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ESSAY

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VULNERABILITY CONFRONTS THE LAW
Marie Failinger, J.D.

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The Paradox in Madness: Vulnerability Confronts the Law

BY MARIE A. FAILINGER*

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I. INTRODUCTION

He was a gentleman, moving through the hospital halls with a kind word for staff members usually invisible to others. He was almost military with his nurses, methodically executing the minute protocols dictated by the surgeon's craft, one order after another, demanding, life-giving. He walked into a patient's room with an aura of assurance and calm so convincing that any thinking person would have trusted her life to his hand. His life was rich beyond measure — he drank deeply from the well of love and admiration that his wife and sons blessed him with, from the mountain air and the busy streets of the places he traveled, from the classical music and untold eclectic books and art that framed his days. He called himself blessed, and even in the cruelty of pain, even though he was robbed of the dignity of bathing and

* Professor of Law, Hamline University School of Law. This opening story comes out of a true experience. I would like to thank Martha Fineman and all of the participants in the "Beyond Rights: Vulnerability and Justice" conference sponsored by the Emory Vulnerability Project and Smith College in May, 2011, for their comments on this project. Thanks to my research assistant, George Blesi, for his careful work on this project.

dressing himself, he recited to anyone who came to see him the love and pride that he felt for his family.

He was also, in the end, cruel and suspicious and confused. Nearly blind, he could dictate a lecture describing step-by-step the most complicated surgery on the most delicate parts of the human body, correcting even slight mistakes. Then in the next moment, he would become fixated on the illusion that his nurses were philandering in the halls. He could praise the steady, endless care his wife lavished on him as she washed stained bed sheets, and gave up her sleep night after night for him, at home and in many hospital stays, and yet, he could also believe she was conspiring to kill him. He could lean upon a son who spent day after day caring for his every need, like a baby's mother, and then turn upon him in a cold fury, cutting him with words like a jagged blade.

In the end, his paranoia robbed him of what he most treasured. He gave up legal control of his life to a relative whom he had not trusted when he was, as people casually say, in his right mind. She took from him, and took him away from, his family, his home, control over the finances he had so carefully shepherded for his family, and control over his very obituary. In his last months, most days he sat alone in a wheelchair in a nursing home, sometimes unkempt, often confused, because he surrendered himself to that relative. The "No Visitors" sign on his door kept out the friends, colleagues, and loved ones who longed to see him. And, apparently under orders from the one who acted legally in his stead, the nursing home administrator called the police to remove his wife in his last hours, and made sure that he died almost alone, save a faithful son who was permitted in the room. As his pastor said, he was lost, not only to others, but to himself. All of this was done in the name of law and human autonomy.

II. THE LAW AND MADNESS

The legal treatment of mental illness in United States jurisprudence is paradigmatic of the inability of Western law to address the complex nature of most human beings. We are rational and irrational, trusting and suspicious, loving and angry, capable and incapable, independent and needy. In the best of circumstances, there is a consistency and integrity to the dynamic flow of rational and irrational, trusting and suspicious, and so forth, so that those who know us best can imagine each of us as a

non-contradictory whole. Our family and friends can largely anticipate, and come to trust, which of these opposites will surface in us in particular situations, and which triggers will set us off in one direction or another. If they are very close, our loved ones can often predict how these opposites will manifest themselves, sometimes even at the same time, in the smoldering kindness of a disappointed partner, the fiercely independent yet needy beckoning defiance of a teenager, or the proud and yet anxious teetering of a newly walking toddler into a mother's arms. Yet our loved ones will surely be surprised, as will we sometimes; there will be those moments when we are "not ourselves," as we describe it, even though physically, emotionally, spiritually, the same human being stands in the place where we are "not ourselves."

As human beings slide into what was once called "madness," the integrity of their actions and emotions, the tight weave of character that makes them unique and known as distinct persons to others and to themselves, begins to unravel, sometimes slowly and imperceptibly over a long period of time, other times dramatically fast. The predictable becomes less predictable. Aspects of character that are subtle, like minor themes in a grand piece of music, are magnified and appear more frequently, drowning out the person people have come to know, and then receding back into the background, while the predictable, the familiar re-appears. Those aspects of the self that we deem distasteful and suppress, either by willpower or by cultivation of habit, re-surface and seem to take over in mental illness. The embarrassing becomes the commonplace: clothing is disrupted and askew, hygiene becomes irrelevant, a sense that one is being loud or disruptive or bizarre goes unnoticed.

In these moments, the liberal concept of autonomy is confounded. There will be many moments in which the "mad" will be "lost to themselves" — searching desperately for the persons they thought they were, but overcome by the darkness, groping for a way out. They may be oblivious to the ways that they have themselves changed, believing they are the same and the world outside has changed radically, and that the trustworthy is now dangerous. Or, as in depression, they may be numb to the

world outside themselves, while inside being stabbed over and over by pain, like a ceaseless knife.¹

In these dark journeys, the self that governs, the autonomous self, becomes a fantastical concept. Within a previously (supposedly) ordered life, no one, including the self, knows which persona will manifest itself, or what will trigger its presence. Those who are becoming paranoid will read the gentlest touch as diabolical, the most innocuous interaction as freighted with danger. They will align with those whom they considered morally reprobate; they will be seduced by constructions of reality they would have resisted. Those who suffer from significant chronic but not fully incapacitating mental illness bring this paradox into high relief for all of us because they can swing from one extreme to another, rational to irrational, for no apparent reason.

American law does not often tolerate ambivalence, ambiguity, or paradox; its values are clarity, consistency, and logic. It eschews open texture in standards or procedures in order to bring organization to the anxiety that the person descending into madness lives within, the chaos that he creates for others around him.

In imagining the life of the “normal” American whom the law serves, the law relies on certain defaults. The default for “normal” in human behavior is “predictable;” we know that a “normal” person will show up for work every day, wearing his usual clothes, interacting in his usual manner, and accomplishing his usual duties, for example. By contrast, unpredictability is a sign of madness. Similarly, the default for describing our “normal” mental processing of the external world and internal thought is “rational.” The “normal” autonomous self will assess the pros and cons of potential behavior; for example, he will decide where to spend financial resources as an economist might, making decisions that increase short- and long-term happiness or wellbeing based on facts. He will be neither profligate nor penurious in spending for food or entertainment — unless that’s the way he always is. By contrast, to be non-rational and non-empirical — to perceive reality differently than the rest of us perceive it, to misjudge or even throw away one’s self-interest “inappropriately”

1. I owe this insight to Teri Popp, an Executive Committee Member of the National Action Alliance for Suicide Prevention.

— is to be crazy. The neighbor who bets his fortune on a useless invention, or suspects that he is being watched by agents of the state, becomes suspect.

The default for emotion is limited and managed kindness, polite distance, and reasonable care for others' concerns that is wedded to a self that protects against exploitation and dominance. "Normal" human beings, in the law's view, are not hostile; nor are they so self-giving that they cannot protect themselves against being taken advantage of. The friend who starts giving his entire fortune away, or who begins a stalking campaign against someone who had never offended him, raises our suspicions about sanity.

Finally, the default assumption for behavior of a normal person is action, not passivity. The law presumes that every adult is capable and independent. The law presumes that the actor will be able to make and carry out decisions about how he will act, that he will not be too emotionally or intellectually crippled to make them. The legal self does not need others, or if he does, the self has the means and skill to negotiate freely for what he needs.

Responding to these default understandings of the "normal" person, American law confers a wide range of freedom: the freedom to choose; the freedom to choose unwisely; the freedom to choose in derogation of others' needs, feelings, and demands; and the freedom to act on these choices. In the past, such autonomy was quickly stripped from anyone who challenged the default, who became unpredictable, who was not willing or able to be "normal," who was not willing or able to follow social norms. Among women, this included those whose sexual behavior was unpredictably non-monogamous, who were addicted, who were disobedient to husbands or who found no joy in housework or childrearing, who asserted themselves in dress or behavior as a man would, or who were bereft of the ability to be good wives and mothers because of their depression.² The response of the law was to hide them in unwed mothers' homes, in insane asylums, or in institutions for the mentally retarded,³ and, as in the case of Carrie

2. PHYLLIS CHESLER, *WOMEN AND MADNESS* 5–6, 32, 42–43, 50–51 (Doubleday & Co. 1972).

3. See JACQUELINE VAUGHN SWITZER, *DISABLED RIGHTS: AMERICAN DISABILITY POLICY AND THE FIGHT FOR EQUALITY* 32–33 (Georgetown Univ. Press 2003) (discussing the institutionalization efforts of the 19th and 20th centuries).

Buck, to make sure that difference was wiped from the future by sterilization.⁴

For important reasons, the mentally ill have been deinstitutionalized.⁵ The autonomy pendulum in American law has swung from hiding and restraining the mentally ill to “mainstreaming” them into their communities, assuming that they should be given maximum freedom until their incapacity is proven in a court of law.⁶ Beyond the proper demands for justice and respect for the mentally ill, law’s demand for simplicity, scientific evidence, and uniform application of an abstract and clear standard, and the American passion for the value of freedom have driven this movement.

At the same time that the mentally ill have been mainstreamed into American society, the ubiquity of the durable power of attorney (DPA) has given rise to a new set of paradoxes created by law. The DPA was developed in response to the growing awareness that at some point in many people’s lives, particularly in old age, they do not fully meet the “default” liberal paradigm of personhood that permits independent decision-making and action by adults.⁷ An instrument intended to streamline the transfer of legal control, the DPA gives the attorney-in-fact the ability to make decisions for the principal.⁸ Its innovation, “durability,” extends this power from the classic situation, when the principal is fully competent to control the attorney’s actions, to the time when the principal becomes incompetent, indeed perhaps even unconscious.⁹

4. *Id.* at 36–38 (discussing *Buck v. Bell* and the American eugenics movement).

5. *Id.* at 39–40 (discussing the deinstitutionalization movement).

6. See CHRIS KOYANAGI, KAISER COMM’N ON MEDICAID AND THE UNINSURED, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 5 (2007), <http://www.kff.org/medicaid/upload/7684.pdf>.

7. Nina A. Kohn, *Elder Empowerment as a Strategy for Curbing the Hidden Abuses of Durable Powers of Attorney*, 59 RUTGERS L. REV. 1, 34 (2006) (describing reasons for and the creation of the first durable power of attorney).

8. Karen E. Boxx, *The Durable Power of Attorney’s Place in the Family of Fiduciary Relationships*, 36 GA. L. REV. 1, 1–2 (2001).

9. *Id.* at 6.

The DPA was originally developed to avoid the cost and complication of court supervision over the transfer of legal responsibility from principal to agent at the time when the principal is no longer able to decide for himself.¹⁰ The 1954 Virginia DPA prototype erased the typical presumption that when the principal became incapacitated, his power of attorney automatically terminated.¹¹ In response to American Bar Foundation and other studies of the needs of disabled and elderly persons, the National Conference of Commissioners of State Laws provided a limited “Model Special Power of Attorney for Small Property Interests Act.”¹² In its original design, it was intended as an instrument of social justice, meant to help those individuals who did not have enough assets to justify a complicated and expensive court process, but who were not so dependent on others as to need a full-blown guardian.¹³

The Model Special Power of Attorney Act attempted to limit the possibilities for abuse that accompany any surrender of a person’s legal power to another.¹⁴ To ensure some “daylighting” of the transfer of legal power, the model act required that the power be signed in front of a judge and that the attorney-in-fact account to the principal or a legal representative or a judge who approved the power.¹⁵ To reach its intended beneficiaries and guard against temptation, the Act provided that the DPA would terminate if the value of property subject to it exceeded a “relatively small” amount, which each state could designate.¹⁶ To account for the differing circumstances and abilities of attorneys-in-fact, the model statute offered various alternatives for liability of attorneys-in-fact if they defaulted on their responsibilities: one option would make attorneys-in-fact liable

10. *Id.* at 6–7.

11. *Id.* at 6.

12. *Id.* at 6–7.

13. *Id.* at 7–8 (noting the drafters’ hope that the judge would know the principal and thus be in a good position to determine whether there were any concerns about the power of attorney).

14. MODEL SPECIAL POWER OF ATTORNEY FOR SMALL PROPERTY INTERESTS ACT, *re-printed in* 73 NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS AND PROCEEDINGS, HANDBOOK AND PROCEEDINGS OF THE ANNUAL CONFERENCE MEETING 275–81 (1964).

15. Boxx, *supra* note 8, at 7–8.

16. *Id.* at 8.

only for intentional wrongdoing or fraud, a second would treat attorneys-in-fact like other fiduciaries, and the third permitted that standard to be waived in the power of attorney if the principal so chose.¹⁷ Yet, because of well-meaning modifications introduced into the Uniform Probate Code to make the DPA less cumbersome,¹⁸ the DPA is now most often given outside the shadow of the formal procedures used to check abuse and overreaching.¹⁹ Its limitation to meager estates managed by trusted friends or family has also been abrogated in many state statutes.²⁰ As a result, financial abuse of elders and others through the durable power of attorney has burgeoned. The National Center for Elder Abuse estimated that over 52,000 persons suffered financial abuse by those entrusted with their property in 2004, many of whom presumably were fleeced through durable powers of attorney.²¹

III. THE USES AND ABUSES OF VULNERABILITY

The paradox created by allowing the law to transfer legal power between private individuals, and the consequences of the American preference for the private transfer of power, are clearly evident in the abuse that has risen from employment of the DPA. A person who has not been declared incompetent by a court may essentially give a durable power of attorney even when he is at times “autonomous” and competent, and at other times

17. *Id.* at 9.

18. *Id.* at 44–45 (noting that the Uniform Probate Code abandoned the dollar limitations on the durable power of attorney and the requirement to account to a legal representative when the principal became incapacitated).

19. *Id.* at 45 (discussing the nature of the durable power of attorney and the attempts or non-attempts at oversight).

20. *Id.*

21. See Jennifer Rhein, Note, *No One in Charge: Durable Powers of Attorney and the Failure to Protect Incapacitated Principals*, 17 ELDER L. J. 165, 167 (2009) (citing PAMELA TEASER ET AL, THE NAT’L CTR. ON ELDER ABUSE, THE 2004 SURVEY OF STATE ADULT PROTECTIVE SERVICES: ABUSE OF ADULTS 60 YEARS OF AGE AND OLDER 5–6 (2006)); see also AARP PUBLIC POLICY INSTITUTE, POWER OF ATTORNEY ABUSE: WHAT STATES CAN DO ABOUT IT 7 (2008) [hereinafter AARP report], available at http://assets.aarp.org/rgcenter/consume/2008_17_poa.pdf (describing several surveys of elder law attorneys and providers and probate and trust lawyers who reported a high percentage of DPA abuse, ranging from 19% of cases in a 1993 study to 78% of respondents in a 2002 study).

incompetent, because the law inquires about competence only at the time of signing, and indeed presumes competence.²² This leads to a paradox: if the principal is not competent when the power is signed, the attorney technically has no legal authority at all, and his actions are essentially illegal, albeit facially valid; if the principal is competent, the attorney has every power, even to overrule the principal's earlier wishes about his life, when he later becomes incompetent to express them.

Thus, there is no way of knowing for sure whether the power of attorney actually confers legitimate legal power or is completely void, absent a full judicial hearing on the competence of the subject, which is exactly what the durable power of attorney was designed to avoid. For those who cannot get the courts to hear a challenge to the principal's competence — either because they lack the resources, or sufficient evidence of the subject's incompetence at the particular place and time of signing — an attorney-in-fact with a document not provably void can take over the principal's very life. Moreover, the rise of well-meaning health privacy legislation such as HIPAA has meant that the attorney-in-fact, allegedly acting to protect the principal's privacy interests, may use his legal document to withhold from loved ones the very evidence that proves that his document is legally void.²³

This paradox becomes alarming when we realize that we are all vulnerable citizens, a key insight by Professor Martha Fineman.²⁴ Particularly with respect to mental illness, every one of us is vulnerable and uncontrollably so. We may be vulnerable from birth, through a genetic predisposition or from an imbalance

22. Rhein, *supra* note 21, at 171 (stating that a general requirement of durable powers of attorney is that the principal be competent at the time of signing the instrument); Carolyn Dessin, *Acting as an Agent Under a Financial Durable Power of Attorney: An Unscripted Role*, 75 NEB. L. REV. 574, 581 n. 32 (1996).

23. See, e.g., HARRIET H. ONELLO, GCP MA-CLE, ANTICIPATING GUARDIANSHIP OR CONSERVATORSHIP § 3.7 (2011) (recommending that durable powers of attorney include a HIPAA clause providing the attorney-in-fact with the power to assert HIPAA rights to medical information otherwise protected against others).

24. See Martha Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1, 8–9 (2008) (stating that being vulnerable is a “universal, inevitable, enduring, aspect of the human condition . . .”).

in brain chemistry. We may become mentally ill or incompetent because of accident, crime, illnesses, or chemicals introduced into our bodies by choice or coercion. We may become mentally ill not only from a series of abusing choices, but from one single mistaken choice.²⁵ We may succumb to extreme mental illness, and sometimes less than extreme illness that fluctuates from day to day,²⁶ unaware and by surprise. This unpredictability should prompt us to recognize not only our current vulnerability, but the possibility of a vulnerable future. It should prompt us to ask: what does the law offer us when we are ourselves and not ourselves all at once, when the integrity of person we display to others becomes fractured or, to put it another way, when the complicated person inside us exceeds our ability to control it?

To recognize that we are vulnerable — acted upon as well as acting, dependent as well as independent — is to recognize that others hold our lives in their hands. Unfortunately, just as we cannot guarantee that we ourselves will be predictable, especially when the ravages of mental illness overcome us, we cannot guarantee that those who hold that life in their hands will be predictable or faithful. The kind of omnipotent power over our lives that traditional legal regimes are designed to transfer — the power of attorney, the guardianship, the conservatorship — is a gamble with our lives. Those who hold these powers may be loving, self-sacrificing persons, who know us well, who will use their common sense to do what we would want to do but cannot do when we succumb to mental illness. Those who hold these powers may also be ruthless and self-involved, believing that they are morally entitled to take property that belongs to incompetents. They may be so heedless of the difference between themselves and their principal that they substitute their own notions of the incompetent's best interests in such a way that lacks any integrity, and is discontinuous with an incompetent person's former life and his objective well-being. Also, of course, they may simply be negligent and indifferent to what happens to the principal and the principal's assets.

The law needs to take full cognizance of, and account for, all of these varieties of relationships. In the best of worlds, where the principal is competent enough to supervise the attorney-in-fact,

25. *See id.* at 9.

26. *See id.* at 12.

who is himself caring and capable, a streamlined, simple, and economical process such as the durable power of attorney is ideal to accomplish the transfer of legal power. At the other extreme, where the principal is fully incompetent and there is a high risk of self-dealing or the agent has the strong desire to control the principal's life (e.g., in a parent-child relationship or among battling siblings or because of a history of conflict between principal and agent), only a high degree of institutional interference will ensure that the newly entrusted agent acts in the best interests of the principal. Modern guardianship and conservator systems, which require traditional application to court, strong evidence of incompetence to manage either personal or financial affairs, continuous accounting and approval of important decisions by the court, and regular review, are the best available, if not ideal, models to respond to these circumstances.

The problem is that the law is confounded in two sets of cases: one in which it is not clear whether the principal is competent and the agent trustworthy; and the other in which the principal seems to move between competence and incompetence, and the personal histories of both principal and agent suggest that the agent may, or may not, do what is in the principal's best interest. These challenging situations illustrate Professor Fineman's warning that the law itself can be a vulnerable institution, in the sense that the goals and values of the law can be so easily thwarted because of its very substance and structures.²⁷ The law grants guardianship or conservatorship because the courts do not want to, or cannot, monitor the lives of mentally ill individuals to the extent necessary to protect them from harm, and their assets from theft. The private resolution of messy situations is the hallmark of American law. Yet, the very delegation of legal power to individuals or private organizations provides the possibility that those agents will make the courts helpless to rectify abuse: as managers of the assets of a mentally ill person, clever attorneys-in-fact, as well as guardians and conservators, can conceal disposal of property and dissipation of income, including self-dealing in expenditures of a type that are inappropriate to secure the principal's situation.

Equally important, as managers of the client's affairs, attorneys-in-fact, like guardians and conservators, can employ the

27. See Fineman, *supra* note 24, at 12–13.

principal's own legal rights to confidentiality and secrecy to hide critical health, financial, and other information from those most likely to be investigating improprieties, or advocate justice for the disabled principal. Unless someone cares enough to take his own time and resources to aggressively double-check, to question others besides the attorney-in-fact (or even the guardian or conservator), and to seek explanation from records, most reports to the courts will be rubber-stamped or ignored. Attorneys-in-fact have a magnified power to abuse as compared with guardians and conservators, since usually they do not even have to report to the court.²⁸

There are a significant number of horror stories about attorneys-in-fact who took severe advantage of their principals using durable powers of attorney. As a result of this abuse, the Uniform Law Commission studied DPA abuse, discovered that most states no longer followed the Uniform Durable Power of Attorney Act, amended in 1987, and undertook a new uniform statute, the Uniform Power of Attorney Act of 2006 (UPOAA), approved by the ABA House of Delegates in 2007.²⁹ In reviewing the types of changes that could be made, we might look to Professor Samuel Bray's helpful division of the types of rules that the law can provide to protect a vulnerable person; he distinguishes between harm rules and power rules. Harm rules penalize the powerful person, here the attorney-in-fact, if he or she violates the rights of the vulnerable person. Power rules limit that person's ability to accumulate power over the vulnerable principal in the first place.³⁰

28. See Dessin, *supra* note 22, at 583 (noting that most attorneys-in-fact do not need to seek court approval for their decisions).

29. AARP report, *supra* note 21, at 8–9. The report catalogues twenty-one provisions of the UPOAA that are intended to protect against abuse, including the breadth of the agent's control, the lack of third-party oversight, and the lack of legal standards and clarity about agent duties. *Id.* at 11. Among its provisions are section 116 which permits court petitions to review attorney-in-fact conduct or construe a power of attorney, section 117 which governs liability of attorneys in fact, and Sections 201 and 301 which prevent the exercise of certain powers unless they are expressed in the power of attorney. *Id.* at 12.

30. Samuel L. Bray, *Power Rules*, 110 COLUM. L. REV. 1172, 1173 (2010).

One response to DPA abuses has been to propose changes to harm rules (i.e., raising the level of fiduciary responsibility undertaken by attorneys-in-fact, expecting economically competent, not just ethical, investment and disposal of assets—and imposing corresponding damages for failure to live up to these duties).³¹ Most notably, the Uniform Power of Attorney Act of 2006 (UPOAA), adopted by only eight states and the Virgin Islands as of 2010, specifies default and mandatory duties owed to the principal in more detail, imposing liability for misconduct and providing for judicial review of agents.³² It also requires that any power to change the principal's estate plan or dispose of his assets be expressly granted.³³ However, these few enacted changes have not been enough to obviate the difficulties caused by the surrender of power to an attorney-in-fact. While the UPOAA has eliminated some of the ambiguity about the duties of an attorney-in-fact, its protective provisions fall short of what is necessary to prevent against exploitation.³⁴

There are at least some commentators who argue that these states' decision to ratchet up DPA "harm rules" and penalties for violating them without clearly specifying the extent of fiduciary duties also deters acceptance of the power by the people most likely to execute DPAs in an inexpensive and meaningful way — family members and friends who do not have the business acumen to ensure that assets are invested or transferred for an optimum price.³⁵ Detering "lay" family and friends from assuming the burden leaves the principal sliding into incompetence with two poor alternatives: hiring an expensive professional agent to administer his assets, or surrendering to a guardianship or conservatorship well before he "needs" one because he has become incompetent under state guardianship law.

31. Boxx, *supra* note 8, at 45 (noting the availability of civil remedies for abuse of vulnerable adults).

32. See Andrew H. Hook and Lisa V. Johnson, *The Uniform Power of Attorney Act*, 45 REAL PROP. TR. & EST. L.J. 283, 287–288 (2010) (noting adoption of the UPOAA, as of 2010, by Idaho, New Mexico, Nevada, Maine, Virginia, Colorado, Maryland, Wisconsin, and the Virgin Islands); Rhein, *supra* note 21, at 176.

33. Rhein, *supra* note 21, at 176.

34. *Id.* at 180 (highlighting three of the UPOAA's provisions that fail to adequately protect individuals).

35. See Boxx, *supra* note 8, at 43 (noting some of the risks to the agent).

Harm rules have largely failed to stem the abuses of the DPA, leading states to propose three types of “power rules” in DPA reforms. First, states have attempted to create more robust execution requirements that will “daylight” DPAs upon creation and provide some minimal assurance that the principal is competent, including notarization of the document, increasing the number of witnesses to the document, and setting qualifications for witnesses.³⁶ Second, states have attempted to limit the attorney-in-fact’s power to act in certain circumstances, such as transactions that benefit the attorney-in-fact.³⁷ Third, states have attempted to create policing mechanisms during the life of the power of attorney.³⁸ Professor Boxx notes, for example, that North Carolina requires the attorney-in-fact to record the power of attorney when the principal becomes incapacitated, account to the court, and file inventories of property that the attorney holds.³⁹ Other states permit interested parties to petition for an accounting or other relief from the attorney-in-fact, and Tennessee permits relatives of the principal to require the attorney-in-fact to post a bond to protect the principal against potential financial wrongdoing.⁴⁰

Another approach to the problem of the sometimes incapacitated principal, which might be borrowed from guardianship law, is to provide more specificity about when a principal will be deemed to be incapacitated, given that many principals are adopting “springing” powers of attorney that do not come into use until the principal is incapacitated. As an analogy, Minnesota’s standard for guardianship and conservatorship was rewritten in 1980 “to make it harder to create a guardianship”⁴¹ by, *inter alia*, including “clear definitions of what incapacity

36. Kohn, *supra* note 7, at 34. The UPOAA provides that financial powers of attorney are durable by default unless otherwise specified, and requires acknowledgement before a notary, for example. Rhein, *supra* note 22, at 175.

37. Kohn, *supra* note 7, at 34 (noting that these reforms either prohibit gift-giving to the attorney-in-fact absent express authorization by the principal, or alter the statutory short form to prohibit gift-giving).

38. *Id.* at 35.

39. Boxx, *supra* note 8, at 45.

40. *Id.*

41. *In re* Conservatorship of Lundgaard, 453 N.W.2d 58, 61 (Minn. Ct. App. 1990) (quoting *In re* Guardianship of Mikulanec, 356 N.W.2d 683, 687 (Minn. 1984)).

involve[s].”⁴² The statute requires a clear and convincing demonstration that the person is “impaired to the extent of lacking sufficient understanding or capacity to make or communicate responsible personal decisions . . . [and] has demonstrated deficits in behavior which evidence an inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety, even with appropriate technological assistance.”⁴³ A conservator may not be appointed unless there is clear and convincing evidence that the principal cannot “manage property and business affairs because of an impairment in the ability to receive and evaluate information or make decisions, even with the use of appropriate technological assistance . . .”⁴⁴

Yet another “power” approach is to limit the specific powers and rights that an attorney-in-fact gains with a power of attorney, absent more extensive oversight. The Minnesota guardianship law is a good example of this. One of the purposes of the 1980 reform stated: “once [a guardianship] is created . . . the powers of the guardian should be kept to the bare minimum necessary to care for the ward’s needs,”⁴⁵ including “specific statements about the powers and duties of a guardian.”⁴⁶

Finally, Professor Kohn has proposed more statutorily required involvement by the principal, so long as he retains any capacity to review the attorney-in-fact’s plans for his life or estate, which includes notice and consultation.⁴⁷ Although only six states require communication to the principal about the agent’s expectations and transactions,⁴⁸ Professor Kohn argues that the

42. *Id.*

43. Minn. Stat. Ann. § 524.5-102(6) (West 2012); *see also* In re Andreszcuk, No. A08-0653, A08-2240, 2009 Minn. App. Unpub. LEXIS 564 at *8 (Minn. Ct. App. June 2, 2009).

44. Minn. Stat. Ann. § 524.5-409 (1)(a) (West 2011).

45. *Lundgaard*, 453 N.W.2d at 61 (citing In re Guardianship of Mikulanec, 356 N.W.2d 683, 687 (Minn. 1984)).

46. *Id.*

47. Kohn, *supra* note 7, at 52. *See also* *Lundgaard*, 453 N.W.2d at 61 (stating the third purpose of the 1980 Minnesota reforms of guardianship law, to provide “sufficient oversight of the guardian’s role and participation by the ward . . . by expand[ing] the due process rights of a proposed ward in a guardianship hearing”).

48. Kansas, Missouri and California require both communication and contact between the attorney-in-fact and the principal, while Texas, South

failure to communicate with the principal violates the agent's duty of obedience and is critical to ensuring appropriate limits on control over the principal's life.⁴⁹ This may not prevent most abuses, but may trigger a principal's inquiry to others in his life at times when he is relatively competent.

IV. PARADIGMS FOR GOVERNMENT INVOLVEMENT

As Professor Fineman has noted, we are all vulnerable, but we are all vulnerable in very distinctive ways.⁵⁰ We need to challenge the law's demand that standards for protecting the mentally vulnerable must be uniform, and that scientific evidence of incapacity must be overwhelming. We must seek a contextual approach that embraces the particularity of the mentally ill person, and outlines his specific capabilities and needs. There is some reason for concern about the robust government involvement in the lives of mentally ill persons that a vulnerability model might suggest. Instead, we might envision a more appropriate model in a public-private partnership: a legal regime that will marshal a circle of persons and resources able to engage the mentally ill person in her paradoxical complexity. Through negotiation and compromise, such a partnership can craft legal powers that will permit dignity and opportunity to mentally ill individuals crying out for the embrace of the community and understanding (even by themselves) of their engagement with a "real" world that has become confusing for them, and for the opportunity to live creative lives and care for others to the limits of their abilities.

The vulnerabilities movement rightly criticizes American legal structures for failing to respond to the needs of vulnerable citizens.⁵¹ However, both historically and in modern times, one cannot help but recognize that the government's decision to acknowledge its duty toward citizens at risk of catastrophes that

Dakota and Louisiana require only that the attorney communicate to the principal. Kohn, *supra* note 7, at 18.

49. Kohn, *supra* note 7, at 52.

50. Fineman, *supra* note 24, at 10 (stating that our different economic and institutional positions create a varying "range" and "magnitude" of our potential vulnerabilities).

51. For a sampling of these articles, see the Emory Law School Vulnerability and Human Condition website bibliography, <http://web.gs.emory.edu/vulnerability/resources/Publications.html> (last visited July 29, 2011).

rob us of a full life can be a two-edged sword. Those advocating for a negative state have made a good case that limited governmental powers are necessary to protect individuals against the overweening power of government. If individual attorneys-in-fact can strip mentally ill people of their lives and wealth, so can governments composed of individual bureaucrats.⁵² Although few states currently take an “all-or-nothing” approach to the troubling issues that mentally ill people confront in living full and meaningful lives, we might imagine what those approaches might look like. This is not difficult given that these approaches characterized our not-too-distant past. One might call the “all” approach the oppressive neglect approach, and the “nothing” approach the indifferent neglect approach.

In the oppressive neglect approach typified by state policies on mental illness through the first half of the 20th century, the government played a relatively aggressive role in responding to persons with mental illness.⁵³ Government policies were both oppressive and neglectful. In their oppressive forms, the policies stripped the institutionalized mentally ill of their freedom of movement.⁵⁴ Through guardianships and other legal transfers of power, they were also stripped of their ability to make decisions about their own lives and property.⁵⁵ What was taken from them were the very things that most of us depend on to create a sense of security and identity in our lives — our family and friendships; our home and those creature comforts we depend on when we step out of our public lives, whether books or art or crafts or furnishings; our clothing and those outward signs we use to tell people how to

52. See Fineman, *supra* note 24, at 7 (responding to concerns about intrusive state intervention).

53. See Antony B. Klapper, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 749-750 (1993) (discussing the large increase in institutionalization of the mentally ill from the beginning of the twentieth century to the mid-1950s); Kristen Ellard, *The Struggle for Identity: Issues and Debates in the Emerging Specialty of American Psychiatry from the Late 19th Century to Post-WWII*, 4 HUM. ARCHITECTURE: J SOC. SELF-KNOWLEDGE 227, 232-33 (2005) (noting a rise in public acceptance of state-funded institutions for diseases promoted as curable).

54. Klapper, *supra* note 53, at 750 n.34.

55. *Id.*; see also Ilissa Watnik, *A Constitutional Analysis of Kendra’s Law: New York’s Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1187 n.29 (2001).

think about us. In some cases, through medication, electroshock, and other treatments, what was taken from them was their very ability to think and feel as they had before. This very oppressive intervention was also neglectful. For many reasons, political and social, the institutionalized mentally ill became invisible to lawmakers and society. Rather than providing for the care that would maximize their capacities as participating and productive members of society, government provided minimal care that perhaps saved their lives and prevented harm they might have done to others, but rarely provided the means for them to live authentic lives.⁵⁶

On the other hand, history shows us the consequences of indifferent neglect as well. When governments did not intervene to provide even basic supportive care for mentally ill persons, the burden came crashing down on families, often unable to cope with the additional demands that mental illness thrust upon them.⁵⁷ Mentally ill persons who manifested self-destructive or violent behaviors were most likely to end up in prisons, or the basements of hospitals, both of which were rarely therapeutic.⁵⁸

Responding to the failure of these two models, current state mental health laws struggle toward a regime that is minimally invasive and maximally beneficial to the mentally ill, focusing on “least restrictive” settings and treatments. However, because of the strong liberal orientation of American law, the “minimally invasive” aspect of this formula is much more successfully carried out than the “maximally beneficial” aspect. With the exception of the durable power of attorney, neither the state nor any other individual is granted comprehensive power over the life of a mentally ill person without an extensive inquiry into the nature and extent of the person’s mental illness; and the presumption of competence is very strong. Similarly, the rights of mentally ill persons to refuse treatment are strong, even when there is a fairly

56. See Ellard, *supra* note 53, at 227 (noting late 19th century overcrowding of public institutions and emphasis on moral treatment of institutionalized mentally ill persons); Klapper, *supra* note 53, at 752, 776 (noting that the ADA doesn’t ensure services but merely requires that existing services be open to the mentally ill).

57. KOYANAGI, *supra* note 6, at 4 (noting how the improved public opinion of the new public mental hospitals encouraged families to turn over their members who were difficult).

58. *Id.* at 3 (noting emphasis on keeping the insane subdued).

compelling state interest, such as the interest in making them competent enough to stand trial for criminal acts that they are accused of having committed.⁵⁹ Institutionalization is a very last resort, usually only when the mentally ill person has demonstrated that he is a danger to himself or others.⁶⁰

On the other hand, the structure of government programs for the mentally ill, combined with ambivalence of social actors toward the mentally ill, has meant that they can rarely lead “maximally beneficial” lives (i.e., lives that reflect their authentic selves and enable them to contribute according to their abilities in the same measure that their non-mentally ill peers are able to do). Government programs for the mentally disabled suffer from two main ills: the usual under-resourcing typical of programs for citizens who require complex and intensive interventions to be successful; and the structure of bureaucratization, which prizes streamlined, uniform programs that guard against charges of unfair treatment.⁶¹

The modern ambivalence of social actors toward the mentally ill contributes to this “no-man’s-land.” The state wants to treat the mentally ill as a private problem of the family, as it traditionally did, but recognizes the need for family supports, both of restraint and of assistance. The state and the individuals who surround the mentally ill want to respect their dignity, but fear their unpredictable and idiosyncratic behavior, or are exhausted by the complex and incessant demands that they place on loved ones. It is difficult to create a government “program” that embraces the ambivalence, complexity, and unpredictability that attends mental illness, for government programs are supposed to work (i.e., accomplishing measurable objectives), work now, and work efficiently (i.e., not spending too much financial or human capital).

59. See, e.g., *Sell v. United States*, 539 U.S. 166, 180–81 (2003) (requiring the state to show that involuntary medication to render a defendant competent must be necessary to meet a significant governmental interest, and medically appropriate to the defendant’s medical condition).

60. See *O’Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975).

61. See Klapper, *supra* note 53, at 774 (noting the reduction of funds for the treatment of mentally ill persons under the Reagan budget proposals).

V. MOVING TOWARDS A WORKABLE MODEL

The recognition of human vulnerability calls for a different response. It asks the state to recognize and even to value the mentally ill person as an equally respected member of the human community, a person who can be exploited or harmed by others, and who can in turn exploit or harm those who love him. It asks the state to acknowledge realistically that in the case of the mentally ill, it truly does “take a village” of public and private citizens to surround that citizen with the kind of care he needs, while including the mentally ill person himself in the planning for long-term care. It asks for legal regimes that neither strip the mentally ill individual of the autonomy he needs to feel truly respected, nor permit him to be exploited by either the individuals or the state.

Such a regime would minimally include a holistic evaluation, a formal legal or administrative proceeding, greater community involvement, and mandatory alternative dispute resolution for contested cases.

A. Holistic Evaluations

A holistic evaluation of any person issuing a DPA who presents signs of mental illness is necessary. That should include an analysis of his capabilities and his dependencies, and should be comprehensive enough to recognize the center and integrity of his life as it has been lived throughout the years. Such an evaluation may require difficult judgments about who this mentally challenged person *really is*, and how this person would have wanted his life to unfold if he had been able to explain his values and needs. It should account for, but not be distorted by, the mental illness that makes him who he is today. This evaluation needs to take account of all of the aspects and all of the seasons of the mentally ill person’s life. This requires the evaluation to be informed by those who have lived with, worked with, and socialized with the individual at risk. This evaluation should be the responsibility of the state if there is any credible evidence that the person might be vulnerable to exploitation. It should be conducted with the cooperation of, and where possible the approval of, the person himself and those around him.

B. Formal Transfer Ritual

A ritual for the transfer of that individual's financial and personal legal power is necessary. It should be fully informed by those who have known the applicant deeply and for a long period. This ritual must ensure that the immediate community, including judges and government actors, can ascertain whether the individual's behavior and attempted legal acts are consistent with the integrity of his person, expressed over time, or rather are the result of an immediate delusion or impulsive act. This requirement provides more protection than the current durable power of attorney provisions, which may be effectuated without the knowledge of those who are closest to the subject, and may not receive the oversight of even a notary public, much less a witness, a judge, or a state administrator. However, there may be less formal ways of accomplishing this proceeding than a traditional trial. Administrative agencies or streamlined court approval processes could be developed to triage DPA requests and refer only those where an issue of competence or overreaching is concerned to a traditional adversarial proceeding.

The need for a careful ritual proceeding suggests that a person executing a power of attorney should be required to notify anyone who would be a legitimate object of the person's bounty or duty of support, including his spouse and children; or if he has none, parents or siblings, as well as any persons named in trusts or wills who are expected to share in his property. Such interested parties should be permitted to file a contest with the newly created administrative review board, arguing that the executing principal is incompetent to grant such a power or is vulnerable to abuse by the attorney-in-fact. Unless there are any compelling circumstances such as imminent surgery, travel, or incapacity that make it necessary for the power to be conferred, the review board should be empowered to issue a stay against the effectiveness of the document.

C. Greater Community Involvement

The state should provide for a person's loved ones to question him about the reasons for his decision to transfer power to someone who would not naturally and obviously be the selected agent for the mentally ill person's transfer of power. In the case of conflicts among loved ones, there should be the opportunity to

consider which agents the mentally ill person would actually have trusted, and to get some perspective from those close to the vulnerable person who are not involved in the conflict. These interested persons should generally be able to secure court or agency assistance in delaying or terminating the power of attorney until a determination of competence can be made, unless the attorney-in-fact can demonstrate the compelling need for transfer of legal power, if the following factors are present:

- the attorney-in-fact has isolated the subject from family, friends or colleagues who have been the natural objects of the principal's affection and bounty;
- the principal has transferred significant economic power and wealth to a single individual or entity that is not bonded or does not have a track record of experience in managing this kind of wealth;
- the instrument does not provide for oversight including checks and balances, either by individuals close to the principal, or by appropriate business or institutional actors with expertise;
- the principal explicitly eliminates family and friends as objects of the principal's benevolence, or there is a simultaneous termination of loving relationships, either in the instrument itself or by acts of the attorney-in-fact; or
- the document specifically attempts to exclude judicial review of abusive practices.

The law should require that the principal give informed consent when he transfers power to an attorney-in-fact. In order for such consent to be informed, the principal must be given an opportunity to consult counsel who will solely represent his interests. Many states have adopted uniform health care powers of attorney, an appropriate model to adopt for PDAs, which usually require the principal to list or check and initial every specific power he is giving the attorney-in-fact. An explanation of what such a power entails is also required to ensure that the principal has not simply signed a boilerplate document, but has instead thought about and chosen to grant each power to the attorney-in-fact.

D. Mandatory Alternative Dispute Resolution for Contested Cases

Finally, the law should provide, as a default to be ordered by the court without evidence, mandatory alternative dispute resolution in cases where a naturally interested party contests the creation of the power of attorney. Such mechanisms would give the principal, or those who care for him, the opportunity to build a trusting community of support around him, which might include family, friends, private professionals, and public actors. The restorative circle model, which constitutes a group of friends, family, professionals, and court personnel who work with someone who has created a rupture in the community, usually involving crime, is a possible model for this trusting community.⁶² In the restorative circle, members have the duty to hold the individual accountable for his actions and, in this case, for his perception of himself as acting “sanely” in the decisions that he is making.⁶³ However, they also have the duty to provide support to him to get his life back on track, including identifying resources that they or others can offer in order to shore up deficits in the subject’s ability to lead a productive and contributing life within the community.

Creating such a model, which will demand both government involvement and private volunteers, poses the best chance of taking the current expression of the principal’s interests into consideration,⁶⁴ while guarding against overreaching and self-dealing by the attorney-in-fact. Studies have shown that if the principal is surrounded by government actors, as well as those who love him, his being called to responsibility and accountability in a circle of care is more likely to keep him “sane.”⁶⁵ At the same time, there will be a larger number of persons who are in a position to judge when he has moved from capacity to incapacity, such that stronger intervention, like a guardianship supervised by a

62. See, e.g., KAY PRANIS ET AL., PEACEMAKING CIRCLES: FROM CRIME TO COMMUNITY 10–14, 34–45 (Living Justice Press 2003) (discussing process and core values animating restorative circles).

63. *Id.* at 10–14, 72–74 (describing process of support and accountability in restorative circles).

64. See *supra* note 45 and accompanying text (discussing Kohn’s advocacy for greater involvement by the principal as long as it is practical).

65. Kohn, *supra* note 7, at 44 n.176 (citing a study showing that greater involvement led to a decrease in depression and increased satisfaction and overall well-being).

traditional court, is warranted. With a circle, the possibilities that an attorney-in-fact will engage in self-dealing, or even assert his power to re-create the principal's life in his own image, will be vastly constrained by the perspectives and opinions of others in the circle. At the same time, the possibilities for government oppressive neglect are limited by the oversight and possibility for "push-back" by private actors who better know and care about the principal than government bureaucrats might.

Refusing to Recognize the Right to Refuse Medical Treatment, or Ensuring Public Safety: An Analysis of New York's Assisted Outpatient Treatment Law

BY ANDREW ZACHER*

After a decade, New York's assisted outpatient treatment (AOT) program remains a source of contention among many groups. While some praise it as successfully reducing instances of hospitalization, homelessness, arrests, and incarcerations among the population of mentally ill individuals, others criticize the law for being ineffective and unconstitutional. Courts have repeatedly upheld AOT on several legal theories, including the argument that the law does not abridge any fundamental rights and, alternatively, that the state's interest as parens patriae and the police power legitimize the AOT program. Following a recent five-year extension, New York's AOT program must be reevaluated to determine whether the extension was appropriate.

This article focuses on New York's AOT program, known as Kendra's Law, to describe the history of AOT in the United States and the challenges that have been made regarding the individual rights involved. It also investigates the court decisions that have repeatedly upheld the law, and analyzes the legitimacy of these decisions. Although this article finds that several of the court's arguments are contrary to judicial precedents, it ultimately determines that the courts' reliance on the police power is a valid reason to uphold the law. The article then describes why the law is

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the least restrictive means of protecting the public from the risks posed by potentially violent mentally ill individuals, and concludes by finding that New York's extension of the law was proper.

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I. INTRODUCTION

In 1999, New York joined an overwhelming majority of states by enacting an assisted outpatient treatment (“AOT”) program in an effort to help manage the population of untreated mentally ill individuals throughout the state.¹ The passage of this legislation was sparked by the tragic death of Kendra Webdale, who was shoved to her death in a New York City subway station by Andrew Goldstein, a man with a diagnosed mental illness and a history of violent behaviors.² Despite his history, Goldstein repeatedly neglected to take his medication and the mental health system failed to offer the necessary support.³ Kendra’s Law,⁴ instituted in 1999, is designed to prevent crimes by identifying potentially violent mentally ill individuals who are unlikely to comply with medical treatment and, therefore, require court ordered intervention.⁵

Kendra’s Law has been an ongoing source of contention between its supporters and those who argue that it unconstitutionally violates the fundamental right to privacy. In reaction to such controversy, the Law was initially enacted for a five-year trial period.⁶ Since its inception, the AOT program has repeatedly been re-enacted in five-year increments.⁷ Most recently, the law was extended for an additional five-year period after sunseting in June of 2010.⁸

1. TOM LIBOUS, N.Y. STATE SENATE INTRODUCER’S MEMORANDUM IN SUPPORT, S. 5762-A (1999).

2. Tom Davis, *Prison is No Place for the Ill*, THE RECORD, Dec. 5, 2006 (discussing the outcome of Andrew Goldstein’s trial for murder in the second degree).

3. *Id.* (following his sentencing it was determined that he did not receive a fair trial and a new trial was ordered).

4. N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2010).

5. See N.Y. STATE OFFICE OF MENTAL HEALTH, AN EXPLANATION OF KENDRA’S LAW (May 2006), <http://bi.omh.ny.gov/aot/about?p=kendras-law>.

6. See CATHARINE YOUNG & AILEEN GUNTHER, MEMORANDUM IN SUPPORT, S 4881, A.6987 (2010) (providing a brief summary of the history of Kendra’s law, including a description of the Law’s expiration dates).

7. *Id.*

8. See *Latest News on Kendra’s Law*, TREATMENT ADVOCACY CENTER www.treatmentadvocacycenter.org/kendras-law-2010 (last visited Mar. 24, 2012) (discussing the extension of Kendra’s Law in 2010).

This article assesses Kendra's Law based on the constitutional paradigm of the right to refuse medical treatment. Through this framework the article argues that the manner in which AOT abridges personal autonomy is justified because it has proven to successfully protect New Yorkers from the violent tendencies of certain mentally ill individuals.

II. BACKGROUND OF KENDRA'S LAW

AOT statutes are common in the United States and have existed for several decades.⁹ New York's AOT program is referred to as Kendra's Law as a result of the events that led to Kendra Webdale's death.¹⁰ The Kendra's Law statute specifies several procedural mechanisms that are designed to properly identify potential AOT candidates, allow those candidates to have a hearing to determine whether AOT is necessary, and provide the opportunity for the candidate to participate in the development of the specific AOT order.¹¹ The law also sets forth the consequences of noncompliance with an AOT order, including temporary detention and the possibility of involuntary commitment.¹² In practice, the statute has been used to mandate AOT orders for patients who suffer from a variety of conditions, and the requirements of individual treatment orders vary significantly.¹³ Because the law restricts an individual's ability to make his or her own decisions, it has been highly criticized.¹⁴

9. See N.C. GEN. STAT. §122C-2 (2010); see also *Improved Treatment Standard*, TREATMENT ADVOCACY CENTER <http://www.treatmentadvocacycenter.org/solution/improved-treatment-standards> (last visited Apr. 1, 2012).

10. See LIBOUS *supra* note 1 (discussing the need to prevent random acts of violence by untreated mentally ill individuals); see also Sally Satel, *Real Help for the Mentally Ill*, N.Y. TIMES, Jan. 7, 1999, at A31.

11. See N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2010).

12. N.Y. MENTAL HYG. LAW § 9.60(n).

13. N.Y. MENTAL HYG. LAW § 9.60(a) (setting forth the different categories of treatment that may be included in an AOT order).

14. See NEW YORK LAWYERS FOR THE PUBLIC INTEREST, INC., IMPLEMENTATION OF KENDRA'S LAW IS SEVERELY BIASED (2005) [hereinafter NYLPI] http://www.prisonpolicy.org/scans/Kendras_Law_04-07-05.pdf. Kendra's Law has been also been criticized based on the belief that it has a disproportionate impact on minority groups. This article focuses solely on opponents' arguments that the law abridges autonomy rights.

Beginning with a brief history of deinstitutionalization and AOT programs throughout the United States, this section outlines the driving forces that led New York to enact AOT legislation, describes the Kendra's Law statute, and provides an explanation of how the AOT program functions. A discussion of the role that medications play in New York's AOT program is also included. This section concludes by briefly highlighting the arguments that proponents and critics of the law rely on when discussing the law.

A. Deinstitutionalization and the Rise of AOT in the United States

AOT programs in the United States began in the 1980s as a means of dealing with the rising population of untreated mentally ill individuals.¹⁵ Although most states now have AOT laws, each AOT program is specific to the individual state and varies in scope.¹⁶

Initially, AOT programs were based on the need to help communities cope with the rising number of untreated mentally ill individuals and the risks posed by this population.¹⁷ This population was on the rise in the latter quarter of the twentieth century as a result of deinstitutionalization in the United States.¹⁸ Through deinstitutionalization, the traditional large long-term stay mental institutions were replaced with smaller community based mental health services.¹⁹ Often, as mental hospitals were shut down, their populations were released into the communities without supervision and left to obtain their own treatment.²⁰ Untreated and unable to obtain necessary treatment, these former

15. See E. Fuller Torrey, *Hope for Cities Dealing With the Mental Illness Crisis*, 22 NATION'S CITIES WKLY. 2 (1999) (describing involuntary outpatient commitment as an alternative to long-term inpatient commitment).

16. See SARAH STEVERMAN, NATIONAL CONFERENCE OF STATE LEGISLATURES, INVOLUNTARY OUTPATIENT COMMITMENT LEGISLATION: STATE PERSPECTIVES (2007).

17. Torrey, *supra* note 15, at 1.

18. Walid Fakhourya & Stephan Priebe, *Deinstitutionalization and Reinstitutionalization: Major Changes in the Provision of Mental Healthcare*, 6 PSYCHIATRY 313, 315 (2007).

19. *Id.* (stating that, initially, deinstitutionalization sought to ease overburdened asylums that were popular throughout America).

20. E. Fuller Torrey & Mary Zdanowicz, *Why Deinstitutionalization Turned Deadly*, WALL ST. J., Aug. 4, 1998, at A18 (describing that mental patients were often released directly into the community when asylums were shut down).

patients often became homeless or ended up incarcerated in jails and prisons for offenses committed while untreated.²¹ The burden of dealing with psychiatric illnesses was placed on law enforcement rather than the medical community.²² In New York City, for example, the number of individuals brought to emergency rooms to receive psychiatric care increased from roughly 1000 in 1976 to over 18,500 in 1986.²³ AOT laws were initiated as a response to the overwhelming number of untreated mentally ill persons in the community.²⁴

Almost every state has some form of AOT program.²⁵ Following the lead of North Carolina, which was the first state to enact an AOT statute, the majority of states enacted similar AOT laws.²⁶ Most recently, New Jersey became the 43rd state to enact an AOT program in August of 2009.²⁷ Although the method of implementation varies, these laws generally involve the use of court orders to require certain mentally ill persons to follow a course of treatment for a diagnosed mental health condition.²⁸ Each statute specifies the criteria used to determine which individuals should be required to undergo AOT.²⁹ Generally, these

21. *Id.* (discussing the lack of community support that existed for those patients who were released into the community).

22. Torrey, *supra* note 15, at 2; *see also* Patrick Flanigan, *Health Care in Jails*, ROCHESTER DEMOCRAT & CHRON., July 29, 2001 (discussing the burden placed on the prison system to cope with rising population of mentally ill inmates).

23. Torrey, *supra* note 15, at 2.

24. *Id.* (offering praise for assisted outpatient commitment as a means of coping with the impact of deinstitutionalization).

25. *See* TREATMENT ADVOCACY CENTER, *Landmark Legislation Brings Much Needed Reform to New Jersey.*, HOSP. BUS. WK., Aug. 30, 2009; *see also* TREATMENT ADVOCACY CENTER, N.J. IS 43RD STATE TO ADOPT ASSISTED OUTPATIENT TREATMENT (2009), [hereinafter N.J. ADOPTS AOT] <http://www.treatmentadvocacycenter.org/home-page/71-featured-articles/1431-new-jersey-is-43rd-state-to-adopt-addisted-outpatient-treatment> (last visited Mar. 24, 2012).

26. *See* STEVERMAN, *supra* note 16 (discussing the increasing number of involuntary outpatient commitment programs in the United States).

27. N.J. ADOPTS AOT, *supra* note 25.

28. Henry Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79, 81 (2008).

29. *See* N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney 2010) (outlining the criteria used to determine which patients should be subject to AOT orders).

criteria target mentally ill people that may pose a threat to the community and are in need of medical supervision, but are incapable of seeking the treatment on their own.³⁰

*B. The Death of Kendra Webdale and the Birth of
AOT in New York*

The impetus behind New York's AOT legislation was a series of violent crimes committed by mentally ill individuals that resulted in death or serious injury to innocent victims.³¹ Following these incidents, the enactment of an AOT program in New York became a priority of lawmakers.³²

New York's AOT law was named after a crime victim who was killed by a mentally ill individual in a New York City subway.³³ The attacker in this case, Andrew Goldstein, suffered from Schizophrenia and despite attempts to obtain treatment to control his sometimes-violent behavior, he was denied the care he needed and failed to comply when treatments were made available.³⁴ While Goldstein was living untreated on the streets of New York in January of 1999, he entered a subway station, approached Kendra Webdale, and pushed her onto the train tracks where she was killed by an oncoming train.³⁵

In a similar situation, Julio Perez, a 43-year-old homeless man with schizophrenia, shoved Edgar Rivera into an oncoming train in New York City.³⁶ Rivera's legs were severed as a result of

30. See *Id.*

31. See LIBOUS, *supra* note 1; see also Andrew Goldstein, *After Kendra Webdale's Death*, N.Y. TIMES, Jan. 8, 1999, at A18; Jeffery Seward, Letter to the Editor, *Kendra's Law*, N.Y. TIMES, Oct. 26, 1999, at A26; *Is Kendra's Law Enough?*, N.Y. POST, Nov. 24, 2001, at 20.

32. See LIBOUS, *supra* note 1; see also Frank Lombardi, *State Pols Vowing to Ok Kendra's Law*, N.Y. DAILY NEWS, Aug. 4, 1999, available at <http://www.nydailynews.com/archives/news/state-pols-vowing-kendra-law-article-1.845450>.

33. Seward, *supra* note 31.

34. Goldstein, *supra* note 31.

35. Amy Waldman, *Woman Killed in a Subway Station Attack*, N.Y. TIMES, Jan. 4, 1999; Robert D. McFadden, *New York Nightmare Kills a Dreamer*, N.Y. TIMES, Jan. 5, 1999; Michael Cooper, *Man Accused in Subway Death Says He Tried a Similar Attack Before, the Police Say*, N.Y. TIMES, Jan. 6, 1999.

36. Andrew Jacobs, *Subway Victim Says He Harbors No Anger*, N.Y. TIMES, Jun. 3, 1999, at A1.

the crime.³⁷ Julio Perez had previously been convicted of drug possession, robbery, and harassment but was systematically denied the closely supervised care that he needed to control his condition.³⁸ On the day of the attack, Perez was seen at an emergency room and later at a police station where he attempted to file a complaint against his “enemies.”³⁹

In response to these incidents, New York’s Governor and legislative leaders expressed a commitment to pass an AOT law, and several AOT bills were subsequently introduced.⁴⁰ The concept of implementing an AOT program in New York was controversial, and advocates and opponents of such a program actively lobbied the Legislature on the issue.⁴¹ The legislation was supported by the New York State Association of Chiefs of Police and by advocacy groups such as the Treatment Advocacy Center.⁴² This group lobbied heavily for the legislation arguing that “for far too long, thousands of vulnerable New Yorkers have eked out a pitiful existence on city streets, underground in subway tunnels, or in jails and prisons as a result of misguided efforts of civil rights advocates to keep the severely ill out of treatment.”⁴³ Supporters

37. *Id.*

38. Katherine Finkelstein, *Man’s Mental State Central to Subway-Pushing Trial*, N.Y. TIMES, Sept. 26, 2000, at B4.

39. John McManamy, “*Forced*” *Meds and Phantom Rights*, MCMAN’S DEPRESSION AND BIPOLAR WEB, http://www.mcmanweb.com/foced_meds.html (last visited Mar. 24, 2012).

40. E. Fuller Torrey & Mary T. Zdanowicz, *Kendra’s Law, The Culmination of a 10-year Battle for Assisted Outpatient Treatment in New York*, CATALYST, (Treatment Advoc.Ctr. 1999 at 4) http://www.treatmentadvocacycenter.org/storage/documents/1999special_edition_welcome_isse_catalyst.pdf.

41. *See Id.*; E. Fuller Torrey & Mary T. Zdanowicz, *Remembering Kendra*, N.Y. POST, Feb. 18, 2005) (discussing support and opposition to Kendra’s Law); *See* E. Fuller Torrey & Mary T. Zdanowicz, *OPED Kendra’s Law Fearmongers*, N.Y. POST, Feb. 25, 2000, http://www.treatmentadvocacycenter.org/index.php?option=com_content&view=article&id=574&itemid=197.

42. *See* Torrey & Zdanowicz, *supra* note 40.

43. Press Release, Mary T. Zdanowicz, Executive Director, Treatment Advoc. Ctr., *New York Should Stand Tall: Don’t Fail the Mentally Ill by Letting the Clock Run Out on Kendra’s Law* (June 16, 1999) http://www.treatmentadvocacycenter.org/index.php?option=com_content&view=article&id=180 (last visited Apr. 1, 2012).

argued that the limited access to mental hospitals and the state's ineffective treatment laws had resulted in increased rates of homelessness, violence, incarceration, suicide, and victimization of this population.⁴⁴ Kendra's Law, therefore, was seen as a means of preventing harm to the community, as well as a means of providing care for those in need.⁴⁵

In contrast to the Treatment Advocacy Center, civil liberties unions opposed the legislation.⁴⁶ New York Civil Liberties Union argued that the law violated the fundamental right of competent, non-dangerous mentally ill individuals who would not otherwise meet the requirements for involuntarily commitment.⁴⁷

The first version of Kendra's Law passed the New York State Legislature with few negative votes; only two senators and four members of the Assembly opposed the bill.⁴⁸ The Governor signed the law in August of 2000 for a five-year trial period.⁴⁹ At the end of this period, legislation was introduced to modify the law and extend it for an additional five-year period.⁵⁰

The proposal to extend Kendra's Law in 2005 was met with much of the same mix of support and opposition as when it was originally proposed.⁵¹ While proponents, such as the Treatment Advocacy Center, touted the program's success, civil liberties

44. *Id.*

45. See N.Y. STATE OFFICE OF MENTAL HEALTH, KENDRA'S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT, CHARACTERISTICS OF AOT RECIPIENTS (2005), <http://bi.omh.ny.gov/aot/files/AOTFinal2005.pdf>.

46. Compare Torrey & Zdanowicz, *supra* note 41 with *New York State's Assisted Outpatient Treatment (AOT) Program: Hearing on Kendra's Law Before the Assem. Standing Comm. on Mental Health, Mental Retardation and Dev. Disabilities and the Assem. Standing Comm. on Codes* (2005) <http://www.nyclu.org/content/testimony-extending-kendras-law> (statement of Beth Haroules, N.Y. Civil Liberties Union) [hereinafter NYCLU Testimony].

47. NYCLU Testimony, *supra* note 46, at 3.

48. N.Y. Assem., *Voting Record: S. 5762A*, Aug. 5, 1999; N.Y. Senate, *Voting Record: S. 5762A*, Aug. 5, 1999.

49. See LIBOUS, *supra* note 1, at 2.

50. *Id.* at 1.

51. NYCLU Testimony, *supra* note 46; see *Hearing on New York State's Assisted Outpatient Treatment (AOT) Program: Testimony of Ron Honberg, Legal Director, Nat'l Alliance for the Mentally Ill* (April 21, 2005) [hereinafter Honberg Testimony].

groups continued to highlight the restrictive nature of the program and potential biases that exist in its implementation.⁵² Other groups, such as the New York Association of Psychiatric Rehabilitation Services (NYAPRS), were on the fence about the program.⁵³ The legislation ultimately passed the Legislature and Kendra's Law was extended until June 2010.⁵⁴ A study to assess the success of the AOT program was commissioned as part of the 2005 extension.⁵⁵

In 2010, both houses of the New York State Legislature introduced legislation to extend Kendra's Law.⁵⁶ The Assembly Bill proposed to make Kendra's Law permanent while the Senate Bill proposed to simply extend the Law until 2010.⁵⁷ More than ever, advocates on either side of the issue expressed their concerns.⁵⁸ During a 2010 public hearing, representatives from

52. NYCLU Testimony, *supra* note 46; see Honberg Testimony, *supra* note 51.

53. See Press Release, Harvey Rosenthal, N.Y. Ass'n of Psychiatric Rehab. Serv., *The Truth About Kendra's Law: Let's Make Policy Based on Facts Not, Fear*, Feb. 8, 2006, available at <http://www.nyaprs.org/e-news-bulletins/2006/2006-02-08-5204.cfm>.

54. Laws of New York 2005 Chapter 158.

55. MARVIN S. SWARTZ ET AL., NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION V (2009) [hereinafter SWARTZ] http://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/report.pdf.

56. S. B. A10421, 2009 Gen. Assemb., Reg. Sess. (N.Y. 2010); S. B. S7254-2009, 2009 Gen. Assemb., Reg. Sess. (N.Y. 2010) <http://open.nysenate.gov/legislation/bill/S7254-2009>.

57. S. B. S7254-2009, 2009 Gen. Assemb., Reg. Sess. (N.Y. 2010) <http://open.nysenate.gov/legislation/bill/S7254-2009>.

58. After the issue of reenacting Kendra's law resurfaced in early 2010 editorial flooded New York media outlets. The majority of these articles were in support of extending the program. Public opinion articles often demonstrate feelings of animosity toward this segment of the population. These articles often refer to Kendra's Law subjects using terms with negative connotations such as "dangerously disturbed individuals" who are "unable to control their bodies." Opinion columnists praise the program as a "landmark statute" that "empowers judges to compel" these individuals to take medication. Notably, the coercive nature of Kendra's law is not unrecognized in these publications; opinion articles often referred to the program's coercive nature but rely on the apparent success of the program as justification for such coercion. See *Guest View: Kendra's Law Helps Law the Ill and Society*, THE TROY REC., March 6, 2010 at 1 (stating "state Legislature must reauthorize and strengthen Kendra's

NYARPS testified before the New York State Legislative Joint Fiscal Committees and called on the legislature to reject certain aspects of Kendra's law.⁵⁹ Rather than supporting aspects of the program, as they had in 2005, the group took a stance against the program.⁶⁰ The group called the report that was commissioned by the Legislature in 2005 a failure, because it did not require the efficacy of Kendra's Law to be compared with other programs designed to help the same population.⁶¹ NYAPRS asked the Legislature to, at a minimum, not make the law permanent.

Despite continued controversy about the need for, and efficacy of Kendra's Law, the Legislature extended the law for an additional five-year period in June 2010.⁶² After unanimously passing the New York Senate, the Senate Majority Press released a statement touting AOT as "an important mental health and public protection program."⁶³ In discussing the previous success of the AOT program New York lawmakers stated that "the Law needed to be extended because it clearly improves a range of important outcomes for its recipients, apparently without negative consequences to recipients."⁶⁴ Notably, the decisions of many lawmakers were based largely in part on the results of the

Law, a landmark statute that empowers judges to compel dangerously disturbed individuals to take medications."); *Renew Kendra's Law: Measure Protects Both the Public and the Mentally Ill*, NY DAILY NEWS, Feb. 28, 2010 at 1 (calling on the legislature to renew the law in order to provide "effective protection against violent attacks by the mentally ill, and the deeply troubled who need proper treatment to prevent them from bloodily losing control." Also, referring to the law as a landmark statute that empowers judges.).

59. Harvey Rosenthal, *NYAPRS Provides Testimony to Legislative Fiscal Committees*, NYAPRS, Feb. 3, 2010 at 1, http://www.nyaprs.org/Pages/View_ENews.cfm?ENewsID=8436.

60. Harvey Rosenthal, *Urge Albany to Reject Proposals to Expand Kendra's Law*, NYAPRS, June 14, 2011 at 1, <http://www.nyaprs.org/e-news-bulletins/2011/2011-06-14-Urge-Albany-to-Reject-Proposals-to-Expand-Kendras-Law.cfm>.

61. Rosenthal, *supra* note 59 ("The Legislature failed to provide the required comparisons with more active, accountable, responsive and well coordinated efforts by providers on a voluntary basis.").

62. N.Y. STATE SENATE MAJORITY PRESS, *Kendra's Law Passes Senate*, June, 18 2010 at 1, <http://www.nysenate.gov/press-release/kendra-s-law-passes-senate>.

63. *Id.*

64. *Id.*

independent study that was commissioned in 2005.⁶⁵ This study will be detailed below.

Although the Kendra's Law has repeatedly been extended by New York lawmakers, it has been subject to challenge in New York courts on numerous occasions throughout the time in which it has been in effect. Thus far, the courts have repeatedly upheld the Law's validity. In order to understand the disposition of these cases, it is important to first understand how Kendra's Law operates.

C. Details of New York's Current AOT Statute

Kendra's Law is codified in New York's Mental Hygiene Law, which outlines the programs requirements.⁶⁶ This section of the law begins by setting forth the procedure for identifying AOT candidates.⁶⁷ Next, the mechanisms used to determine whether AOT is necessary and the requirements for designing a treatment plan are described.⁶⁸ Finally, the law describes the consequences of noncompliance with an AOT order.⁶⁹ Overall, the process involves the participation of several individuals and entities, including local governments, community directors, patients, physicians, social workers, and the court system.

The law broadly defines AOT "as categories of outpatient services which have been ordered by the court."⁷⁰ An individual that is required to partake in an AOT program is referred to as a "subject of the petition," or simply a "subject."⁷¹ In order to initiate the process, a petition must be filed in the supreme court or

65. *Id.* ("Studies have shown that people receiving treatment under Kendra's Law are less likely to need hospitalization, to become homeless and to do harm to themselves or others."); *see also* Felix Ortiz, *Ortiz Applauds the Assembly Passage of Kendra's Law Extension*, June 3, 2010, <http://assembly.state.ny.us/mem/Felix-Ortiz/story/38552/> (stating, "In 2009 the independent study by Duke University, the Macarthur Foundation and PRA was released and concluded that New York State's AOT program had improved outcomes for its recipients, apparently without negative consequences.").

66. *See* N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2010).

67. N.Y. MENTAL HYG. LAW § 9.60(a).

68. N.Y. MENTAL HYG. LAW § 9.60(b)-(m).

69. N.Y. MENTAL HYG. LAW § 9.60(n); AN EXPLANATION OF KENDRA'S LAW, *supra* note 5.

70. N.Y. MENTAL HYG. LAW § 9.60(a)(1).

71. N.Y. MENTAL HYG. LAW § 9.60(a)(6).

county court where the subject is believed to be present.⁷² The law limits the people who can file a petition to certain parties based on the relationship they have with the patient.⁷³ Individuals who are authorized to file a petition include the following:

[A]ny person eighteen years of age or older with whom the subject of the petition resides; or the parent, spouse, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or the director of a hospital in which the subject of the petition is hospitalized; or the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition or in whose institution the subject of the petition resides; or a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; or a psychologist, licensed pursuant to article one hundred fifty-three of the education law, or a social worker, licensed pursuant to article one hundred fifty-four of the education law, who is treating the subject of the petition for a mental illness; or the director of community services, or his or her designee, or the social services official, as defined in the social services law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or a parole officer or probation officer assigned to supervise the subject of the petition.⁷⁴

The petition must state the facts demonstrating the subject's need for AOT and must be accompanied by an affidavit of a physician stating that he or she suspects that the individual is in need of AOT but has been unable to evaluate the subject, or that he or she has examined the subject and recommends AOT.⁷⁵

72. N.Y. MENTAL HYG. LAW § 9.60(e).

73. *Id.*

74. *Id.*

75. N.Y. MENTAL HYG. LAW § 9.60(h).

A hearing is held within three days of the court receiving the petition.⁷⁶ If the subject is not present at the hearing despite efforts to elicit the attendance, the court may conduct the proceeding in his or her absence.⁷⁷ In order to mandate AOT on a subject, seven criteria must be proven by clear and convincing evidence.⁷⁸ First, the individual must be at least 18 years old.⁷⁹ He or she must be suffering from a mental illness and be “unlikely to survive safely in the community without supervision.”⁸⁰ Next, the individual must be identified as one who has a history of failing to comply with prior mental health treatments; the law does not define factors that constitute noncompliance.⁸¹ The noncompliance must have resulted in one of two additional circumstances: (1) he or she must have been hospitalized or received services in a mental health unit of a correctional facility at least twice within the previous three years; or (2) he or she must have committed one or more serious violent behaviors toward themselves or others, or attempts at committing serious physical harm to themselves or others within the previous 48 months, excluding incidents that occurred while they were hospitalized or incarcerated.⁸² The law does not clarify what behaviors are considered to be violent.⁸³ The individual must also be identified as one who is unlikely to voluntarily participate in an outpatient treatment program.⁸⁴ Additionally, the individual must be classified as one who is in need of AOT because he poses a threat to cause serious harm to himself or others.⁸⁵ Finally, it must be likely that the individual will benefit from AOT.⁸⁶

Subjects of petitions are offered the right to counsel at all stages of the proceeding.⁸⁷ Furthermore, the physician who examined the subject and recommended AOT must testify at the

76. *Id.*

77. *Id.*

78. N.Y. MENTAL HYG. LAW § 9.60(c).

79. N.Y. MENTAL HYG. LAW § 9.60(c)(1).

80. N.Y. MENTAL HYG. LAW § 9.60(c)(3).

81. N.Y. MENTAL HYG. LAW § 9.60(c)(4).

82. N.Y. MENTAL HYG. LAW § 9.60(c)(4)(i)-(ii).

83. *See generally* N.Y. MENTAL HYG. LAW § 9.60(h).

84. N.Y. MENTAL HYG. LAW § 9.60(c)(5).

85. N.Y. MENTAL HYG. LAW § 9.60(c)(6).

86. N.Y. MENTAL HYG. LAW § 9.60(c)(7).

87. N.Y. MENTAL HYG. LAW § 9.60(g).

hearing.⁸⁸ If the subject of the petition refuses to be examined by the physician, the court may order peace officers or police officers to take the subject into custody and bring him or her to a hospital for evaluation.⁸⁹ In this case, the individual may not be held for more than 24 hours.⁹⁰ The physician's testimony must include any recommendations for medications that are to be included in the treatment plan, as well as information about the benefits and risks of those medications, and how those medications will be administered.⁹¹ Finally, the physician must testify that AOT is the least restrictive alternative for the patient.⁹²

An additional criterion for ordering AOT is the creation of a written treatment plan.⁹³ This plan must be provided to the court, and it must set forth subject's individual treatment plan detailing the services that will be provided.⁹⁴ Services that must be provided in all plans include case management and coordinated care from a community treatment team.⁹⁵ Optional services that may be part of a treatment plan include any services relevant to prevent a relapse in harmful behavior or further deterioration.⁹⁶ Examples of services include: access to medication as well as accompanying periodic blood tests or urinalysis to determine compliance with prescribed medication; therapy; day programming activities; educational and vocational training; alcohol or substance abuse treatment; and supervised living arrangements.⁹⁷ The patient, patient's physician, and various other parties are authorized to participate in the development of a treatment plan.⁹⁸ Treatment plans are effective for a six-month period and a petition to extend

88. N.Y. MENTAL HYG. LAW § 9.60(h)(3).

89. N.Y. MENTAL HYG. LAW § 9.60(h)(3).

90. *Id.*

91. N.Y. MENTAL HYG. LAW § 9.60(h)(4).

92. *Id.*

93. N.Y. MENTAL HYG. LAW § 9.60(i).

94. N.Y. MENTAL HYG. LAW § 9.60(i).

95. N.Y. MENTAL HYG. LAW § 9.60(a)(1).

96. *Id.*

97. *Id.*

98. See OFFICE OF COUNSEL, N.Y. STATE OFFICE OF MENTAL HEALTH, SUMMARY—AN EXPLANATION OF KENDRA'S LAW (2000), <http://bi.omh.ny.gov/aot/about?p=kendras-law>.

an individual plan may be filed within 30 days prior to its expiration date.⁹⁹

The law also sets forth procedures that must be followed if an AOT patient does not comply with the treatment plan.¹⁰⁰ In the event of noncompliance, an AOT patient may be removed from the community to determine if involuntary hospitalization is necessary as a result of his failure to comply with the order or refusal to take a blood test, urinalysis, or alcohol or drug test.¹⁰¹ The patient can be retained in a hospital for 72 hours in order for a physician to determine whether involuntary hospitalization is needed.¹⁰²

D. Drug Requirements in Kendra's Law Court Orders

If medications are included as part of the AOT plan, Kendra's Law specifically authorizes the court to order the patient to self-administer psychotropic drugs or accept administration of drugs by authorized personnel.¹⁰³ Furthermore, urine and blood screening are often included as part of the treatment plan to ensure that AOT patients are taking the prescribed drugs.¹⁰⁴ Psychotropic medications, by nature, are often unpredictable and sometimes produce severe side effects as a result of specific drugs varying in their effect depending on the recipient; finding a specific treatment is achieved through trial and error.¹⁰⁵ Recognizing the potential side effects of these medications is necessary to understanding the controversy that surrounds Kendra's Law.

The side effects of medications used to treat mental illness, such as Schizophrenia, range in severity from mild to severe and

99. N.Y. MENTAL HYG.LAW § 9.60(j)(2) (McKinney 2010); N.Y. MENTAL HYG. LAW § 9.60(k).

100. N.Y. MENTAL HYG. LAW § 9.60(n).

101. *Id.*

102. *Id.*

103. N.Y. MENTAL HYG. LAW § 9.60(j)(4).

104. N.Y. MENTAL HYG. LAW §9.60(n).

105. Erin Talati, *When a Spoonful of Sugar Doesn't Help the Medicine Go Down: Informed Consent, Mental Illness, and Moral Agency*, 6 IND. HEALTH L. REV. 171, 186 (2009); William M. Brooks, *Reevaluating Substantive Due Process as a Source for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 946 (1991) (explaining that physicians must treat mentally ill patients on a trial and error basis in order to determine how the patient will respond to a particular antipsychotic drug).

manifest in a variety of ways.¹⁰⁶ Side effects can be categorized based on whether the effects relate to the individual's cognitive function or physical condition.¹⁰⁷ Because there is no accurate method of predicting how a patient will react to the treatment, it is important to understand the potential side effects that frequently coincide with the treatment of mental illness.¹⁰⁸

Though the primary purpose of psychotropic medication is to impact a patient's mental state, these drugs often impact the patient's mental state in non-intended ways. In some patients, the drugs act as sedatives and cause mild to severe drowsiness.¹⁰⁹ Drowsiness may be distressing to patients because it prevents them from feeling wide-awake and interferes with the ability to think clearly.¹¹⁰ In contrast to drowsiness, some patients experience the opposite effect; rather than feeling drowsy, these patients feel wide-awake and overactive.¹¹¹ Often, these symptoms manifest as a constant desire to keep moving and an inability to feel comfortable in any position. Other mental side effects include depression, agitation, reduced sex drive, hallucinations, and blackouts.¹¹²

Side effects may also impact a patient's physical functions. Such side effects may render an individual unable to sit still, or may cause him or her to suffer from uncontrollable parkinsonian symptoms, such as rigidity, a mask like face, tremors, drooling, and hand motions.¹¹³ These side effects can be treated with additional medications, which can have side effects of their own.¹¹⁴ Other physical side effects include non-muscular conditions, such as blurred vision, dry mouth, weight gain, dizziness, fainting, low

106. See *Davis v. Hubbard*, 506 F.Supp. 915, 928–29 (1980); Healthy Place Staff Writer, *Side Effects of the Medications Used to Treat Schizophrenia*, Healthy Places (Feb. 10, 2009), <http://www.healthyplace.com/thought-disorders/schizophrenia-treatment/side-effects-of-the-medications-used-to-treat-schizophrenia/>; National Institute of Mental Health, *Mental Health Medications*, NATIONAL INSTITUTES OF HEALTH 1, 2 (2008) [hereinafter NIH REPORT].

107. See generally NIH REPORT, *supra* note 106.

108. Talati, *supra* note 105, at 186.

109. NIH REPORT, *supra* note 106, at 2, 4; Healthy Place, *supra* note 106.

110. NIH REPORT, *supra* note 106; Healthy Place, *supra* note 106.

111. Talati, *supra* note 105, at 186, 187.

112. NIH REPORT, *supra* note 106, at 2, 4, 8.

113. Talati, *supra* note 105, at 187; Brooks, *supra* note 105, at 948.

114. *Davis v. Hubbard*, 506 F.Supp. 915, 928 (1980).

blood pressure, rash and skin discoloration, and even sudden death.¹¹⁵

Certain side effects may also be permanent.¹¹⁶ One permanent condition that is caused by psychotropic medications is a condition called tardive dyskinesia.¹¹⁷ This disease causes involuntary muscle movements, commonly appearing as lip smacking, facial contortions, chewing, and uncontrollable movements of the hands, fingers, legs and pelvic area.¹¹⁸ As this condition progresses, it interferes with motor activities and may result in incomprehensible speech, and difficulty breathing and swallowing.¹¹⁹ This condition is not rare and commonly occurs in individuals with Schizophrenia who are chronically medicated.¹²⁰

As psychotropic drugs may be included as part of an AOT plan, recognizing the potential side effects of these drugs is important to understanding controversial aspects of Kendra's Law.¹²¹ Opponents of the law advance several criticisms in arguing that it is unnecessary.

E. Criticisms of Kendra's Law

Two of the main criticisms of Kendra's Law involve its constitutionality and the manner in which it has been implemented.¹²² One argument criticizes the law because it abridges an individual's fundamental right of autonomy.¹²³ NYARPS lobbying efforts in 2005 provide an overview of the concern.

In 2005, NYAPRS lobbied the legislature to reform Kendra's Law in order to better protect Kendra's Law subjects

115. Talati, *supra* note 105, at 187; NIH REPORT, *supra* note 102, at 13.

116. See Peter Breggin, *Brain Damage, Dementia and Persistent Cognitive Dysfunction Associated with Neuroleptic Drugs: Evidence, Etiology, Implications*, 11 J. MIND AND BEHAVIOR 425 (1990).

117. NIH REPORT, *supra* note 106, at 3.

118. Talati, *supra* note 105, at 188.

119. *Id.* at 189.

120. *Id.* at 188 n. 72.

121. N.Y. MENTAL HYG. LAW § 9.60(j)(4) (McKinney 2010).

122. See *State Lawmakers Extend "Kendra's Law" For 5 Years, Despite Concerns That It Targets Men Of Color*, N.Y. Civil Liberties Union, (June 23, 2005), <http://www.nyclu.org/news/state-lawmakers-extend-kendras-law-5-years-despite-concerns-it-targets-men-of-color> [hereinafter NYCLU Press Release]; see also NYCLU Testimony, *supra* note 46; see also NYLPI, *supra* note 14.

123. See NYCLU Testimony, *supra* note 46.

from unwanted treatment.¹²⁴ NYAPRS strongly opposed the aspects of Kendra's Law that mandated outpatient treatment.¹²⁵ Specifically, the group argued that court-ordered outpatient treatment undermined the efforts of the psychiatric rehabilitation community by incorrectly characterizing the mentally ill as dangerous or too sick to recognize their need for help.¹²⁶ It warned that certain instances of Kendra's Law court orders were used against patients who were not dangerous, but were merely unable to access the services necessary to treat their mental health conditions.¹²⁷

The group also expressed concern that the coercive nature of the law undermines its efficacy by promoting insensitivity toward the mentally ill.¹²⁸ Additionally, they argued that the effect of coercion is to perpetuate a sense of hopelessness and dehumanize those who are forced to undergo treatment against their will.¹²⁹ Furthermore, it stated that the program relies too heavily on the use of medications that result in severe side effects and risks to safety.¹³⁰

NYAPRS argued that one way to address the problems associated with mentally ill individuals who engage in violent behaviors is to provide better access to housing services and non-coercive rehabilitation and treatment programs.¹³¹ Additionally, the group argued that an effective way to handle the problems associated with this population is to increase family involvement in

124. Memorandum from Ray Schwartz and Vuka Stricveic, Public Policy Co-Chairs, and Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services, to NYAPRS Members and Friends (January 21, 2005), <http://www.nyaprs.org/e-news-bulletins/2005/2005-01-21-4101.cfm>. (calling on the legislature to “continue the segments of Kendra’s Law that promote more accountability and service delivery and to reject the provisions that authorize discriminatory forced outpatient treatment.”).

125. *Id.*

126. *Id.*

127. *Id.* (“Increasingly, the use of court orders is not for patients who are dangerous but to afford people in need priority access to scarce services.”).

128. *Id.*

129. *Id.*

130. *Id.* (characterizing the program using prescribing practices that load patients with too many medications in ways that result in severe side effects, medical complications and risks to one’s safety).

131. *Id.*

the medical decision making process.¹³² Accordingly, NYARPS advocated for education programs designed to help families of individuals with mental illnesses better manage difficult behaviors and minimize episodes of instability.¹³³ Rather than mandating specific treatments, the group advocated for expanding the range of services available to this group, increasing access to housing and community services, improving jail diversion services, and expanding access to medications for prisoners suffering from mental illnesses upon their release.¹³⁴ In light of NYAPRS's criticisms, the Legislature commissioned an independent study to examine the effectiveness of the program by June of 2009; the results of this study are detailed in Part 6 of this article.¹³⁵

III. THE RIGHT TO REFUSE MEDICAL TREATMENT

NYAPRS's concerns demonstrate one of the most controversial aspects of Kendra's Law, which is that it arguably requires individuals to undergo medical treatment regardless of their wishes.¹³⁶ Indeed, critics argue that the law violates an individual's right to direct his or her own medical treatment, which has been held to be a fundamental right in American jurisprudence.¹³⁷ This section will provide a description of the framework used to determine whether a decision is made in an autonomous manner, as well as an analysis of court decisions that have relied on this framework to establish the ability to control one's medical treatment as a fundamental liberty interest, and the limits that may be imposed on that interest.

132. *Id.*

133. *Id.*

134. *Id.*

135. LIBOUS, *supra* note 1, at 4; MARVIN S. SWARTZ ET AL., DUKE UNIV. SCH. OF MED., NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION (2009), http://www.macarthur.virginia.edu/aot_finalreport.pdf.

136. *Legislative Memo: Kendra's Law Bills to Curtail Individual Liberty Unconstitutional*, www.nyclu.org/content/legislative-memo-kendras-law-bills-curtail-individual-liberty-unconstitutional (last visited March 24, 2012) [hereinafter NYCLU Memo].

137. *See e.g.*, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *Bouvia v. Superior Court*, 179 Cal.App.3d 1127 (Cal. Sup. Ct. 1986); *Pub. Health Trust of Dade County v. Wons*, 541 So.2d 96 (Fla. 1989).

A. The Ability to Direct One's Medical Treatment

Broadly speaking, autonomy refers to an individual's rights over his or her own body.¹³⁸ From a constitutional perspective, autonomy is a negative right; meaning a right to be left alone without interference from others.¹³⁹ In contrast to negative rights, positive rights imply that an individual is guaranteed the ability to both act autonomously and access the means necessary to fulfill his or her wishes.¹⁴⁰ In the realm of medical treatment, the precedents dealing with individual autonomy have focused on a patient's negative right to be left alone without government interference.¹⁴¹ This right is taken "so seriously that professionals who act against their patients' wishes, even to save their patients' lives, are condemned as morally blameworthy and leave themselves open to charges of battery."¹⁴² From a medical ethics perspective, a four-part test is used to determine whether a medical decision is made autonomously.¹⁴³ This test is designed to ensure that the patient's autonomous choice is respected.

In case law, the ability of a competent adult to act autonomously and direct his or her medical treatment has been established based on the fundamental right of privacy.¹⁴⁴ Based on this right, courts have consistently held that individuals have a fundamental liberty interest in refusing medical treatment.¹⁴⁵ This liberty interest is rooted in the principle of respect for autonomy and the right of self-determination.¹⁴⁶ In case law, the autonomy liberty interest has consistently been interpreted as offering

138. JUDITH ANDRE, *BIOETHICS AS PRACTICE* 50 (2002).

139. ROBERT M. VEATCH, *THE BASICS OF BIOETHICS* 73 (2003).

140. *Id.*

141. *See* *Roe v. Wade*, 410 U.S. 113 (1973); *see also* *Maher v. Roe*, 432 U.S. 454 (1977); *Harris v. McRae*, 448 U.S. 917 (1980) (clarifying the holdings of earlier abortion decisions to recognize abortion as a negative right to be left alone from government to determine whether to have an abortion rather than a positive right to obtain assistance and access to abortion services).

142. *See* THOMAS A. MAPPES & DAVID DEGRAZIA, *BIOMEDICAL ETHICS* 49 (6th ed. 2006).

143. *See id.*

144. *See* *Rochin v. California*, 342 U.S. 165, 172–74 (1952) (holding that an individual's substantive due process rights were violated when he was forced to have his stomach pumped).

145. *See* *Washington v. Glucksberg*, 521 U.S. 702 (1997).

146. MAPPES & DEGRAZIA, *supra* note 142, at 49.

patients the option to refuse medical intervention.¹⁴⁷ Therefore, when a patient's autonomous decision to accept or reject medical intervention is ignored, his or her liberty interest may be violated. This type of state action is not categorically prohibited and courts have placed restrictions on how far the liberty interest extends.¹⁴⁸ One way that patient autonomy may be overridden is through a determination that the patient is incapable of making decisions on his or her own. Certain state interests may also outweigh the autonomy interest to allow for forced medical treatment.

1. A Framework for Autonomy

From an ethical perspective, an act is said to be autonomous if four conditions are met. The act must be intentional, based on a competent choice, sufficiently free from external constraints, and sufficiently free from internal constraints.¹⁴⁹ Assessing whether an act is autonomous is necessary to determine whether a patient's informed consent has been received.¹⁵⁰ Therefore, the following detailed discussion of autonomous decision making criteria and related case law is necessary to provide a foundation for the arguments that are presented in later sections.

The first criterion, intentionality, requires the patient's decision to be made for a specific purpose.¹⁵¹ If, for example, a patient is asked to sign a form that he believes is for the purpose of releasing his medical records when in fact the form is meant to obtain the patient's consent to participate in a study, his act is not intentional.

The next criterion, competent choice, requires the patient's decision to be based on sufficient understanding.¹⁵² Insufficient understanding may result when a patient lacks the mental

147. *Cruzan*, 497 U.S. at 261; *Bouvia*, 179 Cal.App.3d at 1127; *Wons*, 541 So.2d at 96.

148. *See* *Abigail Alliance v. Eschenbach*, 445 F.3d 470 (D.C. Cir. 2006) (holding that the fundamental right of autonomy does not extend to demanding certain medical treatments).

149. *See* *MAPPES & DEGRAZIA*, *supra* note 142, at 41.

150. *Id.* at 42.

151. *Id.* at 41.

152. *Id.* at 42.

capacity¹⁵³ to make an autonomous decision.¹⁵⁴ The ability to make a competent choice depends on the specific choice in question; competency is task-specific and the determination of an individual's competency varies from context to context based the particular task.¹⁵⁵ An individual may be competent to make one decision, but incompetent to make another.¹⁵⁶ Furthermore, an individual may be competent to decide something at one point and incompetent to make that same decision at another point.¹⁵⁷ In regard to medical treatment related decisions, a patient's competence to make a decision is measured by his or her capacity to "understand the material information, make a judgment about the information in light of his or her values, and to freely communicate his or her wishes to caregivers."¹⁵⁸ A patient is not required to have a complete understanding of all of the consequences of a particular decision, but he or she must have a substantial grasp of the central facts related to that decision.¹⁵⁹ Typically, physicians must provide information related to "diagnoses, prognoses, the nature and purpose of the intervention, alternatives, risks and benefits, and recommendations" to ensure that a patient has all the relevant facts to make a decision.¹⁶⁰ Many conditions, such as depression, may undermine an individual's

153. There is a host of literature that attempts to differentiate between mental capacity and mental competency, for the purposes of this article, however, the two terms will be used interchangeably to refer to a patient's ability to sufficiently understand the consequences of his or her actions in determining what course of medical interventions to pursue.

154. See MAPPES & DEGRAZIA, *supra* note 142, at 42.

155. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 134 (4TH ED. 1994).

156. In contrast to task-specific competence, certain classes of individuals are assumed to lack all decision making capacity. Children are a clear example of a class of individuals who are generally said to globally lack the mental capacity to make any autonomous decision. It is typically assumed that children do not have the mental capacity to develop a sufficient understanding of the options involved in medical decision making. In part because they lack such capacity, guardians serve as surrogate decision makers and are supposed to make decisions based on the child's best interest. See MAPPES & DEGRAZIA, *supra* note 142, at 42.

157. BEAUCHAMP & CHILDRESS, *supra* note 155, at 134.

158. *Id.* at 135.

159. *Id.* at 157.

160. *Id.*

ability to process this information and develop a sufficient understanding to make a medical decision.¹⁶¹ Decisions made in the existence of such interferences are not autonomous because the patient is unable to sufficiently understand the information and cannot, therefore, make a competent decision.

An autonomous decision is only made when the decision is sufficiently free from external constraints.¹⁶² External constraints may prevent an individual from making autonomous decisions by creating barriers that deliberately influence that person's decision or coerce that person into acting in a specific manner.¹⁶³ Many laws, such as speed limits, are good examples of external constraints. Drivers are constrained by posted speed limits on the roads that they travel. If a driver attempts to violate a speed limit, he or she may be coerced by law enforcement officials to maintain proper speed limits. The purpose of this coercion is to direct the driver's behavior to prevent him or her from doing something that he or she would otherwise be willing to do. The driver is "harmed" because he is unable to do what he wants to do. This type of coercion, which involves the threat of harm, is known as dispositional coercion.¹⁶⁴ "Whether coercion occurs depends on the subjective responses of the intended target of the coercion."¹⁶⁵ Coercion only occurs when an individual complies with the coercer's directions as a result of a real, credible, and intended threat.¹⁶⁶

In the medical setting, the use of coercion renders a patient's behavior nonautonomous, even if the behavior is intentional and well-informed.¹⁶⁷ For example, a patient's autonomy is voided if his or her decision to undergo surgery is based on threats by his physician to submit to the treatment. In healthcare, the use of coercion through punishment and threat is almost always unjustified.¹⁶⁸ There are, however, instances when a physician's use of coercion is ethically justified. "If [for example,] a physician responsible for a disruptive and childish

161. *Id.* at 42.

162. *Id.*

163. *Id.*

164. *Id.* at 43.

165. BEAUCHAMP & CHILDRESS, *supra* note 155, at 164.

166. *Id.*

167. *Id.*

168. *Id.* at 166.

noncompliant patient threatens to discontinue treatment unless the patient alters certain behaviors, the physician's mandate may be justified even though coercive."¹⁶⁹

The final criterion for making an autonomous decision is that the decision is free from internal constraints. Unlike external constraints, internal constraints do not involve physical barriers or coercion to influence decision making. Internal constraints exist when an individual's cognitive abilities are jeopardized by underlying mental conditions.¹⁷⁰ A person who is under the influence of a hallucinogenic drug, for example, may be unable to make an autonomous decision because of the effect of the drug. In this situation, the drug serves as an internal constraint that may undermine the individual's mental clarity. Similarly, an individual who suffers from a mental illness such as Schizophrenia may be unable to act autonomously because of the impact of the illness.¹⁷¹ If an individual with Schizophrenia acts in a specific way because he hears voices directing him to act that way, the voices are internal constraints that control his behavior.¹⁷² Furthermore, such an illness may prevent the individual from truly understanding the nature and consequences of making medical decisions.¹⁷³

2. Judicial Precedents Establishing the Fundamental Liberty Interest to Reject Treatment

Based on the principle of autonomy, case law has recognized that competent individuals have a fundamental liberty interest in rejecting medical treatment.¹⁷⁴ This interest is protected

169. *Id.*

170. *Id.*

171. *See* MAPPES & DEGRAZIA, *supra* note 142, at 44.

172. *Id.*

173. *Id.*

174. *See* *Vacco v. Quill*, 521 U.S. 793 (1997) (stating, "Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving treatment."); *Nathanson v. Kline*, 186 Kan. 393 (Kan. 1960) (stating "Anglo-American law starts with a premise of a thorough-going self-determination. It follows that each man is considered the master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery or other medical treatment."); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. at 261 (1990); *Bouvia v. Superior Court*, 179 Cal.App.3d 1127 (Cal. Sup. Ct. 1986); *Public Health Trust of Dade County v. Wons*, 541 So.2d at 96 (Fla. 1989).

by several legal theories, including the common law torts of battery and negligence,¹⁷⁵ the federal constitutional right to decisional privacy based on the Fourteenth Amendment,¹⁷⁶ and state constitutional right to privacy based on state constitutions.¹⁷⁷

One way in which courts protect a patient's autonomy liberty interest is through the tort law theory of battery.¹⁷⁸ Based on this theory, before a physician can render medical services, he or she must obtain the patient's informed consent; otherwise, such services constitute battery. Patient autonomy is undermined in instances where informed consent is not obtained because the patient is not given adequate information to freely and voluntarily make his or her own decisions regarding choices that affect his or her person. In order for informed consent to be validly obtained, three components must exist.¹⁷⁹ First, the treating physician must inform the patient about his or her condition and the available treatment alternatives, as well as the risks and benefits of each alternative.¹⁸⁰ Next, the patient must make his or her choice voluntarily, which requires that the choice be free from outside coercion, manipulation, or undue influence.¹⁸¹ Finally, the patient must be competent to provide his or her consent.^{182, 183}

175. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (discussing a physician's duty to disclose certain risks of proposed treatments).

176. See *Bouvia*, 179 Cal.App.3d at 1127.

177. See *Rivers v. Katz*, 67 N.Y.2d 485 (N.Y. 1986).

178. See *Washington v. Glucksberg*, 521 U.S. 702, 703 (1997) (discussing the "common-law rule that forced medication [is] battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment).

179. RHODES ET AL., *THE BLACKWELL GUIDE TO MEDICAL ETHICS* 128 (2007).

180. *Id.*

181. *Id.*

182. *Id.*

183. Informed consent case law throughout the United States has explained what these components mean in practice. In regard to the first component's requirement that physicians explain the risks and benefits of treatment alternatives; for instance, courts have held that physicians are not required to explain all possible risks. Risks that are remote can be omitted, and whether a specific risk must be disclosed depends on the probability and severity of the risk. Doctors are generally required to disclose feasible treatment alternatives that are accepted in the medical community. Furthermore, courts have found that coerced medical treatment may constitute cruel and unusual punishment. See *Canterbury*, *supra* note 175 (explaining that the risk of a five

Another way that courts protect the autonomy liberty interest is premised on privacy rights that are guaranteed by the Fourteenth Amendment of the United States Constitution. In *Bouvia v. Superior Court*, the California Court of Appeals for the Second District recognized the competent patient's right to refuse medical intervention, even when such refusal would have adverse consequences.¹⁸⁴ Here, a patient in a public hospital petitioned the court seeking an order for the removal of a feeding tube that was inserted against her will in order to keep her alive through forced feeding.¹⁸⁵ Based on earlier precedents establishing that "a person of adult years and in sound mind has the right, in the exercise of control over his body, to determine whether or not to submit to lawful medical treatment,"¹⁸⁶ the court held that such a patient has the right to refuse any medical treatment, even life-saving interventions.¹⁸⁷ The court weighed the patient's interest in personal dignity against several state interests, ultimately finding the patient's interest to outweigh the state's interests in preserving life, preventing suicide, protecting innocent third parties, and maintaining the ethical standards of the medical profession.¹⁸⁸ The court concluded that personal dignity is part of one's constitutionally guaranteed right of privacy.¹⁸⁹ Personal dignity is jeopardized when a patient's autonomous decision is not followed.

percent chance of lengthened recuperation does not need to be disclosed, but a one percent risk of paralysis must be); *see also* *Hartke v. McKelway*, 707 F.2d 1544, 1549 (D.C. Cir. 1983) (requiring a doctor to disclose a .1% risk of subsequent pregnancy following a medical procedure intended to prevent pregnancy); *Martin v. Richards*, 192 Wis.2d 156 (1995); *Logan v. Greenwich Hospital Association*, 191 Conn. 282 (1983) (requiring disclosure of alternatives that may more hazardous to the patient than the proposed treatment); *Mackey v. Procnier*, 477 F.2d 877, 878 (9th Cir. 1973) (recognizing a possible Eighth Amendment claim where a prisoner was administered a drug without consent); *Knecht v. Gillman*, 488 F.2d 1136, 1139-40 (8th Cir. 1973) (finding unconsented administration of a drug to induce vomiting constituted cruel and unusual punishment).

184. *Bouvia v. Superior Court*, 179 Cal.App.3d 1127 (1986).

185. *Id.*

186. *Id.* at 1137 quoting *Cobbs v. Grant*, 8 Cal.3d 229, 242 (1972).

187. *Id.* at 1137.

188. *Id.* at 1142.

189. *Id.* at 1145. The right to refuse medical intervention is so entrenched in American law that it has been held that individuals may refuse treatment even if doing so will result in harm to that individual, or even result in his or her

In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court recognized the principle announced in *Bouvia* that competent patients have a liberty interest in refusing medical treatment based on the federal Constitution's protection of privacy rights.¹⁹⁰ At the same time, the Court rejected the contention that incompetent patients have the same interest.¹⁹¹ The Court made a distinction between competent and incompetent patients because incompetent patients are unable to give informed consent.¹⁹² The Court held that in situations where an incompetent patient seeks to refuse medical intervention, statutes may allow a third party to act as a surrogate decision maker.¹⁹³ Moreover, states may limit the authority of a surrogate decision maker by requiring evidence of the patient's wishes regarding the removal of life sustaining treatment.¹⁹⁴

Outside the realm of life sustaining treatment cases, the Supreme Court has protected a patient's liberty interest by preventing the state from administering medications over his or her consent.¹⁹⁵ In *Riggins v. Nevada*, the Court rejected the contention that a state may administer antipsychotic drugs during the course of a defendant's trial over his or her objection without the existence of certain conditions.¹⁹⁶ Specifically, the Court stated that the state could not take such an action without first determining that there were no less intrusive alternatives, that the medication was medically appropriate, and that it was essential for the sake of the defendant's safety or the safety of others.¹⁹⁷ The Court did not announce a specific level of scrutiny to be applied

death. One of the clearest examples of this can be seen in the Jehovah's Witness community. According to Jehovah's Witness' beliefs, the Bible prohibits ingesting blood; this belief extends to the storage and receipt of blood for transfusion purposes. Courts have upheld the right of a competent adult Jehovah's Witness to refuse blood transfusions even when such refusal will result in bodily harm or even death. *See Public Health Trust of Dade County v. Wons*, 541 So.2d 96 (Fla. 1989).

190. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. at 261, 278 (1990).

191. *Cruzan*, 497 U.S. at 280.

192. *Id.*

193. *Id.*

194. *Id.* at 280.

195. *Riggins v. Nevada*, 504 U.S. 127 (1992).

196. *Id.* at 138.

197. *Id.*

when determining whether a state's forced administration of a drug is overridden by the patient's liberty interest. To the contrary, the Court specifically stated that it did not adopt a standard of strict scrutiny, or any other substantive standard, in its decision.¹⁹⁸ The Court found such a determination to be unnecessary because the lower court's decision failed to include any such analysis, therefore making such a determination outside the scope of the Supreme Court's review.¹⁹⁹ *Riggins* demonstrates that the liberty interest in refusing medical treatment is well recognized and protected.

An individual's interest in refusing medical intervention may also be protected through state constitutions. New York, for example, has specifically addressed the issue of a mentally ill individual's interest in refusing medical treatment when he or she is involuntarily confined.²⁰⁰ In *Rivers v. Katz*, the New York Court of Appeals recognized that individuals who suffer from mental illness have the same autonomous right to refuse medical treatment as those who do not suffer from mental illness.²⁰¹ In this case, involuntarily committed patients in a mental hospital brought an action to enjoin the nonconsensual administration of antipsychotic drugs.²⁰² Specifically, the patients in this case wanted the court to recognize their interest in refusing medical treatment and enjoin the state from administering antipsychotic drugs over their objections.²⁰³ The petitioners argued that the due process clause of the New York State Constitution affords involuntarily committed mental patients a fundamental right to refuse medication.²⁰⁴ In agreement with the petitioners' argument, the court held that mentally ill individuals have the right to refuse medical treatments, stating that adults of sound mind are able to determine what should be done with their body, so long as they do not lack capacity to refuse such treatments.²⁰⁵ While this case is discussed in more detail in the next section, it is important to recognize its holding here because it demonstrates how the liberty interest of a

198. *Id.* at 136.

199. *Id.* at 137.

200. *See Rivers v. Katz*, 67 N.Y.2d 485, 493 (N.Y. 1986).

201. *Id.* at 495.

202. *Id.*

203. *Id.* at 492.

204. *Id.*

205. *Id.*

competent individual to refuse medical treatment may be protected by state constitutions.

The liberty interest in directing medical treatment is well established in American case law. Courts have protected this interest based on several legal theories, demonstrating how important the interest is. The interest in refusing medical intervention is protected through tort law, as well as Federal and State Constitutions.

IV. JUDICIAL PRECEDENTS INTERPRETING THE SCOPE OF THE AUTONOMY LIBERTY INTEREST

The right to refuse medical treatment is not absolute. Although this liberty interest is strongly protected, several methods of overriding it may be invoked to restrict autonomy. Forced administration of medical intervention may be allowed if an individual is unable to act autonomously due to incapacity.²⁰⁶ In the case of incapacity, a state may rely on its *parens patriae* interest to administer medical treatment over an objection.²⁰⁷ Additionally, a state may override the autonomous decision of a capable individual in order to achieve certain state interests.²⁰⁸ To determine whether a patient's liberty interest may be overridden, courts weigh the patient's autonomy interest against the state's interest.²⁰⁹ Since the protected liberty interest is considered a fundamental interest, only a compelling state interest will override it.²¹⁰

A. Parens Patriae, Protecting the Patient's Wishes Based on Incapacity

Courts have authorized forced medical intervention when an individual is incompetent or incapable of making his or her own medical decisions. Through the doctrine of *parens patriae*, courts

206. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. at 261, 315 (1990).

207. See *id.*

208. See *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25 (1905).

209. See *id.*

210. *Glucksberg*, 521 U.S. at 721 (“[A]s we recently stated in *Flores*, the Fourteenth Amendment ‘forbids the government to infringe . . . fundamental liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.’”).

have compelled medical treatment on incompetent individuals.²¹¹ This doctrine allows the state to take measures to protect those who cannot protect themselves.²¹² In acting as *parens patriae*, the state does not deny any individual rights because the individual who is being forced to act in some way is so infirm that he or she cannot make particular medical treatment related decisions.²¹³ Therefore, courts have limited the use of this doctrine to instances in which the individual refusing medical intervention is found to be incapable of making medical decisions.²¹⁴ This is the method used to involuntarily commit people.

In *O'Connor v. Donaldson*, Justice Burger, in his concurrence, discussed the history of the *parens patriae* doctrine.²¹⁵ He stated that due process historically requires that patients be unable to act for themselves for the state to implement its *parens patriae* interest.²¹⁶ Furthermore, a state may only use *parens patriae* to mandate medical treatment when the incapacitated patient has previously expressed a desire for treatment.²¹⁷ Unlike other situations in which courts override the patient's liberty interest, *parens patriae* allows courts to protect an individual's autonomy by mandating medical treatment only where

211. See *O'Connor v. Donaldson*, 422 U.S. at 581 (1975) (Burger, C.J., concurring).

212. *Cruzan* 497 U.S. at 315. Here, the Supreme Court discussed the state's *parens patriae* interest in this case. The Court recognized that Missouri had a *parens patriae* interest in directing the patient's care if she was incompetent. The Court reasoned that the state's ultimate decision on how to proceed with the plaintiff's medical care was to determine how the plaintiff herself would want to proceed with such care.

213. See *O'Connor v. Donaldson*, 422 U.S. 563, 581 (1975); see also *In re Martin F.*, 820 N.Y.S.2d 759, 677, 772 (2006) (stating that the *parens patriae* power exists only where an individual is incompetent to make their own medical decisions, and in cases where that patient or his or her guardian objects, the state must determine whether the medication should be administered over the objection).

214. See *Cruzan*, 497 U.S. at 286 (ruling that Missouri could only remove the patient from life support if it was determined by clear and convincing evidence that this was the patient's desire).

215. *O'Connor v. Donaldson*, 422 U.S. at 583.

216. *Id.* (In his concurrence, Justice Burger states that the "States are vested with the historic *parens patriae* power, including the duty to protect 'persons under legal disabilities to act for themselves'").

217. *Id.*

there is evidence that the patient expressed a desire for that treatment when he or she had capacity.²¹⁸

In *Donaldson*, the Supreme Court determined that Donaldson, an involuntarily committed mental patient, was unjustly confined to a mental institution for fourteen years.²¹⁹ Donaldson was initially admitted after the state court determined him to be incompetent.²²⁰ Beyond this initial determination, however, he was never found to pose a threat to himself or others.²²¹ The Court determined that the original confinement, which was based on incapacity, was founded upon a constitutionally adequate basis; however, his continued confinement was not constitutional after this original basis ceased to exist.²²²

In his concurring opinion, Justice Burger discussed the importance of determining one's own medical treatment but stated that incompetents do not have the same ability because their decision-making capacity is undermined by the existence of some condition.²²³ As such, the court relied on the state's role as *parens patriae* to protect the incompetent who is unable to act for himself.²²⁴

In *Winters v. Miller*, the U.S. Court of Appeals for the Second Circuit held that the state's *parens patriae* powers could not be exercised to force treatment upon an involuntarily admitted mental patient without a judicial determination of incompetency.²²⁵ In that case, the plaintiff, who was involuntarily admitted to a hospital but never found to be incompetent, brought an action against the Commissioner of Mental Hygiene of the State of New York after she was repeatedly administered medical treatment over her objection.²²⁶ The plaintiff's refusal was based on her beliefs as a Christian Scientist.²²⁷ The state argued that it assumes the ultimate responsibility for care of its citizens in regard to mental

218. *Id.*

219. *Id.* at 564.

220. *Id.* at 565.

221. *Id.* at 576–57.

222. *Id.*

223. *Id.* at 583.

224. *Id.*

225. *Winters v. Miller*, 446 F.2d 65, 71 (2d Cir. 1971).

226. *Id.* at 68.

227. *Id.*

health, and that it must act in *parens patriae* concerning mentally incompetent individuals.²²⁸ The court rejected this argument, stating:

While it may be true that the state could validly undertake to treat Miss Winters if it did stand in a *parens patriae* relationship to her and such a relationship may be created if and when a person is found legally incompetent, there was never any effort on the part of appellees to secure such a judicial determination of incompetency before proceeding to treat Miss Winters in the way they thought would be 'best' for her.²²⁹

The court noted that New York law clearly establishes that a finding of mental illness and commitment to a hospital does not raise a presumption that a patient is incapable.²³⁰

The *Katz* Court held that forced medical treatment of mentally ill patients was unauthorized absent a finding of incapacity. The court recognized that pursuant to its *parens patriae* power, the state may have a compelling interest in providing care to those who are unable to care for themselves as a result of mental illness.²³¹ However, the court went on to state that the individual must be incompetent to make his own treatment-related decisions before the State may invoke that interest.²³² Based on this decision and the decision in *Winters*, it is clear that New York courts require a finding of incapacity before forcing medical treatment on unwilling patients.

One exception, which the Supreme Court has used to override a competent individual's autonomy in order to compel treatment, occurs in the prison setting.²³³ This exception was established by *Washington v. Harper* and allows forced treatment for certain inmates.²³⁴ In that case, a mentally ill prisoner challenged a prison policy that authorized mandatory treatment

228. *Id.* at 71.

229. *Id.*

230. *Id.* at 68.

231. *Rivers v. Katz*, 67 N.Y.2d at 497.

232. *Id.* at 497.

233. *See Washington v. Harper*, 494 U.S. 210 (1990).

234. *Id.* at 236.

with antipsychotic drugs regardless of the inmate's competency to make treatment decisions.²³⁵ The Court carved out an exception to the general prohibition against forced treatment, holding that the prison policy did not violate the prisoner's fundamental rights.²³⁶ The Court disagreed with the contention that a choice to refuse medical treatment could only be overridden where the individual in question was found to be incompetent.²³⁷ The Court recognized that mentally ill prisoners do possess a significant liberty interest in avoiding unwanted administration of antipsychotic drugs and, therefore, narrowed the exception in several ways.²³⁸ First, the Court focused on the unique nature of the prison setting and the fact that readily available alternatives are severely limited in the prison setting.²³⁹ Additionally, the Court upheld the regulation only to the extent that it permitted treatment of non-consenting prisoners that were found to be mentally ill and gravely disabled or dangerous.²⁴⁰ Therefore, the Court allowed an exception to the rule that the state may not invoke its *parens patriae* power to compel treatment of an individual who is competent to make this decision himself only where the individual is so mentally infirm that she is considered gravely disabled or poses a serious risk to herself or others.

*B. Overriding the Fundamental Liberty Interest Based
on the Police Power*

Courts have also relied on the police power to allow states to administer medical treatment over the autonomous objection of a patient. The police power allows states to restrict liberties in a manner that would otherwise be prohibited based on the rationale that the laws are required to protect the public health, safety, and general welfare.²⁴¹ Before a state can invoke its police power for

235. *Id.* at 214.

236. *Id.* at 236.

237. *Id.* at 222.

238. *Id.* at 225.

239. *Id.*

240. *Id.*

241. See Rachel Scherer, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventative Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 402 (2007); Jessica MacKeigan, *Violence, Fear, and Jason's Law: The Needless Expansion of Social Control Over the Non-Dangerous Mentally Ill in Ohio*, 56 CLEV. ST. L.

public safety purposes, a legislature must determine that the threat posed by the regulated conduct is imminently dangerous.²⁴² This broad power has been used in many different ways, including mental health-related applications.²⁴³

In *Jacobson v. Massachusetts*, the Supreme Court recognized that the common-law right to refuse treatment is not absolute and may be overcome by countervailing state interest.²⁴⁴ In that case, the court discussed the police power, finding that although the limits of a state's police power are not distinctly defined, it is within the state police power to enact laws to protect public health and safety.²⁴⁵ Based on this finding, the Court upheld a Massachusetts statute that fined citizens who refused to receive smallpox vaccinations when such a vaccination was deemed necessary for the public health or safety.²⁴⁶ The Court did, however, stress that its holding was not intended to allow the police power to be used in an arbitrary or oppressive way.²⁴⁷ Although *Jacobson* was decided over a century ago, it provides guidance as to how the police power may be used, and Supreme Court Justices have cited the case for this purpose.²⁴⁸

In *Addington v. Texas*, the Supreme Court relied on the state's authority under its police powers to involuntarily commit members of the community whose dangerous tendencies pose a danger to the rest of the community.²⁴⁹ Here, the Court found that involuntary hospitalization of an individual with a diagnosed mental illness is a valid exercise of police powers where the state

REV. 739, 751 (2008); Jeffery Geller et al., *Settling Doubts About the Constitutionality of Outpatient Commitment*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 127, 137 (2005).

242. *Rivers v. Katz*, 67 N.Y.2d 485, 495 (N.Y. 1986).

243. *Id.*

244. *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 25 (1905).

245. *Id.*

246. *Id.* at 27.

247. *Id.* at 38.

248. *See Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 312 n.12 (1990) (Brennan, J., dissenting) (pointing out that courts have upheld laws that impose punishments for refusing to be vaccinated).

249. *Addington v. Texas*, 441 U.S. 418, 426 (1979).

proves by greater than a preponderance of the evidence that he was dangerous to himself or others.²⁵⁰

In *Katz*, the New York Court of Appeals relied on the Supreme Court's decision in *Addington* and likewise stated that the state has authority pursuant to its police powers to protect the community from potentially dangerous mentally ill individuals.²⁵¹ The court stated that in certain circumstances the liberty interest of the mentally ill in competently refusing medical treatment may be overcome by a compelling state interest.²⁵² However, the court failed to find such a strong state interest in this case. To the contrary, it was held that mentally ill patients must lack the capacity to make medical decisions before New York could invoke its police power and compel medical treatment.²⁵³ Furthermore, the fact that the patients in this case were involuntary committees of a mental institution was not a sufficient basis to find a lack of capacity.²⁵⁴

Additionally, the *Katz* Court held that the circumstances were insufficient to implicate the state's police powers to override the individual rights.²⁵⁵ Based on this decision, the Court of Appeals adopted an interpretation of the New York Constitution that provides greater protection of mentally ill individuals who wish to refuse medical treatment than the protection granted by the Supreme Court's interpretation of the United States Constitution. Although the Supreme Court in *Washington v. Harper* held that mentally ill people who are involuntarily placed in state-run facilities may be administered treatment over their objection, the New York Court of Appeals in *Katz* held that this was not the case.²⁵⁶

Given the history of case law interpreting an individual's liberty interest in avoiding treatment, it is clear that courts are reluctant to find that state interests rise to the threshold necessary

250. *Id.* at 431 (discussing that the preponderance standard falls short of meeting the demands of due process, but the reasonable-doubt standard is not required).

251. *See Addington v. Texas*, 441 U.S. 418, 426 (1979), *cited in Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986).

252. *Id.*

253. *Id.*

254. *Katz*, 67 N.Y.2d at 492.

255. *Id.* at 496.

256. *Id.* at 494.

to abridge this interest. When exceptions are made and mandatory treatment is authorized, the courts specify the narrow scope of these limits.

V. OPPOSITION, SUPPORT, AND CASE LAW CHALLENGING KENDRA'S LAW

Opponents and supporters of Kendra's Law express many different arguments to assert that the law is or is not justified. Opponents argue that it undermines an individual's autonomy liberty interest by forcing unwanted medical treatment. Supporters claim that the law does not violate any liberty interests because it allows AOT patients to participate in developing individualized treatment plans. Additionally, proponents argue that the law is necessary to protect the public from the dangerously mentally ill. The law has been challenged in New York courts on several occasions, but the courts have repeatedly upheld its validity. This section discusses the arguments in opposition and in support of Kendra's Law, as well as the court decisions upholding the AOT program.

A. Arguments in Opposition and Support to Kendra's Law

In arguing that Kendra's Law unconstitutionally infringes on fundamental rights, opponents rely on the fact that AOT authorizes a court to mandate treatment without requiring a finding of the patient's incompetence.²⁵⁷ Opponents claim that the AOT program undermines individual autonomy because AOT subjects are required to undergo medical treatments against their will.²⁵⁸

The primary argument used by opponents to challenge the law's validity is that it violates the liberty interests of competent, non-dangerous, mentally ill persons who would not otherwise meet the requirements for involuntarily commitment in psychiatric facilities.²⁵⁹ Typical AOT orders include provisions that compel the administration of psychotropic drugs and require recipients to participate in mental health services that dictate the subject's daily activities.²⁶⁰ These arguments are supported by AOT statistics.

257. See NYCLU Memo, *supra* note 136.

258. NYCLU Testimony, *supra* note 46.

259. *Id.*

260. See *id.*

According to data from the New York Lawyers for the Public Interest (NYPLI), 88% of AOT orders direct a medication regimen, 75% direct participation in some form of therapy, 40% order participation in substance abuse programs, 37% require blood or urine testing, 31% set forth the location where an individual may live, and 22% direct participation in day program services.²⁶¹

Additionally, opponents argue that the law is not meeting its procedural safeguards because it is primarily used against people who have had more than one psychiatric visit to a hospital but no history of violence toward others.²⁶² Data from NYPLI's investigation showed that only 15% of AOT subjects had been violent toward others prior to their order being started.²⁶³ The statute requires an individual to have a history of noncompliance coupled with having received mental health services in a penitentiary within the previous three years, *or* a history of noncompliance coupled with at least one previous violent behavior.²⁶⁴ The data suggests that AOT orders are used against those meeting the first at a rate that is more than five times greater than those meeting the second.²⁶⁵ The first criterion does not require any history of violence. Therefore, opponents argue that the law is not achieving its primary purpose, which is to protect the public from violent individuals.

In contrast to opposition, supporters of Kendra's Law argue that although the law authorizes court-ordered treatment, it does not violate fundamental rights because it does not allow the use of physical force to ensure patient compliance.²⁶⁶ Alternatively, supporters claim that any fundamental liberty interest in refusing treatment is outweighed by the state's interest in protecting the public from harm.²⁶⁷ Supporters bolster this argument by relying

261. *Id.*

262. *See* NYLPI, *supra* note 14, at 7.

263. *Id.* at 3.

264. N.Y. MENTAL HYG. LAW § 9.60(c)(4).

265. *See* NYLPI, *supra* note 14, at Appendix C (stating, "15% of those under court orders have done any physical harm to another in the period prior to their orders – so 85% have not.").

266. *See* Treatment Advocacy Center, *Uncivil Liberties*, Oct. 31, 2008, <http://www.treatmentadvocacycenter.org>.

267. *See* TREATMENT ADVOCACY CENTER, FROM ADVOCACY TO ACCOMPLISHMENT (2005) [hereinafter FROM ADVOCACY TO

on either the state's interest as *parens patriae* or the state's police power.²⁶⁸

The first argument used by supporters is that the law comports with established constitutional principles, and that no fundamental rights are violated.²⁶⁹ This is because the law does not specifically authorize the state to force individuals to take medicine; courts have interpreted the law in this manner, finding that that medication may not be administered over the individual's objection.²⁷⁰ Instead, the law allows the petitioned individual to work with medical providers and come up with a treatment plan.²⁷¹ In theory, the treatment plan does not have to include medical treatment. The treatment plan is then enforceable by the court, and only if the individual fails to adhere to it will he or she be subjected to consequential measures such as a maximum 72-hour detention.²⁷² Therefore, only if the patient and the doctor work together and determine that specific medicines should be part of the treatment plan will the petitioned individual be forced to take them.²⁷³ Because the law specifically forbids forced drugging, supporters argue that it does not violate the fundamental right to refuse treatment.

Some supporters recognize that the implementation of Kendra's Law has resulted in instances where an individual is forced to comply with court-ordered treatments against his or her will.²⁷⁴ These supporters rely on the state's interest as *parens*

ACCOMPLISHMENT]; Brooks, *supra* note 105, at 1004; Ilissa L. Watnick, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1214 (2001).

268. Watnick, *supra* note 267, at 1215.

269. See Watnick, *supra* note 267, at 1215; Brooks, *supra* note 105, at 1004; FROM ADVOCACY TO ACCOMPLISHMENT, *supra* note 267.

270. See *In re K.L.*, 806 N.E.2d 480 (N.Y. 2004) (Referencing New York's AOT program as "a court-ordered assisted outpatient treatment plan simply does not authorize forcible medical treatment.").

271. AN EXPLANATION OF KENDRA'S LAW, *supra* note 5.

272. *Id.*; see also N.Y. MENTAL HYG. LAW § 9.60(n).

273. AN EXPLANATION OF KENDRA'S LAW, *supra* note 5.

274. See D.J. Jaffe, *Let's Make Kendra's Law Permanent*, THE MENTAL HEALTH MINUTE, January 17, 2010, <http://skwillms.wordpress.com/tag/treatment-advocacy-center/> (arguing, "using the *parens patriae* powers of the state to help those who can't help themselves, the police will help the seriously mentally ill who are homeless and psychotic in ways the mental health system would never consider.").

patriae as justification for the program.²⁷⁵ Here, supporters argue that the AOT program is authorized because it allows the state to help mentally ill people who are unable to help themselves.²⁷⁶

Proponents also justify the law as being a valid exercise of the state's police powers.²⁷⁷ In order to justify the need for the state to exercise its police powers and force treatment on individuals, supporters of Kendra's Law point to figures regarding violent acts of the mentally ill.²⁷⁸ For example, it is commonly cited that an estimated 1000 homicides per year are committed by mentally ill individuals.²⁷⁹ Based on these statistics, it is argued that the forced treatment is necessary to protect society from those mentally ill individuals who are dangerous.²⁸⁰ Indeed, the need to protect the public from potentially violent individuals was the driving force that led the legislature to enact the law after Kendra Webdale was pushed to her death by Andrew Goldestein.²⁸¹

B. Challenges to Kendra's Law and the Court's Response

In the New York court system Kendra's Law has been disputed on several different theories.²⁸² These challenges have been unsuccessful, and the courts have upheld the law's validity each time.

In October of 2000, an unidentified individual who suffered from bipolar disorder challenged the law claiming that it violated his due process and rights, as well as posing the threat of

275. See Brooks, *supra* note 105, at 953; Jessica MacKeigan, *Violence, Fear, and Jason's Law: The Needless Expansion of Social Control Over the Non-Dangerous Mentally Ill in Ohio*, 56 CLEV. ST. L. REV. 739, 751 (2008); Geller et al., *supra* note 241, at 137; Rachel Scherer, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventative Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 401 (2007).

276. Jaffe, *supra* note 274.

277. See Scherer, *supra* note 241, at 402; MacKeigan, *supra* note 241, at 751; Geller et al., *supra* note 241, at 137.

278. LIBOUS, *supra* note 1, at 2; see also Torrey, *supra* note 15, at 2.

279. Mary T. Zdanowicz, *New York Should Stand Tall: Don't Fail the Mentally Ill by Letting the Clock Run Out on Kendra's Law*, TREATMENT ADVOCACY CENTER, June 16, 1999.

280. *Id.*; see also LIBOUS, *supra* note 1, at 2.

281. LIBOUS, *supra* note 1, at 2.

282. See *In re K.L.*, 806 N.E.2d 480 (N.Y. 2004) (presenting challenges based on due process, equal protection and search and seizure grounds.)

unreasonable search and seizure.²⁸³ The treatment order prescribed for this individual included psychiatric outpatient care, case management, individual therapy, and medication that was to be self-administered.²⁸⁴ Additionally, the order required blood testing to ensure that the petitioner was self-administering the medication.²⁸⁵ In the event of noncompliance, the plan required him to voluntarily submit to the administration of further medication by medical personnel.²⁸⁶

The petitioner's main argument was that due process requires a determination that an individual is incapacitated before his or her liberty interest in refusing medical treatments could be taken away.²⁸⁷ Since Kendra's Law does not require a finding of incapacity, it was argued that the law violated the due process rights guaranteed in both the state and federal constitutions.²⁸⁸ In rejecting this argument, the court distinguished this case from *Katz*, finding that Kendra's Law does not permit forced medical treatment, nor does noncompliance with an AOT order permit forced medical treatment.²⁸⁹ Furthermore, the court ruled that requiring a finding of incapacity would "eviscerate" the law because the law specifically authorizes a patient to participate in designing his or her treatment plan; therefore, that patient must have the mental capacity to partake in the design.²⁹⁰

Moreover, the court stated that the state's interest as *parens patriae* validates the law, as this power authorizes the state to provide care to citizens who, due to mental illness, are unable to care for themselves.²⁹¹ Here, the court argued that *parens patriae* was properly invoked because AOT orders have safeguards to

283. *Id.* at 486.

284. *Id.* at 482.

285. *Id.*

286. *Id.*

287. *Id.* at 483.

288. *Id.* at 486.

289. *Id.* at 484.

290. *Id.* at 484; *see also* Watnick, *supra* note 267, at 1222 (describing that the statute presumes that AOT patients have the capacity to actively participate in the development of written treatment plans).

291. *In re K.L.*, 806 N.E.2d at 485 (stating that the state may rely on its *parens patriae* power to provide care to its citizens who are unable to care for themselves because of mental illness); *see also* Rivers v. Katz, 67 N.Y.2d 485, 495–96 (N.Y. 1986).

ensure that the individual is incapable of making medical decisions.²⁹² Such safeguards include the following: the court found the patient to be unlikely to safely survive in the community without supervision; the patient has a history of lack of compliance coupled with a history of violent behaviors; and the patient is in need of supervision to prevent relapse.²⁹³

In addition to finding that Kendra's Law does not abridge any fundamental liberty interest, the court held that an individual's right to refuse medical treatment was outweighed by both the state's police power and its *parens patriae* power.²⁹⁴ The court relied on previous decisions that have authorized the use of the police power to protect society from mentally ill individuals who may be dangerous.²⁹⁵ It ultimately concluded that the right to refuse treatment is outweighed by the state's compelling police power interest to prevent relapse or deterioration that would likely result in serious harm to the patient or others.²⁹⁶ Additionally, the court recognized that the 72-hour detention provision was a substantial deprivation of liberty, but concluded that the risk of a potential erroneous deprivation was minimal and that the government's interest in preventing harm outweighed the risk of erroneous deprivation.²⁹⁷ This was based on the finding that the law includes procedural safeguards to prevent erroneous detentions.²⁹⁸

Since *In re K.L.* was decided in 2004, it has become the precedent used by courts throughout New York State to reject challenges to Kendra's Law.²⁹⁹ These cases use the same methods of reasoning to find that the law does not violate any fundamental

292. *In re K.L.*, 806 N.E.2d at 487.

293. *Id.*

294. *Id.* at 485.

295. *Id.*

296. *Id.* at 487.

297. *Id.* at 487

298. *Id.*

299. See *In re Miguel M.*, 882 N.Y.S.2d 698, 704 (2009); *Mental Disability Law Clinic v. Hogan*, No. CV-06-6320 (CPS)(JO), 2008 WL 4104460, at *8 (E.D. N.Y. 2008); *In re Sullivan*, 781 N.Y.S.2d 563, 565 (2004).

rights and that any liberty interests at stake are overridden by the State's *parens patriae* or police power interests.³⁰⁰

VI. DISCUSSION

What is troubling about forced treatment, particularly in regard to forced treatment of mentally ill individuals, is that the treatment methods and medications used are severely restrictive. Furthermore, when medication is included in AOT orders, the side effects of these drugs are potentially dangerous. Given the constraints placed on an AOT patient's daily activities and the severity of the side effects of psychotropic medications, an individual's refusal to partake in treatment is arguably rational.³⁰¹

In downplaying these concerns, court decisions have upheld the law based on the belief that, because AOT patients participate in the design of individual treatment plans, autonomy is preserved.³⁰² In doing so, courts have failed to recognize the coercive nature of AOT. While AOT subjects are not physically forced to participate, they design treatment plans while under pressure which undermines autonomy and informed consent.

Furthermore, the courts' use of the state's *parens patriae* interest as justification for upholding the AOT program conflicts with other judicial precedents. This is because Kendra's Law does not require a finding of incapacity before compelling participants to receive medical treatment. Based on the police power, however, courts have properly upheld the AOT program. The need to protect the public from potentially violent individuals is a compelling justification for overriding autonomy.

This part argues that the coercive nature of the AOT program undermines patient autonomy in violation of fundamental liberty interests. Additionally, it argues that the court's reliance on the state's *parens patriae* interest is improperly used to uphold the law. It concludes by arguing that the law is justified as a valid exercise of the police power, which properly overrides autonomy.

300. See *In re Miguel M.*, 882 N.Y.S.2d at 704; *In re Baby Boy W.*, 773 N.Y.S.2d 255, 258–59 (2004); *Mental Disability Law Clinic v. Hogan*, 2008 WL 4104460, 8 (N.Y. 2008); *In re Sullivan*, 781 N.Y.S.2d at 565.

301. See *Talati*, *supra* note 105, at 188; *Washington v. Harper*, 494 U.S. 210, 229–31 (discussing the danger of side effects); *Brooks*, *supra* note 105, at 938.

302. See *In re K.L.*, 806 N.E.2d at 484.

A. The Coercive Nature of Kendra's Law Violates the Standard Models of Autonomy and Informed Consent

The argument that the law does not abridge the fundamental right of bodily autonomy is undermined by the coercive effect that the law has on the patient. The coercive nature of AOT prevents Kendra's Law subjects from exercising autonomy rights. Furthermore, this coercion renders physicians unable to obtain informed consent from Kendra's Law subjects. This undermines the well-established principle of legal and medical ethics that doctors may not provide medical care to competent patients without their informed consent.

One previously mentioned justification used to uphold the law is the fact that no fundamental rights are violated because the patients are given the right to participate in the design of their treatment plan, which involves decisions about which medications will be taken.³⁰³ However, the law only gives the illusion of choice for the individual; in reality it presents the patient with a situation in which the individual may be forced to take medication against his will. In practice, almost all AOT orders incorporate medicine as a component of the plan.³⁰⁴ Although the government may not force an assisted outpatient to take medicine, Kendra's Law serves as a means for the government to bypass this restriction and compel the individual to take medicine through coercion. AOT patients are screened through blood and urinalysis tests to ensure that they are taking the drugs prescribed in the order.³⁰⁵ These screening processes pressure AOT subjects to take medicine because those entities that oversee the subject will know whether or not he or she is complying. If the patient attempts to exercise her will to refuse the medications, the law authorizes police or peace officers to apprehend her and confine her for up to 72 hours.³⁰⁶ This evaluation period is used to determine whether the individual has been complying with the treatment regimen and whether involuntary commitment may be required.³⁰⁷ Under other

303. *Id.* at 483.

304. *See* NYLPI, *supra* note 14, at 6 (finding that 88% of AOT orders include medication as a requirement).

305. *See* N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 5; N.Y. MENTAL HYG. LAW § 9.60(n).

306. N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 2010).

307. *Id.*

sections of the mental hygiene law, the patient would be given the opportunity to have a pre-removal hearing.³⁰⁸ The courts have held that such a pre-hearing is not necessary because the government has a strong interest in avoiding time-consuming judicial hearings, and the 72-hour limit on detention length is considered a brief detention.³⁰⁹

The cases upholding the constitutionality of Kendra's Law are premised on the belief that fundamental rights are not violated because the patient is given the "choice" and cannot be physically forced to take medicine.³¹⁰ In reality, however, if a patient chooses not to take medicine, he or she may be apprehended and detained.³¹¹ The Legislature recognized this coercive effect when it enacted the program.³¹² In the sponsor's memo, lawmakers contemplated that failure of compliance with the treatment order would result in detention; failure to comply is evidenced if the individual "refuses to take medications ordered by the court, or refuses to take or fails a blood, urinalysis, alcohol, or drug test . . . required by the court."³¹³

The court briefly addressed the coercive effect of Kendra's Law in *in re K.L.*, arguing that the coercive force of the law is not stronger than the compulsion felt by any other citizen who must comply with court directives.³¹⁴ It further argued that a violation of an AOT order results in no sanctions beyond heightened supervision by the patient's physician.³¹⁵ These arguments, however, downplay the significant force of AOT orders. Studies that investigate the perception of individuals forced to participate in AOT programs demonstrate that these individuals feel strongly pressured to participate.³¹⁶ One such study interviewed Kendra's Law patients at various intervals during treatment and found that AOT subjects feel coerced, and the feeling of coercion intensifies

308. N.Y. MENTAL HYG. LAW §§ 9.27, 9.39, 9.40.

309. *In re K.L.*, 302 A.D.2d 388, 390-91 (N.Y. App. Div. 2003).

310. *In re K.L.*, 806 N.E.2d 480, 487 (N.Y. 2004); *In re Urcuyo*, 714 N.Y.S.2d 862, 868 (N.Y. App. Div. 2000).

311. N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 2010).

312. LIBOUS, *supra* note 1, at 3.

313. *Id.*

314. *In re K.L.*, 806 N.E.2d at 485.

315. *Id.*

316. Sarah D. Rain et al., *Perceived Coercion and Treatment Adherence in an Outpatient Commitment Program*, 54 PSYCHIATRIC SERVICES 399 (2003).

as the AOT treatment continues for longer periods.³¹⁷ Participants in this study expressed that they had little influence in the decision-making process.³¹⁸

Some studies suggest, however, that involuntarily treated patients eventually accept and recognize their need to be treated despite initial objections.³¹⁹ This retrospective theory is used to conclude that coerced treatment is reasonable since patients come to approve the coerced treatment.³²⁰ While this may be sufficient in other situations, the retrospective theory cannot be used to justify Kendra's Law. Studies involving AOT patients have shown that many of those receiving such treatment feel negative about initially receiving the treatment and that these negative feeling do not cease.³²¹ AOT patients do not learn to approve of their treatments in retrospect. Furthermore, studies demonstrate that many AOT patients who initially approve of their treatments grow to feel negative about the mandated treatments.³²² Overall, the majority of AOT patient who receive treatments for one year do not believe that AOT is beneficial.³²³

Alternatively, cases hold that Kendra's Law does not undermine autonomy because AOT subjects are allowed to participate in the design of the treatment plan and, therefore, decide whether or not to take drugs.³²⁴ Moreover, it is clear from the legislative intent of the program that lawmakers did not contemplate a system in which the patient was highly active in developing a treatment plan.³²⁵ The act's Sponsor's Memorandum detailed each section of the bill and its intended purpose; nowhere does it mention patient participation in the development of a treatment plan.³²⁶ The only discussion of the treatment plan states

317. *Id.*

318. *Id.* at 400; see also Jennifer Honig, *New Research Continues to Challenge the Need for Outpatient Commitment*, 31 NEW. ENG. J. ON CRIM. & CIV. CONFINEMENT 109, 118 (2005).

319. William Gardner et al., *Patients' Revisions of Their Beliefs About the Need for Hospitalization*, 156 AM. J. PSYCHIATRY 1385, 1390 (1999).

320. *Id.*

321. Honig, *supra* note 318.

322. *Id.*

323. *Id.*

324. *In re K.L.*, 806 N.E.2d at 484–85.

325. LIBOUS, *supra* note 1, at 3.

326. *Id.*

that the plan must be in written form, prepared by a physician appointed by the Director of an AOT program or by the court.³²⁷

The danger of coercion is that it undermines the models of patient autonomy and informed consent, which form much of the foundation of modern legal and medical ethics. As discussed in Part II, an act is said to be autonomous if it is intentional, based on sufficient understanding, free from external constraints, and free from internal constraints.³²⁸ Respect for personal autonomy requires that individuals be free to voluntarily make their own decisions regarding choices that affect their person. As previously discussed, the emphasis in case law on protecting autonomy in medical decision making demonstrates the lengths to which society is willing to go to prevent individuals from involuntarily undergoing medical treatment. Coercion acts as an external constraint by influencing the decision-making process of AOT patients. AOT patients accept treatments not because they wish to, but because they fear the repercussions of not accepting treatment.

Since AOT patients do not act autonomously, they are unable to give informed consent. It is a well-established principle of legal and medical ethics that doctors may not provide medical care to competent patients without their informed consent.³²⁹ As previously discussed, in order for informed consent to be validly obtained, three components must exist.³³⁰ First, the treating physician must inform the patient about his or her condition and the available treatment alternatives, as well as the risks and benefits of each alternative.³³¹ Next, the patient must make his or her choice voluntarily, which requires that the choice be free from outside coercion, manipulation, or undue influence.³³² Finally, the patient must be competent to provide his or her consent.³³³

Kendra's law calls the second prong of the informed consent process into question. The first prong is not at issue because the program requires the Kendra's law subject and the

327. *Id.*; N.Y. MENTAL HYG. LAW § 9.60(e)(5) (McKinney 2010).

328. *See* MAPPES & DEGRAZIA, *supra* note 142, at 41.

329. *See* RUTH FADEN & TOM BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 56–57 (1986).

330. ROSAMOND RHODES ET AL., THE BLACKWELL GUIDE TO MEDICAL ETHICS, 128 (2007).

331. *Id.*

332. *Id.*

333. *Id.*

physician to discuss treatment options. Similarly, the third prong is not at issue because the law requires subjects to have decision-making capacity. The second prong, however, is called into question by the coercive nature of Kendra's Law.

Kendra's Law subjects are not free to make treatment decisions without outside influence because they have no choice but to adhere to the court's AOT order. Once a court has granted an AOT order, treatment is no longer voluntary; the subject of the petition must adhere to his or her treatment plan. True informed consent can never be obtained from Kendra's law subjects because of the coercive effect that the law has on their decision making.

B. The Use of Parens Patriae to Uphold the Law does not Align with Parens Patriae Case Law

The justification that Kendra's Law is valid based on the state's interest as *parens patriae* is undermined by the existing interpretation of the state's power as *parens patriae*.³³⁴ Traditional interpretations of *parens patriae* require that an individual lack capacity before being forced to undergo treatment; Kendra's Law does not require this finding of incapacity.

Relying on *parens patriae* to justify Kendra's Law is also an erroneous reasoning that the courts have used. The established case law has determined that *parens patriae* specifically requires a finding that an individual lacks capacity.³³⁵ Kendra's Law cannot be justified by state's interest as *parens patriae* because it does not require that the individual lack capacity before treatment is mandated.³³⁶ In fact, Kendra's Law requires the AOT subject to have the capacity necessary to make medical treatment related decisions before being issued an AOT order.³³⁷ The law contemplates that patients must have capacity in order to be subject to an AOT order because it requires patients to actively participate in designing a treatment plan, which requires the individual to competently make decisions.

334. See *In re K.L.*, 806 N.E.2d 480, 483 (N.Y. 2004).

335. See *Addington v. Texas*, 441 U.S. 418, 426 (1979); *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261 (1990).

336. *Id.*; see generally N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2010).

337. N.Y. MENTAL HYG. LAW § 9.60(n).

C. The State's Police Power is a Valid Justification for Upholding Kendra's Law

Despite the invalid arguments that have been used to uphold the validity of Kendra's Law, the state's right to exercise its police powers is a proper premise to uphold the law. This is because certain classes of untreated mentally ill individuals pose a threat to the public, and Kendra's Law is designed to target only this group.

The Millian harm principle, which underlies much of American jurisprudence, can be used to demonstrate why Kendra's Law can be upheld based on the police powers.³³⁸ The harm principle holds that an individual is free to act in any chosen manner, so long as their actions do not harm others.³³⁹ As a limit to this autonomy, Mill argued the only valid reason for the government to exercise its power over a citizen against his will is to prevent harm to others.³⁴⁰ Based on this reasoning, a state may use its police power to intervene when it is necessary to do so in order to prevent one individual from harming another.

Aspects of the harm principle are pervasive in many aspects of American society. Incarceration is perhaps the clearest example of this principle; individuals who commit crimes are separated from the society in order to protect innocent citizens. Through the harm principle, criminals are harmed because their liberties and freedoms are restricted, but this harm is justified in order to protect the greater good. The existence of the harm principle in American law and society is balanced by procedural safeguards that attempt to ensure that no individual's rights or freedoms are unnecessarily restricted for the greater good. Before an individual may be incarcerated, he is given the opportunity to have a trial with a jury of his peers.

From the perspective of securing public health and safety, states are authorized to restrict individual autonomy based on the harm principle. States have used the police power to compel individuals to receive vaccinations in order to protect the public health and safety.³⁴¹ In the context of Kendra's Law, the Millian

338. Ryan Fischer et al., *Sex, Violence, and the Boundaries of the Defense of Consent*, 45 No. 6 CRIM. L. BULL. ART 10 (2009).

339. *Id.*

340. *Id.*

341. *See Jacobson v. Massachusetts*, 197 U.S. 11, 25–26 (1905).

way of thinking argues that New York has an obligation to protect its citizens and, therefore, forcing a relatively small portion of the population to undergo AOT is justified by the safety it provides to the larger segment of society. It can be argued that certain classes of mentally ill persons should not enjoy the same rights to autonomy as individuals who are not mentally ill because these people pose a potential threat to innocent bystanders. Therefore, in order to protect the public, the government must coerce these individuals into obtaining the necessary medical care required to eliminate their violent tendencies.

Kendra's Law properly integrates the procedural safeguards that are necessary to uphold a law that restricts an individual's liberties based on the harm principle. Kendra's Law targets only those who are potentially violent through the procedural mechanisms that it incorporates.³⁴² These safeguards, which are based on an individual's prior history, help to accurately identify those mentally ill patients who may be harmful to the community. Furthermore, this exercise of the police powers is less restrictive than other alternatives because it allows the targeted individuals to live in the community. The police power is the reason that more restrictive AOT laws in other jurisdictions have been upheld.³⁴³ Based on the protections afforded to AOT patients, Kendra's Law can be upheld as a valid exercise of the police power.

VII. KENDRA'S LAW WAS PROPERLY EXTENDED

In addition to having a valid legal basis, Kendra's Law has proven to be an effective way of dealing with the dangerously mentally ill. Because Kendra's Law is a valid exercise of the police powers and it has proven to be successful, New York's extension of the law in 2010 was appropriate. Additionally, because the trial period has proven that Kendra's Law is successful, the law should be made permanent.

Despite the initial opposition to AOT, after the program was adopted, there was early evidence that Kendra's Law was successful. One such investigation followed the first 141 patients in AOT for 10 months and demonstrated that the program's

342. See N.Y. MENTAL HYG. LAW § 9.60(c)(4)(i)-(ii) (McKinney 2010).

343. See Watnick, *supra* note 267, at 1214; SAMUEL J. BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW 24 (1985).

intentions were being met.³⁴⁴ This study showed that these AOT patients experienced a 129% increase in medication compliance; a 194% increase in case management use; a 107% increase in housing services use; a 67% increase in medication management services use; a 50% increase in therapy use; a 26% decrease in harmful behavior; and a 100% decrease in homelessness.³⁴⁵

The study that was commissioned through the 2005 legislation was conducted through a collaborative effort of Duke University School of Medicine, Policy Research Associates, and University of Virginia School of Law.³⁴⁶ Overall, the report found that AOT “reduced rates of hospitalization, increased receipt of psychotropic medications appropriate to the individual’s diagnosis, and reduced likelihood of arrest.”³⁴⁷ The study specifically found that AOT reduced the likelihood of arrest and incarceration.³⁴⁸ Hospitalizations were also reduced; compared to the pre-AOT monthly hospitalization rate of 14%, the probability of hospital admission was reduced to 11% per month during the first six months of AOT and to 9% during the 7-12 month period of AOT.³⁴⁹

These statistics demonstrate the value that Kendra’s Law has in helping New York’s mentally ill population while simultaneously protecting the public from harm. Based on this value, the law was properly extended for an additional five-year period. Moreover, New York should permanently codify the law in order to continue the success of the AOT program.

VIII. CONCLUSION

After more than a decade, Kendra’s Law remains a source of contention among many groups. Although there is substantial evidence that the law has successfully reduced instances of hospitalization, arrests, and incarceration in the population of mentally ill individuals, it is still criticized because of the

344. NEW YORK STATE OFFICE OF MENTAL HEALTH, ASSISTED OUTPATIENT TREATMENT REPORT AS OF JUNE 1, 2001 (2001).

345. *Id.*

346. SWARTZ, *supra* note 55, at vi.

347. *Id.* at 43.

348. *Id.*

349. *Id.* at 44. Notably, the report did not investigate the racial disparities that were previously mentioned.

infringement of autonomy that results from AOT orders. Despite the efforts to eliminate the law on the grounds that it is unconstitutional, New York courts have been reluctant to find the law invalid and have upheld it on several legal theories; upholding the law based on the state's police powers is the only valid justification upon which the courts have relied. Since AOT has been successful and it is constitutionally valid, the legislature properly extended Kendra's Law in June 2010.

Online Investigations and the Americans with Disabilities Act: The Resurgence of Overbroad and Ineffectual Mental Health Inquiries in Character and Fitness Evaluations

BY BERNICE BIRD*

Nationally, state boards of bar examiners' interest to inquire into mental health have been a hotly contested issue invoking the Americans with Disabilities Act ("ADA") for the past two decades.¹ After the enactment of the ADA in 1990, a floodgate of litigation resulted in a litany of publications,² all surrounding the issue of whether mental health based inquiries into character and fitness violated the ADA.³ Consequently, narrowly tailored

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1. See generally Carol J. Banta, *The Impact of the Americans with Disabilities Act on State Bar Examiners' Inquiries into the Psychological History of Bar Applicants*, 94 MICH. L. REV. 167 (1995); Jon Bauer, *The Character of the Questions and the Fitness of the Process: Mental Health, Bar Admissions and the Americans with Disabilities Act*, 49 UCLA L. REV. 93 (2001). But see Michelle Morris, *The Legal Profession, Personal Responsibility, and the Internet*, 117 YALE L. J. POCKET PART 54, 56 (2007).

2. See generally Gail Edson, Comment, *Mental Health Status Inquiries on Bar Applications: Overbroad and Intrusive*, 43 U. KAN. L. REV. 869 (1995); Ann Hubbard, *Improving the Fitness Inquiry of North Carolina Bar Applications*, 81 N.C. L. REV. 2179 (2003); Diane M. Jeffers, Case Comment, *Professional Responsibility—Questions on Rhode Island Bar Application Violate Americans with Disabilities Act—In re Petition & Questionnaire for Admission to Rhode Island Bar*, 683 A.2d 1333 (R.I. 1996), 31 SUFFOLK U. L. REV. 779 (1998); Bauer, *supra* note 1.

3. See generally O'Brien v. Va. Bd. of Bar Exam'rs, No. 98-0009-A, 1998 WL 391019 (E.D. Va. Jan. 23) 1998); Doe v. Jud. Nominating Comm'n for Fifteenth Jud. Cir. of Fla., 906 F. Supp. 1534 (1995); Clark v. VA Bd of Bar Exam'rs, 880 F. Supp. 430 (E.D. Va. 1995); McCready v. Ill. Bd. of Admissions to the Bar, No. 94 C 3582, 1995 WL 29609, *6 (N.D. Ill. Jan. 24, 1995);

mental health inquiries into specific disorders emerged as the trend in a majority of jurisdictions. This article analyzes whether fitness boards' mental health inquiries among social networking profiles may cause a resurgence of overbroad and ineffectual investigations previously proscribed by federal courts interpreting the ADA. Conduct-based online investigations are proposed to effectively prevent future violations of the ADA against applicants with mental health disabilities.

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I. INTRODUCTION

The ADA is the Congressional response to “remedy and prevent what is perceived as serious and widespread discrimination against the disabled.”⁴ Scholars argue that mental health disabilities are associated with far greater social stigma in comparison to other disabilities.⁵ Accordingly, the ADA prohibits licensing agencies, such as bar examiners, from conducting screening practices predicated on mental health disabilities, unless a necessity to protect the public is justified.⁶ This exclusion to prohibitory screening practices is also known in common law as the ADA’s “necessity exception.”⁷

Over nearly twenty years, a split in ideology has emerged among courts and scholars in determining the quality of questions that is prohibited under the ADA’s necessity exception. Opponents of mental health inquiries advocate for conduct-based examinations as a reasonable alternative because conduct, unlike past mental health history, is an empirically validated predictor of future fitness.⁸ Conduct-based inquiries examine behavior, such as employment history, criminal records, or character references concerning reliability.⁹ However, proponents argue that narrow inquiries into mental health limited to substance abuse, Bipolar I

4. *Coolbaugh v. La. ex rel La. Dept. of Public Safety and Corr.*, 136 F.3d 430, 438 (5th Cir. 1998).

5. John W. Parry, *Mental Disabilities Under the ADA: A Difficult Path to Follow*, 17 MENTAL & PHYSICAL DISABILITY L. REP. 100, 110 (1993).

6. 28 C.F.R. § 35.130(b)(8) (2011).

7. *Doe*, 906 F. Supp. at 1540.

8. *Clark*, 880 F. Supp. at 445–46.

9. *Jacobs*, 1993 WL 413016, at *7.

Disorder¹⁰ and psychotic disorders, as well as other specific disorders are necessary to protect the public.¹¹

The ADA based litigation resulted in a general ban of broad-based inquiry into “any emotional, nervous, or mental disorders”¹² diagnosed at any point in the applicant’s lifetime.¹³ As a rule, federal courts uphold narrow inquiries into Bipolar I Disorder, Schizophrenia, other psychotic disorders, and substance abuse in order to protect the public from licensing unfit applicants.¹⁴ The federal courts support narrow investigations because they are limited in scope,¹⁵ in that the queries are limited to rendered diagnoses of specific “serious”¹⁶ disorders occurring within the past five or ten years.¹⁷ Amidst this litigation in 1994, the American Bar Association (“ABA”) passed a resolution (“Resolution”) urging state boards to narrowly tailor their examinations into mental health by asking, “specific, targeted questions about an applicant’s behavior, conduct or any current impairment of the applicant’s ability to practice law.”¹⁸

As the law developed over the last two decades, the federal courts have consistently upheld narrowly tailored inquiries into mental health as the general practice in licensing fit bar

10. *Applicants*, 1994 WL 923404, at *7–8; see *infra* note 204 for a discussion on whether the *Applicants* Court specifically enumerated for and, in turn, if state bar applications inquire into only Bipolar I Disorder or the full spectrum of bipolar disorders, including Bipolar II Disorder, Cyclothymic Disorder, and Bipolar Not Otherwise Specified (NOS).

11. Va. Bd. of Bar Exam’rs, No. 98-0009-A, 1998 WL 391019 (E.D. Va. Jan. 23, 1998); McCready v. Ill. Bd. of Admissions to the Bar, No. 94 C 3582, 1995 WL 29609, *6 (N.D. Ill. Jan. 24, 1995); *Applicants*, 1994 WL 923404.

12. *Ellen S.*, 859 F. Supp. at 1491 (S.D. Fla. 1994); *Plano*, 1993 WL 649283, at *1.

13. *Applicants*, 1994 WL 923404, at *7–8.

14. See *Applicants*, 1994 WL 923404, at *3; McCready, 1995 WL 29609, at *6; *O’Brien*, 1998 WL 391019, at *4.

15. Ann Hubbard, *Improving the Fitness Inquiry of the North Carolina Bar Application*, 81 N.C. L. REV. 2179, 2206 (2003).

16. *Id.*

17. *Id.*

18. H. Rutherford Turnbull III et al., *American Bar Admissions Resolution: Narrow Limits for Questions Related to the Mental Health and Treatment of Bar Applicants*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 597, 598 (1994).

applicants.¹⁹ To date, many states' boards of bar examiners narrowly inquire into treatments and diagnoses rendered of Bipolar I Disorder, Substance Dependence, Schizophrenia, and other psychotic disorders occurring within the past five or ten years.²⁰ State boards investigate into "emotional, nervous or mental disorders" in addition to a narrow investigation of specific disorders.²¹ However, in keeping with the ABA Resolution's guidelines, these state boards examine whether an applicant has "currently"²² been diagnosed with "any emotional, nervous or mental disorders" that may impair the ability to practice law.²³

With the help of the ABA's Resolution, federal courts have reconciled the issue of permissible bar examiner inquiry into mental health. Yet, the integration of the internet in character and fitness evaluations of applicants with mental health disabilities threatens to incite a resurgence of broad investigations, reminiscent

19. See *Applicants*, 1994 WL 923404, at *3; *McCready*, 1995 WL 29609, at *6; *O'Brien*, 1998 WL 391019, at *4.

20. VA. BD. OF BAR EXAM'RS, *Applicant's Character & Fitness Questionnaire*, at 19, <http://www.vbbe.state.va.us/pdf/LRC&FQuestion.pdf> (last visited Mar. 15, 2012) [hereinafter Virginia Character Questionnaire]; For more states, see NAT'L CONFERENCE OF BAR EXAM'RS, *Login to the NCBE Online Character & Fitness Application*, <https://secure.ncbex2.org/php/ea/view.php> (last visited Mar. 15, 2012).

21. See NAT'L CONFERENCE OF BAR EXAM'RS, *Request for Preparation of a Character Report: Alabama*, at 13, <http://www.alabar.org/admissions/files/standard-NCBE2011.pdf> (last visited Mar. 15, 2012) [hereinafter Alabama Character Report]; Virginia Character Questionnaire, *supra* note 20, at 19; FLA. BD. OF BAR EXAM'RS, *Fla. Registrant Bar Application*, available at <http://www.floridabarexam.org/> (last visited Mar. 15, 2012) [hereinafter Fla. Bar Application]. Although not exhaustive, this article sets out the trend of the states' bar application questions and modality of investigation. For more information, see <https://www.ncbex.org> (follow "bar admissions" and "jurisdiction" for the state of interest).

22. Virginia Character Questionnaire, *supra* note 20, at 19. Virginia's Board of Bar Examiners, for example, defines "currently" as "recently enough so that the condition could reasonably have an impact on your ability to function as a practicing attorney." See also CALIF. OFFICE OF ADMISSIONS, *Moral Character Determination*, at 13, <http://admissions.calbar.ca.gov/> (follow "apply for moral character determination") (last visited Mar. 15, 2012) ("California Moral Character Application") (defining "currently" as "recently enough to so that you believe that the mental condition may have an ongoing impact on your functioning as an attorney.").

23. See *Turnbull III et al.*, *supra* note 18, at 598.

of days past. Recently, the Florida Board of Bar Examiners has implemented an online investigation policy in its character and fitness examination in response to the onslaught of bar applicants engaging in web-based social networking.²⁴ Additionally, California, while lacking an enumerated online investigation policy, has denied bar admission to applicants on the basis of “maintaining an [in]appropriate online persona.”²⁵ However, if the ABA adopts recent scholarly proposal to “request a three year history of online aliases and related information,”²⁶ then more states may follow California’s, and possibly, Florida’s lead in creating online investigation policies.

This article asserts that online investigations are “overbroad and ineffectual”²⁷ in scope as well as purpose, and that they pose an additional burden on targeted applicants with mental health disabilities. Online evaluations inherently risk being characterized as overbroad because of the unlimited access to personal information. Moreover, online profile indicia are not reliable predictors of mental health instability, and the methodology for online investigations is not clearly delineated. Thus, unlike traditional character and fitness examinations, online investigations may be unlimited in scope, thereby violating federal precedent²⁸ and the guidelines set forth in the ABA Resolution.²⁹ This article offers several solutions for bar examination authorities to conduct online investigations without violating the ADA.

Part II explains the duties set out in title II of the ADA for public entities and the delineated rights of qualified individuals with disabilities. Further, Part II applies title II to state bar examiners as public entities and outlines the character and fitness

24. See FLA. BD. OF BAR EXAM’RS, *Florida Board of Bar Examiners re Consideration of the Final Report of the Character and Fitness Commission*, at 5, http://www.citmedialaw.org/sites/citmedialaw.org/files/2009_FBBE_Character_Fitness_Response.pdf. (last visited Mar. 15, 2012) (explaining key attributes of the Florida online investigation policy).

25. Michelle Morris, *The Legal Profession, Personal Responsibility, and the Internet*, 117 YALE L. J. POCKET PART 534, 55 (2007). <http://thepocketpart.org/2007/09/08/morris.html>.

26. *Id.* at 54.

27. *Clark*, 880 F. Supp. at 445.

28. *Applicants v. Tex. State Bd. of Law Exam’rs*, 1994 WL 923404, at *3 (W.D. Tex. Oct 11, 1994).

29. *Turnbull III et al.*, *supra* note 18, at 598.

investigation as it pertains to the ADA. Part II also traces the development of the ADA's necessity exception, delving into the precedent upholding conduct-based inquiries, narrow inquiries into mental health, and the current trend of narrow inquiries into mental health. Part III explores bar examiner application of the internet in its character and fitness policies. Moreover, Part III explicates title I of the ADA governing private employers, their duties to refrain from discriminatory pre-screening, and the emerging law of online pre-screening in employment. Additionally, Part III analyzes the Congressional silence of title II regarding screening practices, whether online or offline. Finally, Part III anticipates whether titles I and II will be construed similarly in prohibiting discriminatory pre-screening practices. Alternatively, Part III postulates whether title II's necessity exception may yield online pre-screening practices to bar examiners for the purpose of protecting the public from licensing unfit applicants.

Part IV discusses whether a resurgence in broad questions will occur, as subsequent online investigations are "overbroad and ineffectual" in scope and purpose. First, Part IV asserts that online investigations are overbroad because they exceed the scope of the inquiry by examining more information than is relevant to demonstrate fitness to practice law.³⁰ Second, Part IV argues that online investigations into fitness are ineffectual because online profiles would not necessarily glean insight into past mental health history, thereby failing to reveal effective information into applicants' functional capacity.³¹ Part V notes other policy concerns notwithstanding ADA violations, such as deterring applicants from treatment, discouraging the use of online social networking, and investigating "friends" of targeted populations, unbeknownst to the former. Finally, Part VI offers several solutions for permissible online investigations without violation of the ADA, such as conduct-based inquiries into the online profiles, clear and unambiguous methods dictating conduct-based online investigations, or "blanket searches" for all bar applicants examining only indicia of conduct related to fitness.

30. *O'Brien*, 1998 WL 391019, at *4.

31. *Applicants*, 1994 WL 923404, at *3.

II. DUTIES OF PUBLIC ENTITIES AND RIGHTS OF INDIVIDUALS WITH DISABILITIES

Title II of the ADA provides that “[n]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”³² A public entity is defined as any state or local government,³³ or “any department, agency, special purpose district, or other instrumentality of a State or States or local government[.]”³⁴ A disability is defined as: (A) “a physical or mental impairment that substantially limits one or more of the major life activities of an individual; (B) a record of such an impairment, or; (C) being regarded as having such an impairment.”³⁵ The disabilities of “physical or mental impairment” include a wide variety of diseases, including psychological disorders such as alcoholism, drug addiction, and emotional disorders.³⁶

A drug addiction that substantially limits one or more major life activities is a recognized “disability.”³⁷ Public entities are prohibited from discriminating on the basis of illegal drug use

32. 42 U.S.C. § 12132 (2006).

33. 42 U.S.C. § 12131(A).

34. 42 U.S.C. § 12131(B).

35. 42 U.S.C. § 12102(1)(A)–(C).

36. 28 C.F.R. § 35.104 (1)(i)(B)(ii) (2011). Congress has excluded the following psychiatric disorders as protected disabilities because they do not result from physical impairments: 1) “transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders; [2] compulsive gambling, kleptomania, or pyromania.” *Id.* § 35.104(5)(i)–(ii). In proposing these exclusions amidst much heated political discord, Congress relied partly on the American Psychiatric Association’s (APA)’s empirically validated list of psychiatric disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM), now known as the DSM-IV-TR. Robert Burgdorf, *The Americans with Disabilities Act: Analysis and Implications of a Second Generation Civil Rights Statute*, 26 HARV. C.R.-C.L. L. REV. 413, 451 (1991); see also AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION (DSM-IV-TR) 191 (American Psychiatric Association 2000).

37. 42 U.S.C. § 12102(2) (2006).

against an individual who is not currently engaging in drug use,³⁸ has successfully completed a rehabilitation program,³⁹ is participating in a rehabilitation program⁴⁰ or is erroneously regarded as engaging in current use.⁴¹ However, “current illegal use of drugs” is not a protected status.⁴² Courts have interpreted current illegal use of drugs to include use “that occurred recently enough to justify a reasonable belief that a person’s drug use is current or that continuing use is a real and ongoing problem.”⁴³ Furthermore, drug and alcohol-related misconduct is not protected within the ambit of the ADA.⁴⁴

Congress expressly authorized the Attorney General to promulgate the regulations within title II.⁴⁵ Thus, a public entity’s regulations are given “substantial deference,”⁴⁶ unless the regulations are “arbitrary, capricious or manifestly contrary to the statute.”⁴⁷ While title II generally prohibits discrimination by

38. 28 C.F.R. § 35.131(a)(2) (2006).

39. 28 C.F.R. § 35.131(a)(2)(i); *see also* Hill v. State Med. Bd. of Ohio, 1996 WL 697957, at *6–7 (Ohio App. Dec. 5, 1996) (distinguishing that discipline for substance-related misconduct was not valid claim under ADA whereas discrimination for past use would have been actionable).

40. 28 C.F.R. § 35.131(a)(2)(ii).

41. 28 C.F.R. § 35.131(a)(2)(iii); *see also* A Helping Hand, L.L.C. v. Baltimore Cnty., Md., 2005 WL 2453062, *11 (D. Md. Sept. 30, 2005).

42. 28 C.F.R. § 35.131(a)(1).

43. Colo. State Bd. of Med. Exam’rs v. Davis, 893 P.2d 1365, 1367–68 (Colo. App. 1995). (citing 28 C.F.R. § 35.131, App. A at 454, finding that medical board’s disciplinary hearing for doctor’s recurrent drug abuse was not contrary to the ADA because although the petitioner had refrained from using drugs for approximately five months, the risks of relapse, and short recovery period showed a real and ongoing problem of relapse).

44. McCready v. Ill. Bd. of Admissions to the Bar, No. 94C3582, 1995 WL 29609, *6 (N.D. Ill. Jan. 24, 1995).

45. 42 U.S.C. § 12134(a) (2006).

46. Doe v. Jud. Nominating Comm’n for 15th Jud. Cir. of Fla., 906 F. Supp. 1534, 1540 (1995) (citing Helen L. v. DiDario, 46 F.3d 325, 331 (3d Cir. 1995), *cert. denied sub nom.*, Pa. Sec’y of Public Welfare v. Idell, 516 U.S. 813 (1995)).

47. Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 844 (1984).

public entities, there is no clear language proscribing conduct as discriminatory.⁴⁸

A. State Board Bar Examiners as Public Entities under the ADA

Judicial interpretation of the ADA has extended public entity liability to licensing agencies in the licensure and certification of attorneys.⁴⁹ State bar examiners have the authority to conduct fitness investigations for the purpose of determining whether an applicant is a direct threat to the public.⁵⁰ A “direct threat” is defined as “a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, or by the provision of auxiliary aids or services as provided by § 35.139.”⁵¹ However, bar examiners may not utilize generalizations or stereotypes about the applicant’s disability in concluding that an applicant is a direct threat.⁵²

Accordingly, bar examiners are prohibited from “utilizing criteria or methods of administration that have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability.”⁵³ Moreover, a public entity may not “administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability.”⁵⁴ Finally, licensing agencies are prohibited from imposing eligibility criteria that “screen out or tend to screen out” disabled individuals from services or programs, “*unless such criteria can be shown to be necessary* for the provision of the service, program, or activity being offered.”⁵⁵ The statute’s conditional clause, also known as the common law’s “necessity exception,”⁵⁶ has gained infamy among disability rights advocates

48. *Ellen S. v. Fla. Bd. of Bar Exam’rs*, 859 F. Supp. 1489, 1494 (S.D. Fla. 1994); *Med. Soc’y of N.J. v. Jacobs*, No. 93-3670 (WGB), 1993 WL 413016, *10 (D.N.J. Oct. 5, 1993).

49. *Ellen S.*, 859 F. Supp. at 1493.

50. *In re* Petition to R.I. Bar, 683 A.2d 1333, 1335 (1996).

51. 28 C.F.R. § 35.104(4) (2011).

52. *In re* Petition to R.I. Bar, 683 A.2d at 1335.

53. 28 C.F.R. § 35.130(b)(3)(i).

54. 28 C.F.R. § 35.130(b)(6).

55. 28 C.F.R. § 35.130(b)(8) (emphasis added).

56. *Doe v. Judicial Nominating Comm’n for 15th Jud. Cir. of Fla.*, 906 F. Supp. 1534, 1540 (1995) (reasoning that 28 C.F.R. § 35.130(b)(8) is a “necessity exception” to screen out individuals to insure the safe operation of the program).

for creating an improper justification to inquire into mental health.⁵⁷ Nonetheless, the necessity exception applies in all licensing activities, including character and fitness investigations.⁵⁸

B. Character and Fitness, Generally

The ABA Comprehensive Guide to Bar Admission Requirements sets out standards with the intent that they “will afford guidance and assistance and will lead toward uniformity of objectives and practices in bar admissions throughout the United States.”⁵⁹ The ABA admission requirements serve the purpose of assessing (1) competence, and (2) character and fitness.⁶⁰ Moreover, the ABA directs that board examiners “frame each question on the application in a manner that renders the scope of inquiry clear and unambiguous.”⁶¹

Character and fitness investigations are a requisite component of admission to the Bar.⁶² Generally, state bar examiners view past conduct as a predictor of future conduct.⁶³ As such, pre-admission conduct may be determinative, as long as the basis for denying admission has a “rational connection to the applicant’s fitness or capacity to practice law.”⁶⁴ However, all evidence of wrongdoing must be disclosed in a character and fitness evaluation as a precondition to bar admission.⁶⁵ To date,

57. Jon Bauer, *The Character of the Questions and the Fitness of the Process: Mental Health, Bar Admissions and the Americans with Disabilities Act*, 49 UCLA L. REV. 93, 137–38 (2001).

58. *Ellen S.*, 859 F. Supp. at 1494.

59. NAT’L CONFERENCE OF BAR EXAM’RS & AM. BAR ASS’N SECTION OF LEGAL EDU. & ADMISSIONS TO THE BAR, *Comprehensive Guide to Bar Admission Requirements*, at vii, (last visited Mar. 18, 2012) http://www.ncbex.org/assets/media_files/Comp-Guide/CompGuide.pdf.

60. *BAR ADMISSIONS BASIC OVERVIEW*, & A.B.A. SEC. LEGAL EDUC. & ADMISSIONS TO BAR, (last visited Mar. 18, 2012) available at <http://www.abanet.org/legaled/baradmissions/basicoverview.html>.

61. *Comprehensive Guide to Bar Admission Requirements*, *supra* note 59, at viii.

62. *Schwartz v. Bd. of Bar Exam’rs of the State of N. M.*, 353 U.S. 232, 234 (1957).

63. Michael K. McChrystal, *A Structural Analysis of the Good Moral Character Requirement for Bar Admission*, 60 NOTRE DAME L. REV. 67, 67 (1984).

64. *Schwartz*, 353 U.S. at 240 (Frankfurter, J., concurring).

65. *Strigler v. Bd. of Bar Exam’rs*, 448 Mass. 1027, 1029 (2007).

the methods used to obtain information regarding fitness have traditionally been self-disclosure and character references, given that the burden is on the applicant to demonstrate good character.⁶⁶

The legitimate interests justifying character and fitness investigations are arguably threefold:⁶⁷ “(1) protection of the public;⁶⁸ (2) ‘proper, orderly and efficient administration of justice,’⁶⁹ and (3) protection of the professional image of the legal profession.⁷⁰ Professor Deborah L. Rhode argued that:

The public’s ‘low regard for the profession,’ reflected in recent public opinion polls, is a matter of acute concern to practicing lawyers; ABA members have ranked it as the most urgent issue facing the bar, and ABA presidents have repeatedly pledged to make improving lawyers’ image one of their highest priorities. How exactly that improvement can be secured is a matter of dispute, but bar examiners frequently present character certification as part of the general campaign.⁷¹

In this regard, courts have in some circumstance affirmed fitness boards’ decisions to deny certification of bar applicants partly because certification would undermine the integrity of the profession.⁷² Essentially, the fitness board serves the public and “members of the bar in upholding public confidence in the profession by denying admission to those not demonstrating the requisite moral character and fitness.”⁷³

The character and fitness evaluation has been met with some criticism, primarily that the ABA’s admission requirements

66. *Konigsberg v. State Bar of Cal.*, 366 U.S. 36, 41 n.4 (1961).

67. M.A. Cunningham, *The Professional Image Standard: An Untold Standard of Admission to the Bar*, 66 TUL. L. REV. 1015, 1026 (1992).

68. *Id.*

69. *Id.*

70. Deborah L. Rhode, *Moral Character as Professional Credential*, 94 YALE L. J. 491, 505–07 (1985).

71. *Id.* at 510–11.

72. *In re Childress*, 561 N.E. 2d 614, 622 (Ill. 1990) (upholding fitness board’s rejection of bar applicant partly because of lack of candor of past criminal conduct).

73. *In re Cason*, 249 Ga. 806, 808 n.5 (1982).

have not delineated constructs of “socially acceptable behavior” evidencing moral fitness.⁷⁴ Moreover, scholars have criticized that the majority of state bars have not formulated any standards of “socially acceptable behavior,” pursuant to the ABA’s lack of guidance.⁷⁵ The United States Supreme Court noted that character and fitness evaluations have “shadowy rather than precise bounds[,]” because moral character analysis relies on inherently subjective criteria.⁷⁶ Regardless, subjective criteria will not render a state’s bar admission evaluation unconstitutionally vague, so long as the criteria are read in context with other specific factors, such as a history of criminality, employment, and character references substantiating reliability.⁷⁷ However, although the authority to license applicants is well-established, state bar examiners are still subject to the ADA’s statutory requirements.⁷⁸

*C. Necessity to Inquire into Mental Health:
History of the ADA’s Necessity Exception*

The “necessity exception” of the ADA allows screening of disabled applicants as long as there is a justification to ensure the safe operation of the program or “if the individual poses a direct threat to the health or safety of others.”⁷⁹ However, mental health examinations trigger ADA analysis upon submitting the disabled bar applicant to each of two levels of disability based inquiry.⁸⁰ The first level is the broad, initial inquiry requiring all applicants to disclose mental health disabilities.⁸¹ The second level is the subsequent investigation, which occurs upon the applicant’s submission of an affirmative answer to the initial inquiry.⁸² Only

74. Dina Epstein, *Have I Been Googled? Character and Fitness in the Age of Google, Facebook, and Youtube*, 21 GEO. J. LEGAL ETHICS 715, 718 (2008).

75. *Id.*

76. *Schwabe*, 353 U.S. at 249.

77. *In re Oppenheim*, 159 P.3d 245, 253 (2007).

78. *Clark v. Va. Bd. of Bar Exam’rs*, 880 F. Supp. 430, 436–42 (E.D. Va. 1995).

79. *Doe v. Jud. Nominating Comm’n for Fifteenth Jud. Cir. of Fla.*, 906 F. Supp. 1534, 1541 (1995) (citing 28 C.F.R. § 35.130(b)(8) pt. 35, app. A, at 455 (2011)).

80. *Med. Soc’y of N.J. v. Jacobs*, Civ. A No. 93-3670 (WGB). 1993 WL 413016, *8 (D.N.J. Oct. 5, 1993).

81. *Id.*

82. *Id.*

applicants with mental health disabilities are submitted to these subsequent investigations.⁸³ The subsequent investigations involve identification of the treating professionals and release of records.⁸⁴ Moreover, a failure to authorize the release of relevant medical and mental health records will result in a denial of bar admission.⁸⁵ Disability advocates call subsequent investigations an “additional burden,” because only applicants with disabilities are subject to these additional screening practices, and they are subjected to them on the basis of disability.⁸⁶

Generally, federal courts have upheld bar examiners’ initial inquiries and subsequent investigations provided two requirements are met ensuring narrow inquiry into mental health.⁸⁷ First, the initial inquiry must be narrowly tailored to “respect the privacy rights of the individual applicant.”⁸⁸ Second, the subsequent investigation must be narrowly tailored to “allow access only to information relevant to the applicant’s fitness to practice law.”⁸⁹

Initially, however, the courts were split on whether mental health based inquiries were justifiable under the ADA. This split occurred during the widespread litigation of broad inquiries into the diagnoses or treatments of “any emotional, nervous or mental disorders,” that may have occurred at any point in the applicant’s lifetime.⁹⁰ Some courts rejected disability-based investigations under the premise that conduct-based inquiries were a more reasonable alternative in effectively yielding information into

83. Carol J. Banta, *The Impact of the Americans with Disabilities Act on State Bar Examiners’ Inquiries into the Psychological History of Bar Applicants*, 94 MICH. L. REV. 167, 175 (1995).

84. *Ellen S. v. Fla. Bd. of Bar Exam’rs*, 859 F. Supp. 1489, 1491 (S.D. Fla. 1994).

85. *Id.*

86. Banta, *supra* note 83, at 175.

87. *See Applicants v. Tex. State Bd. of Law Exam’rs*, No. A 93 CA 740 SS, 1994 WL 923404, at *3 (W.D. Tex. Oct. 11, 1994); *O’Brien v. Va. Bd. of Bar Exam’rs*, No. 98-0009 A, 1998 WL 391019, at *4 (E.D. Va. Jan. 23, 1998); *McCready v. Ill. Bd. of Admissions to the Bar*, No. 94 C 3582, 1995 WL 29609, at *6 (N.D. Ill. Jan. 24, 1995).

88. *O’Brien*, 1998 WL 391019, at *4.

89. *Id.*

90. *In re Applications of Plano and Underwood*, 1993 WL 649283, at *1 (Me. 1993); *Ellen S.* 859 F. Supp. at 1491.

mental health.⁹¹ Conduct-based inquiries examine behavior derived from evidence such as criminal and employment records and character references.⁹² Other courts upheld narrowly tailored inquiries into specific mental health disabilities, such as Bipolar I Disorder, Schizophrenia, paranoia, and other psychotic disorders for the necessity of public protection.⁹³

Most of the federal cases were decided between the years of 1993 to 1996, following the enactment of the ADA in 1990.⁹⁴ Further litigation followed a decade later, after the case law had been well established by both federal precedent and the ABA Resolution endorsing narrow mental health inquiries.⁹⁵ The ABA's Resolution encouraged states to limit their mental health investigations according to the following guidelines:

[S]tate and territorial bar examiners. . . should consider the privacy concerns of bar admission applicants, tailor questions concerning mental health and treatment narrowly in order to elicit information about current fitness to practice law, and take steps to ensure that their processes do not discourage those who would benefit from seeking professional assistance with personal problems and issues of mental health from doing so. [Additionally,] . . . fitness determinations may include specific, targeted questions about an applicant's behavior, conduct or any current impairment of the applicant's ability to practice law.⁹⁶

91. *Med. Soc'y of N.J. v. Jacobs*, Civ. A. No. 93-3670 (WGB), 1993 WL 413016, at *7 (D.N.J. Oct. 5, 1993); *Ellen S.*, 859 F. Supp. at 1493; *In re Petition of Frickey*, 515 N.W.2d 741, 741 (Minn. 1994).

92. *Jacobs*, 1993 WL 413016, at *7.

93. *Applicants*, 1994 WL 923404, at *3; *McCready*, 1995 WL 29609, at *6; *Doe v. Jud. Nominating Comm'n for 15th Judicial Cir. of Fla.*, 906 F. Supp. 1534, 1541 (1995).

94. *Jacobs*, 1993 WL 413016, at *7; *Ellen S.*, 859 F. Supp. at 1493; *Frickey*, 515 N.W.2d at 741.

95. *See e.g., O'Brien*, 1998 WL 391019, at *4; *McCready*, 1995 WL 29609, at *6.

96. *Turnbull III et al.*, *supra* note 18, at 598.

Noticeably, there has been a trend in favor of narrow inquiries after the implementation of the ABA Resolution.⁹⁷

The following subsections explain the chronological evolution of bar examiner inquiries in ADA jurisprudence. First, the conduct-based jurisdictions are explicated as those that reject all types of mental health inquiries and subsequent investigations primarily because conduct-based inquiries elicit the same information without violating the ADA.⁹⁸ This is followed by an examination of the jurisdictions that challenged conduct-based inquiries and consequently upheld narrowly tailored inquiries into mental health.⁹⁹ Finally, the modern trend upholding narrowly tailored inquiries is briefly evaluated.

1. No Mental Health Inquiries, Conduct-Based Inquires Preferred

Some jurisdictions upheld conduct-based inquiries as an alternative to inquiries into mental health because conduct, unlike past mental health histories, is an empirically validated predictor of fitness.¹⁰⁰ Moreover, conduct-based inquiries elicit information into mental health, as do direct inquiries into mental health.¹⁰¹

In 1993, the court in *Medical Society of New Jersey v. Jacobs* laid the groundwork for many forthcoming cases in ADA jurisprudence.¹⁰² The District Court of New Jersey in *Jacobs* held that the New Jersey Board of Medical Examiners, as a licensing agency, was not justified in conducting inquiries and subsequent investigations into disability status.¹⁰³ The court further concluded that the inquiries into status did not constitute invidious discrimination by themselves, as it was possible for the medical

97. *O'Brien*, 1998 WL 391019, at *4; *Applicants*, 1994 WL 923404, at *3.

98. *Clark v. Va. Bd. of Bar Exam'rs*, 880 F. Supp. 430, 445 (E.D. Va. 1995); Bauer, *supra* note 57, at 141.

99. *Applicants*, 1994 WL 923404, at *3; Bauer, *supra* note, 57, at 144.

100. *Clark*, 880 F. Supp at 445–46. The *Clark* court heard expert testimony on behalf of the American Psychiatric Association's (APA) position, which rejected questions on psychiatric history because they were not informative as a sole source of information. *Id.* at 436. Rather, the APA's stance was to ask about conduct and current impairment. *Id.*

101. *Jacobs*, 1993 WL 413016, at *8.

102. *Id.*

103. *Id.* at *7.

examiners to inquire into status alone without conducting discrimination against the applicant.¹⁰⁴ However, the true act of discrimination occurred with the subsequent investigations that were triggered by the affirmative answers to the disability based inquires.¹⁰⁵ The court reasoned that the “essential problem with the [mental health based] questions is that they substitute an impermissible inquiry into the status of disabled applicants for the proper, indeed, necessary inquiry into the applicant’s behavior.”¹⁰⁶ Instead, bar examining authorities could have utilized character references, employment records, and current illegal drug use to obtain information into the applicant’s behavior without resorting to disability-based queries.¹⁰⁷ Essentially, only conduct-based inquiries were deemed permissible, as there was no necessity to inquire into mental health.¹⁰⁸

After the *Jacobs* court set forth the doctrine and policy to restrict unfettered mental health based inquisition by public entities, the Supreme Judicial Court of Maine addressed Maine’s initial level of inquiry and subsequent investigation in *In re Applications of Underwood* in 1993.¹⁰⁹ The first question in dispute inquired into whether the applicants had “ever received [a] diagnosis of an emotional, nervous or mental disorder?”¹¹⁰ The second question stated: “within the ten (10) year period prior to the date of this application, have you ever received treatment of emotional, nervous or mental disorder?”¹¹¹ Subsequent to

104. *Id.* at *8.

105. *Id.*

106. *Id.* at *7.

107. *Id.*

108. *Id.*; see also Bauer, *supra* note 57, at 141.

109. 1993 WL 649283, at *2 (Me. 1993).

110. *In re Applications of Plano and Underwood*, 1993 WL 649283, at *1 (Me. 1993). The aforementioned question was listed as Item 29 on the application for the Bar of the State of Maine. *Id.* The exact wording is as follows: “Have you ever received diagnosis of an emotional, nervous or mental disorder? Yes No If so, state the names and addresses of the psychologists, psychiatrists or other medical practitioners who made such diagnosis.” *Id.*

111. *Id.* The aforementioned question was listed as Item 30 on the application for Bar of the State of Maine. *Id.* The exact wording is as follows:

Within the ten (10) year period prior to the date of this application, have you ever received treatment of emotional, nervous or mental disorder? Yes No If so, state the names and complete addresses of each psychologist, psychiatrist or other

affirmative answers disclosing the diagnosis and treatment of any “emotional, nervous, or mental disorder[s],”¹¹² a broad authorization of clinical records from the treating healthcare professional was mandatory to determine the fitness of the applicant.¹¹³ The court rejected both the initial level inquiry and the subsequent investigation of the broad medical authorization because the requirements “discriminated on the basis of disability, and imposed eligibility criteria that unnecessarily screen out individuals with disabilities.”¹¹⁴

Notably, other federal courts in different circuits followed the lead of the *Jacobs* court, even though *Jacobs* did not apply to bar examiners.¹¹⁵ In 1994, the Southern District Court of Florida extended public entity liability to the Florida Board of Bar Examiners in *Ellen S. v. Florida Board of Bar Examiners*.¹¹⁶ The petitioner-bar applicant asserted that the inquiry into her mental health status was tantamount to eligibility criteria predicated on the disability itself.¹¹⁷ The challenged inquiry was whether “applicant ha[d] ever sought treatment for a nervous, mental, or emotional condition, ha[d] ever been diagnosed as having such a condition or ha[d] ever taken any psychotropic drugs.”¹¹⁸ The Florida Board of Bar Examiners also required a release of all mental health records, follow-up investigations, and hearings, upon an affirmative answer.¹¹⁹ Petitioner claimed that the discrimination occurred at the onset of the subsequent investigation, which required the release of clinical records upon her affirmative answer.¹²⁰ The

health care professional, including social worker, who treated you. (THIS QUESTION DOES NOT INTEND TO APPLY TO OCCASIONAL CONSULTATION FOR CONDITIONS OF EMOTIONAL STRESS OR DEPRESSION, AND SUCH CONSULTATION SHOULD NOT BE REPORTED).

Id.

112. *Id.*

113. *Id.*

114. *In re Underwood*, 1993 WL 649283, at *2.

115. *Ellen S. v. Fla. Bd. of Bar Exam'rs*, 859 F. Supp. 1489, 1493 (S.D. Fla. 1994); *Clark v. Va. Bd. of Bar Exam'rs*, 880 F. Supp. 430, 442–46 (E.D. Va. 1995).

116. *Ellen S.*, 859 F. Supp. at 1493–94.

117. *Id.* at 1491–93.

118. *Id.* at 1491.

119. *Id.*

120. *Id.*

court agreed, primarily citing the rationale of the *Jacobs* court insofar as “the questions were used as a screening device to ‘place additional burdens’” on the petitioner.¹²¹ Additionally, the court agreed with *Jacobs* that conduct-based inquiries should have been applied because they could have elicited the same information into the applicant’s fitness without violating the ADA.¹²²

As a policy concern, conduct-based inquiries have been upheld because mental health inquiries deterred applicants from obtaining professional treatment.¹²³ In 1994, the court in *In re Petition of Frickey* balanced the bar examiners’ interest to ask fitness questions against the applicants’ interest to seek mental health counseling without the concern of disclosure.¹²⁴ The court in *Frickey* found that many students refrained from seeking professional help because of the bar’s mental health questions.¹²⁵ Thus, conduct-based inquiries were found to be the best, most reasonable, alternative because they could have elicited the same information necessary to the bar examining authority without intruding on the applicant’s privacy.¹²⁶

In 1995, the District Court for the Eastern District of Virginia analyzed broad mental health inquiries in light of their predictive value to determine future fitness to practice law in *Clark v. Virginia Board of Bar Examiners*.¹²⁷ The court evaluated the wording of the following bar examiners’ question: “Have you within the past five (5) years been treated or counseled for any mental, emotional or nervous disorders?”¹²⁸ Again, pursuant to an affirmative response, the applicant was required to disclose

121. *Id.* at 1493–94 (citing *Med. Soc’y of N.J. v. Jacobs*, Civ. A. No. 93-3670 (WGB), 1993 WL 413016, at *7 (D.N.J. Oct. 5, 1993)).

122. *Id.* at 1494.

123. *In re Petition of Frickey*, 515 N.W.2d 741, 741 (Minn. 1994). *See also* *Turnbull III et al.*, *supra* note 18, at 598. The ABA Resolution also recommends bar examiners to ensure that the investigations do not discourage applicants from seeking professional help, if necessary. *Id.*

124. *Frickey*, 515 N.W.2d at 741.

125. *Id.*

126. *Id.*

127. *Clark v. Va. Bd. of Bar Exam’rs*, 880 F. Supp. 430, 436–42 (E.D. Va. 1995).

128. *Id.* at 433.

specific information.¹²⁹ The court heard multiple psychology experts speak on whether past mental health histories serve as a reliable predictor to the future fitness to practice law.¹³⁰ In fact, the leading expert, Dr. Howard V. Zonana, argued on behalf of the American Psychiatric Association's (APA) position that past behavior was a more reliable predictor of future fitness based on empirical data.¹³¹ The court denied the bar examiners' inquiries for failure to demonstrate evidence that "all or most" of the applicants who affirmatively answered the question were a direct threat to the public.¹³²

Although the *Clark* court found the initial inquiry and subsequent investigation to be "too broad," the court reasoned that the ADA did not preclude narrower inquiries into mental health in light of the ABA Resolution.¹³³ The court noted that the ABA urged state bar examiners to balance the applicants' privacy interests against the public's safety interests by tailoring "questions concerning mental health and treatment narrowly in order to elicit information about current fitness to practice law, and take steps to ensure that their processes do not discourage those who would benefit from seeking professional assistance with personal problems and issues of mental health from doing so."¹³⁴ Although ultimately agreeing with precedent that conduct-based inquiry was a more reasonable alternative, the court, in dicta, allowed room for interpretation for narrow inquiries into mental health.¹³⁵

129. *Id.* Notably, the ABA Resolution's concern to "take steps to ensure" that applicants will not be discouraged to seek counseling resounds with the holding set out in *Frickey*. *Frickey*, 515 N.W.2d at 741. Although the *Frickey* Court's holding endorses conduct-based inquiries and the ABA's Resolution clearly urges a more narrow approach, both entities seem to encourage the mental health of bar applicants while maintaining investigatory access to bar examining authorities. *Frickey*, 515 N.W.2d at 741; Turnbull III et al., *supra* note 18, at 598.

130. *Clark*, 880 F. Supp at 435.

131. *Id.*

132. *Id.* at 442.

133. *Id.* at 440-41 (citing House of Delegates, A.B.A., Proposal 110 (1994)).

134. *Id.*

135. *Id.* at 441. Now, in Virginia, narrowly drawn questions inquiring into specific disorders such as Major Depressive Disorder, Schizophrenia, Bipolar I Disorder, Antisocial Personality Disorder, and substance abuse are the current

In 1996, The Rhode Island Supreme Court in *In re Petition & Questionnaire for Admission to R.I. Bar* further explicated the state bar examiners' burden of proof to inquire into applicants' mental health.¹³⁶ The court stated that:

[T]he burden is on those who propose to ask the questions to show an actual relationship such that (1) applicants with mental-health-and substance-abuse-treatment histories actually pose an increased risk to the public, (2) the admission process has effectively protected the public by using [the contested questions] to identify those persons with mental-health- or substance-abuse-treatment histories who are a danger to the public, or (3) attorneys who have become a danger to the public in their practice of law, when retrospectively reviewed, could have been identified with any degree of reliability by such questions.¹³⁷

The American Civil Liberties Union appealed the challenged questions,¹³⁸ asserting that such inquiries violated the

state of questions. *See O'Brien v. Va. Bd. of Bar Exam'rs*, No. 98-0009-A, 1998 WL 391019 (E.D. Va. Jan. 23, 1998).

136. *In re Petition to R.I. Bar*, 683 A.2d 1333, 1336 (1996).

137. *Id.*

138. *Id.* at 1334. The wording of the questions were as follows:

26. Are you or have you within the past five (5) years been addicted to or dependent upon the use of narcotics, drugs, or intoxicating liquors or been diagnosed as being addicted to or dependent upon said items to such an extent that your ability to practice law would be or would have been impaired? YES — NO —.

Id.

29(a) Have you ever been hospitalized, institutionalized or admitted to any medical or mental health facility (either voluntarily or involuntarily) for treatment or evaluation for any emotional disturbance, nervous or mental disorder? YES — NO —. If yes, state the name and complete address of each hospital, institution or treatment facility; the dates of treatment or evaluation; and the name of each individual in charge of your treatment or evaluation.

Id.

ADA and the individuals' privacy rights.¹³⁹ The court struck the questions and further instructed for limited inquiry into only current illegal use of drugs.¹⁴⁰ The ruling was based on the premise that a bar examiner may screen whether an applicant was a direct threat to the public; however, the bar examiner may not utilize generalizations or stereotypes in determining so.¹⁴¹ The court reasoned that the predictive value of mental health questions was inherently faulty because there was no empirical evidence substantiating that applicants with past mental health treatment endured future disciplinary action.¹⁴² In fact, any data on disciplinary actions of barred attorneys arose after several years of practice, not from the time of original licensure.¹⁴³ Moreover, accurate predictions and assessments of mental health fitness were unreliable, at best, because members of the fitness board were lay individuals, lacking any mental health training.¹⁴⁴

In effect, the Rhode Island Supreme Court created more definitive guidelines on the evidentiary proof needed to establish a correlational relationship between past mental health histories and future fitness. Thus, the aforementioned guidelines could affect whether answers from these questions in similar jurisdictions are even admissible, if contested.

[29](b) Are you now or have you within the past five (5) years been diagnosed as having or received treatment for an emotional disturbance, nervous or mental disorder, which condition would impair your ability to practice law? YES — NO —. If yes, explain, stating the name and complete address of each psychologist, psychiatrist, counselor or other medical practitioner who made such diagnosis or from whom you received treatment, and the relevant dates.

In re Petition to R.I. Bar, 683 A.2d at 1334.

139. *Id.* at 1333.

140. *Id.* at 1337. The reworded question, at the direction of the Special Masters, is as follows: "Question 26: Are you currently using narcotics, drugs, or intoxicating liquors to such an extent that your ability to practice law would be impaired? Yes — No —." *Id.*

141. *Id.* at 1334.

142. *Id.* at 1336.

143. *In re Petition to R.I. Bar*, 683 A.2d at 1336.

144. *Id.*

2. Narrow Inquiries into Mental Health, Justifiable by Necessity

Federal courts upholding narrowly tailored mental health inquiries reason that investigations are justifiable because a history of mental health disorders may present itself as future detrimental symptoms preventing an applicant to function in the practice of law.¹⁴⁵ Unlike the jurisdictions that advocated conduct-based inquiries, narrow inquiry jurisdictions do not require a high threshold of evidence demonstrating a correlation between past mental health histories and future fitness.¹⁴⁶ That is, a past history is not viewed to necessarily predict future fitness.¹⁴⁷ Instead, a past history will grant insight into the functional capacity of the individual.¹⁴⁸

The first court to challenge the ADA based restraints on bar examiner inquiries into mental health was the District Court of the West District of Texas in *Applicants v. Texas State Board of Law Examiners* in 1994.¹⁴⁹ The court upheld reasonable and narrowly tailored inquiries into mental health for the necessity of public safety.¹⁵⁰ The court reasoned that inquiries into Bipolar I Disorder, Schizophrenia, paranoia, and any other psychotic disorders were necessary to determine whether the applicant was fit to practice law.¹⁵¹ The court concurred with *In re Underwood*, stating that broad questions investigating into the entirety of an applicant's mental health history were intrusive.¹⁵² In addition, inquiry should be limited to the past five or ten years of the applicant's adulthood

145. *Applicants v. Tex. State Bd. of Law Exam'rs*, No. A 93 CA 740 SS, 1994 WL 923404, *3 (W.D. Tex. Oct. 11, 1994). Federal courts have established that Florida, Illinois, Texas, Virginia, and Wisconsin employ narrow investigations into mental health. *See generally* Doe v. Jud. Nominating Comm'n for Fifteenth Jud. Cir. of Fla., 906 F. Supp. 1534 (1995); McCready v. Ill. Bd. of Admissions to the Bar, 1995 WL 29609, *6 (N.D. Ill. Jan. 24, 1995); *Applicant*, 1994 WL 923404; O'Brien v. Va. Bd. of Bar Exam'rs, 1998 WL 391019 (E.D. Va. Jan. 23, 1998); Brewer v. Wis. Bd. of Bar Exam'rs, 270 Fed. App'x. 418 (7th Cir. 2007).

146. *Id.*

147. *Id.*

148. *Id.*

149. 1994 WL 923404, *3 (W.D. Tex. Oct. 11, 1994).

150. *Applicants*, 1994 WL 923404, at *3.

151. *Id.*

152. *Id.* at *6–7.

in order to pass muster under the ADA.¹⁵³ The court reasoned that the disorders posing a direct threat develop in adolescence.¹⁵⁴ Thus, bar examiners have an interest in determining whether an applicant's condition had worsened during the past five or ten years.¹⁵⁵ Moreover, the court determined that conduct-based inquiries would fail with those applicants who could not appreciate the nature or quality of their conditions, as conduct-based inquiries required self-disclosure.¹⁵⁶ Hence, under the logic of the *Applicants* Court, many unfit applicants would pass unnoticed if self-disclosure of behaviors were required as evidence of debilitating, or untreated, mental health disorders.¹⁵⁷

Unlike *Clark* and other jurisdictions advocating conduct-based inquiries, the *Applicants* Court noted that any information elicited from narrow mental health inquiries would not necessarily predict future fitness.¹⁵⁸ Instead, the knowledge of applicant's current symptomatology, level of insight into his or her illness, and cooperation with treatment were reasoned as factors that would glean insight in assessing functional capacity to practice law.¹⁵⁹ Notably, the District Court for the Southern District of Florida upheld narrow inquiries into mental health after the *Applicants* Court handed down its opinion,¹⁶⁰ despite previously upholding conduct-based inquiries.¹⁶¹ In 1995, the District Court for the Southern District of Florida in *Doe v. Judicial Nominating Commission for the Fifteenth Judicial Circuit of Florida*, extended the necessity exception to judicial candidates.¹⁶² In *Doe*, the plaintiff was a judicial applicant asserting that inquiries into mental health status were a violation of the ADA and that the defendants were only allowed to inquire into behavior.¹⁶³ However, the court

153. *Id.* at *7.

154. *Id.*

155. *Id.*

156. *Applicants*, 1994 WL 923404, at *7.

157. *Id.*

158. *Id.*

159. *Id.*

160. *Doe v. Jud. Nominating Comm'n for Fifteenth Jud. Cir. of Fla.*, 906 F. Supp. 1534, 1541 (1995).

161. *Ellen S. v. Fla. Bd. of Bar Exam'rs*, 859 F. Supp. 1489, 1494 (S.D. Fla. 1994).

162. *Doe*, 906 F. Supp. at 1541.

163. *Id.* at 1540.

in *Doe* relied on *Applicants v. Texas State Board of Law Examiners*, in reasoning that “when . . . questions of public safety are involved, the determination of whether an applicant meets ‘essential eligibility requirements’ involves consideration [of] whether the individual with a disability poses a direct threat to the health and safety of other[s].”¹⁶⁴ Furthermore, the court reasoned that screening judicial candidates for mental health disorders was even more important than screening bar applicants because judges are “vested with extraordinary power” in deciding cases of life, death, imprisonment, and child custody, among other issues.¹⁶⁵

The District Court for the Northern District of Illinois in *McCready v. Illinois Board of Admissions to the Bar* confirmed federal precedent in favor of narrow investigations.¹⁶⁶ The court held that narrowly tailored inquiry into diagnosed specific disorders over the past ten years is necessary for public protection.¹⁶⁷ The distinction between *McCready* and other similarly situated cases is that the inquiry was made upon a third party reference of the bar applicant’s mental health history.¹⁶⁸ The inquiry was not made upon the bar applicant himself.¹⁶⁹ The court reasoned, in dicta, that the purpose of character and fitness questionnaires is to accumulate a “comprehensive picture,” complete with landmark events in the applicant’s life.¹⁷⁰ As for the ADA, the court reasoned that disabled individuals were intended to be mainstreamed, and, as such, bar applicants should be screened for fitness “despite [a] disability,” not “but for” a disability.¹⁷¹ However, the court reasoned that the request for a reference’s recommendations inquired only into behavior, not disability status.¹⁷² Therefore, the court reasoned that no ADA violation was committed and dismissed the suit.¹⁷³

164. *Id.* at 1541 (quoting *Applicants*, 1994 WL 776693, at *5).

165. *Id.* at 1541.

166. *McCready v. Ill. Bd. of Admissions to the Bar*. No. 94 C 3582, 1995 WL 29609, *6 (N.D. Ill. Jan. 24, 1995).

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.* at *6.

171. *Id.* at *5.

172. *McCready*, 1995 WL 29609, at *6.

173. *Id.*

In 1998, the decision in *O'Brien v. Virginia Board of Bar Examiners* marked the transition of a once conduct-based jurisdiction in Virginia to one that now upholds narrow inquiries into mental health.¹⁷⁴ The transition was arguably the result of the dicta in *Clark*.¹⁷⁵ The petitioner-applicant in *O'Brien* sought a preliminary injunction against the Board for denying bar admission for failure to answer mental health questions and authorize release of medical records.¹⁷⁶ The court reasoned that the challenged question was not as overbroad as in *Clark*, as it had since been rewritten to address ADA concerns.¹⁷⁷ The court argued that screening for mental health issues that distort an individual's perception of reality was justified by a public necessity to ensure that clients received competent representation.¹⁷⁸ As to the initial inquiry, the court found that the rewritten question was narrowly tailored so as not to intrude on the privacy rights of the applicant.¹⁷⁹ The subsequent investigation of the medical release was also narrowly tailored in scope, as it only pertained to the relevant information of fitness to practice law.¹⁸⁰

Almost a decade later in 2007, the Seventh Circuit's holding in *Brewer v. Wisconsin Board of Bar Examiners* addressed the extent that the bar examining authority may require a psychological evaluation as a subsequent investigation.¹⁸¹

174. *O'Brien v. Va. Bd. of Bar Exam'rs.*, No. 98-0009-A. 1998 WL 391019, at *3-4 (E.D. Va. Jan. 23, 1998).

175. *Clark v. Va. Bd. of Bar Exam'rs.*, 880 F. Supp. 430 444 (E.D. Va. 1995).

176. *O'Brien*, 1998 WL 391019, at *1.

177. *Id.* at *3. The rewritten question was worded as follows:

Within the past five years, have you been diagnosed with or have you been treated for any of the following: schizophrenia or any other psychotic disorder, delusional disorder, bipolar or manic depressive mood disorder, major depression, antisocial personality disorder, or any other condition which significantly impaired your behavior, judgment, understanding, capacity to recognize reality, or ability to function in school, work or other important life activities?

Id.

178. *Id.* at *4.

179. *Id.*

180. *Id.*

181. *Brewer v. Wis. Bd. of Bar Exam'rs*, 270 Fed. App'x. 418, 420 (7th Cir. 2007).

Petitioner-applicant sued for loss of her “diploma privilege” for admission into the Wisconsin Bar without the requirement of sitting for the bar examination.¹⁸² The petitioner was denied her diploma privilege because the fitness board never received her release of medical records concerning chronic depression and fatigue.¹⁸³ As a result, the fitness board requested a psychological evaluation, which the petitioner refused.¹⁸⁴ However, the court reasoned that the request for the psychological evaluation was reasonable as that it was “rationally related to its interest in ensuring that only competent persons are admitted to practice law in Wisconsin.”¹⁸⁵

The disputes in the aforementioned cases resulted in amended bar application questions focusing on a narrow inquiry into mental health.¹⁸⁶ The limited scope of inquiry was influenced both by the widespread litigation and the formation of the ABA Resolution recommending narrow mental health inquiry.¹⁸⁷ To date, federal case law has settled that Florida,¹⁸⁸ Illinois,¹⁸⁹ Texas,¹⁹⁰ Virginia¹⁹¹ and Wisconsin¹⁹² narrowly inquire into specific mental health disorders that have been treated or diagnosed within the past five or ten years. Due to the influence of the ABA Resolution and federal courts, state boards nationwide request bar applicants to disclose whether they have been diagnosed or treated for certain disorders within the last five or ten

182. *Id.* at 420.

183. *Id.*

184. *Id.*

185. *Id.* at 421 (citing *Bd. of Trs. of the Univ. of Ala. v. Garrett*, 531 U.S. 356, 366–67 (2001)).

186. *See generally* *Clark v. Va. Bd. of Bar Exam’rs*, 880 F. Supp. 430, 444 (E.D. Va. 1995).

187. *Id.* at 441.

188. *Doe v. Judicial. Nominating Comm’n for Fifteenth Judicial Circuit of Fla.*, 906 F. Supp. 1534, 1540–41 (S.D. Fla.1995); *see also* *Stoddard v. Fla. Bd. of Bar Exam’rs*, 509 F. Supp. 2d 1117, 1124 (N.D. Fla. 2006) (upholding inquiry into mental health of bar applicants).

189. *McCready*, 1995 WL 29609, at *6.

190. *Applicants v. Tex. State Bd. of Law Exam’rs*, No. A-93-CA-740-SS, 1994 WL 923404, *3–6 (W.D. Tex. Oct. 11, 1994).

191. *O’Brien*, 1998 WL 391019, at *4.

192. *Brewer v. Wis. Bd. of Bar Exam’rs*, 270 Fed. App’x. 418 (7th Cir. 2007).

years.¹⁹³ In addition to the narrow inquiry, state boards of bar examiners ask whether the applicant has been “currently”¹⁹⁴ diagnosed with “any emotional, mental, or nervous disorders” that may impair the practice of law.¹⁹⁵

3. Current State of State Bar Examiners’ Mental Health Questions

Essentially, many states employ two types of initial inquiry in determining whether the applicant has a mental health disability that may pose a direct threat to the public.¹⁹⁶ To name a few, Alabama,¹⁹⁷ Florida,¹⁹⁸ Idaho,¹⁹⁹ Louisiana,²⁰⁰ Maryland,²⁰¹ Massachusetts,²⁰² and Virginia²⁰³ apply two types of initial inquiry on their bar applications. Each of these states requests disclosure of: (1) treated or diagnosed disorders within the past five or ten years, such as Schizophrenia, Substance Dependence, or Bipolar I Disorder,²⁰⁴ and; (2) “any emotional, mental, or nervous disorders”

193. See Va. Character Questionnaire, *supra* note 20, La. Character Report, *supra* note 21; Mass. Character Report, *supra* note 20; Ala. Character Report, *supra* note 21; Fla. Bar Application, *supra* note 21 IDAHO STATE BAR, *Application for Examination and Admission to the Idaho State Bar*, at 12, http://isb.idaho.gov/pdf/http://isb.idaho.gov/pdf/admissions/web_be_application.pdf (“Idaho Application”); *Request for Preparation of a Character Report: Maryland*, NAT’L CONFERENCE OF BAR EXAM’RS, <https://secure.ncbex2.org/php/ea/view.php>. (“Maryland Character Report”);

194. Va. Character Questionnaire, *supra* note 20, at 19.

195. Ala. Character Report, *supra* note 21, at 13.

196. *Doe v. Judicial. Nominating Comm’n for Fifteenth Judicial. Circuit. of Fla.*, 906 F. Supp. 1534, 1541 (S.D. Fla. 1995) (citing *Clark v. Va. Bd. of Bar Exam’rs*, 880 F. Supp. 430, 446 (E.D. Va. 1995)).

197. Ala. Character Report, *supra* note 21, at 13.

198. Fla. Bar Application, *supra* note 21.

199. Idaho Application, *supra* note 208.

200. La. Character Report, *supra* note 21.

201. Md. Character Report, *supra* note 208.

202. Mass. Character Report, *supra* note 21.

203. Va. Character Questionnaire, *supra* note 21, at 19.

204. *Applicants of Tex. State Bd. of Law Exam’rs*, No. A-93-CA-740-SS, 1994 WL 923404, *7–8 (W.D. Tex. 1994). The *Applicants* Court set forth the seminal rule of upholding narrow inquiry into the treatment or diagnoses of certain disorders within the span of five or ten years for the purpose of public protection. *Id.* However, the Court does not enumerate with specificity whether bar queries apply only to Bipolar I Disorder or whether the investigations apply to the full spectrum of bipolar disorders, such as Bipolar II Disorder,

that may “currently” impair the practice of law.²⁰⁵ If an affirmative answer is given to either of the two types of initial inquiries, the second level of inquiry involves a follow-up investigation into the mental health condition.²⁰⁶

Florida is very extensive in its list of specific disorders that it identifies in its initial narrow question.²⁰⁷ Aside from the aforementioned disorders, Florida requests disclosure of: “impulse control disorder[s], including kleptomania, pyromania, explosive

Cyclothymic Disorder, and Bipolar Disorder Not Otherwise Specified (NOS). *Id.* The Court merely states that “[b]ipolar disorder, schizophrenia, paranoia, and psychotic disorders are serious mental illnesses that may affect a person’s ability to practice law.” *Id.* Other states’ bar applications use the language “bipolar or manic depressive disorder” in its questions. Va. Character Questionnaire, *supra* note 21, at 19; Cal. Moral Character Application, *supra* note 23. Thus, these questions may specifically intend to investigate for the existence of Bipolar I Disorder, given that Bipolar I Disorder is formerly known as “manic depressive disorder.” See *Bipolar Disorder*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml> (last visited Feb. 25, 2012).

In the alternative, character and fitness questions investigating for the presence of “any emotional, nervous or mental disorders” that “currently” impair the practice of law may serve the purpose of detecting Bipolar II Disorder, Cyclothymic Disorder and Bipolar Disorder NOS, given that these are not directly investigated elsewhere on bar applications. See Ala. Character Report, *supra* note 22, at 13; Va. Character Questionnaire, *supra* note 21, at 19; Fla. Bar Application, *supra* note 22. Arguably, the second type of initial level inquiry is equivalent to a “catchall” provision for requesting information as to any mental health disorders that currently impair the functioning of the bar applicant.

However, the National Institute of Mental Health uses the term “Bipolar Disorder” to encompass all bipolar disorders. *Bipolar Disorder*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml> (last visited Feb. 26, 2012). Thus, the *Applicants* Court and various state boards of bar examiners may have applied the language “bipolar or manic depressive disorder” to include both Bipolar I Disorder (as “manic depressive disorder”) and the remaining bipolar disorders (as “bipolar disorder”) in their narrow inquiries.

205. Va. Character Report, *supra* note 21, at 19; Massachusetts Character Report, *supra* note 21.

206. *Authorization & Release*, ALA. BD. OF BAR EXAM’RS, <http://www.alabar.org/admissions/files/admissionAuthorization.pdf>. [hereinafter Ala. Authorization & Release].

207. Fla. Bar Application, *supra* note 22.

disorder, pathological or compulsive gambling[,] or paraphilia[s] such as pedophilia, exhibitionism, or voyeurism.”²⁰⁸

In contrast, California is very broad in its question, as it does not narrowly tailor its request for information with respect to specific disorders or time.²⁰⁹ However, California examines whether an applicant is currently impaired by any mental health disorders.²¹⁰ Specifically, California asks: “Have you ever been diagnosed or treated for a medically recognized mental illness, disease, or disorder that would currently interfere with your ability to practice law?”²¹¹

Similar to California, North Carolina does not temporally limit its narrow inquiry into specific disorders.²¹² North Carolina’s narrow inquiry is worded as: “*Have you ever* been diagnosed with or have you been treated for bipolar disorder with psychosis or for schizophrenia, paranoia, or any other psychosis or psychotic disorder?”²¹³ Prof. Hubbard argues that the North Carolina Board of Bar Examiners poses overbroad questions on its bar application by using the language “have you ever” instead of investigating whether applicants have suffered mental health disorders within the past five or ten years of their adulthood.²¹⁴ Prof. Hubbard posits that the “have you ever” questions are not valid predictors of fitness because they do not adequately measure whether the applicant is currently impaired from the mental disorder.²¹⁵ Instead, Prof. Hubbard asserts that limiting the inquiry to five to ten years in the applicant’s developmental history serves the purpose of assessing whether the condition has worsened to the detriment of an inability to practice law.²¹⁶

Of the bar examiner authorities examined, the territorial bar examiner of Washington, D.C. requests the least of its

208. *Id.*

209. Cal. Moral Character Application, *supra* note 23. .

210. *Id.*

211. *Id.*

212. *Request for Preparation of a Character Report: North Carolina*, NAT’L CONFERENCE OF BAR EXAM’RS, <https://secure.ncbex2.org/php/ea/view.php>. (“North Carolina Character Report”).

213. *Id.* (emphasis added).

214. Hubbard, *supra* note 16, at 2210–11.

215. *Id.*

216. *Id.* at 2228–29 (citing *Applicants*, 1994 WL 923404, at *7).

applicants.²¹⁷ The District of Columbia Court of Appeals Committee on Admissions requires disclosure of treatment or diagnosis of Substance Dependence and, if applicable, voluntary or involuntary commitment to an institution.²¹⁸

The second level of inquiry entails a subsequent investigation when an applicant affirmatively reveals either a specific disorder or any disorder that currently impairs daily functioning.²¹⁹ Generally, the state board of bar examiner in question may require the applicant to authorize a release of clinical records for more information.²²⁰ Some states only require release of the names and addresses of the treating physician or counselor and, if applicable, institution or hospital for future contact.²²¹ The Alabama Board of Bar Examiners, on the other hand, requires applicants to furnish “any and all medical reports, laboratory reports, X-rays, or clinical abstracts which may have been made or prepared pursuant to, or in connection with, any examination or examinations, consultation or consultations, test or tests, evaluation or evaluations, of the undersigned.”²²²

Courts have addressed and thoroughly quelled the nearly twenty-year-old debate on fashioning the initial level of inquiry.²²³ However, analysis into ADA jurisprudence has not yet peered into the breadth of the second level inquiry into intangible documents, such as online profiles. Although federal precedent has ruled on subsequent investigations of medical records,²²⁴ the required release of user-names and passwords to personal websites raises nostalgic issues of overbroad inquiries, reminiscent of nearly two decades ago.

217. *Request for Preparation of a Character Report: District of Columbia*, NAT’L CONFERENCE OF BAR EXAM’RS, <https://secure.ncbex2.org/php/ea/view.php>. (“D.C. Character Report”).

218. *Id.*

219. Ala. Authorization & Release, *supra* note 206.

220. *Id.*

221. Mass. Character Report, *supra* note 21; La. Character Report, *supra* note 21.

222. Ala. Authorization & Release, *supra* note 206.

223. *See generally* Bauer, *supra* note 57; Banta, *supra* note 91; *But see* Morris, *supra* note 27, at 56.

224. *Ellen S.*, 859 F. Supp. at 1493 (S.D. Fla. 1994); *Med. Soc’y of N.J. v. Jacobs*, 1993 WL 413016, at*8 (D.N.J. Oct. 5, 1993); *O’Brien*, 1998 WL 391019, at *4.

III. THE ONLINE PRESENCE OF BAR APPLICANTS AND STATE BAR EXAMINERS

Online social networking has permeated the legal field.²²⁵ The majority of law students maintain an online presence, as shown in a Suffolk University Law School survey conducted in 2009.²²⁶ The Suffolk University Law School Survey demonstrated that 84% of students activated a Facebook account, 44% had a LinkedIn account, 17% had a Twitter account, and only 10% have never had any online social networking accounts.²²⁷ Moreover, the survey showed that 81.8% of law students had active Facebook accounts, 4.9% had inactive Facebook accounts, and 13.2% reported never activating Facebook accounts.²²⁸ Although many students activate sites such as Facebook to “stay connected” and socialize in a casual manner with their peers, research has shown that maintaining an online presence has the secondary purpose of networking with professors and legal professionals.²²⁹

The ABA may adopt general cyber discovery as a national guideline for character and fitness investigations pursuant to recent scholarly proposals.²³⁰ University of Virginia Professor Michelle Morris in 2007 proposed that bar applicants should provide a “three year history of online aliases, email addresses, IP addresses, blogs, and social networking site profile information on both law school and bar application forms.”²³¹ Other states either have applied online profile indicia towards evidence of character

225. Gena Slaughter & John G. Browning, *Social Networking Dos and Don'ts for Lawyers and Judges*, 73 TEX. B.J. 192, 192 (2010); Nick Pujji, Anahit Tagvoryan, & Joshua Briones, *Facebook: The Future of Service of Process?*, 25 No. 8 ANDREWS PHARM. LITIG. REP. 11 (2009).

226. Eric M. Fink, *Facebook & the Web of Group Affiliation: Socializing, Socialization, & Social Network Site Use Among Law Students*, 27 J. MARSHALL J. COMPUTER & INFO. L. 325, 333–34 (2010).

227. Kathleen E. Vinson, *The Blurred Boundaries of Social Networking in the Legal Field: Just “Face” It*, 41 U. MEM. L. REV. 355, 375 n. 74 (2010) (citing Suffolk University Law School, Technology Survey (Oct. 2009)) (on file with author).

228. Fink, *supra* note 226, at 333–34.

229. Vinson, *supra* note 227, at 362. *Clark*, 880 F. Supp. at 444.

230. Morris, *supra* note 25, at 56.

231. *Id.*

fitness²³² or have implemented online investigation policies in their character and fitness evaluations.²³³ The State Bar of California Committee of Bar Examiners denied an applicant admission to the bar for displaying unfit indicia on a webpage.²³⁴ On July 21, 2009, Florida Board of Bar Examiners instituted a policy investigating personal websites of certain bar applicants on a case-by-case basis, among the applicants were those with a history of substance abuse or dependence.²³⁵ Sober individuals with a history of substance abuse or dependence could qualify as rehabilitated addicts under the ADA if proper records of treatment in a rehabilitation facility are presented.²³⁶

Thus, inquiry into the scope of the state bar examiners' subsequent investigation is relevant as it pertains to the new methodology that is being utilized: online personal websites. The general rule remains that a subsequent investigation, as in the initial level of inquiry, is reasonable in scope if the investigation is narrowly tailored to yield access to only information relevant to the fitness to practice law.²³⁷ Until recently, the methodology of gathering information has been restricted to self-disclosure,²³⁸

232. *Id.* (discussing denial of a California bar applicant for failure to maintain an "appropriate online persona.").

233. Fla. Online Investigation Policy, *supra* note 24, at 5.

234. *Id.*

235. Fla. Online Investigation Policy, *supra* note 24, at 5. The Florida Board of Bar Examiners have a new policy to conduct investigations into the social network profiles of those:

. . . who are required to establish rehabilitation under rule 3–13; *applicants with a history of substance abuse/dependence*; applicants with significant candor concerns . . . ; applicants with a history of [unauthorized practice of law] allegations; applicants who have worked as a Certified Legal Intern, reported self-employment in a legal field, or reported employment as an attorney pending admission; and applicants who have positively responded to Item 27 of the bar application regarding involvement in an organization advocating the overthrow of the government[.]

Id. (emphasis added).

236. 28 C.F.R. § 35.131(a)(2)(i)–(ii) (2006) (stating that a qualified individual with a disability includes one who has completed a supervised rehabilitation program, is rehabilitated successfully, or one who is currently engaged in a rehabilitation program).

237. *O'Brien*, 1998 WL 391019, at *4.

238. *Ellen S.*, 859 F. Supp. at 1491.

release of records,²³⁹ face-to-face hearings with applicants,²⁴⁰ and even psychological evaluations²⁴¹ in determining fitness. However, the integration of online investigations among bar examiner inquiries yields access to personal information. Nonetheless, statutes under title II concerning bar admission are silent as to whether bar examiners may even conduct online investigations as a licensing function. This is a particularly thorny issue because title II's statutory interpretation generally incorporates title I's prohibited acts, duties and rights governing private employers.²⁴²

*A. Employers Can Conduct Pre-Screening Inquiries,
Lest for Disabilities*

Generally, title I of the ADA proscribes disability-based discrimination in employment.²⁴³ Employers are entitled to screen potential job applicants for their ability to perform job-related functions.²⁴⁴ However, employers are prohibited from inquiring into disabilities or the severity thereof.²⁴⁵ Seemingly, character and fitness examinations are the loophole for medically based, psychiatric inquires, whereas such questions may be deemed illegal, beyond the scope, or unnecessary, in employment law.²⁴⁶

Currently, no case law has decided whether employers can conduct online investigations on potential job applicants.²⁴⁷ Therefore, scholars have commented that employers' review of applicants' online social networking sites is an "emerging area of law."²⁴⁸ Scholars further anticipate future litigation primarily because online investigations yield access to information irrelevant

239. *Id.*

240. *Id.*

241. *Brewer*, 270 Fed. App'x. at 420.

242. *Jacobs*, 1993 WL 413016, at *10; *Ellen S.* 859 F. Supp. at 1493.

243. 42 U.S.C. § 12112(a) (2006).

244. 42 U.S.C. § 12112(d)(2)(B) (2006).

245. *Id.* at § 12112(d)(2)(A).

246. *Bauer*, *supra* note 57, at 129.

247. Ian Byrnside, Note, *Six Clicks of Separation: The Legal Ramifications of Employers Using Social Networking Sites to Research Applicants*, 10 VAND. J. ENT. & TECH. L. 445, 459 (2008).

248. *Id.* at 448.

to job-related fitness, such as race, sexual orientation, and religious affiliation.²⁴⁹

B. Public Entities Do Not Have a Clear Mandate for Pre-Screening Licensing Activities

Title II, on the other hand, does not clearly delineate prohibitory pre-screening licensing activities.²⁵⁰ Rather, the House Education and Labor Committee chose “not to list all the types of actions that are included within the term ‘discrimination,’ as was done in titles I and III, because this title . . . simply extends the anti-discrimination prohibition . . . to all state and local governments.”²⁵¹ Therefore, courts have concluded that title II was meant to incorporate enumerated discriminatory acts within titles I and III.²⁵²

C. The Future of Title II: Anticipating Statutory Interpretation of Online Pre-Screening

But for the necessity exception, titles I and II would be read congruently. If employers are entitled to screen applicants for job-related fitness, absent inquiry into disabilities, then it stands to reason that public entities would be prohibited from the same level of inquiry. However, courts have interpreted the necessity exception as granting bar examiners the right to a narrowly tailored inquiry into specific mental disorders.²⁵³ Therefore, until an ADA claim is litigated under either title I or II, then mental health screening of online profiles remains an emerging area of law under both titles I²⁵⁴ and II.²⁵⁵

Nonetheless, a narrowly tailored inquiry cannot feasibly and reasonably be executed in its methodology through the internet, for the same reason that scholars have criticized employers’ review of job applicants’ online profiles. Namely, online investigations are not limited in the scope of inquiry

249. Robert Sprague, *Googling Job Applicants: Incorporating Personal Information into Hiring Decisions*, 23 LAB. LAW 19, 32 (2007).

250. *Jacobs*, 1993 WL 413016, at *10; *Ellen S.* 859 F. Supp. at 1493.

251. H.R. REP. NO. 101-485(II), at 84 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 367.

252. *Jacobs*, 1993 WL 413016, at *10; *Ellen S.* 859 F. Supp. at 1493.

253. *See Applicants*, 1994 WL 923404, at *3.

254. Byrnside, *supra* note 247, at 448.

255. 28 C.F.R. § 35.130(b)(8) (2006).

because they yield access to personal information that is irrelevant to the fitness to practice law, akin to job-related fitness.

IV. ASSESSING FITNESS ONLINE: OVERBROAD AND INEFFECTUAL MENTAL HEALTH INQUIRIES

Online investigations are “overbroad and ineffectual” in assessing indicia of mental health illness.²⁵⁶ First, online investigations are overbroad because they access information that is outside the scope of relevance to the fitness to practice law.²⁵⁷ Second, they are ineffectual because an online profile page is a poor substitute for a medical record in determining if the applicant is cooperating with treatment or is suffering from detrimental symptoms. The online investigation is required because a bar applicant affirmatively answered to the initial narrowly tailored mental health inquiry.²⁵⁸ Thus, the online investigation is, procedurally, a subsequent investigation into mental health. Therefore, the online investigation must be narrowly tailored so that it only yields access to information relevant to the fitness to practice law.²⁵⁹

A. Overbroad

First, online investigations are “overbroad” in that their scope is seeking more than the relevant information towards the fitness to practice law. If the investigation’s purpose is to seek evidence of fitness based on the presence of symptoms of mental illness, then online investigations are intrusive because bar examiners seek evidence of detrimental symptoms where none are likely to exist. A release of medical records would lead to

256. *Clark v. Va. Bd. of Bar Exam’rs*, 880 F. Supp. 430, 435 (E.D. Va. 1995).

257. Lakisha Davis, *A Look Into Your Facebook May Be All It Takes to Determine Your Career as an Attorney*, THE STUDENT APPEAL, Nov. 1, 2011, <http://thestudentappeal.com/constitutional/facebookandfloridabar/0> (last visited Feb. 26, 2011) (arguing that investigations peer into associations or affiliations of the applicants in question).

258. *Med. Soc’y of N.J. v. Jacobs*, Civ. A. No. 93-3670 (WGB), 1993 WL 413016, at *8 (D.N.J. Oct. 5, 1993) (discussing the second level of inquiry, the authorized release of medical records, upon an affirmative answer to the initial inquiry of mental health disorders).

259. *O’Brien v. Va. Bd. of Bar Exam’rs*, No. 98-0009-A, 1998 WL 391019, at *4 (E.D. Va. Jan. 23, 1998).

reasonable inferences of mental health stability and fitness, whereas personal website investigations yield access to personal information. Because of this, an applicant's online profile, regardless of its public domain, is likely to trigger the guarded "privacy interests" discussed by the courts.²⁶⁰

Courts, both upholding conduct-based²⁶¹ and narrow mental health inquiry²⁶² have balanced the applicants' privacy interests against their respective state bar examiners' legitimate interest to seek information on fitness. The balancing test has sought, among other factors, whether another reasonable alternative to attain information is available to the bar examiner and, if so, whether the alternative would yield the same information.²⁶³ A reasonable alternative already exists for the bar examiner to acquire mental health information: the authorized release of medical records.²⁶⁴ As such, the fitness boards can gather mental health information through medical records without intruding into the personal information posted online.

Moreover, state bar examiners could conduct random, systematic, or isolated investigations on the disabled applicant's online profile. Personal websites do not remain stagnant. Unlike medical records, web pages are intangible and continuously updated by the user and can even be updated without the user's knowledge if other people add photographs or comments to the site. Thus, it is possible that the state bar examiners' awareness that new information is available every day would create a new legitimate interest for the bar examiner to "periodically check-up" on the applicant. In contrast, a fixed, tangible medical record is restricted to the printed word and could be read only once with the knowledge that no new information will develop thereafter, unless another evaluation should occur. Therefore, if a bar examiner has discretionary, unfettered, access to an applicant's website, not only could unrestricted information be available, but continuous access may be an issue.

260. *In re* Petition of Frickey, 515 N.W.2d 741 (Minn. 1994); *O'Brien*, No. 98-0009-A, 1998 WL 391019, at *4.

261. *Frickey*, 515 N.W.2d 741.

262. *O'Brien*, No. 98-0009-A, 1998 WL 391019, at *4.

263. *Id.*

264. *Ellen S. v. Fla. Bd. of Bar Exam'rs*, 859 F. Supp. 1489, 1491 (S.D. Fla. 1994).

Bar examiners are limited in what they can directly ask of an applicant.²⁶⁵ Nonetheless, the investigations create a slippery slope because the bar examiners could access information that they are prohibited from directly requesting.²⁶⁶ Bar examiners could readily discern protected and personal information displayed on an online profile, such as sexual orientation, race, creed, and religion.²⁶⁷ Moreover, bar examiners could discover information about other bar applicants that do not fall within the targeted populations. Unfortunately, Facebook “friends” of targeted bar applicants could be subject to investigations that the bar examiner did not delineate at the outset of investigation policies.

Furthermore, it is possible that state bar examiners may be verifying affirmative answers with medical records, and then online profiles, to determine if applicants are candid about their initial responses to the mental health queries. Arguably, state bar examiners’ greatest legitimate interest in conducting online investigations may lie in monitoring the candor of bar applicants. Thus, in effect, bar examiners employing online investigations are submitting the applicants to tertiary investigations, or the “additional, additional burden,” for the purpose of candor.

In *Clark v. Virginia Board of Bar Examiners*, the court discovered that the Virginia Board of Bar Examiners was utilizing a similar practice by “verify[ing] [the applicants’] affirmative answers” with the disclosed mental health professionals.²⁶⁸ The subsequent investigation was denied for its breadth because it was predicated on the applicant’s disability and the Virginia Board of Bar Examiners failed to show that it was necessary to further inquire into the applicant’s disability.²⁶⁹ Similarly, online investigations could be argued as a subsequent investigation for the purported interest of checking candor on the disclosure of the mental health disorder. In effect, online investigations are a

265. *In re Stolar*, 401 U.S. 23, 28 (1971) (holding that questions of affiliations to organizations is a violation of the First and Fifth Amendments of the Constitution).

266. Patrick, *The Florida Bar Is Not Your Facebook Friend*, <http://theshark.typepad.com/weblog/2009/09/the-florida-bar-is-not-your-facebook-friend.html> (last visited Jan. 1, 2010).

267. *Id.*

268. *Clark v. Va. Bd. of Bar Exam’rs*, 880 F. Supp. 430, 434 (E.D. Va. 1995).

269. *Id.* at 442.

tertiary level of investigating mental illnesses, or an “additional, additional burden,” unlike traditional second level inquiries.²⁷⁰ First, the initial inquiry gathers information on the mental health disorders as the first investigation. Then, the additional investigation requires a medical records release for the purpose of gathering information on mental health and candor.²⁷¹ Finally, the online investigation is imposed on only those with mental health disabilities affirmed by medical records. Regardless if the search for candor is a motivating factor, seeking out the truth on the basis of disability on multiple levels, will not likely pass scrutiny under the ADA.

B. Ineffectual

Second, the online investigations are “ineffectual” because there is no determination that an online profile could render better, more reliable indicia of mental health stability and fitness to practice law than a medical record signed by a certified, licensed professional. Peering into an online profile is nothing short of eavesdropping into a conversation midway or reading a private journal. A glimpse into someone’s life may be learned, but certainly any information is likely to be read out of context. In fact, blurbs, photographs, and phrases on a personal website would hardly reveal effective information into one’s fitness, functional capacity, or even if the applicant was cooperating with his or her treatment.²⁷² The diagnostic impressions of the treating professional are a superior indicator of the applicant’s mental health and fitness because the professional can offer data into psychological assessment, method of evaluation, the applicant’s cooperation in treatment sessions, subsequent diagnosis, and prognosis.

Moreover, any indicia that the state bar examiners would attempt to interpret as mental health instability may be to the detriment of the applicant if no one on the character and fitness board has any training in mental health, psychology, social work,

270. *Med. Soc’y of N.J. v. Jacobs*, Civ. A. No. 93-3670 (WGB), 1993 WL 413016, *8 (D.N.J. Oct. 5, 1993).

271. *Id.*

272. *Applicants v. Tex. State Bd. of Law Exam’rs*, No. A 93 CA 740 SS, 1994 WL 923404, *3 (W.D. Tex. 1994).

or psychiatry.²⁷³ Members of the fitness board still rely on assessments, medical records, and evaluations prepared by professionals in concluding applicant fitness even though board members rarely have mental health or psychological training when conducting investigations. Furthermore, even if the online profile were to be used only as a factor for the “comprehensive picture,”²⁷⁴ the investigation still fails because of the breadth of the scope that could access other material not relevant to fitness.

State bar examiners have an interest to gather information on fitness.²⁷⁵ However, state bar examiners are not entitled an unfettered interest in determining fitness. Naturally, the bar authority, in keeping with the times, is maintaining an online presence along with bar applicants to check on candor and other relevant issues.²⁷⁶ However, the scope of the investigation is that much more important if the investigation is occurring online because of the personal information that is posted.

V. POLICY CONCERNS NOTWITHSTANDING ADA VIOLATIONS

Online mental health inquiries also raise other policy concerns that are apparent, aside from those raised under the ADA. First, these inquiries may increase the chances that bar applicants will choose to not disclose mental health information due to fear of stigmatization. Most importantly, future bar applicants with mental health problems might be more likely to refrain from seeking treatment for fear of bar denial, as the court noted in *In re Petition of Frickey*.²⁷⁷

Moreover, online investigations deter online social networking among bar applicants for fear of negative repercussions in character and fitness evaluations.²⁷⁸ Bar applicants may attempt to disable or refrain from using their personal websites altogether

273. *In re Petition & Questionnaire for Admission to R.I. Bar*, 683 A.2d 1333, 1336 (1996).

274. *McCready v. Ill. Bd. of Admissions to the Bar*, 1995 WL 29609, *6 (N.D. Ill. Jan. 24, 1995).

275. *Cunningham*, *supra* note 74, at 1026; *Rhode*, *supra* note 77, at 505–07.

276. *Fla. Online Investigation Policy*, *supra* note 26, at 5; *Morris*, *supra* note 27, at 56.

277. *In re Petition of Frickey*, 515 N.W.2d 741 (Minn. 1994).

278. *Davis*, *supra* note 257.

upon notice of the online investigations. Scholars argue that those who utilize blogs benefit from group collaboration, updates on politics and academia, and the development of interpersonal relationships.²⁷⁹ Legal blogs, or “blawgs,” provide a forum for students and lawyers to discuss pertinent and relevant legal issues.²⁸⁰ “Blawgs” are so commonplace and advocated that the ABA Journal sponsors them on its website.²⁸¹ However, personal website investigations could result in self-censorship, decreased use of online forums, and deprivation of social networking benefits.²⁸²

In modern society, applicants are at a greater professional advantage if they stay current and socially network on the internet.²⁸³ Consequently, an issue may arise in which a rehabilitated addict is erroneously regarded as currently using drugs or alcohol. Usually, networking functions are held at casual venues with food and alcohol where law students and local attorneys mingle. Nonetheless, a bar applicant who is a rehabilitated alcoholic could be erroneously regarded as currently using alcohol if a friend “tags”²⁸⁴ a photograph onto the applicant’s page and the friend is holding an alcoholic drink from, ironically, a law function. Moreover, removing other people’s photographs from the personal website may be out of the applicant’s control or scope of knowledge.²⁸⁵ Thus, analysis of website indicia in such a context would be a harsh remedy for the bar applicant.

279. Jonathan Sabin, *Every Click You Make: How the Proposed Disclosure of Law Students’ Online Identities Violates Their First Amendment Right to Free Association*, 17 J.L. & POL’Y 699, 709–10 (2009).

280. Rob La Gatta, *Law Bloggers Respond to ABA Blawg 100 Post: Real Lawyers Have Blogs*, December 17, 2007, available at <http://kevin.lexblog.com/2007/12/articles/cool-stuff/law-bloggers-respond-to-aba-blawg-100-post/> (last visited Jan. 17, 2010).

281. ABA JOURNAL, *Blawg Directory*, available at <http://www.abajournal.com/blawgs> (last visited Jan. 5, 2010).

282. Epstein, *supra* note 82, at 716.

283. Vinson, *supra* note 249, at 377.

284. *Id.* at 371.

285. *Id.* at 363. (commenting that many Facebook users find it difficult to operate the default and privacy settings).

VI. PROPOSED SOLUTION: CONDUCT-BASED ONLINE INVESTIGATIONS

Although the internet is now an emerging factor in determining fitness, the same issues continue to resonate within bar examiner inquiries into mental health and its impact on the ADA. That is, online investigations are overbroad in their scope and ineffectual in yielding determinative evidence of fitness. Thus, in proposing solutions to conducting online investigations a referral to federal precedent is necessary: conduct-based investigations. Conduct-based online investigations would be feasible if fitness boards enumerated clear and unambiguous methods of inquiry. First, fitness boards should enumerate clear definitions of “conduct” and, analogously, “misconduct,” within the purview of online indicia. Second, unambiguous methodology of online investigations should be delineated within the online investigation policies in order to limit the inquiry to targeted individuals and relevant indicia. If this were accomplished, conduct-based online investigations into the mental health of targeted populations would be in compliance with ABA guidelines to render the scope of inquiry “clear and unambiguous.”²⁸⁶

First, clear policy identification of what website information qualifies as evidence of “conduct” and “misconduct” may narrowly tailor the scope of the investigations. Generally, current illegal use of drugs is not a protected status within the ADA.²⁸⁷ Moreover, the ADA does not protect alcohol or drug-related misconduct.²⁸⁸ Hence, if online investigations were limited to indicia of conduct-based offenses, including current illegal use of drugs, then the ADA would not be violated. However, determining whether photographs and blurbs are, in fact, evidence of misconduct or current illegal use of drugs can be difficult to discern without the assistance of the user’s explanation. This is a particularly important concern in cases where Facebook “friends”

286. NAT’L CONFERENCE OF BAR EXAM’RS & AM. BAR ASS’N SECTION OF LEGAL EDU. & ADMISSIONS TO THE BAR, *supra* note 66, at vii.

287. *McCready v. Ill. Bd. of Admissions to the Bar*, No. 94 C 3582, 1995, WL 29609, at *6 (N.D. Ill. Jan. 24, 1995).

288. *Id.*

post photographs onto another user's page or "wall."²⁸⁹ Thus, fitness boards may consider incorporating into their policies whether non-targeted peoples' postings onto the targeted applicants' wall are discoverable indicia of "misconduct" for purposes of the targeted applicants' online investigation. Moreover, the viewing of a non-targeted bar applicant's online indicia during a targeted bar applicant's investigation raises concerns of excessive scope, particularly if the non-targeted bar applicant did not warrant a subsequent investigation into mental health. Clearly delineated policies may reduce the possibilities of analyzing targeted applicants' and non-targeted applicants' personal information, while maintaining compliance with the ADA.

Second, enumerated unambiguous online investigation methods would assist in preventing future broad-based litigation issues. A primary concern is whether board examiners will enter online forums daily, or periodically, since online profiles are updated at the user's discretion. Fitness boards may consider providing some form of short-term notice prior to the investigations. Limited notice may nullify concerns of applicants disabling personal websites. A fitness board in its policy-making discretion can tailor the scope of the investigation to determine who is evaluated, which indicia is evaluated, and set out the definitions of conduct to meet the modern needs of the internet.

In the alternative to conduct-based inquiries into mental health, a "blanket search"²⁹⁰ consisting of bar applicants' conduct-related profile indicia should be utilized as a valid subsequent investigation for licensure. A "blanket search" would apply to all bar applicants, not only to those who affirmatively respond to the initial inquiries about mental health histories. Thus, regardless of statutory interpretation of bar examiners' duties to screen, a "blanket search" would not run afoul of the ADA as it would not

289. Facebook Help Center, *Wall: How to Use the Wall Feature and Wall Privacy*, <https://www.facebook.com/help/?page=174851209237562> (last visited May 17, 2012).

290. Fla. Online Investigation Policy, *supra* note 26, at 5. The Character and Fitness Commission ("Commission") of the Florida Board of Bar Examiners initially proposed a "blanket search" of all applicants upon implementation of the online investigation policy. *Id.* at 16. However, the Commission later modified the policy to target only selected classes for unspecified reasons. *Id.* at 5.

target qualified individuals with disabilities. Moreover, a “blanket search” would involve looking into only bar applicant’s comments or photographs that are not protected under the ADA. Evidence of occupational misconduct, drug or alcohol misconduct, and criminal activity would be suggested discoverable activity, as it was discussed among the federal courts.²⁹¹ Since candor is a legitimate interest for state bar examiners, it is one that should not be used to conduct online investigations on only bar applicants with mental health disabilities. State bar examiners’ investigations into only bar applicants with mental illnesses implies that only applicants with mental health disorders fail to disclose issues related to mental health. Therefore, state bar examiners are establishing, by policy, that bar applicants with mental health disorders are at heightened risk for candor issues. However, state bar examiners who choose to utilize online investigations may be able to prevent future ADA violations if “blanket searches” are implemented.

VII. CONCLUSION: RESURGENCE VS. PEACEFUL RESOLUTION

Bar examiner inquiries into mental health have been debated thoroughly in the scope of the ADA over the past two decades.²⁹² After extensive litigation from conduct-based inquiries²⁹³ to narrow mental health inquiries into specific disorders,²⁹⁴ the majority of jurisdictions have decided on the latter resolution.²⁹⁵ However, online investigations raises concerns of whether the internet will be the reason for the re-litigation of “overbroad and ineffectual”²⁹⁶ bar examiner inquiries.

291. *Clark v. Va. Bd. of Bar Exam’rs*, 880 F. Supp. 430, 436 (E.D. Va. 1995); *Med. Soc’y of N.J. v. Jacobs*, No. 933670, 1993 WL 413016, at *7 (D.N.J. Oct. 5, 1993).

292. *See generally* Bauer, *supra* note 64; Banta, *supra* note 83. *But see* Morris, *supra* note 27, at 56.

293. *Med. Soc’y of N.J. v. Jacobs*, No. 93-3670, 1993 WL 413016, at *8 (D.N.J. Oct. 5, 1993).

294. *Applicants v. Tex. St. Bd. of Law Exam’rs*, No. A 93 CA 740 SS, 1994 WL 923404, at *3 (W.D. Tex. Oct. 11, 1994).

295. Bauer, *supra* note 57, at 149 n. 178.

296. *Clark*, 880 F. Supp at 445.

Ironically, the “more things change, the more they remain the same.”²⁹⁷ Regardless of the introduction of the internet, the solution of conduct-based inquiries seems to be the most reasonable solution. Hopefully, as the digital age continues evolving, future bar examiner policies affecting applicants with mental health disabilities will be in accord with both federal precedent and the ADA.

297. Jean-Baptiste Alphonse Karr, *Les Guepes* [The Wasps], Jan. 1849. “Plus ca change, plus c’est la meme chose.” [literally “The more it changes, the more it’s the same thing.”].