"Your Old Road Is/ Rapidly Agin": International Human Rights Standards and Their Impact on Forensic Psychologists, the Practice of Forensic Psychology, and the Conditions of Institutionalization of Persons with Mental Disabilities

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"YOUR OLD ROAD IS/ RAPIDLY AGIN'": INTERNATIONAL HUMAN RIGHTS STANDARDS AND THEIR IMPACT ON FORENSIC PSYCHOLOGISTS, THE PRACTICE OF FORENSIC PSYCHOLOGY, AND THE CONDITIONS OF INSTITUTIONALIZATION OF PERSONS WITH MENTAL DISABILITIES

MICHAEL L. PERLIN*

ABSTRACT

For years, considerations of the relationship between international human rights standards and the work of forensic psychologists have focused on the role of organized psychology in prisoner abuse at Guantanamo Bay and Abu Ghirab. That issue has been widely discussed and debated, and these discussions show no sign of abating. But there has been virtually no attention given to another issue of international human rights, one that grows in importance each year: how the treatment (especially, the institutional treatment) of persons with mental and intellectual disabilities violates international human rights law, and the silence of organized forensic psychology in the face of this mistreatment. This issue has become

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even more pointed in recent years, following the ratification of the United Nations’ Convention on the Rights of Persons with Disabilities.

Organized forensic psychology has remained largely silent about the potential significance of this Convention and about how it demands that we rethink the way we institutionalize persons – often in brutal and barbaric conditions – around the world. In many parts of the world, circumstances are bleak: services are provided in segregated settings that cut people off from society, often for life; persons are arbitrarily detained from society and committed to institutions without any modicum of due process; individuals are denied the ability to make choices about their lives when they are put under plenary guardianship; there is a wide-spread denial of appropriate medical care or basic hygiene in psychiatric facilities, individuals are subject to powerful and often-dangerous psychotropic medications without adequate standards, and there is virtually no human rights oversight and enforcement mechanisms to protect against the broad range of institutional abuse. Although there is a robust literature developing – interestingly, mostly in Australia and New Zealand, but little in the US – about how such institutional conditions violate the international human rights of this population, virtually nothing has been written about how organized forensic psychology has been silent about these abuses.

In this paper, I (1) discuss the relevant international human rights law that applies to these questions, (2) examine the current state of conditions in institutions worldwide, (3) argue why forensic psychology needs to become more aggressively involved in this area, and (4) offer some suggestions as to how this situation can be ameliorated.
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INTRODUCTION

For years, the focus of how international human rights standards should govern forensic psychology has been organized around psychology’s impact on and response to prisoner abuse at Guantanamo Bay and Abu Ghraib.¹ That focus has not been substantially changed as discussions and debates on that issue show no sign of abating.² In contrast, scant attention


"Forensic psychology" is defined broadly in the *SPECIALTY GUIDELINES FOR FORENSIC PSYCHOLOGY* (AM. PSYCHOLOGICAL ASS’N 2013) [hereinafter *SPECIALTY GUIDELINES*] as "professional practice by psychologists, within any subdiscipline of psychology (e.g., clinical, developmental, social, experimental) when [...] engaged regularly as [forensic psychologists]." Comm. on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655, 656-57 (1991) [hereinafter *Specialty Guidelines*].

Specifically, the *SPECIALTY GUIDELINES* elaborate that forensic psychology means “all forms of professional psychological conduct when acting, with definable foreknowledge, as a psychological expert on explicitly psychosocial issues, in direct assistance to courts, parties to legal proceedings, correctional and forensic mental health facilities, and administrative, judicial and legislative agencies acting in an adjudicative capacity.” Id. at 657.


This paper will focus on (1) those who work in correctional and psychiatric institutions (both forensic and civil), (2) those who give testimony in forensic cases, and (3) those who do research on topics that relate to the work of forensic psychologists.


Two of the psychologists in question are currently on trial as part of litigation stemming from these
committed to institutions without any modicum of due process; individuals are denied the ability to make choices about their lives when they are put under plenary guardianship, also often known as “civil death”; there is a wide-spread denial of appropriate medical care or basic hygiene in psychiatric facilities; individuals are subject to powerful and often dangerous psychotropic medications without adequate standards, and there is almost no human rights oversight or enforcement mechanisms to protect against the broad range of institutional abuse. Although there is a robust literature developing—mostly in Australia and New Zealand—on how such institutional conditions violate the international human rights of this population, organized forensic psychology has virtually been silent about these abuses in the United States.

7 See Michael L. Perlin, An Internet-Based Mental Disability Law Program: Implications for Social Change in Nations with Developing Economies, 40 FORDHAM INT’L L.J. 435, 447 (2007) (... Internationally, there is a shameful history of human rights abuses in psychiatric institutions: the provision of services in a segregated setting that cuts people off from society, often for life; the arbitrary detention from society that takes place when people are committed to institutions without due process; the denial of people’s ability to make choices about their lives when they are put under plenary guardianship; the denial of appropriate medical care or basic hygiene in psychiatric facilities; the practice of subjecting people to powerful and dangerous psychotropic medications without adequate standards; and the lack of human rights oversight and enforcement mechanisms to protect against the broad range of abuses in institutions.)


10 See Juan E. Mendez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), Rep. on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ¶ 6, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013).

11 See generally Perlin & Schriver, supra note 3; Perlin, supra note 3; Perlin & Schriver, supra note 9. As I discuss below, I believe that is imperative that, in many cases, forensic psychologists consider the impact of institutional conditions on their ultimate conclusions. See infra text accompanying note 141.

This article will first briefly introduce the controversy enveloped in organized psychology for the past fifteen years. Part I discusses the relevant international human rights law that applies to violations against persons with mental and intellectual disabilities. Part II examines the current state of conditions in mental health institutions worldwide. Part III argues why forensic psychology needs to become more aggressively involved in countering international human rights violations at these institutions. Part IV explains the significance of understanding sanism and pretextuality in dealing with the underlying presumptions of forensic psychologists’ behaviors and explains how the principles of therapeutic jurisprudence can ameliorate the situation. Part V concludes the article by advocating for changes in forensic psychology to embrace international human rights mandates.

The title of this article comes from Bob Dylan’s anthemic early song, *The Times They Are A-Changin*, characterized by the critic Howard Soames as “a rallying call ... as America raced through momentous changes,” and by the critic Robert Shelton as “a timeless dialogue between those restrained by old ways and those daring something new.” In this song, Dylan challenged everyone—parents, politicians, and citizens—to “get out of the new [road] if [they] can’t lend [a] hand” because “[t]he [old] order is rapidly fadin.’” And in the same couplet, he sings, “[The] old road is rapidly agin.’” He had that absolutely right in 1963—in the time of the glory of the American civil rights movement—when he wrote that song. But I think his admonition is just as valid for us today.

16 Id.
I. THE RELEVANT INTERNATIONAL HUMAN RIGHTS LAW

A. Recent Developments in International Human Rights Standard’s Impact on Forensic Psychology

The attention to behavioral standards of forensic psychologists and forensic psychiatrists has been rising dramatically in recent years. This new attention mostly flows from revelations of the Bush Administration’s sanctioning torture at prison camps in Guantanamo Bay and Abu Ghraib. This led to a spirited debate on the application of international human rights to what some psychologists and psychiatrists have done in the context of armed conflict. In the words of Kenneth Pope, in his recent “Member of the Year” address to the Canadian Psychological Association: “the torture controversy and the choices that led up to it provide a grim inventory of guild ethics, willful ignorance, denial, and discrediting critics.”

The American Psychological Association’s (“APA”) failure to mandate that psychologists adhere to international human rights standards has been sharply criticized. Among these critics is the NGO Physicians for Human Rights (“PHR”). “PHR was founded on the idea that physicians, scientists, and other health professionals possess unique skills that lend significant credibility to the investigation and documentation of human rights abuses[;] [it uses its] specialized expertise … to advocate for persecuted health workers, prevent torture, document mass atrocities, and hold those who violate human rights accountable.”

18 Portions of this section draw on Perlin & Lynch, supra note 3, and Perlin, supra note 3.
20 Pope, supra note 1, at 56.
22 See Cyrus Ahalt et al., Examining the Role of Healthcare Professionals in the Use of Solitary Confinement, BRIT. MED. J., Oct. 24, 2017, at j4657 (“The APA’s misplaced loyalty to the state directly undermined the health and human rights of patients at Guantanamo Bay”).
23 PHYSICIANS FOR HUM. RTS., About PHR, http://physiciansforhumanrights.org/about/ (last
Amnesty International, PHR sent an open letter to APA about what it termed APA’s “‘grievous mismanagement of this issue’; APA’s ‘providing ethical cover for psychologists’ participation in detainee abuse; [and] APA’s handling of the detainee interrogation issue creating ‘the greatest ethical crisis’ in the profession’s history and making a ‘terrible stain on the reputation of American psychology.’”24 Then, in 2015, PHR subsequently sent a letter to the APA leadership, encouraging the association to adopt a ban on psychologists’ participation in interrogations and any activities that do not comply with obligations under the U.N. Convention against Torture—to which the U.S. is a signatory25—including the use of sleep deprivation, prolonged isolation, and sensory deprivation.26

It is important to underscore that “torture” goes beyond prototypical notions of physical abuse and includes psychological abuse as well.27 In this context, it is also important to note in some jurisdictions—especially, but not solely, in Eastern and Central Europe and China, and some in the United States—the existence of a sorry and shoddy history of mental health professionals complying with governmental officials seeking to suppress political dissenters.28 So this should not be seen as merely a one-time aberration.29

This all leads to a critical question: should international human rights law only function to prevent politically motivated torture in forensic psychology and forensic psychiatry, or should international human rights law have a boarder mandate that governs forensic psychologists and psychiatrists’ general behaviors in all contexts?

I speak often to psychiatrists, psychologists, and criminologists about international human rights law and its relationship to mental disability law,


24 Kenneth S. Pope, Are the American Psychological Association’s Detainee Interrogation Policies Ethical and Effective?: Key Claims, Documents, and Results, 219 ZEITSCHRIFT FÜR PSYCHOLOGIE 150, 153 (2011).


29 Id.
and remained stunned by the few audience members in the United States who are familiar with this relationship, and the even fewer who are familiar with the UN Convention on the Rights of Persons with Disabilities. This differs sharply from my experiences abroad: whether I am lecturing in a nation with a developed economy or a developing economy, virtually every audience member is familiar with this body of law.\(^30\)

Why is this? The reason may be as benignly simple as the fragmentation of scholarly research agendas (that, simply, different cohorts of scholars have chosen to write about the different aspects of this connection), an explanation that appears to be supported by the astonishing paucity of available legal literature in this area. Or, perhaps it is as darkly complex as the reality that this topic is just not of much interest to the main cohorts of individuals whom we most logically might expect to embrace it: international human rights activists, academically-focused forensic psychologists and forensic psychiatrists, and mental disability law scholars. In this context, it is necessary to recall that it was not until January 2002 that Amnesty International acknowledged, albeit grudgingly, that violations of international human rights law in the cases of persons institutionalized in psychiatric facilities \(^{31}\) I am


forced to conclude that the question at the heart of this article—the
relationship between international human rights standards and the
institutional work of forensic psychologists and forensic psychiatrists
-especially, but certainly not exclusively, the work that takes place in the
psychiatric institutions of civil law nations—is one that is essentially
ignored by academics, both as a topic of scholarly discourse, and as a topic
of classroom study.32

I find this pathetic. I also find it baffling, given the shameful history of
human rights abuses in psychiatric institutions on every continent.33 A
series of reports issued over the past twenty years by Mental Disabilities
Rights International (“MDRI,” now Disabilities Rights International,
“DRI”) and the Mental Disability Advocacy Centre (“MDAC”) excoriating
the governments of numerous Central and Eastern European and Central
and South American nations34 have drawn scholars and policymakers to
these issues,35 and have even had an impact on the political process of
European Union accession.36 Furthermore, there has even been some
coverage in the mainstream media.\textsuperscript{37}

So, ignorance on the part of forensic mental health professionals can no longer be—if it ever were—an acceptable excuse. Moreover, I expect that the widespread professional disregard of this issue depressingly and banally results from what I call \textit{sanism} and \textit{pretextuality}.\textsuperscript{38} This, though, does not solve the problem; it merely identifies the cause. And we will blind ourselves if we fail to acknowledge the ways that sanism and pretextuality have served as potent counterweights to the application of human rights law to all institutional mental disability law.\textsuperscript{39}

\textbf{B. The meaning of human rights}

What are human rights?\textsuperscript{40} The University of Minnesota-based Human Rights Resource Center provides a simple definition: “[h]uman rights are the rights a person has simply because he or she is a human being.”\textsuperscript{41} In its Preamble, the Universal Declaration of Human Rights proclaims that recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.\textsuperscript{42} The World Health Organization adds to the description by stating that human rights consist of the basic entitlement accorded to


\textsuperscript{39} See, e.g., Perlin, supra note 4, at 33-37; Perlin, supra note 28, at 89-91.

\textsuperscript{40} See generally PERLIN ET AL., supra note 30, ch. 3.


\textsuperscript{42} G.A. Res. 217A (III), Universal Declaration of Human Rights (Dec. 10, 1948).
every human being. These rights include the right to health, education, shelter, employment, property, food, freedom of expression, and movement.43

Consider the Convention on the Rights of Persons with Disabilities ("CRPD").44 The CRPD “is regarded as having finally empowered the ‘world’s largest minority’ to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection.”45 This Convention is the most revolutionary international human rights document ever applied to persons with disabilities.46 The CRPD furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in almost every aspect of life.47 It firmly endorses a social model of disability, which is a clear and direct repudiation of the medical model that traditionally was part-and-parcel of mental disability law.48 “The Convention responds to traditional models, situates disability within a social model framework, and sketches the full range of human rights that apply to all human beings, all with a particular application to the lives of persons with disabilities.”49 It provides a framework for ensuring that mental health


47 See Perlin & Szeli, supra note 31; Perlin, supra note 4, at 3-21.


laws “fully recognise the rights of those with mental illness.”

There is no question that the Convention has “ushered in a new era of disability rights policy.”

This Convention demands that we reconsider the issues discussed in this article. In light of Convention articles mandating, inter alia, "respect for inherent dignity," and the elimination of discrimination in all matters related to interpersonal relationships, it is time for a radical change of perspective and attitude in how society views the institutionalization of persons with disabilities. The CRPD is unique because it is the first legally binding instrument devoted to the comprehensive protection of the rights of persons with disabilities. It not only clarifies that States should not


52 See generally Perlin & Lynch, supra note 3.


54 CRPD, supra note 44, art. 23.

55 Beyond the scope of this article is an inquiry into the extent to which cases articulating the constitutional rights of persons in psychiatric institutions (and facilities for persons with intellectual disabilities) in the United States comply with the CRPD and other international human rights conventions. See, e.g., Youngberg v. Romeo, 457 U.S. 307 (1982).

discriminate against persons with disabilities, but also sets out explicitly the
many steps that States must take to create an enabling environment so that
persons with disabilities can enjoy authentic equality in society.57

This leads to the next question: how does this all affect what forensic
psychologists, moving forward, should do?

II. CONDITIONS IN PSYCHIATRIC INSTITUTIONS WORLDWIDE

The practice of mental disability law in many parts of the world today
reveals a pattern and practice of ongoing abuses that is “reminiscent of the
state of American mental health facilities thirty-five or more years ago.”58
Early institutional rights cases in the United States revealed persistent and
pervasive mistreatment of persons with mental disabilities.59 As recently as
1958, state hospitals were characterized by the President of the APA as
“bankrupt beyond remedy.”60 Three years later, a witness testified at a
Congressional hearing that “[s]ome [state hospital] physicians I interviewed
frankly admitted that the animals of nearby piggeries were better housed,
fed and treated than many of the patients on their wards.”61 When the
Chairman of the Legal Action Committee of the National Association of
Retarded Children (now “The Arc”) characterized the Pennhurst State

57 On the changes that ratifying states need to make in their domestic involuntary civil commitment
laws to comply with Convention mandates, see Bryan Y. Lee, The U.N. Convention on the Rights of
Persons with Disabilities and Its Impact upon Involuntary Civil Commitment of Individuals with
Developmental Disabilities, 44 COLUMBIA. J. L. & SOC. PROBS. 393 (2011). See also, István Hoffman
& György Könczei, Legal Regulations Relating to the Passive and Active Legal Capacity of Persons
with Intellectual and Psychosocial Disabilities in Light of the Convention on the Rights of Persons with
Disabilities and the Impending Reform of the Hungarian Civil Code, 33 LOY. L.A. INT'L & COMP. L.
REV. 143 (2010) (on the application of the CRPD to capacity issues); Kathryn D. DeMarco, Disabled
by Solitude: The Convention on the Rights of Persons with Disabilities and Its Impact on The Use of
Supermax Solitary Confinement, 66 U. MIAMI L. REV. 523 (2012) (on the application of the CRPD to
solitary confinement in correctional institutions).

58 Bruce Winick, Therapeutic Jurisprudence and the Treatment of People with Mental Illness in
Eastern Europe: Construing International Human Rights Law, 21 N.Y.L. SCH. J. INT'L & COMP. L. 537,

59 See, e.g., Perlin, Universal Factors, supra note 30, at 335; Michael L. Perlin & Heather
Ellis Cucolo, Mental Disability Law: Civil and Criminal, ch. 7 (3d ed. 2016); Perlin, supra note
48, at 121-22.

60 Harry Solomon, Presidential Address: The American Psychiatric Association in Relation to
American Psychiatry, 115 AM. J. PSYCHIATRY 1, 7 (1958).

61 Constitutional Rights of the Mentally Ill: Hearing Before the Subcomm. on Constitutional Rights
School\textsuperscript{62} as “Dachau, without ovens,”\textsuperscript{63} there was never any accusation of exaggeration.

This is not solely a domestic problem but one that exists worldwide. Consider the following, some examples of which I have previously characterized as “stupefying”:\textsuperscript{64}

1. Studies conducted at two Argentinean forensic wards showed unlivable conditions where individuals were housed in small, extremely overcrowded cells by approximately 75\%, with no running water or toilets. Many were denied routine medical care, a basic human right for all individuals regardless of legal status, and some were subjected to unwanted sexual practices and rape. In extreme cases, there were no appropriate treatment facilities in which to release the patients, and some were housed in the facility for over twenty years, receiving no medication or other treatment.\textsuperscript{65}

2. Prison facilities in England revealed a number of discrepancies, including “the lack of treatment facilities, lack of a clear legal framework for treating prisoners with severe mental illness, inadequately designed prison health care wings, and considerable delays in hospital transfers.”\textsuperscript{66}

3. Convicted prisoners from a Budapest prison were used to “keep an eye on” patients housed in the nation’s only high security forensic psychiatric institution. Many of the patients in the institution were deemed “high suicide risk.” One can opine that the prisoners tasked with this responsibility were not given adequate training in the treatment of those with mental illnesses or disabilities, especially those in such vulnerable conditions,

\begin{footnotes}

\textsuperscript{63} Leopold Lippmann & I. Ignacy Goldberg, Right to Education: Anatomy of the Pennsylvania Case and Its Implication for Exceptional Children 17 (1973).

\textsuperscript{64} Perlin, Universal Factors, supra note 30, at 354; see also, Perlin, A Change is Going to Come, supra note 38, at 492.


\textsuperscript{66} Tim Exworthy et al., Asserting Prisoners’ Right to Health: Progressing beyond Equivalence, 63 Psychiatric Serv. 270 (2012).
\end{footnotes}
begging the question of how appropriate care could be rendered.67

4. In Kyrgyzstan, there are no statutory provisions to deal with cases of persons who are potentially incompetent to stand trial. As a result, persons with severe mental illness who are charged with crime have no opportunity to be treated in an effort to improve their condition so as to become competent to stand trial.68

5. Many institutions use prolonged confinement as a way of managing or disciplining individuals deemed dangerous. Tamms Correctional Center in Illinois, for example, held a prisoner with a well-documented history of schizophrenia in solitary for nearly six years.69 While solitary conditions can be psychologically harmful to any individual, they are particularly damaging to one with a mental disability. In fact, a federal judge once equated putting mentally ill prisoners in isolated confinement with “putting an asthmatic in a place with little air…”70

6. Albanian law requires that individuals with mental disabilities who have been charged with criminal offenses be housed in prison units and must comply by all prison rules. Some were institutionalized for five years before their conditions were re-evaluated.71

Conditions in forensic facilities72 thus continue to “violate the ‘decencies

72 Forensic facilities include predominantly those whose residents are primarily those awaiting competency to stand trial evaluations, those who have been found incompetent to stand trial and are awaiting restoration, those permanently incompetent to stand trial, those awaiting evaluations as to their sanity, and those who have been found not guilty by reason of insanity. See, e.g., Michael L. Perlin,
of civilized conduct’,”73 and highlight the dire need for intervention on behalf of those with a mental disability who are subjected to such treatment. This marginalized and often forgotten population continues to be neglected by the very individuals who should be working the most assiduously to end such injustices.74

In some parts of the world, these conditions are fatalistically accepted. By way of example, there is a belief that “the right of a psychiatric patient to receive modern treatment to alleviate suffering is not something within the capacity of most African countries.”75 For example, Uruguayan researchers were told by hospital officials that informing patients about their treatment would be logistically difficult and would actually worsen the patients’ conditions.76 Although the Iron Curtain has long ago fallen, “in some countries, prosecutors still enjoy the Stalin-esque power to order detention in a psychiatric institution without prior medical opinion.”77

The literature is robust, and, when read in its entirety, demonstrates certain universal factors in the treatment of those institutionalized because of mental disability: (1) a lack of comprehensive legislation (in some nations, of any legislation) to govern the commitment and treatment of persons with mental disabilities;78 (2) a lack of independent counsel made available to persons facing commitment and those institutionalized;79 (3) a


73 Perlín, “A Change is Gonna Come,” supra note 38, at 491.

74 See generally Perlín & Schrifer, supra note 9, at 212 (“Articles written by those who self-identify with the ‘psychiatric survivor movement’ largely ignore this population as well. So, even within the world of those who focus broadly on these human rights issues, this population has remained invisible”).


76 MDRI URUGUAY REPORT, supra note 34, at 20, as quoted in Fischer, supra note 75, at 183-84.

77 Lewis, supra note 34, at 295, as quoted in Fischer, supra note 75, at 185; see generally Perlín, supra note 28. This state behavior is emphatically not just “a thing of the past.” See, e.g., Peter Finn, In Russia, Psychiatry Is, Again a Tool Against Dissent, WASH. POST (Sept. 30, 2006), http://www.washingtonpost.com/wp-dyn/content/article/2006/09/29/AR2006092901592_pf.html.


failure to provide humane care to institutionalized persons; failure to provide humane care to institutionalized persons; failure to provide humane care to institutionalized persons; failure to provide humane care to institutionalized persons; failure to provide humane care to institutionalized persons; (4) lack of coherent and integrated community programs as an alternative to institutional care; and (5) a failure to provide humane services to forensic patients (those whose involvement in the mental health system was triggered by involvement in the criminal justice system).

What are the implications of all of this for forensic mental health professionals and the forensic mental health professions? To answer this, I will first consider the standards of practice as set out by ethical codes of the APA and the American Academy of Psychiatry and Law.

III. FORENSIC PSYCHOLOGY’S AND FORENSIC PSYCHIATRY’S NEED TO BE MORE INVOLVED IN THESE ISSUES

The APA first published an ethical code in 1953. Since then, it has been regularly revised, and the most recent version was published in 2002. In this version, the principle of “Justice” is included in the “General Principles” section:

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their

82 See, e.g., MDRI MEXICO REPORT, supra note 34; Perlin, supra note 3; Perlin & Schriver, supra note 9.
85 See generally ETHICAL STANDARDS OF PSYCHOLOGISTS (AM. PSYCHOL. ASS’N 1953).
expertise do not lead to or condone unjust practices.\textsuperscript{87}

This raises a question we cannot escape: to what extent is this “fairness and justice” principle truly met internationally?\textsuperscript{88}

In an effort to “improve the quality of forensic psychological services offered to individual clients and the legal system and thereby to enhance forensic psychology as a discipline and profession,”\textsuperscript{89} the Committee on Ethical Guidelines for Forensic Psychologists of the APA issued \textit{Specialty Guidelines for Forensic Psychologists} ("Specialty Guidelines") to serve, in part, as “an aspirational model for psychologists acting as experts for [and working in relationship with] the judicial system."\textsuperscript{90} The articulated goals of these guidelines are these:

… to improve the quality of forensic psychological services; enhance the practice and facilitate the systematic development of forensic psychology; encourage a high level of quality in professional practice; and encourage forensic practitioners to acknowledge and respect the rights of those they serve. These Guidelines are intended for use by psychologists when engaged in the practice of forensic psychology as described below and may also provide guidance on professional conduct to the legal system, and other organizations and professions.\textsuperscript{91}

These guidelines cover a wide range of behaviors. For example, the guidelines on “Competence” require that:

Forensic psychologists have an obligation to present to the court, regarding the specific matters to which they will testify, the boundaries of their competence, the factual bases (knowledge, skill, experience, training, and education) for their qualification as an expert, and the relevance of those factual bases to their qualification.

\textsuperscript{87} \textit{Id.} at 4. For an important typology of the different sorts of biases demonstrated by expert witnesses, see generally Ansar M. Haroun & Grant H. Morris, \textit{Weaving a Tangled Web: The Deceptions of Psychiatrists}, 10 J. CONTEMP. LEGAL ISSUES 227 (1999). I characterize this as “a blueprint for understanding the pretextual basis of much expert testimony” in Michael L. Perlin, “Half-Wracked Prejudice Leaped Forth”: Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did, 10 J. CONTEMP. LEGAL ISSUES 3, 27–28 (1999).

\textsuperscript{88} For the most recent ethical guidelines for forensic psychiatrists, see \textit{ETHICS GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY} (AM. ACAD. OF PSYCHIATRY & LAW 2005), http://www.aapl.org/docs/pdf/ETHICSGDLNS.pdf [hereinafter AAPL GUIDELINES].

\textsuperscript{89} Speciality Guidelines, supra note 1, at 655.


\textsuperscript{91} SPECIALITY GUIDELINES, supra note 1.
as an expert on the specific matters at issue.\(^92\)

Guidelines on “Relationships” mandate that:

Forensic psychologists have an obligation to ensure that prospective clients are informed of their legal rights with respect to the anticipated forensic service, of the purposes of any evaluation, of the nature of procedures to be employed, of the intended uses of any product of their services, and of the party who has retained the forensic psychologist.\(^93\)

Finally, in the “Public and Professional Communications” section, the guidelines emphasize that forensic psychologists must be “aware that their own professional observations, inferences, and conclusions must be distinguished from legal facts, opinions, and conclusions.”\(^94\)

The Preamble of the far-briefer Guidelines of the American Academy of Psychiatry and Law (“AAPL Guidelines”) stresses that “[f]orensic psychiatrists] should be bound by underlying ethical principles of respect for persons, honesty, justice, and social responsibility,”\(^95\) and, subsequently, mandates that “[r]espect for the individual’s right of privacy and the maintenance of confidentiality should be major concerns when performing forensic evaluations.”\(^96\) These guidelines, however, are in no way as detailed or as comprehensive as those drafted by AAPL’s psychological counterparts.

In a careful and comprehensive analysis of the forensic mental health assessment procedures, Professor Kirk Heilbrun has identified twenty-nine principles of forensic mental health assessment that he grouped according to whether they were “established” or “emerging.”\(^97\) Heilbrun provides us with a carefully established body of proscriptive and prescriptive rules, and it can be said with confidence that these rules apply to all forensic psychologists who are doing such assessments. The empirical question, though, is not answered: do forensic psychologists and psychiatrists follow

\(^{92}\) Specialty Guidelines, supra note 1, at 658. Dr. Harold Hall questions whether it is possible “for psychologists to perform adversarial evaluations and adhere to the Guidelines, EPPCC and the revised testing standards?” E-mail from Dr. Harold Hall to Michael L. Perlin, Professor Emeritus of Law, New York Law School (Sept. 14, 2016) (on file with author). He believes that they can, presuming “mandatory adherence” to the Guidelines, the EPPCC and the revised standards. Id.

\(^{93}\) Specialty Guidelines, supra note 1, at 659.

\(^{94}\) Id. at 665.

\(^{95}\) AAPL GUIDELINES, supra note 88, at 1.

\(^{96}\) Id.

\(^{97}\) Kirk Heilbrun et al., Pragmatic Psychology, Forensic Mental Health Assessment, and the Case of Thomas Johnson, 10 PSYCHOL. PUB. POL’Y & L. 31, 33 (2004); see KIRK HEILBRUN, PRINCIPLES OF FORENSIC MENTAL HEALTH ASSESSMENT, at vii (Ronald Roesch et al. eds., 2001).
these rules in actual practice? And if no, why not? I believe the reasons for a negative answer (as in so many other areas of law, policy and behavior) can be found in what I refer to as “sanism” and “pretextuality.”

It is particularly nettlesome to see this sanism and pretextuality in practicing forensic psychologists. If there is any cohort that should be sanism-and pretextuality-free, it should be forensic mental health professionals. Sadly, that has not been the case.

I am not entirely pessimistic, however. I believe the solution—or at least a partial solution—can be found in the principles of therapeutic jurisprudence.

IV. SANISM, PRETEXTUALITY, AND THERAPEUTIC JURISPRUDENCE

For the past twenty-five years, I have been writing incessantly about the malignant impact of sanism and of pretextuality: the two corrosive factors that contaminate all mental disability law. What do these phrases mean? Sanism “is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry.” It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based predominantly upon stereotype, myth, superstition, and de-individualization, and is sustained and perpetuated by our use of alleged “ordinary common sense” (“OCS”).

98 See infra notes 102-09 and accompanying text (defining and explaining terms “sanism” and “pretextuality”).


100 On how therapeutic jurisprudence can be a tool to remediate the “willful blindness” often exhibited by both the mental health system and the judiciary in related contexts, see Michael L. Perlin, What Is Therapeutic Jurisprudence?, 10 N.Y.L. SCH. J. HUM. RTS. 623, 629–30 (1993).


and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.  

Pretextuality defines the ways in which courts “accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (and frequently meretricious) decisionmaking, specifically where witnesses, especially expert witnesses, show a high propensity to purposely distort their testimony in order to achieve desired ends.”

This pretextuality is poisonous. It “infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt testifying.”

All aspects of mental disability law are pervaded by sanism and by pretextuality, whether the specific presenting topic is involuntary civil commitment law, right to refuse treatment law, the sexual rights of persons with mental disabilities, or any aspect of the criminal trial process. Together, I believe they help explain the contamination of scholarly discourse and of lawyering practices alike. Unless and until we come to grips with these concepts—and their stranglehold on mental disability law development—any efforts at truly understanding this area of the law, or at understanding the relationship between law and psychology, are doomed to failure.

In other works, I have tackled the question of the relationship between sanism and ethics of the forensic mental health professions (specifically, psychology and psychiatry) in the context of clinical evaluations and court testimony. In that context, I argued that, to a great extent, sanism is a disease of attitudes. We generalize about persons with mental disabilities,
stereotype them, typify them, and “slot” their behavior, and by focusing on alleged “‘differentness,’ we deny their basic humanity and their shared physical, emotional, and spiritual needs.” When we engage in this generalization, we are doing two things:

[W]e are distancing ourselves from mentally disabled persons—the “them” —and we are simultaneously trying to construct an impregnable borderline between “us” and “them,” both to protect ourselves and to dehumanize what Sander Gilman calls “the Other.” The label of “sickness” reassures us that “the Other” —seen as “both ill and infectious, both damaged and damaging” not like us and further animates our “keen . . . desire to separate ‘us’ and ‘them.’”

There is no longer any question that such attitudes infect decision-making by judges and by jurors:

on what grounds should we assume that they are somehow strangely absent in the reports and testimony of experts?

Personal bias appears to be “inescapable”, unless and until we come to grip with its underlying causes. Dr. Joel Dvoskin has perceptively noted, in this context: “[j]udgments about groups of people can only lead to stigma and discrimination, while judgments about individuals if based on reason and information, can lead to better treatment outcomes and increased safety for the individuals and their communities.”

The roots of sanism are deep. From the beginning of recorded history, mental illness has been inextricably linked to sin, evil, God’s punishment, crime, and demons. Evil spirits were commonly relied upon to explain

Stereotypes, Stigma and Sanism, in STEREOTYPES AND HUMAN RIGHTS LAW 95–117 (Eva Brems & Alexandra Timmer eds., 2016).


117 See, e.g., JOHN BIGGS, JR., THE GUILTY MIND: PSYCHIATRY AND THE LAW OF HOMICIDE 26-27 (1967) (explaining that insanity was tied to sin, and a special class of priests were the only people capable of ridding the sinner of his demonic possession); WOLF WOLFENSBERGER ET AL., THE
abnormal behavior. The “face of madness has haunted the imagination of Western man.” People with mental illness were considered beasts; a person who lost his capacity to reason was seen as having lost his claim “to be treated as a human being.”

It goes without saying that this is depressing on multiple levels. Fortunately, I believe there is a remedy that we can embrace. That is one of the most important legal theoretical developments of the past twenty-five plus years—the creation and dynamic growth of therapeutic jurisprudence (“TJ”).

Therapeutic jurisprudence presents a new model for assessing the impact of case law and legislation. As a therapeutic agent, the law can have therapeutic or anti-therapeutic consequences. Therapeutic jurisprudence asks whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential without subordinating due process principles. David Wexler clearly identifies how the inherent

PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES 12-25 (1972) (noting that mental retardation [now, intellectual disability] has often been regarded as the result of sin and God’s punishment). See generally JUDITH S. NEAMAN, SUGGESTION OF THE DEVIL: THE ORIGINS OF MADNESS (1975).

118 See, e.g., Richard Gardner, Mind over Matter?: The Historical Search for Meaningful Parity Between Mental and Physical Health Care Coverage, 49 EMORY L.J. 675, 677 (2000) (stating that “[t]reatment for mental illnesses ranged from exorcism to even more bizarre and often inhumane practices, such as torture or the removal of portions of the skull to allow evil spirits to escape”).


120 Perlin, On “Sanism,” supra note 102, at 388, citing, inter alia, BIGGS, supra note 117; WALTER BROMBERG, FROM SHAMAN TO PSYCHOTHERAPIST: A HISTORY OF THE TREATMENT OF MENTAL ILLNESS 63-64 (1975); MICHAEL S. MOORE, LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP 64-65 (1984); NEAMAN, supra note 117, at 31, 50, and 144.

121 The following section is partially adapted from 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). It also distills the work the author has done on this topic for the past two decades plus, beginning with Michael L. Perlin, What Is Therapeutic Jurisprudence?, supra note 100.


tension of this inquiry must be resolved: the law’s use of “mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns.”

Using TJ, we “look at law as it actually impacts people’s lives” and assess law’s influence on emotional life and psychological well-being.

One governing TJ principle is 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.”

One of the central principles of therapeutic jurisprudence thus is a commitment to dignity. Therapeutic jurisprudence allows us to gain “a new and distinctive perspective utilizing socio-psychological insights into the law and its applications.”

It has been described as “a sea-change in ethical thinking about the role of law…a movement towards a more distinctly relational approach to the practice of law…which emphasises psychological wellness over adversarial

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128 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).


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

After studying the 3Vs in the context of, *inter alia*, forced drugging of incompetent patients, “scarlet letter” punishments, preventing sex offender recidivism, competence to engage in voluntary sexual interaction, granting individuals with mental disability autonomy in legal

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decision making,\textsuperscript{139} and access to problem-solving courts,\textsuperscript{140} I concluded that the adoption of the therapeutic jurisprudence principles set forth above would promote the “true therapeutic process” argued by Professor Ronner. The questions are then: do the behavior of the APA and the continuing inaction of forensic psychologists comport with TJ principles? Does it enhance the likelihood that persons in psychiatric institutions—especially forensic institutions—will be validated, have voice, or feel as if they are acting voluntarily? What, then, can and should forensic psychologists do to remediate this situation? I believe that the answer encompasses requirements on both forensic witnesses and forensic researchers. And the application of international human rights law here—specifically, the CRPD—is entirely consonant with TJ values.\textsuperscript{141}

I add here a personal note. I litigated for thirteen years before I became a law professor—as a Deputy Public Defender and the Director of the New Jersey Division of Mental Health Advocacy. I spent many years as a law professor, directing a clinic in which our students represented persons with mental and physical disabilities. I have also served as a consultant in many forensic cases. In these contexts, I have dealt with dozens and dozens of expert witnesses in matters involving the rights of persons with mental disabilities in individual and class action cases.\textsuperscript{142} I have also done countless

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\item[139] Perlin & Weinstein, supra note 99.
\item[141] See PERLIN, supra note 4, at 215 (“The Convention on the Rights of Persons with Disabilities . . . is a document that resonates with TJ values”). On the relationship between international human rights and therapeutic jurisprudence in general, see Winick, supra note 58, at 572: “the remedy for the abuses in the mental health system of Hungary and other Eastern European nations is a healthy dose of international human rights law and therapeutic jurisprudence.” In a manuscript in progress, I am exploring the relationship between the CRPD, therapeutic jurisprudence and trauma. See Mehgan Gallagher & Michael L. Perlin, “\textit{The Pain I Rise Above}”: How International Human Rights Can Best Realize the Needs of Persons with Trauma-Related Mental Disabilities (on file with author). I also believe the application of international human rights law in this context is entirely consonant with procedural justice values. See Perlin, supra note 8, at 1188. “Procedural justice” asserts that “people’s evaluations of the resolution of a dispute (including matters resolved by the judicial system) are influenced more by their perception of the fairness of the process employed than by their belief regarding whether the ‘right’ outcome was reached.” Thomas L. Hafemeister et al., Forging Links and Renewing Ties: Applying the Principles of Restorative and Procedural Justice to Better Respond to Criminal Offenders with a Mental Disorder, 60 BUFF. L. REV. 147, 200 (2012). On procedural justice in the context of mental disability law, see, e.g., Sumner J. Sydeman et al., Procedural Justice in the Context of Civil Commitment: A Critique of Tyler’s Analysis, 3 PSYCHOL. PUB. POL’Y & L. 207, 216 n.49 (1997).
\end{enumerate}
site-visits to psychiatric institutions and to institutions for persons with intellectual disabilities domestically and internationally. I have taught forensic psychologists and psychiatrists in my multiple mental disability law courses at New York Law School for over thirty years, and continue to teach them now through continuing education programs. I believe these experiences have given me a relatively comprehensive picture of what psychiatric institutions are like, and how forensic mental health professionals in these facilities work. Beginning with the baseline that “human rights—including the underlying value of autonomy—should inform correctional practice and forensic psychology,” these experiences have led me to three major conclusions.

First, I believe that witnesses must take seriously the conditions of the institutions they visit, even if the sole purpose of their visit is to assess committability, competency or insanity. Beyond these examples, I believe that this must be done whether the institution is a civil psychiatric facility, a forensic facility, a jail, or a prison. In coming to their expert conclusions about whether an individual meets the statutory standards for commitment, or whether the individual is competent to stand trial, or whether the individual meets the standards for insanity, or whether the mental status should be raised as a potential mitigating factor in a death penalty case, the witness must consider the impact that institutional conditions have on her ultimate conclusion, and—in the appropriate situation—must address these squarely in her report. My experiences have demonstrated to me that what currently is done by psychologists is insufficient. I thus offer a list of means (by no means exclusive) by which forensic psychologists might ameliorate this state of affairs in a proper way:

19-8 (citing Jackson v. Indiana, 406 U.S. 715 (1972) (applying Due Process Clause to incompetent-to-stand-trial defendants)), resulting in a ruling that the indefinite incarceration of individuals in the Vroom Building (NJ’s maximum security facility for the “criminally insane” violated Jackson, and ordered individual hearings for each inmate. The courts ultimately found that 185 of the 225 patients in that facility were illegally detained). See Michael L. Perlin, “May He Stay Forever Young”: Robert Sadoff and the History of Mental Health Law, 33 J. AM. ACAD. PSYCHIATRY & L. 236, 236-37 (2005).
146 By way of example, for a compendium of proposed principles that provide guidance to correctional system administrators to enable forensic disability clients’ access to available rehabilitation
• Attend trainings on international human rights law and policy;
• Stay abreast of international and regional court interpretations of human rights norms;
• Visit institutional facilities that are largely in compliance with such norms to get a sense as to what institutional behavioral changes are feasible;
• Create “best practice manuals” \(^\text{147}\) for approaches to treating patients in accordance with human rights;
• Become active “whistleblowers” \(^\text{148}\) and report human rights violations to the relevant human rights commissions and NGOs;
• Authentically hold each other accountable to take responsibility for human rights violations;
• Advocate for better outpatient services to provide for the sort of less restrictive treatment alternatives that international law demands; \(^\text{149}\) and
• Self-assess so as to best insure that sanism and pretextsutality do not unduly influence the treatment of forensic patients, and incorporate principles of therapeutic jurisprudence into their daily institutional work, keeping in mind professor Ronner’s “three Vs” of voice, validation and voluntariness. \(^\text{150}\)

Second, forensic psychologists should follow the lead of lawyers and

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147 See, e.g., Risa E. Kaufman, State and Local Commissions as Sites for Domestic Human Rights Implementation, in HUMAN RIGHTS IN THE UNITED STATES: BEYOND EXCEPTIONALISM 89, 101-04 (Shareen Hertel & Kathryn Libal eds., 2011).

148 In a related context, see James Thuo Gathii, Defining the Relationship between Human Rights and Corruption, 31 U. PA. J. INT’L L. 125, 150 (2009), discussing how the United Nations Convention against Corruption requires that states enact whistleblower laws to ensure the protection of those who come forward and expose governmental corruption. The failure to enact such laws leaves “witnesses and victims unprotected [, which] encourages corrupt practices and impunity, and discourages witnesses from fulfilling a public responsibility.” Id. at 150 n.87. On how economically and politically disenfranchised groups—and forensic patients are classic examples of such disenfranchised groups—disproportionately suffer from the effects of corruption, see Id. at 148.


150 See supra text accompanying notes 133-134.
provide pro bono services\textsuperscript{151} to NGOs, disability rights organizations, and other offices that provide legal representation to these populations in systemic law reform litigation, both domestically and internationally. They should also make their services available to groups doing other sorts of institutional law reform.\textsuperscript{152}

Third, researchers should bore down and focus on the conditions of confinement of forensic patients. Consider the range of issues crying out for greater consideration:

- Evaluation of the proposition that it is more cost-effective for governments to provide for outpatient services rather than keep people unnecessarily institutionalized;
- Evaluation of the proposition that treating people in accordance with the principles espoused by therapeutic jurisprudence—focusing again on Professor Ronner’s “three Vs” of voice, validation and voluntariness\textsuperscript{153}—will lead to greater treatment adherence on the part of patients, whether they have been committed voluntarily or involuntarily;
- Analysis of the extent to which state and local departments of mental health adhere to U.S. constitutional and statutory law (in the context both of the Americans with Disabilities Act\textsuperscript{154} and the Supreme Court’s “integration mandate” decision of \textit{Olmstead v. L.C.}\textsuperscript{155}) and international human rights law (in the context of the CRPD)\textsuperscript{156} in providing restoration to competency to stand trial and post-insanity acquittal treatment services in the community, rather than in maximum security forensic hospitals;\textsuperscript{157} and
- Consideration of the extent to which certain forensic decision-

\begin{footnotesize}
\begin{itemize}
\item This includes (but is not limited to) the evaluations of indigent patients, working with lawyers to help them understand psychological nuance, and the conducting of site-visits in institutions.
\item See Ronner, supra note 134, at 94-95.
\item 42 U.S.C. §§ 12101 et seq. (2009).
\item See supra text accompanying notes 44-56.
\item See Perlin, \textit{Misdemeanor Outlaw}, supra note 99, for an outline of this argument.
\end{itemize}
\end{footnotesize}
making reflects the implicit bias\textsuperscript{158} of xenophobia in its refusal to acknowledge the relevance of international human rights law to institutional decision-making.\textsuperscript{159}

I am aware that this is no easy task. Psychologists may be pressured by correctional organizations to engage in practices that violate the APA Ethics Code, in inflicting physical or psychological harm on an offender in the quest to meet organizational requirements for safety and community protection (a schemata in which the organization is the client and the offender is a means to an ends). In such circumstances, the psychologist will have to choose between ethical action (refusing to comply and reporting) or unethical inaction (complying and failing to report).\textsuperscript{160} But I believe that international human rights laws demand a different response.

V. CONCLUSION: A CHALLENGE

The revelations of what happened in Guantanamo Bay and Abu Ghraib led to a sober and careful examination by organized psychology (and psychiatry) into the role of mental health professionals in certain military operations. The denouement of these revelations led to inquiries into the relationship between what some psychologists and psychiatrists did and international human rights standards. Activists, advocates and scholars have, in recent years, been bringing their focus to bear on the relationship between international human rights and how individuals are treated in psychiatric institutions around the world. Ethical codes mandate that forensic psychologists and forensic psychiatrists behave to ensure that they maximize the values of "fairness and justice" in their dealings with clients.\textsuperscript{161} Complicating this entire state of affairs is the contaminating influence of the way that sanism and pretextuality affect professionals’ dealings with persons with mental disabilities.

I titled this subsection of my paper "A challenge," because I believe that all of this does present a challenge to concerned psychologists and psychiatrists whose professional work is connected to what goes on in the


\textsuperscript{159} My special thanks to Meaghan Gallagher, Debbie Dorfman and Naomi Weinstein for many of the thoughts and suggestions in this section of the paper.


\textsuperscript{161} ETHICAL PRINCIPLES, supra note 86, at 4.
legal system. It is a challenge because we must remain vigilant in light of the shock-the-conscience state of so many institutions around the world, and because it is essential that mental health professionals involve themselves in efforts to rectify the violations of international human rights law that are omnipresent in so many of those institutions, especially in those cases where being passive about those violations also violates ethical codes. The disclosures of what happened at Guantanamo Bay and Abu Ghraib have opened a window that will not, and cannot, be closed.

But, I believe we can learn from our mistakes, and take that knowledge and apply it to the issue that is the centerpiece of this paper: the need for organized psychology—especially forensic psychology—to embrace international human rights requirements applicable to the institutionalization of persons with mental disabilities, especially forensic patients. In doing so, organized psychology will take a major step in “strip[ping] bare the sanist façade” of the institutions.

The critic Paul Williams calls The Times They Are A-Changin’ a song that is “generous, evangelical, eager to share the truth with the whole world.” The line that I chose to begin the title of this paper—“Your Old Road Is/ Rapidly Agin”—was a challenge by the then twenty-two-year-old Dylan to authority figures at all levels of society, a challenge he issued in 1963, at one of the most tumultuous times of American history. We face a time of challenge and tumult now. I believe that if we heed Dylan’s challenge, we will be taking a major step in the right direction down a new road.

164 It is also essential that this be done within the context of therapeutic jurisprudence. See Birgden & Perlin, supra note 12 (noting how little attention has been paid to the impact of therapeutic jurisprudence on questions of international human rights law and the role of forensic psychologists).