SB

100

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state
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REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Executive Director
Dennis L. DeWitt
Juneau

May 12, 1981

The Honorable Charles Parr
Alaska State Senate
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Senator Parr:

The Alaska State Hospital Association has reviewed the most recent proposed amendments to SB 100 and wishes to inform you of our support.

Senate Bill 100 is a valuable step forward in protecting a mental patient's right while at the same time providing the ability to provide sometimes necessary involuntary treatment. In addition, this measure provides a means for nonstate hospitals to become designated to provide involuntary mental treatment so that these services can be offered at facilities other than the Alaska Psychiatric Institute in Anchorage.

I would also like to take this opportunity to express my appreciation of your willingness to work with us to resolve the initial problems we had with this bill.

Sincerely,

Dennis L. DeWitt
Executive Director

DLD/b

cc: Senate Judiciary Committee
Tom Mingen, Fairbanks Memorial Hospital
Sharon White, Careage North Health Care Center

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
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March 7, 1977

The Honorable Francis S. L. Williamson
Commissioner
Department of Health & Social Services

ATTN: Dr. Gerald Schrader, Director
Division of Mental Health &
Developmental Disabilities

Re: Constitutionality of certain provisions of AS 47.30.010-.340

Dear Commissioner Williamson:

The Division of Mental Health has requested our opinion on the constitutionality of certain provisions of AS 47.30.010-.340, which govern commitments of mentally ill persons to designated hospitals, in view of recent federal court decisions and decisions in other state jurisdictions. The Division has also requested advice as to how it should proceed under the current statute.

Unless the issue is free from all doubt, the constitutionality or unconstitutionality of a statute is for the courts alone to decide. Where the issue has not been ruled on by the Alaska Supreme Court, the United States District Court for the District of Alaska, the Ninth Circuit Court of Appeals, or the United States Supreme Court, we can only attempt to predict whether any parts of AS 47.30.010-.340, if challenged, would be found unconstitutional. With this understanding as to the un-

certain nature of the predictions, this opinion will point out several areas of possible unconstitutionality in Alaska's civil commitment procedures for mentally ill persons, based on recent judicial trends throughout the United States at the federal court level. An analysis of judicial decisions in other jurisdictions in relation to the Alaska statutes will be followed by advice to the Division of Mental Health on how best to proceed under the current statute -- recognizing, however, that the Division cannot control all aspects of the commitment process, which frequently involves police officers, private physicians, relatives and other interested private parties.

We are not aware of specific abuses in civil commitments under AS 47.30.010-.340. In fact, it is our understanding that, at least where the state is involved, the rights of persons being committed are generally provided protections which are not required by the statutes. Our concern is that Alaska's mental commitment statutes, if followed to the letter, permit practices which other courts have found to be unconstitutional, such as a standard for commitment not based on harm to self or others, an absence of an automatic hearing after an involuntary emergency commitment, a long potential delay before a hearing and absence of a notice and hearing mechanism when convalescent leave from a mental institution is revoked. Our general recommendation is for legislative revision of Alaska's current civil commitment statutes.

INTRODUCTION

Advocacy on behalf of mentally ill persons has increased dramatically in recent years throughout the United States and has resulted in federal court decisions striking down parts of several states' civil commitment statutes on constitutional grounds. 1/ Some courts have also interpreted state statutes or state and federal constitutions as providing certain rights to involuntarily committed persons, such as a right to treatment while institutionalized 2/ and a right to be placed in the least restrictive setting consistent with

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1/ For example, the following state's statutes have been found to be unconstitutional in part: Alabama - Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); Georgia - J. L. v. Parham, 412 F. Supp. 112, motion denied at 412 F. Supp. 141 (M.D. Ga. 1976); Hawaii - Suzuki v. Quisenberry, 411 F. Supp. 1113 (D. Ha. 1976); Kentucky - Kendall v. True, 391 F. Supp. 413 (W.D. Ky. 1975); Nebraska - Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Michigan - Bell v. Wayne County General Hospital at Eloise, 384 F. Supp. 1085 (E.D. Mich. 1974); Pennsylvania - Goldy v. Beal, No. 75-791 (N.D. Pa., July 8, 1976); Meisel v. Kremens, 405 F. Supp. 1039 (E.D. Pa. 1975); Dixon v. Attorney General of Com. of Pa., 325 F. Supp. 966 (M.D. Pa. 1971); Wisconsin - Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated on procedural grounds 414 U.S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), vacated on procedural grounds 421 U.S. 957 (1975), on remand 413 F. Supp. 1318 (E.D. Wis. 1976); West Virginia - State ex rel. Hawks v. Lazaro, 202 S.E.2d 109 (W. Va. 1974).

2/ E.g., Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); Nason v. Superintendent of Bridgewater State Hospital, 233 N.E.2d 908 (Masa 1968); Wyatt v. Stickney, 325 F.Supp. 781 (M.D. Ala. 1971), 344 F.Supp. 373, 344 F.Supp. 387 (M.D. Ala. 1972), affirmed sub. nom.; Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Welsch v. Likins, 373 F.Supp. 487 (D. Minn. 1974) dealing with mentally retarded persons; Davis v. Watkins, 384 F.Supp. 1196 (N.D. Ohio 1974); Stachulak v. Coughlin, 364 F.Supp. 686 (N.D. Ill. 1973).

the treatment of the patient and the protection of the patient and others from harm. 3/ The clear trend in judicial decisions in other jurisdictions is toward more specific rights for mental patients and tighter procedural safeguards surrounding the serious deprivation of personal liberty involved in an involuntary commitment.

Civil commitment procedures in other jurisdictions have been challenged for their lack of procedural safeguards and consequent violation of the due process clause of the 14th Amendment of the federal constitution. 4/ The United States Supreme Court has adopted a two-step approach to due process analysis: (1) Is the private interest affected a "liberty" or "property" interest within the meaning of the due process clause? 5/ (2) If so, do the individual

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3/ E.g., Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966); Lessard v. Schmidt, supra; Lynch v. Baxley, supra; Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975); J. L. v. Parham, supra.

4/ Section 1 of the 14th Amendment to the United States Constitution provides in part:

> . . . nor shall any state deprive any person of life, liberty or property without due process of law . . . .

See also, Constitution of the State of Alaska, Article I, Section 7.

5/ See, e.g., Perry v. Sindermann, 408 U.S. 593, 599-603 (1972); Board of Regents v. Roth, 408 U.S. 564, 569-72 (1972).

interests and the importance of the procedure in protecting them outweigh the state's objectives? 6/

In the context of a civil commitment, the individual's interest is physical liberty. The state's interest is confinement of those individuals who pose a significant danger to the community (the police power of the state) and care and treatment of individuals who may do harm to themselves (the parens patriae authority of the state). The deprivation of liberty in a commitment must be balanced against the state's interest in protecting the public and the individual.

The United States Supreme Court has not yet had occasion to address the issue of procedural safeguards in a civil commitment proceeding. In O'Connor v. Donaldson, 422 U.S. 563 (1975), the Supreme Court's most recent decision in the area of civil commitments, the Court did not find it necessary to reach the constitutional questions of standards for civil commitment and procedural safeguards. The Court's holding was a narrow one:

> In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. Since the jury found, upon ample evidence, that O'Connor, as an agent of the State, knowingly did so confine Donaldson, it properly concluded that

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6/ See, e.g., Morrisey v. Brewer, 408 U.S. 471, 481-90 (1972); Bell v. Burson, 402 U.S. 535, 539-42; Richardson v. Perales, 402 U.S. 401-07 (1971); Goldberg v. Kelly, 397 U.S. 254, 263-71 (1970).

O'Connor violated Donaldson's constitutional right to freedom. 422 U.S. at 576.

COMMITMENTS UNDER AS 47.30

AS 47.30 provides for three methods of commitment for persons alleged to be mentally ill: (1) voluntary commitments under section 20; (2) emergency commitments under section 30; and (3) judicial commitments under section 70.

(1) Voluntary Commitments. 7/ Under sec. 20(1) a person may be admitted on his own application, but a minor needs parental consent. Sec. 20(2) does not appear to present independent grounds for admission to a mental hospital, but merely sets out the circumstances under which the head of a designated hospital may receive an individual who is not a voluntary committee. (These grounds are covered by sections 30 and 70).

7/ Sec. 47.30.020. AUTHORITY TO RECEIVE PATIENTS. The head of a hospital designated by the department under § 10 of this chapter may receive for observation, diagnosis, care, and treatment of an individual (1) upon application by the individual, including a minor with the consent of a parent or guardian; (2) upon application by an interested party, by a peace officer, by the department, or by the head of an institution in which the individual may be, subject to the approval of the head of the hospital if the application is accompanied by a certificate of a licensed physician stating that on a basis of an examination held not more than 15 days before the individual's admission, the individual is in the physician's opinion mentally ill, or has symptoms of mental illness, and because of his illness is (A) likely to injure himself or others if allowed to remain at liberty, or (B) in need of care or treatment in a hospital.

(2) Emergency Commitments. 8/ Sec. 30(a) provides that a person may be admitted if: (1) a licensed physician signs a certificate that the individual is likely to harm himself or others if allowed to remain at liberty or is in need of immediate

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8/ Sec. 47.30.030. EMERGENCY HOSPITALIZATION. (a) If the certificate by a licensed physician under § 20 of this chapter states a belief that the individual is likely to injure himself or others if allowed to remain at liberty, or is in need of immediate hospitalization, an interested party or peace officer may, upon endorsement of the certificate for this purpose by the department or by a superior court, take the individual into custody, apply to a designated hospital for his admission, and transport him to the hospital.

(b) An interested party or peace officer who has good and valid reason to believe that an individual is mentally ill, and because of his illness is likely to injure himself or others if not immediately restrained, may, pending examination or certification by a licensed physician, or pending endorsement of the certification as provided in (a) of this section, take the individual into custody, and transport him to the most accessible medical facility and obtain a certificate for endorsement under (a) of this section, or take the steps which are necessary to arrange for a judicial commitment under § 70 of this chapter. Transportation shall be allowed as is set out in § 110 of this chapter. The application for admission shall state the circumstances under which the individual was taken into custody and the reason for the belief.

(c) Sections 10 - 340 of this chapter do not limit the availability and utilization of designated hospitals or designated parts of them for other appropriate purposes, except that the use of the designated hospitals or parts of them shall be primarily for the care and treatment of the mentally ill.

hospitalization; (2) the certificate is endorsed by the Department of Health and Social Services or by a superior court; and (3) an interested party or peace officer who has this endorsed certificate takes the individual into custody, applies to a hospital for admission and transports the person there.

Sec. 30(b) provides that an interested party or a peace officer may take an individual into custody and transport him to a hospital before obtaining an endorsed medical certificate if he has "good and valid" reason to believe that because of mental illness a person is likely to injure himself or others if not immediately restrain After transporting the person to a hospital the interested party or peace officer must either obtain an endorsed medical certificate as in 30(a) or initiate judicial commitment proceedings.

(3) Judicial Commitment Proceedings. 9/ Sec. 70 pro-

9/ Sec. 47.30.070. HOSPITALIZATION UPON COURT ORDER. (a) An interested party, a licensed physician, a peace officer or the head of an institution in which an individual is hospitalized, or the department may, by filing an application with the superior court, start proceedings for the hospitalization of an individual by judicial commitment.

(b) On reciept of an application, the superior court shall give notice of the commencement of proceedings to the proposed patient, to his legal guardian, and to other interested parties.

(c) As soon as practicable after notice of the commencement of proceedings is given, the superior court shall appoint one or more designated examiners to examine the proposed patient and report within 48 hours to the court their findings as to the mental condition of the patient and his need for care or treatment in a hospital. The court may consider the choice

9/ continued:

of the patient in appointing an examiner. If the designated examiner reports that the proposed patient refuses to submit to an examination, the court shall give notice to the proposed patient and order him to submit to the examination. The order may direct that he be taken into custody and detained pending a hearing.

(d) The examination shall be held at a hospital or other medical facility, at the home of the proposed patient, or at another suitable place, inside or outside this state, not likely to have a harmful effect on his health.

(e) If the report of the designated examiner states that the proposed patient is not mentally ill, the court shall terminate the proceedings and dismiss the application. Otherwise, the court shall immediately fix a date for a hearing and give notice of the hearing. The hearing shall be held not more than 15 days from receipt of the report of the designated examiner.

(f) The proposed patient, the applicant, the legal guardian and other interested parties, as determined by the superior court, shall be given notice of the hearing and an opportunity to appear at the hearing, to testify, and to present and cross-examine witnesses. The court may, in its discretion, receive the testimony of any other person. The proposed patient shall not be required to be present, and the court may exclude all persons not necessary for the conduct of the proceedings.

(g) The hearing shall be conducted as informally as is consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the mental health of the proposed patient. The entire proceedings may be recorded stenographically or with the use of mechanical recording devices which the superior court approves. The court shall prepare and maintain a summary record of all relevant and material evidence which is offered concerning the mental condition and the residence of the proposed patient and may relax the rules of evidence to the extent of receiving affidavits, certificates of licensed physicians and other writings of similar apparent authenticity and reliability.

9/ continued:

(h) An opportunity to be represented by counsel or advisor shall be given to the proposed patient, and if neither he nor others provide counsel or advisor, the superior court shall appoint a counsel or advisor. If, not less than two days before the date fixed for the hearing, the proposed patient or his counsel or advisor files a written request with the superior court, the court shall summon and impanel a jury of six adult residents of the judicial district in which the court officiates, preferably from the court's jury list or the last voters' list, if available, to hear and consider the evidence concerning the mental condition and residence of the proposed patient.

(i) The superior court shall terminate the proceedings and dismiss the application upon completion of the hearing and consideration of the record, except that the court shall order the hospitalization of the proposed patient for an indeterminate period if the court or the jury find 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 responsible decisions concerning hospitalization.

(j) If the superior court orders the hospitalization of the proposed patient, a finding shall be made as to the residence of the patient. A copy of the finding and the summary of proceeding shall accompany the patient to the hospital. The order of hospitalization shall be directed to the department. The department shall assure the order's execution.

(k) Notwithstanding any other provision of §§ 10--340 of this chapter, except § 170 of this chapter, commitment proceedings under this section shall not be commenced with respect to a patient admitted under § 20 of this chapter unless release of the patient is first requested in accordance with § 50 of this chapter.

(l) An order for hospitalization under this section is not a judicial determination of legal incompetency, except to the extent provided in § 130(b) of this chapter. Proceedings for a determination of legal incompetency and the appointment of a guardian for a patient who has been ordered hospitalized may be started before, during or after proceedings under this section, if the circumstances of the case require and the condition of the patient permits.

vides for hospitalization upon a court order after a full judicial hearing initiated by a petition from an interested party, physician, peace officer, the Department of Health and Social Services or the head of an institution in which an individual is hospitalized. The proposed patient has an opportunity to be represented by an attorney or an advisor and may request a jury of six. The court orders the person hospitalized for an indeterminate period if the court (or the jury, if requested) finds that the proposed patient is "mentally ill and because of his illness is likely to injure himself or others if allowed to remain at liberty" or 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."

DUE PROCESS CONSIDERATIONS

Areas of AS 47.30 which might be challenged on due process grounds because of an absence of adequate procedural safeguards include the following:

A. Standards for Commitment

(1) Analysis: There are two standards for commitment in AS 47.30: Mental illness which results in (1) likelihood of injury to self or others and (2) need for immediate care or

treatment in a hospital, i.e., that the individual, because of his mental illness, lacks sufficient insight or capacity to make responsible decisions concerning his need for hospitalization. These standards are found at section 20(2), 10/ section 30(a) and (b), 11/ section 40(b), 12/ section 70(i) 13/.

The first standard -- likelihood of harm to self or others -- appears to be constitutionally adequate. A few courts have required that the standard of future dangerousness must include a showing that the person has actually been dangerous in the recent past and that such danger was manifested by an overt act, attempt or threat to do substantial harm to himself or to

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10/ See footnote 7.

11/ See footnote 8.

12/ AS 47.30.040. NEWLY ADMITTED PATIENTS.

> . . . (b) At the end of the 48 hours, a patient admitted under § 20 or 30 of this chapter, shall be discharged without application if a preliminary examination has not been held or if, upon examination, the designated examiner refuses or fails to certify to the head of the designated hospital that in his opinion the patient is mentally ill and is either likely to injure himself or others if allowed at liberty, or in need of care or treatment in a hospital and because of his illness lacks sufficient insight or capacity to make responsible decisions concerning it. All other patients shall be discharged when, in the opinion of the head of the designated hospital, there is no further need for their hospitalization. Notice of discharge shall be given to the department and the court or person responsible for the order of hospitalization, who shall have an additional 48 hours within which to make other arrangements under § 70 of this chapter or otherwise.

13/ See footnote 9.

another. Lynch v. Baxley, 386 F. Supp. at 391; Lessard v. Schmidt, 349 F. Supp. at 1093; Cross v. Harris, 418 F.2d 1095, 1102 (D.C. Cir. 1969); Doremus v. Farrell, 407 F. Supp. at 515.

The second standard -- need for care and treatment -- appears to be open to serious question on due process grounds. In Jackson v. Indiana, 406 U.S. 715 (1972), and Humphrey v. Cady, 405 U.S. 504 (1971) the United States Supreme Court addressed issues relative to involuntary commitment of criminally insane persons. In reaching its decision in these cases, the Court interpreted Indiana's civil commitment standard ("in the interest of the welfare of such persons or others") and Wisconsin's standard ("is mentally ill and a proper subject for custody and treatment") to require an independent showing of dangerousness. The Supreme Court applied the balancing test and found that the state's interest in the welfare of a person was insufficient to justify such a "massive curtailment of liberty", Humphrey v. Cady, 405 U.S. at 509, unless there was an implicit requirement in the statute that the person was dangerous to himself or others.

The following cases have held that the standard of "need for care and treatment" as a basis for involuntary commitment because of mental illness violates due process: Suzuki v. Quisenberry, 411 F. Supp. 1121-25; Kendall v. True, 391 F. Supp. at 417-19; Lessard v. Schmidt, 349 F. Supp. at 1093-94; Lynch v. Baxley, 386 F. Supp. at 389-92; Doremus v. Farrell,

407 F. Supp. at 513-15; Bell v. Wayne County General Hospital at Eloise, 384 F. Supp. at 1096. All of these cases have held that dangerousness -- harm to oneself or others -- is a constitutional requirement for involuntary commitment. In other words, without a showing of dangerousness, the State may not constitutionally deprive an individual of his liberty without his consent, even though it could show that it would be to the individual's benefit to provide him with certain care and treatment.

One court has held that the "in need of care or treatment" standard where no evidence of dangerousness is required is impermissibly vague because the standard is susceptible to several interpretations and may be enforced arbitrarily. The court in Goldy v. Beal, ___ F. Supp. ___ (N.D. Pa., July 18, 1976) stated:

> Such lack of specificity in a statute that authorizes an interference with a constitutionally protected right of physical liberty places insufficient limits on the discretion of officials who are responsible for its implementation, with the result that there is nothing in the statute to prevent it from being enforced arbitrarily. Such a result amounts to vagueness that violates due process. (Reported in Mental Disability Law Reporter, Vol. 1, No. 2, p. 137, Sept-Oct, 1976)

It would seem difficult for a court to save the "in need of care and treatment" standard in AS 47.30 by reading in an implicit requirement of harm to self and others. The statute

specifically sets out two alternative grounds -- either harm to self or others or need of care and treatment in a hospital.

(2) Advice: In order for the Division of Mental Health to operate on safe constitutional grounds it is our advice that it should apply only the first standard -- harm to self or others -- in cases where it is in control of the petitioning process, i.e., where the department or the head of a state institution initiates the commitment. Harm to self can include a proven inability to meet one's fundamental needs, such as food, clothing, shelter, or essential medical care, because of mental illness. See, e.g., Doremus v. Farrell; In re Mostella, 215 S.E.2d 790 (N.C. App. 1975). It might also be well to prove the likelihood of future harm by a recent overt act, threat or attempt to inflict harm on self or others.

B. Time Before Hearing

(1) Analysis: While a prior hearing is normally a prerequisite to the state's interference with a person's liberty, it may be delayed until some time after the deprivation has taken place where there is a compelling state interest to warrant postponement. See, e.g., Goldberg v. Kelly, 397 U.S. 254 (1970). The authorities which approve emergency commitments to mental institutions without prior hearing where there is an immediate threat of harm to self or others are uniform in requiring that a

hearing be held after the commitment to determine if the person should be released or continued under hospitalization.

Some courts have required a preliminary hearing, i.e., an abreviated informal hearing where the state must convince the court that it will probably be able to show that person meets the legal criteria for commitment at a full, formal hearing later. See, e.g., Bell v. Wayne County General Hospital, 384 F. Supp. at 1098 (within 5 days); Lessard v. Schmidt, 349 F. Supp. at 1103 (within 48 hours); Lynch v. Baxley, 386 F. Supp. at 388 (within 7 days); Doremus v. Farrell, 407 F. Supp. at 388 (within 5 days); Kendall v. True, 391 F. Supp. at 419 (requires a preliminary hearing but no specific time limit set); Mignone v. Vincent, 411 F. Supp. 1386, 1389 (S.D.N.Y. 1976) ("quickly after the commitment").

Doremus v. Farrell, 407 F. Supp. at 515 requires a full and formal hearing, i.e., a hearing where each side presents all the evidence it has marshalled in support of its position and where rules of evidence apply, on the necessity for commitment within 14 days after the preliminary inquiry; Lessard v. Schmidt, 349 F. Supp. at 1092, requires a full hearing within 10 to 14 days after detention; Lynch v. Baxley, 386 F. Supp. at 388, sets an outside limit of 30 days from date of the initial detention for the holding of a full hearing; Kendall v. True, 391 F. Supp. at 419, requires a full hearing within 21 days of confinement.

Other courts have not required a preliminary hearing and have approved longer time periods of commitment prior to a full hearing. In Coll v. Hyland, 411 F. Supp. 905 (D. N.J. 1976), the court ruled that confinement of up to 20 days without a preliminary hearing and before a full hearing was constitutionally permissible. In Logan v. Arafeh, 346 F. Supp. 1265 (D. Conn. 1972) aff'd sub nom. Briggs v. Arafeh, 411 U.S. 911 (1973), the United States Supreme Court summarily affirmed a three-judge federal court ruling upholding a Connecticut statute allowing confinement of up to 45 days without a hearing. Some courts have openly disagreed with the length of time before hearing permitted in Logan. See, e.g., Kendall v. True, 391 F. Supp. at 419.

In Alaska, no hearing is automatically provided by statute after an emergency commitment. The main mechanism for triggering a hearing for a patient who has been committed on an emergency basis is a request for discharge, after which the head of the hospital must either issue a release or oppose the discharge by instituting judicial commitment proceedings under AS 47.30.070. Interested parties are notified of the patient's request for discharge and may oppose it by initiating judicial commitment proceedings if the head of the hospital does not.

When a request for discharge is opposed, it is possible under AS 47.30 that a hearing on the need for continued hos-

pitalization will not occur for 32 or more days (15 days limit for initiating the proceeding under section 50(a)(3); 14/ unknown amount of time for notice and appointing examiners; 2 days limit for examination and report; 15 days limit for a hearing after examiner's report under section 70(b), (c), and (e). 15/

14/ Sec. 47.30.050. APPLICATION FOR DISCHARGE AND EMERGENCY DETENTION. (a) An individual, 30 days after admission to a designated hospital under § 20 of this chapter or an individual admitted to a designated hospital under § 30 of this chapter, shall be immediately discharged upon his request or upon the request in writing of an interested party or peace officer, except that

(1) if admitted upon his own application, his discharge may be conditioned upon his agreement;

(2) if under 18 years of age and admitted under § 20 of this chapter, his discharge before becoming 18 years of age may be conditioned upon the consent of his parent or guardian; and

(3) if the head of a designated hospital, within 48 hours after receiving the request, files with the superior court a certification that in his opinion the discharge of the patient would be unsafe to the patient or others, the discharge may be postponed for not more than five days to begin commitment proceedings under § 70 of this chapter; if the court finds that because of justifiable circumstances, proceedings for judicial hospitalization cannot reasonably be instituted in that time, the discharge may be postponed for not more than 15 days.

(b) The head of the designated hospital shall provide reasonable means and arrangements for informing patients of their right to discharge, as provided in §§ 10--340 of this chapter, and for assisting the patients in making requests for discharge under this section.

15/ See footnote 9.

There is always a possibility, too, that a committed person will not understand his right to ask for discharge, and therefore, will not trigger the hearing mechanism for some time.

A longer delay before hearing is possible for a voluntarily committed person who becomes, in essence, an involuntary committee when the person no longer desires to remain voluntarily and is kept against his or her will. Section 50(a) 16/ provides that immediate discharge for a voluntarily committed patient is not required before 30 days after admission, at which time the head of the hospital may file a petition for a judicial commitment if he believes that discharge would be unsafe to the patient or others. If a voluntary patient requests discharge after 5 days of hospitalization, for example, the head of the hospital would not be obliged to grant the discharge, and the patient could be kept for 25 more days before the request for discharge would trigger either a discharge or a judicial commitment proceeding. Thus a voluntary patient who is not discharged on request during the 30 day period after admission might not receive a hearing for the number of days between the first request and the end of the 30 day period plus the 32 or more days discussed above which can elapse under the statute before a hearing.

It is true that section 60 provides that the patient or an interested party may petition the superior court for a judicial

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16/ See footnote 14.

determination of the need for continued hospitalization under section 70. 17/ It is also true that section 100 provides that an individual detained under AS 47.30 as an involuntary committee is entitled to a writ of habeas corpus. 18/ Both of these procedures must be initiated by the patient or an interested person, and the statute does not provide that the patient must be informed of the availability of these procedures. The court in Fahgen v. Miller, 306 F.Supp. 634 (S.D.N.Y. 1969) discussed the habeas corpus remedy in these words:

> It is true that habeas corpus is always available to test the lawfulness of detention [under New York's Mental Hygiene Law]. But this assumes a patient has knowledge or has been advised of his right to so proceed. In any event, not only is the presumption that the confined person knows the law ### highly unrealistic, but if the statute is constitutionally defective, it will not be

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17/ Sec. 47.30.060. Petition for judicial determination. A patient who is hospitalized under § 20, 30 or 70 of this chapter may have the need for his continued hospitalization determined or redetermined on his own petition or that of an interested party or a peace officer, to the superior court. On receipt of the petition, the superior court shall conduct proceedings in accordance with § 70 of this chapter except that the proceedings need not be conducted if the petition is filed sooner than (1) six months after the issuance of an order of hospitalization under § 70 of this chapter; (2) one year after the filing of a previous petition under this section; or (3) 30 days after the voluntary application and admission of a patient.

18/ Sec. 47.30.100. Writ of habeas corpus. An individual who is detained under §§ 10-340 of this chapter is entitled to a writ of habeas corpus upon proper petition by himself or an interested party to a court authorized to issue writs of habeas corpus in the jurisdiction in which he is detained.

> saved by the Great Writ. Nor is it saved by express recognition in the state's Mental Hygiene Law of a patient's right to the writ. 306 F.Supp. at 638. (footnotes omitted.)

In view of cases from other jurisdictions it would seem that AS 47.30.020 - 47.30.070 is subject to attack on due process grounds for failure to provide for an automatic hearing to determine the legality of all emergency commitments which last more than a very short period of time and for providing procedures under which a long period of time may lapse before a hearing occurs in such cases 19/ and also in the case of persons voluntarily committed who no longer wish to remain committed.

(2) Advice: It is our advice that the Division of Mental Health or its designees should initiate a hearing under AS 47.30.070 for persons committed under section 30 and attempt to have the hearing occur within 7 to 10 days of commitment. For voluntary

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19/ In the New Jersey case of Coll v. Hyland, 411 F. Supp. 905 (D. N.J. 1976), and in the Connecticut case of Logan v. Arafeh, where 20 days and 45 days respectively without a hearing were held constitutionally acceptable, the patients involved had been determined by at least one physician (two under the New Jersey statute) to be dangerous to themselves or others as a result of mental illness. Because the Alaska statute allows for a standard of "in need of care or treatment in a hospital" which can probably not be interpreted to include an element of dangerousness to self or others, a person could be institutionalized under AS 47.30.030 without a hearing for a lengthy period of time on the basis of a physician's determination that the person is in need of hospitalization.

patients who desire discharge sooner than 30 days after commitment, it is our advice that the Division either release them or treat them as involuntary patients and promptly initiate a judicial commitment proceeding.

C. Rights of the Subject of a Judicial Commitment Hearing.

(1). Adequate Prior Notice.

(a). Analysis: Several courts have held that adequate prior notice to the subject of a final, i.e., non-preliminary hearing should include: the date, time and place of the hearing; a clear statement of the purpose of the proceedings and the possible consequences to the subject of the proceedings; the alleged factual basis for the proposed commitment; a statement of the legal standard upon which commitment is authorized; the names of examining physicians and other persons who may testify in support of the petition to commit and a summary of proposed testimony (some courts hold that this information does not have to be in the notice but must be made available to counsel in advance of the proceeding); a statement of the right to counsel and the right to jury trial (if the latter right is provided by statute --some courts have found that it is not constitutionally required; AS 47.30.070(h) provides for a jury of six on written request). Some courts have held that notice before a preliminary hearing should include the time and place of the hearing; the

grounds, reasons and necessity for emergency detention; and the right of the person being committed to counsel. See, e.g., Lessard v. Schmidt, 349 F.Supp. at 1092; Lynch v. Baxley, 386 F.Supp. at 388; State ex rel. Hawks v. Lazaro, 202 S.E.2d at 124; Suzuki v. Quisenberry, 411 F.Supp. at 1127; Doremus v. Farrell, 407 F.Supp. at 515; Bartley v. Kremens, 402 F.Supp. at 1050; cf. Commonwealth v. Roop, 339 A.2d 764 (Pa. Super. 1975).

The court in Coll v. Hyland, 411 F.Supp. at 911, held that there was no constitutional necessity that notice to the patient include (1) a factual basis upon which commitment is sought, (2) names of examining physicians, (3) the names of any other individuals who might testify in support of commitment or (4) a summary of proposed testimony, because under New Jersey's scheme there was an absolute requirement of representation by counsel with most relevant information being readily available to the patient's counsel. Under AS 47.30 there is not an absolute requirement of representation by counsel. (See discussion in section (2) below.)

AS 47.30.070(b) and (e) 20/ do not specify the information which the notice to the proposed patient should contain, but this specificity could be added by judicial interpretation.

20/ See footnote 9.

(b). Advice: When the Division of Mental Health initiates a commitment proceeding, it should include the provisions mentioned in the first paragraph of this section in its notice. The notice could omit the summary of proposed testimony if such a summary is made available to counsel for the patient before the hearing.

(2). Representation by Counsel.

(a). Analysis: During a judicial commitment proceeding a patient is given the opportunity to be represented by "counsel or advisor", including an appointed counsel or advisor if he cannot provide one. AS 47.30.070(h). 21/

Almost all the courts which have examined the due process aspects of state civil commitment statutes have held that the subject of an involuntary commitment proceeding has a right to counsel at all stages of the proceeding; a right to be informed of the right to counsel and to appointment of counsel if indigent; a right to have counsel made available far enough in advance of the final commitment hearing to assure adequate opportunity for preparation; and a right to representation by a legally trained and qualified counsel instead of any person. See, e.g., Bell v. Wayne County General Hospital, 384 F.Supp. at 1093-94;

21/ See footnote 9.

Lessard v. Schmidt, 349 F.Supp. at 1097-98; Heryford v. Parker, 396 F.2d 395, 396 (10th Cir. 1968); Suzuki v. Quisenberry, 411 F.Supp. at 1129; Lynch v. Baxley, 386 F.Supp. at 38; Bartley v. Kremens, 402 F.Supp. at 1050-51; Doremus v. Farrell, 407 F.Supp. at 516; Dixon v. Attorney General of Comm. of Pa., 325 F.Supp. at 974.

The Alaska statute allows the proposed patient to choose representation by an advisor, who would presumably be a lay person. There is question as to whether this choice should be offered by the statute. The cases cited above hold that in view of the serious deprivation of liberty involved in a civil commitment, the need for representation by an attorney is similar to the need in a criminal case. In a criminal case the accused may waive the right to counsel only if the court determines that the waiver is voluntary and knowing. See, e.g., Boyd v. Dutton, 405 U.S. 1 (1972); Johnson v. Zerbst, 304 U.S. 458 (1938); Gregory v. State, 550 P.2d 374 (Alaska 1976).

It would almost certainly, therefore, be argued that the proposed patient should not be able to choose an advisor instead of an attorney unless the court determines that his waiver of the right to counsel is voluntary and knowing. Representation by an attorney and an advisor might be a possibility instead of an attorney or an advisor.

(b). Advice: When the Division or its designees initiate commitment proceedings, they should encourage the patient to choose an attorney and encourage the court to appoint an attorney instead of an advisor -- or in addition to an advisor.

(3). Presence of the Proposed Patient at the Judicial Hearing.

(a) Analysis: Section 70(f) of AS 47.30 22/ provides that the proposed patient shall not be required to be present at a hearing under section 70. Some courts have required the presence of the patient at such a hearing unless it is judicially determined that the patient has knowingly and voluntarily waived his right to be present or that presence at the hearing would be harmful to the patient.

In Bell v. Wayne County General Hospital, 384 F.Supp. at 1094, the court found that due process standards were not met where the patient was not present at the hearing unless his presence would be so disruptive that the proceeding could not continue in any reasonable manner, as in the case of a criminal defendant. The Bell court held that the court could not make such a decision in advance of the hearing and solely on the certificate of physicians that the respondent should not be allowed to appear. Where the removal of the defendant to the

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22/ See footnote 9.

court house would be "improper and unsafe", the court in Bell required that some method alternative to total exclusion be attempted first, such as holding the proceedings at the mental health facility. See also, Suzuki v. Quisenberry, 411 F.Supp. at 1129; Lynch v. Baxley, 386 F.Supp. at 388-89; State ex rel Hawks v. Lazaro, 202 S.E.2d at 125.

(b) Advice: Where the Division of Mental Health is involved in a judicial commitment proceeding it should encourage the presence of the patient at the hearing unless the court has made a judicial determination that the patient has effectively waived his right to be present or that presence would be medically harmful to the patient or seriously disruptive of the proceeding.

(4). Standard of Proof.

(a) Analysis: Section 70 23/ of AS 47.30 provides no standard of proof for judicial commitment of an allegedly mentally ill individual. There are essentially three standards of proof which might be required to prove that a person is committable: (1) by a preponderance of evidence, (2) by clear and convincing evidence, or (3) beyond a reasonable doubt. Courts which have considered the issue have concluded that, in view of the deprива-

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23/ See footnote 9.

tion of liberty involved in a commitment, proof must be either by clear and convincing evidence or beyond a reasonable doubt.

Proof by preponderance of the evidence (the standard used in most civil actions) has been rejected in commitment proceedings by at least two courts. Lessard v. Schmidt, 349 F.Supp. at 1094-95; In re Ballay, 482 F.2d 648, 653-5 (D.C. Cir. 1973). As far as we have been able to determine, proof by a preponderance of the evidence has not been approved by any court.

Proof by clear and convincing evidence has been approved by the majority of courts which have considered the issue. Lynch v. Baxley, 386 F.Supp. at 392-94; State ex rel. Hawks v. Lazaro, 202 S.E.2d at 126-7; Castillo v. U.S., 406 F.Supp. 585, 595 (D.N.M. 1975); Doremus v. Farrell, 407 F.Supp. at 517; Bartley v. Kremens, 402 F.Supp. at 1051-53; Dixon v. Attorney General of Pennsylvania, 325 F.Supp. at 974.

Proof beyond a reasonable doubt has been required by some courts. Lessard v. Schmidt, 349 F.Supp. at 1094-95; In re Ballay, 482 F.2d at 653-5; United States ex rel. Stachulak v. Coughlin, 364 F.Supp. 686 (N.D. Ill. 1973), affirmed 520 F.2d 931, 935-37 (7th Cir. 1975); Suzuki v. Quisenberry, 411 F.Supp. at 1132. Cf. In re Winship, 397 U.S. 358 (1970), where the

United States Supreme Court held that the standard of proof in juvenile proceedings which involve a loss of liberty must be beyond a reasonable doubt, even though a juvenile proceeding is not technically a criminal proceeding.

Section 70 of AS 47.30 might be found to be violative of due process in not specifically setting out a higher standard of proof than the preponderance of the evidence standard which is applied in most civil cases. This defect can be cured by judicial interpretation, and, apparently most Alaska courts do apply a higher standard of proof in commitment proceedings.

(b) Advice: When the Division of Mental Health is involved in a judicial commitment proceeding it should be prepared to meet, and if there is any doubt that the court will not do so on its own initiative, should encourage the court to apply a standard of proof higher than in a normal civil case.

(5). Formality of the Proceeding and Rules of Evidence.

(a) Analysis: Subsection (g) of section 70 of AS 47.30 24/ provides that the hearing shall be conducted as informally as is consistent with orderly procedure and that the court may relax rules of evidence to the extent of receiving affidavits,

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24/ See footnote 9.

certificates of licensed physicians and other writings of similar apparent authenticity and reliability.

Several courts have held that there should be no relaxation of the rules of evidence, specifically those governing hearsay (use of out-of-court statements at a judicial proceeding made by someone who is not a witness at the proceeding). See State ex rel. Hawks v. Lazaro, 202 S.E.2d at 125; Lessard v. Schmidt, 349 F.Supp. at 1102-03; Lynch v. Baxley, 386 F.Supp. 394; Suzuki v. Quisenberry, 411 F.Supp. at 1130; Doremus v. Farrell, 407 F.Supp. at 517. These courts hold that the seriousness of the deprivation of liberty and the consequences which follow an adjudication of mental illness make imperative strict adherence to the rules of evidence generally applicable to other proceedings in which an individual's liberty is in jeopardy. Cf. In re Gault, 387 U.S. 1, 11, n. 7 (1967), where the U.S. Supreme Court considered the use of hearsay evidence in an informal non-criminal juvenile proceeding:

> [T]o the extent that the rules of evidence are not merely technical or historical, but like the hearsay rule have a sound basis in human experience, they should not be rejected in any judicial inquiry.

To the extent that a hearing under section 70 may be conducted with relaxed rules of evidence, it appears to be in conflict with the decisions cited above.

(b) Advice: To the extent that the Division of Mental Health has any control of witnesses in favor of commitment, it should have them testify in person rather than by affidavit or certificate.

(6). Other Rights at Hearing.

(a) Analysis: A few courts have found an additional due process requirement that the patient be informed of his or her right to invoke the privilege against self-incrimination before a psychiatric examination on which a finding of mental illness is to be based. Lessard v. Schmidt, 349 F.Supp. at 1100-02; Suzuki v. Quisenberry, 411 F.Supp. at 1130-32. The necessity for this requirement has been questioned in a balancing test of state vs. individual interest. See "Civil Commitment of the Mentally Ill", 1974 Harv. L.Rev. 1191 at 1306-13.

(b) Advice: It is our opinion that recognition of the individual's right to remain silent would seriously impair the state's ability to achieve the valid objectives of civil commitment. The state's interest in protecting the public from a mentally ill person who is likely to cause harm to others and in protecting a mentally ill person from causing harm to himself must outweigh the right of a proposed patient to remain silent during a court-ordered psychiatric examination. The purpose of

the examination is neither accusation nor inquisition but rather to gather current medical information about the patient's mental condition which can be obtained in no other manner. Without this essential information, the state would be unable to proceed with its case, and a person dangerous to himself or others could not be hospitalized.

D. Recommitment After Release on Convalescent Statute.

(1). Analysis: Section 200 of AS 47.30 provides for release on convalescent status when the head of the hospital believes that it is in the best interest of the patient. Section 210 provides in part:

> If there is reason to believe that it is to the best interest of the patient to be re-hospitalized, the department or head of the designated hospital may issue an order for the immediate re-hospitalization of the patient.

The court in Meisel v. Kremens, 405 F.Supp. 1253 (E.D. Pa. 1975) held that a Pennsylvania statute which provides for summary revocation of leaves of absence from state mental health facilities at the discretion of the directors of those facilities is unconstitutional as violative of due process. The Meisel court relied on two decisions from New York: Shaban v. Essen, 386 F.Supp. 1042 (E.D.N.Y. 1974), aff'd 516 F.2d 897 (2d Cir. 1974), and Ball v. Jones, 351 N.Y.S.2d 199 (1974). In these

cases the federal and state courts held that a provision of the New York mental hygiene law providing for revocation of out-patient status of a person adjudged to be a drug dependent person without written notice of violation or opportunity to be heard violated due process.

The courts in Meisel, Shaban and Ball found that the principles of due process enunciated by the United States Supreme Court in Morrisey v. Brewer, 408 U.S. 471 (1972), requiring notice and a hearing with regard to revocation of parole for criminals should apply to revocation of leave for mental patients or drug-addicted patients. The "conditional liberty" of the mental out-patient was not seen to differ in any significant respect from the "conditional liberty" of the paroled criminal.

Section 210 might, therefore, be subject to constitutional attack for failure to provide notice and a hearing when release on convalescent status is revoked and the patient is recommitted. It might also be argued that the same standards should apply for recommitment as for the original commitment.

(2). Advice: The Division or its designee should not recommit a person released on convalescent status without notice and hearing. If there is no emergency, a hearing under AS 47.30.070 should be initiated by the Division or its designee. If emergency

commitment is necessary, the person should have the same safeguards as attend an original emergency commitment.

E. Indeterminate Commitment and Provisions for Periodic Judicial Review.

(1). Analysis: Commitment in Alaska is for an indeterminate period (sec. 70(i); sec. 40(b)) and discharge occurs when, in the opinion of the head of a designated hospital, there is no further need for hospitalization (sec. 220; sec. 40(b)). The United States Supreme Court in O'Connor v. Donaldson, 422 U.S. at 574-5 held that even if the commitment was initially founded on a constitutionally adequate basis, it could not constitutionally continue after that basis no longer existed. This seems to put the burden on the state to re-establish from time to time the basis for continued confinement.

The issue then is whether AS 47.30.060 violates due process because the periodic judicial determinations (where the burden is on the state to re-establish the basis for continued confinement) must be initiated by the patient or an interested party rather than the state and cannot be initiated more than once within a time period of 6 months initially and after that only once a year. One of the only courts which has considered the issue held that a similar provision in the Hawaii statutes

was not violative of a patient's due process rights in Suzuki v. Quisenberry, 411 F.Supp. at 1134. The court nevertheless stated that limitation of the period of confinement to 90 days without another commitment hearing would be "in line with current mental health doctrine" and clearly protective of due process rights.

(2). Advice: Even if the current provisions are not violative of due process, the Division of Mental Health would assure greater protection for patients if it initiated an annual judicial review for all involuntarily committed patients who did not initiate such a review themselves.

F. Minors.

(1) Analysis: Minors are treated specially under AS 47.30 in two ways: (1) a minor needs the consent of a parent or guardian for voluntary admission to a hospital under AS 47.30.-020(1), 25/ and (2) a minor admitted under the voluntary commitment section and discharged while still a minor may have his discharge conditioned upon the consent of his parent or guardian under AS 47.30.050(a)(2). 26/

25/ See fo note 7.

26/ See footnote 14.

We have found no cases addressing the first situation where a minor wishes to be hospitalized and a parent or guardian refuses. The second situation where a voluntarily committed minor's discharge is blocked by a parent or guardian has been addressed by at least one court. In In the Matter of Williams, 336 A.2d 468 (Essex Co., N.J. 1976), the court ruled that a minor voluntarily committed to a mental hospital for treatment with his parent's signature has the right to sign himself out on 72 hours' notice without parental consent. Hospital authorities could invoke involuntary commitment procedures in response to the minor's request for discharge if they believed discharge would be unsafe. The court stated:

> To require parental consent to leave the hospital would, in effect, convert John Williams' status from that of a voluntary patient to that of an involuntary patient. This court will not be party to such a situation. 336 A.2d at 471.

It should be noted that in Williams, the New Jersey statutes did not contain a special provision for minors but stated that any voluntary patient is to be discharged on request within 72 hours.

The state must be able to show a fair and substantial relation between the special restrictions on minors under AS 47.30.020(1) and 47.30.050(a)(2) and the state's interest. We

question whether the state could do so in a situation where a voluntarily committed minor desires discharge, the head of the hospital does not oppose the discharge on grounds of harm to self or others, but the parents of the minor block the discharge.

(2). Advice: The language of AS 47.30.050(a)(2) is discretionary: "discharge may be conditioned upon the consent of his parent or guardian". The heads of designated hospitals under the control of the Division are advised to discharge voluntarily committed minors on the minor's request when the head of the hospital does not believe that discharge of the minor would be harmful to the minor or others, even if the parent or guardian is opposed to the discharge. If the parent or guardian believes that the minor should remain hospitalized, the parent or guardian should initiate judicial commitment proceedings.

G. Substantive Rights of Committed Persons.

(1). Consent to Treatment.

(a) Analysis: Section 130(b) 27/ of AS 47.30 requires consent to surgery and psychiatric therapies which the department

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27/ AS 47.30.130(b) provides:

> (b) Consent to surgery, the psychiatric therapies which the department determines, and autopsies must be obtained for a patient before the undertaking of the surgery,

determines are necessary. This is an area of recent litigation, particularly as concerns those forms of treatment which are considered to be most intrusive, such as electro-shock therapy (ECT), psycho-surgery, lobotomy, and aversion behavior control therapy. 28/

. . . . . .

27/ continued:

chiatric therapies or autopsies from one of the following persons: spouse, guardian, either parent, or oldest adult child. If none of these persons is found in this state within a reasonable time, or in the case of an emergency, the commissioner of health and social services or his designee, upon being notified of the pertinent medical facts, may give the consent. However, when the head of the hospital is of the opinion that the patient has insight or capacity to make a responsible decision, the patient's consent shall be obtained before the surgery or psychiatric therapies; his consent shall be obtained before the surgery or psychiatric therapies; his consent shall be determinative, and no other consent is necessary. However, in the case of a minor, consent shall also be obtained from the parent or guardian. The person giving the consent, or a person who acts after the consent is given and is authorized to perform the act undertaken by him is not liable civilly or criminally if the act is done by him in his official capacity or in the capacity set out in secs. 10 - 340 of this chapter.

28/ See, e.g., Doe v. Younger, California Court of Appeals, April 23, 1976, (reported in Mental Disability Law Rptr., Vol. 1, No. 2, Sept-Oct., p. 119-120), Price v. Sheppard, 239 N.W.2d 905 (Minn. 1976); Scott v. Plante, 532 F.2d 939 (3rd Cir. 1976); Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Mackey v. Procunier, 477 F.2d 65 (2d Cir. 1971), cert. den. 404 U.S. 985 (1971). The most significant decision in this area was Kaimowitz v. Mich. Dept. of Mental Health, Civil No. 73-19434-AW (Cir. Ct., Wayne Co., Mich., July 10, 1973), (an involuntary patient cannot effectively consent to experimental psychosurgery.)

Some of these therapies have significant, permanent and painful side effects (aversion therapy); some are irreversible, highly intrusive and often debilitating (psychosurgery and lobotomy). 29/ A fundamental interest in bodily privacy has long been recognized at common law, and several judicial opinions have sketched the outline of a constitutional right to protection of bodily integrity from unwanted state intrusion. 30/

(b) Advice: The provisions for consent in section 130(b) should be strictly construed, and for intrusive forms of treatment, every effort should be made to see that the patient's informed consent, or the substitute informed consent of a spouse, guardian, parent or oldest adult child, is obtained. Consent is not informed if the person consenting does not understand the dangers and possible negative consequences of the treatment. If informed consent or substitute informed consent cannot be obtained under AS 47.30.130(b) the commissioner or his designee might be wise to obtain a court order before allowing the most intrusive treatments such as psychosurgery or lobotomy (cf. Price v. Sheppard, 239 N.W.2d 905 (Minn. 1976)), even though he has statutory authority to consent under sec. 130(b).

29/ "Civil Commitment of the Mentally Ill", 1974 Harv.L.Rev. 1190, 1345, n. 122.

30/ Id. at 1194-97, n. 11 and 12.

(2). Consideration of less restrictive alternatives.

(a) Analysis: Some courts have held that the burden is on the state to show that the goal of treatment and protection from harm for the mentally ill cannot be more narrowly achieved than by institutionalization, i.e., the state must show that institutionalization is the least restrictive alternative possible.

In Lessard v. Schmidt, 394 F.Supp. at 1096, the United States District Court for the Eastern District of Wisconsin set out the requirement that less drastic means than commitment be investigated. The court said:

> We believe that the person recommending full-time involuntary hospitalization must bear the burden of proving (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable. These alternatives include voluntary or court-ordered out-patient treatment, day treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aid services.

The same requirement was stated in Lynch v. Baxley, 386 F.Supp. at 392, in these words:

> In addition to the findings which are required to be made by the fact-finder, the state . . . shall have the burden of demonstrating the proposed commitment is the least restrictive environment consistent with the needs of the person to be committed.

The principle has been applied in other cases such as Welsch v. Likins, 373 F.Supp. at 502; Suzuki v. Quisenberry, 411 F.Supp. at 1132-33.

In Dixon v. Weinberger, 405 F.Supp. 974 (D. D.C. 1975) the court interpreted a District of Columbia statute to require placement of committed patients in less restrictive appropriate facilities than a hospital and held that the responsible authorities were obliged to create such facilities if they did not currently exist. See also, Covington v. Harris, 419 F.Supp. 617 (D.C. Cir. 1969); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966). The statute for the District of Columbia contains language referring to hospitalization or "alternative treatment".

In the Alaska statutes governing civil comitments, section 20(a)(B), section 30(a), and section 70(i) all set out the standard of "care or treatment in a hospital" or "immediate hospitalization". A court should read these statutory words to require that alternatives short of hospitalization have been considered and are not appropriate.

(b) Advice: The Division of Mental Health is advised to utilize institutionalization only after it has determined that the danger to the subject himself or to others cannot be avoided by out-patient treatment, day treatment in a hospital, night

treatment in a hospital or treatment at a community mental health clinic. When the Division or its designee is involved in a judicial commitment hearing, it should show the court that other alternatives short of institutionalization have been considered. The Division or its designee should attempt to move committed patients to less restrictive treatment settings inside or outside an institution as soon as their mental condition improves, even when a restrictive setting is initially appropriate.

CONCLUSION

A number of areas of AS 47.30 which may be vulnerable to attack on due process grounds have been set out. The most serious defects appear to be the "in need of care or treatment" standard for commitments; the absence of a mandatory hearing to test all involuntary emergency commitments which last more than a short period of time; the long delay which is possible before a judicial determination occurs after an emergency commitment or after a voluntary commitment becomes involuntary; the absence of due process protections when conditional leave is revoked.

This opinion has pointed out other areas of potential legal problems with the statute in view of developing case law in other jurisdictions and has advised the Division of the safest

way to proceed under the present statute. It is obvious, however, that the Division of Mental Health does not control the entire process of civil commitment, which includes the court system, private physicians, police officers, relatives, and other interested parties.

A more definite way to proceed would be to revise Alaska's current civil commitment statutes. We recommend that any new or amended civil commitment statute include the following due process safeguards:

(1) A standard for commitment based on dangerousness to self or others;

(2) A hearing initiated by the state to test the legal basis for all involuntary emergency commitments within a short period of time after the commitment (a preliminary hearing plus a full hearing later or only a full hearing);

(3) Procedural due process at a commitment hearing, which should include:

(a) adequate prior notice;

(b) a neutral judicial officer;

(c) right to effective assistance of counsel;

(d) right to be present at the hearing except in exceptional circumstances;

(e) right to cross-examine witnesses and to offer evidence;

(f) adherence to the rules of evidence;

(g) proof by clear and convincing evidence (or beyond a reasonable doubt, although the clear and convincing standard is recommended as a better balance between individual and state interests, given the lack of consensus among mental health professionals about what constitutes mental illness and whether future harm can be predicted);

(h) consideration of less restrictive alternatives to commitment;

(i) record of the proceedings and written findings of fact;

(j) appellate review;

(k) periodic judicial redetermination of the basis for confinement;

(4) Notice and hearing when conditional leave is revoked, with the same safeguards as in (3)(a) - (k);

(5) Informed consent or informed substitute consent to intrusive or irreversible treatment;

(6) Explanation to the patient of his rights while hospitalized and assistance in exercising these rights.

We are available to assist in amending the current civil commitment statutes by working with the Division of Mental Health, legislators or legislative committees who address the problem, or other interested groups.

Very truly yours,

AVRUM M. GROSS
ATTORNEY GENERAL

By: Elizabeth R. Arnold
Elizabeth R. Arnold
Assistant Attorney General

ERA:md

persons/groups who have commented on SB 100 (HB 472 - HB 2):

Dept. Health & Social Services

Dept Law

Alaska Court System

Public Defender

Alaska Legal Services

Alaska Mental Health Association

Governor's Mental Health Advisory Council

Alaska State Hospital Association

Public Hearings were held in Fairbanks, Anchorage, Kodiak, Ketchikan, Juneau & Soldotna

Other Person's Action Groups

Mauneluk Association

Central Peninsula Mental Health Association

Bristol Bay Area Health Corp.

Dept. Public Safety

Barrow Mental Health Clinic

Tanana Valley Bar Association

Alaska Association of Social Workers

Alaska Psychiatric Association

Citizen Commission on Human Rights
(Washington State)

as of 5-26-81

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

COMMITTEE SUBSTITUTE
FOR SENATE BILL NO. 100

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

The Division of Mental Health and Developmental Disabilities fully endorses the principles of mental health care in the least restrictive setting and the protection for individual civil rights that are addressed in Committee Substitute for Senate Bill 100. The civil commitment process calls for a sensitive balance between the individual's right to the best possible psychiatric treatment, and society's [illegible]o be protected from those persons who are dangerous as a result of mental illness. Committee Substitute for Senate Bill 100 emphasizes treatment in the least restrictive alternatives close to home and provides for outpatient involuntary commitments. Periodic hearings are to be conducted in all involuntary hospitalizations.

The Department of Health and Social Services supports the passage of Committee Substitute for Senate Bill 100 with the following amendments:

Page 4, Line 21, 47.30.690 Change 21 days to 30 days. In addition, all subsequent references to 21 day commitment should be changed to 30 days.

Explanation: The 30 day commitment as established by Senate HESS allows hospital staff to monitor medications such as antidepressants and Lithium salts before the need for a second hearing. These medications require at least three weeks before they effect the behavior of most patients. In addition, this period of time will allow the hospital to properly evaluate, diagnose, and treat the mental disorder and in most cases avoid the necessity for a second commitment hearing. Presently, the average length of hospitalization for all patients (voluntary, involuntary, criminally committed, and evaluation and observation) at the Alaska Psychiatric Institute is 30-35 days. It should be emphasized that the 30 day commitment is only for patients not discharged prior to the 30th day or those that do not become voluntary patients.

Recommended by: Verner Stillner, M.D.

Verner Stillner, M.D., M.P.H.
Director, Division of Mental Health and Developmental Disabilities

Date: 5/26/81

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner
Department of Health and Social Services

Date: 5/26/81

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No. 100 (COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 100)
Title An Act Relating to Mentally Ill Persons.
Requested by _____ Date February 17, 1981

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected Alaska Psychiatric Institute, Admin. & Support Comm., Mental Health Center
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100	PERSONAL SERVICES		99.6	108.6	118.4	129.0	146.6
200	TRAVEL		19.8	21.6	23.6	25.7	28.0
300	CONTRACTUAL		339.0	923.8	1,812.6	3,073.3	5,264.1
400	COMMODITIES		9.1	9.9	10.8	11.8	12.8
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL		467.5	1,063.9	1,965.4	3,239.8	5,451.5

FUNDING (Thousands of Dollars)

GENERAL FUND		467.5	1,063.9	1,965.4	3,239.8	5,451.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME		2	2	2	2	2
TEMPORARY						

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

The intent language in SB 100 emphasizes treatment close to home, least restrictive alternatives and protection of client rights. So far as is determined by the Division of Mental Health and Developmental Disabilities those persons who require involuntary commitment for treatment of mental illness are currently being served, therefore, no increase in the population to be served will result from SB 100. What is required is resources to support the increase of hearings and for the scope of implementation of the intent.

Costs to implement SB 100 are the costs of the increased number of court hearings, the field and medical staff training for the court related activity and an array of costs associated with the establishment of designated facilities. Each of these costs are individually described under their separate heading. In addition spectrum of designated facilities are presented as alternate levels of implementation. Each level provides for

IV. DATE February 17, 1981 PREPARED BY _____
AGENCY Department of Health and Social Services
PHONE 465-3370

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) M&B Approval _____ Date _____

33-001 (Rev. 12/80

an increase in local capacity for treatment and evaluation.

I. Hearings (BRU API)

Base data will be the actual API hospital records of 1023 admissions for FY 80. About 44% of these are involuntary civil admissions equal to 450 patients. Under the current system civil commitment progress hearings may take place 14 to 21 days following admission. Therefore, many of these 450 involuntary patients have become voluntary prior to a hearing date. About 120 hearings are actually scheduled each year. A number of the involuntary admissions to API are Evaluated (screened) and released as not being mentally ill. We therefore conclude that SB 100 will, because of the required 72 hour hearing, the 90 day and the 120 day hearing, result in a minimum of 300 of the 72 hour hearings and an undetermined number of 90 and 120 day hearings. The evaluation and the preparation of reports to be available to the court at the more than 300 additional hearings will represent a major workload increase at API.

One half time psychiatrist	43.9	(Two mental health professionals must sign petition)
One half time psychologist	25.3	
One Clerk III	22.2	
Total Hearing Staff Cost	91.4	

II. Training (BRU Administrative and Support Central Office)

SB 100 presents the function at a local level of a accomplishing the preliminary screening and a possible evaluation for all cases taken into custody i.e., involuntary patients. It also will involve many physicians and mental health professionals in court proceedings and professional demands that are unfamiliar.

Local physicians will need training in recent advances in psychopharmacology and the assessment of medical basis of mental disorders. As these will frequently be general physicians who now do little psychiatric work this update should occur on a yearly basis to insure the best assessment and treatment.

Mental health professionals must be trained in their legal responsibilities to committed and evaluated patients under the act. They must know the legal definition of committable patients and how to assess patients for the commitment hearing. They must be offered a review of appropriate treatment approaches for patients likely to be committed under the act. This must be done on a yearly basis.

Costs:

22 physicians X $451 each of travel and 3 day per diem	9,922.00
Facility, trainer and material costs.	2,500.00
Individual materials as hand-out etc.	550.00
Total training cost for M.D.	12,972.00
22 Mental health professional (same as above)	12,972.00
Forensic material development and distribution for 22 centers	3,000.00
Total training and development cost	28,944.00

III. Designation Costs (BRU Community Mental Health)

All material will require annual update presentations. Additional costs for center-specific training and unique medical update can be funded through Federal Mental Health Manpower Development Grant sources when these 28.9 base matching funds are available.

Patient receipts recover 26.6% of the actual operating costs at API. It is assumed cost recovery for any designated facility would be similar. The State comprehensive health plan reports the combined cost (cost of a bed and all support services, such as medication, X-ray etc.) per patient day totals $397 per patient day for Alaska non-federal acute care hospitals. We calculate that involuntary patient care at a designated facility has a potential to create a deficit of $303 per day per patient, that being the cost incurred but not paid for by the patient. This must be reimbursed to the designated facility.

The health plan reports the cost of a hospital bed without support services to average $175 per day. A bed must be in reserve at all times at a designated facility. Cost of a reserved bed is $63,875 per year (175 X 365). When a prepaid and reserved bed is occupied the additional daily cost is $128 (303 less 175). This is reimburseable to the facility as a non-recoverable patient care cost. We estimate that each designated facility will deliver 200 bed days of treatment and inpatient evaluation service at a cost to the State of $25,600 (200 X 128). We further assume that two beds will be occupied for 30 days per year at a cost of $9,090. (303 X 30).

Summary of designated costs:

"head of facility"		56,950.00
reserved bed		63,875.00
200 days patient care @ 128 per day	25,600	
30 days patient care @ 303 per day	9,090	
	34,690	
		34,690.00
Annual cost per facility		$155,515.00

Levels of Implementation

Level I

A level 1 implementation for SB 100 would assume no additional designated facility beyond API. Cost at this level is limited to the costs for the additional hearings and field staff training.

Training	28.9
API staff	91.4
Level 1 total	120.3

Level II

A level 2 implementation would provide a designated facility in each of four judicial areas of Alaska. Nome, Juneau, Fairbanks in addition to the existing Anchorage API.

API hearing staff costs	91.4
Training and development cost	28.9
3 additional designated facilities @ 155,515	466.5
Level 2 cost	586.8

Level III

A level 3 implementation would provide a designated facility in each of the 10 superior court services districts and would locate a designated facility in Sitka, Ketchikan, Juneau, Kenai, Kodiak, Bethel, Nome, Kotzebue, and Fairbanks, in addition to API Anchorage;

API hearing staff costs	91.4
Training and development cost	28.9
9 designated facilities @ 155,515	1,399.6
Level 2 cost	1,519.9

Level IV

Level 4 implementation will provide a saturation of designated facilities. Evaluation with inpatient treatment capacity would be available in each of the existing 22 community mental health service districts.

API hearing staff costs	91.4
Training and development cost	28.9
21 designated facilities @ 155,515	3,265.8
Level 4 Cost	3,386.1

HB 100 Implementation Schedule

All costs are adjusted for 9% C.O.L.A. annually.

Year FY 82

a. Hearing
b. Training
c. Partial level II designation (Fairbanks, Juneau)

Year FY 83

a. Hearing
b. Training
c. Level II designation
d. Partial level III designation (2 location)

Year FY 84

a. Hearing
b. Training
c. Level II designation
d. Level III designation (4 additional locations)

Year FY 85

a. Hearing
b. Training
c. Level II designation
d. Level III designation
e. Partial level IV designation (5 locations)

Year FY 86

Total implementation 22 designated facilities

NOTE:

The cost of designation of a single facility adjusted by C.O.L.A. of 9% annually is:

FY 82	$ 169,511
FY 83	184,767
FY 84	201,396
FY 85	219,522
FY 86	239,279

INVOLUNTARY CIVIL COMMITMENT UNDER SB 100

Initiation of Petition by any adult

Screening investigation by judge or direct a mental health professional to conduct a screening investigation to determine if individual is mentally ill and as a result gravely disabled or present likelihood of serious harm to himself or others

Ex parte order by judge written or orally within 48 hrs. of screening

Ex parte order not issued individual exits judicial system

Peace officer with probable cause to believe person is gravely disabled or suffering from mental illness & likely to cause serious harm to himself or others may take individual in custody & deliver him/her to treatment or evaluation facility

Nearest appropriate designated evaluation facility

Evaluation & treatment facility has 24 hrs. to physically and mentally examine individual & 72 hrs. for hospitalization & evaluation/Peace officer may complete application for examination or mental health professional may apply for ex parte order

Discharge of individual if he/she does not meet commitment standards

Designated facility 30 day instead of 14 day

14 Day Commitment
If an individual is not released or signs voluntary, he/she is entitled to a court hearing to be set for no later than the end of 72 hours for an additional 14 days

Discharge

Outpatient commitment less restrictive alternative

90 Day Commitment

Discharge

Outpatient commitment less restrictive alternative

120 Day Commitment

Discharge

Outpatient commitment less restrictive alternative

120 Day Commitment

Discharge

Outpatient commitment less restrictive alternative

= Suggested Amendments

ALASKA MENTAL HEALTH ASSOCIATION
1030 W. 26th Ave., #1
Anchorage, Alaska 99503
Telephone 276-1705
A Division of the National Mental Health Association

April 27, 1981

Hon. Senator Pat Rodey, Chairman
Senate Judiciary
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Pat:

The more I think about my testimony the other day, the less satisfied I am that I made clear our support of SB 100. It is a very fine piece of legislation from our point of view and it is high time Alaska's Commitment Statutes are constitutional. However, we would hope for a superior bill that more fully satisfies the Purpose, so beautifully stated in the bill itself.

If our suggested ammendments do not meet with the approval of the legislators, we shall be content with the bill as is for the time being.

Sec. 47.30.690, Page 4, Line 20: The word "voluntary" should be omitted as it is difficult to conceive a youngster 14 or under voluntarily committing himself/herself to a mental facility.

Sec. 47.30.705, Page 6, Line 22: Since a person evidencing obvious mental problems that might require commitment, and the conditions could be exacerbated by confinement in a cell, we feel the wording in this section should strongly suggest that a correctional facility may be used only when NOTHING of a less restrictive nature can be found, including a hospital.

Sec. 47.30.715, Page 7, Line 16: At this point and in all following sections where reference is made to the second commitment period as a 30-day commitment, we strongly urge that it be changed back, as in the original bill, to a 14-day commitment. Considerations of convenience for the Court calendar pale when the rights of an individual's freedom are at stake. In many, if not most, instances, the individuals are guilty of no crime and great care must be taken to ensure due process. Although the policy at the Alaska Psychiatric Institute has been the last several years to guard and protect patients' rights, we feel it should be written into the law to prevent possible abuse in the future. Exceptions could be written into the bill to take into account those times when distances and travel arrangements need

to be considered.

Sec. 47.30.845, Page 25, Line 7: CONFIDENTIAL RECORDS. The patient should also be able to obtain one copy of his/her medical records at no cost. Since the patient is party to his/her treatment plan, there is no reason to deny access to the medical records.

Sec. 47.30.825, Page 21, Paragraph (2): The patient should also have the right to refuse medication unless Court ordered. The national trend is in this direction and we should wisely follow this trend. Again, with the patient an integral part of the treatment plan, the choice should be available to him/her.

With or without these suggested ammendments, SB 100 should be passed this session. It is a milestone piece of legislation of which Alaska can be proud.

We look forward to quick passage.

Sincerely yours,

Natalie Gottstein
Executive Director

cc: Sen. Don Bennett
Sen. Carles Parr
Sen. George Hohman
Sen. Bill Ray