Psych Rights | Law Project for Psychiatric Rights

March 7, 2022

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

Re: SB124

Dear Sen. Wilson:

In my February 22nd letter, I identified some programmatic and constitutional problems with the House Judiciary Work Draft of HB 172, whose companion bill is SB124. This became the House Judiciary Committee Substitute, CSHB 172(JUD), with I think three amendments, including requiring a Report to the Legislature in Sec. 26. The House Judiciary failed to consider any of the constitutional defects in the proposed legislation, and I am submitting proposed amendments to CSHB 172(JUD) to (1) correct the statutes the Alaska Supreme Court has held unconstitutional, (2) correct the most blatantly unconstitutional provisions in CSHB 172(JUD),[1] and (3) include improving patient outcomes in the required Report to the Legislature.

A. Fixing Statutes Declared Unconstitutional by the Alaska Supreme Court

1. Definition of Gravely Disabled.

AS 47.30.915(7) is amended to read:

(9) "gravely disabled" means a condition in which a person as a result of mental illness

(A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or

(B) is so incapacitated that the person is incapable of surviving safely in freedom~~will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently~~;

Authority: *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 384 (Alaska 2007). Frankly, it seems subsection (B) could just be deleted entirely.

[1] There are other provisions that are probably unconstitutional, but I am only addressing the ones for which there is no reasonable argument to the contrary.

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2. Court-ordered administration of medication.

AS 47.30.839 is amended to read:

(a) An evaluation facility or designated treatment facility may use the procedures described in this section to obtain court approval of administration of psychotropic medication if

(1) there have been, or it appears that there will be, repeated crisis situations as described in AS 47.30.838(a)(1) and the facility wishes to use psychotropic medication in future crisis situations; or

(2) the facility wishes to use psychotropic medication in a noncrisis situation and has reason to believe the patient is incapable of giving informed consent.

(b) An evaluation facility or designated treatment facility may seek court approval for administration of psychotropic medication to a patient by filing a petition with the court, requesting a hearing on the capacity of the person to give informed consent.

(c) A patient who is the subject of a petition under (b) of this section is entitled to an attorney to represent the patient at the hearing. If the patient cannot afford an attorney, the court shall direct the Public Defender Agency to provide an attorney. The court may, upon request of the patient's attorney, direct the office of public advocacy to provide a guardian ad litem for the patient.

(d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

(1) the patient's responses to a capacity assessment instrument administered at the request of the visitor;

(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, an advance health care directive under AS 13.52, or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.

(e) Within 72 hours after the filing of a petition under (b) of this section, the court shall hold a hearing to determine the patient's capacity to give or withhold informed consent as described in AS 47.30.837 and the patient's capacity to give or withhold informed consent at the time of previously expressed wishes regarding medication if previously expressed wishes are documented under (d)(2) of this section. The court shall consider all evidence presented at the hearing, including evidence presented by the guardian ad litem, the petitioner, the visitor, and the patient. The patient's attorney may cross-examine any witness, including the guardian ad litem and the visitor.

(f) If the court determines that the patient is competent to provide informed consent, the court shall order the facility to honor the patient's decision about the use of psychotropic medication.

(g) If the court determines by clear and convincing evidence that

1. the patient is not competent to provide informed consent and ~~by clear and convincing evidence~~ was not competent to provide informed consent at the time of previously expressed wishes documented under (d)(2) of this section;~~,~~

2. the proposed medication is in the best interests of the patient considering, at a minimum, the factors listed in AS 47.30.837(d)(2)(A)-(E); and

3. there is no feasible less intrusive alternative,

the court shall approve the administration of a specific drug or drugs at a certain dose or doses it finds to be in the patient's best interests~~the facility's proposed use of psychotropic medication~~. The court's approval under this subsection applies to the patient's initial period of commitment if the decision is made during that time period. If the decision is made during a period for which the initial commitment has been extended, the court's approval under this subsection applies to the period for which commitment is extended.

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(h) If an evaluation facility or designated treatment facility wishes to continue the use of psychotropic medication without the patient's consent during a period of commitment that occurs after the period in which the court's approval was obtained, the facility shall file a request to continue the medication when it files the petition to continue the patient's commitment. The court that determines whether commitment shall continue shall also determine whether the patient continues to lack the capacity to give or withhold informed consent by following the procedures described in (b) - (e) of this section. The reports prepared for a previous hearing under (e) of this section are admissible in the hearing held for purposes of this subsection, except that they must be updated by the visitor and the guardian ad litem.

(i) If a patient for whom a court has approved medication under this section regains competency at any time during the period of the patient's commitment and gives informed consent to the continuation of medication, the evaluation facility or designated treatment facility shall document the patient's consent in the patient's file in writing.

Authority: *Myers v. Alaska Psychiatric Institute*, 138 P3d 238 (Alaska 2006), and *Bigley v. Alaska Psychiatric Institute*, 208 P.3d 168, 187-188 (Alaska 2009).

B. Correct Constitutional Defects in CSHB 172(JUD)

1. Proposed New AS 47.30.707(b)

Insert "the respondent is suffering an acute behavioral health crisis and, as a result, is likely to cause harm to self or others or is gravely disabled and" after (1) "determines that" in line 30 of page 4 of CSHB 172(JUD) to read as follows.

Sec. 47.30.707 (b) If the professional person in charge at the crisis stabilization center determines that the respondent is suffering an acute behavioral health crisis and, as a result, is likely to cause harm to self or others or is gravely disabled and there is probable cause to believe that the respondent's acute behavioral health crisis will be resolved during admission to a crisis residential center and the respondent is not willing to voluntarily go 1 to the crisis residential center, a mental health professional may submit an ex parte application to the court under AS 47.30.700 for detention at the crisis residential center. Based on the application, if the court finds that probable cause exists to believe that the respondent's acute behavioral health crisis will be resolved during admission to a crisis residential center, the court shall grant the application. If the court finds no probable cause, the court shall order the respondent released.

2. Proposed New AS 47.30.707

Insert "and, as a result, is likely to cause harm to self or others or is gravely disabled after "crisis" in line 26 of page 5 to read as follows.

Sec. 47.30.708 (c) If a mental health professional admits a respondent to a crisis residential center and a judicial order has not been obtained, the mental health professional may apply for an ex parte order under AS 47.30.700 authorizing admission to the crisis residential center. Based on the application, if the court finds that probable cause exists to believe that the respondent is suffering an acute behavioral health crisis and, as a result, is likely to cause harm to self or others or is gravely disabled, and the respondent's acute behavioral health crisis will be resolved during admission to a crisis residential center, the court shall grant the application. If the court finds no probable cause, the court shall order the respondent released.

C. Report

At page 12, lines 10, of CSHB 172(JUD) insert "improve patient outcomes and" after "could" to read as follows.

(2) identify and recommend any additional changes to state statutes, regulations, or other requirements that could improve patient outcomes and enhance patient rights, particularly involving involuntary admissions, involuntary medications, and the practical ability of patients to avail themselves of their rights; and

Thank you for your consideration of these amendments. I apologize in advance if I have made any drafting errors; they are inadvertent.

Sincerely,

James B. (Jim) Gottstein, Esq.

CITIZENS COMMISSION ON HUMAN RIGHTS
Alaska/Montana/Washington

March 7, 2022

Senate Health and Social Services Committee

Re: HB 172 mental health facilities & meds

Dear Chair and Committee Members:

We see many issues that need to be dealt with that are part of HB 172.

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 HB 172 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 HB 172 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.

HB 172 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

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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

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March 7, 2022

The Honorable Representative Liz Snyder
Co-Chair, House Health & Social Services Cte
State Capitol Room 421
Juneau, AK 99801

The Honorable Representative Tiffany Zulkosky
Co-Chair, House Health & Social Services Cte
State Capitol Room 416
Juneau, AK 99801

Electronic Letter

RE: Providence Alaska Supports House Bill 172: MENTAL HEALTH FACILITIES & MEDS

Dear Representatives Snyder and Zulkosky,

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 House Bill 172.

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.

HB 172 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

HB 172 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 HB 172 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.

HB 172 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 HB 172.

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
Heather Carpenter, Alaska Department of Health & Social Services

Testimony on House Bill 172 and Senate Bill 124, 3/6/22

Sixty years ago, the Alaska Legislature and others helped facilitate the ongoing mistreatment of disabled psychiatric patients.

The Alaska Legislature in 1962 passed an Enabling Act authorizing a number of private psychiatric facilities or units to detain, evaluate and treat disabled psychiatric patients.

Where the disabled psychiatric patients were left vulnerable: private psychiatric facilities were allowed to keep secrets from the general public and the Legislature of the number and type of psychiatric patient complaints, patient injuries and traumatic events experienced by patients.

With House Bill 172 and Senate Bill 124, the Legislature is planning to make the same mistakes that the Alaska Legislature made sixty years ago.

There must be amendments added to HB 172 and SB124 requiring any psychiatric facility or unit receiving direct funding or grant money from the state to keep and share the statistics I have outlined.

Mental Health Advocates, Faith J. Myers, [redacted] Anchorage, AK. 99508 [redacted]

Reference Information: Language that should be added to House Bill 172 and Senate Bill 124:

Any psychiatric facility or unit where a person stays overnight and is provided or given psychotropic medication must provide the Department of Health and Social Services the following statistics weekly:
The number and type of patient injuries and the cause, the number and type of patient complaints and the resolution, the number and type of traumatic events experience by patients within a psychiatric facility or unit as defined by being strapped to a gurney, placed in isolation, placed in restraints including handcuffs during transportation or physically restrained.
DHSS must make the statistics readily available to the Alaska Legislature and the general public.

Testimony concerning HB172, 3/7/22

Alaska has a 60 year history of making bad choices when providing care for disabled psychiatric patients. Through most of the 1960's, disabled psychiatric patients were still being sent to Oregon. In the 1980's, the Trust Authority's hashtag was "Bring the children home." Because hundreds of adolescents were still being sent out of state for psychiatric patient care.

In 2005, the new Alaska Psychiatric Institute opened its doors. The hospital proved to be inadequate to treat acute care psychiatric patients appropriately. The Supervising Nurse at the time made the statement that the only unit that was designed correctly was the adolescent unit.

Around 2005, the old API, a 126 thousand square foot building and land was sold to Providence Hospital by the Trust and the state. The building should have been remodeled by the state to house hard-to-place psychiatric patients. As of now, the state is leaving these individuals on the streets or in jails.

For the legislature, the Department of Health and Social Services and the Trust Authority not to support a requirement for psychiatric facilities to keep and share statistics of psychiatric patient complaints, injuries and traumatic event would be one more colossal mistake.

If it is decided not to keep statistics of patient complaints, injuries and traumatic events and not conducting patient surveys on a regular basis, it would be more examples of bad decisions by state officials, including the Trust Authority and the Legislature.

There needs to be additions to House Bill 172 requiring that psychiatric facilities keep and share statistics of the number and type of patient complaints and injuries and the number and type of traumatic events experienced by patients and those statistics would be shared with the general public, the DHSS and the Legislature.

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