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"YOU HAVE DISCUSSED LEPERS AND CROOKS": SANISM IN CLINICAL TEACHING

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There has been virtually no attention paid to the role of sanism in the clinical setting. 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. It permeates all aspects of mental disability law, and affects all participants in the mental disability law system: fact finders, counsel, expert and lay witnesses. Sanist myths exert especially great power over lawyers who represent persons with mental disabilities. These phenomena 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. The difficulties can be further exacerbated when the clinical teacher – either overtly or covertly – expresses sanist thoughts or reifies sanist myths. This article will explore the meaning of sanism, the general impact of sanism on the representation of persons with mental disabilities, the special problems faced when sanism infects the clinical teaching process, and some tentative solutions to this dilemma.

INTRODUCTION

There is a robust clinical literature on how issues of race, class, gender, and sexual orientation may influence all aspects of the clinical setting: on the relationship between student and client, between students, between student and clinical supervisor; the attitude of the fact-finder toward the clinical client and student lawyer.[1] But there has been virtually no attention paid to the role of sanism in the clinical

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[1] *See, e.g.*, Jane Aiken, *Striving to Teach "Justice, Fairness, and Morality,"* 4 CLIN. L. REV. 1 (1997); Jon Dubin, *Faculty Diversity as a Clinical Legal Education Imperative*, 51 HASTINGS L.J. 445 (2000); Bill Ong Hing, *Raising Personal Identification of Class, Race, Ethnicity, Gender, Sexual Orientation, Physical Disability, and Age in Lawyering Courses*, 45 STAN. L. REV. 1807 (1993); Kevin Johnson & Amagda Perez, *Clinical Legal Education and the U.C. Davis Immigration Law Clinic: Putting Theory into Practice and Practice into Theory*, 51 SMU L. REV. 1423 (1998); Margaret Montoya, *Voicing Differences*, 4 CLIN. L. REV. 147 (1997).

setting.

Sanism is an irrational prejudice of the same quality and character as other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry.[2] 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.[3] 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 the "pathology of oppression."[4]

Sanist myths exert especially great power over lawyers who represent persons with mental disabilities.[5] The use of stereotypes, typification, and deindividualization inevitably means that sanist lawyers will trivialize both their client's problems and the importance of any eventual solution to these problems. Sanist lawyers implicitly and explicitly question their clients' competence and credibility,[6] a move that significantly impairs the lawyers' advocacy efforts.[7]

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[2] *See generally* MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL (2000) (PERLIN, HIDDEN PREJUDICE). The classic study is GORDON W. ALLPORT, THE NATURE OF PREJUDICE (1955). *But see* ELISABETH YOUNG-BRUEHL, THE ANATOMY OF PREJUDICES (1996).

The phrase "sanism" was, to the best of my knowledge, coined by Dr. Morton Birnbaum. *See* Morton Birnbaum, *The Right to Treatment: Some Comments on its Development*, *in* MEDICAL, MORAL AND LEGAL ISSUES IN HEALTH CARE 97, 106-07 (Frank Ayd ed., 1974) (Birnbaum, *Right to Treatment: Comments*). *See also* Koe v. Califano, 573 F.2d 761, 764 n.12 (2d Cir. 1978). Dr. Birnbaum is universally regarded as having first developed and articulated the constitutional basis of the right to treatment doctrine for institutionalized mental patients. *See* Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499 (1960), discussed in 2 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 3A-2.1, at 8-12 (2d ed. 1999) (PERLIN, MENTAL DISABILITY LAW).

I recognize that the use of the word "sanism" (based on the root "sane" or "sanity") is troubling from another perspective: The notion of "sanity" or "insanity" is a legal construct that has been rejected by psychiatrists, psychologists, and other behavioralists for over 150 years. I nevertheless use it here, in part to reflect the way in which inaccurate, outdated and distorted language has confounded the underlying political and social issues, and to demonstrate, ironically, how ignorance continues to contribute to this bias.

[3] On the way that sanism affects lawyers' representation of clients, *see* PERLIN, HIDDEN PREJUDICE, *supra* note, 2 at 28, 55-56.

[4] *See* Birnbaum, *Right to Treatment: Comments*, *supra* note 2, at 107 (quoting Kennedy). *See also id.* at 106 ("It should be understood that sanists are bigots"). For a more recent consideration in this context, see Bruce Link et al., *The Consequences of Stigma for Persons with Mental Illness: Evidence from the Social Sciences*, *in* STIGMA AND MENTAL ILLNESS 87 (Paul Fink & Allan Tasman eds., 1992) (STIGMA).

[5] *See* Michael L. Perlin, *On "Sanism"*, 46 SMU L. REV. 373 (1992).

[6] *See* Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625 (1993).

[7] *See* Keri K. Gould & Michael L. Perlin, *"Johnny's in the Basement/Mixing Up His*

These phenomena 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. And sanism problems continue at every "critical moment" of the clinical experience: the initial interview, the case preparation, case conferences, planning of litigation (and/or negotiation) strategy, trial preparation, trial and appeal.

This article will explore (1) the meaning of sanism, (2) the general impact of sanism on the representation of persons with mental disabilities (looking closely at the specific ethical dilemmas raised in these cases, the conflicts often faced by lawyers doing this work, and the special roles that such lawyers must perform), (3) the special problems faced when sanism infects the clinical teaching process, and (4) some tentative solutions to this dilemma.

My title draws on Bob Dylan's brilliant masterpiece, *Ballad of a Thin Man*.[8] Interpretations of this song abound, but no one has contradicted Robert Shelton's conclusion that it is about "an observer who does not see."[9] One of its central couplets begins:

> You've been with the professors
> And they've all liked your looks.
> With great lawyers you have
> Discussed lepers and crooks[10]

Since I started teaching a clinic in 1984, I have had this verse in my mind. Clinical teachers are professors who are lawyers. And clinical clients, all too often, strike clinical students as being "lepers and crooks." If we, like the eponymous Thin Man, allow ourselves to be "observer[s] who [do] not see," we will fall prey to sanism's corrosive and malignant power.

I. The Meaning of Sanism

Sanism is as insidious as other "isms"[11] and is, in some ways, even

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Medicine": Therapeutic Jurisprudence and Clinical Teaching, 24 Seattle L. Rev. 339 (2000).

[8] Bob Dylan, Lyrics, 1962-1985, at 198 (1985).

[9] Robert Shelton, No Direction Home: The Life and Music of Bob Dylan 280 (DaCapo ed., 1997).

[10] Dylan, *supra* note 8, at 198.

[11] 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*

more troubling, because it is largely invisible, to a considerable degree socially acceptable, and frequently practiced (consciously and unconsciously) by individuals who ordinarily take "liberal" or "progressive" positions decrying similar biases and prejudices involving gender, race, ethnicity and/or sexual orientation.[12] It is a form of bigotry that "respectable people can express in public."[13] Like other "isms," sanism is based largely upon stereotype, myth, superstition and deindividualization. To sustain and perpetuate it, we use pre-reflective "ordinary common sense" and other cognitive-simplifying devices such as heuristic reasoning[14] in unconscious responses to events both in everyday life and in the legal process.

The practicing bar, courts, legislatures, professional psychiatric

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Olmstead v. L.C.) Anything More than "Idiot Wind?," 35 U. MICH. J.L. REF. 235, 236 (2001-02).

[12] *See, e.g.,* DAVID ROTHMAN & SHEILA ROTHMAN, THE WILLOWBROOK WARS 188-89 (1984) (discussing role of paradigmatically liberal Congresswoman Elizabeth Holtzman in attempting to block group homes for the mentally retarded from opening in her district).

[13] *Cf.* J. Michael Bailey & Richard Pillard, *Are Some People Born Gay?,* N.Y. TIMES (Dec. 17, 1991), at A21 (arguing that *homophobia* is the only form of bigotry that can be so expressed).

[14] For example, I explain how these approaches have distorted our insanity defense policies in Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599 (1989-90) (Perlin, *Myths*), and Michael L. Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning*, 69 NEB. L. REV. 3 (1990) (Perlin, *OCS*); *see generally* MICHAEL L. PERLIN, THE JURISPRUDENCE OF THE INSANITY DEFENSE (1994). I explain how they have distorted our approaches on questions of patient sexuality in Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?*, 20 NYU REV. L. & SOC. CHANGE 302 (1993-94) (Perlin, *Sexual Interaction*); Michael L. Perlin *"Make Promises by the Hour": Sex, Drugs, the ADA, and Psychiatric Hospitalization,* 46 DEPAUL L. REV. 947 (1997) (Perlin, *Promises*). I explain how they have distorted our approaches on questions of criminal competencies in Perlin, *Pretexts, supra* note 6; Michael L. Perlin, *"Dignity Was the First to Leave":* Godinez v. Moran, *Colin Ferguson, and the Trial of Mentally Disabled Criminal Defendants*, 14 BEHAV. SCI. & L. 61 (1996) (Perlin, *Dignity*); Michael L. Perlin, *"For the Misdemeanor Outlaw": The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities,* 52 ALA. L. REV. 193 (2000) (Perlin, *Misdemeanor Outlaw*). I explain how they have distorted our approaches in death penalty cases in Michael L. Perlin, *The Sanist Lives of Jurors in Death Penalty Cases: The Puzzling Role of "Mitigating" Mental Disability Evidence,* 8 NOTRE DAME J. L., ETHICS & PUB. POL. 239 (1994); Michael L. Perlin, *"The Executioner's Face Is Always Well-Hidden": The Role of Counsel and the Courts in Determining Who Dies,* 41 N.Y.L. SCH. L. REV. 201 (1996); Michael L. Perlin, *"Life Is in Mirrors: Death Disappears": Giving Life to* Atkins, N.M. L. REV. (forthcoming 2003). I explain how they have distorted our approaches in right to refuse treatment cases in 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 PSYCHOLOGY, PUB. POL'Y & L.114 (1996); Michael L. Perlin, *Decoding Right to Refuse Treatment Law*, 16 INT'L J. L. & PSYCHIATRY 151 (1993). I explain how they have distorted our approaches in neonaticide cases in Michael L. Perlin, *"She Breaks Just Like a Little Girl": Neonaticide, The Insanity Defense, and the Irrelevance of "Ordinary Common Sense"*, WM. & MARY J. WOMEN & L. (forthcoming 2003) (Perlin, *Neonaticide*).

and psychological associations, and the scholarly academy are all largely silent about sanism. A handful of practitioners, lawmakers, scholars and judges have raised lonely voices,[15] but the topic is simply "off the agenda" for most of these groups.[16] As a result, individuals with mental disabilities — "the voiceless, those persons traditionally isolated from the majoritarian democratic political system"[17] — are frequently marginalized to an even greater extent than are others who

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[15] The most important recent case is In the Matter of the Mental Health of K.G.F., 29 P. 3d 485 (Mont. 2001). *See infra* text accompanying notes 35-66. *See also, e.g.*, City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 454 (1985) (Stevens, J., concurring) (mentally retarded individuals subjected to "history of unfair and often grotesque mistreatment" (quoting Cleburne Living Center, Inc. v. City of Cleburne, Texas, 726 F. 2d 191, 197 (5th Cir. 1974) (decision below)), *and* id. at 461 (Marshall, J., concurring in part & dissenting in part) ("virulence and bigotry" of state-mandated segregation of the institutionalized mentally retarded "rivaled, and indeed paralleled, the worst excesses of Jim Crow"); David Bazelon, *Institutionalization, Deinstitutionalization, and the Adversary Process*, 75 COLUM. L. REV. 897 (1975); Martha Minow, *When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection and Legal Treatment of Difference*, 22 HARV. C.R. - C.L. L. REV. 22 (1987).

For recent scholarly considerations of sanism, see, *e.g.*, PETER BLANCK, THE AMERICANS WITH DISABILITIES ACT AND THE EMERGING WORKFORCE: EMPLOYMENT OF PEOPLE WITH MENTAL RETARDATION 59-60 (1998); Justine Dunlap, *Mental Health Advance Directives: Having One's Say*, 89 KY. L.J. 327, 353 (200-01); Bryan Dupler, *The Uncommon Law: Insanity, Executions, and Oklahoma Criminal Procedure,* 55 OKLA. L. REV. 1, 63 (2002); Sana Loue, *The Involuntary Civil Commitment of Mentally Ill Persons in the United States and Romania*, 23 J. LEG. MED. 211, 235 n.120 (2002); Grant Morris, *Defining Dangerousness: Risking a Dangerous Definition,* 10 J. CONTEMP. LEGAL ISSUES 61, 98 (1999); Christopher Slobogin, *An End to Insanity: Recasting the Role of Mental Disability in Criminal Cases,* 86 VA. L. REV. 1199, 1244 (2000); Winiviere Sy, *The Right of Institutionalized Disabled Patients to Engage in Consensual Sexual Activity,* 23 WHITTIER L. REV. 541, 549 (2001); Bruce Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing,* 10 J. CONTEMP. LEGAL ISSUES. 37, 41 (1999). I am gratified that student authors are also beginning to examine sanism's pernicious effects. *See, e.g.,* Sara Bredemeier, Note, *Hollow Verdict: Not Guilty by Reason of Insanity Provokes Animusbased Discrimination in the Social Security Act,* 31 ST. MARY'S L.J. 697, 730 (2000); Eva Subotnik, Note, *Past Violence, Future Danger?: Rethinking Diminished Capacity Departures under Federal Sentencing Guidelines Section 5k2.13*, 102 COLUM. L. REV. 1340, 1369 n.189 (2002); Elisa Swanson, Note, *"Killers Start Sad and Crazy": Mental Illness and the Betrayal of Kipland Kinkel*, 79 OR. L. REV. 1081, 1103-10 (2001).

[16] Judicial hostility is commonplace. *See, e.g.,* PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 34-35, 63-64; Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 420 n.94 (2000):

> [No example of judicial hostility] is perhaps as chilling as the following story: Sometime after the trial court's decision in Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978) (granting involuntarily committed mental patients a limited right to refuse medication), I had occasion to speak to a state court trial judge about the Rennie case. He asked me, "Michael, do you know what I would have done had you brought Rennie before me?" (the Rennie case was litigated by counsel in the N.J. Division of Mental Health Advocacy; I was director of the Division at that time). I replied, "No," and he then answered, "I'd've taken the sonofabitch behind the courthouse and had him shot."

[17] Perlin, *supra* note 5, at 375-76.

fit within the *Carolene Products* definition of "discrete and insular minorities."[18]

At its base, sanism is irrational. Any investigation of the roots or sources of mental disability jurisprudence must factor in society's irrational mechanisms for dealing with mentally disabled individuals. The entire legal system makes assumptions about persons with mental disabilities — who they are, how they got that way, what makes them different, what there is about them that lets us treat them differently, and whether their conditions are immutable. These assumptions reflect our fears and apprehensions about mental disability, persons with mental disability, and the possibility that we ourselves may become mentally disabled.[19] The most important question of all — why do we feel the way we do about these people? — is rarely asked.[20]

These conflicts compel an inquiry about the extent to which social science data does (or should) inform the development of mental disability law jurisprudence. After all, if we agree that mentally disabled

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[18] I discuss United States v. Carolene Products Co., 304 U.S. 144, 152 n.4 (1938), more broadly in this context in Michael L. Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A. L. REV. 249, 1250-51 (1987).

The Americans with Disabilities Act cites this very language in its findings section. On the question of whether this will be viewed merely as a hortatory aspiration or as a Congressional command for authentic behavioral and societal change, see Perlin, *Promises, supra* note 14, at 958-60; Michael L. Perlin, *"I Ain't Gonna Work on Maggie's Farm No More": Institutional Segregation, Community Treatment, the ADA, and the Promise of* Olmstead v. L.C., 17 T.M. COOLEY L. REV. 53 (2000) (Perlin, *Maggie's*); Perlin, *Misdemeanor Outlaw, supra* note 14; Michael L. Perlin, *"Their Promises of Paradise": Institutional Segregation, Community Treatment, the ADA, and* Olmstead v. L.C., 37 HOUS. L. REV. 999 (2000) (Perlin, *Paradise*).

[19] *See, e.g.*, Joseph Goldstein & Jay Katz, *Abolish the "Insanity Defense" — Why Not?* 72 YALE L.J. 853, 868-69 (1963); Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 108 (1991) (on society's fears *of* persons with mental disabilities), and *id.* at 93 n. 174 ("[W]hile race and sex are immutable, we all *can* become mentally ill, homeless, or both. Perhaps this illuminates the level of virulence we experience here.") (emphasis in original). On the way that public fears about the purported link between mental illness and dangerousness "drive the formal laws and policies governing mental disability jurisprudence," see John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511, 511 (1992). *See generally* MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION AND AMERICAN LAW (1990); SANDER GILMAN, DIFFERENCE AND PATHOLOGY: STEREOTYPES OF SEXUALITY, RACE AND MADNESS (1985).

[20] *See* PERLIN, *supra* note 14, at 6-7 (asking this question). *Compare* Carmel Rogers, *Proceedings Under the Mental Health Act 1992: The Legalisation of Psychiatry*, 1994 N.Z. L.J. 404, 408 ("Because the preserve of psychiatry is populated by 'the mad' and 'the loonies,' we do not really want to look at it too closely — it is too frightening and maybe contaminated").

On the ways that stigma affects psychiatrists and medical students, *see* Howard Dichter, *The Stigmatization of Psychiatrists Who Work with Chronically Mentally Ill Persons*, *in* STIGMA, *supra* note 4, at 203; Leah Dickstein & Lisa Hinz, *The Stigma of Mental Illness for Medical Students and Residents*, *in* STIGMA, *supra* note 4, at 153.

individuals can be treated differently (because of their mental disability, or because of behavioral characteristics that flow from that disability),[21] it would appear logical that this difference in legal treatment is — or should be — founded on some sort of empirical data base that confirms both the existence and the causal role of such difference. Yet, we tend to ignore, subordinate or trivialize behavioral research in this area, especially when acknowledging that such research would be cognitively dissonant with our intuitive (albeit empirically flawed) views.[22] And the steady stream of publication of new, comprehensive research does not promise any change in society's attitudes.[23]

II. SANIST LAWYERS AND SANIST COURTS

A. Sanist Lawyers[24]

Twenty years ago, in a survey of the role of counsel in cases involving individuals with mental disabilities, Dr. Robert L. Sadoff and I observed:

> Traditional, sporadically-appointed counsel . . . were unwilling to pursue necessary investigations, lacked . . . expertise in mental health problems, and suffered from "rolelessness," stemming from near total capitulation to experts, hazily defined concepts of success/failure, inability to generate professional or personal interest in the patient's dilemma, and lack of a clear definition of the proper advocacy function. As a result, counsel . . . functioned "as no more than a clerk, ratifying the events that transpired, rather than influencing them."[25]

Commitment hearings were meaningless rituals, serving only to provide a false coating of respectability to illegitimate proceedings;[26] in one famous survey, lawyers were so bad that a patient had a better chance to be released at a commitment hearing if he or she appeared

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[21] On the Supreme Court's confusion over the meaning of "mental disorder," *see* 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 2A-3.3, at 75-92 (2d ed. 1998), discussing Kansas v. Hendricks, 521 U.S. 346 (1997) (upholding Kansas' Sexually Violent Predator Act).

[22] *See generally* J. Alexander Tanford, *The Limits of a Scientific Jurisprudence: The Supreme Court and Psychology*, 66 IND. L.J. 137 (1990).

[23] For the most comprehensive research on predictions of violence, for example, *see* John Monahan, *Clinical and Actuarial Predictions of Violence*, *in* MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY §§7-2.0 to 7-2.4, at 300 (David Faigman et al. eds., 1997).

[24] This section is generally adapted from PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 55-56.

[25] Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process,* 45 LAW & CONTEMP. PROBS. 161, 164 (Summer 1982) (footnotes omitted).

[26] Virginia Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027, 1030 (1982).

pro se.[27] Merely educating lawyers about psychiatric techniques and psychological nomenclature did not materially improve lawyers' performance because lawyers' attitudes remained unchanged.[28] Counsel was especially substandard in cases involving mentally disabled criminal defendants.[29]

In the past two decades, the myth has developed that organized, specialized and aggressive counsel is now available to mentally disabled individuals in commitment, institutionalization and release matters. The availability of such counsel is largely illusory; in many jurisdictions, the level of representation remains almost uniformly substandard,[30] and, even within the same jurisdiction, the provision of counsel can be "wildly inconsistent."[31] Without the presence of effective counsel, substantive mental disability law reform recommendations may turn into "an empty shell."[32] Representation of mentally disabled individuals falls far short of even the most minimal model of "client-centered counseling."[33] What is worse, few courts even seem to notice.[34]

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[27] Elliot Andalman & David Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43, 72 (1974).

[28] Norman Poythress, *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope With Expert Testimony*, 2 LAW & HUM. BEHAV. 1, 15 (1978). *See infra* text accompanying notes 152-54.

[29] DAVID BAZELON, QUESTIONING AUTHORITY: JUSTICE AND CRIMINAL LAW 49 (1988); *See* Perlin, *Myths*, *supra* note 17, at 654. A survey conducted by Harvard Medical School revealed that the "great majority" of defense counsel interviewed were unaware of the operative criteria for competency to stand trial. 4 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 8A-4.3 at 60 (citing study). For a particularly shocking example of poor counsel in a death penalty case involving a mentally disabled criminal defendant, see Alvord v. Wainwright, 469 U.S. 956 (1984) (Marshall, J., dissenting from denial of *certiorari*).

[30] *See* Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39, 49-52 (1992).

[31] Perlin & Dorfman, *supra* note 14, at 122.

[32] *Id.* at 121.

[33] The standard text is DAVID BINDER & SUSAN PRICE, LEGAL INTERVIEWING AND COUNSELING: A CLIENT-CENTERED APPROACH (1977), updated in DAVID A. BINDER, PAUL BERGMAN & SUSAN C. PRICE, LAWYERS AS COUNSELORS: A CLIENT CENTERED APPROACH (1991). *Compare* Stephen Ellmann, *Lawyers and Clients*, 34 UCLA L. REV. 717 (1987) (critiquing Binder's and Price's work).

[34] *See, e.g., In re* C.P.K., 516 So.2d 1323, 1325 (La. Ct. App. 1987) (discussed in Perlin & Dorfman, *supra* note 14, at 120 n.67) (reversing commitment order where trial court did not comply with statute expressing explicit preference for representation by state Mental Health Advocacy Service, and rejecting as "untenable" the argument that trial court should be excused "since it did not know . . . whether the Service really existed"). *But cf.,* State *ex rel.* Memmel v. Mundy, 75 Wis.2d 276, 249 N.W. 2d 573 (1977) (setting out duties of adversary counsel in involuntary civil commitment cases).

There is now some empirical data suggesting that patients represented by public defender organizations generally obtain significantly more favorable outcomes in contested involuntary civil commitment cases than do patients represented by private counsel hired on short-term contracts. Mary Durham & John La Fond, *The Impact of Expanding a State's Therapeutic Commitment Authority*, *in* THERAPEUTIC JURISPRUDENCE: THE LAW AS A

B. The Significance of K.G.F.

One court that *has* noticed is the Montana Supreme Court. In *In the Matter of the Mental Health of K.G.F.*,[35] that court dramatically launched a rewriting of this area of the law. 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. 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.[37] The court ordered commitment. K.G.F.'s appeal was premised, in part, on allegations of ineffective assistance of counsel.[38]

In a thoughtful and scholarly opinion, the Montana Supreme Court relied on state statutory and constitutional sources to find that "the right to counsel . . . provides an individual subject to an involuntary commitment proceeding the right to effective assistance of counsel. In turn, this right affords the individual with the right to raise the allegation of ineffective assistance of counsel in challenging a commitment order."[39] In assessing what constitutes "effectiveness," the court — startlingly, to my mind — eschewed the *Strickland v. Washington* standard[40] (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 90-day commitment, must indefinitely bear the badge of inferiority of a once 'involuntarily committed' person with a proven mental disorder."[41] Interestingly, one of the key reasons why *Strickland* was seen as lacking was the court's conclusion that "reasonable professional assistance"[42] — 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

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THERAPEUTIC AGENT 121, 122 (David Wexler ed., 1990) (THERAPEUTIC JURISPRUDENCE); Mary Durham & John La Fond, *The Empirical and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395 (1985).

35 306 Mont. 1, 29 P.3d 485 (2001).

36 *Id.* at 488.

37 *Id.*

38 *Id.* at 489.

39 *Id.* at 491.

40 466 U.S. 668 (1984) (establishing weak effectiveness of counsel standard). *See generally* 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 2B-11.1.

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

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

generally disdains zealous, adversarial confrontation."[43]

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."[44] Such pre-hearing matters, the court continued, "clearly involve effective preparation prior to a hearing or trial."[45] The court further stressed state laws guaranteeing the patient's "dignity and personal integrity"[46] and "privacy and dignity"[47] as a basis for its decision; "'[q]uality counsel provides the most likely way — perhaps the *only* likely way' to ensure the due process protection of dignity and privacy interests in cases such as the one at bar."[48]

After noting that the focus of its condemnation was *not* assigned counsel in the case before it (but rather "the failure of the system as a whole that through the ordinary course of the efficient administration of a legal process threatens to supplant an individual's due process rights"),[49] the court again focused on the issue of dignity, quoting an article by Professor Bruce Winick:

> Perhaps nothing can threaten a person's belief that he or she is an equal member of society as much as being subjected to a civil commitment hearing" and when "legal proceedings do not treat people with dignity, they feel devalued as members of society."[50]

The court continued by considering the issues of prejudice, stereotyping, and stigma,[51] and specifically held that even pejorative language — the court here quoted a 1977 state Supreme Court case that had referred to persons with disabilities as "idiots and lunatics"[52] — was "repugnant to our state constitution."[53] Having set out this legal framework, the court observed that state statutes offered "little assis-

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[43] *K.G.F.*, 29 P.3d at 492 (citing Perlin, *supra* note 30, at 53-54 (identifying *Strickland* standard as "sterile and perfunctory" where "reasonably effective assistance" is objectively measured by the "prevailing professional norms")).

[44] *K.G.F.*, 29 P.3d at 492.

[45] *Id.*

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

[47] *Id.* at 493 (quoting MONT. CODE ANN. § 53-21-141(1)); *see also* MONT. CONST. art. II, § 4 ("the dignity of the human being is inviolable"). *See generally* Perlin, *Dignity*, *supra* note 14.

[48] *Id.* at 494 (citing Perlin, *supra* note 30, at 47).

[49] *Id.* at 494.

[50] *Id.* at 495 (quoting Winick, *supra* note 15, at 44-45).

[51] *Id.* at 495-96 (quoting Perlin, *supra* note 5, at 374; Winick, *supra* note 15, at 45).

[52] *Id.* at 495 (quoting Matter of Sonsteng, 175 Mont. 307, 573 P.2d 1149, 1153 (1977)).

[53] *Id.* at 495.

tance" in determining the scope of "effective counsel,"[54] and thus sought to give depth to the terse statutory language.

"At a bare minimum," the court observed, "counsel should possess a verifiably competent understanding of the legal process of involuntary commitments, as well as the range of alternative, less restrictive treatment and care options available."[55] In the initial investigation, counsel must "conduct a thorough review of all available records, . . . necessarily involv[ing] the patient's prior medical history and treatment, if and to what extent medication has played a role in the petition for commitment, the patient's relationship to family and friends within the community, and the patient's relationship with all relevant medical professionals involved prior to and during the petition process."[56]

Also, counsel should be prepared to discuss with his or her client "the available options in light of such investigations," as well as the "practical and legal consequences of those options."[57] It is "imperative," the court stressed, "that counsel request a reasonable amount of time for such an investigation prior to the hearing or trial on the petition."[58] Moreover, counsel "should also attempt to interview all persons who have knowledge of the circumstances surrounding the commitment petition, including family members, acquaintances and any other persons identified by the client as having relevant information, and be prepared to call such persons as witnesses."[59]

After similarly elaborating on counsel's role in the client interview and the need to insure that the patient understands the scope of the right to remain silent,[60] the court concluded by underscoring counsel's responsibilities "as an advocate and adversary."[61] The lawyer must "represent the perspective of the [patient] and . . . serve as a vigorous advocate for the [patient's] wishes,"[62] "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,"[63] and operating on the "presumption that a client wishes to not be involuntarily committed."[64] Thus, "evidence that counsel independently advocated or otherwise

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[54] *Id.* at 497.

[55] *Id.* at 498.

[56] *Id.*

[57] *Id.* (quoting *National Center for State Courts' Guidelines for Involuntary Civil Commitment,* 10 MENT. & PHYS. DIS. LAW RPTR., 409, 465 (Part E2) (1986) (*Guidelines*)).

[58] *Id.* at 498.

[59] *Id.* at 498-99.

[60] *Id.* at 499-500.

[61] *Id.* at 500.

[62] *Id.* at 500 (quoting *Guidelines, supra* note 57, Part E2, at 465).

[63] *Id.* at 500 (quoting *id.*, Part F5, at 483).

[64] *Id.* at 500.

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."[65] In conclusion, the court stated:

> It 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].[66]

Although, on one hand, *K.G.F.* provides an easily transferable blueprint for courts that want to grapple with adequacy of counsel issues in this context but are reluctant to explore totally uncharted waters, the decision remains the exception to the usual practice. Counsel's 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 mentally disabled individuals, many of whom have written carefully, thoughtfully and sensitively about these issues.[67] This inadequacy further reflects sanist practices on the part of the lawyers representing persons with mental disabilities, as well as the political entities vested with the authority to hire such counsel. Although a handful of articulate scholars take this question seriously,[68] the questions raised here do not appear to be a priority agenda item for litigators or for most academics writing in this area.

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[65] *Id.*

[66] *Id.* at 501.

[67] On the involvement of consumer groups in important patients' rights litigation, see 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, §1-2.1, at 10 n.43; Michael L. Perlin, *"Things Have Changed:" Looking at Non-Institutional Mental Disability Law Through the Sanism Filter,* 46 N.Y.L. SCH. L. REV. (forthcoming 2002-03). *See generally Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental Health System*, 11 J. MIND & BEHAV. 1-328 (1990) (symposium issue). *See generally infra* note 88.

[68] *See, e.g.*, Joshua Cook, *Good Lawyering and Bad Role Models: The Role of Respondent's Counsel in a Civil Commitment Hearing*, 14 GEO. J. LEGAL ETHICS 179 (2000); Stanley Herr, *The Future of Advocacy for Persons with Mental Disabilities*, 39 RUTGERS L. REV.. 443 (1987); Stanley Herr, *Representation of Clients with Disabilities: Issues of Ethics and Control*, 17 N.Y.U. REV. L. & SOC. CHANGE 609 (1991); 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); Paul Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 UTAH L. REV. 515; Steven Schwartz, *Damage Actions as a Strategy for Enhancing the Quality of Care of Persons with Mental Disabilities*, 17 N.Y.U. REV. L. & SOC. CHANGE 657 (1989-1990); Christopher Slobogin & Amy Mashburn, *The Criminal Defense Lawyer's Fiduciary Duty to Clients with Mental Disabilities*, 68 FORDHAM L. REV. 1581 (2000). *See also* Perlin, *supra* note 30, at 58-59 (recommending research agenda on this issue).

C. Sanism and Legal Representation

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. I will address each of these factors.[69]

1. Distrust of the Client

One of the basic building blocks of mental disability law is the principle that incompetence cannot be presumed either because of mental illness or because of a past record or history of institutionalization.[70] Furthermore, there is "no necessary relationship between mental illness and incompetency which renders [mentally ill persons] unable to provide informed consent to medical treatment."[71] As stated forcefully by the New York Court of Appeals:

> We conclude however, that neither the fact that appellants are

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[69] Certainly, many lawyers distrust and trivialize their non-mentally disabled clients as well. I believe, however, that the problems here are magnified for several overlapping reasons:

- It remains socially acceptable to treat persons with mental disabilities this way, at a time when we are, finally, becoming more enlightened about our sorry history of trivialization and disparagement of other minority groups.
- There are robust specialized bars and well-funded special interest groups willing to "go to bat" for members of *other* minority groups when their personhood is diminished by callous lawyers.
- The potential outcome of some mental disability cases – the way, for instance, that defendants on whom an insanity defense is imposed may spend far longer in maximum security custody than if they been convicted of the underlying criminal charges, *see, e.g.,* PERLIN, *supra* note 14, at 110-11 – makes the issues here even more problematic.

[70] *See, e.g., In re* LaBelle, 107 Wash.2d 196, 728 P.2d 138, 146 (1986); Perlin & Dorfman, *supra* note 14, at 210; Bruce Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL., PUB. POL'Y & L. 137, 151 n.80 (1996). *See also* Slobogin & Mashburn, *supra* note 68, at 1602, discussing the work of Professor Elyn Saks (*see* Elyn Saks, *Competency to Refuse Treatment,* 69 N.C. L. REV. 945, 948-61 (1991)):

> Professor Saks argues that requiring any degree of rationality beyond that demanded by the basic rationality standard is inappropriate, in light of the "pervasive influence of the irrational and the unconscious" in everyone's decision-making process. As she notes, "[p]sychiatrists and psychologists have demonstrated convincingly the ever-present influence of primitive hopes, wishes, and fears on the mental lives of us all." Under a heightened rationality test (as opposed to a "basic rationality" test), too many decisions would be considered incompetent. (footnotes omitted).

[71] Davis v. Hubbard, 506 F. Supp. 915, 935 (N.D. Ohio 1980); Perlin, *supra* note 19, at 113-14; Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection,* 28 HOUS. L. REV. 15 (1991).

> mentally ill nor that they have been involuntarily committed, without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical wellbeing.[72]

This reasoning is supported by the most important contemporary research. Publications by the MacArthur Foundation's Network on Mental Health and the Law dramatically conclude that mental patients are not always incompetent to make rational decisions and that mental patients are not inherently more incompetent than patients who are not mentally ill.[73] In fact, on "any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly than other patients and non-patients."[74]

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[75] — appears to be based on an empirical fallacy. Yet, lawyers distrust their clients with mental disabilities, both in cases in which mental disability is a central issue, and in those in which it is collateral. Lawyers assume, for example, that a criminal defendant with mental disabilities is not competent to decide whether to plead insanity or another fact-based defense.[76] Such lawyers apply an equivalent assumption of incompetency when representing civil clients with mental disabilities,[77] and that assumption certainly rears its head if the client is institutionalized.[78] Like

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[72] Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 79 (1986).

[73] Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study (III): Abilities of Patients To Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149 (1995) (discussed in Perlin & Dorfman, *supra* note 14, at 120).

[74] Grisso & Appelbaum, supra note 73, at 169.

[75] On this presumption in general, see Winick, *supra* note 70.

[76] *See, e.g.*, State v. Khan, 175 N.J.Super. 72, 417 A.2d 585 (App. Div. 1980) (when Public Defender heard Khan discuss "crazy" ideas, he insisted that Khan plead insanity, notwithstanding Khan's fact-based claim of self-defense) (I served as Khan's lawyer on appeal). Compare Slobogin & Mashburn, *supra* note 68, at 1631 (in more than one-third of insanity defense cases studied, "the attorneys appeared to have pre-empted their clients' participation in the decision-making process") (quoting Richard Bonnie et al., *Decision-Making in Criminal Defense: An Empirical Study of Insanity Pleas and the Impact of Doubted Client Competence*, 87 J. CRIM. L. & CRIMINOLOGY. 48, 57 (1996)).

[77] *See* Perlin, *Maggie's, supra* note 18, at 63 n.78 (citing sources).

[78] *See* Perlin & Dorfman, *supra* note 14, at 134 ("Ward psychiatrists demonstrate a propensity to equate incompetent with makes bad decisions and to assume, in face of statutory and case law, that incompetence in decision making can be presumed from the fact of institutionalization"); Brian Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. FORENS. SCI. 1442 (1993); Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 529 (1993). *See also* Dunlap, *supra* note 15, at 353 ("'healthful decision[making]' is not required of persons who are not mentally ill").

mental health professionals, these lawyers treat their clients as "patients that are sick."[79]

The attitudes displayed by such lawyers are echoed in some case law. On the question of the procedures to be employed in determining whether a witness is competent to testify, the influential case of *Sinclair v. Wainwright*[80] set out the controlling legal standards as follows:

> If a patient in a mental institution is offered as a witness, an opposing party may challenge competency, whereupon it becomes the duty of the court to make such an examination as will satisfy the court of the competency of the proposed witness. *Shuler v. Wainwright,* 491 F.2d 1213, [1223-24] (5th Cir. 1974). And if the challenged testimony is crucial, critical or highly significant, failure to conduct an appropriate competency hearing implicates due process concerns of fundamental fairness.

The assumption that institutionalization ought inevitably lead to a competency challenge is seriously flawed, as demonstrated by the relevant valid and reliable scientific research.[81] Yet, it is clear that some courts, at least, will continue to follow this doctrine, *sub silentio*, especially in criminal cases.

2. *Trivialization of the Client's Complaints*

Clients often have complaints. They complain about the way a case is progressing, the impact the litigation is having on their life, and a plethora of other matters, many of which are only tangentially connected to the lawyer-client relationship.

If a presumably mentally competent client complains to a lawyer, we can expect (or at least hope) that the lawyer will take the complaint relatively seriously, if for no other reason than that the failure to do so may trigger a disciplinary investigation. But if the client has a mental disability — or is perceived as having a mental disability — such complaints are often trivialized, ignored, or mocked.

How do I know this? For the thirty-plus years that I have been a member of the bar, devoting my practice and consultation almost exclusively to issues of mental disability law, I have witnessed such behavior and heard such comments by countless lawyers, many of whom (*e.g.*, criminal defense lawyers, civil legal aid lawyers) should know better (if for no other reason than that they regularly represent clients whose problems are not taken seriously by a large segment of society). I have no empirical data to share at this point, but can estimate —

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[79] BRUCE ARRIGO, PUNISHING THE MENTALLY ILL: A CRITICAL ANALYSIS OF LAW AND PSYCHIATRY 29-30 (2002).

[80] 814 F.2d 1516, 1522-1523 (11th Cir. 1987) (citation omitted).

[81] *See supra* text accompanying notes 73-75.

with absolute confidence — that hundreds of lawyers have expressed this view to me over the years. Clients with mental disabilities are seen as an annoyance, and their problems are simply not as "important" as are the problems of others.[82]

3. *Effects on the Lawyer–Client Relationship*

If lawyers do not take the clients or their legal problems seriously, the lawyers probably will not forge the sort of attorney-client relationship that is the aspirational goal of law practice. Certainly, doubting your client's competence (and/or veracity) and trivializing your client's complaints will not advance the building of such a relationship. Because persons with mental disabilities are trivialized as *persons,*[83] and the essence of their basic humanity is often questioned,[84] an adverse case outcome is simply not taken as seriously as it would be if the client were perceived to be mentally competent.

In problematic attorney-client relationships of this sort, lawyers will be prone to dismiss or ignore the client's view about the course of litigation, including, for example, the selection of a theory of the case, pre-trial discovery, case strategizing, choice of witnesses, structuring of cross-examination, and choice of remedy. Such suggestions are rarely taken seriously. There is some relevant criminal procedure case law on the right of a competent criminal defendant to refuse to plead

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[82] Perhaps I should be more charitable and acknowledge that these lawyers at least had the awareness to reach out and discuss the underlying issues with a colleague specializing in this area of the law. And I am grateful for that. Nonetheless, the rhetoric that is so often used ("Hey, Michael, I am representing a *real* whacko this time") suggests that I don't have to be *that* charitable.

[83] *Compare* HENRY STEADMAN & JOSEPH COCOZZA, CAREERS OF THE CRIMINALLY INSANE (1974).

[84] *See* Lessard v. Schmidt, 349 F. Supp. 1078, 1101-02 (E.D. Wis. 1971), *vac'd & remanded on other grounds*, 414 U.S. 473 (1974):

> [The] conclusion [that due process is mandated at involuntary civil commitment hearings] is fortified by medical evidence that indicates that patients respond more favorably to treatment when they feel they are being treated fairly and are treated as intelligent, aware, human beings.

See also Wyatt v. Stickney, 325 F. Supp. 781, 785 (M.D. Ala. 1971), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) ("To deprive any citizen of his or her liberty upon the altruistic theory that confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process"); Rennie v. Klein, 476 F. Supp. 1294, 1306 (D. N.J. 1979), *modified & remanded*, 653 F.2d 836 (3d Cir. 1981), *vac'd & remanded*, 458 U.S. 1119 (1982) ("Schizophrenics have been asked every question except, 'How does the medicine agree with you?' Their response is worth listening to," quoting Van Putten & Roy, *Subjective Response as a Predictor of Outcome in Pharmacotherapy*, 35 ARCH. GEN. PSYCHIATRY 477, 478-80 (1978)); Falter v. Veterans Administration, 502 F. Supp. 1178, 1184 (D. N.J. 1980) ("When I say that they are treated differently I am not referring to the substance of their medical or psychiatric treatment, I am referring to how they are treated as human beings").

not guilty by reason of insanity.[85] I have found no case law at all on this issue in a civil litigation context, but I do not think that the absence of such case law signifies the absence of a problem.

Another voice that is typically ignored is that of "psychiatric survivor groups."[86] For at least 25 years, formerly-hospitalized individuals and their supporters have formed an important role in the reform of the mental health system[87]and in test case litigation.[88] Yet, there is

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[85] *See, e.g., Khan,* 417 A.2d at 590. For a recent helpful review of all relevant cases, see Martin Sabelli & Stacey Leyton, *Train Wreck and Freeway Crashes: An Argument for Fairness and Against Self-Representation in the Criminal Justice System,* 91 J. CRIM. L. & CRIMINOLOGY. 161, 172, 173 & n.28, 174 (2000). For a thoughtful consideration of the mentally disabled client's autonomy in decision making in criminal cases, see Slobogin & Mashburn, *supra* note 68, at 1627-36. *See also* Linda Fentiman, *Whose Right Is It Anyway?: Rethinking Competency to Stand Trial in Light of The Synthetically Sane Insanity Defendant,* 40 U. MIAMI L. REV. 1109, 1136-37 (1986):

> Thus, the forcible medication of an insanity defendant with psychotropic drugs in order to eliminate the most overt symptoms of his mental illness and make him "competent" to stand trial violates his fundamental due process right to present a defense, because of its impact on both his trial demeanor and his ability to actively participate in the planning of trial strategy.

[86] *See generally* www.narpa.org.

[87] *See, e.g.,* 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), quoting Patricia Spindel & Jo Anne Nugent, *The Trouble with Pact: Questioning the Increasing Use of Assertive Community Treatment Teams in Community Mental Health* 2 <http://www.madnation.org/papcttrouble.htm> (citations omitted):

> Psychiatric survivors are frequent critics of the mental health system's heavy reliance on the biomedical approach: "For over twenty years, the biomedical approach has been repeatedly criticized by psychiatric survivor groups and numerous authors, as being too drug-oriented and too controlling."

[88] In such cases, survivor 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 ALTERNATIVES TO THE MENTAL HEALTH SYSTEM (1979) — is a major development that cannot be overlooked by participants in subsequent mental disability litigation. *See* Kenneth Byalin, *Parent Empowerment: A Treatment Strategy for Hospitalized Adolescents,* 41 HOSP. & COMMUN. PSYCHIATRY 89 (1990); Herbert S. Cromwell, Jr., et al., *A Citizens' Coalition in Mental Health Advocacy: The Maryland Experience,* 39 HOSP. & COMMUN. PSYCHIATRY 959 (1988) (discussing impact of citizens' groups on state budgetary process); Marc Galanter, *Zealous Self-Help Groups as Adjuncts to Psychiatric Treatment: A Study of Recovery, Inc.,* 145 AM. J. PSYCHIATRY 1248, 1253 (1988) (self-help group assessed as providing "meaningful help" to severely distressed ex-patients); Neal Milner, *The Right to Refuse Treatment: Four Case Studies of Legal Mobilization,* 21 LAW & SOC'Y REV. 447 (1987) (discussing impact of ex-patient groups on course of right to refuse treatment litigation); William Snavely, *Mental Illness: NAMI's View,* 39 HOSP. & COMMUN.

little evidence that these groups are taken seriously either by lawyers[89] or academics.[90]

D. *Ethical Issues*[91]

Even a cursory examination of the ethical issues permeating the representation of persons with mental disabilities readily evidences the omnipresence of sanism. To some extent, the fact that persons with mental disabilities have always been significantly underrepresented in all phases of the legal process[92] has led to the relegation of ethical issues to "the 'backburner' until other substantive and procedural issues involving the right to representation[93] and the means of providing such representation[94] are resolved more definitively."[95] Also, because of the nature of the subject matter, "the issues raised by investigating ethical standards in civil commitment representation may dredge up unconscious feelings which lead to avoidance — by clients, by lawyers, and by judges — of the underlying problems."[96] It is likely that, as more persons with mental disabilities are afforded diffuse legal representation,[97] the ethical issues will inevitably receive

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PSYCHIATRY 994 (1988) (letter to the editor)(explaining position of National Alliance for the Mentally Ill). The role of self-help groups is examined in detail in Howard Harp, *Taking a New Approach to Independent Living,* 44 HOSP. & COMMUN. PSYCHIATRY 413 (1993); Peter Margulies, *The Cognitive Politics of Professional Conflict: Law Reform, Mental Health Treatment Technology, and Citizen Self-Governance,* 5 HARV. J.L. & TECH. 25 (1992); Beth Tanzman, *An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services,* 44 HOSP. & COMMUN. PSYCHIATRY 450 (1993).

[89] *But see* Francoise Boudreau, *Partnership as a New Strategy in Mental Health Policy: The Case of Quebec,* 16 J. HEALTH POL., POL'Y & L. 307, 319 (1991); Susan Stefan, *The Two Worlds of Psychiatric Disability: "Discredited," "Discreditable," and the Identities of Disabled People,* WM. & MARY L. REV. (forthcoming 2003).

[90] One important exception is Shin Imai, *A Counter-Pedagogy for Social Justice: Core Skills for Community-based Lawyering,* 9 CLIN. 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).

[91] This section is generally adapted from 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 2B-8, at 227-29.

[92] 4 App., TASK PANEL REPORTS SUBMITTED TO THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 1353, 1366 (1978) (TASK PANEL REPORTS).

[93] *See, e.g.,* 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, §§ 2B-3 to 2B-3.2. *But see K.G.F.,* 29 P.3d at 492:

> "[R]easonable professional assistance" 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.

[94] *See, e.g.,* 1 PERLIN, MENTAL DISABILITY LAW, §§ 2B-4.1 to 2B-6.

[95] Perlin & Sadoff, *supra* note 25, at 163.

[96] *Id. See, e.g.,* Michael L. Perlin, *Psychiatric Testimony in a Criminal Setting,* 3 BULL. AM. ACAD. PSYCHIATRY & L. 143, 147-48 (1975).

[97] TASK PANEL REPORTS, *supra* note 92, at 1366-67.

a fuller airing.[98] But, because counsel's role traditionally has been so murkily defined and because the underlying ethical problems have been so widely ignored, the serious role and process conflicts[99] must be considered in detail so that the specific ethical questions can be addressed.[100]

E. Role of Counsel[101]

Although the U.S. Supreme Court has articulated clearly the role of counsel in criminal trials — "the constitutional requirement of substantial equality and fair process can only be attained where counsel acts in the role of an active advocate on behalf of his client, as opposed to that of *amicus curiae*"[102] — few courts[103] have ever examined closely the role of counsel (and his or her commensurate duties) in the civil commitment process or in the context of other representation of individuals with mental disabilities.[104] Although courts have acknowledged that there are substantial differences between representation in a criminal action and a juvenile delinquency pro-

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98 Perlin & Sadoff, *supra* note 25.

99 *See* 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, §§ 2B-8.2 to 2B-8.3.

100 *Compare* Samuel Jan Brakel, *Legal Schizophrenia and the Mental Health Lawyer: Recent Trends in Civil Commitment Litigation*, 6 BEHAV. SCI. & L. 3, 4 (1988) (characterizing much of then-recent patients' rights litigation as suffering from "florid legal schizophrenia," reflecting "aimless hyperactivity and aggressiveness, under which human problems are needlessly turned into legal battle, fought without regard to internal system costs, the larger societal interests, or even the best interests of the client").

For a typically under-litigated and under-considered issue, *compare* Matter of Grimes, 193 Ill. App.3d 119, 549 N.E.2d 616 (App. 1990) (where record did not indicate whether attorney had been appointed for involuntarily committed patient as of date that hearing was scheduled, as statutorily required, or as of date of hearing, court deemed appointment to have been made in compliance with statute) *with* Matter of Johnson, 191 Ill. App.3d 93, 546 N.E.2d 1176 (App. 1989) (commitment order reversed where trial judge appointed counsel on date of hearing rather than on date when court selected hearing date).

101 This section is generally adapted from 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 2B-8.1, at 229-37.

102 Anders v. California, 386 U.S. 739, 744 (1967). *See also* Pullen v. State, 802 So.2d 1113 (2001) (*Anders* procedure for withdrawal of counsel in criminal proceedings applies to involuntary civil commitments).

103 Three notable earlier exceptions are Quesnell v. State, 83 Wash.2d 224, 517 P.2d 568 (1974); State *ex rel.* Hawks v. Lazaro, 157 W.Va. 417, 202 S.E.2d 109 (1974); and State *ex rel.* Memmel v. Mundy, 75 Wis.2d 276, 249 N.W.2d 573 (1977). For the most recent important case, *see K.G.F.*, 29 P.3d 485, discussed *supra* text accompanying notes 35-66.

104 For an analysis of the American Bar Association's MODEL RULES as they apply to this population, see 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, §§ 2B-10 to 2B-10.2.

I focus here primarily on involuntary civil commitment hearings, as my experience suggests that these are the sort of civil mental disability law case most likely to be assigned in clinical settings. *See generally* JAMES A. HOLSTEIN, COURT-ORDERED INSANITY: INTERPRETIVE PRACTICE AND INVOLUNTARY COMMITMENT (1993); James A. Holstein, *Court Ordered Incompetence: Conversational Organization in Involuntary Commitment Hearings*, 35 SOC. PROBLEMS 458, 459 (1988).

ceeding,[105] the courts — with one important exception[106] — generally have failed to recognize the additional "lawyering qualities"[107] required to represent a person with mental disabilities.[108] An examination of the attorney's duties in such representation, however, reveals that there are *greater* obligations here than in other types of litigation or in other counseling situations. Think about the impact this has in clinical teaching and practice settings.

First, the attorney's initial interview with a person facing civil commitment is usually conducted on alien territory, a factor that may "shape interview content."[109] The first principle of interviewing is that the interview room "should not be threatening, noisy or distracting."[110] When initial interviews are typically held randomly in corners of crowded wards[111] — in a context dramatically unlike that of the prototypical attorney-client office interview[112] — the interviewee often may become "suspicious, terrified, puzzled or simply distrustful of the attorney."[113] Also, just as "examiner bias"[114] is prevalent in the doctor-patient interview, it likely pervades this attorney-client relationship as well.

Second, the attorney's investigation will differ from that of "ordinary cases."[115] The ability to read and understand medical charts[116]

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[105] *See, e.g.,* Miller v. Quatsoe, 332 F. Supp. 1269, 1275 (E.D. Wis. 1971) ("These differences—the need to investigate an entire life, to devise a plan for a useful future and the maturity of his client—emphasize *lawyering qualities which require time to germinate in each case* rather than those qualities which come reflexively to the experienced attorney.") (emphasis added).

[106] *See* K.G.F., 29 P.3d 498, discussed *supra* text accompanying notes 35-66.

[107] *Id.*

[108] *But see id.* at 490-95 (listing duties of counsel in involuntary civil commitment case, including detailed investigations and comprehensive client interviews). One of the leading theoretical commentaries states: "Once the adversary nature of the lawyer's role is reestablished in commitment proceedings, *his role in operational terms resembles that in ordinary cases.*" Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework,* 84 YALE L.J. 1540, 1562 (1975) (emphasis added). For an excellent review of the pertinent issues, see Cook, *supra* note 68.

[109] ERVING GOFFMAN, ASYLUMS 13 (1961); Perlin & Sadoff, *supra* note 25, at 169 (*citing* Lockwood, *How to Represent a Client Facing Civil Commitment,* 26 PRACTICAL LAW. 51, 54 (1980)).

[110] ALFRED BENJAMIN, THE HELPING INTERVIEW 3 (1969).

[111] *See, e.g.,* ROSEMARY BALSAM & ALAN BALSAM, BECOMING A PSYCHOTHERAPIST: A CLINICAL PRIMER 28 (1974).

[112] *See, e.g.,* Steven G. Fey & Steven Goldberg, *Legal Interviewing from a Psychological Perspective: An Attorney's Handbook,* 14 WILLAMETTE L.J. 217, 233-34 (1978)

[113] Perlin & Sadoff, *supra* note 25, at 170. A leading psychotherapy text notes that even a change in office location "may be particularly upsetting for a borderline psychotic or psychotic patient." BALSAM & BALSAM, *supra* note 111, at 30.

[114] *I.e.,* doctors tend to assign more "favorable" diagnostic labels to wealthier patients. *See, e.g.,* JAMES PAGE, PSYCHOPATHOLOGY: THE SCIENCE OF UNDERSTANDING DEVIANCE 164 (1971).

[115] Perlin & Sadoff, *supra* note 25, at 170 n.76:

and the ability to communicate with mental disability professionals[117] are essential aspects of the investigation of virtually every case involving a person who is putatively mentally disabled and facing civil commitment. Also, attorneys will need to employ independent psychiatric (or other medical disability) experts[118] in a significant percentage of such cases.

Third, while attorneys need to develop special skills and sensitivities in interviewing witnesses in *any* case,[119] these skills must be more finely honed and sensitivities heightened in cases involving the interviewing of mental disability professionals and mentally disabled persons with regard to events leading to hospitalization and the fact of hospitalization itself.[120]

Fourth, the attorney must be able to assume responsibility for answering "classic social service"[121] questions regarding the range of alternatives to inpatient hospitalization of the client — questions that likely will play a significant factor in the court's disposition of the case:

> What halfway houses, community mental health centers, or patient-run alternatives are available? What economic benefits and entitlements might the patient receive outside the hospital? Is the alternative program one likely to survive economically in the coming budget cuts? Is the program one specifically suited for persons with

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> The lawyer must be highly aware of "hidden agenda" issues. Such hidden agendas — always a possibility in any case — may be more subtle and nefarious in commitment cases. Is the commitment hearing a cover for a divorce matter or a child custody dispute? Is the case simply a "back door" way of dealing with an adolescent with a drug problem or of attempting to avert a marriage unwanted by other family members? A lawyer's "lawyering" instincts must be at their highest level to ferret out such issues within issues.

See generally Michael L. Perlin, *Representing Individuals in the Commitment and Guardianship Process, in* 1 LEGAL RIGHTS OF MENTALLY DISABLED PERSONS 497, 514-15 (Paul Friedman ed., 1979).

[116] *See Practice Manual: Preparation and Trial of a Civil Commitment Case*, 5 MENT. DIS. L. REP. 281, 285-87 (1981) (*Preparation*); *See generally Guidelines*, *supra* note 57, at 476 (Guideline E6):

> Effective legal representation of a respondent requires that the respondent's attorney have free and immediate access to all pertinent documents, including, but not limited to, the commitment petition, the detention order, the police report, other documents used to initiate commitment proceedings, the screening report, the pre-hearing examination reports, and the medical records of the respondent. Because hearings in civil commitment cases occur much sooner than hearings in most civil cases, discovery should be expedited and not be impeded by restrictive procedures and time limits that generally apply in civil proceedings.

[117] *See generally* ANDREW WATSON, PSYCHIATRY FOR LAWYERS (2d ed. 1976).

[118] Such an expert will probably be "the single most valuable person to testify on behalf of a client in a contested commitment hearing." *Preparation, supra* note 116, at 289.

[119] *See, e.g.,* GARY BELLOW & BEATRICE MOULTON, THE LAWYERING PROCESS 32-157 (1981).

[120] *See, e.g.,* WATSON, *supra* note 117, at 16-27.

[121] Perlin & Sadoff, *supra* note 25, at 170.

the client's condition?[122]

Counsel also must explore all likely outcomes of the commitment hearing[123] and advise the client of all possible dispositions.[124] Because of the more open-ended dispositional phase of the commitment process, the range of outcomes here is often significantly greater than in "ordinary cases."

Fifth, because the prosecution of a civil commitment case often involves multiple parties — hospital staff, the community authority, a patient's family[125] — an attorney often must conduct simultaneous multiple negotiation with parties and nonparties,[126] who often "have radically differing views as to [an individual case's] appropriate disposition."[127] Although "the likelihood of success at this stage is demonstrably greater than at any other,"[128] the demands made on the attorney to develop appropriate negotiation skills[129] are commensurately greater.

Sixth, the attorney's lawyering skills at the commitment hearing must be heightened for at least three overlapping reasons. Because so many of the procedural issues raised by commitment have so rarely been litigated, each contested hearing becomes, to some extent, a "case of first impression,"[130] and a court's procedural decision there-

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[122] *Id.* Of course, if the patient can "surviv[e] safely in freedom," O'Connor v. Donaldson, 422 U.S. 563, 575 (1975), without *any* alternative treatment, "it is *not* the lawyer's role to attempt to impose such treatment over his client's objection." Perlin & Sadoff, *supra* note 25, at 170 (emphasis in original).

[123] *See, e.g.,* Perlin & Sadoff, *supra* note 25, at 170-71 (attorney's role in discussing option of voluntary commitment is analogized to criminal defense counsel's exploration of guilty plea option, *see, e.g.,* McMann v. Richardson, 397 U.S. 759, 768-71 (1970)).

[124] For example, a client may not meet threshold income or residency eligibility requirements for a specific outpatient placement.

[125] *See, e.g.,* N.C. GEN. STAT. § 122C-261 (1997). *Compare* Heller v. Doe, 509 U.S. 312 (1993) (Kentucky statute granting relatives party status at involuntary civil commitment hearings is not unconstitutional).

[126] To some extent, the commitment process here approximates Prof. Chayes' model of public law litigation. *See, e.g.,* Abraham Chayes, *The Role of the Judge in Public Law Litigation,* 89 HARV. L. REV. 1281 (1976).

[127] Perlin & Sadoff, *supra* note 25, at 171.

[128] *Preparation, supra* note 116, at 288. For a statistical confirmation, see Y. Kumasaka & J. Stokes, *Involuntary Hospitalization: Opinions and Attitudes of Psychiatrists and Lawyers,* 13 COMPREHEN. PSYCHIATRY 201 (1972) (over 40% so released); Perlin, *supra* note 115, at 510; Michael L. Perlin, *Mental Patient Advocacy by a Patient Advocate,* 54 PSYCHIATRIC Q. 169, 171 (1982) (over six-year period, almost 29% of all patients represented released to community following entry of advocacy agency as counsel, but prior to formal hearing).

[129] *See generally* ROGER FISHER & WILLIAM URY, GETTING TO YES (2d ed. 1991).

[130] *See, e.g., In re* Watson, 91 Cal. App.3d 455, 154 Cal. Rptr. 151 (1979) (challenging exclusion of patient from commitment hearing); *In re* James, 67 Ill. App.3d 49, 384 N.E.2d 573 (1978) (same); Hashimi v. Kalil, 388 Mass. 607, 446 N.E.2d 1387 (1983) (enforcing statutory time limits for filing petition). *See generally* 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, chapter 2C (discussing other procedural litigation in involuntary civil commit-

fore will have far greater "ripple effects" than in more coherently developed areas of the law.[131] Because of the nature of the proceeding, attorney-client disputes over such issues as whether a certain witness should be called to the stand or whether the patient should testify[132] will likely be heightened, again requiring more sophisticated counseling skills on the attorney's part.[133] Finally, because the court will often be poorly informed as to both substantive and procedural commitment law,[134] the attorney will need to *educate* the court as to the law's nuances.[135]

Seventh, because case dispositions do not fit into a "discrete paradigm,"[136] "there is a far greater burden on the attorney to seek dispositional alternatives than in an ordinary case."[137] A vivid example is that of New Jersey's first "discharged pending placement" (DPP) cases, in which counsel had to assume a heightened role.[138]

Eighth, the attorney should be available for representation at periodic review hearings and appeals. Counsel also should be available

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ment cases).

131 For a general discussion of this issue in a public interest law context, see MICHAEL MELTSNER & PHILIP SCHRAG, PUBLIC INTEREST ADVOCACY: MATERIALS FOR CLINICAL LEGAL EDUCATION (1974).

132 *See, e.g.,* Tyars v. Finner, 518 F. Supp. 502 (C.D. Cal. 1981), *rev'd,* 709 F.2d 1274 (9th Cir. 1983); Cramer v. Tyars, 23 Cal. 3d 131, 588 P.2d 793, 151 Cal. Rptr. 653 (1979); State v. Mathews, 46 Or. App. 757, 613 P.2d 88 (1980), *cert. denied,* 450 U.S. 1040 (1981).

133 *See, e.g.,* BINDER & PRICE, *supra* note 33, at 192-210.

134 In a North Carolina study, fewer than 20% of judges approved of an adversarial model for commitment hearings, *see* Hiday, *supra* note 26, at 1037.

135 *Cf., e.g.,* ROBERT L. SADOFF, FORENSIC PSYCHIATRY: A PRACTICAL GUIDE FOR LAWYERS AND PSYCHIATRISTS 35, 47-48 (1985).

136 *See* Perlin & Sadoff, *supra* note 25, at 166-67.

137 *Id.* at 172 (*citing, in part,* NICHOLAS KITTRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY (1973) (footnotes omitted)):

> While a court-appointed probation officer in the criminal process is specifically charged with finding and monitoring alternatives to incarceration, such officials are rarely present in the commitment process. The impact of "transitional service" social staff at hospitals on structuring such alternatives has been little studied but the findings of such a study would probably show little impact on the day-to-day functioning of the commitment process. Individual courts may consider the full range of social, educational, and religious agencies and may find an acceptable alternative to the commitment process. Such possibilities place a burden on the attorney to search out and study such possible placements for his client, while at the same time avoiding the excesses of what Kittrie has termed "The Therapeutic State."

138 *See* Matter of S.L., 94 N.J. 128, 462 A.2d 1252 (1983). *See also* 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 2C-6.3 (discussing DPP status and the successor "conditions extended placing placement" (CEPP) status in general), and Michael L. Perlin, *Discharged Pending Placement": The Due Process Rights of the Institutionalized Mentally Handicapped With "Nowhere To Go," in* 5 DIRECTIONS IN PSYCHIATRY, Lesson 21 (1985), reprinted in 4 THE SCHIZOPHRENIAS 210 (Frank Flach ed., 1988) (discussing DPP status); *In re* Commitment of B.L., 346 N.J. Super. 285, 787 A.2d 928 (App. Div. 2002) (discussing CEPP status).

to provide legal services in such "collateral" matters[139] as the patient's right to treatment, right to refuse treatment, and protection of civil rights while institutionalized.[140]

F. Counsel's Role[141]

Counsel's role also must be considered through a series of other filters: the reality that legal rights are not implicitly self-executing; the myth that adequate counsel is regularly available to all individuals with mental disabilities; the need for counsel to serve an educative function for the court; the impact of counsel on the vindication of collateral legal rights; and the significance of counsel in the confrontation of other related moral, social and political issues that flow from the trial process when individuals with mental disabilities are at risk.

1. Rights Are Not Self-executing

Legal rights are not necessarily self-executing.[142] A court's declaration of a right "to" a service or a right to be free "from" an intrusion does not *in se* provide that service or guarantee such freedom from intrusion. A right is only a paper declaration without an accompanying remedy.[143] Without counsel to guarantee enforcement, the rights "victories" that have been won in test case and law reform litigation in this area are unlikely to have any real impact on persons with mental disabilities.[144]

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[139] An early and helpful analysis is suggested in Robert J. Golten, *Role of Defense Counsel in the Criminal Commitment Process,* 10 AM. CRIM. L. REV. 385, 408-09 (1972). For other considerations, *see* James Cohen, *The Attorney-Client Privilege, Ethical Rules, and the Criminal Defendant*, 52 U. MIAMI L. REV. 529 (1998); Slobogin & Mashburn, *supra* note 68.

[140] On the interplay of the adjudication of treatment rights and the commitment hearing, see *In re* D.J.M., 158 N.J. Super. 497, 386 A.2d 870 (App. Div. 1978), discussed in 1 PERLIN, MENTAL DISABILITY LAW *supra* note 2, § 2C-8.1, at 507-08.

[141] This section is generally adapted from Perlin, *supra* note 30.

[142] Bruce Winick, *Restructuring Competency to Stand Trial,* 32 UCLA L. REV. 921, 941 (1985). *See also* Grant Morris & J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1, 8 (1993).

[143] *See generally* Donald Zeigler, *Rights Require Remedies: A New Approach to the Enforcement of Rights in the Federal Courts,* 38 HASTINGS L.J. 665 (1987) (Zeigler, *New Approach*). *See also* Donald Zeigler, *Rights, Rights of Action, and Remedies: An Integrated Approach*, 76 WASH. L. REV. 67 (2001). According to Professor Zeigler:

> [A] right without a remedy is not a legal right; it is merely a hope or a wish. . . . Unless a duty can be enforced, it is not really a duty; it is only a voluntary obligation that a person can fulfill or not at his whim. . . .
>
> . . . Rights promote well-being in the broadest sense. They secure the dignity and the integrity of human beings. . . . Rights give people control over their lives and are essential to self-respect.

Zeigler, *New Approach, supra,* at 678-79 (footnotes omitted).

[144] Three examples should suffice. In 1972, the Supreme Court decided in *Jackson v.*

2. *The Myth of Adequate Counsel*

The development of organized and regularized counsel programs has given rise to the supposition that such counsel is regularly available to persons with mental disabilities in individual matters involving their commitment to, retention in and release from psychiatric hospi-

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Indiana that it violates due process to commit an individual awaiting criminal trial for more than the "reasonable period of time" needed to determine "whether there is a substantial chance of his attaining the capacity to stand trial in the foreseeable future." 406 U.S. 715, 733 (1972). Yet, thirteen years later, Professor Bruce Winick reported that, in almost half of the states, *Jackson* had yet to be implemented, and the pre-*Jackson* problem of overlong commitments "still persist[ed]." Winick, *supra* note 142, at 940; *see also* RONALD ROESCH & STEPHEN GOLDING, COMPETENCY TO STAND TRIAL 121-26 (1980); Barbara Weiner, *Mental Disability and the Criminal Law, in* SAMUEL J. BRAKEL ET AL, THE MENTALLY DISABLED AND THE LAW 693, 704 (3d ed. 1985). A decade after Winick published his article, Morris and Meloy reported that *Jackson* remains "ignored [and] circumvented." Morris & Meloy, *supra* note 142, at 8.

In another setting, even though the District of Columbia Code permits patients seek either periodic review of their commitment or an independent psychiatric evaluation, evidence developed in an important case has revealed that, in twenty-two years following the enactment of the relevant provision, not a single patient exercised the rights to this statutory review. Streicher v. Prescott, 663 F. Supp. 335, 343 (D. D.C. 1987). S*ee generally* 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, 133 (1991). *See also* David Wexler, *The Waivability of Recommitment Hearings,* 20 ARIZ. L. REV. 175, 176-78 (1978) (discussing problems inherent in patient-initiated review mechanisms).

Similarly, hard-fought institutional reform "victories" in cases declaring broad rights to treatment had little "real world" impact because there were no lawyers available to ensure that the decisions would be properly implemented. For discussion of the implementation of the broad staffing orders in the landmark right to treatment case of Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala.), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974), see WYATT V. STICKNEY: RETROSPECT AND PROSPECT (L.R. Jones & R. Parlour, eds., 1981); Joseph O'Reilly & Bruce Sales, *Setting Physical Standards for Mental Hospitals: To Whom Should the Courts Listen?,* 8 INT'L J.L. & PSYCHIATRY 301 (1986); Joseph O'Reilly & Bruce Sales, *Privacy for the Institutionalized Mentally Ill: Are Court-Ordered Standards Effective?,* 11 LAW & HUMAN. BEHAV. 41 (1987). S*ee generally* 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, Chapter 3A. The litigation in *Wyatt* finally concluded less than three years ago. *See* Wyatt v. Sawyer, 105 F. Supp. 2d 1234 (M.D. Ala. 2000).

There are many other equivalent examples involving potential collateral actions. Although several cases have recognized patients' right to vote, *see, e.g.,* Doe v. Rowe, 156 F. Supp. 2d 35, 21 NDLR P 155 (D. Me. 2001); Boyd v. Board of Registrars of Voters of Belchertown, 368 Mass. 631, 334 N.E.2d 629 (1975); Carroll v. Cobb, 139 N.J. Super. 439, 354 A.2d 355 (App. Div. 1976), this right becomes an empty shell if, for instance, there is no staff worker available to drive the patient to a poll; counsel could insure vindication of this right by filing a supplemental action to order the hospital to provide such transportation, *compare* Reiser v. Prunty, 224 Mont. 1, 727 P.2d 538, 547 (1986) (hospital and psychiatrist had no responsibility to protect constitutional right to vote of patient detained under emergency detention statute). Similarly, a court order mandating the constitutional right to visitation, *see, e.g.,* Schmidt v. Schubert, 422 F. Supp. 57, 58 (E.D. Wis. 1976), becomes meaningless if a hospital announces that it cannot provide adequate staff to implement such visitation rights; again, counsel would be needed to insure an enforceable remedy.

tals.[145] But, this appearance of general availability is largely illusory.[146] Moreover, such representation is rarely available in a systemic way in law reform or test cases and is rarely provided in any systemic way in cases that involve counseling or negotiating short of actual litigation.[147]

Empirical surveys consistently show that quality of counsel is the single most important factor in the disposition of cases in involuntary civil commitment systems and in the trial of mentally disabled criminal defendants. It is only when counsel is provided in an organized, specialized and regularized way that there is more than a random chance of lasting, systemic change. Yet, few states appear willing to provide such counsel in such a manner.

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,[148] 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.[149] Signifi-

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[145] *See, e.g.,* Alan Stone, *The Myth of Advocacy,* 30 HOSP. & COMMUN. PSYCHIATRY 819, 821-22 (1979) (charging that a "one-sided advocacy system" exists in which patients are regularly represented by zealous and conscientious lawyers); *see also, e.g.,* French v. Blackburn, 428 F. Supp. 1351, 1357 (M.D.N.C. 1977), *aff'd,* 443 U.S. 901 (1979) (rejecting plaintiff's assumption that lawyer in involuntary civil commitment case will not act in client's best interest).

[146] *See* M.C. Olley & James Ogloff, *Patients' Rights Advocacy: Implications for Program Design and Implementation,* 22 J. MENT. HEALTH ADMIN, 368, 369 (1995). *See generally K.G.F.,* 29 P.3d 485.

[147] *See, e.g.,* Washington v. Harper, 494 U.S. 210, (1990) (counsel is not required in hearing to determine whether prisoner has right to refuse involuntary administration of psychotropic medication); Vitek v. Jones, 445 U.S. 480, 500 (1980) (Powell, J., concurring) (counsel is not required in hearing to determine whether prison inmate should be transferred to state psychiatric hospital);

Statistics compiled by the National Institute of Mental Health regarding the provision of counsel by P&A systems to institutionalized individuals suggest that class-action type cases were instituted in fewer than half of all jurisdictions in fiscal year 1989. *FY 1989 Report on Activities Under PL 99-319, the Protection and Advocacy for Mentally Ill Individuals Act* 61, Table 9 (1990).

On the variance in representation in right to refuse treatment cases, see Perlin & Dorfman, *supra* note 14.

[148] As of April 1, 2000, Virginia's population was 7,078,515, while Minnesota's was 4,919,479.

[149] Ingo Keilitz et al., *A Study of the Emergency Mental Health Services and Involuntary Civil Commitment Practices in Virginia* 47 (1989). While Minnesota court rules command patients' counsel to "advocate vigorously" on behalf of their clients, *see* MINN. R. COMMITMENT, Rule 4.01 (1997), there is no comparable provision in Virginia law, *cf.* VA. STAT. § 19.2-169.5 (2002) (role of counsel in raising insanity in criminal proceedings).

Compare K.G.F., 29 P.3d at 498-500 (constitutionally mandating adherence to Commitment Guidelines E5, E 2 and F5 *(see Guidelines, supra* note 57), on client interviews, the attorney's advocacy function, and the attorney's role in the courtroom).

cantly, Minnesota has a tradition of providing vigorous counsel to persons with mental disabilities,[150] while Virginia does not.[151]

3. *Counsel's Educative Function*

The presence of structured counsel — of lawyers supported by mental health professionals — also serves an important internal educative function by making it more likely that all participants in the mental disability trial process, including judges, are sensitized to the social, cultural and political issues involved in representation of such a marginalized class.[152] The disappointing results reported nearly 25 years ago by Dr. Norman Poythress — that merely training lawyers about psychiatric techniques and psychological nomenclature made little difference in ultimate case outcome[153] — reveal that education about the law and the clinical details of mental illness are not enough. Counsel must be attitudinally and ethically[154] educated if they are to provide truly adequate representation.

4. *Implementation of Collateral Rights*

If counsel is not adequate, it is unlikely that attorneys will vigor-

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[150] Under MINN. R. COMMITMENT, Comment to Rule 4.07 (1997):

A. All proceedings under the [Act] are adversarial. Minimum adversary representation ordinarily includes, but is not limited to:

1. being familiar with statute and case law and court rules which govern commitment proceedings; and
2. interviewing respondent no later than 24 hours after confinement . . .; and
3. reviewing respondent's medical records . . . early enough to insure sufficient time to investigate and secure additional medical evaluations, and/or prepare for the hearings; and
4. contacting or interviewing all persons whose testimony might tend to support respondent's position and subpoenaing witnesses if necessary; and
5. investigating alternatives less restrictive than those sought in the petition; and
6. attempting to interview prior to the hearing any persons who might testify for the petitioner at the hearing; and
7. informing respondent of the latter's rights, including the right to appeal.

B. [This rule] is intended to insure that once appointed, the same lawyer will continue to represent respondent

[151] *See* Keilitz et al., *supra* note 149, at 39-45, and especially at 42 ("Given the absence of a district attorney representing the Commonwealth, or an attorney representing the petitioner, commitment proceedings are at best, quasi-adversarial").

[152] *See generally* Perlin & Sadoff, *supra* note 25, at 168-73.

[153] Poythress concluded that the "trained" lawyers' behavior in court was not materially different from that of "untrained" lawyers because the former group's attitudes toward their clients had not changed. Mere knowledge of cross-examination methods, he noted, "did not deter them from taking [the] more traditional, passive, paternal stance towards the proposed patients." Poythress, *supra* note 28, at 15. As one trainee noted: "I really enjoyed your workshop, and I've been reading over your materials and its [*sic*] all very interesting, but this is the real world, and we've got to do something with these people. They're sick." *Id.*

[154] *See* DAVID WEXLER, MENTAL HEALTH LAW 111 n.55 (1981).

ously seek to execute and implement other collateral rights. In *Ake v. Oklahoma,* for instance, the U.S. Supreme Court ruled that a criminal defendant who makes a threshold *ex parte* showing that his or her sanity at the time of the offense is likely to be a "significant factor" at trial is constitutionally entitled to state funded psychiatric assistance.[155] But because *Ake* generally has been read narrowly and with little creativity,[156] the rationale of Justice Marshall's opinion — that psychiatrists will assist lay jurors "to make a sensible and educated determination" about the defendant's medical condition at the time of the offense[157]— has rarely been fulfilled. If litigants with mental disabilities were afforded more adequate counsel, *Ake* probably would have been implemented in a manner that was truer to the spirit of the Supreme Court's decision.[158]

5. *Other Moral, Social and Political Issues*

Adequate counsel also is needed to deal with other collateral moral, social and political issues that, to an important degree, affect legal and public decision-making in this area.[159] These include issues such as the "dilemma of the moral clinician,"[160] the impact of pretextuality on the mental disability trial process,[161] the degree to which

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155 470 U.S. 68, 74 (1985).

156 *See generally* 3 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 10-4.3, at 431-39 (2d ed. 2000), and cases cited in *id.* at nn.635-80.

157 *Ake,* 470 U.S. at 80.

158 *See, e.g., In re* Brown, 1986 WL 13385 (Ohio Ct. App. Nov. 26, 1986), (child custody); Interest of Goodwin, 366 N.W.2d 809, 814-15 (N.D. 1985) (civil commitment case); Matter of Sanders, 108 N.M. 434, 773 P.2d 1241, 1246 (Ct. App. 1989) (treatment guardianship revocation). *Goodwin* is considered in Interest of R.M., 555 N.W.2d 798 (N.D. 1996).

For early consideration of the implementation of *Ake* in general, see Pamela Casey & Ingo Keilitz, *An Evaluation of Mental Health Expert Assistance Provided to Indigent Criminal Defendants: Organization, Administration, and Fiscal Management,* 34 N.Y.L. SCH. L. REV. 19 (1989). On the related ethical implications of *Ake,* see Paul Appelbaum, *In the Wake of* Ake: *The Ethics of Expert Testimony in an Advocate's World,* 15 BULL. AM. ACAD. PSYCHIATRY & L. 15 (1987); Stephen Rachlin, *From Impartial Expert to Adversary in the Wake of* Ake, 16 BULL. AM. ACAD. PSYCHIATRY & L. 25 (1985). For a more recent inquiry, see Amber McGraw, *Life But Not Liberty? An Assessment of Noncapital Indigent Defendants' Rights to Expert Assistance under the Ake v. Oklahoma Doctrine,* 79 WASH. U. L.Q. 951 (2001).

159 *See, e.g.,* Perlin, *OCS, supra* note 14; Michael L. Perlin, *Power Imbalances in Therapeutic and Forensic Relationships,* 9 BEHAV. SCI. & L. 111 (1991).

160 *See, e.g.,* Perlin, *supra* note 144, at 135-36 (considering evidence suggesting that, in response to legislative actions tightening involuntary civil commitment criteria, some forensic mental health professionals responded that such mandates could be ignored if they conflicted with the witnesses' "moral judgment").

161 *Id.* at 133-35 (referring to the dramatic tension between those subject matter areas in which courts accept dishonesty and those in which they appear to erect insurmountable barriers to guard against what is perceived as malingering, feigning or other misuse of the legal system). *See generally* PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 59-75; Michael L. Perlin, *"There's No Success Like Failure/And Failure's No Success at All": Exposing the*

"ordinary common sense" drives decision-making by judges and jurors in such cases,[162] and the pervasiveness of heuristic biases in such decision-making.[163] If these issues are not confronted by counsel, it is likely that the pervasive cognitive and behavioral biases infecting decision-making in this area will continue to go unnoticed and unabated.[164]

It is apparent, therefore, that the role of counsel in the representation of persons with mental disabilities is multi-textured and continually evolving. Systemic decision-makers need to acknowledge the complexity of this role, the historic shortcomings of sporadic counsel serving the population in question, and possible remedies for the long-standing systematic problems. Yet, scant attention has been paid — by judges,[165] by scholars,[166] and practicing lawyers[167] — to the questions that I have posed here. This is a topic that appears — inexplicably — "off the table" for purposes of legal discourse. This contrasts — sharply and sadly — with the legal academy's interest in parallel issues that affect women, people of color, and other minorities.[168] In the following section, I explore some of the possible explanations for this "disconnect."

Pretextuality of Kansas v. Hendricks, 92 Nw. U. L. REV. 1247 (1998).

162 *See, e.g., Perlin,* OCS, *supra* note 14, at 22-39. This concept is examined in detail in Richard Sherwin, *Dialects and Dominance: A Study of Rhetorical Fields in Confessions,* 136 U. PA. L. REV. 729 (1988). I have returned to this topic recently in a criminal law context in Perlin, *Neonaticide, supra* note 14.

163 Perlin, *OCS, supra* note 14, at 12-22 (referring to simplifying cognitive devices that frequently lead to distorted and systematically erroneous decisions due to ignoring or misuse of rationally useful information). *See generally* Michael Saks & Robert Kidd, *Human Information Processing and Adjudication: Trial by Heuristics,* 15 LAW & SOC'Y REV. 123 (1980-81).

164 The "therapeutic jurisprudence" scholarship should lead participants in the system to critically weigh the therapeutic (or anti-therapeutic) effects of the mental disability system. *See* THERAPEUTIC JURISPRUDENCE, *supra* note 34; Mary Berkheiser, *Frasier Meets CLEA: Therapeutic Jurisprudence and Law School Clinics*, 5 PSYCHOL., PUB. POL'Y & L. 1147 (1999); Gould & Perlin, *supra* note 7. *See infra* text accompanying notes 195-200. Adequate counsel is needed to insure consideration of the therapeutic potential inherent in mental disability litigation. *See, e.g.,* John Ensminger & Thomas Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential,* 6 J. PSYCHIATRY & L. 5 (1978), *reprinted in* THERAPEUTIC JURISPRUDENCE, *supra* note 34, at 245.

165 *But see K.G.F.,* 29 P.3d 485.

166 *But see* Cook, *supra* note 68; Slobogin & Mashburn, *supra* note 68.

167 *But see, e.g.*, Deborah A. Dorfman, *Effectively Implementing Title I of the Americans with Disabilities Act for Mentally Disabled Persons: A Therapeutic Jurisprudence Analysis*, 8 J.L. & HEALTH 105 (1993-94); Deborah A. Dorfman, *Through a Therapeutic Jurisprudence Filter: Fear and Pretextuality in Mental Disability Law*, 10 N.Y.L. SCH. J. HUM. RTS. 805 (1993).

168 *See, e.g.,* sources cited *supra* note 1. And this, of course, is not to suggest that this interest is somehow inappropriate or unwarranted. My concern here is the starkly-contrasted lack of interest in the issues that I am discussing in this article.

III. SANISM AND THE CLINICAL SETTING

Given this depressing background, sanism in the clinical classroom must be considered from two different perspectives: the clinical teacher's and the clinic student's. There is no database of empirical evidence on which to draw; I am basing this section largely on my varied personal experiences. As a practitioner, I supervised clinical students for ten years in placements in the New Jersey Department of the Public Advocate (mostly in the Division of Mental Health Advocacy, which I directed from 1974-82).[169] As a professor, I was the director of New York Law School's Federal Litigation Clinic from 1984-90; the bulk of the clinic's caseload involved representation of mentally and physically disabled persons in SSI and SSDI cases.[170] Since 1992, I have taught a course, Mental Disability Litigation Seminar and Workshop, in which students are placed in mental disability law settings (mostly, but not exclusively, with offices of the N.Y. Mental Hygiene Legal Services).[171]

Much of what follows is admittedly impressionistic. I cannot, and do not, offer it as a valid or reliable behavioral study.[172] But I am writing it nonetheless so as to share with the reader the conclusions I have reached after having worked in this area of the law for nearly 30 years.

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[169] The students came from a variety of law schools, local and national, public and private, "top ten" and otherwise.

[170] *See, e.g.,* Tirado v. Bowen, 842 F.2d 595 (2d Cir. 1988); Mejia v. Bowen, 1988 WL 125678 (S.D.N.Y. Nov. 10, 1988); Tirado v. Bowen, 1987 WL 12377 (S.D.N.Y. July 2, 1987); Cabrera v. Heckler, 1986 WL 9228 (S.D.N.Y. Aug. 11, 1986); Barrino v. Bowen, 1986 WL 6482 (S.D.N.Y. June 4, 1986); Hill v. Sullivan, 125 F.R.D. 86 (S.D.N.Y. Apr. 12, 1989); Baran v. Bowen, 710 F. Supp. 53 (S.D.N.Y. 1989); Tirado v. Bowen, 705 F. Supp. 179 (S.D.N.Y. 1989); Alvarez v. Bowen, 704 F. Supp. 49 (S.D.N.Y. 1989); Correa v. Bowen, 682 F. Supp. 755 (S.D.N.Y. 1988). The clinic also filed *amicus* briefs on behalf of coalitions of persons with mental disabilities in at least three United States Supreme Court cases: Colorado v. Connelly, 479 U.S. 157 (1986); U.S. Dept. of Treasury, Bureau of Alcohol, Tobacco and Firearms v. Galioto, 477 U.S. 556 (1986), and Ake v. Oklahoma, 470 U.S. 68 (1985).

To the best of my knowledge, surprisingly few clinical programs have ever provided legal representation to "psychiatric survivor groups." Touro Law School's Mental Disability Law Clinic – directed by William Brooks – is an important exception. I was especially heartened to learn that the Parkdale Community Legal Services Clinic at Osgoode Hall Law School provides assistance to a psychiatric survivor group. *See* Imai, *supra* note 88, at 199.

A recent survey (supplemented by personal knowledge) reveals that approximately ten American law schools – Chicago, Lewis & Clark, New England, New York Law School, Richmond, Texas, Touro, Virginia, William Mitchell, and Yale – offer courses that, broadly, could be called "mental disability law clinics." *See* Jean H. Bliss, Mental Disability Law Class Survey (Jan. 2002) (unpublished; on file with author).

[171] *See* Gould & Perlin, *supra* note 7, at 342 (discussing this course), and *id.* at 365-71(discussing placements).

[172] I acknowledge that my reliance on anecdotal impressions may have inadvertently led me to omit other and different experiences.

A. Sanism and Clinical Teaching

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."[173] 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.[174] 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.[175] 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."[176] 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.[177]

While I recognize that this reaction may be idiosyncratic, I do not think that this is the case. One of my major scholarly interests is the rights of persons institutionalized because of mental illness to engage in voluntary sexual interaction.[178] In my first paper on this topic, par-

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[173] *See* Marjorie Silver, *Love, Hate, and Other Emotional Interference in the Lawyer/client Relationship*, 6 CLIN. L. REV. 259, 288 n.151 (1999) (discussing SALT presentation).

[174] *See* Perlin, *Misdemeanor Outlaw, supra* note 14, at 219, discussing the "heralded 'footnote 4' of the *United States v. Carolene Products* [304 U.S. 144, 152 n.4 (1938)] case, which has served as the springboard for nearly a half century of challenges to state and municipal laws that have operated in discriminatory ways against other minorities." *See supra* note 18.

[175] *9:00 A.M. Opening Plenary,* 75 WASH. U. L.Q. 1586, 1653 (1997) ("The Society of American Law Teachers, for example, is an organization of progressive law professors who have annual or sometimes twice annual teaching conferences, many of which are directed at how our teaching can reflect our social values and how we can effectively raise these issues in the classroom").

[176] *See, e.g.,* Francisco Valdes, *Solomon's Shames: Law as Might and Inequality,* 23 THURGOOD MARSHALL L. REV. 351, 438 n.70 (1998) ("The SALT multiyear Action Campaign was kickedoff with the march held in San Francisco during the 1998 AALS Annual Meeting").

[177] Gould & Perlin, *supra* note 7, at 354 n.93 (quoting Rogelio Lasso, *Diversity Is As Diversity Does,* SALT EQUALIZER, Dec. 1994, at 18-19).

[178] *See, e.g.,* PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 157-74; 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 3C-5.1, at 416-21; Douglas Mossman, Michael Perlin & Deborah Dorfman, *Sex on the Wards: Conundra for Clinicians*, 25 J. AM. ACAD. PSYCHIATRY & L. 441 (1997); Andrew Payne & Michael L. Perlin, *Sexual Activity Among Psychiatric Inpatients: International Perspectives*, 4 J. FORENS. PSYCHIATRY 109 (1993); Perlin,

tially titled, *Beyond the Last Frontier?,* I explained that portion of the title in this manner:

> I have borrowed this phrase from [former] New York Law School Professor Keri Gould's response to my incredulity when I told her of the hostile and astonished responses I received from several other law professors upon telling them that I was researching this topic. Professor Gould (who, like me, represented institutionalized persons with mental disabilities in her prior career) responded, "Michael, why are you surprised? For almost everyone, this really is beyond the last frontier!"[179]

But when I present this topic to a live audience, I elaborate in this manner:

> Last year, I was sitting at my faculty lunch table, and conversation turned to upcoming presentations that we would soon be doing. My colleagues mostly take left-liberal positions on a wide variety of issues, and are generically the exact mix of retro '60s generationists and early baby boomers that you'd expect. They (appropriately) are quick to criticize any behavior that is racist, sexist, ethnically bigoted or homophobic. Rush Limbaugh would probably view them as one of his worst "politically correct" horror fantasies. As you might expect, I'm not terribly out of place in this group . . . .
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> Anyway, when it got to be my turn, I said that I was going to be speaking about the right of institutionalized mentally disabled persons to sexual interaction. All conversation came to a screeching halt.
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> "Michael, are you serious?" "Are you crazy (sic)?" "Michael, even for you, you've gone too far!" "What are you going to say next: that they can get married?!?" Et cetera.
>
> At this stage of my life and career, few things surprise me. Yet, I must admit that I was *stunned* — not by the response (I spend lots of time in places where few people agree with me about anything [my local bait and tackle shop, for instance], so I don't expect (or want) agreement with whatever it is I'm talking about), but by the identity and background of the people who were uttering these sentiments. As I've said, these were classic New York liberals many of whom had spent much of their distinguished professional, academic and personal lives rooting out and exposing prejudiced and stereotypical behavior toward virtually every minority group one could imagine. The buck, though, stopped there.
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> *** *** ***
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> To the general public — and when we talk about the idea of mental patients having sex, a roomful of left-leaning law professors *is* the general public (in the same way that I suspect a roomful of left-

Sexual Interaction; supra note 14; Perlin, *Promises, supra* note 14.

[179] Perlin, *supra* note 14, at 520 n.10.

> leaning psychologists, psychiatrists or social workers would be) — this idea is *far* beyond the last frontier. And that insight (probably not a terribly original one on my part) really is the heart of the meta-thesis of my talk today.[180]

For years, I regularly and religiously attended the full-day Clinical Section program at the AALS January conference. I never miss an issue of the truly-excellent *Clinical Law Review*. My attendance at AALS has gotten spottier over the years, but I generally spend at least some time at the clinical meetings. I cannot recall the last time, if ever, that a mental disability law issue was discussed[181] — and let me be clear, the failure to take mental disability law issues seriously *is* an indicator of sanism – nor can I ever recall sanist student attitudes on the scholarly agenda (although certainly, racist, sexist, and homophobic attitudes have been discussed frequently).[182]

Stigma may be part of the answer. We know that the stigma of mental illness also affects — and stigmatizes — mental health professionals[183] and medical students.[184] The extent to which it affects law

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[180] *See, e.g.*, Michael L. Perlin, Hospitalized Psychiatric Patients and Sexual Interactions: Rights and Responsibilities (keynote presentation, annual conference, National Association of Rights, Protection, and Advocacy, Sacramento, CA, October 2000). I must point out that none of my clinical colleagues participated in this lunchtable discussion.

There was probably only a handful of law professors in the room in Sacramento when I gave this talk. However, if the opportunity ever arises to speak about this topic to a mostly-law professor audience, I will definitely repeat the same story.

[181] Of course, multiple variables affect the decisions of all scholars as to where to publish their articles. By way of example, my friend and colleague, the late Stanley Herr, regularly published articles about mental disability law in a wide range of "traditional" law reviews (*see, e.g.*, *Reforming Disability Nondiscrimination Laws: A Comparative Perspective*, 35 U. MICH. J. L. REFORM 305 (Fall 2001/Winter 2002); *Special Education Law & Children with Reading and Other Disabilities*, 28 J. L. & EDUC. 337 (1999); *Questioning the Questionnaires: Bar Admissions and Candidates with Disabilities*, 42 VILL. L. REV 635 (1997); *A Way to Go Home: Supportive Housing and Housing Assistance Preferences for the Homeless*, 23 STETSON L. REV. 345 (1994)), and chose to publish about clinical pedagogy in this journal (see *Ethical Decision-making and Ethics Instruction in Clinical Law Practice*, 3 CLIN. L. REV. 109 (1996)).

[182] For a rare law review piece discussing this issue from a personal perspective, see Naomi Himmelhoch, *In the Padded Closet: Thoughts on a Secret Life*, 10 HASTINGS WOMEN'S L.J. 463 (1999). Professor Marjorie Silver also shares with students experiences as a person with a diagnosed mental disability. Personal conversation, Oct. 19, 2001. But certainly there is no law review article in the mental disability law literature that parallels, say, Nancy Polikoff, *Am I My Client?: The Role Confusion of a Lawyer Activist*, 31 HARV. C.R. – C.L. L. REV. 443, 443-44 (1996):

> I am a lesbian activist. I support and engage in a variety of activities designed to change the fundamental way in which American society views homosexuality. Some of this work entails changing the law, especially in the area of gaining respect and recognition for lesbian and gay families. Other aspects of this work fall outside the legal system, including organizing and attending demonstrations and conferences, public speaking, fundraising for groups involved in cultural change and political and economic empowerment, and writing for non-legal audiences.

[183] *See* Dichter, *supra* note 20, at 203; Glen Gabbard & Krin Gabbard, *Cinematic Stereo-*

teachers who teach mental disability law, law students who study the subject and practicing psychiatrists and other mental health professionals who treat persons subject to mental disability law is not known, but it would be naive to assume that it is not an issue.[185]

Because sanism is so often invisible and because it remains politically acceptable, sins of omission can be perhaps even more troubling than sins of commission (which can, at least, be addressed frontally). By way of example, I have been told on many occasions by clinical colleagues that sanism simply isn't as "important" or as "hurtful" as is racism or sexism or homophobia. (The use of the descriptor "hurtful" is especially illuminating because it implicitly suggests that persons with mental disabilities do not have the same range of feeling that the rest of us presumably possess.)[186] And this attitude also blindly ignores the reality that so much of our bias toward persons with mental disabilities is race- and class-based.[187] Consider the story with which I begin my recent book, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL:

> Soon after I became Director of New Jersey's Division of Mental Health Advocacy, I read a story in the *New York Times* magazine section that summarized for me many of the frustrations of my job. The article dealt with an ex-patient, Gerald Kerrigan, who wandered the streets of the Upper West Side of Manhattan. Kerrigan never threatened or harmed anybody, but he was described as "different," "off," "not right," somehow. It made other residents of that neighborhood — traditionally home to one of the nation's most

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types Contributing to the Stigmatization of Psychiatrists, in STIGMA, *supra* note 4, at 113.

184 *See* Dickstein & Hinz, *supra* note 20, at 153.

185 I cannot resist sharing this story. In August 2000, I went to San Francisco to speak to the American Psychological Association's annual conference. On the airport shuttle, the shuttle driver asked, "Is anyone here for a convention?" I said, yes, and the driver asked me, "Which one?" When I replied, "The American Psychological Association," the woman sitting next to me on the van moved a few inches in the other direction. I then said, "But I'm not a psychologist." She moved back. When the driver asked me what I did, I said I was a law professor. She stayed where she was. But then another passenger in the back of the van – whom I later learned, coincidentally, was a law student – asked "What do you teach?" When I responded, "Mental disability law," the woman moved away again. As Dave Barry would have said, I am *not* making this up.

186 On the hurtfulness of homophobia, see, *e.g.,* John Russ, *Shall We Dance? Gay Equality and Religious Exemptions at Private California High School Proms*, 42 N.Y.L. SCH. L. REV. 71, 77 n.33 (1998). On the hurtfulness of racism, see, *e.g.,* Richard Delgado & Jean Stefancic, *Hateful Speech, Loving Communities: Why Our Notion of a "Just Balance" Changes So Slowly*, 82 CALIF. L. REV. 851, 860 n.51 (1994). On the hurtfulness of sexism, see, *e.g.,* Ann Freedman, *Feminist Legal Method in Action: Challenging Racism, Sexism, and Homophobia in Law School*, 23 GA. L. REV. 849, 873 (1990).

187 *See* PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 84, and *id.* n.47 (citing studies). On the way that clinics approach race issues, see, e.g., Michelle Jacobs, *People from the Footnotes: The Missing Element in Client-Centered Counseling,* 27 GOLDEN GATE U. L. REV. 345 (1997); Hing, *supra* note 1.

liberal voting blocs — nervous to have him in the vicinity, and the story focused on the response of a community block association to his presence. The story hinted darkly that the social "experimentation" of deinstitutionalization was somehow the villain.

Soon after that, I read an excerpt from Elizabeth Ashley's autobiography in *New York* magazine (a magazine read by many of those same Upper West Siders). Ashley — a prominent (and not unimportantly) strikingly attractive actress — told of her institutionalization in one of New York City's most esteemed private psychiatric hospitals and of her subsequent release from that hospital to live with George Peppard, and to costar with Robert Redford on Broadway in *Barefoot in the Park.*

Ashley was praised for her courage. Kerrigan was emblematic of a major "social problem." Both were persons who had been diagnosed with mental illness. Both of their mental illnesses were serious enough to require hospitalization. Both were subsequently released. Yet their stories are presented — and read — in entirely different ways.

Gerald Kerrigan's story reflected the failures of "deinstitutionalization" and demonstrated why the application of civil libertarian concepts to the involuntary civil commitment process was a failure. Elizabeth Ashley's story reflected the fortitude of a talented and gritty woman who had the courage to "come out" and share her battle with mental illness. No one discussed Gerald Kerrigan's autonomy values (or the quality of life in the institution from which he was released). No one (in discussing Ashley's case) characterized George Peppard's condo as a "deinstitutionalization facility" or labeled starring in a Broadway smash as participation in an "aftercare program."

Ashley was beautiful, talented and wealthy. And thus she was different. Kerrigan was "different," but in a troubling way. But the connection between Kerrigan and Ashley was never made.[188]

Blindness to sanism is epidemic. When I discuss the Americans with Disabilities Act with friends and with other lawyers — a universe that presents prototypically, liberal "takes" on a variety of social issues (race discrimination, homophobia, misogyny, etc) — two issues typically emerge:

First, virtually every person has a horror story about how "unreasonable" ADA demands caused clients to go out of business, pre-

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[188] PERLIN, HIDDEN PREJUDICE, *supra* note 2, at x. I also discuss this anecdote, and its impact on my thinking about sanism, in Michael L. Perlin, *"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEG. ISSUES 3, 8 (1999), and in Michael L. Perlin, *The Deinstitutionalization Myths: Old Wine in New Bottles, in* CONFERENCE REPORT: THE SECOND NATIONAL CONFERENCE ON THE LEGAL RIGHTS OF THE MENTALLY DISABLED 20 (Karl Menninger & Heather Watts eds., 1979).

vented other clients from opening new offices, and so forth. The ADA applications in these stories usually concern ramps and other matters involving physical accessibility. Generally, these stories do not, on the surface at least, appear to have anything to do with mental disability law.

Second, not a single person accepts — on *any* level — my arguments that discrimination against persons based on disability is *like* discrimination based on race, religion, or sexual preference.[189] Even friends who have "outed" themselves by telling of their experiences in psychiatric hospitals, or who have movingly shared the impact of major depression or bipolar illness on their own lives and/or on the lives of loved ones, refuse to take me seriously when I argue that disability-based discrimination is as pernicious, harmful and morally corrupt as other types of discrimination.[190]

Recent years have — happily — seen an outpouring of clinical scholarship on virtually every aspect of clinical law.[191] Yet, a WESTLAW search reveals *no* literature on the question that I have been addressing here.[192] Moreover, there is scant literature on the importance of collaboration between lawyers and mental health professionals in a clinical setting.[193]

There is a further disconnect in constitutional and statutory mental disability law that most of us have perhaps missed. There have

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189 This is not to say, of course, that they are identical. Consider the differences – and similarities – between discrimination based on mental illness and that based on mental retardation. *See e.g.,* Heller v. Doe, 509 U.S. 312 (1993) (statute providing lesser standard of proof in cases involving persons with mental retardation than in cases involving persons with mental illness does not violate equal protection); *compare id.* at 335 (Souter, J., dissenting). My point is this: As a society, we trivialize the discriminatory harms done to persons with mental disabilities when compared with discriminatory harms based on race or religion or sexual preference.

190 *See* Perlin, *supra* note 11, at 249.

191 *See, e.g., Clinical Legal Education: An Annotated Bibliography,* CLIN. L. REV. (Special Issue #1) (2001).

192 A JLR database search of SANISM & "CLINICAL LEGAL EDUCATION" reveals just a handful of articles that cite to earlier articles that I wrote about sanism, and only Marjorie Silver's actually discusses the impact of sanism in this context. *See* Silver, *supra* note 173, at 288. *And see also* Beverly Balos, *Conferring on the MacCrate Report: A Clinical Gaze*, 1 CLIN. L. REV. 349, 357-61 (1994) (critiquing MacCrate Report for failing to sufficiently consider disability-based discrimination).

In the editing of this article for the *Clinical Law Review*, the editor questioned whether the term "sanism" is not sufficiently "widely known and accepted" by other clinical teachers (e-mail, March 10, 2002, on file with author). That may be, though a search of WESTLAW/JLR for SANIS! reveals a data-base of 119 articles (search done February 13, 2003). Assuming that about 25 of these articles are ones I wrote, that still leaves an *n* of nearly 100 scholarly papers the authors of which *are* familiar with the concept.

193 For an important exception, see Paula Galowitz, *Collaboration Between Lawyers and Social Workers: Re-examining The Nature and Potential of the Relationship,* 67 FORDHAM L. REV. 2123 (1999).

been no attempts, so far, to answer the question that has bedeviled civil rights activists since the 1950's: "how to capture 'the hearts and minds' of the American public so as to best insure that statutorily and judicially articulated rights are incorporated — freely and willingly — into the day-to-day fabric and psyche of society."[194]

On the other hand, I am somewhat optimistic about the faint glimmers of interest in the intersection between therapeutic jurisprudence (TJ)[195] and clinical teaching. In a recent article, Professor Keri Gould and I argued that "therapeutic jurisprudence provides a new and exciting approach to clinical teaching. By incorporating TJ principles in both classroom and fieldwork components of clinic courses, law professors can help students gain new and important insights into some of the most difficult problems regularly raised in clinical classes and practice settings."[196] In doing so, we explicitly warned that "therapeutic jurisprudence analyses must be undertaken with a full awareness of the impact of sanism and pretextuality on all aspects of the mental disability law system."[197] In an earlier article, Professor Mary Berkheiser had identified several areas in which TJ holds out "promising prospects" for clinical legal education.[198] She explored four topics: "(a) problem solving, (b) client counseling, (c) self-reflection or 'learning to learn,' and (d) professional responsibility."[199] In all of these, I contend, an understanding of sanism will enrich the entire enterprise.[200]

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194 *See* Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?,* 8 J. L. & HEALTH 15, 22-23 (1993-94). The "hearts and minds" phrase was first used in Chief Justice Warren's opinion in Brown v. Board of Educ. of Topeka, 347 U.S. 483, 494 (1954); *see also, e.g., In re* Demos, 500 U.S. 16 (1991) (Marshall, J., dissenting from denial of *certiorari*); Jones v. Alfred H. Mayer Co., 392 U.S. 409, 445 (1968).

195 Therapeutic jurisprudence presents a new model by which we can assess the ultimate impact of case law and legislation that affects mentally disabled individuals, studying the role of the law as a therapeutic agent, recognizing that substantive rules, legal procedures and lawyers' roles may have either therapeutic or anti-therapeutic consequences, and questioning whether such rules, procedures, and roles can or should be reshaped so as to enhance their therapeutic potential, without subordinating due process principles. Perlin, *Misdemeanor Outlaw*, *supra* note 14, at 228. *See generally* ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1991); LAW IN A THERAPEUTIC KEY: RECENT DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1996); THERAPEUTIC JURISPRUDENCE, *supra* note 34; THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW (Bruce J. Winick ed., 1997); David B. Wexler, *Putting Mental Health Into Mental Health Law: Therapeutic Jurisprudence,* 16 L. & HUM. BEHAV. 27 (1992).

196 Gould & Perlin, *supra* note 7, at 342.

197 *Id.* at 342. *See also* 342-43 n.35 (discussing sanism in this context).

198 Berkheiser, *supra* note 164, at 1155.

199 *Id.*

200 A robust literature has begun to develop in the areas of holistic and preventive law. *See, e.g.*, Warren Anderson, *Ecumenical Cosmology,* 27 TEX. TECH L. REV. 983, 1000

But sadly, clinical educators have — at least in the literature — been largely blind to the corrosive and ravaging forces of sanism.[201] The real tragedy is that no one has mentioned it until now.

B. Sanism and Clinical Students

In considering the ways in which sanism affects clinical students, there are at least three questions that we must seek to answer: (1) Are students who take clinical courses more or less sanist than other students? (2) How do clinical students manifest sanism?, and (3) How can sanism be combated in clinical settings?

1. Clinical Students' Susceptibility to Sanism

Discussing the law school classroom, Lila Coleburn and Julia Spring have suggested: "If [the law student] speaks without emotions, he is untrue to himself, but if he speaks with them, he may be laughed out of the class as touchy-feely."[202] Discussing alternative dispute resolution classes, Professor Jean Sternlight similarly observed:

> ADR survey courses attract a diverse mix of students. Some are drawn to ADR because they are uncomfortable with adversarial approaches and litigation. Such students tend to enjoy the negotiation and mediation portions of the material and recoil a bit from arbitration. Others take the course because they believe it would be useful for litigation or because it meets at a convenient time. Some of these students prefer the traditional arbitration material, focusing on cases and doctrine, to what they perceive as more "touchy feely" content.[203]

And addressing the need for students to develop rapport with the client, Professor Peter Margulies, in an article entitled, *Reframing*

(1996); Susan Daicoff, *Making Law Therapeutic for Lawyers: Therapeutic Jurisprudence, Preventive Law, and the Psychology of Lawyers*, 5 PSYCHOL., PUB. POL'Y. & L. 811 (1999); Dennis P. Stolle, David B. Wexler, Bruce J. Winick & Edward A. Dauer, *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering,* 34 CAL. W. L. REV. 15 (1997); Dennis Stolle, *Professional Responsibility in Elder Law: A Synthesis of Preventive Law and Therapeutic Jurisprudence,* 14 BEHAV. SCI. & L. 257 (1996). *See also* Perlin, *supra* note 16, at 409 ("Therapeutic jurisprudence offers a path by which sanism and pretextuality may, eventually, be neutralized, so that mental disability law may eventually become a law of healing").

[201] This is *not* to say, of course, that "all clinical teachers are sanists." I have been enriched by many discussions with clinical professors who have told me of examples of their practice – in the representation of criminal defendants and civil litigants – that reject sanist assumptions and that reflect thoughtful, sensitive lawyering on behalf of persons with mental disabilities (and those so perceived). By writing this article, I hope to encourage more of my colleagues to follow this path.

[202] Lila Coleburn & Julia Spring, *Socrates Unbound: Developmental Perspectives on the Law School Experience,* 24 LAW & PSYCHOL. REV. 5, 27 (2000).

[203] Jean Sternlight, *Is Binding Arbitration a Form of ADR?: An Argument That The Term "ADR" Has Begun to Outlive Its Usefulness*, 2000 J. DISP. RESOL. 97, 103 n.33.

Empathy in Clinical Legal Education, points out, "Often we 'sell' the importance of connection to students, who are wary of touchy-feely perspectives, by pointing out the instrumental aspects of rapport."[204]

Certainly, clinical courses appear to attract students more comfortable with what these authors refer to as "touchy-feely" perspectives.[205] My experiences in teaching clinical students about "active listening" were certainly mixed. Some were able to grasp it and do it; others simply parroted the text (Binder-Price) and never appeared to internalize the skills in any meaningful way.[206] This, however, begs the question: Does this, in and of itself, make them less likely to be sanist?[207] To this, I have no answers, other than to point out that — and I have certainly never studied this in any way that could be reliably validated — those students who had decided upon a career in mental disability law *did* seem to manifest less sanism in the clinical setting than did other students.[208]

2. *Manifestation of Sanism by Clinical Students*

Clinical students — like virtually all students I have ever

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[204] 5 CLIN. L. REV. 605, 624 (1999).

[205] Women regularly outnumber men by a 3-1 or 4-1 ratio in my clinic. In the mental disability law workshop, a "typical" section has 10 women and 2 men. I most recently taught Mental Health Law (a non-skills course that deals with underlying issues of civil and constitutional mental disability law) in the fall 2001 term. At that time, there were approximately 25 women and five men in my class. This past term, five NYLS students registered for my on-line Survey of Mental Disability Law course; four were female and one was male. In my current seminar on Therapeutic Jurisprudence, there are eight women and two men. These numbers are fully consistent with my experiences since 1985, when I first taught my Mental Health Law course.

[206] See Joshua Rosenberg, *Teaching Empathy in Law School*, 36 U.S.F. L. REV. 621 (2002), for a recent thoughtful article on a related issue.

[207] *See* Pauline Tesler, *Collaborative Law a New Paradigm for Divorce Lawyers*, 5 PSYCHOL., PUB. POL'Y & L. 967, 970 n.10 (1999) (discussing Susan Daicoff, *Lawyer, Know Thyself: A Review of Empirical Research on Attorney Attributes Bearing on Professionalism,* 46 AM. U. L. REV. 1337, 1415 (1997)) (research indicates that one effect of legal education is to "intensify law students' tendencies to ignore emotions, interpersonal concerns, and warm interpersonal relations . . . this preference may become extreme and thus dysfunctional during law school and thereafter. It may contribute to an unbalanced approach to life and difficulties relating to peers . . . and clients, thus increasing dissatisfaction and distress"); *see also* Stephen Reich, *Psychological Inventory: Profile of a Sample of First-Year Law Students,* 39 PSYCHOL. REP. 871 871-74 (1976).

Again, consider the connection to therapeutic jurisprudence: "Therapeutic jurisprudence focuses on the law's impact on emotional life." Gould & Perlin, *supra* note 7, at 353 (citing Dennis P. Stolle & David B. Wexler, *Therapeutic Jurisprudence and Preventive Law: A Combined Concentration to Invigorate the Everyday Practice of Law,* 39 ARIZ. L. REV. 25 (1997)).

[208] On the fascinating collateral question of the impact of disability on the clinical education student *selection* process, see Sande Buhai, *Practice Makes Perfect: Reasonable Accommodation of Law Students with Disabilities in Clinical Placements*, 36 SAN DIEGO L. REV. 137 (1999).

taught[209] — resolutely adhere to a series of myths about persons with mental disabilities.[210] These include the following:

- Like other lawyers, clinical students frequently presume that persons with mental illness are incompetent to engage in autonomous decisionmaking.[211] Students typically apply that presumption to matters directly involving mental disability law issues (commitment, treatment, etc.), choice of trial strategy, and external "life decisions" (choice of housing, employment, etc.).
- Like other lawyers, clinical students often complain, in referring to their clients with mental disabilities, that "the clients could try harder." Students are impatient with persons with mental disabilities (especially in cases involving governmental benefits that turn on one's capacity to work), and do not believe that a mental impairment should be considered disabling in the same way that certain physical impairments may be.[212] Clinical students sometimes complain that persons with mental disabilities "get too much of a free ride" from governmental assistance programs, and may be prone to view such programs as inhibiting their clients from "trying harder." These attitudes track the common sanist myth that mental illness is somehow the mentally ill person's "fault."[213]

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209 In addition to teaching five mental disability law-based courses, I also teach Criminal Law, Civil Procedure, and Criminal Procedure: Adjudication. Again, to be clear: Those students who plan on a career in mental health advocacy rarely (if ever) adhere to these myths. I have been extraordinarily fortunate as a law professor to have had such a high number of my students follow this career path; both in New York and New Jersey, and in distant states (including Washington, New Mexico, Utah, Massachusetts, New Hampshire, and elsewhere). These students are — no coincidences here — among the ones who regularly rejected these myths.

210 See *infra* note 220.

211 *See supra* text accompanying notes 70-72.

212 Each year, I offer the following hypothetical to my Civil Procedure class: "Imagine that you are a personal injury lawyer and have two cases that are ready for jury trial. You will not be able to pay your monthly bills if you are not successful on behalf of your client. One of your clients has a kneecap that was shattered in an automobile accident (and you have x-rays, treatment records, etc.); the other has suffered psychic trauma in a different automobile accident (and you have the testimony of his treating psychologist). Which case would you want to bring to trial?"

In the thirteen years that I have been teaching the course, I have never had a *single student* either "vote" for the psychic trauma case or view that case as a serious alternative. Certainly this may reflect my students' (probably accurate) perceptions of societal views rather than their own prejudices, but the post-hypothetical discussions generally reflect the same sort of sanism I discuss elsewhere in this article.

213 On the perceived connection between sickness and sin, see, *e.g.* Bernard Weiner, *On Sin Versus Sickness: A Theory of Perceived Responsibility and Social Motivation*, 48 AM. PSYCHOLOGIST 957 (1993) (proposing conceptual system of social motivation to balance societal tendencies that encourage punishment for those who demonstrate a "lack of ef-

- Like other lawyers, clinical students look primarily for visual clues as an indicator of whether a client is "truly" mentally disabled, thereby falling into a cognitive error made by trial and appellate judges for decades.[214]
- Like other lawyers, clinical students express fear of their mentally disabled clients' potential dangerousness, rejecting the rich database that has proven — conclusively — that mental illness is only a "modest" risk factor for dangerous behavior[215] and that an overwhelming proportion of the population of persons with mental illness is not dangerous.[216]
- Like other lawyers, clinical students assume that "quality of life" concerns are less significant for persons with mental disabilities, and that issues such as housing, family relationships, and job satisfaction do not "count" as much.
- Like other lawyers, clinic students tend to disbelieve what their mentally disabled clients tell them if the information does not conform to the student's stereotype of what a mentally disabled person "is like."[217] If such a client speaks of past employment as a professional or of having earned graduate degrees or of having once lived in an upper class suburb, such information is rejected out of hand (and often is viewed as evidence of the client's "craziness" (and thus inherent untrustworthiness)).
- Like other lawyers, clinical students express discomfort about representing persons with mental disabilities when the court-ordered outcome of a case might not be in the client's "best interests."[218]

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fort" or are "responsible" for their failure). For a historical overview, see Norman Dain, *Madness and the Stigma of Sin in American Christianity*, *in* STIGMA AND MENTAL ILLNESS 73 (Paul Fink & Allan Tasman eds., 1992).

214 *See, e.g.*, Michael L. Perlin, *"The Borderline Which Separated You From Me": The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375, 1409 (1997) ("defendants' criminal responsibility is still being assessed by visual frames of reference: if he didn't 'seem frenzied' or appear insane, then 'there's no craziness here'"). *Id.* at 1422 (explaining how our insanity defense jurisprudence relies upon "a fixed vision of popular, concrete, visual images of craziness").

215 Monahan, *supra* note 23, §§ 7-2.0-7-2.4, at 300.

216 *Id. See also* Renée Binder, *Are the Mentally Ill Dangerous?*, 27 J. AM. ACAD. PSYCHIATRY & L. 189, 195 (1999); John Monahan, *Assessment, Scientific Validity and Evidentiary Admissibility*, 57 WASH. & LEE L. REV. 901 (2000).

217 For an example of one set of these stereotypes, see William Breakey et al., *Stigma and Stereotype: Homeless Mentally Ill Persons*, *in* STIGMA, *supra* note 4, at 97.

218 I ask my students to think about this attitude and to contrast it with the Sixth Amendment right to counsel in criminal prosecutions. Then I ask what they would do if they were ordered to represent, say, Tony Soprano. Or if they were working for a law firm during the summer, and that firm was representing a corporation accused by a regulatory agency of being a toxic polluter. In both cases, students invariably tell me that my hypo is "different," and that they would have no problems representing such individuals.

- Like other lawyers. clinical students frequently engage in a pre-reflective "ordinary common sense" (OCS) in approaching their clinical case assignments.[219] This OCS frequently involves sanist stereotypes about persons with mental disabilities.[220]

On clinic-specific issues, students often complain in other ways about representing persons with mental disabilities. They complain, specifically, about:

This hypo should not be read to suggest that I do not believe that Tony Soprano has a right to vigorous counsel. I do believe, however, that a lawyer in a private law firm who does not want to represent a civil client may have a right to decline the case assignment, with a full understanding that that decision may adversely affect her employment future with the firm in question.

219 *See* Gould & Perlin, *supra* note 7, at 357; Perlin, *Neonaticide, supra*, note 14.

220 *See* Perlin, *supra* note 5, at 393-97:

These are a few of the sanist myths that dominate our social discourse:

1. Mentally ill individuals are "different," and, perhaps, less than human. They are erratic, deviant, morally weak, sexually uncontrollable, emotionally unstable, superstitious, lazy, ignorant and demonstrate a primitive morality. They lack the capacity to show love or affection. They smell different from "normal" individuals, and are somehow worth less.

2. Most mentally ill individuals are dangerous and frightening. They are invariably more dangerous than non-mentally ill persons, and such dangerousness is easily and accurately identified by experts. At best, people with mental disabilities are simple and content, like children. Either *parens patriae* or police power supply a rationale for the institutionalization of all such individuals.

3. Mentally ill individuals are presumptively incompetent to participate in "normal" activities, to make autonomous decisions about their lives (especially in areas involving medical care), and to participate in the political arena.

4. If a person in treatment for mental illness declines to take prescribed antipsychotic medication, that decision is an excellent predictor of (1) future dangerousness and (2) need for involuntary institutionalization.

5. Mental illness can easily be identified by lay persons and matches up closely to popular media depictions. It comports with our common sense notion of crazy behavior.

6. It is, and should be, socially acceptable to use pejorative labels to describe and single out people who are mentally ill; this singling out is not problematic in the way that the use of pejorative labels to describe women, blacks, Jews or gays and lesbians might be.

7. Mentally ill individuals should be segregated in large, distant institutions because their presence threatens the economic and social stability of residential communities.

8. The mentally disabled person charged with crime is presumptively the most dangerous potential offender, as well as the most morally repugnant one. The insanity defense is used frequently and improperly as a way for such individuals to beat the rap; insanity tests are so lenient that virtually any mentally ill offender gets a free ticket through which to evade criminal and personal responsibility. The insanity defense should be considered only when the mentally ill person demonstrates objective evidence of mental illness.

9. Mentally disabled individuals simply don't try hard enough. They give in too easily to their basest instincts, and do not exercise appropriate self restraint.

10. If "do-gooder", activist attorneys had not meddled in the lives of people with mental disabilities, such individuals would be where they belong (in institutions), and all of us would be better off. In fact, there's no reason for courts to involve themselves in all mental disability cases.

- difficulty in interviewing (especially in coping with narrative styles that may differ radically from those of persons without mental disabilities). If a client says something that appears "crazy," students sometimes may trivialize all of the client's concerns and question the credibility of the client's entire account.
- difficulty in investigating (especially if the client is institutionalized).[221] It is certainly more difficult to investigate a case on behalf of a client who has been deprived of freedom of movement (be it civil or criminal), but the fact that a client is often in a psychiatric hospital makes this a more difficult enterprise in many ways. Such persons will, for example, have limited access to cash, to telephones, and to visitors.
- difficulty in counseling. Many clinical students are extraordinarily uncomfortable about "acting like a social worker,"[222] and *counseling* is the aspect of legal practice that most closely approximates the work of a mental health professional.[223]
- difficulty in negotiating. To some extent, cases involving clients with mental disabilities are negotiated in very different ways than those involving other clients.[224] My years as a Public Defender and mental health advocate taught me that prosecutors,

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221 On the importance of the locus of the interview, see, *e.g.*, Michael Lindsey, *Ethical Issues in Interviewing, Counseling, and the Use of Psychological Data With Child And Adolescent Clients*, 64 FORDHAM L. REV. 2035, 2042 (1996).

222 The roots of this concept are explored in Kara Nelson, *The Release of Juvenile Records Under Wisconsin's Juvenile Justice Code: A New System of False Promises*, 81 MARQ. L. REV. 1101, 1117 (1998).

223 On the confusion often engendered here, see, *e.g.*, Robert Benjamin, *A Critique of Mediation — Challenging Misconceptions, Assessing Risks And Weighing The Advantages*, 146 PITTS. LEGAL J. (June 1998), at 37; Marilyn Levitt, *The Elderly Questionably Competent Client Dilemma: Determining Competency and Dealing with the Incompetent Client,* 1 J. HEALTH CARE, LAW & POLICY 202, 217 (1998).

On the special issues involved when a client is charged with a crime, see Binny Miller, *Telling Stories About Cases and Clients: The Ethics of Narrative*, 14 GEO. J. LEGAL ETHICS 1, 42-43 (2000) ("Even if the lawyer's case theory prevails, this choice of theory means that the lawyer has defined the client as mentally ill to the outside world and that he will be institutionalized until he is found sane. Some clients don't wish to be portrayed as mentally ill or to be committed for mental health treatment. These clients would rather run a greater risk of jail on a weaker case theory where the consequences of a winning theory are so personally devastating").

224 When I was in practice, I represented the class in Schindenwolf v. Klein, No. L4129375 P.W. (N.J. Super. Ct. Law Div. 1979) (final order reprinted in 5 PERLIN, MENTAL DISABILITY LAW, *supra* note 2, § 14-4, at 66-74 (2d ed. 2002)) (requiring compensation for institutionalized persons who perform work for which the institution would otherwise have to pay an employee). Before we approved the final settlement, my co-counsel (John Ensminger, *see e.g.*, Ensminger & Liguori, *supra* note 164) and I went to each of the five state hospitals in which our clients resided, and met with the patients' governing council to explain the tentative settlement, request feedback and suggestions, and determine whether there was, in fact, wide-spread support for the settlement.

attorneys general and other lawyers with whom I came regularly in contact never took negotiation in these cases as seriously, perhaps due to a belief that the stakes were not particularly high for my client, or perhaps due to an inability to empathize with my client.

- difficulty in resisting the tendency to impose the student's own views as to what is in the client's best interests (in ways that are not typical of the ways that lawyers act in "garden variety" civil and criminal cases).[225]

3. *Combating Sanism in the Clinical Setting*

There is no question that participation in a clinical course is stressful – for both students and teacher.[226] A student of mine once came to me, distraught, to tell me that her husband had threatened to leave her if she continued to work with "those people" (forensic patients at a NY state psychiatric institution).[227] In a thoughtful piece on the factors that can influence clinical casework, Professor Ann Juergens includes mental illness as one of the stressors.[228] Students who are thrust into clinical settings are forced to confront "difficult, complex, and often contradictory feelings about what he or she is doing

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[225] *See, e.g.*, Matter of M.R., 135 N.J. 155, 638 A.2d 1274 (1994) (advocacy diluted by excessive concern for the client's best interests would raise troubling questions for attorneys in an adversarial system; counsel acts without well-defined standards if he or she forsakes a client's instructions to pursue the attorney's perception of the client's best interests) (citing Lawrence A. Frolik, *Plenary Guardianship: An Analysis, A Critique and A Proposal for Reform,* 23 ARIZ. L. REV. 599, 635 (1981)). *See also id.* at 634-35 ("if counsel has already concluded that his client needs 'help,'" he is more likely to provide only procedural formality, rather than vigorous representation). *See also* Maria M. Das-Neves, *The Role of Counsel in Guardianship Proceedings of the Elderly,* 4 GEO. J. LEGAL ETHICS 855, 863 (1991) ("[i]f the attorney is directed to consider the client's ability to make a considered judgment on his or her own behalf, the attorney essentially abdicates his or her advocate's role and leaves the client unprotected from the petitioner's allegations"). Finally, the attorney who undertakes to act according to a best interest standard may be put into the position of making decisions about the client's mental capacity that the attorney is unqualified to make. Frolik, *supra* at 635. *See also* Matter of Brantley, 260 Kan. 605, 920 P.2d 433, 443 (1996) ("The client has ultimate authority to determine the purposes to be served by legal representation, within the limits imposed by law and the lawyer's professional obligations. . . . in a case in which the client appears to be suffering mental disability, the lawyer's duty to abide by the client's decisions is to be guided by reference to Rule 1.14."); Buckler v. Buckler, 195 W. Va. 705, 708, 466 S.E.2d 556, 559 (1995) ("It is not the role of an attorney acting as counsel to independently determine what is best for his client and than act accordingly. Rather, such an attorney is to allow the client to determine what is in the client's best interests and than act according to the wishes of that client within the limits of the law.").

[226] Gould & Perlin, *supra* note 7, at 356.

[227] *Id.* at 356 n.99.

[228] Ann Juergens, *Teach Your Students Well: Valuing Clients in the Law School Clinic*, 2 CORNELL J. L. & PUB. POL'Y 339, 355 (1993).

and how he or she is doing it."[229] There is no question that dealing with mental illness in a client is stressful — especially for a law student — and that clinical teachers must acknowledge that and work with students to combat the causes that lead to such stress.[230] The representation of "real clients" in clinics — including persons with mental disabilities — presents "profound moral implications" for every clinical professor and clinical student. It is imperative that clinical teachers take seriously the impact of sanism in what their students do, and how they do it, if this representation is to be authentically meaningful.[231]

IV. CONCLUSION

As I have tried to show in this article, notwithstanding the self-selection of clinical students,[232] clinics are not sanism-free. I believe, however, that sanism can be rebutted in the clinical setting (notwithstanding the fact that the stress of clinical education may exacerbate sanist tensions), perhaps with a healthy infusion of therapeutic jurisprudence,[233] or simply by the clinical professor's use of the "bully pulpit" of the clinical classroom to explain sanism[234] and to discuss

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229 Gould & Perlin, *supra* note 7, at 357.

230 *See, e.g.,* Bruce Winick, *Redefining the Role of the Criminal Defense Lawyer at Plea Bargaining and Sentencing: A Therapeutic Jurisprudence/Preventive Law Model*, 5 PSYCHOL. PUB. POL'Y & L. 1034, 1041 (1999):

> Dealing with their criminal charges can be a highly emotional experience for most defendants. Moreover, when the behavior that resulted in criminal charges is related to substance abuse, mental illness, or psychologically maladaptive behavior patterns, confronting the existence of such a problem and coming to terms with the need to deal with it can produce considerable psychological distress. Dealing with the issue of rehabilitation and relapse prevention in the context of plea bargaining or sentencing thus may be regarded, within the terminology of therapeutic jurisprudence/preventive law, as a psycholegal soft spot. Attorneys involved in these processes need to be sensitive to the emotional difficulties that dealing with such issues can produce, to be able to identify a client's psychological distress, and to be able to deal with it effectively within the attorney-client relationship.

231 Gould & Perlin, *supra* note 7, at 358-59 (footnotes omitted).

232 I am not sure *any* of us is sanism-free. I do believe, however, that this is a goal to which we all should and must aspire. In a subsequent piece, I plan to write about the different perspectives of the "patients' rights," "survivors" and "consumers" movements, and assess those positions through a sanism filter. *See* Stefan, *supra* note 87.

233 *See, e.g.,* Berkheiser, *supra* note 164, at 1171:

> Law school clinics provide an experiential setting that is a natural laboratory for applying therapeutic jurisprudence. As a theory whose purpose is to study the impacts of law on individual wellbeing, therapeutic jurisprudence can enhance clinical practice and its educational, service, and law reform missions.

234 *See* Perlin, *supra* note 188, at 31:

> Participants in the mental disability law system must acknowledge these concepts and must use the "bully pulpits" of the courtroom, the legislative chamber, the public forum, the bar association, the psychology or psychiatry conference, and the academic journals to identify and deconstruct sanist and pretextual behaviors whenever

strategies for dealing with sanist behaviors and attitudes (on the part of the teacher, the student, court personnel, other lawyers, witnesses, and anyone else involved in the case).

What else should we do? We must discuss the underlying issues openly, and "system decision-makers must regularly engage in a series of 'sanism checks' to insure — to the greatest extent possible — a continuing conscious and self-reflective evaluation of their decisions to best avoid sanism's power."[235] At the same time, "judges must acknowledge the pretextual basis of much of the case law in this area and consciously seek to eliminate it from future decision-making."[236]

The issues considered must be added to the research agendas of social scientists, behaviorists and legal scholars so as to "help illuminate the ultimate impact of sanism on this area of the law, aid lawmakers and other policymakers in understanding the ways that social science data is manipulated to serve sanist ends."[237] We must also find ways to "attitudinally educate counsel . . . so that representation becomes more than the hollow shell it all too frequently is."[238] Further, we need to consider carefully the burden of heuristic thinking,[239] especially the ways that judges use such devices in deciding important cases.

There is much for clinical professors to do here. First, as I just indicated, they must explain sanism to their students (not just in the context of "mental disability law" cases,[240] but in *all* cases that in any way involve persons with mental disabilities or the impact of mental disabilities on any direct or tangential legal questions),[241] must identify sanist behaviors, and discuss strategies for confronting, neutralizing and overcoming such behaviors and attitudes. Second, they must be alert to the ways that sanist vocabulary creeps into classroom language and discourse. When a student uses words like "retard" or "nutcase," the teacher should deal with the situation in precisely the way one would if a student were to use a pejorative word to describe

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and wherever they occur.

235 PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 307 (quoting PERLIN, *supra* note 14, at 440).

236 *Id.*

237 PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 307 (quoting PERLIN, *supra* note 14, at 440-41). *Compare* Jacobs, *supra* note 187.

238 PERLIN, HIDDEN PREJUDICE, *supra* note 2, at 307 (quoting PERLIN, *supra* note 14, at 441).

239 *See supra* note 163.

240 On "slotting" in mental disability law cases, see Perlin, *supra* note 139, at 125 n.112.

241 Clinical caseloads no doubt include a disproportionate number of persons with mental disabilities. For the first scholarly consideration of the application of sanism to an area of business law, see Pamela Champine, *A Sanist Will?*, 46 N.Y.L. SCH. L. REV. (forthcoming 2002-03).

women, African-Americans, gays, Jews, or any other racial or religious minority. Third, they must consciously and overtly discuss how perceptions of a client's (or witness's) mental disability affect all aspects of a case — including all aspects of lawyering, trial strategy, and courtroom performance. Fourth, they must be especially vigilant for the sorts of sanist behavior that I discuss in this paper, and must be alert for subtle hints of passive-aggressive sanism (*e.g.*, "I just can't empathize with this guy";[242] "Professor, how can I do active listening with my client if he makes me so uncomfortable?"). Fifth, they must be similarly vigilant in case preparation conferences, so as to identify behavior that potentially trivializes clients' legal problems and needs. Sixth, they must urge their law school administration to create more clinics for representation of persons with mental disabilities.

This list is *not* meant to be exhaustive. Indeed, it barely skims the surface of what is needed. I offer it here, however, as an elementary working blueprint for beginning this struggle.[243]

This is not an easy problem. As Mary Berkheiser candidly and perceptively notes, "Incorporating therapeutic jurisprudence into clinical teaching, . . . could simultaneously create tensions that would further complicate an already complex educational process."[244] Yet, I believe that this is a mission that we must undertake — for the integrity of the clinic and the autonomy and personhood of our clients.

In the chorus of *Ballad of a Thin Man* (from which the title of this paper derives), Bob Dylan sang:

> Because something is happening here
> But you don't know what it is
> Do you Mister Jones?"[245]

For decades we did *not* know what was happening here. But now we do. It is time for us to do something.

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[242] For elaboration on the point that labeling a client as "uncooperative" is "an exercise in power by the labeler," see Gay Gellhorn, Law and Language: "My Client Won't Cooperate" (unpublished manuscript, on file with the *Clinical Law Review*) (Nov. 5, 2001) (discussing Jacobs, *supra* note 187, at 374-75).

[243] I explain how I seek to do this in the clinical classroom in Gould & Perlin, *supra* note 7, at 365-67 (discussing the heroic work by a student, Lisa Bloch, on the Alan Andrews case).

[244] Berkheiser, *supra* note 164, at 1171.

[245] DYLAN, *supra* note 8, at 198.