DISABILITY LAW CENTER

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March 8, 2022 by scan and e-mail to Senate.Health.And.Social.Services@akleg.gov

The Honorable David Wilson
Chair, Senate Health and Social Services Committee
State Capitol
120 Fourth St., M/S 3100
Juneau, Alaska 99801-1182

Re: Proposed CSSB 124 (CS Work Draft V.B)

Dear Chairman Wilson and Members of the Health and Social Services Committee:

Thank you very much for the opportunity to testify and to present written testimony about the significant revisions to SB 124, which follow from the House Judiciary Committee's substitute for its HB 172.

The overall purpose of SB 124 is to build into Alaska law support for the Crisis Now system of helping people who are experiencing mental health crises. Crisis Now would supplement, and to some extent replace, a current system where much short-term treatment depends on involuntary holds at, or outside, a limited number of evaluation facilities, whose main mission is to see whether someone ought to file a petition for the person to be committed to a treatment facility for up to 30 days. This system is cumbersome, subject to delays, and has resulted in people being held in hospital emergency rooms and even jails awaiting admission to an evaluation facility – which led to our court case, filed in the fall of 2018 and settled in summer 2020.

As we noted last year, 2021, SB 124 would make it much easier for people in crisis to get short-term mental health treatment, and would help to ensure that if someone may need civil commitment, the person's wait can be at a crisis residential center which can provide some of the services the person needs.

The new version of SB 124 makes this process simpler and more rational, and does a better job of protecting people's rights.

One major improvement is the clarification that in every case where someone wants to hold a person involuntarily for more than a few hours, there will be a court order providing the person with a court-appointed lawyer. That was an issue with last year's versions, and this year's version fixes it.

A second major improvement is that no matter where you go – a crisis residential center or an evaluation facility like API, Fairbanks Memorial, or Bartlett – if the system wants to hold you for more than 72 hours, there needs to be a hearing within those 72 hours at which the petitioner will have to show why you should continue to be held, as dangerous to yourself or others or as gravely disabled, and you and your lawyer can argue against your being held any longer than 72 hours.

In our view that is an acceptable trade-off for another change in the bill, which is extending the maximum involuntary stay at a crisis residential center to seven days. You would only be subject to the second half of that seven-day stay if a court had authorized this after a hearing at which you and your lawyer could participate.

The new version of the bill now calls for a report, from the Trust and the Department, about the statutes that govern patient rights and possible improvements to them. Disability Law Center looks forward to being part of the diverse stakeholder group identified in the committee substitute. We think that this will be a valuable step forward in protecting patient rights. We also think the time to move forward with a Crisis Now bill is now, this session. As modified, SB 124 is a good bill, the changes over the interim and in House Judiciary have improved it, and we at Disability Law Center urge you to enact it.

Sincerely,

Mark Regan
Legal Director

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Public Safety

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James E. Cockrell

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March 8, 2022

The Honorable David Wilson
Chair, Senate HSS Committee
Alaska State Capitol Room 121
Juneau AK 99801-1182

The Honorable Shelley Hughes
Vice-Chair, Senate HSS Committee
Alaska State Capitol Room 30
Juneau, AK 99801-1182

Subject: Letter of Support for SB 124 Mental Health Facilities & Meds

Dear Chair Wilson, Vice-Chair Hughes, and Members of the Senate Health & Social Services Committee:

I write to you to express the Department of Public Safety's (DPS) support for Senate Bill 124.

DPS views law enforcement's response to mental health calls as a serious priority and supports subacute mental health facilities for people experiencing mental health crises. Troopers often respond to incidents where people are experiencing suicidal thoughts, manic or delusional episodes, depression, or situations where the person isn't safe due to consumption of drugs or alcohol and poses a risk of harm to themselves or others.

These interactions present challenges for law enforcement officers who often must choose between taking the person to the hospital or to jail, when neither seems appropriate. For law enforcement officers, these situations can create tension between their duty to serve and their duty to protect.

Trooper investigations sometimes reveal no crime, but the subject needs immediate assistance; this type of occurrence is when a crisis stabilization center can offer an alternative to inappropriate placement in jails, full-scale medical services, or being left to suffer.

First responders spend excessive amounts of time waiting to make transfers at emergency holding places. This can be difficult and frustrating for officers and yet is a common experience many State Troopers face. Often an officer is seeking care for an individual in crisis, who has not committed a crime, but must keep them in their custody until they are able to find a safe disposition. This means that person is in handcuffs in the back of a law enforcement vehicle.

Troopers respond to rapidly evolving situations and must use the tools, facilities, and services available at the time. This bill creates additional options that are a better resource for the individual in crisis and an additional option for promptly connecting people to the care needed, enabling law enforcement to efficiently get back to community public safety.

Under the proposed statutory changes law enforcement would be able to take individuals in mental health crisis to 23-hour crisis stabilization centers or crisis residential centers as an additional option to local emergency rooms or jail.

SB 124 will ensure people get appropriate care swiftly, keep them out of jails and emergency rooms, and minimize the impact on first responders.

Through training and collaboration with stakeholders, the centers described in SB 124 are the best place to take a person in mental health crisis who is perceived to be a harm to themselves or others. This is an enhancement to our existing options in the community which are limited by what currently exists in law.

I urge your prompt and favorable action on this bill.

Sincerely,

James E. Cockrell
Commissioner

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providence.org

March 8, 2022

The Honorable Senator David Wilson
Chair, Senate Health & Social Services Committee
State Capitol, Room 121
Juneau, AK 99801

Electronic Letter

RE: Providence Alaska Supports Senate Bill 124: MENTAL HEALTH FACILITIES & MEDS

Dear Senator Wilson,

Providence Alaska has set the standard for modern health care in Alaska for more than 100 years. Today we remain the state's largest health care and behavioral health provider, and the largest private employer, with nearly 5,000 caregivers across Alaska. As the Regional Director of Behavioral Health for Providence Alaska, I write in support of Senate Bill 124.

Alaskans experiencing behavioral health crisis face a fractured and often frustrating lack of available services. Multiple stakeholder groups comprised of providers, hospitals, tribal health, advocacy groups and government have been collaborating to find solutions and to begin building out our continuum of care. There is no one solution, but rather a series of steps that must be taken to address the growing need and to safely care for Alaskans experiencing behavioral health struggles.

SB 124 is an opportunity for system transformation and to build on the growing momentum and stakeholder engagement to better serve the most vulnerable Alaskans.

The reality is that individuals who are experiencing a mental health crisis or an acute behavioral health problem are often not in an appropriate care environment. We struggle with an inadequate system of care that forces many Alaskans to languish and for their health to worsen while waiting for appropriate treatment. Emergency medical services, hospital emergency departments, and law enforcement are being relied on to serve individuals experiencing a behavioral health crisis. Already crowded emergency rooms serve as a holding place with the hope that a bed or treatment option may open in another facility. As a result, some spend upwards of two-weeks, in a windowless emergency room, waiting for treatment options or to begin a path toward recovery. This broken system is not only more costly, but also prevents the delivery of the right care at the right time.

The right care at the right time

SB 124 allows for the expansion of crisis stabilization centers and allows more time for stabilization. A medical examination is provided by a mental health professional within three hours of an individual's arrival at the center. This includes both mental health and substance use disorders. Under the current system, many Alaskans in crisis are never seen by a mental health professional and they rarely get care for both a substance use disorder and mental health diagnosis. Crisis stabilization centers offer prompt care for people who need immediate support and observation and to improve symptoms of distress. The goal is to resolve crisis and to avoid not only the emergency department and/or unnecessary incarceration, but to reduce suffering resulting from a lack of supports.

Extending the timeframe to stabilize, and to identify and engage in a treatment plan, from 72 hours to 120-hours can reduce commitments by allowing for more time for stabilization. With more time available to focus on deescalating the existing crisis, there is greater support for the transition to a voluntary and comprehensive treatment plan. These are critical steps toward recovery and avoiding repeated crisis and readmission.

Supporting the Alaska Psychiatric Institute

Crisis stabilization centers combine a community behavioral health model of care and a safe setting designed to care for people in acute behavioral health crisis. Designing a model that allows for crisis stabilization care delivery for up to 7 days supports the Alaska Psychiatric Institute by reducing potential transfers to API. More than half of API stays are 7-days or less; even if a fraction of these clients could be served in crisis stabilization centers, there would be decreased demand on API to provide short-stay services, allowing for the state psychiatric hospital to be available for Alaskans who need long-term treatment.

API is the only in-state provider of long-term and higher-acuity care, yet more than half of their clients can be better served in the community. The short-stay model at API as resulted in a high-volume of highly acute patients in large units, coupled with quick turnovers of patients without sufficient time to fully stabilize them. The recent Ombudsman report [1] highlighted this model as contributing to unsafe working conditions.

The U.S. Supreme Court determined that under the Americans with Disabilities Act, individuals with mental disabilities have the right to live in the community, rather than in institutions. Anchorage Superior Court Judge William Morse ruled in 2019[2] that Alaska's practice of detaining people held on civil psychiatric holds in jails due to API's inability to treat them, has caused irreparable harm and it should end. Caring for Alaskans in community-based crisis stabilization centers, reduces API volume and frees the state facility to serve the most acute and chronically ill. This helps fulfill the requirements of the Morse settlement agreement and SB 124 is a step toward decriminalizing mental health, providing the ability to stabilize and treat those in severe crisis closer to home.

[1] February 2022 Ombudsman Investigation Alaska Psychiatric Institute
[2] October 2019 Anchorage Superior Court Judge William Morse Ruling

Path toward transformation and better serving Alaskans

Providence Alaska has partnered with the Alaska Mental Health Trust Authority, Southcentral Foundation, Anchorage emergency medical services, the Anchorage Police Department, and other key stakeholders to advocate for change. As part of this process, we have evaluated and planned for an intentional design of low-to-no barrier crisis stabilization services. Providence is working to become the designated (non-tribal health) Crisis Now stabilization provider in Anchorage. We have pledged and invested significant resources because we know this is the right thing to do for our most vulnerable friends, neighbors, and family members. But we need your help to allow this vision to take shape.

SB 124 allows us to begin the transformation process and to better serve Alaskans. We can build on the exciting partnerships and momentum coming together to create a better vision and to better care for Alaskans with behavioral health conditions across the State of Alaska.

Thank you for your service to our state and I encourage support of SB 124.

Sincerely,

Renee Rafferty

Renee Rafferty, MS, LPC
Regional Director of Behavioral Health Services
Providence Alaska

Cc: Steve Williams, Alaska Mental Health Trust Authority
Katy Baldwin-Johnson, Alaska Mental Health Trust Authority
April Kyle, Southcentral Foundation
Michelle Baker, Southcentral Foundation
Tom Chard, Alaska Behavioral Health Association
Jared Kosin, Alaska State Hospital and Nursing Home Association
Commissioner Adam Crum, Alaska Department of Health & Social Services
Heather Carpenter, Alaska Department of Health & Social Services

American College of Emergency Physicians®

ALASKA CHAPTER

ADVANCING EMERGENCY CARE

The Honorable Mike Dunleavy
Governor
3rd Floor, State Capitol
Juneau, AK 99801

Dear Governor Dunleavy:

Thank you for introducing HB 172/SB 124. We represent members of the Alaska Chapter of the American College of Emergency Physicians (ACEP). We strongly support the Crisis Now model of mental health crisis care and support passage of this bill which would help facilitate adoption of this model in Alaska.

Alaska, as well as much of the US, is facing a trend of increasing mental health crises. Emergency department visits have increased for mental health emergencies. There is also not enough capacity to care for these patients at other acute facilities which results in patients boarding for days and in extreme cases weeks in an Emergency Department room. These types of emergencies include patients with depression, suicidal ideation, suicide attempts, psychosis, behavioral disorders and substance use disorders. Often these patients are at risk of immediate harm to themselves or others.

For patients in mental health crisis, prolonged stays in the emergency department are less than ideal and can often worsen the underlying mental health issues. Usually for patient and staff safety the patients are kept in secure rooms with little interaction with peers and are provided minimal therapy while awaiting assessment and transfer to appropriate mental health facilities. Emergency departments have done their best to accommodate these patients but are tasked with providing many other types of medical care and are not designed to be optimal therapeutic environments for multi day stays for patients experiencing an acute mental health crisis.

The large increase in visits for mental health emergencies and delayed transfer of these patients to appropriate facilities has been very taxing for emergency departments. These patients often have longer stays in the emergency department and consume more resources than other patients which disrupts care to patients visiting the emergency department for medical emergencies. These patients require 1:1 observation, which takes a dedicated ED Tech or Nurse away from being able to care for other ED patients. When beds are occupied for multiple days, waiting rooms fill up with patients who are sick or injured awaiting evaluation. Law enforcement and EMS personnel have also spent more time and resources with individuals

in mental health crisis diverting them from other emergent situations and duties in the community.

Implementation of the Crisis Now model, which includes crisis stabilization centers, in other states has been proven to be beneficial first and foremost for patients in mental health crisis. These environments are designed to be optimized for mental health, allow space for cooling off and deescalation, and have the right services for either a short or prolonged stay. This leads to improved outcomes for these patients with more rapid resolution of their crisis. It also has enhanced the delivery of vital emergency department, law enforcement, and EMS operations for the community. Law enforcement and EMS resources have been more available to the community for other emergencies. Emergency departments have had increased capacity to treat other conditions as well.

As part of ensuring the safety of patients in mental health crisis and staff members who treat these patients it is essential that staff have access to medications and restraints when necessary for patients in extreme crisis. As emergency physicians we daily treat patients in mental health crisis and have all regularly witnessed injuries to both patients and staff and significant property destruction from patients in extreme crisis. Utilizing physical and chemical restraints is a tool of absolute last resort after all other interventions have failed, but unfortunately there are times when these less restrictive interventions do fail. The experience of crisis stabilization centers in other states has actually shown a decrease in the rates at which these interventions are needed, due to the fact that these environments are tailored to the care of these patients.

The medications used for acute stabilization of patients in extreme mental health crisis with violent behavior are used only briefly to calm and sedate the patient in order to ensure the safety of the patient and treating staff. Often only a single dose of the medication is required. These medications have been shown to be very safe and effective. Many of these medications are used to provide sedation for procedures or surgery or are used to treat other conditions like migraine headaches, and nausea/vomiting.. While the goal of treating patients in a mental health crisis is to use physical or chemical restraints as little as possible, they are vital tools for safe operation of a crisis stabilization center and we are pleased to see these facilities are given this tool in this statute.

Again we strongly support HB 172/SB 124 and are grateful for its introduction. We believe that it will pave the way for improving treatment of Alaskans experiencing mental health crises and enhance emergency department, law enforcement, and EMS capacity . There will still be work to do to make sure these patients get ongoing outpatient non-crisis care, have safe housing, as well as treatment for co-occurring substance use disorders, but this is an important step on the way to optimizing mental health care in Alaska.

Thank you for your time,
Thomas Quimby MD

Thomas Quimby MD

American College of Emergency Physicians (ACEP), Alaska Chapter Vice President

Nicholas Papacostas MD

ACEP, Alaska Chapter President

cc: Commissioner Adam Crum
Akis Gialopsos, Legislative Director
Heather Carpenter, Health Care Policy Advisor

Signature: Thomas Quimby
Thomas Quimby (Mar 11, 2022 22:11 AKST)

Email: tom.quimby@gmail.com

Alask ACEP Crisis Now Support

Final Audit Report 2022-03-12

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CITIZENS COMMISSION ON HUMAN RIGHTS
Alaska/Montana/Washington

March 8, 2022

Senate Health and Social Services Committee

Re: SB 124 mental health facilities & meds

Dear Chair and Committee Members:

We see many issues that need to be dealt with that are part of SB 124.

1. Hearings are only within 72 hours if the person is picked up on a Monday or Tuesday, otherwise the hold period is going to average closer to 5 days – there should be administrative remedy to make it a legitimate 72 hours for all who are admitted.
2. Minors are mentioned in this bill, but specific protocols are not worked out in regard to obtaining parental permission for treatment and administering psychotropic drugs. There needs to be protections for parents/families/guardians on process and notifications – this would have to be addressed.
3. The adoption of an expanded statewide process of detention for psychiatric evaluation and treatment opens the door to increased use of force on citizens on a broad scale that will have negative health and safety ramifications for individuals and communities due to failed and damaging treatments.
4. This new push for increases in involuntary treatment is completely opposite to advances in understanding and implementation of a human rights, non-coercive approach as outlined by the World Health Organization Report *Guidance On Community Mental Health Services: Promoting person-centered and rights-based approaches.*
5. The bill lacks accountability and oversight for legislators and system managers – there should be a reporting requirement on ITA usage at all facilities and actual hold times which is sent to the Mental Health Division and the legislature.
6. The new system lacks health outcome emphasis and tracking – does not emphasize health – it emphasizes system utilization which is not the same thing. The bill is not designed to address the real world needs of the individuals that are the targets of this legislation.

Due to the planned increase in use of involuntary commitment under this statute and the effect on the lives of those committed, it is a misnomer to say hearings will be within 72 hours. For anyone picked up on a Monday or Tuesday this could be correct. But for anyone picked up on any other day of the week they would be looking at 5 days/120 hours routinely before a hearing. An amendment to consider would be to make Monday a hearing day for anyone detained on a Wednesday or Thursday and Tuesday the hearing for anyone detained Fri/Sat.

With only 2 passing mentions of minors in this bill there should be no plans of applying it to children and adolescents. If this is not the case there are notification of parents or legal guardians as well as timelines and processes that must be scrutinized.

This draft of SB 124 represents a dramatic expansion of the public mental health system. In its current and intended form it will increase the use of forced detention and it's inevitable psychiatric treatments and powerful mind-altering drugs. This will increase the number of individuals that will be returned to communities across Alaska in some form of drugged state, dependent on the assumption their treatments will chemically manage the person's social interactions by continuing to take the drugs. Then what follows are the liabilities of psychiatric treatment and the desire to remedy those issues.

> "There is now unequivocal evidence of the failures of a system that relies too heavily on the biomedical model of mental health services, including the front-line and excessive use of psychotropic medicines, and yet these models persist."
>
> "…the field of mental health continues to be over-medicalized and the reductionist biomedical model, with support from psychiatry and the pharmaceutical industry, dominates clinical practice, policy, research agendas, medical education and investment in mental health around the world… We have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions." - *former UN Special Rapporteur* Dainius Pūras, M.D.

The increased use of involuntary commitment facilities represents an increase of focus on system and resources for its own sake and not on the individual and the creation of health:

> "A fundamental shift within the mental health field is required, in order to end this current situation. This means rethinking policies, laws, systems, services and practices across the different sectors which negatively affect people with mental health conditions and psychosocial disabilities, ensuring that human rights underpin all actions in the field of mental health. In the mental health service context specifically, this means a move towards more balanced, person-centered, holistic, and recovery-oriented practices that consider people in the context of their whole lives, respecting their will and preferences in treatment, implementing alternatives to coercion, and promoting people's right to participation and community inclusion. World Psychiatric Association - *Guidance On Community Mental Health Services: Promoting person-centered and rights-based approaches.*

The reality of the damage that involuntary commitment can cause, can be seen in a study that looked at why individuals labelled mentally ill stop taking their prescribed ani-psychotic drugs:

> "… that 74% of the patients quit the antipsychotic drug they were taking "owing to inefficacy or intolerable side effects or for other reasons." http://www.schizophrenia.com/sznews/archives/002424.html#

These intolerable side effects show the toxic nature of psychiatric drugs. And yet one of the typical questions when hearing of someone experiencing emotional crises is are they off their medication? While other possibilities include self-medicating and drug-induced psychosis.

> "Neuroscience hasn't yet been able to describe what a "balanced" brain looks like, let alone how to assess one. So how can we claim to create it with drugs? In most cases, psychiatric symptoms are just that: symptoms. They are signs that the body and mind are struggling.
>
> "Drugs may suppress symptoms, but they do nothing to address the reasons you're feeling lousy. Content with prescribing pharmaceutical solutions, providers are not asking *why* patients are sick.

> They are not discussing evidence-based alternatives to medication treatment that address and fix root causes. - Dr. Kelly Brogan with Louise Kuo Habakus - *CHANGE YOUR FOOD HEAL YOUR MOOD - 3 Steps to a Happier Body and a Healthier Brain*

A requirement should be added to SB 124 for anyone entering the public mental health system to receive a searching physical examination to locate undiagnosed, misdiagnosed and any number of ailments that mimic psychiatric disorders. See attachment 3 – the exam created by Dr. Sydney Walker III, and also see attachment 4 which is a sample of Amendment/statute for the physical examination to rule out non-psychiatric causes of emotional crises.

A quick look at the web pages of the advocates for this legislation: Crises Now, the Hospitals or NAMI and you will see none or at best very limited information about the toxic nature of psychiatric drugs, the long list of dangerous side effects which include violence and death, the addictive nature of some of the drugs, the common misuse of many of these drugs and especially withdrawal from these drugs. The World Psychiatric Association (WHO) has released extensive material on the need for a Human Rights based approach in the mental health field and has provided research on these approaches.

We do recognize that individuals do experience emotional crises and can represent harm to themselves or others and the legislature must work out a system to safeguard the public, but it must be done with safeguards for the individual as well as society.

SB 124 at best represents a streamlining of the detention system – but not a step forward in helping those in emotional crises resolve those issues. What is really needed is a system with a focus on creating health. The system would identify physical ailments and disorders that mimic psychiatric disorders and life and environmental factors that can be addressed and resolved so individuals can recover their basic human rights and not be sentenced to psychiatric disability and dependence.

We are available for further discussion of this issue. Please see amendments and the multiple attachments addressing the issues raised here.

Sincerely,

Steven Pearce

Steven Pearce
Director

POB 19633 * Seattle, WA 98109 * 206.755.5230 * cchrseattle@outlook.com

Attachment # 1 Amendments

////////////////////////////////

Add language to 47.30

Part A: Add language to 47.30 to modify the definition of respondent under this bill to be "adult respondent" (not a minor).

Part B: Add language to 47.30 to include specific timelines and requirements for legal notification of Parents and Guardians and authorizations for treatment before psychotropic drugs are administered.

Remove any mention of minors unless specific and detailed protections and protocols are worked out in regard to timelines and rapid notification of parents/guardian. Include the stipulation that parental/guardian permission must be obtained before any treatment is initiated (this applies to administering psychotropic drugs) and the parents/guardian are fully informed of the possible side effects of whatever psychotropic drug the professional wishes to administer.

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Sec 18 – on page 8 starting on line 22 - 47.30.805 (a) should be amended as follows – insert text in bold:

…legal holidays, **if the person is picked up on Wednesday or Thursday the hearing deadline is Monday, if person is picked up on Friday/Saturday the hearing deadline is Tuesday**, or any period …

//

Amend Section *13, **Sec. 47.30.707 Admission to and hold at a crisis stabilization center or crisis residential center; psychotropic medications; rights; notifications;** (a) at the end to include language to the effect of: any individual being admitted for 24 hour stabilization or being considered for additional commitment evaluation must also be evaluated for medication psychosis caused by currently prescribed drugs; self-medicating with other drugs or psychoactive substances; or suffering drug withdrawal psychosis and seek consultation with qualified medical personnel to address what is found. See Attachment 4 about medical causes of ailments that mimic psychiatric disorders.

//

Amend Section 13, **Sec. 47.30.709 Rights of respondents at crisis stabilization centers and crisis stabilization centers ; psychotropic medication; time. At the end of (d) add:** Psychotropic medication should be a last resort. Ascertain when was the last time a searching physical examination has been done, and run through a checklist of common known issues that can contribute to conditions that mimic psychiatric disorders. [material for this is the Loran Koran Exam that the State of California has used, the Incredible Walker Exam (both available on www.alternativementalhealth.com) and others listing medical causes)

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Add *Sec 29. (a) Outcomes –. Health outcomes are essential to be tracked as part of the mental health systems day to day efforts and must go beyond system utilization to track the object effect of system efforts on the individual. Using an object scale such as the GAF – Global Assessment of Functioning one can readily observe level of function and communicate this level of functioning to legislators and non-mental health professionals and track program outcomes in human terms, with dignity and respect of their individuality.

(b) Require quarterly reports from all facilities described in this bill to report to Alaska Behavior Health who will combine data into one report for the Legislature. Example of possible health outcomes tracking system, using the "GAF" Global Assessment of Functioning scale.

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Attachment #2

Existing mental health systems often continue to fail those seeking support.

Either because many people with psychosocial disabilities and with mental health conditions are still either lacking access to recovery-based support services, or because they are caught in a vicious cycle of violence in their interaction with them.

Would you seek mental health support from a system that denies you choice and control over decisions that affect you, lock you up and prevent you from having contact with friends and family? If you managed to overcome these challenges, could you go back to this system?
Let us consider two scenarios.

If a person in emotional distress is met with violence when searching for health care, it is fair to say they may never want to re-engage with such a service. Reoccurring lack of support increases the risk of exclusion, homelessness and further violence.

On the other hand, what if a person's encounter with the mental health system is one where their dignity and rights are respected? Where relevant professionals understand that how their intersecting identities impact how they access and navigate the system? A system that will not only empower an individual as an agent of their own recovery, but it will support their journey of health and well-being.

This system is based on human rights. It is an approach that promotes trust, enables recovery and provides both users and professionals with a framework in which their dignity and rights are valued and respected.
…

In line with the Convention on the Rights of Persons with Disabilities, there needs to be an urgent shift away from institutionalization and towards inclusion and the right to independent living in the community.

That requires greater investment in community-based support services that are responsive to people's needs Governments must also increase investments in narrowing human rights gaps that can lead to poor mental health – such as violence, discrimination and inadequate access to food, water and sanitation, social protection and education.

Michelle Bachelet - *UN High Commissioner for Human Rights <> End*

End Attachment #2

Attachment #3

Looking for a Medical Cause

When a person remains depressed despite normal efforts to remedy the problem, a physical source of the depression should be considered. This is particularly true in the case of debilitating or suicidal depression.
Physiological causes of depression are so common, in fact, that the American Assn. of Clinical Endocrinologists states, "The diagnosis of subclinical [without obvious signs] or clinical hypothyroidism must be considered in every patient with depression."

Physical sources of depression include:

- Nutritional deficiencies
- Lack of exercise
- Lack of sunshine
- Hypothyroidism
- Hyperthyroidism
- Fibromyalgia
- Candida (yeast infection)
- Poor adrenal function

Other hormonal disorders including:

- Cushing's Disease (excessive pituitary hormone production)
- Addison's disease (low adrenal function)
- High levels of parathyroid hormone
- Low levels of pituitary hormones
- Hypoglycemia
- Food Allergies
- Heavy metals (such as mercury, lead, aluminum, cadmium, and thallium)
- Selenium toxicity
- Premenstrual syndrome
- Sleep disturbances
- Dental problems
- TMJ (Temporo Mandibular Joint) Problems

Infections including:

- AIDS
- Influenza
- Mononucleosis
- Syphilis (late stage)
- Tuberculosis
- Viral hepatitis
- Viral pneumonia

Medical conditions including:

- Heart problems
- Lung disease
- Diabetes
- Multiple sclerosis
- Rheumatoid arthritis
- Chronic pain
- Chronic inflammation
- Cancer
- Brain tumors
- Head injury
- Multiple sclerosis
- Parkinson's disease
- Stroke
- Temporal lope epilepsy
- Systemic lupus erythematosus
- Liver disease

Drugs including:

- Tranquilizers and sedatives
- Antipsychotic drugs
- Amphetamines (withdrawal from)
- Antihistamines
- Beta-blockers
- High blood pressure medications
- Birth control pills
- Anti-inflammatory agents
- Corticosteroids (adrenal hormone agents
- Cimetidine
- Cycloserine (an antibiotic)
- Indomethacin
- Reserpine
- Vinblastine
- Vincristine

https://www.alternativementalhealth.com/the-physical-causes-and-solutions-of-depression-2

End Attachment #3

Attachment #4

Sample statute of physical examination to rule out non-psychiatric causes

Question: When does a patient need to be examined by a health practitioner?
Answer: Florida Statute 394.459 Rights of patients, Section (2) RIGHT TO TREATMENT, Subsection (c) states:

"(c) Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility."

It is important to understand that according to the Florida Administrative Code 65E-5.160 Right to Treatment that this examination must include a determination that abnormalities of thought, mood or behavior due to non-psychiatric causes have been ruled out.

"(3) The physical examination required to be provided to each person who remains at a receiving or treatment facility for more than 12 hours must include:

(a) A determination of whether the person is medically stable; and

(b) A determination that abnormalities of thought, mood, or behavior due to non-psychiatric causes have been ruled out."

It is medically known that there is a very real possibility that what seems to be a psychiatric problem can be caused by some physical illness with more than 100 medical disorders having been documented to mimic mental illness symptoms.

There are many different physical disorders that may lead a doctor to misdiagnose someone as having depression or bi-polar disorder such as influenza, infectious mononucleosis, viral pneumonia, cancer, sleep apnea and thyroid disease to name just a few.

Ideally this examination would be by a non-psychiatric and independent medical doctor and documented as having been administered to rule out non-psychiatric causes of thought, mood or behavior including the following tests to rule out physical ailments that can present as mental illness:

- sTSH (thyroid test)
- CBC (complete blood count)
- SGOT (liver function test)
- Serum albumin
- Serum calcium
- Vitamin B12
- Urinalysis
- 12 panel drug test

End