

“I Might Need a Good Lawyer, Could Be Your Funeral, My Trial”: Global Clinical Legal Education and the Right to Counsel in Civil Commitment Cases

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INTRODUCTION

If there has been any constant in modern mental disability law in its thirty-five-year history,¹ it is the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment cases is likely to be ineffective. We knew this at the dawn of the modern era.² We knew it when some courts started taking more seriously some of the other substantive and procedural rights of persons who were the subjects of such hearings.³ We knew it when so

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1. See generally Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972) (holding that a statute that fails to provide a person alleged to be mentally ill with adequate procedural safeguards is unconstitutional); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (holding that the mentally ill have a constitutional right to adequate treatment in a mental hospital); Michael L. Perlin, “Chimes of Freedom:” *International Human Rights and Institutional Mental Disability Law*, 21 N.Y.L. SCH. J. INT’L & COMP. L. 423, 423 (2002) (citing Jackson v. Indiana, 406 U.S. 715 (1972) (holding that a statute that effectively condemned defendant to permanent institutionalization deprived him of equal protection and due process under the Fourteenth Amendment)).

2. See, e.g., Elliott Andalman & David L. Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43, 72 (1974) (speculating that counsel was so inadequate in the sample study that patients’ chances for hospital release were enhanced if no lawyer was present); George E. Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH U. L.Q. 485, 540 (1968) (noting that only two of 1700 contested cases resulted in patient release).

3. See Leslie Scallet, *The Realities of Mental Health Advocacy: State ex rel. Memmel v. Mundy*, in MENTAL HEALTH ADVOCACY: AN EMERGING FORCE IN CONSUMERS’ RIGHTS 79, 81 (Louis E. Kopolow & Helene Bloom eds., 1977) (stating that the former system of

few states chose to follow the examples of New York,⁴ New Jersey,⁵ and a handful of other jurisdictions that legislatively created regularized, dedicated, specialized legal services offices whose primary job was to provide representation at such hearings.⁶ We knew it when academics and practitioners began to unpack the ethical issues that permeated civil commitment hearings.⁷ We knew it when it became clear that only in those jurisdictions that had dedicated counsel programs was there any coherent body of reported civil commitment case law.⁸ And we knew it when we began to discover—as our attention turned, far too tardily, to *international* and *comparative* mental disability law⁹—that, in many nations, there was no mental disability “law,”¹⁰ and that even where there was such law, the promise of counsel was little more than an illusion.¹¹

representation in Milwaukee County operated as a “greedy runaway to the county mental health center”).

4. See, e.g., N.Y. MENTAL HYG. LAW §§ 47.01–.03 (McKinney 1996).

5. See, e.g., N.J. STAT. ANN. § 52:27EE-20 (West 2006).

6. See 1 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL §§ 2B-1 to 7.2 (2d ed. 1998).

7. See, e.g., James R. Elkins, *Legal Representation of the Mentally Ill*, 82 W. VA. L. REV. 157 (1979); Stanley S. Herr, *The Future of Advocacy for Persons with Mental Disabilities*, 39 RUTGERS L. REV. 443 (1987); Peter Margulies, “Who Are You to Tell Me That?”: *Attorney-Client Deliberation Regarding Nonlegal Issues and the Interests of Nonclients*, 68 N.C. L. REV. 213 (1990); Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161 (1982); Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39 (1992); Steven J. Schwartz et al., *Protecting the Rights and Enhancing the Dignity of People with Mental Disabilities: Standards for Effective Legal Advocacy*, 14 RUTGERS L.J. 541 (1983).

8. See, e.g., Michael L. Perlin, “You Have Discussed Lepers and Crooks”: *Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 708–09 (2003):

A contrast between the development of case law in Virginia and Minnesota is especially instructive. Notwithstanding the fact that Virginia’s population is approximately 15% greater than Minnesota’s, Virginia had only two published litigated civil cases on questions of mental hospitalization during the decade from 1976 to 1986, while Minnesota had at least 101 such cases in the same period. Significantly, Minnesota has a tradition of providing vigorous counsel to persons with mental disabilities, while Virginia does not.

Id. (footnotes omitted).

9. See MICHAEL L. PERLIN ET AL., INTERNATIONAL HUMAN RIGHTS AND COMPARATIVE MENTAL DISABILITY LAW: CASES AND MATERIALS (2006).

10. That is, there was not even a statute that purported to govern such cases. See, e.g., Michael L. Perlin, *International Human Rights Law and Comparative Mental Disability Law: The Universal Factors*, 34 SYRACUSE J. INT’L L. & COM. 333, 337 (2007) (“A recent report by

And so it remains today. The quality of counsel assigned to represent individuals who face involuntary civil commitment to psychiatric hospitals is, in most United States jurisdictions, mediocre or worse.¹² Legal challenges to the status quo have been rare.¹³ Perhaps startlingly, this reality goes almost unmentioned in the legal literature.¹⁴ Also, those of us who identify with the clinical legal education movement cannot pat ourselves on the back too vigorously; in a recent survey, I identified only *ten* domestic law schools that offered courses that, broadly, could be called “mental disability law clinics.”¹⁵ In other countries, there are far fewer.¹⁶

As of the writing of this Article, in only one U.S. jurisdiction—Montana—has a court grasped the scope of the problem.¹⁷ As I will discuss subsequently, this decision has had almost no discernable impact on the state of the law elsewhere,¹⁸ but at least gives us a baseline against which we can assess the enormity of the problem in other jurisdictions.

the World Health Organization (WHO) revealed that 25% of all nations in the world have no mental health law.”).

11. *See id.* at 341 (“It is rare for even minimal access to counsel to be statutorily (or judicially) mandated, and, even where counsel *is* legislatively ordered, it is rarely provided. Moreover, the lack of meaningful judicial review makes the commitment hearing system little more than a meretricious pretext.”).

12. *See* Perlin, *supra* note 7, at 43. *See also* 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, 738 (2005) (“The data suggests that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile.”).

13. *See* 1 MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 2B-11-3, at 88–91 (2d ed. Supp. 2007) (discussing *In re* Mental Health of K.G.F., 29 P.3d 485 (Mont. 2001) (using an expansive interpretation of adequacy of counsel in civil commitment cases and noting how that decision is “the exception to the usual practice”)).

14. A Westlaw search of “(adequacy effectiveness) +3 counsel /s ‘civil commitment,’” reveals no articles other than those written by this author.

15. Perlin, *supra* note 8, at 712 n.170. These schools are Chicago, Lewis & Clark, New England, New York Law School, Richmond, Texas, Touro, Virginia, William Mitchell, and Yale. *Id.*

16. *See infra* Part IV.

17. *See infra* text accompanying notes 35–59 (discussing *K.G.F.*, 29 P.3d at 485).

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

Yet I am unwilling to be entirely pessimistic. Encouragingly, a variety of interrelated factors may shed some light on this scandal and lead to positive social change in this area: the new, robust case law from the European Court on Human Rights on virtually all aspects of mental disability law;¹⁹ the ratification of the United Nations Convention on the Rights of Persons with Disabilities²⁰ and the publication of the World Health Organization Resource Book on Mental Health,²¹ both of which will eventually attract international attention to this issue;²² the first burst of professional interest in this issue, as evidenced by programs, workshops, and panels focusing precisely on the extent of this dilemma at the 2007 Congress of the International Academy of Law and Mental Health,²³ and the 2006 conference of the Australia and New Zealand Association of Psychiatry, Psychology, and Law;²⁴ the focus by mental disability law-specific NGOs (e.g., Mental Disability Rights International; Mental Disability Advocacy Center) on institutional conditions in Central and Eastern Europe and in Central and South America, calling attention to this issue;²⁵ greater interest globally in what can broadly be called “access to justice” issues;²⁶ and the emergence of

19. See, e.g., PERLIN ET AL., *supra* note 9, at 451–789.

20. The United Nations Convention on the Rights of Persons with Disabilities was adopted in December 2006 and opened for signature in March 2007. It entered into force—thus becoming legally binding on State parties—on May 3, 2008, thirty days after the 20th ratification. G.A. Res. 61/611, U.N. Doc. A/RES/61/611 (Dec. 6, 2006). On the 20th ratification, see <http://www.un.org/News/Press/docs/2008/hr4941.doc.htm> (last visited Oct. 1, 2008). The final version of the Convention is found at: <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf> (last visited Sept. 29, 2008).

21. See MICHAEL L. PERLIN ET AL., INTERNATIONAL HUMAN RIGHTS AND COMPARATIVE MENTAL DISABILITY LAW: DOCUMENTS SUPPLEMENT 63–105 (2006) (reprinting excerpts from WHO Book).

22. See, e.g., Lance Gable, *The Proliferation of Human Rights in Global Health Governance*, 35 J.L. MED. & ETHICS 534 (2007); Arlene S. Kanter, *The Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities*, 34 SYRACUSE J. INT'L L. & COM. 287 (2007).

23. See 30th International Congress on Law and Mental Health Final Program, http://ialmh.org/Padua2007/Final_Program.doc (last visited Sept. 15, 2008).

24. See Australian and New Zealand Association of Psychiatry, Psychology and Law, <http://www.anzappl.org> (last visited Sept. 15, 2008).

25. I discuss this extensively in Perlin, *supra* note 10.

26. See, e.g., Margaret Woo et al., *Migrant Access to Civil Justice in Beijing*, 4 LOYOLA U. CHI. INT'L L. REV. 101 (2007); Gary K.Y. Chan, *The Right of Access to Justice: Judicial Discourse in Singapore and Malaysia*, 2 ASIAN J. COMPAR. L. (2007), available at <http://www.bepress.com/asjcl/vol2/iss1/art2/>.

the Global Alliance for Justice Education as a factor in the promotion of socially relevant legal education.²⁷

So the question is joined: Do we have any reason to feel even a shred of optimism about likely future developments in this area? Are we doomed simply to repeat the dreary experiences of the past thirty-five years, or are there any glimmers of hope that might lead us to expect that, globally, there will be some point in the future when lawyers who represent persons facing civil commitment will no longer be, in Judge David Bazelon’s memorable phrase, “walking violations of the Sixth Amendment”?²⁸ And, finally, what role can clinical programs play in ameliorating this miserable situation?²⁹

In Part I of this Article, I will review developments in the United States, with special focus on the Montana case of *In re Mental Health of K.G.F.*,³⁰ 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. In Part II, I will survey an array of other jurisdictions (common law, civil law, and mixed) and consider the range of findings (from nations in which there is no counsel, to perfunctory-at-best counsel, to almost-adequate counsel). In Part III, I will consider other major legal, political, and social developments that might, it is hoped, illuminate these issues. In Part IV, I will examine these issues from the perspective of clinical legal education. In Part V, I will consider the impact of sanism³¹ and pretextuality³² on these developments. Finally, I will offer some modest conclusions.

27. See, e.g., Frank S. Bloch, Access to Justice and the Global Clinical Movement, NYLS Clinical Research Institute Paper No. 07/08-8 (Oct. 10, 2007) (unpublished manuscript on file with Social Science Research Network), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1022685; Margaret Martin Barry et al., *Justice Education and the Evaluation Process: Crossing Borders*, 28 WASH. U. J.L. & POL’Y 195 (2008).

28. David L. Bazelon, *The Defective Assistance of Counsel*, 42 U. CIN. L. REV. 1, 2 (1973).

29. See Bloch, *supra* note 27, at 25 (“The global clinical movement may be the best hope for moving the access to justice movement along.”).

30. 29 P.3d 485 (Mont. 2001).

31. 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. See *infra* Part V.

32. Pretextuality defines the ways in which courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (and frequently meretricious) decision-making. See *infra* Part V.

My title is drawn from Bob Dylan's 2001 song, *Cry a While*.³³ It is found in these couplets:

Well, you bet on a horse and it ran on the wrong way
I always said you'd be sorry and today could be the day
I might need a good lawyer, could be your funeral, my trial
Well, I cried for you, now it's your turn, you can cry a while.³⁴

For many persons with mental disabilities, the lack of a good lawyer turns their trial into a (legal) funeral. It is time that this pernicious practice be ended.

I. THE SIGNIFICANCE OF *K.G.F.*³⁵

As I have already noted, *K.G.F.* is the most important case ever litigated in this area. *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.³⁶ Counsel was appointed, and a commitment hearing was scheduled for the next day.³⁷ 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.³⁸ The court ordered commitment.³⁹ *K.G.F.*'s appeal was premised, in part, on allegations of ineffective assistance of counsel.⁴⁰

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

33. BOB DYLAN, *Cry a While*, on LOVE AND THEFT (Sony BMG 2001).

34. *Id.* The line in question apparently derives from an older blues song by Sonny Boy Williamson. See ANDREW MUIR, TROUBADOUR: EARLY & LATE SONGS OF BOB DYLAN 284 (2003).

35. This section is largely adapted from Perlin, *supra* note 8, at 691–94.

36. *In re* Mental Health of *K.G.F.*, 29 P.3d 485, 488 (Mont. 2001).

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

of counsel. In turn, this right affords the individual with the right to raise the allegation of ineffective assistance of counsel in challenging a commitment order.”⁴¹ In assessing what constitutes “effectiveness,” the court—startlingly, to my mind—eschewed the *Strickland v. Washington* standard⁴² (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.”⁴³ Interestingly, one of the key reasons why *Strickland* was seen as lacking was the court’s conclusion that “reasonable professional assistance”⁴⁴—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.”⁴⁵

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 counsel and client as to how best to proceed.”⁴⁶ Such pre-hearing matters, the court continued, “clearly involve effective preparation prior to a hearing or trial.”⁴⁷ The court further emphasized the role of state laws guaranteeing the patient’s “dignity and personal integrity”⁴⁸ and “privacy and dignity”⁴⁹ in its decision: “[q]uality counsel provides the most likely

41. *Id.* at 491.

42. *Strickland v. Washington*, 466 U.S. 668 (1984) (establishing weak effectiveness of counsel standard). *See generally* PERLIN, *supra* note 6, § 2B-11.2, at 261–67.

43. *K.G.F.*, 29 P.3d at 491.

44. *See Strickland*, 466 U.S. at 689.

45. *K.G.F.*, 29 P.3d at 492 (citing Perlin, *supra* note 7, at 53–54 (“identifying the *Strickland* standard as ‘sterile and perfunctory’ where ‘reasonably effective assistance’ is objectively measured by the ‘prevailing professional norms’”)).

46. *K.G.F.*, 29 P.3d at 492.

47. *Id.*

48. *Id.* at 493 (quoting MONT. CODE ANN. § 53-21-101(1)).

49. *K.G.F.*, 29 P.3d at 493 (quoting MONT. CODE ANN. § 53-21-142(1)). *See also* MONT. CONST. art. II, § 4 (“The dignity of the human being is inviolable.”). *See generally* Michael L.

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.”⁵⁰

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.”⁵¹ The lawyer must “represent the perspective of the [patient] and . . . serve as a vigorous advocate for the [patient’s] wishes,”⁵² 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,”⁵³ and operating on the “presumption that a client wishes to not be involuntarily committed.”⁵⁴ 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.”⁵⁵ In conclusion, the court stated:

[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].⁵⁶

On one hand, *K.G.F.* provides an “easily transferable blueprint for courts that want to grapple with adequacy of counsel issues”;⁵⁷ on the other, no other state court has adopted its reasoning in the six-plus years since it was decided. As indicated earlier, its rationale was

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).

50. *K.G.F.*, 29 P.3d at 494 (citing Perlin, *Fatal Assumption*, *supra* note 7, at 47).

51. *Id.* at 500.

52. *Id.* (internal quotations omitted).

53. *Id.* (internal quotations omitted).

54. *Id.*

55. *Id.*

56. *Id.* at 501.

57. PERLIN & CUCOLO, *supra* note 13, § 2B-11.3, at 90.

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.⁵⁸

Writing about this issue in a domestic context several years ago, I 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 disabilities, many of whom have written carefully, thoughtfully, and sensitively about these issues.⁵⁹

The question is joined: If we use *K.G.F.* as a benchmark, to what percentage of persons subject to involuntary civil commitment is adequate counsel provided? And if this percentage is woefully low, what, if anything can be done about it?

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

59. Perlin, “*And My Best Friend, My Doctor/Won’t Even Say What It Is I’ve Got*”, *supra* note 12, at 741–42.

II. A GLOBAL CONSIDERATION

Globally, there is little good news.⁶⁰ In many nations, there is no mental health law *at all*.⁶¹ In others, there is simply no provision for counsel.⁶² In others, counsel appears to be present in name only, what is referred to disparagingly in the literature as the “warm body” problem.⁶³ In only a few instances does counsel appear to be doing a remotely adequate job.⁶⁴ Persons with mental disabilities are a paradigmatic example of the individuals—in Frank Bloch’s words:—“deprived of basic rights and needs [who] are unable to benefit from relief that might be available through their local legal system and legal regime.”⁶⁵

Again, globally, the picture is dismal. On the African continent, South Africa is apparently the only nation that provides counsel prior to civil commitment.⁶⁶ A recent comprehensive analysis of the law in

60. For a particularly pessimistic view of the state of affairs in the former Soviet bloc nations, see Oliver Lewis, *Mental Disability Law in Central and Eastern Europe: Paper, Practice, Promise*, 8 J. MENTAL HEALTH L. 293 (2002).

61. See generally Perlin, *supra* note 10, at 337–40 (listing multiple examples).

62. *Id.* at 340–42 (listing examples).

63. See, e.g., Pamela Metzger, *Doing Katrina Time*, 81 TUL. L. REV. 1175, 1198 (2007) (“This right to counsel is not satisfied by the mere appearance of a warm body wearing a business suit and holding a copy of the [statute book].”).

64. There has been significant litigation in Western Europe on matters involving, e.g., involuntary civil commitment and institutional rights, stemming largely from the promulgation of the Human Rights Act of 1998, that brought certain rights articulated in the European Convention of Human Rights into domestic law. See Jonathan Bindman et al., *The Human Rights Act and Mental Health Legislation*, 182 BRIT. J. PSYCHIATRY 91 (2003); David Kingdon et al., *Protecting the Human Rights of People with Mental Disorder: New Recommendations Emerging from the Council of Europe*, 185 BRIT. J. PSYCHIATRY 277 (2004); Perlin, *supra* note 10, at 348; Kris Gledhill, *Patient Representation* (Nov. 10, 2006) (unpublished manuscript, on file with author); Valerie Williams, *The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation Before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience?* (Nov. 12, 2006) (unpublished manuscript, on file with author). There also have been encouraging developments from Israel. See Public Defender Office, *Representation of Mentally Ill Clients at the District Psychiatric Committees* (paper presented at 29 Annual Congress, International Academy of Law and Mental Health, Paris, France, July 2005) (PowerPoint slides on file with author). But these appear to be the stark exceptions.

65. Bloch, *supra* note 27, at 8.

66. Mental Health Act of 2002 s. 15 (S. Afr.). A recent comprehensive study of access to justice in Africa does not reveal any other example of the existence of such a right. See ACCESS TO JUSTICE IN AFRICA AND BEYOND: MAKING THE RULE OF LAW A REALITY (Penal Reform

Uganda, in fact, focuses on that legislation’s failure to provide counsel as one of its major “human rights gaps.”⁶⁷ Although there is a right to counsel in India,⁶⁸ research has revealed no such right in a range of other Asian nations including, inter alia, Afghanistan, China, Indonesia, Pakistan, South Korea, Sri Lanka, Thailand, and Vietnam; similarly, no such right appears to exist in a range of South American nations, including Argentina, Peru, and Venezuela.⁶⁹ The only non-U.S.-based evidence I could find in the literature, of a hospital administration urging the extended appointment of counsel in civil commitment cases, is from Israel.⁷⁰

This is troubling for many reasons, not the least of which is that, without the availability of such counsel, it has been “virtually impossible” to imagine the existence of the bodies of involuntary civil commitment law, right to treatment law, right to refuse treatment law, or any aspect of forensic mental disability law that are now taken for granted in the United States.⁷¹ Without the presence of

Int’l & Bluhm Legal Clinic eds., National Institute for Trial Advocacy 2007) [hereinafter JUSTICE IN AFRICA].

67. Mulumba Moses, Analysis of the Uganda Mental Treatment Act from a Human Rights and Public Health Perspective, at 12–13 (Aug. 13, 2007) (unpublished manuscript on file with the Social Science Research Network), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1006230.

68. India Mental Health Act § 91, 1987, No. 14, Acts of Parliament, available at <http://www.disabilityindia.org/mentalact.cfm>.

69. Memorandum from An Truong to Author (Aug. 27, 2007) (on file with author).

70. See Arie Bauer et al., *Regional Psychiatric Boards in Israel: Expectations and Realities*, 28 INT’L J.L. & PSYCHIATRY 661, 668 (2005) (“[I]t seems advisable that all persons hospitalized compulsorily . . . be legally represented at RPB [Regional Psychiatric Board] hearings, in order to ensure the greatest possible protection for their rights, first and foremost their liberty.”). Bauer works for the Forensic Psychiatry Unit of the Mental Health Services Division of the Israel Ministry of Mental Health. See also Arie Bauer, *Trends in Involuntary Psychiatric Hospitalization in Israel 1991–2000*, 30 INT’L J.L. & PSYCHIATRY 60, 67 (2007) (speculating that amendment to national mental health law providing for counsel in all RPB proceedings “will bring about a diminution in the number of involuntary hospitalizations”).

On the implications of Israel’s activist judiciary, see Eli Salzberger, *Judicial Activism in Israel: Sources, Forms and Manifestations* (May 10, 2007) (unpublished manuscript, on file with the Social Science Research Network), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=984918. On the uniqueness of Israel’s “mixed” legal system, see Nir Kedar, *Civil Codification, Law and Culture in a Mixed Legal System* (Jan. 20, 2007) (unpublished manuscript, on file with the Social Sciences Research Network), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=957592.

71. Perlin, *supra* note 10, at 341.

counsel, legal reform—in nations with developing economies, at least—“will all too often be a hollow shell.”⁷²

III. OTHER MAJOR LEGAL, POLITICAL AND SOCIAL DEVELOPMENTS

There is an important paradox here that needs to be highlighted. At the same time that the non-developments that I have outlined above have taken place, there have been many important and overlapping *positive* developments, all five of which, when considered together, shine new light on the underlying issues and promise to focus new attention on them in the near future.

First is the first international case law that begins to articulate a broad right to counsel in *all* cases. Decisions such as *Airey v. Ireland*⁷³ and *Currie v. Jamaica*⁷⁴ (both concluding that a litigant’s right to effective access to the courts may sometimes require the state to provide for the assistance of a lawyer) have begun to give litigators the tools through which they can seek to “craft arguments supporting the right to counsel in civil proceedings under international law.”⁷⁵ It is essential that advocates bring cases in international courts to articulate this specific right *in the specific context of involuntary civil commitment*.⁷⁶

Second are the ratification of the United Nations Convention on the Rights of Persons with Disabilities and the publication of the World Health Organization Resource Book on Mental Health, both of which will eventually attract international attention to this issue. The new U.N. convention mandates that “States Parties shall take appropriate measures to provide access by persons with disabilities to

72. Stephen Golub, *The Importance of Legal Aid in Legal Reform*, in JUSTICE IN AFRICA, *supra* note 66, at xv, xviii.

73. 32 Eur. Ct. H.R. (ser. A) at 15 (1979).

74. U.N. Human Rights Committee, Communication No. 377/1989, P 13.6, U.N. Doc. CCPR/C/50/D/377/1989 (1994), as cited in Sarah Paoletti, *Deriving Support from International Law for the Right to Counsel in the Civil Cases*, 15 TEMP. POL. & CIV. RTS. L. REV. 651, 655 n.32 (2006).

75. Paoletti, *supra* note 74, at 51.

76. On the question of the theoretical and constitutional underpinnings of right to counsel in *all* civil cases, see *infra* note 77 (citing sources).

the support they may 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

77. G.A. Res. 61/106, ¶ 12.3, U.N. Doc. A/RES/61/106 (Dec. 13, 2006). *See generally* Michael Ashley Stein, *Disability Human Rights*, 95 CAL. L. REV. 75 (2007). For a thoughtful and comprehensive predecessor article, see 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 (2005).

On the potential international law bases of a global right to counsel in all *civil* cases, see Paoletti, *supra* note 75; Raven Lidman, *Civil Gideon as a Human Right: Is the U.S. Going to Join Step with the Rest of the Developed World*, 15 TEMP. POL. & CIV. RTS. L. REV. 769 (2006); Russell Engler, *Shaping a Context-Based Civil Gideon from the Dynamics of Social Change*, 15 TEMP. POL. & CIV. RTS. L. REV. 697 (2006). In the United States, at least, civil commitment cases—for purposes of such matters as burden of proof—occupy a space between civil and criminal cases. *See, e.g.*, *Addington v. Texas*, 441 U.S. 418 (1979) (finding that an intermediate burden of clear and convincing evidence is required, explaining why neither the traditional criminal nor civil burden is appropriate in such a case). *Addington* is discussed in this context in PERLIN, *supra* note 6, § 2C-5.1a, at 395–400.

78. G.A. Res. 61/106, ¶ 13.1, U.N. Doc. A/RES/61/106 (Dec. 13, 2006).

79. Distinguished commentators have raised important, but still-unanswered, questions: *To what extent will the Convention, in fact, be a “human rights convention for the 21 century”?* *See, e.g.*, Lisa Waddington, *A New Era in Human Rights Protection in the European Community: The Implications [of] the United Nations’ Convention on the Rights of Persons with Disabilities for the European Community* 4 (Sept. 27, 2007) (unpublished manuscript, on file with the Social Sciences Research Network), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1026581.

Will the convention be a “clear moral compass”? *See, e.g.*, Gerard Quinn, *Keynote Speech at the European Conference on the Integration of Persons with Disabilities: The UN Convention on the Human Rights of Persons with Disabilities* 3 (June 10, 2007), available at <http://www.nhri.net/2007/Berlin-Quinn.2.pdf>.

For a discussion of the specific potential impact of Article 13, see Waddington, *supra* note 79. Professor Simon Rice has argued persuasively that legal aid is a human right. *See* Simon Rice, *A Human Right to Legal Aid* (Macquarie Univ. Div. of Law, Working Paper No. 2007–

The third development is the first burst of professional interest in this issue, as evidenced by programs, workshops and panels focusing precisely on the extent of this dilemma at the Congress of the International Academy of Law and Mental Health (“IALMH”), and the conference of the Australia and New Zealand Association of Psychiatry, Psychology, and Law (“ANZAPPL”).

It is not insignificant that the first scholarly developments in this area have come in the guise of interdisciplinary conferences that involved lawyers and mental health professionals. The most recent IALMH Congress featured a program on *Advocating Care—The Models and Roles in the Experience of Advocacy*;⁸⁰ I led a workshop at the 2006 ANZAPPL Congress on *The Provision of Advocacy Services and the Role of Counsel in Cases of Persons with Mental Disabilities*,⁸¹ examining the same issues explored in this Article. I believe that, in the coming years, there will be more and more interdisciplinary professional focus on these issues, and that, as a result of that heightened focus, the concerns raised here will be considered far more widely.

Fourth is the focus by mental disability law-specific NGOs (e.g., Mental Disability Rights International; Mental Disability Advocacy Center) on institutional conditions in Central and Eastern Europe and in Central and South America, calling attention to this issue. Recent years have seen the emergence of two important NGOs, one based in Washington, D.C., and one based in Budapest, that have done a heroic job⁸² of calling the world’s attention to worldwide conditions in psychiatric institutions and to the inhuman and degrading treatment of persons institutionalized by reason of mental disability.⁸³

14, 2007), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1061541. It is still far too early to speculate as to what impact such scholarship will have on the issues addressed in this Article.

80. See Final Conference Program, International Scientific Committee, 30th International Congress on Law and Mental Health (June 25, 2007), available at http://www.ialmh.org/Padua2007/Final_Program.doc.

81. See Program and Registration, Human Rights in a World of Fear and Diminishing Resources, Australian and New Zealand Ass’n of Psychiatry, Psychology, and Law 4 (Nov. 9, 2006), available at http://www.anzappl.org/documents/ANZAPPL2006AnnualCongress_003.pdf.

82. See Perlin, *supra* note 10, at 334.

83. For discussions of the work done by MDRI and MDAC, see Perlin, *supra* note 10, at 337; Gable, *supra* note 22, at 540; Kanter, *supra* note 22, at 316; Alex Geisinger & Michael

It is not an exaggeration to say that, together, these two groups have done more than all the “traditional” human rights offices combined to call the world’s attention to these issues.⁸⁴ And the lack of counsel available to persons institutionalized because of mental disability is one of those issues emphasized in their reports and other documents.⁸⁵

The fifth development is the emergence of the Global Alliance for Justice Education (“GAJE”) as a factor in the promotion of socially relevant legal education, similarly calling attention to these issues. GAJE is a global alliance of “people committed to achieving justice through education, with a focus on clinical education and other forms of socially relevant legal education,”⁸⁶ and on preserving and supporting a social justice focus for clinical legal education around the world,⁸⁷ as a means of creating “a valuable tool in developing countries to help promote equal justice for the poor.”⁸⁸ Seeking to empower “marginalized” sectors of society is one of its articulated aims.⁸⁹

Ashley Stein, *A Theory of Expressive International Law*, 60 VAND. L. REV. 77, 107–09 (2007); Laura E. Hortas, *Asylum Protection for the Mentally Disabled: How the Evolution of Rights for the Mentally Ill in the United States Created a “Social Group,”* 20 CONN. J. INT’L L. 155, 181–82 (2004). See generally PERLIN ET AL., *supra* note 9, at 803–09, 855–57, 862–63, 867–69, 872–81.

84. See, e.g., Michael L. Perlin & Eva Szeli, *Mental Health Law and Human Rights: Evolution and Contemporary Challenges*, in MENTAL HEALTH AND HUMAN RIGHTS (Michael Dudley ed., forthcoming 2008); Michael L. Perlin, *International Human Rights and Mental Disability Law: The Core Issues*, in PRINCIPLES OF MENTAL HEALTH LAW—POLICY AND PRACTICE (Lawrence Gostin ed., forthcoming 2008).

85. See, e.g., Lewis, *supra* note 60, at 195–96. See also Mental Disability Rights International, Projects: Neuro-Psychiatric Hospital of Paraguay, <http://www.mdri.org/projects/americas/paraguay/index.htm> (last visited Sept. 17, 2008); MENTAL DISABILITY RIGHTS INTERNATIONAL, HUMAN RIGHTS AND MENTAL HEALTH: MEXICO (2000); MENTAL DISABILITY RIGHTS INTERNATIONAL, HUMAN RIGHTS AND MENTAL HEALTH URUGUAY (1995).

86. Elizabeth Cooper, *Global Collaboration in Law Schools: Lessons to Learn*, 30 FORDHAM INT’L L.J. 346, 347 (2007).

87. Frank S. Bloch & M.R.K. Prasad, *Institutionalizing a Social Justice Mission for Clinical Legal Education: Cross-National Currents from India and the United States*, 13 CLINICAL L. REV. 165, 166 n.2 (2006).

88. Peggy Maisel, *Expanding and Sustaining Clinical Legal Education in Developing Countries: What We Can Learn from South Africa*, 30 FORDHAM INT’L L.J. 374, 419 (2007).

89. See GAJE.org, 5th Worldwide Conference on the Global Alliance for Justice Education, <http://www.gaje.org/Conf08-home.htm> (last visited Sept. 16, 2008).

Individuals with mental disabilities—people who are largely “voiceless” and “traditionally isolated from the majoritarian democratic political system”—are frequently marginalized to an even greater extent than are others who fit within the definition of “discrete and insular minorities.”⁹⁰ The emergence of GAJE as an important force in the promotion of social justice should be yet another factor in focusing positive attention on this marginalization and the issues discussed in this Article.⁹¹

IV. THE ROLE OF CLINICS

There are remarkably few clinics at U.S.-based law schools that provide representation in civil commitment cases.⁹² Internationally, the picture is even drearier.⁹³ Notwithstanding the significance of representation to the disposition of civil commitment cases,⁹⁴ this is simply an area of representation that has captured neither the imagination nor the attention of clinicians at home or elsewhere.

There is some irony here, for we are beginning to realize the profound impact that law school clinics can have on the entire enterprise of “justice education” throughout the world.⁹⁵ Recent scholarship focuses on the “real life” impact of clinics in this context

90. Perlin, *supra* note 8, at 687. The “discrete and insular minorities” phrase is found in *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938).

91. For a discussion of the significance of human rights education in promoting the rule of law in nations with developing economies, see Sisay Alemahu Yeshnew, *Utilising the Promotional Mandate of the African Commission on Human and Peoples’ Rights to Promote Human Rights Education in Africa*, 7 AFR. HUM. RTS. J. 191 (2007).

92. See Perlin, *supra* note 8, at 712 n.170 (listing clinics).

93. See *infra* text accompanying note 104.

94. “Empirical surveys consistently demonstrate that the quality of counsel remains the single most important factor in the disposition of involuntary civil commitment cases.” 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 Cases*, 2 PSYCHOL. PUB. POL’Y & L. 114, 120 (1996) (citation and internal quotation marks omitted).

95. See, e.g., Barry et al., *supra* note 27, at 200–09 (discussing justice education as “one of the primary goals of legal education”).

in nations as disparate as Japan,⁹⁶ the Czech Republic,⁹⁷ China,⁹⁸ India,⁹⁹ and nations with developing economies in Central and South America,¹⁰⁰ and the similar impact of U.S.-based clinics on citizens of nations as disparate as Jamaica, Ghana, and Poland.¹⁰¹ Clinical education should also, optimally, be able both to make students aware of any pre-existing sanist perspective they “bring to the table,”¹⁰² and to turn such students into more assertive advocates for their clients with mental illness (or perceived mental illness).¹⁰³ Yet a recent survey by Professor Roy Stuckey of clinical law teachers with international teaching or consulting experience only appears to reveal *one* non-U.S.-based professor involved with this enterprise in mental disability law contexts in other nations.¹⁰⁴

96. See, e.g., Peter A. Joy et al., *Building Clinical Legal Education Programs in a Country Without a Tradition of Graduate Professional Legal Education: Japan Educational Reform as a Case Study*, 13 CLINICAL L. REV. 417 (2006).

97. See, e.g., Vendula Bryxová, *Introducing Legal Clinics in Olomouc, Czech Republic*, J. CLINICAL LEGAL EDUC. 149 (2006).

98. See, e.g., Note, *Adopting and Adapting: Clinical Legal Education and Access to Justice in China*, 120 HARV. L. REV. 2134 (2007); Mao Ling, *Clinical Legal Education and the Reform of the Higher Legal Education System in China*, 30 FORDHAM INT’L L.J. 421 (2007); Pamela N. Phan, *Clinical Legal Education in China: In Pursuit of a Culture of Law and a Mission of Social Justice*, 8 YALE HUM. RTS. & DEV. L.J. 117 (2005).

99. See, e.g., Bloch & Prasad, *supra* note 87; Frank S. Bloch & Iqbal S. Ishaq, *Legal Aid, Public Service and Clinical Legal Education: Future Directions from India and the United States*, 12 MICH. J. INT’L L. 92 (1990).

100. See, e.g., Richard J. Wilson, *Training for Justice: The Global Reach of Clinical Legal Education*, 22 PENN. ST. INT’L L. REV. 421 (2004); Richard J. Wilson, *Three Law School Clinics in Chile, 1970–2000: Innovation, Resistance and Conformity in the Global South*, 8 CLINICAL L. REV. 515 (2002).

101. For a discussion of these examples, see *Teaching International Law—“The Visible College of International Clinicians Making a Real Difference in Law School and in the World*, 95 AM. SOC’Y INT’L LEGAL PROC. 188 (2001) (remarks by Diane Edelman).

102. See *supra* text of note 31; Perlin, *supra* note 8.

103. Perlin, *supra* note 8, at 685:

The . . . phenomena [of sanist myths] are especially troubling in the clinical setting, in which students are exposed for the first time to the skills that go to the heart of the lawyering process: interviewing, investigating, counseling and negotiating. All of these are difficult for us (and our students) to learn, but this difficulty is significantly increased when the client is a person with mental disability (*or one so perceived*). The difficulties can be further exacerbated when the clinical teacher—either overtly or covertly—expresses sanist thoughts or reifies sanist myths.

Id. (emphasis added). Sanism is discussed extensively *infra* Part V. See also *supra* note 31.

104. Roy Stuckey, *Compilation of Clinical Law Teachers with International Teaching or Consulting Experience*, manuscript at 43 (updated June 15, 2005), <http://law.sc.edu/clinic/does/>

I believe, as I will discuss more extensively below, that this is due, at least in part, to the ravages of sanism,¹⁰⁵ both active and passive. But this revelation is no longer new. I have written in the past how clinical professors are not immune from the same sanist attitudes that infect the rest of society,¹⁰⁶ and it is essential that we remember this as we seek to implement progressive social change in this area.

There is, to be sure, some positive light peeking through the mist. Several colleagues, both in the United States and abroad, have done inspiring work in focusing on the need for clinical programs to involve themselves more comprehensively in human rights education and in preparing their students to focus on global justice issues.¹⁰⁷ On

internationalsurvey.pdf (last visited Sept. 16, 2008). Professor Kate Diesfeld has spoken extensively about a mental health and learning disability clinic that she established at the University of Kent at Canterbury in the United Kingdom. See http://www.aut.ac.nz/about/faculties/health_and_environmental_sciences/research_centres_and_institutes/national_centre_for_health_and_social_ethics/consultation_and_public_services.htm (last visited Sept. 29, 2008).

105. See Perlin, *supra* note 8, at 713:

Several years ago, I gave the keynote presentation at a Society of American Law Teachers (SALT) conference, and presented a paper titled, "Mental Disability, Sanism, Pretextuality, Therapeutic Jurisprudence, and Teaching Law." SALT regularly provides speaking forums for professors whose primary scholarly (and often personal) interests are the rights of the "discrete and insular minorities" described in footnote 4 of the *Carolene Products* case. SALT draws from the ranks of politically progressive law professors, including many who articulate a commitment to social justice as one of the reasons they joined the academy. The organization has been a consistent voice in the fight to insure diversity in the classroom and the curriculum. Each year, at the Association of American Law Professors' annual conference, there is a SALT meeting, and often (if not always), some political activity "in the streets." Yet, the response to my talk was strikingly at odds with this commitment to diversity and social justice. In an article subsequently published in the *SALT Equalizer*, Professor Rogelio Lasso wrote that he found it particularly disturbing that "Sanism" merited a plenary presentation but that the "disgraceful lack of racial diversity of law school faculties" did not.

Id. (citations omitted).

106. See generally Perlin, *supra* note 8.

107. See, e.g., Roy T. Stuckey, *Preparing Students to Practice Law: A Global Problem in Need of Global Solutions*, 43 S. TEX. L. REV. 649 (2002); Philip Iya, *Enhancing the Teaching of Human Rights in African Universities: What Role for Law School Clinics?*, 7 INT'L J. CLINICAL LEGAL EDUC. 20 (2005); David McQuoid-Mason, *The Supply Side: The Role of Lawyers in the Provision of Legal Aid—Some Lessons from South Africa*, in JUSTICE IN AFRICA, *supra* note 66, at 97. Professor Louise McKinney, by way of example, is currently working in Gaborone, Botswana, assisting the University of Botswana Department of Law's clinical education program. Posting of Louise McKinney, louise.mckinney@case.edu, to owner-

the specific issue of mental disability law representation, two law schools in Japan—one with no tradition of any clinical education, and the other with perhaps the strongest tradition of providing such courses—have given me tentative oral commitments that they will create clinical programs to represent individuals in civil commitment hearings.¹⁰⁸ In addition, Nkumba University Law School in Uganda has agreed to create a similar program, contingent on availability of funding.¹⁰⁹ But there is no evidence that these developments will have an immediate effect on the global lack of clinical involvement.

V. THE MEANING AND SIGNIFICANCE OF SANISM AND PRETEXTUALITY

Sanism¹¹⁰ 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. 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). It reflects what civil rights lawyer Florynce Kennedy has characterized as the “pathology of oppression.”¹¹¹

“Pretextuality”¹¹² is especially poisonous where witnesses, especially expert witnesses, show a “high propensity to purposely distort their testimony in order to achieve desired ends.”¹¹³ This pretextuality infects all participants in the judicial system, breeds

gaje@vanderbilt.edu on behalf of GAJE Listserv Messages (Oct. 13, 2007) (on file with author).

108. E-Mail from Yoshikazu Ikehara, Esq., Director, Tokyo Advocacy Law Office, to Author (Jan. 21, 2008) (on file with author) (memorializing the agreement).

109. E-Mail from Author to Prof. Joseph Kakooza, Dean, Nkumba University Law School (Jan. 13, 2008) (on file with author) (memorializing the agreement).

110. See *supra* note 31; *infra* Part V.

111. See Michael L. Perlin, “Half-Wracked Prejudice Leaped Forth”: *Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. CONTEMP. LEGAL ISSUES 3 (1999); MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL (2000); Perlin, *supra* note 8; Michael L. Perlin, *On “Sanism,”* 46 SMU L. REV. 373 (1992).

112. See *supra* note 32.

113. Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of “Ordinary Common Sense,” Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 131, 135 (1991).

cynicism and disrespect for the law, demeans participants, and reinforces poor-quality lawyering, blasè judging, and, at times, perjurious and corrupt testifying.¹¹⁴

In previous works, I have explored the relationships between sanism and pretextuality in matters involving, inter alia, competency to stand trial,¹¹⁵ sexual autonomy,¹¹⁶ the right to refuse treatment,¹¹⁷ “autonomous decisionmaking,”¹¹⁸ and competency to plead guilty or waive counsel.¹¹⁹ I have begun to explore it specifically in the context of international human rights law.¹²⁰ But, as I have discussed elsewhere, these factors can be more pernicious as they relate to lawyers’ representation of persons with mental disabilities in court proceedings. Writing about this latter topic four years ago, I alleged:

Sanism permeates the legal representation process both in cases in which mental capacity is a central issue, and those in which such capacity is a collateral question. Sanist lawyers (1) distrust their mentally disabled clients, (2) trivialize their complaints, (3) fail to forge authentic attorney-client relationships with such clients and reject their clients’ potential contributions to case-strategizing, and (4) take less seriously case outcomes that are adverse to their clients.¹²¹

114. See generally PERLIN, *supra* note 111.

115. E.g., Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625 (1993); Michael L. Perlin, “Everything’s a Little Upside Down, As a Matter of Fact the Wheels Have Stopped”: *The Fraudulence of the Incompetency Evaluation Process*, 4 HOUS. J. HEALTH L. & POL’Y 239 (2004).

116. E.g., Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?* 20 N.Y.U. REV. L. & SOC. CHANGE 517 (1994).

117. See, e.g., Perlin, “*And My Best Friend, My Doctor/Won’t Even Say What It Is I’ve Got*,” *supra* note 12; Perlin & Dorfman, *supra* note 94.

118. E.g., Perlin, *supra* note 8, at 722.

119. E.g., Perlin, *supra* note 49.

120. See, e.g., Perlin, *supra* note 10, at 333; Michael L. Perlin, *International Human Rights and Comparative Mental Disability Law: The Role of Institutional Psychiatry in the Suppression of Political Dissent*, 39 ISR. L. REV. 69, 89–91 (2006); PERLIN ET AL., *supra* note 6, at 283–319. Other authors have begun to explore the dimensions of the same issue. See, e.g., Jennifer Fischer, *A Comparative Look at the Right to Refuse Treatment for Involuntarily Hospitalized Persons with a Mental Illness*, 29 HASTINGS INT’L & COMP. L. REV. 153, 162–64 (2006); David R. Katner, *The Mental Health Paradigm and the MacArthur Study: Emerging Issues Challenging the Competence of Juveniles in Delinquency Systems*, 32 AM. J.L. & MED. 503, 570–71 (2006).

121. Perlin, *supra* note 8, at 695.

Although there is a robust “psychiatric survivor” movement both in the United States and elsewhere,¹²² this voice is typically ignored.¹²³ For at least twenty-five years, formerly hospitalized individuals and their supporters have performed an important role in the reform of the mental health system and in test case litigation. “Yet, there is little evidence that these groups are taken seriously either by lawyers or academics.”¹²⁴

122. See, e.g., Peter Margulies, *The Cognitive Politics of Professional Conflict: Law Reform, Mental Health Treatment Technology, and Citizen Governance*, 5 HARV. J.L. & TECH. 25, 57–58 n.132 (1992); Jennifer Honig & Susan Fendell, *Meeting the Needs of Female Trauma Survivors: The Effectiveness of the Massachusetts Mental Health Managed Care System*, 15 BERKELEY WOMEN’S L.J. 161, 185 (2000); Letters to the Editor, *Taking Issue with Taking Issue: “Psychiatric Survivors” Reconsidered*, 48 PSYCHIATRIC SERVICES 601–05 (1997).

123. But see Perlin, *supra* note 8, at 700 n.90:

One important exception is Shin Imai, *A Counter-Pedagogy for Social Justice: Core Skills for Community-based Lawyering*, 9 CLINICAL L. REV. 195, 199 (2002) (discussing Osgoode Hall Law School’s clinic’s collaborative work with Parkdale Community Legal Services in representing one such group). See also *Tewksbury v. Dowling*, 169 F. Supp. 2d 103 (E.D.N.Y. 2001), and *Charles W. v. Maul*, 214 F.3d 350 (2d Cir. 2000) (litigants represented by Prof. William Brooks and the Mental Disability Law Clinic of Touro Law School).

Id. at 700 n.90. Survivors, on the other hand, were an important voice in the drafting of the UN Convention. See, e.g., MindFreedom, News about the MFI Global Campaign Committee, <http://www.mindfreedom.org/campaign/global/news-about-the-mfi-international-campaign-committee> (last visited Sept. 16, 2008) (discussing role of MindFreedom in enabling “psychiatric survivors [to] enter the UN to participate in international negotiating sessions about the human rights of people labeled with disabilities”). For an early discussion of the role of such groups in the UN drafting process, see Theresia Degener, *International Disability Law—A New Legal Subject on the Rise: The Interregional Experts’ Meeting in Hong Kong, December 13–17, 1999*, 18 BERKELEY J. INT’L L. 180, 189 n.38 (2000).

124. Perlin, *supra* note 8, at 699–700 (citations omitted). See also Michael L. Perlin, *An Internet-Based Mental Disability Law Program: Implications for Social Change in Nations with Developing Economies*, 30 FORDHAM INT’L L.J. 435, 444 n.39 (2007):

[S]urvivor groups generally have opposed the constitutionality or application of involuntary civil commitment statutes, see, e.g., *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983), or supported the right of patients to refuse the involuntary administration of psychotropic drugs, see *Rennie v. Klein*, 653 F.2d 836, 838 (3d Cir. 1981) (Alliance for the Liberation of Mental Patients, amicus curiae), but also have involved themselves in a far broader range of litigation. See, e.g., *Colorado v. Connelly*, 479 U.S. 157 (1986) (impact of severe mental disability on Miranda waiver; Coalition for the Fundamental Rights and Equality of Ex-patients, amicus). The involvement of such groups in test case litigation—exercising the right of self-determination in an effort to control, to the greatest extent possible, their own destinies, see, e.g., JUDI CHAMBERLIN, ON OUR OWN: PATIENT-CONTROLLED

In the civil commitment context, any sanism-inspired blunders by lawyers can easily be fatal to the client's chance of success. If a lawyer rejects the notion that his client may be competent (indeed, if he engages in the not-atypical "presumption of incompetency" that is all too often *de rigeur* in these cases),¹²⁵ the chances are far slimmer that he will advocate for such a client in the way that lawyers have been instructed—or, at the least, should be instructed—to advocate for their clients. In nations with no tradition of an "expanded due process model,"¹²⁶ in cases involving persons subject to commitment to psychiatric institutions or those already institutionalized, a lawyer's sanism can kill his client's chance for release or for a judicial order mandating amelioration of conditions of confinement, or access to or freedom from treatment.

CONCLUSION

The legislative and judicial creation of rights—both positive and negative—is illusory unless there is a parallel mandate of counsel that is (1) free and (2) regularized and organized.¹²⁷ Without the presence of such counsel, any rights articulated by a court, human rights commission, or legislature become merely "paper victories."¹²⁸

ALTERNATIVES TO THE MENTAL HEALTH SYSTEM (197[8])—is a major development that cannot be overlooked by participants in subsequent mental disability litigation.

Id.

125. Michael L. Perlin et al., *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 193 (2003) ("In short, the presumption in which courts have regularly engaged—that there is both a de facto and de jure presumption of incompetency to be applied to medication decision making—appears to be based on an empirical fallacy: psychiatric patients are not necessarily more incompetent than nonmentally ill persons to engage in independent medication decision making.") (citation omitted).

126. See Michael L. Perlin, "Make Promises by the Hour": *Sex, Drugs, the ADA, and Psychiatric Hospitalization*, 46 DEPAUL L. REV. 947, 971 (1997).

127. See generally PERLIN, *supra* note 6, at Chapter 2B.

128. 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, 246 (2002) ("Mental disability law is strewn with examples of 'paper victories,' ..." (quoting Michael Lottman, *Paper Victories and Hard Realities*, in PAPER VICTORIES AND HARD REALITIES: THE IMPLEMENTATION OF THE LEGAL AND CONSTITUTIONAL RIGHTS OF THE MENTALLY DISABLED 93 (Valerie J. Bradley & Gary J. Clarke eds., 1976))).

Further, to be authentically effective, counsel needs to be available both for individual cases (in which commitment of the patient is being sought) and in “affirmative” cases (that is, cases consciously thought of as “public interest” or “law reform” cases in which persons with disabilities file suit as plaintiffs seeking variously to have courts articulate procedural or substantive due process rights in the commitment process,¹²⁹ or to have courts articulate such rights with regard to conditions of confinement, the latter encompassing both positive rights, e.g., a right to treatment services,¹³⁰ and negative rights, e.g., the right to refuse treatment).¹³¹

An argument certainly can be made that the presence of sanism (which affects lawyers—even those active in the clinical movement¹³²—and lay persons alike) and the technical complexity of involuntary civil commitment cases (involving, necessarily, expert testimony by mental health professionals and subtle predictions about “future dangerousness”)¹³³ augment the necessity and importance of adequate representation in such cases. In arguing why the United States should ratify the new UN Convention, Tara Melish focused on the “deeply entrenched attitudes and stereotypes about disability that have rendered many of the most flagrant abuses of the rights of persons with disabilities ‘invisible’ from the mainstream human rights lens.”¹³⁴ These stereotypes are the essence of sanism; vigorous, advocacy-focused counsel is needed to answer and rebut them.

I believe that the creation and expansion of legal clinics into mental disability law is an important and necessary step in its evolution. The confluence of developments in international case law, the UN Convention publication, scholarly awareness, and the

129. *E.g.*, *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (holding that a statute that fails to provide a person alleged to be mentally ill with adequate procedural safeguards is unconstitutional).

130. *E.g.*, *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *aff’d sub. nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (holding that the mentally ill have the constitutional right to adequate treatment in mental hospitals).

131. *E.g.*, *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (holding that patients with mental illness committed involuntarily retain their constitutional right to refuse antipsychotic drugs).

132. *See* Perlin, *supra* note 8.

133. *See generally* PERLIN, *supra* note 6, at Ch. 2A.

134. Tara Melish, *The UN Disability Convention: Historic Process, Strong Prospects, and Why the U.S. Should Ratify*, 14 HUM. RTS. BRIEF, 37, 44 (2007).

involvement of GAJE are all necessary steps toward a sensitive, comprehensive body of law. We must all do our part to ensure that defendants facing involuntary commitment have access to competent and adequate representation, in an effort to return to the Dylan lyric with which the Article's title begins, to make it less likely that a patient's "trial" is nothing more than, symbolically, his legal "funeral."