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# Tolling For the Aching Ones Whose Wounds Cannot Be Nursed': The Marginalization of Racial Minorities and Women in Institutional Mental Disability Law

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# “Tolling For the Aching Ones Whose Wounds Cannot Be Nursed”: The Marginalization of Racial Minorities and Women in Institutional Mental Disability Law Policing Rape Complaints

Michael L. Perlin\* and Heather Ellis Cucolo\*\*

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## I. INTRODUCTION

Individuals with mental disabilities have traditionally been, and continue to be, subjected to rights violations and pervasive discrimination because of their mental disabilities, both domestically and internationally.<sup>1</sup> Seen as “the other,” individuals who are racial minorities, women, or both are marginalized to an even greater extent than other persons with mental disabilities in matters related to civil commitment and institutional treatment (especially involving the right to

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<sup>1</sup> See generally, e.g., Michael L. Perlin, *International Human Rights Law and Comparative Mental Disability Law: The Universal Factors*, 34 SYRACUSE J. INT’L L. & COM. 333 (2007) (examining mental disability laws and their interaction with international law).

refuse medication).<sup>2</sup> This extra marginalization also extends to questions of discharge planning, community mental health care, and forensic mental health.<sup>3</sup>

Expert testimony—testimony that is essential and necessary in all these cases—is often infected with bias that leads to skewed legal decision making. It is impossible to examine these questions critically without coming to grips with this reality.<sup>4</sup> Beginning with a consideration of disparities in the access and quality of mental health care among those women and racial and ethnic minorities with mental disabilities,<sup>5</sup> we need to focus on why the struggle to overcome rights violations is often greater for persons who are not of the dominant race or gender, and why it is essential that this area of law must be studied in the context of prevailing social policies as they relate to these topics.

There is no question that the struggle to overcome rights violations is often greater for persons with mental disabilities who are not of the dominant race or gender, and it is necessary to study this area of law in the context of prevailing social policies as they relate to these issues. Here we cannot avoid consideration of the significance of the interrelationships between social biases and “scientific” judgment, as reflected in expert testimony in cases related to all the sub-areas of mental disability law referred to above.<sup>6</sup> In this paper, we thus consider how race and gender relate to decisions made about the civil commitment process and the implications of these findings in multiple contexts including, but not limited to, state-sanctioned racial segregation, misdiagnosis and over-diagnosis, the pernicious use of racial and gender stereotypes, the deeper significance of disparities in access to health services, and cultural competency.<sup>7</sup> We also consider how race and gender relate to decisions made about institutional rights and the implications of these findings, considering issues related to restraint and seclusion, administration of antipsychotic

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<sup>2</sup> See generally, e.g., Carolyn S. Salisbury, *From Violence and Victimization to Voice and Validation: Incorporating Therapeutic Jurisprudence in a Children’s Law Clinic*, 17 ST. THOMAS L. REV. 623 (2005) (discussing the structural system’s further abuse of victims); Michael L. Perlin & Deborah A. Dorfman, “*The Sources of This Hidden Pain*”: *Why a Class in Race, Gender, Class and Mental Disability?*, in VULNERABLE POPULATIONS & TRANSFORMATIVE LAW TEACHING: A CRITICAL READER 313 (2011).

<sup>3</sup> This paper will be limited almost exclusively to matters of civil psychiatric institutionalization. The authors are currently researching the same issues in forensic contexts.

<sup>4</sup> See, e.g., Megan A. Yarnall, *Dueling Scientific Experts: Is Australia’s Hot Tub Method a Viable Solution for the American Judiciary?*, 88 OR. L. REV. 311, 320 (2009) (“Selection bias, conscious and unconscious bias, and professional self-interest pose significant threats to obtaining justice in cases requiring expert testimony.”).

<sup>5</sup> See generally, e.g., Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of all Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL’Y 45 (2002) (discussing racial disparities in the U.S. healthcare system).

<sup>6</sup> See Michael L. Perlin, *Pretexes and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 641 (1993) (quoting Peggy C. Davis, *Law, Science, and History: Reflections Upon the Best Interests of the Child*, 86 MICH. L. REV. 1096, 1107 (1988)).

<sup>7</sup> See *infra* text accompanying notes 22–101.

medication, dual diagnosis (along with substance abuse), and the extent to which information about side-effects of medication is shared with patients. Our findings are not a surprise: our most vulnerable populations—racial, cultural, and gender minorities—are consistently harmed by marginalization that targets persons with mental disabilities.

In an attempt to understand how the current state of affairs developed, we then consider the four key factors that permeate and poison all of mental disability law: sanism, pretextuality, heuristic reasoning, and (false) “ordinary common sense” (OCS).<sup>8</sup> One of the co-authors, Michael L. Perlin, wrote some eighteen years ago that “it is impossible to truly understand the jurisprudence in any of these areas without first understanding sanism and pretextuality.”<sup>9</sup> In another article—this about the relationship between mental disability law and international human rights law—Perlin referred to the “[p]ervasive corruption of sanism that permeates all of mental disability law, and . . . reflects a blinding pretextuality that contaminates legal practice in this area.”<sup>10</sup> We believe that these factors—along with heuristics and OCS—that “distort our abilities to consider information rationally”<sup>11</sup>—equally contaminate practice in these areas. We will contextualize all of this within the model of therapeutic jurisprudence—a vehicle through which we can assess the impact of case law and legislation on the subjects of such law.<sup>12</sup> Therapeutic jurisprudence recognizes “the law as a therapeutic agent” and that it can have “therapeutic or anti-therapeutic”

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<sup>8</sup> See generally MICHAEL L. PERLIN, *A PRESCRIPTION FOR DIGNITY: RETHINKING CRIMINAL JUSTICE AND MENTAL DISABILITY LAW* [hereinafter PERLIN, *A PRESCRIPTION FOR DIGNITY*] (discussing how these factors control the relationship between mental disability and the entire criminal justice system).

<sup>9</sup> Michael L. Perlin, “*Half-Wracked Prejudice Leaped Forth*”: *Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 4 (1999) [hereinafter Perlin, *Half-Wracked Prejudice*].

<sup>10</sup> Michael L. Perlin, “*A Change Is Gonna Come*”: *The Implications of the United Nations Convention on the Rights of Persons with Disabilities for the Domestic Practice of Constitutional Mental Disability Law*, 29 N. ILL. U. L. REV. 483, 487 (2009).

<sup>11</sup> Michael L. Perlin, “*Wisdom Is Thrown into Jail*”: *Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness*, 17 MICH. ST. U.J. MED. & L. 343, 365 n.127 (2013) (citing PERLIN, *A PRESCRIPTION FOR DIGNITY*, *supra* note 8, at 31).

<sup>12</sup> See generally Michael L. Perlin, “*Yonder Stands Your Orphan with His Gun*”: *The International Human Rights and Therapeutic Jurisprudence Implications of Juvenile Punishment Schemes*, 46 TEX. TECH. L. REV. 301 (2013) (discussing the incarceration of juvenile offenders with disability through the lens of therapeutic jurisprudence, specifically with regard to international human rights law); 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 (2014) [hereinafter Perlin & Lynch, *Sexless Patients*] (exploring the implications of therapeutic jurisprudence when discussing the competency of an individual with mental disabilities to engage in sexual activity); 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) [hereinafter Perlin & Lynch, *Wasteland*] (discussing how therapeutic jurisprudence lends perspective on the use of brain imaging as evidence in a criminal trial).

consequences.<sup>13</sup> “The ultimate aim of [therapeutic jurisprudence] is to determine whether legal rules, procedures, and the role of lawyers can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles.”<sup>14</sup> The law can and should use therapeutic jurisprudence as a mechanism “to expose pretextuality and strip bare the law’s sanist façade,” and thus “become a powerful tool that will serve as a means of attacking and uprooting the ‘we/they distinction’ that has traditionally plagued and stigmatized” persons with mental disability.<sup>15</sup> This must be kept in mind throughout the consideration of these issues, *especially* in the context of the “we/they distinction.” We will conclude by offering some modest suggestions as to how the current situation might best be remediated, using therapeutic jurisprudence as the basis of our proposed solutions.

Our title comes, in part, from the final verse of Bob Dylan’s masterpiece, *Chimes of Freedom*.<sup>16</sup>

Starry-eyed an’ laughing as I recall when we were caught  
 Trapped by no track of hours for they hanged suspended  
 As we listened one last time an’ we watched with one last look  
 Spellbound an’ swallowed ’til the tolling ended  
 Tolling for the aching ones whose wounds cannot be nursed  
 For the countless confused, accused, misused, strung-out ones  
 an’ worse

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<sup>13</sup> See, e.g., 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).

<sup>14</sup> See, e.g., Heather Ellis Cucolo & Michael L. Perlin, “Far from the Turbulent Space”: Considering the Adequacy of Counsel in the Representation of Individuals Accused of Being Sexually Violent Predators, 18 U. PA. J.L. & SOC. CHANGE 125, 165 (2015).

<sup>15</sup> See, e.g., Michael L. Perlin, “Things Have Changed”: Looking at Non-Institutional Mental Disability Law Through the Sanism Filter, 19 N.Y. L. SCH. L. REV. 165, 174 (2003) (internal quotations omitted).

<sup>16</sup> BOB DYLAN, *Chimes of Freedom*, on ANOTHER SIDE OF BOB DYLAN (Columbia Records 1964) (lyrics available at <http://bobdylan.com/songs/chimes-freedom/>).

One of the authors (MLP) has turned to this song multiple times before—in solo articles and in articles with other co-authors—as the inspiration for titles of other scholarly articles about institutional mental disability law. See, e.g., Michael L. Perlin, “Chimes of Freedom”: International Human Rights and Institutional Mental Disability Law, 21 N.Y.L. SCH. J. INT’L & COMP. L. 423 (2002); Michael L. Perlin, “Striking for the Guardians and Protectors of the Mind”: The Convention on the Rights of Persons with Mental Disabilities and the Future of Guardianship Law, 117 PENN ST. L. REV. 1159 (2013); 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) [hereinafter Perlin, *Misdemeanor Outlaw*]; Michael L. Perlin, “Through the Wild Cathedral Evening”: Barriers, Attitudes, Participatory Democracy, Professor TenBroek, and the Rights of Persons with Mental Disabilities, 13 TEX. J. ON C.L. & C.R. 413 (2008); Astrid Birgden & Michael L. Perlin, “Tolling for the Luckless, the Abandoned and Forsaken”: Therapeutic Jurisprudence and International Human Rights Law as Applied to Prisoners and Detainees by Forensic Psychologists, 13 LEGAL & CRIMINOLOGICAL PSYCHOL. 231 (2008); Michael L. Perlin & Alison Lynch, “Toiling in the Danger and in the Morals of Despair”: Risk, Security, Danger, the Constitution, and the Clinician’s Dilemma, – IND. J. L. & SOC. EQUALITY – (2016) (forthcoming).

An’ for every hung-up person in the whole wide universe  
An’ we gazed upon the chimes of freedom flashing<sup>17</sup>

Per the critic, Robert Sheldon, “*Chimes* is Dylan’s ‘most political song’ and an expression of ‘affinity’ for a ‘legion of the abused.’”<sup>18</sup> Dylanologist Oliver Trager concludes that, in *Chimes*, “Dylan dangles the notion that humanity has yet to grasp the promises of liberty floating just out of reach.”<sup>19</sup> We have chosen this lyric for this article because the individuals about whom we write—and whom we have each represented as practicing lawyers<sup>20</sup>—are “aching” from the discrimination they have faced. And, unfortunately, some have been so badly wounded that their “wounds cannot be nursed.”<sup>21</sup>

## II. RACE, GENDER, AND CIVIL COMMITMENT

The confluence of mental disability, gender, race, culture, and class often result in unique legal issues that have a far-reaching impact on virtually every aspect of the lives of those with mental disabilities. We do not believe that it is possible to understand any aspect of mental disability law (civil or criminal, constitutional or statutory, private or public) without understanding the intersection of race, gender, class, and culture with mental illness. To answer the questions before us, we must also consider carefully why the struggle to overcome rights violations is often greater for persons with mental disabilities

<sup>17</sup> See DYLAN, *supra* note 16.

<sup>18</sup> ROBERT SHELTON, NO DIRECTION HOME: THE LIFE AND MUSIC OF BOB DYLAN 157–58 (1997); see also, as quoted in Michael L. Perlin, *Tangled Up in Law: The Jurisprudence of Bob Dylan*, 38 FORDHAM. URB. L.J. 1395, 1418 (2011) (quoting ROBERT SHELTON, NO DIRECTION HOME: THE LIFE AND MUSIC OF BOB DYLAN 157–58 (1997)).

<sup>19</sup> OLIVER TRAGER, KEYS TO THE RAIN: THE DEFINITIVE BOB DYLAN ENCYCLOPEDIA 105 (2004).

<sup>20</sup> Before MLP became a law professor, he spent thirteen years as a lawyer representing persons with mental disabilities, including three years in which his focus was primarily on such individuals charged with a crime. In this role, during his time as a Deputy Public Defender in Mercer County (Trenton) NJ, he represented several hundred individuals at the “maximum security hospital for the criminally insane” in New Jersey habeas corpus hearings and was the forerunner to civil commitment hearings, both in individual cases and in the following class action: *Dixon v. Cahill*, No. L30977/y-71 P.W. (N.J. Super. Ct. Law Div. 1973), reprinted in 3 MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 19-8 (3d ed. 2016) [hereinafter PERLIN & CUCOLO]; see generally Perlin, *Misdemeanor Outlaw*, *supra* note 16, at 207 n.94 (discussing *Dixon v. Cahill*, No. L30977/y-71 P.W. (N.J. Super. Ct. Law Div. 1973)).

For the next eight years, he was the director of the N.J. Division of Mental Health Advocacy. In this role, he supervised the representation of tens of thousands of individuals facing civil commitment at psychiatric facilities in New Jersey. See generally Michael L. Perlin, *Mental Patient Advocacy by a Patient Advocate*, 54 PSYCHIATRIC Q. 169 (1982) (advocating for legal advocacy at commitment hearings); Michael L. Perlin, “*Infinity Goes up on Trial*”: *Sanism, Pretextuality, and the Representation of Defendants with Mental Disabilities*, 16 QUT L. REV. 106, 106–07 (2016).

HEC practiced sex offender civil commitment law full-time for seven years and continues to take cases on a referral basis. Currently, she is an adjunct professor at New York Law School and teaches a variety of courses in criminal and mental disability law including, *Race, Gender, Class, Culture and Mental Disability Law*.

<sup>21</sup> See DYLAN, *supra* note 16.

who are not of the dominant race, gender, class, or culture and why it is essential that this area of law must be contextualized in the prevailing social policies that relate to race, gender, class, and culture.

The outline of the law that governs involuntary civil commitment is relatively straightforward. To be eligible for such commitment a person must be mentally ill, and as a result of that mental illness be dangerous to self or others.<sup>22</sup> The burden of proof is on the prosecuting authority by a standard of clear and convincing evidence.<sup>23</sup> Virtually every aspect of the civil commitment process—questions dealing with the meaning of “dangerousness,” the application of the “least restrictive doctrine,” the meaning of “grave disability” in the commitment context, the role of counsel, the right to periodic review of a civil commitment, the relationship between civil commitment and the forensic process—has been considered extensively in the literature in the past 40 years.<sup>24</sup> But, there has been shockingly little attention paid to the questions we are addressing here.

We begin with a sobering reality. Virtually all state psychiatric facilities in the South were segregated until the mid-1960s,<sup>25</sup> a full decade after the Supreme Court’s decision in *Brown v. Board of Education*.<sup>26</sup> Conditions in hospitals were particularly abysmal for black patients,<sup>27</sup> and the continuation of these abysmal conditions was supported by expert testimony.<sup>28</sup> Mental health professionals opposed desegregation, testifying that “integration is not in the best interest of

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<sup>22</sup> O’Connor v. Donaldson, 422 U.S. 563, 575–76 (1975); see PERLIN & CUCOLO, *supra* note 20, § 3-5.1.2, at 3-102 to 3-112.

<sup>23</sup> Addington v. Texas, 441 U.S. 418, 433 (1979); see generally PERLIN & CUCOLO, *supra* note 20, § 4-2.3.2, at 4-93 to 4-98.

<sup>24</sup> See generally PERLIN & CUCOLO, *supra* note 20, Chapters 3, 4, 13, 14 (providing detailed summaries of case law concerning the civil commitment process and mental disabilities in the law).

<sup>25</sup> For an historic consideration, see LYNN GAMWELL & NANCY TOMES, *MADNESS IN AMERICA: CULTURAL AND MEDICAL PERCEPTIONS OF MENTAL ILLNESS BEFORE 1914* 56 (1995).

<sup>26</sup> *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954).

<sup>27</sup> See, e.g., *Marable v. Ala. Mental Health Bd.*, 297 F. Supp. 291, 294 n.7 (M.D. Ala. 1969) (“the Negro patients at Treatment Center Number Two do not have the benefit of special psychiatric projects available to the white patients at the main complex such as the project of intensive treatment for young male schizophrenics financed by the Public Health Service”); *id.* at 294 (“the medical services and facilities for care and rehabilitation of Negro patients are not only separate from but are typically inferior to those available to white patients”). On the history of racial inequality in health care in the United States, see, e.g., Vernellia R. Randall, *Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-Discrimination Law*, 10 DEPAUL J. HEALTH CARE L. 1, 8–16 (2006) (describing the history of racial inequality in healthcare laws). See generally David B. Smith, *The Racial Segregation of Hospital Care Revisited: Medicare Discharge Patterns and Their Implications*, 88 AM. J. PUB. HEALTH 461 (1998) (researching the long-term effects of desegregated health care services).

<sup>28</sup> *But see* W.E.B. DUBOIS, *DUSK OF DAWN* 309 (1940) (“Segregated hospitals are better than those where the Negro patients are neglected or relegated to the cellar.”). As one scholar has noted, “DuBois’ practical approach here does not minimize the crime of segregation, much as the work of the Red Cross in World War II did not legitimize Nazi atrocities.” Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 769 n.181 (2005).

the patients,”<sup>29</sup> and that “psychiatric care can best be delivered in a segregated setting.”<sup>30</sup>

There are strong vestiges of this sorry history today. We know, by way of example, that African-Americans are frequently misdiagnosed with psychotic disorders, especially schizophrenia; African-Americans in inpatient units are almost twice as likely to be diagnosed with schizophrenia as are whites.<sup>31</sup> Professor Susan Stefan stated bluntly, “[i]n the public mental health system, being Black is associated with diagnoses of schizophrenia and with lower socioeconomic status.”<sup>32</sup> Further, African-Americans are more likely to be overdiagnosed as having a psychotic disorder.<sup>33</sup> Research has shown that within the population of people admitted to state psychiatric hospitals, African-Americans are almost five times more likely to be diagnosed with schizophrenia as compared with Euro-Americans.<sup>34</sup>

It is vital to stress that this differential is *not* due to actual epidemiological differences; there is no difference between the rate of schizophrenia and psychotic disorders among African-Americans and white Americans when controlled for socio-economic class.<sup>35</sup> Within the vast array of race and diagnostic trend-related studies, it appears that a clinician’s own race does not alter this diagnostic trend, although “very few literature reviews have complied

<sup>29</sup> Susan Stefan, *Issues Relating to Women and Ethnic Minorities in Mental Health Treatment and Law*, in LAW, MENTAL HEALTH, AND MENTAL DISORDER 240, 246–47 (Bruce D. Sales & Daniel W. Shuman eds., 1996) [hereinafter Stefan, *Women and Ethnic Minorities*].

<sup>30</sup> Charles Prudhomme & David F. Musto, *Historical Perspectives on Mental Health and Racism in the United States*, in RACISM AND MENTAL HEALTH: ESSAYS 25 (Charles Vert Willie, Bernard M. Kramer & Bertram S. Brown eds., 1973). See also Tony B. Lowe, *Nineteenth Century Review of Mental Health Care for African Americans: A Legacy of Service and Policy Barriers*, 33 J. SOC. & SOC. WELFARE 29, 39 (2006). For the largely-unknown “back story,” see David Barton Smith, *Healthcare’s Hidden Civil Rights Legacy*, 48 ST. LOUIS U. L.J. 37 (2003). These attitudes persist today. See, e.g., Kellee White, Jennifer S. Haas, & David R. Williams, *Elucidating the Role of Place in Health Care Disparities: The Example of Racial/Ethnic Residential Segregation*, 47 HEALTH SERVS. RES. 1278 (2012).

<sup>31</sup> Lonnie R. Snowden & Freda K. Cheung, *Use of Inpatient Mental Health Services by Members of Ethnic Minority Groups*, 45 AM. PSYCHOLOGIST 347, 349 (1990). By way of example, 79% of blacks in a public sector hospital were diagnosed with schizophrenia, versus 43% of whites. Stephen M. Strakowski, Richard C. Shelton & Meredith L. Kolbrener, *The Effects of Race and Comorbidity on Clinical Diagnosis in Patients with Psychosis*, 54 J. CLINICAL PSYCHIATRY 96, 97 (1993); see generally Stephen M. Strakowski et al., *The Effects of Race on Diagnosis and Disposition from a Psychiatric Emergency Service*, 56 J. CLINICAL PSYCHIATRY 101 (1995).

<sup>32</sup> Susan Stefan, *Race, Competence Testing, and Disability Law: A Review of the MacArthur Competence Research*, 2 PSYCHOL. PUB. POL’Y & L. 31, 42 (1996).

<sup>33</sup> See generally Michelle DeCoux Hampton, *The Role of Treatment Setting and High Acuity in the Overdiagnosis of Schizophrenia in African Americans*, 21 ARCHIVES PSYCHIATRIC NURSING 327 (2007).

<sup>34</sup> Arnold Barnes, *Race, Schizophrenia, and Admission to State Psychiatric Hospitals*, 31 ADMIN. & POL’Y MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 241, 250 (2004).

<sup>35</sup> LEE N. ROBINS & DARREL A. REGIER, PSYCHIATRIC DISORDERS IN AMERICA: THE EPIDEMIOLOGIC CATCHMENT AREA SURVEY 47 (1991).



information for future research or practice purposes.”<sup>36</sup> Thus, one answer in combating this overdiagnosis trend is to value “diversity, objectivity, and the ethical principles of beneficence and nonmaleficence” by incorporating cultural sensitivity into the provision of services for mental health care.<sup>37</sup>

Furthering the application of cultural sensitivity becomes even more important with the multifaceted factors of class and economic status. These findings cannot be meaningfully extricated from findings that deal with class. By way of example, research shows that the over-diagnosis of schizophrenia among blacks virtually disappears in very high poverty areas, where blacks and whites are diagnosed with schizophrenia at almost the same rate.<sup>38</sup> The differential is at its greatest in areas where people are relatively better off: in lower poverty areas, 39% of black public mental health service users are diagnosed with schizophrenia versus 29% of white public mental health service users.<sup>39</sup> Studies have also shown Asians and Asian-Americans to be greatly overrepresented in diagnoses of schizophrenia, regardless of poverty level.<sup>40</sup>

The issues here are confounded by parallel issues involving *access* to health care services. Black individuals have significantly less access to mental health services than do white individuals. One study looked at the provision of mental health services to children in the school system and found that white youth were *twice* as likely to access such school provided services, as were black youth with the same diagnoses.<sup>41</sup> Barriers to access of services were commonly reported by both ethnic groups and an unfortunate trend towards the greater the need, the more numerous the barriers, was cited.<sup>42</sup> In a similar study, researchers found the same ratio in adult populations.<sup>43</sup>

Beyond the question of access to health care services, it is also vital to assess the quality of treatment provided to these populations. An overdiagnosis of schizophrenia is especially detrimental because it increases the potential for

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<sup>36</sup> Robert C. Schwartz & David M Blankenship, *Racial Disparities in Psychotic Disorder Diagnosis: A Review of Empirical Literature*, 4 *WORLD J. PSYCHIATRY* 133, 135 (2014).

<sup>37</sup> *Id.* See also Richard H. Dana, *Mental Health Services for African Americans: A Cultural/Racial Perspective*, 8 *CULTURAL DIVERSITY & ETHNIC MINORITY PSYCHOL.* 3 (2002) (discussing how cultural information can inform service delivery and improve services to African Americans).

<sup>38</sup> See generally Stephen M. Strakowski et al., *Racial Differences in the Diagnosis of Psychosis*, 21 *SCHIZOPHRENIA RES.* 117 (1996).

<sup>39</sup> Julian Chun-Chung Chow, Kim Jaffee & Lonnie Snowden, *Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas*, 93 *AM. J. PUB. HEALTH* 792, 794 (2003).

<sup>40</sup> *Id.*

<sup>41</sup> Adrian Angold et al., *Psychiatric Disorder, Impairment, and Service Use in Rural African American and White Youth*, 59 *ARCHIVES GEN. PSYCHIATRY* 893, 897 (2002).

<sup>42</sup> *Id.* at 899.

<sup>43</sup> Kenneth Wells et al., *Ethnic Disparities in Unmet Need for Alcoholism, Drug Abuse, and Mental Health Care*, 158 *AM. J. PSYCHIATRY* 2027, 2030 (2001).

treatment with the wrong medications.<sup>44</sup> Studies have reported that African-Americans were less likely than whites to receive guideline-adherent treatment when suffering from anxiety disorders and depression.<sup>45</sup> Additionally, African-Americans were relatively unlikely to receive guideline-based care.<sup>46</sup> We also now know that physicians are more verbally dominant and engage in less patient-centered communication with African-American patients than with white patients.<sup>47</sup> Incorrect treatment and misdiagnosis has a substantial effect on a person’s ability to function well within a community.

In the community context, behavior by African-Americans is more often interpreted as “dangerous” than *identical behavior* by whites<sup>48</sup> and African-Americans are more often diagnosed with a conduct disorder<sup>49</sup> than whites.<sup>50</sup> The diagnosis of a conduct disorder can signify to civil commitment fact-finders that the individual has a greater propensity for dangerousness.<sup>51</sup>

This concept of dangerousness is furthered distorted through how individuals come into contact with the mental health system. We can analyze this within the context of emergency room (ER) usage and at what point police

<sup>44</sup> Arnold Barnes, *Race and Hospital Diagnoses of Schizophrenia and Mood Disorders*, 53 SOC. WORK 77, 80–82 (2008).

<sup>45</sup> Alexander S. Young et al., *The Quality of Care for Depressive and Anxiety Disorders in the United States*, 58 ARCHIVES GEN. PSYCHIATRY 55 (2001).

<sup>46</sup> Philip S. Wang et al., *Recent Care of Common Mental Disorders in the United States*, 15 J. GEN. INTERNAL MED. 284, 290 (2001).

<sup>47</sup> Rachel L. Johnson et al., *Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits*, 94 AM. J. OF PUB. HEALTH 2084, 2084 (2004).

<sup>48</sup> See, e.g., Sandra Graham & Brian S. Lowery, *Priming Unconscious Racial Stereotypes About Adolescent Offenders*, 28 LAW. & HUMAN BEHAVIOR 483, 499–501 (2004); James Hicks, *Ethnicity, Race, and Forensic Psychiatry: Are We Color-Blind?*, 32 J. AM. ACAD. PSYCHIATRY LAW 21, 23 (2004).

In a very different context, the United States Supreme Court has just reversed a death penalty sentence in a case in which a defendant’s own trial lawyer called an expert witness who testified the man was more apt to be dangerous in the future because he is black. See *Buck v. Davis*, 137 U.S. 759 (2017).

<sup>49</sup> A conduct disorder is a common childhood psychiatric problem that increases in incidence in adolescence. The primary diagnostic features of conduct disorder include aggression, theft, vandalism, violations of rules, and/or lying. H. Russel Searight et al., *Conduct Disorder: Diagnosis and Treatment in Primary Care*, 63 AM. FAM. PHYSICIAN 1579 (2001).

<sup>50</sup> Melissa P. Delbello et al., *Effects of Race on Psychiatric Diagnosis of Hospitalized Adolescents: A Retrospective Chart Review*, 11 J. CHILD & ADOLESCENT PSYCHOPHARMACOLOGY 95 (2001).

<sup>51</sup> See, e.g., Maribel Morey, *The Civil Commitment of State-Dependent Minors: Resonating Discourses that Leave Her Heterosexuality and His Homosexuality Vulnerable to Scrutiny*, 81 N.Y.U. L. REV. 2129, 2136 (2006). By comparison, a recent study of institutionalized juveniles revealed that 32% of committed males had a disruptive diagnosis (e.g., conduct disorder or attention deficit hyperactivity disorder). See David R. Katner, *The Mental Health Paradigm and the MacArthur Study: Emerging Issues Challenging the Competence of Juveniles in Delinquency Systems*, 32 AM. J.L. & MED. 503, 509 (2006).

intervention becomes necessary.<sup>52</sup> Firstly, individuals who seek psychiatric treatment in the ER are more likely to be involuntarily committed, and we know that—for a variety of issues, mostly having to do with poverty access to health care and lack of medical insurance<sup>53</sup>—African-Americans are at least twice as likely to go to the ER than whites.<sup>54</sup> Secondly, because episodes of psychiatric crisis violate norms of acceptable behavior, it is often members of the community who decide whether to contact mental health authorities or police, thereby initiating emergency room visits.<sup>55</sup> African-Americans are more likely to be brought to the ER by police than whites and those who are brought to the ER by police are even more likely to be involuntarily committed.<sup>56</sup>

Consider these findings in the context of other findings that relate to one of the statutory predicates for civil commitment—a finding of dangerousness<sup>57</sup>—and one of the “real life” predicates for civil commitment—an increase in mental health symptoms due to non-compliance with medication.<sup>58</sup> Although one study found insignificant ethnic disparities in the use versus non-use of antipsychotics,<sup>59</sup> it observed that African-American patients and other ethnic minorities were consistently less likely than non-ethnic minorities to be treated with newer antipsychotics.<sup>60</sup> Consider then, the further likelihood that African-American patients would abandon prescribed medications—especially in the community—given the severity of the side effects of older generation

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<sup>52</sup> See generally Harriet L. Wolfe & Chris Hatcher, *The Role of Violence in Decisions About Hospitalization from the Psychiatric Emergency Room*, 149 AM. J. PSYCHIATRY 207 (1992) (noting that clinical variables such as diagnosis and overall severity of psychiatric impairment were more important than violent behavior in predicting hospitalization decisions). Evidence reveals that African-Americans typically receive poorer emergency room treatment than whites. See, e.g., David R. Williams & Pamela Braboy Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325 (2005).

<sup>53</sup> See, e.g., SUSAN STEFAN, EMERGENCY DEPARTMENT TREATMENT OF THE PSYCHIATRIC PATIENT: POLICY ISSUES AND LEGAL REQUIREMENTS 20–22 (2006).

<sup>54</sup> *Id.* at 25 (citing Linda McCaig & Catharine W. Burt, *National Hospital Ambulatory Medical Care Survey, 2002 Emergency Department Summary* (2004), n.72).

<sup>55</sup> See generally Lonnie R. Snowden, *Barriers to Effective Mental Health Services for African Americans*, 3 MENTAL HEALTH SERVS. RES. 181 (2001).

<sup>56</sup> See STEFAN, *supra* note at 53 (citing Lawrence W. Reinish & J. Richard Ciccone, *Involuntary Hospitalization and Police Referrals to a Psychiatric Emergency Department*, 23 AM. ACAD. PSYCHIATRY & L. 289 (1995), n.114).

<sup>57</sup> See *O'Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975).

<sup>58</sup> See generally Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL., PUB. POL'Y & L. 183 (2003). See, e.g., *A.E. v. State*, 83 So.3d 1000 (Fla. Dist. Ct. App. 2012).

<sup>59</sup> Joseph H. Puyat et al., *Racial and Ethnic Disparities in the Use of Antipsychotic Medication: A Systematic Review and Meta-Analysis*, 48 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 1861, 1869 (2013).

<sup>60</sup> *Id.*

antipsychotics.<sup>61</sup> A recurrence of an increase in mental health civil commitments might very well be fueled by both the mischaracterization of African-American behavior as more dangerous and by the likelihood that this cohort of individuals might be disproportionately noncompliant with antipsychotics, a noncompliance that is due to the significant detrimental side effects in older generation drugs.<sup>62</sup>

In summary, there are multiple reasons why African-Americans are more likely to be committed to psychiatric hospitals than whites, although they are no more likely to have psychotic disorders or schizophrenia than whites when controlled for socio-economic class:

- Misdiagnosis and overdiagnosis of schizophrenia and psychotic disorders,
- Misinterpreting non-dangerous behavior as dangerous,
- Later onset of treatment and quality of treatment, and
- The commitment process more likely to be triggered by police or ER admission.<sup>63</sup>

The question of why differences occur in rates of civil commitment and in rates of incarceration associated with mental illness remains to be answered.<sup>64</sup> Race is now accepted as socially constructed, and contemporary discourse is also beginning to consider the ways in which mental status is socially constructed.<sup>65</sup> One hypothesis is that mentally ill individuals who are also members of minority groups are more visible and thus deviant behavior is more readily recognized.<sup>66</sup> This hypothesis, known as the “visibility hypothesis,” indicates that mentally ill individuals are more likely to be challenged under these circumstances and efforts of social control are aimed “more at minority individuals, especially male African-Americans, who exhibit symptoms of mental illness.”<sup>67</sup>

<sup>61</sup> See *United States v. Algere*, 396 F. Supp. 2d 734, 743 (E.D. La. 2005). See, e.g., Rachel A. Scherer, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 381–82 (2007).

<sup>62</sup> In the context of elderly patients, there are clear associations between medication adherence and race. See Rajesh Balkrishnan, *Predictors of Medication Adherence in the Elderly*, 20 CLINICAL THERAPEUTICS 764 (1998) (drawing a conclusion from study of 35-year range of scholarly articles concerning predictors of medication compliance in the elderly).

<sup>63</sup> See *supra* text accompanying notes 52–56.

<sup>64</sup> Lonnie R. Snowden, *Bias in Mental Health Assessment and Intervention: Theory and Evidence*, 93 AM. J. PUB. HEALTH 239, 241 (2003).

<sup>65</sup> Camille A. Nelson, *Racializing Disability, Disabling Race: Policing Race and Mental Status*, 15 BERKELEY J. CRIM. L. 1, 16 (2010).

<sup>66</sup> Ann F. Garland et al., *Minority Populations in the Child Welfare System: The Visibility Hypothesis Reexamined*, 68 AM J. ORTHOPSYCHIATRY 142, 143 (1998).

<sup>67</sup> Snowden, *supra* note 64, at 241.

Consider next the role of gender.<sup>68</sup> Historically, women were more likely to be committed to psychiatric institutions for reasons having nothing to do with statutory criteria and startlingly, for many years, consent to sterilization was necessary for release of female patients.<sup>69</sup> Commitment to psychiatric institutions beyond the legal statutory criteria included being pregnant out of wedlock, disobeying their husbands, being politically active, and for making accusations of rape.<sup>70</sup> Two anecdotal examples from the practice career of one of the co-authors (MLP) are illustrative:

- The “back stories” of the only contested commitments prior to the creation of the Division of Mental Health Advocacy.<sup>71</sup>
- The “three Ms”<sup>72</sup> ward discovered during pretrial discovery in the *Matter of S.L.* case in New Jersey.<sup>73</sup>

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<sup>68</sup> See generally PERLIN & CUCOLO, *supra* note 20, Chapter 10 (discussing the rights of individuals with mental disabilities in various community settings).

<sup>69</sup> This practice continued through, at least, the 1960s. See, e.g., *In re Cavitt*, 159 N.W.2d 566, 567 (Neb. 1968) (finding constitutional a statute which allowed sterilization of female patients); Michelle Oberman, *Thirteen Ways of Looking at Buck v. Bell: Thoughts Occasioned by Paul Lombardo's Three Generations, No Imbeciles*, 59 J. LEGAL EDUC. 357 (2010) (describing the tradition of sterilization of committed female patients through the story of *Buck v. Bell*).

<sup>70</sup> Susan Stefan, *The Protection Racket: Rape Trauma Syndrome, Psychiatric Labelling, and Law*, 88 NW. U. L. REV. 1271, 1312 (1994); Stefan, *Women and Ethnic Minorities*, *supra* note 29.

<sup>71</sup> When MLP became director of the N.J. Division of Mental Health Advocacy in 1974, he asked the Mercer County (Trenton) Assignment Judge, “Who did these cases in the past?” The judge said, “No one, Michael. You’ll be the first one.” Then he paused, and went on. “Well, actually, no. I can recall two cases, but”—here he laughed, mordantly, and continued — “they were basically the same fact pattern. A doctor wanted to marry his receptionist but didn’t want to be saddled with alimony, so he got a friend to certify that his wife was ‘crazy.’ In each case, the wife had squirreled away some money, so she was able to retain counsel. But, in the 16 years that I have been a judge here, those were the only two.” See also *Fair Oaks Hosp. v. Pocrass*, 628 A.2d 829, 831 (N.J. Law Div. 1993) (describing a case where, after a husband sought consultation from his attorney about marital problems, he took his wife to a psychiatrist who committed the woman against her will).

<sup>72</sup> The “three Ms” refer to: (1) miscegenation (commitment followed parental disapproval of their daughter dating someone of another race); (2) menstruation (heavy menstrual periods were seen as indicative of mental illness); and (3) masturbation (female masturbation also seen as indicative of mental illness). See C.B. Davenport, *The Effects of Race Intermingling*, 56 PROC. AM. PHIL. SOC’Y 364, 367 (1917) (arguing that miscegenation can lead to a diminution of “mental vigor”); Megan Stuart Mills, *Some Comments on Stereotypes of the Anglo-Indians, Part 1*, 1 INT’L J. ANGLO-INDIAN STUD. 31, 37 (1996) (“Racialist theory of course, contributed its concepts of ‘miscegenation’, including mental and moral degeneracy as genetic results of hybridisation”); THOMAS LAQUEUR, *MAKING SEX: BODY AND GENDER FROM THE GREEKS TO FREUD* 222 (1990) (noting that nineteenth-century feminists disputed the assertion that, “because of the supposed ovarian drain” during menstruation, women’s “mental and physical energy . . . was . . . in short supply”); Thomas Szasz, *Psychiatry and the Control of Dangerousness: On the Apotropaic Function of the Term “Mental Illness”*, 39 J. SOC. WORK EDUC. 375, 378 (2003) (on how masturbation was seen traditionally as a sign of mental illness); MICHAEL L. PERLIN & ALISON J. LYNCH, *SEXUALITY, DISABILITY AND THE LAW: BEYOND THE LAST FRONTIER?* 100–03 (2016); E.H. Hare, *Masturbatory Insanity: The History of an Idea*, 108 BRIT. J. PSYCHIATRY 2 (1962) (delving in to the history of the hypothesis that masturbation amounts to a mental disorder).

In addition, women are more often victims of physical and sexual abuse.<sup>74</sup> In the late 1990’s, an international report by the World Health Organization (WHO) indicated that “women are more likely than men to be adversely affected by: specific mental disorders, the most common being depression; the effects of domestic violence; the effects of sexual violence; [and] escalating rates of substance use.”<sup>75</sup> Additional and increased quality of treatment was recommended because “the multiple roles that they fulfill in society render them at greater risk of experiencing mental disorders than others in the community.”<sup>76</sup> There is ample evidence that women have been diagnosed as “mentally ill” for violating gender stereotypes: by showing anger, aggression, promiscuity, or being a lesbian.<sup>77</sup> Violent women, for example, are more likely to be evaluated for psychiatric conditions, while African-American men are less likely to receive psychiatric evaluation.<sup>78</sup> In *The Manufacture of Madness*, Thomas Szasz analogized the historic practice of the persecution of witches with the twentieth century practice of psychiatry and the persecution of persons labeled mentally ill.<sup>79</sup>

Gender stereotypes also infect determinations of dangerousness. Stereotypes dictate that women are weaker, more passive, less dangerous, less responsible for their crimes, and more amenable to treatment than men.<sup>80</sup>

<sup>73</sup> See *In re S.L.*, 462 A. 2d 1252, 1258–59 (N.J. 1983) (describing how a ward of female patients had been “discovered” at Greystone Psychiatric Hospital in New Jersey, and had, according to ward staff, been committed (decades previously) for one of the “3 Ms.”). Applicants for release in the S.L. case had been institutionalized for as long as 52 years prior to the court’s decision. *Id.*

<sup>74</sup> Shannon Catalano et al., *Female Victims of Violence*, BUREAU OF JUSTICE STATISTICS 1–5 (Sept. 2009) (describing how women are disproportionately victims of violence—particularly intimate partner violence, and sexual assault); See also Erica L. Weiss et al., *Childhood Sexual Abuse as a Risk Factor for Depression in Women: Psychosocial and Neurobiological Correlates*, 156 AM. J. PSYCHIATRY 816, 816 (1999) (noting that sexual abuse is a risk factor for depression in women).

<sup>75</sup> Michelle K. Gomei, *A Focus on Women*, WORLD HEALTH ORG. 2 (1997), [http://apps.who.int/iris/bitstream/10665/67225/1/WHO\\_MSA\\_NAM\\_97.4.pdf](http://apps.who.int/iris/bitstream/10665/67225/1/WHO_MSA_NAM_97.4.pdf) [hereinafter WORLD HEALTH ORG.]

<sup>76</sup> *Id.* at vi.

<sup>77</sup> See Deborah A. Denno, *Gender, Crime, and the Criminal Law Defenses*, 85 J. CRIM. L. & CRIMINOLOGY 80, 90 n.55, (1994) (citing MABEL RUTH FERNALD ET AL., A STUDY OF WOMEN DELINQUENTS IN NEW YORK STATE 525–26 (1986) and CLYDE B. VEDDER & DORA B. SOMERVILLE, THE DELINQUENT GIRL 49–50, 153–54 (1970)) (discussing the purported relationship between female crime and an inability to adjust to “feminine roles”). See also Gabriel Arkles, *Gun Control, Mental Illness, and Black Trans and Lesbian Survival*, 42 SW. L. REV. 855, 877 (2013).

<sup>78</sup> Melissa Thompson, *Gender, Race, and Mental Illness in the Criminal Justice System*, NAT’L INST. OF CORR. (Mar. 2, 2011, 1:29 PM), <http://community.nicic.gov/blogs/mentalhealth/archive/2011/03/02/gender-race-and-mental-illness-in-the-criminal-justice-system.aspx>; Melissa Thompson, *Race, Gender, and the Social Construction of Mental Illness in the Criminal Justice System*, 53 SOC. PERSP. 99, 105–106 (2010).

<sup>79</sup> THOMAS S. SZASZ, THE MANUFACTURE OF MADNESS xxiii (1970).

<sup>80</sup> Ilene H. Nagel & Barry L. Johnson, *The Role of Gender in a Structured Sentencing System: Equal Treatment, Policy Choices, and the Sentencing of Female Offenders Under the United States Sentencing Guidelines*, 85 J. CRIM. L. & CRIMINOLOGY 181, 188 (1994).

Women who are subject to commitment are more often perceived as dangerous to *themselves* than dangerous to *others*, so, paradoxically, in terms of commitment, they *benefit* from perceptions that they are less dangerous to others, at least in cases involving evaluations by female clinicians.<sup>81</sup> On the other hand, virtually any display of self-injurious behavior is likely to be perceived as a precursor of imminent suicidality.<sup>82</sup>

Diagnoses that are distinctly attributed to either men or women also have an impact on care and treatment and potential confinement. Specific mental illnesses that are perceived as gender-specific influence and reveal gender-based stereotypes. “‘Gender-specific mental illness’ refers to mental health problems that only affect women or men because of biological and neurological differences between the sexes.”<sup>83</sup> An example of such illness is post-traumatic stress disorder (PTSD). Stereotypes of PTSD identify the illness as one that primarily affects males who have experienced some form of combat within military service.<sup>84</sup> Although PTSD has, in fact, been recognized as a gender-prevalent mental illness—one that is more commonly experienced by one gender over another—the prevalence exists within the female population even though it is perceived as a male-dominant illness.<sup>85</sup> Resulting effects from domestic violence, sexual assault, and other forms of physical abuse are manifested through symptoms of PTSD that include “insomnia, flashbacks, phobias, panic attacks, anxiety, depression, dissociation, a numbed toughness, amnesia, shame, guilt, self-loathing, self-mutilation, and social withdrawal.”<sup>86</sup> As a result of societal expectations and norms, women suffering from PTSD fall under the radar,<sup>87</sup> when in fact “chronic, hidden family/domestic violence is actually more, not less, traumatic than sudden violence at the hands of a stranger, or of an enemy during war.”<sup>88</sup> In 2004, “researchers from the Veterans

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<sup>81</sup> See, e.g., Eric B. Elbogen et al., *Gender and Perceptions of Dangerousness in Civil Psychiatric Patients*, 6 LEGAL & CRIMINOLOGICAL PSYCHOL. 215 (2001).

<sup>82</sup> See, e.g., Karen Guan, Kathryn R. Fox & Mitchell J. Prinstein, *Nonsuicidal Self-Injury as a Time-Invariant Predictor of Adolescent Suicide Ideation and Attempts in a Diverse Community Sample*, 80 J. CONSULTING & CLINICAL PSYCHOL. 842 (2012); David Brent, *Nonsuicidal Self-Injury as a Predictor of Suicidal Behavior in Depressed Adolescents*, 168 AM. J. PSYCHIATRY 452 (2011).

<sup>83</sup> Leslie Prentice, “*At Risk for Incarceration*”: *Women in Poverty, Post-Traumatic Stress Disorder, and Medicaid*, 32 WOMEN’S RTS. L. REP. 81, 89 (2010).

<sup>84</sup> *Id.* at 90.

<sup>85</sup> *Id.* at 89–90.

<sup>86</sup> Phyllis Chesler, *Confessions of an Expert Witness*, 19 WOMEN’S RTS. L. REP. 161, 163 (1998).

<sup>87</sup> Bonita M. Veysey, *Specific Needs of Women Diagnosed with Mental Illnesses in U.S. Jails*, in WOMEN’S MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE 368, 371 (Bruce Lubotsky Levin et al. eds., 1998) (noting that “22.3 percent of women in jail were diagnosed with Post-Traumatic Stress Disorder”).

<sup>88</sup> Chesler, *supra* note 86; see Michael L. Perlin, “*I Expected It to Happen/I Knew He’d Lost Control*”: *The Impact of PTSD on Criminal Sentencing After the Promulgation of DSM-5*, 2015 UTAH L. REV. 881, 917–18 (2015) (discussing the significance of the American Psychiatric Association’s expansion of the definition of PTSD in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)).

Administration reported that women with PTSD have more medical conditions and worse physical health than non-traumatized women, even those with depression.”<sup>89</sup>

This leads to a related question: do women who alleged they had been raped and sexually abused have a right to treatment specific to their conditions as women whose psychiatric disabilities were *caused by* their rape and trauma? In *Caroline C. v. Johnson*, a consent judgment committed state officials to detailed provisions mandating “the development and implementation of appropriate mental health treatment for class members” who made these allegations.<sup>90</sup> The hope is that through advancements in neuroscience, evidence showing brain function disparities and abnormalities will be more readily acknowledged within the legal and medical communities to better assess, understand, and treat the pervasiveness of PTSD in women.<sup>91</sup>

It is also important to weigh these issues in the context of culture.<sup>92</sup> Lawyers have thus suggested that cultural information and cultural evidence should be brought to the civil commitment hearing, and should be integrated into psychiatrists’ assessments to insure authentic client-centered approaches to psychiatric diagnosis and treatment.<sup>93</sup> In this context, consider the range of culturally-relevant issues that may have an impact on the disposition of a civil

<sup>89</sup> *Not Getting Over It: Post-Traumatic Stress Disorder*, HARV. WOMEN’S HEALTH WATCH 1, 5 (Mar. 2005).

<sup>90</sup> *Caroline C. v. Johnson*, 174 F.R.D. 452 (D. Neb. 1996) (certifying class action); *Caroline C. v. Johnson*, No. 4:CV95–22 (D. Neb. Oct. 29, 1998) (entering consent judgment); see also Winiviere Sy, *The Right of Institutionalized Disabled Patients to Engage in Consensual Sexual Activity*, 23 WHITTIER L. REV. 545, 546–47 (2001) (discussing policies regarding consensual sexual activities at two California hospitals). See generally PERLIN & LYNCH, *supra* note 72.

<sup>91</sup> Chesler, *supra* note 86; see also, e.g., Vasiliki Michopoulos, Seth Davin Norrholm & Tanja Jovanovic, *Diagnostic Biomarkers for Posttraumatic Stress Disorder (PTSD): Promising Horizons from Translational Neuroscience Research*, 78 BIOLOGICAL PSYCHIATRY 344 (2015).

<sup>92</sup> See, e.g., Michael L. Perlin & Valerie McClain, “Where Souls Are Forgotten”: *Cultural Competencies, Forensic Evaluations, and International Human Rights*, 15 PSYCHOL. PUB. POL’Y & L. 257 (2009) (discussing the relevance of cultural competency to the forensic mental health process); see also Sierra Villaran, *Narratives of Cultural Collision and Racial Oppression: How to Reconcile Theories of a Cultural Defense and Rotten Social Background Defense to Best Serve Criminal Defendants*, 88 S. CAL. L. REV. 1239, 1240–41 (2015) (“Courtrooms are sites for the production of cultural meaning, as scenes from the justice system play out and actors both within and outside courtrooms are affected.”).

<sup>93</sup> See, 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, 35 (2016) (recommending further that “cultural and other intersectional factors [be probed] during the hearing processes.”). On how culture can shape the entire *risk assessment process* “from instrument construction and validation, to risk marker sensitivity, symptom articulation, and client-clinician interaction,” see Stephanie M. Shepherd & Roberto Lewis-Fernandez, *Forensic Risk Assessment and Cultural Diversity: Contemporary Challenges and Future Directions*, 22 PSYCHOL. PUB. POL’Y & L. 427, 427 (2016) (discussing implications of the decision of *Ewert v. Canada*, [2015] FC 1093 (Fed. Ct.), allowing an action against Correctional Services of Canada for an unjustified violation of the plaintiff’s claims of right to life, liberty, and security of the person under the Canadian Charter of Rights and Freedoms.).



commitment hearing. These include facial expression; frankness; suspiciousness; anger; speech volume; clarity; and coherence.<sup>94</sup>

Above and beyond these issues, it is further necessary to consider the reality that ethnic minorities report and demonstrate significantly lower levels of interracial/ethnic trust than do non-Hispanic whites.<sup>95</sup> Consider this in the context of the brief doctor–patient interviews that regularly precede civil commitment.<sup>96</sup>

We know that clinicians are frequently unaware of patient cultural views around preferred illness labels, perceived illness causes, hesitancy to take medications, side effects, and preferences for treatments.<sup>97</sup> By way of example, we minimize the “importance of cultural mistrust as a psychological construct in the lives of African Americans.”<sup>98</sup> Ethnic minorities who are “unconvinced that clinicians understand their cultural views have seven times higher odds than Whites of ending treatment.”<sup>99</sup>

In this context, it is vital to also consider the role of the expert witness. The cultural differences that complicate clinical interactions are likely to play a role in forensic evaluations as well. “As some researchers have pointed out, transference and countertransference may be accentuated in forensic evaluations of subjects from an ethnic minority group.”<sup>100</sup> This important issue is rarely, if ever, considered by courts.<sup>101</sup>

### III. A CONSIDERATION OF INSTITUTIONAL ISSUES

It is necessary to also consider the impact of race and gender in matters related to institutionalization once a trial court orders commitment. We believe it is impossible to uncouple the data and the findings about these issues from what we have previously discussed with regards to the commitment process.

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<sup>94</sup> Josepha Campinha-Bacote, *Cultural Considerations in Forensic Psychiatry: The Issue of Forced Medication* 50 INT’L J. L. & PSYCHIATRY 1, 3 (forthcoming 2017).

<sup>95</sup> Javier Boyas & Tanya Sharpe, *Racial and Ethnic Determinant of Interracial and Ethnic Trust*, 20 J. HUM. BEHAV. SOC. ENV’T. 618, 618 (2010); see also Chanita Hughes Halbert et al., *Racial Differences in Trust in Health Care Providers*, 166 ARCHIVES INTERNAL MED. 896, 898 (2006).

<sup>96</sup> JAMES A. HOLSTEIN, COURT-ORDERED INSANITY: INTERPRETIVE PRACTICE AND INVOLUNTARY COMMITMENT 32 (1993).

<sup>97</sup> See generally Campinha-Bacote, *supra* note 94 (discussing cultural views as implicated in medical treatment).

<sup>98</sup> See Arthur J. Whaley, *Cultural Mistrust: An Important Psychological Construct for Diagnosis and Treatment of African Americans*, 32 PROF’L PSYCHOL. RES. & PRAC. 555, 555 (2001).

<sup>99</sup> Neil Aggarwal et al., *The Development of the DSM-5 Cultural Formulation Interview-Fidelity Instrument (CFI-FI): A Pilot Study*, 25 J. HEALTH CARE POOR & UNDERSERVED 1397, 1398 (2014).

<sup>100</sup> Hicks, *supra* note 48, at 28 (citing Silva JA, Leong GB, Weinstock R., *Cultural & Ethnic Minorities*, in PRINCIPLES & PRACTICE OF FORENSIC PSYCHIATRY 479–84 (Rosner R. New York 1994)).

<sup>101</sup> Certainly, in our (aggregate) two decades-plus of representation of this population in individual and class actions, it was never considered a single time.

First, we introduce a brief background. An individual who is involuntarily committed to an institutional setting has certain rights under the U.S. Constitution.<sup>102</sup> These rights include the right to a reasonably safe environment, the right to be free from unreasonable restraint, and the right to minimally adequate treatment or training necessary to realize the rights to safety and freedom from restraint.<sup>103</sup> In addition, a fourth right urged by Justice Blackmun in his concurring opinion, the right not to deteriorate in an institutional setting,<sup>104</sup> has been adopted by many states.<sup>105</sup> Whether or not there is a constitutional violation is determined by what is now known as the “professional judgment” standard: whether “the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”<sup>106</sup>

Nothing in this law mentions or considers issues of race or of culture. But the history of institutional mental disability law cannot be uncoupled from these issues. In 1969, a federal district court in Alabama concluded that “[racial] segregation and discrimination in the operation of Alabama’s mental health system clearly violate[s] the Equal Protection Clause.”<sup>107</sup> This case was decided only three years before the case of *Wyatt v. Stickney*,<sup>108</sup> the landmark Alabama case, the first right-to-treatment class action,<sup>109</sup> that was characterized by one of the co-authors (MLP) as “the most important institutional rights case litigated in the history of domestic mental disability law.”<sup>110</sup>

Turn next to questions of gender in the context of *Youngberg*’s constitutional requirement of a “safe environment.” Women have sued hospitals in many cases on both constitutional and state tort grounds because of rape and sexual assault in institutional settings.<sup>111</sup> For instance, a court has found that a facility director may be constitutionally liable for failure to protect a teenage

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<sup>102</sup> *Youngberg v. Romeo*, 457 U.S. 307 (1982).

<sup>103</sup> *Id.* at 315–19.

<sup>104</sup> *Id.* at 327.

<sup>105</sup> PERLIN & CUCOLO, *supra* note 20, § 7-5.1, at 7-111– to 7-118 (discussing cases adopting Justice Blackmun’s formulation).

<sup>106</sup> *Youngberg*, 457 U.S. at 323.

<sup>107</sup> *Marable v. Alabama Mental Health Bd.*, 297 F. Supp. 291, 298 (M.D. Ala. 1969).

<sup>108</sup> *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff’d in part, rev’d in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

<sup>109</sup> See generally Michael L. Perlin, “Abandoned Love”: *The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, 35 L. & PSYCHOL. REV. 121 (2011) (discussing the historical importance of the *Wyatt* litigation).

<sup>110</sup> *Id.* at 121.

<sup>111</sup> See generally *Davis v. Holly*, 835 F.2d 1175 (6th Cir. 1987); *Elizabeth M. v. Montenez*, 458 F.3d 779 (8th Cir. 2006).

patient who engaged in a sexual relationship with a staff member.<sup>112</sup> Courts have allowed assaulted patients to recover when the incidence of sexual assault is clear and rampant.<sup>113</sup> Too often, though, the doctrine of qualified immunity, the doctrine that protects state officials, has barred the recovery of women who claim sexual assault while involuntarily confined.<sup>114</sup>

Compounding the legal barriers to recovery are entrenched opinions on women regarding promiscuity and consent. An involuntarily committed pregnant woman was prevented from recovering on her claim that she was raped during observation because the court found insufficient evidence of past rapes at the facility.<sup>115</sup> Because the state raised qualified immunity, the plaintiff needed to show that the federal "rights" allegedly violated were "clearly established."<sup>116</sup> Although the court noted that the state was aware of sexual activity within the facility, the woman could not prevail without demonstrated evidence of other, prior incidents of rape.<sup>117</sup> The court distinguished *Youngberg* because, "unlike [here], the patient in *Youngberg* had been injured on many occasions, both by his own violence and by the reactions of other patients to him."<sup>118</sup> The court reasoned that *Youngberg* did not apply because "[n]o evidence exists of previous sexual assault or other serious battery upon [the patient] or any other patient (by another patient or by a member of the staff)."<sup>119</sup> The court stressed that since her doctors "[n]ever had reason to believe that she was at risk of assault,"<sup>120</sup> and that "[she] made no complaints about any male patient in the admissions unit,"<sup>121</sup> the "case is simply too unlike the pattern of sixty to seventy injuries shown in

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<sup>112</sup> *Ammons v. Wash. Dep't of Soc. & Health Servs.*, 648 F.3d 1020, 1032–34 (9th Cir. 2011), *cert. denied*, 132 S. Ct. 2379 (2012).

<sup>113</sup> *Neely v. Feinstein*, 50 F.3d 1502, 1505 (9th Cir. 1995) (denying qualified immunity for failure to supervise a staff person who repeatedly sexually assaulted patients).

<sup>114</sup> *Beck v. Wilson*, 377 F.3d 884, 886–87, 892 (8th Cir. 2004) (concluding that qualified immunity protected state officials in a lawsuit by an involuntarily committed raped woman who was the only woman in a ward full of men); *Davis*, 835 F.2d at 1177 (involving a claim brought by mental patient who had sex with a staff member and gave birth to a child); *Elizabeth M. v. Ross*, No. 8:02CV585, 2005 U.S. Dist LEXIS 45107, at \*4, \*7–8, \*29 (D. Neb. May 11, 2005) (certifying a class of women subject to rape, sexual assault, sexual harassment, sexual exploitation, and physical assault at three state institutions), *vacated by Elizabeth M. v. Montenez*, 458 F.3d 779, 785–88 (8th Cir. 2006) (finding a lack of typicality in that some women alleged being raped and sexually assaulted by staff and others by other patients, that most of the women were from one institution, and that most had already been discharged).

<sup>115</sup> *Rodgers v. Horsley*, 39 F.3d 308, 311–12 (11th Cir. 1994) (*per curiam*) (holding that the director and officer were entitled to qualified immunity because at the time of patient's alleged rape, it was not clearly unconstitutional for mental institutions to fail to supervise patients for fifteen minutes, and there was no history of rape for the past twelve years).

<sup>116</sup> *Id.* at 310.

<sup>117</sup> *Id.* at 311.

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> *Id.* at 312.

<sup>121</sup> *Horsley*, 39 F.3d at 312.

*Youngberg* for that case to have settled the applicable law in these circumstances for the purposes of qualified immunity.”<sup>122</sup> Remarkably, and, to our view, incomprehensibly, it would appear that underlying the court’s legal reasoning, is the conventional opinion that a sexual encounter that stands alone, is considered consensual without other additional examples or proof of rape.<sup>123</sup>

Aside from the gender implications of *Youngberg v. Romeo*, the case also focused on the right to be free from “unreasonable restraint.”<sup>124</sup> A number of studies have shown that minorities are restrained and secluded more often and longer than whites.<sup>125</sup> The perception that African–Americans and Hispanics, are “more hostile, aggressive, and potentially dangerous”<sup>126</sup> contributes to the unequal treatment. “In other instances, researchers indicated that different rates of seclusion and/or restraint could have been due to differences in diagnoses when racial groups were compared.”<sup>127</sup>

Past studies have recognized the significance of admission status as an important independent predictor of both seclusion and restraint.<sup>128</sup> Specifically, voluntary patients or those whose commitment was mandated by the courts, were less likely to undergo seclusion or restraint than those who were admitted to the hospital on an emergency basis.<sup>129</sup> Several other studies have shown that involuntarily hospitalized patients were significantly more likely to undergo seclusion or restraint, but there has been a lack of verifiable research to conclude the overall significance of admission status in the area of seclusion and restraint.<sup>130</sup> If in fact, researchers conducted studies to further solidify this connection, we would no doubt see a continued disproportionate number of

<sup>122</sup> *Id.*

<sup>123</sup> *See id.*

<sup>124</sup> *See Youngberg v. Romeo*, 457 U.S. 307, 319–21 (1982).

<sup>125</sup> *See, e.g.*, Gregory M. Smith et al., *Pennsylvania State Hospital System’s Restraint Reduction Program*, 56 PSYCHIATRIC SERVS. 1115 (2005) (discussing how minorities are more likely to be secluded for longer period of time than whites); Joseph A. Flaherty & Robert Meagher, *Measuring Racial Bias in Inpatient Treatment*, 137 AM. J. PSYCHIATRY 679 (1980) (discussing the increased use of restraints and seclusion for African American patients, as opposed to white patients).

<sup>126</sup> Tracy Benford Price et al., *The Use of Restraint and Seclusion in Different Racial Groups in an Inpatient Forensic Setting*, 32 J. AM. ACAD. PSYCHIATRY L. 163, 163 (2004).

<sup>127</sup> *Id.* at 166.

<sup>128</sup> *See* Paul H. Soloff & Samuel M. Turner, *Patterns of Seclusion: A Prospective Study*, 169 J. NERVOUS & MENTAL DISEASE 37 (1981).

<sup>129</sup> Abigail Donovan et al., *Two-Year Trends in the Use of Seclusion and Restraint Among Psychiatrically Hospitalized Youths*, 54 PSYCHIATRIC SERVS. 987, 989 (2003).

<sup>130</sup> *Id.*; *see also* Armando Barragán, Jr., *Seclusion and Mechanical Restraints Among Ethnic Minorities: Understudied and Needed Area of Research*, 1 MENTAL HEALTH L. & POL’Y J. 99 (2012).

minorities in seclusion and restraint given the frequency that minorities are brought in through the criminal justice system.<sup>131</sup>

We turn our attention next to the question of involuntary medication over objection. There is, at the least, a qualified right to refuse medication that can be overridden only in cases in which the patient poses an immediate danger to self or others or is incompetent to make the decision in question.<sup>132</sup> This body of law results from the widespread findings of permanent (often life-threatening) side-effects from the first generation of antipsychotic medications.<sup>133</sup>

Here, some important disparities jump out at us. As discussed previously, African-American patients appear to have their conditions more “commonly misdiagnosed, to be administered higher doses of antipsychotic medication, not to receive proper antidepressant or other psychotropic treatment, and to have higher rates of tardive dyskinesia . . .”<sup>134</sup> Importantly, in cases of individuals with psychiatric disorders who are substance abusers, “racial and ethnic disparities exist in the availability of [psychiatric] medications.”<sup>135</sup>

Gender issues, although equally troubling, are somewhat different in focus and stem from issues related to sexual autonomy.<sup>136</sup> The valid and reliable evidence is unanimous: women clearly feel less able to talk—significantly less able, when compared to male patients—to their healthcare providers about the *sexual* side effects of prescribed psychotropic medications. Juxtapose this with evidence that almost three times as many male patients than female patients felt justified in stopping medication because of effect on sexual function.<sup>137</sup>

On the question of cultural competency, the lack of cultural competence of forensic psychiatrists can negatively affect decisions regarding forced medication—especially if the patient in question is from an ethnically or

<sup>131</sup> Melissa Thompson & Kimberly Barsamian Kahn, *Mental Health, Race, and Police Contact: Intersections of Risk and Trust in the Police*, 39 POLICING: INT’L J. POLICE STRATEGIES & MGMT. 807 (2016).

<sup>132</sup> See, e.g., *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), *stay denied in part, granted in part*, 481 F. Supp. 552 (D.N.J. 1979), *modified & remanded*, 653 F.2d 836 (3d Cir. 1981), *vacated & remanded en banc*, 458 U.S. 1119 (1982); *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff’d in part, rev’d in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>133</sup> See, e.g., PERLIN & CUCOLO, *supra* note 20, § 8-2, at 8-4 to 8-16.

<sup>134</sup> Hicks, *supra* note 48, at 28, (citing, *inter alia*, William M. Glazer et al., *Race and Tardive Dyskinesia Among Outpatients at a CMHC*, 45 PSYCHIATRIC SERS. 38 (1994)). See also Stephen Strakowski et al., *Racial Influence on Diagnosis in Psychotic Mania*, 39 J. AFFECTIVE DISORDERS 157 (1996) (discussing the over-diagnosis and over-medication of African-Americans wrongly diagnosed with schizophrenia).

<sup>135</sup> Hannah K. Knudsen et al., *Racial and Ethnic Disparities in SSRI Availability in Substance Abuse Treatment*, 58 PSYCHIATRIC SERVS. 55, 55 (2007).

<sup>136</sup> See generally PERLIN & LYNCH, *supra* note 72.

<sup>137</sup> Kenneth Paul Rosenberg et al., *A Survey of Sexual Side Effects Among Severely Mentally Ill Patients Taking Psychotropic Medications: Impact on Compliance*, 29 J. SEX & MARITAL THERAPY 289, 289 (2003).

racially diverse cultural group.<sup>138</sup> It should go without saying that cultural assessment of every patient is vital in any decision involving pharmacology.<sup>139</sup> This is confounded by findings that there is virtually no research available on the relationship between cultural competency and evidence-based medicine practices *at all*.<sup>140</sup>

We are limiting ourselves to considerations of matters related to commitment and institutionalization. This limitation, though, should in no way be interpreted to suggest that, in matters related to psychiatric institutionalization, the law disproportionately mistreats women and minorities in solely these cases. If one expands one’s vision to issues involving any relevant aspect of criminal procedure—e.g., the incompetency status, the use of the insanity defense, sentencing, forensic evaluations, the special issues involved in juvenile cases—one finds deadeningly similar parallels.<sup>141</sup>

#### IV. FOUR FACTORS

Our careers in mental disability law—as practitioners, academics, and scholars—have made it crystalline-clear to us that it is impossible to understand this area of the law without a full consideration of the malignant and corrosive impact of sanism, pretextuality, heuristic reasoning and (false) “ordinary common sense.”<sup>142</sup> These factors have “poisoned and corrupted” all of mental disability law,<sup>143</sup> and have “malignantly distort[ed] both the legislative and judicial processes.”<sup>144</sup> In the following sub-sections, we discuss each of these factors.

##### A. Sanism

Sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) racism, sexism,

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<sup>138</sup> Campinha-Bacote, *supra* note 94.

<sup>139</sup> Cora Muñoz & Cheryl Hilgenberg, *Ethnopharmacology: Understanding How Ethnicity Can Affect Drug Response Is Essential to Providing Culturally Competent Care*, 105 AM. J. NURSING 40, 40 (2005); Josepha Campinha-Bacote, *Becoming Culturally Competent in Ethnic Psychopharmacology*, 45 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVS. 27 (2007).

<sup>140</sup> See Rob Whitley, *Cultural Competence, Evidence-Based Medicine, and Evidence-Based Practices*, 58 PSYCHIATRIC SERVS. 1588, 1588 (2007).

<sup>141</sup> The authors will be exploring these issues in a subsequent article.

<sup>142</sup> See, e.g., 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, 6 (2003) (referencing Michael L. Perlin, *Psychodynamics and the Insanity Defense: “Ordinary Common Sense” and Heuristic Reasoning*, 69 NEB. L. REV. 3 (1990)).

<sup>143</sup> See Perlin, *supra* note 142, at 17. See Michael L. Perlin & Meredith R. Schriver, “You Might Have Drugs at Your Command”: *Reconsidering the Forced Drugging of Incompetent Pre-trial Detainees from the Perspectives of International Human Rights and Income Inequality*, 8 ALBANY GOV’T L. REV. 381, 395 (2015).

<sup>144</sup> See, e.g., Michael L. Perlin, *Simplify You, Classify You: Stigma, Stereotypes and Civil Rights in Disability Classification Systems*, 25 GA. ST. U. L. REV. 607 (2009).

homophobia, and ethnic bigotry.<sup>145</sup> Sanism “infects both our jurisprudence and our lawyering practices” and is largely invisible and largely socially acceptable, “based predominantly upon stereotype, myth, superstition, and deindividualization,”<sup>146</sup> sustained and perpetuated by use of alleged “ordinary common sense” (OCS) and heuristic reasoning in unconscious response to events both in everyday life and in the legal process.<sup>147</sup>

### B. Pretextuality

Pretextuality describes the ways in which courts accept testimonial dishonesty—especially by expert witnesses—and engage similarly in dishonest (and frequently meretricious) decision-making.<sup>148</sup> It is especially poisonous where courts accept witness testimony that shows a “high propensity to purposely distort their testimony in order to achieve desired ends.”<sup>149</sup>

It is impossible to understand any aspect of mental disability law without understanding how these two concepts and factors totally dominate all jurisprudential developments (and do so *invisibly*). These factors affect all participants in the judicial system, including: 1) Lawyers; 2) Jurors; 3) Judges; 4) Administrators; 6) Witnesses; and 7) Scholars.<sup>150</sup>

### C. Heuristics

Heuristics refers to a cognitive psychology construct that describes the implicit thinking devices that individuals use to simplify complex, information-processing tasks, the use of which frequently leads to distorted and systematically erroneous decisions, and causes decision-makers to ignore or misuse items of rationally useful information.<sup>151</sup> “One single vivid, memorable

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<sup>145</sup> See, e.g., Michael L. Perlin & Deborah A. Dorfman, *Sanism, Social Science, and the Development of Mental Disability Law Jurisprudence*, 11 BEHAV. SCI. & L. 47, 49 (1993). The classic study is GORDON ALLPORT, *THE NATURE OF PREJUDICE* (1954); see generally ELIZABETH YOUNG-BRUEHL, *THE ANATOMY OF PREJUDICE* (1996) (discussing forms of prejudice); see generally MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 21–35 (2000) (discussing roots of sanism).

<sup>146</sup> See, e.g., Michael L. Perlin, “*Everybody Is Making Love/Or Else Expecting Rain*”: *Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia*, 83 U. WASH. L. REV. 481, 486 (2008).

<sup>147</sup> See, e.g., Michael L. Perlin, *On Sanism*, 46 S.M.U. L. REV. 373 (1992).

<sup>148</sup> See, e.g., Michael L. Perlin, *There’s No Success like Failure/ and Failure’s No Success at All: Exposing the Pretextuality of Kansas v. Hendricks*, 92 NW. U. L. REV. 1247 (1998).

<sup>149</sup> See, e.g., Perlin, *Half-Wracked Prejudice*, *supra* note 9, at 5 (quoting Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of “Ordinary Common Sense,” Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 131, 133 (1991)).

<sup>150</sup> As to all categories, see, e.g., Michael L. Perlin, “*You Have Discussed Lepers and Crooks*”: *Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 684 (2003).

<sup>151</sup> See, e.g., Heather Ellis Cucolo & Michael L. Perlin, “*They’re Planting Stories in the Press*”: *The Impact of Media Distortions on Sex Offender Law and Policy*, 3 U. DENV. CRIM. L. REV. 185, 212 (2013).

case overwhelms mountains of abstract, colorless data upon which rational choices should be made.”<sup>152</sup> Empirical studies reveal jurors’ susceptibility to the use of these devices.<sup>153</sup> Similarly, legal scholars are notoriously slow to understand the way that the use of these devices affects the way individuals think.<sup>154</sup> The use of heuristics “allows us to willfully blind ourselves to the ‘gray areas’ of human behavior,”<sup>155</sup> and predispose “people to beliefs that accord with, or are heavily influenced by, their prior experiences.”<sup>156</sup>

#### D. False “Ordinary Common Sense”

Finally, in this context, we must consider the meretricious allure of a false “ordinary common sense” (OCS) that has long pervaded our jurisprudence in this area—a “self-referential and non-reflective” way of constructing the world “(I see it that way, therefore everyone sees it that way; I see it that way, therefore that’s the way it is).”<sup>157</sup> It is supported by our reliance on a series of heuristics-cognitive-simplifying devices that distort our abilities to rationally consider information.<sup>158</sup>

#### E. The Keys to Future Progress

Sanism, pretextuality, heuristics, and ordinary common sense must continue to be acknowledged and dismantled. They infect our daily lives and contribute to the further marginalization of women and racial minorities in institutional mental health law.<sup>159</sup> The unquestioning acceptance of certain “common sense”

<sup>152</sup> See Michael L. Perlin, “*The Borderline Which Separated You from Me*”: *The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375, 1417 (1997) (discussing David Rosenhan, *Psychological Realities and Judicial Policy* 19 STAN. LAW. 10, 13 (1984)).

<sup>153</sup> Jonathan Koehler & Daniel Shaviro, *Veridical Verdicts: Increasing Verdict Accuracy Through the Use of Overtly Probabilistic Evidence and Methods*, 75 CORNELL L. REV. 247, 264–65 (1990).

<sup>154</sup> Thomas Tomlinson, *Pattern-Based Memory and the Writing Used to Refresh*, 73 TEX. L. REV. 1461, 1461–62 (1995).

<sup>155</sup> See Perlin, *supra* note 142.

<sup>156</sup> See Cucolo & Perlin, *supra* note 151, at 213 (quoting Russell Covey, *Criminal Madness: Cultural Iconography and Insanity*, 61 STAN. L. REV. 1375, 1381 (2009)).

<sup>157</sup> 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, 38 (2012).

<sup>158</sup> Perlin, *supra* note 152, at 622.

<sup>159</sup> On the relationship between race and pretextuality in the judicial process, see Perlin, *supra* note 144, at 622–23. On the relationship between heuristic thinking and our attitudes towards racial minorities who had previously been hospitalized, see Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 139 (1991). On race and sanism, see Sonia Meerai, Idil Abdillahi & Jennifer Poole, *An Introduction to Anti-Black Sanism*, 5 INTERSECTIONALITIES: GLOBAL J. SOC’L WORK ANALYSIS, RES., POLITY, & PRAC. 18 (2016). On gender and sanism, see Jemma Tosh & Krista Carson, *A Desire to be ‘Normal’? A Discursive and Intersectional Analysis of ‘Penetration Disorder,’* 5 INTERSECTIONALITIES: GLOBAL J. SOC’L WORK ANALYSIS, RES., POLITY, & PRAC. 151 (2016). See



beliefs that are inherent within each of the four factors is the ultimate barrier that we have enacted against the protection and provision of equal rights for vulnerable populations. To sustain and perpetuate our stereotypes, we use sanism, ordinary common sense, and other cognitive-simplifying devices such as heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.<sup>160</sup> Each of these “hidden” concepts pollute our thought processes, which are deeply influenced by our understanding and perception of culture.<sup>161</sup> Reflective thought about cultural conditions needs to be unburdened by ordinary common sense and sanism—especially in the area of institutionalization—and is the first step in the creation of better legal and medical protections of marginalized populations. In many ways, true change must begin with the courts and judicial acknowledgment of pretextual tendencies. Although pragmatism emphasizes reliance on judges’ inherent faculties of common sense and good judgment, it does not call for judges to use the tools of other disciplines more pertinent to its methods to become expertly analytical of themselves.<sup>162</sup> One of those disciplines must necessarily be the incorporation of therapeutic jurisprudence.

#### V. THERAPEUTIC JURISPRUDENCE<sup>163</sup>

Therapeutic jurisprudence<sup>164</sup> “look[s] at law as it actually impacts people’s lives”<sup>165</sup> and assesses law’s influence on “emotional life and psychological well-

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generally Perlin, *supra* note 131, at 393–97 (citing, inter alia, SANDER GILMAN, *DIFFERENCE AND PATHOLOGY: STEREOTYPES OF SEXUALITY, RACE AND MADNESS* (1985)). See also, e.g., Christian Breheny et al., *Gender Matters in the Insanity Defense*, 31 L. & PSYCHOL. REV. 93 (2007) (reporting on valid and reliable research confirming the role of sanism in insanity defense attitudes).

<sup>160</sup> Perlin, *supra* note 147, at 373, 374.

<sup>161</sup> John D. Brewer, *Competing Understandings of Common Sense Understanding: A Brief Comment on “Common Sense Racism,”* 35 BRIT. J. SOC. 66, 70 (1984) (“Common sense knowledge . . . is a personal construction. . . . It is constructed on the basis of each member’s personal biography of past experiences and socially transmitted ‘recipes’ and categories.”).

<sup>162</sup> Nancy Levit, *Practically Unreasonable: A Critique of Practical Reason*, 85 NW. U. L. REV. 494, 507 (1991) (reviewing RICHARD A. POSNER, *THE PROBLEMS OF JURISPRUDENCE* (1990)) (practical reason theorists have turned their attention to justifying methods of judicial decision making).

<sup>163</sup> This section is generally adapted from Perlin & Lynch, *Sexless Patients*, *supra* note 12; Perlin & Lynch, *Wasteland*, *supra* note 12; and Michael L. Perlin & Naomi 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*, — CARDOZO PUB. L., POL’Y & ETHICS J. — (2017) (in press). Further, it distills the work of one of the co-authors (MLP) over the past two decades, beginning with Michael L. Perlin, *What Is Therapeutic Jurisprudence?*, 10 N.Y.L. SCH. J. HUM. RTS. 623 (1993).

<sup>164</sup> See, e.g., DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* (1990); LAW IN A THERAPEUTIC KEY: RECENT DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds. 1996); BRUCE J. WINICK, *CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL* (2005); David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 TOURO L. REV. 17 (2008); PERLIN & CUCOLO, *supra* note 20, § 2-6, at 2-43 to 2-66. 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 L. & HUM. BEHAV. 27, 27, 32–33 (1992).

being.”<sup>166</sup> Therapeutic jurisprudence mandates that “law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law, should attempt to bring about healing and wellness.”<sup>167</sup>

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.<sup>168</sup> From therapeutic jurisprudence, we gain “a new and distinctive perspective utilizing socio-psychological insights into the law and its applications.”<sup>169</sup> Therapeutic jurisprudence is “. . . a sea-change in ethical thinking about the role of law . . . a movement towards a more distinctly relational approach to the practice of law . . . [emphasizing] psychological wellness over adversarial triumphalism.”<sup>170</sup> It thus supports an ethic of care.<sup>171</sup>

Professor Amy Ronner describes the “three Vs”: voice, validation and voluntariness,<sup>172</sup> arguing:

What “the three Vs” commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a

<sup>165</sup> Bruce J. Winick, *Foreword: Therapeutic Jurisprudence Perspectives on Dealing with Victims of Crime*, 33 NOVA L. REV. 535, 535 (2009).

<sup>166</sup> David B. Wexler, *Practicing Therapeutic Jurisprudence: Psychological Soft Spots and Strategies*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION 45 (Dennis P. Stolle et al. eds., 2000).

<sup>167</sup> Bruce Winick, *A Therapeutic Jurisprudence Model for Civil Commitment*, in INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVE ON CIVIL COMMITMENT 23, 26 (Kate Diesfeld & Ian Freckelton eds., 2003).

<sup>173</sup> 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).

<sup>169</sup> Ian Freckelton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence*, 30 T. JEFFERSON L. REV. 575, 576 (2008). It is also part of a growing comprehensive movement in the law towards establishing more humane and psychologically optimal ways of handling legal issues collaboratively, creatively, and respectfully. Susan Daicoff, *Afterword: The Role of Therapeutic Jurisprudence within the Comprehensive Law Movement*, in PRACTICING THERAPEUTIC JURISPRUDENCE, *supra* note 166, at 465.

<sup>170</sup> Warren Brookbanks, *Therapeutic Jurisprudence: Conceiving an Ethical Framework*, 8 J.L. & MED. 328, 329–30 (2001); *see also* Bruce J. Winick, *Overcoming Psychological Barriers to Settlement: Challenges for the TJ Lawyer*, in THE AFFECTIVE ASSISTANCE OF COUNSEL: PRACTICING LAW AS A HEALING PROFESSION 342 (Marjorie A. Silver ed., 2007); 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, 605–06 (2006).

<sup>171</sup> *See, e.g.*, Winick & Wexler, *supra* note 170, at 605–07; David B. Wexler, *Not Such a Party Pooper: An Attempt to Accommodate (Many of) Professor Quinn’s Concerns about Therapeutic Jurisprudence Criminal Defense Lawyering*, 48 B.C. L. REV. 597, 599 (2007); Brookbanks, *supra* note 170. The use of the phrase dates to CAROL GILLIGAN, IN A DIFFERENT VOICE (1982).

<sup>172</sup> 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). On the importance of “voice,” *see also* Freckelton, *supra* note 169, at 588.

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.<sup>173</sup>

The question we must confront is this: do our practices related to the commitment process and institutional treatment of racial minorities, women and those from other cultures comport with the "3V's" seen by Professor Ronner as the *sine qua nons* of therapeutic jurisprudence? We believe the answer is, sadly, "absolutely not."

In another article, Professor Ronner discusses the Supreme Court's decision in *Price Waterhouse v. Hopkins*,<sup>174</sup> holding that a lower court had erred in holding that an employer may escape liability for a Title VII sex discrimination violation "if it proves, by clear and convincing evidence, that it would have made the same decision in the absence of discrimination."<sup>175</sup> She notes: "The *Price Waterhouse* decision is not just about fair play in the workplace. With its debunking of gender stereotypes and censure of the 'intolerable and impermissible catch 22,'<sup>176</sup> *Price Waterhouse* effectively fosters the 'three Vs' of therapeutic jurisprudence."<sup>177</sup> Similarly, in an article discussing "rape myths," Professor Christian Diesen calls on therapeutic jurisprudence as an interpretive tool: "Another therapeutic jurisprudence approach to the issue is promoting education, in schools and other social circuits, about rape myths and gender inequality—the reluctance of reporting seems to be proportional to a society's acceptance of the rape myth."<sup>178</sup>

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<sup>173</sup> Amy D. Ronner, *Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles*, 71 U. CIN. L. REV. 89, 94–95 (2002) (internal citations omitted). See generally AMY D. RONNER, LAW, LITERATURE, AND THERAPEUTIC JURISPRUDENCE (2010) (globally discussing these principles in a therapeutic jurisprudence context).

<sup>174</sup> *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

<sup>175</sup> *Id.* at 237.

<sup>176</sup> Amy D. Ronner, *Let's Get the "Trans" and "Sex" Out of It and Free Us All*, 16 J. GENDER RACE & JUST. 859, 867 (2013) (quoting *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)).

<sup>177</sup> *Id.* at 867–68.

<sup>178</sup> Christian Diesen, *The Importance of Reporting Rape*, 6 PHOENIX L. REV. 933, 961 (2013).

Our practices related to the commitment and institutionalization of women and racial minorities fly in the face of what therapeutic jurisprudence counsels. It mocks the “ethic of care”<sup>179</sup> that is central to the heart of therapeutic jurisprudence, and turns its back on therapeutic jurisprudence’s mandate of “psychological health.”<sup>180</sup> The very act of discrimination—either intentional or unintentional—is anti-therapeutic and against the goals of cultural sensitivity. Discrimination in any form should be banned from our treatment centers and courtrooms; however, in order to achieve that end, we must recognize inherent and ingrained misconceptions and faulty beliefs. By incorporating therapeutic jurisprudence into our practices, we can utilize diverse perspectives and tools to erase the marks of cultural insensitivity. Therapeutic jurisprudence’s ultimate goal, in this area specifically, is to recognize the flaws in our perceptions and practices in order to create a better approach to achieving guaranteed rights and liberties for all persons.

Some twenty years ago, one of the authors (MLP)— with another law professor and a practitioner— writing about institutional mental health law, concluded that “therapeutic jurisprudence may indeed offer a path to redemption for a constitutionally based mental disability law jurisprudence.”<sup>181</sup> The authors of this article believe that is still so, and especially more so in any analysis that focuses on the issues of race and gender that are at the heart of this paper.

## VI. CONCLUSION

Some of our most vulnerable populations—racial, cultural, and gender minorities— are consistently harmed by marginalization that targets persons with mental illness. If we continue to ignore the pervasive stereotypes and false “ordinary common sense” ingrained within this area (both in the legal system and society at large), we will continue to impede necessary advances in care, treatment and legal protections for this cohort of individuals. Our hope is that this article inspires lawyers, practitioners, and researchers to take seriously the deleterious impact of cultural insensitivity on all areas of the mental health assessment, treatment and litigation processes.

The toxicity of racism and sexism is intensified in the context of sanism. Our practices of civil commitment and institutionalization are poisoned even more when we fold in the ways that we stereotype and typify racial minorities, women, and those from the non-dominant culture.<sup>182</sup> Society continues to

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<sup>179</sup> See, e.g., Winick & Wexler, *supra* note 170, at 605–07.

<sup>180</sup> Winick, *supra* note 167, at 26.

<sup>181</sup> 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, 119 (1995), reprinted in LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE, *supra* note 166, at 739.

<sup>182</sup> See Perlin, *Half-Wracked Prejudice*, *supra* note 9, at 28 (“[M]ental disability law is premised on stereotype and prejudice, on typification and on fear.”).

marginalize and dehumanize such individuals,<sup>183</sup> and does so often in invisible ways.<sup>184</sup> And this marginalization is often most pernicious in the context of cases involving racial, cultural and gender minorities. It is time that we heed Judge David “Bazelon’s admonition that we need to be vigilant about not ‘overgeneraliz[ing] about citizens whom it is easy to overgeneralize about.’”<sup>185</sup>

We believe that, through the conscious adoption of therapeutic jurisprudence principles, there is a chance that there may be some light at the end of a very dark tunnel. Current practices—based on statistically invalid and socially pernicious stereotypes of “dangerousness” in matters involving African-Americans or of women—make a mockery of the “validation” principle that is at the heart of therapeutic jurisprudence. Certainly, these practices fly in the face of promoting the “psychological health” that TJ efforts demand and, again, flaunt the ‘ethic of care’<sup>186</sup> that is a *sine qua non* of TJ.

Again, in *Chimes of Freedom* (the source of the initial part of the title of this article), “Dylan dangles the notion that humanity has yet to grasp the promise of liberty floating just out of reach.”<sup>187</sup> Liberty *does* “float . . . out of reach” of the individuals about whom we are writing today. Our hope is that, finally, this will change.

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<sup>183</sup> 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, 12 (2008–09).

<sup>184</sup> See generally MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* (2000); Perlin & Dorfman, *supra* note 2, at 318–21.

<sup>185</sup> Perlin & Douard, *supra* note 183, at 26 (quoting David Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 909 (1975)). See also Michael Perlin, ‘*My Sense of Humanity Has Gone Down the Drain*’: *Stereotypes, Stigma and Sanism*, in STEREOTYPING AND HUMAN RIGHTS LAW 95, 98 (Eva Brems & Alexandra Timmer, eds. 2016) (quoting David Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 909 (1975)).

<sup>186</sup> Winick & Wexler, *supra* note 170, at 605–07.

<sup>187</sup> TRAGER, *supra* note 19, at 105.