

HOUSE FINANCE COMMITTEE

April 13, 2022

9:01 a.m.

9:01:29 AM

CALL TO ORDER

Co-Chair Merrick called the House Finance Committee meeting to order at 9:01 a.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Kelly Merrick, Co-Chair
Representative Dan Ortiz, Vice-Chair
Representative Ben Carpenter
Representative Bryce Edgmon
Representative DeLena Johnson
Representative Andy Josephson
Representative Bart LeBon
Representative Sara Rasmussen (via teleconference)
Representative Steve Thompson (via teleconference)
Representative Adam Wool

MEMBERS ABSENT

None

ALSO PRESENT

Heather Carpenter, Health Care Policy Advisor, Office of the Commissioner, Department of Health and Social Services; Steve Williams, Chief Executive Officer, Alaska Mental Health Trust Authority.

PRESENT VIA TELECONFERENCE

Steven Bookman, Senior Assistant Attorney General, Department of Law; James Cockrell, Commissioner, Department of Public Safety; Mark Regan, Legal Director, Disability Law Center; Shirley Holloway, National President and Alaska Vice President, National Alliance on Mental Illness; Dr. Helen Adams, Alaska Chapter, American College of Emergency Physicians.

SUMMARY

HB 172 MENTAL HEALTH FACILITIES & MEDS

HB 172 was HEARD and HELD in committee for further consideration.

Co-Chair Merrick reviewed the agenda for the meeting.

#hb172

HOUSE BILL NO. 172

"An Act relating to admission to and detention at a subacute mental health facility; establishing a definition for 'subacute mental health facility'; establishing a definition for 'crisis residential center'; relating to the definitions for 'crisis stabilization center'; relating to the administration of psychotropic medication in a crisis situation; relating to licensed facilities; and providing for an effective date."

9:02:07 AM

HEATHER CARPENTER, HEALTH CARE POLICY ADVISOR, OFFICE OF THE COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced herself.

STEVE WILLIAMS, CHIEF EXECUTIVE OFFICER, ALASKA MENTAL HEALTH TRUST AUTHORITY, provided a PowerPoint presentation titled "Transforming a Behavioral Health Crisis System of Care: HB 172 Mental Health Facilities and Meds," dated April 13, 2022 (copy on file). He thanked members for hearing HB 172 to address the psychiatric crisis in Alaska.

Mr. Williams began the presentation on slide 2 to discuss why change was needed. He explained that the Alaska Mental Health Trust Authority (AMHTA) had been looking at a variety of systems that would help bring about change, including working with community stakeholders, members of law enforcement, and patient advocates.

Ms. Carpenter continued to address the need for change on slide 2. She indicated that currently, Alaskans in crisis were primarily served by law enforcement, emergency rooms, and other restrictive environments. Some communities in the state had Designated Evaluation and Treatment (DET) centers which were facilities designated by the Department of

Health and Social Services (DHSS) to serve individuals experiencing an acute psychiatric crisis and need of an in-patient level of care. The DET centers could serve patients that needed involuntary commitment under the Title 47 statutes but the centers could also serve voluntary patients. The DET centers only had capacity in Juneau, Fairbanks, the Matanuska-Susitna Valley, and Anchorage.

Co-Chair Merrick indicated Representative Thompson had joined the meeting online and Representative Wool had joined the meeting in person.

[9:04:49 AM](#)

Mr. Williams continued to slide 3: "HB 172 is a Path Forward." He explained that HB 172 would facilitate a transformation of the behavioral health system of care. He summarized the slide as follows:

HB172 will:

- 1) Effectuate a "No Wrong Door" approach to stabilization services
- 2) Enhance options for law enforcement and first responders to efficiently connect Alaskans in crisis to the appropriate level of crisis care
- 3) Support more services designed to stabilize individuals who are experiencing a mental health crisis
 - 23-hour crisis stabilization centers
 - Short-term crisis residential centers
- 4) Protect patient rights

Co-Chair Merrick indicated the committee had been joined by Representative Edgmon.

Representative Wool recalled a horrendous recent incident in the state in which an 11-year-old was threatened to be held involuntarily, pepper sprayed, and handcuffed. He asked if the situation would fall under the bill.

Mr. Williams agreed that it was a tragic situation.

Representative Wool added that the parents were in the room with the child at the time of the incident.

Mr. Williams indicated that he was aware of the circumstances. He thought it was an excellent example of

the way in which the system was broken. If the comprehensive system proposed by HB 172 was in place at the time of the incident, the school and law enforcement would have had different tools and there may have been a different outcome.

Representative Wool asked if the option for involuntary commitment would apply to 11-year-olds.

Ms. Carpenter responded that it did apply to minors, though there were different protections for minors, and parents had certain protections as well. The facility types proposed in the bill could serve youth patients and some were specifically designed to serve youth patients.

[9:08:01 AM](#)

Ms. Carpenter reviewed the building blocks of psychiatric crisis system reform on slide 4. She indicated DHSS had been working to improve its system of care over the last six years. The work had been done in tandem with AMHTA and input from stakeholders. Some of the changes that had been made were listed on the slide as follows:

- 1) SB74 - Medicaid Reform (2016)
 - Improve Access, quality, outcomes, and contain costs
- 2) 1115 Behavioral Health Waiver
 - Targets resources and services to "super utilizers"
 - Provides flexibility in community behavioral health services and supports
 - Creates new crisis service types that promote interventions in the appropriate settings and at the appropriate levels
- 3) System must be intentionally designed and promote a "no wrong door" philosophy

[9:09:58 AM](#)

Mr. Williams turned to slide 5 and indicated that the goal of the legislation was to design and implement a behavioral health crisis response system analogous to the physical health system. The trust wanted to follow the model on the slide and make it possible for a person in crisis to call a crisis call center and be transferred to a mental health professional who could respond to and ideally deescalate

the situation on the phone. If the situation could not be deescalated on the phone, there would be available resources other than the default law enforcement response, such as a mobile crisis team. The model on the lower part of the slide depicting the process by which a behavioral health emergency should be addressed was used nationally. He indicated several entities supported the model and significant research had been done with the model.

Representative Carpenter asked if a situation involving substance abuse would be considered a physical or mental health crisis. He wondered how a responder would determine which response was needed.

Mr. Williams replied that the dispatcher on the phone would assess the situation and dispatch the appropriate response. The department did not want law enforcement to make the determination in mental health or substance abuse situations.

Representative Carpenter asked that if law enforcement was not doing the assessment, who would be doing the assessment and how would it apply to drug related emergencies. An officer might not be able to distinguish between a mental health issue and another issue.

Mr. Williams responded that if an officer in the field noticed that an individual required medical attention, the officer would take the individual to the hospital. However, if an officer were to take an individual to the hospital, it would not be a quick turnaround as it involved substantial paperwork. If the department were to use a "no wrong door" approach, law enforcement could take a person to the 23-hour crisis stabilization center and put them in the care of mental health professionals if the officer thought a person was having a mental health crisis.

Co-Chair Merrick thought Commissioner Jim Cockrell from the Department of Public Safety was online.

Co-Chair Merrick indicated Representative Rasmussen had joined the meeting online.

Representative Josephson asked if the crisis call center was the 9-8-8 number.

Mr. Williams explained that the state was working towards implementing the number.

Representative Josephson asked if a person was in crisis due to an overdose and it was a repeat problem, would law enforcement have access to the information given to dispatch at 9-8-8.

[9:17:24 AM](#)

Ms. Carpenter responded that she would have to confer with the legal department because there might be issues with potential HIPAA violations.

Representative Wool supported the legislation. He thought that the confluence of mental health crises and law enforcement had been an issue. He offered an example of a constituent who had a child with mental health issues that had committed a crime. It was a tug-of-war between determining whether a situation was criminal or a behavioral health issue. He wondered if the bill helped to clarify such a situation.

Ms. Carpenter responded that the first ten sections of the Committee Substitute (CS) for the bill made conforming edits to the alternative to arrests statutes under HB 290 in 2020, which was eventually folded into SB 120. The past bill allowed for peace officers to determine whether a crime could be diverted into treatment in mental health crisis situations. She viewed HB 172 as a necessary "part two" to SB 120 to ensure that involuntary commitment statutes reflected the full continuum. It would ensure that a person brought to a 23-hour crisis center could not simply leave once the officer that brought them to the center left. Currently, the state could only serve the person in a voluntary way. An individual could only be diverted with a prosecutor's sign-off under HB 272.

Representative Wool commented that the converse of the situation would be if a police officer decided an incident was a crime and brought a person to jail. He wondered at what point it could be determined that the situation was behavioral health related rather than criminal. He asked if it was as easy to undo as a situation in which a person wrongfully ended up in a crisis center.

Ms. Carpenter would have to consult the criminal side of the Department of Law for more information. There was a robust option of therapeutic courts in the state that had been successful at ensuring treatment through restorative justice.

[9:21:51 AM](#)

Vice-Chair Ortiz noted that the bill referenced there being limited space in DET centers. He wondered if there were any 23-hour crisis stabilization centers in operation in the state.

Ms. Carpenter replied that there were providers that had started to develop services through the 1115 behavioral health waiver. The services would look different in different communities.

[9:23:16 AM](#)

Mr. Williams discussed stakeholder engagement on slide 6. The slide was an illustration of the diverse stakeholder involvement and collaboration that had been occurring over the past several years in order to transform the mental health system. There had been over 100 organizations that had engaged in collaboration.

Ms. Carpenter reviewed slide 7 which showed the enhanced psychiatric crisis continuum of care. It explained where the new suite of services would fit between the current community-based services. She noted that mobile crisis teams, 23-hour stabilization, and short-term stabilization were all services billable to Medicaid.

Representative LeBon asked Ms. Carpenter to provide a short explanation of a 1115 waiver.

Ms. Carpenter explained that an 1115 waiver allowed the state to waive the normal rules and test out a new suite of services for a five-year period of time. Many states had 1115 waivers for years and the time frame did not necessarily mean the project would not be renewed. The rules could be waived as long as it was cost neutral to the federal government.

[9:26:36 AM](#)

Co-Chair Merrick asked how many years the state was into the five-year period.

Ms. Carpenter responded that the state was in year four but clarified that the federal government had split the state's waiver to fast-track the substance use disorder waiver first.

[9:27:03 AM](#)

Mr. Williams advanced to slide 8 and offered a high-level overview of what care looked like at a 23-hour crisis stabilization center. The bill created a no wrong door approach and allowed an organization to provide services to both voluntary and involuntary patients. He summarized from the slide as follows:

- No wrong door - walk-in, referral, and first responder drop off
- Staffed 24/7, 365 with a multi-disciplinary team
- High engagement/Recovery oriented (Peer Support)
- Immediate assessment and stabilization to avoid higher levels of care where possible
- Safe and secure
- Coordination with community-based services

Co-Chair Merrick asked if the peer support individuals were voluntary positions or paid positions.

Mr. Williams replied that they were paid positions.

Representative Josephson asked whether a court order would be needed should the holding time exceed 23 hours.

Ms. Carpenter replied that it was 23 hours and 59 minutes because anything over 24 hours was considered in-patient care. It was a billing mechanism to avoid billing for more expensive services.

Representative Josephson thought there might be a need for additional magistrates.

Ms. Carpenter replied that there was a small fiscal note that would be addressed later in the meeting. The fiscal note was to reflect the addition of new clerk positions, not magistrates.

[9:30:18 AM](#)

Mr. Williams advanced to slide 9 to discuss the details of the short-term crisis residential stabilization center. The slide depicted the next level of care above the 23-hour center and would allow a person to receive care for up to seven days. Rather than automatically taking someone to the highest-level care facility first, it allowed a crisis team to intervene earlier to prevent future problems.

Mr. Williams turned to slide 10 and reported that the enhanced crisis response would reduce the number of people entering the most restrictive levels of care. The slide showed an infographic of over ten years of crisis call data analysis in the state of Georgia. For every 100 calls to the crisis hotline in Georgia, 90 of the calls were resolved over the phone. A mobile crisis team was dispatched to the location of the remaining ten callers, and the team resolved seven of the ten calls. Two of the remaining three situations were resolved at the center. That left only one individual who was admitted to a short-term stabilization center. He noted that Alaska had mobile crisis teams operating in Fairbanks and Anchorage. The team in Fairbanks had been operating around the clock since November of 2021 and had a resolution rate of 88 percent, which was above Georgia's resolution rate.

[9:33:28 AM](#)

Representative Johnson asked if the crisis calls were coming through 9-1-1.

Mr. Williams replied that in other states that had the plan fully implemented, the calls went through a "care traffic control center." If a call went through 9-1-1 and dispatch determined that it was a mental health related issue and did not require a public safety response, the call would be transferred to a mental health professional. In Fairbanks, dispatch and the care center were working together to dispatch the mobile crisis team through 9-1-1. The goal was to ensure that calls could be transferred either direction depending on whether the situation was determined to be of a mental or physical health concern.

[9:34:56 AM](#)

Representative Johnson wanted to better understand the statistics on slide 10. She asked whether the 100 crisis calls listed had already been transferred.

Mr. Williams reminded the committee that the example on the slide related to the system in place in Georgia. He thought that the 100 calls had already gone through the crisis center rather than to 9-1-1.

Representative Johnson thought 10 percent of crisis calls needing a crisis dispatch team seemed high.

Mr. Williams responded that the 10 percent meant that 90 percent of the 100 calls were resolved over the phone.

Representative Johnson had worked answering a crisis line. She did not think dispatching a crisis team happened frequently.

[9:36:56 AM](#)

Representative Josephson had the opposite thought as Representative Johnson. He did not understand how 90 percent of the calls could be resolved without dispatching help.

Mr. Williams responded that many of the calls were situations in which a person simply needed someone to talk to. The ability to connect with someone helped to resolve many crises.

Representative Wool thought that it was difficult to determine whether a situation was behavioral health related or if the Alaska State Troopers needed to be called. He offered an example of a suicidal individual who had a gun that could be arrested for "waving a gun around." He understood that it was a mental health situation but that others might want the person arrested due to the irresponsible handling of the weapon. He asked what was done at such a confluence.

[9:39:31 AM](#)

Mr. Williams explained that what Representative Wool had described was the current system in Alaska with the exception of Fairbanks and Anchorage. He relayed that if a

call came in, the troopers would be dispatched and that there was no other option.

Ms. Carpenter added that the bill would help fill the gaps of the situation described by Representative Wool. If a mobile crisis team responded in the situation, the team would see there was a need for law enforcement due to the weapon and safety concerns. Under the bill, the individual in crisis could get transferred to a crisis center and get the treatment they needed.

Mr. Williams explained that communities were currently relying on law enforcement and psychiatric treatment in all situations, and potentially criminal justice if it was deemed necessary.

[9:41:07 AM](#)

Representative Josephson asked if someone with a behavioral health issue was waving a weapon around, would it be considered a felony if other people were present in the room. She thought that constituents would be very angry if the individual was diverted to a crisis center, but the incident happened again three months later and resulted in violence. She asked for comments.

Ms. Carpenter indicated Commissioner Cockrell was online. The situation described by Representative Josephson was the reason why the Department of Corrections was the largest provider of mental health services in the state. The goal was to provide early treatment to individuals to prevent dangerous situations from happening.

Representative Josephson commented that success was reliant on the early treatment working and being appropriately funded.

[9:43:36 AM](#)

Representative Johnson suggested that at some point, public safety would need to reenter the situation.

Mr. Williams responded that was already happening in Fairbanks. If a situation was beyond the skillset of a mobile crisis team, the team could always bring in the appropriate first responder to provide support.

9:44:39 AM

Ms. Carpenter reviewed Title 47 on slide 11. She wanted to provide additional context on the work DHSS and AMHTA had done through close work with stakeholders. A cross section of individuals went on a sponsored trip in 2019 to Phoenix, Arizona to look at the behavioral health model in action. The model was built off the 1115 waiver to improve the system of care. In 2018, the department was sued by the Disability Law Center because people on a Title 47 involuntary commitment hold were waiting in jails and other correctional facilities to get into an Alaska Psychiatric Institute (API) center. At the time there were only two DET hospitals: one in Fairbanks and one in Juneau. The department settled the case in 2020 and worked with the Department of Law and AMHTA to improve the system of care. The bill was the result of the collaborative work.

Ms. Carpenter presented the key takeaways from the presentation on slide 12. The bill was a win for patients, hospitals and emergency rooms, and law enforcement. She elaborated that it was a win for patients because it created a less restrictive system of care for individuals who were suffering from mental illness. It was a win for hospitals and emergency rooms because it would offer more resources to free up emergency room beds for people who were being held on observational holds until a DET bed was available. It helped law enforcement because the bill provided police officers with broader options for handling individuals experiencing a mental health crisis, such as mobile crisis teams. The bill did not interfere with an officer's ability to make an arrest. It also did not change the statutory authority of who could make an involuntary commitment or who can administer crisis medication. Finally, it would not reduce the individual rights of the adult or juvenile in crisis, the parents' rights of care for their child, or existing due process rights of the individual in crisis.

Mr. Williams moved to slide 13 which showed the current flow for involuntary commitment. He drew attention to the bottom left portion of the slide and explained that a hospital emergency department, jail, or secure facility were the primary locations that could currently hold a person who needed care. If DETs were at capacity, people were waiting at emergency rooms or correctional facilities.

[9:49:09 AM](#)

Representative Carpenter returned to the last bullet on slide 12. The bullet stated that it was not reducing the parents' rights or an individual's rights. He wondered about the decision-making power of a peace officer. He wondered how allowing a peace officer to decide whether a child needed a hold would not be reducing the rights of a parent. He asked if a trooper would have the right to take a child away from their parents.

Ms. Carpenter explained that the bullet he was referring to meant that the bill was not reducing an individual's rights from the rights that individuals currently had. Minors had the same rights as adults in the civil commitment statutes and would also get appointed a guardian ad litem by the court. Both minors and parents would have their own attorneys appointed to them. If for some reason a parent did not agree with the suggestion of the child's attorney, the parent would have representation also. She thought Commissioner Cockrell could better to respond to the question.

Representative Carpenter could wait until invited testimony to ask further questions.

[9:51:31 AM](#)

Mr. Williams reported that the flow for involuntary commitment with statutory changes was depicted on slide 14. He drew attention to the bottom left portion of the slide and explained that it was different than slide 13 because there was the addition of a mobile crisis team and a crisis stabilization center. It also maintained law enforcement and hospitals as part of the system but were no longer the default solution for everyone. Additionally, the new system would allow a person in need to be sent to a crisis residential center instead of defaulting to a DET location. If someone needed longer-term care, the DETs would still be available.

Ms. Carpenter reviewed the committee substitute highlights for HB 172 (version N) on slide 15. The department, the trust, and other stakeholders had collaborated to make improvements to the bill. There was new language that changed the term "peace officer" to "health officer" in

Section 25. Another change included new provisions for protecting patient rights as follows:

- 72 hrs. clock for an ex-parte hearing starts when a person (respondent) is delivered to a Crisis Stabilization or Crisis Residential Center;
- Attorney is appointed for the respondent;
- Court shall notify the respondent's guardian, if any
- Computation for seven-days at a Short-term Crisis Residential Center includes, time the respondent was receiving care at a Crisis Stabilization Center, if applicable

Ms. Carpenter continued that the bill included the addition of Section 29, which directed DHSS and AMHTA to submit a report and recommendations to the legislature regarding patient rights. The goal was to increase transparency with additional reporting. There also had to be a robust public comment period and the comments needed to be considered before any plan could be completed.

[9:55:51 AM](#)

Representative Carpenter appreciated the work that had been done to protect patient rights. He wondered about parental rights. He was concerned about parents' rights and that the rights might be limited.

Ms. Carpenter indicated parents would receive counsel and notifications from the court. She deferred to an invited testifier from the Department of Law who handled Title 47 cases.

[9:57:11 AM](#)

STEVEN BOOKMAN, SENIOR ASSISTANT ATTORNEY GENERAL, DEPARTMENT OF LAW (via teleconference), responded that the bill did not affect the constitutional rights of parents to direct the care of their children. The 23-hour center was something that could be utilized on an involuntary basis by an emergency hold, which was a process that was already in place. However, in order to authorize a longer stay, it had to be approved by a judge. The statutes stated that the child had to be discharged if the child no longer met the standards for needing assistance. He wanted to make sure that in cases where parents were not involved, the child could still receive care. He argued that by offering fewer

restrictions it would make it easier for parents to be involved.

Representative Carpenter asked if statute currently allowed a law enforcement officer to remove a child in a mental health crisis and take the child to a facility without the parents' consent.

Mr. Bookman responded that was in current law. The question was not whether there was a disagreement on what was best for the child, but whether the child had a mental illness and had the potential to hurt themselves and others and was unsafe.

Representative Carpenter commented that if a child was unsafe, that was up to the discretion of the law enforcement officer. If the parents disagreed with the law enforcement officer, the parents' ability to make a decision for their child would be put in the hands of the state.

Mr. Bookman responded that he was accurate.

[10:01:21 AM](#)

Ms. Carpenter continued to review the key improvements resulting from HB 172 on slide 16 as follows:

- 5) Adds requirement that notifications in the alternative to arrest statutes also go to the peace officer's employing agency to ensure victim notification will happen even if the arresting officer is off duty. (Sections 4, 6, and 10)
- 6) Addresses statutes found unconstitutional by the Alaska Court System to align with the court rulings.
 - Amends the definition of "gravely disabled" in AS 47.30.915(9) (Section 23)
 - Clarifies standards for court to order administration of noncrisis medication (Sections 19 & 20)

[10:02:54 AM](#)

Representative Josephson directed attention to slide 13 which detailed the current flow for involuntary commitment. He asked how it would apply to a homeless person.

Ms. Carpenter responded that it could mean the individual would be discharged to a homeless shelter and would still receive community resources.

Representative Wool wondered if smaller communities had short-term residential facilities.

Ms. Carpenter indicated there were communities across the state that were in different stages of establishing the facilities. She reminded the committee that the services provided in the facilities were billable to Medicaid. For example, Providence Hospital in Anchorage was looking at the crisis model and deciding between building designs. She could follow-up with the information on which communities had asked for approval through the department to stand-up the voluntary facilities.

Representative Carpenter asked at which point in the process would Medicaid billing begin. He wondered when the demand for federal dollars would appear.

Ms. Carpenter responded that it would depend on the model. A mobile crisis team would provide Medicaid billable services once the team arrived on the scene. The next billable service would begin when an individual entered into a 23-hour crisis center. She expected some providers in larger communities to design facilities so that the 23-hour center and the longer-term facilities were right down the hall from each other to make the transition easy.

[10:05:56 AM](#)

Representative Carpenter asked to return to slide 10 which depicted the crisis response in Georgia. He asked what the financial incentive was to weed out 90 of the 100 crisis calls. It appeared to him that the business model was more successful as the amount of people admitted into facilities increased.

Ms. Carpenter highlighted that the crisis center was the only piece that was not billable to Medicaid. It was not a service covered by the 1115 waiver. It was important to provide an appropriate response and appropriate level of care to the people who needed it. It was not about making money and Medicaid was not the highest payer in the state. However, Medicaid was covering about 85 percent of the cost in the model on slide 10.

Co-Chair Merrick indicated the committee would move to invited testimony.

10:08:04 AM

JAMES COCKRELL, COMMISSIONER, DEPARTMENT OF PUBLIC SAFETY (via teleconference), spoke to the Department of Public Safety's support for the bill. He also supported the bill personally. He had a close family member who had experienced a mental health crisis, was arrested, and spent 81 days in jail. The offense should not have been deemed a criminal case because the individual was experiencing a mental health crisis. Too often law enforcement officers responding to mental health crises would state that training did not equate to a professional response to a mental health crisis. On many occasions, the presence of a uniformed officer escalated the situation because the individual experiencing the crisis assumed they were going to jail. He thought the state was behind the rest of the country in responding to such crises. The bill would make a significant difference for the people of Alaska and would help move the state in the right direction.

Representative Wool was reassured by Commissioner Cockrell's words. He referred to the aforementioned incident where an 11-year-old in the Matanuska-Susitna Valley was pepper sprayed and handcuffed. He asked at what point could an individual get treatment if there was a crime affiliated with a mental health incident. He asked how inappropriate jailing could be avoided and if Commissioner Cockrell had any insight into possible solutions. He supported the legislation.

10:13:58 AM

Commissioner Cockrell responded that if the crisis process proposed by the bill was in place when the incident with the 11-year-old occurred, law enforcement would not have been present on the scene. He spoke to the trooper on the scene and thought the trooper took the appropriate actions based on the circumstances. However, there had to be a better way to deal with similar situations than what was currently in place. He reiterated that the legislation was a huge step in the right direction.

Representative Wool thought his question had been answered. He was more concerned with an individual being sent to jail when it was the inappropriate place for them. He thought this would be more difficult to undo once prosecutors and judges were involved and hoped constraints could be loosened when someone with a mental health issue had committed a crime. He agreed that the correctional facilities were not the best places to treat mental health issues.

Commissioner Cockrell agreed. Looking at his personal experience with his background in law enforcement, he felt helpless trying to deal with his relative that was in prison for 81 days when they were in crisis. He thought as the system continued to grow, there would be more partnerships between law enforcement and mental health crisis teams. At some point in time, a person could be charged with a crime after they received help for the mental illness. He reiterated that the bill represented progress but it would be a process to work out the kinks.

[10:19:14 AM](#)

Representative Edgmon asked for clarification on the difference between law enforcement, peace officers, and police officers. He asked whether the bill fully encapsulated law enforcement, which would include Village Public Safety Officers (VPSO).

Commissioner Cockrell replied that he did not think the bill would affect the ability of VPSOs to step into a greater role.

[10:20:12 AM](#)

Representative Carpenter asked about safeguards to ensure that adults and children were not treated in the same facilities. He asked how the bill would prevent children from spending a long period of time away from parents without parental consent.

Commissioner Cockrell thought Mr. Bookman had addressed the question. The bill would not change the process that was currently in place under Title 47. He was unaware of any situation where Representative Carpenter's example would occur. The only situation in which a police officer could take a child away from a parent would be if the child was

seemingly in danger. There were mechanisms to return the child to the parents and the child would most likely go into the custody of the Office of Children's Services (OCS). He did not know whether the scenario in question could occur under the legal system.

[10:21:36 AM](#)

Representative Johnson was trying to envision how the law would function with local police. She wondered if officers would be encouraged to engage in some sort of training. She also wanted to ensure that officers had access to crisis facilities. She wondered if there would be a fiscal responsibility placed on local law enforcement if the bill were to pass.

Commissioner Cockrell replied that local law enforcement would respond to mental health crises, not state law enforcement like the troopers. Instead of responding with a police officer, a mental health officer would respond if the bill were to pass. He thought that the fiscal note would be minimal. Realistically, it would likely save DPS some money over time. He did not see it being a burden to local law enforcement.

Representative Johnson suggested that a crisis team would be resource to local police officers.

Commissioner Cockrell responded that was his understanding. The implementation of crisis teams was intended to be a resource for all local and state law enforcement.

Co-Chair Merrick intended to adjourn by 10:45 a.m.

[10:25:35 AM](#)

MARK REGAN, LEGAL DIRECTOR, DISABILITY LAW CENTER (via teleconference), relayed that in Alaska, the way in which people were receiving short-term mental health treatment involved them being evaluated for civil commitment in the long-term. Current law stated that someone in crisis would be picked up and taken to a facility to get short-term treatment and a 72-hour evaluation for potential further treatment. However, current law did not match up well with what people really needed. People needed short-term treatment in a therapeutic setting, which was what the bill

would provide. Unfortunately, the current system had difficulty providing short-term treatment.

Mr. Regan provided a situation in which an individual was taken into an involuntary hold and brought to Central Peninsula Hospital, but API was at capacity and the individual could not be evaluated. The individual spent a few days at the hospital in custody without being evaluated and therefore not receiving treatment. The situation worsened in 2018 when API was unable to take new patients to do evaluations for various reasons. He relayed that API indicated people would have to stay in jail longer awaiting evaluation or would have to go to hospital emergency rooms. He thought the system had essentially broken down. In response, the Disability Law Center (DLC) and the public defender sued. He explained that AMHTA and the state proposed changing the system to ensure that crises would trigger a crisis-now process for short-term treatment. It would replace hospital emergency rooms and jails as places to hold patients experiencing mental health crises. The lawsuit was settled on the basis of encouraging the implementation of crisis-now facilities. He explained that Fiscal Notes 2 and 6 (with control codes tljii and UDVnD respectively, offered by DHSS) indicated that DLC helped begin the process. He could not claim credit for it, because the credit instead belonged to the trust and the state. The bill would allow for individuals to receive necessary short-term treatment without the difficulty of being sent to an inappropriate facility like a jail or emergency room. He wanted members to understand why the bill was necessary.

Representative Edgmon asked Mr. Regan to speak to why the issue was being addressed presently rather than five or ten years ago.

Mr. Regan replied that typically, people in more rural communities would be flown or taken to a hospital for the 72-hour evaluation and hold. There were situations that could be resolved in a person's home community, but it might be necessary that the person be flown to a larger community. Generally, Alaska had not been successful at providing community-based treatment and it was more common for people to be flown to large hubs. The bill offered the opportunity for relatively small communities to have at least a crisis stabilization center to offer short-term treatment. The other reason for the timing of the

legislation was money. He explained that the 1115 waiver helped to provide money to communities across the state. He thought a small hub community providing a crisis center was preferable to flying an individual across the state to a crisis center or an API. The bill would make it possible to implement crisis centers in many more parts of the state.

10:34:01 AM

SHIRLEY HOLLOWAY, NATIONAL PRESIDENT AND ALASKA VICE PRESIDENT, NATIONAL ALLIANCE ON MENTAL ILLNESS (via teleconference), supported the bill. She explained that National Alliance on Mental Illness (NAMI) Alaska was part of the national NAMI chapter, which was the largest grassroots mental health organization dedicated to building better lives for people impacted by mental illness. She unfortunately became involved with NAMI when her daughter, who had a mental illness, committed suicide during a mental health crisis. She was out of town when her daughter contacted her, and it was immediately clear that her daughter was in crisis. She asked her daughter to go to the emergency room, but her daughter had been there many times before and had negative experiences. Her daughter had also been to API which was a bad experience as well. She called everyone she could to help her daughter: her daughter's psychiatrist, therapist, neurologist, and others. She could not find help. She relayed that this experience had lasted for four hours while she waited to board a plane to be with her daughter. As a last resort, she called the police and explained the situation while she was boarding the plane. Tragically, when the police found her daughter, it was too late.

Dr. Holloway relayed that mental illness affected more than one in five adults, which was about 50 million people in the United States, or 108,000 people in Alaska. Emergency rooms and jails were not appropriate holding rooms for patients in a mental health crisis who needed expert care as quickly as possible. The crisis system needed to offer help, not handcuffs. She supported the multitude of stakeholders and collaborators that came together to craft the legislation. The bill would ensure that people received appropriate services in a timely manner and take undue pressure off of first responders. She noted that there was more work to be done, but the legislation was a critical step in providing a continuum of care for mental health. She supported the requirement of a report due to the

legislature at the year mark to evaluate the effectiveness of the legislation and provide opportunity for public input.

Co-Chair Merrick thanked the testifier for sharing her personal experience.

10:40:32 AM

DR. HELEN ADAMS, ALASKA CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (via teleconference), had been part of the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) program and returned to the state as an emergency room doctor. She thought the crisis-now model would be transformative for her job. There were a few different categories of patients that she would share with the committee. The first category was patients with psychiatric illnesses who were experiencing an acute medical condition due to their psychiatric illness. She offered an example of an opioid overdose patient who would always and rightfully be sent to the emergency department for medical stabilization. Once the patient was stabilized, they would be sent to the appropriate psychiatric care facility. She relayed that the crisis-now model would not change the process.

Dr. Adams indicated that she wanted to focus on patients who were not experiencing medical emergencies but were in crisis. These patients often showed up in the emergency department because they did not know what else to do and would sit unsupported in an emergency room for hours. The experience of patients like this would be transformed by the bill because patients would be able to call the crisis hotline and access a professional quickly. The next category was patients that were not experiencing a mental health crisis. The bill would make it possible for these patients to go through the crisis now system and avoid the emergency department. She echoed Mr. Cockrell's earlier comments that the presence of law enforcement often escalated a situation. Under the new model, a crisis team could verbally deescalate a situation. Often times, security appeared on the scene of a crisis at the hospital before she did, but she would be able to deescalate the situation in minutes due to her training and she could excuse security. Another example of de-escalation was the presence of dogs with security officers to make patients feel more comfortable. The other group of patients that

would benefit from the bill would be people who were in the emergency room for any other reason. Patients experiencing mental health issues were overwhelming the emergency department, and if these patients had other resources, other people in the emergency room would experience fewer delays. She stressed streamlining the process and endorsed the open-door policy.

Co-Chair Merrick thanked the testifiers and reviewed the agenda for the afternoon.

HB 172 was HEARD and HELD in committee for further consideration.

ADJOURNMENT

[10:46:12 AM](#)

The meeting was adjourned at 10:46 a.m.