HB

733

Alaska State Legislature

House

JUNEAU ALASKA

HOUSE HESS COMMITTEE MEETING

MARCH 22, 1976

Present: Sullivan Beirne, Ostrosky Kelley

HB 734 - Rights and Guardianship for disabled - HESS

Dr. Hotchkiss, Pres. of St. Association for Retarded Citizens, very opposed to HB 734

Robert Mothershed, citizens, wishes to stress rehabilitation rather than treatment. 47.70.100 too limiting, shouldn't be limited only to danger to ourselves or others. Call it "habilitation, rather than treatment plan. Under federal law, council has more than advising powers, membership should reflect consumers as provided for in federal law. REcommends putting council in Gov's office.

47.70.170
Should consider possibility of private non-profit corp. for advocacy function. Should be separate advocacy office for mentally ill and dd. Office of advocacy for the mentally disabled in 1 office and "DD" definition in 734 contrary to federal law. Replace Sec 9 with lang. from HB 645. More comprehensive bill necessary to provide more services for DD.

HB 733 - Commitment procedures, mentally ill -HESS

Payment by parents - incorporate the $50 maximum. If only 733 passes, add 47.70.100 from HB 734

Helen Mothershed, DD council recommends substitute for bill for 734. Council should be more than advisory board reflecting federal law.

Robert Mothershead = composition and duties of council should reflect changing federal requirements

EVENING - same agenda

Oseruk, Supports office for DD , services not available in rural areas though Oseruk, A.F.N. Inc.

Dr. William Moore, St. of Ak. Div. of mental health, worked with task force, problems with diagnostic services only available in Anchorage. 733 would be more agreeable if it provided services for communities.

Bob Swain, President of Local Association for retarded citizens.

Jennie Selides opposed to 733

William Mueller for patient of A.P.I.

Fred Selkregg, HB 733 Ak. Mental Health Ass., is in favor of it.

Helen Beirne, should advocacy office be under Gov's office or public defenders office?

Dr. Aaron Wolfe - Pres. of Ak. branch of American Psy. Ass.

Dr. Joe Bloom, secion chief for psyc. at Providence Hosp. HB 733 would prevent treatment of people who need it. No abuse under present statute.

Dr. F. Whelan, A.S.M.A. Mental Health Committee, chairman, the Committee is opposed, present statute adequate and unabused. Representated testamony of psych. who wouldn't attend. all opposed, he is personally opposed.

Judge Moody, representating himself, opposed, no abuse in present system.

Marjorie Bell- usually conducts hearings on commitment anyway

Dr. Rader, Psy. in Anch. Need to protect rights of minors, but 733 goes to far.

Dr. Langdon,= Total bill bad, unnecessary. Present bill was adopted in 1956 federal model act, reworked by the city attorney, Jim Fitzgerald. Problem with administration not with present statute.

Dr. J. Wregget, Child Psy. Problems of criminal provision for doctors, problems with massive paperwork.

Dr. Barry Mendolsohn, child psy. opposed

Dr. Aaron Wolf - opposed

Carol Craig, Psy. intern at U. of Washington. Feels 733 is much like Washingtons law which they have found from experience is unworkable.

Joan Katz, private psychairtrists were asked to join task force and refused..

Gues list-Testimony on HB 733 & 734 in Anchorage, March 22, 1976

Charles Oxereok	A.F.N. Inc.
Dr. William Moore	Ak., Div. of Mental Health
Helen Mothershead	A.R.C.A.
Bob Mothershead	Alaska St. Retarded Childrens Assoc.
Joan M. Katz	Mental Health Task Force Group
Bob Swain	A.R.C.A.
Francis Whelen	Private psychiatrist, Fairbanks
Aaron Wolfe	Pres. Ak. Psy. Assoc.
Joe Bloom	Priv. Psychiatrist, Anchor.
Pat Mills	A.P. I.
Dr. Langdon	Langdon Clinic
Barry ,emde;spjm	Provate Psy. in Anchorage
William Rader	Psychiatrist
Ralph Moody	Superior court judge
Carol Craig	Langdon clinic, psy.
Dr. Wreggit	private psychiatrist.

Alaska State Legislature

House

JUNEAU ALASKA

HOUSES HESS COMMITTEE MEETING

MARCH 16, 1976 7:00 P.M.

Present: Sullivan Ostrosky
Beirne Hackney Parr

Testifying:
Joan Katz, Private Attorney
Richard Peter, Dept. of Law
Carmen Massey, Alaska Legal Services
Joyce Munson, Mental Health Assoc.

HB 733 - Committment procedures/mentally ill HESS

Joan Katz - A.S. 47.30 is poor enough so that it could well lead into sucessful litigation. Biggest problem is that soneone could be held up to 66 days before commitment procedure would go tc court. No right tc council under present statute. Can be indeterminate commitment. Minors have no rights, can be committed at bequest of parents. Justa few problems with present statutes. Task force looked into laws from several other states. Feels that Office of Mental Health Advocate crucial, giving person in commitment process same rights as criminals. Recognize that commitment procedure is complicated and may need simplification, hopefully not at sacrifice of patients rights. New law sets standards for comitment, presently only standards that person can be helped by commitment. Important principle incporporated in bill - least restrictive alternative.

Parr - what could be done with someone who was still dangerous after third 90 day period.

Jim Handy, D.A. Offive, problem with new commitment standard, couldn't commit someone who needed help and wasn't able to judge this.

Joyce Munson, appalled by the present condition of the statutes.

Carmen Massey, presented some technical problems, legal services has had with this bill.

Dick Peters, presented a few practical problems that the A.G.'s office found with the bill.

No motion on bill

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LAW

Office of the Attorney General

Pouch K - State Capitol
Juneau 99811

April 14, 1976

The Honorable Susan Sullivan
Representative
Chairman
House Committee on Health, Education
and Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: HB 733 (mental health law revision)

Dear Representative Sullivan:

This letter is to inform you of the Department of Law's position on this bill. We support what appears to be the basic motivation behind the effort to revise AS 47.30. As we understand that motivation, it is a desire to protect more fully the rights of individuals confronted with mental health problems, and to resolve various problems present in the existing law.

Sharing that general concern with the members of the Mental Health Task Force, it with reluctance that we would urge the legislature not to enact this bill this session and to continue the study of the matter. We would be pleased to work with a committee or task force of the legislature in developing legislation to be introduced in the Tenth Legislature.

Through an assistant attorney general in Anchorage, the Department of Law has participated with the task force's work on the bill before you. Attorney Joan Katz, in her December 3, 1975 cover memo for what appears to be a final draft of the bill, after mentioning various participants, states "The Attorney General's Office, finally, consistently provided us with sound legal insight." Based on this familiarity with the work product of the task force, it is the recommendation of that assistant attorney general and of this department that more work should go into the bill.

We would like to be able to give you at this time a thorough analysis of constitutional requirements relevant to all issues in the bill, and compare those requirements with various provisions in the bill and with the costs and feasibility of implementing those provisions. However, time does not allow such an extensive analysis. We note the various references in Ms. Katz' December 3 memorandum to the fact that the version covered by that memorandum was a draft for which she was soliciting further comments and refinements; and we hope that our few, brief comments in this letter will be taken in the same spirit of cooperation with which they are offered; we believe that further refinements of the bill are essential.

Here are five representative concerns of a policy nature:

1. The commitment standard in proposed AS 47.30.056 is too restrictive. We have already expressed to you and your committee our concern that this proposed commitment standard would not allow for the commitment of individuals who could be committed under the current law and who, we firmly believe everyone will agree, should be committed for their own benefit.

2. As we have also discussed with you, the involuntary commitment procedure in Article 1B, with its 14-day period and then 90-day periods, with a limitation of three of the latter (proposed AS 47.30.161), appears overly restrictive without assuring that the patient will benefit from those restrictions. The review procedure at the end of each commitment period would necessitate considerable amounts of judicial, attorney, and medical time even when it is apparent that the particular patient must necessarily receive treatment for a longer period. When considering the patient's right not to be simply "stored on a shelf" in a mental hospital, the administrative feasibility of proposals to assure him of that right must be carefully considered. An alternative to the approach presently in the bill, and hopefully an improvement of the present law, might be a provision which would assure judicial review at least annually but allow for it more frequently if the judge orders it in particular cases or if administrative or medical officials believe it is advisable. This would appear to be more appropriately tailored to each individual's problems, while not unduly burdening the administrative and judicial systems.

3. The proposal in AS 47.30.016 for an office of mental health advocate may have merit as an ideal, but is the sort of thing that must be weighed carefully against the financial capabilities of the state.

4. A fundamental change made by the bill is the decentralization of the commitment process. Petitions for evaluation are to be made to district offices. District officials make investigations and initiate 72-hour evaluations at evaluation facilities by mental health professionals. These professionals then petition for judicial commitment. However, practically speaking, there are no district offices and officials, no evaluation facilities, and no treatment facilities in the various districts throughout the state. Alaska is not at this time geared for the type of procedure proposed in the bill.

5. Proposed AS 47.30.321(15), the definition of "mental illness", excludes mental retardation. This would prevent the hospitalization of the severely mentally retarded under this bill. Currently pending House Bill No. 734, however, provides for commitment of the "developmentally disabled" under the terms of this bill. The two bills must be thoughtfully coordinated.

In addition, the assistant attorney general who has worked with the revision task force has mentioned at least two dozen examples of difficulties with the details of the bill. These are problems of internal inconsistency, ambiguity, uncertainty, curiousity (in the sense of not knowing why a particular provision says what it says), and miscellaneous style and language difficulties. He has mentioned these examples of the kinds of difficulties presented by the bill not to denigrate the work of the task force or any of its members, nor to thwart mental health law revision, but in an effort to improve the bill before its eventual enactment. (A listing here of the points he has mentioned would serve no useful purpose, and would merely further lengthen this letter.)

Again, let me emphasize our willingness to work with a legislative task force or committee during the legislative interim in order to further refine the product before you.

Yours truly,

AVRUM M. GROSS
ATTORNEY GENERAL

By: Wilson L. Condon
Deputy Attorney General

WLC:md:AHP

cc: The Honorable Genie Chance
Senator
Alaska State Legislature

The Honorable Clark Gruening
Representative
Alaska State Legislature

March 18, 1976

Senator Kay Poland
State of Alaska
Pouch V
Juneau, AK 99801

Dear Senator Poland:

I have recently become aware of legislation entitled HB 733 which, as far as I am concerned, is a step backward almost into the dark ages with respect to commitment proceedings.

You may recall the difficulty we had committing patients in the past. It required a trial by jury, consumed a lot of time, and sometimes left people who were really dangerous to themselves and/or to others at large for days.

Finally, with the passage of new legislation, we are now able to hospitalize the patients almost at a moment's notice. This only requires a physician's certificate of necessity of hospitalization and is limited to three days at which time the patient can, if they desire, demand a course hearing or a trial by jury to determine if they are "sane" or not.

I know of no violation of human dignity that have resulted from this law in our area. I know of several cases where patients who were rather profound suicide risks where hospitalization possibly prevented them from eliminating themselves from out society as well as several others who were dangerous to others that could be taken off the streets and placed in the hospital. In Kodiak, this sometimes only means a short period of hospitalization with medication and then discharge, or in other cases it means transfer to the Alaska Psychiatric Institute if they do not respond to care locally.

The new system recomplicates the commitment procedure and, as far as I am able to determine, provides employment for more lawyers to get on adjudicating panals, and I think we certainly do not need that in Alaska at this time.

Sincerely,

R. Holmes Johnson, M.D.

RHJ:n

In a meeting of the Mental Health Committee of the Alaska State Medical Association held in Anchorage, March 18, 1976, a position was taken on House Bill 733, and it is as follows:

The Alaska State Medical Association Mental Health Committee is on record as opposing HB 733 and recommends its defeat or withdrawal for the following reasons.

1. The present mental health commitment law has generally worked adequately and contains safeguards for civil rights of committed patients;

2. No significant abuses of civil rights have occurred under this law;

3. Such variances as may have occurred are due to failures of either the court system or department personnel. No law can be more adequate than those administering it;

4. HB 733, although using the term mental illness, tends to deny it as a medical practice by codifying in law methods of diagnosis and treatment;

5. HB 733 would set up still another costly layer of bureaucratic machinery (the mental health advocate) with its own human frailties and inadequacies; especially since the existing legislation already calls for counsel.

6. Although no fiscal note is seen, it is obvious that this bill would enormously increase the costs of public mental illness care in addition to making it much more cumbersome.

7. That we would be willing to work toward further improvement of the already existing statutes (title 47.0).

Francis J. Whelan, M.D.
Chairman

Fairbanks
3-22-76

Dear Dr Whelan

This letter is intended to affirm my opposition to the passage of H B 733, the proposed revision of the mental health code. You may use the letter in any way you see fit.

Because of the pressure of time, I will not be exhaustive in my criticism of the proposed legislation. As indicated in our previous conversation, I am in general agreement with the stand taken by our psychiatric association against this bill.

It has been estimated that the proposed revision would cost at least one million dollars for its implementation in the Northern Region alone, and Alaska could use this money better to increase the resources available for the diagnosis and treatment of mental illness.

I see nothing in this proposed revision which would be of direct benefit to any mentally ill person. Rather than pass this legislation, I would prefer to have the legislature simply rescind any part of the present statutes which they feel are faulty.

Sincerely yours

Harold South

Lib 23

January 9, 1976

Representative Clark Gruening
310 K Street, Suite 701
Anchorage, Alaska 99504

RE: Revised Alaska Mental Health Laws

Dear Representative Gruening,

Our office belatedly received a copy of the working draft revision of Title 47, Chapter 30. I commend you and your Task Force Sub-committee on what appears to be, on first reading, an excellent job on a very formidable task. The obvious effort and manhours that went into the proposed revision is reflected in the quality of your working draft. Joan Katz should be especially commended. Unfortunately the belated receipt (1/6/76) of the working draft allowed little time for review and comment prior to your designated January 8, 1976 request for input. Our office staff is presently reviewing the draft and I will forward our collective commentary approximately January 12 or 13. In the interim however, I wanted to respond to the January 8 deadline with some specific, highly personal concerns of mine referring to your present definition of "Psychologist".

"Psychologist" is presently defined as "a person with a doctoral degree from an accredited university or college in a program that is primary psychological and with no less than two years of supervised experience, one of which is subsequent to the granting of the doctoral degree; or a person licensed or certified as a psychologist for the independent practice of psychology by the State Board of Examiners of Psychology". This definition was obviously offered by the Alaska Psychological Association and/or the Psychology Board of Examiners. It is important to note that licensure in this state is contingent upon a doctoral degree.

I would like to emphatically point out that this state, as others, contains many experienced professional psychologists who do not have a doctoral degree. Indeed, the bulk of psychological services in most states is provided by persons who do not meet your proposed definition of "Psychologist". To confine "Psychologist" to your present definition has many ramifications, some very personal to me and some that relate more broadly to eventual program development capability statewide.

Indeed, if the present definition remains, I, along with others, would be excluded in the standing definitions of "Mental Health Professional", "Treatment Team", "Evaluation Personnel", etc. This seems rather ironic in view of my Masters Degree in Clinical Psychology, serving a one year internship and several subsequent years of

supervision, employment by two state governments for 17 years in a professional Psychologist capacity, and licensure in the state of Illinois for the independent practice of Psychology. It is particularly ironic in view of the fact that I participated in the clinical training and supervision of those persons (PhD candidates and post-doctoral interns) who now propose that I may not call myself a "Psychologist", or even a "Mental Health Professional". I presently have on my staff one of the most capable and competently trained Child Psychologists in the state who also lacks a doctoral degree and would be similarly excluded, as would many other capable existing providers. In this sense, adhering to the present definition would substantially reduce existing statewide resources and make the legislation even more difficult and expensive to implement.

It is important to note that the present state psychologist licensing laws offer no assurance whatsoever of competence in the area of mental illness. <u>There are persons presently licensed for the independent practice of Psychology in the state who have never had professional dealings with an emotionally ill person!</u> Please understand that I am not taking our present psychologist licensing laws to task. I feel that they are somewhat remiss in not requiring more rigid experiential requirements and that they lean too heavily and arbitrarily upon the doctoral degree. I can however give some support to that requirement for the <u>independent</u> practice of psychology where there is no potential for external quality control or professional accountability. Under such circumstances requiring the doctoral degree <u>may</u> assure higher quality services to the public, though this has never been demonstrated. To force that particular requirement on "mental health systems" (MH Clinics, CMHC's, etc) where there is a designated line of professional accountability and quality control appears unrealistic and frankly uneconomical.

The present definition of "Psychologist" requiring the terminal degree is also inconsistent with definitions of other professions. Note that "Psychiatrist" does not require Board Certification, and "Social Worker" does not require ACSW status or licensure. Indeed, "Social Worker" is defined as "a person with a Masters' or further advanced degree from an accredited school of social work". This definition even fails to include experience requirements beyond the Masters' degree, yet this catagory has equal standing as a Mental Health Professional along with psychiatrists and doctoral level psychologists.

In short, I feel that the requirement for a doctoral degree or state licensure (which requires the doctoral degree) for a person to be entitled "Psychologist" under the law is unrealistic, inconsistent with the definitions of the other professional groups, and would deprive the state of a substantial portion of the services that are presently rendered. As an alternative, I offer the following definition:

> "<u>Psychologist</u>": A person with a Masters' or further advanced degree from an accredited university or college in a program that is primary psychological and with no less than three years of supervised experience in the evaluation and treatment of the mentally ill.

Please note that this propose. definition specifies the area of training and experience and allows status under the law for many of

those persons who are presently providing the bulk of psychological services in the state. If anyone objects to a Masters' degree level designation, note that it exceeds significantly the definition of "social worker".

I am confident that my proposed ammendment will meet considerable resistance from the Alaska Psychological Association and the Psychological Board of Examiners, but historically both of these groups have been (at least in this state) quite intent on establishing a closed system and have been largely guided by the profit motive. Adopting their arbitrary, impractical standards imposes a severe penalty on some individuals as well as eventual program development, and frankly has listle application to systems where there is a line of professional clinical accountability.

Some objection may also be anticipated regarding eventual JCAH accreditation standards and designing the law to conform to their eventual definitions for "Qualified" staff. If this holds for psychologists, then it must hold for all professions. To do this however would overnight reduce the state's public psychiatric manpower to approximately two persons who are Board Certified, and the Social Worker force to a mere handfull who have ACSW status. In short, adopting probably JCAH standards is totally unrealistic if the law is to be implemented. In addition, JCAH standards are voluntary for CMHC programs, and though desirable, with the present state of the art, totally unreachable by any program in the state within the next five years.

Thank you for your consideration of this ammendment and our staff will be forwarding a collective, broader commentary as soon as possible.

Sincerely yours,

Jack G. McCombs
Regional Supervisor

JGM:wb

cc: Joan Katz
Jim Price
Bill Moore, PhD

STATE OF ALASKA / WILLIAM A. EGAN, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF MENTAL HEALTH / 103 CUSHMAN
FAIRBANKS 99701

January 29, 1975

Representative Clark Gruening
Chairman Mental Health Code Revision
Sub Committee
310 K Street
Suite 701
Anchorage, Alaska 99501

Dear Representative Gruening:

I apologize for the delay in getting this review and comment on the proposed Mental Health Code Revision to your office, but somehow our office was omitted from the original distribution of your draft copy. Unfortunatly, the pressures of providing direct services delayed staff input for an additional period.

First of all, you and your committee are to be commended on the immense amount of work that went into this draft copy. The entire document reflects a thoughtfulness about protecting patient rights which is exceptionally refreshing, especially in light of the present statutes. Our staff had a lengthy list of very specific questions about the proposed legislation, most of which is related to specific operational details of the law or specific definitions. In view of the fact that this is a work draft, I will save you and your committee those questions, many of which will probably be answered in a revised draft.

I sincerely hope that the following comments are not interperted as a criticism of your efforts; rather, as observations about the present draft and its implications. In a very broad sense, the persistent attention to patient rights overides any potential negative comments, and certainly comprises the core of strength of the entire document. At the same time, it poses certain weaknesses.

Unfortunately, the amount of detail necessary to adequately protect patient rights poses a paradox when one considers implementation of the law. In its present form, though I strongly agree in principle with the intent, I feel the law is quite impossible to implement, especially in the rural areas. It appears that many of the provisions that consider rural contingencies are so loose that they many actually provide statewide "loopholes" subject to abuse. An example of this would be the section

allowing detention of the person in a jail or correctional facility until after an emergency has passed or no longer than 7 days, whichever limit is reached first. Though it may be that this provision was included for rural areas that have no medical facilities, it is subject to abuse in urban areas as well. In addition the draft copy provides only superficial client right protection, because many on the "shalls" fundamently reduce down to an individual physicians' judgement, and in these instances, though patient rights are addressed, there is no practical difference from the situation as it now exists. I'm sure that it has been indicated to you by many sources that the actual time frames specified in the law, though I strongly support them in general, may be difficult to achieve with the present capability of both our legal and mental health systems. I would suggest that these circumstances alone would move people to seek every loophole possible in the name of psychiatric and social management which may actually lead to more overt abuses than exist with the present statutes. In short, I guess that's the primary concern;the lack of present capability compounded by cumbersome and expensive legal mechanisms would, in effect, result in more abuse of rights than the present statutes.

An additional factor related to the above is the immense cost that would be involved in gearing up both the legal and mental health systems to allow implementation. The specified personnel are simply absent in most rural areas, as is the legal capability. The present systems, especially the legal, are presently overloaded to the point which precludes ability to accomodate this legislation. Though it is difficult to estimate the cost of implementing this legislation, my rough calculation approximates a minimum of 1 million dollars per annum for the Northern Region alone. This figure would include added costs to the judiciary, transportation, attorneys fees, additional mental health manpower and contractiogal hospital services. It does not include anticipated program start-up costs. I may be way off, but I am confident that I did not underestimate.

Our staff also unanimously felt that the Mental Health Advocate Office should not be attached to the Department of Health and Social Services, rather it should be attached to the Department of Law, most likely responsible directly to the Attorney General.

It would also be very useful at the beginning of the statute itself to state some of the guiding principles, extracting them from the procedural mechanisms, which should be in their own section. I note for example that "Placement

in the closest facility", though certainly a guiding principle in the draft, is somewhat hidden away in one of the procedural mechanisms and easily missed by those persons actually responsible for implementing procedures.

One final comment from our staff addresses the necessity for psychologists to have a Doctoral Degree to be considered a "Mental Health Professional", member of a "treatment team", etc, under the proposed draft. As I pointed out in separate, earlier correspondence with you, this definition eliminates many capable experienced psychologists who are presently providing a broad range of valuable services from consideration under the act. Indeed, this definition was seemly adopted from the State Licencing Act which pertains primarily to the independent practice of psychology where there is no established line of clinical accountability. Applying this particular standard (which I also have some very practical questions about) to a public system with delineated lines of clinical accountability has questionable relevance, and would substantially reduce our already thinnly-stretched mental health manpower. This definition is also inconsistant with that of "Social Worker" who has full status under the law with a Masters Degree without even the requirement of postgraduate training or experience. Our proposed alternative definition, which provides firm experience requirements and is immensly more practical is:

> "Psychologist"; a person with a Masters or further advanced advanced degree from an accredited University or College in a program that is primarily psychological and with no less than three years of supervised experience in the evaluation and treatment of the mentally ill.

Please refer to my earlier correspondence of January 9, 1976 for a more detailed discussion of this issue.

In closing, I would like to thank you and your committee for the work you have done on this legislation. It is obvious that you have made efforts to walk the thin line between adequate protection of civil rights and practical implementation. Unfortunately, I do not beleive you have quite succeeded in this respect. I am looking forward to future drafts and hope that our review and comment has been useful.

Sincerely yours,

Jack McCombs
Regional Supervisor

JC/mc

cc: Joan Katz
James Price

JOAN M. KATZ
ATTORNEY AT LAW
645 G. STREET, SUITE 401
ANCHORAGE, ALASKA 99501
(907) 272-1731

March 25, 1976

Dr. Jerry L. Schrader
Director
Division of Mental Health
Pouch H-04
Juneau, Alaska 99811

Dear Dr. Schrader:

I enjoyed meeting with you in Juneau. As promised there, the following are my item-by-item responses to your Department's comments on HB 733. I hope the psychiatrists' testimony in Anchorage has not rendered this issue entirely moot.

1. Page 1, Line 15 & 16. No objection.

2. Page 4, Line 10. No objection.

3. Page 8, Line 27. The concept of anyone in the State paying for a private attorney may have to be reconsidered. But if the Mental Health Advocate is not involved, I do not think the funds should come out of that agency's budget. This is not a legal concern, however, and others would be more suited to respond. The Task Force did not address this issue in detail.

4. Page 11, Line 11. No objection.

5. Page 13, Line 6. No objection.

6. Page 14, Line 11. No objection.

7. Page 16, Line 24. See number 3, above.

8. Page 28, Line 1. No objection.

9. Page 29, Lines 1 & 2. No objection, but not necessary because authorized absence must be in patient's "best interests" which would include the fact that he would not be likely to cause serious harm to himself.

10. Page 38, Line 17. No objection.

11. Page 41, Line 28. No legal objection, but certain members of the Task Force felt strongly about this matter of confidentiality.

12. Page 42, Lines 21 & 22. If judicial remedies are totally independent of the grievance process, patients would not have to exhaust their administrative remedies prior to going to court. Since many of these rights are in the nature of constitutional guaranties, the judicial system would be the appropriate place of final resort for the grievance process. From a practical standpoint, I would be reluctant to see an additional layer of appeals added by including the Director of the Division after the head of the facility and before the courts. Thus, I would recommend against any change in this area.

13. Page 43, Line 25. This provision was taken without discussion from the existing law; no comment from a legal standpoint.

14. Page 47, Line 1. I would prefer that "amount of money" be left in the bill and the words "or other provision" be added following that phrase to completely protect the patient.

15. Page 48, Line 28. Without the word "all" there would be no way of knowing on which property a lien would attach. Thus, you would either need to devise a more specific provision specifying the kinds of property on which, or circumstances in which, a lien would attach, or live with the fact that the State does not have to execute on any given lien when to do so would be detrimental to the patient's welfare.

16. Page 49, Line 3. No objection to content. Wording might be changed to read: "The department may waive this debt when it finds that such waiver is in the best interest of the State."

17. Page 50, Line 3. No objection.

18. Page 50, Line 25. No objection.

19. Page 51, Line 1. This language refers to the fact that certain facilities will be designated "evaluation facilities" under the terms of the bill, while others may merely be used as places of evaluation by evaluation personnel transported into a community without such a facility.

20. Page 51, Line 2. This was not discussed in detail by the Task Force, and I am not certain of what members' views would be. It is possible that they would prefer transport to another locale if a correctional facility were the only place where an evaluation could take place in the respondent's community.

21. Page 51, Line 14. Agree to delete words "intermediate and long-range" but believe the rest of paragraph (B) to be an essential part of the treatment plan.

22. Page 53, Line 13. No objection.

23. Page 53, Line 23 (16) - "minor" and Line 24(17) "Peace officers". The definition of "minor" was discussed at considerable length. Because the effect of AS 9.65.100 is unclear, it was thought that the age of 16 was necessary to protect the 16 and 17 year old as much as possible. It was recognized that this provision would be inconsistent with the age of minors in other statutes. In light of the fact that the whole treatment of minors in HB 733 will probably be receiving more in-depth examination, any decision as to the appropriate age limit might best be postponed. The definition of "peace officer" was taken directly from the existing statute. No objection to a revision.

24. Page 54, Line 9(20). I am aware of numerous comments on the definition of "psychologist". Bill Moore suggested the definition used. While revision seems necessary, the Department's suggestion is too vague. "[A]dequate experience" should be defined either in the law or in regulations.

25. Page 55, Line 5(26). No objection to content. For clarity, I would suggest that the phrase read "psychiatrist or licensed physiscian designated by the department as a mental health professional".

These are my comments--a mixture of Task Force thinking and legal reasoning. Hope they are of use to you. Please advise if I can be of further assistance.

Sincerely,

Joan M. Katz

JMK/am

cc: Mr. Doug Schoenberg
Ms. Louise Ma

POSITION PAPER

HB 733

Alaska Legal Services Corporation
By: Carmen Massey
Supervising Attorney
Juneau Office

Alaska Legal Services Corporation's interest in HB 733 results from its involvement with persons who are being involuntarily committed and with persons who are already committed but who want to be released or transferred or who have a grievance against the institution or personnel who are involved with their case. Our special concern is with the procedures that are currently authorized under law for involuntary commitments and releases.

Our office is currently involved in litigation regarding the constitutionality of current A.S. 47.30.010-340.

Currently, a person may be involuntarily hospitalized or re-hospitalized without a judicial hearing (A.S. 47.30.020, .030, .210). Or, he may be involuntarily hospitalized after a judicial proceeding (A.S. 47.030.070) which, in our opinion, does not provide procedural safeguards mandated by the Constitution of the United States and the State of Alaska. If a person who is hospitalized wants to be released he may obtain a judicial hearing by filing a petition with the Superior Court (A.S. 47.30.060) or by filing a Complaint for a Writ of Habeas Corpus. These provisions authorize commitment not only of those who are dangerous but also those who are "mentally ill and in need of [immediate] care or treatment in a hospital [and because of illness, lack sufficient capacity to make responsible decisions concerning hospitalization]."[1]

Our interest is in securing for any person who is in danger of being involuntarily committed:

1. Clear and precise standards for involuntary commitment including the provision that no person shall be involuntarily committed unless he is clearly dangerous to others.

2. A judicial hearing with all the procedural protection

1/ The words in brackets reflect the different tests authorized by A.S. 47.30.020, 47.30.030 and 47.30.070. A.S. 47.30.210 authorizes involuntary rehospitalization if there is a "reason to believe that it is to the best interest of the patient to be rehospitalized."

required by the Constitution before the commitment or, in emergency situations, immediately afterward. A constitutionally adequate judicial proceeding includes the provision of appointed counsel from the first stage, a warning of all constitutional rights, including the privilege against self-incrimination, at the first stage, notice with particularity of all alleged facts which form the basis of a commitment proceeding and the names of all witnesses who will testify as to the alleged facts, and a standard of proof that assures that no person will be committed unless the judicial officer is convinced beyond a reasonable doubt that the proposed patient is dangerous. There should not be any relaxation of the rules of evidence.

3. A right to an automatic review or release after a specified period of commitment.

We support HB 733 in that it is a great improvement over existing law. The following comments are mainly concerned with matters of drafting in that we found some of the provisions unclear, especially when read in connection with other provisions. The comments are limited to the areas discussed above. We do not take a position on the other areas covered by HB 733 such as the creation of the Office of Mental Health Advocate and interstate transfers.

--On page 7, line 22 is "less restrictive alternative", the same as "least restrictive alternative" as defined on page 52, lines 20-27? If so, the words used should be reconciled; if not, a definition of "less restrictive alternative" should be included in Sec. 47.30.321.

--Page 11, lines 14-23. This provision should specify that when the district official begins his investigation he has to deliver a copy of the petition and a notice of his rights to the respondent.

--Page 11, line 27- page 12, line 5. We recommend that this section specify that if there is no evaluation facility in the respondent's community, the preferred method of evaluation is to have evaluation personnel brought into the community and only where this is impractical should the respondent be forced to travel.

--Page 12, line 25, the following words should be added: (6)"notice that the respondent has a right to remain silent and he is not required to give information to or answer questions of any person."

--Page 12, lines 25-29. This provision should specify that if a new investigation is made, this fact plus the results of the investigation must be set out in writing and served with the Summons.

--Page 13, lines 1-8. This section should specify the procedures which a district official must follow in order to have a respondent taken into custody by a peace officer. At the very least, an endorsement from a superior court judge should be required.

--Page 13, lines 15-18. Same comment as above.

--Page 14, lines 21-22. See comment above regarding page 11, lines 14-23. It should be made clear that the petition and a notice of his rights regarding commitment procedures should be served on the respondent at the time the investigation is commenced. It may be appropriate to also serve a copy at the time the person is detained as set forth in proposed Section 47.30.071.

--Page 15, lines 7-13. This provision should make clear that if the respondent does not have an attorney, a copy of the investigative report must be served on the respondent.

--Page 15, line 29 - page 16, line 16. Again, it should be made clear that the respondent has a right to receive notice of his rights at the time the investigation is begun.

--Page 19, lines 15-19. See comment above regarding page 7, line 22.

--Page 20, lines 5-7. This provision should specify how long before the probable cause hearing the petition must be sent to the respondent, his attorney and his guardian.

--Page 21, lines 7-14. We believe this section weakens the rights of the proposed mental patient. Evidentiary rules applicable in other judicial proceedings should be applicable. Hearsay statements should not be admissable.

--Page 21, line 17. The words "by a preponderence of the evidence" should be deleted and in their place inserted the words "beyond a reasonable doubt."

--Page 24, lines 7-8. The time in which the petition must be sent should be specified.

--Page 29, lines 3-8. This section is unclear as to what procedures must be followed to cause the respondent to be taken into custody. This should be clarified.

--Page 30, lines 18-25. It is unclear if a person may be committed to 3-90 day periods of outpatient care in addition to 3-90 day periods of institutionalization or if the total number of commitment periods cannot exceed 3-90 day periods. This should be made clear.

--Page 32, lines 12-21. See comment to page 30, lines 18-25.

--Page 38, lines 22-24. The term "in full accord with full rights of due process" is unclear. The rights should be specified.

--Page 39, line 16. Unless "proscribed" is substituted for "prescribed", this section is very unclear.

--Page 53, lines 14-15. The office of the Mental Health Advocate should be furnished with a list of qualifications of all "mental health professionals" involved in commitment proceedings and should be entitled to challenge the designation of physicians and registered nurses as mental health professionals if they do not satisfy the requirements regarding education and training levels in the psychiatric field.

DATED: March 16, 1976.

Carmen Massey
Supervising Attorney

RECOMMENDATIONS OF DEPARTMENT OF LAW ON HOUSE BILL 733 (Mentally ill persons.)

Attorneys in the Department of Law who are involved directly with the commitment of mentally ill persons have made these comments on House Bill 773.

In general they feel that this measure requires some additional work because the task force has been hampered by time limitations and there is need for further revision before enactment.

1. This bill would provide for specific commitment periods rather than the indeterminate term allowed by the present statute. There is certainly a need to insure that the patient's condition is reviewed frequently enough to perceive significant changes, which is not required now, but the Department of Law believes that the proposed 90-day commitments with the necessity of a hearing before an extension is made, may be unduly cumbersome. As an alternative we would suggest that the bill provide for a statutory annual review of commitments, with the court authorized to order more frequent reviews if it sees fit, and then give administrative and medical officials discretion to make additional reviews at any time their judgement dictates. This approach would be tailored more closely to the needs of the individual patient, and the severity of his condition. It is often recognized at the outset that a patient will not be ready for release at the end of 90 days or even 180 days.

2. There is concern that the new commitment standard provided by proposed Sec. 47.30.050 will be so restrictive that it will prevent the

desirable hospitalization of many who are covered by present law. AS 47.30.070(i) now provides these standards for hospitalization by the court:

> . . . the proposed patient is mentally ill and (1) because of his illness is likely to injure himself or others if allowed to remain at liberty; or (2) is in need of immediate care or treatment in a hospital, and because of his illness, lacks sufficient insight or capacity to make reasonable decisions concerning hospitalization.

The proposed Sec. 56 standard is:

> . . . he has a mental illness and as a consequence is likely to cause serious harm to himself or others and if there is reason to believe that immediate inpatient care and treatment could improve his mental condition.

This removes the test of "lack of sufficient insight or capacity to make reasonable decisions concerning hospitalization" and substitutes for it "reason to believe that immediate inpatient care and treatment could improve his mental condition." It also describes the harm as "serious", and replaces "or" with "and". Thus, instead of requiring the likelihood of injury or need of care and lack of capacity; this bill would require the likelihood of serious harm and the belief that care would improve the patient's condition.

Attorneys have cited several instances recently where patients have done minor but actual injury to themselves, or their behavior toward others has fallen short of even a threat of injury, but is not socially acceptable. They see the possibility that if direct commitment is not possible in the latter case, criminal harges may be brought which could result in eventual commitment but only after the stigma of crim-

inality has attached. They say that frequently although a patient has no injurious tendencies, he requires hospitalization to remove him from his usual environment although his mental condition may not be improved by such a change.

3. It is also suggested that the requirements of the proposed Sec. 47.30.141 on jury findings could be modified to facilitate justifiable commitment. Subsection (3) requires that the court or jury find "that the respondent has received adequate care and treatment under the 14-day commitment"; and subsection (4) requires "that there is reason to believe that the respondent's mental condition will be improved by the 90-day commitment." It is claimed that the 14-day commitment is often in a local facility where treatment and care cannot be completely adequate. And there is the frequent situation where the patient's condition is so serious that no improvement can be foreseen during a 90-day commitment, but there is no doubt that hospitalization is indicated.

4. An objection has been raised too, to the elimination of mental retardation alone from the definition of mental illness in proposed Sec. 47.30.321(15). It would provide:

> . . . mental retardation, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;

This change would prevent the hospitalization, under the terms of House Bill 733, of the severely mentally retarded unless they have other mental illness. Another bill under consideration, House Bill 734, makes provision in proposed Sec. 47.70.100 for judicial commitment under House Bill 733 of the developmentally disabled -- which includes mentally retarded -- "who constitute a danger to themselves or to others", but this cross authority is unwieldy and possibly in direct conflict with House

Bill 733. Its effect would also be dependent upon the passage of House Bill 734. The present practice is to commit the severely mentally retarded first to the Alaska Psychiatric Institute, and eventually to such institutions as Harborview Memorial Hospital in Valdez which are equipped to care for the mentally retarded.

These are the chief concerns of the Department of Law with the revision of AS 47.30 proposed by House Bill 733.

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POSITION PAPER
HB 733

"An Act relating to services and commitment procedures for mentally ill. persons; and providing for an effective date."

Effect: This Act replaces the existing mental health statutes. It substantilly modifies the present commitment procedures, clarifies the basic rights of mentally ill individuals and restricts the care of the mentally retarded to those individuals who are mentally ill. In addition, it creates an Office of the Mental Health Advocate to assume the proper functioning of these laws. The overall effect is to provide that all mental commitments are subject to due process. It mandates the designation of district evaluation facilities and adapts a more restrictive admission criteria. This Act will focus the delivery of mental health services in the community.

Discussion: Following the Report of the Joint Commission on Mental Health in 1961, the trend in the United States has been to stimulate the development of community mental health services and restrict the utilization of state mental institutions. In recent years, numerous states, including Washington, California, and Oregon have revised their commitment laws to assure that these procedures are subject to due process. The basic purpose is to ensure that persons are not unnecessarily deprived of their freedom by commitment to mental institutions and to ensure that those who are committed have their rights protected, including the right to adequate treatment. The right to treatment requires that treatment will be based on a plan provided by qualified practitioners and periodically reviewed. This Act substantially corrects the deficiencies in the present mental health act. We have suggested some minor revisions for the purpose of clarification and administration of the Act. The following is a list of these recommendations by page and line number:

Page 1, Line 15&16 - The referral to the Surgeon General is no longer necessary. This is a holdover from territorial days - Delete "and submit to the Surgeon General of the United States Public Health Service."

Page 4, Line 10 - The reference to "The department" should be deleted and "The Office of the Mental Health Advocate" substituted for the sake of consistency.

Page 8, Line 27 - Delete "department's" expense and add "Office of the Mental Health Advocate's" expense.

Page 11, Line 11 - Delete "all" persons. The addition of "all" might make it impossible to carry out the intent of the Act, since "all" persons who have knowledge of facts may not be remembered under stress by the petitioner and negate the proceedings on a technical basis.

Page 13, Line 6 - Delete "may" take and substitute "shall" take. This should be an obligation of the peace officer and not permissive.

Page 14, Line 11 - Delete "possible" and substitute "practicable".

Page 16, Line 24 - Delete "department's" expense and add "Office of Mental Health Advocate's" expense.

Page 28, Line 1 - Insert "consecutive" to read "three consecutive 90-day" for the sake of clarity.

Page 29, Lines 1&2 - Add "to himself" to read "serious bodily harm to himself or others" for the sake of consistency.

Page 38, Line 17 - A recommended change in language to further clarify the restricted treatment modalities. Delete "electric shock" and substitute and add"electric-convulsive therapy, aversive conditioning, psychosurgery".

Page 41, Line 28 - The necessity to obtain consent from each person would make statistical research practically impossible and historical research impossible. Therefore it is recommended that for the purposes of maintaining health statistics "his consent is given" be deleted and a separate paragraph of provisions of current authorized research be developed.

Page 42, Lines 21&22 - Delete "court" and substitute "Director of the Division of Mental Health and Developmental Disabilities". Add "The decision of the Director is final for the purpose of a grievance." The appeal procedure is already guaranteed in the law and is substantially different from a grievance procedure which is designed to avoid going to a court procedure.

Page 43, Line 25

Sec 47.30.266 - We do not object to this section but as a practical and enforceable provision we have found that U.S. agencies follow the law of the State in which they are located and attempts to maintain jurisdiction have resulted in a refusal to accept transfer.

Page 47, Line 1 - Delete "amount of money" and add "provision". This change is necessary to assist some persons where "in kind" resources would be more in the interest of the patient rather than money.

Page 48, Line 28 - Delete "all" in "against all property". "All" property is too all-inclusive and does not recognize individual circumstances.

Page 49, Line 3 - Add, after "have been paid", "The Department may waive this debt when they find it is in the best interests of the State." This additional language is necessary to expedite accounting procedures to remove uncollectable debts from the account's receivable ledgers without the necessity of seeking legislative approval for every accounting transaction.

Page 50, Line 3 - After "peace officer" add"or other state or local government employees".

Page 50, Line 25 - Add "Likelihood of imminent serious harm to himself or others or an active." - For the purpose of consistency.

Page 51, Line 1 - Delete maybe "or be" used. No meaning.

Page 51, Line 2 - Add "if there is another practicable place of detention providing security." Consistency of language.

Page 51, Line 14 - Delete "statement of intermediate and long range objectives." - Undefinable.

Page 53, Line 13 - Add to "licensed physicians and registered nurses", "and paraprofessionals". The addition of paraprofessionals is required in Alaska where professional personnel are not available nor always desirable. Certified or Licensed paraprofessionals can often provide emergency care and evaluation and are necessary in bush communities.

Page 53, Line 23 (16) - "minor"
Line 24 (17) - "peace officers"
These definitions should be researched for consistency with other Alaska Statutes and probably should not be redefined. A "peace officer" definition including a public health nurse is not acceptable. It is also not necessary to define a minor at age 16 in order to expedite voluntary admission. AS.9.65.100 provides for the admission of minors without parental consent for the purposes of medical care.

Page 54, Line 9 (20) - Defining "psychologist". This definition should be expanded to include Master's degree psychologists. Master's degree psychologists with adequate experience are now providing a great deal of the care and treatment of the mentally ill. Restrictive definitions will not automatically produce the needed personnel to do the job. Add "or a person holding a Master's degree in Psychology with adequate experience".

Page 55, Line 5 (26) - To the definition of "treatment team" add "must include a psychiatrist or a licensed physician". This addition of "a licensed physician" is necessary to make the bush area treatment team practical and available. Psychiatric personnel are rare in the bush but there are a number of physicians who could be trained and supported through consultation by psychiatrists who are willing and able to serve on the treatment team.

Recommendation: The Department supports HB 733 jointly with companion bill, HB 734, with the exceptions discussed and with the knowledge that the maximum implementation allowed by this bill will not be obtained because of budget restrictions.

Recommended: Thomas R. Branton, Asst. Director, Division of Mental Health and Developmental Disabilities — 2/27/76 Date

Approved: Francis S.L. Williamson, Commissioner

FISCAL NOTE

Second Session - Ninth Legislature

I. REQUEST

Bill No. HB 733

Title: "An Act relating to services & commitment procedures for mentally ill"

Requested by: _____ Date: _____

Return Date Requested: _____

Agency: Health & Social Services Program: Division of Mental Health

II. FISCAL DETAIL

Budget Request Unit(s) Affected: Community Operated Mental Health Centers & State Operated Mental Health Centers

A. EXPENDITURES: (Thousands of dollars)

	OBJECT	FY 76	FY 77	FY 78	FY 79	FY 80	FY 8
100	PERSONAL SERVICES	133.8	179.0	303.3	330.6	373.6	442.
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.	1327.8	2349.5	2987.5	3970.1	4883.2	6006
	TOTAL	1461.6	2528.5	3290.8	4300.7	5256.8	6448.

B. FUNDING: (Thousands of dollars)

GENERAL FUND		2528.5	3290.8	4300.7	5256.8	6448.
FEDERAL FUNDS						
OTHER						

C. POSITIONS:

PERMANENT/TEMPORARY	6 /	9 /	9 /	9 /	9 /	10 /
MAN MONTHS (P./T.)	72 /	108 /	108/	108 /	108/	133 /

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

(SEE ATTACHED)

IV. ATTACHMENTS

V. DATE: _____ PREPARED BY: Thomas R Brandt

Assistant Director, Division of Menta Health and Developmental Disabilities

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

H/S 50

FISCAL NOTE

III ANALYSIS

The major fiscal impact of HB 733 will be the requirement of the state to increase its community mental health programs through the acceleration of the development plan now in effect.

The current operating budget (FY 76) provides 1238.4 to fund community mental health programs. Requested for FY 77 to provide growth under existing statutes is 1580.4. This does not assure funding of community mental health centers at all locations which we deem necessary to adequately carry out the purpose of HB 733.

Costs for accelerated community mental health center development based on the existing practices of match funding assume FY 78 planning must be fully funded for FY 77. Also, existing Federal Title XIX regulations will be unchanged. Community clinic programs will not materially increase their demand for State funds as they increase their services.

The administrative State staff will need strengthening as programs are developed at additional locations. Also provisions for quality control will be necessary. An Administrative Officer II and an Accountant III and a Clerk Typist III are added for these reasons.

It is assumed the basic community frame work will be established by FY 78. Growth is then set at 15% plus a 9% C.O.L.A. factor.

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ELIZABETH ROOSEN-RUNGE, M.S.W.
MARIANNE ROBINSON, M.S.W.
READING THERAPY
TROY SULLIVAN, ED.D.

March 4, 1976

Representative Susan Sullivan
Chairman, House Committee on
Health, Education & Welfare
House of Representatives
Juneau, Alaska

Dear Mrs. Sullivan,

It has recently been brought to our attention that House Bill 733 which deals with committment proceedings for mentally ill individuals has been presented to the House and is now in your committee. Our clinic as a whole has very strong feelings against this bill for many deverse reasons. We feel that it was hastily drawn up without any consensus in the psychiatric end or mental health communities, that it represents a response to an unproven abuse, and that it will drastically alter the practice of many of the professionals in this field and expose to extreme danger a number of individuals who are currently being treated. We strongly urge that this bill not be rushed through committee and that ample hearings be held in the major cities of Alaska so that each and every mental health professional desiring to testify can do so. We would like to be informed of the progress of the bill and very much would like to be notified as soon as possible as to when hearings will take place in Anchorage.

Sincerely,

Joseph D. Bloom, M.D.

JDB:seh

Good idea

S. R. Box 60722
Fairbanks, Alaska 99701
February 29, 1976

Senator Genie Chance
Pouch V
Juneau, Alaska 99801

Re: House Bills 733 and 734

Dear Senator Chance,

Thank you for a layman's opportunity to review the drafts of H.B. 733 and H. B. 734 concerning mental health and developmental disabilities as regards rights of patients and commitment proceedings.

H.B.734 Of the two bills I believe H.B. 734 dealing with care and treatment of development disabilities will have the most beneficial and far-reaching impact, if it is adequately funded. I urge its passage. I have no comments on its weak spots, if any do exist. It is a good, broad bill which will include the needs of many incapacitated people in our state. The developmentally disabled are not usually mentally ill, but the mentally ill are almost always developmentally disabled. Both kinds of individuals have great difficulty holding jobs so as to support themselves and both often need occasional or continuous care which their families may be hard pressed to provide alone.

H.B.733 I have mixed feelings regarding H. B. 733 covering mentally ill and insane persons. As I read the present statute, A.S. 30.010-340, it seems adequate in intent. It is broad enough to allow flexibility on the part of the courts but yet lacks the "human factor" which your H.B. 733 includes. I submit the following thoughts on this bill but found myself qualifying each item:

Sec. 47.30.016. Adding the Office of Mental Health Advocate to both bills is good. The variety of agencies which one must deal with is overwhelming, to say the least.

Sec. 47.30.066(c). Not holding people in jail is certainly to be desired but where else can they presently be held where adequate security, if necessary, is available.

Sec. 47.30.076. Good re peace officers wearing plain clothes to pick up respondent but is unrealistic. The police in the normal course of their duties are usually the first contact by people in any kind of trouble.

Sec. 47.30.151. Placement at closest facility is good but there is only A.P.I. at present. Regional facilities in general hospitals and/or smaller facilities in the villages are needed badly. Art. 2, Sec. 40.30.380 in the present statutes is the applicable appropriation bill for construction of mental health hospitals and facilities but has never been adequately funded to my knowledge.

Sec. 47.30.221(3). Good that patients should be able to help formulate their own medical treatment plan, but in the case of the mentally ill, they do not always have the insight nor judgment to do this, so necessarily must rely on what others think is presently best for them. And they often reject medication recommended. More counseling is needed to help them overcome rigid attitudes.

Sec. 47.30. 271. Allowing and financially helping a relative of patient to accompany patient to a treatment facility is most humane. Patient is often very frightened and fearful. Knowing he cannot depend on his own mind or judgment is a scary thing. Accompaniment by a trusted relative, if any, may help to alleviate patient's fears and perhaps ease his transition and help patient's attitude toward institutional help.

Sec. 47.30.271(c). Good to help patient maintain family ties. Better communication is needed between agencies and families of patients. Agencies apparently very seldom elicit "next of kin" upon admitting patient. It is true patients often don't consent to family being notified of their predicament because some families are not interested possibly and also because patient usually knows he is a problem to himself and others and is reluctant to burden his family further. However, by notifying next of adult kin, of any drastic change in patient's status, it gives the family and/or the community a chance to help relieve the State's burden.

In the case of a Title 12 commitment, the patient's right of consent to notify families is generally respected and this is good, to a degree. However, what happens to patient's property if he lives alone; if he is on medication is it available to him; what happens to his mail and/or subsistence checks if he is not at home to receive them? These humane considerations are lacking at present. Upon discharge, often without notification of adult next of kin, patient has no money, no clothes and no place to go. And, without family or community support, patient again becomes a police problem. Sec. 47.30.291 would help alleviate these problems perhaps.

Sec. 47.30.321(25). Under "Definitions", this appears to exclude other types of commitment other than a court commitment. Why put more burden on the judicial process if patient knows he needs a refuge and would, if properly counseled at the time, go voluntarily to another facility if such were available close by patient's home, which is not presently the case. In the case of a Title 12 commitment this, I admit, could present a problem.

To sum up, end result of both bills if passed, will not make any appreciable change in care of developmentally disabled persons unless and until funding for more regional facilities are provided. Funding and staffing at A.P.I. is a problem I understand and morale among the staff must be very low there.

Our overworked state and local police do a tremendous job for our less fortunate citizens especially. I have found them to be humane and cooperative and discreet to a remarkable degree, considering their many duties. Their efforts are negated however, when these same individuals end up back in their home communities with the same problems and no relief in sight.

In the case of the mentally ill, I am glad the trend of treatment is moving away from permanent incarceration to that of the viewpoint that many times minds too heal and become whole again, and such people do become productive, happy and useful citizens. Unfortunately, the social stigma attached to mental illness continues and the general public tend to shy away from them as they would a leper. Incapacitating physical illness and mental illness are no respector of persons -- it could happen to any of us.

If a Developmental Disabilities Advisory Council is created, I would be privileged to serve.

Respectfully yours,

Jeannie Silides

(Mrs.) Jeanne A. Silides

P. S. In a lighter vein, it is a wonder in itself why all legislators do not get crooks in the neck from reading bills stapled in the present fashion!

cc: Gov. Jay Hammond
Sen. Ted Stevens
Sen. Mike Gravel
Rep. Don Young
Attorney General Mellow, Fbx
Chairman Ferguson, Senate HE &SS Comm.
✓ Chairman Sullivan, House HE&SS Comm.
Comm. Francis Williamson
Dir. Jerry Schrader, Mental Health Div.
Judge Hugh Connolly
Commander, local state troopers
Captain, local city police
Mrs. Mary Cochran, Episcopal Vestry Ch'man, Com. Rel.
Dr. Hal South, Fbx Mental Health Div.
Mr. Dave Andrus, Dir., VA Reg. Ofce, Jno
Mr. Gordon Taylor, Mgr., Fbx Soc. Security Ofce.
Mr. Al Finneseth, Fbx Comm. Hosp.

MEMORANDUM

TO: Alaska Mental Health Association

FROM: Joan M. Katz

RE: Initial Formulation of Issues in Title 47, Chapter 30, Alaska Statutes

DATE: July 7, 1975

This memorandum is intended to provide a starting point for discussion of the many philosophical and legal issues raised by Alaska's mental health statutes. It is hoped that after consideration of these issues by persons knowledgeable and interested in this field, appropriate revisions of the law may be agreed upon. Eventually, it is our intention to prepare a comprehensive legislative packet on mental health to be introduced in the Legislature during the next legislative session. The comments that follow simply address the sections of the Code in question in the order in which they appear in the Statutes. The opinions stated are simply my first impression views, and differing viewpoints are welcome.

AS 47.30.010. Powers and duties of department. Subsection (a) provides that the department is to develop and submit to the surgeon general of the United States and administer a complete and comprehensive program for the prevention of mental illness and the care and treatment of the mentally ill, etc. Has this been done, and if not, would a mandamus action be desirable and legally appropriate?

AS 47.30.020. Authority to Receive Patients. This section provides, in part, for voluntary admission to a hospital. A minor needs the consent of his parents. Yet such consent may not be

readily obtainable if the parents are part of the minor's problem or have anachronistic views regarding mental illness. Some provision should be made whereby a minor should be taken in temporarily and if consent is withheld by parents, a medical certification or judicial procedure should be available to allow the child's hospitalization against his parents' wishes.

The second part of this section deals with involuntary admissions and raises several questions. First, and most basic: should Alaska allow involuntary commitment under any circumstances, short of criminal court order? Involuntary commitment is similar to, and really more abhorrent than, preventive detention. In preventive detention there is generally good cause to believe that the individual involved has already committed a crime. In cases of involuntary commitment, a person may be interred not for any past actions, but simply out of fear for what he might do in the future. We do not incarcerate ex-cons simply because their recidivism rate is so high. Similarly, it is questionable whether we should incarcerate anyone in a mental institution out of concern that they might harm someone (including themselves) in the future.

Looking more specifically at the language of this section, it provides, first, that certification may occur, in part, on the grounds that the physician believes that the patient is not necessarily mentally ill, but merely has "symptoms of mental illness." It would seem that if the doctor cannot form a fairly confident opinion that the person involved is mentally ill, (and does not merely show "symptoms" of such illness), then the doctor has no business signing a paper which can result in the individual's institutionalization. Second, the section allows for certification of an individual who is "likely to injure himself or others if

allowed to remain at 'iberty". The kind of injury is not specified, and there is no requirement in this section that the threat of injury be probable and imminent. This provision also raises the basic question of whether society has any business confining someone who poses no threat to anyone but himself. Then, the section includes, as an alternative standard for certification, that the physician may find that the individual is merely " in need of care or treatment in a hospital." This without any showing of danger even to himself. This provision seems both undesirable and unlawful. Finally, the certification can result from a physician's examination conducted two weeks prior to the date of admission. An individual totally psychotic on one date may be back in touch with reality and functioning well another day, not to mention 15 days later. It should be required, thus, that the examination be conducted within the 48 hours immediately preceeding the admission.

AS 47. 30.030. Emergency hospitalization. Many of the comments on the preceding section are applicable here. No indication of the imminency of harm to the patient or others is required prior to emergency hospitalization. No standards are set forth as to why an individual who is not a threat to himself or others might be in need of "immediate" hospitalization. If such a provision has any chance of surviving, it should include standards such as a person's inability, because of his mental illness, to obtain for himself the basic necessities of life. In addition, subsection (b) of this section allows for the hospitalization of an individual who is considered an immediate threat to himself or others, prior to certification or endorsement of the certificate; no time limits are set for the period in which the individual may be held in a

hospital against his will while the legalities surrounding his certification or commitment are pending. Such time limits should be set.

I might note that I am unclear as to the relationship between subsection (a) of AS 47.30. 030, which seems to suggest the necessity for endorsement of the physicians certificate prior to hospitalization, with AS 47.30.020, which seems to provide for involuntary admission on the basis of certification alone.

AS 47.30.040. Newly-admitted patients. Subsection (a) allows for 48 hours to elapse from the close of the date of admission before the hospital must conduct an examination. No mention is made of a purely physical examination, which should also be required. It would seem that both examinations should be made within 24 hours of the patient's admission. There is also the question as to whether the hospital itself should conduct the examination upon which the patient's freedom or lack thereof will turn. A private hospital, at least, could be said to have a vested interest in finding the patient "sick". Again, the standard of being "in need of care or treatment..." seems inadequate, and the added criterion that the patient lack sufficient insight or capacity to make responsible decisions concerning his illness is a frightening one. The standard does not say that the individual has to be truly psychotic, out of his mind, but merely that he lacks "insight" or "capacity"--very subjective criteria.

AS 47.30.050. Application for discharge and emergency detention. This section marks the beginning of the extended time period which may elapse before a patient entitled to release from a mental hospital may actually be discharged. For some reason, it appears that

even the voluntary admittee is required to wait thirty days before release, when in fact he or she may be functional after only a few days. It also appears that a Sec. 30 emergency admittee shall have the right to "immediate" discharge barring the institution of commitment proceedings, while a Sec. 20, involuntary but not "emergency", patient must wait 30 days. No logic appears to support this different treatment.

Minors are again discriminated against. Under Sec. 47.30.050 (a)(2), a minor cannot be discharged regardless of his or her medical condition, without parental consent. Given the fact that negative parental attitudes may have been a causal factor in a minor's illness, this provision seems inadvisable. Given the fact that minors are people with rights, this provision seems unlawful.

In addition, the reference to being "discharged immediately" in subsection (a) seems to be contradicted by (a)(3) which allows the hospital 48 hours to initiate commitment proceedings. While a two-day period for the hospital to make this determination is not unreasonable, the confusing language of "immediate" discharge should be changed in the interest of clarification.

Other questions arise in connection with commitment. No definition of "unsafe" is give. The standard of being in need of treatment, applicable to certification, does not appear to be applied to commitment. While I oppose this standard, there is a question of consistency.

The 15 day postponement of the actual commencement of commitment proceedings also seems excessive—a 10 day maximum should be sufficient in light of the serious deprivation of liberty involved.

Under subsection (b), it should be stated here or elsewhere that patients should be informed, orally and in writing, of their

rights pertaining to discharge, etc. This information should be provided to patients upon their admission to the hospital or as soon thereafter as they are able to comprehend it.

AS 47.30.060. Petition for judicial determination. This section sets time limits which must expire before a new judicial order of hospitalization or discharge may be sought. The six month period may be reasonable, but the one year requirement between Section 60 petitions seems unreasonable. And a voluntary patient who desires to leave and is then held involuntarily should not have to wait 30 days to petition the court for review.

AS 47.30.070. Hospitalization upon court order. This section sets forth the judicial commitment proceedings. In subsection (c), the court is required as soon as practicable to appoint one or more "designated examiners" to examine the proposed patient. Possibly, the court should have no more than 48 hours to appoint the examiners. "Designated examiners" moreover, are defined in Section 47.030.340 (7 as meaning "licensed physician(s)...qualified... in the diagnosis of mental illness, except that for areas in which no licensed physician so qualified is available, any licensed physician may be designated." Thus, a doctor who is not a psychiatrist could be called on to determine an individual's mental state. This should not be allowed. The examiners, moreover, are required to report to the court only "their findings as to the mental condition of the patient and his need for care or treatment in a hospital". Yet the standards for commitment are more specific (see subsection [i]); the examining physicians should be required to address those standards.

It is also provided that "The court may consider the choice

of the patient in appointing the examiner." No standards are established for the court to determine whether or not to heed the request of the patient. Further, no provision is made to insure that a physician with whom the patient has had prior contact -and maybe left in dissatisfaction- is not retained for this purpose, over the patient's objection.

Subsection (e) requires a hearing merely on the basis that the examiners find that the patient may be mentally ill. Again, such a finding would not constitute "probable cause" that he or she is likely to injure himself or herself or others, etc., as would be required for commitment. A fifteen day period is allowed between receipt of the examiner's report and the hearing. Seven days notice should suffice, in light of the fact that the individual is being detained during this period prior to a finding that he or she is committable.

Under subsection (h), the court is required to appoint counsel for patients who have no attorney of their own. Yet no provision is made as to how soon such counsel should be appointed and made available to the patient. And an "advisor" rather than counsel is also permitted. It would appear that to fully protect the patient's rights in a court of law, a lawyer must be present. Other "advisors" such as clergymen or social workers should also be allowed, but not as an alternative to legal counsel.

Subsection (i) authorizes the court to order hospitalization of the patient for "an indeterminate period "if he or she is found "mentally ill" and

> (1) because of his illness is likely to injure himself or others if allowed to remain at liberty; or (2) is in need of immediate care or treatment in a hospital, and because of his illness, lacks sufficient insight or capacity to make responsible decisions concerning hospitalization.

First, some time limit, probably no more than six months, should be placed on the court's order. The burden should not be on the patient to reopen the proceedings under AS.47.30.060. Rather, the hospital or persons interested in continued institutionalization of the patient should be required to reopen the proceedings after 6 months or so. The first standard -injury- is again inadequately defined. No distinction is made between physical as opposed to emotional injury (e.g., the impact of an unbalanced mother upon her young children). And no degree of likelihood or extent of injury or frequency of occurrence are detailed. Perhaps this is a matter for judicial dtermination, but the standard does seem overbroad. Second, the standard of being in need of immediate care or treatment in a hospital again seems inappropriate for an involuntary commitment. Moreover, it is not clear how a finding of "lack of capacity" to make a "responsible" decision (for the patient? his family? society?) about hospitalization would be determined. One can surmise that any patient who was contesting hospitalization that medical personnel deemed advisable would be found to be "incapable" of making a "responsible" decision about hospitalization.

Nowhere in section 47.30.070 is the possibility of appeal from the superior court's decision mentioned. Yet, presumably, such an appeal would lie under the Alaska Rules of Court. Provision should be made in the statutes to inform patients of their rights, to insure expedited proceedings, to establish what should happen to the patient while an appeal is pending. Also, the department is not specifically mentioned as a necessary party to these proceedings. Yet orders of hospitalization are to be directed to the department--it should be a party in each case.

AS 47.30.080. Commitment or transfer to a United States agency.

This section allows a court which commits a patient to place him or her in a United States hospital inside or outside the state. No provision is made for the patient's desires to be considered, for his or her need to be close to a family or friends to be taken into account.

AS 47.30.090. Detention under special circumstances. Subsection (b) requires detention of patients pending judicial hospitalization proceedings when the head of the hospital determines that it would be "unsafe" to the patient or other to release him or her. This is yet another standard, and again, is too vague. Subsection (c) has a wholly arbitrary provision that "No patient held on order of a court in an action or proceeding arising out of a criminal offense may be discharged except after 15 days written notice to the court." If the patient was temporarily insane but has returned to sanity within one or two days, the 15-day limit makes no sense.

AS 47.30.120. Notice of hospitalization. This section requires notification of next of kin when a patient is involuntarily admitted to a hospital. This requirement may not be appropriate in the case of an adult who may not want his parents or other kin notified. The statute also requires notification of superior court and the department whenever a patient-voluntary or involuntary- is discharged. Where a patient has not been involved in commitment proceedings, there would seem to be no justification for notifying superior court that he or she had ever been hospitalized.

AS.47.30.130. Right to humane care and treatment and consent to surgery, certain psychiatric therapies, and autopsies. This section

provides that "when the head of the hospital [believes] that the patient has...capacity to make a responsible decision, the patient's consent shall be obtained before the surgery or psychiatric therapies." There should be no qualification in the case of surgery—a patient's refusal to give consent should be determinative. Even in regard to psychiatric therapies, it is possible that the hospital should have the burden of proving that the patient is not capable of responsible decisions about his or her treatment.

AS 47.30.140 Mechanical restraints. This section could be improved by a provision that mechanical restraints should not be used unless no least restrictive alternative would suffice, and that the least restrictive, effective restraint (of the mechanical types) should be used. Hopefully, limits on specific types of unnecessarily cruel restraints are not necessary in this State.

AS 47.30.150 Rights of Patients. This section leaves out many significant rights that should be included. E.g., right to contact attorney or clergy without restriction; right to be furnished with writing materials; right to be informed of all the procedures for certification and commitment; right to retain personal property while hospitalized; right to consent to medication unless psychotic; right to some form of daily physical exercise; right to treatment, including individualized plans with periodic review and evaluation at least every three months; right to have and be informed of routes through which grievances may be expressed and resolved; and, possibly right to see own medical record and be informed of treatment plan. There should be no exceptions to these rights except "time place, and manner" regulations and findings, subject to hospital and maybe judicial review that restrictions are medically required.

AS 47.30.160. Transfer. No criteria, other than the maintenance of family and other relationships, are given for transfer decisions. Discretion should certainly be governed by patient desires, where preferable treatment could be obtained, cost, and other such factors in addition to the important maintenance of relationships criterion.

AS 47.30.170. Non-resident patients. The same comments apply to this section, as to section 47.30.160, discussed above.

AS 47.30.200. Release on convalescent status. Once a patient is released from in-patient status, it is unclear why he or she should not be discharged. Hospitals should provide out-patient transitional services for their patients, but there appears no reason why such individuals should continue to be hospital patients. (This is to be distinguished from the weekend-home situation where the patient is expected and required to return to the hospital on an in-patient basis prior to discharge.)

Assuming the convalescent status is continued, more definite provisions for review, e.g., every 30 days, should be specified, rather than the existing "intervals consistent with good medical practice and with existing circumstances."

AS 47.30.210. Re-admission. This section allows a hospital to order the reinstitutionalization of a patient on convalescent status "if there is reason to believe it is to the best interest of the patient". With court endorsement of such order, a peace officer may take the patient into custody and to the hospital.

This provision underscores the need to do away with the preceeding section. The threat of involuntary rehospitalization should

not hang over the head of a patient who has left the hospital and is trying to make it like a "normal" citizen. This section is deficient in that it provides no standards for judicial determination, no provision for review of the court order (other than the existing habeas corpus), and makes no distinction between patients who come to the hospital voluntarily or involuntarily at the outset. Certainly, for those patients who have never been certified or judicially committed, the same standards that would have been required to hospitalize them involuntarily to begin with should have to be applied at this juncture.

AS 47.30.220. Discharge upon medical review. This section provides for review of the "condition" of every patient "as often as is consistent with good medical practice". A more specific time period should be set forth. And the treatment program should also be periodically evaluated, not just the patient.

AS 47.30.260. Disclosure of information. This section requires that patient records be kept confidential. Subsection (a)(1) allows a minor's parent or guardian to consent to disclosure; perhaps the minor's consent, if he or she is old enough to comprehend, should also be required. Subsection (a)(3) allows court-ordered disclosure when necessary for judicial proceedings and in the "public interest". The kind of judicial proceeding is not specified and could apparently include any court action. Moreover, it is the "public" interest rather than the patient's interest which is the applicable standard. Finally subsection (b) allows disclosure of "information concerning current medical condition to the members of the immediate family of a patient". This provision does not allow for the situation where a patient might not want his or her family to have such

information. Thus, the section generally does not afford mental patients adequate protection against disclosure of confidential information.

AS 43.30.340. Definitions. Subsection (10) defines "mentally ill individual" as an individual

> having a psychosis or senile changes which substantially impair his mental health to the degree that he is a danger to himself or others, or a mentally deficient and severely mentally retarded person whom the commissioner of health and social services or his designee admits for treatment subject, however, to all the other admission and discharge procedures provided for in secs. 10-340 of this chapter. The definition does not include an individual suffering from acute alcoholism or drug addiction.

There are numerous problems with this definition. It does not provide for neurosis. In regard to the mentally retarded it is tautological, since a retarded individual is mentally ill if the commissioner finds him or her so. An alcoholic or drug addict is not allowed to be treated as mentally ill, when in some cases such treatment might be appropriate. Moreover, mental illness, per se should not be defined to necessarily include the "danger" standard, and that, if used at all, needs to be more specific.

Conclusion

This memorandum is intended simply to raise numerous questions. It is written from a lawyer's vantage point, with admittedly inadequate knowledge from the psychiatric or hospital administrator's perspectives. Much input from different quarters is therefore needed if we are in fact to reform our mental health statutes in the best interests of patients, hospital administration, and society at large.

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December 3, 1975

To Interested Persons:

Attached please find a copy of proposed mental health legislation in working draft form. Your comments on the underlying policies, or on any specific provisions of the draft, would be appreciated.

Background Information

The history of this proposed legislation dates back to April of this year when, at the request of Joyce Munson, Executive Director of the Alaska Mental Health Association, I undertook a review of the existing mental health statutes in Title 47, Chapter 30 of the Alaska Code. Numerous deficiencies in the present legislative framework were discovered, the most glaring of which is that under these statutes, a person against whom commitment proceedings are initiated could conceivably be held for 66 days prior to receiving a judicial hearing, at which time the court might determine that the person was not in fact subject to commitment under the Alaska statutes.

As a result of this survey of the existing law, a memorandum, dated July 7, 1975, was prepared; its primary purpose was to identify the problems in the Alaska mental health provisions. The hope was that enough concern could be aroused through this vehicle so that citizens of the community with a particular interest in mental health could come together to formulate a more humane, lawful, and constructive approach to commitment and other aspects of mental health legislation. The Mental Health Association circulated the memorandum among approximately 50 people. An initial meeting was set for August 13, 1975.

At that first meeting it was suggested that we attempt to get formal sanction from the Legislature for our work. With the support of Clark Gruening and Genie Chance, limited funding was obtained from the Legislative Affairs Agency to prepare a draft of new mental health laws for the State. Meetings of the group, which subsequently became known as the Mental Health Task Force, were held regularly on a bi-monthly schedule from mid-August through the end of November. A list of persons who

attended one or more of these meetings is attached to this letter. Virtually all of these people put considerable effort into the meetings and made valuable contributions. Special mention should be made, however, of the great amounts of time and energy invested by certain menbers of the Task Force. The contingent from API, including Dr. Robison, Veronica Heideman, and Elizabeth Shaw was particularly conscientious. Dr. Bill Moore, Regional Supervisor in Anchorage for the Division of Mental Health was also a regular participant in the meetings and a strong advocate for his various viewpoints on how to best advance the patients' health and well-being. Joyce Munson was a continuous supporter, and also helpful in providing backup services on the telephone and otherwise. The Attorney General's Office, finally, consistently provided us with sound legal insight.

As major areas of the legislation were taken up, guidance would first be obtained from Task Force members to determine the group's basic policy on a specific issue. I would then prepare a draft of the provisions involved, and the specific language would eventually be the subject of further discussion and much revision. The language used, as well as some of the ideas themselves, were generally a composite of group thoughts, provisions from the laws of other states such as Washington, Arizona and California, provisions from the model code prepared by the Washington D.C.-based Mental Health Law Project, and my own ideas.

Before beginning a more detailed commentary on specific provisions of the proposed legislation, it should be noted that while over 100 hours have been spent in drafting thus far, no one on the Task Force conceives of the bill in its present form as a finished piece of legislation. In the interest of obtaining much more widespread review by persons throughout the State who have an interest in this field, it was determined to release the draft at this time, knowing full well that even amongst themselves, the Task Force members had not yet ironed out all of the questions and difficulties which they might see in the legislation. It should be noted further, that specific attention was given only to four areas: involuntary commitment, voluntary admissions, patients' rights and definitions. Thus, there are many provisions taken from the existing legislation with only minor revisions, if any, which provisions would conceivably benefit from far more extensive changes. It was felt that the interest in expeditious development of legislation that would reform the most blatant

injustices in the existing system was of top priority; other, less eggregious problems, could be handled in subsequent legislation.

Commentary

Article 1. Mental Health Program. The first section of this article is taken almost directly from the existing Chapter 30. The second section, "Office of Mental Health Advocate", at the top of page 3, is entirely new. The proposed legislation would make much more extensive use of legal counsel than is presently the case. A system that can insure prompt state-wide delivery of services to mental health respondents is thus essential.

Initially, it was assumed that the Public Defender Agency would handle the bulk of this work. Upon consultation with Brian Shortell, head of that agency in Anchorage, it was determined that this idea was not practical. With its orientation towards the criminal side of the law and its heavy caseload, the Public Defender Agency would probably not function as an effective mental health advocate. It was thus decided to form a new office whose staff would come from the private Bar as well as from established organizations such as the Public Defender Agency and Legal Services, providing maximum flexibility to insure prompt service in rural areas as well as the urban centers. It was recognized that the location of this office within the Department poses certain conflicts. Suggestions for alternative placements would be welcome.

Article 2. Voluntary Admission for Treatment. The standard for voluntary admission (page 5 of the draft) is not materially different from that now contained in AS 47.30.020. A person may choose to enter a treatment facility simply because he is suffering from mental illness and recognizes the desirability of in-patient treatment. He need not be dangerous to either himself or others. There are, however, two critical changes in this article from the present law. First, there is no longer a 30-day waiting period before a person voluntarily admitted to a hospital may seek discharge. Such time lapse is required by AS 47.30.050. Second, under the proposed legislation (page 7 of draft), minors could be admitted voluntarily against the wishes of their parents or guardians. They would have to submit themselves to a procedure analogous to the adult commitment process. The order entered by a court in such case would be one for voluntary admission against parental wishes, and would enable the minor to leave the facility under the same

circumstances that an adult voluntary admission might obtain his discharge. The problem of minors desiring to obtain in-patient treatment against their parents' wishes has been serious and persistent enough to warrant the inclusion of such a provision in the legislation.

Article 3. Involuntary Admission for Treatment. Discussion of this article consummed the vast majority of the Task Force meeting time. Fundamental issues thought to be laid to rest would be resurrected as new members joined the Task Force, so that the basic policy positions found in the involuntary commitment sections were given extensive thought and consideration.

By way of general comment, it should be noted that the Task Force was greatly concerned by the number of steps to be followed, time limits to be adhered to and documents to be filed under the involuntary commitment sections. Simplification was continually attempted. The questions of how the courts would function in outlying areas, and in which courts documents would be filed when respondents were transported to different places for investigation, evaluation and treatment, were also troublesome. Some of these difficulties would probably be ironed out in practice. Ideally, however, the legislation itself will still be improved in this regard.

The first section of Article 3, the "Commitment Standard", on page 11 of the draft, was the first subject taken up by the Task Force. Under the present statute, AS 47.30.020, an individual can be involuntarily hospitalized merely because he or she is "in need of care or treatment in a hospital". There was unanimous agreement that neither the police power nor the parens patrie aspects of statehood justify this degree of control over human liberty from a legal or moral standpoint. The more difficult decisions were seen to be whether commitment should be allowed in cases where the person was dangerous either to himself or to others. There was discussion to the effect that since the criminal defendant could not be incarcerated until such time as he had allegedly committed a crime, neither should an allegedly homicidal mental patient be subject to commitment prior to having acted out his homicidal tendencies. An even stronger argument was waged in connection with the suicidal person, where it was the philosophy of some that the

person was entitled to take his own life without the State's interference to prevent such occurence. As the draft reflects, however, the decision was ultimately made to allow commitment of persons who are mentally ill and present a danger to either themselves or others. The term used was "likelihood of serious harm", and this term is spelled out in the definitions in a highly restrictive manner, limiting the danger to a substantial risk of imminent bodily harm to either the person himself or others. The commitment standard also contains the requirement that there be "reason to believe that immediate inpatient care and treatment could improve [the individual's] condition." This insures against the use of treatment facilities for those persons who, for example through brain damage, are not in a position to be helped by such confinement. Clearly, other provision must be made for such persons, perhaps in guardianship legislation, if the State is to fulfill its responsibilities toward all citizens.

The evaluation provisions (beginning on page 11) were perhaps the most intensely studied. The Task Force recognized that a period of brief but intensive evaluation was essential to a fair and informed commitment process. The most difficult decision in this context was determining what means should be used to bring the person involuntarily into the evaluation phase. It was concluded that physicians' certificates could seldom be obtained. It was also felt that the courts were not particularly well equipped to determine when an evaluation was needed. Therefore, the burden was placed on the mental health community to conduct investigations upon receipt of appropriate requests, or "petitions". In order to insure that the mental health professionals conducting these examinations were properly trained and familiar with the procedures, it was decided that the districts established under the Mental Health Community Services Act would be charged with the responsibility for these investigations. To be effective, this procedure will obviously require funding of specific district facilities currently existing on paper only.

The Task Force was aware that in some circumstances the danger to a respondent or the community would be of such an immediate nature that the 24-hour summons required by the proposed legislation would not provide sufficient protection. Thus, detailed provisions for emergency detention by either District officials or peace officers were included in the draft (beginning bottom of page 13 of the draft). In all cases, however, emphasis was placed on affording the respondent prompt

notice of his rights in regard to the involuntary evaluation and potential for commitment. Perhaps of central importance, it is emphasized that the respondent is to be notified promptly of his right to contact an attorney immediately, his right to actually see such attorney within 24 hours of his arrival at an evaluation facility, and his right to free legal representation in the event he is indigent.

While it is hoped that within a reasonable time, evaluation facilities will be widespread in this State, one of the problems grappled with by the Task Force was the existing scarcity of such facilities outside of the urban centers. In an effort to alter the present practice of bringing virtually all respondents into API for evaluation and, ultimately, commitment, provision was made for evaluation of respondents in their local communities whenever possible. An attempt was also made to allow reasonable extensions of time for transporting either respondents or medical or legal personnel in and out of the Bush.

Another area of considerable controversy was that of medication prior to the commitment hearing (page 18). Certain members of the Task Force vigorously insisted on their right to medicate in order to alleviate an individual's suffering. Ultimately, however, it was the prevailing view that medication against a respondent's wishes could be allowed only where "necessary to prevent bodily harm to the respondent or others or deterioration of the respondent's mental condition such that subsequent treatment might not enable him to recover."

The length of commitment periods was another crucial factor to be decided by the Task Force. Unlimited commitment periods were seen as too great a restriction on a person's right to liberty. Further, such extensive periods were not seen as conducive to prompt treatment and rehabilitation of the mentally ill person. On the basis of experience in other states, it was determined to have an initial 14-day commitment period (after which it appears that the majority of patients may be released as no longer presenting a danger to themselves or others). Subsequent commitment periods for patients who require longer-term treatment were set at 90 days each. A limit on three such consecutive 90-day periods was set (page 30) on the basis of a general consensus among the medical representatives on the Task Force that if substantial improvement in a person's mental condition could not be made over such a period of time, the person was probably not receiving adequate treatment or was not susceptible to the form of treatment administered in the facility involved.

Throughout the commitment sections, the concept of "least restrictive alternatives" is in evidence. Facilities or persons petitioning for commitment of a respondent, and courts ruling on such proposed commitments, are thus obliged to take into account whether some means short of in-patient treatment would suffice to improve the person's mental condition and protect him and society adequately. This is an emerging concept in the field of mental health law. The proposed language probably only anticipates what the courts will soon require.

In keeping with the references to "least restrictive alternatives", sections were added (beginning page 31 of the draft) pertaining to involuntary out-patient care and treatment. They provide, first, for the release of a person committed to in-patient care, prior to the expiration of his commitment period, on condition that he obtain out-patient treatment. And, second, there is provision for placement of a person in a treatment facility when it becomes apparent that court-ordered out-patient treatment is not providing adequate protection against an individual's dangerous tendencies.

The draft provides that such out-patients could be (in emergencies) taken into custody and placed on in-patient status in a treatment facility, with a hearing to be held subsequent to such placement. It may be the view of some that such commitment hearings should take place before an out-patient is transferred to in-patient status. The reasoning behind the draft's present formulation was that persons ordered to undergo involuntary out-patient treatment had already, in the recent past, been afforded the right to a full court hearing where they had in fact been found to present likelihood of serious harm. Some discretion in the hands of the person providing the out-patient care was thus seen as reasonable, so long as the placement in an in-patient facility was followed quickly by a full due process hearing.

Although the concepts for the out-patient sections were discussed by the Task Force, it should be noted that unfortunately, the Task Force never had an actual draft of these provisions before them. Thus, this part of the proposed legislation, in particular, could undoubtedly benefit from comments by interested persons.

Article 4. Patient's Rights. The first patients' right covered, the "right to treatment" (page 37), is derived from another emerging concept in the field of mental health law. While the Supreme Court has thus far only held such right applicable to non-dangerous committed persons, it is probable that in the future the right to treatment will be extended to the allegedly dangerous as well. Thus, again, the proposed legislation only anticipates what it is expected the case law will ultimately require. The right to treatment, moreover, is seen as a moral imperative as well as a legal necessity.

The cornerstone of this right to treatment is the individualized treatment plan, the requirements of which are spelled out in the definitional section of the proposed legislation. Formulation and adherence to such a plan should serve to insure that no patient is merely warehoused for the duration of his or her commitment period, and that treatment is in fact geared to each patient's particular needs.

Because abuses of the use of medication are of such a potentially destructive nature, extensive safeguards on the use of medication were deemed appropriate (page 38 of the draft). Since the patient is also the only one who knows what it feels like for him to be under the influence of any given medication, the draft provides for maximum feasible participation by the patient himself in the decision by the physician to prescribe psychotrophic drugs.

An attempt was also made to enable the patient to choose whether he would prefer some form of physical restraint to the use of medication in certain circumstances. At least one member of the Task Force vigorously objected to the mention of any physical restraint, excluding use of the quiet room, in the draft. But although great strides have been made in reducing and in Alaska, perhaps eliminating use of the straight jacket, sheet packs and restraints of a similar ilk, it must be recognized that from the patient's standpoint the indignity, distress and suffering occasioned by medication administered in good faith, can sometimes be as great or greater than that occasioned by the use of the physical restraints.

On the delicate subject of electroconvulsive therapy (page 41), it was concluded that only brief mention of this form of treatment should be made. Thus, ETC is to be allowed only with informed consent and court order. It is understood that detailed regulations on the subject of such therapy could be adopted by the Department or hospitals or other facilities involved.

Among the non-medical patients' rights, the section prohibiting discrimination in obtaining or retaining licenses (page 46) was stressed by the Task Force as highly important. This provision would have the effect of repealing the inconsistent sections of the Motor Vehicle Code which now allow application for motor vehicle licenses to include questions as to the person's past hospitalization for mental illness. Under existing procedures, an individual who has in fact been hospitalized in the last five years and answers the application form accordingly, will be required to get a note from a treating physician indicating that such person may safely drive a motor vehicle. Such provision is clearly discriminatory, inasmuch as a person discharged from a mental hospital or other such treatment facility is no more likely to be a dangerous driver than the average citizen who may or may not, at any given time, be preoccupied with a particular problem. An individual who has received treatment may, in fact, be better able to cope with his difficulties than someone facing a similar dilemina who has received no outside help.

Article 5. Miscellaneous Provisions. Virtually all of the provisions of this section (page 47) are taken from the existing statute without major modification. These were provisons that the Task Force simply did not have time to address. They were included in the draft so that it would constitute an essentially complete mental health statute.

The definitional section (beginning on page 55), on the other hand, received considerable attention and contains the heart of many of the provisions of the proposed legislation. Reference has previously been made to the critical terms of "individualized treatment plan", "least restrictive alternatives" and "likelihood of serious harm". The definition of "mental illness" was also discussed at some length. There was great concern that certain conditions such as mental retardation could be mistaken for mental illness, and yet the Task Force wanted to insure that a retarded person, for example, could receive mental health services if he happened to be afflicted with mental illness in addition to his state of retardation. The definition was designed to meet these ends.

The definition of a "minor" was arrived at in consultation with a representative from Alaska Youth Advocates. While it was recognized that the "below 16" age limit would not necessarily coincide with that found in other statutes pertaining to minors, it was determined that for purposes of commitment or voluntary admission to a treatment facility, a person 16 years or older should be entitled to make his own decisions.

Effective date. It was difficult to arrive at a time frame within which such a sweeping revision of the mental health statutes could realistically be expected to take effect. While the necessity for more time could always be argued, it was concluded that the basic provisions of the statute could be implemented within six months; any extensions would only serve to encourage delay on the part of the officials involved in appropriating funds for or implementing the new law.

Conclusion.

This commentary was intended to highlight the areas which were of particular importance and/or very controversial to members of the Task Force. It is hoped, that this information provides some basis for understanding the proposed legislation.

In conclusion, it should be reiterated that the authors of this draft by no means consider it a finished product. The Task Force recognizes that much refinement--and quite possibly fundamental changes--may be in order. It is hoped that your comments will assist in this work. Thank you for your consideration.

Sincerely,

Joan M. Katz

Joan M. Katz,
Consultant to the
Mental Health Task Force
Legislative Affairs Agency

JMK/am

Enclosure

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER / POUCH H-01 – JUNEAU 99811

November 18, 1975

Donald L. Hitchcock
Chairman, Steering Committee on
Planning and Service Development
Developmental Disabilities Planning
Council
Office of Vocational Rehabilitation Services
9th Floor - MacKay Building
Anchorage, Alaska 99501

Dear Mr. Hitchcock:

This letter is being written in response to the request for information made at the meeting of the Steering Committee on November 13, 1975

First, the Steering Committee asked for information regarding the nature of ICF-MR programs and the number of clients currently in need of ICF-MR services. ICF-MR programs are designed primarily for the diagnosis, treatment, habilitation, and rehabilitation of mentally retarded persons and other developmentally disabled persons with conditions similar to mental retardation. Standards associated with this type of program demand (a) an active treatment program, (b) individualized plans for each client, and (c) interdisciplinary professional evaluations and programming for each client.

Before an ICF-MR program is approved for funding by the State, the agency (whether public or private) must provide detailed documentation on the specific programs to be offered and their manner of implementation. These plans must be approved and must meet standards as specified under Title 45, Part 249.13, as detailed in the Federal Register on January 17, 1974. These standards are attached for your information.

The major difference between an ICF program and an ICF-MR program is that the regular ICF program does not demand specific training programs for the development of maximum independence nor for speech therapy, occupational therapy, physical therapy, and social services of the same kind of intensity as are required under ICF-MR programs. Also, ICF-MR programs are more adequately staffed and have policy requirements designed specifically for programs for the mentally retarded.

The major difference between Skilled Nursing Home programs and ICF-MR programs is that Skilled Nursing Homes are heavily oriented toward medical/nursing care. ICF-MR programs are oriented toward a developmental model in which training and habilitation are emphasized. Skilled nursing care is available in an ICF-MR on a 24 hour basis, but medical/nursing care is only one of many subprograms that are required.

Based on medical reviews and daily census reports of Alaska's skilled nursing facilities and private intermediate care facilities (non ICF-MR type), compiled by the Section of Medical Assistance in the Division of Public Assistance, it is estimated that there are 30 individuals who would be appropriately served in ICF-MR type of programs. In addition, some 10 to 15 clients at API are in need of similar services. In addition, there are approximately 25 to 50 persons receiving Aid-to-the-Disabled payments whose condition is such that they may periodically be in need of ICF-MR services. The present availability of adequate residential program services (including skilled nursing and regular ICF programs) has little or no capability of dealing with the demand. Adding to the demand is the current situation at Harborview Memorial Hospital in Valdez. Harborview must (unless a waiver is granted) reduce its population of clients to 96 by January 1977. Harborview's resident population now stands at 113. Therefore, 17 clients will have to be placed in other facilities by that time in order to continue to meet the ICF-MR standards.

In addition, data supplied by the Department of Education indicates that there are approximately five individuals who are presently being served out-of-state and who may be in need of ICF-MR type programs within the next year or two. Also out-of-state are approximately 20 adults who are residing in ICF type programs in Oregon. Some of the latter have been residing out-of-state for up to 40 years! The State of Alaska is currently working on determining their legal status, resident State, and having an appropriate guardian appointed in cases where there is question. Depending on the outcome of this work, we may have up to 20 additional persons in need of ICF-MR programs in Alaska.

Taken together, this data indicates a need to establish ICF-MR programs as soon as possible. The availability of the Chugiak location, as well as the potential willingness of Hope Cottage, Inc. to operate such a program is seen by the Department as a rational solution to the needs of at least some of our developmentally disabled citizens.

Second, the Steering Committee asked for written information regarding the "emergency" situation at API. This refers to the original intention of the Department to provide residential services at API for a 60-day period for 24 clients who were previously located at Ridgeview Manor, and who were in need of care when Ridgeview suddenly closed its doors. The placement of most of these 24 individuals at API (many of whom are developmentally disabled) was considered to be inappropriate but necessary. They were admitted to API because of concern for their life and safety, and because other options (i.e., Harborview Memorial Hospital, out-of-state facilities, ANS Hospital, existing nursing homes, group homes, etc.) were either inappropriate or considered to be even more inappropriate than API.

The current situation is better characterized as one of "urgency" rather than "emergency". The Alaska Psychiatric Institute has since partially adjusted itself to the influx of "Ridgeview" clients. The "emergency" situation no longer exists at API because temporary internal shifts have been made, (along with hiring of temporary staff) to accomodate

the clients. However, the original situation that dictated the phase out of the care of the mentally retarded at API still exists. The rise in population with increased admission to API in conjunction with increased numbers of court commitments and a somewhat more violent type of patient has exceeded the treatment capacity at API.

When the study regarding phasing out of the Koutsky Unit was instigated, a situation existed whereby all mentally ill adults were being treated in one 50 bed unit. With admissions of 50-60/month, it was frequently necessary to refuse admissions to prospective patients or to discharge a patient to make room for a new admission. As a result, patients were sometimes precipitately returned to their communites without adequate follow-up or planning.

This situation was temporarily alleviated by hiring the Psychiatric Security Staff earlier than expected or budgeted for. This enabled the Alaska Psychiatric Institute to open an 11 bed intensive treatment unit for the most violent and dangerous patients. However, availability of 11 additional beds for the care of the mentally ill is a far cry from what is needed. With the phase out of the care of the non-mentally ill mentally retarded at API, plans call for an 18 bed acute treatment unit, an 11 bed intensive treatment unit, an 18 bed unit for intermediate length of stay and a 50 bed unit for mentally ill patients who need a long-term length of stay. In addition, an 18 bed psychiatric security unit will be opened March 1, 1975 to provide specialized security care--primarily for adults. In other words, 115 beds instead of 50 will be devoted to the care of the adult psychiatric patient. This is a substantial increase in beds but is dictated by the current level of need in the State of Alaska.

Therefore, it is intended that residential service specifically for the developmentally disabled be curtailed as soon as possible in favor of the establishment of a program for the short and long term care of mentally ill adults.

Mental retardation is not viewed by the Department as being a psychiatric disability in the usual sense. Rather it is a condition of the person that frequently if not most often demands different programs and services thatn those associated with psychiatric treatment, per se. Accordingly, it is intended that the Alaska Psychiatric Institute be a resource to mentally retarded citizens for the amelioration of emotional and mental problems, just as it is for citizens who are not mentally retarded. It will still be possible for API to continue to care for the mentally retarded within the programs being designed for the chronically mentally ill but it seems far better to design programs for the mentally retarded that are more appropriate to their needs. For many of the developmentally disabled clients at API, an appropriate program would be one designed under the standards and guidelines for ICF-MR, rather than a plain ICF, a nursing home, or a residential program for the chronically mentally ill.

Third, the Steering Committee asked for information on the feasibility of State vs. private operation of ICF-MR facilities. The policy of the Department is that the State should operate programs only when the private sector is unable to meet the public's need. Not only are there advantages regarding flexibility of operation, but utilizing the private sector allows governmental agencies to be regulators and monitors of public funds rather than having governmental agencies regulating and monitoring the same programs it operates. In addition, it is the judgment of the Department that private local facilities are more responsive to local needs than are governmental agency operations that may be administered from a remote location. In the case of the current intention by the Department (i.e., that Hope Cottage, Inc. operates an ICF-MR program) it is well known that Hope Cottage has been responsive to public needs concerning residential placement for developmentally disabled citizens. The successful application of modern concepts pertaining to community based programs has provided Hope Cottage, Inc. with the experience and reputation for providing reliable services. As far as we know, no other private organization providing community residential services to Alaska's developmentally disabled citizens is more qualified to operate such a program. It is hoped that other private or local governmental agencies in communities throughout Alaska will be developed that have capabilities and strength equal to Hope Cottage, Inc.

Fourth, the Steering Committee wanted information on the Department's intent with respect to planning for future services to the developmentally disabled. It is the Department's intent to take the lead from the Developmental Disabilities Planning Council. The Council will soon be formally a Planning Body as specified by PL 94-103. We are now preparing a request to the Governor's Office to re-establish the Council under the provision of PL 94-103. Many months ago, Commissioner Williamson approved the establishment of planning and service-development support services to the Council. The Budget and Audit Committee of the Legislature has more recently approved the use of funds for the planning function. Both these actions provide evidence to support the commitment of the Department to utilize the DD Council for planning future services for the developmentally disabled. The Department would like to see the development of community programs in all areas of the State, not just Anchorage alone.

Fifth, the Steering Committee requested information concerning when persons would be able to be cared for in an ICF-MR and, in particular, when clients would be admitted if the Chugiak location was chosen. No client for whom the State is responsible will be placed in such a facility (whether in Chugiak or elsewhere) until the facility meets life and safety codes regarding the physical structure and staffing/program standards for an ICF-MR. The federal regulations pertaining to these standards are attached for your information. In addition, before a facility is accepted for use as an ICF-MR, approval for use of the facility must be obtained by means of what is called the "1122" process. This process is mandated by Section 1122 of the Social Security Act in order to protect potential clients as well as to protect the general public from the overuse of public funds. This means that if the Chugiak location is to be utilized as an ICF-MR by Hope Cottage, Inc. (or any other agency), it must first obtain approval through the

1122 process. A pamphlet giving information on this process is enclosed. In addition to this process, the plans and actual construction (or renovation) of such a facility must be approved by the Facilities Construction Section of the Office of Planning and Research of the Department of Health and Social Services.

Therefore, once the facility meets physical and program standards and once the necessary approvals are obtained, then (and only then) will State and federal funds be able to pay for services rendered.

I hope you find that the above information meets the requests of the Steering Committee. I think that after seeing this information, the Committee will agree that possible establishment of an ICF-MR at the Chugiak location is likely to be a good alternative both in terms of meeting the needs of many of our citizens and in terms of its timeliness.

As mentioned above, a variety of steps must be taken before such a service is certified and approved.

We seek your endorsement so that we can proceed with a request to Hope Cottage, Inc. to develop the detailed program plan and the renovation necessary.

Sincerely,

Lois M Judd

Lois Judd
Deputy Commissioner
Program Management
Department of Health and Social Services

LJ:prv

Enclosures

State of
Washington

Department
of Social & Health
Services

April 9, 1976

Jerry L. Schrader, M.D., Director
Dept. of Health and Social Services
Division of Mental Health
Pouch H-04
Juneau, Alaska 99811

Dear Doctor Schrader:

Muriel asked me to review the copy of your new mental health statute which you sent to her recently, and to forward any comments to you.

Your statute is very much like ours, and incorporates the features which we have found to be most valuable--placing the receipt of mental illness allegations in the hands of a professional who can often handle the problem by referral to agencies other than those providing involuntary treatment, and the emphasis at every step on the consideration of less restrictive alternatives.

My only comment would be that we have identified the need to provide for the involuntary evaluation and treatment of those persons who are truly unable to provide for their essential human needs, but who are not dangerous to others or to themselves (at least in an overtly suicidal sense). This group of patients are those termed "gravely disabled" within our statute.

I am enclosing a copy of the latest version of our statute (RCW 71.05) for your study.

Sincerely,

David A. Evans

DAVID A. EVANS
Program Administrator
Bureau of Mental Health
Community Services Division

DAE:jh