ALASKA STATE LEGISLATURE
SENATE JUDICIARY STANDING COMMITTEE
April 27, 2022
1:36 p.m.

MEMBERS PRESENT

Senator Roger Holland, Chair
Senator Shelley Hughes
Senator Robert Myers
Senator Jesse Kiehl

MEMBERS ABSENT

Senator Mike Shower, Vice Chair

COMMITTEE CALENDAR

CONFIRMATION HEARINGS

State Board of Parole
Richard "Ole" Larson - Wasilla

- CONFIRMATION ADVANCED

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
04/27/21	(S)	Heard & Held

04/27/21	(S)	MINUTE(HSS)
04/29/21	(S)	HSS AT 1:30 PM BUTROVICH 205
04/29/21	(S)	-- MEETING CANCELED --
05/04/21	(S)	HSS AT 1:30 PM BUTROVICH 205
05/04/21	(S)	Heard & Held
05/04/21	(S)	MINUTE(HSS)
05/05/21	(S)	JUD REFERRAL ADDED AFTER HSS
05/06/21	(S)	HSS AT 1:30 PM BUTROVICH 205
05/06/21	(S)	<Bill Hearing Canceled>
03/08/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/08/22	(S)	Heard & Held
03/08/22	(S)	MINUTE(HSS)
03/15/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/15/22	(S)	Heard & Held
03/15/22	(S)	MINUTE(HSS)
03/17/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/17/22	(S)	Heard & Held
03/17/22	(S)	MINUTE(HSS)
03/22/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/22/22	(S)	Heard & Held
03/22/22	(S)	MINUTE(HSS)
03/23/22	(S)	JUD AT 1:30 PM BUTROVICH 205
03/23/22	(S)	<Bill Hearing Canceled>
03/25/22	(S)	JUD AT 1:30 PM BUTROVICH 205
03/25/22	(S)	-- MEETING CANCELED --
03/29/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/29/22	(S)	Heard & Held
03/29/22	(S)	MINUTE(HSS)
04/07/22	(S)	HSS AT 1:30 PM BUTROVICH 205
04/07/22	(S)	Heard & Held
04/07/22	(S)	MINUTE(HSS)
04/12/22	(S)	HSS AT 1:30 PM BUTROVICH 205
04/12/22	(S)	Moved CSSB 124(HSS) Out of Committee
04/12/22	(S)	MINUTE(HSS)
04/15/22	(S)	HSS RPT CS 1DP 2AM NEW TITLE
04/15/22	(S)	DP: WILSON
04/15/22	(S)	AM: COSTELLO, HUGHES
04/27/22	(S)	JUD AT 1:30 PM BUTROVICH 205

WITNESS REGISTER

RICHARD "OLE" LARSON, Appointee
State Board of Parole
Department of Corrections
Wasilla, Alaska
POSITION STATEMENT: Testified as appointee to the State Board of Parole.

HEATHER CARPENTER, Health Care Policy Advisor
Office of the Commissioner
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Co-presented a PowerPoint on SB 124, Transforming a Behavioral Health Crisis System of Care.

STEVE WILLIAMS, Chief Executive Officer
Alaska Mental Health Trust Authority
Anchorage, Alaska
POSITION STATEMENT: Co-presented a PowerPoint on SB 124, Transforming a Behavioral Health Crisis System of Care.

JAMES COCKRELL, Commissioner
Department of Public Safety
Anchorage, Alaska
POSITION STATEMENT: Provided invited testimony in support of SB 124.

MARK REGAN, Legal Director
Disability Law Center
Anchorage, Alaska
POSITION STATEMENT: Provided invited testimony in support of SB 124.

HELEN ADAMS, Emergency Medical Physician; Board Member
Alaska Chapter of ACEP
Anchorage, Alaska
POSITION STATEMENT: Provided invited testimony in support of SB 124.

ANN RINGSTAD, Executive Director
NAMI Alaska
Fairbanks, Alaska
POSITION STATEMENT: Provided invited testimony in support of SB 124.

ACTION NARRATIVE

1:36:45 PM
CHAIR ROGER HOLLAND called the Senate Judiciary Standing Committee meeting to order at 1:36 p.m. Present at the call to order were Senators Myers, Kiehl, and Chair Holland. Senator Hughes arrived shortly thereafter.

CONFIRMATION HEARING(S)

State Board of Parole

1:37:42 PM
CHAIR HOLLAND announced the consideration of Governor Appointees to Boards and Commissions.

CHAIR HOLLAND called on Richard "Ole" Larson, appointee to the State Board of Parole.

1:37:54 PM
RICHARD "OLE" LARSON, Appointee, State Board of Parole, Department of Corrections, Wasilla, Alaska, provided his background, including that he earned a Bachelor of Science degree in Biology from the University of Nebraska and a Secondary Teaching Certificate from the University of Alaska Anchorage. He began his career in the Department of Corrections as a youth counselor working with juveniles at McLaughlin Youth Center. He subsequently worked at the Palmer Correctional Center as a correctional officer, shift supervisor, and facility administrator. He also worked at the Goose Bay Correctional Center.

1:38:57 PM
SENATOR HUGHES joined the meeting.

MR. LARSON said he was promoted to assistant superintendent at the 6th and C Jail. He served as an assistant superintendent at the Palmer Correctional Center, Mat-Su Pretrial and Cook Inlet Pretrial facilities. He noted that the Cook Inlet Pretrial Facility serves as part of the Anchorage complex.

MR. LARSON stated that he transferred to Hiland Mountain Correctional Center. He related he then worked as a superintendent at the Mat-Su Pretrial Facility, Point MacKenzie Correctional Farm and the Fairbanks Correctional Center. He said he retired with 29 years of prison experience. Since then, he served for five terms on the Mat-Su Borough School Board, including as vice-president and president. He was appointed to serve on the Alaska Parole Board in 2010, serving two five-year terms.

MR. LARSON stated that in 2020, he joined the Nakamoto Group, Inc., a contracting company that hires correctional professionals to work in detention facilities to ensure compliance with performance-based national detention standards.

1:41:03 PM

MR. LARSON said he is currently on sabbatical with the Nakamoto Group.

MR. LARSON stated that he brings to the Alaska Board of Parole his prior experience in the Alaska Department of Corrections and on the Board of Parole. He said he has the time and desire to serve on the board and would like to give back to his community.

1:41:57 PM
CHAIR HOLLAND remarked that he has a lot of experience serving in the field of corrections.

1:42:13 PM
SENATOR HUGHES disclosed that she had known him for 32 years. She said their children went to school together and her husband also worked with him for a few years. She offered her view that he was well suited to serve on the board.

1:42:44 PM
SENATOR KIEHL agreed with Senator Hughes that he has an excellent resume. He asked how he sees his role and goal in serving on the board.

MR. LARSON stated that he viewed his role as working with offenders, assuring the safety of Alaskans, and listening to victims. He emphasized the importance of not releasing someone until the offender had put in the effort to change their lives. He offered his belief that about 20 percent of offenders should stay in prison, and 20 percent made a mistake but will never return to jail. He indicated that he viewed the remaining 60 percent of the prison population as the ones the board addresses, ensuring reformation, so offenders are not released too soon, potentially causing mayhem in society.

1:44:40 PM
SENATOR KIEHL asked how he saw the board working with offenders and what the legislature should do differently to get the best outcome from the 60 percent of inmates.

MR. LARSON stated that the board works with parole and probation officers and treatment programs in the facilities and communities. He explained that offender treatment does not stop at the door but is a continuation once offenders leave jail. During that time, offenders transition to work, work programs, and communities. In terms of the legislature, the state tried restorative justice, but it did not work. He offered his view that the department should weigh in on what offenders, victims,

and law enforcement need to ensure safety and maintain the current level of incarceration. He offered his belief that the state currently has that balance.

1:46:30 PM
SENATOR KIEHL remarked that the state changed the penalties but did not do the restoration part of restorative justice.

MR. LARSON agreed with Senator Kiehl. He said he served on the parole board when restorative justice was going through the legislature. He suggested that it should have happened over a 4-5 year period instead of six months because the state did not have the programs to carry restorative justice forward.

1:47:27 PM
CHAIR HOLLAND opened public testimony on the governor appointee to Boards and Commissions; he found none and closed public testimony on the confirmation hearing for Ole Larson to the Board of Parole.

1:48:00 PM
SENATOR KIEHL stated that in accordance with AS 39.05.080, the Senate Judiciary Standing Committee reviewed the following and recommends the appointments be forwarded to a joint session for consideration:

State Board of Parole
Richard "Ole" Larson - Wasilla

[Signing the reports regarding appointments to boards and commissions in no way reflects individual members' approval or disapproval of the appointees; the nominations are merely forwarded to the full legislature for confirmation or rejection.]

1:48:38 PM
At ease

SB 124-MENTAL HEALTH FACILITIES & MEDS

1:49:40 PM
CHAIR HOLLAND reconvened the meeting and 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."

[CSSB 124(HSS) was before the committee.]

CHAIR HOLLAND noted that he did not have an opportunity to thank Mr. Larson, but he wanted to do so publicly.

1:50:33 PM
HEATHER CARPENTER, Health Care Policy Advisor, Office of the Commissioner, Department of Health and Social Services, Juneau, Alaska, stated that the department is carrying this bill in conjunction with the Alaska Mental Health Trust Authority.

1:51:09 PM
STEVE WILLIAMS, Chief Executive Officer, Alaska Mental Health Trust Authority, Anchorage, Alaska, co-provided a PowerPoint on Crisis Now. He reviewed 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
>
> 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 explained that the way the state currently responds to Alaskans in mental health or behavioral health crisis is broken. The state uses law enforcement and other first

responders to address the crisis in need. The tools to access the treatment to the highest level of service they require are often costly. The state does not have anything in the middle to fill out that continuum. SB 123 intends to address that middle section so the state is not reliant on limited access to designated evaluation treatment facilities.

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

1:51:59 PM

MS. CARPENTER stated that the department has Designated Evaluation and Treatment facilities (DETs), which are facilities designated by the department to serve an individual experiencing an acute psychiatric crisis who needs an inpatient level of care, either involuntary commitment and or voluntary care. Currently, DET facilities are only in four communities: Juneau Bartlett Regional Hospital with 12 beds, Fairbanks Memorial Hospital with 20 beds, Mat-Su Regional Medical Center with 16 beds, and Anchorage Psychiatric Institute (API). When space is unavailable at DETs, these individuals must wait in an emergency room. However, emergency rooms are not designed to serve someone in a psychiatric emergency because they can be overstimulating. Suppose someone is being held there before being transported. Medical care providers must put them on a one-to-one observation and remove things from the room to avoid injuries. It is not a therapeutic environment.

MS. CARPENTER turned to the graphics on slide 3, GOAL: Design and implement a behavioral health crisis response system analogous to the physical health system. The top graphic depicts a physical health emergency, showing a person in crisis, 9-1-1, ambulance/fire, emergency department, and inpatient unit. The Behavioral Health Emergency on the low section of the slide shows the sequences of a person in crisis, including the crisis call center, mobile crisis team, and 23-hour stabilization center.

1:53:43 PM

MR. WILLIAMS added comments about slide 3. He stated that this slide illustrated what is meant by "No Wrong Door." This bill allows for the full implementation of the model by creating locations for facilities where services can be provided for voluntary or involuntary status during a behavioral health crisis. He emphasized that it enhances the options for law enforcement by allowing them to take someone directly to a location where the appropriate mental health professionals can meet their needs. When fully implemented in communities, they will have options to have a 23-hour stabilization center and a short-term residential center to treat someone for up to seven days. SB 124 is a path forward since mobile crisis teams respond instead of law enforcement or emergency medical personnel. It is an intentionally-designed system that the department and AMHTA had reviewed in other states, spending the last couple of years working with other states to examine and understand their models and translate them to Alaska.

1:55:19 PM
MS. CARPENTER reviewed slide 4, Stakeholder Engagement. She related that over the last six years, the department has been working very intentionally to improve the system of care. It has been done hand-in-hand with the Trust and its many stakeholders. One key item was in 2016 when the legislature passed Senate Bill 74, a comprehensive Medicaid reform bill. While it had metrics to improve access and contain costs, one key provision was the requirement for the department to apply for a Section 1115 waiver from the Centers for Medicare and Medicaid Services to redesign Alaska's behavioral health system. The 1115 waiver requests the federal government waive the standard rules to allow the state to try new programs and systems. It must be cost-neutral to the federal government. She stated that the goal of using the 1115 waiver was to have more treatment options, including Crisis Stabilization Centers and Crisis Residential Centers in all nine regions of the behavioral health waiver. She pointed out that 23 new lines of services in the Medicaid program use that waiver.

MS. CARPENTER stated that the department and Trust also are working to establish a "No Wrong Door" system. Most people who need mental health treatment in Alaska are seen voluntarily. The state needs a robust and improved Crisis Psychiatric Response System for those in a crisis who cannot ask for that help. She said that system must be able to respond quickly so law enforcement and first responders can benefit.

1:56:59 PM

MR. WILLIAMS briefly reviewed slide 4, GOAL: Design and implement a behavioral health crisis response system analogous to the physical health system. The top of slide 4 illustrates what Ms. Carpenter spoke about earlier. If someone collapses in the grocery store, a bystander can pick up their phone and dial 9-1-1, knowing that someone will answer the call, initiate the appropriate response, and emergency personnel will respond.

MR. WILLIAMS reiterated that the bottom of the slide shows the Behavioral Health Emergency System that is analogous to the physical health emergency system. He said Arizona, Georgia, and other states currently operate this system. The Substance Abuse Mental Health Services Administration (SAMHSA), the National Alliance on Mental Illness (NAMI), the National Action Alliance on Suicide Prevention (Action Alliance), and the National Association of State Mental Health Program Directors support this system. He characterized it as a well-understood model considered a model of excellence.

1:58:17 PM
MR. WILLIAMS reviewed slide 6, Stakeholder Engagement. He described the opportunity of the broken system, the lawsuit that followed in 2018 filed by the Public Defender Agency and the Disability Law Center. Although they viewed it as the time to change the system, it was not something the Alaska Mental Health Trust Authority (AMHTA) or the department could do independently. It includes state agencies, including the Department of Public Safety (DPS), the Department of Corrections (DOC), beneficiary advocates and nonprofits, Alaska State Hospital and Nursing Home Association (ASHNHA), the Alaska Behavioral Health Association, the Alaska Mental Health Board, tribal organizations, and local governments. Over 100 organizations have been engaged in this effort, representing over 300 participants helping guide and intentionally design this system. The AMHTA and the department continue to hold work groups, primarily in Fairbanks, Anchorage, the Mat-Su Valley, and Bartlett Hospital, although Bartlett is more on point for that effort.

1:59:48 PM
MS. CARPENTER reviewed slide 7, Enhanced Psychiatric Crisis Continuum of Care. She directed attention to the suite of services in the center of the slide. She noted that community-based services and inpatient care would continue to be offered. She highlighted that the mobile crisis team, 23-hour stabilization, and short-term stabilization are billable in the Medicaid program via the 1115 waiver.

2:00:37 PM
MR. WILLIAMS reviewed slide 8 Crisis Stabilization Center (23 hour). He said this slide provides a little more detail on stabilization.

- 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

MR. WILLIAMS stated that ideally, members of a mobile crisis team would bring someone to this location, but law enforcement could also bring someone to the center. The Crisis Stabilization Center would operate 24/7, 365 days per year. Staff would include medical professionals, mental health professionals, and people who have gone through a behavioral health crisis, engaged in treatment, and are on a path to recovery. Those who have gone through the program can assure the patient that the center will meet their needs.

2:01:48 PM
MR. WILLIAMS reviewed slide 9, Short-Term Crisis Residential Stabilization Center

- 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 during the first 23 hour period, allowing up to seven days, rather than being sent to DETs like API. It is recovery oriented and designed to accept voluntary and involuntary patients. Again, these crisis centers services are provided by medical professionals, mental

health professionals, peers, and individuals with mental health crisis experience.

2:02:33 PM
MR. WILLIAMS reviewed slide 10, Enhanced crisis response would reduce the number of people entering the most restrictive levels of care. This slide provides a snapshot of the review of 10 years of data from Georgia.

MR. WILLIAMS stated that for every 100 calls received, the crisis call center resolved 90 of them by phone. A dispatched mobile crisis team consisting of a peer and a mental health professional resolved 7 of the 10 remaining cases through assessment, de-escalation, and referrals to support services. The remaining three individuals were transported to a 23-hour stabilization center, where 1 out of the initial 100 was admitted for short-term care. No law enforcement or emergency medical services intervention was needed. The remaining three individuals were taken to a 23-hour crisis stabilization center where the medical, mental health professionals, and a peer met. Two of the three cases were resolved in less than 24 hours. The final person was taken to the higher level of care, where their situation was resolved.

MR. WILLIAMS noted that having a full continuum of care can resolve the situation without the default response of law enforcement or taking someone to a DET or API.

2:04:46 PM
MS. CARPENTER turned to slide 11, Alaska Statute Title 47.

> Collaborative Approach to Transforming our Response to Alaskans in a Behavioral Health Crisis SB124 Mental Health Facilities & Meds

2:04:57 PM
MS. CARPENTER provided a brief history, stating that in 2016 the legislature passed Medicaid reform. The Trust subsequently worked with the department to identify the Crisis Now model as the path forward to further the 1115 waivers. The team pulled together communities and stakeholders to look at this first-hand. The Trust has sponsored trips to Arizona for policymakers and law enforcement to walk through their facilities. In addition, the department settled the lawsuit with the Public Defenders and Disability Law Centers that was filed in 2018. Individuals who had committed no crime were waiting at correctional facilities because there was no room at API or

another DET to treat their psychiatric crisis. As part of that settlement, the department had to put forward statutory fixes that would allow an evaluation to occur at other places besides the highest level of care. That effort led to the development of SB 124.

2:06:07 PM
MS. CARPENTER turned to slide 12, Key Takeaways.

SB 124 Does:
Create a "no wrong door" approach to providing medical care to a person in psychiatric crisis

- Provide law enforcement with additional tools to protect public safety
- Expand the number of facilities that can conduct a 72-hour evaluation
- Add a new, less restrictive level of care
- Facilitate a faster and more appropriate response to a crisis, expand the types of first responders that can transport an individual in crisis to an appropriate crisis facility

SB124 Does Not:

- Interfere with an officer's authority or ability to make an arrest
- Change who has the current statutory authority to administer crisis medication
- Change current statutory authority for who can order an involuntary commitment
- 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

MS. CARPENTER elaborated on slide 12. She said it is a win for patients, hospitals, emergency rooms, and law enforcement. The bill would provide less restrictive care options for a person suffering from a mental health crisis. It frees up medical resources and beds for patients. It gives police officers broader options for handling someone suffering from a mental health crisis, including the Mobile Crisis Team response. This bill does not interfere with an officer's authority or ability to arrest because the officer has the discretion to make those decisions. It doesn't change the current statutory authority for who can administer crisis prescriptions, which is a physician, physician's assistant, or an advanced nurse practitioner. It

does not change the current statutory authority for the person who can order an involuntary commitment.

2:07:35 PM
MR. WILLIAMS reviewed slide 13, Current Flow for Involuntary Commitment, which consisted of a graphic flowchart of the current system. He focused on the bottom left corner, which read "Hospital ED, Jail, Secure Facility." This provides the current initial response today for someone in crisis, whether that is the level of response they need or not. Instead, it means someone doesn't seem safe, so this is where they are taken because these are the only tools available today.

2:08:22 PM
MR. WILLIAMS turned to slide 14, Flow for Involuntary Commitment with Statutory Changes. He highlighted the bottom left-hand corner, which now has several additional tools to build out the continuum of care. Although law enforcement and emergency medical services (EMS) are still represented, it would add a Mobile Crisis Team would and a Crisis Stabilization Center (23-hour) to API and hospital emergency rooms. He emphasized that the Mobile Crisis Team would access the lower levels of care needed rather than using the current default response. This would relieve law enforcement from responding to people with a behavioral health crisis and allow them to handle traditional law enforcement activities, such as protecting public safety and investigating crimes. This model only moves the patient up to higher levels of care after professionals have assessed the individual and determined that the next level of care is necessary.

2:09:42 PM
MS. CARPENTER paraphrased slide 15, SB 124 Committee Substitute Highlights (for Version I)

Key Improvements

1) Adds new language for a "health officer", newly defined in Section 28
2) Changes length of stay from up to 5 days to up to 7 days at a Short-term Crisis Residential Center
3) Adds provisions for protecting patient rights
   - 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

4) Adds a new section (Sec. 32) directing the Department of Health & Social Services and the Alaska Mental Health Trust Authority to submit a report and recommendations to the Legislature regarding patient rights.

- Patient grievance and appeal policies
- Data collection on patient grievances, appeals and the resolution
- Patient reports of harm, restraint and the resolution
- Requirements that could improve patient outcomes and enhance patient rights

MS. CARPENTER elaborated that the court must notify the respondent's guardian because the court has the state's only complete list of guardians, including public and private guardians. Section 32 was added based on feedback from stakeholders who wanted the bill to look at some things, including patient grievances and appeals and data collection on reports of harm or restraint. The department thought it would be best to do this comprehensively. It requested one year to bring together a broad group of stakeholders to examine and make recommendations on statutory changes and how to develop and place the data on Dashboard. The group included individuals with lived experiences, patient advocates, the Disability Law Center, the ombudsman, Alaska Mental Health Board, and psychiatric care providers to examine and make recommendations on statutory changes and how to develop and place the data on Dashboard.

2:12:10 PM

MS. CARPENTER paraphrased slide 16, SB 124 Committee Substitute Highlights (ver. 1).

Key Improvements Continued

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 26)
- Clarifies standards for court to order administration of noncrisis medication (Sections 22 & 23)

7) Adds sections that requires further notification of parents, guardians and other family members when a patient is admitted. (Sections 11 &13)

MS. CARPENTER stated that domestic violence advocates requested item 5. Mr. Jim Gottstein, Psychiatric Rights, requested Sections 22 and 23. The previous committee added sections that require further notification of parents, guardians, and other family members when a facility admits a patient.

2:14:09 PM
SENATOR KIEHL directed attention to slide 10. He asked for a sense of the scope of mental health crisis calls and hospitalizations in Alaska.

CHAIR HOLLAND wondered about the percentage of 911 calls that the Behavioral Health Emergency process could divert.

2:15:09 PM
MR. WILLIAMS answered that in 2018 the Department of Health and Social Services (DHSS) and the Alaska Mental Health Trust Authority (AMHTA) began examining how to redesign the system. The Trust contracted with RI International, a group that operates a similar model in Arizona, which assessed the call volume and need in Anchorage, Fairbanks, and the Mat-Su Valley.

MR. WILLIAMS stated that the department and the Trust considered how to build out the system in those communities based on their assessment. He agreed that 100 crisis calls do not necessitate admission for 100 people to a 23-hour Crisis Stabilization Center or API. He pointed out that slide 10 was intended to illustrate the current high volume of crisis calls that could be resolved via the telephone. He indicated that he does not have those figures. He added that Alaska has a Careline for those in crisis [1-877-266-4357].

2:16:42 PM
MS. CARPENTER offered to provide statistics for Fairbanks Mobile Crisis Teams, which operate quite successfully, surpassing the national average.

2:17:03 PM

SENATOR MYERS asked whether the Trust and department were trying to create a dedicated number similar to 911.

MR. WILLIAMS answered no; the intention was to use the existing number and not create a new number. He described the way the model works in other states. If someone calls 911, the dispatcher will go through their triage. If the dispatcher determines that the person is having a behavioral health crisis, they will do a warm transfer to mental health professionals who will respond to them by phone. The reverse can also happen, such that if a person calls the crisis line and the dispatcher recognizes that this is a public safety issue, they will transfer the call to 911.

2:18:08 PM
SENATOR MYERS directed attention to slide 7. He offered his view that this looks like a good model. He expressed concern about how this process would operate in smaller communities without a mobile crisis team. He related his understanding that Fairbanks would not have a 23-hour stabilization center anytime soon. He further asked at what point patients would be transported from their home communities to hubs, such as Fairbanks or Anchorage.

MS. CARPENTER answered that the 1115 waiver would initiate the new services in each state region. She acknowledged that all rural villages would not have a 23-hour Stabilization Center or a short-term Crisis Stabilization Center, but a hub community such as Kotzebue could add one. The only option to treat someone having a mental health crisis is to transport them to Anchorage or Fairbanks. Under the new model, the patient would be closer to home, where the family could have more access. The person could be stabilized by the tribal behavioral health provider and receive community outpatient care when they go home. She stated that the department and the Trust built in flexibility when they developed the statutes to provide a statewide solution. If a community only has a short-term Crisis Stabilization Center, the patient initially will not need to go to a 23-hour Crisis Stabilization Center. She highlighted the goal is to work with communities and avoid overbuilding services because the provider needs to be financially solvent and not require the state to subsidize the program with general fund dollars. She stated the goal was to stabilize an individual, if possible, at home via the call line or by providing services close to home. If this can be accomplished, it will reduce the number of people that need to be transported to city hubs, saving state dollars. Currently, if someone in crisis is not stable enough to travel

on commercial airlines, the department must charter a plane to the rural location to bring them to Anchorage or Fairbanks.

2:21:26 PM
MR. WILLIAMS added that it is important to recognize that this sets up the framework for communities, but it does not mandate that communities establish these centers. In terms of demand, Fairbanks may not need all of these facilities currently, but if the population were to increase, the structure and framework would be in place to meet community members' needs

2:22:16 PM
SENATOR HUGHES commented that she heard the bill in the Senate Health and Social Services Committee. The committee considered seven amendments that brought up concepts, but the amendments had unresolved issues. She indicated some SHSS members asked her to revisit the issues in SJUD. She expressed her interest in reconsidering those amendments at some point.

SENATOR HUGHES asked whether anything in SB 124 would expand the power or authority or broaden the scope related to involuntary commitment, such as someone appearing at the person's door telling them they are being involuntarily committed. She noted that the rumor is that SB 124 could expand the power for someone with political disagreements or religious differences to be involuntarily committed and given psychotropic drugs against their will.

2:24:28 PM
MS. CARPENTER answered no. She directed attention to the new language in Section 12, which would require a peace officer to have probable cause. She read:

> (a) A peace officer who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody ....

MS. CARPENTER explain that when a mental health professional has a person delivered to a facility, they must meet the criteria. The court would review if the person can be held. If a mental health professional were to lie on the application and the

person doesn't meet the criteria, they would be subject to a felony conviction and risk their professional licensure.

SENATOR HUGHES wondered if Mr. Williams had anything to add.

2:25:48 PM
MR. WILLIAMS answered no.

2:25:53 PM
SENATOR HUGHES related her understanding that passing SB 124 would make things less restrictive and provides greater patient protections against involuntary commitment. She reiterated rumors about the bill were that it would make it easier to commit someone involuntarily. Instead, it's more important than ever to have the bill pass. She encouraged anyone with questions to contact members because this bill is an improvement over the existing statute.

2:27:18 PM
CHAIR HOLLAND clarified that besides a peace officer, the portion of Section 12 Ms. Carpenter read also includes a health officer, mental health professional, or physician assistant licensed by the State Medical Board to practice in this state. He acknowledged that some might see that as an expansion of persons who can make involuntary commitment decisions since the only person empowered to make those decisions previously were peace officers. He wondered whether a peace officer was the best person to make those decisions. He offered his view that it is an improvement to include the health care professionals. He asked whether the health officer would typically be a mobile crisis team member.

MS. CARPENTER agreed. She stated that the bill also would change the definition of a peace officer to align with other statutes. She indicated that the definition in Section 27 would have the meaning given in AS 01.10.060(a). She directed attention to the deleted terms in Section 27 in the new definition of health officer, which was a creative method to make a new term that made sense. In addition, an emergency medical technician, paramedic, or firefighter was added to the mobile crisis team. She said the other deleted terms all fell under the definition of mental health professionals. She noted that a physician's assistant was also added to the definition.

2:29:34 PM
SENATOR KIEHL highlighted that the legislature balances protecting public safety and people's rights to the greatest

extent possible. He referred to slide 14. He would like to understand the treatment flow better when someone is in crisis. He wondered whether any of the steps could be skipped. He related a scenario where someone had a break from reality and became violent. He asked whether that person would need to go through the 23-hour intervention first or could a court order be issued to provide more serious treatment to protect public safety.

MS. CARPENTER answered yes. She referred to Section 14, which sets up the statutory requirements for using crisis stabilization centers or crisis residential centers. Section 15 relates to the current hospitalization track. The bill does not remove any tools, so if the situation warrants it and it's not appropriate to go to the first two centers, it's possible to petition the court directly for the hospital track. Meanwhile, the crisis stabilization center would offer better care initially than waiting in a hospital emergency room. It still allows the professionals to make the best decisions for the patient.

CHAIR HOLLAND turned to invited testimony.

2:33:12 PM
JAMES COCKRELL, Commissioner, Department of Public Safety, Anchorage, Alaska, offered his view that SB 124 would significantly improve the state's response to anyone experiencing a mental health crisis. He stated that on a personal level, he had a family member who spent 81 days in prison and was in and out of emergency rooms. All of the calls were directed to law enforcement to handle. Not only did it not help his family member, but it put the person in the system. However, it did not address the problem.

2:35:24 PM
SENATOR HUGHES asked what officers currently encounter because the behavioral crisis model is not yet established.

MR. COCKRELL said that since statehood, Alaska has expected local law enforcement or the Alaska State Troopers to respond to mental health crises. Even with police training, police officers do not have the tools to do so and are not mental health experts. He offered his view that the situation could be handled much differently with the system proposed in SB 124. He estimated that approximately 75 percent of the instances of mental health crises are not law enforcement related. He said it is personally important to him and the department. The Alaska

State Troopers and the Department of Public Safety support SB 124.

2:37:31 PM
SENATOR HUGHES related her understanding that he was speaking about the autistic boy who was pepper-sprayed. She said he told three different encounters. She recalled an incident where a minor or young adult was taken to Mat-Su Regional Medical Center, but due to COVID-19, the person was held for five days and could not see their family, which was not the appropriate care. She heard anecdotally that a trooper drove around all day with a person experiencing a mental health crisis because there was no place to take them.

2:38:39 PM
COMMISSIONER COCKRELL agreed that troopers sometimes must take mentally ill people into custody late in the evenings, trying to find the appropriate place for the person to obtain treatment. He related that the Mat-Su Regional Medical Center increased its beds from 2 to 16, which is a massive help for the department and the people needing mental health services. The Central Peninsula Hospital only has two beds. The troopers typically will take someone experiencing a mental health crisis to a hospital, and the person waits in the emergency room for up to two hours for a psychological evaluation. Currently, Alaska State Troopers' policy is to handcuff anyone put in a patrol car for their safety and to have control over them when they exit the vehicle. However, he opined that is not the right approach to take for those experiencing a mental health crisis.

COMMISSIONER COCKRELL recalled his first experience transporting an 18- year-old woman from the Kenai Peninsula to API. She had threatened suicide and was very frightened from that experience. Those images have haunted him for over 40 years. He offered his belief that the state should be a leader in mental health issues, and it has an opportunity to do so.

2:41:44 PM
MARK REGAN, Legal Director, Disability Law Center, Anchorage, Alaska, spoke in support of SB 124 because the rights of people in crisis are protected under the bill.

MR. REGAN, in response to Senator Hughes' question on the standards and methods used to bring someone in for involuntary treatment or to evaluate them for civil commitment, stated that the standard in current law would apply. A police officer or anyone else must have probable cause that the person is likely

to harm themselves or others or that the person is gravely disabled. SB 124 did not change this language.

MR. REGAN stated that the bill also protects the rights of people at a crisis residential center or a crisis stabilization center if the person in charge wants to hold the person for longer. In those instances, the person in charge must go to a magistrate or judge to request an ex parte order, which requires appointing the public defender agency or another attorney to represent them. This means the person will have an attorney at the beginning of the process with an opportunity to have a hearing within 72 hours if the crisis residential center believes the problem will be resolved or stabilized within seven days. Thus, the person will be able to present their case at the hearing.

2:44:57 PM
MR. REGAN opined that the bill poses no greater risk for those who want their rights protected or for people who do not wish to be brought into the system involuntarily, which is part of the civil commitment system for evaluation.

MR. REGAN provided background information. In 2018, the overstressed evaluation system, particularly at API, collapsed. At that point, API indicated that people would need to be held in jail or hospital emergency rooms, awaiting their civil commitment evaluations, which led to a lawsuit. At the same time, the Trust and the state were working on a Crisis Now proposal to provide therapeutic treatment rather than to place people in crisis in a hospital emergency room or jail. The settlement to the lawsuit was that a Crisis Now system would partially replace the system with one that was easier on people in crisis. He said he hoped that the bill would lead to an improvement for people in crisis.

2:47:25 PM
HELEN ADAMS, Emergency Medical Physician, Alaska Chapter of ACEP, Anchorage, Alaska, provided invited testimony in support of SB 124. She stated that she is an emergency room physician and she also serves on the board of the Alaska Chapter of the American College of Emergency Physicians and the Alaska Psychiatric Institute (API) Board.

DR. ADAMS suggested that this bill would be transformative for Alaskans. She provided her perspective as the physician who signs the paperwork for involuntary commitment. Thus, she makes the determination whether someone is an immediate threat to

themselves or to others. She agreed that this bill would not expand the provisions for involuntary commitment. The current form designates peace officers, police officers, or physicians as the ones to make the determination. This bill would broaden that list to include physician assistants.

DR. ADAMS offered her view that mental health providers and the crisis stabilization center are valuable to Alaskans because health care providers are more specifically trained to determine when this provision should be used. The opportunities to create a hold are not changing under the bill. However, the bill would change who can make involuntary commitment decisions.

DR. ADAMS said she means no disrespect to police officers who must make decisions under incredibly stressful conditions, such as when a person is undergoing a mental health crisis on a bridge. Other times, the situation is more nuanced, such as when an officer is in someone's home where angry people are yelling. It may not be clear which people are in crisis. Further, people are involuntarily committed sometimes because they displayed inappropriate behavior when a police officer's presence triggered a trauma response. However, once the patient is alone with a mental health clinician trained to deescalate the situation, sometimes the person can be treated, released, and use outpatient resources. She characterized the bill as transformative for everyone.

DR. ADAMS described her experience working a shift at a facility with 52 beds, with 18 patients being held voluntarily or involuntarily in emergency room beds awaiting placement. At the same time, 19 people with medical ailments waited 2-4 hours to be seen. She opined that the state needs a 23-hour stabilization center, which might lead to a seven day or longer treatment. She viewed SB 124 as an improvement.

2:52:03 PM
SENATOR HUGHES wondered if a person's medical condition could worsen in the waiting room.

DR. ADAMS agreed. She stated that holding people with mental health disorders in the emergency room (ER) awaiting beds harms them. She explained that proper mental health treatment provides soothing and restorative treatment. Patients receive group therapy and therapeutic activities with an occupational therapist. However, the ER is devoid of those resources. She explained that those mental health patients awaiting placement are in uncomfortable clothing, in rooms stripped of all wires

and tools they might use to harm themselves. A stranger sits on a stool outside a glass door, watching their every movement. They have zero privacy or natural light. A physician and mental health clinician must check them once a day. She characterized this as putting mental health patients in solitary confinement while awaiting placement, which is harmful. These practices should be used as short-term solutions to keep people safe from their self-harming attempts until they can be placed in a proper clinical environment.

DR. ADAMS agreed that patients with appendicitis could rupture because doctors do not have beds available to perform examinations. Further, many mental health patients sit in police vehicles in hospital parking lots awaiting treatment for hours. These patients have no criminal history but need help. She had checked on people with a mental health condition in cuffs, somewhat hogtied, to ensure that the cuffs did not hamper their circulation. Once these patients are under the hospital's care, medical staff must check these patients within an hour of being placed in restraints. Thus, this bill could transform the system.

2:55:34 PM
SENATOR KIEHL remarked that her comments comport with what he has heard in the Juneau community. He asked about an emergency room physician's ability to assess whether someone needs to go to a 23-hour facility, a 7-day facility, or for a longer commitment. He asked how confident she was about the resources an emergency room had to make those determinations.

DR. ADAMS offered her view that as this process rolls out, it will result in more innovative treatment. Some communities will be more equipped than others. Each facility will need to create its triage process and make decisions on a case-by-case basis. She stated that acutely violent, dangerous, patients would likely be cared for at larger hospitals with more security staff. She predicted that those patients would probably be sedated. Anyone who has harmed themselves by ingesting substances and is very intoxicated or drugged poses a threat to society. These patients must be managed at the highest security facilities, such as Mat-Su, Alaska Regional or Providence hospitals, with sufficient capabilities to care for their medical and psychiatric needs. She anticipated that patients would deescalate faster because medical professionals could meet them at their level with a peer and mental health professional. She predicted that patients and staff would be safer. She suggested that people might be surprised that historically

violent patients react differently in peer-appropriate settings. Those patients may use the 23-hour and 7-day resources better than anticipated. She stated that medical personnel at the new facilities would know when they could not handle someone and needed transfer the person having a crisis to the higher level of facilities such as hospitals.

2:58:55 PM
SENATOR KIEHL stated that she addressed that fewer individuals displaying violent behavior will be in emergency rooms under the bill.

DR. ADAMS agreed.

2:59:54 PM
ANN RINGSTAD, Executive Director, NAMI Alaska, Fairbanks, Alaska, provided invited testimony in support of SB 124. She read prepared remarks.

[Original punctuation provided.]

> Thank you for giving us an opportunity to provide testimony in support of SB 124, regarding crisis residential centers and crisis stabilization centers. NAMI Alaska is part of the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.
>
> Mental illness affects more than 1 in 5 adults (50 million people) in the U.S. In Alaska, which translates to over 108,000 individuals – more than three times the population of Juneau!
>
> We know first-hand how those with mental health challenges can struggle with an inadequate system of care, especially those who are experiencing a behavioral health crisis.
>
> She stated he is providing testimony for Dr. Shirley Holloway, the president of NAMI national, and vice president of NAMI Alaska because I think it demonstrates the importance of this legislation. in her previous testimony on HB 172 to the house Finance Committee a few weeks back Doctor Holloway shared the story of her daughter Kathleen's long journey with mental illness and why she became involved with NAMI.

3:01:21 PM
MS. RINGSTAD continued to read prepared remarks.

[Original punctuation provided.]

> Kathleen's last contact with her mother was when she called her during a mental health crisis. Shirley was out of state at the time and she immediately sprang into action, calling her physicians, therapists, neurologists – anyone she could think of to provide support. All who responded said they could maybe see her in two weeks or maybe just take her to the ER and they could deal with it. Four hours into her calls for help, Shirley with boarding and plane to Anchorage to get to Kathleen. She called the Anchorage police and ask for their assistance. By the time they located her, it was too late.
>
> I agree with the ER physician who just testified. I can personally vouch that emergency rooms are not the appropriate 'holding rooms' to assist those individuals who need professional evaluation and treatment in an expedient fashion. ERs deal with medical emergencies, not behavioral health emergencies. I also agree with Steve William's assessment of the current system is broken. If there was a crisis response system in place 10 years ago, Shirley's story might have had a different outcome.
>
> Subacute mental health facilities, including crisis residential centers and crisis stabilization centers are a proven care alternative offering prompt support and evaluation to assist with the real issues of why the individual was brought there in the first place, evaluating what resources they may require, and taking steps to help resolve their mental health challenges.
>
> This "No wrong door" approach to providing care to a person in a psychiatric crisis will facilitate a faster and more appropriate response to a behavioral health crisis.

3:03:04 PM
> We need to reimagine our crisis response system to one that offers help, not handcuffs.

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

We support the work of the Alaska Mental Health Trust Authority and the collaborative efforts of multiple stakeholders including emergency service responders, hospitals and health care providers, the Department of Health and Social Services, Public Safety, Corrections, and Law, and Trust beneficiaries throughout the state who are a part of making the Crisis Now initiative work in their communities.

There is still much work to be done, and this legislation is an important step in the continuum of care for mental health. I will also add that we support the requirements to provide a report to the legislature for one year mark of passage of this legislation to assess the outcomes of the legislation and provide recommendations to strengthen and improve patient outcomes. With the identification of recommended changes to state statutes, regulations, and requirements.

We look forward to a future where this type of behavioral health system is in place throughout Alaska.

We strongly support SB 124 and ask you to support this important legislation to provide a critical piece to the Crisis Now continuum of care. Thank you, Mr. Chairman for allowing me us to testify.

3:05:08 PM
CHAIR HOLLAND held SB 124 in committee.

3:05:19 PM
There being no further business to come before the committee, Chair Holland adjourned the Senate Judiciary Standing Committee meeting at 3:05 p.m.