“YONDER STANDS YOUR ORPHAN WITH HIS GUN”: THE INTERNATIONAL HUMAN RIGHTS AND THERAPEUTIC JURISPRUDENCE IMPLICATIONS OF JUVENILE PUNISHMENT SCHEMES

Professor Michael L. Perlin*

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* Director, International Mental Disability Law Reform Project; Director, Online Mental Disability Law Program. The author wishes to thank Alison Lynch for her excellent research assistance.
I. INTRODUCTION

In the last decade, the United States Supreme Court has ruled that the death penalty, a life sentence without the possibility of parole (LWOP), and mandatory LWOP for homicide convictions violate the Eighth Amendment in the cases of juvenile defendants.1 These decisions were premised, in large part, on findings that “developments in psychology and brain science continue to show fundamental differences between juvenile and adult minds,”2 and that those findings both lessened a child’s “moral culpability” and enhanced the prospect that, as the years go by and neurological development occurs, his “deficiencies will be reformed.”3

The Court’s rulings in these cases—Roper, Graham, and Miller—have, by and large, been welcomed by juvenile justice advocates4 as “game-changing” landmarks,5 and as reflecting “a positive result for juvenile

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3. Miller, 132 S. Ct. at 2464–65; Graham, 130 S. Ct. at 2027 (quoting Roper, 543 U.S. at 570) (internal quotation marks omitted).


None of these changes, however, speaks directly to the case of the juvenile with mental illness or intellectual disabilities who is incarcerated in either an adult or juvenile facility for a lesser crime, or for a less severe sentence than LWOP. Such incarceration, in many instances, violates international human rights law and may violate the Eighth Amendment as well.

In its juvenile death penalty and LWOP cases, the Supreme Court stressed that international law supported its decisions. Consider Justice Kennedy’s language for the majority in *Roper*:

Our determination that the death penalty is disproportionate punishment for offenders under 18 finds confirmation in the stark reality that the United States is the only country in the world that continues to give official sanction to the juvenile death penalty. This reality does not become controlling, for the task of interpreting the Eighth Amendment remains our responsibility. Yet at least from the time of the Court’s decision in *Trop v. Dulles*, 356 U.S. 86 (1958), the Court has referred to the laws of other countries and to international authorities as instructive for its interpretation of the Eighth Amendment’s prohibition of “cruel and unusual punishments.” 356 U.S., at 102–03 (plurality opinion) (“The civilized nations of the world are in virtual unanimity that statelessness is not to be imposed as punishment for crime”); *see also Atkins*, supra, at 317, n. 21 (recognizing that “within the world community, the imposition of the death penalty for crimes committed by mentally retarded offenders is overwhelmingly disapproved”); *Thompson v. Oklahoma*, 487 U.S. 815 (1988), 830–31, and n. 31 [(1988)] (plurality opinion) (noting the abolition of the juvenile death penalty “by other nations that share our Anglo-American heritage, and by the leading members of the Western European community,” and observing that “[w]e have previously recognized the relevance of the views of the international community in determining whether a punishment is cruel and unusual”). . . .

After *Roper* was decided, scholars and advocates were quick to point out that this rationale would apply equally to LWOP sentences for
juveniles. In one post-Graham analysis—concluding that the Graham decision must “compel system-wide adherence and attention to its principles of difference and its expressed commitment to affording youth offenders a second chance at freedom, citizenship, and life”—the author stressed that “compliance with Graham would entail a far more transformative project than simply revising sentencing rules.” Another post-Graham analysis focused on the Court’s “greater willingness to consider international human rights standards and practices when assessing sentencing practices within the United States.” An article written after Miller speculated that “the Miller and Graham decisions may suggest a new willingness to expand the Eighth Amendment doctrine.”

Again, in the wake of Roper, commentators argued that LWOP in murder cases violated international human rights (IHR) standards. In the wake of Graham, commentators argued that LWOP in any case violated such standards. Although the Supreme Court, in these decisions, has endorsed such positions, it has not yet had the opportunity to consider the IHR implications of either (1) the routine housing of juveniles in adult jails and prisons or (2) the disproportionate number of incarcerated juveniles—


10. Beth Caldwell, Twenty-Five to Life for Adolescent Mistakes: Juvenile Strikes as Cruel and Unusual Punishment, 46 U.S.F. L. REV. 581, 599 (2012) (arguing that “three strikes” laws, as applied to juveniles, were unconstitutional following Graham).


both in juvenile and in adult correctional facilities—with mental disabilities. In 2008, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) was ratified. The Disability Convention “furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in most aspects of life,” calling for “[r] espect for inherent dignity” and “[r] non-discrimination.” Subsequent articles declare “freedom from torture or cruel, inhuman or degrading treatment or punishment,” “freedom from exploitation, violence and abuse,” and a right to protection of the “integrity of the person.”

The Supreme Court has not yet had the occasion to consider the significance of the CRPD. In Graham, however, the Court did note that LWOP violated the United Nations (UN) Convention on the Rights of the Child (CRC), a convention signed by every UN member except for the United States and Somalia. So, failure to ratify in no way stops the Court from considering the CRPD in subsequent litigation.

15. See, e.g., Simone S. Hicks, Note, Behind Prison Walls: The Failing Treatment Choice for Mentally Ill Minority Youth, 39 Hofstra L. Rev. 979, 982–83 (2011) (stating that it has been estimated that 50%–75% of all incarcerated juveniles have mental disabilities); see generally infra Part II (discussing the alarming number of incarcerated juveniles with mental disabilities).


This Article will explore the relationship between the incarceration of juveniles with mental disabilities and international human rights law, especially the CRPD, and will conclude that our current system of warehousing juveniles with mental illnesses in juvenile detention facilities and reformatories and in prisons following pre-adjudication transfers violates international human rights law, including, but not limited to, the CRC and the CRPD. This Article will first consider the data available as to the mental statuses of incarcerated juveniles, with special attention to issues of race and gender. It will next consider the conditions of confinement faced by such juveniles, looking at how jails and detention facilities are increasingly relied upon to provide mental health services—albeit meager and often counterproductive—and how this reliance has created a deficiency that is exacerbated by current transfer and waiver policies. It will then review the important international human rights documents that apply to the questions under discussion. Finally, it will consider all of these issues through the prism of therapeutic jurisprudence, with an eye towards some specific remedies that might, optimally, ameliorate the situation with which we are faced. In this context, I will also look at

We also note, as petitioner and his amici emphasize, that Article 37(a) of the United Nations Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 2, 1990), ratified by every nation except the United States and Somalia, prohibits the imposition of ‘life imprisonment without possibility of release . . . for offences committed by persons below eighteen years of age.


22. See infra Part II.

23. See infra Part III.

24. See infra Part IV.

25. See infra Part V.
issues raised by considerations of the quality of counsel made available to such juveniles.26

The title of this article is drawn, in part, from Bob Dylan’s epic song, It’s All Over Now, Baby Blue. The first verse includes the key language:

You must leave now, take what you need, you think will last
But whatever you wish to keep, you better grab it fast
Yonder stands your orphan with his gun
Crying like a fire in the sun
Look out the saints are comin’ through
And it’s all over now, Baby Blue.27

The song—capturing the sadness of one “with tears that would burn a hole within the largest star”28—tells us that we must be willing to “jettison . . . [our] own identity.”29 My sense is that it is the perfect description of what I am discussing in this paper.

II. THE MENTAL STATUS OF INCARCERATED JUVENILES

A. Introduction

As the evidence demonstrates, the number of incarcerated juveniles with mental disorders is alarming and is disproportionate to the juvenile population as a whole. This disproportion is exacerbated when controlled for race, gender, or family stability. Finally, this population of incarcerated juveniles is inflated by the failure of the criminal justice system to properly apply the laws that govern determinations of incompetency status, the insanity defense, and Miranda waivers for this population.

B. Juveniles in Detention Facilities, Jails, and Prisons30

“Youths in the justice system are at high risk for mental health problems that may have contributed to illegal behavior.”31 The research of

26. See infra Part V.C.
27. Bob Dylan, It’s All Over Now Baby Blue, on Bringing It Back Home (Columbia Records 1965).
Dr. Linda Teplin and her colleagues reveal that nearly 60% of male juvenile detainees and more than two-thirds of female detainees meet diagnostic criteria for one or more psychiatric disorders, and that these findings may underestimate the true prevalence of these disorders—in part, because of commonly underreported symptoms and impairments, especially in cases of disruptive behavioral disorders.\textsuperscript{32} If undetected learning disabilities are included, the prevalence rate climbs to at least 80%.\textsuperscript{33} Juveniles with intellectual disabilities may be overrepresented in such facilities by a factor of five.\textsuperscript{34} Prevalence rates for affective disorders range from 30% to 75% in the various studies,\textsuperscript{35} nearly half suffered from severe or moderate depression.\textsuperscript{36} A Chicago study revealed that 79.7% of detained juveniles were found to have at least one mental disorder, a percentage characterized

\textsuperscript{31} Gail A. Wasserman et al., \textit{The Voice DISC-IV with Incarcerated Male Youths: Prevalence of Disorder}, 41 J. AM. ACAD. CHILD & ADOLESCENTS PSYCHIATRY 314, 314 (2002).


\textsuperscript{33} Michael L. Perlin, “\textit{Simplify You, Classify You}”: Stigma, Stereotypes and Civil Rights in Disability Classification Systems, 25 GA. ST. U. L. REV. 607, 625 (2009). Beyond the scope of this Article are the circumstances specific to juveniles with substance abuse disorders. The research clearly demonstrates that juveniles with a substance use disorder, with or without co-occurring disorders, were at greater risk for escalations in offense seriousness over time. \textit{See, e.g., Olivier Collins et al., Psychiatric Disorder in Detained Male Adolescents as Risk Factor for Serious Recidivism}, 56 LA REVUE CANADIENNE DE PSYCHIATRIE 44 (2011); Machteld Hoeve et al., \textit{The Influence of Mental Health Disorders on Severity of Reoffending in Juveniles}, 40 CRIM. JUST. & BEHAV. 289 (2013).


\textsuperscript{35} THOMAS GRISSO, \textit{FORENSIC EVALUATION OF JUVENILES} 32 (1998) (citing research reported in R. Otto et al., \textit{Prevalence of Mental Disorders Among Youth in the Juvenile Justice System}, in \textit{RESPONDING TO THE MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM} 8 (J. Cocozza ed., 1992)).

by one researcher as “staggering.” At the lower end, there is no dispute that in any studied cohort, at least 20% of these disorders involve a “serious mental illness.”

Such juveniles also have higher rates of physical injuries. Seventy percent of juveniles being held in juvenile facilities “for mental health purposes” in California have made suicide attempts. In at least one state system, over half of incarcerated juveniles meet the full or partial criteria for Post Traumatic Stress Disorder (PTSD).

These statistics should not be a surprise, given what we know about prevalence rates in adults in jail and prison settings. It is estimated that 15% of male adults in prisons and jails have a mental illness, as do 31% of female adults, a rate of two to four times that of the general population.


39. Theresa A. Hughes, Juvenile Delinquent Rehabilitation: Placement of Juveniles Beyond Their Communities as a Deterrent to Inner-City Youths, 36 NEW ENG. L. REV. 153, 164 (2001). Juveniles housed in adult prisons have a significantly higher suicide risk than those in all-juvenile facilities. Jennifer L. Boothby, Contemporary United States Corrections, Mental Health, and Social Policy, in CORRECTIONS, MENTAL HEALTH, AND SOCIAL POLICY: INTERNATIONAL PERSPECTIVES 41, 44 (Robert K. Ax & Thomas J. Fagan eds., 2007). This data becomes especially important in the context of what we know about the outcomes of transfer and waiver decisions. See infra text accompanying notes 100–13.

40. Corbit, supra note 38, at 82; see Albert R. Roberts & Kimberley Bender, Overcoming Sisyphus: Effective Prediction of Mental Health Disorders and Recidivism Among Delinquents, 70 FED. PROBATION 19, 19–20; see generally John M. Memory, Juvenile Suicides in Secure Detention Facilities: Correction of Published Rates, 13 DEATH STUDIES 455 (1989) (providing an earlier archival study).


43. See Linda A. Teplin, The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program, 80 AM. J. PUB. HEALTH 663, 664–65 (1990); see also Jamie Fellner, A Corrections Quandary: Mental Illness and Prison Rules, 41 HARV. C.R.-C.L. L. REV. 391, 391–95 (2006); William E. Narrow et al., Revised Prevalence Estimates of Mental Disorders in the United States, 59 ARCHIVES OF GEN. PSYCHIATRY 115, 118–22 (2002); Michael L. Perlin, “Wisdom Is Thrown into Jail”: Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness, 18 MICH. St. U. J.L. & MED. (forthcoming 2013) (manuscript at 5 n.12) (discussing the implications of these findings); Christina Canales, Note, Prisons: The New Mental Health System, 44 CONN. L. REV. 1725 (2012); sources cited supra note 42; see generally Jacqueline Buffington-Vollum, Mental Illness and the Criminal Justice System, in FLAWED
There is little doubt that, just as (depending on where one lives) Rikers Island, the Cook County House of Detention, or the Los Angeles County Jail could be characterized as the “nation’s largest mental institution”, policymakers are aware “that the juvenile justice system is becoming a de facto dumping ground for youth with mental health issues.”

C. Issues of Gender

As noted earlier, the disorder rate for female detainees and inmates is significantly higher than for males, and thus, females demonstrate an “elevated risk” for psychiatric disorders. Significantly more females (56.5%) than males (45.9%) met criteria for two or more psychiatric and related disorders, and females have a significantly higher prevalence of PTSD.

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44. See, e.g., Gregory L. Acquaviva, Comment, Mental Health Courts: No Longer Experimental, 36 SETON HALL L. REV. 971, 978 (2006) (observing that, “in 1992, the Los Angeles County jail became the nation’s largest mental institution, with Cook County Jail, Illinois, and Riker’s Island, New York, as second and third respectively” (footnote omitted)). Judges concur with this finding. See Stephen S. Goss, Mental Health Court Programs in Rural and Nonaffluent Jurisdictions, 33 CRIM. JUST. REV. 405, 405 (2008) (“Our jails have become the de facto mental health treatment centers for many persons . . . .”).


46. See Teplin et al., Psychiatric Disorders in Youth in Juvenile Detention, supra note 32, at 1138 (“Females had higher rates than males of many psychiatric disorders, including major depressive episode[s] and some anxiety disorders . . . .”).

47. See Gail A. Wasserman et al., Gender Difference in Psychiatric Disorders at Juvenile Probation Intake, 95 AM. J. PUB. HEALTH 131, 135–36 (2005) (discussing a sampling of individuals studied at probation intake); see also Stephane M. Shepherd et al., Gender and Ethnicity in Juvenile Risk Assessment, 40 CRIM. JUST. & BEHAV. 388 (2013).

48. This included major depressive, dysthymic, manic, psychotic, panic, separation anxiety, overanxious, generalized anxiety, obsessive-compulsive, ADHD, conduct, oppositional defiant, alcohol, marijuana, and other substance disorders. See Garascia, supra note 36, at 506 (citing Karen M. Abram et al., Comorbid Psychiatric Disorders in Youth in Juvenile Detention, 60 ARCHIVES GEN. PSYCHIATRY 1097, 1099 (2003)); see also Gina Vincent et al., Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSJ-2 National Meta-Analysis, 47 J. AM. ACAD. CHILD & ADOLESC. PSYCHIATRY 282 (2008) (showing that sexual differences in mental health symptoms of youth in the juvenile justice system are “even larger” than statistics imply).

49. FORD ET AL., supra note 41, at 2 (finding a 49% prevalence rate for girls, as compared to 32% for boys).
D. Issues of Race

The “disproportionate minority representation” in juvenile detention facilities has especially pernicious impacts on the questions addressed here, and minority youth are also “disproportionately represented among youth with mental health issues.” This must be considered in the context of data showing that “minority youth are more likely than whites to be arrested and detained for the same charges, twice as likely to be held in secure pretrial confinement, and once securely detained, are confined for longer periods of time than white youth.” Although there is some evidence that, for certain disorders, there are higher prevalence rates among non-Hispanic white youths, at the least, two-thirds of black youths and 70% of Hispanic youths present significant psychiatric disorders. “The significant levels of unmet mental health needs” are particularly significant in this cohort.

E. Impact of Broken Homes

There is no question that the impact of stressors such as broken homes contributes significantly to incidences of juvenile delinquency. “The United States Office of the Surgeon General has identified ‘broken homes’ and ‘separation from parents’ as risk factors for juvenile delinquency”; this recognition indicates the propensity of children from broken homes to

50. Tamar R. Birchead, The Age of the Child: Interrogating Juveniles After Roper v. Simmons, 65 WASH. & LEE L. REV. 385, 448 (2008); see also Shepherd et al., supra note 47; Corbit, supra note 38, at 77 (stating “minority youth are only one-third of the U.S. adolescent population, yet they account for two-thirds of incarcerated adolescents”); see generally Kristin Henning, Criminalizing Normal Adolescent Behavior in Communities of Color: The Role of Prosecutors in Juvenile Justice Reform, 98 CORNELL L. REV. 383 (2013) (highlighting the disparity among incarcerated individuals that are part of minority groups).

51. Hicks, supra note 15, at 982.

52. Conward, supra note 32, at 2454.

53. See Teplin et al., Psychiatric Disorders in Youth in Juvenile Detention, supra note 32, at 1138.

54. GRISSO, FORENSIC EVALUATION OF JUVENILES, supra note 35, at 10.

55. Henning, supra note 50, at 451; see Debra Srebnik et al., Help-Seeking Pathways for Children and Adolescents, 4 J. EMOTIONAL & BEHAV. DISORDERS 210 (1996) (describing how the unmet needs of juveniles differ from those of adults).

56. See, e.g., DAVID P. FARRINGTON & BRANDON C. WELSH, SAVING CHILDREN FROM A LIFE OF CRIME: EARLY RISK FACTORS AND EFFECTIVE INTERVENTIONS 68–69 (2007). Astonishingly, a survey has revealed that 20% of parents of children with serious mental disorders have been told by authorities that they must relinquish custody to either the child welfare system or juvenile justice system in an effort to obtain intensive mental health services for their children. Scott Nolen, Adolescent Mental Health and Justice for Youth, 7 WHITTIER J. CHILD. & FAM. ADVOC. 189, 224 (2008).

commit violent acts significantly more frequently than those who do not have such backgrounds. By way of example, an Australian study showed “that children were ten to fifteen percent more likely to commit crimes” if they came from “broken homes” than from “intact families.” Male delinquents are significantly more likely to come from broken homes than male youths in the general population.

F. Relationship with Substantive and Procedural Criminal Law

In a recent article, I discussed how the past thirty years have seen a cluster of changes to criminal procedure (via statute and judicial decisions, both leading to changes in practice) that, “in the aggregate, make the use of an insanity defense or the raising of a mental status issue a much less attractive option to the defendant than ever before.” As part of my inquiry into this topic, I considered

- The narrowing of the insanity defense;
- The constitutional sanctioning of lengths of commitment for insanity acquittees that are far longer than the maximum sentences for the underlying charged offenses;
- Supreme Court decisions making it less likely that jurors will accept the insanity defense;
- The extended sentences faced by defendants who unsuccessfully raise the insanity defense; and
- The failure of most states to comply with the now forty-year-old mandate of *Jackson v. Indiana*, barring, on paper at least, the indeterminate commitment in maximum security forensic facilities of defendants who are not likely to regain their competency to stand trial in the foreseeable future.

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When we look collaterally at these issues in the context of juveniles with mental disabilities charged with crimes, some evidence emerges. It is clear that the criminal justice system has not made substantial efforts to clarify the application of incompetency status to juveniles awaiting trial, a question that, according to Professor Thomas Grisso, remains “almost entirely unexplored and unspecified in most jurisdictions.” In other research, Professor Grisso and his colleagues have found that juveniles under the age of fifteen tended to perform at a level of impairment consistent with that of adults who have been found incompetent to stand trial. In some states, determinations of juveniles’ competencies are precluded by the prohibition of “mental health evaluations prior to the entry of delinquency adjudications.” In others, however, courts have mandated appropriate treatment for juveniles found incompetent to stand trial, but “[l]ittle is known about the nature of [the] treatment” such juveniles actually receive.

Further, not all states allow juveniles to raise the insanity defense, an issue of significant importance as “evidence continues to accumulate that the juvenile justice system is generally failing in its primary, articulated


64. GRISSO, DOUBLE JEOPARDY, supra note 32, at 170. Professor Grisso and a colleague, working with the National Youth Screening and Assessment Project, have crafted model statutes to be used in the determination of competency to stand trial in juvenile proceedings, but there is no evidence that any states have adopted their sound suggestions. See generally KIMBERLY LARSON & THOMAS GRISSO, DEVELOPING STATUTES FOR COMPETENCE TO STAND TRIAL IN JUVENILE DELINQUENCY PROCEEDINGS: A GUIDE FOR LAWMAKERS (2011), available at http://modelsforchange.net/publications/330 (providing an example of statutory language to aid states in determining whether a juvenile is competent to stand trial).


68. GRISSO, DOUBLE JEOPARDY, supra note 32, at 170; see Annette Christy et al., Juveniles Evaluated Incompetent to Proceed: Characteristics and Quality of Mental Health Professionals’ Evaluations, 35 PROF. PSYCHOL.: RES. & PRAC. 380, 386–87 (2004) (discussing the quality of expert evaluations in cases in which concerns exist regarding a juvenile’s competency to stand trial); Jodi L. Vlijoen et al., Defense Attorneys’ Concerns About the Competence of Adolescent Defendants, 28 BEHAV. SCI. & L. 630 (2010) (explaining the role of counsel when concerns are raised about a juvenile’s competence to stand trial).

rehabilitative goals.”70 Again, Professor Grisso points out that “most juvenile justice jurisdictions have never seen an insanity defense . . . . Either the relevance of the insanity defense has not been discovered by the juvenile court, or it has simply been deemed unnecessary.”71

Another issue that must be considered is how *Miranda* waiver must be contextualized in cases involving juveniles.72 Again, Professor Grisso’s research is essential:

As a class, juveniles of ages 14 and below demonstrate incompetence to waive their rights to silence and legal counsel. This conclusion is generally supported across measures of both understanding and perception in our studies, and in relation to both absolute and relative (adult norm) standards.

As a class, juveniles of ages 15 and 16 who have IQ scores of 80 or below lack the requisite competence to waive their rights to silence and counsel.

About one-third to one-half of juveniles 15 and 16 years of age with IQ scores above 80 lack the requisite competence to waive their rights when competence is defined by absolute standards (that is, the satisfaction of scoring criteria for adequate understanding). As a class, however, this group demonstrates a level of understanding and perception similar to that of 17–21-year-old adults for whom the competence to waive rights is presumed in law.73

This evidence—later supported by independent empirical studies74 that remain “uncontroverted”75—led Professor Grisso to call for a per se
exclusionary rule for *Miranda* waivers by juveniles.\textsuperscript{76} And, as Professor Mary Berkheiser has perceptively noted, the evidence is “particularly disturbing when viewed in light of the disproportionate number of juveniles adjudicated delinquent who have been diagnosed as learning disabled.”\textsuperscript{77}

When taken together, the evidence as to incompetency, insanity and *Miranda* waivers paints a troubling picture. Because the criminal justice system ignores the fact that juveniles may not be competent to stand trial and the fact that they may not be criminally responsible, their opportunities for diversion to mental health facilities are diminished.\textsuperscript{78} Because the system, in large part, shuts its eyes to the meaninglessness of *Miranda* waivers (and subsequently countenances the conviction of confessing juveniles), even more juveniles wind up in long-term detention facilities.\textsuperscript{79} When added to the data reported on above, the results are especially toxic.\textsuperscript{80}

### III. CONDITIONS OF CONFINEMENT

#### A. Introduction

Given the bleak picture just painted, it is necessary to consider a cohort of related questions whose significance is magnified by data as to the relationship between mental disorder and juvenile incarceration.\textsuperscript{81} In this section, I will consider the conditions of confinement in the juvenile detention system in general, and will look more specifically at the ways in which the treatment interventions offered may be anti-therapeutic, at the implications of reliance on jails and prisons as mental health facilities, and at the impact of transfer and waiver rules on this population.\textsuperscript{82}

#### B. Conditions in General

Over thirty years ago, Jane Knitzer, one of the nation’s most prominent children’s advocates, reported that the needs of children with mental disorders in the juvenile justice system were largely neglected and


\textsuperscript{78} See *supra* notes 64–66 and accompanying text.

\textsuperscript{79} See *supra* notes 72–75 and accompanying text.

\textsuperscript{80} See *supra* notes 33–41 and accompanying text.

\textsuperscript{81} See *supra* notes 71, 78 and accompanying text.

\textsuperscript{82} See *infra* Part III.B–D.
ignored, a judgment echoed a decade later by Joseph Cocozza, who noted ruefully that “the situation had not changed.” Revisiting this issue a decade ago, Mark Soler concluded that, by and large, the entire range of problems—poor assessment, meager treatment, inadequate training, and dangerous institutions—still remained.

None of the research reported upon in the past decade gives us any hope that there has been any significant amelioration. “[M]ost states are barely able to ensure the physical safety of their juvenile inmates”; “inhumane conditions of confinement . . . and inadequate rehabilitative services” are still common. “[P]unishment, retribution, and a tolerance of harsh conditions of confinement” are still the indicia of most juvenile justice detention facilities. Little has changed in the fourteen years since Professor Barry Feld concluded that “[c]riminological research, judicial opinions, and investigative studies report staff beatings of inmates, the use of medications for social control purposes, extensive reliance on solitary confinement, and a virtual absence of meaningful rehabilitative programs.”

Some of the data is nearly unbelievable. Professor Douglas Abrams reported on findings at the Oakley Training School and the Columbia Training School, both in Mississippi:

The Justice Department found that children at Oakley and Columbia were hog-tied, pole-shackled, locked in mechanical restraints and isolation units, and routinely assaulted by staff. . . . Pole-shackled children had

88. Sussman, supra note 9, at 389.
their hands and legs handcuffed around a utility pole for hours while other youths performed military drills around them.

Oakley and Columbia staff also regularly sprayed children with potentially lethal oleoresin capiscum (OC) pepper spray as punishment for minor infractions when no safety risks existed. . . .

The Justice Department found that guards sometimes stripped suicidal girls naked and hog-tied them in Columbia’s “dark room,” where they were held for three days to a week. The room was a locked, windowless isolation cell with nothing but a drain in the floor through which the girls urinated and defecated but which they could not flush. . . . Staff sometimes used restraint chairs for punishment, sometimes hog-tied the girls, and sometimes used OC spray on them for minor misbehavior. The girls were often denied water, personal hygiene items, bathroom facilities, and sufficient mental health care, even though many of the girls suffered from forms of mental disorders, particularly separation anxiety disorder.

Girls reported being forced to eat their own vomit if they threw up while exercising in the hot sun. Youths recommitted to Oakley were taken to an isolation room and punched and slapped by staff as punishment. Staff confirmed that one counselor choked a boy, and another boy reported that a staff member had shoved his head into a toilet. . . .

At both institutions, youths with mental health conditions received only “haphazard and cursory” treatment, and many youths were denied the psychiatric medications they had previously taken. Rather than receiving counseling, rehabilitative treatment, and education, suicidal youths were kept, sometimes naked, on the concrete floor of bare isolation cells with no mattresses during the day. Justice Department consultants observed a thirteen-year-old boy sitting in the restraint chair near the control room at Oakley, reportedly to prevent self-mutilation. Family members had severely sexually abused the boy, who had been in several psychiatric hospitals. As described in the report:

No staff approached him, and he was not allowed to attend school or receive programming, counseling, or medication. . . . Just before our arrival, he had been locked naked in his empty cell. His cell smelled of urine, and we observed torn pieces of toilet paper on the concrete floor that he had been using as a pillow.90

Professor Beth Caldwell’s observation that “[c]onditions of confinement in juvenile detention facilities are troubling from a human rights perspective as well” must be considered in light of data such as that reported by Professor Abrams.91

C. Anti-Therapeutic Medical Interventions

What treatment that is offered is often anti-therapeutic. Professor Angela Burton’s comprehensive review documents how juveniles are overly medicated through the use of “indiscriminate and unchecked” psychotropic medications.92 Professor Abrams reports on a juvenile judge in Florida complaining that some of the incarcerated youths who appeared before him in court seemed to be “sort of in a semicoma.”93 Thomas Grisso underscores the issue: “Providing . . . clinical treatment that does not have a clear necessity, purpose, and potential benefit incurs risks of harm without adequate justification.”94

Professor Thomas Hafemeister has called for the implementation of an affirmative right to mental health treatment for all detained juvenile offenders,95 but it is clear that this has not happened in the near-decade since he articulated the foundations of this right.96 A significant number of incarcerated juveniles simply receive no mental health treatment.97

91. Caldwell, Punishment v. Restoration: A Comparative Analysis of Juvenile Delinquency Law in the United States and Mexico, supra note 14, at 134; see generally infra Part IV.
92. Angela Olivia Burton, “They Use It Like Candy”: How The Prescription of Psychotropic Drugs to State-Involved Children Violates International Law, 35 BROOK. J. INT’L L. 453, 512 (2010); see also Sussman, supra note 9, at 401; Ashley A. Norton, Note, The Captive Mind: Antipsychotics as Chemical Restraint in Juvenile Detention, 29 J. CONTEMP. HEALTH L. & POL’Y 152, 153–54 (2012); see generally infra Part IV (discussing the international human rights implications of these practices). On racial disparities in drug use in the related context of foster care, see Susan dosReis et al., Antipsychotic Treatment Among Youth in Foster Care, 128 PEDIATRICS 1459 (2011).
94. GRISSO, FORENSIC EVALUATION OF JUVENILES, supra note 35, at 130.
jurisdictions, there is no mental health screening at all. The majority of juvenile detention centers have retained juveniles with mental disabilities “because there was nowhere else for them to go.” But again, the juvenile justice system has become “a de facto dumping ground for youth with mental health issues,” a problem exacerbated by the reality that the mental health service and treatment needs of juveniles will grow while they are incarcerated.

D. Transfers

All of this is exacerbated by our juvenile waiver and transfer policies, policies that have “profound” consequences. In all states, special proceedings are available to transfer youth under the usual age threshold from juvenile to criminal court. Judicial transfers require a hearing and findings as to the juvenile’s “dangerousness” and “amenability to treatment.” Statutory exclusion transfers and prosecutorial discretion transfers rarely include any consideration of the juvenile’s psychological characteristics or mental state. Such transfers are often pretextual.

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98. See Sussman, supra note 9, at 400 (“Many juvenile justice facilities routinely fail to conduct the necessary mental health screenings, even when such screenings are mandated by state law. Over half of youth offenders are in facilities that do not screen all residents; 64% of facilities do not use standardized mental health assessments; and very few facilities adapt their assessments to the variation in needs accompanying increased system penetration or screen for trauma-related symptoms. And when mental health screenings are conducted, it is often ‘in a haphazard fashion or by untrained staff.’” (quoting Richard A. Mendel, Annie E. Casey Found., No Place for Kids: The Case for Reducing Juvenile Incarceration 24 (2011)) (footnotes omitted)).


100. Garascia, supra note 36, at 504; see also Sally Terry Green, Realistic Opportunity for Release Equals Rehabilitation: How the States Must Provide Meaningful Opportunity for Release, 16 Berkeley J. Crim. L. 1, 2 (2011) (discussing how Graham might support a finding of a right to rehabilitation in the juvenile justice system).

101. Compare Sussman, supra note 9, at 395, with Youngberg v. Romeo, 457 U.S. 307, 327 (1982) (Blackmun, J., concurring) (“[I]t would be consistent with the Court’s reasoning today to include within the ‘minimally adequate training required by the Constitution,’ such training as is reasonably necessary to prevent a person’s pre-existing self-care skills from deteriorating because of his commitment.” (citation omitted)); see also Perlman, Mental Disability Law: Civil and Criminal, supra note 66, § 3A-9.9, at 106–08 (discussing the significance of the concurring opinion in Youngberg).


104. Grisso, Forensic Evaluation of Juveniles, supra note 35, at 192. Although judicial waiver is generally less problematic than prosecutorially initiated waiver, judicial waiver “can have the same constitutional concerns as statutory or prosecutorial waiver.” See Jennifer Park, Balancing Rehabilitation and Punishment: A Legislative Solution for Unconstitutional Juvenile Waiver Policies, 76 Geo. Wash. L. Rev. 786, 802 (2008).

105. Grisso, Forensic Evaluation of Juveniles, supra note 35, at 192–93; see also Vanessa L. Kolbe, A Cloudy Crystal Ball: Concerns Regarding the Use of Juvenile Psychopathy Scores in Judicial
There is little question that these policies were implemented and expanded as part of the “get tough” policies of the punitive juvenile justice system.107 The principal focus of waivers based on prosecutorial discretion and automatic transfer emphasizes the crime committed to the near exclusion of consideration of the juvenile who transgresses.108 And there is little question, again quoting Grisso, that “transferring youths with mental disorders to the criminal justice system is almost certain to provide some volume of cases in which the justice system fails to provide treatment in the interest of long-range public safety.”109

The most comprehensive aggregate analysis of transfer policies yields three findings:

First, transfer appears to be counterproductive: transferred youths are more likely to reoffend, and to reoffend more quickly and more often, than those retained in the juvenile justice system. In addition, research suggests that the differential effects of criminal and juvenile justice processing are not dependent on sentence type or sentence length. That is, the mere fact that juveniles have been convicted in criminal rather than juvenile court increases the likelihood that they will reoffend. Finally, the risk of reoffending is aggravated when a sentence of incarceration is imposed.110

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107. Feld, The Transformation of the Juvenile Court—Part II: Race and the “Crack Down” on Youth Crime, supra note 89, at 345, 361.
108. See Barry C. Feld, Juvenile Transfer, 3 CRIMINOLOGY & PUB. POL’Y 599, 602 (2004); see, e.g., Perry L. Morencre, Combating the Color-Coded Confinement of Kids: An Equal Protection Remedy, 32 N.Y.U. REV. L. & SOC. CHANGE 285, 306 (2008) (“[T]he decision to waive a juvenile to adult court is often based as much on the attributes of the offender as it is on the attributes of the offense.”). Remarkably, no state has yet reexamined its transfer and waiver policy in the context of racial and ethnic disparities. See Mark Soher, Missed Opportunity: Waiver, Race, Data, and Policy Reform, 71 LA. L. REV. 17, 17 (2010).
110. Donna Bishop & Charles Frazier, Consequences of Transfer, in THE CHANGING BORDERS, supra note 103, at 261 (citation omitted) (referencing, inter alia, Jeffrey Fagan, The Comparative Advantage of Juvenile Versus Criminal Court Sanctions on Recidivism Among Adolescent
Consider these empirical findings: Juveniles incarcerated in adult institutions are “5 times more likely to be sexually assaulted, twice as likely to be beaten by staff, and 50% more likely to be attacked with a weapon than youth in juvenile facilities.”\textsuperscript{111} These conditions may be especially damaging for youths with mental disorders, who are almost eight times more likely to commit suicide in adult jails than in juvenile institutions.\textsuperscript{112}

In short, conditions faced by juveniles in detention and incarceration in adult facilities are dangerous, damaging, and life-threatening.\textsuperscript{113}

IV. INTERNATIONAL HUMAN RIGHTS LAW

A. Introduction

There is a rich body of literature that discusses the intersection between international human rights law and the Supreme Court’s death penalty and LWOP decisions as they apply to juveniles.\textsuperscript{114} Most—but not all—focus on the CRC, and specifically, Article 37, which states:

\begin{quote}
\end{quote}


\textsuperscript{112} Id.; see also Sussman, supra note 9, at 400 (“Only 31% of youth offenders are in facilities that require this screening to be done by mental health professionals.” (quoting ANDREA J. SEDLAK & KARLA S. MCPHERSON, U.S. DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, YOUTH’S NEEDS AND SERVICES: FINDINGS FROM THE SURVEY OF YOUTH IN RESIDENTIAL PLACEMENT 3 (2010), available at www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf).

\textsuperscript{113} See Beth Caldwell, Appealing to Empathy: Counsel’s Obligation to Present Mitigating Evidence for Juveniles in Adult Court, 64 ME. L. REV. 391, 393 (2012) (discussing how Roper and Graham constitutionally obligate counsel to present mitigating evidence in cases in which juveniles are tried in adult courts).

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age.\textsuperscript{115}

I will discuss that body of literature briefly in this section, but will focus predominantly on the potential impact of the United Nations CRPD.\textsuperscript{116} To this point in time, there has been discussion in neither the case law, nor the literature about the CRPD in this context, but I believe, given the picture I have sought to paint in Parts I and II of this Article, it is a document to which we must turn our attention if we are to think seriously about possible remedies for the current state of affairs in which, as one student author began the title of her Note, “The United States Stands Alone.”\textsuperscript{117}

\textbf{B. Human Rights in General in This Context}\textsuperscript{118}

Offenders have enforceable human rights.\textsuperscript{119} For instance, individual rights of offenders are safeguarded against “cruel, inhuman or degrading treatment or punishment”;\textsuperscript{120} prisoners should be treated with humanity and dignity and should be provided with reformation and social rehabilitation;\textsuperscript{121} individuals are guaranteed the right to the “highest attainable standard of


\textsuperscript{116.} See Convention on the Rights of Persons with Disabilities, supra note 18.


\textsuperscript{118.} This section is largely adapted from 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).


\textsuperscript{121.} Id. at art. 10.
physical and mental health”, 122 individuals are guaranteed respect for human rights and fundamental freedoms in forensic and correctional systems; 123 and prisoners should be treated in a humane manner and with dignity. 124 It goes without saying—or, at least, it should go without saying—that these rights apply to juveniles, as well as to adults.

C. The CRC and Other International Human Rights Documents

I begin with what may surprise those who are new to this area of law and policy. As noted earlier, every nation in the world—except for the United States and Somalia—has ratified the CRC, forbidding juvenile execution and LWOP for juveniles. 125 Importantly, as noted in the introduction to this paper, the Supreme Court’s decisions in Roper and in Graham both, nonetheless, squarely implicate international human rights law in the context of death penalty and LWOP issues.

Roper, by way of example, explains how both international treaties and international practice support the majority’s position in banning the juvenile death penalty. 126 The Court noted that besides the CRC, there exist parallel prohibitions in the International Covenant on Civil and Political Rights, 127 the Inter-American Convention on Human Rights, 128 and the African Charter on the Rights and Welfare of the Child. 129 In addition, the Court looked at international practice, noting that only seven countries other than the United States have executed juvenile offenders since 1990, 130 and that, since that time, “each of these countries has either abolished capital


126. There is no question in my mind that Jason Chandler is right when he notes that “Roper has become a lightning rod in the foreign law debate.” See Jason Chandler, Note, Foreign Law—A Friend of the Court: An Argument for Prudent Use of International Law in Domestic, Human Rights Related Constitutional Decisions, 34 Suffolk Transnat’l L. Rev. 117, 126 (2011).

127. Roper, 543 U.S. at 576 (referring to Art. 6(5), 999 U.N.T.S., at 175, which prohibits capital punishment for anyone under eighteen at the time of the offense, and was signed and ratified by the United States, subject to a reservation regarding Article 6(5)).


129. Id. (referring to Art. 5(3), OAU Doc. CAB/LEG/24.9/49 (1990) (entered into force Nov. 29, 1999)).

130. Id. at 577. The nations are Iran, Pakistan, Saudi Arabia, Yemen, Nigeria, the Democratic Republic of Congo, and China. Id.
punishment for juveniles or made public disavowal of the practice."

It stressed that international opinion was not controlling, but merely confirmatory, and concluded on this point that “[i]t does not lessen our fidelity to the Constitution or our pride in its origins to acknowledge that the express affirmation of certain fundamental rights by other nations and peoples simply underscores the centrality of those same rights within our own heritage of freedom.”

Later, in *Graham*, the Court re-emphasized this point:

There is support for our conclusion in the fact that, in continuing to impose life without parole sentences on juveniles who did not commit homicide, the United States adheres to a sentencing practice rejected the world over. This observation does not control our decision. The judgments of other nations and the international community are not dispositive as to the meaning of the Eighth Amendment. But “‘[t]he climate of international opinion concerning the acceptability of a particular punishment’ is also ‘not irrelevant.’”

Again, in *Graham*, the Court returned to Article 37 of the CRC for support.

In the years since *Roper*, scholars have argued that international law should also be applied to other aspects of the juvenile correctional and detention system, as well as the criminal justice system, with regard to

131. *Id.*


133. *Roper*, 543 U.S. at 578. The majority opinion was trivialized and mocked by Justice Scalia in his dissent, in which he rejected the notion that international law or opinion was relevant at all to the question before the Court. *See id.* at 622–28.


135. *Id.* at 2034. On the near-universal rejection of LWOP in other nations, see Agyepong, *supra* note 5, at 83. See, by way of example, the criminal code of Sierra Leone, as discussed in Danielle Fritz, *Note, Child Pirates from Somalia: A Call for the International Community to Support the Further Development of Juvenile Justice Systems in Puntland and Somaliland, 44 CASE W. RES. J. INT’L L. 891*, 908 n.114 (2012) (“Should any person who was at the time of the alleged commission of the crime between 15 and 18 years of age come before this court, he or she shall be treated with dignity and a sense of worth, taking into account his or her young age and the desirability of promoting his or her rehabilitation, reintegration into and assumption of a constructive role in society, and in accordance with international human rights, in particular the rights of the child.” (quoting Statute of the Special Court for Sierra Leone, art. 7 ¶ 1, Jan. 16, 2002, 2178 U.N.T.S. 137)).

136. Some scholars also wrote about this question in the years before *Roper*. *See, e.g.*, Peter J. Spiro, *The States and International Human Rights, 66 FORDHAM L. REV. 567*, 570 n.5 (1997) (considering conditions in which juveniles are housed in adult correctional facilities).
matters ranging from statutory rape laws,137 to standards in juvenile
detention facilities,138 to issues of disparate gender treatment,139 to the
conditions to which juveniles are subject in adult correctional institutions,140
and to the misuse of psychotropic medications in juvenile facilities.141  Most
of this literature looks carefully at the CRC;142 other international treaties,
conventions, and rules are also considered.143  But, to date, none has looked
at the CRPD.144

137. See, e.g., Lisa Pearlstein, Note, Walking the Tightrope of Statutory Rape Law: Using
International Legal Standards to Serve the Best Interests of Juvenile Offenders and Victims, 47 AM.

138. See, e.g., Jelani Jefferson & John W. Head, In Whose “Best Interests”?—An International and
Comparative Assessment of US Rules on Sentencing of Juveniles, 1 HUM. RTS. & GLOBALIZATION L.
REV. 89 (2007–2008); Deborah Labelle, Bringing Human Rights Home to the World of Detention, 40
COLUM. HUM. RTS. L. REV. 79 (2008); Marsha Levick et al., The Eighth Amendment Evolves: Defining
Cruel and Unusual Punishment Through the Lens of Childhood and Adolescence, 15 U. PA. J. L. & SOC.
CHANGE 285 (2012); Yun, supra note 117, at 735–36.

139. See, e.g., Christina Okereke, Note, The Abuse of Girls in U.S. Juvenile Detention Facilities:
Why the United States Should Ratify the Convention on the Rights of the Child and Establish a National

140. See, e.g., Andrea Wood, Comment, Cruel and Unusual Punishment: Confining Juveniles with
Adults After Graham and Miller, 61 EMORY L.J. 1445 (2012).

141. See Burton, supra note 92.

142. See, e.g., Millich, supra note 114, at 37; Moriearty & Carson, supra note 114, at 299;
Chandler, supra note 126, at 117 n.2; Okereke, supra note 139, at 1710–13.

143. See, e.g., Burton, supra note 92, at 468–71; Levick et al., supra note 138, at 318; David Sloss,
Legislating Human Rights: The Case for Federal Legislation to Facilitate Domestic Judicial Application
Jefferson and Head discuss a wide range of international human rights law documents in this context,
including, in addition to the ICCPR and the JDL, the International Covenant on Economic, Social and
Cultural Rights, the Inter-American Convention on Human Rights, the African Charter on the Rights
and Welfare of the Child, the UN Standard Minimum Rules for the Administration of Juvenile Justice
(the “Beijing Rules”), and the UN Guidelines for the Prevention of Juvenile Delinquency (commonly

144. There has traditionally been robust literature about the relationship between adult correctional
facilities and international human rights law.  See, e.g., Alvin J. Bronstein & Jenni Gainsborough,
for U.S. Prison Reform, 24 PACE L. REV. 811, 814–15 (2004); Jamie Fellner, A Corrections Quandary:
Mental Illness and Prison Rules, 41 HARV. C.R.-C.L. L. REV. 391, 405–10 (2006); Sara A. Rodriguez,
The Impotence of Being Earnest: Status of the United Nations Standard Minimum Rules for the
Treatment of Prisoners in Europe and the United States, 33 NEW ENG. J. ON CRIM. & CIV.
CONFINEMENT 61, 62 (2007).  However, in an article that I co-authored in 2009, I noted that there had
heretofore “been no scholarly literature on the question of the implications of the CRPD on the state of
prisoners’ rights law in a U.S. domestic context.” See Perlin & Dlugacz, supra note 119, at 677.  Since
that time, several scholars have raised that issue in the context of adults.  See, e.g., Janet E. Lord, Shared
Understanding or Consensus-Masked Disagreement? The Anti-Torture Framework in the Convention
Ribet, Naming Prison Rape as Disablement: A Critical Analysis of the Prison Litigation Reform Act,
The Americans with Disabilities Act, and the Imperatives of Survivor-Oriented Advocacy, 17 VA. J. SOC.
POL’Y & L. 281, 313–16 (2010); Kathryn D. DeMarco, Note, Disabled by Solitude: The Convention on
the Rights of Persons with Disabilities and Its Impact on the Use of Supermax Solitary Confinement, 66
U. MIA.MI L. REV. 523, 541–44 (2012).  But only one article has discussed both juvenile detention issues
and the CRPD, and that article did not discuss them in the same context.  See Johanna Kalb, Human
Rights Treaties in State Courts: The International Prospects of State Constitutionalism After Medellin,
115 PENN ST. L. REV. 1051, 1063–65 (2011). On the related question of the implications of the
D. The CRPD

1. Introduction

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.” This Convention is the most revolutionary international human rights document that applies to persons with disabilities ever created. As noted in its Introduction, the Disability Convention “furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in” almost every aspect of life. It firmly endorses a social model of disability—a clear and direct repudiation of the medical model that traditionally was part and parcel of mental disability law. “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


149. Michael Perlin, “Abandoned Love”: The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law, supra note 17, at 139 (2011); see supra text accompanying notes 17–23; e.g., Dhir, supra note 17.

particular application to the lives of persons with disabilities.”

It provides a framework for ensuring that mental health laws “fully recognize the rights of those with mental illness.” There is no question that it “has ushered in a new era of disability rights policy.”

It describes disability as a condition arising from “interaction with various barriers [that] may hinder their full and effective participation in society on an equal basis with others” instead of inherent limitations, reconceptualizes mental health rights as disability rights, “extends existing human rights to take into account the specific rights experience of persons with disabil[ies].” Again, as noted in the Introduction, it calls for “[r]espect for inherent dignity” and “[n]on-discrimination.” Subsequent articles declare “[f]reedom from torture or cruel, inhuman or degrading treatment or punishment,” “[f]reedom from exploitation, violence and abuse,” and a right to protection of the “integrity of the person.”

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


154. Convention on the Rights of Persons with Disabilities, supra note 18, art. 1 and pmbl., ¶ E.


157. See supra text accompanying notes 19–23.


159. Id. art. 3(B).

160. Id. art. 15.

161. Id. art. 16.

162. Id. art. 17.

163. 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 Colum. J.L. & Soc’l Probs. 393 (2011) (discussing the changes that ratifying states need to make in their domestic involuntary civil commitment laws to comply with Convention mandates); see also István Hoffmann & György Könczei, Legal Regulations Relating to the Passive and Active Legal Capacity of
critical issues in seeking to bring life to international human rights law in a mental disability-law context is the right to adequate and dedicated counsel. The CRPD mandates that “States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.” Elsewhere, the convention commands “[t]he extent to which this Article is honored in signatory nations will have a major impact on the extent to which this entire Convention affects persons with mental disabilities.” If, and only if, there is a mechanism for the appointment of dedicated counsel can this dream become a reality.

The ratification of the CRPD marks the most important development ever seen in institutional human rights law for persons with mental disabilities. The CRPD is detailed, comprehensive, integrated, and the result of a careful drafting process. It seeks to reverse the results of centuries of oppressive behavior and attitudes that have stigmatized persons with disabilities. Its goal is clear: to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms of all persons with disabilities and to promote respect for their inherent dignity. Whether this will actually happen is still far from a settled matter.

2. The Key Articles

Article 7 of the CRPD sets out the basic law that applies to children:

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.

2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.

3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and

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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) (discussing the application of the CRPD to capacity issues); DeMarco, supra note 144 (discussing the application of the CRPD to solitary confinement in correctional institutions).


165. Id. at 253.


maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.\textsuperscript{168}

In a later article—one that focuses on “[f]reedom from exploitation, violence and abuse”—this requirement is added: “States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.”\textsuperscript{169}

Subsequently, the CRPD also requires that States Parties shall “[p]rovide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children . . . .”\textsuperscript{170} It also, as part of its command for access to justice, requires that “States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.”\textsuperscript{171} In an important article about the relationship of the CRPD to prison conditions, Janet Lord also focuses on Article 15, the right to “freedom from torture or cruel, inhuman or degrading treatment or punishment.”\textsuperscript{172} Lord notes that “conditions within prisons and other institutional settings have long been the subject of scrutiny by disability organizations.”\textsuperscript{173} In another important piece, Beth Ribet considers how the CRPD acknowledges “the disproportionate vulnerability of people with disabilities to violence, and conceives of this problem as within the terrain of disability human rights,”\textsuperscript{174} looking, \textit{inter alia}, at Article 15 as well.

3. Juveniles in Detention and the CRPD

Think again about what was discussed in Parts I and II of this Article. At least two-thirds of all incarcerated juveniles have a mental disorder.\textsuperscript{175} The disorder rate for female detainees and inmates is significantly higher than for males.\textsuperscript{176} Minorities are “disproportionately” locked up in juvenile

\textsuperscript{168.} \textit{Id.} art. 7.
\textsuperscript{169.} \textit{Id.} art. 16(5).
\textsuperscript{170.} \textit{Id.} art. 25(b).
\textsuperscript{171.} \textit{Id.} art. 13(2).
\textsuperscript{172.} \textit{Id.} art. 15.
\textsuperscript{173.} Lord, \textit{supra} note 144, at 69.
\textsuperscript{174.} Ribet, \textit{supra} note 144, at 315.
\textsuperscript{175.} Teplin et al., \textit{Psychiatric Disorders in Youth in Juvenile Detention}, \textit{supra} note 32, at 1137; see sources cited \textit{supra} note 32.
\textsuperscript{176.} Teplin et al., \textit{Psychiatric Disorders in Youth in Juvenile Detention}, \textit{supra} note 32, at 1138 (“Females had higher rates than males of many psychiatric disorders, including major depressive episode[s and] some anxiety disorders.”).
detention facilities.177 In institutions, staff beatings of inmates, the use of medications for social control purposes, extensive reliance on solitary confinement, and a virtual absence of meaningful rehabilitative programs are all common.178 Much of the “treatment” that is offered is per se anti-therapeutic.179 Worst of all, juveniles who are incarcerated in adult prisons following the transfer or waiver process are far more likely to be sexually assaulted or beaten by staff,180 and these conditions are exacerbated in the cases of youths with mental disorders.181

V. THERAPEUTIC JURISPRUDENCE182

A. Introduction

One of the most important theoretical legal developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence (sometimes “TJ”).183 Initially employed in cases involving individuals with mental disabilities, but subsequently expanded far beyond that narrow area, therapeutic jurisprudence presents a new model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law can have therapeutic or anti-therapeutic consequences.184 The ultimate aim of therapeutic jurisprudence is to

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177. Birckhead, supra note 50, at 448; Corbit, supra note 38, at 76.
179. See, e.g., Abrams, supra note 90, at 1011–12; Burton, supra note 92, at 512.
180. Soler, supra note 85, at 323, 327; Geary, supra note 111, at 700; see also Levick et al., supra note 138, at 307; Wood, supra note 140, at 1453.
181. Geary, supra note 111, at 700.
184. See Kate Diesfeld & Ian Freckelton, Mental Health Law and Therapeutic Jurisprudence, in DISPUTES AND DILEMMAS IN HEALTH LAW 91 (Ian Freckelton & Kerry Petersen eds., 2006) (for a
determine whether legal “rules, procedures, and [lawyer] roles can or should be reshaped so as to enhance their therapeutic potential while not subordinating due process principles.”185 There is an inherent tension in this inquiry, but David Wexler clearly identifies how it must be resolved: the law’s use of “mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns.”186 As I have written elsewhere, “[A]n inquiry into therapeutic outcomes does not mean that therapeutic concerns ‘trump’ civil rights and civil liberties.”187

Therapeutic jurisprudence “asks us to look at law as it actually impacts people’s lives” and “focuses on the law’s [influence] on emotional life and psychological well-being.”188 It suggests 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.”189 Therapeutic jurisprudence understands that, “when attorneys fail to

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186. David B. Wexler, Therapeutic Jurisprudence and Changing Conceptions of Legal Scholarship, 11 BEHAV. SCI. & L. 17, 21 (1993); see also, e.g., David Wexler, Applying the Law Therapeutically, 5 APPLIED & PREVENTATIVE PSYCHOL. 179, 182 (1996) (explaining that their right to refuse treatment encourages therapists to respect the dignity and autonomy of patients).


189. Bruce J. Winick, A Therapeutic Jurisprudence Model for Civil Commitment, in INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVES ON CIVIL COMMITMENT 23, 26 (Kate Diesfeld & Ian Freckelton eds., 2003).
acknowledge their clients’ negative emotional reactions to the judicial process, the clients are inclined to regard the lawyer as indifferent and a part of a criminal system bent on punishment.”¹⁹⁰ By way of example, therapeutic jurisprudence “aims to offer social science evidence that limits the use of the incompetency label by narrowly defining its use and minimizing its psychological and social disadvantage.”¹⁹¹

In recent years, scholars have considered a vast range of topics through a therapeutic jurisprudence lens, including, but not limited to, all aspects of mental disability law, domestic relations law, criminal law and procedure, employment law, gay rights law, and tort law.¹⁹² As Ian Freckelton has noted, “it is a tool for gaining a new and distinctive perspective utilizing socio-psychological insights into the law and its applications.”¹⁹³ 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.¹⁹⁴ These alternative approaches optimize the psychological well-being of individuals, relationships, and communities dealing with a legal matter, and acknowledge concerns beyond strict legal rights, duties, and obligations. In its aim to use the law to empower individuals, enhance rights, and promote well-being, therapeutic jurisprudence 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 triumphalism.”¹⁹⁵ That is, therapeutic jurisprudence supports an ethic of care.¹⁹⁶

¹⁹³. Freckelton, Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence, supra note 185, at 576.
¹⁹⁶. See, e.g., Gregory Baker, Do You Hear the Knocking at the Door? A “Therapeutic” Approach to Enriching Clinical Education Comes Calling, 28 WHITTIER L. REV. 379, 385 (2006); Brookbanks, supra note 195; David B. Wexler, Not Such a Party Pooper: An Attempt to Accommodate
One of the central principles of therapeutic jurisprudence is a commitment to dignity. Professor Amy Ronner describes “the three Vs”: voice, validation, and voluntariness, 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 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.

The question to be addressed here is this: Given the system of juvenile punishment that is currently in place, is it remotely possible that Professor Ronner’s vision—of voice, voluntariness, and validation—will be fulfilled?

B. The Juvenile System

Could there be any system that is less consonant with Professor Ronner’s values, less consonant with the ethos and esprit of therapeutic jurisprudence than the current system of incarcerating juveniles, especially those with mental disabilities? There is no evidence whatsoever that anything about the system is “voluntary.” Professor Burton’s article about the overuse and the misuse of antipsychotic medications illuminates how one discrete area of mental disability law—one that generally, at least on

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200. See Ronner, Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles, supra note 199, at 102–13 (discussing how the Miranda waiver system fails under therapeutic jurisprudence standards).

201. See Burton, supra note 92.
paper, acknowledges that there are critical differences between the voluntary and involuntary administration of such medications, and one in which, in both civil and forensic mental disability law, comprehensive and elaborate constitutional doctrines of right-to-refuse medication have been articulated—has had virtually no impact whatsoever on what is regularly done in juvenile facilities.

There is no evidence that juveniles have any “voice” in their treatment or as to the conditions of their confinement. There is no evidence that juveniles in this system are “validated” in any way. The “shock[] the conscience” level of conditions reported in Professor Abrams’s article—conditions that sound Gulag-like in their level of repression—are as anti-therapeutic as one could conjure.

Subjecting juveniles with mental disabilities to sexual assaults, environments that spike suicide rates, and incarceration with adults speaks to conditions that, again, are anti-therapeutic per se, and reflect the reality that, by and large, there has been very little penetration of therapeutic jurisprudence concepts and principles into the “on the ground” practice of juvenile justice in a criminal law setting. Certainly, the incompetency and insanity procedures—as applied to juveniles—do not provide this.

Certainly, there are examples of court systems that have made use of the theories and practices of therapeutic jurisprudence in “attempts to


204. See Rochin v. California, 342 U.S. 165, 172 (1952) (finding that a forced stomach pumping procedure to retract pills swallowed by a defendant “shocks the conscience,” and thus, violates due process).

205. See Abrams, supra note 90, at 1046–49.

206. See Geary, supra note 111, at 700.

207. See Corbit, supra note 38, at 82.

208. See Geary, supra note 111, at 700.


210. See supra text accompanying notes 56–74.
balance punishment, prevention, and adjudication. Therapeutic jurisprudence’s use of positive reinforcement in the juvenile parole revocation process is a “basic psychological principle that should be imported into the legal system.” Scholars and clinicians have urged that a comprehensive approach in dealing with juveniles with mental illness in this context—a pathway from an assessment center, to a detention center with treatment planning, to a mental health court, to a court order for community-based services—would best “allow the juvenile courts to embrace the tenets of therapeutic jurisprudence.”

And there have been some scholarly explorations. In a thoughtful article, Professor Grisso and Richard Barnum apply therapeutic jurisprudence concepts to the juvenile competence-to-stand-trial process. Professor Bruce Winick and Judge Ginger Lerner-Wren have articulated the therapeutic jurisprudence foundations of a right to counsel on behalf of juveniles facing civil commitment. Other scholars have incorporated therapeutic jurisprudence precepts into articles and essays on a full range of issues dealing with juvenile detention and juvenile justice. But these are, by and large, exceptions, and by no means do they dominate the discourse in this area of law and policy.

In three recent books, I have explored the relationships between therapeutic jurisprudence and international human rights, between therapeutic jurisprudence and the death penalty, and between therapeutic jurisprudence and criminal procedure. In these works, I concluded that it was impossible to make any meaningful headway in the resolution of the difficult, seemingly intractable issues that have emerged in all of these areas.

211. See Marsha B. Freeman, Florida Collaborative Family Law: The Good, the Bad, and the (Hopefully) Getting Better, 11 FLA. COASTAL L. REV. 237, 253 (2010); see also Nolen, supra note 56, at 210–18 (discussing the therapeutic jurisprudence basis of special drug courts for juveniles).


213. Gene Griffin & Michael J. Jenuwine, Using Therapeutic Jurisprudence to Bridge the Juvenile Justice and Mental Health Systems, 71 U. CIN. L. REV. 65, 86 (2002); see Buffington-Vollum, supra note 43, at 242 (discussing the failure to provide diversion programs); see also Geary, supra note 111, at 693–706 (characterizing this plan as “effective” and providing recommendations for juvenile mental health detention systems that are consonant with therapeutic jurisprudence values).


of the law without carefully considering the therapeutic jurisprudence implications of the actions of judges, legislators, lawyers, and other policymakers. The same arguments could be made in any therapeutic jurisprudence analysis of the questions I am addressing in this paper.

C. The Special Issues Related to Counsel

Another issue to be considered through the therapeutic jurisprudence lens is the appointment of counsel to the cohort of juveniles in question. Professor Grisso is clear that “[i]f there is a single most important obligation of the system for protecting the legal interests of youths with mental disorders, it is the obligation to provide them with competent defense attorneys . . . .”

These issues are especially exacerbated in juvenile cases where the person facing institutionalization rarely, if ever, has the funds to retain a lawyer of his or her own choice. The disparity between quality of counsel in jurisdictions in which there is an organized public defender system and in which there is none is well known. Certainly, the quality of representation available to juveniles in jurisdictions without such a system fails miserably under any therapeutic jurisprudence metric. The issues are


219. See Donald N. Duquette & Julian Darwell, Child Representation in America: Progress Report from the National Quality Improvement Center, 46 FAM. L. Q. 87, 88–122 (2012) (discussing questions related to the appointment of counsel to juveniles in the family law system); see also David Katner, Revising Legal Ethics in Delinquency Cases by Consulting with Juveniles’ Parents, 79 UMKC L. REV. 595, 595–632 (2011) (discussing the related issue of the ethical implications of consulting with the parents of a juvenile in delinquency proceedings).


also similarly exacerbated because of juveniles’ unique developmental status. 222

In my discussion of the CRPD above, 223 I focused on issues related to the right to counsel. 224 Again, in both books and law review articles, I have stressed the importance of access to dedicated and organized counsel systems if the CRPD is to be more than a “paper victory” for persons with disabilities. 225 Professor Ronner and Judge Juan Ramirez characterize the right to counsel as “the core of therapeutic jurisprudence,” 226 and I have previously argued that “[t]he failure to assign adequate counsel bespeaks . . . a failure to consider the implications of therapeutic jurisprudence.” 227 But virtually none of the scholarly literature or commentary applies to the plight of the incarcerated juvenile with mental disabilities. It is time we focus on this population.

VI. CONCLUSION

Juvenile punishment and incarceration schemes are morally bereft. They subject the most at-risk population to unspeakably brutal conditions, they ignore the ubiquity of mental disabilities in this population, and they provide few meaningful diversion programs. These calamities are exacerbated when questions of race, gender, and family cohesion are the subject of focus. Our policies of transfer and waiver and the way that the criminal justice system treats questions of incompetency, insanity, and Miranda waiver further exacerbate the situation. 228 Our policies violate international law, deny individuals the dignity which they are due, and turn their backs on the precepts of therapeutic jurisprudence. In an article


223. See supra text accompanying notes 163–67.


227. 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, supra note 185, at 750; see also Perlmutter, supra note 185, at 570 n.53 (citing sources that consider other juvenile justice questions from therapeutic jurisprudence perspectives).

228. Many thoughtful recommendations have been made, but there has been, in many jurisdictions, absolutely no positive response. See, e.g., Mark Soler et al., Juvenile Justice: Lessons for a New Era, 16 GEO. J. ON POVERTY L. & POL’Y 483, 538–41 (2009).
critiquing the incompetency-to-stand-trial process, I characterized mental disability law in this context as a “fraud and charade.”229 I would apply the same, precise words to the system under consideration in this paper.

Oliver Trager refers to “It’s All Over Now, Baby Blue” (the song on which I drew for my title) as depicting “a cold world in which nothing is certain” but one that “still brims with a kind of dark hope.”230 The world of juveniles that I have depicted is “cold,” and little, if anything, is “certain.” But I retain some “hope”—albeit “dark hope”—that if we begin to take seriously the principles of international human rights law and therapeutic jurisprudence, our “orphan with his gun” may finally have a world that is a better place. For all of us.
