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The Aspiring Attorney with ADHD: Bar Accommodations or a Bar to Practice?

NEHA M. SAMPAT AND ESMÉ V. GRANT*

Introduction

Sasha¹ moved to the United States from South Asia when she was four years old, at a time of conflict in her birth country.² Her parents did everything they thought was necessary to ensure that she would succeed. Sasha always faced difficulties taking timed tests and avoided an academic path that required formal rigorous testing. She pursued and received a degree in the social sciences and, when she was in her mid-twenties, decided to go to law school. Sasha struggled tremendously with her legal studies and could not avoid the testing requirements of her law school program. She was referred to a cognitive psychologist to explore the possible causes of her particular struggle with timed examinations.

After hours of thorough psycho-educational testing, Sasha's evaluation report diagnosed her with Attention-Deficit/Hyperactivity Disorder ("ADHD"). She worked with the cognitive psychologist on ways to address her challenges given this diagnosis.

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1. Student's name has been changed to protect identity.

2. Interview with Sasha, Golden Gate Univ., in S. F., Cal. (2009).

The expert provided Sasha's law school with specific recommendations for how to accommodate Sasha in light of her significant difficulty with concentration and focus during her exams.

Through the remainder of her law school career, Sasha adjusted to her diagnosis and worked to implement her evaluator's recommendations. Her law school provided her with extended time for examinations and a private exam room as accommodations. Sasha excelled in her remaining courses. Moreover, she was relieved that she was able to overcome the struggles she had faced but been unable to name all her life. Although Sasha realized that extended time on the California Bar Examination, an accommodation she had received on law school exams, could mean additional days of testing, she knew that it would be necessary for her to pass the test.

Months after requesting accommodations for her disability for the bar examination, Sasha received a letter from the state bar denying her request. The denial letter acknowledged that Sasha's testing clearly showed difficulties in academic performance compared to her potential. However, citing the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"), the letter stated that without proof that her ADHD was present since childhood, she did not qualify for accommodations on the bar examination.³

Sasha's family had not retained records of, or acknowledged any references to, childhood behaviors indicative of ADHD. In fact, because of their cultural background, Sasha's family did not recognize the diagnosis of ADHD. Even as an adult, her family rejected the diagnosis and felt it was an excuse for a poor work ethic.

Unfortunately for people like Sasha, the legitimate lack of childhood history documentation results in a disadvantage in taking the bar examination and thereby a potential bar to entry in the legal profession. This bar to entry in the profession is experienced more by applicants from underrepresented or protected backgrounds (such as Sasha), as ADHD diagnosis rates vary significantly by race or ethnicity, socioeconomic status, age, gender, and location.⁴ Diagnosis and treatment rates for ADHD are highest for affluent,

3. Letter from Section Chief for Admin., State Bar of Cal. (2009) (quoting consultant in letter denying bar accommodations for ADHD diagnosis).

4. Helen Schneider & Daniel Eisenberg, *Who Receives a Diagnosis of Attention-Deficit/Hyperactivity Disorder in the United States Elementary School Population?*, 117 *PEDIATRICS* 601, 601-09 (2006); Jane D. McLeod et al., *Public Knowledge, Beliefs, and Treatment Preferences Concerning Attention-Deficit Hyperactivity Disorder*, 58 *PSYCHIATRIC SERVICES* 626, 626 (2007); Eunice Sigler, *ADD Women: Why Girls and Moms Go Undiagnosed*, *ADDitude: Living Well with Attention Deficit* (March 26, 2009), <http://www.additudemag.com/adhd/article/740.html>.

male, non-minority children under age ten.⁵ Minority children and children of immigrants are less likely to be diagnosed than non-minority children and children whose parents grew up in the United States.⁶ This is not the only significant discrepancy in diagnosis characteristics. Children from poorer or less educated families are less likely to be recognized as having symptoms of ADHD and related impairments.⁷ Older people are less likely to be able to meet the childhood history requirement, as are women.⁸ People from rural areas and other specific locations also are less likely to have evidence of childhood history of ADHD.⁹

The likelihood of diagnosis for a particular individual depends on a range of factors, because it may be noticed first by teachers, parents, or medical professionals.¹⁰ Thus, access to healthcare (which also varies by race, education level, and socioeconomic status),¹¹ educational services, and local practices of health care and education professionals all play a role in whether a child's ADHD symptoms and impairment are appropriately recognized and recorded.¹² Parental attitudes toward behavioral and learning conditions also play a role in the recognition of ADHD in a child.¹³ As Sasha experienced, the culture or gender of the child impacts how parents understand, contextualize, and determine the cause of their child's behavior, and in turn that has an effect on the services parents seek for their child.¹⁴ For Sasha, the detrimental outcome many years down the line was the denial of accommodations on the bar examination.

5. Gretchen B. LeFever & Andrea P. Arcona, *ADHD Among American Schoolchildren Evidence of Overdiagnosis and Overuse of Medication*, 2 SCI. REV. OF MENTAL HEALTH PRAC. 1, 8 (2003); Craig Lerner, *Accommodations for the Learning Disabled: A Level Playing Field or Affirmative Action for Elites?*, 57 VAND. L. REV. 1041, 1107 (2004); Mark Olfson et al., *National Trends in the Treatment of Attention Deficit Hyperactivity Disorder*, 160 AM. J. PSYCHIATRY 1071, 1074-75 (2003).

6. Schneider & Eisenberg, *supra* note 4, at 601-09.

7. *Id.* at 607; McLeod et al., *supra* note 4, at 626.

8. Sigler, *supra* note 4.

9. Schneider & Eisenberg, *supra* note 4, at 602.

10. *Id.* (finding that ADHD is first suggested by teachers (52.4%) and parents (30%), and then medical professionals (14.4%)).

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

12. Patricia N. Pastor & Cynthia A. Reuben, U.S. Dep't of Health & Human Services, *Diagnosed Attention Deficit Hyperactivity Disorder and Learning Disability: United States, 2004-2006*, 10 VITAL & HEALTH STAT. 237, 6 (July 2008).

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

14. *See id.* at 563 (examining how parental explanatory models of ADHD differ based on gender and culture).

Sasha is not alone in this experience. In fact, a significant number of state bars, including in the largest legal markets of New York and California, require the bar applicant to provide a well-documented childhood history of ADHD symptoms.¹⁵ Because many of the factors making it impractical or impossible to obtain childhood history documentation disproportionately affect people of minority backgrounds, legally protected classes, and other populations significantly underrepresented in the legal profession, the common state bar requirement of documented childhood history for provision of ADHD accommodations on the bar exam has a discriminatory impact on applicants who are female, members of a racial or ethnic minority, from a lower socioeconomic strata or rural geographic location, and those who are relatively older when applying for bar membership. The consequence of this is differentiated standards for bar exam takers. Such a practice not only is contrary to the mission and key principles of justice, fairness, and access held by the American Bar Association (“ABA”), the body that empowers bar examiners as the gatekeepers to the legal profession,¹⁶ but also exposes state bars to liability and is patently unjust.

This Article is the first in the academic literature to examine how a strict application of the childhood history requirement reduces the likelihood that applicants will receive ADHD accommodations on the bar exam based on race, sex, socioeconomic status, location, and age. Part One provides an introduction to ADHD, explaining the diagnostic framework and its limitations, specifically with regard to childhood diagnosis and adult ADHD. Part Two describes the legal and policy framework applicable to bar examiner agencies, focusing on the Americans with Disabilities Act (“ADA”). The Article sets forth, in Part Three, state bar policies and practices regarding ADHD accommodations. Within that context, Part Four demonstrates how the childhood history requirement exposes state bars to liability under the ADA. Part Five reveals how the childhood history requirement negatively impacts protected classes and, thus, the diversity of the legal profession. Finally, the analysis concludes in Part Six with specific, groundbreaking recommendations to address and mitigate the injustice that bar applicants from underrepresented populations in the profession.

15. John Ranseen, *Lawyers with ADHD: The Special Test Accommodation Controversy*, 29 PROF. PSYCHOL. RES. & PRAC. 450, 458 (1998).

16. *Association Goals*, AM. B. ASS’N, http://www.americanbar.org/utility/about_the_aba/association_goals.html (last visited May 1, 2012).

I. ADHD and the DSM: Description, Diagnosis, and Developments in Adult ADHD

A. Description of ADHD

ADHD is a relatively common neurobehavioral disability that can affect people throughout their lives.¹⁷ ADHD is estimated to have a current prevalence in this country of three percent to seven percent in school-aged children,¹⁸ and about 4.4% in adults,¹⁹ although some studies have estimated higher rates of prevalence.²⁰

As a chemical pathway disorder in the brain,²¹ ADHD can impair a person's ability to stay focused and mentally and physically calm.²² It commonly interferes with a person's ability to meet academic, work, and relationship potentials, and to comply with societal norms.²³ For adults in particular, ADHD can interfere not only with focus, but also with memory and processing speed.²⁴ However, ADHD does not impair logical problem solving,²⁵ which is at the crux of the practice of law. Although it often is experienced along with a separate learning disability, ADHD is not itself a learning disability, as it may interfere with a person's "availability for learning," without impacting the actual ability to learn.²⁶

Research indicates that genetics may play a role in a person's

17. S.N. Visser et al., *Increasing Prevalence of Parent-Reported Attention-Deficit/Hyperactivity Disorder Among Children – United States, 2003 and 2007*, 59 MORBIDITY & MORTALITY WKLY. REP. 1439, 1439 (2010).

18. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR 91 (4th ed. rev. 2000) [hereinafter "DSM-IV-TR"].

19. R.C. Kessler et al., *The Prevalence and Correlates of Adult ADHD in the United States: Results from the National Comorbidity Survey Replication*, 163 AM. J. PSYCHIATRY 716, 718 (2006).

20. *Data & Statistics*, CENTER FOR DISEASE CONTROL, <http://www.cdc.gov/ncbddd/adhd/data.html> (last visited May 1, 2012) (finding higher rates of ADHD prevalence in community samples, i.e., statistical studies being conducted within a subset of the general community).

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

22. *Facts About ADHD*, CENTER FOR DISEASE CONTROL, <http://www.cdc.gov/ncbddd/adhd/facts.html> (last visited May 1, 2012).

23. K.M. Antshel et al., *Is Adult Attention Deficit Hyperactivity Disorder a Valid Diagnosis in the Presence of High IQ?* 39 J. PSYCHIATRIC MED. 1325, 1325 (2009).

24. James McCracken & James McGough, *Adult Attention Deficit Hyperactivity Disorder: Moving Beyond DSM-IV*, 163 AM. J. PSYCHIATRY 1673, 1674 (2006).

25. Lenard A. Adler, *Managing ADHD in an Adult with Psychiatric Comorbidity*, MEDSCAPE EDUC. (July 30, 2008), <http://www.medscape.org/viewarticle/578010>.

26. Larry B. Silver, *Attention Deficit-Hyperactivity Disorder: Is It a Learning Disability or a Related Disorder?*, 23 J. OF LEARNING DISABILITIES 394, 395-96 (1990).

likelihood of having ADHD, but many other factors also may have an impact, including environmental determinants, gestational and birth difficulties, and brain injury.²⁷ Contrary to somewhat popular notions, parenting, poverty, and other social factors do not cause ADHD.²⁸

ADHD often is treated with medication, cognitive behavioral therapy, or a combination of both.²⁹ The primary medication treatment is psychostimulants (e.g., Adderall and Ritalin),³⁰ which generally stimulate the central nervous system, yet have a calming effect on individuals with ADHD.³¹ Anti-depressants are a secondary medication used for treatment of ADHD.³² Treating individuals with a combination of medication and therapy is the recommended approach.³³ Treatment plans, however, are highly individualized and require monitoring and possible adjustments.³⁴

Although individuals with ADHD “do not have a general intellectual deficit relative to the rest of the population,”³⁵ treatment alone may not eliminate the need for accommodations.³⁶ That said, ADHD treatment can be very successful, and individuals with ADHD can accomplish great achievements in their professions,³⁷ particularly if diagnosed with, treated for, and accommodated as necessary for ADHD.

B. Diagnosis of ADHD

i. *The Diagnostic and Statistical Manual of Mental Disorders*

The primary tool for diagnosing ADHD, as other mental disabilities, is the *Diagnostic and Statistical Manual of Mental Disorders*

27. *Facts About ADHD*, *supra* note 22.

28. *Id.*

29. Drew Barzman et al., *Attention-Deficit Hyperactivity Disorder Diagnosis and Treatment: Separating Myth from Substance*, 25 J. LEGAL MED. 23, 31 (2004).

30. *Id.*

31. Raul R. Gainetdinov et al., *Role of Serotonin in the Paradoxical Calming Effect of Psychostimulants on Hyperactivity*, 283 SCI. 397, 398 (1999).

32. Barzman et al., *supra* note 29, at 31–32.

33. *Id.*; *Facts About ADHD*, *supra* note 2222.

34. *Facts About ADHD*, *supra* note 2222.

35. Claire Advokat et al., *College Students With and Without ADHD: Comparison of Self-Report of Medication Usage, Study Habits, and Academic Achievement*, 15 J. ATTENTION DISORDERS 656, 663 (2011).

36. 42 U.S.C.A. § 12102(4)(E)(i)(I) (West 2011) (discussed in Part Two of this Article).

37. Abiola O. Dipeolu, *College Students with ADHD: Perspective Concepts for Best Practices in Career Development*, 38 J. CAREER DEV. 408, 424–425 (2011) (In fact, “[ADHD] might function in a positive manner . . . in career and occupational context.”).

(DSM).³⁸ The state bar requirements for ADHD accommodations on the bar examination stem from the DSM's clinical definition of ADHD.³⁹ The DSM creates a classification system for mental disorders that was developed "to provide a helpful guide to clinical practice," further research and communication among clinicians and researchers, offer an educational tool in the field of psychopathology, and create a tool for collecting and presenting public health statistics.⁴⁰

The DSM categorizes mental disorders into types based on sets of criteria with different features.⁴¹ Describing the limitations in this categorical classification approach, the DSM acknowledges that it is not ideal given that people with a particular diagnosis class are not homogeneous and that different classes overlap or have unclear boundaries.⁴² The DSM also stresses the importance of giving due consideration to ethnic and cultural backgrounds in interpreting and applying its diagnostic criteria.⁴³

The DSM goes on to further emphasize that the criteria are "meant to serve as guidelines to be informed by clinical judgment . . . are not meant to be used in a cookbook fashion," and must "not be applied mechanically by untrained individuals."⁴⁴ The DSM explicitly allows clinicians in the field of psychology to exercise their judgment to provide a DSM diagnosis even when the clinical presentation does not quite meet the full criteria.⁴⁵ Hence, many clinicians start from the basis of the DSM diagnostic criteria to understand a disorder, but acknowledge that these criteria cannot strictly be applied in all instances. In fact, one study found that only thirty-eight percent of clinicians surveyed use the DSM criteria, while the remaining sixty-two percent may be presumed to have diagnosed ADHD based on their own intuition and judgment or another form of assessment.⁴⁶ Many clinicians use their professional

38. See generally DSM-IV-TR, *supra* note 18.

39. THE STATE BAR OF CAL., GUIDELINES FOR EVALUATING PETITIONS FOR TESTING ACCOMMODATIONS BASED ON ATTENTION DEFICIT/HYPERACTIVITY DISORDER 1, http://admissions.calbar.ca.gov/LinkClick.aspx?fileticket=0cNK_373Kuc%3D&tabid=267 (last visited March 29, 2012).

40. DSM-IV-TR, *supra* note 18, at xxiii.

41. *Id.* at xxxi.

42. *Id.*

43. *Id.* at xxxiv.

44. *Id.* at xxxii.

45. *Id.*

46. Andrew S. Rowland et al., *The Epidemiology of Attention-Deficit/Hyperactivity Disorder (ADHD): A Public Health View*, 8 MENTAL RETARDATION DEVELOPMENTAL DISABILITIES RES. REV. 162, 164 (2002) (citing a survey of 3900 clinicians).

judgment to determine how strictly to interpret the criteria in making a diagnosis in acknowledgement, also, of the fact that the DSM criteria are in flux⁴⁷ and cannot keep up with the constant advances in medical and clinical research.⁴⁸

ii. *The Historical Development of ADHD Diagnosis*

The understanding of ADHD has evolved tremendously over the past sixty years, and it continues to evolve. ADHD-like behaviors in children were clinically labeled starting in the 1950s, with medication treatment starting in the 1960s.⁴⁹ With prevalence in school-aged children around one percent,⁵⁰ ADHD symptoms in adults started to gain some very limited recognition in the 1970s,⁵¹ but diagnosis still required childhood symptoms.⁵²

In 1980, the DSM-III was published, naming the disorder "attention deficit disorder," or "ADD," describing it as residual for adults, and providing a vague description of adult symptoms.⁵³ With the advent of the DSM-III-R, a 1987 revision, the name changed to what it is now, "Attention-Deficit/Hyperactivity Disorder."⁵⁴ This alteration acknowledged that although distractibility remained a primary issue, hyperactivity also was an important issue in the disorder.⁵⁵ The DSM-III-R provided a formal classification for adult ADHD, stating that one-third of children experienced symptoms into adulthood, but it still required the childhood onset of symptoms.⁵⁶ The 1980s saw prevalence in school-aged children reach three percent to five percent.⁵⁷

In the early to mid-1990s, the prevalence of ADHD in school-aged children was around five percent, settling at around four percent by the late 1990s.⁵⁸ In 1994, the DSM-IV was published, definitively stating that ADHD persists into adulthood.⁵⁹ However, the DSM criteria still had not been examined and supported by data

47. *Id.* at 162-70.

48. McCracken & McGough, *supra* note 24, at 1673.

49. LeFever & Arcona, *supra* note 5, at 1.

50. *Id.* at 5.

51. Adler & Cohen, *supra* note 21.

52. LeFever & Arcona, *supra* note 5, at 5.

53. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III 41-45 (3d ed. 1980).

54. *See, e.g.*, AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III-R 50 (3d ed. rev. 1987) [hereinafter "DSM-III-R"].

55. Silver, *supra* note 26, at 395.

56. DSM-III-R, *supra* note 54, at 51-53.

57. LeFever & Arcona, *supra* note 5, at 5.

58. LeFever & Arcona, *supra* note 5, at 5.

59. Adler & Cohen, *supra* note 21.

in adults and contained some serious limitations for adult diagnosis that persist today.⁶⁰

When the text revision DSM-IV-TR was published in 2000, it did not include significant changes to the DSM-IV definition of ADHD.⁶¹ Prevalence in school-aged children having a diagnosis rose to around 7.8% in 2003⁶² and about 9.5% in 2007.⁶³

As suggested by the historical timeline, the understanding of ADHD continues to develop and evolve, and with it, the rates of treatment have changed. One study compared ADHD identification and treatment in three- to eighteen-year-olds in the years 1987 and 1997.⁶⁴ During this ten-year period, researchers found a significant increase in treatment rates for ADHD across almost all groups, with the largest increases among those with historically low treatment rates, specifically those from lower income families, children aged twelve to eighteen, and children from racial and ethnic minorities.⁶⁵ ADHD diagnosis and treatment rates have grown as a result of the general acceptance of medication treatments,⁶⁶ greater general awareness of the disorder,⁶⁷ increased resources for identifying and supporting children with ADHD,⁶⁸ and the broadening of the diagnostic criteria, as seen in the current version of the DSM.

iii. DSM-IV-TR

Although it already is twelve years outdated, the DSM-IV-TR is the current edition, and its diagnostic criteria remain the main framework for diagnosis of ADHD.⁶⁹ The criteria⁷⁰ include two

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

61. Compare AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV 82-83 (4th ed. 1994), with DSM-IV-TR, *supra* note 18, at 91.

62. Pastor & Reuben, *supra* note 12, at 6.

63. *Data & Statistics*, *supra* note 20.

64. Olfson et al., *supra* note 5, at 1071.

65. *Id.* at 1074.

66. LeFever & Arcona, *supra* note 5, at 1.

67. Schneider & Eisenberg, *supra* note 4, at 602.

68. Olfson et al., *supra* note 5, at 1074-75.

69. DSM-IV-TR, *supra* note 18. Although the DSM-IV-TR is the most widely used criteria, it is not the only set of criteria to address ADHD. The Wender-Utah criteria is another diagnostic tool, which has been criticized in part because it fails to identify many adults with predominantly inattentive symptoms, which are the majority of adult ADHD cases. McGough & Barkley, *supra* note 60, at 1953. Brown and Conners diagnostic interviews are other tools that are better equipped to ascertain adult ADHD symptoms, but these are underused. *Id.* at 1948-56.

70. DSM-IV-TR, *supra* note 18, at 92-93. The DSM-IV-TR diagnostic criteria for Attention-Deficit/Hyperactivity Disorder are as follows:

A. Either (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 schoolwork 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 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).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months.

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months for

categories of symptoms. The first, inattention, includes nine different symptoms related to inattention.⁷¹ The second, hyperactivity/impulsivity, includes six different symptoms of hyperactivity and three different symptoms of impulsivity.⁷² The criteria require that six or more symptoms from either of the two categories “have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level,” and that some of the symptoms were present before age seven.⁷³

The criteria are structured to result in a diagnosis of one of three types of ADHD: the Predominantly Inattentive Type; the Predominantly Hyperactive-Impulsive Type; and the Combined Type.⁷⁴ The type of ADHD diagnosed is based on the category or categories of symptoms in which the individual meets the six symptom threshold.⁷⁵

Although these criteria and their structure seem straightforward, there is significant controversy over the criteria, particularly with regard to adult ADHD and the childhood history requirement. As Part Three will discuss, many state bars rely on the childhood history requirement to deny accommodations, exhibiting skepticism of those not diagnosed until adulthood. Hence, it is critical to focus on the reasons diagnosis may not occur until adulthood and how the DSM addresses this reality.

C. Adult ADHD under DSM-IV-TR

ADHD is believed to be common among adults, but often goes unrecognized and untreated.⁷⁶ Studies indicate that four to five percent of adults in this country have ADHD, but only fifteen percent to twenty-five percent of them know they have it.⁷⁷ Three-quarters of adults believed to have ADHD do not seek medical

the past 6 months.

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months for the past 6 months.

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, “In Partial Remission” should be specified.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. S.L. Able et al., *Functional and Psychosocial Impairment in Adults with Undiagnosed ADHD*, 37 *PSYCHOL. MED.* 97, 97-98 (2007).

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

assistance for it, and even those who seek assistance often are not appropriately identified as having ADHD.⁷⁸ One obvious reason why adults are underdiagnosed is that it only recently was confirmed that ADHD persists into adulthood for the majority of children who have it.⁷⁹ Additionally, a person who was not diagnosed as a child often remains undiagnosed in adulthood.⁸⁰

There are many reasons why an adult may not have recognized the symptoms or sought treatment.⁸¹ First, adults with a high intelligence quotient are less likely to have come to clinical attention for symptoms.⁸² A person's complacent behavior also could have kept them from receiving clinical attention.⁸³ An adult from a highly structured school or home environment also may have avoided clinical attention.⁸⁴

Many undiagnosed adults make it all the way through college by compensating for their symptoms or relying on their coping mechanisms, such as working harder or longer, their social support network, organization, and time management.⁸⁵ However, changes in an adult's life may worsen the symptoms or may render previously effective coping mechanisms useless.⁸⁶ For instance, law schools' academic assessment of students generally relies on one uniformly timed exam to constitute most, if not all, of a student's grade in each class. Thus, the coping mechanism of working harder and longer loses effect, as the student does not have a longer time to work on the exam, and the student's exam grade is not supplemented by grades on other assignments for which this coping mechanism has impact, such as un-timed papers.

Medical providers' failure to recognize symptoms also explains the underdiagnosis of adults. Studies show that primary care doctors may not have the appropriate training, experience, and diagnostic tools to realize that an adult's symptoms point to

78. ASCRIBE NEWswire: HEALTH, ADULT ADHD OFTEN UNDERDIAGNOSED BY PRIMARY CARE PHYSICIANS (2003).

79. Able et al., *supra* note 76, at 97.

80. *Id.* at 98.

81. *Id.* at 97-98.

82. *Id.* at 98.

83. *Id.*

84. *Id.*

85. Patricia Kaminski et al., *Predictors of Academic Success Among College Students with Attention Disorders*, 9 J. C. COUNSELING 60, 61 (2006) (describing a survey of 84 college students, which found that the most commonly described method of coping with ADHD was working harder and longer than other students (78%)); Lenard A. Adler, *Clinical Presentations of Adult Patients with ADHD*, 65 J. CLINICAL PSYCHIATRY 8, 8 (2004).

86. Adler, *supra* note 25.

ADHD.⁸⁷ In fact, one survey indicated that almost half of primary care doctors do not feel confident in diagnosing adults with ADHD, sometimes because they still view it as a childhood disorder.⁸⁸

Physicians not only miss the appropriate ADHD diagnosis, but they often misdiagnose the symptoms as another disorder.⁸⁹ Adults who have typical ADHD symptoms of procrastination, lack of motivation, moodiness, anxiety and low self-esteem but do not have a childhood diagnosis are likely to be diagnosed with other, more commonly recognized disorders in adults, such as Major Depressive Disorder, Bipolar Disorder, or Generalized Anxiety Disorder instead of ADHD.⁹⁰ In some cases, the patient may in fact have a depression or anxiety disorder, as these disorders often are experienced in conjunction with ADHD,⁹¹ but the diagnosis of these other disorders alone does not fully address the patient's symptoms and difficulties.

D. Limitations of Diagnostic Framework in Identifying Adult ADHD

Both the historical view that ADHD is a childhood disorder that spontaneously resolves by early adulthood and the relatively recent acknowledgment that ADHD persists into adulthood are reflected in the DSM diagnostic criteria, which still fail to appropriately incorporate adult ADHD.⁹² Although widely used,⁹³ these diagnostic criteria never have been validated in adults and rely on field trials that included only school-aged children.⁹⁴

i. *Flaws in ADHD Symptomology*

Close examination of the DSM criteria reveals a host of flaws. For example, Criterion A requires that six or more inattention or hyperactivity/impulsivity symptoms "have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level."⁹⁵ Adult ADHD is commonly indicated by distractibility, impulsive decisionmaking and challenges with

87. ASCRIBE NEWSWIRE: HEALTH, *supra* note 78.

88. Able et al., *supra* note 76, at 98; ASCRIBE NEWSWIRE: HEALTH, *supra* note 78.

89. Able et al., *supra* note 76, at 97-98.

90. *Id.* at 106.

91. DSM-IV-TR, *supra* note 18, at 91.

92. Adler & Cohen, *supra* note 21.

93. Ranseen, *supra* note 15, at 452-54.

94. McGough & Barkley, *supra* note 60, at 1948-56; McCracken & McGough, *supra* note 24, at 1673-75; Russell A. Barkley & Kevin Murphy, *Identifying New Symptoms for Diagnosing ADHD in Adulthood*, ADHD REP., Aug. 2006, at 7.

95. DSM-IV-TR, *supra* note 18, at 91.

executive functioning.⁹⁶ However, as discussed above, adult ADHD is not commonly indicated by hyperactivity.⁹⁷ Nevertheless, hyperactivity remains an important element of one of the two categories of symptoms for ADHD diagnosis, likely due to the fact that the diagnostic criteria were developed for children through field testing on children.⁹⁸ This criterion includes symptoms that are not age-appropriate for adults, such as, “runs about or climbs excessively” and “has difficulty playing . . . quietly.”⁹⁹ Some believe hyperactivity should not be on the adult symptom list¹⁰⁰ because what was hyperactivity and restlessness in children is indicated by internal restlessness and low frustration tolerance in adults.¹⁰¹

In addition, the threshold of six symptoms is flawed. Evidence indicates that adults with fewer than six symptoms can still be significantly impaired compared to other adults.¹⁰² In fact, many with “meaningful” impairment were unable to meet the six symptom threshold for diagnosis.¹⁰³ Another study found that the presence of four hyperactive or inattentive symptoms identified college students with significant enough impairment to need treatment.¹⁰⁴ However, when a strict reading of the DSM criteria is applied, many adults with ADHD go undiagnosed¹⁰⁵ and without requisite accommodations. Thus, the DSM cautions against strict interpretation of the criteria, and many clinicians are flexible in implementing the criteria when assessing adults’ symptoms.¹⁰⁶

ii. Flaws in Age of Onset Criterion

Criterion B requires that “[s]ome hyperactive-impulsive or inattentive symptoms that cause impairment were present before age seven years.”¹⁰⁷ This does not mean that childhood diagnosis is required, but that evidence of significant ADHD-related symptoms and impairment is required.¹⁰⁸ However, without a childhood

96. McCracken & McGough, *supra* note 24, at 1673–74.

97. Barkley & Murphy, *supra* note 94, at 10.

98. *Id.* at 7.

99. McGough & Barkley, *supra* note 60, at 1950.

100. Barkley & Murphy, *supra* note 94, at 9.

101. Adler & Cohen, *supra* note 21.

102. McCracken & McGough, *supra* note 24, at 1673–74.

103. McGough & Barkley, *supra* note 60, at 1950–51. A study that followed adults who had been diagnosed as children found that the six symptom threshold was 3.5 standard deviations above the mean. *Id.*

104. *Id.* at 1951.

105. *Id.*

106. DSM-IV-TR, *supra* note 18, at xxxii.

107. DSM-IV-TR, *supra* note 18, at 92.

108. Adler, *supra* note 85, at 8.

diagnosis, it is very difficult to find sufficient evidence of childhood symptoms.¹⁰⁹

The origin of this requirement is the historical view of ADHD as a childhood disorder, which implied that symptoms experienced after childhood indicated another disorder. Even when the specific age of onset was introduced in the DSM-III, it was not based on reliable scientific evidence.¹¹⁰ Field trials for DSM-IV showed that a significant percentage of children believed to have ADHD, particularly those with the inattentive type, were not able to meet this age of onset requirement.¹¹¹ In fact, ADHD symptoms often do not create impairment until several symptoms have emerged, which could take years after the first symptom, and may not occur until a child faces a particularly demanding academic or social situation.¹¹² The timing of when those demands are made on a child may differ based on a number of factors.¹¹³

Even if an adult had symptoms and impairment by age seven, they may find it difficult to recall childhood symptoms or resulting impairment from such a young age.¹¹⁴ This is compounded by the fact that people who have ADHD are less self-aware of behaviors present since childhood, which leads to inaccurate recollection or mis-attribution of ADHD symptoms.¹¹⁵

As acknowledged by the DSM,¹¹⁶ the school records and family member interviews to support childhood evidence of symptoms are “not always logistically possible”¹¹⁷ and, in fact, are “often

109. McGough & Barkley, *supra* note 60, at 1951; Marla Zucker et al., *Concordance of Self- and Informant Ratings of Adults' Current and Childhood Attention-Deficit/Hyperactivity Disorder Symptoms*, 14 *PSYCHOL. ASSESSMENT* 379, 379-80 (2002).

110. B. Applegate et al., *Validity of the Age-of-Onset Criterion for ADHD: A Report From the DSM-IV Field Trials*, 36 *J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY* 1211, 1219 (1997); McGough & Barkley, *supra* note 60, at 1951.

111. McGough & Barkley, *supra* note 60, at 1951; Applegate et al., *supra* note 110, at 1211 (describing a 1997 study of youth aged four to seventeen specifically indicated that eighteen percent of the youth with the combined type and forty-three percent of those with the predominantly inattentive type did not display symptoms by age seven); McCracken & McGough, *supra* note 24, at 1673 (describing a DSM field trial that indicated that those with the inattentive type often cannot meet criteria for symptoms with associated impairment until at least age nine).

112. Rowland et al., *supra* note 46, at 163.

113. Different children will find different situations at different times demanding, due to, e.g., rigor of academic program or social pressures on a child.

114. McGough & Barkley, *supra* note 60, at 1951.

115. Zucker et al., *supra* note 109, at 379-80.

116. DSM-IV-TR, *supra* note 18, at 89. Supporting documentation may not always be available, but corroborating information from other informants, including prior school records, is helpful for improving the accuracy of the diagnosis.

117. Ranssen, *supra* note 15, at 454.

impossible”¹¹⁸ to acquire. The reliance on parental recollection is further complicated by the fact that ADHD is in some part attributed to genetics, i.e., parents with ADHD are more likely to have children with ADHD. In fact, many adults often do not get diagnosed until their children are diagnosed with the disorder.¹¹⁹ Consider the experience of Roger,¹²⁰ who did not receive a diagnosis of ADHD until after he struggled in law school.¹²¹ Roger later reported that, subsequent to his diagnosis, one of his parents was diagnosed with ADHD.¹²² Parental ADHD and the obstacles it can pose on recollection and awareness of their child’s ADHD behaviors create another barrier to reporting childhood ADHD symptoms in their now adult children.

Further, those for whom childhood symptoms are difficult if not impossible to prove are just as likely to legitimately have ADHD as those who can procure and provide such evidence. A study comparing adults who met all DSM-IV criteria and late-onset adults who met all criteria except the age requirement indicated that these adults showed similar personality profiles.¹²³ The authors of that study concluded that the results called into question the stringent age of onset criterion for adults being diagnosed with ADHD.¹²⁴

These and other limitations within the DSM criteria for ADHD diagnosis are significant.¹²⁵ Fortunately, the DSM itself acknowledges that its diagnostic criteria may be too limiting or insufficient, not only by recommending flexibility and professional judgment in applying the criteria, but also by including the “in partial remission” and “not otherwise specified” (“NOS”)

118. Allyson Harrison et al., *Identifying Students Faking ADHD: Preliminary Findings and Strategies for Detection*, 22 ARCHIVES CLINICAL NEUROPSYCHOLOGY 577, 578 (2007).

119. Adler, *supra* note 25; Rubin, *supra* note 77, at D1.

120. Student’s name has been changed to protect identity.

121. Interview with Roger, Golden Gate Univ., in S. F., Cal. (2009).

122. Interview with Roger, Golden Gate Univ., in S. F., Cal. (2011).

123. Stephen V. Faraone et al., *Diagnosing Adult Attention Deficit Hyperactivity Disorder: Are Late Onset and Subthreshold Diagnoses Valid?*, 163 AM. J. PSYCHIATRY 1720, 1720 (2006).

124. *Id.* at 1725; McCracken & McGough, *supra* note 24, at 1674; McGough & Barkley, *supra* note 60, at 1953 (supporting the view of invalidity of the current age of onset criterion and suggesting an increase to age twelve if not removal of the criterion altogether).

125. For instance, Criterion C, requiring some impairment from the symptoms in two or more settings, fails to encompass the greater number and more important settings that adults have and that are impacted by symptoms, such as the larger organized community (e.g., participating in government, driving, abiding by laws), financial management (e.g., banking, credit card use), raising children (e.g., providing sustenance, financial and social support, and education) marital functioning, and routine health maintenance. McGough & Barkley, *supra* note 60, at 1948–56.

categories.¹²⁶ Those who have symptoms or impairment but do not meet the threshold may be diagnosed as “in partial remission” (if subject currently does not meet the threshold)¹²⁷ or NOS (if subject never met the threshold).¹²⁸ Thus, clinicians may diagnose a person with ADHD when, for instance, symptoms may be met, but not at clinically significant levels¹²⁹ or when the requisite symptoms and impairment for the Predominantly Inattentive Type are present, but when the age of onset is seven years or older.¹³⁰ In fact, the NOS category exists in part to account for the fact that adult ADHD is not sufficiently addressed in the diagnostic criteria and that fewer symptoms may warrant ADHD diagnosis for adults than for children.¹³¹

E. DSM-5: Developments in Adult ADHD

The DSM-5, set for publication in May 2013,¹³² is expected to ameliorate the adult diagnosis of ADHD. Significant changes are being proposed by the American Psychiatric Association (“APA”) work groups¹³³ in response to the APA’s own acknowledgement of criticisms of the current diagnostic criteria, including that the structure of the subtypes is flawed and leads to some individuals meeting many symptoms in the different categories, but not enough in one category to warrant a diagnosis.¹³⁴ The criteria also are criticized for not accounting for certain manifestations of adult ADHD, “including the decline in the number of criteria with age without a reduction in impairment.”¹³⁵ The APA also acknowledges that the age of onset was arbitrarily set and does not account for the large number of cases with onset at or after age seven.¹³⁶

A number of changes that will impact adult ADHD diagnosis

126. DSM-IV-TR, *supra* note 18, at 93.

127. *Id.*

128. *Id.*

129. Zucker et al., *supra* note 109, at 387.

130. DSM-IV-TR, *supra* note 18, at 93 (specifically look at 314.9).

131. Ranseen, *supra* note 15, at 454.

132. News Release, Am. Psychiatric Ass’n, *DSM-5 Publication Date Moved to May 2013* (Dec. 10, 2009), available at <http://www.dsm5.org/Newsroom/Documents/09-65%20DSM%20Timeline.pdf>.

133. The American Psychiatric Association publishes the DSM and establishes work groups to examine and propose revisions to current criteria.

134. AM. PSYCHIATRIC ASS’N, *DSM-5: OPTIONS BEING CONSIDERED FOR ADHD 2* (2010), available at <http://www.dsm5.org/Proposed%20Revision%20Attachment/APA%20Options%20for%20ADHD.pdf>.

135. AM. PSYCHIATRIC ASS’N, *supra* note 134.

136. *Id.*

have been proposed for the DSM-5 ADHD diagnostic framework,¹³⁷

137. AM. PSYCHIATRIC ASS'N, A 10 ATTENTION DEFICIT/HYPERACTIVITY DISORDER PROPOSED REVISION (2010), available at <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=383#>. The DSM-5 proposed revision of diagnostic criteria for Attention-Deficit/Hyperactivity Disorder is as follows:

A. Either (1) and/or (2).

1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that impact directly on social and academic/occupational activities. *Note:* for older adolescents and adults (ages 17 and older), only 4 symptoms are required. The symptoms are not due to oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions.

(a) Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (for example, overlooks or misses details, work is inaccurate).

(b) Often has difficulty sustaining attention in tasks or play activities (for example, has difficulty remaining focused during lectures, conversations, or reading lengthy writings).

(c) Often does not seem to listen when spoken to directly (mind seems elsewhere, even in the absence of any obvious distraction).

(d) Frequently does not follow through on instructions (starts tasks but quickly loses focus and is easily sidetracked, fails to finish schoolwork, household chores, or tasks in the workplace).

(e) Often has difficulty organizing tasks and activities. (Has difficulty managing sequential tasks and keeping materials and belongings in order. Work is messy and disorganized. Has poor time management and tends to fail to meet deadlines.)

(f) Characteristically avoids, seems to dislike, and is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework or, for older adolescents and adults, preparing reports, completing forms, or reviewing lengthy papers).

(g) Frequently loses objects necessary for tasks or activities (e.g., school assignments, pencils, books, tools, wallets, keys, paperwork, eyeglasses, or mobile telephones).

(h) Is often easily distracted by extraneous stimuli. (for older adolescents and adults may include unrelated thoughts.)

(i) Is often forgetful in daily activities, chores, and running errands (for older adolescents and adults, returning calls, paying bills, and keeping appointments).

2. **Hyperactivity and Impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that impact directly on social and academic/occupational activities. *Note:* for older adolescents and adults (ages 17 and older), only 4 symptoms are required. The symptoms are not due to oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions.

(a) Often fidgets or taps hands or feet or squirms in seat.

(b) Is often restless during activities when others are seated (may leave his or her place in the classroom, office or other workplace, or in other situations that require remaining seated).

(c) Often runs about or climbs on furniture and moves excessively in

including more age appropriate symptoms for adults, such as “has difficulty remaining focused during lectures, conversations, or reading lengthy writings.”¹³⁸ Another example is the proposed alteration of the current symptom of “often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)” to remove “toys” and add, “wallets, keys, paperwork, eyeglasses, or mobile telephones.”¹³⁹

Notably, the proposed revision adds a fourth subtype of ADHD (in acknowledgement of the fluid nature of a person’s ADHD presentation, the proposed revision replaces the term “subtype” with “current presentation”),¹⁴⁰ Inattentive Presentation (Restrictive),

inappropriate situations. In adolescents or adults, may be limited to feeling restless or confined.

(d) Is often *excessively loud* or noisy during play, leisure, or social activities.

(e) Is often “*on the go*,” acting as if “driven by a motor.” Is uncomfortable being still for an extended time, as in restaurants, meetings, etc. Seen by others as being restless and difficult to keep up with.

(f) Often *talks excessively*.

(g) Often *blurts out an answer* before a question has been completed. Older adolescents or adults may complete people’s sentences and “jump the gun” in conversations.

(h) Has *difficulty waiting his or her turn* or waiting in line.

(i) Often *interrupts or intrudes* on others (frequently butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission, adolescents or adults may intrude into or take over what others are doing).

(j) Tends to *act without thinking*, such as starting tasks without adequate preparation or avoiding reading or listening to instructions. May speak out without considering consequences or make important decisions on the spur of the moment, such as impulsively buying items, suddenly quitting a job, or breaking up with a friend.

(k) Is often *impatient*, as shown by feeling restless when waiting for others and wanting to move faster than others, wanting people to get to the point, speeding while driving, and cutting into traffic to go faster than others.

(l) Is *uncomfortable doing things slowly and systematically* and often rushes through activities or tasks.

(m) Finds it *difficult to resist temptations or opportunities*, even if it means taking risks (A child may grab toys off a store shelf or play with dangerous objects; adults may commit to a relationship after only a brief acquaintance or take a job or enter into a business arrangement without doing due diligence).

B. Several noticeable inattentive or hyperactive-impulsive symptoms were present by age 12.

Id. (emphasis in original).

138. *Id.*

139. AM. PSYCHIATRIC ASS’N, *supra* note 137.

140. *Id.*; Keath Low, *Changes Being Considered for ADHD Diagnosis in DSM-5*, ABOUT.COM (July 15, 2011), <http://add.about.com/od/evaluationanddiagnosis/a/Adhd-Diagnosis-Changes-Being-Considered.htm>.

to the existing framework of three subtypes.¹⁴¹ The rationale behind this addition is to provide a descriptive name for ADHD presentation that involves little or no hyperactivity.¹⁴² As discussed previously, adult ADHD is not commonly indicated by hyperactivity,¹⁴³ but rather by inattention,¹⁴⁴ so this proposed fourth presentation could prove to be invaluable in the adult diagnosis of ADHD.¹⁴⁵

The proposed revision also includes four new impulsivity symptoms, which may help address the DSV-IV-TR's underrepresentation of impulsivity in the symptomology.¹⁴⁶ Since adult experience of ADHD more commonly includes impulsivity¹⁴⁷ and less commonly includes hyperactivity, the increased number of and attention to impulsivity symptoms in the DSM-5 proposed revision should assist with diagnosis of adults with ADHD.

The APA also proposes a lower symptom threshold for adolescents and adults.¹⁴⁸ The current DSM-IV-TR requires six symptoms, whereas the DSM-5 proposal requires only four symptoms for older adolescents and adults (ages seventeen and older).¹⁴⁹ Another important proposed change is the shift in the age of onset from seven years of age to twelve years of age.¹⁵⁰

II. The Legal and Policy Framework: Equal Rights and Diversity

Even with modern research revealing new and sophisticated developments regarding the diagnosis of ADHD, people with ADHD still face discrimination in terms of receiving equal treatment. Moreover, since the resources and methods for early identification of ADHD may vary based on a person's age, race, socioeconomic status, location, or gender,¹⁵¹ the childhood history documentation requirement unfairly impacts these specific groups. This section will focus on the legal protections afforded to bar

141. AM. PSYCHIATRIC ASS'N, *supra* note 137.

142. AM. PSYCHIATRIC ASS'N, *supra* note 134, at 7.

143. Barkley & Murphy, *supra* note 94, at 9.

144. McCracken & McGough, *supra* note 24, at 1673-74.

145. Barkley & Murphy, *supra* note 94, at 10.

146. Low, *supra* note 140.

147. McCracken & McGough, *supra* note 24, at 1673-74.

148. Barkley & Murphy, *supra* note 94, at 5-6.

149. AM. PSYCHIATRIC ASS'N, *supra* note 137.

150. *Id.*

151. *See infra* Part V.

applicants with ADHD by the Americans with Disabilities Act (“ADA”), address how these protections have been expanded and redefined by the ADA Amendments Act, and highlight other relevant state and federal antidiscrimination laws as well as ABA and state bar legal and policy concerns.

A. Discrimination Based on Disability

The Americans with Disabilities Act of 1990¹⁵² was the first federal civil rights legislation to apply to bar examinations.¹⁵³ The ADA “prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications.”¹⁵⁴ Title I of the ADA covers employment issues; Title II covers public services offered through state and local governments; Title III covers public accommodations and services operated by private entities; and Title IV covers telecommunications.¹⁵⁵ Clearly, this landmark legislation intended to protect people with disabilities and ensure their inclusion within American society.

Upon the signing of the ADA, President George H.W. Bush remarked that: “[E]very man, woman, and child with a disability can now pass through once-closed doors into a bright new era of equality, independence, and freedom . . . Let the shameful wall of exclusion finally come tumbling down.”¹⁵⁶

The ADA is a groundbreaking piece of legislation that seeks to remove all kinds of barriers for people with disabilities to engage equally in society — including becoming attorneys.¹⁵⁷

i. Protected Class: Individuals with ADHD

The ADA requires that a claimant suing for violation of the law prove membership in the protected class.¹⁵⁸ In order to qualify as a

152. Americans With Disabilities Act of 1990 §1, 42 U.S.C. § 12101 note (2006).

153. Judith Gunderson, *The ADA and the Bar Exam*, THE B. EXAMINER, May 2009, at 40.

154. U.S. DEP’T OF JUSTICE, CIVIL RIGHTS DIV., A GUIDE TO DISABILITY RIGHTS LAW (2005), available at <http://www.ada.gov/cguide.htm>.

155. 42 U.S.C. § 12101 note.

156. Pres. George H.W. Bush, Remarks on the Signing of the Americans with Disabilities Act (July 26, 1990).

157. Americans With Disabilities Act Amendments Act, 42 U.S.C.A. § 12101 (West 2011).

158. Definition of disability under section 35.104 of the Americans with Disabilities Act Amendments Act, 42 U.S.C.A. § 12102 (West 2011); Definition of impairment under the same:

person with a disability, one must have a physical or mental impairment that substantially limits a major life activity, a record of such impairment, or are regarded as having such impairment.¹⁵⁹ People with ADHD, who generally fall under this first classification, have faced ongoing challenges to qualification into this class even though most persons with a valid ADHD diagnosis meet the definition of disability under ADA coverage without having to document a childhood history. In many cases, students with cognitive or neurobehavioral disabilities were denied accommodation, because courts struggled with definitions of “major life activities” or “substantial limitations.”¹⁶⁰ Qualifying limitations

§ 35.104 Definitions.

(i) The phrase physical or mental impairment means—

§ (A) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine;

§ (B) Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

(ii) The phrase physical or mental impairment includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Id.

159. *Id.*

160. Robert Dinerstein, *The Americans with Disabilities Act of 1990; Progeny of the Civil Rights Act of 1964*, HUM. RTS. MAG., Summer 2004, at 10-11 (“[T]o the initial surprise of many experienced legal observers, an extraordinary number of cases have focused on this threshold definition, and many courts have held that individuals with disabilities that the ADA’s drafters clearly meant to cover . . . were insufficiently disabled to meet the statutory definition.”); See *Bartlett v. N.Y. State Bd. of Law Exam’rs*, 226 F.3d 69, 75-85 (2nd Cir. 2000) (finding that applicant with dyslexia who was denied accommodations did not qualify under the protected disability class of the ADA). In *Bartlett*, the court clarified prior court holdings, and ruled that professional licensing boards, including bar examiners, have to provide accommodations to people with cognitive disabilities, noting that a history of self accommodation does not necessarily remove an applicant from this class. *Id.* Note that Supreme Court Justice Sotomayor ruled in favor of *Bartlett* in 2002, rejecting the state board’s claims that the plaintiff was faking her disability. See Jim Dwyer, *On the Bench, With Fairness and Empathy*, N.Y. TIMES (May 26, 2009), <http://www.nytimes.com/2009/05/27/nyregion/27about.html>.; See also *Love v. Law School Admission Council*, 513 F. Supp. 2d 206, 208-28 (E.D. Pa. 2007) (holding that plaintiff with ADHD was not substantially limited in a major life activity because even with an extensive history of prior academic accommodations, the district court held that Love was not substantially limited by his impairment).

have impacted not only people with ADHD. According to a 2004 study, plaintiffs lost 97 percent of the overall ADA employment discrimination claims that actually made it to trial, often due to the definition of disability.¹⁶¹ Although ADHD has qualified as a disability in previous cases, arguments from defendants have tried to exclude individuals with ADHD from qualification within the ADA's protections.¹⁶² It was not until the ADA Amendments Act was enacted in 2008 that the definition of disability was broadened¹⁶³ to open this front door for students with ADHD and clarify their protections.¹⁶⁴

ii. Titles II and III as Applied to State Bars

Once an individual is verified as a person with a disability, the question then becomes what the law requires of a licensing agency, such as the state bar, to provide equal access to exams. The fact that the ADA is the first federal civil rights statute to apply unequivocally to state occupational licensing tests¹⁶⁵ suggests that policymakers understood the need to regulate licensing exams in order to ensure equal access for people with disabilities.

Another interesting component of the ADA as it applies to licensing exams is that protection of the rights of people with disabilities falls under two titles of the legislation. Because state bars receive government funding, they are considered public entities. Therefore, Section 12132 of Title II ("Public Services") applies to their policies and practices.¹⁶⁶ This section states:

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.¹⁶⁷

Title III ("Public Accommodations and Services Operated by Private Entities") also applies to licensing exams. The relevant language states:

161. Sandra B. Reiss & J. Trent Scofield, *The New and Expanded Americans with Disabilities Act*, 2009 THE ALA. L. 39, 39 (2009).

162. *See Love*, 513 F. Supp. 2d at 208-28 (holding that plaintiff with ADHD was not substantially limited in a major life activity).

163. 42 U.S.C.A. § 12132 (West 2011).

164. *See infra* Part IV.

165. 42 U.S.C.A. § 12189 (West 2011).

166. 42 U.S.C.A. § 12132.

167. *Id.*

Any person that offers examinations or courses related to applications, licensing certifications, or credentialing for secondary or postsecondary education, professional, or trade purposes shall offer such examinations or courses in a place or manner accessible to persons with disabilities or offer alternative accessible arrangements for such individuals.¹⁶⁸

There has been some debate as to whether Title III applies specifically to state bars.¹⁶⁹ However, the ADA has been clear in this designation as shown through their ADA Title III Technical Assistance Manual:

Examinations covered by this section include examinations for admission to secondary schools, college entrance examinations, examinations for admission to trade or professional schools, and **licensing examinations such as bar exams**, examinations for medical licenses, or examinations for certified public accountants.¹⁷⁰

With multiple sections of the ADA regulating state bars to administer their exams in a nondiscriminatory manner, applicants with disabilities are guaranteed significant protections of their civil rights by law.

iii. The ADA Amendments Act of 2008

Although key frameworks have been established to develop a disability rights structure in the United States, laws continue to develop in order to provide full protection of the intended class. For bar applicants, Title II and Title III have provided protection to people with disabilities who take bar examinations since the enactment of the ADA in 1990. However, there was tremendous confusion in the courts about even the most basic application of the ADA.¹⁷¹ Courts struggled with definitions of disability and the ADA's essential standards of "significant difficulty," and "major life activity."¹⁷² The result was that courts often held that students with

168. 42 U.S.C.A. § 12189.

169. Gunderson, *supra* note 153, at 40.

170. AMERICANS WITH DISABILITIES ACT, ADA TITLE III TECHNICAL ASSISTANCE MANUAL, III.-4.6100 EXAMINATIONS (emphasis added).

171. See sources cited, *supra* note 160.

172. *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 196–203 (2002) (limiting the broad scope of protection intended by Congress in enacting the ADA); *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 481–88 (1999) (also limiting broad scope of protection).

ADHD did not qualify as having a disability, and therefore the ADA's protections did not apply. As policymakers and disability advocates followed the implementation of this legislation, many were not satisfied with how it was playing out in the legal system.¹⁷³ As a result, President George W. Bush signed the 2008 ADA Amendments Act ("ADAAA")¹⁷⁴ eighteen years after his father signed the original act.

a. Broadening Protected Class

The ADAAA provided a number of changes to guarantee better implementation of the original civil rights act, including for people with disabilities generally and people with ADHD specifically.¹⁷⁵ The amended law broadened the protected class, or rather, clarified the definition to explain the broad range of the protected class. For instance, it added reading, concentrating, communicating, and thinking to the list of major life activities.¹⁷⁶

The ADAAA also removed the mitigating measures requirement, meaning someone taking medication for an impairment no longer is excluded from the definition of being disabled.¹⁷⁷ In addition, courts have clarified that self-accommodation does not remove one from the protected class.¹⁷⁸ Moreover, the ADAAA made it clear that an impairment that substantially limits one major life activity need not limit other major life activities to qualify as a disability.¹⁷⁹

The new interpretation of the definition of disability has lowered the threshold for individuals with respect to the amount of proof or evidence they must offer to establish they have a disability. Courts have held that the effect of the ADAAA on boards of bar examiners is that their focus should shift from scrutiny of the question of whether the applicant actually has a disability to the reasonableness of the accommodation(s) requested.¹⁸⁰ The ADAAA has lowered the threshold for the qualifying class, and the law supports construing the definition of disability in favor of broad

173. 42 U.S.C.A. § 12101 (a)(2) (West 2011).

174. Gunderson, *supra* note 153, at 40.

175. 42 U.S.C.A. § 12102 (2)(A) (West 2011).

176. *Id.*

177. 42 U.S.C.A. § 12102 (4)(E)(i)(I).

178. *Id.* § 12102 (4)(E)(i)(IV) ("learned behavioral . . . modifications"); *See Bartlett v. N.Y. State Bd. of Law Exam'rs*, 226 F.3d 69, 80 (2nd Cir. 2000) (finding that a history of self accommodation does not necessarily remove an applicant from this definition).

179. 42 U.S.C.A. § 12102 (4)(C).

180. Gunderson, *supra* note 153, at 43.

coverage to the maximum extent permitted.¹⁸¹

As early as 2009, although implementation of the Amendments Act was at its beginning, cases already were interpreting a more broad understanding of disability in higher education.¹⁸² Courts have held in both academic and nonacademic cases that while individuals still must present something more than a diagnosis, the failure to present an exhaustive listing of the manifestations of a condition no longer will defeat a disability claim.¹⁸³

b. Impact on Title III Entities

In addition to the newly clarified interpretations of the ADA's general provisions, the federal regulations weighed in on Title III's licensing exam portion. The regulations added three additional requirements to which licensing exam agencies must adhere in regards to their evaluation process.¹⁸⁴ First, requests for documentation must be "reasonable" and "limited" to the need for the accommodation.¹⁸⁵ Second, the licensing entity must give considerable weight to documentation of past accommodations in similar testing situations.¹⁸⁶ Finally, the entity must respond in a timely manner for requests for accommodations.¹⁸⁷

In "Appendix A to Part 36: Guidance on Revisions to ADA Regulation on Nondiscrimination on the Basis of Disability by Public Accommodations and Commercial Facilities," the Department of Justice explains the reasoning behind the new regulations, acknowledging that significant problems remain for individuals with disabilities who seek accommodations to examinations and courses.¹⁸⁸ The Appendix continues:

181. 42 U.S.C.A. § 12102(4)(A).

182. *Jenkins v. Nat'l Bd. Med. Examiners*, No. 08-5371, 2009 WL 331638, at *1 (6th Cir. Feb. 11, 2009) (applying the ADA retroactively to find Plaintiff, who had a reading disorder, was eligible to file suit as a person with a disability where originally he was denied relief for not being able to meet this definition).

183. *Rohr v. Salt River Project Agric. Improvement & Power Dist.*, 555 F.3d 850, 861 (9th Cir. 2009) (finding that "beginning in January 2009, "disability" was to be broadly construed and coverage will apply to the "maximum extent" permitted by the ADA and the ADA."); *Brodsky v. New England School of Law*, 617 F. Supp. 2d 1, 4 (D.C. MA 2009) (finding that "the ADA amendment is undoubtedly intended to ease the burden of plaintiffs bringing claims pursuant to that statute.").

184. 28 C.F.R. § 36.309 (2011).

185. *Id.* § 36.309(b)(1)(iv) ("Any request for documentation, if such documentation is required, is reasonable and limited to the need for the modification, accommodation, or auxiliary aid or service requested.").

186. 28 C.F.R. § 36.309.

187. 28 C.F.R. § 36.303 (2010).

188. *Id.* § 36.309, Appx. A.

It remains the Department's view that, when testing entities receive documentation provided by a qualified professional who has made an individualized assessment of an applicant that supports the need for the modification, accommodation, or aid requested, they shall generally accept such documentation and provide the accommodation.¹⁸⁹

In sum, the ADAAAA is an improved tool for advancing the disability rights of those most vulnerable to discrimination. The adjustments to the original act clarify that Congress' intent for the ADA was for the law to apply to a broad class. The ADAAAA is the primary legal safeguard for bar applicants with ADHD. The next section considers additional ways people with ADHD are protected by federal and state laws and policies.

B. Discrimination Based on Other Characteristics

Because this Article asserts that the childhood history requirement disproportionately impacts people based on age, race, socioeconomic status, location, and gender, it is important to briefly review other types of anti-discrimination laws and policies that also are implicated by state bar ADHD accommodations practices. The following summary is relevant to understand the pervasive inequitable impact of state bars' childhood history requirements.

i. Federal Anti-Discrimination Laws

In addition to the ADA, state bars also risk violation of other federal statutory laws for denial of accommodations based on lack of childhood history. Even where not explicitly applied to state bars, federal laws fortify how certain classes are more vulnerable and thus require legal protection. Although there is no specific reference in the law to examinations, some argue that Title VII of the Civil Rights

189. *Id.* § 36.309. The Department of Justice has held similar views as far back as 1992, stating in an amicus curiae memo that:

[a] testing entity should accept without further inquiry documentation establishing a disability and the need for special accommodations where that documentation represents the judgment of a qualified professional who has made an individualized assessment of the test candidate based on expertise relating to the disability in question.

Brief for the Government as Amicus Curiae supporting Plaintiff, *Rosenthal v. N.Y. St. Bd. of Law Exam'rs*, (S.D.N.Y. 1992) (No. 92 Civ. 1100), available at <http://www.ada.gov/briefs/rosenthr.pdf>.

Act of 1964 should apply to discriminatory practices of state bar exam administrators that affect racial minorities and women unfairly in employment.¹⁹⁰ Federal laws like the Age Discrimination in Employment Act of 1967 show a clear intent to protect people from discrimination on the basis of age,¹⁹¹ and similar laws have been replicated by states. While not recognized explicitly within anti-discrimination laws, discrimination based on socioeconomic status and location (which have a correlation with each other and with race) has been recognized as problematic by Congress¹⁹² and by case law.¹⁹³

ii. State Anti-Discrimination Laws

In addition to federal laws, states have enacted their own anti-discrimination laws to ensure equal access to their programs and services. State laws, like California's Unruh Civil Rights Act, enhance existing federal protections by clarifying that discrimination based on race, gender and age is not tolerated.¹⁹⁴ New Jersey's Law Against Discrimination is perhaps one of the nation's most comprehensive anti-discrimination laws and prohibits differential treatment based on race, color, age, sex, and disability.¹⁹⁵ New York's Human Rights Law provides another example of state-based protections based on age, race, sex, and disability and seeks to ensure that "every individual shall have an equal opportunity to participate fully in the economic, cultural and intellectual life of the state."¹⁹⁶ Illinois, where the American Bar Association is based, also forbids discrimination based on race, sex, and age based on its expansive Human Rights Act.¹⁹⁷

190. W. Sherman Rogers, *The ADA, Title VII, and the Bar Examination: The Nature and Extent of the ADA's Coverage of Bar Examinations and an Analysis of the Applicability of Title VII to Such Tests*, 36 HOW. L. J. 1, 2 (1993).

191. Age Discrimination in Employment Act (ADEA) of 1967, 29 U.S.C. §§ 621-34 (2006); CAL. CIV. CODE § 51 (2011).

192. The Equal Credit Opportunity Act, 15 U.S.C. § 1691 (2006); Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121 (Both references to equality based on socioeconomic status in the Equal Credit Opportunity Act, U.S. Code Title 42, Chapter 21, and Title III of the Disaster Relief and Emergency Assistance Act signal a recognition of this vulnerable class).

193. *Brown v. Bd. of Educ.*, 347 U.S. 483, 496 (1954) (connecting socioeconomic disadvantage to segregation); *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 23-30 (1971) (upholding the constitutionality of "forced busing").

194. CAL. CIV. CODE § 51.

195. N.J.S.A. § 10:5-1 et seq.

196. NY EXEC. L. § 290 et seq.

197. 775 Ill. Comp. Stat. Ann. 5/1-101 et seq. (2008)

iii. American Bar Association and State Bar Association Anti-Discrimination Policies

The American Bar Association's constitution denies access to its House for state or local bar associations that discriminate based on age, sex, race, ethnicity, and disability.¹⁹⁸ The Rules of the State Bar of California include similar standards for law schools:

Equal Opportunity and Non-Discrimination: Consistent with sound educational policy and these rules, the law school should demonstrate a commitment to providing equal opportunity to study law and in the hiring, retention and promotion of faculty without regard to sex, race, color, ancestry, religious creed, national origin, disability, medical condition, age, marital status, political affiliation, sexual orientation, or veteran status.¹⁹⁹

Both the ABA and state bars have developed thorough programs to combat discrimination and promote diversity within their memberships. California State Bar's Council on Access and Fairness,²⁰⁰ New Jersey State Bar Association's Diversity Committee,²⁰¹ New York State Bar Association's Committee on Diversity and Inclusion,²⁰² and Illinois State Bar Association's Diversity Leadership Council²⁰³ are just a few examples of state bar commitments to fostering greater diversity within the legal community.

While the main legal issue that arises from requiring a childhood history of ADHD is based on violations of the ADA, other

198. AM. BAR ASS'N, CONSTITUTION AND BYLAWS: RULES OF PROCEDURE OF THE HOUSE OF DELEGATES 1, 7 (2011), available at http://www.americanbar.org/content/dam/aba/administrative/aba_constitution_and_bylaws.authcheckdam.pdf. The ABA Constitution states, "A state or local bar association may not be represented in the House if its governing documents discriminate with respect to membership because of race, sex, religion, creed, color, national origin, ethnicity, age, sexual orientation or persons with disabilities." *Id.* § 6.4(e). This standard applies for disability as well.

199. CAL. BAR EXAM'RS, ADMISSION AND EDUCATIONAL STANDARDS, DIVISION, 2: ACCREDITED LAW SCHOOL RULES, 1, 10 (2007), available at <http://rules.calbar.ca.gov/LinkClick.aspx?fileticket=d-EEG4iWTQM%3d&tabid=1227> (according to the California Rule 4.160(M)).

200. *Council on Access & Fairness*, CAL. ST. B. ASS'N <http://cc.calbar.ca.gov/Committees/Commissions/Special/CouncilonAccessandFairness.aspx> (last visited May 1, 2012).

201. *Diversity Committee*, N.J. St. B. Ass'n <http://www.njsba.com/about/standing-committees/diversity-committee.html> (last visited May 1, 2012).

202. *New York State Bar Association's Committee on Diversity and Inclusion*, N.Y. St. B., http://www.nysba.org/AM/Template.cfm?Section=Committee_on_Minorities_in_the_Profession_Home (last visited May 1, 2012).

203. *Diversity Leadership Council*, Ill. St. B. Ass'n, <http://www.isba.org/committees/diversityleadershipcouncil> (last visited May 1, 2012).

legal and policy concerns arise from this practice. Therefore, in addition to directly violating the ADA, state bars may indirectly violate federal laws, their own state antidiscrimination laws, and their own policies of diversity inclusiveness.

C. Diversity in the Legal Profession

As evidenced in part by their antidiscrimination policies, a paramount policy consideration for state bars with regard to the provision of ADHD accommodations is the issue of diversity. From the national perspective, the ABA has expressed that the legal profession must be more inclusive and has identified its goal is to promote full and equal participation of lawyers with disabilities.²⁰⁴ The ABA's Presidential Initiative Commission Report from 2010 lists four specific arguments for diversifying the profession: the democracy, business, leadership, and demographic arguments.²⁰⁵ These arguments present a persuasive argument that it is not only morally right, but legally imperative, to have a diverse legal profession.

In the state with the largest number of lawyers, the California Bar's Council on Access and Fairness is the state bar's response to the challenge of diversifying the profession.²⁰⁶ Similar organizations exist in many states.²⁰⁷ The Council's role is to make recommendations to the Board of Governors to advance state bar diversity strategies and goals.²⁰⁸ To analyze the current status of diversity in the California legal profession, the Council compared census data and state-by-diversity data.²⁰⁹ The results showed a

204. AM. BAR ASS'N, DIVERSITY IN THE LEGAL PROFESSION: THE NEXT STEPS 3 (2010), available at <http://mldc.whs.mil/download/documents/Readings/Next%20Steps%20FinalVirtual%20Accessible%20042010.pdf>.

205. *Id.* at 5 (listing the democracy, business, leadership, and demographic arguments for why the legal field should be diverse: *Democracy* "Lawyers and judges have a unique responsibility for sustaining democracy." *Business* "The profession must be diverse to thrive in a global and domestically inclusive business environment." *Leadership* "Diversity is critical if the profession wishes to maintain a societal leadership role." *Demographic* "Changing demographics in society compel the profession to change its own demographics.").

206. *Council on Access & Fairness*, *supra* note 200. The authors commonly provide California as an example because it is the nation's largest legal market and given the experience the authors have with the California State Bar.

207. *Diversity Committee*, *supra* note 201; *New York State Bar Association's Committee on Diversity and Inclusion*, *supra* note 202; *Diversity Leadership Council*, *supra* note 203.

208. *Council on Access & Fairness*, *supra* note 200.

209. COUNCIL ON ACCESS & FAIRNESS, STATE BAR OF CALIFORNIA DIVERSITY PIPELINE ROAD SHOW SLIDES (2010); DIVERSITY PIPELINE TASKFORCE, REPORT AND RECOMMENDATIONS FROM DIVERSITY (2010), available at <http://cc.calbar.ca.gov/Com>

continuing deficit in terms of diversity and, in some cases, a step back in the progress that had been made toward diversifying the profession in earlier years.

Specifically, the Council's 2006 analysis reveals that the representation of African Americans²¹⁰ in the profession in California actually has decreased since 2001 and never reflected their proportion of the general population in the state.²¹¹ In California, African-Americans represented 2.4% of the profession in 2001 and, by 2006, had decreased to 1.7%.²¹² According to census figures, African Americans represent about six percent of the population,²¹³ a significant difference from their representation within the legal community.

Also, other minorities, such as Asian/Pacific Islanders and Hispanic/Latinos continue to grow in their proportion of the California population, but their representation in the attorney population in the state has not grown as significantly. Asian/Pacific Islanders represent twelve percent of the state population as recorded in the 2004 Census,²¹⁴ but they constitute only 5.3% of state's lawyers.²¹⁵ Even more alarming, Hispanic Americans represent thirty-five percent of the state population,²¹⁶ but only 3.8% of its attorneys.²¹⁷

In California, Caucasians represent over eighty percent of the profession in a state where they represent less than half of the population.²¹⁸ These trends are not much different on a national level. The 2010 ABA report cites that Caucasians constitute seventy percent of working people over age sixteen, but are overrepresented among lawyers.²¹⁹ As an example of this, eighty-nine percent of attorneys nationwide are Caucasian,²²⁰ and 89.3% of judges

mitteesCommissions/Special/CouncilonAccessandFairness.aspx (last visited May 1, 2012).

210. In this Article, the terms African American, Caucasian, Asian American/Pacific Islanders, and Hispanic American/Latino will be used to describe categories of race and ethnicity.

211. DIVERSITY PIPELINE TASKFORCE, REPORT AND RECOMMENDATIONS FROM DIVERSITY 2 (2006), available at <http://cc.calbar.ca.gov/CommitteesCommissions/Special/CouncilonAccessandFairness.aspx>.

212. *Id.* at 2.

213. *Id.*

214. COUNCIL ON ACCESS & FAIRNESS, *supra* note 209.

215. *Id.*

216. U.S. CENSUS BUREAU, ACS-03, THE AMERICAN COMMUNITY - HISPANICS: 2004 6 (2007), available at <http://www.census.gov/prod/2007pubs/acs-03.pdf>.

217. COUNCIL ON ACCESS & FAIRNESS, *supra* note 209.

218. DIVERSITY PIPELINE TASKFORCE, *supra* note 211, at 2.

219. AM. BAR ASS'N, *supra* note 12.

220. U.S. CENSUS BUREAU, EMPLOYED PERSONS BY DETAILED OCCUPATION, SEX,

nationwide are Caucasian.²²¹ This evidence of a lack of racial diversity in the profession is particularly disconcerting given the stated intentions of the ABA and state bars to prioritize diversity.

Like all minority lawyers, lawyers with disabilities face clear under representation in the legal profession. Lawyers with disabilities are much more difficult to survey and track for a number of reasons, including unwillingness to self-identify.²²² However, a 2001 survey administered by the California State Bar concluded that four percent of attorneys have a disability,²²³ compared to a 2001 Census report that found that 17.4% of Californians had disabilities.²²⁴ Interestingly, a 1991 demographic survey by the State Bar of California following the enactment of the Americans with Disabilities Act (“ADA”) determined that more than six percent of practicing attorneys identified themselves as having a disability.²²⁵ This estimate is in stark contrast to the national data from 2006 citing that only 0.33% of all lawyer members of the American Bar Association identified themselves as having a disability of any type.²²⁶ Regardless, the Census has long held the national disability statistic to be close to 20%.²²⁷ Therefore, any of the referenced percentages of attorneys with disabilities are well below a fair representation of this population within the American public.

RACE, AND HISPANIC OR LATINO ETHNICITY (2010), available at <http://www.bls.gov/cps/cpsaat11.pdf> (showing that in 2010, 4.3% of attorneys are Black or African American, 3.4% are Asian and 3.4% are Hispanic or Latino).

221. Pat K. Chew & Robert E. Kelley, *Myth of the Color-Blind Judge: An Empirical Analysis of Racial Harassment Cases*, 86 WASH. U. L. REV. 1117, 1125 (2009).

222. Joshua Pila, *A Defining Moment in the Legal Profession*, 13 YOUNG L., Feb.-Mar. 2009, at 4 (noting that individuals with certain types of disabilities must decide whether to “self-identify” as a person with a disability,” bearing in mind that “[s]elf-identification brings risks of stereotypes, employers concerned about expensive accommodations, and a negative feeling of being different from others.”).

223. DIVERSITY PIPELINE TASKFORCE, *supra* note 211.

224. *Id.*

225. *Employment of Legal Professionals with Disabilities and Chronic Medical Conditions*, Cal. St. B. Ass’n (June 1, 1996), <http://www.calbar.org/2ent/3gps/3clpd2.htm>.

226. Alexis Anderson & Norah Wylie, *Beyond the ADA: How Clinics Can Assist Law Students with “Non-Visible” Disabilities to Bridge the Accommodations Gap Between Classroom and Practice*, 15 CLINICAL L. REV. 1, 6 (2008).

227. *Selected Social Characteristics in the United States: 2009*, U.S. CENSUS BUREAU, http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_1YR_DP2&prodType=table (last visited May 1, 2012).

III. State Bar Policies and Practices Regarding ADHD Accommodations

In order to understand how the diversity of the legal profession is negatively impacted by the flawed childhood history requirement, it is important to first explore the framework of this unreasonable standard imposed by many state bars. This framework is evidenced by state bar accommodations processes, guidelines and denial letters.

As aforementioned, Title II and Title III of the Americans with Disabilities Act require that state bar examinations adhere to federal standards in order to provide equal opportunity for people with disabilities and to work to eradicate general stereotypes.²²⁸ In response to these legal obligations, each state bar established its own application process for accommodations. The documentation requirements for accommodations from the student's law school may differ substantially from the state bar's requirements, just as one state's bar's requirements may differ from another state bar. While a student's academic institution(s) may have required only documentation of a diagnosis and proof of any previous accommodations, the state bar process often cites lack of childhood history as the basis for denial of a request for accommodations.²²⁹

A student with ADHD applying for state bar accommodations in most states is required to submit full documentation of all

228. Americans with Disabilities Act §§ 202-203, 309, 42 U.S.C.A §§ 12132, 12189 (West 2006).

229. Examples of other accommodations processes that do not reference childhood history as a determining factor of diagnosis include *ADHD Form*, UNIV. CAL. HASTINGS, <http://www.uchastings.edu/disability/docs/ADHDDisabilityForm.pdf>; *ADHD Form*, UNIV. CAL. BERKELEY, <http://dsp.berkeley.edu/docs/ADHDCertification.pdf>; *ADHD Requirements Form*, GOLDEN GATE UNIV., http://www.ggu.edu/school_of_law/law_student_services/law_school_disability_services/application_process_and_forms. Note that Disability Rights California of California's Protection & Advocacy System issued a guide that clarifies that "Each school may impose its own criteria . . . to establish a disability and need for accommodation. However, the criteria established by the school cannot be so burdensome that they prevent individuals with disabilities from getting accommodations to which they are entitled." DISABILITY RIGHTS CALIFORNIA, LEGAL RIGHTS OF STUDENTS WITH DISABILITIES UNDER FEDERAL LAW: A GUIDE FOR COLLEGE AND UNIVERSITY STUDENTS 10 (2007). See also Laura F. Rothstein, *Disability Issues Continue to Challenge Legal Educators and Bar Admission Authorities*, ABA GENERAL PRAC.: SOLO & SMALL FIRM DIV. (1997) (noting that while universities and law schools have been subject to disability discrimination laws since 1973, Richard Bartlett, Chair of the National Conference of Bar Examiners has stated that "undergraduate schools and law schools are considerably less rigorous than bar examiners in determining the existence of a disability under the ADA, and then in determining the appropriate accommodations.").

previous testing evaluations that have diagnosed the student with ADHD or confirmed such a diagnosis.²³⁰ Where there is not a childhood diagnosis, students may and are encouraged to submit any evidence from their childhood that indicates ADHD symptoms were present.²³¹ In the experience of law school disability services professionals, this has resulted in submission by student bar applicants of a broad array of documents including primary school grade reports with faded pencil markings of “John Doe talks a lot,” to report cards in later years exhibiting academic struggle, and personal letters from parents who have admitted to the state bar committee that cultural beliefs or lack of information prevented them from getting their child the help they needed. Although the bar accommodations process is otherwise uniform and carefully structured, the documentation request for childhood history lacks clarity and specificity. Law school disability service professionals are advised to have their students send in everything the student has, but are not advised on what does and does not meet the standard held by the state bar.

A. California

In California, like many states, the process for applying for bar exam accommodations is form-based. Applicants with ADHD must complete Form A, which is the general request form for accommodations.²³² Applicants then need the diagnosing psychologist and evaluator to complete Form D to provide additional insight into the psychologist’s evaluation for ADHD.²³³ Finally, the law school disability services provider fills out Form F, confirming any accommodations the student received while in law school.²³⁴

Along with the forms described above, the California State Bar provides a three-page document of guidelines for applicants with

230. THE STATE BAR OF CAL., *supra* note 39, at 1-3; STATE OF MICH. BD. OF LAW EXAM’RS, RULES, STATUTES, AND POLICY STATEMENTS 20 (2011), available at <http://courts.michigan.gov/SUPREMECOURT/BdofLawExaminers/BLERules.pdf>, (last visited May 1, 2012); MASS. BD. OF BAR EXAMR’S, NONSTANDARD TESTING ACCOMMODATIONS: GUIDELINES AND INSTRUCTIONS FOR APPLICANTS AND LICENSED PROFESSIONALS vi (2011), available at <http://www.mass.gov/bbe/july2011ntaapplication.pdf> (last visited Aug. 4, 2011).

231. THE STATE BAR OF CAL., *supra* note 39, at 1.

232. The State Bar of California, *Testing Accommodations*, OFFICE OF ADMISSIONS FORMS, <http://admissions.calbar.ca.gov/LinkClick.aspx?fileticket=fH1p38XMjsc%3d&tabid=258> (last visited May 1, 2012).

233. THE STATE BAR OF CAL., *TESTING ACCOMMODATIONS FOR APPLICANTS WITH DISABILITIES* 3 (2011), available at <http://admissions.calbar.ca.gov/LinkClick.aspx?fileticket=68SGCOfZR8s%3d&tabid=258> (last visited May 1, 2012).

234. *Id.*

learning disabilities and ADHD.²³⁵ This document focuses on the childhood history requirement as a determining factor in providing bar accommodations.²³⁶ Part two of the requirements emphasizes that applicants “warranting an ADHD diagnosis must meet basic DSM-IV criteria,” including “evidence that symptoms of inattention and/or hyperactivity-impulsivity were present during childhood.”²³⁷

Guidelines consideration number two, below, exemplifies the standard to be achieved by applicants with ADHD:

[An] ADHD evaluation is primarily based on in-depth history consistent with a chronic and pervasive history of ADHD symptoms beginning during childhood and persisting to the present day. The evaluation should provide a broad, comprehensive understanding of the applicant’s relevant background, including family, academic, social, vocational, medical, and psychiatric history. There should be a focus on how ADHD symptoms have been manifested across various settings over time, how the applicant has coped with the problems, and what success the applicant has had in coping efforts. There should be a clear attempt to rule out a variety of other potential explanations for the applicant’s self-purported ADHD difficulties.²³⁸

Although cognitive evaluations that diagnose ADHD typically include a background history portion, they focus primarily on how to adjust the subject’s future learning potential. Typically, evaluations include a brief biography statement, and the majority of the evaluation will analyze the subject’s performance on a variety of cognitive tests. Therefore, cognitive psychologists generally are more focused on the scientific results from the battery of testing than one’s biographical background, thus rendering the fulfillment of such rigorous guidelines impractical if not impossible.²³⁹

The weight of the childhood history requirement also is made clear through state bar denial letters. A number of California State Bar denials of ADHD bar accommodations include language from a State Bar evaluator concluding that without evidence satisfying the childhood history requirement, the diagnosis should not be applied. In one instance, a student received a letter in which the evaluator noted that, “The diagnosis of ADHD hinges on evidence of clinically

235. THE STATE BAR OF CAL., *supra* note 39, at 1-3.

236. *Id.* at 1.

237. *Id.* at 1-2.

238. *Id.*

239. This is based on the authors’ experience working with cognitive psychologists.

significant impairment that has a childhood onset... Without compelling evidence of early-appearing and chronic impairment across settings, the diagnosis is regarded as inappropriate."²⁴⁰ Such responses imply that childhood history is not merely a consideration amongst several other DSM criteria, but a hard requirement.

B. Other States

Unfortunately the denial of accommodations based on lack of childhood history documentation is not solely a California issue, but is the practice of state bars across the country. Our 2010 investigation of all state bars in the United States revealed that at least sixteen other state bars require evidence of childhood history of ADHD for an applicant to qualify for ADHD accommodations.²⁴¹

The Michigan State Bar specifically requests documentation such as "educational transcripts, report cards, teacher comments, tutoring evaluations, job assessments and the like."²⁴² Massachusetts' instructions for applicants offer additional insight into what state bars are seeking, including "kindergarten, elementary, middle school, and high school report cards . . . teacher comments, [and] disciplinary records."²⁴³ Ultimately, these state bars and at least fourteen others are sending the troubling message to bar applicants with ADHD that they need to have retained childhood evidence to prove their disability if they hope to get accommodations on the bar exam.

240. Letter from Section Chief for Admin., State Bar of California (2009) (quoting consultant in letter denying bar accommodations for ADHD diagnosis) (on file with the authors).

241. This assessment was conducted by the authors, who gathered applications of and/or contacted all fifty state bars to ascertain whether each state bar required childhood history documentation of ADHD for provision of ADHD accommodations. The following states indicated childhood history evidence requirement: Arizona, California, Colorado, Connecticut, Florida, Louisiana, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, and Wyoming.

242. STATE OF MICH. BD. OF LAW EXAM'RS., *supra* note 230.

243. MASS. BD. OF BAR EXAMR'S, *supra* note 230.

IV. Requirement of Childhood History Documentation Exposes State Bars to Liability under ADA

The state bars that require childhood history of ADHD through a strict reading of select portions of the DSM are exposing themselves to liability under the ADA. The diagnostic criteria are more flexible and the ADA is broader in coverage than these state bars' childhood history requirement implies.

A. State Bars' Childhood History Requirement is Unsupported by the DSM

State bars' reliance on the flawed "age of onset" diagnostic factor is an inaccurate interpretation of what ADHD is and how it is to be diagnosed. As observed in letters from the state bars to applicants denying ADHD accommodations,²⁴⁴ as well as guidelines made available to bar applicants,²⁴⁵ the DSM seems to be the tool to which state bars refer in their requirement for childhood history documentation. However, as the DSM acknowledges, and as discussed above, the DSM criteria for ADHD are not appropriate for many people who were not diagnosed in childhood and thus should be interpreted more flexibly by state bars, as it often is by experts in the field of psychology.

In reality, people who have been diagnosed with ADHD as children generally have recorded childhood history from their diagnostic tests and exams and thus do not face the significant hurdles in receiving ADHD accommodations on the bar exam as compared to those who were not diagnosed until early adulthood or later. Many law students, as with the general population and more so with specific populations as described in Part Five below, are not diagnosed until adulthood,²⁴⁶ and thus often do not have and cannot reasonably meet the childhood history requirement.

One naturally might wonder how a person can reach adulthood and, specifically, law school matriculation, without having been diagnosed with or accommodated for ADHD. Bar examiners' skepticism is apparent in their denial of ADHD accommodations for applicants who received an ADHD diagnosis relatively recently (often during law school)²⁴⁷ and is at the root of their strict

244. Letter from Section Chief for Admin., *supra* note 240.

245. THE STATE BAR OF CAL., *supra* note 39.

246. Bernd Hesslinger et al., *Attention Deficit Hyperactivity Disorder in Adults – Early vs. Late Onset in a Retrospective Study*, 119 PSYCHIATRY RES. 217, 218 (2003).

247. Letter from Section Chief for Admin., *supra* note 240.

requirement that applicants present evidence of a childhood history of ADHD.

As discussed in Part One, being diagnosed for the first time in adulthood is not at all uncommon, and there are many reasons why individuals with ADHD, particularly law students, may not have been recognized as such earlier.²⁴⁸ As previously described, many adults have not been diagnosed earlier due to their high intelligence quotient which masks their symptoms.²⁴⁹ Indeed, this could explain how a number of law students who legitimately have ADHD have not been diagnosed until law school. Many students also are not diagnosed until law school due to the unique nature of the academic endeavor. For instance, law school may be the first time a person is assessed academically based on two- to three-hour timed exams (often solely on one final exam in each class) that may raise ADHD issues that were not raised by prior academic assessment techniques, such as take-home, untimed papers.

Matriculating in law school, itself, undoubtedly is a large change in a person's life, adding significant responsibilities and pressure, and thus may worsen symptoms or mitigate the effect of coping mechanisms. This can make the disability's symptoms more evident. Recall the experience of Sasha, described in the Introduction.²⁵⁰ The unique law school academic requirements also can make it clear that a prior diagnosis of another disorder does not completely address the impairment. This was the case with Maya,²⁵¹ a law student previously diagnosed with Major Depression and later diagnosed during law school with ADHD. She recounted that it was not until her subsequent ADHD diagnosis that all of her symptoms were properly addressed.²⁵² Hence, it is not uncommon for people who have made it through grade school and college to finally realize they have ADHD when they begin their higher education coursework²⁵³ and specifically may explain why a number of law students seek and receive their first diagnosis in law school.

The bar examiners' requirement for corroborating information is supported by a strict reading of the DSM guidelines, which recommend the use of caution in diagnosing ADHD solely on an adult's recall of his or her own symptoms, because the validity of

248. See *supra* Part I.C. and accompanying notes.

249. See Able et al., *supra* note 76, at 98.

250. See *supra* Introduction and accompanying notes.

251. Student's name has been changed to protect identity.

252. Interview with Maya, Golden Gate Univ. in S. F., Cal. (2010).

253. Rubin, *supra* note 77, at D1.

such retrospective self-report is “often problematic.”²⁵⁴ However, even when able to recall their own childhood symptoms accurately, many applicants are unable to fulfill the bar examiners’ requirement for corroborating evidence of the disorder, either via retrospective parental reports or childhood academic records such as report cards.

Interestingly, the same experts who have implored clinicians to use the standard of proving childhood history, also have acknowledged clearly that it is no easy task, citing that one’s parents may be deceased (especially with older students), ADHD may not have been widely acknowledged during the applicant’s elementary school years (perhaps for cultural reasons or due to the older age of the student), one’s school environment may have affected lack of diagnosis (especially in poorer neighborhoods), or school report cards may be difficult to obtain (especially for older students or those from immigrant or less stable economic backgrounds).²⁵⁵ Although evaluators of applicants for bar accommodations have acknowledged that applicants face significant difficulties documenting a childhood history of ADHD, unfortunately they do not give applicants a viable path to overcome these barriers.²⁵⁶

Some state bars’ requirement of childhood history documentation indicates that they rely on a strict reading of some parts of the DSM criteria but do not consider the reality of ADHD underdiagnosis in childhood. Nor do they appropriately heed the DSM’s caution to avoid applying the criteria strictly in all circumstances and to utilize all of the available diagnostic tools the DSM provides, such as the “in partial remission” and “NOS” diagnosis. This approach by state bars leaves a number of applicants who legitimately have ADHD without the accommodations mandated by the law.

B. State Bars’ Childhood History Requirement Violates the ADA

A survey of Florida attorneys conducted in 2006 provides a vivid illustration of what bar applicants with disabilities are facing when it comes to bar accommodations.²⁵⁷ In this survey, one-third of attorneys with disabilities indicated that they thought the Florida State Bar’s testing accommodation documentation requirements and

254. DSM-IV-TR, *supra* note 18, at 89.

255. RUSSELL A. BARKLEY & KEVIN R. MURPHY, ATTENTION-DEFICIT HYPERACTIVITY DISORDER: A CLINICAL WORKBOOK 431-32 (3d. ed. 2005).

256. Ranseen, *supra* note 15, at 455.

257. THE DISABILITY INDEPENDENCE GROUP, FLORIDA LAWYERS WITH DISABILITIES: A SURVEY REPORT, 2006 8 (2007).

the application for admission were unfair.²⁵⁸ Nineteen percent of these lawyers reported having difficulty in the bar accommodation process, and twenty-one percent reported that policies and practices created barriers in the bar exam process.²⁵⁹ This survey explains how a general perception has developed about the accommodations process of the state bar: that it is flawed and in many cases unreasonable.

The specific barrier to equal access for applicants with ADHD to the bar exam is two-fold. First, a number of state bars require applicants with ADHD to provide childhood history documentation of the disorder in order to be qualified as a person with a disability. Due to an inability to meet this burden, students are not eligible to receive protections guaranteed under the ADA. Second, even if a state bar determines a person with ADHD as a qualifying person with a disability, they then require evidence of childhood history in order to justify the provision of any reasonable accommodation for the licensing exam. The recent amendments to the ADA underscore that the manner in which many state bars are preventing students with ADHD from receiving accommodations is an injustice unsupported by the law both in defining a person as having a disability and in the determination of reasonable accommodations.

i. ADHD under the ADA Amendments Act

As discussed in Part Two, one first must meet the ADA definition of a person with a disability in order to receive its protections under Title II and Title III for licensing exams.²⁶⁰ Although people with ADHD have faced obstacles being qualified under this definition in the past, the ADA Amendments Act ("ADAAA") makes it clear that this class should be covered under its protections.

A person with a disability is defined under the ADA as someone with a physical or mental impairment that substantially limits a major life activity.²⁶¹ The ADA Amendments Act clarifies that this protected class is intended to be broad.²⁶² The added language to include reading, concentrating, communicating, and thinking to the list of major life activities shows the intention of

258. *Id.*

259. *Id.*

260. Definition of disability under the Americans with Disabilities Act Amendments Act, 42 U.S.C.A. § 12102 (West 2011); definition of impairment under the same.

261. Definition of disability under the Americans with Disabilities Act Amendments Act, 42 U.S.C.A. § 12102; definition of impairment under the same.

262. 42 U.S.C.A. § 12101 (West 2011).

Congress to create not only a broad class of protection, but also to include the types of cognitive or neurobehavioral impairments that people with ADHD have.²⁶³

Bar evaluators have argued that if an individual with ADHD either takes medication or has a history of academic success through self-accommodation, the individual is not considered disabled.²⁶⁴ The ADAAA has clarified that this was not the intent of Congress when it adopted the original act and that both medications and self-accommodation (referred to in the statute as “learned behavioral modifications”) do not prevent a person from being qualified as a person with a disability.²⁶⁵

With these intentional adjustments to the law to ensure extensive coverage, there is little if nothing to support the position that someone with ADHD should not qualify for protection for lack of a childhood history. Rather, the law is clear, and the amendments now further clarify, that a person with a mental impairment who is substantially limited in a major life activity is qualified for protection under federal law.²⁶⁶ Receipt of a diagnosis from a valid professional should afford the applicant protection, without in-depth historical backgrounds. Accordingly, people with ADHD should qualify for protection and not be held to unreasonable documentation standards such as proving childhood manifestation of a condition to receive reasonable accommodations.

ii. The Childhood History Requirement Violates the ADA Amendments Act

People with ADHD, as a qualified class, receive protections against discrimination in licensing exams under Title II and Title III of the ADA (as amended). To require thorough evidence of a previously undiagnosed condition from childhood is a violation of the ADAAA’s new regulations for licensing exams which include a clarification that any request for documentation must be reasonable and limited to the need for accommodation.²⁶⁷ State Bars’ requests for report cards from elementary school, teacher comments, and disciplinary records to support a request for accommodations are

263. 42 U.S.C.A. § 12102 (2)(A).

264. John Ranseen, *Reviewing ADHD Accommodation Requests: An Update*, THE BAR EXAMINER, Aug. 2000, at 6, 13.

265. 42 U.S.C.A. § 12102 (4)(E)(i).

266. 42 U.S.C.A. § 12101.

267. 28 C.F.R. § 36.309(b)(1)(iv) (2011) (“Any request for documentation, if such documentation is required, is reasonable and limited to the need for the modification, accommodation, or auxiliary aid or service requested.”).

not reasonable requirements under the ADA.

Students already are asked to provide cognitive tests to support their diagnosis.²⁶⁸ This assessment, in most cases, should suffice for state bars evaluating accommodations requests. However, state bars historically have shown distrust for many clinical psychologists who provide an applicant's diagnosis,²⁶⁹ often rejecting the conclusions or diagnoses of the clinicians. Therefore, students receive denials for requests based on a lack of childhood history information, despite thorough cognitive assessments confirming their diagnosis.²⁷⁰

While most documentation for one's disability can be personal and confidential information, the requirement of childhood history obligates applicants with ADHD to reveal unnecessary private information. State bar guidelines make it apparent that bar applicants with ADHD have a steep hill to climb to qualify for accommodations. For example, California's guidelines state that an applicant's evaluation should include a thorough compilation of one's family, academic, social, vocational, medical, and psychiatric history.²⁷¹ In requiring this unreasonable evidence, state bars ask students to provide highly personal information that may not have been required for receipt of previous academic support, and above all, are unreasonable investigations into one's privacy.

In one particular instance, Maya, the aforementioned student with an adult ADHD diagnosis, felt compelled to submit a heartfelt and deeply personal letter written from her father because she could not meet these hefty demands for childhood history documentation.²⁷² In the letter, Maya's father confessed that he believed he had failed his daughter by not getting her tested for ADHD as a child and felt tremendously guilty that she did not receive the services she needed earlier in her academic career, thus causing her to struggle throughout it.²⁷³ The state bar's implicit encouragement of this level of personal information surpasses the realm of reasonableness.

268. The State Bar of California, *Testing Accommodations for Applicants with Disabilities*, Office of Admissions, 3, <http://admissions.calbar.ca.gov/LinkClick.aspx?fileticket=vzyGLTZxddg%3d&tabid=267> (last visited August 3, 2011).

269. Ranseen, *supra* note 15, at 451, 453 ("[C]linicians often seem quite willing to base their diagnoses and rationale for accommodations on very limited information . . . There is a good deal of concern that ADHD is often being diagnosed as a catch-all category for individuals with various emotional complaints and general life difficulties.").

270. Interviews with anonymous students, Golden Gate Univ., in S.F., Calif. (2008–2010).

271. THE STATE BAR OF CAL., *supra* note 39, at 1–2.

272. Interview with Maya, *supra* note 252.

273. *Id.*

Consider also the experience of Marcus,²⁷⁴ a law student who received a diagnosis of ADHD as a child and had documentation of that diagnosis, but whose testing needed to be updated in order to measure his current learning potential.²⁷⁵ During his first year of law school, Marcus wanted testing that would meet the requirements of a state bar examination and thus made an appointment to see a cognitive psychologist who was familiar with bar exam accommodation requirements.²⁷⁶ Marcus did, in fact, receive a very thorough report with an in-depth summary of his background, from birth until law school, just as the bar guidelines encourage.²⁷⁷

Once the report was issued, Marcus asked the evaluator to submit to his law school an edited version with an abridged biography.²⁷⁸ Later, Marcus revealed that the full report detailed private information that he did not want to share, specifically, his adoption and other family background that nobody beyond his immediate family knew.²⁷⁹ Although he ultimately decided to submit the full report to the law school with the belief he would have a better chance of acquiring the accommodations he needed,²⁸⁰ one could understand his hesitation to reveal something so personal and not necessarily related to receiving academic accommodations. In conversations with the cognitive psychologist who provided the report, the law school ascertained that the evaluator created the unabridged report in response to what her experience indicated state bars expected.²⁸¹

In addition to unreasonable requests under the ADA, state bars sometimes create additional barriers to receiving ADHD accommodations, such as an impractical appeal deadline. Students applying for bar accommodations in California are informed that their decision can take up to five months, and if a denial is given close to the exam date, they are given a limited number of days or no time to appeal.²⁸² In one instance, bar applicant Luis²⁸³ was given

274. Student's name has been changed to protect identity.

275. Interview with Marcus, Golden Gate Univ., in S.F., Calif. (2009).

276. *Id.*

277. *Id.*

278. *Id.*

279. *Id.*

280. *Id.*

281. Telephone Interview with anonymous cognitive psychologist, Golden Gate Univ., in S.F., Calif. (2009).

282. CAL. BAR EXAM'RS, ADMISSION AND EDUCATIONAL STANDARDS, ADMISSION TO PRACTICE LAW IN CALIFORNIA 23-24 (2007), available at <http://rules.calbar.ca.gov/LinkClick.aspx?fileticket=-2KV5j0w6Cw%3d&tabid=1227>.

ten days from the time his denial letter was received to gather childhood history documentation to prove his adult ADHD diagnosis.²⁸⁴ Within the ten day period, Luis planned a trip to his junior high school find the teacher who had mentioned something about his undiagnosed behavior as a child.²⁸⁵ He was over thirty years old at this point, and his teacher no longer worked at the school.²⁸⁶ Thus, beyond an appeal letter from his law school and his cognitive testing results (which already had been dismissed for lack of childhood history), the student was on his own to prove the existence of his condition to the bar.²⁸⁷

Despite the strong legal framework in place to protect them, students with ADHD who apply for accommodations on state bar examinations still face significant barriers to equal access. Bar examiners' strict standards for students with non-visible disabilities, including ADHD, are in part derived from fears that a bar applicant is faking an impairment²⁸⁸ in order to gain an advantage or that if qualified, the student will not be able to perform the functions of a lawyer. However, the research on extended time for examinations for postsecondary students shows that, although most students may raise their scores with additional time, students with learning disabilities make significantly greater gains than those without.²⁸⁹ Some have held that "to label lawyers with non-visible disabilities as the probable class of incompetent lawyers only strengthens the position that the ADA's purpose of eradicating stereotypes and misconceptions regarding qualified individuals with disabilities is legitimate."²⁹⁰

The law is clear that people with ADHD are protected under the ADA. Recent amendments have clarified the original intent of the

283. Student's name has been changed to protect identity.

284. Interview with Luis, Golden Gate Univ., in S.F., Calif. (2009).

285. *Id.*

286. *Id.*

287. Interview with Luis, Golden Gate Univ., in S.F., Calif. (2010) (confirming that after several failed attempts at the bar examination without bar accommodations, the student upon appeal did successfully get bar accommodations and was able to take the bar exam with accommodations, albeit over a year later.).

288. See *Bartlett v. N.Y. State Bd. of Law Exam'rs*, 226 F.3d 69, 76 (2nd Cir. 2000) (highlighting defendant's argument implying that Plaintiff was working with psychologists to create a fabricated diagnosis).

289. Ellen R. Julian et al., *The Impact of Testing Accommodations on MCAT Scores: Descriptive Results*, 79 *ACADEMIC MEDICINE* 360, 360-64 (2004). This article also notes that "the AAMC is investigating whether speed of processing written material is an element of performance on the MCAT, and whether it should be." *Id.* at 364.

290. Bruce Familant, *Comment: The Essential Functions of Being a Lawyer with a Non-visible Disability*, 15 *T.M. COOLEY L. REV.* 517, 565 (1998).

legislation and broadened the protected class to ensure it covers people with ADHD.²⁹¹ Specific changes to the safeguards to prevent discrimination in licensing exams are an indication that state bars are restricted in requesting documentation that is unreasonable such as childhood history. The ADA^{AAA} serves as the legislative enforcement to ensure that applicants with ADHD are no longer subject to such unreasonable requirements; and if they are, this is a clear violation of their federal rights.

V. Requirement of Childhood History Documentation Disproportionately Impacts Other Protected Classes and Impedes Diversity in the Legal Profession

Ultimately, the ambition of this research is to not only challenge the childhood history requirement of some state bars, but also to reveal how the diversity of the legal profession is negatively impacted by this requirement. State bars fail to recognize the serious issues the childhood history requirement presents for minorities and other underrepresented populations with an adult diagnosis who are thus denied equal access into the legal profession. The reduced likelihood of older, minority, socioeconomically disadvantaged and geographically disadvantaged, and female groups to be able to provide childhood history documentation presents dire circumstances for the legal profession, one of the least diverse professions in the country.

A. Reduced Likelihood of Childhood History Documentation: Older Applicants

The age of a person has a direct impact on whether they are likely to have or be able to receive a “by the book” diagnosis of ADHD. As long as the age of onset criterion exists, older students will be less likely to receive a diagnosis and thus receive ADHD accommodations on the bar exam, because they were under the threshold age of seven at a time when awareness and understanding of ADHD was very low and, thus, the disorder was underdiagnosed.

As noted earlier, the number of children diagnosed with ADHD has risen substantially since the 1970s.²⁹² Diagnosis of ADHD has increased due to broader diagnostic criteria of the DSM-IV, greater acceptance of medication treatments, and improved general

291. 42 U.S.C.A. § 12101 (West 2011).

292. Adler & Cohen, *supra* note 21.

awareness of the disorder.²⁹³ Relatively older law school students are less likely to have heard of ADHD because they grew up during a time when it was less widely recognized.²⁹⁴

Using our own institution²⁹⁵ as a model, the 2008 full-time matriculant class (in other words, those who likely applied for ADHD accommodations for the July 2011 bar exam), the average age at matriculation was twenty-six.²⁹⁶ Thus, the average student was age seven or under in 1989, a time when their elementary schools remained unequipped to properly identify students with ADHD and when minority, female, and poor students were extremely underidentified.²⁹⁷ Some of these underidentified populations started to become better identified, but limitations still remained.²⁹⁸ For instance, one survey of teachers in the mid-1990s indicated that eighty-five percent of them had taught children with ADHD, but the majority had received no training to do so.²⁹⁹ This means that many students in our sample set were under age seven before many people even knew what ADHD was. Thus, they were less likely to have their symptoms identified by either their parents or their schools.

Add to that the fact that the older the person, the less likely they are to remember their own childhood symptoms, and the less likely their parents are available and able to remember or provide their school report cards. It also is very difficult, if not impossible in most scenarios, to track down a teacher from many years earlier, as experienced by another typical applicant, Luis.³⁰⁰ The older the student, the less likely the student will be able to provide the childhood history of ADHD required by many state bars for provision of ADHD accommodations, which indicates that older students are not only less likely to be granted ADHD accommodations, but as a result are disadvantaged in passing the bar and entering practice.

293. Schneider & Eisenberg, *supra* note 4, at 602.

294. McLeod et al., *supra* note 4, at 627.

295. Authors' home institution is Golden Gate University School of Law.

296. This data is based on a query run by the Registrar at Golden Gate University School of Law.

297. Olfson et al., *supra* note 5, at 1074.

298. *Id.*

299. Soleil Gregg, *ADHD – New Legal Responsibilities for Schools*, APPALACHIA EDUC. LABORATORY ST. POL'Y PROGRAM 4 (1994).

300. Interview with Luis, *supra* note 284.

B. Reduced Likelihood of Childhood History Documentation: Racial and Ethnic Minority Applicants

Research indicates that a number of racial, cultural and ethnic minority groups — African Americans, Hispanic Americans, and children of immigrant parents in general — are less likely to be identified in childhood as having symptoms of ADHD.³⁰¹ African American and Hispanic American populations likely have a similar incidence of ADHD as the general population; the actual prevalence of Hispanic-Americans diagnosed is lower.³⁰²

Minority children, particularly African-American children, are not only underdiagnosed, but also undertreated.³⁰³ One study found that, between 1987 and 1997, large numbers of children belonging to racial or ethnic minority groups were brought into treatment, so their underdiagnosis was significantly more severe in the late 1980s.³⁰⁴ This is the time period when a number of law schools' current students were under age seven. Even with the increase over that ten-year period, the treatment rates of racial and ethnic minorities remain significantly below those of Caucasian children, with Caucasian children still at least twice as likely to receive ADHD treatment as minority children.³⁰⁵ Thus, there still is a ways to go before this disparity is adequately addressed.³⁰⁶

Even controlling for income and other characteristics (as there are some links between racial or ethnic classification and socioeconomic level), non-Caucasian children and children of immigrants are diagnosed with ADHD at relatively lower rates than other elementary school students.³⁰⁷ Hispanic-American and African-American children remain less likely to be diagnosed after controlling for other characteristics.³⁰⁸

Race, culture, and ethnic minority status and discrimination based on such factors have been found to impact whether certain populations are identified as having and receiving appropriate treatment for ADHD.³⁰⁹ These factors can be broken down into two

301. Schneider & Eisenberg, *supra* note 4, at 601-09.

302. Pastor & Reuben, *supra* note 12, at 3; Rahn K. Bailey, *Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in African-American and Hispanic Patients*, 97 SUPP. TO J. NAT'L MED. ASS'N 3S, 3S (2005) (listing prevalence of ADHD in Hispanic-Americans at 3.3%).

303. Able et al., *supra* note 76, at 97-107; Bailey, *supra* note 302.

304. Olsson et al., *supra* note 5, at 1074.

305. *Id.*

306. *Id.*

307. Schneider & Eisenberg, *supra* note 4, at 607.

308. *Id.*

309. Charmayne Maddox, *Race Matters: Disparities in African-American Children with*

categories: (1) race, culture, and ethnic minority status – in other words, the experiences and perspectives of the people in these groups; and (2) discrimination – in other words, the attitudes and behavior of others about the people in these groups.

i. Race, Culture, Ethnic Minority Status – Intrinsic Factors

Many minorities with ADHD cannot meet the childhood history requirement due to a number of reasons intrinsic to their racial or ethnic background or membership in a minority population. First, parental and cultural views of clinical issues, particularly ADHD, and parental engagement with medical providers may cause a child not to be identified as having ADHD symptoms.

Minority parents are less likely to identify ADHD in their child than Caucasian parents.³¹⁰ Case studies have indicated that there is a lack of trust and effective communication between minority patients and non-minority medical providers, and this may prevent the best ADHD care and treatment for minority patients, given the lack of minority health care providers.³¹¹ Historical events³¹² have led to a number of African Americans having an even greater lack of trust and a fear of the unknown with regard to medical research.³¹³ African-American parents also are more likely to indicate lack of knowledge of appropriate treatment for their child and less likely to request medication treatment.³¹⁴

Parental and cultural discomfort with clinical issues in general also negatively impact likelihood of recognition of symptoms. Ethnic minority parents are less likely to recognize their child's clinical problems than Caucasians.³¹⁵ Studies show Caucasian

Attention Deficit Hyperactivity Disorder, 10 PENN ST. MCNAIR J. 145, 149 (2003).

310. Heather Hervey-Jumper et al., *Deficits in Diagnosis, Treatment and Continuity of Care in African-American Children and Adolescents with ADHD*, 98 J. NAT'L MED. ASS'N, 233, 234 (2006).

311. Bailey & Owens, *supra* note 11, at 7S.

312. E.g., The Tuskegee Experiment, which was an experiment from 1930s to 1970s in which a U.S. government public health organization studied the natural untreated progression of syphilis by studying a group of rural, poor African-American men who did not know they had syphilis and were told they were just receiving free health care. *U.S. Public Health Service Syphilis Study at Tuskegee: The Tuskegee Timeline*, CTRS FOR DISEASE CONTROL, <http://www.cdc.gov/tuskegee/timeline.htm> (last updated June 14, 2011). Even when penicillin was discovered to treat syphilis in the 1940s, the study continued, and these men were not treated. *Id.*

313. Bailey & Owens, *supra* note 11, at 7S.

314. Bussing et al., *supra* note 13, at 569.

315. Mery J. Macaluso, *The Role of Culture in Parental Perceptions of Psychological Disorders in Children and Help-Seeking Behaviors* 57 (2005) (Ph.D. dissertation, University of Kansas), (No. 3185188), *microformed on* ProQuest Information and Learning Company,

parents to be more effective at advocating for care for their children than African-American parents,³¹⁶ who also may not seek medical attention for the symptoms out of fear of over diagnosis or misdiagnosis.³¹⁷

Specifically, parental and cultural beliefs and knowledge about ADHD vary by race or ethnicity³¹⁸ and impact the likelihood of a child being recognized as having ADHD symptoms. Racial and ethnic minority groups are less likely to have heard of ADHD,³¹⁹ which may be a cause of their under diagnosis relative to Caucasian children.³²⁰ For example, African-American parents' relative lack of knowledge and health beliefs about ADHD could prevent them from seeking help for their children, pointing to the need for culturally sensitive parent education.³²¹

Even those who have heard of ADHD may have specific beliefs about it that result in under diagnosis. A study of African-American and Caucasian educators, medical personnel, and social workers who work with parents of children attending four inner city schools with large African-American populations found that African-American parents and other African Americans who interact with them are more likely to view ADHD as a social construct and less likely to view it as a biological issue than their Caucasian counterparts.³²² They may instead attribute ADHD to an excess of sugar in the diet.³²³ Research also has found that African-American parents believe that their child will outgrow the symptoms.³²⁴

Hispanic-American parents also are less likely than Caucasian parents to view ADHD as a biological issue.³²⁵ Instead, they place a high value on behavior demonstrating respect and compliance and are concerned with perceived disrespect from their children, and this perspective impacts how they assess and whether they report their child's behavior.³²⁶ In fact, Hispanic-American children with ADHD

Ann Arbor, MI (on file with the authors).

316. Bussing et al., *supra* note 13, at 571.

317. Bailey & Owens, *supra* note 11, at 7S.

318. Regina Bussing et al., *Knowledge and Information About ADHD: Evidence of Cultural Differences Among African-American and White Parents*, 46 SOC. SCI. & MED. 919, 925 (1998).

319. *Id.* at 926.

320. Bailey & Owens, *supra* note 11, at 6S.

321. Bussing et al., *supra* note 13, at 572; Hervey-Jumper et al., *supra* note 310, at 233-38.

322. Maddox, *supra* note 309, at 154-55.

323. Bussing et al., *supra* note 318, at 923; McLeod et al., *supra* note 4, at 626-31.

324. Bailey & Owens, *supra* note 11, at 6S.

325. Cynthia E. Perry et al., *Latino Parents' Accounts of Attention Deficit Hyperactivity Disorder*, 16 J. TRANSCULTURAL NURSING 312, 313 (2005).

326. Perry et al., *supra* note at 319.

have associated the disorder with “getting into trouble.”³²⁷

The fear of the social stigma associated with ADHD also results in more marked underdiagnosis of ADHD in racial or ethnic minorities.³²⁸ Minority parents feel that their children already are disadvantaged due to racial discrimination and thus believe that ADHD diagnosis will cause additional discrimination against their children.³²⁹

Specific research on this issue has found that African-American parents are concerned that their child’s future employment or military service options will be limited by an ADHD diagnosis and thus do not pursue diagnosis and treatment of their child’s symptoms.³³⁰ African-American beliefs and attitudes concerning mental health reinforces the view that being labeled as having a behavioral problem has particularly negative consequences for African-American children.³³¹ African-American parents also feel significant pressure from their social networks to refrain from seeking treatment for symptoms, and they worry that their parenting skills will be viewed in a negative light if they seek attention for their child’s symptoms.³³²

Roger, from Part One above, was African American, and his lack of childhood diagnosis was due in part to this social stigma.³³³ He reported that, although at least one teacher prior to law school had raised the issue of possible ADHD, he never had been tested for or diagnosed with ADHD.³³⁴ He acknowledged that lack of prior recognition of ADHD was due, in significant part, to family and community pressure against ADHD testing and diagnosis.³³⁵ Societal pressure also may have played a role in Roger’s parent not getting diagnosed with ADHD until after his parent learned of and accepted Roger’s diagnosis.³³⁶

Many parts of Asian-American culture emphasize societal reputation, view disability as a taboo, and treat people with

327. *Id.* at 313.

328. Paul Ruffins, *Creating an Atmosphere of Acceptance*, 25 DIVERSE ISSUES IN EDUC., 14, 15 (2008).

329. Bailey & Owens, *supra* note 11, at 75; Rashmi Goel, *Delinquent or Distracted? Attention Deficit Disorder and the Construction of the Juvenile Offender*, 27 L. & INEQUALITY 1, 33 (2009).

330. Bailey & Owens, *supra* note 11, at 75.

331. Bussing et al., *supra* note 318, at 919-28.

332. Perry et al., *supra* note 325, at 316-17.

333. Interview with Roger, *supra* note 121.

334. *Id.*

335. *Id.*

336. Interview with Roger, *supra* note 122.

disabilities as social outcasts, so many Asian-American parents do not want their children tested for or labeled as having a cognitive disability.³³⁷ Immigrants in general feel a pressure to assimilate at any cost, and being labeled as having a disability often is viewed as counterintuitive to assimilation.³³⁸ Research has found that Hispanic-American parents also fear the stigma related to mental disorders.³³⁹

Another reason for underdiagnosis of racial or ethnic minorities is the competing pressures on and priorities of these parents. In a study of reasons for underdiagnosis of African-American children, it was found that competing concerns rank higher in parental priority.³⁴⁰ African-American families are more likely to be single mother families, often where the mother has less education,³⁴¹ and this may impact the parental ability to identify the symptoms in their child.

Language barriers for ethnic minorities and children of foreign-born parents also may cause dismissal of ADHD symptom concerns or parental difficulties in bringing the issues sufficiently to the attention of medical providers or schools.³⁴² There is significantly lower prevalence of ADHD among primarily non-English speaking children.³⁴³

In addition, there are a number of ways that minorities' engagement with schools also may impact recognition of ADHD symptoms. One study indicated a disconnect between African-American parents and the schools, which could help explain why African-American students appear to have more limited access to support services regarding ADHD.³⁴⁴ Immigrant parents do not have as much personal knowledge of the American education system and may not realize the resources available through the

337. Heejin Kim, *Challenges of Neuropsychological Testing with Asian American Adults: A Critical Review of the Literature* 44 (June 2011) (unpublished Ph.D. dissertation, Pepperdine University), available at: <http://gradworks.umi.com/3459907.pdf>.

338. *Id.* at 46.

339. Perry et al., *supra* note 325, at 316-17.

340. Bailey & Owens, *supra* note 11, at 68.

341. Hervey-Jumper et al., *supra* note 310, at 236.

342. Perry et al., *supra* note 325, at 319-20 (setting forth that the lower prevalence of childhood diagnosis of ADHD among Hispanic children, as compared to non-Hispanic children, is due in part to language barriers).

343. S.N. Visser & C.A. Lesesne, *Prevalence of Diagnosis and Medication Treatment for Attention-Deficit/Hyperactivity Disorder – United States, 2003*, 54 MORBIDITY & MORTALITY WKLY. REP. 842, 844 (2005).

344. Bussing et al., *supra* note 13, at 571.

schools to help with their child's difficulties.³⁴⁵

ii. Race, Culture, Ethnic Minority Status – Extrinsic Factors

Discrimination and inequality among medical providers and schools, whether conscious or unconscious, result in underdiagnosis of ADHD in racial or ethnic minority children. With regard to medical providers, such discrimination could be due to the minority's actual access to healthcare or the medical treatment they eventually receive.

Although more likely than Caucasian children to use emergency care, minority children are less likely to have a regular source of healthcare,³⁴⁶ such as a primary care physician. In fact, minority children have "usual sources of care" eleven percent less often than Caucasian children, which means barriers to their access to primary care.³⁴⁷ Specifically, some have argued that the lower prevalence of diagnosed ADHD in Hispanic-American children is due in part to less access to health care.³⁴⁸ African-American children with ADHD symptoms are less likely to receive clinical care than children of other racial/ethnic backgrounds.³⁴⁹ One large factor in access to healthcare is insurance, and African-American and Hispanic-American children are less likely to have health insurance than Caucasian children.³⁵⁰ Given that health insurance is closely tied to socioeconomic status, this topic will be further discussed in the section addressing socioeconomic disparities in diagnosis.

Racial discrepancies in access to basic health care also result from discrimination issues among health care providers.³⁵¹ Medical providers may dismiss concerns regarding ADHD symptoms due to language barriers and medical provider bias.³⁵² The medical undertreatment of ADHD in African- and Hispanic-Americans may be tied to discrimination.³⁵³ Clinicians' statistical discrimination – having different expectations for different ethnicities – may play a role, as some researchers have found that clinicians may view

345. Gustavo Pérez Carreón et al., *The Importance of Presence: Immigrant Parents' School Engagement Experiences*, 42 AM EDUC RES J. 465, 467–68, 470 (2005).

346. Maddox, *supra* note 309, at 151–52.

347. *Id.*

348. Pastor & Reuben, *supra* note 12, at 3.

349. David S. Mandell et al., *Ethnic Disparities in Special Education Labeling Among Children With Attention-Deficit/Hyperactivity Disorder*, 16 J. EMOTIONAL & BEHAV. DISORDERS 42, 49 (2008); Olfson et al., *supra* note 5, at 1074.

350. Maddox, *supra* note 309, at 152.

351. *Id.* at 151.

352. Perry et al., *supra* note 325, at 319–20.

353. Maddox, *supra* note 309, at 151.

African-American children's behavior as more related to environment and Caucasian children's behavior as more related to a biological cause, which may lead to more disruptive disorder diagnosis in African-American children and more ADHD diagnosis and treatment in Caucasian children, when they exhibit the same symptoms.³⁵⁴ African-American children generally are misperceived as being more active than non-African-American children,³⁵⁵ and this view on the part of a medical provider may cause them to miss an ADHD diagnosis.

Discrimination and unequal access to resources in schools is another reason minority children are underdiagnosed. According to the U.S. Department of Education in 2005, African-American and Hispanic-American students underused school-based services ("SBSs").³⁵⁶ Teachers play a very large role in whether and how a student is identified as having symptoms of a disability, as they serve as the primary referral points for special education, and their perspectives are viewed by the assessment teams as very relevant.³⁵⁷ In fact, the assessors usually confirm the teacher's recommendations, even in spite of contrary evidence.³⁵⁸

Just as school resources play a role in determining the likelihood of receiving a merited ADHD diagnosis, the resources of the child's family play a large role in whether the child with ADHD symptoms will be identified as such. Thus, it is important to examine the impact socioeconomic background has on the ability to provide childhood documentation of ADHD.

C. Reduced Likelihood of Childhood History Documentation: Socioeconomically Underprivileged Applicants

A person's socioeconomic background has an impact on whether their ADHD symptoms are identified. One study found that students requesting and receiving a diagnosis of "learning disabled" (which, for purposes of that study, included ADHD) are disproportionate as compared to affluent communities.³⁵⁹ Rates in treatment have increased between 1987 and 1997 for all socioeconomic groups, but the largest increases were among children from low income families. In 1987, children from medium

354. Mandell et al., *supra* note 349, at 46.

355. Bailey & Owens, *supra* note 11, at 8S.

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

357. Mandell et al., *supra* note 349, at 43.

358. *Id.*

359. Lerner, *supra* note 5, at 1116.

or high income families were more than twice as likely to receive treatment for ADHD than those from low income families, but by 1997, this disparity narrowed.³⁶⁰ This bodes well for the lower income students who will start to trickle into law schools in the next few years. However, current students were age seven or under, on average, when this disparity was still fairly large.

The underdiagnosis of ADHD in less affluent communities is linked to the lack of resources of the student and their family, as well as to the lack of resources in schools in less affluent areas. The student and their family's lack of financial resources and socioeconomic status play a large role in their not being identified with ADHD symptoms. Lack of resources is related to lack of access to healthcare, including lack of insurance, and also lack of resources for psycho-educational testing.

Obviously, there are economic discrepancies in access to basic health care. Many people just cannot afford health care, and many families do not have any type of insurance.³⁶¹ Some costs associated with ADHD are private clinical assessment, which easily can cost into the range of \$2500 for a timely assessment.³⁶² Under the IDEA, the testing should be covered in elementary school.³⁶³ However, many students from affluent families pay for their own testing to make sure it is thorough and accurate as opposed to what the school might provide.³⁶⁴ Lack of insurance plays a role in that people without insurance often cannot afford the needed medication and other treatment.³⁶⁵ As with children from minority backgrounds, children from poor families are less likely to have the "usual sources of care," which creates barriers to accessing primary care,³⁶⁶ which is where ADHD is sometimes identified.

Children with health insurance, whether private or Medicaid, have a higher prevalence of ADHD diagnosis and are more likely to

360. Olfson et al., *supra* note 5, at 1073.

361. Hervey-Jumper et al., *Identifying, Evaluating, Diagnosing, and Treating ADHD in Minority Youth*, 5 J. ATTENTION DISORDERS 522, 525 (2008); Maddox, *supra* note 309, at 152.

362. See, e.g., *Learning Disability & ADHD Testing*, NORMANDELE COMMUNITY C., http://www.normandale.mnscu.edu/osd/resources/pdfs/LD_ADHD_Testing_Options.pdf (last visited Apr. 15, 2012); *About Neuropsychological Assessment*, WILLOW TREES PSYCHOLOGICAL SERVICES, http://www.willowtrees.org/neuro_assessmnt.php (last visited Apr. 15, 2012).

363. See Matthew Cohen, *AD/HD Under IDEA*, THE CHILD ADVOCATE (Jan. 11, 2011), http://www.childadvocate.net/adhd_and_idea.htm.

364. This is based on the authors' experience working with students with disabilities.

365. Hervey-Jumper et al., *supra* note 361, at 525.

366. Maddox, *supra* note 3099, at 152.

be diagnosed than those without insurance.³⁶⁷ Even though the disparity between low income and high income diagnosis has narrowed, one study found that the rate of treatment for uninsured children remained less than half of the rate of treatment of those with insurance.³⁶⁸

Even at the law school stage, many students lack the resources to get recent testing as required by the bar examiners. At a conference on assisting law students with disabilities, a speaker aptly stated: "Now it is very clear under the law that it is your obligation to produce documentation that is necessary. On the other hand, there is a very distinct problem with it not being very equal in terms of economic justice."³⁶⁹

Education level of parents also is a factor in whether a child is identified with ADHD symptoms. One study found that higher socioeconomic status, as determined by educational attainment and income, indicated "greater awareness of ADHD and an endorsement of biomedically oriented treatments."³⁷⁰ People with higher income are more likely to believe ADHD is a real disorder, and people with higher education are more likely to have heard of ADHD³⁷¹ and seek assistance for ADHD symptoms in their children than parents with lower levels of education.³⁷² African-American parents on average have lower levels of education, which is related to awareness of health care and medical issues and treatments.³⁷³ In addition, the social stigma associated with the diagnosis and treatment of a mental health issue is likely more prevalent in populations with less education and lower socioeconomic status.³⁷⁴

ADHD behaviors and symptoms often appear in school settings. Therefore schools play an important role in ADHD identification and treatment.³⁷⁵ In some less-resourced schools, identification of a student with ADHD may be hindered by the fact that the demands triggering evidence of symptoms may not appear until higher grade levels due to a less demanding curriculum in the lower grades. Also, when schools are under-resourced, they may not have the practical ability to identify ADHD symptoms in students as

367. Pastor & Reuben, *supra* note 12, at 4.

368. Olfson et al., *supra* note 5, at 1073.

369. American University Journal of Gender, Social Policy & the Law, Conference Panel: *The Bar Examination*, 15 AM. U. J. GENDER SOC. POL'Y & L. 861, 867 (2007).

370. McLeod et al., *supra* note 4, at 627.

371. *Id.* at 626.

372. Hervey-Jumper et al., *supra* note 310, at 523; Macaluso, *supra* note 315, at 61-62.

373. Hervey-Jumper et al., *supra* note 310, at 523.

374. Able et al., *supra* note 76, at 105.

375. Leslie et al., *supra* note 356, at 164.

effectively as schools that are properly resourced. While education accountability laws have resulted in a greater likelihood of diagnosis, probably due to increased pressure for student performance,³⁷⁶ these pressures are relatively recent, so the underprivileged, underperforming schools that our current students attended were not subject to such pressures.

Also, the resources at schools for students with ADHD grew significantly when, in 1991, the U.S. Department of Education recognized that students with ADHD can be considered disabled and therefore eligible for special education services.³⁷⁷ This special education eligibility reform brought more students into treatment, many of whom had not previously received treatment, since in poorer communities, many of the children receiving mental health services received them solely through what is available in their schools.³⁷⁸ Nonetheless, a 1999 study indicated that the existence of ADHD had been recognized only relatively recently, and many K-12 schools still did not have comprehensive and effective screening programs, often leaving students unidentified as having ADHD until college or law school.³⁷⁹ Unfortunately, such a late diagnosis makes it difficult to provide the childhood history documentation required by some state bars and puts socioeconomically disadvantaged bar applicants at a further disadvantage in access to the bar examination.

D. Reduced Likelihood of Childhood History Documentation: Applicants from Rural or Certain Geographic Regions

There also are discrepancies in diagnosis based on location, which means that people from certain areas face a greater challenge in receiving ADHD bar accommodations due to lack of a childhood history. For instance, people in rural and semi-rural areas are less likely to be diagnosed with ADHD.³⁸⁰

Geographically, the western region of the U.S. has significantly lower rates of ADHD diagnosis.³⁸¹ Data collected by the Center for Disease Control indicates that ADHD diagnosis varies dramatically

376. Schneider & Eisenberg, *supra* note 4, at 602.

377. ROBERT R. DAVILA ET AL., JOINT POLICY MEMORANDUM (ADD), OFFICE OF SPECIAL EDUC. & REHABILITATIVE SERVICES (Sept. 16, 1991), available at http://www.wrightslaw.com/law/code_regs/OSEP_Memorandum_ADD_1991.html.

378. Olsson et al., *supra* note 5, at 1074.

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

380. Schneider & Eisenberg, *supra* note 4, at 602; Rowland et al., *supra* note 46, at 165.

381. Schneider & Eisenberg, *supra* note 4, at 601.

from state to state, from a parent-reported diagnosis of 5.6% in Nevada to 15.6% in North Carolina.³⁸² Treatment rates also vary from state to state. A Drug Enforcement Agency study indicated that the rate of Ritalin use from 1990–1995 was six times higher in some states compared to others.³⁸³ From 1997–1999, some states had thirty times more Ritalin use than other states, and some communities used one hundred times more than other communities.³⁸⁴ Ritalin use is not necessarily an indication of appropriate diagnosis of ADHD, but the shocking disparity in Ritalin-based treatment must point to some diagnostic differences regionally. Given significant differences in identification of ADHD based on location, the ability to provide childhood documentation of symptoms may depend on regional trends in diagnosis, making reliance on a strict age of onset standard intrinsically unfair.

E. Reduced Likelihood of Childhood History Documentation: Female Applicants

Female children are less likely to be diagnosed with ADHD than male children.³⁸⁵ In fact, the prevalence of ADHD is reported to be anywhere between two to four times higher in males than in females.³⁸⁶ The Centers for Disease Control (“CDC”) sets the prevalence of ADHD without a learning disability as being more than two times higher for boys than for girls and sets the prevalence of ADHD with a learning disability as being about two times higher for boys than for girls.³⁸⁷ This disparity has not changed much over the years, as one study found that in both 1987 and 1997, boys were about three times as likely to receive ADHD treatment as girls.³⁸⁸ Some suggest a biological basis for this,³⁸⁹ but many attribute the discrepancy in diagnosis at least in part to how the behaviors of girls versus boys are viewed and understood.³⁹⁰

The view that ADHD is a male disorder still is commonly held,³⁹¹ which results in referral and sampling bias.³⁹² Teachers, often the first to identify a student as possibly having ADHD, tend

382. *Data & Statistics*, *supra* note 20.

383. LeFever & Arcona, *supra* note 5, at 4.

384. *Id.*

385. Schneider & Eisenberg, *supra* note 4, at 607.

386. Barzman et al., *supra* note 29, at 27.

387. Pastor & Reuben, *supra* note 12, at 3.

388. Olfson et al., *supra* note 5, at 1073.

389. Barzman et al., *supra* note 29, at 27.

390. Sigler, *supra* note 4.

391. *Id.*

392. Barzman et al., *supra* note 29, at 27.

to suspect ADHD more in boys than in girls.³⁹³ Boys' behavior is more likely to be viewed as disruptive,³⁹⁴ which leads to greater referral for ADHD testing.³⁹⁵

In girls, ADHD is exhibited less by disruptive behavior and more by sitting quietly and daydreaming,³⁹⁶ so they tend to go undetected. Girls are twice as likely as boys to have the predominantly inattentive type of ADHD³⁹⁷ which, as was discussed in Part One, is much more difficult to identify by age seven.³⁹⁸ This may explain why many girls have a harder time meeting the age of onset requirement.

Girls also make a greater effort to compensate, cover up ADHD symptoms, and generally fit in by studying more and asking for assistance.³⁹⁹ If their symptoms are identified, they often are mistakenly viewed as symptoms of depression or another psychiatric disorder.⁴⁰⁰

Because many girls go unidentified in their childhood, women often go undiagnosed for not being able to meet the childhood history requirement.⁴⁰¹ They often realize they have ADHD only after major adult life stresses, such as balancing family and career or a difficult higher education experience.⁴⁰² But by then, it is too late to be able to provide the childhood history the bar seeks, so women as a group are disadvantaged in receiving ADHD accommodations on the bar exam.

VI. Recommendations

The relative inability of these underrepresented and legally protected groups to provide the childhood history documentation of ADHD required by many state bars has serious legal and policy implications that must be addressed. Current diagnostic criteria are outdated and will soon be replaced.⁴⁰³ Pursuant to diagnostic instructions and legal mandates, and consistent with the goal of

393. Sigler, *supra* note 4.

394. Mandell et al., *supra* note 349, at 48; Pastor & Reuben, *supra* note 12, at 7.

395. Rowland et al., *supra* note 46, at 165.

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

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

398. See *supra* Part I.

399. Sigler, *supra* note 4.

400. *Id.*

401. *Id.*

402. *Id.*

403. See News Release, American Psychiatric Association, *supra* note 132.

increasing the diversity of the legal profession, state bars should promptly shift to employing flexibility in applying diagnostic criteria, and the American Bar Association should mandate that shift. In the meanwhile, law schools should push for this change while also taking practical, mitigating steps to support their students applying for accommodations.

A. Recommendations for State Bars and the American Bar Association

The representation of lawyers with disabilities is far below this class' representation in society. Whether this is based on concerns about stigma in the profession or barriers to access to the legal community, it is a problem that needs to be prioritized in all state bars. The fear, therefore, should not be about providing unnecessary accommodations; it should be about not providing fair and equal access.

Thus, until the DSM-5 is published, and in anticipation of the proposed changes, state bars should exercise reasonable judgment in the application of DSM criteria to adults with great deference to qualified clinicians who have conducted medically accepted diagnostic testing. Moreover, state bars should consider all information to determine whether impairment has occurred over the lifetime of the applicant. They also should provide accommodations with a threshold of less than six symptoms when circumstances justify it. They should seek third-party corroboration of lifetime symptoms when available, but provide accommodations, perhaps via the ADHD-NOS diagnosis, when such corroboration is not available for an otherwise qualified applicant. State bars should no longer view seven as the magic age by which symptoms and impairments must appear. Certainly state bars should continue to request childhood history and any corroborating information a person can reasonably acquire, but they then need to accept that it is wholly possible, and for some people very likely, that they are not going to be able to provide such documentation or even self-report relevant childhood history.

Further, state bars need to ensure that they are viewing disability and accommodations in the context of diversity and equal access. This is not only in terms of diversifying the legal profession for lawyers with disabilities, but also realizing how these documentation requirements affect applicants with disabilities who are minorities or females, or members of other underrepresented populations. Awareness of the disproportionate number of minority, older, female, rural, and socioeconomically underprivileged

applicants less likely to be able to provide childhood history documentation (but not less likely to have ADHD) should prompt state bars to study in-depth the impact the strict childhood history documentation requirement has on the provision of ADHD bar accommodations to different populations.

State bars should recognize that an applicant wrongfully denied ADHD accommodations is thereby denied equal access to the bar exam and legal profession. Therefore, state bars should scrutinize their ADHD bar accommodations policy and reconsider the validity of their strict interpretation of the childhood history requirement. Applying such scrutiny, they will realize the invalidity of their policies and practices and, these authors hope, employ greater flexibility in applying the DSM criteria for diagnosis of ADHD diagnosis.

State bars are encouraged to work in conjunction with law students and law schools in a positive way and provide a service rather than a barrier. Further, there must be improved transparency between state bars and law schools. It is difficult to ascertain how pervasive the childhood history issue is because many state bars, like California, are hesitant to reveal how many students apply for accommodations, how many are denied, and on what basis. This information is imperative for law schools that work directly with students with disabilities and have an obligation to ensure the fair treatment of these students as they advance their legal careers. Thus, an open dialogue between state bars and law schools is necessary.

Finally, state bars must ensure compliance with governing laws. The ADA and the subsequent Department of Justice regulations (in effect since March 2011),⁴⁰⁴ should have a clear effect on the way that bar applicants with ADHD apply for accommodations. The law and its regulations clarify that people with ADHD can qualify within the protected class and that licensing exams are not permitted to request unreasonable documentation for the provision of accommodations, among other restrictions.

Both legal and moral obligations should motivate each state bar to establish a task force empowered to review changes in the law and regulations, as well as changes in the diagnostic criteria and tools (such as the DSM), in order to provide applicants with disabilities the fairest process. This task force should make practical recommendations to bring state bar procedures into compliance with the law and into closer conformity with best practices of law schools and medical professionals. Indeed, much of this work could be

404. 28 C.F.R. § 36.101 (2011).

centralized, and the results should be uniform. Hence, a role for the ABA also may exist, specifically to assess the current practices of all state bars with regard to disability accommodations on the bar exam, in light of the ADA, other laws and policies, and the evolving DSM, and to bring state bars into compliance.

B. Recommendations for Law Schools

Until the state bars in question alter their policies and practices to create more flexibility with regard to childhood history, law schools need to act proactively. They should explain to their students applying to these state bars the challenges that they may face with ADHD bar accommodations. Specifically, law school professionals must discuss the need to have thorough testing with as much documentation as exists of the student's childhood history. Law schools should recommend that students who were not diagnosed as children to be prepared to answer the state bar's difficult question of why they were not diagnosed until adulthood. Students should begin this preparation, including the gathering of any information related to diagnosis, as early as possible before they enter their third year. In addition, law schools should encourage these students to identify to their testers and the state bars the coping techniques that worked for them and might have contributed to their later diagnosis, as well as whatever cultural, economic, or bias based reasons may explain the lack of earlier diagnosis. Also, law schools should work closely with the testers to whom they refer students to ask them to make explicit in their reports their efforts to procure documented childhood history and why those efforts proved fruitless for a particular individual.

Although students are likely uncomfortable with providing personal information, and this should not be necessary, this approach may be preferable from the student's perspective to waiting for a possible denial from a state bar and then, under a possible unreasonable timeline and during the stressful lead-up to the bar exam, having to file an appeal. However, law schools and law students are cautioned to consider that proactively including such detailed childhood history information or the reasons for lack of such information may seem to legitimize the state bar's strict childhood history requirement. Therefore, care must be taken in how the volunteered information regarding childhood history is framed.

Along these lines, law schools need to recommend that students apply very early for bar accommodations to ensure that they have the time to appeal if they are denied. If they are denied based at all

on childhood history, then the law school should write letters in support of their appeals, explaining (with the student's express approval) what the school understands about the student's reasons for not having been diagnosed earlier. When applicable, law schools should not be afraid to raise their concerns about the discriminatory impact of the strict requirement of childhood history, and also to share some of the basis of these concerns as outlined in this Article.

Conclusion

State bars' childhood history requirements for provision of bar examination accommodations to applicants with Attention-Deficit/Hyperactivity Disorder are the result of a strict and unfounded reading of the *Diagnostic and Statistical Manual on Mental Disorders* and an erroneous application of the laws that are intended to protect people with disabilities. The unfortunate result is unfair and illegal treatment of people with ADHD. This injustice is compounded by its disproportionate impact on persons historically denied access to the legal profession based on their race, sex, socioeconomic status, age, or location.

The law is clear that people with ADHD may not be unfairly disadvantaged on account of their disability. Neither rule-based nor procedural discrimination against them, including requirements of unreasonable documentation, will be tolerated. State bars' strict application of an outdated and inaccurate interpretation of ADHD diagnostic criteria exposes them to liability and impedes the legal profession's own quest to diversify. Inappropriate implementation of the childhood history criterion must be addressed promptly by a multilateral approach to ensure it does not continue to serve as yet another barrier restricting equal access to the profession. The threshold of the legal profession's front door must be rebuilt to allow applicants like Sasha, Maya, Luis, Marcus and Roger the opportunity to enter.