still commonly held,<sup>103</sup> which results in referral and sampling bias.<sup>104</sup> Teachers, again, often the first to identify a student as possibly having ADHD, tend to suspect ADHD more in boys than in girls.<sup>105</sup> Boys' behavior is more likely to be viewed as hyperactive,<sup>106</sup> which leads to greater referral for ADHD testing.<sup>107</sup>

In girls, ADHD is exhibited less by disruptive behavior and more by sitting quietly and daydreaming,<sup>108</sup> so they fly under the radar, so to speak. Girls are twice as likely as boys to have the predominantly inattentive type of ADHD,<sup>109</sup> and as I mentioned earlier, this type is much more difficult to identify at the age of seven or before, and that may explain why many girls have a harder time meeting the age of onset requirement. If their symptoms happen to be identified early on, they're unfortunately often mistakenly viewed as symptoms of depression or another psychiatric disorder.<sup>110</sup>

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99. Kevin Smith, *Disabilities, Law Schools, and Law Students: A Proactive and Holistic Approach*, 32 AKRON L. REV. 1, 19-20 (1999).

100. Schneider & Eisenberg, *supra* note 60, at 602.

101. Olfson, et al., *supra* note 51, at 1073.

102. Drew Barzman et al., *Attention-Deficit Hyperactivity Disorder Diagnosis and Treatment: Separating Myth from Substance*, 25 J. LEGAL MED. 23, 27 (2004).

103. Eunice Sigler, *ADD Women: Why Girls and Moms Go Undiagnosed*, ADDITUEMAG.COM, (Mar. 26, 2009), <http://www.additudemag.com/adhd/article/740.html>.

104. Barzman et al., *supra* note 102, at 27.

105. Sigler, *supra* note 103.

106. Mandell et al., *supra* note 84, at 48; U.S. Department of Health and Human Services, *supra* note 54, at 7.

107. Rowland et al., *supra* note 47, at 165.

108. Patricia O. Quinn, *Treating Adolescent Girls and Women with ADHD: Gender-Specific Issues*, 61 J. CLINICAL PSYCHOL. 579, 583 (2005).

109. Joseph Biederman et al., *Influence of Gender on Attention Deficit Hyperactivity Disorder in Children Referred to a Psychiatric Clinic*, 159 AM. J. PSYCHIATRY 36, 37-38 (2002).

110. Sigler, *supra* note 103.



Because many girls go unidentified in childhood, women often go undiagnosed for not being able to meet the childhood history requirement.<sup>111</sup> They often realize they have ADHD only after major adult life stresses, such as balancing family and career or, for instance, starting law school. However, by then it's too late to be able to provide the childhood history the bar seeks, so women as a group are disadvantaged in receiving ADHD accommodations on many bar exams.

So, we can see that a number of factors have contributed to the discrepancies in childhood recognition of symptoms. We'd like to acknowledge that some of these factors and opportunities for remedy are beyond the scope of what the people in this room and in the legal community can address, such as ways to improve childhood identification in minority populations with ADHD. So instead we are going to focus on the steps our colleagues at the state bars and we, legal educators, can take to improve the fairness and ADHD accommodations on the bar exam and thereby clear one path to diversity in the profession.

**ESMÉ GRANT:** What the state bars can do in embracing diversity, which a lot of state bars have recently done and made a priority, is view disability and accommodations in the context of diversity. This is not only in terms of diversifying the legal profession for lawyers with disabilities, but also realizing how these documentation requirements affect students with disabilities that are minorities and may have had different circumstances when growing up and thus difficulty meeting these childhood documentation requirements.

Furthermore, we encourage state bars to work in conjunction with law students and law schools in a positive way and provide a service and not a barrier. As Bill Phelan mentioned earlier on his panel, the number of students receiving accommodations in law schools is very low and, so our fear is not over-accommodating, it's about not providing equal access.

And then finally, state bars can ensure compliance with governing laws. Next week we are seeing changes in regulations that will hopefully explain further, what is expected in terms of documentation requirements. We encourage state bars to not wait for March 15th, but to really start to look at these laws ahead of time and not wait for the enforcement mechanisms or regulations.

**NEHA SAMPAT:** With regard to ADHD accommodation, it's important for the state bars and for us to not get tied to the diagnostic criteria that are already outdated and are soon going to be replaced by the

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111. *Id.*

DSM-V criteria for ADHD diagnosis.

We obviously don't have time to go into the DSM-V proposals in detail, but we've provided some copies of what is being proposed for the DSM-V criteria for ADHD. We are heartened to see some important changes, including more age-appropriate symptoms for adults and a lower symptom threshold for adolescents and adults. The current DSM-IV requires six symptoms, the DSM-V proposal would require four symptoms, and a shift in the age of onset from seven years of age to twelve years of age.

But until the DSM-V is published, in anticipation of the changes that are being proposed, state bars should exercise reasonable judgment in the application of DSM criteria to adults with great deference to the clinicians who did the testing. For instance, state bars should look at all information to see if impairment is over the lifetime and should be comfortable in providing accommodations with the threshold of four symptoms instead of six. They should try to get third-party corroboration of lifetime symptoms when available, but be open to providing accommodations when it is not available, perhaps via the ADHD-NOS diagnosis.

State bars should obviously no longer view seven as the magic age by which symptoms and impairments must appear. Certainly they can and should hope to see childhood history and any corroborating information a person can get, but they then need to accept that it is wholly possible, and for some people very likely, that they're not going to be able to provide that documentation or even self reports of childhood history.

What can we in the law schools do? We need to explain to our students upfront the challenges that they may face with ADHD bar accommodations and the need to have thorough testing with as much documentation as exists of the student's childhood history. We also need to ask our students the difficult question of why they were not diagnosed until now and encourage them to share with their testers whatever coping techniques worked for them and might have caused them to not be identified earlier, as well as whatever cultural, economic, or bias-based reasons may explain the lack of earlier diagnosis. Also we should work closely with the testers to whom we refer our students to ask them to explicitly explain—and a lot of them already do this—to explicitly explain in their reports how they tried to get documented childhood history and why they couldn't get it for a particular individual so that the state bars are aware that this effort was made and don't feel like they have to redo this and make the student go through this effort again.

We also need to recommend that our students apply very early for our accommodations so that they have the time to appeal if they are denied. And if they are denied based at all on childhood history, then we need to write letters in support of their appeals, explaining what we understand of

the person's reasons for not having been diagnosed earlier. And, when applicable, we shouldn't be afraid to, one, raise the concerns we have about the discriminatory impact of the strict requirement of childhood history, and two, share some of the basis of these concerns as we outlined in the presentation today.

**ESMÉ GRANT:** Believe it or not, this is just a preview of our research. We will continue to monitor the effect of the childhood history requirement on law students with ADHD, and we hope to submit our article in the near future for publication. We encourage you to get in contact with us if you have your own stories and also if you have any questions. And furthermore, if anyone here is from a state bar, we definitely encourage you to get in contact with us as well, as we are constantly seeking more information.

**DAVID JAFFE:** Let me just say quickly in closing, I continue to be personally and professionally just moved and inspired by the number of individuals who continue to work on these issues. It seems each year that we have the opportunity to host this conference we're finding new individuals working on various areas. I hope that some of you have made some new friends or colleagues with whom to communicate. And those of you who are here for the first time will stay in touch with us at the law school as we continue to look for the avenues in which we can assist our students.

If Myra and I are here two years hence, there will be a conference here as well, and so we look forward, if not before then, to seeing you at that time. So safe travels to wherever you're heading. Thank you very much for being with us today.

(Applause)

**END TRANSCRIPT**