

Delinquent or Distracted? Attention Deficit Disorder and the Construction of the Juvenile Offender

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Introduction

William and Billy,¹ two boys, each 13 years old, appear in juvenile court. Neither has any criminal history. Both are doing poorly in school. Both have been cited for truancy in the past. Both are appearing on assault charges arising out of schoolyard fights. If we could peer into their brains, we would find that both have the same brain chemistry, characteristic of Attention Deficit Hyperactivity Disorder (ADHD).² In the end, the court finds one

†. Professor Goel, Assistant Professor, University of Denver, Sturm College of Law. This Article is dedicated to my brother Sanjay and my husband Michael, with gratitude for all they have taught me about struggling and striving for success. I am thankful to colleagues Fred Cheever, Robert Chang, Camille Nelson, and Nancy Ehrenreich for their insightful commentary and encouragement. Thanks also to those whose research assistance contributed to this article in ways great and small: Mandeav Brar, Julie Sheker, Ryan Crane, Leah Jensen, Todd Stoneman, and the incomparable Diane Burkhardt. Special thanks are owed to the excellent editorial staff of *Law & Inequality: A Journal of Theory and Practice*. All errors are my own.

1. William and Billy are fictional characters created for this Article.

2. Since functional impairment is an important aspect in assessing health, ADHD has been included for some time in the Diagnostic and Statistical Manual for Mental Disorders (DSM). It was first included in the DSM III, in 1980, and while the name and definition have undergone some revision, it remains listed in the revised DSM IV. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR 92-93 (4th ed., text rev. 2000) [hereinafter DSM-IV-TR] The criteria for diagnosing ADHD are described as:

A. [e]ither (1) or (2):

(1) six or more of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level: Inattention (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities (b) often has difficulty sustaining attention in tasks or play activities (c) often does not seem to listen when spoken to directly (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) (e) often has difficulty organizing tasks and activities (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework) (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools) (h) is often easily distracted by extraneous stimuli (i) is often forgetful in daily

delinquent, and the other merely distracted. The court finds one in need of confinement, and the other in need of care. One boy will be removed from his home and given a custodial disposition with close supervision. The other will return home, with the court satisfied that he is back on the path to becoming a responsible adult. Two different prescriptions, two different prognoses, but these boys are not really so different. In all material respects, these boys are the same, yet the juvenile justice system, well-intentioned and founded on the principle that every child is deserving of a chance,³ treats them differently.⁴ One, Billy, is Black and poor. The other, William, is White and financially secure.

Given the purpose and promise of the juvenile justice system,⁵ differences like these are a serious concern. The purpose

activities

(2) six or more of the following symptoms of

hyperactivity/impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level: Hyperactivity (a) often fidgets with hands or feet or squirms in seat (b) often leaves seat in classroom or in other situations in which remaining seated is expected (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) (d) often has difficulty playing or engaging in leisure activities quietly (e) is often "on the go" or often acts as if "driven by a motor" (f) often talks excessively Impulsivity (g) often blurts out answers before questions have been completed (h) often has difficulty awaiting turn (i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning. . . .

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder, and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Id. (emphasis in original).

3. See Alan J. Tomkins et al., *Subtle Discrimination in Juvenile Justice Decision Making: Social, Scientific Perspectives and Explanations*, 29 CREIGHTON L. REV. 1619, 1622-23 (1996) (discussing the juvenile justice system's original goal of protecting every child from the social stigma of being identified as a criminal so as to develop them into productive, law-abiding adults).

4. See generally *id.* at 1629 (noting that large discretionary powers in juvenile proceedings can lead some decisionmakers to be improperly influenced by such factors as race and socioeconomic class).

5. See *id.* at 1628 (explaining the juvenile justice system's goal of

of this Article is to expose and examine why juvenile courts treat these two youth differently based on a complex mix of race, class, and mental health.

This is not a new claim; scholars seem to agree that race, class, and mental health matter when examining delinquency,⁶ but to date, these factors have been examined largely in isolation from one another. Numerous authors elucidate the links between mental health and delinquency,⁷ but the particularities of race in that equation are rarely examined.⁸ Similarly, other scholars have examined the troubling connections between race, class, and delinquency in America,⁹ but these examinations rarely attend to the complications of mental health.¹⁰ The convergence of these factors, however, is fundamentally and qualitatively different than their operation in isolation. This Article seeks to fill that gap by

rehabilitation by being "more responsive to what the child needs, rather than to what the child has done"; James Hoge Ricks, *The Juvenile Court and Public Welfare*, 1 J. SOC. FORCES 118, 119 ("The cardinal principle of the juvenile court is to protect and safeguard the welfare of the child.").

6. See Mareasa R. Isaacs, *Assessing the Mental Health Needs of Children and Adolescents of Color in the Juvenile Justice System*, in *RESPONDING TO THE MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM* 141, 150–51 (Joseph J. Coccozza ed., 1992) (noting that race, socioeconomic background, and mental health influence demographics in the juvenile justice system).

7. See, e.g., KAY MCKINNEY, U.S. DEP'T OF JUSTICE, OJJDP MENTAL HEALTH INITIATIVES 30 OJJDP FACT SHEET (2001), available at <http://www.ncjrs.gov/pdffiles1/ojjdp/fs200130.pdf> (recognizing that in order to lower juvenile delinquency rates we must address the mental health problems facing American's youth); Isaacs, *supra* note 6, at vii (stating that there is a need for a national focus on mental health disorders in order to better achieve the goals of the criminal justice system).

8. See Tomkins et al., *supra* note 3, at 1636 (noting the difficulty of identifying racial influences on delinquency decisions due to the emergence of subtle discrimination within the juvenile justice system). But see Untress L. Quinn, *The Invisible Child: Disparities in the Mental Health Treatment of the African American Male in the Juvenile Justice System*, 28 CHILDREN'S LEGAL RTS. J. 1, 16 (2008).

9. See, e.g., Kenneth B. Nunn, *The Child as Other: Race and Differential Treatment in the Juvenile Justice System*, 51 DEPAUL L. REV. 679 (2002) (focusing on the treatment of African American children as the "other" in the juvenile justice system); Mary E. O'Connell & J. Herbie DiFonzo, *The Family Law Education Reform Project Final Report*, 44 FAM. CT. REV. 524, 535 & n.69 (2006) (discussing the disturbing trend of poor minorities being disproportionately represented in the juvenile justice system); Tomkins et al., *supra* note 3, at 1619 (arguing that the social scientific knowledge of modern racism can help to provide a context for understanding the likely presence of subtle discrimination in the juvenile justice system); Floyd Weatherspoon, *The Devastating Impact of the Justice System on the Status of African American Males: An Overview Perspective*, 23 CAP. U. L. REV. 23, 23 (1994) (providing an overview of the plight of African-American males in this country and to identify how their status is directly or indirectly impacted by our justice system).

10. See Isaacs, *supra* note 6, at 1 (discussing the lack of research and discussion regarding mental health problems in the juvenile justice system).

charting the space where mental health, race, class, and delinquency converge. Exposing the links among these concepts reveals the shortcomings in our juvenile justice system, and perhaps, helps to discover better solutions to these deficiencies.

Among the many well-known mental health issues, ADHD is the one most commonly associated with youth.¹¹ Therefore, a close study of ADHD and juvenile justice can teach us a great deal about mental illness in the juvenile justice system generally. This approach would certainly provide the theoretical benefit we seek. However, because of the ways in which ADHD overlaps with delinquent behaviors, and the ways in which race and class can obscure ADHD, there are significant practical benefits to remaining grounded in the specific disorder. Although ADHD is considered a manageable disorder that need not relegate sufferers to institutions, hospitals, or prisons,¹² nationally, almost half of all juveniles in custody (of whom more than half are youth of color¹³) have ADHD.¹⁴ This is alarming given that ADHD affects only three to five percent of the nation's children.¹⁵ By educating juvenile justice workers, including judges, about ADHD and its intersections with race and class in delinquency cases, we may be able to change those numbers.

11. See generally Bertha Nelda Garza, *Attention Deficit Hyperactivity Disorder (ADHD): A Childhood Diagnosis or a Criminal's Defense?*, 4 SCHOLAR 81, 83 (2001) (noting ADHD's history as an adolescent disorder, as illustrated by some of its previous names like "hyperactive child syndrome" and "hyperkinetic disorder of childhood").

12. See ADAM RAFALOVICH, FRAMING ADHD CHILDREN 68–69 (2004) (noting that there are a variety of approaches to treatment, including those that are pharmacological and psychotherapeutic in nature, but whatever the remedy, ADHD remains a manageable disorder).

13. See NAT'L COUNCIL ON CRIME AND DELINQUENCY, AND JUSTICE FOR SOME: DIFFERENTIAL TREATMENT OF YOUTH OF COLOR IN THE JUSTICE SYSTEM 2 (2007) [hereinafter NAT'L COUNCIL ON CRIME AND DELINQUENCY] (finding that in 1999, sixty-two percent of youth in detention were youth of color).

14. See Isaacs, *supra* note 6, at vii (noting estimates that as high as sixty percent of youth in the juvenile system suffer from a mental health disorder); see generally Bruce Kamradt, *Wraparound Milwaukee: Aiding Youth with Mental Health Needs*, 7 JUV. JUST. 14, 17 (2000) (noting that current figures estimate that forty-four percent of youth in Wraparound Milwaukee have attention deficit).

15. INST. OF MENTAL HEALTH, ATTENTION DEFICIT HYPERACTIVITY DISORDER 2, available at <http://www.nimh.nih.gov/health/publications/adhd/complete-publication.shtml>; Travis C. Pratt et al., *The Relationship of Attention Deficit Hyperactivity Disorder to Crime and Delinquency: A Meta-Analysis*, 4 INT'L J. POLICE SCI. & MGMT. 344, 345 (2002). But see PRESIDENT'S COUNCIL ON BIOETHICS, HUMAN FLOURISHING, PERFORMANCE ENHANCEMENT, AND RITALIN (Dec. 2002) [hereinafter PRESIDENT'S COUNCIL ON BIOETHICS] (noting that studies have shown that up to seventeen percent of all school-age children suffer from ADHD); Garza, *supra* note 11, at 83 (stating that one study found that ADHD affects twelve to thirteen percent of all schoolchildren in America).

Part I of this Article briefly maps the history of the juvenile justice system and its current mandate. Part II explains what ADHD is and describes both its symptomology and its status as a bona fide medical disorder. Part III examines the connections between ADHD and delinquent behavior in three areas: status offenses; involvement in violent incidents; and illegal substance use. Part IV of this Article hones in on the particular difficulties of economically disadvantaged youth with ADHD, especially the barriers to diagnosis. Part V examines the disparate results for ADHD youth in the juvenile justice system, uncovering the ways in which a lack of diagnosis, social factors, and race can operate to prevent juvenile justice judges from recognizing the disorder in the youth before them. Part VI then examines how, under the current juvenile justice provisions, undiagnosed ADHD and its related behavior accelerates a determination of delinquency and harsher sanctions. Part VII proposes several recommendations to address the crisis created by the convergence of ADHD, poverty, and race in the juvenile justice system, and concludes with some hopeful models for change.

I. Juvenile Justice: Its Mandate and Failure

In 1899, the State of Illinois passed An Act to Regulate the Treatment and Control of Dependent, Neglected and Delinquent Children.¹⁶ This Act created the first juvenile justice court in the United States.¹⁷ The last paragraph of the Act states: "This Act shall be liberally construed, to the end that its purpose may be carried out, to-wit: That the care, custody and discipline of a child shall approximate as nearly as may be that which should be given by its parents"¹⁸

Though this child-centered message seems natural to us now, in 1899 it represented a sea change in the State's approach to delinquent children.¹⁹ Prior to this Act, the State treated children like adults in terms of criminal culpability and sanctions.²⁰

16. See Juvenile Court Act of 1899 § 21, 1899 Ill. Laws 131, 137.

17. JOHN T. WHITEHEAD & STEVEN P. LAB, JUVENILE JUSTICE: AN INTRODUCTION 46 (2d ed. 1996) ("The first recognized individual juvenile court was established in Cook County, Illinois, in 1899.").

18. Juvenile Court Act of 1899 § 21; see also NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, JUVENILE DELINQUENCY GUIDELINES (2005) ("The court was charged . . . to 'as far as practical, treat children not as criminals but as children in need of aid, encouragement and guidance.'").

19. See GUS MARTIN, JUVENILE JUSTICE: PROCESS AND SYSTEMS 43-44 (2005) (noting the implementation of novel procedural rules and a shift in objectives from retributivism to rehabilitation under the newly created juvenile court system).

20. See Jane Rutherford, *Juvenile Justice Caught Between The Exorcist and a*

During the 19th Century, there was little sentiment that a child's age should lead to either a reduction in culpability or punishment.²¹ In the late 1800s, however, American legislators took notice of the British doctrine of *parens patriae*,²² under which the State has the right and obligation to intervene to ensure a child receives a moral upbringing.²³ Under Illinois's new model, children were viewed as rehabilitatable, and in need of the State's care and assistance.²⁴ Over the next twenty-five years, almost every other state followed Illinois's example,²⁵ all focusing on rehabilitation instead of punishment.²⁶ Thus, at its inception, the juvenile justice system's core mandate was to provide youth with the care, protection, and guidance needed to help them become productive citizens.²⁷

Three distinctive elements were integral to this new system: confidential proceedings; a more informal process than that of the adult court; and individualized justice focused on the best interests of the child.²⁸ Dispositions were based less on the offense

Clockwork Orange, 51 DEPAUL L. REV. 715, 719 (2002) (pointing to the courts' long history of adopting retributivist measures, as dictated by cultural and religious norms, in determining juvenile delinquency cases).

21. See MARTIN, *supra* note 19, at 41 (discussing the rise of the Child Saving Movement at the end of the nineteenth century, which focused on differentiating between adult and juvenile offenders).

22. See Ricks, *supra* note 5, at 119 (noting the influx of state legislation adopting a parental approach to the juvenile justice system); see generally BLACK'S LAW DICTIONARY 1144 (8th ed. 2004) (defining *parens patriae* as "the state in its capacity as provider of protection to those unable to care for themselves").

23. See Ricks, *supra* note 5, at 119–20 (equating the court's role with that of a father helping to diminish the impact of immoral influences on a child's life and promoting adoption of positive stimuli).

24. See *id.* at 119 (stating that "the eyes of [America's] citizens have been opened to the great injustice which has been worked upon her children . . . [A] court . . . should be guided by the purpose to protect and save [these] troubled youth.").

25. Robert E. Shepherd, Jr., *The Juvenile Court at 100: Birthday Cake or Funeral Pyre?*, 13 CRIM. JUST. 47, 48 (1999) ("The juvenile court idea spread very rapidly . . . taking hold in 46 states by 1925.").

26. See Tomkins et al., *supra* note 3, at 1622 (noting the popularity of the juvenile justice system among the states as a rehabilitative rather than retributivist construct).

27. See WHITEHEAD & LAB, *supra* note 17, at 46 (discussing the overreaching goal of every juvenile court to assist juveniles in becoming law abiding members of society).

28. See Ricks, *supra* note 5, at 119 (noting the importance of privacy in juvenile case hearings); Tomkins et al., *supra* note 3, at 1628 (explaining that less formal procedures allow courts expansive discretionary powers vital to preserving a child's best interest); see generally NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at ch. 12 (outlining guidelines which, if followed, will help a juvenile court meet the system's core objectives).

committed and more on the needs of the specific youth.²⁹

For more than fifty years, juvenile justice courts operated without any other guidance or constraint,³⁰ but over time many juveniles were "institutionalized indefinitely in the name of treatment."³¹ Critics became alarmed at the unbridled judicial discretion.³² They called for greater due process safeguards in the juvenile justice system.³³ This demand led to what is now described as the due process wave³⁴ in juvenile justice reform. In a series of cases, many of the due process protections already standard in adult proceedings were instituted in the juvenile justice system.³⁵ Judges discarded the original informality of the

29. Tomkins et al., *supra* note 3, at 1629 ("[The purpose of] juvenile court dispositions . . . is to address the rehabilitative needs of the offender."); see NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18 at 205 (emphasizing the need of the juvenile justice system to focus on helping "delinquent youth . . . become law abiding citizens").

30. See Tomkins et al., *supra* note 3, at 1623 (noting that the juvenile courts' expansive discretionary powers came under increased scrutiny beginning in the early 1960s).

31. HOWARD N. SNYDER, *JUVENILE OFFENDERS & VICTIMS: A NATIONAL REPORT* 71 (Nat'l Ctr. For Juvenile Justice ed., 1995).

32. See Tomkin, et al., *supra* note 3, at 1623 (indicating that "there was significant concern that the juvenile justice system was not realizing its goals of rehabilitating delinquents and was, in fact, depriving many juveniles of basic constitutional rights").

33. See David L. Bazelon, *Racism, Classism, and the Juvenile Process*, 53 JUDICATURE 373, 375 (1970) ("Whether the intentions of our courts are punitive or rehabilitative, an adversial [sic] hearing accompanied by . . . basic procedural protections . . . is necessary insurance for a fair fact-finding proceeding.").

34. See Tomkins et al., *supra* note 3, at 1627 (noting the issuance of eight "United States Supreme Court decisions . . . subplant[ing] [sic] some of the procedural safeguards accorded criminal defendants."); see also Juvenile Justice and Delinquency Prevention Act, 42 U.S.C. §§ 5601–5602 (1974) (reforming the juvenile justice system to better implement delinquency prevention initiatives); Douglas W. Nelson, *A Road Map for Juvenile Justice Reform*, in THE ANNIE E. CASEY FOUNDATION'S 2008 KIDS COUNTY ESSAY AND DATA BRIEF 1, 5 (2008) (noting the extension of many due process protections already held by adults to youth).

35. See Tomkins et al., *supra* note 3, at 1624 (noting that beginning in 1948 the United States Supreme Court issued eight decisions expanding juvenile rights within the juvenile justice system); see, e.g., *In re Winship*, 397 U.S. 358, 364 (1970) (requiring that a plaintiff show proof beyond a reasonable doubt for conviction in juvenile court); *Breed v. Jones*, 421 U.S. 519, 541 (1975) (holding that the double jeopardy clause of the Fifth Amendment applies in juvenile court, thereby barring prosecution as an adult for the same conduct); *In re Gault*, 387 U.S. 1, 41, 55–57 (1967) (holding that the rights to notice and counsel, rights of confrontation and cross-examination, and the privilege against self-incrimination exist in the juvenile system); *Kent v. United States*, 383 U.S. 541, 562 (1966) (recognizing a juvenile's right to a waiver hearing); *Haley v. Ohio*, 332 U.S. 596, 601 (1948) (holding that the Fourteenth Amendment proscribes forced confessions by both juveniles and adults). But see *New Jersey v. T.L.O.*, 469 U.S. 325, 340–41 (1985) (finding that a search on school grounds shall be upheld as constitutional if found to be reasonable, whereas searches off school grounds must meet the higher standard of probable cause);

system in favor of stronger due process safeguards that they felt might increase the overall efficacy of rehabilitation efforts.³⁶

The juvenile justice system shifted once again in the late 1980s and early 1990s in response to a significant increase in violent crime by juveniles.³⁷ Rehabilitation efforts did not appear to be working.³⁸ Citizens again complained that juvenile justice courts were failing to fulfill their mandate, including some who accused juvenile courts of being too soft.³⁹ In response, legislatures adjusted juvenile court processes by relaxing confidentiality provisions, transferring youth to criminal court for certain crimes, expanding the prosecutorial role in the juvenile justice process, and increasing the severity of juvenile court sanctions.⁴⁰ Furthermore, legislatures lowered the age for transfer to adult court, and reduced judicial discretion as to when such transfer could take place.⁴¹ Thus, legislatures incorporated an "accountability" mandate into the mission of the juvenile court. Now, courts had to balance the best interests of the child with public safety and holding youth accountable for their actions.⁴²

Schall v. Martin, 467 U.S. 253, 264 (1984) (upholding the pre-trial detention of juveniles based on a "legitimate and compelling state interest" in protecting the community from crime . . ."); McKeiver v. Pennsylvania, 403 U.S. 528, 545 (1971) (holding that juvenile proceedings do not necessitate a right to a jury and recognizing that such a right would raise doubts for maintaining a separate juvenile system).

36. See Tomkins et al., *supra* note 3, at 1623 (noting concerns that the original juvenile justice system denied youth many of their constitutional rights while still failing to rehabilitate them); see also NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at 12 (discussing the trend to increase due process rights beginning in the 1960s).

37. See PANEL ON JUVENILE CRIME: PREVENTION, TREATMENT, AND CONTROL, JUVENILE CRIME JUVENILE JUSTICE 25 (Joan McCord et al. eds., 2001) (noting that in reaction to the increase in violent crimes by juveniles both state and federal legislators moved to refocus the juvenile system to reflect a more punitive approach to juvenile delinquency); see also NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at 13 (discussing the alarming sixty-two percent increase in violent crimes committed by juveniles from 1988 to 1994).

38. See PANEL ON JUVENILE CRIME: PREVENTION, TREATMENT, AND CONTROL, *supra* note 37, at 25 (mentioning "a general belief that young people are increasingly violent and uncontrollable and that the response of the [rehabilitative-focused] juvenile justice system has been inadequate"); see also NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at 13 (noting the rapid increase in the number and severity of youth crime).

39. See NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at 13; see also PANEL ON JUVENILE CRIME: PREVENTION, TREATMENT, AND CONTROL, *supra* note 37, at 25 (noting that rehabilitation efforts fell short as reflected in the increase of violent crimes by juvenile offenders in the late 1980s and early 1990s).

40. See NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at 13.

41. See *id.*

42. See PANEL ON JUVENILE CRIME: PREVENTION, TREATMENT, AND CONTROL,

The majority of current statutes⁴³ reflect this effort to balance accountability and rehabilitation.⁴⁴ Consider, for example, California's provisions.⁴⁵ California's juvenile justice system is the largest in the nation⁴⁶ and recently underwent a review⁴⁷ that has led to some juvenile justice reforms.⁴⁸ Therefore, it is fair to say that California's provisions are representative of the modern philosophy of juvenile justice.⁴⁹ It is

supra note 37, at 25 (discussing the adoption of a more punitive approach to the juvenile justice system in reaction to an increase in violence among children and adolescents).

43. It is useful to note that the statutes governing juvenile justice and the detention of juveniles vary significantly from jurisdiction to jurisdiction — not only in substance, but in location and integration as well. See generally National Center for Juvenile Justice, State Juvenile Justice Profiles, <http://www.ncjj.org/stateprofiles/> (last visited Oct. 6, 2008) (providing information and analysis of the fifty-one juvenile justice systems in the United States). For example, Connecticut and Illinois locate juvenile provisions in a separate Juvenile Justice Act, while Alaska and Massachusetts include them in preexisting Public Welfare Codes. *Id.* Still other states, like Florida and Maine, tack on the provisions at the end of their criminal codes, and some, including Mississippi and Arkansas, lack state level rules governing youth court proceedings. *Id.* In most states, the provisions, though interconnected, are scattered amongst three or four codes — Education, Family Services, Penal Code, and Juvenile Act, for instance. *Id.*

44. See PATRICK GRIFFIN ET AL., NATIONAL OVERVIEWS (2006), <http://www.ncjj.org/stateprofiles/overviews/faq9.asp> (noting that the majority of states adopted juvenile court purpose clauses that provided for a variation on the theme of accountability with rehabilitation).

45. See CAL. WELF. & INST. CODE § 202 (West 2008) (providing general juvenile court provisions). In California, juvenile justice provisions are primarily found in the Welfare and Institutions Code. See National Center for Juvenile Justice, *supra* note 43.

46. Dorothy E. Roberts, *Criminal Justice and Black Families: The Collateral Damage of Over Enforcement*, 34 U.C. DAVIS L. REV. 1005, 1020 (2001) ("California [is] the state with the highest number of juveniles in custody.").

47. See SAFETY AND WELFARE PLANNING TEAM, CAL. DEP'T OF CORR. AND REHAB. DIV. OF JUVENILE JUSTICE, SAFETY AND WELFARE PLAN: IMPLEMENTING REFORM IN CALIFORNIA 1 (2006) (identifying the California juvenile justice system in 2006 as "broken" and in need of expansive reform to fix the system's underlying deficiencies).

48. See MODELS FOR CHANGE, THE ACCELERATING PACE OF JUVENILE JUSTICE REFORM: A JUSTICE POLICY INSTITUTE SUMMARY, 2–3 (2007), <http://modelsforchange.net/pdfs/statehighlightsFINAL.pdf> (identifying efforts by California to reduce the number of youth detainees in state facilities; provide improved after care accessibility to health care, including mental health services; shift funds away from state programs to help facilitate community-based treatment; and, provide guidelines for the appointment of counsel in juvenile court); see also CAL. WELF. & INST. CODE § 202 (West 2008) (codifying these reforms).

49. See LEADERSHIP CONFERENCE ON CIVIL RIGHTS, LEADERSHIP CONFERENCE EDUCATION FUND, JUSTICE ON TRIAL: RACIAL DISPARITIES IN THE AMERICAN CRIMINAL JUSTICE SYSTEM 41 (2000) (noting that national trends mirror California's shift to a more retributivist approach to juvenile justice).

interesting to see how the California statute details both the original and modern purposes of the juvenile justice system:

(a) The purpose of this chapter is to provide for the protection and safety of the public and each minor under the jurisdiction of the juvenile court If the minor is removed from his or her own family, it is the purpose of this chapter to secure for the minor custody, care, and discipline as nearly as possible equivalent to that which should have been given by his or her parents. This chapter shall be liberally construed to carry out these purposes.

(b) Minors . . . shall, in conformity with the interests of public safety and protection, receive care, treatment, and guidance that is consistent with their best interest, that holds them accountable for their behavior, and that is appropriate for their circumstances. This guidance may include punishment that is consistent with the rehabilitative objectives of this chapter. . . . When the minor is no longer a ward of the juvenile court, the guidance he or she received should enable him or her to be a law-abiding and productive member of his or her family and the community. . . .

. . . .

(d) Juvenile courts . . . shall consider the safety and protection of the public, the importance of redressing injuries to victims, and the best interests of the minor in all deliberations pursuant to this chapter. Participants in the juvenile justice system shall hold themselves accountable for its results.⁵⁰

Legislatures have tried to meet these objectives by mandating the integration of juvenile justice with other government services that youth may require, such as health or education services.⁵¹ This approach is consistent with the underlying belief that most youth commit antisocial acts either because they lack a solid foundation at home, they are ill, or they are so impoverished that they act out of desperation.⁵²

Unfortunately, integration efforts have not been particularly effective in rehabilitating and properly caring for delinquent youth.⁵³ Instead, juvenile violent crime continues⁵⁴ and

50. CAL. WELF. & INST. CODE § 202 (West 2008).

51. See, e.g., ALASKA ADMIN. CODE tit. 7, §§100, 155 (2008) (providing provisions regarding health and education services in the juvenile justice system).

52. See NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at 13–14 (noting an increased congressional awareness of the causal connection between delinquency and child abuse and neglect); see also WHITEHEAD & LAB, *supra* note 17, at 124 (discussing social, psychological, and economic theories surrounding the juvenile delinquency phenomenon).

53. See HOWARD N. SNYDER & MELISSA SICKMUND, JUVENILE OFFENDERS AND VICTIMS: 2006 NATIONAL REPORT 232 (2006) (finding that forty-three percent of female and thirty-nine percent of male re-entry candidates who had been in custody before “said they had been held five or more times”).

recidivism rates remain high.⁵⁵ Furthermore, minorities are disproportionately represented throughout the system.⁵⁶ In 1999, the Department of Juvenile Justice (DOJJ) reported that juveniles of color represented two-thirds of the “detained and committed population in secure juvenile facilities.”⁵⁷ Most of those detained were African American⁵⁸ even though African Americans constitute only fifteen percent of the youth population overall.⁵⁹ More recent figures from the DOJJ show only slight improvement; in 2003, youth of color were sixty-one percent of the overall juvenile custodial population.⁶⁰ However, this is still grossly disproportionate to the number of minority children in the population overall.⁶¹ The problem gets progressively worse as youth make their way through the juvenile justice system.⁶² While percentages at first contact with officers are slightly more even,⁶³ statistics show that when youth make it to a judicial

54. Although the juvenile male violent crime rate has seen a twenty-six percent decline between 1980 and 2003, the female rate has increased forty-seven percent over the same time period. See *id.* at 132.

55. *Id.* at 234 (“[N]early 6 in 10 juveniles return[] to juvenile court by the time they turn[] 18.”).

56. See SHAY BILCHIK, U.S. DEPT OF JUSTICE, MINORITIES IN THE JUVENILE JUSTICE SYSTEM 1 (1999), available at

<http://www.ncjrs.gov/pdffiles1/ojdp/179007.pdf>; NAT’L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13, at 1–2 (finding, among other things, that African American youth comprised a disproportionate number of arrests in twenty-six offense categories in 2004, made up thirty-seven percent of the detained population while only accounting for thirty percent of referrals, and that over seventy-five percent of drug cases that reached the formal processing level involved Black youth); PANEL ON JUVENILE CRIME: PREVENTION, TREATMENT, AND CONTROL, *supra* note 37, at 231 (discussing racial disparities throughout the juvenile system).

57. BILCHIK, *supra* note 56, at 1.

58. See *id.* (noting that Black juveniles make up forty-five percent of all “delinquency cases involving detention”).

59. *Id.*

60. See SNYDER & SICKMUND, *supra* note 53, at 211 (noting that the proportion of minorities in custody has remained relatively constant, with only a slight decline from sixty-two percent to sixty-one percent from 1997 to 2003).

61. See NAT’L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13, at 3 (noting that from 2002 to 2004 sixteen percent of the youth population was Black); Roberts, *supra* note 46, at 1012 (finding that in 2001 Black children made up seventeen percent of the youth population).

62. See Roberts, *supra* note 46, at 1023 (noting the snowball effect that ensues as more Black than White youth are detained at intake, from which more intake detainees are held at a preliminary hearing, which leads to harsher sentences for those juveniles held than for juveniles staying at home during adjudication). The result is “[a] larger and larger percentage of [nonwhite] juveniles in the system as they proceed from arrest to intake and eventually to detention or incarceration.” *Id.*

63. See NAT’L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13, at 6, 16 fig. 6 (noting that White youth represented seventy percent of arrests, but only fifty-

proceeding, significantly more youth of color than White youth are adjudicated delinquent.⁶⁴ Similarly, more youth of color than White youth are elevated to adult court.⁶⁵

Perhaps most alarming is the rate of youth with mental health disorders in the juvenile justice system. Although approximately twenty percent of youth in the general population suffer from some form of a mental disorder,⁶⁶ current research suggests that mental disorders among youth in the juvenile justice system are at least two to three times more prevalent.⁶⁷ While the most recent Office of Juvenile Justice and Delinquency Prevention (OJJDP) report states concern over these figures, there has been little progress in deflating them.⁶⁸ Clearly, the juvenile justice system is not adequately or equally serving all youth.⁶⁹ As this Article will demonstrate, for youth with ADHD, particularly those who are undiagnosed, the challenges within the system are

four percent of formally processed cases in 2003).

64. See Nunn, *supra* note 9, at 685 (stating that in 1997, 66 percent of referrals involved White youth, but only 63 percent of those cases went on to be formally processed, whereas Black youth comprised 31 percent of referrals with 34 percent of those resulting in formal petitioning); Roberts, *supra* note 46, at 1011 (noting that from 1988 to 1997 Black youth detention increased fifty-two percent, more than double the twenty-five percent increase seen among White youth).

65. See Nunn, *supra* note 9, at 685 (noting that in 1997 forty-six percent of cases waived to adult court involved African American youth). This is a distressing figure since Black youth make up thirty-four percent of cases considered for waiver. *Id.*; see also Roberts, *supra* note 46, at 1025 (remarking that waiver cases involving Black youth rose thirty-five percent as compared to a fourteen percent increase among White youth between 1988 and 1997).

66. See U.S. PUBLIC HEALTH SERVICE, REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH: A NATIONAL ACTION AGENDA 17 (2000) (estimating the prevalence of mental illness among youth to be between 17.6 percent and 20 percent); Isaacs, *supra* note 6, at 5 (providing estimates of 14 percent to 22 percent of the general youth population suffer from mental health disorders).

67. NAT'L CTR. FOR MENTAL HEALTH AND JUVENILE JUSTICE, KEY ISSUES, <http://www.ncmhjj.com/faqs/default.asp> (last visited Oct. 13, 2008); see SNYDER & SICKMUND, *supra* note 53, at 233 (finding that seventy-one percent of reentry youth reported multiple emotional and mental health problems); Isaacs, *supra* note 6, at 21 (noting that prevalence rates of mental health disorders are likely significantly higher among youth in the juvenile justice system).

68. RICHARD E. REDDING ET AL., JUVENILE DELINQUENCY: PREVENTION, ASSESSMENT, AND INTERVENTION 85 (Kirk Heilbrun et al. eds., 2005) (recognizing that policy makers have begun investigating mental health problems facing juvenile delinquents, but little tangible progress has emerged). Although juvenile delinquents are increasingly being diagnosed with mental health disorders, judges continue to overlook this factor in issuing rulings. *Id.* at 3, 13 ("Additionally, substantial barriers continue to exist in the delivery of mental health services within the juvenile justice system.").

69. Isaacs, *supra* note 6, at 1 ("[T]his population [of juvenile delinquents suffering from mental health disorders] places great stress on the system . . . their needs have been largely ignored.").

particularly great.

II. What is ADHD?

To examine the links between ADHD and juvenile delinquency, it is first necessary to understand the disorder. ADHD impairs optimal life functioning for those afflicted.⁷⁰ The DSM, a handbook for mental health professionals, defines ADHD as “a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development”⁷¹

Many mental health professionals believe ADHD is grossly over diagnosed.⁷² They argue that society expects more quiet attention from children today than in years past.⁷³ Crowded classrooms make it difficult for teachers to handle intelligent and exuberant students, and such children, even if “normal,” are more likely to come to the teacher’s attention.⁷⁴ Further, authorities argue that ADHD behavior is merely at one end of “normal” within the spectrum of diverse human behavior.⁷⁵ Critics say that

70. See Russell A. Barkley et al., *Adolescents with ADHD: Patterns of Behavioral Adjustment, Academic Functioning, and Treatment Utilization*, 30 J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 752, 752 (1991) (stating that ADHD brings with it a host of problems including inattentiveness, agitation, antisocial behavior, and increased risk of academic failure); Mona M. Shattell et al., “*I Have Always Felt Different*”: *The Experience of Attention-Deficit/Hyperactivity Disorder in Childhood*, 23 J. PEDIATRIC NURSING 49, 49 (2008) (noting that participants in an ADHD study felt “difference, misunderstanding, and struggle in all areas of their lives”).

71. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 78 (4th ed. 1994).

72. See William B. Carey, *Is ADHD a Valid Disorder?*, in ATTENTION DEFICIT HYPERACTIVITY DISORDER, ch. 3, at 2 (Peter S. Jensen & James R. Cooper eds., 2002) [hereinafter JENSEN & COOPER] (discussing the increasing diagnosis, as parents, child-care workers, professionals, and others are quick to find mental illness to blame for a child’s antisocial behavior); Connie Lenz, *Prescribing a Legislative Response: Educators, Physicians, and Psychotropic Medication For Children*, 22 J. CONTEMP. HEALTH L. & POL’Y 72, 72 (2005) (noting that many physicians have been criticized for diagnosing and prescribing medication for attention deficit disorders without adherence to standard diagnostic procedures).

73. See Carey, *supra* note 72, ch. 3, at 2 (noting that parents and teachers are increasingly demanding medical answers, thereby placing tremendous social pressures on doctors to find a medical rationale for a child’s behavior); Lenz, *supra* note 72, at 72 (explaining educators’ support of diagnosis in an attempt to alleviate classroom disruption and promote classroom management).

74. Joel Turtel, *Is ADHD a Real Disease?*, <http://www.mental-health-matters.com/articles/article.php?artID=849> (last visited Sept. 9, 2008).

75. See Benjamin B. Lahey & Erik G. Willcutt, *Validity of the Diagnosis and Dimensions of Attention Deficit Hyperactivity Disorder*, in JENSEN & COOPER, *supra* note 72, ch. 1, at 1 (discussing critics of ADHD diagnosis who view the alleged disease as nothing more than a collection of traits along the “normalcy”

medicalizing this behavior constricts the range of normalcy⁷⁶ and casts a stigma on behavior that should be accepted.⁷⁷ In addition, critics claim that the ADHD diagnosis may be a tool for social control,⁷⁸ and has much more to do with our ability to handle "active" youth than the youth themselves.⁷⁹

No one is sure what causes ADHD, or when it develops.⁸⁰ Some researchers have argued that it is mostly genetic,⁸¹ while others have argued that there are many external, post partum factors that contribute to its manifestation.⁸²

However, medical professionals generally agree that, regardless of the cause or concerns about overdiagnosis, ADHD is a real disorder with actual behavioral indicators and significant consequences for those who suffer from it.⁸³ Neurological studies suggest that a shortage of dopamine and norepinephrine in the brain leads to ADHD symptoms.⁸⁴ Dopamine and norepinephrine

continuum); Turtel, *supra* note 74 ("[M]any children diagnosed with ADHD may simply be bright, normal kids, full of energy, and bored out of their minds sitting in public-school classrooms.").

76. See Turtel, *supra* note 74 (discussing how the increase in ADHD diagnoses among children created a new subclass of children who were once identified as normal, but are now placated by ADHD medications).

77. See *id.* (noting that many so-called ADHD symptoms are simply behavioral traits of the proverbial "kid just being a kid").

78. See PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 15 (discussing generally the ethical issue raised by Ritalin use, specifically its function as a means for "social control").

79. See *id.* (discussing whether Ritalin, a commonly prescribed medication for ADHD, offers just a "'quick and easy' substitute for the slower and more difficult process of developing impulse control" via commendation and punishment).

80. See generally Lily Hechtman, *Long-Term Outcome and its Predictors in Children with Attention Deficit Hyperactive Disorder (ADHD)*, in ATTENTION DEFICIT HYPERACTIVITY DISORDER: THE CLINICAL SPECTRUM 209, 219–21 (Brian T. Rogers et al. eds., 2001) (summarizing a variety of positions on causes of ADHD).

81. See *id.* (summarizing genetic studies which indicate that adult relatives of ADHD children have a higher prevalence of ADHD).

82. See Gerald E. Rouse & Sam Goldstein, *Responding to ADHD Youth in the Juvenile Justice System*, 50 JUV. & FAM. CT. J. 53, 54–56 (1999) (noting strong correlations between ADHD incidence and brain injury, poor nutrition, and exposure to lead pipes and pain, in addition to genetic traits).

83. See C.K. Conners & P.S. Jensen, *Validity of the Diagnosis and Dimensions of Attention Deficit Hyperactivity Disorder*, in JENSEN & COOPER, *supra* note 72, ch. 1, at 3; see also Stephen P. Hinshaw, *Is ADHD an Impairing Condition in Childhood and Adolescence?*, in JENSEN & COOPER, *supra* note 72, ch. 5, at 3, 6–12.

84. See Robert D. Hunt, *Functional Roles of Norepinephrine and Dopamine in ADHD*, MEDSCAPE TODAY, Mar. 9, 2006,

<http://www.medscape.com/viewarticle/523887>; M. Glanzman, *An Update on the Pathophysiology of ADHD*, in ATTENTION DEFICIT HYPERACTIVITY DISORDER: THE CLINICAL SPECTRUM, *supra* note 80, at 3, 5 (describing general effects of brain chemicals); Larry Silver, *What is ADHD? Attention Deficit Diagnosis and Treatment Information*, ADDITUDE, at 2,

are complementary neurological chemicals, each responsible for attention, cognitive processing, and a feeling of well-being.⁸⁵ The brain produces dopamine and norepinephrine in the regular course of life, balancing them through production and reuptake.⁸⁶ When one needs to concentrate on a difficult task, the brain produces more dopamine, and simultaneously suppresses the dopamine reuptake receptors to optimize brain functioning.⁸⁷ In ADHD sufferers, lack of dopamine appears to be due to weak dopamine production or overactive dopamine reuptake.⁸⁸ ADHD sufferers experience a consistently lower level of dopamine than normal, making it difficult to pay attention or focus for extended periods.⁸⁹ Ritalin, a common ADHD medication, contains methylphenidate,⁹⁰ a stimulant that increases focus and concentration by raising production levels of dopamine and norepinephrine in the brain.⁹¹ Since both of these chemicals are deficient in the ADHD brain, methylphenidate has been an effective treatment for ADHD.⁹²

Spectrography scans of “normal” and ADHD brains further demonstrate that ADHD is a genuine medical disorder.⁹³ Spectrography scans measure the blood flow and physical features in different parts of the brain by performing a tomographic scan.⁹⁴ These scans demonstrate unequivocally that there are differences in the ways ADHD and normal brains develop and function.⁹⁵

In a groundbreaking study,⁹⁶ researchers first measured

<http://www.additudemag.com/adhd/article/1572-2.html> (last visited Dec. 17, 2008).

85. See Hunt, *supra* note 84.

86. *Id.*

87. ERIC R. KANDEL ET AL., PRINCIPLES OF NEURAL SCIENCE (4th ed. 2000), 253–55; Hunt, *supra* note 84.

88. Hunt, *supra* note 84; see also KANDEL ET AL., *supra* note 87, at 280–83 (describing chemical processes of the brain).

89. See Hunt, *supra* note 84; see also Glanzman, *supra* note 84, at 3, 5 (describing general effects of brain chemicals); Silver, *supra* note 84, at 2.

90. NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 22.

91. Brookhaven National Laboratory, *New Brookhaven Lab Study Shows How Ritalin Works*, Jan. 16, 2001, <http://www.bnl.gov/bnl/web/pubaf/pr/2001/bnlpr011501a.html>.

92. NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 22.

93. Daniel G. Amen & Blake D. Carmichael, *High-Resolution Brain SPECT Imaging in ADHD*, 9 ANNALS OF CLINICAL PSYCHIATRY 81, 81–86 (1997).

94. *Id.* at 82.

95. See *id.* at 84–85 (indicating decreased levels of prefrontal brain activity in ADHD individuals); Stephen V. Farone & Joseph Biederman, *Pathophysiology of Attention Deficit/Hyperactivity Disorder*, in NEUROPSYCHOPHARMACOLOGY, 577, 580–82 (Kenneth L. Davis et al. eds., 2002) (describing empirical findings on brain development and general functions).

96. Amen & Carmichael, *supra* note 93, at 81–86; see also Hans C. Lou et al., *Focal Cerebral Hypoperfusion in Children with Dysphasia and/or*

brain activity in normal and ADHD subjects.⁹⁷ Then subjects were asked to concentrate on a particular task – a math problem or a complex reading.⁹⁸ Subjects' brains were then scanned while they performed the task.⁹⁹ In normal subjects, blood flow in the brain's frontal lobe (the central cognitive processor) had increased, rendering it orange and red in the thermal scans.¹⁰⁰ In ADHD subjects, however, blood actually appeared to have left the frontal lobe, leaving it blue under the scan.¹⁰¹ The visible difference confirmed the claims of ADHD subjects that they found it difficult to complete the task, despite their efforts and their continued insistence that they were really trying to concentrate and focus.¹⁰²

In further studies, ADHD subjects were given a psychostimulant, like methylphenidate, and then scanned.¹⁰³ Subsequent scans revealed that blood flow to the frontal lobe increased with medication.¹⁰⁴ Subjects demonstrated dramatic improvement in behavior, including decreased hyperactivity and increased attention span.¹⁰⁵ Researchers concluded that ADHD brains operate differently and that methylphenidate actually affects the brain and its ability to function.¹⁰⁶

More recent studies also detected physical differences in the ways ADHD brains develop.¹⁰⁷ Brain scans revealed that crucial parts of an ADHD child's brain develop slower than those in non-ADHD children's brains.¹⁰⁸ Researchers measured the cortex thickness at 40,000 points in the brains of 223 children with ADHD and 223 children developing normally.¹⁰⁹ They discovered that portions of the front and sides of the brain, the parts that integrate information from sensory areas with higher order

Attention Deficit Disorder, 41 ARCHIVES OF NEUROLOGY 825, 825–29 (1984).

97. Amen & Carmichael, *supra* note 93, at 82.

98. *Id.*

99. *Id.*

100. *Id.* at 83.

101. *Id.* at 83, 85.

102. Daniel G. Amen & Jack H. Paldi, *Brain SPECT Imaging*, 32 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1080 (1993).

103. Boong-Nyun Kim et al., *Methylphenidate Increased Regional Cerebral Blood Flow in Subjects with Attention Deficit/Hyperactivity Disorder*, 42 YONSEI MED. J. 1, 20–22 (2001).

104. *Id.* at 23.

105. *Id.* at 22.

106. *Id.* at 27.

107. See P. Shaw et al., *Attention-Deficit/Hyperactivity Disorder is Characterized by a Delay in Cortical Maturation*, 104 PROCS. OF THE NAT. ACAD. OF SCI. OF THE U.S. 49 19649–54 (2007).

108. *Id.* at 19650.

109. *Id.* at 19649–50.

functions, lagged behind developmentally in ADHD children.¹¹⁰

As a result of this and similar studies, ADHD is now well-accepted as a neurological developmental disorder.¹¹¹ Not only is it well established in medicine, but ADHD has become part of our general consciousness.¹¹² Over the last twenty-five years, diagnosis of the disorder has risen dramatically,¹¹³ and now national estimates suggest that three to five percent of children are ADHD sufferers.¹¹⁴ Nevertheless, thousands of children remain undiagnosed,¹¹⁵ and these are the children with whom this Article is concerned.

III. Overlap Between ADHD and Delinquent Behaviors

If suffering with ADHD was merely about high energy and lack of concentration, there would be little cause for concern. However, the life impairment associated with ADHD has been well documented since the early 20th Century.¹¹⁶ ADHD children are more likely to do poorly in school.¹¹⁷ They are much more likely to be involved in delinquent behavior,¹¹⁸ almost three times more likely to use illegal drugs,¹¹⁹ and more likely to end up arrested

110. *Id.* at 19650.

111. See National Institute of Neurological Disorders and Stroke, NINDS Attention Deficit-Hyperactivity Disorder Information Page, <http://www.ninds.nih.gov/disorders/adhd/adhd.htm> (last visited Dec. 17, 2008).

112. Consider these stories about ADHD in the popular media: Dan Childs, *ADHD Ads Target Back-to-School Crowds*, ABC NEWS, Aug. 23, 2007, available at <http://www.abcnews.go.com/Health/Drugs/Story?id=3515271&page=1>; Viveca Novak, *New Ritalin Ad Blitz Makes Parents Jumpy*, TIME, Sept. 2, 2001, available at <http://www.time.com/time/magazine/article/0,9171,173468,00.html>.

113. Carey, *supra* note 72, ch.3, at 1–2.

114. NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 2.

115. See Regina Bussing et al., *Barriers to Detection, Help-Seeking, and Service use for Children with ADHD Symptoms*, 30 J. BEHAV. HEALTH SERVICES. & RES. 176, 184–86 (2003) (describing problems with properly diagnosing all of the children who have ADHD).

116. See RAFALOVICH, *supra* note 12, at 7–8; Garza, *supra* note 11, at 82–83 (2001).

117. See Charlotte Johnston, *Impact of ADHD on Adult Social and Vocational Functioning*, in JENSEN & COOPER, *supra* note 72, ch. 6, at 4, 7, 9 (tracking lower educational performance among children with ADHD).

118. See Russell A. Barkley, *ADHD—Long-Term Course, Adult Outcome, and Comorbid Disorders*, in JENSEN & COOPER, *supra* note 72, ch. 4, at 8; Garza, *supra* note 11, at 90 (noting that “individuals with ADHD are as much as seven times more likely than others to develop an antisocial personality or drug abuse problem in adulthood”).

119. Brooke S.G. Molina & William E. Pelham, *Childhood Predictors of Adolescent Substance Use in a Longitudinal Study of Children With ADHD*, 112 J. ABNORMAL PSYCHOL. 497, 504 (2003); see also Garza, *supra* note 11, at 90 (noting that “individuals with ADHD are as much as seven times more likely than others

than children without ADHD.¹²⁰ While ADHD children are not doomed to lives of crime, they do face greater social and academic challenges than children without ADHD.¹²¹

Recent figures reveal that a significant proportion of all detained youth have ADHD.¹²² This is no coincidence; real factors contribute to the high percentage of ADHD children who end up in juvenile detention.¹²³ In particular, as the rest of this Part will explain, ADHD behaviors can contribute to, and overlap with, delinquency in three categories: status offenses, involvement in violent incidents, and illegal substance use.

A. Status Offenses and ADHD

In the juvenile justice context, status offenses are those acts committed by juveniles that would not be criminal if committed by an adult.¹²⁴ Such offenses might include general misbehavior and disobedience: for example, running away from home or truancy.¹²⁵ These actions are offenses due to the offender's age and society's need to control youth as part of the socialization process.¹²⁶

Schooling is integral to the system of community control, playing a significant role in socialization and success.¹²⁷ Studies show that grade school and high school performance are some of the best indicators of success or failure later in life.¹²⁸ Children

to develop an antisocial personality or drug abuse problem in adulthood").

120. See Laetitia L. Thompson et al., *Contribution of ADHD Symptoms to Substance Problems and Delinquency in Conduct-Disordered Adolescents*, 24 J. ABNORMAL CHILD PSYCHOL. 325, 325-26 (1996).

121. Pratt et al., *supra* note 15, at 353-54.

122. See Betty Chemers, *The Impact of Attention Deficit Hyperactivity Disorder on the Juvenile Justice System*, in JENSEN & COOPER, *supra* note 72, ch. 25, at 3 (stating that one study found ADHD in seventy-six percent of incarcerated male juveniles and sixty-eight percent of females); see generally Kamradt, *supra* note 14, at 17 (stating that forty-four percent of youth in the Wraparound Milwaukee program were diagnosed with attention deficit).

123. See Rouse & Goldstein, *supra* note 82, at 53 (describing factors that contribute to youth commonly appearing before juvenile courts).

124. NAT'L COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, *supra* note 18, at 15.

125. *Id.*

126. See *id.* at 37-39 (describing the jurisdictional variation in the criminalization of status offenses).

127. See generally Jim Comstock-Galagan & Rhonda Brownstein, *Stopping the Schoolhouse to Jailhouse Pipeline by Enforcing Federal Special Education Law*, S. POVERTY L. CENTER,

<http://www.splcenter.org/images/dynamic/main/SpecialEducationLaw.pdf> (last visited Nov. 12, 2008) (describing the problematic aftermath after a school failed to respond to ADHD in children properly).

128. See Stephen P. Hinshaw, *Is ADHD an Impairing Condition in Childhood and Adolescence?*, in JENSEN & COOPER, *supra* note 72, ch. 5, at 1, 6.

who perform poorly in school or drop out are much more likely to end up incarcerated than those who stay in school and do well.¹²⁹ As such, it is not surprising that school-related offenses, such as truancy, have become the classic example of status offenses.¹³⁰

For instance, consider the California provisions on truancy.¹³¹ Section 48260 of the California Educational Code reads:

Any pupil . . . who is absent from school without valid excuse three full days in one school year or tardy or absent for more than any 30-minute period during the school day without a valid excuse on three occasions in one school year, or any combination thereof, is a truant and shall be reported to the attendance supervisor or to the superintendent of the school district.¹³²

Section 48264 of the Educational Code provides for the arrest and temporary custody of truants.¹³³ Furthermore, the California Welfare Code provides that habitual truancy can lead to the minor being declared a ward of the court.¹³⁴

Conduct within the school is equally at issue; section 48900 of the Education Code provides for suspension or expulsion at the direction of the school's principal or superintendant if the student: "[d]isrupt[s] school activities or otherwise willfully defie[s] the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties."¹³⁵

Given the breadth of these provisions, it is useful to examine how ADHD youth experience school. Many people envision ADHD as a condition marked by merely poor concentration, sometimes accompanied by fidgetiness.¹³⁶ However, even in the classroom,

129. Charles Edward Pell, *Pre-Offense Monitoring of Potential Juvenile Offenders: An Examination of the Los Angeles County Probation Department's Novel Solution to the Interrelated Problems of Truancy and (Juvenile) Crime*, 73 S. CAL. L. REV. 879, at 883 n.19 (2000).

130. See NAT'L COUNCIL OF JUVENILE & FAMILY COURT JUDGES, *supra* note 18, at 37–38.

131. See CAL. EDUC. CODE §§ 48260–73 (West 2008).

132. *Id.* § 48260.

133. *Id.* § 48264 (“[A] probation officer may arrest or assume temporary custody, during school hours, of any minor . . . found away from his or her home and who is absent from school without valid excuse . . .”).

134. CAL. WELF. & INST. CODE § 601 (West 2008) (“[I]f a minor has four or more truancies within one school year as defined in Section 48260 of the Education Code . . . the minor is then within the jurisdiction of the juvenile court which may adjudge the minor to be a ward of the court.”).

135. CAL. EDUC. CODE § 48900 (West 2008).

136. See NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 1–6 (discussing general views of children with ADHD).

ADHD is much more complicated.¹³⁷ Untreated ADHD children do find it difficult to concentrate.¹³⁸ Many ADHD children do poorly in school.¹³⁹ Difficulty in school is compounded by the frustration that ADHD youth feel when they try to do their work.¹⁴⁰ If the ADHD student is fidgety and hyperactive, the student can be a distraction to other students and disruptive in the classroom, resulting in further isolation.¹⁴¹ The low self-esteem that results from these effects is often an underlying cause of disruptive behavior.¹⁴²

Furthermore, ADHD adversely affects a youth's relationships at school, with teachers and with peers.¹⁴³ In particular, the disorder's incongruities can prematurely fracture the bond of trust between teacher and student.¹⁴⁴ For instance, ADHD youth may be able to organize a complex party with entertainment for a group of fifty friends in short order, yet they struggle to organize words in a list or materials in their lockers.¹⁴⁵ Similarly, many ADHD youth struggle with procrastination, but kick into overdrive the night before a deadline, and churn out a beautiful project by working through the night.¹⁴⁶ Consequently, others perceive ADHD behaviors as weak will and poor work ethic, not inability.¹⁴⁷ This accounts for the common misperception of

137. *See id.* at 7–12.

138. Barkley et al., *supra* note 70, at 752.

139. *Id.*

140. *See* NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 5 (discussing feelings commonly felt by ADHD children in social settings); RAFALOVICH, *supra* note 12, at 96.

141. *See* RAFALOVICH, *supra* note 12, at 96; Barkley et al., *supra* note 70, at 757–60 (explaining ADHD students behavior in the classroom).

142. *See* RAFALOVICH, *supra* note 12, at 96; Barkley et al., *supra* note 70, at 757–60 (explaining teachers' perceptions of ADHD students and potential reasons for ADHD students' delinquent behavior).

143. *See generally* NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 3; RAFALOVICH, *supra* note 12, at 96.

144. *See* RAFALOVICH, *supra* note 12, at 98; Barkley et al., *supra* note 70, at 757 (reporting the results of a teacher survey indicating that ADHD students are more likely to misbehave in class than non-ADHD students).

145. *See generally* EDWARD M. HALLOWELL & JOHN J. RATEY, *DRIVEN TO DISTRACTION: RECOGNIZING AND COPING WITH ATTENTION DEFICIT DISORDER FROM CHILDHOOD THROUGH ADULTHOOD* 221–25 (1994) (discussing ADHD individuals' problems with organization); NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 5–6.

146. *See* HALLOWELL & RATEY, *supra* note 145, at 221–25; Jonathan Mooney, *Procrastination at School: Helping ADHD Students Cram for Tests*, <http://www.additudemag.com/adhd/article/3238.html> (last visited Dec. 18, 2008).

147. *See generally id.* at 221–25 (observing societal perceptions of individuals with ADHD).

ADHD sufferers as lazy.¹⁴⁸ To teachers and fellow students, it appears that ADHD students simply do not apply themselves.¹⁴⁹

Finally, many ADHD youth exhibit reckless behavior at school that appears antisocial.¹⁵⁰ While there are legitimate thrills in amusement parks and skateboard runs, behaviors such as tailgating (using the bumper of a passing car for a tow while on a skateboard or rollerskates), reckless stunts (such as jumping off rooftops), or engineering small explosions (cherry bombs and firecrackers) can place youth in the purview of the law.

Brain chemistry, however, provides a distinctly amoral explanation for some of this behavior, if we recall that ADHD can be treated with medicines that increase dopamine levels.¹⁵¹ ADHD youth may work better when excited because, biologically, excitement increases dopamine production.¹⁵² Higher levels of dopamine facilitate blood flow to the frontal lobe.¹⁵³ Therefore, many ADHD students often excel at tasks they find exciting,¹⁵⁴ but protest inability when asked to complete tasks that are more mundane.¹⁵⁵

Unable to peer into the brain itself, teachers often instruct ADHD students to “try harder” and “concentrate” without understanding how difficult it is for an ADHD student to concentrate any harder and achieve results.¹⁵⁶ Such encouragement is no different than asking a blind person to try harder when he protests he cannot read a printed page. The child continues to insist that he cannot, yet the teacher believes he just will not. Aside from the inner turmoil this may create, this treatment by teachers and others can lead to low self-esteem and a

148. See *id.* at 43 (discussing the stereotype of individuals with ADHD that they are lazy).

149. See *id.*

150. See Barkley et al., *supra* note 70, at 757–60.

151. See Hunt, *supra* note 84.

152. CNN, *Fuzzy Brain? Improve Your Attention Span*, <http://www.cnn.com/2008/HEALTH/11/14/rs.increase.your.attention.span> (last visited Dec. 18, 2008) (quoting Lucy Jo Palladino, Ph. D. who stated: “When dopamine levels rise, you subconsciously want more of the good feeling it gives you, so you’re driven to concentrate on whatever you’re doing to keep getting it.”).

153. See Boong-Nyun Kim et al., *supra* note 103, at 23.

154. See Rouse & Goldstein, *supra* note 82, at 54 (“When tasks are interesting, [ADHD youths’] capacity to sustain attention may be equal to their peers.”).

155. See *id.* (“As tasks become less interesting . . . their performance drops off sooner.”).

156. See *id.* (“Children with ADHD are able to learn but they have difficulty performing in school due to the impact of ADHD symptoms upon efficient school performance.”).

profound feeling of being misunderstood.¹⁵⁷

Consciously or subconsciously, low dopamine may also drive some ADHD youth and adults to be risk-takers and to seek out exciting situations.¹⁵⁸ In a way, one could say that children who engage in risky behavior are self-medicating, using a sort of pharmacy in their brains because exciting situations result in increased dopamine production.¹⁵⁹ Thus, for ADHD youth, the disruptive behavior, frustrated outbursts, and risk taking behavior can all be related to the neurological disorder.

B. Involvement in Violent Incidents and Missing Social Cues

Another area in which ADHD behaviors intersect with offenses is violent incidents. Paradoxically, ADHD youth do not test high for aggression,¹⁶⁰ yet often show a greater tendency to be involved in fights; ADHD youth seem to "find themselves" in fights and later say "I didn't do anything."¹⁶¹ This makes sense. Communication is complex, encompassing not only spoken words, but body language, intonation, facial expressions, and context.¹⁶² These social cues are vitally important to building relationships,

157. See HALLOWELL & RATEY, *supra* note 145, at 157 (describing how the ADHD experience can be "living with an overflow of energy but an undersupply of self esteem").

158. See Nita A. Farahany & James E. Coleman, Jr., *Behavioral Genetics: The Science of Antisocial Behavior*, 69 LAW & CONTEMP. PROBS. Winter/Spring 2006, at 7, 37 (describing a correlation between dopamine-related enzymes and impulsive and risk-taking behaviors).

159. CNN, *supra* note 152 (noting that exciting and pleasurable experiences lead to a release of dopamine).

160. See generally RAFALOVICH, *supra* note 12, at 97 (stating ADHD children's tendency to fight is not always the result of neurological dysfunction); Kathleen E. McKay & Jeffrey M. Halperin, *ADHD, Aggression, and Antisocial Behavior Across the Lifespan*, 931 ANNALS NEW YORK ACAD. SCI. 84, 85–86 (2001) (describing a "subset" of ADHD children who demonstrate a pattern of "impulse aggression").

161. See RAFALOVICH, *supra* note 12, at 97 (stating that while children with ADHD are frequently involved in playground fights, they are not always the ones starting them; the altercations stem from communication and social barriers); see generally Stephen Rothenberg, *Nonverbal Learning Disabilities and Social Functioning*, GAZETTE J. LEARNING DISABILITIES ASSOC. MASS., Oct.–Nov. 1998 (describing how children with nonverbal learning disabilities struggle to discern social cues during interactions with others).

162. See generally Shattell et al., *supra* note 70, at 51–54 (describing some ADHD children's problems with friendships and suggesting that the problems, in part, are due to difficulty following rules of social interaction); Leanne M. Williams et al., *Misinterpreting Emotional Expressions in Attention Deficit/Hyperactivity Disorder: Evidence for a Neural Marker and Stimulant Effects*, 63 BIOLOGICAL PSYCHIATRY 917, 917 (2008) ("Facial expressions of emotion are innate and biologically salient signals of emotion central to human social interaction and pertinent to the study of emotional function.") (footnote omitted).

and equally important in avoiding altercations.¹⁶³ Since ADHD youth suffer from distractibility, they tend to miss social cues.¹⁶⁴ ADHD sufferers may not hear conciliatory words like “look” and “I only meant to,” or may not hear them in the same way.¹⁶⁵ Similarly, an ADHD sufferer may miss subtle conciliatory body language, like stepping back, or moving one’s arms down.¹⁶⁶ As a result, ADHD youth may continue to think that they are being threatened when the threat has already dissipated.¹⁶⁷ Therefore, instead of culminating, the conflict may escalate again.

A fight on school property is grounds for expulsion under section 48900 of the California Educational Code.¹⁶⁸ Concurrently, such expulsion can result in a referral to the juvenile justice system under section 601 of the California Welfare and Institutions Code.¹⁶⁹ Alongside this, section 241.2 of the California Penal Code covers assault and battery and section 415.5 criminalizes fights on school property.¹⁷⁰ Criminal offenses committed by juveniles are within the jurisdiction of the juvenile court under section 602 of the California Welfare and Institutions Code.¹⁷¹ Criminal offenses, and particularly violent ones, are

163. J. Marlene Snyder, *ADHD: Separating Fact from Fiction*, JUV. & FAM. CT. J. 39, 43 (2001).

164. *Id.*; see generally Nancy Cowardin, *Disorganized Crime: Learning Disability and the Criminal Justice System*, CRIM. JUST. Summer 1998, at 11, 13 (describing possible effects of social miscues on teens in conflicts); Shattell et al., *supra* note 7069, at 51–54 (describing some ADHD children’s problems with friendships and suggesting the problems, in part, are due to difficulty following rules of social interaction); Williams et al., *supra* note 162, at 1.

165. See generally RAFALOVICH, *supra* note 12, at 97 (attributing some fights involving ADHD children to communication and social barriers); Cowardin, *supra* note 164, at 13 (describing possible effects of social miscues on conflicts). *But see* Hinshaw, *supra* note 83, ch. 5, at 11 (stating that social difficulties of children with ADHD “do not appear related specifically to deficits in social knowledge or social skill . . . their deficits are ones of performance rather than knowledge, or implementation of skills rather than skills per se”).

166. See generally RAFALOVICH, *supra* note 12, at 97 (attributing some fights involving ADHD children to communication and social barriers); Cowardin, *supra* note 164, at 13 (describing possible effects of social miscues on conflicts). *But see* Hinshaw, *supra* note 83, ch. 5, at 11.

167. See generally HALLOWELL & RATEY, *supra* note 145, at 52–53 (“People with ADD often do not pick up on the subtle social cues and messages that are crucial in getting along with others.”); RAFALOVICH, *supra* note 12, at 97; Cowardin, *supra* note 164, at 13. *But see* Hinshaw, *supra* note 83, ch. 5, at 11.

168. CAL. EDUC. CODE § 48900 (West 2008).

169. CAL. WELF. & INST. CODE § 601 (West 2008) (stating that a minor is within the juvenile court’s jurisdiction if he or she persistently or habitually refuses to obey reasonable and proper orders or directions of school authorities).

170. CAL. PENAL CODE § 241.2(a)(1) (West 2008); CAL. PENAL CODE § 415.5(a) (West 1999).

171. CAL. WELF. & INST. CODE § 602 (West 2008).

appropriately viewed as much more serious than status offenses.¹⁷² In fact, if a fight was serious, and characterized as a felony, it could lead to a juvenile being found unfit for treatment.¹⁷³

While we must take violent offenses seriously, it is equally important that we understand that ADHD youth may engage in this behavior due in part to their developmental disorder, specifically because they failed to apprehend social cues. Under the California statutes, their involvement with violent offenses will classify them with individuals who are anti-social, even if their involvement was not the result of an anti-social personality.

C. *Illegal Substance Use and Self-Medication*

ADHD related behavior also overlaps with delinquent conduct in the realm of illegal substance use.¹⁷⁴ Though ADHD youth are not necessarily genetically predisposed to alcoholism or drug addiction, they are more prone to using illegal and intoxicating substances as a coping response.¹⁷⁵

Individuals with all manner of medical disorders often self medicate through a variety of substances.¹⁷⁶ ADHD sufferers are no different. Research shows that ADHD youth tend to self-medicate to treat their anxiety and their depression, the two most common comorbid ailments.¹⁷⁷ Some estimate that as many as seventy-five percent of ADHD sufferers also suffer from

172. Compare CAL. BUS. & PROF. CODE § 25662(a) (West, Supp. 2008) (stating that underage alcohol possession is subject to a \$500 fine and community service on second offense) with CAL. PENAL CODE § 241.2(a)(1) (stating that assault on school property is punishable by up to \$2,000 fine and one year in jail).

173. CAL. WELF. & INST. CODE § 707(a)(2)(A) (West 2008) (noting when a minor will be declared unfit for treatment). This statute states:

[t]his paragraph shall apply to a minor alleged to be a person described in Section 602 by reason of the violation, when he or she has attained 16 years of age, of any felony offense when the minor has been declared to be a ward of the court pursuant to Section 602 on one or more prior occasions if both of the following apply: (i) The minor has previously been found to have committed two or more felony offenses.; (ii) The offenses upon which the prior petition or petitions were based were committed when the minor had attained 14 years of age.

Id.

174. See Molina & Pelham, *supra* note 119, at 504 (finding that severity of childhood inattention symptoms predict future substance use and abuse).

175. See Daniela Plume, *The Self-Medication Hypothesis: ADHD & Chronic Cocaine Abuse*, <http://www.addcentre.co.uk/selfmedcocaine.htm> (last visited Dec. 17, 2008) (stating that one study found that cocaine abusers with ADHD tend to be younger at the time of first treatment and report earlier onset of abuse, while another study found greater drug use among ADHD youth).

176. See *id.*

177. See *id.*

depression,¹⁷⁸ with as many as forty-four percent suffering from anxiety.¹⁷⁹ Depression and anxiety do not manifest in criminal behavior, but they do exacerbate the challenges of living with ADHD.¹⁸⁰ In fact, doctors commonly prescribe anti-depressants alongside Ritalin, Adderall, or other ADHD medication.¹⁸¹ Some studies indicate a propensity of ADHD youth, particularly the undiagnosed, to experiment earlier with marijuana and alcohol, both of which depress the nervous system and alleviate anxiety.¹⁸²

Here too, the ADHD related behavior overlaps with delinquent behavior. Underage alcohol possession is prohibited under section 25662 of the California Business and Professions Code, which provides:

(a) Any person under the age of 21 years who has any alcoholic beverage in his or her possession on any street or highway or in any public place or in any place open to the public is guilty of a misdemeanor A second or subsequent violation shall be punishable as a misdemeanor¹⁸³

Section 11357 of the California Health and Safety Code speaks specifically to the possession and use of marijuana by youth on school property:

(e) Except as authorized by law, every person under the age of 18 who possesses not more than 28.5 grams of marijuana . . . upon the grounds of, or within, any school [K-12] . . . is guilty of a misdemeanor and shall be subject to the following dispositions:

(1) A fine of not more than two hundred fifty dollars (\$250), upon a finding that a first offense has been committed.

(2) A fine of not more than five hundred dollars (\$500), or commitment to a juvenile hall, ranch, camp, forestry camp, or secure juvenile home for a period of not more than 10 days, or both, upon a finding that a second or

178. See Barkley, *supra* note 118, ch. 4 at 7 (finding an ADHD-depression comorbidity range of fifteen percent to seventy-five percent); Joseph Biederman et al., *Psychiatric Comorbidity Among Referred Juveniles with Major Depression: Fact or Artifact?*, 34 J AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 579, 585-86 (1995) (discussing the ADHD-depression correlation).

179. See Barkley, *supra* note 118, ch. 4 at 7.

180. See generally Timothy E. Wilens, *Attention Deficit Hyperactivity Disorder and Substance Use Disorders—The Nature of the Relationships, Subtypes at Risk, and Treatment Issues*, in JENSEN & COOPER, *supra* note 72, ch. 19, at 1-2 (describing the risk of substance-use disorders in ADHD patients).

181. See generally NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 24 ("Other types of medication may be used if stimulants don't work or if the ADHD occurs with another disorder. Antidepressants and other medications can help control accompanying depression and anxiety.").

182. Wilens, *supra* note 180, ch. 19, at 8.

183. CAL. BUS. & PROF. CODE § 25662(a) (West Supp. 2008).

subsequent offense has been committed.¹⁸⁴

Whether ADHD youth are prosecuted for a status offense involving alcohol or for a criminal offense involving marijuana, both types of illicit self-medication lead to juvenile court by virtue of section 602 of the Welfare and Institutions Code.¹⁸⁵

ADHD youth can also self-medicate for their attention deficit symptoms.¹⁸⁶ In this case, self-medication involves the more serious street drug, cocaine.¹⁸⁷ Cocaine increases dopamine production in the brain and suppresses dopamine reuptake.¹⁸⁸ Cocaine also increases norepinephrine production and suppresses its reuptake.¹⁸⁹ Indeed, cocaine actually functions just like methylphenidate, only faster.¹⁹⁰

If an undiagnosed ADHD youth uses cocaine, he derives the same benefits from cocaine that he would from Ritalin – higher dopamine levels.¹⁹¹ In the ADHD brain, cocaine actually operates to approximate normal brain function.¹⁹² ADHD patients likely do not experience the same euphoric high of other cocaine users;¹⁹³ instead, they experience the “high” of normal brain function.¹⁹⁴ One can only imagine what this must be like for a child of fourteen or fifteen who has been struggling with ADHD for his entire life.

184. CAL. HEALTH & SAFETY CODE § 11357(e) (West 2007).

185. See CAL. WELF. & INST. CODE § 602 (West 2002).

186. See Wilens, *supra* note 180, ch. 19, at 8–9 (discussing self-medication as a “likely factor” for substance-use disorders in individuals with ADHD, although other reasons may explain the correlation).

187. See Nadine M. Lambert, *Stimulant Treatment as a Risk Factor for Nicotine Abuse and Substance Abuse*, in JENSEN & COOPER, *supra* note 72, ch. 18, at 4 (listing studies that indicate self-medicating cocaine use).

188. See Plume, *supra* note 175 (describing the effects of cocaine).

189. See B. Jill Venton et al., *Cocaine Increases Dopamine Release by Mobilization of a Synapsin-Dependent Reserve Pool*, 26 J. OF NEUROSCIENCE 3206, 3208 (2006).

190. See GENETICS SCIENCE LEARNING CENTER, THE UNIVERSITY OF UTAH, *RITALIN AND COCAINE: THE CONNECTION AND THE CONTROVERSY* (2008) (stating that prescription medicines take longer to reach the brain than cocaine); Plume, *supra* note 175 (describing the effects of cocaine). This might explain Ritalin’s street value. See Karen Blumenschein, *Prescription Drug Diversion: Fraudulent Tactics Utilized in the Community Pharmacy*, 61 AM. J. OF PHARMACEUTICAL ED. 184, 185 tbl.1 (1997) (noting that the street value of Ritalin is five dollars per five milligrams).

191. See GENETICS SCIENCE LEARNING CENTER, *supra* note 190 (describing the effects of prescription medicines and cocaine).

192. See Plume, *supra* note 175 (describing the effects of cocaine and self-medication theories); see generally Johnston, *supra* note 117, ch. 6, at 12 (indicating that some studies point to self-medication as a reason for cocaine use by adults with ADHD).

193. See Plume, *supra* note 175 (describing some case studies of cocaine users with ADHD).

194. *Id.*

Suddenly, he is able to think clearly, finish a task in record time, actually absorb everything going on around him, and still carry on a conversation. For these youth, the first experience with normal brain function must be remarkable. Logically, the therapeutic effect of cocaine in ADHD users means that they will use more often,¹⁹⁵ and thus are more likely to get caught.

When ADHD youth try cocaine, they are really getting something like a medicine, not a stimulant high as others experience.¹⁹⁶ This claim is borne out by studies.¹⁹⁷ One 1999 study found that ADHD patients on medication were eighty-five percent less likely than those not on medication to develop substance abuse disorders.¹⁹⁸ Additionally, the same study found that unmedicated ADHD patients were six times more likely to develop substance abuse disorders.¹⁹⁹ Indeed, there is anecdotal evidence that even diagnosed ADHD patients sometimes choose cocaine for self-medication instead of prescription drugs.²⁰⁰

195. *Id.*

196. See GENETICS SCIENCE LEARNING CENTER, *supra* note 190 (describing the effects of prescription medicines and cocaine); see also Plume, *supra* note 175 (describing case studies of ADHD cocaine users).

197. See generally Joseph Biederman et al., *Pharmacotherapy of Attention-Deficit/Hyperactivity Disorder Reduces Risk for Substance Use Disorder*, 104 PEDIATRICS 2, e20 (1999), available at <http://pediatrics.org/cgi/content/full/104/2/e20> (noting the higher risk of substance use disorders among those with ADHD); see also Plume, *supra* note 175 (describing case studies of ADHD cocaine users). But cf. Biederman et al., *supra* (noting that conclusions should not be drawn regarding non-White subjects).

198. Biederman et al., *supra* note 197, at 1.

199. *Id.*

200. See Plume, *supra* note 175 (describing case studies of cocaine users with ADHD); see also posting of ML Mountjoy to http://www.myomancy.com/2006/05/stim_nation_rit (June 8, 2006, 10:15). The post states:

[I] have been told by cocaine users that methylphenidate gives exactly the same effect. [I] know 2 coke users who have ADD/ADHD and who admittedly self-medicate rather than seeking a prescription (so they can use it "only when they need it"). This would suggest that the need for the drug is created by the condition of the body, except for the matter of all of the other illicit drug users. Are we to suppose that they "need" the drugs too?

As for the crash after the high, it is less pronounced with methylphenidate, but the effect is still definitely there. It is in fact used by many professionals to convince parents to keep their child on medication, by recommending short holidays of a few days or a week off the drug, and then saying, "Now you see how he behaves without it, so he is not ready to stop taking it yet." I can vouch for the reality of the rebound effect. I took Ritalin for 3 months, then stopped because all of my carefully developed coping strategies were going out the window, and I didn't want to be dependant [sic] on the drug. I found myself useless if I missed a day's dosage. After I stopped, I had two weeks of being completely unable to concentrate. I was 22, and

But all this statistical evidence is unlikely to make much difference to a police officer who finds a youth with cocaine. If the youth is caught on school grounds with cocaine, school authorities can suspend him and are further obligated to report the incident to law enforcement.²⁰¹

Clearly, many ADHD-related behaviors overlap with behaviors defined as delinquent and criminal.²⁰² Because of this overlap, it is highly likely that numerous ADHD youth, particularly the undiagnosed, are being swept into the juvenile justice system. This helps explain the significant number of youth in custody that are reported to have ADHD.²⁰³ Since their behaviors are manifestations of the disorder, criminalizing these youth is essentially criminalizing the disorder. But while ADHD is a significant risk factor for delinquent behavior, diagnosis and treatment can significantly reduce the chances that ADHD youth will engage in criminal behavior.²⁰⁴ Given the rehabilitative mandate of the juvenile justice system, diagnosing and treating the disorder is vitally important.

climbing furniture, unable to hold a conversation, getting distracted and wandering off at work [-] I had not been that bad since [I] was a kid! It was very embarrassing. I have friends who were put on Ritalin (not necessarily for ADHD) as children, but are stuck on it as adults because they can't afford the time off work to come off the drug.

Id.

201. CAL. EDUC. CODE § 48902 (West 2006). The statute states:

[n]otification of law enforcement authorities, liability for making report; failure to notify; penalty; exceptional needs children

(b) The principal of a school or the principal's designee shall, within one school day after suspension or expulsion of any pupil, notify, by telephone or any other appropriate method chosen by the school, the appropriate law enforcement authority of the county or the school district in which the school is situated of any acts of the pupils that may violate subdivision (c) or (d) of Section 48900.

(c) Notwithstanding subdivision (b), the principal of a school or the principal's designee shall notify the appropriate law enforcement authorities of the county or city in which the school is located of any acts of a student that may involve the possession or sale of narcotics or of a controlled substance or a violation of Section 626.9 or 626.10 of the Penal Code.

Id.

202. *See, e.g.*, CAL. PENAL CODE § 241.2 (West 2008); CAL. WELF. & INST. CODE § 601 (West 2008); Molina & Pelham, *supra* note 119, at 502-05.

203. *See* Chemers, *supra* note 122, ch. 25, at 3 (stating that one study found ADHD present in seventy-six percent of incarcerated male juveniles and sixty-eight percent of females); *see generally* Kamradt, *supra* note 14, at 17 (stating that forty-four percent of youth in the Wraparound Milwaukee program were diagnosed with attention deficit).

204. *See* Chemers, *supra* note 122, ch. 25, at 4 ("Early diagnosis and treatment of conduct disorders are an important key to preventing future delinquency.").

IV. Being a Poor Kid of Color – Barriers to Diagnosis

The criminalization of ADHD alone does not explain the racial disparity among incarcerated youth. In fact, we not only criminalize a treatable disease among our youth, we do so in a discriminatory manner.²⁰⁵ Disparities in ADHD diagnosis are significant, particularly along racial and/or socioeconomic lines.²⁰⁶ Though both affluent and underprivileged children are equally at risk for ADHD, affluent children, most of whom are White, are much more likely to be diagnosed,²⁰⁷ and that diagnosis may be the key to freedom in the juvenile justice system.²⁰⁸ The court's involvement does not alleviate these disparities, despite strong statutory evidence that this is exactly what the court is supposed to do.²⁰⁹ Although ADHD is considered treatable and manageable, for those who escape diagnosis and land in legal trouble, the court deems their conduct criminal, not medical.²¹⁰

One significant barrier to detecting all children with ADHD is the diagnostic method itself.²¹¹ Unlike diabetes or a broken bone, there is no simple blood test or x-ray to diagnose ADHD.²¹²

205. Isaacs, *supra* note 6, at 150–51 (noting that race, socioeconomic background, and mental health influence demographics in the juvenile justice system).

206. See Bussing et al., *supra* note 115, at 181–82 (noting that White children had twice the chance of Black children of being evaluated, diagnosed, and treated for ADHD).

207. See Jack Stevens et al., *Race/Ethnicity and Insurance Status as Factors Associated with ADHD Treatment Patterns*, 15 J. CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY 88, 91 (2005); see generally Bussing et al., *supra* note 115, at 181–82 (noting that White children had twice the chance of Black children to be evaluated, diagnosed, and treated for ADHD).

208. See generally GABRIELLE WEISS & LILY TROKEN HECHTMAN, *HYPERACTIVE CHILDREN GROWN UP: EMPIRICAL FINDINGS AND THEORETICAL CONSIDERATIONS* 56–57 (1986) (comparing arrest rates for hyperactive children across economic classes and finding more multiple arrests in the lowest economic class).

209. See, e.g., CAL. WELF. & INST. CODE § 202 (West 2002) (stating rehabilitative goals of juvenile court).

210. See, e.g., CAL. PENAL CODE § 241.2 (West 2008) (stating that “no minor shall be relieved of attending counseling because of the minor’s parents’ inability to pay for the counseling imposed by this section”); CAL. WELF. & INST. CODE § 601 (West 2008) (discussing when truancy may result in the child becoming a ward of the court).

211. See Bussing et al., *supra* note 115, at 186 (mentioning poverty as a barrier to care).

212. See Bruce M. Familant, *The Essential Functions of Being a Lawyer with a Non-Visible Disability: On the Wings of a Kiwi Bird*, 15 T.M. COOLEY L. REV. 517, 530–31 (1998) (stating that ADHD diagnosis is entirely clinical and depends on an expert’s experience); see also Larry B. Silver, *Clinical Diagnosis of ADHD, A Medical Perspective*, in ATTENTION DEFICIT HYPERACTIVITY DISORDER: THE CLINICAL SPECTRUM, *supra* note 80, at 87 (“Unfortunately, there are no specific physical examination findings . . . that establish the diagnosis.”).

While positron emission tomography (PET) scans might be definitive, they are generally used only for research, not diagnosis.²¹³ Instead, doctors diagnose ADHD through a series of tests and interviews, many of which pose significant barriers for underprivileged families.²¹⁴ An overview of the diagnostic process is therefore instructive.

A. *The Diagnostic Process*

To begin, someone must alert a physician to a child's possible ADHD.²¹⁵ If a parent or teacher has not identified a concern, and if the child does not identify a concern, then it may never come to the attention of health professionals.²¹⁶ Once a physician is alerted, there is a long road ahead to diagnosis. Initially, the physician distributes questionnaires to family members (parents, siblings, grandparents, etc.) and teachers.²¹⁷ Generally, for a positive diagnosis, ADHD symptoms should be consistently present prior to age seven in more than one setting (i.e. at school and at home).²¹⁸ Numerous types of questionnaires and checklists exist for teachers to evaluate students, and they all include many questions relating to classroom performance.²¹⁹

213. A number of clinics that provide SPECT analysis for the purposes of diagnosis have sprung up. See, e.g., <http://www.brainmattersinc.com> (last visited Dec. 17, 2008) (providing information regarding a corporation that provides technology for SPECT imaging); <http://www.amenclinics.com> (noting the clinics now operated by Dr. Amen after his innovative studies on SPECT scans). But see NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 16 (stating that researchers stress PET and other imaging tests are research tools "and cannot be used to diagnose ADHD in any given child"); CNN *Study: ADHD Kids' Brain Areas Develop Slower*, CNN, Nov. 11, 2007, <http://www.cnn.com/2007/HEALTH/conditions/11/12/adhd.brain.ap/index.html> (describing ADHD diagnosis as clinical and stating that brain imaging is not ready for use diagnostically).

214. See Bussing et al., *supra* note 115, at 185 (stating that if Medicaid is not accepted, that can be a barrier to care); see generally Gerald A. Gioia & Peter K. Isquith, *New Perspectives on Educating Children with ADHD: Contributions of the Executive Functions*, 5 HEALTH CARE L. & POLY 124, 130 (2002) (noting the cost barriers to diagnosis).

215. OFFICE OF SPECIAL EDUC. PROGRAMS, U.S. DEPT OF EDUC., IDENTIFYING AND TREATING ATTENTION DEFICIT HYPERACTIVITY DISORDER: A RESOURCE FOR SCHOOL AND HOME 8-9 (2003) [hereinafter U.S. DEPT OF EDUC., IDENTIFYING AND TREATING].

216. See *id.* at 9 (finding parents and teachers are the two most common identifying parties of ADHD).

217. See *id.* at 6.

218. See *id.* at 3 (discussing the different criteria used to diagnose ADHD).

219. Bruce K. Shapiro, *The Use and Abuse of Behavior Checklists*, in ATTENTION DEFICIT HYPERACTIVITY DISORDER: THE CLINICAL SPECTRUM, *supra* note 80, at 78-80 [hereinafter Shapiro, *Checklists*].

The physician reviews the questionnaires for a consistent pattern of ADHD symptoms across external circumstances (including settings or life changes).²²⁰ If this pattern exists, the physician interviews the child to look for signs of ADHD.²²¹ Most often, however, more than one interview is necessary.²²² Many children appear symptom-free in the first interview because it represents a new situation, and they are on their guard.²²³ Sometimes, instead of manifesting inattention in the first visit, children exhibit “hyperfocus,”²²⁴ an ability to attain a heightened state of focus in high pressure situations.²²⁵ This is consistent with increased dopamine production in exciting or stressful situations.²²⁶ Therefore, often it is only after physicians develop a rapport with the child that they can personally observe inattentive behavior.²²⁷

Another test sometimes used by physicians to assess ADHD is the Test of Variables of Attention (T.O.V.A.).²²⁸ The T.O.V.A. takes approximately twenty-two minutes to administer, but cannot replace written questionnaires and personal interviews.²²⁹ The T.O.V.A. remains an accepted testing method in the field, although its reliability is unproven.²³⁰ Most physicians use the

220. See NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 10 (discussing how sudden life changes can trigger ADHD-like behavior in children).

221. See Shapiro, *Checklists*, *supra* note 219, at 81–83 (outlining the diagnostic process).

222. See *id.* at 82 (discussing the depth to which physicians go in diagnosing ADHD).

223. See NAT'L INST. OF MENTAL HEALTH, *supra* note 15, at 11 (noting that evaluating children for ADHD needs to be done in different settings, with different stimuli, in order to see how they react over a spectrum of restrictiveness); Shapiro, *Checklists*, *supra* note 219, at 75.

224. Royce Flippin, *Learn About ADHD: Focus on Hyperfocus*, ADDITUDE, Oct. – Nov. 2005, available at <http://www.additudemag.com/adhd/article/612.html> [hereinafter Flippin, *Hyperfocus*] (describing how this heightened state of focus can become so intense that children become unaware of the world around them).

225. LARRY B. SILVER, ATTENTION DEFICIT/HYPERACTIVITY DISORDER: A CLINICAL GUIDE TO DIAGNOSIS AND TREATMENT FOR HEALTH AND MENTAL HEALTH PROFESSIONALS 35 (3d. 2004) [hereinafter SILVER, CLINICAL GUIDE].

226. See *supra* notes 154, 155 and accompanying text.

227. See *id.* at 35.

228. THE TOVA COMPANY, ABOUT THE T.O.V.A.: INTRODUCING THE T.O.V.A. (TEST OF VARIABLES OF ATTENTION), <http://www.tovatest.com/about-the-t-o-v-a/> (last visited Nov. 13, 2008) [hereinafter TOVA COMPANY, INTRODUCING] (“The T.O.V.A. is the most widely used objective measure of attention in the world, and is considered the ‘Gold Standard’ among measures of its type.”).

229. See ADHDtesting.org, A Real Look Inside the Issue, <http://ADHDTesting.org/tova.htm> (last visited Oct. 10, 2008) (discussing the unreliable results of TOVA and its inability to prove the existence of ADHD).

230. Compare ROBERT A. LEARK, LAWRENCE M. GREENBERG, CAROL L. KINDSCHI, TAMMY R. DUPUY, STEVEN J. HUGHES, THE TOVA COMPANY, T.O.V.A.

T.O.V.A. examination to confirm ADHD diagnoses and to assess ADHD's degree, rather than its presence.²³¹

B. Barriers to Diagnosis for Poor Youth of Color

There is great debate over the under-diagnosis of ADHD.²³² Many children are never diagnosed because of the numerous barriers to diagnosis,²³³ and many others are incorrectly diagnosed because they are assessed by teachers, psychologists, and general practitioners who lack sufficient background or training in ADHD.²³⁴ This makes sense when one considers the long and complex process required to effectively diagnose ADHD.²³⁵ The complexities of the diagnostic process itself can reduce the likelihood that poor youth will receive accurate diagnoses. For someone like Billy, our poor Black youth facing an assault charge, there are many barriers:

1. Families must find a physician capable of diagnosing ADHD and then be able to pay that physician.²³⁶

PROFESSIONAL MANUAL TEST OF VARIABLES OF ATTENTION CONTINUOUS PERFORMANCE TEST 18-30 (Feb. 27, 2007), *available at* http://www.tovatest.com/manuals/tova_7_3_Professional_Manual_2007_02_27.pdf (offering data to support reliability indicia), *with* ADHDtesting.org, A Real Look Inside the Issue, <http://ADHDTesting.org/tova.htm> (last visited Oct. 10, 2008) (arguing that TOVA is unreliable in diagnosing ADHD). The article stated:

The TOVA has been determined to be unreliable as an indicator of ADD/ADHD. No State or Local Government, or Federal Government Agency (NIH, CDC, FDA, DHE&W) has approved, certified, authenticated or validated this test as being able to determine the presence of ADD/ADHD in life or at autopsy. Nor has the test Manufacturer provided us with a US Government Certificate of Compliance proving the tests [sic] validity and or acceptance.

Id.

231. TOVA COMPANY, INTRODUCING, *supra* note 228 (“[A]s is true with all tests, the T.O.V.A. does not make a diagnosis - only a clinician does.”).

232. *See generally* Mark A. Stein, *ADHD in Primary Care: Over diagnosed, Under treated, and Frequently Misunderstood*, in ATTENTION DEFICIT HYPERACTIVITY DISORDER: THE CLINICAL SPECTRUM, *supra* note 80, at 51-69 [hereinafter Stein, *Misunderstood*] (discussing the potential over- and under-diagnoses of children based upon, among other things, access to resources and adult tolerance for misbehavior).

233. *See id.* at 53 (“It appears that ADHD is often under-diagnosed in inner city and rural areas where there is less access to treatment, and where numerous economic and sociocultural barriers to treatment exist, such as clinician and parent biases against stimulant treatment for behavior disorders such as ADHD.”).

234. *See generally* Silver, *supra* note 21280, at 87-101 (stating that “the reason some children and adolescents are misdiagnosed with ADHD is that the clinician involved . . . does not use the appropriate approach for making the diagnosis”).

235. *See id.* (discussing the process of establishing a clinical history).

236. *See* Stein, *Misunderstood*, *supra* note 232, at 63 (discussing the complexity and cost of multidisciplinary evaluations, and how independent testing may not be covered by insurance).

Unfortunately, many poor families do not have health insurance.²³⁷

2. Even with health insurance, many programs do not cover mental health needs²³⁸ and do not honor referrals to specialists (child psychiatrists, for instance) if they consider a general practitioner to be adequate.²³⁹ Though there are many problems associated with having general practitioners diagnose ADHD,²⁴⁰ many insurance companies still authorize general practitioners to make the diagnosis.²⁴¹
3. Stigma of mental disorders may prevent families from moving forward with a full diagnostic assessment.²⁴² Some families may feel that the child is already at a disadvantage due to racial or class prejudice, and wish to avoid the added stigma of a mental disorder.²⁴³
4. Finding people to complete the questionnaires can be

237. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, <http://www.census.gov/prod/2007pubs/p60-233.pdf> ("With an uninsured rate in 2006 at 19.3 percent, children in poverty were more likely to be uninsured than all children.").

238. See U.S. DEPT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 418 (1999), *available at* <http://surgeongeneral.gov/library/mentalhealth/pdfs/c6.pdf>. The report states:

[p]rivate health insurance is generally more restrictive in coverage of mental illness than in coverage for somatic illness Federal public financing mechanisms, such as Medicare and Medicaid, also imposed limitations on coverage, particularly for long-term care, of "nervous and mental disease" to avoid a complete shift in financial responsibility from state and local governments to the Federal government.

Id.

239. See Helpguide, Diagnosing ADD & ADHD: Making the Diagnosis in Children and Adults, http://www.helpguide.org/mental/adhd_add_diagnosis.htm (last visited Oct. 7, 2008) (stating that some insurance policies will not cover ADHD evaluations from certain specialists).

240. See New York University Medical Center and School of Medicine, *Adult ADHD Often Undiagnosed by Primary Care Physicians*, June 26, 2003, <http://www.medicalnewstoday.com/articles/3838.php> (finding that nearly one half of primary care physicians do not feel confident in diagnosing ADHD, citing a lack of training and tools to evaluate patients).

241. Stein, *Misunderstood*, *supra* note 232, at 52–53 (stating that a consultation with a pediatric subspecialist is often not covered by insurance carriers, and that ADHD has become one of the most common disorders treated by primary care physicians).

242. See Garza, *supra* note 11, at 89–91 (finding stigmas such as "loner" or "learning disabled" attached to ADHD sufferers).

243. See *id.* at 89 ("Ultimately, ADHD affects a child's self-esteem by creating feelings of vulnerability, inability, and inadequacy. Consequently, several studies show that individuals with ADHD are as much as seven times more likely than others to develop an antisocial personality.").

difficult.²⁴⁴ It is critical that a child be evaluated at both home and school because, according to the DSM IV, symptoms must manifest themselves in more than one setting.²⁴⁵ At the extreme, in cases where families have split up or separated due to foster care and other arrangements, no relative may be available. In addition, finding a teacher who has known the child for several years can also be challenging, especially in poor school districts with high faculty turnover.²⁴⁶

5. Ensuring that the questionnaires are completed is yet another hurdle. Literacy problems and stigma surrounding mental illness may prevent people from filling out the forms.²⁴⁷
6. Personal interviews with physicians are cost-prohibitive.²⁴⁸ Families living in poverty can hardly afford the numerous doctor visits required to diagnose ADHD.²⁴⁹ Even if they can afford the co-pay, the time off work to attend the doctor visits could jeopardize the family's income source.²⁵⁰

Thus, the existing diagnostic barriers (concern about ADHD being a real disorder, locating trained professionals, and the time, money, and overall commitment required for the assessment process) are exacerbated for economically disadvantaged children by stigma, family disintegration, lack of health insurance, poor school districts with high turnover rates, and all the associated costs of the diagnostic process. Underclass youth often escape diagnosis even when a teacher or relative is concerned about ADHD symptoms.²⁵¹

244. See Shapiro, *Checklists*, *supra* note 219, at 83 (discussing the difficulties associated with evaluations from parents and teachers).

245. See DSM-IV-TR, *supra* note 2, at 92.

246. See Jessica Blanchard, *Poor schools have tough time keeping teachers*, SEATTLEPI.COM, Apr. 6, 2005, http://seattlepi.nwsourc.com/local/219000_teachers06.html (finding that poverty rates were among the biggest factors in determining teacher retention, and also discussing a correlation between high minority enrollment and high teacher turnover).

247. See Shapiro, *Checklists*, *supra* note 219, at 84 ("[S]ome respondents cannot read the questionnaire, but will complete it.").

248. See The ADHD Information Library, *Diagnosis of ADHD, Diagnosis of Attention Deficit Disorder*, http://newideas.net/attention_deficit/dianosis/htm (last visited Oct. 10, 2008) [hereinafter Information Library] (discussing the potential cost of an ADHD diagnosis).

249. See *id.* (explaining in detail the depth of analysis necessary to have a reliable ADHD diagnosis).

250. See *id.* (discussing the various time commitments, separate clinical visits, tests, office treatments, and other steps necessary for a diagnosis of ADHD).

251. See Shapiro, *Checklists*, *supra* note 219, at 83 (discussing the many barriers to diagnosis, including the potential obstacle of parents believing that an

For youth of color, racial bias in the medical profession aggravates these barriers.²⁵² Despite the Hippocratic Oath to do no harm, physicians are not immune from harboring racial bias.²⁵³ Several studies report racial bias in the diagnosis and provision of medical services and have pointed out the negative effect on the health of minority communities in general.²⁵⁴ This pattern persists in ADHD diagnosis.²⁵⁵ Although there is no evidence that ADHD is more prevalent in children of one race or another,²⁵⁶ rates of ADHD diagnosis are lower among ethnic minorities.²⁵⁷ In a report based on a sample of more than 6,000 children from a North Carolina county, Latino children were much less likely (4.0%) than African-American children (9.1%) and White children (10.8%) to have been diagnosed with ADHD.²⁵⁸ Other researchers found that, among elementary school students considered at risk for ADHD (as determined by very high scores on parent or teacher rating scales), forty-four percent of Caucasian students had been diagnosed with ADHD, compared to only twenty percent of

observation of possible ADHD behavior is a reflection of poor parenting).

252. See Zito JM et al., *Racial Disparity in Psychotropic Medications Prescribed for Youths with Medicaid Insurance in Maryland*, 37 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 179, 179 (1998) (finding that African American youths receive disparate treatment for their mental disorders).

253. See Samuel R. Bagenstos, *Implicit Bias, "Science," and Antidiscrimination Law*, 1 HARV. L. & POL'Y REV. 477, 477 (2007) [hereinafter Bagenstos, *Implicit Bias*] ("[W]hite Americans, on average, show strong implicit preference for their own group and relative bias against African Americans Interestingly, the studies also show that minorities and women often harbor the same implicit biases against their own group that [W]hites and men harbor against them.") (citations omitted); see also Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequalities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J. L. & MED. 159, 170 (2003) [hereinafter Davoli, *Inn*] (explaining how diagnosis can result from discrimination in access to care).

254. See Bussing et al., *supra* note 115, at 182 tbl. 1 (finding that, as compared to White youths, African American youths are markedly less likely to receive treatment).

255. Andrew S. Rowland, Catherine A. Lesesne & Ann J. Abramowitz, *The Epidemiology of Attention-Deficit/Hyperactivity Disorder (ADHD): A Public Health View*, 8 MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES RES. REV. 162, 166 (2002) [hereinafter Rowland, *Epidemiology*] (citing a study showing little difference between races in diagnosis, but large gaps in treatment of ADHD).

256. See *id.* (stating that there is little evidence to suggest differences in ADHD prevalence among different racial or ethnic groups, but also suggesting that more research is needed).

257. Andrew S. Rowland et al., *Prevalence of Medication Treatment for Attention Deficit-Hyperactivity Disorder Among Elementary School Children in Johnston County, North Carolina*, 92 AM. J. PUB. HEALTH 231, 232 (2002) [hereinafter Rowland, *Prevalence of Medication*]. But see Rowland, *Epidemiology*, *supra* note 255, at 166 (referencing a study showing only small gaps in diagnosis between races).

258. Rowland, *Prevalence of Medication*, *supra* note 257, at 232.

African-American students.²⁵⁹ The 2002 United States Report on Mental Health similarly reported that fifty-one percent of at-risk Caucasian youth received needed evaluations, compared to twenty-eight percent of at-risk African American youth.²⁶⁰

Given the multiple barriers, poor youth of color have a significantly lower chance of obtaining an accurate ADHD diagnosis than White, affluent youth, even when they exhibit exactly the same symptoms.²⁶¹

V. Being a Poor Kid of Color: When Your ADHD is Invisible

The diagnostic hurdles could be overcome if the juvenile justice system were more alert to signs of ADHD.²⁶² The juvenile justice provisions implicitly acknowledge that, for some, a mental disorder may be what is behind delinquent behavior.²⁶³ If a mental disorder is the suspected cause of a juvenile's delinquent behavior, the juvenile court may divert the child toward other methods of rehabilitation.²⁶⁴ Unfortunately, several factors can obscure ADHD in the court's assessment.²⁶⁵ These factors fall mainly along racial and socioeconomic divides.²⁶⁶

Juvenile courts are particularly attuned to social factors that might lead a youth to criminal activity.²⁶⁷ After all, one of the system's initial premises was that juveniles committed crimes

259. See Bussing et al., *supra* note 115, at 182 tbl. 1.

260. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., U. S. DEPT OF HEALTH AND HUMAN SERVICES ANNUAL REPORT ON MENTAL HEALTH UNITED STATES, 2002, at 143 (2002); see A.D.A.M., *Attention Deficit Hyperactivity Disorder*, N.Y. TIMES, <http://health.nytimes.com/health/guides/disease/attention-deficit-hyperactivity-disorder-adhd/diagnosis.html> (last visited Nov. 12, 2008).

261. See Bussing et al., *supra* note 115, at 181–83 (discussing the finding that there are fewer barriers for White children than Black children in diagnosis).

262. See Joseph J. Cocozza & Kathleen R. Skowrya, *Youth with Mental Health Disorders: Issues and Emerging Responses*, 7 JUV. JUST. 3, 9 (2000) ("One of the major obstacles in recognizing and treating youth with mental health disorders in the juvenile justice system is the lack of screening and assessment. All youth in contact with the juvenile justice system should be screened and . . . assessed for mental health . . . disorders.").

263. See *id.* at 5 ("Youth in the juvenile justice system experience substantially higher rates of mental health disorders than youth in the general population.").

264. See generally BARRY C. FELD, JUVENILE JUSTICE ADMINISTRATION 353–75 (2d ed. 2004) (discussing the considerations that different groups analyze in determining whether to divert a youth toward such methods of rehabilitation).

265. See *id.*

266. See NAT'L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13, at 3.

267. See *id.* (discussing that judges consider a child's home life, as well as the present and past offenses committed, in determining proper action to take).

because they lacked adequate support and guidance at home.²⁶⁸ Even contemporary social science tends to support this hypothesis, with some studies correlating single-parent homes and underclass neighborhoods with criminal propensity.²⁶⁹ Thus, it is probable that judges are paying close attention to social factors, while overlooking possible medical explanations for delinquent behavior.

Consider again the two boys, William and Billy. William, in court on an assault charge, lives in a nice neighborhood, and attends a good school, though his grades are poor. His father has a good job and his mother is a homemaker. His family is financially secure. William has his own room, his own computer, and his own phone. He wants for nothing – not affection, nor funding, nor guidance. His life is not a struggle. Yet William continues to “act out.” William’s parents assure the judge that they have done everything that they can think of to help their son, but he is a difficult child and they cannot understand him. There is no discernible social cause behind William’s behavior. If William’s parents continue to assert that they believe something is really wrong with William, the judge is most likely to agree. Finding no discernible social cause for William’s behavior, the judge is more likely to consider some sort of undiagnosed illness as a cause, and refer William for a detailed assessment.

Contrast this with Billy’s experience. Billy, in court on an assault charge, lives in an economically depressed neighborhood. He lives with his mom and his younger brother and sister in a two-bedroom apartment. Billy attends a school with a metal detector at the door. Billy is not doing well at school. There is gang violence. There are drug problems in his neighborhood. Billy’s mom is a single parent. Billy’s dad left a long time ago and Billy does not really remember him. Billy’s mom works two jobs – but neither provides health insurance. Billy’s family has just enough money to get by, but none to spare. Billy’s life is a struggle, a constant negotiation between the harsh elements of the outside world and the harsh elements at home. Billy’s mother says she is at her wit’s end and can find no way to help Billy. She asks the

268. See Coccozza & Skowyr, *supra* note 262, at 5 (discussing the initial role of the juvenile court as a *parens patriae*, focusing on treatment and rehabilitation); see also Randy K. Otto, Jonathan J. Greenstein, Michael K. Johnson & Robert Friedman, *Prevalence of Mental Disorders Among Youth in the Juvenile Justice System*, in *RESPONDING TO THE MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM* 8 (J. Coccozza ed., 1992) (viewing the juvenile justice system as initially one of rehabilitation).

269. See *PANEL ON JUVENILE CRIME: PREVENTION, TREATMENT, AND CONTROL*, *supra* note 37, at 75–78, 89–90 (associating single parent homes and poverty stricken neighborhoods with higher juvenile delinquency rates).

judge to help her.

The judge sees many problems in Billy's life: insufficient parental supervision, access to and influence of gangs and drugs, lack of a male role model, the lure of an easier life on the street as opposed to the hard work of school. To the judge, these are the reasons Billy acts out. The judge tells Billy's mother that Billy needs more structure, more supervision, and that she needs to be tough on him now before things really get out of hand. The judge decides Billy should spend three weeks in juvenile detention.

William has ADHD. His social circumstances make it more likely that his ADHD will be detected. Billy has ADHD, but his social circumstances make it difficult for the judge to recognize the signs. This is not discrimination in its most classic sense. It makes sense that a judge would focus on the simplest explanations instead of looking beyond those factors to consider medical causes. However, the effects are discriminatory: social factors like single parents and poverty disproportionately affect youth of color.²⁷⁰ Indeed, sixty-five percent of all Black children are in single-parent families,²⁷¹ and between twenty-one and twenty-four percent of all families of color are living below the poverty line in the United States.²⁷²

Notions about race and culture also play a role. Scholars argue that racial disparities in the criminal justice system can be explained in part by implicit bias.²⁷³ They contend that, even when overt and conscious discrimination is not evident, unconscious racism may be present.²⁷⁴ Unconscious racism may

270. THE ANNIE E. CASEY FOUNDATION, KIDS COUNT DATA CENTER, http://www.kidscount.org/datacenter/compare_results.jsp?i=722 (last visited Nov. 13, 2008) (showing that only twenty-three percent of children who are in single-parent families are White).

271. *Id.* (finding that forty-nine percent of American Indian families are single-parent families and thirty-seven percent of Hispanic or Latino Families are single-parent families).

272. National Poverty Center, Poverty in the United States: Frequently Asked Questions, <http://www.npc.umich.edu/poverty/> (last visited Nov. 12, 2008).

According to the National Poverty Center:

[t]he poverty rate for all persons masks considerable variation between racial/ethnic subgroups. Poverty rates for [B]lacks and Hispanics greatly exceed the national average. In 2004, 24.7 percent of [B]lacks and 21.9 percent of Hispanics were poor, compared to 8.6 percent of non-Hispanic [W]hites and 9.8 percent of Asians.

Id.

273. See Bagenstos, *Implicit Bias*, *supra* note 253, at 477–83 (discussing implicit biases, their impact on antidiscrimination scholarship, their role in the legal field, and doctrinal proposals to account for their presence).

274. See *id.* at 477 (“[A]n expanding mass of evidence from experimental psychology . . . appears to demonstrate the pervasiveness of unconscious bias based

be based on negative racial stereotypes as much as overt racism is, but these stereotypes are buried deep beneath the surface, so deep that even the actor may be unaware of them.²⁷⁵ As a result, the malicious intent with which racism is usually associated is absent in these cases, making racism itself difficult to discern, even when the effects appear evident along racial lines.²⁷⁶

The operation of unconscious racism and group dynamics is only exacerbated by the fact that the majority of juvenile court judges are still White men.²⁷⁷ Unconsciously held biases and cultural misunderstandings about families of color may affect judges when they adjudicate cases involving youth offenders.²⁷⁸ Judges of all races may have unconscious negative assumptions regarding people of color and unlawfulness.²⁷⁹ This is epitomized by the stereotype of the "big Black kid"²⁸⁰ as bestial, uncontrollable, and aggressive.²⁸¹ This stereotype is in direct conflict with the juvenile court's original view of juvenile offenders as misguided but rehabilitatable youth who lacked culpability.²⁸²

Judges might also believe that Black culture, either

on race, gender, and other legally protected characteristics . . .").

275. See *id.* at 482 (discussing how people must, at times, have their strong implicit biases called to their own attention).

276. See *id.* ("People may have negative, race-based implicit associations for a variety of reasons that do not stem from personal prejudice.").

277. COMMISSION ON RACIAL & ETHNIC DIVERSITY IN THE PROFESSION, AMERICAN BAR ASSOCIATION, STATISTICS ABOUT MINORITIES IN THE PROFESSION FROM THE CENSUS, <http://www.abanet.org/minorities/links/2000census.html> (last visited Nov. 12, 2008) (finding that in 2000, 54.3% of the Judges, Magistrates, and other Judicial Workers in the U.S. were White, non-Hispanic males).

278. See Tomkins et al., *supra* note 3, at 1631 ("[D]iscretionary decision making, which necessarily utilizes substantive factors [such as the juvenile's personal and social environment, and his/her situation at home, in the community, and in school], serves to facilitate disproportionately adverse outcomes for minorities, particularly African Americans.").

279. See Bagenstos, *Implicit Bias*, *supra* note 253, at 484–86 (finding that implicit bias against minority groups can be shared by minority groups, and commenting on separate studies of "rational reactions" to, among other things, the incrimination rates of Blacks).

280. See Kasey Corbit, *Inadequate and Inappropriate Mental Health Treatment and Minority Overrepresentation in the Juvenile Justice System*, 3 HASTINGS RACE & POVERTY L.J. 75, 83 (2005) (discussing the stereotype of the "big Black kid"); see also Jody D. Armour, *Race Ipsa Loquitur: Of Reasonable Racists, Intelligent Bayesians, and Involuntary Negrophobes*, 46 STAN. L. REV. 781, 784–85 (1994) (discussing the "big Black" stereotype as it was used in the Rodney King trial).

281. See Armour, *supra* note 280, at 784–85 (utilizing the Rodney King trial to describe the "big Black" stereotype).

282. See FELD, *supra* note 264, at 1–20 (describing the context of the creation of the juvenile court, which initially viewed children as vulnerable, innocent, and dependent beings).

inherently or due to the perils of poverty, is essentially criminal.²⁸³ Therefore, the homes and communities of people of color in the inner cities may be seen as breeding grounds for crime.²⁸⁴ From this perspective, a judge may believe it is imperative that the child be removed from his home for any real chance at success, especially if the child has already demonstrated through delinquent acts that he is unable to withstand the pressures and temptations of his environment.²⁸⁵ In these cases, while poverty prevents the youth from getting the medical assessment that he needs, race can be a finger on the scale tipping it toward a determination of delinquency.

VI. Undiagnosed ADHD: A Fast Track to Delinquency

Delinquency determinations and custodial dispositions in juvenile cases are not the immediate outcome for most juvenile offenders or most types of offenses.²⁸⁶ Rather, custodial detention is intended for those juveniles who: 1) engage in extremely serious delinquent or criminal behavior, especially those whose behavior poses a threat of physical harm to others; 2) are repeat offenders who have already been given several "chances" but whose behavior does not seem to be improving; and 3) clearly lack a support or discipline structure at home.²⁸⁷

283. See Bagenstos, *Implicit Bias*, *supra* note 253, at 482 (finding that people may have negative, race-based associations due to "depressing realities").

284. See *id.* at 486 ("[B]ecause African Americans have, on average . . . more of the bad things in life (higher rates of imprisonment, violence, drug-abuse, out of wedlock births, etc.) it is perfectly rational, and indeed inevitable, that [B]lackness will come to carry a substantial network of negative associations.") (citations omitted).

285. See CAL. WELF & INST. CODE § 636 (West 2006) (delineating the aspects that a court will consider in removing a child from his home).

286. Brandi Miles Moore, *Blended Sentencing for Juveniles: The Creation of a Third Criminal Justice System?*, 22 J. JUV. L. 126, 127 (2001-2002). The article states that:

The juvenile justice system was established in 1899 "in part to insulate minors from the harshness of criminal prosecutions, to promote rehabilitation over punishment, and to eliminate the taint of criminal conviction after incarceration by characterizing such actions as delinquent rather than criminal." It was based on the principle that "the state must care for those who cannot take care of themselves." The first juvenile courts were built around an informal, quasi-civil process where juvenile court judges had broad discretion to intervene. Juvenile offenders had minimal procedural protections, but that was balanced by the promise that a court would focus on the juvenile's best interests. "The mission of the juvenile court was to help young law violators get back on the right track, not simply punish their illegal behavior."

Id. (footnotes omitted).

287. Task Force on Juvenile Justice, *The Massachusetts Juvenile Justice System*

The juvenile justice system's interest is in keeping families together (so long as the home is not a negative influence), and encouraging parental involvement in the rehabilitative process.²⁸⁸ Consider for example the Utah provisions on sentencing. Several elements can be considered mitigating factors which can be used to downgrade the offense and provide for probation or even dismissal:

1. **Significant Improvement since the Offense:** Offender has demonstrated significant improvement since the time of the offense; offender has voluntarily sought treatment; offender compensated or made a good faith effort to compensate victim.
2. **Physical/Mental Impairment:** Offender, because of physical or mental impairment, lacked substantial capacity for judgment when the offense was committed; or the offender is mentally retarded. . . . The voluntary use of intoxicants does not fall within the purview of this category.
3. **Limited Adjudication History:** Offender has no or only minor prior adjudications; long period of time since previous referral; or extreme length of time since the offense occurred.
4. **Age and Maturity of Offender:** Offender's age and maturity suggest that the offender did not fully understand the impact or nature of the delinquent conduct.
5. **Current Status:** Offender is currently in an appropriate level of treatment or supervision.
6. **Treatment Needs Exceed Need for Punishment:** The offender is in greater need of an available treatment program than of punishment through incarceration. . . .²⁸⁹

In general, parents who present a medical and therapeutic plan for their child's rehabilitation are much more likely to return home with their child.²⁹⁰ More affluent parents have greater resources available to determine if their child's acts are primarily behavioral or medical in nature.²⁹¹ If they recognize signs of

of the 1900s: *Re-Thinking a National Model*, 21 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 339, 351 (1995).

288. See generally SAMANTHA HARVELL, BELEN RODAS & LEAH HENDEY, PARENTAL INVOLVEMENT IN JUVENILE JUSTICE: PROSPECTS AND POSSIBILITIES (2004) (asserting that the successful rehabilitation of youth relies upon the mutual support of juvenile justice systems and families).

289. UTAH SENTENCING COMM'N, JUVENILE SENTENCING GUIDELINES 11 (2004), available at

<http://www.sentencing.utah.gov/Guidelines/Juvenile/JuvenileManual2004.pdf>.

290. See Rachel A. Gordon et al., *Family and Neighborhood Income: Additive and Multiplicative Associations with Youths' Well-Being*, 32 SOC. SCI. RES. 191, 191 (2003) (stating that because ADHD is more frequently diagnosed in affluent neighborhoods, those parents are better able to provide treatment for their ADHD children).

291. See generally *id.* (finding that ADHD is more often found among youth who are financially advantaged in relation to their neighbors).

ADHD, they are better able to marshal the resources necessary to obtain a diagnosis.²⁹² Therefore, since affluent children are more likely to be diagnosed, they are more likely able to present the court with a palatable alternative to incarceration.²⁹³ Unfortunately, statistics in this area are inconclusive.²⁹⁴ Experts working with youth in the juvenile justice system, however, assert that such a conclusion is warranted and makes sense given the goals enunciated in juvenile justice statutes and sentencing guidelines across the country.²⁹⁵

Poor youth, who are more likely to escape diagnosis simply because of the time and cost involved are thus less likely to be seen as having options when it comes time for a determination.²⁹⁶ While these children exhibit the same "delinquent" behavior, their lack of resources makes it more likely they will receive a custodial disposition.²⁹⁷

Alone, the confluence of ADHD behaviors with the diagnostic barriers for poor kids of color would not dictate that all undiagnosed children of color will receive a custodial disposition or delinquency determination. However, the juvenile justice system is concerned with two factors in dispositions: rehabilitation and accountability.²⁹⁸ Undiagnosed ADHD youth are more likely to

292. See generally *id.* (arguing that ADHD is more frequently diagnosed in more affluent neighborhoods).

293. See Helen Schneider & Daniel Eisenberg, *Who Receives a Diagnosis of Attention Deficit/Hyperactivity Disorder in the United States Elementary School Population?*, 117 PEDIATRICS e601 (2006) (suggesting that, in some samples, low family income or poverty status are associated with lower probabilities of ADHD diagnosis); Rouse & Goldstein, *supra* note 82, at 59–61.

294. Schneider & Eisenberg, *supra* note 293 (noting that due to conflicting data, the impacts of socioeconomic status on diagnosis and treatment remain unclear).

295. See Kristen L. Aggeler, *Is ADHD a "Handy Excuse"? Remediating Judicial Bias Against ADHD*, 68 U. MO. KAN. CITY L. REV. 459, 462 (1999–2000) (suggesting that, "disparaging language attacking the validity and respectability of ADHD is inappropriate and unjustified in a judicial opinion" and noting how the media promotes that individuals, even children, take responsibility for their own actions); Interview with Dr. Marina Tolou-Shams, director of Rhode Island Family Court's Juvenile Mental Health Clinic (June 27, 2007) [hereinafter Interview with Dr. Marina Tolou-Shams].

296. Corbit, *supra* note 280, at 90.

297. See generally Bussing et al., *supra* note 115, at 181–82 (finding that White juveniles are twice as likely to be evaluated, diagnosed, and treated for ADHD than Black juveniles).

298. The primary purposes of punishment are deterrence (general and specific), protection of the public, denunciation, retribution and rehabilitation. Michele Cotton, *Back With a Vengeance: The Resilience of Retribution as an Articulated Purpose of Criminal Punishment*, 37 AM. CRIM. L. REV. 1313, 1313–15 (2000). In fact, these characteristics can be condensed and align directly with the dual purposes of juvenile justice – rehabilitation and accountability. Deterrence, protection of the public and rehabilitation address the offender's future conduct and

fail under both of these considerations.²⁹⁹

A. Rehabilitation and Recidivism

When ADHD sufferers remain undiagnosed they cannot get the help they need—medically, or psychologically.³⁰⁰ Because ADHD behaviors are not matters of will, the court's stern sanction is highly unlikely to change the juvenile's behavior, no matter how scared he is.³⁰¹ As a result, undiagnosed ADHD youth suffer high rates of recidivism.³⁰²

Occasionally, a juvenile is diagnosed with ADHD while in custody.³⁰³ Depending upon the length of his stay, he may be evaluated regularly by a psychologist and even prescribed medicines to alleviate his condition.³⁰⁴

Upon release, however, all of that vanishes; youth are released with a short supply of medication and perhaps a prescription for their next month's worth, but in order to receive further treatment and medication, they must see a doctor on their own.³⁰⁵ Doctors who serve the detention facilities are unavailable to treat the juveniles outside of the facility.³⁰⁶ Here, the lack of

therefore can be condensed into rehabilitation. Similarly, denunciation and retribution go to accountability. Juvenile courts measure rehabilitation by looking at the likelihood of recidivism. *See, e.g.*, CAL. WELF. & INST. CODE §502 (West 2008) (indicating that the number of arrests is a factor in determining whether a youth will be subject to programs for youth offenders). They measure accountability by evaluating the severity of the offense committed. *See generally id.* (listing the factors to be weighed for a custodial disposition).

299. Rouse & Goldstein, *supra* note 82, at 54–56.

300. *See* Bussing et al., *supra* note 115, at 181–82 (finding that poverty predicted lower ADHD treatment rates).

301. *See* Aggeler, *supra* note 295, at 462.

302. *See* Corbit, *supra* note 280, at 81.

303. *See id.* at 85.

304. *See* Rouse & Goldstein, *supra* note 82, at 54–56. Ironically, these children must be treated as delinquents before they can garner a diagnosis that their condition is in fact medical. Diagnosed, treated, and living in a highly structured setting, such children may actually benefit (at least vis-à-vis their ADHD) from this detention. *See id.* at 62 (finding that individuals with ADHD function best in structured, consistent environments).

305. Interview with Dr. Marina Tolou-Shams, *supra* note 295; *see also* DEPARTMENT OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, PARENT AND/OR GUARDIAN INFORMATION ON STRATTERA, May 2004, http://www.ncdjdp.org/resources/policy_manual/detention_center_medical_policies_forms/medical_forms/0073-0107/DCMP-0105.pdf. (requiring parents to seek out an outside doctor upon the juvenile's release).

306. *See, e.g.*, New Hampshire Department of Health and Human Services, Frequently asked Questions, <http://www.dhhs.state.nh.us/dhhs/JJINSTITUTSRVC/FAQs/default> (last visited Dec. 19, 2008) (noting that once a youth is discharged, the Youth

health insurance can be devastating. Even knowing what is wrong, the family is unable to get an appointment with a specialist or unable to pay for it.³⁰⁷ They cannot get another prescription, and they cannot get the counseling that helps the youth develop mechanisms to cope with his ADHD.³⁰⁸ As a result, ADHD youth without support tend to relapse into the delinquent behaviors already identified.³⁰⁹

B. Accountability and Offense Severity

The system's accountability goal is often measured vis-à-vis offense severity. The more severe the offense, the more important it is to hold the juvenile accountable. This factor is of particular concern when considering those juveniles self-medicating with cocaine. In many states, certain drug offenses are automatically elevated to adult court.³¹⁰ Certainly, in all states the potency and perceived dangerousness of the drug is regularly taken into account.³¹¹ While repeated use of marijuana and alcohol could lead to a delinquency finding, cocaine use most certainly would.³¹² Given cocaine's ability to mimic the effects of Ritalin and other ADHD medications, an undiagnosed ADHD youth may be more likely to use this drug than other youth.³¹³ Not knowing the neurochemical effects of cocaine on the ADHD brain, judges may see youth who are using cocaine as hard core drug addicts using the substance for its hallucinogenic and euphoric effects, rather than its dopamine stabilizing properties. Such youth are much

Services contract doctor cannot continue to treat or prescribe medication).

307. See generally Information Library, *supra* note 248 (discussing the potential cost of an ADHD diagnosis).

308. *Id.*

309. See Corbit, *supra* note 280, at 85 (discussing that juveniles who lack mental health access have a higher potential for recidivism).

310. See generally NAT'L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13 (noting that African American youth were more likely to waived into adult court for drug offenses); MICHAEL H. TONRY & KATHLEEN HATLESTAD, SENTENCING REFORM IN OVERCROWDED TIMES: A COMPARATIVE PERSPECTIVE 38 (1997) (examining how since the mid-1980s, in certain instances, certain states have elevated drug offenses to very high severity levels).

311. See e.g., TONRY & HATLESTAD, *supra* note 310, at 38 ("Minnesota now has five degrees of drug crimes elaborately described on the basis of sale or possession, type of drug, and amount of drug.").

312. See Plume, *supra* note 175 ("In recent years, ADHD has been frequently reported in cocaine abusing populations. . . . Adolescents appropriately treated for ADHD showed similar, and in some cases, less incidences of substance abuse than controls." (citations omitted)).

313. See *id.* (mentioning that one study found that cocaine abusers with ADHD tend to be younger at time of first treatment and report earlier onset of abuse, while another study found greater drug use among ADHD youth).

more likely to receive a determination of delinquency and a custodial disposition.³¹⁴

The operation of all these factors is particularly distressing given the position and responsibility of the judge, with whom we charge not only the meting out of justice, but the rehabilitative prescription for our youth, along with the ultimate responsibility that all this should happen fairly and equitably.³¹⁵ Equitably apprehending the risks associated with ADHD can only happen when judges have access to ADHD screening that will capture equally both affluent and poor children, White children and children of color.³¹⁶

Currently, there is no such screening.³¹⁷ Neither New York nor California, the states with the largest number of juvenile delinquency cases each year, has any form of screening or pre-adjudication diagnosis available for mild to moderate mental disorders.³¹⁸ In the few cases where judges do refer children for pre-detention assessment, psychologists, not psychiatrists, do the testing.³¹⁹ For poor underclass youth, these assessments are subject to the same challenges that contribute to under-diagnosis outside the justice system.³²⁰

314. See, e.g., CAL. EDUC. CODE § 48902 (West 2006) (requiring that principals notify law enforcement of all juveniles found on school grounds with drugs, and that children can be suspended and obligated to report the incident to law enforcement).

315. See Rouse & Goldstein, *supra* note 82, at 60.

316. See generally Bussing et al., *supra* note 115, at 181–82 (noting that White children had twice the chance of Black children to be evaluated, diagnosed, and treated for ADHD); see also Chemers, *supra* note 122, ch. 25, at 4 (asserting that early diagnosis and treatment may help prevent delinquency).

317. See generally MENTAL HEALTH SCREENING AND ASSESSMENT IN JUVENILE JUSTICE (Thomas Grisso et al. eds., 2005) (discussing that the absence of mental health screening in the juvenile justice system is detrimental to juveniles with mental health issues, including ADHD).

318. See Coccozza & Skowrya, *supra* note 262, at 9 (discussing the failure in court systems to properly cope with juveniles with ADHD). But note that Santa Clara County, CA has integrated greater screening for children with *severe* mental illness, including severe ADHD, for referral and transfer to Juvenile Mental Health Courts. ELLEN HARRIS & TAMMY SELTZER, BAZELON CTR. FOR MENTAL HEALTH L., THE ROLE OF SPECIALTY MENTAL HEALTH COURTS IN MEETING THE NEEDS OF JUVENILE OFFENDERS (Lee Carty ed., 2004), available at <http://www.bazelon.org/issues/criminalization/publications/mentalhealthcourts/juvenilemhcourts.htm>.

319. See Coccozza & Skowrya, *supra* note 262, at 9 (discussing the failure in court systems to properly cope with juveniles with ADHD); Rouse & Goldstein, *supra* note 82, at 60 (noting that juveniles of a low socioeconomic class have more difficulty accessing treatment for ADHD).

320. See Coccozza & Skowrya, *supra* note 262, at 9 (discussing the failure in court systems to properly cope with juveniles with ADHD); Rouse & Goldstein, *supra* note 82, at 60 (noting that juveniles of a low socioeconomic class have more

VII. Recommendations

All of the foregoing demonstrates that we are currently punishing many children for behaviors associated with a disorder rather than for a detriment of will or good upbringing.³²¹ Furthermore, because of the difficulties and disparities associated with diagnosing ADHD, this punishment is occurring in a racially unequal manner.³²² If our goal is to save youth, and to dispense justice in a fair and impartial fashion, we are failing dismally.

To counteract the current crisis, we must implement changes in the short term and in the long term, both within and beyond the juvenile justice system. In the short term, and within the juvenile justice system, three things should be done immediately: the purpose of the juvenile justice system must be clarified; legal actors in the juvenile justice system must be educated about ADHD; and screening and diagnostic measures must be drastically improved.

The first prerequisite to reform is purpose clarification. Currently, there is disagreement as to the actual reason for the juvenile justice system.³²³ The system's original intent was to provide the guidance and structure necessary to rehabilitate youngsters, with the full confidence and intention of turning out productive members of society.³²⁴ Over time, however, the intent has shifted to become more punitive and less rehabilitative.³²⁵ Now, instead of rehabilitation being the primary purpose, it is balanced with accountability, a goal that often materializes as punishment.³²⁶

Organizations responsible for promoting and supporting the juvenile justice system, like the OJJDP, the National Council of Juvenile and Family Court Judges, and the MacArthur Foundation Models for Change Initiative, all advocate for greater attention to the original premises of the system.³²⁷ This renewed

difficulty accessing treatment for ADHD).

321. See Corbit, *supra* note 280, at 83 (asserting that there is a tendency to view juveniles as threatening rather than mentally ill).

322. See *id.* at 84; *infra* Part V.

323. See Mears et al., *Public Opinion and the Foundation of the Juvenile Court*, 45 CRIMINOLOGY 223 (2007).

324. NAT'L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13, at 37.

325. *Id.*

326. *Id.*

327. Cf. Mears et al., *supra* note 323 (finding that adults and children are fundamentally and developmentally different; that youth by virtue of their age and developmental immaturity are capable of rehabilitation and thus possess greater potential; and that the state, under the doctrine of *parens patriae*, has the authority and the obligation to intervene and provide wayward youth with the

focus would reconnect the system with its original purpose—rehabilitation as the primary objective.³²⁸

To achieve the primary objective of saving youth, the next step is education. In general, the law must be more open to, and educated about, the progress of medical science. The premise has always been that juveniles, by virtue of their youth and immaturity, are rehabilitatable.³²⁹

This historic common sense principle is substantiated by modern medical science.³³⁰ Recent studies confirm that the typical adolescent brain is not merely lacking in experience, but is physically different from the adult brain, and, consequently, differs in its ability to process information and consequences and avoid impulsive activity.³³¹ Particularly with children, where the goal is rehabilitation, understanding the adolescent brain from a medical perspective is invaluable. If ever there was an occasion where law could gain from medicine, surely this is it.

For this scientific knowledge to have an effect, however, all juvenile justice workers, especially intake officers and judges, require training. While most people are familiar with the term ADHD, few fully understand how the disorder manifests in young people, and fewer still understand how ADHD behaviors overlap with delinquent behaviors.³³² If juvenile justice workers and judges were more familiar with the overlap, they might be better attuned to ADHD symptoms in youth they encounter, and order assessments.

Furthermore, legal actors must be alerted to the ways that ADHD can be misperceived as a social, behavioral problem, rather than as a medical problem. While natural, this misperception

assistance, guidance and treatment needed to redirect them from delinquent activity and rehabilitate them to more fully achieve that potential).

328. See Mears et al., *supra* note 323, at 223.

329. See Coccozza & Skowrya, *supra* note 262, at 16; Mears et al., *supra* note 323, at 223 (“Over 100 years ago, juvenile courts emerged out of the belief that juveniles are different from adults—less culpable and more rehabilitatable—and can be ‘saved’ from a life of crime and disadvantage.”).

330. See generally DANIEL R. WEINBERGER ET AL., THE ADOLESCENT BRAIN: A WORK IN PROGRESS (2005) (arguing that efforts to understand, guide, and help teens should be based in part on a deeper appreciation of their neurobiology).

331. *Id.* at 3 (finding that the key areas of the adolescent brain are not fully developed “until the third decade of life”).

332. See Lynda Thompson & Michael Thompson, *Understanding ADD*, ADD CENTRE, <http://www.addcentre.mb.ca/5.html> (last visited Oct. 28, 2008) (noting that most people are familiar with ADHD but few understand how the disorder manifests in young people); see generally Hunt, *supra* note 84 (noting that disruptive behavior, truancy, and risk taking are all related to the neurological disorder of ADHD).

nonetheless significantly disadvantages poor youth of color.³³³ Without this training, judges will continue to see ADHD behaviors as disciplinary matters instead of medical conditions, and continual "delinquent" behavior of an ADHD youth will eventually force a custodial disposition.³³⁴ Once in the system, there is little opportunity to obtain adequate counseling or treatment.³³⁵

Finally, mechanisms to reliably identify and treat youth with ADHD must be implemented. Screening and diagnostic measures must be drastically improved. Currently, intake screening is either entirely absent or superficial, capturing only the most serious mental disorders.³³⁶ Intake screening should be mandatory and detailed, identifying conditions, like ADHD. If a youth exhibits warning signs, the family should be referred, early on in the process, to state-employed physicians who are trained in diagnosing such conditions. This would help alleviate the numerous economic and racial barriers to diagnosis. That way, when youth return to court for disposition, they could have a diagnosis in hand, which would undoubtedly lead to more appropriate dispositions. Furthermore, since many children actually outgrow ADHD as their brains develop more fully,³³⁷ long-term monitoring is essential.

The costs associated with these proposals are indeed high. Mandatory and detailed intake screening will require better training. Testing will require more hours and more professionals.

333. See generally NAT'L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13, at 2 (finding that in 1999 sixty-two percent of youth in detention were youth of color).

334. See generally Pratt et al., *supra* note 15, at 352–53 (discussing how causes of criminal behavior, such as low self-control, can also be attributed to ADHD).

335. See Corbit, *supra* note 280, at 89 (stating that juvenile justice facilities are "not equipped to meet the mental health needs" of the children and will commit the children to a public psychiatric clinic or overmedicate them); see generally Coccozza & Skowrya, *supra* note 262, at 9 ("One of the major obstacles in recognizing and treating youth with mental health disorders in the juvenile justice system is the lack of screening and assessment. All youth in contact with the juvenile justice system should be screened and . . . assessed for mental health . . . disorders."). But see Corbit, *supra* note 280, at 89 (stating that juvenile justice facilities are "not equipped to meet the mental health needs" of the children and will commit the children to a public psychiatric clinic or overmedicate them).

336. See generally Coccozza & Skowrya, *supra* note 262, at 9 ("One of the major obstacles in recognizing and treating youth with mental health disorders in the juvenile justice system is the lack of screening and assessment. All youth in contact with the juvenile justice system should be screened and . . . assessed for mental health . . . disorders.").

337. See Krista Mahr, *ADHD Kids Can Get Better*, TIME Nov. 12, 2007; Lindsey Minnema, *Will Kids Outgrow ADHD?: Experts Help Parents put Findings in Perspective*, WASH. POST, Nov. 27, 2007, at HE08; Julie Rawe, *Children Can Outgrow ADHD*, TIME, Nov. 15, 2007; Shaw et al., *supra* note 107 at 19650.

However, such costs must be measured against the already astronomical costs associated with housing and punishing thousands of juveniles whose behaviors are medical in origin. Furthermore, we must not ignore the significant social toll on minority and poor communities when so many of their children are detained for treatable behaviors. Countless numbers of these children never get free of the system once they enter it. Instead, poor youth of color are first branded delinquent and then criminal, contributing to the stereotypes and racial animus that already bitterly divide us.

Many of these youth are never diagnosed and instead fall into lives of more serious risk taking, delinquency, and crime, ultimately leading to adult involvement with the criminal justice system.³³⁸ Though it may not be possible to save all children, it is clear that for ADHD youth, their behavior can be substantially ameliorated with treatment.³³⁹ These children can be "rehabilitated" with relative ease. Recent studies estimate that almost twenty-five percent of the prison population suffers from identifiable ADHD.³⁴⁰ This is not to say that all criminal behaviors associated with this population are due to ADHD; but, if even a portion is, as the evidence suggests, then keeping those individuals out of the criminal justice system through early diagnosis and treatment would bring tremendous savings, socially and financially.³⁴¹

Beyond these immediate measures within the system, there are longer-term solutions outside the juvenile justice system that should also be initiated. Schools are integral to implementing these measures. In general, ADHD children must be identified

338. See Sam Goldstein, *ADHD and Implications for the Criminal Justice System*, http://www.mental-health-matters.com/articles/article_test.php?artID=682&page=0 (last visited Dec. 20, 2008) (finding that "the worse an individual's ADHD symptoms get, the more likely that the individual might progress to criminal behavior").

339. See Robert Wood Johnson U. Hosp., *Attention-Deficit/Hyperactivity Disorder (ADHD)* http://www.rwjuh.edu/health_information/adult_pediatrics_add.html (last visited Dec. 20, 2008) (stating that early diagnosis of ADHD has been shown to help people overcome their problems).

340. Lynn L. Eyestone & Robert J. Howell, *An Epidemiological Study of Attention-Deficit Hyperactivity Disorder and Major Depression in a Male Prison Population*, 22 BULL. AM. ACAD. PSYCHIATRY L. 181 (1994) (reporting that "diagnosable ADHD was found to occur in 25.5 percent of the inmates").

341. See Goldstein, *supra* note 338 (finding that "the worse an individual's ADHD symptoms get, the more likely that the individual might progress to criminal behavior").

early on and given counseling and medication if needed. Because young children are more likely to have regular schooling than doctor visits, the most effective way to diagnose these children's ADHD would probably be at school.

Such a program would involve three separate components. First, schools need to incorporate screening for signs of ADHD into their general assessment of youngsters, starting at age five. The general recording of these factors and reporting to parents would alert parents to any difficulties early, without the stigma associated with disciplinary problems. Since school records are usually transferred with the child and are maintained at the school, this would also make it much easier to track a child's growth and development should a medical evaluation for ADHD become appropriate.

Second, health assessments at school, like those currently used to test students' eyesight and hearing, should incorporate screening for emotional health and ADHD signs for evaluation. Frustration due to ADHD is typically more evident in school children who cannot overcome their symptoms with personal attention.³⁴² Younger students often have better rapport with school nurses and administrators.³⁴³ If children are asked questions about their health regularly and early on, they are more likely to respond honestly.³⁴⁴ This will help to identify potential ADHD symptoms earlier.

Third, when such signs exist, the state should help families obtain reliable diagnoses. This could easily take place under the umbrella of education. Individualized Education Plan initiatives already recognize that quality education includes individualized instruction in keeping with a student's disabilities.³⁴⁵ This suggestion merely goes one step further to assist families in having those disabilities diagnosed. While it may not be possible to have a school physician, schools might implement partnerships

342. See CLAIRE HELEN DE JAGER, *THE EXPRESSION OF FRUSTRATION BY THE CHILD WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER WITHIN THE CLASSROOM SETTING: A SOCIAL WORK STUDY* 33 ("The acquisition of basic academic skills can be interfered with by the child's inability to sustain attention. This pent-up frustration can be internalised causing the child to develop a low self-esteem and therefore never reaching his/her full potential.").

343. See RANDY W. KAMPHAUS, *CLINICAL ASSESSMENT OF CHILD AND ADOLESCENT INTELLIGENCE* 99-101 (Springer 2d ed. 2005) (stating that young children build rapport with adults more easily than older children).

344. See *id.* (noting that children who build trust with an adult are more willing to interact).

345. See U.S. DEPARTMENT OF EDUCATION, *A GUIDE TO THE INDIVIDUALIZED EDUCATION PROGRAM* 1-2 (Lisa Küpper ed., 2000).

with local physician networks to ensure access to diagnosis and treatment for children regardless of income status.

Obviously, the best possible solution for dealing with the surfeit of children who suffer from mental and behavioral disorders is to provide universal health care, including mental health services, for everyone. This would help limit the use of the juvenile justice system to those youth who have discipline problems.³⁴⁶ Even if the United States were to make significant strides in achieving universal health care, the chances that such a system would cover mental health services are exceedingly slim.³⁴⁷ The past three decades have seen a slow but steady erosion in the provision of mental health services for the population in general, and youth and the economically underprivileged in particular.³⁴⁸ Thus it is necessary to work within the school and juvenile justice systems to overcome this deficiency.

By implementing the measures outlined above, we can overcome the numerous barriers to diagnosis, social and economic, that prevent so many youth of color from getting the assessment and care they need.

Conclusion

The juvenile justice system is founded on the premise that society has an obligation to rescue youth going astray before they become irretrievably embroiled in crime and dysfunction.³⁴⁹ Intrinsic to this premise is the belief that every child is capable of being saved and that wayward conduct is a result of deficiencies in guidance, support, or material resources. From the outset, it was resolved that the juvenile justice system would examine every child as an individual, just as a parent would, to determine the right prescription to rescue the child from a life of crime.³⁵⁰ Individual treatment, however, does not mean inequitable treatment. The two youth appearing before the juvenile court,

346. See generally Stephen Buka & Felton Earls, *Early Determinants of Delinquency and Violence*, 12 HEALTH AFF. 46 (1993) (suggesting that efforts in education and health should be expanded to reduce later violent behavior).

347. See generally Peter Cunningham, Kelly McKenzie & Erin Fries Taylor, *The Struggle to Provide Community-Based Care to Low-Income People with Serious Mental Illnesses*, 25 HEALTH AFF. 694 (2006) (stating that service gaps for mental health for low-income people have grown in recent years and continue to grow).

348. See generally *id.*

349. See generally Mears et al., *supra* note 323, at 223 ("Over 100 years ago, juvenile courts emerged out of the belief that juveniles are different from adults—less culpable and more rehabilitatable—and can be 'saved' from a life of crime and disadvantage.").

350. See *id.*

William and Billy, each deserve treatment as *individuals*; yet one boy is denied a second chance because the court overlooks the intersectional experience that makes him the very individual he is.

The juvenile justice system seeks to serve the whole child, but is often blind to the confluence of social factors, mental health, race and class, which create the whole child. The problem is deeply embedded in juvenile justice statutes and processes, along with the realities of societal inequality. Instead of ameliorating these inequities, the system functions to entrench and perpetuate them. Many children never get free of the system once they enter it.³⁵¹ Instead, youth of color are first branded delinquent, and then criminal.³⁵² Ultimately, this contributes to the stereotypes and racial animus that already bitterly divide us. As a result, the juvenile justice system is not only failing to meet the needs of these youth, but it actually helps to create the problems it is supposed to eliminate.

This examination of ADHD demonstrates how, even in the context of this single and ubiquitous disorder, the problem is multifaceted and complex. However, the problem's complexity does not relieve the juvenile justice system of its obligation to tackle it. On the contrary, the juvenile justice system's mandate demands that the problem be addressed so that all children get the second chance to which they are entitled.

351. See Corbit, *supra* note 280, at 81 (stating that by not identifying mental illnesses, recidivism rates are higher, thus creating a "revolving door" to delinquency).

352. See generally NAT'L COUNCIL ON CRIME AND DELINQUENCY, *supra* note 13, at 37 (arguing that throughout the juvenile justice system, youth of color receive "different and harsher" treatment).