"To Be a Good Lawyer, One Has to Be a Healthy Lawyer": Lawyer Well-Being, Discrimination, and Discretionary Systems of Discipline

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ABSTRACT

In 2017, a National Task Force on Lawyer Well-Being comprised mostly of representatives from lawyer assistance programs (LAPs) issued a report recommending "modify[ing] the rules of professional conduct to endorse well-being as part of a lawyer's duty of competence." This Article evaluates one of the premises underlying the report's recommendations: "[t]o be a good lawyer, one has to be a healthy lawyer." A review of medical studies and evidence offered by LAPs and others in support of these claims indicates that there is no empirical evidence that substance use and other mental health disorders "are leading causes of malpractice suits and ethical disciplinary actions against attorneys." Further, medical evidence strongly suggests that many lawyer well-being interventions currently being proposed offer little to no mental health benefits and are more likely to prevent than encourage treatment engagement.

This Article then evaluates professional well-being (or wellness) policies, communications, and ideology, focusing specifically on discrimination based on mental health disorders and disabilities. It contends that lawyer well-being policies and communications are likely to result in biased appraisals of lawyers under the American Bar Association's Model Rules of Professional Conduct 1.1, 1.16(a)(2), and 8.3(a), and act as a subterfuge for violating the Americans with Disabilities Act. It also discusses the potential for well-being policies to create and sustain hierarchy, and result in discretionary systems of discipline

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and social control over the private conduct of legal employees. Finally, it concludes with recommendations to reinforce the employment rights of legal employees; eliminate the role of LAPs and associated entities in providing education about mental health and well-being; improve protections from unwarranted mental health inquiries and evaluations; and reject lawyer well-being policies and derogatory rhetoric that put people with mental health disorders and disabilities down.

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INTRODUCTION

It seems like everyone in the legal profession is talking about "lawyer well-being." The number of law review articles on "lawyer well-being" (or "lawyer wellness") increased from 7 per decade in the 1980's and 1990's to 16 (2000–2005), 26 (2005–2010), 66 (2010–2015), and 169 since 2016.[1] American Bar Association (ABA) publications depicting the profession in the midst of a "well-being crisis"[2] seem to be everywhere, with forecasts of crisis based on surveys allegedly suggesting an elevated prevalence of depression and substance use among lawyers and law students. In a 2017 report entitled *The Path to Lawyer Well-Being*, a National Task Force on Lawyer Well-Being (Task Force)—comprised of a majority of members affiliated with lawyer assistance programs (LAPs) and the ABA's

1. HeinOnline search performed on August 21, 2020 of (title:(wellbeing OR well-being OR wellness) AND (lawyer!)).

2. AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS ET AL., REPORT OF THE NATIONAL TASK FORCE ON LAWYER WELL-BEING, THE PATH TO LAWYER WELL-BEING: PRACTICAL RECOMMENDATIONS FOR POSITIVE CHANGE 14 (2017), https://www.americanbar.org/content/dam/aba/images/abanews/ThePathToLawyerWellBeingReportRevFINALpdf [https://perma.cc/6DMS-LRYZ] (last visited Sept. 25, 2020) [hereinafter TASK FORCE REPORT].

Commission on Lawyer Assistance Programs (CoLAP)[3]—cast the stakes for the profession and clients in dire terms:

> To be a good lawyer, one has to be a healthy lawyer. Sadly, our profession is falling short when it comes to well-being. The two studies referenced above reveal that too many lawyers and law students experience chronic stress and high rates of depression and substance use. These findings are incompatible with a sustainable legal profession, and they raise troubling implications for many lawyers' basic competence. This research suggests that the current state of lawyers' health cannot support a profession dedicated to client service and dependent on the public trust.[4]

The authors of the report ("Task Force report") had a solution. They recommended "modif[ying] the rules of professional conduct to endorse well-being as part of a lawyer's duty of competence,"[5] and staked out an expansive role for the Task Force and LAPs in educating members of the legal community about lawyer well-being.[6] Other recommendations included practicing mindfulness and developing personal resilience. But most were the same recommendations that CoLAP and LAPs have been making for years—identifying, reporting, and referring members of the legal community with suspected mental health symptoms to their employers and LAPs.[7] Though the fate of these proposals and activities remains uncertain, they had gained sufficient momentum by December 2018 for ABA

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3. *See* TASK FORCE REPORT, *supra* note 2, at 63–68. The two Task Force Chairs, Bree Buchanan and James C. Coyle, were CoLAP members. Other members included Charles Gruber ("serves on the board of Utah Lawyers Helping Lawyers"); Terry Harrell (LAP director and CoLAP chair); David Jaffe ("served on the D.C. Bar Lawyer Assistance Program including as its chair, and continues to serve on" CoLAP); Tracy Kepler ("was a Commission member"); Patrick Krill ("founder of Krill Strategies, a behavioral health consulting firm exclusively for the legal profession"; "alcohol and drug counselor"; lead author of CoLAP study); Sarah Myers ("Clinical Director of the Colorado Lawyer Assistance Program"); Judge David Shaheed (CoLAP member); William Slease ("served as the chair of the NOBC-APRL-CoLAP Second Joint Committee on Aging Lawyers charged with studying and making recommendations for addressing the so-called 'senior tsunami' of age-impaired lawyers."). Entities represented by the Task Force included CoLAP, the Association of Professional Responsibility Lawyers (APRL), the ABA Standing Committee on Professionalism, the ABA Center for Professional Responsibility, among others. The Task Force was "conceptualized and initiated" by CoLAP, the NOBC, and the APRL. TASK FORCE REPORT, *supra* note 2, at 1.

4. TASK FORCE REPORT, *supra* note 2, at 1.

5. *Id.* at 26 (capitalizations omitted).

6. *See id.* at 4-5. The Task Force recommended that *bar associations* "encourage education on well-being topics in association with lawyer assistance programs;" that *regulators* "expand continuing education requirements to include well-being topics" and "require law schools to create well-being education for students as an accreditation requirement;" that *legal employers* "provide training and education on well-being, including during new lawyer orientation;" and that *law schools* "assess law school practices and offer faculty education on promoting well-being in the classroom," and "provide education opportunities on well-being related topics." (capitalizations omitted). It also recommended well-being education specifically for judges: "[j]udicial associations should invite lawyer assistance program directors and other well-being experts to judicial conferences who can provide programming on topics related to self-care." *Id.* at 23.

7. *See, e.g.*, AM. BAR ASS'N, STANDING COMM. ON LAWYER COMPETENCE, COMM'N ON IMPAIRED ATTORNEYS, REPORT TO THE HOUSE OF DELEGATES 2 (1990), https://www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/ls_colap_model_law_firm_personnel.pdf [https://perma.cc/NJ3F-J6LE] (last visited Sept. 25, 2020) [hereinafter MODEL LAW FIRM IMPAIRMENT 1990], discussed *infra* notes 14, 27, and 33.

President Bob Carlson to publicly reiterate one of the report's core messages—"To be an ethical, competent lawyer, you first need to be a healthy lawyer."[8]

This Article argues that these lawyer well-being policies being promoted by CoLAP and LAPs are very unlikely to improve well-being or mental health for law students and lawyers and instead will have negative effects on those they purport to be helping. Lawyer well-being initiatives are justified and promoted through stigmatization, using misleading, often false claims about the alleged dangers and deficiencies of lawyers with mental health disorders and disabilities to sell well-being interventions and programs that do not work to law firms and law schools. These programs, like other workplace wellness programs, institutionalize disability bias, discriminate against lawyers with actual and perceived mental health disorders and disabilities, and act as a subterfuge for violating Americans with Disabilities Act (ADA) prohibitions on mental health inquiries and examinations of employees. By arming employers (and their agents) with broad descriptions of signs and symptoms that facilitate branding of almost anyone as impaired, these policies can result in discretionary systems of discipline, create and sustain hierarchy, and cede to legal employers control over the private conduct and out-of-work lives of their employees.

Section I traces the origins of LAPs and CoLAP, their rise in influence, and their use of lawyer well-being programming and unsubstantiated claims about lawyers with mental health disorders to encourage referrals. Section II critically evaluates the evidence behind three of these claims: that mental health disorders are leading causes of misconduct, that lawyers with mental health disorders are unproductive and economically burdensome, and that lawyer well-being interventions and LAPs are effective.

Section III elucidates harms resulting from lawyer well-being programming, including discrimination from misapplication of ABA Model Rules of Professional Conduct 1.1, 1.16(a)(2), and 8.3(a). It then describes business and employer efforts ongoing since the mid-2010s to weaken workplace wellness regulations. It then gives examples of various ways in which lawyer well-being programming may effectively circumvent ADA prohibitions on disability-related inquiries and requests for examinations of employees: through policies inconsistent with the ADA's rules; through the use of proxies, such as burnout, resilience, and personality characteristics; and through the use of employers' agents, such as coworkers, to make inquiries, referrals, and evaluations on employers' behalf. It then describes how well-being ideology shifts blame from institutions to individuals, and how encouraging peers to be on the lookout for coworkers manifesting

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8. *See* Bob Carlson, *It's Time to Promote Our Health: ABA Mobilizes on Multiple Fronts to Address Well-Being in the Legal Profession*, ABA J. (Dec. 1, 2018), http://www.abajournal.com/ magazine/article/its_time_to_promote_our_health [https://perma.cc/Z32X-W9M8] (last visited Sept. 25, 2020)).

signs and symptoms alleged to indicate mental health impairment can result in discretionary discipline.

Section IV describes analogous developments in the medical profession in order to illustrate the harms of any advocacy that involves stigmatization. It first discusses the adoption of well-being as a component of resident physician competence, and then describes a World Health Organization strategy for mental health programs in the workplace.

Section V considers the role of Model Rule 8.4(g) in reducing mental disability bias and concludes with recommendations to eliminate CoLAP and LAP educational programming and materials on lawyer well-being, educate law students and legal employees about the ADA's rules, be wary of all well-being/wellness claims being made in empirical research, and reject wellness rhetoric that demeans vulnerable groups and individuals. Finally, it argues for the creation of structural changes within the legal profession that focus on rights rather than health.

I. THE RISE OF LAWYER ASSISTANCE PROGRAMS, LAWYER WELL-BEING PROGRAMMING, AND RHETORIC

A. ORIGINS, DESIGN, AND STRUCTURE OF LAPS

State LAPs are non-profit organizations that are approved by state bar associations and have a collaborative relationship with state bars and the ABA through CoLAP.[9] LAPs were originally created to provide treatment for lawyers with substance use disorders.[10] They also "monitor a recovering attorney's progress in treatment."[11] These programs were designed to allow lawyers with addictions to "confidentially"[12] seek treatment under arrangements with state bar associations

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9. *See* Samantha Wilson, *The Rise of the Lawyer Counseling Movement; Confidentiality and Other Concerns Regarding State Lawyer Assistance Programs*, 27 GEO. J. LEGAL ETHICS 951, 951, 963 (2014) [hereinafter Wilson, *Rise of the Lawyer Counseling Movement*].

10. *See* AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS, GUIDING PRINCIPLES FOR A LAWYER ASSISTANCE PROGRAM 1 (1991), https://www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/ls_colap_model_lawyer_assistance_program.authcheckdam.pdf [https://perma.cc/J42W-83Y7] (last visited Sept. 25, 2020) [hereinafter GUIDING PRINCIPLES] ("[T]he American Bar Association approves the guiding principles set forth below to assist state and local bar associations in the development and maintenance of effective programs to identify and assist those lawyers and law students impaired by alcoholism, other forms of substance abuse or for other causes.").

11. *See* AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS, AN OVERVIEW OF LAWYER ASSISTANCE PROGRAMS IN THE UNITED STATES 1 (1991) [hereinafter OVERVIEW OF LAPS].

12. *See* Wilson, *Rise of the Lawyer Counseling Movement*, *supra* note 9, at 951, 963. Wilson describes the practice of law firms requiring legal employees to waive confidentiality of LAP records, citing *In re* Clegg, 41 So. 3d 1141, 1144 (La. 2010). These waivers may make these treatments not "confidential." *See also* Nicholas D. Lawson & J. Wesley Boyd, *Flaws in the Methods and Reporting of Physician Health Program Outcome Studies*, 54C GEN. HOSP. PSYCHIATRY 65, 65 (2018) [hereinafter Lawson & Boyd, *Flaws in PHP Outcome Studies*] ("It is also troubling that many PHPs describe their evaluations as confidential even when there is often an expectation or demand on the part of employers for employees to waive confidentiality and grant their employers the right to communicate with these programs. Additionally, at their initial encounter, many PHPs ask participants to sign releases to various entities, including boards of medicine, and if these forms are signed, the board will be notified if the participant fails to comply with any PHP recommendation, which often results in public sanctioning of the physician.").

that exempt LAP participants, LAP staff, and volunteer attorneys working with LAPs, from their duties to report under the states' professional ethics rules.[13] Yet one of the ironies of LAPs is that while they seek to protect the privacy of lawyers who participate in LAPs, they also encourage firm personnel to identify and report lawyers to management through surveillance efforts "aimed at identifying people with problems of substance abuse, mental-emotional instability, severe physical problems, and/or practice management problems."[14]

Many LAPs offer "free" initial evaluations; however, an LAP may subsequently refer lawyers to preferred evaluation and treatment centers that may be costly.[15] To date, no studies or investigations have been performed to evaluate potential conflicts of interest between LAPs and the evaluation/treatment centers to which LAPs send lawyers for treatment.[16] In the medical profession, however, former associate directors of physician health programs (PHPs, a similar model to LAPs[17]) have described many ways in which "the relationships between PHPs

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13. OVERVIEW OF LAPS, *supra* note 11, at 1, claims that "[v]olunteer attorneys provide the peer support which is essential to the program." It not clear what role, if any, the volunteers play in subsequent treatment or whether they have affiliations with the evaluation/treatment programs discussed *infra*.

14. *Id.* at 2 (describing a California program); *see also* MODEL LAW FIRM IMPAIRMENT 1990, *supra* note 7, at 4 ("The purpose of this policy statement and guidelines is not to punish, degrade or embarrass impaired persons but to identify them. . . ."); GUIDING PRINCIPLES, *supra* note 10, at 1 ("to identify and assist those lawyers and law students").

15. No information currently exists regarding the costs of evaluation/treatment centers referred to by state LAPs. In the medical profession, however, "doctors are often referred by state [physician] health programs to three-month inpatient treatment centers that can cost up to $1000 a day." Jeanne Lenzer, *Physician Health Programs Under Fire*, 353 BMJ i3568 (2016) [hereinafter Lenzer, *PHPs Under Fire*]. For a more general discussion related to the addiction treatment industry, see *Addiction Inc.*, N.Y. TIMES, (Dec. 27, 2017), https://www.nytimes.com/interactive/2017/12/27/ business/addiction-inc.html [https://perma.cc/GN2L-4KTF] (last visited Sept. 25, 2020).

16. *But see* Objections to Board Recommendations at 9, 12, Lorain Cty. Bar Ass'n v. Lindon, No. 2019-0216 (Ohio 2019), http://supremecourt.ohio.gov/pdf_viewer/pdf_viewer.aspx?pdf=862492.pdf [https://perma.cc/GP76-UFPF] (last visited Sept. 25, 2020), in which the lawyer took issue with the fact that the state government, through the Board and Ohio LAP (OLAP), was coercing him to participate in Alcoholics Anonymous, a religious program. The lawyer argued that the "Board's recommendation would also require Respondent to fund OLAP's *de facto* religious program" in violation of the Establishment Clause. Similar arguments have been made recently against an occupational program for pilots with substance abuse. Complaint at 3-5, EEOC v. United Airlines, Inc., No. 2:20-cv-09110 (D.N.J. July 20, 2020) (Buddhist pilot objected to the religious content of Alcoholics Anonymous in United's program and sought to substitute regular attendance at a Buddhism-based peer support group. United refused and, as a result, the pilot was unable to obtain a new FAA medical certificate permitting him to fly again); *see also* Wilson, *Rise of the Lawyer Counseling Movement*, *supra* note 9, at 957 (describing potential conflicts of interest arising from "interplay between the judiciary and disciplinary actors of both the state and the bar and these lawyer assistance programs. . . . A whopping ninety-five percent of state LAPs take referrals from the judiciary and ninety-six percent from disciplinary agencies") (footnote omitted). Wilson also describes that "[w]hile the D.C. Bar Counsel is officially an arm of the court, and the D.C. LAP is part of the Bar Association, funding for both comes from the D.C. Bar Association." *Id.* at 958 (footnote omitted).

17. *See, e.g.*, TASK FORCE REPORT, *supra* note 2, at 20 (describing PHP research "outcomes [as] not only exceptional and encouraging, they offer clear guidance for how the legal profession could better address its high rates of substance use disorders and increase the likelihood of positive outcomes").

and evaluation/treatment centers are replete with potential conflicts of interest."[18] There appears to be a similar problem with programs for nurses.[19]

LAPs, like their counterparts in other professions, operate with considerable discretion, limited accountability,[20] and sometimes absolute civil immunity.[21] And the "interplay between the judiciary and disciplinary actors of both the state and the bar and these lawyer assistance programs" creates its own conflicts of interest concerns.[22] Further factual investigations are needed to determine the nature and severity of conflicts of interest between LAPs and evaluation/treatment centers.

B. RISE IN INFLUENCE

In 1980, twenty-six state bar associations sponsored LAPs.[23] By 1991, LAPs existed in every state.[24] The ABA, which published a how-to kit on "Alcohol and

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18. See J. Wesley Boyd & John R. Knight, *Ethical and Managerial Considerations Regarding State Physician Health Programs*, 6 J. ADDICTION MED. 243, 244-45 (2012) for subsections on "Conflict of Interest in Referrals for Evaluation and Treatment" and "Intertwined Relationships with State Licensing Boards."

19. *See* Charlotte A. Ross, Sonya L. Jakubec, Nicole S. Berry & Victoria Smye, *The Business of Managing Nurses' Substance-Use Problems*, 27 NURSING INQUIRY e12324, 10 (2020), https://doi.org/10.1111/nin.12324 [https://perma.cc/U9VH-MDZF] (last visited Sept. 25, 2020) [hereinafter Ross, *Business of Managing Nurses' SUDs*] ("[T]he regulatory body's abdication and outsourcing of their own power and expertise to physicians and private corporations created a situation that was rife with potential for abuse, incentivization of conflicts of interest, and insertion of corporate imperatives in the nurses' treatment processes.").

20. See Gregory E. Skipper & Robert L. DuPont, *The Physician Health Program: A Replicable Model of Sustained Recovery Management,* in ADDICTION RECOVERY MANAGEMENT: THEORY, RESEARCH AND PRACTICE 281, 283 (John F. Kelly & William L. White eds., 2011), in which the authors, themselves directors of PHPs and evaluation/treatment centers, explained:

> [U]nlike [state medical] boards, PHPs are not constrained by due process and other legal impediments to action. Regulatory boards, as legal entities, are usually required to conduct an investigation, develop a case, give notices, conduct due process and judicial hearings, and allow appeals. This process regularly takes months or even years to resolve. In contrast, PHPs only need credible symptoms (and not probable cause) to recommend discontinuation of practice and thorough evaluation.

21. State LAP immunity provisions are broad with some variations.

Some states grant immunity to LAPs for official actions taken in good faith. *See, e.g.*, S.C. CODE ANN. § 428 (c) (West 2019) ("The Attorneys to Intervene, the Executive Director of the South Carolina Bar, and the President of the Bar shall be immune from civil action for their actions taken in good faith under this rule.").

Others explicitly extend immunity to LAPs' agents. *See, e.g.*, WYO. STAT. ANN. R. 6(b) (West 2014) ("[T]he Director and all WyLAP employees and agents including volunteers are immune from any liability that might otherwise result from good faith acts permitted by these Rules.").

Others grant "absolute" immunity to LAPs and their agents. *See, e.g.*, N.J. STAT. ANN. R.1:28B-4 (West 2002) ("Members of the LAP Board of Trustees, program employees and other staff, agents, program volunteers, attorney peer counselors, and attorneys providing practice assistance shall be absolutely immune from suit, whether legal or equitable in nature, based on their respective conduct in performing their official LAP duties.").

And Louisiana provides one of the most detailed descriptions of its broad immunity grant. *See* LA. STAT. ANN. § 37:221(c)(1)(b) (2015) (granting civil immunity for "[a]ny act, decision, omission, communication, writing, report, finding, opinion, or conclusion of the Committee on Alcohol and Drug Abuse, or the Judges and Lawyers Assistance Program, Inc., or any of their members, agents, or employees").

22. *See* Wilson, *Rise of the Lawyer Counseling Movement*, *supra* note 9, at 957.

23. OVERVIEW OF LAPS, *supra* note 11.

24. *Id.*

Drug Abuse Programs for Lawyers and Judges" in the early 1980s,[25] established its Commission on Impaired Attorneys in 1988 (the name was changed to CoLAP in 1996), which functions to support LAP development, communications, and outreach to the legal community.[26] In 1990, the ABA adopted the Commission on Impaired Attorneys' "Model Law Firm/Legal Department Personnel Impairment Policy and Guidelines," to "identify and assist"[27] "personnel who have impairments arising from emotional or behavioral problems and including drug and alcohol abuse and dependency."[28] In February 1991, the Commission on Impaired Attorneys published "An Overview of Lawyer Assistance Programs in the United States" (Overview or Overview of LAPs),[29] and the ABA adopted its set of "guiding principles" to help state bar associations establish LAPs,[30] such as the principle that "[m]embers of the profession who serve in lawyer assistance programs should be immune from civil liability."[31]

What accounts for the rise in influence of LAPs during this time is not clear. The Overview stated that "[i]t has been demonstrated that lives and careers can be salvaged through the efforts of such programs."[32] So far, however, there have not been any studies of LAP outcomes or effectiveness.

The Overview also stated that "[b]ars have estimated that 40% to 75% of all complaints stem from lawyer impairment,"[33] but nothing in the report supports

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25. *Id.* at 1 ("Since the ABA published its MAP package on *Alcohol and Drug Abuse Programs for Lawyers and Judges* eight years ago, the recognition of substance abuse within the legal profession has spurred bar association involvement with this problem.").

26. *See, e.g.*, AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS, INFORMATIONAL REPORT TO THE HOUSE OF DELEGATES 1 (2018) ("The Commission (1) supports and seeks to improve existing services, including diversity outreach, and, as appropriate, assists in the development of new lawyer assistance programs, (2) provides educational and training opportunities for lawyer assistance program staff and volunteers, the legal profession, the judiciary, law students, legal educators and the public, (3) disseminates information to and creates and fosters platforms for communication among lawyer assistance program staff and volunteers, and (4) develops and advances policies that better enable lawyers and judges to obtain assistance and return to good health, protect the integrity of the legal profession and the judiciary and protect the public.").

27. MODEL LAW FIRM IMPAIRMENT 1990, *supra* note 7, at 4.

28. *Id.* at 2 (encouraging the "earliest possible intervention, counseling, treatment and rehabilitation by qualified outside agencies or persons, i.e., Lawyer Assistance and Employee Assistance Programs").

29. *See* OVERVIEW OF LAPS, *supra* note 11.

30. *See* GUIDING PRINCIPLES, *supra* note 10, at 1 (explaining the guiding principles were approved "to assist state and local bar associations in the development and maintenance of effective programs to identify and assist those lawyers and law students impaired by alcoholism, other forms of substance abuse or for other causes").

31. *Id.*; *see also* AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS ET AL., MODEL LAWYER ASSISTANCE PROGRAM 9 (2004), https://www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/ls_colap_model_lawyer_assistance_program.pdf [https://perma.cc/NS9Y-RHF9] (last visited Sept. 25, 2020) [hereinafter MODEL LAP] ("The state's highest court and the state legislature should arrange for an appropriate form of immunity from civil liability for all persons participating in the LAP, including its volunteers. . . ."). See OVERVIEW OF LAPS, *supra* note 11, at 1, for state provisions of immunity for LAPs.

32. OVERVIEW OF LAPS, *supra* note 11, at 3.

33. *Id.* at 1; *see also* MODEL LAW FIRM IMPAIRMENT 1990, *supra* note 7, at 3 ("Alcoholism and other chemical dependency taken together have been estimated to be a factor in 40 to 60 percent of professional discipline cases.").

these estimates. These claims nevertheless seem to have played an important role in promoting LAPs.

C. TWO LAWYER WELL-BEING PREVALENCE STUDIES

The Task Force report cited two studies said to "reveal that too many lawyers and law students experience chronic stress and high rates of depression and substance use."[34] The studies—one of law students,[35] the other of lawyers[36]—were conducted by CoLAP representatives and were said to demonstrate that the prevalence of mental health disorders like depression and substance abuse are higher among law students and lawyers than the general population.

These two studies are repeatedly cited by CoLAP and other proponents of lawyer well-being policies in legal publications.[37] A letter to the editor criticizing the study concerning lawyers as being "so deeply flawed statistically that none of its results can be trusted. . . . [It is] utterly worthless and should be ignored,"[38] has been cited only once.

The two studies are of limited value primarily due to response bias. The law student survey had a response rate of "just under 30%,"[39] and the lawyer survey[40] did not report a response rate, but used a voluntary, nonrandom, convenience sample. It is universally accepted within the scientific community that "[l]ow response rates might compromise the generalizability of population survey data."[41] In addition, "[n]on-response is an important source of inaccurate reporting of alcohol and illicit drug use existing from population surveys . . . [and] there is a serious chance of bias when a response rate is below 70%."[42] Despite their critical scientific flaws, CoLAP continues to proclaim the lawyer survey a "landmark study," and cites both as important reasons to support CoLAP lawyer well-

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34. *See* TASK FORCE REPORT, *supra* note 2, at 1.

35. Jerome M. Organ, David B. Jaffe & Katherine M. Bender, *Suffering in Silence: The Survey of Law Student Well-Being and the Reluctance of Law Students to Seek Help for Substance Use and Mental Health Concerns*, 66 J. LEGAL EDUC. 116, 118–19 (2016) [hereinafter Organ, *Survey of Law Student Well-Being*].

36. Patrick R. Krill, Ryan Johnson & Linda Albert, *The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys*, 10 J. ADDICTION MED. 46 (2016) [hereinafter Krill, *Prevalence of Substance Use Among Attorneys*].

37. As of August 21, 2020, the law student study has been cited by 35 articles in HeinOnline, and 70 articles in Google Scholar; the lawyer study (not available in HeinOnline) has 129 citations in Google Scholar [hereinafter STUDY SEARCH].

38. Paul F. Velleman & Ann C. Lapinski, *Statistics Failures Make Lawyer Addiction Estimates Worthless*, 10 J. ADDICTION MED. 286, 286–87 (2016); *cf.* Patrick R. Krill, *Author's Response to Statistics Failures Make Lawyer Addiction Estimates Worthless*, 10 J. ADDICTION MED. 287, 287 (2016) (critiquing criticisms as "logical fallacies and unsupported opinions" but acknowledging that "random sampling was not possible").

39. *See* Organ, *Survey of Law Student Well-Being*, *supra* note 35, at 124.

40. *See* Krill, *Prevalence of Substance Use Among Attorneys*, *supra* note 36, at 47.

41. *See, e.g.*, Jinhui Zhao, Tim Stockwell & Scott MacDonald, *Non-Response Bias in Alcohol and Drug Population Surveys*, 28 DRUG & ALCOHOL REV. 648, 648 (2009) (internal citations omitted) (also observing that "[s]ome studies showed that non-participants were more likely to abstain from alcohol than participants").

42. *See id.* (internal citations omitted).

being policies.[43] Based on respect for the ABA and CoLAP, these results are assumed prima facie to be valid and are thus widely cited.[44] However, frequent citation does not improve their scientific validity.

Recent, higher-quality studies have yielded mixed results on whether the prevalence of mental health disorders among lawyers is higher or lower than average. Some have suggested a slightly higher prevalence.[45] Others, however, have suggested a lower prevalence.[46] However, even if the prevalence of mental health disorders among law students and lawyers were extremely high, it is not clear why these findings would "raise troubling implications for many lawyers' basic competence."[47] Such findings could just as likely imply that many lawyers with mental health disorders are capably practicing and are not impaired. They might imply that lawyers with chronic stress, depression, or substance use disorders are not as incompetent, undedicated, or incapable of public trust as the Task Force authors seem to believe.

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43. *See* TASK FORCE REPORT, *supra* note 2, at 35 ("The 2016 Survey of Law Student Well-Being found troublesome rates of alcohol use, anxiety, depression, and illegal drug use at law schools across the country."), 47 (stating that the "studies cited above show that our members suffer at alarming rates" of mental health conditions); AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS ET AL., REPORT TO THE HOUSE OF DELEGATES, RESOLUTION 105, at 12 (Feb. 2018) ("[R]esearch conducted by the ABA Commission on Lawyer Assistance Programs demonstrates that alcohol use, substance use and mental health disorders among law students and lawyers far exceed other professions and populations. These circumstances undermine the ability of the legal profession to assure the public that the system of American justice is competent, fair and just.").

44. *See* STUDY SEARCH, *supra* note 37.

45. *See* Beth Han, Alex E. Crosby, LaVonne A.G. Ortega, Sharyn E. Parks, Wilson M. Compton & Joseph Gfroerer, *Suicidal Ideation, Suicide Attempt, and Occupations Among Employed Adults Aged 18–64 Years in the United States*, 66 COMPREHENSIVE PSYCHIATRY 176, 179 (2016) (finding a 12-month prevalence of suicidal ideation among lawyers to be 4.2%, compared with 3.5% for all employed U.S. adults; response rates 60.2% to 66.8%); Albert Woodward, Rachel Lipari & William Eaton, *Occupations and the Prevalence of Major Depressive Episode in the National Survey on Drug Use and Health*, 40 PSYCHIATRIC REHABILITATION J. 172, 174–75 (2017) (reporting on the same study and describing a 12-month prevalence of a major depressive episode as 7.1% among lawyers, compared with 6.6% for all U.S. adults).

46. *See* Cora Peterson, Aaron Sussell, Jia Li, Pamela K. Schumacher, Kristin Yeoman & Deborah M. Stone, *Suicide Rates by Industry and Occupation — National Violent Death Reporting System, 32 States, 2016*, 69 CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 24, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6903a1-H.pdf [https://perma.cc/DX4U-J9K3] (finding a completed suicide rate for the legal profession of 16.3 per 100,000 for men and 7.9 for women, compared to 27.4 and 7.7 for all industries/occupations); Raees A. Shaikh, Asia Sikora, Mohammad Siahpush & Gopal K. Singh, *Occupational Variations in Obesity, Smoking, Heavy Drinking, and Non-Adherence to Physical Activity Recommendations: Findings from the 2010 National Health Interview Survey*, 58 AM. J. INDUS. MED. 77, 80 (2015) (finding 12-month prevalence of heavy drinking within the legal occupation of 4.72% compared with 5.5% for all occupations; the response rate was 60.8%).

47. TASK FORCE REPORT, *supra* note 2, at 1; *cf.* R. Tyssen, *What Is the Level of Burnout That Impairs Functioning?*, 283 J. INTERNAL MED. 594, 594 (2018) (reporting that "[s]ome studies in the review have shown an alarming prevalence of burnout, reaching up to 50% amongst US doctors," and commenting that "[i]t seems unlikely that almost half of all US doctors provide poor quality of care for their patients").

D. TASK FORCE REPORT: "THE PATH TO LAWYER WELL-BEING"

The publication of CoLAP's report on lawyer well-being in 2017 and the increase in coverage of lawyer well-being in law reviews[48] coincided with the rise of wellness industry lobbying and communications discussed further in III. C.1. Workplace wellness has become a multibillion-dollar industry within the U.S.,[49] wellness programs have exploded in prevalence,[50] and the wellness program personnel workforce continues to rise.[51] The Task Force's report on *The Path to Lawyer Well-Being* can be partly explained by the rise of wellness discussions broadly within the United States.

One of the Task Force report's core recommendations is to "modify the rules of professional conduct to endorse well-being as part of a lawyer's duty of competence."[52] "Well-being," a term used interchangeably with "wellness," loosely refers to health.[53] Redefining lawyer competence to depend on well-being would focus appraisals of lawyers' abilities not on their performance but on their health. The proposed amendment appears to mandate that lawyers be physically and mentally healthy, whatever that means.

The Task Force provided the following rationale for its recommended change:

> The goal of the proposed amendment is not to threaten lawyers with discipline for poor health but to underscore the importance of wellbeing in client representations. It is intended to remind lawyers that their mental and physical health impacts clients and the administration of justice, to reduce stigma associated with mental health disorders, and to encourage preventive strategies and self-care.[54]

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48. See *supra* note 1 and accompanying discussion.

49. *See, e.g.*, Al Lewis, *The Outcomes, Economics, and Ethics of the Workplace Wellness Industry*, 27 HEALTH MATRIX 1, 21 (2017) [hereinafter Lewis, *Workplace Wellness Industry*].

50. *See* Kenneth Matos & Ellen Galinsky, *2012 National Study of Employers*, FAMILIES & WORK INST. 2,7 (2012), https://cdn.sanity.io/files/ow8usu72/production/3ec6d5b16b5cc1d8f2e37c77d119bb4b2ba40080.pdf [https://perma.cc/J5M2-S4WZ] (last visited Sept. 25, 2020) (surveying 1,126 private employers with 50 or more employees and finding prevalence of employee assistance programs rose from 46% (2005) to 74% (2012); prevalence of wellness programs rose from 47% (2005) to 63% (2012)).

51. *See* BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, *Occupational Outlook Handbook: Health Educators and Community Health Workers* (Apr. 10, 2020), https://www.bls.gov/ooh/community-and-social-service/health-educators.htm [https://perma.cc/G36L-PBDN] (127,100 workers "teach people about behaviors that promote wellness [and] collect data and discuss health concerns with members of specific populations or communities" as of 2019; the projected percent change in employment from 2019 to 2029 is 13% for wellness workers, which is "much faster than the average for all occupations" of 4%).

52. TASK FORCE REPORT, *supra* note 2, at 26.

53. *See* Keri J. S. Brady, Mickey T. Trockel, Christina T. Khan, Kristin S. Raj, Mary Lou Murphy, Bryan Bohman, Erica Frank, Alan K. Louie & Laura Weiss Roberts, *What Do We Mean by Physician Wellness? A Systematic Review of Its Definition and Measurement*, 42 ACAD. PSYCHIATRY 94, 95 (2018) (stating that the term "physician wellness [is] used interchangeably with physician well-being"); *see also* WORLD HEALTH ORG., *Global Observatory on Health R&D, Analyses and Syntheses, Mental Health: Global Strategic Direction*, https://www.who.int/research-observatory/analyses/mentalhealth/en/ [https://perma.cc/QQ2Y-U9B5] (last visited Sept. 4, 2020) (explaining that "[m]ental health is a state of well-being. . . .").

54. TASK FORCE REPORT, *supra* note 2, at 26.

The authors seem to acknowledge the illogic of equating poor health with incompetence. They also allude to the potential for unwarranted discipline and harm to lawyers with health conditions that might result from defining competence in terms of health. Nevertheless, they seem to view the amendment as justified to encourage legal employees to seek treatment. The same justifications might also underlie many stigmatizing, misleading, and categorically false statements provided throughout the Task Force report. Their report claims, for example, that "[f]reedom from substance use and mental health disorders [is] an indispensable predicate to fitness to practice."[55]

The inspiration to make well-being a component of competence in lawyers may have come from the Accreditation Council for Graduate Medical Education (ACGME). The ACGME is a non-profit organization that accredits residency programs and creates a basic set of standards or program requirements for training and preparing resident physicians.[56] The ACGME adopted well-being as a component of resident competence in 2017,[57] the same year the Task Force report was published. In support of their recommendation to "require law schools to create well-being education for students as an accreditation requirement,"[58] the Task Force authors cited the ACGME's program requirement "that teaching hospitals have a documented strategy for promoting resident well-being and, typically, hospitals develop a wellness curriculum for residents."[59] Just as the representatives of LAPs have pushed aggressively for greater involvement in educating members of the legal profession about lawyer well-being, representatives of PHPs have pushed for greater involvement in educating members of the medical profession about physician and resident well-being.[60]

E. COLAP LAWYER WELL-BEING EDUCATIONAL PROGRAMMING

The many stigmatizing claims made by CoLAP in the Task Force report and other communications would be of less import were CoLAP and LAPs not currently engaged in an aggressive effort to educate members of the legal

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55. *Id.* at 17. See Sections II.A and II.B and accompanying discussion, refuting these and other similar claims.

56. *See What We Do*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., https://www.acgme.org/What-We-Do/Overview [https://perma.cc/D2QE-H4SD] (last visited July 29, 2020).

57. *See* Accreditation Council for Graduate Med. Educ., COMMON PROGRAM REQUIREMENTS (RESIDENCY), VI.C. (July 1, 2020), https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf [https://perma.cc/84RK-PFVW] [hereinafter CPR] ("Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence.").

58. TASK FORCE REPORT, *supra* note 2, at 27.

59. *Id.*

60. *See, e.g.*, Amanda L. Parry, Elizabeth Brooks & Sarah R. Early, *A Retrospective Cross-Sectional Review of Resident Care-Seeking at a Physician Health Program*, 42 ACAD. PSYCHIATRY 636, 639 (2018) ("PHPs should use various methods of outreach including attendance at academic events (e.g., resident orientation, grand rounds) and informal communications (e.g., e-mails, electronic newsletters, personal contacts)" to encourage engagement at PHPs).

profession about mental health and lawyer well-being,[61] especially at law schools.

According to a "Law School Wellness Survey" of 103 schools conducted by CoLAP in the spring of 2018, "[n]inety percent of the CoLAP survey respondents reported that their law school engages with their state LAP to provide programming or resources to students."[62] The survey also found that some "LAP representatives meet with the dean of students or other administrators on a yearly or biennial basis to collaborate and advise on matters related to well-being,"[63] that "LAP representatives collaborate with the school's faculty well-being committee,"[64] and that "state LAP[s] designate[] student ambassadors to promote their services."[65] Many law schools also ask student peer mentors or peer advisers to teach other "students how to recognize signs of substance use disorders and mental health concerns and respond effectively."[66]

According to the survey results, "[t]he most commonly reported forms of LAP participation on campus were presentations at orientation and co-curricular well-being programs."[67] At some schools, "LAP representatives deliver presentations throughout the year on topics such as substance use disorders, mental health problems, stress management, cultivating resilience and balance, and character and fitness concerns."[68] "[T]he most common means of publicizing counseling and other well-being resources is promotion on the school's website, followed by orientation and Mental Health Day or Wellness Week programming."[69]

"[S]ome schools have taken a more forceful approach [to well-being education], obligating 1Ls to partake as part of the first-year curricular requirements."[70] And "[s]ixty-two percent of the CoLAP Survey respondents reported that their law school incorporates well-being topics into courses on professional responsibility. Of these, seventy-three percent indicated that the course professors address such topics."[71]

F. COLAP LAWYER WELL-BEING PLEDGE, TOOLKIT, AND TEMPLATE FOR LEGAL EMPLOYERS

Since the release of the Task Force report, CoLAP has asked law firms to sign a Well-Being Pledge for Legal Employers (Well-Being Pledge) to commit to

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61. See *infra* notes 62–71 and accompanying text.

62. Jordana A. Confino, *Where Are We on the Path to Law Student Well-Being?: Report on the ABA CoLAP Law Student Assistance Committee Law School Wellness Survey*, 68 J. LEGAL EDUC. 650, 656 (2019).

63. *Id.* at 658.

64. *Id.*

65. *Id.*

66. *Id.* at 693.

67. *Id.* at 657.

68. *Id.*

69. *Id.* at 661.

70. *Id.* at 665.

71. *Id.* at 679.

"supporting programs to improve physical, mental and emotional well-being" and "develop[ing] visible partnerships with . . . lawyer assistance programs." It also asks law firms to ensure "assessment and treatment of substance use and mental health problems" and "access to addiction and mental health experts and resources."[72] CoLAP distributed a Well-Being Toolkit for Lawyers and Legal Employers (Well-Being Toolkit or Toolkit) in 2018,[73] and in 2019, CoLAP distributed a Well-Being Template for Legal Employers (Well-Being Template) to place in their contracts with legal employees mandating peer surveillance and reporting of coworkers who "may be impaired" to firm management.[74] In the absence of an obvious transgression of explicit rules and regulations, judgment of possible impairment is almost surely subjective. These surveillance and reporting policies will be especially likely to result in inappropriate disciplinary attention and discipline to lawyers with mental health disorders and disabilities if lawyers are taught to absorb the many stigmatizing claims made about lawyers with mental health disorders and disabilities through lawyer well-being programming. Making matters worse, stigmatizing claims about lawyers with mental health disorders and disabilities (three of which are discussed in Section III), like LAPs in general,[75] are infrequently scrutinized within the legal community.

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72. *See* AM. BAR ASS'N, CHALLENGING THE STATUS QUO: A CAMPAIGN OF INNOVATION TO IMPROVE THE SUBSTANCE USE AND MENTAL HEALTH LANDSCAPE OF THE LEGAL PROFESSION (2019), https://www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/ls_colap_working_group_pledge_and_campaign.PDF [https://perma.cc/N7EU-RQDZ].

73. *See* Anne M. Brafford, *Well-Being Toolkit for Lawyers and Legal Employers*, AM. BAR ASS'N (Aug. 2018), https://www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/ls_colap_well-being_toolkit_for_lawyers_legal_employers.pdf [https://perma.cc/A8Y2-KVL2] [hereinafter WELL-BEING TOOLKIT].

74. *See* AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS, WELL-BEING TEMPLATE FOR LEGAL EMPLOYERS 2 (2019), https://www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/well-being-template-for-legal-employers-final-3-19.pdf [https://perma.cc/KB8A-W3YF] [hereinafter WELL-BEING TEMPLATE]. In its section entitled "Addressing Impairment Concerns," the template states, "Personnel who: 1. believe they are themselves impaired or at risk of becoming impaired, or 2. reasonably suspect that a lawyer or staff member may be impaired, [choose one: shall/should] report their concerns to [name and title of designee]" (brackets in original). A footnote on the word "designee" advises that "this contact person could be a department head or practice group leader, member of the executive or leadership committee, general counsel, chief operating officer, or managing partner." *See also* New York State Bar Ass'n, *New York State Bar Association Lawyer Assistance Committee Model Policy* (Apr. 9, 2010), https://www.nysba.org/workarea/DownloadAsset.aspx?id=5205710 [https://perma.cc/92U8-AN7R] (modeled on the ABA's Well-Being Template).

75. *See* Fred C. Zacharias, *A Word of Caution for Lawyer Assistance Programming*, 18 GEO. J. LEGAL ETHICS 237, 239–40 n.8 (2004) (observing that "[d]espite the growing literature on the subject of lawyer assistance programs, virtually all commentators have focused on the importance of developing programs . . . . Virtually no one has addressed the potentially adverse side effects of such programs"). There have been no studies evaluating the prevalence of mental health inquiries and examinations in the legal workplace. But for ADA cases involving a lawyer required to undergo mental health examinations, see Roberts v. Rayonier, Inc., 135 F. App'x 351, 353, 360 (11th Cir. 2005) (ruling for the lawyer-employee, where referring supervisor allegedly stated to in-house attorney: "[B]oy am I going to have fun with you. I'm going to have you scheduled and find out what makes you tick"); Fritsch v. City of Chula Vista, No. 98-0972-E-CGA, 2000 WL 1740914, at *6 (S.D. Cal. Feb. 22, 2000) (ruling against lawyer-employee).

II. EVALUATING THE MEDICAL EVIDENCE UNDERLYING KEY CLAIMS ABOUT LAWYER WELL-BEING

A. CLAIMS "THAT MENTAL ILLNESS AND SUBSTANCE ABUSE ARE LEADING CAUSES OF MALPRACTICE SUITS AND ETHICAL DISCIPLINARY ACTIONS AGAINST ATTORNEYS"[76] HAVE LONG BEEN DISCREDITED

The Task Force's claim that "freedom from substance use and mental health disorders [is] an indispensable predicate to fitness to practice" was shown to have no foundation many years ago. This claim was disproven in the mid-1990s when many courts recognized that "[r]esearch has failed to establish that a history of previous psychiatric treatment can be correlated with an individual's capacity to function effectively in the workplace"[77] and that "past behavior is the best predictor of present and future mental fitness."[78] This was the case in 2002 when Professor Jon Bauer reported that "[t]here is simply no empirical evidence that [bar] applicants' mental health histories are significantly predictive of future misconduct or malpractice as an attorney."[79] This was also the case in 2014, when the Department of Justice issued a letter to the Louisiana Supreme Court informing it that mental health questions on its bar licensure applications violated the ADA,[80] and in 2015, when Professor Leslie Levin's study for the Law School Admissions Council found that male sex appears to be a better predictor of future misconduct or malpractice than the presence of a mental disorder or disability.[81] Some authors of the Task Force report have even acknowledged that

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76. Amiram Elwork & G. Andrew H. Benjamin, *Lawyers in Distress*, 23 J. PSYCHIATRY & L. 205, 216 (1995) [hereinafter Elwork & Benjamin, *Lawyers in Distress*].

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

78. Clark v. Va. Bd. of Bar Exam'rs, 880 F. Supp. 430, 446 (E.D. Va. 1995) (licensing questions related to mental health status or treatment were unnecessary where "the Board presented no evidence of correlation between obtaining mental counseling and employment dysfunction"); *see also* AM. BAR ASS'N, RESOLUTION 102 (2015), https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/102.pdf [https://perma.cc/92ML-Y7ZW] [hereinafter ABA CDR RESOLUTION].

79. Jon Bauer, *The Character of the Questions and the Fitness of the Process: Mental Health, Bar Admissions and the Americans with Disabilities Act*, 49 UCLA L. REV. 93, 141 (2001) [hereinafter Bauer, *Character and Fitness*].

80. *See* Letter from Jocelyn Samuels, Acting Asst. Att'y Gen., Civil Rights. Div., U.S. Dep't. of Justice, to Hon. Bernette J. Johnson, C.J., La. Sup. Ct. 2 (Feb. 5, 2014), https://www.ada.gov/louisiana-bar-lof.pdf [https://perma.cc/S8ZJ-SEQV] [hereinafter DOJ Letter]; *see also id.* at 23 (citing Am. Bar Ass'n, Comm'n on Mental and Physical Disability Law, *Recommendation to the House of Delegates*, 22 MENTAL & PHYSICAL DISABILITY L. REP. 266, 267 (Feb. 1998) ("Research in the health field and clinical experience demonstrate that neither diagnosis nor the fact of having undergone treatment support any inferences about a person's ability to carry out professional responsibilities or to act with integrity, competence, or honor.")).

81. *See* Leslie C. Levin, Christine Zozula & Peter Siegelman, *The Questionable Character of the Bar's Character and Fitness Inquiry*, 40 LAW & SOC. INQUIRY 51, 62-63 (2015) (finding that among disciplined lawyers, 83.4% were male, and 16.6% were female. Lawyers who were subsequently disciplined were about twice as likely to report having had a preapplication psychological diagnosis/treatment as those who were not (4.1% vs. 1.9%)); *see also* Gregory G. Sarno, Annotation, *Mental or Emotional Disturbance as Defense or Mitigating Factor in Attorney Disciplinary Proceeding*, 46 AM. JURIS. PROOF OF FACTS 2D § 563 (Dec. 2019) (identifying cases in which the most common mental health disorders, like depression and anxiety, have been raised as a

"a history of mental health or substance use issues has not been shown to reflect in a lawyer's ability to practice law."[82] To understand why these claims have persisted, it is worth evaluating their sources and considering possible reasons for misunderstanding.

1. CONFLATING OF PREVALENCE AND CAUSAL EFFECTS

CoLAP and LAP representatives have repeatedly suggested that mental health disorders cause a substantial proportion of professional misconduct cases. While reviewing every claim here would be impracticable, two of the most commonly cited sources include CoLAP's 1991 Overview of LAPs, reporting that state "bars have estimated that 40% to 75% of all disciplinary complaints stem from lawyer impairment,"[83] and a 1992 article by psychologist G. Andrew H. Benjamin, Director of the Washington State Bar Association's LAP from 1986 to 1993, claiming that "in 1988, the [ABA] determined that 27 percent of all nationwide disciplinary cases involved alcohol abuse . . . [and that an] earlier ABA survey conducted in New York and California indicated that 50–70 percent of all disciplinary cases involved alcoholism."[84] Professor Bauer has observed that "no information concerning the methodology or scope of these surveys of lawyer discipline cases has ever been published."[85] I have not been able to obtain details concerning the methodology of these studies from G. Andrew H. Benjamin, the ABA, or their sources through e-mail communications despite repeated requests.

Much of the language in these prevalence studies is ambiguous (e.g., "involved," "linked to"). What does it mean to say that 27%, 50%, or 75% of "disciplinary cases nationwide *involved* alcohol abuse"?[86] These statistics might simply reflect the percentage of lawyers who were the subject of a disciplinary complaint and *who also had* alcohol abuse—not the percentage of the lawyer discipline cases *caused by* alcoholism. Similarly, what does it mean to say that "[a]pproximately 40% to 70% of attorney disciplinary proceedings and malpractice actions are *linked to* alcohol abuse or a mental illness"?[87] Whether or not

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defense or mitigating factor in attorney disciplinary proceedings); Debra T. Landis, Annotation, *Attorney's Commingling of Client's Funds with His Own as Ground for Disciplinary Action—Modern Status*, 94 A.L.R. 3d § 17, at 846 (Jan. 2020) (describing cases in which "[a]ttorney[s'] physical, mental, or emotional disability," including substance use disorders, were factors affecting degree of discipline).

82. *See* David Jaffe & Janet Stearns, *Conduct Yourselves Accordingly: Amending Bar Character and Fitness Questions to Promote Lawyer Well-Being*, 26 PROF. LAW. 4 (Jan. 22, 2020), https://www.americanbar.org/groups/professional_responsibility/publications/professional_lawyer/26/2/conduct-yourselves-accordingly-amending-bar-character-and-fitness-questions-promote-lawyer-wellbeing/ [https://perma.cc/ENN9-K8HG].

83. *See* OVERVIEW OF LAPS, *supra* note 11, at 1.

84. *See* G. Andrew H. Benjamin, Bruce Sales & Elaine Darling, *Comprehensive Lawyer Assistance Programs: Justification and Model*, 16 LAW & PSYCHOL. REV. 113, 118 (1992) [hereinafter Benjamin, *Comprehensive LAPs*].

85. *See* Bauer, *Character and Fitness*, *supra* note 79, at 177 n.289.

86. *See* Benjamin, *Comprehensive LAPs*, *supra* note 84, at 118 (emphasis added).

87. Douglas B. Marlowe, *Alcoholism, Symptoms, Causes & Treatments*, *in* STRESS MANAGEMENT FOR LAWYERS, 104 (Amiram Elwork ed., 2d ed. 1997) [hereinafter Marlowe, *Alcoholism*] (emphasis added) (citing

these proceedings and actions are "linked to" mental health disorders says very little about whether or not a mental health disorder caused these attorneys to engage in misconduct that precipitated these proceedings. The ambiguous phrasing in the reports of these statistics, combined with the absence of clarifying information about methodology, raises questions about what conclusions may be inferred. Other sources suggest that reports on the percentage of disciplinary cases that "involve" or are "linked to" alcohol or drug abuse actually refers to the percentage of lawyers made the subject of a disciplinary complaint *who have* alcohol abuse.[88] Though Benjamin has asserted "that mental illness and substance abuse are leading causes of malpractice suits and ethical disciplinary actions against attorneys,"[89] he has not provided sufficient information on methodology to support this claim.

2. CONFUSION ABOUT THE WORD "IMPAIRMENT"

Some of the confusion regarding these prevalence estimates likely relates to the term "impairment." In professional ethics, impairment is a term that is often selectively applied to professionals with substance use and other mental health disorders.[90] Impaired lawyers represent a subset of incompetent lawyers whose incompetence is caused by physical and mental health disorders.[91] Impaired

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Michael A. Bloom & Carol L. Wallinger, *Lawyers and Alcoholism: Is It Time for a New Approach?*, 61 TEMP. L. REV. 1409, 1413 n.37 (1988) ("Surveys taken in New York and in California reveal that as many as fifty to seventy percent of all disciplinary cases involve alcoholism."); Laurie B. Dowell, Comment, *Attorneys and Alcoholism: An Alternative Approach to a Serious Problem*, 16 N. KY. L. REV. 169 (1988) [hereinafter Dowell, *Attorneys and Alcoholism*]; Patricia S. Heil, Comment, *Tending the Bar in Texas: Alcoholism as a Mitigating Factor in Attorney Discipline*, 24 ST. MARY'S L.J. 1263, 1265 (1993); TASK FORCE REPORT, *supra* note 2, at 8 ("At least one author suggests that 40 to 70 percent of disciplinary proceedings and malpractice claims against lawyers involve substance use or depression, and often both.") (citing Marlowe, *Alcoholism*, at 104).

88. *See* Dowell, *Attorneys and Alcoholism*, *supra* note 87, at 172 ("The lowest estimate is that forty percent of all disciplinary cases involve individuals who have or are abusing alcohol and/or drugs. . . . While at the other extreme, the New York Bar Association estimates that the incidence of alcohol abuse among those members before their Grievance Committee is as high as seventy-five percent.").

89. Elwork & Benjamin, *Lawyers in Distress*, *supra* note 76, at 216 ("Preliminary evidence within several jurisdictions suggests that mental illness and substance abuse are leading causes of malpractice suits and ethical disciplinary actions against attorneys. For example, it has been estimated that 60% of the recently taken disciplinary actions against lawyers in California and in Oregon involved chemical dependency or stress related mental illness.") (citing OVERVIEW OF LAPS, *supra* note 11).

90. *See, e.g.*, ARK. CODE ANN. § 17-80-203 (2019) ("'Impaired' or 'impairment' means the presence of the diseases of alcoholism, drug abuse, or mental illness."); AMA Policy H-95.955, *Physician Impairment* (2019) ("The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program."); MODEL CODE OF JUDICIAL CONDUCT Canon 2.14 (2020) ("A judge having a reasonable belief that the performance of a lawyer or another judge is impaired by drugs or alcohol, or by a mental, emotional, or physical condition, shall take appropriate action, which may include a confidential referral to a lawyer or judicial assistance program.").

91. See *infra* notes 94–95 and accompanying discussion. For studies shining light on causes of incompetence or misconduct in the medical profession, see James M. DuBois, Emily E. Anderson, John T. Chibnall, Jessica Mozersky & Heidi A. Walsh, *Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States From 2008–2016*, 19 AM. J. BIOETHICS 16, 20 (2019) (finding serious mental illness such as major depression, bipolar disorder, or schizophrenia in only 1% of ethical violation cases, and

lawyers likely make up only a small number of lawyers who are incompetent or who are reported or disciplined for misconduct.[92]

Another likely cause of misunderstanding is that impairment is a legal term of art under the ADA that simply refers to the presence of a disability.[93] By definition, all persons with disabilities have impairments, but this does not mean that all lawyers with disabilities are impaired lawyers in the way this term is used in professional ethics. Consider, for example, the 2018 Annual Report from the Attorney Registration and Disciplinary Commission of the Supreme Court of Illinois (ARDC), which found that "[t]wenty out of the 78 lawyers disciplined in 2018, or 26%, had at least one substance abuse or mental impairment issue."[94] This statement does not suggest that 26% of disciplined lawyers had a substance use or other mental health disorder as the cause of their misconduct and subsequent discipline.[95] And while the 26% prevalence might strike some readers as very high and suggest overrepresentation of lawyers with mental health disorders among those subjected to discipline, this is lower than the prevalence of mental health disorders in the general U.S. population—31.1% to 43.8% of the general U.S. population meets criteria for a common mental disorder every year.[96]

It is also important to remember that although persons with mental health disorders and disabilities may have impairments in one particular area of functioning (e.g., certain types of social situations), this does not mean that they have impairments in *occupational* functioning. It is likely that at least some misunderstanding regarding the statistics described in Section II.A relates to misunderstanding

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only 5.4% involved a wrongdoer with a substance use disorder); Amir A. Khaliq, Hani Dimassi, Chiung-Yu Huang, Lutchmie Narine & Raymond A. Smego, *Disciplinary Action Against Physicians: Who Is Likely to Get Disciplined?*, 118 AM. J. MED. 773, 776 (2005) (finding "[o]nly 3.8% of 371 cases involved substance abuse").

92. See *supra* note 91, *infra* notes 94–95, and accompanying discussion.

93. *See* 42 U.S.C. § 12102(1) ("The term 'disability' means, with respect to an individual (A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.").

Similar confusion exists about the term "disability." The ADA definition of "disability" should not be confused with the definition of "disability" under the Social Security Act: "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 423(d)(1) (2018).

94. Attorney Registration & Disciplinary Commission of the Supreme Court of Illinois, ANNUAL REPORT 39 (2018) [hereinafter ARDC REPORT].

95. *Id.* at 23–24, also indicated that of 4,419 disciplinary investigations docketed in 2018, "[i]ncapacity due to chemical addiction or mental condition" represented only 7 (0.16%) of violations alleged. It is also worth differentiating the term as commonly used: *Impaired*, MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY, 1582 (11th ed. 2012) means "being in a less than perfect or whole condition." All lawyers are imperfect, but not all are impaired lawyers as the term is used in professional ethics.

96. *See* Nat'l Comorbidity Surv. Replication (2007) *Twelve-Month Prevalence Of DSM-IV/WMH-CIDI Disorders by Sex and Cohort* (last updated July 19, 2007), https://www.hcp.med.harvard.edu/ncs/ftpdir/NCS-R_12-month_Prevalence_Estimates.pdf [https://perma.cc/W6TF-KEMP] (reporting 12-month prevalence estimates for any common substance use or other mental health disorder to be 43.8% for those 18-29, 36.9% for those 30-44, and 31.1% for those 45-59).

about these terms, in addition to more general confusion about mental health disorders themselves, and to stigmatizing coverage in the news media.[97]

B. CLAIMS THAT WORKERS WITH MENTAL HEALTH DISORDERS ARE LESS PRODUCTIVE AND ARE ECONOMICALLY BURDENSOME TO THEIR EMPLOYERS ARE FLAWED

The Toolkit's introductory section, "The Business, Professional, and Moral Case for Improving Lawyer Well-Being," states that "[w]orker mental health and alcohol use disorders cost businesses billions,"[98] referring to the costs of paying for health insurance and time lost from work. The Toolkit explains:

> Troubled lawyers can struggle with even minimum competence. This can be explained, in part, by declining mental capacity due to mental health conditions. For example, major depression and alcohol abuse is associated with impaired executive functioning, including diminished memory, attention, problem-solving, planning, and organizing—core features of competent lawyering.[99]

Evaluation of some of the most important flaws of these claims, which appear almost verbatim in the Task Force report,[100] indicates their lack of empirical validity.

First, while it may be true that these workers' health insurance and time lost from work "cost businesses billions," health insurance and time lost from work for *any* large enough group of workers, when considered in aggregate, cost

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97. Emma E. McGinty, Alene Kennedy-Hendricks, Seema Choksy & Colleen L. Barry, *Trends in News Media Coverage of Mental Illness in the United States: 1995–2014*, 35 HEALTH AFF. 1121, 1124–25 (2016) reported that in the period from 1995-2014, of all news stories on mental disorders, 55% mentioned violence, and 38% mentioned interpersonal violence. About half (47%) contained a depiction of an individual with a mental disorder, most often a depiction of interpersonal violence by a person with a mental disorder (28%) and rarely a depiction of discrimination experienced by a person with a mental disorder (6%).

Such depictions do not accord with the reality about persons with mental illness. *See* Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 101, 118 (John Monahan & Henry J. Steadman eds., 1994) ("In the course of one year, 4% to 7% of people with [schizophrenia spectrum or major affective disorders] were violent (depending on how measured), while their particular risk for being violent accounted for about 4% to 5% of the total violence in the population.").

It is also worth stressing that disciplinary complaints are not suitable proxies for professional misconduct. Just as persons with mental health disorders are more likely to be victims of violence than perpetrators, so might lawyers with mental health disorders be more likely to be victims of erroneous accusations and reports for professional discipline. *See generally* Paul S. Appelbaum, *Violent Acts and Being the Target of Violence Among People with Mental Illness—The Data and Their Limits*, 77 [J]AMA PSYCHIATRY 345, 345 (2020).

98. WELL-BEING TOOLKIT, *supra* note 73, at 6.

99. *Id.*

100. *See* TASK FORCE REPORT, *supra* note 2, at 8–9 ("Troubled lawyers can struggle with even minimum competence . . . This can be explained, in part, by declining mental capacity due to these conditions. For example, major depression is associated with impaired executive functioning, including diminished memory, attention, and problem-solving. Well-functioning executive capacities are needed to make good decisions and evaluate risks, plan for the future, prioritize and sequence actions, and cope with new situations. Further, some types of cognitive impairment persist in up to 60 percent of individuals with depression even after mood symptoms have diminished, making prevention strategies essential.") (footnote omitted).

businesses billions. (American workers with blonde hair, for example, when considered in aggregate, would almost certainly cost U.S. employers billions.) And "[f]or employers who fund workers' health insurance, pregnancy can be one of the biggest and most unpredictable health-care expenses."[101] Yet neither the Toolkit nor the Task Force report single out women of childbearing age for the costs that they may impose on law firm employers. Professor Bauer has also observed that "[i]t is difficult to justify singling out depression for scrutiny when bar examiners do not ask about numerous physical disabilities that can make it difficult or impossible for an attorney to meet deadlines and get work done."[102] In fact, "mental or emotional problems" account for only 4.8% of the main causes of disability in the U.S., behind "arthritis or rheumatism" (19.2%), "back or spine problems" (18.6%), "heart trouble" (5.5%), and "diabetes" (4.9%).[103]

The Toolkit also provides a link[104] to a summary of depression productivity studies, which also have important methodological flaws. One of the most widely cited studies[105] reported that major depressive disorder (MDD) accounts for "substantially more [disability days] than most other physical and mental conditions," that "[d]epression is among the most burdensome disorders worldwide," and that workers with MDD cost employers $210.5 billion per year. Yet the authors' estimates of productivity were based on self-reports from workers with MDD who are likely to underestimate their own productity, as one of the authors acknowledged:

> [E]rrors in respondent retrospective self-reports about work impairments could lead to additional bias in estimates. This is an issue of special concern for mental disorders, because evidence exists that some types of mental disorders lead to distorted and pessimistic perceptions about personal self-worth that could help explain the finding that the reported work impairments due to mental disorders are higher than those for most physical disorders.[106]

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101. Drew Harwell, *Is Your Pregnancy App Sharing Your Intimate Data with Your Boss?,* WASH. POST (Apr. 10, 2019), https://www.washingtonpost.com/technology/2019/04/10/tracking-your-pregnancy-an-app-may-be-more-public-than-you-think/?arc404=true [https://perma.cc/YSF9-A9KQ].

102. Bauer, *Character and Fitness*, *supra* note 79, at 162–63. Bauer also reviewed cases and other evidence at 164 n.229, suggesting that "[d]epression inquiries can be expected to uncover, at best, a very small number of cases in which conditional admission or denial might be appropriate," and at 162 n.224, that "[i]n cases in which depressed attorneys are involved in acts of dishonesty, the circumstances often suggest causes other than depression."

103. Kristina A. Theis, Amy Steinweg, Charles G. Helmick, Elizabeth Courtney-Long, Julie A. Bolen & Robin Lee, *Which One? What Kind? How Many? Types, Causes, and Prevalence of Disability Among U.S. Adults*, 12 DISABILITY & HEALTH 411, 416 (2019).

104. AM. PSYCHIATRIC ASS'N FOUND., CTR. FOR WORKPLACE MENTAL HEALTH, *Quantifying the Cost of Depression,* http://workplacementalhealth.org/Mental-Health-Topics/Depression/Quantifying-the-Cost-of-Depression [https://perma.cc/F77H-J5DW] (last visited Nov. 18, 2020). [hereinafter, *Depression Cost*].

105. Paul E. Greenberg, Andree-Anne Fournier, Tammy Sisitsky, Crystal T. Pike & Ronald C. Kessler, *The Economic Burden of Adults with Major Depressive Disorder in the United States (2005 and 2010)*, 76 J. CLINICAL PSYCHIATRY 155, 155 (2015) [hereinafter Greenberg, *Burden of MDD*] (which has been cited by 276 articles in PubMed, and 1094 articles in Google Scholar as of August 22, 2020).

106. Ronald C. Kessler, Paul E. Greenberg, Kristin D. Mickelson, Laurie M. Meneades & Philip S. Wang, *The Effects of Chronic Medical Conditions on Work Loss and Work Cutback*, 43 J. OCCUPATIONAL & ENVTL. MED. 218,

In other words, workers with MDD might be more self-critical, more honest, and more likely to *report* having reduced work performance in these surveys when they actually do not.[107] This methodological limitation in measuring the productivity of these workers is particularly significant because the authors based their estimates of the overall burdens largely on these productivity measurements: the authors claimed that 37% of the overall $210.5 billion burden to employers posed by workers with MDD were attributable to reduced productivity.[108] This measurement flaw substantially limits the inferences that can reliably be drawn from this type of research, and other studies derived from their findings.[109] Another methodological limitation of the foregoing study was that the authors based their estimates of the overall cost of workers with MDD on the most costly subset of workers with MDD: those who used healthcare services resulting in health insurance claims for MDD.[110] The authors' estimates of the overall burdens of workers with MDD did not take into account the many, less costly workers with MDD who did not use these services.

Needlessly amplified by CoLAP, depression productivity studies—and the hundreds of articles citing them—harm employees, including lawyers with MDD, in at least two important ways. They create stigmatizing narratives that depressed workers are unproductive without empirically valid evidence, and they

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223 (2001). The survey used to calculate productivity was based on Walter F. Stewart, Judith A. Ricci, Elsbeth Chee, Steven R. Hahn & David Morganstein, *Cost of Lost Productive Work Time Among US Workers with Depression*, 289 [J]AMA 3135, 3143 (2003), and included:

> [H]ow often on average during the [previous 2 weeks] they lost concentration, repeated a job, worked more slowly than usual, felt fatigued at work, and did nothing at work on days when they were at work and not feeling well. . . . A sixth question asked respondents about the average amount of time it took them to start working after arriving at work on days not feeling well during the recall period.

107. *See also* Nicholas D. Lawson, *Burnout Is Not Associated with Increased Medical Errors*, 93 MAYO CLINIC PROC. 1683, 1683 (2018) [hereinafter Lawson, *Burnout Is Not Associated with Medical Errors*] (providing the same explanation for why "burnout in health care providers, although associated with *self-reported* medical errors, does not appear to be associated with actual medical errors when measured objectively" (emphasis in original)).

108. Greenberg, *Burden of MDD*, *supra* note 105, at 159.

109. *See* Ronald C. Kessler, *The Costs of Depression*, 35 PSYCHIATRIC CLINICS N. AM. 1, 7 (2012) [hereinafter Kessler, *Costs of Depression*] (citing two randomized controlled trials with "positive returns on investment to employers" of expanded primary care depression treatment of employees. Both relied upon the same flawed methods to assess productivity.); Kathryn Rost, Jeffrey L. Smith & Miriam Dickinson *The Effect of Improving Primary Care Depression Management on Employee Absenteeism and Productivity: A Randomized Trial*, 42 MED. CARE 1202, 1207 (2004) (finding statistically significant effects of enhanced depression treatment on "productivity" in only one of two groups, and 6% after two years.) and Philip S. Wang, Amanda Patrick, Jerry Avorn, Francisca Azocar, Evette Ludman, Joyce McCulloch, Gregory Simon & Ronald Kessler, *The Costs and Benefits of Enhanced Depression Care to Employers*, 63 ARCHIVES GEN. PSYCHIATRY 1345, 1351 (2006) (did not attempt to assess "productivity" but rather "indirectly estimated intervention consequences through their effects on depression and then linked these with known relationships between depression reduction and improved work outcomes").

110. *See* Greenberg, *Burden of MDD*, *supra* note 105, at 156 ("Patients with MDD were included for analysis if they had at least 2 ICD-9-CM claims for MDD—296.2 (single episode) or 296.3 (recurrent episode)—occurring on different dates during 1 of the 2 study years.").

are often used to justify wellness interventions[111] subjecting these employees to heightened disciplinary attention and the possibility of coerced mental health treatments that are more likely to harm than help.[112]

C. CLAIMS ABOUT THE EFFECTIVENESS OF WELL-BEING INTERVENTIONS ARE UNSUBSTANTIATED

Most discussions of workplace wellness programs in other occupations concern physical and general medical conditions,[113] health, weight, or pregnancy discrimination. Well-being initiatives in the medical and legal professions, however, predominantly relate to mental health. The Task Force report and the Toolkit provide a number of treatment recommendations and health tips, and the Toolkit suggests various survey measures of depression, anxiety, burnout, resilience, or other mental health characteristics.[114] They also describe health mobile apps, breathing and mindfulness techniques, suicide surveillance, and provide many reminders and recommendations to "train staff to be aware of lawyer assistance program resources and refer members."[115]

Any reliable evidence that exists on the effectiveness of well-being interventions comes from studies conducted in medical or other workforce populations.[116] There are no empirical studies to date on the effectiveness of LAPs or well-being interventions in the legal profession. Here, I review research from multiple professional contexts relevant to the outcomes of lawyer well-being interventions to reduce occupational stress, burnout, and suicide, and summarize the best available evidence on the effectiveness of workplace wellness programs targeting physical health conditions in other occupations. Lastly, I consider the as-yet unstudied effectiveness of LAPs and the state of research on PHP outcomes from the medical profession.

Occupational stress and burnout. Interventions to prevent occupational stress in healthcare workers,[117] and interventions to prevent or reduce burnout among

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111. *See, e.g.*, *Depression Cost*, *supra* note 104, which cites Kessler, *Costs of Depression*, *supra* note 109, and states that "[u]ntreated depression appears to imperil the health and productivity of employees as well as companies and their financial livelihood." The question is how to "drive employer efforts to adopt depression care services and invest in the well-being of their workers."

112. *See infra* Sections II.C and III.

113. *See* Regulations Under the Americans with Disabilities Act, 81 Fed. Reg. 31, 126 (proposed May 17, 2016) (to be codified at 29 C.F.R. pt. 1630) (describing wellness programs' health risk assessments as including "medical screening for high blood pressure, cholesterol, or glucose; classes to help employees stop smoking or lose weight; physical activities in which employees can engage (such as walking or exercising daily); coaching to help employees meet health goals; and/or the administration of flu shots").

114. *See* WELL-BEING TOOLKIT, *supra* note 73, at 25–28.

115. *See, e.g.*, TASK FORCE REPORT, *supra* note 2, at 41.

116. See *infra* notes 117-23 and accompanying discussion.

117. Jani H. Ruotsalainen, Jos H. Verbeek, Albert Mariné & Consol Serra, *Preventing Occupational Stress in Healthcare Workers*, COCHRANE DATABASE OF SYSTEMATIC REVS. Art. No.: CD002892, at 2 (2015) (finding that "[t]here is low-quality evidence that [cognitive behavioral therapy] CBT and mental and physical relaxation reduce stress

medical trainees have generally not been found effective.[118] These interventions may also selectively benefit only participants who are particularly enthusiastic about mindfulness or other wellness components, and these studies do not consider possible unintended consequences of these initiatives.

Suicide. Publications from LAP representatives often cite the importance of suicide prevention and monitoring of legal employees.[119] Yet systematic reviews of suicide prevention strategies consistently show "no effect on actual suicidal behavior,"[120] and there is "insufficient evidence to support widespread implementation of any programs or policies for primary suicide prevention in post-secondary educational settings."[121]

Workplace wellness programs in other occupations. The randomized controlled trials of workplace wellness programs that have been performed in other occupations have demonstrated little to no improvements in health or cost-savings.[122] Wellness studies are also not designed to identify problems or unintended

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more than no intervention but not more than alternative interventions" such as computer training, passive attendance of psychologist at staff meetings, and lessons of the participant's own choice).

118. Anne L. Walsh, Susan Lehmann, Jeffrey Zabinski, Maria Truskey, Taylor Purvis, Neda F. Gould, Susan Stagno & Margaret S. Chisolm, *Interventions to Prevent and Reduce Burnout Among Undergraduate and Graduate Medical Education Trainees: A Systematic Review*, 43 ACAD. PSYCHIATRY 386, 386 (2019) (finding only "[s]ix of the 14 studies reported statistically significant changes in burnout scores," with three of the six interventions simply involving reductions in duty hours).

119. *See, e.g.*, WELL-BEING TOOLKIT, *supra* note 73, at 18 ("'Suicide prevention is everyone's business.' The same is true for other mental health and alcohol use disorders. Accordingly, legal employers should provide training on identifying" lawyers with these conditions (citation omitted)); *see also* Joan Bibelhausen, Katherine M. Bender & Rachael Barrett, *Reducing the Stigma: The Deadly Effect of Untreated Mental Illness and New Strategies for Changing Outcomes in Law Students*, 41 WM. MITCHELL L. REV. 918, 918 (2015).

120. Gil Zalsman, Keith Hawton, Danuta Wasserman, Kees van Heeringen, Ella Arensman, Marco Sarchiapone, Vladimir Carli, Cyril Höschl, Ran Barzilay, Judit Balazs et al., *Suicide Prevention Strategies Revisited: 10-Year Systematic Review*, 3 LANCET PSYCHIATRY 646, 651 (2016).

121. *See* Curtis S. Harrod, Cynthia W. Goss, Lorann Stallones & Carolyn DiGuiseppi, *Interventions for Primary Prevention of Suicide in University and Other Post-Secondary Educational Settings*, COCHRANE DATABASE OF SYSTEMATIC REVS., Art. No.: CD009439, at 2 (2014) (also reporting that the "effects of training 'gatekeepers' to recognize and respond to warning signs of emotional crises and suicide risk in students they encountered . . . [demonstrate] no evidence of an effect on participants' suicide-related attitudes or behaviors").

For more discussion, see generally Amy Barnhorst, Opinion, *The Empty Promise of Suicide Prevention*, N.Y. TIMES, Apr. 28, 2019 (explaining that "almost half of people who try to kill themselves do so impulsively" and "there is very little convincing evidence to show that [antidepressants] reduce suicide."); Matthew Large, Cherrie Galletly, Nicholas Myles, Christopher James Ryan & Hannah Myles, *Known Unknowns and Unknown Unknowns in Suicide Risk Assessment: Evidence from Meta-Analyses of Aleatory and Epistemic Uncertainty*, 41 BRIT. J. PSYCHIATRY BULL. 160, 162 (2017) ("We need to acknowledge our powerlessness to usefully classify individuals or groups of patients according to future suicide risk. We need to acknowledge this to ourselves, and communicate this to health departments, to the courts. . . ."); Roger Mulder, Giles Newton-Howes & Jeremy W. Coid, *The Futility of Risk Prediction in Psychiatry*, 209 BRIT. J. PSYCHIATRY 271, 271-72 (2017) ("[I]t is finally time to acknowledge that rare events such as suicide – no matter that they are tragic for all involved or how much we wish to prevent them – are impossible to predict with a degree of accuracy that is clinically meaningful. . . . [W]e need to acknowledge the impossibility of predicting individual risk accurately and educate the public that this fact, although unfortunate, is true.").

122. *See* Damon Jones, David Molitor & Julian Reif, *What Do Workplace Wellness Programs Do? Evidence from The Illinois Workplace Wellness Study*, NAT'L BUREAU ECON. RES., No. 24229, at 2 (Jan. 19, 2018), https://www.nber.org/system/files/working_papers/w24229/w24229.pdf [https://perma.cc/6TDT-

consequences of these programs or initiatives,[123] so the nature and extent of harms resulting from these interventions remains somewhat unclear.

LAP effectiveness. Studies evaluating the effectiveness of LAPs do not exist. The Task Force report[124] cited studies from PHPs, however, describing:

> [L]ong-term recovery rates for [the physician] population that are between 70-96 percent, which is the highest in all of the treatment outcome literature.[125] One study[126] found that 96 percent of medical professionals who were subject to random drug tests remained drug-free compared to only 64 percent of those who were not subject to mandatory testing. . . . [Another study[127] reported that] among medical professionals who completed their prescribed treatment requirements (including monitoring), 95 percent were licensed and actively working in the health care field at a five-year follow-up.

Yet, as I have commented previously, "program completion, return to practice, and no relapse/recurrence may not reflect treatment [effectiveness]."[128] Many

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2DYG] [hereinafter Jones, *Illinois Workplace Wellness Study*] (concluding "these programs may act as a screening mechanism: even in the absence of any direct savings, differential recruitment or retention of lower-cost participants could result in net savings for employers"); Zirui Song & Katherine Baicker, *Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes: A Randomized Clinical Trial*, 321 [J]AMA 1491, 1491 (2019) [hereinafter Song & Baicker, *Wellness RCT*] ("The finding of no significant effects on clinical measures of health, health care spending, or employment outcomes is consistent with a recent trial of a wellness program implemented at the University of Illinois.").

123. *See* Kristin M. Madison, *The Risks of Using Workplace Wellness Programs to Foster a Culture of Health*, 35 HEALTH AFF. 2068, 2073 (2016) [hereinafter Madison, *Risks of Wellness*].

124. TASK FORCE REPORT, *supra* note 2, at 19–20 (internal citations omitted).

125. The Task Force report cited Robert L. DuPont, A. Thomas McLellan, William L. White, Lisa J. Merlo & Mark S. Gold, *Setting the Standard for Recovery: Physicians' Health Programs*, 36 J. SUBSTANCE ABUSE TREATMENT 159, 160 (2009), which in turn cited several PHP-authored articles reporting on a PHP study with flaws described *infra*. Note that differential outcomes for addiction treatment for physicians (compared to other treatment populations) may relate to differences in the treatment populations themselves rather than effectiveness. *See generally* Rudolf H. Moos & Bernice S. Moos, *Rates and Predictors of Relapse After Natural and Treated Remission from Alcohol Use Disorders*, 101 ADDICTION 212 (2006).

126. The Task Force report here incorrectly cited James H. Shore, *The Oregon Experience with Impaired Physicians on Probation: An Eight-Year Follow-Up*, 257 [J]AMA 2931, 2932–33 (1987), which mentions nothing at all about remaining drug-free. Rather, Shore stated only "there was a significant difference for the improvement rate for monitored subjects (96%) compared with treated but unmonitored addicted physicians (64%)," and "improvement" was subjectively defined and rated by Shore, who "rated [physicians] as improved in status if they were engaged in their professional activities and showed stable professional and interpersonal relationships . . . with substantially greater communication to medical colleagues and the hospital medical board." This suggests that simply the fact of a physician's being unmonitored may have sufficed for Shore to regard him or her as unimproved.

127. The Task Force here cited Robert L. DuPont, A. Thomas McLellan, Gary Carr, Michael Gendel & Gregory E. Skipper, *How Are Addicted Physicians Treated? A National Survey of Physician Health Programs*, 37 J. SUBSTANCE ABUSE TREATMENT 1, 3 (2009), which describes "failure to comply with the plan and/or return to alcohol or drug use" as triggering consequences but does not clearly define "contract completion."

128. Lawson & Boyd, *Flaws in PHP Outcome Studies*, *supra* note 12, at 65 (citing T. Cameron Wild, Jody Wolfe & Elaine Hyshka, *Consent and Coercion in Addiction Treatment*, *in* ADDICTION NEUROETHICS 153, 163 (Adrian Carter, Wayne Hall & Judy Illes eds., 2012)); *see also* Nicholas D. Lawson & J. Wesley Boyd, *Physician Health Program Outcome Data Should Be Viewed with Caution*, 58 JUDGES' J. 36, 36 (2018), https://www.americanbar.org/groups/judicial/publications/judges_journal/2018/fall/physician-health-program-outcome-data-should-be-viewed-caution/ [https://perma.cc/8VSG-K26N].

physicians who are forced to sign monitoring agreements with PHPs might not actually have an addiction or problematic performance in the first place.[129] If individuals such as these are included as indicia of "treatment" success (e.g., "remain[ing] drug free"[130]), these numbers will be inflated. In addition, many physicians will easily "complete[] their prescribed treatment"[131] at a PHP if they do not have an addiction in the first place. If this is the case, these success rates will also be inflated. Furthermore, being "licensed and actively working in the health care field at a five-year follow-up"[132] also may not reflect treatment effectiveness.

A physician could enter and exit a PHP while remaining free of addiction and still qualify as "licensed and actively working in the health care field at a five-year follow-up." "[L]ong term-recovery rates"[133] for PHP graduates must also be viewed with caution as many programs do not track individuals who drop out of monitoring while being monitored, which can also lead to inflated success rates.

Another factor complicating efforts to determine treatment effectiveness is that mild and even severe alcohol use disorders typically remit within one year.[134] Many addictions simply self-resolve without treatment. So far, there have been no outcome comparisons between physicians participating in PHPs and other similarly situated physicians who are never referred for evaluations or treatment and who do not present to a PHP. Lastly, the overwhelming majority of the literature on PHPs and on their effectiveness come from individuals with close ties to PHPs or to the evaluation/treatment centers that PHPs often mandate these physicians utilize.[135]

The Task Force report has suggested that "[s]uch outcomes are not only exceptional and encouraging, they offer clear guidance for how the legal profession could better address its high rates of substance use disorders and increase the likelihood of positive outcomes."[136] Yet there are many reasons to doubt the

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129. *See, e.g.*, Lenzer, *PHPs Under Fire*, *supra* note 15, at 1–2 (describing cases calling into question whether "bias and profit are forcing some doctors into unnecessary treatment programs for impaired physicians").

130. *See* TASK FORCE REPORT, *supra* note 2, at 19–20 (internal citations omitted).

131. *Id.*

132. *Id.*

133. *Id.*

134. *See* Carla de Bruijn, Wim van den Brink, Ron de Graaf & Wilma A.M. Vollebergh, *The Three Year Course of Alcohol Use Disorders in the General Population: DSM-IV, ICD-10 and the Craving Withdrawal Model*, 101 ADDICTION 385, 385 (2006) ("DSM-IV abuse, ICD-10 harmful use and CWM abuse all showed a favourable course with remission rates of 81, 89 and 71%, respectively, at 1-year follow-up and 85, 92 and 79% at 3-year follow-up. Dependence according to DSM-IV, ICD-10 and CWM had a somewhat less favourable course, with remission rates (no dependence) of 67, 67 and 57% at 1-year follow-up and 74, 69 and 73% at 3-year follow-up, respectively. Subjects who were remitted at 1-year follow-up showed relapse-rates of 0–14% for dependence and 4–12% for abuse at 3-year follow-up.").

135. *See* Lawson & Boyd, *Flaws in PHP Outcome Studies*, *supra* note 12, at 65.

136. TASK FORCE REPORT, *supra* note 2, at 20.

effectiveness of these programs.[137] There is also almost nothing that a lawyer can get through an LAP by way of mental health treatment that cannot be obtained from providers not affiliated with or connected to LAPs, and lawyers actually in need of treatment with very severe addictions might get better treatment somewhere else.

Irrespective of treatment effectiveness, LAPs pose a problem to the profession by disseminating and perpetuating inaccurate information about lawyers with mental health disorders and disabilities. Whether these LAP practices have something to do with strong personal opinions among LAP staff about particular treatments, conflicts of interest, or the fact that LAPs and those associated with LAPs generally operate with near-absolute civil immunity[138] is less important than recognizing the fact of these repeated misleading claims and their potential negative impact.

III. HARMS RESULTING FROM WELL-BEING PROGRAMS, INITIATIVES, AND COMMUNICATIONS

A. ENGAGEMENT AND AUTONOMY

The harms of mental health inquiries were recognized by the DOJ in 2014 when it called for the elimination of mental health questions on applications for bar licensure. To the extent that lawyer well-being proponents support limiting mental health inquiries on licensure applications,[139] one might expect them to also support limiting mental health inquiries of legal employees. Indeed, the rationale provided by the DOJ for limiting these inquiries spoke of harms resulting from both state bar and *employer* access to applicants' mental health information.[140] The DOJ explicitly referred to the potential for exposing this information to

> enable[] prospective employers, clients, or opposing counsel to act on their preconceived notions about individuals with mental health diagnoses. It also creates a chilling effect that could deter individuals with disabilities from pursuing the legal profession or seeking treatment, and reduces employment opportunities available to lawyers with disabilities by allowing their prospective employers to access information about their disability to which employers would not otherwise be entitled.[141]

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137. It is also important to consider unintended adverse consequences of PHP policies when considering LAPs and associated policies related to surveillance and lawyer well-being.

138. *See supra* note 21.

139. See *supra* note 82 and accompanying discussion.

140. *See* DOJ Letter, *supra* note 80. The DOJ noted concerns about harms from applicants' disclosures to peers and prospective employers at multiple points in its letter, observing at 29 n.61: "The fact that applicants must unnecessarily disclose their mental health diagnoses during the admissions process renders them more vulnerable to employment discrimination, stigma, and the potential for inappropriate disability-based animus by opposing counsel in the future."

141. *Id.* at 31.

The authors of the Task Force report, in response to the DOJ's argument "that the deterrent effect of those inquiries discourages persons in need of help from seeking it," stated (without reference), that "[n]ot everyone agrees with that premise, and some argue that licensing of professionals necessarily requires evaluation of all risks that an applicant may pose to the public."[142] Empirical research within the medical profession, however, suggests these licensure questions do have a deterrent effect.[143]

Whatever the effects on engagement, policies recommending identification, reporting, and referrals of peer lawyers with suspected impairment offend principles of dignity, privacy, and autonomy. The Task Force report and other CoLAP documents sometimes cite denial, lack of insight, or stigma as reasons to support peer reporting and coerced mental health treatment in the lawyer's self-interest. But lawyers with mental health disorders will almost always retain capacity to make their own decisions about whether or not to engage in mental health treatments,[144] and their preferences and privacy rights must be respected.

B. DISCRIMINATORY EFFECTS OF LAWYER WELL-BEING POLICIES UNDER MODEL RULES 1.1, 1.16(A)(2), AND 8.3(A)

Lawyer well-being policies and programming may result in discrimination against lawyers with mental health disorders and disabilities under Model Rules 1.1, 1.16(a)(2), and 8.3(a).

Model Rule 1.1 stipulates that "competent representation requires the legal knowledge, skill, thoroughness, and preparation reasonably necessary for the representation."[145] The Task Force report has recommended modifying Rule 1.1 to "endorse well-being as part of a lawyer's duty of competence."[146] Defining lawyer competence in terms of well-being (aka wellness or health[147]) focuses appraisals of lawyers' abilities not on their performance, but on their health. This definition runs afoul of the principles articulated in the passage of the ADA that an employee's "actual performance on the job is, of course, the best measure of

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142. *See* TASK FORCE REPORT, *supra* note 2, at 27.

143. *See* Liselotte N. Dyrbye, Colin P. West, Christine A. Sinsky, Lindsey E. Goeders, Daniel V. Satele & Tait D. Shanafelt, *Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions*, 92 MAYO CLIN. PROC. 1486, 1486-87 (2017) (surveying attitudes about help-seeking in states with and without medical licensure application questions about mental health and finding the questions about mental health presented a barrier to physicians seeking help).

144. Given findings in Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUMAN BEHAV. 149, 171 (1995) that roughly 50-75% of patients hospitalized with schizophrenia and 76-90% of patients hospitalized with major depressive disorder respectively retain decisional capacity, overriding the will of *non-hospitalized* legal employees suspected of having *common mental health disorders* will almost never be appropriately justified on the basis of incapacity.

145. MODEL RULES OF PROF'L CONDUCT R. 1.1 (2018) [hereinafter MODEL RULES].

146. See TASK FORCE REPORT, *supra* note 2, at 26.

147. See *supra* note 53 and accompanying discussion.

ability to do the job."[148] It also seems inconsistent with ADA Title III prohibitions on "standards or criteria or methods of administration that have the effect of discriminating on the basis of disability, or that perpetuate the discrimination of others who are subject to common administrative control."[149]

Though the exact wording of the language proposed remains unclear, the authors suggest adopting language similar to California's Rule of Professional Conduct 3-110, which defines "competence" to include the "mental, emotional, and physical ability reasonably necessary" for representing clients.[150] Presumably, such redefinitions would leave the determination of what "mental, emotional, and physical abilit[ies are] reasonably necessary" to LAPs, employers, and other entities applying the Rule to legal employees.

Such broad definitions create even greater potential for discrimination against legal employees with mental health disorders when members of the legal community are provided with inaccurate information about mental health disorders. If lawyers are taught to link mental health disorders with inability and are taught that "freedom from substance use and mental health disorders [is] an indispensable predicate to fitness to practice,"[151] lawyers with mental health disorders and disabilities will very likely be subjected to unfair appraisals and unwarranted discipline by their employers under the *Model Rules*.

Model Rule 1.16(a)(2) bars lawyers from representing clients when "the lawyer's physical or mental condition materially impairs the lawyer's ability to represent the client."[152] If peers, employers, and judges are led to believe that physical or mental conditions by definition materially impair a lawyer's ability to represent clients, they may discriminate against lawyers with these conditions.

Model Rule 8.3(a) states that "a lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate professional authority."[153] Peers taught that lawyers with mental health disorders or disabilities are incompetent and in violation of Rule 1.16(a)(2) may also perceive these attorneys as unfit, and feel required to report these individuals to authorities for probable disciplinary scrutiny. The Well-Being Template also mandates self-reporting (and, presumably, reporting those failing to self-report) of persons who believe they "*may be at risk of being impaired*"[154] from these conditions to LAPs or management personnel. This would probably broaden the net for reportable persons to capture the

148. *See* S. REP. No. 101-116, at 36 (1989); H.R. REP. No. 101-485, pt. 2, at 75 (1990).

149. 28 C.F.R. § 36.204.

150. *See* TASK FORCE REPORT, *supra* note 2, at 26; CAL. RULES PROF'L CONDUCT R. 3-110(B) (STATE BAR OF CAL. 1989).

151. *See* TASK FORCE REPORT, *supra* note 2, at 17.

152. MODEL RULES R. 1.16(a)(2).

153. MODEL RULES R. 8.3(a).

154. *See* WELL-BEING TEMPLATE, *supra* note 74, at 2 (emphasis added).

entire legal community, though lawyers with mental health disorders and disabilities would be particularly likely to face unwarranted disciplinary scrutiny and discrimination.

C. WELL-BEING POLICIES, COMMUNICATIONS, AND PRACTICES AS A SUBTERFUGE FOR VIOLATING THE ADA

1. BACKGROUND AND FRAMEWORK OF WORKPLACE WELLNESS REGULATIONS

The ADA's rule. Debates about workplace wellness programs in recent years have concerned an ADA provision prohibiting medical inquiries and examinations of employees.[155] The ADA protects *all* employees from unwarranted medical inquiries or requests for medical examinations (here mental health inquiries and examinations).[156] These rules protect even those who do not have a disability or any history of a disability from inquiries and examinations that are not "job-related and consistent with business necessity."[157]

Under the ADA, an employer cannot implicitly or explicitly request mental health information from, or request a mental health examination of, an employee without a reasonable belief, based on objective evidence that the employee "(1) is unable to perform essential job functions because of a disability; or (2) poses a direct threat to self or others because of a disability."

"Direct threat" is defined as a high risk of substantial, imminent harm to self or others because of a disability.[158] Employers cannot implicitly or explicitly "retaliate against, interfere with, coerce, intimidate, or threaten" employees[159] to comply with mental health inquiries or examinations in the absence of these criteria, even in the context of a "voluntary" workplace wellness program.

Background and purpose. The ADA medical inquiries provision was designed to protect employees with "'hidden' disabilities such as epilepsy, diabetes, emotional illness, heart disease and cancer"[160] from exclusion resulting from acquisition of private medical information that could reveal their disability status, as Congress recognized that "[b]eing identified as having a disability often carries both blatant and subtle stigma."[161] In addition, these privacy protections preempt

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155. *See generally* Samuel R. Bagenstos, *The EEOC, the ADA, and Workplace Wellness Programs*, 27 HEALTH MATRIX 81, 85-92 (2017) [hereinafter Bagenstos, *EEOC and Wellness*].

156. *See* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM'N, EEOC No. 915.002, ENFORCEMENT GUIDANCE: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS OF EMPLOYEES UNDER THE AMERICANS WITH DISABILITIES ACT (ADA) (July 27, 2000) [hereinafter U.S. EEOC, MEDICAL INQUIRIES GUIDANCE] ("*Any* employee, therefore, has a right to challenge a disability-related inquiry or medical examination that is not job-related and consistent with business necessity.") (emphasis in original).

157. 42 U.S.C. § 12112(d)(4)(A) (2018).

158. 29 C.F.R. § 1630.2(r) (2012) ("The risk can only be considered when it poses a significant risk, i.e., high probability, of substantial harm; a speculative or remote risk is insufficient.").

159. *See* 29 C.F.R. § 1630.14(d)(2)(iii) (2020).

160. *See* H.R. REP. 101-485(II), 51 (1990).

161. *See id.* at 75 ("An inquiry or medical examination that is not job-related serves no legitimate employer purpose, but simply serves to stigmatize the person with a disability.").

discrimination[162] that might result, for example, were an employer to discover that an employee had cancer requiring costly medical treatments, or that another employee had a mental health diagnosis associated with various myths, fears, and stereotypes that could lead to employment discrimination upon discovery in the absence of a privacy rule.

Wellness regulation debates. Recent debates about workplace wellness programs roughly began in 2015, when business groups aggressively lobbied the White House to prevent the U.S. Equal Employment Opportunity Commission (EEOC) from further regulating workplace wellness programs under the ADA.[163] Business groups have pursued regulatory changes making it harder for employees to avoid participating in workplace wellness programs and "voluntarily" submitting to medical inquiries, while disability rights advocates have strongly opposed these changes.[164] Litigation over the regulations is still ongoing.[165]

Wellness programs also seem to violate several other provisions of the EEOC's regulations. Wellness programs, for example, must "have a reasonable chance of improving health or preventing disease"[166] and cannot be "a subterfuge for violating the ADA or other laws prohibiting employment discrimination," or "highly suspect in the method chosen to promote health or prevent disease."[167] Many of the well-being programs and interventions recommended in the Task Force report and the Toolkit do seem suspect, but the regulations provide insufficient guidance with which to make such a determination. The medical evidence described in Section II.C, *supra*, seems to suggest that lawyer well-being interventions do not have a "reasonable chance of improving health or preventing disease."[168] At best, the data show that wellness programs have a reasonable chance of improving health for elites, the already-healthy, gym rats,[169] or mindfulness

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162. *See generally* Jessica L. Roberts, *Protecting Privacy to Prevent Discrimination*, 56 WM. & MARY L. REV. 2097 (2015).

163. *See* Bagenstos, *EEOC and Wellness*, *supra* note 155, at 93; *see also* Lewis, *Workplace Wellness Industry*, *supra* note 49, at 48 (including a subsection, "Deliberate or Negligent Data Falsification," discussing misrepresentations of wellness research).

164. *See* Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, 76 Fed. Reg. 16,978 (Mar. 25, 2011) (codified at 29 C.F.R. pt. 1630) (dividing stakeholders providing comment on wellness rulemaking into two groups: "the business/employer community and the disability advocacy community").

165. *See* Kwesell v. Yale Univ., No. 3:19-cv-01098 (KAD) (D. Conn. Oct. 17, 2019).

166. 29 C.F.R. § 1630.14(d)(1) (2020).

167. *Id.*

168. *See* Bagenstos, *EEOC and Wellness, supra* note 155, at 82 ("Although those programs may work well in shifting health costs to sicker employees, this body of evidence indicates that they are unlikely to actually improve health in any significant way."); *see also* Jones, *Illinois Workplace Wellness Study*, *supra* note 122, at 2; Song & Baicker, *Wellness RCT*, *supra* note 122, at 1491.

169. *See* Damon Jones, David Molitor & Julian Reif, *A Reason to Be Skeptical of the Workplace Wellness Industry*, SCIENTIFIC AMERICAN (Mar. 19, 2019), https://www.scientificamerican.com/article/a-reason-to-be-skeptical-of-the-workplace-wellness-industry/ [https://perma.cc/QR5J-8Z89] ("Are gym rats, like your office-mates who already run marathons or lead healthy lifestyles, the ones opting into these types of programs? If so,

enthusiasts, but may likely hurt everyone else. Finally, another unresolved question is how the overall health effects of wellness programs are to be evaluated when wellness research does not evaluate for adverse effects or unintended consequences.[170]

2. PROFESSIONAL POLICIES AND COMMUNICATIONS RELATED TO WELL-BEING VS. THE ADA

Members of the legal community, including judges, may receive misinformation about mental health disorders and disabilities[171] and harbor negative stereotypes and prejudice towards these attorneys that result in discrimination. The challenges faced by attorneys with mental health disorders and disabilities or who are perceived by employers as having these conditions are likely complicated by lack of familiarity within the legal community of the ADA's rules on prohibited medical inquiries.

The ADA's rules do not appear in either the Task Force report or the Toolkit, despite their 172 combined pages in length.[172] But members of the legal workforce must be aware of these rules to protect their right to be free from unwarranted inquiries or requests for examinations. These employment rights are not taught as part of the required law school curriculum, and legal employees are more likely to be familiar with ABA *Model Rules* and CoLAP policies related to lawyer well-being than with federal civil rights laws protecting their rights as legal employees.

Only once does the Toolkit mention any possible legal issues that might be raised by employers conducting the Toolkit's recommended mental health assessments of employees. The Toolkit states: "If legal employers have any concerns that collecting such information would create legal risks, they may wish to discuss these issues with their legal counsel or with Employee Assistance Programs and insurance carriers that have experience in this area."[173] But the statement

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are the programs really improving people's health and reducing costs, or are they just attracting healthier (or wealthier, younger, etc.) people?").

170. *See* Madison, *Risks of Wellness*, *supra* note 123, at 2073; Luke Wolfenden, Sharni Goldman, Fiona G. Stacey, Alice Grady, Melanie Kingsland, Christopher M. Williams, John Wiggers, Andrew Milat, Chriss Rissel, Adrian Bauman et al., *Strategies to Improve the Implementation of Workplace-Based Policies or Practices Targeting Tobacco, Alcohol, Diet, Physical Activity and Obesity*, 11 COCHRANE DATABASE SYSTEMATIC REVS., Art. No.: CD012439, at 3 (2018) ("[N]one [of the studies reported] on the unintended adverse consequences of implementation strategies.").

171. *See* Michael L. Perlin, *Sanism and the Law*, 15 AMA J. ETHICS 878, 881 (2013) (critiquing judicial disregard for social science data empirically refuting mental disability myths and arguing that "[e]ven when courts do acknowledge the existence and possible validity of studies that take a position contrary to their decisions, this acknowledgement is frequently little more than mere 'lip service'").

172. *See also* Ronald E. Mallen, Annotation, *Managing Risk from Impaired Lawyers—Law Firm Prevention and Remedial Services*, 1 LEGAL MALPRACTICE § 2:137 (2020 ed.) (critiquing the ABA Comm. on Ethics & Prof'l Responsibility, Formal Op. 03–429 (2003), "the Formal Opinion did not address the obligations of the law firm to the mentally impaired lawyer under the Americans with Disabilities Act of 1990").

173. *See* WELL-BEING TOOLKIT, *supra* note 73, at 24.

does not provide sufficient notice or information to employers or employees about these legal issues.[174]

Ironically, while some professional entities have increasingly encouraged mental health inquiries and evaluations of lawyers in the workplace, there has been some progress in efforts to reduce mental health inquiries on bar applications. In 2015, for example, the ABA passed a resolution sponsored by its Commission on Disability Rights "urg[ing] state and territorial bar licensing entities to eliminate any questions that ask about mental health history, diagnoses, or treatment when determining character and fitness for the purpose of bar admission."[175] The problem is one of inadequate reconciliation between professional entities on the problem of mental health inquiries on applications for licensure as well as the simultaneous propagation of policies that promote mental health inquiries in the workplace in spite of the ADA's rules.

3. BURNOUT, RESILIENCE, EMOTIONAL INTELLIGENCE, AND PERSONALITY ASSESSMENTS

Professional well-being policies can also act as a subterfuge for violating the ADA in relation to concepts like burnout, resilience, personality characteristics, or other proxies for mental health disorders and disabilities. The Toolkit, in particular, recommends assessments and suggests specific measurement instruments for burnout, resilience, and personality characteristics in addition to depression, anxiety, etc.[176]

Burnout "is not classified as a medical condition nor disability by the World Health Organization, but as an occupational condition."[177] A recent peer reviewer for a general internal medicine journal has cited this as a condition "that preclude[s] it from being considered under the ADA."[178] But this is incorrect.

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174. It is a problem that professional organizations' policies on these issues are almost certainly more well-known than substantive federal employment law. Professor Sandra Johnson has observed that "[t]here is substantial evidence that these internal norms and procedures have a significantly more powerful effect on the daily work of health care professionals than do statutes, regulations, and case law. . . . [An] organization's internal standards and procedures may differ significantly from what the law requires . . . and may frustrate the goals of reform." Sandra H. Johnson, *What Law Really Requires*, 42 HASTINGS CTR. REP. 11, 11 (2012); *see also* Terri D. Keville, *Dealing with Physician Impairment and Misconduct in the Hospital Medical Staff Setting: Practical and Legal Issues*, 13 ABA HEALTH ESOURCE (2017) (providing detailed guidance on identifying physicians with mental health disorders and disabilities from the American Medical Association (AMA), The Joint Commission, the Federation of State Medical Boards, and the Federation of State Physician Health Programs, but alluding to the ADA only once, stating that "[f]ederal and state antidiscrimination laws also may be implicated in impaired physician situations, e.g., the federal Americans with Disabilities Act").

175. *See* ABA CDR RESOLUTION, *supra* note 78. More appropriate questions "focus on conduct or behavior, including deceit, fraud, financial irresponsibility, criminal arrests and convictions, academic, employment and professional discipline, and driving under the influence of drugs or alcohol." *Id.*

176. *See* WELL-BEING TOOLKIT, *supra* note 73, at 25–28.

177. E-mail from Donna Windish, Assoc. Editor, Journal of General Internal Medicine, to author (Aug. 21, 2019, 09:50 AM EST) (on file with author).

178. *Id.*

Assessments that "provide evidence that would lead to identifying a mental disorder or impairment (for example, those listed in the American Psychiatric Association's most recent" DSM) are considered medical exams under the ADA.[179] The most widely used measures to assess burnout and resilience include many items that would lead to identifying whether the individual has depression,[180] a DSM-5 listed condition. Accordingly, these assessments are likely medical exams that are covered under the ADA.[181]

Resilience[182] and emotional intelligence are concepts related to personality, with some characterizing the later as "little more than a thinly veiled repackaging of personality tests."[183] Personality traits are not considered mental impairments or disabilities under the ADA,[184] and some commentators have suggested that "psychological and personality tests can circumvent the protections provided" in Title VII and the ADA.[185] Wellness policies, communications, and practices may act as a subterfuge for violating the ADA simply by describing target traits (e.g.,

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179. *See* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM'N, EEOC No. 915.002, ENFORCEMENT GUIDANCE: PREEMPLOYMENT DISABILITY RELATED QUESTIONS AND MEDICAL EXAMINATIONS (1995) (also giving the following hypothetical: "An employer gives applicants the RUOK Test (hypothetical), an examination which reflects whether applicants have characteristics that lead to identifying whether the individual has excessive anxiety, depression, and certain compulsive disorders (DSM-listed conditions). This test is medical" and therefore covered under the ADA); *see also* Karraker v. Rent-A-Center, Inc., 411 F.3d 831, 831 (7th Cir. 2005) (employer's administration of Minnesota Multiphasic Personality Inventory, which was designed, in part, to reveal mental illness, as part of management test was medical examination and violated ADA).

180. *See* Christina Maslach & Susan E. Jackson, *The Measurement of Experienced Burnout*, 2 J. OCCUPATIONAL BEHAV. 99, 102-03 (1981) (containing items such as "I feel fatigued when I get up in the morning," "I worry that this job is hardening me emotionally," etc.); *see also* Bruce W. Smith, Jeanne Dalen, Kathryn Wiggins, Erin Tooley, Paulette Christopher & Jennifer Bernard, *The Brief Resilience Scale: Assessing the Ability to Bounce Back*, 15 INT'L J. BEHAV. MED. 194, 196 (2008) ("I tend to take a long time to get over set-backs in my life.").

181. *Cf.* Sharona Hoffman, *Healing the Healers: Legal Remedies for Physician Burnout*, 18 YALE J. HEALTH POL'Y, L. & ETHICS 56, 107 (2019) (recommending that "[p]hysicians should be required to complete the [Maslach Burnout Inventory (MBI)] or an equivalent assessment tool annually," despite wellness regulations requiring that such assessments be "voluntary." 29 C.F.R. § 1630.14(d)(1)). *But see* Nicholas D. Lawson, *Physician Burnout and the Americans with Disabilities Act*, 50 HASTINGS CTR. REP. 47, 47 (2020).

182. *See generally* Diann S. Eley, C. Robert Cloninger, Lucie Walters, Caroline Laurence, Robyn Synnott & David Wilkinson, *The Relationship Between Resilience and Personality Traits in Doctors: Implications for Enhancing Well Being*, 1 PEERJ e:216 (2013).

183. Kevin W. Eva, *Dangerous Personalities*, 10 ADVANCES HEALTH SCI. EDUC. 275, 275 (2005).

184. *See* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM'N, EEOC No. 915.002, ENFORCEMENT GUIDANCE ON THE AMERICANS WITH DISABILITIES ACT AND PSYCHIATRIC DISABILITIES (1997).

185. *See* Sujata S. Menjoge, *Testing the Limits of Anti-Discrimination Law: How Employers' Use of Pre-Employment Psychological and Personality Tests Can Circumvent Title VII and the ADA*, 82 N.C. L. REV. 326, 328-29 (2003) (describing "three major ways that such discrimination can occur: (1) the tests may contain questions that employers would not normally be permitted to ask during a pre-employment interview; (2) the tests may eliminate candidates on the basis of specific character traits traditionally possessed by certain minority groups; and (3) the tests may be standardized in a way that reflects cultural bias against those who do not fit within the middle-class, racial and religious norm"); *see also* Quinisha Jackson-Wright, *Questioning Personality Assessments*, N.Y. TIMES, Aug. 26, 2019, at B8 (arguing "to promote inclusivity, stay away from personality assessments" and asking whether they "help managers learn their team's working styles, or just encourage them to hire and promote people like them").

burnout, resilience, personality characteristics) that are not widely recognized among the public as being protected under the ADA's rules.

4. THE EMPLOYERS' AGENTS: COWORKERS, WELL-BEING ADVOCATES, AND EMPLOYEE ASSISTANCE PROGRAM AND LAP PERSONNEL

The Well-Being Template is fairly explicit in instituting employment policies mandating legal employees to make inquiries or perform exams on their peers and report their findings to employers.[186] It is not entirely clear how current ADA rules would apply to these situations. The ADA prohibits only *employers* from making inquiries and exams, not *peer employees*; however, the ADA does prohibit the employers' agents from making inquiries and performing exams of employees on employers' behalf.[187] If employers mandate that peer employees make medical inquiries and perform examinations of other employees—as CoLAP recommends that they do[188]—the reporting employees might be regarded as agents of the employer, and the employer may be liable.[189] Similar principles might apply to the law firm "well-being advocates" recommended in the Task Force report.[190]

In general, employees are also protected under the ADA from unwarranted referrals to Employee Assistance Programs (EAPs).[191] But confusion regarding the ADA rules that apply to EAPs may be one reason they have been involved in a sizeable number of ADA cases addressing psychological or psychiatric testing of employees as a violation of the ADA.[192] Overall, the proliferation of various

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186. *See* WELL-BEING TEMPLATE, *supra* note 74, at 2.

187. *See* 42 U.S.C. § 12111(5) (2009) (defining "employer" as including agents of the employer); 29 U.S.C. § 203(d) (2018) ("'Employer' includes any person acting directly or indirectly in the interest of an employer in relation to an employee."); U.S. EEOC, MEDICAL INQUIRIES GUIDANCE, *supra* note 156 ("The definition of 'employer' includes persons who are 'agents' of the employer, such as managers, supervisors, or others who act for the employer (e.g., agencies used to conduct background checks on applicants and employees).").

188. *See* WELL-BEING TEMPLATE, *supra* note 74, at 2.

189. *See* Dittman v. Quest Diagnostics, Inc., 756 Fed. App'x 616, 618 (7th Cir. 2019). The opinion discusses agents in the context of a workplace wellness program and explains that "courts presume . . . 'Congress intended to describe the conventional master-servant relationship as understood by common-law agency doctrine'" (citations omitted). The opinion notes that "[i]n applying agency doctrine, we look primarily to whether an entity has sufficient 'control' over a particular worker." (citing Frey v. Coleman, 903 F.3d 671, 676 (7th Cir. 2018)).

190. *See* TASK FORCE REPORT, *supra* note 2, at 31 (recommending firms appoint a "well-being advocate" to "form strategic partnerships with lawyer assistance programs and other well-being experts").

191. See U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM'N, Informal Discussion Letter on ADA: Definition of Disability – In General (July 19, 2000), https://www.eeoc.gov/foia/eeoc-informal-discussion-letter-7 [https://perma.cc/BK7M-78D5], which explains that "a referral to an EAP in combination with other relevant evidence could raise an inference that the employer regarded the person as [disabled and that an] . . . employer may not force the individual with a disability to choose between treatment or EAP participation and discipline in situations where other employees would not be disciplined" (citations omitted).

192. *See* Morgan v. City of Tallahassee, No. 4:16cv100-RH/CAS, 2016 WL 6916814, at *1 (N.D. Fla. Nov. 21, 2016); Small v. Memphis-Shelby Cnty. Airport Auth., No. 2:13-cv-02437-JMP-dkv, 2015 WL 7776605, at *13 (W.D. Tenn. Dec. 2, 2015); Dengel v. Waukesha Cty., 16 F. Supp. 3d 983, 991 (E.D. Wis. 2014); Oliver v. TECO Energy, Inc., No. 8:12–cv–2117–T–33TBM, 2013 WL 6836421, at *7-8 (M.D. Fla. Dec. 26, 2013);

wellness entities acting as agents of employers makes it easier to circumvent the ADA rules, especially when few employees are informed and aware of existing protections.

D. SOCIAL CONTROL, SURVEILLANCE, AND DISCRETIONARY SYSTEMS OF DISCIPLINE

1. WELL-BEING IDEOLOGY SHIFTS BLAME FROM INSTITUTIONS TO INDIVIDUALS

The legal profession today faces important structural problems that remain at the periphery of the lawyer well-being movement's individualistic focus. Like in the medical profession, such problems include inequality; unfairness for stigmatized groups, whistleblowers, and public interest attorneys; and inadequate attention to these problems.[193] Professor Nancy Levit has described why legal employees, particularly those lawyers subject to stigmatization, typically have very little recourse against their employers at law firms: "Legal communities are often small and may be unforgiving if lawyer plaintiffs sue their own firms."[194] Professor Levit also described how the subjectivity of assessments of legal work makes it difficult to challenge stigmatization and discrimination in legal employment.[195] Courts, she says, "have given employers a large ambit of discretion to decide what practices further their 'legitimate' business or employment goals."[196]

At-will employment law, contract protections and stability, unions, employment rights, education about employment protections, and public defender caseloads more than five times what can reasonably be accomplished,[197] almost never figure into lawyer well-being discussions. Meanwhile, state bar associations and state medical boards continue to ask questions unlikely to comply with ADA rules.[198] State LAPs and PHPs and mandated peer reporting policies targeting professionals with mental health disorders have rarely been scrutinized.

Jenkins v. Med. Labs. of E. Iowa, Inc., 880 F. Supp. 2d 946, 956 (N.D. Iowa 2012); Shannon v. Verizon N.Y., Inc., No. 1:05–CV–0555 (LEK/DRH), 2009 WL 1514478, at *4 (N.D.N.Y. May 29, 2009); Pence v. Tenneco Auto. Operating Co., 169 Fed. App'x 808, 812 (4th Cir. 2006); Traveler v. CSX Transp., Inc., No. 1:06-CV-56-TS, 2007 WL 2500173, at *1 (N.D. Ind. Aug. 30, 2007); Conrad v. Bd. of Johnson Cnty. Comm'rs, 237 F. Supp. 2d 1204, 1213 (D. Kan. 2002).

193. See *infra* notes 194–214 and accompanying discussion.

194. *See* Nancy Levit, *Lawyers Suing Law Firms: The Limits on Attorney Employment Discrimination Claims and the Prospects for Creating Happy Lawyers*, 73 U. PITT. L. REV. 65, 69 (2011) [hereinafter Levit, *Lawyers Suing Law Firms*].

195. *See id.* at 77 ("[S]ubtle forms of exclusion are rampant within law firms but, in most cases, are hard to document . . . The channels for workflow are often chaotic . . . [and it] is difficult to trace these more subtle forms of bias, subjective evaluation mechanisms, and exclusions from networking opportunities.").

196. *See id.* at 83.

197. *See* Richard A. Oppel, Jr. & Jugal K. Patel, *One Lawyer, 194 Felony Cases, and No Time*, N.Y. TIMES (Jan. 31, 2019), https://www.nytimes.com/interactive/2019/01/31/us/public-defender-case-loads.html [https://perma.cc/R82K-YFCE].

198. *See* James T.R. Jones, Carol S. North, Suzanne Vogel-Scibilia, Michael F. Myers & Richard R. Owen, *Medical Licensure Questions About Mental Illness and Compliance with the Americans with Disabilities Act*, 46 J. AM. ACAD. PSYCHIATRY & L. 458, 458 (2018) ("[T]he majority still ask questions that are unlikely to meet ADA standards.").

Several commentators have criticized lawyer wellness policies, initiatives, and ideology for shifting blame from institutions to individuals. Content analysis of the Task Force report reveals an overwhelming focus on individual-level mental health variables of legal employees to the neglect of structural problems.[199] Professor Paula Baron has described

> the extraordinary "sleight of hand" that has occurred in the wellbeing discourse by which responsibility for lawyer distress, both in terms of cause and solution, is deflected away from institutions and increasingly attributed to the individual. . . . [T]here are institutional interests at work in prioritising productivity and efficiency, as we will see, that can lead to the individual attribution of responsibility for lawyer distress; and the attribution of responsibility to the individual benefits the burgeoning industry in mental health.[200]

Law firms today are also placing individual resilience high on their list of must-haves in leadership positions.[201] As one worksite psychologist put it: "[w]hen employees must do more with less, cope with inefficiencies or inequities in the workplace or work with leaders who 'don't get it,' they understandably want to see sweeping changes in the team, the organization or the industry."[202] But she advises employees to develop personal resilience and "stop resisting it"; they should "believe that they, and not their circumstances, determine their success"; "[h]appy people are more successful than people who are stressed out and cynical."[203] On the Georgetown University Law Center for Wellness Promotion

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199. *See generally* TASK FORCE REPORT, *supra* note 2. Content analysis of the Task Force report reveals the following hit counts for words: "well-being" 437; "mental" 164; "lawyer assistance" 121; "substance use" 92; "burnout" 53; "alcohol" 52; "wellness" 48; "depression" 45; "resilience" 44; "wellbeing" 40; "physical" 34; "mindfulness" 27; "addiction" 25; "impairment" 23; "anxiety" 21; "impaired" 18; "suicide" 18; "identifying" 16; "crisis" 11; "older" 9; "senior lawyers" 6; "reporting" 5; "strive" 4; "senior lawyer" 3; "denial" 3; "discrimination" 1; "retaliation" 0; "discriminate" 0; "incompetent" 0; "Americans with Disabilities Act" 0.

200. Paula Baron, *Sleight of Hand: Lawyer Distress and the Attribution of Responsibility*, 23 GRIFFITH L. REV. 261, 262, 264 (2014). *See generally* Margaret Thornton, *Law Student Wellbeing: A Neoliberal Conundrum*, 58 AUSTL. U. REV. 42 (2016).

201. *See* Paula Davis-Laack, *What Resilient Lawyers Do Differently*, FORBES MAG. (Sept. 26, 2017), https://www.forbes.com/sites/pauladavislaack/2017/09/26/what-resilient-lawyers-do-differently/#2a6162034958 [https://perma.cc/8BPV-HWZL].

202. Christine Allen, *Resilience is a Competitive Advantage: How to Stop Resisting It and Start Building It*, FORBES MAG. (Feb. 27, 2018), https://www.forbes.com/sites/forbescoachescouncil/2018/02/27/resilience-is-a-competitive-advantage-how-to-stop-resisting-it-and-start-building-it/#39e5178a1f20 [https://perma.cc/TVV2-EWHZ].

203. *Id.*; see also Christopher Lane, *The Surprising History of Passive-Aggressive Personality Disorder*, 19 THEORY & PSYCHOL. 55, 62, 64-66 (2009), describing the DSM history of passive-aggressive personality disorder, "when a patient 'feels misunderstood' while displaying a 'negative attitude (chip on shoulder),'" "complains of being victimized, misunderstood, and unappreciated by those with whom he or she lives and works," "expresses envy and resentment toward those apparently more fortunate," "claims to be luckless, ill-starred, and jinxed in life," and "often criticize[s] and voice[s] hostility toward authority figures with minimal provocation. They are also envious and resentful of peers who succeed and who are viewed positively by authority." "A housewife with the disorder may fail to do the laundry or to stock the kitchen with food because of procrastination and dawdling." Lane also describes the DSM history of chronic complaint disorder, afflicting persons who "heretofore were known by the synonyms: 'kvetch,' 'scootch,' 'noodge.'"

website, law students are advised in large bold letters: "Resilience and positive perspective are essential lawyering skills."[204] Cynical interpretations of these messages are not to complain, criticize, or become a cynic about the administration and hierarchy; resistance is a sign of employee ineffectiveness.[205]

Many wellness messages on law schools' websites relate to an individualistic striving ideal. The University of Pennsylvania Law School website reports that, in recognition of "how important mental and physical wellbeing of lawyers is to providing clients of legal professionals with the best services possible,"[206] it became the first top law school to "incorporate a session on attorney well-being into every section of the mandatory Professional Responsibility course"[207] in 2018. The University of Michigan Law School's Student Wellness Week flier reads: "Leaders at Their Best," "Peak Performance, Healthy Striving, and Excellence."[208] The Task Force report's description of the Preamble to the ABA Model Rules also describes how

> lawyer well-being influences ethics and professionalism. . . . Minimum competence is critical to protecting clients and allows lawyers to avoid discipline. But it will not enable them to live up to the aspirational goal articulated in the Preamble to the ABA's Model Rules of Professional Conduct, which calls lawyers to '*strive* to attain the highest level of skill. . . .'[209]

Professor Anna Kirkland has described how "[t]he striving, becoming, improving person has been at the center of wellness discourse for many decades and has seamlessly become the ideal employee. Why companies would want this person held up as the ideal worker is obvious . . . ."[210]

The striving ideal also illustrates why there is, according to disability rights advocate and attorney Carrie G. Basas, a "fundamental conflict between disability and wellness."[211] The disability rights perspective accepts that certain people have limitations, that some people with "physical or mental impairments will

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204. GEORGETOWN UNIVERSITY LAW CENTER, *Mind,* CENTER FOR WELLNESS PROMOTION, https://www.law.georgetown.edu/your-life-career/health-fitness/center-for-wellness-promotion/mind/ [https://perma.cc/BV29-7E3B] (last visited October 12, 2020).

205. *See* Helena Winston & Bruce Fage, *Resilience, Resistance: A Commentary on the Historical Origins of Resilience and Wellness Initiatives*, 70 PSYCHIATRIC SERVS. 737, 738 (2019).

206. PENN LAW, *Wellness at Penn Law* (Jan. 23, 2020), https://www.law.upenn.edu/live/news/9704-wellness-at-penn-law [https://perma.cc/6ANN-W854].

207. PENN LAW, *Penn Law to Launch Unique Pilot Program Incorporating Attorney Well-Being into Professional Responsibility Curriculum* (Nov. 29, 2018), https://www.law.upenn.edu/live/news/8696-penn-law-to-launch-unique-pilot-program [https://perma.cc/LF34-AP7Q].

208. MICHIGAN LAW, *Student Wellness Week*, https://studentlife.umich.edu/article/student-wellness-week [https://perma.cc/3V5V-U8WG] (last visited October 12, 2020).

209. TASK FORCE REPORT, *supra* note 2, at 8 (emphasis added).

210. Anna Kirkland, *Critical Perspectives on Wellness*, 39 J. HEALTH POL. POL'Y & L. 971, 973 (2014) [hereinafter Kirkland, *Critical Perspectives on Wellness*].

211. Carrie Griffin Basas, *What's Bad About Wellness? What the Disability Rights Perspective Offers About the Limitations of Wellness*, 39 J. HEALTH POL. POL'Y & L. 1035, 1054 (2014) [hereinafter Basas, *What's Bad About Wellness?*].

not be able to control many aspects of their health, even with concerted efforts,"[212] and that "best efforts are spent not on trying to change the impossible but in removing the social and economic barriers that stigmatize illness."[213] The wellness perspective does not acknowledge that many disabilities may only mildly affect, interfere with, or impair a person's work performance and leave the worker still performing at a very high level; it is uncomfortable with imperfection.[214] Implicit from the Task Force report, lawyers who do not participate in their recommended wellness activities are not *striving* to attain the highest level of skill; they are, accordingly, unprofessional.[215]

2. PEER REPORTING POLICIES AT LAW SCHOOLS

State LAPs and proponents of lawyer well-being policies encourage training students and coworkers to "recognize signs of substance use disorders and mental health concerns and respond effectively" by reporting these individuals to their law school's administration or their legal employers. For example, Georgetown University Law Center encourages students to report other students who exhibit signs of suicide.[216] Yet school-based suicide prevention policies lack evidence of effectiveness.[217] Proponents of these policies also appear to have disregarded the advice of state high courts that "[n]onclinicians are also not expected to

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212. *Id.* at 1035.

213. *Id.* at 1054.

214. *See* Grace W. Gengoux & Laura Weiss Roberts, *Ethical Use of Student Profiles to Predict and Prevent Development of Depression Symptoms During Medical School*, 94 ACAD. MED. 162, 163 (2019) (describing the critique of wellness as "reinforce[ing] the unwelcome normative ideal of physicians endeavoring at all times to be, or become, perfect" (citing Kirkland, *Critical Perspectives on Wellness*, *supra* note 210, at 973)).

215. *See* TASK FORCE REPORT, *supra* note 2; *see also* Basas, *What's Bad About Wellness?*, *supra* note 211, at 1058 (arguing that the wellness approach "suggests that employers can, and should be, in the business of monitoring and regulating their employees' health . . . and that employers (and their wellness contractors) know best in creating wellness programs") (citation omitted).

Similar critiques have been made about "professionalism" in general. For example, Maria Athina Martimianakis, Jerry M. Maniate, & Brian David Hodges, *Sociological Interpretations of Professionalism*, 43 MED. EDUC. 829, 833–34 (2009) [hereinafter Martimiankis, *Sociological Interpretations of Professionalism*] describe professionalism in the medical field as functioning "to justify the performance by its most junior members of skills that could otherwise be taken up by other professions . . . . [and] legitimate [professionals'] claims to professional privilege . . . [through] discourses of self-reflection and self-assessment [that] might actually be part of the process of professional control and normalisation that could submerge and repress any authentic discussion and examination of personal thoughts and behaviours and replace them with 'appropriate' self-reflections shaped by institutions. . . . Being a 'good' medical student essentially entailed suppressing manifestations of gender, culture and sexual orientation."

216. *See* Organ, *Survey of Law Student Well-Being*, *supra* note 35, at 152 (explaining that Georgetown University Law Center "has established a procedure whereby anyone concerned about a student can send an email containing only the student's name; trained law school officials then check in with one another and investigate further to determine if a meeting with the student is warranted") (citation omitted).

217. See *supra* notes 120–21 and accompanying discussion. Note, also, that even studies of school-based suicide prevention strategies reporting positive outcomes on student-reported suicidal ideation typically do not report reductions in actual suicides.

discern suicidal tendencies where the student has not stated his or her plans or intentions to commit suicide."[218] Psychiatrist and former American Psychiatric Association President Paul S. Appelbaum advises that "[e]fforts to anticipate rare acts such as suicide and homicide inevitably result in overprediction, meaning that many of the targets of preventive actions will be misidentified."[219] The result, according to Appelbaum, is lack of disclosure, isolation, and avoidance of mental health care.[220] These reporting policies also fit within a broader pattern of recent federal and state school surveillance proposals that civil and disability rights advocates say disproportionately affect minority youth.[221]

3. BROAD SURVEILLANCE NETS AND DISCRETIONARY DISCIPLINE

In the professional workplace, encouraging lay reporting of lawyers with suspected "signs of distress" or "warning signs of substance use or mental health disorders" will very likely subject almost all employees to possible branding as impaired. The "warning signs of impairment" that CoLAP publications describe[222] (e.g., "Overreaction to real or imagined criticism," "Complaints of fatigue," "Alternate periods of high and low productivity") will not detect lawyers

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218. Dzung Duy Nguyen v. Mass. Inst. of Tech., 96 N.E.3d 128, 144 (Mass. 2018) (discussing universities' possible duties *in loco parentis* to prevent student suicide and finding that "[e]ven a student's generalized statements about suicidal thoughts or ideation are not enough, given their prevalence in the university community. The duty is not triggered merely by a university's knowledge of a student's suicidal ideation without any stated plans or intentions to act on such thoughts.").

219. Paul S. Appelbaum, *Responsibility for Suicide or Violence on Campus*, 70 PSYCHIATRIC SERVS. 350, 352 (2019).

220. *See id.*; *see also* Paul S. Appelbaum, *"Depressed? Get out!": Dealing with Suicidal Students on College Campuses*, 57 PSYCHIATRIC SERVS 914, 915 (2006) ("[T]he odds that a student with suicidal ideation will actually commit suicide are 1,000 to 1.") (citation omitted). *See generally* SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 386–407 (2016) [hereinafter RATIONAL SUICIDE] (describing cases of discrimination against students by institutions of higher education on the basis of suicidality).

221. *See* Valerie Strauss, *Civil Rights, Disabilities Groups Urge Florida to Stop Building Student Database They Call 'Massive Surveillance Effort'*, WASH. POST, July 10, 2019, https://www.washingtonpost.com/education/2019/07/10/civil-rights-disabilities-groups-urge-florida-stop-building-student-database-they-call-massive-surveillance-effort/ [https://perma.cc/52D4-RXLE] (describing Florida officials' efforts to collect data on student histories of being a victim of "bullying based on protected characteristics, foster care records and homelessness status, history of mental illness and substance abuse, social media posts, and feelings of anger and persecution . . . to try to prevent school shootings by tracking students who may become violent"); *see also* Jennifer Mathis, *Mental Health Privacy: Do Inquiring Minds Really Need to Know?*, 41 HUM. RTS. 10, 11 (2016) (describing a bill that would have "limit[ed] privacy protections for students with serious mental illness under the Family Educational Rights and Privacy Act (FERPA). The legislation would [have] create[d] a two-tier system of privacy where people with serious mental illness have fewer privacy rights than everyone else.").

222. AM. BAR ASS'N, STANDING COMM. ON SUBSTANCE ABUSE & AM. BAR ASS'N, COMM'N ON LAWYER ASSISTANCE PROGRAMS, SUBSTANCE ABUSE AND ETHICS: THE JUDICIAL DUTY TO RESPOND, 9–10, (Aug. 2001), https://www.texasbar.com/AM/Template.cfm?Section=Judges1&Template=/CM/ContentDisplay.cfm&ContentID=15129 [https://perma.cc/6ZPD-H6VB].

who are likely to harm a firm's clients. Instead, these descriptions will more likely result in inappropriate disciplinary attention to those alleged to be impaired.

Though an empirical analysis of LAPs' descriptions of possible "warning signs" has not been conducted, the descriptions appear very similar to those provided by PHPs, which are regularly reinforced at hospitals, orientations, and educational settings.[223] A study conducted in 2017 by the author and psychiatrist J. Wesley Boyd analyzed all 571 PHP descriptions of signs and symptoms of allegedly describing physician impairment provided on PHP websites. The study found that more than 95% of the general population in full-time employment would report that at least two of these descriptions (out of a typical list of twenty-five) describe them; on average, a member of the general population in full-time employment would meet criteria for 10/25 (40%) of these descriptions.[224] These descriptions of impairment are so broad they make almost anyone susceptible to being branded as impaired. Even so, they are likely to subject certain professionals, such as those with mental health disorders and disabilities, to disproportionate disciplinary attention and scrutiny.[225] Other PHP descriptions of physician impairment problematically include denial (e.g., "denying or expressing guilt or shame about personal use")[226] or complaining or asserting one's rights against management (e.g., "involvement in litigation against hospital"), making it harder for all employees to exercise their rights to be free from harassment, discrimination, and retaliation, or to blow the whistle on

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223. Nicholas D. Lawson & J. Wesley Boyd, *How Broad Are State Physician Health Program Descriptions of Physician Impairment?*, 13 SUBSTANCE ABUSE TREATMENT PREVENTION & POL'Y 1 (2018).

224. *Id.*

225. *See* Nicholas D. Lawson & J. Wesley Boyd, *Do State Physician Health Programs Encourage Referrals That Violate the Americans with Disabilities Act?*, 56 INT'L J.L. & PSYCHIATRY 65, 65–67 (2018) [hereinafter Lawson & Boyd, *State PHPs Violate ADA?*] (describing how some of these descriptions of "impairment" are overtly discriminatory (e.g., "continual asking of special accommodations," "unusual medical problems or disabilities," "multiple medical problems"). Some could discriminate against persons with attention-deficit/hyperactivity disorder, specific learnings disorders (learning disabilities), and other alternative learning and working styles (e.g., "making rounds at unusual hours"). Some could discriminate by association (e.g., "spouse in therapy or taking psychoactive medication," "frequently associates with known alcohol or substance users/abusers"). Some could discriminate against past victims of discrimination by describing social withdrawal (e.g., "isolative, withdrawn"), which is a common reaction to discrimination; unemployment (e.g., "unexplained gaps in resume"); or low socioeconomic status (e.g., "financial problems"). The authors explain that most are only loosely related to mental health disorders or performance (e.g., "frequent trips to the bathroom," "wearing long sleeves in warm weather") and that no more than four percent of the descriptions could provide sufficient justification under the ADA for an employer to make medical inquiries or request examinations).

226. *See id.* at 66; *see also* Ross, *Business of Managing Nurses' SUDs*, *supra* note 19, at 9–10 (extensively critiquing nurse program policies "targeting what is seen as the nurses' cardinal characterological failing, their 'denial,' in order to secure their submission to the dominant ideology: 'Denial is the chief characteristic of all addictive diseases. . . . In this way, the nurses' compliance to the mandated regime was considered to be one and the same as their recovery from substance-use problems. . . . Mandated compliance with specific activities cannot be considered an accurate measure of commitment to, or actual recovery from, substance-use problems. . . . [Y]et nurses' protests of their [programs'] decisions were categorized as substantiation of their 'denial' or 'treatment resistance,' however valid they may have been. The only escape from this Kafkaesque circular reasoning was complete subordination.").

employers and management.[227] Leaders within the legal community should evaluate similar descriptions being used in the legal profession to avoid similar problems.

IV. ON ADVOCATING FOR PEOPLE WITHOUT STIGMATIZING THEM

This Article has been highly critical of the Task Force, CoLAP, and LAPs for disseminating stigmatizing claims about lawyers with mental health disorders and disabilities, but these claims are part of a broader problem: the strategic use of stigma in the name of advocacy.[228] Section IV.A describes two other examples

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227. Lawson & Boyd, *State PHPs Violate ADA?*, *supra* note 225, at 69; see *id.* at 66–67, for further discussion and representative citations. For recent discussion on the disruptive physician label, see Roy M. Poses & Wally R. Smith, *How Employed Physicians' Contracts May Threaten Their Patients and Professionalism*, 165 ANNALS INTERNAL MED. 55, 55 (2016) (describing "termination for 'disruptive' behavior, as defined by the employer" and noting that "'disruptive behavior' may be defined so expansively that it means dissenting with management, even whistleblowing about quality or ethics issues"); *see also* Zachary R. Paterick & Timothy E. Paterick, *Peer Review – Legal and Ethical Issues Faced by Medical Staff: The Mandate for Physician Leadership*, 4 HOSP. PRACS. & RES. 76, 76 (2019); Cara Marie Rogers, Gary Simonds, Darlene A. Mayo, Mark E. Linskey & Jeremy Phelps, *Commentary: Addressing Concerns Regarding the Evolving "Disruptive Physician" Label*, 84 NEUROSURGERY E225, E225–27 (2019); Rajesh Swaroop, *Disrupting Physician Clinical Practice Peer Review*, 23 THE PERMANENTE [PERM] J. 18-207 (2019), https://dx.doi.org/10.7812%2ftpP%2F18-207 [https://perma.cc/VL7A-J64Q].

Psychiatry in general also has a tendency to psychopathologize persons who dissent or stick up for their civil rights. The only mention of the ADA in John W. Barnhill, DSM-5 CLINICAL CASES 309 (1st ed. 2013) is a patient with antisocial personality disorder threatening to sue if he does not receive disability accommodations:

> When the head of human resources met with him to discuss termination, Mr. Crocker quickly pointed out that he had both attention-deficit/hyperactivity disorder (ADHD) and bipolar disorder. He said that if not granted an accommodation under the Americans with Disabilities Act, he would sue. . . . Diagnosis Antisocial personality disorder.

228. For critiques of using "stigma as a public health tool" see Kirsten Bell, Amy Salmon, Michele Bowers, Jennifer Bell & Lucy McCullough, *Smoking, Stigma and Tobacco "Denormalization": Further Reflections on the Use of Stigma as a Public Health Tool. A Commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue (67: 3)*, 70 SOC. SCI. & MED. 975, 975 (2010) (observing that "tobacco control advocates appear to have embraced the use of stigma as an explicit policy tool" and "suggest[ing] that stigmatizing smoking will not ultimately help to reduce smoking prevalence amongst disadvantaged smokers – who now represent the majority of tobacco users. Rather, it is likely to exacerbate health-related inequalities by limiting smokers' access to healthcare and inhibiting smoking cessation efforts in primary care settings."); PATRICK W. CORRIGAN, THE STIGMA EFFECT: UNINTENDED CONSEQUENCES OF MENTAL HEALTH CAMPAIGNS 71 (2018) [hereinafter THE STIGMA EFFECT] (asking "is it really acceptable to use stigma as a public health tool?"); Scott Burris, *Disease Stigma in U.S. Public Health Law*, 30 J. L. MED. ETHICS 179, 187 (2002) (explaining why "[t]he notion of stigmatizing a person because of a disease or addiction is offensive at the outset. . . . No one need take responsibility for imposing the sanction. It simply happens. There is no form of appeal or clarification."); Jennifer Stuber, Ilan Meyer & Bruce Link, *Stigma, Prejudice, Discrimination and Health*, 67 SOC. SCI. & MED. 351, 355 (1982) ("The prevailing wisdom is that stigma is damaging to health and should be combated by policy makers and public health institutions.").

For an ethical perspective endorsing "stigma as a public health tool" in limited circumstances, see Andrew Courtwright, *Stigmatization and Public Health Ethics*, 27 BIOETHICS 74, 78–79 (2013) ("[W]hen we assess the moral status of a policy or program [using stigma as a public health tool], the appropriate question is whether it could be justified to reasonable individuals who do not know whether they will be affected by that policy. . . . In asking whether someone might accept a policy that may lead to her stigmatization, there are several specific areas to consider. She would want to know whether there are alternative policies and how effective they might be in achieving the same ends; whether the stigmatization will be effective; whether the policy must aim to stigmatize the behavior or whether such stigmatization is an unintended side effect; the extent to which the

of this flawed approach to advocacy, and Section IV.B describes a preferable approach that avoids stigmatization.

A. TWO STIGMATIZING APPROACHES

1. THE ACGME DEFINES WELL-BEING AS A COMPONENT OF RESIDENT COMPETENCE

a. History

In 2017, the same year of the Task Force report and its proposal to "modify the rules of professional conduct to endorse well-being as part of a lawyer's duty of competence," the ACGME named "well-being" as a component of competence for resident-physicians.[229] The ACGME's 2017 Common Program Requirements included an entirely new subsection on resident well-being, which has remained relatively unchanged in spite of revisions.[230] The requirements state that "[p]rograms, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence."[231] The requirements explained:

> The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must:
>
> encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence. . . .[232]

The idea to create a "professionalism subcompetency related to wellness"[233] appears to have started in earnest with a 2015 article in the Association of

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stigmatized trait will be made salient across multiple social contexts; the degree of social isolation that will occur as a result; whether such stigmatization will create broader health or economic inequalities; and whether these inequalities will disproportionately fall on individuals at risk for health or economic disparities.").

229. *See* CPR, *supra* note 57, at 44.

230. The February 2017, June 10, 2018, and February 3, 2020 versions of the ACGME well-being requirement are almost identical. Recent action taken by the U.S. EEOC against Yale New Haven Hospital for its medical inquiry policies and practices, however, suggests that there may be greater liability risks of maintaining similar policies in the medical field and perhaps other professional settings. *See* EEOC v. Yale New Haven Hosp., Inc., No. 3:20-cv-00187 (D. Conn. Feb. 11, 2020); *see also* Ilene N. Moore, *Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory?* 28 HEALTH MATRIX 95, 95 (2018) (reviewing why these screenings, allegedly to promote patient safety, are "empirically unjustified and legally prohibited.").

231. CPR, *supra* note 57, at 44.

232. *Id.* at 45.

233. *See* M.L. Jennings & Stuart J. Slavin, *Resident Wellness Matters: Optimizing Resident Education and Wellness Through the Learning Environment*, 90 ACAD. MED. 1246, 1247 (2015) ("[P]rograms should seek to promote resilience and engagement in residents by teaching them advanced coping skills. The fields of

American Medical Colleges (AAMC) journal. The changes were made in collaboration with the National Academy of Medicine (NAM) and the AAMC, then led by psychiatrist and President Darrell Kirch.

Psychiatrists seem to have played an important role. "It is a substantial advance for the field of psychiatry that the major accrediting bodies have acknowledged the profound stakes of trainee wellness,"[234] reflected the editors of *Academic Psychiatry* about the new requirements. The *American Psychiatric Association Publishing Textbook of Psychiatry* stated: "[p]sychiatrists will play an increasingly important role as leaders in medicine in the future and can help to emphasize the links among physician well-being [and] clinical competence ... while stressing the importance of well-being as an ethical imperative. ..."[235]

b. Rationale

The background and intent to the requirements state:

> Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care.[236]

The ACGME's rationale can be summed as follows: residents fear their program directors (and/or medical boards, PHPs, or other entities) will treat them unfairly; this prevents them from engaging in treatment; and that is why program directors should have everyone be on the lookout for these residents and report them to their program directors, who will make sure that they get appropriate care.

If the ACGME acted in good faith, its position must be either: (1) residents' fear of being unfairly targeted on the basis of mental health is irrational because program directors will not unfairly target them; or (2) residents' fear that program directors will target them unfairly has merit, but the real problem is that they are

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cognitive psychology, positive psychology, and mindfulness offer a rich variety of evidence-based approaches to reduce distress and cultivate meaning and resilience.").

234. Adam M. Brenner, John Coverdale, Anthony P. S. Guerrero, Richard Balon, Eugene V. Beresin, Alan K. Louie & Laura Weiss Roberts, *An Update on Trainee Wellness: Some Progress and a Long Way to Go*, 43 ACAD. PSYCHIATRY 357, 357 (2019).

235. Laura Weiss Roberts & Laura B. Dunn, *Ethical Considerations in Psychiatry,* in AMERICAN PSYCHIATRIC ASSOCIATION PUBLISHING TEXTBOOK OF PSYCHIATRY 177, 183 (Laura Weiss Roberts ed., 7th ed. 2019).

236. CPR, *supra* note 57, at 46.

not getting treated, and it is better to get them treated through coercion than by making sure that program directors do not target them unfairly.

Yet some commentators have been critical of the motives underlying these changes, suggesting they were designed "[i]n order to *demonstrate* concern and provide *evidence* of intervention,"[237] without reflecting sincere attempts to help residents. Some health economists would probably suggest that the requirements distract regulators and the public from economic exploitation of residents.[238] From many psychiatrists' comments, one might infer they were intended to expand the reach and respectability of psychiatry within the medical profession.[239] Perhaps they function to impose personal favorite therapies and lifestyle choices on employees, consistent with other wellness critiques.[240] Or perhaps they were created because academic medical centers, professional medical organizations, and management might benefit in some way from creating a situation akin to a police state of reporting on employees.

Whatever its reasons for creating the well-being requirements, however, the ACGME probably did not want resident-employees to be aware of their ADA rights to be free from unwarranted medical inquiries and requests for examinations.[241] The requirements plainly advise that "personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution"[242] and *not* the ADA. In effect, the requirements further stigmatize[243] the

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237. Richard Balon & Mary K. Morreale, *The Madness of Mandated Wellness*, 31 ANNALS CLINICAL PSYCHIATRY 81, 82 (2018) (emphasis added). The authors explain, "In order to demonstrate concern and provide evidence of intervention, some residency programs require all trainees be evaluated by psychology and psychiatry services. . . ."

238. *See* Aaron S. Kesselheim & Kirsten E. Austad, *Residents: Workers or Students in the Eyes of the Law?*, 364 NEW ENG. J. MED. 697, 698–99 (2011) (describing Supreme Court testimony from academic medical centers claiming that they "'permit their residents to care for patients purely for educational purposes . . . residents do not provide a net economic benefit.' This contention, however, is implausible."). *See generally* Sarah L. Geiger, *The Ailing Labor Rights of Medical Residents: Curable Ill or a Lost Cause?*, 8 U. PA. J. LAB. & EMP. L. 523 (2006); Robert N. Wilkey, *The Non-Negotiable Employment Contract—Diagnosing the Employment Rights of Medical Residents*, 44 CREIGHTON L. REV. 705 (2011).

239. See *supra* notes 234-35 and accompanying discussion.

240. *See* Kirkland, *Critical Perspectives on Wellness, supra* note 210, at 974 ("[C]ritics describe wellness as an ideology that suppresses human variation and creates hierarchies based on the achievement (or the appearance of achievement) of health goals and lifestyle practices of the elites in contemporary Western societies. . . .").

241. I have sent multiple e-mails over the years to Thomas Nasca, CEO, ACGME; Darrell Kirch and David J. Skorton, Presidents, AAMC; and Victor Dzau, President, NAM, expressing concerns about these requirements and requesting education for members of the academic medical community about the ADA's rules. I have also spoken on the phone to Frank Trinity, Gen. Counsel, AAMC, about these issues. And I have raised these concerns in publications including the ACGME's official journal. *See, e.g.*, Nicholas D. Lawson, *Comply with Federal Laws Before Checking Institutional Guidelines on Resident Referrals for Psychiatric Evaluations*, 9 J. GRADUATE MED. EDUC. 666 (2017).

242. *See* CPR, *supra* note 57, at 46 ("In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.").

243. *See* Erene Stergiopoulos, Brian Hodges & Maria Athina Martimianakis, *Should Wellness Be a Core Competency for Physicians?*, 95 ACAD. MED. 1350, 1351 (2020) ("[F]raming wellness as a competency may

residents alleged to benefit from their implementation, while continuing to leave them unprotected from discrimination at the hands of their residency programs and institutions, despite evidence suggesting that more trainees file discrimination lawsuits against medical education institutions on the basis of disability than race, gender, or any other categories, for both medical students and residents.[244]

c. Lessons for the Legal Profession

The legal profession need not follow the medical profession's bad example. The legal profession need not define well-being as a component of lawyer competence just because the medical profession defined well-being as a component of resident competence. It need not institute peer surveillance and reporting policies to blow the whistle on lawyers with disabilities in the name of self-regulation. It need not adopt the position that lawyers with warning signs, distress, burnout, poor well-being (or various other proxies for mental health disabilities) are in denial because of stigma, and that employers (and their wellness vendors) know best. It should reject lawyer well-being as the caring approach for suffering lawyers and victimized clients otherwise left unprotected by menacing, dangerous professionals with mental health disorders.

Lawyers should recognize that the ACGME's resident well-being requirements plainly discriminate against residents with mental health disorders and disabilities. They were enacted by some of the most respected authorities in medicine, trumpeted in the most high-indexed medical journals, by leading experts on psychiatry ethics, in the context of dire warnings about a resident burnout epidemic and misreporting on its links with medical errors and clinical care.[245] And they were enacted without any attempt to make residents aware of their ADA rights to be free from unwarranted mental health inquiries and evaluations.[246]

It would be naïve to assume that the problems just described are substantially limited to the medical profession. The medical and legal professions may differ culturally to some extent; however, the same arguments made by proponents of well-being policies in the medical profession are made by proponents of lawyer well-being policies. This rhetoric may also be more dangerous to lawyers, as appraisals of lawyers' performance may be more subjective than appraisals of

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perpetuate stigma against learners with disabilities . . . by labelling them as 'not competent,'" with "profound implications for evaluation and licensure.").

244. *See* Richard F. Minicucci & Bryan F. Lewis, *Trouble in Academia: Ten Years of Litigation in Medical Education*, 78 ACAD. MED. S13, S14 (2003) (in the period from 1993-2002); *see also* Nicholas Lawson & Adina Kalet, *How Is "Stigma" Conceived Within the Biomedical Literature on Trainee Wellness? A Directed Content Analysis*, 8 MEDEDPUBLISH 32 (2019), https://doi.org/10.15694/mep.2019.000032.1 [https://perma.cc/56CX-WN4H] (concluding that the biomedical literature on medical trainee wellness "appears to have largely ignored mental health discrimination as a negative influence").

245. *See* TASK FORCE REPORT, *supra* note 2, at 50 (citing medical research said to find that "[b]urnout also undermines professionalism and quality of patient care by eroding honesty, integrity, altruism, and self-regulation") (citation omitted); *cf.* Lawson, *Burnout Is Not Associated with Medical Errors*, *supra* note 107, at 1683.

246. *See supra* notes 241–42.

physicians' performance; their jobs may be less secure; and the ultimate effects of bias and discrimination resulting from well-being policies may be more consequential within the legal profession than in medicine.[247] Lawyer well-being policies are similarly promoted at the highest levels of the profession, and law schools similarly do not educate law students or lawyers about their ADA rights.

2. THE WORLD HEALTH ORGANIZATION'S STRATEGY

Stigmatization in the name of advocacy is not an isolated problem limited to the medical and legal workplace. It is a strategy widely deployed by international mental health leaders to promote policies and treatments. The example of the World Health Organization's (WHO) *Mental Health Policies and Programmes in the Workplace*, illustrates how these strategies may be particularly harmful to employees with mental health disorders.

The WHO's report largely recommended various workplace mental health screenings of employees, as well as investments in workplace mental health services. To obtain buy-in from businesses and employers, the authors suggested the following strategy: "In making the business case, general data showing the link between mental ill-health and reduced productivity and increased costs should be presented."[248] Accordingly, the report is filled with statements that emphasize how "[m]ental health problems, such as depression, anxiety, substance abuse and stress . . . have a direct impact on workplaces through increased absenteeism, reduced productivity, and increased costs."[249]

An important part of the solution to these problems, a "clear and present danger"[250] according to the report, is for employers to "ensure the early recognition and treatment of mental health problems,"[251] and "train[] staff to recognize indicators of occupational stress in both themselves and their colleagues,"[252] because "[i]f an employee experiencing symptoms of mental illness does not get timely managerial support and medical attention, the outcome is likely to be negative and costly."[253] "Inadequate management of mental illnesses can result in a

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247. See *supra* notes 194–97 and accompanying discussion.

248. WORLD HEALTH ORG., MENTAL HEALTH POLICIES AND PROGRAMMES IN THE WORKPLACE 35 (2005), https://www.who.int/mental_health/policy/workplace_policy_programmes.pdf [https://perma.cc/5KVH-JGVN]. The authors explained, at 35:

> It is important to make the case for developing a mental health policy in the workplace in order to gain the explicit endorsement and commitment of the employer and other key stakeholders. This is vital for the actual development and acceptance of a workplace mental health policy. The employer is more likely to support the introduction of a policy if you can demonstrate that it will have a positive impact on the workplace, will be financially viable, and will be beneficial to work outcomes, that is, increase profits, efficiency or improve the product. Employers are often motivated to address mental health issues in the workplace when they understand the link with productivity.

249. *Id.* at 2.

250. *Id.* at 44.

251. *Id.* at 9.

252. *Id.* at 45.

253. *Id.* at 36.

myriad of business costs, including absenteeism, disability payments, medication costs, accidents, and recruitment expenses. In addition, there are indirect expenses such as lost productivity, replacement payroll, training expenses, and time spent administering disability claims."[254]

The WHO report provides facially convincing data to support its productivity arguments for treating employees through workplace mental health services,[255] but the authors admit that they were not able to document the burdens imposed by these workers to the extent they would have liked. They describe "many indirect costs of mental disorders in the workplace, related to poor work performance, reduced morale, high staff turnover, early retirement and work complaints and litigation. . . These indirect costs can be difficult to quantify."[256] Finally, in addition to *their own* poor work performance, the WHO report asserts that these workers also "reduce[] morale of staff,"[257] not to mention "complaints and possibly litigation associated with mental health problems."[258]

Even assuming—for the sake of argument—that these statements are true, that the treatments envisioned by the WHO for workers with mental health disorders are effective, and that the strategies they propose to incentivize these workers to get help actually lead to greater engagement and cost savings, it is doubtful that even effective treatments could overcome the damage done to these employees through stigmatizing rhetoric and put-downs to their employers. Employers receiving this information will not want to hire or retain these employees. More likely, they will try to avoid hiring applicants with these conditions or else find out which current employees have them through mental health inquiries and evaluations, and then fire them.

B. NONSTIGMATIZING APPROACHES

Reducing stigma and bias against marginalized groups and individuals is an important goal of many lawyers and legal organizations. The ABA, for example, recognizes "eliminat[ing] bias in the legal profession and the justice system"[259]

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254. *Id.*

255. *Id.* ("A recent study undertaken in the USA has demonstrated that high quality care for depression can improve productivity at work and lower rates of absenteeism." It is beyond the scope of this Article to discuss these studies).

256. *Id.* at 20.

257. *Id.*

258. *Id.* at 21; *see also* WORLD HEALTH ORG., MENTAL HEALTH IN THE WORKPLACE (May 2019), https://www.who.int/mental_health/in_the_workplace/en/ [https://perma.cc/4PCP-VWRB] (discussing economic burdens caused by persons with depression and anxiety in the workforce and suggesting "[i]nterventions and good practices that protect and promote mental health in the workplace include . . . identification of distress, harmful use of psychoactive substances and illness and providing resources to manage them").

259. AM. BAR ASS'N, *ABA Mission and Goals* (2020), https://www.americanbar.org/about_the_aba/aba-mission-goals/ [https://perma.cc/5CTA-N43U] ("Goal III: Eliminate Bias and Enhance Diversity": (1) "Promote full and equal participation in the association, our profession, and the justice system by all persons," and (2) "Eliminate bias in the legal profession and the justice system.")

as one of its explicit goals. And prominent theories of antidiscrimination law (e.g., anti-essentialism or anti-subordination) have as "their goal the rectifying of long-standing historic subordination and harmful stereotyping and the recognition that labels and group distinctions are often social constructs."[260] In the case of persons with mental health disorders and disabilities, it is unlikely that they will get their fair shake before the judiciary so long as members of the judiciary believe that they are dangerous, deficient, and dependent on healthcare providers.[261] Lawyers are also now prohibited under Model Rule 8.4(g) from "engaging in conduct that manifests bias or prejudice"[262] in the practice of law, and lawyers should take care to avoid stigmatization in all forms of their advocacy.

That said, perhaps there is a case to be made that negative portrayals of some sort may be important to some forms of legitimate advocacy. A personal injury lawyer, for example, when making her client's case before a judge, may want to describe how an injury has rendered her client incapacitated in some way. The lawyer's negative portrayals of the client before the judge might lessen the judge's opinion of the client's abilities in, say employment or social settings. But these descriptions are unlikely to negatively impact the client in employment or social settings because the judge will probably never see the client after the trial. And the lawyer's negative portrayals are not likely to exacerbate stigma and prejudice against other individuals from marginalized groups. Accordingly, limited put-downs in this context might be a part of legitimate advocacy.

The DOJ's letter to the Louisiana Supreme Court,[263] which called for eliminating certain mental health questions on bar applications, provides a model example of an effective, nonstigmatizing approach to advocacy that contrasts with the approach of the Task Force report. Like the Task Force, the DOJ invoked mental health counseling and treatment, arguing that "[t]he Questions are likely to deter applicants from seeking counseling and treatment for mental health concerns."[264] Unlike the Task Force report, however, the DOJ did not invoke stigma; it did not dramatically depict applicants with mental health disorders and disabilities as unstable and dependent on counseling and treatment in order to make the case to remove these questions.[265] The point was to counter the argument that these questions and inquiries would make them *more* likely to engage in mental health

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260. *See* Valarie K. Blake & Mark E. Hatzenbuehler, *Legal Remedies to Address Stigma-Based Health Inequalities in the United States: Challenges and Opportunities*, 97 MILBANK Q. 480, 497–98 (2019).

261. See *supra* note 171 and accompanying discussion; *see also* Genna L. Sinel, *Working to Destigmatize Mental Illness: A Critique of Federal Employment Law*, 11 N.Y.U. J.L. & LIBERTY 1131, 1176–77 (2018) (observing that many mental disability rights advocates agree that "no matter how strongly a civil rights act is written nor how clearly its mandate is articulated, the aims of such a law cannot be met unless there is a concomitant change in public attitudes about psychological disorders" and that their goal is to "eliminate the stigma and misunderstanding surrounding mental illness.") (internal citations omitted).

262. MODEL RULES R. 8.4(g) cmt. 3.

263. DOJ Letter, *supra* note 80.

264. *Id.* at 23.

265. *See id.*

counseling and treatment. Furthermore, this was Argument 2c; the bulk of the DOJ's arguments related to the fact that the questions "tend to screen out persons with disabilities and subject them to additional burdens" (Argument 1)[266] and "are not necessary to determine whether applicants are fit to practice law" (Argument 2).[267] Nowhere in the letter were there any suggestions that these applicants were incompetent, dangerous, or economically burdensome unless treated; if anything, the letter argued the opposite. The DOJ's approach was a non-stigmatizing, legitimate forms of advocacy; the approach taken by the Task Force, however, was not.

V. GOING FORWARD

A. IS THERE ANYTHING GOOD ABOUT COLAP'S LAWYER WELL-BEING INITIATIVES?

This Article does not argue that mental health is not important. Rather, it argues that making the mental health of law students and legal employees the business of school administrators, employers, or their various agents—EAPs, LAPs, PHPs, wellness programs, well-being advocates, and peers—will cause discrimination. School counseling and mental health services could be beneficial, but if students have health insurance, they can receive counseling outside school of their own accord, with greater assurance of confidentiality.[268] There is also nothing wrong with providing members of the legal profession with *accurate* information to *voluntarily self*-diagnose and assess themselves for mental health disorders. The problem is that CoLAP and lawyer well-being proponents are providing stigmatizing, *inaccurate* information and encouraging the diagnosis and assessment of *other* people in a manner that is hardly free from coercion.

Even if law students and lawyers were provided *accurate* information purely for *voluntary self*-diagnosis, assessment, and screening purposes, the following assumptions would need to be true for these screenings to provide mental health benefits (using addiction as an example):

1. People with addictions are not aware that they have addictions.
2. People with addictions will respond truthfully to screening questionnaires about addiction.
3. Positive screens will result in a moment of catharsis ("Holy Moley! I have an addiction!").
4. That will prompt them to seek out and engage in treatment.
5. Treatments will be effective.

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266. *Id.* at 19.

267. *Id.*

268. *See* RATIONAL SUICIDE, *supra* note 220, at 406 ("[I]t may be better all around for colleges and universities to give all students vouchers for a specific number of completely confidential mental health sessions by independent community providers located convenient to the university but unconnected with it.").

6. There will be no adverse unintended consequences of screening (e.g., discrimination, privacy breaches, overdiagnosis, and treatment).

These assumptions might hold for the screening of hypertension or COVID-19. But they are questionable at best for screening addictions and other mental health disorders.[269]

Lastly, CoLAP's effort to shine light on the near-universal prevalence of mental health disorders among lawyers might have a positive outcome, but not for the reasons CoLAP intended. There may be an association of some kind between public recognition of the near-universal prevalence of mental health disorders and more tolerant, less stigmatizing views about people with these conditions.[270] The problem is that CoLAP highlights the high prevalence of mental health disorders in a stigmatizing way by implying that there is a crisis of impaired lawyers.

The high prevalence of mental health disorders and disabilities among lawyers (and employees in other professions)[271] contrasts with the extraordinarily low prevalence of lawyers known by large firms to have a disability: 0.5%.[272] Stereotypes and prejudices associated with mental health disorders and disabilities in the profession may make it simply too dangerous to come out as a lawyer with a mental health disorder (and thereby reduce these stereotypes and prejudices). To effectively reduce mental health stigma within the legal profession, leaders at law schools and firms could commit to electing leaders with disclosed mental health disorders and disabilities, or they could create employment protections for current employees who choose to disclose these conditions. Providing contract protections for existing legal employees who decide to publicly disclose having a mental health disorder could facilitate interactions with peers that would disconfirm stereotypes and prejudice about mental health disorders within the legal profession.[273]

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269. *See* Jennifer Radden, *Public Mental Health and Prevention*, 11 PUB. HEALTH ETHICS 126, 126 (2018) ("To suppose that public mental health can be entirely modeled on other public health programs is mistaken. Instead, it must proceed with awareness of the particular features typifying many mental disorders. These include (i) features of the disorders themselves; (ii) the preliminary nature of scientific knowledge about them; (iii) the contested applicability of traditional disease models to them; (iv) the dearth of established research data available about preventive interventions currently in place or proposed; and (v) the effects of stigma and discrimination on any such interventions."). In addition, screenings that might be appropriate for elementary school children might not be appropriate for 20-something adult law students and legal employees.

270. *See* Nicholas D. Lawson, *Public Perception of the Lifetime Morbid Risk of Mental Disorders in the United States and Associations with Public Stigma*, 5 SPRINGERPLUS 1342, 1342 (2016).

271. See *supra* Section I.C, ARDC Report, *supra* note 94, and accompanying discussion. It seems reasonable to assume that the prevalence of common mental disorders among lawyers is roughly similar to that of other occupations and the general U.S. population: 31.1–43.8% every year for persons 18-59.

272. NAT'L ASS'N FOR LAW PLACEMENT, *2019 Report on Diversity in U.S. Law Firms* 2 (Dec. 2019), https://www.nalp.org/uploads/2019_DiversityReport.pdf [https://perma.cc/PA82-PGUH].

273. *See* THE STIGMA EFFECT, *supra* note 228, at 164 (describing how face-to-face exchanges through contact between persons with disclosed mental health disorders and their "normal" peers (e.g., coworkers) can effectively reduce stigma by allowing "normal" peers to check out mental health stereotypes for themselves through continuing interactions). In general, "social contact is the most effective type of intervention to

B. CONSIDERING THE ROLE OF MODEL RULE 8.4(G) IN REDUCING MENTAL DISABILITY BIAS

Model Rule 8.4(g) provides that "[i]t is professional misconduct for a lawyer to . . . (g) engage in conduct that the lawyer knows or reasonably should know is harassment or discrimination on the basis of . . . disability . . . in conduct related to the practice of law. . . ."[274]

1. IMPORTANCE FOR LAWYERS WITH MENTAL HEALTH DISORDERS AND DISABILITIES

Model Rule 8.4(g) could go a long way towards furthering inclusion of lawyers with mental health disorders and disabilities within the profession by correcting the many stigmatizing claims that are made about attorneys with these conditions. Application of this rule could send a message about "the profession's values both within the profession and to the public"[275] that "traditionally unrepresented groups within the profession [should not have to] exist within a shroud of silence"[276] while those with larger megaphones disseminate inaccurate claims about them. Rule 8.4(g) sanctions (typically public censure or reprimand) can signal conduct that is currently not widely recognized as contributing to bias within the profession and therefore remains most insidious.[277] Rule 8.4(g) could therefore function well to correct the many ways in which the profession gets it wrong about people with mental health disorders and disabilities, and to correct

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improve stigma-related knowledge and attitudes." Graham Thornicroft, Nisha Mehta, Sarah Clement, Sara Evans-Lacko, Mary Doherty, Diana Rose, Mirja Koschorke, Rahul Shidhaye, Claire O'Reilly & Claire Henderson, *Evidence for Effective Interventions to Reduce Mental-Health-Related Stigma and Discrimination*, 387 LANCET 1123, 1123 (2016).

274. MODEL RULES R. 8.4(g); *see also* MODEL RULES R. 1.0(j) ("Reasonably should know . . . denotes that a lawyer of reasonable prudence and competence would ascertain the matter in question.").

275. *See* Veronica Root Martinez, *Combating Silence in the Profession*, 105 VA. L. REV. 805, 855 (2019) [hereinafter Martinez, *Combating Silence*] (describing the expressive function of the lawyer disciplinary process; endorsing 8.4(g) and professional codes "that the drafters anticipate will be enforced only rarely," but may nevertheless play an important role in changing social norms) (internal citation omitted).

276. *See id.* at 806 ("They are often forced to silence themselves for fear of being labeled angry, troublesome, sensitive, or unwilling to be a 'team player.'").

277. Stephen Gillers, *A Rule to Forbid Bias and Harassment in Law Practice: A Guide for State Courts Considering Model Rule 8.4(g)*, 30 GEO. J. LEGAL ETHICS 195, 200 (2017) [hereinafter Gillers, *Rule to Forbid Bias*] ("The reported decisions [on Rule 8.4(g)] suggest that biased conduct based on race or ethnicity occurs, but less often. Perhaps lawyers realize that racially-biased conduct is indefensible but do not view gender bias equally so."). Accordingly, 8.4(g) might also be important to address biased conduct toward lawyers with mental health disorders and disabilities, which is most likely even less well recognized within the legal profession. *Id.* at 219 ("Adding 'should have known' to the rule has the salutary effect of encouraging lawyers to learn what conduct is deemed harassing because ignorance will not be a defense.").

See Martinez, *Combating Silence*, *supra* note 275, at 805–06 (supporting 8.4(g) to "(i) address covert discrimination throughout the profession and (ii) encourage individual attorneys to stop remaining silent and instead give voice to their experiences of discrimination, harassment, and bias."); *see also* Alex B. Long, *Employment Discrimination in the Legal Profession: A Question of Ethics?*, U. ILL. L. REV. 445, 450 (2016) ("[W]orkplace biases now often result from 'patterns of interaction, informal norms, networking . . . mentoring, and evaluation . . .' Thus, workplace inequality is often 'structurally embedded in the norms and cultural practices of an institution.'") (internal citations omitted).

categorically inaccurate claims about lawyers with mental health disorders and disabilities. The most problematic, bias-promoting comments about lawyers with mental health disorders and disabilities are not "controversial viewpoints"[278] or political debate (described as endangered by those most critical of the 8.4(g) Model Rule[279]), but categorically false claims about these lawyers' conditions.

2. TWO IMPLEMENTATION CONSIDERATIONS

The mens rea *requirement.* States debating implementation of an 8.4(g) Rule should consider how adding a *mens rea* requirement to the rule could effectively preclude bias claims related to mental disability.[280] Harassment or discrimination against lawyers with actual or perceived mental health disorders and disabilities should be sanctioned and must never be excused on paternalistic grounds. It is "critical that paternalistic concerns for the disabled person's own safety not be used to disqualify an otherwise qualified applicant"[281] or employee because "[p]aternalism is perhaps the most pervasive form of discrimination for people with disabilities"[282]; "[l]ike women, disabled people have identified 'paternalism' as a major obstacle to economic and social advancement."[283] Just as allusions to "women's 'natural and proper timidity and delicacy'" in the late nineteenth century helped "protect" (and exclude) women from practicing law,[284] "[d]iscrimination based on disability often occurs under the guise of extending a helping hand."[285] These practices will continue to exclude persons with mental health

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278. *See, e.g.*, Josh Blackman, *Reply: A Pause for State Courts Considering Model Rule 8.4(g): The First Amendment and "Conduct Related to the Practice of Law"*, 30 GEO. J. LEGAL ETHICS 241, 246 (2017) [hereinafter Blackman, *Pause 8.4(g)*] (giving the hypothetical of a continuing legal education (CLE) "speaker [who] explains that people with mental handicaps should be eligible for the death penalty" as a remark that someone at the CLE event could find disparaging of persons with disabilities, but which, in Blackman's view, should not warrant sanction through Rule 8.4(g)).

279. *See generally* Rebecca Aviel, *Rule 8.4(g) and the First Amendment: Distinguishing Between Discrimination and Free Speech*, 31 GEO. J. LEGAL ETHICS 31 (2018); Blackman, *Pause 8.4(g)*, *supra* note 278, at 246; George W. Dent, Jr., *Model Rule 8.4(g): Blatantly Unconstitutional and Blatantly Political*, 32 NOTRE DAME J.L. ETHICS & PUB. POL'Y 135, 166–67 (2018).

280. *See In re* Gourvitz, No. DRB 05-117, 41–48 (N.J. 2005), http://drblookupportal.judiciary.state.nj.us/DocumentHandler.ashx?document_id=1064112 [https://perma.cc/387Q-6XL9] (lawyer found by jury to have engaged in unlawful disability discrimination against his secretary with cancer, was found not to have violated 8.4(g) as there was no clear and convincing evidence of discriminatory intent).

281. *See* Samuel R. Bagenstos, *The Supreme Court, the Americans with Disabilities Act, and Rational Discrimination*, 55 ALA. L. REV. 923, 932 n.70 (2004) (citing H.R. REP. No. 101-485, pt. 2, at 72, 74 (1990)).

282. *Id.* (citation omitted).

283. *Id.* (citation omitted).

284. *See* Martinez, *Combating Silence*, *supra* note 275, at 816 (quoting Bradwell v. Illinois, 83 U.S. 130, 141 (1872) (Bradley, J., concurring)); *see also* Automobile Workers v. Johnson Controls, Inc., 499 U.S. 187, 188–89, 211 (1991) ("Concern for a woman's existing or potential offspring historically has been the excuse for denying women equal employment opportunities," and "decisions about the welfare of future children [should] be left to the parents who conceive, bear, support, and raise them rather than to the employers who hire those parents or the courts.").

285. *See* Tricia M. Patterson, *Paternalistic Discrimination: The Chevron Deference Misplaced in* Chevron U.S.A., Inc. v. Echazabal, 23 J. NAT'L ASS'N ADMIN. L. JUDICIARY 147, 147 (2003) ("Overprotective rules and

disorders and disabilities from the legal profession and society so long as disability discrimination is excused on the grounds of trying to help.

Requiring proof of harm. States debating implementation of an 8.4(g) Rule should also consider how requiring proof of harm from biased conduct may pose significant obstacles for lawyers with mental health disorders and disabilities. Professor Stephen Gillers has described why:

> There is good reason not to require proof that the words or conduct described in Rule 8.4(g) harmed a targeted lawyer. That requirement would turn the inquiry into a question about the fortitude (or lack thereof, the sensitivity) of the lawyer, which in turn will discourage reporting. No lawyers will relish cross-examination asking whether they were able 'to take it.'[286]

Requiring proof of harm from biased conduct, such as demonstration of psychological injury or an emotional breakdown,[287] may prevent lawyers with mental health disorders and disabilities from raising concerns about mental disability bias. By raising these concerns and describing their psychological symptoms, these lawyers leave themselves vulnerable to attack as being unfit to practice law.[288]

Overall, Rule 8.4(g) seems important for the profession and could help reduce bias against lawyers with mental health disorders and disabilities. Irrespective of whether and how states decide to implement an antibias rule, the profession and society would be better off with more people correcting inaccurate myths, fears, and stereotypes about mental health disorders. These and similar efforts might also combat the perception that "the bar disciplinary system unfairly targets small firms and minority lawyers"[289] like persons with disabilities, or functions, in many ways, "to keep 'undesirables' out of their ranks."[290]

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policies become the backbone for employers in creating a paternalistic discrimination for which a disabled person is made helpless to defend himself and has no other recourse but to plead to the mercy of the courts.") (citations omitted).

286. *See* Gillers, *Rule to Forbid Bias*, *supra* note 277, at 222–23 ("Cases have not required proof of an effect on the individual who is the target of biased or harassing conduct. Rather, they talk about the harm to the legal profession or the system or goals of justice.").

287. *See* Harris v. Forklift Sys., Inc., 510 U.S. 17, 22 (1993) (establishing that a victim of harassment need not experience an emotional breakdown to establish a cause of action).

288. *See* Andrew Hsieh, *The Catch-22 of ADA Title I Remedies for Psychiatric Disabilities*, 44 MCGEORGE L. REV. 989, 1035 (2013) ("[F]or people who suffer discrimination on the basis of psychiatric disabilities, the act of seeking a remedy often undermines the remedy itself by revealing the plaintiff's previously hidden disability. This strongly discourages litigation and, in turn, allows potential defendants to refuse to enter settlement negotiations or alternative dispute resolution.").

289. *See* Michael S. Frisch, *No Stone Left Unturned: The Failure of Attorney Self-Regulation in the District of Columbia*, 18 GEO. J. LEGAL ETHICS 325, 356 (2005).

290. *See* Alyssa Dragnich, *Have You Ever...? How State Bar Association Inquiries into Mental Health Violate the Americans with Disabilities Act*, 80 BROOK. L. REV. 677, 732–33 (2015) (describing how character and fitness standards have been used to exclude women, Jews, immigrants, suspected communists, and sexual minorities from legal employment); *see also* Martimiankis, *Sociological Interpretations of Professionalism*, *supra* note 215, at 833–34.

C. OTHER RECOMMENDATIONS

1. ELIMINATE LAP EDUCATIONAL PROGRAMMING ON LAWYER WELL-BEING AND MENTAL HEALTH

CoLAP and LAPs have been expanding their educational programming on lawyer well-being to bar associations, regulators, legal employers, judicial associations, and law schools.[291] LAP educational programming, however, seriously misinforms members of the legal community about the alleged dangers and deficiencies of lawyers with mental health disorders and disabilities, invoking fears, myths, and stereotypes about these conditions in order to prompt more referrals to LAPs. These communications make it much more likely that law students and lawyers with mental health disabilities will be treated unfairly, and LAPs should not play an educational role in informing members of the legal profession about mental health issues. In the long term, the ABA and state bars should consider whether their affiliations with these entities give rise to conflicts of interest, the implications of granting LAPs near-absolute civil immunity,[292] and why a special program for lawyer addictions (and now all mental health issues) is needed at all.[293]

2. PROTECT LEGAL EMPLOYEES FROM UNWARRANTED INQUIRIES AND EVALUATIONS

It is imperative that law schools educate law students about their rights under the ADA to be free from unwarranted medical inquiries and about other important civil rights employment protections.[294] Education about these substantive laws should take precedence over lawyer well-being education in a law school. Legal employees need to be aware of these rules in order to protect their rights—especially when lawyer well-being programming recommends employers make inquiries and conduct examinations of legal employees.[295] If lawyers are not aware of their rights, there will be few complaints when they are violated. Accordingly, there will be limited awareness within the profession about the scope of these problems, and limited efforts to correct them.

The legal community should reject CoLAP recommendations that legal employees report colleagues they suspect of impairment from mental health disorders to their employers. It is appropriate to encourage peer reporting of legal employees actually engaging in serious professional misconduct.[296] But it is not appropriate to selectively target legal employees with mental health disorders and

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291. See *supra* note 6, Sections I.E and I.F, and accompanying discussion.

292. See *supra* note 21 and accompanying discussion.

293. *See* Ross, *Business of Managing Nurses' SUDs*, *supra* note 19, at 10 ("Why is a special program required for nurses' substance-use problems at all?").

294. Such as Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, and the Equal Pay Act.

295. See, e.g., WELL-BEING TEMPLATE, *supra* note 74 and accompanying discussion.

296. *See* MODEL RULES R. 8.3(a).

disabilities[297] for extra disciplinary scrutiny without placing nondisabled employees within the same punitive context. The disproportionate impact of these policies on employees with mental health disorders and disabilities is made even greater through CoLAP misrepresentations reinforcing perceptions within the profession that they are dangerous and incompetent.[298]

All prospective legal employees, and not just those with mental health disorders and disabilities, should be wary of firms adopting the Well-Being Template, which asks coworkers to "identify signs and symptoms of substance use and behavioral health issues"[299] in their peers. Any legal employee can potentially be branded as impaired in a competitive law firm that asks employees to report any peers displaying broad signs and symptoms allegedly describing impairment from mental health disorders and disabilities.[300] Law firms are also competitive cultures, and peer reporting to employers based on such vague criteria will not always be in good faith.

3. BE WARY OF WELL-BEING/WELLNESS CLAIMS AND RESEARCH

This Article has reviewed exaggerated or misleading claims related to well-being from some of the most authoritative, trusted sources in medicine and the academic literature such as the WHO,[301] the American Psychiatric Association, and the NAM. Wellness information from public health authorities, including the Centers for Disease Control and Prevention (CDC)[302] and its Workplace Health

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297. *See, e.g.*, WELL-BEING TEMPLATE, *supra* note 74, at 2 ("Impairment may be due to the use of alcohol or drugs (prescribed or non-prescribed), a mental health disorder, or a physical illness or condition that would adversely affect cognitive skills.").

298. *E.g.*, "to be a good lawyer, one has to be a healthy lawyer," "freedom from substance use and mental health disorders [is] an indispensable predicate to fitness to practice," etc.

299. *See* WELL-BEING TEMPLATE, *supra* note 74, at 2. Prospective legal employees considering firms signing onto the Well-Being Pledge might want to take extra precautions to make sure that the firm has not adopted a peer surveillance policy. A list of law firms signing onto the Well-Being Pledge is available here: https://www.americanbar.org/groups/lawyer_assistance/working-group_to_advance_well-being_in_legal_profession/ [https://perma.cc/5MTN-DR2Y] (last visited October 12, 2020).

300. *See, e.g.*, *supra* Section III.D.3.

301. This Article impugns the credibility of these organizations with respect to wellness/well-being issues. It is not intended to call into question their expertise on COVID-19 policies and recommendations (e.g., on quarantines or facial mask protections).

302. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *Workplace Health Promotion: Workplace Health Strategies: Depression Interventions, Benefits* (Feb. 27, 2020), https://www.cdc.gov/workplacehealthpromotion/health-strategies/depression/interventions/programs.html [https://perma.cc/SH64-JLKR] (advising readers to "[r]aise awareness of the signs and symptoms of depression among managers and employees through training. Managers and employees who are able to recognize the signs and symptoms of depression such as tardiness, complaints of fatigue, reduction in work output or quality, safety problems or accidents, and changes in attitude may help in the early identification and referral to screening and treatment services for affected employees."); CTRS. FOR DISEASE CONTROL & PREVENTION, *Workplace Health Promotion, Workplace Health Strategies: Depression Interventions, Benefits*, (Apr. 1, 2016), https://www.cdc.gov/workplacehealthpromotion/health-strategies/depression/interventions/benefits.html [https://perma.cc/6SNP-4BCL] ("Depression screening and treatment with psychotherapy and medications can be highly effective. Research suggests that 80% of patients with depression will improve with treatment.").

Resource Center ("Make Wellness Your Business"),[303] as well as the Agency for Healthcare Research and Quality (AHRQ),[304] should also be viewed with caution.[305] Because so much reporting of well-being-related research is misleading or tendentious, stakeholders within the legal profession should be extremely careful before citing any of it.

It is very difficult to have a substantive conversation about lawyer well-being, wellness, mental health, discipline, and many other legal workplace issues when so many of these discussions are based on accounts of research and statistics inaccurately portraying persons with these conditions and disabilities as dangerous and incompetent. These accounts and reports waste resources and mislead policymakers, and stakeholders should accordingly be skeptical of even trusted sources that report on well-being, wellness, and other occupational health issues.[306]

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303. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *Workplace Health Promotion, Workplace Health Initiatives*, (Feb. 29, 2020), https://www.cdc.gov/workplacehealthpromotion/initiatives/resource-center/index.html [https://perma.cc/GU3J-3DGV] ("The CDC Workplace Health Resource Center (WHRC) is a one-stop shop for workplace health promotion that gives employers . . . credible tools and step-by-step resources employers can use to" create workplace wellness programs).

304. See David Meyers, *Caring for the Healers,* AGENCY FOR HEALTHCARE RES. & QUALITY (Oct. 5, 2018), https://www.ahrq.gov/news/blog/ahrqviews/caring-for-the-healers.html [https://perma.cc/VL5R-DAM3], which reports that "AHRQ is proud to be a member of the National Academy of Medicine's (NAM) Action Collaborative on Clinician Well-Being and Resilience" which redefined resident competence in terms of well-being. The Collaborative provides resources including well-being survey instruments, case studies, and research from leading physician well-being leaders, and reports that "clinician well-being is essential for safe, high-quality patient care," "[c]linician burnout can have serious, wide-ranging consequences, from reduced job performance and high turnover rates to—in the most extreme cases—medical error and clinician suicide." *See* NAT'L ACAD. OF MED., *Action Collaborative on Clinician Resilience and Well-Being*, https://nam.edu/initiatives/clinician-resilience-and-well-being/ [https://perma.cc/53U9-W3FP] (last visited Nov. 17, 2020). None of these expert entities inform readers about ADA rules and regulations protecting employees from unwarranted medical inquiries and evaluations.

305. The CDC (and to a lesser extent, the AHRQ, as part of the U.S. Public Health Service) has been recognized by the DOJ as one of the "[s]ources for medical knowledge" for assessments of direct threat posed by persons with disabilities in places of public accommodation, in addition to the National Institutes of Health, including the National Institute of Mental Health. *See* 28 C.F.R. § 36.208(c) (2020); 28 C.F.R. § 36, app. C (2020).

306. See Anna Kirkland, *What Next?*, in AGAINST HEALTH: HOW HEALTH BECAME THE NEW MORALITY 195, 198–201 (Jonathan M. Metzl & Anna Kirkland eds., 2010), explaining that "[t]he powers arrayed in the health business have never been so great" with "more opportunities for crooks, hacks, and alarmists." Health "is simultaneously becoming more and more available as a source of self-concept and achievement at the same time as it is more and more propped up by powerful economic and research interests, forceful and overblown rhetoric, public panic and misinformation, and a very solid and shiny veneer of scientific validity. These features mean that health seems to be much more neutral than it is, allowing us to pretend that we are not taking on a moral view when we aim for health." *Id.* Accordingly, Professor Kirkland advises reforms in which "[t]he targets should be the usual bugbears in the pharmaceutical industry, but should also include those closer to home: university grant recipients, granting agencies, journal editors and reviewers, journalists and their editors, and media decision-makers." *Id.*

4. STRUCTURAL "WELL-BEING" INTERVENTIONS ARE FINE, BUT SHOULD NOT BE PROMOTED BY STRESSING THE "BURDENS" OF PERSONS WITH MENTAL HEALTH DISORDERS

Reinforcing lawyers' employment rights through contract protections, ending at-will employment law, providing education about employment protections, and reducing public defender case-loads are important targets for structural change.[307] Well-intentioned leaders in the profession genuinely wishing to improve the lots of legal employees should focus on rights rather than health; they could start by getting rid of the "well-being," "wellness," and other "health"-justifications for their initiatives and instead try to reinforce lawyers' employment rights,[308] especially for those working in government and public interest.

None of these interventions, however, should be promoted by stressing costs and "burdens"[309] that workers with mental health disorders and disabilities might impose on their employers. It is *not* acceptable to promote even important structural workplace changes by calling employers' attention to studies dubiously reported to indicate legal employees with these conditions are unproductive, likely to be absent, expensive, litigious, or infectiously negative.[310] Nor would this be acceptable if there were appropriate grounds to support these conclusions.

CONCLUSION

This Article should make it clear how current lawyer well-being programming may cause harm to the legal profession, to legal employees, and especially to lawyers with mental health disorders and disabilities. To disseminate these lawyer well-being publications, such as the Task Force report, would be unfair to law students, lawyers with mental health disorders and disabilities, and many other marginalized groups (e.g., the "'senior tsunami' of age-impaired lawyers"[311]) described as incompetent and dependent on LAPs. It is very difficult to compete with the megaphones of LAP programming targeting every segment of the profession, with LAP staff and agents often operating with absolute civil immunity,

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307. See *supra* Section III.D.1 and accompanying discussion.

308. "Employment rights" do not refer to the right to be subjected to a free workplace medical exam or the right to receive coerced mental health treatment.

309. *See, e.g.*, *supra* Sections II.B and IV.B.

310. *See* Emma E. McGinty, Howard H. Goldman, Bernice A. Pescosolido & Colleen L. Barry, *Communicating About Mental Illness and Violence: Balancing Stigma and Increased Support for Services*, 43 J. HEALTH POL. POL'Y & L. 185, 188, 213 (2018) (describing how leading psychiatrists argue that "despite their stigmatizing effects, messages emphasizing a link between [severe mental illness] and violence are the best way to . . . garner support for expanding services," despite empirical evidence that non-stigmatizing messages can be equally effective).

311. *See* TASK FORCE REPORT, *supra* note 2, at 68. For recommendations to "guide and support the transition of older lawyers," and "provide education to detect cognitive decline," see *id.* at 18–19. For additional recommendations to "develop educational programs, checklists, and other tools to identify lawyers who may be experiencing incapacity issues" and "[d]evelop[] a formal, working plan to partner with Judges and Lawyer Assistance Programs to identify, intervene, and assist lawyers demonstrating age-related or other incapacity or impairment," see *id.* at 58.

as well as enthusiastic support from state bars, the ABA, and increasingly, law school administrations. Law schools should not be teaching law students that people with mental health disorders and disabilities are dangerous and incompetent, firms should not encourage peer surveillance of lawyers with mental health disorders and disabilities, and prospective legal employees should be wary of firms that adopt these policies.

Other issues raised in this Article are of somewhat less immediate concern to the legal community, broader in scope, and requiring of national reform. Workplace surveillance through proxies, agents, EAPs, and workplace wellness programs should be aggressively regulated. Health-related inquiries and evaluations of employees are almost never job-related and consistent with business necessity, and ought to be prohibited. Employees should be evaluated on the basis of their performance—not their health, disabilities, ages, weights, pregnancies, or various proxies for them.

There should be no more character and fitness questions *at all* relating to mental health on professional licensure applications and no more efforts on the part of LAPs to encourage peer identification and reporting of mental health disorders and disabilities in their coworkers to their employers and LAPs. The CoLAP publications discussed in this Article should be removed from the internet and should not be replaced. But the problems described in this Article may continue to recur so long as LAPs remain connected to the ABA and state bars, immune from liability, and permitted to advertise through educational programming allegedly designed to help lawyers with mental health disorders and disabilities.

This Article has heavily criticized LAPs and associated entities, but also medical and mental health professionals for disseminating inaccurate claims about employees with mental health disorders and disabilities. Other commentators place more blame on uncritical consumers, such as the judiciary, for dismissing empirical evidence plainly correcting various myths and stereotypes about people with mental health disorders and disabilities.[312] To reduce mental health stigma, prejudice, and discrimination within the profession, law students and lawyers need to "better understand how social science data is manipulated"[313] in ways that perpetuate bias, and they need to correct false claims about lawyers and other people with mental health disorders and disabilities. Members of the legal community should remind each other that save for all but the most exceptional cases, the presence of a mental health disorder or disability has nothing to do with professional misconduct. And they must not let claims to the contrary go without correction, spread them around, or otherwise act as agents of the ongoing "lawyer well-being" movement.

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312. *See* Perlin, *supra* note 171, at 881.
313. *Id.*