2018

Who Will Judge the Many When the Game Is Through: Considering the Profound Differences between Mental Health Courts and Traditional Involuntary Civil Commitment Courts

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Recommended Citation
Perlin, Michael L., "Who Will Judge the Many When the Game Is Through: Considering the Profound Differences between Mental Health Courts and Traditional Involuntary Civil Commitment Courts" (2018). Articles & Chapters. 1158.
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"Who Will Judge the Many When the Game is Through?": Considering the Profound Differences Between Mental Health Courts and "Traditional" Involuntary Civil Commitment Courts

Michael L. Perlin, Esq.*

INTRODUCTION

For forty years, we have known that involuntary civil commitment hearings are—in most jurisdictions—"charades."1 When the Supreme Court noted, in *Parham v. J.R.*, that the average length of a civil commitment hearing ranged from 3.8 to 9.2 minutes,2 the reaction of many

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2. Parham v. J.R., 442 U.S. 584, 609 n.17 (1979) (countenancing fewer procedural due process protections for juveniles facing civil commitment than in cases involving adults); see also Michael L. Perlin & Alison J. Lynch, "She's Nobody's Child/The Law Can't Touch Her at All": Seeking to Bring Dignity to Legal Proceedings Involving Juveniles, 56 FAM. CT. REV. 79, 88 (2018) (assessing the extent to which *Parham* has contributed to the shaming and humiliation of juveniles facing psychiatric institutionalization).
who had done these cases was, “What? So long?!” The characterization of such hearings as being a “greased runway” to a state institution has never been disputed. Lawyers representing these individuals were bored or contemptuous; judges simply wanted to get cases moving; opposing counsel looked at their wrist watches to see when the cases would be done.

This is not news to anyone who regularly did civil commitment hearings at any time since 1972 (the beginning of contemporary civil commitment law, coinciding with the Supreme Court’s decision in

3. Before I became a professor, I spent thirteen years as a lawyer representing persons with mental disabilities, including three years in which my focus was primarily on such individuals charged with a crime. In this role, when I was Deputy Public Defender in Mercer County (Trenton), NJ, I represented several hundred individuals at the “maximum security hospital for the criminally insane” in habeas corpus hearings, the forerunner to civil commitment hearings, both in individual cases and in a class action. Dixon v. Cahill, No. L3097 7/1-71 P.W. (N.J. Super. Ct. Law Div. 1973) (final order reprinted in MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, MENTAL DISABILITY LAW § 19-8 (3d ed. 2017) and discussed in 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, 206–07 n.94 (2000)). For the next eight years, I was director of the NJ Division of Mental Health Advocacy. In that role, I supervised the representation of tens of thousands of individuals facing civil commitment at psychiatric facilities in New Jersey. See, e.g., Michael L. Perlin, “Infinity Goes Up on Trial”: Sanism, Pretextuality, and the Representation of Defendants with Mental Disabilities, 16 QUT L. REV. 106 (2016); Michael L. Perlin, Mental Patient Advocacy by a Public Advocate, 54 PSYCHIATRIC Q. 169 (1982).


5. See Michael L. Perlin & Alison J. Lynch, “Mr. Bad Example”: Why Lawyers Need to Embrace Therapeutic Jurisprudence to Root Out Sanism in the Representation of Persons with Mental Disabilities, 16 WYO. L. REV. 299, 314 n.96 (2016) [hereinafter Perlin & Lynch, Mr. Bad Example]. [The author] had occasion to speak to private counsel who had been assigned to represent a patient in a county in which the New Jersey Division of Mental Health Advocacy did not represent patients. The assigned counsel asked [the author], “Why is the State wasting money to pay me to do this bullshit?”

Id.

6. See PERLIN & CUCOLO, supra note 3, § 2-6.3.3, at 2-74 n.458 (“Mental disability law generally regulates powerless individuals represented by passive counsel in invisible court proceedings conducted by bored or irritated judges.”). Judges for such cases are frequently retired judges called back into service on “recall.” The state of New Jersey’s official policy requires judges seeking recall work to be willing to hear involuntary civil commitment cases. See N.J. STATE JUDICIARY, POLICY GOVERNING RECALL FOR TEMPORARY SERVICE WITHIN THE JUDICIAL SYSTEM § 11(b) (July 19, 2001), https://www.judiciary.state.nj.us/attorneys/assets/directives/dir_12_01.pdf [https://perma.cc/8R4N-8DTV]. “Priority for approving requests for recall service will be based on the following factors: . . . b. Willingness to serve on a designated statewide priority for recall judges, e.g., civil commitment hearings, ISP, sexually violent predator cases.” Id.
Jackson v. Indiana'); I, and others, have written about this many times. Some sixteen years ago, I wrote the following (and to the best of my knowledge, it has never been contradicted): "[T]he overwhelming number of cases involving mental disability law issues are ‘litigated’ in pitch darkness. Involuntary civil commitment cases are routinely disposed of in minutes behind closed courtroom doors."

In this Article, I will contrast this shabby track record with the promises of those mental health courts (MHCs) that operate as problem-solving courts are supposed to operate, and I will discuss how these courts may provide due process and fair hearings. I will assess—via traditional "compare and contrast" means—these two ways of adjudicating cases involving persons with mental disabilities via the models of procedural justice and therapeutic jurisprudence, and I will end with some thoughts about other topics that must be considered in this context.

I. QUALITY OF COUNSEL AT TRADITIONAL CIVIL COMMITMENT HEARINGS

If there has been any constant in modern mental disability law, "it is the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment cases is likely to be ineffective." We knew


This is not to say that all states operate in the same way. In New York—not coincidentally, where there is a dedicated state-wide program to provide representation to the population in question—hearings are open to the public and take substantially longer. Personal Communication with Naomi Weinstein, Senior Staff Attorney, Mental Hygiene Legal Services, in N.Y.C., N.Y. (Oct. 22, 2016).

this as the modern era began. We knew it when some courts (the case of Lessard v. Schmidt is the perfect example) started taking more seriously some of the other substantive and procedural rights of persons who were the subjects of such hearings. We knew it when so few states chose to follow the examples of New York, New Jersey, and a handful of other jurisdictions that legislatively created regularized, dedicated, specialized legal services offices whose primary job was to provide representation at such hearings. We knew it when the first empirical research showed that most lawyers prepared much less for civil commitment cases than for other cases, many did not speak to clients before the hearing, and they "rarely


Also, in many U.S. jurisdictions, lawyers' caseloads are far too heavy to allow individualized representation. Years ago, a study in Chicago found that a single public defender was assigned to handle all civil commitment cases in the city of Chicago—a prohibitive case load of forty to sixty cases per week and 2,000–3,000 cases per year. See Elliott Andalman & David L. Chambers, Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal, 45 Miss. L.J. 43, 61 (1974). When that study was replicated twenty years later, it found a caseload of 2,000 per year in another county (presumably in Florida). Sumner J. Sydeman et al., Procedural Justice in the Context of Civil Commitment: A Critique of Tyler's Analysis, 3 PSYCHOL. PUB. POL'Y & L. 207, 216 n.49 (1997). The American Bar Association takes the position that the maximum caseload should be 200, one-tenth of this number. See Megan Anmitto, Juvenile Justice on Appeal, 66 U. MIAMI L. REV. 671, 674 n.9 (2012) (citing and quoting AM. BAR ASS'N, STANDING COMM. ON LEGAL AID & INDIGENT DEFENDANTS, TEN PRINCIPLES OF A PUBLIC DEFENSE DELIVERY SYSTEM 1, 5 n.19 (2002)).

Beyond the scope of this paper is a consideration of an important collateral issue: that there are often not the community support services in place (e.g., housing and less restrictive alternative treatment facilities) that should be available to all who are subject to the involuntary civil commitment process. See Naomi M. Weinstein & Michael L. Perlin, "Who's Pretending to Care for Him?" How the Endless Jail-to-Hospital-to-Street-Repeat Cycle Deprives Persons with Mental Disabilities the Right to Continuity of Care, WAKE FOREST J. L. & POL'Y (forthcoming 2018) (manuscript at 13–14) (on file with authors) [hereinafter Weinstein & Perlin, Who's Pretending to Care for Him?].

11. See, e.g., Andalman & Chambers, supra note 10, at 72 (speculating that counsel was so inadequate in the sample study that patients' chances for hospital release were enhanced if no lawyer was present); George E. Dix, Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study, 1968 WASH. U. L.Q. 485, 540 (1968) (noting that only two of 1,700 contested cases resulted in patient release).

12. 349 F. Supp. 1078, 1087 (E.D. Wis. 1972) (holding that a statute that fails to provide a person alleged to be mentally ill with adequate procedural safeguards is unconstitutional).

13. Sclaret, supra note 4, at 81.

14. See, e.g., In re Judicial Commitment of C.P.K., 516 So. 2d 1323, 1325 (La. Ct. App. 1987) (reversing commitment order where trial court failed to comply with statute expressing explicit preference for representation by state Mental Health Advocacy Service and rejecting as "untenable" argument that trial court should be excused "since it did not know . . . whether the Service really existed"); MASS. GEN. LAWS ch. 123, § 23 (2016); OHIO REV. CODE ANN. § §123.60 (West 2017).

15. See, e.g., N.Y. MENTAL HYG. LAW §§47.01–47.03 (McKinney 2017); N.J. STAT. ANN. 52:27E-55 (West 2017).
took an adversary role to obtain release of their clients whom psychiatrists had recommended for commitment."16 And importantly, we knew it when it became clear that only in those jurisdictions that had dedicated counsel programs was there any coherent body of reported civil commitment case law.17 There are dedicated offices that provide top-flight legal representation to persons with mental disabilities in civil commitment hearings, but these offices represent a small percentage of those subject to commitment.18

Sadly, "the quality of counsel assigned to represent individuals who face involuntary civil commitment to psychiatric hospitals is, in most United States jurisdictions, mediocre or worse."19 The data tells us that, in many jurisdictions, counsel is "woefully inadequate—disinterested, uninformed, roleless, and often hostile."20 Startlingly, "this reality goes almost unmentioned in the legal literature."21


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

18. See PERLIN & CUCOLO, supra note 3, §§ 6-4.2 to 6-4.3.
19. Perlin, Could Be Your Funeral, supra note 10, at 243. In a white paper that I prepared for the American University School of Public Affairs’ Justice Programs Office on the question of the quality of representation of criminal defendants with mental disabilities, I focused on several issues that required attention in determining adequacy of counsel in cases involving this population: the “fear of faking,” the likelihood of undiagnosed or misdiagnosed disabilities, and the impact of prescribed medications on mental functioning. MICHAEL L. PERLIN, AM. UNIV., JUSTICE PROGRAMS OFFICE, REPRESENTING CLIENTS WITH MENTAL HEALTH AND/OR COGNITIVE IMPAIRMENTS IN TREATMENT COURTS 3 (2016), http://www.american.edu/spa/jpo/initiatives/drug-court/upload/Perlin-Mental-Impairments-7-8-16.pdf [https://perma.cc/DM26-89EL]. Certainly, the vast majority of lawyers appointed episodically or randomly to represent persons with mental disabilities at civil commitment hearings invariably miss these issues.

There are also institutional pressures: The attorney who depends on the goodwill of others in the system (e.g., judges, state attorneys, or prosecutors) may pull his punches, even unwittingly, in order to retain credibility for future interactions (which he would put to use for his future clients). Judges want cases resolved.

Counsel on the “other side of the table” does not have a sterling track record either. In his concurrence in *O'Connor v. Donaldson*, then-Chief Justice Warren Burger noted that, at retrial, “I would hope these sensitive and important issues would have the benefit of more effective presentation and articulation on behalf of petitioner [defendant/state psychiatrist].” In this context, Professor David Wexler has noted that “it does not appear that the state’s public protection and therapeutic interests are being advanced under a scheme defendable as a coherent policy of appropriate advocacy in mental health cases.” Importantly, in the same article—written nearly thirty-five years ago—Wexler noted that “discussions of advocacy in mental health law have rarely touched on the appropriate role of attorneys representing commitment petitioners or state hospitals.” As Professor Wenona Whitfield has observed, “state’s attorneys . . . have little incentive or interest in making this area of the law their specialty.”

Further, judges “generally have little judicial experience and little incentive to develop expertise in this area.” Their lack of interest “conveys the message that patients’ rights . . . are not important.” Simply put, judges subordinate mental disability law issues (a reflection and
extension of their subordination of mentally disabled persons). This subordination translates into a failure to inform patients of their rights at such hearings. A study by Charles D. Parry and Eric Turkheimer revealed that, at the patient’s initial hearing, fewer than one-third of judges told patients of their right to counsel, fewer than one-fourth told patients of their right to voluntary status, and about two-fifths told patients of their right to appeal; by the second review hearing after six to twelve months in the hospital, less than five percent of judges mentioned the right to counsel and less than eight percent mentioned voluntary admissions, while fifteen percent referred to the right to appeal. There is no contesting Professor Sarah Gordon’s conclusion that “civil commitment proceedings tend to be short and perfunctory.”

Judges typically defer to the judgments of state experts without any acknowledgement of the robust, valid, and reliable evidence that tells us


32. See, e.g., Morris, supra note 21, at 314–15 ("[D]espite the fallibility of psychiatric testimony, judges and juries, serving as fact finders in civil commitment and conservatorship proceedings, typically defer to psychiatric judgments that the person has a mental disorder and that the mental disorder meets the statutory standard for commitment or a conservatorship."). The only two studies of judges’ views on this question found that judges consider expert testimony to be the most important factor in their commitment decisions. See Stephanie Evans & Karen Salekin, Involuntary Civil Commitment: Communicating with the Court Regarding “Danger to Other,” 38 LAW & HUM. BEHAV. 325, 326 (2014).

Most courts that have considered the question have agreed that constitutional due process in a civil commitment hearing “includes the right to an independent psychiatric examination.” In re Gannon, 301 A.2d 493, 494 (N.J. Super. Ct. 1973). See Scott F. Uhler, The Constitutional Right of the Indigent Facing Involuntary Civil Commitment to an Independent Psychiatric Examination, 20 AKRON L. REV. 71, 72 (1986). See generally PERLIN & CUCOLO, supra note 3, § 6-9, at 6-104 to 6-106.1. But see Goetz v. Crosnoo, 967 F.2d 29, 36–37 (2d Cir. 1992) (affirming a trial court opinion holding that the Due Process Clause does not confer an absolute right to state-provided psychiatric assistance at involuntary civil commitment hearings and mandating such a right only when the hearing judge determines that expert testimony “is necessary to a reliable assessment of a patient”). There are no statistics available, but the forty years I have spent litigating these cases and observing them in multiple jurisdictions has made it clear to me that in most venues, such expert witnesses are virtually never engaged. But see Stefan Sjöström, Maritha Jacobsson & Anna Hollander, Collegiality,
how imprecise clinical predictions of dangerousness often are. By doing so, they allow “psychiatrist experts [to] actually become the decision-makers in the civil commitment process,” serving as “rubber stamps of psychiatrists’ testimony.” As Professor Gordon points out, “civil commitment proceedings may not be given priority by judges with busy caseloads, who may therefore lack an incentive to carefully scrutinize psychiatrists’ recommendations.”

What I have reported on here is all infinitely depressing, but it is not new; nor is the lack of interest in the subject matter new. The Scallet article—the first using the phrase “greased runway” in this context—is nearly forty years old. Important pieces, such as Wexler’s, on the role of the state in this context have been cited only a handful of times. There has been no discernable impact of studies such as the one done by Parry and Turkheimer. In short, in the nearly forty years since I started writing about this topic (a topic to which I continue to return), very little has changed in the context of involuntary civil commitment trials. They remain, in the words of the eminent forensic psychiatrist Paul Appelbaum,
the "disfavored stepchild in the large family of concerns that must be addressed by the justice system."41

II. THE PROMISE OF MENTAL HEALTH COURTS

However, consider next the parallel universe of MHCs.42 There is no question that one of the most important developments in the past two decades in the way that criminal defendants with mental disabilities are treated in the criminal process has been the creation and expansion of MHCs, one kind of "problem-solving court."43 The creation of these courts is particularly critical as we—tardily—begin to come to grips with the ways that persons with mental disabilities are disproportionately arrested for "nuisance crimes" and the significance of MHCs grows.44 There is a wide range of dispositional alternatives available to judges in these cases45 and an even wider range of judicial attitudes.46 And the entire concept of MHCs is certainly not without controversy.47

There is no question, however, that MHCs offer a new approach—perhaps a radically new approach—to the problems at hand.48 They

41. Appelbaum, supra note 36, at 66 (as quoted in Gordon, supra note 31, at 678).
47. See, e.g., Tammy Seltzer, A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illness, 11 PSYCHOL. PUB. POL’Y & L. 570, 576 (2005). For a recent—and sobering—empirical critique of such courts in one jurisdiction, see Johnston & Flynn, infra note 84.
48. Some jurisdictions are beginning to seek out other alternative and complementary solutions to these issues. For recently-passed New York City local laws addressing the issue of mental health in
become even more significant because of their articulated focus on dignity, as well as their embrace of therapeutic jurisprudence, their focus on procedural justice, and their use of the principles of restorative justice. It is time to restructure the dialogue about MHCs and to begin to take seriously the potential ameliorative impact of such courts on the ultimate disposition of all cases involving criminal defendants with mental disabilities.

It needs to be stressed that MHCs are set up differently in different jurisdictions. There are now over 375 such courts in operation in the


United States, some dealing solely with misdemeanors, some dealing solely with nonviolent offenders, and some dealing with no such restrictions.

Although there is no single prototype, virtually all MHCs include a special docket handled by a particular judge, with the primary goal of diverting defendants from the criminal justice system and into treatment. MHCs are premised on team approaches, representatives from justice and treatment agencies assist the judge in screening offenders to determine whether they would present a risk of violence if released to the community, devising appropriate treatment plans, and supervising and monitoring the individual’s performance in treatment. The MHC judge functions as part

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56. Roger A. Boothroyd et al., The Broward Mental Health Court: Process, Outcomes, and Service Utilization, 26 INT’L J.L. & PSYCHIATRY 55, 55 (2003). At least one evaluation of such courts has concluded “most... defendants have been ‘nuisance’ offenders who have a high incidence of drug co-morbidity, treatment plan noncompliance, and recidivism... Their high recidivism rate and the problem of severe jail overcrowding made the mental health court experiment especially attractive to some county policy makers.” Gerald Nora, Prosecutor As “Nurse Ratched”? Misusing Criminal Justice as Alternative Medicine, CRIM. JUST., Fall 2007, at 18, 22. Individuals before MHCs are also often in need of legal services dealing with matters such as housing or domestic issues. Beyond the scope of this paper is an inquiry into how the problem-solving courts that have been created to deal with these problems could best be integrated with MHCs. See Perlin & Gallagher, supra note 51 (relying upon, inter alia, Raymond H. Brescia, Beyond Balls and Strikes: Towards a Problem-Solving Ethic in Foreclosure Proceedings, 59 CASE W. RES. L. REV. 305 (2009)); Raymond L. Pianka, Community Control Supervision of Building Code Offenders in Cleveland’s Housing Court: Making the Most of Ohio’s Direct Sentencing for Misdemeanors, 46 U. MEM. L. REV. 903 (2016)).


of a mental health team that assesses the individual's treatment needs and decides whether he or she can be safely released to the community. The team formulates a treatment plan, and a court-employed case manager and court monitor track the individual's participation in the treatment program and submit periodic reports to the judge concerning his or her progress. Participants are required to report to the court periodically so the judge can monitor treatment compliance, and additional status review hearings are held on an as-needed basis.

To serve effectively in this sort of court setting and to best achieve the objectives of these courts, the judge needs to develop enhanced interpersonal skills and awareness of a variety of psychological techniques to persuade the individual to accept treatment and motivate him or her to participate effectively in it. The judge must be able to build trust and manage risk.

These skills include the ability to convey empathy and respect, communicate effectively with the individual, listen to what the individual has to say (thereby fulfilling the individual’s need for voice and validation), earn the individual’s trust and confidence, and 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 ‘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. According to former Judge Randal Fritzler, a successful mental health court thus needs: (1) a therapeutic environment and dedicated team; (2) an environment free from stigmatizing labels; (3) opportunities for deferred sentences and diversion away from the criminal system; (4) the least restrictive alternatives; (5) decision-making that is interdependent; (6) coordinated treatment, and (7) a review process that is meaningful.

65. For a thoughtful critique of MHCs, see Johnston, supra note 55. On the role of the legislature in insuring the success of such courts, see Sheila Moheb, Jamming the Revolving Door: Legislative Setbacks for Mental Health Court Systems in Virginia, 14 RICH. J.L. & PUB. INT. 29, 38-41 (2010).


67. See Perlin & Weinstein, supra note 40, at 100 (“Cultural competence is a key component in providing effective representation and resolving any ethical dilemmas that may arise in elder law, just as it is in mental disability law.”); see also, e.g., Ruby Dhand, Creating a Cultural Analysis Tool for the Implementation of Ontario’s Civil Mental Health Laws, 45 INT’L J.L. & PSYCHIATRY 25, 32 (2016) (recommending further that cultural and other intersectional factors be probed during the civil commitment hearing processes). See generally Michael L. Perlin & Valerie R. McClain, “Where Souls Are Forgotten”: Cultural Competencies, Forensic Evaluations and International Human Rights, 15 PSYCHOL. PUB. POL’Y & L. 257 (2009); Casey Schutte, Mandating Cultural Competence Training for Dependency Attorneys, 52 FAM. CT. REV. 564 (2014).

68. For a discussion on how the public psychiatric system disproportionately marginalizes persons who are racial minorities, see Michael L. Perlin & Heather Ellis Cuolo, “Tolling for the Aching Ones Whose Wounds Cannot Be Nursed”: The Marginalization of Racial Minorities and Women in Institutional Mental Disability Law, 20 J. GENDER RACE & JUST. 431 (2017).


is essential that such courts be free of the "pretextual dishonesty" that is so often the hallmark of judicial proceedings in cases of individuals with mental disabilities.  

Because MHCs can divert persons with mental disabilities out of the criminal justice system (where they are likely to be treated as third- or fourth-class citizens, if those terms have any meaningful content or context), MHCs make it less likely that the person with mental disabilities will suffer at the hands of others because of that status. By way of example, Sana Loue concludes that sanist biases may be reduced by the establishment of MHCs, staffed by a "sensitive" judiciary. A study of Judge Ginger Lerner-Wren’s MHC in Broward County concluded that participants in that court self-reported coercion levels lower than almost any comparable measure of perceived coercion previously reported in the literature. The actual, real-life experiences of the litigants in cases before
Judge Lerner-Wren thus demonstrate that an MHC can be a non-coercive, dignified experience that provides procedural justice and therapeutic jurisprudence to those before it. In such courts, defendants participate more actively and directly than in typical criminal courts, often speaking directly with the judge instead of sitting silently while their defense attorney speaks for them. Treatment courts that provide the most time and attention from the presiding judge have been shown to be more successful. Professor Vicki Lens underscores the importance of a judge who "buys into" the principles of therapeutic jurisprudence (TJ): "[E]ven a well-resourced problem-solving court may not work if the judge fails to adopt TJ and other problem-solving strategies effectively."
Professor Ursula Castellano has thoughtfully and insightfully argued that for MHCs to be successful, the presiding judge need practice what she calls "the politics of benchcraft," rising "to the larger challenges embedded in the alternative courtroom." Such judges "selectively apply, blend and transform" elements from the treatment and legal spheres to adjudicate cases therapeutically and to "generate more effective solutions."

In this context, it should be noted that studies of the MHCs referred to here conclude that such courts actually work as they are intended to. Participants in Judge Ginger Lerner-Wren's MHC had significantly lower arrest rates after enrollment in treatment programs than before enrollment and lower post-enrollment arrest rates than comparison groups; in fact, MHCs evaluated in a multi-site study "were more successful at reducing recidivism—recidivism rates of 25% versus 10%-15%—than were drug courts." And these statistics are constant when juvenile MHCs are

81. Castellano, supra note 43, at 403. She defines this, in part, as "learning to finesse elements of treatment and law into new professional practices." Id.
82. Id. at 417.
83. Id. Professor Castellano, in her study of four separate MHCs, found that the judges she observed were "deeply involved in investigating problems, collecting personal client information, and actively consulting with treatment professionals and law enforcement offices." Id. at 405.
84. These findings are not universal. I do have some concerns about the operationalization of the courts in some jurisdictions. See E. Lea Johnston & Conor Flynn, Mental Health Courts and Sentencing Disparities, 62 VILL. L. REV. 685, 693 (2017) (empirical study of MHCs in Erie County, PA, concluding that anticipated treatment court sentences—for all grades of offense—typically exceed county court sentences by more than a year).
86. Id. See PERLIN & CUCOLO, supra note 3, § 1-2.2.3, at 1-32 to 1-33 n.194 (citing, inter alia, Leonora Kopelovich et al., Procedural Justice in Mental Health Courts: Judicial Practices, Participant Perceptions, and Outcomes Related to Mental Health Recovery, 36 INT'L J.L. & PSYCHIATRY 113 (2013)) (noting that procedural justice is positively correlated with participants' attitudes toward their own recovery); Mark R. Munetz et al., Mental Health Court and Assisted Outpatient Treatment: Perceived Coercion, Procedural Justice, and Program Impact, 65 PSYCHIATRIC SERVICES 352 (2014) (noting that mental health court graduates perceived significantly
studies.\textsuperscript{87} Research also suggests that mental health court participation increases access to and utilization of mental health care,\textsuperscript{88} reduces the use of crisis or high-intensity services, and reduces substance use.\textsuperscript{89} The most recent relevant study—authored by a sitting trial judge—has thus concluded that “[p]roblem-solving treatment courts are the best way to

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less coercion and more procedural justice in court than did those involved in assisted outpatient treatment proceedings); Allison Redlich & Woojae Han, \textit{Examining the Links Between Therapeutic Jurisprudence and Mental Health Court Completion}, 38 \textsc{Law} \& \textsc{Hum. Behav.} 109, 109 (2014) (noting that increased levels of procedural justice and perceived voluntariness led to decreased rates of new arrests in mental health court populations)); see also Perlin \& Cuocolo, supra note 3, §§ 4-3.3; Priscilla Ferrazzi \& Terry Krupa, \textit{Mental Health Rehabilitation in Therapeutic Jurisprudence: Theoretical Improvements}, 46 \textsc{Int’l J. L. \& Psychiatry} 42 (2016) (arguing that greater consideration of mental health rehabilitation will improve the theoretical validity of therapeutic jurisprudence in this context); Evan Lowder, Sarah Desmarais \& Daniel J. Baucom, \textit{Recidivism Following Mental Health Court Exit: Between and Within-Group Comparisons}, 40 \textsc{Law \& Hum. Behav.} 118, 118 (2016) (noting that MHCs are particularly effective for high-risk participants, and time spent in such courts has positive effects on recidivism).


88. See, e.g., Boothroyd et al., supra note 56, at 68; Andrea M. Odegaard, \textit{Therapeutic Jurisprudence: The Impact of Mental Health Courts on The Criminal Justice System}, 83 \textsc{N. D. L. Rev.} 225, 231 (2007). See generally Woojae Han \& Allison Redlich, \textit{The Impact of Community Treatment on Recidivism Among Mental Health Court Participants}, 67 \textsc{Psychiatric Services} 384 (2016) (noting that data showed increased in the receipt of community treatment among MHC participants and decreases in recidivism).

supervise criminal defendants in the community who present with high needs and a high risk to re-offend absent intervention.”

A. From the Perspective of Procedural Justice

Consider both these court systems in the context of procedural justice. "Procedural justice" asserts that "people's evaluations of the resolution of a dispute (including matters resolved by the judicial system) are influenced more by their perception of the fairness of the process employed than by their belief regarding whether the 'right' outcome was reached." The research is consistent: "[T]he principal factor shaping [the] reactions [of the general public] is whether law enforcement officials exercise authority in ways that are perceived to be fair." And, the fairness of the process used to reach a given outcome is critical to perceptions of legitimacy. The question to be asked is this: does the criminal justice system treat defendants fairly and respectfully regardless of the substantive outcome reached?

90. Kerry Meyer, Hennepin County Criminal Mental Health Court: Experiences in a Large Metropolitan Mental Health Court, 42 Mitchell Hamline L. Rev. 485, 521 (2016). On how MHCs in some states can vary radically from county to county, see Monte Staton & Arthur Lurigio, Mental Health Courts in Illinois: Comparing and Contrasting Program Models, Sanction Applications, Information Sharing, and Professional Roles, FED. PROB., June 2015, at 21. Of course, given the direct link with the criminal justice system, the potential power for coercion is certainly, at the least, a dormant issue. See, e.g., Stacey M. Faraci, Slip Slidin' Away? Will Our Nation's Mental Health Court Experiment Diminish the Rights of the Mentally Ill?, 22 Quinnipiac L. Rev. 811, 853 (2004) (arguing that mental health court defendants "endure much more liberty restrictions and privacy intrusions" and that labeling the ‘sentence ‘treatment,' rather than ‘punishment,’" allows the court to exert more coercion over the participant than would otherwise be available). See generally Johnston & Flynn, supra note 84 (reporting on negative mental health court data from one Pennsylvania county). I believe that when courts are modeled after the examples set by Judge Lerner-Wren, Judge D’Emic, and Judge Finkle, this will not happen. See Lerner-Wren, supra note 78, at 114–15.

91. The following section is generally adapted from PERLIN, A PRESCRIPTION FOR DIGNITY, supra note 50, ch. 6.


When those affected by decision-making processes perceive the process to be just, “they are much more likely to accept the outcomes of the process, even when the outcomes are adverse.”96 Professor Tom Tyler’s groundbreaking research has taught us that individuals with mental disabilities, like all other citizens, are affected by such process values as participation, dignity, and trust, and that experiencing arbitrariness in procedure leads to “social malaise and decreases people’s willingness to be integrated into the polity, accepting its authorities and following its rules.”97

“There is a growing body of research showing that the experience of procedural justice not only enhances evaluations of persons, institutions, and specific outcomes, but also leads to greater overall satisfaction with the legal experience and more positive affect with respect to an encounter with the justice system.”98 Perceptions of systemic fairness are driven, in large part, by “the degree to which people judge that they are treated with dignity and respect.”99 And, “[t]he public’s perception of procedural

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Procedural justice research has shown that procedural justice effects are present in a wide range of settings. Civil litigants in court care about their treatment by a judge, criminal defendants care about their treatment by judge and jury, disputing parties in arbitration and mediation care about their treatment by an arbitrator or mediator, and even disputing parties in negotiation care about their treatment by the other party. Research outside the legal dispute resolution system has demonstrated that people care about their treatment by other authority figures, such as police officers, work supervisors, and health-care administrators. Beyond both the legal dispute-resolution context and the third party context, research has suggested that individuals care about procedural justice in highly relational settings like the family and even in classic economic settings like markets. Effects are found in field studies, simulations and experimental settings, and in situations with both low and very high stakes.

Hollander-Blumoff, supra note 95, at 133–34.


97. Tom Tyler, The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings, 46 SMU L. REV. 433, 443 (1992) (as discussed in Perlin & Dorfman, supra note 21, at 119); see also Vidis Donnelly et al., Working Alliances, Interpersonal Trust and Perceived Coercion in Mental Health Review Hearings, 5 INT’L J. MENTAL HEALTH 29, 29 (2011) (noting that hearings perceived as lacking in procedural justice worsened working alliances between patients and physicians and diminished interpersonal trust) (cases heard in Ireland); Bruce J. Winick, Therapeutic Jurisprudence and the Civil Commitment Hearing, 10 J. CONTEMP. LEGAL ISSUES 37, 44 (1999) (noting that increasing a patient’s “sense of participation, dignity, and trust” during a civil commitment proceeding will “increase his or her acceptance of the outcome of the hearing”).


99. Perlin, supra note 9, at 415 (quoting Tyler, supra note 96, at 442). See generally P. Christopher Earley & E. Allan Lind, Procedural Justice and Participation in Task Selection: The Role
justice—whether the criminal justice system treats defendants fairly and respectfully regardless of the substantive outcome reached—determines the public’s willingness to engage in and comply with the system.”

The procedural justice differences between traditional civil commitment courts—dark, “greased runways” with disinterested judges and lawyers—and modern MHCs—dignity-enforcing and coercion-avoiding—could not be starker. In a thoughtful article about the role of procedural justice in the civil commitment process, Brian McKenna and his colleagues note “the clinical and ethical importance of procedural justice principles in the enactment of civil commitment,” stressing that “these principles involve allowing patients to have their say, listening to them seriously, providing patients with information and treating them with concern, fairness and respect.” The late Professor Bruce Winick has observed that “[p]erhaps 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, in this context, when “legal proceedings do not treat people with dignity, they feel devalued as members of society.”

100. Conway, supra note 95, at 1732 (citing LIND & TYLER, supra note 98, at 76–81).

101. On how the lawyers who represent patients in such courts often exhibit the worst of sanism, see generally Perlin, Could Be Your Funeral, supra note 10; Perlin, supra note 17. Although, state laws promise dignity in such proceedings. See, e.g., COLO. REV. STAT. ANN. § 27-65-101 (West 2016) as discussed in People v. In Interest of Vivekanathan, 338 P.3d 1017, 1025 (Colo. Ct. App. 2013) (civil commitment procedures must “provide the fullest possible measure of privacy, dignity, and other rights to persons undergoing care and treatment for mental illness”), this promise is often not met.

102. See Michael L. Perlin, Therapeutic Jurisprudence in Action, INT’L SOC’Y FOR THERAPEUTIC JURIS. (Sept. 5, 2015), https://mainstreamtj.wordpress.com/2015/09/05/therapeutic-jurisprudence-in-action/ [https://perma.cc/9H6Y-NMEX] (discussing my experiences observing top-flight problem-solving courts in New Zealand and concluding that “I have never, in such a short period of time, had the honor to observe such examples of therapeutic jurisprudence in action”). I discuss this further in Perlin & Lynch, Mr. Bad Example, supra note 5, at 314–15.


104. Winick, supra note 96, at 44–45. Importantly, this observation of Winick’s was relied on by the Montana Supreme Court in In re Mental Health of K.G.P., 29 P.3d 485, 495 (Mont. 2001), a commitment case that I have previously referred to as “the most important case ever litigated in this
Nearly forty years ago, John Ensminger and Thomas Liguori wrote that the civil commitment process had great therapeutic potential, stressing that such hearings optimally give patients an opportunity to present and hear evidence in a meaningful court procedure. The traditional civil commitment court does not give patients the opportunities highlighted by McKenna and his colleagues, by Winick, and by Ensminger and Liguori; however, the well-functioning mental health court does.

B. From the Perspective of Therapeutic Jurisprudence

Consider next both these court systems in the context of therapeutic jurisprudence. Therapeutic jurisprudence presents a model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law can have therapeutic or anti-therapeutic consequences. "The ultimate aim of therapeutic jurisprudence is to determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles."

In the context of this paper, consider the impact of therapeutic jurisprudence specifically in the context of (1) the extent to which "legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process area." Perlin, Could Be Your Funeral, supra note 10, at 246. Recently, however, this case—which had found that the "adequacy of counsel" standard established by the U.S. Supreme Court for criminal cases was inadequate for civil commitment cases—was partially overruled in Matter of J.S., 401 P.3d 197 (Mont. 2017), calling for adherence to the Strickland standard.


106. On the significance of dignity values in involuntary civil commitment hearings, see 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, 121 (1994), and Tyler, supra note 97, at 444–45. On how it is more likely in a well-functioning juvenile mental health court that those before the court will be consulted about decisions made about them, see Marinos, Tales of a Court, supra note 87.


108. Perlin, Cast His Robe, supra note 42, at 7–8 (footnotes omitted).
principles,"\textsuperscript{109} (2) how the law "actually impacts people's lives,"\textsuperscript{110} (3) whether the court system supports an "ethic of care,"\textsuperscript{111} and (4) the extent to which the legal system abides by the "three Vs" articulated by Professor Amy Ronner: voice, validation, and voluntariness.\textsuperscript{112} It is important to note that in his analysis of these issues, Professor Winick considered both individuals' emotional life and psychological well-being.\textsuperscript{113}

I am struck with an anomaly that is at the core of this paper: civil commitment courts are—virtually across the board—the antithesis of therapeutic jurisprudence, in stark contrast to the TJ-modeling MHCs of the sort presided over by Judge Wren (and others, e.g., Judge Matthew


\textsuperscript{112} Amy D. Ronner, The Learned-Helpless Lawyer: Clinical Legal Education and Therapeutic Jurisprudence as Antidotes to Bartleby Syndrome, 24 Touro L. Rev. 601, 627 (2008). According to Professor Ronner:

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.


\textsuperscript{113} Winick, supra note 110, at 535; see also David B. Wexler & Bruce J. Winick, Putting Therapeutic Jurisprudence to Work: The Term May Sound Academic, but It Embodies a Hands-On Approach to Solving Problems Rather than Simply Winning Cases, ABA J., May 2003, at 54, 54.
D’Emic in Brooklyn and Judge Michael Finkle in Seattle. MHCs—when structured properly and when chaired by a judge who “buys into” the TJ model—are perfect exemplars of the practical utility of therapeutic jurisprudence. As one commentator has noted, therapeutic jurisprudence “has expanded the role of courts to include a rehabilitative process.”

The promotion and creation of such courts are consistent with TJ’s aims and aspirations, especially where litigants are given the “voice” that TJ demands. The courts are grounded and rooted in TJ; they reflect TJ “theory in practice,” and they acknowledge that a defendant’s appearance in such a court comes at a “painful and crucial point in life.” But these TJ-friendly, TJ-inspiring, and TJ-enforcing courts—courts that, better than any others, provide an environment that is not stigmatizing and not sanist—have had no impact at all on the “greased runways” of the courts, where litigation is done in “pitch darkness.”


123. D’Emic, Bridging, supra note 114, at 376.


125. I know of only one exception: in Maricopa County (Phoenix), Arizona, one unified court hears both traditional civil commitment cases and the sorts of criminal cases typically diverted to
In a book and in a series of recent papers, I have focused on the need for dignity in the legal process in cases involving persons with mental disabilities.\textsuperscript{126} One of the central principles of TJ is a commitment to dignity.\textsuperscript{127} With my colleagues, Keri Gould and Deborah Dorfman, I have concluded that “[t]he 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.”\textsuperscript{128} In a recent article about dignity and the civil commitment process, Professors Jonathan Simon and Stephen Rosenbaum embrace therapeutic jurisprudence as a modality of analysis and focus 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.”\textsuperscript{129} With my colleague Naomi Weinstein, I have recently argued that “attorneys must embrace the principles and tenets of therapeutic jurisprudence as a means of best ensuring the dignity of their clients and of maximizing the likelihood that voice, validation and


\textsuperscript{127} See \textit{generally Winick, supra note 107}, at 161. Dignity inquiries permeate the criminal justice system, especially as the concept applies to persons with mental disabilities.

\textsuperscript{128} \textsc{Perlin, Gould & Dorfman, supra note 28}, at 114 (emphasis added).

voluntariness\textsuperscript{130} will be enhanced.\textsuperscript{131} I believe that rejecting the traditional civil commitment court model and embracing the modern mental health court model is the single-best way that this dignity can be provided.\textsuperscript{132}

III. CONCLUSION

There are other issues to consider as well. Although a robust literature has developed about MHCs, and although researchers have begun to focus on a broad-range of empirical issues, such as the extent to which defendants are competent to waive their trial rights in such settings, the quality of counsel, the significance of diversion, etc.,\textsuperscript{133} there is still virtually nothing in the legal literature on these precise questions in this context.\textsuperscript{134} Bruce Winick has sketched the outlines of what lawyers must

\textsuperscript{130}See Ronner, \textit{Songs of Validation}, supra note 112. Ironically, and importantly, a “voluntary” status in mental health commitment is not always truly voluntary. On the ways that hospital staff can routinely manipulate such disparity in bargaining to coerce patients into accepting voluntary commitment status (thus avoiding court hearings), see Susan Reed & Dan Lewis, \textit{The Negotiation of Voluntary Admission in Chicago’s State Mental Hospitals}, 18 J. PSYCHIATRY & L. 137, 143-48 (1990); see also Joel Haycock et al., \textit{Mediating the Gap: Thinking About Alternatives to the Current Practice of Civil Commitment}, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 265, 278 (1994) (“[The patient’s lawyers], in collusion with the care-givers, disempower him or her and effectively thwart the establishment of a voluntary treatment compact between the patient and mental health professionals.”).


\textsuperscript{132}See \textit{Cast His Robe}, supra note 42, at 16-17 (discussing, among other things, Steven Erickson et al., \textit{Variations in Mental Health Courts: Challenges, Opportunities, and a Call for Caution}, 42 COMM. MENTAL HEALTH J. 335, 339 (2006); Faraci, \textit{ supra note 90, at 828-29 (discussing competency of defendants to accept transfer to MHCs)); see also Terry Carney, \textit{The Mental Health Service Crisis of Neoliberalism—An Antipodean Perspective}, 31 INT’L J.L. & PSYCHIATRY 101, 111 (2008) (discussing competency of counsel assigned to defendants in MHCs); Erickson et al., \textit{ supra note 133, at 340; Allison D. Redlich, \textit{Voluntary, but Knowing and Intelligent?}, 11 PSYCHOL. PUB’L POL’Y & L. 605 (2005) (discussing competency of MHC defendants to fully comprehend court processes and requirements).

\textsuperscript{133}I believe the questions that I have raised about quality of counsel in the representation of criminal defendants with mental disabilities in the criminal justice system in \textit{Perlin, supra note 19}, must be considered in the context of MHCs, but I know of no scholarly research in the legal literature that has focused on these issues. See Michael L. Perlin, “\textit{Wisdom Is Thrown into Jail}”: Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness, 17 MICH. ST. U. J. & MED. 343, 368-69 (2013) [hereinafter Perlin, \textit{Wisdom Is Thrown}] (raising this issue); Michael L. Perlin, “\textit{To Show That . . . the Courts Are on the Level}”: Addressing Questions of Competency and Adequacy of Counsel in Mental Health Courts (Nov. 2016) (unpublished manuscript presented to the American Society of Criminology, New Orleans, La.) (PowerPoint on file with author).
do in the representation of clients in these courts, but little scholarly attention has been given to a range of important issues that affect the operation of these courts and the role of lawyers representing clients in them. Even a TJ-centric court will only be able to do so much if we do not take seriously questions as to the adequacy of counsel in this specific context. For it is fair process norms, such as the right to counsel, that "operate as substantive and procedural restraints on state power to ensure that the individual suspect is treated with dignity and respect." And if this right is ensured, then and only then will courts administering civil commitment proceedings live up to their potential.

The title of this paper draws on Bob Dylan's song, Ring Them Bells, and is found in the fourth line of this stanza:

Ring them bells for the blind and the deaf
Ring them bells for all of us who are left
Ring them bells for the chosen few
Who will judge the many when the game is through

Here, Dylan sings of the bells ringing for others with disabilities ("the blind and the deaf") and those who are outsiders ("us who are left"). According to the preeminent Dylanologist Oliver Trager, the song "ach[es] with compassion," and I think that is appropriate for use in this paper. Therapeutic jurisprudence "ach[es] with compassion." Traditional civil commitment courts make me ache with sadness. I am hoping that some of the TJ spirit that imbues successful MHCs will eventually be

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135. For a valuable recommendation as to what attorneys should do in such circumstances, see Perlin, Wisdom Is Thrown, supra note 134, at 369–70 (quoting Stefan & Winick, supra note 61, at 511, 517, 520). Professor Winick made the following comments: "Lawyers should adequately counsel their clients about the advantages and disadvantages of accepting diversion to mental health court... . As a result, judges and defense counsel in mental health courts should ensure that defendants receive dignity and respect, [and] are given a sense of voice and validation." Id. at 516, 523.

136. On other important questions raised about the use of MHCs, see Canada, Halloran & Peters, supra note 89, at 58–59 (discussing whether the low numbers of such courts means that they play "no more than a niche role" in the criminal justice/mental health system; whether admission into such courts "prioritize[s] and privilege[s]" some defendants over others; whether lack of additional resources will lead such courts into becoming "a dangerous extension of state authority"; whether court gatekeepers are rigorous in clearly identifying who should be included and who should be excluded from such courts; and whether justice and therapy are ultimately incompatible, a question that the authors readily concede "may be as irresolvable as it is unlikely to disappear").


139. Id.

shared with those traditional civil commitment courts to bring some light to the darkness that still envelops them.