Discussion Paper:
Organizing Grass Roots for Human Rights in Mental Health

by
James B. (Jim) Gottstein, Esq.

of

PsychRights®
Law Project for
Psychiatric Rights, Inc.
http://PsychRights.Org

MindFreedom Action Conference Activism for Human Rights in Mental Health: How the Law Can Support Grassroots Action for Human Rights in the Mental Health System.

April 9-May 2, 2005

I. Table of Contents

I. Table of Contents 1
II. Purpose and Summary 1
III. Unifying Principles 2
IV. Goals 3
A. Elimination of Forced "Treatment." 3
B. Public Awareness About the Lack of Effectiveness and Extreme Harm of Treatments 4
(1) Public Awareness that There is No Evidence Supporting the Broken Brain Theory of Mental Illness 5
C. Availability of Truly Helpful Alternatives 5
V. Roots of Psychiatric Power 6
VI. Psychiatry's Strengths 7
VII. Psychiatry's Vulnerabilities 7
VIII. Our Strengths 8
IX. Our Weaknesses 9
X. Organizational Structure 9

II. Purpose and Summary

The purpose of this paper is to provoke discussion around how to organize the grass roots efforts for human rights in mental health by laying out a potential approach. There are two central themes of this paper. The first is that while an attack on human/civil rights abuses could be viewed primarily as a legal issue, success hinges on three key elements:

(1) Public Education,
(2) the Availability of Alternatives, and
(3) Legal efforts,

to which can naturally be added the Action Conference's two additional tracks,

(4) Government Relations and
(5) International.

Government is an omnipresent force in coercive psychiatry as well as controlling what services will be provided and establishes the legal framework. It clearly justifies a focused effort as well. Similarly, with the rise in forced psychiatry around the world, particularly electroshock, the international arena is important too.

The second theme is there needs to be a consensual organizational structure to coordinate our grass roots efforts.

Currently, society not only tolerates, but actively supports the violation of legal rights through forced psychiatry. I believe this is because of two fundamental factors: 1. People are afraid. 2. They think it is "good for them." Since judges (and governments)

are a reflection of the society in which they operate, they condone, if not actively participate in the violations of legal rights.[1] Thus, until society can be educated to understand that forced psychiatry is both harmful to its recipients and does not make them safer, ultimate success will elude us.

Similarly, we must have alternatives to forced psychiatry because by definition we are talking about disturbed and disturbing people. It is unrealistic to expect that people will not be involuntarily committed and forced drugged (or electro-shocked), even when they don't meet the legal requirements, if there is no alternative. Individual cases can be won through large individual efforts, but changing the environment of force requires there to be viable alternatives available.

The legal process may very well establish the right to the "less restrictive alternative" and as a legal matter, the state could not lock people up and force "treat" them if there was a viable less restrictive alternative whether it was actually available or not, but as a practical matter such alternatives need to be available.[2]

Finally, with the recent revelations about the drug companies withholding information about the dangers and lack of efficacy of the Selective Serotonin Re-Uptake Inhibitor (SSRI) anti-depressants, Big Pharma has a moment of vulnerability which must be exploited. This is an historic opportunity that won't last long and it is important to take advantage of it.

The Psycho-Pharmaceutical Complex has literally billions of dollars behind it and we are poor. We have truth and justice on our side. It is not enough. We need to be smart in how we go about it and we need to be unified. The "movement" has a number of differing outlooks on various issues, but it is suggested here that everyone should be able to unite around the issue of human rights in psychiatry, while respecting everyone's right to pursue other, related issues where there might not be agreement. Similarly, there are a number of organizations who share the fundamental value against forced psychiatry which are natural allies.

III. Unifying Principles

It seems to me there are a number of principles that we all ought to be able to agree on.[3] The first and most basic is that people are entitled to freedom, equality and human rights.

We all ought to also be able to agree that psychiatry has and uses abusive power driven by fear and absolution, justified by faulty science, and sustained by lies.[4]

---

[1] *See*, Appendix 1, Corruption in the Courts, Psychiatry: Force of Law.
[2] However, litigation is necessary both to establish the right to alternatives and probably necessary to force their utilization.
[3] And people who don't agree with them probably don't belong in this effort.
[4] It is beyond the scope of this paper to support these statements, other than to explain what is meant by "sustained by absolution." Probably the two most important and

Arising out of this is the principle that people are entitled to the truth. A related principle is that people are entitled to be free of coercive treatment that is based on lies.[5,6]

IV. Goals

A. Elimination of Forced "Treatment."

Most people, including myself, believe it is unrealistic to think that forced "treatment" will be eliminated completely.[7] Others on "our side" may believe it is warranted in certain circumstances. My view is the goal should be elimination if for no reason other than the system we have now is legally supposed to be used only in the most extreme cases, but in practice many times the number of people who actually legally qualify for

---

complete works to consult are *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the mentally Ill*, by Robert Whitaker and *Toxic Psychiatry: Why Therapy, Empathy and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry",* by Peter Breggin. Additionally, there is a wealth of support for these statements on PsychRights website, http://psychrights.org, particularly the "Scientific Research by Topic page. Additional reading suggestions are also made at http://psychrights.org/Market/storefront.htm.

With respect to the "sustained by absolution" statement, this refers to the seductive nature of the message that people diagnosed with mental illness have some sort of biological brain defect which is nobody's fault. This "absolves" people of responsibility for both the problems and their solutions and turn them over to the pills and electroshock of psychiatry. I have written a paper about this which appeared in the International Center for the Study of Psychiatry and Psychology (ICSPP) Fall/Winter 2003/2004 newsletter, titled Recovery: Responsibilities and Roadblocks (http://akmhcweb.org/recovery/RecoveryResponsibilitesRoadblocks.pdf) where I write about this some.

[5] In Corruption in the Courts, Psychiatry: Force of Law, Appendix 1, I discuss how the legal proceedings involving forced psychiatry are a sham, with the courts knowingly accepting perjury.

[6] Many people also assert that coercive psychiatry should never be allowed -- that if people's behavior is illegal they should be prosecuted and if it is not, they should be left alone. This constitutes a divergence of opinion which should not prevent people from agreeing that people are entitled to be free of coercive treatment that is based on lies and without fulfilling the statutory and constitutional requirements before it is lawful to impose it. Currently, as a practical matter, coercive treatment is always, or at least virtually always, based on lies (about the safety and efficacy of the coerced "treatment" at least and usually about the other elements as well) so, in practice, there is no real difference between the positions.

[7] Of course, at some level the idea of us toppling (or playing a major role in toppling) the Psycho-Pharmaceutical Complex may seem unrealistic. Suspend that thought for now.

forced "treatment" under the current laws are subjected to it.[8] In other words, theoretically legitimate reasons for confinement of a small number of people becomes the unrestrained confinement of a very large number of people who do not meet commitment criteria. As to forced drugging and electroshock, I have a hard time coming up with any legitimate scenarios to employ them. As a practical matter, however, if their use were limited to the actual legal requirements for employing them, I estimate the problem would be reduced by at least 90%.[9]

B. Public Awareness About the Lack of Effectiveness and Extreme Harm of Treatments

The Pharmaceutical Industry, aided and abetted by organized Psychiatry has lied about the effectiveness and safety of psychiatric treatments and the public has accepted these lies as truth. They have no demonstrated effectiveness, particularly long term, and especially if quality of life is considered. These drugs are also extremely harmful -- essentially not only intentionally brain damaging, but with other serious physical toxicities.[10] Not only are they ineffective in the long run, they increase the probability of relapse. In other words, the public thinks they are being protected from the insane by insisting on these medications, but the truth is they are increasing the problem.[11]

---

[8] Many people believe we need changes in the laws governing forced "treatment." My view is that while there could be good changes, the real problem is that the current laws are not followed. The main reason for this is, as Professor Michael Perlin puts it, "Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission." Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization, Houston Law Review, 28 Hous. L. Rev. 63 (1991).

[9] It is beyond the scope of this paper to discuss this at any length, but perhaps one example can exemplify the issue. It is my belief that the constitution requires there be "no less restrictive alternative" before it is permissible to force drug someone. In the 1970's Loren Mosher, with his Soteria House project, proved that 75% of people initially diagnosed with schizophrenia (i.e., first psychotic break) could be gotten through their problems without medication. In fact, no one at Soteria was ever forced to take medication, although some did. These were the same people who would have universally been given neuroleptics, either voluntarily or involuntarily. *See*, Soteria: Through Madness to Deliverance, by Loren Mosher and Voyce Hendrix with Deborah Fort (2004)

[10] *See*, Appendix, 2, The case against antipsychotic drugs: a 50-year record of doing more harm than good, by Robert Whitaker, and Scientific Research By Topic at http://psychrights.org/Research/Digest/Researchbytopic.htm, including Happy birthday neuroleptics! 50 year later: la folie du doute, by Emmanuel Stip, *European Psychiatry* 2002 ; 17 : 1-5.

[11] In fact, people diagnosed with serious mental illness are not more likely than others to be violent and, in fact, are much more likely to be the victims of crimes than the perpetrators. Marnie E. Rice *et al*., "The Appraisal of Violence Risk," *Current Opinion Psychiatry* 15(6): 589-593 (2002)

As mentioned above, it is my view that the only way to truly achieve a change in the way the legal system works is to destroy the value the public sees in forced psychiatry.

(1) Public Awareness that There is No Evidence Supporting the Broken Brain Theory of Mental Illness

While as a strictly logical matter, challenging the "Medical Model" of mental illness, i.e., the theory that mental illness is the result of a biological defect of some kind in a person's brain, is not necessary to show that the current treatments are neither safe nor effective, in truth, this belief in the medical model is the foundation upon which the drug and electroshock "treatment" is built upon. The Fast for Freedom's (incredibly successful) challenge to the Medical Model understood this dynamic. Unless the Medical Model is debunked, Psychiatry can, as it has for hundreds of years now (since it took over from the exorcists), "discover" miracle "treatments" that are imposed on people with great harm, only to be replaced by the next miracle "treatment" that comes along when it is found out they are ineffective and extremely harmful. Therefore, even though as a strictly logical matter, debunking the Medical Model is not a necessary element, as a practical matter I think it is.[12]

C. Availability of Truly Helpful Alternatives

Unless there are viable alternatives to the current regime for people who are behaving in ways that are frightening to others (and often themselves) I think we are doomed to failure.[13] Thus, the third leg of the stool for human rights in mental health is the availability of truly helpful alternatives. And, if truth be known, even though the "less restrictive alternative" is applicable (i.e., one can't be forced drugged if there is a less restrictive alternative) even if no alternatives are available, as a practical matter they need to be.[14] To be truly helpful, these alternatives must be voluntary and the Soteria experience shows that it is possible.[15]

---

[12] Of course, there is the theoretical risk that even if they haven't proven a biological brain defect basis of mental illness yet, they might still. However, 30 years of involvement in this issue with countless people diagnosed with mental illness convinces me that it is people's adaptations to their environment, i.e., reactions to events in their lives that create what are considered psychiatric symptoms. That is those that actually have what might legitimately be described as psychiatric symptoms, such as hearing troubling voices, as opposed to just being non-conformist and/or bother people.

[13] Plus, it is the right thing to do.

[14] If, however, an alternative is available, the state should be legally required to make it available under constitutional principles. Again, the potential legal strategies involved are beyond the scope of this paper, but I will say that litigation can be utilized to both force the availability of alternatives and then fill them up. In other words, there can be a positive feedback loop between legal efforts and the availability of alternatives (with public awareness of the true state of affairs adding to both).

[15] *See* Soteria: Through Madness to Deliverance.

V. Roots of Psychiatric Power

Perhaps it need not be said because it may be too obvious, but I think it is important for people to understand that I see the effort as a contest, competition -- or even war, if you will -- where our objective is to "win" against the forces of coercive psychiatry.[16] In order to win such a war, it is important to understand our enemy(ies)/opponent(s), their strengths and weaknesses as well as our own.

To me the first question that arises is how did psychiatry come to have so much power that it can have people locked up who have committed no crime and subject them to harmful, brain disabling treatments such as forced drugging and electroshock,[17] which often completely ruin people's lives?

I think the answer is two-fold. First, society has abdicated its responsibility to psychiatry out of fear and the unwillingness to otherwise deal with people whose behavior it finds objectionable. Turning them over to psychiatrists to deal with is easy. Prior to the medicalization of madness, people were considered "possessed" (either divinely or by evil spirits depending on culture and/or behavior). The priests with their religious theories have been replaced by the psychiatrists and their medical theories. Just as the priests had an explanation that fit with the times, psychiatry's Medical Model does so today. The supreme seductiveness, both to the parents of those labeled mentally ill and, often, to their children, of no-fault mental illness is extremely compelling. The Medical Model, while not having scientific support, seems internally consistent, and fits with society's belief system generally. These mechanisms positively reinforces its sway over the public."[18]

Of course, Big Pharma's making literally Billions of Dollars from psychiatric drugs and its (completely rational, if immoral) willingness to spend liberally to protect those profits,

---

[16] Many people believe the entire psychiatric profession should be eliminated, while others find some value in it some of the time or from some people. To me, the whole industry is built upon the flawed premise that objectionable behaviors or unwanted emotions resulting in psychiatric diagnosis are medical problems and therefore it is hard to see any validity to the profession as such. However, what I would like to emphasize here is that whichever way one feels about the existence of psychiatry as a medical specialty, fighting coercive psychiatry can and should be supported.

[17] Following in its tradition of comparable treatments, such as lobotomies, insulin comas, and Metrazol induced seizures to name those most recently in vogue prior to the psychopharmaceutical era.

[18] *See*, Chapter 7 of Schizophrenia: A Scientific Delusion, 2nd Ed, by Mary Boyle, for a detailed discussion of how psychiatry positively reinforces its hold on the idea that schizophrenia describes a set of attributes that meaningfully describes a single condition in spite of there being no scientific support for it.

including essentially buying off and in support of the psychiatry industry is another root of its power.[19]

VI. Psychiatry's Strengths

As important as understanding the roots of psychiatry's power is, it is even more important to understand psychiatry's strengths.[20]

Perhaps the most important strength, for all practical purposes, is the unlimited financial resources available to support it, courtesy of Big Pharma.

Another is psychiatrists' stature in society as the presumed experts on "mental illness."[21]

Another is the Psycho-Pharmaceutical Complex's virtual stranglehold on the story presented by the media.[22] Control of the story is hugely important.

Another hugely important source of psychiatry's strength is its alliance with family members as exemplified by NAMI[23] and CHADD.[24] In other words, through its alliance with the parents of people labeled with mental illness, Medical Model Psychiatry has literally positioned itself to be a "motherhood issue."

VII. Psychiatry's Vulnerabilities

Of course, finding and exploiting coercive psychiatry's vulnerabilities are the keys to prevailing.

Mainstream psychiatry's vulnerabilities include that it is intellectually and morally bankrupt. It's whole claim to authority is based upon it being part of medical science, yet has, as yet failed to produce any valid evidence in support of its claims.[25] The same goes

---

[19] *See*, Loren Mosher's resignation letter to the American Psychiatric Association (APA), at http://www.moshersoteria.com/resig.htm.

[20] Here, one must consider the entirety of psychiatry's strengths, not just forced psychiatry.

[21] It is my understanding Mickey Weinberg believes this is the most important thing to attack and bring down.

[22] While the recent revelations about the lies told regarding SSRIs and other FDA approved drugs has had an impact, there continues an unabated series of stories about "breakthroughs" in understanding the biology of mental illness and medications to control it.

[23] National Alliance for the Mentally Ill, which is primarily driven by family members of those labeled with serious mental illness.

[24] Children and Adults with Attention-Deficit/Hyperactivity Disorder, which is primarily driven by the parents of children labeled with ADHD.

[25] *See*, the exchange between the Hunger Strikers and the APA as a result of the 2003 Fast for Freedom, which can be found at:

for the validity of its treatments.[26] In other words, it forces people to undergo harmful, ineffective "treatments" through a dishonest legal process.[27]

These are general vulnerabilities, but more recently the pharmaceutical industry has been exposed as jeopardizing people's health and lives on the altar of profits. The industry's concealing data about suicidality from SSRI's and causing heart attacks from Vioxx and the other Cox-2 Inhibitors creates a unique opportunity to press the point about the industry hiding information about the harmfulness and lack of effectiveness of the stronger psychiatric medications.

Another vulnerability is that the cost of all of this psychopharmacology has gotten to the point where policy makers are starting to see it as a problem.[28] Also, a paradigm that unnecessarily creates people who are permanent financial burdens on the government is something the government(s) may finally be willing to look at.

Another vulnerability are the psychiatrists who engage in forced psychiatry, themselves. In my view, people who commit perjury to obtain court orders are not, as a general matter courageous. In fact, I would posit the opposite, and that if they began to see themselves as personally vulnerable to legal liability as a result of their activities many would run for cover.

VIII. Our Strengths

What are the strengths that we bring to this effort?

We are in the right.

We have grass roots support. We potentially have a lot of people who are willing to put in a lot of effort. We have people who are willing to demonstrate and potentially commit civil disobedience to draw attention to our cause. We have allies and potential allies.

Organizations (and their members) that appear perfectly aligned with this effort include:

- MindFreedom/Support Coalition International.[29]

---

http://psychrights.org/education/HungerStrike/TheDebate.htm. The APA essentially admitted they have no scientific evidence to back up their claims.

[26] *See*, The case against antipsychotic drugs: a 50-year record of doing more harm than good, by Robert Whitaker, *Medical Hypotheses*, Volume 62, Issue 1, which can be found at http://psychrights.org/Research/Digest/Chronicity/50yearecord.pdf and the studies available at http://psychrights.org/Research/Digest/Researchbytopic.htm, including Happy birthday neuroleptics! 50 year later: la folie du doute, by Emmanuel Stip, *European Psychiatry* 2002 ; 17 : 1-5.

[27] *See*, Appendix 1, Corruption in the Courts, Psychiatry: Force of Law.

[28] This is another area where the availability of alternatives is key.

[29] MindFreedom/Support Coalition International also has 100 grassroots organizations affiliated with it who participate to varying degrees. http://mindfreedom.org/

- Law Project for Psychiatric Rights (PsychRights)[30]
- International Center for the Study of Psychiatry and Psychology (ICSPP)[31]
- National Association of Rights Protection and Advocacy (NARPA).[32]

There are no doubt more.[33] In addition there are many C/S/X[34] groups that seem like natural allies and Internet communities with memberships that should be allies. There are also many parents and other family members of people labeled with mental illness that are very much against the current regime.

IX. Our Weaknesses

We have two huge weaknesses: We are as poor as church mice and we don't have an organizational structure that allows us to assign people to tasks.

X. Organizational Structure

We obviously need to raise money and if we raised enough, we could have some paid staff, but as a practical matter, we are composed of volunteers, although some organizations seem likely contribute some staff time, such as MindFreedom, PsychRights and ICSPP.[35] Those contributions are functionally the same as being volunteers though, in the sense that such staff time will only be contributed to the extent it is consistent with the organization's purpose(s).

Any organizational structure must recognize this basic fact. Volunteers tend to only do the things they want to do. We need a large number of volunteers and we need to have them used effectively. In other words, it is a (hopefully) huge volunteer management effort. The key features are to keep track of tasks that have been identified to be accomplished, match them with volunteers, keep track of results, etc. This needs to be part of some sort of overall organizational structure. The Action Conference, which prompted this paper is designed to come up with specific actions to be taken and people who sign up to work on them. These need to be kept track of and the effort needs to be

---

[30] http://psychrights.org
[31] http://icspp.org/
[32] http://narpa.org/
[33] For example, the American Association of Physicians and Surgeons may be on our side. It is unclear where the Bazelon Center for Mental Health Law is on the entirety of this effort, but they have offered office space and equipment in Washington, D.C. for "the movement." The United States chapter of International Society for the Psychological Treatment of Schizophrenia and other Psychoses (ISPS-US) and their members, would seem to be natural ally, but that is far from clear at this point.
[34] "C/S/X" stands for mental health Consumers/psychiatric Survivors/eX-patients. Personally, I don't like any of these names, preferring "psychiatrized" instead. *See,* http://psychiatrized.org/ for a discussion of these names.
[35] I am a volunteer for PsychRights anyway, and the only paid staff of ICSPP is their new lobbyist, Michael Ostrolenk.

managed as things go forward.[36] Even though the Action Conference is a bottom up effort in designing the agenda, in order to be effective, the effort needs to be coordinated.

This requires a structure. The Action Conference Tracks can be thought of as "Spheres of Action" with a person or committee charged with following up on the Action Conference agenda for that sphere and all of them joining together as a Follow-up Committee that would coordinate things between action conferences. Ideally, we would have an action conference annually to set/adjust the action agenda.[37] The following diagram hopefully captures the idea:

[36] For example, it seems obvious it would be beneficial to have a mechanism for people who didn't make the Action Conference to be able to "sign on."

[37] There are already a number of annual conferences, such as "Alternatives" and the NARPA conference and perhaps it makes sense to try and dovetail with an existing one. Alternatives is not a good fit -- in fact it is my understanding that organizing is a prohibited activity at Alternatives (dictated by the government funding). NARPA is perhaps a much better fit. Full disclosure requires that I mention I was recently elected to the board of directors of NARPA. In any event, the main point is that there should be relatively frequent opportunity for our grass roots to build the ongoing action agenda.

Appendix A

PsychRights®
Law Project for
Psychiatric Rights

Psychiatry: Force of Law

by James B. Gottstein, Esq.
November, 2002

The purpose of this article is to set forth just the basic legal principles, underpinnings and practices employed in the widespread use of legal force to compel unwilling patients into locked psychiatric hospitals and, most importantly, force brain damaging drugs and other brain damaging treatments such as Electroshock upon them over their desperate, but hopeless objections. The companion article, Unwarranted Court Ordered Medication: A Call to Action, describes what might be done about it and this article is really background for that one. In addition, there are a number of excellent law review articles on the subject, a small sampling of which are listed at the end of this article.

The impetus for this article is the realization that the scientific basis for these forced treatments is non-existent and they are permanently damaging hundreds of thousands, if not millions, of people. No other field of medicine allows this sort of forced treatment. Of course, there are many people who see psychiatrists and voluntarily, even eagerly, take psychiatric medications. This article has absolutely no complaint about this. It is unwarranted forced treatment that is being addressed. This article also does not address the issue of somewhat more subtle coercion such as "if you don't take the medication, we will take your housing away from you" or "if you don't take your medication, we will have you committed to the mental hospital." This article is solely concerned with using the force of law (court orders) to compel people to submit to unwarranted psychiatric treatments they do not want. What unfolds is a legal system of Catch-22's for the patients and one where the courts have not only abdicated to "professionals" their responsibility to protect the rights of people coming before them, but also condones perjury in furtherance of this abdication.

This outright disregard of the law is done in the name of "we know what is right for the person" and therefore it is okay to ignore the law. It is not the purpose here to show that this assertion (of knowing what is right) is scientifically invalid. See, Psychiatric Myths and Scientific Research by Topic for places to learn about that. There is a growing revolt among principled psychiatrists over the abuses of forced psychiatry. For purposes here, it will only be suggested that one should be very skeptical of the validity of a process that relies on lies to achieve its results.

- Involuntary Commitment
- Forced Medication
- Corruption in the Courts
- Other References
  - Law Review Articles

- Annotated List of Cases
- FACT SHEET: Tort Litigation Against Pharmaceutical Companies Involving Psychiatric Drugs: Lessons For Attorneys And Advocates, by Susan Stefan, Center for Public Representation.
- Mental Health Law from Cornell's Legal Information Institute
- New York Involuntary Commitment/Treatment Cases
- Center for Community International's Involuntary Treatment News Archive
  - News Archive
  - Major Sites and Overview
- List of Landmark Cases from the American Academy of Psychiatrists and the Law

---

Involuntary Commitment

While using different specific language, most states provide that people can be involuntarily committed to a mental institution if the person is:

1. Mentally ill, and
2. Danger to self or others.

In many states, the dangerousness is supposed to be fairly immediate or "imminent." Also, many states provide that even if the person is not dangerous, he/she can be committed if he/she is unable to take care of him/herself. In most states this is called being "gravely disabled."

The United States Supreme Court case of *Foucha v. Louisiana*, 504 U.S. 71 (1992) held that "The State may [in addition to punishment for a crime] also confine a mentally ill person if it shows 'by clear and convincing evidence that the individual is mentally ill and dangerous." (emphasis added) In the recent case of *Kansas v. Crane*, 122 S.Ct. 867 (2002), the US Supreme Court reiterated:

> "[w]e have consistently upheld such involuntary commitment statutes" when (1) "the confinement takes place pursuant to proper procedures and evidentiary standards," (2) there is a finding of "dangerousness either to one's self or to others," and (3) proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.' "

So, the first thing that jumps out at one is that the "gravely disabled" (or similar) standard for involuntary commitment is unconstitutional, or at least the U.S. Supreme Court has never said it is constitutional.

As is explored at more (but not great) length in Unwarranted Court Ordered Medication: A Call to Action and Psychiatric Myths, the scientific reliability of diagnosing someone with a mental illness is very questionable. Even more questionable is the ability to reliably predict dangerousness. Thus, a vigorous attack on the scientific basis of psychiatric (expert) testimony on these elements can be mounted. In addition, attacks can be made on the way that the psychiatrist arrived at his or her opinion. For example, what was the standard for determining dangerousness? What authoritative work

was used that sets the criteria? What level of dangerousness? As is shown by the Corruption in the Courts section, below, the way that most of these commitment orders are obtained is quite simple. They lie about meeting the legal requirements for getting the orders.

With respect to the mental illness diagnosis, itself, when a psychiatrist decides that a person has a mental illness and that person disagrees, according to the psychiatrist, that disagreement just shows the person lacks "insight" and is in itself proof of the mental illness. Catch-22.

Forced Medication

The United States Supreme Court decisions of *Youngberg v. Romeo*, 102 S.Ct. 2452, U.S.Pa.,1982, *Mills v. Rogers,* 102 S.Ct. 2442 (1982) and *Rennie v. Klein*, 102 S.Ct. 3506 (Mem), U.S.,1982, have been widely interpreted as holding that federal constitutional safeguards involving a person's right to refuse psychiatric medications are mostly defined by state law and that federal protection is limited to whether the treatment is "a substantial departure from accepted professional judgment, practice or standards" (the "Professional Judgment" standard). Under the "professional judgment" standard, if scientifically invalid pharmacology is "accepted practice" then, it doesn't matter that it is invalid. Catch-22. For example, in *Kulak v. City of New York*, 88 F.3d 63 (C.A.2 1996), mentioned in the annotated list of cases, held that the involuntary administration of Haldol was a proper exercise of professional judgment. Ultimately, however, it makes absolutely no sense that "professional judgment" prevails when the professional judgment can be shown to be fallacious.

It has been suggested that this is not what the Supreme Court actually held and that the Professional Judgment standard never was supposed to apply to forced medication cases. *See,* Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs, Indiana Law Review, 1998, 31 INLR 937. This view is lent great credence in the June, 2003, case of *Sell v. United States*, 539 U.S. 166, 123 S.Ct. 2174 (2003), which while a competence to stand trial case, demonstrates much less deference to "professional judgment" than has been suggested the Supreme Court held in *Youngberg.* In *Sell*, the U.S. Supreme Court laid down the following constitutional guidelines:

> First, a court must find that *important* governmental interests are at stake.
>
> Second, the court must conclude that involuntary medication will *significantly further* those concomitant state interests.
>
> Third, the court must conclude that involuntary medication is *necessary* to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results.
>
> Fourth, as we have said, the court must conclude that administration of the drugs is *medically appropriate*, i.e., in the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels

> of success.

(italics in original) While *Sell* is a competence to stand trial case, it is hard to see how a person facing forced drugging in the context of civil commitment has fewer rights. Moreover, all of these guidelines are basic constitutional principles that should be applicable to the civil forced psychiatric medication context. The question of what federal constitutional rights people facing forced drugging in the civil context have should be taken to the United States Supreme Court in an appropriate case. PsychRights has raised these issues in an Alaskan *case, Myers v. Alaska Psychiatric Institute*, S-11021, which is awaiting decision by the Alaska Supreme Court. It seems fairly likely, however, that the *Myers* case will be decided on state constitutional grounds.

Corruption in the Courts

It turns out that psychiatrists, with the full understanding and tacit permission of the trial judges, regularly lie in court to obtain involuntary commitment and forced medication orders:

> [C]ourts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .
>
> Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .
>
> This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met . . .. In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.

The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone? by Michael L. Perlin, Journal of Law and Health, 1993/1994, 8 JLHEALTH 15, 33-34.

The psychiatric profession explicitly acknowledges psychiatrists regularly lie to the courts in order to obtain forced treatment orders. E. Fuller Torrey, M.D., probably the most prominent proponent of involuntary psychiatric treatment says:

> It would probably be difficult to find any American Psychiatrist working with the mentally ill who has not, at a minimum, exaggerated the dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment.

Torrey, E. Fuller. 1997. *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York:

John Wiley and Sons. 152. Dr. Torrey goes on to say this lying to the courts is a good thing. Dr. Torrey also quotes Psychiatrist Paul Applebaum as saying when "confronted with psychotic persons who might well benefit from treatment, and who would certainly suffer without it, mental health professionals and judges alike were reluctant to comply with the law," noting that in "'the dominance of the commonsense model,' the laws are sometimes simply disregarded."

It is also well known that:

> Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission.

Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization, Michael L. Perlin, Houston Law Review, 28 Hous. L. Rev. 63 (1991).

So, sad to say, in what will no doubt be shocking to most all Americans who have not experienced this process, but is not even surprising to those who are involved with the system, it turns out that the legal protections for people diagnosed as mentally ill are illusory and the court proceedings are fairly characterized as a sham. The effect of this is eloquently described by Professor Perlin:

> Its toxin infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blase judging, and, at times, perjurious and/or corrupt testifying. The reality is well known to frequent consumers of judicial services in this area: to mental health advocates and other public defender/legal aid/legal service lawyers assigned to represent patients and criminal defendants who are mentally disabled, to prosecutors and state attorneys assigned to represent hospitals, to judges who regularly hear such cases, to expert and lay witnesses, and, most importantly, to the person with a mental disability involved in the litigation in question.

Sanist Attitudes, *supra*.

Law Review Articles

The following is just a small sampling of the Law Review articles on the subject have been written, focusing on those within the last 15 years.

- Therapeutic Justice: Our Commitment Process Could Stand a Second Look, 28-JUN VTBJ 48, Vermont Bar Journal, June, 2002
- PROTECTING OUR MENTALLY ILL: A CRITIQUE OF THE ROLE OF INDIANA STATE COURTS IN PROTECTING INVOLUNTARILY COMMITTED MENTAL PATIENTS' RIGHT TO REFUSE MEDICATION, 76 INLJ 983, Indiana Law Journal, Fall, 2001
- Mental Health Law: Three Scholarly Traditions, 74 SCALR 295, Southern California Law

Review, November, 2000
- Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs, Indiana Law Review, 1998, 31 INLR 937
- The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone? by Michael L. Perlin, Journal of Law and Health, 1993/1994, 8 JLHEALTH 15, 33-34.
- Competency to Refuse Treatment, April, 1991, North Carolina Law Review, 69 NCLR 945
- THE RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS: SAFEGUARDING THE MENTALLY INCOMPETENT PATIENT'S RIGHT TO PROCEDURAL DUE PROCESS, 73 MARQLR 477, Marquette Law Review, Spring, 1990
- Nonconsensual Treatment of Involuntarily Committed Mentally Ill Persons With Neuroleptic or Antypsychotic Drugs as Violative of State Constitutional Guaranty, 74 A.L.R.4th 1099 (1989)
- The Mentally Ill's Right to Refuse Drug Treatment: A Panacea or a Bitter Pill to Swallow? , 29 Washburn L.J. 62, 105 (1989)
- The Right to Refuse Mental Health Treatment: A First Amendment Perspective, 44 UMIALR , September, 1989
- THE NIGHTMARE OF FORCIBLE MEDICATION: THE NEW YORK COURT OF APPEALS PROTECTS THE RIGHTS OF THE MENTALLY ILL UNDER THE STATE CONSTITUTION, 53 BKNLR 885, Brooklyn Law Review, Fall, 1987
- ABUSE OF THOSE CONSIDERED MENTALLY ILL, prepared by Prof. Donald Bersoff Villanova University Law School and Eric Rosenthal Mental Disability Rights International

---

minor modifications
1/10/2003
8/24/2003
9/21/2003
10/15/2003
4/13/2004
1/10/2005
1/13/2005
2/14/2005
3/23-5/2005