

MENTAL ILLNESS: ACCESS AND FREEDOM

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INTRODUCTION

A goal of the Americans with Disabilities Act of 1990 (“ADA”)¹ is to counter historical isolation of people with disabilities, and to create opportunities for them to flourish as full social participants. Overcoming the substantial barriers that stand between social isolation and full citizenship involves a long and ongoing struggle. Over the recent past, the emphasis in advocacy for people with disabilities has been to increase a sense of agency in those with disabilities, and decrease the focus on disabilities as differences to be corrected.² This approach encourages a shift in perspective, one characterized by movement away from describing disabilities in medical terms or as misfortunes to be overcome through welfare-oriented interventions, and toward the use of equalitarian civil rights doctrine as a means to attack unjustified and isolating mistreatment.³

The shift from a paternalistic medical model to an equalitarian civil rights regime, however, did not provide some groups of disabled people, including those with significant physical, cognitive, or psychiatric conditions, with the necessary tools for social integration.⁴ For those groups, competing for jobs, participating in government services, and availing themselves of public accommodations remained difficult or impossible. Mark Weber and others have argued that, for

¹ Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified as amended at 42 U.S.C. §§ 12101–12213 (2012)).

² See, e.g., Jasmine E. Harris, *Processing Disability*, 64 AM. U. L. REV. 457 (2015); Lisa Schlesinger, Note, *The Social Model’s Case for Inclusion: “Motivating Factor” and “But For” Standards of Proof Under the Americans with Disabilities Act and the Impact of the Social Model of Disability on Employees With Disabilities*, 35 CARDOZO L. REV. 2115 (2014); Arlene S. Kanter, *The Law: What’s Disability Studies Got To Do With It or An Introduction to Disability Legal Studies*, 42 COLUM. HUM. RTS. L. REV. 403 (2011).

³ See generally SAMUEL R. BAGENSTOS, *LAW AND THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT* (2009) (criticizing the ADA and the Supreme Court’s ADA decisions, but also looking inward, within the ranks of the disability rights movement, to resolve internal tensions and craft useful policy proposals); Michael A. Stein, *Disability Human Rights*, 95 CAL. L. REV. 75 (2007); Mary Crossley, *Reasonable Accommodation as Part and Parcel of the Antidiscrimination Project*, 35 RUTGERS L.J. 861 (2004) (examining the theoretical implications of placing “disability” within the existing canon of human rights).

⁴ See Mark C. Weber, *Disability and the Law of Welfare: A Post-Integrationist Examination*, U. ILL. L. REV. 889, 906–07 (2000); Jane B. Korn, *Crazy (Mental Illness Under the ADA)*, 36 U. MICH. J.L. REFORM 585, 603–04 (2003).

such groups, some recognition of special needs, through targeted welfare and other programs, would be necessary to support social integration.⁵

Of course, combining the ADA with affirmative, targeted programs goes beyond addressing needs susceptible to “reasonable accommodation,” which is the antidiscrimination platform on which the ADA was built.⁶ Even so, while this second-order disability rights program creates structural complication, it is entirely consistent, in spirit, with the argument that people with disabilities are entitled to full social integration, self-direction, and an opportunity to flourish.⁷ It also acknowledges the reality that social integration sometimes requires unequal treatment, via adjustments to the standard social practices premised on the treatment of people without disabilities.⁸ The theme tying together the social structure of ADA-based accommodations and welfare-enhancing targeted benefits is the imperative that our society should be structured so as to maximize the autonomy and social flourishing of people with disabilities.⁹ However, can this augmented disability rights framework function when a psychiatric disability affects a person’s ability—or inclination—to request or accept the accommodations and support needed to further actual social integration? In such a case, autonomy and human flourishing can be in direct conflict, and difficult policy choices must be made.

In Part I, this Article provides a brief overview of the bumpy ride—from historical shunning, to medial management and welfare support, and eventually civil rights laws aimed at equal treatment—people with mental illness and their advocates have experienced.¹⁰

⁵ See Weber, *supra* note 4, at 889–90; Korn, *supra* note 4, at 585.

⁶ See Crossley, *supra* note 3, at 861–63.

⁷ See Samuel R. Bagenstos, “Rational Discrimination,” *Accommodation, and the Politics of (Disability) Civil Rights Law*, 89 VA. L. REV. 825, 939 (2003) (“Antidiscrimination law is best justified as a policy tool that aims to dismantle patterns of group-based social subordination, and that does so principally by integrating members of previously excluded, socially salient groups throughout important positions in society.”).

⁸ See Crossley, *supra* note 3, at 869–70.

⁹ See generally BAGENSTOS, *supra* note 3.

¹⁰ See *infra* Part I.

Part II provides an introduction to, and discussion of, the drive to mental health parity within the health insurance context. Mental health treatments have historically been, at best, an afterthought in health insurance coverage.¹¹ In fact, the inadequacy of the ADA, and other equalitarian tools, as guarantors of much-needed mental health insurance coverage necessitated resort to the creation of specific, remedial legislation mandating coverage of mental health services.¹² Such parity legislation addresses shortcomings in the ADA's treatment of health insurance, pointing the way toward potential equal access, but inequality remains the rule, and refinements in parity implementation are sorely needed.¹³

Part III turns to involuntary outpatient commitment. For most people without mental illness, access to health treatment is governed in part by well-established principles of decisional autonomy.¹⁴ The right of individuals of full age to choose or refuse medical treatment is ordinarily respected even where the refusal places the patient in danger.¹⁵ However, decisional competence is a prerequisite for the exercise of this right, meaning that where a person has been adjudged incapable of understanding the nature and effect of the care he refuses, his refusal can be overcome.¹⁶ The world is slightly more complex for people with mental illness because they can be involuntarily hospitalized, usually if they pose a threat of harm to themselves or others.¹⁷ Once committed to inpatient care, people with mental illness are often denied the right to make choices as to the medical care they receive and refuse, even if they are not judged to be lacking decisional

¹¹ See Stacey A. Tovino, *All Illnesses are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. LEGIS. 1, 6-7 (2012); Colleen L. Barry et al., *Design of Mental Health Benefits: Still Unequal After All These Years*, 22 HEALTH AFF. 127, 127 (2003).

¹² See *infra* text at notes 92-93 (discussing parity legislation).

¹³ *Id.*

¹⁴ See Marsha Garrison, *The Empire of Illness: Competence and Coercion in Health-Care Decision Making*, 49 WM. & MARY L. REV. 781, 797 (2007).

¹⁵ See *id.* at 791-92.

¹⁶ See *id.* at 789-90.

¹⁷ See Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitments*, 45 U. MICH. J.L. REFORM 561, 566-67 (2012).

competence.¹⁸ Decisional autonomy is reduced for people with mental illness outside of the hospital setting as well. Involuntary outpatient commitment laws have proliferated in recent years, subjecting people to mandatory outpatient treatment even if they do not qualify for involuntary inpatient commitment.¹⁹ Discussion of the treatment of people with disabilities in these circumstances reveals substantial tension between the goals of autonomy and flourishing. As a result, the more decisional autonomy drives the discussion, the more a person's material well-being is at risk, but the more safety and comfort drive the discussion, the greater the pressure on a person's autonomy. Those engaged in disability rights discourse struggle to resolve these seemingly adverse goals.²⁰

I. STIGMA, PATERNALISM, AND CIVIL RIGHTS – ACCOUNTING FOR PEOPLE WITH MENTAL ILLNESS

This historic mistreatment of people with mental illness or psychiatric disability underlies any discussion of their legal rights. This history is well-known, and was eloquently summarized in the then Surgeon General's 1999 report on Mental Health:

Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia. It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse.

¹⁸ See, e.g., *Disability Rights N.J., Inc. v. Comm'r, N.J. Dep't of Human Servs.*, 796 F.3d 293 (3d. Cir. 2015); *Washington v. Harper*, 494 U.S. 210 (1990).

¹⁹ See Candice T. Player, *Involuntary Outpatient Commitment: The Limits of Prevention*, 26 STAN. L. & POL'Y REV. 159, 161 (2015).

²⁰ See Harris, *supra* note 2, at 514–20; Michael L. Perlin, "Their Promises of Paradise": Will *Olmstead v. L.C.* Resuscitate the Constitutional "Least Restrictive Alternative" Principle in Mental Disability Law?, 37 HOUS. L. REV. 999, 1028–46 (2000).

More tragically, it deprives people of their dignity and interferes with their full participation in society.²¹

Because of the pervasive and categorical mistreatment of people with disabilities, Congress, in the original wording of the ADA, invoked the language that has come to identify groups entitled to heightened scrutiny of their civil rights claims when it declared that “individuals with disabilities are a discrete and insular minority.”²² People with mental disabilities have faced particularly pervasive stigma and mistreatment.²³ Although this language was removed from the ADA through the ADA Amendments Act of 2008 (“ADAAA”),²⁴ the position that people with disabilities are a disadvantaged class entitled to civil rights protection through antidiscrimination law still animates much of the disability rights movement.²⁵ The civil rights approach to the law affecting people with disabilities in general, and people with mental disabilities in particular, remains the dominant paradigm.²⁶

²¹ U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 6 (1999) [hereinafter REPORT OF THE SURGEON GENERAL] (citations omitted).

²² Americans with Disabilities Act of 1990, Pub. L. No. 101-336, §2(a)(7), 104 Stat. 327 (1990) (codified at 42 U.S.C. § 12101(a)(7) (2006)), *repealed by* The ADA Amendments Act of 2008, Pub. L. No. 110-325, § 3(2) (2008). In *United States v. Carolene Products Co.*, the court observed that “prejudice against discrete and insular minorities may be a special condition, which tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities, and which may call for a correspondingly more searching judicial inquiry” by courts. This dictum eventually led to strict scrutiny review of government action restricting the rights on the basis of race, national origin, religion and (in cases of state, but not federal law) alienage. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938).

²³ See Wendy F. Hensel & Gregory T. Jones, *Bridging the Physical-Mental Gap: An Empirical Look at the Impact of Mental Illness Stigma on ADA Outcomes*, 73 TENN. L. REV. 47, 50–52 (2005).

²⁴ ADA Amendments Act of 2008, Pub. L. No. 110-325, § 3(2), 122 Stat. 3553 (2008); Jeannette Cox, *Crossroads and Signposts: The ADA Amendments Act of 2008*, 85 IND. L.J. 187, 205–06 (2010).

²⁵ Professor Cox explains that the *Carolene Products* language was removed not because Congress had changed its mind that people with disabilities are entitled to heightened civil rights protection as a result of their historic mistreatment, but because the Supreme Court in *Bd. of Tr. of the Univ. of Ala. v. Garrett*, 531 U.S. 356, 370–72 (2001), had found wanting the record produced by Congress supporting its characterization of people with disabilities as members of a discrete and insular minority. Cox, *supra* note 24, at 206–10.

²⁶ See generally Elizabeth F. Emens, *Disabling Attitudes: U.S. Disability Law and the ADA Amendments Act*, 60 AM. J. COMP. L. 205 (2012) (discussing the antidiscrimination orientation of the ADA Amendments Act).

The heart of the civil rights paradigm, as applied in the areas of race and gender, has been an equalitarian effort to end the disparate treatment of people belonging to disadvantaged minorities, and to enforce norms of equal treatment.²⁷ The ADA, a complex manifestation of the principles embodied in the equalitarian civil rights laws, is a hybrid, styled as a “national mandate for the elimination of discrimination against people with disabilities,” that provides “enforceable standards” for the elimination of discrimination against people with disabilities.²⁸ But it goes beyond a mandate for only equal treatment.²⁹ In recognition of both the social construction of the disabling aspects of many people’s conditions,³⁰ as well as the need for people with those (partially) socially-constructed disabilities for affirmative accommodations to gain equal social freedom,³¹ the ADA includes, as a form of “discrimination,” the failure to make “reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual.”³² The ADA, then, requires more than equal treatment; instead, it requires that government and private parties provide assistance to, and incur cost on behalf of, people with disabilities. These affirmative accommodations provide for “equality of opportunity” such that, Congress hoped, people with disabilities

²⁷ See A. Leon Higginbotham, Jr., *A Tribute to Justice Thurgood Marshall*, 105 HARV. L. REV. 55, 63 (1991) (“The Supreme Court’s opinion in *Brown* condemned state ‘separate treatment’ of discrete groups on the presupposition that they are inferior. The implicit overruling of the *Plessy* rationale and *Brown*’s equalitarian thrust became the catalyst for successful protests challenging discrimination based on age, disability, gender, religion, and national origin.”).

²⁸ 42 U.S.C. §§ 12101(b)(1)–(2) (2012).

²⁹ See Bonnie P. Tucker, *The ADA’s Revolving Door: Inherent Flaws in the Civil Rights Paradigm*, 62 OHIO ST. L.J. 335, 344 (2001).

³⁰ See Michelle A. Travis, *Impairment as Protected Status: A New Universality for Disability Rights*, 46 GA. L. REV. 937, 971–81 (2012).

³¹ *Id.*

³² 42 U.S.C. § 12112(b)(5)(a) (defining discrimination in the employment setting); see also Arlene B. Mayerson & Sylvia Yee, *The ADA and Models of Equality*, 62 OHIO ST. L.J. 535, 538 (2001) (“[T]he disability movement has known from the outset that for people with disabilities, a civil rights statute based solely on equal treatment would fall far short of achieving the goals of inclusion and participation. In other words, we [the drafters of the ADA] conceptualized equal protection as equal opportunity, which by necessity required affirmative steps to eliminate barriers to participation.”).

would gain “full participation [in society], independent living, and economic opportunity.”³³

There has been a call to expand or transform disability theory beyond the civil rights, equalitarian framework.³⁴ The argument for a different perspective on disability theory is supported by the observation that purely equalitarian measures have not had the effect disability advocates had hoped for, even as augmented by the ADA’s requirement that people with disabilities be afforded reasonable accommodations in employment.³⁵ As Mark Weber has observed, the root of the disability rights movement in the 1960s was the desire to shift from the then-dominant “custodialism” orientation, whereby people with disabilities were largely kept out of sight and treated separately, to “integrationism,” whereby people with disabilities claimed a right to be fully a part of their society, receive equal treatment, and be free from disability-related fetters.³⁶ While Weber argues that goal is an appropriate and noble one, he also observes that “[t]he ADA has benefited only a narrow class of persons with disabilities—those who can successfully compete with others once their disabilities have been accommodated and for whom the needed accommodations do not cause the employer undue hardship.”³⁷

One method of augmenting equalitarian civil rights theory is through a “post-integrationist” understanding of disability rights that combines civil rights perspectives with welfare law approaches that are calculated together to aid those unable to work despite “accommodations.”³⁸ As advanced by Professor Weber, this refinement of equalitarian theory would work to ensure that programs such as independent living and client-controlled services are available

³³ 42 U.S.C. § 12101(a)(7) (reciting Congress’s findings and purpose).

³⁴ See Weber, *supra* note 4, at 904–08.

³⁵ The ADA’s affirmative requirements include: (1) “reasonable accommodations” in employment; (2) “reasonable modifications” to public services’ policies and practices; and (3) “reasonable modifications” to public accommodations’ policies and practices. 42 U.S.C. §§ 12112(b)(5)(A), 12182(b)(2)(A)(ii); 28 C.F.R. § 35.130(b)(7) (2013). In this Article, these requirements are collectively referred to as “reasonable accommodations” for convenience.

³⁶ See Weber, *supra* note 4, at 889–90.

³⁷ *Id.* at 918.

³⁸ *Id.* at 923.

through welfare programs, in order to assure those with serious disabilities an opportunity for social integration.³⁹ The approach of Stein and Stein goes beyond the ADA's modified equalitarian framework and advocates for a "disability human rights" approach, which "combines the type of civil and political rights provided by antidiscrimination legislation (also called negative or first-generation rights) with the full spectrum of social, cultural, and economic measures (also called positive or second-generation rights)."⁴⁰

A more sweeping theory, also animated by concerns that civil rights law fails to reach the needs of those most in need of its protection, is Martha Fineman's vulnerability approach.⁴¹ Fineman argues that the liberal tradition's focus on the values of autonomy, self-sufficiency, and independence fails to recognize the essential interconnectedness and characteristic mutual reliance of everyone in society, as they "presently and . . . in the past rel[y] on others and on social institutions."⁴² She argues that group-based civil rights law's focus on equality fails in many cases to produce substantive equality.⁴³ Eschewing group-based analysis, she posits that everyone experiences periods of vulnerability and the need for assistance at some points in their lives.⁴⁴ Thus, vulnerability should be seen as part of the human condition, present in every individual to varying degrees and over different spans of time. The role of law, under such circumstances, is to relate vulnerability to the state's responsibility to assist persons with

³⁹ *Id.* at 940–42.

⁴⁰ Michael A. Stein & Penelope J.S. Stein, *Beyond Disability Civil Rights*, 58 HASTINGS L.J. 1203, 1205 (2007).

⁴¹ See generally Martha A. Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1 (2008) ("The vulnerability approach I propose is an alternative to traditional equal protection analysis; . . . in that it is not focused only on discrimination against defined groups, but concerned with privilege and favor conferred on limited segments of the population by the state and broader society through their institutions."); see also Ani B. Satz, *Disability, Vulnerability, and the Limits of Antidiscrimination*, 83 WASH. L. REV. 513, 527–33 (2008) (applying Fineman's theoretical framework to disability discrimination).

⁴² See Martha A. Fineman, "Elderly" as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility, 20 ELDER L.J. 71, 88 (2012).

⁴³ See Fineman, *supra* note 41, at 9–15.

⁴⁴ *Id.* at 20.

vulnerabilities.⁴⁵ The state's fundamental purpose, she argues, is to respond to these vulnerabilities through the provision of positive assistance in social services and health care.⁴⁶

These thumbnail descriptions are not intended to do justice to the nuanced theoretical approaches aimed at addressing the shortfall of the ADA's reach in addressing the range of needs experienced by those with serious disabilities, or whose interests are otherwise met by equalitarian models. Those proposing an understanding of disability law that incorporates positive entitlements to goods and services traditionally connected with welfare systems, often strive to remain true to the central disability rights notion that justice for people with disabilities entails changes in society rather than the individual.⁴⁷ Professor Weber, for example, argues that disability rights theory should be rich enough to acknowledge the "continuing poverty and need for economic support for people with disabilities."⁴⁸ He advocates for a nuancing of the ADA approach such that people with disabilities are afforded access to services calculated to relieve poverty in a system where the recipients are treated "as agent[s] rather than passive recipients of social interventions."⁴⁹

As is evidenced by these theoretical complexities, one of the struggles of civil rights law, including disability law, is the relative place of individual agency and group identity. Although the 2008 amendments expanded, or rather reinstated, the broad definitions of the people entitled to the ADA's protections, group membership is still a prerequisite for entitlement to the protections of civil rights law. Equalitarian civil rights laws are structured around a model by which people in a well-defined class are protected from disparate treatment in comparison to the general population.⁵⁰

⁴⁵ *Id.*

⁴⁶ See Martha A. Fineman, *The Vulnerable Subject and the Responsive State*, 60 EMORY L.J. 251, 257-58 (2010).

⁴⁷ See Travis, *supra* note 30, at 937, 971-81.

⁴⁸ Mark C. Weber, *Disability Rights, Welfare Law*, 32 CARDOZO L. REV. 2483, 2487 (2011).

⁴⁹ *Id.*

⁵⁰ Under the ADA, people with disabilities (or those regarded as disabled or with a record of disability) may not be disparately treated in (1) employment, so long as they can perform the essential functions of the employment with or without reasonable accommodations, (2)

The push to extend disability rights beyond the ADA's augmented equalitarian vision flows from the observation that the ADA fails to address the societal barriers not susceptible to removal through class-based antidiscrimination efforts, either because the service is difficult to assess in class-based terms, or because, even with requirements for modification, equalitarian efforts will not redress some inhibitions to full social flourishing for those with serious disabilities.⁵¹ Weber's work advocates the incorporation of aspects of welfare law into the disability rights enterprise in order to more comprehensively address social isolation.⁵² Stein and Stein advocate for the incorporation of the positive rights of "disability human rights" to serve the same rights-enhancing function.⁵³ Fineman's emphasis on substantive equality also counsels a shift in focus from formal equality to entitlement to the material means necessary for individuals to thrive notwithstanding their disabilities.⁵⁴

These theoretical approaches highlight a basic question, and frustration, in disability law. As many have observed, the enforcement of the ADA has assisted many, but has predominantly helped those whose disabilities posed the least significant practical barriers to their achieving full practical independence.⁵⁵ Those with more profound disabilities, however, are often unable to benefit from the ADA because, *inter alia*, they are not "qualified," even with reasonable accommodations, for a job, public service, or public accommodation since the accommodations necessary for their being "qualified" present an undue burden to a respondent or would cause a fundamental alteration in the very program the person with a

participation in public services, so long as they meet the essential requirements of the service with or without reasonable modification of rules, policies, practices, or physical barriers, or (3) access to public accommodations, if such access can be achieved with or without reasonable modifications in policies, practices, procedures, or, as to physical barriers, with the readily achievable removal of such barriers. See 42 U.S.C. §§ 12102(1), 12111(8), 12131(2), 12182(b)(2)(i),(ii),(iv) (2012).

⁵¹ See, e.g., Weber, *supra* note 4, at 904–08.

⁵² See Mark C. Weber, *Home and Community-Based Services, Olmstead, and Positive Rights: A Preliminary Discussion*, 39 WAKE FOREST L. REV. 269, 273–78 (2004).

⁵³ See Stein & Stein, *supra* note 40, at 1205.

⁵⁴ See Fineman, *supra* note 46, at 257–58.

⁵⁵ See, e.g., Weber, *supra* note 4, at 904–08.

disability seeks to engage.⁵⁶ If the ADA is of limited utility in addressing numerous needs of many disabled people, then next steps must be examined, and the examination of those sorts of next steps is central to the theoretical enterprise of those who push the boundaries of equalitarian civil rights approaches.⁵⁷

In the first of the two case examples that follow, the augmented disability rights framework shows promise. Behavioral health services have historically been poorly represented in the health insurance system.⁵⁸ As physical health services covered by health insurance grew in number, complexity, and cost, services vital to people with mental illness were missing.⁵⁹ The ADA has proven inadequate to the task of remedying this inequity. Specific mental health parity laws have been offered as gap fillers, correcting insurance law's failure to offer those with mental illness benefits equivalent to those offered to persons with physical illness.⁶⁰ The combination of antidiscrimination principles, requirements for parity between physical and mental health coverage, and the possibility of specific mandates for behavioral health care offer a way forward, albeit one that will require much regulatory attention.

The second case example concerns gradual extensions of involuntary commitment and involuntary treatment laws for people with mental illness.⁶¹ Historically, courts committed a person found "dangerous" as a result of mental illness to a locked ward in a hospital.⁶² However, many states have moved beyond traditional hospital commitment to also subject people with mental illness to involuntary submission to outpatient treatment.⁶³ In both settings—

⁵⁶ *Id.*

⁵⁷ *Id.* at 923–56.

⁵⁸ See *infra* Part II.

⁵⁹ See Tovino, *supra* note 11, at 6–7; Barry et al., *supra* note 11, at 127.

⁶⁰ See John V. Jacobi, *Parity and Difference: The Value of Parity Legislation for the Seriously Mentally Ill*, 29 AM. J.L., MED. & ETHICS 185, 185 (2003).

⁶¹ See *infra* Part III.

⁶² See generally Alexander Tsesis, *Due Process in Civil Commitments*, 68 WASH. & LEE L. REV. 253 (2011) (arguing that the "clear and convincing standard" of proof inadequately protects patients' due process rights).

⁶³ See Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 187–91 (2003).

inpatient and outpatient commitment – people with mental illness can be subjected to involuntary medical treatment, often including the administration of antipsychotic medication.⁶⁴ These expansions of state power deep into realms central to individuals' autonomy rights are motivated, in part, by a desire to protect society, but also by paternalistic concerns for the safety of the person with mental illness.⁶⁵

Health insurance parity is a promising, if difficult, application for augmented equalitarian principles. Health insurance should connect all, regardless of their disability or ability, to medically appropriate care. The *means* by which equal access to health insurance can be accomplished requires fidelity to equality at a sufficient level of generality, coupled with the use of tools to permit the validation of comparable coverage in a range of applications. Involuntary outpatient commitment and treatment is advocated by many as a means by which the state can, by eliding equal access to autonomy rights, advance *substantive* equality to the means of achieving comfort or survival.⁶⁶ This is the way Martha Fineman's vision of support for vulnerable people's material welfare is advanced, even at the cost of their retention of liberal freedoms.⁶⁷ These intrusive laws permit an examination of the argument that rejection of liberal civil rights principles in preference for emphasis on the delivery of the basic necessities of a comfortable existence can go too far, and highlight the need to evaluate the overlay of paternalism evident in the push for substantive equality.⁶⁸

⁶⁴ *Id.*

⁶⁵ See Donald H. Stone, *Confine Is Fine: Have the Non-Dangerous Mentally Ill Lost Their Right to Liberty: An Empirical Study to Unravel the Psychiatrist's Crystal Ball*, 20 VA. J. SOC. POL'Y & L. 323 (2012).

⁶⁶ See, e.g., John K. Cornwell et al., *Exposing the Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCHOL. PUB. POL'Y & L. 209 (2003); Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269 (2000).

⁶⁷ Fineman, *supra* note 46, at 262, 275.

⁶⁸ See Nina Kohn, *Vulnerability Theory and the Role of Government*, 26 YALE J.L. & FEMINISM 1, 14–21 (2014).

II. HEALTH INSURANCE AND MENTAL HEALTH — EQUALITY AND DIFFERENCE

Historically, health insurance companies have thrived by understanding difference, using it both in their underwriting (i.e., deciding who to insure) and rating (i.e., deciding how much to charge) practices.⁶⁹ When state insurance law gave insurers broad discretion to use actuarial analysis to differentiate among classes of risk on the basis of both the expected cost of providing coverage and the level of uncertainty in the computation of the expected costs, differences abounded.⁷⁰ Young men were charged less than young women because one group, but not the other, could be expected to incur pregnancy costs.⁷¹ People with a history of heart disease were uninsurable at any cost.⁷² These differences were muted in group policies, and were nearly nonexistent in large group coverage where the large number of covered lives assured ample distribution of risk.⁷³ Over the last several decades, federal and state laws began to chip away at the extent to which health insurers could select among applicants on the basis of risk.⁷⁴

The Patient Protection and Affordable Care Act (“ACA”) firmly moved the health insurance underwriting system away from a competition in which insurers rose or fell depending on how well they attracted healthy people and turned away those in genuine need of

⁶⁹ See Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 77–81 (2005).

⁷⁰ *Id.*

⁷¹ See Theresa J. Neisen, Comment, *A Liberal Feminist Perspective on Gender Rating and the Patient Protection and Affordable Care Act – Is Limited Protection Enough?*, 11 LOY. J. PUB. INT. L. 469, 472–76 (2010).

⁷² See Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 JAMA 2503, 2504 (1992).

⁷³ See Crossley, *supra* note 69, at 84–85.

⁷⁴ See generally Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287 (1993) (describing the political changes that have shifted momentum in favor of greater restraints on health insurance underwriting, but emphasizing that more reform is needed); Leah Wortham, *Insurance Classification: Too Important to be Left to the Actuaries*, 19 J.L. REFORM 349 (1986) (arguing that public debate over health insurance classification should extend beyond the two traditional perspectives of “fair discrimination” and “anti-discrimination”).

coverage.⁷⁵ It largely ended pre-existing illness exclusions and denials of coverage based on medical history.⁷⁶ For these reasons, people with a history of mental illness or substance use disorder are less likely to be shut out of the insurance market. The importance of the shift, in law and policy, from insurance premised on segmenting risk to one built on socially-shared risk, is difficult to overstate.⁷⁷

But concerns remain. Access to insurance is not the same as access to care; the *content* of coverage matters. Each insurance plan is a recipe for the health care services that will be covered on behalf of insureds.⁷⁸ It is not enough, then, to simply broaden access to coverage. It is also important that the insurance policy cover those services that meet the health care needs of the insured. Importantly, what an insurance plan covers is determined both by what the policy describes as a covered service and by how the insurer manages the utilization of those coverage services. This second factor – utilization management – can be vitally important. For example, all insurers cover cancer treatment, but they may impose conditions or refuse to cover some treatments.⁷⁹ So, if an insured’s physician prescribes an expensive procedure such as high-dose chemotherapy with stem cell transplants (“HDC-SCT”), an insurer may require that the patient “try and fail” less expensive treatments as a condition of gaining access to HDC-SCT, or may even deny coverage altogether in the case of a solid tumor on the grounds that such use is experimental.⁸⁰ Thus, through contractual exclusions

⁷⁵ See Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 13–14 (2011).

⁷⁶ *Id.*

⁷⁷ See Stone, *supra* note 74, at 287 (describing the distinction between health insurance systems that price coverage according to risk and those premised on social solidarity).

⁷⁸ See Janet L. Dolgin, *Unhealthy Determinations: Controlling “Medical Necessity”*, 22 VA. J. SOC. POL’Y & L. 435, 438–40 (2015).

⁷⁹ See William M. Sage, *Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 596, 605–06 (2003) (noting that health insurance covers broad categories of care, such as surgical and hospital care, but refuses to cover some instances of that care, e.g., if it is experimental or not medically necessary).

⁸⁰ See *id.*

or utilization management techniques, some insureds may be denied care that they and their physician believe they need.⁸¹

Many people with disabilities, including mental disabilities, believed that insurers discriminated against them by limiting access to the care they needed.⁸² Shortly after the passage of the ADA, advocates began to argue that insurers' refusal to cover, or differently cover, care for particular disabling conditions such as AIDS constituted unlawful discrimination.⁸³ The ADA was to prove an effective tool for advancing the interests of people with disabilities to gain integrated use of health care facilities.⁸⁴ It was recognized as embodying a mandate for community-based care for unnecessarily institutionalized people in some circumstances.⁸⁵ The ADA did not, however, effectively serve the goal of ending differential treatment of people with disabilities in access to health insurance.⁸⁶ The ADA was ineffective in combatting differential insurance treatment due to the ADA's "insurance safe harbor" provision.⁸⁷ That provision allowed insurers to use the traditional tools of the insurance trade to assess and classify risks, choosing to cover some risks but not others, so long as those methods were consistent with preexisting insurance law and were not employed as a "subterfuge" to avoid the antidiscrimination goals of the ADA.⁸⁸ The term "subterfuge" had been used extremely restrictively by the courts to interpret discrimination statutes, and

⁸¹ *Id.*

⁸² See Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 26-32 (discussing mental health coverage).

⁸³ See Michael T. Isbell, *AIDS and Access to Care: Lessons for Health Care Reformers*, 3 CORNELL J.L. & PUB. POL'Y 7 (1993) (discussing the failures of health care delivery mechanisms and the elements needed for meaningful reform); Alan I. Widiss, *To Insure or Not to Insure Persons Infected with the Virus That Causes Aids*, 77 IOWA L. REV. 1617 (1992) (discussing the implications of underwriting restrictions that aim to make insurance policies available to beneficiaries with acquired immune deficiency syndrome (AIDS)).

⁸⁴ See *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 581-82 (1999).

⁸⁵ *Id.* at 600-01.

⁸⁶ See generally Steven Eisenstat, *Capping Health Insurance Benefits for AIDS: An Analysis of Disability-Based Discriminations under the Americans with Disabilities Act*, 10 J.L. & POL. 1 (1993) (examining whether coverage exclusions based on specific disabilities violate the ADA).

⁸⁷ 42 U.S.C. § 12201(c) (2012).

⁸⁸ *Id.*

courts followed suit in the ADA context.⁸⁹ Under this stringent test, a challenge to a plan design that omits or restricts coverage of treatments for people with disabilities (including those with mental illness) must show more than actuarial difference. Instead, the challenge must show a conscious plan to discriminate.⁹⁰ Such a showing is, in practice, nearly impossible to make, as the insurer can justify almost any difference as a cost-saving measure.⁹¹

State legislatures stepped into the breach to address insurance inequity by enacting a variety of mental health parity laws. These laws shared the goal of improving coverage of treatment for mental health conditions, but their methods differed.⁹² Some of the statutes required the coverage of mental health services, while others required only the offer of such coverage.⁹³ State statutes applied different mandates depending on whether the coverage was for large groups or small groups.⁹⁴ In addition, the mandates varied in terms of the conditions that were required to be covered; some mandated coverage of “severe” or “serious” mental illness, while others extended coverage for all mental illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.⁹⁵ The statutes created a patchwork of different standards from state to state. Further, a growing number of privately

⁸⁹ See, e.g., *Pallozzi v. Allstate Life Ins.*, 204 F.3d 392 (2d Cir. 2000); *Leonard F. v. Isr. Disc. Bank of N.Y.*, 199 F.3d 99 (2d Cir. 1999); *Ford v. Schering Plough*, 145 F.3d 601 (3d Cir. 1998); *E.E.O.C. v. Deloitte & Touche LLP*, 2000 WL 1024700 (S.D.N.Y. 2000) (mem.).

⁹⁰ See 42 U.S.C. § 12201(c). This “safe harbor” provision of the ADA permits insurers to use actuarial principles to treat applicants for health insurance differently depending on their health status. See *supra* text at notes 69–74 (describing historic actuarial principles of health insurance industry); see also Jennifer S. Geetter, Note, *The Condition Dilemma: A New Approach to Insurance Coverage of Disabilities*, 37 HARV. J. ON LEGIS. 521, 534–38 (2000) (describing the safe harbor provision).

⁹¹ See Geetter, *supra* note 90, at 536–37.

⁹² See Jacobi, *supra* note 60, at 185; Marcia C. Peck & Richard M. Scheffler, *An Analysis of the Definitions Used in State Parity Laws*, 53 PSYCHIATRIC SERV. 1089, 1089 (2002).

⁹³ Jacobi, *supra* note 60, at 190–91.

⁹⁴ *Id.*

⁹⁵ *Id.* The Diagnostic and Statistical Manual of Mental Disorders (commonly referred to as the “DSM”) is a compendium of “standard classifications of mental disorders” produced periodically by the American Psychiatric Association. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) (1952).

insured persons are enrolled in plans exempt from state regulation altogether, through ERISA preemption.⁹⁶

The uneven nature of states' responses to inequity in coverage, as well as the limits on state power to affect the growing self-insured market, led to federal parity protection.⁹⁷ Federal intervention came in three steps: the passage of the Mental Health Parity Act ("MHPA") in 1996,⁹⁸ the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA") in 2008,⁹⁹ and the passage of the ACA¹⁰⁰ in 2010. The MHPA's passage was widely regarded as important more for its symbolism than functional attributes, as it did not mandate mental health coverage, but only imposed requirements should it be included. For example, plans (both state-regulated insured plans, and ERISA-governed, self-funded plans) voluntarily including mental health benefits could impose annual and lifetime limits no more restrictive than those for physical health coverage.¹⁰¹ However, there were no requirements for types of treatment covered,¹⁰² and the plan was free to impose scope, duration, and cost-sharing provisions different from those for physical health coverage.¹⁰³ Lastly, the MHPA did not apply to individual and small group coverage.¹⁰⁴

⁹⁶ See BETH LEVIN CRIMMEL, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, MEDICAL EXPENDITURE PANEL SURVEY: SELF-INSURED COVERAGE IN EMPLOYER-SPONSORED HEALTH INSURANCE FOR THE PRIVATE SECTOR, 2000 AND 2010, at 2 (Sept. 2011), https://meps.ahrq.gov/data_files/publications/st339/stat339.pdf ("From 2000 to 2010, the overall percent of enrollees with employer-sponsored health insurance that had self-insured coverage rose from 48.3 percent to 57.5 percent.").

⁹⁷ Jacobi, *supra* note 60, at 191-92.

⁹⁸ Mental Health Parity Act of 1996, Pub. L. No. 104-204, §§ 701-703, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26 (2012)).

⁹⁹ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3765 (codified as amended at 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26 (2012)).

¹⁰⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 145 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

¹⁰¹ 29 U.S.C. §§ 1185a(1)-(2) (2012); 42 U.S.C. § 300gg-5(a)(1)-(2) (2012).

¹⁰² 29 U.S.C. § 1185a(e)(4); 42 U.S.C. § 300gg-5(e)(4).

¹⁰³ 29 U.S.C. § 1185a(b)(2); 42 U.S.C. § 300gg-5(b)(2).

¹⁰⁴ 29 U.S.C. § 1185a(c)(1)(A).

Like the MHPA, the MHPAEA does not mandate that covered plans provide mental health coverage, but simply sets conditions on such coverage should a plan so provide.¹⁰⁵ By its terms, it applies primarily to large employer groups, although, as described below, the ACA extended its application to include individual and small group plans.¹⁰⁶ Most importantly, the MHPAEA extended the reach of federal parity law to substance use disorder.¹⁰⁷ If mental health services are provided, the MHPAEA requires “general equivalence” of coverage decisions for mental health and substance use disorder services, meaning any treatment limits or cost sharing provisions must be no more restrictive than limits applied to substantially all medical/surgical benefits.¹⁰⁸

The ACA built on the protections of the MHPAEA by placing mental health and substance use disorder treatment front and center.¹⁰⁹ The ACA describes ten “essential health benefits” (“EHBs”) that must be included in any individual or small group plan.¹¹⁰ Listed among those benefits are mental health and substance use disorder treatments, which means individual and small group plans are thereby required to offer those treatments and, to do so, must offer them in compliance with the terms of the MHPAEA.¹¹¹ Therefore, the MHPAEA and the ACA extend parity protections to most large group plans, self-funded or insured, that choose to offer behavioral health coverage (most do),¹¹² as well as all individual and small group

¹⁰⁵ *Id.* § 1185a(b)(1); 42 U.S.C. § 300gg-26(b)(1).

¹⁰⁶ 42 U.S.C.A. § 18022 (West 2014).

¹⁰⁷ 29 U.S.C. § 1185a.

¹⁰⁸ *Id.*

¹⁰⁹ See 42 U.S.C. § 18031(c) (extending MHPAEA coverage to “qualified health plans” offered to individuals and small groups).

¹¹⁰ 42 U.S.C.A. § 18022.

¹¹¹ *Id.*

¹¹² See KIRSTEN BERONIO ET AL., OFF. OF ASSISTANT SEC’Y FOR PLANNING & EVALUATION, DEP’T OF HEALTH & HUMAN SERVS., AFFORDABLE CARE ACT WILL EXPAND MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND PARITY PROTECTIONS FOR 62 MILLION AMERICANS 1 (Feb. 2016), http://www.integralcare.org/sites/default/files/files/Mental_health_parity_final_19Feb20151%20v5.pdf (“[A]lmost all large group plans and most small group plans include coverage for some mental health and substance use disorder services[.]”).

plans.¹¹³ As a result, the final MHPAEA regulations, adopted for plan years beginning in 2014,¹¹⁴ apply to most health coverage.

Furthermore, the regulations add detail to the statutory definition of parity. Determining whether a plan is “no more restrictive” when setting treatment or day limits and cost sharing for behavioral health services requires scrutiny of categories of coverage, including inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drug.¹¹⁵ Cost sharing and treatment limits for each of those six types of services, then, must be comparable between physical and behavioral health services. For example, a plan cannot, consistent with the parity rule, impose a coinsurance charge for an out-of-network inpatient mental health stay that exceeds that for a comparable stay for cardiac care, and limits on in-network outpatient visits must be at least as generous for substance use disorder as they are for hypertension care.¹¹⁶

These numerical, or “quantitative” limits on coverage are important, and relatively easy to assess, as the amount of copayments and the extent of treatment limits can be measured and evaluated for differential treatment. As drafters of the final regulations discerned, however, some instances of plan management are more difficult to describe and assess.¹¹⁷ In addition to quantitative limits on coverage, plans may use non-quantitative treatment limits (“NQTLs”).¹¹⁸ The regulations provide a non-exhaustive list of NQTLs, including medical management standards limiting or excluding benefits based on medical necessity, formulary design, network tier design, standards for in-network status for providers, reimbursement rates for different providers, use of fail-first or step therapy, exclusions based on failure

¹¹³ See 29 U.S.C. §§ 1185a(1)–(2) (2012); 42 U.S.C. § 18031(c).

¹¹⁴ Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,252 (Nov. 13, 2013).

¹¹⁵ 45 C.F.R. § 146.136(c)(2)(ii) (2014).

¹¹⁶ *Id.* §§ 146.136(c)(2)–(3).

¹¹⁷ See 78 Fed. Reg. 68,240, 68,244–45 (noting that the final rules pulled back from the endorsement of certain “clinically appropriate standards of care” as a basis for allowing differentials between physical and behavioral non-quantitative treatment limits, but recognizing that some flexibility for clinical appropriateness will be recognized).

¹¹⁸ 45 C.F.R. § 146.136(c)(4) (illustrating, with examples, the meaning of “non-quantitative treatment limits”).

to complete a course of treatment, and restrictions based on facility type or provider specialty.¹¹⁹

The use of these tools for plan management can be innocent, and even consistent with proper insurance practices. It is, for example, proper for an insurer to refuse payment for treatment in a context for which there is no medical or scientific justification, and it can be appropriate to exclude from a network a professional with a history of providing substandard care.¹²⁰ On the other hand, it is clear that these NQTLs present an opportunity for discriminatory treatment. Objective measurement of medical necessity is elusive at best, for example, and it is challenging to disentangle the many factors that go into formulary management to discern disparate intent or effect.¹²¹

Evaluation of the use of NQTLs is likely to be a flash point for behavioral health parity for the foreseeable future.¹²² Coverage for behavioral health services has come a long way. Over time, the practice of excluding people with a history of mental illness or substance use disorder from insurance enrollment has found disfavor,¹²³ and the passage of the ACA seems to have irrevocably ended that form of exclusion from coverage. As federal and state parity laws evolve, exclusions of and restrictions on behavioral health coverage in health plans have come under greater scrutiny, and advocates for the rights of people with behavioral health conditions have acquired more legal tools to challenge disparate plan design.¹²⁴

The stakes are high. As is true for all people with significant chronic illness, people with mental illness or substance use disorder

¹¹⁹ *Id.*

¹²⁰ See Dolgin, *supra* note 78, at 438–42; see also 45 C.F.R. § 146.136(c)(4)(iii)(Example 8) (describing, with approval, uniformly applied “medical management” techniques, including assessing the quality of the provider and the “clinical efficacy” of the treatment).

¹²¹ See Dolgin, *supra* note 78, at 438–44.

¹²² See generally Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addictions Equity Act End the Discrimination?* 43 GOLDEN GATE U.L. REV. 179 (2013) (discussing whether the MHPAEA will fulfill its promise of equitable health care coverage).

¹²³ *Id.* at 181–83.

¹²⁴ *Id.* at 255–57.

can be quite expensive to insure.¹²⁵ In addition, insurers have long asserted that providing broad behavioral health benefits encourages marginally necessary consumption of services more significantly than does providing broad physical health services.¹²⁶ Further, insurers have feared that offering generous behavioral health benefits would attract high-cost patients with behavior health needs wishing to consume such services.¹²⁷ The disparity in the cost of coverage for those with and without behavioral health conditions, and insurers concerns for excessive consumption of services, creates an incentive—whether or not it is acted upon—for insurers and sponsors of health plans to cut corners on behavioral health care. Such stinting would serve two (illicit) purposes: it would immediately cut costs; and it would drive expensive insureds away to competitor plans.¹²⁸ Risk adjustment and reinsurance mechanisms notwithstanding, plans have much to gain by disparately treating behavioral health care. For that reason, the thoughtful enforcement of the ban on improper use of NQTLs will be essential.¹²⁹

The final regulations have created a thoughtful starting point for enforcement of equitable treatment in this area. The regulations require that NQTLs be employed in behavioral health care in a manner that is “comparable to, and are applied no more stringently than” the application of those limits in physical health care.¹³⁰ Regulators will attempt to apply that standard so as to sensitively permit proper utilization management by plans, while still guarding against

¹²⁵ See Eric Q. Wu et al., *The Economic Burden of Schizophrenia in the United States in 2002*, 66 J. CLINICAL PSYCHIATRY 1122, 1122 (2005) (cost of schizophrenia care in U.S. in 2002 was over \$22 billion); Kathleen M. Schneider et al., *Prevalence of Multiple Chronic Conditions in the United States' Medicare Population*, 7 HEALTH & QUALITY LIFE OUTCOMES 82 (2009), <http://hqlo.biomedcentral.com/articles/10.1186/1477-7525-7-82> (noting that the cost of care for Medicare patients increases with the number of chronic conditions).

¹²⁶ Weber, *supra* note 122, at 193–94.

¹²⁷ *Id.*

¹²⁸ *Id.* at 194.

¹²⁹ The final regulations were published at 78 Fed. Reg. 68,240 (Nov. 13, 2013). For discussion of the issues raised by the final regulations, see John V. Jacobi et al., *Health Insurer Market Behavior after the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform*, 120 PENN. ST. L. REV. 109 (2015); Weber, *supra* note 122.

¹³⁰ 45 C.F.R. § 146.136(c)(4) (2014).

discrimination, in a new guise, against people with behavioral health conditions.¹³¹

As discussed above, the ACA significantly amplified the effects of the MHPAEA by extending mental health parity to individual and small group insurance.¹³² The ACA accomplishes that extension by including mental health and substance use disorder services on the list of ten EHBs that must be included in individual and small group plans.¹³³ While many of the services included in the list of EHBs are routinely covered by all health insurance, the addition of mental health and substance use disorder services solidified the growing social consensus that omitting these services renders a plan substantively inadequate.¹³⁴ Implementation of this substantive requirement is essential to the lives of people with behavioral health conditions.¹³⁵

The details of what services would be required to be covered within each EHB category was left to the Secretary of the U.S. Department of Health & Human Services (“DHHS”).¹³⁶ The Secretary was charged with ensuring that the coverage is “equal to the scope of benefits provided under a typical employer plan.”¹³⁷ Disappointing some, the Secretary largely left it at that, allowing any plan mirroring the “benchmark plan,”¹³⁸ subject to some minor augmentation, to be

¹³¹ See *id.*

¹³² See *supra* text at notes 109–14.

¹³³ 42 U.S.C.A. § 18022 (West 2014).

¹³⁴ See Richard G. Frank et al., *The Politics and Economics of Mental Health “Parity” Laws*, 16 HEALTH AFF. 108, 112–13 (1997) (describing growing support for mental health parity in state legislatures, Congress, and among the public); Kristina W. Hanson, *Public Opinion and the Mental Health Parity Debate: Lessons From the Survey Literature*, 49 PSYCHIATRIC SERV. 1059, 1066 (1998) (describing public support for some but not all aspects of parity); see also Bernice A. Pescosolido, “A Disease Like Any Other”? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence, 167 AM. J. PSYCHIATRY 1321, 1325 (2010) (reporting shifts in public perception of people with mental illness).

¹³⁵ See Weber, *supra* note 122, at 200–04; Jacobi, *supra* note 60, at 189–90.

¹³⁶ 42 U.S.C.A. § 18022(b)(1).

¹³⁷ *Id.* § 18022(b)(2)(A).

¹³⁸ See Ctr. for Consumer Info. & Ins. Oversight, *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/ccio/resources/data-resources/ehb.html> (last visited July 23, 2016) (providing guidance on each state’s benchmark plan).

deemed compliant with the essential health benefits provisions.¹³⁹ This result was frustrating because the EHB listing was seen as implicit criticism of the content of many plans, and an indication that Congress expected plans in the future to comport with a national standard of coverage, yet the Secretary's response ran the risk of allowing the content of plans to remain largely unchanged, leaving most of the pre-ACA deficits in place.

By incorporating the protections of the MHPAEA, hope was raised that the ACA could work meaningful change in plan design, and that the Secretary's regulations would reinforce the conceptual difficulties in maintaining the explicit goal of the statute, which is to improve access to insurance coverage for people with behavioral health conditions. So, how does one determine the relevant comparators? How does one determine whether mental health access is "equal" to physical health access? The QTL and NQTL provisions go a long way, but they do not assure the realization of access embodied in the EHB formulation.¹⁴⁰

If a plan is less likely to find an in-patient stay medically appropriate for anorexia nervosa or opioid detoxification than for cardiac disease, is the plan operated in a way that is unequal, and therefore in violation of parity requirements? The obvious substantive goal of the EHB provisions of the ACA was to make sure that all relevant plans provide appropriate services in each of the EHB categories to all insureds.¹⁴¹ The MHPAEA requires quantitative parity

¹³⁹ The Secretary announced this method of defining EHBs through an informal Bulletin. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 1 (Dec. 2011) [hereinafter ESSENTIAL HEALTH BENEFITS BULLETIN], https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf. The informality of the publication raises some concerns, as did the ceding of the definition of the ACA's EHB provisions to existing health plans. See Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J.L. HEALTH POL., POL'Y & L. 441 (2014). The Secretary subsequently promulgated regulations, which incorporated the benchmark plan methodology of the Bulletin. 45 C.F.R. §§ 156.100, 156.110 (2014).

¹⁴⁰ See generally Meiram Bendat, *In Name Only? Mental Health Parity or Illusory Reform*, 42 PSYCHODYNAMIC PSYCHIATRY 353 (2014) (examining how lax regulatory enforcement and low consumer sophistication contribute to continued deprivation of insurance coverage for mental health and substance abuse treatment).

¹⁴¹ See Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,857-58 (Feb. 25, 2013) (describing purpose of ACA's EHB provisions); see also ESSENTIAL HEALTH BENEFITS BULLETIN,

between treatment limits applied to physical and behavioral care,¹⁴² protecting people with behavioral conditions from facing higher out of pocket costs for behavioral than for physical health care. The combination of the MHPAEA's parity provisions and the ACA's extension of that parity provision to small and individual health insurance, then, provides assurance that people with behavioral health needs will no longer be denied coverage or suffer disparate out-of-pocket costs for their care. The remaining challenge for parity is ensuring that plans do not use non-quantitative methods, such as medical necessity review, to deny a behavioral service (anorexia nervosa care) under circumstances in which it would not deny physical care (cardiac care).

To address this last component of parity, MHPAEA requires, as is described above,¹⁴³ parity in non-quantitative treatment limits.¹⁴⁴ It is the interpretation of these non-quantitative treatment limits that will determine the extent to which MHPAEA and the ACA will protect people with behavioral health needs from disparate treatment at the medical necessity stage. The task of ensuring that parity principles do the work of eliminating disparate treatment limits for behavioral health will be a difficult one for regulators and the regulated community.

How will the application of these statutes fare? The dispute over non-quantitative limits is at least in part about plans' use of medical necessity judgments to restrain the use of care to reduce costs.¹⁴⁵ If medical necessity is, as many commentators suggest, indeterminate at its core, then attempts to regulate its use, including attempts to mandate parity in its use in behavioral health cases, are likely to fail. The concerns for its indeterminacy are substantial; one commentator opined that "medical necessity determinations depend on the knowledge, politics, motives, and inclinations of those who render

supra note 139, at 8 (describing purposes of EHB provisions).

¹⁴² 29 U.S.C. § 1185a(3)(A)(i) (2012).

¹⁴³ *See supra* text at notes 141–42.

¹⁴⁴ 29 U.S.C. § 1185a(3)(A)(ii).

¹⁴⁵ *See* 45 C.F.R. § 146.136(c)(4)(A) (2014) (putting forth the first in the parity regulations' illustrative list of permissible (if non-disparately applied) non-quantitative treatment limits: "Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness[.]").

them far more than they depend on objective truths.”¹⁴⁶ And as the leading legal commentator on medical necessity trenchantly observed,

[A]mbiguity in the interpretation of medical necessity is inevitable, especially in the private, pluralistic health care system that will exist in the United States for the foreseeable future. This counsels against mandating intricate, but supposedly less ambiguous, definitions of medical necessity. . . . If the serious problems of resource allocation underlying the notion of medical necessity are not well-suited either for free-market contracting or political resolution, but are more matters of professional ethics and social norms, one should not rely on medical necessity to set strict boundaries. Instead, one should look for other ways to control costs and assure quality in insured systems.¹⁴⁷

If these pessimistic views of the coherence of medical necessity are correct, then the goal of behavioral health parity is only partly solved by the MHPAEA and ACA. Those statutes substantially limit the ability of insurers to exclude behavioral health care from plans, or rather the ability to saddle people with behavioral health needs with high out of pocket costs. But they may be inadequate in controlling case-by-case disparate treatment. If medical necessity judgments are sufficiently ungovernable then claims of disparate treatment in behavioral care treatment cases are unlikely to be subject to convincing proof. As Professor Sage suggests, it may be that medical necessity judgments are simply unsuited to the task of preventing wasteful use of behavioral health services.¹⁴⁸

III. IOC: THE CLASH BETWEEN CIVIL RIGHTS AND SUBSTANTIVE EQUALITY

The right to direct one’s own medical care is well established in American law.¹⁴⁹ Even in situations where treatment is necessary to sustain life, common law and constitutional principles empower a

¹⁴⁶ Dolgin, *supra* note 78, at 443.

¹⁴⁷ Sage, *supra* note 79, at 604–05.

¹⁴⁸ *Id.*

¹⁴⁹ See Garrison, *supra* note 14, at 797 (explaining that courts have developed the doctrine of “informed consent” to protect the patient’s right to make a decision based on accurate information about the risks and benefits of the procedure in question).

competent adult the right to refuse that treatment.¹⁵⁰ That right has been recognized in many cases involving medical treatments.¹⁵¹ The difficult cases tend to be those in which a patient has lost the capacity to consent, requiring courts to struggle with nebulous determinations of what the patient would choose if competent, or what course of action is in the incompetent patient's best interest.¹⁵² The law is generally solicitous of a patient's right to refuse treatment if he or she has not been determined to be incompetent to make such a treatment choice.¹⁵³ Some older cases limited the right where a patient's minor children would suffer from the death of the patient, but more recent cases have rejected that exception, more broadly recognizing patient autonomy to accept or reject treatment.¹⁵⁴

Our society and our courts have not yet settled the question of when people with mental illness retain or lose that right.¹⁵⁵ The confused social understanding of the treatment autonomy rights of people with mental illness is highlighted in two contexts. First, the law is unsettled on whether, and to what extent, rights to treatment choice may be exercised by patients who have been involuntarily committed to a psychiatric hospital, but have not been determined by a court to

¹⁵⁰ *Id.*

¹⁵¹ *See id.*

¹⁵² *See Lois Shepherd, The End of End-of-Life Law*, 92 N.C. L. REV. 1693, 1702-03 (2014).

¹⁵³ *Id.* at 1697-98.

¹⁵⁴ *In re President & Dirs. of Georgetown Coll., Inc.*, 331 F.2d 1000 (D.C. Cir. 1964) (providing an example of a case limiting a patient's range of choices to prevent harm to her children); *but see Fostire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990) (providing an example of a more recent case rejecting that exception to the general autonomy rule). For cases on the general right to refuse treatment, *see Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (1986) (upholding a competent patient's right to refuse life-sustaining treatment); *Lane v. Candura*, 376 N.E. 2d 1232 (Mass. App. 1978) (upholding same right); *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 (1990) (assuming without deciding that Cruzan had a Fourteenth Amendment liberty interest in refusing treatment, finding lack of "clear and convincing evidence" that currently incompetent patient would have chosen to withdraw treatment if competent); *In re Conroy*, 98 N.J. 321, 346-48 (1985) (recognizing common law right to refuse life-sustaining treatment, finding sufficient evidence that currently incompetent patient would have chosen to refuse life-sustaining treatment).

¹⁵⁵ *See Jennifer Honig & Susan Stefan, New Research Continues to Challenge the Need for Outpatient Commitment*, 31 NEW ENG. J. CRIM. & CIV. CONFINEMENT 109, 109-11 (2005) (people with mental illness not in need of hospitalization are forced by laws of many states to accept medication treatments).

have lost decisional capacity to direct their medical care.¹⁵⁶ Second, the definition of involuntary commitment itself has been changing in recent decades, broadening to such an extent as to allow the involuntary treatment, in a psychiatric hospital, of people who have not even been determined to be sufficiently dangerous to themselves or others.¹⁵⁷

It was long the practice of mental health practitioners to conflate the determination that a person is subject to involuntary commitment (usually after a court finding that he is an imminent danger to himself or others) with the decision that the committed person was simply incompetent to make treatment decisions.¹⁵⁸ On the surface, that conflation was understandable, as the decision to commit is a weighty one involving a dramatic loss of liberty, and it was widely assumed that the arguably greater deprivation (involuntary hospitalization) implied the arguably lesser one (loss of decisional power).¹⁵⁹ In practice, the untangling of those two issues has been controversial.¹⁶⁰ As courts have been confronted with challenges to the logic of that chain of reasoning, the two issues have been separately considered, with mixed results.¹⁶¹

Analysis of the federal right to due process, which an involuntarily committed patient is entitled to, finds its origins in cases involving prisoners.¹⁶² When explaining the extent to which committed patients have rights to refuse drug treatment, federal courts tend to rely on *Washington v. Harper*. In *Harper*, a state prisoner was

¹⁵⁶ See Klein, *supra* note 17, at 564–66.

¹⁵⁷ See Perlin, *supra* note 63, at 187–91.

¹⁵⁸ See Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1178–80 (1997).

¹⁵⁹ *Id.*

¹⁶⁰ See, e.g., Erin Talati, *When a Spoonful of Sugar Doesn't Help the Medicine Go Down: Informed Consent, Mental Illness, and Moral Agency*, 6 IND. HEALTH L. REV. 171 (2009); Jennifer Colangelo, *The Right to Refuse Treatment for Mental Illness*, 5 RUTGERS J.L. & PUB. POL'Y 492 (2008); William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937 (1998); Grant H. Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343 (1995).

¹⁶¹ See *infra* text at notes 162–74 (discussing *Washington v. Harper* and *Disability Rights New Jersey, Inc. v. Comm'r*).

¹⁶² *Washington v. Harper*, 494 U.S. 210, 214 (1990).

housed in a prison's mental health unit, where he initially consented to the administration of antipsychotic drugs.¹⁶³ When he later revoked his consent to treatment, a committee of prison employees, including a psychiatrist, psychologist, and prison administrator, found that he "suffer[ed] from a mental disorder and [was] gravely disabled or dangerous."¹⁶⁴ In response to the prisoner's claim that his rights under the Due Process Clause of the Fourteenth Amendment protected his right to choose, the Washington State Supreme Court agreed, finding that the prisoner's liberty interest in controlling his medical treatment entitled him to judicial process through which the state could be required to prove by "clear, cogent, and convincing evidence" that the administration of medication to a competent, nonconsenting prisoner was "both necessary and effective for furthering a compelling state interest."¹⁶⁵

On review, the United States Supreme Court disagreed, finding that the prison's process amply protected the prisoner's due process rights.¹⁶⁶ The Court's majority assumed that the treating psychiatrist would only prescribe appropriate medications and that the committee of prison employees was an appropriate body to review the treating psychiatrist's judgment.¹⁶⁷ Furthermore, the Court determined that the panel's decision was a mixed medical and penological one, a range of issues into which courts should be reluctant to enter.¹⁶⁸ While the Court acknowledged that the prisoner's liberty interest in medical autonomy was substantial, it found the prison's process constitutionally adequate, thereby permitting the involuntary medication of a competent prisoner without providing access to any judicial or quasi-judicial process.¹⁶⁹

Harper could have been regarded as an anomalous case, limited in its application to prisoners, but the rationale of *Harper* has been applied

¹⁶³ *Id.*

¹⁶⁴ *Id.* at 210.

¹⁶⁵ *Id.* at 214–19.

¹⁶⁶ *Id.* at 227.

¹⁶⁷ *Id.* at 233–34.

¹⁶⁸ *Id.* at 235–36.

¹⁶⁹ *Id.*

more broadly, by courts faced with federal due process challenges from competent civilly-committed persons, to the involuntary administration of drugs.¹⁷⁰ In *Disability Rights New Jersey, Inc. v. Commissioner*, for example, the United States Court of Appeals for the Third Circuit applied *Harper* to a claim by patients involuntarily committed to a psychiatric hospital.¹⁷¹ The court found that permitting the hospital's medical and administrative personnel, and not the judiciary, to review involuntary treatment decisions was appropriate because the decision was largely a "medical" one.¹⁷² In explaining why the *Harper* standard was appropriate, the court elided the distinction between the dangerousness standard that must be met for *commitment* purposes, and the capacity standard that must be met for *competency* purposes:

It would be passing strange if due process were to permit the State to forcibly medicate a criminal whose conviction bears no suggestion of physical dangerousness without a judicial hearing, while mandating judicial hearings for mentally ill people who have already been adjudicated to be so dangerous as to require civil commitment.¹⁷³

The modern doctrine of informed consent – accepted in many but not all American jurisdictions – is interpreted as empowering patients to make decisions on treatment autonomously, even when those decisions run counter to the medical advice they receive.¹⁷⁴ Under this doctrine, physicians are obliged to disclose information material to the patient's decision-making process because treatment decisions involve a mixture of expert information (provided by the physician) and patient preference.¹⁷⁵ After obtaining expert advice from their physician, the doctrine recognizes that patients have the right to make decisions according to their own risk tolerance, life goals, and personal circumstances.¹⁷⁶ In other words, while the advice is expert, the

¹⁷⁰ See *Disability Rights N.J., Inc. v. Comm'r*, 796 F.3d 293, 307-10 (3d Cir. 2015).

¹⁷¹ *Id.*

¹⁷² *Id.* at 310.

¹⁷³ *Id.* at 307.

¹⁷⁴ See Garrison, *supra* note 14, at 785-87.

¹⁷⁵ *Id.* at 786.

¹⁷⁶ *Id.* at 785-86.

weighing of options (e.g., tolerance for side-effects, particular aversion to possible negative outcomes, and aversion to the possibility of becoming dependent on others) is not, and is therefore properly within the patient's power. Under this reasoning, Harper's ability to make a choice to accept or reject the side-effects that accompany psychoactive medications, while informed by expert medical input, should be regarded as an expression of self-determination, not a "medical" judgment.¹⁷⁷

The informed consent doctrine is rooted in the "concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body[.]'"¹⁷⁸ For all but those with cognitive impairments (and children), the modern informed consent doctrine regards treatment decision-making as a personally held right, i.e., not a medical matter, with competent patients empowered to overrule medical judgment as to the wisdom or necessity of treatment.¹⁷⁹ Denying this autonomy right to children, of course, is an exercise in paternalism.¹⁸⁰ So too in regards to people without the capacity to understand the substance and ramifications of medical choices.¹⁸¹ But *Harper* extends that judgment to those with mental illness regardless of a determination of competency.¹⁸² People with mental illness have conditions that implicate the nature and quality of their cognitive abilities, and courts that deny autonomy rights to people with mental illness, without more, likely believe that these cognitive differences

¹⁷⁷ See generally Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994) (examining the origins and prominence of informed consent doctrine in American legal thought).

¹⁷⁸ *Canterbury v. Spence*, 464 F.2d 772, 780 (1972) (quoting *Schoendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.)). Not all jurisdictions accept the patient-centered doctrine of informed consent. About half of the states continue to treat the choice of treatment as largely a medical one. See Jaime S. King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Decision-Making*, 32 AM. J. LAW & MED. 429, 440 (2006).

¹⁷⁹ See Garrison, *supra* note 14, at 785–87.

¹⁸⁰ See Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEVELOPMENT 1589, 1589 (1982) (citing *Parham v. J.R.* 442 U.S. 584 (1979)) (noting the reasons for deeming children not competent to make health care decisions).

¹⁸¹ See Bernard Lo, *Assessing Decision-Making Capacity*, 18 LAW, MED. & HEALTH CARE 193, 194 (1990).

¹⁸² *Washington v. Harper*, 494 U.S. 210, 227 (1990).

render paternalism as appropriate for people with mental illness as it is with children.¹⁸³

However, not all courts acquiesce in this paternalistic assumption. Several state courts, interpreting state law, reject the notion that involuntary commitment permits a competent person with mental illness to be involuntarily medicated as a matter of medical judgment.¹⁸⁴ Instead, these courts require judicial process to overcome the objections of a committed person to a course of treatment, which is the requirement for any non-mentally ill person whose treatment judgments are challenged.¹⁸⁵ These courts require a judicial determination either that the patient is incompetent (in which case a guardian would be appointed in the normal course to make treatment decisions) or that a court review, as to whether the patient is an imminent threat to himself or others without the forcible treatment, is necessary.¹⁸⁶

The impulse to protect the mentally ill from their own bad choices has some plausible basis, especially when one considers that we limit the decision-making power of people in categories that bespeak diminished decision-making ability, such as children and people determined by a court to be incompetent. However, *Harper* and *DRNJ* involve people in neither of those categories, but, instead, mark a third category: people with mental illness who have not been found incompetent, but have been physically committed to a psychiatric institution.¹⁸⁷ Since the law presumes competence absent a judicial finding to the contrary,¹⁸⁸ the new category of paternalistic intervention should require some justification. But those generally relied on by courts—relative accuracy of medical treatment choices and the inconvenience of invoking judicial process—would swallow

¹⁸³ See *Lo*, *supra* note 181, at 194–95.

¹⁸⁴ See, e.g., *Rivers v. Katz*, 495 N.E. 2d 337, 337–38 (N.Y. 1986); *Rogers v. Comm’r*, 448 N.E. 2d 308, 343 (Mass. 1983).

¹⁸⁵ See, e.g., *Rivers*, 495 N.E. 2d at 337; *Rogers*, 448 N.E. 2d at 343.

¹⁸⁶ See, e.g., *id.*

¹⁸⁷ *Washington*, 494 U.S. at 214; *Disability Rights N.J., Inc. v. Comm’r*, 796 F.3d 293, 307–08 (3d Cir. 2015).

¹⁸⁸ See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 21–22 (1991).

the rule entirely, if taken at face value.¹⁸⁹ Instead, the real justification is likely simple paternalism in the form of a seldom-articulated belief that people with mental illness, serious enough to justify involuntarily commitment, categorically and substantially lack decision-making capacity.¹⁹⁰ But this seldom-discussed tendency toward paternalism finds more explicit expression in a related area: involuntary outpatient commitment.¹⁹¹

The involuntary commitment process for people with serious mental illness has undergone a number of changes over the last fifty years.¹⁹² Prior to the 1960s, hospital commitment often followed a somewhat circular finding that the patient was “in need” of inpatient psychiatric care.¹⁹³ With the advent of effective medications and the emergence of the due process revolution after mid-century, the standard generally shifted to one of “dangerousness,” and permitted the state to exercise its police power when the patient was dangerous to others, or its *parens patriae* power when the patient was dangerous to himself.¹⁹⁴ Allegations that these standards were too restrictive, allegedly leading to the emergence of a class of homeless people unable to care for themselves, but still not presenting an imminent danger, led to further change, eventually resulting in more relaxed standards of dangerousness and the allowance of commitment on the grounds of self-neglect presenting a *threat* of grave harm.¹⁹⁵

One important development in civil commitment law over recent years is the expansion of Involuntary Outpatient Commitment

¹⁸⁹ See Lo, *supra* note 181, at 198.

¹⁹⁰ See generally David D. Doak, Note, *Theorizing Disability Discrimination in Civil Commitment*, 93 TEX. L. REV. 1589 (2015) (exploring the reforms needed to ensure the fairness of “commitment” as a legal institution).

¹⁹¹ See Player, *supra* note 19, at 211–12.

¹⁹² See Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 80–93 (1991).

¹⁹³ See John K. Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCHOL. PUB. POL’Y & L. 377, 380–82 (1998).

¹⁹⁴ *Id.* at 377–78.

¹⁹⁵ See Stone, *supra* note 65, at 323.

("IOC").¹⁹⁶ In several ways, states' commitment laws have expanded to apply to persons with mental illness who are not consigned to inpatient facilities and are allowed to remain in the community.¹⁹⁷ One common thread running through various forms of IOC is that it entails a judicial order that the committed person regularly receive described mental health treatment from a specified provider of care.¹⁹⁸

The initial, and long-standing, form of IOC has been uncontroversial.¹⁹⁹ Many states have long mandated community treatment for inpatient committed persons when they are conditionally released to the community. Under conditional release, an inpatient committed person is permitted provisional return to the community prior to full release, in order to provide gradual reintegration into society.²⁰⁰ This conditional release is consistent with the general requirement that civil commitment be maintained under the least restrictive environment consistent with the committed person's condition.²⁰¹ Conditional release permits the committed person to live in the community so long as he meets a set of treatment goals.²⁰² Beyond those presented by inpatient commitment, this first form of IOC raises few autonomy concerns. Therefore, as a formal matter, claims to a right to refuse treatment would be treated consistent with the analysis applied to the right in the inpatient context, where the analysis is split between treating such a claim as a medical matter, permitting a resolution process controlled by physicians, and treating it as a matter giving rise to the right to a

¹⁹⁶ See Player, *supra* note 19, at 174–78. IOC is sometimes referred to as "outpatient commitment" ("OP" or "OPC"), "assisted outpatient treatment" ("AOT"), and "assisted outpatient commitment" ("AOPC"). See Player, *supra* note 19, at 163; Honig & Stefan, *supra* note 155, at 109–11; Bruce J. Winnick et al., *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as a Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 183–84 (2003). This Article uses "IOC" or "involuntary outpatient commitment."

¹⁹⁷ Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 58 (2014).

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.* at 59–60.

²⁰² See Player, *supra* note 19, at 175–76; Boldt, *supra* note 197, at 58; Bruce Winnick et al., *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL'Y & L. 94, 96 (2003) [hereinafter Winnick, *IOC*].

judicial determination in the first instance.²⁰³ Of course, as a practical matter, “parole” still might not be granted to a non-compliant committed person.²⁰⁴

By contrast, the second form of IOC does raise substantial new autonomy concerns for people with mental illness. Under this form, IOC is ordered a less protective substantive standard than that which applied to inpatient commitment. While inpatient commitment may require a finding of dangerousness to self or others, outpatient commitment may be ordered under easier-met standards.²⁰⁵ One such standard requires a showing of mental illness, ability to survive in the community with treatment, and the need for treatment to prevent deterioration that would “predictably lead to dangerousness.”²⁰⁶ Such a standard is less stringent than one that requires a showing of current or imminent dangerousness, and therefore represents an extension of states’ power over people with mental illness.²⁰⁷

²⁰³ Compare text at notes 57–66 (medical determination in the first instance) with text at note 67 (legal determination in the first instance).

²⁰⁴ Boldt, *supra* note 197, at 60.

²⁰⁵ Player, *supra* note 19, at 175–82.

²⁰⁶ Player, *supra* note 19, at 181 (quoting N.C. GEN. STAT. ANN. § 122C-263(d)).

²⁰⁷ See *id.* at 176; Boldt, *supra* note 197, at 58–60; Winick, *IOC*, *supra* note 202, at 95. A third, intermediate form of IOC, with aspects of the first two, is identified by some scholars. In this intermediate form of IOC, outpatient care is ordered from the outset of commitment (as in the second form of IOC described in the text), but the *standard* of commitment (as in the first form of IOC described in the text) is not broadened beyond that applied for inpatient commitment. Most commentators regard this intermediate form of IOC as creating no autonomy questions for committed person beyond those posed by the first (conditional release), as it applies the stringent standard for commitment applicable to inpatient commitment. See Player, *supra* note 19, at 176; Boldt, *supra* note 197, at 58–60; Winick, *IOC*, *supra* note 202, at 95. A danger is potentially presented in this intermediate form, however. A court would apply the same *formal* standard in this intermediate form of IOC as is applied to inpatient commitment, the argument goes, and therefore the committed person is protected by ample process, and committed persons only benefit as they would be institutionalized absent an outpatient option. See Boldt, *supra* note 197, at 174–75. It is reasonable to predict, however, that a judge may be marginally more likely to grant a petition for commitment if it is “only” a commitment for outpatient treatment and not inpatient confinement. If this supposition is true, more people with mental illness will face involuntary medication due to this intermediate form of IOC than would without it. This supposition is subject to empirical examination that has not been undertaken to the Author’s knowledge, and is at any rate beyond the scope of this Article.

If it is true that the first form of IOC raises no new autonomy concerns for people with mental illness, because it applies the same standard of commitment as is applied to inpatient commitment, then the same cannot be said for the second form of IOC. The second form of IOC applies, by design, a lesser commitment standard, one which is not applied to inpatient commitment.²⁰⁸ Courts have been consistent in finding that IOC laws comport with the due process rights of people with mental illness.²⁰⁹ Even so, the move from conditional release from a psychiatric hospital to mandatory outpatient medication for those not subject to inpatient commitment is nevertheless a significant one, as it represents a paternalism creep that should only be legitimized after it is measured against the disability rights goals of fostering autonomy and facilitating human flourishing.²¹⁰

IOC regimes are supported by genuine humanistic tendencies.²¹¹ People with serious mental illness have experienced the breaking of the social compact that was reached when asylum doors were opened in the mid-twentieth century, freeing hundreds of thousands of people from confinement.²¹² Many of those deinstitutionalized required continuing care in the community, so the closing of the asylums was coupled with a variety of programs to provide that care.²¹³ However, those programs have never been sufficiently funded or implemented, leaving many persons with serious mental illness without appropriate community supports.²¹⁴ That being the case, is IOC a net benefit or detriment to social integration?

If the rejection of IOC were to foster more inpatient commitments and hospital care for people with mental illness, the integrative goals

²⁰⁸ See Player, *supra* note 19, at 175–82.

²⁰⁹ See, e.g., *In re K.L.*, 806 N.E.2d 480 (N.Y. 2004); *Wisc. v. Dennis H.*, 647 N.W.2d 851 (Wisc. 2002); *In re LaBelle*, 728 P.2d 138 (Wash. 1986); see also Jeffrey Geller & Jonathan A. Stanley, *Settling the Doubts About the Constitutionality of Outpatient Commitment*, 31 NEW ENG. J. CRIM. & CIV. CONFINEMENT 127 (2005); Kress, *supra* note 66.

²¹⁰ See Honig & Stefan, *supra* note 155, at 119–20.

²¹¹ See generally Cornwell et al., *supra* note 66.

²¹² See H. Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & CMTY. PSYCHIATRY 899 (1984).

²¹³ See Player, *supra* note 19, at 167–69.

²¹⁴ See Lamb, *supra* note 212, at 902–03.

of the disability rights movement in general, and the ADA in particular, would be frustrated.²¹⁵ It may be that some people experiencing serious, potentially dangerous, psychiatric symptoms need some intervention, and outpatient intervention might be both the most effective and the least restrictive alternative. In those cases, paternalistic intervention would be warranted, and the application of IOC is appropriate. In other cases, the facts may not warrant state intervention in the decision-making of a person with mental illness, no matter how unwise his behavior seems to be. If this case is carefully examined on its facts, and not through a lens of stereotypic and dismissive views of mental illness, a judge may acknowledge the difference in the mentally ill person, while nevertheless finding that difference an insufficient basis on which to deprive the person of his or her decisional autonomy.

If the availability of IOC leads to less restrictive treatment of people who meet a commitment standard, to that extent IOC is a positive, rather than a negative, step and is consistent with the desegregation mandate of the ADA as interpreted by *Olmstead*.²¹⁶ So far so good, but there is another possible outcome. Without IOC, judges are left with a stark choice: find that a person meets the commitment standard and consign him or her to a psychiatric hospital, or refuse to make such a finding and allow the person to go home. The existence of IOC creates a middle ground. Without it, courts may redirect some committed people from psychiatric hospitals to outpatient care, or judges may rethink the marginal cases, that previously would have led to freedom, and instead commit those people to outpatient care. Whether the standard contemplates this phenomenon or not, a judge is likely to have a lower threshold for outpatient than for inpatient care, thereby leading to the possibility of more deprivation of autonomy for people with mental illness.²¹⁷

²¹⁵ See *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999) (finding that the ADA recognized that “unjustified institutional isolation of persons with disabilities is a form of discrimination”); see also David Ferleger, *The Constitutional Right to Community Services*, 26 GA. ST. U. L. REV. 763 (2010); John V. Jacobi, *Federal Power, Segregation, and Mental Disability*, 39 HOUS. L. REV. 1231 (2003).

²¹⁶ See *Olmstead*, 527 U.S. at 581.

²¹⁷ It has been argued that IOC responds to the wrong problem, as many people with mental illness who become dangerous have not avoided treatment, but rather have sought treatment

Resolving whether and when to resort to IOC requires grappling with a paradox of difference: are people with mental illness improperly being treated differently by IOC, or is it their differences that render IOC acceptable? It may be that deprivation of autonomy for people with mental disabilities is a continuation of the historic treatment of the mentally ill as a second-class of citizens.²¹⁸ As a result, the frequently stigmatizing portrayal in society of mental illness, and our residual fear and distrust of the mentally ill, may explain their differential treatment.²¹⁹ If so, then the ADA might have something to say about this differential treatment, as the ADA was intended by Congress to combat the historical stigma experienced by people with disabilities.²²⁰

Even so, these decisions are only permissible if different autonomy standards apply to people with mental disabilities than apply to others. For those without mental illness, only incapacity or minority permits deprivation of decisional autonomy.²²¹ Therefore, the paternalism justifying forced medication and outpatient commitment for competent people with mental illness subjects them to a unique deprivation of rights. Whether this deprivation is appropriate turns on the resolution of these questions: To what extent should people with mental disabilities be protected in their rights by an autonomy-driven disability law? And how should they be protected from harm by a vision that seeks to assure them, to the extent possible, substantive equality in the pursuit of human flourishing?

out and been poorly served by the delivery system. See Boldt, *supra* note 197, at 52–54. Coercion as a tool to treat people with serious mental illness is not a universally embraced strategy. See Cornwell et al., *supra* note 66, at 231–32 (discussing the Australian intensive, but voluntary, outreach system).

²¹⁸ See REPORT OF THE SURGEON GENERAL, *supra* note 21, at 6.

²¹⁹ *Id.*

²²⁰ See 42 U.S.C. §§ 12101(a)(2)–(3), (5) (2012); see also MARTHA NUSSBAUM, HIDING FROM HUMANITY: DISGUST, SHAME, AND THE LAW 309–11 (2004) (discussing the stigma felt by people with disabilities).

²²¹ See Garrison, *supra* note 14, at 785–87.

CONCLUSION

The development of disability rights theory has particular resonance for people with significant mental illness. For them, equalitarian treatment, even with reasonable accommodations, does little to advance their interests. However, they are, or can be, substantially benefited by a “post-integrationist” view of disability law that recognizes needs peculiar to people with significant disabilities, and attempts to interpret the basic principles of disability law with a leavening of welfare principles. This view offers a path forward for mental health parity, as the genuine differences between physical and mental health treatments suggest a need for affirmative mandates for treatments and procedures particular to mental health.

The road becomes harder with involuntary treatment and outpatient commitment for competent patients with mental illness, because such treatment singles out people with mental illness for deprivation of core autonomy rights without a finding of cognitive incapacity. The motivation for such deprivation is clearly paternalistic, but may be consistent with the goal of providing an opportunity for full human flourishing that is otherwise elusive for those with mental disabilities in our society. Even so, the harm from the deprivation of autonomy is significant, and should be considered a significant counterweight to the gains to physical safety provided by involuntary treatment. The autonomy deprivations seem contrary to the integrationist spirit of the ADA in one sense, as they literally and figuratively set people with mental illness apart. The deprivations could be consistent with the ADA’s integrationist mandate, however, if we regard interactionism literally, and worry that a person who suffers physical harm due to rejection of mental health care, or literal segregation in a mental hospital due to rejection of outpatient commitment, can set a person apart in another, more palpable way.