"There Are No Trials Inside the Gates of Eden": Mental Health Courts, the Convention on the Rights of Persons with Disabilities, Dignity, and the Promise of Therapeutic Jurisprudence

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Introduction

The ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD)\(^1\) (Melish 2007: 44, Stein 2007: 1203) radically changes the scope of international human rights law as it applies to all persons with disabilities. It is most significantly changed in the area of mental disability law (Perlin 2009: 483). Always marginalized, individuals with mental disabilities have always been “outsiders” in the world of international human rights law, with many important global human rights agencies traditionally expressing little or no interest in the plight of this cohort.\(^{ii}\) Internationally, persons in forensic mental health systems generally receive, if this even seems possible, less humane services than do civil patients (Perlin 2007). Prisoners with mental disabilities are treated inhumanely in most nations, both in correctional facilities and in forensic mental health facilities. (Perlin 2009: 675).

Advocates have begun to consider whether the CRPD can potentially remediate this situation, but ratification is too recent to see much concrete change. One potential remedy lies in the expanded use of mental health courts (Stefan & Winick 2005: 507) as a means of 1) infusing therapeutic jurisprudence (TJ) into the legal process (Winick & Wexler 2003); 2) assuring that the standards of the CRPD are met; and 3) treating persons with mental disabilities with dignity in the court process. There are now multiple mental health courts in the United States, as well as others in Canada, the United Kingdom and Australia, but few in civil law nations (for a discussion of drug courts in a civil law nation (Portugal), see Kreit, 2010). Advocates should seize upon the ratification of the CRPD as a launching pad for an international...
movement to create such courts to emulate the successes of those in common law nations that have operated with dignity using a TJ model while adhering to civil rights and civil liberties principles.

This chapter seeks to explore the intersection between international human rights and the mental health court movement. I begin here, however, with a cautionary note. Notwithstanding the potential great value that mental health courts have for persons with mental disabilities involved in the criminal justice system, it is essential that these courts do not lose their original focus as therapeutic jurisprudence-based courts, and that judges and court administrators resist the temptation to use these courts as coercive vehicles through which to simply expedite case dispositions without any meaningful attention being paid to issues of civil rights, civil liberties, dignity and autonomy (LaFond 2003:164-5). This warning underscores the importance of the responsibility on mental health court judges and administrators to consider the impact of the CRPD – and international human rights law, in general -- on the operation of these courts, especially regarding issues of potentially coercive treatment.

It is time to restructure the dialogue about mental health courts and to (1) consider whether the development of such courts will finally allow us to move away from society’s predominant opinion that mental illness reflects a defect of morality or will (Pustilnick 2005: 263, Rachlinski 2011: 1694), (2) take seriously the potential ameliorative impact of such courts on the ultimate disposition of cases involving criminal defendants with mental disabilities, (3) assess the impact that such courts might have on the extent to which individuals are treated with dignity in the court process (Lerner-Wren 2010: 577).

I remain a strong supporter of mental health courts but believe firmly that supporters
must do a better job of responding to some of the critiques of the courts (especially those coming from what I will somewhat-awkwardly characterize as the “political left) (Seltzer 2005: 570).” As I will discuss below, the critiques that, I believe, have the most merit are these: that these courts may provide “false hope” to those who come before them, and that the success of the courts is overly-dependent on the personal charisma of the presiding judge.

I believe that our “culture of blame” (Feigenson 1997: 60, Haney 2008: 956) still infects the entire criminal justice process, and that it continues to demonize persons with mental illness for their status. Until this is remediated, there can be no assurances that mental health courts -- or any other such potentially-ameliorative alternative – will be ultimately “successful” (however we choose to define that term).

Much of the recent debate on mental health courts has focused either on empirical studies of recidivism or on theorization. All of this discussion, while important and helpful, bypasses the critical issue that must be at the heart of the ultimate inquiry here: do such courts provide additional dignity to the criminal justice process or do they detract from the measure of dignity provided? Until we re-focus our sights on this issue, much of the discourse on this topic remains wholly irrelevant.

My paper will proceed in this manner. In Part I, I will discuss the underpinnings of therapeutic jurisprudence. In Part II, I will briefly discuss some of the universal factors that contaminate mental disability law in all nations. In Part III, I will look at the new Convention and its general implications for the future of mental disability law, with a special focus on the importance of dignity considerations in a Convention context. In Part IV, I will first consider the role of blame in the criminal justice system, and then briefly outline the history of the
development of mental health courts and consider some of the more serious criticisms of those courts. I will conclude by offering some suggestions as to how therapeutic jurisprudence can best inform a MHC model that can be counted on to enforce international human rights and promote dignity.

The title of this paper draws on Bob Dylan’s *Gates of Eden*, a song I have previously characterized as a “brilliant and transcendental vision of an earthly paradise,” and as a “quest for salvation” (Perlin 2000: 1004-5). Inside these gates, there are “no kings, no sins, no trials” (Tamarin 2009: 135). There are no “trials” in the generally-understood sense of that word in mental health courts. The open question is this: will they provide “salvation” – in ways that are consonant with international human rights law – for those who appear there?

I. Therapeutic jurisprudence

One of the most important legal theoretical developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence (TJ) (Wexler 1990, Wexler & Winick 1996, Winick 2005, Wexler 2008: 17, Perlin 1998: 534-41, Wexler 1992: 32-33). 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 can have therapeutic or anti-therapeutic consequences (Perlin 2009a: 912, Diesfeld & Freckelton 2006: 91). The ultimate aim of therapeutic jurisprudence is to determine whether legal rules, procedures, and lawyers’ roles can or should be reshaped to enhance their

As I have written elsewhere, “An inquiry into therapeutic outcomes does not mean that therapeutic concerns `trump’ civil rights and civil liberties” (Perlin 2000: 412, Perlin 1998: 782).

Therapeutic jurisprudence “asks us to look at law as it actually impacts people’s lives” (Winick 2009: 535) and focuses on the law’s influence on emotional life and psychological well-being (Stoulle et al 2000: 45). 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” (Diesfeld & Freckelton 2003: 23, 26). 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” (Steinberger 2003: 65).

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 (Perlin 2002-03: 535). 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 applications” (Freckelton 2008: 582). 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 (Stolle et al 2000: 365). 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” (Brookbanks 2001: 329-30). That is, therapeutic jurisprudence supports an ethic of care (Winick & Wexler 2006: 605-607, Wexler 2007: 599, Baker 2006: 385).

Ronner describes the “three Vs” -- voice, validation and voluntariness -- which are all critical to the creation of a sense of dignity in the proceedings, and are core principles of therapeutic jurisprudence (Ronner 2008: 627). She argues:

What “the three Vs” commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant’s story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronunciation 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 (Ronner 2002: 94-95).
Ultimately, we must determine if mental health courts can indeed promote a vision consonant with the principles that Professor Ronner sketches out in this paragraph.

II. Universal factors (Perlin 2011: 81-102)

An examination of comparative mental disability law reveals that there are at least five dominant, universal, core factors that must be considered carefully in any evaluation of whether international human rights standards have been violated. Each of these five factors is a reflection of the shame that the worldwide state of mental disability law brings to all of us who work in this field. Each is tainted by the pervasive corruption of sanism that permeates all of mental disability law. Each reflects a blinding pretextuality that contaminates legal practice in this area (Perlin 2011: 81). And finally, each of these factors are constant no matter where we observe the practice of mental disability law and wherever we observe the treatment of persons institutionalized because of mental disability (Perlin 2011: 488).

First, what do I mean by “sanism”? Sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry (Perlin 1992: 374-375). It permeates all aspects of mental disability law and affects all participants in the mental disability law system: litigants, fact finders, counsel, expert and lay witnesses. Its corrosive effects have warped mental disability law jurisprudence in involuntary civil commitment law, institutional law, tort law, and all aspects of the criminal process (pretrial, trial and sentencing) (Perlin 2002: 684).

And what do I mean by “pretextuality”? Pretextuality defines the ways in which courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest
(and frequently meretricious) decisionmaking, specifically where witnesses, especially expert witnesses, show a high propensity to purposely distort their testimony in order to achieve desired ends. This pretextuality is poisonous. It infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blase judging, and, at times, perjurious and/or corrupt testifying (Perlin 2003: 25).

All aspects of mental disability law are pervaded by sanism and pretextuality, whether the specific presenting topic is involuntary civil commitment law, right to refuse treatment law, the sexual rights of persons with mental disabilities, or any aspect of the criminal trial process, and whether we are talking about domestic or international law (Id.). Together, I believe they help explain the contamination of scholarly discourse and of lawyering practices alike (Perlin 2003: 26). I have written to argue that, unless and until we come to grips with these concepts—and their stranglehold on mental disability law development—any efforts at truly understanding this area of the law are doomed to failure (Id.).

These are the universal factors one must consider in determining if international human rights standards have been violated:

A. Core factor #1: Lack of comprehensive legislation to govern the commitment and treatment of persons with mental disabilities, and failure to adhere to legislative mandates.

B. Core factor #2: Lack of independent counsel and lack of consistent judicial review mechanisms made available to persons facing commitment and those institutionalized.

C. Core factor # 3: Failure to provide humane care to institutionalized persons.

D. Core factor #4: Lack of coherent and integrated community programs as an alternative to institutional care, and
E. Core factor # 5: Failure to provide humane services to forensic patients.

I know that this is a bleak picture. Examples that I have written about are actually far bleaker. But, and I want to stress this, I am optimistic that change is going to come. And it is to this potential for change that I will turn my attention.

III. The UN Convention

Disability rights have taken center stage at the United Nations in the most significant historical development in the recognition of the human rights of persons with mental disabilities, due to the drafting and adoption of a binding international disability rights convention (Mergret 2008: 261, Mergret 2008a: 494, Perlin & Szeli 2012, Perlin & Szeli 2010: 241, Heyns & Viljoen 2001: 483). 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. . . . (G.A. Res. 56/168 (2001))." The Ad Hoc Committee drafted a document over the course of five years and eight sessions, and the new CRPD was adopted in December 2006 and opened for signature in March 2007 (G.A. Res. A/61/611 (2006); G.A. Res. A/61/106 (2006)). It entered into force - thus becoming legally binding on States parties - on May 3, 2008, thirty days after the 20th ratification. One of the hallmarks of the process that led to the publication of the UN Convention was the participation of persons with disabilities and the clarion cry, "Nothing about us, without us (Kayess & French 2008: 4)." 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 (Id.)."
This Convention is the most revolutionary international human rights document ever created that applies to persons with disabilities (Perlin & Szeli 2009: 3-21). The Disability Convention furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in most every aspect of life (Dhir 2005: 181). 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 (Perlin 2011a: 121). “The Convention responds to traditional models and situates disability within a social model framework (Lord, Suozzi & Taylor 2010: 564, Kaiser 2009: 139) 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” (Lord & Stein 2009: 256, McCallum 2010). It provides a framework for insuring that mental health laws “fully recognize the rights of those with mental illness” (McSherry 2008: 8).

The CRPD categorically affirms the social model of disability (Lord, Suozzi & Taylor 2010: 568, Perlin 2011b, Perlin 2011c). by describing it as a condition arising from "interaction with various barriers [that] may hinder their full and effective participation in society on an equal basis with others" instead of inherent limitations (CRPD, art. 1 and pmbl., para. e.,), reconceptualizes mental health rights as disability rights (Fennel 2008: 95), and extends existing human rights to take into account the specific rights experiences of persons with disabilities (Megret 2008). To this end, it calls for "respect for inherent dignity" (CRPD, Article 3(a).) and "non-discrimination" (CRPD Article 3(b)). Subsequent articles declare "freedom from torture or cruel, inhuman or degrading treatment or punishment" (CRPD Article 15), "freedom from exploitation, violence and abuse" (CRPD Article 16), and a right to protection of the "integrity of the person" (CRPD Article 17).
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 (Lee 2011: 393, Hoffman & Konczei 2010: 143, DeMarco 2012: 523). 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 require in exercising their legal capacity” (Perlin 2008: 252-253) 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 (CRPD Article 13).

It is important to note that “[t]he 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” (Perlin 2008: 253) If and only if, there is a mechanism for the appointment of dedicated counsel (Stein, Waterstone & Wilkins 2010: 1658), can this dream become a reality.

The ratification of the CRPD marks the most important development ever seen in institutional human rights law for persons with mental disabilities (see M.L. Perlin, 1998, for a
full discussion of institutional mental disability law). 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 their inherent dignity (CRPD Article 1). Whether this will actually happen is still far from a settled matter.

It is critical, in the context of this paper, to take a close look at the Convention’s mentions of “dignity,” and the commentary about those mentions. As noted above, as ratified, the Convention calls for “respect for inherent dignity” (CRPD Article 3(a)). The Preamble characterizes "discrimination against any person on the basis of disability [as] a violation of the inherent dignity and worth of the human person...." (CRPD Article 3(a)). These provisions are consistent with the entire Convention’s “rights-based approach focusing on individual dignity” (Dhir 2005: 195), 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” (Quinn & Degener 2002: 14, Vischer 2012) Prof. Michael Stein summarizes this nicely: A “dignitary perspective compels societies to acknowledge that persons with disabilities are valuable because of their inherent human worth”(Stein 2007: 106, Schultziner & Rabinovici 2011). In Prof. Cees Maris’s summary: “The Convention's object is to ensure disabled persons enjoy all human rights with dignity” (Maris 2010: 1156).

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 them to extremes of suffering, when they segregate them from society- we call these violations of fundamental human rights” (Chaffin 2005: 140).

In his exhaustive evaluation of dignity in the specific context of international human rights law, Professor Christopher McCrudden reviews cases from the International Court of Justice, the European Court of Human Rights, the European Court of Justice and the constitutional courts of many nations, and finds multiple categories of cases in which “dignity” is relied on as a basis for a court’s judgment:

- Cases involving prohibition of inhuman treatment, humiliation, or degradation by one person over another;
- Cases involving individual choice and the conditions for self-fulfillment, autonomy, and self-realization;
- Cases involving protection of group identity and culture, and
- Cases involving the creation of necessary conditions for individuals to have essential needs satisfied (McCrudden 2008: 686-94).

Having said this, McCrudden’s reading of the case law has led him to the conclusion that “the use of the concept of human dignity has not given rise to a detailed universal interpretation” (McCrudden 2008: 724). Notwithstanding this insight, however, he finds that the concept of dignity can provide “a language in which judges can appear to justify how they deal with issues such as the weight of rights, the domestication and contextualization of rights, and the generation of new or more extensive rights” (Id.)
The test of whether the CRPD will have authentic meaning or will be little more than a “paper victory” (Perlin 2008: 490) will be whether, as a result of the ratification of the Convention, persons with mental disabilities – especially institutionalized persons with mental disabilities – are, in fact, treated with the level of dignity that they are owed as a key component of international human rights law.

The enforcement of the Disability Convention remains a critical issue. Think about the Core Factors that I discussed earlier, and the impact that the Convention might have on them: I noted in #1 that there was often no mental health law at all in other nations. The new United Nations Convention on the Rights of Persons with Disabilities obligates all state parties to “adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention (CRPD Article 4.1(a)).

The extent to which this obligation is honored will reveal much about the Convention’s ultimate “real world” impact.

I noted in #2 that there was often no counsel provided to persons facing institutionalization. The new UN convention mandates that “States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.” (CRPD Article 12.3).” Elsewhere, the Convention commands that “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 (CRPD Article 13.1).”
extent to which this Article is honored in signatory nations will have a major impact on
the extent to which this entire Convention “matters” to persons with mental disabilities
(Perlin 2008: 490).

I noted in # 3 that conditions in psychiatric institutions around the word shocked the
conscience. Consider here Article 22 of the new UN Convention: “No person with
disabilities, regardless of place of residence or living arrangements, shall be subjected to
arbitrary or unlawful interference with his or her privacy (CRPD Article 22).” What
impact will this Article have on cases that might be brought in the future to ameliorate
conditions such as those described here?

I noted in #4 that, internationally, virtually all nations were deficient in providing
community services. Think about the potential application of Article 19:

States Parties to the present Convention recognize the equal right of all
persons with disabilities to live in the community, with choices equal to others,
and shall take effective and appropriate measures to facilitate full enjoyment by
persons with disabilities of this right and their full inclusion and participation in
the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their
place of residence and where and with whom they live on an equal basis with
others and are not obliged to live in a particular living arrangement (CRPD Article
1).

The phrase “rep ipsa loquitor” applies here, I think.
Finally, I noted in #5 that conditions in forensic facilities were even more abysmal than in civil facilities. Some of the examples I discovered in my research – in Hungary, until very recently, convicted prisoners from Budapest Prison were used to “keep an eye on” patients in that nation's only high security forensic psychiatric institution) “with high suicide risk”; 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; these inmates were regularly institutionalized for five years before a re-evaluation of their condition – were stupefying, and amount to wholesale violations per se of the UN Convention (Perlin 2008: 490).

So, what does all this mean? Commentators have 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 (Kayess 2008: 1)” Rosemary Kayess and Phillip French observed that, “Proponents emphasised that a convention on the human rights of persons with disability would give shape to the nature of, and add specific content to, human rights as they apply to persons with disability, and in turn, provide a substantive framework for the application of rights within domestic law and policy (Id.). Prof. Arlene Kanter said: “The extent to which the Convention can realise its goals will depend in large part on the extent to which the Convention is ratified, and whether the world's nations will comply with and further the goals of the Convention through enactment of or changes to their domestic laws (Kanter 2007:309)” And, earlier, I had noted:

all state parties “[t]o adopt all appropriate legislative, administrative and other
measures for the implementation of the rights recognised in the present Convention.”

The extent to which this obligation is honored will reveal much about the Convention’s
ultimate “real world” impact (Perlin 2008: 490).

The Convention leaves open many important questions in many areas of law and policy
(Kayess 2008: 1). Its focus- and the focus of the scholarly debate now taking place - has
certainly been more on questions of empowerment than on questions of trial procedure (Iid.).
Yet, it is clear that it opens up for reconsideration the full panoply of issues discussed in this
paper as they relate to persons with mental disabilities. If, by way of example, rules of evidence
and procedure create an environment that perpetuates the sort of sanism and pretextuality
that has had such a negative impact on the lives of persons with mental disabilities, and that
condones teleological judicial behavior through overreliance on cognitive-simplifying heuristics,
then, a strong argument could be made that these rules must be re-crafted in the context the
Convention. Certainly, this question must be “on the table” for lawyers and for advocates in the
coming years.

IV. Mental health courts

A. Introduction: the role of blame (Perlin 2007)

Society has always demonized persons with mental illness. Ever since Prince Ptah-hotep
attempted the first classification of mental illness almost five thousand years ago, conceptions
of such illness have been inextricably linked to the notion of sin (Perlin: 1994). This linkage
appears in the Old Testament, and in other religious volumes throughout the centuries
Similarly, mental illness has been inextricably linked to evil (Bromberg 1975: 63, Moore 1984: 64, Neaman 1975: 31, 144) and to the supernatural world (Harding 1989: 153-155). These conflations have profound implications for both the criminal justice and the mental disability law systems, and are, in large part, responsible for our needs to blame individuals with mental disabilities for their mental disabilities, as part of our “culture of punishment.”

Thousands of years ago, it was commonly believed that sickness was “a punishment sent by God (Biggs 1955: 26, Neaman 1975: 50).” The historian Judith Neaman thus has concluded that “demonic possession remains the simplest, the most dramatic, and secretly, the most attractive of all explanations of insanity in the Middle Ages (Neaman 1975: 31, Rosen 1969: 80).” Society saw madness as a condition “in which a person was `possessed, controlled, or affected by some supernatural power or being’” (Perlin 2008: 39) and this connection has remained “extremely resilient in western culture” (Midelfort 1980: 247, 254).

Thus, historically, mental illness has been positively associated with "sin, evil, God's punishment, crime, and demons” (Guiduli 1996: 1157) or signs of “divine punishment” (Zanotti, Becker 1997: 64). People with mental illness were considered beasts, or persons possessed by evil spirits (Spaulding 2000: 140, Curran 1998: 129); a person who lost his capacity to reason was seen as having lost his claim "to be treated as a human being" (Scull 1981: 108-109). In some cases, portions of such persons’ skulls were removed “to allow evil spirits to escape” (Gardner 2000: 677). European scholars typically associated psychopathology with demonic possession or with punishment for sin (Carson 2000), and researchers conclude that the view “that psychopathology is punishment for sin persists today” (Skeem 2001: 594)
These attitudes persist to modern times. A Virginia state senator has stated within the past decade – apparently on multiple occasions – that mental illness is caused by “spiritual demons” (Hanse 2003). Scholars and clinicians continue to grapple with the concept of “evil” in modern psychiatry (Perring 1999). The spectre of an opponent’s mental illness remains a potent political weapon. The Deputy Secretary of State in the Bush Administration characterized a critic as “off his medications and out of therapy” (NAMI 2003); a political advertisement in the early 2000’s shows a man in a straightjacket with the text, “Gormel’s [the name of the incumbent] Medication Not Working; Let’s Send Him Away Before They Take Him Away” (Sullivan 2003) The not-so-subtle undercurrent here is that mental illness is a dangerous, static state and that persons with mental illness – even those who are otherwise productive members of society – can be freely demonized with impunity.

It is thus no wonder that any reform of the criminal justice system as it deals with defendants with mental disabilities that promises to be less punitive and less unforgiving faces significant obstacles. If this population is viewed as having a “defect of morality or will” (Pustilnick 2005: 217), it is little wonder that our “culture of punishment” (Perlin 1997a) stands in the way of meaningful reform.

B. The structure of mental health courts

What, then, of mental health courts? I draw here in great part on the work of my friend and colleague, the late Prof. Bruce Winick ((Winick 2003: 107, Stefan 2005: n.6)). Mental health courts are designed to deal holistically (Talesh 2007: 112) with people arrested for nonviolent

Mental health courts are premised on team approaches (Lurigio & Snowden 2009: 210, Moore, Hiday 2006: 660); representatives from justice and treatment agencies assist the judge in screening offenders to determine whether they would present a risk of violence if released to the community, in devising appropriate treatment plans, and in supervising and monitoring the individual's performance in treatment (Winick 2009: 125-6, Redlich 2006: 347). The mental health court judge functions as part of a mental health team that decides whether the individual has treatment needs and can be safely released to the community (Castellano 2011: 484). The team formulates a treatment plan, and a court-employed case manager and court monitor track the individual's participation in the treatment program, and submit periodic reports to the judge concerning his or her progress. Participants are required to report to the court periodically so that the judge can monitor treatment compliance, and additional status review hearings are held on an as-needed basis (Stefan & Winick 2005: 520-1).

To serve effectively in this sort of court setting, the judge needs to develop enhanced interpersonal skills and awareness of a variety of psychological techniques that can help the judge to persuade the individual to accept treatment and motivate him or her to participate effectively in it (Petrucci 2002: 263, Miller 2008: 128). She must be able to build trust and
manage risk (Fisler 2005: 587). These skills include the ability to convey empathy and respect, to communicate effectively with the individual, to listen to what the individual has to say, thereby fulfilling the individual's need for voice and validation, to earn the individual's trust and confidence, and to engage in motivational interviewing and various other techniques designed to encourage the individual to accept treatment and comply with it (Johnston 2011: in press, Moheb 2010: 29). These courts provide “nuanced” approaches (McManus 2006: 598), and may signal a “fundamental shift” in the criminal justice system (Harvard Note 2008: 1174). According to Judge Randal Fritzler, a successful mental health court thus needs: 1) a therapeutic environment and dedicated team; 2) an environment free from stigmatizing labels; 3) opportunities for deferred sentences and diversion away from the criminal system; 4) the least restrictive alternatives; 5) decisionmaking that is interdependent; 6) coordinated treatment; and 7) a review process that is meaningful (Fritzler: 118, Sims 2009: 1079).²

By far, the most influential such court is in Broward County, Florida (Ft. Lauderdale), presided over by Judge Ginger Lerner-Wren (Perlin 2002: 432, Kondo 2000: 373, Lerner-Wren & Appel 2001: 453, Petrila 2002: 14, Lerner-Wren 2000; 5, Popvic 2005). Founded in 1997, the Mental Health Court in Broward County was the nation's first court dedicated to the decriminalization and treatment of the mentally ill in the criminal justice system (Lerner-Wren 2010: 589). Judge Lerner-Wren’s explicit goals for the court, and those modeled after it, included "absolute diversion, humane treatment, and a trauma informed recovery model which honors choice and is client-centered" (Lerner-Wren 2010: 589) In order to achieve those goals, she dedicated the court to the tenets of therapeutic justice, which "focus[es] on the emotional and psychological health" of the individual (Lerner-Wren 2010: 582, King 2008: 1115). The
Broward County Mental Health Court model has led to the creation of more than 175 mental health courts throughout the country (Lerner-Wren 2010: 587, Boothyrod 2003: 55, Auty). Research shows that mental health courts do reduce the number of new arrests among the population of individuals with mental disabilities.

The mental health court is but one of an ever-widening array of “problem-solving courts” (including drug courts, domestic violence courts, homelessness courts, and others) that acknowledge that the one-size-fits-all structure of the American criminal justice system often leaves much to be desired. One of the primary tenets of therapeutic jurisprudence (and frankly, to my way of thinking, one of its non-negotiable essentials) is the premise that therapeutic outcomes cannot trump due process. This remains a bottom line demand of mine before I would endorse any alternative to the traditional criminal process. But, as I will explain, this does not worry me in the case of mental health courts, if - and it is a big “if” - they follow the model created by Judge Ginger Lerner-Wren in Broward County, Florida.

There have been criticisms of mental health courts from all points on the political spectrum (Cress 2006: 340-2, Hafemeister, Garner & Bath 2012: 183-191). The inchoate criticism from the right is the usual dreary railing against “touchy-feely” judges acting as surrogate therapists or psychiatrist-wannabes (Bozza 2007: 124), allowing criminals to escape punishment (King 2008: 1116, Harvard Note 2008: 1174), an implicit or explicit endorsement of our “culture of blame” (Feigenson 1997: 60 & n.258). The important criticisms, though, have come from the left, and I can identify six of these that deserve response. Four, I believe, are
flawed; I remain agnostic about one, and concerned about one. The criticisms - and I draw here largely on a report by the Judge David Bazelon Center on Mental Health Law (Seltzer 2005: 570) - are these:

1. Is there any evidence that MHCs encourage defendants to plead guilty (Seltzer 2005: 570)?

2. Do MHCs make it more likely that defendants will be medicated against their will (Seltzer 2005: 570)?

3. Do MHCs contribute to the relegation of persons with mental disabilities to second-class citizenship (Seltzer 2005: 570)?

4. Do MHCs unduly segregate persons with mental disabilities in a court system that is sanist per se (Seltzer 2005: 570, Mack 2008: 306)?

5. Do MHCs provide false hope (Seltzer 2005: 570)?

6. Are MHCs too dependent on the charisma of the presiding judge (Seltzer 2005: 570)?

Let me address these sequentially.

1. There is no empirical evidence whatsoever that mental health courts encourage guilty pleas (whether or not we are discussing defendants who are “factually guilty”). First, none of the empirical work that has been done on mental health courts offers as much as a single example of that happening. Second, it appears that the percentage of MHC-eligible defendants who plead guilty is nearly the same as the percentage of all defendants who plead guilty to misdemeanors. Third, it is likely that MHC judges listen more closely to the plea allocation stage than do other judges, because they realize, accurately, that so much more is at stake.
Consider what I said earlier about Core Factor #6 (the way forensic patients are treated on all continents), and then re-consider MHCs in this context.

2. The question of involuntarily medicated individuals in the criminal trial process is a contentious one, and the process of deconstructing forensic categories is, at once, baffling and incoherent. The NY Court of Appeals case of *Matter of K.L* (N.Y. 2004), upholding the constitutionality of the assisted outpatient commitment Kendra’s Law, dismisses, incorrectly, in my view, the arguments made by potential Kendra’s Law patients against forced drugging in a community setting (Perlin 2003: 183). Yet, this is a very different issue from the question of whether misdemeanor defendants who plead guilty can be involuntarily medicated in court-ordered treatment as part of a diversionary sentence. This is a question that remains bereft of judicial attention, and, to do it justice, a court would have to seek to integrate the court holdings in *Washington v. Harper* (1990), *Riggins v. Nevada* (1992), and *Sell v, United States* (2003), as well as the body of law that developed around civil right to refuse treatment cases (Perlin 1998: chapter 3). That has not been done, and, in the absence of case law or empirical evidence to the contrary, I see no reason to assume this is a real issue (Kinscherff 2010: 745).

There are few nations that pay even lip service to this right. The CRPD may force them to begin doing just that.

3. I take the “second class citizenship” issue seriously, in large part because I believe it is impossible to discuss *any* aspect of mental disability law without thinking seriously about stigma and stereotyping (Miller & Perelman 2009: 118, King 2008: 1123, Carney 2009, Kaiser 2010: 23). Indeed, this has been the focus of all of my work on sanism and pretextuality (Perlin 1999: 18, Perlin 2000, Perlin 2002: 689-90). But, I think the issue is off point here; if
anything, MHCs, by increasing the likelihood of a person with mental disability being diverted out of the criminal justice system (where he is likely to be treated as a third- or fourth-class citizen, if those terms have any meaningful content or context) make it less likely that the person with mental disabilities will suffer at the hands of others because of that status (Carney 2007: 54, Slate 2003: 6). By way of example, Sana Loue concludes that sanist biases may be reduced by the establishment of mental health courts, staffed by a “sensitive” judiciary (Loue 2002: 211, Boothyrod 2003: 67). A study of Judge Wren’s MHC in Broward County concluded that participants in that court self-reported coercion levels lower than almost any score on a comparable measure of perceived coercion previously reported in the literature (Poythress 2002: 529, Tait 2003: 94-5, Dorf & Fagan 2003: 1501). The CRPD explicitly calls for the "respect for inherent dignity (UN CONVENTION, Article 3(a))" of all persons with disabilities. In practice, such dignity is more available in mental health courts than in any other tribunal (Daicoff 2008: 558). An Australian judge has even written that justice may not be served in the absence of such courts (Popovic 2006: 60, Beaupert 2007: 223, Carney et al 2009: 356, Kaye 2007: 748).

4. Certainly, all mental health systems and facilities are, to some extent, segregationist. But, in this context, I think this charge is a tautology. The Supreme Court’s important 1999 decision in Olmstead v. L.C. (1999). rightly endorses the anti-segregation principles of the Americans with Disabilities Act, and, on paper, at least, should serve as a blueprint for carefully-crafted litigation strategies that would lead to more and better community treatment. Olmstead, however, cannot be read as an argument to abolish mental health systems; it makes this explicit (The ADA,, "is not reasonably read to . . . phase out institutions, placing patients in close care at risk" (Olmstead, 604). nor is the law's mission "to
drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter[.]" (Olmstead, 604)). For better or worse, we will continue to have some sort of public mental health system; that is the reality, and I believe that the value of MHCs must be debated and weighed in that context. Parenthetically, although some believe the CRPD calls for the abolition of all mental health systems (Minkowitz), I do not believe that any court will ever agree to that interpretation.

5. The question of “false hope” is an important one, and, on the surface, is one of the two most persuasive to be made by opponents of MHCs. And it is one about which I remain agnostic. For MHCs to work, there must be in place in the community, a coherent, organized, co-ordinated and well-structured system of mental health services delivery (Moore, Hiday 2006: 670). Such systems are, to be charitable, few and far between. But this is not the fault of the MHC. It is the fault of cowardly politicians, reactionary judges, and a sanist public (Kimber 2010: 281). To say that an incomplete social reform causes a “loss of hope” is defeatist and ultimately counter-productive.

Again, think of Core Factor #4, discussed above (the global lack of coherent and integrated community programs). Now think of CRPD’s Article 19 that recognizes the equal right of “all persons with disabilities to live in the community, with choices equal to others.” MHCs will only be ultimately effective if this Article is given authentic life.

Finally, comes the one argument that I cannot shrug off: that MHCs are too dependent on the aura of the charismatic judge (Spinak 2008: 269-71). I have observed several mental health courts and I have spoken at length to other mental health court judges. By and large, I have been impressed by the dedication of the judges, by their thoughtfulness, their creativity,
their treatment of the persons who comprise their caseload with compassion and with dignity. On the other hand, colleagues whom I respect have told me stories about other mental health court judges in other jurisdictions that paint an entirely different picture: stories of prosecutors using the court as a coercive tool, stories of persons with mental illness being “railroaded” into inadequate diversionary programs, and stories of persons with mental illness not being taken seriously by the judge or by court personnel (Erickson 2006: 335). And I have no doubt that there is truth in these charges.

But the fact that some MHC judges do a mediocre job does not mean that MHCs are a terrible idea, any more than the fact that some MHC judges do a great job means that MHCs are necessarily a great idea. However, there’s one difference here and it is one that I wish to explore.

We do have a database of research on the way certain cases have been heard before one MHC, the one run by Judge Lerner-Wren, and that data base is spectacular (Pogorzelski 2005: 539). Basically, as I already hinted, it tells us that defendants before Judge Lerner-Wren report a higher score on a “dignity” scale (and a lower score on a “perceived coercion” scale) than any group of criminal defendants who have ever been studied (Poythress 2002: 529). In short, the actual, real life experiences of the persons before Judge Lerner-Wren demonstrate that one MHC can be a non-coercive, dignified experience that provides procedural justice and therapeutic jurisprudence to those before it. And the experiences of these defendants are exactly what I have observed on the days that I sat in on that court. They are also what I observed when I sat in on Justice Matthew D’Emic’s Brooklyn MHC, although there are some significant structural differences between the courts (most importantly, the fact that Justice
D’Emic’s court includes felony defendants up through and including homicide whereas Judge Lerner-Wren’s is limited to misdemeanors (Sammon 2008: 925).

But, having said this, I must now acknowledge that the sixth critique listed above is one that concerns me: that the MHC may be too dependent on the charismatic persona of the presiding judge (Allen 2008: 186). There is no question in my mind: Judge Lerner-Wren is a charismatic woman. She believes in what she does, she articulates the court’s mission, and she dispenses justice in way utterly consistent with that mission. And I think that that is great.

But there is always the gnawing question: what if the Assignment Judge assigns her to other cases? What if the voters decide, quoting President Reagan’s malaprop, that they don’t want any more sociology majors on the bench (Perlin 1991: 109, Rowland et al 1988: 194)? What if her successor isn’t like Judge Wren, doesn’t have her values, her commitment, her persona? I would be concerned about any of these scenarios (and none is beyond the realm of possibility), and my concern leads me to take this one criticism seriously.

I am not sure of how to solve this problem. My friend Shelley Mitchell, a domestic relations lawyer in coincidentally Fort Lauderdale (and a teaching colleague in the New York Law School Online Mental Disability Law program), has urged her bar association to adopt a resolution that no judge should be allowed to sit on family court cases without having studied psychology. To the surprise of no one, this argument has gone nowhere. Judge Wanda Cruz who sits on the bench in the Commonwealth of Puerto Rico and I proposed two years to the judicial training office of that Commonwealth that we offer mental disability law training (in a variety of subject matters, including International Human Rights and Mental Disability Law). To date, there has been no answer. Bruce Winick and his co-author, David Wexler, have written
Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts, a book that should be required reading for every judge who sits on a mental health law case. So, there are some options. But, the question that I raised a moment ago still troubles me: what to do with judges who are not like Judge Lerner-Wren or Judge D’Emic? That is a question that we cannot ignore.

To return to the primary focus, most of the potentially-legitimate criticisms are based on conjecture and speculation. The evidence demonstrates that, in reality, individuals are generally given “voice” (Ronner 2008: 94-95, Ferencz & McGuire 2000: 51), and treated with a measure of respect and dignity missing from virtually all other interpersonal court interactions. I am persuaded beyond any doubt - -by the Florida study that much of the “left critique” is without empirical basis.

But perhaps the same research does support the final prong of the “left critique”: that the success of the MHC is too dependent on the charisma of the presiding judge. There is no question that Judge Lerner-Wren is charismatic. But I also know that hers is not the only MHC in the nation in which litigants are treated with dignity and respect (my impressionistic views of Justice D’Emic’s courts certainly bear this out). On the other hand, her court is radically different than non-specialized MHCs I have observed across the nation, in which persons with mental disabilities are regularly treated as third-class citizens by (at the best) bored or (at the worst) malevolent trial judges. The solution is not, it seems to me, to eliminate MHCs, but to insist that we begin to take seriously the question of judicial attitudes, that we make judicial training compulsory, and that we replicate the Broward study elsewhere.

As I indicated earlier, I have two concerns that have not been the focus of much scholarly attention. It is these two concerns that temper my full enthusiasm for mental health
courts, but I believe, if we take TJ principles seriously, these can be remediated: the lack of concern paid to the question of competency in the mental health court process, and the lack of concern paid to the question of the quality of counsel made available to individuals in the mental health court process. I believe both of these must be addressed.

Dr. Steven Erickson and his colleagues point out the obvious. Given the impaired cognition that accompanies many mental disorders, “there is little evidence to suggest that mental health courts ensure that prospective candidates are competent to accept [the] plea bargains [into which many enter], as required by constitutional law” (Erickson 2006: 339). Allison Redlich similarly worries that “the very types of people MHCs were designed for may be the people who do not fully comprehend the purpose, requirements, and roles in the courts” (Redlich 2005: 616). Subsequent research done by Redlich and her colleagues in fact reveals that the majority of defendants at two mental courts lacked “nuanced information” about the trial process, and that a minority of defendants had “impairments in legal competence” (Redlich 2010: 91); the researchers concluded, however, that there were some indications that “the clients in the [mental health courts] in this study made knowing, intelligent and voluntary enrollment decisions.” Clearly, “a thorough evaluation of the offender’s mental competence ... is essential” in the mental health court process (Keele 2002: 202).

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

Dr. Steven Erickson and his colleagues have expressed concern – drawing in part on my
work -- “as to whether defendants in mental health courts receive adequate representation by their attorneys” (Erickson 2006: 340). Terry Carney – also partially relying on my research (Perlin 1992: 39) -- characterizes the assumption that adequate counsel will be present at hearings to guarantee liberty values as a “false hope” (Carney 2008: 112, Carney 2009).

Henry Dlugacz and Christopher Wimmer summarize the salient issues:

It is not reasonable to expect a client to repose trust in an attorney unless she is confident that he is acting in accordance with her wishes. The client with mental illness may already doubt the attorney's loyalty. This risk is exacerbated when the attorney is appointed by the court. The client may wonder whether the attorney has been assigned in order to zealously represent her, or instead to facilitate her processing through the legal system. ...There are strong personal disincentives to thorough preparation, even for the committed attorney. There are also institutional pressures: The attorney who depends on the goodwill of others in the system (e.g., judges, state attorneys, or prosecutors) may pull his punches, even unwittingly, in order to retain credibility for future interactions (which he would put to use for his future clients). Judges want cases resolved (Dlugacz & Wimmer 2011: 353-54, see also, King 2008: 1122).

Some solutions -- largely drawing upon TJ imperatives (Potter 2006: 96, Clarke & Neuhard 2005: 786-804) -- have been offered. Bruce Winick has argued that “lawyers should adequately counsel their clients about the advantages and disadvantages of accepting diversion to mental health court.... As a result, judges and defense counsel in mental health courts should ensure that defendants receive dignity and respect, are given a sense of voice and validation (Stefan & Winick 2005: 510-11, 520).” Turning to the law education clinical context, David
Wexler has suggested that “Students might “consider the kind of dialogue a lawyer might have with a client about the pros and cons of opting into a [drug treatment court] or mental health court” (Wexler 2005: 750, Perlin 2010: 475). It is essential that counsel has “a background in mental health issues and in communicating with individuals who may be in crisis” Seltzer 2005: 576, Epright 2010: 801)\textsuperscript{xviii}

In short, mental health courts – when structured properly and when chaired by a judge who “buys in” to the TJ model – are perfect exemplars of the practical utility of therapeutic jurisprudence.\textsuperscript{xix} The promotion and creation of such courts are consistent with TJ’s aims and aspirations (Kondo 2000: 446-7), especially where litigants are given the “voice” that TJ demands (Ferencz & McGuire 2000: 51). They are grounded (Nolan 2003: 1541) and rooted (Waiscek 2012) in TJ; they reflect TJ “theory in practice” (Codben & Albers 2010: 56).

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

IV. TJ, MHCs and international human rights

How does this relate to international human rights law concerns? Professor Neil Rees has made explicit his concerns:

From a human rights perspective, the immediate focus of mental health review tribunals should be to safeguard the foundational human rights of freedom of movement and freedom of bodily integrity. These freedoms are best protected by timely, external review of decisions to interfere with them (Rees 2003: 40, Carney & Beaupert 2008: 199).
Similarly, Professor Terry Carney and his colleagues – again, relying in part on my research (Perlin 2010: 341-42) -- urge a broad reading of international human rights law documents to insure effective representation for persons in mental health tribunal proceedings (Carney 2008: 125).

In a series of articles that I have written with Prof. Astrid Birgden, we assert that it is essential to consider the role of therapeutic jurisprudence in the enforcement of international human rights in matters involving correctional law. In one of these articles, we make this argument:

Therapeutic jurisprudence offers a potentially redemptive solution to this state of affairs. We believe that therapeutic jurisprudence principles can, and should, be taken seriously to address the human rights problems that we discuss in this paper. Therapeutic jurisprudence can suggest therapeutic laws, procedures, and roles that maximise the core values of freedom and well-being (and the related objects) for prisoners and detainees with a mental illness. Therapeutic jurisprudence offers an intersection between forensic psychology and human rights with its normative, humanistic, and inter-disciplinary approach. Conversely, the normative base of therapeutic jurisprudence can be strengthened by the application of human rights principles regarding moral, social, and legal rights and when values conflict, therapeutic jurisprudence ought to always support well-being and only accept curtailed freedom as the least restrictive alternative (Birgden & Perlin 2008: 240-41, Birgden & Perlin 2009: 256).
These same TJ principles apply to the operationalization of mental health courts.

Return now to the CRPD. The Convention on the Rights of Persons with Disabilities is a document that resonates with TJ values. It reflects the three principles articulated by Prof. Ronner -- voice, validation and voluntariness -- and “look[s] at law as it actually impacts people’s lives” (Winick 2006: 535). Each section of the CRPD empowers persons with mental disabilities, and one of the major aims of TJ is explicitly the empowerment of those whose lives are regulated by the legal system (Baker 2008: 215, Barton 1999: 921, Freeman 2010: 237, Perlmutter 2005: 561). I believe that the time is right for scholars to engage in a close and careful reading of the TJ literature, and then apply their findings to questions related to the implementation of this Convention.

Consider the mandates of the CRPD discussed earlier. Consider most closely the emphasis on dignity. I believe that this move to mental health courts is fully supported by a reading of both the CRPD and the CRPD-inspired scholarship on this issue that stresses the role of dignity in the legal process (Perlin 1996: 61).

Of course, the CRPD does not exist in a vacuum. Although therapeutic jurisprudence has grown exponentially in the past 20 years, there has been remarkably little written about it in the international human rights context (King 2008: 1112), and even less in the international human rights context as it relates to mental disability law, and virtually nothing about how it relates to the CRPD. A preliminary exploration of this relationship reveals significant and robust connections between TJ principles and international human rights principles as they relate to mental disability law-specific questions. My hope is that TJ scholars (and international human rights law scholars) will consider these connections seriously in the future. I believe that the
expanded use of mental health courts (ones that follow the model that Judge Wren has
trailblazed in Florida) will be the best way to insure that this happens.

In *Gates of Eden*, Bob Dylan shared a vision of the other-worldly. “[T]here are no trials inside the Gates of Eden.” Like so many of Dylan's key lines, this is ultimately ambiguous: Do his words refer to legal trials, the trials of living, or something else? Whichever interpretation (or interpretations) we prefer, Dylan's vision is an egalitarian one (“There are no kings inside the Gates of Eden”), based on pure freedom (“Leaving men wholly, totally free/To do anything they wish to do but die”) (Perlin 2000: 1054).

There are no “trials” -- in the common use of that word – in mental health courts. Of course, I am not so naïve as to believe that *anything* about the criminal justice process can be in any way “Eden-ic.” But I do believe that the aspirations for freedom and for an egalitarian life²⁰ are far more likely to be realized in a mature mental health system -- one like Judge Lerner-Wren’s reflecting “coercion levels “‘lower than almost any score on a comparable measure of perceived coercion previously reported in the literature” (Poythress 2002: 517) -- than within the traditional court process.²¹

I recently quoted another Dylan line in a TJ piece (about the forensic psychiatrists Robert L. Sadoff) titled, in part, “Justice’s Beautiful Face.”²² In the conclusion of that piece, I wrote, “So is ‘justice’ the foundational principle of therapeutic jurisprudence.” If justice *is* to have a beautiful face, and if it *is* the “foundational principle” of TJ, in the context of mental health courts, international human rights principles must be given life – especially the principle of dignity that is embedded in the CRPD. In the mental health court context, that is as close to the *Gates of Eden* as we can get.
On the 20th ratification, see http://www.un.org/News/Press/docs/2008/hr4941.doc.htm. As of the time of the completion of this paper, there were 109 ratifications and 153 signatories of the Convention and 53 ratifications and 90 signatories of the Optional Protocol. See http://www.un.org/disabilities/ (last accessed, January 12, 2012)

Symposium Transcript, Comments of Eric Rosenthal (2002):

I began my research ... by examining the human rights studies of non-governmental organizations such as Human Rights Watch and Amnesty International. I also looked at the U.S. Department of State’s Country Reports on Human Rights Practices. What I found is shocking: those human rights organizations and human rights reports criticized governments when political dissidents were put in psychiatric facilities, but they did not speak out about the abuses against other people who may or may not have mental disabilities.

“Though technically considered a component of the criminal justice system, a mental health court in reality diverts mentally disordered minor offenders to outpatient commitment rather than punishing them in jail .... They should be considered as another strategy for expanding the net of coercive mental health control and treatment through the functional equivalent of outpatient commitment.” (LaFond 2003: 164-5.

Furthermore, the guiding principles and values articulated in the United Nations Convention on the Rights of Persons with Disabilities should be implemented and fully integrated into every mental health court process in order to ensure the promotion of dignity, civil rights and human rights

I cannot resist one burst of self-referentiality. I saw Dylan perform the world premiere of Gates in New York City in October 1964.

Wexler first used the term in a paper he presented to the National Institute of Mental Health in 1987.

The most thoughtful sympathetic critique of TJ remains Slobogin, 1995.

The earliest use I can find of the phrase in an academic context is in Todd Clear, The Punishment Addiction: Twenty Years of Compulsive Punishment Lifestyle, IN NATIONAL CONFERENCE ON SENTENCING ADVOCACY 55, 56 (1989) (“Our culture suffers from a punishment addiction.”).
On the concept of “blame” in the criminal justice system, see Richard Boldt’s *The Construction of Responsibility in the Criminal law*.


— On the question of whether this diversion is swifter than traditional court processing, see Redlich et al 2012 (although diversion may not be swifter, that may be less important than the fact of diversion itself).

— By this, Judge Wren refers to the ways that conducting judicial proceedings should comport with therapeutic jurisprudence principles/ (Lerner-Wren 2010).

— I must add that I say this with some measure of trepidation when it comes to some of the other problem-solving courts (one of which a former student described to me relatively recently as existing in a due process-free zone). See Holland’s *Lawyering and Learning in Problem-Solving Courts*, discussing the position of the National Association of Criminal Defense Lawyers as being “relatively sanguine about mental health courts, [but] thoroughly repudiating drug courts, calling for their abolition”).

— I also have two criticisms of my own that I will address subsequently.

— “Litigants need ‘voice,’ for those in positions of authority to treat them with respect and dignity, and to have a chance to participate in decision-making, if possible, to maximize their ‘buy-in’ to the decision and compliance therewith”.

— Kaye (2007) wrote, “mental health courts ... divert defendants from jail to treatment, reconnect them, where possible, with family and friends who care whether they live or die, and restore their greatest loss--their sense of human dignity.” Kaye, at the time of writing this article, was Chief Judge of the State of New York.

— On the other hand, they noted:

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

— See Perlin 1996, at 241: “If there has been any constant in modern mental disability law in its thirty-five-year history, it is the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment cases is likely to be ineffective”; “Nearly twenty
years ago, when surveying the availability of counsel to mentally disabled litigants, President Carter’s Commission on Mental Health noted the frequently substandard level of representation made available to mentally disabled criminal defendants. Nothing that has happened in the past two decades has been a palliative for this problem”.

Epright (2010) writes: “Ideally, in mental health courts all courtroom personnel (i.e., judge, prosecutor, defense counsel and other relevant professionals) have experience and training in mental health issues and available community resources.”

On the other hand, E. Lea Johnston (2011) argues thoughtfully that therapeutic jurisprudence is not an adequate basis upon which to support mental health courts. I disagree with Prof. Johnston because I believe she fails to acknowledge the due process underpinnings of TJ theory: “Therapeutic jurisprudence offers no opinion—in general or in specific instances—as to whether therapeutic considerations should be valued more heavily than autonomy, fairness, accuracy, consistency, perceived legitimacy of the criminal justice system, public safety, or a host of other values”). I believe this is simply not so: “An inquiry into therapeutic outcomes does not mean that therapeutic concerns ‘trump’ civil rights and civil liberties.”

See e.g.:
At times I think there are no words
But these to tell what’s true
And there are no truths outside the Gates of Eden

Nora (2007) writes, “The bottom line is that mental health courts are heroic efforts to bring some justice to a severely underserved population. It is society’s failure, not the criminal justice system’s failure, if these courts continue to be the brightest candles in the darkness we have imposed upon the mentally ill. “

The line is from Dylan’s song I and I. See http://www.bobdylan.com/songs/i-and-i.
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