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Some Things Are Too Hot to Touch: Competency, the Right to Sexual Autonomy, and the Roles of Lawyers and Expert Witnesses

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**“SOME THINGS ARE TOO HOT TO TOUCH”:
COMPETENCY, THE RIGHT TO SEXUAL AUTONOMY, AND
THE ROLES OF LAWYERS AND EXPERT WITNESSES**

Michael L. Perlin, Alison J. Lynch** & Valerie R. McClain****

I. INTRODUCTION

For nearly the last five years, Bob Dylan has begun each night’s set with his Oscar-winning song, *Things Have Changed* (from the movie, *The Wonder Boys*). It includes this verse:

I’ve been walking forty miles of bad road
If the bible is right, the world will explode
I’ve been trying to get as far away from myself as I can
Some things are too hot to touch
The human mind can only stand so much
You can’t win with a losing hand¹

What does it mean? That is often an unanswerable question when it comes to Bob’s lyrics. But perhaps this is a clue: When Bob

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¹ *Things Have Changed*, BOB DYLAN, <http://bobdylan.com/songs/things-have-changed/> (last visited Dec. 2, 2018). One of the co-authors (MLP) has used the song title once before. See Michael L. Perlin, “*Things Have Changed*.” *Looking at Non-Institutional Mental Disability Law Through the Sanism Filter*, 46 N.Y.L. SCH. L. REV. 535 (2002-03). When MLP most recently saw Dylan in Dec. 4, 2018, this remained the opening song. See Michael Perlin, *Review*, BOB LINKS (Dec. 3, 2018), <http://www.boblinks.com/120318r.html#3> (discussing the role of this song as the set list opener).

received his Oscar for this song,² he said in his acceptance speech, “[It is] a song that doesn’t pussyfoot around nor turn a blind eye to human nature.”³ Consider the line used in this article’s title and the next one—“Some things are too hot to touch / The human mind can only stand so much.” When we decided to write this paper, this is the song that exploded in *our* minds. Because the topic about which we are writing *is* “too hot” for most of us “to touch.” And when we try to take it seriously, unfortunately, we learn quickly that “The human mind can only stand so much.”

One of the co-authors (MLP) started talking and writing about sex and disability to professional audiences over 25 years ago,⁴ and was immediately struck by the intense interest shown in the topic, especially on the part of staff—professional and otherwise—at state forensic hospitals.⁵ From the beginning of this venture, it was clear that there were multiple (and contradictory) responses: on occasion, questions from the audience went on for longer than the talk took to present;⁶ on other occasions, there were no questions at all. Sometimes the responses were, there is no other word for it, stupefying.⁷

² See Oscars, “*Things Have Changed*” Wins Original Song: 2001 Oscars, YOUTUBE (Jan. 8, 2015), <https://www.youtube.com/watch?v=LOSD7iOEtq0>.

³ *Id.*; Tony Attwood, *Things Have Changed: The Meanings Behind Bob Dylan’s Song*, UNTOLD DYLAN (Nov. 16, 2008), <http://bob-dylan.org.uk/archives/17>.

⁴ See Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?*, 20 N.Y.U. REV. L. & SOC. CHANGE 517 (1993-94).

⁵ Two of the co-authors (MLP & AJL) discuss this extensively in MICHAEL L. PERLIN & ALISON J. LYNCH, *SEXUALITY, DISABILITY, AND THE LAW: BEYOND THE LAST FRONTIER?* 1-2 (2016).

⁶ The initial presentation clearly tapped a hidden issue that screamed out for debate. The audience was composed of forensic mental health professionals who worked at the maximum-security hospital where the talk was given, including psychiatrists, psychologists, nurses, allied therapists, therapy aides, hospital administrative staff, and a few lawyers who frequently represented Kirby patients. On the differing attitudes on the part of varying professionals on the questions discussed here, see Michael L. Commons, Judi T. Bohn, Lisa T. Godon, Mark J. Hauser & Thomas G. Gutheil, *Professionals’ Attitudes Towards Sex Between Institutionalized Patients*, 46 AM. J. PSYCHOTHERAPY 571 (1992).

⁷ When the same co-author presented on this topic to a public audience at the Florida Mental Health Institute (part of the University of South Florida in Tampa) some years ago, an audience member (from the general public) leapt to his feet, and denounced him: “Professor Perlin, you are an agent of the devil!” At a New York City hospital presentation, a nurse folded her arms across her chest, and announced, “Professor, you are the very embodiment of evil!” A nurse at a New Jersey state hospital told him that “God explicitly forbids what you are talking about,” the nurse adding that he would “pray for [MLP’s] soul.” See Michael L. Perlin, “*Limited in Sex, They Dare*”: *Attitudes Toward Issues of Patient Sexuality*, 26 AM. J. FORENSIC PSYCHIATRY 25, 38 (2005). Alternatively, audience members attending presentations in which MLP has addressed the topic, have commented—often in graphic language—that this endeavor is largely unprecedented and much needed, in spite of the fact that the presentation

This all must be contextualized in the ways that sanism⁸ permeates the law and law teaching:

I was sitting at my faculty lunch table, and conversation turned to upcoming presentations that we would soon be doing. My colleagues mostly take left-liberal positions on a wide variety of issues, and are generically the exact mix of retro '60s generationists and early baby boomers that you'd expect. They (appropriately) are quick to criticize any behavior that is racist, sexist, ethnically bigoted or homophobic. Rush Limbaugh would probably view them as one of his worst "politically correct" horror fantasies. As you might expect, I'm not terribly out of place in this group

.....

[W]hen it got to be my turn, I said that I was going to be speaking about the right of institutionalized mentally disabled persons to sexual interaction. All conversation came to a screeching halt. "Michael, are you serious?" "Are you crazy (sic)?" "Michael, even for you, you've gone too far!" "What are you going to say next: that they can get married?!?"⁹ Et cetera.¹⁰

And more

I must admit that I was stunned—not by the response (I spend lots of time in places where few people agree with me about anything) so I don't expect (or want) agreement with whatever it is I'm talking about, but by the identity and background of the people who were uttering these sentiments. As I've said, these were classic New York liberals, many of whom had spent much of their distinguished professional, academic and personal lives rooting out and exposing prejudiced and stereotypical behavior toward virtually every minority

has delved into an area previously considered deviant and unacceptable, as the topic was seen as so forbidden and transgressive. See PERLIN & LYNCH, *supra* note 5, at 10 ("[T]he whole idea of persons with mental disabilities having sex is *transgressive*." (emphasis in original)).

⁸ See *infra* note 21 and accompanying text.

⁹ This was said by a prominent gay rights' activist.

¹⁰ Michael L. Perlin, "You Have Discussed Lepers and Crooks": Sanism in Clinical Teaching, 9 CLINICAL L. REV. 683, 714 (2003) (alteration in original).

group one could imagine. The buck, though, stopped there.¹¹

We have begun this way because we think it is impossible to unpack the specific legal issues that are at the heart of this article—how we construct “competency” in cases involving sexual autonomy and disability, and the role of lawyers and expert witnesses in such cases—without acknowledging the controversies that the mere *discussion* of these topics engender, and the level of animosity and fury that this topic brings out. The problem is that we begin with the initial presenting problem of conflicting stereotypes:¹²

Society tends to infantilize the sexual urges, desires, and needs of the mentally disabled. Alternatively, they are regarded as possessing an animalistic hypersexuality, which warrants the imposition of special protections and limitations on their sexual behavior to stop them from acting on these “primitive” urges. By focusing on alleged “differentness,” we deny their basic humanity and their shared physical, emotional, and spiritual needs. By asserting that theirs is a primitive morality, we allow ourselves to censor their feelings and their actions. By denying their ability to show love and affection, we justify this disparate treatment.¹³

The three of us believe that this observation is still salient, and that it characterizes the views, not only of society in general, but of most lawyers and mental health professionals. The idea that persons with mental disabilities have the same right as all others to sexual autonomy—to a free and individualized sexual life with the same options (to have sex, to not have sex; to have sex monogamously, to have sex polygamously; to masturbate, to not masturbate; to have heterosexual sex, to have homosexual sex) as all others have—is still “beyond the last frontier” for most of society.¹⁴ Of course, these

¹¹ *Id.*

¹² This is not the only area of mental disability law in which conflicting stereotypes are presented, often in the same argument. See Michael L. Perlin, “*She Breaks Just Like a Little Girl*”: Neonaticide, the Insanity Defense, and the Irrelevance of “Ordinary Common Sense”, 10 WM. & MARY J. WOMEN & L. 1, 5 (2003).

¹³ Perlin, *supra* note 4, at 537 (footnotes omitted).

¹⁴ See PERLIN & LYNCH, *supra* note 5; Perlin, *supra* note 4. MLP and AJL present on this topic frequently. When either of us, talking about this topic in multiple venues, merely uses

attitudes ignore what has been revealed in a recent comprehensive data-driven study: that “sexuality leads to boosts in mood and meaning in life with no evidence for the reverse direction.”¹⁵

Our focus in this article is on the way that we globally ignore the law and the science about competency determinations when it comes to matters involving this population, how it is critical that both lawyers and expert witnesses take this seriously and incorporate it into their professional selves and how our failure to take this seriously—a failure that is steeped in both sanism and false “ordinary common sense”¹⁶—violates every precept of therapeutic jurisprudence (hereinafter “TJ”),¹⁷ as well as constitutional law.¹⁸ We will specifically consider the obligations on lawyers (to vigorously represent these clients in court and administrative proceedings,¹⁹ and to respond forthrightly to those who ask “how can you argue that your client has a right to sexual interaction?”),²⁰ and on expert witnesses (who must put aside their own personal feelings—if they interfere—and seek to assess individuals as objectively in this context as they would on questions of criminal incompetency or on civil competencies involving matters such as ability to enter into contracts). As we will discuss subsequently, we believe that it is *only* through the lens of therapeutic jurisprudence that we can bring any clarity to the issues in question.

We begin with short definitions of “sanism” and (false) “ordinary common sense,” as we think it is critical to keep these in mind during this talk, and when we think about this subject. What is sanism? It is the irrational prejudices that cause, and are reflected in,

the words “masturbation” or “polygamous,” the anger and ire from some in the audience is often palpable.

¹⁵ See generally Todd B. Kashdan, Fallon R. Goodman, Melissa Stikma, Cayla R. Milius & Patrick E. McKnight, *Sexuality Leads to Boosts in Mood and Meaning in Life with No Evidence for the Reverse Direction: A Daily Diary Investigation*, 18 *EMOTION* 563 (2018).

¹⁶ See *infra* notes 24-25 and accompanying text.

¹⁷ See *infra* Part V.

¹⁸ On how our current policies also violate Supreme Court case law interpreting the Americans with Disabilities Act, see Natalie M. Chin, *Group Homes as Sex Police and the Role of the Olmstead Integration Mandate*, 42 *N.Y.U. REV. L. & SOC. CHANGE* 379, 447 (2018) (characterizing “sexuality as an integral aspect of community integration”).

¹⁹ See Michael L. Perlin & Naomi M. Weinstein, *Said I, ‘But You Have No Choice’: Why a Lawyer Must Ethically Honor a Client’s Decision About Mental Health Treatment Even if It Is Not What S/he Would Have Chosen*, 15 *CARDOZO PUB. L. POL’Y & ETHICS J.* 73 (2016).

²⁰ *Id.* at 75; see also Michael L. Perlin, Heather Ellis Cucolo & Alison J. Lynch, *Sex, Sexuality, Sexual Offending and the Rights of Persons with Mental Disabilities*, 6 *LAWS* 20 (2017).

prevailing social attitudes toward persons who are mentally disabled, and those so perceived. Largely invisible and largely socially acceptable, it is based upon stereotype, myth, superstition and deindividualization, and it is sustained and perpetuated by our use of a false “ordinary common sense” and heuristic reasoning in our unconscious responses to events in everyday life and the legal process.²¹ We believe that “therapeutic jurisprudence can be an effective and dramatic tool for ferreting out sanism,”²² but is essential that we identify how sanism is at the roots of what lawyers (even progressive lawyers whose practices involve a civil rights practice) and judges do—often unconsciously—on a daily basis in courtrooms and in law offices.²³

“[O]rdinary common sense” (hereinafter “OCS”) is a “‘prereflective attitude’ exemplified by the attitude of ‘What I know is ‘self-evident’; it is ‘what everybody knows.’”²⁴ OCS is susceptible to idiosyncratic, reactive decision-making that “ignores our rich, cultural, heterogenic fabric” and substitutes “medieval conceptions of sin, redemption, and religiosity.”²⁵ TJ is the vehicle through which we can best understand the pernicious power of OCS.²⁶

²¹ See generally MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 21-58 (2000).

²² Michael L. Perlin, *Therapeutic Jurisprudence: Understanding the Sanist and Pretextual Bases of Mental Disability Law*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 369, 372 (1994). See also 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 (2016).

²³ See Michael L. Perlin, *On “Sanism”*, 46 SMU L. REV. 373, 374-75 (1992) (“[S]anism is frequently practiced, consciously or unconsciously, by individuals who regularly take liberal or progressive positions decrying similar biases and prejudices that involve sex, race, ethnicity or sexual orientation.”).

²⁴ Keri K. Gould & Michael L. Perlin, “*Johnny’s in the Basement/Mixing Up His Medicine*”: *Therapeutic Jurisprudence and Clinical Teaching*, 24 SEATTLE U. L. REV. 339, 357 (2000) (footnotes omitted).

²⁵ Michael L. Perlin & John Douard, “*Equality, I Spoke That Word/As If a Wedding Vow*”: *Mental Disability Law and How We Treat Marginalized Persons*, 53 N.Y.L. SCH. L. REV. 9, 18 (2008-09) (discussing the public’s view of traditional substantive criminal law doctrines). On how OCS leads individuals to come to conclusions “based disproportionately on visual cues and clues,” see Heather Ellis Cucolo & Michael L. Perlin, *Promoting Dignity and Preventing Shame and Humiliation by Improving the Quality and Education of Attorneys in Sexually Violent Predator (SVP) Civil Commitment Cases*, 28 U. FLA. J. L. & PUB. POL’Y 291, 325-26 (2017).

²⁶ Michael L. Perlin & Alison J. Lynch, *How Teaching about Therapeutic Jurisprudence Can Be a Tool of Social Justice, and Lead Law Students to Personally and Socially Rewarding Careers: Sexuality and Disability as a Case Example*, 16 NEV. L.J. 209, 216-17 (2015). See *infra* Part V.

Consider all of this through the filter of the public “take” on the issues we discuss here. One argument frequently made in opposition to providing autonomy and support for sexual expression is that of *capacity*: people undergoing treatment will not have the capacity to make these decisions.²⁷ However, this is again short-sighted, contrary to the established law, and based on perceptions, fears and bias, rather than facts and data. Importantly—and we have known this for decades—it is essential that we educate mental health professionals about the multiple issues involved in assessing sexual consent capacity of persons with psychosocial and intellectual disabilities.²⁸ There will not be a “one size fits all” approach to determining whether someone has the capacity to understand how to exercise their own sexual autonomy in a safe way.²⁹

This is not a topic that has received significant scholarly attention in most quarters.³⁰ It has entirely escaped the attention of

²⁷ On how fact-finders rely on their own “amorphous” sense of what capacity means, see Lawrence A. Frolik, *Science, Common Sense, and the Determination of Mental Capacity*, 5 PSYCHOL. PUB. POL’Y & L. 41, 41 (1999).

²⁸ Carrie Hill Kennedy, *Assessing Competency to Consent to Sexual Activity in the Cognitively Impaired Population*, 1 J. FORENSIC NEUROPSYCHOLOGY 17, 32 (1999). See also Robyn P. Thom, Albert J. Grudzinskas & Fabian M. Saleh, *Sexual Behavior Among Persons with Cognitive Impairments*, 19 CURR. PSYCHIATRY REP. 24, 25 (2017).

²⁹ On the special issues when patients are in long-term care, see Jennifer Hillman, *Sexual Consent Capacity: Ethical Issues and Challenges in Long-Term Care*, 40 CLINICAL GERONTOLOGIST 43 (2017). Perlin & Weinstein, *supra* note 19, at 99 (“[E]lderly people are perceived as asexual, or, if interested in sex, then hypersexual to the point of perversion.”); see also Stephanie L. Tang, *When “Yes” Might Mean “No”: Standardizing State Criteria to Evaluate the Capacity to Consent to Sexual Activity for Elderly with Neurocognitive Disorders*, 22 ELDER L.J. 449, 458 (2015); James Cook, *When One Spouse Has It: Dementia and the Permissibility of Marital Sex under Criminal Statute*, 49 J. MARSHALL L. REV. 1225 (2016). For contemporaneous press accounts, see Pam Belluck, *Sex, Dementia and a Husband on Trial at Age 78*, N.Y. TIMES (Apr. 13, 2015), <https://www.nytimes.com/2015/04/14/health/sex-dementia-and-a-husband-henry-rayhons-on-trial-at-age-78.html> (covering an incident where husband of wife with dementia faced criminal prosecution for third-degree felony sexual abuse for having sex with his wife in a nursing home); Pam Belluck, *Iowa Man Found Not Guilty of Abusing Ailing Wife with Alzheimer’s*, N.Y. TIMES (Apr. 22, 2015), <https://www.nytimes.com/2015/04/23/health/iowa-man-found-not-guilty-of-sexually-abusing-wife-with-alzheimers.html> (covering an incident where husband found not guilty by the jury).

³⁰ Jeremy Coid has argued that freedom of sexual expression should be placed at the third level of the hierarchy of needs created by Abraham Maslow—see ABRAHAM H. MASLOW, *MOTIVATION AND PERSONALITY* (1954)—for detained patients along with occupation, education, physical exercise, leisure, companionship, sense of belonging and religious freedom, but noted that all the other aspects of this third level of the hierarchy are being actively addressed in forensic services but that the area of sexual expression has been neglected. Jeremy W. Coid, *Quality of Life for Patients Detained in Hospital*, 162 BRIT. J. PSYCHIATRY 611, 614 (1993).

almost all law professors.³¹ Often, what has been written comes from a perspective that we can only characterize as “bizarre.” By way of example, as recently as three years ago, an article published in a peer-reviewed scientific journal began with this startling comment: “The recognition that individuals with disabilities have a *desire* for sexual relationships with other people is a relatively new concept in the scientific community.”³²

Here, it is also important to acknowledge that there are often radically-different views held by clinical staff and ward staff on these issues.³³ A thorough study in the UK found that “discriminatory attitudes perceived to be in operation were located in the ward staff and were understood to be a consequence of a difference of cultural and religious viewpoints.”³⁴ The authors concluded that “[t]he prohibition and regulation of sexual behaviour among patients indeed tends to fit into a protective, conservative and moralistic discourse.”³⁵

We have also learned that tailored sexual education—something often entirely missing both in institutions and in the community³⁶—“can improve capacity to make sexuality-related decisions” among individuals in this population.³⁷ This flies in the face of prevailing social attitudes of many parents and treatment providers: there is not widespread sex education for persons with intellectual

³¹ The recent work of Professor Alexander Boni-Saenz and the very recent work of Professor Jasmine Harris and Professor Natalie Chin are rare and welcome exceptions. See e.g., Alexander A. Boni-Saenz, *Sexuality and Incapacity*, 76 OHIO ST. L.J. 1201 (2015); Alexander A. Boni-Saenz, *Sexual Advance Directives*, 68 ALA. L. REV. 1 (2016); Jasmine E. Harris, *Sexual Consent and Disability*, 93 N.Y.U. L. REV. 480 (2018); Chin, *supra* note 18.

³² Laura Gilmour, Veronica Smith & Melike Schalomon, *Sexuality and ASD: Current State of the Research*, in 1 COMPREHENSIVE GUIDE TO AUTISM 569 (Vinood B. Patel, Victor R. Preedy & Colin R. Martin eds., 2014) (emphasis added), as quoted in Michael L. Perlin & Alison J. Lynch, “All His Sexless Patients”: *Persons with Mental Disabilities and the Competence to Have Sex*, 89 WASH. L. REV. 257, 258 (2014).

³³ See Kalpana Elizabeth Dein, Paul Simon Williams, Irina Volkonskaia, Ava Kanyeredzi, Paula Reavey & Gerard Leavey, *Examining Professionals’ Perspectives on Sexuality for Service Users of a Forensic Psychiatry Unit*, 44 INT’L J.L. & PSYCHIATRY 15, 21 (2014). In such circumstances, the absence or ignorance of any formal policy “may permit authoritarian perspectives to prevail while maintaining the semblance of liberal attitudes among clinicians.” *Id.* at 19. See generally PERLIN & LYNCH, *supra* note 5, at 1-3; Perlin, *supra* note 4.

³⁴ Dein et al., *supra* note 33, at 20.

³⁵ *Id.* at 22.

³⁶ See, e.g., C. Deshays, *Sexuality in Psychiatric Institutions: Initiating Some Ethical Reflections*, 25 SEXOLOGIES e47 (2016).

³⁷ Eileen Dukes & Brian E. McGuire, *Enhancing Capacity to Make Sexuality-Related Decisions in People with an Intellectual Disability*, 53 J. INTELL. DISABILITIES RES. 727, 727 (2009).

disabilities, in large part due to parental objections to sexual education for their intellectually disabled children,³⁸ because they feel their children are not capable of understanding the information, or they feel it would be “bad for them,” by giving them “wrong ideas” and “overstimulat[ing] them.”³⁹ Many parents of this population also have succumbed to what is called the “forever child syndrome,” as a result of which children are regarded as “eternally innocent” and asexual.⁴⁰ As a result, basic information and education are often not given to individuals with significant disabilities in regard to sexuality.⁴¹ This will hamper their development in community settings, where opportunities to engage in safe explorations of sexuality may arise and this group of individuals may be unprepared because they have been so sheltered in the name of “protection.”⁴²

II. COMPETENCY

So how does this play out in the context of the sexuality-related questions—competency and the role of experts—that we seek to address here? The following are some of the questions that MLP regularly raised in class when he taught the right to sexual interaction in *Survey of Mental Disability Law*:

- “Does it make a difference if we are discussing monogamous heterosexual sex, polygamous heterosexual sex, monogamous homosexual sex, polygamous homosexual sex, or bisexual sex?”⁴³

³⁸ PERLIN & LYNCH, *supra* note 5, at 108. See also Thom, Grudzinskas & Saleh, *supra* note 28, on the significance of the limited sexual education typically made available to persons with intellectual disabilities.

³⁹ LYDIA FEGAN, ANNE RAUCH & WENDY MCCARTHY, *SEXUALITY AND PEOPLE WITH INTELLECTUAL DISABILITY* 11 (1993).

⁴⁰ Elizabeth J. Reed, *Criminal Law and the Capacity of Mentally Retarded Persons to Consent to Sexual Activity*, 83 VA. L. REV. 799, 804 (1997) (quoting Winifred Kempton & Emily Kahn, *Sexuality and People with Intellectual Disabilities: A Historical Perspective*, 9 *SEXUALITY & DISABILITY* 93, 94-97 (1991)).

⁴¹ PERLIN & LYNCH, *supra* note 5, at 108 (citing Holly Ann Wade, *Discrimination, Sexuality and People with Significant Disabilities: Issues of Access and the Right to Sexual Expression in the United States*, 22 *DISABILITY STUD. Q.* 9 (2002)).

⁴² Compare Robert E. Freeman-Longo, *Reducing Sexual Abuse in America: Legislating Tougher Laws or Public Education and Prevention*, 23 *NEW ENG. J. ON CRIM. & CIV. CONFINEMENT* 303, 320-21 (1997) (discussing how sex education for adolescent abusers and would-be abusers may deter future child sexual abuse).

⁴³ PERLIN & LYNCH, *supra* note 5, at 140.

- “Should erotic or pornographic material be made available to patients?”⁴⁴
- “Should a patient’s decision to engage in what is sometimes perceived as ‘deviant’ sexual behavior subsequently be used as evidence of their danger either to self or others or of ‘grave disability’?”⁴⁵
- “How should ‘competency’ be assessed in the context of patients’ ability to consent to sexual activity?”⁴⁶
- “To what extent are international human rights instruments of significance in assessing the extent to which institutionalized patients can exercise a right to sexual autonomy?”⁴⁷

These are all important questions, and at the core of all of them is the question of competency. For if a patient is competent to engage in autonomous decisionmaking about questions of sex, how can any institutional caretaker preempt those decisions any more than the State can preempt decisions we make about all of this in our own lives?

We are immediately faced with an important dilemma.⁴⁸ It is clear there is *no* unitary definition of competency in this area. Often, there are *no* definitions, and when there *are* definitions, they are often circular and contradictory.⁴⁹ “Where policies do exist, they are often stigmatizing and marginalizing, and do not allow for the range of opportunities to engage in sexual activities afforded to those without mental disabilities.”⁵⁰ Importantly, we reject the notion that incompetency can be presumed; the law presumes that mentally ill persons are competent, unless proven otherwise in a court of law.⁵¹

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Perlin & Lynch, *supra* note 26, at 220.

⁴⁷ *Id.*

⁴⁸ See generally Michael L. Perlin, Heather Ellis Cucolo & Alison J. Lynch, *A TJ Approach to Mental Disability Rights Research*, in *THE METHOD AND PRACTICE OF THERAPEUTIC JURISPRUDENCE* (Nigel Stobbs, Michel Vols & Lorana Bartels eds., forthcoming 2019).

⁴⁹ Perlin & Lynch, *supra* note 22, at 300. On competence issues in general, see MICHAEL L. PERLIN, PAMELA CHAMPINE, HENRY DLUGACZ & MARY CONNELL, *COMPETENCE IN THE LAW: FROM LEGAL THEORY TO CLINICAL APPLICATION* (2008).

⁵⁰ PERLIN & LYNCH, *supra* note 5, at 10.

⁵¹ See Perlin & Weinstein, *supra* note 19, at 76 (noting the widespread public belief that “persons institutionalized because of mental disabilities are presumptively incompetent to engage in autonomous decision-making”); Michael L. Perlin, *Everybody Is Making Love/Or Else Expecting Rain: Considering the Sexual Autonomy Rights of Persons Institutionalized*

“Contemporaneous constitutional case law and some statutory law generally reject the idea that mental illness and incompetency can be equated.”⁵² One of the basic building blocks of mental disability law is the principle that incompetence cannot be presumed either because of mental illness or because of a past record or history of institutionalization.⁵³ This reasoning is supported by the most important contemporary research. Publications by the MacArthur Foundation’s Network on Mental Health and the Law dramatically conclude that mental patients are not always incompetent to make rational decisions and that mental patients are not inherently more incompetent than patients who are not mentally ill.⁵⁴ In fact, on “any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly than other patients and nonpatients.”⁵⁵

It is apparent that there remain some serious disconnects between public perception of “competency to engage in sex” and the competency determinations made in the legal profession that surround this type of behavior. While the public may frequently rely on the routine, shock-value nature of conversations surrounding sexuality, attorneys for individuals with mental illness who express a desire to have sex, especially when institutionalized, have to consider the nuances of the laws surrounding competence to make these types of decisions.⁵⁶

We must start with “the assumption that all individuals have the capacity to consent to sexual relations,” and that the presence of a mental disorder by itself does not mean that the individual lacks this

Because of Mental Disability in Forensic Hospitals and in Asia, 83 U. WASH. L. REV. 481, 503 (2008) (discussing the myth that “[m]entally ill individuals are presumptively incompetent to participate in ‘normal’ activities [or] to make autonomous decisions about their lives”).

⁵² Michael L. Perlin & Deborah A. Dorfman, *Is It More Than “Dodging Lions and Wastin’ Time?” Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 PSYCHOL., PUB. POL’Y & L. 114, 120 (1996).

⁵³ See, e.g., *In re LaBelle*, 728 P.2d 138, 146 (Wash. 1986).

⁵⁴ Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study (III): Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149 (1995) (discussed in Perlin & Dorfman, *supra* note 52, at 120).

⁵⁵ *Id.* at 169.

⁵⁶ On the specific question of the long-term ramifications of “sexual competence,” see Melissa J. Palmer, Lynda Clarke, George B. Ploubidis, Catherine H. Mercer, Lorna J. Gibson, Anne M. Johnson, Andrew J. Copas & Kaye Wellings, *Is “Sexual Competence” at First Heterosexual Intercourse Associated with Subsequent Sexual Health Status?*, 54 J. SEX RES. 91 (2017).

capacity.⁵⁷ With this as a “given,” it is first necessary to unpack the different modes of analysis to be engaged in determining capacity and competency, and in understanding the important distinctions between the two concepts. Capacity “refers to an individual’s actual ability to understand, appreciate, and form a relatively rational intention with regard to some act”;⁵⁸ however, inquiries into capacity are an insufficient basis for decisionmaking about persons with mental disabilities engaging in sexual interactions.⁵⁹ There is no question that a functional, rather than a diagnostic, approach to determining capacity is now the preferable means of assessment.⁶⁰

Competency is a *legal* assessment that varies based on the act or decisionmaking that is being considered.⁶¹ Most famously, dissenting in *Godinez v. Moran*,⁶² in which the Supreme Court imposed a unitary standard of competency in criminal cases, holding that competency to either waive counsel or plead guilty was to be assessed by the same standard as competency to stand trial, Justice Harry Blackmun noted archly, “A person who is ‘competent’ to play basketball is not thereby ‘competent’ to play the violin. . . . Competency for one purpose does not necessarily translate to competency for another purpose.”⁶³

Importantly, the Supreme Court subsequently receded from the rigidity of the *Godinez* holding in *Indiana v. Edwards*,⁶⁴ ruling that the right of self-representation was not absolute, and the State could insist

⁵⁷ MENTAL WELFARE COMMISSION OF SCOTLAND, *CONSENTING ADULTS? GUIDANCE FOR PROFESSIONALS AND CARERS WHEN CONSIDERING RIGHTS AND RISKS IN SEXUAL RELATIONSHIPS INVOLVING PEOPLE WITH A MENTAL DISORDER* 4 (2007).

⁵⁸ Steven B. Bisbing, *Competency and Capacity: A Primer*, in *LEGAL MEDICINE* 325 (Shafeek S. Sanbar ed., 7th ed. 2007).

⁵⁹ Andreas Dimopoulos, *Let’s Misbehave: Intellectual Disability and Capacity to Consent to Sex 1* (Sept. 1, 2012) (unpublished paper presented to Society of Legal Scholars), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2332259.

⁶⁰ Glynis H. Murphy & Ali O’Callaghan, *Capacity of Adults with Intellectual Disabilities to Consent to Sexual Relationships*, 34 *PSYCHOL. MED.* 1347 (2004).

⁶¹ See generally MICHAEL L. PERLIN, PAMELA R. CHAMPINE, HENRY A. DLUGACZ & MARY A. CONNELL, *COMPETENCE IN THE LAW: FROM LEGAL THEORY TO CLINICAL APPLICATION* (2008).

⁶² 509 U.S. 389 (1993).

⁶³ *Id.* at 412 (Blackmun, J., dissenting). On the need to consider competencies in matters of sexuality as a distinct area of inquiry, see Oana Georgiana Girescu, *Sexuality and Disability: An Assessment of Practices under the Convention for the Rights of Persons with Disabilities* 64 (2012) (unpublished thesis, Central European University), http://www.etd.ceu.hu/2013/girescu_oana.pdf.

⁶⁴ 554 U.S. 164 (2008).

that an attorney be appointed to represent a mentally ill defendant even though he had been found competent to stand trial. In the course of the *Edwards* decision, it characterized the issue in a multitextured way that should be taken seriously in any consideration of the issues under consideration in this article, holding that “[m]ental illness itself is not a unitary concept. It varies in degree. It can vary over time. It interferes with an individual’s functioning at different times in different ways.”⁶⁵

It is also important here to seek to assess the extent to which a person can exercise informed consent. In the context of this inquiry, such consent encompasses:

- An individual’s ability to understand the sexual nature of an act, and to understand that participation in such an act must be voluntary;
- An individual’s understanding of the potential consequences and implications of the decision to engage in a sexual act; and
- An individual’s ability to communicate a decision in an overt manner as to whether he or she wishes to engage in such an activity.⁶⁶

Besides an assessment of legal capacity, attorneys must also take into account clinical capacity. This is frequently when attorneys and experts will need to work together to understand the standards of competency from the other’s perspective, in order to build a strong case for the client. This is made more troublesome by the reality that it is often difficult to establish “clinical” competency, for those persons who are institutionalized. There is no standard that clinicians regularly apply when determining competency; in fact, it is an extraordinarily fluid determination.⁶⁷

In a survey of institutions’ views on their ability to handle ethical concerns of patient sexual expression, the sociologist Eric Wright and his colleagues found, “aside from formal legal declarations

⁶⁵ *Id.* at 175-76. See, e.g., Cucolo & Perlin, *supra* note 25, at 313-14 (discussing *Edwards* in this context).

⁶⁶ Suzanne Doyle, *The Notion of Consent to Sexual Activity for Persons with Mental Disabilities*, 31 LIVERPOOL L. REV. 111, 117-18 (2010); see also Martin Lyden, *Assessment of Sexual Consent Capacity*, 25 SEXUALITY & DISABILITY 3 (2007); Paul R. Abramson, Terry Gross & Annaka Abramson, *Consenting to Sex and Severe Mental Illness: Terra Incognita and a Priest with AIDS*, 30 SEXUALITY & DISABILITY 357, 363 (2012).

⁶⁷ *Niswonger v. State*, No. 60419, 2013 WL 285594, *1 n.2 (Nev. Jan. 23, 2013).

of incompetence, establishing competence to engage in sexual activity during treatment is further complicated by the dynamic nature of psychiatric symptoms, variation in patients' sexuality-related knowledge and experience, and institutional policies."⁶⁸ In this context, it is also important to consider the reality that, *in general*, "Americans and their legal systems became increasingly liberal regarding adult sexuality and the privacy afforded private, consensual, adult sexual relationships in the twentieth century."⁶⁹ But, in the context of the current inquiry, the relationship between sexuality and privacy is "directly related to assessments about . . . competence."⁷⁰

This is not to say that there are not models that could be followed. By way of example, Murphy and O'Callaghan have created a multi-step instrument that could be adopted by inpatient psychiatric institutions as a guide, an instrument that could be of great aid to expert witnesses who are asked to do evaluations in such cases. They conclude that these are all important areas to be considered in assessing capacity:

- (1) basic sexual knowledge (e.g. of body parts, sexual relations, and sexual acts);
- (2) knowledge of the consequences of sexual relations, including sexually transmitted diseases and pregnancy;
- (3) an understanding of appropriate sexual behaviour and the context for this;
- (4) an understanding that sexual contact should always be a matter of choice;
- (5) the ability to recognize potentially abusive situations; [and]

⁶⁸ Eric R. Wright, Heather A. McCabe & Harold E. Koorman, *Institutional Capacity to Respond to the Ethical Challenges of Patient Sexual Expression in State Psychiatric Hospitals in the United States*, 7 J. ETHICS MENTAL HEALTH 1, 2 (2012). Many institutions have no guidelines or policies at all to promote a therapeutic milieu in the context of sexual relationships. See Sabrina Kastner & Michael Linden, *Relations Between Patients in Psychiatric and Psychotherapeutic Inpatient Care: A Literature Review and Conclusions for Clinical Practice and Research*, 18 INT'L J. PSYCHIATRY IN CLINICAL PRAC. 222 (2014). For an earlier consideration of sexual knowledge in secure hospital settings, see Marie Quayle, Nashater Deu & Sharon Giblin, *Sexual Knowledge and Sex Education in a Secure Hospital Setting*, 8 CRIM. BEHAV. & MENTAL HEALTH 66 (1998).

⁶⁹ Shelly Elimelekh, *The Constitutional Validity of Circuit Court Opinions Limiting the American Right to Sexual Privacy*, 24 CARDOZO ARTS & ENT. L.J. 261, 262 (2006).

⁷⁰ Michael Gill, *Sex Can Wait, Masturbate: The Politics of Masturbation*, 15 SEXUALITIES 472, 476 (2012).

(6) the ability to show skills of assertion in social and personal situations and to thereby reject any unwanted advances at a given time.⁷¹

Tragically, lawyers have traditionally presumed incompetency *in all matters* that relate to their institutionalized clients,⁷² the latter notwithstanding the fact that, in many jurisdictions, it is statutorily impermissible to do precisely that.⁷³ But it is done unthinkingly, and virtually universally, in the context of the population considered here, and it is clear what a “damaging message”⁷⁴ this is. This, more than anything else, leads to the confusion, dissonance and tension in this area of law, society and personhood.

III. THE ROLE OF LAWYERS

What about, specifically, the lawyer’s role in such cases? Beyond simply making legal determinations about competency, attorneys must also be mindful that another part of their responsibility to their client—and their duty to provide zealous advocacy, “the central ethical mandate for criminal lawyers”⁷⁵—is to respect their client’s wishes and advocate for that client’s right to sexual autonomy, if that is a priority for the client. The courts have made clear forever: “[t]he governing standard for the representation of [persons with disabilities] is not the protection of their best interests, but, to the extent possible, the zealous advocacy of their expressed preferences.”⁷⁶ It is not insignificant that the “zealous advocacy” literature in law reviews—extensive in the case of criminal defense—is virtually absent in the case of questions involving civil commitment to psychiatric hospitals.⁷⁷

⁷¹ Murphy & O’Callaghan, *supra* note 60, at 1349. From a legal perspective, see Anna Arstein-Kerslake, *Understanding Sex: The Right to Legal Capacity to Consent to Sex*, 30 DISABILITY & SOC’Y 1459 (2015).

⁷² See generally Michael L. Perlin, “I Might Need a Good Lawyer, Could Be Your Funeral, My Trial”: *Global Clinical Legal Education and the Right to Counsel in Civil Commitment Cases*, 28 WASH. U. J.L. & POL’Y 241 (2008).

⁷³ See, e.g., N.J. STAT. ANN. § 30:4-24.2(c) (2018).

⁷⁴ Eli K. Best, *Atypical Actors and Tort Law’s Expressive Function*, 96 MARQ. L. REV. 461, 488 (2012).

⁷⁵ Abbe Smith, *Burdening the Least of Us: “Race-Conscious” Ethics in Criminal Defense*, 77 TEX. L. REV. 1585, 1589 (1999).

⁷⁶ *Gross v. Rell*, 40 A.3d 240, 263 (Conn. 2012).

⁷⁷ Perlin & Weinstein, *supra* note 19, at 93:

As we have discussed, the representation of persons with mental disabilities is infected by sanism, and this sanism leads to paralytic rolelessness on the part of many persons who represent this population.⁷⁸ It can make negative case outcomes nearly inevitable, and such outcomes are the cause of much of the frustration that befalls those who do try to provide adequate representation in these cases.

There are several specific issues that arise when an attorney begins representing individuals with mental illness, and frequently, these issues are only exaggerated when the subject material is something seen as taboo—like sexual autonomy—and even more so when this taboo subject affects an already-marginalized group, such as individuals with a disability, especially a *mental* disability. As two of the co-authors (MLP & AJL) have previously written:

[A]ttorneys often deal ineffectively with what they perceive as their clients' "differentness,"⁷⁹ as they are unused to developing relationships with clients who may be passive, frightened, inarticulate, and unaware of their possible options. Beyond this, because a patient's demeanor may be *different*, an attorney may feel foolish or awkward in representing such a client's views, for fear the judge might ascribe the views to the attorney.⁸⁰ This "differentness" may engender acute embarrassment that inevitably will diminish the scope and quality of the attorney's advocacy.⁸¹

It is not insignificant that the phrase "zealous advocacy" has been used in over 2400 published cases but, when the phrase "civil commitment" "psychiatric hospitalization"> is added to a WESTLAW search, there are zero cases to be found.

Id.

⁷⁸ See Perlin & Lynch, *supra* note 22, at 309.

⁷⁹ See Perlin, *supra* note 23, at 398 (stating "[l]egislators have traditionally responded to socially-expressed fears by enacting laws that focus on the perceived differentness of people with mental disabilities in almost all aspects of social intercourse"). On the role of difference in this area in general, see generally MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW (1990).

⁸⁰ Perlin & Lynch, *supra* note 22, at 305. This conflict becomes more significant in light of the court's view of the entire process. See, e.g., Thomas K. Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L. REV. 503, 516 (1976) (explaining that 80% of surveyed Wisconsin judges endorsed "best interests" model; 12% adopted adversary position).

⁸¹ Perlin & Lynch, *supra* note 22, at 305-06.

Frequently, at the root of this ineffective advocacy is sanism. Sanist lawyers (1) distrust their clients with mental disabilities, (2) trivialize their complaints, (3) fail to forge authentic attorney-client relationships with such clients and reject their clients' potential contributions to case-strategizing, and (4) take less seriously case outcomes that are adverse to their clients.⁸² Sanism is dangerous because not only does it yield these unfair, detrimental outcomes, but it also is often unnoticed by the attorney himself, who may genuinely believe he is providing the best possible representation to his client. However, the attitudes and views he has internalized over the course of his life, especially surrounding sexuality as it applies to persons with disabilities, can lead to this insidious bias that can affect his practice. As we will discuss soon, this is the reason why therapeutic jurisprudence is immensely beneficial, and necessary, especially for education of legal professionals.⁸³

At its core, the tenets of therapeutic jurisprudence reflect the belief that all clients deserve the dignity of voicing their opinions, beliefs and thoughts throughout their time in the legal system.⁸⁴ This includes those taboo subjects like sexual autonomy. It is the lawyer's job to not only acknowledge the importance of this type of discussion, but to use the information the client is providing in a way that furthers that client's dignity and voice within a system that so frequently tunes him or her out.⁸⁵

The attorney must also become comfortable with being an educator, as well as an advocate. Frequently, for populations whose needs are overlooked, there are not only biases against these needs, but a lack of understanding. A TJ-oriented attorney, in consultation with his or her clients, will work to provide information and education about the problem. It is not enough, especially where something as "taboo" as sexual autonomy is concerned, to just advocate. In order to bring more comprehensive change and understanding to the issue, it is very likely that there will need to be some education that goes along with forceful advocacy.

⁸² Perlin, *supra* note 4, at 695.

⁸³ Bruce J. Winick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 CLINICAL L. REV. 605 (2006).

⁸⁴ Amy D. Ronner, *Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles*, 71 U. CIN. L. REV. 79, 94-95 (2002).

⁸⁵ *Id.*

Attorneys who agree to work with this population, on these issues, will need to become comfortable confronting potentially unconscious sanist biases while providing the zealous advocacy that these clients deserve. The roles of attorneys in cases such as these extend beyond what is taught in law school.⁸⁶ The principles of therapeutic jurisprudence are critical to understanding how best to serve this population, especially while confronting issues that the majority of the public will find uncomfortable.⁸⁷

IV. THE ROLE OF EXPERT WITNESSES⁸⁸

A. Introduction

Forensic experts are in a unique position to assist in cases involving alleged sexual offenses by individuals who have been diagnosed with intellectually disabled or autism spectrum disorder. Opportunities to provide feedback to the courts and lawyers representing these individuals arise frequently due to the vulnerability of these targeted individuals both as victims and alleged perpetrators. Psychological testing and a comprehensive review of relevant contributing developmental factors can yield critical information that can provide mitigation and potential solutions consistent with the goals of therapeutic jurisprudence. The ability to intervene in the initial phase of the entry of these targeted individuals into the criminal justice system is particularly critical with regard to promoting ethical and effective case dispositions that include rehabilitation.

B. The Research

Research compiled by the ARC's National Center on Criminal Justice & Disability (hereinafter "NCCJD") provides a bridge between criminal justice and disability professionals, such as lawyers, treating

⁸⁶ See Perlin & Lynch, *supra* note 26.

⁸⁷ See Perlin & Lynch, *supra* note 22.

⁸⁸ Much of this section draws on the personal experience of co-author VRMcC, who, as an expert witness and consultant, has had frequent opportunities to evaluate individuals facing legal consequences related to their own victimization and their own intellectual limitations, both of which often place them at great risk for exploitation. This co-author has testified frequently in cases involving this population in matters related to competency, restorability and sentence mitigation, and has regularly addressed questions of culpability and intent in such cases.

therapists, psychologists and service coordinators.⁸⁹ The goal of NCCJD is to promote fairness, safety and justice for people with intellectual and developmental disabilities (hereinafter “I/DD”) as suspects, offenders, victims or witnesses.⁹⁰ A White Paper Series entitled “Pathways to Justice: Barriers and Solutions,”⁹¹ discusses current issues, research and emerging practices regarding people with intellectual and developmental disabilities in the criminal justice system. Each paper in the series is written by an expert regarding a particular topic relevant to the work done by forensic mental disability professionals and lawyers who represent the population in question. For example, Prof. Heather Ellis Cucolo and MLP address the legal warehousing of people with I/DD charged with sexual offenses. Essentially, the message is that citizens with disabilities have a right to equal access to our nation’s criminal justice system.⁹² Relatedly, both the criminal justice system and professionals working with those with disabilities are encouraged to acknowledge and address areas in which services and procedures are lacking so as to move towards enhancing effective treatment.⁹³

People with intellectual and developmental disabilities who allegedly violate sex act-related laws frequently face serious consequences, often because the law—and law enforcement—falls far short of accommodating the disability in question. Professionals involved in the criminal justice system must be able to identify the disability, and they must be able to understand its consequent impact on the individual’s behavior. Armed with this knowledge, the professionals involved—whether forensic psychologist, other forensic mental health professional, judge or lawyer—can both more effectively respond by protecting the legal rights of the individual, and by establishing strategies to mitigate both the individual’s rights, and, in the case of the forensic mental health professional, the victims’

⁸⁹ See ARC, WWW.THEARC.ORG (LAST VISITED DEC. 5, 2018).

⁹⁰ THE ARC: NAT’L CTR. ON CRIM. JUST. & DISABILITY, *JUSTICE-INVOLVED YOUTH WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES: A CALL TO ACTION FOR THE JUVENILE JUSTICE COMMUNITY* (2015), <https://www.thearc.org/document.doc?id=5343>.

⁹¹ *Pathways to Justice*, ARC, <https://www.thearc.org/what-we-do/programs-and-services/national-initiatives/nccjd/pathways-to-justice> (last visited Dec. 5, 2018).

⁹² Heather Ellis Cucolo & Michael L. Perlin, *The Legal Warehousing of People with I/DD Charged with Sex Offenses*, in *SEX OFFENDERS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES: A CALL TO ACTION FOR THE CRIMINAL JUSTICE COMMUNITY* 9 (2016), <https://www.thearc.org/document.doc?id=5253>.

⁹³ *Id.* at 9-10.

rights. Rehabilitation and education are key components to accomplish this balance.⁹⁴

The professional must first identify the presence of I/DD so as to proceed with related legal and treatment options to present to the court. As we have already discussed, individuals with these disabilities often did not—when they were children or youth—receive education concerning sexuality, often because their parents were uncomfortable and uncertain as to how to provide such education in a meaningful and comprehensive manner.⁹⁵

Different criminal charges will require different strategies. For example, public masturbation should be viewed in a different light than more serious charges such as repeated cultivated child molestation (that is, the grooming of victims who are vulnerable being gradually “set up” over time).⁹⁶ In cases involving such serious charges, it is important to recognize that individuals with I/DD are often susceptible to coercion, and they may thus become implicated in criminal acts involving sexual offenses due to being victims themselves. For example, this examiner recently evaluated a woman who was intellectually disabled and accused of production of child pornography. Investigation into her background yielded important findings including her own history of victimization at the age of 13 years old when she was gang raped. She had met her partner on an online dating site and was groomed over time leading to two pregnancies resulting in two daughters. The perpetrator molested the young toddlers and was physically abusive to the client threatening to harm her, the children and her family when she would not provide bath time pictures which he said he was using to “make a photo album.” Despite the client’s efforts to obtain a restraining order, the perpetrator successfully manipulated her through verbal threats and violence leading to her involvement in federal charges of production of child pornography. This examiner was asked to identify developmental factors which would contribute to her vulnerability and conduct neuropsychological and intellectual deficits to identify the extent of her disability. The results are still pending in the federal case.

⁹⁴ NCCJD, ARC, www.thearc.org/NCCJD (last visited Dec. 5, 2018).

⁹⁵ See, e.g., Kempton & Kahn, *supra* note 40, and text accompanying *supra* notes 36–42.

⁹⁶ See, e.g., *United States v. Johnson*, 132 F.3d 1279, 1283 n.2 (9th Cir. 1997) (defining grooming as “the process of cultivating trust with a victim and gradually introducing sexual behaviors until reaching a point of intercourse”).

Research indicates that treatment plans which promote community involvement, successful employment and positive self-images are largely more effective than those which confine and isolate offenders and focus primarily on suppressing problem behaviors.⁹⁷ For example, individuals who are found incompetent to proceed due to I/DD can be placed in group homes which permit opportunities to cultivate responsiveness, learning style, cognitive skills and exposure to life experiences which allow healthy sexual behavior and appropriate outlets for sexual expression such as same aged peer relationships.⁹⁸ We reject as both unconstitutional and clinically unwise the protocol that exists in many states in which individuals currently incompetent to stand trial are incarcerated in a maximum security forensic facility pending restoration.⁹⁹

Consider also cases involving the registration of sex offenders.¹⁰⁰ This examiner is frequently asked to evaluate individuals identified as sex offenders who have I/DD and have failed to meet the registration requirements established by law.¹⁰¹ In such cases, the reality is often that limited resources to promote community involvement including a lack of social service mechanisms to facilitate registration combined with geographic restrictions are obstacles which contribute to recidivism and promote social shame.¹⁰² Multiple factors contribute to the failure of individuals with I/DD to be able to comply with registration requirements, including a lack of basic skills such as communication (understanding consequences, expressing needs),

⁹⁷ THE ARC: NAT'L CTR. ON CRIM. JUST. & DISABILITY, *supra* note 90; *see also About Safer Society*, FAY HONEY KNOPP INST., <http://www.safersociety.org/foundation/about-us/> (last visited Dec. 5, 2018).

⁹⁸ *See*, for a review of the relevant research, Tonya N. Davis, Wendy Machalicek, Rachel Scalzo, Alicia Kobylecky, Vincent Campbell, Sarah Pinkelman, Jeffrey Michael Chan & Jeff Sigafoos, *A Review and Treatment Selection Model for Individuals with Developmental Disabilities Who Engage in Inappropriate Sexual Behavior*, 9 BEHAV. ANALYSIS PRAC. 389 (2016).

⁹⁹ *See, e.g.*, Michael L. Perlin, "For the Misdemeanor Outlaw": *The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193 (2000); Susan McMahon, *Reforming Competence Restoration Statutes: An Outpatient Model*, GEO. L.J. (forthcoming 2019), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3132700.

¹⁰⁰ *See* MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, SHAMING THE CONSTITUTION: THE DETRIMENTAL RESULTS OF SEXUAL VIOLENT PREDATOR LEGISLATION 43-55 (2017).

¹⁰¹ *NCCJD*, *supra* note 94.

¹⁰² *See generally* Michael L. Perlin & Naomi M. Weinstein, "Friend to the Martyr, a Friend to the Woman of Shame": *Thinking About the Law, Shame and Humiliation*, 24 S. CAL. REV. L. & SOC. JUST. 1 (2014) (discussing sex offender laws in the context of shame); Cucolo & Perlin, *supra* note 25 (same).

deficits in sex education, lack of knowledge of how to seek supportive resources (mental health counseling, drug treatment, medical care) and moral reasoning deficits.¹⁰³ Cognitive deficits in individuals with I/DD including slowed and concrete reasoning necessitate steps in ensuring individuals comprehend and appreciate the supervision requirements.¹⁰⁴

Further challenges include the necessity of repetition, impaired verbal comprehension and reading skills, difficulties with abstraction and generalization, tendency towards acquiescence bias and sensitivity to criticism.¹⁰⁵ Relatedly, professionals frequently display behaviors which further impede communication, including infantilizing the client due to identified I/DD, over-pathologizing the client and attributing the behavior to sexual deviance, minimizing accountability for behavior, ignoring risk potential and reacting disproportionately by citing examples such as community anger towards sex offenders in the neighborhood.¹⁰⁶

Opportunities for rehabilitating individuals with I/DD who are found incompetent to proceed related to sexual offenses can be provided within the context of group homes which provide 24/7 supervision. Step-wise behavioral modification is used to promote appropriate sexual expression and decrease the frequency of inappropriate sexual behavior through identifying triggers and setting appropriate interpersonal boundaries.¹⁰⁷ In many cases, co-morbid psychiatric disorders such as ADHD, Bipolar Disorder or Schizophrenia which contribute to poor impulse control and impaired perceptions are identified and treated through medication. This

¹⁰³ See generally Murphy & O'Callaghan, *supra* note 60, at 1354 (discussing how persons with intellectual disabilities lack knowledge about such topics as pregnancy, masturbation, contraception, birth control, STDs, types of sexual relationships, and legal aspects of sex).

¹⁰⁴ *NCCJD*, *supra* note 94.

¹⁰⁵ On acquiescence bias in the context of this population, see Bradley A. Areheart, *Disability Trouble*, 29 *YALE L. & POL'Y REV.* 347, 372-73 (2011).

¹⁰⁶ THE ARC: NAT'L CTR. ON CRIM. JUST. & DISABILITY, *supra* note 90. According to disability rights advocates, the infantilization of adults with disabilities has been a significant rationale for stripping away autonomy. See Mitchell Levitz, *Voices of Self-Advocates*, in *THE HUMAN RIGHTS OF PERSONS WITH INTELLECTUAL DISABILITIES: DIFFERENT BUT EQUAL* 453, 458 (Stanley S. Herr, Lawrence O. Gostin & Harold Hongju Koh eds., 2003), as quoted in János Fiala-Butora, Michael Ashley Stein & Janet E. Lord, *The Democratic Life of the Union: Toward Equal Voting Participation for Europeans with Disabilities*, 55 *HARV. INT'L L.J.* 71, 88 n.101 (2014).

¹⁰⁷ *About Safer Society*, *supra* note 97.

combined therapeutic milieu helps to promote personal and sexual autonomy and increased independence for individuals with I/DD.

Consider further individuals with Autism Spectrum Disorder as defined by the DSM-V.¹⁰⁸ This cohort of individuals—including those previously categorized as persons with Asperger's—can become involved in the criminal justice system for various reasons including alleged sexual offenses or misconduct.¹⁰⁹ Research exploring the impact that the symptoms of ASD have on these alleged sexually inappropriate behaviors is much needed to promote effective legal outcomes. ASD is characterized by social difficulties including deficits in verbal and non-verbal understanding and responding appropriately in social situations and interpersonal relationships.¹¹⁰ Relatedly, individuals with ASD have difficulty initiating, understanding and maintaining relationships.¹¹¹ The marked features of restrictive, repetitive and fixed patterns of behavior presents challenges in trying to promote appropriate sexual responses and outlets.¹¹²

For example, individuals with ASD may become fixated on a specific person, body parts, or obsession with pornography, all of which may result in stalking or unwanted sexual advances. This examiner evaluated an individual with ASD who had been conditioned with urethral electrical stimulation to regulate bladder control. This same individual developed inappropriate behaviors including soliciting other children to come to the restroom and urinate in front of him. In another case, a young man who was very isolated from peers and had no dating history, developed a pattern of viewing child pornography as a sexual outlet. He had not been identified as ASD yet when the offense occurred. Review of his academic and developmental history, coupled with interviewing him regarding the offense, yielded effective mitigation to provide to his lawyer a yield that ultimately led to a sentence of probation as opposed to incarceration.

¹⁰⁸ See generally Jerrod Brown, Gabrea Anderson, Laura Cooney-Koss, Bethany Hastings, Hal Pickett, Diane Neal, Julie Martindale, Kimberly D. Dodson & Leslie Barfknecht, *Autism Spectrum Disorder and Sexually Inappropriate Behaviors: An Introduction for Caregivers and Professionals*, 1 J. SPECIAL POPULATIONS 1 (2017).

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

Individuals with ASD can become fixated on collecting objects, toys or pictures.¹¹³ This pattern of behavior can easily lead to fixating on pictures that would be inappropriate such as child pornography whether intentional or accidental. For example, individuals with ASD can develop a rigid and repetitive pattern of using the computer for playing games and leisure activities. The accessibility of various websites including adult pornography can lead to messages being sent through email from inappropriate websites including child pornography sites. While the individual did not intend to specifically seek out child pornography, they are now put in a position in which they become targets for predators. When an individual with ASD has lower intellectual functioning it becomes even more important for the expert witness to explain how the combined factors place them more at risk for actions which may be better explained by the developmental and intellectual limitations.

Forensic psychologists can play a vital role in identifying and explaining the presence of I/DD as it relates to criminal charges involving sexual offenses. A comprehensive inquiry into the client's social, developmental, academic, medical and psychiatric history can provide critical information in fleshing out the nature of the disability and streamlining efforts to further diagnose relevant mitigating factors. When an individual who is suspected of having an I/DD has not yet been identified or diagnosed as such, selective psychological testing including intellectual assessment (Wechsler Adult and Children's Intelligence Tests)¹¹⁴ adaptive testing (Adaptive Behavioral Assessment Scale),¹¹⁵ and autism, Aspergers interviews and measures (Gilliams Autism Rating Scale)¹¹⁶ can be used to further define the disorder and make appropriate recommendations for effective intervention.

The forensic evaluator is in a unique position to provide appropriate input regarding mitigation and related strategies to accomplish appropriate resolutions in the criminal justice system. Such strategies should incorporate rehabilitation and protective

¹¹³ See, e.g., K. Gillespie-Smith, D.M. Riby, P.J.B. Hancock & G. Doherty-Sneddon, *Children with Autism Spectrum Disorder (ASD) Attend Typically to Faces and Objects Presented within Their Picture Communication Systems*, 58 J. INTELL. DISABILITY RES. 459 (2014).

¹¹⁴ DAVID WECHSLER, *WECHSLER ADULT INTELLIGENCE SCALE -IV* (2008).

¹¹⁵ PATTI L HARRISON & THOMAS OAKLAND, *ADAPTIVE BEHAVIOR ASSESSMENT SYSTEM* (2d ed. 2000).

¹¹⁶ JAMES E. GILLIAM, *GILLIAM AUTISM RATING SCALE (GARS-3)* (3d ed. 2013).

strategies for potential victims. Resources often exist in the community for sentencing options that can be incorporated through a pre-sentence plan. Advocates from support and advocacy groups such as The Arc can collaborate with the district attorney's office and the probation department and present relevant and needed information to the judge. Examples of options involving personalized justice¹¹⁷ are being implemented by The Arc and include 24-48 hours incapacitation in a safe environment along with sex/relationship training, restitution for charges, and confinement to a residential facility for a designated period of time. Some communities also have programs designed for individuals with developmental disabilities including The Safer Society Foundation Inc.¹¹⁸ The forensic psychologist is thus in a unique position to utilize existing resources to forge a path within the criminal justice system and provide creative options that accommodate individuals with disabilities while providing legitimate sentencing options.

V. THERAPEUTIC JURISPRUDENCE¹¹⁹

One of the most important legal theoretical developments of the past three decades has been the creation and dynamic growth of TJ.¹²⁰ TJ presents a new model for assessing the impact of case law

¹¹⁷ *Healthcare Analytics Best Practices*, DDOP (June 19, 2017), <http://www.ddop.org>.

¹¹⁸ Leigh Ann Davis, *People with Intellectual Disability & Sexual Offenses*, ARC (Aug. 2009), <https://www.thearc.org/what-we-do/resources/fact-sheets/sexual-offenses>.

¹¹⁹ Text *infra* accompanying notes 120-29 is generally adapted from Perlin & Lynch, *supra* note 32; 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*, 8 WAKE FOREST J.L. & POL'Y 455 (2018), and Michael L. Perlin & Alison J. Lynch, "In the Wasteland of Your Mind": *Criminology, Scientific Discoveries and the Criminal Process*, 4 VA. J. CRIM. L. 304 (2016). Further, it distills the work of one of the co-authors over the past 25+ years beginning with Michael L. Perlin, *What Is Therapeutic Jurisprudence?*, 10 N.Y.L. SCH. J. HUM. RTS. 623 (1993). See generally Michael L. Perlin, "Have You Seen Dignity?": *The Story of the Development of Therapeutic Jurisprudence*, 27 NEW ZEALAND U. L. REV. 1135 (2017); Michael L. Perlin, "Changing of the Guards": *David Wexler, Therapeutic Jurisprudence, and the Transformation of Legal Scholarship*, INT'L J. L. & PSYCHIATRY (forthcoming 2019).

¹²⁰ See, e.g., DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990); DAVID B. WEXLER & BRUCE J. WINICK, LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (1996); BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL (2005). Wexler first used the term in a paper he presented to the National Institute of Mental Health in 1987. See David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 LAW & HUM. BEHAV. 27, 27, 32-33 (1992); David B. Wexler, *Therapeutic Jurisprudence Forum: The Development of Therapeutic Jurisprudence: From Theory to Practice*, 68 REV. JUR. U.P.R.

and legislation, recognizing that, as a therapeutic agent, the law can have therapeutic or anti-therapeutic consequences.¹²¹

Therapeutic jurisprudence asks whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles.¹²² David Wexler clearly identifies how the tension inherent in this inquiry must be resolved: the law's use of "mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns."¹²³ Such an inquiry into therapeutic outcomes does not mean that "therapeutic concerns 'trump' civil rights and civil liberties."¹²⁴

Using TJ, we "look at law as it actually impacts people's lives"¹²⁵ and assess law's influence on emotional life and psychological well-being.¹²⁶ One governing TJ principle is that "law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent

691, 693-94 (1999). See generally David B. Wexler, *Mental Health Law and the Seeds of Therapeutic Jurisprudence*, in THE ROOTS OF MODERN PSYCHOLOGY AND LAW: A NARRATIVE HISTORY 78 (Thomas Grisso & Stanley Brodsky eds., 2018).

¹²¹ See Michael L. Perlin, "His Brain Has Been Mismanaged with Great Skill": How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?, 42 AKRON L. REV. 885, 912 (2009).

¹²² Perlin, *supra* note 47; Michael L. Perlin, "And My Best Friend, My Doctor, Won't Even Say What It Is I've Got": The Role and Significance of Counsel in Right to Refuse Treatment Cases, 42 SAN DIEGO L. REV. 735, 751 (2005). See also Ian Freckelton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence*, 30 THOMAS JEFFERSON L. REV. 575, 585-86 (2008).

¹²³ David B. Wexler, *Therapeutic Jurisprudence and Changing Conceptions of Legal Scholarship*, 11 BEHAV. SCI. & L. 17, 21 (1993). See also David B. Wexler, *Applying the Law Therapeutically*, 5 APPLIED & PREV. PSYCHOL. 179 (1996).

¹²⁴ Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 412 (2000); Michael L. Perlin, "Where the Winds Hit Heavy on the Borderline": *Mental Disability Law, Theory and Practice*, "Us" and "Them", 31 LOY. L.A. L. REV. 775, 782 (1998).

¹²⁵ Bruce J. Winick, *Foreword: Therapeutic Jurisprudence Perspectives on Dealing With Victims of Crime*, 33 NOVA L. REV. 535, 535 (2009).

¹²⁶ David B. Wexler, *Practicing Therapeutic Jurisprudence: Psycholegal Soft Spots and Strategies*, in DANIEL P. STOLLE, DAVID B. WEXLER & BRUCE J. WINICK, PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION 45 (2006).

with other values served by law, should attempt to bring about healing and wellness.”¹²⁷ TJ supports an ethic of care.¹²⁸

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 pronouncement 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.¹²⁹

The question to be posed here is this: does our current system comply with these precepts of therapeutic jurisprudence? Consider the range of topics that one must consider when one thinks about patient sexuality: sterilization, the special circumstances of forensic facilities, medication side effects, sex education, sexual interaction when one or both participants have irreversible neurological deficits, institutional placements, institutional conditions, and reproductive technologies and rights.¹³⁰ In each instance, an evaluation of our findings in the

¹²⁷ Bruce J. Winick, *A Therapeutic Jurisprudence Model for Civil Commitment*, in *INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVES ON CIVIL COMMITMENT* 23, 26 (Kate Diesfeld & Ian Freckelton eds., 2003).

¹²⁸ See, e.g., Bruce J. Winick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 *CLINICAL L. REV.* 605, 605-07 (2006).

¹²⁹ Ronner, *supra* note 84, at 94-95 (footnotes omitted); see also Amy D. Ronner, *The Learned-Helpless Lawyer: Clinical Legal Education and Therapeutic Jurisprudence as Antidotes to the Bartleby Syndrome*, 24 *TOURO L. REV.* 601, 627 (2008).

¹³⁰ See generally PERLIN & LYNCH, *supra* note 5.

context of Professor Ronner's TJ prescriptions would show that our policies fail miserably (a finding that should not surprise us terribly, given the legal system's long-standing and well-documented woeful track record of comporting with therapeutic jurisprudence in many of these areas).¹³¹

TJ allows for several end goals: it targets sanism, sets up a legal system where the therapeutic benefit of legal solutions is not just discussed but actually made to be a targeted outcome, and teaches attorneys and judges how to appropriately interact with individuals with mental disabilities in all types of representation. We believe that it is a meaningful and critical solution to the problems faced by both new and veteran attorneys in the realm of mental health litigation and counseling. Its precepts offer a radically different perspective on the provision of counsel—whether the case is a civil commitment case, institutional reform case, criminal case, or even a civil case that, on its surface, appears to have nothing to do with “mental disability law.” TJ is and can be a way to implement positive psychology in the litigational relationship,¹³² and can be a critically important tool of persuasion in all aspects of the lawyer/client relationship, case negotiations, and the courtroom process.¹³³ TJ provides a ready-made tool kit for lawyers representing this population, in that it allows and encourages them to focus on the critical concepts of voluntariness, voice, and validation.

A great deal of advocacy can be done using the tools of therapeutic jurisprudence, but attorneys first need to accept it as a part of their practice, and then embrace it as a way of bringing a different approach to traditional lawyering. This will help to ensure that attorneys are truly doing as much zealous advocacy as possible for their client, despite what may be seen initially as discomfort based on the subject matter.

Finally, consider the roots of the dilemmas we face: our *attitudes* towards the sexual autonomy of persons with mental disabilities, especially those who are institutionalized.¹³⁴ The TJ implications of these attitudes should be crystal-clear to all of us. But

¹³¹ See *id.* at 145-57.

¹³² See Perlin & Lynch, *supra* note 26, at 300.

¹³³ *Id.*

¹³⁴ See, e.g., Heather Ellis Cucolo & Michael L. Perlin, *Preventing Sex-Offender Recidivism Through Therapeutic Jurisprudence Approaches and Specialized Community Integration*, 22 TEMP. POL. & CIVIL RTS. L. REV. 1, 41 (2012) (“TJ instructs us to step back from myths and prevailing attitudes and to carefully consider the prescriptions of therapeutic jurisprudence principles.”).

when MLP and AJL wrote a book-length treatment of all these issues, we were stunned to discover that a whole array of collateral issues—the weight of historical attitudes, the continuing power of religiosity in the creation of policies, how we view sexualization and desexualization, how we assess sexuality/sexual desire in older adults, attitudes of hospital staffs, medical professionals and patient advocates—had never been previously considered from a TJ perspective. We devoted much of our book to that reality, and we are hoping that we inspire others to do the same.

A decade ago, MLP said this:

In the past four decades, a sexual revolution changed the way we think about gender, sex roles, personal relationships, and sexual expression. The last thirty years have seen a legal civil-rights revolution affect the way that we think about persons with mental disabilities, both in institutional and community settings. The last twenty years have seen a revolution in the joining together of the international human-rights movement and the mental disability law movement. Perhaps we can now turn our attention to the relationship between these two revolutions.¹³⁵

The three of us still hold this sentiment as true today. Through advocacy, understanding and implementation of principles consistent with TJ, this area of law and policy can and must continue in the wake of so many other successes for the rights of individuals with mental disabilities.

VI. CONCLUSION

Before we conclude, some related thoughts. Over twenty years ago, writing about civil commitment law, right to treatment law and right to refuse treatment law, writing with others, MLP said, “[W]e believe that therapeutic jurisprudence analyses may be a strategy to redeem civil rights litigation in this area and to reinvigorate this body

¹³⁵ Perlin, *supra* note 47, at 511-12. On the relationship between the Convention on the Rights of Persons with Disabilities and sexualities, see Felipe Jaramillo Ruiz, *The Committee on the Rights of Persons with Disabilities and Its Take on Sexuality*, 25 REPRODUCTIVE HEALTH MATTERS 92 (2017).

of mental disability law.”¹³⁶ A few years later, this thought was expanded to argue that TJ “carries with it the potential to offer redemption for all mental disability law,”¹³⁷ and then, yet later, “to redeem the law for [all] persons who have been marginalized.”¹³⁸

There are no groups more marginalized than the persons about whom we are speaking here, and this marginalization consistently causes shame, humiliation and lack of dignity for these individuals,¹³⁹ and may in turn “diminish their investment in mainstream social values and increase their resentment toward society.”¹⁴⁰ Writing about the same topic, two of the co-authors have characterized the “suppression of all sexual desire and action [as] . . . a form of social torture”¹⁴¹ for individuals with disabilities who reside in institutionalized care.¹⁴² Our hope is that this article inspires lawyers, mental health professionals, expert witnesses, and policy makers to take seriously the ways that we deprive persons with mental disabilities of their right to sexual autonomy, presuming, in violation of the law, science and common sense, that they are incompetent to do so.¹⁴³ We believe that a turn to the principles of therapeutic jurisprudence is the best way that we can do this.

Return now to the last line of the verse from which we took our title—“You can’t win with a losing hand.” Since time immemorial, persons with disabilities *have* had a “losing hand” in this area of law and behavior. We hope, finally, that—back to the title—times and things truly have changed.

¹³⁶ Michael L. Perlin, Keri K. Gould & Deborah A. Dorfman, *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?*, 1 PSYCHOL. PUB. POL’Y & L. 80, 84 (1995).

¹³⁷ Perlin, *supra* note 1, at 544.

¹³⁸ Perlin & Douard, *supra* note 25, at 14.

¹³⁹ See generally Perlin & Weinstein, *supra* note 102.

¹⁴⁰ Jill S. Levenson, David A. D’Amora & Andrea L. Hern, *Megan’s Law and Its Impact on Community Re-Entry for Sex Offenders*, 25 BEHAV. SCI. & L. 587, 598 (2007).

¹⁴¹ Perlin & Lynch, *supra* note 32, at 262.

¹⁴² See Chin, *supra* note 18, at 381.

¹⁴³ In a recent piece, Professor Jasmine Harris refers to “the urgency of [this] conversation.” Harris, *supra* note 31, at 557.