# MEMORANDUM

# State of Alaska

**Department of Law**

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| TO: | DHSS | DATE: | March 3, 2022 |
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| FROM: | Steven Bookman<br>Sr. Ass't Attorney General<br>Human Services Section | TEL. NO.: | (907) 334-4488 |
| | | SUBJECT: | CSHB 172 – Response to Gottstein comments dated February 22, 2022 |

This memorandum responds to certain issues raised by Jim Gottstein's February 22, 2022, comments regarding CSHB 172.

I. Background

CSHB 172 has its roots in 2016's Senate Bill 74, which was a far-reaching reform of Medicaid, including behavioral health. Under Senate Bill 74, DHSS was instructed to apply for a Medicaid waiver, meaning a program under which Alaska would be granted flexibility from traditional Medicaid billing structures if Alaska could demonstrate that its proposed system would be at least cost-neutral. Applying for the waiver was a complex, years-long process. The Centers for Medicare and Medicaid Services approved the behavioral health component of Alaska's "1115 Waiver" in September 2019.

CSHB 172 is intended to allow Medicaid providers that are now able to bill new behavioral health services to implement the Crisis Now model, which is not a billing mechanism, but an evidence-based model of how to address people in acute behavioral health crises.

The 1115 Waiver allows new direct billing of Medicaid for services. The Crisis Now model provides a way to think about which services to provide. CSHB 172 is the third leg of the stool: it provides legal structure for the new service providers, and protects the rights of the minority of respondents who we expect to receive treatment on an involuntary basis.

CSHB 172 is not an omnibus bill, and is not intended to be one. It is specifically targeted to expand options for *less* restrictive alternatives. This bill changes nothing about the current law regarding involuntary 30-day commitments at hospitals. CSHB 172 is

aimed at providing less restrictive care that will, hopefully, keep respondents from having to be hospitalized. As was seen in the "DLC" case, over-reliance on hospitalization can lead to unacceptable wait times to receive care, which is why the settlement included that the administration would advocate for statutory changes that would permit involuntary holds and 72-hour evaluations at less restrictive community-based settings. (*Disability Law Center of Alaska, Inc. v. State of Alaska et al.*, 3AN-18-09814 CI.)

II. Response to "The Big Picture" Comments

Mr. Gottstein has strong feelings about mental health care. Mr. Gottstein's first comments are entitled "The Big Picture" (pages 2-6). He believes that there are many problems with the standards of mental health care. He is entitled to his opinion. At issue here, however, is CSHB 172. This bill does *not* address psychotropic medication except in the very limited situation when a respondent poses an imminent risk of harm to self or others. Rather than limit providers to the less humane and archaic practice of physical restraint, CSHB 172 permits providers to use psychotropic medication to avoid injuries. CSHB 172 does not affect existing law about when psychotropic medications may be given on an involuntary, long-term basis. (Existing law provides that only a court may order involuntary medication during a commitment to a hospital. AS 47.30.839.) Later in his letter, at page 10, Mr. Gottstein appears to recognize that the current bill only permits involuntary medication only in emergency situations and states that "THIS IS GOOD."

III. Response to "The Proposed Legislation – Statutes Held Unconstitutional Should be Amended to be Constitutional" Comments

These comments address a topic that is not at issue in CSHB 172. As explained above, this bill does not address involuntary, long-term psychotropic medication.

IV. Response to "The Proposed Legislation – More Robust Grievance Procedures and Legitimate, Independent Oversight Should be Included" Comments

As to the issue of grievances, CSHB 172 incorporates existing law on grievances. Under existing law, the hospitals that accept civil commitment patients must have a grievance procedure. AS 47.30.847. CSHB 172 incorporates that right. *See* Sec. 13, page 8, line 1. CSHB 172 now also incorporates a requirement that DHSS and the Alaska Mental Health Trust study grievance processes, including how facilities track data about grievances, appeal policies, and practical challenges patients may face in exercising their rights. DHSS and the Trust must convene a diverse group of stakeholders including patients, patient advocates, and providers, and must allow for public comment on a draft

report. DHSS and the Trust must jointly report to the Legislature within one year with recommendations. *See* Section 26, page 12, line 30, to page 13, line 24, in version "O."

As to the issue of oversight, Mr. Gottstein's comment that former Commissioner Perdue "gutted" the authority of the API governing body is out-of-date. Whatever happened before, API has developed a fully functioning Governing Body that meets monthly. Two of the voting members of the Governing Body are members-at-large who are advocates for individuals with mental illness, individuals with mental illness, or family members of a consumer of mental health services (one member nominated by the National Alliance on Mental Illness, and one by the Alaska Mental Health Board). The Governing Body minutes are at https://dhss.alaska.gov/API/Pages/documents.aspx; they do need updating due to the cyberattack, and DHSS is working on that. Again, however, CSHB 172 does not address API.

## V. Response to "'Acute Behavioral Crisis' is an Unconstitutional Basis for Psychiatric Confinement" Comments

Mr. Gottstein comments that proposed AS 47.30.707 and AS 47.30.708 are unconstitutional where those proposed statutes allow respondents to be detained or held only because a respondent is suffering an acute behavioral health crisis, without also requiring there be a finding that the respondent is either likely to cause harm or is gravely disabled.

This comment appears to misunderstand the requirements of CSHB 172, because proposed AS 47.30.707 and AS 47.30.708 *do* require a finding that a respondent is suffering an acute behavioral health crisis *and* is either likely to cause harm or is gravely disabled.

Crisis stabilization centers, the "23-hour centers," are mostly addressed in AS 47.30.707. *Admission* to a crisis stabilization center, however, is addressed in the existing law that authorizes emergency holds, which is AS 47.30.705. This existing law provides that an emergency hold is authorized only when there is probable cause to believe that "a person is gravely disabled or suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow" the non-emergency commitment procedures to be used.

Crisis residential centers, the "short-term centers," are mostly addressed in AS 47.30.708. *Admission*, however, is addressed in two sections. There are two ways that a respondent might involuntarily enter a crisis residential center. First, if a mental health professional at a crisis stabilization center believes that a respondent at that center should

be involuntarily transferred to a crisis residential center, then the mental health professional at the crisis stabilization center must apply for a court order. *See* Section 13, page 5,line 2, in version "O." That application is "under AS 47.30.700." *See* Section 13, page 5, line 3, in version "O." Under AS 47.30.700, an application must allege that a respondent is gravely disabled or likely to cause harm. Second, a respondent could, after having been placed on an emergency hold under AS 47.30.705, be delivered directly to a crisis residential center. *See* Section 13, page 5, line 9, in version "O." Again, an emergency hold requires a belief that a person is gravely disabled or likely to cause harm. After the respondent arrives on an involuntary basis to the crisis residential center, the respondent must be examined within three hours. The respondent may only be admitted if the mental health professional has probable cause to believe that the respondent is gravely disabled or is likely to cause harm. *See* Section 13, page 5, lines 16-18, in version "O.". And if the respondent is unwilling to remain, then the mental health professional must apply to the court for an order under AS 47.30.700. As explained above, an application under AS 47.30.700 must allege that a respondent is gravely disabled or likely to cause harm.

VI. Response to "Except for Emergencies…" Comment Regarding Psychotropic Medication

Again, CSHB 172 does not speak to involuntary, long-term psychotropic medication. It only addresses emergency situations.

VII. Response to Comment in Footnote 18 Regarding "Probable cause is probably a constitutionally insufficient basis to confine someone for anything other than a short time for evaluation"

Mr. Gottstein comments that the seven-day detention hold must be justified by clear and convincing evidence, and not a probable cause standard. He cites a United States Supreme Court case, *Kansas v. Crane*, 534 U.S. 407 (2002). *Crane* does not address the question of "probable cause" versus "clear and convincing evidence." *Crane* addressed Kansas' attempt to commit a sexually violent predator, and the *Crane* court held that the Constitution requires States to prove that such a respondent has "serious difficulty in controlling behavior," in addition to having a mental illness.

There is no constitutional difficulty with a court ordering a seven-day detention period on the basis of "probable cause," rather than "clear and convincing evidence." In *In the Matter of Vern H.*, 486 P.3d 1123 (Alaska 2021), the Alaska Supreme Court held that a "probable cause" basis was sufficient to justify detention while a respondent is awaiting

evaluation for a 30-day commitment. Vern H. was in jail for approximately 4 days, not receiving any treatment, whereas under CSHB 172, respondents would be in a medical environment and would be receiving treatment. Other states have held that no judicial hearing at all is required for periods much longer than 7 days. For example, the New Mexico Supreme Court held that a 14 day period before a hearing did not violate due process. *See New Mexico v. Compton*, 34 P.3d 593 (New Mex. 2001). The United States Supreme Court affirmed a decision that it did not violate due process to hold an individual for up to 45 days on an initial mental health hold prior to any judicial hearing on commitment. *See Briggs v. Arafeh*, 411 U.S. 911 (1973)(summarily affirming *Logan v. Arafeh*, 346 F.Supp. 1265 (D.Conn. 1972)). If a respondent may be held for 14 days without any judicial hearing, then due process does not require that the clear and convincing evidence standard must be used for a 7 day hold.

VIII. Response to "There is a Constitutional Limit to How Long a Person Can be Confined Without Court Authorization" Comment

CSHB 172 addresses this point. An involuntary respondent at a crisis stabilization center can only be held for 23 hours and 59 minutes. *See* Section 24, page 12, lines 25-26, in version "O." An involuntary respondent at a crisis residential center shall receive a court hearing within 72 hours of being held or detained. (If the respondent had previously been at a crisis stabilization center before coming to the crisis residential center, the time at the crisis stabilization center counts in the 72 hours.) *See* Section 13, page 5, line 30, through page 6, line 4, in version "O." This includes time spent at the crisis residential facility while the court is considering the *ex parte* order for detention. The Alaska Court System has 24-hour a day coverage to consider petitions. The 72 hours matches the current 72-hour evaluation period for 30-day commitment, and does not present constitutional issues.

## Conclusion

CSHB 172 is a targeted bill that is intended to use the Crisis Now model to create new practical and effective options for less restrictive care in the community. This should help reduce the heavy reliance on a hospital-based system. Other states that have implemented the Crisis Now model, or even parts of it, have seen reductions in hospitalizations. The goal of CSHB 172 is to supplement the existing system, not to change it. It is, intentionally, not an omnibus bill.

Mr. Gottstein's comments about "the Big Picture" and the involuntary long-term administration of psychotropic medication do not reflect what this bill is about. Likewise,

this bill is not about the API Governing Body. His comments about grievance procedures are important, but the current bill includes a provision that DHSS and the Trust will study grievance procedures, involve community stakeholders, and report back to the Legislature within a year. Mr. Gottstein's concerns that a court-ordered hold at a crisis residential center would not require a finding of a likelihood of harm or grave disability are mistaken. The bill does in fact require that a court may only order detention if a respondent is either gravely disabled or likely to cause harm. The bill also requires that the court finds that the acute behavioral health crisis is likely to resolve during the detention at the crisis residential center. Finally, an up-to-seven day detention at a crisis residential center may, consistent with the principles of due process, be based on a probable-cause level of evidence. Courts have concluded that a respondent may be held longer than seven days without a hearing.

The Crisis Now model has been implemented in other states, in full or in part. It has been shown to be effective and to reduce government involvement in people's lives. It has not been found to be unconstitutional in other states. The new provisions of CSHB 172 are well within existing legal standards.