ADD On Trial: "Winning" is Still Losing

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Over the past ten years, cases of diagnosed Attention Deficit Hyperactivity Disorder (ADHD) and related information processing deficits appear to have increased in frequency, not only in the general population, but among criminal defendants. Accordingly, criminal justice professionals now require additional information to recognize and accommodate these cognitive differences and to better understand how disorders of attention impact human behavior. The following case studies represent three young men with similar attentional disorders, but different advocacy needs with courts, juries, and/or corrections. Each was provided extensive services, including psychoeducational assessment, case analysis, and/or expert testimony, in hopes of promoting fairness for all clients through a more enlightened criminal justice system.

Personalizing ADD/ADHD: Case Studies

> ***Chris*** *is a 20 year old defendant with documented behavioral issues since toddlerhood, and subsequent diagnosis of ADHD in early elementary school. No long-term medical solution was ever put into effect due to the family's instability. Here, after being abandoned by his parents as a preschooler and again by his grandparents at the age of 14, Chris was placed in a succession of 21 foster care and institutional settings. While in placement, the youth's maladaptive behavior escalated to the point that he accumulated six arrest petitions and was remanded to the California Youth Authority by the age of 17. Now a young adult, Chris had violated a court restraining order and found himself in the County Jail, where he quickly established a negative reputation. On the day of his recent assessment, he had just been released from a month of solitary confinement for a minor disciplinary infraction. Jailers characterized Chris as a troublemaker who would periodically enter and exit the correctional system"like a revolving door".*

Testing for this client revealed a classic and ongoing ADHD condition characterized by impulsivity, response inconsistency, and distractiblity. Although a young adult, he still lacked self-control strategies despite numerous and varied social interventions. This was probably because parents and schools had "dropped the ball" when it came to appropriate medical intervention; and former hospital placements, as well as his present correctional setting, had chosen to deal with him by prescribing tranquilizer medications which rendered him stuporous much of the time. As a result, Chris was never adequately tested to obtain an accurate representation of his learning profile and complex attentional issues. Records contain no indication that any educational or therapeutic placement attempted to 1) assist in medical management of his ADHD condition, 2) teach cognitive behavior modification (CBM) techniques designed to empower him to direct and monitor his own actions, or 3) structure the environment to accommodate his escalating, disability-based behavior problems. In one of its final reports related to the "Chris problem", his school district provided only sparse and rather pathetic recommendations including "consideration" of programs in the "least

restrictive environment", nebulous "other interventions" to assist with behavior and growing emotional problems, and a suggestion to his caregivers: "...check on the location of his glasses." What followed was a total abdication of responsibility to the local Mental Health Department which responded by arranging the string of out-of-home placements mentioned above. While in these court-ordered placements, Chris was subjected to countless rounds of group and individual therapy, tranquilizer medications, medical tests for defective thyroid function (which proved inconsequential), shortened day assignments, and eventually, classroom suspension, all of which failed to effect positive change. At the time of the March, 1999 evaluation arranged by his attorney, Chris had never participated in any court, school, correctional, or social program which considered his ADHD in both the diagnostic and prescriptive phases of assessment.

> *Now 17, **Andrew** was retried earlier this year for the murder of his sister which occurred when the youth was only 14½ year of age. The youngster had a long-standing diagnosis of ADHD and had been taking Ritalin prior to a recent relocation to live with his father's "new family" in Virginia. He entered his new home on shaky ground, having been banished by his natural mother due to escalating behavior problems. Although drug therapy in his former school setting was successful, Andrew's father never refilled the prescription, thus the youth began high school in his new location without this support. Within two weeks, he received a suspension notice for a rules violation, and arrived home early to nervously await his fate. At this time, the youngster accessed a loaded shotgun from his father's bedroom closet and took it to his room. Three gunshots were fired that afternoon, the first of which surprised Andrew as it went through his mattress and into the floor below. The additional shots also appear to be the result of a succession of random and clumsy movements which are typical of children with ADHD: one of these went through his bedroom ceiling while the other resulted in his sister's death. This youngster was tried as an adult, found guilty of purposeful murder, and sentenced to 17 years in a state prison for adults. Were it not for his grandparents' work to reveal several instances of juror bias, this verdict would not have been overturned. His attention deficit condition was raised as a mitigating factor <u>for the first time</u> during the 1999 appeal of his murder conviction.*

Advocacy for this client included a thorough review of school and medical records, as well as the inservice education of Andrew's appeal attorneys to insure that they were familiar with all aspects of this disability condition. As such, his report focused on defining attentional deficits like ADD/ADHD as "chronic limited alertness" and associating them with other medical disorders which may fall under the broader heading, Physical Handicaps (e.g., Other Health Impairments). Childhood indicators of the condition were reviewed as far back as his preschool years, where the boy was described as able to "destroy a room faster than you could believe!" It was suggested that medical attention for this condition should have been sought well prior to junior high, when failure

behaviors and attitudes had become well established in this youngster. Next, proper assessment of information processing, as well as variables of attention was outlined. Here, discussion focused on specific analysis of "breakdowns" which may occur at information intake, organization and storage, retrieval, and/or expression. It was further observed that ADD tends to interfere with initial intake, and that this may manifest throughout the processing chain. In other words, not paying attention at intake is likely to impact organization, storage, retrieval, and expression via "cascade-effect". Specific variables of attention, as measured by the Test of Variables of Attention* (TOVA), were also defined as follows:

- ***Omissions*** of attention are distractions and/or lapses in vigilance over the length of a task. Omissions tend to produce a pattern of cycling attention which, in turn, results in spotty knowledge, incomplete intake of directions and/or information, and partial learning of academic content. *Omissions* are the most recognized attentional deficits, tending to occur in younger and/or lower IQ test subjects.

- ***Commissions*** are false positives associated with impulsive and/or random behavior. This dimension describes an individual's ability to inhibit himself and his physical actions. High *Commissions* usually involve random, purposeless, and/or clumsy reactions which seem outside of the physical control of the test subject.

- ***Reaction Time*** is simply the amount of time it takes for a person to formulate and produce responses to desired stimuli. *Reaction Time* is measured over task conditions which change from low-stimulus (infrequent) to high-stimulus (very frequent) conditions.

- ***Variability*** refers to the consistency of reaction time and intensity across test conditions. As such, this measure helps explain changes in frequency of Omissions and Commissions in test subjects, as well as functional variations in performance over time.

Since no TOVA results were obtainable for this client, this analysis relied on statements of his parents, teachers, and medical professionals which documented and described his ADHD condition. For example, his grandfather described Andrew as inattentive (Inattention = high *Omission* rate), stating that he was "fine for a few minutes... then it was like talking to a wall." Reports from school personnel also described *Omission* errors related to distractibility which interfered with task vigilance and concentration over time. The youngster's *Commission* errors were documented as random or clumsy "overflow" movements associated with spatial and timing misjudgments, as well as failure to consistently envision probable consequences of his actions.

* For additional TOVA information, contact Universal Attention Disorders at 1-800- PAY-ATTN.

Individuals with these impairments often require extended time to think through their impulsive actions, make sense of them, then plan and initiate remedial actions. Finally, evidence was reviewed which indicated that Andrew's responses were marked by lapses in both *Response Time* and *Variability*. Review of TOVA variables contributed information that became important in making sense of the boy's seemingly odd and undirected post-crime behaviors. These included taking his sister's body into the bathroom (to access first aid?); his preoccupation with cleaning the carpet as well as completing several assigned household chores (thought to promote internal organization); and his eventual, though almost completely forgotten, flight to a nearby wooded area where he remained cold, wet, and without food until reappearing back at home the next afternoon.

Along with the information processing analysis, TOVA discussion helped to depict the possibility that 14 year old Andrew could not mentally accommodate the horrible results of random and impulsive actions that remained outside of his physical control. Much of the shocking scene that followed may not have been fully encoded, leaving informational gaps at intake. It is also likely that the youngster's attention may have cycled as he tried to organize and store information about the shooting, thus rendering the final information processing phase, retrieval/expression, clearly dysfunctional during the ensuing videotaped police interview. In fact, the interviewing officer did a superb job using probe questioning to "jog" the youth's memory of facts and details related to the previous afternoon's events. However, due to the processing and *Omission* errors noted above, it remains possible that some details and information derived from their reciprocal conversation were mere conjecture on Andrew's part, i.e., "fillers" of informational gaps which would bring some modicum of internal closure for the boy while at the same time, pleasing the officer. Here, regardless of the interviewer's dedication to duty, we must question his decision to interview a distraught 14 year old with a known history of attentional deficits, without an advocate present to facilitate and monitor accurate two-way communication. The interview also took place without the presence of legal counsel.

A final area which required discussion in advocating for Andrew concerned normal vs. atypical adolescent development. Here, attorneys were familiarized with the development of cognitive strategies which typical teens utilize to assist information processing. These "memory tricks" include strategies such as "verbal rehearsal" where an individual repeats information sequences to himself until verbal expression is required, "chunking" parts of the whole for easier initial encoding, and "clustering" like pieces of information together for easier storage and retrieval. None of these techniques are actually taught to us, but appear to develop naturally in typical 12 to 14 year old children. Importantly, research with adolescents who have cognitive deficits such as ADHD indicates that they may require an additional two or more years to begin developing such strategies, take longer to stabilize them, then tend to discard them even though they may prove effective for accessing certain desirable outcomes.

Thus, it is probable that at only 14 years of age, Andrew had not achieved the level of cognitive development we might expect simply looking at his outward presentation. Certainly, cognitive immaturity affected his actions related to and following the shooting incident, as well as during the subsequent police interrogation. In this particular interview, the officer knew of Andrew's ADHD condition, but took no action to call an appropriate advocate for the youth. What he did instead was to offer friendship and understanding ("You're the only boy, huh?... That's got to be kind of tough"), apply many prompts to recall the previous day's events ("Well, what's the next thing you remember after you hung up the phone with her... Then what did you do?"), and provide discrete pieces of information to fill in memory gaps ("Well, when she was in your room yesterday... *were the two of you talking* in there?"; "What did you have to clean up - *did you drop something*?") These techniques were highly effective in getting the boy to talk for hours; however, knowing the nature of *Omission* and *Commission* errors inherent in ADHD as a syndrome, the accuracy of his recall and statements remains questionable even today.

> ***Carl*** *faced the death penalty having been found guilty of the robbery-murder of a convenience store cashier. As the lone assailant, all of his actions were video- and/or audiotaped via store surveillance equipment. Here, the 21 year old ADHD client can be seen entering the stimulus-laden environment and approaching the counter where he attempts to purchase cigarettes. He alternately stares at the counter and at another uncluttered surface, presumably in order to gather his wits and proceed with the robbery. He then orders the cashier onto the floor, face down, while he empties money from the register. As Carl steps behind the counter for this purpose, he is out of camera range, but can be clearly heard demanding time and time again that the clerk remain still and lie face down on the floor. After several minutes of repeated pleas of this sort, two shots are heard, followed by Carl's final comment before fleeing: "Stupid m— f—."*

On the surface, Carl's case looked like a lost cause, even from the most optimistic defense attorney's perspective. This attractive, biracial young man had been a basketball star throughout his school career and was never enrolled in special education. Additionally, although parents, teachers, and coaches recalled many behaviors consistent with ADHD, the family had refused medical intervention in the form of drug therapy for the condition. His court-ordered cognitive assessment revealed an IQ in roughly the normal range, and only borderline Learning Disability qualification in a few academic splinter skills. However, his ADHD condition was clearly observable in the various jail settings accessed for assessment purposes. For example, only minimal impulsivity was observed when Carl was tested in a private cubicle facing a blank wall on Day 1; but he fell apart completely when tested at an interview "counter" in the main attorney room on Day 2. Here, he was observed to scatter his focus to any and all external stimuli, with particular difficulties whenever any form of visual distraction occurred. Since he was facing the entry door where there was much inmate and guard activity, he remained virtually untestable in this highly charged setting. Accordingly, Day 3 was arranged in a private office inside the medical unit of the jail where only

minimal outside distractors could impact his concentration. Still, he was observed to monitor the most minimal visual stimuli outside the room's small window, requiring redirection to task following any such occurrence. Carl also required external "transitioning" across tasks, following breaks, and even where significant body position changes occurred. Finally, when a gnat entered the test area, he could not focus on tasks until it was eliminated. With distractibility of this magnitude, TOVA assessment became imperative for this client.

The TOVA print-out not only verified an ADHD diagnosis, but analysis further suggested that neurological assessment was in order due to his high *Omissions* rate (Standard Score <25). *Reaction Time* was deviant due to its slowness (SS of 28), while *Response Variability* was high (SS <25). In addition, information processing testing verified extreme variability and performance cycling in the face of not only visual, but also auditory distractors. Here, distractibility occurred whenever any extraneous noise occurred, such as a door closing or distant conversation. In some cases, Carl could not recall *any* information just presented to him following such an occurrence, so the entire test item was repeated. Thus, the information processing age scores obtained in this assessment (12 and 13 years), were assisted by repetitions which would not be likely to occur in everyday life. Carl's cognitive deficit profile helped to explain his initial confusion upon entering the high stimulus store environment and his need to "recover" cognitively by limiting visual distractors. It also regarded his pleading demands of the noncompliant victim, and his final impulsive decision to shoot him. Carl's final recorded statement appeared to rebuke the clerk for his "stupid" decision to defy orders: he was found lying face up, more then ten feet away from the initial counter location.

Carl's family, friends, and particularly his basketball coach recalled consistent observations of attentional issues which interfered with performance consistency. For example, his coach recalled numerous instances where he would set up a play during time-out and send the team back on the court, only to find Carl out of position or otherwise unprepared to do his part. In these instances, teammates covered for him until the information "kicked in". Both the coach and teammates came to expect that Carl "would have to go through and screw it up once" before he could transition to the new play. Other episodes of distractibility during game time were handled simply by calling Carl's name or "grabbing his arm" to prompt and direct attention. The coach's recollection that "something" interfered with continuity and decision-making in this player was interesting in light of the findings of the current assessment. Data derived from these psychoeducational tests helped to quantify and qualify that nebulous "something" precisely and to explain it to the penalty phase jury. Due to this and other advocacy on behalf of the client and his family, Carl was granted life without parole when the jury "hung" 8 to 4 in opposing the death penalty.

The three cases presented above represent differential advocacy needs in the courtroom, yet all required explaining ADD/ADHD to those in decision-making positions. In Chris' case, variability and impulsivity related to his ADD condition was finally explained, with information offered that would affect future placement and treatment options. The Court in this matter needed to understand what can result when severe ADHD goes medically untreated in childhood and continues to be ignored through adolescence and into adulthood. Like many untreated children, Chris never developed self-monitoring strategies with which to ameliorate escalating problems during task vigilance. For example, during the low stimulus TOVA condition, he attempted conversation with the Examiner which interfered only minimally with consistency during task vigilance. However, once the high stimulus condition began, his attempts at conversation became more problematic. Unable to look away from the computer screen for fear of missing a target, he continued to ask questions and make off-hand comments, but these were far out-numbered by self-regulating remarks ("Caught myself again!"; "I don't know why I pushed the button -- I didn't even want to!") Many times, his poorly timed comments were followed almost immediately by a near miss ("Oh shoot -- I almost missed it!") but this lesson appeared to be lost on Chris. Thus, failure to teach self-regulating strategies and behavior to this client *as a child* have resulted in an immature and ineffective adult style which requires and can now benefit from medical intervention. If Chris' brush with the criminal justice system accomplishes this outcome, then perhaps the "revolving door" prediction can be averted.

Andrew's case presented an opportunity to educate the Court and jury about ADD/ADHD and other developmental issues related to very young offenders. This client had much to gain through such advocacy, and could have walked away a free teenager if his sister's death were ruled accidental. In that the 14 year old Andrew was no longer available for assessment or questioning, a written analysis presented to the Court the <u>possibility</u> that the shooting could have resulted from clumsy, random, and/or unplanned actions which were disability-based. It was further proposed that unraveling Andrew's *intent* presented a virtual impossibility, even for professionals with much expertise in ADD/ADHD and related cognitive disorders, and remained well outside the expertise of the layperson. Unfortunately, the judge in this matter refused to allow funding or the time extension needed to present such testimony.

"Winning" LWOPP

Carl's case was successful from a trial attorney's perspective, in that he got **L**ife **W**ith**O**ut the **P**ossibility of **P**arole in lieu of the death penalty. Although his grateful family cried tears of joy at this decision, it should be evaluated critically considering probable outcomes for this and other disabled clients. First among our concerns is the fact that treatment for ADD/ADHD is virtually nonexistent in California correctional settings. Here, Ritalin, Cylert, and other such medications are restricted prescriptions which are not administered to inmates. We know of several cases where adult prisoners with attentional disorders were drugged with antipsychotic medications to "calm" them, with potentially disastrous effects. Gene is one such prisoner who was prescribed Lithium

to ameliorate behaviors associated with his long term ADHD diagnosis. Unfortunately, corrections

staff knew little about the potential side effects of this and other heat-sensitive medications until Gene suffered a seizure in the hot exercise yard. Since then, he has experienced intermittent seizures for which he understandably desires medical information and reassurance. However, since Gene also suffers from a Learning Disability which renders him illiterate, he requires staff assistance to fill out prison forms requesting medical appointments, and this has apparently become an administrative annoyance. Thus, Gene has been branded a "pest" and admonished that he may only ask one medical question per month related to his prison-imposed seizure condition.

Inmates like Carl can look forward to little or no actual treatment related to their disability conditions. Indeed, Reception Centers assess certain skills in incoming prisoners such as academic (as per a multiple-choice format test) or vocational ability, but final placement decisions are far more concerned with an inmate's security rating due to past convictions, his commitment offense, and social affiliations (e.g., gang membership). Thus, a client like Carl is likely to end up in a maximum security housing unit such as the notorious "SHU" at Corcoran and Pelican Bay. These placements require in-cell isolation for up to 23 hours per day, with one hour allotted for solitary recreation. Under these conditions, no educational, vocational, or other programming is accessible, regardless of disability verification in the Central file.

Even if an inmate is housed with the general population, as a "lifer" he may be barred from certain beneficial and/or therapeutic activities. For example, Tony is serving a life sentence at Corcoran Prison, with classification that does not allow him to obtain vocational training which will lead to gainful employment. A model prisoner, Tony has now qualified to take the GED examination in order to obtain his high school diploma. However, several months following this qualification, his instructor had neither requested nor arranged test administration.

These and other inmates with special education qualification are out of luck in the California prison system, in that no formal offerings exist. Despite losing several recent class action lawsuits related to disability accommodation in prison populations, the California Department of Corrections (CDC) has not taken appropriate steps to assure that special needs are met, even for those prisoners below the age of 22 years and who have current school classification at the time of incarceration. In that more commonly understood disorders such as Deafness or Mental Retardation are not being appropriately accommodated in educational and vocational programs, at hearings, or in daily prison life, it remains unlikely that ADD/ADHD will fare any better without major changes in the correctional system. As mentioned above, one avenue to change appears to be through litigation based on the Americans with Disabilities Act of 1990*; but even where successful, administrative remedies have been slow in coming. There has also been interest on the part of certain California Legislature subcommittees in overseeing and monitoring the CDC more closely where disability-related issues are concerned. All agree that much training in identifying and accommodating cognitive disabilities is needed in corrections and parole, thus it is hoped that the Courts and/or Legislature can and will be instrumental in making positive change a reality. Until then, "winning" for ADD/ADHD and other disabled defendants is still "losing" as they enter a closed system which neither understands nor accommodates their individual differences.

* For full text of Judge Wilkin's Findings of Fact and Conclusions of Law in the *ARMSTRONG V. DAVIS* disability rights lawsuit, visit the Northern District of California Web Site at: www.cand.uscourts.gov