'The Pain I Rise Above': How International Human Rights Can Best Realize the Needs of Persons with Trauma-Related Mental Disabilities

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I. INTRODUCTION

Persons with disabilities, especially mental disabilities, are disproportionately traumatized by the existence of their disability and their treatment by others, both in community and institutional settings. Although there is a robust literature about this phenomenon in the context of refugee populations, domestic violence victims, returning war veterans (especially as it relates to the question of the prevalence of posttraumatic stress disorder (PTSD)), and persons who suffered childhood physical and/or sexual abuse, there is less so in the context of persons who have had a lifetime of chronic mental illnesses, notwithstanding the clear findings that childhood traumatic events are strongly associated with mental, behavioral, and physical health problems in adulthood.

Although a range of behavioral intervention remedies has been suggested, there has been little attention paid to potential legal


2. See, e.g., Kenneth E. Miller & Andrew Rasmussen, War Exposure, Daily Stresses, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide Between Trauma-Focused and Psychosocial Frameworks, 70 SOC. SCI. MED. 7 (2010); Zachary Steel et al., Association of Torture and Other Potentially Traumatic Events with Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement: A Systematic Review and Meta-Analysis, 302.5 JAMA, no. 5, 537 (2009); Dawne Vogt et al., Deployment Stresses, Gender, and Mental Health Outcomes Among Gulf War I Veterans, 18 J. TRAUMATIC STRESS 115 (2005).

3. See generally, e.g., Victoria L. Banyard et al., The Long-Term Mental Health Consequences of Child Sexual Abuse: An Exploratory Study of the Impact of Multiple Traumas in a Sample of Women, 14 J. TRAUMATIC STRESS 697 (2001); Allan V. Horwitz et al., The Impact of Childhood Abuse and Neglect on Adult Mental Health: A Prospective Study, 42 J. HEALTH & SOC. BEHAv. 184 (2001); Nancy Wu et al., Childhood Trauma and Health Outcomes in Adults with Comorbid Substance Abuse and Mental Health Disorders, 35 ADDICTIVE BEHAVIORS 68 (2010).


5. R. Jay Turner & Donald A. Lloyd, Lifetime Traumas and Mental Health: The Significance of Cumulative Adversity, 36 J. HEALTH & SOC. BEHAV. 360, 361 (1995); see also Janet Lord, Child Rights Trending: Accommodating Children with Disabilities in the Global Human Rights Framework and US Foreign Policy, 16 WHITTIER J. CHILD & FAM. ADVOC. 1, 16 (2017) [hereinafter Lord, Child Rights] ("[persons with mental disabilities] are at higher risk for abuse and violence, which can, in turn, aggravate existing disabilities or create secondary disabilities, such as psychosocial trauma."). See generally Cassandra Kisiel et al., Understanding Strengths in Relation to Complex Trauma and Mental Health Symptoms Within Child Welfare, 26 J. CHILD & FAM. STUD. 437 (2017) (urging targeted trauma-informed assessments in mental health evaluations).

6. JEA KOH PETERS, REPRESENTING CHILDREN IN CHILD PROTECTIVE PROCEEDINGS:
interventions, even though there has been important recent focus on the need for lawyers to develop and use tools through which they can provide better representation for traumatized clients. This may be compounded by the fact that going to court in and of itself may exacerbate the underlying trauma.

There is a high correlation between exposure to trauma and the impact on mental health. For example, people with mental disabilities and people who have been involved in the criminal justice system have a much higher risk of being exposed to trauma and developing PTSD, compared to the general population. Additionally, many people who experience life in institutions—both short term and residential institutions—are often subjected to trauma, simply by virtue of being in the institution, but also are often subjected to forced medication, restraint, and seclusion, all of which are traumatic events that can have long lasting

7. See generally Sarah Katz & Deeya Haldar, The Pedagogy of Trauma Informed Lawyering, 22 CLINICAL L. REV. 359 (2016). Professors Katz and Haldar identify four “hallmarks” of trauma-informed legal practice: “(1) identifying trauma; (2) adjusting the lawyer-client relationship; (3) adapting litigation strategy; and (4) preventing vicarious trauma,” id. at 363, and conclude that, by focusing on these hallmarks, “clinical law professors can not only enhance the advocacy of their students while in the clinic, but also convey lasting skills which will set their students on the path to being excellent lawyers throughout their careers.” Id. at 393.

8. Reynaldo Anaya Valencia & Miguel A. Ortiz, The Persistent Challenge of Gender and Law: View’s from One Law School’s Student Body, 3 SCHOLAR 157, 160 n.3 (2001) (discussing how women and minorities injured by discrimination often choose to forego legal remedies, rather than risk the trauma that they expect courtroom exposure to entail); see also Alexandra P. West, Implying Plaintiffs’ Waivers of the Psychotherapist-Patient Privilege After Jaffee v. Redmond, 59 U. PITT. L. REV. 901, 917 (1998) (“in order to keep their childhood traumas private, [victims of childhood abuse] must forego all legal remedies for future emotional injuries caused by others’ wrongful acts.”).

9. See, e.g., Karen Oehme et al., Trauma-Informed Co-Parenting: How a Shift in Compulsory Divorce Education to Reflect New Brain Development Research Can Promote Both Parents’ and Children’s Best Interests, 39 U. HAW. L. REV. 37, 46–47 (2016) (discussing how exposure to childhood trauma can have a profound impact on individual development, and lead to serious long-term physical, interpersonal, and mental health problems).

impacts on an individual's mental and physical health. It is important to note that, "[e]ven as a practice of last resort, the threat of force can cause distress and undermine recovery." 

Significantly, in considering these issues, there has been virtually no attention paid to the impact of international human rights law—specifically, the U.N. Convention on the Rights of Persons with Disabilities (CRPD)—as a means of remediating mental health traumas. The CRPD is a "revolutionary... human rights document" that clearly establishes the international human and legal rights of persons with disabilities, and "radically changes the scope of international human rights law as it applies to all persons with disabilities," characterizing discrimination against any person on the basis of disability as "a violation of the inherent dignity and worth of the human person." Importantly, it


13. As of March 5, 2018, a WESTLAW search of "<Convention #on the rights #of persons #with disabilities>CRPD/p trauma" revealed only four "hits."


abandons the long-prevailing “medical model” of disability and replaces it with a “social model.”

In this Article, we will first discuss the meaning of trauma in this context, and then consider the impact of international human rights law on the sorts of trauma that persons with mental disabilities typically experience, and will suggest how this body of law might be used as a tool to potentially remediate some of the conditions in question. We will also look at these issues through the prism of therapeutic jurisprudence, in an effort to determine how we can bring more dignity—and concomitantly, less shame and humiliation—to the population in question, with a special focus on the potential use of problem-solving courts in this context. We will then conclude by offering some thoughts on how to better utilize a human rights approach to ensure that people with trauma-related mental disabilities are treated with dignity and respect.

Our title comes, in part, from Bob Dylan’s brilliant song, *Idiot Wind,* and is the latter part of this lyric: “You’ll never know the hurt I suffered nor the pain I rise above.” We believe that this lyric best describes how persons with trauma-related mental disabilities often feel. No two people experience trauma in the same way, and so no “other” can truly know or understand the pain that someone with a trauma-related injury or disability feels, even if that person has suffered through a similar experience. Oftentimes, this pain is hidden—especially in a society where it is not socially acceptable to publically feel pain or sadness. Although family members, lawyers, medical professionals, and therapists can try to
empathize with someone who has suffered through trauma, it is impossible to truly understand the intimacies of the pain and experiences that someone with a trauma-related disability navigates on a daily basis.

II. WHAT IS TRAUMA?

It is necessary to begin with a definition of trauma. The American Psychological Association (APA) defines trauma in this manner:

[A]n emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.22

According to one study, approximately one third of the population will experience trauma—in one form or another—at some point in their lives.23 Trauma responses can be short or long-term.24 Re-experiencing the traumatic event, avoiding stimuli associated with the trauma, and acting or feeling as if the event is reoccurring are all examples of short-term responses to trauma.25 Examples of long-term responses to trauma include chronic shame and guilt, difficulty trusting others and/or maintaining relationships, and vulnerability to re-victimization.26 Another symptom is PTSD, recently redefined in DSM-5 as including these factors:

A. Exposure to actual or threatened death, serious injury, or sexual violence . . . .
B. Presence of one (or more) . . . intrusion symptoms associated with the traumatic event(s) . . . .
C. Persistent avoidance of stimuli associated with the traumatic event(s) . . . .
D. Negative alterations in cognitions and mood associated with the

25. Id.
26. Id.; see also Perlin, Criminal Sentencing, supra note 19.
traumatic event(s)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s) . . . . 27

As a result of PTSD, many people suffer from outbursts of anger, difficulty falling asleep, increased irritability, and hypervigilance. 28

The psychological effects of trauma can manifest long after the traumatic experience occurred. 29 This is because, for some people, conditioned stimuli can be linked to the traumatic event, which can cause recurrence of fear and anxiety similar to that experienced during the initial traumatic event when re-exposed to a similar environment, 30 and the brain cannot always differentiate between what is real and a memory or reoccurrence. 31

There is no universal response to or indicator of traumatic events, because the reactions to trauma are, in large part, psychobiologic, and are influenced by a variety of individual and social contexts, which effect how an individual processes trauma. 32 And although trauma is a common human experience, a wide range of factors influence how it is manifested in different individuals including ego strength, personality style, diatheses for mental and physical illness, and cultural background. 33 This Article will focus primarily on trauma-related mental disabilities. 34


29. See CENTER FOR SUBSTANCE ABUSE TREATMENT, UNDERSTANDING THE IMPACT OF TRAUMA IN TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES 77 (2014).


33. Klufet al., supra note 24, at 82.

34. It is necessary to pay particular attention to the current plight of individuals with mental disabilities who are incarcerated—either in jails awaiting trial or in Immigration and Customs Enforcement (ICE) facilities—prior to potential deportation. See, e.g., Helen Eisner, Disabled, Defenseless, and Still Deportable: Why Deportation Without Representation Undermines Due
Because of their experiences, individuals who have experienced trauma are often more prone to becoming addicted to substances or to committing criminal offenses.\(^{35}\) Problem-solving courts—which seek to find individualized alternatives for offenders and increase the likelihood that a person with a mental disability will be diverted out of the criminal justice system\(^{36}\)—play an important role in protecting the rights of persons with trauma-related mental disabilities, particularly by decreasing the likelihood that “the person with mental disabilities will suffer at the hands of others because of that status.”\(^{37}\)

### III. INTERNATIONAL HUMAN RIGHTS LAW AND TRAUMA

#### A. Convention on the Rights of Persons with Disabilities (CRPD)

The CRPD “radically changes the scope of international human rights law as it applies to all persons with disabilities, and in no area is this more significant than in the mental disability law context.”\(^{38}\) It “reconceptualizes mental health rights as disability rights and extends existing human rights to take into account the specific rights experiences

\(\text{Process Rights of Mentally Disabled Immigrants, 14 U. PA. J. CONST. L. 511, 511 (2011).}\)

For an experience termed “Kafkaesque” by one commentator, see Jennifer L. Aronson, The Kafkaesque Experience of Immigrants with Mental Disabilities: Navigating the Inexplicable Shoals of Immigration Law, 6 INTERDISC. J. HUM. RTS. L. 145, 147 (2011). There has been a smattering of litigation alleging mental and physical trauma in such circumstances. See, e.g., Liriano v. ICE/DHS, 827 F. Supp. 2d 264, 264 (S.D.N.Y. 2011). For comparative law considerations, see generally Mauro Giovanni Carta et al., Human Rights of Asylum Seekers with Psychosocial Disabilities in Europe, 12 CLIN. PRAC. & EPIDEMIOLOGY IN MENTAL HEALTH 64 (2016); Derrick Silove et al., No Refuge from Terror: The Impact of Detention on the Mental Health of Trauma-Affected Refugees Seeking Asylum in Australia, 44 TRANSCULTURAL PSYCHIATRY 359 (2007).

\(\text{35. See Jillian M. Cavanaugh, Helping Those Who Serve: Veterans Treatment Courts Foster Rehabilitation and Reduce Recidivism for Offending Combat Veterans, 45 NEW ENG. L. REV. 463, 468 (2011); van der Kolk, supra note 24, at 389; see generally A.N. Groth, Sexual Trauma in the Life Histories of Sex Offenders, 4 VICTOMOLOGY 6-10 (1979); Theoharis Seghorn et al., Childhood Sexual Abuse in the Lives of Sexually Aggressive Offenders, 26 J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 262, 265 (1987).}\)

\(\text{36. Terry Carney et al., Mental Health Tribunals: “TJ” Implications of Weighing Fairness, Freedom, Protection and Treatment, 17 JUDICIAL ADMIN. 46, 54 (2007); Risdon Slate, From the Jailhouse to Capitol Hill: Impacting Mental Health Court Legislation and Defining What Constitutes a Mental Health Court, 49 CRIME & DELINO. 6, 18 (2003).}\)

\(\text{37. Michael L. Perlin, “Who Will Judge the Many When the Game is Through?”: Considering the Profound Differences Between Mental Health Courts and “Traditional” Involuntary Civil Commitment Courts, 41 SEATTLE U. L. REV. (forthcoming 2018), manuscript at 21 [hereinafter Perlin, Who Will Judge] (citing Carney et al., supra note 36, at 54; Slate, supra note 36, at 6).}\)

\(\text{38. Perlin, Striking, supra note 16, at 1159.}\)
of persons with disabilities." The CRPD is also the only international
convention on the rights of persons with disabilities that is legally binding
and enforceable (also known as "hard law"). Other international
documents, such as the U.N. Principles for the Protection of Persons with
Mental Illness and for the Improvement of Mental Health Care ("MI
Principles") and the Declaration on the Rights of Mentally Retarded
Persons ("MR Declaration"), are soft law, and thus not legally binding or
enforceable.41

It is necessary to carefully consider the language of the CRPD—and
its potential application to the population in question—both in the context
of its proscriptive rights and its prescriptive rights.42 We believe that the
CRPD can be, and should be, a blueprint for advocates representing
persons traumatized as a result of their mental disabilities.

At the outset, it is necessary to clarify that the United States has
signed, but has not ratified, the CRPD.43 Under such circumstances, "a
state's obligations under it are controlled by the Vienna Convention on
the Law of Treaties . . . which requires signatories 'to refrain from acts

Intersection Between International Human Rights and Domestic Mental Disability Law, 35 LAW
& PSYCHOL. REV. 121, 139 (2011) (citing Phil Fennell, Human Rights, Bioethics, and Mental
Disorder, 27 MED. & L. 95, 107 (2008); Frédéric Mégrét, The Disabilities Convention: Human
Rights of Persons with Disabilities or Disability Rights?, 30 HUM. RTS. Q. 494, 494 (2008)).

40. "Hard law . . . 'refers to legally binding obligations that are precise (or can be made
precise through adjudication or the issuance of detailed regulations) and that delegate authority
for interpreting and implementing the law.'" Gregory C. Shaffer & Mark A. Pollack, Hard Versus
Abbott & Duncan Snidal, Hard and Soft Law in International Governance, 54 INT'L ORG. 421,
421 (2001)).

41. On the significance of soft law in the development of international human rights, see
Christian Courtis, Disability Rights in Latin America and International Cooperation, 9 S.W.J.L.
& TRADE AM. 109 (2002). Soft law "may guide the interpretation, elaboration, or application of
hard law; constitute norms that aspire to harden; serve as evidence of hard law; exist in parallel
with hard law obligations and act as a fall-back; or serve as a source of relatively hard obligations
through acquiescence or estoppel." See Jose Alvarez, The New Dispute Settlers: (Half) Truths and
Consequences, 38 TEX. INT'L L.J. 405, 421 (2003). On how soft law becomes hard law via court
decisions, see Gerald L. Neuman, Import, Export, and Regional Consent in the Inter-American

42. Perlin & Schriver, supra note 18, at 386. Prescriptive rights require certain conduct,
whereas proscriptive rights forbid particular behavior. Edward J. Imwinkelried, Expert Testimony
by Ethicists: What Should be the Norm?, 33 J.L. MED. & ETHICS 198, 200 (2005); see Robert J.
Quinn, Will the Rule of Law End? Challenging Grants of Amnesty for the Human Rights
Violations of a Prior Regime: Chile's New Model, 62 FORDHAM L. REV. 905, 920 (1994) (noting
the significance of the inclusion of proscriptive and prescriptive rights in human rights treaties in
general).

43. See Michelle Diament, Obama Urges Senate to Ratify Disability Treaty, DISABILITY
Scoop (May 18, 2012), https://www.disabilityscoop.com/2012/05/18/obama-urges-senate-
treaty/15654/.
which would defeat [the Disability Convention’s] object and purpose.”

Domestic courts in New York have cited the CRPD approvingly in cases involving guardianship matters. In one such case, Surrogate Judge Kristin Booth Glen noted that the CRPD was “entitled to ‘persuasive weight’ in interpreting our own laws and constitutional protections.” Thus, we approach this issue from the perspective that the CRPD must be taken seriously in the United States by all domestic courts.

Article 1 of the CRPD outlines the purpose of the Convention, which is to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.” The definition is all-inclusive and includes “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” This is particularly important in the context of persons with trauma-related mental disabilities because, as discussed above, such individuals are particularly susceptible to institutionalization and human rights violations, and consequently, to additional trauma simply by virtue of their disability. The CRPD further calls for non-discrimination and “full and effective participation and inclusion in society.” This includes people who have experienced trauma-related mental disabilities.

Article 12 declares that persons with disabilities have equal recognition before the law. This is particularly relevant within the


45. See PERLIN & CUCOLO, supra note 28, § 2-8, at 2-73 to 2-78.
46. Dameris L., 956 N.Y.S.2d at 855. See generally Perlin & Schriver, supra note 18, at 386; Perlin, God Said, supra note 14, at 486 n.57.
47. See Perlin, Striking, supra note 16, at 1160.
48. CRPD, supra note 17, art. 1; see, e.g., Leslie Salzman, Guardianship for Persons with Mental Illness—A Legal and Appropriate Alternative?, 4 ST. LOUIS U. J. HEALTH L. & POL’Y 279, 283–84 (2011) (“The CRPD is predicated on the obligation to respect each person’s inherent dignity, autonomy, and independence, including the freedom to make one’s own choices”).
49. CRPD, supra note 17, art. 1.
51. CRPD, supra note 17, art. 3.
52. Id. art. 12.
context of both therapeutic jurisprudence (TJ)—the concept that the law can have therapeutic or anti-therapeutic consequences—and trauma-informed lawyering (both of which will be discussed in detail below) as both of these approaches recognize the importance of authentically including the client in the legal process and recognizing him/her before the law.

Article 13 of the CRPD proclaims that persons with disabilities shall have equal access to justice on an equal basis with others. This includes the provision of accommodations for persons with disabilities “in order to facilitate their effective role as direct and indirect participants . . . in all legal proceeding. . . .” Access to adequate and dedicated counsel is one of the most critical issues in bringing life to international human rights law within a mental disability law context. In many nations, there are no mental health laws at all, effectively meaning those States’ legislative bodies have completely failed to address people with mental disabilities, while other countries lack provisions for legal counsel altogether, in that there is no statutory right to legal counsel at an adjudication or civil commitment proceeding. Most other countries have what is referred to as the “warm body” problem, where legal counsel appears to be present in name only. At a very minimum, ensuring people with mental disabilities receive due process provides the appearance of fairness. This is therapeutic because it contributes to the individual’s sense of dignity and conveys the sense that he or she is being taken seriously. It is important for persons with disabilities to have the option

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55. CRPD, supra note 17, art. 13.
58. Id. at 340-42.
59. See, e.g., Pamela Metzger, Doing Katrina Time, 81 TUL. L. REV. 1175, 1198 (2007) (“This right to counsel is not satisfied by the mere appearance of a warm body wearing a business suit and holding a copy of the [statute book].”)
61. See John Ensinger & Thomas Liguori, The Role of Counsel in the Civil Commitment
to actively participate in legal proceedings. This can help to ensure that they feel included in the process which can initiate healing.

Article 14 of the CRPD states that all persons with disabilities shall enjoy the right to liberty and security of person, and that States must ensure that people with disabilities are not deprived of their liberty unlawfully or arbitrarily. U.S. constitutional law has also codified this right in a number of important court cases. In 1975, the U.S. Supreme Court held that states cannot confine a person who is mentally ill "without more."

Four years later the Supreme Court ruled that the standard of proof for involuntary civil commitment of a psychiatric patient is clear and convincing evidence. The right to liberty and security of person is especially important within the context of persons with trauma-related mental disabilities because being deprived of one's liberty can trigger memories of past trauma, causing a string of painful emotions and reactions.

Article 15 of the CRPD states that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."


See generally Bruce J, Winick, Therapeutic Jurisprudence and the Civil Commitment Hearing, 10 J. CONTEMP. LEGAL ISSUES 37, 41–52 (1999).

See infra notes 119–22, at 51–52; see also infra text accompanying notes 119–22.

CRPD, supra note 17, art. 14.


See Addington v. Texas, 441 U.S. 418, 426 (1979) (holding that "the state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.").

See Charney, supra note 30 and accompanying text.

CRPD, supra note 17, art. 15. It is important to underscore that torture "goes beyond prototypical notions of physical abuse and includes psychological abuse as well. See generally The Trauma of Psychological Torture (Almerindo E. Ojeda ed., 2008); Herman Reyes,
important case brought before the European Court of Human Rights (ECtHR) illustrates this right where the Court recognized that poor conditions of confinement can constitute inhuman or degrading treatment. In *Stanev v. Bulgaria*, the Court found that being improperly detained without a court hearing, for seven years in a dilapidated facility lacking adequate food, running water, access to toilets, privacy, or almost any form of meaningful activity amounted to “degrading” treatment. | 70 |

The Court further found that long-term detainment in the facility without a court hearing constituted deprivation of liberty. | 71 |

As with potential deprivations of Article 14, such a deprivation of this right can implicate reliving a traumatic experience; exposing a person to such treatment not only creates a traumatic experience for that individual, but it can also recreate a traumatic experience for an individual with a trauma-related mental disability by triggering memories of past experiences. | 72 |

According to Article 16 of the CRPD, State Parties are under an obligation to protect persons with disabilities from all forms of exploitation, violence, and abuse. | 73 |

It has been argued that this Article should be read to also promote alternatives to seclusion and restraint, which can lead to increased trauma and cause long-term effects on patients. | 74 |

Further, due to the harms that are associated with seclusion and restraint on individuals generally—but particularly on persons who have previously suffered trauma—such interventions are arguably classified as violations of Article 16 whereas they are forms of exploitation, violence, and abuse. | 75 |

In fact, former Special Rapporteur on the Convention against

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71. Id.

72. See Charney, supra note 30, and accompanying text; see also, e.g., Stephen Paskey, *Telling Refugee Stories: Trauma, Credibility, and the Adversarial Adjudication of Claims for Asylum*, 56 SANTA CLARA L. REV. 457, 484 (2016) (discussing how traumatic events may trigger painful memories or feelings).

73. CRPD, supra note 17, art. 16.


75. Id. at 3 (citing MELB. SOC. EQUITY INST., SECLUSION & RESTRAINT PROJECT: REP., Report Prepared for the Nat’l Mental Health Comm’n (Univ. of Melbourne, 2014); Stuart A. Kinner et al, *Attitudes Towards Seclusion and Restraint in Mental Health Settings: Findings From a Large, Community-Based Survey of Consumers, Carers and Mental Health Professionals*, EPIDEMIOLOGY & PSYCHIATRIC SERVS. 1–10 (2016) (A study conducted in by the Melbourne Social Equity Institute, University of Melbourne surveying 1451 mental health consumers found that “[b]etween 80 and 90% of participants believed that seclusion and all forms of restraint infringed human rights and that seclusion, physical and mechanical restraint compromised therapeutic trust and would often or always cause trauma or trigger past trauma.”).

76. McSherry, supra note 74, at 41.
Torture, Manfred Nowak, has noted that seclusion and solitary confinement can constitute torture or ill-treatment. It is important to note that 30% of inmates in solitary confinement suffer from a mental disability.

There is very little scholarship focusing on the application of the CRPD in cases involving trauma. In an article focusing on the CRPD's application to matters involving children and juveniles, Janet Lord has noted that that population is "at higher risk for abuse and violence, which can, in turn, aggravate existing disabilities or create secondary disabilities, such as psychosocial trauma." In a paper considering the ways that persons with albinism are subject to torture in Tanzania, Stacy Larson has invoked the CRPD in seeking to craft remedies for a population "living in fear of attack along with the awareness of how severe an attack can be [that] creates mental trauma . . . amounting to torture." And disability rights activist Tina Minkowitz has argued that the CRPD can and should be used by "users and survivors of psychiatry" as a means of avoiding "nonconsensual interventions [that] have been a source of trauma." But other than these pieces, there has been no legal scholarship at all on this important issue.

While the CRPD is the most recent and inclusive document on the rights of persons with disabilities, prior to the CRPD, there were other international instruments that provided substantive protections for

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77. Interim Report on Torture and other cruel, inhuman or degrading treatment or punishment, transmitted by Note of the Secretary-General, ¶ 56, U.N. Doc. A/63/175, 53 (July 28, 2008).


79. See infra note 124. But see Liz Brosnan & Eilionoir Flynn, Freedom to Negotiate: A Proposal Extricating “Capacity” from “Consent,” 13 INT’L J.L. IN CONTEXT 58, 68 (2017) (discussing “the role that supported decision-making such as by - trauma-informed, intentional peer support . . . can play in establishing the person’s will and preference”) (citations omitted).


83. There has been some mention in the behavioral science literature. See, e.g., Watson et al., supra note 12; Jeffrey Chan et al., Applying the CRPD to Safeguard the Rights of People with a Disability in Contact with the Criminal Justice System, 19 PSYCHIATRY, PSYCHOL & L. 558 (2012).
persons with mental disabilities, including the International Convention on Civil and Political Rights (ICCPR) and the European Convention on Human Rights (ECHR). It is valuable to assess the impact of some of these documents on the questions we raise in this Article.

**B. International Covenant on Civil and Political Rights (ICCPR)**

The International Covenant on Civil and Political Rights (ICCPR) is an important international human rights treaty that was entered into force in 1976. It is part of the International Bill of Human Rights, and it ensures basic human rights principles of dignity and autonomy, as well as the right to be recognized as a person before the law. Article 7 of the ICCPR ensures protection from torture or other forms of inhuman or degrading treatment and provides that no one shall be subjected to medical or scientific experimentation. Article 14 states that all persons shall have equal rights before the courts. These important provisions help ensure that persons with trauma-related mental disabilities are protected from torture, and other acts that could cause memories of past traumatic events to resurface and when such events do occur, the Covenant ensures that judicial remedies are available.

**C. The Declaration on the Rights of Mentally Retarded Persons (MR Declaration)**

The Declaration on the Rights of Mentally Retarded Persons (the MR Declaration) was adopted by the General Assembly in 1971. It encourages persons with mental disabilities to live with their families and to participate in community life. It further states that if an institution is

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84. Karl C. Procaccini, *Constructing the Right “Not to Be Made a Refugee” at the European and Inter-American Courts of Human Rights*, 22 Harv. Hum. Rts. J. 271, 283 nn.65 & 67 (2009). While the ECHR is an important document, we will not discuss it in detail for the purposes of this Article.


87. ICCPR, *supra* note 85, art. 7.


necessary, it should be provided in surroundings and other circumstances as close to normal life as possible. It further states that persons with mental disabilities have a right to protection from exploitation, abuse, and degrading treatment. It guarantees protections and allows for legal safeguards for when persons with mental disabilities' rights are not able to be exercised in a meaningful way. These protections are relevant to persons with trauma-related disabilities because they all help to foster an environment where such individuals feel safe and secure, thereby reducing the chances of experiencing reoccurring memories related to past traumatic experiences. An unanswered question is the extent to which criminal procedure decisions that allow for defendants to face and question their accusers can actually, in some cases, negatively affect victims who have experienced trauma by forcing them to relive the painful experience.

D. Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)

In 1991 the MI Principles first established due process standards for admission into institutions in international law. This was the first international document that provided basic minimum standards for treatment of people with mental disabilities in institutional and community settings. The MI Principles restrict seclusion and physical

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92. Id.
93. See, e.g., Crawford v. Washington, 541 U.S. 36 (2004) (affirming a defendant's right to stand and face accusers, but also affirming the power of victims of domestic violence to exercise control over their own cases, specifically over whether or not to pursue charges).
94. See, e.g., Anoosha Rouhanian, A Call for Change: The Detrimental Impacts of Crawford v. Washington on Domestic Violence and Rape Prosecutions, 37 B.C. J.L. & SOC. JUST. 1, 2 (2017) (charging that Crawford "punishes victims.").
95. PERLIN ET AL., supra note 91, at 243–53.
restraints. This restriction is not absolute, but only allows seclusion or restraint when “it is the only means available to prevent immediate or imminent harm to the patient or others,” and it is not allowed to be used for longer than “the period which is strictly necessary for this purpose.” Further, a personal representative must be given notice of the physical restraint or seclusion of a patient. The MI Principles were revolutionary in terms of setting the standard for civil commitment for persons with disabilities in international law. The MI Principles also have a specific section for rights in and conditions of mental health facilities.

There were very few procedural protections for persons with trauma related mental disabilities before the MI Principles. The CRPD is less specific than the MI Principles with regard to the right to refuse treatment, however, it has more “teeth” than the MI Principles (which have been severely critiqued in this regard), because the CRPD is a binding international document with enforcement mechanisms.

E. U.N. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)

CAT, which was adopted in 1984, is another important treaty for the rights of persons with mental disabilities. According to CAT, a practice must be an act or omission of a government authority, cause severe pain, and intent and purpose must be present in order to constitute torture. Even when a practice does not rise to the level of torture, it may still constitute ill-treatment (“cruel, inhuman or degrading treatment or punishment”)

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97. Perlin et al., supra note 91, at 243–53.
98. Id.
99. Id.
100. See, e.g., T.W. Harding, Human Rights Law in the Field of Mental Health: A Critical Review, 101 ACTA PSYCHIATRICA SCANDINAVICA 24, 24 (2000) (discussing how the MI Principles are “basically flawed” and specifically referring to the right to refuse treatment).
102. CAT was intended to strengthen existing international law prohibitions on torture. J. Herman Burgers & Hans Danelius, The United Nations Convention Against Torture: A Handbook on the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1 (1988); see also Juan Mendez (Special Rapporteur on Torture and Cruel, Inhuman or Degrading Treatment or Punishment), para. 78, U.N. Doc. A/66/268, 172 (Aug. 5, 2011); see also, e.g., Selimouni v. France, App. No. 25803/94, 29 Eur. H.R. Rep. 403, 443 (1999) (holding that physical and mental violence committed against applicant while in police custody, which caused severe pain and suffering, was an act of torture in violation of Article 3).
punishment”) which is prohibited under Article 16.105 The intent to cause pain requirement does not require specific evidence of the motivations of treating professionals, rather it can be implied. Also, a practice is not excluded from being labeled as torture by stating that its purpose is therapeutic.106 Thus, certain types of coerced treatment or the use of seclusion and restraints can be considered a CAT violation as well as a violation of the CRPD and other international human rights treaties.107 Such protections are important for individuals with trauma-related mental disabilities because, as mentioned above, being subjected to any sort of cruel treatment or punishment—or even the threat of such treatment—can stir up memories of past trauma for individuals forcing them to relive painful experiences over and over again.108

F. WHO International Classification of Functioning, Disability and Health (ICF)

Another important international document relevant to the human rights of persons with trauma-related disabilities is the WHO International Classification of Functioning, Disability and Health (ICF). The ICF is the “WHO framework for measuring health and disability at both individual and population levels.”109 It was officially endorsed “as the international standard to describe and measure health and disability” by all the 191 WHO Member States at the Fifty-Fourth World Health Assembly in May 2001.110

The ICF has been cited as demonstrating a broader, more modern view of the concepts of “health” and “disability” by acknowledging that every individual is capable of experiencing at least some degree of disability throughout their lifetime, whether it be through a change in health or environment.111 It acknowledges that “disability is a universal human experience, sometimes permanent, sometimes transient” and that it is not restricted to a small portion of the population.112

However, this document looks at disability in more of a traditional

106. See id.; see also ERIC ROSENTHAL & LAURIE AHERN, TORMENT NOT TREATMENT: SERBIA’S SEGREGATION AND ABUSE OF CHILDREN AND ADULTS WITH DISABILITIES 47, 49 (2007).
108. See generally Perlin, God Said, supra note 14, at 483–86.
111. Id.
112. Id.
and medical sense. The traditional medical model of disability is not sufficient to examine the needs of trauma-related mental disabilities, because it tends to be exclusionary toward people with disabilities. Instead, it is important to utilize a social model, which looks more at the individual and what he/she can do rather than what he/she cannot do. While we recognize and can appreciate the importance of such a document that provides medical definitions of disability, the authors conclude that the CRPD takes a much more protective and human rights-based approach to persons with disabilities, and therefore prefer its definitions and stance on disability.

All of the above international human rights documents provide important protections for the rights of people with disabilities. However, these other instruments do not have the enforcement mechanisms that the CRPD has. The authors believe that the CRPD is the most comprehensive, all-inclusive, protective, and relevant document for the purposes of this discussion.

IV. THERAPEUTIC JURISPRUDENCE

How can therapeutic jurisprudence be employed in efforts to implement meaningful remedies to help realize the rights of persons with trauma-related mental disabilities? Therapeutic jurisprudence (TJ) recognizes that the law can have therapeutic or anti-therapeutic consequences. It assesses the law’s influence on emotional and psychological well-being, and allows us to “look at law as it actually impacts people’s lives.” According to TJ, the “law should value

113. See supra text accompanying note 17.
114. DeMarco, supra note 102, at 524.
psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law, should attempt to bring about healing and wellness.\footnote{119} The ultimate goal of TJ is to “determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles.”\footnote{120}

Professor Amy Ronner describes the “three Vs”: voice, validation and voluntariness, and argues:

What “the three Vs” commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant’s story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronunciation that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings prosper when they feel that they are making, or at least participating in, their own decisions.\footnote{121}

Although there has been significant scholarly investigation of the relationship between TJ and international law,\footnote{122} there has been virtually
none in the specific context of international human rights law. Self-evidently, TJ is extremely important within the context of international human rights law, and it is essential that the TJ community turns to international human rights law as a future source and potential direction for TJ scholarship. One of the authors (MLP) has called on TJ scholars to immerse themselves in international human rights law and has listed ten areas in which they might focus their research. One such area was an investigation of "[t]he [TJ] implications of instituting reform of forensic facilities." While there is a plethora of scholarship on the relationship between TJ and prisons and other detention facilities, there is still perilously little on the relationship between TJ and international human rights law. As such, this is an area that calls for new investigations and considerations. Professor Astrid Birgden, by way of example, notes how combining TJ and international human rights law "provides for liberty, due process, the right to receive or refuse treatment, and the exercise of informed decision making."

TJ also informs how lawyers should interact with their clients. Lawyers should be particularly aware of their interactions with clients who have experienced trauma, and how their actions may affect these
individuals. These clients may, for example, be withdrawn, have high anxiety, or be suspicious and untrusting. It is important for lawyers to be sensitive to these needs to effectively represent these clients. Further, re-exposure to a past event may trigger feelings of fear and anxiety that were felt during the original event for many people who have experienced past trauma. This is why it is imperative to treat people with trauma-related injuries in accordance with the principles of TJ in order to best avoid bringing up past memories that could trigger such feelings. The principles of TJ are also in line with the CRPD’s requirement to treat individuals with disabilities with inherent dignity and respect and to ensure “full and effective participation and inclusion in society” for persons with disabilities.

In recent years, TJ scholars have turned their attention to the potential value of problem-solving courts (mental health courts and others) as a way of “attempt[ing] to get at the root of the individual and social problems that motivate criminal behavior” by “changing the future behavior of litigants and ensuring the future well-being of communities.” When such courts operate as they are intended to, they are grounded and rooted in TJ, and they reflect TJ “theory in


133. Charney, supra note 30, at 195.


135. CRPD, supra note 17, art. 1.

136. Id. art. 3(c).


141. Andrew Wasicek, Mental Illness and Crime: Envisioning a Public Health Strategy and
practice." We turn now to a short discussion of these courts in an effort to determine whether they might serve as a palliative (or, at least, a partial palliative) for traumatized individuals.

A. The Role of Problem-Solving Courts in the Implementation of this Remedy

Problem-solving courts serve two important roles. First, they help get to the root of the problem by understanding and addressing the cause, and second, they aid in preventing recidivism and preventing recurring court involvement. Problem-solving courts take a holistic approach where other courts may just put a "band-aid" on the issue in that they look to alternatives to assist offenders in the long-term rather than perpetuating a revolving door between court and prison. Such alternatives include drug treatment centers or domestic violence counseling instead of incarceration.

Problem-solving courts are imperative within the context of caring for the needs of persons with trauma-related mental, disabilities because they treat the person as an individual with specialized needs and look for a treatment for the problem rather than simply locking up the accused where he/she will likely not have access to essential services and be exposed to more trauma.

Mental health courts are premised on team approaches. On such
teams, justice and treatment agencies provide representatives who screen offenders as to potential risk of violence in the community, help create individualized treatment plans, and supervise participants’ performance in treatment.\textsuperscript{148} The mental health court judge is a team member,\textsuperscript{149} helping to decide questions of treatment needs and safety issues if the defendant is to be released.\textsuperscript{150} A case manager and court monitor track the defendant’s progress and participation, and submit periodic reports to the court.\textsuperscript{151} Participants report to the court periodically for the monitoring of treatment compliance; extra status review hearings are held when needed.\textsuperscript{152}

To be effective in this context, “the judge needs to develop enhanced interpersonal skills and awareness of a variety of psychological techniques that can help the judge to persuade the individual to accept treatment and motivate him or her to participate effectively in it.”\textsuperscript{153}
Optimally, this will best achieve the courts’ objectives, by building trust and managing risk. It is essential that the judge is able:

to convey empathy and respect, to communicate effectively with the individual, to listen to what the individual has to say—thereby fulfilling the individual’s need for voice and validation—to earn the individual’s trust and confidence, and to engage in motivational interviewing and various other techniques designed to encourage the individual to accept treatment and comply with it.

Judges in such courts must have the capacity to “break free from the statutory shackles that [sic] ‘transformed them into mid-level bureaucrats.’” It is also far more likely that these judges will be culturally competent, and thus able to “unpack” the testimony of persons subject to civil commitment who do not come from the mainstream culture. These courts provide “nuanced” approaches, and may signal a “fundamental shift” in the criminal justice system.


It is essential to keep in mind that one of the central principles of TJ is a commitment to dignity.161 Indeed, "the perception of receiving a fair hearing is therapeutic because it contributes to the individual’s sense of dignity and conveys that he or she is being taken seriously."162 Professors Jonathan Simon and Stephen Rosenbaum have embraced therapeutic jurisprudence, focusing specifically on this issue of voice: "When procedures give people an opportunity to exercise voice, their words are given respect, decisions are explained to them their views taken into account, and they substantively feel less coercion."163 Naomi Weinstein and one of the co-authors (MLP) have recently argued that “attorneys must embrace the principles and tenets of TJ as a means of best ensuring the dignity of their clients and of maximizing the likelihood that voice, validation and voluntariness will be enhanced.”164 We believe that an embrace of the modern mental health court model is the single best way that this dignity can be provided, and that traumatized persons will be treated more fairly.165 In addition, it is also imperative to ensure that lawyers working with individuals with trauma-related mental disabilities are sensitive to the rights and needs of such individuals by utilizing a trauma-informed approach to lawyering.166

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161. See Bruce J. Winick, Civil Commitment: A Therapeutic Jurisprudence Model 161 (2005). Dignity inquiries permeate the criminal justice system, especially as the concept applies to persons with mental disabilities.


166. Veterans’ courts—another sort of problem solving court—have been criticized specifically because they “have no inherent measures in place that are sensitive to or cognizant of combat trauma.” Mark A. McCormick-Goodhart, Leaving No Veteran Behind: Policies and Perspectives on Combat Trauma, Veterans Courts, and the Rehabilitative Approach to Criminal Behavior, 117 PENN. ST. L. REV. 895, 923 (2013).
B. The Benefits of Trauma-Informed Practice

Trauma-informed services are designed to respond to the impact that past trauma has on individuals, as well as disclosure of current harm.167 It recognizes the importance of trust, safety, and respect in relationships between service providers and individuals who have experienced harm.168

"Trauma-informed practice recognizes the ways in which trauma impacts systems and individuals."169 Trauma-informed practice is the idea that the practitioner puts the needs of the trauma-exposed client at the forefront of his/her approach to lawyering.170 This involves the lawyer adjusting his/her practice approach to better work with a client who has experienced trauma. Put another way, a trauma-informed perspective asks clients "What happened to you?" instead of "What is wrong with you?"171 It is important for lawyers to recognize that mental health diagnoses, behavioral systems, and involvement in the criminal justice system do not indicate sickness or badness, but are instead manifestations of injury or traumatic experience.172 Thus, trauma-informed services and programs have a tendency to be more supportive (rather than punitive) so as to best avoid re-traumatizing the client, and vicariously, the person serving the trauma survivor.173 In fact, "[e]ffective trauma-informed services are services not just designed to treat symptoms or syndromes related to significant sexual, physical, or emotional abuse; they are services where staff are aware of, and sensitive to, doing no further harm

167. For the application of these principles in a different (but perhaps overlapping) area of law, see Martina E. Vandenber, Innovations in the Fight Against Human Trafficking: Listening to Trafficking Survivors, Fighting for Justice, 60 N.Y.L. SCH. L. REV. 631, 647 (2015–16) ("Attorneys who specialize in human trafficking have a responsibility to train pro bono attorneys on appropriate trauma-informed representation.").


172. SANDRA BLOOM & BRIAN FARRAGHER, RESTORING SANCTUARY: A NEW OPERATING SYSTEM FOR TRAUMA-INFORMED SYSTEMS OF CARE 1, 7–9 (2013).

Trauma-informed practice also includes self-care for the lawyer in order to counterbalance the impacts of dealing with clients exposed to trauma.175 Clients generally seek legal advice at times when they are particularly vulnerable and emotional.176 In order to effectively represent their clients, lawyers must often ask for clients to share some of the most intimate and painful details of their lives, and often must ask to expose some of their most closely-held secrets.177 It is important for lawyers to recognize and understand trauma and its impacts on clients—particularly on clients with mental disabilities—instead of simply being sympathetic to said clients.178

The implementation of trauma-informed practice is of particular importance for lawyers because they have traditionally been trained not to get emotionally attached to their clients.179 However, by utilizing a
trauma-informed approach to lawyering, attorneys are better able to represent their clients by serving them in a more well-rounded way.\textsuperscript{180} This also allows them to help refer clients to outside services including counseling and trauma-informed therapeutic services.\textsuperscript{181} Legal professionals must recognize that seeking legal assistance in of itself can be a traumatic experience—and this is particularly true for clients who are forced to relive traumatic events in their interactions with the legal system.\textsuperscript{182} Lawyers need to be especially sensitive to the needs and intricacies of working with clients who have experienced trauma—particularly those with mental disabilities—and a trauma-informed approach to lawyering helps to ensure a more client-centered, holistic approach.\textsuperscript{183} Trauma-informed lawyering comports with the CRPD’s principles of treating people with disabilities with inherent dignity and respect.\textsuperscript{184}

\section*{V. CONCLUSION}

Trauma-related mental disabilities affect the lives of individuals and the entire community in a variety of ways. For some, the impacts of trauma are brief, but for others the effects are permanent. After

\textsuperscript{180} There is apparently a course offered at Santa Clara Law School, “Trauma, Vicarious Trauma, and Legal Representation of Trauma Victims.” See Lisa Morgillo, \textit{Do Not Make Their Trauma Your Trauma: Coping with Burnout as a Family Law Attorney}, 53 \textit{FAM. CT. REV.} 456, 464 (2015). One of the co-authors (MLP) created a course in “Trauma and Mental Disability Law” that was taught regularly at New York Law School from 2009-14. Along with Professor Heather Ellis Cuocolo, he will be offering a webinar-based version of that course in the fall 2018 term under the auspices of Consolidated Continuing Education & Professional Training (CONCEPT), see https://www.concept-ce.com/about/.

\textsuperscript{181} Parker, \textit{supra} note 179, at 163; \textit{see also} ABA POLICY ON TRAUMA-INFORMED ADVOCACY FOR CHILDREN AND YOUTH (2014), available at https://www.americanbar.org/content/dam/aba/administrative/child_law/ABA%20Policy%20on%20Trauma-Informed%20Advocacy.authcheckdam.pdf; ELIZA PATTEN & TALIA KRAEMER, PRACTICE RECOMMENDATIONS FOR TRAUMA-INFORMED LEGAL SERVICES (2013). In this context, consider what Professor Susan Brooks calls “relationship-centered lawyering,” arguing that there are “three broad areas of competency every effective lawyer needs, regardless of his or her type of practice: (a) understanding theories about the person-in-context, (b) promoting procedural justice, and (c) appreciating interpersonal, cultural, and emotional issues.” Susan Brooks, \textit{Teaching Relational Lawyering}, 19 \textit{RICH. J.L. & PUB. INT.} 401, 402 (2016).

\textsuperscript{182} Katz & Haldar, \textit{supra} note 7, at 366.

\textsuperscript{183} Cf. Gina Maisto Smith & Leslie M. Gomez, \textit{The Regional Center for Investigation and Adjudication: A Proposed Solution to the Challenges of Title IX Investigations in Higher Education}, 120 \textit{PENN ST. L. REV.} 977, 979–80 (2016) (“Successful processes require that educational institutions integrate these concepts to develop a coordinated and holistic response that is trauma-informed, fair, impartial, principled, and balanced in its attention to the welfare and safety of students, faculty, staff, and community members.”).

\textsuperscript{184} See, e.g., Salzman, \textit{supra} note 48, at 283–84.
experiencing trauma, many individuals experience a variety of emotions and reactions, responses that can impair their ability to seek and retain employment, to stay out of the criminal justice system, to have relationships, and to otherwise live "normal" lives. This is generally not the fault of the individuals who experienced the trauma, but is a result of the fact that their environments are not adapted to sufficiently fulfill the needs of persons who have experienced trauma-related mental disabilities. Therefore, it is important to utilize a human rights approach to addressing the needs of people with trauma-related mental disabilities.

It is essential for people working with persons with trauma-related mental disabilities to recognize the specific needs of this population. The CRPD provides an excellent framework for a person-centered, inclusive approach to protecting the human rights of persons with disabilities, and more specifically, people with trauma-related mental disabilities. It is important to treat individuals with trauma-related mental disabilities as unique individuals with unique needs and abilities. A one-size-fits-all approach is not sufficient to deal with this population because each person deals with one's own trauma in different ways. It is imperative that "counsel [has] a background in mental health issues and in communicating with individuals who may be in crisis . . . ." Also, "judges and defense counsel in mental health [and other problem-solving] courts should ensure that defendants receive dignity and respect, [and] are given a sense of voice and validation . . . ."

Although it is impossible to truly know the pain felt by people with trauma-related mental disabilities, at the very least lawyers, therapists, and other professionals can ensure people with mental disabilities are treated in a way that is in compliance with the CRPD. We remain hopeful that with the increased attention to the practice of therapeutic jurisprudence, the increased recognition of the importance of problem-

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185. For some, of course, the trauma leads directly to involvement in the criminal justice system. See Perlin, Criminal Sentencing, supra note 19, at 916–17.

186. This is mandated in some nations. See, e.g., Amy Raub et al., Constitutional Rights of Persons with Disabilities: An Analysis of 193 National Constitutions, 29 HARV. HUM. RTS. J. 203, 224 (2016) (quoting the Constitution of Ecuador: "Persons with disabilities are recognized the following rights: 1. Specialized attention in public and private entities that provide healthcare services for their specific needs, which shall include the free provision of medicines, especially for those persons that require lifetime treatment.").

187. Tammy Seltzer, Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses, 11 PSYCHOL. PUB. POL’Y & L. 570, 576 (2005); see also M. Carmela Epright, Coercing Future Freedom: Consent and Capacities for Autonomous Choice, 38 J.L. MED. & ETHICS 799, 801 (2010) ("Ideally, in mental health courts all courtroom personnel, i.e., judge, prosecutor, defense counsel and other relevant professionals, have experience and training in mental health issues and available community resources.").

188. Stefan & Winick, supra note 149, at 516.
solving courts, and the momentum towards utilizing and teaching trauma-informed practice, the needs of persons with trauma-related mental disabilities will be recognized and met in a way that is in accordance with international human rights principles of dignity, respect, and equality.

A recent biography of Bob Dylan presciently describes the song *Idiot Wind*—from which we have drawn part of our title—as “an image of democracy’s decay.”¹⁸⁹ Our treatment of traumatized persons with mental disabilities—especially those institutionalized because of mental disabilities—has contributed to that “decay.”¹⁹⁰ We believe a turn to international human rights law might help alleviate some of the “pain” in question.

¹⁸⁹. IAN BELL, TIME OUT OF MIND: THE LIVES OF BOB DYLAN 36 (2015 ed.).

¹⁹⁰. For a recent consideration of how our treatment of racial minorities, women and those from other cultures fails to comport with therapeutic jurisprudence standards, see Perlin & Cucolo, supra note 115, at 456.