

MENTAL HEALTH LAW & POLICY JOURNAL

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“The Judge, He Cast His Robe Aside”: Mental Health Courts, Dignity and Due Process

MICHAEL L. PERLIN*

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INTRODUCTION¹

* Professor of Law and Director, Online Mental Disability Law Program, New York Law School; Director, International Mental Disability Law Reform Project, Justice Action Center. Portions of this paper were presented at the biennial congress of the International Academy of Law and Mental Health, July 2009 (NYC), at the annual meeting of the Human Dignity and Humiliation Network, December 2011 (NYC), at the Prato Workshop on Coercive Care: Law and Policy, sponsored by the Monash University Centre for the Advancement of Law and Mental Health, May 2012 (Prato, Italy), and the Association of American Law Schools’ annual meeting, January 2013 (New Orleans, LA). The author wishes to thank Alison Lynch for her helpful research and editorial assistance.

1. See generally, Michael L. Perlin, “*There Are No Trials Inside the Gates of Eden*”: *Mental Health Courts, the Convention on the Rights of Persons with Disabilities, Dignity, and the Promise of Therapeutic Jurisprudence*, in COERCIVE CARE: RIGHTS, LAW AND POLICY 193 (Bernadette McSherry & Ian Freckelton eds., 2013).

One of the most important developments in the past two decades in the way that criminal defendants with mental disabilities are treated in the criminal process has been the creation and the expansion of mental health courts, one kind of “problem-solving court.”² There are now, according to the Council of State Governments’ Justice Center, over 300 such courts in operation in the United States,³ some dealing solely with misdemeanors,⁴ some solely with non-violent offenders,⁵ and some with no such restrictions.⁶ There is a wide range of dispositional alternatives available to judges in these cases,⁷ and an even wider range of judicial attitudes.⁸ And the entire concept of “mental health courts” is certainly not without controversy.⁹

There is no question, however, that these courts offer a new approach – perhaps a *radically* new approach – to the problems at hand. They become even more significant because of their articulated focus on dignity,¹⁰ as well as their embrace of therapeutic jurisprudence, their focus on procedural justice, and their use of the

2. See, e.g., Greg Berman & Aubrey Fox, *The Future of Problem-Solving Justice: An International Perspective*, 10 U. MD. L.J. RACE, RELIGION, GENDER & CLASS 1, 3 (2010); Greg Berman & John Feinblatt, *Problem-Solving Courts: A Brief Primer*, 23 LAW & POL’Y, 125, 127 (2001).

3. See JUSTICE CENTER: THE COUNSEL FOR STATE GOVERNMENTS, <http://www.consensusproject.org/programs?q=mental+health+court&submit=Go> (last visited Oct. 15, 2013).

4. See, e.g., Ursula Castellano, *Courting Compliance: Case Managers as “Double Agents” in the Mental Health Court*, 36 LAW & SOC. INQUIRY 484, 490 (2011).

5. See, e.g., Julie Grachek, *The Insanity Defense in the Twenty-First Century: How Recent United States Supreme Court Case Law Can Improve the System*, 81 IND. L.J. 1479, 1495 (2006).

6. See, e.g., E. Leah Johnston, *Theorizing Mental Health Courts*, 89 WASH. L. REV. 519, 521 (2012).

7. See, e.g., Henry J. Steadman et al., *From Referral to Disposition: Case Processing in Seven Mental Health Courts*, 23 BEHAV. SCI. & L. 215, 220 (2005).

8. See, e.g., Michael S. King, *Should Problem-Solving Courts Be Solution-Focused Courts?*, 80 REV. JUR. U.P.R. 1005 (2011).

9. See, e.g., Tammy Seltzer, *A Misguided Attempt to Address the Criminal Justice System’s Unfair Treatment of People with Mental Illness*, 11 PSYCHOL. PUB. POL’Y & L. 570, 576 (2005).

10. See Ginger Lerner Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 593 (2010) (explaining dignity in the context of mental health courts); see generally, *infra* text accompanying notes 79–120.

principles of restorative justice.¹¹ It is time to restructure the dialogue about mental health courts and to begin to take seriously the potential ameliorative impact of such courts on the ultimate disposition of all cases involving criminal defendants with mental disabilities.

Mental health courts have come under attack from both the right and the left. Of these attacks, I believe that the only relevant one is that they may provide “false hope” to those who come before them.¹² I believe this is so because our “culture of blame” still infects the entire criminal justice process, and that it continues to demonize persons with mental illness for their status.¹³ Until this is remediated, there can be no assurances that mental health courts — or any other such potentially-ameliorative alternative — will be ultimately “successful” (however we choose to define that term). Two issues that, however, have *not* been the subject of much atten-

11. See Henry J. Steadman et al., *Mental Health Courts: Their Promise and Unanswered Questions*, 52 LAW & PSYCHIATRY 457, 457–58 (2001) (discussing therapeutic jurisprudence in this context); Thomas L. Hafemeister, Sharon G. Garner & Veronica E. Bath, *Forging Links and Renewing Ties: Applying the Principles of Restorative and Procedural Justice to Better Respond to Criminal Offenders with a Mental Disorder*, 60 BUFF. L. REV. 147, 201–02 (2012) (on procedural justice); MICHAEL L. PERLIN, A PRESCRIPTION FOR DIGNITY: RETHINKING CRIMINAL JUSTICE AND MENTAL DISABILITY LAW 88–96 (2013) (on restorative justice). On the relationship between these three approaches, see *id.* at 96–98; Michael L. Perlin, *Considering the “Alternative Jurisprudences” as a Tool of Social Change to Reduce Humiliation and Uphold Dignity*, (2012), <http://www.humiliationstudies.org/documents/PerlinNY12AlternativeJurisprudences.pdf> (paper presented to the 20th annual conference of the Human Dignity and Humiliation Studies Network).

12. See Perlin, *supra* note 1, at 195, 204, 208, 210.

13. For a consideration of the many obstacles faced by such courts, see Kevin Daly, Chrysanti Leon & Margaret Mahoney, *Delaware Mental Health Courts’ Process Evaluation: Progressive Treatment and Systematic Obstacles*, available at http://papers.ssrn.com/soL3/papers.cfm?abstract_id=1584835, http://papers.ssrn.com/soL3/papers.cfm?abstract_id=1584835 (last accessed Oct. 15, 2013; see, e.g., Michael L. Perlin, “Baby, Look Inside Your Mirror”: *The Legal Profession’s Willful and Sanist Blindness to Lawyers with Mental Disabilities*, 69 U. PITT. L. REV. 589, 606 (2008) (discussing the “culture of blame” in a different mental disability law context and how bar committees on ethics deal with lawyers with mental disabilities); see generally, Neil R. Feigenson, *Sympathy and Legal Judgment: A Psychological Analysis*, 65 TENN. L. REV. 1, 60 & n.258 (1997).

tion must, I believe, be considered seriously: the quality of counsel available to persons in mental health courts, and the question of whether the individual at risk is competent to engage in mental health court proceedings. These are both discussed extensively below.

Much of the recent debate on mental health courts has focused either on empirical studies of recidivism or on theorization.¹⁴ These entire discussions, while important and helpful, bypass the critical issue that is at the heart of this paper: do such courts provide additional dignity to the criminal justice process or do they detract from that? Until we re-focus our sights on this issue, much of the discourse on this topic remains wholly irrelevant.

In Part I of this paper, I will first discuss the underpinnings of therapeutic jurisprudence. I will next, in Part II, look at the structure of mental health courts, and will then raise the two concerns about such courts that are, I believe, of particular relevance to which I just alluded: questions of adequacy of counsel and the competency of defendants to voluntarily participate in such court proceedings. In Part III, I will then consider the role of dignity in this process, and look to ways that therapeutic jurisprudence can promote dignity in this context.

The title of this paper comes, in part from Bob Dylan's song, *Drifter's Escape*,¹⁵ a song that combines revengeful elements of the Old Testament with "a taste of Old West frontier justice."¹⁶ The beginning of the song eerily tracks the circumstances of so many defendants who eventually come before mental health courts:

"Oh, help me in my weakness"
I heard the drifter say
As they carried him from the courtroom
And were taking him away
"My trip hasn't been a pleasant one
And my time it isn't long

14. See, e.g., Richard Wiener et al., *A Testable Theory of Problem Solving Courts: Past Empirical and Legal Failures*, 33 INT'L J. L. & PSYCHIATRY 417 (2010).

15. BOB DYLAN, *DRIFTER'S ESCAPE* (Columbia 1967).

16. See OLIVER TRAGER, *KEYS TO THE RAIN: THE DEFINITIVE BOB DYLAN ENCYCLOPEDIA* 164 (2004).

And I still do not know
What it was that I've done wrong"

Well, the judge, he cast his robe aside
A tear came to his eye
"You fail to understand," he said
"Why must you even try?"¹⁷

Certainly, many such defendants have had "trips" that were not "pleasant ones," and often "still do not know/What it was that [they had] done wrong." The judge, in a mental health court, *does* symbolically "cast his robe" aside, as his role is so radically different than it is in traditional criminal courts. But I hope, in contrast to the situation depicted in this song, that judges *do* encourage litigants to "[try] to understand" the court process. Because I believe it is then, and only then, that some sort of remediation is possible.¹⁸

Therapeutic Jurisprudence¹⁹

One of the most important legal theoretical developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence (TJ).²⁰ Initially employed in cases involving individuals with mental disabilities, but subsequently expanded far beyond that narrow area, therapeutic jurisprudence pre-

17. DYLAN, *supra* note 15.

18. For those interested, I have seen Dylan sing this song only twice: On May 10, 2003, at the Atlantic City (NJ) Hilton, and on August 9, 2003, in Holmdel, NJ. He has not played it since November 27, 2005; *see* <http://www.bobdylan.com/us/songs/drifters-escape> (last accessed, Jan. 22, 2013).

19. Perlin, *supra* note 1, at 196.

20. *See, e.g.*, DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990); DAVID B. WEXLER & BRUCE J. WINICK, LAW IN A THERAPEUTIC KEY: RECENT DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (1996); BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL (2005); David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 TOURO L. REV. 17 (2008); 1 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL, § 2D-3, at 534-41 (2d ed. 1998). Wexler first used the term in a paper he presented to the National Institute of Mental Health in 1987. *See* David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 LAW & HUM. BEHAV. 27, 32-33 (1992).

sents a new model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law that can have therapeutic or anti-therapeutic consequences.²¹ The ultimate aim of therapeutic jurisprudence is to determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles.²² There is an inherent tension in this inquiry, but David Wexler clearly identifies how it must be resolved: “the law’s use of ‘mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns.’”²³ As I have written elsewhere, “an inquiry into therapeutic outcomes does not mean that therapeutic concerns ‘trump’ civil rights and civil liberties.”²⁴

Therapeutic jurisprudence “asks us to look at law as it actually impacts people’s lives,”²⁵ and focuses on the law’s influence on emotional life and psychological well-being.²⁶ It suggests that

21. See Michael L. Perlin, “*His Brain Has Been Mismanaged with Great Skill*”: How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?, 42 AKRON L. REV. 885, 912 (2009). See Kate Diesfeld & Ian Freckelton, *Mental Health Law and Therapeutic Jurisprudence*, in DISPUTES AND DILEMMAS IN HEALTH LAW 91 (Ian Freckelton & Kerry Anne Peterson eds., 2006) for a transnational perspective.

22. Michael L. Perlin, “*You Have Discussed Lepers and Crooks*”: Sanism in Clinical Teaching, 9 CLINICAL L. REV. 683 (2003); Michael L. Perlin, “*And My Best Friend, My Doctor/ Won’t Even Say What It Is I’ve Got*”: The Role and Significance of Counsel in Right to Refuse Treatment Cases, 42 SAN DIEGO L. REV. 735 (2005) (Perlin, *Best Friend*); Michael L. Perlin, “*Everybody Is Making Love/Or Else Expecting Rain*”: Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia, 83 WASH. U. L. REV. 481 (2008) (Perlin, *Expecting Rain*).

23. David B. Wexler, *Therapeutic Jurisprudence and Changing Concepts of Legal Scholarship*, 11 BEHAV. SCI. & L. 17, 21 (1993).

24. Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 412 (2000) (Perlin, *Healing*); Michael L. Perlin, “*Where the Winds Hit Heavy on the Borderline*”: Mental Disability Law, Theory and Practice, “Us” and “Them,” 31 LOY. L. REV. 775, 782 (1998).

25. Bruce J. Winick, *Foreword: Therapeutic Jurisprudence Perspectives on Dealing With Victims of Crime*, 33 NOVA L. REV. 535, 535 (2009).

26. David B. Wexler, *Practicing Therapeutic Jurisprudence: Psychological Soft Spots and Strategies*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION 45 (Daniel P. Stolle, David B. Wexler & Bruce J. Winick eds., 2000) (hereinafter STOLLE).

“law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law should attempt to bring about healing and wellness.”²⁷ By way of example, therapeutic jurisprudence “aims to offer social science evidence that limits the use of the incompetency label by narrowly defining its use and minimizing its psychological and social disadvantage.”²⁸

In recent years, scholars have considered a vast range of topics through a therapeutic jurisprudence lens, including, but not limited to, all aspects of mental disability law, domestic relations law, criminal law and procedure, employment law, gay rights law, and tort law.²⁹ As Ian Freckelton has noted, “it is a tool for gaining a new and distinctive perspective utilizing sociopsychological insights into the law and its applications.”³⁰ It is also part of a growing comprehensive movement in the law towards establishing more humane and psychologically optimal ways of handling legal issues collaboratively, creatively, and respectfully.³¹ These alternative approaches optimize the psychological well-being of individuals, relationships, and communities dealing with a legal matter, and acknowledge concerns beyond strict legal rights, duties, and obligations. In its aim to use the law to empower individuals, enhance rights, and promote well-being, therapeutic jurisprudence has been described as “...a sea-change in ethical thinking about the role of law...a movement towards a more distinctly relational approach to

27. Bruce Winick, *A Therapeutic Jurisprudence Model for Civil Commitment*, in *INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVE ON CIVIL COMMITMENT* 23, 26 (Kate Diesfeld & Ian Freckelton eds., 2003).

28. Claire B. Steinberger, *Persistence and Change In The Life Of The Law: Can Therapeutic Jurisprudence Make A Difference?* 27 *LAW & PSYCHOL. REV.* 55, 65 (2003). See also Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 *PSYCHOL. PUB. POL’Y & L.* 193 (1995) (for the most thoughtful, sympathetic critique of TJ).

29. Michael L. Perlin, “*Things Have Changed*”: *Looking at Non-institutional Mental Disability Law Through the Sanism Filter*, 46 *N.Y.L. SCH. L. REV.* 535 (2002–03).

30. Ian Freckelton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence*, 30 *T. JEFFERSON L. REV.* 575, 582 (2008).

31. Susan Daicoff, *The Role of Therapeutic Jurisprudence Within The Comprehensive Law Movement*, in *STOLLE ET AL.*, *supra* note 26, at 365.

the practice of law...which emphasises psychological wellness over adversarial triumphalism.”³² That is, therapeutic jurisprudence supports an ethic of care.³³

One of the central principles of therapeutic jurisprudence is a commitment to dignity. Prof. Amy Ronner describes the “three Vs”: voice, validation and voluntariness,³⁴ arguing:

What ‘the three Vs’ commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant’s story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronouncement that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings prosper when they feel that they are making, or at least participating in, their own decisions.³⁵

32. Warren Brookbanks, *Therapeutic Jurisprudence: Conceiving an Ethical Framework*, 8 J.L. & MED. 328, 329–30 (2001).

33. See, e.g., Bruce J. Winick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 CLINICAL L. REV. 605, 605–07 (2006); David B. Wexler, *Not Such a Party Pooper: An Attempt to Accommodate (Many of) Professor Quinn’s Concerns about Therapeutic Jurisprudence Criminal Defense Lawyering*, 48 B.C. L. REV. 597, 599 (2007); Brookbanks, *supra* note 32; Gregory Baker, *Do You Hear the Knocking at the Door? A “Therapeutic” Approach to Enriching Clinical Legal Education Comes Calling*, 28 WHITTIER L. REV. 379, 385 (2006).

34. Amy D. Ronner, *The Learned-Helpless Lawyer: Clinical Legal Education and Therapeutic Jurisprudence as Antidotes to Bartleby Syndrome*, 24 TOURO L. REV. 601, 627 (2008).

35. Amy D. Ronner, *Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles*, 71 U. CIN. L. REV. 89, 94–95 (2002); see generally, AMY D. RONNER, LAW, LITERATURE, AND THERAPEUTIC JURISPRUDENCE (2010).

The question before us is this: do mental health courts promote a vision that is consonant with the principles that Professor Ronner sketches out for us in this paragraph?

THE STRUCTURE OF MENTAL HEALTH COURTS³⁶

Mental health courts—one form of “problem-solving courts”³⁷—follow the legal theory of therapeutic jurisprudence, in

36. See generally, Bruce J. Winick, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCHOL. PUB. POL’Y & L. 107 (2003); Susan Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL’Y & L. 507 (2005). These courts are different from and independent of traditional involuntary civil commitment courts, currently operating in many states. For a critique of such courts, see Perlin, *Healing*, *supra* note 24, at 425–26 (“[T]he overwhelming number of cases involving mental disability law issues are ‘litigated’ in pitch darkness. Involuntary civil commitment cases are routinely disposed of in minutes behind closed courtroom doors.”); Perlin, *supra* note 1, at 209, discussing such courts that “I have observed across the nation, in which persons with mental disabilities are regularly treated as third-class citizens by (at the best) bored or (at the worst) malevolent trial judges.” For a thoughtful reconsideration of such courts in a transnational perspective, see Terry Carney, David Tait & Fleur Beaupert, *Pushing the Boundaries: Realising Rights Through Mental Health Tribunal Processes?*, 30 SYDNEY L. REV. 329, 344 (2008).

37. Problem-solving courts grew out of an interdisciplinary approach to address the underlying problem, not just the symptoms, of substance abuse, domestic violence, child abuse, mental illness, and certain kinds of criminality. See generally, Bruce J. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, 30 FORDHAM URB. L.J. 1055, 1060 (2003). For overviews, see Michael Dorf & Jeffrey Fagan, *Problem-Solving Courts: From Innovation to Institutionalization*, 40 AM. CRIM. L. REV. 1501 (2003); Jeffrey Fagan & Victoria Malkin, *Theorizing Community Justice Through Community Courts*, 30 FORDHAM URB. L.J. 897 (2003). Included in this array are mental health courts, drug courts, domestic violence courts, juvenile justice courts, sex offense courts, community courts, truancy courts, veteran’s courts, and homeless courts. For a full list, see Deborah Chase & Peggy Hora, *The Best Seat in the House: The Court Assignment and Judicial Satisfaction*, 47 FAM. CT. REV. 209, 210 n.8 (2009). For a critical reading on the ways that such courts “redefine” criminal justice, see James L. Nolan, *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 40 AM. CRIM. L. REV. 1541 (2004). For a critical reading of the impact on child welfare cases, see Jane Spinak, *A Conversation About Problem-Solving Courts: Take 2*, 10 U. MD. L.J. RACE, RELIGION, GENDER & CLASS 113 (2010). For a consideration of an evidence-based model in one state, see Melissa Aubin, *The District of Oregon Reentry Court: An Evidence-Based*

an attempt “to improve justice by considering the therapeutic and anti-therapeutic consequences that ‘flow from substantive rules, legal procedures, or the behavior of legal actors.’”³⁸ They are designed to deal holistically³⁹ with people arrested (usually, but not exclusively, for nonviolent misdemeanors)⁴⁰ when mental illness

Model, 27 FED. SENT’G. REP. 39 (2009). I have recently considered veterans courts from a TJ perspective in Michael L. Perlin, “*John Brown Went Off to War*”: *Considering Veterans’ Courts as Problem-Solving Courts*, 37 NOVA L. REV. (2014).

38. Nancy Wolff, *Courts as Therapeutic Agents: Thinking Past the Novelty of Mental Health Courts*, 30 J. AM. ACAD. PSYCHIATRY L. 431, 431 (2002); see also, Randal Fritzler, *How One Misdemeanor Mental Health Court Incorporates Therapeutic Jurisprudence, Preventive Law, and Restorative Justice*, in MANAGEMENT AND ADMINISTRATION OF CORRECTIONAL HEALTH CARE: POLICY, PRACTICE, ADMINISTRATION 14-1, 14-3 (Jacqueline Moore ed., 2003) (“the fundamental principle underlying therapeutic jurisprudence is the selection of options that promote health and are consistent with the values of the legal system”). This is not a phenomenon limited to the United States. See, e.g., RICHARD D. SCHNEIDER, HY BLOOM & MARK HEEREMA, MENTAL HEALTH COURTS: DECRIMINALIZING THE MENTALLY III (2007); Sarah Ryan & Darius Whelan, *Diversion of Offenders with Mental Disorders: Mental Health Courts*, 1 WEB J. CURR. LEG. ISSUES (2012), available at <http://webjcli.ncl.ac.uk/2012/issue1/ryan1.html><http://webjcli.ncl.ac.uk/2012/issue1/ryan1.html> (Ireland); James Duffy, *Problem-Solving Courts, Therapeutic Jurisprudence and the Constitution: If Two Is Company, Is Three a Crowd?*, 35 MELB. U. L. REV. 394, 395 (2011).

39. See Shauhin Talesh, *Mental Health Court Judges as Dynamic Risk Managers: A New Conceptualization of the Role of Judges*, 57 DEPAUL L. REV. 93, 112 (2007).

40. Although, historically, most mental health courts typically heard only cases of *nonviolent* offenders, see Grachek, *supra* note 5, at 1495, or only misdemeanor cases, see Castellano, *supra* note 4, at 490, some traditionally heard felony cases as well, see Talesh, *supra* note 39, at 112. The trend is towards the expansion of predicate case jurisdiction to include felonies, including violent felonies, see Johnston, *supra* note 6, at 521. See, e.g., Andrew Wasicek, *Mental Illness and Crime: Envisioning a Public Health Strategy and Reimagining Mental Health Courts*, 48 CRIM. L. BULL. 106, 135 (2012):

Mental health courts should accept violent felonies because it is morally unsound to punish criminal behavior that is mainly a product of mental disease.

With appropriate eligibility criteria, the new mental health court model would encapsulate persons who are not shielded by the insanity defense — especially persons from post-Jones v. U.S., 463 U.S. 354 (1983) approving stringent statutory measures governing releases of persons found not guilty by reason of insan-

rather than criminality appears to be the precipitating reason for the behavior in question.⁴¹ The mental health court judge⁴² seeks to divert the individual from the criminal court in exchange for an agreement to participate in community treatment,⁴³ and to “help participants avoid future criminal court involvement.”⁴⁴

ity era, *see* 4 PERLIN, *supra* note 20, § 9B-2.3, at 290–98 (2d ed. 2002)]— but should still be held blameless.

41. *See generally*, Stefan & Winick, *supra* note 36, relying on, *inter alia*, Fritzler, *supra* note 38; Arthur Lurigio et al., *Therapeutic Jurisprudence in Action: Specialized Courts for the Mentally Ill*, 84 JUDICATURE 184 (2001); John Petrila et al., *Preliminary Observations from an Evaluation of the Broward County Mental Health Court*, 37 CT. REV. 14 (2002); Ian Freckelton, *Mental Health Review Tribunal Decision-making: A Therapeutic Jurisprudence Lens*, 10 PSYCHIATRY, PSYCHOL. & L. 44 (2003); *see also* BUREAU OF JUSTICE ASSISTANCE, MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS (2008). Positive and negative arguments about mental health courts are collected in Andrea M. Odegaard, *Therapeutic Jurisprudence: The Impact of Mental Health Courts on the Criminal Justice System*, 83 N.D. L. REV. 225, 250–54 (2007); *see generally*, Arthur J. Lurigio & Jessica Snowden, *Putting Therapeutic Jurisprudence into Practice: The Growth, Operations, and Effectiveness of Mental Health Court*, 30 JUST. SYS. J. 196 (2009).

42. Judges are the most common referral source of participants into diversion programs (100% of survey respondents), with mental health personnel (93% of survey respondents) coming in second, and attorneys (90% of survey respondents) coming in a close third. For those agencies that chose the “other” category, they indicated that referrals could come from families, service providers, law enforcement personnel, community agencies, and parole officers. Julie B. Raines & Glenn T. Laws, *Mental Health Court Survey*, 45 CRIM. L. BULL. 627, 632 (2009).

43. Marjorie A. Silver, *Lawyering and Its Discontents: Reclaiming Meaning in the Practice of Law*, 19 TOURO L. REV. 773, 803 (2004); *see also* Talesh, *supra* note 39, at 110; Camille Nelson, *Racializing Disability, Disabling Race: Policing Race and Mental Status*, 15 BERKELEY J. CRIM. L. 1, 2 (2010) (on the necessity of diversion); John Cummings, *The Cost of Crazy: How Therapeutic Jurisprudence and Mental Health Courts Lower Incarceration Costs, Reduce Recidivism, and Improve Public Safety*, 56 LOY. L. REV. 279, 306 (2010) (discussing mental health courts’ “palpable results”). On the question of whether this diversion is swifter than traditional court processing, *see* Allison Redlich et al., *Is Diversion Swift: Comparing Mental Health Court and Traditional Criminal Justice Processing*, 39 CRIM. JUST. & BEHAV. 420 (2012) (although diversion may not be swifter, that may be less important than the fact of diversion itself).

44. Kirk Kimber, *Mental Health Courts – Idaho’s Best Kept Secret*, 45 IDAHO L. REV. 249, 270 (2008); *see also*, Brenda Desmond & Paul Lenz, *Men-*

Mental health courts are premised on team approaches;⁴⁵ representatives from justice and treatment agencies assist the judge in screening offenders to determine whether they would present a risk of violence if released to the community, in devising appropriate treatment plans, and in supervising and monitoring the individual's performance in treatment.⁴⁶ The mental health court judge functions as part of a mental health team that decides whether the individual has treatment needs and can be safely released to the community.⁴⁷ The team formulates a treatment plan, and a court-employed case manager and court monitor track the individual's participation in the treatment program, and submit periodic reports to the judge concerning his or her progress. Participants are required to report to the court periodically so that the judge can monitor treatment compliance, and additional status review hearings are held on an as-needed basis.⁴⁸

To serve effectively in this sort of court setting, the judge needs to develop enhanced interpersonal skills and awareness of a variety of psychological techniques that can help the judge to persuade the individual to accept treatment and motivate him or her to participate effectively in it.⁴⁹ She must be able to build trust and

tal Health Courts: An Effective Way of Treating Offenders with Serious Mental Illness, 34 MENTAL & PHYSICAL DISABILITY L. REP. 525, 526 (2010). On the creation of juvenile mental health courts, see Daniel M. Filler & Austin Smith, *The New Rehabilitation*, 91 IOWA L. REV. 951, 971 n.105 (2006).

45. See e.g., Lurigio & Snowden, *supra* note 41, at 210; Marlee E. Moore & Virginia A. Hiday, *Mental Health Court Outcomes: A Comparison of Re-arrest and Re-arrest Severity Between Mental Health Court and Traditional Court Participants*, 30 LAW & HUM. BEHAV. 659, 660 (2006).

46. Winick, *supra* note 36, at 125–26. On the role of jail as a potential sanction in the cases of non-compliant defendants, see Allison Redlich et al., *Patterns and Practice in Mental Health Courts: A National Survey*, 30 LAW & HUM. BEHAV. 347, 355–56 (2006).

47. On the often-conflicting roles of case managers in mental health courts, see Castellano, *supra* note 4, at 490–91.

48. Stefan & Winick, *supra* note 36, at 520–21.

49. Winick, *supra* note 36, at 126 (citing Carrie Petrucci, *Respect as a Component in the Judge-Defendant Interaction in a Specialized Domestic Violence Court that Utilizes Therapeutic Jurisprudence*, 38 CRIM. L. BULL. 263 (2002)). On the “collateral institutional authority of the judge” in mental health courts, see Eric J. Miller, *The Therapeutic Effects of Managerial Re-entry Courts*, 30 FED. SENT’G REP. 127, 128 (2008). On the way that judgmental descriptive language can adversely affect the work of such courts in civil cases, see

manage risk.⁵⁰ These skills include the ability to convey empathy and respect, to communicate effectively with the individual, to listen to what the individual has to say, thereby fulfilling the individual's need for voice and validation, to earn the individual's trust and confidence, and to engage in motivational interviewing and various other techniques designed to encourage the individual to accept treatment and comply with it.⁵¹

These courts provide “nuanced” approaches,⁵² and may signal a “fundamental shift” in the criminal justice system.⁵³ According to former Judge Randal Fritzler, a successful mental health court thus needs: 1) a therapeutic environment and dedicated team; 2) an environment free from stigmatizing labels; 3) opportunities for deferred sentences and diversion away from the criminal system; 4) the least restrictive alternatives; 5) decision-making that is interdependent; 6) coordinated treatment; and 7) a review process that is meaningful.⁵⁴ It is essential that such courts be free of the “pretextual dishonesty”⁵⁵ that is so often the hallmark of judicial proceedings in cases of individuals with mental disabilities.⁵⁶

Ian Freckelton, *Distractors and Distressors in Involuntary Status Decision-Making*, 12 *PSYCHIATRY, PSYCHOL. & L.* 88 (2005).

50. Carol Fidler, *Building Trust and Managing Risk: A Look at a Felony Mental Health Court*, 11 *PSYCHOL. PUB. POL'Y & L.* 587 (2005).

51. For a thoughtful critique of mental health courts, see Johnston, *supra* note 6. On the role of the legislature in ensuring the success of such courts, see Sheila Moheb, *Jamming the Revolving Door: Legislative Setbacks for Mental Health Court Systems in Virginia*, 14 *RICH. J.L. & PUB. INT.* 29 (2010).

52. Patricia C. McManus, *A Therapeutic Jurisprudential Approach to Guardianship of Persons with Mild Cognitive Impairment*, 36 *SETON HALL L. REV.* 591, 598 (2006).

53. *Developments in the Law —The Law of Mental Illness: Mental Health Courts and the Trend Toward a Rehabilitative Justice System*, 121 *HARV. L. REV.* 1168, 1177 (2008).

54. Randal B. Fritzler, *10 Key Components of a Criminal Mental Health Court*, reprinted in *JUDGING IN A THERAPEUTIC KEY: THERAPEUTIC JURISPRUDENCE AND THE COURTS* 118 (Bruce J. Winick & David B. Wexler eds., 2003), and Fritzler, *supra* note 38, at 14–18 (“The [mental health court] must avoid contributing negative stigma to its clients”). See also Georgia Lee Sims, *The Criminalization of Mental Illness: How Theoretical Failures Create Real Problems in the Criminal Justice System*, 62 *VAND. L. REV.* 1053, 1079 (2009).

55. I define “pretextuality” as the ways in which courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest

Some defense attorneys fear that problem-solving courts, in general, “arm twist ... [their clients] into diversion with a condition of entry being that they take a plea, and/or that the effective treatment is raised above the least restrictive treatment.”⁵⁷ By way of example, Cait Clarke and James Neuhard raise this potential dilemma:

For example, a defense attorney may devote less attention to the desires of the defendant, focusing more on the goals of the ‘team’ (including the defense attorney, prosecutor, judge, and probation officer). An illustration of this would be where the ‘team’ decides the defendant requires in-custody treatment, although the defendant has previously told the defense attorney that she does not want to participate in an in-custody treatment program.⁵⁸

Skeptics argue that MHCs are too dependent on the aura of the charismatic judge.⁵⁹ However, we *do* have a database of research on the way that persons whose cases have been heard before one MHC, the one run by Judge Ginger Lerner-Wren in Ft. Lauderdale, FL and that database is spectacular.⁶⁰ Basically, it tells us

(and frequently meretricious) decision-making. *See, e.g.*, Michael L. Perlin, “Simplify You, Classify You”: Stigma, Stereotypes and Civil Rights in Disability Classification Systems, 25 GA. ST. U. L. REV. 607, 621 (2009).

56. *See, e.g.*, Ian Freckelton, *Mental Health Review Tribunal Decision-making: A Therapeutic Jurisprudence Lens*, 10 PSYCHIATRY, PSYCHOL. & L. 44, 59 (2003) (citing Michael L. Perlin, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* (2000)); Michael L. Perlin, *Preface to INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVES ON CIVIL COMMITMENT* xxxiii (Kate Diesfeld & Ian Freckelton eds., 2003); Ian Freckelton, *Ideological Divarication in Civil Commitment Decision-making*, 10 PSYCHIATRY, PSYCHOL. & L. 390, 395 (2003).

57. Cait Clarke & James Neuhard, “From Day One”: *Who’s in Control as Problem Solving and Client-Centered Sentencing Take Center Stage?*, 29 N.Y.U. REV. L. & SOC. CHANGE 11, 29 (2004).

58. Clarke & Neuhard, *supra* note 57, at 29 n.49.

59. A caution on relying on such charisma in the context of *other* problem solving courts is raised in Jane Spinak, *Romancing the Court*, 46 FAM. CT. REV. 258, 269–71 (2008).

60. On the difficulties generally in assessing mental health courts, *see* Nancy Wolff & Wendy Pogorzelski, *Measuring the Effectiveness of Mental Health Courts*, 11 PSYCHOL. PUB. POL’Y & L. 539 (2005).

that defendants before Judge Lerner-Wren report a higher score on a dignity scale (and a lower score on a perceived coercion scale)⁶¹ than any group of criminal defendants who have ever been studied.⁶² In short, the actual, real life experiences of the litigants in cases before Judge Lerner-Wren demonstrate that one MHC *can* be a non-coercive, dignified experience that provides procedural justice and therapeutic jurisprudence to those before it.⁶³

61. On the role of therapeutic jurisprudence in dealing with coercion in the mental health court process, see Bruce Winick, *A Therapeutic Jurisprudence Approach to Dealing with Coercion in the Mental Health System*, 15 PSYCHIATRY, PSYCHOL. & L. 25 (2008). On the significance of the presence of dignity in mental health tribunals in Australia, see David Tait, *The Ritual Environment of the Mental Health Tribunal Hearing: Inquiries and Reflections*, 10 PSYCHIATRY, PSYCHOL. & L. 91 (2003). On dignitarian issues in general, see PERLIN, *supra* note 11, at 99–108.

62. See Norman G. Poythress et al., *Perceived Coercion and Procedural Justice in the Broward Mental Health Court*, 25 INT'L J.L. & PSYCHIATRY 517 (2002). Judge Wren discusses her judicial philosophy in Wren, *supra* note 10. On how levels of emotional intelligence correlate with judicial success in problem-solving courts, see James Duffy, *Problem-Solving Courts, Therapeutic Jurisprudence and the Constitution*, 35 MELB. U. L. REV. 394 (2011); Michael King, *Restorative Justice, Therapeutic Jurisprudence, and the Rise of the Emotionally Intelligent Justice*, 35 MELB. L. REV. 1096 (2008). On the role of restorative justice, see generally PERLIN, *supra* note 11, at 88–96, in problem-solving courts, see Megan Stephens, *Lessons from the Front Lines in Canada's Restorative Justice Experiment: The Experience of Sentencing Judges*, 33 QUEEN'S L.J. 19, 63–64 (2007).

63. See Judith Kaye, *Lecture 81* ST. JOHN'S L. REV. 743, 748 (2007) (“[M]ental health courts, which . . . divert defendants from jail to treatment, reconnect them, where possible, with family and friends who care whether they live or die, . . . restore their greatest loss—their sense of human dignity”) (author former Chief Judge of New York Court of Appeals); Hafemeister, Garner & Bath, *supra* note 11, at 201–02 (“[P]rocedural justice is a key to the success of mental health courts”). For a less sanguine attitude (based on a visit to a mental health court in Washington, D.C.), see Allegra M. McLeod, *Decarceration Courts: Possibilities and Perils of a Shifting Criminal Law*, 100 GEO L.J. 1587, 1613–14 (2012) (“[A]ctual therapeutic or other effects of this engagement remain uncertain”). On the important related issue of the impact of such courts on racial and ethnic minorities, see Robert V. Wolf, *Race, Bias, and Problem-Solving Courts*, 21 NAT'L BLACK L.J. 27, 46–47 (2009) (research by National Center for State Courts reveals that African-Americans and Latinos show more support for practices and procedures promoted by problem-solving courts than

Two Concerns

I do have two concerns that have not been the focus of much scholarly attention. It is these two concerns that temper my full enthusiasm for mental health courts, especially in the context of the issues I focus on in this paper, but I believe that they can be remediated: the lack of concern paid to the question of *competency* in the mental health court process,⁶⁴ and the lack of concern paid to the question of the quality of *counsel* made available to individuals in the mental health court process.

Dr. Steven Erickson and his colleagues point out what should be obvious: Given the impaired cognition that accompanies many mental disorders, “there is little evidence to suggest that mental health courts ensure that prospective candidates are competent to accept [the] plea bargains [into which many enter], as required by constitutional law.”⁶⁵ Allison Redlich similarly worries that “the very types of people MHCs were designed for may be the people who do not fully comprehend the purpose, requirements, and roles in the courts.”⁶⁶ Subsequent research done by Redlich and her colleagues, in fact, reveals that the majority of defendants at two mental courts lacked “nuanced information” about the trial

do whites). On the impact of such courts on immigrants, see Alina Das, *Immigrants and Problem-Solving Courts*, 33 CRIM. JUST. REV. 308 (2008).

64. See generally, Kathleen Stafford & Dustin Wygant, *The Role of Competency to Stand Trial in Mental Health Courts*, 23 BEHAV. SCI. & L. 245 (2005) (over three-quarters of potential mental health court defendants in one Ohio court were found to be incompetent).

65. Steven Erickson et al., *Variations in Mental Health Courts: Challenges, Opportunities, and a Call for Caution*, 42 COMM. MENTAL HEALTH J. 335, 339 (2006); see also Stacey M. Faraci, *Slip Slidin' Away? Will Our Nation's Mental Health Court Experiment Diminish the Rights of the Mentally Ill?*, 22 QUINNIPIAC L. REV. 811, 828–29 (2004) (“[O]ne of the first orders of business is to determine whether the individual is competent [E]ven among those deemed competent to stand trial, serious questions may be raised about the ability of persons to truly understand the choices being presented and the consequences of those choices”), quoting John S. Goldkamp & Cheryl Irons-Guynn, Bureau of Justice Assistance, *U.S. Dep't of Justice, Emerging Judicial Strategies For the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage* xi (Apr. 2000), available at <http://www.ncjrs.org/pdffiles/bja/182504.pdf>.

66. Allison Redlich, *Voluntary, But Knowing and Intelligent?*, 11 PSYCHOL. PUB. POL'Y & L. 605, 616 (2005).

process and that a minority of defendants had “impairments in legal competence”;⁶⁷ the researchers concluded, however, that there were some indications that “the clients in the [mental health courts] in this study made knowing, intelligent and voluntary enrollment decisions.”⁶⁸ Clearly, “a thorough evaluation of the offender’s mental competence . . . is essential” in the mental health court process.⁶⁹ Judge Michael Finkle and several colleagues have recommended that “competency courts” be created as subspecialty courts *within* mental health courts to “improve the competency process and reduce the unnecessary time that mentally ill persons spend in jail,”⁷⁰ but there are no signs that this recommendation is being acted upon.

What about counsel? I have written often about the scandalous lack of effective counsel made available to persons with mental disabilities in the civil commitment and criminal justice processes.⁷¹ What is the quality of counsel available to litigants in mental health courts?

67. Allison Redlich et al., *Enrollment in Mental Health Courts: Voluntariness, Knowingness, and Adjudicative Incompetence*, 34 LAW & HUM. BEHAV. 91, 91 (2010).

68. *Id.* at 101. On the other hand, they noted:

[I]ndividuals making important legal and treatment decisions should have more than a basic knowledge of procedures, requirements, and consequences, particularly given that there are sanctions for non-compliance. Thus, MHCs must now ask: What information do we want MHC participants to have at the time of enrollment and how can we ensure that the information is meaningfully understood, particularly the complicated nuances?

Id. at 103.

69. Christin E. Keele, *Criminalization of the Mentally Ill: The Challenging Role of the Defense Attorney in the Mental Health Court System*, 71 UMKC L. REV. 193, 202 (2002).

70. Michael J. Finkle et al., *Competency Courts: A Creative Solution for Restoring Competency to the Competency Process*, 27 BEHAV. SCI. & L. 767 (2009). However, with the exception of one student note, see Nicholas Rosinia, *How ‘Reasonable’ Has Become Unreasonable: A Proposal for Rewriting the Lasting Legacy of Jackson v. Indiana*, 89 WASH. U. L. REV. 673, 693 n.115 (2012), this suggestion has heretofore gone unnoticed in the legal literature.

71. See Michael L. Perlin, “*I Might Need a Good Lawyer, Could Be Your Funeral, My Trial*”: *A Global Perspective on the Right to Counsel in Civil Commitment Cases, and Its Implications for Clinical Legal Education*, 28

Dr. Steven Erickson and his colleagues have expressed concern “as to whether defendants in mental health courts receive adequate representation by their attorneys.”⁷² Terry Carney characterizes the assumption that adequate counsel will be present at hearings to guarantee liberty values as a “false hope.”⁷³ Henry Dlugacz and Christopher Wimmer summarize the salient issues:

It is not reasonable to expect a client to repose trust in an attorney unless she is confident that he is acting in accordance with her wishes. The client with mental illness may already doubt the attorney’s loyalty. This risk is exacerbated when the attorney is appointed by the court. The client may wonder whether the attorney has been assigned in order to zealously represent her, or instead to facilitate her processing through the legal system There are strong personal disincentives to thorough preparation, even for the committed attorney. There are also institutional pressures: The attorney who depends on the goodwill of others in the system (e.g.,

WASH. U. J. L. & SOC’L POL’Y 241, 241 (2008) (“If there has been any constant in modern mental disability law in its thirty-five-year history, it is the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment cases is likely to be ineffective”); Michael L. Perlin, “*The Executioner’s Face Is Always Well-Hidden*”: *The Role of Counsel and the Courts in Determining Who Dies*, 41 N.Y.L. SCH. L. REV. 201, 207–08 (1996) (“Nearly twenty years ago, when surveying the availability of counsel to mentally disabled litigants, President Carter’s Commission on Mental Health noted the frequently substandard level of representation made available to mentally disabled criminal defendants. Nothing that has happened in the past two decades has been a palliative for this problem”). See generally, MICHAEL L. PERLIN, MENTAL DISABILITY AND THE DEATH PENALTY: THE SHAME OF THE CRIMINAL JUSTICE SYSTEM 123–38 (2013).

72. Erickson et al., *supra* note 65, at 340.

73. Terry Carney, *The Mental Health Service Crisis of Neoliberalism - An Antipodean Perspective*, 31 INT’L J. L. & PSYCHIATRY 101, 111 (2008). See also Terry Carney, *Best Interests or Legal Rectitude? Australian Mental Health Tribunal Stakeholder & Case Flow Implications* (paper presented at Irish Mental Health Commission Conference ‘Mental Health Act 2001-Promoting Best Interest,’ Dublin, November 2009), manuscript at 33 (“The issue of legal advocacy before [mental health tribunals] is a vexed one.”) (paper on file with author). See also Perlin, *supra* note 37 (discussing this same issue in the context of veterans courts).

judges, state attorneys, or prosecutors) may pull his punches, even unwittingly, in order to retain credibility for future interactions (which he would put to use for his future clients). Judges want cases resolved.⁷⁴

Some solutions have been offered. Bruce Winick has argued that “lawyers should adequately counsel their clients about the advantages and disadvantages of accepting diversion to mental health court.”⁷⁵ As a result, judges and defense counsel in mental health courts should ensure that defendants receive dignity and respect, are given a sense of voice and validation, and are treated with fairness and good faith.⁷⁶ Turning to the legal education clinical context, David Wexler has suggested that students might “consider the kind of dialogue a lawyer might have with a client about the pros and cons of opting into a [drug treatment court] or mental health court.”⁷⁷ It is essential that counsel has “a back-

74. Henry A. Dlugacz & Christopher Wimmer, *The Ethics of Representing Clients with Limited Competency in Guardianship Proceedings*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 331, 353–54 (2011). On the need for lawyers taking a TJ approach to view their clients “holistically,” see King, *supra* note 63, at 1122.

75. Stefan & Winick, *supra* note 36, at 523.

76. *Id.* at 516. See also Winick, *supra* note 36; Stefan & Winick, *supra* note 36, at 510–11, 520 (comments by Professor Winick).

77. David B. Wexler, *Therapeutic Jurisprudence and the Rehabilitative Role of the Criminal Defense Lawyer*, 17 ST. THOMAS L. REV. 743, 750 (2005). See Cait Clarke & James Neuhard, *Making the Case: Therapeutic Jurisprudence and Problem Solving Practices Positively Impact Clients, Justice Systems and Communities They Serve*, 17 ST. THOMAS L. REV. 781, 807 (2005) (discussing the role of therapeutic jurisprudence in clinical legal education). I consider dialogues that defense lawyers might have with their clients in incompetency status or insanity defense cases in Michael L. Perlin, “*Too Stubborn To Ever Be Governed By Enforced Insanity*”: *Some Therapeutic Jurisprudence Dilemmas in the Representation of Criminal Defendants in Incompetency and Insanity Cases*, 33 INT’L J. L. & PSYCHIATRY 475 (2010). On the parallel set of issues raised in the context of drug courts, compare David B. Wexler, 17 ST. THOMAS L. REV. 743, 750 (2005), see Clarke & Neuhard, *supra* note 57, at 29 (considering a parallel set of issues in drug courts) (“In addition to concerns about net-widening, some defense attorneys fear that these courts and the defense attorneys who practice in them are forcing their clients into the drug courts, arm twisting them into diversion with a condition of entry being that they take a plea, and/or that the effective treatment is raised above the least restrictive treatment”); see generally,

ground in mental health issues and in communicating with individuals who may be in crisis.”⁷⁸

ON DIGNITY⁷⁹

Introduction

Dignity is at the core of therapeutic jurisprudence,⁸⁰ and it also is the key underpinning of mental health courts.⁸¹ Prof. Carol Sanger suggests that dignity means that people “possess an intrinsic worth that should be recognized and respected,” and that they should not be subjected to treatment by the state that is inconsistent with that intrinsic worth.⁸² Treating people with dignity and respect makes them more likely to view procedures as fair and the motives

Mae C. Quinn, *Whose Team Am I on Anyway: Musings of a Public Defender about Drug Treatment Court Practice*, 26 N.Y.U. REV. L. & SOC. CHANGE 37 (2001). For an overview of drug courts, see also Peggy Hora & Theodore Stalcup, *Drug Treatment Courts in the Twenty-First Century: The Evolution of the Revolution in Problem-Solving Courts*, 42 GA. L. REV. 717 (2008). For a recent article by sitting trial judges contrasting mental health courts and drug courts, see Anne Harper & Michael J. Finkle, *Mental Health Courts*, 51 JUDGES' J. 4 (2012). For a critique of juvenile drug courts, see Jason Rayne, *An Exposition of the Effectiveness of and the Challenges Plaguing Maine's Juvenile Drug Treatment Court Program*, 62 ME. L. REV. 649 (2010). For a consideration of family drug courts, see Janet York et al., *Family Drug Treatment Courts and Social Determinants of Health*, 50 FAM. CT. REV. 137 (2012). On the question as to whether drug courts should be operated as civil rather than criminal courts, see Alex Kreit, *The Decriminalization Option: Should States Consider Moving from a Criminal to a Civil Drug Court Model?*, U. CHI. LEGAL F. 299 (2010).

78. Wexler, *supra* note 77, at 750.

79. See generally, Perlin, *supra* note 11, at 99–108 & 217–39; Michael L. Perlin, *Understanding the Intersection between International Human Rights and Mental Disability Law: The Role of Dignity*, in THE ROUTLEDGE HANDBOOK OF INTERNATIONAL CRIME AND JUSTICE STUDIES 191 (Bruce Arrigo & Heather Bersot, eds., 2013).

80. See Christina A. Zawisza & Adela Beckerman, *Two Heads Are Better Than One: The Case-Based Rationale for Dual Disciplinary Teaching in Child Advocacy Clinics*, 7 FLA. COASTAL L. REV. 631 (2006); David C. Yamada, *Human Dignity and American Employment Law*, 43 U. RICH. L. REV. 523 (2009).

81. Perlin, *supra* note 1, at 209 (relying on, *inter alia*, Poythress et al., *supra* note 62).

82. Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18 COLUM. J. GENDER & L. 409, 415 (2009).

behind law enforcement's actions as well meaning.⁸³ What individuals want most "is a process that allows them to participate, seeks to merit their trust, and treats them with dignity and respect."⁸⁴ All concepts of human rights have their basis in some understanding of human dignity.⁸⁵ Dignity has been characterized as one of "those very great political values that defines our constitutional morality."⁸⁶

The legal process upholds human dignity by allowing the litigant—including the criminal defendant—to tell his own story.⁸⁷ A notion of individual dignity, "generally articulated through concepts of autonomy, respect, equality, and freedom from undue government interference, was at the heart of a jurisprudential and moral outlook that resulted in the reform, not only of criminal procedure, but of the various institutions more or less directly linked with the criminal justice system, including juvenile courts, prisons, and mental institutions."⁸⁸ Fair process norms such as the right to counsel "operate as substantive and procedural restraints on state power to ensure that the individual suspect is treated with dignity and respect."⁸⁹ Dignity concepts are expansive; a Canadian Supreme Court case has declared that disenfranchisement of incarcerated persons violated their dignity interests.⁹⁰ By way of example,

83. Tamar R. Birkhead, *Toward a Theory of Procedural Justice for Juveniles*, 57 *BUFF. L. REV.* 1447, 1474 (2009).

84. Luther Munford, *The Peacemaker Test: Designing Legal Rights to Reduce Legal Warfare*, 12 *HARV. NEGOT. L. REV.* 377, 393 (2007).

85. *Buddhism and Human Dignity*, *SGI QUARTERLY*, (July 2000) available at <http://www.sgi.org/buddhism/buddhist-concepts/buddhism-and-human-dignity.html>.

86. William A. Parent, *Constitutional Values and Human Dignity*, in *THE CONSTITUTION OF RIGHTS: HUMAN DIGNITY AND AMERICAN VALUES* 47, 71 (Michael J. Meyer & William A. Parent eds., 1992).

87. Katherine Kruse, *The Human Dignity of Clients*, 93 *CORNELL L. REV.* 1343, 1353 (2008).

88. Eric Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 *OHIO ST. L.J.* 1479, 1569 n.463 (2004).

89. Peter Arenella, *Rethinking the Functions of Criminal Procedure: The Warren and Burger Courts' Competing Ideologies*, 72 *GEO. L.J.* 185, 200 (1983).

90. *Sauvé v. Canada*, [2002] 3 S.C.R. 519, discussed in Michael Pinard, *Collateral Consequences of Criminal Convictions: Confronting Issues of Race and Dignity*, 85 *N.Y.U. L. REV.* 457, 464 (2010).

“the moral dignity of the criminal process would be frustrated if grossly incompetent defendants were permitted to plead guilty.”⁹¹ One of the critical functions of counsel is to “protect the dignity and autonomy of a person on trial.”⁹² Perhaps counterintuitively to much of the lay public, dignity may trump “truth” as a core value of the criminal justice system.⁹³ In short, dignity inquiries permeate the criminal justice system, especially as the concept applies to persons with mental disabilities.

Dignity must also be contextualized with what I call “sanism” and “pretextuality.” Sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause, and are reflected in, prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry.⁹⁴ It permeates mental disability law, affecting all participants in the mental disability law system: litigants, fact-finders, counsel, and expert and lay witnesses. Its corrosive effects have warped mental disability law jurisprudence.⁹⁵ Along with pretextuality,⁹⁶ it has controlled, and continues

91. Bruce J. Winick, *Reforming Incompetency to Stand Trial and Plead Guilty: A Restated Proposal and a Response to Professor Bonnie*, 85 J. CRIM. L. & CRIMINOLOGY 571, 593 (1995).

92. *Jones v. Barnes*, 463 U.S. 745, 759 (1983) (Brennan, J., dissenting). See also, e.g., Philip Halpern, *Government Intrusion into the Attorney-Client Relationship: An Interest Analysis of Rights and Remedies*, 32 BUFF. L. REV. 127, 172 (1983) (“The right to counsel embraces two separate interests: reliable and fair determinations in criminal proceedings, and treatment of defendants with dignity and respect regardless of the effect on the outcome of criminal proceedings.”).

93. Erik Luna & Paul G. Cassell, *Mandatory Minimalism*, 32 CARDOZO L. REV. 1, 52 (2010). On the application of human dignity principles to limit the scope of criminalization of victimless crimes (specifically, drug offenses), see generally, Michal Buchhandler-Raphael, *Drugs, Dignity, and Danger: Human Dignity as a Constitutional Constraint to Limit Overcriminalization*, 80 TENN. L. REV. 291 (2013).

94. Perlin, *Expecting Rain* *supra* note 22, at 506.

95. *Id.* at 487.

96. See *supra* note 55. See generally, Michael L. Perlin, “*Half-Wracked Prejudice Leaped Forth*”: *Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 18 (1999) (footnotes omitted):

The pretexts of the forensic mental health system are reflected both in the testimony of forensic experts and in the decisions of legislators and fact-finders. Experts frequently testify in accor-

to control, modern mental disability law.⁹⁷ A careful examination of mental disability law reveals that judges are often pretextual because of their own “instrumental, functional, normative and philosophical” dissatisfaction with non-sanist constitutional decisions that grant a measure of dignity to persons with mental disabilities.⁹⁸

I believe that therapeutic jurisprudence is the best tool available to us to infuse the legal process with needed dignity.⁹⁹ The expanded use of dignity-providing mental health courts would allow for diversion of more of this cohort of defendants out of the criminal court process (and ultimately, out of destructive correctional facilities) into alternative placements where it is more likely they will be treated with at least a modicum of dignity.¹⁰⁰

dance with their own self-referential concepts of ‘morality’ and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment or that articulate functional standards as prerequisites for an incompetency to stand trial finding. Often this testimony is further warped by a heuristic bias. Expert witnesses—like the rest of us—succumb to the seductive allure of simplifying cognitive devices in their thinking, and employ such heuristic gambits as the vividness effect or attribution theory in their testimony.

Id. at 18.

97. Michael L. Perlin, *Promoting Social Change in Asia and the Pacific: The Need for a Disability Rights Tribunal to Give Life to the U.N. Convention on the Rights of Persons with Disabilities*, 44 *GEO. WASH. INT’L L. REV.* 1, 31 (2012).

98. Michael L. Perlin, “*Life Is In Mirrors, Death Disappears*”: *Giving Life to Atkins*, 33 *N.M. L. REV.* 315, 344 (2003) (quoting, in part, Michael L. Perlin, “*There’s No Success Like Failure/and Failure’s No Success at All*” *Exposing the Pretextuality of Kansas v. Hendricks*, 92 *NW. U. L. REV.* 1247, 1258 (1997)).

99. Keri K. Gould & Michael L. Perlin, “*Johnny’s in the Basement/Mixing Up His Medicine*”: *Therapeutic Jurisprudence and Clinical Teaching*, 24 *SEATTLE U. L. REV.* 339, 354 n.93 (2000) (“Therapeutic jurisprudence may also lend dignity to the voice of persons subordinated even by those who profess to represent the powerless.”); Perlin, *supra* note 11, at 217–39.

100. “The purpose of the mental health court is to insure that mentally ill people are treated with dignity and provided with the opportunity for treatment while at the same time protecting the public’s safety” and “preventing criminalization of the mentally ill.” *See Faraci, supra* note 65, at 824.

The arbitrary limitation in some mental health courts cutting off eligibility either for persons who are charged with committing felonies or crimes of “violence”¹⁰¹ self-evidently greatly limits the cohort of individuals who can be diverted to such courts.¹⁰² Absent any empirical justification for these limitations – and none has been offered¹⁰³ – it makes no sense to perpetuate these cut offs,¹⁰⁴ especially in the context of the vast discretion traditionally vested in prosecutors with regards to the charging process.¹⁰⁵

To a great extent, prosecutors’ decisions follow the initial judgments of police officers. But the near-boundless discretion vested in police decision-making makes this counterproductive. By way of example, consider the factual settings in the Supreme Court cases of *Addington v. Texas*¹⁰⁶ and *Jones v. United States*.¹⁰⁷

101. See Grachek, *supra* note 5, at 1495; Castellano, *supra* note 4, at 490. Misdemeanors are accepted by 87% of mental health courts responding to a recent survey; 77% of such courts accept non-violent felonies, and over one-third of the courts accept violent felonies. Raines & Laws, *supra* note 42, at 630.

102. One rarely-discussed but powerfully-important issue is that of “clutchability,” a consideration of “when the state has legitimate hold or power over an individual.” On the concept of “clutchability” in general in criminal law, see, e.g., Joel Feinberg, *Crime, Clutchability, and Individuated Treatment*, in *DOING & DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY* 252 (1970). On the concept in this context of mental health courts, see Chelsea Davis, *With the Best of Intentions*, 3 MENTAL HEALTH L. & POL’Y J. 101 (2013).

103. The rationale appears to be purely political: “Violent offenders have traditionally been excluded from mental health courts because of *public outcry* to the heinous nature of their crimes vis-a-vis the public’s empathetic perception of mentally ill, nonviolent offenders.” Jared Hodges & Brett Williams, *Courts*, 28 GA. ST. U. L. REV. 293, 303 (2011) (emphasis added). Of course, not all felonies are remotely “heinous.” See *infra* notes 106–11 accompanying text.

104. See Wasicek, *supra* note 40, at 139 (“Mental health courts should accept [cases of defendants charged with] violent felonies”).

105. See, e.g., Norman Abrams, *Internal Policy: Guiding the Exercise of Prosecutorial Discretion*, 19 UCLA L. REV. 1, 2 (1971); Conor Clark & Austin Sarat, *Beyond Discretion: Prosecution, the Logic of Sovereignty, and the Limits of Law*, 33 LAW & SOC. INQUIRY 387, 389 (2008).

106. *Addington v. Texas*, 441 U.S. 418 (1979) (burden of proof in civil commitment case at least “clear and convincing evidence”).

107. *Jones v. United States*, 463 U.S. 354 (1983) (constitutionally acceptable to provide insanity acquittees with fewer procedural due process protections in a retention hearing than civil committees).

Addington, who was subjected to the involuntary civil commitment process, had originally been apprehended following an alleged “assault by threat” on his mother.¹⁰⁸ Jones, for whom an insanity defense plea had been entered, had originally been apprehended after he allegedly attempted to shoplift a jacket in a downtown Washington, D.C. department store.¹⁰⁹ Addington’s acts appear to have been more serious (and more “dangerous”) than did Jones’s; yet, for undisclosed and unarticulated extra-judicial reasons, Addington was brought into the mental health system while Jones was arrested and thus brought into the criminal justice system.¹¹⁰ Notwithstanding the fact that Jones was charged with a felony (attempted petit larceny [shoplifting]), it makes no sense to suggest that this was the sort of “heinous” crime that would automatically disallow diversion to a mental health court.¹¹¹

Scholars and practitioners who have written about mental health courts frequently stress the need for “creativity” in the use of such courts as a tool for enhancing the decision to divert a defendant from traditional criminal court.¹¹² In such courts, judges must seek to craft “creative judicial responses to offending conduct that address the root causes of that conduct in the hope that, in the end, the prevalence of such conduct will subside.”¹¹³ An expansion of these courts will best serve the population under consideration in this work. Consider here the thoughts of Gerald Nora, an Illinois state’s attorney:

108. *Addington*, 441 U.S. at 420.

109. *Jones*, 463 U.S. at 359.

110. I discuss the implications of this in Perlin, *supra* note 96, at 30 n.158.

111. *Id.* at 29–30 (“Untrammelled discretion vested in police officers leads to inexplicable disjunctions in mental disability law developments.”).

112. *See, e.g.*, Clarke & Neuhard, *supra* note 77, at 781 (on how “creative” advocacy can achieve diversion or alternatives to incarceration in this context); Sandra F. Cannon & Joseph Krake, *Mental Health Diversion Alternatives to Jail: Thirteen Pilot Programs Funded by ODMH in April 2000: Where Are They Now and What Have We Learned?*, 32 *CAP. U. L. REV.* 1021, 1027 (2004) (“Diversion programs that pool resources from different systems—mental health, substance abuse and criminal justice—and those that utilize creative strategies to approach housing and other treatment issues will undoubtedly fare the best”).

113. Raymond H. Brescia, *Beyond Balls and Strikes: Towards a Problem-Solving Ethic in Foreclosure Proceedings*, 59 *CASE W. RES. L. REV.* 305, 315 (2009).

The bottom line is that mental health courts are heroic efforts to bring some justice to a severely underserved population. It is society's failure, not the criminal justice system's failure, if these courts continue to be the brightest candles in the darkness we have imposed upon the mentally ill. We are prosecuting the mentally ill as criminals. And many mental health workers are prevented from doing their jobs unless they are partnered with lawyers, probation officers, and court orders. And our preferred patients are those who commit crimes. We let the law-abiding suffer alone.¹¹⁴

Nora's indictment is a powerful one: "If we persist in prosecuting mentally ill defendants in willful ignorance of their medical problems, our system will stand as an asylum whose keepers are as deluded as the inmates."¹¹⁵ The expansion of mental health courts — following the models of Judge Wren,¹¹⁶ Judge Matthew D'Emic,¹¹⁷ Judge Michael Finkle,¹¹⁸ and others¹¹⁹ — is a major component in the prescription of dignity for this population, and, importantly, as a way to minimize sanism.¹²⁰

114. Gerald Nora, *Prosecutor as "Nurse Ratched"? Misusing Criminal Justice as Alternative Medicine*, 22 CRIM. JUST. 18, 22 (Fall 2007).

115. *Id.*

116. See Wren, *supra* note 10, at 593 (explaining dignity in the context of mental health courts).

117. See Matthew J. D'Emic, *The Promise of Mental Health Courts*, 22 CRIM. JUST. 24 (Fall 2007).

118. See Anne Harper & Michael J. Finkle, *Mental Health Courts*, 51 JUDGES' J. 4 (Spring 2012).

119. E.g., Judge Stephanie Rhoades of Alaska; see Shauhin Talesh, *Mental Health Court Judges as Dynamic Risk Managers: A New Conceptualization of the Role of Judges*, 57 DEPAUL L. REV. 93, 115 (2007) (discussing Judge Rhoades).

120. See Sana Loue, *The Involuntary Civil Commitment of Mentally Ill Persons in the United States and Romania: A Comparative Analysis*, 23 J. LEGAL MED. 211, 235 n.120 (2002) ("sanist biases may be reduced through the establishment of mental health courts, with a judiciary trained to be sensitive to such issues") (citing Elaine M. Andrews & Stephanie Rhoades, *Anchorage District Court Initiates Two New Programs: People with Disabilities Offered Alternatives in Judicial Proceeding*, 23 ALASKA BAR RAG 1 (May/June 1999)). I discuss this proposition in Perlin, *Best Friend*, *supra* note 22, at 748.

CONCLUSION

Mental health courts – when structured properly and when chaired by a judge who “buys in” to the TJ model – are perfect exemplars of the practical utility of therapeutic jurisprudence.¹²¹ The promotion and creation of such courts are consistent with TJ’s aims and aspirations,¹²² especially where litigants are given the “voice” that TJ demands.¹²³ They are grounded¹²⁴ and rooted¹²⁵ in TJ; they reflect TJ “theory in practice.”¹²⁶ Although both of these

121. See Kate Diesfeld & Brian McKenna, *The Therapeutic Intent of the New Zealand Mental Health Review Tribunal*, 13 PSYCHIATRY PSYCHOL. & L. 100 (2006); Kate Diesfeld & Brian McKenna, *The Unintended Impact of the Therapeutic Intentions of the New Zealand Mental Health Review Tribunal? Therapeutic Jurisprudence Perspectives*, 14 J. L. & MED. 566 (2007); see also Jelena Popovic, *Court Process and Therapeutic Jurisprudence: Have We Thrown the Baby out with the Bathwater?*, http://elaw.murdoch.edu.au/archives/issues/special/court_process.pdf (last visited Oct. 15, 2013). *But see* Johnston, *supra* note 6, at 521 (arguing thoughtfully that therapeutic jurisprudence is not an adequate basis upon which to support mental health courts). I disagree with Prof. Johnston because I believe she fails to acknowledge the due process underpinnings of TJ theory (*see id.* at 533) (“Therapeutic jurisprudence offers no opinion—in general or in specific instances—as to whether therapeutic considerations should be valued more heavily than autonomy, fairness, accuracy, consistency, perceived legitimacy of the criminal justice system, public safety, or a host of other values”). I believe this is simply not so. See Michael L. Perlin, *“Justice’s Beautiful Face”: Bob Sadoff and the Redemptive Promise of Therapeutic Jurisprudence*, 40 J. PSYCHIATRY & L. 265, 267 (2012) (quoting Perlin, *Healing*, *supra* note 24, at 412 (“An inquiry into therapeutic outcomes does not mean that therapeutic concerns ‘trump’ civil rights and civil liberties.”)).

122. See Leroy Kondo, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 24 SEATTLE L. REV. 373, 446–47 (2000).

123. Nicola Ferencz & James McGuire, *Mental Health Review Tribunals in the UK: Applying a Therapeutic Jurisprudence Perspective*, 37 COURT REV. 48, 51 (2000).

124. James L. Nolan, Jr., *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 40 AM. CRIM. L. REV. 1541, 1541 (2003).

125. Wasicek, *supra* note 40, at 126; John Cummings, *The Cost of Crazy: How Therapeutic Jurisprudence and Mental Health Courts Lower Incarceration Costs, Reduce Recidivism, and Improve Public Safety*, 56 LOY. L. REV. 279, 280–81 (2010).

126. Michael Codben & Ron Albers, *Beyond the Squabble: Putting the Tenderloin Community Justice Center in Context*, 7 HASTINGS RACE & POVERTY L. J. 53, 56 (2010).

issues — counsel and competence — are extraordinarily critical ones, I do not believe there is any evidence that mental health courts cannot be redirected to confront them and to craft creative solutions to the problems raised.

Mental health courts offer a new way of considering the linkage between mental disability and the criminal justice process. These courts are not without controversy, but the research appears to reveal, in general, a robust relationship between the operation of well-run mental health courts and enhanced dignity. I believe that the expansion of such courts — keeping in mind the due process foundation of therapeutic jurisprudence — is the best way to insure dignity to persons with mental disabilities in the criminal justice system.

In *Drifter's Escape*, the judge casts aside his robe as he presides over a case about which the defendant has no understanding. Later in the song, Dylan tells us:

“Outside, the crowd was stirring. You could hear it
from the door.”¹²⁷

Certainly, public vengeance is a key component of our criminal justice policies as they apply to persons with mental disabilities.¹²⁸

The song concludes with the drifter escaping after a bolt of lightning strikes the courthouse.¹²⁹ This is not a particularly valuable strategy — hoping for lightning to strike — for lawyers representing persons with mental disabilities. The expansion of dignity-providing mental health courts is, I think, a much better option.

127. DYLAN, *supra* note 15.

128. In discussing the roots of the public enmity toward the insanity defense and insanity defense pleaders, I have noted, “By nurturing emotions of vengeance, the punishment of criminals ‘further[s] social solidarity and protects against the terrifying anxiety that the forces of good might not triumph against the forces of evil after all.’” Michael L. Perlin, “*The Borderline Which Separated You From Me*”: *The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375, 1386 (1997) (quoting Bernard Diamond, *From Durham to Brawner, A Futile Journey*, 1973 WASH. U. L. Q. 109, 110 (1973)).

129. DYLAN, *supra* note 15.

Prophet Or Patient: The Impact Of The Religious Land Use And Institutionalized Persons Act On Mental Health Facilities

*ALEXANDER PRELLER

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The Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA) is Congress’ most recent attempt to broaden protection of religious activity. Among its provisions is the first federal codification of the religious rights of mental health patients in government-funded facilities, an addition which has received little or no attention from legal scholarship. Due to its patient-friendly provisions, however, RLUIPA has put courts in the unfortunate position

of determining whether a patient's beliefs are "sincere" or are merely a symptom of mental illness. Such determinations run directly afoul of both long-standing jurisprudence and common sense, for adjudicating the "truth" of religious beliefs is not an appropriate province for the court. Therefore, this paper argues that because RLUIPA forces courts to consider this issue much more directly, the psychological community should develop standards for separating illness from faith, so that courts have a map with which to traverse this philosophical quagmire.

INTRODUCTION

When one person suffers from a delusion, it is called insanity. When many people suffer from a delusion, it is called a Religion.¹

In 2000, Congress enacted the Religious Land Use and Institutionalized Persons Act (RLUIPA).² RLUIPA was designed to repair the mistakes of the Religious Freedom Restoration Act (RFRA),³ which had recently been ruled unconstitutional by the Supreme Court in *City of Boerne v. Flores*.⁴ Most Congressional attention was focused on the land use component of RLUIPA,⁵ but

* Mr. Preller is a graduate of Northwestern University and Columbia Law School, and is currently employed in the New York office of Bickel & Brewer. The views expressed in this article are his own. This article is neither intended as legal advice, nor does it necessarily reflect the views of Bickel & Brewer.

1. RICHARD DAWKINS, *THE GOD DELUSION* 5 (Bantam Press 2006) (quoting philosopher Robert M. Pirsig, author of *Zen and the Art of Motorcycle Maintenance: An Inquiry into Values*).

2. 42 U.S.C. § 2000cc (2006).

3. *Id.* § 2000bb.

4. *Boerne v. Flores*, 521 U.S. 507 (1997). While RFRA was a statute of general applicability, the relevant portion of RLUIPA is limited to institutions which "receive federal finance assistance" or to when the substantial burden affects interstate or foreign commerce, implicitly invoking the Taxing and Spending Clause and Commerce Clause rather than the First Amendment. 42 U.S.C. § 2000cc-1(b)(1)(2) (2006). See also *Cutter v. Wilkinson*, 544 U.S. 709, 732 (2005) (Thomas, J., concurring) (noting that states can avoid RLUIPA by refraining from taking government funds).

5. Yusuf Z. Malik, *The Religious Land Use and Institutionalized Persons Act: A Perspective on the Unreasonable Limitations Provision*, 78 TENN. L.

this statute also significantly re-shaped the religious landscape for government institutions by mandating strict judicial scrutiny of religious exercise claims by both prisoners and mental patients.⁶ In *Cutter v. Wilkinson*, the Supreme Court upheld RLUIPA's application to individuals in state institutions,⁷ but there has been very little discussion as to how RLUIPA has impacted claims brought by those within mental institutions specifically.⁸ Furthermore, Congress seems to have overlooked a fundamental problem with adjudicating religious rights within mental institutions: the basic method by which the field of psychology separates delusion from reality is that delusions cannot be proved,⁹ which is precisely why the DSM-IV excludes religion when diagnosing a delusional mental disorder.¹⁰

To that end, the Supreme Court has long held that attempting to determine whether a person's religious beliefs are in fact

REV. 531, 540 (2011) ("The legislative findings leading up to RLUIPA's passage were the result of three years of hearings mainly focused on circumstances of religious discrimination in land use regulations") (citing 146 CONG. REC. 16,698 (2000) (joint statement of Sens. Hatch and Kennedy)).

6. 42 U.S.C. § 2000cc-1(a) (2006).

7. *Cutter v. Wilkinson*, 544 U.S. 709 (2005).

8. See Morgan F. Johnson, *Heaven Help Us: The Religious Land Use and Institutionalized Persons Act's Prisoners Provisions in the Aftermath of the Supreme Court's Decision in Cutter v. Wilkinson*, 14 AM. U. J. GENDER SOC. POL'Y & L. 585 (2006) (discussing RLUIPA's prisoner revisions, which are frequently transplanted to the mental institution context); Tanya Kessler, "Purgatory Cannot be Worse than Hell": *The First Amendment Rights of Civilly Committed Sex Offenders*, 12 N.Y. CITY L. REV. 283, 312–20 (2009) (discussing in detail RLUIPA's applicability to civilly committed sex offenders, with a passing discussion of mental patients generally).

9. See also Joseph M. Pierre, *Faith or Delusion? At the Crossroads of Religion and Psychosis*, 7 J. PSYCHIATRIC PRAC. 163–72 (2001) ("In clinical practice, no clear guidelines exist to distinguish between normal religious beliefs and pathological religious delusions").

10. See Grant H. Morris & Ansar Haroun, "God Told Me to Kill": *Religion or Delusion?*, 38 SAN DIEGO L. REV. 973, 1026 (2001) (noting as to the definition of "delusion" in Appendix C to the DSM-IV, "[t]he second sentence is a negative statement about what a delusion is not: 'The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith),' which by comparison limits religion to cultural background).

true is a non-justiciable issue, a “forbidden domain.”¹¹ Thus under the jurisprudence developed for the Free Exercise clause of the First Amendment, courts have several alternative means by which to dispose of these cases *without* examining the truthfulness, or “sincerity,” of a patient’s beliefs in detail.¹² RLUIPA expressly closes those loopholes, forcing courts to examine this issue like never before; in the only published opinion on the merits under RLUIPA where a mental patient asserted a religious belief as grounds to refuse medication, the trial court used the dictionary definition of the word “religion” in order to reach a decision,¹³ an absurd result contrary to the entire purpose of RLUIPA.

This Article examines the history of religious claims by involuntarily committed patients under both the Free Exercise clause of the First Amendment and RLUIPA, and argues that if interpreted strictly, RLUIPA significantly changes the method of adjudicating mental patients’ religious claims, and should have a far greater impact on courts, mental institutions and the psychological community. Part II details the status of religion in mental institutions; Part II.A explores the legal doctrine that has developed around the Free Exercise clause of the First Amendment and RLUIPA for religious claims by mental patients, and Part II.B examines the specific religious claims frequently brought by mental patients, including the potential impact of RLUIPA. Part III addresses the philosophical problem of judicially determining the “sincerity” of mental patients’ religious beliefs, and details how poorly courts typically address this question. Part IV argues that courts will face this sincerity problem more frequently under RLUIPA than under the First Amendment, and thus the psychiatric community should create uniform standards for determining whether a patient’s religious beliefs are sincere or a symptom of mental illness, so that courts reach decisions which are both well-reasoned and in the best interests of patients.

11. U.S. v. Ballard, 322 U.S. 78, 87 (1944).

12. See *infra* Part II.A.

13. *In re L.A.*, 912 A.2d 977, 983 (Vt. 2006). See also Jennifer D. Larson, *RLUIPA, Distress and Damages*, 74 U. CHI. L. REV. 1443, 1451 n.63 (2007) (discussing *In re L.A.* and noting that “[t]he court had difficulty distinguishing sincere belief from delusion.”)

RELIGION IN MENTAL HEALTH FACILITIES

According appropriate religious accommodation to those confined to state mental facilities has always presented a difficult challenge, one that courts prefer to avoid if possible. Part II.A of this paper explores the development of the religious rights of mental patients under the First Amendment and RLUIPA, while Part II.B addresses the various claims commonly brought by mental patients as to whether institutional policies create a “substantial burden” on religious expression.

Legal Background: The Free Exercise Clause and RLUIPA

The legal system has paid little attention to the First Amendment rights of mental patients in state facilities, particularly as it relates to the Free Exercise clause.¹⁴ However, courts have long dealt with the free exercise rights of prisoners, and typically import those standards when examining the rarer cases of the involuntarily committed.¹⁵

In the prison context, courts begin by examining whether the plaintiff’s rights to religious exercise under the Free Exercise clause have in fact been infringed, requiring the plaintiff to show a substantial burden on his religious beliefs.¹⁶ The “substantial burden” test requires the plaintiff to establish he was either forced to engage in conduct which conflicts with his beliefs or was prevented from engaging in religious conduct mandated by his faith.¹⁷ This requirement is designed to filter out cases with *de minimus*

14. The Free Exercise clause states that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof ...” U.S. CONST. AMEND. I, § 1.

15. See *Lombardo v. Holanchock*, No. 07 Civ. 8674 (DLC), 2008 WL 2543573, at *6 n.6 (S.D.N.Y. June 15, 2008) (“No party has suggested that the analysis for a free exercise claim by an involuntarily committed individual is different from the analysis applied to prisoners’ free exercise claims. Accordingly, the free exercise analysis applied in the prison context will apply”).

16. See *Salahuddin v. Goord*, 467 F.3d 263, 274–75 (2d Cir. 2006).

17. *Midrash Sephardi, Inc. v. Town of Surfside*, 366 F.3d 1214, 1227 (11th Cir. 2004) (“[A] substantial burden can result from pressure that tends to force adherents to forego religious precepts or from pressure that mandates religious conduct.”).

burdens on religion imposed by institutionalization.¹⁸ It is also worth noting that simply asserting a religious background is insufficient to overturn the claimed burden; the burden must infringe upon some particular exercise or tenet of a person's religious beliefs, not merely cause discomfort for the plaintiff.¹⁹ Part II.B, *infra*, will discuss in greater detail the issues which mental patients commonly claim impose a substantial burden on their religious practices.

In rare cases, once the plaintiff has established that the burden is substantial, he must also establish the relationship of this burden to his beliefs. There is some dispute among circuits as to whether this is a test of "sincerity" of the plaintiff's belief, or if it requires that a "central tenet of his faith" has been burdened as well.²⁰ In practice this distinction has little effect in the prison context, as the primary purpose of this requirement is to prevent prisoners from fraudulently claiming religious beliefs in order to obtain special treatment.²¹ However, this distinction is of crucial importance in cases involving mental patients, as is discussed thoroughly in Part III *infra*.

Once the plaintiff makes this initial showing, the government must then demonstrate the legitimacy of the imposed burden. Some earlier twentieth century cases on this issue tended to construe prisoner rights very liberally, applying scrutiny standards comparable to those found for government restrictions on religious

18. See *Abdul-Matiyn v. Allen*, No. 06-CV-1503 (GTS/DRH), 2010 WL 3880687, at *8 (N.D.N.Y. Mar. 4, 2010).

19. See, e.g., *In re R.M.*, 90 S.W.3d 909, 912 (Tex. Ct. App. 2002) ("R.M. testified that she is very religious and a devout Catholic. She did not testify that taking the psychoactive medication would be in violation of her religious beliefs. Instead, R.M. simply testified that she did not like the effects of the medication ...").

20. See *Shakur v. Shiriro*, 514 F.3d 878, 884–85 (9th Cir. 2008) (noting this ambiguity in Supreme Court doctrine, and adopting the sincerity test); *Banks v. Almazar*, No. 07-cv-5654, 2011 WL 1231142, at *8 (N.D. Ill. March 30, 2011) ("First Amendment jurisprudence protects only 'the observation of [] central religious belief[s] or practice[s].'"), (quoting *Civil Liberties for Urban Believers v. City of Chicago*, 342 F.3d 752, 760 (7th Cir. 2003)).

21. See, e.g., *Patrick v. LeFevre*, 745 F.2d 153, 157 (2d Cir. 1984) ("This test provides a rational means of differentiating between those beliefs that are held as a matter of conscience and those that are animated by motives of deception and fraud.").

expression for the general populace, albeit with some deference to the dangers posed by a prison population.²² However, in *Turner v. Safley*,²³ the Supreme Court broadened the scope of activities receiving complete deference to institutions to include “legitimate penological interests,”²⁴ with an accompanying four-part balancing test:

- (1) Whether there is a “valid, rational connection between the prison regulation and the legitimate governmental interest put forward to justify it”;
- (2) Whether there are “alternative means of exercising the right that remain open to prison inmates”;
- (3) Whether “accommodation of the asserted constitutional right” will “impact ... guards and other inmates, and on the allocation of prison resources generally”; and
- (4) Whether there is an “absence of ready alternatives” versus the “existence of obvious, easy alternatives.”²⁵

Formally, courts are required to weigh the significance of the burden and the sincerity of the plaintiff’s religious beliefs before addressing the government’s penological interest.²⁶ However, because this standard can be much easier to resolve (and frequently in the government’s favor), courts will often presume substantiality and sincerity in order to decide the case under *Turner*.²⁷

22. See *Battle v. Anderson*, 457 F. Supp. 719 (E.D. Okla. 1978) (“The state has the burden of justifying policies or practices which prevent inmates from engaging in religious or spiritual practices which do not present a threat to the security, discipline and good order of the institution”).

23. *Turner v. Safley*, 482 U.S. 78 (1987).

24. *Id.* at 89.

25. *Id.* at 89–90.

26. See *Ali v. Dixon*, 912 F.2d 86, 89 (4th Cir.1990) (“Implicit in the *Turner* approach is the principle that the four-factor analysis applies only after it is determined that the policy impinges on a first amendment right.”).

27. See, e.g., *Newberg v. GEO Grp., Inc.*, No. 2:09-cv-625-FtM-36DNF, 2011 WL 2533804, at *9 (M.D. Fla. June 27, 2011) (applying *Turner* without first addressing substantiality or sincerity).

As a result, in practice the burden of proof is entirely upon the plaintiff to show that the government was not justified in burdening his right to religious expression, because each of the *Turner* factors presumes the legitimacy of the regulation. Furthermore, although these factors on their face only apply to prison inmates, courts have routinely applied them in cases involving the involuntarily committed.²⁸ However, courts which do so then universally quote the following passage from *Youngberg v. Romeo*, a landmark Supreme Court precedent examining the rights of mental patients: “Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.”²⁹ Thus committed persons have a somewhat higher likelihood of success on the merits than those who are incarcerated; courts in a number of cases have simply asserted that “[p]ersons civilly committed retain the right to freely practice their chosen religion”³⁰ without much analysis, and then ruled in favor of the plaintiff.³¹

The Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA) changed this method of adjudication for both prisoners and involuntarily committed patients, stating that:

No government shall impose a substantial burden on the religious exercise of a person residing in or confined to an institution...even if the burden results from a rule of general applicability, unless the

28. *Lombardo v. Holanchock*, No. 07 Civ. 8674 (DLC), 2008 WL 2543573, at *6 n.6 (S.D.N.Y. June 15, 2008); *Abdul-Matiyn v. Allen*, No. 06-CV-1503 (GTS/DRH), 2010 WL 3880687, at *7 (N.D.N.Y. March 4, 2010); *Banks v. Almazar*, No. 07-cv-5654, 2011 WL 1231142, at *8 (N.D. Ill. March 30, 2011).

29. *Youngberg v. Romeo*, 457 U.S. 307, 321–22 (1982), cited by *LaBlanc v. San Bernadino Cnty Bd. of Sup’rs*, No. CV 07-04361-TJH (VBK), 2010 WL 5559683, at *9 (C.D. Cal. Sept. 29, 2010); *Lombardo*, 2008 WL 2543573, at *7; *Abdul-Matiyn*, 2010 WL 3880687, at *7; *Banks*, 2011 WL 1231142, at *8.

30. *Brull v. Jordan*, No. 101,755, 2011 WL 420700, at *5 (Kan. Ct. App. Jan. 28, 2011).

31. *Carney v. Hogan*, Nos. 9:08-CV-1251 (DNH/ATB), 9:08-CV-1280 (DNH/ATB), 2010 WL 2519121, at *3 (N.D.N.Y. Mar. 30, 2010).

government demonstrates that imposition of the burden on that person—

- (1) is in furtherance of a compelling governmental interest; and
- (2) is the least restrictive means of furthering that compelling governmental interest.³²

RLUIPA further defines the term “religious exercise” as “any exercise of religion, whether or not compelled by, or central to, a system of religious belief”³³ and expansively defines the term ‘institution’ to include state facilities which house “persons who are mentally ill, disabled, or retarded, or chronically ill or handicapped.”³⁴ RLUIPA was thus designed to address and/or override every component of Free Exercise doctrine in this area.

First, Congress sustained the “substantial burden” requirement of Free Exercise claims, but did not specifically define the term. This ambiguity has left courts to either transplant traditional substantiality requirements from Free Exercise doctrine or to redesign the standard to be consistent with the spirit of RLUIPA, and has therefore resulted in some imprecision by lower courts.³⁵ However, “[i]n practice, it is not clear that the decisional nuances in defining a substantial burden have any practical significance.”³⁶

Second, Congress clarified the ‘religious belief’ prong by specifically excluding any requirement that the practice be “central” to the individual’s beliefs, which most courts have read as an implied affirmation of the “sincerity” test used in some circuits’ First Amendment doctrine.³⁷ This clarification has significantly lightened the plaintiff’s burden because it respects individual religious beliefs which are “sincere” but do not conform to a traditional religion.³⁸ This issue will figure prominently in Part III *infra*.

32. 42 U.S.C. § 2000cc-1(a) (2006).

33. *Id.* § 2000cc-5(7)(A).

34. *Id.* § 1997(1)(B)(i).

35. *Blake v. Murphy*, No. 05-10508-RGS, 2010 WL 447780, at *2 n.9 (Mass. Dist. Ct. Feb. 9, 2010).

36. *Id.*

37. *See, e.g., Shakur v. Shiriro*, 514 F.3d 878, 884–85, 888 (9th Cir. 2008).

38. *Id.* at 885 (“Here the district court impermissibly focused on whether ‘consuming Halal meat is required of Muslims as a central tenet of Islam,’ rather

Third, and most clearly, Congress overrode the four-prong test of *Turner* in favor of traditional strict scrutiny, shifting the burden onto the state to prove that the regulation serves a compelling state interest using the least restrictive means available.³⁹ This has two major effects: one, it places the focus on the specific treatment of the plaintiff rather than on institutional concerns; and two, it eliminates limited state resources as a sufficient basis to restrict patients' free exercise rights.

In 2005, a unanimous Supreme Court in *Cutter v. Wilkinson* ruled that the portion of RLUIPA relating to the institutionalized does not violate the Establishment Clause of the First Amendment.⁴⁰ While the Court recognized that the Establishment Clause and the Free Exercise clause are often in tension, the majority reiterated that there is some 'play in the joints' between the two,⁴¹ and found that this measure does not advance religion *per se* but instead "protects institutionalized persons who are unable freely to attend to their religious needs and are therefore dependent on the government's permission and accommodation for exercise of their religion."⁴² Furthermore, the Court found that this section of RLUIPA served to equalize opportunities for expression enjoyed by "mainstream faiths," and thus did not present a problem that inmates would "get religion" in order to enjoy special benefits.⁴³ The *Cutter* opinion, however, did make clear that the burden facing prisons under strict scrutiny analysis is not as severe as it may seem: "We do not read RLUIPA to elevate accommodation of religious observances over an institution's need to maintain order and safety. Our decisions indicate that an accommodation must be measured so that it does not override other significant interests."⁴⁴ Thus, RLUIPA has not fundamentally changed the way courts

than on whether Shakur sincerely believes eating kosher meat is consistent with his faith.").

39. 42 U.S.C. § 2000cc-1(a) (2006).

40. *Cutter v. Wilkinson*, 544 U.S. 709 (2005).

41. *Id.* at 719 (citing *Walz v. Tax Comm'n of City of New York*, 397 U.S. 664, 669 (1970)).

42. *Id.* at 721.

43. *Id.* at 721 n.10.

44. *Id.* at 722–23 (noting penological concerns reminiscent of the four-prong *Turner* test: "good order, security and discipline, consistent with consideration of costs and limited resources").

handle claims by prisoners, but in the context of mental institutions it has created some interesting side effects.

There have been two major themes in lower court opinions involving mental institutions since RLUIPA and *Cutter v. Wilkinson*. First, courts have been going out of their way to avoid addressing a RLUIPA claim on the merits. While courts had frequently construed jailhouse *pro se* pleadings liberally for Free Exercise claims under the First Amendment,⁴⁵ many courts have used improper *pro se* RLUIPA pleadings to avoid facing the merits of the cases.⁴⁶ This improper rejection of RLUIPA-based pleadings shows the difficulty in adjudicating these claims in a mental health context.

Second, despite the heightened scrutiny required by RLUIPA, courts still routinely transplant safety and security justifications for prison regulations into the mental facility context,⁴⁷ particularly given the burgeoning population of sexual felons who have been involuntarily committed.⁴⁸ As such, much of RLUIPA's protection remains unfulfilled as courts fail to draw distinctions between prisoners, sexually violent predators and other involuntarily committed patients.⁴⁹ For instance, in *Strutton v. Meade*, a pa-

45. See *Carney v. Hogan*, Nos. 9:08-CV-1251 (DNH/ATB), 9:08-CV-1280 (DNH/ATB), 2010 WL 2519121, at *3 (N.D.N.Y. Mar. 30, 2010) (“Although he has not stated a specific ‘religion,’ in affording the *pro se* plaintiff the utmost liberality, the court will assume that his status as a Native American encompasses particular religious beliefs.”).

46. See, e.g., *Spicer v. Richards*, No. C07-5109 FDB, 2008 WL 3540182, at *10 n.10 (W.D.Wash. Aug. 11, 2008) (“Mr. Spicer has not brought a RLUIPA claim, thus only the constitutional analysis and the *Turner* standard applies here.”). But see, *Kalwasinski v. Maxymillian*, No. 9:09-CV-0214 (DNH/GHL), 2010 WL 5620908, at *3 n.6 (N.D.N.Y. Dec. 23, 2010) (RLUIPA claim in *pro se* plaintiff's summary judgment motion sufficient for court to examine its application).

47. See *Strutton v. Meade*, No. 4:05CV02022 ERW, 2008 WL 4534015, at *26 (E.D.Mo. Sept. 30, 2008) (“While Plaintiff is not a prisoner, ‘his confinement is subject to the same safety and security concerns.’”) (citing *Revels v. Vincenz*, 382 F.3d 870, 874 (8th Cir. 2004)).

48. See *Kessler*, *supra* note 8, at 291 (With regard to constitutional claims, “[Courts] rarely recogniz[e] any distinction between criminal imprisonment and civil commitment.”).

49. See *Sumahit v. Parker*, No. CIV S-03-2605 FCD KJM P, 2008 WL 449713, at *4 (E.D.Cal. Feb. 15, 2008) (rejecting the defendant's argument that

tient wished to order Wiccan literature and participate in a Wiccan correspondence course, but the Missouri Sexual Offender Treatment Center had not approved any vendors of such materials.⁵⁰ The court acknowledged the strict scrutiny standard imposed by RLUIPA and then wholly failed to conduct a proper analysis, stating that “[t]he MSOTC must approve vendors for security reasons,” which was sufficient to satisfy a “compelling government interest by the least restrictive means.”⁵¹ Similarly, in *Newberg v. GEO Group, Incorporated*, Native American patients wanted a sweat lodge built at the Florida Civil Commitment Center, and the court granted summary judgment against them on the RLUIPA claim based on a similar case decided against inmates at a maximum security prison, finding “the security concerns identified by GEO are equally significant, especially in the context of an institution like the FCCC.”⁵²

These cases were both brought by committed sex offenders, and thus the ‘contextual’ requirement of *Cutter v. Wilkinson* lends some support for these decisions.⁵³ However, they set a distinct tone for future cases dealing with mental patients: if the institution can claim the regulation relates to safety, courts will still defer to the institution. RLUIPA expressly distinguishes mental patients from prisoners,⁵⁴ and the Supreme Court has long held that mental patients deserve more considerate treatment.⁵⁵ Therefore, even if the institution’s asserted safety concerns are a compelling state interest, the institution should still be required to show that the burden at issue is the least restrictive means of accomplishing that

“those committed under the [Sexually Violent Predators Act] are not similarly situated to other civilly committed or detained people.”).

50. *Meade*, 2008 WL 4534015, at *23.

51. *Id.* at *26.

52. *Newberg v. GEO Grp., Inc.*, No. 2:09-cv-625-FtM-36DNF, 2011 WL 2533804, at *10–11 (M.D.Fla. June 27, 2011).

53. *See Cutter v. Wilkinson*, 544 U.S. 709, 710 (2005) (“While [RLUIPA] adopts a ‘compelling interest’ standard, § 2000cc-1(a), ‘context matters’ in the application of that standard.”) (internal citations omitted).

54. *See* 42 U.S.C. § 1997(1)(B)(i), (ii) (2006).

55. *Youngberg v. Romeo*, 457 U.S. 307, 321–22 (1982) (“Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.”).

interest, under presumptively higher standards than those required of a prison.

In sum, the history of Free Exercise claims in mental health facilities has been one of restriction. Under current First Amendment analysis, the plaintiff bears the entire burden of the claim, and must prove that the government action substantially burdens a sincerely held religious belief (and burdens a central tenet of his faith depending on the jurisdiction), and that there is no legitimate penological interest under the government-deferential four-prong *Turner* test. While RLUIPA changed this structure to make the pleading process far easier for plaintiffs, many courts have responded by avoiding the complexities of these protections, particularly given the continued deference to penal interests implied by *Cutter*. Thus to date, RLUIPA has had less impact in cases involving mental health facilities than expected from the deliberate breadth of the language of the statute.

*Various Issues as “Substantial Burdens” on Mental Patients’
Religious Rights*

There are a large number of issues that religious beliefs pose for the administration of government facilities, in particular mental health institutions. This section is devoted exclusively to whether courts find patients’ religious beliefs have been ‘substantially burdened’ by a particular practice, a requirement which is facially identical under both RLUIPA and the Free Exercise clause. RLUIPA’s added scrutiny requirements, however, merit discussion of its expected impact on each type of burden, because as noted in Part II.A, *supra*, cases actually applying RLUIPA to mental patients are extremely limited. Parts III and IV discuss the difficulty in determining “sincerity” of mental patients’ religious beliefs under RLUIPA, and thus this material is not strictly applicable to that later discussion. However, these cases do highlight that the issues facing mental institutions on a regular basis parallel those facing other state institutions, which may help explain why Congress was not concerned about including mental institutions within the provisions of RLUIPA.

Personal Objections to Religiously-Neutral Treatments

Courts are generally receptive to patients' personal religious objections to medication.⁵⁶ That finding is dependent, however, upon a determination that the patient is competent to assert such an objection.⁵⁷ Thus in the mental health context, these cases give rise to the sensitive issue of veracity of mental patient's religious beliefs, and to overcome this hurdle, courts often engage in procedural and temporal formalism regarding the patient's religiosity.

For instance, in *Winters v. Miller*, Miriam Winters was committed to Bellevue Hospital on an emergency basis by the management of a hotel when she refused to change rooms.⁵⁸ Ms. Winters refused treatment as a practicing Christian Scientist, and was treated against her will with "heavy doses of tranquilizers, both orally and intramuscularly."⁵⁹ Ms. Winters brought suit, and the Second Circuit upheld her right to refuse treatment on religious grounds:

[A] finding of "mental illness" even by a judge or jury, and commitment to a hospital, does not raise even a presumption that the patient is 'incompetent' or unable adequately to manage his own affairs. Absent a specific finding of incompetence, the mental patient retains the right . . . to manage his own affairs.⁶⁰

The Second Circuit then ruled that because Ms. Winters had not been adjudicated "incompetent," and because Ms. Winters had repeatedly informed the staff of Bellevue of her religious objec-

56. See, e.g., *Winters v. Miller*, 446 F.2d 65, 68 (2d Cir. 1971) ("[I]f we were dealing here with an ordinary patient suffering from a physical ailment, the hospital authorities would have no right to impose compulsory medical treatment against the patient's will and indeed, that to do so would constitute a common law assault and battery.").

57. See, e.g., *Fosmire v. Nicoleau*, 551 N.E.2d 77, 81 (N.Y. 1990) (affirming "the basic right of a *competent* adult to refuse treatment even when the treatment may be necessary to preserve the person's life.") (emphasis added).

58. *Winters*, 446 F.2d at 67.

59. *Id.* at 68.

60. *Id.*

tions, forced medication violated her First Amendment rights.⁶¹ However, a factor critical to that outcome was that Ms. Winters had been an adherent of Christian Science for over a decade before she was committed, allowing the court to easily rule that this was a religious conviction.⁶²

The District of Columbia Court of Appeals confronted the same issue in *In re Boyd*, except Lucille Boyd had been adjudicated incompetent, allowing the court the power of “substituted judgment,” whereby “[t]he court, as surrogate for the incompetent, is to determine as best it can what choice that individual, if competent, would make with respect to medical procedures.”⁶³ The D.C. Appeals court remanded the case to the district court to make such a determination, issuing detailed guidelines regarding examination of her religious convictions.⁶⁴ However, given the attention given by the trial court to Ms. Boyd’s religious beliefs at her competency hearing, the court strongly implied that her religious objections were sound.⁶⁵

RLUIPA will likely have little impact on these claims. As *Winters v. Miller* and *In re Boyd* demonstrate, courts are already extremely deliberate in these cases under traditional First Amendment standards, and accordingly are quite deferential to the patient (so long as the court accepts the patient’s religiosity). Thus RLUIPA’s added scrutiny requirements are gratuitous.

General Objections to Allegedly Religious Treatments

Patients also object on religious grounds to treatments which are in and of themselves religious and in conflict with the patient’s beliefs, and thus amount to government compulsion in

61. *Id.* at 70–71.

62. *Id.* at 67–68.

63. 403 A.2d 744, 750 (D.C. Cir. 1979).

64. *Id.* at 752 (“[W]hether the objection, if religious, is a recognizable, established one, such as the well-known views of a Jehovah’s Witness or Christian Scientist; whether the individual has acted upon these views in ways that demonstrate they have been deeply felt; and whether these views have been long held, perhaps as a matter of family tradition, or if more recently adopted, have been the result of demonstrable experience, such as a religious conversion, which would justify a court’s conclusion that the views are unequivocal.”).

65. *Id.* at 746–48.

religious participation. This objection covers even atheistic beliefs, because “the [Supreme] Court has unambiguously concluded that the individual freedom of conscience protected by the First Amendment embraces the right to select any religious faith or none at all.”⁶⁶ This issue typically arises as part of court-ordered rehabilitation programs, most notably Alcoholics Anonymous.⁶⁷ However, unlike personal objections to religiously-neutral medical treatments (presumptively a substantial burden), here the patient must show that the program has content with a religious message or background *and* that the patient’s participation is required.

In the mental health context, the only cases involving a required treatment program concern involuntarily committed sex offenders. Four parallel cases arose in New York recently based around the Sex Offender Treatment Program (SOTP) administered at the Central New York Psychiatric Center.⁶⁸ Each of the four plaintiffs alleged that the SOTP programs “incorporate or are predicated upon Buddhist and Christian beliefs” and required participants to “believe in something denoted as spirituality” in order to complete the program and be released.⁶⁹ All four opinions found the allegations sufficient to survive a motion to dismiss; however, each opinion also expressed skepticism with the ability of the plaintiff to prove his claims.⁷⁰ For instance, the plaintiff in *Decker v. Hogan* requested a preliminary injunction against his participation in the program, and the district court denied it based on an insufficient showing of probable success on the merits, since it was

66. *Wallace v. Jaffree*, 472 U.S. 38, 52–53 (1985).

67. *See, e.g., Warner v. Orange Cnty. Dep’t of Prob.*, 115 F.3d 1068, 1075 (2d Cir.1997) (holding that because the plaintiff was sent to Alcoholics Anonymous as a condition of his probation, without offering a choice of other providers, he was “plainly” coerced in violation of the First Amendment).

68. *McChesney v. Hogan*, Civil Action Nos. 9:08-CV-1186 (NAM/DEP), 6:08-CV-1290 (NAM/DEP), 2010 WL 1027443 (N.D.N.Y. Feb. 26, 2010); *Carney v. Hogan*, Nos. 9:08-CV-1251 (DNH/ATB), 9:08-CV-1280 (DNH/ATB), 2010 WL 2519121 (N.D.N.Y. Mar. 30, 2010); *Pratt v. Hogan*, Civil Action No. 6:08-CV-1003 (DNH/DEP), 2009 WL 87587 (N.D.N.Y. Jan. 9, 2009); *Decker v. Hogan*, No. 9:09-CV-0239 (TJM/GJD), 2009 WL 3165830 (N.D.N.Y. Sept. 28, 2009).

69. *Decker*, 2009 WL 3165830, at *2; *McChesney*, 2010 WL 1027443, at *2.

70. *Pratt*, 2009 WL 87587, at *3; *Decker*, 2009 WL 3165830, at *4; *McChesney*, 2010 WL 1027443, at *10; *Carney*, 2010 WL 2519121, at *3.

“unaware of a controlling decision that equates spirituality with religion;” thus the patient had not shown that the SOTP programs were “in fact religious in nature in First Amendment terms.”⁷¹ Therefore patients participating in such programs have a more difficult burden in substantiating their case under the First Amendment, since generalized discomfort with religious overtones may be insufficient to reach a judicial determination of explicit religious coercion. However, the government still bears the burden of rebutting the plaintiff’s pleadings, and the institution will likely fall short if it fails to provide the materials in question to the court for review.⁷²

RLUIPA may have a more significant impact on this issue than on religious objections to neutral materials. Although the patient must still prove the substantiality of the burden, courts should ratchet down their tolerance for “spiritual” content in treatment programs, since if there is any religiously-neutral alternative, such elements are not the least restrictive means available.

Access to Religious Services

Courts have to walk a fine line on access to religious services in the prison and mental health facility contexts. If an institution fails to provide patients with freedom of worship, they run afoul of the Free Exercise clause. If, however, the institution works too hard to facilitate access to religion by patients, it could end up supporting particular faiths in violation of the Establishment Clause. An excellent example of this tension appears in *Carter v. Broadlawns Medical Center*.⁷³ the hospital was allowed to hire a chaplain for secular counseling purposes who could conduct religious services for hospitalized patients, but he could *not* provide religious counseling for outpatients and employees who could get these services outside the hospital.⁷⁴

71. *Decker*, 2009 WL 3165830, at *4.

72. *See* *Kollyns v. Hughes*, No. C/A3:05-90-JFA-JRM, 2006 WL 2716407, at *7 (D.S.C. Sept. 22, 2006); *Francis v. Hughes*, C/A No. 3:05-418-JFA-JRM, 2006 WL 2716458, at *7 (D.S.C. Sept. 22, 2006) (suits survived motion to dismiss in part due to facility’s failure to provide the allegedly religious video tape).

73. *Carter v. Broadlawns Med. Ctr.*, 667 F. Supp. 1269 (S.D. Iowa 1987).

74. *Id.* at 1278–82.

As a general rule, committed persons must be afforded “every reasonable opportunity to attend religious services, whenever possible.”⁷⁵ This does not mean that everyone’s particular beliefs must be directly facilitated.⁷⁶ For instance, having a single service for all Christian patients can be sufficient, regardless of their denomination.⁷⁷ Institutions may also pay these religious practitioners, and allow them to conduct religious services within state facilities.⁷⁸

However, because a patient must initially show a “substantial burden” on his religious beliefs, such burdens are insufficient if the court deems them “inconsequential”⁷⁹ or burdensome on an insignificant aspect of their faith.⁸⁰ As a result, courts are more willing to protect religious ceremonies they are familiar with, which tends to favor larger religions such as Sunday Mass for Catholics,⁸¹ Saturday services for Jews⁸² and Friday Al Jumu’ah services for Muslims.⁸³ Finally, if the patient’s views are unique

75. See *Young v. Coughlin*, 866 F.2d 567, 570 (2d Cir. 1989) (regarding prisoner rights).

76. See, e.g., *Treece v. S.C. Dep’t of Mental Health SCDMH*, Civil Action No. 3:08-3909-DCN-JRM, 2010 WL 3781726, at *13 (D.S.C. Feb. 19, 2010) (“There is no affirmative duty requiring that prison administrators provide each inmate with the spiritual counselor of his choice.”).

77. See *Banks v. Almazar*, No. 07-cv-5654, 2011 WL 1231142, at *2-4 (N.D. Ill. Mar. 30, 2011) (The Elgin Mental Health Center hired one Christian priest to conduct services for patients who were “Baptist, Catholic, Eastern Orthodox, Episcopalian, Lutheran, and Methodist.”).

78. *Id.*

79. *Abdul-Matiyn v. Allen*, No. 06-CV-1503 (GTS/DRH), 2010 WL 3880687, at *8 (N.D.N.Y. Mar. 4, 2010).

80. *Strutton v. Meade*, No. 4:05CV02022 ERW, 2008 WL 4534015, at *22 (E.D. Mo. Sept. 30, 2008).

81. *Samuels v. Stone*, No. 98 Civ. 776(WHP), 1999 WL 624549, at *1 (S.D.N.Y. Aug. 17, 1999).

82. *Lombardo v. Holanchock*, No. 07 Civ. 8674(DLC), 2008 WL 2543573, at *6 (S.D.N.Y. June 25, 2008).

83. *Kalwasinski v. Maxymillian*, No. 9:09-CV-0214 (DNH/GHL), 2010 WL 5620908, at *3 (N.D.N.Y. Dec. 23, 2010) (“Al Jumu’ah is an important service for Muslims . . . It is a congregational prayer performed every Friday after the sun reaches its zenith and before the Asr . . . Attendance at the congregational prayer is obligatory on all men in the Muslim religion.”).

within the institution, courts simply rule that the “[p]laintiff has the alternative of worshipping in his own room,” and dismiss the case.⁸⁴

RLUIPA should have a significant impact on this type of complaint. Although courts have protected the right to attend religious services under the Free Exercise clause (so long as the patient can establish how that service is connected to their faith),⁸⁵ RLUIPA eliminates several relevant *Turner* factors, particularly allocation of institution resources and the patient’s burden of showing alternatives.⁸⁶ As evidenced by *Cutter*, courts continue to respect institutional interests in patient safety,⁸⁷ so RLUIPA would treat potentially dangerous services the same way.

Religious Materials: Objects and Nutrition

The tendency by courts to “normalize” faith is especially strong when it comes to possession of religious objects; if the religion falls outside of the “mainstream,” the patient must establish how possession of that object is necessitated by his faith.⁸⁸ Furthermore, objects are automatically subject to heightened safety concerns, and thus even if possession is linked to a particular religious tenet, it may be rationally refused under *Turner*.⁸⁹ Courts are also reticent to require institutions to provide these objects for pa-

84. *Treece v. S.C. Dep’t Mental Health SCDMH*, Civil Action No. 3:08-3909-DCN-JRM, 2010 WL 3781726, at *13 (D.S.C. Feb. 19, 2010).

85. *Kalwasinski*, 2010 WL 5620908, at *3.

86. *Treece*, 2010 WL 3781726, at *13.

87. *Cutter v. Wilkinson*, 544 U.S. 570, 722–23 (2005); *Newberg v. GEO Grp., Inc.*, No. 2:09-cv-625-FtM-36DNF, 2011 WL 2533804, at *10–11 (M.D. Fla. June 27, 2011); *Strutton v. Meade*, No. 4:05CV02022 ERW, 2008 WL 4534015, at *26 (E.D. Mo. Sept. 30, 2008).

88. *Strutton*, 2008 WL 4534015, at *22 (“[W]hile the Plaintiff has presented the Court with a list of items he requested that were denied, he has not stated that any of these items are ceremonial items or that any of these items were necessary to his practice of the Wiccan religion. This evidence is necessary to show which tenet or belief is burdened, so that the Court may determine if the restriction infringes upon that tenet or belief.”).

89. *Tainter v. State of Wis. Dep’t of Health & Family Servs.*, No. 02-C-540-C, 2003 WL 23200348, at *6 (W.D. Wis. Aug. 5, 2003) (“[P]laintiff’s chokers presented a security risk because they contained bone or polished stone material not detectable by metal detectors and because these materials could be fashioned into a wide variety of sharp-pointed weapons.”).

tients (either for purchase or for free) based on both economic concerns and Establishment Clause interests.⁹⁰ However, to date there have been no cases that reached this phase under RLUIPA, which should have a significant impact. Possession of some objects may still pose safety concerns, but otherwise institutions will be hard-pressed to justify why refusal of those materials is the least-restrictive means available.

As for religious diet, courts generally impose higher standards on institutions because the vast majority of cases arise under two common religious food restrictions: Muslim halal and Jewish kosher. This accommodation is especially pronounced because under any penological or institutional standard, the state has an obligation to provide proper nourishment to those in its care.⁹¹ However, the same pleading requirements excluding “incidental” burdens apply;⁹² thus a patient must show that the denial of proper nutrition was regular, either by being served food prohibited by his faith⁹³ or by the institution’s failure to provide an adequate diet once faith-based restrictions were taken into account.⁹⁴ Since courts already take a keen interest in this subject, RLUIPA should have an appreciable impact only in cases where the provided diet is nutritionally deficient and thus interferes with the patient’s ability to engage in religious practices because administrative concerns in providing alternative nutrition are no longer sufficient to deny an accommodation.⁹⁵

Religious Activism

So long as the patients behave towards each other as equals, courts seem perfectly willing to allow group participation in faith-based activities of all kinds, from congregational worship

90. *Young v. Bass*, No. 01 C 7944, 2004 WL 765874, at *7 (N.D. Ill. Apr. 7, 2004).

91. *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982).

92. *Abdul-Matiyn v. Allen*, No. 06-CV-1503 (GTS/DRH), 2010 WL 3880687, at *8 (N.D.N.Y. Mar. 4, 2010).

93. *Banks v. Almazar*, No. 07-cv-5654, 2011 WL 1231142, at *16 (N.D. Ill. Mar. 30, 2011).

94. *Kalwasinski v. Maxymillian*, No. 9:09-CV-0214 (DNH/GHL), 2010 WL 5620908, at *9 (N.D.N.Y. Dec. 23, 2010).

95. *Id.* at *8.

to prayer circles to bible study (assuming there is adequate supervision).⁹⁶ However, courts are extremely skeptical of a patient acting as a religious *leader* within the institution:

The categorical determination that mentally ill persons will not be permitted to conduct religious services for other mentally ill patients is reasonably based upon concerns that the illness of the officiant might affect his ability to perform such services appropriately, to the detriment of the officiant's own treatment or that of others who might participate in such services.⁹⁷

This is particularly true for patients who have been involuntarily committed for acts of sexual violence, as courts believe that such a person serving as a religious figure (either in good faith or as a ruse) would pose too great a risk to the safety of other patients.⁹⁸

RLUIPA may have a slight impact on allowing religious groups to form within mental institutions, since lack of institutional resources is no longer a sufficient justification on its face to deny patients that right. However, RLUIPA should have no impact on the right of patients to behave as religious leaders within institutions. This stems from the initial skepticism that denying a patient a leadership role somehow affects that patient's *personal* ability to worship in the faith of their choosing. Furthermore, the continued concern for patient safety acknowledged by *Cutter* would have the same preclusive effect.

In sum, determining what is or is not a "substantial burden" on a patient's religious expression is generally a fact-intensive affair, and is often colored by traditional Judeo-Christian mores. If a patient is a member of a mainstream religion with widely-known practices, then courts generally give more leeway, in effect taking judicial notice of the fact that such practices are essential to the

96. *Strutton v. Meade*, No. 4:05CV02022 ERW, 2008 WL 4534015, at *9 (E.D. Mo. Sept. 30, 2008).

97. *Morgan v. Mo. Dep't of Mental Health*, No. 4:06CV727-DJS, 2007 WL 3026938, at *2 (E.D. Mo. Oct. 15, 2007).

98. *Spicer v. Richards*, No. C07-5109 FDB, 2008 WL 3540182, at *11 (W.D. Wash. Aug. 11, 2008) ("Due to Plaintiff's sexual offense history, grooming behaviors and use of his 'ministry' to engage in grooming behaviors with vulnerable residents, there is a valid, rational justification in directing Plaintiff to first coordinate his 'ministry' [with] the Chaplain . . .").

faith. If, however, a patient's religion has unusual practices, he bears a greater burden in substantiating their religious necessity, with diminishing success as the beliefs become more individualized. RLUIPA's impact on these claims is still in its infancy, but should vary in accordance with the type of justification institutions proffer to defend the restriction.

DETERMINING SINCERITY OF A MENTAL PATIENT'S BELIEFS

Part III strikes at the very heart of a debate that has plagued philosophers and First Amendment scholars for centuries: how does one distinguish between deeply-felt religious beliefs, and a mental disorder which manifests symptoms involving religious ideology? While available precedent on this issue is sparse, it still reveals how difficult this question is for courts.

As a general matter, the Supreme Court loathes defining "religion" explicitly.⁹⁹ The traditional viewpoint of non-justiciability of such issues is best described in *United States v. Ballard*.¹⁰⁰ The Ballards claimed that "by reason of supernatural attainments" they possessed "the power to heal persons of ailments and diseases and to make well persons afflicted with any diseases," and subsequently charged people for their services.¹⁰¹ The Ballards were indicted for fraud, and their primary defense was that they actually possessed such powers based on a good faith religious belief.¹⁰² The Supreme Court refused to address whether such religious beliefs were in fact true:

The religious views espoused by respondents might seem incredible, if not preposterous, to most people. But if those doctrines are subject to trial before a jury charged with finding their truth or falsity, then

99. Mason Blake Binkley, *A Loss for Words: "Religion" in the First Amendment*, 88 U. DET. MERCY L. REV. 185, 195-96 (2010) ("[T]he pendulum of what 'religion' in the First Amendment means has swung from embarrassingly parochial underinclusiveness to a seemingly all-welcoming overinclusiveness. . . . The inability to grasp and define the essence of religion explains both this wild disparity over the previous century and why the Court has nothing to really show for its efforts.").

100. *United States v. Ballard*, 322 U.S. 78 (1944).

101. *Id.* at 80.

102. *Id.* at 80-81.

the same can be done with the religious beliefs of any sect. When the triers of fact undertake that task, they enter a forbidden domain.¹⁰³

The Supreme Court affirmed and expanded that position in *Thomas v. Review Board of Indiana Employment Security Division*, stating that “religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection.”¹⁰⁴ Thus, in situations where courts are required to determine sincerity of religious beliefs, courts are willing to concede their own inadequacy: “The task of distinguishing a religion from something else (e.g., a delusion, a personal credo, or a fraud) is a recurring and perplexing problem, and the outer limits of what is ‘religious’ may be ultimately unascertainable.”¹⁰⁵

Therefore, two lines of Free Exercise doctrine are in direct conflict. Under the deferential standard of *Ballard* and *Thomas*, courts must accept even “preposterous” and “incomprehensible” religious beliefs.¹⁰⁶ However, in the context of mental institutions, courts must still determine the patient’s sincerity,¹⁰⁷ and courts implicitly understand that ‘true’ beliefs are distinctive from beliefs caused by symptoms of mental illness, which would disappear if the illness were cured.¹⁰⁸ Thus, courts are faced with an impossible question: does this person, with a mental illness severe enough to warrant institutionalization, truly hold his espoused beliefs?

There is a narrow range of cases that address this issue, centered on spiritual beliefs which cause harm to the patient but are not immediately fatal. First, non-harmful beliefs are usually not significant enough to require judicial interference, and are settled within the institution. Second, being religiously compelled to harm

103. *Id.* at 87.

104. *Thomas v. Review Bd. of Ind. Emp’t Sec. Div.*, 450 U.S. 707, 714 (1981).

105. *Unification Church v. I.N.S.*, 547 F. Supp. 623, 628 (D.D.C. 1982). *See also Pierre, supra* note 9 (“Determining whether a religious belief is delusional is especially difficult because there is no objectively observable (empirical) evidence to prove or disprove the belief.”).

106. *Thomas*, 450 U.S. at 714; *Ballard*, 322 U.S. at 87.

107. *See Shakur v. Shiriro*, 514 F.3d 878, 884–85 (9th Cir. 2008).

108. *See, e.g., U.S. v. Mitchell*, 706 F. Supp. 2d 1148, 1194 (D. Utah 2010) (reviewing psychiatric testimony that religious beliefs and delusions are separable based on information processing).

others has been considered in criminal cases for centuries, and has been categorically rejected as an acceptable religious practice based on the greater government interest in public safety.¹⁰⁹ In fact, such justification is considered prima facie evidence of mental illness under the “deific decree doctrine,” but in practice this antiquated principle is rarely used, and has been heavily criticized by modern scholarship.¹¹⁰ Finally, while religious convictions held prior to the onset of mental illness have been found sufficient for incompetent persons to refuse medical treatment (as discussed in Part II), courts are more skeptical when the patient’s condition is life-threatening. When the patient’s life is at risk, courts often reject the rationale that someone who is currently incompetent would wish to die if they had the capacity to make an informed decision, even if it means overriding the patient’s stated religious principles.¹¹¹ By process of elimination, the most difficult questions faced by courts concern patients who wish to significantly harm their bodies based on their religious beliefs without directly causing death, either through actively hurting themselves or through denial of necessary medication.

There are two additional jurisprudential factors which contribute to making these cases exceptionally difficult to adjudicate. First, although self-destructive behavior is fairly common-place,¹¹² the general societal norm is that physically harming one’s self is indicative of mental abnormality or emotional instability, and it is

109. See *People v. Schmidt*, 110 N.E. 945 (N.Y. 1915) (“The devotee of a religious cult that enjoins polygamy or human sacrifice as a duty is not thereby relieved from responsibility before the law.”) (citing *Guiteau’s Case*, 10 Fed. 161, 175, 177 (D.C.D.C. 1882)). See also John S. Hilbert, *God in a Cage: Religion, Intent, and Criminal Law*, 36 BUFF. L. REV 701 (1987).

110. *Morris & Haroun*, *supra* note 10.

111. See, e.g., *In re Osborne*, 294 A.2d 372, 375 (D.C. App. 1972) (“[W]here the patient is comatose, or suffering impairment of capacity for choice, it may be better to give weight to the known instinct for survival which can, in a critical situation, alter previously held convictions.”). See also Samantha Weyrauch, *Decision Making for Incompetent Patients: Who Decides and by What Standards?*, 35 TULSA L.J. 765, 775 (2000) (“When life is at stake, a court may focus on the smallest ambiguity to cast doubt on the patient’s competency to make medical decisions.”).

112. Some have even argued it should receive constitutional protection. See Natalie Rezek, *Is Self-Harm by Cutting a Constitutionally Protected Right?*, 12 QUINNIPIAC HEALTH L.J. 303 (2008–2009).

considered *prima facie* evidence of mental illness in the psychological community.¹¹³ Second, although some cultures engage in ritual suicide or in physical disfigurement, there is not yet a judicially-recognized religious basis for damaging one's body.¹¹⁴ Therefore, these cases force courts to examine a religious practice that goes against traditional social and psychological mores and which is often individualistic, eliminating two primary methods courts use to avoid the touchy subject of sincerity of a mental patient's religious beliefs.

The first significant case to address this question is *Mayock v. Martin*.¹¹⁵ Peter Mayock was first committed in October 1943.¹¹⁶ Upon his first release in 1944, Mayock removed his right eye and was recommitted; upon his second release in 1947, he removed his right hand, and was committed permanently.¹¹⁷ Mayock believed that he was a religious prophet, and that these actions were offerings to God.¹¹⁸ His religious ideation was the sole basis of his commitment under a diagnosis of "dementia praecox, paranoid type;" the trial court found that Mayock was otherwise competent, noting his ability to handle the sales and finances of the hospital newspaper stand and to run the patient recreation center.¹¹⁹ Mayock challenged the constitutionality of his ongoing detention as infringing on his religious beliefs, despite his desire to remove his right foot for similar religious reasons.¹²⁰ The trial court upheld the committal and the Connecticut Supreme Court affirmed:

It is common knowledge that the mental illness of many persons is associated with apparently fervent

113. *Id.* at 313, n.86 (likelihood of 'self-mutilation' satisfies one of the four civil commitment criteria under the American Psychological Association's model statute).

114. There are religious ceremonies that involve self-harm, but there are no cases examining those ceremonies in the mental hospital context. *See id.* at 305 ("Some Hindus pierce their bodies to make themselves more pleasing to the god Murugon.' During the festival of Husain, thousands of Shiites whip their own bodies screaming the words of Husain ... Some [Catholics] use the cilice, a metal chain with prongs ... worn tightly around the thigh.").

115. *Mayock v. Martin*, 245 A.2d 574 (Conn. 1968).

116. *Id.* at 575.

117. *Id.*

118. *Id.* at 576.

119. *Id.* at 566–67.

120. *Id.*

religious beliefs. The [trial] court found, on the basis of expert psychiatric evaluation, that the incidents wherein the plaintiff removed his eye and his hand were not manifestations of a religious belief but were symptoms of mental illness which continued to exist to the date of trial.¹²¹

This case predates much of the Supreme Court doctrine on both the standards for involuntary commitment and deference to individual religious beliefs, and the *Mayock* court cited no precedent for the proposition above. However, more recent cases demonstrate that the conclusions of psychiatric experts continue to guide courts' judgments.

In *People v. Pietromonaco*, Dennis Pietromonaco had been involuntarily committed for schizophrenia, suffered from diabetes, and refused to take insulin because he believed he was the Son of God and would be healed through faith.¹²² The psychiatric testimony at trial stated that Pietromonaco's illness was "[h]ighlighted by persistent delusions of religious flavor."¹²³ The Napa County court accepted this testimony as sufficient to involuntarily medicate, and the Court of Appeal affirmed: "Appellant does not contend he is 'a' son of God, but 'the' Son of God. For our present psychiatric and jurisprudential purposes, the distinction is significant. His belief is part of his delusional process, [per] the psychiatric evidence."¹²⁴

Alternatively, psychiatric testimony has also been used to uphold the free exercise rights of mental patients. In *In re Milton*, Nancy Milton refused surgery for a tumor on the grounds that she was a faith healer, and the trial court ruled against her because she "had a fixed long-standing delusion that she was the spouse of Rev. LeRoy Jenkins, a faith healer and evangelist who is well known in the central Ohio area."¹²⁵ The Supreme Court of Ohio reversed, citing *Ballard's* broad religious protection language, and noting "[t]he testimony of Dr. Green . . . supports a conclusion that

121. *Id.* at 577–78.

122. *People v. Pietromonaco*, No. A098650, 2003 WL 1196059, at *1 (Cal. Ct. App. Mar. 17, 2003).

123. *Id.* at *2.

124. *Id.* at *4.

125. *In re Milton*, 505 N.E.2d 255, 256 (Ohio 1987).

appellant's belief in spiritual healing stands on its own, without regard to her delusion."¹²⁶

These cases exclusively focused on the sincerity of mental patients' beliefs under the First Amendment, and only one case has yet dealt with such a claim under RLUIPA. In *In re L.A.*, the plaintiff was committed to Vermont State Hospital for a variety of psychological problems, and refused antipsychotic medications on religious grounds, which he described as "a splendid relationship within [himself] and with the spiritual being that flows through [him]."¹²⁷ Although there was no psychiatric testimony as to whether these beliefs were mere delusions, the trial court rejected his RLUIPA claim, finding that there was "no clue as to whether [the patient] believes in God or gods" and thus the patient's beliefs were "secular in nature, not religious," per the definition of religion in the Oxford American Dictionary.¹²⁸ The Vermont Supreme Court reversed, allowing the patient to argue for a "more expansive interpretation of religious exercise than the dictionary definition" and citing *Ballard* and *Thomas* regarding the breadth of protected religious beliefs.¹²⁹

This extended discussion of case law is intended to substantiate three key observations. First, courts give tremendous deference to psychiatric opinions regarding whether a patient's religious belief is sincere or delusional. This deference comes in spite of the fact the DSM-IV definition of "delusion" specifically excludes religious beliefs, while at the same time using a much narrower definition of "religion" than the Supreme Court.¹³⁰ Furthermore, because there are no diagnostic criteria regarding religious delusions, this gives individual psychologists a great deal of discretion, who then make judgments of religious 'authenticity' based on their own cultural backgrounds.¹³¹

Second, when a court make this decision of its own accord, the bench often fails to follow Supreme Court precedent regarding

126. *Id.* at 258.

127. *In re L.A.*, 912 A.2d 977, 979 (Vt. 2006).

128. *Id.* at 983.

129. *Id.* at 984.

130. *See Morris & Haroun, supra* note 10, at 1026.

131. *Id.* at 1038 (discussing a recent study in which clinical diagnosis of authentic religious beliefs were correlated with how conventional those beliefs were from a Judeo-Christian perspective).

the non-justiciability of religiosity, and ends up categorizing beliefs as religious or delusional based on word choices in patient testimony,¹³² as well as such absurdly rigid sources as the dictionary.¹³³ This type of decision-making is precisely the “forbidden domain” cautioned against in *Ballard* and subsequent Supreme Court precedents.

Third, when courts cite to the *Ballard* line of precedent, the patient always wins (or at least does not lose).¹³⁴ Even in the event of conflicting expert testimony regarding the patient’s mental state, due to *Ballard*, the court will opt in favor of religious sincerity.¹³⁵ This outcome is also wrong because courts should be citing the *Ballard* line of precedents in all such cases regardless of its ultimate decision, and to allow *Ballard* to act as a bar would deny treatment to all patients suffering from religious delusions.

In short, whenever a court has addressed whether a mental patient’s religious beliefs are sincere, regardless of whether the outcome was just, the reasoning has been inescapably flawed. Although such cases are rare, they do show how judicial determination of these issues is woefully inadequate and once again highly colored by how “usual” the patient’s beliefs are based on a Judeo-Christian ethic. Given the higher standard imposed on mental institutions by RLUIPA, the frequency with which such issues reach the court is thus designed to continue to increase.

RLUIPA’S HEIGHTENED SCRUTINY REQUIRES IMPROVED MEANS OF DIFFERENTIATING BETWEEN RELIGION AND MENTAL ILLNESS

As discussed in Part II, in defining an accepted “religious exercise” under RLUIPA, Congress rejected the idea that the practice must be “central” to the individual’s beliefs.¹³⁶ This left court to imply that Congress wanted this to be a “sincerity” requirement

132. *People v. Pietromonaco*, No. A098650, 2003 WL 1196059, at *4 (Cal. Ct. App. Mar. 17, 2003).

133. *In re L.A.*, 912 A.2d at 983.

134. *Id.* at 984 (reversed and remanded); *In re Milton*, 505 N.E.2d 255, 258 (Ohio 1987) (plaintiff victorious).

135. *Milton*, 505 N.E.2d at 257.

136. 42 U.S.C. § 2000cc-5(7)(A) (2006).

akin to First Amendment doctrine.¹³⁷ Furthermore, RLUIPA deliberately overrides *Turner*'s institution-deferential framework and instead forces courts to apply strict scrutiny even where the individual has religious convictions unique to themselves.¹³⁸ In doing so, RLUIPA eliminates convenient methods of avoiding the difficult question of sincerity of a mental patient's religious beliefs. Therefore, as RLUIPA claims become more common-place and more expertly utilized by patients, it is logical to presume that the issue of mental patients' sincerity will more frequently be at issue, and will force courts into the absurd position cautioned against by *Ballard* and *Thomas* of defining *where* a person's beliefs come from. This situation is untenable, and necessitates revision of some component of this process.

The clearest option would be to amend RLUIPA's application to mental patients; however, when confronted with the task of *articulating* that amendment, all of the available options seem flawed on principle. First, RLUIPA could be revised to eliminate mental patients altogether, in which case prisoners and mental patients would enjoy different levels of religious protection, which in practical effect discriminates among those in state institutions on the basis of disability. Second, RLUIPA could continue to cover mental patients, but the standards imposed on courts could be lowered, perhaps to mirror the *Turner* analysis used for Free Exercise claims. This option, however, would undermine the very purpose of RLUIPA, which is to provide more procedural safeguards for the religious rights of those in state facilities. Third, Congress could add a provision directing courts' behavior when the "sincerity" of a plaintiff with a psychological condition is at issue. However, this option faces the same problem of execution. If courts are directed to presume sincerity, patients who require treatment may be unreachable by their physicians. If courts are directed to presume delusion, then patients with sincere beliefs will be treated against their will and to no effect, violating a core principle of American medical treatment. If courts are directed to balance some set of guidelines in between these two presumptions, they would then in effect have to make an individual assessment of a person's

137. See, e.g., *Shakur v. Shiriro*, 514 F.3d 878, 884–885, 888 (9th Cir. 2008).

138. See 42 U.S.C. §§ 2000cc-1(a)–2000cc-5(7)(A) (2006).

religion, which is precisely what courts are doing so inexpertly right now.¹³⁹

Therefore, while there is no perfect solution to this problem, the best available option is for the psychiatric community to develop a more uniform set of factors for clinicians to consider when making recommendations to courts as to the sincerity of a patient's beliefs. For example, in the recent competency case of *United States v. Mitchell*, the trial court relied on the following factors to separate religion from mental illness, assembled from the testimony of psychiatric experts:

- (1) if the patient's beliefs are "consistent with his subculture";
- (2) if the patient's behavior "demonstrates his beliefs are not fixed because they change to meet his needs";
- (3) if the patient's beliefs "do not cause him to be preoccupied or distressed";
- (4) if the patient's beliefs "are merely 'encapsulated' delusions because [he] has the ability to turn off his beliefs in situations where a religious delusion would have been firmly engaged";
- (5) if the patient's "presentation and history demonstrates that his beliefs have not resulted in any deterioration in functioning"; and
- (6) if the patient's symptoms are "inconsistent" with delusional disorders and/or are highly consistent with some other mental disorders not prone to delusions, such as personality disorders.¹⁴⁰

The list above, though not conclusive, demonstrates how a uniform list of diagnostic criteria would be extremely helpful in reaching decisions which strike the appropriate balance between mental health treatment and respect for religious expression rights

139. Another option would be for courts to amend their RLUIPA jurisprudence rather than the statute itself. This faces the same fundamental difficulties as amending RLUIPA; changing the standard applied to such cases in order to *avoid* the issue does nothing to *address* the underlying problem of respecting patients' religious freedoms while providing the best course of treatment.

140. *U.S. v. Mitchell*, 706 F. Supp. 2d 1148, 1193–94 (D. Utah 2010).

of patients. First, it would help eliminate the current practitioner bias in determining authenticity of religious beliefs based upon the clinician's personal background.¹⁴¹ Second, it would allow for a method of examining and comparing the testimony of multiple psychiatric experts by requiring them to provide analyses according to discrete diagnostic criteria, which are far easier to discuss and dispute than the 'ultimate question' of sincerity. Third, the topic of religious beliefs caused by non-delusional mental illnesses, as is discussed in *United States v. Mitchell*, is a relatively unexplored area of both law and psychiatry, and would be an invaluable asset in these difficult cases; religious beliefs based on non-delusional mental disorders are far easier to determine legally to be insincere because courts and psychologists alike can say more confidently that such beliefs would not exist absent the mental illness, and thus such cases do not pose the same problem as delusional disorders in determining the "truth" of the patient's beliefs.

CONCLUSION

The Religious Land Use and Institutionalized Person Act of 2000 created sweeping protection for the religious rights of mental patients. For the most part, RLUIPA's impact on mental institutions is consistent with both Congressional intent and similar issues facing other state institutions. However, because RLUIPA eliminates both the *Turner* standard as an easy means of disposing of difficult cases, and the "central tenet" aspect of religious burden claims, it forces courts to take on the thorny issue of determining the sincerity of a mental patient's beliefs which are both unusual and contrary to traditional social mores. Since courts are ill-equipped to make factual determinations in this area, and given the mandatory prohibition on such determinations under *Ballard* and subsequent Supreme Court precedent, the burden thus falls to the psychiatric community to distinguish religion from mental illness. Therefore, as RLUIPA becomes more common-place in religious burden claims by patients, clinicians should work to develop a uniform set of guidelines (perhaps as an amendment within the upcoming DSM-V) for determining whether a patient's religious be-

141. See Morris & Haroun, *supra* note 10, at 1038.

liefs stem from a mental disorder, in order to provide the most objective means of appropriately balancing patient care with respect for a patient's religion.

The DMS-5 and Its Potential Effects on *Atkins v. Virginia*

KATE JANSE VAN RENSBURG*

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INTRODUCTION

In May 2013, the American Psychiatric Association (hereinafter APA) released its new version of “the psychiatrists’ bible,” the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (hereinafter DSM-5).¹ The DSM-5 has been widely criticized since the APA released a preliminary version to the public for a “comment period” in early 2012.² Among the sweeping changes to its diagnostic system, the DSM-5 includes a new definition of mental retardation (now more commonly known as intellectual disability), coins the term “Intellectual Developmental Disorder,” and moves away from its former definition, which paralleled the American Association on Intellectual and Developmental Disabilities’ (hereinafter AAIDD) definition of intellectual disability. This drastic change, both in terms of diagnostic criteria and name, has the potential to impact one of the most important cases in capital punishment law: *Atkins v. Virginia*, which held that executing intellectually disabled defendants was unconstitutional.³ If courts

* Kate Janse van Rensburg received her J.D. from the University of Houston Law Center in August, 2013. She received her B.A. in History from the University of St. Thomas in 2008. The author would like to thank her husband, Henry Janse van Rensburg, and her parents, Paul and Margo Salmonsens, for all their love and support throughout her life and academic career. She would also like to extend special thanks to Professor David Dow of the University of Houston Law Center for his assistance in developing this topic; to Kirsty Davis, Matt Silverman, and Cortney Busch for their friendship, training, and inspiration; and to the Gulf Region Advocacy Center. The author also wishes to thank the *Mental Health Law and Policy Journal*’s editorial board and associates for all their hard work during the current academic year.

1. David Kupfer & Darrel Regier, *DSM-5 Implementation and Support*, AMERICAN PSYCHIATRIC ASSOCIATION DSM-5 DEVELOPMENT, <http://www.dsm5.org/Pages/Default.aspx>; AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5].

2. Allen Frances, *Diagnosing the DSM*, N.Y. TIMES, (May 12, 2012), at A19, http://www.nytimes.com/2012/05/12/opinion/break-up-the-psychiatric-monopoly.html?_r=0.

3. *Atkins v. Virginia*, 536 U.S. 304 (2002). N.B. *Atkins*, and some other earlier materials, use the term “mental retardation” instead of “intellectual disability.” For the purposes of this article, the term intellectual disability will be used throughout for clarity, unless an alternate term appears in a direct quotation.

shift from using the more common AAIDD definition to the new DSM-5 definition, there may be serious ramifications for capital defendants—some harmful, and some possibly beneficial.

This article seeks to explore those potential ramifications. It will begin with a discussion of the relevant principles and definitions involved before outlining problems with the current application of *Atkins*. It will then address the new DSM-5 definition, criticism of the DSM-5, and the potential problems and benefits to intellectually disabled individuals created by the new definition. The discussion will then move into how courts treat the previous version of the DSM (the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Third Revision, hereinafter DSM-IV-TR), why courts may or may not decide to shift to the new definition, and what that might mean for capital defendants.

ATKINS V. VIRGINIA

In 2002, the Supreme Court of the United States ruled on *Atkins v. Virginia*, a case in which the Court held that executing the intellectually disabled constituted “cruel and unusual punishment” under the Eighth Amendment.⁴ *Atkins* was a landmark case, abrogating the previous holding in *Penry v. Lynaugh* that there was no constitutional bar to such executions.⁵ The Court held that because intellectually disabled individuals have “diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reaction of others,” they did not “act with the level of moral culpability that characterizes the most serious adult criminal conduct,” and their intellectual limitations jeopardized the capital trial process.⁶ While intellectual disability does not absolve intellectually disabled defendants from guilt, it does significantly diminish their moral culpability, and therefore diminishes the appropriateness of the death pen-

4. *Id.*

5. *Penry v. Lynaugh*, 492 U.S. 302 (1989).

6. Sarah Cardwell, *Atkins v. Virginia*: “[I]n the End Our Own Judgment Will Be Brought to Bear . . .”, 55 BAYLOR L. REV. 829, 849–50 (2003) (quoting *Atkins*, 536 U.S. at 318).

alty as a punishment, as it is intended to be reserved for only the “most serious crimes.”⁷

In addition to diminished moral culpability, executing individuals with intellectual disabilities poses additional problems for the justice system. The two main issues articulated in *Atkins* were that executing the intellectually disabled did not serve either the retributivist or deterrent functions of the death penalty, and that the mentally disabled are at greater risk for wrongful conviction because of false confessions, the inability to meaningfully assist counsel with their defense, and the like.⁸

THE AAIDD DEFINITION OF INTELLECTUAL DISABILITY

In defining intellectual disability, courts currently most often look to the standard laid out by the AAIDD. The AAIDD defines intellectual disability as “characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before the age of 18.”⁹ These first two crite-

7. *Atkins*, 536 U.S. at 318–19 (citing *Gregg v. Georgia*, 428 U.S. 153 (1976)).

8. *Id.* at 318–21 (quoting *Lockett v. Ohio*, 438 U.S. 586, 605 (1978)) (citing *Penry*, 492 U.S. 302, 323–25) (internal citations omitted) (“First, there is a serious question as to whether either justification that we have recognized as a basis for the death penalty applies to mentally retarded offenders The reduced capacity of mentally retarded offenders provides a second justification for a categorical rule making such offenders ineligible for the death penalty. The risk “that the death penalty will be imposed in spite of factors which may call for a less severe penalty,” is enhanced, not only by the possibility of false confessions, but also by the lesser ability of mentally retarded defendants to make a persuasive showing of mitigation in the face of prosecutorial evidence of one or more aggravating factors. Mentally retarded defendants may be less able to give meaningful assistance to their counsel and are typically poor witnesses, and their demeanor may create an unwarranted impression of lack of remorse for their crimes. As *Penry* demonstrated, moreover, reliance on mental retardation as a mitigating factor can be a two-edged sword that may enhance the likelihood that the aggravating factor of future dangerousness will be found by the jury. Mentally retarded defendants in the aggregate face a special risk of wrongful execution.”).

9. AMERICAN ASS’N ON INTELLECTUAL AND DEVELOPMENTAL DISABILITY, *INTELLECTUAL DISABILITY: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORT* (11th ed. 2010). (hereinafter “AAIDD MANUAL”).

ria—intellectual functioning limitations and adaptive deficits—work in concert with each other to paint a picture of not simply an individual with a subnormal IQ, but of one who suffers from multiple challenges, intellectual and functional, in his daily life. The third criteria—onset before the age of eighteen—limits the diagnosis to deficits occurring in the crucial developmental period prior to adulthood to distinguish it from non-developmental disorders which can have similar effects.¹⁰

Significant Limitations in Intellectual Functioning

Intellectual functioning is typically assessed through intelligence tests, and a significant limitation in intellectual functioning is defined as an IQ score “approximately two standard deviations below the mean, considering the standard error of measurement for the specific assessment instruments used and the strengths and limitations of the instruments.”¹¹ However, the AAIDD Manual cautions that significant limitation in intellectual functioning is only one of three criteria that must be met for a diagnosis of intellectual disability—an IQ score should not exist in a vacuum.¹² Because of the individual differences from case to case, there should not be a bright-line IQ cutoff point for establishing intellectual disability, as tests vary in reliability for a number of reasons, and an individual may be able to achieve a higher IQ score than other intellectually disabled individuals, but have such significant limitations in adaptive functioning that a combination of the two elements clearly show him as intellectually disabled.¹³ While the

10. *Id.* at 28.

11. *Id.* at 35.

12. *Id.*

13. *See id.* (“The intent of this definition is not to specify a hard and fast cutoff point/score for meeting the significant limitations in intellectual functioning criterion of ID [intellectual disability]. Rather, one needs to use clinical judgment in interpreting the obtained score in reference to the test’s standard error of measurement, the assessment instrument’s strengths and limitations, and other factors such as practice effects, fatigue effects, and age of norms used . In addition, significant limitations in intellectual functioning is only one of the three criteria used to establish a diagnosis of ID [T]he decision-making process cannot be viewed as only a statistical calculation.”) (internal reference omitted); *Id.* at 35–41 (Among the variables that affect test reliability are measurement error, test fairness, the Flynn Effect, variability of scores between dif-

AAIDD Manual does not define a cutoff score, an IQ score two standard deviations below the mean is approximately a score of 70, although, as the AAIDD cautions, that should not be used as a bright-line cutoff.¹⁴

Significant Limitations in Adaptive Behavior

Limitations in adaptive behavior (also known as adaptive deficits) is a far more complex and varied criterion than intellectual functioning limitations. While all intellectually disabled individuals share some level of deficient intellectual functioning, adaptive deficits express themselves across a broad spectrum, and may vary wildly from case to case. The AAIDD Manual defines adaptive behavior as:

[T]he effectiveness with which the individual copes with the nature and social demands of his environment. It has two major facets: the degree to which the individual is able to function and maintain himself independently, and the degree to which he meets satisfactorily the culturally-imposed demands of personal and social responsibility.¹⁵

Limitations in adaptive behavior, therefore, are best expressed as:

[S]ignificant limitations in adaptive behavior are operationally defined as performance that is approximately two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical or (b) an overall score on a standardized measure of conceptual, social, and practical skills.¹⁶

ferent assessment tools, and the practice effect.); *Id.* at 45 (“Adaptive behavior and intellectual functioning should be given equal consideration.”).

14. *Id.* at 35; AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 41, *Mental Retardation* (4th ed., 3rd rev. 2000) (hereinafter “DSM-IV-TR”).

15. AAIDD MANUAL, *supra* note 9, at 44 (quoting Rick F. Heber, A MANUAL ON TERMINOLOGY AND CLASSIFICATION OF MENTAL RETARDATION 61 (1959)).

16. *Id.* at 43.

Adaptive deficits are crucial to establishing an intellectual disability diagnosis because “intelligence test performances do not always correspond to level of deficiency in total adaptation.”¹⁷

There are three main areas in which adaptive deficits can be expressed: conceptual skills, social skills, and practical skills, which “have been learned and are performed by people in their everyday lives.”¹⁸ Conceptual skills refer to such skills as developing language, learning to read and write, and dealing with abstract and concrete concepts such as money, time, and numbers.¹⁹ Social skills consist of interpersonal skills, self-esteem, gullibility, naïveté or wariness, social responsibility, the ability to follow rules or obey laws, the ability to avoid being victimized, and interpersonal problem solving.²⁰ Practical skills, meanwhile, encompass the everyday tasks of life, such as taking care of oneself, hygiene, occupational skills, the ability to follow schedules or routines, use public (or personal) transport, deal with money, and use common devices like a telephone.²¹ For example, an individual may have an average IQ score of 75, but may not be able to hold down a job because he is unable to follow instructions, or be able to take the bus alone from his home to work without getting lost, or be able to read, or he might believe everything he is told, or may act impulsively or rashly without fully understanding the potential consequences of his actions. All of these are examples of adaptive deficits which help to create a full picture, in conjunction with an intelligence assessment, of an intellectually disabled individual.

Onset Before the Age of Eighteen

The requirement that the intellectual functioning and adaptive deficits must manifest before the age of eighteen, as stated above, exists to “distinguish [intellectual disability] from other forms of disability that may occur later in life.”²² This limitation on development of the disability has not always been set in stone at eighteen—indeed, it has fluctuated slightly over the years from “an early age” at the beginning of the century, to age sixteen by 1959,

17. *Id.* at 44 (quoting Heber, *supra* note 15, at 55–56).

18. *Id.* at 43.

19. *Id.* at 44.

20. *Id.*

21. *Id.*

22. *Id.* at 27.

and has been fairly stable at eighteen since the early 1970s.²³ Typically, onset occurs during fetal development or at or shortly following birth, but may occasionally manifest later in the developmental period due to disease or environmental factors such as malnutrition.²⁴ The crucial requirement is that the disability originates sometime during the brain's most formative years—sometime between the prenatal stage and the late teen years to early twenties.²⁵

The limitation on the age of onset exempts many individuals from an intellectual disability diagnosis, even though their symptoms may be identical to, and as severe as, other individuals with intellectual disability. If *Atkins*' statement that intellectually disabled individuals are less morally culpable than those who do not suffer from intellectual and adaptive deficits, then this cutoff age can actually lead to arbitrariness in capital sentencing practices:

[O]ne need only consider two criminal defendants: the first was mentally retarded from birth; the second suffered a traumatic brain injury at the age of twenty-two; and both have identical cognitive, behavioral, and adaptive impairments. Under state statutes cited approvingly in *Atkins* and others enacted since, the first defendant cannot be executed, but the second one can.²⁶

A prime example of this distinction is the case *State v. Brown*.²⁷ The defendant, Gregory Brown, was shot in the eye at the age of twenty-two, and the bullet lodged in his brain, damaging his right frontal lobe and temporal region.²⁸ This injury severely reduced his intellectual functioning and damaged his "ability to control impulses and interpret nonverbal stimuli."²⁹ Brown was sentenced to death, and his sentence was upheld by the Louisiana Supreme Court despite evidence that Brown suffered significant limitations

23. *Id.* at 9.

24. *Id.* at 27.

25. *Id.*

26. Nita A. Farahany, *Cruel and Unequal Punishments*, 86 WASH. U. L. REV. 859, 863 (2009).

27. *State v. Brown*, 907 So. 2d 1 (La. 2005).

28. *Id.* at 32.

29. *Id.*

in his “cognitive, behavioral, and adaptive functioning.”³⁰ The Court held that Brown was not intellectually disabled, because the onset of his limitations occurred after the age of eighteen, and therefore he did not fit the AAIDD or Louisiana statutory definition (which is identical to the definition put forth by the AAIDD) of the disorder.³¹ Brain damage occurring after the age of eighteen, along with other factors such as mental illness and neurological disorders, are specifically named in the statute as not constituting mental retardation.³²

PROBLEMS WITH THE CURRENT APPLICATION OF *ATKINS*

As *Brown* indicates, *Atkins* is not a perfect solution for the problem of executing intellectually disabled capital defendants. There are problems with the decision creating arbitrariness in its application. First, as seen in *Brown*, *Atkins* does not apply to cognitive or psychiatric disorders or physiological conditions such as organic or traumatic brain damage, which can similarly decrease a defendant’s intellectual functioning and therefore, his moral culpability. Second, *Atkins* failed to define “mental retardation,” giving rise to states creating their own interpretations of the term and leaving the decision of who meets those state-created definitions up to death-qualified juries.

Atkins Does Not Apply To Mental Disorders Or Brain Injury

One of the biggest issues with *Atkins*’ application is that it cannot be extended to mental disorders which may produce the same symptoms of intellectual disability. The two most commonly cited examples of disorders which produce similar effects to intellectual disability are dementia and traumatic brain injury.³³ Both disorders are “very closely related to the clinical definition of

30. Farahany, *supra* note 26, at 861.

31. *Brown*, 907 So. 2d at 31–32 (citing LA. CODE CRIM. PROC. ANN. art. 905.5.1(H)(1) (2010)).

32. LA. CODE CRIM. PROC. ANN. art. 905.5.1(H)(2) (2010).

33. See Judith M. Barger, *Avoiding Atkins v. Virginia: How States Are Circumventing Both the Letter and the Spirit of the Court’s Mandate*, 13 BERKELEY J. CRIM. L. 215, 233 (2008); Corena G. Larimer, *Equal Protection from Execution: Expanding Atkins to Include Mentally Impaired Offenders*, 60 CASE W. RES. L. REV. 925, 947 (2010).

‘mental retardation,’ in both substance and effect. Depending on their severity, both traumatic brain injury and dementia can result in the same intellectual and adaptive functioning deficits as mental retardation.”³⁴ The only real difference between intellectual disability and these conditions is the age of onset—both dementia and traumatic brain injury commonly arise after the age of eighteen.³⁵ Dementia and brain injury are not the only disorders, however, which may produce the same effects as intellectual disability—a wide range of conditions may similarly reduce a defendant’s intellectual and adaptive functioning:

[C]onditions as wide-ranging as traumatic brain injury, dementia, autism, epilepsy, and bacterial meningitis can produce many of the same deficits that the Court noted as relevant to its *Atkins* holding: a reduced ability to engage in logical reasoning, process information, communicate with others, control impulses, abstract from mistakes, learn from experience, and care for oneself.³⁶

Drug abuse, as well as other cognitive and psychiatric disorders, such as schizophrenia, attention deficit hyperactivity disorder, low brain serotonin, manic depression, bipolar disorder, and post-traumatic stress disorder can all likewise create limitations comparable to those of intellectual disability.³⁷

Because the *Atkins* court limited its holding to individuals with intellectual disability, “[s]tate legislatures have in turn failed to include all those individuals with medically equivalent conditions.”³⁸ As a result, individuals who are similarly-situated to intellectually disabled defendants still face the death penalty, and can be executed, which has injected arbitrariness into capital sentenc-

34. Barger, *supra* note 33.

35. *Id.*

36. Larimer, *supra* note 33, at 947; *see also* Douglas Mossman, M.D., *Atkins v. Virginia: A Psychiatric Can of Worms*, 33 N.M. L. REV. 255, 279–80 (2003) (“Particularly when the brain’s frontal lobes are affected, persons lose their ability to integrate information, utilize experience, and control impulses. If a psychiatric definition is all that is required to lead courts to believe that retarded defendants are not fully accountable for their acts, then consistency requires courts to exempt brain-damaged defendants from execution, too.”).

37. Mossman, *supra* note 36, at 279–82, 285–87.

38. Farahany, *supra* note 26, at 904.

ing and the application of the Eighth Amendment, and given rise to questions of Equal Protection:

Through the Court's new jurisprudence, a new disproportionality has emerged—a capital defendant who suffers traumatic brain injury at age twenty-two, and exhibits all of the same behavioral manifestations as a medically diagnosed mentally retarded capital offender, can be subject to the death penalty while one with early onset mental retardation cannot.³⁹

While an *Atkins*-type cause of action for the mentally ill or brain damaged defendant is not currently widely recognized, an increasing number of scholars and professional organizations, including the APA and the American Bar Association (hereinafter “ABA”) have spoken out demanding that *Atkins* be extended to these defendants, whose moral culpability is lessened by the same deficits as an intellectually disabled defendant.⁴⁰ Despite increasing sup-

39. *Id.* at 915; *see also id.* at 885 (“[T]he medical term mental retardation, however, is simply a linguistic quirk rather than the meaningful basis for a legal classification. An adult with intellectual and adaptive functioning loss due to illness, accident, infection, or disease does not suffer retardation in his development. His cognitive, behavioral, and adaptive functioning diminishes or regresses, rather than being retarded. So the linguistic label for those individuals has been distinguished from mental retardation based on language, diagnosis, and treatment, rather than legal criteria about their relative culpability. Likewise, the adult with traumatic brain injury has arrested or diminished development after his injury. To base a legal classification of individuals entitled to exercise the right to be free from cruel and unusual punishments upon a linguistic quirk seems the epitome of arbitrary and unequal treatment.”); Mossman, *supra* note 36, at 265 (“Yet the diagnosis of mental retardation—despite its clinical usefulness—is an entirely artificial construct: the line that separates persons who receive this diagnosis from individuals whose mental capacities are only well below average is a changing and arbitrary one.”).

40. *See* Mossman, *supra* note 36, at 265; Timothy S. Hall, *Mental Status and Criminal Culpability After Atkins v. Virginia*, 29 U. DAYTON L. REV. 355, 362 (2004) (“If we justify the prohibition against execution of the mentally retarded primarily by reference to the nature of the cognitive impairment suffered by the defendant, how are we to justify applying different standards to individuals suffering functionally identical cognitive impairments? In response to this problem, some capital defendants have argued for an extension of *Atkins*' Eighth Amendment reasoning to the severely mentally ill, though not mentally retarded. However, as of this writing, no court has countenanced a broad Constitutional

exemption from execution for mentally ill defendants who do not satisfy either the *Ford* or the *Atkins* criteria.”); Larimer, *supra* note 33, at 926 (“[T]he juvenile-onset requirement is inappropriate in the legal context and arguably violates the Equal Protection Clause because it requires different punishments for similarly impaired offenders based solely on the legally insignificant question of when their retardation began.”); Mossman, *supra* note 36, at 278 (“Rather than worry about an onslaught of malingered mental retardation in the wake of *Atkins*, courts should ready themselves to address the decision’s most obvious logical consequence: the claim that defendants with other serious mental limitations deserve diagnosis-based death penalty exemptions. Indeed, prominent psychiatrists called for this shortly after *Atkins* was announced.”); AMERICAN PSYCHIATRIC ASSOCIATION, REPORT OF THE TASK FORCE ON MENTAL DISABILITY AND THE DEATH PENALTY 2 (2005), available at <http://www.apa.org/pubs/info/reports/mental-disability-and-death-penalty.pdf> (“Paragraph 2 of the Recommendation is meant to prohibit execution of persons with severe mental disabilities whose demonstrated impairments of mental and emotional functioning at the time of the offense would render a death sentence disproportionate to their culpability The same reasoning [in *Atkins*] applies to people who, in the words of the Recommendation, have a ‘severe mental disorder or disability’ that, at the time of the offense: ‘significantly impaired their capacity’ (1) ‘to appreciate the nature, consequences, or wrongfulness of their conduct’; (2) ‘to exercise rational judgment in relation to the conduct’; or (3) ‘to conform their conduct to the requirements of law.’”); AMERICAN PSYCHIATRIC ASSOCIATION, POSITION STATEMENT ON DEATH SENTENCES FOR PERSONS WITH DEMENTIA OR TRAUMATIC BRAIN INJURY 1, available at <http://www.psychiatry.org/advocacy-newsroom/position-statements> (“Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury.”); Bruce J. Winick, *The Supreme Court’s Evolving Death Penalty Jurisprudence: Severe Mental Illness As the Next Frontier*, 50 B.C. L. REV. 785, 789–90 (2009) (“At least five leading professional associations—the American Bar Association (‘ABA’), the American Psychiatric Association (‘APsya’), the American Psychological Association (‘APA’), the National Alliance on Mental Illness (‘KAMI’), and Mental Health America (‘MHA’) (formerly known as the National Mental Health Association)—have adopted policy statements that recommend prohibiting the execution of those with severe mental illness. These organizations recommend a non-categorical, case-by-case determination of whether the severity of a defendant’s mental illness at the time of the crime should bar the prosecution from seeking the death penalty. Although this joint recommendation might prompt future legislative change, it has not yet succeeded in doing so.”).

port, however, only Connecticut “has countenanced a broad Constitutional exemption from execution for mentally ill defendants who do not satisfy either the *Ford* or the *Atkins* criteria.”⁴¹

Atkins Left the Definition of Intellectual Disability to the States

Another issue with *Atkins* is that the Court failed to define intellectual disability, instead leaving the definition of the term up to the states.⁴² Those states which still use capital punishment each dealt with the term differently, although many, such as Louisiana, simply adopted the AAIDD or DSM-IV-TR definition, while still others imposed additional restrictions on the three basic criteria of intellectual impairments, adaptive deficits, and onset before the age of eighteen.⁴³ Some states implement a bright-line cutoff IQ score, above which a defendant can never be found “legally” intellectually disabled, despite adaptive deficits, while other states have no such IQ threshold for a claim.⁴⁴ Similarly, in regard to adaptive

41. Hall, *supra* note 40, at 362; Lyn Entzeroth, *The Challenge and Dilemma of Charting A Course to Constitutionally Protect the Severely Mentally Ill Capital Defendant from the Death Penalty*, 44 AKRON L. REV. 529, 564 (2011) (quoting CONN. GEN. STAT. § 53a-46a (2010)).

42. Cardwell, *supra* note 6, at 851 (“The Court determined that any ‘serious disagreement about the execution of mentally retarded offenders . . . is in determining which offenders are in fact retarded.’ Concluding that ‘[n]ot all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus,’ the Court adopted its approach in *Ford v. Wainwright* of leaving ‘to the States the task of developing appropriate ways to enforce the constitutional restriction upon its execution of sentences.’”).

43. See LA. CODE CRIM. PROC. ANN. art. 905.5.1(H)(1) (2010); Barger, *supra* note 33, at 215–16 (“While many states have adopted the clinical definition endorsed by the American Association on Intellectual and Developmental Disabilities (‘AAIDD’) and/or the American Psychiatric Association (‘APA’), in their desire to limit the impact of *Atkins* they have twisted the definition to something that could exclude even severely mentally retarded individuals.”).

44. Barger, *supra* note 33, at 227–28 (“[A]pproximately half of the jurisdictions set a specific IQ threshold for purposes of determining cognitive impairment. Most jurisdictions set the requisite IQ level at 70 or below. Of these jurisdictions, New Mexico and Nebraska not only set the threshold at 70 or below, but provide that such a score ‘shall be presumptive evidence of mental retardation.’ Arkansas and Illinois have created presumptions supporting a finding of mental retardation when the IQ level is at or below 65, or at or below 75, respectively. Conversely, South Dakota’s statute provides that an IQ score ex-

deficits, many states follow the AAIDD or DSM-IV-TR definition, but others “have created definitions that have no support in the clinical literature.”⁴⁵

While most enacted state statutes implementing *Atkins* predominantly fall in line with the AAIDD or DSM-IV-TR definitions of the disorder, the states relying on common law definitions are dangerously out of sync with the accepted medical diagnoses.⁴⁶ Part of the problem with this system is that states which impose additional restrictions on an intellectual disability definition are creating a legal, rather than medical or psychiatric, definition of intellectual disability which is guided not by concern for the patient, but by a desire to limit the number of defendants who can raise a legally meritorious claim under *Atkins*.⁴⁷ This practice cir-

ceeding 70 ‘is presumptive evidence that the defendant does not have significant subaverage general intellectual functioning.’ Connecticut, Florida, Kansas, and Virginia have not adopted a particular IQ cutoff, but instead require a score on a standardized testing instrument that is ‘at least two standard deviations below the mean.’ Many other jurisdictions simply refer generally to a requirement that the defendant have ‘significantly subaverage general intellectual functioning.’”) (internal citations omitted).

45. *Id.* at 228–29 (“For example, Kansas defines the component as subaverage intellectual functioning ‘to an extent which substantially impairs one’s capacity to appreciate the criminality of one’s conduct or to conform one’s conduct to the requirements of law.’ This definition reads more like an insanity defense than a mental retardation diagnosis and is not supported in the clinical field. Utah has adopted a similar definition, requiring ‘significant deficiencies in adaptive functioning that exist primarily in the areas of reasoning or impulse control, or in both of these areas.’ Ironically, Utah has also adopted the clinical definition for adaptive functioning, but applies it only where the prosecution intends to present evidence of a ‘confession by the defendant which is not supported by substantial evidence independent of the confession.’ As with Kansas’ definition, this definition is not clinically supported.”) (internal citations omitted).

46. Lee Kovarsky, *Death Ineligibility and Habeas Corpus*, 95 CORNELL L. REV. 329, 351–52 (2010) (“Although state legislation defining retardation is mostly consistent with the clinical definitions in *Atkins*, state judicial formulations are not. This problem, which usually involves a selective focus by the courts on the adaptive strengths of *Atkins* claimants, disproportionately affects litigants in states with active capital dockets, such as Alabama, Florida, and Mississippi.” Kovarsky includes Texas in this list as well, but discusses it separately).

47. *Id.* at 351 (“Federal courts are likely to hear meritorious *Atkins* claims because certain states use under-inclusive definitions of retardation”).

cumvents both the letter and the spirit of *Atkins*, yet it has not been addressed or amended by the Supreme Court. Equally problematic is that these disparate definitions and approaches to *Atkins* from state to state increase the risk of arbitrariness and disproportionate application, as it means “some states will execute persons whom the statutes of other states would have exempted from the death penalty.”⁴⁸

These state-adopted definitions are likewise flawed because they are often convoluted (especially in the case of Texas, see below) and confuse capital jurors—in fact, even when the AAIDD definition itself is used without any additional criteria, jurors have a difficult time establishing what intellectual disability is and whether or not the defendant exhibits it.⁴⁹ This is partly because:

Mentally retarded individuals are not a homogeneous category of interchangeable persons. They are not “all cut from the same pattern . . . they range from those whose disability is not immediately evident to those who must be constantly cared for.” Each mentally retarded person “has a personality—a complex array of motivational and emotional features that permeate his or her everyday functioning.”⁵⁰

Often intellectually disabled individuals will attempt to mask their disability, or their reactions and emotions will seem out of place to a juror.⁵¹ Expert witnesses confuse the issue further, by

48. Mossman, *supra* note 36, at 275.

49. Marla Sandys et al., *Taking Account of the “Diminished Capacities of the Retarded”*: Are Capital Jurors Up to the Task?, 57 DEPAUL L. REV. 679, 691 (2008) (“In reviewing the transcripts of these interviews, several patterns become apparent. First, jurors are confused by the terminology used to diagnose persons as mentally retarded. Second, there is a disconnect between jurors’ perceptions of defendants’ mental retardation and their actual capabilities. Third, jurors’ personal experiences inform their evaluations of evidence of mental retardation. Fourth, jurors’ perceptions of experts who testify about defendants’ mental capabilities vary”).

50. Cardwell, *supra* note 6, at 831–32 (quoting Edward Zigler, *The Individual with Mental Retardation as a Whole Person*, in PERSONALITY DEVELOPMENT IN INDIVIDUALS WITH MENTAL RETARDATION 1, 14 (Edward Zigler & Diane Bennett Gates eds., 1999)).

51. Sandys et al., *supra* note 49, at 692 (quoting James R. Patton & Denis W. Keyes, *Death Penalty Issues Following Atkins*, 14 EXCEPTIONALITY 237,

talking above the jury's heads, by coming off as "hired guns" or not credible, or simply by cancelling each other out.⁵² This may cause jurors to either not listen to either expert, or to disregard one in favor of the other simply because of personal considerations such as "likability."⁵³

Capital jurors are not the most receptive audience for a defense expert, either, especially one perceived as arguing that the defendant was not responsible for his crimes or, at least, not responsible enough to warrant being put to death:

[D]eath-qualified jurors are hostile to mental health testimony, defenses, and mitigation. Further, death-qualified jurors more willingly accept aggravating circumstances than mitigating factors—many of which involve mental health issues. Death-qualified jurors are also much less likely to accept the insanity defense, believing it to be a "loophole allowing too many guilty people to go free." So, considering capital murder evidence of mental retardation is unsurprisingly difficult for the death-qualified jury. Death-qualified juries have a tendency to believe that, if you cannot see something, it does not exist.⁵⁴

Coupled with the already confusing definitions and expert testimony sure to be a crucial part of any capital trial, this tendency of death-qualified jurors to view any mitigating evidence put forth by the defense as "excuses" or "loopholes" further prejudices the intellectually disabled capital defendant. His disability will not be assessed and voted on by experts trained in identifying and treating

239–40 (2006) ("Another way in which juror misunderstanding about the mental retardation diagnosis was revealed in the interviews is through jurors' references to the defendants' inappropriate behaviors during the trial. As previously discussed, mild retardation is often characterized by a 'cloak of competence' and may be revealed through 'a behavior (e.g., smiling or laughing) that suggests a lack of remorse (e.g., happiness) at an inappropriate time (e.g., during trial).").

52. *Id.* at 695–96.

53. *Id.* ("[S]ome jurors disregarded the testimony of dueling experts. For other jurors, the perceived poor performance on the part of the expert may allow them to dismiss other evidence of the defendant's intellectual dysfunction").

54. Andrea D. Lyon, *But He Doesn't Look Retarded: Capital Jury Selection for the Mentally Retarded Client Not Excluded After Atkins v. Virginia*, 57 DEPAUL L. REV. 701, 712–13 (2008).

intellectual disability, but by capital jurors more prone to vote for death than believe a man might not have understood or appreciated the consequences of his actions.⁵⁵ For the death-qualified juror,

. . . allegations of mental retardation were just another way that defendants try to avoid responsibility for their actions. Moreover, defendants were seen as malingering, putting on “a show,” and, by implication, attempting to mislead the jury. If the defendants were truly mentally retarded, the reasoning goes, they would not have engaged in a particular behavior or have been capable of communicating as effectively. Unlike jurors who failed to understand what mental retardation is and how it differs from an insanity defense, these jurors did not believe that the defendant’s intellectual disabilities were severe enough to warrant consideration as mitigation.⁵⁶

Even though *Atkins* was decided eleven years ago as of this writing, Texas – the state which executes more people than any other – has still not adopted a statutory definition of intellectual disability.⁵⁷ The common law decision in *Ex parte Briseno* guides Texas intellectual disability claims in its capital jurisprudence.⁵⁸ The *Briseno* Court:

. . . adopted a widely-accepted definition of mental retardation and modified it with a number of evi-

55. See Sandys, *supra* note 49, at 691–92 (“[T]here was a lack of understanding about how to evaluate the evidence of mental retardation. That theme was echoed by a Kentucky juror, who said, ‘The defense tried to portray him as semi-retarded . . . [but the psychiatrists] also concluded that he knew right from wrong, so, if he was retarded in any way, that wasn’t a factor as far as we were concerned.’ This juror basically dismissed the potential mitigating influence of the defendant’s ‘semi-retard[ation]’ and concluded that it was irrelevant after hearing testimony that the defendant knew right from wrong.”).

56. *Id.* at 694.

57. Kovarsky, *supra* note 46, at 351 (“The Texas legislature has twice forgone the opportunity to statutorily define the term ‘retardation,’ thus leaving that responsibility to state courts.”).

58. *Id.* (“The state’s highest criminal court has identified seven ‘evidentiary factors . . . indicative of mental retardation or of a personality disorder’ to guide lower state courts in deciding *Atkins* claims”); William Lee Hon, *Claims of Mental Retardation in Capital Litigation*, 69 TEX. B.J. 742 (2006) (citing *Briseno*, 135 S.W.3d at 1).

dentiary considerations which the court regarded as probative in determining one's level of criminal culpability A defendant who claims exemption from the death penalty under *Atkins* must prove that his mental retardation is sufficient to warrant a finding of diminished culpability.⁵⁹

The Texas analysis takes the three factors included in the AAIDD (then known as the American Association of Mental Retardation, or AAMR) definition of the disability, combines it with the DSM-IV-TR's requirement of an IQ score of 70 or below, and adds additional considerations relevant less to intellectual disability and more to criminal culpability:

1. Did those who knew the person best during the developmental stage—his family, friends teachers, employers, authorities—think he was mentally retarded at that time, and, if so, act in accordance with that determination?
2. Has the person formulated plans and carried them through or is his conduct impulsive?
3. Does his conduct show leadership or does it show that he is led around by others?
4. Is his conduct in response to external stimuli rational and appropriate, regardless of whether it is socially acceptable?
5. Does he respond coherently, rationally, and on point to oral or written questions or do his responses wander from subject to subject?
6. Can the person hide facts or lie effectively in his own or others' interests?
7. Putting aside any heinousness or gruesomeness surrounding the capital offense, did the commission of that offense require forethought, planning, and complex execution of purpose?⁶⁰

Additionally, the defendant bears the burden of proof in this analysis—he must show by a preponderance of the evidence

59. Graham Baker, *Defining and Determining Retardation in Texas Capital Murder Defendants: A Proposal to the Texas Legislature*, 9 SCHOLAR 237, 240–41 (2007).

60. *Briseno*, 135 S.W.3d at 8–9.

that he is intellectually disabled.⁶¹ Briseno himself had an IQ of 74, which, although it falls within the allowable standard error of measurement for an IQ of 70, was insufficient for the Court of Criminal Appeals to find him intellectually disabled.⁶² Texas' definition has not been successful in achieving any of *Atkins*' aims, but has been successful in severely limiting the number of defendants who are actually found to be intellectually disabled. Many cannot prove it by a preponderance of the evidence in light of these additional factors—factors which “have morphed from a means of distinguishing retardation from personality disorder into an independent definition of mental retardation,” and “have no scientific or clinical content.”⁶³ Equally problematic are that “the approach provides no rules for how courts are to weigh the factors in making a retardation determination,” and that “the factors emphasize the cognitive attributes that committing the crime required, but a clinical retardation inquiry involves no such emphasis.”⁶⁴

The biggest problem with the Texas definition of intellectual disability is that, because of its focus on criminal culpability and its tendency to present intellectual disability as an aggravating as well as mitigating factor, defendants who may be intellectually disabled, and even found to be so to a severe degree, can still be executed “if the fact finder concludes the evidence of impairment is aggravating instead of mitigating.”⁶⁵ This result, not uncommon in Texas capital trials, not only violates the absolute prohibition against executing intellectually disabled individuals in *Atkins*, but violates the underpinning notion that intellectually disabled defendants have reduced moral culpability as a result of their disability.

61. *Id.* at 12.

62. *Id.* at 14.

63. Kovarsky, *supra* note 46, at 352–53.

64. *Id.*

65. Baker, *supra* note 59, at 241–42 (“A defendant who claims exemption from the death penalty under *Atkins* must prove that his mental retardation is sufficient to warrant a finding of diminished culpability. The result is a trial in which the defense attempts to convince the jury that the retarded defendant lacks the cognitive ability to learn from his mistakes, while the prosecutor uses the same evidence to explain why this makes the defendant a future danger. The result is, therefore, absurd: a mentally retarded defendant can be executed for being mentally retarded if the fact finder concludes the evidence of impairment is aggravating instead of mitigating.”).

Briseno and its subsequent application in Texas use culpability considerations *against* the intellectually disabled defendant, instead of allowing diminished culpability to be the *result* of the analysis, as intellectual disability, according to *Atkins*, “by definition” reduces culpability.⁶⁶

THE DSM-5 AND INTELLECTUAL DEVELOPMENTAL DISORDER

The DSM-5 has made fairly sweeping changes in its definition of intellectual disability, even changing the name from the outdated “mental retardation” to the both more modern and slightly confusing “Intellectual Disability/Intellectual Developmental Disorder.”⁶⁷ This definition, along with many other changes in the DSM-5, has drawn criticism and raises some potential ramifications for *Atkins* and intellectually disabled capital defendants. To appreciate these changes and their impact, it is important first to look at the DSM-IV-TR’s definition of mental retardation before addressing the new definition and its potential impact.

The DSM-IV-TR Definition of Mental Retardation

The DSM-IV-TR defines mental retardation as:

[S]ignificantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C).⁶⁸

While this preliminary definition largely matches the AAIDD definition of intellectual disability, it does break down the categories of adaptive functioning into more discrete classifications. In addition to the above criteria, however, and in opposition to the AAIDD definition, the DSM-IV-TR lays out specific IQ ranges for

66. *Atkins*, 536 U.S. at 318.

67. DSM-5, *supra* note 1, at 33.

68. DSM-IV-TR, *supra* note 14, at 41.

varying levels of intellectual disability. A score between 50-55 and 70 is classified as Mild Mental Retardation, 35-40 up to a range of 50-55 constitutes Moderate Mental Retardation, a score between 20-25 to 35-40 is Severe Mental Retardation, and a score lower than 20-25 constitutes Profound Mental Retardation.⁶⁹ This is the biggest departure from the AAIDD definition, which cautions against using bright-line cutoff IQ scores to establish intellectual functioning.⁷⁰ The DSM-IV-TR also defines “adaptive functioning” as the “person’s effectiveness in meeting the standards expected for his or her cultural group.”⁷¹ The DSM-IV-TR does caution, however, that great care should be taken in using any of the diagnostic criteria included in the DSM-IV-TR for legal purposes:

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a “mental disorder,” “mental disability,” “mental disease,” or “mental defect.” In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis.⁷²

The DSM-5 Definition of Intellectual Developmental Disorder

The DSM-5 does away with the stigmatizing name “Mental Retardation,” and replaces it instead with “Intellectual Disability/Intellectual Developmental Disorder.”⁷³ The new entry provides:

69. *Id.* at 42.

70. AAIDD MANUAL, *supra* note 9.

71. DSM-IV-TR, *supra* note 14, at 49.

72. *Id.* at xxxii-xxxiii.

73. DSM-5, *supra* note 1, at 33.

Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
- C. Onset of intellectual and adaptive deficits during the developmental period.⁷⁴

While this new definition maintains the emphasis on the two main criteria for intellectual disability (intellectual and adaptive deficits), it does away with the strict requirement of “onset before age 18 years”⁷⁵ and replaces it with “onset during the developmental period.”⁷⁶ It also provides a more detailed assessment of what constitutes intellectual deficits, and reconfigures the definition of adaptive deficits to take “socio-cultural standards” into account and places a greater emphasis on “personal independence.”⁷⁷ Other than the name of the disability, the biggest change in the DSM-5 classification is the removal of the IQ ranges that characterized various levels of the disability in the DSM-IV-TR.⁷⁸ No longer is

74. *Id.*

75. DSM-IV-TR, *supra* note 14, at 41.

76. DSM-5, *supra* note 1, at 33.

77. *Id.*

78. *Id.*

intellectual functioning characterized by a raw IQ score, but by “[d]eficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience.”⁷⁹

Criticism of the DSM-5

The new DSM-5 has been roundly criticized, not only for the changes made to the definition of “Intellectual Disability/Intellectual Developmental Disorder,” but for many of the changes within its pages.⁸⁰ One of the biggest criticisms is that the DSM-5 adds too many new “diseases,” broadening the scope of psychiatric intrusion into day-to-day life.⁸¹ This huge expansion of

79. *Id.*

80. See, e.g., COALITION FOR DSM-5 REFORM, <http://www.dsm5-reform.com>; Frances, *Diagnosing the DSM*, *supra* note 1; Allen Frances, *Newsflash from APA Meeting: DSM 5 Has Flunked its Reliability Tests*, PSYCHOL. TODAY (May 6, 2012), <http://www.psychologytoday.com/blog/dsm5-in-distress/201205/newsflash-apa-meeting-dsm-5-has-flunked-its-reliability-tests>; Paula J. Caplan, *Psychiatry's Bible, the DSM, Is Doing More Harm than Good*, WASH. POST (Apr. 27, 2012), available at http://articles.washingtonpost.com/2012-04-27/opinions/35450916_1_bipolar-disorder-psychiatric-ward-psychiatric-drugs.

81. See Kate Kelland, *New Mental Health Manual is “Dangerous” Say Experts*, REUTERS (Feb. 8, 2012, 2:24 PM EST) R18.2.2, <http://www.reuters.com/article/2012/02/09/us-mental-illness-diagnosis-idUSTRE8181WX20120209> (“Millions of healthy people—including shy or defiant children, grieving relatives and people with fetishes—may be wrongly labeled mentally ill by a new international diagnostic manual, specialists said on Thursday. In a damning analysis of an upcoming revision of the influential Diagnostic and Statistical Manual of Mental Disorders (DSM), psychologists, psychiatrists and other experts said new categories of mental illness identified in the book were at best ‘silly’ and at worst ‘worrying and dangerous.’ ‘Many people who are shy, bereaved, eccentric, or have unconventional romantic lives will suddenly find themselves labeled as mentally ill,’ said Peter Kinderman, head of Liverpool University’s Institute of Psychology at a briefing in London about widespread concerns over the manual. ‘It’s not humane, it’s not scientific, and it won’t help decide what help a person needs.’”); Johnathan Fish, (not necessary to include degree accolades, can’t find rule) *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL’Y 181, 184 (2012) (“A growing number of critics from both within and outside of psychiatry contend that psychiatry has recklessly medicalized variants of normal human existence and that increases in the number of Americans with mental illness include millions of false positives, i.e.,

what classifies as a “disorder” has occurred at the expense of existing diagnoses, such as Autism, which has had its definition limited to the point where it

. . . could have devastating effects on people with intellectual and developmental disabilities, including Autism. They stand to lose special education services, supportive housing, income supports, job training, long-term services and supports, and a host of other services that allow them to live as independently as possible.⁸²

In addition to the vocal criticism of the entire Manual, there has been substantial criticism of the new “Intellectual Disability/Intellectual Developmental Disorder” classification as well.

Problems with the DSM-5 Classification of “Intellectual Disability/Intellectual Developmental Disorder”

One of the problems with the new classification is the removal of the IQ score guidelines contained in the DSM-IV-TR. In an area of law where IQ score cutoffs vary wildly from state to state for an intellectual disability defense, this change could poten-

individuals whose behavior satisfies the diagnostic criteria for a diagnosis even though they are not disordered. Thus, it has proven difficult to arrive at a stable negotiated consensus between society and psychiatry as to the validity of mental disorders that lie on the fringe of normality.”); *Id.* at 254 (quoting Allen Frances, *A Warning Sign on the Road to DSM-5: Beware of its Unintended Consequences*, PSYCHIATRIC TIMES, June 26, 2009, available at <http://www.psychiatristimes.com/dsm-5/content/article/10168/1425378>) (“Taken as a whole, the proposed revisions demonstrate that ‘therapeutic zeal’ continues to take priority over all other considerations in defining the scope of mental illness, despite the perceived objectivity of modern psychiatry. Both professional and lay critics claim the proposals for DSM-V will create millions of false positives. If DSM-V ultimately codifies these proposals, Frances writes, it will be ‘a bonanza for the pharmaceutical industry but at a huge cost to the new false-positive patients caught in the excessively wide DSM-V net.’ The potential for a significant number of false-positive children amplifies these concerns.”).

82. Letter from Peter V. Berns, C.E.O., The Arc, to Dr. Dilip V. Jeste, President, American Psychiatric Ass’n RE: DSM-5 Draft Diagnostic Criteria for “Intellectual Developmental Disorder” and “Autism Spectrum Disorder,” (Jun. 15, 2012), available at www.thearc.org/document.doc?id=3782.

tially increase variability in those statutes.⁸³ A state that has not yet adopted a statutory definition, such as Texas, may potentially decide to implement one which sets the cutoff at 60 or even 50, as the DSM-5 has even removed the language in the diagnostic criteria requiring an IQ score that sits two standard deviations or more below the mean.⁸⁴ This increased vagueness could serve to muddy the already troubled waters of an intellectual disability claim for a capital defendant by making an already complicated concept for juries even harder to quantify.

Another major issue with the change in the classification is the inclusion of the term “disorder” in the name and the use of the term in its diagnostic criteria, which moves away from the accepted AAIDD terminology of “disability.”⁸⁵ The fact that the DSM-5 is clearly aware of the backlash surrounding its new “dis-

83. Baker, *supra* note 59, at 238.

84. AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 1, at 33 (“The various levels of severity are defined on the basis of adaptive functioning, and not IQ scores, because it is adaptive functioning that determines the level of supports required. Moreover, IQ measures are less valid in the lower end of the IQ range.”). While the requirement of an IQ score two standard deviations below the mean has been removed from the diagnostic criteria, the language does still remain in the diagnostic feature portion of the description. The DSM-5 strongly cautions against reliance on IQ scores alone, however, as many factors may influence IQ scores; *Id.* at 37.

85. The DSM-5 does note that the term “intellectual disability” is the one “in common use by medical, educational, and other professions and by the lay public and advocacy groups,” a distinction which was missing from the initial definition released during the comment period. *Id.* See also Berns, *supra* note 82 (“Promoting the term ‘intellectual developmental disorder’ is certain to lead to confusion among those who establish eligibility criteria for the services needed by many children and adults. People with intellectual disability whose diagnosis is the basis for early intervention, health care, training, employment, citizenship, and civil and criminal justice determinations could find their eligibility for services disrupted should this term be used.”) (emphasis added); Letter from Sharon Gomez, President, AAIDD, & Margaret A. Nygren, C.E.O., AAIDD, to John Oldham, President, American Psychiatric Ass’n, RE: *DSM-5 Draft Diagnostic Criteria for “Intellectual Developmental Disorder,”* (May 16, 2012), available at <http://aaid.org/docs/default-source/comments/aaid-dsm5-comment-letter.pdf> (“The term intellectual disability is preferred because it . . . (d) provides a logical basis for understanding supports provision due to its basis in a social-ecological framework; and (e) is less offensive to people with disabilities (i.e., ‘disability’ is preferred to ‘disorder’)”).

order,” yet persists in using the term, is cause for concern. It may seem like a small change, but it could potentially have deep implications for *Atkins* claims. Intellectual disability is a disability, not a disorder, although it may be related to some disorders, and is often distinguished from other psychiatric diagnoses or illnesses on that basis.⁸⁶ By reclassifying intellectual disability as a “disorder,” the DSM-5 runs the risk of lumping the disability in with other mental disorders, from which it has been eliminated since the decision in *Atkins*.

Such a result could effectively cut the legs out from under *Atkins*, giving courts and prosecutors alike the ability to argue that, as it is just another form of mental illness or psychological disorder, the intellectually disabled should not be exempted from the death penalty, or, at the very least, the mitigating effect of intellectual disability evidence should be greatly reduced. This may seem like reactionary hair-splitting, but it is just the kind of hair-splitting courts commonly partake in, and just because intellectual disability is held out separately from mental disorders now does not mean that will always be the case: “diagnoses and prognoses of mental disorders vary historically based on changing social perceptions and on new medical discoveries; what is perceived as a mental disorder today may not be in a few years and vice versa.”⁸⁷

86. See John H. Blume et al., *Of Atkins and Men: Deviations from Clinical Definitions of Mental Retardation in Death Penalty Cases*, 18 CORNELL J.L. & PUB. POL’Y 689, 726 (2009) (“It is well recognized by clinical professionals that mental retardation and mental disorders coexist, and may even be interrelated.”); Rebecca J. Covarrubias, *Lives in Defense Counsel’s Hands: The Problems and Responsibilities of Defense Counsel Representing Mentally Ill or Mentally Retarded Capital Defendants*, 11 SCHOLAR 413, 423–24 (2009) (“Mental retardation is not a form of mental illness . . . [while] a mentally ill person may improve or even be cured with therapy or medication but mental retardation is a life long disability While mental retardation is not the same thing as mental illness, this does not mean that a mentally retarded individual cannot suffer from a mental illness. Indeed, mental retardation often ‘coexists with other mental disorders.’ In fact, ‘between twenty to thirty-five percent of all non-institutionalized mentally retarded persons also have some form of mental illness.’”).

87. Liliana Lyra Jubilut, *Death Penalty and Mental Illness: The Challenge of Reconciling Human Rights, Criminal Law, and Psychiatric Standards*, 6 SEATTLE J. FOR SOC. JUST. 353, 366 (2007).

The removal of the cutoff age of eighteen for the onset of intellectual disability could also be problematic. Without a bright-line age cutoff, as with the removal of the IQ score ranges, states could make their own determinations of when the “developmental period” ends, creating a cutoff age of sixteen, for example, or deciding that the developmental period ends with the onset of puberty at around twelve to thirteen years old. The DSM-5 is no more specific than that it must be “present during childhood or adolescence.”⁸⁸ This change, however, is more likely to actually create a benefit to intellectually disabled capital defendants than a disadvantage, as discussed below.

Potential Benefits of the DSM-5 Classification

All of the above problems have their flip side, as well. The new DSM-5 classification is potentially a double-edged sword. While there is a possibility that classifying intellectual disability as a “disorder” could lead to undercutting the strength of *Atkins*, there is an equal possibility that the terminology could be used to narrow the gap between intellectual disability and mental illness in such a way as to finally bring severe mental illness under the protection of *Atkins*. There is a push occurring in the capital punishment system already towards such a goal—breaking down another barrier between intellectual disability and severe mental illness might help along that path and finally achieve greater protection for all capital defendants who suffer from disorders or illnesses which give them all the impairments of intellectual disability without any of the protections.⁸⁹

There is an additional possibility that the lessened emphasis on IQ scores could actually be a good thing for capital defendants in states with a bright-line cutoff score. If the DSM-5 does not set a score range and places more emphasis on adaptive deficits, it might influence courts and legislatures to adapt their definitions of

88. AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 1, at 38.

89. See Hall *supra* note 40; Larimer, *supra* note 33; AMERICAN PSYCHIATRIC ASSOCIATION, REPORT OF THE TASK FORCE ON MENTAL DISABILITY AND THE DEATH PENALTY, *supra* note 40, at 2; AMERICAN PSYCHIATRIC ASSOCIATION, POSITION STATEMENT ON DEATH SENTENCES FOR PERSONS WITH DEMENTIA OR TRAUMATIC BRAIN INJURY, *supra* note 40; Winick, *supra* note 40 (noting that the ABA, APA, APsYA, KAMI, and MHA all favor this move).

intellectual disability to reflect that change, particularly in regard to the DSM-5's caution that "IQ measures are less valid in the lower end of the IQ range."⁹⁰ The diagnostic features section of the disability's description takes a much stronger tone than the DSM-IV-TR in cautioning against relying on IQ scores alone.⁹¹ It describes the factors which may produce inaccurate scores, such as the Flynn Effect, group testing, short-form IQ tests, discrepancies in individual scores across various tests, and the effects of socio-cultural background and native language, all of which are known issues with IQ tests, but were absent from the prior DSM-IV-TR description.⁹² The inclusion of these factors may be a boon to intellectually disabled capital defendants, as it gives them powerful additional support from a widely-recognized and court-preferred source for highly valid issues with raw IQ scores which have largely been discounted by courts as controversial.

This new emphasis on adaptive functioning may be beneficial because adaptive deficits are far more expressive to a jury than a raw number attempting to quantify intelligence.⁹³ Most jurors

90. AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 1, at 33.

91. *Id.* at 37.

92. *Id.*; DSM-IV-TR, *supra* note 14, at 41–49.

93. See Hon, *supra* note 58, at 742–43 (quoting Nicole Usher, *Dallas Morning News*, Oct. 2, 2002) ("Many defense experts place undue emphasis upon low IQ scores, which can be misleading and against current trends in the mental health profession, which minimize the importance of IQ in diagnosing mental retardation . . . [e]xperts now support a theory of multiple intelligences—theorizing that intelligence stretches beyond logical reasoning and analytic skills and that even emotional intelligence is important. IQ scores mean very little to most educators, who are wary of any potential stigmas that could arise if students became just an IQ number."); Kimberly A. Meany, *Comment: Atkins v. Virginia: The False Finding of A National Consensus and the Problems with Determining Who Is Mentally Retarded*, 11 WIDENER L. REV. 137, 165–66 (2004) (quoting Pasquale J. Accardo & Arnold J. Capute, *Mental Retardation*, 4 MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES RES. REVS. 2, 4 (1998)) ("Although IQ tests have been used to diagnose mental retardation, mental health professionals have recognized a number of inherent problems in the use of these tests. Health professionals argue that using a single cutoff score to determine mental retardation is 'arbitrary, because some children with mental retardation will score above that number. . . .' As demonstrated by this statement, one of the problems with an IQ test is that the score appears to be absolute and definite, but the test fails to reveal errors of measurement or to reflect the adaptive components of mental retardation."); *Id.* at 166–67 (quoting *Stripling*

cannot picture what an IQ of 65 looks like, but when adaptive and intellectual deficits are put forth and woven into a successful story, a jury can picture what it means if the defendant cannot make canned soup without assistance, or cannot ride the bus without another person guiding him, or cannot keep a job stacking shelves because he cannot understand basic instructions. Deemphasizing the importance of IQ scores and replacing that emphasis on daily functioning creates a fuller and more accurate picture of an individual and his deficits, and thus may weigh more heavily in jurors' minds when considering an intellectual disability claim. Likewise, as the DSM-5 notes, an individual can have significant adaptive functioning deficits, yet still score in the "normal" range on an IQ test, creating a false perception that his intellectual disability is far less severe than it actually is.⁹⁴ An increased focus on adaptive functioning may help to better identify intellectually disabled capital defendants who score near or above 70 on an IQ test.

The removal of the cutoff age of eighteen may also be beneficial to capital defendants. Replacing a set cutoff age with the term "during the developmental period" could act to broaden the definition to include people like Brown, who was only twenty-two when his brain injury occurred, and, thus, it could have been argued that he was still within that developmental window.⁹⁵ All states which have adopted a definition of intellectual disability include the requirement that the disability manifest itself before

v. State, 401 S.E.2d 500, 503 (Ga. 1991)) ("Another problem with using IQ tests to determine mental retardation arises with the variability and arbitrariness that results from determining something as imprecise as an IQ. While psychologists can try to guarantee the validity of IQ tests, these tests are subject to a margin of error. For instance, 'cultural biases' and 'emotional factors, including depression,' can affect an IQ score. Economically deprived people and ethnic minorities are the groups most often erroneously found to be mentally retarded. Thus, the reasons for concern with using IQ tests stem from the assertions that intelligence tests have a cultural bias, national norms are inappropriate for minorities, minorities are handicapped in test-taking skills, and the race of the examiner may affect the intelligence score. In addition to producing false positives, psychologists may also have the ability to rig scores by at least ten points.").

94. DSM-5, *supra* note 1, at 37.

95. *Id.* at 33; *State v. Brown*, 907 So. 2d 1, 8–9 (La. 2005).

adulthood.⁹⁶ Removing the defined upper age limit could potentially reduce the arbitrariness in the current system, which “requires different punishments for similarly impaired offenders based solely on the legally insignificant question of when their retardation began.”⁹⁷

HOW COURTS MIGHT TREAT THE NEW DSM-5 CLASSIFICATION

While the new DSM-5 definition might be attractive to various courts for a number of reasons, the most commonly used criteria is currently the AAIDD classification. Even those which use the DSM-IV-TR definition are not far out of line, as the DSM-IV-TR definition aligns closely with the AAIDD definition. Courts, however, seem to be placing increasing reliance on the DSM-IV-TR not only to define intellectual disability, but also to define and assess a myriad of psychiatric and cognitive disorders. The DSM-IV-TR is a “one-stop shop” for all things relating to mental disorders of any kind, and thus is attractive because of the simplicity of only having one reference. There are several reasons why courts may or may not choose to shift from the AAIDD definition to the new DSM-5 definition.

Courts Are Increasingly Shifting to DSM Definitions

The DSM-IV-TR has, in recent years, effectively become the “bible of psychiatry.”⁹⁸ Practically every court and decision relating to mental health looks to the DSM in some respect for explanation and definition, despite the fact that the DSM-IV-TR cautions it should not be used for forensic purposes.⁹⁹ *Atkins* itself, in addition to the AAIDD definition, looked to the DSM-IV-TR to determine what intellectual disability was.¹⁰⁰ It is as common in

96. Larimer, *supra* note 33, at 926 (“There is, however, one common element of states’ mental retardation definitions: the requirement that symptoms manifest before adulthood.”).

97. *Id.*

98. Renee L. Binder & Dale E. McNiel, *Some Issues in Psychiatry, Psychology, and the Law*, 59 HASTINGS L.J. 1191 (2008).

99. DSM-IV-TR, *supra* note 14, at xxxii-xxxiii.

100. See Binder & McNiel, *supra* note 98, at 1198-99 (quoting *Atkins*, 536 U.S. at 318, 353) (“In the Supreme Court decision of *Atkins v. Virginia*, which considered the constitutionality of imposing the death penalty on defendants

the criminal—and especially capital—courtroom as the Code of Criminal Procedure:

No empirical studies seek to measure the frequency of DSM's use or its impact on judges or juries. Nonetheless, anecdotal evidence suggests that it is rare for psychiatric or psychological expert testimony to be presented without a DSM diagnosis. "In both civil and criminal cases the DSM has been used extensively. Psychiatrists and other mental health professionals testifying in a wide variety of cases from workers compensation, insanity defense, and sexual assault, to domestic relations refer extensively to the DSM. Lawyers and judges analyzing the weight to be given expert witnesses utilize the DSM and compare the consistency of their testimony with it."¹⁰¹

Part of this increasing presence of the DSM in the courtroom is likely due to *Daubert v. Merrell Dow Pharmaceuticals, Incorporated*, which held that expert testimony may only be admissible within the bounds of Federal Rule of Evidence 702 if the theory

who are mentally retarded, Justice Stevens refers to the DSM-IV, and the joint amicus curiae brief of the American Psychological Association and the American Psychiatric Association. Justice Stevens stated, 'clinical definitions of mental retardation require not only subaverage intellectual functioning, but also significant limitations in adaptive skills . . . that became manifest before age 18.' In contrast, Justice Scalia, focusing on this definition in his dissent stated, 'the symptoms of this condition can readily be feigned.' Thus, we see that the DSM-IV was used by some of the Justices in their decision making about whether there is a true diagnosis of mental retardation and how it can be diagnosed in any one defendant.").

101. Stuart A. Greenberg et al., *Forensic Psychiatric Diagnosis Unmasked*, 88 JUDICATURE 210, 211–12 (2005) (citing Daniel W. Shuman, *The Diagnostic and Statistical Manual of Mental Disorders in the Courts*, 17 BULL. OF AM. ACAD. OF PSYCHIATRY AND L. 25, 27 (1989); Daniel W. Shuman, *Persistent Reexperiences in Psychiatry and Law: Current and Future Trends in Post-traumatic Stress Disorder Litigation*, POSTTRAUMATIC STRESS DISORDER IN LITIGATION: GUIDELINES FOR FORENSIC ASSESSMENT 4 (Robert I. Simon ed., 1995)); see also Laurence Loeb, M.D., *Forensic Testimony: What Judges Want*, 24 PACE L. REV. 211, 214 (2003) ("The fact is that lawyers in every court in which I have testified have brandished the volume, using it as a "paint by numbers' method of extracting a diagnosis from the witness.").

upon which the testimony is based is generally accepted in the scientific community, has been subjected to peer review and publication, has been tested or can be tested, and the potential rate of error for the theory is known and within reasonable bounds.¹⁰² Because the DSM has been tested in development, used for many years, is generally accepted, and has been subject to peer review and publication, it is the easiest and perhaps best way for psychiatric professionals testifying as experts to establish the basis upon which their theories or diagnoses are based, despite the prohibition against using the DSM for such purposes contained within its pages. As Greenberg noted, the reliance on the DSM in courtrooms has gone so far that “[i]ndeed, failure to refer to and comply with the DSM may provide the basis for a *Daubert* challenge to admissibility of expert mental health testimony.”¹⁰³

Why Courts May Use the DSM-5 Classification

Courts may shift to using the new DSM-5 definition because of the increasing reliance on the old DSM-IV-TR discussed above. With the arrival of the DSM-5 will also come a veneer of increased scientific reliability—after all, it is new, so it must be better—which will make it exceedingly attractive to judges who understand little of the complex classifications and changes it contains, and need the expert assistance of the DSM to assist them.¹⁰⁴

102. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 592–94 (1993).

103. See Greenberg, *supra* note 101, at 212 (“DSM’s incorporation into legal standards articulated by the courts, legislatures, and administrative agencies, as well as its centrality in the presentation and challenge of psychiatric and psychological evidence, provides cause for concern. Psychiatric diagnosis provides a ‘Good Housekeeping Seal of Approval’ that appears to validate the relevance and the reliability of expert testimony in language that seems familiar yet professional.”).

104. See Elaine E. Sutherland, *Undue Deference to Experts Syndrome?*, 16 IND. INT’L & COMP. L. REV. 375, 381–82 (2006) (“Somewhat paradoxically, it is this very ignorance of science that often results in non-scientists being mesmerized by it. Science is perceived as solid, knowable, measurable: in short, science offers certainty. These factors combine to place the person who does understand science, the expert, in an incredibly powerful position. After all, if one is coming from a position of ignorance, the person who holds the key to that certain body of knowledge is something of a savior. The danger for the legal system is that this empowerment of the expert witness will result in undue deference to his or

The DSM-IV-TR is such an ubiquitous presence in the courtroom that it is hard not to imagine the shift to the DSM-5 taking place almost immediately, as courts toss away their old toys for the shiny new one they have been handed.

Newness is not the only thing that might make the DSM-5 more attractive to courts, however. The new definition of Intellectual Disability/Intellectual Developmental Disorder, as discussed *supra*, could easily be used to limit the applicability of claims, thus possibly helping courts clear their dockets faster by eliminating an entire category of people who are even eligible to assert them.

Problems Courts' Use of the DSM-5 May Create for Capital Defendants

The risks of misapplication, misdiagnosis, and misunderstanding will not be new ones if the DSM-5 definition is adopted by courts, but the new classification of Intellectual Disability/Intellectual Developmental Disorder may exacerbate those already prevalent problems if widely adopted. If misapplied, the new DSM-5 criteria may hurt capital defendants with valid intellectual disability claims by misclassifying the disorder, misleading juries, and trivializing the diagnosis. It could even potentially increase the perception of intellectual disability as an aggravating, rather than mitigating, factor.

The misapplication of scientific and psychiatric evidence is nothing new.¹⁰⁵ Because of the great weight juries give scientific

her opinion. The deference to scientific expertise is magnified when it involves experts who are not only scientists but also doctors. Lawyers are constantly amazed at (and mildly irritated by) how well the medical profession has managed public relations when the legal profession has been so spectacularly unsuccessful in that arena. Despite the prevalence of medical malpractice actions, members of the public, at least, remain largely deferential to, if not in awe of, the medical profession.”).

105. See Larimer, *supra* note 33, at 943 (quoting the DSM-IV-TR, *supra* note 14, at xxxiii) (“The psychiatric community recognized the possibility of clinical diagnostic definitions being misapplied in the legal setting, warning that ‘[t]he clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.’ It follows that the clinical need to differentiate between mental retardation and other impairments does not necessarily provide a legally significant basis for the distinction.”).

expert testimony, it is easy for an unscrupulous or simply misguided psychiatrist to sway the jury's (and indeed, appellate judges') minds with promises of certainty and reliability in flawed diagnoses.¹⁰⁶ A famous example of this is the psychiatrist Dr. James Grigson, who, among other cases, provided expert testimony in *Barefoot v. Estelle*.¹⁰⁷ Grigson "was frequently permitted to testify during death penalty sentencing that there was a 'one hundred percent and absolute' chance that the accused would commit violent acts in the future without even examining the defendant."¹⁰⁸ He frequently "claimed that his predictions constituted 'medical opinion[s] . . . particular to the field of psychiatr[y] and not to the average layman.'"¹⁰⁹ Justice Blackmun, dissenting in *Barefoot*, roundly criticized Grigson and warned that "the specious testimony of a psychiatrist, colored in the eyes of an impressionable jury by the inevitable untouchability of a medical specialist's words, equates with death itself."¹¹⁰

Such heavy reliance on and deference to medical and psychiatric experts is exacerbated when those experts' assessment tools are flawed. Under-recognition of intellectual disability is already a problem due to the tendency of other disorders or conditions, or indeed, defendants themselves, to mask symptoms.¹¹¹ The lack of a clear IQ requirement and the confusion created by the DSM-5 between whether intellectual disability is, in fact, a disability or simply another mental illness, and its divergence from the

106. See Samantha Godwin, *Bad Science Makes Bad Law: How the Deference Afforded to Psychiatry Undermines Civil Liberties*, 10 SEATTLE J. FOR SOC. JUST. 647, 680–81 (2012); see also Joanmarie Ilaria Davoli, *Psychiatric Evidence on Trial*, 56 SMU L. REV. 2191, 2228–29 (2003) ("[T]he risks of an inaccurate diagnosis and prediction of violence in capital murder cases are immense since an execution is irreversible . . . [y]et the courts tend to rely on psychiatric predictions most when the risks of misdiagnoses are greatest.").

107. *Barefoot v. Estelle*, 463 U.S. 880 (1983) (This cite is to the Supreme Court decision—Grigson originally testified in *Barefoot*'s case at the trial level.).

108. Godwin, *supra* note 106 at 680–81.

109. *Id.*

110. *Barefoot*, 463 U.S. at 916 (Blackmun, J., dissenting).

111. Blume, *supra* note 86, at 728 (quoting the AAIDD MANUAL, *supra* note 9, at 16) ("When dual diagnoses are appropriate there is always a risk of 'diagnostic overshadowing,' or 'under-recognition of intellectual impairments among individuals with depression, psychosis, or anxiety disorders.'").

more accepted criteria used by the AAIDD may only serve to exacerbate that under-recognition of the condition, and confuse juries as to what it really means.

If expert witnesses, particularly for the State, begin defining intellectual disability as a mental illness rather than a disability, there is also an increased risk that juries may apply the evidence as an aggravating factor warranting death rather than a mitigating factor compelling a life sentence. The general perception of mental illness among laypeople is that mental illness compels a future dangerousness finding:

Research clearly shows that, despite the fact that offenders with serious disorders are no more likely to reoffend than the general offender population, the public tends to equate mental disorder with dangerousness. Capital sentencing juries are not immune from this misperception, with the result that they often treat mental disorder not as a mitigating circumstance (as the law requires) but as an aggravating circumstance supporting imposition of the death penalty.¹¹²

This view persists despite the fact that such evidence is supposed to be mitigating, and mentally ill defendants are no more likely to reoffend than psychologically “healthy” offenders.¹¹³

112. Christopher Slobogin, *Is Atkins the Antithesis or Apotheosis of Anti-Discrimination Principles?: Sorting Out the Groupwide Effects of Exempting People with Mental Retardation from the Death Penalty*, 55 ALA. L. REV. 1101, 1107 (2004).

113. Ronald J. Tabak, *Executing People with Mental Disabilities: How We Can Mitigate an Aggravating Situation*, 25 ST. LOUIS U. PUB. L. REV. 283, 289 (2006) (“There are two major problems with a legal system in which such severe mental illness is viewed by sentencers as aggravating or is never presented in the sentencing hearing out of concern that it will be viewed as aggravating (or due to counsel’s failure to find evidence of the mental illness). First, this is inconsistent with the role that mental illness is supposed to play in capital sentencing proceedings. What the capital sentencer should do is recognize that someone with severe mental illness is seriously disabled in a way that is really important to, and diminishes, moral culpability. Yet, it does not help a capital defendant that jurors’ or judges’ perceptions about the impact of mental illness on future dangerousness is wrong if they are allowed to act on their misconceptions or if defense counsel fails to present mental illness due to concern about those misconceptions. Second, it is inconsistent with studies showing that ‘offenders with

Intellectual disability has, at least, been partially protected from this view since the decision in *Atkins*. However, if the prosecution in capital cases were to use the DSM-5, coupled with a willing expert, to reclassify intellectual disability as a mental illness to a jury, then that evidence, too, would likely be given a far more powerful aggravating effect. One expert witness misrepresenting intellectual disability before a capital jury could easily prejudice or confuse the jury into giving evidence of intellectual disability the completely wrong effect in a capital proceeding.¹¹⁴ When the confusion created by trivializing the nature and import of intellectual disability is coupled with capital juries' tendencies to discount evidence of intellectual disability and to find prosecution experts more credible than defense experts, a potential recipe for disaster for intellectually disabled capital defendants may result.¹¹⁵

Why Courts May Choose Not to Apply the DSM-5 Classification

There are equally valid reasons, however, that the DSM-5 diagnosis might not be applied in capital trials in a way that would be detrimental to intellectually disabled capital defendants. First, the modern trend—if not in legal decisions, at least in scholarship—seems to be moving towards a more inclusionary application of *Atkins*, which would encompass severely mentally ill defendants under its auspices:

mental disorder do not pose a greater risk than their non-disordered counterparts.”).

114. See Godwin, *supra* note 106.

115. See Sandys et al., *supra* note 49, at 682–83 (“Because jurors’ opinions may differ from those of the general public, researchers have also studied prospective jurors. For instance, Boots and her coauthors administered a questionnaire to all persons called for jury duty over the course of three days in Tampa, Florida. While the general pattern of findings was mostly consistent with the results of the Gallup Poll discussed above, there were notable differences. For instance, 83.4% of respondents were in favor of capital punishment. That greater favorability among prospective jurors in Florida was also apparent for each of the groups of special offenders. For example, Boots found that 29.1% of respondents supported capital punishment for ‘adults who are mentally retarded and are legally convicted of murder.’); Scott E. Sundby, *The Jury As Critic: An Empirical Look at How Capital Juries Perceive Expert and Lay Testimony*, 83 VA. L. REV. 1109, 1125 (1997) (“Jurors tend to view defense experts as ‘hired guns’ and generally find them less credible than prosecution experts.”).

Notwithstanding the absence of a legislative trend, there are some indications that society's standards may be moving away from the acceptance of death sentences for those with severe mental illnesses. The *Atkins* Court, even though it relied primarily on the legislative and court records, nevertheless noted the opinions of professional groups in reaching its conclusions that society had evolved beyond death sentences for the mentally retarded. Specifically, the Court relied in part on the views of the American Association on Mental Retardation and the American Psychological Association in its evolving standards analysis. This indicates that even if the views of such organizations may not be the principal determinant of evolving standards, such views do matter in the calculus.¹¹⁶

116. Pamela A. Wilkins, *Rethinking Categorical Prohibitions on Capital Punishment: How the Current Test Fails Mentally Ill Offenders and What to Do About It*, 40 U. MEM. L. REV. 423, 438–39 (2009); see also Sandys et al., *supra* note 49, at 682 (“While polls show that 28% of the public was generally opposed to capital punishment, polls cited in *Atkins* found that at least 50%, and frequently more than 70%, of respondents were opposed to the death penalty for offenders with mental retardation. A 2002 Gallup Poll looking at attitudes toward the death penalty for selected groups found the least support for defendants with mental retardation. In particular, while general support for the death penalty was 72%, only 13.5% indicated that they were in favor of the death penalty for persons with mental retardation. In comparison, 19% favored the death penalty for offenders who are mentally ill, 26% were in favor of the death penalty for juvenile offenders, and 67.6% favored the death penalty for female offenders. Thus, while there is little difference between general support for the death penalty and support for the death penalty for female offenders, there is substantially less support for the other groups of offenders. . . .”) (internal citations omitted); Hall, *supra* note 40, at 362; Larimer, *supra* note 33, at 926; AMERICAN PSYCHIATRIC ASSOCIATION, REPORT OF THE TASK FORCE ON MENTAL DISABILITY AND THE DEATH PENALTY, *supra* note 40, at 2; AMERICAN PSYCHIATRIC ASSOCIATION, POSITION STATEMENT ON DEATH SENTENCES FOR PERSONS WITH DEMENTIA OR TRAUMATIC BRAIN INJURY, *supra* note 40, at 1; Winick, *supra* note 40, at 789–90 (2009) (Noting that the ABA, APA, APsya, KAMI, and MHA all favor this move) (citing *Atkins*, 536 U.S. at 321; *Roper v. Simmons*, 543 U.S. 551 (2005)) (“Severe mental illness is a compelling next frontier at which to apply the Court’s evolving death penalty jurisprudence. Certain mental illnesses bear some striking similarities to both mental retarda-

One state—Connecticut, before abolishing the death penalty last year—has already instituted legislation barring the execution of the severely mentally ill:

The court shall not impose the sentence of death on the defendant if the jury or, if there is no jury, the court finds by a special verdict, as provided in subsection (e), that at the time of the offense (1) the defendant was under the age of eighteen years, or (2) the defendant was a person with mental retardation, as defined in section 1-1g, or (3) the defendant's mental capacity was significantly impaired or the defendant's ability to conform the defendant's conduct to the requirements of law was significantly impaired but not so impaired in either case as to constitute a defense to prosecution¹¹⁷

As of 2011, several other states had legislation pending that would protect severely mentally ill defendants from the death penalty, including Indiana, North Carolina, and Tennessee.¹¹⁸ Thus, if the trend continues to move as it has, the potential re-classification of intellectual disability as a “disorder” may not make a difference based on the “evolving standards of decency” which played such an important role in the *Atkins* decision.¹¹⁹ If more states take up the mantle of inclusion, mental illness and psychological disorders relevant to culpability may be granted heightened status to equal intellectual disability's, rather than intellectual disability's status being lowered to remove *Atkins*' protections.

An additional reason is that with *Atkins*' protections removed, the intellectually disabled would have few protections

tion and juvenile status. Severe mental illness at the time of the offense may significantly diminish the offender's blameworthiness and amenability to deterrence in ways not unlike mental retardation and juvenile status . . . In both *Atkins* and *Roper*, the Court stressed the trend of statutory change in the direction of abolishing the death penalty for those with mental retardation or who were juveniles at the time of the offense.”)

117. Entzeroth, *supra* note 41, at 564 (quoting CONN. GEN. STAT. § 53a-46a (2010)).

118. *Id.* at 564–66.

119. *Atkins*, 536 U.S. at 321.

from a death sentence. The only possible claims left under which an intellectually disabled defendant could seek relief are under *Ford v. Wainwright* or *Panetti v. Quarterman*.¹²⁰ But intellectual disability is not insanity or incompetency, and cannot be medicated into submission. Intellectual disability:

. . . does not absolve the offender; it exempts him from the death penalty. Mental retardation, unlike the insanity defense or incompetence, is not temporary. The mentally retarded offender was under the influence of his condition at the time of the act, just as he will be at the time of his trial and punishment; therefore, the typical judicial and clinical procedures and their motivations for restoration of competency do not apply.¹²¹

There is a fundamental difference between intellectual disability and an insanity or incompetency claim, and thus intellectually disabled defendants cannot be shoehorned into a *Ford* or *Panetti* claim.¹²² Leaving them without the protection of *Atkins* would effectively leave them with no protection whatsoever, and the “evolving standards of decency” should never allow for that.¹²³

120. See *Ford v. Wainwright*, 477 U.S. 399 (1986); *Panetti v. Quarterman*, 551 U.S. 930 (2007). (Combining *Ford* and *Panetti* together provides protection to capital defendants who are legally insane and/or incompetent at the time of execution from execution).

121. *Baker*, *supra* note 59, at 263.

122. See John Matthew Fabian et al., *Life, Death, and IQ: It's Much More Than Just A Score: Understanding and Utilizing Forensic Psychological and Neuropsychological Evaluations in Atkins Intellectual Disability/Mental Retardation Cases*, 59 CLEV. ST. L. REV. 399, 403 (2011) (“[A]n *Atkins* claim is unique, as the legal determination reflects the diagnostic requirements of MR/ID pursuant to the American Association of Mental Retardation (AAMR), now American Association on Intellectual and Developmental Disabilities (AAIDD), and the American Psychiatric Association’s (APA) Diagnostic & Statistical Manual (DSM-IV) for mental disorders. As a consequence, a defendant’s IQ, adaptive functioning scores, and ultimate psychiatric diagnosis will determine the defendant’s fate, rather than an application of psychiatric diagnoses to legal terms such as ‘mental abnormality,’ ‘rational,’ ‘wrongfulness,’ and ‘appreciate.’”).

123. *Atkins*, 536 U.S. at 321.

CONCLUSION

The release of the DSM-5 and its reclassification of “Intellectual Disability/Intellectual Developmental Disorder” poses both potential problems and potential benefits for intellectually disabled capital defendants. How those changes will play out in a court of law, or if they will make any difference at all, remains to be seen, but there is potential for both misuse and creative application in them. However, ultimately, the current shift toward including severely mentally ill defendants in the encompassing protection of *Atkins* and the diminishing support for the death penalty in general in the United States will likely either provide defendants with the same protections they have now, or, hopefully, expand those protections to a more inclusive definition, which will protect the most broken members of society from the harshest punishment the American legal system can apply to them.

With the Best of Intentions

CHELSEA DAVIS*

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INTRODUCTION

Drug courts and mental health courts are the primary nexus of public health and the criminal justice system. Seemingly in conflict, growing criminalization and medicalization of drug addiction and mental illness have resulted in a large burden placed upon both the U.S. legal and public health systems.¹ As a result of the success

* B.A., Vanderbilt University; MPH, Mailman School of Public Health at Columbia University. The author is currently the coordinator of the Mass Incarceration and Public Health Initiative at Mailman School of Public Health and faculty in the Bard Prison Initiative.

1. See Gregory L. Acquviva, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 975–77 (2006). Criminalization of mental illness refers to conditions which led to statistics such as sixteen percent of inmates have some kind of mental illness, and about 250,000 individuals with mental illness are incarcerated. About forty percent of those who are mentally ill encounter the criminal justice system at some point. Forty-eight percent of people with mental illness in federal prison have three or more prior probations as oppose to twenty-eight percent of non-mentally ill prisoners; see also Lara Nohomovitz & Franklin J. Jickman, *Mental Health, Mental Health Courts, and Minorities*, in DETERMINANTS OF MINORITY MENTAL HEALTH AND HEALTH AND WELLNESS 39, 39 (Sona Love & Martha Sajatovic eds., 2009). Where such statistics are viewed as precarious, as other reports claim forty-five percent of fed-

of these courts, defined by a few specific outcome measures, predominantly recidivism, there has been rapid proliferation of specialty courts in the United States. The first drug court was created in 1989 parallel to the growing scholarship of therapeutic jurisprudence (TJ), a term coined two years earlier.² The formation of mental health courts followed in the mid-1990s, arguably built directly on the principles of TJ. This article serves as an examination of these courts, which have separate dockets for mental illness, for which this paper will focus, drugs, prostitution, domestic violence, quality of life offenses, and sexual abuse. However, they are a story of contested success, as applied TJ could have unexpected consequences for public health, the criminal justice system, and the role of the state in the lives of individuals. An examination of the ideology behind TJ and the underlying theory guiding research in mental health courts could have important implications for this rapidly growing intervention. It remains unclear whether these courts represent a systemic or paradigmatic shift for either public health or criminal justice or whether such a shift is needed.

Therapeutic jurisprudence, spearheaded in legal scholarship by Bruce Winick and David Wexler (Winick and Wexler), defines itself as the use of social science tools to analyze the law and its consequences as a social force. It is a form of consequentialism, the study of the law's therapeutic or anti-therapeutic ends and subsequent encouragement of furthering those ends that promote well-being of the individuals it affects. Focusing on outcomes instead of underlying ideology has resonated at this historical juncture where economic rationality and effectiveness seem paramount. As a legal

eral inmates, fifty-six percent of state inmates, and sixty-four percent of persons in local jails have some kind of mental health problem; *see also* Joanne Csete & Jonathon Cohen, *Health Benefits of Legal Services for Criminalized Populations: The Case of People Who Use Drugs, Sex Workers and Sexual and Gender Minorities*, 38 J.L.MED. & ETHICS 816, 818 (2010). Only sixty percent of mentally ill prison inmates and forty-one percent of jail inmates receive mental health services. In terms of drug use, despite the growth of addiction as disease conception, criminalization refers to the fact that six percent of prisoners in state facilities and twenty-five percent of prisoners in federal prisoners were serving drug related sentences in 1980. In 2003, however, those numbers were twenty percent and fifty-five percent, respectively.

2. Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL. PUB. POL'Y & L. 184 (1997).

inquiry, it considers substantive law, whether law promotes therapeutic objectives by balancing community and individual rights, legal procedures, and legal roles.³ The influence of therapeutic jurisprudence has been gaining momentum.⁴ TJ opposes the traditional adversarial model of regular courts when such a model has anti-therapeutic potential. However, it claims to remain “normative,” absorbing and reflecting the culture in which the legal system currently exists, only claiming therapeutic effects are the most desirable all else being equal.⁵ Its supposed application relies on interdisciplinary teamwork, taking a holistic and coordinated approach to criminal offenders, alternative sentencing, and often-mandated treatment.⁶ The intentionally ambiguous definition of therapeutic jurisprudence and TJ’s professed normativity are intended to keep the scholarship non-ideological. Its authors claim it is an analytical tool, a lens through which traditional legal practices can be seen differently. However, TJ is currently used as much more than a lens in its application, particularly in drug and mental health courts; it is used to justify a large scope of interventions and reforms, some of which may be in tension.⁷

Debates surrounding the state’s role in promoting therapeutic ideals took hold in the early 1960s as the judicial system began to show deference to the rapidly evolving field of psychiatry. Karl Menninger (Menninger) and Thomas Szasz (Szasz), two psychiatrists with diametrically opposed viewpoints regarding what they saw as the impending therapeutic state, Judge David Bazelon (Bazelon), a United States Court of Appeals for the District of Columbia Circuit for almost thirty years for which he served as chief judge from 1962 to 1978, and Nicolas Kittrie (Kittrie), a social scientist critical of the implications of both Menninger and Szasz’s

3. Astrid Birgden, *Compulsory Drug Treatment Program for Offenders in Australia: Therapeutic Jurisprudence Implication*, 30 T. JEFFERSON L. REV. 367, 388 (2007).

4. Ian Freckelton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: Price and Risks of Influence*, 30 T. JEFFERSON L. REV. 575 (2007); Acquaviva, *supra* note 1, at 975.

5. Winick, *supra* note 2, at 1.

6. Nadav Davidovitch & Michal Alberstein, *Therapeutic Jurisprudence and Public Health: A Broad Perspective on Dialogue*, 30 T. JEFFERSON L. REV. 507, 514 (2007).

7. Acquaviva, *supra* note 1, at 986.

positions, were the ideological progenitors of Therapeutic Jurisprudence and its contemporary critics.⁸ Wexler and Winick are clear that through therapeutic jurisprudence, they are not calling for a therapeutic state or deference to clinical judgment, but the underlying philosophical struggles remain relevant.⁹ Discussions about the therapeutic state that emerged in the context of the 1960s and 1970s are important not because those ideals are now realized but because the same concerns and ideals find their own expression in TJ and specialty courts. The ambiguity of the word therapeutic is far from new, as therapeutic needs have been used as an overriding common interest among scientists, inmates, and prison authorities, often to justify a particular set of social interactions.¹⁰ Kittrie also recognized that general growth in the therapeutic ideal, humanistic sentiment, and beliefs about scientific effectiveness resulted in certain segments of the therapeutic state to accommodate only their own purposes.¹¹

Part 1 of this paper presents an introduction to the concept of Therapeutic Jurisprudence, a short background of its ideological progenitors, a discussion of TJ's relationship to public health, and an overview of the mental health court movement. Part 2 is a summary of advocacy and four major criticisms of mental health courts (MHCs). Here I present a fifth critique of MHCs from a public health perspective. Part 3 is an analysis of the relationship between TJ and mental health courts and how it potentially impacts the courts' success and viability. The conclusion discusses whether MHCs can truly be considered a public health intervention and whether they accomplish one of their stated goals of impacting the root causes of mental illness and criminal conduct. Woven through the discussion are tensions present in TJ, criminal justice, and pub-

8. See NICHOLAS N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* (1972); KARL MENNINGER, *THE CRIME OF PUNISHMENT* 126 (1968); THOMAS SZASZ, *THE MYTH OF MENTAL ILLNESS*, 4 (KGC Magnetic Tape Library 1968).

9. See generally, DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* 1034 (1996).

10. RONALD BAYER, *HOMOSEXUALITY AND AMERICAN PSYCHIATRY: THE POLITICS OF DIAGNOSIS* 15-41 (1981).

11. KITTRIE, *supra* note 8.

lic health, including paternalism, coercion, and Joel Feinberg's conception of clutchability.

BACKGROUND

History, Therapeutic Jurisprudence, and Mental Health Courts

During the 1960s, the growth of psychiatric influence over criminology caused undue anticipation that the United States would turn into a therapeutic state. The New York State Narcotic Addiction Control Commission released a pamphlet in 1968 advocating for closed ward treatment of narcotic addicts.¹² They claimed the “historical evolution of law in our culture reflects our gradually increasing willingness to subject more subtle aspects of socially significant moral conduct to reasonable social control.”¹³ It was in this context that Kittrie ruminated over the precarious implications of a criminal justice system with psychiatric goals that lacked proper boundaries or serious consideration of its societal aims.¹⁴ He suggested that incorporating therapeutic objectives into criminal justice represented a departure from the moral-religious conception of crime and would result in experimentation with offenders, eventually leading to more effective social defense. However, whether the main thrust of the therapeutic movement was humanistic, scientific, or arbitrary and without safeguards was unclear to Kittrie.¹⁵ The aims of this kind of state could either be a greater tolerance of deviant behavior or even more stringent social control. Kittrie feared that despite the benevolent nature of therapeutic goals, the therapeutic state could possess tools of human control that far exceeded the threat to individual liberty posed by sanctions inherent in the penal system.¹⁶

Menninger was a psychoanalyst who came from a strongly deterministic tradition, which began in the nineteenth century and

12. David P. Ausubel, *Why Compulsory Closed-Ward Treatment of Narcotic Addicts?*, 40 *PSYCHIATRIC Q. SUPPLEMENT* 1, 3. NEW YORK: NEW YORK STATES NARCOTIC ADDICTION CONTROL COMMISSION (1968).

13. Ausubel, *supra* note 12, at 3.

14. KITTRIE, *supra* note 8.

15. *See generally*, KITTRIE, *supra* note 8.

16. *Id.*

aided in the transition from classical to social welfare liberalism.¹⁷ He wanted to transform criminal justice through the lens of psychiatry and advocated for a therapeutic state in 1968 with *The Crime of Punishment* by creating a “thoroughgoing equation of criminality and psychopathology.”¹⁸ He argued that crime was preventable with psychiatric treatment; punishment for criminal behavior was cruel, ineffective, and outdated.¹⁹ Menninger starkly criticized the criminal penal model, claiming the entire system was merely an unplanned product of history: “I suspect that all the crimes committed by all the jailed criminals do not equal in total social damage the crimes committed against them.”²⁰ To him, jails were analogous to hospitals and mental institutions that were once thought of as embarrassing, taboo “pest houses” because mental illness was once believed to be incurable.²¹

Most problematic was the lack of distinction made in punishment for the majority of individual characteristics of the offender. The criminal model resulted in prisons promoting precisely what society was beginning to want psychiatry to fix. Society’s worst crime, in Menninger’s eyes, was its ignorance about crime control and the neglect of preventative measures.²² His remedy for these ills rested in psychiatry’s potential to transform criminal justice through its relationship with law, keeping in mind the ultimate aim of public safety. Menninger believed this therapeutic transition would amount to carrying out the scientific method, melding the science of criminology with psychiatry and resulting in effective deterrence from crime. For psychiatrists, Menninger explained, injustice lay in treating all criminal offenders the same.²³ Not only did the conception of psychiatric mental illness not equate to legal insanity, but the very word insanity lacked any real correspondence to modern psychiatry at all. The current system, consisting of psy-

17. See generally, Ronald Bayer, *Heroin Addiction, Criminal Culpability, and the Penal Sanction*, 24 CRIME & DELINQUENCY 221 (1978).

18. BAYER, *supra* note 10, at 167.

19. MENNINGER, *supra* note 8, at 19.

20. MENNINGER, *supra* note 8, at 126.

21. *Id.* at 53.

22. *Id.*

23. See *id.* at 202 (“Not some cases, but all cases are exceptions.”) (lauding the 1963 Model Sentencing Act, which upheld consideration of individual characteristics, circumstances, needs, and potentialities).

chiatrists testifying as expert witnesses, put them in a position to make inappropriate diagnostic and legal determinations. These testimonies were merely the legal system unburdening itself of certain responsibilities by placing them onto psychiatrists.²⁴

Bazelon disagreed, and wrote in 1974 that he foresaw more psychiatric involvement in the adversarial process; he saw this model as a positive way to openly reconcile adversity while uncovering underlying conflicts between patients and institutions. However, like Menninger, Bazelon felt uneasy with the court determining the correctness or wisdom of decisions for which they had no expertise, for it was only the role of the court to fully explore relevant facts.²⁵ William Alanson White (White), a leading American psychoanalyst, claimed that the sole purpose of a trial should be guilt determination, a position held by several theorists.²⁶

Bazelon wrote *The Perils of Wizardry* in 1974. Psychiatry was still using what he called conclusory labels in the courtroom that were irrelevant and uncertain instead of real explanations that included a focus on the origins and development of mental illness. Bazelon did not intend to give moral responsibility of determining guilt to doctors, as the rule was supposed to be for legal, not medical purposes. However, recognition of the public psychological need for the crime-punishment model caused Menninger to conclude that the whole system was an excuse for misplaced vengeance.²⁷

Though the practical implications of this advocacy extend far beyond drug courts and mental health courts as it applies to all those considered criminals, many lines of argument inform the philosophy inherent in specialty courts. Menninger argued for community mental health and diagnostic centers and continually criticized the adversarial court model. Treatment rather than punishment for criminal behavior was seen as a scientific endeavor which could be carried out with a humanistic spirit resulting in effective outcomes.²⁸

24. MENNINGER, *supra* note 8, at 107–33.

25. David L. Bazelon, *The Dilemma of Criminal Responsibility*, 72 KY. L.J. 263 (1983).

26. BAYER, *supra* note 10.

27. David L. Bazelon, *The Perils of Wizardry*, 131 AM. J. PSYCHIATRY 1317–1322 (1974).

28. *See generally*, MENNINGER, *supra* note 8.

Beginning in 1961, Thomas Szasz (Szasz) espoused a diametrically opposed philosophy to Menninger,²⁹ as he did not believe there was anything scientific about psychiatry or benign about its role in criminal justice. Coming from a libertarian political philosophy, Szasz feared precisely for what Menninger was waiting. While some liberals advocated for increased commitment, others were forced into libertarianism or compelled to remain silent. Thus, “libertarian tolerance [served] a profoundly conservative ideological function.”³⁰ In *The Myth of Mental Illness* he claimed psychology deals with moral problems that are unanswerable through scientific and medical methods.³¹ Ascribing psychiatric labels to individuals enfeebles them as moral agents and acts to authenticate political preference as values of health while obfuscating a religious-therapeutic alignment. Mental illness and addiction, to Szasz, are not medical matters of health and disease but moral determinations of good and evil. Doctors serve a medical role in society, to cure disease, but also a social role, to control deviance.³² The “medical perspective on moral conduct”³³ hides the latter purpose, thus concealing the part of treatment that demands social control.

The terms labeling mental illness and addiction are used to stigmatize and control people whose behavior offends society.³⁴ These diagnoses are “fakery and pretense whose purpose is to medicalize certain aspects of the study and control of human behavior.”³⁵ Szasz sees drug policy and mental illness as part of an

29. See Letter from Karl Menninger, M.D. to Thomas S. Szasz, M.D., Reading Notes, *Bulletin of the Menninger Clinic* (July 1989), available at <http://www.szasz.com/menninger.html>. (In 1988, Menninger and Szasz exchanged two letters that imply they might not have been as much at odds as previously thought. They expressed respect toward each other, and Menninger admitted that he thought the advent of widespread use of chemical drugs for treating psychiatry represented a turning point for him. Szasz claimed he realized Menninger was also trying to reconcile free will and responsibility with psychiatry, but lamented that it was an impossible task as the basis of psychiatry is wrong. However, he saw benevolent potential in psychoanalysis.)

30. BAYER, *supra* note 10, at 232.

31. See SZASZ, *supra* note 8, at 4.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.* at 4.

escalating historical pattern of prohibitions that leave unchanged the fabric of social organization and social control.³⁶

Employing psychiatry for use in criminal law corrupts it; those who are supposedly getting treatment are indeed victimized, as there is no scientific, moral, or legal justification for any involuntary intervention.³⁷ Szasz was sure that care does not ever require coercion, as science and medicine have become quasi-religious ideals that hide the moral purpose of the therapeutic function.³⁸ Any utilization of coercion by psychiatry is a legal or political procedure, not a therapeutic intervention. A “political order that uses physicians and hospitals rather than policemen and prisons to coerce and confine miscreants and justifies constraint and compulsion as therapy rather than punishment”³⁹ is precisely what Szasz sees as the emergent therapeutic state.

Kittrie reflects on these ideologies, their historical evolution, and the potential for a therapeutic state in *The Right to be Different* in 1972.⁴⁰ Though existing in the historical context of an emerging rehabilitative ideal, Kittrie’s questioning remains relevant to contemporary attempts of government to use the judicial system for therapeutic ends. His main argument centers on the importance of understanding the deep philosophical basis for the therapeutic state, including its purpose and potential consequences, in order to prevent the dangers of unchecked power which result from uncertain philosophy. Kittrie believes that therapeutic ideals are inherently humanistic. Yet, the complex forces that mold their application often lead to theoretical confusion.⁴¹ Though Menninger saw hope in a therapeutic state,⁴² and Szasz feared a potential tyranny of social control,⁴³ Kittrie saw the growing movement as overworked and overzealous, not perverse or undermining of existing social structures. It merely denied its own driving force, utilitarian determinism.⁴⁴

36. *Id.* at 158–60.

37. *Id.* at 4.

38. *Id.* at 154.

39. *Id.* at 4.

40. KITTRIE, *supra* note 8.

41. *See generally, id.*

42. *See generally, MENNINGER, supra* note 8.

43. *See generally, SZASZ, supra* note 8.

44. *See KITTRIE, supra* note 8.

The imagined therapeutic state is built on the distinction between criminals and deviants, both which have different levels of dangerousness and act illegally, but the latter deserve treatment over punishment because of shifting ascriptions of guilt.⁴⁵ A social problem rather than an offense is dealt with while science over faith is valued. In this sense, Kittrie agrees with many of Menninger's philosophies with regard to the mentally ill but shares Szasz's fears of their practical application:

... the new therapeutic state has from the beginning contained mixed strains of both social defense and individual welfare, carrying out programs of confinement and compulsory therapy which could not be justified by considerations other than those of social defense, yet relying upon its manifested dedication to welfare in order to combat criticisms of its disregard for the traditional safeguards of the criminal process [T]he nonpenal aims and the deviant's mental aberration continue to be asserted in opposition to the granting of procedural and substantive safeguards to the beneficiaries of therapy; and the therapeutic state's preventative ideal similarly militates against strict substantive standards limiting state intervention. As a result the therapeutic model now offers the only system of social control unlimited in potential applications.⁴⁶

Mental illness as an argument against criminal responsibility creates a duty of society for treatment.⁴⁷ Kittrie worried that the definition of mental illness was not delineated well enough by experts, and he lacked confidence in the public care sector.⁴⁸ "The greatest step . . . will be made not so much through an insistence of legal formalities as through a fundamental change in the character of institutional care."⁴⁹ Additionally, Kittrie believed drug addiction was the core of criminal recidivism because government regu-

45. *Id.* at 21–29.

46. *Id.* at 360–62.

47. *Id.* at 254, 398–400.

48. *Id.* at 95–101.

49. *Id.* at 101.

lation of drugs caused their inextricable link with crime.⁵⁰ But civil commitment for addicts modeled after mental health law did not work because of a lack of long-term supervision and indeterminate confinement.⁵¹ As opposed to the voluntary nature of the welfare state, the therapeutic state's paternalism is compulsory.⁵²

The early critics of the therapeutic state had concerns similar to the contemporary critics of therapeutic jurisprudence and specialty courts. Firstly, Kittrie described concerns regarding legal problems inherent in the relationship between therapeutic ideals and due process.⁵³ Without certain procedural safeguards, the therapeutic state could ignore the burden of proof as to whether a particular offense was committed in the first place. Additionally, the goals of social defense and the treatment of the individual could conflict.⁵⁴ Kittrie did not believe the justice system would be fundamentally changed by a more therapeutic state, as he thought the system was too much of a hybrid, causing both criminal and therapeutic goals to be compromised.⁵⁵

Unlike Szasz's contention that psychiatry did not have the necessary knowledge and skill to really constitute a scientific discipline and was really a moral crusade, Kittrie was afraid the therapeutic state possessed too much knowledge and too many skills for the "modification of man."⁵⁶ Although a huge influence on the depth of mental health law and development of mental health court ideology, Bazelon concluded "The Perils of Wizardry" with a deep concern regarding the unchecked power of psychiatry.⁵⁷ He claimed that unlike the wizard in *The Wizard of Oz*, who claimed to be a good man but a very bad wizard, psychiatrists could one day awaken to realize they are "good wizards but very bad men."

Kittrie believed in the humanistic possibility of the therapeutic state and its potential to enliven a new positive right to treatment such as that advocated for by Bazelon. Kittrie thought

50. *Id.* at 212.

51. *Id.* at 243–58.

52. *Id.* at 41.

53. *Id.* at 46–49.

54. *Id.* at 366–69.

55. *Id.*

56. *Id.* at 365.

57. *See* Bazelon, *supra* note 27.

new developments in community based treatment, legal scrutiny, and judicial review of innovative scientific claims were coming.⁵⁸ In this sense, he was right; deinstitutionalization did result in more community treatment and debates regarding positive rights to care. However, it also deepened involvement of the mentally ill in the criminal justice system. Whether the purpose, aims, or philosophical ground the therapeutic state rested upon were ever sufficiently debated or agreed upon remains uncertain:

The therapeutic state disclaims penal aims and asserts, therefore, freedom from limitations upon punishment. Moreover, by ignoring or at least bypassing personal culpability and guilt, the therapeutic state finds itself with no measuring stick by which to determine the propriety of its sanctions, other than effectiveness . . . the time has come to recognize that therapeutic excesses, like penal excesses, need be and can be curbed.⁵⁹

Therapeutic Jurisprudence and Public Health

Therapeutic jurisprudence was developed in the late 1980s as a scholarship narrowly focused on the law's impact on mental and physical health. TJ grew in response to mental health law which eschewed the "psychiatrization of law" that Menninger espoused and Szasz opposed. TJ recognizes the law itself as a social force and sees the potential for mental health law to have anti-therapeutic consequences. TJ does not attempt to be used to resolve legal debates but to enrich decision making through exploration of how social science and mental health disciplines can add to the evaluation of legal theory, "relating a body of therapeutically-relevant psychology to a body of law and exploring the fit between the two."⁶⁰ Therapeutic goals are not a trump card but an additional value brought to a balancing process, a value that says the law should be critiqued when it has anti-therapeutic effects. TJ is supposed to be normative, meaning that it explores consequences of the law in order to inform policy discussions underlying legal re-

58. See KITTRIE, *supra* note 8.

59. *Id.* at 387-88.

60. WEXLER & WINICK, *supra* note 9, at 13.

form but only when other legal values do not conflict, as it is not an attempt to trump such values.

Wexler describes how mental health law in the United States has been doctrinal, constitutional, and rights-oriented.⁶¹ Much like the bioethics movement, mental health law was conjured during the civil liberties revolution. It questioned whether those with mental illness should be afforded rights existing elsewhere in the legal system and found competency a central issue. Thus, it focused on expanding individual rights, autonomy, beneficence, and informed consent in a legal context. Mirroring the bioethics movement's relationship to medical paternalism, the authors see mental health law as a part of the anti-psychiatry movement that was skeptical toward that discipline, but was not itself truly interdisciplinary.⁶²

One of the main questions TJ has and remains to ask is whether compulsory treatment given with therapeutic intentions can have anti-therapeutic effects because of the detrimental consequences inherent to coercion. For instance, Winick and Wexler describe a 1988 study by Durham and Lafond claiming there was little evidence that there was a difference in efficacy between voluntary and involuntary treatment, and if anything, the latter may harm the patient. Winick advocates for "making autonomy therapeutic" throughout the text.

Despite its expanding definitional boundaries, the meaning of therapeutic is left intentionally ambiguous and connections to its ideological progenitors are intentionally absent. Winick and Wexler claim it is not dependent on ideological concerns because of its normative, inquisitive nature and vague definition, but as shown by historical arguments, even this position on the role of law in therapeutic outcomes is based on underlying philosophies. TJ raises similar questions posed by Kittrie but, through Winick and Wexler's conception of normativity (though maddeningly vague in its own right) and ambiguity, it attempts to sidestep the ideological issues Kittrie found so vital to consider.

The connection between public health and TJ is both tangible and analogous. Nadav Davidovitch (Davidovitch) and Michal Alberstein (Alberstein) claim that TJ as a legal reform movement

61. See generally, WEXLER & WINICK, *supra* note 9.

62. *Id.*

parallels contemporary public health as a reform of medicine.⁶³ Both TJ and public health aim to enter previously private spheres of well-established professions under the main rationalization that they are more “competent in dealing with the social order.”⁶⁴ The study of root causes is vital to both disciplines. Like public health, TJ inherently investigates social-psychological dimensions of behavior and health. “Surely if the law is to have any role in reversing mental illness in promoting therapy, we must be alert to manipulative social forces that cause, contribute to, exacerbate, alleviate, etc., mental illness.”⁶⁵ TJ takes a cue from public health in asserting that a multifaceted analysis of the individual, the public dimension, and unique socio-historical factors is needed to understand any specific health outcome.

A common critique of therapeutic jurisprudence is that its reticence to define the word therapeutic could potentially justify paternalism. Winick vehemently disagrees because TJ can be used to analyze whether paternalism itself is anti-therapeutic.⁶⁶ Wexler and Winick assure that TJ is not a proxy for paternalism or excuse for coercion.⁶⁷ Legal protection for autonomy, particularly for mentally ill individuals, can have therapeutic consequences.⁶⁸ However, they acknowledge the possibility that if the right to refuse treatment, for instance, had negative health impacts, a balance would need to be struck between constitutional values and beneficence. Susan Daicoff (Daicoff) portrays TJ as one emergent discipline within a larger comprehensive law movement that focuses on human wellbeing more than individual rights.⁶⁹

A Public Health Approach to Law?

Public health and TJ are connected not only because of the legal system’s therapeutic influence but because of the analogous

63. Davidovitch & Alberstein, *supra* note 6, at 514.

64. *Id.*

65. WEXLER & WINICK, *supra* note 9, at 37.

66. Winick, *supra* note 2.

67. *Id.*

68. *Id.*

69. Susan Daicoff, *Growing Pains: The Integration vs. Specialization Question for Therapeutic Jurisprudence and Other Comprehensive Law Approaches*, 30 T. JEFFERSON L. REV. 551, 561–64 (2008).

nature of the two disciplines, the criticisms they face, the central position law has in public discourse on public health, and the ways in which they can learn from each other.⁷⁰ Further still, Davidovitch and Alberstein assert that TJ is in fact a public health approach to criminal justice.⁷¹ “TJ and the new problem solving courts actually represent a public health approach to the problems of juvenile delinquency, drug addiction, domestic violence, and mental illness.”⁷² They are both potential areas for hegemonic control and consistently struggle with their boundaries. Both disciplines require deep consideration of “the social philosophical basis of the entire relationship between the individual and the state.”⁷³

Public health and TJ’s main contemporary nexus, mental health courts, embody the underlying philosophical issues inherent to both of the discipline’s development and uncertain application. These issues coalesce to inform criticism and advocacy for specialty courts while informing the debating regarding the use of compulsory treatment and how important outcome effectiveness has become. Finding balance between competing values is the main challenge of public health and TJ as they struggle to neither overstep their bounds nor merely focus on the symptoms of underlying social problems.

The boundaries between TJ, medicine, and social phenomena are as unclear as the limits of public health. Though TJ was developed in the context of mental health, public health and law intersect in several other areas including prostitution and domestic violence. The general or specific integration of TJ has consequences for its application in specialty courts and their proliferation from drug and mental health courts to other areas. TJ cannot remain non-ideological when applied in a field as ideologically charged as criminal justice, while its application sits in tension with its original purpose of an analytical, non-strategic tool. If TJ remains a separate discipline, it could become an arbitrary means of promoting therapeutic ideals. On the other hand, its general in-

70. Davidovitch & Alberstein, *supra* note 6; *see generally*, Ellen Waldman, *Therapeutic Jurisprudence: Growing Up and Looking Forward*, 30 T. JEFFERSON L. REV. 345, 345–49 (2007).

71. *See generally*, Davidovitch & Albertstein, *supra* note 6.

72. *Id.* at 514.

73. *Id.* at 510.

tegration could reignite Kittrie's fears of boundless social control. However, as opposed to judicial deference to psychiatry in the 1960s, the TJ movement as a lens through which to view all law would represent more of an integration of the two fields. Ironically, the intentional vagueness of the terms therapeutic and normative, meant to keep TJ from becoming an ideological movement, is just what allows its momentum to be ideologically co-opted in its application, specifically in drug and mental health courts.

The Mental Health Court Movement

The scope of the problem solving methodology is expanding: "No longer are state Supreme Court justices arguing about whether drug courts (or similar courts) are appropriate...the chiefs now debate how specialized . . . courts should be integrated into the overall judicial system."⁷⁴ Ian Freckelton (Freckelton) claims that the momentum of TJ has a major role in the emergence and proliferation of problem solving courts.⁷⁵ It is unclear what kind of relationship TJ and specialty courts have. Many authors claim that both mental health courts and drug courts are based on TJ, perhaps with a symbiotic power/knowledge relationship.⁷⁶ Others, such as Cait Clarke and James Neuhard (Clarke and Neuhard)⁷⁷ and Wexler⁷⁸ assert they have shared values but different ancestry, while Greg Berman (Berman) and John Feinblatt (Feinblatt) claim there is no real uniting theory behind problem solving courts at all.⁷⁹

74. John S. Goldkamp, *Impact of Drug Courts*, 2 CRIMINOLOGY & PUB. POL'Y 197, 203 (2006).

75. Freckelton, *supra* note 4.

76. Henry J. Steadman et al., *Mental Health Courts*, 52 PSYCHIATRIC SERV. 457, 457-58 (2001); Frank Sirocich, *Reconfiguring Crime Control and Criminal Justice: Governmentality and Problem-Solving Courts*, 55 NAT'L BLACK L.J. 11, 12-13 (2006).

77. See generally, Cait Clarke & James Neuhard, *Making the Case: Therapeutic Jurisprudence and Problem-Solving Practices Positively Impact Clients, Justice Systems and Communities They Serve*, 17 ST. THOMAS. L. REV. 781 (2005).

78. See generally, David B. Wexler, *Rehabilitating Lawyers: Principles of Therapeutic jurisprudence for Criminal law Practice* (2008), available at <http://www.cap-press.com/pdf/1844.pdf>.

79. Greg Berman & John Feinblatt, *Problem-Solving Courts: A Brief Primer*, 23 LAW & POL'Y 125 (2001).

Problem solving courts are supposed to create a web of accountability between courts, defendants, and service providers, and they can monitor provisions that go beyond their jurisdiction.⁸⁰ The Center for Court Innovation in New York City claims these courts aim to use legal authority to create new responses to social problems and broken systems that have been historically resistant to other solutions, thus broadening the focus of traditional legal proceedings while giving courts more accountability.⁸¹ More theoretically, Frank Sirotech (Sirotech) claims that these courts represent a refiguring of crime control altering four main discourses – the object of inquiry, ordering principles, the role of subjectivities of the judge and offender, and the techniques of knowledge formation and power.⁸²

Sirotech claims this movement, particularly drug and mental health courts, represents a paradigm shift for crime control in the United States. Clearly the ideological questions are not new, but it is unclear whether the transformed role of courtroom actors based on offender recovery is a fundamentally new way of doing justice or just an updated method of plea bargaining and supervised probation. Whether these courts are accomplishing their goals, which are differently conceptualized by different stakeholders, and whether those goals are actually based on a conception of applied therapeutic jurisprudence informs their evaluation, advocacy, and criticism. Though there are both advantages and disadvantages of decentralized court reform, the disadvantages can be particularly salient when opposing reform ideologies exist, as is the case with problem solving courts.⁸³

Though this analysis focuses on MHCs and the MHC movement, there is much to be learned through the conflicting goals of their predecessors, drug treatment courts. Three institutional imperatives gave rise to drug courts – docket pressure from War on Drugs, revolving door justice and recycling, and judicial

80. Michael C. Dorf & Jeffrey A. Fagan, *Problem-Solving Courts: From Innovation to Institutionalization*, 40 AM. CRIM. L. REV. 1501, 1508 (2003).

81. Berman & Feinblatt, *supra* note 79.

82. Sirotech, *supra* note 76.

83. See generally, Candace McCoy, *Politics of Problem-Solving: An Overview of the Origins and Development of Therapeutic Courts*, 40 AM. CRIM. L. REV. 1513 (2003).

dissatisfaction.⁸⁴ They responded to the war on drugs, addressed case overload, reduced high expenditures of other criminal justice agencies, and reduced incarceration. They were also seen as a therapeutic approach to drug addiction, a way to increase judicial involvement, and an alternative to adversarial model. Thus, drug courts have had divergent goals and methods from the start. By 1993, the drug court movement was still split between management and therapeutic rationales, but was tipping toward the therapeutic. New drug courts became known as “second generation,” and were treatment and monitoring based with additional secondary goals of reducing recidivism, saving incarceration costs, and returning human capital to communities.⁸⁵

Drug courts are becoming institutionalized.⁸⁶ They engender political common ground as they emphasize addiction as a disease while enforcing individual responsibility within the criminal justice system. Their main political issues are efficacy and cost-effectiveness with regard to crime, and these are their chief selling points.⁸⁷ Despite the ideological balance tipping in favor of therapeutic ideals, their practical justification can be supported by stakeholders with divergent philosophies, and thus their evaluations often focus on what might be considered at one point their secondary goals. While drug courts are inherently tied to the illegality of drugs, mental health courts are inherently tied to functioning of the public mental health system.

Mental health courts are meant to fill the gap for people who don't fill traditional incompetency criteria but still have a mental illness seriously contributing to their criminal behavior.⁸⁸ As opposed to drug courts, which have a standardized albeit general operating model, mental health courts have an unclear, non-established, conceptual model or infrastructure to guide their crea-

84. Dorf & Fagan, *supra* note 80, at 1501–02.

85. McCoy, *supra* note 83.

86. Dorf & Fagan, *supra* note 80.

87. *Id.*

88. Brenda C. Desmond & Paul J. Lenz, *Mental Health Courts: An Effective Way for Treating Offenders with Serious Mental Illness*, 34 MENTAL & PHYSICAL DISABILITY L. REP. 525, 525–30 (2010).

tion; each operates idiosyncratically.⁸⁹ All MHCs claim a problem solving orientation with unique success measurements, treatments provisions, illness mitigation strategies, legal actors with non-traditional roles, and an active judiciary. Many more mental health courts than drug courts claim to be based on the tenets of therapeutic jurisprudence by having been developed with those principles in mind. Their general model includes a separate docket for defendants with mental illness and a judicial process diverting those with mental illness into long term, community based treatment. Newer courts have begun accepting those arrested for felonies and sometimes require a guilty plea for participation.⁹⁰ One of their main goals is to get at the root of criminal conduct for such individuals, while their secondary objectives include improving public safety, formulating compassionate treatment, decriminalizing mental illness, and reducing recidivism.⁹¹ However, not unlike drug courts, MHC's goals are defined differently by different researchers and stakeholders. Greg Berman (Berman) and Derek Denckla (Denckla), from the Center for Court Innovation, for instance, describe their common procedures and goals as also including identification of mental illness, innovative plea structures, and system integration.⁹²

Berman and Denckla⁹³ identify several common challenges to implementing these courts despite their varying operation, eligibility characteristics, definitions of success, and procedural safeguards.⁹⁴ Mental health court participants are often under court supervision longer than if they were sentenced in criminal court, and sanctions are often handed down if a participant requests a transfer back to criminal court, particularly if a guilty plea was

89. Steadman et al., *supra* note 76; Christin E. Keele, *Criminalization of the Mentally Ill: The Challenging Role of the Defense Attorney in the Mental Health Court System*, 71 UMKC L. REV. 193, 197–04 (2002).

90. *See generally*, Susan S. Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 507 (2005).

91. Acquaviva, *supra* note 1, at 985–88.

92. Derek Denckla & Greg Berman, *Rethinking the Revolving Door: A Look at Mental Illness in Courts*, ST. JUST. INST. 1, 8–10 (2001), available at <http://www.courtinnovation.org/sites/default/files/rethinkingtherevolvingdoor.pdf>.

93. Denckla & Berman, *supra* note 92, at 12–14.

94. Acquaviva, *supra* note 1, at 1010–12.

required for entrance into the MHC.⁹⁵ In addition to their briefer history, mental health courts are different from drug courts as mental illness is not a crime; in MHCs there are a broad range of offenses. Jail is used less often as a sanction, and there are more individualized treatment plans.⁹⁶ Their historical development is different, as well, as it was a movement encouraged more by mental health and criminal justice advocates following the lead of drug courts and explicitly claiming a tie to therapeutic jurisprudence from the start.

Gregory Acquaviva (Acquaviva), arguing that MHCs are no longer experimental demonstration projects but an institutionalized part of the legal system, claims they arose from criminal justice systemic failures, judicial dissatisfaction, high recidivism of people with mental illness and revolving door justice, and institutional problems.⁹⁷ Seltzer adds that they flourished because of systemic failures in both criminal justice and public mental health systems.⁹⁸ Not only are a high percentage of people with mental illness in jails and prisons, but these individuals experience longer incarceration, are particularly vulnerable to assault while incarcerated, and are treated more harshly by traditional courts than other populations.⁹⁹ Arrest and incarceration also impedes access to mental health services and housing.¹⁰⁰ 83-89% of people with mental illness get no treatment at all while incarcerated.¹⁰¹

MHCs were created to address the public health risk posed by offenders with mental illness, the challenges and costs of housing the mentally ill in local jails, and the criminal justice system's inability to respond effectively and humanely to mentally ill indi-

95. Denckla & Berman, *supra* note 92, at 10.

96. Desmond & Lenz, *supra* note 88, at 526.

97. Acquaviva, *supra* note 1, at 974.

98. Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses*, 11 PSYCHOL. PUB. POL'Y & L. 570, 572 (2005).

99. Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illness: The Role of Mental Health Courts in System Reform*, 7 UDC/DCSL L. REV. 143, 143-44 (2003).

100. *Id.* at 143.

101. Acquaviva, *supra* note 1, at 979.

viduals.¹⁰² Despite the recognition of distal causes for such problems and the involvement of advocates from the mental health system, MHCs were born of the criminal justice system.

Judge Ginger Lerner-Wren (Lerner-Wren), the first judge to preside over the Broward County MHC said it was born out of desperation from a failing mental health system. She thought it would “improve individual and social outcomes from offenders with underlying mental illness.”¹⁰³ As the loosely adoptable model spread, various first order goals were explicated by different courts, including public safety in King County and post-plea adjudication in Anchorage.¹⁰⁴ Since the MHC model is broad and idiosyncratic, what counts as a mental health court remains ambiguous.

Berman and Denckla¹⁰⁵ think MHCs will test three hypotheses: What is the connection between mental illness and criminal conduct? Does coercion improve accountability? Can MHCs incite system integration (Can the mental health system and criminal justice system collaborate? Will MHCs incite systemic change?)? While the first question can perhaps be tested by measuring recidivism, the others are more difficult to quantify or evaluate. Even if the goals outlined by MHC creators are accomplished, do these courts or drug courts actually meet the challenge of addressing the root causes of failures in the criminal justice and public health systems? Though more agreement exists around the use of therapeutic jurisprudence for the development of mental health courts than drug courts, both movements were built upon various stakeholders espousing different, often conflicting purposes, goals, and ideologies, including a claim to atheoretical pragmatism.

102. Arthur J. Lurigio & Jessica Snowden, *Putting Therapeutic Jurisprudence into Practice: The Growth, Operations, and Effectiveness of Mental Health Court*, 30 JUST.SYS. J. 196, 198 (2009).

103. Acquaviva, *supra* note 1, at 984–85 (quoting Jenni Bergal, *Justice That Works; Mentally Ill Defendants Avoid the Revolving Door of Jail, Get Their Lives Back on Track Through Mental Health Court's Assistance*, SUN-SENTINEL (Ft. Lauderdale, Fla.), Nov. 24, 2002, at 1A).

104. Lurigio & Snowden, *supra* note 102, at 203–04.

105. Denckla & Berman, *supra* note 92.

What Works?

There is an obligation to explore what is claimed to be implemented in mental health courts and whether such implementation is achieving desired outcomes.¹⁰⁶ Are they working to change the adversarial model of the courts themselves or perhaps having a larger impact on bringing doubt to the adversarial model more generally? “Developing the yardsticks to measure outcomes, collecting data and presenting it effectively will bring partners to the process from all parts of the system to produce a truly fundamental shift in the goals of the justice community. . . .”¹⁰⁷ Although some impetus for mental health court proliferation involved systemic change and therapeutic aims, the main thrust of their evaluations has been on quantitative and ultimately pragmatic, utilitarian outcome measures; this is both because of their often short operating duration and the desire to find common political ground that can fit all stakeholder’s needs.

The essential therapeutic component of drug and mental health courts is mandated treatment. Lawrence Gostin (Gostin) describes the historical evolution of mandated treatment in addiction and jail diversion contexts. He champions the benefits of compulsory treatment to the individual and society, largely citing its efficacy. He acknowledges the critique that many who want treatment cannot receive it, thus establishing the right to treatment as integrally tied to controversial mandatory treatment and the right to refuse treatment. In terms of addiction specifically, Gostin contends that given the options of criminal justice-based penal sanctions, compulsory treatment, and drug legalization, compulsory treatment is the public health approach; it has the highest odds of reducing morbidity, mortality, and future criminal behavior.¹⁰⁸ He believes diversion programs, of which contemporary specialty courts are a kind, are preferable to civil commitment: “The criminal justice system provides a key forum for an effective public health program.”¹⁰⁹ It is asserted that this public health program is

106. Freckelton, *supra* note 4, at 576.

107. Clarke & Neuhard, *supra* note 77, at 871.

108. Lawrence O. Gostin, *Compulsory Treatment for Drug-Dependent Persons: Justifications for a Public Health Approach to Drug Dependency*, 69 *MILBANK Q.* 561, 575–79 (1991).

109. *Id.* at 576.

therapeutic jurisprudence resulting in mandatory treatment in the context of specialty courts, and Gostin asserts this balances justice and social welfare well.

Results for specialty courts are more varied and politically charged than Gostin's analysis might suggest, and they often do not include an analysis of whether compulsory treatment is just or ethical, regardless of effectiveness. There is often conflation of drug courts and MHCs in evaluation review.¹¹⁰ One of the main differences complicating the comparison of evaluations is that drug courts have clearly defined success measures precisely because of the criminalization of drug use, despite the disease classification of addiction, making defining success in MHCs much more precarious.

Doug Marlowe (Marlowe) laments that gaps in knowledge are fodder for policy makers bent on obfuscating court success.¹¹¹ Study disparities should give insight to researchers but instead "have led reputable scholars to diametrically opposed conclusions about the efficacy of drug courts and have permitted advocates to selectively underscore isolated findings to support their agendas."¹¹² When empirical evidence regarding drug courts is considered, particularly the lack of comparison groups and intent-to-treat analysis, using them as a model for mental health courts seems problematic.¹¹³ However, it is likely that MHCs will continue to the path of drug courts in their model and evaluation.¹¹⁴ Much like drug courts, results of MHCs are lauded by some and denied by others, but considerably less data and subsequent commentary is available for MHCs because of their later emergence and inadequate measures of success.

Marlowe concludes that these courts are not either successful or unsuccessful, as they work for some and not for others.¹¹⁵ The answer is more research, not advocacy or criticism. They

110. Lurigio & Snowden, *supra* note 102, at 213.

111. *See generally*, Doug B. Marlowe et al., *A Sober Assessment of Drug Courts*, 16 FED. SENT'G REP. 153, 153–57 (2003).

112. Marlowe et al., *supra* note 111, at 153.

113. Lurigio & Snowden, *supra* note 102, at 201.

114. Nancy Wolff & Wendy Pogorzelski, *Measuring the Effectiveness of Mental Health Courts: Challenges and Recommendations*, 11 PSYCHOL. PUB. POL'Y & L. 539, 540 (2005).

115. Marlowe et al., *supra* note 111, at 155.

claim there is nothing worse for a simple intervention than to be turned into a movement:

Drug courts have fallen victim to this insidious process. Influential proponents of drug courts have linked its fate to that of “therapeutic jurisprudence” (or “TJ”), a liberal philosophy which holds that the law ought to advance psychological health as an important or “fundamental” legal interest. From this perspective, drug courts are no longer viewed as being a circumscribed intervention; instead, they stand as a proxy for the proper role of the judiciary. Critics of drug courts have taken a contrary tack by linking drug courts to conservative political philosophy. To these critics, drug courts are the embodiment of a “law and order” mentality that criminalizes private conduct and unacceptably extends the sphere of government influence over its citizens. Drug courts are *neither* of these things. They are a specific type of intervention, nothing more.¹¹⁶

In the context of the historical development of penal sanctions and therapeutic ideals and the politically charged field of criminal justice, it is unlikely that specialty courts are nothing more than a specific type of intervention. Though misguided on this point, Marlowe is correct regarding the existence of partisan political struggle. There were troubling and often conflicting concerns spurning the origins of drug and mental health courts intersecting with the antithetical nature of applied therapeutic jurisprudence resulting from the ideologically steeped context of its application. As opposed to remaining a normative lens for which to view the law’s consequences, therapeutic jurisprudence ends up co-opted in its application by whoever can use its ambiguous definition for their own, often predetermined, purpose. Perhaps the use of therapeutic jurisprudence in the development of mental health courts, and applied retroactively to drug courts, is evidence of the uncertain basis for such interventions and the need for something more ideologically convincing than outcomes measuring effectiveness and efficiency. Instead of masking an ideological debate, the

116. Marlowe et al., *supra* note 111, at 155.

focus on effectiveness inadvertently becomes its own underlying ideology, but it can only go so far in convincing critics. Marlowe's contention that larger issues are not at stake is misguided. The wisdom of an experimentalist government, the proper relationship of such a government to its citizens, and the role of courts in public health and the lives of individuals are certainly questions that need to be discussed in order to discern whether or not specialty courts are really doing justice.

ADVOCACY, CRITICISM, AND DEFENSE

In 1970, Joel Feinberg (Feinberg), a social and political philosopher of criminal law and responsibility, published *Crime, Clutchability, and Individuated Treatment*, which introduced a concept integral to today's consideration of the merits and limitations of drug and mental health courts. Clutchability refers to "whether the state has the right to get a defendant in its clutches." In other words, this concept attempts to establish when the state has legitimate hold or power over an individual. Feinberg claims an alleged criminal act is necessary before the decision regarding clutchability is made, but he implies that clutchability can be legitimized by more than criminal action as in the case of severe mental illness. Feinberg says people with mental illness are "not fit to be free, and not fit to be tied." Thus, there is basis for the state's clutch on the mentally ill, but its legitimization is precarious. He acknowledges the question of whether the presence of mental illness in an individual should decrease their clutchability because of decreased blameworthiness or increase their clutchability as a result of justified paternalism. "What justice demands is that the condemnatory aspect of the punishment suit the crime, that the crime be of a kind that is truly worthy of reprobation."¹¹⁷ It is established that part of the rationale for drug and mental health courts is that they allow for a focus on the individual in addition to the crime. Thus we must ask whether the treatment compelled by MHCs should be considered punishment. Since the crimes committed by those in mental health courts are no different from crimes committed in traditional criminal courts, the condition of

117. JOEL FEINBERG, APPLYING THE PROBLEM-SOLVING MODEL OUTSIDE OF PROBLEM-SOLVING COURTS 118 (Princeton Univ. Press 1970).

the individual, not the crime, is determining the worthiness of reprobation. Is the status of the individual as mentally ill altering the clutchability of the offender in mental health courts?

Feinberg saw a societal need to develop a variety of types of institutions in order to achieve flexibility and individuated treatment or punishment in the criminal justice system without giving up the protection of individual rights and due process. He believed any evidence of mental illness that is strong enough to bring an offender's guilt into question is strong enough to establish legitimate clutchability. Once the clutch line, as he calls it, has been crossed, then inquiries that were banned before become allowable and important. Thus, crossing the clutch line constitutes a forfeiture of liberty and privacy. In mental health courts, considerations of personal and medical history, not permissible or relevant in a criminal court, are vital to establishing treatment dispositions. We must question whether these courts are increasing the state's clutchability over mentally ill and addicted individuals through these interventions (contributing to a process called net-widening, which will be discussed shortly) or allowing for flexibility, meaning individuated treatment for those already deemed clutchable regardless of their illness. Are they improving what occurs after the clutch line has already been crossed or moving the line forward and justifying increased social control?

It is with this concept of clutchability that potentially essential differences between drug and mental health courts become apparent. They pose similar issues if the clutchability justification of drug courts is based on the offender's drug addiction as a mental illness. However, since defendants participate in drug courts because of a similar type of crime, drug use or possession, the issue of the original merit of criminalization of drugs is integral. Ignoring this question, as is often done in critique of drug courts because of its political and practical difficulty, renders it impossible to broach the topic of root causes of the drug problem if in fact the drug court defendant's clutchability rests on this criminal act. This is an additional reason why understanding the underlying ideology of specialty courts is vital to determining their merit.

With Feinberg in mind, one needs to understand the potential positive and negative impacts of this intervention to understand its limitations. Praise and criticism for drug and mental health courts often revolves around whether they represent a departure from traditional criminal justice, some kind of paradigm shift, or

are merely a familiar attempt at reform with a new name. Both of these positions foster advocacy and disapproval depending on the predisposition or outlook of the critic.

Mae Quinn (Quinn) argues that problem-solving courts are not only lacking in novelty, but in fact are anachronistic.¹¹⁸ She claims they originated a century ago from progressive attempts at paternalism, particularly in the context of sexually active young women. For instance, she cites the Wayward Minor's Court for Girls and its parallel women's court founded by Judge Anna Kross in the 1930s. They had individualized treatment plans and no formal guilt finding procedures. Quinn claims that emerging civil rights, appointment of counsel standards, and rights of privacy became inconsistent with this kind of social engineering.¹¹⁹ Presiding judge of the Colorado Second Judicial District, Morris Hoffman (Hoffman) contends that the courts have quietly refocused on post-adjudicative treatment and are officially becoming what he claims they have always been, merely expensive and glorified probation.¹²⁰ Berman from the Center for Court Innovation claims they represent a change in methodology rather than a theory of justice.¹²¹ Henry Steadman (Steadman) maintains that some problem solving courts, particularly mental health courts, have so little definition and such unstandardized models that they could in fact be any diversion program.¹²²

Others, however, see the courts, their wide acceptance, and their rapid proliferation as signaling a larger shift in the U.S. criminal justice system.¹²³ Heather Barr (Barr) explains that the values of particular offenses are altered in the courts while treat-

118. Mae C. Quinn, *The Modern Problem-Solving Court Movement: Domination of Discourse and Untold Stories of Criminal Justice Reform*, 31 WASH. U. J.L. & POL'Y 57, 79–80 (2009).

119. Quinn, *supra* note 118, at 70–76.

120. Morris B. Hoffman, *The Rehabilitative Ideal and the Drug Court Reality*, 14 FED. SENT'G REP. 172, 172–78 (2001).

121. Berman & Feinblatt, *supra* note 79, at 1313–19.

122. Steadman et al., *supra* note 76.

123. See generally, Tamar M. Meekins, *Specialized Justice: The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1 (2006).

ment is changed into a new punishment option.¹²⁴ Problem-solving courts have been likened to a developing postmodern critique of traditional judiciary and a manifestation of Foucault's governmentality.¹²⁵ Analyzing courts through governmentality shows a substantive change in criminal justice, according to Frank Sirotych (Sirotych), as guilt becomes subordinate to diagnosis, authority over an individual moves to the accused based on their psychological makeup rather than conduct, non-conformity rather than past criminality is sanctioned, and the accused is employed as an agent in his or her own rehabilitation.¹²⁶

Political alliance to liberal or conservative ideology breaks down in this context, just as it did during debates over the therapeutic state and rehabilitative ideal. The worth of drug and mental health courts is no longer a clear liberal or conservative issue. Hoffman asserts their political popularity comes from the perception that supporting this intervention will give them cover from contentious issues.¹²⁷ The political ambiguity of drug and mental health courts is partly because of the movements' complex relationship with an emerging ideology of effectiveness. They seem to be politically compatible with different ideologies in many cases because of their utilitarian aims, particularly cost effectiveness, but such effectiveness has perhaps not been sufficiently proven. Thus, the political and symbolic capital of effectiveness and innovation has become more important than evidence of effectiveness or newness. Sirotych calls this an "ascendance of an economic rationality behind the governance of crime and criminal justice."¹²⁸ On the other hand, Seddon counters that framing the debate about whether it works is misleading as the heart of the debate is really about different conceptions of freedom and risk.¹²⁹ Barr seems to agree, claiming that even if we knew they worked, we have to ask what

124. Heather Barr, *Mental Health Courts: An Advocate's Perspective*, URBANJUSTICE.ORG, <http://www.urbanjustice.org/pdf/publications/mentalhealth/MentalHealthCourts.pdf>.

125. See generally, Edward G. Armstrong, *The Drug Court as Postmodern Justice*, 16 CRITICAL CRIMINOLOGY 271, 275 (2008).

126. Sirotych, *supra* note 76, at 12.

127. Hoffman, *supra* note 120, at 174.

128. Sirotych, *supra* note 76, at 12.

129. See generally, Toff Seddon, *Coerced Drug Treatment in the Criminal Justice System*, 7 CRIMINOLOGY & CRIM. JUST. 269, 280 (2007).

they are substantively doing, in terms of their social, economic, and political functions.¹³⁰ Their lack of clear goals and defined success complicates every effectiveness study. It is likely, however, that most conservative or radical criticisms of the courts have been framed in advance of first hand examination of the bases and functioning of the courts themselves.¹³¹

Critiques of drug and mental health courts range from the belief that there are procedural problems, which could be mended to contentions that intrinsic problems render problem-solving courts untenable and even dangerous. Advocates of the courts claim isolated bad practices do not negate the positive innovation, while critics lament that a few, publicized successes do not override a flawed model. Berman believes there is no case to be made that bad practice is intrinsic to the courts; the opposite is in fact true, as they are closely watched experiments.¹³² What is agreed upon is the status of the emergence of the courts as a judicial experiment, and thus the merit of an experimentalist government is at stake. Court advocates claim that the different roles and team approach, cross training, involvement of experts from the mental health system, multiple layers of services, voluntary informed consent, and appropriate sanctions are positive judicial innovations.¹³³ According to Michael Dorf (Dorf) and Charles Sabel (Sabel), experimentalism allows for monitoring and information pooling. It enables and obliges continual improvement as a program must change in response to the change it facilitates, simultaneously monitoring and acting without facing tradeoffs between efficacy and accountability.¹³⁴ They think accountable government is reimagined by drug courts specifically.

Acquaviva contends that mental health courts are no longer experimental, as they are part of the criminal justice system.¹³⁵ In fact, he claims, the pilot model is what leads to some of their procedural problems as they have inadequate funding and need more

130. Barr, *supra* note 124.

131. Armstrong, *supra* note 125, at 282.

132. Greg Berman, *Redefining Criminal Courts: Problem-Solving and the meaning of Justice*, 41 AM. CRIM. L. REV. 1313, 1314 (2004)

133. See Lurigio & Snowden, *supra* note 102.

134. Michael C. Dorf & Charles F. Sabel, *Drug Treatment Courts and Emergent Experimentalist Government*, 53 VAND L. REV. 829, 829 (2000).

135. See generally, Acquaviva, *supra* note 1.

community support, personnel, and permanent infrastructure. Calls have been made to further institutionalize problem solving type innovations throughout the justice system, outside of specialized courts.¹³⁶ Quinn sees these contentions as constituting a linear success story of the problem solving movement that obscures other experiences, particularly a negative history of criminal court experimentation in the U.S.¹³⁷

At least five interconnected groups of criticisms of drug and mental health courts exist that, if true, condemn their inherent viability, purpose, and value. The Foucauldian critique resembles those of the therapeutic state and condemns the potential coercion and social control of such an intervention. Foucault's formulation of governmentality claims that power is exerted by subtle discipline, which manifests as internal coercion and can cause coerced choices to appear freely chosen. Seemingly value-neutral medicalization processes are a veil for social forces. Participants in mental health courts have the illusion of voluntariness and control while the state's power for social control is actually increasing. Problem solving courts and therapeutic jurisprudence equate justice with therapy but in actuality, according to this Foucauldian critique, forced treatment, justified by TJ according to the author, is harmful and unjust in and of itself.¹³⁸ Benedikt Fischer (Fischer) claims drug courts are a microcosm of governmentality as well, serving to increase the role of medical professionals in controlling deviant behavior.¹³⁹ He contends, however, that they are actually reinforcing punishment ideals, since treatment components are always tied to punishments.¹⁴⁰ It is for this reason that Fischer claims there is little to no novelty in problem solving courts.¹⁴¹ Sirotich, also

136. See generally, Donald J. Farole et al., *Applying the Problem-Solving Model Outside of Problem-Solving Courts*, 89 JUDICATURE 40 (2005).

137. Quinn, *supra* note 118, at 58.

138. See generally, James L. Nolan, Jr., *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 40 AM. CRIM. L. REV. 1541 (2003).

139. See generally, Benedikt Fischer, *Doing Good with a Vengeance: A Critical Assessment of the Practices, Effects, and Implications of Drug Treatment Courts in North America*, 3 CRIM. JUST. INT'L J. POL'Y & PRAC. 227, 244 (2003).

140. Fischer, *supra* note 139, at 241.

141. *Id.* at 241–42.

equating problem-solving courts with governmentality, comes to the opposite conclusion.¹⁴² He believes the emergence of problem solving courts reproblematises crime regulation and newly rationalizes governance of criminal justice because of a significant permeation of human services in the criminal justice system, the focus on the potential of an individual rather than the crime, and the utilitarian economic principles upon which the courts are based.

The coercive nature of the intervention has been called an inherent flaw.¹⁴³ Winick frames the decision to participate in a PSC as a constrained choice as opposed to coercion, but admits that whether or not the decision is really voluntary is one of the most important questions in determining their worth.¹⁴⁴ However, Christin Keele (Keele) claims that 95% of mentally ill offenders choose the mental health court system when given the option.¹⁴⁵ Dorf & Sabel remind us that treatment outside the criminal justice court system can be coercive as well.¹⁴⁶ In Winick's dialogue with Susan Stefan, she contends mental health courts are social control cloaked as beneficence; even if they are not more coercive than outpatient commitment or other diversion/treatment programs, they are more effective at being coercive.¹⁴⁷ Toff Seddon (Seddon) elucidates three principles underlying coerced treatment—a causal connection between addiction or mental illness and crime, that treatment is effective at reducing drug or mental illness-related crime, and that coerced treatment is effective treatment.¹⁴⁸ All three principles are at least somewhat precarious, particularly in the context of mental health courts.

The criminalization critique contends the very existence of the courts causes net-widening when law enforcement officers arrest more drug addicted and mentally ill offenders for low level crimes that they would not have been arrested for before the courts' emergence because the police know they probably will not go to jail and will get some kind of treatment or service. This cri-

142. Sirotych, *supra* note 72.

143. Seltzer, *supra* note 98, at 571.

144. See Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1754 (1992).

145. Keele, *supra* note 89, at 199.

146. Dorf & Sabel, *supra* note 134, at 868–74.

147. Stefan & Winick, *supra* note 90, at 516, 519.

148. Seddon, *supra* note 129, at 270.

tique claims MHCs increase the clutchability of mentally ill individuals. Several studies contend that mental health courts expand criminalization, particularly because they cannot help people actually facing lengthy prison sentences at all.¹⁴⁹ Judge Hoffman describes four unintended consequences of problem solving courts; the first is net-widening, and the second and third are the consequences of this process.¹⁵⁰ MHCs can reinforce criminalization of mental illness by unintentionally signaling a public acceptance of the rates in which people with mental illness are entering the criminal justice system, thus representing an inherent flaw in mental health courts.¹⁵¹ Additionally, rather than aiding, dispelling, or further researching the causative connection or correlation between mental illness, addiction, and criminal activity discussed above, reinforced criminalization could perpetuate this assumption, contributing further to increasing stigma and discrimination, the basis of the third major critique of specialty problem solving courts.¹⁵²

The segregation critique acknowledges the unintended consequences of stigma and separation. Susan Stefan admits that mental health courts were formed to ameliorate large structural issues and to address the ill-equipped criminal justice and penal systems that criminalize and thus discriminate against the mentally ill population.¹⁵³ However, she asks for inherent suspicion and distrust of any system created for the explicit purpose of segregating a marginalized group: "The obvious solution when a criminal justice system acts in discriminatory ways is to fix the criminal justice system and end the discrimination, not to create a separate system."¹⁵⁴ In the words of Feinberg, a long held tenet of the criminal justice system is that similar cases are treated in similar ways and

149. Heather Barr, *Mental Health Courts: An Advocate's Perspective*, URBANJUSTICE.ORG, <http://www.urbanjustice.org/pdf/publications/mentalhealth/MentalHealthCourts.pdf>; see generally, Barr, *supra* note 90.

150. Morris B. Hoffman, *Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism: the Least Dangerous Branch Becomes Most Dangerous*, 29 FORDHAM L. REV. 2063, 2085-97 (2001).

151. Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses*, 11 PSYCHOL. PUB. POL'Y & L. 570 (2007).

152. *Id.*

153. Stefan & Winick, *supra* note 90, at 511.

154. *Id.*

dissimilar cases are treated in dissimilar ways.¹⁵⁵ However, what kinds of differences allow for dissimilar treatment is contentious. The perceived need for this separate system comes from a history of stigma against individuals with psychiatric disability and addiction but could also engender additional stigma. Allen holds that the true challenge for TJ and mental health policy will be minimizing stigma, prejudice, and discrimination.¹⁵⁶

The legal critique explicates tensions problem-solving courts have with traditional legal purpose and practice. The roles of the courtroom actors are different, particularly, judges and defense attorneys.¹⁵⁷ One of the largest concerns is that problem-solving courts decrease procedural due process.¹⁵⁸ An expert panel discussion elucidated several more legal concerns such as the reinforcement of the order-preserving function of courts as opposed to the rights-preserving function.¹⁵⁹

It is not among the purposes of courts to serve as a recruiting office for treatment programs. When moral fervor overtakes justice and the effort to be responsive is overwhelmed by the politics of punishment, the appropriate use of therapeutic and restorative alternatives in the work of the courts is seriously undermined.¹⁶⁰

The fifth critique I will offer comes from a public health perspective and mainly regards the merit of using the criminal justice system to access treatment resources, the utilization and distribution of those resources, and finally, the question of whether drug and mental health courts live up to the challenge of addressing the root cause of problems as they were intended. Many PSC critics

155. Feinberg, *supra* note 117.

156. See generally, Alfred Allan, *The Past, Present, and Future of Mental Health Law: A Therapeutic Jurisprudence Analysis*, 20 LAW IN CONTEXT 2, 24–53 (2003).

157. See Tammy Seltzer, *Mental Health Courts: A Misguided Attempt To Address The Criminal Justice System's Unfair Treatment Of People With Mental Illnesses*, 11 PSYCHOL. PUB. POL'Y L. 570 (2005).

158. See generally, Albert J. Grudzinskas & Johnathan C. Clayfield, *Mental Health Courts and the Lesson Learned in Juvenile Court*, 32 J. AM. ACAD. PSYCHIATRY & L., 223 (2004).

159. See generally, Carl Baar et al., *What the Data Shows*, 29 FORDHAM URB. L.J. 1827 (2002).

160. *Id.* at 8331.

and mental health advocates believe that the criminal justice system is not the appropriate front door to mental health care, particularly when that care is compulsory and it is likely that the offender has voluntarily sought treatment in the past and been denied access.¹⁶¹ This concern becomes even more prescient if net-widening really does occur and treatment becomes a justification for arrest. Even if it is an inappropriate front door, access to care can help break a recidivist or revolving door cycle. However, few mental health courts have any comprehensive plan to address the underlying service system failure that necessitated their emergence.¹⁶² Therefore, Robert Bernstein (Bernstein) and Tammy Seltzer (Seltzer) conclude they cannot solve the systemic problems that cause disproportionate criminalization of the mentally ill.¹⁶³ Additionally, according to McCoy's research, there is no evidence that courts are better at coordinating or providing services, particularly in the mental health realm, than other entities.¹⁶⁴ Funding these court treatment programs could exacerbate the original problem, the lack of funding, and support for social welfare agencies.¹⁶⁵

Corey Shdaimah (Shdaimah), while on an advisory board starting a prostitution PSC, worried that they were appropriating public resources and placing them under criminal justice system purview.¹⁶⁶ It also remains unclear whether the availability of services is actually increasing or whether PSC defendants are moving to the front of the line for existing resources.¹⁶⁷ Arthur Lurigio (Lurigio) and Jessica Snowden (Snowden) found that 63% of mental health courts studied had no influence over their health or social services networks and that participants still faced a paucity of treatment options, showing the lack of effect the courts have had on the systemic failure of mental health care.¹⁶⁸ It also remains possible that providing service to some individuals through the

161. Seltzer, *supra* note 98, at 582.

162. Bernstein & Seltzer, *supra* note 99, at 161–62.

163. *Id.*

164. See McCoy, *supra* note 83.

165. *Id.*

166. Corey Shdaimah, *Taking a Stand in a Not-So-Perfect World: What's a Critical Supporter of Problem-Solving Courts to Do?*, 10 U. MD. L. J. RACE, RELIGION, GENDER & CLASS 89, 101 (2010).

167. Steadman et al., *supra* note 76, at 458.

168. Lurigio & Snowden, *supra* note 102, at 212.

criminal justice system will lead to further fragmentation of service delivery. “The very problems that brought the MHCs into existence make it unlikely that they can succeed in their mission.”¹⁶⁹

In contrast, several advocates hold their ground that treatment for mental illness and drug addiction is the best hope for society, no matter the immediate results, as there is often greater consequence in the failure to compel treatment.¹⁷⁰ Despite the unknown causal connection between addiction, mental illness, and crime, it is clear there is striking overlap between public health threats, drug abuse, and crime. Thus, the criminal justice system should be recognized as a point of contact or a bridge for connections to health services, despite the connections remaining poorly understood. Therefore, according to advocates, drug and mental health courts represent an innovative approach to linking those in need of treatment in the criminal justice system to health services.¹⁷¹ Despite this reality, Barr, a staunch mental health advocate, contends that the outcomes of MHCs are more beneficial to the criminal justice system than the mental health community.¹⁷² When truly beneficial and criminalization-reducing structures are set up in MHCs, they become politically problematic and detrimental to the criminal justice system: “Mental health courts will not fix the mental health system. In fact, their efficacy will be limited and undermined by the deficits of the mental health system.”¹⁷³

Though both conflicted in purpose, MHCs and drug courts were both created with the expressed purpose of dealing with root causes as opposed to symptoms of particular problems. Whether they are inherently capable of doing that and if so, whether they have lived up to that mission, is dubious. Judge Hora contends drug courts are capable of addressing the root causes of drug related crime¹⁷⁴ and Roberts from the Department of Justice agrees

169. Stefan & Winick, *supra* note 90, at 510.

170. See generally, Joseph E. Gubbay et al., *The Changing Face of Justice: The Evolution of Problem Solving*, 29 FORDHAM URB. L.J. 1790 (2002).

171. Suzanne L. Wenzel et al., *Drug Courts: A Bridge Between Criminal Justice and Health Services*, 29 J. CRIM. JUST. 241, 241 (2001).

172. Barr, *supra* note 124.

173. *Id.*

174. See generally, Peggy Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice Sys-*

that they deal with the addiction causing crime as opposed to the resulting crime.¹⁷⁵ He claims there is anecdotal evidence beyond evaluations and recidivism data that they are working for this purpose, creating a much better system than the traditional courts have. Most mental health advocates are much more skeptical, claiming the existence of mental health courts makes it more difficult to generate political will to deal with the actual root of the problem. The paradox created by a court-based program requiring arrest for participation in order to address the overrepresentation of people in jails and prisons with mental illness renders it hopeless. Substantial gaps in community treatment, precisely what is not affected by appropriating treatment for the criminal justice system, is the actual root cause of criminalization.¹⁷⁶

Different understandings of the root causes of criminalization, mental illness, crime, addiction, and drug use exist in the literature. However, as a solution stemming from judges and stakeholders within the court system, drug and mental health courts were not created to deal with the root causes or social determinants of the public health problems within the criminal justice system, but the root causes of the excessive involvement of populations with those problems with the criminal justice system. The crux of the public health critique of drug and mental health courts is that they are an intervention born of the criminal justice system whose success is mainly determined by outcomes benefitting that system.

Shdaimah calls himself a critical supporter of PSCs, mainly because they are better than what is currently predominating.¹⁷⁷ “If advocates of PSCs are serious about wanting to ameliorate social conditions that underlie crime, the best thing they can do is heed concerns raised by the most vulnerable members of society and their representatives.”¹⁷⁸ Dorf and Sabel contend drug courts shouldn’t be attacked, as public or mental health advocates should fight for better treatment outside the criminal justice system as well; the perfect should not be the enemy of the good.¹⁷⁹ Though

tem’s Response to Drug Abuse and Crime in America, 74 NOTRE DAME L. REV. 439 (1999).

175. Gubbay et al., *supra* note 170.

176. Seltzer, *supra* note 98, at 583.

177. Shdaimah, *supra* note 166, at 110.

178. Shdaimah, *supra* note 166, at 110.

179. Dorf & Sabel, *supra* note 134.

not ideal, the criminal justice system as it is right now needs to be integrated into the continuum of care for mentally ill offenders and addicts.¹⁸⁰ If Seltzer is incorrect in arguing that PSCs can actually be counterproductive to the public health mission, and if they really are analogous to a criminal justice harm reduction intervention, they could be an imperfect but effective way to alleviate the harmful effects of criminalization.¹⁸¹ However, part of the mission of drug and mental health courts is to affect root causes. Should this be factored into measuring their success or merit?

Shdaimah contends PSCs cannot represent a true public health approach as they lack a real preventative function; they are an intervention at the point of failure.¹⁸² Andrew Wasicek (Wasicek) disagrees and maintains that these courts can recharacterize the criminal justice system as a social service provider and address the root causes of criminal behavior if they are thought of as tertiary prevention.¹⁸³ Primary prevention in the shape of reforming the mental health system and secondary prevention in the shape of specialized police response must be carried out in tandem.

However, what the deepest determinants of crime actually are is highly contested. Many people with serious mental illness have exacerbated problems because of the social settings in which they live: “. . . [H]omelessness, crime, undereducation, and underemployment are endemic to such neighborhoods. A large percentage of poor persons experience these difficulties—irrespective of whether they have mental illness or not—which render them more susceptible to criminal activities and victimization.”¹⁸⁴ In many ways, an intervention born of the criminal justice system as opposed to the public or mental health system that contends theoretical beginnings cannot hope to combat root causes of crime, mental illness, or addiction. Innovative interventions for drug or mental-illness related crime does not necessarily imply an innovative strategy to preventing or altering society’s response to addiction or

180. Grudzinskas & Clayfield, *supra* note 122, at 226.

181. *See generally*, Seltzer, *supra* note 98.

182. Shdaimah, *supra* note 166.

183. *See generally*, Andrew Wasicek, *Mental Illness and Crime: Envisioning a Public Health Strategy and Reimagining Mental Health Courts*, 48 CRIM. L. BULL. 106 (2012).

184. Lurigio & Snowden, *supra* note 102, at 197.

mental illness.¹⁸⁵ Deborah Small from the Lindesmith Center reminds us that drug courts stem from the inability to deal with the contradiction posed by the disease model of addiction and the illegality of drugs. Similar contradictions exist within the criminalization of mental illness which renders the clutchability of offenders in drug and mental health courts uncertain. For this reason we have to remember that drug and mental health courts are a kind of compromise, a way of using the criminal justice system to deal with problems that are ultimately social or even medical and recognizing that although it will never be completely successful at dealing with those problems, it could address their harmful consequences.¹⁸⁶

Seemingly value-neutral late-modern ideas like diversion, effectiveness, or therapeutic actually represent powerful codes or agendas of morality.¹⁸⁷ However, because of their political palatability, complicated histories, and vague nature, they can be co-opted. These ideologies if ill understood, as Kittrie feared four decades ago, can become unchecked and used to justify social control, increased clutchability, or even reinforce criminalization that they were once used to combat.

In his 1983 paper *The Dilemma of Criminal Responsibility*, Bazelon contended that the insanity defense was rightly under scrutiny, but for misguided reasons. He condemned keeping the legal system's purposes separate from potential therapeutic ends and believed it is "only through an expansion of our tests of criminal responsibility that we can hope to alert the community to the root causes of crime...to move toward solutions."¹⁸⁸ Bazelon grew disillusioned to the application of psychiatry to criminal law as it became clear to him that criminal responsibility, guilt or innocence, was a societal issue, a moral question rather than a medical one: "We will never resolve the problem of crime without first addressing its root in poverty and social injustice."¹⁸⁹

185. See generally, Candace McCoy, *Politics of Problem-Solving: An Overview of the Origins and Development of Therapeutic Courts*, 40 AM. CRIM. L. REV. 1513 (2003).

186. See generally, Gubbay, *supra* note 170, at 1970.

187. Fischer, *supra* note 139, at 244.

188. Bazelon, *supra* note 25, at 264.

189. *Id.*

The unclear goals and contested ideas of success represent a chasm between the theory and practice of these courts, which really does matter here. Is this gap because of a conflicting ideological basis for the courts? Is the tension rectifiable or are the problems inherent to the structure of drug and mental health courts? What is their actual relationship to applied TJ? Does applied TJ require specialty courts, or are they a distortion of this ideal? Perhaps answering these questions can allow for a more informed critique of drug and mental health courts based on a deeper understanding of what they should and can accomplish.

APPLIED TJ AS MENTAL HEALTH COURT IDEOLOGY

There is a rift between the rhetoric and reality of modern problem-solving court reform.¹⁹⁰ Because of tensions created by positions of various stakeholders, concerns for efficacy, fairness, and procedural justice, and the legal and service providing aspects of the courts, the goals of drug courts and MHCs may be in conflict. Mixed ideology can lead to paradoxical practices, particularly if punishment and treatment are truly irreconcilable. Because mental health courts involve actions classified as criminal and individuals classified as diseased, a theory behind them is needed that does not result in fundamentally conflicting assumptions, practices, and goals.¹⁹¹ Additionally, a “coherent theoretical justification should support the decision to create a separate system of justice for a historically stigmatized population.”¹⁹² Wasicek has faith that PSCs could be touted as a partial solution to criminalization, but only if certain changes are made, as a more elaborate theoretical model is needed for a more robust policy solution.¹⁹³ Astrid Birgden (Birgden) tentatively agrees that PSC aims are in line with TJ, as they both attempt to balance therapeutic ideals and justice principles.¹⁹⁴ Mental health courts were developed explicitly as applied therapeutic jurisprudence but still embrace contrary and often antagonistic purposes. There is no rigorous inquiry into the

190. Quinn, *supra* note 118.

191. Fisher, *supra* note 139.

192. E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 523 (2011).

193. Wasicek, *supra* note 183.

194. Birgden, *supra* note 3, at 388.

connection between one offender's mental illness and their corresponding criminal behavior. Thus, they are in danger of reinforcing stigma, isolation, and stereotypes regarding mental illness's connection with criminality. Particularly because MHCs are merely separated from the criminal court because of the disease and not the crime, they shift the rationale of clutchability to reasons of illness as opposed to just criminal behavior. The discussion regarding whether applied therapeutic jurisprudence is robust enough for problem solving courts, and whether TJ necessitates specialty courts, is relevant to both drug and mental health courts despite their different relationships with TJ as they both rest on conflicting utilitarian and therapeutic principles.

Berman, a problem-solving court advocate, cautions against the conflation of TJ and problem-solving courts.¹⁹⁵ TJ, Berman says, is either a political liability causing some stakeholders to shy away or a label that does not adequately describe the origins or methods of the courts. There is too much of the rehabilitation ideal in TJ, and much of the court's activities are not meant for therapeutic purposes. In order to keep the problem solving court model from being co-opted, McCoy claims there needs to be an agreed upon theory and method.¹⁹⁶ TJ is becoming the universal answer to this problem but has its own danger of being co-opted as well.

TJ is simultaneously accused of justifying paternalism by finding coercion therapeutic and justifying anti-psychiatric, civil-libertarian sentiments by finding that refusal of treatment could be more therapeutic than compulsory treatment. Edward Armstrong (Armstrong) describes the conservative critique of TJ as claiming it is anti-intellectual, de facto legalization, amateur psychiatry, and soft on crime.¹⁹⁷ The radical critique claims TJ is not the paradigm shift that is needed, but a political strategy using symbolism to hide the hegemony of punitive social control, a reaffirmation of addiction policy, human experimentation, and a perversion of authentic humanitarian concern.

TJ has several problems, which may prevent it from providing solid theoretical guidance for problem solving courts or gener-

195. Berman, *supra* note 132, at 1314–15.

196. McCoy, *supra* note 83.

197. Edward G. Armstrong, *The Drug Court as Postmodern Justice*, 16 CRITICAL CRIMINOLOGY 271, 281–82 (2008).

ally being unable to justify the divergence between PSCs and traditional courts. Firstly and perhaps more fundamentally, applied therapeutic jurisprudence may be an oxymoron. Johnston, in arguing that TJ is insufficient for mental health courts, claims that it does not find a means to mediate competing values as it is only a research agenda or a field of inquiry.¹⁹⁸ The refusal to define therapeutic with precision, what Slobogin deemed the Definitional Dilemma, means that what one decides is therapeutic will vary by previous ideology, interests, values, or perspectives and make it virtually impossible to measure the therapeutic outcomes of drug or mental health courts. Hoffman agrees that TJ is functionally untestable empirically.¹⁹⁹ TJ claims to only call for altering a legal decision in favor of therapeutic aims “all else being equal” in an attempt to remain neutral and normative regarding rehabilitative ideology, but Johnston amongst others points out that there is no set way to determine when other values are in equilibrium, so TJ is at risk of promoting therapeutic values arbitrarily.²⁰⁰ For instance, MHC’s concerns with treatment as opposed to blame could undermine the traditional court system in general, and TJ, though not rendered totally useless, cannot deal with this issue because of what Slobogin called TJ’s balancing dilemma, the inability to balance internal and external interests.

Samuel Brakel (Brakel) claims the commonsense perspective of public health and legal powers was fundamentally to facilitate treatment.²⁰¹ In light of this, Brakel claims TJ is essentially redundant and unhelpful for rectifying mental health care problems or recognizing the successes of mental health law. He attests that the whole conception of TJ is spurious verbal association and an epistemological free fall, skewing the history of mental health law, denying the efficacy of treatment, and engaging in the misapprehension of the nature of mental illness. He claims TJ has skewed ethics; instead of focusing on compulsion and wrongful coercion, access and wrongful withholding of treatment are the real prob-

198. Johnston, *supra* note 192.

199. Hoffman, *supra* note 150, at 2079.

200. Johnston, *supra* note 192, at 17.

201. See generally, Samuel J. Brakel, *Searching for the Therapy in Therapeutic Jurisprudence*, 33 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 455 (2007).

lems of today. Brakel does think that the law has failed to keep up with psychiatry, but contends the answer is not to eschew the purpose of the law as he claims TJ does. Quinn does not attack the idea of TJ but its application, which she believes departs significantly from its scholarly claim of being a lens.²⁰²

In application, the movement lost form and substance and ended up assuming guilt in the criminal defense population. Quinn says TJ became overly idealistic as “no rehabilitative plan of service provided through our overworked criminal courts can even begin to address this multifaceted problem.”²⁰³ Unlike the study of biological-psychiatric roots of violence,²⁰⁴ this emerging scholarship attempts to sidestep their importance by focusing on a seemingly agreed upon positive outcome. However, it actually ends up assuming ideology and conceptions of the roots of violence, thus making them implicit in many drug courts and mental health courts.

One of TJ’s major problems allowing it to be appropriated on all sides is its refusal to acknowledge its connection to rehabilitation or the therapeutic state. Hoffman²⁰⁵ calls TJ ineffective and dangerous, as it treats complex behavior as a fictitious disease. Hoffman gleans how its proponents rarely question its theoretical heritage: “[b]y expanding the therapeutic model into non-mental health areas, the TJ movement not only intrudes without any basis for intrusion, it profoundly changes the judicial function.”²⁰⁶ It blurs the distinction between action and excuse, victim and offender, without being able to deal with the consequences.²⁰⁷ Hoffman worries that despite its intention as interdisciplinary reflexivity, TJ rhetoric runs the risk of legitimating medical authority under the guise of benevolent therapeutic intervention.²⁰⁸ He maintains that most proponents of drug courts do not believe drug use should be a crime so they use prison as a sanction for refusing

202. See generally, Mae C. Quinn, *An RSVP to Professor Wexler’s Warm Therapeutic Jurisprudence Invitation to the Criminal Defense Bar: Unable to Join You, Already (Somewhat Similarly) Engaged*, 48 B.C.L. 539 (2007).

203. Quinn, *supra* note 202.

204. BAYER, *supra*, note 10.

205. See generally, Hoffman, *supra* note 150.

206. Hoffman, *supra* note 150, at 2084.

207. Bernstein & Seltzer, *supra* note 99.

208. Hoffman, *supra* note 150.

treatment rather than the crime itself. In other words, they alter the offender's clutchability to be justified because of treatment refusal rather than criminal action or illness itself. The new therapeutic courts, drug and mental health courts, are based on what Hoffman and Szasz both believe are medicalized choices, as free will becomes a "shadowy illusion of looming disease."²⁰⁹ Hoffman firmly believes drug courts are neo-rehabilitation serving to "dehumanize objects of our humanitarianism."²¹⁰

E. Lea Johnston (Johnston)²¹¹ believes TJ is insufficient as a utilitarian justification for mental health courts not because it is ideologically dangerous but because by definition, TJ cannot solve conflict, which is exactly what mental health courts aim to accomplish. She also believes an earlier and more integrated rehabilitation theory is insufficient as it assumes a causal connection between mental illness and crime that might not exist for the MHC population. A TJ conception with a more robust historical, rehabilitative awareness could potentially support PSCs better but would end up calling for general systemic change, as opposed to specialty courts based, on real criminogenic risks, not just mental illness and addiction.²¹² Wexler and Winick have consistently advocated for general integration of TJ principles as opposed to a separate system of applied TJ as well.

TJ claims that mental health law ignores the effects of the very rules it establishes and aims to focus on practical outcomes of the law, what Fred Cohen and Joel Dvoskin call a functional attitude, as opposed to ideology or rights, and this garners high praise.²¹³ However, John Petrla (Petrla) mentions that it fails to question whom decides what represents a therapeutic outcome. It is here that Petrla claims, despite the intentions of Wexler and Winick, lies the inherent paternalism of TJ.²¹⁴ As opposed to

209. *Id.* at 176.

210. *Id.* at 177.

211. *See generally*, E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 1 (2011).

212. Johnston, *supra* note 211, at 1.

213. *See generally*, Fred Cohen & Joel Dvoskin, *Therapeutic Jurisprudence and Corrections: A Glimpse*, 10 N.Y.L. SCH. J. HUM. RTS. 777-04 (1993).

214. John Petrla, *Paternalism and The Unrealized Promise of Essays in Therapeutic Jurisprudence*, 10 N.Y.L. SCH. J. HUM. RTS. 877, 891 (1993) (ex-

Brakel, Petrila fears TJ idealizes the experience of mental health treatment, and assumes, despite evidence from early arguments over the therapeutic state, that therapeutic ends are an obvious goal. Without inherent recognition of its ideological genealogy and without a clear definition of therapeutic, TJ cannot be meaningfully applied.

CONCLUSION

Therapeutic jurisprudence, drug treatment courts, and mental health courts have historical roots in rehabilitative justice and the therapeutic state despite their consistent focus on effectiveness and reluctance to associate themselves with such movements. However, TJ and PSCs do not represent judicial deference to psychiatry as argued in the 1960s and 70s but a new form of judiciary that is becoming a kind of helping profession. Determining whether drug and mental health courts truly are a public health approach to criminal justice, we must explore whether they meet the challenge they set out for themselves – to address the root causes of the problems necessitating their own emergence.

As PSCs consistently emerge throughout the country for prostitution, domestic violence, sexual abuse, quality of life offenses, and several other categories, historically and ideologically based criticisms must be taken into consideration or unintended consequences might not be foreseen. There is no heuristic for figuring out what types of social problems or what types of crime are amenable to problem solving courts.²¹⁵ Much of the justification for drug and mental health courts lies in the disease model of addiction and mental illness. Is a scientific basis for disease classification necessary for a functioning problem solving court? Additionally, it is difficult to truly tackle how the criminalization of drug use and prostitution, for instance, could be root causes of public health and criminal justice problems that PSCs could never address since an individual's clutchability often relies on the illegality of the offenders' combined actions and psychology. Process

plaining how mental health law fails to question who is deciding what represents a therapeutic outcome).

215. Dorf & Fagan, *supra* note 80, at 1507.

concerns can be dealt with by legal scholars and could improve the efficacy of mental health courts, but without recognition of their historical position, ultimate goals, and systemic impact on both criminal justice and public health, outcome effectiveness will become its own ideology, and the problem solving court methodology could proliferate without a coherent goal. Furthermore, without a coherent underlying ideology, drug and mental health courts will be left with conflicting purposes, paradoxical practices, and confused measures of success. Even Bazelon argued, however, that steps need to be taken in the meantime to help the ailing criminal justice system. Drug courts, mental health courts, and emerging PSCs are a positive step for the this system as long as they do not distract public health from recognizing the complex ideological history of rehabilitation in terms of what really makes an individual clutchable for the state and addressing the root causes of problems like prostitution, addiction, and mental illness.

The Black Box Warning: Antidepressant Medication, Monitoring, HIPAA Confidentiality, and Suicide

A LETTER TO CONGRESS

BY: WARREN HOWE* DONNA VEREST**

On April 24, 2013, the staff of the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, sent a Memorandum to Subcommittee members addressing the question: “Does HIPAA (The Health Insurance Portability and Accountability Act of 1996) Help or Hinder Patient Care and Public Safety?”¹ A hearing on the subject was to be held in two days, April twenty-sixth.² The Memorandum emphasized a finding based on testimony obtained during an earlier Subcommittee sponsored bipartisan public forum, on March 5th, an event inspired by the tragic December 12, 2012 school shooting at Newtown, Connecticut.³ The forum concluded that “[t]he inability of families and caregivers to obtain crucial health information affecting the care of

* Warren Howe, Ed.D., is a mental health advocate in Washington, DC. He holds a Doctor of Education Policy & Administration Degree from Fordham University.

** Donna Verest is a health care administrator in Washington, D.C., with expertise in medical costs and finance.

1. Memorandum from the House Comm. on Energy and Commerce, Subcommittee on Oversight and Investigations (Apr. 24, 2013) (hereinafter Memorandum). *See also Does HIPAA Help or Hinder Patient Care and Public Safety?*, 113th Cong. (2013).

2. *See* Deven McGraw, *Does HIPAA Help or Hinder Patient Care and Public Safety?*, (Apr. 26, 2013), http://www.cdt.org/files/pdfs/McGrawHIPAA_testimony.pdf

3. *See id.*

a loved one can have tragic consequences.”⁴ The staff report cited a case where mental health care providers were unwilling to share with a father their concerns about the self-destructive tendencies of his son who eventually took his life.⁵ The absence of communication with the parent was considered a contributing factor in the suicide.⁶

This letter addresses a similar case.⁷ Several years before the Newtown shooting and follow-up Congressional investigation, in November 2008, a woman – whom we shall call Paula⁸ – was under treatment for depressive illness and took her life. Paula was a wife, mother, and grandmother. She had been taking the antidepressant, Effexor.⁹ Her doctor changed her prescription and placed Paula on Effexor XR four days before her death.¹⁰ Several circum-

4. Memorandum, *supra* note 1. *The Health Insurance Portability and Accountability Act* became law in 1996 and is intended to protect the privacy of individually identifiable health information. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191 (Aug. 21, 1996). Patients have an array of rights with respect to that information, including when a patient’s health information can be shared with family and others. *Id.*

5. *Id.*

6. *Id.*

7. This letter is motivated by the authors’ belief that significant improvements in mental health care can be accomplished if Congress and the medical community address several issues of health policy, especially those relating to HIPAA confidentiality.

8. To preserve confidentiality, the name, Paula, is fictitious.

9. Effexor is an antidepressant used to treat depression and anxiety disorders. *About Effexor XR*, EFFEXORXR.COM, <http://www.effexorxr.com/about-effexor-xr.aspx> (last visited Dec. 14, 2013) (hereinafter *About Effexor XR*).

10. Effexor XR is an extended release form of effexor. *Id.*

11. The circumstances involve family awareness of patient mental health care and constitute the substance of this letter: (1) the HIPAA Privacy Rule, confidentiality, and the challenge of mutual understanding between doctor and patient; (2) accurate diagnosis of the patient’s illness with consideration of family input; (3) monitoring the patient on anti-depressant medication, especially after a medication change, with the advantage of family involvement; and (4) the current direction of HIPAA and the frustration of family involvement by emphasis on penalties rather than on collaboration among the treatment team, patient, and family.

stances¹¹ suggest that this tragedy could have been avoided with enhanced family awareness.

This letter raises issues that both Congress and the mental health community should consider to prevent tragedies like Paula's suicide from happening to other families. Congress should address the issues raised in this letter and amend HIPAA's confidentiality rules to include a family awareness of patient mental health care section. These issues are identified and explained in four sections: (1) HIPAA confidentiality between doctor and patient; (2) the diagnosis of patient illness; (3) monitoring of the patient on medication; and (4) the current direction of HIPAA policy.

The HIPAA Confidentiality Agreement Between Doctor and Patient

HIPAA requires confidentiality between a doctor and his or her patient.¹² When Paula began treatment, she understood that her sessions with the psychiatrist and social worker would be treated as confidential under HIPAA guidelines. She believed that confidentiality would apply only to the personal psychotherapy discussions that took place during office visits with her psychiatrist and social worker. The psychiatrist, however, held a different understanding and believed that HIPAA's confidentiality requirement also extended to Paula's prescribed medications, along with the content in the black box warnings¹³ that the manufacturer included with the drug.¹⁴ Effexor XR carried a warning that stressed the importance of notifying family members if a loved one was prescribed Effexor

12. See 45 C.F.R. § 164.501 (2013). See also OCR HIPAA Privacy, *Research*, HHS. GOV (2013), <http://www.hhs.gov/ocr/privacy/HIPAA/understanding/special/research.pdf>.

13. A black box warning or boxed warning informs patients that certain drugs may have special problems, particularly issues that may lead to death or serious injury. Michael Bihari, *Black Box Warnings*, ABOUT.COM (Aug. 18, 2008), <http://drugs.about.com/od/medicationabcs/a/BlackBoxWarning.htm>. The warning is often referred to as a boxed or black box warning because of the black border surrounding the text that appears on the package insert label and marketing materials that describe the medication. *Id.* It is the most serious warning required by the FDA. *Id.*

14. In this particular case, an antidepressant, Effexor.

XR.¹⁵ Effexor XR's black box warning stated that a person taking the antidepressant could have serious behavioral changes that may result in potential harm to the patient, even suicide.¹⁶ Thus, Effexor XR's recommendation for family awareness creates a potential conflict with HIPAA's confidentiality rules.

Paula did not consider her medication information confidential. Paula told her husband- whom we shall call Jim¹⁷-that she was taking anti-depressant and anti-anxiety prescriptions for her depression. Jim was fully aware of Paula's psychiatric appointments but had neither met her medical team nor received a briefing from Paula's psychiatrist or social worker on the danger signs as stressed in Effexor XR's black box warnings. Paula's doctor did not inform Jim about the possible side effects of Effexor XR or explain the black box warnings to him.¹⁸ The doctor was also unaware of Paula's desire that Jim understand her medication schedule.¹⁹ Thus, Paula's doctor did not follow the manufacturer's recommendations to inform family members about the possible side effects from taking Effexor XR.²⁰ Doctors are permitted, but not required, to use and disclose protected health information, with

15. See *About Effexor XR*, *supra* note 9.

16. See *id.*

17. The name "Jim" is fictitious to preserve confidentiality.

18. Paula's doctor felt restricted by HIPAA's Privacy Rule, which protects all individually identifiable health information from unauthorized disclosures. See *About Effexor XR*, *supra* note 9.

19. See U.S. Department of Health & Human Services, *Health Information Privacy*, (2013), <http://www.hhs.gov/ocr/hipaa>.

20. See *About Effexor XR*, *supra* note 9. The Black Box Warning states that "... [f]amilies and caregivers should be advised of the need for close observation and communication with the prescriber." *Id.*

21. It is important to note here that doctors have discretion to prescribe anti-depressants without advising family of risks. The rationale is based on the patient's option, to forego use of the drug if family will be advised, even though medication is needed. The patient, at least in the doctor's view, could then be at greater risk. Doctors, faced with this apparent dilemma, must choose what they believe to be the option of lesser risk. Neither choice is free from potential harm – no medication use or medication use but without family knowledge and the probable inability of loved ones to recognize potential danger signs. See Interview by Warren Howe with James Bradley, Chief of Psychiatry, Behavioral Health Clinic, Walter Reed Army Medical Center in Washington, D.C. (Feb. 18, 2010).

patient authorization.²¹ The question becomes why did Paula's doctor not seek permission from Paula to inform her husband of the possible side effects of her medication? Why are family members, such as Jim, not informed of this part of a loved one's treatment?²²

Assuming Paula knew HIPAA's provision permitting disclosure to family and others with patient permission, Paula's doctor may have thought it unnecessary to raise the issue because Paula signed the standard HIPAA form at the beginning of treatment. So the extent of confidentiality coverage and the specific application of confidentiality was never discussed between Paula and her doctor. Another possibility is that Paula's doctor—a foreign national—did not understand the HIPAA law and was fearful of large fines and jail terms resulting from noncompliance.²³

Whatever the thought process between doctor and patient in this case, there was no meeting of the minds regarding the HIPAA confidentiality agreement. To make an intelligent decision on HIPAA confidentiality, therefore, doctors and mental health patients might best consider several questions before a decision. For example, (1) Does the doctor realize that the medication black box warning may stress family awareness, especially if the drug carries a suicide risk? (2) If so, has the doctor explained the need for family awareness to the patient? (3) Does the doctor realize that the patient's family may already know about the patient's mental condition, perhaps in great detail? (4) Does the doctor understand HIPAA option for informing others with patient permission?

Diagnosis of Patient Illness

An additional consideration regarding family awareness is accuracy of diagnosis, especially an evaluation of the patient as

22. See 45 C.F.R. are given if the individual is not present or cannot express consent due to incapacity or emergency circumstances. *Id.* There are also criteria for disclosures for disaster relief purposes. *Id.*

23. See Jane Gross, *Keeping Patients' Detail Private, Even from Kin*, N.Y. TIMES, July 3, 2007, http://www.nytimes.com/2007/07/03/health/policy/03hipaa.html?pagewanted=all&_r=0; see also, Psychiatric News Alert, *APA Issues Updated Guide to Help Psychiatrists Manage HIPAA Rules*, AMERICAN PSYCHIATRIC ASS'N, (Oct. 16, 2013).

trustworthy. In this sense, a patient's trustworthiness means mentally capable of living independently without risk of harming oneself or others as a result of the effects of depressive illness or possible side effects of medication.

Paula was judged to be trustworthy by her medical providers because of their personal interaction time with her.²⁴ Paula was deemed trustworthy enough to be home with Jim, her spouse, who was unaware of any risks or dangers of Paula's medications. Jim, who was with Paula daily, was never consulted about Paula's possible behavioral changes during the morning, afternoon, evening or at night. These times were the critical periods between Paula's appointments with her doctors and her time at home when her illness and possible medication side-effects manifested major behavioral influence, including the danger signs specified in the black box.²⁵ Thus, if Paula's doctors had discussed with Jim Effexor XR's warnings and recommendations, he may have been more alert to Paula's condition and possible behavioral changes.²⁶

Monitoring the Patient on Medication

Possibly the most critical implication of family exclusion from awareness when loved ones are prescribed antidepressant medication is the probability of family or others close to the patient not recognizing danger signs.²⁷ The patient is "de facto" alone – without monitoring – until the next appointment with the doctor or

24. Paula saw her psychiatrist and social worker on the average of once per week during a one-hour office visit.

25. *About Effexor XR, supra* note 9. Effexor XR's warnings state that [a]ll patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. *Id.*

26. Under HIPAA § 164.510 (b), disclosure of a patient's health information may be directed to not only a spouse, but to another ...a family member, other relative, or close personal friend of the individual, or any other person identified by the individual. 45 C.F.R. § 164.51.

27. Opinion from Col. James Bradley, M.D.

social worker. In Paula's case, the next appointment was scheduled seven days following the previous session, the latter, an appointment which included a medication change, usually a time when monitoring is especially vital. The seven-day appointment pattern is the sequence recommended by the American Psychiatric Association.²⁸

Seven days was too late for Paula who took her life four days following her last appointment and medication change. Without family awareness, she was expected to call the doctor on her own if there was a problem. This expectation is unrealistic given that the patient, especially when having a negative drug experience, would most likely be unable, physically or mentally, to call anyone.

No reliable causal connection was established between Paula's medication change, the negative character of her demeanor that appeared shortly thereafter, and her suicide. The National Institutes of Health, U.S. Department of Health and Human Services,²⁹ has the capability of determining a possible relationship if their Brain Study Program has access to the patient's remains shortly after death. But this access did not occur in Paula's case.

What is known is that four days before Paula took her life, her prescription was changed from the anti-depressant, Effexor,³⁰ to Effexor XR.³¹ After the medication change, Paula's behavior changed and showed the type of changes that Effexor XR's black box warning explicitly warned about, such as irritability or negative demeanor and the desire to sleep most of the day. Jim, who noticed all of Paula's behavioral signs, did not have the benefit of counseling from the prescribing physician and did not see Paula's

28. See generally, American Psychiatric Association, *APA Practice Guidelines*, PSYCH.ORG, <http://www.psych.org/practice/clinical-practice-guidelines.com>.

29. National Institute of Health, *Mission*, NIH.GOV, <http://www.nih.gov/about/mission.htm> (last visited Dec. 15, 2013).

30. Paula's daily antidepressant was Effexor at 37.5 milligrams per day, gradually increasing over six days to 112.5 milligrams per day.

31. Paula's new daily dose was Effexor XR where she received 150 milligrams per day.

behavior change as indicators of danger, especially the danger of suicide.

There are circumstances where a patient may not want family awareness about his or medication or private sessions with his or her doctors. There are other circumstances, however, where the patient needs detailed information about the need for family awareness when taking certain types of medication. This was Paula's case. Medication confidentiality was not Paula's intent. Paula told her husband that she was taking anti-depressant and anti-anxiety medications. In these types of situations, the patient needs to be informed of the family awareness provision and the necessity for family members to know about their loved ones' medications and side effects.

After Paula's death, the director of the behavioral health clinic where Paula was under treatment emphasized to the clinic staff that family awareness of medication warnings was the preferred policy and strongly recommended that doctors counsel patients accordingly. In its revised guidelines on Effexor XR, Wyeth Pharmaceuticals, Inc. stated:

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, psychomotor restlessness, hypomania, and mania have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder.³²

Paula demonstrated many of these warning signs. Wyeth's further stressed family awareness and implied the need to utilize the HIPAA "patient permission" option for disclosure of protected health information:

The Families and caregivers of patients being treated with antidepressants for major depressive

32. See *About Effexor XR*, *supra* note 9.

disorder or other indications, both psychiatric and non-psychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers.³³

Wyeth's warning and emphasis on family awareness show the necessity of alerting family members to the side effects and recognize behavioral changes when a loved one is taking Effexor XR.

The Current Direction of HIPAA Policy

A final issue is the fear among physicians that they will violate some section of the extremely complicated set of HIPAA regulations, and that they will then be punished for their noncompliance with a HIPAA requirement. Some physicians may be worried about both malpractice litigation and government regulations due to the strict requirements and trainings on HIPAA. William Bernet, M.D. (Dr. Bernet)³⁴ discussed the typical HIPAA training sessions:

I have attended several training sessions regarding HIPAA, which are put on by the legal staffs of the hospital, medical center, or university. The trainers wear their legal hats and emphasize HIPAA rules, warnings, and the dire consequences of breaking the rules. They emphasize what doctors are not allowed to do. The trainers fail to explain what the doctors are allowed and even encouraged to do, such as collaborate with other members of the treatment team and work out arrangements to communicate with appropriate family members.³⁵

These training sessions should emphasize and focus on what doctors can tell family members. In fact, HIPAA allows disclosure in certain circumstances:

33. *Id.*

34. Dr. Bernet has practiced psychiatry for over forty years and received his medical degree from Harvard Medical School in 1967.

35. See the U.S. Department of Health & Human Services, *supra* note 19.

A covered entity may, in accordance with paragraphs (b)(2) or (3) of this section, disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information directly relevant to such person's involvement with the individual's care or payment related to the individual's health care.³⁶

Dr. Bernet believes that this sentence should not be interpreted as forbidding physicians and psychotherapists from communicating with family members, but rather he believes this sentence should be interpreted to encourage practitioners to set up a plan for including family members to participate in assessing, monitoring, and supporting their loved ones.³⁷ This principle needs to be communicated more clearly to all mental health practitioners.

Final Thoughts

This letter was written to gain attention and seek revision on HIPAA's confidentiality and family awareness sections. Paula's case and this letter raises several issues that need debate in Congress and within the medical community:

1. *Confidentiality*: Should more emphasis be given to achieving a meeting of the minds between doctor and patient when a HIPAA confidentiality statement is signed?
2. *Diagnosis*: Can a patient be reasonably judged *trustworthy*³⁸ by a doctor who sees the patient for an hour once or twice per week, and who never contacts family members who are with the patient daily?
3. *Monitoring*:
 - (a) Should a patient be prescribed anti-depressant medication without family awareness when the manufacturer's black box warning stresses the need for loved ones to know the risks, danger signs, and have the capability to call for help if needed?

36. 45 C.F.R. § 164.510 (1996).

37. Interview with William Bernet, M.D., (October 2013).

38. Trustworthy includes a patient not being a suicide risk.

- (b) Should doctors prescribing psychotropic drugs be permitted to bypass black box warnings stressing family awareness, especially for reasons relating to HIPAA *confidentiality*?
 - (c) Is the American Psychiatric Association (APA) guideline³⁹ recommending patient monitoring at least once every seven days adequate when there has been an anti-depressant medication dose change?⁴⁰
 - (d) Is it reasonable to expect a patient taking anti-depressants without family awareness to call for help on his or her own, especially when the drug may negatively affect mental capacity to conclude that help is essential?
4. *HIPAA Briefings*: Have HIPAA briefings for medical providers become too focused on fines and other penalties while ignoring the *spirit* of the statute and regulations which intend the protection of personal medical records but allow for family awareness? Have medical providers become *paranoid* about HIPAA violations to the point where authorizing family awareness with patient permission is underused?

Mental health care laws need not place us at risk from policies we can correct. This letter encourages debate and reform for HIPAA's confidentiality and family awareness sections. We urge Congress and the medical health community to seek action about this extremely important issue.

39. American Psychiatric Association, *supra* note 28.

40. Also important is the time when a pharmaceutical company issues a new warning that includes suicide and unusual changes in behavior. *See About Effexor XR, supra* note 9.

**Protecting Against the
Deprivation of Life and
Liberty: Curing the
Constitutional Defects of
T.C.A. § 33-3-210 While
Enhancing the Protection of
Public Safety Against Gun
Violence**

MACKENZIE HOGAN*

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INTRODUCTION

Mourning the death of her husband, Amy seeks emotional support from a therapist. She explains that her husband was riding

in a car driven by his best friend who had been drinking. Their car ran off the road and hit a tree, killing Amy's husband. She expresses her anger at her husband's best friend and says that she wishes she could kill him too. The therapist asks Amy if she would really do that. Amy replies, "It's illegal, isn't it?" The therapist, fearing liability if Amy acts on her anger, reports Amy to the police informing them that Amy is dangerous and that she has communicated a threat of death or bodily harm to her husband's best friend.¹

A few months later, Amy, now living alone, decides to purchase a gun to defend herself in case of an intruder. When the gun dealer runs her background check, it alerts the dealer that she is prohibited from purchasing a firearm. Embarrassed and confused she leaves the store, feeling more vulnerable than ever. Amy attempts to find out why an individual might be prohibited from purchasing a firearm. Finding that she does not knowingly fall under any of the prohibitions listed in T.C.A. § 39-17-1316,² she contacts

* Juris Doctor Candidate, May 2014, The University of Memphis, Cecil C. Humphreys School of Law, *Mental Health Law & Policy Journal*, Executive Editor. The author would like to thank Professor Andrew J. McClurg for his comments and guidance throughout the writing process.

1. In this hypothetical situation is the therapist correct? Does Amy pose a risk of violence toward her husband's best friend? Did the therapist report Amy in order to protect herself from liability? Therapists have always had the tendency to over predict dangerousness in their patients, resulting in the reporting and commitment of patients that do not actually pose a threat of harm to others. According to a study conducted by the *Wisconsin Law Review* in 1984, forty-five percent of psychotherapists who participated in the study had issued "Tarasoff warnings," alerting third parties that a patient had communicated a threat of violence against them, when he or she did not actually believe that the patient posed a risk of harm to the individual. Brian Ginsberg, *Tarasoff at Thirty: Victim's Knowledge Shrinks the Psychotherapist's Duty to Warn and Protect*, 21 J. CONTEMP. HEALTH L. & POL'Y 1, 17 (2004).

2. TENN. CODE ANN. § 39-17-1316 provides in relevant part:

(a)(1) Any person appropriately licensed by the federal government may stock and sell firearms to persons desiring firearms; however, sales to persons who have been convicted of the offense of stalking, as prohibited by § 39-17-315, who are addicted to alcohol, who are ineligible to receive firearms under 18 U.S.C. § 922, or who have been judicially committed to a mental institution pursuant to Title 33 or adjudicated as a mental defective are prohibited. For purposes of this subdivi-

the therapist she had seen a few months prior and finds that the therapist had reported her as dangerous to law enforcement. Because the therapist has the authority to unilaterally determine whether her patient has communicated a legitimate threat of violence to an identifiable third party, it cannot be determined whether Amy was actually dangerous.³

The hypothetical scenario described above can now happen in Tennessee. On July 1, 2013, T.C.A. § 33-3-210⁴ took effect,

sion (a)(1), the offense of violation of a protective order as prohibited by § 39-13-113 shall be considered a “misdemeanor crime of domestic violence” for purposes of 18 U.S.C. § 921.

TENN. CODE ANN. § 39-17-1316 (West 2012).

3. *See infra* Part IV.

4. TENN. CODE ANN. § 33-3-210 provides:

(a) If a service recipient has communicated to a qualified mental health professional or behavior analyst an actual threat of serious bodily harm or death against a reasonably identifiable victim or victims, the qualified mental health professional or behavior analyst, using the reasonable skill, knowledge, and care ordinarily possessed and exercised by the professional’s specialty under similar circumstances, who has determined or reasonably should have determined that the service recipient has the apparent ability to commit such an act and is likely to carry out the threat unless prevented from doing so, shall immediately report the service recipient to local law enforcement, who shall take appropriate action based upon the information reported.

(b) If a mental health professional or behavior analyst is required to report pursuant to subsection (a), the professional or analyst shall report the following information:

(1) Complete name and all aliases of the service recipient;

(2) Name of the mental health professional or behavior analyst and name of private or state hospital or treatment resource from which the individual may be receiving services; and

(3) Date of birth of the service recipient.

(c) The information in subdivisions (b)(1)-(3), the confidentiality of which is protected by other statutes or regulations, shall be maintained as confidential and not subject to public inspection pursuant to such statutes or regulations, except for such use as may be necessary in the conduct of any proceedings pursuant to §§ 39-17-1316, 39-17-1353 and 39-17-1354.

TENN. CODE ANN. § 33-3-210 (West 2012).

requiring mental health professionals to report their clients that communicate “an actual threat of serious bodily harm or death to a reasonably identifiable victim.”⁵ Section (c) requires law enforcement to keep this information confidential except for use in conducting “proceedings pursuant to §§ 39-17-1316, 39-17-1353, and 39-17-1354.”⁶ T.C.A. § 39-17-1316 describes who is prohibited from purchasing a weapon in Tennessee, tracking the language of the federal Gun Control Act.⁷ The new Tennessee statute uses the same language as the existing duty to warn statute requiring mental health professionals to “predict, warn of, or take precautions” to protect against their patient’s “threats of bodily harm against a clearly identified victim.”⁸ This new law adds a layer of protection of the public to each of these statutes by requiring mental health professionals to report these clients directly to law enforcement.⁹

5. *Id.* § 33-3-210(a)(1).

6. *Id.* § 33-3-210(c). TENN. CODE ANN. §§ 39-17-1353 and 39-17-1354 describe the procedures required for the review of a suspension or revocation of a handgun carry permit. Under TENN. CODE ANN. § 33-3-210, not only will the client be deprived of their right to purchase and possess a weapon, but the legislature also included the statutes for the suspension or revocation of a handgun carry permit. These procedures are triggered when the individual receives notice that their license will be suspended or revoked for the reasons listed in TENN. CODE ANN. § 39-17-1352, including when the individual “poses a material likelihood of risk of harm to the public.” *Id.* § 39-17-1352(a)(3). These statutes provide a procedure for challenging the suspension or revocation of a carry permit that are not afforded to an individual deprived of their right to possess a firearm when they had not previously obtained a carry permit. *See id.* §§ 39-17-1352–1354.

7. Gun Control Act of 1968, 18 U.S.C. §§ 921–998 (West 2012). The types of people that Congress deemed unfit to possess a weapon include: ex-felons, minors, those that have been dishonorably discharged from the military, those who use illegal narcotics, illegal aliens, and those who have been adjudicated to be mentally defective or have been committed to a mental institution. 18 U.S.C. § 922 (2006). An individual is “adjudicated as a mental defective” if they (1) are a danger to themselves or others; (2) lack the mental capacity to enter into contracts or to manage their affairs; or (3) they were found to be insane, incompetent to stand trial, or not guilty by reason of insanity by a criminal court. 27 C.F.R. § 478.11 (2012).

8. TENN. CODE ANN. § 33-3-206 (West 2013).

9. *Id.* § 33-3-210(a). Tennessee already has a duty to warn statute. TENN. CODE ANN. § 33-3-210 adds a layer of protection by requiring the mental health professional to report their patient directly to law enforcement. Law en-

Law enforcement will then use that information to prevent the individual from purchasing or possessing a firearm by placing their name on a registry that will alert gun dealers that the individual is prohibited from possessing a firearm.¹⁰ The law does not, however, provide notice to the individual that they have been prohibited from possessing a firearm, it does not provide a hearing prior to the deprivation of the right to possess a firearm, and it does not provide a method for applying to have their right to possess a firearm restored.

While this law is well-intended as a means to protect public safety, it elicits serious questions concerning its infringement of the due process, privacy, and Second Amendment rights of some mental health clients. This article will focus on the due process issue and will propose procedural safeguards that protect the due process rights of individuals who are unilaterally determined to be dangerous. The Supreme Court has recognized the right to bear arms as a fundamental liberty interest.¹¹ A government entity cannot deprive an individual of a fundamental liberty interest without providing certain due process procedures such as notice and an evidentiary hearing prior to the deprivation.¹² The proposed changes to T.C.A. § 33-3-210 in this article include notice to the patient within seven days of the report, an evidentiary hearing

forcement is to take the appropriate steps to protect the identifiable victim. This includes using this information for proceedings pursuant to TENN. CODE ANN. § 39-17-1316, the statute requiring a background check for firearm purchases. This statute already prohibits someone that has been “adjudicated as a mental defective” or “committed to a mental institution” from possessing a weapon. The purpose of TENN. CODE ANN. § 33-3-210 is to add a layer of protection by allowing law enforcement to place the names of individuals reported to law enforcement as posing an actual threat of bodily harm or death to an identifiable victim on a registry used for background checks conducted for the purposes of a firearm purchase.

10. “Under the [law], police must be notified. The information received would be entered into state databases used for checking gun purchases as well as those who apply for or already have a state-issued handgun-carry permit to go armed in public.” Andy Sher, *Tennessee Senate targets mental health on gun control*, TIMES FREE PRESS (Mar. 22, 2013), <http://www.timesfreepress.com/news/2013/mar/22/tennessee-senate-targets-mental-health-on-gun/>.

11. *D.C. v. Heller*, 554 U.S. 570 (2008) (holding that the right to self-defense is inherent in the Second Amendment).

12. U.S. CONST. amend. V.

within thirty days, and an application process to have their rights restored following the deprivation. These proposed changes could balance the statute's intended purpose of protecting the public from dangerous individuals with the due process rights of those individuals who have been reported as dangerous.¹³

Part II of this paper will discuss the civil tort and statutory duty of a doctor/therapist to warn reasonably identifiable third parties when their clients communicate a threat of violence to an identifiable third party. This Part will specifically describe how Tennessee has addressed the duty to warn third parties established in *Tarasoff v. Regents of the University of California*.¹⁴ Part III will describe the background to federal law regarding the prohibition of firearm possession by those who have been adjudicated as a mental defective or committed to a mental institution. Part IV will discuss the Second Amendment right to bear arms as a fundamental liberty interest. Part V will discuss the due process rights required for the deprivation of a fundamental liberty interest and argue that T.C.A. § 33-3-210 violates the due process rights of mental health patients deprived of the right to bear arms without being committed or adjudicated as a mental defective. This Part will also propose changes to the Tennessee law that would require notice to the individual of the deprivation of a right, an evidentiary hearing prior to the deprivation, and an application process allowing the individual to petition to have his or her rights restored. Part VI will offer brief closing remarks.

DUTY TO WARN THIRD PARTIES

Tarasoff v. Regents of the University of California

While T.C.A. § 33-3-210, prescribing a duty to warn law enforcement when a patient communicates a threat of bodily harm or death to an identifiable third party, took effect on July 1, 2013,

13. Proponent of the law, Mental Health Commissioner, Doug Varney, said, "We want to make sure that we protect individuals' rights and that too wide a net isn't cast when you try to do that." Sher, *supra* note 10.

14. *Tarasoff v. California Bd. of Regents (Tarasoff I)*, 529 P.2d 553 (Cal. 1974), *vacated*, (*Tarasoff II*) 551 P.2d 334 (Cal. 1976). *See also* Turner v. Jordan, 957 S.W.2d 815, 819 (Tenn. 1997).

the tort law duty to warn third parties of this type of threat was recognized almost forty years ago by the California Supreme Court. In *Tarasoff v. Regents of the University of California*, the California Supreme Court held that when a therapist determines that his or her patient “presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such a danger.”¹⁵ Failure to exercise the duty to warn their patient’s intended victim subjects the therapist to civil liability for damages resulting if the patient harms the victim.¹⁶

In *Tarasoff*, the California Supreme Court found that the therapist treating a graduate student at the University of California at Berkeley, Prosenjit Poddar, had the duty to warn his intended victim, Tatiana Tarasoff, of Poddar’s threats on her life made during their psychotherapy session.¹⁷ The therapist reported to campus police that Poddar was potentially dangerous and attempted to have him committed to a mental institution.¹⁸ The police detained Poddar but released him a few hours later, finding that he was thinking rationally.¹⁹ The therapist did not attempt to warn Tarasoff once his attempts to have Poddar committed were ineffective.²⁰ Poddar never returned to therapy and, upon Tarasoff’s return from vacation, he entered her home, chased her into the backyard, shot her with a pellet gun, and fatally stabbed her with a knife.²¹ Poddar returned to the house and called the police, admitting what he had done and requesting to be handcuffed.²²

The Tarasoff family brought suit against the police, the therapist that treated Poddar, and the University of California for acting negligently in failing to protect their daughter from Pod-

15. *Tarasoff II*, 551 P.2d at 340.

16. *Id.* at 446.

17. *Id.* at 340.

18. *People v. Poddar*, 518 P.2d 342, 345 (Cal. 1974).

19. *Tarasoff I*, 529 P.2d at 554.

20. *Id.* at 555.

21. *Poddar*, 518 P.2d at 345.

22. *Id.* Poddar’s criminal case lasted for many years due to his mental state and the inability of the courts to decide on a proper jury instruction, and he was eventually deported to India. Vanessa Merton, *Confidentiality and the “Dangerous” Patient: Implications of Tarasoff for Psychiatrists and Lawyers*, 31 EMORY L.J. 263, 290 (1982).

dar.²³ The California Supreme Court found that the therapist had a duty to warn Tarasoff that Poddar had posed a threat against her.²⁴ This was not the last word on the matter, however.

Citing the sanctity of doctor/patient confidentiality and the necessity that mental health patients feel they can divulge private information to their therapist without fear that it will be revealed to the public, the psychotherapeutic community filed amicus briefs in support of a rehearing of the case.²⁵ The Court agreed to rehear the case and the second time they found that the therapist had a duty to protect the patient's intended victim when the patient presents a legitimate threat of violence against a third party.²⁶ In this second opinion, known as *Tarasoff II*, the court held that a therapist must exercise a 'reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances' to predict dangerous or violent behavior in their patients.²⁷ Once the therapist has identified such behavior, he or she has a duty to use reasonable care to pro-

23. *Tarasoff I*, 529 P.2d 553, 555 (Cal. 1974).

24. *Id.* at 561. The Court found that the police had a duty to warn Tatiana of the dangerous threats against her. The plaintiffs claimed that their failure to warn increased the risk of harm to their daughter. Also, the Court found that the special relationship that existed between the therapist and patient was sufficient to give rise to a duty of care for third parties. *Id.* at 558.

25. *Tarasoff II*, 551 P.2d 334, 344-45 & n.11 (Cal. 1976). Naturally, this opinion received criticism from the psychotherapeutic community. They are now forced to violate doctor/patient confidentiality and to disclose private information to the patient's intended victim, arguably the one person to whom the patient would rather their private thoughts, feelings, desires, and fears not be disclosed. *Id.* at 354 (dissenting opinion in part) (stating that requiring psychiatrists to adhere to an industry standard in predicting violence would "take us from the world of reality into the wonderland of clairvoyance"). This paper is not going to address the privacy issues that have arisen since *Tarasoff* was decided. One of the main issues however, has been the inability to predict dangerousness. *See supra* note 1, at 15.

26. *Id.* at 340. ("When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger").

27. *Id.* at 345 (citing *Bardessono v. Michels*, 478 P.2d 480 (Cal. 1970); *Quintal v. Laurel Grove Hosp.*, 397 P.2d 161 (1964)).

protect the patient's potential victim(s).²⁸ According to the majority opinion, written by Justice Tobriner, "the protective privilege ends where the public peril begins."²⁹

Tennessee Has Also Recognized The Duty To Warn

Today, the majority of states have applied the *Tarasoff* principles,³⁰ holding that "where a psychiatrist, in accordance with accepted standards of the profession, knows or reasonably should know that a mentally ill patient poses an unreasonable risk of harm to a foreseeable third party, he or she must take reasonable steps to prevent that harm."³¹ In 1993, the Tennessee Supreme Court first recognized the *Tarasoff* duty to warn in *Bradshaw v. Daniel*.³² In *Bradshaw*, the Court found that, even though a doctor/patient relationship did not exist between the defendant physician and his patient's wife, he owed her a duty to inform her that her husband had died of Rocky Mountain Spotted Fever and to advise her of the risks of contracting the disease.³³

28. *Tarasoff II*, 551 P.2d at 340. It's important to note that this is a civil liability case for damages. Under the California duty to protect statute, a mental health psychotherapist is immune from liability for failing to protect a third party unless their patient "has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims." CAL. CIVIL CODE § 43.92 (West 2013).

29. *Tarasoff II*, 551 P.2d 334, 347 (Cal. 1976). Like most states, California followed this holding with a codification of the duty to protect. CAL. CIVIL CODE § 43.92 (West 2013). Tennessee codified the duty to warn in 2007. TENN. CODE ANN. § 33-3-206 (West 2007).

30. See e.g., *Hamman v. Cnty. of Maricopa*, 775 P.2d 1122, 1127–28 (Ariz. 1989) (extending the duty to warn to all potential victims within the "zone of danger" encompassing those that the patient poses a probable risk of harm); *Perreira v. State*, 768 P.2d 1198, 1214–15 (Col. 1989) (balancing all the factors that effect a psychiatrist's decision to release a patient from involuntary commitment when they pose a risk of violence to a potential victim); *Naidu v. Laird*, 539 A.2d 1064, 1075 (Del. 1988) (finding that a special relationship between mental health professional and patient gives rise to an affirmative duty to take whatever steps reasonably necessary to protect the patient's intended victim).

31. *Turner v. Jordan*, 957 S.W.2d 815, 819 (Tenn. 1997).

32. *Bradshaw v. Daniel*, 854 S.W.2d 865, 872–73 (Tenn. 1993).

33. *Id.*

In determining whether the defendant in *Bradshaw* owed a legal duty to his patient's wife,³⁴ the Tennessee Supreme Court found that the special relationship between doctor and patient in this case was analogous to the *Tarasoff* line of cases in which the mental health professional had a duty to warn an identifiable third party of a reasonable risk of danger posed by their patient.³⁵ The Court found that here, like in *Tarasoff*, the relationship between the physician and his patient was sufficient to impose a duty upon the physician to warn identifiable third parties in the patient's immediate family against the foreseeable risks associated with contracting the patient's illness.³⁶

In 1997, in *Turner v. Jordan*,³⁷ the Tennessee Supreme Court applied these same principles to the psychotherapist's duty to protect identifiable third parties from a threat of violence communicated by his or her patient.³⁸ The Court was confronted with the question of whether a psychiatrist at an in-patient mental health facility owed a duty to protect a nurse at the hospital from his patient that had presented "aggressive, grandiose, intimidating, combative, and dangerous" behavior.³⁹ The psychiatrist had failed to discharge the patient after he exhibited hostile and violent behavior.⁴⁰ The evening after the defendant examined him, the patient

34. For a common law negligence claim, five elements must be satisfied: "(1) a duty of care owed by the defendant to the plaintiff; (2) conduct falling below the applicable standard of care amounting to a breach of that duty; (3) an injury or loss; (4) causation in fact; (5) proximate, or legal cause." *Id.* at 869 (citing *McClenahan v. Cooley*, 806 S.W.2d 767, 774 (Tenn. 1991)); *Lindsey v. Miami Dev. Corp.*, 689 S.W.2d 856, 858 (Tenn. 1985)). In this case, the Court only considered the element of a legal duty owed by the defendant to the plaintiff. *Id.* at 873.

35. *Bradshaw*, 854 S.W.2d at 872 (comparing the duty to warn a third party of the risk of harm posed by their patient to the duty to warn a third party of the risks associated with exposure to a contagious disease, and finding that "[h]ere, as in those cases, there was a foreseeable risk of harm to an identifiable third party, and the reasons supporting the recognition of the duty to warn are equally compelling here").

36. *Id.*; see also *Tarasoff II*, 551 P.2d 334, 340 (Cal. 1976).

37. 957 S.W.2d 815 (Tenn. 1997).

38. *Id.* at 819.

39. *Id.* at 817.

40. *Id.*

attacked the nurse causing severe injuries to her head.⁴¹ The nurse sued the defendant on the theory that he proximately caused her injuries by violating his duty to treat his patient with reasonable care.⁴² The Court held that “the psychiatrist owed a duty of care because he knew or should have known that his patient posed an unreasonable risk of harm to a foreseeable, readily identifiable third party.”⁴³

Tennessee subsequently codified this duty to warn at TCA § 33-3-206, which states:

IF AND ONLY IF

(1) a service recipient has communicated to a qualified mental health professional or behavior analysis an actual threat of bodily harm against a clearly identified victim, AND

(2) the professional, using the reasonable skill, knowledge, and care ordinarily possessed and exercised by the professional’s specialty under similar circumstances, has determined or reasonably should have determined that the service recipient has the apparent ability to commit such an act and is likely to carry out the threat unless prevented from doing so,

THEN

(3) the professional shall take reasonable care to predict, warn of, or take precautions to protect the identified victim from the service recipient’s violent behavior.⁴⁴

41. *Id.*

42. *Id.*

43. *Turner*, 957 S.W.2d at 816. The Court determined that “a duty of care may exist where a psychiatrist, in accordance with professional standards, knows or reasonably should know that a patient poses an unreasonable risk of harm to a foreseeable, readily identifiable third person.” *Id.* at 820–21.

44. TENN. CODE ANN. § 33-3-206 (West 2007). If the mental health professional has satisfied their duty under §§33-3-206 and 33-3-208, they are immune from liability and no cause of action will arise against them for not predicting, warning, or taking precautions to protect the identified victim from the “violent behavior by the person with mental illness, serious emotional disturbance, or developmental disability.” *Id.* § 33-3-209.

The language of this statute adheres to the *Tarasoff* line of cases, imposing a duty upon the mental health professional to protect reasonably identifiable third parties from their patient's potentially violent behavior.⁴⁵

BACKGROUND ON FEDERAL LAW REGARDING THE PROHIBITION OF FIREARM POSSESSION BY INDIVIDUALS ADJUDICATED AS A MENTAL DEFECTIVE OR COMMITTED TO A MENTAL INSTITUTION

In 2013, weary of gun violence and the recent mass shootings throughout the country, the Tennessee legislature employed the *Tarasoff* doctrine in an effort to enhance public safety. T.C.A. § 33-3-210 requires therapists to report their clients to law enforcement when he or she has communicated a threat of harm to an identifiable victim. Law enforcement may use this information to prohibit the client from purchasing or possessing a firearm.⁴⁶ This law expands the category of persons with mental health issues prohibited from possessing a firearm in Tennessee.⁴⁷ Both the federal Gun Control Act⁴⁸ and Tennessee law⁴⁹ prohibit individuals who have been “adjudicated as a mental defective” or “judicially committed to a mental institution” from possessing a firearm. Under the new law, any client that a mental health professional determines they have a duty to report as dangerous will be placed on a “state database used for checking on gun purchases as well as those who apply for or already have a state-issued handgun-carry permit.”⁵⁰ Despite the lack of judicial proceedings determining whether the individual is mentally ill or presents a threat of danger to public safety, the new law adds to the list of prohibited persons

45. *Id.* § 33-3-206.

46. *See id.* § 33-3-206; Sher, *supra* note 10.

47. T.C.A. § 39-17-1316 prohibits individuals “who have been judicially committed to a mental institution pursuant to title 33 or adjudicated as a mental defective.” TENN. CODE ANN. § 39-17-1316(a)(1) (2013).

48. 18 U.S.C. § 922(g) (2006).

49. TENN. CODE ANN. § 39-17-1316(a)(1) (2013). In addition to using the same language to describe an individual who is prohibited from possessing a weapon for mental health reasons, the Tennessee statute also explicitly prohibits anyone ineligible under 18 U.S.C. § 922.

50. Sher, *supra* note 10.

those individuals that a mental health professional has unilaterally determined to be dangerous.

The Second Amendment of the United States Constitution provides “A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.”⁵¹ While the majority of Americans can exercise this liberty interest without putting the lives of others in danger, our country also has a history of high profile mass shootings that have given rise to a number of attempts to prevent these horrific murders through firearm regulation.⁵² In 1968, Congress passed the Gun Control Act in response to the assassination of President John F. Kennedy.⁵³ The Gun Control Act sought to prohibit the sale of firearms to those it deemed too unreliable or dangerous to possess a weapon safely.⁵⁴ Among those prohibited from purchasing a weapon are individuals who have been “adjudicated as a mental defective or who [have] been committed to a mental institution.”⁵⁵

51. U.S. CONST. amend. II.

52. See Keersten Heskin, *Easier Than Obtaining a Driver’s License: The Federal Licensing of Gun Dealers*, 46 FLA. L. REV. 805, 819 (1994).

53. Gun Control Act, 18 U.S.C. § 921-998 (2006). See Heskin, *supra* note 52, at 819 (“The fact that Lee Harvey Oswald allegedly killed the President using a gun purchased through the mail prompted a public outcry for more gun control legislation.”).

54. The types of people that Congress deemed unfit to possess a weapon included: ex-felons, minors, those that have been dishonorably discharged from the military, those who use illegal narcotics, illegal aliens, and those that have been adjudicated to be mentally defective or have been committed to mental institution. 18 U.S.C. § 922(g) (2006).

55. *Id.* § 922(g)(4). Title VII and Title IV of the Gun Control Act both pertained to mentally ill persons. Title VII prohibited those adjudicated as “mentally incompetent” and Title IV prohibited those who have been “adjudicated as a mental defective or committed to a mental hospital.” *Id.* § 922. The Bureau of Alcohol, Tobacco and Firearms’ implemented regulations enforcing the statute. BATF used the terms “adjudicated as a mental defective,” “committed to a mental institution,” or “adjudicated by a court of the United States or State or any political subdivision thereof as being mentally incompetent.” 26 C.F.R § 178.32 (1970). An individual is “adjudicated as a mental defective” if they (1) are a danger to themselves or others; (2) lack the mental capacity to enter into contracts or to manage their affairs; or (3) they were found to be insane, incompetent to stand trial, or not guilty by reason of insanity by a criminal court. 27 C.F.R. § 478.11 (2012). The Bureau of Alcohol, Tobacco, and Firearms’ implemented regulations enforcing this statute.

The 1968 Act primarily regulates the interstate transportation and sale of firearms.⁵⁶ The prohibitions it enumerates apply to firearms that have been transported in interstate commerce.⁵⁷

In 1986, Congress amended the Gun Control Act, lifting many of its prohibitions and creating a mechanism for the removal of disabilities.⁵⁸ The Firearms Owners' Protection Act (FOPA) is viewed as legislation protecting the civil rights of gun owners. FOPA established a "relief from disabilities" program allowing those who have previously been disqualified to petition the Bureau of Alcohol, Tobacco, and Firearms (BATF) to have their right to possess a firearm restored.⁵⁹ The Attorney General may remove the

56. 18 U.S.C. § 922(a)(1)-(2) (2006) ("It shall be unlawful for any person . . . to engage in the business of importing, manufacturing, or dealing in firearms, or in the course of such business to ship, transport, or receive any firearm in interstate or foreign commerce" subject to the enumerate exceptions). See also FIREARMS LAW DESKBOOK, 2:1 (2013).

57. 18 U.S.C. § 922(g)(1)-(9) (2006) (It is unlawful for any person listed in § 922(g)(1)-(9) to "ship or transport in interstate or foreign commerce, or possess in or affecting commerce, any firearm or ammunition; or to receive any firearm or ammunition which has been shipped or transported in interstate or foreign commerce").

58. In 1985, an action was brought against the Department of Treasury, Bureau of Alcohol, Tobacco, and Firearms by a former mental patient challenging the denial of his application for the removal of his firearm disability. The District Court of New Jersey found that § 925(c) of the Gun Control Act was unconstitutional as an invalid infringement "upon the plaintiff's right to due process as guaranteed by the fifth amendment to the United States Constitution." *Galioto v. Dept. of Treasury, Bureau of Alcohol, Tobacco & Firearms*, 602 F.Supp. 682, 683 (1985). A former mental patient is denied due process because her or she is not afforded the opportunity to "establish that they no longer present the danger against which the statute was intended to guard." *Id.* at 690. The district court also found that the statute violated equal protection because it did not provide the same application for relief for former mental patients that it provided for convicted felons. *Id.* The Supreme Court took appeal and held that the constitutional issue was moot because Congress amended the Gun Control Act to allow for an application for relief from disabilities for anyone prohibited under the statute. 18 U.S.C. § 925(c) (2013).

59. 18 U.S.C. § 925(c) (2003). An application must include: (1) statements from three individuals recommending they be granted relief; (2) written consent to allow a background check of all employment, medical, military, and criminal history; (3) all medical records concerning their mental health history, including the reasons for commitment and diagnosis; (4) they must be determined by a "court, board, commission, or other lawful authority to have been

disability of a prohibited individual if he determines that the individual is not a danger to public safety.⁶⁰ If the petition is denied, the individual may seek judicial review.⁶¹ The court may admit evidence and grant a relief from disabilities if it does not agree with the Attorney General's decision.⁶² With this relief from disabilities petition, Congress provided a measure of due process that had not been provided to those prohibited under the Gun Control Act until that point.⁶³

However, in 1992, Congress criticized the program for allowing relief for too many ex-felons and argued that it was too expensive to administer.⁶⁴ Consequently, Congress ceased funding of the program and the BATF stopped accepting applications to restore the rights of those who are no longer considered to be mentally defective.⁶⁵ While FOPA § 925(c) allows for the review of administrative denial of relief, the United States Supreme Court ruled, in *United States v. Bean*,⁶⁶ that inaction by the BATF did not constitute administrative denial of relief under § 925(c) so that it could not be challenged in district court.⁶⁷ If the BATF did not

restored to mental competency, to be no longer suffering from a mental disorder, and to have had all rights restored.” 27 C.F.R. § 478.144(c)-(e) (2013).

60. See 18 U.S.C. § 925(c) (2003); FIREARMS LAW DESKBOOK, § 2:29 (2013).

61. *Id.*

62. FOPA amended 18 U.S.C. § 925(c) to provide:

Any person whose application for relief from disabilities is denied by the Secretary may file a petition with the United States district court for the district in which he resides for a judicial review of such denial. The court may in its discretion admit additional evidence where failure to do so would result in a miscarriage of justice.

18 U.S.C. § 925(c) (2003).

63. *Galioto v. Dept. of Treasury, Bureau of Alcohol, Tobacco and Firearms*, 602 F.Supp. 682, 683 (1985) (holding that not allowing persons with mental disabilities to apply for relief from firearm disabilities violates due process and equal protection).

64. James Jacobs & Jennifer Jones, *Keeping Firearms Out of the Hands of the Dangerously Mentally Ill*, 47 CRIM. L. BULL. 388, 392 n.24 (2011).

65. *Id.*

66. *United States v. Bean*, 537 U.S. 71 (2002).

67. See 18 U.S.C. § 925(c) (2003) (a person prohibited from possessing a firearm may apply to have their rights reinstated if the Attorney General determines that the individual is no longer dangerous to the public); 28 C.F.R. §

consider a petition for removal of a disability, the petitioner was not entitled to judicial review.⁶⁸ In effect, those adjudicated as a mental defective or committed to a mental institution were barred indefinitely from purchasing or possessing a firearm from a federally licensed firearm dealer.⁶⁹

FOPA retains the prohibition of individuals such as felons or the mentally defective listed in the Gun Control Act, but it does not require a firearms dealer to determine if a purchaser is a member of a disfavored class.⁷⁰ The sale is only prohibited if the dealer knows or has reason to believe that the individual is prohibited under the Gun Control Act.⁷¹ In 1993, the Brady Law was passed, requiring federally licensed firearms dealers to check with the Chief Local Law Enforcement Officer (CLEO) in their jurisdiction to determine whether the potential purchaser of a firearm is prohibited under the law.⁷² This information proved to be difficult for CLEOs to ascertain because states were not required to maintain centralized lists or databases of persons that are prohibited for being mentally defective.⁷³ To rectify this deficiency the Brady Law directed the US Attorney General to establish an electronic National Instant Criminal Background Check System (NICS).⁷⁴ Federally licensed firearms dealers are able to immediately run a check of the name of the individual purchasing a weapon to determine whether they are legally prohibited.⁷⁵

25.10 (2005) (allowing an individual to appeal an erroneous report indicating that they are prohibited from purchasing a weapon). *See also* Jacobs & Jones, *supra* note 64, at n.27.

68. *Bean*, 537 U.S. at 588.

69. Jacobs & Jones, *supra* note 64, at 392.

70. *See* Heskin, *supra* note 52, at 822.

71. *Id.*

72. Jacobs & Jones, *supra* note 64, at 392–93 & n.28.

73. *Id.* at n.29.

74. The Brady Act created 18 U.S.C. § 922(t), providing for the NICS database used to keep track of individuals that are prohibited from purchasing guns for various reasons, including those with mental health conditions. *See* The Federal Bureau of Investigation, *National Instant Criminal Background Check System*, <http://www.fbi.gov/about-us/cjis/nics> (last visited Sept. 7, 2013).

75. There are significant privacy protections for lawful firearm purchasers under the Brady Act. Once a firearm dealer contacts the system and requests a background check, the system will provide the purchaser with a unique identification number telling the dealer that they are a lawful purchaser. If the pur-

This system has had significant inadequacies since its inception. In 1997, the Supreme Court ruled that states could not be compelled to report prohibited persons to the federal NICS system.⁷⁶ This would be akin to forcing a state to comply with a federal regulatory program.⁷⁷ As a result, reporting is sporadic at best, with some states over-reporting and others not reporting at all.⁷⁸ Therefore, in 2008 following the Virginia Tech massacre, Congress passed the Act to Improve the National Instant Criminal Background Check System, allowing for a form of relief from disabilities for all individuals who have previously been prohibited from purchasing a firearm due to mental adjudication or commitment.⁷⁹ The federal entity that adjudicated the individual as mentally defective or committed the individual to a mental institution shall provide a program for relief.⁸⁰ The federal entity must provide notice to the individual “at the commencement of the process of the prohibitions on receipt of firearms, the criminal penalties, and the availability of relief from disabilities.”⁸¹ The Act also provides a grant for States that report mental commitment and adjudication.

chaser is not prohibited from possessing a weapon, all of their information, other than the identification number and date of request, shall be destroyed. FIREARMS LAW DESKBOOK, §2:7 (2013). *See also* Guide to Medical Privacy & HIPPA Newsletter, *HHS Considering New HIPPA Exemption for Reporting to Gun Background Check Database*, 4 GUIDE MED. PRIVACY & HIPPA NEWSLETTER, 5 (2013).

76. *Printz v. United States*, 521 U.S. 898, 935 (1997).

77. *Id.* (noting that the Court previously held in *New York v. United States*, 505 U.S. 144, 161 (1992), that “Congress cannot compel the States to enact or enforce a federal regulatory program”).

78. According to a 2007 Press Release by the FBI, twenty-two states report mental health information of those deemed to be a “mental defective” to the NICS. *See* Katherine L. Record & Lawrence O. Gostin, *A Robust Individual Right to Bear Arms Versus the Public’s Health: The Court’s Reliance on Firearm Restrictions on the Mentally Ill*, 6 CHARLESTON L. REV. 371, 374–75 n.15 (2012).

79. NICS Improvement Amendments Act of 2007, Pub. L. No. 110-180, 122 Stat. 2559 (codified as amended in 18 U.S.C. § 922 (2007)). *See also* FIREARMS LAW DESKBOOK § 2:40 (2013).

80. *Id.*

81. *See Id.*

cations, a percentage of which is required to be used for the enactment of a similar form of relief.⁸²

THE RIGHT TO BEAR ARMS AS A FUNDAMENTAL LIBERTY INTEREST

As explained in Part V below, when a government entity deprives an individual of a fundamental right, they must provide that individual with certain due process procedures. In 2008, the United States Supreme Court found that the right to possess a weapon was an individual liberty interest protected by the Second Amendment of the United States Constitution.⁸³ In *District of Columbia v. Heller*, the Court addressed the issue of whether a state can deny its citizens the right to possess a handgun in their homes.⁸⁴ Following an extensive history of the Second Amendment and analysis of its language, the Court held that the right to self-defense was inherent in the Second Amendment and, therefore, a law banning all handguns in the home is unconstitutional.⁸⁵ The Court stated, “There seems to us no doubt, on the basis of both text and history, that the Second Amendment conferred an individual right to keep and bear arms.”⁸⁶ The Court also made a point to recognize the concerns that many have raised regarding handgun violence in this country.⁸⁷ However, they found that the constitu-

82. The grant is provided to states that report records of commitment and mental adjudication, a percentage of this grant is devoted to a relief from disabilities program. NICS Improvement Amendments Act of 2007, Pub. L. No. 110-180, 122 Stat. 2559 (codified as amended in 18 U.S.C. § 922 (2007)).

83. *District of Columbia v. Heller*, 554 U.S. 570, 595 (2008).

84. *Id.* at 629–30.

85. *Id.* at 628–29 (stating, “We start with a strong presumption that the Second Amendment right is exercised individually and belongs to all Americans”).

86. *Id.* at 595, 626 (noting that they will not take on an exhaustive analysis of the Second Amendment but that nothing in their opinion should be construed to alter longstanding prohibitions on the sell of firearms to those that have always been defined as mentally ill under the existing laws).

87. Many believe that the Second Amendment is considered antiquated in a society with well-trained police forces, an even more powerful standing army, and a serious problem with gun violence. However, the Court stated, “That is perhaps debatable, but what is not debatable is that it is not the role of this Court to pronounce the Second Amendment extinct.” *Id.* at 636.

tional guarantee enshrined in the Second Amendment outweighs certain policy choices meant to curb gun violence.⁸⁸

The Supreme Court extended the right to bear arms to the states in *McDonald v. City of Chicago, Illinois*⁸⁹ The Supreme Court made it abundantly clear in its decision in *Heller*, and reiterated this point in *McDonald*, that the right to bear arms is an individual right bestowed upon the people of the United States, and that to deprive an individual of his or her right to bear arms, subject to longstanding limitations, is unconstitutional.⁹⁰ In asking the question of whether the right to bear arms is incorporated into the due process concept, the Court stated, “Our decision in *Heller* points unmistakably to the answer. Self-defense is a basic right recognized by many legal systems from ancient times to the present day, and in *Heller*, we held that individual self-defense is ‘the central component’ of the Second Amendment right.”⁹¹ In both cases, the Court recognized the deeply rooted tradition allowing for the citizens of this country to bear arms. When an individual is deprived of a right so fundamental to our society, they must be afforded the protections of due process of law.⁹²

DUE PROCESS

The Supreme Court has held that the right to bear arms is a fundamental right afforded to all citizens of the United States, subject to certain prohibitions set forth in the Gun Control Act.⁹³ A government entity cannot deprive an individual of a fundamental

88. *Id.*

89. *McDonald v. City of Chi., Ill.*, 130 S.Ct. 3020, 3026 (2010) (“Applying the standard that is well established in our case law, we hold that the Second Amendment right is fully applicable to the States”).

90. *Heller*, 554 U.S. at 595. The Court in *McDonald* reiterated the language it used in *Heller*, making it clear that it did not intend to eliminate longstanding prohibitions on the purchase of weapons by those deemed mentally ill under the 1968 Gun Control Act. *McDonald*, 130 S. Ct. at 3047.

91. *McDonald*, 130 S. Ct. at 3036.

92. “In sum, it is clear that the Framers and ratifiers of the Fourteenth Amendment counted the right to keep and bear arms among those fundamental rights necessary to our system of ordered liberty.” *McDonald*, 130 S. Ct. at 3042.

93. *See* *District of Columbia v. Heller*, 554 U.S. 570, 595 (2008); *McDonald v. City of Chi., Ill.*, 130 S. Ct. 3020, 3047 (2010).

right without providing certain due process procedures such as notice and an opportunity to be heard.⁹⁴ Because the Supreme Court held that the Second Amendment right to bear arms applies to the states, when Tennessee deprives a mental health client of their right to bear arms under T.C.A. § 33-3-210, they must provide certain due process procedures.⁹⁵ The client, who is reported as dangerous to law enforcement under this statute but has not been adjudicated as mentally defective or committed to a mental institution, does not fall into any of the classes of people prohibited from possessing a firearm under federal or state law.⁹⁶ Therefore, to deprive the individual of his or her fundamental right to bear arms without due process of law, violates the Due Process Clause of the Constitution.⁹⁷

Those that truly fit the criteria set forth in T.C.A. § 33-3-210 could be a threat to public safety if allowed to possess a weapon and should be prohibited from such possession following certain due process procedures. However, there are also mental health clients who are reported by therapists in fear of liability.⁹⁸ These individuals are not actually dangerous, and yet, they have been deprived of a fundamental liberty interest without due process and without justification. Not only do they not receive notice of the

94. U.S. CONST. amend. XIV, § 1.

95. *McDonald*, 130 S. Ct. at 3026 (2010).

96. See 18 U.S.C. § 922(g) (2006); TENN. CODE ANN. § 33-3-210(a) (2013).

97. U.S. CONST. amend. XIV, § 1.

98. “Because of the extremely low probability that a mental patient will commit a violent act and the inherent inability of psychiatrists to predict dangerousness, over-commitment is statistically inevitable.” Theodore A. Olsen, *Imposing a Duty to Warn on Psychiatrist—A Judicial Threat to the Psychiatric Profession*, 48 U. COLO. L. REV. 283, 298 (1977) (exploring the implications of *Tarasoff* on the therapist’s potential for over-commitment of the mentally ill). See also Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990’s*, 16 LAW & PSYCHOL. REV. 29, 36 (1992) (“Others expressed concern that *Tarasoff* might lead to the overcommitment of patients as means of attempting to insure the potential victim’s safety”); Ginger Mayer McClarren, *Psychiatric Duty to Warn: Walking a Tightrope of Uncertainty*, 56 U. CIN. L. REV. 269, 284 (1987) (“This option is also contrary to public policy and may result in the incarceration of hundreds of innocent, non-dangerous mental patients”).

deprivation or an evidentiary hearing to challenge it, but they also do not have the ability to apply for relief from firearm disability.

Due Process Rights Required For The Deprivation Of A Fundamental Right

Under the United States and Tennessee Constitutions, an individual may not be deprived of their life, liberty, or property by a government entity without due process of law.⁹⁹ By enacting T.C.A. § 33-3-210, Tennessee is depriving those who are reported to law enforcement as dangerous of their liberty interest in the right to bear arms.¹⁰⁰ Under the due process clause, when a citizen is deprived of a fundamental liberty interest, they must be provided with notice and an opportunity to be heard.¹⁰¹ Procedural safeguards such as notice of the deprivation of an individual liberty interest and an evidentiary hearing allowing the individual to challenge the deprivation, protect the mental health client from an erroneous deprivation of their right to bear arms.

As explained in Part III, federal law allows for a relief from disabilities program that provides the opportunity for anyone who has had their right to possess a firearm removed to have that right restored.¹⁰² This law was expanded to include those who have been adjudicated as mentally defective or committed to a mental institution under federal law in 2008. Tennessee provides this opportunity to individuals who have had their handgun carry permit suspended or revoked, but it does not provide a relief from disabilities program for individuals who have had their right to possess a weapon revoked under T.C.A. § 33-3-210. Additionally, T.C.A. § 33-3-210 does not provide the due process procedures of notice or an evidentiary hearing required under the Fourteenth Amendment.

99. U.S. CONST. amend. XIV, § 1; TN CONST. art. I, § 8.

100. TENN. CODE ANN. § 33-3-210 (2013) (requiring mental health professionals to report to law enforcement when their patient has communicated a threat of harm to an identifiable third party).

101. 16C C.J.S. *Constitutional Law* § 1506 (2013) (citing *Crismore v. Montana Bd. of Outfitters*, 111 P.3d 681 (2005)); *Guardianship Estate of Keffeler ex rel. Pierce v. State*, 88 P.3d 949 (2004) (stating that “the state may not deprive a person of life, liberty, or property without notice and opportunity for a hearing appropriate to the nature of the case”).

102. 18 U.S.C. § 925(c) (2003).

TCA § 33-3-210 Violates Due Process

Tennessee law significantly expands the class of individuals that can have their right to possess a firearm revoked. It allows law enforcement to prevent individuals from possessing a firearm who have been reported by a mental health professional upon communication of a threat of death or bodily harm to an identifiable victim.¹⁰³ These individuals have not been adjudicated as a mental defective or committed to a mental institution per federal and state law, and yet, a unilateral, untested, and unchallenged determination of dangerousness by a mental health professional is enough to deprive them of the right to possess a firearm, indefinitely.

Additionally, T.C.A. § 33-3-210 does not require that the mental health client be given notice of the deprivation. As a result, clients would not become aware of the deprivation until they attempt to purchase a firearm. They also would not know why they could no longer possess a firearm. T.C.A. § 33-3-210 simply requires a mental health professional to report a client that has communicated a threat against an identifiable victim.¹⁰⁴ It does not require that they report the details of the threat or the mental illness, if any, from which the client is suffering.¹⁰⁵ Accordingly, the client is being deprived of a fundamental right based solely on the word of a therapist, without notice or the ability to challenge the deprivation at a hearing.

Some courts have addressed the issue of whether something less than a “commitment to a mental institution” can result in the deprivation of the right to bear arms without due process under the Gun Control Act. The First Circuit addressed the issue of whether an emergency commitment rises to the level of a “commitment” under the federal Gun Control Act as well as the state firearm prohibition statute.¹⁰⁶ In *United States v. Rehlander*, the defendants were charged with the unlawful possession of a weapon following an emergency commitment in which they were released after the

103. See TENN. CODE ANN. § 33-3-210(a)(1) (2013); Sher, *supra* note 10.

104. *Id.* § 33-3-210(a)(1) (2013).

105. *Id.* § 33-3-210(b) (2013).

106. *United States v. Rehlander*, 666 F.3d 45, 50 (2012).

requisite three-day period.¹⁰⁷ The Court held that the emergency commitment of the defendants does not constitute a commitment under the federal or state law for purposes of prohibiting gun purchases.¹⁰⁸ They pointed out that the Gun Control Act does not address *ex parte* hospitalizations and does not provide for temporary suspensions of the right to bear arms pending future proceedings on mental competency.¹⁰⁹ The Act also does not allow for the recovery of gun rights following a temporary hospitalization.¹¹⁰ The Court found that, because *Heller* established an individual liberty interest in the right to bear arms, the defendants could not be deprived of that right without due process.¹¹¹

107. The defendants, Benjamin Small and Nathan Rehlander, were involuntarily admitted to psychiatric hospitals under Maine’s “emergency hospitalization” statute, requiring a maximum of three days hospitalization. This statute is an “emergency hospitalization,” not a “commitment,” and so provides less strenuous procedures for the admittance. An emergency hospitalization under Maine law allows for a temporary admittance to a psychiatric hospital following an *ex parte* proceeding. “The procedures include an application by a health or law enforcement office, a certifying medical examination by a medical practitioner, and an endorsement by a judge or justice of the peace confirming that these procedures have been followed.” On the other hand, “commitments” require the procedures accompanying traditional adversary proceedings. Under Maine law, commitment causes the loss of the right to bear arms but an emergency hospitalization does not. *Id.* at 46–47.

108. *Id.* at 50. The First Circuit is not the only Court that has reached this conclusion. The Eighth Circuit held that the Gun Control Act did not “prohibit the possession of firearms by persons who had been hospitalized for observation and examination, where they were found not to be mentally ill. The statute makes it clear that a commitment is required.” *United State v. Hansel*, 474 F.2d 1120, 1123 (8th Cir. 1973).

109. *Rehlander*, 666 F.3d at 49.

110. *Id.*

111. *Id.* at 48. The Court found that *Heller* added a constitutional component that must be considered in depriving an individual of the right to bear arms.

Although the right established in *Heller* is a qualified right, . . . the right to possess arms (among those not properly disqualified) is no longer something that can be withdrawn by government on a permanent and irrevocable basis without due process. Ordinarily, to work a permanent or prolonged loss of a constitutional liberty or property interest, an adjudicatory hearing, including a right to offer and test evidence if facts are in dispute, is required.

In *Rehlander*, an emergency commitment with an ex parte proceeding determining whether the individual is dangerous does not afford the defendants the appropriate due process protections for the deprivation of a fundamental liberty interest. Under T.C.A. § 33-3-210, the mental health client is not provided any form of adjudication whatsoever. In light of the First Circuit's holding in *Rehlander*, T.C.A. § 33-3-210 does not provide the appropriate due process protections for individuals who have been deprived of their right to bear arms. The mental health professional's determination of dangerousness is the only evidence and procedure supporting the deprivation of a constitutional right. In the Gun Control Act, "Congress did not prohibit gun possession by those who were or are mentally ill and dangerous, and such a free floating prohibition would be very hard to administer, although perhaps not impossible."¹¹² That is why Congress sought to use determinations of mental incompetence made in prior judicial proceedings to establish the prohibition of firearm possession by those individuals that a court has determined should no longer be afforded the right to bear arms.¹¹³ T.C.A. § 33-3-210 seeks to undertake the arduous task of prohibiting gun possession by those unilaterally determined to be dangerous by a mental health professional. Without the protection of a judicial proceeding, Tennessee's mental health clients have no protection against an erroneous deprivation and an indefinite prohibition of their right to bear arms.

Federal law provides a mechanism for restoring the gun rights of individuals who have lost those rights through the judicial process.¹¹⁴ Tennessee does not provide such a mechanism for relief from disabilities. If an individual who has been adjudicated as a mental defective or committed to a mental institution can apply to have their rights restored, an individual who does not receive the same pre-deprivation due process protections should at least be afforded the opportunity to apply for relief following the deprivation. In the same way, if an individual subjected to a temporary

Id. Accordingly, the Court found that Maine's emergency hospitalization statute does not provide the appropriate due process for a permanent deprivation of the right to bear arms.

112. *Id.* at 50.

113. *Id.*

114. 18 U.S.C. § 925(c) (2003).

hospitalization should be provided due process procedures,¹¹⁵ then an individual that has not been subjected to hospitalization of any kind should also be provided such protections against a deprivation of their right to bear arms.

Proposed Changes

In order to rectify the problems described above, this paper proposes changes to T.C.A. § 33-3-210. The proposed changes would be a reasonable way to ensure that T.C.A. § 33-3-210 adheres to the Fourteenth Amendment and provides the patient who is being deprived of his or her liberty interest the appropriate due process procedures. The proposed changes should require that the patient be given notice by law enforcement within a reasonable time period that the person is now prohibited from possessing a firearm. The changes should also advise the person that they are now prohibited from possessing or purchasing a firearm and provide them with the opportunity to have an evidentiary hearing to challenge the prohibition. Finally, the changes should add a method for requesting that his or her name be removed from the registry of disqualified gun purchasers. This method could include an application process similar to that required by T.C.A. 39-17-1363 for the revocation or suspension of a handgun carry permit.¹¹⁶

While the purpose of this Note is not to propose model legislation, the following provisions could cure the constitutional defects found in T.C.A. § 33-3-210. The proposed changes should include:

- Within seven days of the mental health professional reporting an individual to law enforcement, law enforce-

115. *United States v. Rehlander*, 666 F.3d 45, 50 (2012) (holding that an individual subjected to an emergency hospitalization for a maximum three day period pursuant to an ex parte procedure should be afforded due process prior to a deprivation of his or her right to bear arms).

116. In Tennessee, an individual may challenge a suspension or revocation of their handgun carry permit. These individuals receive notice of the suspension or revocation and are afforded an opportunity to challenge it. Under TENN CODE ANN. § 33-3-210, if the individual does not have a handgun carry permit, they do not receive notice of the deprivation, they do not receive an evidentiary hearing, and they do not have the opportunity to challenge the deprivation. TENN. CODE ANN. §§ 39-17-1353 & 39-17-1354 (West 2012).

ment should notify the individual that they will no longer be able to purchase or possess a firearm.

- The person should then be afforded an evidentiary hearing within thirty days of receiving notice of the report.
- The evidentiary hearing should provide all of the rights afforded to an individual in an adversarial hearing, including the right to present evidence and cross-examine witnesses.
- Following the determination by an impartial adjudicator that an individual poses a threat to public safety, the individual's name should be placed on the state and federal registries prohibiting the individual from purchasing or possessing a firearm.
- Upon the deprivation of this constitutional right, the individual should also be afforded the opportunity to apply for relief from firearm disabilities.
- They should be afforded the opportunity to submit an application for relief every six months.

CONCLUSION

Tennessee passed T.C.A. § 33-3-210 with good intentions, serving the valuable purpose of protecting the public from gun violence. The proposed changes would not deprive the statute of its intended purpose of protecting public safety. It would allow law enforcement to take the appropriate precautions in protecting the intended victim, including prohibiting the client from purchasing or possessing a firearm. However, there are individuals who are erroneously reported to law enforcement by mental health professionals in fear of liability.¹¹⁷ Requiring certain due process protections such as an evidentiary hearing would protect the individual from an erroneous deprivation of their right to bear arms while providing a formal adjudication of whether the individual has communicated a legitimate threat of harm to an identifiable victim. The proposed changes would balance the due process rights of the individual being deprived of a liberty interest with the protection of public safety such that all interests would be protected.

117. Olsen, *supra* note 98.

Protecting the Victims of Cyberbullying: An IDEA

CAROLINE E. SAPP*

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WHOSE TIME HAS COME

You may remember bullying from your elementary or secondary education years. It may have happened occasionally or frequently. It may have happened to you or someone that you knew. The victim was either bruised and beaten or openly ostracized from groups. Public schools could take action by suspending or reprimanding the bully and (or) bullies. However in today's public schools, a different type of beast can torment and publicly humiliate victims. Now, school bullies have the option to ridicule victims via the Internet and through social networking forums.¹ Public school students who cyberbully their victims often are suspended for their actions. However, often this suspension is the only remedial action that the victim receives for the cyberbully's damage to his or her mental and emotional health. Depending on the jurisdiction, school officials may not even suspend the cyberbully. While suspension may fit the punishment for the perpetrator who inflicted harm upon the victim, victims need a more comprehensive solution than they now have.

This Note addresses the need for such a solution to help victims of cyberbullying. It also urges Congress to enact a new federal law addressing the problem. This Note looks to Congress' Individuals with Disabilities Education Act for a model on how public school systems could implement solutions to victims of cyberbullying. State statutes merely require bullying procedures for its school systems to follow rather than comprehensive solutions for the victim.² Existing scholarship focuses on the school's sus-

* Juris Doctor Candidate, May 2014, The University of Memphis, Cecil C. Humphreys School of Law; *Mental Health Law & Policy Journal*, Editor-in-Chief; M.A. 2011, Tennessee Technological University; B.S. 2005, Tennessee Technological University. The author would like to thank Professor of Law Christina A. Zawisza of The University of Memphis, Cecil C. Humphreys School of Law, Dustin M. Hudson, and the entire *Mental Health Law & Policy Journal* staff.

1. Social networking forums include, but are not limited to, Twitter, YouTube, Vine, Instagram, Facebook, and Instant Messaging.

2. See also CAL. EDUC. CODE §32261 (2013) (addressing cyberbullying: "bullying committed personally or by means of an electronic act"); IDAHO CODE ANN. § 18-917(A) (2013) (bullying could be committed via computer or computer network); KAN. STATE. ANN. § 72-8256 (2013) (using "cyberbullying" in its bullying definition); ARK. CODE ANN. §6-18514 (2013) (stating that bullying

pension of the cyberbully and First Amendment free speech protection.³ For example, the United States Supreme Court created a two-prong test to determine whether a student has First Amendment protection in secondary schools: schools can only suppress a student's speech if it causes or "substantially" disrupts a school's activities or the speech violates another student's rights.⁴ Other articles discuss the inability of a school system to punish a cyberbully or the other tests courts can use to punish the cyberbully's off-campus speech.⁵ Thus in *J.C. v. Beverly Hills Unified School District*, students created a video after school at an off-campus restaurant describing a fellow student in derogatory terms and posted the video on YouTube.⁶ The *J.C.* court held that without more, the school cannot suspend the cyberbully because no confrontation occurred and a student's hurt or embarrassed feelings do not rise to the level of a substantial disruption at school.⁷

This Note proposes that public school systems use the model developed by Individuals with Disabilities Education Act's (IDEA) Individualized Education Program (IEP) to create an individualized counseling program for the victimized student, and provide the victim with a more comprehensive solution than now exists. This specialized counseling program should be implemented

can occur via electronic act whether on school grounds or not); TENN. CODE ANN. § 49-6-1016 (2013).

3. Karly Zande, *When the School Bully Attacks in the Living Room: Using Tinker to Regulate Off-Campus Student Cyberbullying*, 13 BARRY L. REV. 103, 106–36 (2009) (discussing the effects of student cyberbullying and recommending that school officials use the *Tinker* test established in *Tinker v. Des Moines Indep. Cnty. Sch. Dist.*, 393 U.S. 503, 511 (1969), to suppress cyberbullies' speech).

4. *Tinker v. Des Moines Indep. Cnty. Sch. Dist.*, 393 U.S. 503, 511 (1969) (two-prong test to determine when a school violated a student's First Amendment right).

5. John T. Ceglia, *The Disappearing Schoolhouse Gate: Applying Tinker in the Internet Age*, 39 PEPP. L. REV. 939, 959–67 (2012) (describing the lower court's confusion at applying the *Tinker* standard to internet speech and applying whether bullying occurred on or off campus, Impact upon Campus Application of *Tinker*, and third-circuit split on what test to use when students use internet speech).

6. *J.C. v. Beverly Hills Unified Sch. Dist.*, 711 F.Supp.2d 1094, 1101 (C.D.Cal. 2010).

7. *Id.* at 1118.

by the public school systems that receive IDEA's federal funding to help victims of cyberbullying cope with the mental and emotional affects derived from the cyberbully's behavior. Rather than focusing on the cyberbully, this article advocates that this solution concentrates on the victim. This article, further, argues that it takes a tried and true statutory scheme like IDEA to effectively protect students from cyberbullying and encourage schools to implement a model by using the mechanisms of IDEA, such as federal funding incentives.⁸ Public school systems would be forced to investigate cyberbullying when teachers or concerned students alert administration of possible cyberbullying incidents or upon request by the victim or the victim's parent or guardian. After the investigation, the school should use its guidance counselors, trained to help students cope with difficult issues, to counsel the victims of cyberbullying and create an IEP for the victim. The guidance counselors would work with the victim, his or her parents, and other school administrators to create this IEP for the victim. The IEP would address the mental and emotional health issues of the victim and help the victim adjust back into the public school setting in his or her least restrictive learning environment. Additionally, in cases in which the public school identifies the victim's cyberbully, schools could require the individual who cyberbullies the victim to pay for additional counseling.

This Note will encourage public school systems to focus on the victim and his or her protection, rather than focus on the cyberbully and his or her one-week suspension or other means of punishment.⁹ Part I defines the scope of school bullying, cyberbullying, and how bullying affects students. Part II discusses the inadequacy of civil remedies for victims of cyberbullying. Part III discusses the relevant Supreme Court cases and a public school student's First Amendment rights. Part IV describes the IDEA and a public school system's requirement to provide students with special needs an Individual Education Plan. Part V addresses IDEA's IEP and how an IEP should and can be used as a solution to help victims of cyberbullying.

8. EILEEN ORDOVER, *EDUCATION RIGHTS OF CHILDREN WITH DISABILITIES 1* (The Avocado Press 2001).

9. *See Zande, supra* note 3, at 106–07.

SCOPE OF THE ISSUE

School Bullying

In the past, school bullying referred to adolescents using physical acts or aggressive behavior to intimidate another student.¹⁰ Bullying is when one person systematically and chronically inflicts either physical pain or psychological distress on another person.¹¹ Bullying can involve teasing another person, socially excluding someone, threats, intimidating someone, stalking, using physical violence against someone, stealing, sexual harassment, religious harassment, racial harassment, public or private humiliation, or destructing property.¹² School bullying can occur when it has the effect of destroying property, when it physically, mentally, and emotionally hurts a student, or when a bully insults or demeans another student or a group at school creating a substantial disruption with the school's operation.¹³

Bullies are not the insecure caricatures of a novel or a television drama's creation. Rather than showing insecurity, statistics show that most bullies have an immense amount of confidence and self-esteem.¹⁴ Typically, male bullies are strong and big rather than weak or small.¹⁵ Also, statistics generally show that students who bully others can create friendships with others easily, especially with aggressive students who may encourage or join in to bully another student.¹⁶ Bullies typically make lower grades than students who do not bully, and have certain characteristics, such as acting impulsively, disliking school, and encountering disciplinary issues.¹⁷ Students can use either direct or indirect mechanisms to bully others, such as ostracizing or spreading hurtful rumors about another student.¹⁸

10. Robin M. Kowalski & Susan P. Limber, *Electronic Bullying Among Middle School Students*, 41 J. ADOLESCENT HEALTH S22, S22 (2007); see also MERIAM-WEBSTER DICTIONARY (2009).

11. See FLA. STAT. ANN. § 1006.147(3)(a)(b) (2013).

12. *Id.*

13. See CODE L. S. CAR. § 59-63-120(1)(a)(b) (2013).

14. Kowalski & Limber, *supra* note 10, at S22.

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

Cyberbullying

Unlike regular school bullies who are easily detected by their physical presence, cyberbullying occurs when other adolescents can hide behind a computer screen or a cell phone and torment another student via text message, email, instant messaging, or through social networks.¹⁹ Cyberbullying is bullying that occurs via electronic devices.²⁰ Electronic devices can be any type of phone, including a cellular phone or regular telephone, other wireless telecommunication devices, personal digital assistants (PDAs), computers, any electronic mail, instant messaging, text messaging, and web sites.²¹ Cyberbullying is online harassment that occurs multiple times and involves power imbalances.²² Online harassment is aggressive behavior that includes insults or exclusion and activities that involve hacking, damaging websites, and damaging profiles.²³

Defining Cyberbullying

Cyberbullying occurs when a person uses an electronic device to harass another person. Cyberbullying can also occur when the cyberbully creates a webpage or blog and assumes the identity of another person to inflict psychological distress on an individual.²⁴ Other cyberbullying activities include knowingly impersonating another person and posting content and (or) messages intend-

19. *Id.*

20. TENN. CODE ANN. § 49-6-1015 (2013); *see also* BULLYING & HARASSMENT: TDOE. Definitions, http://www.tn.gov/education/safe_schls/safety_cntr/bullying.html (last visited Dec. 31, 2012). Cyber-bullying is bullying that takes place using electronic technology. Electronic technology includes devices and equipment such as cell phones, computers, and tablets, as well as communication tools including social media sites, text messages, chat, and websites. Examples may include mean text messages or emails, rumor sent by email or posted on social network sites, and embarrassing pictures, videos, websites, or fake profiles. *Id.*

21. *See* TENN. CODE ANN. § 49-6-1015(a)(2) (2013).

22. *Id.*

23. Pew Research Center's Internet & American Life Project, *Cyberbullying 2010: What the Research Tells Us*, <http://www.slideshare.net/PewInternet/cyberbullying-2010-what-the-research-tells-us-4009451> (last visited Sept. 13, 2013) (hereinafter Pew Research Center).

24. *See* FLA. STAT. ANN. § 1006.147(3)(a) (2013).

ing to cause harm, electronically distributing communication to multiple individuals or posting materials on the Internet that is accessible by multiple people with the intent of harassing a victim.²⁵

Studies indicate that cyberbullies might use electronic devices to bully their victim by sending repetitive messages to create emotional trauma in the victim.²⁶ Depending on the study, many statistics reveal that most middle and high school students use the Internet daily, and forty-five percent own cell phones.²⁷ Students' significant use of the Internet creates an opportunity for a silent bully that differs from the traditional bully who beats, bruises, and belittles his or her victim in a face-to-face physical interaction or exclusion from a social group. As a result, a cyberbully has different means to inflict emotional trauma upon a student without the quick detection of parents and/or educators.

Cyberbullying can occur to adolescents at home or at school. For example, harassment in the cyberbullying context can be felt at school when the cyberbully's act substantially interferes with a student's educational performance, opportunities, or benefits, and if the harassing act occurs on the school's campus, any school-sponsored function, on school equipment, school transportation, or an official bus stop.²⁸ A cyberbully's act is harassment when the act physically harms a student or damages a student's property.²⁹ Harassment can be an act that places a student in rea-

25. See *id.* § 1006.147(3)(b).

26. *Id.*; see also David Finkelhor et al., *Online Victimization of Youth*, ENCYCLOPEDIA OF CRIME & PUNISHMENT, 1109–12 (2002), available at <http://www.unh.edu/ccrc/pdf/jvq/CV48.pdf>; David Finkelhor et al., *Online Victimization: Five Years Later*, U. N. HAMP. NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN (2006), <http://www.unh.edu/ccrc/pdf/CV138.pdf>.

27. Harlan Lebo et al., *The UCLA Internet Report: Surveying the Digital Future Year Three*, UCLA CTR. COMM'N. P. Nov. 10, 2012, available at <http://ccp.ucla.edu>. These statistics found that ninety-seven percent of students, ages twelve to eighteen, use the Internet; see also Amanda Lenhart, *Teen and Technology: Youth are leading the transition to a fully wired and mobile nation*, PEW INTERNET & AM. LIFE PROJECT (2005), available at http://www.pewinternet.org/~media/Files/Reports/2005/PIP_Teens_Tech_July2005web.

26. See TENN. CODE ANN. § 49-6-1015 (2013).

27. *Id.* § 49-6-1015(a)(2). The author is using Tennessee's code because she worked in Tennessee's secondary school systems. Prior to attending law school, the author worked as a student teacher in one high school and one mid-

sonable fear of physical harm or damages the student's property. Additionally, harassment can be an act that causes emotional distress to a student or students or creates a hostile educational environment.³⁰ Furthermore, if a student's act takes place off school property or outside of a school-sponsored activity and the student's actions are directed specifically at a student or students with the effect of creating a hostile educational environment or creating a substantial disruption to the educational environment or learning process, that student's act will be considered cyberbullying.³¹

Most states define cyberbullying³² in their anti-bullying statute, and the definition usually includes a bully's electronic acts

dle school in Middle Tennessee, along with teaching two writing classes at Tennessee Technological University as a graduate teaching assistant.

28. *See id.* §§ 49-6-1015(a)(3)(A).

29. *See id.* §§ 49-6-1015(a)(3)(B).

31. *See id.* §§ 49-6-1015(a)(3)(B).

32. *See* ARK. CODE ANN. §6-18-514 (2013) (stating that bullying can occur via electronic act whether on school grounds or not); FLA. STAT. § 1006.147 (2013) (prohibiting cyberbullying that is accessed through data or computer software, even when the cyberbullying occurs at nonschool related-functions, activities, programs, through technology, and even when it occurs through electronic devices that are not owned by the school or the school district); GA. CODE ANN. § 20-2-751.4 (2011) (defines cyberbullying); IDAHO CODE ANN. § 18-917 (2013) (including that bullying can be committed against another student via computer, computer network, car phone, wireless phone, use of data, or computer software); 105 ILL. COMP. STAT. 5/27-13.3 (2009) (defines cyberbullying); KAN. STAT. ANN. § 72-8256 (defining cyberbullying); KY. REV. STAT. ANN. § 525.080 (West 2008) (making electronic harassment a crime while enrolled as a student in a school district); LA. REV. STAT. ANN. § 40.3 (2010) (defining cyberstalking and making it a crime); ME. REV. STAT. 20, § 6554 (2012) (includes cyberbullying in its prohibition against bullying in public schools); MD. CODE ANN., EDUC. § 7-424.3 (West 2011) (identifying that bullying includes bullying through electronic communication); MASS. GEN. LAWS. ch. 71, § 370 (2003) (includes a definition of cyberbullying); MICH. COMP. LAWS § 380.1310b (2011) (includes definition of cyberbullying); MINN. STAT. § 121A.0695 (2007) (defining cyberbullying as bullying through electronic forms); MISS. CODE ANN. §37-11-67 (2013) (includes bullying through electronic communications); MO. REV. STAT. § 160.775 (2010) (identifying cyberbullying); NEV. REV. STAT. § 392.915 (2010) (making cyberbullying a crime and stating that persons shall not cyberbully another student, charter school, or school employee); N. H. REV. STAT. ANN. § 193-F: 4 (2010) (defines cyberbullying); N. M. STAT. ANN. 1978 § 22-2-21 (2013) (identifying cyberbullying); N. Y. EDUC. LAW § 11 (McKinney 2013) (includes cyberbullying in the harassment

that occur either on school grounds on or off school property or equipment.³³ Generally, the electronic act constitutes bullying when the act is specifically directed at students or school personnel and is maliciously intended for the purpose of disruption at school or has a high likelihood of disrupting a school.³⁴ Thus, as long as the bullying is directed at the school, regardless of whether it occurred on school grounds, some states force school officials to investigate the incident.³⁵

The Cyberbully

Cyberbullies are often victims of bullying or cyberbullying themselves.³⁶ Cyberbullies have a “damaged sense of self,” and the Internet is where they can target others.³⁷ A cyberbully can strike at any time or place if his or her victim has access to the Internet.³⁸

and bullying statute); N. C. GEN. STAT. § 14-458.1 (2012) (making cyberbullying a penalty); N. D. CENT. CODE § 15.1-19-17 (2013) (bullying definition includes bullying through electronic means); OHIO REV. CODE ANN. § 3313.666 (2012) (includes cyberbullying definition); OKLA. STAT. tit. 70, § 24-100.3 (2013) (amended by 2013 Okla. Sess. Law. Serv. Ch. 311 (H.B. 1661)) (defining bullying, include bullying through an electronic form); OR. REV. STAT. § 339.356 (2013) (requiring that schools adopt a policy and procedures to address bullying, including prohibiting cyberbullying); 24 PA. CONS. STAT. § 13-1303.1-A (2013) (defines bullying, including cyberbullying definition); 1956 R. I. GEN. LAWS § 16-21-33 (2013) (defining cyberbullying); S. C. CODE ANN. § 59-63-120 (2013) (defines bullying, including bullying through electronic form); S. D. CODIFIED LAWS § 13-32-13 (2013) (defining cyberbullying); UTAH CODE ANN. § 53A-11a-301 (West 2013) (defines bullying, including bullying through electronic form); VA. CODE ANN. § 22.1-279.6 (2013) (defining bullying, including bullying via electronic form); WASH. REV. CODE § 28A.300.285 (2013) (defining bullying, including bullying through electronic form); W. VA. CODE § 18-2C-2 (2011) (defining bullying, including intentional bullying through electronic form); WYO. STAT. ANN. § 21-4-312 (2013) (defines bullying including bullying through electronic means).

33. See ARK. CODE ANN. §6-18514(2)(B)(ii)(b) (2013).

34. See *id.* §6-18514(2)(B)(ii)(b).

35. See *id.* §6-18514(2)(B)(2)(e)(1).

36. Mary Winter, *Phoebe Prince: Victim of Bullycide—or of a Deeper Problem?*, <http://www.politicsdaily.com/2010/04/20/phoebe-prince-victim-of-bullycide-or-of-a-deeper-problem/> (last visited Sept. 13, 2013).

37. *Id.*

38. See Bill Belsey, *What is Cyberbullying?* (2004), <http://www.bullying.org/external/documents/ACF6F8.pdf>.

As students transition from middle school to high school, the Internet becomes integrated into part of their day because students may complete or type their homework on computers, have access to the Internet at school or at home, and more importantly, participate in social networking sites.³⁹ With the increased number of adolescents owning cellular phones, having unlimited access to the Internet, and being a member of a social networking website, a cyberbully can even torment a victim at his or her own home.⁴⁰

Seventy-eight percent of teenagers now own a cell phone, and forty-seven percent of those teens own a Smartphone.⁴¹ Seventy-three percent of teens use an online social networking website to connect with other teens.⁴² Thirty-seven percent of teens send messages through social networking websites.⁴³ Through these social networking sites, teens can create their own profiles or change their identity.⁴⁴ If a teen chooses to change his or her identity, the teen can become anonymous.⁴⁵

The Silent Cyberbully

An adolescent can easily create an anonymous profile on the Internet⁴⁶ and use that anonymous identity to cyberbully a victim.⁴⁷ Without a victim knowing who continues to bully him or her, the anonymity issue can create additional emotional trauma for the victim because the victim does not know whether one or multiple individuals are bullying him or her.⁴⁸ Further, the enemy that one knows may be less stressful to an adolescent than the one who is unknown.⁴⁹ This ambiguity creates more fear in a victim because the lack of witnesses to a cyberbully's actions form a limitless

39. Students not only use the internet to complete homework or type papers but also use for social networking websites; Kowalski & Limbar, *supra* note 10, at S28.

40. See Bill Belsey, *supra* note 38.

41. Pew Research Center, *supra* note 23.

42. *Id.*

43. *Id.*

44. Kowalski & Limbar, *supra* note 10, at S28.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

realm to bully another via the Internet.⁵⁰ Studies show that adolescents admit to playing tricks on others by pretending to be someone else when on the Internet.⁵¹ Further, with social networking websites now reaching out to young adults, a new playing field has opened to create more cyberbullies and more victims.⁵²

The Silent Victim

With neither bruises nor black eyes, parents and school officials may have a hard time identifying that a child is being cyberbullied. Thirty-two percent of teens have experienced online bullying.⁵³ A study surveyed over twenty thousand students, and thirty percent admitted to writing mean messages to others over the Internet.⁵⁴ Another study indicates that thirteen percent of students admit to bullying others, eleven percent admitted to being bullied, and six percent of students admitted to both bullying and being bullied.⁵⁵ Thus, almost thirty percent of students either bully other students or are the victims of a bullying themselves.⁵⁶ Victims of bullying can be scared to tell parents, friends, or teachers because victims fear that the bullying will only increase if other people find out about it.⁵⁷ Cyberbullying victims are afraid to tell others about being cyberbullied because victims fear that the adult will overreact, take away their cell phone, computer, or other devices used to access the Internet.⁵⁸ This removal from the Internet is “increasingly unthinkable for the ‘Always On’ generation [because] not

50. *Id.*

51. ROBIN M. KOWALSKI ET AL., CYBERBULLYING: BULLYING IN THE DIGITAL AGE, 9 (2008) (2001 Pew Report where adolescents surveyed admitted to pretending to be someone else on the internet).

52. KOWALSKI ET AL., *supra* note 51, at 9 (discussing how technology is here to stay, and the creation of social networks as adolescents’ social hub).

53. Pew Research Center, *supra* note 23.

54. *Id.* at 10 (i-SAFE America conducted the survey). i-SAFE America is a non-profit organization that partners with educators, leaders, police, and parents to provide internet safety information to children. i-SAFE creates internet standards and conducts surveys on how to further their goals of providing children and teens safe and responsible ways to navigate the internet.

55. Kenneth Walker, Address at the University of Memphis (Nov. 2012).

56. Walker, *supra* note 55.

57. See Bill Belsey, *supra* note 38.

58. *Id.*

being online means not being able to socialize or communicate with their peers, and this fear of exclusion is paramount in the lives of most adolescents and teens.”⁵⁹

Online encounters not only provide teens with anonymous identities but also give them the power to scare others that face-to-face encounters might not provide. One adolescent female admitted that after a breakup with her boyfriend, she began to receive obsessive emails stating how he was going to kill her.⁶⁰ The female did not report the emails but noted that while she was scared, she knew that he would not really kill her.⁶¹

Consequences of Cyberbullying

Students’ constant use of the Internet may increase cyberbullying among students, but it can also inflict additional harms on a victim. Research has shown that Internet usage for adolescents may not only increase cyberbullying, but it also can increase depression levels and loneliness.⁶² Because victims of cyberbullying have little opportunity to fight the cyberbully back, the victim can feel helpless and hopeless.⁶³ Studies show that bullied teens are more likely to have psychological problems, abuse illegal substances, and carry weapons.⁶⁴

Not only can bullying cause depression, loneliness and anxiety, but students targeted by bullies will sometimes either avoid school or have trouble concentrating.⁶⁵ Victims of bullying can also have lower academic achievement and aspirations, be depressed, show post-traumatic stress, demonstrate a general deterioration in their physical health, inflict self-harm, have suicidal thoughts, or can feel alienated in the school environment or by one’s peers.⁶⁶ With sixty-six percent of bullying victims believing that school professionals handled their bullying situation poorly,⁶⁷ school systems should not only look at ways to stop bullying

59. *Id.*

60. A young adult discussed her interactions via Internet for a study. *Id.*

61. *Id.*

62. KOWALSKI ET AL., *supra* note 51, at 9.

63. Mary Winter, *supra* note 36.

64. Pew Research Center, *supra* note 23.

65. *See Walker, supra* note 55.

66. *See id.*

67. *See id.*

and/or cyberbullying but also implement a solution to help victims of cyberbullying.

Suspending or punishing a bully is only a band-aid to the situation because there is no long-term recovery or coping mechanisms for the victim.⁶⁸ For example, an estimated 160,000 students skip school to avoid daily bullying occurring at school.⁶⁹ Additionally, thirty-two percent of students admitted to being bullied at school.⁷⁰ For those teens that are severely cyberbullied, the cyberbullying, ultimately, can happen twenty-four hours day, and the victim can feel like there is no escape.⁷¹ Congressional findings on cyberbullying show that:

- (1) Four out of five of United States children aged 2 to 17 live in a home where either they or their parents access the Internet.
- (2) Youth who create Internet content and use social networking sites are more likely to be targets of cyberbullying.
- (3) Electronic communications provide anonymity to the perpetrator and the potential for widespread public distribution, potentially making them severely dangerous and cruel to youth.
- (4) Online victimizations are associated with emotional distress and other psychological problems, including depression.
- (5) Cyberbullying can cause psychological harm, including depression; negatively impact academic performance, safety, and the well-being of children in school; force children to change schools; and in some cases lead to extreme

68. *Id.*

69. *Id.*

70. *Id.*

71. South Florida Parenting, *Cyberbullying: A More Complex Form of Bullying*, SUN SENTINEL, Aug. 23, 2013, available at http://articles.sun-sentinel.com/2012-08-23/features/sfe-sfp-cyberbullying_1_hurtful-messages-rivero-social-media. South Florida Parenting was quoting Dr. Sara Rivero-Conil. *Id.* Dr. Sara Rivero-Conil is a psychologist at Miami's Children's Hospital's Psychiatry Department. *Id.*

violent behavior, including murder and suicide.

- (6) Sixty percent of mental health professionals who responded to the Survey of Internet Mental Health Issues report having treated at least one patient with a problematic Internet experience in the previous five years; 54 percent of these clients were 18 years of age or younger.⁷²

Ryan Patrick Halligan (Ryan) is a stark face to the cold statistics. At thirteen, Ryan committed suicide because he was constantly bullied at school and online.⁷³ Ryan received instant messages alleging that he was gay, and in hopes of suppressing this rumor, Ryan messaged back and forth with another girl who forwarded their conversations to other students.⁷⁴ Due to the on-campus school bullying and continued cyberbullying at home, Ryan took his own life.⁷⁵ Neither the school nor Ryan's parents could give him the help that he needed.⁷⁶ If Ryan would have talked to someone about the cyberbullying or reported the incident to a teacher or guidance counselor, counseling services may have addressed the issue at school or put his parents on alert. If the school system had a comprehensive solution procedure in place for victims of cyberbullying, school officials responsible for enforcement of the procedure could have helped Ryan by placing him in counseling services.

Megan Meier (Megan) was also a victim of cyberbullying.⁷⁷ A boy, supposedly named Josh, contacted Megan through MySpace.com.⁷⁸ After a few weeks of flirting online, Josh's be-

72. 110 H.R. 6123, 2008 H.R. 6123. This act is a bill to amend title 18, United States Code, and the act can also be cited as the Megan Meier Cyberbullying Prevention Act.

73. KOWALSKI ET AL., *supra* note 51, at 13.

74. *Id.* Ryan's father found these messages on his computer, along with other conversations.

75. *Id.*

76. *Id.*

77. Christopher Maag, *A Hoax Turned Fatal Draws Anger But No Charges*, N.Y. TIMES, Nov. 28, 2007, available at http://www.nytimes.com/2007/11/28/us/28hoax.html?_r=0.

78. *Id.* Myspace.com is a social networking website.

havior towards Megan changed, and he stated that “the world would be a better place without you.”⁷⁹ After Josh’s last online message, Megan committed suicide.⁸⁰ Megan was thirteen years old.⁸¹

Rebecca Sedwick (Rebecca) was also bullied online, and at twelve-years old, she committed suicide.⁸² Rebecca’s problems with cyberbullying began over a “boyfriend issue.”⁸³ Over a dozen middle school girls harassed Rebecca online.⁸⁴ Multiple social media applications showed hate messages that were sent to Rebecca, such as “Go kill yourself” and “Why are you still alive?”⁸⁵ The Polk County Sheriff that investigated Rebecca’s suicide stated that she had been despondent, “beat down,” and “absolutely terrorized.”⁸⁶ Prior to her suicide, Rebecca was placed in a mental facility.⁸⁷ After receiving treatment, Rebecca began attending a new high school and was away from her ex-classmates.⁸⁸ The new high school did not keep Rebecca’s cyberbullies away. Investigators discovered that Rebecca told a twelve-year-old boy that she was going to kill herself: “I’m jumping. I can’t take it anymore.”⁸⁹ The twelve-year-old boy told no one.⁹⁰

Public School’s Cyberbullying Policies

While some states still do not identify cyberbullying in their bullying polices, a majority of states do include cyberbully-

79. *Id.*

80. *Id.*

81. *Id.*

82. The Associated Press, *Florida: Bullying Investigated After Girl, 12, Kills Herself*, NEW YORK TIMES, Sept. 12, 2013, available at http://www.nytimes.com/2013/09/13/us/florida-bullying-investigated-after-girl-12-kills-herself.html?ref=cyberbullying&_r=1&.

83. *Id.*

84. *Id.*

85. *Id.*

86. Barbara Liston, *Cyberbullying investigating in death of Florida girl*, NBC NEWS, Sept. 14, 2013, available at <http://www.nbcnews.com/technology/cyberbullying-investigated-death-florida-girl-8C11157763>.

87. *Id.*

88. *Id.* It is unknown if Rebecca received psychiatric help after she started her new school.

89. *Id.*

90. *Id.*

ing.⁹¹ The states that do include cyberbullying in their anti-bullying statutes require school districts to adopt bullying policies and pro-

91. See also ALA. CODE § 13A-11-8(b) (2013) (making harassing electronic communications a misdemeanor, but not addressing cyberbullying); ALA. CODE § 16-28B-6 (1975) (addressing the duties of schools, including developing and implementing harassment practices but does not specifically identify cyberbullying); ALASKA STAT. § 11-16-120(a)(4) (2013) (not specifically addressing cyberbullying in schools but containing an anti-harassing provision through electronic communication); ARIZ. REV. STAT. § 13-2921.01 (2013) (not containing cyberbullying statute but addressing aggravated harassment); ARK. CODE ANN. § 6-18-514 (2013) (stating that bullying can occur via electronic act whether on school grounds or not); CAL. EDUC. CODE § 32261 (2012) (intending that California public schools develop safety plans and strategies to prevent bullying committed by electronic means); COLO. REV. STAT. ANN. § 22-32-109.1 (West 2013) (not containing a cyberbullying statute but addressing bullying); CONN. GEN. STAT. ANN. § 10-222d (West 2011) (requiring that schools develop plans to prevent bullying and cyberbullying); 14 DEL. CODE ANN. § 4123A (West 2007) (stating that each school district must receive training on how to identify and report bullying prevention, including bullying via electronic communication); D.C. CODE § 22-404 (2013) (addressing assaults, threats, and stalking, but no cyberbullying statute); FLA. STAT. § 1006.147 (2013) (prohibiting cyberbullying that is through data or computer software, even when the cyberbullying occurs at non-school related-functions, activities, programs, through technology, and occurring through electronic devices that are not owned by the school or the school district); GA. CODE ANN. § 20-2-751.4 (2011) (including cyberbullying and requiring that schools adopt policies to prohibit the bullying of another student); HAW. REV. STAT. § 302A-1002 (2013) (requiring the school board to adopt rules on reporting a crime, but not containing a bullying or a cyberbullying statute); IDAHO CODE ANN. § 18-917 (2013) (including that bullying can be committed against another student via computer, computer network, car phone, wireless phone, use of data, or computer software); 105 ILL. COMP. STAT. 5/27-13.3 (2009) (schools must incorporate an Internet safety component into their curriculum, including recognizing and reporting online harassment and cyberbullying); IND. CODE § 20-33-8-13.5 (2013) (requiring that schools' discipline rules prohibit bullying and include bullying through data or computer software); IOWA CODE § 280.28 (2007) (requiring that schools' policies prohibit harassment and bullying, including cyberbullying); KAN. STAT. ANN. § 72-8256 (defining cyberbullying); KY. REV. STAT. ANN. § 525.080 (West 2008) (making electronic harassment a crime while enrolled as a student in a school district); LA. REV. STAT. ANN. § 40:3 (2010) (defining cyberstalking and making it a crime); ME. REV. STAT. 20, § 6554 (2012) (including cyberbullying in its prohibition against bullying in public schools); ME. REV. STAT. 20, § 254 (2012) (requiring that schools develop a policy to address bullying); MD. CODE ANN., EDUC. § 7-424.1 (West 2008) (requiring schools to develop procedures of re-

porting incidents); MD. CODE ANN., EDUC. § 7-424.3 (West 2011) (identifying that bullying includes bullying through electronic communication); MASS. GEN. LAWS. ch. 71, § 370 (2003) (including a definition of cyberbullying and mandates that each schools develop a plan and procedures to address bullying); MICH. COMP. LAWS § 380.1310b (2011) (requiring that schools implement a policy and procedures to report bullying, including cyberbullying); MINN. STAT. § 121A.0695 (2007) (requiring the school board to adopt a bullying policy, including bullying through electronic forms); MISS. CODE ANN. § 37-11-69 (2010) (requiring schools to prohibit bullying and adopt procedures); MISS. CODE ANN. § 37-11-67 (2013) (includes bullying through electronic communications); MO. REV. STAT. § 160.775 (2010) (identifying cyberbullying, requiring schools to adopt a bullying policy and to report on any bullying incidents); MONT. CODE ANN. § 20-2-101 (2013) (no§ 20-2-101 (2013) (giving the board of public education authority to plan, coordinate, and evaluate policies for the public schools but no policies addressing cyberbullying); NEB. REV. STAT. § 79-2-137 (2012) (not addressing cyberbullying but requiring school districts to develop and adopt a bullying policy); NEV. REV. STAT. § 392.915 (2010) (making cyberbullying a crime and stating that persons shall not cyberbully another student, charter school, or school employee); N.H. REV. STAT. ANN. § 193-F:4 (2010) (defining cyberbullying and requiring schools to adopt a policy to prohibit cyberbullying); N.J. STAT. ANN. § 18A:37-15 (West 2012) (requiring school districts to adopt a policy on bullying and describe procedures for reporting bullying); N.J. STAT. ANN. § 18A:37-20 (2011) (mandating that each school shall appoint a anti-bullying specialist and describes the duties of an anti-bullying specialist); N.M. STAT. ANN. 1978 § 22-2-21 (2013) (requiring that schools must promulgate a specific cyberbullying policy and list requirements of the policy); N.Y. EDUC. LAW § 13 (McKinney 2013) (requiring the board of education to create policies, procedures, and guidelines to stop, report, and orally notify of bullying); N.Y. EDUC. LAW § 11 (McKinney 2013) (including cyberbullying in the harassment and bullying statute); N.C. GEN. STAT. § 115C-407.16 (2009) (requiring schools to adopt policies prohibiting bullying); N.C. GEN. STAT. § 14-458.1 (2012) (making cyberbullying a penalty); N.D. CENT. CODE § 15.1-19-20 (2013) (requiring school systems to implement bullying prevention programs); N.D. CENT. CODE § 15.1-19-17 (2013) (bullying definition includes bullying through electronic means); OHIO REV. CODE ANN. § 3313.666 (2012) (requiring schools to adopt policies and procedures on bullying, includes cyberbullying definition); OKLA. STAT. tit. 70, § 24-100.4 (2013) (amended by 2013 Okla. Sess. Law. Serv. 311 (H.B. 1661)) (requiring schools adopt and implement bullying policies); OKLA. STAT. tit. 70, § 24-100.3 (2013) (amended by 2013 Okla. Sess. Law. Serv. 311 (H.B. 1661)) (defining bullying, include bullying through an electronic form); OR. REV. STAT. § 339.356 (2013) (requiring that schools adopt a policy and procedures to address bullying, including prohibiting cyberbullying); 24 PA. CONS. STAT. § 13-1303.1-A (2013) (requiring schools implement procedures for bullying and defines bulling, including cyberbullying definition); 1956 R.I. GEN. LAWS § 16-21-33 (2013) (defining cyberbullying); S.C. CODE

vide these policies to teachers and students.⁹² Statutes like Tennessee's law encourage teachers and students who have reliable information to report bullying because the statute grants immunity to the person who reports the bullying to school officials.⁹³ These bullying policies require definitions, descriptions, procedures for investigation, school responses, consequences and appropriate remedial action for a bully, identification of the job title of persons responsible for handling the situation, and requires the school to provide bullying information to students at the beginning of the year.⁹⁴ Nevertheless, the statutes omit one important part: a comprehensive solution to address the harm that the cyberbullying victim has suffered.⁹⁵

ANN. § 59-63-140 (2013) (mandating that schools implement policies and procedures for bullying at school); S.C. CODE ANN. § 59-63-120 (2013) (defining bullying, including bullying through electronic form); S.D. CODIFIED LAWS § 13-32-13 (2013) (defining cyberbullying); S.D. CODIFIED LAWS § 13-32-19 (2013) (creating a model bullying policy); TENN. CODE ANN. § 49-6-1016 (2013) (requiring schools to implement a bullying policy); TEX. EDUC. CODE ANN. § 37.0832 (West 2013) (mandating that schools create a bullying policy, including implementing counseling, and defines bullying); UTAH CODE ANN. § 53A-11a-301 (West 2013) (requiring that schools must implement a bullying procedure and defines bullying, including bullying through electronic form); VT. STAT. ANN. tit. 16, § 570 (2013) (requiring schools to have in place bullying policies); *see also* VT. STAT. ANN. tit. 16, § 570(c) (2013); VA. CODE ANN. § 22.1-279.6 (2013) (requiring procedures for schools to deal with bullying and defining bullying, including bullying via electronic form); WASH. REV. CODE § 28A.300.285 (2013) (requiring schools to have procedures to report and prevent bullying and defining bullying, including bullying through electronic form); W. VA. CODE § 18-2C-3 (2011) (mandating that schools implement bullying procedures); W. VA. CODE § 18-2C-2 (2011) (defining bullying, including intentional bullying through electronic form); WIS. STAT. § 118.46 (2010) (requiring that schools implement a bullying policy); WYO. STAT. ANN. § 21-4-314 (2013) (mandating that schools must implement a bullying policy and procedures to address bullying); WYO. STAT. ANN. § 21-4-312 (2013) (defining bullying to include bullying through electronic means).

92. TENN. CODE ANN. § 49-6-1016 (2013).

93. *Id.* § 49-6-1019. School districts are encouraged to form harassment, intimidation, bullying or cyber-bullying prevention task forces, programs and other initiatives involving school employees, students, administrators, volunteers, parents, guardians, law enforcement and community representatives. *See also* § 49-6-1018.

94. *Id.* § 49-6-1016 (a)(b)(1-13).

95. *Id.*

The Tennessee statute is typical in that it discusses ways to report bullying and (or) cyberbullying, procedures for dealing with the problem, and disciplinary reports submitted to the state.⁹⁶ However, the statute does not include solutions, reports, or procedures to help the victim cope with the mental or emotional issues caused by cyberbullying.⁹⁷ Generally, a Tennessee secondary school only has to implement a procedure to address reports of bullying and (or) cyberbullying.⁹⁸ Then, the school official in charge of investigating bullying situations must “promptly” investigate and make a report.⁹⁹ After the report, the school official must make a statement of how the school will respond to the act,¹⁰⁰ the “consequences and appropriate remedial measures” to be taken towards the aggressor,¹⁰¹ consequences to others who retaliate against the informant,¹⁰² and consequences to one who falsely accuses another of bullying.¹⁰³ However, there are no procedural requirements in Tennessee’s statute to enforce any remedial action for the victim of cyberbullying.

THE INADEQUACY OF LEGAL REMEDIES FOR VICTIMS OF CYBERBULLYING

With neither help nor protection available at school, a cyberbullying victim’s only avenue of redress would be to seek damages. A typical victim of school cyberbullying would likely file a common law tort claim against either the school system or his or her cyberbully.¹⁰⁴ However, some state statutes grant immunity to school officials who report bullying, and do not let a victim sue the public school or school officials.¹⁰⁵ Thus, a victim is likely to pro-

96. TENN. CODE ANN. § 49-6-1016 (a)(b)(1–13)(c)(d).

97. *Id.*

98. *Id.* § 49-6-1016 (a)(b)(4)(5).

99. *Id.* § 49-6-1016 (a)(b)(6).

100. *Id.* § 49-6-1016 (a)(b)(7).

101. *Id.* § 49-6-1016 (a)(b)(8).

102. *Id.* § 49-6-1016 (a)(b)(9).

103. *Id.* § 49-6-1016 (a)(b)(10).

104. Shira Auerbach, Comment, *Screening Out Cyberbullies: Remedies for Victims on the Internet Playground*, 30 CARDOZO L. REV. 1641, 1647 (2009).

105. See *infra* Part III (discussing public schools and a student’s First Amendment rights).

ceed against his or her cyberbully using the common law tort of defamation or intentional infliction of emotional distress.¹⁰⁶ While it is an option to file a common law tort claim, a victim of cyberbullying would not receive the mental or the emotional help that he or she needed *at home* or *at school*.

A Victim's Defamation Claim

A victim of cyberbullying can file a defamation case against his or her cyberbully. In order for a victim to succeed on a defamation claim, the victim must prove four elements: (1) there is a false and defamatory statement concerning the plaintiff; (2) there is an unprivileged publication to a third party; (3) there is fault amounting to at least negligence on the part of the publisher; and (4) there is either actionability of the statement irrespective of special harm or the existence of special harm caused by the publication.¹⁰⁷ It is unlikely, however, that a cyberbullying victim would succeed in bringing a defamation claim because the statements may be opinions,¹⁰⁸ and statements that are merely opinions and not actual facts are protected by the First Amendment.¹⁰⁹ Furthermore, the communication between the parties may be private,¹¹⁰ and a plaintiff in a defamation case must prove the element of publication, which may not exist in a private electronic communication.¹¹¹ For example in *Finkel v. Dauber*,¹¹² Finkel filed a defamation claim against a group of teenagers for statements posted on a Facebook group.¹¹³ The name of the Facebook group was “90 Cents Short of a Dollar,” and the group contained six members.¹¹⁴ The Facebook group was only accessible by the six members, and

106. Todd D. Erb, *A Case for Strengthening School District Jurisdiction to Punish Off-Campus Incidents of Cyberbullying*, 40 ARIZ. ST. L.J. 257, 277 (2008); see also Auerbach, *supra* note 103, at 1647–48.

107. 50 AM. JUR. 2D *Libel and Slander* § 21 (2013); see also Erb, *supra* note 105, at 277.

108. See Auerbach, *supra* note 103, at 1667.

109. *Milkovich v. Lorain Journal Co.*, 497 U.S. 1, 20 (1990).

110. See Auerbach, *supra* note 103, at 1667.

111. 50 AM. JUR. 2D *Libel and Slander* § 21 (2013).

112. *Finkel v. Duaber*, 906 N.Y.S.2d 697, 700 (2010).

113. *Id.* at 700.

114. *Id.*

Finkel's name was never explicitly mentioned in the group.¹¹⁵ Finkel alleged that the group posted an edited photograph of her, stated that she contracted AIDS from a prostitute, and used drugs.¹¹⁶ The *Finkel* Court held that these statements were not facts and that a reasonable reader would not take these facts as literal.¹¹⁷ The Court found that these statements were "vulgar attempts at humor"¹¹⁸ and dismissed the case.

Defamation claims may be hard for victims of cyberbullying to win because of the cyberbully's private conversation with the victim, opinions, and taunts.¹¹⁹ A cyberbully's opinions may refute defamation's factual element.¹²⁰ Additionally, teen victims may have issues proving reputational damage when teens do not have professional reputations.¹²¹

A Victim's Intentional Infliction of Emotional Distress Claim

Intentional infliction of emotional distress (IIED) is another common law tort claim that a cyberbullying victim could bring against his or her cyberbully. A claim of IIED requires that a victim prove either (1) that a tortfeasor's conduct was extreme and outrageous, and that the conduct intentionally or recklessly caused severe emotional distress to the victim, including if bodily harm results from the emotional distress; or (2) where the tortfeasor's extreme and outrageous conduct was directed at a third party and the intentional or reckless conduct caused emotional distress either to a member of a victim's immediate family who was present at the time of the tortfeasor's conduct or to any other individual that was present and that person has suffered bodily harm from the tortfeasor's conduct.¹²²

Mental distress can be actionable as an IIED claim when a factfinder believes that a reasonable person would be unable to

115. *Id.*

116. *Id.* at 700–01.

117. *Id.*

118. *Id.* at 702.

119. Alison Virginia King, *Constitutionality of Cyberbullying Laws: Keeping the Online Playground Safe for Both Teens and Free Speech*, 63 VAND. L. REV. 845, 852–53 (2010).

120. *Id.* at 853.

121. *Id.*

122. RESTATEMENT (SECOND) OF TORTS §46 (2013).

cope with the mental stress created by the circumstances.¹²³ Insults or hurtful statements will not satisfy the extreme and outrageous requirement.¹²⁴ Conduct that is rude, demeaning, or insensitive will also not qualify as extreme and outrageous.¹²⁵ Thus, IIED claims are hard to win.¹²⁶ For example, a Sexual Education teacher brought an IIED claim against a participant in a call-in radio show where the participant stated that the teacher was much more interested in teaching sexual information to students and that the teacher “actually derives . . . a very secret sort of sexual gratification” from teaching that sexual information.¹²⁷ The court found that the Sexual Education teacher did not state an IIED claim and held that the defendant’s statement was an opinion protected by the First Amendment.¹²⁸

Civil Remedies and Lack of a Comprehensive Solution

Apart from the causation issues in tort law, civil remedies do not give victims of cyberbullying a comprehensive solution.¹²⁹ Rather, victims must relive their cyberbullying experience in court and may not prevail on their claim due to evidentiary and causation issues in proving defamation and IIED. For example, prior to committing suicide, high school student Brandon Swartwood¹³⁰ sued his high school for damages after he was beaten in his high school cafeteria.¹³¹ Brandon was called “gay,” “Satanist,” “pussy,” and “faggot,”¹³² yet because he was neither gay nor a Satanist, his

123. 38 AM. JUR. 2D *Fright, Shock, and Mental Disturbance* § 9 (2013).

124. *Id.*

125. *Id.*

126. See Elizabeth M. Jaffee, *Cyberbullies Beware: Reconsidering Vosburg v. Putney in the Internet Age*, 5 CHARLESTON L. REV. 379, 391 (2011).

127. *Dupree v. Iliff*, 860 F.2d 300, 302 (8th Cir. 1988).

128. *Id.* at 303.

129. King, *supra* note 118, at 853.

130. Brenda High, *Bullycide in America*, <http://bullycide.org/BullycideInAmericaOnline01Edition.pdf>. Bullycide in America is an online compilation of mothers telling about their children’s experiences with bullying and the connection between bullying and teen suicide. Brandon Swartwood’s mother told his bullying story.

131. *Id.*

132. *Id.*

civil rights were not violated.¹³³ Additionally, there was a cap on the amount of tort damages¹³⁴ that Brandon could receive when suing a school district or a municipality.¹³⁵ After both Brandon and his mother gave sworn testimony about the beatings at school, Brandon's mother stated that he was angry and trembling because he had to relive the event.¹³⁶ Trembling, angry, and upset, Brandon left the courtroom after listening to the school district's attorney arguing why Brandon's case should be dismissed.¹³⁷ After that hearing, Brandon began a downward spiral and eventually committed suicide.¹³⁸ Brandon neither received damages nor a solution to help him deal with his mental health and emotional issues.¹³⁹

133. *Id.*; see 42 U.S.C. § 1983 (2013). (“Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.”).

134. See VA. CODE ANN. § 8.01-220.1:2 (2013) (no school employee liable for bullying if they report the bullying to school administrator); OKLA. STAT. ANN. tit. 51, §154 (2003).

135. High, *supra* note 129. (The school district must be found to have reasonably foresaw that injuries to Brandon would occur, but did not prevent it.); see *Lockhart v. Loosen*, 943 P.2d 1074, 1079 (1997) (“Under Oklahoma's extant jurisprudence the three essential elements of a prima facie case of negligence are: (1) a duty owed by the defendant to protect the plaintiff from injury, (2) a failure to properly perform that duty, and (3) the plaintiff's injury being proximately caused by the defendant's breach. Actionable negligence requires that the act complained of be the *direct cause* of the harm for which liability is sought to be imposed. Further, whether the complained of negligence is the proximate cause of the plaintiff's injury is dependent upon the harm (for which compensation is sought) being the result of **both the natural and probable** consequences of the primary negligence. This latter determination is critical to asaying the foreseeability of the injury as a result of the initial negligence and hence to establishment of a prima facie case.”).

136. High, *supra* note 129, at 34. See also *Monell v. Dep't Soc. Servs.*, N.Y. C., 436 U.S. 658 (1978).

137. *Id.* at 35.

138. *Id.* at 36.

139. *Id.*

Rather Brandon had to relieve his brutal beating at school and listen to the school district's attorney pick apart his story.

A common law tort claim is unlikely to help a victim of cyberbullying. In addition to the issues in proving defamation and IIED, a cyberbullying victim may not prevail on his or her claim because he or she may not have the money available for the high transaction costs that occur from litigation.¹⁴⁰ Also, a cyberbully defendant that is insolvent and thus judgment-proof could be another issue.¹⁴¹ Lastly, cyberbullying itself is not a tort.¹⁴² So, who or what should a victim of cyberbullying turn to? His or her public school? Generally, public schools focus on the bully and attempt to punish or suspend the student bully.¹⁴³ But even if a public school wanted to stop a cyberbully attack, schools run into the issue of infringing on a student's First Amendment rights when attempting to stop a cyberbullying attack.¹⁴⁴

FEDERAL LAW AND CYBERBULLYING

Neither Congress nor the Supreme Court have addressed the issue of cyberbullying and public school systems.¹⁴⁵ Currently, no federal law addresses cyberbullying.¹⁴⁶ Remarkably, no federal

140. King, *supra* note 118, at 853.

141. *Id.*

142. Finkel v. Duaber, 906 N.Y.S2d 697, 703 (Sup. Ct. Nassau County 2010).

143. See J.C. v. Beverly Hills Unified Sch. Dist., 711 F. Supp. 2d 1094, 1101 (C.D. Cal. 2010); J.S. ex rel. H.S. v. Bethlehem Area Sch. Dist., 807 A.2d 847, 851 (Pa. 2002).

144. See OR. REV. STAT. § 339.362 (2013) (if a school employee reports cyberbullying or bullying to school officials, the school official is immune from a civil suit); TENN. CODE ANN. § 49-6-1019 (2013) (allowing teachers and students to receive immunity from civil suits when they report bullying).

145. U.S. Dept. of Health & Human Services, *Cyberbullying*, STOPBULLYING.GOV, <http://www.stopbullying.gov/laws/federal/index.html> (last visited Feb. 23, 2013) (hereinafter STOPBULLYING). Stopbullying.gov is a federal government website that is managed by the U.S. Department of Health and Human Services.

146. STOPBULLYING, *supra* note 145 (“However, bullying can overlap with discriminatory harassment when “it is based on race, national origin, color, sex, age, disability, or religion.”). Congress, however, did enact the Communications Decency Act, see 47 U.S.C.A. § 230 (1998) (addressing content on the Internet and mentions harassment). *Id.*

law addresses bullying, either.¹⁴⁷ The Supreme Court only addresses whether the student's, the bully's, or the aggressor's First Amendment rights were violated.¹⁴⁸ Nonetheless, there are federal civil right laws that address discriminatory harassment and are enforced by the federal Department of Justice (DOJ) and Department of Education (DOE).¹⁴⁹ However, schools only violate these federal civil right laws when they fail to respond to a victim of a protected class.¹⁵⁰ Thus, the only federal protection mechanisms for victims are to be part of a protected class.¹⁵¹ Without persons bullying others based upon "race, national origin, color, sex, age, disability, or religion," the school commits no violation when it does not respond to a victim's harassment complaints.¹⁵²

Supreme Court Decisions and Off-Campus Student Speech

The Constitution grants every citizen a First Amendment right of freedom of expression.¹⁵³ This right extends to public school students.¹⁵⁴ While public school students do not have the same First Amendment rights in school as adults would have,¹⁵⁵ public schools cannot infringe on students' First Amendment right.¹⁵⁶ Nonetheless, the United States Supreme Court has allowed school officials to suppress student speech in a few instances, such as a student's speech containing obscene language on school

147. STOPBULLYING, *supra* note 145.

148. *See generally*, Hazelwood Sch. Dist. v. Kulmeier, 484 U.S. 260 (1988); Bethel Sch. Dist. No. 403 v. Fraser, 478 U.S. 675 (1986); Tinker v. Des Moines Indep. Cnty. Sch. Dist., 393 U.S. 503 (1969).

149. STOPBULLYING, *supra* note 145.

150. *Id.*

151. *Id.*

152. *Id.*; *see also* Americans with Disabilities Act, 42 U.S.C. § 12132 (2013); Individuals with Disabilities Education Act, 20 U.S.C. § 1414 (2013); Rehabilitation Act of 1973, 29 U.S.C. § 791 (1973); The Education Amendments of 1972, 20 U.S.C. § 1681 (1972); Civil Rights Act of 1964, 42 U.S.C. § 2000c-6 (1964).

153. U.S. CONST. amend. I.

154. U.S. CONST. amend. I; Tinker v. Des Moines Indep. Cnty. Sch. Dist., 393 U.S. 503, 510 (1969).

155. Bethel Sch. Dist. No. 403 v. Fraser, 478 U.S. 675, 682 (1986) (quoting (Rights of public school students) "are not automatically coextensive with the rights of adults in other settings").

156. U.S. CONST. amend. IV; Tinker, 393 U.S. at 510.

grounds,¹⁵⁷ information in a school newspaper that contained the school's name,¹⁵⁸ and a student's promotion of illegal drugs directed at the school's campus.¹⁵⁹ In all these instances, the Supreme Court only addresses whether the student's First Amendment rights were violated, not the students that were affected by those messages.

The United States Supreme Court (Court) decided in *Tinker v. Des Moines Independent Community School District* that schools can suppress a student's speech only if the speech causes or "substantially" disrupts a school's activities or the speech violates another student's rights.¹⁶⁰ In *Tinker*, students wore black armbands in war protest, and upon discovery of the students' plan, school officials issued a policy that prohibited wearing armbands to school.¹⁶¹ Because the three students wore the armbands, they were suspended, and the *Tinker* court held that the students' actions were protected by the First Amendment.¹⁶² With students' silent and passive projection of protesting the Vietnam War by wearing black armbands, the Court found that this expression did not substantially disrupt the school's activities.¹⁶³

Further, the urgency of school officials to avoid controversy and the lack of school officials suppressing all symbols worn by students established an additional reason in the Court's finding that school officials suppressed student speech.¹⁶⁴ Looking to the "marketplace of ideas," the Court noted how that exchange is necessary to the educational environment, its free flow of ideas, and the creation of future leaders.¹⁶⁵ The Court extended a student's First Amendment protection past the classroom and into the "cafeteria" and "playing field," yet *Tinker* did not decide whether this

157. See *Bethel Sch. Dist. No. 403 v. Fraser*, 478 U.S. 675, 683–84 (1986).

158. See *Hazelwood Sch. Dist. v. Kulmeier*, 484 U.S. 260, 271 (1988).

159. See *Morse v. Frederick*, 551 U.S. 393 (2007).

160. *Tinker*, 393 U.S. at 511.

161. *Id.* at 504.

162. *Id.* at 505.

163. *Id.* at 510–11.

164. *Id.*

165. *Id.* at 512–13.

test applied to off-campus speech, outside of the classroom, cafeteria, and playing field.¹⁶⁶

Other Constitutional Reasons to Suppress Student Speech

Public schools can also suppress student speech when the government could suppress the speech. For example, if a student promotes illegal activity,¹⁶⁷ uses obscenity and indecent speech,¹⁶⁸ fighting words,¹⁶⁹ libel incitement to violence,¹⁷⁰ or true threats,¹⁷¹ a public school can suppress that student's speech similar to how the government can suppress an adult's speech for his or her expression.¹⁷² Therefore, school officials may be able to suppress a student's off-campus Internet speech when the speech uses true threats or violence. In *J.S. ex rel. H.S. v. Bethlehem Area School District*, a student created a website, directed the website at his school, his principal, his teachers, requested money to hire a hit man to kill his algebra teacher, and explained why his teacher deserved to die.¹⁷³ The school suspended the student, and the *J.S.* court held that the student's First Amendment rights were not violated because the website "created disorder and significantly and adversely impacted the delivery of instruction."¹⁷⁴ The court reasoned that both students and faculty were scared by the website's content, and thus school officials could punish the student's off-campus Internet speech.¹⁷⁵ However, the *J.S.* court stated that absent threats or expression suppressed by governmental concerns, the school cannot suppress a student's off-campus Internet speech.

166. *Id.*

167. *See* Bethel Sch. Dist. No. 403 v. Fraser, 478 U.S. 675 (1986).

168. *See* Morse v. Frederick, 551 U.S. 393 (2007).

169. *See* Virginia v. Black, 538 U.S. 343 (2003).

170. *See* Brandenburg v. Ohio, 395 U.S. 444 (1969).

171. *See* Roth v. United States, 354 US 476 (1957); Beauharnasi v. Illinois, 343 U.S. 250 (1952); Chaplinsky v. New Hampshire, 315 U.S. 568 (1942).

172. *See* Tinker v. Des Moines Indep. Cnty. Sch. Dist., 393 U.S. 503, 511 (1969).

173. *J.S. ex rel. H.S. v. Bethlehem Area Sch. Dist.*, 807 A.2d 847, 851 (Pa. 2002).

174. *Id.* at 869.

175. *Id.*

Circuit Split on Off-Campus Speech

The Supreme Court's *Tinker* test does not provide much guidance for circuit courts to apply when the court did not address whether *Tinker* applied to a student's off-campus speech. Nonetheless, some circuit courts apply the *Tinker* test on whether a school can suppress a student's speech.¹⁷⁶ For example, a school can suppress a student's speech if the speech causes or "substantially" disrupts a school's activities or the speech violates another student's rights.¹⁷⁷ However, there are other Supreme Court decisions that circuit courts follow, such as when a school can suppress a student's off-campus speech that substantially disrupts a school's activity,¹⁷⁸ a student's illegal drug promotion directed at the school,¹⁷⁹ or when a student's speech occurs on a school's campus or occurs at an off-campus school-related function.¹⁸⁰ With these multiple decisions, there is neither a precise test nor a rule for circuits to apply for off-campus Internet speech cases. Thus, the circuits have developed different tests with different results for similar cases.

Some circuits have dealt with public schools' suppression of student speech by applying the *Tinker* test.¹⁸¹ Other circuits have held that *Tinker* does not apply to off-campus Internet speech and do not apply the *Tinker* test to suppress student speech.¹⁸² Even a state legislature adopted one of the circuit tests for school officials to apply when dealing with a cyberbully.¹⁸³ Nonetheless, in all these situations, the lower courts focus on the student and/or cyberbully's First Amendment rights.¹⁸⁴ Neither the state legisla-

176. See *Bethlehem Area Sch. Dist.*, 807 A.2d at 851.

177. *Tinker v. Des Moines Indep. Cnty. Sch. Dist.*, 393 U.S. 503, 510 (1969).

178. *Bethel Sch. Dist. No. 403 v. Fraser*, 478 U.S. 675, 683–84 (1986).

179. *Morse v. Fredrick*, 511 U.S. 393, 410 (2007).

180. *Hazelwood Sch. Dist. v. Kulmeier*, 484 U.S. 260, 271 (1988).

181. See *Beussink ex rel. Beussink v. Woodland R-IV Sch. Dist.*, 30 F. Supp. 2d 1175, 1178 (E.D. Miss. 1998).

182. See *T.V. ex rel. B.V. v. Smith-Green Comm. Sch. Corp.*, 807 F. Supp. 2d 767, 772 (N.D. Ind. 2011).

183. See ARK. CODE ANN. §6–18514 (B)(2)(d) (West 2012).

184. See *id.*; *Beussink ex rel. Beussink v. Woodland R-IV Sch. Dist.*, 30 F. Supp. 2d 1175, 1178 (E.D. Miss. 1998).

tures nor the lower courts consider the victim and his or her rights.¹⁸⁵

The Supreme Court has held that students are free to express their opinion unless the school system has constitutionally valid reasons to suppress that speech.¹⁸⁶ Now, the issue becomes when and how can public schools suppress a cyberbully's speech without violating his or her First Amendment rights.¹⁸⁷ The issue should be, however, whether suppression of a cyberbully's speech is enough. A school system's focus should not be placed only on procedures and punishment of the cyberbully, but focus rather on the victim and implement a comprehensive solution to address the victim's mental health and emotional issues resulting from the cyberbully's speech. Schools should be required to implement certain procedures to identify, recognize, and create a plan for victims of cyberbullying.

EXPANDING A FEDERAL STATUTE

Congress should expand IDEA to address the issue of cyberbullying of public school students. First, there is no federal law that addresses bullying.¹⁸⁸ Second, there is no federal law that addresses cyberbullying.¹⁸⁹ If victims are not within a protected class, the school does not violate any federal law if it fails to respond to the bully's harassment.¹⁹⁰ Due to this hole in the law, Congress must be encouraged to expand an existing law to addresses bullying, and in particular, cyberbullying.

For reasons to expand IDEA,¹⁹¹ Congress should look to the purpose of the original act. The purpose behind the original act was to encourage handicapped students who were excluded in

185. See U.S. CONST. amend. XIV; see also U.S. CONST. amend. IV.

186. *Tinker*, 393 U.S. at 511.

187. *J.C. v. Beverly Hills Unified Sch. Dist.*, 711 F. Supp. 2d 1094, 1101 (C.D.Cal. 2010) (where a student posted a video of other students saying cruel comments about another classmate on YouTube).

188. STOPBULLYING, *supra* note 145. However, bullying can overlap with discriminatory harassment when "it is based on race, national origin, color, sex, age, disability, or religion." *Id.*

189. *Id.*

190. *Id.*

191. See 20 U.S.C. § 1400 (2004).

school to complete their education and anticipated those students reaching an age where he or she could drop out of school.¹⁹² Additionally, Congressional hearings show the importance of a school's involvement in a child's emotional and mental well being. For example, a medical expert testified that:

[S]chools are a critically important source of information for families about their children and their emotional and mental well being. The importance of open communication between school professionals and families about the health and well being of students, and where indicated, the freedom to recommend a comprehensive medical evaluation cannot be overstated.¹⁹³

It was summarized that “[S]upport is recommended for all efforts to sustain and expand training programs for all child mental health professionals, including programs for child and adolescent psychiatrists.”¹⁹⁴

IDEA was intended to include services for students who were emotionally disturbed.¹⁹⁵ Prior to passing IDEA, Congress held hearings that specifically discussed emotionally disturbed students' needs in a school system.¹⁹⁶ The hearings focused on services for those students, such as psychological counseling, behavioral support programs, and specialized diagnostic evaluations.¹⁹⁷ IDEA reflects those hearings¹⁹⁸ and requires educators to accom-

192. George Miller, Address at the House of Representatives (May 19, 1997).

193. Dr. Lance Clawson, Board Certified Child and Adolescent Psychiatrist, Address at the House of Representatives (May 6, 2003) (testifying about the treatment of children and mental illness).

194. Use of Medication Schools, 2003 WL 21020900 (citing H.R. 1359).

195. H.R. REP. NO., 94-332, at n.12 (1975); S. REP. NO. 94-168, at 5-8 (1975), reprinted in 1976 U.S.C.C.A.N. 1425; see also ORDOVER, *supra* note 8, at 47.

196. *Educ. for All Handicapped Children Act, 1973-74: Hearing on S.6 Before Subcomm. on the Handicapped of the Senate Comm. on Labor and Pub. Welfare*, 93d Cong. 45, 87, 797, 809, 813, 790, 833; (Mar. 20, 21, 23, 1973) (hereinafter *Hearings*); see also ORDOVER, *supra* note 8, at 47.

197. See ORDOVER, *supra* note 8, at 47.

198. *Id.*

moderate students with behavioral manifestations.¹⁹⁹ In order to qualify for a special education, a child must meet the definition of emotionally disturbed or the definition of a special education disability. Most victims of cyberbullying, however, do not meet this definition.

Furthermore as President Clinton indicated in his signing of the amended IDEA in 1997: “[T]his bill also gives school officials the tools they need to ensure that the Nation’s schools are safe and conducive to learning for all children, while scrupulously protecting the rights of children with disabilities.”²⁰⁰ Because one of the purposes of IDEA is to give public school systems tools to ensure school safety and equal learning opportunity, IDEA’s expansion to cyberbullying victims will further this purpose by giving victims comprehensive solutions to help victims stay in school. By expanding IDEA, cyberbullying victims will receive a comprehensive solution because a school system will be required to give services that address the victim’s mental health issues, ensure the victim’s safety at school, and grant victims an equal learning opportunity in a least restrictive learning environment.

Individuals With Disabilities Education Act

IDEA was created because public school systems were not providing the appropriate education to children with disabilities.²⁰¹ IDEA requires that states adhere to the Act’s substantive and procedural requirements, and in exchange, the states receive federal funds to provide special education services to students with disabilities.²⁰² These requirements compel states to provide students with disabilities a free appropriate public education (FAPE).²⁰³ A FAPE may include providing certain services, such as specialized instruction in the least restrictive environment (LRE).²⁰⁴ If a state violates these requirements, the Office of Special Education Pro-

199. *Id.*

200. William J. Clinton, President of the United States, Address at the White House (June 4, 1997).

201. ORDOVER, *supra* note 8, at 1 (The Avocado Press 2001) (The Act was originally named Education for All Handicapped Children Act and enacted in 1975; the Act was later renamed Individuals With Disabilities Act in 1990).

202. *Id.*; see 20 U.S.C. § 1412(a).

203. See 20 U.S.C. § 1412(a)(5).

204. ORDOVER, *supra* note 8, at 1.

grams (OSEP) can take enforcement actions.²⁰⁵ Each state's department of education is responsible for a school system's compliance with IDEA's requirements.²⁰⁶ Additionally, either a parent or a student who believes that a school violated his or her IDEA rights can take action.²⁰⁷

Free Appropriate Public Education

IDEA requires that public schools give students with disabilities a free appropriate public education.²⁰⁸ A FAPE requires that this education be given in a student's least restrictive learning environment, along with special education services that correlate with the student's individual needs determined by an Individualized Education Program.²⁰⁹ For example, if a student has a disability that satisfies a learning disability definition, FAPE requires that schools provide that student with a special education.²¹⁰ If a school system does not accommodate a student, the school violates the FAPE requirement of IDEA.²¹¹

Individualized Education Program

IDEA requires that public schools act, identify, and evaluate certain students who either have a disability or need special education and related services.²¹² Students that qualify for services must have an Individualized Education Program (IEP).²¹³ Once a

205. ORDOVER, *supra* note 8, at 1.

206. *See* 20 U.S.C. § 1402(a) (2005). A state's department of education watches not only its local districts, but is also responsible for other public institutions and some private agencies' compliance with the IDEA requirements. *Id.*; *see also* ORDOVER, *supra* note 8, at 1.

207. ORDOVER, *supra* note 8, at 1.

208. *See* ORDOVER, *supra* note 8, at 47.

209. *See id.*

210. *Id.* at 48. Ordover describes that special education is "specifically designed instruction." Special education focuses not only at behavioral issues, but also that special education accommodate students with any behaviorally related services. *Id.*

211. *Id.*

212. *Id.* at 54–55. School systems must conduct a comprehensive and individualized evaluation on the identified student before the student receives services. *Id.*

213. ORDOVER, *supra* note 8, at 72.

school system determines that a student is eligible for IDEA services, a meeting must occur within thirty days of that decision, and an IEP must be created for the student.²¹⁴ There are eight requirements to an IEP:

[First,] written statement for each child with a disability that is developed, reviewed, and revised in accordance with this section and that includes—a statement of the child’s present levels of academic achievement and functional performance, including—how the child’s disability affects the child’s involvement and progress in the general education curriculum; for preschool children, as appropriate, how the disability affects the child’s participation in appropriate activities; and for children with disabilities who take alternate assessments aligned to alternate achievement standards, a description of benchmarks or short-term objectives;

[Second] a statement of measurable annual goals, including academic and functional goals, designed to—meet the child’s needs that result from the child’s disability to enable the child to be involved in and make progress in the general education curriculum; and meet each of the child’s other educational needs that result from the child’s disability;

[Third] a description of how the child’s progress toward meeting the annual goals described in subclause (II) will be measured and when periodic reports on the progress the child is making toward meeting the annual goals (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards) will be provided;

[Fourth] a statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child—to advance appropriately

214. 34 C.F.R. § 300.343(b).

toward attaining the annual goals; to be involved in and make progress in the general education curriculum in accordance with subclause (I) and to participate in extracurricular and other nonacademic activities; and to be educated and participate with other children with disabilities and nondisabled children in the activities described in this subparagraph;

[Fifth] an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in the activities described in subclause (IV)(cc);

[Sixth] a statement of any individual appropriate accommodations that are necessary to measure the academic achievement and functional performance of the child on State and district wide assessments consistent with section 1412(a)(16)(A) of this title; and if the IEP Team determines that the child shall take an alternate assessment on a particular State or district wide assessment of student achievement, a statement of why—the child cannot participate in the regular assessment; and the particular alternate assessment selected is appropriate for the child;

[Seventh] the projected date for the beginning of the services and modifications described in subclause (IV), and the anticipated frequency, location, and duration of those services and modifications; and

[Eighth] beginning not later than the first IEP to be in effect when the child is 16, and updated annually thereafter—appropriate measurable postsecondary goals based upon age appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills; the transition services (including courses of study) needed to assist the child in reaching those goals; and beginning not later than 1 year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this chapter, if any, that will

transfer to the child on reaching the age of majority under section 1415(m) of this title.²¹⁵

An IEP team will address the IEP requirements. An IEP team consists of certain individuals at the student's school, and both the parent and the student are involved in the IEP process.²¹⁶ A student's IEP includes the student's current performance in school, along with how his or her disability affects the progress of his or her current performance.²¹⁷ The IEP will describe the student's disability both on an academic and non-academic platform.²¹⁸ School systems must use a student's IEP or that school system violates IDEA.²¹⁹

Least Restrictive Learning Environment

Public schools must provide qualifying students with an education in a least restrictive learning environment.²²⁰ The LRE requirement ensures that public school students with disabilities learn among their peers.²²¹ Because IDEA requires that students with disabilities receive an education in their LRE, public school systems have to consider a student's behavior based on a wide reaching spectrum.²²²

Application of IDEA to Cyberbullying Cases

IDEA only applies to a student who has a defined disability.²²³ IDEA identifies certain disabilities that qualifies a student for special education, such as hearing, visual, speech, orthopedic, or other health impairments.²²⁴ IDEA explicitly defines each dis-

215. 20 U.S.C. § 1414 (2013).

216. 20 U.S.C. § 1414 (d)(1)(A)(i) (14), (15); *see* 34 C.F.R. part 300, App. A, question 1.

217. ORDOVER, *supra* note 8, at 73.

218. *Id.*

219. 20 U.S.C. § 1408(8) (2013); *see* 34 C.F.R. §300.350(a)(1) (2013); *see also* 34 C.F.R. part 300, App. A, question 31.

220. *Id.* § 1412(a)(5)(A).

221. *Id.* § 1412(a)(5)(A); *see* ORDOVER, *supra* note 8, at 49.

222. *See* ORDOVER, *supra* note 8, at 49.

223. *Id.* § 1401(3)(A).

224. Under IDEA, [t]he term "child with a disability" means a child with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional

ability, and if a child falls into one of those categories, IDEA protects that student and requires local school systems to provide special services to that student.²²⁵ If a student does not fit into one of those specific definitions, IDEA will not protect and will not provide the student with special services. IDEA should be expanded to reach victims of cyberbullying, because cyberbullying victims do have mental health and emotional issues that effect their learning capacity, school attentiveness, and success in school. Because IDEA does not address cyberbullying victims, victims are not given a free appropriate public education in his or her least restrictive learning environment. However with an IEP, a victim of cyberbullying can receive that free appropriate public education in his or her least restrictive learning environment.

An IEP implemented at school could help a victim of cyberbullying. For example at the IEP meeting, the IEP team would address the victim's mental health and emotional issues resulting from the cyberbullying attacks. The IEP team could discuss options and create plans to help the victim deal with those issues, including the victim's educational performance and social interaction at school.²²⁶ The victim's IEP team would create measureable goals to address the student's lack of engagement in school activities and avoidance of peer interaction. As the IEP requires, school officials measure these goals and the victim's progress by meeting and receiving reports from the school counselor.

Creating an IEP for victims of cyberbullying could help the victim cope with depression, alleviate the fear of social interaction, and focus on academic success.²²⁷ Also, an IEP would alert teachers to possible behavioral changes of a victim. Because schools must periodically review a student's IEP,²²⁸ the school and the victim's parents and (or) guardians could decide whether the IEP is helping the victim with his or her mental health and emotional issues resulting from the cyberbullying attacks.

disturbance ..., orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities." *Id.*

225. *Id.* § 1412(a)(6)(A); *see also* 34 C.F.R. §§ 300.121(e)(1) (2013).

226. *See id.* IDEA requires certain criteria that must be included in a student's IEP. *Id.*

227. Kowalski & Limbar, *supra* note 10, at 13.

228. *Id.* § 1414(d)(4)(A); 34 C.F.R. §300.343(c). *See also* ORDOVER, *supra* note 8, at 82.

CONCLUSION

Congress should expand IDEA to include victims of cyberbullying as a disability mental health condition. Because public schools must comply with IDEA, school administrators and teachers would be familiar with the requirements. More importantly, expanding IDEA would finally give victims of cyberbullying a comprehensive solution. Victims would receive an IEP that addresses their mental health and emotional issues, along with providing victims safety in the classroom and encouraging academic performance—the purpose of the original IDEA.²²⁹ With an IEP, school administrators, teachers, and guidance counselors would be on alert to behavioral changes that are identified with victims of cyberbullying, such as suicide, depression, fear of social interaction, poor academic performance, and constant absences from school.²³⁰ Just like students with disabilities, cyberbullying victims require special services to ensure their safety and provide them with a free appropriate public education in their least restrictive learning environment.

229. *Hearings, supra*, note 196.

230. *See* Kowalski & Limbar, *supra* note 10, at 13.

Abusing Drugs and Discretion: Risk of Relapse into Drug Addiction as a Disability under ERISA-Governed Employee Benefit Plans

*GREG SIEPEL

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INTRODUCTION

There are millions of Americans receiving disability benefits under employee-benefit plans governed by the Employee Retirement Income Security Act (ERISA)¹ because they are unable to perform the duties of their jobs. When employees file for disability benefits under an ERISA governed employee-benefit plan, the administrators of these plans are required to act in the best interests of the employee.² Because most ERISA governed employee-benefit plans give the administrators discretion to interpret the language of the plan,³ problems arise when the administrator denies an employee's claim for a disability not mentioned in the plan. This problem is accentuated when the plan administrator, such as an insurance company, determines and pays the benefits under the plan, *i.e.*, operates under a conflict of interest.

Although the ERISA thoroughly governs employee-benefit plans, it does not specify the standard of review that courts must use to evaluate the administrator's decision to deny benefits. The Supreme Court of the United States pronounced the standard of review in *Firestone Tire & Rubber Company v. Bruch*.⁴ However, the Court did not articulate how courts should determine whether a conflict of interest exists or how the standard of review should be altered when the reviewing court concluded that a conflict of interest existed. As a result, Courts of Appeals developed their own approaches to these issues. In some circuits, a conflict of interest was said to exist when the plan administrator both determined and

* Juris Doctor Candidate, May 2014, West Virginia University, College of Law; *West Virginia Law Review*, Senior Notes Editor; Bachelor of Arts, 2009, Knox College. The author thanks Professor Anne Lofaso for her advice and guidance, and my friends and family for their encouragement and support.

1. 29 U.S.C. § 1001 (2006); *ERISA Regulation of Health Plans: Fact Sheet*, CONG. RES. SERVICE, available at <http://www.allhealth.org/briefingmaterials/erisaregulationofhealthplans-114.pdf>.

2. See *infra* Part II.A.

3. See *infra* note 10.

4. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

paid claims, but in other circuits this dual role was not necessary to determine that a conflict of interest existed.⁵ Further, once a conflict of interest was determined to exist, Courts of Appeals altered the standard of review differently.⁶ Courts of Appeals developed the sliding scale approach, the combination of factors test, and the burden shifting approach, each of which placed a different emphasis on the weight given to the conflict of interest and the degree by which the standard of review was altered.⁷

Nearly twenty years later, the United States Supreme Court decided *Metropolitan Life Insurance Company v. Glenn*,⁸ which finally addressed these issues by adopting a uniform standard. In *Glenn*, the Court held that a conflict of interest exists when the administrator of an employee-benefit plan both determines claims and pays them with its own funds.⁹ Further, the Court held that when a conflict of interest exists, the combination of factors test must be used to determine whether plan administrator abused his discretion.¹⁰ Thus, *Glenn* addressed both the uncertainty of *Firestone* and the inconsistent approaches to the standard of review developed by the Courts of Appeal.

Recently, a circuit split has developed in regard to the issue of whether the plan administrator of an ERISA governed employee benefit plan—acting under a conflict of interest—abused its discretion by denying long-term disability (LTD) benefits to an employee who is at risk of relapse into drug addiction when the plan is silent on the issue. The United States Court of Appeals for the Fourth Circuit held, pre-*Glenn*, that a plan administrator did not abuse its discretion in such a situation.¹¹ The Fourth Circuit used the sliding scale approach to reach its decision.¹² Shortly after the Fourth Circuit decided this issue using the sliding scale approach, *Glenn* was decided and held that the combination of factors test, not the sliding scale approach, should be used in circumstances

5. See *infra* Part II.B.2.b.

6. See *infra* Part II.B.2.b.

7. See *infra* Part II.B.2.b.

8. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

9. *Id.* at 112.

10. *Id.* at 115.

11. *Stanford v. Continental Cas. Co.*, 514 F.3d 354, 358 (4th Cir. 2008). See also *infra* part III.A.

12. *Standard*, 514 F.3d at 356–57.

where a plan administrator—acting under a conflict of interest—denies LTD benefits to an employee under an ERISA governed employee benefit plan.¹³ Recently, the United States Court of Appeals for the First Circuit held that a plan administrator acting under a conflict of interest abused its discretion by denying LTD benefits to an employee at risk of relapse into drug addiction.¹⁴

This Note will argue that the First Circuit's approach should be adopted because it conforms to the purpose behind the ERISA. The First Circuit's approach would allow employees at risk of relapse into drug addiction to collect disability benefits so that they would not be forced to return to a work environment that would almost certainly cause them to start reusing drugs. Also, the First Circuit's approach would prevent plan administrators from acting in their own financial self-interests by preventing them from creating exceptions not enumerated in the plan. The Fourth Circuit's approach, on the other hand, would give plan administrators the incentive to make decisions in their own financial self-interests, and would force the employee to choose between losing his disability benefits or returning to the work environment that impelled his drug addiction. Finally, this Note will demonstrate that the Fourth Circuit's approach is incorrect in light of *Glenn*. The First Circuit used the combination of factors test articulated in *Glenn*, whereas the Fourth Circuit used the sliding scale approach, which is inconsistent with the combination of factors test. Thus, the Fourth Circuit's approach does not survive *Glenn*, even though it may have been correctly decided at that time.

Part II provides background on ERISA and the standard of review that circuit courts use to evaluate the plan administrator's decision to deny disability benefits. This part will explain the purposes behind ERISA and the Supreme Court cases that have affected the standard of review of ERISA benefit denials.

Part III examines the current view of the First and Fourth Circuits in regard to whether a plan administrator—when acting under a conflict of interest—has the discretion to deny benefits to an employee at risk of relapse into drug addiction when the plan is silent on the issue. This part analyzes the decisions from these circuits, and highlights the different standard of review used by each.

13. *Glenn*, 554 U.S. at 115.

14. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58, 59–60 (1st Cir. 2013).

Finally, Part IV argues that courts should follow the approach taken by the First Circuit. This part will argue that the First Circuit's approach protects employees by allowing them to recover disability benefits when they are at a risk of relapse into drug addiction, rather than forcing them to return to an environment that impelled their addiction. Also, the First Circuit's approach would prevent plan administrators from abusing their discretion by acting in their own self-interest, rather than the interest of their employees.

LEGAL BACKGROUND: ERISA AND THE STANDARD OF REVIEW
APPLIED TO ERISA PLAN BENEFIT DENIALS

The ERISA comprehensively regulates life, health, disability, and pension benefits that are provided by employers to employees through employee benefit plans.¹⁵ More than 130 million Americans receive health coverage and other employee benefits under plans governed by the ERISA.¹⁶ Disputes often ensue when an ERISA plan member or beneficiary is denied benefits to which he feels entitled under the plan. Any thoughtful analysis of whether a risk of relapse into a drug addiction is a disability under an ERISA governed employee-benefit plan must be based on an understanding of ERISA's purpose and the standard of review that courts use to review the decisions made by plan administrators to deny benefits to employees.

The Employee Retirement Income Security Act of 1974

Congress enacted the ERISA to promote and protect the interests and expectations of employee-benefit plan participants.¹⁷ The Supreme Court has also acknowledged that the principal goal of ERISA is to protect the interests of plan participants and beneficiaries.¹⁸ All persons who exercise discretionary authority¹⁹ over

15. 29 U.S.C. § 1001 (2006).

16. ERISA Regulation of Health Plans: Fact Sheet, *supra* note 1.

17. *Id.* § 1001(c).

18. *Boggs v. Boggs*, 520 U.S. 833, 834 (1997).

19. Nearly all ERISA employee-benefit plans contain discretionary clauses that give plan administrators the discretion to interpret language in the policy and determine eligibility for benefits. John Morrison, *Exercising Discretion: The Death of Caprice in ERISA Claims Handling*, 56 S.D. L. REV. 482,

ERISA plan assets are designated as ERISA fiduciaries.²⁰ And the ERISA imposes, *inter alia*, a duty of loyalty upon plan fiduciaries whereby the fiduciary “shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries.”²¹ This duty of loyalty requires fiduciaries to administer plan funds “for the exclusive purpose of . . . providing benefits to participants and their beneficiaries” and “defraying reasonable expenses of administering the plan.”²² In other words, when an ERISA fiduciary makes fiduciary decisions—those involving discretionary judgment over plan assets—such as determining benefits due to a plan member, the ERISA requires the fiduciary to disregard its own interests and make the determination for the sole benefit of the beneficiary and the plan as a whole.²³

Despite this duty of loyalty, an ERISA fiduciary may have financial interests that are adverse to the plan’s participants and beneficiaries.²⁴ For example, an administrator that both underwrites and administers employee-benefit plans may take certain actions that disadvantage plan members.²⁵ Stated another way, an administrator, such as an insurance company, responsible for both

482 (2011); Nearly all ERISA plan sponsors have written discretionary language into their plans so that the reviewing court will give deference to the administrator’s decision in the event of a benefit denial. *Id.* at 483.

20. *Id.* § 1002(21)(A) states:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Id.

21. *Id.* § 1104(a)(1).

22. *Id.* § 1104(a)(1)(A).

23. Beverly Cohen, *Divided Loyalties: How the Metlife v. Glenn Standard Discounts ERISA Fiduciaries’ Conflict of Interest*, 2009 UTAH L. REV. 955, 958 (2009).

24. Cohen, *supra* note 23, at 958.

25. Cohen, *supra* note 23, at 958.

determining and paying benefits may have an incentive to deny benefits to an employee to save money.

If an ERISA plan member or beneficiary is denied benefits to which he feels entitled, ERISA provides a cause of action for that employee “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”²⁶ Despite its length and its thorough treatment of employee-benefit plans, ERISA leaves many important issues to be interpreted by the courts.²⁷ These gaps in the statute demonstrate that Congress intended for the courts to experiment and refine the law surrounding benefit plans.²⁸ Specifically, the ERISA does not specify the standard of review that courts should apply when reviewing a plan member’s claim that a fiduciary wrongfully denied his claim.²⁹

The Standard of Review Applied to ERISA Plan Benefit Denials

This standard of review of ERISA plan benefit denials has been examined by two Supreme Court (Court) decisions. The Court first adopted the standard of review in *Firestone Tire & Rubber Company v. Bruch*,³⁰ such that the decision of a plan administrator—who is acting under a conflict of interest—is governed by the abuse of discretion standard, and the conflict of interest is one factor among others that is to be used to determine whether the administrator acted reasonably.³¹ However, the Court in *Firestone* did not provide any guidance on how to determine whether a conflict of interest existed. As a result, Circuit Courts of Appeals defined a “conflict of interest” differently and developed their own approaches in making such a determination. Accord-

26. 29 U.S.C. § 1132(a)(1)(B) (2006).

27. Jay Conison, *Foundations of the Common Law of Plans*, 41 DEPAUL L. REV. 575, 576 (1992). See also Ryan M. Lorusso, *Metropolitan Life Insurance Company v. Glenn: Will the Supreme Court Decision Reduce Confusion After Firestone?*, 17 CONN. INS. L.J. 189, 194 (2010).

28. Lorusso, *supra* note 27, at 194.

29. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) (noting that the “ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations”). See also Cohen, *supra* note 23, at 959.

30. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

31. *Id.* at 103.

ingly, some circuits concluded that a plan administrator who paid and determined claims did not act under a conflict of interest, and some circuits held that such a role was in fact a conflict of interest.³² In *Metropolitan Life Insurance Company v. Glenn*,³³ the Court upheld the combination of factors approach, but finally defined a “conflict of interest” under ERISA-governed employee benefit plans. An examination of these two cases and the Court’s development of this standard of review is necessary to fully understand how the denial of disability benefits affects a member who has a risk of relapse.

Firestone Tire & Rubber Company v. Bruch

In *Firestone*, the company acted as a fiduciary of the employee-benefit plan, but did not have discretion over benefit administration.³⁴ The plan had a termination clause that stated that Firestone’s employees were entitled to receive benefits if the workforce was reduced.³⁵ Firestone sold five of its plants to Occidental Petroleum Company (Occidental), and Occidental rehired most of the salaried employees at the five plants at the same pay.³⁶ Six former employees sued the company under the ERISA, claiming that they were entitled to benefits because the sale of Firestone’s plants constituted a “reduction in work force” within the meaning of the termination clause.³⁷ Firestone argued that Occidental hired all of the workers at the same positions and wages, and therefore, the workforce was not reduced.³⁸ Firestone had the discretion to deny these benefits to the employees.³⁹

The Court set out different standards for situations that may arise under challenges to ERISA plan benefit denials. The Court held that a denial of benefits challenged under the ERISA is “to be

32. See *infra* notes 57–60 and accompanying text.

33. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

34. *Firestone*, 489 U.S. at 111 (finding “no evidence that under Firestone’s termination pay plan the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference”).

35. *Id.* at 105.

36. *Id.*

37. *Id.*

38. *Id.* at 191.

39. *Id.* at 105.

reviewed under the de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”⁴⁰ If the administrator or fiduciary does have discretion, then its interpretation of provisions in the plan will stand so long as it is reasonable⁴¹—also known as the abuse of discretion standard. Finally, and most relevant to this Note, the Court held that when an employee-benefit plan grants discretionary authority on a fiduciary *who acts under a conflict of interest*, the review will be deferential but the “conflict [of interest] must be weighed as a factor in determining whether there is an abuse of discretion.”⁴²

In sum, a de novo standard of review applies when a fiduciary does not have discretion over the employee-benefit plan.⁴³ But when a fiduciary has discretion, the abuse of discretion standard applies—and if the fiduciary acts under a conflict of interest, then the conflict must be weighed as a factor to determine whether there was an abuse of discretion.⁴⁴

In developing these standards, the Court reasoned that a fiduciary’s denial of benefits under the ERISA should be governed by principles of trust law.⁴⁵ Specifically, the Court concluded that although the ERISA didn’t set out a standard of review in these circumstances, the ERISA “abounded” with language borrowed from the body of trust law.⁴⁶ The Court also concluded that Congress wanted the courts to develop a body of common law in regard to the standard of review for denials of ERISA employee-benefit plans.⁴⁷

Firestone’s Effect

The *Firestone* decision had an immediate impact on ERISA plans and on the Circuit Courts of Appeal. After *Firestone*, nearly all ERISA governed employee-benefit plans were amended to give

40. *Id.* at 115.

41. *Firestone*, 489 U.S. at 111.

42. *Id.* at 103.

43. *Id.* at 115. *See also* Cohen, *supra* note 23, at 959–60.

44. *See Firestone*, 489 U.S. at 103.

45. *Id.* at 110–11.

46. *Id.* at 110.

47. *Id.*

fiduciaries discretion so that their interpretation would be entitled to deference on review.⁴⁸ And Circuit Courts of Appeal took different approaches on when a conflict of interest existed or how weighing the conflict of interest as a factor should affect the review, as *Firestone* failed to provide any guidance on these issues.⁴⁹

ERISA Governed Employee-Benefit Plans

In the wake *Firestone*, virtually all ERISA plans were amended to give plan fiduciaries the discretion to construe or interpret the terms of their employee-benefit plans.⁵⁰ Through these amendments, fiduciaries ensured that their interpretation of the terms of the plan would be given deferential review, as opposed to de novo review when plan members challenged benefit denials.⁵¹ Fiduciaries understood that a deferential standard of review is financially beneficial because they could control the costs of their employee-benefit plans.⁵² Fiduciaries could construe the terms of the plan in a cost-effective way, and would be reversed by a court only if their interpretations would be arbitrary and capricious.⁵³ Thus, *Firestone* provided a means for fiduciaries to insulate their benefit denials from a tough de novo review standard.⁵⁴

Circuit Court Approaches to *Firestone*

Firestone announced that when a plan fiduciary has discretion over the terms of the plan, a conflict of interest must be weighed as a factor to determine whether there was an abuse of discretion.⁵⁵ However, the Court in *Firestone* did not specify how this conflict of interest should be taken into account. First, it did not specify how to determine whether a conflict of interest existed.

48. Cohen, *supra* note 23, at 960.

49. *Id.*

50. *Id.*; Roy F. Harmon III, *The Debate Over Deference in the ERISA Setting—Judicial Review of Decisions by Conflicted Fiduciaries*, 54 S.D.L. REV. 1, 9–10 (2009).

51. Cohen, *supra* note 23, at 960.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 103 (1989).

Second, it did not specify how the standard of review should be altered when a conflict of interest was one of the factors to be weighed.

Courts of Appeal took their own approaches in determining whether a conflict of interest existed. Courts generally agreed that when an ERISA plan purchased health or disability coverage from an insurance company and the insurance company determined whether claims would be paid or denied under the plan, then a conflict of interest was present.⁵⁶ Courts of Appeal disagreed, however, on whether the mere *possibility* that an insurance company might deny claims due to financial self-interest was a conflict of interest sufficient enough to alter the abuse of discretion standard of review.⁵⁷ Some courts found that a conflict of interest existed when the insurer had a financial incentive to deny claims,⁵⁸ while other courts required a more concrete showing.⁵⁹

Courts also developed their own approaches to altering the standard of review of benefit denials when a conflict of interest was identified.⁶⁰ For example, the Eleventh Circuit adopted a

56. *Id.*

57. Cohen, *supra* note 23, at 961.

58. *See, e.g.,* Lemaire v. Hartford Life & Accident Ins. Co., 69 F. App'x 88, 92 (3d Cir. 2003) (concluding that "a conflict of interest is presumed where an insurance company both determines eligibility for benefits and pays out those benefits from its own funds, because there exists 'an active incentive to deny those claims in order to keep costs down and keep themselves competitive.'").

59. *See, e.g.,* Schatz v. Mutual of Omaha Ins. Co., 220 F.3d 944, 947 (8th Cir. 2000) (concluding that a "less deferential standard of review is triggered where the claimant presents 'material, probative evidence demonstrating that . . . a palpable conflict of interest existed which caused a serious breach of the plan administrator's fiduciary duty'" (quoting *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998)); *Jones v. Aetna U.S. Healthcare*, 136 F. Supp. 2d 1122, 1132 (C.D. Cal. 2001) (stating that the beneficiary "must provide 'material, probative evidence beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary'" (quoting *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995)). For an excellent in-depth discussion on how lower courts differed on how to determine whether a conflict of interest existed, *see* Cohen, *supra* note 23, at 960–66.

60. LoRusso, *supra* note 27, at 197; Cohen, *supra* note 23, at 966.

“burden shifting” approach.⁶¹ Upon identification of a potential conflict of interest, the Eleventh Circuit shifted the burden to the fiduciary to show that its interpretation of the plan was not tainted by self-interest and the decision was made in the best interest of the plan members and their beneficiaries.⁶² The Sixth Circuit adopted the “combination of factors” test.⁶³ The Sixth Circuit stated that a conflict of interest was to be weighed by a reviewing court as one factor among other relevant factors that could lead the reviewing court to find an abuse of discretion.⁶⁴ And the United States Courts of Appeal for the Third, Fourth, Fifth, and Tenth Circuits adopted the “sliding scale” approach,⁶⁵ under which the reviewing court would always apply the arbitrary and capricious standard, but decreased the level of deference given to the administrator in proportion to the degree of the conflict of interest.⁶⁶

Metropolitan Life Insurance Company v. Glenn

The Supreme Court granted certiorari in *Metropolitan Life Insurance Company v. Glenn*⁶⁷ to resolve the differences among the lower courts regarding when a conflict of interest existed and how it affected the standard of review in ERISA benefit denial cases.⁶⁸ Metropolitan Life Insurance Company (MetLife) was the administrator and insurer for Sears, Roebuck & Company’s (Sears) LTD plan, which was governed by the ERISA.⁶⁹ The plan granted

61. *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990). This approach is also known as the “presumptively void” approach. *Cohen*, *supra* note 23, at 969.

62. *Id.*

63. *Calvert v. Firststar Fin., Inc.*, 409 F.3d 286, 295 (6th Cir. 2005).

64. *Id.* This was the approach adopted by the Supreme Court in *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). For a discussion of the Supreme Court’s adoption of the combination of factors in *Glenn*, see *supra* Part II.B.3.

65. *Lasser v. Reliance Standard Life Ins. Co.*, 344 F.3d 381, 385 (3d Cir. 2003); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 824–27 (10th Cir. 1996); *Doe v. Grp. Hospitalization Med. Servs.* 3 F.3d 80, 87 (4th Cir. 1993); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 638–42 (5th Cir. 1992).

66. *Lasser*, 344 F.3d at 385; *Chambers*, 100 F.3d at 824–27; *Doe*, 3 F.3d at 87; *Wildbur*, 974 F.2d at 638–42.

67. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

68. *Id.* at 108.

69. *Id.*

MetLife the discretionary authority to determine employees' claims; and MetLife also paid these claims with its own funds.⁷⁰ Glenn was an employee of Sears, and she was diagnosed with dilated cardiomyopathy, a heart condition whose symptoms include fatigue and shortness of breath.⁷¹

Because of the cardiomyopathy, Glenn stopped working in April 2000 and applied for plan disability benefits in June 2000.⁷² MetLife agreed that she was entitled to an initial twenty-four months of benefits because she could not "perform the material duties of [her] own job."⁷³ After the initial twenty-four month period ended, Glenn was required under the employee-benefit plan to meet a stricter standard to continue receiving benefits: she would have to show that she was not only incapable of performing her own job, but of performing "the material duties of any gainful occupation for which she [was] reasonably qualified."⁷⁴ MetLife determined that Glenn was capable of performing full-time sedentary work, i.e., secretarial work, and denied the extended benefits.⁷⁵ Glenn sued MetLife in federal court. The District Court concluded that MetLife's decision to deny benefits to Glenn was reasonable,⁷⁶ and the Sixth Circuit Court of Appeals reversed.⁷⁷ The Supreme Court granted certiorari.⁷⁸

70. *Id.*

71. *Id.* at 109.

72. *Id.*

73. *Id.*

74. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

75. MetLife's conclusion was based on two doctors' assessment that Glenn was capable of sedentary work. *Glenn v. Metro. Life Ins. Co.*, 461 F.3d 660, 664 (6th Cir. 2008). After MetLife denied these benefits, Glenn asked MetLife to reconsider. *Id.* at 665. After meeting again with one of the doctors, the doctor concluded that Glenn was still having "significant difficulty" returning to any type of work because the emotional stress of the job exacerbated her condition. *Id.* at 664–65. Nevertheless, MetLife again denied extending her disability benefits. *Id.* MetLife seemingly disregarded this second assessment and relied on the doctors' previous assessment that Glenn was able to perform sedentary work.

76. *Glenn v. Metro. Life Ins. Co.*, No. 2:2003CV0572, 2005 WL 1364625, at *8 (E.D. Ohio June 8, 2005).

77. *Glenn v. Metro. Life Ins. Co.*, 461 F.3d 660, 662 (6th Cir. 2006).

78. *Metro Life Ins. Co.*, 554 U.S. at 110.

The Supreme Court first concluded that a conflict of interest exists when a plan administrator both evaluates the claims and pays benefits out of its own funds.⁷⁹ When an employer holds these dual roles, it is torn between fulfilling its duty of loyalty to the plan beneficiaries and protecting its own financial interests.⁸⁰ On one hand, the employer as the administrator of the plan has a duty of loyalty to act in the best interest of the beneficiaries by granting the claims to which they are entitled.⁸¹ On the other hand, the Court reasoned, “every dollar provided in benefits is a dollar spent . . . by the employer; and every dollar saved . . . is a dollar in [the employer’s] pocket.”⁸² Therefore, in close situations, the employer as administrator would be torn between fulfilling both of these interests.⁸³ Therein lies the conflict of interest. The Court conceded that the answer is “less clear” when an insurance company is the plan administrator, but the Court concluded that a conflict of interest nonetheless exists in such a situation.⁸⁴

The Supreme Court next addressed the question of how the conflict of interest should be taken into account on judicial review of a discretionary benefit denial. The Court first concluded that the “abuse of discretion” standard should remain the standard of review.⁸⁵ The Court next reaffirmed the conflict of interest standard exactly as it was worded in *Firestone*: that a conflict of interest “should be weighed as one factor in determining whether there is an abuse of discretion.”⁸⁶ The Court stated that this is a case-specific inquiry—any one factor could act as a “tiebreaker” when the other factors are closely balanced.⁸⁷ The conflict could be weighed more heavily if there was an increased likelihood that it affected the benefit denial or where the administrator had a history

79. *Id.* at 112.

80. *Id.*

81. *Id.*

82. *Id.* (quoting *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 (3d Cir. 1987)).

83. *Id.* at 112.

84. *Id.* at 114.

85. *Id.* at 115.

86. *Id.* (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)).

87. *Id.* at 117.

of biased claims decisions.⁸⁸ The conflict could be less important where the administrator has taken steps to reduce potential bias and to promote accuracy.⁸⁹

The Court reasoned that the combination of factors test, as previously used by the Sixth Circuit, was the best approach, because benefit decisions “arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts—which themselves vary in kind and in degree of seriousness—for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review.”⁹⁰ The Court conceded that this approach does not provide “a detailed set of instructions.”⁹¹ Developing a bright line rule, however, would be impossible given the wide range of factual disputes that arise in benefit cases.⁹² Accordingly, the Court concluded that this approach was appropriate in light of “the intractability of any formula to furnish definiteness of content for all the impalpable factors involved in judicial review.”⁹³

Although *Glenn* adopted *Firestone*’s abuse of discretion standard of review and combination of factors test, it pronounced a new, universal definition of a conflict of interest.⁹⁴ Because virtually every ERISA plan gives its administrator discretion⁹⁵ and virtually all administrators operate under *Glenn*’s conflict of interest definition,⁹⁶ the *Glenn* conflict of interest standard will be universally applied.⁹⁷ Therefore, approaches that had been previously used to determine whether a conflict of interest existed and that altered the standard of review when a conflict of interest existed

88. *Id.*

89. *Id.*

90. *Id.* at 116.

91. *Id.* at 119.

92. *Id.*

93. *Id.*

94. See *supra* notes 60–73 and accompanying text.

95. Cohen, *supra* note 23, at 960; Harmon, *supra* note 50, at 9–10.

96. *Glenn*, 554 U.S. at 111–15 (noting that virtually all insurers, as well as the employers who hired them, perform their fiduciary duties under a conflict of interest).

97. Cohen, *supra* note 23, at 960.

were no longer valid after *Glenn*.⁹⁸ Instead, nearly every Court of Appeals that faced a challenge to ERISA benefit denials after *Glenn* has adopted the combination of factors test.⁹⁹

ERISA-GOVERNED EMPLOYEE-BENEFIT PLANS AND THE RISK OF
RELAPSE INTO DRUG ADDICTION

Whether the risk of relapse into drug addiction could qualify as a disability under an ERISA governed employee-benefit plan is an unsettled question among the circuits. It is to that question that this Note now turns. The Fourth Circuit, in *Stanford v. Continental Casualty Company*,¹⁰⁰ held that the administrator of an ERISA governed employee-benefit plan, acting under a conflict of interest, was within its discretion to deny benefits to a member at risk of relapse into drug addiction.¹⁰¹ The First Circuit, in *Colby v. Union Security Insurance Company*,¹⁰² on the other hand, recently concluded that the administrator of an ERISA governed employee-benefit plan—also acting under a conflict of interest—abused its discretion in such a situation.¹⁰³ This part will highlight this circuit split by explaining the facts and holdings of *Stanford* and *Colby*.

98. See, e.g., *Estate of Schwing v. Lilly Health Plan*, 562 F.3d 522, 525 (3d Cir. 2009) (concluding that the “sliding scale” approach was no longer valid in light of *Glenn*); *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126, 132–33 (2d Cir. 2008) (concluding that its “shifting standards” review was no longer valid in light of *Glenn*); *Champion v. Black & Decker Inc.*, 550 F.3d 353, 358–59 (4th Cir. 2008) (concluding that the “sliding scale” approach was no longer valid in light of *Glenn*); *Doyle v. Liberty Life Assurance Co. of Bos.*, 542 F.3d 1352, 1359–60 (11th Cir. 2008) (concluding that its “burden shifting” approach was no longer valid in light of *Glenn*). *But see*, *Crowell v. Shell Oil Co.*, 541 F.3d 295, 311 n.66 (5th Cir. 2008) (acknowledging that the Fifth Circuit must adopt *Glenn*’s combination of factors test in cases where there is a conflict of interest, but the “sliding scale” approach can be used to measure and evaluate the conflict of interest factor); *Weber v. GE Grp. Life Assurance Co.*, 541 F.3d 1002, 1010–11 (10th Cir. 2008) (concluding that the “sliding scale” approach is consistent with *Glenn*).

99. See *supra* note 87.

100. *Stanford v. Cont’l Cas. Co.*, 514 F.3d 354 (4th Cir. 2008).

101. *Id.* at 361.

102. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58 (1st Cir. 2013).

103. *Id.* at 59–60.

The Fourth Circuit's Approach: Stanford v. Continental Casualty Company

To fully understand whether a risk of relapse into drug addiction could constitute a disability under an ERISA governed employee-benefit plan, it is necessary to look at decisions that have come down on both sides of this issue. An examination of *Stanford* will show that pre-*Glenn*, an employee at risk of relapse into drug addiction had an extremely high burden to meet to be awarded disability benefits.

Robert Stanford was a nurse anesthetist at Beaufort Memorial Hospital (Beaufort).¹⁰⁴ Stanford began self-administering Fentanyl, a powerful painkiller and narcotic.¹⁰⁵ He ultimately became addicted to the drug.¹⁰⁶ He left his position at Beaufort and entered a drug addiction treatment and rehabilitation program.¹⁰⁷ He completed the program, but relapsed before he returned to work.¹⁰⁸ He then entered a second drug treatment program where he remained for three months.¹⁰⁹

While Stanford was attending the second treatment program, he applied for LTD benefits under the employee-benefit plan offered by his former employer, Continental Casualty Company (Continental).¹¹⁰ The plan was governed by the ERISA.¹¹¹ Continental both insured and administered Beaufort's employee benefit plan—which means that Continental was acting under a conflict of interest.¹¹² As the plan administrator, Continental had the discretion to interpret the language of the plan.¹¹³ The plan was silent in regard to a risk of relapse into drug addiction, and therefore, Continental had the discretion to interpret the plan's language as it applied to this dispute.¹¹⁴

104. *Stanford*, 514 F.3d at 355.

105. *Id.*

106. *Id.*

107. *Id.* at 356.

108. *Id.*

109. *Id.*

110. *Stanford*, 514 F.3d at 356

111. *Id.* at 355.

112. *Id.* at 357.

113. *Id.*

114. *Id.*

Continental approved Stanford's application for long-term benefits.¹¹⁵ Upon completing the program, he was discharged and was approved to return to work.¹¹⁶ Stanford returned to work, but started taking Fentanyl again.¹¹⁷ He left work a second time, and again sought treatment for his drug use.¹¹⁸ While he was attending the third treatment program, he again applied for LTD benefits and Continental approved his second application for benefits, but only for the duration of his treatment program.¹¹⁹ Seven months later, a nurse consultant with Continental spoke with Stanford's treating physician, who told the nurse consultant that Stanford was able to return to work and perform his regular duties.¹²⁰ Based on this information, Continental terminated Stanford's LTD benefits.¹²¹

Stanford requested that Continental review the decision, providing Continental with letters from his physician stating that he was at a risk of relapse into drug addiction if exposed to Fentanyl, as well as an article from a medical treatise that discussed the risk of relapse among anesthesiologists.¹²² Continental had discretionary authority as the plan administrator, and denied Stanford's appeal.¹²³ Continental concluded that the plan did not cover "potential risk" of a relapse, and therefore, he was not entitled to further LTD benefits, even though the plan was silent in regard to a future risk of relapse.¹²⁴ In other words, Continental categorically excluded risk of relapse into drug addiction from the plan when the plan was silent on the matter. Stanford exhausted his administrative appeals and filed in Federal District Court,¹²⁵ which upheld Continental's decision as reasonable.¹²⁶

115. *Id.* at 356.

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.*

123. *Stanford*, 514 F.3d at 356.

124. *Id.*

125. *Id.*

126. *Stanford v. Cont'l Cas. Co.*, 455 F. Supp. 2d 438, 446 (E.D.N.C. 2006).

The court concluded that Continental did not abuse its discretion in determining that Stanford's risk of relapse into drug addiction was not a disability under the employee-benefit plan.¹²⁷ Under the pre-*Glenn* standard of review, the decisions of plan administrators are given discretion by the reviewing court, and the decision will only be overturned if it is determined to be unreasonable.¹²⁸ The administrator of an ERISA governed employee-benefit plan, acting under a conflict of interest, has the discretion to categorically exclude the risk of relapse into drug addiction as a disability under the plan, so long as the plan is silent in regard to a risk of relapse into drug addiction and it gives the administrator the discretion to interpret the terms of the plan.¹²⁹

The Fourth Circuit used the "sliding scale" standard of review,¹³⁰ as *Stanford* was decided before the Supreme Court pronounced the combination of factors test in *Glenn*. The court articulated its standard of review, stating that in ERISA benefit denial cases where a conflict of interest exists, "the fiduciary decision will be entitled to some deference, but this deference will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict."¹³¹ And the "administrator's decision will not be disturbed if it is reasonable, even if the reviewing court would have come to a different conclusion."¹³² The court noted that Stanford did not show that Continental's conflict of interest affected its decision in any way.¹³³ Using the sliding scale standard of review, the court noted that it must, therefore, defer to Continental's determination that the benefit plan did not cover risk of relapse.¹³⁴

Against this standard, the court concluded that Continental did not abuse its discretion in categorically excluding risk of relapse from the employee-benefit plan.¹³⁵ To qualify for LTD bene-

127. *Stanford*, 514 F.3d at 355.

128. *Id.* at 356-57.

129. *Id.* at 358-59.

130. *Id.* at 356-57.

131. *Id.* at 357 (quoting *Doe v. Grp. Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993)).

132. *Stanford*, 514 F.3d at 356-57.

133. *Id.* at 359.

134. *Id.*

135. *Id.* at 358.

fits under the plan, a claimant was required to establish a “disability,” which under the plan meant an “injury or sickness caus[ing] physical or mental impairment to such a degree of severity that you are . . . continuously unable to perform the material and substantive duties of your regular occupation.”¹³⁶ Continental reasoned that after Stanford left rehab, he no longer had a mental or physical impairment as a result of his drug use, and therefore, a future risk of relapse did not render him “unable to perform the material and substantive duties of [his] regular occupation.”¹³⁷

The court concluded that this interpretation of the plan was reasonable, for several reasons. First, the court noted that there was conflicting authority on whether a future risk is sufficient to render a person unable to perform the duties of his occupation.¹³⁸ Noting that lower courts have come down on both sides of the issue,¹³⁹ Continental’s decision was therefore not unreasonable.¹⁴⁰

Second, the court concluded that a risk of relapse into drug addiction is fundamentally different from the risk of relapse into heart conditions.¹⁴¹ In support of his argument, Stanford cited cases in which the courts concluded that it was arbitrary and capricious for the insurer to deny long-term benefits to physicians who were at a risk of orthopedic complications in light of their current heart conditions.¹⁴² The court said that the risk of orthopedic complications is fundamentally different from the risk of relapse into drug use.¹⁴³ Doctors who return to work in a high stress environment, like an operating room, are at a risk of relapse because “the performance of his job duties may *cause* a heart attack.”¹⁴⁴ But an

136. *Id.*

137. *Id.*

138. *Stanford*, 514 F.3d at 358–59.

139. *Id.* (citing *Lasser v. Reliance Standard Life Ins. Co.*, 344 F.3d 381 (3d Cir. 2003) (concluding that a future risk renders a person unable to perform the duties of his current job); *Saliamonas v. CNA, Inc.*, 127 F. Supp. 2d 997 (N.D. Ill. 2001); *Allen v. Minn. Life Ins. Co.*, 216 F. Supp. 2d 1377, 1383 (N.D. Ga. 2001) (rejecting an anesthesiologist-addict’s claim that “future potentialities rather than any present impediment to plaintiff’s return” to work qualified as a disability under an ERISA-governed benefit plan).

140. *Id.* at 358–60.

141. *Id.* at 358.

142. *Lasser*, 344 F.3d at 383–84; *Saliamonas*, 127 F. Supp. 2d at 998–99.

143. *Stanford*, 514 F.3d at 358.

144. *Id.*

anesthesiologist who returns to the environment where drugs are available, the court reasoned, only risks relapse in a sense that he is tempted to start using the drug again.¹⁴⁵ Therefore, a person has the ability to control his temptation to relapse into a drug addiction whereas a person does not have the ability to control whether his heart condition will reoccur.¹⁴⁶

Third, the court rejected Stanford's argument that this line of reasoning would require him to return to work and suffer a relapse in order to qualify for LTD benefits under Continental's plan.¹⁴⁷ The court conceded that this "creates a somewhat troubling—some might say perverse—incentive structure," but found that it rested on the false assumption that disability benefits are an award for sobriety.¹⁴⁸ The court stated that the reward for sobriety is the fact that Stanford will be rehabilitated and will have other opportunities that he did not previously have as an addict.¹⁴⁹ Although he may not be able to return to his old job, he will have other opportunities available; the court reasoned that this is a "significant cost" of drug addiction, but it is "greatly outweighed by the opportunities sobriety provides."¹⁵⁰ The court concluded that it would be "perverse" if he were to have success at another job and be able to collect insurance checks based on the risk of relapse into drug addiction if he returned to his anesthesiologist job.¹⁵¹

Finally, the court rejected Stanford's argument that Continental abused its discretion by failing to consider the medical materials he submitted in support of his appeal for benefit denial.¹⁵² The court noted that Stanford did not introduce any evidence that supported this argument.¹⁵³ The court stated, "[t]he fact that Continental was not persuaded by Stanford's submission does not mean that [Continental] did not consider it."¹⁵⁴

145. *Id.*

146. *Id.*

147. *Id.* at 359.

148. *Id.*

149. *Stanford*, 514 F.3d at 359

150. *Id.*

151. *Id.*

152. *Id.* at 360.

153. *Id.*

154. *Id.* at 360–61.

The First Circuit's Approach: Colby v. Union Security Insurance Company

A recent case decided by the First Circuit reached the opposite conclusion with facts virtually identical as those in *Stanford*. Decided after *Glenn*, the First Circuit in *Colby v. Union Security Insurance Company* concluded that the administrator of an ERISA governed employee benefit plan—also acting under a conflict of interest—abused its discretion by denying a member long term disability benefits when the member was at a risk of relapse into drug addiction.¹⁵⁵

In *Colby*, the plaintiff was an anesthesiologist employed at Merrimack Valley Anesthesia Associates (MVAA).¹⁵⁶ She began self-administering Fentanyl and had become addicted to the drug by July 2004.¹⁵⁷ Within weeks after her addiction was discovered, she took a leave of absence and checked into a drug rehabilitation program at Talbott Recovery Campus (Talbott).¹⁵⁸ She stayed at Talbott until November 2004¹⁵⁹ and after she was released from Talbott, her attending physician recommended that she should not return to work for six months so that she could continue to work on her recovery.¹⁶⁰ After her discharge, she remained under medical supervision on an outpatient basis.¹⁶¹

While *Colby* was a patient at Talbott, she filed for LTD benefits under the employee benefit plan offered by MVAA.¹⁶² The plan was governed by ERISA.¹⁶³ The plan was also underwritten and administered by Union Security Insurance Company & Management Company for Merrimack Anesthesia Associates Long Term Disability Plan (USIC)¹⁶⁴—which means that USIC was op-

155. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58, 59–60 (1st Cir. 2013).

156. *Id.* at 60.

157. *Id.*

158. *Id.*

159. *Id.*

160. *Colby*, 705 F.3d 58. at 63.

161. *Id.* at 60.

162. *Colby v. Assurant Emp. Benefits*, 818 F. Supp. 2d 365, 370 (D. Mass. 2011).

163. *Colby*, 705 F.3d at 60.

164. *Id.* at 60.

erating under a conflict of interest.¹⁶⁵ As the plan administrator, USIC had the discretion to interpret the terms of the plan.¹⁶⁶

USIC approved Colby's application for LTD benefits for the remainder of her stay at Talbott, but it refused to provide LTD benefits to Colby thereafter.¹⁶⁷ USIC reasoned that after she left rehab, a risk of relapse into drug addiction was not a current disability under the plan.¹⁶⁸

Colby appealed USIC's decision to terminate her LTD benefits after she was discharged from rehab.¹⁶⁹ She submitted several medical records, including a treatment summary from her therapist at Talbott, Patricia Dell-Ross, and statements from a number of medical experts indicating that Colby would likely relapse if she returned to work at MVAA.¹⁷⁰ Dell-Ross wrote that if Colby returned to work, her access to Fentanyl "combined with the usual stressors of everyday life and work would make relapse almost inevitable."¹⁷¹ Dr. Alan A. Wartenberg similarly wrote, "to a reasonable degree of medical certainty, Dr. Colby is at a high risk of relapse should she return to the practice of anesthesia, or to any situation where she could access anesthetic opioids."¹⁷²

165. See nn. 60–65 and accompanying text.

166. *Colby*, 705 F.3d at 60–61.

167. *Id.* The plan had a 90-day waiting period for LTD benefits. *Id.* After the 90-day waiting period, Colby received her benefits for a total of twelve days until she was discharged from Talbott, at which point USIC refused to continue to provide benefits for risk of relapse into drug addiction. *Colby*, 818 F. Supp. 2d at 370.

168. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58, 60 (1st Cir. 2013).

169. *Id.* at 63.

170. *Id.*

171. *Id.*

172. *Id.* at 64. Other medical experts agreed with these statements made by Dell-Ross and Wartenberg. Dr. Marcus Goldman wrote that Colby "could not work from July 2004 through to December 2005" because her "risk of relapse . . . was significant." *Id.* Dr. William Land concluded that her addiction to Fentanyl "rendered her unable to perform the duties not only of an anesthesiologist, but also for a physician generally given [her] access to opioids." *Id.* Working full-time, Lamb stated, "would clearly increase [her] risk of relapse" and "[h]er strong attraction to her drug of choice (Fentanyl) would distract her and preclude her from conducting her essential duties." *Id.* Finally, Dr. Milton Jay wrote that Colby had a "moderate severity relapse risk profile" such that she did not have "functional capacity for returning to work." *Id.*

Despite this medical evidence, USIC stood by its decision that after Colby left rehab, risk of relapse into drug addiction was not a disability under MVAA's employee benefit plan.¹⁷³ After exhausting her administrative remedies, she filed suit in federal court against USIC.¹⁷⁴ The district court concluded that USIC's denial of LTD benefits to Colby after she left Talbott was unreasonable.¹⁷⁵

The First Circuit concluded that USIC abused its discretion by categorically excluding a risk of relapse into drug addiction as a disability from the ERISA-governed employee benefit plan.¹⁷⁶ Under the post-*Glenn* standard of review, the reasonableness of the plan administrator's decision is determined by a combination of factors—a conflict of interest being one of several factors for the court to consider.¹⁷⁷ The administrator of an ERISA-governed employee-benefit plan, acting under a conflict of interest, does not have the discretion to categorically exclude the risk of relapse into drug addiction as a disability under the plan just because the plan is silent in regard to a risk of relapse into drug addiction and the administrator has the discretion to interpret the terms of the plan.¹⁷⁸ In sum, a risk of relapse into drug addiction can “swell to so significant a level as to constitute a current disability.”¹⁷⁹

The court used the combination of factors test to determine the reasonableness of USIC's decision, as *Colby* was decided after *Glenn*. The court articulated the standard, stating that “[i]n order to withstand scrutiny, the plan administrator's determinations must be ‘reasoned and supported by substantial evidence.’ In short, they must be reasonable.”¹⁸⁰ An “inherent conflict of interest may be weighed as a factor in assessing the reasonableness of USIC's decision, but its existence does not perforce alter our standard of review.”¹⁸¹

173. *Id.* at 60.

174. *Id.*

175. *Id.*

176. *Id.* at 65.

177. *Id.* at 61–62.

178. *Id.* at 65–66.

179. *Id.* at 60.

180. *Id.* at 62 (citations omitted) (quoting *D & H Therapy Assocs., LLC v. Boston Mut. Life Ins. Co.*, 640 F.3d 27, 35 (1st Cir. 2011)).

181. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58, 59–60 (1st Cir. 2013).

Against this standard, the court concluded that USIC's determination that a risk of relapse was not a disability under the plan was unreasonable.¹⁸² USIC noted that the language of the plan was crafted in the present tense: a claimant is disabled if a sickness "prevents" her from performing the essential duties of her job.¹⁸³ USIC argued that a risk of relapse is a "speculative future possibility," and it has the discretion to categorically exclude this future possibility as a disability.¹⁸⁴

The court disagreed with USIC's position for several reasons. First, the language of the plan neither addressed a risk of relapse into drug addiction, nor did it exclude risk of relapse into drug addiction as a basis for finding of disability.¹⁸⁵ The court pointed out that "this silence is telling in an ERISA case" because the plan administrator's discretion is confined "by the text of the plan and the plain meaning of the words used."¹⁸⁶ If USIC could "pluck an exclusion for risk of relapse out of thin air," then it would undermine the integrity of the ERISA plan¹⁸⁷ because exclusions from coverage are not favored in ERISA plans. The insurance company must spell out exclusions distinctly.¹⁸⁸ If USIC could import into the plan an unwritten provision that categorically excludes risk of relapse as a basis for a disability, then it would undermine its obligation to use its discretion to process claims "solely in the interests of the plan participants and beneficiaries of the plan."¹⁸⁹ Also, the provisions of an ERISA plan must be read in a natural and commonsense way.¹⁹⁰ In the opinion of the court, "it is a commonsense proposition" that a person's risk of relapse can be so severe as to constitute a disability.¹⁹¹

Second, the court concluded that a risk of relapse into drug addiction was analogous to the risk of relapse into cardiac distress

182. *Id.*

183. *Id.*

184. *Id.*

185. *Id.* at 65.

186. *Id.*

187. *Id.*

188. *Id.* at 65–66.

189. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58, 66 (1st Cir. 2013). *See also* nn. 4–9 and accompanying text.

190. *Id.*

191. *Id.*

or a risk of relapse into orthopedic complications.¹⁹² Colby's risk of relapse into drug addiction, according to the court, is analogous to the plaintiff's risk present in *Lasser v. Reliance Standard Life Insurance Company*, in which the United States Court of Appeals for the Third Circuit found arbitrary and capricious the insurer's denial of LTD benefits to an orthopedic surgeon who was at risk of additional heart attacks.¹⁹³ An employee can be totally disabled with respect to her regular occupation because the work conditions put her at risk of relapse.¹⁹⁴ Even though she would be able to physically perform the functions of her job, the risk of relapse is "prohibitively impairing" and becomes a *current* disability.¹⁹⁵

Finally, the court concluded that a claimant should not have to relapse before receiving LTD benefits.¹⁹⁶ Under USIC's interpretation of the plan, Colby would only be entitled to benefits if she relapsed and became addicted to narcotics, as mere risk of relapse into addiction would be insufficient.¹⁹⁷ The court noted that this debate arose in *Stanford*, and that the Fourth Circuit held that the claimant did have to undergo a relapse first.¹⁹⁸ The First Circuit disagreed, citing Judge Harvie Wilkinson's dissent in *Stanford*, and held requiring a claimant either to relapse into drug addiction or lose his disability benefits would "thwart the very purpose for which disability plans exist: to help people overcome medical adversity if possible, and otherwise to cope with it."¹⁹⁹

192. *Id.*

193. *Lasser v. Reliance Standard Life Ins. Co.*, 344 F.3d 381, 391–92 (3d Cir. 2003); *Colby*, 705 F.3d at 66.

194. *Colby*, 705 F.3d at 66.

195. *Id.* The court uses an example of an air traffic controller to illustrate this point. The court states that an air traffic controller who is at risk of seizures would be disabled if she had a seizure disorder because the flickering lights would put her at grave risk of convulsive episodes, even though she could physically perform the duties of her job.

196. *Id.*

197. *See id.* at 61.

198. *Id.* at 66.

199. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58, 66 (1st Cir. 2013) (quoting *Stanford v. Cont'l Cas. Co.*, 514 F.3d 354, 362 (3d Cir. 2008) (Wilkinson, J., dissenting)).

COURTS CONFRONTED WITH RISK OF RELAPSE INTO DRUG
ADDICTION UNDER ERISA-GOVERNED EMPLOYEE-BENEFIT PLANS
SHOULD FOLLOW THE FIRST CIRCUIT'S APPROACH

This Part will argue that courts confronted with the issue of whether risk of relapse into drug addiction can constitute a disability under an ERISA governed employee-benefit plan should follow the First Circuit's approach. This part will explain that the Fourth Circuit's approach, if universally adopted, would give plan administrators the discretion to interpret employee benefit to the detriment of their employees. Such a result is contrary to the policy behind ERISA and employee-benefit plans. Next, this part will argue that the Fourth Circuit incorrectly equated a risk of relapse into drug addiction and the risk of relapse into orthopedic complications.

The Fourth Circuit's Approach: Too Much Discretion to Plan Administrators

In both *Stanford* and *Colby*, the administrator interpreted the plan to exclude a risk of relapse into drug addiction as a disability under an ERISA governed employee-benefit plan, even though the plan said nothing about a risk of relapse into drug addiction.²⁰⁰ The majority in *Stanford* treated the administrator's decision as an exercise of discretion,²⁰¹ while *Colby* concluded that such an interpretation is unreasonable.²⁰²

As both *Colby* and the dissent in *Stanford* point out, such an interpretation is hardly an exercise of discretion, even under the pre-*Glenn* sliding scale scheme.²⁰³ Although neither plan mentions anything about future risk, the administrator's decision must be supported by plain language of the plan itself.²⁰⁴ But the Fourth Circuit permits the plan administrator to carve an unwritten excep-

200. *Colby*, 705 F.3d at 65; *Stanford*, 514 F.3d at 356.

201. *Stanford*, 514 F.3d at 359.

202. *Colby*, 705 F.3d at 65.

203. *Id.* at 66–67; *Stanford*, 514 F.3d at 362 (Wilkinson, J., dissenting).

204. *Colby*, 705 F.3d at 66; *Stanford*, 514 F.3d at 362 (Wilkinson, J., dissenting); see also *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 277–78 (1st Cir. 2000); *Lockhard v. United Mine Workers of Am. 1974 Pension Trust*, 5 F.3d 74, 78 (4th Cir. 1993).

tion out of the plan's promise of coverage.²⁰⁵ There is a fair way to make exceptions under an ERISA plan, and that is to include them in the plan before the claimant comes asking for benefits.²⁰⁶ The plan administrators could have easily done so in both instances.

Further, if administrators had the discretion to carve exceptions to coverage into the plans, despite the absence of language, then such a grant of discretionary power would conflict with the purpose of the ERISA. ERISA was passed to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits,²⁰⁷ and an administrator accordingly is required to "discharge [its] duties in respect to discretionary claims processing 'solely in the interest of the [plan's] participants and beneficiaries.'"²⁰⁸ If the Fourth Circuit's approach were adopted, then plan administrators could easily act in their own self-interest while disregarding the interests of the plan beneficiaries. Insurance companies that both determine and pay benefits, if given the choice, would likely use this discretion to deny any claims that do not fit squarely within the language of the plan, as "every dollar saved . . . is a dollar in [its] pocket."²⁰⁹ So long as the exception to coverage is not spelled out in the plan, the Fourth Circuit's approach gives the insurance company the incentive to pocket the money at the expense of the beneficiary, despite ERISA's purpose.

*The Fourth Circuit Incorrectly Distinguished the Risk of
Relapse into Drug Addiction from the Risk of Relapse into Or-
thopedic Complications*

That the denial of LTD benefits to beneficiaries who are at a risk of relapse into orthopedic complications has been determined to be arbitrary and capricious finds support in prior case

205. *Colby*, 705 F.3d at 67; *Stanford*, 514 F.3d at 362 (Wilkinson, J., dissenting).

206. *Colby*, 705 F.3d at 67; *Stanford*, 514 F.3d at 362 (Wilkinson, J., dissenting).

207. *Mass. v. Morash*, 490 U.S. 107, 112 (1989).

208. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 106 (2008) (quoting 29 U.S.C. § 1104(a)(1)).

209. *Id.*

law.²¹⁰ The First Circuit concluded that these two potential risks are similar,²¹¹ but the Fourth Circuit found that a risk of relapse is fundamentally different from a risk of relapse into orthopedic complication.²¹² The Fourth Circuit reasoned that a risk of relapse into an orthopedic complication is involuntary, while a person has the choice to resist the temptation to use drugs.²¹³

This analysis is legally unsupported, however, because the court is simply using its equitable power to distinguish these two types of future risks. As the dissent in *Stanford* points out, this distinction rests on “moral considerations of choice and temptation on the one hand, and medical considerations of physical inability on the other.”²¹⁴ Neither of these considerations was found in the language of the plan, and therefore are not the court’s choices to make.²¹⁵ Instead, these considerations belong to the administrator and beneficiaries of the plan, as both have a stake in it.²¹⁶

Further, it is a “basic tenant of insurance law” that an insured is considered disabled when the activity in question would “aggravate a serious condition affecting the insured’s health.”²¹⁷ Similarly, the treatise definition of disability holds that “[t]he insured is considered to be permanently and totally disabled when it is impossible to work without hazarding his or her health or risking his or her life.”²¹⁸ In both *Stanford* and *Colby*, the claimants would have risked their health had they both returned to work as anesthes-

210. See, e.g., *Lasser v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321 (11th Cir. 2001).

211. *Colby*, 705 F.3d at 66.

212. *Stanford v. Cont’l Cas. Co.*, 514 F.3d 354, 358 (4th Cir. 2008).

213. *Id.*

214. *Stanford*, 514 F.3d at 363 (Wilkinson, J., dissenting).

215. *Id.* (Wilkinson, J., dissenting).

216. *Id.* (Wilkinson, J., dissenting).

217. *Id.* at 362–63 (Wilkinson, J., dissenting) (citing *Stark v. Weinberger*, 497 F.2d 1092, 1098–99 (7th Cir. 1974); *Lasser v. Reliance Standard Ins. Co.*, 146 F. Supp. 2d 619, 628 (D.N.J. 2001), *aff’d*, 344 F.3d 381 (3d Cir. 2003); *Oppenheim v. Finch*, 495 F.2d 396, 398 (4th Cir. 1974); *Stillwell v. Sullivan*, 1992WL401971, at *6 (D. Kan., Dec. 30, 1972).

218. JOHN ALAN APPLEMAN, APPLEMAN ON INSURANCE § 187.05[A] (2d ed. 2007). (“This principle is so well-settled among jurisdictions that ‘it travels under the name of the “common care and prudence rule”’); *Lasser*, 146 F. Supp. 2d at 628. *Accord Oppenheim*, 495 F.2d at 398; 46 C.J.S. *Insurance* § 1551 (2007); 44 AM. JUR. 2D *Insurance* § 1470 (2003).

siologists because they would have had easy access to Fentanyl, the drug to which they became addicted. And in both cases, the claimant submitted medical evidence that they were addicted to Fentanyl and at a risk of relapse if they were to return to work. Under the definitions above—and in light of the absence of language in regard to risk of relapse under the plans—the claimants in *Stanford* and *Colby* seemingly fit within the definition of a disabled person. Like a person with a back condition that risks paralysis upon returning to work and lifting heavy objects and an air traffic controller that risks seizures by returning to work and seeing the flickering lights of the runway, a patient at such a high risk of relapse into drug addiction risks returning to the environment where his drug of choice is easily accessible and therefore deserves LTD benefits.

The Fourth Circuit's Standard of Review Applied to Risk of Relapse into Drug Addiction Does Not Survive Glenn

The Supreme Court in *Firestone* held that when a fiduciary acts under a conflict of interest, then the conflict must be weighed as a factor to determine whether there was an abuse of discretion.²¹⁹ However, the Court did not specify how this conflict of interest should be taken into account: it did not address how the standard of review should be altered when a conflict of interest was one of the factors to be weighed. Therefore, the Circuits were free to develop their own approaches to determine whether a plan administrator acting under a conflict of interest abused its discretion in denying LTD benefits to an ERISA plan member. These approaches included the sliding scale approach, the combination of factors test, and the burden shifting approach.²²⁰ The Fourth Circuit used the sliding scale approach.²²¹ Under this approach, the reviewing court would always apply the arbitrary and capricious standard, but decrease the level of deference given to the administrator in proportion to the degree of the conflict of interest.²²²

219. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 103 (1989).

220. *See supra* Part II.B.2.b.

221. *Stanford v. Cont'l Cas. Co.*, 514 F.3d 354, 357 (4th Cir. 2008) (citing *Doe v. Grp. Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993)).

222. *See Lasser*, 344 F.3d at 385.

Stanford illustrates the Fourth Circuit's application of the sliding scale approach to a plan administrator's decision to deny LTD benefits to an ERISA plan member who was at risk of relapse into drug addiction. But regardless of whether the Fourth Circuit reached the correct decision on this issue using the then valid sliding scale approach, the framework used to reach its decision—the sliding scale approach—does not survive *Glenn*. Thus, the First Circuit's decision in *Colby* on this issue is the sole decision that uses the correct framework—the combination of factors approach—to decide this issue.

Assuming that the Fourth Circuit correctly applied the sliding scale approach to the plan administrator's decision to deny LTD benefits to a plan member who was at risk of relapse into drug addiction, and that is a big assumption, the sliding scale approach cannot survive the combination of factors approach articulated in *Glenn*. Shortly after *Glenn* was decided, the Fourth Circuit acknowledged this in *Champion v. Black & Decker Incorporated*.²²³ The court concluded that it was forced to switch to the combination of factors test because the sliding scale approach was no longer valid:

The principles announced in *Glenn* alter some of our court's earlier approaches to reviewing discretionary determinations made by ERISA administrators allegedly operating under a conflict of interest. . . . [B]efore *Glenn*, when we found a conflict of interest, we applied a 'modified' abuse-of-discretion standard that reduced deference to the administrator to the degree necessary to neutralize any untoward influence resulting from the conflict of interest. . . . [A]s it now stands after *Glenn*, a conflict of interest is readily determinable by the dual role of an administrator or other fiduciary, and courts are to apply simply the abuse-of-discretion standard for reviewing discretionary determinations by that administrator, even if the administrator operated under a conflict of interest. . . . [A]nd any conflict of interest

223. *Champion v. Black & Decker Inc.*, 550 F.3d 353, 358–59 (4th Cir. 2008) (concluding that the “sliding scale” approach was no longer valid in light of *Glenn*).

is considered as one factor, among many, in determining the reasonableness of the discretionary determination.²²⁴

In sum, *Stanford* used the sliding scale approach to determine whether the plan administrator acted reasonably in denying LTD benefits to a plan member at risk of relapse into drug addiction.²²⁵ Subsequently, *Glenn* was decided and adopted the combination of factors approach to determine whether such discretionary determinations are reasonable.²²⁶ The Fourth Circuit later concluded in *Black & Decker* that its sliding scale approach was inconsistent with *Glenn*, and adopted the combination of factors approach to determine whether these discretionary determinations are reasonable.²²⁷

The First Circuit is therefore the only circuit to use the *Glenn* combination of factors approach to determine whether a plan administrator abused its discretion in denying LTD benefits to a plan member at risk of relapse into drug addiction. *Glenn* makes it clear that the First Circuit correctly decided this issue, because unlike the Fourth Circuit, it used the combination of factors approach.²²⁸ The Fourth Circuit's conclusion, on the other hand, was reached using a standard that is incompatible with *Glenn*. Accordingly, circuits that will address this issue in the future must begin by looking to *Colby*, and not *Stanford*.

CONCLUSION

Issues arising under ERISA benefit denial cases are usually controversial because the livelihood of the employee is implicated. The ERISA was enacted to protect employees by requiring ERISA plan administrators to act in the employees' best interest. Although plan administrators often enjoy discretion to interpret the language of the plan, such discretion is not without limits. If plan administrators are given the discretion to deny benefit claims to employees at risk of relapse into drug addiction when the plan is silent on

224. *Id.* at 358–59.

225. *Stanford v. Continental Cas. Co.*, 514 F.3d 354, 356–57 (4th Cir. 2008).

226. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 116 (2008).

227. *Black & Decker Inc.*, 550 F.3d at 358–59.

228. *Glenn*, 554 U.S. at 116.

whether the claim qualifies as a disability, then the ERISA would lose its force. The First Circuit's approach in *Colby* would conform to the purpose of the ERISA because it protects the employee by preventing the administrator from acting in its own self-interest at the expense of the employee's well being. The First Circuit is also the only circuit to use the correct standard of review, the combination of factors approach. Thus, courts deciding this issue for the first time should look to the First Circuit's decision in *Colby* rather than the Fourth Circuit's approach in *Stanford*.