

ARTICLES

RETHINKING THE CHILDHOOD-ADULT DIVIDE: MEETING THE MENTAL HEALTH NEEDS OF EMERGING ADULTS

*Barbara L. Atwell**

TABLE OF CONTENTS

- I. INTRODUCTION 1
- II. ADHD & ABUSE OF MEDICATIONS USED TO TREAT IT 8
 - A. ADHD 8
 - B. Abuse of ADHD Medications 11
- III. EMERGING ADULTS..... 14
- IV. EMERGING ADULTS, MENTAL HEALTH & THE LAW 21
 - A. Lack of Mental Health Parity 21
 - B. HIPAA 25
 - C. Medical Malpractice Standard of Care 28
 - D. Awareness Campaign 34
- V. CONCLUSION 36

I. INTRODUCTION

What usually is done may be evidence of what ought to be done,

* Associate Professor of Law and Director of Diversity Initiatives, Pace Law School. B.A. 1977, Smith College, J.D. 1983, Columbia University.

*but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not.*¹

The Virginia Tech shooting, the deadliest mass shooting in United States history, was committed by a twenty-three year old.² The disturbed shooter responsible for the tragedy in Newtown Connecticut, in which twenty children and six adults were killed, was twenty years old.³ And the shooter in the Aurora, Colorado movie theatre was twenty-four.⁴ The 2014 mass shooting in Santa Barbara California was committed by a twenty-two year old.⁵ One thing that these individuals have in common is that they were all “emerging adults”—adults between the ages of eighteen and approximately thirty—when they committed their crimes.⁶ In fact, they were all “young emerging adults,” which for purposes of this article are defined as emerging adults twenty-five years of age or younger.⁷

While mass shootings are rare, whether by young emerging adults or others, the mental health needs of young emerging adults are not. Although mental health statistics are rarely broken down specifically for those in the emerging adult years, general mental health statistics give some sense of the extent of mental illness in the United States. It is estimated that “one in five Americans has a diagnosable mental illness.”⁸ Approximately

¹ *Tex. & Pac. Ry. Co. v. Behymer*, 189 U.S. 468, 470 (1903).

² The killer was 23-year-old Cho Seung-Hui. He killed 32 people before killing himself. Matti Friedman, *Holocaust Survivor Killed in Va Shooting*, WASH. POST, Apr. 17, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/04/17/AR2007041701224.html>.

³ James Barron, *Nation Reels After Gunman Massacres 20 Children at School in Connecticut*, N.Y. TIMES, Dec. 14, 2012, http://www.nytimes.com/2012/12/15/nyregion/shooting-reported-at-connecticut-elementary-school.html?page_wanted=all&r=0.

⁴ *Colorado Theater Shooting Fast Facts*, CNN, July 13, 2014, <http://www.cnn.com/2013/07/19/us/colorado-theater-shooting-fast-facts/>.

⁵ Ian Lovett & Adam Nagourney, *Video Rant, Then Deadly Rampage in California Town*, N.Y. TIMES, May 24, 2014, <http://www.nytimes.com/2014/05/25/us/california-drive-by-shooting.html?module=Search&mabReward=relbias%3Ar%2C%7B%221%22%3A%22RI%3A7%22%7D>.

⁶ See CHRISTIAN SMITH ET AL., *LOST IN TRANSITION: THE DARK SIDE OF EMERGING ADULTHOOD* 3, 14 (Oxford Univ. Press ed., 2011). See also *infra* notes 73–92 and accompanying text.

⁷ Until the age of twenty-five, the brain is still developing, suggesting that this group should be considered differently from a legal perspective. See *infra* note 81 and accompanying text.

⁸ Abby Goodnough, *Expansion of Mental Health Care Hits Obstacles*, N.Y. TIMES, Aug. 28, 2014, at A1.

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 3

40 million adults suffer from anxiety disorders⁹ and about one in ten adults report suffering from depression.¹⁰ Another 1.5 million or more have been diagnosed with some form of psychosis.¹¹ In addition, approximately 4.4 percent of adults between the ages of eighteen and forty-four suffer from one or more symptoms of attention deficit and hyperactivity disorder (“ADHD”).¹² Regardless of the type of mental illness, mental health needs often go unmet.¹³ The focus of this article is on young emerging adults who have been diagnosed with ADHD. There is ample evidence that young emerging adults are abusing ADHD medications in large numbers.¹⁴

Prescription drug abuse is now the number one cause of injury death in seventeen states.¹⁵ Among the most abused prescription

⁹ U.S. DEP’T OF HEALTH & HUMAN SERVS., ANXIETY DISORDERS 1 (Nat’l Inst. of Mental Health 2009), *available at* <http://www.nimh.nih.gov/health/publications/anxiety-disorders/index.shtml>.

¹⁰ *An Estimated 1 in 10 U.S. Adults Report Depression*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/features/dsdepression/> (last updated Mar. 31, 2011).

¹¹ *See FastStats – Mental Health*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchs/fastats/mental-health.htm> (last updated July 14, 2014) (noting that 1.5 million hospital discharges listed psychosis as the main diagnosis. This figure includes patients with major depressive disorders, but does not include those who suffer from psychosis but who are not hospitalized).

¹² *See Harvard Study Suggests Significant Prevalence of ADHD Symptoms Among Adults*, NAT’L INST. OF MENTAL HEALTH (Apr. 1, 2006), <http://www.nimh.nih.gov/news/science-news/2006/harvard-study-suggests-significant-prevalence-of-adhd-symptoms-among-adults.shtml>. (acknowledging that ADHD is typically diagnosed in childhood and that the symptoms of ADHD are sufficiently varied to make diagnosis difficult, especially in adults).

¹³ *See infra* notes 92–106 and accompanying text.

¹⁴ *See infra* notes 49–60 and accompanying text.

¹⁵ *See Obama Administration Releases Action Plan to Address National Prescription Drug Abuse Epidemic; Announces FDA Action Requiring Drug Makers to Develop Education Program for Prescribers About Safe Use of Opioids*, OFFICE OF THE NAT’L DRUG CONTROL POLICY (Apr. 19, 2011), <http://www.whitehouse.gov/ondcp/newsreleases-remarks/obama-administration-releases-action-plan> (“Unintentional drug overdose is a growing epidemic in the U.S. and is now the leading cause of injury death in 17 states” (quoting Dr. Thomas Frieden, Director of the U.S. Centers for Disease Control and Prevention)); *see also* SUBSTANCE ABUSE & MENTAL HEALTH ADMIN., THE DAWN REPORT: EMERGENCY DEPARTMENT VISITS INVOLVING ATTENTION DEFICIT/HYPERACTIVITY STIMULANT MEDICATIONS 1 (2013), *available at* <http://www.samhsa.gov/data/sites/default/files/DAWN073/DAWN073/sr073-ADD-ADHD-medications.htm> [hereinafter THE DAWN REPORT] (stating that Emergency Department visits increased significantly between 2005 and 2010 for adults over the age of 18, and for nonmedical use of ADHD stimulant medications).

drugs by emerging adults are those used to treat ADHD,¹⁶ a behavioral disorder with symptoms normally presenting by the age of seven.¹⁷ Amphetamines such as Adderall or Ritalin are generally prescribed to treat patients with ADHD.¹⁸ The use of these medications, however, has expanded well beyond those who have been accurately diagnosed with ADHD.¹⁹ For example, college students with no history or symptoms of ADHD often obtain and use these drugs, creating a significant public health threat.²⁰ As recently reported: “[t]he number of young adults who end up in the emergency room after taking Adderall, Ritalin or other such stimulants has quadrupled in recent years . . . The number of emergency room visits . . . among people ages eighteen to thirty-four increased to 23,000 in 2011 from 5,600 in 2005.”²¹

¹⁶ See generally Alan Schwarz, *Drowned in a Stream of Prescriptions*, N.Y. TIMES, Feb. 2, 2013, <http://www.nytimes.com/2013/02/03/us/concerns-about-adhd-practices-and-amphetamine-addiction.html?pagewanted=all&module=Search&mabReward=relbias%3Ar%2C%7B%221%22%3A%22RI%3A8%22%7D&r=0> (describing a twenty-four year old who became addicted to Adderall). In the United States, about 5 million adults take medication for ADHD. *Id.* High levels of abuse are also reported for prescription painkillers like Oxycodone and Vicodin. See Benedict Carey, *Prescription Painkillers Seen as a Gateway to Heroin*, N.Y. Times, Feb. 10, 2014, <http://www.nytimes.com/2014/02/11/health/prescription-painkillers-seen-as-a-gateway-to-heroin.html?module=Search&mabReward=relbias%3Aw%2C%7B%221%22%3A%22RI%3A8%22%7D> (“Rates of prescription opiate abuse have risen steadily over the last decade.”).

¹⁷ ELAINE A. MOORE, THE AMPHETAMINE DEBATE: THE USE OF ADDERALL, RITALIN AND RELATED DRUGS FOR BEHAVIOR MODIFICATION, NEUROENHANCEMENT AND ANTI-AGING PURPOSES 53 (McFarland & Co. 2011).

¹⁸ See THE DAWN REPORT, *supra* note 15, at 1 (explaining that “stimulant medications,” such as Adderall and Ritalin, “remain the first-line treatment” for ADHD); see also DRUG ENFORCEMENT ADMIN., DRUG FACT SHEET: STIMULANTS, available at http://www.justice.gov/dea/druginfo/drug_data_sheets/Stimulants.pdf [hereinafter DEA DRUG FACTSHEET] (“Stimulants speed up the body’s systems.”). While other frequently abused drugs include painkillers, anti-anxiety medications, and anti-depressants, among others this article focuses on ADHD medications because they appear to have special appeal for emerging adults. See discussion *infra* Part II; see also THE DAWN REPORT, *supra* note 15, at 1 (noting abuse of ADHD medications especially on the part of young adults between the ages of eighteen and twenty-five). Other drugs like painkillers, which are also abused in large numbers, are not necessarily associated with a particular age demographic.

¹⁹ See Alan Schwarz, *supra* note 16 (describing the methods in which college-aged students are obtaining prescriptions by faking symptoms).

²⁰ See *id.* (“Adderall and its stimulant siblings are classified by the Drug Enforcement Administration as Schedule II drugs, in the same category as cocaine, because of their highly addictive properties.”).

²¹ See Sabrina Tavernise, *New Sign of Stimulants’ Toll on Young*, N.Y. TIMES, Aug. 9, 2013, http://www.nytimes.com/2013/08/09/health/sharp-rise-among-young-in-emergency-care-after-stimulant-use.html?_r=0 (examining

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 5

Claiming that they suffer from ADHD,²² college students often use Adderall to gain a competitive edge academically.²³ Adderall reportedly improves the students' ability to focus and, as a stimulant, may also assist when they are sleep-deprived.²⁴ “[This] tunnel-like focus . . . has led growing numbers of teenagers and young adults to fake symptoms to obtain steady prescriptions for highly addictive medications that carry serious psychological dangers.”²⁵ Emerging adults take ADHD medications in the belief that they are relatively benign and helpful agents as they pursue their studies and careers. The ease with which they obtain these prescriptions, however, “highlights widespread failings in the [health care] system . . . [F]ive million Americans take medication for A.D.H.D.”²⁶

Legal and practical changes can minimize the overuse of ADHD medications for emerging adults. First, emerging adults between the ages of eighteen and twenty-five should be recognized as a separate legal category in matters involving mental health.²⁷ Laws and policies should be implemented to

data from the Substance Abuse and Mental Health Services Administration). The abuse is most pronounced among young adults between the ages of eighteen and twenty-five. *Id.* See also THE DAWN REPORT, *supra* note 15, at 1 (noting abuse of ADHD medications especially on the part of young adults between the ages of eighteen and twenty-five).

²² See *infra* note 46 and accompanying text.

²³ The use of Adderall as a “performance-enhancing drug” renders it analogous to performance enhancing drugs in sports. See Ali Mohamadi, *Medical Report: The Effects and Risks of Adderall Use Among Athletes*, SB NATION (Dec. 5, 2012), <http://www.sbnation.com/2012/12/5/3731824/athletes-adderall-effects-suspensions> (examining the effects of Adderall use on professional athletes). Because Adderall is a stimulant that can help students stay awake longer, and because anxiety is a potential side effect, the student may then seek a depressant like Xanax, explaining to the doctor that he or she has an anxiety disorder or needs help sleeping. See Lisen Stromberg, *The New Face of Addiction*, DIABLO MAG. (Feb. 22, 2013), <http://www.diablogmag.com/March-2013/The-New-Face-of-Addiction/> (providing an explanation of how the “occasional use of Adderall [can lead] to abusing Xanax”).

²⁴ See Shaheen E. Lakhan & Annette Kirchgessner, *Prescription Stimulants in Individuals with and without attention deficit hyperactivity disorder: Misuse, cognitive impact, and adverse effects*, 2 BRAIN & BEHAVIOR 661, 665 (2012) (stating that college students use ADHD medications for staying awake to study and for focus).

²⁵ Schwarz, *supra* note 16.

²⁶ *Id.*

²⁷ While many define emerging adulthood to extend to the age of thirty, some suggest that it goes anywhere from the age of twenty-six to thirty. There is neurological evidence that brain development continues at least until the age of twenty-five. See *infra* note 81 and accompanying text (indicating that brain development continues until age twenty-five). For this reason, among others,

meet the specific needs of this demographic.²⁸ The mental health system makes it difficult for caring parents and health care providers to collaborate to best treat the mental health needs of young emerging adults, whether they are suffering from ADHD or some other mental health diagnosis. Instead, our legal paradigm, with limited exceptions, distinguishes between those who are under the age of eighteen and are therefore considered minors, and those who are over eighteen and legally considered adults.²⁹

Psychologists divide the stages of human development into many more components, including infancy, early childhood, childhood, adolescence, emerging or young adulthood, and adulthood.³⁰ The stage of emerging adulthood, encompassing ages eighteen through about thirty, has no separate *legal* significance

the suggestions here are for “young emerging adults” between the ages of eighteen and twenty-five.

²⁸ Cf. Barbara L. Atwell, *The Modern Age of Informed Consent*, 40 U. RICH. L. REV. 591, 592–93 (2006) (arguing that additional safeguards should be made for informed consent among young adults ages 18–30).

²⁹ There are certain exceptions. For example, mature minors may be permitted to make their own medical decisions prior to the age of eighteen. See JESSICA FEIERMAN ET AL., *TEENAGERS, HEALTH CARE & THE LAW: A GUIDE TO THE LAW ON MINORS’ RIGHTS IN NEW YORK STATE 22* (The New York Civil Liberties Union, 2d ed. 2009) (allowing a minor who is “emotionally and intellectually mature” to give informed consent to medical treatment without the consent of his or her parent). Mature minors are generally at least sixteen years of age. See, e.g., 750 ILL. COMP. STAT. ANN. 30/3-2 (West 2014) (defining a “mature minor” as “a person sixteen years of age or over and under the age of eighteen years who has demonstrated the ability and capacity to manage his own affairs and to live wholly or partially independent of his parents or guardian”). In addition, the legal drinking age is twenty-one, rather than eighteen. See 23 U.S.C. § 158 (Supp. 2013) (establishing the national minimum drinking age). Some jurisdictions also restrict those legally permitted to smoke cigarettes to individuals over the age of eighteen. See, e.g., N.J. STAT. ANN. § 2A:170-51.4 (West 2014) (prohibiting the sale of tobacco to persons under the age of nineteen). New York City recently prohibited sales of cigarettes to people under the age of twenty-one. See N.Y.C. LOCAL LAW 94, Int. No. 250-A (Oct. 22, 2013), available at <http://www.nyc.gov/html/doh/downloads/pdf/smoke/tob-21-law.pdf>. The town of Needham, Massachusetts also has a twenty-one-year-old age requirement. See Anemona Hartocollis, *Behind New York’s New Antismoking Law, a Persistent Councilman*, N.Y. TIMES, Nov. 12, 2013, http://www.nytimes.com/2013/11/12/nyregion/behind-new-yorks-new-antismoking-law-a-persistent-councilman.html?_r=0 (comparing NYC’s local tobacco law to other municipalities in other states). In Nassau and Suffolk Counties in Long Island and in the states of Alabama, Alaska, New Jersey and Utah, you must be nineteen years old to legally purchase cigarettes. *Id.*

³⁰ Cynthia S. Darling-Fisher & Nancy K. Leidy, *Measuring Eriksonian Development In The Adult: The Modified Erikson Psychosocial Stage Inventory*, 62(3) PSYCHOL. REP. 747, 747–54 (1988).

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 7

despite its distinct psychological significance.³¹ The law's failure to take into account emerging adulthood as a separate stage of development for mental health purposes—at least through the age of twenty-five—has created, among other things, a dilemma when it comes to the growing problem of prescription drug abuse, particularly of psychotropic drugs.³²

Second, because emerging adults have unique needs and characteristics, the Health Insurance Portability and Accountability Act (“HIPAA”) must be amended to permit mental health care providers to collaborate and share information with parents of young emerging adults.³³ Third, while the *de jure* medical malpractice standard of care may be adequate, the *de facto* application of that standard needs to shift. Whether or not HIPAA is amended, mental health care providers must not hide behind HIPAA as a reason for not thoroughly investigating young emerging adults' mental health history and needs. These health care providers must, especially in cases involving potential ADHD medications, use their best efforts to actively encourage their young emerging adult patients to consent to parental involvement. Failure to do so should form a basis for medical malpractice. Finally, emerging adults and society at large should be educated about the dangers associated with prescription drugs in general.

Part I of this article describes ADHD and explores the extent of ADHD medication abuse, especially among young adults. Part II discusses the characteristics of emerging adults, who may be more likely than their older counterparts to make unwise decisions about medications and other life choices.³⁴ While we

³¹ See *infra* notes 61–91 and accompanying text.

³² This is especially true for psychotropic drugs, which include antipsychotics, anti-depressants, anti-anxiety medications, mood stabilizers, stimulants and anti-panic agents. See generally Enjoli Francis, *What You Need to Know About Psychotropic Drugs*, ABC NEWS (Dec. 2, 2011, 5:05 PM), <http://abcnews.go.com/Health/what-you-need-to-know-about-psychotropic-drugs/blogEntry?id=15076785&ref=http%3A%2F%2F> (providing a summary and description of the different types of psychotropic drugs).

³³ See *infra* notes 106–13 and accompanying text. An exception would be made where there is a history of neglect or abuse on the part of the parent or parents.

³⁴ See generally, JEFFREY JENSEN ARNETT, *ADOLESCENCE AND EMERGING ADULTHOOD: A CULTURAL APPROACH* xii–xiii (Prentice Hall, 4th ed. 2010) (discussing the developmental period for young adults); JEFFREY JENSEN ARNETT, *EMERGING ADULTHOOD: THE WINDING ROAD FROM THE LATE TEENS THROUGH THE TWENTIES* 3–25 (Oxford University Press 2004)[hereinafter ARNETT, *EMERGING ADULTHOOD*] (detailing the differences and nuances

protect minors by requiring parental consent for their medical treatments, emerging adults are effectively able to obtain any drug on the market if they convince the doctor that they have the requisite diagnosis.³⁵ Part III explores HIPAA, the medical malpractice standard of care and the challenges associated with a society that is overly dependent on prescription drugs. It recommends that we work towards greater mental health parity, enabling those who need them, to affordably obtain mental health services. Part III also recommends that HIPAA be amended to provide for presumed consent for health care providers to share information, including at least an initial meeting, with parents of young emerging adults. It also suggests that mental health care providers' failure to use best efforts to include parental contact in cases of young emerging adults violates the medical malpractice standard of care, especially in cases involving ADHD medications. Finally, this article advocates for an awareness campaign to address the challenges associated with the public health problem of prescription drug overuse and abuse.

II. ADHD & ABUSE OF MEDICATIONS USED TO TREAT IT

A. ADHD

Attention Deficit Hyperactivity Disorder is characterized by behaviors both of inattention and hyperactivity.³⁶ Behaviors associated with ADHD include impulsivity, difficulty paying attention to detail, disorganization, fidgeting and excessive talking.³⁷ It is defined in the Diagnostic and Statistical Manual of Disorders (DSM-5) as “[a] persistent pattern of inattention and/or

associated with today's hurdles for new adults); *Information, information, information*, SOC'Y FOR THE STUDY OF EMERGING ADULTHOOD, www.ssea.org/resources/index.htm (last visited Dec. 29, 2014) (providing various academic resources regarding the topic of emerging adulthood).

³⁵ See CATHERINE WEISS, PROTECTING MINORS' HEALTH INFORMATION UNDER THE FEDERAL MEDICAL PRIVACY REGULATIONS 5 (Jennifer Dalven ed., 2003) (discussing parents' legal right to make health care decisions for their children).

³⁶ NAT'L INST. OF MENTAL HEALTH, ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) 1 (U.S. Dep't of Health & Human Servs. 2012), available at http://education.ucsb.edu/sites/default/files/hosford_clinic/docs/adhd_booklet.pdf.

³⁷ AM. PSYCHIATRIC ASS'N, ATTENTION DEFICIT/HYPERACTIVITY DISORDER FACT SHEET 1 (Am. Psychiatric Publ'g 2013), <http://www.dsm5.org/Documents/ADHD%20Fact%20Sheet.pdf>.

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 9

hyperactivity-impulsivity that interferes with functioning or development,” because of behaviors like being distracted, careless mistakes, and losing things, among others.³⁸ Symptoms and/or diagnosis of ADHD generally occurs by the age of seven.³⁹ “ADHD is characterized by persistent (symptoms lasting at least six months) inattention and/or hyperactivity/impulsivity in an individual that is observed more frequently and severely compared to the behavior of other individuals with similar levels of development.”⁴⁰

Most of the prevalence data surrounding ADHD focuses on children because ADHD is typically diagnosed during childhood.⁴¹ Approximately 9 percent of adolescents have been diagnosed with ADHD,⁴² although as of 2007, twenty states had prevalence rates at or above 10 percent.⁴³ While in 1970, approximately 150,000 children were diagnosed with ADHD, by the early 2000s, this figure had risen to millions.⁴⁴ Thus, while conventional wisdom for years had been that somewhere between 3-5 percent of children suffered from ADHD, the percentage of children treated for the condition can be more than 15 percent in some areas.⁴⁵ In

³⁸ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 59 (5th ed. 2013). These behaviors, broken down into 1) inattentiveness and 2) hyperactivity and impulsivity, include failure to pay close attention to detail, making careless mistakes, difficulty paying attention, difficulty organizing tasks, losing things, being easily distracted, fidgets with hands or feet or squirms in seat, running or climbing when it is not appropriate, talking excessively, blurting out an answer before question is completed, and difficulty waiting one's turn, among other things. *Id.*

³⁹ MOORE, *supra* note 17, at 53.

⁴⁰ *Id.* at 52–53.

⁴¹ See *ADHD Throughout the Years*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncbddd/adhd/timeline.html> (last updated Oct. 6, 2014) (explaining that the percent of children with ADHD has changed through the years).

⁴² Sabrina Tavernise, *Brain Test to Diagnose A.D.H.D. is Approved*, N.Y. TIMES, July 15, 2013, http://www.nytimes.com/2013/07/16/health/brain-test-to-diagnose-adhd-is-approved.html?_r=0. See also *State-based Prevalence Data of ADHD Diagnosis by a Health Care Provider*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncbddd/adhd/prevalence.html> (last updated Oct. 6, 2014) [hereinafter *Prevalence Data of ADHD Diagnosis*] (providing data of the percent of 4-17 year olds ever diagnosed with ADHD from 2003-2011).

⁴³ See *Prevalence Data of ADHD Diagnosis*, *supra* note 42 (indicating states that had prevalence rates at or above 10 percent).

⁴⁴ MOORE, *supra* note 17, at 63.

⁴⁵ See *What is Attention Deficit-Hyperactivity Disorder?*, NAT'L INST. OF NEUROLOGICAL DISORDERS & STROKE, <http://www.ninds.nih.gov/disorders/adhd/adhd.htm> (last updated Dec. 20, 2013) (stating that 3 to 5 percent of American children are affected by ADHD).

one school, an entire class was on medication because the teacher believed that her students were “inattentive and could perform better on psychostimulant medication.”⁴⁶ “Five times as much [ADHD] medication is used in the United States as anywhere else in the world except Australia.”⁴⁷

For those children who are accurately diagnosed with ADHD, medications like Adderall or Ritalin that are the “first-line” of treatment may be enormously helpful.⁴⁸ Often, these therapies are used in conjunction with behavioral interventions.⁴⁹ In addition, complementary and alternative approaches may be used to treat ADHD.⁵⁰ The most commonplace treatment for ADHD, though, is medication – specifically Adderall or Ritalin.

Many college students and other emerging adults who obtain ADHD medication have never been diagnosed with ADHD.⁵¹ This raises a question of why so many young adults are able to obtain prescription medications for a disease that is normally symptomatic by the age of seven, without providing proof that they have ever had such symptoms. Perhaps for some of these young adults, there was a failure to diagnose ADHD; they should have received such diagnosis, but did not. The vast majority,

⁴⁶ JULIAN STUART HABER, *ADHD: THE GREAT MISDIAGNOSIS 2* (Taylor Trade Publ'g 2003).

⁴⁷ *Id.* at 4.

⁴⁸ See MOORE, *supra* note 17, at 6–7 (noting the improvements seen in properly diagnosed children on stimulant medications). Amphetamines may also be used to treat narcolepsy, to treat depression and to facilitate weight loss. *Id.* at 9–10. In some cases, alternative treatments may be as useful as amphetamines for ADHD. See *id.* at 102 (describing a parent who took her son off of Adderall and implemented behavioral changes like more playing outside and playing of drums which alleviated the son's ADHD behaviors.).

⁴⁹ See *Treatment*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncbddd/adhd/treatment.html> (last updated Oct. 6, 2014) (stating that behavioral therapy is an important part of the treatment of ADHD in children); see also *Treatment Overview*, NAT'L RES. CTR. ON ADHD, <http://www.help4adhd.org/en/treatment/treatmentoverview> (last reviewed Apr. 2014) (indicating that behavior management is one of the modes of treatment that can be employed along with stimulant medication).

⁵⁰ See MOORE, *supra* note 17, at 102 (noting that psychological counseling and alternative medicine have seen some positive outcomes in ADHD treatment). Cf. *Attention-deficit/hyperactivity disorder (ADHD) in Children: Alternative Medicine*, MAYO CLINIC (Mar. 05, 2013), <http://www.mayoclinic.org/diseases-conditions/adhd/basics/alternative-medicine/con-20023647> (noting that most of the CAM modalities have yet to be proven effective).

⁵¹ Cf. Roger Cohen, Op-Ed., *The Competition Drug*, N.Y. TIMES, Mar. 4, 2013, http://www.nytimes.com/2013/03/05/opinion/global/roger-cohen-adderall-the-academic-competition-drug.html?_r=0 (illustrating how college students without Adderall prescriptions attempt to get them).

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 11

however, does not have, and never has had ADHD.⁵² Instead, we have a health care system that has made access to these drugs far too easy. Adderall and Ritalin can be obtained without real proof that the patient has ADHD.⁵³ Adderall and Ritalin should generally not be prescribed to college students or other young adults without some evidence of a history of ADHD.

ADHD medications, like any others, can have serious side effects, including “elevated blood pressure, constriction of peripheral vessels, stimulation of heart muscles, relaxation of bronchial and intestinal muscles, dilation of pupils, and stimulation of the cerebrospinal axis.”⁵⁴ Adderall is a Schedule II controlled substance under the Controlled Substances Act.⁵⁵ Other Schedule II drugs include cocaine.⁵⁶ One reason for its classification as a Schedule II controlled substance is that Adderall can be addictive.⁵⁷ Because of the potential for harm, ADHD medications must be properly monitored, and access limited to those for whom it is medically necessary. Unfortunately, in practice, that is not the case.

B. Abuse of ADHD Medications

That amphetamines like Adderall, Ritalin and other ADHD medications are being abused, and that such abuse constitutes a public health problem, is not seriously in doubt.⁵⁸ Evidence has

⁵² See HABER, *supra* note 46, at xiii (noting that disease of ADHD “is massively overdiagnosed” despite its legitimacy); MOORE, *supra* note 17, at 120–21 (describing college students who may “fake having symptoms of ADHD in an effort to get legitimate prescriptions” and those who buy them “from acquaintances or online”).

⁵³ “What to say to doctors to get a prescription is now so widely known among students . . . as to have become a kind of joke. ‘If there are no A.D.H.D. symptoms prior to college I have a very hard time writing a prescription,’ Jill Kasper, a pediatrician, told me. ‘But if somebody wants a prescription for Adderall, they can find someone to give it to them.’” Cohen, *supra* note 51.

⁵⁴ MOORE, *supra* note 17, at 170. This is a partial list. Other adverse effects may include, heart palpitations, psychotic episodes, dry mouth, and diarrhea among others. *Id.* at 173.

⁵⁵ *Drug Schedules*, U.S. DRUG ENFORCEMENT ADMIN., <http://www.dea.gov/druginfo/ds.shtml> (last visited Oct. 28, 2014).

⁵⁶ *Id.*

⁵⁷ MOORE, *supra* note 17, at 149–69 (discussing possibility of sensitization, tolerance, addiction, dependence and habituation to these drugs).

⁵⁸ In its 2005 report, the International Narcotics Control Board found that “[o]ne out of 10 teenagers has used prescription stimulants (Ritalin® and/or Adderall®) without a doctor’s prescription.” INT’L NARCOTICS CONTROL BD., REPORT OF THE INTERNATIONAL NARCOTICS CONTROL BOARD FOR 2005, at 58 (2005), available at <http://www.incb.org/documents/Publications/AnnualReports>

been mounting since at least the early 2000s that teenagers are abusing Adderall, Ritalin and other drugs they believe are useful to help with concentration.⁵⁹ While precise numbers are difficult to assess, a 2006 report estimated that close to 10 percent of college students use these drugs.⁶⁰ Another small study found that 31 percent of college students misused ADHD medications.⁶¹

There are a number of contributing factors to the growing abuse of ADHD medications. One cause of the problem is over-diagnosis.⁶² There has been a dramatic increase in the number of students diagnosed with ADHD.⁶³ Instead of engaging in talk therapy as was once the norm,⁶⁴ psychiatrists routinely write prescriptions for controlled substances and other psychotropic drugs with little doctor-patient interaction.⁶⁵ Other medical

/AR2005/AR_05_English.pdf. See also MOORE, *supra* note 17, at 25–26 (noting that abuse of amphetamines was a concern as far back as the 1930s); *id.* at 150 (“[W]hile the legitimate uses of amphetamines are few, the illegal manufacture and sale of amphetamine and methamphetamine compounds is a major operation.”); Tavernise, *supra* note 21 (noting the rise in emergency room visits after taking Adderall or Ritalin).

⁵⁹ See David L. Rabiner, et al., *Motives and Perceived Consequences of Nonmedical ADHD Medication Use by College Students: Are Students Treating themselves for Attention Problems?*, 13 J. ATTENTION DISORDERS 259, 267–68, (2009) (explaining that Adderall and Ritalin may enhance a student’s concentration). But see *supra* note 54 and accompanying text (providing examples of a number of adverse side effects).

⁶⁰ Christian J. Teter et al., *Illicit Use of Specific Prescription Stimulants Among College Students: Prevalence, Motives, and Routes of Administration*, 26(10) PHARMACOTHERAPY 1501, 1504 (2006). A later report published in 2010 found similar results. Christian J Teter et al., *Prevalence and Motives for Illicit Use of Prescription Stimulants in an Undergraduate Student Sample*, 53(6) J. AM. C. HEALTH 253, 256 (2005). See also MOORE, *supra* note 17, at 156 (“Regional drug databases, police charges, custom’s seizures and community surveys all indicate that amphetamines are the most prevalent illicit drugs after cannabis.”). New York’s senator Chuck Schumer said “an estimated one-sixth to one-third of students have taken [Adderall or Ritalin].” Tyler Kingkade, *Chuck Schumer: Adderall, Study Drug Use at Colleges Should Be Curbed*, THE HUFFINGTON POST, Jun. 20, 2013, http://www.huffingtonpost.com/2013/06/20/chuck-schumer-adderall_n_3468288.html. This means that approximately “64,000 students popped Adderall or a drug like it in New York City alone.” *Id.*

⁶¹ David Rabiner et al., *Motives and Perceived Consequences of Nonmedical ADHD Medication Use by College Students*, 13 J. ATTENTION DISORDERS 259, 260 (2008).

⁶² See MOORE, *supra* note 17, at 63.

⁶³ See *supra* notes 58–61 and accompanying text.

⁶⁴ See R. Morgan Griffin, *Adult ADHD Therapy: Finding the Right Therapist*, WEBMD.COM (Sept. 4, 2008), <http://www.webmd.com/add-adhd/features/adult-adhd-therapy-finding-right-therapist> (describing the processes that therapists participate in when treating their ADHD clients).

⁶⁵ Alexandra Sifferlin, *Majority of Doctors Do Not Follow Treatment*

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 13

doctors are also too quick to prescribe medications.⁶⁶ The first step in curbing the misuse of ADHD medications is to ensure a sufficient factual basis for the underlying diagnosis.

Second, college students who grew up with friends or relatives taking ADHD medications may consider them to be useful, benign tools. It is likely that even students who were never diagnosed with ADHD know someone who was. It is also likely that by the time a student graduates from high school, he or she has been offered one of the stimulants used to treat ADHD. They are not properly educated about the potential harms associated with ADHD drugs.⁶⁷ On the contrary, it is more likely that they consider prescription drug use the norm in a culture that looks to a pill for almost any ailment.⁶⁸ Third, emerging adults have come of age at a time when the sharing of prescription drugs was

Guidelines for ADHD, TIME MAG. (Oct. 24, 2014), <http://healthland.time.com/2013/05/06/majority-of-medical-specialists-do-not-follow-guidelines-for-treating-adhd/>.

⁶⁶ This is not new. Nor is it limited to psychotropic drugs. The overuse of antibiotics, the fen-phen disaster, hormone replacement therapy, among others, have all been subjects of headline news. Cf. Barbara L. Atwell, *Mainstreaming Complementary and Alternative Medicine in the Face of Uncertainty*, 72 U.M.K.C. L. REV. 593, 593 (2004) (calling attention to the fact that customary practice among medical doctors is the result of trial and error).

⁶⁷ See DEA DRUG FACTSHEET, *supra* note 18 (“Therapeutic levels of stimulants can produce exhilaration, extended wakefulness, and loss of appetite. These effects are greatly intensified when large doses of stimulants are taken.”). Adderall is potentially addictive, and when abused, can cause serious side effects. *Id.* “When used as drugs of abuse and not under a doctor’s supervision, stimulants are frequently taken to: produce a sense of exhilaration, enhance self-esteem, improve mental and physical performance, increase activity, reduce appetite, extend wakefulness for prolonged period, and ‘get high.’” *Id.* “Chronic, high-dose use is frequently associated with agitation, hostility, panic, aggression, and suicidal or homicidal tendencies.” *Id.* “Paranoia, sometimes accompanied by both auditory and visual hallucinations, may also occur.” *Id.* “Tolerance, in which more and more drug is needed to produce the usual effects, can develop rapidly, and psychological dependence occurs.” *Id.* “In fact, the strongest psychological dependence observed occurs with the more potent stimulants, such as amphetamine, methylphenidate, methamphetamine, cocaine and methathinone.” *Id.* “Abrupt cessation is commonly followed by depression, anxiety, drug craving, and extreme fatigue, known as a ‘crash.’” *Id.* See also MOORE, *supra* note 17, at 28–33 (recognizing high dose side effects as including restlessness, dizziness, tremors, irritability, insomnia, fever, psychosis and, in some cases, death).

⁶⁸ The rise in popularity of complementary and alternative medicine (“CAM”) is a push back against the pill-popping culture. Cf. Atwell, *supra* note 66, at 606–07 (considering a sample of CAM therapies which includes chiropractic, acupuncture, massage therapy, homeopathy, reflexology, iridology, kinesiology, nutritional therapy, color therapy, and reiki).

considered acceptable if not routine.⁶⁹ As a result, they are willing to share or sell pills to their friends, just as they might share marijuana or alcohol.⁷⁰ In sum, when they arrive at college, many emerging adults will have some level of exposure both to the diagnosis of ADHD and to the medications used to treat it. That familiarity may lead them to believe that ADHD medications are safe and can be used for performance enhancement without consequence. In sum, there are at least four contributing factors to the current problem: over-diagnosis of ADHD, a resulting sense of familiarity with ADHD drugs, sharing of prescription medications, and an uneducated population.⁷¹ This confluence of factors creates a perfect storm for disaster.

The full range of harms caused by ADHD medications may last well beyond college. First, a student who becomes addicted to these medications in college will not necessarily find it easy to stop upon graduating. Instead, they will likely continue to use the medications as they enter the workforce. Moreover, even those who are not addicted may decide to continue using these medications as they transition from college to the workforce. If they believe the medications enhance their ability to focus and concentrate, they are likely to find these enhancements useful as employees, just as they did as college students. Therefore, what is primarily being discussed as a problem for college students may quickly evolve into a problem of young college graduates and beyond, potentially encompassing all of the emerging adult years of ages 18–30.

III. EMERGING ADULTS

*“The undeniable reality . . . is that emerging adult problems are ultimately problems of our entire culture and society.”*⁷²

⁶⁹ Tavernise, *supra* note 21 (noting the sharing of prescriptions among friends and relatives).

⁷⁰ *Id.*

⁷¹ MOORE, *supra* note 17, at 120–21; Tavernise, *supra* note 21. In addition to ADHD stimulant medication abuse, depressants like Xanax and prescription painkillers are also being heavily abused. See CTRS. FOR DISEASE CONTROL & PREVENTION, POLICY IMPACT: PRESCRIPTION PAINKILLER OVERDOSES 2 (Nov. 2011), <http://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf> (discussing the misuse and abuse of prescription painkillers). Between 1990 and 2008, the number of drug overdose deaths from painkillers tripled. *Id.* at 1.

⁷² SMITH ET AL., *supra* note 6, at 11.

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 15

For all practical purposes, the law uses the age of eighteen to distinguish between children and adults.⁷³ Minors have limited legal rights. For example, they cannot vote and they lack capacity, by and large, to enter into contracts.⁷⁴ Prior to the age of eighteen, they cannot marry or enter the armed services without parental consent.⁷⁵ Minors must also obtain parental consent for most medical procedures.⁷⁶ The criminal justice system also distinguishes between minors and adults.⁷⁷ While the legal age of some activities, like drinking alcoholic beverages, recreational marijuana use (where legal), and cigarette smoking in some municipalities, is twenty-one,⁷⁸ as a general rule, one becomes a legal adult in the United States at the age of eighteen. It is as if a light switch gets flipped on one's eighteenth birthday, so that things one may have been considered too immature to do the day before now become legally sanctioned. Bright lines like this are relatively simple and easy to enforce. It ignores, however, the reality of human development, which occurs on a continuum.

Psychologists recognize varying stages of human development. They understand that for most people, a great deal of immaturity

⁷³ The legal drinking age, however, is twenty-one, and there are other exceptions such as localities that impose a higher age before being legally able to purchase tobacco products. *See New Jersey May Become First State to Raise Smoking age to 21*, FOXNEWS.COM, Aug. 7, 2014, <http://www.foxnews.com/politics/2014/08/07/new-jersey-may-become-first-state-to-raise-smoking-age-to-21/>.

⁷⁴ *See, e.g., Oregon v. Mitchell*, 400 U.S. 112, 118 (1970) (upholding constitutionality of eighteen year old voting age). Contracts, with limited exceptions (e.g., necessities) are voidable by the minor. *See Woodman v. Kera*, 785 N.W.2d 1, 9 (Mich. 2010) (finding a waiver of liability signed by a parent on behalf of a minor to be invalid).

⁷⁵ *Cf. Kirkpatrick v. Eighth Jud. Dist. Ct.*, 64 P.3d 1056, 1057 (Nev. 2003) (approving a minor's marriage with one parent's consent); *U.S. v. Blanton*, 23 C.M.R. 128, 131 (C.M.A. 1957) (finding that a minor enlisted in the armed forces could not be subject to a court martial for desertion because he was never legally competent to serve in the military).

⁷⁶ *Cardwell v. Bechtol*, 724 S.W.2d 739, 744 (Tenn. 1987).

⁷⁷ All too often, however, the criminal justice system treats minors as adults. *Cf. Barry Feld, The Youth Discount: Old Enough to Do the Crime, Too Young to Do the Time*, 11(1) OHIO ST. J. CRIM. L. 107, 107–08 (2013) (discussing the United States Supreme Court's recent jurisprudence on the Eighth Amendment and punishment of minors who commit crimes).

⁷⁸ *Ryan Jaslow, NYC Raises Smoking Age to 21, Sets Cigarette Pack Minimum Price at \$10.50*, CBSNEWS.COM, Nov. 19, 2013, <http://www.cbsnews.com/news/nyc-raises-smoking-age-to-21-sets-cigarette-pack-minimum-price-at-1050/>.

remains, even after reaching the age of eighteen.⁷⁹ In fact, as brain research has developed, it is apparent that there is a neurological basis for some of that immaturity. Evidence suggests that brain development continues until the age of twenty-five.⁸⁰ Psychologists have identified and labeled the time between the ages of eighteen and about thirty as the period of “emerging” or “transitional” adulthood.⁸¹ As one author notes, “[i]n the United States, the years between the ages of 18 and 30 have long been heralded for their formative potential.”⁸² Emerging adults are characterized by Jeffrey Jensen Arnett, the person who coined the term, as a stage that includes “(1) seeking identity, (2) experiencing instability, (3) focusing on self-

⁷⁹ See Lucy Wallis, *Is 25 the New Cut-Off Point for Adulthood?*, BBC NEWS, Sept. 23, 2013, <http://www.bbc.com/news/magazine-24173194> (acknowledging that “adolescence now effectively runs up until the age of 25” and not age eighteen).

⁸⁰ See generally Rob Logan, *NLM Director’s Comments Transcript Child Mental Health and Brain Development: 06/16/2014*, NAT’L LIBRARY OF MED., June 16, 2014, <http://www.nlm.nih.gov/medlineplus/podcast/transcript061614.html> (explaining that cortical development is not complete until the age of twenty-five); Vivian E. Hamilton, *Immature Citizens and the State*, 2010 BYU L. REV. 1055, 1115–16 (2010) (acknowledging research showing a period between the ages of eighteen until about twenty-five in which brain development continues, and the kind of risk taking associated with adolescence has not yet disappeared).

⁸¹ DAVID P. SETRAN & CHRIS A. KIESLING, *SPIRITUAL FORMATION IN EMERGING ADULTHOOD: A PRACTICAL THEOLOGY FOR COLLEGE AND YOUNG ADULT MINISTRY* 19–20 (2013); JEFFREY JENSEN ARNETT ET AL., *DEBATING EMERGING ADULTHOOD: STAGE OR PROCESS* 4–5 (Oxford Univ. Press 2011); SHARON DALOZ PARKS, *BIG QUESTIONS, WORTHY DREAMS: MENTORING EMERGING ADULTS IN THEIR SEARCH FOR MEANING, PURPOSE AND FAITH* 4–6 (Jossey-Bass 2011); RICHARD SETTERSTEN & BARBARA E. RAY, *NOT QUITE ADULTS: WHY 20-SOMETHINGS ARE CHOOSING A SLOWER PATH TO ADULTHOOD, AND WHY IT’S GOOD FOR EVERYONE* x (Bantam Books 2010); VARDA KONSTAM, *EMERGING AND YOUNG ADULTHOOD: MULTIPLE PERSPECTIVES, DIVERSE NARRATIVES* 1–2 (Springer 2010); ARNETT, *EMERGING ADULTHOOD*, *supra* note 34, at 3–4. See also SMITH ET AL., *supra* note 6, at 15–17 (focusing on emerging adults ages 18–23); Melissa S. Caulum, *Post Adolescent Brain Development: A Disconnect Between Neuroscience, Emerging Adults, and the Corrections System*, 2007 WIS. L. REV. 729, 740 (2007) (“[T]he passage from emerging adulthood to adulthood is much less definite”). Cf. JENNIFER M. SILVA, *COMING UP SHORT: WORKING CLASS ADULTHOOD IN AN AGE OF UNCERTAINTY* 7–8 (Oxford Univ. Press 2013) (focusing on emerging adults from working class backgrounds).

⁸² SETRAN & KIESLING, *supra* note 81, at 1. Emerging adults under the age of twenty-five may face even greater challenges than those approaching the age of thirty. One scholar focuses on emerging adults between the ages of 18 and 23. See SMITH ET AL., *supra* note 6, at 3. Those under the age of twenty-five are less mature as a group and may engage in more impulsive and risk taking behaviors typically associated with adolescence than older emerging adults. *Id.* at 15–16.

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 17

development, (4) feeling in-between adolescence and adulthood, and (5) optimistically believing in many possible life pathways.”⁸³ In essence, emerging adults are trying to figure out who they are, and are beginning the process of charting an independent life.⁸⁴

Part of figuring out who they are includes making a number of important decisions. In fact, the period between the age of eighteen and thirty will likely include more life transitions than other decades. During this period, many emerging adults will move from school to work, move out of their parents’ homes, marry and begin families.⁸⁵ Each of these transitions is significant and involves decision-making and adjusting to new realities. One of the first decisions these young adults must make is whether to go to college. Regardless of what decision they make, one of the biggest transitions for emerging adults is the movement at some point during emerging adulthood from school to work. For some, this change may occur very smoothly, but for others, it can be quite difficult. Some “reported feeling unprepared for the abrupt shift that occurred once they entered the workforce,” especially those in entry-level jobs.⁸⁶ In addition to making decisions about education, emerging adults must think about where to work and live, whether to marry, have children, and how to create a life for themselves.

In addition to making external life choices, emerging adults are also looking internally at their moral, ethical and religious values.⁸⁷ They are beginning to focus on what holds meaning for

⁸³ ARNETT ET AL., *supra* note 81 at 15; FRANK D. FINCHAM, MING CUI, *ROMANTIC RELATIONSHIPS IN EMERGING ADULTHOOD* 3–4 (Cambridge Univ. Press 2010). There is some debate about whether this period of one’s life constitutes a separate psychological stage or simply reflects a society in which markers of adulthood, like marriage, parenting, moving into one’s own house and the like are happening later than they did just a few decades earlier.

⁸⁴ ARNETT, *EMERGING ADULTHOOD*, *supra* note 34, at 8–9 (noting that “[a]lthough research on identity formation has focused mainly on adolescence, this research has shown that identity achievement has rarely been reached by the end of high school and that identity development continues through the late teens and the twenties”).

⁸⁵ Shmuel Shulman & Jari-Erik Nurmi, *The Role of Goals in Navigating Individual Lives During Emerging Adulthood*, 130 *NEW DIRECTIONS FOR CHILD & ADOLESCENT DEV.* 2 (Winter 2010).

⁸⁶ KONSTAM, *supra* note 81, at 45. Emerging adults “believed that their work life would approximate college life, with some modifications,” and were surprised to learn that the complexities of the global economy, the insecurity of being an at will employee, among other things. *Id.* at 45–46.

⁸⁷ See generally SMITH ET AL., *supra* note 6, at 18–69 (noting, in part, that emerging adults have a very individualistic view of morality); PARKS, *supra* note 81, at 10 (emerging adults are “seeking and discovering meaning in the most

them.⁸⁸ For example, is money going to be the driving force in their lives, or will it be service to the community, spirituality, health, personal relationships or some other motivating factor?⁸⁹ Undoubtedly, there will be some balance among these factors. There is some evidence, though, that emerging adults may be too focused on material gain.⁹⁰ Also of concern is evidence that today's emerging adults have little opportunity to engage in "constructive discussion[s] about moral differences with other people who disagree."⁹¹

Many emerging adults are finding it more and more difficult to successfully move through the transitions of emerging adulthood. In terms of external decision-making, for example, the decision of where to live may be made for them. It is not uncommon for emerging adults to be saddled with student loans, and unable to move out of their parents' homes.⁹² Even those with college degrees sometimes find it difficult to obtain jobs that will provide them with a middle class lifestyle.⁹³ Also, as noted above, moving from the structure of school to work can be a difficult transition even when the job constitutes a highly sought after position. Many emerging adults "reported feeling unprepared for the abrupt shift that occurred once they entered the workforce."⁹⁴

comprehensive dimensions of [their] experience"). Parks labels this search for meaning as "faith." *Id. Cf.* ARNETT, EMERGING ADULTHOOD, *supra* note 34, at 6 ("It may be that the most important reason of all for the rise in the typical ages of entering marriage and parenthood is less tangible than changes in sexual behavior or more years spent in college and graduate school. There has been a profound change in how young people view the meaning and value of becoming an adult and entering the adult roles of spouse and parent.").

⁸⁸ See PARKS, *supra* note 81, at 10 (explaining that the "twenty-something years" are ripe for "seeking and discovering meaning in the most comprehensive dimensions of [human] experience—that is, *faith*").

⁸⁹ See, e.g., SETRAN & KIESLING, *supra* note 81, at 20 (discussing the life phase of a young adult and how developmental and environmental factors can play a role in shaping spiritual formation during that time).

⁹⁰ SMITH ET AL., *supra* note 6, at 9 ("Many emerging adults . . . focus . . . almost exclusively on materialistic consumption and financial security as the guiding stars of their lives."). This is not a formula for happiness. *Cf.* Arthur C. Brooks, Op-Ed., *Love People, Not Pleasure*, N.Y. TIMES, July 20, 2014, at SR1 (reviewing evidence suggesting that it is our loving relationships with others that is most important for happiness).

⁹¹ SMITH ET AL., *supra* note 6, at 9.

⁹² See SILVA, *supra* note 81, at 3–5 (describing the experiences of a college graduate who could not pay back his loans and accrues \$5,000 a year in interest, and a college drop-out with \$100,000 in loan debt).

⁹³ *Id.* (discussing the experience of a college graduate barely able to pay rent and a college dropout trying to make rent as a cashier).

⁹⁴ Konstam, *supra* note 81, at 45.

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 19

And those who either choose not to attend college or who fail to complete college may find themselves stuck in low-income, service sector jobs.⁹⁵ For these reasons, among others, many emerging adults are living with their parents for extended periods of time and cannot simply decide where they want to live.⁹⁶

Perhaps because of their relative immaturity, or perhaps in part due to the many demands and decisions and life changes facing emerging adults, this stage of development is marked by greater instability than adolescents or older adults.⁹⁷ This instability is undoubtedly one reason why emerging adults are more prone to engaging in certain risk-taking behaviors than older adults.⁹⁸ Engaging in routine drug use or intoxication, for example, is not uncommon, especially among younger emerging adults.⁹⁹ Some evidence suggests that more than half of emerging adults engage in, or have engaged in, drug and alcohol use in unhealthy ways,¹⁰⁰ including the abuse of amphetamines.¹⁰¹ Our “normative culture” contributes to the problem by accepting the idea that when emerging adults leave home they will:

⁹⁵ See SILVA, *supra* note 81, at 5 (providing an example of a college dropout who works as a cashier).

⁹⁶ See SETTERSTEN & RAY, *supra* note 81, at x (explaining that since 1970, the number of eighteen to twenty-four year olds still living at home has increased by 37 percent.).

⁹⁷ ARNETT ET AL., *supra* note 81, at 16.

⁹⁸ See Jeannette Brodbeck et al., *Comparing Growth Trajectories of Risk Behaviors From Late Adolescence Through Young Adulthood: An Accelerated Design*, 49 DEVELOPMENTAL PSYCHOL. 1732, 1732 (2013), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760598/pdf/dev_49_9_1732.pdf (explaining that risk behavior common in adolescence does not last beyond adulthood, and is originally a result of distress caused by adolescent neurobiological and physical changes).

⁹⁹ See *id.* at 1733 (stating that substance use typically begins during adolescence, and is greatest during the early to mid-twenties.).

¹⁰⁰ SMITH ET AL., *supra* note 6, at 116 (“46 percent of the emerging adults we interviewed, represent relatively reasonable and healthy approaches to alcohol and drugs.”). Others, who are labeled as partiers, recovering partiers, and addicts had more challenges with drug and alcohol use. See *id.* (discussing the prevalent use of alcohol, marijuana, and hard drug use among the “partier” group). Cf. KONSTAM, *supra* note 81, at 144 (discussing an emerging adult’s previous drug use). Sexual behavior among emerging adults may also reflect their relative immaturity. See SMITH ET AL., *supra* note 6, at 10 (explaining that emerging adults may be unable to understand sex as a means of achieving intimacy, as opposed to simply self-gratification).

¹⁰¹ See SMITH ET AL., *supra* note 6, at 138 (providing an emerging adult’s perspective of an incident following a period of heavy, long-time amphetamine use).

[E]xercise their new freedom by partying, acting wild and crazy, perhaps idiotically, particularly by consuming large amounts of alcohol and maybe some drugs . . . The script also says that eventually, in one's late 20s or early 30s, one needs to stop this partying, settle down, and become a good, successful, financially secure family person.¹⁰²

This normative culture comes with the risk that some emerging adults will embrace unhealthy patterns that will follow them beyond the emerging adult years. The opportunities, challenges and choices that emerging adults make may affect not only themselves, but society at large: “[f]or . . . young . . . adults—and [as a consequence] for all of us—there is much at stake in how they are heard, understood, and met by the adult world in which they are seeking participation, meaning, purpose, and a faith to live by.”¹⁰³

If emerging adults transition successfully to full adult lives, both financially, personally and spiritually, they will impact society and future generations in positive ways. If, on the other hand, they are lonely, depressed, abusing drugs and/or struggling to make ends meet throughout their twenties and possibly beyond, they will have much more limited opportunities to meaningfully contribute to the larger community. Thus, it behooves us as a society to do what we can to help emerging adults come out at the end of their twenties as fully whole human beings, secure and ready to lead the country forward.¹⁰⁴

One way to best serve emerging adults is to recognize that their brain development continues until the age of twenty-five.¹⁰⁵

¹⁰² *Id.* at 142. Friendships can be particularly influential among emerging adults in predicting whether one will abuse drugs and alcohol. Cf. ARNETT, *supra* note 34, at 192–93 (providing an example of an individual who used drugs and alcohol before the period of emerging adulthood, then married and stopped his substance abuse with the help of his wife who was his “best friend”); *see also* SETTERSTEN & RAY, *supra* note 81, at 103, 109 (discussing the importance of a strong friend-network in an individual's life); SETRAN & KIESLING, *supra* note 81, at 88 (expressing concern that many young adults may shy away from religion because they engage in what are considered immoral behaviors of intoxication and premarital sex).

¹⁰³ PARKS, *supra* note 81, at 3. *See also* SMITH ET AL., *supra* note 6, at 11 (explaining that many of the problems and struggles faced by emerging adults often stem from the complicity of adults around which emerging adults are maturing).

¹⁰⁴ *See* SMITH ET AL., *supra* note 6, at 11 (“The undeniable reality . . . is that emerging adult problems are ultimately problems of our entire culture and society.”).

¹⁰⁵ *See* CLEA MCNEELY & JAYNE BLANCHARD, *THE TEEN YEARS EXPLAINED: A GUIDE TO HEALTHY ADOLESCENT DEVELOPMENT 2* (Johns Hopkins Bloomberg

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 21

To meet the mental health needs of emerging adults—at least those between the ages of eighteen and twenty-five, or “young emerging adults,” new rules or policies can be implemented to meet the needs of this demographic. This applies not just to issues connected to ADHD, but to mental health needs in general. It is critical to take meaningful steps to help address those needs. The following section sets forth a number of suggestions.

IV. EMERGING ADULTS, MENTAL HEALTH & THE LAW

*[W]e must ensure that greater access to prescription drugs confers better health, not harm.*¹⁰⁶

A. Lack of Mental Health Parity

Access to adequate mental health care in this country has historically been inadequate. While lip service has been given to the idea of “mental health parity”—that mental health coverage would be on par with physical ailments—the reality has been something else entirely.¹⁰⁷ Rarely, if ever, is reimbursement for mental health treatments on par with that for physical health.¹⁰⁸ It is extremely difficult to obtain and pay for high quality mental health care in the United States.¹⁰⁹ Health insurance policies

Sch. of Pub. Health 2009) (“Yet the process of transforming the relatively inefficient brain of the child into a leaner, more proficient adult brain may not be completed until age 25.”).

¹⁰⁶ Nancy E. Morden et al., *Accountable Prescribing*, 396(4) NEW ENG. J. MED. 299, 302 (2013) available at <http://www.nejm.org/toc/nejm/369/4/>.

¹⁰⁷ See generally Jeffrey M. Barrett, Comment, *A State of Disorder: An Analysis of Mental-Health Parity in Wisconsin and a Suggestion for Future Legislation*, 2008 WIS. L. REV. 1159, 1159 (2008) (proposing legislative action in Wisconsin to remedy the lack of mental health parity by requiring terms and conditions of mental health coverage reflect those of physical-health coverage); see also Aviv Shamash, Note, *A Piecemeal, Step-by-Step Approach Toward Mental Health Parity*, 7 J. HEALTH & BIOMEDICAL L. 273, 274–75 (2011), available at http://www.suffolk.edu/documents/Law%20Journal%20of%20H%20and%20B/d_Shamash_273-324.pdf (discussing the legislative history and debate regarding the disparity in access to adequate mental health insurance and treatment).

¹⁰⁸ See ERIC GOPLERUD, U.S. DEP’T. OF HEALTH & HUMAN SERVS., CONSISTENCY OF LARGE EMPLOYER AND GROUP HEALTH PLAN BENEFITS WITH REQUIREMENTS OF THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTIN EQUITY ACT OF 2008, at x, xiii (2013), available at <http://aspe.hhs.gov/daltcp/reports/2013/mhpaAct.pdf> (explaining that for mental health services, non-quantitative treatment limitations included reimbursement rates which were lower than comparable medical/surgical rates).

¹⁰⁹ See SUSAN WILE SCHWARZ, NAT’L CTR. FOR CHILDREN IN POVERTY,

have routinely applied annual and/or lifetime limits on mental health coverage.¹¹⁰ Moreover, the panel of providers included for mental health coverage is often much more restrictive than panels of providers for physical well-being.¹¹¹ Despite passage of the Mental Health Parity Act of 1996,¹¹² political compromises made to pass the Act resulted in a system in which mental health benefits continued to be subpar compared to their physical health counterparts:

The Mental Health Parity Act of 1996 does not mandate that an employer provide mental-health coverage. Instead, it merely requires insurance plans that already offer mental-health benefits to provide annual- or lifetime-spending caps equal to those imposed for physical-health benefits . . . [T]he Act completely ignores other terms and conditions that can be used in an equally discriminatory fashion, such as disparate cost-sharing provisions, outpatient-visit maximums, inpatient-day maximums, and medical-necessity requirements.

Insurers have completely sidestepped the Act's requirement that mental- and physical-health benefits have equal spending caps by converting those spending caps to inpatient-day and outpatient-visit limits . . . Such a manipulation of coverage, while legal, undermines the spirit of the law and highlights the urgent need for more comprehensive legislation.

ADOLESCENT MENTAL HEALTH IN THE UNITED STATES (2009), http://nccp.org/publications/pdf/text_878.pdf (noting that in the United States, 70 percent of adolescents with mental health needs do not receive the care they need, due to lack of adequate insurance coverage and lack of referral services); SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., NATIONAL SURVEY ON DRUG USE AND HEALTH REPORT: AFFORDABILITY MOST FREQUENT REASON FOR NOT RECEIVING MENTAL HEALTH SERVICES (Sept. 2013), <http://www.samhsa.gov/data/sites/default/files/spot075-services-affordability-2013/spot075-services-affordability-2013.pdf> (indicating that from 2009 to 2011, not being able to afford mental health care was one of the most frequently mentioned reasons for not receiving mental health services).

¹¹⁰ See NAT'L. CONFERENCE OF STATE LEGISLATURES, MENTAL HEALTH BENEFITS: STATE LAWS MANDATING OR REGULATING MENTAL HEALTH BENEFITS (Jan. 2014), <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> (describing that discrepancies between the level of benefits provided between mental illnesses and physical illnesses include annual and lifetime visit limits).

¹¹¹ See Erica Mu, *As Mental Health Coverage Expands, Providers Not Always There*, REMAKING HEALTH INS.: THE AFFORDABLE CARE BLOG (May 22, 2014), <http://www.reportingonhealth.org/2014/05/21/mental-health-coverage-expands-providers-not-always-there> (indicating that the list of mental health care providers is restrictive to the point that there are not enough to meet the demand for mental health care).

¹¹² Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-5 (2012)).

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 23

The Act's efficacy is further undercut by its failure to provide a specific definition of mental health. Instead, it defers to the definition listed in an insurance policy's terms and conditions. This leaves too much power in the hands of insurance companies . . . [In addition] the Mental Health Parity Act of 1996 does not apply to small-employer group health plans, which are defined as plans sponsored by employers with more than two but fewer than fifty employees. Employees of small employers make up half of all U.S. workers. This means that about 80 million employees and dependents are not included within the scope of the Act. Employers are also exempted from the Act's reach if abiding by its requirements raises costs under the group health plan by at least 1 percent.¹¹³

Since the Mental Health Parity Act of 1996 did not actually require that mental health benefits be offered, but only imposed certain restrictions if they were, its impact has been limited. Moreover, the exemption when mental health coverage raises group health plan costs by at least 1 percent further restricted its efficacy. The prevalence of mental illness in this country makes it likely that mental health coverage will increase costs by more than 1 percent.¹¹⁴

Another effort to address the lack of mental health parity was the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA).¹¹⁵ The MHPAEA, however, suffers from many of the same shortcomings as the Mental Health Parity Act of 1996. It does not require employers to provide mental health or substance abuse coverage. It simply imposes restrictions on employers that elect to provide such coverage.¹¹⁶ It also exempts small employers and permits insurers to define mental health and substance abuse disorders.¹¹⁷ Like the Mental Health Parity Act of 1996, it also exempts employers from compliance if the cost of compliance

¹¹³ Barrett, *supra* note 107, at 1177–78.

¹¹⁴ See *supra* notes 9–14 and accompanying text.

¹¹⁵ Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, 122 Stat. 3765 (codified as amended at 26 U.S.C. § 9812, 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-5 (2012)). See also Justin C. Wilson, Comment, *Will Full Benefits Parity Create Real Parity? – Congress's Second Attempt at Ending Discrimination against Mental Illness: The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008*, 3 ST. LOUIS U. J. HEALTH L. & POL'Y 343, 343–44 (2010) (comparing and contrasting the MHPA to the MHPAEA).

¹¹⁶ See Wilson, *supra* note 115, at 387–88 (describing the restrictions on providing substance abuse coverage).

¹¹⁷ Shamash, *supra* note 107, at 286.

is too great,¹¹⁸ although the MHPAEA raises the cost of compliance exemption from 1 to 2 percent.¹¹⁹ Nonetheless, the MHPAEA does provide for greater mental health parity for employers who offer mental health coverage.¹²⁰ To obtain genuine mental health parity, more must be done, including the elimination of cost of compliance restrictions and mandated mental health coverage.

Under the Patient Protection and Affordable Care Act (ACA),¹²¹ mental health is considered one of the “essential benefit[s]” that must be covered by health plans and Medicaid.¹²² This, in conjunction with the individual mandate and the Medicaid expansion for states that choose it,¹²³ broadly increases access to mental health services.¹²⁴ The ACA also works to make mental health services more affordable since it provides for premium cost sharing assistance for those who make less than 400 percent of the federal poverty level.¹²⁵ Since the ACA also prohibits exclusions for pre-existing conditions, insurers cannot avoid covering mental health benefits for those with a history of mental

¹¹⁸ *Id.* at 286–87 (citing 29 U.S.C. § 1185a(c)(2)(A)–(B)).

¹¹⁹ *Id.* at 287 (citing 29 U.S.C. § 1185a(c)(2)(A)–(B)).

¹²⁰ *See id.* at 284–85 (discussing the improvements in coverage created by the MHPAEA). It also goes beyond annual and lifetime parity, requiring parity with other covered health plan service. *Id.* at 284.

¹²¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

¹²² *See* Abby Goodnough, *Expansion of Mental Health Care Hits Obstacles*, N.Y. TIMES, Aug. 28, 2014, at A1 (“The Affordable Care Act has paved the way for a vast expansion of mental health coverage in America, providing access for millions of people who were previously uninsured or whose policies did not include such coverage before. Under the law, mental health treatment is an “essential” benefit that must be covered by Medicaid and every private plan sold through the new online insurance marketplaces.”).

¹²³ The United States Supreme Court held that the Medicaid expansion, which was a fundamental part of the ACA, could not be imposed on the states. Instead, state participation in Medicaid expansion is voluntary. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2608 (2012).

¹²⁴ *See* Suann Kessler, *Mental Health Parity: The Patient Protection and Affordable Care Act and the Parity Definition Implications*, 6 HASTINGS SCI. & TECH. L.J. 145, 158–60 (2014) (discussing expansion of mental health coverage under the ACA). Coverage for emerging adults was also expanded by the ACA by allowing parents to keep their children on their health plans until the age of twenty-six. *Id.* at 159. The ACA is providing health coverage to millions of Americans who were previously uninsured. Since one of the essential benefits under the ACA includes mental health coverage, this too has expanded. *Cf.* Goodnough, *supra* note 122 (explaining that large numbers of mental health patients who are now covered under the ACA previously could not access such coverage).

¹²⁵ Kessler, *supra* note 124, at 159.

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 25

illness.¹²⁶

While the ACA goes further than the MHPA or the MHPAEA toward mental health parity, the mental health system is still not meeting the needs of all who need it. For example, under the ACA, grandfathered plans need not satisfy all of the requirements otherwise set forth in the act.¹²⁷ It also does not define mental illness or clarify the extent of the coverage required.¹²⁸

Given the unique needs and concerns of young emerging adults and their continuing brain development until the age of twenty-five, additional policies need to be implemented to address their mental health needs. In addition to the ongoing lack of mental health parity, even those who have mental health coverage may not have their mental health needs met. First, HIPAA generally bars communication between health care providers and the parents of their young emerging adult patients.¹²⁹ Second, the current standard of care for health care professionals who prescribe Adderall, Ritalin and other controlled substances does not encompass parental involvement for emerging adults.¹³⁰ Because such parental involvement can be critically important, the next sections suggest legal changes to make that happen.

B. HIPAA

The Health Insurance Portability and Accountability Act (HIPAA), was enacted by Congress in 1996.¹³¹ One of its purposes is to protect patient privacy.¹³² HIPAA's Privacy Rule requires

¹²⁶ *Id.*

¹²⁷ *Id.* at 160–61.

¹²⁸ *Id.* at 161.

¹²⁹ See Eleanor Clift, *SB Shooting Prompts Question: Should Parents of Mentally Ill Adults Be Able to Commit Them?*, THE DAILY BEAST, May 30, 2014, <http://www.thedailybeast.com/articles/2014/05/30/sb-shooting-prompts-question-should-parents-of-mentally-ill-adults-be-able-to-commit-them.html> (stating that HIPAA “has rigorous privacy guidelines that prevent family members from gaining access to medical records or making decisions for children over 18.”).

¹³⁰ Ruth Hughes, *Substance Abuse, ADHD, and Medications: The Real Issues*, CHADD LEADERSHIP BLOG (Feb. 4, 2013), <http://www.chadleadershipblog.blogspot.com/2013/02/substance-abuse-adhd-and-medications.html>.

¹³¹ Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 18, 26, 29 and 42 U.S.C. (2012)). In addition to its Privacy Rule, HIPAA also deals with health insurance portability and electronic transmission of medical information, among other things. *Id.*

¹³² *Id.* HIPAA was also designed to make health insurance more “portable” in order to facilitate employee movement from one job to another. *Id.*

that authorization be obtained before a “covered entity” (which includes mental health care providers)¹³³ is permitted to disclose “protected health information” (PHI).¹³⁴ It attempts to balance the patient’s right to confidentiality with the reality that there are circumstances in which disclosure of PHI is beneficial for the public good.¹³⁵ The Privacy Rule requires oral consent on the part of a patient before his or her PHI can be released to a family member.¹³⁶ This applies to anyone over the age of eighteen, therefore encompassing young emerging adults.¹³⁷

In addition to the general privacy rule, psychotherapy notes taken by mental health professionals are subject to even greater restrictions than other health care records.¹³⁸ Psychotherapy notes cannot be disclosed without patient authorization. Therefore, patients seeking mental health treatment will often

¹³³ 45 C.F.R. § 160.103 (2014). A “covered entity” includes health care providers, most private health plans, and health clearinghouses. *Id.* Health care providers are only covered if they transmit rather than simply maintain PHI. *Cf.* Sean T. McLaughlin, *Pandora’s Box: Can HIPAA Still Protect Patient Privacy Under a National Health Care Information Network?*, 42 GONZ. L. REV. 29, 60 (2007) (suggesting that more restrictions should be placed on viewing PHI by covered entities to further protect patient privacy).

¹³⁴ PHI is a subset of “individually identifiable health information.” Stacey A. Tovino, *Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits*, 21 ANNALS OF HEALTH L. 147, 152 (2012). *See also* 45 C.F.R. § 164.501(2) (defining “record” in the context of Privacy of Identifiable Health Information).

¹³⁵ *See* Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,464 (Dec. 28, 2000) (codified at 45 C.F.R. pts. 160, 164) (“The rule seeks to balance the needs of the individual with the needs of the society.”); *see also id.* at 82,468 (“The task of society and its government is to create a balance in which the individual’s needs and rights are balanced against the needs and rights of society as a whole.”); *id.* at 82,472 (discussing the balance between preserving privacy of health information as well as access to health information for research purposes).

¹³⁶ 45 C.F.R. § 164.510.

¹³⁷ *See id.* § 164.502(g)(2) (indicating that a person other than an adult individual could make decisions about that individual’s protected health information where the person has the authority to do so; therefore, a non-minor, unless authority has been given to another, needs to give oral consent before his or her private health information can be disclosed).

¹³⁸ *See, e.g., id.* § 164.508(b)(3)(ii) (“An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes.”); *see also* Stephanie O. Corley, *Protection for Psychotherapy Notes Under the HIPAA Privacy Rule: As Private as a Hospital Gown*, 22 HEALTH MATRIX 489, 491 n.5 (2013) (Psychotherapy notes apply to psychotherapists, therapists, psychologists, mental health practitioners, or other mental health professionals who are “documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session”).

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 27

have greater privacy protections under HIPAA than patients who are being treated for physical disorders.

While the HIPAA Privacy Rule may work well for physical ailments and many mental health issues, it makes it difficult, if not impossible for parents of young emerging adults to help shed light on their child's condition for the benefit of the mental health care provider, or for the mental health provider to share his or her thoughts with the parents without patient authorization. Therefore, for young emerging adults, the HIPAA rule should be amended to include a provision for presumed consent on the part of the patient for an initial family consultation. This is especially important for young emerging adults seeking ADHD medications, because there should be some evidence from childhood of a history of ADHD on which the parents can shed light. If it is clear after speaking with parents that the young emerging adult has no history of ADHD, the health care provider should refuse to write a prescription for ADHD medications. Even minimal parental involvement—one interaction with the mental health care provider—can play a key role in reducing the abuse and overuse of ADHD medication.

In non-ADHD mental health situations, the benefits of a presumed consent provision for an initial family consultation also outweighs the risks. An initial exchange of information between parents and therapists may provide useful information to everyone concerned, information that can ultimately help young emerging adults. Without consent, parents of young emerging adults are generally in the dark about the state of their children's mental health issues.¹³⁹ It may be that the younger and more

¹³⁹ This was an issue in the shootings by Elliot Rodger in Santa Barbara California in 2014. See *Colorado Theater Shooting Fast Facts*, *supra* note 4 (providing background information on a similar shooting in Colorado). Elliot Rodger's parents expressed frustration that after Elliot turned eighteen they were not permitted contact with his mental health care providers without Elliot's consent, which he refused. See Katie Moisse, *Santa Barbara Rampage Spotlights Therapists' Duty to Protect*, ABC NEWS, May 26, 2014, <http://abcnews.go.com/Health/santa-barbara-massacre-spotlights-therapists-duty-protect/story?id=23869975> (explaining how the Santa Barbara shooting shed light on the fact that when a mental health patient makes a credible threat to harm others, HIPAA permits mental health professionals to alert law enforcement and family of the patient). An act entitled "The Helping Families in Mental Health Crisis Act" would facilitate families' ability to exchange information with mental health providers for their children over the age of eighteen. See Clift, *supra* note 129 ("The Helping Families in Mental Health Crisis Act would allow families to intervene without being blocked by HIPAA (Health Insurance Portability and Accountability Act), which has rigorous

immature the emerging adult, the more likely he or she may be to refuse to consent to parental involvement. Moreover, the more mentally disturbed the emerging adult, the less likely he or she may be to provide such consent because of his or her failure to see the wisdom of including the insights their parents may have. So while privacy is important to maintaining a relationship of trust between the patient and the therapist, HIPAA should be amended to include a provision for presumed consent to an initial family consultation for young emerging adult patients.¹⁴⁰

If therapists have an opportunity to consult with parents, they can use their training to discern family dynamics and determine the credibility and importance of the information received. And since the patient likely will receive ongoing care, he or she will have ample opportunity to comment on the information the therapist learns from the parents. This proposal does not suggest that therapists share with parents what their patients reveal, although they have some discretion in that regard when they perceive a danger to their patients or others. While this proposal runs some risk that young emerging adults will be discouraged from seeking mental health care in the first place, that risk is minimized by limiting the presumed consent amendment to one initial consultation between parents and mental health care provider. Thereafter, the parties will work out among themselves whether further parental involvement should continue. Moreover, the young emerging adult can rebut the presumption of consent. Even if HIPAA is not amended, mental health providers must adapt their standard of care to reflect their knowledge that emerging adults may be attempting to game the system.

C. Medical Malpractice Standard of Care

The *de facto* standard of care for health care providers treating young emerging adults for mental health needs should also shift toward greater parental involvement. Before a health care

privacy guidelines that prevent family members from gaining access to medical records or making decisions for children over 18.”).

¹⁴⁰ The HIPAA amendment would include an exception in cases of parental neglect or abuse. *Health Information Privacy: Personal Representatives*, See U. S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/personalreps.html> (last updated Sept. 19, 2013) (excepting a covered entity from disclosing protected health information in “endangerment situations”).

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 29

provider can be liable for medical malpractice, one must find, like the common law tort of negligence: a duty, breach of duty, causation and damages.¹⁴¹ The difference between simple negligence and medical malpractice lies in the nature of the duty.¹⁴² The duty of a doctor is a professional one rather than a layperson's duty to use reasonable care.¹⁴³ Thus, in medical malpractice cases, the duty of the physician is to use the standard of care normally possessed by other physicians in the same or similar circumstances.¹⁴⁴ The standard of care in medical malpractice cases, while articulated slightly differently from case to case, is by and large as follows:

[E]ach physician has a duty to use his or her knowledge [to] treat . . . each patient, with such reasonable diligence, skill, competence, and prudence as . . . practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options.¹⁴⁵

Because this standard of care requires only that physicians use such skill, competence and prudence as other "minimally competent physicians" with similar resources, physicians can shield themselves from liability as long as they demonstrate that their medical practices are consistent with other physicians. Even if their care is consistent with only a minority rather than the majority of physicians, they will escape liability so long as they can demonstrate that their treatment is consistent with

¹⁴¹ See *Hall v. Hilbun*, 466 So.2d 856, 866 (Miss. 1985) ("If a patient sustains injury because of the physician's failure to perform the duty he had assumed under our law, the physician may be liable in damages.").

¹⁴² See *id.* at 871 (discussing how physicians are liable for malpractice, rather than simple negligence, because they are professionals).

¹⁴³ See *id.* at 869 (explaining that a physician has a duty consistent with the level of expertise one holds himself out as possessing and consistent with the circumstances). Additionally, each physician is held to this standard of care, which is a standard of care a layperson would not be held to, as they do not possess the requisite knowledge or experience compared to that of a physician. *Id.*

¹⁴⁴ While historically, local standards of care were applied in medical malpractice cases to account for variations in education and resources, today, a national standard may apply. The national standard reflects the uniform nature of medical education, and the increased access to updated information via the internet and other avenues of communication. *Id.* at 869, 871.

¹⁴⁵ *Id.* at 873. This standard includes obtaining the informed consent of the patient. See *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) (holding that a doctor must disclose material risks of treatment to patient and obtain consent before treatment).

others similarly situated.¹⁴⁶ This definition of the standard of care essentially permits the medical profession to set its own standard of care.

There are cases, however, in which doctors have been found liable for medical malpractice notwithstanding their adherence to the generally accepted practice. In *Helling v. Carey*,¹⁴⁷ for example, the patient came to defendant ophthalmologists, complaining of eye irritation. She visited the defendants on ten occasions between September of 1963 and October of 1968.¹⁴⁸ Finally, in October, 1968, defendants tested plaintiff for glaucoma.¹⁴⁹ She tested positive, but by this time had substantial loss of both her peripheral and central vision.¹⁵⁰ Plaintiff was thirty-two years old at the time of the glaucoma test.¹⁵¹

Defendants in *Helling* argued that they complied with the standard of care, which did not call for glaucoma testing on patients under the age of forty.¹⁵² In essence, they argued that their care of the plaintiff was consistent with the prevailing standard at the time.¹⁵³ The court, however disagreed.¹⁵⁴ Quoting the sentence set forth at the outset of this article, the court said “[w]hat usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually complied with or not.”¹⁵⁵ In *Helling*, the court concluded that performing a glaucoma test at an earlier stage of treatment would have been reasonable—waiting was not. The court noted that the test is simple, inexpensive, harmless, and painless.¹⁵⁶ The burden of doing the test as part of

¹⁴⁶ See, e.g., *In re Williams*, 573 N.E.2d 638, 639 (Ohio 1991) (finding that the Ohio State Medical Board had inadequate evidence for disciplining Dr. Williams where his practice complied with a “minority view” among physicians).

¹⁴⁷ *Helling v. Carey*, 519 P.2d 981, 981 (Wash. 1974).

¹⁴⁸ *Id.*

¹⁴⁹ See *id.* (indicating that plaintiff’s eye pressure and field of vision were tested for the first time in October of 1968).

¹⁵⁰ *Id.* at 981–82.

¹⁵¹ *Id.*

¹⁵² *Id.* at 981–82.

¹⁵³ See *Helling v. Carey*, 519 P.2d 981, 982 (Wash. 1974) (indicating that defendants argued that they were not liable since the reason for there being no requirement to test persons under forty for glaucoma was because the risk of having glaucoma at that age was so low).

¹⁵⁴ See *id.* at 983 (finding the defendants negligent for failing to conduct a pressure test for glaucoma).

¹⁵⁵ *Id.* at 518–19 (quoting *Tex. & Pac. Ry. Co. v. Behymer*, 189 U.S. 468, 470 (1903)).

¹⁵⁶ *Id.* There is evidence, however, that the glaucoma test was not as accurate

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 31

a routine eye-exam was less than the probability times the likelihood of harm if the test was not performed, and therefore was required.¹⁵⁷ This instance of judicial standard setting has been criticized, but it amply demonstrates that sometimes, adherence to an existing standard is simply inadequate.¹⁵⁸

In addition to the rare instance of judicial standard setting demonstrated in *Helling*, there are also challenges to medical standards of care when those standards are evolving.¹⁵⁹ In *Burton v. Brooklyn Doctors Hospital*,¹⁶⁰ for example, the oxygen levels provided to premature newborns was a subject of debate.¹⁶¹ There was some evidence suggesting that prolonged exposure to high levels of oxygen caused retrolental fibroplasia (RFL), causing blindness.¹⁶² A 1954 study indicated that discontinuing oxygen after forty-eight hours would reduce the risk of RFL without increasing other health risks to the newborn.¹⁶³ Given the available information suggesting risks associated with prolonged exposure to oxygen, the court found that the physician could not escape liability by arguing that he complied with accepted practice.¹⁶⁴ He also was required to exercise his best judgment.¹⁶⁵

as the court assumed. *Id.* at 521–22.

¹⁵⁷ *Cf.* *United States v. Carroll Towing Co.*, 159 F.2d 169 (2d Cir. 1947). In *Carroll Towing*, Judge Learned Hand used an algebraic equation to define the standard of care in common law negligence cases. *Id.* at 173. He assessed whether the burden of greater caution was less than the probability times the likelihood of harm. *Id.* He summed it up as whether $B < PL$. *Id.* If the answer were yes, than the reasonable person would undertake a greater burden given the probability and likelihood of harm. *Id.*

¹⁵⁸ *See* *Lundahl v. Rockford Mem'l Hosp. Ass'n*, 235 N.E.2d 671, 674 (Ill. App. Ct. 1968) (“[C]ustomary procedure might itself be negligence.”); *see also* *Toth v. Cmty. Hosp. at Glen Cove*, 239 N.E.2d 368, 373 (N.Y. 1968) (“[F]ollow[ing] customary practice is not the sole test of professional malpractice.”).

¹⁵⁹ *See* *Washington v. Wash. Hosp. Ctr.*, 579 A.2d 177, 183 (D.C. 1990) (stating that the issue was whether carbon dioxide monitors were the standard of care at the time of plaintiff’s surgery); *see also* *Burton v. Brooklyn Doctors Hosp.*, 452 N.Y.S.2d 875, 881 (N.Y. App. Div. 1982) (explaining that the oxygen treatment of newborn babies used by the defendant hospital was in accordance with community standards at the time of the injury, but was nevertheless still negligence).

¹⁶⁰ 452 N.Y.S.2d 875.

¹⁶¹ *Id.* at 877.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.* at 881.

¹⁶⁵ *Id.* at 880. *See also* *Toth v. Cmty. Hosp. at Glen Cove*, 239 N.E.2d 368, 372–73 (N.Y. 1968) (noting the principle that a physician should use his best judgment in light of his training and knowledge).

Specialists are often held to a higher standard of care, consistent with their degree of specialization.¹⁶⁶ Psychiatrists, therefore, would generally be held to a higher standard than a general practitioner in matters of mental health.

Applying the principles above, it is clear that more needs to be done prior to diagnosing a young emerging adult with ADHD. Young emerging adults are often quite adept at describing ADHD symptoms for purposes of getting the prescriptions they seek.¹⁶⁷ The mental health care provider should not simply take the patient's word at face value. Since ADHD is normally diagnosed by the age of seven, the practitioner should delve into the patient's medical history. This includes a detailed interview asking the patient about specific ADHD symptoms. A patient with no history of such symptoms should raise red flags for the physician. Unless there is a clearly established history of ADHD, young emerging adults should not be permitted to simply walk into and out of a doctor's office with a same-day prescription. Failure to do a full medical history and to be sure the patient's symptoms are real is inconsistent with a standard of reasonableness. Too many doctors "skip established diagnostic procedures, renew prescriptions reflexively and spend too little time with patients to accurately monitor side effects."¹⁶⁸

Health care providers treating young emerging adults for mental health issues should also impress upon them the need for at least some initial parental involvement. Even with no changes to HIPAA, it is incumbent on the health care providers to stress the importance of at least some parental interaction so that a more complete history can be obtained. As one scholar noted: "[C]linicians should seek third party corroboration of symptoms and impairment and confirm that impairment is best accounted for as ADHD rather than another disorder. Such careful diagnostics have rarely been followed in studies of ADHD in college students."¹⁶⁹

¹⁶⁶ Zaverl v. Hanley, 64 P.3d 809, 817 (Alaska 2003).

¹⁶⁷ See Schwarz, *supra* note 16 (reporting the story of a college student who lied about having ADHD symptoms to receive medication).

¹⁶⁸ *Id.*

¹⁶⁹ Andrea L. Green & David L. Rabiner, *What Do We Really Know about ADHD in College Students?*, 9(3) NEUROTHERAPEUTICS 559, 560 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3441934/> (emphasis added). The studies suggested that between 2-8 percent of college students had ADHD, and "that approximately 25 % of college students receiving disabilities services [were] diagnosed with ADHD." *Id.* at 559.

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 33

In sum, medical malpractice law may not need to change, but the actual practice on the part of doctors prescribing ADHD medications should. Their practice must reflect the facts—that ADHD is normally diagnosed early in life, and that without evidence of early symptoms and a history of treatment, greater due diligence is required before simply writing an ADHD prescription for young emerging adults. The medical malpractice standard of care for mental health care providers treating young emerging adults should include parental collaboration. An exchange of information between doctors and parents could be critically important.¹⁷⁰ For young emerging adults, we should presume consent for the doctor to speak to the parents. If the patient rebuts the presumption, the doctor should ask whether there are other adults, such as former teachers, who could be contacted. If the patient refuses to allow consultation with adults who could provide insight to her childhood behavioral patterns, this factor should be taken into account by the doctor.

The law could facilitate the doctors' ability to responsibly treat young emerging adults by imposing a judicial standard of care that requires them to use their best efforts to include parental involvement.¹⁷¹ Alternatively, it could hold mental health care

¹⁷⁰ On May 23, 2014, twenty-two-year-old Elliot Rodger killed six people in Santa Barbara California, before going on to kill himself. Another thirteen people were injured. Rodger had a long history of mental health issues and parents who tried desperately to get suitable help for him, including on the day of the tragedy. Ian Lovett & Adam Nagourney, *Video Rant, Then Deadly Rampage in California Town*, N.Y. TIMES, May 24, 2014, <http://www.nytimes.com/2014/05/25/us/california-drive-by-shooting.html?module=Search&mabReward=relbias%3Ar%2C%7B%22%22%3A%22RI%3A7%22%7D>; Emma G. Fitzsimmons & Brian Knowlton, *Gunman Covered Up Risks He Posed, Sheriff Says*, N.Y. TIMES, May 25, 2014, <http://www.nytimes.com/2014/05/26/us/gunman-was-able-to-fly-under-the-radar-says-santa-barbara-sheriff.html?module=Search&mabReward=relbias%3Ar%2C%7B%22%22%3A%22RI%3A7%22%7D>; Adam Nagourney, *Parents' Nightmare: Futile Race to Stop Killings*, N.Y. TIMES, May 25, 2014, <http://www.nytimes.com/2014/05/26/us/parents-nightmare-failed-race-to-stop-killings.html?module=Search&mabReward=relbias%3Ar%2C%7B%22%22%3A%22RI%3A7%22%7D>. Since he was over the age of 18, however, HIPAA prevented Rodger's parents from accessing information from his health care providers. Schwarz, *supra* note 16. Equally as important, without consent, Rodger's parents could not provide critically important information to his therapist. Therefore, while Rodger was twenty-two years old — what psychologists call an “emerging adult” for legal purposes, he was treated as fully adult. While mass shootings are rare, whether by emerging adults or others, mental health issues are not.

¹⁷¹ See *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974) (holding that the

providers to a higher standard as specialists who should understand the need for parental involvement and perhaps the involvement of other adults who could shed greater light on the patients' medical histories.¹⁷²

If doctors fail to take these and perhaps other steps, and attempt to shield themselves from liability by arguing that they are complying with accepted practice, the law should stop them in their tracks. Cases like *Helling*, *Burton*, *Zaverl* and others provide the precedent for holding doctors to a higher standard. Mental health care providers must engage in a rigorous evaluation of their patients, or risk liability for medical malpractice.

D. Awareness Campaign

A public awareness campaign would help educate young emerging adults and the public at large about the dangers of prescription drug use and abuse, whether of ADHD medications or others.¹⁷³ Overuse of prescription drugs is not new. This massive public challenge has been a long time in the making. We have overused prescription drugs in a whole host of contexts. The overuse of antibiotics, for example, is an ongoing, well documented, public health problem.¹⁷⁴ Painkillers are also abused in large numbers.¹⁷⁵ In addition to abuse of prescription medications, more than 100,000 people die each year from appropriate use of prescription drugs.¹⁷⁶ There seems to be little

courts have a duty to establish reasonable standards of care); *see also* Shamash, *supra* note 107 (discussing the legislative history and debate regarding the disparity in access to adequate mental health insurance and treatment).

¹⁷² *See* *Burton v. Brooklyn Doctors Hosp.*, 452 N.Y.S.2d 875, 880 (N.Y. App. Div. 1982) (stating that physicians should use their superior knowledge, skills, intelligence and best judgment they have acquired in their practice).

¹⁷³ *See* Abigail Zuger, *A General in the Drug War*, N.Y. TIMES, June 13, 2011, <http://www.nytimes.com/2011/06/14/science/14volkow.html?pagewanted=all> ("The toll from soaring rates of prescription drug abuse, including both psychiatric medications and drugs for pain, has begun to dwarf that of the usual illegal culprits.").

¹⁷⁴ *See* LAURIE GARRETT, *BETRAYAL OF TRUST: THE COLLAPSE OF GLOBAL PUBLIC HEALTH* 324 (Hyperion, 1st ed. 2000) (discussing the overuse of antibiotics by private physicians).

¹⁷⁵ *See supra* note 15 and accompanying text; *see also* *CDC Grand Rounds: Prescription Drug Overdoses – A U.S. Epidemic*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jan. 13, 2012), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm> (explaining that prescription drug abuse is driven by an increase in opioid usage).

¹⁷⁶ Atwell, *supra* note 66, at 604. A shift in medical school education may also

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 35

understanding of the real risks associated with prescription drug use. Not only do young emerging adults overuse and abuse prescription drugs, they often share prescription drugs with friends who would not otherwise have access to them.¹⁷⁷ This sharing of drugs reflects an attitude that the sharing is no big deal and is not dangerous. It is incumbent on public health officials to widely distribute accurate information into the public sphere.

The Affordable Care Act, which expands overall access to health care,¹⁷⁸ unfortunately does virtually nothing to expand health insurance coverage to non-traditional forms of health care that could minimize the need for prescription medications.¹⁷⁹ Complementary and alternative medicine (CAM) modalities are often not eligible for insurance coverage or reimbursement.¹⁸⁰ As a result, the health care system promotes prescription drugs and traditional medicine over other forms of treatment. We have become something of a pill-popping culture in which patients expect a pill for virtually every ailment. This enriches the prescription drug industry to the tune of billions of dollars per year.¹⁸¹ Prescription drugs can be highly beneficial when used

be warranted. With so many patients dying each year because of adverse reactions to prescription drug medications, some attention needs to be directed to the problem while medical students are still in training. It is unclear whether medical schools sufficiently highlight the dangers associated with prescription drugs in general and with ADHD drugs in particular. In addition, to highlighting the risk associated with prescription drugs, medical education should also provide basic training in complementary and alternative medicine. Relaxation techniques, including yoga and meditation might be equally effective for young emerging adults who seek ADHD medication for better concentration. But if the doctor has only one tool in his or her toolbox—the ability to write a prescription, none of the other approaches is likely to be discussed.

¹⁷⁷ Amy Harmon, *Young, Assured and Playing Pharmacist to Friends*, N.Y. TIMES, Nov. 16, 2005, <http://www.nytimes.com/2005/11/16/health/16patient.html?pagewanted=all&r=0>.

¹⁷⁸ *Affordable Care Act*, AM. HEALTH INS. PLANS, <http://www.ahip.org/Issues/Affordable-Care-Act/> (last visited Dec. 29, 2014).

¹⁷⁹ Ankita Rao, *Health Law Boosts Status of Alternative Medicine—At Least on Paper*, KAISER HEALTH NEWS, July 26, 2013, <http://kaiserhealthnews.org/news/alternative-medicine-boosted-from-health-law-on-paper/>.

¹⁸⁰ See Jann Bellamy, *Obamacare and CAM*, SCIENCE-BASED MED., July 12, 2012, <http://www.sciencebasedmedicine.org/obamacare-and-cam/> (explaining that The Affordable Care Act expands access to certain preventive procedures, like annual checkups and contraception, but it does not expand access to alternative treatments).

¹⁸¹ See *Pharmaceutical Industry*, WORLD HEALTH ORG., <http://www.who.int/trade/glossary/story073/en/> (last visited Dec. 29, 2014) (stating that The World Health Organization estimates the global pharmaceutical market is worth

properly, although there is almost always a risk of side effects.¹⁸² They can be deadly, however, when abused, when there is an allergic drug reaction, or simply as a result of known side effects. It would behoove us as a society, to rely less on prescription drugs and more on healthy lifestyles that would eliminate or minimize the need for prescription medications. Until we change the drug culture, young emerging adults will continue to believe that using prescription drugs is safe with or without an actual prescription.

V. CONCLUSION

Young emerging adults, like the rest of the American populace, have significant mental health needs. We should recognize young emerging adults as a unique demographic, one that retains some characteristics of adolescence along with characteristics of adulthood. Currently we meet the mental health needs of young emerging adults primarily by prescribing medications, like Adderall or Ritalin as in the case of ADHD. Mental health care providers should, however, take greater precautions before writing prescriptions for young emerging adults. Mental health care providers who treat young emerging adults should be permitted some initial contact with their parents. To do this, HIPAA should be amended to include a provision for presumed consent on the part of the young emerging adult patient, to at least one interaction between the provider and the parents. The common law medical malpractice standard of care for mental health care providers who treat young emerging adults should also shift to encourage those providers to seek out parental involvement, at least on a one time basis if not more. This is especially true in cases of young emerging adults seeking ADHD medications. ADHD is typically symptomatic by early childhood. If the patient's parents do not confirm evidence of ADHD symptoms by the young emerging adult, the doctor should investigate further before prescribing medication. A public

approximately \$300 billion, with six of the ten largest companies in the world being located in the United States).

¹⁸² Anyone who listens to television advertisements for prescription drugs has heard the warnings that come at the end of the ad. In addition, when you pick up a prescription at a pharmacy, virtually every drug has a list of warnings that go along with it. See, e.g., *Drug Side Effects*, DRUGS.COM, <http://www.drugs.com/sfx/> (last visited Dec. 29, 2014) (providing a comprehensive index for the side effects of over "24,000 prescription drugs, over-the-counter medicines and natural products").

2015] RETHINKING THE CHILDHOOD-ADULT DIVIDE 37

awareness campaign to alert the public to the dangers associated with prescription drug use and abuse should also be undertaken.