ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
April 27, 2021
1:33 p.m.

MEMBERS PRESENT

Senator David Wilson, Chair
Senator Shelley Hughes, Vice Chair
Senator Mia Costello
Senator Lora Reinbold
Senator Tom Begich

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

SENATE BILL NO. 124
"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."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: SB 124
SHORT TITLE: MENTAL HEALTH FACILITIES & MEDS
SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

04/12/21	(S)	READ THE FIRST TIME - REFERRALS
04/12/21	(S)	HSS, FIN
04/27/21	(S)	HSS AT 1:30 PM BUTROVICH 205

WITNESS REGISTER

STEVE WILLIAMS, Chief Operating Officer
Alaska Mental Health Trust
Anchorage, Alaska

POSITION STATEMENT: Gave an overview of SB 124.

HEATHER CARPENTER, Senior Policy Advisor
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Presented the sectional analysis for SB 124.

GENNIFER MOREAU, Director
Division of Behavioral Health
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Answered questions on SB 124

STEVEN BOOKMAN, Senior Assistant Attorney General
Civil Human Services Division
Department of Law
Anchorage, Alaska
POSITION STATEMENT: Answered questions on SB 124.

ELIZABETH RIPLEY, President and CEO
Mat-Su Health Foundation
Wasilla, Alaska
POSITION STATEMENT: Testified in support of SB 124.

KENNETH MCCOY, Acting Chief
Anchorage Police Department
Anchorage, Alaska
POSITION STATEMENT: Testified in support of SB 124.

ELIZABETH KING, Director
Behavioral Health and Workforce
Alaska State Hospital and Nursing Home Association
Anchorage, Alaska
POSITION STATEMENT: Testified in support of SB 124.

SHIRLEY HOLLOWAY, Ph.D., President
National Alliance on Mental Illness (NAMI)
Vice President NAMI Alaska
Anchorage, Alaska
POSITION STATEMENT: Testified in support of SB 124.

ACTION NARRATIVE

1:33:27 PM
CHAIR DAVID WILSON called the Senate Health and Social Services Standing Committee meeting to order at 1:33 p.m. Present at the

call to order were Senators Costello, Begich, Hughes, Reinbold, and Chair Wilson.

SB 124-MENTAL HEALTH FACILITIES & MEDS

1:33:58 PM
CHAIR WILSON announced the consideration of SENATE BILL NO. 124 "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."

He noted it was the first hearing for SB 124, sponsored by the Senate Rules Committee by request of the governor. He asked Steven Williams and Heather Carpenter to introduce the bill.

1:35:31 PM
STEVE WILLIAMS, Chief Operating Officer, Alaska Mental Health Trust, Anchorage, Alaska, explained that SB 124 is part of a larger effort to improve Alaska's psychiatric crisis response system and began his presentation, *Implementing A Behavioral Health Crisis System of Care* by reading slide 2, Change Is Needed:

Currently, Alaskans in crisis are primarily served by law enforcement, emergency rooms, and other restrictive environments

- Behavioral health crisis response is outside the primary scope of training for law enforcement, and reduces focus on crime prevention
- Emergency rooms are not designed for and can be overstimulating to someone in an acute psychiatric crisis

MR. WILLIAMS stated that individuals are often inappropriately placed in emergency rooms and restrictive environments, such as jails. SB 124 provides an opportunity to create needed innovative change to Alaska's psychiatric system.

SB 124 will:

- Effectuate a "No Wrong Door" approach to stabilization services

- Enhance options for law enforcement and first responders to efficiently connect Alaskans in crisis to the appropriate level of crisis care
- Support more services designed to stabilize individuals who are experiencing a mental health crisis
  - 23-hour crisis stabilization centers
  - Short-term crisis residential centers

MR. WILLIAMS elaborated that No Wrong Door means first responders who encounter a person in psychiatric crisis specifically know which facility is best equipped to deal with a patient's needs and take them there. The No Wrong Door approach allows first responders to spend less time making transfers. Areas that have implemented the system report transfer times of 3-10 minutes. Transfer time in Alaska is several hours. The bill will allow the Department of Health and Social Services (DHSS) to designate and license lower levels of acute psychiatric care. SB 124 describes these as 23-hour and residential crisis stabilization centers. These licensed centers can accept individuals who are in emergency custody holds and those who are there involuntarily.

1:39:01 PM
MR. WILLIAMS stated that the goal of the No Wrong Door approach is to have a behavioral health emergency system analogous to the 911 physical health emergency system. A person experiencing a behavioral health emergency would be able to quickly receive help at their location and be transported to a facility for 23-hour stabilization if needed. They would be admitted for short term stabilization if further help was needed. (Slide 3, Goal)

1:41:21 PM
At ease

1:43:13 PM
CHAIR WILSON reconvened the meeting.

1:43:14 PM
MR. WILLIAMS pointed out that a transfer by the mobile crisis team to a 23-hour stabilization center is critical for a person in a psychiatric crisis. The system drastically reduces the amount of time law enforcement spends making transfers to appropriate medical care. He noted that the system is sponsored by the Substance Abuse Mental Health Services Administration), National Alliance on Mental Illness, Crisis Intervention Team

International (a law enforcement organization), the Action Alliance on Suicide Prevention and several others.

In 2019 stakeholder organizations consisting of healthcare providers, state agencies, first responders, nonprofits, local governments, and tribal organizations began participating in the assessment of community strengths and weaknesses. This was done so psychiatric crisis response could be redesigned. Mr. Williams said he has met with 300 organizations and individuals throughout the process. (Slide 4, Stakeholder Engagement)

The 1115 Behavior Health Waiver is the foundation for being able to implement systematic change. It is the work of DHSS to apply and be awarded the waiver. The service and support behavioral health providers give their communities is enhanced by the waiver. The waiver provides funding for pieces of the emergency behavioral response system. The parts of the system mentioned in SB 124 are 23-hour Stabilization and Short-term Stabilization Centers. (Slide 5, Enhanced Psychiatric Crisis Continuum of Care)

1:47:38 PM
MR. WILLIAMS read slide 6, Crisis Stabilization (23-Hour):

> Provides prompt crisis observation and stabilization services, offers low barrier access to mental health and substance use care in a secure environment
>
> - No wrong door - walk-in, referral and first responder drop off
> - High engagement/Recovery oriented (Peer Support)
> - Staffed 24/7, 365 with a multi-disciplinary team
> - Immediate assessment and stabilization to avoid higher levels of care where possible
> - Safe and secure
> - Coordination with community-based services

He defined a Crisis Stabilization Center as a location designated and licensed by DHSS that would provide up to twenty-three hours and fifty-nine minutes of crisis stabilization care. An individual's mental needs would be assessed but their medical and behavioral needs could also be addressed. Having a designated locale would alert first responders that the individual would be accepted right away.

MR. WILLIAMS read slide 7, Short-Term Crisis Residential Stabilization Center:

> A 24/7 medically monitored, short-term, crisis residential program that provides psychiatric stabilization
>
> - Safe and secure – serves voluntary and involuntary placements
> - High engagement/Recovery oriented (Peer Support)
> - Multi-disciplinary treatment team
> - Short term with 16 or fewer beds
> - Stabilize and restore – avoid need for inpatient hospitalization where possible
> - Coordination with community-based services

MR. WILLIAMS said a short-term crisis center is one step up in care from 23-hour care and is where a person would be sent if they could not be stabilized at the lower level. It is recovery oriented and designed to accept voluntary and involuntary patients.

In speaking to the outcomes Georgia experienced after implementing a crisis system, he stated that for every 100 calls received, the crisis call center resolves 90 of them. A dispatched mobile crisis team, consisting of a peer and a mental health professional, resolves 7 out of the 10 remaining cases through assessment, de-escalation, and referrals to support services. The remaining three individuals are transported to a 23-hour stabilization center where 1 out of the initial 100 is admitted to short term care.

By having a progression that provides early intervention, qualified personnel and appropriate levels of care, the impact on first responders can be significantly minimized. Moreover, individuals get faster and better care. (Slide 8, Enhanced Crisis Response)

1:51:43 PM
MR. WILLIAMS noted that the point where first responders spend excessive amounts of time waiting to make transfers is at emergency holding places. He shared a difficult, frustrating, yet common experience many state troopers face. In Mat-Su a trooper picked up an individual experiencing a psychiatric crisis. The trooper was unable to resolve the situation on-site,

handcuffed the individual and attempted to find a local place of transfer. Unsuccessful in finding a place to accept the patient in Mat-Su, he drove to Anchorage. As the officer searched for care the in-crisis individual, who had not committed a crime, spent the officer's entire eight-hour shift in handcuffs. (Slide 10, Current Flow for Involuntary Commitment)

MR. WILLIAMS commented that under the new system law enforcement and mobile crisis teams would be able to take patients to 23-hour crisis stabilization centers. Transfers take less than ten minutes in Georgia and Phoenix, Arizona, where 23-hour crisis stabilization centers have been established. (Slide 11, Proposed Statutory Changes)

He asked members to picture what the redesigning of a psychiatric crisis system could look like and what SB 124 would help effectuate. It would ensure people get appropriate care swiftly, keep them out of jails and emergency rooms, and minimize the impact on first responders (Slide 12, Flow for Involuntary Commitment with Statutory Changes)

1:57:13 PM
HEATHER CARPENTER, Senior Policy Advisor, Department of Health and Social Services (DHSS), Juneau, Alaska, presented the sectional analysis for SB 124:

> **Section 1**: Amends AS 12.25.031(i)(1) to define "crisis stabilization center" as a subacute mental health facility that has a maximum stay of 23 hours and 59 minutes.

She stated the statute was added last session as HB 290, an alternative to arrest procedure, sponsored by Representative Claman, and passed as SB 120.

> **Section 2:** Amends AS 47.30.705(a) to expand the category of who can cause a person to be taken into custody for delivery to a crisis stabilization center or an evaluation facility. The new language would allow "a 'mental health professional' as defined in AS 47.30.915(13), or a physician assistant licensed by the State Medical Board to practice in this state," in addition to a peace officer.

She noted that a definition sheet for involuntary commitment statutes was provided. All provider types being deleted were captured in the definition of a mental health professional. A

physician assistant was not in the definition of a mental health provider, so it was specifically included in Section 2.

Clarifies that a person is taken "into custody" by a peace officer and then delivered to the nearest crisis stabilization center or evaluation facility.

MS. CARPENTER commented that the desire is to divert care to the most appropriate facility and receive immediate care, instead of being placed in an emergency room or jail.

Clarifies that a person taken into custody may not be placed in jail or other correctional facility except for protective custody purposes while they await transportation to a subacute mental health facility or an evaluation facility.

Replaces "crisis stabilization center" with "subacute mental health facility" to align with the definitions in Section 15 which categorize crisis stabilization center as a subtype of a subacute mental health facility.

Section 3: Adds a new subsection (c) to AS 47.30.705 that requires a peace officer to prioritize delivery to a crisis stabilization center if one exists in the area served by the peace officer.

2:00:18 PM
MS. CARPENTER added the desire is not to have a peace officer transport someone from Dillingham to Anchorage. However, if someone were having a crisis in Houston and a stabilization center existed in Wasilla, the peace officer would prioritize delivering the individual to the Wasilla center rather than an emergency room.

Section 4: Adds a new section AS 47.30.707 for admission to and detention at a subacute mental health facility with the following options and rights for a patient:

(a) Creates legal parameters for emergency admission and holds at a 23-hour 59-minute crisis stabilization center. It also requires a mental health professional to examine the patient (respondent) delivered to a crisis stabilization center within 3 hours after arrival.

(b) Creates a new process for evaluation, stabil-ization, and treatment at crisis residential centers which provides a less restrictive alternative to traditional involuntary commitment holds at a Designated Evaluation and Treatment Facility (DET) or the Alaska Psychiatric Institute (API). If there is probable cause to believe the person's crisis could be stabilized by admitting to a crisis residential center, the mental health professional in charge at the 23-hour, 59-minute crisis stabilization center can apply to the court for an ex parte detention order after which the person could be detained at a crisis residential center for no more than 120 hours.

2:02:08 PM
MS. CARPENTER noted that the meaning of "professional in charge" was defined in AS 47.30.915.17 as the senior mental health professional at a facility, or that person's designee in the absence of a mental health professional. It means the chief of staff, or the physician designated by the chief of staff.

(c) Retains the option to use the current process of application for an ex parte order for delivery to a hospital designated as a DET (such as API) if the individual is determined to still be in acute behavioral health crisis and needs further evaluation.

(d) Requires that if at any time during an involuntary hold at a subacute mental health facility, the patient (respondent) no longer meets the standards for a stabilization hold or detention, that they be released.

(e) Provides for the patient's (respondent's) rights when being involuntarily held at a subacute mental health facility.

2:03:13 PM
She offered that some examples of patient's rights are the right to communicate immediately with a guardian or attorney of their choice, the right to be represented by an attorney and the right to be notified of their rights.

(f) Allows for the patient (respondent) to convert to voluntary status for care.
(g) Allows a subacute mental health facility to administer crisis psychotropic medication consistent with the practice permitted in AS 47.30.838 for evaluation and designated treatment facilities.
(h) Adds language to clarify how time is calculated in this section for the 23-hour, 59- minutes and 120- hour periods.

2:04:09 PM

Section 5: Provides clarifying edits to AS 47.30.710 and adds language to allow admission to subacute mental health facilities (in addition to evaluation facilities).

Adds language to allow a mental health professional, after examination, to either:

1. Hold the person at a crisis stabilization center;
2. Admit the person to a crisis residential center;
3. Readmit the person to a crisis residential center if it is within 24 hours of a previous admission with department prior authorization;
4. Hospitalize the respondent; or
5. Arrange for emergency hospitalization.

Section 6: Adds a new subsection (c) to AS 47.30.710 to require application for an ex parte order if a judicial order is not in place.

Adds a new subsection (d) outlining the patient's (respondent's) right to request a court hearing and receive representation by a public defender if the patient (respondent) is readmitted within 24 hours of a discharge and is not willing to stay voluntarily.

Section 7: Amends AS 47.30.715 to clarify the facility type as an "evaluation facility" and to require admission of the patient (respondent) when it is safe to do so for a 72-hour evaluation to determine if a petition for 30-day commitment should be filed.

MS. CARPENTER explained the reason for adding the language is facilities can have different staffing patterns or there may be several highly acute patients in one facility at the same time. Such circumstances can require a 2:1 staffing ratio. A facility must have the clinical staff available for treatment before they can admit a new patient, even if a bed is vacant. This is a clinical judgement in order to ensure the patient number does not exceed capacity or result in unnecessary injuries to patients or providers. This also ensures a facility can comply with all the patient safety conditions required by the joint commission and Centers for Medicare and Medicaid Services (CMS).

> **Section 8:** Amends AS 47.30.805(a), a computation of time statute, to include computation for proceedings or transportation to a crisis residential center.

2:07:22 PM

MS. CARPENTER said only a physician, advanced practice nurse, or physician assistant can determine the need for crisis medication.

> **Section 9:** Amends AS 47.30.838(c) to include the subacute mental health facility type as a type of facility authorized to administer psychotropic crisis medication when there is a crisis situation where the patient requires immediate medication to prevent significant physical harm to themselves or others.

She explained that crisis medication can be given when there is a crisis situation or impending crisis situation. A crisis happens when medication must be used immediately to preserve life or prevent significant physical harm. Only a physician, advanced nurse practitioner or physician assistant can make the determination; a regular nurse cannot. Providers universally say that physical restraint is much worse for patients than medication.

An order for crisis medication is initially valid for only twenty-four hours. It may be renewed for up to seventy-two hours total. A facility can administer crisis medication for no more than three crisis periods without court approval. This means medication can be renewed for up to nine 24-hour periods. This almost never happens because regularly scheduled medication reduces the use of crisis medication.

Section 10: Adds a new section to AS 47.30 to require the department to adopt regulations to implement these changes to the involuntary commitment statutes.

Section 11: Amends AS 47.30.915(7) to clarify that "evaluation facility" means a department-designated hospital or crisis residential center.

MS CARPENTER explained that technically, using the current definition of the term healthcare facility, a hospice facility could be an evaluation and treatment center. DHSS would not do this, but it demonstrates why precise language is needed.

Section 12: Amends the definition of "peace officer" in AS 47.30.915(15) to include "emergency medical technician; paramedic; or firefighter."

2:09:39 PM
MS. CARPENTER said the amendment in Section 12 changes the definition of peace officer so that SB 124 aligns with the established definition of mobile crisis teams in Anchorage.

Section 13: Amends AS 47.30.915 to provide definitions:

- "subacute mental health facility" is defined in AS 47.32.900.
- "crisis residential center" means a subacute mental health facility that has a maximum stay of 120 hours.
- "crisis stabilization center" means a subacute mental health facility that has a maximum stay of 23 hours and 59 minutes.

Section 14: Amends the licensing statutes in AS 47.32.010(b) to change "crisis stabilization centers" to "subacute mental health facilities."

MS. CARPENTER stated the term "subacute mental health facilities" is used to encapsulate a comprehensive set of wrap-around services that can occur in a variety of different crisis settings. The umbrella term affords the state the flexibility to grow the suite of crisis services over time.

Section 15: Adds a new paragraph to AS 47.32.900 to define "subacute mental health facility" in the licensing statutes.

Section 16: Repeals AS 47.32.900(5).

Section 17: Adds a new section to the uncodified law to clarify that DHSS will consider previously issued "crisis stabilization center" licenses as a license for "subacute mental health facility."

Section 18: Adds a new section to the uncodified law to allow the department to adopt regulations to implement this act.

Section 19: Provides for an immediate effective date for the bill

2:12:16 PM
SENATOR HUGHES asked how a person having a behavioral health crisis will be handled if they have broken a law.

MR. WILLIAMS replied the situations described during this meeting did not involve laws being broken.

SENATOR HUGHES asked if there was support from Alaska law enforcement.

MR. WILLIAMS answered he is partnering with Fairbanks Police Department, Alaska State Troopers, Anchorage Police Department, and other first responders.

2:14:00 PM
SENATOR BEGICH asked if the state is anticipating that tribal entities will provide crisis stabilization centers in rural communities. He wondered whether they would be eligible for matching federal funds. He also wanted to know if consideration had been given to rural staffing concerns. He asked how the hospital and other two facilities came to be listed in the fiscal note and where they would be located.

MS. CARPENTER replied that DHSS does anticipate tribal partners setting up services. Services can be billed to Medicaid through the 1115 Health Waiver. By statute the department is required to pay for those who do not have insurance but need involuntary commitment care. Traditionally payment is made using Disproportionate Share Hospital (DSH) funds, which is a 50 – 50 match of state and federal funds. Tribal health organizations are not eligible for federal match through DSH, and the fiscal notes reflect that.

DHSS has several tribal partners interested in setting up services in rural communities, such as Kotzebue and Nome. The model will look different for rural Alaska. The trust is working with tribal partners to determine how to scale the model for rural communities.

2:16:51 PM
SENATOR BEGICH asked where the hospitals would be located and how the estimates in the second fiscal note were identified.

MS. CARPENTER deferred to Gennifer Moreau who helped prepare the fiscal note.

GENNIFER MOREAU, Director, Division of Behavioral Health, Department of Health and Social Services (DHSS), Anchorage, Alaska, replied that DHSS has been working through trust sponsored stakeholder engagements and the 1115 waiver implementation path. DHSS has received requests for approval from agencies across the state to provide Medicaid based services, short term crisis residential centers and 23-hour stabilization centers. Estimates were based on those agencies' requests for department approval.

2:18:55 PM
SENATOR REINBOLD asked if there have been any formal letters written in support of SB 124.

CHAIR WILSON responded that a letter of support arrived just before the meeting and will be shared with members.

MR. WILLIAMS replied that the trust has not received any letters from law enforcement to date. However, since 2019 when training efforts and the process of developing a better psychiatric response system began, law enforcement has been very supportive.

2:21:07 PM
SENATOR REINBOLD remarked that she has a bill to repeal SB 120. She requested an explanation of how SB 124 works with SB 120.

MS. CARPENTER answered that Section 1 of SB 124 interacts with SB 120 by amending one definition. Everything else both in involuntary commitment and licensing statute, stands alone.

SENATOR REINBOLD requested a list of the medications that can be administered within the first 23-hours of admission to a facility. People can have serious adverse reactions to psychotropic drugs, she said.

MS. CARPENTER replied she will speak with the Alaska Psychiatric Institute's psychiatrist regarding examples of administered drugs. She explained that the medication given would change depending on the clinical judgement of the provider. She reminded members that providers must physically restrain a patient if they are not able to give crisis medication and physical restraint is worse for patients.

2:23:18 PM
SENATOR REINBOLD responded she understands people can be freaked-out by being restrained but taking medications can have severe consequences. She asked where the numbers and statistics presented on slide 8 came from. The graphic depicted outcomes of 100 calls to a crisis center. She asked how many involuntary commitments have been sent to the subacute mental health facility based on the graphic.

MR. WILLIAMS replied that the data for the graphic came from the state of Georgia based on ten years of information and 1.5 million callers. Data gathered in Phoenix, Arizona, demonstrated similar results using the same operating model.

SENATOR REINBOLD asked for a list of medications that can be administered in the first 23 hours.

MR. WILLIAMS responded he does not have a list.

CHAIR WILSON said Ms. Carpenter would obtain a sample list of medications because the medication administered depends on the type of crisis a patient is going through.

2:25:20 PM
SENATOR REINBOLD stated she has ex parte concerns and asked when she could ask questions about SB 120.

CHAIR WILSON answered that the next Department of Health and Social Services Committee meeting might be an appropriate time.

SENATOR COSTELLO asked how care of a minor is dealt with in SB 124.

MS. CARPENTER replied that the system works for minors so long as a facility accepts them. DHSS would need to know if a 23-hour stabilization center or crisis residential center has the capacity to accept minors. DHSS does have some facilities that

are preparing to establish minor services. Ketchikan is very interested in serving minors.

SENATOR COSTELLO asked what provisions are in SB 124 that would allow parents to be notified if their minor child was taken to a facility.

MS. CARPENTER deferred to Mr. Bookman.

2:28:06 PM
STEVEN BOOKMAN, Senior Assistant Attorney General, Civil Human Services Division, Department of Law, Anchorage, Alaska, replied that [Section 4] incorporates the rights under 725 [AS 47.30.725]. One of those rights is the right to communicate at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent.

SENATOR COSTELLO asked whether the minor gets to choose who is informed or whether it is in statute that a parent will be communicated with.

MR. BOOKMAN responded both; statute provides that the guardian and an adult designated by the respondent be notified. This is also in AS 47.30.775 labeled Commitment of Minors, which addresses how earlier provisions, including the 725 rights statute [AS 47.30.725] applies to minors. It further states that any notices required to be served on the respondent shall also be served on the parent or guardian of a minor and any parents or guardians shall be notified that they may appear as parties and retain an attorney or have an attorney appointed for them.

2:30:09 PM
SENATOR HUGHES requested the committee reach out to law enforcement for letters of support. She was relieved to know the system is for individuals who have not committed a crime. She asked how much time Alaska law enforcement officers would gain if they did not have to deal with mental health crises. She asked if there is data showing improved patient outcomes, such as fewer 911 calls. She specifically was interested in suicide, since it is a problem in Alaska. She speculated a suicidal individual might be more receptive to help from a healthcare worker than law enforcement.

MR. WILLIAMS replied that he does not have all the data points requested but offered the Anchorage Police Department (APD) averages 400 behavioral health crisis calls per month.

He stated the amount of time saved by Phoenix, Arizona, law enforcement not responding to behavioral health crises was thirty-seven full time equivalents (FTEs). Those thirty-seven FTEs were applied to resolving criminal matters. He did not have suicide information available but would inquire about it.

2:34:09 PM
SENATOR REINBOLD stated she sees similarities between HB 76 and SB 124 in changing definitions. Section 12 changed the definition of peace officer. Section 2 deleted licensed psychiatrists, physicians and other qualified professions and replaced them with peace officers and physician assistants. She offered her belief that experienced people should be the ones to commit individuals. Another concern with SB 124 is in Section 14, which includes maternity centers, nursing homes and residential childcare as listed facilities. She stated there are multiple significant changes in SB 124 and recommended the bill be reviewed closely.

CHAIR WILSON stated SB 124 will be heard several times.

2:37:29 PM
SENATOR HUGHES asked if concerns regarding provider types and facilities could be addressed.

MS. CARPENTER replied that the concerns mentioned are minor changes. In Section 2 licensed psychiatrists, physicians and others are being deleted because they are included in the definition of a mental health professional, as found in Alaska Statute 47.30.915.13. Physician assistant was specifically mentioned in SB 124 because it is not included in the definition of a mental health provider.

The change to the definition of peace officer only applies to involuntary commitment statutes. It is being amended to add EMTs, paramedics and firefighters to accommodate Anchorage's model of a mobile crisis team.

Section 14 is a conforming change with state licensing statutes found in AS 47.32. The healthcare facilities Senator Reinbold mentioned are listed in licensing statute because they are facilities that are licensed by DHSS, through state healthcare facility licensing. It is licensing statute, not involuntary commitment statute.

EMTs are only allowed to do the first emergency hold. They cannot do holds at crisis stabilization centers. Those holds are done according to current statute.

2:39:30 PM
ELIZABETH RIPLEY, President and CEO, Mat-Su Health Foundation, Wasilla, Alaska, stated she represents the Mat-Su Health Foundation on the Mat-Su Regional Medical Center Board of Directors. The foundation shares ownership in Mat-Su Regional Medical Center and invests its share of profits back into the community through grants and scholarships to improve the health and wellness of Alaskans living in Mat-Su.

MS. RIPLEY said SB 124 would allow the Crisis Now model to be developed in Mat-Su and Alaska. She reported that during twenty-four community forums, as part of the 2013 Mat-Su Community Health Needs Assessment, the people of Mat-Su were asked what their top five health concerns where. The top five answers were all mental health and substance abuse related. Residents told the foundation they wanted an improved and coordinated system of care that would make treatment for behavioral health more readily accessible.

To better understand the gaps and challenges in care across the behavioral health continuum, the foundation examined the behavioral health crisis response system in Mat-Su. It found the Mat-Su Regional Medical Center Emergency Department saw 2,391 behavioral health patients in 2013 for a total of 6,053 visits, which cost an estimated $23 million. These patients had higher charges, more frequent visits and were more likely to return to the hospital within 30 days. An additional $1.6 million was spent on law enforcement, 911 dispatch and transportation. Alaska State Troopers responded to 851 health related emergency calls. Ambulance services responded to an average of 432 calls. Since then, the prevalence of mental health and substance abuse crises has increased in Mat-Su and statewide.

2:41:47 PM
MS. RIPLEY said the average annual growth rate for visits to the Mat-Su Regional Medical Center Emergency Department by patients with behavioral health diagnoses grew twenty percent from 2015 to 2017 due to the opioid epidemic and lack of treatment access. In 2016, 3,443 patients with behavioral health diagnoses went to the Mat-Su Regional Medical Center Emergency Department. Their charges totaled $43.8 million, which does not count the additional cost born by law enforcement or Mat-Su Borough EMS for dispatch and ambulance services. Additionally, from 2014 -

2017 the number of behavioral health assessments required for patients in crisis in the emergency department grew from 349 to more than 1000.

She reported that Mat-Su Regional Medical Center opened a sixteen-bed behavioral health wing last January, which provides in-patient behavioral health treatment. It has reduced boarding in the emergency department but not eliminated it. There are still people who need detox, space to sober up, and other behavioral health services that do not necessarily require an emergency department visit or in-patient treatment.

2:43:01 PM
MS. RIPLEY said despite the work of the foundation and its partners to create treatment upstream of the emergency department, there are still many people needing crisis intervention downstream. Cost-effective options are needed, which is why the Mat-Su Health Foundation became involved in the Crisis Now model. Research estimated Mat-Su has 2,583 behavioral health crisis episodes occurring annually. These could be served by any level of crisis services within the Crisis Now model. About 2,500 of these episodes, can be served by the Crisis Now call-line or mobile crisis team. The rest may require involuntary holds in crisis facilities provided by SB 124. Mat-Su is projected to need nine short term residential beds under the Crisis Now model.

Ray Michaelson, Program Officer of the Health Minds portfolio at the foundation, has been meeting with thirty behavioral health providers and emergency system partners over the last nine months to establish these needed services in the Mat-Su community. The Mat-Su Health Foundation has budgeted grant dollars to help support capital and start-up costs. The 1115 Health Wavier should help cover some of the operating costs. The foundation is committed to getting Crisis Now into operation in Mat-Su. Legislation is needed to make it legally possible. Legislation will make a new option possible to support residents who experience behavior health crises. It also supports law enforcement and healthcare workers. She respectfully asked that SB 124 be moved forward.

2:44:51 PM
KENNETH MCCOY, Acting Chief, Anchorage Police Department, Anchorage, Alaska, stated the Anchorage Police Department (APD) supports building a complete crisis response system, consisting of a crisis call center, mobile crisis teams, and 23-hour

stabilization centers. These components of the system are needed to adequately address mental and behavioral health.

Law enforcement's response has not led to desired outcomes. A large percentage of situations end with the police using force against people who are in a mental health crisis. The police department recognizes that these situations are better suited for mental and behavioral health professionals. About half of the mental and behavioral health calls APD receives result in an officer taking the individual into custody and transporting them to a jail or emergency room. Sometimes officers and individuals are left for hours at a time in the police vehicle trying to find an appropriate safe location to drop the person off.

CHIEF MCCOY said it is a drain on police resources, which could be better spent investigating actual crime. Being in the back of a police car increases emotional trauma for citizens experiencing a mental health crisis. APD recognizes there are situations when law enforcement is the most appropriate response, such as when crimes have been committed or weapons are reported. A crisis system augments what APD can do for the community.

2:49:24 PM
SENATOR REINBOLD expressed concerns about changing the definition of peace officer, the ability to administer drugs and minor parental consent. She asked for a description of a person in a [behavioral health crisis].

CHIEF MCCOY replied there are times when people are seen walking on streets in obvious mental distress causing a disturbance. There is not a lot an officer can do. A crime has not been committed so taking them to jail is not appropriate and they do not require an emergency room level of medical care. Having professionals in the field respond to the individual is a win-win for the community. Law enforcement has found that their uniforms, lights, and radios can act as a catalysis for use of force. Police are provided with some crisis intervention training, but it is not enough. The resources of SB 124 would compliment law enforcement and better serve the community.

2:52:58 PM
SENATOR REINBOLD asked if he can identify any way [the emergency behavioral health crisis system] can be abused.

CHAIR WILSON replied that the department [DHSS] will get an answer to the committee.

2:53:33 PM
ELIZABETH KING, Director of Behavioral Health, Alaska State Hospital and Nursing Home Association (ASHNHA), Anchorage, Alaska, said the Alaska State Hospital and Nursing Home Association (ASHNHA) supports the intent of SB 124. Its members continue to review the legislation and are working to see if changes are needed. SB 124 is intended to support individuals experiencing mental health crises through increased availability of services, specifically by allowing the use of 23-hour crisis care stabilization centers and short-term crisis residential centers.

There have been on going challenges with accessible, adequate, and appropriate care for individuals experiencing mental health crises. Alaska primarily relies upon law enforcement and hospital emergency rooms for their care. Emergency rooms are one of the most restrictive and expensive levels of care. Patients who end up at emergency departments are often held for several hours or days waiting for access to needed treatment. On average, behavioral health patients stay in emergency departments three times longer than patients with medical diagnoses. SB 124 offers the ability to support patients in crisis in a less restrictive environment and with a more appropriate level of care, regardless of whether they have a court order for involuntary commitment. The capacity to provide crisis care for any Alaskan in need is the cornerstone to building a successful model of crisis services.

2:56:06 PM
SHIRLEY HOLLOWAY, Ph.D., President, National Alliance on Mental Illness (NAMI), Vice President NAMI Alaska, Anchorage, Alaska, shared that she joined NAMI after losing her daughter to suicide. NAMI is the largest grassroots mental health organization in the nation. NAMI Alaska was created in 1984 and serves the entire state with affiliates in Anchorage, Fairbanks, Juneau, and the North Slope. On behalf of NAMI and as a parent she testified in support of SB 124.

Alaska relies on law enforcement, EMS, and hospital emergency rooms to serve people in behavioral health crises. Most communities do not have appropriate facilities and services where officers can take people to receive appropriate care. This legislation will help to create a full continuum of behavioral health crisis response services, particularly at the appropriate lower levels of care. SB 124 will allow Alaska to implement proven crisis response improvements. The nationally recognized

Crisis Now model, allows first responders to bring individuals in crisis to a low to no barrier crisis stabilization center.

The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks. This results in multiple hospital readmissions, life in the criminal justice system, homelessness, early death, and suicide.

A comprehensive and integrative crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives and a waste of resources.

2:59:29 PM
MS. HOLLOWAY declared that there is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. The Crisis Now model is a continuum of three components that are already working in many communities to prevent suicide, reduce wait time in emergency rooms and correctional settings, and provide the best support for individuals in crisis.

The Crisis Now model includes a crisis call center, centrally deployed 24/7 mobile crisis teams and a 23-hour stabilization and short-term residential center. It provides a safe and appropriate behavioral crisis placement for those who can not be stabilized by initial call center or mobile crisis team response.

This new approach to the mental health crisis follows the national guidelines of behavior health crisis care, using best practices endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services. These guidelines were developed on the experience of veteran crisis system leaders and administrators.

3:01:04 PM
MS. HOLLOWAY stated her testimony is personal:

> I have a beautiful talented daughter who lived with mental illness that I lost by suicide. For someone in crisis there can now be an alternative to jail, API [Alaska Psychiatric Institute], and hospital emergency rooms. A more systemic response is needed, and this legislation is critical to getting us where we need to be to develop a comprehensive mental health response system...

3:01:58 PM
CHAIR WILSON held SB 124 in committee.

3:02:59 PM
There being no further business to come before the committee, Chair Wilson adjourned the Senate Health and Social Services Standing Committee meeting at 3:02 p.m.