



**TESTIMONY OF  
THE DEPARTMENT OF THE ATTORNEY GENERAL  
KA 'OIHANA O KA LOIO KUHINA  
THIRTY-THIRD LEGISLATURE, 2026**

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**ON THE FOLLOWING MEASURE:**

S.B. NO. 2288, RELATING TO MENTAL ILLNESS.

**BEFORE THE:**

SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

**DATE:** Friday, February 13, 2026                      **TIME:** 1:00 p.m.

**LOCATION:** State Capitol, Room 225

**TESTIFIER(S):** Anne E. Lopez, Attorney General, or  
Ian T. Tsuda, Deputy Attorney General

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Chair San Buenaventura and Members of the Committee:

The Department of the Attorney General (Department) opposes this bill.

This bill: (1) adds several definitions to chapters 334 and 704, Hawaii Revised Statutes (HRS), that relate to issues of mental illness and treatment interventions; (2) adds to chapter 704, HRS, a new section titled, "Order for treatment", that will require criminal defendants who avoid penal responsibility due to mental impairment or illness to be subject to orders for treatment and ongoing supervision by the court; (3) amends sections 704-402, 704-404, and 704-406, HRS, by revising the current procedures for issues relating to penal responsibility and fitness to proceed and inserting wording that will direct courts to provide orders for treatment or commitment in all cases where such issues are raised; and (4) repeals sections 704-407, 704-407.5, 704-411, 704-412, 704-413, 704-414, 704-415, and 704-421, HRS.

While we appreciate the intent of this bill, the Department is concerned that the amendments conflate the procedures, roles, and purposes that are attributable to separate and distinct criminal and civil processes and proceedings. The criminal law provisions of chapter 704, HRS, employ a comprehensive framework of criminal procedures that address issues of penal responsibility, fitness to proceed, and mental illness to ensure a fair criminal legal process. The civil law provisions of Hawaii's mental health code under chapter 334, HRS, prioritize safety, care, and treatment for individuals suffering from mental illness. Combining these two different systems could

lead to confusion and legal complications and could have unintended and undesirable consequences.

For example, the bill in sections 9 to 16, at page 40 to page 68 (part IV of the bill), repeals multiple sections of chapter 704, HRS, introduces terminology and concepts unfamiliar to the Hawaii Penal Code, and inserts civil mechanisms such as orders for treatment, review hearings, and provisions to allow family members and other interested parties to intervene in criminal proceedings. The result will restrict the criminal court's ability to dictate case directions as it deems appropriate under existing law, leaving the fate of established and frequently used procedures, such as conditional release, uncertain.

In addition, the bill in sections 2 and 3, at page 5 to page 8, introduces the concept of danger to property as a basis for involuntary hospitalization. This standard is likely not to survive constitutional scrutiny under current law. When the standard was previously included in Hawaii law, the Ninth Circuit Court of Appeals found Hawaii's definition of "dangerous to property" to be unconstitutional, because it would permit involuntary hospitalization "for danger to any property regardless of value or significance." Suzuki v. Yuen, 617 F.2d 173, 176 (9th Cir. 1980). This bill does not address the Court's concerns and would be subject to challenge.

The Department is committed to ensuring Hawaii's criminal and civil laws address the needs of individuals suffering from mental illness by providing workable solutions that were made in collaboration with all stakeholders involved in these systems. We believe the bill's intent can be accomplished through existing provisions passed in recent legislative sessions, which already function properly within Hawaii's law and other bills currently before the Legislature that were made in consultation with multiple stakeholders in the community.

For example, Act 219, Session Laws of Hawaii (SLH) 2025, recently provided a comprehensive reexamination of Hawaii's mental health laws to better serve individuals suffering from mental illness to update and modernize the mental health code. The amendments under Act 219 provide clear guidance to professionals treating these individuals and bolstered the tools available to respond to and treat individuals

experiencing mental health crises. The improvements under Act 219 have already yielded positive results as providers utilizing those tools are better equipped to provide care and treatment to Hawaii's most vulnerable.

Further, Act 245, SLH 2024, requested the Judicial Council to appoint a committee to reexamine the Hawaii Penal Code and provide recommendations on areas of improvement, including implementation of more effective protocols for the criminal justice system to appropriately respond to mentally ill offenders. The product of that yearlong effort is Senate Bill No. 2721 and House Bill No. 2414, Relating to the Administration of Justice, spearheaded by the Judiciary, which propose implementing the recommendations of the committee, including proposed amendments to chapter 704, HRS.

For these reasons, the Department respectfully asks that this bill be deferred.

Thank you for considering our testimony.



*The Judiciary, State of Hawai‘i*  
*Ka ‘Oihana Ho‘okolokolo, Moku‘āina ‘o Hawai‘i*

**Testimony to the Thirty-Third Legislature, 2026 Regular Session**

**Senate Committee on Health and Human Services**  
Senator Joy A. San Buenaventura, Chair  
Senator Angus L.K. McKelvey, Vice Chair

Friday, February 13, 2026 at 1:00 p.m.  
State Capitol, Conference Room 225 & Videoconference

By

Jeannette Castagnetti  
Chief Judge, First Circuit

Peter Cahill  
Chief Judge, Second Circuit

Wendy DeWeese  
Chief Judge, Third Circuit

Michael Soong  
Chief Judge, Fifth Circuit

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**Bill No. and Title:** Senate Bill No. 2288, Relating to Mental Illness.

**Purpose:** Clarifies the procedures for assisted community treatment, examination, and hospitalization for individuals who may be mentally ill or suffering from substance abuse who are imminently dangerous to self, others, or property. Amends the procedures for involuntary hospitalizations and assisted community treatment petitions. Amends the Hawai‘i Penal Code to streamline the determination process for penal responsibility and fitness to proceed, including requiring courts to issue orders for treatment to defendants excluded from penal responsibility due to a mental disease, disorder, or defect.



### **Judiciary's Position:**

The Judiciary respectfully but **strongly opposes** this bill and respectfully requests that the measure be deferred. While the stated intent of the bill contained in the preamble is to address petty misdemeanor and misdemeanor offenders, the measure as currently drafted will have the effect of completely overhauling the long-established and nuanced process in Chapter 704 of the Hawai'i Revised Statutes ("H.R.S.") for all offenders, including the more serious felony offenders.

Importantly, the recent completion of the Penal Code Review resulted in Senate Bill 2721. The 2025 Advisory Committee on Penal Code Review (the "Committee"), was appointed by the Honorable Mark E. Recktenwald (Ret.), then Chief Justice of the State of Hawai'i, and the Judicial Council, to carry out the request of the 2024 Legislature in Act 245, Sessions Law of Hawai'i 2024, to review and recommend revisions to the Hawai'i Revised Statutes Title 37 (the "Penal Code"). The Committee consisted of 61 members from a diverse cross-section of the community affected by the criminal laws in Hawai'i. The membership included the Senate Judiciary Committee Chairperson, the House of Representatives Judiciary and Hawaiian Affairs Committee Chairperson, sixteen jurists representing all courts (Supreme Court, Intermediate Court of Appeals, Circuit Court, Family Court, and District Court) and all four Judicial Circuits, prosecutors from all counties and the Department of the Attorney General, lawyers from the Public Defender's Office and the private defense bar, medical professionals from the Department of Health and the Governor's office, law enforcement officers, advocates for victims' rights, advocates for prisoner rights, the Director of the Department of Corrections and Rehabilitation, and interested members of the public, advocacy groups, and government staff. The Committee was divided into eight subcommittees. Each of the subcommittees had the primary responsibility to review one or more assigned chapters of the Penal Code, analyze issues of concern in their assigned chapter(s), and craft and propose legislative solutions for those issues. The subcommittees then presented proposed legislation to the overall Committee in plenary session.

As pertinent here, **one of the subcommittees was solely dedicated to H.R.S. Chapter 704 and its stakeholder membership included the Chair of the Senate Committee on Judiciary, the Chief of the Court Evaluation Branch of the Department of Health, the Senior Advisor to the Governor for Mental Health and the Justice System, the Special Assistant to the Attorney General, judges from Hawai'i Island and O'ahu, defense attorneys from Hawai'i Island and O'ahu, prosecutors from Hawai'i Island, Kaua'i, and O'ahu, and members of the Judiciary.** For over a year they reviewed the provisions of Chapter 704 as directed by the Legislature to ensure that the Chapter was: (1) consistent and proportional across classes of offenses; (2) aligned with national best practices and utilizing evidence-based strategies; (3) cost-effective in advancing penal interests and providing equal justice to all in our community; and (4) responsive to offenders suffering from mental illness.<sup>1</sup> None of the provisions of Senate Bill 2288 were presented to the subcommittee for consideration

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<sup>1</sup> Act 245 SLH2024, Section 2, pages 2-3.



or discussion. The recommendations of the Chapter 704 subcommittee that gained supermajority approval in plenary session are contained in Senate Bill 2721.

The present legislation, according to Section 1<sup>2</sup>, attempts to address the “unfit to proceed paradox” for low-level offenders by completely eliminating the most critical provisions of H.R.S. Chapter 704, rewriting the laws relating to defendants who lack the capacity to understand the proceedings against them and to assist in their own defense (“unfit”) and those defendants who lacked cognitive and/or volitional capacity at the time of their alleged offense (“not penally responsible”), and re-describing the definitions of those terms in the context of criminal cases.<sup>3</sup>

The measure contains a number of provisions that are of serious concern to the Judiciary. For instance the bill, *inter alia*, limits the time for all defendants to become fit to proceed, except for those charged with “A” felonies or murder, to four months or the charges are dismissed<sup>4</sup> (an incredibly short limitation for most defendants)<sup>5</sup>; requires all defendants suspected of either being unfit or not penally responsible to be committed to the custody of the director of health<sup>6</sup> (resulting in a significant increase in the census at the state hospital); requires the court to determine whether a defendant had the state of mind to be found guilty of the offense charged<sup>7</sup> (the determination of which is exclusively in the purview of the trier of fact); permits the State

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<sup>2</sup> Section 1 appears to be premised on an understanding that the court routinely orders the administration of involuntary medications over objection on defendants simply because they are found not guilty by reason of a physical or mental disease, disorder, or defect as part of the defendant’s commitment and/or conditional release terms. That is not permitted by current law and does not accurately describe judicial decisions in these circumstances. For defendants who are unfit to proceed and defendants who are acquitted by reason of mental disease, disorder, or defect, there must be a petition and a hearing wherein the court finds that the defendant suffers from a physical or mental disease, disorder, or defect, they are imminently dangerous to self or others, the proposed treatment is medically appropriate, and considering less intrusive alternatives, the treatment is necessary to forestall the danger posed by the defendant. H.R.S. § 334-161. *See also, State v. Kotis*, 91 Hawai’i 319, 984 P.2d 78 (1999).

<sup>3</sup> The newly defined terms and criteria for “fitness” and “penal responsibility,” and the intertwining of the same, as set forth in Sections 6 and 7, may be contrary to well settled federal and state constitutional law regarding competency and procedural and substantive due process. Further, the combined definition of “severe cognitive impairment” set forth in Section 6 may be misleading in that the term generally refers to organic brain disorders and not psychiatric disorders which are far more common among criminal defendants going through the H.R.S. Chapter 704 process.

<sup>4</sup> *See*, Senate Bill (“SB”) 2288, pages 31 and 33.

<sup>5</sup> It should be noted that the intent and purpose of the seven to fourteen day commitments of Act 26 SLH2020 and Act 87 SLH2024 (H.R.S. § 704-421 – born from the Mental Health Summit in 2019) was to get non-violent justice involved individuals with serious mental illness into the best treatment right away (involuntary commitment, assisted community treatment, or case management services) – essentially to triage to the right services and divert them entirely from the fitness restoration path and the criminal justice system. It was hoped that preventing these low-level non-violent offenders who suffer from a mental illness from serving extended terms of incarceration awaiting fitness restoration (for far longer than their sentence could have been) would provide the best opportunity to extend essential case management services and peer specialist support to those individuals and would free up both hospital and jail bed space for higher level offenders who required it.

<sup>6</sup> *See*, SB2288, page 18. Although the bill also purports to permit the court to commit the defendant for custodial care and examination to “other mental health facilities or professionals,” there are currently no other available custodial facilities, or professionals who have custodial powers, that are likely to take on that obligation.

<sup>7</sup> *See*, SB2288, page 15.



and the court, not just the defendant, to raise the affirmative defense of the lack of penal responsibility<sup>8</sup> (raising significant federal and state constitutional concerns); requires treating physicians directly responsible for a defendant's custody, care, and treatment to opine on the newly re-defined criteria for fitness and penal responsibility<sup>9</sup> (typically prohibited due to the fundamental conflict between their therapeutic roles and forensic opinions); permits the court to order the involuntary administration of medication<sup>10</sup> (without the required constitutional and statutorily required findings); and removes all the provisions of conditional release after a defendant is found not guilty by reason of physical or mental disease, disorder, or defect as well as all of the consequences for violation of those terms.<sup>11</sup>

Furthermore, as currently drafted, the measure contains provisions and references that appear contradictory. For example,<sup>12</sup> the measure references, in at least two instances, repealed provisions of Chapter 334;<sup>13</sup> contains provisions that require that the case "shall be dismissed" then instructs the court to issue an order for treatment that requires revisions to that order and review hearings in perpetuity;<sup>14</sup> provides that a defendant who is either found not guilty by reason of mental disease, disorder, or defect or whose case was dismissed because they did not become fit to proceed within four months can move, or others can move for them, to expunge their misdemeanor and petty misdemeanor convictions;<sup>15</sup> provides that an order for treatment issued under the proposed new statute in Section 5 can be issued as part of a defendant's conditional release or probation but eliminates the provisions of conditional release in Sections 11-15 and probation is not available to either defendants who are not guilty by reason of physical or mental disease, disorder, or defect or defendant's whose cases were dismissed;<sup>16</sup> requires the court to determine whether the defendant had the requisite state of mind to be found guilty of the offense charged, but leaves the provisions relating to when the affirmative defense is submitted to a jury;<sup>17</sup> requires all defendants who are found not guilty by reason of mental disease, disorder, or defect to be subject to an order to treat under Section 5 "[n]otwithstanding any law to the contrary," but in Section 6 permits the defendants release without such an order in some instances;<sup>18</sup> and requires ("shall") the commitment of all defendants subject to an examination under H.R.S. § 704-404, but then leaves the language that they "may" be examined while in custody.<sup>19</sup>

In light of the recent endeavors of the Advisory Committee on Penal Code Review and the proposed measure's significant revision to the fitness to proceed, penal responsibility, and post-acquittal process, the Judiciary respectfully requests that the measure be deferred until such

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<sup>8</sup> *Id.*

<sup>9</sup> *See*, SB2288, pages 18-21.

<sup>10</sup> *See*, SB2288, page 11.

<sup>11</sup> *See*, SB2288, pages 49-64.

<sup>12</sup> This is not an exhaustive list of apparent contradictory provisions in the measure.

<sup>13</sup> *See*, SB2288, page 31.

<sup>14</sup> *Id.* If the case is dismissed, there is no mechanism for the court to issue or maintain such an order.

<sup>15</sup> *See*, SB2288, page 14. Neither of those categories of defendants would have a conviction in those two scenarios.

<sup>16</sup> *See*, SB2288, page 12.

<sup>17</sup> *See*, SB2288, page 16.

<sup>18</sup> *See*, SB2288, page 10 and 17.

<sup>19</sup> *See*, SB2288, page 18, 23.



Senate Bill No. 2288, Relating to Mental Illness  
Senate Committee on Health and Human Services  
Friday, February 13, 2026 at 1:00 pm  
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time as all stakeholders are able to thoroughly evaluate and consider the proposals contained therein to determine their appropriateness and effectiveness on the process.

Thank you for the opportunity to testify on Senate Bill 2288.



The Institute for Human Services, Inc.  
Ending the Cycle of Homelessness

**TO:** Honorable Senator Joy A. San Buenaventura,  
Chair, Senate Committee on Health and Human Services

Honorable Senator Angus L.K. McKelvey,  
Vice Chair, Senate Committee on Health and Human Services

**FROM:** Angie Knight, Community Relations Manager  
IHS, The Institute for Human Services, Inc.

**RE:** SB 2288 - Relating to Mental Illness

**DATE:** February 12, 2026

**POSITION:** IHS supports SB 2288

As a homeless service provider with extensive outreach experience with chronically homeless individuals, including filing petitions for Assisted Community Treatment (ACT) in Family Court of the State of Hawai'i, IHS, The Institute for Human Services, supports the intent of SB2288.

We witness daily how treatment can dramatically change outcomes, allowing people to start work, find housing, and build new lives. Currently, **individuals diverted to the Hawaii State Hospital** from incarceration under ACT 26 **often fail to receive the treatment that they need in order not repeat the offense once released.** Once an individual is found "unfit to proceed" under criminal proceedings, they're dismissed and ultimately released, sometimes untreated for their mental illness, or not given the long-acting medication that would keep them stable for longer upon release. Some individuals have over 50 findings of "unfit to proceed" due to mental incapacities; yet, no petition to treat has been ordered that extends into the community where they are discharged. As the Hawaii State Hospital's burgeoning census incentivizes the earliest possible release to make room for incoming patients, they are hard-pressed to petition ACT, which could add weeks to months to their length of stay at the facility, if no changes are made to court processes. Connecting criminal court dismissals to petitions for court-mandated treatment will create timely, critical opportunities to connect people to the treatment they need – real intervention that will have a lasting impact by targeting the root causes of the misdemeanors they keep getting picked up for. We urge law enforcement, judiciary, and HSH to aid the family court and GALs by compiling their findings for the individual to be used in their petition packet.

Passing this measure does have the potential in the immediate future to further strain the Hawaii State Hospital's capacity for treating the mentally ill and addicted if no system process change is made across the State of Hawai'i. However, in the long run, it will be a substantive cost and resource saver by cutting off the revolving-door 'paradox' and freeing up the time and resources of our law enforcement, courts, Hawaii State Hospital, and case managers. We encourage proper consideration of increased funding or reallocation in light of anticipated demand for care arising from court orders. Otherwise, the lack of capital needed could cause the existing barriers to remain, despite the interventions this measure is intended to resolve.

Mahalo for the opportunity to testify.



## **SB2288 Involuntary Treatment**

### COMMITTEE ON HEALTH AND HUMAN SERVICES

Sen. Joy San Buenaventura, Chair

Sen. Angus McKelvey, Vice Chair

Friday, Feb 13, 2026: 1:00: Room 225 Videoconference

## **Hawaii Substance Abuse Coalition Supports SB2288:**

*ALOHA CHAIR, VICE CHAIR, AND DISTINGUISHED COMMITTEE MEMBERS. My name is Alan Johnson. I am the ad hoc leader of the Hawaii Substance Abuse Coalition (HSAC), a statewide organization for substance use disorder and co-occurring mental health disorder prevention and treatment agencies and recovery-oriented services.*

**While HSAC is not in a position for a legal argument, we can speak to the value of treatment** (for mental illness and substance use disorders).

The biggest upside is **preventing serious harm before it happens**. Allows intervention when there's credible risk based on **recent acts, attempts, or threats**, not just speculation.

**Protects:** The Individual, Potential victims, First responders and bystanders

1. When someone is suicidal, psychotic, severely depressed, manic, intoxicated, or withdrawing, **they may not be capable of choosing safety**.
2. Suicide attempts; Overdoses; Violent escalation; and Medical emergencies from withdrawal.
3. For substance use, this can literally mean **preventing death during relapse or detox**.

**Provides stabilization when impaired judgment directly impairs insight and decision-making.** Involuntary holds can get someone **rapid mental health evaluation, stabilization, and treatment** when they refuse care, especially for acute psychosis, mania, severe depression, or intoxication.

Involuntary treatment gives time for:

- Medications to take effect
- Intoxication or psychosis to clear
- Reality testing to return
- **It creates a pause in destructive cycles**
- **Families get relief and breathing room and** preserve family relationships that might otherwise be permanently damaged

Once stabilized, many **people later agree they needed help**, even if they resisted at first.

The **public often expects the system to act** when someone is clearly dangerous by showing that credible threats are taken seriously.

While HSAC presents the value of treatment, we cannot answer the legal questions: Risk to civil liberties and due process, Subjectivity and inconsistent application, Potential overreach or misuse, Trauma and trust, or Blurring mental illness and criminal behavior

Involuntary treatment is a **bridge to recovery, not the recovery itself**. It's **always a balancing act** between: Public safety and prevention balanced with Individual rights, dignity, and autonomy.

**HSAC appreciates the opportunity to provide testimony and are available for questions.**

**SB-2288**

Submitted on: 2/11/2026 2:21:15 PM

Testimony for HHS on 2/13/2026 1:00:00 PM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
Brian Baker	Testifying for Hina Mauka	Support	Written Testimony Only

Comments:

While we are always concerned about the delicate balancing act between public safety and individual rights, dignity and autonomy, Involuntary Treatment is a bridge to recovery and offers time, support and a much needed pause for many people.

**SB-2288**

Submitted on: 2/11/2026 5:48:25 PM

Testimony for HHS on 2/13/2026 1:00:00 PM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
Jillian Anderson	Testifying for Waikiki Neighborhood Board	Support	Written Testimony Only

Comments:

**The Waikiki Neighborhood Board SUPPORTS SB2288**, and on behalf of our community, urges its passage by the Senate Committee on Health and Human Services.

The individuals this measure targets are of specific concern to Waikiki’s residents, tourists, and businesses alike. Our community suffers greatly from habitual misdemeanor and petty misdemeanor offenders, many of whom fall into the gray area this bill seeks to address. In order to close the revolving door of offense and to improve the safety of the general public, it is imperative that individuals who are found unfit to proceed still undergo treatment as opposed to returning to the streets.

The passage of SB2288 would offer substantial positive impacts for Waikiki and all other communities who find themselves victims of habitual crime from individuals suffering from mental illness and substance addictions.

Mahalo for your strong consideration of this measure and the opportunity to support this bill’s many merits.

**SB-2288**

Submitted on: 2/11/2026 6:56:31 PM

Testimony for HHS on 2/13/2026 1:00:00 PM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
Louis Erteschik	Testifying for Hawaii Disability Rights Center	Comments	In Person

Comments:

We agree that the “fitness to proceed” paradox is a legitimate concern and is worth addressing. However, the language in the bill is not really clear as to what the next steps are. It sounds as though if someone is found unfit they are automatically subject to a court order. We have concerns about the legality of that and question whether the mere fact alone of being found to lack fitness to proceed forms a legal basis for the actions this bill sets forth. We do not believe that a finding of unfitness in and of itself should be sufficient to be an automatic trigger to compulsory treatment. Perhaps it would be appropriate to screen these individuals for the ACT proceeding in the event they are found unfit to proceed. Then, if they meet the criteria that the law already sets out under the ACT statute the Court can proceed from there. But this appears to add a finding of unfitness as a de-facto trigger under the ACT law. We don’t necessarily support that as a policy and we do not believe it complies with the law.

It also appears that this Bill is extremely overbroad .For example on page 6 it defines “dangerous to others” to include the commission of any crime. That can clearly include conduct that nobody considers dangerous and does not seem appropriate to be in the definition. On page 12 it says that even if a person is not imminently dangerous but might become imminently dangerous they can be subject to an ACT order. Since the law creating the ACT process already defines imminently dangerous in terms of speculating about a person’s future conduct this bill appears to take that speculation to several degrees removed and essentially defines it as “maybe they might maybe become dangerous.” We don’t believe there is any way the law can be stretched to such a degree.

In general, this Bill is very difficult to read. It is extremely long and deletes entire sections of the Hawaii Revised Statutes while creating new ones. The language is convoluted. It needs substantial revisions. If the problem the bill is trying to solve is that people found unfit to proceed can be released on a serial basis, then perhaps that problem can be addressed by mandating an appropriate screening for ACT or any other process or treatment that the law currently provides. That would be a reasonable approach and would be a bill that is much easier to understand.

**SB-2288**

Submitted on: 2/12/2026 10:37:13 AM

Testimony for HHS on 2/13/2026 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Travis Sanders	Testifying for Habilitat, Inc.	Comments	Written Testimony Only

Comments:

**To:** Chair and Members of the Committee

**Re:** SB2288 — Relating to Involuntary Treatment for Mental Illness and Substance Use Disorder

**Position:** Comments

Aloha Chair and Members of the Committee,

My name is Travis Sanders, and I am submitting testimony on SB2288.

At Habilitat, we work with individuals experiencing severe substance use disorder and co-occurring mental health conditions. We recognize that in some cases, a person may be so impaired that they are unable to recognize the need for treatment, and families and communities are left without meaningful options to prevent harm.

At the same time, any expansion of involuntary treatment must be approached carefully. If the State considers moving forward with this type of framework, it is essential that it include strong due process protections, clear clinical standards, independent oversight, and a focus on connecting individuals to evidence-based treatment rather than punitive confinement.

Involuntary treatment should never be used as a substitute for voluntary services, housing, or accessible outpatient care. Hawai'i must also ensure that any policy change is matched with adequate funding for treatment capacity, workforce, and continuity of care otherwise individuals may be ordered into systems that do not have the resources to serve them appropriately.

We appreciate the intent of SB2288 and respectfully request the Committee consider amendments to ensure protections, accountability, and treatment-centered implementation.

Mahalo for the opportunity to testify.

Respectfully,  
Travis Sanders  
Habilitat, Inc.



# Hawai'i Psychological Association

*For a Healthy Hawai'i*

P.O. Box 833  
Honolulu, HI 96808

[www.hawaiiopsychology.org](http://www.hawaiiopsychology.org)

Phone: (808) 521-8995

SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES  
Senator Joy A. San Buenaventura, Chair  
Senator Angus L.K. McKelvey, Vice Chair

Friday, February 13, 2026, 1:00 PM  
Conference Room 225 & Videoconference

## OPPOSITION FOR SB 2288, RELATING TO MENTAL ILLNESS

The Hawai'i Psychological Association (HPA) strongly opposes SB 2288. This bill seeks to address what is described as the “unfit to proceed paradox” by expanding involuntary treatment criteria for individuals with severe mental illness who repeatedly commit low-level offenses. SB2288 also broadens the court’s authority to evaluate fitness to proceed and to issue orders for involuntary treatment. While HPA recognizes the Legislature’s desire to increase engagement with mental health treatment amongst individuals with severe mental illness, this bill raises several serious concerns regarding the expansion of involuntary treatment beyond its intended scope and the erosion of constitutional and clinical safeguards.

HPA opposes SB2288 for the following reasons:

1. **Increased Judicial Discretion and Elimination of Critical Clinical Safeguards**  
SB2288 grants courts broad discretionary authority to issue and modify “orders for treatment,” including involuntary hospitalization, outpatient mandates, housing directives, and geographic restrictions. Although clinical evaluations by qualified examiners remain part of the process, SB2288 significantly shifts authority from established psychiatric panel procedures and clinical determinations to judicial oversight. Importantly, SB2288 eliminates the existing requirement that evaluations be conducted by specifically indicated Department of Health examiners. These court-appointed evaluators provide high-quality, standardized forensic assessments compared to evaluations conducted independently. The bill also lacks clarity regarding how many evaluations may be required in various cases. It does not clearly preserve the three-panel structure nor specify whether courts may rely on a single evaluation. The current three-examiner panel system in felony cases has worked well in Hawai'i, ensuring independent examinations paid directly by the court, rather than by one party or another, thereby protecting neutrality and due process. The three-examiner panel system reduces error by correcting variability amongst clinical judgment. Furthermore, determinations of fitness to proceed and appropriate treatment conditions should be clinically grounded decisions informed by mental health expertise. Expanding judicial authority in this domain diminishes the role of independent mental health professionals and weakens existing safeguards designed to protect substantive due process. Treatment planning and risk assessment should be guided by clinical standards and evidence-based practice.
2. **Broadening “Harm” to Include Minor Damages**  
SB2288 expands the concept of dangerousness to include minor physical or emotional injury to self, others, or property. This represents a departure from traditional civil commitment standards,

which are grounded in evidence of serious risk of harm to self or others. Existing involuntary treatment criteria include evidence of both mental illness and dangerousness and are intended to function as a protective health intervention. Expanding these criteria to encompass minor conduct lowers the threshold to justify involuntary commitment and may increase the demand for already strained treatment facilities.

In conclusion, while addressing the “unfit to proceed paradox” and recidivism may be warranted, SB2288 proposes amendments that risk overexpansion of involuntary treatment and may disproportionately impact already marginalized populations. This bill may also further strain Hawai‘i’s judicial and behavioral health systems without addressing underlying treatment capacity challenges.

Thank you for the opportunity to submit testimony and for your thoughtful consideration of this important matter.

Sincerely,

A handwritten signature in cursive script that reads "Alex Lichten, Ph.D." The signature is written in dark ink on a light-colored background.

Alex Lichten, Ph.D.  
Chair, HPA Legislative Action Committee



**MIKE GOODMAN ATTORNEY AT LAW L.L.L.C.**

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Aloha;

I want to thank Chair San Buenaventura and other Members of the Committee, for the opportunity to submit my testimony in strong support of SB2288. My name is Mike Goodman. In addition to my law practice, I regularly serve as a Guardian ad Litem for severely mentally ill subjects of Assisted Community Treatment Act Petitions, most of whom are chronically homeless; I'm also Chair of the Partners In Care Advocacy Committee, but since the membership hasn't had a chance to vote on this bill, I'm submitting this testimony as an individual, and not as a representative of Partners In Care.

I wrote the original draft of this bill, before it was submitted to the Legislature. I also conducted the legal research it's based on. I'm therefore qualified to answer any questions you may have about its' constitutional and statutory foundations.

**Chronic homelessness and mental illness are inextricably intertwined.** Roughly 97% of chronically homeless individuals living on the streets, are mentally ill, addicted, and usually a combination of both.

**Obviously, we need to have sufficient resources for them to live where they can be provided with sufficient care and supervision.** But unless we confront the legal issues that make it unduly difficult for courts to order involuntary treatment, all the mental health resources and housing in the world won't end chronic homelessness, or tame the chaos on the streets of our communities.

**Most Chronically homeless individuals routinely refuse offers of psychiatric care and shelter.** For some, their ability to make decisions in their own best interests are overwhelmed by powerful addictions; Others are rendered incapable of correctly perceiving reality by psychotic delusions. In the cruelest of ironies, a majority of individuals diagnosed with schizophrenia are also afflicted with Anosognosia, meaning they're literally incapable of understanding they're mentally ill and need help.

In Hawaii and other jurisdictions, social workers in outreach teams spend months and sometimes years, trying to convince chronically homeless, severely mentally ill individuals, their lives would be better if they agreed to treatment with antipsychotic medication, and accepted offers of shelter. But trying to reason with people who lack the ability to make rational decisions, is at best a flawed strategy.

Even permanent supportive housing, which is the gold standard for homeless who aren't severely mentally ill, usually doesn't work for those who are; Their delusions, erratic thought-patterns, and volatile disposition, creates the same chaos in permanent supportive housing as it did on the streets; Most are eventually evicted and return to homelessness.

**A SHORT SUMMARY OF WHY SERVICE-RESISTANCE HAS BEEN A DIFFICULT LEGAL CHALLENGE.**

In 1975, in the case of *O'Connor v. Donaldson*, the U.S. Supreme Court ruled that involuntary psychiatric commitment implicates the same fundamental liberties as incarceration after a criminal conviction; Just as there must be a compelling reason to put someone in prison, there must also be a compelling reason to lock someone away in mental hospital or even medicate them involuntarily; In sum, a person has to pose an “imminent danger to themselves or others”. See *O'Connor v. Donaldson*, 422 U.S. 563, 575, 95 S. Ct 2486, 2493 (1975); *State v. Kotis*, 91 Haw. 319, 340, 984 P.2d 78, 99 (1999); *In re Doe*, 102 Hawaii 528, 78 P.3d 341 (Haw. App. 2003).

Since then, Hawaii and many jurisdictions across the country, have grappled with how to define “imminent dangerousness”. Most construe “danger to others” as requiring violence, the threat of violence, or at least a risk of physical harm. For instance, HRS §334-1 provides in pertinent part, “‘Dangerous to others’ means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat.” Jurisdictions who tried broadening these definitions, often faced a spate of litigation.

**The problem with construing “dangerousness” with violence or physical harm, is that it leads to a host of absurd outcomes.** An example of this in Hawaii is “the unfit to proceed” paradox, which plays out as follows: Under the U.S. Constitution, mentally ill defendants who suffer from cognitive impairments of such severity they’re unable to understand the proceedings or participate in their own defense, cannot be tried, and the charges against them must be dropped. In Hawaii, when a defendant charged with a non-violent petty misdemeanor is found unfit to proceed, under current law, he’s usually found to be not imminently dangerous to others<sup>1</sup>.

Having been found not imminently dangerous, the defendant can’t be subjected to involuntary psychiatric care, or be ordered to forego living on the streets. Although some mentally ill defendants have been arrested hundreds of times for petty non-violent offenses, there’s nothing in Hawaii law, which specifies that being a habitual petty non-violent offender is prima facie evidence of imminent dangerousness. Accordingly, even defendants with hundreds of arrests are typically released on their own recognizance without treatment or supervision; They invariably re-offend, are re-arrested, found unfit to proceed and not imminently dangerous, released on their own recognizance, whereupon the entire cycle repeats, over and over and over again. The most glaring absurdity of this scenario, is that defendants who are less severely mentally ill, can understand the proceedings and participate in their defense, are more likely to get help, because their cases aren’t dismissed.

In *Jones v. United States*, the U.S. Supreme Court ruled "This Court never has held that 'violence', however that term might be defined, is a prerequisite for a constitutional [psychiatric]

---

<sup>1</sup> There is always an examination ordered, where a Psychiatrist, APRN or other physician or psychologist, in addition to determining whether the person is capable of understanding court proceedings and participating in their own defense, must opine as to whether the person is dangerous. If the person was charged with a non-violent petty crime, is not threatening to harm others or himself, most doctors will conclude the person isn’t dangerous, and report those findings to the court. Courts often rely on examination reports to determine whether a defendant is imminently dangerous (which is a conclusion of law). The problem is that the doctor’s opinions in the psychiatric examination report, are based on the common-every-day understanding of what it means to be a dangerous person, which is a propensity to cause physical harm to others. This differs in many respects from the legal definition.

commitment.” *Jones v. United States*, 463 U.S. 354, 365, 103 S. Ct. 3043, 3050 (1983)(underline added). The fact a person is “found to have committed a criminal act is strong evidence that his continued liberty could imperil the preservation of public peace . . .” The *Jones* Court further specified, “We do not agree with petitioner’s suggestion that the requisite dangerousness is not established by proof that a person committed a non-violent crime against property.” *Jones*, at 364—65 & 3049—50 (underlines added)(internal citations and quotation marks omitted).

**The hard truth, is that the vast majority of Mentally ill and addicted homeless individuals, are incapable of living untreated without committing dozens and sometimes hundreds of non-violent petty misdemeanors, and occasionally more serious crimes.** — There is absolutely no constitutional right to refuse medication for a condition that makes it impossible to live without violating the rights of others, even if such violations are non-violent petty offenses.

**The purpose of this bill is not to punish; It’s to compel service-resistant, mentally ill habitual offenders to undergo treatment and move off the streets.** Although self-harm can be used as evidence of imminent danger for involuntary hospitalization under civil code Part IV, Chapter 334, proving someone is likely to harm themselves in the next 45-days (e.g. predicting the future) is on much softer constitutional ground than evidence of crimes that person has already committed. Therefore, using the penal code to get people the help they need is more efficient and less prone to judicial error.

**The purpose of this bill is also not to lock offenders away in a mental ward. It’s to use “the least restrictive means necessary” as required by the U.S. Constitution, to get these individuals the help they need;** (see *Gresham v. Peterson*, 225 F.3d 899, 906, 2000 U.S. App. LEXIS 22359 at 17 (7th Cir. 2000); *Shelton v. Tucker*, 364 U.S. 479, 488, 81 S. Ct. 247, 252 (1960); See also HAW. REV. STAT. § 334-60.2 "Involuntary hospitalization criteria." which provides in pertinent parts that a court may commit persons to a psychiatric facility or involuntary hospitalization, upon finding they are "(1) [] mentally ill or suffering from substance abuse; (2) . . . imminently dangerous to self or others . . . (3) . . . in need of care or treatment . . ." and there is no less restrictive alternative. (underline added).)

**Notwithstanding the foregoing, the purpose of this bill is to use “means that are sufficiently restrictive”.** In part, SB2288 enables courts to order defendants to undergo psychiatric care and forego living on the streets, by amending the definitions imminent of imminent dangerousness under §334-1, to comport with the U.S. Supreme Court’s decision in *Jones v. U.S.* It also modifies other sections of the Assisted Community Treatment Act under Chapter 334, and several sections of the penal code, to take habitual offenses into account as evidence of imminent dangerousness. It also gives courts discretion to tailor orders to the needs of individual defendants.

Mahalo nui loa for the opportunity to testify. I’ll be available to answer questions during the hearing, or afterwards by phone or email.

Very truly yours;

  
Mike Goodman, Esq.

Chair, Partners in Care Advocacy Committee

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**SB-2288**

Submitted on: 2/10/2026 3:45:31 PM

Testimony for HHS on 2/13/2026 1:00:00 PM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
John Deutzman	Individual	Support	Written Testimony Only

Comments:

**Aloha Chair San Buenaventura, Vice Chair McKelvey, and members of the Senate HHS Committee,**

**Senate Bill 2288 is designed to stop the absurd and dangerous practice of releasing known severely mentally ill individuals back immediately to the streets.**

**A frightening real-life consequence occurred in Waikiki last year when a man who was declared unfit for trial three times within 18 months allegedly beat up a 69-year-old male in the bathroom at Ross department store, and is facing 10 years in prison. (See Star Advertiser Article Attached).**

**In that case, the defendant was declared unfit for trial three days before the attack on a harassment strike-shove case, which was considered a “non-violent” petty misdemeanor.**

**Additionally, an 84-year-old homeless man has been declared unfit for trial 18 times in less than three years and keeps getting tossed out on the street. He languishes on park benches and the sand of Waikiki in between arrests for petty crimes.**

**In 12 months, in my small section of Waikiki, there were 49 cases involving 34 individuals who were declared unfit for trial, and all 34 were tossed back to the street.**

**Simply put its time to stop the insanity when it comes to those declared insane.**

**John Deutzman, Waikiki Resident**

**SB-2288**

Submitted on: 2/12/2026 7:48:59 AM

Testimony for HHS on 2/13/2026 1:00:00 PM

<b>Submitted By</b>	<b>Organization</b>	<b>Testifier Position</b>	<b>Testify</b>
Kendrick Farm	Individual	Support	Written Testimony Only

Comments:

Please pass this measure

THE SENATE

KA 'AHA KENEKOA

THE THIRTY-THIRD LEGISLATURE

REGULAR SESSION OF 2026

**COMMITTEE ON HEALTH AND HUMAN SERVICES**

Senator Joy A. San Buenaventura, Chair

Senator Angus L.K. McKelvey, Vice Chair

DATE: Friday, February 13, 2026

TIME: 1:00 PM

PLACE: Conference Room 225 & Videoconference

State Capitol, 415 South Beretania Street

SB 2288 RELATING TO MENTAL ILLNESS.

Clarifies the procedures for assisted community treatment, examination, and hospitalization for individuals who may be mentally ill or suffering from substance abuse who are imminently dangerous to self, others, or property. Amends the procedures for involuntary hospitalizations and assisted community treatment petitions. Amends the Hawaii Penal Code to streamline the determination process for penal responsibility and fitness to proceed, including requiring courts to issue orders for treatment to defendants excluded from penal responsibility due to a mental disease, disorder, or defect. HHS, JDC/WAM

TESTIMONY IN SUPPORT OF SB 2288

Submitted by James Waldron Lindblad

[James.Lindblad@gmail.com](mailto:James.Lindblad@gmail.com)

808-780-8887

**Chair San Buenaventura, Vice Chair McKelvey, and Members of the Committee:**

My name is James Waldron Lindblad. As a bail agent who has monitored arrest logs since 1980 and, together with my wife Evelyn, conducted countless pretrial release interviews, I have witnessed firsthand the persistent “revolving door” that traps severely mentally ill individuals in repeated low-level arrests, jail bookings, emergency room visits, and releases without sustained treatment. Over more than four decades in and around Hawai‘i’s courts and jails, I have seen

the same people cycle through the system endlessly—often committing minor offenses driven by untreated mental illness or substance abuse—while meaningful intervention remains out of reach. This personal experience has convinced me that legislative relief like SB 2288 is urgently needed to break this harmful pattern humanely and effectively.

I submit this testimony in strong support of SB 2288.

For many years, Hawai'i has struggled with a narrow but extremely high-impact population: severely mentally ill individuals who cycle repeatedly through low-level criminal offenses, emergency rooms, crisis units, and jail bookings without receiving sustained treatment.

SB 2288 directly confronts what the bill properly describes as the “unfit to proceed paradox.”

Under our current framework:

- If a defendant is mentally ill but fit to proceed, the court can reach a verdict and order treatment in lieu of punishment.
- If a defendant is more severely impaired and found unfit to proceed, the case is suspended.
- The individual is often released without meaningful treatment.
- The cycle repeats.

This is not humane. It is not constitutional necessity. And it is not good public policy.

SB 2288 does several important things:

### **Clarifies and Corrects the Definition of “Imminently Dangerous”**

Current law already contains a forty-five-day window. However, the existing definition is circular and unnecessarily tied to narrow concepts of violence or serious harm. It effectively defines danger in terms of becoming dangerous, rather than in terms of actual risk of harm.

SB 2288 corrects this by directly defining imminent danger in terms of the likelihood of causing harm within forty-five days, without requiring proof of violent conduct or “substantial” injury. This gives courts a clearer, more workable standard that better reflects real-world behavioral deterioration patterns seen in severe mental illness.

1. That clarity is critical. Judges need guardrails, not guesswork.

## **Allows Treatment Orders When Penal Responsibility Is Excused**

When a defendant is found not guilty by reason of severe cognitive impairment, the bill requires an order for treatment using the least restrictive means necessary.

2. That is balanced.
  - It does not mandate incarceration.
  - It does not mandate hospitalization.
  - It gives courts discretion. But it does prevent release with no structure whatsoever.

## **Aligns Penal Code and Mental Health Statutes**

3. The bill streamlines fitness and penal responsibility examinations under Chapter 704. It ensures reports address:
  - Risk of harm
  - Ability to control conduct
  - Likelihood of reoffending within 45 days
  - Least restrictive treatment setting
4. That is practical, evidence-based decision-making.

## **Protects Due Process**

5. SB 2288:
  - Requires hearings every 120 days.
  - Allows petitions for modification or termination.
  - Places burden of proof standards in statute.
  - Allows appointment of guardian ad litem and counsel.
  - Uses least restrictive treatment language.
6. This is not unchecked state power. It is structured judicial supervision.

## **Why This Matters**

Hawai'i has thousands of mentally ill individuals committing hundreds of low-level offenses over their lifetimes. Each offense in isolation may appear minor. But cumulatively:

- Businesses close.
- Families are harmed.

- Communities lose faith.
- The individuals themselves deteriorate further.

The status quo is neither compassionate nor protective.

Treatment without accountability fails. Accountability without treatment fails.

SB 2288 attempts to reconcile both.

### **A Measured Recommendation**

I support SB 2288 and encourage continued careful refinement in implementation to ensure:

- Clear coordination between DOH, courts, and community providers.
- Adequate funding for outpatient treatment infrastructure.
- Judicial training to ensure uniform application statewide.

### **Conclusion**

The Constitution does not require us to release severely impaired repeat offenders without treatment.

SB 2288 restores coherence between mental health law and criminal law.

It is humane.

It is structured.

It is constitutionally mindful.

And it is long overdue.

Thank you for your consideration.

Respectfully submitted, James Waldron Lindblad

[James.Lindblad@gmail.com](mailto:James.Lindblad@gmail.com) 808-780-8887

**JAMES B. (Jim) GOTTSTEIN, Esq.**

(808) 446-3440 – jim.gottstein@psychrights.org

February 12, 2026

Senate Committee on Health and Human Services  
Senator Joy A. San Buenaventura, Chair  
Senator Angus L.K. McKelvey, Vice Chair

Re: Opposition to SB 2288

Dear Chair San Buenaventura and Vice Chair McKelvey:

I have been a licensed attorney in Alaska since 1978 and moved to West Maui full-time in 2019. In Anchorage, I co-founded the public interest law firm Law Project for Psychiatric Rights (PsychRights) whose mission is to mount a strategic litigation campaign against forced psychiatric drugging and electroshock. Through PsychRights I have won five Alaska Supreme Court appeals declaring various aspects of Alaska's involuntary psychiatric proceedings unconstitutional or otherwise illegal.<sup>1</sup>

In September of last year, I was appointed as an attorney member of the federally required Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act Advisory Council (Council) to the Hawaiian Disability Rights Center (HDRC) and last December elected the Council's vice chair.

HDRC's mandate under the PAIMI Act includes "to ensure that the rights of individuals with mental illness are protected," including "protect and advocate the rights of [individuals with mental illness] through activities to ensure the enforcement of the Constitution and Federal and State statutes."<sup>2</sup> While I am on the HDRC PAIMI Advisory Council and its vice chair, this testimony is submitted on my own behalf.

I agree that that people who repeatedly commit crimes but are not criminally prosecuted because they have been found incompetent to stand trial is a problem. However, SB 2288 is a wrong-headed approach to deal with the problem on a number of levels. One is there are several unconstitutional provisions. Another is some of its provisions are not susceptible to legitimate proof, such as predictions of violence.

However, most importantly, before addressing these it is important to note the more global problem of our failed mental health system which is horrendously counterproductive and harmful. Since, improving Hawaii's mental health system is within the jurisdiction of your committee I have attached the [Report on Improving Mental Health Outcomes](#), which it is respectfully suggested should guide the state's mental health policy.

---

<sup>1</sup> *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006); *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371 (Alaska 2007); *Wayne B. v. Alaska Psychiatric Institute*, 192 P.3d 989 (Alaska 2008); *Bigley v. Alaska Psychiatric Institute*, 208 P.3d 168 (Alaska 2009); and *In the Matter of Heather R.*, 366 P.3d 530 (Alaska 2016).

<sup>2</sup> 42 U.S.C. § 10801.

In a nutshell, the mental health system's standard treatments are colossally counter-productive and harmful and forcing them on unwilling patients is certainly not in their best interests. For example, psychiatric incarceration, euphemistically called "involuntary commitment," is massively associated with suicide and doing so to prevent self harm is illogical and ludicrous. Locking people up to keep them from committing further crimes, one of the approaches taken by SB 2288, is logical, but also wrong-headed.

Forcing people to take psychiatric drugs, especially the neuroleptics<sup>3</sup> is catastrophically counterproductive and harmful. The ubiquitous use of psychiatric drugs reduces the recovery rate of people diagnosed with serious mental illness from a possible 80% to 5% and reduces their life spans by 20 years or so. This is meticulously documented in the attached [Report on Improving Mental Health Outcomes](#), as well as what should be done instead.

A big reason why we are seeing so many of the habitual offenders who evade criminal responsibility because they are found unfit to proceed to trial that SB 2288 was introduced to address, is the failure of Hawaii's mental health system to help this group recover. It is my hope the committee will focus instead on this, rather than further consideration of SB 2288.

As to the provisions of SB 2288, they violate the United States Constitution in a number of ways. Time and space do not allow a line by line analysis, but there are a few key principles that must be followed for the legislation to pass constitutional muster.

The first is that, except for a short evaluation period, the grounds for civil psychiatric incarceration must be proven by clear and convincing evidence.<sup>4</sup> SB 2288 violates this constitutional requirement in various places.

The second is that forced psychiatric drugging must be found by a court to be in the person's best interests, and that the least intrusive means be used.<sup>5</sup> In connection with the latter, in its *Myers* decision, the Alaska Supreme Court noted that psychiatric drugs have been equated with the intrusiveness of electroshock and lobotomy.<sup>6</sup>

A third is there must be procedural fairness, which includes a determination under proper procedural and evidentiary standards.<sup>7</sup> In connections with this, in *Myers*, the Alaska Supreme Court stated,

Many cases describe the unavoidable tensions between institutional pressures and individual best interests that can arise in this setting: "The doctors who are attempting to treat as well as to maintain order in the hospital have interests in

---

<sup>3</sup> Marketed as "antipsychotics" even though they don't have anti-psychotic effects for most.

<sup>4</sup> *Addington v. Texas*, 441 U.S. 418 (1979).

<sup>5</sup> *Sell v. United States*, 539 U.S. 166 (2003).

<sup>6</sup> 138 P.3d at 242.

<sup>7</sup> *Kansas v. Crane*, 534 U.S. 407 (2002).

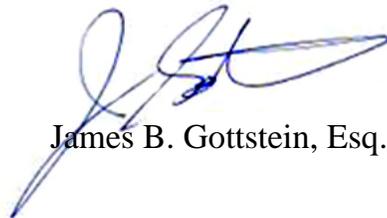
conflict with those of their patients who may wish to avoid medication.... Economic considerations may also create conflicts [.]” Courts and commentators alike have documented numerous instances in which these tensions have actually resulted in abuse “by those claiming to act in [a patient's] best interests.”<sup>8</sup>

Two of the hallmarks of Due Process are a meaningful opportunity to be heard, such as through cross-examination and presentation of evidence, and that the decision be made by a neutral decision maker.<sup>9</sup> SB 2288 runs afoul of these most basic constitutional Due Process requirements.

There are other constitutional infirmities in SB 2288,<sup>10</sup> but the last one I will mention is that in order to permissibly confine someone for being gravely disabled, the disability must be so severe that the person is "unable to survive safely in freedom,"<sup>11</sup> including through the "aid of willing family members or friends."<sup>12</sup>

In short, it is respectfully suggested that because of all these constitutional infirmities and the counterproductive and harmful nature of the remedies no more time should be spent on SB 2288. Instead, it is my hope the committee will take a serious look at dramatically improving Hawaii's mental health system as laid out in the attached Report on Improving Mental Health Outcomes. I would be pleased to work with the committee on this.

Sincerely,

A handwritten signature in blue ink, appearing to read 'J. B. Gottstein', with a long horizontal flourish extending to the right.

James B. Gottstein, Esq.,

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<sup>8</sup> 138 P.3d at 250, footnotes omitted.

<sup>9</sup> *Hamdi v. Rumsfeld*, 542 U.S. 507 (2004).

<sup>10</sup> I also agree with the testimony of Louis Erteschik, Esq., Executive Director of the Hawaiian Disability Rights Center, that a finding of unfitness to proceed alone cannot permissibly form the basis of the actions set forth in SB 2288, and that the commission of any crime does not, by itself, satisfy the dangerousness criteria. Finally, SB 2288 oxymoronicly creates the presumption that someone who has been found unfit to proceed is guilty of the alleged crime.

<sup>11</sup> *O'Connor*, 422 U.S. at 576.

<sup>12</sup> *O'Connor*, n9.

REPORT  
ON  
IMPROVING  
MENTAL HEALTH  
OUTCOMES

---

James B. (Jim) Gottstein, Esq.; Peter C. Gøtzsche, MD;  
David Cohen, PhD; Chuck Ruby, PhD; Faith Myers

September 2023

## I. EXECUTIVE SUMMARY

The mental health system's standard treatments are colossally counterproductive and harmful, often forced on unwilling patients. The overreliance on psychiatric drugs is reducing the recovery rate of people diagnosed with serious mental illness from a possible 80% to 5% and reducing their life spans by 20 years or so. Psychiatric incarceration, euphemistically called "involuntary commitment," is similarly counterproductive and harmful, adding to patients' trauma and massively associated with suicides. Harmful psychiatric interventions are being imposed on people without consideration of the facts about treatments and their harms, and are a violation of International Law.

The most important elements for improving patients' lives are People, Place and Purpose. People—even psychiatric patients—need to have relationships (People), a safe place to live (Place), and activity that is meaningful to them, usually school or work (Purpose). People need to be given hope these are possible. Voluntary approaches that improve people's lives should be made broadly available instead of the currently prevailing counterproductive and harmful psychiatric drugs for everyone, forever, regime often forced on people. These approaches include Peer Respite, Soteria Houses, Open Dialogue, Drug-Free Hospitals, Housing First, Employment, Warm Lines, Hearing Voices Network, Non-Police Community Response Teams, and emotional CPR (eCPR).

By implementing these approaches, mental health systems can move towards, and even achieve, the 80% possible recovery rate.

As bad as it is for adults, the psychiatric incarceration and psychiatric drugging of children and youth is even more tragic and should cease. Instead, children and youth should be helped to manage their emotions and become successful, and their parents should be given support and assistance to achieve this.

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### III. THE CURRENT MENTAL HEALTH SYSTEM IS EXTREMELY COUNTERPRODUCTIVE AND HARMFUL

#### The Overuse of Psychiatric Drugs

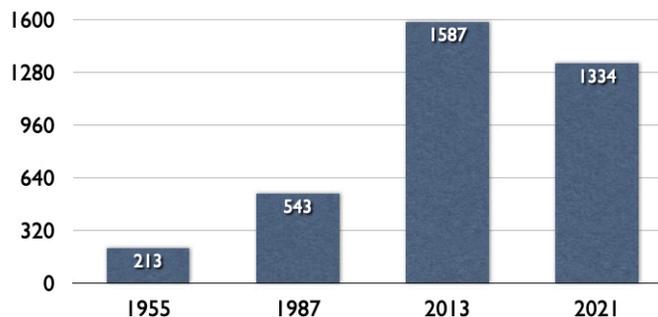
It is fairly universally accepted that the mental health system is a failure, especially regarding what has been accomplished with the most noteworthy feature of psychiatric treatment since the 1950s and exponentially so since the early 1980s, psychiatric drugs. At great public expense, the system’s ubiquitous deployment of psychiatric drugs, including being forced upon unwilling patients, often by holding them down and injecting them against their will, or threatening to do so to obtain “compliance,” dramatically worsens outcomes and suffering.

Since the introduction of the so-called miracle drug Thorazine (chlorpromazine) in the mid-1950s, the disability rate of people diagnosed with serious mental illness has increased more than six-fold.<sup>1</sup>

#### The Disabled Mentally Ill in the United States, 1955-2021

(under government care)

■ Per 100,000 population



Source: Silverman, C. *The Epidemiology of Depression* (1968): 139. U.S. Social Security Administration Reports, 1987-2021.

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<sup>1</sup> The charts in this section are from award winning journalist Robert Whitaker, author of *Anatomy of an Epidemic* (2010) and *Mad in America* (2002) including his highly recommended July 16, 2021, talk to the Soteria Network in the UK, “[Soteria Past, Present, and Future: The Evidence For This Model of Care.](#)”

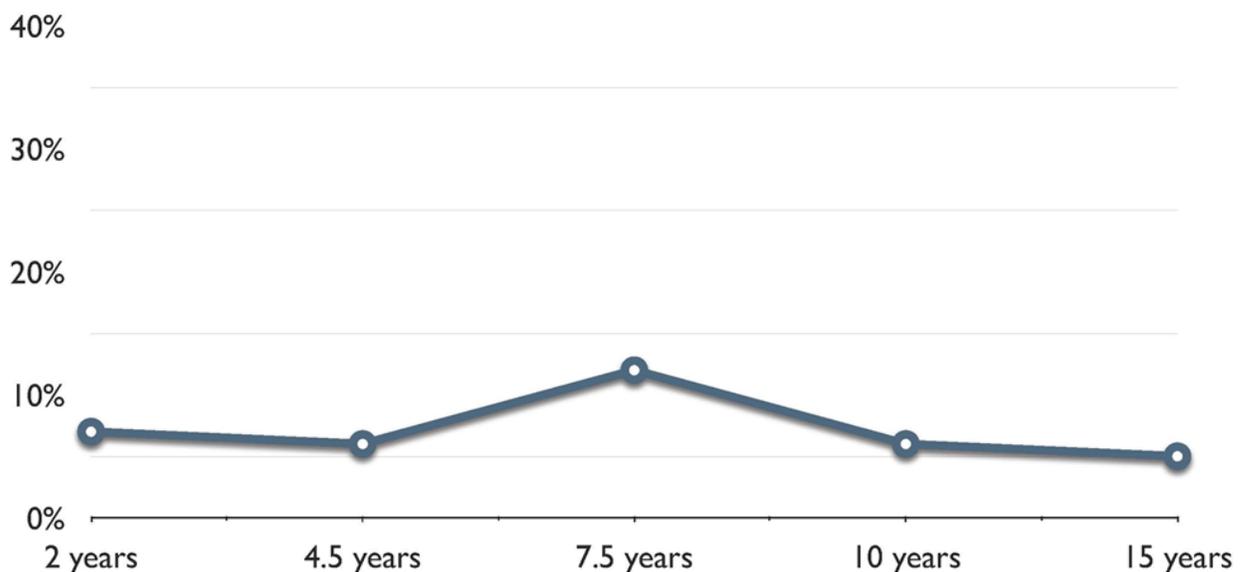
It is likely at least some of the increase after 1987 was because people were thrown off welfare under the “welfare to work” legislation passed in 1996,<sup>2</sup> and had to be certified as disabled to continue to receive financial assistance. The decrease since 2013 is in large part due to the government making it harder to qualify for such disability payments. This in turn may very well have increased the number of homeless people.

Thomas Insel, who for 12 years was Director of the National Institute of Mental Health (NIMH) frankly stated in 2009 and repeatedly thereafter that, “despite five decades of antipsychotic medication and deinstitutionalization, there is little evidence that the prospects for recovery have changed substantially in the past century.”<sup>3</sup>

We now have a recovery rate of only 5% for people diagnosed with schizophrenia who are maintained on neuroleptics.<sup>4,5</sup>

## Long-term Recovery Rates for Schizophrenia Patients on Antipsychotics

(Martin Harrow’s study)



<sup>2</sup> [Personal Responsibility and Work Opportunity Reconciliation Act of 1996](#), Pub. Law. 104-193, August. 22, 1996; 110 Stat. 2105.

<sup>3</sup> Insel, Thomas R. (2009). [“Translating Scientific Opportunity Into Public Health Impact: A Strategic Plan for Research on Mental Illness.”](#) *Archives of General Psychiatry* 66(2): 128-133.

<sup>4</sup> Harrow, Martin; & Jobe, Thomas H. (2007). [“Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study.”](#) *Journal of Nervous and Mental Disease* 195(5): 406-414.

<sup>5</sup> Neuroleptics are marketed as “antipsychotics” even though they don’t have specific anti-psychotic effects for most people.

This is far worse than anything seen before the advent of the neuroleptics in the mid-1950s.

### Outcomes in Select Studies from Pre-Antipsychotic Era

(Patients diagnosed as insane, schizophrenic or psychotic)

Study	Time	Good Outcome*
York Retreat	1796-1811	70%
Worcester Asylum	1833-1846	65%
Pennsylvania Hospital	1841-1882	45% to 70%
Warren State Hospital	1946-1950	73%
Delaware Hospital	1948-1950	70%
Boston Psychopathic Hospital	1947-1952	76%
Norway	1948-1952	63%
California FEP study	1956 (no neuroleptics)	88%

\* Good outcome = discharge from hospital, or living in community at end of study period

Yet if we try to avoid the use of neuroleptics when people experience their first psychotic break, a nearly 80% recovery rate can be achieved. The following chart shows results from the “Open Dialogue” program in Northern Finland in which the use of neuroleptics is avoided if possible.<sup>6</sup>

#### Five-Year Outcomes for First-Episode Psychotic Patients in Finnish Western Lapland Treated with Open-Dialogue Therapy

<b>Patients (N=75)</b>	
Schizophrenia (N=30)	
Other psychotic disorders (N=45)	
<b>Antipsychotic use</b>	
Never exposed to antipsychotics	67%
Occasional use during five years	33%
Ongoing use at end of five years	20%
<b>Psychotic symptoms</b>	
Never relapsed during five years	67%
Asymptomatic at five-year followup	79%
<b>Functional outcomes at five years</b>	
Working or in school	73%
Unemployed	7%
On disability	20%

Source: Seikkula, J. “Five-year experience of first-episode nonaffective psychosis in open-dialogue approach.” *Psychotherapy Research* 16 (2006):214-28.

<sup>6</sup> Seikkula, Jaakko, et al. (2006). “[Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies.](#)” *Psychotherapy Research* 16(2): 214–228.

Similar results were achieved during the Soteria-House study in the 1970s conducted by Loren Mosher, MD, then Chief of Schizophrenia Research at the NIMH:

**Soteria-House Study**

At six weeks, psychopathology reduced comparably in both groups.

At two years:

- Soteria patients had better psychopathology scores
- Soteria patients had fewer hospital readmissions
- Soteria patients had higher occupational levels
- Soteria patients were more often living independently or with peers

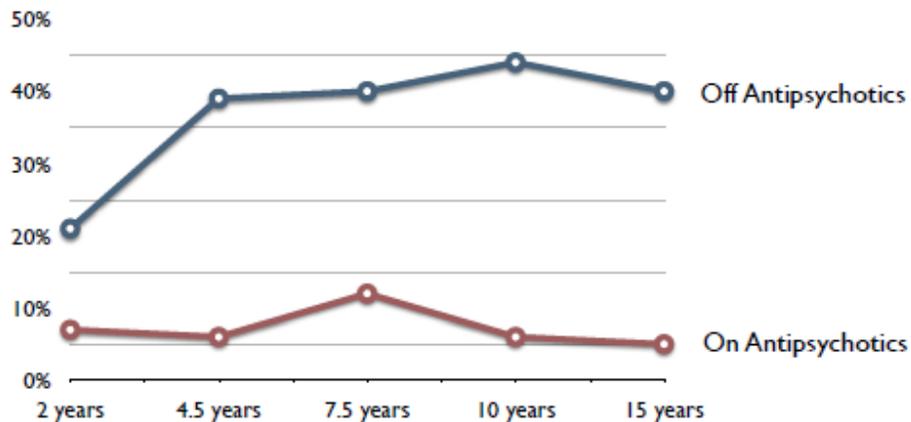
Neuroleptic use in Soteria patients:

- 76% did not use antipsychotic drugs during first six weeks
- 42% did not use any antipsychotic during two-year study
- Only 19% regularly maintained on drugs during follow-up period

Mosher (1999). *J Nerv Ment Dis* 187(3):142-149  
 Bola & Mosher (2003). *J Nerv Ment Dis* 191(4): 219-229

The recovery rate of people who get off neuroleptics after they have been on them goes from 5% to 40%.<sup>7</sup>

### Long-term Recovery Rates for Schizophrenia Patients



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

<sup>7</sup> Harrow, Martin; & Jobe, Thomas H. (2007). "Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study." *Journal of Nervous and Mental Disease* 195(5): 406-414.

While this is 8 times better than staying on them (40% vs. 5%), it is half of what can be achieved by avoiding the use of neuroleptics in the first place (80%), as established by the Open Dialogue and Soteria House studies.<sup>8</sup> **This demonstrates the importance of avoiding the use of neuroleptics in the first place.** In addition to their lives being so much better, allowing 16 times more people to recover not only saves a tremendous amount of treatment expense, it converts people who would otherwise be receiving life-long publicly paid services and transfer payments into productive, taxpaying citizens.<sup>9</sup>

The Harrow and Jobe results were so unexpected and contrary to mainstream psychiatry's beliefs that other explanations were proposed, such as it was the people with the best prognosis in the first place who got off the drugs and therefore had better outcomes, that additional analysis was undertaken. None of the alternate explanations proved correct.<sup>10</sup>

In addition to dramatically reducing the recovery rate, **the ubiquitous use of psychiatric drugs is extremely harmful physically, reducing lifespans by 20 years or so.**<sup>11</sup> In a given time period, the relative risk of dying increases markedly with the number of neuroleptics the person takes.<sup>12</sup> Neuroleptic users have an increased risk of cardiac mortality, all-cause mortality, and sudden cardiac death compared to psychiatric patients

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<sup>8</sup> While there might not be a 100% overlap between the 80% who recovered and the 80% who were not taking the neuroleptics long term, clearly minimizing the use of the neuroleptics produces dramatically better outcomes.

<sup>9</sup> The best book to understand the impact of psychiatric drugs in general, not just the neuroleptics, is *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (2010) by Robert Whitaker, from whose work this section is largely drawn.

<sup>10</sup> Harrow, Martin; Jobe, Thomas H.; & Faull, Robert N. (2012). ["Do All Schizophrenia Patients Need Antipsychotic Treatment Continuously Throughout Their Lifetime? A 20-Year Longitudinal Study."](#) *Psychological Medicine* 42(10): 2145–2155; Harrow, Martin; & Jobe, Thomas H. (2013). ["Does Long-Term Treatment of Schizophrenia With Antipsychotic Medications Facilitate Recovery?"](#) *Schizophrenia Bulletin* 39(5): 962–965; Harrow, M.; Jobe, T. H.; & Faull, R. N. (2014). ["Does Treatment of Schizophrenia With Antipsychotic Medications Eliminate or Reduce Psychosis? A 20-Year Multi-Follow-up Study."](#) *Psychological Medicine* 44(14): 3007–3016; Harrow, Martin, et al. (2017). ["A 20-Year Multi-Followup Longitudinal Study Assessing Whether Antipsychotic Medications Contribute to Work Functioning in Schizophrenia."](#) *Psychiatry Research* 256: 267–274; and Harrow, Martin; & Jobe, Thomas H. (2018). ["Long-Term Antipsychotic Treatment of Schizophrenia: Does it Help or Hurt Over a 20-Year Period?"](#) *World Psychiatry* 17(2): 162–163; Harrow, Martin; Jobe, Thomas H; & Tong, Liping. (2022). ["Twenty-Year Effects of Antipsychotics in Schizophrenia and Affective Psychotic Disorders."](#) *Psychological Medicine* 52(13): 2681–2691.

<sup>11</sup> Gøtzsche, Peter C. (2015), *Deadly Psychiatry and Organized Denial*, p. 165, et. seq. (Copenhagen: People's Press). See also Parks, Joe, et al. (2006), *Morbidity and Mortality in People With Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors). The report documents mortality in people diagnosed with serious mental illness in the public mental health system has accelerated to the point where they are now dying 25 years earlier than the general population. The report does not attribute this to psychiatric drugs, but it is clear the major change is the advent of the second generation neuroleptics, and the great increase in polypharmacy.

<sup>12</sup> Joukamaa, Matti, et al. (2006). ["Schizophrenia, Neuroleptic Medication and Mortality."](#) *British Journal of Psychiatry* 188(2): 122–127.

not taking them.<sup>13</sup> People prescribed even moderate doses of neuroleptics have large relative and absolute increases in the risk of sudden cardiac death.<sup>14</sup>

Citing Robert Whitaker's 2002 book, *Mad in America*, Gøtzsche, recently wrote about the drug companies hiding large numbers of deaths in their clinical trials of neuroleptics:

One in every 138 [initial number, later updated to 145] patients who entered the trials for newer neuroleptics died, but none of these deaths were mentioned in the scientific literature, and the FDA didn't require them to be mentioned. Many patients killed themselves, and the suicide rate was two to five times the usual rate for patients with schizophrenia. A major reason was drug-withdrawal akathisia.<sup>15</sup>

The result of introducing more and more psychiatric drugs is the standard mortality rates of schizophrenia patients worsen over time, which Robert Whitaker of *Mad in America* recently summarized:<sup>16</sup>

Standard mortality rates (SMRs) tell of the higher mortality rates for patient groups compared to the general population. For instance, a standard mortality rate of 2 for schizophrenia patients means that they are twice as likely to die over a set period than the general population. SMRs for schizophrenia and bipolar patients have *worsened* over the last 50 years.

In 2007, [Australian researchers](#) conducted a systematic review of published reports of mortality rates of schizophrenia patients in 25 nations. They found that the SMRs for "all-cause mortality" rose from 1.84 in the 1970s to 2.98 in the 1980s to 3.20 in the 1990s.

Here is a summary of the increase in SMRs for the seriously mentally ill from various studies:

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<sup>13</sup> Murray-Thomas, Tarita, et al. (2013). "[Risk of Mortality \(Including Sudden Cardiac Death\) and Major Cardiovascular Events in Atypical and Typical Antipsychotic Users: A Study With the General Practice Research Database.](#)" *Cardiovascular Psychiatry and Neurology* 2013: 247486.

<sup>14</sup> Ray, Wayne A., et al. (2001). "[Antipsychotics and the Risk of Sudden Cardiac Death.](#)" *Archives of General Psychiatry* 58(12): 1161-1167.

<sup>15</sup> Gøtzsche, Peter C. (25 Feb 2023). "[A New Paradigm for Testing Psychiatric Drugs is Needed.](#)" *Mad in America*.

<sup>16</sup> Whitaker, Robert. (6 Apr 2023). "[Answering Awaits Aftab: When it Comes to Misleading the Public, Who is the Culprit?](#)" *Mad in America*, citing Saha, Sukanta; Chant, David; & McGrath, John. (2007). "[A Systematic Review of Mortality in Schizophrenia: Is the Differential Mortality Gap Worsening Over Time?](#)" *Archives of General Psychiatry* 64(10): 1123-1131; Hayes, Joseph F., et al. (2017). "[Mortality Gap for People With Bipolar Disorder and Schizophrenia: UK-Based Cohort Study 2000-2014.](#)" *British Journal of Psychiatry* 211(3): 175-181; Lilly, Samantha (6 Oct 2022). "[Long Term Antidepressant Use Associated With Increased Morbidity and Mortality.](#)" *Mad in America*.

### All-Cause Mortality Among The Seriously Mentally Ill

Investigator	Patient Population	Country	Time Period	Standardized Mortality Rate
Saha	Schizophrenia	Global	1970s-1990s	2.98
Joukamaa	Schizophrenia	Ireland	1978-1995	1 antipsychotic = 2.97 2 antipsychotics = 3.21 3 antipsychotics = 6.83
Tiihonen	Schizophrenia/ Schizo affective	Finland	1995-2004	4.5
Olson	Schizophrenia	United States	2001-2007	3.7
Torniainen	Schizophrenia	Sweden	2006-2010	4.8

In 2017, [UK investigators](#) reported that the SMR for bipolar patients had risen steadily from 2000 to 2014, increasing by 0.14 per year, while the SMR for schizophrenia patients had increased gradually from 2000 to 2010 (0.11 per year) and then more rapidly from 2010 to 2014 (0.34 per year.) “The mortality gap between individuals with bipolar disorders and schizophrenia, and the general population, is widening,” they wrote.

Long-term use of antidepressants has also been found to be associated with [increased morbidity and mortality](#).

In addition to the neuroleptics killing people due to direct physical harm, such as cardiac arrest and diabetes, they dramatically increase the suicide rate,<sup>17</sup> as do the so-called antidepressants,<sup>18</sup> anti-seizure/anti-epileptic drugs marketed as “mood stabilizers,”<sup>19</sup>

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<sup>17</sup> Lehmann, Peter. (2012). [“About the Intrinsic Suicidal Effects of Neuroleptics: Towards Breaking the Taboo and Fighting Therapeutic Recklessness.”](#) *International Journal of Psychotherapy* 16(1): 30-49; Whitaker, Robert. (2 May 2020). [“Do Antipsychotics Protect Against Early Death? A Review of the Evidence.”](#) *Mad in America*; Healy, David, et al. (2006). [“Lifetime Suicide Rates in Treated Schizophrenia: 1875-1924 and 1994-1998 Cohorts Compared.”](#) *British Journal of Psychiatry* 188(3): 223-228.

<sup>18</sup> Healy, David; & Aldred, Graham. (2005). [“Antidepressant Drug Use & the Risk of Suicide.”](#) *International Review of Psychiatry* 17(3): 163-172; Hengartner, Michael P.; & Plöderl, Martin. (2019). [“Newer-Generation Antidepressants and Suicide Risk in Randomized Controlled Trials: A Re-Analysis of the FDA Database.”](#) *Psychotherapy and Psychosomatics* 88(4): 247-248; Hengartner, Michael P.; & Plöderl, Martin. (2019). [“Reply to the Letter to the Editor: ‘Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl’s Re-Analysis’.”](#) *Psychotherapy and Psychosomatics* 88(6): 373-374; Fergusson, Dean, et al. (2005). [“Association Between Suicide Attempts and Selective Serotonin Reuptake Inhibitors: Systematic Review of Randomised Controlled Trials.”](#) *BMJ* 330,7488: 396.

<sup>19</sup> Britton, Jeffery W.; & Shih, Jerry J. (2010). [“Antiepileptic Drugs and Suicidality.”](#) *Drug, Healthcare and Patient Safety* 2: 181-189; Food and Drug Administration, Center for Drug Evaluation and Research. (2008). [“Statistical Review and Evaluation: Antiepileptic Drugs and Suicidality.”](#) As a result, the FDA requires the labels for these drugs to carry the warning “Antiepileptic drugs, including increase the risk of suicidal thoughts or behavior.” See the FDA labels for [Neurontin \(gabapentin\)](#), and [Lyrica \(pregabalin\)](#).

and benzodiazapines.<sup>20</sup> Also, as discussed in the next section, psychiatric incarceration itself is associated with a massive increase in suicides.

While some people find these drugs helpful, on the whole, they are harmful and counterproductive, dramatically reducing recovery rates and life spans. **Forcing psychiatric drugs into people is an atrocity.**

## **The Clinical Trial Literature on Psychiatric Drugs is Unreliable**

Since psychiatric drugs are so harmful and counterproductive the question naturally arises as to why they are so predominant. One reason, as Marcia Angell, MD, former editor of *The New England Journal of Medicine* points out, is the unreliability of the clinical drug trial literature.

It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of *The New England Journal of Medicine*.<sup>21</sup>

Dr. Angell states psychiatry is the worst (the problems with psychiatry reach "their most florid form").

As a general matter this is because the studies are designed and reported in ways to promote drug sales, rather than reveal the truth. This is often accomplished by misleading or even outright dishonest statistical manipulations.<sup>22</sup> Drug companies publish as positive trials the FDA has classified as negative,<sup>23</sup> and much of the clinical drug trial literature is ghost written.<sup>24</sup> "Study 329" of paroxetine (Paxil) in teenagers and the two pivotal studies of fluoxetine (Prozac) in children and adolescents diagnosed with depression are examples

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<sup>20</sup> Dodds, Tyler J. (2017). "[Prescribed Benzodiazepines and Suicide Risk: A Review of the Literature.](#)" *Primary Care Companion for CNS Disorders* 19(2): 16r02037.

<sup>21</sup> Angell, Marcia (19 Jan 2009). "[Drug Companies & Doctors: A Story of Corruption.](#)" *The New York Review*.

<sup>22</sup> *Ibid.* and Gøtzsche, Peter C. (2013). [Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare.](#) London: CRC Press.

<sup>23</sup> Turner, Erick H., et al. (2008). "[Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy.](#)" *New England Journal of Medicine* 358(3): 252–260; Gøtzsche, Peter C.; & Healy, David. (2022). "[Restoring the Two Pivotal Fluoxetine Trials in Children and Adolescents With Depression.](#)" *International Journal of Risk & Safety in Medicine* 33(4): 385–408.

<sup>24</sup> PLoS Medicine Editors. (2009). "[Ghostwriting: The Dirty Little Secret of Medical Publishing That Just Got Bigger.](#)" *PLOS Medicine* 6(9): e1000156; Gøtzsche, Peter C., et al. (2007). "[Ghost Authorship in Industry-Initiated Randomised Trials.](#)" *PLOS Medicine* 4(1): e19.

of negative studies that were published as positive and of omission of serious harms in the publications.<sup>25</sup>

The truth is hard to ferret out because drug companies claim the clinical data are trade secrets and deny even the listed authors, let alone peer reviewers, and other potential reviewers access to the trial data.<sup>26</sup> The validity of clinical trials cannot be assessed without access to the underlying data. When this has been investigated, usually when data has been revealed through litigation, some serious harms – including suicidal events – have often occurred in the clinical trials but have been omitted in the published results. Companies state their drugs have no known serious side effects to be concerned about when they know the opposite is true.<sup>27</sup>

The claimed benefit in psychiatric drug trials typically involves a minor change in a rating scale score, which is not clinically relevant, while at the same time more people die from the active treatment than die on placebo.<sup>28</sup> Many of these deaths are hidden in the published studies. About half of the deaths including half of the suicides occurring in trials of psychiatric drugs have been left out of published trial reports.<sup>29</sup>

One of the ways drug companies make neuroleptics look beneficial is to have a so-called placebo arm consisting of people abruptly withdrawn from a neuroleptic, which is known to cause many people to become psychotic, thereby making the drug company drug look good by comparison. These trials are highly unethical as well as flawed because they harm patients in the placebo group in order to make the company's drug look better.<sup>30</sup>

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<sup>25</sup> Le Noury, Joanna, et al. (2015). [“Restoring Study 329: Efficacy and Harms of Paroxetine and Imipramine in Treatment of Major Depression in Adolescence.”](#) *BMJ* 351: h4320; Gøtzsche, Peter C.; & Healy, David. (2022). [“Restoring the Two Pivotal Fluoxetine Trials in Children and Adolescents With Depression.”](#) *International Journal of Risk & Safety in Medicine* 33(4): 385–408; Gøtzsche, Peter C. (2015). [Deadly Psychiatry and Organised Denial.](#) Copenhagen: People’s Press; Healy, David; Le Noury, Joanna; & Jureidini, Jon. (2019). [“Paediatric Antidepressants: Benefits and Risks.”](#) *International Journal of Risk & Safety in Medicine* 30(1): 1–7.

<sup>26</sup> Gøtzsche, Peter C., et al. (2006). [“Constraints on Publication Rights in Industry-Initiated Clinical Trials.”](#) *JAMA* 295(14): 1641–1646.

<sup>27</sup> Gøtzsche, Peter C. (2013). [Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare.](#) London: CRC Press; Hudson, Ian. (2000). [“Video Deposition of Ian R. B. Hudson, M.R.C.P., M.D.”](#) *Tobin v SmithKline Beecham*. In the United States District Court for the Eastern District of Pennsylvania, Case No. 00CV0025; Healy, David; Germán Roux, Augusto; & Dressen, Brianne. (2023). [“The Coverage of Medical Injuries in Company Trial Informed Consent Forms.”](#) *International Journal of Risk & Safety in Medicine*: 1–8; Healy, David. (2023). [“Diagnosis, Verdict, Conclusion, and Causality.”](#) *Ethical Human Psychology and Psychiatry*.

<sup>28</sup> Gøtzsche, Peter C. (2015). [Deadly Psychiatry and Organized Denial.](#) Copenhagen: People’s Press.

<sup>29</sup> Hughes, Shannon; Cohen, David; & Jaggi, Rachel. (2014). [“Differences in Reporting Serious Adverse Events in Industry Sponsored Clinical Trial Registries and Journal Articles on Antidepressant and Antipsychotic Drugs: A Cross-Sectional Study.”](#) *BMJ Open* 4(7): e005535.

<sup>30</sup> Gøtzsche, Peter C. (2022). [Critical Psychiatry Textbook.](#) Copenhagen: Institute for Scientific Freedom (freely available); Gottstein, Jim (2021). [The Zyprexa Papers.](#) Toronto: Samizdat Health Writer’s Co-operative, Jackson, Grace E. (2003). [“An Analysis of the Olanzapine Clinical Trials— Dangerous Drug, Dubious Efficacy”](#) [affidavit]. *In the Matter of the Hospitalization of Faith J. Myers*. Anchorage Superior Court, Case No. 3AN 03-277 P/S.

Because people in the so-called placebo group were unethically withdrawn abruptly from the neuroleptic they were taking, causing additional deaths, it is not possible to accurately estimate the effect on mortality, but we do know that "One in every 145 patients who entered the trials—for risperidone, olanzapine, quetiapine, and a fourth atypical called sertindole—died, and yet those deaths were never mentioned in the scientific literature."<sup>31</sup>

In sum, the ubiquitous use of psychiatric drugs for treating people diagnosed with serious mental illness, including forcing them into people, is driven in part by unreliable and often fraudulent clinical trial literature.

## **Inpatient Hospitalizations Associated with Astronomically Higher Suicide Rates**

Similarly, the notion people need to be psychiatrically incarcerated to keep them from harming themselves is directly contradicted by suicides dramatically increasing following hospitalization. For example, a 2019 study concluded: "Among patients recently discharged from psychiatric hospitalization, rates of suicide deaths and attempts were far higher than...in unselected clinical samples of comparable patients."<sup>32</sup>

Another study of all suicides in Denmark between 1981 and 1997 found the risk of suicide 102 times higher for men and 246 times higher for women in the first week after discharge (compared to hundreds of thousands of control subjects matched for age, sex, and calendar time of suicide). These rates decline the longer someone is hospitalized and after discharge, but still greatly exceed what would otherwise be expected.<sup>33</sup>

Gøtzsche describes another Danish study in his 2015 book, *Deadly Psychiatry and Organised Denial*:<sup>34</sup>

The fact that forced treatment can be fatal was recently underlined in a Danish register study of 2,429 suicides.<sup>35</sup> It showed that the closer the contact with psychiatric staff — which often involves forced treatment — the worse the outcome. Compared to people who had not received any psychiatric treatment in the preceding year, the adjusted rate ratio for suicide was six for people receiving only psychiatric medication, eight for people with psychiatric outpatient contact, 28 for people with psychiatric emergency room contacts, and 44 for people who had been admitted to a

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<sup>31</sup> Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books; Whitaker, Robert (17 Nov 1998). "Lure of Riches Fuels Testing." *Boston Globe*, p. A01.

<sup>32</sup> Forte, Alberto, et al. (2019). "Suicidal Risk Following Hospital Discharge: A Review." *Harvard Review of Psychiatry* 27(4): 209–216.

<sup>33</sup> Qin, Ping; & Nordentoft, Merete. (2005). "Suicide Risk in Relation to Psychiatric Hospitalization: Evidence Based on Longitudinal Registers." *Archives of General Psychiatry* 62(4): 427–432.

<sup>34</sup> Gøtzsche, Peter C. (2015). *Deadly Psychiatry and Organized Denial*. Copenhagen: People's Press.

<sup>35</sup> Hjorthøj, Carsten Rygaard, et al. (2014). "Risk of Suicide According to Level of Psychiatric Treatment: A Nationwide Nested Case–Control Study." *Social Psychiatry and Psychiatric Epidemiology* 49(9): 1357–1365.

psychiatric hospital. Patients admitted to hospital would of course be expected to be at greatest risk of suicide because they were more ill than the others (confounding by indication), but the findings were robust and most of the potential biases in the study were actually conservative, i.e. favoured the null hypothesis of there being no relationship. An accompanying editorial noted that there is little doubt that suicide is related to both stigma and trauma and that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment — particularly if involuntary — might cause suicide.<sup>36</sup> The editorialists believed that a proportion of people who commit suicide during or after an admission to hospital do so because of conditions inherent in that hospitalisation.

Thus, the justification that someone should be psychiatrically incarcerated to prevent suicide is fallacious, even absurd.<sup>37</sup> If the best society has to offer someone grappling with a life-and-death decision is to remove their agency and lock them up until they say what others want to hear, then it is easy to imagine why people would lose faith in society's ability to help them, and be more likely to commit suicide as soon as they are released.

## **Treatment Should Be Voluntary**

All of this makes clear psychiatric incarceration and forced drugging should be abolished.<sup>38</sup> Unwanted psychiatric interventions are violence perpetrated against the patient. Restraining psychiatric patients, pulling down their pants and injecting them with psychiatric drugs they do not want is violence, justified on the grounds patients don't know what is good for them. Patients protesting and saying what is true—that the drugs hurt them and do not help—are said to be delusional, and their statements prove they "lack insight" and should be drugged against their will.<sup>39</sup> That this occurs every day does not make it right.

Forced psychiatric interventions are not for the benefit of patients; they are used to manage troublesome people thereby benefiting the staff.

[The] coercive function is what society and most people actually appreciate most about psychiatry. That families and other people in crisis can call upon

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<sup>36</sup> Large, Matthew M.; & Ryan, Christopher J. (2014). "[Disturbing Findings About the Risk of Suicide and Psychiatric Hospitals.](#)" *Social Psychiatry and Psychiatric Epidemiology* 49(9): 1353–1355.

<sup>37</sup> See, e.g., Harris, Leah. (14 Jan 2023). "[You Can't Coerce Someone Into Wanting to be Alive: The Carceral Heart of the 988 Lifeline.](#)" *Mad in America*.

<sup>38</sup> The same is true of electroshock. See Andre, Linda. (2009). *Doctors of Deception: What the Doctors Don't Want You to Know About Shock Treatment*. New Brunswick, NJ: Rutgers University Press.

<sup>39</sup> Tasch, Gail; & Gøtzsche, Peter C. (2023). "[Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients in Alaska.](#)" *Psychosis*: 1–10; Gøtzsche, Peter C; & Sørensen, Anders. (2020). "[Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients.](#)" *Indian Journal of Medical Ethics* 5(4): 312–318.

the police to restrain someone acting in a seemingly incomprehensible or dangerous way and have that person taken by force to a place run by psychiatrists is truly where psychiatry as a profession distinguishes itself.<sup>40</sup>

Many effective and non-coercive services exist for the treatment of psychiatric patients. They are psychosocially focused rather than medically focused, and always voluntary. While they differ because they have been developed within different geographical and cultural contexts, they share the following values:

1. Voluntariness and informed choice.
2. Relationships as the first line of treatment.
3. Respect for the individual and their life experience.
4. Emphasizing community inclusion (continuing to participate as student, worker, family member).

When Dr. Loren Mosher testified as a court-qualified expert witness at the trial in *Myers v. Alaska Psychiatric Institute*<sup>41</sup> he stated involuntary treatment should be difficult to implement and should be used only in the direst of circumstances, and then:

[I]n the field of psychiatry, it is the therapeutic relationship which is the single most important thing ... Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to ... In my career I have never committed anyone ... I make it my business to form the kind of relationship [through which the mentally ill person and I] can establish a[n] ongoing treatment plan that is acceptable to both of us.<sup>42</sup>

In addition to the other state-sanctioned violence inflicted on psychiatric inmates, forcing unwanted psychiatric drugs into a patient, especially when the patient is knowledgeable about their counterproductive and harmful effects, is traumatic, often extremely so. Even when a patient agrees to take the drug(s), they are not giving informed consent because they are not told about the likely or common outcomes, or the agreement is not a true agreement because the patients know that if they disagree, they will be forced to take the drug anyway. While some states have changed this, at common law, failure to

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<sup>40</sup> Cohen, David. (21 Oct 2014). "It's the Coercion, Stupid!" *Mad in America*. See also Kirk, Stuart A.; Gomory, Tomi; & Cohen, David. (2017). *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs*. New York: Routledge.

<sup>41</sup> *Myers v. Alaska Psychiatric Institute*. 138 P.3d 238 (Alaska 2006).

<sup>42</sup> *In the Matter of F.M. Transcript of proceedings (March 5 and March 10, 2003)*, p. 177. Anchorage Superior Court, Case No. 3AN-02-00277 CI.

obtain informed consent constitutes a battery.<sup>43</sup> This is also a recognition that forced drugging is violence perpetrated against the patient.

**If it is not voluntary it is not treatment.** In short, unwanted psychiatric interventions are traumatic, counterproductive and harmful, and should be abolished. They are also violations of International Law.

## **Unwanted Psychiatric Interventions Violate International Law and Can Constitute Torture**

Under Articles 12 and 14 of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD),<sup>44</sup> governments are prohibited from denying people decision-making authority, from confining people, or administering any unwanted psychiatric intervention on the basis of a disability, including being diagnosed with a mental illness. Because there was a general misunderstanding of the scope of Article 12 of the CRPD, the United Nations Committee on the Rights of Persons with Disabilities issued General Comment No. 1 (2014) to clarify that taking away someone's decision making rights and forced psychiatric interventions are prohibited.<sup>45</sup> See also Guidelines on the right to liberty and security of persons with disabilities (the practice of detaining people on the grounds of actual or perceived impairment provided there are other reasons including that they are deemed dangerous to themselves or others is incompatible with article 14).<sup>46</sup>

The UN has also repeatedly stated such **unwanted psychiatric interventions can amount to torture**.<sup>47</sup>

## **Patients' Rights Are Uniformly Violated**

While the United States has not ratified the CRPD there are constitutional and statutory rights and procedures in the United States that are uniformly violated to the great

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<sup>43</sup> Gottstein, James B. (2007). "Psychiatrists' Failure to Inform: Is There Substantial Financial Exposure?" *Ethical Human Psychology and Psychiatry* 9(2): 117–125.

<sup>44</sup> United Nations General Assembly. (2006). Convention on the Rights of Persons With Disabilities (CRPD). A/RES/61/106. New York: United Nations.

<sup>45</sup> UN Committee on the Rights of Persons with Disabilities (11th Session). (2014). "General Comment No. 1 (2014): Article 12, Equal Recognition Before the Law." CRPD/C/GC/1. Geneva: United Nations.

<sup>46</sup> UN Committee on the Rights of Persons with Disabilities. (2017). "Guidelines on the Right to Liberty and Security of Persons With Disabilities." In Report of the Committee on the Rights of Persons With Disabilities (13th Through 16th Sessions (2015–2016)), pp. 16–21. A/72/55. Geneva: United Nations.

<sup>47</sup> UN Human Rights Council. (19 June 2020). "Mental Health and Human Rights: Resolution 43/13 Adopted 19 June 2020." A/HRC/RES/43/13. Geneva: United Nations; UN Human Rights Council. (20 Mar 2020). Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Report of the Special Rapporteur. A/HRC/43/49. Geneva: United Nations; Méndez, Juan E. (4 Mar 2013). "Statement By Mr. Juan E Méndez, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd Session of the Human Rights Council of the United Nations." Geneva: United Nations. See also the related Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez (2013), A/HRC/22/53. Geneva: United Nations.

detriment of people ensnared by the coercive psychiatric system. As a general rule, people cannot be constitutional confined for being mentally ill in the United States unless the government proves by clear and convincing evidence that

1. as a result of being mentally ill they are a danger to themselves or others, or
2. so disabled by mental illness they cannot survive safely in freedom without the help of willing friends and family,
3. and there is no less restrictive alternative.<sup>48</sup>

"Clear and convincing evidence" is more than the "preponderance of the evidence" standard used in civil cases, meaning "more likely than not" or just over 50%, but less than the "beyond a reasonable doubt" standard used in criminal cases where defendants also face incarceration. In holding beyond a reasonable doubt was not required, the U.S. Supreme Court noted that meeting commitment criteria could never be proven beyond a reasonable doubt.<sup>49</sup>

People diagnosed with mental illness are not significantly more violent than the general population,<sup>50</sup> and psychiatrists are notoriously bad at predicting violence, being no better than chance.<sup>51</sup> This has been known for a long time. In fact, in the 1983 United States Supreme Court case of *Barefoot v. Estelle*,<sup>52</sup> the American Psychiatric Association filed an *amicus* brief in which they stated psychiatrists cannot accurately predict violence. (See also *Reign of Error* by Lee Coleman, MD.)<sup>53</sup> Psychiatrists are no more able to accurately predict suicidality.<sup>54</sup>

A related problem is the treatment patients universally get while psychiatrically incarcerated—psychiatric drugs—often against the person's wishes, are known to cause both violence and suicidality, including in people who have never exhibited these previously to being administered these drugs.

Before 1955, four studies found that patients discharged from mental hospitals committed crimes at either the same or a lower rate than the general population. However, eight studies conducted from 1965 to 1979 determined that discharged patients were being arrested at rates that exceeded those of the general population. And while there may have been

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<sup>48</sup> *O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486 (1975).

<sup>49</sup> *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804 (1979).

<sup>50</sup> Teplin, Linda A. (1985). "[The Criminality of the Mentally Ill: A Dangerous Misconception.](#)" *American Journal of Psychiatry* 142(5): 593–599; Fazel, Seena, et al. (2009). "[Schizophrenia and Violence: Systematic Review and Meta-Analysis.](#)" *PLoS Medicine* 6(8): e1000120; Elbogen, Eric B.; & Johnson, Sally C. (2009). "[The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions.](#)" *Archives of General Psychiatry* 66(2): 152–161.

<sup>51</sup> Garrett, Brandon L.; & Monahan, John. (2020). "[Judging Risk.](#)" *California Law Review* 108(2): 439–493.

<sup>52</sup> *Barefoot v. Estelle*. 463 U.S. 880, 103 S. Ct. 3383, 77 L. Ed. 2d 1090 (1983).

<sup>53</sup> Coleman, Lee. (1984). *Reign of Error: Psychiatry, Authority and Law*. Boston: Beacon Press. (Now a free download.)

<sup>54</sup> Franklin, Joseph C., et al. (2017). "[Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research.](#)" *Psychological Bulletin* 143(2): 187–232.

many social causes for this change in relative arrest rates (homelessness among the mentally ill is an obvious cause), akathisia was also clearly a contributing factor.<sup>55</sup>

Since then, there has been increasing evidence that diminished metabolism of psychiatric drugs due to cytochrome P450 gene variations is associated with an increase in violence.<sup>56</sup>

As explained above, psychiatric incarceration dramatically increases suicides, so preventing self-harm cannot be a legitimate basis for locking someone up.

The United States Supreme Court has not specifically ruled on the constitutional limits for psychiatrically drugging someone against their will in the civil commitment context, but has in the competence to stand trial context, holding such drugging is constitutional only if,

1. Important governmental interests are at stake,
2. It will significantly further those state interests - substantially unlikely to have side effects that will interfere significantly (with achieving state interest),
3. It is necessary to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results, and
4. It is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition, considered on drug-by-drug basis.<sup>57</sup>

Civil forced drugging proceedings are usually prosecuted under state law and different state supreme courts considering the issue can take different positions, but many are consistent with *Sell*, holding forced drugging is only constitutional if it is proven by clear and convincing evidence the forced drugging is in the person's best interest and there is no less intrusive alternative.<sup>58</sup>

While some people find psychiatric drugs helpful and adults at least should have access to them if so, as set forth above, on the whole psychiatric drugs are massively counter-productive and harmful. There are no studies showing psychiatric treatment improves patient outcomes.<sup>59</sup> Thus, **forced psychiatric drugging on the grounds it is in people's best interest can never be legally justified.**

Unfortunately, the inability to accurately predict violence or self-harm and the massively counterproductive and harmful nature of psychiatric drugs has proven to be no

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<sup>55</sup> Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books, citing Rabkin, Judith Godwin. (1979). "[Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research.](#)" *Psychological Bulletin* 86(1): 1-27.

<sup>56</sup> Clarke, Catherine; Evans, Jan; & Brogan, Kelly. (2019). "[Treatment Emergent Violence to Self and Others: A Literature Review of Neuropsychiatric Adverse Reactions for Antidepressant and Neuroleptic Psychiatric Drugs and General Medications.](#)" *Advances in Mind-Body Medicine* 33(1): 4-21.

<sup>57</sup> *Sell v. United States*, 539 U.S. 166, 177-8, 123 S.Ct. 2174, 2183 (2003).

<sup>58</sup> See, e.g., *Rivers v. Katz* 495 N.E.2d 337 (New York, 1986); *Steele v. Hamilton County Community Mental Health Board*, 736 N.E.2d 10 (Ohio 2000); *Myers v. Alaska Psychiatric Institute*. 138 P.3d 238 (Alaska 2006).

<sup>59</sup> See chapter 22 of Wipond, Rob. (2023). *Your Consent is Not Required: The Rise in Psychiatric Detentions, Forced Treatment, and Abusive Guardianships*. Dallas, TX: BenBella Books.

impediment keeping courts from psychiatrically incarcerating people and drugging them against their will:

[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 ensure 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.<sup>60</sup>

As a result, it has been estimated no more than 10% of the people psychiatrically incarcerated actually meet commitment criteria.<sup>61</sup>

The legal representation of people facing psychiatric incarceration and forced drugging is supposed to prevent this, but the assigned lawyers are almost universally ineffective or worse by taking the attitude “if my client wasn't crazy they'd know locking them up and drugging them against their will is good for them.”<sup>62</sup> The information in this Report is not presented to the courts. This ineffective representation is not completely the assigned lawyers' fault as they are not allowed the time, nor given the resources, such as expert witness testimony, to present an adequate defense. The result is these proceedings can fairly be characterized as shams.<sup>63</sup> That people are being locked up and drugged against their will when there is such overwhelming proof the legal prerequisites for doing so do not exist is a failure of effective legal representation and the legal system as a whole, resulting in immense harm.

By abandoning their core principle of zealous advocacy, lawyers representing psychiatric respondents interpose little, if any, defense and are

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<sup>60</sup> Perlin, Michael L. (1993). [“The ADA and Persons With Mental Disabilities: Can Sanist Attitudes be Undone.”](#) *Journal of Law and Health* 8(1): 15–45.

<sup>61</sup> Gottstein, James B. (28 Oct 2005). [“How the Legal System Can Help Create a Recovery Culture in Mental Health Systems.”](#) Paper presented at Alternatives 2005: Leading the Transformation to Recovery, Phoenix, AZ.

<sup>62</sup> Gottstein, James B. (2008). [“Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course.”](#) *Alaska Law Review* 25(1): 51–106.

<sup>63</sup> Tasch, Gail; & Gøtzsche, Peter C. (2023). [“Systematic Violations of Patients’ Rights and Safety: Forced Medication of a Cohort of 30 Patients in Alaska.”](#) *Psychosis*: 1–10; Gøtzsche, Peter C; & Sørensen, Anders. (2020). [“Systematic Violations of Patients’ Rights and Safety: Forced Medication of a Cohort of 30 Patients.”](#) *Indian Journal of Medical Ethics* 5(4): 312–318.

not discovering and presenting to judges the evidence of the harm to their clients. By abandoning their core principle of being faithful to the law, judges have become instruments of oppression, rather than protectors of the rights of the downtrodden.<sup>64</sup>

## **Children and Youth Should Not be Given Psychiatric Drugs**

The psychiatric drugging of children and youth, especially those on Medicaid and in foster care, is the most heartbreaking and tragic example of the misuse of psychiatric drugs. They are told there is something incurably wrong with their brain, their unacceptable behavior is the result of this defect and not their responsibility, they need to take debilitating psychiatric drugs for the rest of their lives, and the best they can hope for is to minimize psychiatric hospitalizations. These are exactly the wrong messages to give children and youth.

One of the most important things children and youth should learn is how to cope with their emotions without engaging in unacceptable behavior. In other words, take responsibility for their behavior. We should not be telling children and youth they are defective and unable to control themselves. Rather than take children and youth away from their parents, parents should be helped to raise their children to be successful, which is often a viable avenue.

One of the terms of the multi-state settlement of consumer fraud claims regarding the illegal marketing of the prescription drug Neurontin® was funding a rigorous review of psychiatric drugs administered to children and youth. This resulted in the [\*CriticalThinkRx\*](#) curriculum as a series of eight modules:<sup>65</sup>

- [Module One](#): Why a Critical Skills Curriculum on Psychotropic Medications?
- [Module Two](#): Increasing Use of Psychotropics: Public Health Concerns.
- [Module Three](#): The Drug Approval Process.
- [Module Four](#): Pharmaceutical Industry Influences on Prescribing.
- [Module Five](#): Specific Drug Classes: Use, Efficacy, Safety.
- [Module Six](#): Non-Medical Professionals and Psychotropic Medications: Legal, Ethical and Training Issues.
- [Module Seven](#): Medication Management: Professional Roles and Best Practices.
- [Module Eight](#): Alternatives to Medication: Evidence-Based Psychosocial Interventions

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<sup>64</sup> Gottstein, James B. (2008). "[Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course.](#)" *Alaska Law Review* 25(1): 51-106.

<sup>65</sup> Cohen, David; & Sengelmann, Inge; et al. (Jun 2008). "[A Critical Curriculum on Psychotropic Medications.](#)" *CriticalThinkRx*.

There are also 10–20 minute [videos](#) on each on these modules.

In Chapter Seven of [Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It](#), child psychiatrist Tony Stanton describes Seneca, the extremely successful non-drug residential program where the most difficult youth were sent.<sup>66</sup> It turned out that whether the success achieved at Seneca lasted depended upon the environment to which the youth was returned. This illustrates that rather than blaming parents, we should be helping them raise their children to be resilient and successful. While there are some parents who deliberately abuse their children, almost all want the best for them and do the best they can. We should invest in parents' and children's and youths' success, not abusive children and youth-drugging prisons.<sup>67</sup>

So-called residential treatment facilities for children and youth have been exposed as abusive.<sup>68</sup> **Children and youth should not be psychiatrically incarcerated or drugged.**

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<sup>66</sup> Stanton, Tony. (2012). "Drug-Free Mental Health Care for Children and Youth: Lessons From Residential Treatment." In Sharna Olfman & Brent Dean Robbins (eds.), [Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It](#), pp. 119–138. Santa Barbara, CA: Praeger.

<sup>67</sup> The very profitable abuse by what is called the Troubled Teen Industry has been the subject of recent exposés. See, e.g., Stockton, Alexander (11 Oct 2022). ["Can You Punish a Child's Mental Health Problems Away?"](#) *New York Times*.

<sup>68</sup> See, e.g., The National Youth Rights Association on ["The 'Troubled Teen' Industry"](#) (2023) and the American Bar Association's ["Five Facts About the Troubled Teen Industry"](#) (2021).

## IV. VOLUNTARY, EFFECTIVE, SAFE AND HUMANE APPROACHES

In stark contrast to mainstream professionals driven psychiatric practices which are horrendously harmful and counterproductive, there are a number of very successful, **voluntary** programs that help people get through what they are going through and back on track. Many of these have been developed by people with lived experience of the coercive mental health system who know what is helpful, often called "peers."

### The Power of Peer Support

Peer Support is one such proven approach for recovery, i.e., much better outcomes for people diagnosed with serious mental illness such as schizophrenia and bipolar disorder.<sup>69</sup> Peer Support arose from the Mental Health Consumer/Psychiatric Survivor Movement and is steeped in the use of relationship and support to help people get through a crisis or difficult time that is otherwise likely to result in hospitalization or some other form of hospital emergency services.<sup>70</sup>

Peer-developed peer support is a non-hierarchical approach with origins in informal self-help and consciousness-raising groups organized in the 1970s by people in the ex-patients' movement. It arose in reaction to negative experiences with mental health treatment and dissatisfaction with the limits of the mental patient role. Peer support among people with psychiatric histories is closely intertwined with experiences of powerlessness within the mental health system and with activism promoting human rights and alternatives to the medical model.<sup>71</sup>

It is defined by the use of people who have experienced extreme states and/or the behavioral health system. Most have been subjected to psychiatric incarceration and forced drugging and/or electroshock.

The magic of peers is (1) their ability to relate and connect to people currently ensnared in the mental health system through shared experience and (2) they belie the mental health system's message of hopelessness by their example of recovery. True Peer Support is egalitarian and based on respect, reciprocity, validation, self-help and mutual aid. Peer Support is always voluntary. If it is not voluntary it is not Peer Support.

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<sup>69</sup> See National Empowerment Center, "[Evidence for Peer-Run Crisis Alternatives](#)" (website). Accessed 18 Sep 2023.

<sup>70</sup> Judi Chamberlin's *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (National Empowerment Center), originally published in 1978, is considered to have started this approach in the modern era.

<sup>71</sup> Penney, Darby. (10 Feb 2018). "[Who Gets to Define 'Peer Support?'](#)" *Mad in America*.

The dramatic success of peer support has led the Substance Abuse and Mental Health Services Administration (SAMHSA) to designate it as an evidence based practice<sup>72</sup> and it is now a Medicaid reimbursable service. This has also unfortunately led to the co-optation of peer support, especially when incorporated into traditional mental health programs.<sup>73</sup> It is not just the lived experience that works its magic; it must be combined with true Peer Support Principles. SAMHSA articulates the following core competencies for behavioral health peer workers.<sup>74</sup>

1. Recovery oriented
2. Person centered
3. Voluntary
4. Relationship focused
5. Trauma informed

A peer specialist who is tasked with medication compliance, for example, is not engaging in true peer support and is not likely to achieve any more success than traditional mental health services. Thus, it is especially important to maintain fidelity to Peer Support Principles.<sup>75</sup> **It is pointless and counterproductive to deploy peers in violation of Peer Support Principles.**

## World Health Organization Recommendations

In 2021, the World Health Organization published *Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches*, (WHO Guidelines) identifying these key messages:

- Many people with mental health conditions and psychosocial disabilities face poor quality care and violations of their human rights, which demand profound changes in mental health systems and service delivery.
- In many parts of the world examples exist of good practice, community-based mental health services that are person-centered, recovery-oriented and adhere to human rights standards.
- In many cases these good practice, community-based mental health services show lower costs of service provision than comparable mainstream services.

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<sup>72</sup> See, e.g., “[Peer Support Services in Crisis Care.](#)” *SAMHSA Advisory*, June 2022.

<sup>73</sup> Alberta, Anthony J.; & Ploski, Richard R. (2014). “[Cooptation of Peer Support Staff: Quantitative Evidence.](#)” *Rehabilitation Process and Outcome* 2014(3): 25–29.

<sup>74</sup> SAMHSA. (2015). “[Core Competencies for Peer Workers in Behavioral Health Services.](#)” *Bringing Recovery Supports to Scale — Technical Assistance Center Strategy (BRSS TACS)*.

<sup>75</sup> The [International Peer Respite/Soteria Summit \(Summit\)](#) has posted a 35 minute video of one of its Mentoring Circle’s meetings discussing this, [Navigating a Misguided System](#) (2022).

- Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities.
- It is essential to scale up networks of integrated, community-based mental health services to accomplish the changes required by the CRPD.<sup>76</sup>

Recognizing the requirements of the CRPD, the WHO Guidelines join the call for "eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion and tackling the power imbalances that exist between health staff and people using the services." In doing so the WHO acknowledges that complying with the CRPD "will require considerable changes in practice." And then states:

This guidance presents diverse options for countries to consider and adopt as appropriate to improve their mental health systems and services. It presents a menu of good practice options anchored in community-based health systems and reveals a pathway for improving mental health care services that are innovative and rights-based. There are many challenges to realizing this approach within the constraints that many services face. However, despite these limitations, the mental health service examples showcased in this guidance show concretely – it can be done. . . .

[C]ritical social determinants that impact people's mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, and lack of access to housing, social safety nets, and health services, are factors often overlooked or excluded from mental health discourse and practice.

The WHO Guidelines include seven "technical packages" on specific mental health categories and

- showcase, in detail, a number of mental health services from different countries that provide services and support in line with international human rights standards and recovery principles;
- outline in detail how the good practice services operate in order to respect international human rights standards of legal capacity, non-coercive practices, community inclusion, participation and the recovery approach;
- outline the positive outcomes that can be achieved for people using good practice mental health services;
- show cost comparisons of the good practice mental health services in contrast with comparable mainstream services;

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<sup>76</sup> World Health Organization. (9 Jun 2021). [\*Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches\*](#). Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization.

- discuss the challenges encountered with the establishment and operation of the services and the solutions put in place to overcome those challenges; and
- present a series of action steps towards the development of a good practice service that is person centred and respects and promotes human rights and recovery, and that is relevant to the local social and economic context.

## Peer Respite

Peer Respite are voluntary, short-term, overnight programs providing community-based, non-clinical crisis support to help people find new understanding and ways to move forward. They operate 24 hours a day in a homelike environment and are designed as psychiatric hospital diversion programs to support individuals experiencing or at risk of a psychiatric crisis. Typically, people can stay for 7–10 days at Peer Respite. The WHO Guidelines support them.

The premise behind Peer Respite is psychiatric emergency services can be avoided if non-coercive supports are available in the community. They are 100% staffed and operated by people who have lived experience of extreme states and/or the behavioral health system, normally psychiatric incarceration and/or forced drugging, and are either operated by a peer-run organization, or has an advisory group with over 50% or more of members having lived experience.<sup>77</sup>

Since the first completely peer operated respite house was developed in 1997 in New Hampshire by Shery Mead (the originator of [Intentional Peer Support](#) — the approach implemented as a foundation of the house)<sup>78</sup> — they have proliferated around the country because of their outstanding success.<sup>79</sup> Three prominent Consumer Operated Service Programs (COSPs) that operate Peer Respite are [People USA's Rose Houses](#) in New York State, [Wildflower Alliance](#) in Massachusetts, formerly known as the Western Massachusetts Recovery Learning Community, and the [Promise Resource Network](#) in Mecklenburg, North Carolina. All three have a great deal of information about how these kinds of programs should be operated.<sup>80</sup>

The [International Peer Respite/Soteria Summit](#) has posted a five minute video on YouTube, "[How Afiya House Helped Me.](#)" pulled from the December 5, 2021, follow-up day that provides a good picture of how a Peer Respite approaches people who would otherwise be locked up in a psychiatric hospital and the tremendously beneficial effects of such an approach.

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<sup>77</sup> This description of Peer Respite was pulled from Live & Learn, Inc. "[Peer Respite: Action + Evaluation](#)" (website).

<sup>78</sup> [Intentional Peer Support](#). (website). Accessed 18 Sep 2023. See also Mead, Shery; Kuno, Eri; & Knutson, Sarah. (2013). "[Intentional Peer Support.](#)" *Vertex* (Buenos Aires, Argentina) 24(112): 426-433.

<sup>79</sup> There is a [somewhat outdated list](#) at the National Empowerment Center website.

<sup>80</sup> [People USA's Rose Houses](#); [Wildflower Alliance](#); [Promise Resource Network](#). Websites Accessed 18 Sep 2023.

## Housing First

“Without adequate housing, mental health ‘treatment’ is mostly a waste of time and money.”<sup>81</sup> The [CRPD](#) promotes the right to housing for persons with disabilities including the right to a secure home and community. Housing is an important determinant of mental health and an essential part of recovery. Addressing adequate housing is not only a human right but should also be a public health priority.

The Housing First approach was pioneered in the 1990s by two organizations, Pathways to Housing in New York City (now [Pathways Housing First Institute](#)), and by what was then called the Downtown Emergency Service Center in Seattle, Washington (DESC).<sup>82</sup> Its underpinnings were person-centered—asking people on the street “what do you need or how can I help you?” They didn’t say counselling. They didn’t say medication—they said “a home” and to not have strings attached. There is evidence to support the beneficial effects of the Housing First approach on people’s quality of life, including dimensions such as community adjustment and social integration, and some aspects of health.<sup>83</sup> As the research base is growing in favor of this approach, the Housing First model is now expanding across European countries and has even become national policy in Finland. Housing First is money well spent, reducing other costs, likely by multiples.

## Employment

Behind housing, employment is perhaps the most important therapeutic element for people diagnosed with serious mental illness. In a 30-year longitudinal research study involving 269 subjects who were discharged from the backwards of public institutions, it was found the strongest link to successful recovery and integration into community roles was involvement in community based rehabilitation, particularly vocational rehabilitation leading to employment.<sup>84</sup>

In “Employment is a Critical Mental Health Intervention,” Robert E. Drake and Michael A. Wallach, state, “[E]mployment improves the mental health and wellbeing of people with serious mental disorders, including improved self-esteem, symptom control, quality of life,

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<sup>81</sup> Mosher, Loren R. (5 Mar 2003). [Affidavit of Loren R. Mosher, M.D.](#) In *The Matter of the Hospitalization of Faith J. Myers*. Anchorage Superior Court, Case No. 3AN 03-277 P/S.

<sup>82</sup> See Downtown Emergency Service Center (DESC). [“What is Housing First?”](#) (website). Accessed 18 Sep 2023.

<sup>83</sup> National Low Income Housing Coalition; & National Alliance to End Homelessness. (2020). [The Case for Housing First](#); Mackelprang, Jessica L.; Collins, Susan E.; & Clifasefi, Seema L. (2014). [“Housing First is Associated With Reduced Use of Emergency Medical Services.”](#) *Prehospital Emergency Care* 18(4): 476–482.

<sup>84</sup> DeSisto, Michael J., et al. (1995). [“The Maine and Vermont Three-Decade Studies of Serious Mental Illness: I. Matched Comparison of Cross-Sectional Outcome.”](#) *British Journal of Psychiatry* 167(3): 331–338.

social relationships and community integration, without harmful side effects.”<sup>85</sup> Drake and Wallach summarize the data on employment:

“The great majority of people with serious mental disorders desire employment as a primary treatment goal (Wescott et al., 2015).”

“[P]eople with mental disorders view ‘recovery’ as a meaningful, active, functional life, not as a complete absence of symptoms (Deegan, 1988). People can learn to tolerate and cope with symptoms if they have a life that they consider valuable.”

“They want a safe apartment; a part-time job; and the chance to meet people, have friends, contribute to society and participate in community life that comes with a job and a modest income. They also value the secondary benefits — a positive identity, structure to the day, enhanced self-esteem, friends at work, less interaction with the mental health system and reduced personal and social stigma — gains that do not usually follow hospitalisation, polypharmacy or involuntary treatment.”

“[E]mployment is both a critical health intervention and a meaningful outcome for people with serious mental disorders such as schizophrenia, bipolar disorder and depression (Knapp and Wong, 2020). This recognition follows patients’ own expressed goals as well as actual work outcomes. People with even the most serious mental disorders report a higher quality of life, greater self-esteem and fewer psychiatric symptoms when they are employed (Luciano et al., 2014).”

“[E]mployment improves the mental health and wellbeing of people with serious mental disorders, including improved self-esteem, symptom control, quality of life, social relationships and community integration, without harmful side effects (Drake et al., 2013).”

“Supported employment is a relatively inexpensive intervention (Latimer et al., 2004) and employment leads to steady reductions in mental healthcare costs over at least 10 years (Bush et al., 2009).”

**“[H]elping people with employment should be a standard mental health intervention.”**

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<sup>85</sup> Drake, Robert E.; & Wallach, Michael A. (2020). [“Employment is a Critical Mental Health Intervention.”](#) *Epidemiology and Psychiatric Sciences* 29: e178 — citing Drake, Robert E., et al. (2013). [“Assisting Social Security Disability Insurance Beneficiaries With Schizophrenia, Bipolar Disorder, or Major Depression in Returning to Work.”](#) *American Journal of Psychiatry* 170(12): 1433–1441.

## Soteria Houses

Soteria House, whose outstanding outcomes are set forth above, was established in San Jose, California by Loren Mosher, MD, a psychiatrist and schizophrenia expert who was at the time the Chief of Schizophrenia Studies for the National Institute of Mental Health.<sup>86</sup> The original Soteria House was a research project for more than 10 years to answer the question: *Can people newly diagnosed with schizophrenia recover in the community without the conventional treatment of hospitalization and debilitating neuroleptic medications?* The answer was a resounding yes. Soteria is a home-like environment focusing on psychological and physical safety through compassionate relationships between staff and residents. The mantra of Soteria House is “being with, rather than doing to.”

A colleague of Dr. Mosher, Luc Ciompi, MD, opened a Soteria House in Berne, Switzerland in 1984 and ran it for decades. In 2004 or thereabouts, Dr. Ciompi and Dr. Mosher published the following Soteria Critical Elements:<sup>87</sup>

### SOTERIA CRITICAL ELEMENTS

Luc Ciompi, Loren Mosher

#### 1. FACILITY:

- a. Small, community based
- b. Open, voluntary home-like
- c. sleeping no more than 10 persons including two staff ( 1 man & 1 woman) on duty
- d. preferably 24 – 48 hour shifts to allow prolonged intensive 1:1 contact as needed

#### 2. SOCIAL ENVIRONMENT:

- a. respectful, consistent, clear and predictable with the ability to provide asylum, safety, protection, containment, control of stimulation, support and socialization as determined by individual needs
- b. over time it will come to be experienced as a surrogate family

#### 3. SOCIAL STRUCTURE:

- a. preservation of personal power to maintain autonomy, diminish the hierarchy, prevent the development of unnecessary dependency and encourage reciprocal relationships
- b. minimal role differentiation ( between staff and clients) to encourage flexibility of roles, relationships and responses
- c. daily running of house shared to the extent possible; “usual” activities carried out to maintain attachments to ordinary life – e.g. cooking, cleaning, shopping, art, excursions etc.

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<sup>86</sup> Mosher, Loren R. (1999). “[Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review.](#)” *The Journal of Nervous and Mental Disease* 187(3): 142-149.

<sup>87</sup> Ciompi, Luc, & Mosher, Loren, R. (ca. 2004). [Soteria Critical Elements](#). Accessed 18 Sep 2023 (psychiatrized.org).

#### **4. STAFF:**

- a. may be mental health trained professionals, specifically trained and selected non- professionals, former clients, especially those who were treated in the program or a combination of the three types
- b. on the job training via supervision of work with clients, including family interventions, should be available to all staff as needed

#### **5. RELATIONSHIPS: these are central to the program's work**

- a. facilitated by staff being ideologically uncommitted ( i.e. to approach psychosis with an open mind)
- b. convey positive expectations of recovery
- c. validate the psychotic person's subjective experience of psychosis as real by developing an understanding of it by "being with" and "doing with" the clients
- d. no psychiatric jargon is used in interactions with these clients

#### **6. THERAPY:**

- a. all activities viewed as potentially "therapeutic" but without formal therapy sessions with the exception of work with families of those in residence
- b. in-house problems dealt with immediately by convening those involved in problem solving sessions

#### **7. MEDICATIONS:**

- a. no or low dose neuroleptic drug use to avoid their acute "dumbing down" effects and their suppression of affective expression, also avoids risk of long term toxicities
- b. benzodiazepines may be used short term to restore the sleep/wake cycles

#### **8. LENGTH OF STAY:**

- a. sufficient time spent in program for relationships to develop that allow precipitating events to be acknowledged, usually disavowed painful emotions to be experienced and expressed and put into perspective by fitting them into the continuity of a person's life

#### **9. AFTER CARE:**

- a. post discharge relationships encouraged (with staff and peers) to allow easy return ( if necessary) and foster development of peer based problem solving community based social networks
- b. the availability of these networks is critical to long term outcome as they promote community integration of former clients and the program itself

The research demonstrated the typical Soteria resident became stabilized in about six weeks with an average stay of three months. At six weeks, when compared to hospitalized, medicated patients, persons served at Soteria House had similar outcomes. After one and two-year follow-ups the patients treated at Soteria House were doing significantly better than conventionally treated patients in terms of symptoms, rehospitalization, social functioning and employment, thus averting a trajectory of chronic mental illness.<sup>88</sup>

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<sup>88</sup> Bola, John R.; & Mosher, Loren R. (2003). ["Treatment of Acute Psychosis Without Neuroleptics: Two-Year Outcomes From the Soteria Project."](#) *Journal of Nervous and Mental Disease* 191(4): 219-229.

With respect to cost:

In the first cohort, despite the large differences in lengths of stay during the initial admissions (about 1 month versus 5 months), the cost of the first 6 months of care for both groups was approximately \$4000. Costs were similar despite 5-month Soteria and 1-month hospital initial lengths of stay because of Soteria's low per diem cost and extensive use of day care, group, individual, and medication therapy by the discharged hospital control clients.<sup>89</sup>

The original Soteria House closed after its study funding ended. Its extremely good results challenged bio-psychiatry and was largely buried by the psychiatric establishment until Robert Whitaker wrote about it in his influential 2002 book, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*.<sup>90</sup> Since then the approach has seen increased interest, directly leading to the establishment of Soteria Houses in Alaska, Vermont and Israel.

The Burlington, Vermont Soteria House is funded by the state of Vermont and operated by Pathways Vermont.<sup>91</sup> In Israel, there are several Soteria Houses and other similar programs incorporated into the mental health system to the point where they are not considered alternatives, but part of Israel's mainstream mental health system.<sup>92</sup>

Despite its success, Soteria-Alaska closed due to a change in leadership and direction by the organization operating it, impacted by several factors including, but not limited to the fatigue of securing sufficient funding in the face of chronic inadequate governmental financial support. This is a cautionary tale — sustainability is impacted, not just by funding but by commitment and fidelity to a vision and historical purpose.<sup>93</sup>

Similarly, Soteria Berne operated successfully for decades by Dr. Ciompi under the *Soteria Critical Elements* principles they developed. However, since Dr. Ciompi retired, Soteria Berne has drifted away from these elements. This demonstrates the danger of backsliding when the visionary founder leaves. This was also a key factor in Soteria-Alaska's closure. It is thus extremely important to develop a critical mass of people who understand and support Soteria principles. There are also other programs that claim to be Soteria programs even though they do not comply with the Soteria Critical Elements and may even be involved in psychiatric incarceration and forced drugging.

As demonstrated above, it is critically important to prevent people from being put on neuroleptics and Soteria Houses should be the first option for people who experience a first episode of psychosis who would otherwise be psychiatrically hospitalized and drugged

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<sup>89</sup> Mosher, Loren R. (1999). "[Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review.](#)" *Journal of Nervous and Mental Disease* 187(3): 142-149.

<sup>90</sup> Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books.

<sup>91</sup> [Pathways Vermont Soteria House](#). Accessed 18 Sep 2023.

<sup>92</sup> Friedlander, Avraham; Tzur Bitan, Dana; & Lichtenberg, Pesach. (2022). "[The Soteria Model: Implementing an Alternative to Acute Psychiatric Hospitalization in Israel.](#)" *Psychosis* 14(2): 99-108.

<sup>93</sup> Gottstein, Jim. (29 Jun 2015). "[Lessons From Soteria-Alaska.](#)" *Mad in America*.

under the current system. They have been proven to be successful with people already drugged, but their best use is to help people from being put on the neuroleptics in the first place.

## Drug Free Hospitals

Psychiatric inpatients should be given the option of no drugs. In 2010, at the urging of patient organizations, the Norwegian parliament mandated patients be allowed to choose a drug-free psychiatric hospital. As a result, the private Hurdalsjøen Recovery Center was opened and operated with extreme success.<sup>94</sup> Unfortunately, more recently the Norwegian government decided not to continue financially supporting private hospitals, forcing its closure.<sup>95</sup> Drug free hospitals should be made generally available for inpatients who choose not to take the drugs.

## Open Dialogue

The Open Dialogue approach, as set forth above, can also achieve remarkable results in the 80% recovery range.<sup>96</sup> There are Seven Principles of the Open Dialogue Approach:

1. Immediate help
2. Social network perspective
3. Flexibility and mobility
4. Responsibility
5. Psychological continuity
6. Tolerance of uncertainty
7. Dialogue (& polyphony).<sup>97</sup>

As stated on the Developing Open Dialogue website:

The principles and values of Open Dialogue are simple. People are met in crisis within 24 hours of contact and daily until the crisis is resolved. Hospitalisation is avoided and its consequential stigma, preferring to meet in the homes of those seeking their services. They avoid the use of anti-psychotic medication wherever possible. All those who have something to say are invited including the networks of the person and mental health services. The latter are integrated into a comprehensive service and the same

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<sup>94</sup> Whitaker, Robert. (8 Dec 2019). "[Medication-Free Treatment in Norway: A Private Hospital Takes Center Stage.](#)" *Mad in America*.

<sup>95</sup> Whitaker, Robert. (11 Jan 2023). "[A Revolution Wobbles: Will Norway's 'Medication-Free' Hospital Survive? Politics, Mainstream Psychiatry May Shutter Lake Hurdal Recovery Center.](#)" *Mad in America*.

<sup>96</sup> Seikkula, Jaakko, et al. (2006). "[Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies.](#)" *Psychotherapy Research* 16(2): 214–228.

<sup>97</sup> Olson, Mary; Seikkula, Jaakko; & Ziedonis, Douglas. (2014). "[The Key Elements of Dialogic Practice in Open Dialogue.](#)" Worcester, MA: University of Massachusetts Medical School.

Open Dialogue team work with the client and their social network throughout the life of the problem. In addition people are offered other therapies as required e.g. employment support, individual therapy, occupational therapy etc.<sup>98</sup>

Open Dialogue, or the dialogic approach as it is sometimes called, with variations, is being deployed as an alternative to the traditional psychiatric drug and coercion system around the world.<sup>99</sup> It needs to become part of the mainstream system as it has in Lapland, where it reduced schizophrenia diagnoses by 90% because they were getting people through what they were going through and their lives back on track before the six months of symptoms required for a schizophrenia diagnosis to properly be made.<sup>100</sup> This was possible because the Open Dialogue Approach was the first and preferred treatment.

## Hearing Voices Network

Hearing Voices Groups bring together people who hear voices, in peer-supported group meetings that seek to help those with similar experiences explore the nature of their voices, meanings and ultimately, acceptance. Hearing Voices Groups have grown in popularity in no small part because suppressing voices using medication and other interventions are often ineffective or worse. Hearing Voices groups ask not what is wrong with you, but what happened to you? The *WHO Guidance* endorses the Hearing Voices Network.<sup>101</sup>

The Hearing Voices Movement began in the Netherlands in the late 1980s. It now has national networks in 30 countries. Some groups are co-founded by professionals and closely aligned with mental health services while others are initiated independently by voice hearers. Due to the independent nature of these groups, it is challenging to research outcomes. In spite of limited research, some reported outcomes include: decrease in hospital admissions, voice frequency and use of medication, increase in support that is often otherwise unavailable and better understanding of voice experiences.<sup>102</sup> Most importantly, the participants value Hearing Voices groups and they should be encouraged and supported.

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<sup>98</sup> Developing Open Dialogue. [“Open Dialogue Finland”](#) (web page). Accessed 18 Sep 2023.

<sup>99</sup> Mosse, David, et al. (2023). [“Introduction: Open Dialogue Around the World – Implementation, Outcomes, Experiences and Perspectives.”](#) *Frontiers in Psychology* 13.

<sup>100</sup> Seikkula, Jaakko, et al. (2006). [“Five-Year Experience of First-Episode Non-affective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies.”](#) *Psychotherapy Research* 16(2): 214–228.

<sup>101</sup> World Health Organization. (9 Jun 2021). [Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches](#). Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization. See also the [Hearing Voices Network](#) website.

<sup>102</sup> Branitsky, Alison. (2017). [“Commentary: Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups.”](#) *Frontiers in Psychology* 8; Beavan, Vanessa; de Jager, Adele; & dos Santos, Bianca. (2017). [“Do Peer-Support Groups for Voice-Hearers Work? A Small Scale Study of Hearing Voices Network Support Groups in Australia.”](#) *Psychosis* 9(1): 57–66.

Minimal costs are involved, usually only rent for a weekly meeting space and a possible fee for the facilitator, if even that. **The very low cost Hearing Voices Network approach should be encouraged and facilitated.**

## Warmlines

Warmlines are different than crisis/suicide lines, also called "hot lines," which often betray callers by having the police dispatched to haul them off to the psychiatric hospital in handcuffs even though they advertise themselves as confidential and/or anonymous.<sup>103</sup> This betrayal went national with the rollout of the 988 line in the United States, which is often linked with mental health crisis response programs, such as Crisis Now.<sup>104</sup> The rationale for the betrayal is they only call for the apprehension of people who are at risk of suicide so they can be incarcerated safely in a psychiatric ward. Not only does this make people unwilling to call the hotline, but as set forth above, increases suicides.

A fundamental principle of warmlines is to only do what the person wants. If they want to go to the hospital—fine. If they don't, that is respected. Confidentiality is never breached. In order to achieve this, people staffing warmlines cannot be mandatory reporters. The purpose of a warmline is connection to combat isolation, support through distress, troubleshoot life challenges, and provide information on resources if desired by the caller. They focus on crisis prevention and diversion from hospitals, 911, and mobile crisis.

"Standalone peer-run warm lines are garnering national attention as a part of states' responses since they are cost effective, highly utilized and are the most accessible way for people, regardless of age, gender, sexual orientation, race, ethnicity, geography, insurance/no insurance and financial circumstances to get support and prevent emergency department, 911 and involuntary hospital stays."<sup>105</sup> Forty states have warmlines.<sup>106</sup>

## Emotional CPR (eCPR)

Emotional CPR ([eCPR](#)) is an educational program designed to teach people to assist others through an emotional crisis<sup>107</sup> by three simple steps:

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<sup>103</sup> Chapter 10 of the comprehensive and authoritative book on forced psychiatric interventions, *Your Consent is Not Required: The Rise in Psychiatric Detentions, Forced Treatment, and Abusive Guardianships* (2023) by investigative reporter Rob Wipond, documents the tracing of promised confidential and/or anonymous calls and dispatching of police to take people into custody.

<sup>104</sup> National Association of State Mental Health Program Directors (NASMHP). "[Crisis Now: Transforming Crisis Services](#)" (website). Accessed 18 Sep 2023.

<sup>105</sup> From a presentation by Cherene Caraco, Warm Lines, part of her series of [webinars on Peer Run Crisis Alternatives](#), presented by the Café TA Center, Tallahassee, FL.

<sup>106</sup> [warmlines.org](#) maintains a directory of known warmlines in the U.S.

<sup>107</sup> The terrific book *Heartbeats of Hope: the Empowerment Way to Recover Your Life* (2018) by psychiatric survivor and psychiatrist Daniel Fisher includes a description eCPR and its development.

C = Connecting  
P = emPowering, and  
R = Revitalizing

The Connecting process of eCPR involves deepening listening skills, practicing presence, and creating a sense of safety for the person experiencing a crisis. The emPowering process helps people better understand how to feel empowered themselves as well as to assist others to feel more hopeful and engaged in life. In the Revitalizing process, people re-engage in relationships with their loved ones or their support system, and they resume or begin routines that support health and wellness which reinforces the person's sense of mastery and accomplishment, further energizing the healing process. eCPR is based on the principles found to be shared by a number of support approaches: trauma-informed, counseling after disasters, peer support to avoid continuing emotional despair, emotional intelligence, suicide prevention, and cultural attunement. It was developed with input from a diverse cadre of recognized leaders from across the U.S., who themselves have learned how to recover and grow from emotional crises. **eCPR Training should be made widely available.**

eCPR is to be contrasted with Mental Health First Aid, which funnels people into the traditional mental health system with its message of hopelessness and psychiatric drugging.

## **Non-Police Community Response Teams**

It is being recognized more and more that the police should not be involved in responding to what are termed mental health crises. So many of these police encounters end in tragedy in the United States with the police shooting and killing people for whom they were asked to check on. Mobile Crisis Teams are meant to address the problem of police being first responders, but they are set up to psychiatrically incarcerate people which, as set forth above, is counterproductive and cause people to avoid contact with the system no matter what problems they may be having. Instead, non-coercive non-police community response teams should be utilized.

## Non-Police Community Response Teams

- An alternative to 911, police intervention and mobile crisis
- Diversion from involuntary commitment and incarceration
- Various models exist – for example:
  - co-responders which include a peer supporter and clinician
  - completely peer staffed team
  - a peer supporter and paramedic
- Receiving national attention due to the racial injustices and use of police force when responding to people experiencing mental health crisis

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Open Dialogue teams could be viewed as community response teams that continue the engagement with the person and the person's close community. They are often used in situations where mobile crisis teams would be deployed, but with the outstanding outcomes set forth above.

## Psychotherapy

Psychotherapy is often overlooked, or even dismissed, as an effective approach for people diagnosed with serious mental illness, but much of what works in the approaches discussed above could be considered psychotherapy in a broad sense, and good psychotherapy is provided in a way that is consistent with these voluntary, relationship-based approaches. As set forth above, Dr. Mosher testified as a qualified expert witness in the *Myers* case, that "in the field of psychiatry, it is the therapeutic relationship which is the single most important thing."<sup>109</sup>

Many patients desire psychotherapy and it has been shown to be very effective.<sup>110</sup> The 1966–1971 Michigan Psychotherapy Project found that psychotherapy was significantly more effective than neuroleptic treatment for people diagnosed with schizophrenia.<sup>111</sup>

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<sup>108</sup> [“Peer Run Crisis Alternatives: Community Response Teams”](#) (video) by Cherene Caraco, 16 Jun 2021, from the [CAFE TAC Peer-Run Crisis Alternatives Webinar Series](#). These are really worth watching.

<sup>109</sup> [In the Matter of F.M. Transcript of proceedings \(March 5 and March 10, 2003\)](#), p. 177. Anchorage Superior Court, Case No. 3AN-02-00277 CI; See also Duncan, Barry L. (2015). [“The Person of the Therapist: One Therapist’s Journey to Relationship.”](#) In Kirk J. Schneider, J. Fraser Pierson, & James F. T. Bugental (eds.), *The Handbook of Humanistic Psychology: Theory, Research, and Practice*, 2nd ed., pp. 457–472. Thousand Oaks, CA: Sage Publications.

<sup>110</sup> Gøtzsche, Peter C. (22 Dec 2022). [“Psychotherapy: Less Expensive and Better Than Pills, it’s What the Patients Want But Don’t Get.”](#) *Mad in America*; Irwin, Matt. (Jan 2004). [“Treatment of Schizophrenia Without Neuroleptics: Psychosocial Interventions Versus Neuroleptic Treatment.”](#) *Ethical Human Sciences and Services* 6(2): 99–110.

<sup>111</sup> Karon, Bertram P.; & VandenBos, Gary R. (1972). [“The Consequences of Psychotherapy for Schizophrenic Patients.”](#) *Psychotherapy: Theory, Research & Practice* 9(2): 111-119; Karon, Bertram P.; & VandenBos, Gary R. (1981). [Psychotherapy of Schizophrenia: The Treatment of Choice](#). New York: Roman &

Studies with long-term follow-up show that psychotherapy has an enduring effect that outperforms psychiatric drugs.<sup>112</sup>

## Other Person-Centered and Rights-Based Approaches

In addition to the programs described above endorsed by the [WHO Guidelines](#), a number of other effective, humane, person-centered and rights-based programs are identified.<sup>113</sup> Similarly, the [Compendium Report: Good Practices In The Council Of Europe To Promote Voluntary Measures In Mental Health](#) (Good Practices Compendium), was published to assist member States by developing a compendium of good practices to promote voluntary measures in mental healthcare, both at a preventive level and in situations of crisis, by focusing on examples in Council of Europe countries.<sup>114</sup>

One of programs described in the [WHO Guidelines](#) is the Friendship Bench program in Zimbabwe:

The name Friendship Bench derives from the shona term, chigaro chekupanamazano, which translates literally as, “bench to sit on to exchange ideas”. It provides a short-term form of problem-solving therapy to people with common mental health conditions, known in shona as kufungisisa, which translates literally as “thinking too much.” The free service is linked to the local primary health care centre and is usually delivered outside the centre on a wooden bench. People can self-refer or be referred by schools, police stations or the primary care clinic.

This seems somewhat similar to the tōjisha-kenkyū program in Japan, which roughly translates as “the science of the self” or “self-supported research”, where people with disabilities and/or mental illness learn to study their own experiences.<sup>115</sup>

Both of these are examples of a community developing solutions that work for them. There should be room in the mental health system to support approaches the people

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Littlefield; Morrison, Anthony P, et al. (2014). [“Cognitive Therapy for People With Schizophrenia Spectrum Disorders Not Taking Antipsychotic Drugs: A Single-Blind Randomised Controlled Trial.”](#) *The Lancet* 383(9926): 1395–1403.

<sup>112</sup> Cuijpers, Pim, et al. (2013). [“Does Cognitive Behaviour Therapy Have an Enduring Effect That is Superior to Keeping Patients on Continuation Pharmacotherapy? A Meta-Analysis.”](#) *BMJ Open* 3(4): e002542; Shedler, Jonathan. (2010). [“The Efficacy of Psychodynamic Psychotherapy.”](#) *American Psychologist* 65(2): 98-109; Bighelli, Irene, et al. (2021). [“Psychosocial and Psychological Interventions for Relapse Prevention in Schizophrenia: A Systematic Review and Network Meta-Analysis.”](#) *The Lancet Psychiatry* 8(11): 969–980.

<sup>113</sup> World Health Organization. (9 Jun 2021). [Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches](#). Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization.

<sup>114</sup> Gooding, Piers. (2021). [Compendium Report: Good Practices in the Council of Europe to Promote Voluntary Measures in Mental Health](#). Report commissioned by the Committee on Bioethics, Council of Europe.

<sup>115</sup> Ayaya, Satsuki; & Kitanaka, Junko (12 Jun 2023). [“Tōjisha-Kenkyū: Japan’s Radical Alternative to Psychiatric Diagnosis.”](#) *Aeon*.

themselves develop and want to implement. When a community comes up with a solution they want to pursue, there is “buy-in” which succeeds because the community makes it succeed. Such programs are not necessarily susceptible to being replicated because the buy-in is such a critical component. This does not diminish its effectiveness for that community.

An example is **Ionia** in Alaska.<sup>116</sup> Five refugee couples from the psychiatric system on the East Coast settled in Kasilof after trying out a number of other locales. They pooled their individually meager assets to purchase land. Starting out in yurts the first winter, they then built cabins with wood stoves. They have a macrobiotic diet, growing as much of their own food as they can, and gathering other food such as seaweed. They have a community meeting every day to work out conflicts and they consider their simple but hard, close to the earth work to be therapy. These couples, at least one of which in each was written off as hopelessly mentally ill, have created a life that works for them. A whole generation of their children grew up there and there is a blossoming third generation. The point is not that Ionia is a model program that should be replicated, but an example of people finding their own solutions.

One of the programs identified by the [Good Practices Compendium](#) is **TANDEMplus** in Belgium, a mobile crisis service involving interdisciplinary teams that support people during and shortly after a mental health crisis. The crisis teams help a person to (re)activate her/his local support network, including connecting to both formal and informal sources of support. Emphasis is placed on the person defining the kind of support she/he would like to receive.

Another program identified by the [Good Practices Compendium](#) is "**Citizen Psychiatry**," in the French City of Lille. "Over the past three decades, the city of Lille has progressively developed a program of ‘citizen psychiatry’ in which mental health services’ aim to avoid resorting to traditional hospitalisation, and instead ‘integrate the entire health system’ into the city, via a network involving all interested partners: service users, carers, families and elected representatives. Within this broad approach to mental health services, there are several specific practices detailed in the report."

Another is the **Trieste, Italy model** "described as an ‘open door—no restraint’ initiative which aims to ‘de-hospitalise’ responses to mental health across the city of Trieste. The core of the program involves a network of ‘Community Mental Health Centres’ with relatively few beds, one general hospital psychiatric unit, a network of supported housing facilities, and several social enterprises/cooperative businesses."

**Healing Homes** operated by the Family Care Foundation in Gothenburg, Sweden,<sup>117</sup> backed by over twenty years of experience, places people who have been failed by

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<sup>116</sup> [Ionia](#). (website). Accessed 18 Sep 2023.

<sup>117</sup> [Family Care Foundation \(Familjevårdsstiftelsen\)](#). (website). Accessed 18 Sep 2023. See also Håkansson, Carina. (5 Feb 2012). "[In Gothenburg, Ordinary Homes Serve as Havens for Healing.](#)" *Mad in America*.

traditional psychiatry with host families — predominately farm families in the Swedish countryside — as a start for a whole new life journey without psychiatric drugs. Host families are chosen not for any psychiatric expertise, but for their compassion, stability, and desire to give back. People live with these families for upwards of a year or two and become an integral part of a functioning family system.

Staff members offer clients intensive psychotherapy and provide host families with intensive supervision. The Family Care Foundation eschews the use of diagnosis, works within a framework of striving to help people come safely off psychiatric drugs, and provides their services, which operate within the context of the Swedish national health service, for free. There is a movie, *Healing Homes*, by Daniel Mackler, now a free download, about this program that has been translated into 20 languages and viewed over 66,000 times.<sup>118</sup> Like Soteria Houses and Peer Respite, Healing Homes provide a home or home-like environment with the expectation people can get through their experiences and come out the other side able to have meaning, purpose and connection in their lives.

Healing Homes is similar to the more well-known city of Geel in Belgium, which has a centuries-long tradition of taking people into their homes and making them part of their families.

**Warfighter Advance** is another example of a community fashioning a solution.<sup>119</sup> In this case, the community are people who have been deployed to wars overseas and come home with psychiatric diagnoses, put on psychiatric drugs and told there is something wrong with their brain and they essentially have no future. Warfighter Advance changes the trajectory of the warfighter's post-deployment life, so that rather than an existence characterized by an endless cycle of mental illness diagnoses, drugs, medical appointments and disappointments, the warfighter has a life characterized by pride, productivity, healthy relationships, continued service, and advocacy for the same outcomes for their fellow service members. Warfighter Advance eschews psychiatric drugs and force, instead encouraging informed consent. It has outstanding results in helping traumatized veterans live fulfilling lives. This program and two of its participants are featured in the award winning documentary film, *Medicating Normal*.<sup>120</sup>

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<sup>118</sup> Mackler, Daniel (2011). *“Healing Homes: Recovery From Psychosis Without Medication”* (documentary). 1h20m.

<sup>119</sup> *Warfighter Advance*. (website). Accessed 18 Sep 2023.

<sup>120</sup> Cunningham, Lynn; & Ractliffe, Wendy. (2020). *“Medicating Normal”* (documentary). 1h 16m: Periscope Moving Pictures.

## **V. ACKNOWLEDGMENTS**

The authors give great thanks to Melissa S. Green for editing and formatting assistance and to Susan Musante, LPCC, for her input. Melissa was the publication specialist at the University of Alaska Anchorage's Justice Center for 29 years. Among many other things, Susan was the founding director of Soteria-Alaska and thus has personal experience successfully implementing the types of programs recommended in this Report.

## VI. AUTHORS

### James B. (Jim) Gottstein, Esq.

[James B. \(Jim\) Gottstein, Esq.](#), author of *The Zyprexa Papers* (2021) is an Alaskan lawyer who in 1982, at the age twenty-nine, experienced a manic episode as a result of sleep deprivation and was held at the Alaska Psychiatric Institute (API) for 30 days. He was told he would never practice law again and the best he could hope for was to minimize his hospitalizations by taking one or more neuroleptics for the rest of his life. Instead, with one other brief hospitalization in 1985, Mr. Gottstein learned how to manage his life to avoid getting into trouble again.

Mr. Gottstein was one of the plaintiffs' lawyers in the Alaska Mental Health Trust Lands Litigation over the State of Alaska's illegal 1978 redesignation (theft) of Alaska Mental Health Trust Lands as General Grant Land, resulting in a 1994 settlement, reconstituting the trust and creating the Alaska Mental Health Trust Authority. From 1998 to 2004, Mr. Gottstein was a member of the Alaska Mental Health Board, the state agency charged with planning and coordinating mental health services in the State of Alaska.

In 2002, Mr. Gottstein founded the Law Project for Psychiatric Rights (PsychRights) to mount a strategic litigation campaign against forced psychiatric drugging and electroshock, winning five Alaska Supreme Court Cases, three on constitutional grounds, and one in the Seventh United States Circuit Court of Appeals.

- [Myers v. Alaska Psychiatric Institute](#), 138 P.3d 238 (Alaska 2006)
- [Wetherhorn v. Alaska Psychiatric Institute](#), 156 P.3d 371 (Alaska 2007)
- [Wayne B. v. Alaska Psychiatric Institute](#), 192 P.3d 989 (Alaska 2008)
- [Bigley v. Alaska Psychiatric Institute](#), 208 P.3d 168 (Alaska 2009)
- [In the Matter of Heather R.](#), 366 P.3d 530 (Alaska 2016)
- [United States v. King-Vassel](#), 728 F.3d 707 (7th Cir. 2013)

PsychRights' Mission also includes informing the public about the counterproductive and harmful nature of the drugs and electroshock.

In addition, Mr. Gottstein co-founded a number of organizations to help psychiatric patients, all but one of which were peer-run:

- Mental Health Consumers of Alaska
- Alaska Mental Health Consumer Web
- Peer Properties
- CHOICES, Inc.
- Soteria-Alaska

See [Multifaceted Grassroots Efforts To Bring About Meaningful Change To Alaska's Mental Health Program](#) (2012).

## Peter C. Gøtzsche, MD

Peter C. Gøtzsche is a specialist in internal medicine but has a special interest in psychiatry; has published numerous scientific articles and several books about psychiatric drugs and the harms of forced treatment; and has had five PhD students who worked with psychiatric drugs.

Gøtzsche is an internationally recognized expert in research methodology, which resulted in a professorship at the University of Copenhagen in Clinical Research Design and Analysis in 2010. Co-founded the Cochrane Collaboration and established the Nordic Cochrane Centre in 1993. Co-founded Council for Evidence-based Psychiatry in the UK in 2014 and International Institute for Psychiatric Drug Withdrawal in Sweden in 2016. Founded the Institute for Scientific Freedom in 2019.

Gøtzsche's greatest contribution to public health was when he, in 2010, [opened the archives](#) of clinical study reports in the European Medicines Agency (EMA) after a 3-year long battle that involved a complaint to the European Ombudsman. EMA was solely concerned with protecting the drug industry's interests while ignoring those of the patients. The Ombudsman ruled there was no commercially confidential information in the study reports.

Gøtzsche has published over 100 papers in "the big five" (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*) and his scientific works have been cited over 190,000 times (his H-index is 91 according to Web of Science, June 2022, which means that 91 papers have been cited at least 91 times). Gøtzsche is the author of several books. The ones most relevant for psychiatry are:

- [Critical psychiatry textbook](#) (2022) (freely available)
- [Mental health survival kit and withdrawal from psychiatric drugs: A user's guide](#) (2022, exists in 8 languages).
- [Deadly psychiatry and organised denial](#) (2015, in 9 languages).
- [Deadly medicines and organised crime: How big pharma has corrupted health care](#) (2013, in 16 languages). Winner, British Medical Association's Annual Book Award, Basis of Medicine in 2014.

Gøtzsche has given numerous interviews, one of which — about organised crime in the drug industry — has been seen [by half a million](#) on YouTube. Gøtzsche was in The Daily Show in New York on 16 Sept 2014 where he played the role of Deep Throat revealing secrets about big pharma. A documentary film about Peter's reform work, [Diagnosing Psychiatry](#), appeared in 2017, and another one is in the making, [The honest professor and the fall of the Cochrane empire](#).

Peter has an interest in statistics and research methodology. He has co-authored guidelines for good reporting: [CONSORT](#) for randomised trials, [STROBE](#) for observational studies, [PRISMA](#) for systematic reviews and meta-analyses, and [SPIRIT](#) for trial protocols. Peter was an editor in the Cochrane Methodology Review Group 1997–2014.

## David Cohen, PhD

David Cohen is a Professor and Associate Dean for Research and Faculty Development at UCLA's Luskin School of Public Affairs. He looks at psychoactive drugs (prescribed, licit, and illicit) and their desirable and undesirable effects as socio-cultural phenomena "constructed" through language, policy, attitudes, and social interactions. He also documents treatment-induced harms (iatrogenesis), and pursues international comparative research on mental health trends, especially involving alternatives to coercion. Public and private institutions in the U.S., Canada, and France have funded him to conduct clinical-neuropsychological studies, qualitative investigations, and epidemiological surveys of patients, professionals, and the general population.

In his clinical work for over two decades, Cohen has developed person-centered methods to withdraw from psychiatric drugs and given workshops on this topic around the world. He designed and launched the CriticalThinkRx web-based [Critical Curriculum on Psychotropic Medications](#) for child welfare professionals in 2009, since taken by thousands of practitioners and updated in 2018. Tested in a 16-month longitudinal controlled study, CriticalThinkRx was shown to reduce psychiatric prescribing to children in foster care.

He has authored or co-authored over 120 articles and book chapters. His edited books include *Challenging the Therapeutic State* (1990), *Médicalisation et contrôle social* (1996), and *Critical New Perspectives on ADHD* (2006). His co-authored books include *Guide critique des médicaments de l'âme* (1995), *Your Drug May Be Your Problem* (1999/2007), and *Mad Science* (2013).

Dr. Cohen previously taught at Université de Montréal and Florida International University. In Montreal, he directed the Health & Prevention Social Research Group, and at Florida International University where he was PhD Program Director and Interim Director of the School of Social Work. He held the Fulbright-Tocqueville Chair to France in 2012.

## Chuck Ruby, PhD

Chuck Ruby, author of [Smoke and Mirrors: How You Are Being Fooled About Mental Illness - An Insider's Warning to Consumers](#), is a licensed psychologist in private practice in southern Maryland. He is the Executive Director of the International Society for Ethical Psychology and Psychiatry (ISEPP), a non-profit research and public education organization that rejects the traditional medical notion of "mental illness" and calls for humane ways of helping people who suffer from significant life distress. Dr. Ruby was trained in clinical psychology at the Florida State University, earning his Ph.D. in 1995. He is also a retired U.S. Air Force Lieutenant Colonel who served in counterespionage, counterintelligence, and criminal investigative assignments across the globe.

## **Faith J. Myers**

Faith J. Myers is the author of the book *Going Crazy in Alaska: A History of Alaska's Treatment of Psychiatric Patients* (2020). For approximately 5 years, from 1999 to 2003, Faith was in and out of acute care psychiatric facilities or units and at times, homeless. She is the Myers in *Myers v. Alaska Psychiatric Institute*, declaring Alaska's forced drugging regime unconstitutional.

On seven occasions, Faith ended up in a psychiatric facility, four times in a psychiatric evaluation unit and six times she was escorted to those facilities by the police in handcuffs. She was in crisis treatment centers three times. Faith stated, "It was the indifference of my treatment and mistreatment that led me to become a mental health psychiatric patient rights activist."

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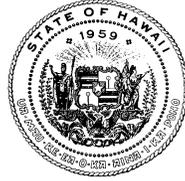
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GOVERNOR OF HAWAII  
KE KIA'AINA O KA MOKU'AINA 'O HAWAII



KENNETH S. FINK, M.D., M.G.A., M.P.H.  
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**LATE**

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**Testimony COMMENTING on SB 2288  
RELATING TO MENTAL ILLNESS**

SENATOR JOY SAN BUENAVENTURA, CHAIR  
SENATOR ANGUS L.K. McKELVEY, VICE CHAIR  
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Hearing Date: Friday, February 13, 2026 1:00 p.m.

Room Number: 225 & Video

1 **Fiscal Implications:** Undetermined.

2 **Department Testimony:** The Adult Mental Health Division offers the following testimony on  
3 behalf of the Department.

4 The Department appreciates the Legislature's continued commitment to strengthening  
5 Hawaii's mental health and criminal justice systems and improving service delivery for  
6 individuals with behavioral health needs in our community. The Department acknowledges the  
7 enormous time and effort the Legislature has put in to providing the resources and tools  
8 necessary to build out and operationalize the continuum of care in the State.

9 SB 2288 proposes extensive amendments to multiple provisions of the Hawaii Penal  
10 Code, particularly those governing fitness to proceed, penal responsibility, and related  
11 treatment orders.

12 As a participating member of the 2025 Advisory Committee on Penal Code Review,  
13 convened pursuant to Act 245, SLH 2024, the Department supports SB 2721 and HB 2414.  
14 These measures advance the Final Report recommendations of the 2025 Advisory Committee  
15 on Penal Code Review following a systematic evaluation of the Hawaii Penal Code.

1           The recommendations contained in the Final Report reflect substantial deliberation,  
2 legal analysis, and consensus-building across multiple and diverse stakeholders. The  
3 Department believes that proposed changes to the Penal Code, particularly those affecting  
4 competency, penal responsibility, and involuntary treatment, benefit from this comprehensive  
5 and multidisciplinary review process.

6           Thank you for the opportunity to testify on this measure.

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February 12, 2026

**LATE**

**SB 2288: RELATING TO MENATL ILLNESS**

**Chair Joy A. San Buenaventura, Vice Chair Angus L. K. McKelvey and  
Members of the Committee on Health and Human Services**

The Office of the Public Defender (OPD) **strongly opposes SB 2288:**

While the OPD understands the general perception of the legislature and the community regarding issues involving mental illness and the criminal courts, including what is described as the “unfit to proceed paradox”, it feels that resolving these issues is a monumental task which requires the input of all stake holders. SB 2288 attempts to completely rewrite how our criminal justice system deals with issues related to mental illness and criminal liability as currently enumerated in HRS chapter 704, without first having allowed for input by stakeholders in a meaningful and comprehensive manner. It is our understanding that the changes proposed in SB 2288 were not vetted by the subcommittee on chapter 704 at the 2025 Advisory Committee on Penal Code Review, and thus the ramifications for such suggested changes have not been fully considered. Thus, it would be the recommendation of the OPD to have this proposed measure deferred and a committee of stake holders be formed to discuss the concerns outlined in SB 2288, and to then propose legislative changes. The OPD feels that SB 2288 would have a tremendous impact on many of our clients, as well as on the fiscal and personnel matters of our office. We wish to outline just a few below:

First, the proposed addition to HRS section 334-1 regarding the definition of the term “imminently dangerous to self, others or property” means “the person will **more likely than not** cause harm to self, others or property within the next forty-five (45) days” would require a court to use a crystal ball in decision making, as

well as, asking medical and psychological experts to predict the future in an exacting manner. Such decision-making is without legal structure and will greatly impact clients of the OPD. The same argument can be made regarding the second proposed definition of “dangerous to others”, wherein under (4)(b) a court is required to consider by **clear and convincing** evidence of the defendant’s history of repeatedly harming others. What if the defendant has no history, as this might be the defendant’s first mental breakdown or encounter with the law after a mental disease has taken hold. Is this defendant to be treated differently under the law, as such predictions would be impossible to make. Decisions made under HRS chapter 704 should be made based upon the current mental health needs of the person before the court, and not based upon possible predictions.

Second, SB 2288 would allow for additions to be made to HRS 701-118 with a term called: “Involuntary treatment” which would include the following language “under custodial confinement as an inpatient at any **facility** or hospital. The OPD has a great fear that this proposed definition could mean that our clients could undergo involuntary treatment while in jail and not in a therapeutic placement. Furthermore, we are concerned that said clients could be forced to receive treatment, even after the court has lost jurisdiction or after said person has been sentenced to a jail term. Under current law, a defendant that has been convicted of a crime is placed on probation or given a jail term. If the sentence is a term of imprisonment conditions are usually not attached, because a person’s jail sentence cannot be lengthened if they are not amenable to or able to properly receive medical treatment. The OPD understands the perception that there are those within the community that **should** receive mental health treatment, which might include medication, however the criminal justice system is ill equipped to be the vehicle for such forced treatment as there are legal and constitutional limitations which must be followed.

Third, proposed section (b)(4) would require that a person subject to conditional release or probation, be required to have a “review” hearing before a judge at least every 120 days. This would place a very heavy burden on the OPD, as well as on the judiciary and the treatment team personnel that would be supporting said individuals in the community. A review hearing would require a report be generated by the treatment team (including a treating doctor) and sent to a probation officer who would then generate another report that would then be distributed to the court, which would have to utilize its limited calendar time for a hearing, which would include the appearance of the defendant, a member of the treatment team, the prosecuting attorney, the defense counsel (usually from the OPD) and the probation officer. Currently, the court does have review hearings,

but these are scheduled by way of necessity, meaning that they can be set by a frequency commensurate with need, and not by statutory directive.

Fourth, the OPD is concerned regarding the proposed sections on examinations of the defendant, which seem to invade the province of the medical professional doing the evaluation, and the defendant's right to choose whether to utilize a defense of penal irresponsibility. Medical professionals have their own set of scientific and medical protocols to evaluate a defendant for fitness as well as penal responsibility. In fact, it is only professionals trained in forensic psychology or psychiatry that should be allowed to opine on penal responsibility. SB 2288 lists numerous guidelines for determining penal responsibility instead of leaving those criteria to the medical professionals and asking them only to opine if the person being evaluated was volitionally or cognitively substantially impaired.

Furthermore, under proposed changes to HRS 704-404 the defendant's right to choose whether to utilize a defense of penal irresponsibility due to a mental disease, disorder or defect seems to be usurped, as the court can order and then consider the findings of a mental examination. The current usual practice is for the defendant to choose whether to use said defense, namely because of the ramifications of a finding of not guilty by reason of a mental disease, disorder or defect. Also, some defendants, though suffering from a mental disease, disorder or defect may actually be innocent of said criminal charges, and such a finding after trial would free them of the court and justice system. However, if forced to utilize a "mental" defense, their actual innocence becomes irrelevant. This would serve as a tragedy of our criminal justice system, and not a triumph over mental illness.

The OPD would also like to point out that there are some valuable parts of SB 2288 as well, including (1)(b) which would allow for a court to order non-compulsory assisted community treatment, (5) which allows for a petition to modify or terminate an order for treatment and (6) which would allow for the petitioning of the court for expungement of prior petty misdemeanor and misdemeanor offenses.

Regardless however, resolving the perceived problems of HRS chapter 704 should be the result of discussion, debate, careful consideration and compromise after lengthy input by those who are stakeholders in this area. These issues cannot be properly resolved by SB 2288.

Thank you for the opportunity to comment on this measure.





To: The Honorable Joy San Buenaventura, Chair  
The Honorable Angus McKelvey, Vice Chair  
Members, Senate Committee on Health & Human Services

From: Jacce Mikulanec, Director, Government Relations, The Queen's Health Systems

Date: February 13, 2026

Re: Comments on SB2288 – Relating to Mental Illness.

The Queen's Health Systems (Queen's) is a nonprofit corporation that provides expanded health care capabilities to the people of Hawai'i and the Pacific Basin. Since the founding of the first Queen's hospital in 1859 by Queen Emma and King Kamehameha IV, it has been our mission to provide quality health care services in perpetuity for Native Hawaiians and all of the people of Hawai'i. Over the years, the organization has grown to four hospitals, and more than 10,000 affiliated physicians, caregivers, and dedicated medical staff statewide. As the preeminent health care system in Hawai'i, Queen's strives to provide superior patient care that is constantly advancing through education and research.

Queen's appreciates the opportunity to provide comments on SB2288, which clarifies the procedures for assisted community treatment, examination, and hospitalization for individuals who may be mentally ill or suffering from substance abuse who are imminently dangerous to self, others, or property. We share the concern expressed in this measure toward attempting to improve care and services for those suffering from mental and behavioral health illness in our state. Our health system is particularly attuned to the impact of policies that effects how this subset of patients interacts within the healthcare system – Queen's Manamana (Punchbowl) receives the majority of patients that are referred via the 334-1 processes (and we have the largest inpatient psych unit in the state-Kekela). This measure, while well intended, could place additional burden on the existing emergency departments at our hospitals and do little to affect the overall care for individuals experience acute and chronic mental and behavioral health crises.

In particular, the addition of "property" in Section 2(1) will not only be challenging to evaluate but, could also be used indiscriminately to initiate a transfer for emergency evaluation.

"Imminently dangerous to self, others, or property" means that, without intervention, the person will more likely than not cause harm to self, others, or property within the next forty-five days."

While we defer to the Judiciary on their capacity to implement provisions under Section 5, we would urge the Committee to consider whether the court system has the appropriate clinical training and/or capacity to oversee this level of directed treatment. And related, whether there are investments within the state mental health delivery landscape to effectively provide services. Without

*The mission of The Queen's Health System is to fulfill the intent of Queen Emma and King Kamehameha IV to provide in perpetuity quality health care services to improve the well-being of Native Hawaiians and all of the people of Hawai'i.*

necessary investments in wrap-around services individuals will have little chance of getting the care they require.

Queen's shares the Committee's desire to meaningfully address and improve care for individuals with serious mental and behavioral health conditions in our state and we are committed to working with you on finding long-term solutions to this challenge. Mahalo for allowing Queen's to provide comments on SB2288.



**LATE**

Committee: Senate Committee on Health and Human Services  
Hearing Date/Time: Friday, February 13, at 1:00pm  
Place: Conference Room 225 & Via Videoconference  
Re: **Testimony of the ACLU of Hawai'i in Opposition to SB2288 Relating to Mental Illness**

Dear Chair San Buenaventura, Vice Chair McKelvey, and Members of the Committee:

The **ACLU of Hawai'i opposes SB2288**, which clarifies the procedures for assisted community treatment, examination, and hospitalization for individuals who may be mentally ill or suffering from substance abuse who are imminently dangerous to self, others, or property. It also amends the procedures for involuntary hospitalizations and assisted community treatment petitions and amends the Hawai'i Penal Code to streamline the determination process for penal responsibility and fitness to proceed, including requiring courts to issue orders for treatment to defendants excluded from penal responsibility due to a mental disease, disorder, or defect.

While we understand the intent of SB2288 to help and support individuals experiencing mental illness or substance abuse given the public health crisis in our communities, given our mandate to safeguard civil rights and liberties enshrined in our federal and Hawai'i Constitutions, **we strongly oppose this bill.**

First and foremost, the bill appears to see mentally ill individuals as criminals rather than patients. The bill therefore seeks to address their illness not as an issue of health, but rather as one of crime prevention.

The ACLU of Hawai'i sees these individuals as victims of mental illness in a society that prioritizes punishment and forced treatment as proper means to address this issue, when instead the focus should be on expansion of community mental health services. We should ensure that our state laws protect a person's fundamental right to bodily autonomy and to make our own health care decisions: This bill does the opposite.

### ***Property Crime Concerns***

Among the statutory amendment this bill seeks to make, it adds danger to "property" to the list of considerations for forced treatment. At the same time, the bill

acknowledges damage or theft is often minor. Rather than expand the criteria for imposing forced treatment on these individuals, the legislature should be prioritizing environments and policies that encourage and increase access to voluntary treatment avenues.

While the preamble acknowledges that individuals experiencing mental illness and/or substance abuse need support, research shows that voluntary treatment is more effective than involuntary treatment. The State must increase investments in more voluntary community based mental health and substance abuse treatment options and supportive housing to the scale required to meet the needs of vulnerable community members.

Further, involuntary hospitalization can lead to outcomes that are antithetical to those intended. A study published in July 2025 found involuntary hospitalization resulted in “a 79% increase in risk of being charged with a violent crime and almost a doubled risk of dying by suicide or overdose, in the three months following evaluation for hospitalization.”<sup>1</sup>

### ***Constitutional Concerns Relating to the Right of Bodily Autonomy, Due Process, Equal Protection, and Privacy***

A state may not commit somebody unless “his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty.” *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

Similarly, Hawai‘i courts have consistently held that involuntary commitment statutes result in significant deprivation of liberty interests and require due process safeguards.

- *Suzuki v. Yuen*, 617 F.2d 173, 176 (9th Cir. 1980) noted that the state interest must be equally significant to the liberty interest that is being deprived: “In drafting involuntary commitment statutes, states should be cognizant of the ‘significant deprivation of liberty,’ . . . and of the requirement that the countervailing state interest be equally significant.” *Suzuki v. Yuen*, 617 F.2d 173, 176 (9th Cir. 1980)

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<sup>1</sup> iSPS-US, *New Research Shows Risks of Coercive Psychiatric Treatment*, July 24, 2025. <https://isps-us.org/news-events/newsroom.html/article/2025/07/24/new-research-shows-risks-of-coercive-psychiatric-treatment>

- “[C]ivil commitment of the mentally ill for any purpose constitutes a significant deprivation of liberty that requires due process protection.” *In re Doe*, 102 Hawai‘i 528, 543, 78 P.3d 341, 356 (App. 2003)
- “To be considered ‘dangerous to self’ under the Hawai‘i statutory scheme ... it is not enough that an individual is unable to satisfy the need for nourishment, essential medical care, shelter or self-protection without supervision and assistance of others. There must also be clear and convincing evidence that the individual's inability to satisfy [their] need for nourishment, essential medical care, shelter or self-protection without supervision and assistance of others *will probably* result in death, substantial bodily injury, or serious physical debilitation or disease unless adequate treatment is afforded to the individual.” *In re Doe*, 102 Hawai‘i at 554, 78 P.3d at 367.

In short, Hawai‘i courts recognize that there must be clear and convincing evidence that a person is dangerous to others or themselves before civil commitment and involuntary treatment is authorized under the law given the significant deprivation of liberty.

### ***Supportive Community Alternatives***

Law enforcement officers are not properly trained to assess and evaluate individuals experiencing a mental health crisis and should not be responsible for making judgement calls regarding whether someone is or isn’t “a danger to self, others, or property.” First responders to calls of this nature should be social workers and/or trained counselors who can appropriately assess and interact with individuals in crisis.

In Honolulu, there is the CORE (Crisis Outreach Response and Engagement) program.<sup>2</sup> Currently, the program is arguably underresourced and improperly staffed to meet its primary mission, but we know this approach to houseless and mentally ill individuals is far more successful than the approach expanded by SB2288.

CORE is intended to be modeled after the CAHOOTS program in Oregon which has been tremendously successful in addressing individuals experiencing houselessness and mental health crises.

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<sup>2</sup> About the Crisis Outreach Response and Engagement (C.O.R.E.) Program.  
<https://emergencyservices.honolulu.gov/core/>.

The legislature should support programs like this one, rather than essentially further criminalizing the houseless and mentally ill in our communities.

In sum, the ACLU of Hawai'i strongly supports increasing investments in the diversion infrastructure and delivery of community-based health care and treatment to persons experiencing mental health and co-occurring disorders in Hawai'i. This robust infrastructure will divert people from our jails and prisons who do not belong there, and divert people from the Hawai'i State Hospital who do not meet the level of acuity required for that placement – and providing step down levels of supportive housing. In light of the number of provisions that violates rights to liberty, due process, equal protection and privacy under our Constitution, we **respectfully ask that you hold SB2288.**

Sincerely,

**Josh Frost**

Josh Frost  
Policy Advocate  
ACLU of Hawai'i  
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*With more than 4,000 Hawaii-based members, the mission of the American Civil Liberties Union of Hawai'i is to protect the fundamental freedoms enshrined in the United States and Hawai'i State Constitutions through legislative, litigation, and public education work. The ACLU of Hawai'i is a non-partisan and private non-profit organization that provides its services at no cost to the public and does not accept government funds. The ACLU of Hawai'i has been serving our communities in Hawai'i for over 60 years.*

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**LATE**

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February 12, 2026

Senator Joy A. San Buenaventura, Chair  
Senator Angus L.K. McKelvey, Vice Chair  
Committee on Health and Human Services  
The Senate  
33<sup>rd</sup> Legislature, State of Hawai'i

via: <http://www.capitol.hawaii.gov>

Dear Committee leadership and members,

Re: **COMMENTS ON SB2288 RELATING TO MENTAL ILLNESS**

DATE: February 13, 2026  
TIME: 1:00 PM  
PLACE: Conference Room 225 & Videoconference  
State Capitol  
415 South Beretania Street

The stated purpose of this bill is “to address the revolving ‘unfit to proceed paradox’ of habitually mentally ill criminal offenders remaining untreated.” It is based on a proposition that “this paradox occurs when a mentally ill person is convicted of a crime can be compelled to undergo psychiatric care because the crime itself constitutes evidence of ‘imminent dangerousness’. However, a person found ‘unfit to proceed’ cannot be tried, and therefore cannot be convicted of a crime,” and that is because “State’s laws fail to adequately address mentally ill habitual misdemeanor and petty misdemeanor offenses.”

I offer this testimony having represented several clients in matters involving chapter 704 examinations and proceedings here in the Third Circuit. While my direct experience is in circuit court felony cases, I write to suggest that the problem with untreated mentally ill habitual misdemeanants is not State law but State failure to sustain our Jail Diversion programs. See, e.g., *Puahala Graduates Jail Diversion Program* (June 2020), available at: <https://www.courts.state.hi.us/wp-content/uploads/2020/06/Puahala-graduates-Jail-Diversion-Program-West-Hawaii-Today-6-19-2020.pdf>; see, *LEAD [Law Enforcement Assisted Diversion] Program To Deal With Substance Abuse, Homelessness And Low-Level Crime Comes To Big Island* (November 2020), available at: <https://hopeserviceshawaii.org/lead-program-to-deal-with-substance-abuse-homelessness-and-low-level-crime-comes-to-big-island/>; and see, 2019

*Second Chance Act: Improving Reentry For Adults With Co-Occurring Substance Abuse And Mental Illness Grantee* (2022), available at:

[/https://nationalreentryresourcecenter.org/sites/default/files/inlinefiles/scaSuccessStory\\_hawaiiDOH\\_web.pdf](https://nationalreentryresourcecenter.org/sites/default/files/inlinefiles/scaSuccessStory_hawaiiDOH_web.pdf).

The bill proposes legislative findings including “that the vast majority of mentally ill persons who habitually commit low-level crimes, are doing so as the product of severe cognitive impairment, not free will. It is therefore just and proper for them to avoid *penal responsibility*. However, the current legal framework allows them to refuse treatment and other services, while simultaneously avoiding penal responsibility, an absurd contradiction that is not required by the United States Constitution.” (emphasis added).

As a matter of law, it is not an absurd contradiction under the U.S. or State Constitution. “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” U.S. Const. amend. VIII.; Haw. const. art. 1, § 12. That is why the maximum sentence for a petty misdemeanor conviction is 30 days, HRS § 701-107(4), and why when “a defendant committed to the custody of the director of health for a limited period [for a petty or nonviolent misdemeanor offense] is not found fit to proceed prior to the expiration of the commitment, the charge for which the defendant was committed for a limited period shall be dismissed,” HRS § 704-406(7). And a matter of fact, the bill does not propose any legislative finding that the mentally ill misdemeanants that allegedly are “refusing treatment and other services” are refusing treatment and services that are, as a matter of fact, extant, available, and accessible. And that includes not only community based treatment and services, like jail diversion programs, but also within DOH and the State Hospital.

Section 5 of the bill proposes a new section of chapter 704 that provides for an “order for treatment” for any person “entitled to avoid penal responsibility due to mental disease, order, or defect.” But that already is the law. “When a defendant is acquitted on the ground of physical or mental disease, disorder, or defect excluding responsibility, the court, on the basis of the report made pursuant to section 704-404, if uncontested, or the medical or psychological evidence given at the trial or at a separate hearing, shall order that: (a) The defendant shall be committed to the custody of the director of health to be placed in an appropriate institution for custody, care, and treatment if the court finds that the defendant: (i) Is affected by a physical or mental disease, disorder, or defect; (ii) Presents a risk of danger to self or others; and (iii) Is not a proper subject for conditional release[.]” HRS § 704-411(1).

The bill proposes a term with definition of “severe cognitive impairment” in Section 6 such that “physical or mental disease, disorder or defect,” may “collectively be referred to as “cognitive impairment”, but we don’t know why or to what end. There are no legislative findings proposed that that chapter 704 penal responsibility proceedings require or are otherwise improved by calling “physical or mental disease, disorder, or defect” something else.

The bill's actual beef appears not with penal responsibility examinations and proceedings, but with fitness to proceed proceedings involving petty and nonviolent misdemeanants, specifically that, if a fitness to proceed determination is not made for such person that has been in jail or DOH custody for 30 days, the constitution as executed by the sentencing statute, requires dismissal of the charge and release of the defendant. Section 7 of the bill proposes to marry distinct fitness and responsibility statutes and proceedings and by doing so undermines the stated purpose of this bill. DOH and providers do not cease treatment services upon determination of unfitness, instead the treatment program becomes one *to restore fitness*. The bill, specifically at Section 7, would eliminate fitness restoration *treatment*, the operational purpose of which is to allow the case to proceed to trial.

The bill proposes that upon suspension of proceedings for examination, all defendants shall be committed to DOH jurisdiction. Presently, such pretrial persons also may be released on own recognizance, bail, supervised release, or in combination, or may be held in county jail. The bill presumes DOH capacity where there is none. See DOH AMHD HSH FY 2024 Report To The 33<sup>rd</sup> Legislature (2025), at 1 (“Hale Ho‘ōla, the hospital’s new forensic facility, opened in 2022, is already operating at overcapacity and continues challenging the HSH with building deficiencies and unexpected repairs. . . . Due to the surge in admissions among individuals arrested on petty misdemeanor offenses, the HSH is utilizing, repurposing, and reinvesting in old and outdated buildings to care for patients.”); at 2 (21% increase in admissions = 602 from previous year = 498). DOH also reports , at 9, that “Forty-four patients admitted for fitness evaluations were discharged as fit to proceed (§704-405) and released to DCR to stand trial for their criminal charges; five (5) of these patients had been committed to HSH under Act 26 for expedited evaluation and hearing.”

What’s broken as concerns mentally ill habitual misdemeanants is not the law but the political will to sustain capacity of community based collaborations of the AMHD, police, treatment providers, prosecutors, defense counsel and allies through preventive and jail diversion action. The legislature took a welcome and necessary step last year in this regard with passage of Act 274 that increased the pay of the private examiners to \$2,000 per examination/report. Currently, there are only 15 forensic examiners statewide, 8 of which accept appointments to Third Circuit cases.

Thank you for your consideration of this testimony. Aloha. Mahalo.

Sincerely,

/s/ Georgette A. Yaindl  
GEORGETTE ANNE YAINDL