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COMMENT

THE DISCRIMINATORY REALITIES OF MENTAL DISABILITIES AND THE BAR APPLICATION

Joshua C. Dawson†

I. INTRODUCTION

Mental illness type disabilities are the most common disabilities in the U.S. and Canada.1 It is estimated by the World Health Organization that 26.4% of the total population in the United States suffers from some form of mental illness during each calendar year.2 That roughly translates to 33.7 million individuals that are affected by mental illnesses.3 Of those 33.7 million, only 5.7% suffer from what is considered to be a serious mental illness.4

Legal professionals are not exempt from mental illnesses—in fact, the legal profession has been known to have higher rates of substance abuse and mental illness than the general public.5 Law school is stressful and creates a competitive environment that makes it more likely that certain types of students will suffer from a mental disorder.6 Currently, students that face

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2. Id.

3. Id.


Substance use and abuse by students, including alcohol, performance-enhancing drugs such as Adderall and Ritalin, and other illicit drugs, exists at law schools throughout the United States. Such behaviors by law students can
mental illness challenges during law school are in need of professional help, but fear that seeking such help will hinder their chances of becoming a licensed attorney.7

This fear partly stems from questions applicants must answer when applying for admission to the bar.8 Mental health questions began to appear on bar applications in the United States between the 1970s and 1980s.9 Since then there has been a sharp debate between those who criticize the use of mental health questions on bar applications and those in the legal profession who favor the use of mental health questions on bar applications.10 The adversely affect their academic (and, ultimately, professional) interests, along with their physical well-being. Stressors unique to law school, including new vocabulary, the Socratic method, and limited feedback leaving some at least initially confused; higher levels of competition; increasing debt coupled with employment concerns; expectations from family members, are exacerbated for many by their undergraduate experience and concomitant experimentation in things illicit (or even legal). Law school can be an erratic time, one of excitement and anticipation, but also of transition and anxiety.

Id. (footnote omitted).


9. Id.

10. American Bar Association, Model Rule on Conditional Admission to Practice Law (08M112) (2008), http://www.americanbar.org/content/dam/aba/migrated/legalservices/downloads/colap/ABAModelRule_ConditionalAdmission_Feb2008.authcheckdam.pdf. At the end of the Model Rule on Conditional Admission, the ABA lists six reasons for adopting the rule that reflect the conflict between protecting the interest of the general public and alleviating the discrimination against applicants with mental illnesses:

1. The interests of the public and bar applicants are best served by bar admission rules that promote early detection of substance abuse and dependency, and mental or other illness that may render an applicant unfit to practice law absent effective treatment or rehabilitation.

2. Utilizing a confidential conditional admission process can remove impediments to early diagnosis and treatment for chemical dependency or mental illness by encouraging law students to seek assistance and treatment early, rather than avoiding treatment for fear of being refused a license because of treatment.

3. The interests of the public and bar applicants are best served by encouraging early treatment and rehabilitation from conduct or behavior or a condition that would otherwise render an applicant unfit to practice law.

4. Utilizing a confidential conditional process can reduce the apprehension of full disclosure by bar applicants, and thereby increase an applicant's
contention between these two sides escalated in 1990 when Congress passed the Americans with Disability Act (ADA).\textsuperscript{11} This Act has been the driving force for the quickly evolving bar application standards.\textsuperscript{12}

This Comment will address the issues that surround the current bar application protocol practiced by many states. It will also propose a solution that seeks to balance the reduction of discriminatory effects against individuals suffering with mental illnesses wishing to enter the legal profession and the legitimate concerns of many bar application boards across the country that these individuals are fit to practice law. Part II will show how a broad reading of the ADA aligns with Congressional intent. Part III will examine the evolving nature of bar applications' focus on mental health. Part IV will discuss the model rule on conditional admission to practice law established by the American Bar Association and the failure of that rule to completely address the discrimination issues inherent in many bar applications across the country. Part V will define the more common mental disabilities encountered by bar application boards and highlight the changes that are reflected in the \textit{Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)}, published in May of 2013, and what those changes will possibly bring to the outlook on mental health. Part VI considers the common concerns that law students express when determining if they want to seek professional help for mental health issues prior to applying for the bar. It will additionally discuss the concerns that law students have about answering mental health questions honestly with regard to their mental health status. Part VII will propose a common sense structure for the bar application process that is both effective and

candor and provide for a more solid foundation on which to make an accurate assessment of character and fitness and create conditions that increase the likelihood of continued fitness.

5. Utilizing a confidential conditional admission process will enable bar admissions or disciplinary authorities to more quickly act to minimize or prevent harm to the public in cases of rehabilitation or effective treatment that are sufficiently recent to indicate a risk to the public if the conduct recurs or a relapse results in a lack of fitness.

6. A bar applicant who is otherwise qualified to practice law should not be denied access solely because she or he has been recently treated for a substance abuse or a mental or other illness and has been rehabilitated.

\textit{Id.}

12. \textit{See} discussion infra Part III.
appropriate in addressing mental disability inquiries by the bar examining boards nationwide.

II. ADA INTRODUCTION

The Americans with Disabilities Act (ADA) was considered by many of the individuals who worked on its development as the next major Civil Rights legislation of its time.13 Discussion on the ADA commenced in 1988 and was passed with overwhelming support in 1990 under the presidency of George H.W. Bush.14 This Part will discuss how Title II should be interpreted in light of Title I. It will also examine how a broad reading of the ADA is in line with Congress’s original intent.

A. Title I of the ADA

Title I of the ADA15 provides that no discrimination will be allowed against qualified individuals “in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.”16 Title I facilitates protection for disabled individuals against discriminatory practices by private employers, employment agencies, or unions, but not against governmental or bona fide organizations.17 The following provisions


17. ADA § 101(5)(B), 42 U.S.C. § 12111(5)(B) (2009) ("The term "employer" does not include (i) the United States, a corporation wholly owned by the government of the United States, or an Indian tribe; or (ii) a bona fide private membership club (other than a labor organization) that is exempt from taxation under section 501(c) of Title 26").
to be discussed of Title I are applicable to the discussion on discriminatory practices by bar associations towards individuals with mental disabilities.

Under section 102(b) of the ADA, it is stated that "the term 'discriminate against a qualified individual on the basis of disability,'" as found in subsection (a), includes "limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee." A "qualified individual" is defined under section 101(8) as:

[A]n individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. For the purposes of this subchapter, consideration shall be given to the employer’s judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job.

Although bar associations are not technically hiring bar applicants, they have a direct impact on an applicant’s ability to find gainful employment in the applicant’s state of interest. State bar application boards have the authority to recommend the approval or denial of an application to the presiding state supreme court. This is not like a job application that will only have a one time adverse effect. Rather, denying an applicant based on grounds of mental illness carries a lasting deleterious affect that will prove to have negative connotations for the applicant for a sustained period of time.

Inquiries into a bar applicant’s mental status includes “classifying” qualified applicants in a “way that adversely affects the opportunities or status of such applicant . . . because of the disability of such applicant.” Required disclosure of mental disabilities on the bar application not only puts qualified applicants at a disadvantage, it directly conflicts with Title I of the ADA. Questions

19. Id.
24. See discussion infra note 30.
directly relating to the mental health of an applicant should be disallowed pursuant to the regulations of the ADA; and a fair alternative to direct mental health questions are behavioral based questions.25

Another provision of section 102(b) that is in direct conflict with state bars inquiring about the mental health status of all applicants is subsection 6.26 Under section 102(b)(6), “the term ‘discriminate against a qualified individual on the basis of disability’”27 includes:

[U]sing qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity.28

As discussed later,29 courts that have struck down broad mental health questions on bar applications have done so because the questions “screen[ed] out” applicants with mental illnesses without proving a particular necessity to the questions.30 Applicants are screened out based on their classification as having a mental disability rather than the applicants’ qualifications to practice law. Under the interpretations by the courts under a strict or relaxed scrutiny approach, there must be a certain amount of “necessity” to the questions to determine if the applicants are fit to practice law in order to protect the general public.31 There is residual confusion

25. See discussion infra Part III.
27. Id.
28. Id. (emphasis added).
29. See discussion infra Part III.
30. Ellen S. v. Fla. Bd. of Bar Examiners, 859 F. Supp. 1489, 1493 (S.D. Fla. 1994). The court noted that “the broad anti-discriminatory language of Title II is read in conjunction with the regulations promulgated by the Department of Justice pursuant to § 12134 of the ADA.” Id. Under this the court stated that 28 C.F.R. § 35.130(b)(6) “prohibits a public entity from administering a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability.” Id. The court also noted that “28 C.F.R. § 35.130(b)(8) restricts a public entity from imposing or applying ‘eligibility criteria that screen out an individual with a disability . . . from fully enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity offered.’” Id. (emphasis added).
31. Med. Soc’y of N.J. v. Jacobs, 62 USLW 2238, at *7 (D.N.J. 1993). The court stated that “[t]he Court is confident that the Board can formulate a set of effective questions that
regarding whether Title I should apply to the bar application process or, at the very least, as a guide to reading Title II.32

B. Title II of the ADA

Title II prohibits discrimination by all public entities at the state and local levels.33 The relevant portion of Title II, section 202, states:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.34

Under this language, it is forbidden for any public entity to discriminate against individuals with a disability.35 The definition of disability under the ADA will be further examined in subsections (C) and (D) of this part.36 The major issue with this provision is that "discrimination" is not sufficiently defined—it is left ambiguous for purposes of Title II. Courts may use the following rule or a similar rule for construing the original intent of Congress at the time the ADA was passed.

The primary rule for the interpretation of [a] statute or a contract is to ascertain, if possible, and enforce, the intention which the legislative body that enacted the law, or the parties who made the agreement, have expressed therein. But it is the intention expressed in the law or contract, and that only, that the courts may give effect to. They cannot lawfully assume or presume secret purposes that are not indicated or expressed by

screen out applicants based only on their behavior and capabilities." Id. (emphasis added).

The court then listed some examples of acceptable behavioral and capability based questions:

[T]he Board is not foreclosed by Title II from screening out applicants based on their employment histories; based on whether applicants can perform certain tasks or deal with certain emotionally or physically demanding situations; or based on whether applicants have been unreliable, neglected work, or failed to live up to responsibilities. In these areas, the applicants’ references remain a valuable source of information.

Id.

32. See discussion infra Part II.B.
35. Id.
36. See discussion infra Part II.C-D.
the statute itself and then enact provisions to accomplish these supposed intentions. While ambiguous terms and doubtful expressions may be interpreted to carry out the intention of a legislative body which a statute fairly evidences, a secret intention cannot be interpreted into a statute which is plain and unambiguous, and which does not express it. The legal presumption is that the legislative body expressed its intention, that it intended what is expressed, and that it intended nothing more. 37

The purpose of the Americans with Disabilities Act of 1990 was to address the discriminatory practices being faced by individuals with disabilities. 38 In Title I, Congress gives specific instances of discrimination. 39 The ADA most logically should be interpreted in a manner that views each Title as complimenting the others. 40 Although the statute should be read in a complimentary manner, there is some language from Title I that will be inapplicable to Title II because Title I only pertains to private businesses, whereas Title II specifically addresses discrimination by public entities. 41 Professor Jon Bauer, at the University of Connecticut School of Law, stated that "Title I . . . should not be ignored as an important guide for assessing what discrimination means in a setting that is closely analogous to employment: occupational licensing." 42

C. Disability Defined Under the ADA

Under the original text of the Americans with Disability Act of 1990, "disability" was defined as, "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." 43

This definition has caused a direct conflict between the Supreme Court and Congress. Ultimately, Congress amended the ADA in 2008 to counter what the Supreme Court determined to be the proper interpretation of the

40. See Bauer, supra note 8, at 190.
42. Bauer, supra note 8, at 190.
ADA's usage of the word "disability" in Toyota Motor Manufacturing, Inc. v. Williams. The ensuing analysis shows the conflict between the two entities and the language of the ADA as it stands today with regard to the Americans with Disability Act.

1. Supreme Court's Narrowing of the Scope of "Disability"

From 1998 to 2003 the Supreme Court made a series of decisions that were intended to interpret the Americans with Disability Act. In the Supreme Court's inaugural ADA decision, Pennsylvania Department of Corrections v. Yeskey, the Supreme Court held that "the plain text of Title II of the ADA unambiguously extends to state prison inmates." It stated that "the fact that a statute can be 'applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth.' This statement made by the Court in Yeskey is reiterated in PGA Tour, Inc. v. Martin where the Court found that Title III's coverage is consistent with the "expansive purpose" of the ADA. Both of these decisions provide a broad interpretive approach to the breadth of the ADA's coverage.

Although the Court discusses the "expansive purpose" of the ADA in Yeskey and Martin, the Court abandoned this broad approach when interpreting the definition of "disability" with regard to the ADA in more recent cases. The subsequent sections will discuss the Supreme Court cases that have been the most influential in narrowing the scope of the ADA prior to the enactment of the ADA Amendments Act of 2008.

a. Sutton, Murphy, Kirkingburg, and "mitigating factors"

In 1999, the Supreme Court made three decisions that narrowed the scope of the ADA through "mitigating factors." The first case was Sutton

47. Id. at 213.
50. Id. at 680.
52. Id.
v. United Air Lines, Inc.,\textsuperscript{53} in which the Court held that "the approach adopted by the agency guidelines—that persons are to be evaluated in their hypothetical uncorrected state—is an impermissible interpretation of the ADA."\textsuperscript{54} The Sutton case dealt with the "mitigating issue" of corrective lenses.\textsuperscript{55} Under this approach, an individual with less than 20/20 vision would not be determined to be disabled based on the "uncorrected state" of the individual's eyes, but rather what the individual's eyesight would be with corrective lenses.\textsuperscript{56}

The second case based on "mitigating factors" was Murphy v. United Parcel Service,\textsuperscript{57} where the Court utilized the Sutton approach in determining if an individual is disabled under the ADA.\textsuperscript{58} The Court applied that approach to disabilities that are treatable by way of medication.\textsuperscript{59} The petitioner was suffering from hypertension (high blood pressure), but was not "substantially limited" from doing one or more major life activities when on medication.\textsuperscript{60} Under this framework of analysis, an individual with a mental illness will be deemed "disabled" with regards to determining if he or she is disabled based on the corrected state of the individual on medication, rather than on the underlying mental illness itself.

The last case that the Court decided based on "mitigating factors" was Albertson's, Inc. v. Kirkingburg,\textsuperscript{61} in which the Court stated that it saw "no principled basis for distinguishing between measures undertaken with artificial aids, like medications and devices, and measures undertaken, whether consciously or not, with the body's own systems."\textsuperscript{62} The respondent in this case suffered from "amblyopia, an uncorrectable condition that leaves him with 20/200 vision in his left eye and monocular vision in effect."\textsuperscript{63} The Court ultimately held that Kirkingburg did not fall under the ADA because he did not meet the standard of disability required

\textsuperscript{54} Id. at 482.
\textsuperscript{55} Id. at 475.
\textsuperscript{56} Id. at 475, 482.
\textsuperscript{57} Murphy v. United Parcel Serv., 527 U.S. 516 (1999).
\textsuperscript{58} Id. at 520.
\textsuperscript{59} Id.
\textsuperscript{60} Id. at 521-22.
\textsuperscript{61} Albertson's, Inc. v. Kirkingburg, 527 U.S. 555 (1999).
\textsuperscript{62} Id. at 565-66.
\textsuperscript{63} Id. at 559.
by the ADA according to the Court.64 Under this framework of analysis, an individual suffering with a mental condition would not be deemed "disabled" if that person were currently in some sort of remission because that would be considered that individual's body's own corrective system.

The effects of these decisions were widespread up until the enactment of the ADA Amendments Act of 2008 (ADAAA).65 According to the National Council on Disability, in an article preceding the enactment of the ADAAA, "[Because of the] Court's rulings in the Sutton, Murphy, and Kirkingburg cases, individuals who are currently functioning well due to mitigating measures such as medications or prosthetic devices are not protected as individuals with disabilities under the ADA."66 The National Council on Disability also stated that "[t]he lower courts have applied this unfortunate legal doctrine in a variety of circumstances, dismissing ADA claims because plaintiffs have not demonstrated the existence of a disability, without reaching the issue of alleged discriminatory conduct."67

The National Council on Disability made it clear that the Sutton, Murphy, and Kirkingburg cases were "effective vehicles for the Court to make technical distinctions to exclude classes of potential ADA claimants."68 The Toyota case was the next natural step towards eroding the "classes of potential ADA claimants."69

b. *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*

The respondent in *Toyota* claimed to be disabled due to her carpal tunnel syndrome:70

Respondent based her claim that she was "disabled" under the ADA on the ground that her physical impairments substantially limited her in (1) manual tasks; (2) housework; (3) gardening; (4) playing with her children; (5) lifting; and (6) working, all of which, she argued, constituted major life activities under the Act. Respondent also argued, in the alternative, that she was disabled under the ADA because she had a record of a substantially

64. *Id.* at 566.
66. *Id.* at 7.
67. *Id.*
68. *Id.*
69. *Id.* at 11.
limiting impairment and because she was regarded as having such an impairment.\textsuperscript{71}

The district court held that respondent was not a "qualified individual with a disability . . . ."\textsuperscript{72} The court of appeals overturned the district court and held that "in order for respondent to demonstrate that she was disabled due to substantial limitation," the respondent "had to 'show that her manual disability involve[d] a 'class' of manual activities affecting the ability to perform tasks at work.'"\textsuperscript{73} The court of appeals stated that the respondent met this standard because her "ailments 'prevent[ed] her from doing the tasks associated with certain types of manual assembly line jobs, manual product handling jobs and manual building trade jobs.'"\textsuperscript{74} The Supreme Court noted that the court of appeals failed to consider activities relating to personal hygiene and household chores in determining limitations to major life activities, which was the main point of disagreement between the Supreme Court and the court of appeals.\textsuperscript{75}

The Supreme Court stated that there are "two potential sources of guidance for interpreting the terms" of the definition of "disability" found in the ADA.\textsuperscript{76} The first is "the regulations interpreting the Rehabilitation Act of 1973" and the second is the "EEOC [Equal Employment Opportunity Commission] regulations interpreting the ADA."\textsuperscript{77} As for utilizing the Rehabilitation Act of 1973 for guidance on interpretation, the Court stated: "Congress drew the ADA's definition of disability almost verbatim from the definition of 'handicapped individual' in The Rehabilitation Act, § 706(8)(B)."\textsuperscript{78} Under the EEOC regulations, the Court stated that "Congress' repetition of a well-established term generally implies that Congress intended the term to be construed in accordance with pre-existing regulatory interpretations."\textsuperscript{79}

\begin{itemize}
\item \textsuperscript{71} Id. at 190 (emphasis added).
\item \textsuperscript{72} Id. at 191 (quoting 42 U.S.C. § 12111(8) (1994)).
\item \textsuperscript{73} Id. at 192.
\item \textsuperscript{74} Id.
\item \textsuperscript{75} Id.
\item \textsuperscript{76} Id. at 193-94.
\item \textsuperscript{77} Id. at 193.
\item \textsuperscript{78} Id. "Disability" is defined in The Rehabilitation Act of 1973 as "a physical or mental impairment that constitutes or results in a substantial impediment to employment." 29 U.S.C. § 705 (2006).
\item \textsuperscript{79} Toyota Motor Mfg., 534 U.S. at 193-94.
\end{itemize}
The Supreme Court, through utilizing the Rehabilitation Act of 1973 and the EEOC regulations, found that there is a two-step process to determine if an individual is disabled under the ADA.\(^8\) The first step is for the individual seeking the ADA's protections to "qualify as disabled . . . [by proving] that he or she has a physical or mental impairment."\(^8\) The second step is that the claimant needs to prove that the impairment limits a major life activity.\(^8\) The Court stated that "[m]erely having an impairment does not make one disabled for purposes of the ADA. Claimants also need to demonstrate that the impairment limits a major life activity."\(^8\) The Supreme Court ultimately agreed with the district court and denied the complainant a remedy under the ADA.\(^8\)

With its decision in Toyota, the Supreme Court limited the definition of disability to only include those individuals whose impairments cripple daily functions.\(^8\) The impairment "must also be permanent or long term."\(^8\) This ruling narrowed the scope and functionality of the ADA.\(^8\) The difficulties of proving a disability with regards to the ADA through the stringent two part test produced by the Supreme Court in Toyota make it virtually impossible for most individuals suffering from less severe ailments to be covered under the ADA.\(^8\) Under the first part of the test, the Court will consider if the disability falls under the ADA based on its mitigated form.\(^8\) In order for an individual to meet the second part of the test, the disability must be crippling and permanent or long term.\(^8\) This was not the intent of

\(^8\) Id. at 194-96.
\(^81\) Id. at 194.
\(^82\) Id. at 195.
\(^83\) Id.
\(^84\) Id. at 202.
\(^85\) Id. at 198 ("We . . . hold that to be substantially limited in performing manual tasks, an individual must have an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people's daily lives.").
\(^86\) Id.
\(^88\) Id. at 849.
\(^89\) Id. at 842-44.
\(^90\) Toyota Motor Mfg., 534 U.S. at 196.
Congress in passing the ADA, and runs counter to Justice Scalia's decision in Yeskey, which demanded that the ADA be interpreted broadly.

2. The ADA Amendments Act of 2008

a. Pressure from the National Council on Disability

Beginning on October 16, 2002, the National Council on Disability (NCD) commenced writing a “Policy Brief Series” on “Righting the ADA,” in opposition to the Supreme Court decisions. The NCD understood the Supreme Court decision to be antithetical to the original intent of Congress. This series of writings included nineteen short “briefs” and concluded with a 157 page report entitled “Righting the ADA,” which addresses alternative legislative approaches to the problems created by the Supreme Court’s rulings.

NCD proposed the ADA Restoration Act of 2004, which aimed to “restore” the [ADA] to its original congressionally intended course. Within the Restoration Act, the NCD proposed amendments to the ADA of 1990 to limit the constructionism of the Supreme Court. In those amendments, the NCD proposed to revise “references in the ADA to discrimination ‘against an individual with a disability’ to refer instead to discrimination ‘on the basis of disability.’” The NCD states that the “change recognizes the social conception of disability and rejects the notion of a rigidly restrictive protected class.”

Another proposed change was how the NCD would define “disability.” The term “disability” would be amended to “clarify that it shall not be construed narrowly and legalistically by drawing fine technical distinctions based on relative differences in degrees of impairment, instead of focusing

91. Annas, supra note 87, at 846.
94. Id.
96. Id.
97. Id. at 39.
98. Id. at 13.
99. Id.
on how the person is perceived and treated." The NCD also proposed to invalidate the "Supreme Court's rulings in Sutton v. United Airlines, Murphy v. United Parcel Service, and Albertson's, Inc. v. Kirkingburg by clarifying that mitigating measures, such as medications, assistive devices, and compensatory mechanisms shall not be considered in determining whether an individual has a disability." The NCD proposed, through the Restoration Act amendments, that "the elements of the definition of 'disability' are to be interpreted broadly." The proposal countered the holding in Toyota Motor Mfg. in that ADA protection should be "interpreted strictly to create a demanding standard for qualifying." NCD was one of the first organizations to propose a reformation of the ADA and was soon followed by H.R. 6258, which is better known as the ADA Restoration Act of 2006.

b. ADA Restoration Act of 2006: House of Representatives

Congressman Jim Sensenbrenner introduced the ADA Restoration Act of 2006 to the House of Representatives on September 29, 2006. The purpose of the proposed act was to "restore the intent of the Americans with Disabilities Act of 1990 to more fully remove the barriers that confront disabled Americans." The influence by the NCD is apparent in the language of the 2006 Act, but most strongly in regard to the provisions on the "rule of construction" and the change in the definition of "disability." These two provisions include basically the same language as the NCD's proposed act. The last provision of the 2006 Restoration Act reinforces the notion that there should be broad construction by stating under section 6(e) that "[i]n order to

101. Id. at 13.
102. Id. at 14.
103. Id. at 15.
104. Toyota Motor Mfg., 534 U.S. at 197.
107. Id.
108. Id.
109. Id.
ensure that this Act achieves its purpose . . . the provisions of this Act shall be broadly construed to advance their remedial purpose.”

c. The ADA Restoration Act of 2007: Senate

The ADA Restoration Act of 2007 (2007 Act) was introduced by Senator Tom Harkin, the author of the original ADA of 1990, on July 26, 2007.112 This date marked the seventeenth anniversary of the enactment of the ADA of 1990. The purpose of the proposed bill was “[t]o amend the [ADA of 1990] to restore the intent and protections of that Act.”113 The 2007 Act recognized that Congress’s intent of section 504 of the Rehabilitation Act of 1973 was contrary to the Supreme Court’s ruling in Toyota Motor Mfg.114

Just like the House of Representatives’ version, the Senate’s version of the ADA Restoration Act recognized that:

[The] determination of whether an individual has a physical or mental impairment shall be made without regard to—(I) whether the individual uses a mitigating measure; (II) the impact of any mitigating measures the individual may or may not be using; (III) whether any manifestation of the impairment is episodic; or (IV) whether the impairment is in remission or latent.115

This is in direct conflict with the determinations made by the Supreme Court on “mitigating factors.”116 Also, like the House of Representatives’ version of the ADA Restoration Act, the Senate’s version made broad constructionism the proper construction for the Supreme Court to adhere to by stating, “In order to ensure that this Act achieves the purpose of providing a comprehensive prohibition of discrimination on the basis of disability and to advance the remedial purpose of this Act, the provisions of this Act shall be broadly construed.”117

113. Id.
114. See id. at § 2(a)(6). The language of section 504 of the Rehabilitation Act states “that adverse action based on a person’s physical or mental impairment is often unrelated to the limitation caused by the impairment itself.” 29 U.S.C. § 794 (2006).
116. See discussion supra Part II.C.
d. The enactment of the ADA Amendments Act of 2008

After seven months of further discussions on the proposed ADAAA between the business and disability communities, the amendments to the ADA officially went into effect on January 1, 2009.118 The amendments were passed "unanimously in both the Senate and House of Representatives, and President George W. Bush signed the act into law on September 25, 2008."119 This officially displaced the Supreme Court’s definition of "disability" with regard to the ADA and broadened the scope of the ADA in accordance with the original intent of Congress in enacting the ADA.120

119. Id.
120. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553, available at http://www1.eeoc.gov/laws/statutes/adaaa.cfm?renderforprint=1. Under section 2(b) of the ADAAA, there are four provisions specifically referring to the overturning of the Supreme Court cases that narrowed the scope of the ADA by stating that the purposes of the act are:

(2) to reject the requirement enunciated by the Supreme Court in Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999) and its companion cases that whether an impairment substantially limits a major life activity is to be determined with reference to the ameliorative effects of mitigating measures;
(3) to reject the Supreme Court’s reasoning in Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999) with regard to coverage under the third prong of the definition of disability and to reinstate the reasoning of the Supreme Court in School Board of Nassau County v. Arline, 480 U.S. 273 (1987) which set forth a broad view of the third prong of the definition of handicap under the Rehabilitation Act of 1973;
(4) to reject the standards enunciated by the Supreme Court in Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002), that the terms "substantially" and "major" in the definition of disability under the ADA “need to be interpreted strictly to create a demanding standard for qualifying as disabled,” and that to be substantially limited in performing a major life activity under the ADA “an individual must have an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people’s daily lives”;
(5) to convey congressional intent that the standard created by the Supreme Court in the case of Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002) for “substantially limits”, and applied by lower courts in numerous decisions, has created an inappropriately high level of limitation necessary to obtain coverage under the ADA, to convey that it is the intent of Congress that the primary object of attention in cases brought under the ADA should be whether entities covered under the ADA have complied with their
The ADA definition of disability itself has been left unchanged by the ADAAA, with the exception that “being regarded as having such an impairment,” now is fully described under subsection 3 of section 12102. This description includes that:

An individual meets the requirement of “being regarded as having such an impairment” if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.

Subsection 3 of section 12102 also minimally limits this description by including “[p]aragraph (1)(C) [being regarded as having an impairment] shall not apply to impairments that are transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less.” This is a broadening of the scope of the ADA to include, under the definition of disability, any individual that has an actual or perceived limitation without regards to whether it limits or perceives to limit a major life activity. Congress further demonstrated that it truly intended a broad definition of disability through section 12102(4)(a) by stating: “[t]he definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter, to the maximum extent permitted by the terms of this chapter.”

The rest of the changes presented by the ADAAA were minor in nature in comparison to the language that overruled the holdings of the Supreme Court that narrowed the scope of the ADA. The eroding of the ADA’s broad scope by the Supreme Court was stopped in its tracks when Congress passed the ADAAA.

regulations, and to convey that the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis . . . .

Id.  
127. Id.
D. Closing Thoughts on the ADA and Its Impact on Bar Application Questions

Congress has been clear that it intends for the ADA to be broadly inclusive to individuals with disabilities.\(^\text{128}\) The broad definition that is applied to the term “disability” should also be applied in determining the definition of “discrimination” found in Title II.\(^\text{129}\) The impact of applying this broad standard to the term “discrimination” is three-fold.

First, if construed broadly, then all mental health inquiries on the bar application will immediately become a violation of the ADA because the questions tend to “screen out” applicants with mental disabilities.\(^\text{130}\) Through the ADAAA, it appears that Congress intends for coverage of the ADA to extend to all individuals who are being discriminated against due to a disability without regard to whether the discriminating entity is private or public.\(^\text{131}\) Mental health questions are facially discriminatory and akin to what Congress intended to be in violation of the ADA.

Second, if the mental health inquiries are found to be in violation of the ADA, then so will conditional admission standards based on the applicant’s mental health status. Conditional admissions have allowed bar application boards to discriminate against applicants with mental illnesses without having to admit that its form of discrimination is unconstitutional. Once mental health questions are found to be invalid, then so will the practice of conditional admissions, which will be discussed further in Part IV of this Comment.\(^\text{132}\)

Third, if bar applicants are discriminated against based on their status of suffering from a mental health disability, they will be more able to challenge the discriminatory practices of the bar application boards. This will create new judicial precedents that will in turn create new standards that the bar application boards will have to follow. This will give rise to a more just system that is in line with congressional intent in enacting the ADA.

\(^{128}\) Id.
\(^{130}\) ADA § 102(b)(6), 42 U.S.C. § 12112(b)(6) (2012).
\(^{131}\) See discussion infra Part III.
\(^{132}\) See discussion infra Part IV.
III. The Evolving Nature of the Mental Health Inquiries on Bar Applications

Mental health inquiries by bar application boards did not begin to appear until the 1970s. Such questions are likely to lead to discrimination against the applicants and deter law school students from seeking professional help for even minor mental issues such as acute depression. Furthermore, the questions have proven that they are unlikely to "identify applicants who pose a risk" to the general public. This part will identify the evolving nature of mental health questions on bar applications since the passing of the ADA by Congress in 1990 and where the questions are likely headed in the future.

A. The Effects of The Americans with Disabilities Act Of 1990

Congressional legislation tends to have a major impact on different societal functions, and the ADA is no different. The ADA continues to have its largest impact on employers under Title I and on licensing boards, such as state bar associations, under Title II. There is a more stringent standard applied to employers under Title I, but Title II also places restrictions upon public entities to ensure they do not discriminate against individuals suffering from a physical or mental disability. Title I should be considered to help interpret ambiguous language found in Title II.

1. Striking Down Broad Mental Health Questions

There are two popular interpretations of Title II by the courts in determining if the mental health questions are deemed discriminatory. The first is a strict scrutiny approach, which would invalidate any questions on

133. Michael J. Place & Susan L. Bloom, Mental Fitness Requirements for the Practice of Law, 23 BUFF. L. REV. 579, 582 (1974).
134. Id. at 583.
135. Id. at 585.
137. 42 U.S.C. §12132 (1990). This is the discrimination section of the Americans with Disability Act of 1990, which states "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities, of a public entity, or be subjected to discrimination by any such entity." Id.
138. See discussion supra Part II.
the bar application pertaining to mental illness that do not have a predictive value. The second interpretation is a relaxed scrutiny approach. In order to establish the validity of a question under a relaxed scrutiny approach, the courts must balance the discriminatory nature of the question with its necessity in accordance with what the local bar association is legitimately attempting to accomplish.

a. Strict scrutiny approach

Under the strict scrutiny approach, it is likely that the questions will be found to be in violation of the ADA, unless strong empirical evidence can be given to their validity. The baseline test for proving empirical evidence was given through the opinion of the Rhode Island Supreme Court in 1996. Specifically, the court stated that:

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

The court found that two questions on the Rhode Island bar application failed to comply with the ADA, and then recommended replacement questions that the committee should have adopted in place of the original questions. The first question replaced on the Rhode Island bar application was question twenty-six. The question originally asked:

Are you or have you within the past five (5) years been addicted to or dependent upon the use of narcotics, drugs, or intoxicating liquors or been diagnosed as being addicted to or dependent

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139. Bauer, supra note 8, at 139.
140. Id. at 143-44.
141. Id. at 139.
143. Id. at 1336 (emphasis added).
144. Id. at 1337.
145. Id.
upon said items to such an extent that your ability to practice law would be or would have been impaired?\textsuperscript{146}

The recommended replacement question for question twenty-six states: “Are you currently using narcotics, drugs, or intoxicating liquors to such an extent that your ability to practice law would be impaired?”\textsuperscript{147}

The second question that was replaced was question twenty-nine on the Rhode Island bar application. It originally stated, “Have you ever been hospitalized, institutionalized or admitted to any medical or mental health facility (either voluntary or involuntary) for treatment or evaluation for any emotional disturbance, nervous or mental disorder?”\textsuperscript{148} The recommended replacement question for question twenty-nine states: “Are you currently suffering from any disorder that impairs your judgment or that would otherwise affect your ability to practice law?”\textsuperscript{149} The court narrowed the scope of the questions between the original and the recommended replacement. The time span in the drugs and alcohol question was considered by the court to be too broad and failed to generate any useful information with regard to the individual’s current “risk to the public.”\textsuperscript{150} The court also found that the “[r]esearch [on mental health questions] . . . failed to establish that a history of previous psychiatric treatment [could] be correlated with an individual’s capacity to function effectively in the workplace.”\textsuperscript{151} According to this finding, the court stated that the only relevant information that the local board could possibly use is the current mental status of the applicant.\textsuperscript{152} The court defines “currently” as “recently enough so that the condition could reasonably be expected to have an impact on your ability to function as a lawyer.”\textsuperscript{153}

The court’s recommended replacement questions bear a closer resemblance to a relaxed scrutiny approach, which is discussed below.\textsuperscript{154} The three-part analysis given by the court is the standard for strict

\textsuperscript{146} Id. at 1334.
\textsuperscript{147} Id. at 1337.
\textsuperscript{148} Id. at 1334.
\textsuperscript{149} Id. at 1337.
\textsuperscript{150} Id. at 1335-36.
\textsuperscript{151} Id.
\textsuperscript{152} Id. at 1337.
\textsuperscript{153} Id.
\textsuperscript{154} See discussion infra Part III.A.1.b.
The strict scrutiny approach more closely resembles the broad congressional intent for the scope of the ADA.\textsuperscript{156}

b. Relaxed scrutiny approach

Unlike the strict scrutiny approach, which requires an evidentiary basis for upholding bar application questions, a relaxed scrutiny approach presumes that "the symptoms of some mental disorders can interfere with a person's ability to practice law."\textsuperscript{157} This is the approach that the United States District Court for the Western District of Texas took in \emph{Applicants v. Texas Board of Law Examiners}.\textsuperscript{158} In \emph{Texas Board}, the plaintiffs challenged Texas Government Code section 82.027(b) for violating the ADA because it required applicants to submit an affidavit stating that they were not mentally ill.\textsuperscript{159} The applicants also expressed concerns about the Texas Supreme Court's ability under section 82.022(b) to arbitrarily and unilaterally change Texas bar application questions pertaining to mental illness.\textsuperscript{160}

In making its determination, the district court noted that the "prohibition against discrimination extends to 'qualified individuals with a disability' and that a "'person is a 'qualified individual with a disability' in the context of licensing or certification if the person can meet the essential eligibility requirements for receiving a license or certification."\textsuperscript{161} The court held that the applicants are "qualified individuals with a disability" if they were otherwise qualified to become a licensed professional according to the standards of the state, were it not for the questions about their overall fitness to practice law based on their mental state.\textsuperscript{162} The court found that all three of the applicants who challenged the statute met this standard.\textsuperscript{163}

\begin{center}
\begin{tabular}{l}
155. \textit{R.L. Bar}, 683 A.2d at 1336.  \\
156. See discussion \textit{supra} Part II.  \\
157. Bauer, \textit{supra} note 8, at 144.  \\
159. \textit{Tex. Gov't Code Ann.} § 82.027(b)(2) (West 1987) ("The application consists of a verified affidavit stating that since the filing of the applicant's original declaration of intention to study law, the applicant: . . . is not mentally ill . . . "). This is still the language of the current statute in Texas and was last updated on September 1, 2003. \textit{Id.}  \\
160. \textit{Tex. Bd. of Law Exam'rs}, at *3.  \\
161. \textit{Id.} at *6.  \\
162. \textit{Id.}  \\
163. \textit{Id.} at *3. \\
\end{tabular}
\end{center}
The court held that this was a case that involved concerns of public safety because of the mental state of the individuals.\textsuperscript{164} Because this was an issue that concerned public safety, the court made an exception and allowed for a certain amount of discrimination against individuals with a mental illness, when that “disability poses a direct threat to the health and safety of others.”\textsuperscript{165} The court further warned that:

\begin{quote}
A determination that a person poses such a threat may not be based on generalizations or stereotypes about the effects of a particular disability but must be based on “an individualized assessment, based on reasonable judgment that relies on current medical evidence or on the best available objective evidence, to determine: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.”\textsuperscript{166}
\end{quote}

The court ultimately held that if the Board did not investigate the mental health of prospective lawyers, it would not be doing its duty.\textsuperscript{167} It found the current version of question eleven to be sufficiently narrow in scope because it dropped the all-inclusive language in favor of language focusing only on serious mental illness.\textsuperscript{168} The court stated that question eleven was “necessary” in its narrow focus “to ensure the integrity of the Board’s licensing procedure, as well as to provide a practical means of striking an appropriate balance between important societal goals.”\textsuperscript{169}

Although the court rejected the plaintiffs’ argument that all mental health inquires should be precluded, the court did recognize that broad questions on mental health violated the ADA.\textsuperscript{170} Below is the evolution of question eleven from 1992 to the current question that was adopted and upheld by the district court in 1994.

Language of question eleven used before April 1992:

Have you, within the last ten (10) years: (a) been examined or treated for any mental, emotional or nervous conditions? . . . (b)

\begin{enumerate}
\item \textsuperscript{164} \textit{Id.} at *6.
\item \textsuperscript{165} \textit{Id.}
\item \textsuperscript{166} \textit{Id.} (emphasis added) (quoting 28 C.F.R. pt. 35, app. A, at 448).
\item \textsuperscript{167} \textit{Id.} at *9.
\item \textsuperscript{168} \textit{Id.}
\item \textsuperscript{169} \textit{Id.}
\item \textsuperscript{170} \textit{Id.} at *10.
\end{enumerate}
been voluntarily or involuntarily admitted to a hospital or institution as a result of mental, emotional or nervous conditions?\textsuperscript{171}

Language of question eleven used between April 1992 and July 1993:

(a) Have you, within the last ten (10) years, been treated for \textit{any} mental illness? (b) Have you, within the last ten (10) years, been admitted to any hospital or other facility for the treatment of \textit{any} mental illness?\textsuperscript{172}

Language of question eleven used from July 1993 through the present:

(a) Within the last ten years, have you been diagnosed with or have you been treated by [sic] bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? (b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?\textsuperscript{173}

The first two versions of question eleven are broadly worded, but the third version is specifically tailored. Similar trends can be seen across the country, with the latest challenge coming in 2011 to a question on the Indiana bar application.\textsuperscript{174} The relaxed scrutiny approach is the most popular approach because it allows state bar application boards to find a compromise between adhering to the ADA prerogatives and still accomplishing the boards' objective of protecting the general public.

\textbf{B. Concluding Remarks on Mental Health Questions}

The ADA has had a huge impact on state bar applications.\textsuperscript{175} Applying a strict scrutiny approach, a court will, for all practical purposes, find that any questions based on an applicant's mental health will be in violation of the ADA.\textsuperscript{176} This is closely related to what Congress intended when it enacted

\textsuperscript{171} Id. at *11 (emphasis added).
\textsuperscript{172} Id. (emphasis added).
\textsuperscript{173} Id.
\textsuperscript{174} ACLU of Ind.—Ind. Univ. Sch. of Law—Indianapolis Chapter v. Individual Members of the Ind. State Bd. of Law Exam'rs, 2011 WL 4387470 (S.D. Ind. 2011).
\textsuperscript{175} See discussion \textit{infra} Part III.
\textsuperscript{176} See discussion \textit{infra} Part III.A.1.a.
the ADA because it prevents bar applications from screening out individuals with mental disabilities who are otherwise qualified to practice law. The more popular method is the relaxed scrutiny approach, which still will limit the invasiveness and breadth of questions that bar application boards will be allowed to ask on bar applications. Under either view, broad questions with indefinite time periods will almost always be struck down for being in violation of the ADA.

An alternative to mental health questions is pure behavioral questions that give no concern to the mental condition of the applicants. "The Board’s legitimate fitness concern is how a lawyer behaves, not how she feels." As will be discussed, the purpose of the moral charter and fitness questions on bar exams is to protect the public from injustice. Mental health questions do not, for the most part, prevent or help to prevent injustice, but behavioral questions are more likely to establish a positive result. Behavioral questions will not run afoul of the ADA because they do not discriminate against applicants with mental disabilities. Behavioral questions are appropriate and will rightfully exclude applicants who lack the proper character and fitness from becoming licensed attorneys.

178. See discussion infra Part IV.

The only study that purports to find a connection between character and fitness application problems and later misconduct is a retrospective study of fifty-two attorneys disciplined for misconduct in Minnesota. Half of those disciplined attorneys—compared to twenty percent of all bar applicants—revealed problems on their character and fitness applications. This result includes all types of character and fitness problems, such as employment termination, arrests, academic probation, financial problems, substance abuse, and mental health treatment. When looking at reports of mental health treatment alone, the study found that only four percent, or two out of fifty-two attorneys, of the disciplined attorneys had reported mental health treatment on the application, compared to the estimated fifteen to twenty-six percent of bar applicants who seek treatment prior to admission. While the sample size is too small to draw a statistically significant conclusion about the connection between character and fitness problems and later discipline, the numbers fail to support the contention that prior mental health treatment is related to later misconduct. If anything, the numbers support the opposite conclusion, that applicants who report mental health treatment on their bar application are less likely to be disciplined.

Id.
IV. CONDITIONAL ADMISSIONS

A. The ABA Conditional Admission Model Rule Of 2008

In 2008, the American Bar Association (ABA) created a Model Rule for Conditional Admission to Practice Law for local bar application boards to follow.180 The model rule “is a compilation of the best practices from the nineteen states (19) and Puerto Rico that have a conditional admission rule.”181 According to the ABA, the purpose for the model rule is to create a tool for bar application boards that will protect the public, while at the same time encourage law students to seek the help that they need for substance abuse problems, depression, and other mental health issues.182 The model rule is an attempt to streamline the interests of the local bar application boards, to protect the public from unfit lawyers, and to protect those individuals that are tasked with dealing with some sort of mental disorder.183 But there are some blatant issues with the model rule that will be addressed below.184

The model rule allows for the admission of an applicant who otherwise meets all of the requirements to be accepted to the bar with the exception of fully meeting the prerequisite character and fitness requirements.185 It combines mental disabilities with behavioral issues, such as cheating on a law school exam. There are problems with doing this that will be addressed in Part VI of this Comment.186 The following reflects the major flaws in the model rule and how those flaws affect individuals suffering with a mental

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181. Id. at 9.
182. Id.
183. Id.
184. Id. at 11 (discussing the interests of the ABA to somewhat protect the rights of the applicants suffering with a mental disorder); see National Conference of Bar Examiners and American Bar Association Section of Legal Education and Admissions To The Bar, Comprehensive Guide to Bar Admission Requirements 2013, http://www.ncbex.org/assets/media_files/Comp-Guide/CompGuide.pdf (discussing the need for the moral character and fitness screening).
186. See discussion infra Part VI.
disability, beginning with how the National Conference of Bar Examiners defines the purpose of the moral character and fitness screening.

The National Conference of Bar Examiners points out certain "Bar Admission Requirements" generally applicable to a majority of jurisdictions. The purpose of the Moral Character and Fitness screening:

[I]s the protection of the public and the system of justice. The lawyer licensing process is incomplete if only testing for minimal competence is undertaken. The public is inadequately protected by a system that fails to evaluate character and fitness as those elements relate to the practice of law. The public interest requires that the public be secure in its expectation that those who are admitted to the bar are worthy of the trust and confidence clients may reasonably place in their lawyers.

The purpose of the Moral Character and Fitness screening is not adequately accomplished through the conditional admissions process. The subsequent section intends to identify why the purpose is not accomplished and compares how the states of Indiana and West Virginia approach the conditional admission process in regard to the parts discussed.

1. Part One: Conditional Admissions Defined

In accordance with the model rule:

[If] an applicant who currently satisfies all essential eligibility requirements for admission to practice law, including fitness requirements, and who possesses the requisite good moral character . . . [the applicant] may be conditionally admitted to the practice of law if the applicant demonstrates recent rehabilitation from chemical dependency or successful treatment for mental or other illness, or from any other condition this Court deems appropriate, that has resulted in conduct or behavior that would otherwise have rendered the applicant currently unfit to practice law, and the conduct or behavior, if it should recur,
would impair the applicant’s current ability to practice law or pose a threat to the public.\textsuperscript{189}

First, there is an issue with how the model rule defines “conditional admission” since it leaves “successful treatment” subjectively open for interpretation by the jurisdictions that adopt this model rule as their own.\textsuperscript{190} The model rule fails to give examples of what would be considered appropriate treatment for particular mental disabilities. According to the World Health Organization:

A substantial majority of persons with serious mental illness take medication. When appropriately prescribed and monitored, these medications, especially the newer molecules, not only control the positive symptoms of illness (agitation, restlessness, etc.), but also have a significant impact on negative symptoms such as apathy, passivity and social withdrawal, as well as interpersonal relationships. All in all, 60-80% of persons with serious mental illness can be substantially helped with a well-monitored medication regime and an appropriate psychosocial management and support programme.\textsuperscript{191}

This begs an important question: what constitutes “successful treatment”? Is medication enough or is more extensive treatment required in order for these individuals suffering with a mental illness to be considered fit to practice law by local bar application boards? In 2009, the ABA somewhat addressed this issue by stating that “[t]hose states that have adopted conditional admission rules have set differing standards of proof to make the determination about an applicant’s successful rehabilitation.”\textsuperscript{192} Therefore, the model rule “does not set out a standard of proof, but recognizes that states will make their own determination of a standard of


\textsuperscript{190} Id.


proof for conditional admission in the jurisdictions.\textsuperscript{193} This creates indecisive standards in the jurisdictions that have adopted some sort of standard of conditional admission to practice law. The following are two different approaches to conditional admissions.

According to the Indiana Rules for Admission to the Bar,\textsuperscript{194} a conditional admission will be allowed if the applicant meets all of the requirements to be accepted to practice law in Indiana with the exception of the applicant fully proving his or her “moral character and fitness based upon evidence of drug, alcohol, psychological or behavioral problems.”\textsuperscript{195} The Indiana rules on conditional admission do not give any specific language on what would be considered “successful treatment” of a mental disorder in order to overcome the burden placed on the applicant to prove his or her fitness to practice law. This creates uncertainties for bar applicants suffering with a mental illness, and will likely deter them from seeking help. West Virginia’s viewpoint on “successful treatment” is also treated in a similar fashion, ultimately leaving a subjective power of determination with the board of law examiners.\textsuperscript{196}

There is no clear standard set forth by the model rule or by the state’s conditional admission rules. The issue with this is that there is no set standard for applicants to compare their current condition with. Without that knowledge, the applicants will be more likely than not to withhold information for fear that they will be subjected to strict scrutiny of their situation, whether it be a serious or a minor mental disability.\textsuperscript{197} The ABA tries to save face through its model rule by stating that “fitness determinations [should] be made on the basis of specific, targeted questions

\begin{itemize}
  \item \textsuperscript{193} Id.
  \item \textsuperscript{194} Ind. Rules for Admission to the Bar and the Discipline of Attorneys, Rule 12 (Dec. 16, 2013), http://www.in.gov/judiciary/rules/ad_dis/#_Toc341254986.
  \item \textsuperscript{195} Id.
  \item \textsuperscript{197} World Health Organization, Mental Health and Work: Impact, Issues and Good Practices (2000) (emphasis added), http://www.who.int/mental_health/media/en/712.pdf. This statement from the World Health Organization on mental health in relation to employment is applicable here: “In the past, and still today, many persons with psychiatric backgrounds have had to lie to a potential employer about their illness.” Id. Then it goes on to state that “[s]ome of the most successful programmes are those where a mutual trusting and respectful attitude has been developed so that issues that may arise are easier to address.” Id.
\end{itemize}
about an applicant’s behavior, conduct, or any current impairment of the applicant’s ability to practice law.\textsuperscript{198}

As discussed in Part III, under either a strict or relaxed scrutiny approach, a state’s bar examination questions pertaining to the mental health status of an applicant must be based on some sort of “necessity” to protect the general public.\textsuperscript{199} Without any particularity in the standards set forth on how to determine if the mental health of an applicant is deemed “successfully treated,” board of law examiners will not be able to justifiably say that the conditional admission is based on a necessity to protect the general public.\textsuperscript{200} Either particularity is required to obtain honest results from the questions or a completely new system must override the conditional admission process. The latter will be articulated in the solution that appears in Part VII of this Comment.\textsuperscript{201}

2. Part Two: Conditions Placed On Conditional Admission

The second issue of the Model Rule on Conditional Admission to Practice Law is the conditions that are placed on the conditional admission. According to the model rule, the jurisdictions that adopt a conditional admissions policy must have an “Admissions Authority,” which oversees and adopts the conditions that will be placed on the conditional admission.\textsuperscript{202} The model rule goes on to suggest:

The [Admissions Authority] may recommend that an applicant’s admission be conditioned on the applicant’s complying with conditions that are designed to detect behavior that could render the applicant unfit to practice law and to protect the clients and the public, such as submitting to alcohol, drug, or mental health treatment; medical, psychological, or psychiatric care; participation in group therapy or support; random chemical


\textsuperscript{199} See discussion supra Part III.


\textsuperscript{201} See discussion infra Part VII.

\textsuperscript{202} Tex. Bd. of Law Exam’rs, 1994 WL 923404 at *2. “The terms ‘Admissions Authority’, ‘Monitoring Authority’ and ‘Disciplinary Authority’ are used to describe the nature of the functions being performed rather than the particular agency performing them.” \textit{Id}. The ABA goes on to state that, through the model rule, “this permits each jurisdiction to determine which entity in its jurisdiction is best suited to perform these functions.” \textit{Id}.
screening; office practice or debt management counseling; and monitoring, supervision; mentoring or other conditions deemed appropriate by the Admissions Authority.\textsuperscript{203}

The ABA continues to place limitations on the type of conditions that may be placed on the applicant, stating:

The conditions shall be tailored to detect recurrence of the conduct or behavior which could render an applicant unfit to practice law or pose a risk to clients or the public and to encourage continued abstinence, treatment, or other support. The conditions should be established on the basis of clinical or other appropriate evaluations, take into consideration the recommendations of qualified professionals when appropriate, and protect the privacy interests of the conditionally admitted lawyer to professional treatment records to the extent possible.\textsuperscript{204}

Indiana takes a more subjective approach than the model rule recommends.\textsuperscript{205} Just like the model rule, Indiana allows its “Admissions Authority” to determine what conditions are appropriate under the circumstances that warrant a conditional admission.\textsuperscript{206} Indiana differs from the model rule because it does not require that the conditions be “established on the basis of clinical or other appropriate evaluations.”\textsuperscript{207} This language is absent from the Indiana Rules for Admission to the Bar.\textsuperscript{208}

West Virginia follows closer to the model rule in regard to conditions placed upon the applicant’s conditional admittance.\textsuperscript{209} The “conditions imposed shall be tailored to detect recurrence of behavior which could render an applicant unfit to practice law . . . .”\textsuperscript{210} West Virginia still does not

\begin{thebibliography}{210}
\bibitem{203} \textit{Id.}
\bibitem{204} \textit{Id.} at *3.
\bibitem{206} \textit{Id.}
\bibitem{210} \textit{Id.}
\end{thebibliography}
adhere to the ABA Model Rule exception that the conditions need to be “established on the basis of clinical or other appropriate evaluations.”

This important limitation is lost and subjectivity of determining the conditions is regained.

Even if the model rule established by the ABA is perfect, it is clear through just examining two state rules that the model rule is either disregarded completely or that it is only adopted partially. The most important aspect of the conditions language of the model rule in regard to mental illness is that the conditions must be made through clinical or other appropriate evaluations. Without this language it is basically up to whoever has been nominated to be a member of the Admissions Authority to determine what conditions will be applied to each individual. There is an inherent need for flexibility in the type of conditions that must be applied to each individual because mental illnesses vary from case to case. The model rule does not put the ultimate authority in the hands of medical professionals or psychologists to determine what conditions are appropriate to be applied to applicants, or to establish a standard for determining what type of mental illnesses make an applicant unfit to practice law.

3. Part Three: Length of Conditional Admission

The third issue with the ABA Model Rule is the length of conditional admission. “The conditional admission period . . . shall not exceed sixty (60) months.” The exception to this maximum conditional admission term is that if one of the conditions that have been placed on the conditional admission agreement has been violated, the maximum term may be extended beyond the sixty months. In the commentaries on the model rule, the ABA notes that, “a majority provide for a maximum term of twenty-four months.”

211. Id.
212. Id.
214. Id.
215. Id.
216. Id.
217. Id.
218. Id.
Indiana applies a maximum sixty-month period on all of its conditional admissions. According to the ABA, Indiana is in the minority of jurisdictions that allow for a maximum conditional admission period of sixty months. Indiana is on the upper end of what the model rule would allow, but is still within what the ABA would consider to be a sufficient time period to apply to the conditional admission. Indiana, like the ABA, recognizes that the sixty-month period can be extended if any of the conditions are violated in regard to the admissions agreement between the state and the applicant.

West Virginia adheres to a maximum twenty-four-month rule. Like the ABA, West Virginia allows for an extension beyond this initial twenty-four-month period if the conditions that are placed upon the conditional admission are violated. As the ABA commentary stated, this is what a majority of the jurisdictions that have a conditional admission rule follow.

In relation to the Americans with Disabilities Act, a shorter period of time for the conditional admission should be applied. As discussed in Part III of this Comment, questions on bar exams must be limited in scope as far as duration is concerned. This rule should be applied to the duration of conditional admissions. Sixty months is exceedingly long and may "run afoul of the Americans with Disabilities Act, which has been interpreted to


221. *Id.*


224. *Id.*


226. See discussion supra Part III.
prevent licensing authorities from placing additional burdens on qualified persons with a disability.”

4. Part Four: Costs of Conditional Admission

The model rule states that the “applicant shall be responsible for any direct costs of investigation, testing and monitoring.” The ABA makes it clear that the applicant will be held responsible for all of the costs of the application process, including the costs involved with the conditional admission. Indiana and West Virginia do not make it clear who will bear the costs for the conditional admission process, but a reasonable assumption can be made that the state bars will not bear the cost of the conditional admission process.

In particular, there is an issue with the applicants bearing these costs when the extra costs are directly correlated with their mental disabilities alone. When reading the Americans with Disabilities Act and the Amended Act from 2008, it becomes clear that the ADA is in existence to protect individuals with mental disabilities from additional burdens that are based solely on their disabilities. For example, forcing applicants with mental disabilities to bear costs that other applicants will not bear reflects a discriminatory practice that runs afoul of the standards set forth in the ADA. The conditional admissions process will look less like discrimination and more like protection of the general public if the additional costs, over and above what an applicant without disabilities would typically pay throughout the bar application process, are borne by state bar associations and not the disabled individual.

B. Closing Thoughts on Conditional Admissions

Conditional admissions fail to do anything productive for the bar examination process. Indeed, the conditional admissions process is discriminatory in nature and allows for state bars to screen out individuals


228. Id.
229. Id.
230. Hubbard, supra note 177, at 2235.
they believe do not meet certain standards of moral character and fitness.\textsuperscript{231} The model rule is an attempt to strike a balance between protecting clients and the general public from incompetent attorneys and the interest of the applicants.\textsuperscript{232}

There is a certain amount of flexibility under the model rule on how applicants are determined to be unfit to practice law or have at least demonstrated “successful treatment” in order to be eligible for conditional admission. Mental disabilities are unique to each individual, so a flexible “successful treatment” standard is needed. The problem is not the flexibility, but rather, who the ABA leaves in charge to determine when applicants are unfit to practice law. As was discussed earlier, and will be discussed again later in this Comment,\textsuperscript{233} these types of determinations need to be made by a group of medical professionals who are independent of the board of bar examiners. Leaving these types of determinations up to a group of attorneys will create subjective results based on their inward biases and overall ignorance towards individuals suffering from mental disorders.\textsuperscript{234}

Conditional admissions are more likely to be in accordance with the Americans with Disabilities Act if the state bars do the following: shorten the maximum duration of the conditional admission to a maximum of twenty-four months; eliminate the costs associated with the conditional admission process outside of what every applicant will have to pay; and most importantly, allow for medical professionals dealing with mental disorders to make the determinations on whether an applicant is fit to practice law if he otherwise meets the rest of the requirements to be accepted to the bar. The solution found in Part VII will establish why the conditional admission process is not necessary, and will formulate a methodology to help align the mental health questions with the ADA.\textsuperscript{235}

\begin{itemize}
\item \textsuperscript{231} Denzel, \textit{supra} note 179, at 896. “These questions, like those about religion, politics, or immigration, serve to both \textit{deter and screen out} people who the bar feels are undesirable.” \textit{Id.} (emphasis added).
\item \textsuperscript{232} \textit{Id.}
\item \textsuperscript{233} \textit{See discussion infra Part VII.}
\item \textsuperscript{234} \textit{See discussion infra Part VI.}
\item \textsuperscript{235} \textit{Id.}
\end{itemize}
V. THE IMPACT OF THE PUBLICATION OF THE Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) took twelve years to go through the publishing process. The goal of the efforts by the American Psychiatric Association was to enhance "the clinical usefulness of [the] DSM-5 as a guide in the diagnosis of mental disorders." The introduction of the DSM-5 recognizes that the science of mental disorders is ever evolving and difficult to create a standard of diagnosis for. Since World War II, there have only been five editions of the DSM published, showing the significance of the DSM-5's official publication in 2013. The following is a brief overview of the changes from the DSM-IV-TR to the DSM-5. The following also only touches on the differences between DSM-IV-TR and the DSM-5 with regard to the more common severe mental disorders—it does not even begin to shed light on the complexities of diagnosing mental disabilities or the differing kinds of mental disorders that are present within each of the broad mental disorder categories. The distinctions are being made to show the complexities that are involved in diagnosing an individual with a mental disorder. Furthermore, the distinctions show why individuals outside of the medical

236. AM. PSYCHIATRIC ASS'N, Diagnostic and Statistical Manual of Mental Disorders 5 (5th ed. 2013).

237. Id.

238. Id. The following is proof that, even to the American Psychological Association and the scientific community, mental disorders have been tough to keep a handle on—this is part of the reasoning for not allowing lawyers to make determinations based on mental disorders that they do not fully understand, but rather allowing the determinations to be made by medical professionals.

While DSM has been the cornerstone of substantial progress in reliability, it has been well recognized by both the American Psychiatric Association (APA) and the broad scientific community working on mental disorders that past science was not mature enough to yield fully validated diagnoses—that is, to provide consistent, strong, and objective scientific validators of individual DSM disorders. The science of mental disorders continues to evolve. However, the last two decades since DSM-IV was released have seen real and durable progress in such areas as cognitive neuroscience, brain imaging, epidemiology, and genetics. The DSM-5 Task Force overseeing the new edition recognized that research advances will require careful, iterative changes if DSM is to maintain its place as the touchstone classification of mental disorders. Finding the right balance is critical.

Id. (emphasis added).

239. Id. at 6.
profession should not be making determinations on the dangers an individual poses to society solely on the basis of being diagnosed with a mental disorder.

Briefly, before discussing the differences between the *DSM-IV-TR* and the *DSM-5*, there are a couple of important insights into the world of mental disorder diagnoses that need to be noted. First, each mental disorder has a diagnostic criterion that the *DSM* attaches to it to help medical physicians make the correct diagnosis.\(^{240}\) Many of the differences between the *DSM-IV-TR* and the *DSM-5* stem from these different criteria. Second, there are many mood disorders that have particular specifiers attached to them.\(^{241}\) Specifiers are important because they help diagnose the severity, course, or special features of certain mood disorders.\(^{242}\) The specifiers in the *DSM-IV-TR* and the *DSM-5* may differ in one way or another, so there is also a discussion in this part about some of the important differences in this regard between the two within the disorders discussed in this section.


For each disorder included in DSM, a set of diagnostic criteria indicate what symptoms must be present (and for how long) as well as symptoms, disorders, and conditions that must not be present in order to qualify for a particular diagnosis. Many users of DSM find these diagnostic criteria particularly useful because they provide a concise description of each disorder. Furthermore, use of diagnostic criteria has been shown to increase diagnostic reliability (i.e., likelihood that different users will assign the same diagnosis to an individual). However, it is important to remember that these criteria are meant to be used as guidelines informed by clinical judgment and are not meant to be used in a cookbook fashion.

Id.

\(^{241}\) JAMES P. CHOCA & ERIC J. VAN DENBURG, MANUAL FOR CLINICAL PSYCHOLOGY TRAINEES 25 (3d ed. 1996).

[There are numerous specifiers for most [mood disorders] that help to increase diagnostic specificity and to improve the prediction of prognosis. While each disorder has some specifiers that are unique, the specifiers generally can be placed into six categories: severity/psychotic/remission specifiers, a melancholic specifier, an atypical specifier, longitudinal course specifiers, a seasonal pattern specifier, and a rapid cycling specifier.

Id. (emphasis added).

\(^{242}\) Id.
A. Common Mental Disorders

1. Anxiety Disorders

In accordance with the Encyclopedia of Psychology, "an anxiety disorder refers to . . . [twelve] disorders that have as their central organizing theme, the emotional state of fear, worry, or anxious apprehension."243 The DSM-IV-TR recognizes anxiety disorders to include panic disorder without agoraphobia,244 panic disorder with agoraphobia,245 agoraphobia without history of panic disorder,246 specific phobia,247 social phobia,248 obsessive-compulsive disorder,249 posttraumatic stress disorder,250 acute stress


244. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 429 (4th ed. 2000). There are a couple of important terms to define in order to understand panic disorder without agoraphobia and panic disorder with agoraphobia, and agoraphobia without history of panic disorder; they are as follows:

A Panic Attack is a discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of “going crazy” or losing control are present.

Agoraphobia is anxiety about, or avoidance of, places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a Panic Attack or panic-like symptoms.

Id. With those terms being defined, and for purposes of this footnote, a “Panic Disorder Without Agoraphobia is characterized by recurrent unexpected Panic Attacks about which there is persistent concern.” Id.

245. Id. The DSM-IV-TR defines “Panic Disorder With Agoraphobia [as being] characterized by both recurrent unexpected Panic Attacks and Agoraphobia.” Id.

246. Id. The DSM-IV-TR defines “Agoraphobia Without History of Panic Disorder [as being] characterized by the presence of Agoraphobia and panic-like symptoms without a history of unexpected Panic-Attacks.” Id.

247. Id. (“Specific Phobia is characterized by clinically significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behavior.”).

248. Id. (“Social Phobia is characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.”).

249. Id. (“Obsessive-Compulsive Disorder is characterized by obsessions (which cause marked anxiety and distress) and/or by compulsions (which serve to neutralize anxiety).”)

250. Id. (“Posttraumatic Stress Disorder is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.”).
disorder,251 generalized anxiety disorder,252 anxiety disorder due to a general medical condition,253 substance-induced anxiety disorder,254 and anxiety disorder not otherwise specified.255 The DSM-5 "no longer includes obsessive-compulsive disorder (which is included with the obsessive-compulsive and related disorders) or posttraumatic stress disorder and acute stress disorder (which is included with the trauma and stressor-related disorders) as anxiety disorders."256 The DSM-5 does "reflect[] the close relationships among" anxiety disorders and the disorders that have been removed from the anxiety disorder category.257 The DSM-5 now includes separation anxiety disorder and selective mutism under anxiety disorders, because of their close relation to anxiety, where the DSM-IV-TR did not.258

a. Panic disorder

The DSM-IV-TR makes a distinction between panic disorders with and without the presence of agoraphobia.259 The following are the diagnostic criteria that are suggested by the DSM-IV-TR for medical physicians to use in diagnosing mental disorders. Generally, Criterion A is the same for both,

251. Id. ("Acute Stress Disorder is characterized by symptoms similar to those of Posttraumatic Stress Disorder that occur immediately in the aftermath of an extremely traumatic event.").

252. Id. ("Generalized Anxiety Disorder is characterized by at least 6 months of persistent and excessive anxiety and worry.").

253. Id. at 430. ("Anxiety Disorder Due to a General Medical Condition is characterized by prominent symptoms of anxiety that are judged to be a direct physiological consequence of a general medical condition.").

254. Id. ("Substance-Induced Anxiety Disorder is characterized by prominent symptoms of anxiety that are judged to be a direct physiological consequence of a drug of abuse, a medication, or toxin exposure.").

255. Id. ("Anxiety Disorder Not Otherwise Specified is included for coding disorders with prominent anxiety and phobic avoidance that do not meet criteria for any of the specific Anxiety Disorders defined in this section (or anxiety about which there is inadequate or contradictory information.").


257. Id.

258. Id. at 7.

and states that there must be a presence of both Criteria A(1)-(2).\textsuperscript{260} Criterion A(1) states that there must be "recurrent unexpected Panic Attacks."\textsuperscript{261} Criterion A(2) states:

\begin{quote}
[A]t least one of the attacks has been followed by [one] month (or more) of one (or more) of the following: (a) persistent concern about having additional attacks; (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, 'going crazy'); [or] (c) a significant change in behavior related to the attacks.\textsuperscript{262}
\end{quote}

Criterion B is where the distinction is made between the presence and absence of agoraphobia.\textsuperscript{263} Criterion C makes certain that "[t]he Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism)."\textsuperscript{264} Criterion D makes sure that "[t]he Panic Attacks are not better accounted for by another mental disorder . . . ."\textsuperscript{265}

The \textit{DSM-5} does not make the distinction between panic disorders with or without the presence of agoraphobia; instead, it provides a general diagnosis of panic disorders.\textsuperscript{266} Criterion A states that there must be "[r]ecurrent unexpected panic attacks."\textsuperscript{267}

The \textit{DSM-5} goes on to define a:

\begin{quote}
[P]anic attack [as] an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur: . . . (1) [p]alpitations, pounding heart, or accelerated heart rate; (2) [s]weating; (3) [t]rembling or shaking; (4) [s]ensations of shortness of breath or smothering; (5) [f]eelings of choking; (6) [c]hest pain or discomfort; (7) [n]ausea or abdominal distress; (8) [f]eeling dizzy, unsteady, light-headed, or faint; (9) [c]hills or
\end{quote}

\begin{footnotesize}
\begin{enumerate}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS} 208 (5th ed. 2013).
\end{enumerate}
\end{footnotesize}
heat sensations; (10) [p]aresthesias (numbness or tingling sensations); (11) [d]erealization (feelings of unreality) or depersonalization (being detached from oneself); (12) [f]ear of losing control or 'going crazy'; or (13) [f]ear of dying.268

Criterion B requires that:

At least one of the attacks has been followed by [one] month (or more) of one or both of the following: (1) [p]ersistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, ‘going crazy’); or (2) [a] significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).269

Criterion C of the DSM-5, like Criterion C of the DSM-IV-TR, makes certain that the “disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).”270 Criterion D makes sure that the “disturbance is not better explained by another mental disorder.”271

The greatest distinction between DSM-IV-TR and the DSM-5 in regard to panic disorders is that “[p]anic disorder and agoraphobia are unlinked in the DSM-5.”272 This means that in the DSM-5 the linkage from DSM-IV-TR is “replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria.”273 According to the DSM-5 the “[twelve]-month prevalence estimate for panic disorder across the United States and several European countries is about 2%-3% in adults and adolescents.”274 The DSM-5 also states that the “median age at onset for panic disorder in the United States is [twenty to twenty-four] years.”275 There are few cases beginning in

268. Id.
269. Id.
270. Id. at 209.
271. Id.
273. Id.
275. Id.
childhood, and "onset after age [forty-five] years is unusual but can occur." The DSM-5 also points out that "[o]nly a minority of individuals have full remission without subsequent relapse within a few years [and t]he course of panic disorder typically is complicated by a range of other disorders, in particular other anxiety disorders, depressive disorders, and substance use disorders." 

b. Specific phobia

The DSM-IV-TR criteria for Specific Phobia include the following:Criterion A requires that there be a "[m]arked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood)." Criterion B is that "[e]xposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack." Criterion C requires that "the person recognizes that the fear is excessive or unreasonable." Criterion D requires that the "phobic situation(s) is avoided or else is endured with intense anxiety or distress." Criterion E states that the "avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal

276. Id.

277. Id. The following is an excerpt from the Highlights of Changes from DSM-IV-TR to the DSM-5:

Changes in criteria for agoraphobia, specific phobia, and social anxiety disorder (social phobia) include deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. This change is based on evidence that individuals with such disorders often overestimate the danger in "phobic" situations and that older individuals often misattribute "phobic" fears to aging. Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after taking cultural contextual factors into account. In addition, the 6-month duration, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages. This change is intended to minimize overdiagnosis of transient fears.


279. Id.

280. Id.

281. Id.
routine . . . or there is marked distress about having the phobia.”282 Criterion F requires that if the individual is under the age of eighteen years, “the duration [of the specific phobic] is at least [six] months.”283 Criterion G makes certain that the “anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder . . . .”284

The DSM-5’s criteria for Specific Phobia “core features” remain the same as the DSM-IV-TR.285 The only difference between the DSM-IV-TR and the DSM-5 is that Criterion F now applies to all ages.286 According to the DSM-5, “In the United States, the [twelve]-month community prevalence estimate for specific phobia is approximately 7%-9%.”287 “Specific phobia usually develops in early childhood, with the majority of cases developing prior to age [ten] years.”288 The “median age at onset is between [seven] and [eleven] years, with the mean at about [ten] years.”289 Specific phobia “sometimes develops following a traumatic event . . . , observation of others going through a traumatic event . . . , an unexpected panic attack in the to be feared situation . . . , or informational transmission[,]” but “many individuals with specific phobia are unable to recall the specific reason for the onset of their phobias.”290 Specific phobias that “develop in childhood and adolescence are likely to wax and wane during that period[,]” but “phobias that do persist into adulthood are unlikely to remit for the majority of individuals.”291 “Individuals with specific phobia show similar patterns of impairment in psychosocial functioning and decreased quality of life as individuals with other anxiety disorders and alcohol and substance
use disorders, including impairments in occupational and interpersonal functioning."\textsuperscript{292}

c. Social phobia

The \textit{DSM-IV-TR} criterion for Social Phobia is as follows. Criterion A requires that there be a "marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny of others."\textsuperscript{293} It also requires that the "individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing."\textsuperscript{294} Criterion B states that "[e]xposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack."\textsuperscript{295} Criterion C requires that the "person recognizes that the fear is excessive or unreasonable."\textsuperscript{296} Criterion D requires that the "feared social or performance situations are avoided or else are endured with intense anxiety or distress."\textsuperscript{297} Criterion E states that the "avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia."\textsuperscript{298} Criterion F states that if the individual is under the age of eighteen years, the duration of the phobia "is at least [six] months."\textsuperscript{299} Criterion G requires that the "fear or avoidance is not due to the direct physiological effects of a substance . . . or a general medical condition and is not better accounted for by another mental disorder."\textsuperscript{300} Criterion H states that if "a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa."\textsuperscript{301}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{292} Id. at 201.
\item \textsuperscript{293} \textsc{Am. Psychiatric Ass'n}, \textsc{Diagnostic and Statistical Manual of Mental Disorders} 456 (4th ed. 2000).
\item \textsuperscript{294} Id.
\item \textsuperscript{295} Id.
\item \textsuperscript{296} Id.
\item \textsuperscript{297} Id.
\item \textsuperscript{298} Id.
\item \textsuperscript{299} Id.
\item \textsuperscript{300} Id.
\item \textsuperscript{301} Id.
\end{itemize}
\end{footnotesize}
The DSM-5 changes the name of the mental disorder from social phobia to social anxiety disorder.302 There are a few changes between the DSM-IV-TR and the DSM-5303; the following are the criteria for social anxiety disorder under the DSM-5. Criterion A requires that there be a "[m]arked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others."304 Criterion B requires that the "individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated."305 Criterion C states that the "social situations almost always provoke fear or anxiety."306 Criterion D requires that the "social situations are avoided or endured with intense fear or anxiety."307 Criterion E requires that the "fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context."308 Criterion F requires that the "fear, anxiety, or avoidance is persistent, typically lasting for [six] months or more."309 Criterion G requires that the "fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning."310 Criterion H requires that the "fear, anxiety, or avoidance is not attributable to the physiological effects of a substance or another medical condition."311 Criterion I requires that the "fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder . . . "312 Criterion J states that if "another medical condition is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive."313

One of the first changes that has been made in the DSM-5 is the "deletion of the requirement that individuals over age [eighteen] years must
recognize that their fear or anxiety is excessive or unreasonable, and duration criterion of 'typically lasting for [six] months or more' is now required for all ages. A more significant change has been that the "generalized specifier" has been removed and replaced with a "performance only" specifier. The "generalized specifier" was found to be problematic in that fears that include most social situations were difficult to operationalize. Whereas, "[i]ndividuals who fear only performance situations (i.e., speaking or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response."

According to the DSM-5, the "[twelve]-month prevalence estimate of social anxiety disorder for the United States is approximately 7%. The "[p]revalence rates decrease with age." The "[twelve]-month prevalence for older adults ranges from 2% to 5%. The "[m]edian age at onset of social anxiety disorder in the United States is [thirteen] years, and 75% of individuals have an age at onset between [eight] and [fifteen] years." The "[o]nset of social anxiety disorder may follow a stressful or humiliating experience (e.g., being bullied, vomiting during a public speech), or it may be insidious, developing slowly." The initial "onset in adulthood is relatively rare and is more likely to occur after a stressful or humiliating event or after life changes that require new social roles." "Social anxiety disorder is associated with elevated rates of school dropout and with decreased wellbeing, employment, workplace productivity, socioeconomic status, and quality of life."

315. Id.
316. Id.
317. Id. at 6-7.
318. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 204 (5th ed. 2013).
319. Id.
320. Id.
321. Id. at 205.
322. Id.
323. Id.
324. Id. at 206.
d. Obsessive compulsive disorder (OCD)

The *DSM-IV-TR* criteria for OCD is as follows. Criterion A is split into two categories in order to determine if it is either an obsession or a compulsion.\(^{325}\) Obsessions are defined by (1), (2), (3), and (4) under Criterion A, the obsessions category.\(^{326}\) The section (1) definition of obsession is: “repetitive and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.”\(^{327}\) The section (2) definition of obsession is: “the thoughts, impulses, or images are not simply excessive worries about real life problems.”\(^{328}\) The section (3) definition of obsession is when: “the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.”\(^{329}\) The section (4) definition of obsession is when “the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).”\(^{330}\) Compulsions are defined by sections (1) and (2) under the Criterion A, the compulsions category.\(^{331}\) Section (1) of the compulsions category defines “repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.”\(^{332}\) Section (2) of the compulsions category is: “the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.”\(^{333}\) Criterion B requires that “at some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.”\(^{334}\) Criterion C requires that the


\(^{326}\) Id.

\(^{327}\) Id.

\(^{328}\) Id.

\(^{329}\) Id.

\(^{330}\) Id.

\(^{331}\) Id.

\(^{332}\) Id.

\(^{333}\) Id.

\(^{334}\) Id.
"obsessions or compulsions cause marked distress, are time consuming (take more than [one] hour a day), or significantly interfere with the person’s normal routine, occupational (or academic) functioning, or usual social activities or relationships."335 Criterion D states that if "another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it . . . ."336 Criterion E states that the "disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition."337

The DSM-5 has some significant changes that will be discussed later in this subsection, so the following are the criteria set forth in the DSM-5.338 Criterion A in the DSM-5 also categorizes obsessions and compulsions in different sections of Criterion A.339 Obsessions are defined by sections (1) and (2) under Criterion A, the obsessions category.340 Section (1) of the obsessions category is: "[r]ecurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress."341 Section (2) under obsession is: "[t]he individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action . . . ."342 Compulsions are defined by sections (1) and (2) under Criterion A, the compulsions category.343 Section (1) under compulsion is "[r]epetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to the rules that must be applied rigidly."344 Section (2) is that the "[b]ehaviors or mental acts are aimed at preventing or

335. Id. at 463.
336. Id. Axis I disorders are clinical disorders, which include, but are not limited to, substance related disorders, mood disorders, anxiety disorders, schizophrenia and other psychotic disorders, eating disorders, and sleep disorders. Id. at 27-28.
337. Id. at 463.
340. Id.
341. Id.
342. Id.
343. Id.
344. Id.
reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive."\textsuperscript{345} Criterion B requires that the "obsessions or compulsions are time-consuming (e.g., take more than [one] hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."\textsuperscript{346} Criterion C requires that the "obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition."\textsuperscript{347} Criterion D requires that the "disturbance is not better explained by the symptoms of another mental disorder . . . ."\textsuperscript{348}

Obsessive-compulsive disorders have their very own chapter in the DSM-5, which differs from the DSM-IV-TR.\textsuperscript{349} The DSM-5 "reflects the increasing evidence that [OCD and related disorders] are related to one another in terms of a range of diagnostic validators, as well as clinical utility of grouping these disorders in the same chapter."\textsuperscript{350} The new disorders that are included in this section are "hoarding disorder, excoriation (skin-picking) disorder, substance-/medication-included obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition."\textsuperscript{351} The DSM-5 also deletes DSM-IV-TR's Criterion B, which requires that at "some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable."\textsuperscript{352} The DSM-5 removes the Axis I language of Criterion D, creating the assumption that OCD should not be diagnosed if there is some

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{345} Id.
\item \textsuperscript{346} Id.
\item \textsuperscript{347} Id.
\item \textsuperscript{348} Id.
\item \textsuperscript{349} American Psychiatric Association, \textit{Highlights of Changes from DSM-IV-TR to DSM-5}, at 7 (2013), http://www.dsm5.org/Documents/changes\%20from\%20dsm-iv-tr\%20to\%20dsm-5.pdf.
\item \textsuperscript{350} Id.
\item \textsuperscript{351} Id.
\item \textsuperscript{352} Id. AM. PSYCHIATRIC ASS'N, \textit{DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS} 462 (4th ed. 2000); see also American Psychiatric Association, \textit{Highlights of Changes from DSM-IV-TR to the DSM-5}, at 6 (2013), http://www.dsm5.org/Documents/changes\%20from\%20dsm-iv-tr\%20to\%20dsm-5.pdf.
\end{itemize}
\end{footnotesize}
other more relevant mental disorder for the individual to be diagnosed under, including Axis I disorders.\textsuperscript{353}

Also, the "with poor insight" specifier for obsessive-compulsive disorder has been refined in the DSM-5 to allow a distinction between individuals with good or fair insight, poor insight, and 'absent insight/delusional' obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true).\textsuperscript{354} The specifiers "are intended to improve differential diagnosis by emphasizing that individuals with these two disorders may present with a range of insight into their disorder-related beliefs, including absent insight/delusional symptoms."\textsuperscript{355} This distinction also stresses that the "presence of absent insight/delusional beliefs warrants a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder."\textsuperscript{356}

The "[twelve]-month prevalence of OCD in the United States is 1.2%."\textsuperscript{357} "In the United States, the mean age at onset of OCD is 19.5 years, and 25% of cases start by age [fourteen] years."\textsuperscript{358} "Onset after age [thirty-five] years is unusual but does occur."\textsuperscript{359} "OCD is associated with reduced quality of life as well as high levels of social and occupational impairment."\textsuperscript{360} "Impairment occurs across many different domains of life and is associated with symptom severity."\textsuperscript{361}

e. Posttraumatic stress disorder (PTSD)

The DSM-IV-TR criteria for PTSD is as follows:

A. The person has been exposed to a traumatic event in which both of the following were present:

\begin{itemize}
\item[354.] Id. at 7.
\item[355.] Id.
\item[356.] Id. What has been discussed in this Comment on obsessive compulsive disorders is small in comparison to the complexities that go into diagnosing an individual with OCD or related disorders.
\item[357.] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 239 (5th ed. 2013).
\item[358.] Id.
\item[359.] Id.
\item[360.] Id. at 240.
\item[361.] Id.
\end{itemize}
(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
(2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
   (2) recurrent distressing dreams of the event.
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feelings of detachment or estrangement from others
   (6) restricted range of affect (e.g., unable to have loving feelings)
   (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.362

The "DSM-5 criteria for posttraumatic stress disorder differ significantly from those in DSM-IV."363 "[T]he stressor criterion (Criterion A) is more explicit with regard to how an individual experienced 'traumatic' events."364 The article discussing the differences between the DSM-5 and DSM-IV-TR also states, "Criterion A2 (subjective reaction) has been eliminated" from the DSM-5.365 Furthermore, "there were three major symptom clusters in DSM-IV—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in the DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood."366

According to the DSM-5, "the United States projected lifetime risk for PTSD using DSM-IV-TR criteria at age [seventy-five] years is 8.7%."367 The "[t]welve-month prevalence among U.S. adults is about 3.5%."368

PTSD can occur at any age, beginning after the first year of life. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before criteria for the diagnosis are met. PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical

364. Id.
365. Id.
366. Id.
368. Id.
utilization. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains.369

2. Major Depressive Disorder

Major depression “is characterized by a combination of symptoms that interfere with a person’s ability to work, sleep, study, eat, and enjoy once-pleasurable activities.”370 “Major depression is disabling and prevents a person from functioning normally.”371 There has been no change in the diagnostic criteria for major depressive disorder between the DSM-IV-TR and the DSM-5.372 Criterion A under the DSM-5 requires that:

Five (or more) of the following symptoms have been present during the same [two]-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. . . . [A1] Depressed mood most of the day, nearly every day, as indicated by either subjective report . . . or observation made by others . . . . [A2] Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day . . . . [A3] Significant weight loss when not dieting or weight gain . . . ., or decrease or increase in appetite nearly every day . . . . [A4] Insomnia or hypersomnia nearly every day. [A5] Psychomotor agitation or retardation nearly every day . . . . [A6] Fatigue or loss of energy nearly every day. [A7] Feelings of worthlessness or excessive or inappropriate guilt . . . . [A8] Diminished ability to think or concentrate, or indecisiveness, nearly every day . . . . [A9] Recurrent thoughts of death . . . ., recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.373

369. Id. at 278-79.
371. Id.
Criterion B requires that "[t]he symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." Criterion C requires that "[t]he episode is not attributable to the physiological effects of a substance or to another medical condition." Criterion D requires that "[t]he occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum, and other psychotic disorders." Criterion E requires that "[t]here has never been a manic episode or a hypomanic episode."

According to the DSM-5, the "[t]welve-month prevalence of major depressive disorder in the United States is approximately 7%, with marked differences by age group such that the prevalence in [eighteen]- to [twenty-nine]-year-old individuals is threefold higher than the prevalence in individuals age [sixty] years or older." "Major depressive disorder may first appear at any age, but the likelihood of onset increases markedly with puberty. In the United States, incidence appears to peak in the [twenties]; however, first onset in late life is not uncommon." The functional consequences that accompany major depressive disorder vary depending on individual symptoms. Impairment ranges from an individual being mildly impaired to being completely incapacitated. Within the medical setting, individuals diagnosed with major depressive disorder "have more pain and physical illness and greater decreases in physical, social, and role functioning."

3. Bipolar Disorder

"Bipolar disorder is a lifelong illness. Episodes of mania and depression eventually can occur again, if [an individual does not] get treatment. Many people sometimes continue to have symptoms, even after getting treatment.
for their bipolar disorder." Bipolar disorders are divided into two main categories, Bipolar I and Bipolar II disorders. "Bipolar I disorder involves periods of severe mood episodes from mania to depression." Bipolar II disorder is a milder form of mood elevation, involving milder episodes of hypomania that alternate with periods of severe depression. There have been no significant changes between the DSM-IV-TR and the DSM-5 with regard to Bipolar disorder, and this section will focus on Bipolar I. Due to the nature of this Comment and the complexity of this disorder this section will only focus on the significant changes.

There is a recognized change between the DSM-IV-TR and the DSM-5—"Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood." The DSM-5 has also removed the requirement "that the individual simultaneously meet full criteria for both mania and major depressive episode" from the diagnosis of Bipolar I episode, mixed episode. Rather, "a new specifier, 'with mixed features,' has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present."

This is a relatively rare disorder with "[t]he [twelve]-month prevalence estimate in the continental United States was 0.6% for bipolar I disorder as defined in DSM-IV." The "[m]ean age at onset of the first manic, hypomanic, or major depressive episode is approximately [eighteen] years for bipolar I disorder." Over "90% of individuals who have a single manic episode go on to have recurrent mood episodes [and] [a]pproximately 60% of manic episodes occur immediately before a major depressive episode."

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384. Id.
385. Id.
387. Id.
388. Id.
389. Id.
391. Id.
392. Id.
According to the DSM-5, "Although many individuals with bipolar disorder return to a fully functional level between episodes, approximately 30% show severe impairment in work role function."\(^{393}\) Notably, "Functional recovery lags substantially behind recovery from symptoms, especially with respect to occupational recovery, resulting in lower socioeconomic status despite equivalent levels of education when compared with the general population."\(^{394}\)

4. Schizophrenia

The American Psychological Association defines Schizophrenia as “a serious mental illness characterized by incoherent or illogical thoughts, bizarre behavior and speech, and delusions or hallucinations, such as hearing voices[,]"\(^{395}\) which is further discussed in the Encyclopedia of Psychology.\(^{396}\) Schizophrenia is also extremely complex, so this portion of the Comment will only focus on the significant changes.

The DSM-5 recognizes two major changes from the DSM-IV-TR when diagnosing schizophrenia.\(^{397}\) First “is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations . . .”\(^{398}\) The “special attribution was removed due to the nonspecificity of Schneiderian symptoms\(^{399}\) and the poor reliability in

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393. Id. at 131.
394. Id.
396. See Kazdin, supra note 243, at 160-63.
398. Id.
399. The term “Schneiderian” comes from the German psychiatrist, Kurt Schneider: Kurt Schneider, a German psychiatrist and a pupil of Karl Jaspers, pointed out certain symptoms as being characteristic of schizophrenia and therefore exhibiting a “first-rank” status in the hierarchy of potentially diagnostic symptoms. The “first-rank” symptoms (FRS) have played an extremely important role in the recent diagnostic systems: in the International Statistical Classification of Diseases, tenth Revision (ICD-10) as well as in Diagnostic and Statistical Manual of Mental Disorder, Third and Fourth Edition (DSM-III-IV), the presence of one FRS is symptomatically sufficient for the schizophrenia diagnosis.

distinguishing bizarre from nonbizarre delusions.” The second major change “is the addition of a requirement in Criterion A, that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech.” The American Psychiatric Association recognizes that the presence of “one of these core ‘positive symptoms’ is necessary for a reliable diagnosis of schizophrenia.”

The DSM-5 recognizes that “[t]he lifetime prevalence of schizophrenia appears to be approximately 0.3%-0.7% . . . .” The onset of schizophrenia prior to adolescence is rare. Significant social and occupational dysfunction has been caused by Schizophrenia. There has also been a link between schizophrenia and the impairment of educational progress even when cognitive levels are sufficient.

B. Conclusion on the Differences Between the DSM-IV-TR and the DSM-5

The differences that are formulated in the DSM-5 from its DSM-IV-TR counterpart make new diagnoses of mental disorders even more challenging for medical physicians. There is a debate on “what disorders should be included . . . and what should not be included; what is science and what is opinion . . . ; what stigmatizing dangers may exist from diagnosis; and the sheer volume of conditions that [have found] their way into the printed pages of [the DSM-5].” So does the medical community follow the new diagnostic criteria that is presented in the DSM-5 or does the medical community rebel against the DSM-5 and follow the former criteria presented in the DSM-IV-TR? Questions like this one will be hashed out in


404. Id.

405. Id. at 104.

406. Id.

the near future, but the official stance of the American Psychiatric Association is that the DSM-5 is the new standard for diagnostic criteria (this makes sense since this is the organization that has published the DSM-5).

To make things even more complicated, the World Health Organization will be releasing the eleventh edition of the International Classification of Diseases (ICD) in 2017. More than 100 countries use the ICD as the standard to define diseases and study disease patterns. It is mere speculation at this point to try to determine the differences that will be reflected by the eleventh edition in comparison to the tenth edition, but it can be assumed that this publication will have a major impact on the future diagnoses of mental disorders.

If modern medical physicians will have a hard time in making mental disorder diagnoses, then what gives a bar application boards the right to determine if an individual is fit to practice law based on one of those very mental disorders that is becoming difficult to diagnose? The answer seems to be that determinations that are made by bar application boards that are based on an individual’s mental disability are more discriminatory, an issue further discussed in this Comment. If medical professionals are and will be scrambling to initiate the new medical standards presented through the DSM-5 and the ICD 11 in a consistent manner, then how can judges and attorneys accurately create and execute conditions on a conditional admission if the very standards that they are utilizing to create the conditions are subject to change and evolve with modern medical standards?

VI. CONCERNS OF LAW STUDENTS WITH MENTAL DISABILITIES ABOUT CURRENT BAR APPLICATION STANDARDS AND CHARACTER AND FITNESS HEARING COMMITTEES

In 2012, Janice Lloyd of USA Today wrote an article based on the pervasiveness of mental disorders and the lack of individuals with those

409. Id.
410. See discussion infra Part VI.
disorders seeking out professional help. Through the study utilized, Lloyd found that 20% of American adults (45.9 million) reported suffering from a mental illness, but of that group, only 39.5% sought help. The study also found that among the 45.9 million found to have a mental illness, 20% of them also met the criteria for substance or chemical abuse, compared to only 6.1% among the individuals found not to have a mental illness. The research seems to prove a correlation between higher rates of substance abuse and mental illness.

An article by the National Alliance on Mental Illness may best explain the reasoning for this “dual diagnosis” of mental illness and substance abuse problems. Drugs and alcohol, according to the article, represent a form of “self-medication” that may cause the abuser to feel less pain from the mental illness, while simultaneously worsening the condition. Also, an individual that is “self medicating” is less likely to follow through with treatment plans created by a licensed medical physician or achieve lasting sobriety. The article by Janice Lloyd also comes to a similar conclusion that “[t]he primary response in the country (to mental disorders) is medication . . . ,” but therapy should always be the primary response before medication.

The Association of American Law Schools (AALS) found “that substance abuse is involved in [fifty] to [seventy-five] percent of the major attorney disciplinary cases.” These types of dependencies among lawyers typically develop in law school. A majority of the individuals that will develop

412. Id.
413. Id.
414. Id.
416. Id.
417. Id.
418. Lloyd, supra note 411.
419. Report of the AALS Special Committee on Problems of Substance Abuse in the Law Schools, supra note 7, at 36.
420. Id.
these addictions will not have a mental disorder to accompany it, but it is more likely for an individual suffering from mental disability without the proper help to adhere to self-medication.\textsuperscript{421} The following results are from a survey that was conducted by the AALS, and some of the results were found to be "extremely disturbing and indicative of a continuing problem that demands attention."\textsuperscript{422}

Extrapolating from the data in the Law Student Survey, there may be as many as 4,900 law students nationally who are already using alcohol on essentially a daily basis, and over 15,000 may have abused alcohol at some time since entering law school. Over 10,600 may have used marijuana within the past 30 days, and almost 1,700 may have used cocaine during the same period. Over 2,400 may have used psychedelic drugs (including LSD) during the previous month. Overall, there may be more than 11,400 law students nationally who have used some illicit drug during the past month.\textsuperscript{423}

In response to the study by AALS, the American Bar Association (ABA) has tasked itself with addressing both substance abuse problems and mental health issues that are present in law schools.\textsuperscript{424} In 2008, the ABA authored the tool kit for student bar associations and administrators.\textsuperscript{425} The tool kit gives great information on different signs to be aware of in order to allow a student to determine if he is suffering from a mental disability, similar to the criterion presented in the DSM-IV-TR for diagnosing mental disorders.\textsuperscript{426} It also lists ways that an individual can prevent mental illnesses, such as maintaining a balanced life, coping with stress in a healthy way, maintaining his identity, and never losing his passion or purpose.\textsuperscript{427} The ABA tool kit further tasks the Student Bar Associations (SBA) and the law school administration of every law school to establish programs that will

\textsuperscript{421} See Duckworth, supra note 415.
\textsuperscript{422} Report of the AALS Special Committee on Problems of Substance Abuse in the Law Schools, supra note 7, at 44.
\textsuperscript{423} Id.
\textsuperscript{425} Id. at 2.
\textsuperscript{426} Id. at 6-8.
\textsuperscript{427} Id. at 9-14.
not only educate students on potential mental illness but also establish help lines for the students to get the help they need.\textsuperscript{428}

The ABA tool kit recognizes that students need to seek out help for mental health issues, but issues such as "stigma, bar examiner questions . . . emotional macho law school culture . . . [and] availability of trusted resources to help" are significant barriers that deter law students from seeking professional help.\textsuperscript{429} The ABA tool kit is a complete failure when it comes to bar application questions due to a lack of control over the development of such questions. Both the AALS and the ABA discuss the issue of bar application questions deterring law students from seeking help for mental health issues, and both recognize the need to reform the mental health questions, but any recommendations made by these organizations are seen as purely advisory and not binding on the state bars. Therefore, if change is to come, it must come in the form of either a Supreme Court decision interpreting the ADA or congressional legislation that is binding on all jurisdictions within the United States. Without this type of reform, three areas of particular concern will remain facing law students who are forced to decide whether to receive help for their mental needs or to answer questions on the bar exam honestly.

A. Stigma

Many studies have shown a widespread stigma against individuals with mental disabilities.\textsuperscript{430} In 2000, the University of Hawaii conducted a survey on the general adult population of Great Britain to determine the opinions of the general population of those with mental illnesses as baseline data for a campaign to combat stigmatization.\textsuperscript{431} The results of this study were used as baseline data for such a campaign.\textsuperscript{432} The University of Hawaii included the major mental disabilities of severe depression, panic attacks, and schizophrenia.\textsuperscript{433} The study found that "[a]pproximately 70% of respondents rated people with [schizophrenia] as dangerous to others and about 80% rated [schizophrenia] as unpredictable."\textsuperscript{434} Furthermore,
"[a]pproximately 62% of respondents rated people with severe depression as hard to talk to, 19% responded that they could pull themselves together, 23% that they would not eventually recover, and 23% that they are dangerous to others, yet only 16% thought that they would not respond to treatment."435 Across the board, "most respondents were optimistic and accurate about prospects for improvement with treatment."436 Even with the optimism shown by the respondents, the study still found evidence of social distancing between the respondents and individuals with mental disabilities.437 It is that "social distancing [that] ensures a continuing lack of familiarity with the realities of sufferers' experiences and of their illnesses."438

There are three distinguishable components of stigma: stereotypes, prejudice, and discrimination.439 "Stereotypes represent [collective] notions of groups," in this case a notion about the mentally ill, that have been agreed upon and adopted by the groups.440 Prejudice represents the behavioral response to such stereotypical notions.441 The University of Hawaii's study found that there is a need to differentiate between the components of stigma as well as between the various mental disorders.442 Different mental disabilities will have different stigmatization connotations.443

"The stigma associated with mental illness harms the self-esteem of many people who have serious mental illnesses."444 "An important consequence of reducing stigma would be to improve the self-esteem of people who have mental illnesses."445 The general stigmatization that society possesses against individuals with mental illnesses is also applicable to lawyers and judges

435. Id.
436. Id.
437. Id. at 4.
438. Id. at 6.
440. Id.
441. Id.
442. Id.
443. Id.
445. Id.
who serve on bar admission committees. Lawyers and judges do not possess the medical knowledge that is required to overcome “social distancing.”

An applicant that is required to “disclose mental disabilities to those who will pass on their fitness to practice the profession are acutely aware of the ‘blatant and subtle stigma’ that these conditions carry.” Fear of discrimination would give such an application an objective reason for not answering mental health questions accurately.

B. Subjectivity

As is evident with most state jurisdictions in regard to how they handle mental health criteria to determine fitness to practice law, the ABA Model Rule allows for continued subjectivity. As discussed in the stigmatization section, subjectivity in determining the criteria to determine fitness opens the door for severe discrimination and prejudice against applicants with mental disabilities. The Americans with Disabilities Act was enacted to ensure that discrimination does not occur against individuals with disabilities, but with subjectivity present in the questioning process, discrimination is likely to prevail. This issue will be addressed in the solution section by addressing the need for a streamlined objective standard across the country, so that every jurisdiction will be in adherence with the Americans with Disabilities Act when dealing with mental disorders.

C. Confidentiality

The Model Rule on Conditional Admission to Practice Law, formulated by the American Bar Association, has a section on confidentiality. It states that:

The fact that an individual is conditionally admitted and the terms of the Conditional Admission Order shall be confidential provided that applicant shall disclose the entry of any
Conditional Admission Order to the admissions authority in any jurisdiction where the applicant applies for admission to practice law. In addition to ensuring that the relevant records of the [Admissions, Monitoring, and Disciplinary Authority] are confidential, the [Admissions Authority] shall structure the terms, conditions, and monitoring of conditional admission to ensure that the conditional admission does not pose a significant risk to confidentiality.451

The rule also recognizes in its commentary that there is a tension between confidentiality and the public’s interest “in access to all material information about the applicant’s fitness to practice.”452 Although it is true that there is a tension present, the issue is that the model rule does not take a stance on how this tension should be identified, but rather allows for there to be “differences in approaches to confidentiality and defers to state courts of highest appellate jurisdiction to make this ultimate decision.”453 There is subjectivity within the model rule to allow for states to choose how much confidentiality rights shall be extended to each applicant. This does not give an objective test to apply and can create a significant variance in results based on what each state adopts.

If a state follows this rule fully, it will be allowed to decide how much information is needed in order for its board of bar examiners to make a determination as to whether the applicant is fit to practice law. This type of disclosure has even been known to encompass the requirement that the applicant turn over all medical records to be examined by the board of bar examiners. This Comment’s solution discusses the need for an independent examination of applicants who answer affirmatively to mental disability questions, so they are never pressed with a confidentiality dilemma.454

VII. SOLUTION

This Comment proposes a reform to the current bar application system in a way that will minimize discrimination by the bar application examiners. This proposal shows the dynamics that are at play between the interests of the bar examiners to protect the general public and the interests

451. Id.
452. Id.
453. Id.
454. See discussion infra Part VII.
of the applicants that are affected with a mental disability. The solution is defined in a four-part analysis.

First, a guidepost needs to be created by the ABA that will highlight the mental disorders that the Board of Law Examiners deems to be of specific concern.455 The guidepost must be formulated “on the basis of clinical or other appropriate evaluations.”456 If the board of bar application examiners creates the guideline solely on their own understandings, then discriminatory practices will not be avoided. In order for this to be effective, the guidepost must also be continually updated to stay current with quickly evolving medical standards. The guidepost will be disseminated to applicants several different ways. First, this will need to be uniformly adopted by each jurisdiction and posted on their corresponding board of bar examiners websites. This will allow for bar applicants to have easy access to the information. Second, the guidepost must be posted on all law school websites so that prospective and current law students will know if their current mental condition will put them at risk of being denied entry into the practice of law.

Second, the ABA needs to shift all questions pertaining to the mental status of an applicant to a separate form that will go directly to a team of psychologists or relevant medical physicians. These medical professionals are in the best place to make a determination about whether an individual is fit to practice law because they have been educated and have practiced in the field of psychology. Every mental disability needs be put on a scale that calculates the severity of the disability. That disability can then be graded on the likelihood that it will have a major negative effect on the general public. The mental disabilities are so complex that these types of readings and scales need to be applied to the applicants by a medical physician. Additionally, most attorneys and judges have not studied at an accredited medical or psychology school or practiced in the field of psychology, so this proposed solution takes that determinative power out of the hands of those who lack the prerequisite knowledge to make sound judgments without having to rely on stereotypes and biased opinions.

This medical board will be made up of at least three medical physicians so that every application received is adequately reviewed and a consensus is reached as to whether that individual truly is a danger to the general

455. The suggested guidepost would be used purely to educate bar applicants. The Medical Board would still have the ultimate authority to make fitness determinations.
The medical board members will be selected through criteria that is similar to that utilized by the Federation of Medical Boards. The ABA will preapprove a list of physicians to analyze the mental fitness answers on bar applications and, if need be, examine the applicants themselves. If the applicant is subject to a medical examination, he may choose any preapproved physician, independent of the board, to perform the necessary mental fitness examination. The applicant may be subject to a "complete medical evaluation" by an independent medical examiner if the medical board deems it necessary. Also, the medical board may require the applicant to undergo a "comprehensive psychological evaluation" by an independent psychologist if it is necessary for them to make an informed decision.

The determinations by the medical board will be made on the ability of the applicant to remedy his condition through medication and counseling, the severity of the condition, and many other subject lines that the medical board deems necessary to accomplish the goal of protecting the general public. The court in Applicants v. Tex. Bd. of Law Exam'rs, 1994 WL 923404 (W.D. Tex. 1994), recognized the importance of balancing societal goals (protecting the public) with the rights of the mentally disabled under the ADA, so it was critical according to that court to make the questions necessary.

Policy on Physician Impairment, Federation of Med. Bd's. 18 (2011), http://www.fsmb.org/pdf/grpol_policy-on-physician-impairment.pdf. "Providers performing evaluations/assessments should have demonstrable expertise in the recognition of the unique characteristics of health professionals with addictive and/or psychiatric illness. The psychiatric history and mental status examination should be performed by a clinician knowledgeable in addictive and/or psychiatric illness." Id. (emphasis added).

"Whenever possible, the licensee should be allowed to select evaluator(s) from a PHP approved list of evaluator[s] or facilities. The licensee should not be allowed to select an evaluator not approved by the PHP." Id. (emphasis added).

"The licensee should undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate toxicology screens." Id.

The PHP may refer a licensee for comprehensive psychological evaluation. Evaluation by a clinical psychologist can be useful to evaluate personality dynamics and to screen for cognitive deficits. For in-depth evaluation of memory and other cognitive functions, referral should be made to a certified neuropsychologist. The psychological evaluation report should specify the instruments utilized. The report should indicate whether or not there is impairment and to what degree.
public. This process should not take more than sixty days for the board to review and, once a determination is made, the medical board will send its final determination, and nothing more, to the official board of bar examiners. The medical board can extend this time period for applicants who need to be evaluated more extensively, but not more than six months.\footnote{See discussion supra Part IV.A.3 (discussing how a long period of time will become unduly burdensome on a mentally disabled applicant and run afoul of the ADA).}

Third, all of the additional costs over and above what is required by the typical applicant must be borne by the state bar, not the applicants themselves. This will remove any additional burdens that individuals with a mental disability will have to overcome in order to become a licensed attorney. As discussed in Part III,\footnote{See discussion supra Part IV.A.4 (discussing if the state bar associations bore the costs associated with additional expenditures relating to applicants solely on the basis of their mental disabilities and whether it would be less discriminatory).} the fact that applicants are made to bear these additional costs points to a discriminatory practice and does not protect the general public. Removal of these additional costs will allow for the applicants to be on fair ground with the other applicants. This includes all costs associated with any additional measures the medical board requires of an applicant.

Fourth, the conditional admissions process should be fully eradicated. The conditional admission process is a front to allow state bar examiners to discriminate against applicants with a mental disability. With a new system in place, one that allows for medical physicians to determine the fitness of the applicants, there would no longer be a need for conditional admissions. If the medical board decides that the applicant is fit to practice law, then the applicant should be fully admitted to the bar. If the medical board decides that the applicant is not fit to practice law, then he will not be admitted to the bar at all. This will reduce excess burdens on applicants with a mental disability by allowing them to be fully admitted to the bar without having to jump through hoops for the state bar association.

There may be concerns about the lack of checks on particular applicants with mental disabilities who are allowed to join the bar, but the ultimate check is disbarment if the applicant develops behavioral problems. Attorneys with or without mental illnesses will be judged on the same grounds for disbarment. Those determinations will be based on the actions rather than the mental status of the attorney. Another check that is already in place to protect the general public is the malpractice lawsuit. Every
attorney can be subject to such a lawsuit and, just like disbarment, the courts will be able to decide malpractice suits based on actions rather than the mental status of the attorney. There is no need to create unduly burdensome conditions for an applicant because he has a mental disability—the checks are already in place.

A. Benefits to Mentally Disabled Individuals

The benefits to the mentally disabled will be two-fold. First, individuals affected by a mental disability will be able to take comfort in the fact that the discriminatory effect of the board of bar examiners will be greatly limited. Through the process of allowing medical professionals to be the ultimate decision makers on the applicant’s fitness to practice law despite a mental disability, the decision will be much more objective, rather than purely subjective. Second, the confidentiality issue that is flawed in the model rule will no longer be an issue. The board of bar examiners will no longer have the right to review the medical information of each applicant, or even the right to know that the applicant has a mental disability. The medical board will hold all of the medical information; and the only information that will be released to the board of bar examiners is the medical board’s decision on the applicant’s danger to society. The concerns about releasing confidential medical information to the board of bar examiners will no longer be an issue under this new approach.

B. Benefits to State Bar Application Boards

The benefits to the state bar application boards will be three-fold. First, the applicants will be more likely to be honest about their mental status if they know that medical professionals, rather than attorneys and judges, will examine their medical conditions. The goal of the mental health questions is to protect the general public, but the general public cannot be protected if applicants are not being honest about their medical conditions; this proposal helps to solve that problem. Second, one of the goals of the model rule was to promote law school students to seek help that they need for mental or substance abuse type problems as they arise, instead of prolonging the help that is needed for fear of not being accepted to the bar. Law students are more likely to seek out help for mental or substance abuse under this proposed solution than they have been under the conditional admission approach because of the knowledge that their conditions will be looked at objectively rather than subjectively. Third, the state bars will no longer have costs associated with the conditional admission process to keep
tabs on individuals for at least two years. These types of programs are expensive, even when forcing applicants to bear most of the costs.

VIII. CONCLUSION

In conclusion, inquiries into the mental health of bar applicants cause discriminatory results based on general stereotypes that society holds against individuals with mental illnesses. Congress has expanded the definition of “disability” to allow for the ADA to protect more individuals who are affected with a mental health disability. Courts have been active in narrowing the scope of the mental health questions on bar applications, and have decided that broad mental health questions in regard to scope and duration are incompatible with the regulations presented through the ADA. The ABA attempted to solve the mental health problem through its adoption of the Model Rule on Conditional Admission to Practice Law, but failed to remedy the discrimination problems completely. In 2013, the American Psychiatric Association published the DSM-5, which will have a major affect on the diagnosis of individuals with mental disabilities in the future.

The solution that is presented above has been created with the goals of adhering to the ADA regulations and limiting discrimination against applicants with mental disabilities, while giving state bar application boards the ability to protect the general public from individuals who are perceived to be a danger to society. The ADA, when it was passed, was championed as the next big Civil Rights Act through eradicating discrimination by employers and by public organizations. It is about time that the bar application process fully adheres to the ADA’s regulations; and the solution proposed in this Comment will be a start to make sure that becomes a reality.

465. See discussion supra Part II.C.2.d.
466. See discussion supra Part III.
467. See discussion supra Part IV.
468. See discussion supra Part V.
469. See discussion supra note 13.