

**“There Must Be Some Way Out of Here”: Why the Convention on the Rights of
Persons with Disabilities Is Potentially the Best Weapon in the Fight Against
Sanism in Forensic Facilities**

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Introduction

It is impossible to consider the impact of anti-discrimination law on persons with mental disabilities without a full understanding of how sanism permeates all aspects of the legal system – judicial opinions, legislation, the role of lawyers, juror decisionmaking—and the entire fabric of American society. For those unfamiliar with the phrase, I define “sanism” as an irrational prejudice of the same quality and character as other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry¹ that permeates all aspects of mental disability law and affects all participants in the mental disability law system: litigants, fact finders, counsel, and expert and lay witnesses.²

Notwithstanding two decades-plus of anti-discrimination laws³ and, in many jurisdictions, an impressive corpus of constitutional case law and state statutes,⁴ the attitudes of judges and jurors – not to mention clinicians, expert witnesses and lawyers -- often reflect the same level

¹ The word “sanism” was, to the best of my knowledge, coined by Dr. Morton Birnbaum. See Morton Birnbaum, *The Right to Treatment: Some Comments on Its Development*, in MEDICAL, MORAL AND LEGAL ISSUES IN HEALTH CARE 97, 105 (Frank Ayd ed., 1974); see also *Koe v. Califano*, 573 F.2d 761, 764 n.12 (2d Cir. 1978). I have relied on it constantly for the past twenty years to explain the roots of our attitudes towards persons with mental disabilities. See e.g., Michael L. Perlin, *A Half-Wracked Prejudice Leaped Forth@: Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEG. ISS. 3(1999) (Perlin, *Half-Wracked Prejudice*); Michael L. Perlin, *On Sanism*, 46 SMU L. REV. 373 (1992) (Perlin, *Sanism*).

² On the way that sanism affects lawyers' representation of clients, see Michael L. Perlin, *A You Have Discussed Lepers and Crooks@: Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 689-90 (2003).

³ 42 U.S.C. §§ 12101 et seq.

⁴ See Michael L. Perlin, *A They Keep It All Hid@: The Ghettoization of Mental Disability Law and Its Implications for Legal Education*, 54 ST. LOUIS U. L. J. 857, 857-58 n.1 (2010) (listing cases).

of bigotry that defined this area of law a half century ago.⁵ The reasons for this are complex and, to a great extent, flow from centuries of prejudice – often hidden prejudice, often socially-acceptable prejudice⁶ – that has persisted in spite of prophylactic legislative and judicial reforms, and a seeming (on the surface) significance uptick in public awareness. I have railed multiple times about the “irrational,” “corrosive”, “malignant” and “ravaging” effects of sanism, but its “pernicious power” still poisons all of mental disability law.⁷

When I started writing about sanism, the potential redemptive influence of international human rights law was only dimly on the horizon. Eric Rosenthal and Leonard Rubenstein had written their groundbreaking piece⁸, *International Human Rights Advocacy Under the “Principles For The Protection Of Persons With Mental Illness,”*⁹ in 1993, but it had been barely

⁵ See generally, Michael L. Perlin, *You Have Discussed Lepers and Crooks@: Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683 (2003).

⁶ See generally, MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* (2000).

⁷ See e.g., Michael L. Perlin, *And My Best Friend, My Doctor/ Won't Even Say What It Is I've Got: The Role and Significance of Counsel in Right to Refuse Treatment Cases*, 42 SAN DIEGO L. REV. 735, 750(2005) (Perlin, *Best Friend*) (“irrational”); Michael L. Perlin, *Life Is In Mirrors, Death Disappears@: Giving Life to Atkins*, 33 N. MEX. L. REV. 315, 346 (2003) (“ravaging”); Michael L. Perlin, *She Breaks Just Like a Little Girl: Neonaticide, The Insanity Defense, and the Irrelevance of Ordinary Common Sense*, 10 WM. & MARY J. WOMEN & L. 1, 25 (2003) (Perlin, *She Breaks*) (“malignant and corrosive”); Michael L. Perlin, *Everybody Is Making Love/Or Else Expecting Rain@: Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia*, 83 U. WASH. L. REV. 481, 502 (2008) (Perlin, “Expecting Rain”) (“corrosive”); Michael L. Perlin, *Things Have Changed@: Looking at Non-institutional Mental Disability Law Through the Sanism Filter*, 46 N.Y.L. SCH. L. REV. 535, 541 (2002-03) (Perlin, *Sanism Filter*) (“pernicious power”).

⁸ MICHAEL L. PERLIN, *INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCED ARE HEARD*, chapter 1 (2011).

⁹ 16 INT’L J. L. & PSYCHIATRY 257 (1993).

mentioned in the law journals.¹⁰ When Rosenthal and Rubenstein first illuminated how the MI Principles¹¹ came from “an individualistic, libertarian perspective that emphasizes restrictions on what the state can do to a person with mental illness,”¹² they inspired lawyers, advocates, professors and progressive mental health professionals to begin thinking seriously about the intersection between international human rights law and mental disability law. This led me to put on a symposium at New York Law School in 2002 on International Human Rights Law and the Institutional Treatment of Persons with Mental Disabilities: The Case of Hungary.¹³ This was the first such program ever put on at any US-based law school.¹⁴

¹⁰ A WESTLAW search reveals only eight citations prior to 2002.

¹¹ The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care are widely referred to as the “MI Principles.” G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No. 49, Annex at 189, U.N. Doc. A/46/49 (1991).

¹² Rosenthal & Rubenstein, *supra* note 9, at 260. On the way that the MI Principles became the “centerpiece of the human rights based approach to mental health care” in Australia, see Neil Rees, *International Human Rights Obligations and Mental Health Tribunals*, 10 PSYCHIATRY, PSYCHOL. & L. 33 (2003); see also Terry Carney, *Mental Health in Postmodern Society: Time for New Paradigms?* 10 PSYCHIATRY, PSYCHOL. & L. 12 (2003).

But see Tina Minkowitz, *The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions*, 34 SYRACUSE J. INT'L L. & COM. 405, 407 (2007) (criticizing MI Principles for not being sufficiently protective of the rights of persons with psychosocial disabilities, especially in the context of the right to refuse treatment); T.W. Harding, *Human Rights Law in the Field of Mental Health: A Critical Review*, 101 ACTA PSYCHIATRICA SCANDINAVICA 24, 24 (2000) (discussing how MI Principles are “basically flawed,” also specifically referring to the right to refuse treatment). Criticisms of the MI Principles are discussed in H. Archibald Kaiser, *Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State*, 17 HEALTH L.J. 139, 160 (2009).

¹³ 21 N.Y.L. SCH. J. INT'L & COMP. L. 340 (2002). Presenters at this conference included Rosenthal, Krassimir Kanev, a human rights advocate with the Bulgaria Helsinki Committee, Gabor Gombos, head of the most important psychiatric survivor organization in Hungary, and Eva Szeli, then Director of European Operations at MDRI's Budapest office. See *id.* at 346-48.

¹⁴ Major articles based on conference presentations include Eric Rosenthal & Clarence J. Sundram, *International Human Rights in Mental Health Legislation*, 21 N.Y.L. SCH. J. INT'L & COMP. L. 469 (2002), and Bruce J. Winick, *Therapeutic Jurisprudence and the Treatment of People with Mental Illness in Eastern Europe: Construing International Human Rights Law*, 21 N.Y.L. SCH. J. INT'L & COMP. L. 537 (2002).

In the years following that conference, developments moved on with dizzying rapidity. Disability rights took center stage at the United Nations in the most significant historical development in the recognition of the human rights of persons with mental disabilities: the drafting and adoption of a binding international disability rights convention.¹⁵ In late 2001, the United Nations General Assembly established an Ad Hoc Committee “to consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities,”¹⁶ The Ad Hoc Committee drafted a document over the course of five years and eight sessions, and the new *Convention on the Rights of Persons with Disabilities* (sometimes “Convention” or “CRPD”)¹⁷ was adopted in December 2006 and opened for signature in March 2007.¹⁸ It entered into force - thus becoming legally binding on States parties - on May 3, 2008, thirty days after the 20th ratification.¹⁹ One of the hallmarks of the process that led to the publication of the UN Convention was the participation of persons with

¹⁵ On the singular role of this Convention, see e.g., Frederic Megret, *The Disabilities Convention: Toward a Holistic Concept of rights*, available at <http://ssrn.co/abstract=1267726>, and Frederic Megret, *The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?*, 30 HUM. RIGHTS 494(2008) (Megret, *Disability Rights*); Michael L. Perlin & Eva Szeli, *Mental Health Law and Human Rights: Evolution and Contemporary Challenges*, in MENTAL HEALTH AND HUMAN RIGHTS (Michael Dudley ed. 2011) (in print) (Perlin & Szeli, *Evolution and Contemporary Challenges*); Michael L. Perlin & Eva Szeli, *Mental Health Law and Human Rights: Evolution, Challenges and the Promise of the New Convention*, in UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: MULTIDISCIPLINARY PERSPECTIVES 241 (Jukka Kumpuvuori & Martin Scheninen, eds. 2010).

¹⁶G.A. Res. 56/168 (2001).

¹⁷G.A. Res. A/61/611 (2006).

¹⁸G.A. Res. A/61/106 (2006).

¹⁹On the 20th ratification, see <http://www.un.org/News/Press/docs/2008/hr4941.doc.htm>. See generally, Tara Melish, *The UN Disability Convention: Historic Process, Strong Prospects, and Why the U.S. Should Ratify*, 14 HUM. RTS. BRIEF 37, 44 (Winter 2007); Michael Ashley Stein & Penelope J.S. Stein, *Beyond Disability Civil Rights*, 58 HASTINGS L. J. 1203 (2007).

disabilities and the clarion cry, "Nothing about us, without us."²⁰ This has led commentators to conclude that the Convention "is regarded as having finally empowered the 'world's largest minority' to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection."²¹

This Convention is the most revolutionary international human rights document – ever -- that applies to persons with disabilities.²² The Disability Convention furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in most

²⁰See e.g., Rosemary Kayess & Phillip French, *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, 8 HUM. RTS. L. REV. 1, 4 n.15 (2008):

See, for example, Statement by Hon Ruth Dyson, Minister for Disability Issues, New Zealand Mission to the UN, for Formal Ceremony at the Signing of the Convention on the Rights of Persons with Disability, 30 March 2007: "Just as the Convention itself is the product of a remarkable partnership between governments and civil society, effective implementation will require a continuation of that partnership." The negotiating slogan 'Nothing about us without us' was adopted by the International Disability Caucus, available at: http://www.un.org/esa/socdev/enable/documents/Stat_Conv/nzam.doc [last accessed 13 November 2007].

²¹*Id.*, n. 17 (See, for example, statements made by the High Commissioner for Human Rights, Louise Arbour, and the Permanent Representative of New Zealand and Chair of the Ad-Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ambassador Don Mackay, at a Special Event on the Convention on Rights of Persons with Disabilities, convened by the UN Human Rights Council, 26 March 2007, available at: [http://www.unog.ch/80256EDD006B9C2E/\(httpNewsByYear_en\)/7444B2E219117CE8C12572AA004C5701?OpenDocument](http://www.unog.ch/80256EDD006B9C2E/(httpNewsByYear_en)/7444B2E219117CE8C12572AA004C5701?OpenDocument) [last accessed 13 November 2007].).

²²Perlin & Szeli, *Evolution and Contemporary Challenges*, *supra* note 15; PERLIN, *supra* note 8, chapter 1; Michael L. Perlin, "A Change Is Gonna Come": *The Implications of the United Nations Convention on the Rights of Persons with Disabilities for the Domestic Practice of Constitutional Mental Disability Law*, 29 NO. ILL. U. L. REV. 483 (2009).

every aspect of life.²³ It firmly endorses a social model of disability – a clear and direct repudiation of the medical model that traditionally was part-and-parcel of mental disability law.²⁴ It furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in most aspects of life. “The Convention responds to traditional models and situates disability within a social model framework²⁵ and sketches the full range of human rights that apply to all human beings, all with a particular application to the lives of persons with disabilities.”²⁶ It provides a framework for insuring that mental health laws “fully recognize the rights of those with mental illness.”²⁷

The CRPD categorically affirms the social model of disability²⁸ by describing it as a condition arising from “interaction with various barriers [that] may hinder their full and effective

²³See e.g., Aaron Dhir, *Human Rights Treaty Drafting Through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 STAN. J. INT'L L. 181 (2005).

²⁴ See generally, Michael L. Perlin, “Abandoned Love”: *The Impact Of Wyatt v. Stickney On The Intersection Between International Human Rights And Domestic Mental Disability Law*, 35 LAW & PSYCHOL. REV. 121 (2011).

²⁵ See e.g., Janet E. Lord, David Suozzi & Allyn L. Taylor, *Lessons From The Experience Of U.N. Convention On The Rights Of Persons With Disabilities: Addressing The Democratic Deficit In Global Health Governance*, 38 J.L. MED. & ETHICS 564 (2010); Kaiser, *supra* note 12.

²⁶ Janet E. Lord & Michael A. Stein, *Social Rights And The Relational Value Of The Rights To Participate In Sport, Recreation, And Play*, 27 B.U. INT'L L. J. 249, 256 (2009); see also, Ronald McCallum, *The United Nations Convention on the Rights of Persons with Disabilities: Some Reflections*. Accessible at <http://ssrn.com/abstract=1563883> (2010).

²⁷ Bernadette McSherry, *International Trends In Mental Health Laws: Introduction*, 26 LAW IN CONTEXT 1, 8 (2008).

²⁸ See Lord, Suozzi & Taylor, *supra* note 25, at 568.

participation in society on an equal basis with others” instead of inherent limitations,²⁹ reconceptualizes mental health rights as disability rights,³⁰ and extends existing human rights to take into account the specific rights experiences of persons with disabilities.³¹ To this end, it calls for “respect for inherent dignity”³² and “non-discrimination.”³³ Subsequent articles declare “freedom from torture or cruel, inhuman or degrading treatment or punishment,”³⁴ “freedom from exploitation, violence and abuse,”³⁵ a right to protection of the “integrity of the person,”³⁶ “equal recognition before the law,”³⁷ equal “access to justice,”³⁸ and the right to liberty and security of [the] person.”³⁹

My hopes are, of course, that the CRPD serves as a vehicle that will finally extinguish the toxic stench of sanism that permeates all levels of society. In my time today, I will consider whether the Convention –ratified or not -- is likely to do that, with specific focus on forensic

²⁹ CRPD, art. 1 and pmb., para. e.,

³⁰ Phillip Fennel, *Human Rights, Bioethics, and Mental Disorder*, 27 MED. & L. 95 (2008).

³¹ Megret, *Disability Rights*, *supra* note 22; see PERLIN, *supra* note 8, Chapter 7.

³² CRPD, Article 3(a).

³³ *Id.*, Article 3(b).

³⁴ *Id.*, Article 15.

³⁵ *Id.*, Article 16.

³⁶ *Id.*, Article 17.

³⁷ *Id.*, Article 12.

³⁸ *Id.*, Article 13

³⁹ *Id.*, Article 14.

facilities. First, I will briefly discuss both our sanist past and our sanist present. Then, I will consider how the CRPD has the greatest potential for combating sanism, and for changing social attitudes. In this latter inquiry, I will also draw on the tools of therapeutic jurisprudence.⁴⁰ Then, I will offer some brief and modest conclusions.

The title of my paper begins with the first line of Bob Dylan's brilliant and iconic song, *All Along the Watchtower*,⁴¹ a song that captures the "fragility of the human condition,"⁴² and that reflects "the storm of history."⁴³ Globally, our treatment of persons with mental disabilities has spoken to the way we have ignored (and exacerbated) that "fragility"; the ratification of the UN Convention is part of a major new "storm of history." As Dylan reminds us later in the same song, "the hour is getting late."⁴⁴

I. **Our sanist past**⁴⁵

Judges are not immune from sanism. "[E]mbedded in the cultural presuppositions that engulf us all,"⁴⁶ judges take deeper refuge in heuristic thinking and flawed, non-reflective

⁴⁰ Therapeutic jurisprudence presents a new model by which we can assess the ultimate impact of case law and legislation on mentally disabled individuals. It requires (1) studying the role of the law as a therapeutic agent; (2) recognizing that substantive rules, legal procedures, and lawyers' roles may have either therapeutic or anti-therapeutic consequences; and (3) questioning whether such rules, procedures, and roles can or should be reshaped so as to enhance their therapeutic potential, while not subordinating due-process principles. See Perlin, *She Breaks*, *supra* note 5, at 30-31 n.233.

⁴¹ <http://www.bobdylan.com/songs/all-along-the-watchtower>.

⁴² OLIVER TRAGER, KEYS TO THE RAIN: THE DEFINITIVE BOB DYLAN ENCYCLOPEDIA 9 (2004).

⁴³ MIKE MARQUEE, CHIMES OF FREEDOM: THE POLITICS OF BOB DYLAN'S ART 238 (2003).

⁴⁴ See *supra* note 41.

⁴⁵ This section was adapted from Perlin, "Half-Wracked Prejudice," *supra* note 1, at 14-19.

“ordinary common sense,” both of which continue the myths and stereotypes of sanism.⁴⁷ They reflect and project the conventional morality of the community, and judicial decisions in all areas of civil and criminal mental disability law continue to reflect and perpetuate sanist stereotypes.⁴⁸ Their language demonstrates bias against mentally disabled individuals⁴⁹ and contempt for the mental health professions.⁵⁰ Courts often appear impatient with mentally disabled litigants, ascribing their problems in the legal process to weak character or poor resolve. Thus, a popular sanist myth is that “[m]entally disabled individuals simply don’t try hard enough. They give in too easily to their basest instincts, and do not exercise appropriate

⁴⁶ Anthony D’Amato, *Harmful Speech and the Culture of Indeterminacy*, 32 WM. & MARY L. REV. 329, 332 (1991).

⁴⁷ Michael L. Perlin, *Psychodynamics and the Insanity Defense: “Ordinary Common Sense” and Heuristic Reasoning*, 69 NEB. L. REV. 3 (1990); Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599, 618-30 (1989-90) (Perlin, *Myths*).

⁴⁸ Perlin, *Sanism*, *supra* note 1, at 400-04.

⁴⁹ See *Corn v. Zant*, 708 F.2d 549, 569 (11th Cir. 1983), reh’g. denied, 714 F.2d 159 (11th Cir. 1983), cert. denied, 467 U.S. 1220 (1984) (defendant referred to as a “lunatic”); *Sinclair v. Wainwright*, 814 F.2d 1516, 1522 (11th Cir., 1987) (quoting *Shuler v. Wainwright*, 491 F.2d 1213, 1223 (5th Cir. 1974) (using “lunatic”)); *Brown v. People*, 134 N.E.2d 760, 762 (Ill. 1956) (judge asked defendant, “You are not crazy at this time, are you?”); *Pyle v. Boles*, 250 F. Supp. 285, 289 n.3 (N.D. W. Va. 1966) (trial judge accused habeas petitioner of “being crazy”). But cf. *State v. Penner*, 772 P.2d 819 (Kan. 1989) (unpublished disposition), at *3 (witnesses admonished not to refer to defendant as “crazy” or “nuts”).

⁵⁰ See *Commonwealth v. Musolino*, 467 A.2d 605, 614 (Pa. Super. Ct. 1983) (reversible error for trial judge to refer to expert witnesses as “headshrinkers”). Compare *State v. Percy*, 507 A.2d 955, 957 n.1 (Vt. 1986), appeal after remand, 595 A.2d 248 (Vt. 1990), cert. denied, 502 U.S. 927 (1991) (reversing a conviction where prosecutor, in closing argument, referred to expert testimony as “psycho-babble”), with *Commonwealth v. Cosme*, 575 N.E.2d 726, 731 (Mass. 1991) (not error where prosecutor referred to defendant’s expert witnesses as “a little head specialist” and a “wizard”). See generally Douglas Mossman & Marshall Kapp, *“Courtroom Whores” ?--or Why Do Attorneys Call Us? Findings from a Survey on Attorneys’ Use of Mental Health Experts*, 26 J. AM. ACAD. PSYCHIATRY & L. 27 (1998).

self-restraint.”⁵¹ We assume that “[m]entally ill individuals are presumptively incompetent to participate in ‘normal’ activities [and] to make autonomous decisions about their lives (especially in the area of medical care)”⁵²

At its base, sanism is irrational. Any investigation of the roots or sources of mental disability jurisprudence must factor in society’s irrational mechanisms that govern our dealings with mentally disabled individuals.⁵³ The entire legal system makes assumptions about persons with mental disabilities—who they are, how they got that way, what makes them different, what there is about them that lets us treat them differently, and whether their conditions are immutable.⁵⁴ These assumptions reflect our fears and apprehensions about mental disability, persons with mental disability, and the possibility that we may become mentally disabled.⁵⁵ The most important question of all—why do we feel the way we do about these people?—is rarely asked.⁵⁶

⁵¹Perlin, *Sanism*, *supra* note 1, at 396; see, e.g., J.M. Balkin, *The Rhetoric of Responsibility*, 76 VA. L. REV. 197, 238 (1990) (Hinckley prosecutor suggested to jurors, “if Hinckley had emotional problems, they were largely his own fault”); see also *State v. Duckworth*, 496 So. 2d 624, 635 (La. App. 1986) (juror who felt defendant would be responsible for actions as long as he “wanted to do them” not excused for cause) (no error).

⁵² Perlin, *Sanism*, *supra* note 1, at 394.

⁵³ See generally Perlin, *Myths*, *supra* note 47.

⁵⁴See generally MARTHA MINOW, *MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW* (1990); SANDER GILMAN, *DIFFERENCE AND PATHOLOGY: STEREOTYPES OF SEXUALITY, RACE, AND MADNESS* (1985).

⁵⁵ See, e.g., Joseph Goldstein & Jay Katz, *Abolish the “Insanity Defense”--Why Not?* 72 Yale L.J. 853, 868-69 (1963); Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 108 (1991) (on society’s fears of mentally disabled persons), and *id.* at 93 n.174 (“[W]hile race and sex are immutable, we all can become mentally ill, homeless, or both. Perhaps this illuminates the level of virulence we experience here.”). On the way that public fears about the purported link between mental illness and dangerousness “drive the formal laws and policies”

I believe that sanism -- along with pretextuality⁵⁷ -- has controlled—and continues to control—modern mental disability law. Just as importantly (perhaps, more importantly), they continue to exert this control invisibly. This invisibility means that the most important aspects of mental disability law—not just the law “on the books,” but, more importantly, the law in action and practice—remains hidden from the public discussions about mental disability law.

II. **Our sanist present**⁵⁸

Although we are more aware now of the impact of sanism than we were 20 years ago when I began to write about it, it is not at all clear that the legal system has made the sort of structural changes needed to combat sanism’s power. I will consider here just one example: the

governing mental disability jurisprudence, see John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511, 511 (1992).

⁵⁶ See MICHAEL L. PERLIN, *THE JURISPRUDENCE OF THE INSANITY DEFENSE* 6-7 (1994) (asking this question). Cf. Carmel Rogers, *Proceedings Under the Mental Health Act 1992: The Legalisation of Psychiatry*, 1994 N.Z. L.J. 404, 408 (“Because the preserve of psychiatry is populated by ‘the mad’ and ‘the loonies,’ we do not really want to look at it too closely--it is too frightening and maybe contaminating.”).

⁵⁷

The pretexts of the forensic mental health system are reflected both in the testimony of forensic experts and in the decisions of legislators and fact-finders. Experts frequently testify in accordance with their own self-referential concepts of “morality” and openly subvert statutory and caselaw criteria that impose rigorous behavioral standards as predicates for commitment or that articulate functional standards as prerequisites for an incompetency to stand trial finding. Often this testimony is further warped by a heuristic bias. Expert witnesses--like the rest of us--succumb to the seductive allure of simplifying cognitive devices in their thinking, and employ such heuristic gambits as the vividness effect or attribution theory in their testimony.

See Perlin, “*Half-Wracked Prejudice*,” *supra* note 1, at 18.

⁵⁸ This section is largely adapted from Michael L. Perlin, *AI Might Need a Good Lawyer, Could Be Your Funeral, My Trial@: A Global Perspective on the Right to Counsel in Civil Commitment Cases, and Its Implications for Clinical Legal Education*, 28 WASH. U. J. L. & SOC=L POL=Y 241, 246-49 (2008).

adequacy of counsel in involuntary civil commitment cases,⁵⁹ an issue that has a direct and inevitable impact on forensic facilities “down the road.”.

The Montana case of *In re K.G.F.*⁶⁰ is, “without doubt, the most comprehensive decision on the scope and meaning of the right to counsel in this context from any jurisdiction in the world.”⁶¹ K.G.F. was a voluntary patient at a community hospital in Montana whose expressed desire to leave the facility prompted a State petition alleging her need for commitment. Counsel was appointed, and a commitment hearing was scheduled for the next day. The State’s expert recommended commitment; patient’s counsel presented the testimony of the plaintiff herself and a mental health professional who recommended that the patient be kept in the hospital a few days so that a community-based treatment plan could be arranged nearer to her home. The court ordered commitment. K.G.F.’s appeal was premised, in part, on allegations of ineffective assistance of counsel.⁶²

In a thoughtful and scholarly opinion, the Montana Supreme Court relied on state statutory and constitutional sources to find that “the right to counsel . . . provides an individual subject to an involuntary commitment proceeding the right to effective assistance of counsel. In turn, this right affords the individual with the right to raise the allegation of ineffective assistance of

⁵⁹ See generally for a historical overview, Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161 (Summer 1982).

⁶⁰ 29 P.3d 485 (Mont. 2001).

⁶¹ Perlin, *supra* note 58, at 245.

⁶² *K.G.F.*, 29 P. 3d at 488.

counsel in challenging a commitment order.”⁶³ In assessing what constitutes “effectiveness,” the court—startlingly, to my mind—eschewed the *Strickland v. Washington* standard⁶⁴ (used to assess effectiveness in criminal cases) as insufficiently protective of the “liberty interests of individuals such as K.G.F. who may or may not have broken any law, but who, upon the expiration of a ninety-day commitment, must indefinitely bear the badge of inferiority of a once ‘involuntarily committed’ person with a proven mental disorder.”⁶⁵ Interestingly, one of the key reasons why *Strickland* was seen as lacking was the court’s conclusion that “reasonable professional assistance”⁶⁶—the linchpin of the *Strickland* decision—“cannot be presumed in a proceeding that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.”⁶⁷

In assessing the contours of effective assistance of counsel, the court emphasized that it was not limiting its inquiry to courtroom performance; even more important was counsel’s “failure to fully investigate and comprehend a patient’s circumstances prior to an involuntary civil commitment hearing or trial, which may, in turn, lead to critical decision-making between

⁶³ *Id.* at 491.

⁶⁴ *Strickland v. Washington*, 466 U.S. 668 (1984) (establishing weak effectiveness of counsel standard). See generally 4 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* (2d ed. 2002), § 2B-11.2, at 261-67.

⁶⁵ *K.G.F.*, 29 P.3d at 491.

⁶⁶ *Strickland*, 466 U.S. at 689.

⁶⁷ *K.G.F.*, 29 P.3d at 492 (citing Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 *LAW & HUM. BEHAV.* 39, 53-54 (1992); (“identifying the *Strickland* standard as ‘sterile and perfunctory’ where ‘reasonably effective assistance’ is objectively measured by the ‘prevailing professional norms’”)).

counsel and client as to how best to proceed.” Such pre-hearing matters, the court continued, “clearly involve effective preparation prior to a hearing or trial.” The court further emphasized the role of state laws guaranteeing the patient’s “dignity and personal integrity” and “privacy and dignity” in its decision: “[q]uality counsel provides the most likely way—perhaps the only likely way’ to ensure the due process protection of dignity and privacy interests in cases such as the one at bar.”⁶⁸

After similarly elaborating on counsel’s role in the client interview and the need to ensure that the patient understands the scope of the right to remain silent, the court concluded by underscoring counsel’s responsibilities “as an advocate and adversary.”⁶⁹ The lawyer must “represent the perspective of the [patient] and . . . serve as a vigorous advocate for the [patient’s] wishes,” engaging in “all aspects of advocacy and vigorously argu [ing] to the best of his or her ability for the ends desired by the client,” and operating on the “presumption that a client wishes to not be involuntarily committed.” Thus, “evidence that counsel independently advocated or otherwise acquiesced to an involuntary commitment—in the absence of any evidence of a voluntary and knowing consent by the patient-respondent—will establish the presumption that counsel was ineffective.”⁷⁰ In conclusion, the court stated:

⁶⁸ *K.G.F.*, 29 P. 3d at 492-494, quoting MONT. CODE ANN. § 53-21-101(1), MONT. CODE ANN. § 53-21-142(1), and Perlin, *supra* note 67, at 47; see generally, Michael L. Perlin, “Dignity Was the First to Leave”: *Godinez v. Moran*, *Colin Ferguson*, and the Trial of Mentally Disabled Criminal Defendants, 14 BEHAV. SCI. & L. 61 (1996).

⁶⁹ *K.G.F.*, 29 P. 3d at 500.

⁷⁰ *Id.*

[I]t is not only counsel for the patient-respondent, but also courts, that are charged with the duty of safeguarding the due process rights of individuals involved at every stage of the proceedings, and must therefore rigorously adhere to the standards expressed herein, as well as those mandated under [state statute].⁷¹

On one hand, *K.G.F.* provides an “easily transferable blueprint for courts that want to grapple with adequacy of counsel issues”;⁷² on the other, no other state court has adopted its reasoning in the decade since it was decided. In fact, its rationale was specifically rejected by the Washington Supreme Court in an opinion that concluded, with no supporting empirical or other statistical evidence:

We do not share the Montana Supreme Court’s dim view of the quality of civil commitment proceedings, or their adversarial nature, in the state of Washington. The Strickland standard appears to be sufficient to protect the right to the effective assistance of counsel for a civil commitment respondent in this state.⁷³

Writing about this issue in a domestic context, I have noted:

[G]lobally, counsel’s continuing failure here still appears to be inevitable, given the bar’s abject disregard of both consumer groups (made up predominantly of former recipients, both voluntary and involuntary, of mental disability services) and individuals with mental

⁷¹ *Id.* at 501.

⁷² MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL*, § 2B-11.3 (2010 Cum. Supp .).

⁷³ *In re Detention of T.A. H.-L.*, 97 P.3d 767, 771-72 (Wash. Ct. App. 2004).

disabilities, many of whom have written carefully, thoughtfully, and sensitively about these issues.⁷⁴

In short, sanism is *not* an issue that has gone away. Although, as I have noted already, it is recognized more and more by scholars,⁷⁵ it still remains “under the radar,” at least for most courts in the United States.

III. The CRPD

A. In general⁷⁶

The CRPD is unique because it is the first legally binding instrument devoted to the comprehensive protection of the rights of persons with disabilities. It not only clarifies that States should not discriminate against persons with disabilities, but also sets out explicitly the many steps that States must take to create an enabling environment so that persons with disabilities can enjoy authentic equality in society. One of the most critical issues in seeking to bring life to international human rights law in a mental disability law context is the right to adequate and dedicated counsel. The CRPD mandates that “States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may

⁷⁴ Perlin, “*Best Friend*”, *supra* note 7, at 741-42.

⁷⁵ See e.g., Camille A. Nelson, *Racializing Disability, Disabling Race: Policing Race And Mental Status*, 15 BERKELEY J. CRIM. L. 1, 19 n. 63 (2010); Deirdre M. Smith, *The Disordered And Discredited Plaintiff: Psychiatric Evidence In Civil Litigation*, 31 CARDOZO L. REV. 749, 809 n. 329 (2010); Bruce J. Winick, *The Supreme Court's Evolving Death Penalty Jurisprudence: Severe Mental Illness As The Next Frontier*, 50 B.C. L. REV. 785, 847 (2009); John W. Parry, *The Death Penalty and Persons with Mental Disabilities: A Lethal Dose of Stigma, Sanism, Fear of Violence, and Faulty Predictions of Dangerousness*, 29 MENTAL & PHYSICAL DISABILITY L. REP. 667 (2005). A recent search of the WESTLAW JLR database found 152 references to “sanism” in articles other than those by the author.

⁷⁶ This section is generally adapted from PERLIN, *supra* note 8, Chapter 7.

require in exercising their legal capacity”⁷⁷ Elsewhere, the convention commands:

States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.⁷⁸

“The extent to which this Article is honored in signatory nations will have a major impact on the extent to which this entire Convention affects persons with mental disabilities.”⁷⁹ If and only if, there is a mechanism for the appointment of dedicated counsel,⁸⁰ can this dream become a reality.

The ratification of the CRPD is the most important development – ever – in institutional human rights law for persons with mental disabilities. The CRPD is detailed, comprehensive, integrated and the result of a careful drafting process. It seeks to reverse the results of centuries of oppressive behavior and attitudes that have stigmatized persons with disabilities. Its goal is clear: to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms of all persons with disabilities, and to promote respect for

⁷⁷ See Perlin, *supra* note 58, at 252-53, quoting CRPD, Article 12.

⁷⁸ CRPD, Article 13.

⁷⁹ Perlin, *supra* note 58, at 253.

⁸⁰ On the significance of “cause lawyers” in the development of mental disability law in the United States, see Michael A. Stein, Michael E. Waterstone & David B. Wilkins, *Book Review: Cause Lawyering For People With Disabilities*, 123 HARV. L. REV. 1658 (2010).

their inherent dignity.⁸¹ Whether this will actually *happen* is still far from a settled matter.

B. Issues of dignity⁸²

When the United Nations embarked upon the drafting process of the Convention on the Rights of Persons with Disabilities, it established an ad hoc committee “to consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities.”⁸³ This was consonant with the perspectives of observers such as Professor Aaron Dhir: “Degrading living conditions, coerced “treatment,” scientific experimentation, seclusion, restraints—the list of violations to the dignity and autonomy of those diagnosed with mental disabilities is both long and egregious.”⁸⁴

As ratified, the Convention calls for “respect for inherent dignity.”⁸⁵ It requires state parties to requiring States Parties “to adopt immediate, effective and appropriate measures... [t]o raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities.”⁸⁶ The Preamble characterizes “discrimination against any person on the basis of disability [as] a violation of the

⁸¹ CRPD, Article 1.

⁸² This section is generally adapted from PERLIN, *supra* note 8, Chapter 2.

⁸³ G.A. Res. 56/168, U.N. Doc. A/RES/56/168 (Dec. 19, 2001) (General Assembly Resolution).

⁸⁴ Aaron A. Dhir, *Human Rights Treaty Drafting Through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 STAN. J INT’L L., 181, 182 (2005).

⁸⁵ CRPD, Article 3(a).

⁸⁶ CRPD, Article 8.

inherent dignity and worth of the human person....”⁸⁷ And these provisions are consistent with the entire Convention’s “rights-based approach focusing on individual dignity,”⁸⁸ placing the responsibility on the State “to tackle socially created obstacles in order to ensure full respect for the dignity and equal rights of all persons.”⁸⁹ Prof. Michael Stein puts it well this way: A “dignitary perspective compels societies to acknowledge that persons with disabilities are valuable because of their inherent human worth.”⁹⁰ In Prof. Cees Maris’s summary: “The Convention’s object is to ensure disabled persons enjoy all human rights with dignity.”⁹¹ Step back for a moment and reflect upon the reality that this measure of dignity is often *not* afforded persons with mental disabilities in forensic facilities, both at home and abroad.⁹²

In his testimony in support of the UN Convention, Eric Rosenthal, the director of Mental Disability Rights International, shared with Congress his observations of the treatment of institutionalized persons with mental disabilities in Central and Eastern European nations: “[w]hen governments deny their citizens basic human dignity and autonomy, when they subject

⁸⁷ CRPD, Preamble, para. h.

⁸⁸ Dhir, *supra* note 84, at 195.

⁸⁹ Gerard Quinn & Theresia Degener, HUMAN RIGHTS AND DISABILITY: THE CURRENT USE AND FUTURE POTENTIAL OF UNITED NATIONS HUMAN RIGHTS INSTRUMENTS IN THE CONTEXT OF DISABILITY, 14 (United Nations Publication 2002).

⁹⁰ Michael Ashley Stein, *Disability Human Rights*, 95 CALIF. L. REV. 75, 106 (2007).

⁹¹ Cees Maris, *A not= A: Or, Freaky Justice* 31. CARDOZO L. REV., 1133, 1156 (2010).

⁹² See e.g., Michael L. Perlin, *International Human Rights Law and Comparative Mental Disability Law: The Universal Factors*, 34 SYRACUSE J. INT=L L. & COMMERCE 333 (2007).

them to extremes of suffering, when they segregate them from society- we call these violations of fundamental human rights”.⁹³

Dignity issues self-evidently affect institutionalization issues as well, both civil and forensic.⁹⁴ An intermediate appellate court U.S. case—in holding that a state welfare department regulation requiring certain patients to receive services in the segregated setting of a nursing home, rather than in their own homes, violated the Americans with Disabilities Act (ADA) – has read the ADA to intend to ensure that “qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them.”⁹⁵ Courts in Canada have similarly stressed the role of dignitarian values in cases involving the autonomy of persons with mental disabilities: “Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be

⁹³ Sally Chaffin, *Challenging The United States Position On A United Nations Convention On Disability*, 15 TEMP. POL. & CIV. RTS. L. REV. 121, 140 (2005) (quoting Rosenthal).

⁹⁴ See, *Indiana v. Edwards*, 554 U.S. 164 (2008), for a recent discussion of the role of dignity in the criminal trial process in cases involving criminal defendants with mental disabilities.

⁹⁵ *Helen L. v. DiDario*, 46 F. 3d 325, 334 (3d Cir. 1995, cert. denied, 516 U.S. 813 (1995)); see also, Michael L. Perlin & Deborah A. Dorfman, “*Is it More Than Dodging Lions and Wastin’ Time?*” *Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment*, 2 PSYCHOL. PUB. POL’Y & L., 114-136 (1996) (on how hearings in right to refuse treatment cases can enhance dignity values). See, Michael L. Perlin, “*What’s Good Is Bad, What’s bad Is Good, You’ll Find Out When You Reach The Top, You’re on The Bottom:*” *Are The Americans with Disabilities Act (and Olmstead v. L.C.) anything more than “Idiot Wind,”?* 35 U. MICH. J.L. REFORM, 235-261 (1991) (on the ADA and dignity in general).

treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection ...”⁹⁶

There has been scant caselaw that has yet interpreted the UN Convention.⁹⁷ Yet, it is clear that the articulation of these rights will bring new focus on institutional forensic psychiatry worldwide. It is necessary for psychiatrists and other mental health professionals who work in institutional forensic settings (especially for those treating and caring for individuals charged or convicted of serious violent offenses) to begin to take seriously this Convention, with special focus on these sub-issues:

- How will the Convention affect the treatment of violent offenders in correctional institutions and in forensic mental health institutions?
- What will the Convention’s implications be for expert witnesses who testify in cases involving such offenders?
- To what extent will new developments in risk assessment have an impact on the interpretation of the Convention with regard to this population?
- What are the Convention’s implications for attorneys representing such offenders?
- How will the ratification of this Convention alter the “landscape” in nations that have not yet ratified the Convention?

⁹⁶ *Fleming v. Reid*, 4 O.R. 3d 74, 86-87 (C.A.) (1991), as discussed in Aaron A. Dhir, *Relationships of Force: Exploring the legal and Social Issues Surrounding Disability*, 25 WINDSOR REV. LEGAL & SOC. ISSUES 103, 109 (2008).

⁹⁷ See PERLIN, *supra* note 8.

- What implications will the Convention have on ethical issues that surround the practice of institutional psychiatry and psychology in the treatment of such individuals?
- What will (or what should) the role of organized psychiatry and psychology be (if any) in such cases?, and
- How, in cases involving violent offenders, will regional human rights courts and commissions likely decide cases in which the Convention is raised?

We know that conditions in forensic facilities in many (perhaps most parts of the world) stand in glaring violation of many of these Articles . Persons in the forensic system⁹⁸ receive - if this even seems possible - less humane services than do civil patients.⁹⁹ Professor Gostin refers – without contradiction -- to the near-universal “inhuman and degrading” treatment of forensic patients.¹⁰⁰ In many nations, there is not even a forensic psychiatry department in any medical school.¹⁰¹

⁹⁹ See Perlin, *supra* note 92, recounting examples. See generally, Michael L. Perlin & Henry A. Dlugacz, “It’s Doom Alone That Counts”: Can International Human Rights Law Be An Effective Source of Rights in Correctional Conditions Litigation?, 27 BEHAV. SCI. & L. 675 (2009).

¹⁰⁰ Larry Gostin, *Old@ and ANew@ Institutions for Persons with Mental Illness: Treatment, Punishment, or Preventive confinement?* 122 PUBLIC HEALTH 906 (2008).

¹⁰¹ A.M. Alhamed, *Forensic Psychiatry in Saudi Arabia: An Overview*, 27 AM. J. FORENS. PSYCHIATRY 71 (2006).

Some examples are, for want of a better word, stupefying. In Hungary, until relatively recently, convicted prisoners from Budapest Prison were used to “keep an eye on” patients in IMEI (Hungary’s only high security forensic psychiatric institution) “with high suicide risk.”¹⁰² In Albania, persons with mental disabilities who have been charged with a criminal offense reside in a prison unit and must comply with prison rules while institutionalized. “Although Albanian law stipulates one year of treatment to be followed by a re-evaluation, the average length of stay is five years.”¹⁰³

In Kyrgyz, there are no statutory provisions to deal with cases of persons who are potentially incompetent to stand trial.¹⁰⁴ As a result, persons with severe mental illness who are charged with crime have no opportunity to be treated in an effort to improve their condition so as to become competent to stand trial.¹⁰⁵ In insanity cases, although Kyrgyz law allows for an independent evaluation of a defendant prior to trial, “legal aid attorneys [said] that they have never retained an independent expert because they have no money to do so.”¹⁰⁶ This right thus

¹⁰² Press Release, *Shaky Mental Health Rules Fuel Abuse of Patients' Rights*: WHO (June 21, 2005).

¹⁰³ Perlin, *supra* note 92, at 354, citing Harvey Weinstein et al., *Protecting the Mentally Disabled*, CARNEGIE COUNCIL, May 6, 2001, http://www.cceia.org/resources/publications/dialogue/2_06/online_exclusive/654.html.

¹⁰⁴ Arman Vardanyan et al., *Mental Disability Advocacy Center, Mental Health Law of the Kyrgyz Republic and Its Implementation* § 421.1 (2004), available at <http://www.eurasiahealth.org/attaches/81502/118-e.pdf>.

¹⁰⁵ See *Jackson v. Indiana*, 406 U.S. 715 (1972) (unconstitutional to retain untried defendant indefinitely in maximum security forensic hospital if it is not probable he will regain his competency to stand trial in the foreseeable future). But, on the failure of many U.S. jurisdictions to implement *Jackson*, see Michael L. Perlin, “*For the Misdemeanor Outlaw: The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*,” 52 ALA. L. REV. 193, 213 (2000).

¹⁰⁶ On the right of a criminal defendant to an expert witness in an insanity case in the United States, see *Ake v. Oklahoma*, 470 U.S. 68 (1985).

becomes illusory. Although, in Hungary, patients have the right to a retention hearing following a finding of non-responsibility for a criminal act (insanity), such “[p]roceedings are over in less than 5 minutes, and the issues remain untested: similar to detention hearings under civil law, lawyers do not meet their clients or take instructions.”¹⁰⁷ Experiences in other nations are depressingly similar.¹⁰⁸

This is a very bleak picture. I believe though, that the ratification of the UN Convention may be an important ray of light. Consider again the questions I raised a moment ago in the context of both these sorry facts and the Convention ratification. I believe that the Convention -- that applies to all individuals with disabilities, no matter where they are housed—will force policymakers to re-evaluate the treatment of violent offenders in correctional institutions and in forensic mental health institutions. I believe that expert witnesses will need to familiarize themselves with the Articles of the Convention since they, inevitably, will become the “best practices” in this area.¹⁰⁹ There is a robust literature on risk assessment – both in community and in institutional settings;¹¹⁰ both institutional mental health professionals and expert witnesses will have to have the facility to contextualize this literature with the new Convention

¹⁰⁷ Oliver Lewis, *Mental Disability Law in Central and Eastern Europe: Paper, Practice, Promise*, 8 J. MENTAL HEALTH L. 293, 297 (2002).

¹⁰⁸ Annual Report 2007. *Global Initiative on Psychiatry*. Retrieved September 25, 2010, from <http://www.gip-global.org/images/40/389.pdf> (Serbia).

¹⁰⁹ See e.g., Michael Perlin, Astrid Birgden & Kris Gledhill, “*The Witness Who Saw /He Left Little Doubt*”: *A Comparative Consideration of Expert Testimony in Mental Disability Law Cases*, 6 J. INVESTIGATIVE PSYCHOL. & OFFENDER PROFILING 59 (2009).

¹¹⁰ See generally, 1 PERLIN, *supra* note 64, Chapter 2A(2d ed. 1998).

mandates. There is no question that the Convention will have major impacts on the ethical issues that surround the practice of institutional psychiatry in the treatment of such individuals. In a recent article, along with my colleague, Prof. Astrid Birgden, I argued that, given the Convention's mandates, forensic psychologists and psychiatrists were compelled to "devise an ethical framework that is based on enforceable universally shared human values regarding dignity and rights."¹¹¹ I believe that the time for this action has come. In this context, the time is also right for organized psychiatry and organized psychology to assume a leadership role in this area, and demand that forensic facilities and penal facilities housing mentally disabled offenders comport with Convention mandates.¹¹² Also, it should go without saying that attorneys representing individuals in forensic facilities will also have to incorporate the Convention's principles into their representation of offenders, both those in penal and those in forensic facilities.¹¹³

At least one of the questions I listed earlier that cannot yet be answered: We have no way of knowing the extent which (if at all), the ratification of this Convention will alter the "landscape" in nations that have not ratified it. However, we do know that nations -- such as the United States -- that have signed but not yet ratified the Convention, and that have also

¹¹¹ Astrid Birgden & Michael L. Perlin, "Where the Home In The Valley Meets The Damp Dirty Prison": A Human Rights Perspective On Therapeutic Jurisprudence And The Role Of Forensic Psychologists In Correctional Settings, 14 AGGRESSION & VIOLENT BEHAVIOR 256 (2009).

¹¹² Astrid Birgden & Michael L. Perlin, "Tolling for the Luckless, the Abandoned and Forsaken": Community Safety, Therapeutic Jurisprudence and International Human Rights Law as Applied to Prisoners and Detainees, 13 LEGAL & CRIMINOL. PSYCHOL. 231 (2008).

¹¹³ On the inadequacy of counsel globally in such cases, see Perlin, *supra* note 58.

ratified the Vienna Convention on the Law of Treaties – are obligated to “refrain from acts which would defeat [the CRPD’s] object and purpose.”¹¹⁴ But it is still impossible to make even educated guesses as to the impact, if any, in non-signing, non-ratifying states. Again, the extent to which the ratification of the CRPD actually affects our sorry history of stigmatization and marginalization will, in many ways, be the bellwether of the Convention’s actual success.

IV. Therapeutic Jurisprudence¹¹⁵

One of the most important legal theoretical developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence (TJ).¹¹⁶ Initially employed in cases involving individuals with mental disabilities, but subsequently expanded far beyond that narrow area, therapeutic jurisprudence presents a new model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law that can have therapeutic or anti-therapeutic consequences.¹¹⁷ The ultimate aim of therapeutic jurisprudence is to determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles.¹¹⁸

¹¹⁴ *In the Matter of Mark C.H.*, 28 Misc. 3d 765, 906 N.Y.S. 2d 419 (Sur. 2010), citing Vienna Convention, Art. 18.

¹¹⁵ This section is generally adapted from PERLIN, *supra* note 8, Chapter 10.

¹¹⁶ See e.g., DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* (1990) ; DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY: RECENT DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* (1996); BRUCE .J. WINICK, *CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL* (2005).; David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 *TOURO L. REV.* 17 (2008).

¹¹⁷ See, Kate Diesfeld & Ian Freckelton, *Mental Health Law and Therapeutic Jurisprudence*, in *DISPUTES AND DILEMMAS IN HEALTH LAW* 91 (Ian Freckelton & Kerry Anne Peterson eds., 2006) (for a transnational perspective).

¹¹⁸ . Perlin, *supra* note 5; Perlin, “*Best Friend*,” *supra* note 7; Perlin, “*Expecting Rain*,” *supra* note 7.

Therapeutic jurisprudence “asks us to look at law as it actually impacts people’s lives”¹¹⁹ and focuses on the law’s influence on emotional life and psychological well-being.¹²⁰ It suggests that “law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law should attempt to bring about healing and wellness”.¹²¹ By way of example, therapeutic jurisprudence “aims to offer social science evidence that limits the use of the incompetency label by narrowly defining its use and minimizing its psychological and social disadvantage”).¹²² In recent years, scholars have considered a vast range of topics through a therapeutic jurisprudence lens, including, but not limited to, all aspects of mental disability law, domestic relations law, criminal law and procedure, employment law, gay rights law, and tort law.¹²³ As Ian Freckelton has noted, “it is a tool for gaining a new and distinctive perspective utilizing socio-psychological insights into the law and its

¹¹⁹ Bruce J. Winick, *Forward: Therapeutic Jurisprudence Perspectives on Dealing With Victims of Crime*, 33 NOVA L. REV. 535, 535 (2009).

¹²⁰ David B. Wexler, *Practicing Therapeutic Jurisprudence: Psychological Soft Spots and Strategies* (2000) in DANIEL P. STOLLE, DAVID B. WEXLER & BRUCE J. WINICK, PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION 45-68. (2000).

¹²¹ Bruce Winick, *A Therapeutic Jurisprudence Model for Civil Commitment*, in INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVE ON CIVIL COMMITMENT, 23, 26 (Kate Diesfeld & Ian Freckelton, eds. 2003).

¹²² Claire B. Steinberger, *Persistence and Change In The Life Of The Law: Can Therapeutic Jurisprudence Make A Difference?* 27 LAW & PSYCHOL. REV. 55, 65 (2003).

¹²³ Perlin, *Sanism Filter*, *supra* note 7. See, Roberto P. Aponte Toro, *Sanity in International Relations: An Experience in Therapeutic Jurisprudence*, 30 U. MIAMI INTER-AM. L. REV. 659 (1999) (on its potential application to international law issues in general).

applications”.¹²⁴ It is also part of a growing comprehensive movement in the law towards establishing more humane and psychologically optimal ways of handling legal issues collaboratively, creatively, and respectfully.¹²⁵

These alternative approaches optimize the psychological well-being of individuals, relationships, and communities dealing with a legal matter, and acknowledge concerns beyond strict legal rights, duties, and obligations. In its aim to use the law to empower individuals, enhance rights, and promote well-being, therapeutic jurisprudence has been described as “...a sea-change in ethical thinking about the role of law...a movement towards a more distinctly relational approach to the practice of law...which emphasises psychological wellness over adversarial triumphalism”.¹²⁶ That is, therapeutic jurisprudence supports an ethic of care.

One of the central principles of therapeutic jurisprudence is a commitment to dignity. Professor Amy Ronner describes the “three Vs”: voice, validation and voluntariness,¹²⁷ arguing:

What “the three Vs” commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant’s story, the litigant feels a

¹²⁴ Ian Freckelton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence*, 30 T. JEFFERSON L. REV. 575, 582 (2008).

¹²⁵ Susan Daicoff, *The Role of Therapeutic Jurisprudence Within The Comprehensive Law Movement*, in STOLLE, WEXLER & WINICK, *supra* note 120, at 365-92.

¹²⁶ Warren Brookbanks, *Therapeutic Jurisprudence: Conceiving an Ethical Framework*, 8 J.L. & MED. 328, 329-330 (2001).

¹²⁷ Amy D. Ronner, *The Learned-Helpless Lawyer: Clinical Legal Education and Therapeutic Jurisprudence as Antidotes to Bartleby Syndrome*, 24 TOURO L. REV. 601, 627 (2008),

sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronouncement that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings prosper when they feel that they are making, or at least participating in, their own decisions.¹²⁸

I believe that TJ has the best capacity to rid the law of sanism and pretextuality. Elsewhere, in a book-length treatment of the insanity defense, I have written:

[W]e must rigorously apply therapeutic jurisprudence principles to each aspect of the insanity defense. We need to take what we learn from therapeutic jurisprudence to strip away sanist behavior, pretextual reasoning and teleological decision making from the insanity defense process. This would enable us to confront the pretextual use of social science data in an open and meaningful way.¹²⁹

¹²⁸ Amy D. Ronner, *Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles*, 71 U. CIN. L. REV. 89, 94-95 (2002); *See generally*, AMY D. RONNER, LAW LITERATURE AND THERAPEUTIC JURISPRUDENCE (2010).

¹²⁹ MICHAEL L. PERLIN, THE JURISPRUDENCE OF THE INSANITY DEFENSE 443 (1994); *See also*, Perlin, *supra* note 4, at 876.

To teach mental disability law meaningfully, it is necessary to teach about the core characteristics that contaminate it (sanism and pretextuality), to teach about the cognitive approaches that distort it (false ordinary common sense and cognitive-simplifying heuristics), and to teach the school of jurisprudence that can optimally redeem it (TJ).

I believe the same principles apply to the subject matter of this paper as well. Janet Lord and her colleagues focus on the significance of “voice accountability” in the drafting of the CRPD.¹³⁰ The application of TJ enhances the likelihood that the “silenced” voices will be heard.¹³¹

Conclusion

The CRPD, at base, is a document that seeks to eradicate and eviscerate “stigmas and stereotypes,”¹³² and that emphasizes and upholds the “social inclusion [and] anti-stigma agenda.”¹³³ It reflects the view of Canadian human rights activists that “only positive state action can combat the deeply entrenched patterns of disability disadvantage arising from stigma, devaluation, stereotyping and exclusion.”¹³⁴ Its purpose is to “combat combat stereotypes, prejudices and harmful practices relating to persons with disabilities.”¹³⁵

¹³⁰ Lord, Suozzi & Taylor, *supra* note 25, at 567. On the role of “voice” in other similar UN Conventions, see Aisling Parkes, *Tokenism Versus Genuine Participation: Children’s Parliaments and the Right of the Child to be Heard Under International Law*, 16 WILLIAMETTE J. INT’L L. & DISP. RESOL. 1, xxx (2008) (discussing how children’s “voices are all too often frequently overlooked and undervalued”).

¹³¹ See generally, PERLIN,, *supra* note 8.

¹³² Janet E. Lord & Michael A. Stein, *The Domestic Incorporation of Human Rights Law and the United Nations Convention on the Rights of Persons with Disabilities*, 83 WASH. L. REV. 449, 475 (2008).

¹³³ Fennell, *supra* note 30, at 107.

¹³⁴ Ena Chadha & C. Tess Sheldon, *Promoting Equality: Economic and Social Rights for Persons with Disabilities under Section 15*, 16 NAT’L J. CONST’L L. 27, 42 (2004).

¹³⁵ CRPD, Article 8.

It is also a document that demands law reform at the local and national level all over the world,¹³⁶ whether in the United States or the tiny island nation of Vanuatu.¹³⁷ Although much of its framework was inspired by the principles and concepts in the ADA,¹³⁸ the CRPD goes far beyond the ADA in its positive mandates, its focus on stigma and prejudice, its uncompromising adoption of the social model, its reporting requirements, and its identification of the specific steps that States must take to ensure an environment for the enjoyment of human rights (awareness-raising, ensuring accessibility, ensuring protection and safety in situations of risk and humanitarian emergencies, promoting access to justice, ensuring personal mobility, enabling habilitation and rehabilitation, and collecting statistics and data).¹³⁹ It also – perhaps most importantly – makes visible what has long been “invisible to the world’s political, social and economic process.”¹⁴⁰

Mary Donnelly was precisely accurate when she argued that “the goal of [mental disability] law reform must include delivery on the right... to dignity.”¹⁴¹ I believe that the CRPD has the capacity to do this, but only if signatory nations grasp the extent to which sanism has pervaded

¹³⁶ On the law reform obligations of the CRPD, see Lord & Stein, *supra* note 131, at 471

¹³⁷ See Paul Harpur & Richard Bales, *The Positive Impact of the Convention on the Rights of Persons with Disabilities: A Case Study on the South Pacific and Lessons from the U.S. Experience*, 37 N. KY. L. REV. 363 (2010) (making this comparison).

¹³⁸ See Janet Lord, *The U.N. Disability Convention: Creating Opportunities for Participation*, BUSINESS L. TODAY (May/June 2010), at 23, 24.

¹³⁹ See PERLIN, *supra* note 8, Chapter 7A.

¹⁴⁰ Peter Blanck, “The Right to Live in the World”: Disability Yesterday, Today, and Tomorrow, 13 TEX. J. ON C.L. & C.R. 367, 401 (2008).

¹⁴¹ Mary Donnelly, *From Autonomy To Dignity: Treatment For Mental Disorders and The Focus For Patient Rights*, 26 LAW IN CONTEXT 37, 57 (2008).

all mental disability law policy and enforcement over the centuries. I believe that the application of TJ principles will, finally, allow us to see this and to, I hope, make this truly the “dawn of a new era.”¹⁴²

All Along the Watchtower (to end by returning to my title) is the most played of Dylan’s songs.¹⁴³ One popular analysis suggests it reflects what he sees as a “loss of humanity” and Dylan’s resentment at “society’s arrogance.”¹⁴⁴ We have, since time immemorial, through the device of sanism treated persons with mental disabilities – especially those institutionalized” with “arrogance” in way that reveals a “loss of humanity.” Perhaps, the CRPD will finally, and redemptively, offer us “a way out of here.”

This is all, very obviously, a very new area of law, policy and discourse. I am never surprised when I give a presentation about the CRPD and find that very few in the audience are familiar with it (although, the further I go from the US, the more likely it is that audience members *will* know of it and about it). But I think that now -- with over 100 nations having ratified the Convention, and more than three years having elapsed since the Convention went into effect – it is time for all to begin to take it seriously. I know that I am.

¹⁴² Perlin, *supra* note 22, at 498.

¹⁴³ Most recently, in Boston, on the last night of his summer 2011 tour. See <http://boblinks.com/082111s.html> (concert of August 21, 2011).

¹⁴⁴ <http://www.lyricinterpretations.com/Bob-Dylan/All-Along-the-Watchtower>.