PsychRights®
Law Project for
Psychiatric Rights, Inc.

MEMORANDUM
(Preliminary)

TO: New York Bar
FROM: James B. (Jim) Gottstein, Esq.
RE: Forced Psychiatric Drugging in the Community --*Pro Bono* Opportunity of Great Significance
DATE: August 15, 2008

I. Summary, Purpose and Scope

This Memorandum outlines an important *pro bono* opportunity, both in terms of helping prevent grave harm and also the opportunity to make law.

By way of background, because of the extreme harm they cause without countervailing benefits for most, the Law Project for Psychiatric Rights (PsychRights) was founded in late 2002 to mount a strategic litigation campaign in the United States against unwarranted forced psychiatric drugging and Electroshock.[1]

PsychRights has already had significant success before the Alaska Supreme Court. In *Myers v. Alaska Psychiatric Institute*,[2] the Alaska Supreme Court, citing, among others, the New York case of *Rivers v. Katz*,[3] invalidated Alaska's statutory forced drugging regime on constitutional grounds, holding:

> We conclude that [under] the Alaska Constitution's guarantees of liberty and privacy . . . in future non-emergency cases a court may not permit a treatment facility to administer psychotropic drugs [to someone found incompetent to decline] unless the court makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available.

Myers has been characterized as "the most important state Supreme Court decision on this topic in many years, perhaps the most important since [the New York case of] *Rivers v. Katz* some 20 years ago."[4]

Since I am licensed to practice law in Alaska, I have been able to mount cases here, while it is necessary to recruit lawyers to do so in other jurisdictions. The purpose of this memo is to recruit members of the New York bar and their firms to devote some or all of their *pro bono* efforts to this very needed area.

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[1] PsychRights is a tax-exempt 501(c)(3) public interest law firm.
[2] 138 P.3d 238 (Alaska 2006).
[3] 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337, 342 (N.Y.1986);
[4] 1 Michael L. Perlin & Heather Ellis Cucolo, Preface to Mental Disability Law: Civil and Criminal, at iii (2d ed. Supp. 2007)

All lawyers should agree people facing court ordered psychiatric drugging ought to receive proper legal representation, but as Prof. Grant Morris noted in discussing one of Prof. Perlin's recent articles:[5]

> Lawyers who represent mentally disabled clients in civil commitment cases and in right to refuse treatment cases, Michael tells us, are guilty of several crimes. They are inadequate. They are inept. They are ineffective. They are invisible. They are incompetent. And worst of all, they are indifferent. Is Michael right in his accusations? You bet he is![6]

It is not entirely the attorneys' fault because the public representation system does not provide funding for, nor really permit, serious representation of respondents. People facing court ordered psychiatric drugging should receive proper legal representation even if the drugs being forced on them were helpful as is commonly believed. However, this is not the case, as will be briefly summarized below and is thoroughly demonstrated in the attached Whitaker and Jackson affidavits filed in recent Alaska cases.

This Memorandum is specifically directed at what is known around the country as "Outpatient Commitment," enacted in New York at Mental Hygiene Law § 9.60 and popularly referred to here as "Kendra's Law." It is also euphemistically referred to in New York as "Assisted Outpatient Treatment," or "AOT."

As will be discussed below, the New York Court of Appeals in *Matter of K.L.*, held that Kendra's Law is not a forced drugging statute, but the reality is far different. It will take some well-thought out lawyering to address the Outpatient Commitment situation in New York because of *K.L.*, some initial thoughts on which are set forth below.

It is hoped members of the New York Bar will recognize that the gross violations of rights involved in the implementation of Kendra's Law is every bit as deserving of *pro bono* efforts as other issues.

This memorandum is directed towards violations of people's rights under Kendra's Law, not inpatient forced drugging, but much of it is applicable to both. Similarly, while PsychRights' mission includes mounting a strategic litigation campaign against court ordered electroshock, it is not covered in this memorandum. It is anticipated this Memorandum will be supplemented in the future by material directed at both inpatient court ordered psychiatric drugging and court ordered electroshock.

Finally, with respect to the scope of this memorandum, while PsychRights has formally adopted mounting a strategic litigation campaign against the psychiatric drugging of children taken into state custody, this memorandum does not cover that either. The massive over-drugging of America's children with very harmful and ineffective drugs is an emergency, if largely unrecognized.

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[5] Michael L. Perlin, And My Best Friend, My Doctor / Won't Even Say What It Is I've Got": The Role and Significance of Counsel in Right to Refuse Treatment Cases, 42 San Diego L. Rev. 735 (2005).
[6] Grant H. Morris, "Pursuing Justice for the Mentally Disabled," 42 San Diego Law Review 757, 758 (2005).

Even though this Memorandum does not cover these topics, PsychRights is interested in working with members of the New York Bar who do wish to participate in representing people who want to resist these awful practices as well.

II. The Scientific Evidence About the Neuroleptics

As the attached affidavits of Robert Whitaker and Grace E. Jackson, MD, detail, the scientific evidence on the neuroleptics, also misnamed "antipsychotics, which are the psychiatric drugs almost always forced on people can be summarized as follows:

(a) Neuroleptics dramatically increase the likelihood that a person will become chronically disabled.

(b) Long-term recovery rates are much higher for unmedicated patients than for those who are maintained on neuroleptic drugs.

(c) Neuroleptics cause a host of debilitating physical, emotional and cognitive negative effects, including substantial brain damage, and lead to early death.

(d) The new "atypical" neuroleptics are not better than the old ones in terms of their safety and tolerability, and quality of life may even be worse on the new drugs than on the old ones.

III. Involuntary Administration of Neuroleptics is Experienced as Torture by Many

Forced psychiatric drugging is experienced as torture by those who have to endure it, and internationally, human rights activists assert it is a violation of the universal prohibition against torture.[7] The following gives one an idea of what it feels like to be subjected to such treatment:

> These drugs, in this family, do not calm or sedate the nerves. They attack. They attack from so deep inside you, you cannot locate the source of the pain. . . .
>
> The muscles of your jawbone go berserk, so that you bite the inside of your mouth and your jaw locks and the pain throbs. For hours every day this will occur. Your spinal column stiffens so that you can hardly move your head or your neck and sometimes your back bends like a bow and you cannot stand up. The pain grinds into your fiber . . . . You ache with restlessness, so you feel you have to walk, to pace. And then as soon as you start pacing, the opposite occurs to you: you must sit and rest. Back and forth, up and down you go in pain you cannot locate; in such wretched anxiety you are overwhelmed, because you cannot get relief even in breathing.[8]

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[7] *See* Tina Minkowitz, *The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free From Nonconsensual Psychiatric Interventions*, 34 SYRACUSE J. INT'L L. & COM. 405 (classifying forced psychiatric interventions as torture).

[8] JACK HENRY ABBOT, IN THE BELLY OF THE BEAST: LETTERS FROM PRISON, 35–36 (Vintage Books 1991) (emphasis omitted).

These are some of the negative effects described in dry scientific/medical language in the attached affidavits of Robert Whitaker and Grace Jackson, but it is hoped this gives one an idea of what it feels like when these drugs are forced upon people.

When the unwilling recipients complain about these effects, their complaints are dismissed as the ravings of lunatics. The real benefit of these drugs run not to the people given them against their will but the people they have been bothering.

IV. Kendra's Law (Mental Hygiene Law § 9.60)

Mental Hygiene Law § 9.60, commonly called "Kendra's Law" in New York (MHL §9.60), is an "Outpatient Commitment" statute also sometimes referred to in the literature as "Community Treatment Orders." In New York, it is often called "Assisted Outpatient Treatment" or "AOT." The purpose of such laws, including MHL §9.60 is to make people keep taking psychiatric drugs after they have been released from the hospital, or maybe even if they have not been hospitalized.[9] They will be called Community Drugging Orders here because that is the best description.

However, in order to find MHL §9.60 constitutional, the New York Court of Appeals in *Matter of K.L.*,[10] held it wasn't a forced drugging statute at all, stating:

> Mental Hygiene Law § 9.60, however, neither authorizes forcible medical treatment in the first instance nor permits it as a consequence of noncompliance with court-ordered AOT.
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> * * *
>
> [A] violation of the order, standing alone, ultimately carries no sanction. Rather, the violation, when coupled with a failure of efforts to solicit the assisted outpatient's compliance, simply triggers heightened scrutiny on the part of the physician, who must then determine whether the patient may be in need of involuntary hospitalization.[11]

The New York Court of Appeals had to reach extremely far, with very dubious logic at best, to achieve this result,[12] but there are many attack points in resisting Community Drugging Orders under MHL §9.60.[13]

Following are some non-exhaustive thoughts about seriously defending people facing Community Drugging Orders under MHL §9.60. It should go without saying, but because it is often not the case in these proceedings, it seems worth noting that in *Kansas v. Crane*, the United

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[9] A copy of Mental Hygiene Law § 9.60, with annotations, is attached hereto or available on the Internet at http://psychrights.org/States/NewYork/MHL9.60-KendrasLaw.pdf.

[10] 1 N.Y.3d 362, 806 N.E.2d 480, 774 N.Y.S.2d 472, 2004 N.Y. Slip Op. 0096.

[11] 1 N.Y.3d at 369, 806 N.E. 2d at 484, 774 N.Y.S.2d at 476.

[12] Perhaps the most charitable thing that can be said about *K.L.* is it is an Ivory Tower decision divorced from reality.

[13] The *K.L.* case is so out-of-bounds that a federal challenge to the constitutionality of MHL §9.60 should be considered, but as is discussed here, there are many grounds upon which to resist Community Drugging Orders even under *K.L.* If an attorney or firm is interested in mounting a challenge to *K.L.*, please contact me; I have some ideas.

States Supreme Court reiterated that the United States Constitution requires "proper procedures and evidentiary standards" in involuntary commitment cases.[14] The same must also be required for outpatient commitment cases. If not, the legal proceedings are a sham.

To the extent desired and possible, PsychRights will work with attorneys in specific cases to provide assistance. One example of some very practical assistance is that certified copies of the Whitaker and Jackson affidavits could be provided for filing in the trial court, which would potentially make a sufficient record for appeal. PsychRights will also do whatever strategizing, research and writing that might be desired and possible.

A. Criteria & Standard for

Under MHL §9.60(c), Criteria, "A person may be ordered to receive assisted outpatient treatment if the court finds that such person:

(1) is eighteen years of age or older; and

(2) is suffering from a mental illness; and

(3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and

(4) has a history of lack of compliance with treatment for mental illness that has:

(i) prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or

(ii) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; and

(5) is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community; and

(6) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others as defined in section 9.01 of this article; and

[14] 534 U.S. 407, 409–10 (2002) (quoting *Kansas v. Hendricks*, 521 U.S. 346, 357–58 (2002)).

(7) is likely to benefit from assisted outpatient treatment.

Under MHL §9.60(i)(3), the physician testifying against the person, must include " the beneficial and detrimental physical and mental effects of [the proposed] medication."

In order for a petition to be granted, MHL §9.60(j)(2) provides the court must find all the criteria have been proven by clear and convincing evidence and the proposed treatment is the least restrictive appropriate and feasible treatment.

(1) Survive Safely

As set forth above, MHL §9.60(c)(3), one of the criteria, requires that the subject "is unlikely to survive safely in the community without supervision, based on a clinical determination." It seems worthwhile to briefly discuss the probable genesis of this criteria. In *O'Connor v. Donaldson*[15], the United States Supreme Court held:

> In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.[16]

This, in turn, is based on the United States Supreme Court holding that constitutional justification for commitment can only be when the potential for doing harm, to self or to others, is great enough to justify such a "massive curtailment of liberty."[17]

I have not found any case law that explains what surviving safely in freedom means.[18] Exactly this issue is before the Alaska Supreme Court in *W.S.B. v. Alaska Psychiatric Institute*, Case No. S-12677. In oral argument I was asked what "safely" means under the "survive safely in freedom" standard. I responded that it was the Alaska Supreme Court which had used that term, pulling it from *O'Connor v. Donaldson*, and I didn't know exactly what it meant, but it needed to be sufficiently serious to justify locking someone up, such as "serious illness, injury or death."

With respect to MHL §9.60, I didn't find anything about what "survive safely in the community without supervision" means in the case law. However, The legislative findings in L.1999, c. 408, §2 includes:

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[15] 422 U.S. 563, 95 S.Ct. 2486 (1975).

[16] 422 US at 576, 95 S.Ct. at 2494.

[17] *Humphrey v. Cady*, 405 U.S. 504, 509, 92 S.Ct. 1048, 1052 (1971). In *O'Connor*,at n9, the United States Supreme Court cited to *Cady*, saying:

> Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.

[18] However, in *Robinson v. Sanchez*, 168 Misc.2d 546, 554, 639 N.Y.S.2d 897, 903 (N.Y.Sup. 1996), involving a 41-year-old man who as a child fell three stories to the ground, suffering injuries to his head, and had been hospitalized for 32 years, the Bronx Supreme Court reversed a jury verdict finding he didn't need continued care and treatment as a danger to himself or others, mentioning in passing:

> Nor is there evidence to support a belief that petitioner could survive safely in a less restrictive setting, when he still manages to injure himself in the most restrictive setting possible.

> The legislature finds that there are mentally ill persons who are capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization. The legislature further finds that there are mentally ill persons who can function well and safely in the community with supervision and treatment, but who without such assistance, will relapse and require long periods of hospitalization.

It is noted here that under MHL §9.60(c)(6), in addition to not being able to survive safely in the community without the Community Drugging Order being a criteria for issuance, the failure to issue the Community Drugging Order must also be "likely to result in serious harm to the person or others." Since "survive safely" and "serious harm" are two different criteria, both of which are required, "serious harm" has to be the lowest hurdle the state has to meet. "Survive safely," could very well be a higher bar.

(a) Clinical Judgment

MHL §9.60(c)(3)'s "based on clinical judgment" clause seems worth separate mention. As set forth above, a Community Drugging Order must be based on proper procedures and evidentiary standards. To the extent that "clinical judgment" in an individual, or even on a category basis, does not meet this standard, it is not proper to subject people to a Community Drugging Order. For example §VII.A., of the attached law review article, "Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course,"[19] sets forth the science (or lack of it) behind predictions of dangerousness.

(2) Unlikely to Voluntarily Participate

In order to issue a Community Drugging Order, MHL §9.60(c)(5) requires "as a result of his or her mental illness, [the respondent is] unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community." One of the disingenuous ways in which MHL §9.60 operates is that forced drugging is only one of the potential options when in fact, it tends to be the only one used. By its terms, however, MHL §9.60 contemplates many different types of outpatient assistance. My experience is that most recipients of mental health services would welcome other types of services. This memorandum is written for an audience with no experience with the mental health system, and therefore it is likely to be surprising for such readers that I need to even suggest that what tends to be most beneficial to recipients of mental health services is to obtain the services they feel they need or want. In terms of the unlikely to voluntarily participate criteria of MHL §9.60(c)(5), it seems possible to turn the proceedings around by demanding that the court order the provision of services the respondent feels are necessary and desirable. This is also related to the "least restrictive alternative" requirement discussed below.

(3) Serious Harm Likely if Community Drugging Order Not Granted

MHL §9.60(c)(6) requires that "in view of his or her treatment history and current behavior, [the respondent] is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others." There are

[19] James Gottstein, 25 Alaska L.Rev. 51, 90 (2008).

two places to resist such a finding that immediately come to mind. The first is, as set forth in the Whitaker and Jackson affidavits, the drugs increase, rather than decrease relapses, and increase rather than decrease violence.[20] The second is the evidentiary unreliability of predictions of harm.[21]

(4) Likely to Benefit

MHL §9.60(7) requires that the respondent is likely to benefit from assisted outpatient treatment. Two aspects of this are especially subject to challenge: (a) Community Drugging Orders, generally, doesn't work, and (b) the Drugs don't benefit most people.

(a) Outpatient Commitment Doesn't Work

The scientific research is very clear that Outpatient Commitment doesn't work. The Cochrane study, "Compulsory community and involuntary outpatient treatment for people with severe mental disorders,"[22] found that it takes 85 Community Drugging Orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest. It does not seem this can possibly satisfy the "likely to benefit" criteria. Similarly, in "International experiences of using community treatment orders,"[23] which says it is the most comprehensive and thorough review of Community Drugging Orders, concluded "it is not possible to state whether [Community Drugging Orders] are beneficial or harmful to patients." This body of research led to an editorial in the *British Journal of Psychiatry* in 2007, titled "Does compulsory or supervised community treatment reduce 'revolving door' care? Legislation is inconsistent with recent evidence."[24]

(b) The Drugs Don't Benefit Most People

The attached Whitaker and Jackson affidavits present the scientific evidence on this in a succinct, yet compelling way.[25] My experience in Alaska is the hospital psychiatrists don't come close to having the knowledge to even begin to attempt to rebut the scientific evidence presented in the Whitaker and Jackson affidavits,[26] but I suspect that will not always be the case in New

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[20] *See*, also, Theodore Van Putten, *Behavioral Toxicity of Antipsychotic Drugs*, 48 J. CLINICAL PSYCHIATRY 13, 14 (1987); J.N. Herrera, *High Potency Neuroleptics and Violence in Schizophrenics*, 176 J. NERVOUS & MENTAL DISEASE 558, 560–561 (1988); Igor I. Galynker & Deborah Nazarian, *Letters to the Editor: Akathisia as Violence*, 58 J. CLINICAL PSYCHIATRY 16, 31–32 (1997).

[21] *See*, James Gottstein, §VII.A., of the attached law review article, "Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course,"25 Alaska L.Rev. 51, 90 (2008).

[22] Kisely S, Campbell LA, Preston N., *The Cochrane Database of Systematic Reviews* 2005, Issue 3. Art. No.: CD004408.pub2. DOI: 10.1002/14651858.CD004408.pub2

[23] Institute of Psychiatry at the Maudsley (UK), March 2007

[24] Stephen Kisely and Leslie Anne Campbell, *British Journal of Psychiatry*, 197, 373-374 (2007)

[25] The version of the Whitaker Affidavit on the Internet at http://psychrights.org/Litigation/WhitakerAffidavit.pdf includes hyperlinks to all of the studies cited, which allows them to be downloaded and used as exhibits.

[26] In fact, at the last forced drugging trial I conducted, the hospital psychiatrists were not allowed to testify as to any scientific evidence regarding the drugs because they were not qualified experts. Alaska has adopted the *Daubert* standard, 509 U.S. 579, 113 S.Ct. 2786 (1993), for "scientific" evidence in *State v. Coon*, 974 P.2d 386 (Alaska 1999), but rejected the *Kumho Tire*, 526 U.S. 137, 147, 119 S.Ct. 1167

York. If a real rebuttal is attempted that will present an even better opportunity to debunk the common wisdom about the drugs.

B. Least Restrictive Alternative

MHL §9.60(j)(2) does not allow issuance of a Community Drugging Order unless, "the court finds by clear and convincing evidence that the subject of the petition meets the criteria for assisted outpatient treatment, and there is no appropriate and feasible less restrictive alternative . . . ."[27] The attached Whitaker and Jackson affidavits present the scientific evidence regarding far more effective, and entirely feasible, less restrictive alternatives. I know there are some such programs in New York and PsychRights will try to identify them.

Also, as mentioned above in connection with the respondent not voluntarily accepting treatment, many, if not most, respondents want services other than the drugs. Upon a petition being filed, a the respondent's right to such less restrictive alternatives springs into being and the court should be asked to order the provision of such services.[28]

C. Appeals & Stays Pending Appeal

My experience, not only in Alaska, but also from talking to people around the country, is that most trial judges do not come close to following the law with respect to forced drugging (or involuntary commitment for that matter), virtually always just going along with whatever the doctor says. However, *K.L.*, notwithstanding, appellate courts, especially the higher one goes, tend to treat psychiatric respondents' rights more seriously. Appealing adverse trial court decisions is an integral part of PsychRights' strategic campaign against forced psychiatric drugging.[29] Of course, a good record needs to be made to maximize the chances for success on appeal.[30]

I haven't researched the procedures for seeking a stay pending appeal to adverse rulings under MHL §9.60, nor the standard(s) for granting such a stay, but seeking such a stay(s) can also be

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(1999), extension of *Daubert* with respect to experience based expertise in *Marron v. Stromstad*, 123 P.3d 992 (Alaska 2005). The transcripts of this trial and other documents on this case can be found at http://psychrights.org/States/Alaska/CaseSeven.htm#08-00493.

[27] Emphasis added.

[28] *See*, "Implementation of 'Kendra's Law" Is Severely Biased," at 2, by *New York Lawyers for the Public Interest*, April 7, 2005.

[29] However, even just vigorous representation at the trial court level is extremely beneficial for a number of reasons. One is that currently obtaining Community Drugging Orders is the path of least resistance, resulting in no serious effort to find other, less harmful and more helpful approaches. By making such orders harder to obtain, more effort goes into finding alternatives to the forced drugging. This has proven to be very much true in Alaska where I have gotten people out with a phone call or an e-mail because the hospital knows that if I represent someone, it will be an all-out legal battle. *See*, http://psychrights.org/States/Alaska/Alaska.htm for some examples of this. To the extent that Community Drugging Orders generally become harder to obtain, PsychRights' mission is advanced even without appellate victories.

[30] The trial court judges often refuse to allow relevant testimony and because of this and for other reasons, I have taken the approach of filing written testimony of which the Whitaker and Jackson affidavits are examples. This guarantees a good record on appeal.

very important. The Alaska Supreme Court in *Bigley v. Alaska Psychiatric Institute*,[31] recently granted such a stay finding we had made a sufficient showing at the trial court that Mr. Bigley faced the danger of irreparable harm if the hospital was allowed to administer Risperdal Consta to him. In my view, true relief can not be obtained for one's clients in these cases on appeal unless a stay is obtained and they should be the object of serious efforts. Unfortunately, for continuation petitions, under MHL §9.60(n), the current order remains in effect until disposition, so a stay wouldn't work for such cases.

V. Concluding Comments

This memorandum is written in what is hoped is professional language, but which does not convey the true horror of forced psychiatric drugging. the Whitaker and Jackson affidavits, also written in professional language, convey more of it.[32] This practice is causing an almost unimaginable amount of harm, ruining and shortening the lives of thousands upon thousands of people. PsychRights views its efforts as akin to Thurgood Marshall and the NAACP efforts in the 1940's and 50's on behalf of African American civil rights.[33] We hope you find the analogy to the Civil Rights Movement is apt. Devoting *pro bono* effort towards the amelioration of forced drugging and electroshock is every bit as worthy as other *pro bono* efforts and it is fervently hoped this memorandum will result in you devoting such *pro bono* resources towards it. Please contact us to do so.

The reason the trial judges do not require the state to actually meet its legal burden(s) is they believe the proposed forced drugging is truly helpful to the person. In other words, that if the respondent wasn't crazy, he or she would know it was good for them. In defending these cases, it is thus essential to come in with a compelling case against the drugs and, for that matter, in favor of less restrictive alternatives. For various reasons, the Mental Hygiene lawyers assigned to do these cases, with rare exceptions do not do so. Often it is because they, like the judges, believe that the forced drugging is in their clients' best interests and for that reason fail to interpose any meaningful defense. Even if they want to vigorously represent their clients, they are essentially stymied from doing so. It is for this reason, PsychRights is seeking *pro bono publico* legal services to address this problem in the best tradition of the American bar.

VI. Attachments/Internet Links

1. Affidavit of Robert Whitaker.
2. Affidavit of Grace E. Jackson, MD.
3. Mental Hygiene Law § 9.60 (a/k/a Kendra's Law).
4. Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a matter of Course, 25 Alaska L.Rev. 51 (2008).
5. Alaska Supreme Court Order granting stay pending appeal in *Bigley v. Alaska Psychiatric Institute*, Case No. S-13116.

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[31] Case No. S-13116.

[32] Probably the best thing to get a good sense of it is to read Robert Whitaker's book, *Mad in America*. There is also a fairly extensive reading list at http://psychrights.org/Market/storefront.htm, with Dr. Breggin's recent 2nd Edition of Brain Disabling Treatments in Psychiatry, being a comprehensive analysis.

[33] PsychRights is a tax-exempt 501(c)(3) public interest law firm.