# MISDIAGNOSED AND OVERMEDICATED: HOW U.S. SCHOOLS PATHOLOGIZE BLACK BOYS WITHOUT PROVIDING COMPREHENSIVE MENTAL HEALTH CARE

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## ABSTRACT

Attention-deficit/hyperactivity disorder (ADHD) and conduct-related disorders, including oppositional defiant disorder (ODD) and conduct disorder (CD), are commonly used to classify children's behavior in school settings. When applied appropriately, these diagnoses can support academic and social functioning. However, national disparities in behavioral referral and classification raise concerns about how diagnostic pathways operate for Black boys. This paper examines patterns of ADHD and conduct-related diagnoses among Black boys ages 6 to 14, focusing on how similar behaviors are interpreted and classified differently across racial groups. It argues that Black boys are disproportionately labeled as disruptive or defiant and are more likely to be diagnosed with conduct-related disorders rather than ADHD, even when presenting comparable symptoms as their white peers, reflecting patterns of racialized misclassification. This increases their use of psychiatric medication, while they are less likely to receive counseling, trauma-informed care, or comprehensive mental health support. Drawing on research on adultification bias and structural racism, this paper demonstrates how disparities in diagnosis and treatment are shaped by institutional processes, including referral systems, behavioral documentation, and resource inequities in under resourced schools. It further examines how surveillance practices and diagnostic decision-making influence long-term developmental outcomes. This analysis calls for structural reform grounded in trauma-informed screening, culturally responsive assessment, strengthened Multi-Tiered Systems of Support (MTSS), and social work–informed practice to promote more equitable school-based mental health evaluation.

*Keywords:* ADHD, adultification bias, Black boys, conduct-related disorders, diagnostic misclassification, disruptive, impulse control and conduct disorders, Multi-Tiered Systems of Support, racial disparities, school social work, structural racism, trauma-informed care

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Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by persistent patterns of inattention and/or hyperactivity-impulsivity that interfere with functioning, as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Symptoms may include difficulty sustaining attention, excessive movement, and impulsive decision-making, and must be present across multiple settings. Oppositional defiant disorder (ODD) is defined by a pattern of angry or irritable mood, argumentative or defiant behavior, and vindictiveness toward authority figures lasting at least six months. Conduct disorder (CD), a more severe behavioral disorder, involves a persistent pattern of behavior that violates the rights of others or major societal norms, including aggression, destruction of property, deceitfulness, or serious rule violations. These disorders are commonly used in clinical and school-based settings to assess and classify children's behavioral concerns.

ADHD is one of the most commonly diagnosed neurodevelopmental disorders among children in the United States, with prevalence estimates ranging from approximately 9% to 11% (Danielson et al., 2018). In school settings, behavioral concerns are typically identified through teacher observations, which often serve as the primary entry point into referral, evaluation, and diagnostic processes. In most

districts, educators initiate the majority of ADHD evaluations through classroom-based concern documentation and behavioral rating scales (Morgan et al., 2013). Educators, school counselors, and psychologists play a central role in determining whether a child is referred for further assessment, shaping early pathways into mental health and special education systems.

Research demonstrates that Black boys are more likely to be perceived as disruptive, aggressive, or intentionally defiant compared to their white peers, even when exhibiting similar behaviors. Skiba and colleagues (2014) analyzed national school discipline data and found that African American students were more likely to receive office referrals and suspensions than white students, even for similar behavioral patterns. This suggests that disciplinary decisions are influenced not only by student behavior but also by how that behavior is interpreted. Okonofua and Eberhardt (2015) found that teachers were more likely to interpret identical behaviors as more severe and indicative of future misbehavior when attributed to Black students. These perceptions increase the likelihood that Black boys will be referred for behavioral evaluation or subjected to exclusionary discipline practices, such as suspension, removal from the classroom, or placement in alternative settings. These practices limit their access to supportive interventions and increase the likelihood that their behaviors are pathologized rather than contextualized.

Beyond disparities in discipline and referral processes, research has also identified racial differences in diagnostic outcomes. Black boys are more likely to be diagnosed with disruptive behavior disorders, such as ODD and CD, and less likely to receive ADHD diagnoses, even when presenting similar behavioral symptoms. Stevens and colleagues (2005)

identified disparities in diagnostic classification, with African American youth more frequently labeled with conduct-related disorders rather than attention-based or internalizing conditions. These patterns suggest that differences in diagnosis may reflect interpretations and categorizations of behavior, rather than actual differences in behavior.

## MISDIAGNOSIS VS. OVERDIAGNOSIS AND NATIONAL PATTERNS OF ADHD AMONG BLACK BOYS

### OVERDIAGNOSIS VS. MISCLASSIFICATION

Although often used interchangeably, the terms "overdiagnosis" and "misclassification" refer to distinct processes. Overdiagnosis refers to the identification of a condition that would not have caused significant impairment or symptoms if left untreated, often resulting from broadened diagnostic criteria or increased screening sensitivity (Moynihan et al., 2012; Welch et al., 2011). This process may lead to the labeling of individuals whose symptoms do not meet the threshold for clinical necessity, increasing the likelihood of unnecessary intervention. In contrast, misclassification refers to the incorrect assignment of a diagnosis due to errors in interpretation, assessment, or bias, resulting in an individual being placed into an inappropriate diagnostic category (American Psychiatric Association [APA], 2013).

Misdiagnosis occurs when a child's behavioral presentation is inaccurately categorized, often resulting in alternative labels such as ODD or CD. For example, in school settings, behaviors commonly associated with ADHD, such as difficulty sustaining attention, impulsiveness, or restlessness, may be interpreted as intentional defiance or aggression rather than symptoms of a neurodevelopmental disorder. These labels are often

interpreted as reflecting intentional misconduct rather than developmental or regulatory challenges, which can shape how educators respond to and support students. Diagnoses of CD and ODD are associated with more severe disciplinary consequences than diagnoses of ADHD, including higher rates of suspension, expulsion, and placement in alternative or restrictive educational settings (Fairchild et al., 2019). In contrast, ADHD is more often addressed through academic accommodation, behavioral supports, or individualized education plans (IEPs).

## RACIAL DISPARITIES IN DIAGNOSTIC CLASSIFICATION

A substantial body of research documents racial disparities in how childhood mental health conditions are diagnosed and classified within school and clinical settings. Black children are more often diagnosed with behavior disorders within the DSM-5 category of disruptive, impulse-control, and conduct disorders such as ODD and CD, which emphasize patterns of defiance, rule-breaking, and aggression, often interpreted as willful or intentional within school-based contexts (Stevens et al., 2005). Stevens and colleagues (2005) found that African American boys were more likely to be classified with conduct-related disorders compared to attention-based diagnoses.

Morgan and colleagues (2013) found that even when controlling for similar behavioral presentations, African American children were approximately 69% less likely than white children to be diagnosed with ADHD and more likely to be identified with disruptive behavior disorders. This suggests that identical behaviors may be categorized differently depending on how they are perceived and documented within the educational and clinical systems. Distinguishing between overdiagnosis and racialized misclassification is essential for understanding whether disparities reflect inflated rates of

diagnosis overall or systematic differences in how diagnoses are applied across populations.

## ADULTIFICATION BIAS AND STRUCTURAL RACISM IN SCHOOLS

### DEFINING ADULTIFICATION BIAS

Adultification bias refers to the perception that Black children, particularly Black boys, are older, less innocent, and more responsible for their actions than white peers of the same age (Goff et al., 2014). This bias leads adults to interpret typical childhood behaviors as intentional misconduct rather than developmentally appropriate actions. This can lead to distorted perceptions that influence disciplinary responses and classroom expectations. Research demonstrates that Black boys are perceived as less innocent than their white peers as early as age 10, with participants overestimating their age by an average of 4.5 years (Goff et al., 2014). These distorted perceptions shape how behavior is interpreted before any formal diagnostic or intervention process begins.

### DISCIPLINARY SYSTEMS AND RACIAL DISPARITIES

These biased interpretations are embedded within school disciplinary systems that rely heavily on punitive responses such as suspensions, expulsions, and behavioral referrals, with Black boys representing a disproportionate share of these disciplinary actions. National data indicate that Black students are suspended at nearly three times the rate of white students (Office for Civil Rights, 2014). In some districts, Black boys account for over 30 to 40% of suspensions despite representing a significantly smaller proportion of the student population. This disparity reflects not only differences in disciplinary outcomes but also differences in how behavior is perceived and categorized.

Within these systems, behavior is documented through mechanisms such as incident reports, office referrals, and behavioral write-ups. These records are not neutral; they are shaped by adult interpretation, which can see minor behaviors as patterns of "aggression" or "noncompliance." This suggests that early interpretations of behavior can shape long-term disciplinary trajectories. Over time, this documentation contributes to cumulative disciplinary action and increases the likelihood of exclusionary practices, reinforcing the school-to-prison pipeline for marginalized youth.

## INTERPRETIVE PROCESSES AND STRUCTURAL BIAS

Several stages within the school-based behavioral and disciplinary process rely on subjective interpretation. These include teacher observations, behavioral documentation, incident reporting, and disciplinary decision-making. Because these stages lack fully standardized criteria and depend heavily on adult perception, they are particularly vulnerable to implicit bias.

Experimental research demonstrates that teachers are more likely to label Black students as "troublemakers" and anticipate future misbehavior after a single infraction compared to white students (Okonofua & Eberhardt, 2015). Similarly, research shows that Black students are more likely to receive harsher punishments for comparable behaviors, even when controlling for severity of behavior (Skiba et al., 2011).

Behaviors such as hyperactivity or emotional reactivity may be interpreted as intentional misconduct rather than potential indicators of developmental or mental health needs. This contributes to patterns in which Black boys are disproportionately funneled into punitive disciplinary

pathways rather than supportive interventions. Rather than reflecting true differences in behavior, these outcomes highlight how systems of interpretation, documentation, and discipline collectively shape how children, particularly Black boys, are understood and treated within educational environments.

## TEACHER REFERRAL PRACTICES AND RACIALIZED PERCEPTION

### DEFINING DISRUPTIVE BEHAVIOR IN A CLASSROOM CONTEXT

Disruptive behavior in classroom settings is not defined solely by objective criteria but is shaped by classroom norms, teacher expectations, and institutional standards of compliance. Behaviors such as talking out of turn, difficulty remaining seated, impulsiveness, or failure to follow directions may be interpreted differently depending on context. In early educational settings, many of these behaviors fall within the range of typical neurodevelopmental variability, particularly among children ages 6 to 14, when executive-function skills are still developing.

However, national data indicate that Black students are disproportionately disciplined for subjective behavioral categories or offenses such as “defiance,” “disrespect,” and “disruption,” rather than objective infractions, whereas white students are more often disciplined for observable and clearly defined infractions (Skiba et al., 2011). These subjective categories lack clear operational definitions and allow greater room for interpretation, increasing the likelihood that interpretation, not behavior alone, drives disciplinary response and increasing the influence of bias in disciplinary decision-making. Implicit bias research demonstrates that

when repeated minor behavioral incidents are interpreted through racialized perception, the incidents are seen as more serious when coming from Black children (Okonofua & Eberhardt, 2015). Behaviors such as talking out of turn, failing to follow directions, or displaying restlessness may be interpreted as patterns of defiance for Black students, while similar behaviors in white students are more likely to be viewed as situational or developmentally typical.

These differences influence classroom responses, including increased surveillance, stricter disciplinary actions, and quicker escalation to referral, contributing to cumulative behavioral documentation that disproportionately positions Black students for formal evaluation. This distinction is critical, as behaviors associated with ADHD, including inattention, impulsiveness, and difficulty with task persistence, may overlap with behaviors labeled as disruptive in classroom environments.

## STRUCTURAL CONTEXT AND RACIALIZED REFERRAL PATTERNS

Referral processes do not occur in isolation but are embedded within broader structural and institutional contexts. Several stages of the referral process, including behavioral observation, incident documentation, and referral decision-making, are inherently interpretive and influenced by subjective judgment. These processes are further shaped by classroom management demands, school disciplinary policies, and institutional expectations regarding behavioral compliance.

Teacher perception and referral practices play a central role in shaping how student behavior is interpreted before formal evaluation begins. Structural constraints within school-based

evaluation systems further contribute to misclassification: School psychologists and evaluators often manage high caseloads, limiting time available for comprehensive environmental assessment (National Association of School Psychologists [NASP], 2020). As a result, assessments may rely more heavily on teacher-reported behavior and less on contextual factors such as trauma exposure, family dynamics, and cultural context. In combination with inconsistent implementation of intervention frameworks such as MTSS, these conditions create a diagnostic environment in which behaviors are more likely to be pathologized than contextualized.

In school settings, teachers often serve as the first point of identification for behavioral concerns, and their observations, referral narratives, and rating scales frequently become the foundation for later assessment and classification. Because ADHD-related behaviors such as distractibility, impulsivity, and difficulty following directions can overlap with behaviors interpreted as defiance or noncompliance, early distinctions are often shaped by subjective interpretation rather than clinical certainty. Referral can be a pathway to needed support; however, when referrals are made before classroom-based interventions are meaningfully attempted, or when behavior is framed primarily through willfulness rather than context, students may be positioned within diagnostic systems through a deficit-oriented lens. In under-resourced settings, where comprehensive neuropsychological evaluation may be less accessible and school-based documentation carries greater weight, these early interpretations can have disproportionate influence on diagnostic trajectories.

The racial climate and teacher–student relational trust also shape behavioral interpretation and academic engagement (Huguley et al., 2019). Lower levels of relational trust and

school belonging are associated with decreased engagement and increased likelihood of disengagement-related behaviors. In this context, behaviors such as withdrawal or noncompliance may reflect unmet relational or environmental needs rather than individual deficits. These factors should be considered prior to referral, as interventions that strengthen relationships and classroom belonging may reduce unnecessary referrals and improve outcomes.

## TRAUMA, THE DIFFERENTIATION BETWEEN HYPERVIGILANCE AND HYPERACTIVITY, AND CULTURAL MISINTERPRETATION

Trauma-related hypervigilance refers to a persistent state of heightened alertness in response to real or perceived threat, often developed through repeated exposure to stress or adversity. This may include increased scanning of the environment, difficulty concentrating, rapid emotional reactivity, and sensitivity to perceived danger or correction. Black boys must often navigate racialized school climates characterized by disproportionate discipline, increased behavioral surveillance, lowered academic expectations, and experiences of bias or differential treatment. Additional sources of chronic stress may include exposure to community violence, over-policing, school-based disciplinary disparities, and racial discrimination within educational settings.

National Center for Education Statistics (2022a, 2022b) data indicate that approximately 79% of public school teachers identify as white, while Black students represent approximately 15% of the public school population. Research suggests that this demographic incongruence can influence expectations, disciplinary responses, and interpretations of classroom behavior (Gershenson et al., 2016). This disparity reflects a structural mismatch between racial composition

of the teaching workforce and the student population, increasing the likelihood of cross-racial interpretations of behavior, which has been linked to disparities in expectations, disciplinary responses, and referral decisions. Black students are less likely to be identified for gifted programs and more likely to receive disciplinary referrals, even when exhibiting similar behaviors as white students.

Both ADHD and trauma-related hypervigilance can present with difficulty sustaining attention, impulsive responses, and increased motor activity. However, ADHD symptoms are typically persistent across settings, whereas trauma-related behaviors are often context-dependent and may intensify in environments perceived as unsafe. When this distinction is not recognized, trauma-related responses may be misinterpreted as oppositional or defiant behavior, increasing the likelihood of classification under conduct-related disorders such as ODD or CD.

Many educators receive limited preparation in differentiating trauma-related hypervigilance from neurodevelopmental hyperactivity or in assessing how environmental stressors influence classroom behavior (Milner, 2012). In the absence of structured pre-referral intervention protocols such as Multi-Tiered Systems of Support (MTSS), teacher-generated observations and documentation may disproportionately shape early referral and evaluation processes before targeted supports are consistently implemented. When teachers do not systematically assess contextual factors, they may misinterpret behaviors rooted in adaptive vigilance as evidence of impulsivity or defiance rather than stress responses (Carter, 2007; Overstreet & Chafouleas, 2016).

Cultural differences in communication and expression may further contribute to misinterpretation. Expressive

communication patterns, assertiveness, and call-and-response interactions common in many Black cultural contexts may be misread as disruptive in classrooms structured around dominant behavioral norms (Emdin, 2016). These misinterpretations can shape referral processes, classroom discipline, and teacher expectations, often resulting in increased correction, social labeling, or exclusion.

## MEDICATION AS A DEFAULT INTERVENTION

In under-resourced school districts, pharmacological intervention may be a more accessible behavioral management tool than longitudinal treatments. Although stimulant medications are well established as evidence-based treatments for ADHD when diagnostic criteria are appropriately met (APA, 2022; MTA Cooperative Group, 1999), national data indicate that African American children are less likely to be diagnosed with ADHD and, as a result, are less likely to receive stimulant medications, despite exhibiting similar behavioral symptoms (Danielson et al., 2018; Morgan et al., 2013). However, when behavioral concerns escalate or are classified under conduct-related frameworks, intervention pathways may rely more heavily on medication in the absence of comprehensive mental health support.

Access to psychotherapy and school-based mental health professionals is uneven across districts, particularly in schools serving predominantly low-income and marginalized populations (Thomas & Holzer, 2006). In these contexts, medication may be viewed as the most efficient mechanism for stabilizing classroom behavior because it requires fewer resources than implementing ongoing behavioral interventions or coordinating sustained support. But while medication may be perceived as more efficient within school

systems, the ongoing financial burden—including prescription costs, required follow-up care, and inconsistent insurance coverage—may limit access and continuity of treatment for many families.

There are no FDA-approved medications specifically for treating ODD or CD; however, medications such as atypical antipsychotics, including risperidone and aripiprazole, may be prescribed to address severe irritability or aggression. In contrast, stimulant medications commonly used for ADHD, such as methylphenidate (e.g., Ritalin, Concerta) and amphetamine-based medications (e.g., Adderall, Vyvanse), are evidence-based treatments when diagnostic criteria are appropriately met. This distinction highlights the importance of accurate diagnosis in guiding appropriate pharmacological intervention.

When trauma exposure, cultural expression, environmental instability, and academic challenges are not fully explored during assessment, pharmacological treatment risks targeting surface-level symptoms rather than underlying causes. This concern is compounded by systemic constraints, including limited access to school-based mental health services, high student-to-provider ratios, and pressure on teachers to manage classroom behavior efficiently, which may position medication as a first-line response. These disparities are further intensified for Black children, who are less likely to receive consistent follow-up care and more likely to experience fragmented treatment pathways. In the absence of coordinated care, psychotherapy, or family- or school-based supports, medication may be used in isolation, limiting opportunities to assess effectiveness, monitor adherence, and develop a comprehensive understanding of the child's behavioral and emotional needs (Stevens et al., 2005).

## SPECIAL EDUCATION LABELING, SURVEILLANCE, AND DEVELOPMENTAL IMPLICATIONS

### LABELING AND SPECIAL EDUCATION DECISIONS

Behavioral documentation within school systems accumulates through disciplinary records (e.g., office discipline referrals, suspension reports), teacher-generated documentation (e.g., behavior logs, incident reports, and communication with administrators or parents), and formal evaluation materials (e.g., psychological assessments, IEP eligibility reports, and functional behavioral assessments conducted under the Individuals with Disabilities Education Act [IDEA]).

African American boys are disproportionately represented in behavioral disability categories, including emotional disturbance and conduct-related classifications (U.S. Department of Education, 2020). Because special education eligibility determinations rely on patterns of documented behavior, early disparities in discipline can influence later special education placement decisions. This means referral patterns are part of a cumulative record that shapes institutional perception.

The IEP is a legally mandated document under IDEA that outlines a student's eligibility for special education services, learning needs, and required support. Eligibility is determined by a multidisciplinary team based on evaluation data and documented patterns of academic and behavioral functioning. Teacher reports, disciplinary records, and observational summaries become embedded in documentation that follows students across grade levels.

The distinction between ADHD and conduct-related diagnoses carries practical consequences within special education classification systems. Under IDEA, ADHD is

commonly classified under “other health impairment,” while conduct-related diagnoses such as ODD or CD are more often associated with the “emotional disturbance” category. These classifications influence the types of services students receive. Other health impairments are associated with academic accommodations and executive functioning supports, while emotional disturbance is more often linked to behavior-focused interventions, increased monitoring, or more restrictive placements.

Documentation may be framed as supportive, but it also produces written evidence of behavioral concerns that shapes how students’ behavior is interpreted in future evaluations. The accumulation of behavioral records can influence eligibility discussions for special education classification, particularly when evaluators rely on documented history rather than comprehensive contextual assessment. Repeated documentation of behaviors such as noncompliance, aggression, or disruption may support eligibility under categories like emotional disturbance and lead to behavior-focused interventions, increased monitoring, or placement in more restrictive settings, rather than academic accommodations or executive functioning supports.

Labeling theory suggests that once students are categorized, these labels influence how their future behavior is interpreted and responded to, reinforcing deficit-based narratives (Fergus, 2016). Students identified with behavioral disabilities are more likely to experience increased monitoring, exclusionary discipline, and placement in more restrictive educational settings (Skiba et al., 2011; U.S. Department of Education, 2020). Conduct-related labeling has also been linked to increased rates of suspension and expulsion, school disengagement, and higher likelihood of contact with school-based policing and juvenile justice systems, reflecting

pathways that connect school discipline to broader carceral involvement (Skiba et al., 2014).

## SURVEILLANCE AND DEVELOPMENTAL IMPLICATIONS

While special education services can provide essential support, disproportionate placement raises concerns about how labeling interacts with surveillance practices. Once categorized, students may experience increased monitoring, altered academic expectations, and more restrictive environments (Sullivan & Bal, 2013), including reduced access to rigorous coursework and increased behavioral compliance demands.

These shifts occur during critical developmental stages when identity formation, peer relationships, and academic self-concept are evolving (Huguley et al., 2019). Persistent framing of a student's behavior as oppositional or disruptive may contribute to the student's internalized stigma, decreased academic engagement, and increased risk of exclusionary discipline (Okonofua & Eberhardt, 2015; Skiba et al., 2014).

## LONG-TERM CONSEQUENCES

The cumulative effects of misdiagnosis, overmedication, and disproportionate disciplinary practices may extend beyond the elementary and middle school years. Research linking exclusionary discipline and behavioral labeling to academic disengagement indicates that students who experience early disciplinary removal are more likely to demonstrate lower academic achievement, decreased school attendance, reduced participation in extracurricular activities, and increased likelihood of repeated disciplinary actions over time (Annamma et al., 2019). When Black boys are repeatedly categorized through conduct-oriented frameworks rather

than neurodevelopmental or trauma-informed lenses, they may encounter reduced access to advanced coursework, diminished teacher expectations, and heightened disciplinary scrutiny. This may occur through gatekeeping practices such as teacher recommendations for advanced classes, where students with documented behavioral concerns are less likely to be nominated or encouraged to enroll, as well as limited opportunities for enrichment or flexible academic support (Gershenson et al., 2016; Okonofua & Eberhardt, 2015).

Long-term implications also extend to mental health engagement. If early interventions are experienced primarily as behavioral control rather than supportive care, trust in educational and healthcare systems may erode. The framing of behavior as willful misconduct rather than contextualized dysregulation may influence self-perception and help-seeking patterns across adolescence, contributing to increased internalized stigma, reduced trust in educators and mental health providers, and lowered likelihood of seeking support for emotional or behavioral concerns. Some studies also link these patterns to higher risk of disengagement and substance use among marginalized youth (Carter, 2007; Okonofua & Eberhardt, 2015).

Addressing disparities in ADHD and conduct-related diagnosis among Black boys ages 6 to 14 is therefore not solely a matter of immediate classroom management; it represents an investment in long-term educational equity and psychological well-being.

## POLICY FAILURES AND REFORMING DIAGNOSTIC PRACTICE

Although IDEA mandates equitable evaluation and placement procedures, racial disparities in diagnosis and special

education classification persist. Enforcement mechanisms are often weak, as patterns of misdiagnosis among Black boys ages 6 to 14 remain obscured. Addressing disparities in ADHD and conduct-related diagnoses requires reform that extends beyond individual bias to institutional safeguards. School-based social workers can lead culturally responsive practices (National Association of Social Workers [NASW], 2021); however, reform must move beyond aspirational commitments toward standardized, enforceable protocols that reduce subjectivity.

One critical reform involves embedding structured, trauma-informed differential screening prior to formal behavioral classification. Incorporating trauma-informed tools (Trauma and Justice Strategic Initiative, 2014) and requiring cross-setting symptom consistency can improve diagnostic accuracy and align evaluation practices with DSM-5-TR criteria for ADHD diagnosis (APA, 2022), while evaluating conduct-related labels helps distinguish persistent behavioral patterns from context-driven responses. The Trauma and Justice Strategic Initiative (2014) emphasizes that trauma-informed systems must recognize how environmental stressors including discrimination, housing instability, and community violence shape behavioral presentation. Incorporating validated trauma-screening tools during the pre-evaluation phase would help differentiate hypervigilance from hyperactivity and reduce premature conduct-related labeling. Requiring documentation of environmental context, cross-setting symptom consistency, and prior intervention attempts would strengthen diagnostic precision.

Strengthening the fidelity of MTSS represents another critical intervention point. MTSS frameworks are designed to provide graduated behavioral and academic support prior to referral for special education evaluation (Sugai & Horner, 2002), yet

implementation varies across districts, particularly in under-resourced schools. Policy reform should require documented evidence that Tier 1 and Tier 2 interventions were implemented with fidelity before children are classified under emotional disturbance or conduct-related categories. School social workers can coordinate Tier 2 interventions, monitor progress, and ensure that referral reflects demonstrated need rather than classroom frustration.

Positive Behavioral Interventions and Supports (PBIS) models may also be strengthened through culturally responsive adaptation. While PBIS emphasizes proactive reinforcement and behavioral skill-building (Bradshaw et al., 2010), its implementation must explicitly address implicit bias and adultification to prevent differential interpretation of similar behaviors across racial groups. This can be supported through structured training modules that include implicit bias assessment, case-based analysis, and ongoing coaching to help educators differentiate between culturally normative behaviors and behavioral concerns.

Transparency and accountability mechanisms are equally essential. Schools should collect and report referral rates, diagnostic classifications, medication patterns, and disciplinary outcomes disaggregated by race and gender to identify disproportionality trends and evaluate reform efforts, while maintaining compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). Both the NASW (2021) and NASP (2020) emphasize culturally responsive and anti-oppressive practice as ethical obligations, and embedding these standards within district-level accountability systems would shift reform from individual discretion to institutional responsibility.

Importantly, reform does not require rejecting ADHD diagnosis when clinically warranted. Rather, it requires ensuring that diagnostic decisions for Black boys are grounded in contextual assessment, equitable access to intervention, and structured safeguards against misclassification. Strengthening referral protocols, trauma screening, tiered intervention fidelity, and data oversight can reduce disparities while preserving appropriate treatment access. Transforming school-based mental health systems in this way prioritizes developmental support over behavioral containment and aligns policy with principles of clinical precision and educational equity.

## CONCLUSION

Disparities in ADHD and conduct-related diagnoses among Black boys ages 6 to 14 cannot be fully explained by differences in behavioral prevalence. While ADHD is a well-established neurodevelopmental disorder requiring appropriate intervention when criteria are met (APA, 2022), Black boys may not simply be over-identified with ADHD. The distinction between overdiagnosis and misdiagnosis is therefore critical. The pathways leading to diagnosis for Black boys are shaped by adultification bias, racialized teacher referral practices, trauma misinterpretation, and institutional policy pressures, so that they are often differentially classified into conduct-related categories such as ODD or CD when their behaviors are interpreted through racialized disciplinary lenses.

These disparities are the product not of isolated decision-making but of cumulative processes embedded within educational systems. From initial behavioral documentation to special education placement and medication initiation, institutional structures influence how behaviors are

understood and managed. When trauma exposure, cultural expression, and environmental stressors are insufficiently considered, diagnostic precision is compromised. Ensuring accurate differentiation between hyperactivity, hypervigilance, and oppositional behavior is essential to preventing inequitable labeling and inappropriate intervention.

Addressing inequities in ADHD diagnosis and overmedication does not require rejecting clinical categories or pharmacological treatment. Rather, it requires strengthening contextual assessment, enforcing bias-aware referral safeguards, and expanding access to comprehensive mental health services within schools. By centering developmental science, cultural responsiveness, and structural accountability, educational systems can move toward diagnostic practices that prioritize clinical accuracy and equitable care. For Black boys navigating elementary and middle school, such reforms would lead to not only improved mental health evaluation but expanded opportunity for academic and psychological development. Without these reforms, disparities in diagnosis and treatment will continue to shape not only educational outcomes but also long-term trajectories of mental health, opportunity, and systemic inequity.

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