SB
100

COMMITTEE REPORT

SENATE

FURTHER: Judiciary

1/19/81

Date: ______________

Mr. President:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had SB 100

mentally ill persons

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[✓] replace with CS for SB 100 (HESS) [✓] same title [ ] new title

and recommends ______________

[ ] AND attaches a "Letter of Intent" [✓] New Fiscal Notes

[ ] reports it back without recommendation

[ ] referred to the ______________ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

CHAIRMAN

S 60 (Rev. 12/78)

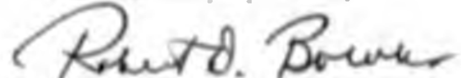
March 17, 1981

State Senator Charlie Parr
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I appreciate the work you are doing on Senate Bill 100 and the thoughtfulness with which the legislation has been considered. I promised to send you the Mental Health Advisory Council's input after our meeting in February. When I have reviewed our notes I find that our input is essentially the same as that of the Division of Mental Health. The Division in its testimony has pretty much covered the ground we wished to cover. We believe the bill is a good one as ammended and would like to encourage its passage this year as a much needed piece of legislation. We also approve of the fiscal note which has b een provided by the Divisior of Mental Health.

Sincerely yours,



Robert D. Bowers, Chairman
MENTAL HEALTH ADVISORY COUNCIL

alaska state hospital association

319 Seward St., Juneau, Alaska 99801 (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Providence Hospital
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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

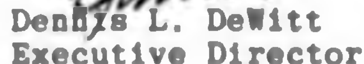
Dear Senator Parr:

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

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
POUCH X – STATE CAPITOL
JUNEAU 99811

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 (Mass 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. AUTH 'ITY 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 'ys 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 restrained. 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

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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 a lay 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 depriva-

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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 52 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 convelescent 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 footnote 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.

C. 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 o 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

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

SUMMARY FOR CSSB 100 (JUDICIARY) - AN ACT RELATING TO MENTALLY ILL PERSONS

This bill is a major revision of Alaska civil commitment statutes. Its purpose is to protect the legal rights of persons suffering from mental illness, protect society from persons who are dangerous to others, and protect persons who are dangerous to themselves.

The following principles of modern mental health care have guided this revision:

(1) that persons be given every opportunity to accept voluntary treatment before involvement with the judicial system;

(2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;

(3) that treatment occur as promptly as possible and as close to the individual's home as possible;

(4) that a system of mental health community facilities and supports be available;

(5) that patients be informed of their legal rights and be informed of and allowed to participate in their treatment program as much as possible;

(6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

The Department of Health & Social Services' powers and duties are listed on pages 2 and 3 of the bill.

Article 7, which begins on page 3, includes standards for voluntary admission for persons 14 or older and admission of minors under 14.

Beginning on page 5, Article 8 explains the process for involuntary commitment. It establishes a 72-hour evaluation period, a 21-day, 90-day, and 120-day commitment period. A court hearing is mandatory for each commitment period.

Article 9, which begins on page 21, lists patient rights. They include:

(1) patient participation in a treatment plan;

(2) the right to examine records;

(3) the right to know the name of, and refuse medication;

(4) the right to use a quiet room;

(5) the right to refuse or accept shock therapy;

(6) protection from psychosurgery and lobotomy;

(7) the right to have life-saving surgery;

(8) the right to participate in, and be given a discharge plan.

Additionally, Article 9 prohibits experimental treatments, establishes patient rights to privacy and personal possessions, and states that patient records remain confidential. It protects civil rights and prohibits discrimination of persons evaluated or treated for mental illness. All patient rights must be explained to patients in a language understood by the patient.

Article 10, which begins on page 27, explains miscellaneous provisions. They include: transportation, nonresident patients, patient rights outside the state, the disposition of personal effects, unclaimed funds, definitions, and commitment after a judgment of not guilty by reason of insanity or incompetency to stand trial.

Though not tried in a court, the current mental health statutes' constitutionality has been questioned by many. This bill would repeal AS 47.30.010 through 47.30.170 and AS 47.30.190 through 47.30.340.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 0
JUNEAU, ALASKA 99811
PHONE: 465-3030

April 14, 1981

Document# 102-81

Honorable Charles H. Parr
Chairman, Senate HESS Committee
Alaska State Legislature
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

COST OF CARE RATE HEARINGS
REPORT TO THE LEGISLATURE

Alaska Statutes, Chapter 47.05.010(14), mandate a public meeting be held by the Department of Health and Social Services "in February to review, study, and propose the necessary levels of care and the rates it (the department) will pay to anyone for the services required during the succeeding year; before final adoption by the department, the proposed levels of care and the rates of payment shall be reviewed by the Legislature annually while in session."

The meetings to conform to the statutes were held during February, 1980 as required. Testimony was presented on both the rates of payments and the levels of care during the hearing process. Attachments 1 and 2 list the estimated rates which need to be paid during FY 1981 based upon testimony given by the providers. Funding in the Governor's FY 82 budget for both institutional and foster care is sufficient to meet the estimated expenditures.

The rates for Institutional Care reflected in Attachment 1 were developed using a 14% increment for salary increases and a 14% cost of living allowance for all expenditure categories other than salaries and benefits. These increases were requested by the majority of providers during the rate hearing.

The rates also reflect a 4.8% increment related to allowable FY 81 costs which were not covered in the provisional FY 81 rates. This is necessary because, under the statute, a provider's rate for FY 82 is set based upon the actual per diem cost experience in FY 81. This per diem cost is calculated by dividing the provider's total allowable costs for FY 81 by the actual census for FY 81. Thus, either unanticipated expenditures during FY 81 (such as increases in staffing mandated to meet wage laws) or lower than expected utilization of the facility (reducing the census) will increase the base upon which the FY 82 rate is set, beyond the increase normally expected due to inflation. An analysis of the providers' financial reports for the first six months of FY 81 and of anticipated utilization for the second six months indicate a 4.8% increment should be sufficient to allow for these factors.

06-F38LH

Only two of the providers requested more than the 14% increment for salary increases and cost of living allowances. One requested an 18% increase and the other requested the 14% plus additional salary monies to allow for: 1) all full-time employees to earn at least $18,000 annually; and 2) a 3% increase for a retirement plan as part of a 10% of salary retirement benefit.

The overwhelming testimony was in favor of a 14% increase. The CPI for Anchorage in 1980 was 12.5%. The Department of Health and Social Services recognizes the continuing impact of these high inflation rates and recommends to the legislature the granting of the 14% across the board rate increase. The CPI for 1981 is predicted to be equal to or more than the 1980 percentage.

Institutional Care Costs as Requested by Providers at Hearings

Institutional Care	Family Services (In-State)	Youth Services (In-State)	Department Total
Budgeted Amount	$9,307,033	$3,637,590	$12,944,623
Estimated Cost	6,747,166	2,891,621	9,638,787
Balance	$2,559,867	$ 745,969	$ 3,305,836

The Department prepared the FY 82 budget reflecting a 26.7% increment for allowable costs not covered in the provisional FY 81 rates and an 11.3% cost of living allowance. The actual institutional rates in FY 81 were considerably lower than expected permitting the Department to reduce the increment for allowable costs from 26.7% to 4.8%. In addition, we have recommended the 14% cost of living allowance which would be 2.7% higher than the budget figure. As a result, the estimated average daily rate for FY 82 would be $105.63.

Base FY 81 Provisional Rate		Adjustments for Allowable Expenditures not Included in Base Rate		Recommended COLA Inrease		Estimated Provisional Average FY 82 Daily Rate
$87.00	+	4.8%	+	14%	=	$105.63

The 4.8% adjustment for allowable expenditures made by facilities during FY 81 is an estimate prior to development of audited rates. That factor is being utilized only because that proved to be the actual factor increase for the FY 81 provisional rate over the FY 80 rate. The adjustment factor for FY 80 over FY 79 was 9.8%, and for FY 79 over FY 78 was 22.8%. Thus, if the FY 82 adjustment factor actually exceeds 4.8%, a supplemental appropriation will need to be requested.

Foster Care rates were developed according to 7 AAC 50.720(c) assuming a 14% change in the Consumer Price Inucx during FY 81. Attachment 2 displays the projected rates for FY 1982.

Foster Care Costs

	Family Services (In-State)	Youth Services (In-State)	Department Total (In-State)
Budgeted Amount	$2,488,519	$520,699	$3,009,218
Estimated Cost	2,470,813	488,107	2,958,920
Balance	$ 17,706	$ 32,592	$ 50,293

Sincerely,

Helen D. Beirne
Commissioner

Enclosures

Projected Payments for Services
Full Cost of Care
FY 1982

IN-STATE ONLY

PROVIDER	FY 81 Provisional Rate	+	Allow Exp. Adjust. 4.8%*	+	COLA Increase 14%	=	FY 82 Proposed Rate	+	State Census	=	Annual Cost
Alaska Children's Services											
Anchorage Receiving Home	115.32		5.54		16.92		137.78		2,138		294,537.64
** Rabbit Creek	142.30		6.83		20.88		170.01		2,260		384,222.60
Aquarius Creek	89.90		4.32		20.53		114.75		1,518		174,190.50
Colletti House	81.24		3.90		11.92		97.06		1,348		130,836.88
North Star House	79.99		3.84		11.74		95.57		1,694		161,895.58
** Jesse Lee Home	124.47		5.97		18.26		148.70		12,178		1,810,868.60
Alaska Baptist Family Svce.Ctr.	60.35		2.90		8.86		72.11		1,366		98,502.26
*** Alaska Youth Village	72.30		3.47		10.61		86.38		6,836		494,242.80
Bethel Group Home	42.01		2.02		6.16		50.19		2,624		131,698.56
Bethel Receiving Home	64.02		3.07		9.39		76.48		1,610		123,132.80
Booth Memorial Home	113.60		5.45		16.67		135.72		4,800		651,456.00
Covenant High School	28.17		1.35		4.13		33.65		365		12,282.25
Hilltop Home	74.32		3.57		10.90		88.79		5,734		775,491.86
Juneau Receiving Home	76.89		3.69		11.28		91.86		4,176		383,607.36
** Kenai Peninsula Center	81.84		3.93		12.01		97.78		2,592		253,445.76
Ketchikan Children's Home											
Teen 1	59.55		2.86		8.74		71.15		3,596		255,855.40
Teen 2	68.12		3.27		9.99		81.38		3,162		257,323.56
Kodiak Baptist Mission	54.42		2.61		7.98		65.01		4,604		299,306.04
Nome Receiving Home	105.99		5.09		15.55		126.63		1,706		216,030.78
North Star Children's Home	54.02		2.59		7.93		64.54		4,055		261,709.70
North Slope Borough	106.05		5.09		15.56		126.70		2,048		259,481.60
Presbyterian Hospitality Hse.	98.34		4.72		14.43		117.49		7,398		869,191.02
** St. Jude Center	72.33		3.47		10.61		86.41		290		25,058.90
St. Mary's Mission	8.33		.40		1.22		9.95		457		4,547.15
Turning Point Boys' Ranch	84.33		4.05		12.37		100.75		13,624		1,372,618.00
Youth Advocates (Sitka Rec.)	38.39		1.84		5.63		45.86		1,368		62,736.48
Totals							N/A		92,435		9,764,270.08
Total - Averages							$105.63		253 FTE		9,764,270.08

* 4.8% is only an estimate based on the adjustment for FY 81 over FY 80 and may be low. The adjustment for FY 80 over FY 79 was 9.8%, and for FY 79 over FY 78 was 22.8%. Thus a supplemental request may be necessary for FY 82.

** Contracts

*** Census estimated - not rec'd this date. This facility said to be closed to state children as of 4/1/81.

ATTACHMENT 1

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Calculation of Foster Care Rates
FY 1982

Multiplier for CPI Increase

CPI:	
March, 1980	223.5
January, 1981	240.1
March, 1981 - Projected	243.4

Multiplier:

$$\frac{\text{CPI - March, 1981}}{\text{CPI - 1970}} \quad \frac{243.4}{111.5} = 2.1830$$

Multiplier for Regional Differentials	14A Pay Schedule	Multiplier
Southeastern, Southern, Southcentral	1995	1.0000
Fairbanks	2291	1.1484
Bethel	2640	1.3232
Kotzebue	2736	1.3714

Calculation of Rates

Location	Age Group	1970 Annual	CPI Multiplier	Differential Multiplier	Annual	Monthly	Daily Rates
Southeastern, Southern, Southcentral:	4 & under	1.935	2.1830	1.0000	4224	352	11.57
	5 - 11	2.140	2.1830	1.0000	4672	389	12.80
	11 & over	2.557	2.1830	1.0000	5582	465	15.29
Fairbanks:	4 & under	1.935	2.1830	1.1484	4850	404	13.29
	5 - 11	2.140	2.1830	1.1484	5365	447	14.70
	11 & over	2.557	2.1830	1.1484	6410	534	17.56
Bethel:	4 & under	1.935	2.1830	1.3233	5590	466	15.32
	5 - 11	2.140	2.1830	1.3233	6182	515	16.94
	11 & over	2.557	2.1830	1.3233	7387	616	20.24
Kotzebue, Barrow:	4 & under	1.935	2.1830	1.3714	5793	483	15.87
	5 - 11	2.140	2.1830	1.3714	6407	534	17.55
	11 & over	2.557	2.1830	1.3714	7655	638	20.97

ATTACHMENT 2

POSITION PAPER

COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 100

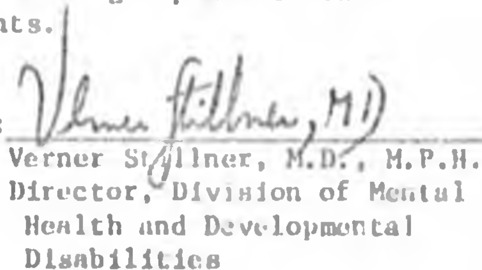
"An Act relating to mentally ill persons; and providing for an effective date."

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 right to 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., M.P.H.
Director, Division of Mental Health and Developmental Disabilities

Date: 5/26/81

Approved by:
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)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		467.5	1,063.9	1,965.4	3,239.8	5,451.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
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 imp[illegible]ment SB 100 are the [illegible]ts of the increased number of court hearings, the field and m[illegible]al staff training [illegible] the court related activity and an array of costs associated with the establishment of designated fa[illegible]ities. Each of these costs are individually described under their separate headi[illegible] In addition spectrum of designated facilities are presented as alternate levels of implementation. Each level provides [illegible]

IV. DATE February 17, 1981 PREPARED BY [signature] [signature] 5/5/81
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 [signature] Date 2/18/81

33-001 (Rev 12/80)

an increase 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 numbe 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 processes 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 2 .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"		5[illegible] 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

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

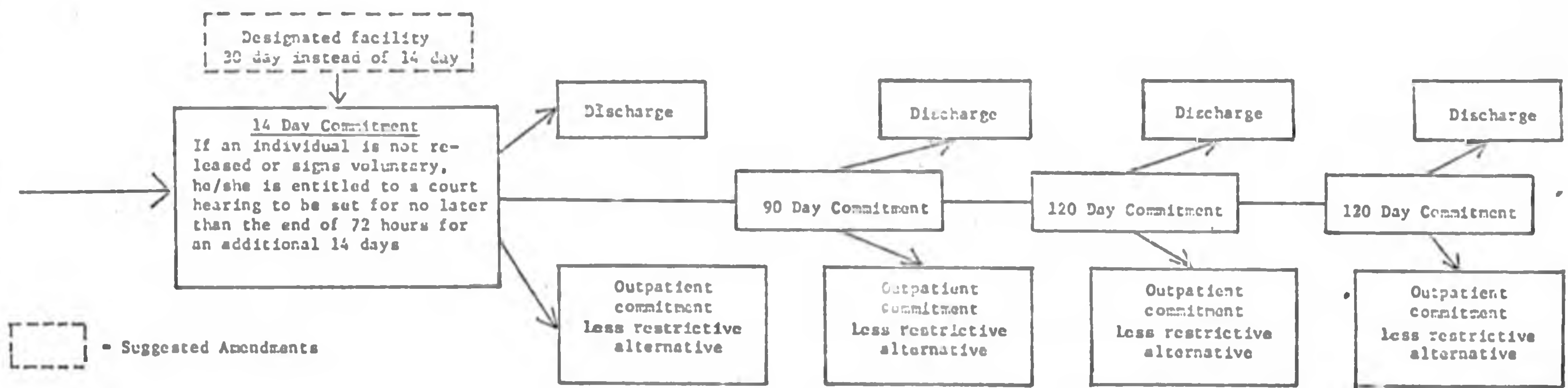
Ex parte order not issued individual exits judicial system

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

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

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



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

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Senate Bill 100

Title An act relating to mentally ill persons

Requested by Senator Parr   Date January 28, 1981

II. FISCAL DETAIL

Agency Affected Administration

Program Category Affected Justice

BRU, Program, or Subprogram(s) Affected Public Defender - Third District

(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		53.0	58.3	64.1	70.5	77.6
200 TRAVEL						
300 CONTRACTUAL		4.0	4.4	4.8	5.3	5.9
400 COMMODITIES		.5	.6	.6	.7	.7
500 EQUIPMENT		1.0	1.1	1.2	1.3	1.5
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		58.5	64.4	70.7	77.8	85.7

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		58.5	64.4	70.7	77.8	85.7
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME		1.0	1.0	1.0	1.0	1.0
PART TIME						
TEMPORARY						

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

This bill would increase the workload of the Public Defender as it relates to the caseload at Alaska Psychiatric Institute by three times the present caseload. There are currently 4 to 6 hearings per week at API. The work involved in these hearings occupies the time of one attorney one-half time. It is estimated that there would be a total of 18 hearings per week and that the additional hearings would require the addition of an Attorney III full time. Other costs are associated with the addition of the new position. Costs for FY 83 and beyond are based on 10% inflation.

IV. DATE 1-29-81   PREPARED BY Judy Crondahl

AGENCY Administration

PHONE 465-2277

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

Senator Parr

Keith Specking

33-001 (Rev 12/80)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SB 100
Title "An Act relating to mentally ill persons; and providing for an effective date"
Requested by ______ Date 2/18/81

II. FISCAL DETAIL
Agency Affected Department of Law
Program Category Affected General Government
BRU, Program, or Subprogram(s) Affected Legal Services
(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		52.3	56.5	61.0	6[illegible].9	71.2
200 TRAVEL		3.0	3.2	3.5	3.8	4.1
300 CONTRACTUAL		3[illegible]	3.2	3.5	3.8	4.1
400 COMMODITIES		[illegible]	1.1	1.2	1.3	1.4
500 EQUIPMENT		1.0				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		61.8	64.0	69.2	74.8	80.8

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		61.8	64.0	69.2	74.8	80.8
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME		1.0	1.0	1.0	1.0	1.0
PART TIME						
TEMPORARY						

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

Enactment of SB 100, which will provide a greatly increased mental commitment process, will require an equivalent increase in attorney time to represent the state during the hearing process. It has been estimated that there will be an increase of seven hearing hours per week which will also require 14+ hours of additional attorney preparation time. Increased Public Defender representation anticipates additional appeals from commitment rulings which, in turn, will require further attorney time. We therefore believe that the full-time service of an Attorney III (Range 22) will be needed at Anchorage, to implement the state's statutory responsibilities under this Act.

An inflation factor of 8 percent has been used for succeeding years' projected expenses.

Richard L. Pegues

IV. DATE February 18, 1981 PREPARED BY Richard L. Pegues, Dir., Admin. Svcs.
AGENCY Department of Law
PHONE 465-3605

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

33-001 (Rev. 12/80)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No. 100
Title An Act Relating to Mentally Ill Persons
Requested by Senate HESS Committee Date 2/15/81

II. FISCAL DETAIL
Agency Affected Alaska Court System
Program Category Affected Administration of Justice
BRU, Program, or Subprogram(s) Affected Alaska Court System
(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		30.4	43.8	47.3	51.1	55.2
200 TRAVEL						
300 CONTRACTUAL		28.1	40.5	43.7	47.2	51.0
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		58.5	84.3	91.0	98.3	106.2

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		58.5	84.3	91.0	98.3	106.2
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME						
PART TIME		.9	.9	.9	.9	.9
TEMPORARY						

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

The fiscal impact of SB 100 on the Alaska Court System will come in two areas: 1) increased number of hearings will require additional professional and clerical staff time; 2) the Court System, when requested, must appoint and pay for independent physicians to examine patients prior to the hearing held within 14 days of their commitment.

The Court System, in conjunction with the staff of API, has developed rough estimates of the number of additional hearings required under SB 100. These estimates are:

72 hour hearing - 100-150/year
14 day hearing - 100/year
90 day hearing - 10-20/year

IV. DATE 2/25/81 PREPARED BY
AGENCY Alaska Court System - Administration
PHONE 264-0545

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

33-001 (Rev. 12/80)

At the present time, the court is conducting 150-200 hearings per year, which require an average of two afternoons per week for three hours. Hearings are conducted at API, and the Probate Master and In-Court Clerk for the Court System travel to API for the hearings. It is projected that the increase of approximately 250 hearings/year will require a 30 percent increase in available time for the Probate Master and In-Court Clerk.

In addition to in-court time, the calendaring, noticing, and clerical follow-up of the additional hearings will require approximately 30 percent of a full-time clerical position.

The personnel cost associated with this bill is therefore:

Probate Master	(Range 24)	$59,952 x 30% =	17,986
In-Court Clerk	(Range 12)	24,756 x 30% =	7,427
Court Clerk	(Range 10)	19,356 x 30% =	5,807
			31,220
		Benefits at 30%	9,366
			$40,586

The cost to the Court System for psychiatric examination by independent physicians is projected as follows:

150 evaluations at $250 = $37,500

The projected fiscal impact for FY 82 reflects 75 percent of a total year's cost, due to the October 1, 1981 effective date. The following years are projected at 8 percent inflation increases.

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. 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)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		467.5	1,063.9	1,965.4	3,239.8	5,451.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME		1	1	1	1	1
PART TIME		2	2	2	2	2
TEMPORARY						

II. 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 Thomas R. Brown
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 [signature] Date 2/18/81

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% o 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 processes 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

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CABLE "ZENAS SEATTLE"
TELEX 329473 BURGESS SEA

May 15, 1981

Senator Parr
State Capitol
Pouch V
Juneau, AK 99811

Dear Senator Parr:

I am aware that Senate Bill 100 is presently pending in your legislature and that action moving the bill out of committee and through both Houses of the legislature must take place within days if the bill is to become law this year. I urge you to give it immediate attention and get it into law.

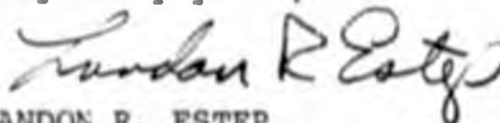
I have been active for many years handling legal cases dealing with the rights of the mentally ill and have served on several governmental commissions charged with revising the involuntary treatment laws and procedures of this state. I am a draftsman of the present Washington Involuntary Treatment Act.

It seems clear that your present statute would not stand a judicial test of constitutionality. It is lacking in numerous procedural and substantive rights the courts have held essential. A 1976 study by Dr. Darold A. Treffart and Richard W. Krajeck, published in Forensic Psychiatry, indicates Alaska's present law conforms with the provisions of the Model Commitment Statute in only nine of forty elements.

Senate Bill 100, on the other hand, is a thoughtful and well-drafted alternative which, to the best of my knowledge, satisfies presently articulated constitutional requirements for involuntary treatment procedures. There is a vast difference between this and the present law. A failure to substitute this bill for the present law would be to completely ignore the rights and interests of the mentally ill.

I urge you to do what you can to get Senate Bill 100 into law.

Very truly yours,



LANDON R. ESTEP

LRE:kt

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

President
Sister Barbara Haase
Ketchikan General Hospital
Ketchikan

President Elect
Tom Mingen
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
Ron Pavelles
Alaska Hospital & Medical Center
Anchorage

Immediate Past President
Al Camosso
Providence Hospital
Anchorage

Executive Director
Dennis L. DeWitt
Juneau

June 2, 1981

The Honorable Fred Brown
House of Representatives
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Brown:

The Alaska State Hospital Association has reviewed CSSB 100 and wishes to inform you of our support.

Senate Bill 100 is a valuable step forward in protecting a mental patient's rights 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. This legislation is long over due. Prompt action by the House Judiciary Committee could make this legislation law this year. We believe that such an action would be in the best interest of the citizens of Alaska.

Sincerely,

Dennis L. DeWitt
Executive Director

DLD/b

cc: House Judiciary Committee
Senator Charles Parr

SB 100 file

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

President
Sister Barbara [illegible]
Ketchikan General Hospital
Ketchikan

President Elect
Tom Mingen
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
Ron Pavellas
Alaska Hospital & Medical Center
Anchorage

Immediate Past President
Al Camosso
Providence Hospital
Anchorage

Executive Director
Dennis L. DeWitt
Juneau

[illegible] 24, 1981

The Honorable Jay Hammond
Governor of the State of Alaska
Pouch A
Juneau, Alaska 99811

Dear Governor Hammond:

The Alaska State Hospital Association wishes to take this opportunity to inform you of our support for CSSB 100 (Judiciary) which is before you for your consideration.

Senate Bill 100 is a valuable step forward in protecting the rights of mental patients while at the same time providing the ability to provide sometimes necessary involuntary treatment. In addition, this measure provides a means for non-state 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 was involved in many of the hours of work which were spent on this bill. While no one would claim it to be the perfect piece of legislation, I assure you that it is legislation of which we can be proud. There is a general belief, in my judgement, by all those who were involved in this bill that it will work and that it will protect individual rights and provide for a high quality of patient care.

The Alaska State Hospital Association respectfully requests that you sign this measure into law.

Sincerely,

Dennis L. DeWitt
Executive Director

cc: Senator Charles Parr

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for Senate Bill No. 100
Title "An Act relating to mentally ill persons;..."
Requested by ______ Date ______

II. FISCAL DETAIL

Agency Affected Department of Public Safety
Program Category Affected Administration of Justice
BRU, Program, or Subprogram(s) Affected Detachments & CIB, Judicial Services, Academy
(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		1,158.2	1,660.5	1,793.[illegible]	1,936.8	2,091.7
200 TRAVEL		1,544.4	2,203.2	2,379.5	2,569.9	2,775.5
300 CONTRACTUAL		277.8	334.5	361.3	390.2	421.4
400 COMMODITIES		59.6	78.3	84.6	91.4	98.7
500 EQUIPMENT		465.2				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		3,505.2	4,276.5	4,618.7	4,988.3	5,387.3

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		3,505.2	4,276.5	4,618.7	4,988.3	5,387.3
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME		25	25	25	25	25
PART TIME						
TEMPORARY						

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

The Division review of the potential impact of this Bill upon its operations indicates the need for twenty-five additional Troopers to transport individuals to and from A.P.I. as ordered by Judges and Magistrates whom we assume will take advantage of the provisions of this bill to solve the problem that presently exist relating to alcohol and drug abuse, child abuse, alcohol and non-alcohol aggressive behavior problems, domestic violence problems and possibly divorce and child custody cases. An inflation factor of 8% is added each year after F.Y.'82.

See the attached schedules for supporting financial data.

IV. DATE May 6, 1981

PREPARED BY Francis C. Allan
AGENCY Administrative Services/Alaska State Troopers
PHONE 269-5691

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

33-001 (Rev. 12/80)

PROJECTED FIRST YEAR COSTS

CODE	DESCRIPTION	BASIC TROOPER COSTS (1)	TRAVEL COSTS (2)	TIMES 1ST YEAR % (3)	ACADEMY BRU Costs (4)	1ST YEAR TOTALS
100	Personal Services	1,537,525		1,153,144	5,068	1,158,212
200	Travel		2,040,000	1,530,000	14,364	1,544,364
300	Contractual	309,725		232,294	45,500	277,79[illegible]
400	Commodities	72,500		54,375	5,175	59,550
500	Equipment	465,250		465,250		465,250
	TOTAL	2,385,000	2,040,000	3,435,063	70,107	3,505,170

SUBSEQUENT YEARLY BASE COSTS

100	Personal Services	1,537,525
200	Travel	2,040,000
300	Contractual	309,725
400	Commodities	72,500
	TOTAL	3,959,750

(1) These costs are for twenty-five Troopers. See the attached schedule for individual costs.

(2) Travel expenses are expected to be high. They are based upon the movement of approximately 500 people each fiscal year in each Detachment Approximately 30% of the costs are anticipated to be for "bush" charter flights. Detachment breakdown is as follows:

"A" Detachment	$540,000
"B" & "C" Detachments	150,000
"D" Detachment	540,000
"E" Detachment	540,000
Anchorage J.S.	270,000
	$2,040,000

(3) The bill is due to come into effect on October 1, 1981. Thus only three quarters of FY82 yearly costs would be incurred in all line items except equipment.

(4) These amounts represent the cost of training the twenty-five Troopers at the Public Safety Academy in Sitka. Because of the large number of Troopers required, an additional class would need to be held.

TROOPER COSTS

PERSONAL SERVICES - 100		
TROOPER 76-E		
$3,164 x 12 months =	$37,968	
+ 208 hours OT @ $28.33	5,893	
Shift Differential 3.75%	1,428	
Sub Total	$45,289	
+ 27.33% Benefits	12,437	
+ 6.65% FICA	1,975	
+ $150 per month - Health Benefits	1,800	
TOTAL PERSONAL SERVICES		$61,501
TRAVEL & PER DIEM - 200		
See separate discussion.		
CONTRACTURAL - 300		
Telephone/Postage $60 per month X 12	720	
Photo Processing, $25 per month X 12	300	
PSEA Physical Exam, Average	300	
Uniform PSEA Cleaning Allowance	425	
HWCF Vehicle - Monthly Cost Replacement $347 month + 2,000 miles X .27 cents 887 X 12	10,644	
TOTAL CONTRACTUAL		12,389
COMMODITIES - 400		
Uniforms/with all accessories; jacket, hats, handcuffs, etc.	1,600	
Film Supplies + Office Supplies	700	
Vehicle Accessories - Blankets, tire chains, snow tires, flares, etc.	600	
TOTAL COMMODITIES		2,900
EQUIPMENT - 500		
Patrol Vehicle - initial cost	10,750	
Portable Light	200	
Underhood Speaker	200	
Car Radio	3,000	
Siren/Amplifier	200	
MX 360 Radio-Portable w/charger	3,000	
Moving Radar Gun	600	
Firearms (revolver, shotgun & rifle)	660	
TOTAL EQUIPMENT		18,610
TOTAL TROOPER COST TO THE BRU		$95,400

Academy Costs

	Student Costs	Class Cost	Total
100 Personal Services		5,068	5,068
200 Travel		14,364	14,364
300 Contractual	1,820 X 25 = 45,500		45,500
400 Commodities	207 X 25 = 5,175		5,175
TOTALS	2,027 X 25 = 50,675	19,432	70,107

Special Note: The Department of Health & Social Services, Division of Mental Health, felt that there will be a minimal impact in terms of an increase in involuntary committments. However, the experience of the Alaska State Troopers in dealing with the judiciary leads this Department to the conclusion that the impact of this bill, if enacted, will be widespread in terms of involuntary evaluation. It is believed that an estimated 2500 additional people statewide would come under this bill, requiring Trooper escorts and the associated transportation costs.

Senator Parr

SECTIONAL ANALYSIS

CSSB 100 (Jud.)

Section 1.

ARTICLE 6. MENTAL HEALTH PROGRAM.

page 1 - 3

The main thrusts of the bill are to balance an individual's constitutional right to liberty and the state's interest in protecting society from persons who are dangerous to others or to themselves. The Department of Health and Social Services is given the authority and responsibility for administering the program and supervising the facilities involved.

ARTICLE 7. VOLUNTARY ADMISSION FOR TREATMENT.

page 3 - 5

Sets a cutoff age of 14 years for a child being committed by parents, and specifies the rights of persons who voluntarily enter a mental health facility. This Article further provides that an adult may be released from voluntary treatment unless the mental health professionals initiate involuntary commitment proceedings, and that a child under 14 may be released on parent's request unless involuntary commitment proceedings are initiated.

ARTICLE 8. INVOLUNTARY ADMISSION FOR TREATMENT.

page 5 - 6

Describes the procedure for involuntary commitment. Upon petition by an adult, the judge initiates a screening investigation, and upon completion of it, may issue an order directing an evaluation. The petition must allege, and the judge must find, that there is probable cause to believe that the respondent is mentally ill and likely to cause serious harm to himself or others, or that he is gravely disabled. The evaluation must be conducted within 72 hours.

page 6 - 7

If the evaluation facility finds that the person is mentally ill and presents a danger to himself or others, or is gravely disabled, the facility shall notify the court so that a hearing on a 21-day commitment may be held. Two mental health professionals who have examined the respondent must sign the petition for commitment. If the person does not meet these tests, he must be released.

page 8 - 9

At the evaluation facility the respondent must be notified of his rights in a language he understands, and has a right to be free of medication at the time of the hearing.

page 9 - 11

At the court hearing for a 21-day commitment, the respondent has a right to be present, to have an attorney present evidence on his behalf, cross-examine witnesses, be silent, to have an interpreter if he does not understand English, and to have the hearing open or closed, as he elects. The court may commit, for not more than 21 days, if there is no less restrictive alternative available.

page 11 - 13

Following the 21-day commitment, there may be a 90-day commitment. The respondent has the same rights as for the 21-day commitment.

page 13 - 16

Following the 90-day commitment, there may be a series of 120-day commitments. In all of these the respondent has the same rights as he has under the 21-day commitment.

page 15 - 19

The respondent must be committed to the treatment facility nearest his home, if that is possible. He also may be given leave from the facility and may be released for specified outpatient care. He must be released if he is no longer gravely disabled or likely to cause serious harm as a result of mental illness.

page 20 - 21

This Article also contains a provision that the right of habeas corpus is not limited, and a provision to hold blameless those persons who act in good faith on a commitment procedure. It is a felony to wilfully initiate an involuntary commitment procedure without good cause.

ARTICLE 9. PATIENT RIGHTS.

page 21

This Article provides that the patient has a right to participate in his treatment program, to know about the medication he is asked to take, and not to be kept in a locked quiet room unless such restraint is necessary to keep him from harming himself or others. It further provides safeguards when the person must be so restrained.

page 22 - 23

Additional rights guaranteed are freedom from unnecessary or excessive medication, the right to refuse electro-convulsive therapy or aversive conditioning, and the prohibition of psychosurgery, lobotomy, or other such treatment, without a court order. The facility must prepare a discharge plan when the patient is released.

page 23 - 27

Experimental treatments which involve risk may not be administered, and the Commissioner of Health and Social Services must make a decision as to whether a treatment is experimental. A person who is undergoing evaluation treatment does not lose any of his or her civil rights, including

the right to privacy and personal possessions. Records obtained in evaluation and treatment are confidential. Rights must be posted in all treatment facilities, must be explained in a language the person understands, and discrimination on the basis of evaluation or treatment for mental illness is prohibited.

ARTICLE 10. MISCELLANEOUS PROVISIONS.

page 27 - 29

This Article provides that the State pays for necessary transportation in the case of involuntary commitment. It also provides that persons who are not residents of Alaska may be returned to the state of residence, and that the Department may enter into a reciprocal agreement or compact with another state concerning custody of mentally ill persons. A third provision is that a person whom the Department hospitalizes in another state under a contract keeps all the rights which Alaska guarantees.

page 29 - 30

Personal property and unclaimed effects of a patient who dies or leaves are kept by the Department for one year if they are not claimed by a legal heir.

page 30 - 32

Provision is made for paying the expenses of witnesses, peace officers, attorneys, and the jury, in commitment cases. The Department has the authority to charge for care, transportation, and treatment of a patient, but has the discretion to relieve the patient or other person responsible for payment if it is in the best interests of the state and the other party. Charges assessed may not exceed the actual cost of the care and treatment.

page 32 - 35

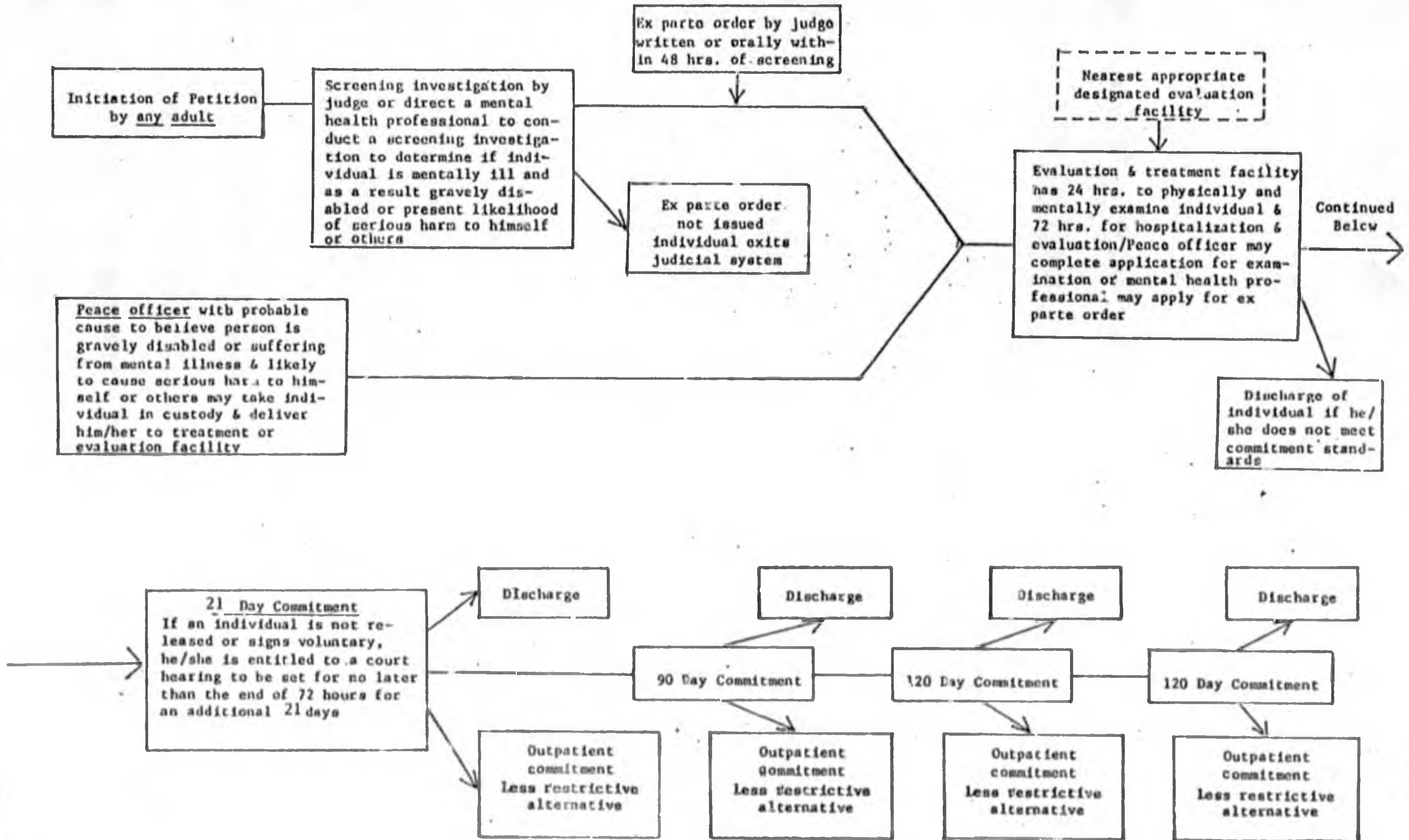
The final three pages of Article 10 are definitions. This is an important section. Definitions specify more precisely the grounds for involuntary commitment and which mental health professionals may sign involuntary commitment reports. There is also a definition of designated treatment facility, which is necessary if persons are to be hospitalized in some place other than API.

Section 2.

page 36

This section of the bill deals with a person being tried for a crime, who intends to rely on a defense of mental disease or defect. It closes a possible loophole so that a person found not guilty because of mental disease could not then automatically be set free.

INVOLUNTARY CIVIL COMMITMENT UNDER SB 100



POSITION PAPER/Department of Health & Social Services

SB 100 file

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 right to be protected from those persons who are dangerous as a result of mental i lness. 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, MD
Verner Stillner, M.D., M.P.H.
Director, Division of Mental Health and Developmental Disabilities

Date: 5/26/81

Approved by: [signature]
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	1,06[illegible].9	1,965.4	3,239.8	5,451.5

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		467.5	1,063.9	1,965.4	3,239.8	5,451.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME		[illegible]	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

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

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) MPB Approval [illegible] Date 2/18/81

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 processes 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

I.I. 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.

Bill No. SB 100 Fiscal Note (continuation)

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	1,5[illegible]9.9

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

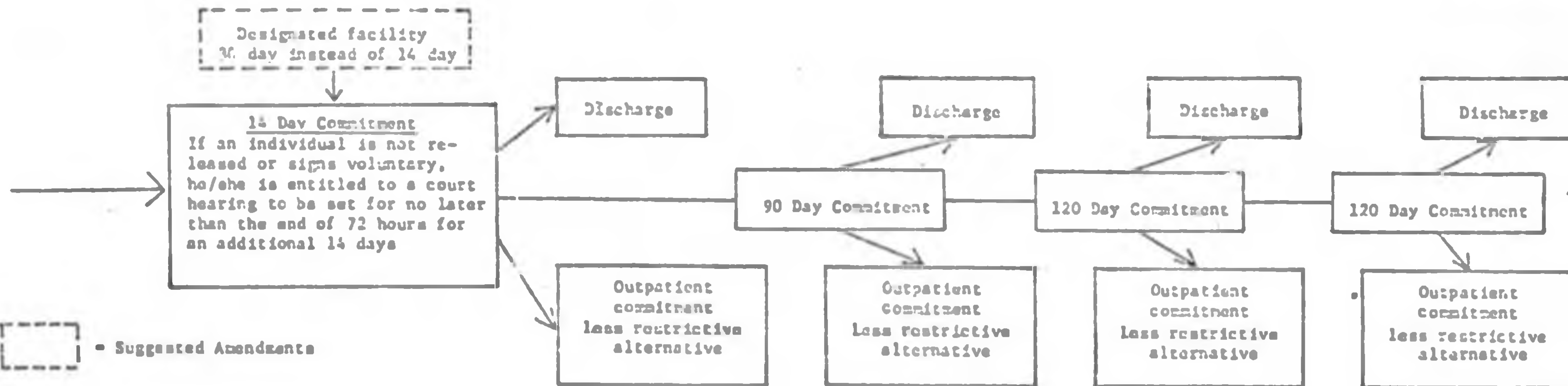
Ex parte order not issued individual exits judicial system

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

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

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



ASSOCIATION OF SCIENTOLOGISTS FO
701 VANCE BLDG
SEATTLE WA 98101

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SENATOR PARR
STATE CAPITOL
POUCH V
JUNEAU AK 99811

THIS IS A CONFIRMATION COPY OF THE MESSAGE SENT TO GOVERNOR HAMMOND:

I AM COMMUNICATING TO YOU REGARDING SB 100, GENTLEMEN, AS YOU WILL PROBABLY BE THE KEY INDIVIDUAL SHAPING THE FUTURE OF YOUR CITIZENS REGARDING MENTAL HEALTH IN YOUR STATE. I HAVE A RATHER SPECIALIZED LAW PRACTICE IN SEATTLE DEALING WITH ABUSES OF THE COMMITMENT PRACTICE OF THE STATE, AND SERVE AS THE LEGAL ADVISOR OF THE CITIZENS COMMISSION ON HUMAN RIGHTS.

I UNDERSTAND THAT SB 100 HAS BEEN INTRODUCED INTO THE SENATE AFTER A SIMILAR BILL HAS PASSED THE HOUSE DURING THE LAST THREE SESSIONS. THIS BILL IS FAR AND AWAY SUPERIOR TO THE PRESENT LAW, AND SHOULD BE PUSHED THROUGH IMMEDIATELY.

IN MY DEALINGS AS A LAWYER IN NUMEROUS COMMITMENT CASES IN WASHINGTON, I HAVE RUN ACROSS FREQUENT VIOLATIONS OF RIGHTS OF PATIENTS, AND INSTANCES OF VIOLENT FORCED TREATMENT WHICH I BELIEVE NO LAW CAN BE STRONG ENOUGH OUTSIDE OF TOTAL BANNING OF THIS KIND OF "HELP". SB 100 IS A STRONG STEP IN THE RIGHT DIRECTION, AND SHOULD BE TAKEN TO INSURE [illegible] FOR YOUR RESIDENTS.

SINCERELY,
RICHARD B SANDERS, ESQ

CC: SENATOR PARR
SENATOR [illegible]
SENATOR [illegible]

1935 EST

[illegible]

March 30, 1981

Mr. Robert D. Bowers, Chairman
Mental Health Advisory Council
Room 222, Mackay Building
338 Denali Street
Anchorage, Alaska 99501

Dear Mr. Bowers:

Thank you for your letter of March 17 about SB 100.

The bill should have been out of the Committee by now, but was delayed in Legal Services, and we found a few errors when we finally got it. Hopefully it will be in the Judiciary Committee this week.

I certainly appreciate the support you have given in this attempt to improve mental treatment for all of our citizens.

Sincerely,

Charles H. Parr

CHP:vc

ALASKA MENTAL HEALTH ASSOCIATION

1030 W. 26th Ave., #1

~~5401 Cordova Street, #304~~ 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 preven 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.

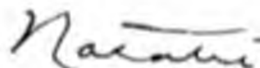
Sec. 47.30.845, Page 25, Line 7: CONFIDENTIAL RECORDS. The patient should also be able to obtain one copy of his/her medical records at no cost. Since the patient is party to his/her treatment plan, there is no reason to deny access to the medical records.

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

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.

Older Person's Action Group

Maunelük Association

Central Peninsula Mental Health Association

Bristol Bay Area Health Corp.

Dept. Public Safety

Baranof 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

API revokes passes to criminally insane

by Maureen Blewett
Times Writer

Alaska Psychiatric Institute has revoked its policy of allowing unescorted passes for patients declared not guilty by reason of insanity, the hospital superintendent said Tuesday.

The change comes in the wake of the confession by a 34-year-old patient at the institute that he killed four teen-agers while on a pass to work at Sears Roebuck and Co. The patient, Charles Louman Meach III, had been declared not guilty by reason of insanity after the beating death of Robert Alexander Johnson in 1973.

Meach was to appear in Superior Court Tuesday on a request by his public defender to be returned to API. Although a District Court judge ordered Meach to jail last week, officials at Sixth Avenue Jail, the state's only pre-trial facility, have refused to say whether Meach is being held there.

Dr. Harold Conrad, API superintendent, said two patients — Meach and another person — were allowed passes at the time of the murders. No unescorted passes will be allowed until the institute and the state have revised the law and policies involving patients declared not guilty by reason of insanity, Conrad said.

In other developments Tuesday, the Department of Law in Anchorage has proposed a law requiring mentally ill defendants to serve prison time after they have been declared cured of their illness.

The proposal would also:

- Make it harder to successfully claim a defendant was not guilty of criminal conduct because he was insane when a crime was committed. Under the proposal, a person who did not understand he was attacking a human being would be allowed to plead insanity as a defense. An example would be if a murder defendant believed he was attacking the ghost of his mother rather than a living human being.
- Make it more difficult for a defendant declared not guilty by reason of insanity to leave a mental institution. The proposal would require the defendant to prove he was no longer suffering from any mental illness. "Mental illness" would mean any condition that increases the chances the defendant might be a danger.
- Allow a court to find a defendant guilty but mentally ill. An example would be a defendant who knew he was doing something wrong. This defendant would be one who might shoot a person, thinking the person was Hitler.
- Put a guilty but mentally ill patient in prison to serve the remainder of his term once he had been declared cured of his mental illness.

The proposal, written by special prosecutors Tim Petumenos and David Mannheimer with API forensic psychiatrist Dr. David Coons, is in the hands of Alaska's chief prosecutor, Dan Hickey.

green marks Steve Lipen's concerns (from Stalgulewski's office) (3816

Original sponsors: Parr, Stimson, and Fischer

Offered: 5/14/81
Referred: Finance

1 IN THE SENATE BY THE JUDICIARY COMMITTEE

2 CS FOR SENATE BILL NO. 100 (Judiciary)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TWELFTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to mentally ill persons; and providing

7 for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 47.30 is amended by adding new sections to read:

10 ARTICLE 6. MENTAL HEALTH PROGRAM.

11 Sec. 47.30.655. PURPOSE. The purpose of this major revision of

12 Alaska civil commitment statutes is to more adequately protect the legal

13 rights of persons suffering from mental illness. The legislature has

14 attempted to balance the individual's constitutional right to physical

15 liberty and the state's interest in (1) protecting society from persons

16 who are dangerous to others; and (2) protecting persons who are dan-

17 gerous to themselves, by providing due process safeguards at all stages

18 of commitment proceedings. In addition, the following principles of

19 modern mental health care have guided this revision:

20 (1) that persons be given every opportunity to accept volun-

21 tary treatment before involvement with the judicial system;

22 (2) that persons be treated in the least restrictive alter-

23 native environment consistent with their treatment needs;

24 (3) that treatment occur as promptly as ~~possible~~ and as close ?

25 to the individual's home as possible; ~~as~~ economically reasonable ?

Charlie's NO!

26 (4) that a system of mental health community facilities and

27 supports be available;

28 (5) that patients be informed of their legal rights and be

29 informed of and allowed to participate in their treatment program as

1 much as possible;

2 (6) that persons who are mentally ill but not dangerous to
3 others be committed only if there is a reasonable expectation of im-
4 proving their mental condition.

5 Sec. 47.30.660. POWERS AND DUTIES OF DEPARTMENT. The department
6 is the mental health authority of the state and shall

7 (1) administer a comprehensive program for the prevention of
8 mental illness and the care and treatment of the mentally ill, including
9 inpatient and outpatient care and treatment and the procurement of
10 services of specialists or other persons on a contractual or other
11 basis;

12 (2) take the actions and undertake the obligations which are
13 necessary to participate in federal grants-in-aid programs and accept
14 federal or other financial aid from whatever sources for the study,
15 examination, care, and treatment of the mentally ill;

16 (3) administer AS 47.30.655 - 47.30.915;

17 (4) designate, operate, and maintain treatment facilities
18 equipped and qualified to provide inpatient and outpatient care and
19 treatment for the mentally ill;

20 (5) provide for the placement of mentally ill patients in
21 designated treatment facilities;

22 (6) enter into arrangements with governmental agencies for
23 the care or treatment of the mentally ill in facilities of the govern-
24 mental agencies in the state or in another state;

25 (7) enter into contracts with treatment facilities for the
26 custody and care or treatment of the mentally ill;

27 (8) enter into contracts which incorporate safeguards consis-
28 tent with AS 47.30.655 - 47.30.915 and the preservation of the civil
29 rights of the patients with another state for the custody and care or

treatment of patients previously committed from this state under 48 U.S.C., sec. 46 et seq., and P.L. 830, 84th Congress, 2nd Session, 70 Stat. 709;

(9) prescribe the form of applications, records, report., requests for release, and consents to medical or psychological treatment required by AS 47.30.655 - 47.30.915;

(10) require reports from the head of a treatment facility concerning the care of patients;

(11) visit each treatment facility at least annually to review methods of care or treatment for patients;

(12) investigate complaints made by a patient or an interested party on behalf of a patient;

(13) delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility designated, any of the duties and powers imposed upon it by AS 47.30.655 - 47.30.915; and DH&SS Shouldn't loose respons

(14) adopt regulations to implement the provisions of AS 47.-30.655 - 47.30.915.

ARTICLE 7. VOLUNTARY ADMISSION FOR TREATMENT.

Sec. 47.30.670. STANDARDS FOR VOLUNTARY ADMISSION. A person 14 years of age or older may be voluntarily admitted to a treatment facility if he is suffering from mental illness and he voluntarily signs the admission papers.

Sec. 47.30.675. NOTICE OF RIGHTS. (a) Upon the application of a person for voluntary admission, or at the time a person admitted under AS 47.30.690 reaches the age of 14, he shall be given a copy of the following documents which shall be explained to him as necessary:

(1) notice of rights as set out in AS 47.30.825 - 47.30.865 and an explanation of any document served upon him; and

(2) notice tha should he desire to leave at a time when the treatment facility determines that he is mentally ill and as a result is likely to cause serious harm to himself or others or is gravely disabled, the facility could initiate commitment proceedings against him.

(b) If an applicant for voluntary admission does not understand English, the explanation shall be given in a language he understands.

Sec. 47.30.680. DISCHARGE OF VOLUNTARY PATIENTS. A patient who no longer meets the standards established in AS 47.30.670 shall be discharged from the treatment facility.

Sec. 47.30.685. NOTICE OF INTENT TO LEAVE FACILITY; COMMITMENT. A voluntary patient who is 14 years of age or older and who desires to leave a treatment facility must submit to the facility a written notice of intent to leave on a form provided to him by the facility. Upon immediate investigation, the patient shall be evaluated in writing and discharged immediately or given written notice that involuntary commitment proceedings will be initiated against him. The treatment facility may detain the patient for no more than 48 hours after receipt of the patient's notice of intent to leave in order to initiate involuntary commitment proceedings.

Sec. 47.30.690. ADMISSION OF MINORS UNDER 14 YEARS OF AGE. (a) A minor under the age of 14 may be admitted for 21 days evaluation, diagnosis, and treatment at a designated treatment facility if his parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,

(1) he is gravely disabled or is suffering from mental illness and as a result he is likely to cause serious harm to himself or others;

(2) there is no less restrictive alternative available for his treatment; and

(3) there is reason to believe that the patient's mental condition could be improved by the course of treatment.

(b) The minor may be released by the treatment facility at any time during the 21-day period if the professional person in charge or his designated mental health professional determines the minor would no longer benefit from continued hospitalization and the minor is not dangerous. The minor's parents or his guardian must be notified by the facility of the contemplated release and that, unless they initiate involuntary commitment proceedings, the minor will be released.

Sec. 47.30.695. NOTICE OF REQUEST FOR RELEASE OF MINORS UNDER 14 YEARS OF AGE FROM DETENTION AND COMMITMENT. The parent or guardian of a minor who is less than 14 years of age may request and obtain immediate release of the minor at any time, unless as the result of mental illness, the minor is likely to cause serious harm to himself or others.

ARTICLE 8. INVOLUNTARY ADMISSION FOR TREATMENT.

Sec. 47.30.700. INITIATION OF INVOLUNTARY COMMITMENT PROCEDURES. (a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program which receives money from the department under AS 47.30.520 - 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to himself or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a

likelihood of serious harm to himself or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the person into custody and deliver him to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section shall allege that the respondent is reasonably believed to present a likelihood of serious harm to himself or others or is gravely disabled as a result of mental illness and shall specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

Sec. 47.30.705. EMERGENCY DETENTION FOR EVALUATION. A peace officer who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to himself or others of such an immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A correctional facility may be used as an emergency evaluation facility if an evaluation facility is not available. Upon arrival at the evaluation facility, the peace officer shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.

Sec. 47.30.710. EXAMINATION. (a) A respondent who is delivered under AS 47.30.700 or 47.30.705 for emergency examination and treatment

to an evaluation facility shall be examined and evaluated as to his mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the person to be gravely disabled or to present a likelihood of serious harm to himself or others, and (2) is in need of mental health care or treatment, the mental health professional may hospitalize him, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation.

Sec. 47.30.715. ACCEPTANCE OF ORDER. When a facility receives a proper order for evaluation, it must accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time and place for a 21-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, his attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent.

Sec. 47.30.720. RELEASE BEFORE EXPIRATION OF 72-HOUR PERIOD. If at any time in the course of the 72-hour period the mental health professionals conducting the evaluation determine that the respondent does not meet the standards for commitment specified in AS 47.30.700, the respondent shall be discharged from the facility or the place of evaluation by evaluation personnel and the petitioner and the court so notified.

Sec. 47.30.725. COMMITMENT PROCEEDING RIGHTS; NOTIFICATION. (a) When a respondent is detained for evaluation under AS 47.30.655 - 47.-30.915, he shall be immediately notified orally and in writing of his rights under this section. Notification shall be in a language understood by the respondent. His guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

(b) Unless a respondent is released or voluntarily admits himself for treatment within 72 hours of his arrival at the facility or, if he is evaluated by evaluation personnel, within 72 hours from the beginning of his meeting with evaluation personnel, he is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause to detain him after the 72 hours have expired for up to an additional 21 days on the grounds that he is gravely disabled or mentally ill and as a result presents a likelihood of serious harm to himself or others. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS 47.30.700 - 47.30.820.

(c) The respondent has a right to communicate immediately, at the department's expense, with his guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice

(d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against him at the hearing.

(e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 21-day commitment hearing; however, the facility or evaluation personnel may treat him with medication under prescription by a

1 licensed physician or by a less restrictive alternative of his pre-
2 ference if, in the opinion of a licensed physician in the case of
3 medication, or of a mental health professional in the case of alterna-
4 tive treatment, the treatment is necessary to
5 (1) prevent bodily harm to the respondent or others;
6 (2) prevent such deterioration of the respondent's mental
7 condition that subsequent treatment might not enable him to recover; or
8 (3) allow the respondent to prepare for and participate in
9 the proceedings.
10 (f) A respondent, if he is represented by counsel, may waive,
11 orally or in writing, the 72-hour time limit on the 21-day commitment
12 hearing and have the hearing set for a date no more than seven calendar
13 days after his arrival at the facility. The respondent's counsel shall
14 immediately notify the court of the waiver.
15 Sec. 47.30.730. PROCEDURE FOR 21-DAY COMMITMENT; PETITION FOR
16 COMMITMENT. (a) In the course of the 72-hour evaluation period, a
17 petition for commitment to a treatment facility may be filed in court.
18 The petition must be signed by two mental health professionals who have
19 examined the respondent, one of whom is a physician. The petition must
20 (1) allege that the respondent is mentally ill and as a
21 result is likely to cause harm to himself or others or is gravely dis-
22 abled;
23 (2) allege that the evaluation staff has considered but has
24 not found that there are any less restrictive alternatives available
25 that would adequately protect the respondent or others; or, if a less
26 restrictive involuntary form of treatment is sought, specify the treat-
27 ment and the basis for supporting it;
28 (3) allege with respect to a gravely disabled respondent
29 that there is reason to believe that the respondent's mental condition

1 could be improved by the course of treatment sought;

2 (4) allege that a specified treatment facility or less re-
3 strictive alternative that is appropriate to the respondent's condition
4 has agreed to accept the respondent;

5 (5) allege that the respondent has been advised of the need
6 for, but has not accepted, voluntary treatment, and request that the
7 court commit the respondent to the specified treatment facility or less
8 restrictive alternative for a period not to exceed 21 days;

9 (6) list the prospective witnesses who will testify in sup-
10 port of commitment or involuntary treatment;

11 (7) list the facts and specific behavior of the respondent
12 supporting the allegation in (1) of this subsection.

13 (b) A copy of the petition shall be served on the respondent, his
14 attorney, and his guardian, if any, before the 21-day commitment hear-
15 ing.

no jury? NO for a 21-day commitment only?

16 Sec. 47.30.735. 21-DAY COMMITMENT. (a) Upon receipt of a proper
17 petition for commitment, the court shall hold a hearing at the date and
18 time previously specified according to procedures set out in AS 47.30.-
19 715.

20 (b) The hearing shall be conducted in a physical setting least
21 likely to have a harmful effect on the mental or physical health of the
22 respondent, within practical limits. At the hearing, in addition to
23 other rights specified in AS 47.30.655 - 47.30.915, the respondent has
24 the right

25 (1) to be present at the hearing; this right may be waived
26 only with the respondent's informed consent; if the respondent is in-
27 capable of giving informed consent, the respondent may be excluded from
28 the hearing only if the court, after hearing, finds that the incapacity
29 exists and that there is a substantial likelihood that the respondent's

presence at the hearing would be severely injurious to his mental or physical health;

(2) to view and copy all petitions and reports in the court file of his case;

(3) to have the hearing open or closed to the public as he elects;

(4) to be proceeded against according to the rules of evidence applicable to civil proceedings;

(5) to have an interpreter if he does not understand English;

(6) to present evidence on his behalf;

(7) to cross-examine witnesses who testify against him;

(8) to remain silent.

(c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 21 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to himself or others or is gravely disabled.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 21 days if the program accepts the respondent.

(e) The court shall specifically state to the respondent, and give him written notice, that if commitment or other involuntary treatment beyond the 21 days is to be sought, the respondent shall have the right to a full hearing or jury trial.

Sec. 47.30.740. PROCEDURE FOR 90-DAY COMMITMENT FOLLOWING 21-DAY COMMITMENT. (a) At any time during the respondent's 21-day commitment, the professional person in charge, or his professional designee, may

file with the court a petition for 90-day commitment of that respondent. The petition must include all material required under AS 47.30.730(a) except that references to "21 days" shall be read as "90 days"; and

(1) allege that the respondent has attempted to inflict or has inflicted serious bodily harm upon himself or another since his acceptance for evaluation, or that he was committed initially as a result of conduct in which he attempted or inflicted serious bodily harm upon himself or another, or that he continues to be gravely disabled, or that he demonstrates a current intent to carry out plans of serious harm to himself or another;

(2) allege that the respondent has received appropriate and adequate care and treatment during his 21-day commitment;

(3) be verified by the professional person in charge, or his professional designee, during the 21-day commitment. how? person in charge has to "okay" it

(b) The court shall have copies of the petition for 90-day commitment served upon the respondent, his attorney, and his guardian, if any. The petition for 90-day commitment and proofs of service shall be filed with the clerk of the court, and a date for hearing shall be set, by the end of the next judicial day, for not later than five judicial days from the date of filing of the petition. The clerk shall notify the respondent, his attorney, and the petitioner of the hearing date at least three judicial days in advance of the hearing.

(c) Findings of fact relating to the respondent's behavior made at a 21-day commitment hearing under AS 47.30.735 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. Can't change 21 -> 90 why?

Sec. 47.30.745. 90-DAY COMMITMENT HEARING RIGHTS. (a) A respondent subject to a petition for 90-day commitment has, in addition to the rights specified elsewhere in this chapter, or otherwise applicable,

the rights enumerated in this section. Written notice of these rights shall be served on the respondent, his attorney, his guardian, if any, and may be served on an adult designated by the respondent at the time the petition for 90-day commitment is served. An attempt shall be made by oral explanation to insure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language he understands.

(b) Unless the respondent is released or voluntarily admits himself following the filing of a petition and before the hearing, he is entitled to a judicial hearing within five judicial days of the filing of the petition as set out in AS 47.30.740(b) to determine if he is mentally ill and as a result is likely to cause harm to himself or others, or if he is gravely disabled. If the respondent voluntarily admits himself following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS 47.30.740 or under AS 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written notice of intent to leave, the professional person in charge may file with the court a petition for 120-day commitment of the respondent under AS 47.30.770. The 120-day commitment hearing shall be scheduled for a date not earlier than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be continued for no more than 10 calendar days. The jury shall consist of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10

calendar days.

(e) The respondent has a right to retain an independent licensed physician or other mental health professional to examine him and to testify on his behalf. Upon request by an indigent respondent, the court shall appoint an independent licensed physician or other mental health professional to examine hi[illegible] testify on his behalf. The court shall consider an indigent [illegible]ident's request for a specific physician or mental health profess[illegible]nal. A motion for the appointment may be filed in court at any reasonable time before the hearing and shall be acted upon promptly. Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shal[illegible] in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS 47.30.700 - 47.30.915, the rules of evidence and procedure in civil proceedings. → is appeal part of due process NO const.

(g) Until the court issues a fina[illegible] decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If no decision has been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, he shall be released.

Sec. 47.30.750. CONDUCT OF HEARING. The hearing shall be conducted in the same manner, and with the same rights for the respondent, as set out in AS 47.30.735(b). jury trial?

Sec. 47.30.755. COURT ORDER. (a) After the hearing and within the time limit specified in AS 47.30.745, th[illegible] court may commit the respondent to a treatment facility for no more [illegible]han 90 days if the court or jury finds by clear and convincing evidence that the respondent is mentally ill and as a result is likely to cause harm to himself or

others, or is gravely disabled.

(b) If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days.

Sec. 47.30.760. PLACEMENT AT CLOSEST FACILITY. Treatment shall always be available at a state-operated hospital; however, if space is available and upon acceptance by another treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to his home unless the court finds that

(1) another treatment facility in the state has a program more suited to the respondent's condition, and this interest outweighs the desirability of the respondent being closer to home;

(2) another treatment facility in the state is closer to the respondent's friends or relatives who could benefit him through their visits and communications; or

(3) the respondent wants to be further removed from his home, and the mental health professionals who sought his commitment concur in the desirability of removed placement.

Sec. 47.30.765. APPEAL. The respondent has the right to an appeal from any order of involuntary commitment. The court shall inform the respondent of this right.

Sec. 47.30.770. ADDITIONAL 120-DAY COMMITMENT. (a) The respondent shall be released from involuntary treatment at the expiration of 90 days unless the professional person in charge files a petition for a 120-day commitment conforming to the requirements of AS 47.30.740(a) except that all references to "21-day commitment" shall be read as "the

previous 90-day commitment" and all references to "90-day commitment" shall be read as "120-day commitment".

(b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS 47.30.740 - 47.30.750. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 120 days from the date on which the first 90-day treatment period would have expired.

(c) Successive 120-day commitments are permissible on the same ground and under the same procedures as the original 120-day commitment. An order of commitment may not exceed 120 days.

(d) Findings of fact relating to the respondent's behavior made at a 21-day commitment hearing under AS 47.30.735, a 90-day commitment hearing under AS 47.30.750, or a previous 120-day commitment hearing under this section shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.

Sec. 47.30.775. COMMITMENT OF MINORS. The provisions of AS 47.-30.700 - 47.30.815 apply to minors. However, all notices required to be served on the respondent in AS 47.30.700 - 47.30.815 shall also be served on the parent or guardian of a respondent who is a minor, and parents or guardians of a minor respondent shall be notified that they may appear as parties in any commitment proceeding concerning the minor and that as parties they are entitled to retain their own attorney or have one appointed for them by the court. A minor respondent has the same rights to waiver and informed consent as an adult respondent under AS 47.30.655 - 47.30.915; however, he shall be represented by counsel in waiver and consent proceedings.

Sec. 47.30.780. EARLY DISCHARGE. The professional person in charge shall at any time discharge a respondent on the ground that the respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness. A certificate to this effect shall be sent to the court which shall enter an order officially terminating the involuntary commitment.

Sec. 47.30.785. AUTHORIZED ABSENCES. A respondent undergoing involuntary treatment on an inpatient basis under AS 47.30.700 - 47.30.-815 may be authorized to be absent from the treatment facility during times specified by the professional person in charge, or his professional designee, when an authorization to be absent is in the best interests of the respondent and he is not likely to cause harm to himself or others.

Sec. 47.30.790. RETURN FROM UNAUTHORIZED ABSENCE. When a respondent undergoing involuntary treatment on an inpatient basis is absent from the treatment facility without, or in excess of, authorization under AS 47.30.785, the professional person in charge, or his professional designee, may contact the appropriate peace officers who shall take the respondent into custody and return him to the treatment facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody.

Sec. 47.30.795. INVOLUNTARY OUTPATIENT CARE FOR COMMITTED PERSONS. (a) A respondent who was originally committed to involuntary inpatient care under AS 47.30.700 - 47.30.915 may be released before the expiration of his commitment period if a provider of outpatient care accepts him for specified outpatient treatment for a period of time not to exceed the duration of his commitment, and if the professional person in charge, or his professional designee, finds that

(1) it is not necessary to treat the respondent as an inpatient to prevent him from harming himself or others; and

(2) there is reason to believe that the respondent's mental condition would improve as a result of the outpatient treatment.

lower cost?

(b) A copy of the conditions for early release shall be given to the respondent, [illegible] attorney, his guardian, if any, the provider of outpatient care, and the court.

(c) If during the commitment period the provider of outpatient care determines that the respondent can no longer be treated on an outpatient basis because he is likely to cause harm to himself or others or is gravely disabled, the provider shall give the respondent oral and written notice that he must return to the treatment facility within 24 hours, with copies to the respondent's attorney, his guardian, if any, the court, and the inpatient treatment facility. If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge may contact the appropriate peace officers who shall take the respondent into custody and transport him to the facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody.

(d) If the provider of outpatient care determines that the respondent will require continued outpatient care after the expiration of his commitment period, the provider may initiate further commitment proceedings as if he were the professional person in charge, and the provisions of AS 47.30.655 - 47.30.915 apply, except that provisions relating to inpatient treatment shall be read as applicable to outpatient treatment.

Sec. 47.30.800. CONVERSION OF INVOLUNTARY OUTPATIENT TREATMENT TO

1 INPATIENT COMMITMENT. (a) A respondent ordered by the court under the
2 provisions of AS 47.30.700 - 47.30.915 to receive involuntary out-
3 patient treatment may be required to undergo inpatient treatment when
4 the provider of outpatient care finds that (1) the respondent is
5 mentally ill and is likely to cause serious harm to himself or others
6 or is still gravely disabled; (2) the respondent's behavior since the
7 hearing resulting in court-ordered treatment indicates that he now
8 needs inpatient treatment to protect himself or others; (3) there is
9 reason to believe that the respondent's mental condition will improve
10 as a result of inpatient treatment; and (4) there is an inpatient
11 facility appropriate to the respondent's need which will accept him as
12 a patient. Treatment for these respondents shall be available at
13 state-operated hospitals at all times.
14 (b) Upon making the findings specified in (a) of this section,
15 the provisions of AS 47.30.795(b) relating to notice and AS 47.30.745
16 relating to hearing apply.
17 Sec. 47.30.805. COMPUTING PERIODS OF TIME. (a) Except as pro-
18 vided in (b) of this section,
19 (1) computations of a 72-hour evaluation period do not in-
20 clude Saturdays, Sundays, legal holidays, or any period of time neces-
21 sary to transport the respondent to the treatment facility;
22 (2) a 21-day commitment period expires at the end of the
23 21st day after the 72 hours following initial acceptance;
24 (3) a 90-day commitment period expires at the end of the
25 90th day after the expiration of a 21-day period of treatment;
26 (4) a 120-day commitment period expires at the end of the
27 120th day, after the expiration of a 90-day period of treatment or
28 previous 120-day period, whichever is applicable.
29 (b) When a respondent has failed to appear or absented himself

contrary to any order properly made or entered under AS 47.30.655 - 47.30.915, the relevant commitment period shall be extended for a period of time equal to the respondent's absence if written notice of absence is promptly provided to the respondent's attorney and his guardian, if there is one, and if, within 24 hours after the respondent has returned to the evaluation or treatment facility, written notice of the corresponding extension and the reason for it is given to the respondent, his attorney, his guardian, if any, and to the court.

Sec. 47.30.810. HABEAS CORPUS. Nothing in AS 47.30.655 - 47.30.-915 may be construed as limiting a person's right to a writ of habeas corpus.

Sec. 47.30.815. LIMITATION OF LIABILITY; PENALTY FOR FALSE APPLICATION. (a) A person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person under AS 47.30.700 - 47.30.915 is not subject to civil or criminal liability.

(b) The following persons may not be held civilly or criminally liable for detaining a person under AS 47.30.700 - 47.30.915 or for releasing a person under AS 47.30.700 - 47.30.915 at or before the end of the period for which the person was admitted or committed for evaluation or treatment if the persons have performed their duties in good faith and without gross negligence:

(1) an officer of a public or private agency;

(2) the superintendent, the professional person in charge, the professional designee of the professional person in charge, and the attending staff of a public or private agency;

(3) a public official performing functions necessary to the administration of AS 47.30.700 - 47.30.915;

(4) a peace officer responsible for detaining a person under

AS 47.30.700 - 47.30.915.

(c) A person who wilfully initiates an involuntary commitment procedure under AS 47.30.700 without having good cause to believe that the other person is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to himself or others, is guilty of a felony.

ARTICLE 9. PATIENT RIGHTS.

Sec. 47.30.825. PATIENT RIGHTS; MEDICAL. Each patient who is receiving services under AS 47.30.655 - 47.30.915 has the following rights:

(1) A patient, or his counsel or guardian, or the adult designated in accordance with AS 47.30.725 if the patient is mentally incapable of participation, is entitled to participate in formulating his individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in his treatment program, and being informed as to his present medical and psychological condition and prognosis. The treating physician may not withhold any of this information from the patient.

(2) A patient has the right to know the name of medication that he is asked to take, what its purpose is, and what side effects may occur with this medication. If the patient is incapable of understanding the purpose and side effects of the medication, the treating physician or mental health professional shall explain it to the patient's counsel or guardian, or if there is no guardian the adult designated in accordance with AS 47.30.725.

(3) A locked quiet room, or other form of physical restraint, may not be used, except as provided in this paragraph, unless a patient is likely to physically harm himself or others unless restrained. The

form of restraint used shall be that which is in the patient's best interest and which constitutes the least restrictive alternative available. When practicable, the patient shall be consulted as to his preference among forms of adequate, medically advisable restraints including medication, and his preference shall be considered. Nothing in this section is intended to limit the right of staff to use a quiet room at the patient's request or with his knowing concurrence when considered in the best interests of the patient. Patients placed in a quiet room or other physical restraint shall be checked at least every 15 minutes or more often if good medical practice so indicates. Patients in a quiet room must be visited by a staff member at least once every hour and must be given adequate food and drink and access to bathroom facilities. At no time may a patient be kept in a quiet room or other form of physical restraint against his will longer than necessary to accomplish the purposes set out in this paragraph. All uses of a quiet room or other restraint shall be recorded in the patient's medical record, the information including but not limited to the reasons for its use, the duration of use, and the name of the authorizing staff member.

(4) A patient has the right to be free from unnecessary or excessive medication. Psychotropic medication shall be administered only on the order of a licensed physician when the physician determines that such medication is in the best interest of the patient or will prevent serious harm to others.

(5) A patient capable of giving informed consent has the absolute right to accept or refuse electro-convulsive therapy or aversive conditioning. A patient who lacks substantial capacity to make this decision may not be given such therapy or conditioning without a court order.

Standard term

example - stuff to make alcoholic vomit

1 (6) In no event may treatment include psychosurgery, lobo-
2 tomy, or other comparable form of treatment without specific informed
3 consent of the patient, including a minor unless he is clearly too
4 young or disabled to give an informed consent in which case the consent
5 of his legal guardian is required. In addition, such treatment may not
6 be given without a court order after hearing compatible with full due
7 process.

8 (7) When, in the written opinion of a patient's attending
9 physician, a true medical emergency exists and a surgical operation is
10 necessary to save the life, physical health, eyesight, hearing or
11 member of the patient, the professional person in charge, or his pro-
12 fessional designee, may give consent to the surgical operation if time
13 will not permit obtaining the consent of the proper relatives or
14 guardian or appropriate judicial authority. However, an operation may
15 not be authorized if the patient is not a minor and knowingly withholds
16 consent on religious grounds.

17 (8) A patient upon discharge shall be given a discharge plan
18 specifying the kinds and amount of care and treatment he should have
19 after discharge and such other steps as he might take to benefit his
20 mental health after leaving the facility. The patient shall have the
21 right to participate, as far as practicable, in formulating his dis-
22 charge plan. A copy of the plan shall be given to the patient, his
23 guardian, the court if appropriate, and any follow-up agencies.

24 Sec. 47.30.830. PROHIBITION OF EXPERIMENTAL TREATMENTS. (a)
25 Experimental treatments involving any significant risk of physical or
26 psychological harm may not be administered to a patient.

27 (b) If the personnel of an evaluation or treatment facility are
28 uncertain as to whether a proposed treatment is experimental or is
29 experimental as applied to a particular patient or would involve a

significant risk of mental or physical harm to the patient, the matter may be referred to the commissioner of health and social services for a determination. The patient, his attorney, his guardian, if any, and an adult designated by the patient, shall, simultaneously with the referral to the commissioner, be provided with copies of all the documents by which the referral is made and shall have the opportunity to provide evidence to the commissioner on the question.

(c) A determination by the commissioner that a treatment is experimental and entails significant risks of mental or physical harm is binding upon all persons involved in the administration of treatment to a patient.

Sec. 47.30.835. CIVIL RIGHTS NOT IMPAIRED. (a) A person may not deny to a person who is undergoing evaluation or treatment under AS 47.-30.655 - 47.30.915 a civil right, including but not limited to, the right to free exercise of religion and the right to dispose of property, sue and be sued, enter into contractual relationships, and vote. A person who violates this subsection commits the crime of interference with constitutional rights under AS 11.76.110.

(b) Court-ordered evaluation or treatment under AS 47.30.655 - 47.30.915 is not a determination of legal incapacity under AS 13.26.

Sec. 47.30.840. RIGHT TO PRIVACY AND PERSONAL POSSESSIONS. A person undergoing evaluation or treatment under AS 47.30.655 - 47.30.915 shall

(1) not be photographed without his consent and that of his guardian if a minor, except that he may be photographed upon admission to a facility for identification and for administrative purposes of the facility; all photographs shall be confidential and may only be released by the facility to the patient or his designee unless a court orders otherwise;

1 (2) at the time of admission to an evaluation or treatment
2 facility, have reasonable precautions taken by the staff to inventory
3 and safeguard his personal property; a copy of the inventory signed by
4 the staff member making it shall be given to the patient and made
5 available to his attorney and any other person authorized by the
6 patient to inspect the document;
(reasonable)
7 (3) have access to an individual storage space for his
8 private use while undergoing evaluation or treatment;
9 (4) be permitted to wear his own clothing, to keep and use
10 his own personal possessions including his toilet articles if they are
11 not considered unsafe for him or other patients who might have access
12 to them, and to keep and be allowed to spend a reasonable sum of his
13 own money for his own needs and comfort;
14 (5) be allowed to have visitors at reasonable times;
15 (6) have ready access to letter writing materials, including
16 stamps, and have the right to send and receive unopened mail;
17 (7) have reasonable access to a telephone, both to make and
18 receive confidential calls.
19 Sec. 47.30.845. CONFIDENTIAL RECORDS. Information and records
20 obtained in the course of a screening investigation, evaluation,
21 examination, or treatment are confidential and are not public records,
22 except as the requirements of a hearing under AS 47.30.655 - 47.30.915
23 may necessitate a different procedure. Information and records may be
24 copied and disclosed under regulations established by the department
25 only to
26 (1) a physician or a provider of health, mental health, or
27 social and welfare services involved in caring for, treating, or
28 rehabilitating the patient;
29 (2) the patient or an individual to whom the patient has

1 given written consent to have information disclosed;

2 (3) a person authorized by a court order;

3 (4) a person doing research or maintaining health statistics,
4 if the anonymity of the patient is assured, and the facility recognizes
5 the project as a bona fide research or statistical undertaking;

6 (5) the division of corrections in a case in which a prisoner
7 confined to the state prison is a patient in the state hospital on
8 authorized transfer either by voluntary admission or by court order;

9 (6) a governmental or law enforcement agency when necessary
10 to secure the return of a patient who is on unauthorized absence from a
11 facility where the patient was undergoing evaluation or treatment.

12 Sec. 47.30.850. EXPUNGEMENT OF RECORDS. Following the discharge
13 of a respondent from a treatment facility or the issuance of a court
14 order denying a petition for commitment, the respondent may at any time
15 move to have all court records pertaining to the proceedings expunged
16 on condition that he file a full release of all claims of whatever
17 nature arising out of the proceedings and the statements and actions of
18 persons and facilities in connection with the proceedings.

19 Sec. 47.30.855. POSTING OF RIGHTS. The rights set out in AS 47.-
20 30.825 - 47.30.855 shall be prominently posted in all treatment facili-
21 ties in places accessible to all patients. A patient who does not
22 understand English shall have his rights explained to him in a language
23 he understands.

24 Sec. 47.30.860. NOTICES IN LANGUAGES OTHER THAN ENGLISH. When
25 practicable all documents and notices required by AS 47.30.655 -
26 47.30.915 to be served on a respondent, or on his parents, guardian or
27 adult designee, shall be explained in a language the person understands
28 if he is not competent in English.

29 Sec. 47.30.865. DISCRIMINATION PROHIBITED. (a) The fact that a

person is or has been evaluated or treated for mental illness may not be a basis for discrimination in

(1) seeking employment;

(2) resuming or continuing professional practice or previous occupation;

(3) obtaining or retaining housing;

(4) obtaining or retaining licenses or permits, including but not limited to a motor vehicle license, motor vehicle operator's and chauffeur's license, and a professional or occupational license.

(b) Applications for positions, licenses, and housing may not contain requests for information concerning evaluation or treatment experiences.

(c) It is unlawful for a person to aid, abet, incite, compel, or coerce the doing of an act forbidden under this section or to attempt to do so.

ARTICLE 10. MISCELLANEOUS PROVISIONS.

Sec. 47.30.870. TRANSPORTATION. When a person is to be involuntarily committed to a facility, the department shall arrange, and is authorized to pay for, the person's necessary transportation to the designated facility accompanied by appropriate persons and if necessary by a peace officer. The department shall pay return transportation of a person, his escorts, and if necessary a peace officer, after a determination that the person is not committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility following an evaluation conducted in accordance with AS 47.30.715. When advisable, one or more relatives or friends shall be permitted to accompany the person. The department may pay necessary travel, housing, and meal expenses incurred by one relative or friend in accompanying the person if the department determines that the person's best interests

1 require that he be accompanied by the relative or friend and the rela-
2 tive or friend is indigent.

3 Sec. 47.30.875. NONRESIDENT PATIENTS. (a) The admission papers
4 of a person who is admitted to a treatment facility under AS 47.30.655 -
5 47.30.915 shall include a statement as to his residence. The department
6 may return a patient who is not a resident of the state to the state of
7 his residence with court approval if the person has been committed. If
8 the state in which he has residence does not accept him as a patient,
9 the person shall be treated as a resident of this state under the pro-
10 visions of AS 47.30.655 - 47.30.915.

11 (b) To facilitate the return of nonresident patients the depart-
12 ment may enter into a reciprocal agreement or compact with another
13 state providing for the prompt return under appropriate supervision of
14 residents of that state who are mentally ill. A mentally ill resident
15 of this state who has been placed in a facility outside this state may
16 be admitted with the approval of the department to a treatment facility
17 in the state designated by the department. The department may enter
18 into reciprocal agreements or contracts with another state providing
19 for custody, care or treatment, or return of mentally ill residents of
20 this state by the other state and for the custody and care or treatment
21 of mentally ill residents of that state by this state on a reimbursable
22 basis. A resident of this state who has been committed in another
23 state and is returned in accordance with this section shall, within 72
24 hours of his admission to the designated facility, be examined. After
25 examination the mental health professional in charge shall release him
26 or shall petition for involuntary commitment as prescribed in AS 47.30.-
27 740.

28 (c) In taking action under (a) and (b) of this section, consider-
29 ation shall be given to the best interests of the patient, particularly

to the relationship of the patient to his family, legal guardian, or friends to maintain relationships and encourage visits beneficial to the patient.

Sec. 47.30.885. RIGHTS OUTSIDE STATE. Nothing in AS 47.30.655 - 47.30.915 alters or impairs the application or availability to a patient, while hospitalized in another state under contractual arrangements entered in accordance with AS 47.30.655 - 47.30.915, of the rights, remedies or safeguards provided by the laws of this state.

Sec. 47.30.890. PROVISION FOR PERSONAL NEEDS UPON DISCHARGE. The department shall insure that

(1) a patient is not discharged from a treatment facility without suitable clothing; and

(2) a discharged indigent patient is furnished

(A) suitable transportation to his permanent residence in this state or to another suitable place at the discretion of the department; and

(B) a reasonable amount of money to meet his immediate needs.

Sec. 47.30.895. DISPOSITION OF PERSONAL PROPERTY AND UNCLAIMED MONEY. (a) Articles of personal property and unclaimed money in the custody of a treatment facility which belong to a patient who [illegible] before discharge, or to a patient who leaves the hospital without authority, if unclaimed by the patient or his legal heirs or representatives within one year after the death or departure of the patient, shall be disposed of in the manner prescribed by the department and the proceeds shall be deposited in the state treasury.

(b) If a mentally ill individual has died in a foreign facility and the department desires to recover the patient's personal property under this section, the commissioner of health and social services or

his designated representative may secure the property and for that purpose only is designated the decedent's administrator. Property so recovered shall be disposed of as provided by law.

Sec. 47.30.900. DISPOSITION OF MONEY AND PERSONAL PROPERTY SUBJECT TO CLAIM. The department shall make diligent inquiry in every instance after departure without authority or death of a patient, to ascertain the whereabouts of the patient or that of his legal heirs or representatives, and shall turn over to the proper person the money or articles of personal property in the custody of the facility to the credit of the patient. Claims to the money or articles of personal property, including claims by the state, may be presented to the department at any time. If a claim other than by the state is established by clear and convincing evidence more than one year after the death or departure without authority of a patient, it shall be certified to the legislature for consideration and the legislature may pay the claim.

Sec. 47.30.905. FEES AND EXPENSES FOR JUDICIAL PROCEEDINGS. (a) The witnesses, expert witnesses, and the jury in commitment proceedings under AS 47.30.655 - 47.30.915 are entitled to the fees, compensation, and mileage established by the administrative rules of court for other jurors and witnesses. Compensation, mileage, fees, transportation expenses for a respondent, and other expenses arising from evaluation and commitment proceedings shall be audited and allowed by the superior court of the judicial district in which the proceedings are held. To the extent that services of a peace officer are used to carry out the provisions of AS 47.30.655 - 47.30.915, he is entitled to fees and actual expenses from the same source and in the same manner as for his other official duties.

(b) An attorney appointed for a person under AS 47.30.655 - 47.-30.915 shall be compensated for his services as follows:

1 (1) the person for whom an attorney is appointed shall, if
2 he is financially able under standards as to financial capability and
3 indigency set by the court, pay the costs of the legal services;
4 (2) if the person is indigent under those standards, the
5 costs of the services shall be paid by the state.
6 Sec. 47.30.910. LIABILITY FOR EXPENSE OF PLACEMENT IN A TREATMENT
7 FACILITY. (a) A patient, or his legal representative acting in a
8 representative capacity, or his spouse, or his parents if the patient
9 is under the age of 18, shall pay or contribute to the payment of the
10 charges for the care, transportation, and treatment of the patient when
11 hospitalized under AS 47.30.655 - 47.30.915. Charges assessed after an
12 order for commitment for treatment is issued and charges assessed when
13 a patient is hospitalized at a facility operated by the department, or
14 under a contract for services with the department, may not exceed the
15 actual cost of the care and treatment. The department may order
16 payment by the patient or by the person responsible for payment for the
17 patient's care and treatment under this subsection, according to
18 ability to provide for payment. The department may make necessary
19 investigations to determine the ability to pay and may require sworn
20 statements of income by the patient, or his legal representative acting
21 in a representative capacity, or his spouse or parent. In the exercise
22 of his descretion, the commissioner may impose full liability for the
23 patient's actual cost of care and treatment on the patient, his legal
24 representative, his spouse, or parent for refusal to supply a sworn
25 statement of income. An order for payment shall be issued by the de-
26 partment within six months after the date on which the charge was in-
27 curred. The order shall remain in full force and effect unless modi-
28 fied by subsequent court or department order. Liability under this
29 subsection shall be determined as follows: a patient hospitalized under

1 AS 47.30.655 - 47.30.915, or the person responsible for payment of
2 charges for the patient, may be required to pay according to his
3 ability to provide for payment, and in the manner and proportion which
4 the department finds is not detrimental to the patient's rehabilitation.
5 The department shall, at any time that it determines the action will
6 serve the best interests of the state and the patient or the person
7 responsible for payment, relieve the patient or the person responsible
8 for payment from liability for charges for the care, transportation,
9 and treatment of the patient.

10 (b) As used in (a) of this section, the term "actual cost of the
11 care and treatment" means either the rate provided for by a contract
12 entered into under AS 47.30.655 - 47.30.915, or, in the absence of a
13 contract, a daily rate approved by the department.

14 (c) The department may charge, or accept from a person money or
15 property, for the care or treatment of an inpatient or outpatient or
16 for other purposes, even if the payment is not required by an order of
17 the department, so long as the total payments received do not exceed
18 the actual cost of care or treatment.

19 (d) All money paid by the patient or on his behalf to the depart-
20 ment under this section shall be deposited in the state treasury.

21 (e) If an order for payment is entered by the department under
22 this section, and delinquency in the payment of any amount due the
23 state under the order continues for a period of more than 30 days after
24 the notification to the patient or the legal representative, spouse, or
25 parent of the patient by the department, the state may proceed to col-
26 lect the amounts due by appropriate proceedings. An action to enforce
27 the collection of payments may only be brought within three years after
28 the date of notification of a delinquent payment.

29 (f) The orders of the department issued under this section may

relate only to charges incurred after October 1, 1981.

Sec. 47.30.915. DEFINITIONS. In AS 47.30.655 - 47.30.915

(1) "commissioner" means the commissioner of health and social services;

(2) "court" means a superior court of the state;

(3) "department" means the Department of Health and Social Services;

(4) "designated treatment facility" means a hospital, clinic, institution, center, or other health care facility which has been designated by the department for the treatment or rehabilitation of mentally ill persons and for the receipt of these persons by court-ordered commitment, but does not include correctional institutions;

(5) "evaluation facility" means a health care facility that has been designated or is operated by the department to perform the evaluations described in AS 47.30.655 - 47.30.915; or a medical facility licensed under AS 18.20.020;

(6) "evaluation personnel" means mental health professionals designated by the department to conduct evaluations as prescribed in AS 47.30.655 - 47.30.915 who conduct evaluations in places in which no staffed evaluation facility exists;

(7) "gravely disabled" means a condition in which a person, as a result of mental illness, is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness or death highly probable if care by another is not taken;

(8) "inpatient treatment" means care and treatment rendered inside or on the premises of a treatment facility, or a part or unit of a treatment facility for a continual period of 24 hours or longer;

(9) "least restrictive alternative" means mental health

1 treatment facilities and conditions of treatment which are

2 (A) no more harsh, hazardous, or intrusive than neces-
3 sary to achieve the treatment objectives of the patient; and

4 (B) involve no restrictions on physical movement nor
5 supervised residence or inpatient care except as reasonably neces-
6 sary for the administration of treatment or the protection of the
7 patient or others from physical injury;

8 (10) "likely to cause serious harm" means a person who

9 (A) poses a substantial risk of imminent and substan-
10 tial bodily harm to himself, as manifested by recent attempts at
11 suicide or bodily harm;

12 (B) poses a substantial risk of imminent and substantial
13 bodily harm to one or more other persons as manifested by behavior
14 causing, or attempting harm, including, in regard to evaluations,
15 at least one incident within 30 days before the filing of a peti-
16 tion for emergency hospitalization; or

17 (C) demonstrates a current intent to carry out plans of
18 serious harm to himself or another;

19 (11) "mental health professional" means a psychiatrist or
20 physician who is licensed to practice in this state or employed by the
21 federal government; a clinical psychologist licensed by the state Board
22 of Psychologists and Psychological Associate Examiners; a psychological
23 associate with a clinical psychology or counseling specialty licensed
24 by the Board of Psychologists and Psychological Associate Examiners; a
25 registered nurse with a master's degree in psychiatric nursing, licensed
26 by the State Board of Nursing; and a social worker with a master's
27 degree in social work and experience in the field of mental illness;

28 (12) "mental illness" means an organic, mental, or emotional
29 impairment which has substantial adverse effects on an individual's

1 ability to exercise conscious control of his actions or ability to
2 perceive reality or to reason or understand; mental retardation, epi-
3 lepsy, drug addiction, and alcoholism do not per se constitute mental
4 illness, although persons suffering from these conditions may also be
5 suffering from mental illness;

6 (13) "peace officer" includes a state police officer, muni-
7 cipal or other local police officer, state, municipal, or other local
8 health officer, public health nurse, United States marshal or deputy
9 United States marshal, or a person authorized by the court;

10 (14) "provider of outpatient care" means a mental health pro-
11 fessional or hospital, clinic, institution, center, or other health
12 care facility who has been designated by the department to accept for
13 treatment patients who are ordered to undergo involuntary outpatient
14 treatment by the court or who are released early from inpatient commit-
15 ments on condition that they undergo outpatient treatment;

16 (15) "screening investigation" means the investigation and
17 review of facts which have been alleged to warrant emergency exam-
18 ination or treatment, including interviews with the persons making the
19 allegations, any other significant witnesses who can readily be con-
20 tacted for interviews, and, if possible, the respondent, and an investi-
21 gation and evaluation of the reliability and credibility of persons
22 providing information or making allegations;

23 (16) "state" means a state of the United States, the District
24 of Columbia, the territories and possessions of the United States, and
25 the Commonwealth of Puerto Rico, and, with the approval of the United
26 States Congress, Canada;

27 (17) "professional person in charge" means the senior mental
28 health professional at a facility or his designee; in the absence of a
29 mental health professional it means the chief of staff or a physician

designated by the chief of staff.

* Sec. 2. AS 12.45.087(a) is amended to read:

(a) If a defendant has filed a notice of intention to rely on the defense of mental disease or defect excluding responsibility, or there is reason to doubt his fitness to proceed, or there is reason to believe that mental disease or defect of the defendant will otherwise become an issue in the cause, the court shall appoint at least one qualified psychiatrist, or a forensic psychologist certified by the American Board of Forensic Psychology, or shall request the superintendent of the Alaska Psychiatric Institute to designate at least one qualified psychiatrist, which designation may be or include himself, to examine and report upon the mental condition of the defendant. If the defendant has filed notice under AS 12.45.090(a) the report shall consider whether the defendant can still be committed under AS 12.45.090. The court may order the defendant to be committed to a hospital or other suitable facility for the purpose of the examination for not more than 60 days or such longer period as the court determines to be necessary for the purpose and may direct that a qualified psychiatrist retained by the defendant be permitted to witness and participate in the examination.

* Sec. 3. AS 12.45.090 is repealed and reenacted to read:

Sec. 12.45.090. PROCEDURE AFTER RAISING DEFENSE OF MENTAL DISEASE OR DEFECT. (a) At the time the defendant files notice to raise the affirmative defense of mental disease or defect as excluding responsibility he shall also file notice as to whether if found not guilty by reason of mental disease or defect as excluding responsibility he will assert that he is not presently suffering from a mental disease or defect that causes him to be dangerous to the public peace or safety.

(b) If the defendant is found not guilty by reason of mental

disease or defect as excluding responsibility and he has not filed the notice required under (a) of this section, the court shall immediately commit him to the custody of the commissioner of health and social services.

(c) If the defendant is found not guilty by reason of mental disease or defect as excluding responsibility, and he has filed the notice required under (a) of this section, a hearing shall be held immediately after the verdict is returned to determine the necessity of further commitment. The hearing shall be held before the same trier of fact as the underlying charge, but if a jury was the trier of fact, the hearing shall be held before a jury of six drawn from the original jury in accordance with rules adopted by the supreme court. At the hearing, the defendant has the burden of proving by a preponderance of the evidence that he is not presently suffering from a mental disease or defect that causes him to be dangerous to the public. If the court or jury determines that the defendant has failed to meet his burden of proof, the court shall order the defendant committed to the custody of the commissioner of health and social services.

(d) A defendant committed under (b) or (c) of this section shall be held in custody for a period of time not to exceed the maximum term of imprisonment for the crime for which the defendant was acquitted under AS 12.45.083 or until the mental disease is cured or the defect corrected as determined at a hearing under (e) of this section.

(e) A defendant committed under (b) or (c) of this position may have the need for his continued hospitalization determined or redetermined under a petition filed in the superior court at intervals beginning no sooner than six months from his initial commitment and yearly thereafter. The burden and standard of proof at a hearing under this subsection is the same as at a hearing under (c) of this section except

1 that the defendant is not entitled to a jury unless he files a motion
2 for a jury no later than 15 days before the date set for the hearing.
3 A copy of all petitions for release shall be served on the attorney
4 general at Juneau, Alaska. A copy shall also be served upon the attor-
5 ney of record, if he is not the attorney general, who represented the
6 state or a municipality at the time the defendant was first committed.
7 (f) Continued commitment following expiration of the maximum term
8 of imprisonment for the crime for which the defendant was acquitted
9 under AS 12.45.083 is governed by the standards pertaining to civil
10 commitments as set out in AS 47.30.735.
11 (g) A person committed under this section may not be released
12 during the term of commitment except upon court order following a
13 hearing in accordance with (c) of this section. On the grounds that
14 the defendant has been cured of the mental disease or defect and is no
15 longer dangerous to public peace or safety the state may at any time
16 request the court to hold a hearing to decide if the defendant should
17 be released.
18 (h) The commissioner of health and social services or his autho-
19 rized representative shall submit periodic written reports to the court
20 on the mental condition of a person committed under this section.
21 * Sec. . AS 12.45.110 is repealed and reenacted to read:
22 Sec. 12.45.110. COMMITMENT ON FINDING OF INCOMPETENCY. (a) When
23 the trial court determines by a preponderance of the evidence, in
24 accordance with AS 12.45.100, that a defendant is so mentally incompe-
25 tent that he is unable to understand the proceedings against him or
26 properly to assist in his own defense, the court shall order the pro-
27 ceedings against him stayed, except as provided in (d) of this section,
28 and may commit the defendant to the custody of the commissioner of
29 health and social services or his authorized representative for further

evaluation and treatment until the defendant is mentally competent to stand trial, or until the pending charges against him are disposed of according to law, but in no event longer than 90 days.

(b) On or before the expiration of the initial 90-day period of commitment the court shall conduct a hearing to determine whether or not the defendant remains incompetent. If the court finds by a preponderance of the evidence that the defendant remains incompetent, the court may recommit the defendant for a second period of 90 days. The court shall determine at the expiration of the second 90-day period whether the defendant has become competent. If at the expiration of the second 90-day period the court determines that the defendant continues to be incompetent to stand trial, the charges against him shall be dismissed without prejudice and continued commitment of the defendant shall be governed by the provisions relating to civil commitments under AS 47.30.700 - 47.30.915 unless the defendant is charged with a crime involving force against a person and the court finds that the defendant presents a substantial danger of physical injury to other persons and that there is a substantial probability that the defendant will regain competency within a reasonable period of time, in which case the court may extend the period of commitment for an additional six months. If the defendant remains incompetent at the expiration of the additional six-month period, the charges shall be dismissed without prejudice and either civil commitment proceedings shall be instituted or the court shall order the release of the defendant. If the defendant remains incompetent for five years after the charges have been dismissed under this subsection, the defendant may not be charged again for an offense arising out of the facts alleged in the original charges, except if the original charge is murder.

(c) The defendant is not responsible for the expenses of hospital-

1 ization or transportation incurred as a result of his commitment under
2 this section. Liability for payment under AS 47.30.910 does not apply
3 to commitments under this section.
4 (d) A defendant receiving medication for either a physical or a
5 mental condition may not be prohibited from standing trial, if the
6 medication either enables him to understand the proceedings against him
7 and to properly assist in his own defense or does not disable him from
8 understanding the proceedings and assisting in his own defense.
9 Sec. 5. AS 12.45.115 is amended to read:
10 Sec. 12.45.115. DETERMINATION OF SANITY AFTER [RELEASE FROM]
11 COMMITMENT. (a) When, in the medical judgment of the custodian of an
12 accused person committed under AS 12.45.110 [AS 12.45.110(a)], the
13 accused is considered to be mentally competent to stand trial, the
14 committing court shall hold a hearing, after due notice, as soon as
15 conveniently possible [AFTER RELEASE OF THE ACCUSED FROM CUSTODY]. At
16 the hearing, evidence as to the mental condition of the accused may be
17 submitted including reports by the custodian to whom the accused was
18 committed for care.
19 (b) If at the hearing the court determines that the accused is
20 presently mentally competent to understand the nature of the proceedings
21 against him and [OR] to assist in his own defense, appropriate criminal
22 proceedings may [SHALL] be commenced against the accused.
23 (c) If at the hearing the court determines that the accused is
24 still presently mentally incompetent, the court shall recommit the
25 accused in accordance with AS 12.45.110 [AS PROVIDED IN AS 12.45.-
26 110(a)].
27 (d) A finding by the court that the accused is mentally competent
28 to stand trial in no way prejudices the accused in a defense based on
29 mental disease or defect excluding responsibility. This finding may

not be introduced in evidence on that issue or otherwise be brought to the notice of the jury.

* Sec. 6. Except as provided in this Act, the provisions of AS 47.30.-660 - 47.30.815 enacted by sec. 1 of this Act do not in themselves impair any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981.

* Sec. 7. AS 47.30.010 - 47.30.170 and AS 47.30.190 - 47.30.340 are repealed.

* Sec. 8. This Act takes effect October 1, 1981.

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MEMORANDUM October 2, 1980

TO: Representative Hugh Malone

FROM: Betty Barton BB and Susan Brody SB
Research Staff

RE: Alternatives to Institutional Care for the Elderly
Research Request No. 165

This memorandum is in response to your request for information concerning alternatives to the existing Pioneer Home Program. You have asked us to examine existing and proposed alternatives to the Pioneer Homes and to compile information on residential and health care programs for the elderly in other states. To compile information on other state programs, we have contacted staff from the National Conference of State Legislatures, who will be sending us reports on this subject. Following receipt of these materials, it is our intent to contact several nationally recognized authorities to determine their ideas regarding the future direction of elderly housing and support services. We will assemble these findings in a second memorandum, which will be forwarded to you upon its completion.

To obtain a good introductory overview, interested members of the committees may wish to review Housing and Social Services for the Elderly, a book by Elizabeth D. Huffman (Praeger Publishers, 1977). We have enclosed several excerpts from this book, as well as a few other reports on programs for the elderly in Alaska. We have also included a resource list of individuals who may be able to provide the steering committees with additional assistance.

Pioneer Homes: A Descriptive Overview

Introduced as a program in 1913, the Pioneer Home was initially established for residential purposes to enable elderly Alaskans to afford continued residency in the state. According to Vernon Perry, Director of Pioneer Benefits for the State, "the homes" function has always been to provide care, including nursing, for the remainder of a Pioneer's life. Gradually, the homes assumed an increased responsibility for providing health care services. The average age of Pioneer Home residents is over 80 years of age.

Pioneer homes basically offer the following services: 1) housing; 2) nursing care;[1] and 3) personal care, e.g. assistance with bathing, walking, correspondence, or shopping. Included within this structure are room and board. Each home retains a physician on contract (residents desirous of using their family physicians are responsible for payment of these services). Physical and occupational therapy are available in all homes. All homes also provide residents with a central dining room, reading room, television room, and recreational activities. All facilities provide private bedrooms with baths. No facilities offer apartment units or kitchenettes. Additional features vary among the homes; Palmer's home has a greenhouse and gardening program and Fairbanks' home has a covered shelter that is used for outdoor dining and special events.

Unlike any program currently offered in other states, Pioneer Homes restrict admissions to Alaskans who have had a continuous residency in the state for 15 or more years. Residents over 65 years of age meeting this criterion are eligible applicants.[2] Pioneer Homes offer free residency to financially needy residents, while a monthly fee ($225 for housing or $275 for nursing care) is charged to those who can afford to pay. According to a September 15, 1979 report prepared by South Central Health Planning and Development, Inc., the majority of the Homes' residents are able to pay the monthly fee.

Unlike most continuing care programs in the United States, the Pioneer Homes are operated, for the most part, at the expense of the State of Alaska. In 1978, it was estimated that the actual monthly cost of providing skilled nursing care was $3,420 per person and $1,860 per person for residential care. Fees charged to residents represent only about 10 per cent of the actual cost of providing nursing care to patients and about 21 per cent of the actual cost of care for ambulatory residents. Because of the Homes' exclusionary admittance practice, nursing home care provided within the program is ineligible for Medicaid, Medicare, and other federal funds.

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1. Limited nursing care or intermediate care, is available to the majority of all pioneer residents. Twenty-four hour nursing is available only to those residents occupying beds licensed for nursing care. As of July 1, there were 179 licensed nursing beds in Pioneer Homes throughout the state.

2. Some state health professionals have speculated that this admissions procedure may be challenged in light of the recent Zobel opinion of the Alaska Supreme Cou[illegible] concerning residency waivers for state income taxes.

Pioneer Homes are currently located in Anchorage, Palmer, Sitka, Fairbanks, and Kotzebue. In 1979, the five homes had a total of 538 beds of which 359 are reserved for residential care and 179 (33 per cent) are licensed for skilled nursing. Anchorage has the largest Pioneer Home with 153 beds, of which 20 are licensed for nursing. (Fifty nursing beds are available in Sitka, 54 in Fairbanks, and 55 in Palmer.) Following the construction of a new wing, the Anchorage Pioneer Home will have 100 nursing beds and 153 residential beds available.[3]

In FY 80, $10,800,600 was appropriated for the operating budget of the Pioneer Home Program with an additional $1,652,400 reserved for capital improvements and debt retirement. The Pioneer Home program is administered by the State Department of Administration.

Alternative Models to Institutional Care for the Elderly

Although alternatives to institutional care vary widely, they can be found in one of three forms: 1) senior citizen housing; 2) congregate housing; and 3) continued residency in one's original home.

Senior Citizen Housing

Senior citizen housing is any public or non-profit complex designed for the purpose of residency by the elderly. It could be comprised of cottage

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3. The construction of the new wing was recently under dispute. According to Alaska law, one must apply for a Certificate of Need before building a health care facility in order to ascertain that needs are not already adequately served by existing health care services in the community or region. South Central Health and Development, Inc., a regional planning agency, argued that the Certificate of Need process had not been undertaken and that additional nursing beds would place the Pioneer Home in a competitive role with existing, privately owned nursing homes in the Anchorage area. It was further argued that expansion of the Home's skilled nursing capabilities was unnecessary, as the Home showed a high number of empty beds as of July 1979; only five of its twenty nursing beds were occupied. South Central Health Planning and Development's efforts to seek an injunction against construction were denied in a Superior Court ruling. A final hearing has yet to be held.

units, triplexes, or apartments in a high-rise building. The purpose of this form of housing, essentially, is to meet the specific social, economic, and physical needs of the elderly, e.g. kitchens that could accommodate wheel chairs. With the occasional exception of meal service in a communal dining room, little or no services are offered within a senior citizen housing complex. Generally, there is no health care, emergency or otherwise, provided on the premises. Existing services within the community are relied upon for health care and other needs.

Congregate Housing

Congregate housing differs from senior citizen housing in offering a more comprehensive range of services. The International Center for Social Gerontology defines congregate housing as:

> A residential environment which includes services, such as meals, housekeeping, health, personal hygiene, and transportation, which are required to assist impaired, but not ill, elderly tenants to maintain or return to a semi-independent life-style and avoid institutionalization as they grow older.

Congregate housing is considered by many health professionals to be the "missing link" in elderly housing. Its purpose is to prolong an elderly member's semi-independent lifestyle in a community by postponing his placement into a nursing home. Consequently, its housing function is more health-related than senior citizen housing.

Congregate care facilities are designed for the individual who is moderately impaired and in need of personal care services not provided within senior citizen housing. Because of its personal care emphasis, a congregate care facility frequently includes bedroom-bathroom living units, rather than the fully equipped units found in regular senior citizen housing. Residents of congregate facilities tend to be older than those living in senior citizen housing. Unlike a senior citizen housing complex, congregate housing staff may include some nursing personnel. Although nursing care is available, it generally is not of a level sufficient for eligibility in Medicaid and Medicare. Nonetheless, a congregate care facility is considered to be a less expensive mode of care than that provided in nursing homes.

Continued Home Residency

Although some senior citizens may find relocation into special housing attractive, many elderly persons would prefer to remain within their own homes, but cannot, due to economic, social, or health constraints. The purpose of continued home residency programs is to postpone institutional placement through the alleviation of these constraints. A number of mechanisms may be employed to enhance an elderly person's capability to remain at home, including tax incentives, community service programs, and home-delivered personal and health care services. Certain health services provided by home health care programs are eligible for Medicaid and Medicare payment. Preliminary research indicates that home care programs can be more cost-efficient than nursing home care (see enclosed report on Home Health Care for additional information).

Existing Alaskan Alternatives for the Elderly

There are a number of programs in Alaska that provide housing alternatives. However, the extent of their availability is in some instances limited to certain regions or municipalities within the state. Current alternatives in the areas of senior citizen housing, congregate housing, and continued home residency are as follows:

Senior Citizen Housing

The State's Senior Citizen Housing Development Bond Program, administered by the Department of Community and Regional Affairs, provides a means for communities to initiate housing projects for the elderly. Through a $7.5 million bond authorizaton, the program leverages state funds with federal dollars available through several programs of the U.S. Department of Housing and Urban Development and the Farmers' Home Administration. These funds are then used for the design and construction costs of community housing. A community may establish its own standards for maintenance, operations, and eligibility.

Residents eligible for housing are seniors aged 60 years or older who are capable of living independently in an apartment setting. Preference is given to elderly persons living within a low-income range. Residents of a senior

citizen complex pay a monthly fee that is computed in accordance with their adjusted monthly income. The fee derived is not to exceed 25 per cent of their monthly adjusted income. (Generally, an average person's monthly rent consumes one-third or more of his adjusted income.) For those individuals determined to be unable to afford the monthly fees, a rental subsidy program is available. The rental subsidy program, offered through HUD Section 8, is guaranteed for a twenty year period. Money collected from the fees and subsidies is used to pay the maintenance and operation costs of the housing complex.

Most of the existing housing complexes provide apartment units with a communal living/lounge area and a dining roo , the use of which is an option for residents. However, Wasilla, in its planning stages f a senior citizen project, is giving some consideration to the feasibility of duplexes. The Chugiak Senior Citizens complex may include both a greenhouse and an elderly day care and physical therapy center, where protective or rehabilitative services would be available as options. Juneau currently planning its second senior citizen housing complex, is considering extended personal care services including facilities for physical therapy.

Congregate Housing

It is arguable whether or not congregate care options currently exist in Alaska. The concept of congegate care connotes a postponement of an individual's placement in an institutional setting; it is an intermediary step between home residency and nursing home care. Alaska's Pioneer Homes, in part, meet these criteria but maintain an institutional atmosphere that does not appear to be commensurate with the residential concept of congregate care.

Generally, personal care services available within Alaska's senior citizen complexes are not extensive. Beyond transportation and meals, few other services are currently provided by the complexes (though they may be readily available in the larger community). Congregate care possibly could be rendered within a senior citizen housing project. However, personal care services of this nature could be in conflict with the program's current eligibility standards that require residents to be capable of living independently.

Recently enacted legislation may augment a community's abilities to provide services for the elderly. House Bill No. 611 am S (enclosed) establishes

an Older Alaskans Service Programs account located in the Department of Administration and allocated by the Department of Health and Social Services' Office on Aging in grants to sponsors of community service programs for the elderly. The types of service programs that may receive grants include: nutritional, health (including home health and homemaker), recreational, housing, and other services.

Continued Home Residency

The issues concerning continued home residency are especially complex in Alaska. For years, the state's high cost of living, rural nature, and harsh climate have contributed to making home residency, and in many instances, continued state residency, particularly difficult for the elderly. In 1979 the State Legislature formed a Committee on Services to the Elderly, an eleven-member body comprised of four legislators and seven citizens, whose statutory function it was to consider the problems of elderly Alaskans and to make recommendations regarding improved delivery of benefits and services. In its findings, according to Jim Kelly, Staff Assistant, the committee recognized the need and value of the Pioneer Homes and other similar long-term care programs, but concurred that placement in continuing care facilities should be the last alternative for the aged. The committee supported a goal for Alaska's elderly that permits and encourages them to remain in their own homes for as long as is feasible. In other words, elderly care programs should be designed with prolonged autonomy for senior citizens in mind. Because of this, according to Jim Kelly, the committee regarded its highest priority to be the need for expanded home care programs in the state.

The following programs, as well as support services such as transportation and Meals-On-Wheels assistance, may enhance senior citizens' capabilities to remain in their own homes:

Senior Citizen Property Tax Exemption

This program exempts property-owners 65 years of age or older from municipal property taxes on their permanent place of residence. The municipality is reimbursed by the state for its tax revenue losses.

Senior Citizen Renter Property Tax Equivalency Payment

Designed to equalize the senior citizen renter benefits with the senior

citizen home owner exemption, this program reimburses renters 65 years of age or older for the portion of rent paid which was presumed to be property tax. Payments are based on the municipality's mill rate of taxation. For each mill, one-half per cent of annual rent is reimbrused, e.g. a 16 mill levy rate for an individual paying $4,800 annually in property rental would result in an 8 per cent reimbursement, or $384 annually. Recently enacted legislation (SB 324, enclosed) increases the property tax equivalent percentage by which a senior citizen who rents property may be reimbursed from one-half percent per mill to one percent per mill. The program is administered by the Department of Community and Regional Affairs' Division of Local Government Assistance.

Longevity Bonus

As a component of the pioneers' benefits program, the longevity bonus pays a monthly amouut to those state residents 65 years of age and older who resided in Alaska on or before January 3, 1959 and who have lived in the state continuously for 25 years Recently enacted legislation (SB 15 am) increased the monthly bonus from $150 to $200. The program is administered by the Department of Administration's Division of Pioneer Benefits.

Homemaker-Home Health Aide Services

A special appropriation in the Eleventh Legislature provided the Homemaker Services Program with $2.5 million in order to expand program coverage to include health aide services. Formerly, the program was limited to those services that provided no "hands-on" care, e.g. lifting a patient. The program now provides chronically impaired clients with assistance in maintenance and personal care (including both health-related and non health-related services). The State DHSS-DSS purchases these program services through an annually awarded contract.

Home Health Services

This program, which provides skilled nursing care to individuals having either chronic or acute conditions is not currently available on a statewide basis. Administered by the Department of Health and Social Services' Public Health Nursing Section, as a pilot project, the program is ongoing only in Fairbanks, Ketchikan, and Juneau. An expanded home health program which offers physical and occupational therapy services as well as skilled nursing and health aide care, is operated by the

Municipality of Anchorage. For Medicare/Medicaid eligibility, home health services must be delivered by a certified home health agency, such as the Anchorage Home Health Agency.

Proposed Alaskan Alternatives

Opinions in the state seem to diverge concerning housing and general service needs of the elderly. The Committee on Services for the Elderly, for example, maintained that service and housing options are of a complexity that requires the development of established State policy. The committee regarded the best vehicle for policy development to be an Older Alaskan Commission, which would review the housing problem and other needs of senior citizens, in order to establish and implement a long-range, comprehensive program. This concept has yet to be approved by the Legislature. Other proposed alternatives are as follows:

Expansion of the Pioneer Home Program Service Definition

A limitation of the Pioneer Home Program is that in certain instances it can result in a person having to leave his family, his home, and occasionally his community or region in order to obtain the care offered through his Pioneer Benefits. Consider as an example a 65 year old male pioneer in need of skilled nursing care. He is married to a 55 year old woman. Both live in Juneau; the nearest Pioneer Home is located in Sitka. To receive care under the current program, he would be faced with a choice of whether or not to leave his wife and home for the protective care to which he is entitled or to pay for nursing care in Juneau. To alleviate this type of problem, policy-makers have contemplated extending pioneer benefits to include the purchase of equivalent nursing home services in the community of his choice. Proposed legislation of this nature was introduced in the Eleventh Legislative Session but was not approved for passage.

Extending the Senior Citizen Housing Plan

Policy-makers within the Departments of Administration, Health and Social Services, and Community and Regional Affairs have held recent joint discussions concerning the possibility of expanding the senior citizen housing program to include an eight-plex design format in every community. The purpose of the program would be to increase elderly persons capabilities to remain within their own communities rather than to leave their homes for regional housing services. As is the case under the current program, housing of this nature would offer no on-site health care and would employ existing community health services.

Social and Rehabilitative Day Care Centers

Day care center services offer a significant means for extending a person's capabilities to remain at home. There are two forms of day care service for the elderly — one maintains a social services emphasis while the other maintains a rehabilitative, physical therapy focus. Both types of service enable older persons to maintain home residency rather than undergo hospitalization or nursing home treatment. A social day care program may include supervision, activities, rest periods, and meal service in a comfortable, safe setting; no health care is provided on the premises but am emergency preparedness plan is designed. A rehabilitative center provides day care for the physically disabled or ill persons. Standard services might include physical therapy or surgical dressing changes.

Day care services are not currently available in the state, although planners for several senior citizen housing projects are considering programs. The Department of Health and Social Services is also interested in launching a pilot program.

Conclusion

It is apparent that several options to long-term institutional care exist; however, their feasibility for the Kenai Peninsula will depend on the specific needs of its senior citizens. Should additional research concerning the subject of continuing care be required in the course of this project, we would be pleased to provide you with additional assistance. We will be transmitting to you our memorandum concerning other states' elderly housing programs in the very near future.

BB:SB:bf
Attachments

ATTACHMENTS

Huttman, Elizabeth, Housing and Social Services for the Elderly (excerpts)

House Research Agency, Home Health Care

South Central Health & Development, Inc., A Review of Long-Term Inpatient Care with Emphasis on the Pioneers Program

Dept. of Health & Social Services, Caring for Senior Alaskans

State Committee on Services to the Elderly, Final Report

House Bill 611 am S

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MEMORANDUM

October 7, 1980

TO: Representative Hugh Malone

FROM: Betty Barton BB and Susan Brody SB
Research Staff

RE: Alternatives to Institutional Care for the Elderly
Research Request No. 165 (Additional Material)

The enclosed report on alternatives to nursing homes arrived today from the National Conference of State Legislatures. It contains a concise description of alternative programs in seven states: Arkansas, Connecticut, New York, Oregon, Texas, Utah, and Virginia. The report also includes a discussion of recently proposed federal legislation which would make funds available for a wide variety of alternative programs for the elderly.

We will be providing you with additional information on possible design options for elderly care programs following our interviews with several national authorities. Our findings will be forwarded to you promptly upon conclusion of our data collection.

SB:BB:bf
Encl.

National Conference of State Legislatures

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President
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Speaker Pro Tempore, Florida House of Representatives

Executive Director
Earl S. Mackey

"Alternatives to Nursing Homes"

Statement of Russell W. Hereford
Program Manager, Human Resources
National Conference of State Legislatures

Health Care Cost Seminar
held by the
Hawaii Legislature
and
Department of Social Services and Housing

October 3, 1980

On behalf of the National Conference of State Legislatures, I would like to welcome you to this meeting. I am pleased to be with you to discuss programs which some states have undertaken to establish "alternatives to nursing homes."

As you know, the National Conference of State Legislatures is the only non-partisan organization which represents the nation's 7500 state legislators. The NCSL has three basic objectives: to improve the quality and effectiveness of state legislatures; to assure state legislatures a strong, cohesive voice in the federal decision making process; and to foster interstate communication and cooperation. The NCSL is headquartered in Denver, Colorado, and maintains an office of State-Federal Relations in Washington, D.C.

Much of our activity in the health care field is funded through a grant from the Health Care Financing Administration, U.S. Department of Health and Human Services. Through this grant we are able to provide a number of services to state legislatures as they work to control the rising costs of health care. These services include assisting with seminars such as this; providing information at public hearings; publishing periodic reports on significant state and federal health care cost containment activities; and providing a central information clearinghouse on state and federal health care initiatives.

I would like to offer the continued assistance of the National Conference of State Legislatures, now and in the future, as you examine issues in the health care field.

In my presentation today, I would like to deal with four general issues: The reasons that long term care is now a major public issue; the factors that led to this situation; activities which states have undertaken in the area of alternatives; and federal legislation which, if enacted, would encourage the provision of long term care in the community.

I. LONG TERM CARE AS A PUBLIC POLICY ISSUE

The manner in which long term care is provided and financed has only recently become a major public policy issue. It is interesting to note, for example, that when the 1971 White House Conference on the Aging convened, long term care did not even merit a place on the agenda (although the conference did establish an ad hoc task force). In recent years, however,

two overriding concerns — one financial and one social — have focused increased public attention on long term care.

A. Costs

Long term care is heavily dependent on public funding. According to the Health Care Financing Administration, in 1978 over 53 percent of the nation's $15.8 billion bill for nursing home care was paid by government. Forty-six percent of those public expenditures — over $7 billion — was funded through Medicaid. State and local governments paid some $3.6 billion for nursing home care. Nationally, these figures correspond to 39.5 percent of state and local government expenditures paid under the Medicaid program. Indeed, the General Accounting Office found that 37 states spent more than 40 percent, and 19 states spent more than half, of their Medicaid budgets on nursing home care. Of particular interest to you, the GAO estimates that in Fiscal Year 1978, Hawaii spent 43.3 percent of its Medicaid budget on nursing home care.

Nursing Home Expenditures
As a Percentage of Total Medicaid
Expenditures by State, FY 1978 (Note a)

State	Percent	State	Percent
South Dakota	67.8	Alabama	45.8
Minnesota	64.2	Vermont	45.2
Alaska	63.2	Georgia	44.7
New Hampshire	62.3	South Carolina	44.6
Colorado	60.1	New York	44.3
Wyoming	60.5	Kansas	44.2
Iowa	58.5	Hawaii	43.3
Texas	58.1	Rhode Island	43.3
Nebraska	57.9	Kentucky	42.7
Wisconsin	56.9	Mississippi	41.1
Idaho	56.7	Florida	40.3
Arkansas	55.5	Ohio	40.0
Montana	54.0	North Carolina	39.9
North Dakota	53.8	Delaware	39.7
Connecticut	53.2	Michigan	39.3
Indiana	53.1	Missouri	38.8
Oklahoma	52.8	Massachusetts	38.7
Utah	52.5	Washington	38.4
Nevada	51.0	New Jersey	36.4
Oregon	48.9	Maryland	34.3
Maine	48.4	New Mexico	31.3
Pennsylvania	47.6	Illinois	29.5
Louisiana	47.3	California	23.9
Virginia	46.3	West Virginia	22.5
Tennessee	46.3	District of Columbia	13.1

a/Arizona does not have a Medicaid program. Guam, Puerto Rico and the Virgin Islands are not included.

Source: Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, DHEW Publication No. (HCFA) 79-[illegible], Research Report B-5 (FY 78) (Preliminary), June 1979, Table 2.

3.3 General Accounting Office, "Entering a Nursing Home — Costly Implications for Medicaid and the Elderly"

It appears likely that the cost problem will continue unabated over the foreseeable future. A major reason for this trend is the increasing elderly population which, in both absolute and relative numbers, is growing more rapidly than any other age group. Of a national population estimated at 220 million today, approximately 24 million people, or 10.9 percent of the total population are age 65 or older; two million people are 85 or older.

These proportions will increase in the future: Projections of a 260 million person U.S. population in the year 2000 estimate that almost 32 million people (12.3 percent) will be over 65, and 13.5 million (5.2 percent) will be 75 or older. Some estimates indicate that by the year 2030, 55 million people — over 18 percent of a projected population of 300 million — will be 65 or older, and that one of every ten Americans will be 85 or older.

While these projections forecast a long term growth in long term care expenditures, even in the short term expenditures for nursing home care are anticipated to leap dramatically. The Health Care Financing Administration projects that state and local government expenditures will increase to $9.6 billion by 1985 — more than two and one-half times their 1978 levels.

B. Social Considerations

The fiscal consequences of failing to redirect the long term care delivery system are severe enough. Yet another consequence of the current delivery system — and many persons would argue that this issue is of even greater importance than the fiscal aspect — is the social impact of living in an institution. Current estimates are that 5-6 percent of the elderly reside in nursing homes. While a number of the frail elderly do require a 24 hour protective environment, placing the bulk of public funding in institutions where five percent of the elderly reside appears to neglect the 95 percent who live in the community, and who also require health, social and other services.

A number of studies have found that many persons were admitted to nursing homes for what might be called "social" reasons. A 1978 study in Utah, for example, determined that 40 percent of nursing home admissions were made for such reasons as: The individual lived alone; the family needed a respite from the burden of caring for the individual; or the family was unwilling or unable to provide care. A particularly common crisis which leads to nursing home admission is the death of a spouse, and the subsequent depression and isolation.

There is little doubt that most elderly — just like most people — prefer to live outside of nursing homes, where family, friends, and a familiar community make the home environment a much preferable (and often more healthy) place to live. On the other hand, placement in a nursing home usually reduces personal independence, leads to the loss of life-long possessions, severs community ties, and separates citizens from close friends and relatives.

Increased availability of programs which provide necessary social supports, as well as needed health and medical care, are a vital part of a system which enables the elderly to remain in the community.

II. WHY HAS THE LONG TERM CARE SYSTEM DEVELOPED AN INSTITUTIONAL BIAS?

The nation's long term care system has become predominantly institutionally based for two broad reasons.

A. Incentives Toward Institutional Care

In its 1979 report "Entering A Nursing Home — Costly Implication for Medicaid and the Elderly," the General Accounting Office identified a number of incentives which have led to a dependence on nursing homes for the provision of long term care. The GAO cited state restrictions on Medicaid benefits for non-institutional care, low reimbursement rates to providers, and only limited implementation of in-home services as barriers to the developme[nt] of noninstitutional long term care services. (As one explanation for [th]is reluctance of states to take further action in these areas, the GAO reported that many states believe that expansion of these services will lead to another uncontrollable cost in their Medicaid budgets.)

The other major publically funded health program, Medicare, is oriented much more to acute care than to long term maintenance care. For example, a three-day stay in an acute care hospital is required prior to admission to a skilled nursing facility, or for home nursing services. Thus, the acute care orientation of Medicare limits its usefulness as a funding source for the chronically ill.

The GAO noted that many low and moderate income elderly can receive Medicaid coverage while in an institution — but not while living in the community — for a number of reasons: 1) Due to such impediments as low reimbursement rates and the lack of alternative services, long term care services are often available for the Medicaid eligible elderly only in nursing homes. 2) The elderly poor who are ineligible for Medicaid coverage while

living in the community because their income is too high, can become Medicaid eligible in a nursing home where a different income standard applies.
3) Many elderly enter nursing homes as private pay patients, but become eligible for Medicaid coverage by transferring their assets to relatives or by spending their resources on nursing home bills.

B. Difficulties in Obtaining Community Based Care

While incentives in public funding programs tend to encourage the use of nursing homes, fragmented community services often make finding a comprehensive home support system exceedingly difficult. Someone in need of long term care can receive virtually all needed services under the single roof of a nursing home; however, finding, arranging for, and determining eligibility for home services is often a frustrating, time consuming and energy depleting exercise.

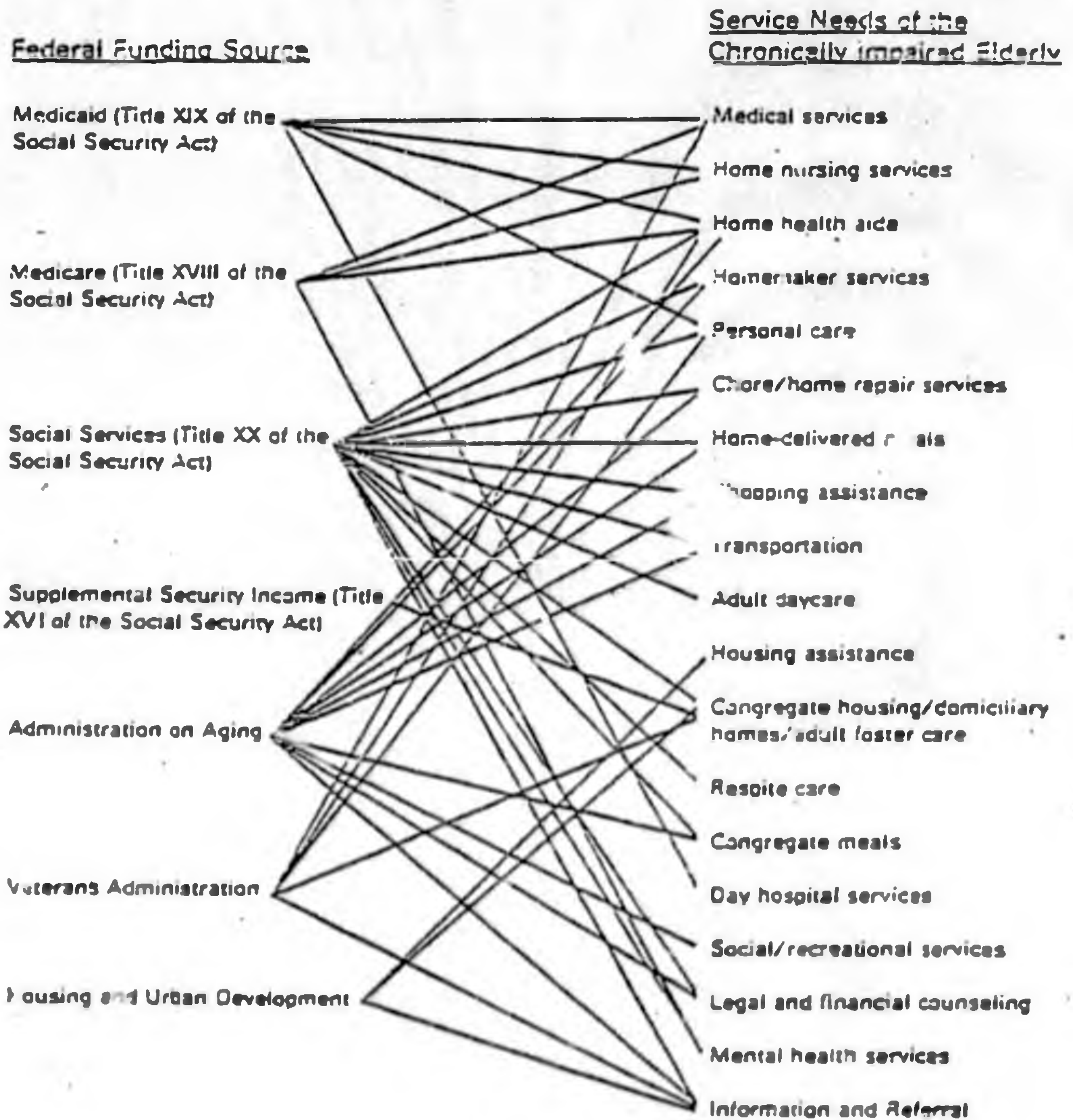
Community services are provided through a myriad of sources: local government agencies, profit making organizations, church groups, non-profit associations, volunteer organizations, etc.

Funding sources vary widely. While some services (physician, home health care, therapies) are covered under Medicaid or Medicare, social services are available under limited Title XX funding. Other services are available only under separate provisions of the Older American Act. Still other services may be available only through volunteer or church groups. And — perhaps most frustrating of all — in many areas the services are simply nonexistant.

Eligibility requirements for different programs, and therefore for different services, also are disparate. An individual may be eligible for Medicare, but not Medicaid; for Medicaid, but not Title XX; for Title XX, but not for Supplemental Security Income.

Needless to say, the foregoing maze (which, incidentally, barely scratches the surface of the problems) only serves to add to the confusion and frustration of those needing long term care. The figure on the following page shows this maze in more detail.

Major Federal Programs Funding Community Services for the Elderly



Source: U.S. General Accounting Office, "Entering A Nursing Home — Costly Implications for Medicaid and the Elderly"

III. STATE PROGRAMS FOR ALTERNATIVES TO NURSING HOMES

In spite of these obstacles, a number of states have established programs which make available a community based support system for the elderly. In this section, it will be useful to describe eight programs which are underway in seven states.

As a caveat, these are only general descriptions of the programs, not formal evaluations. In addition, there are many other such programs, so this list is not exhaustive. Nevertheless, each program offers a different approach to establishing options for the elderly to remain in their community.

I would like to mention two studies which will provide a more in-depth look at alternative programs. Both should be completed early next year. One is being prepared by the Intergovernmental Health Policy Project at George Washington University in Washington, D.C., and the second is one product of a contract from the National Center for Health Services Research, being performed by Lewin and Associates, a Washington, D.C. consulting firm. Each study should provide additional detail on alternatives to nursing home programs.

A. Arkansas: In-Home Services Program

The Arkansas In-Home Services Program began in 1978 as an effort to coordinate the delivery of in-home services to the elderly. The program is administered by the State Office for the Aging through the local area agencies on aging.

Although some state money is involved, the program ties together funding from a variety of federal sources. Arkansas uses money from the Older Americans Act and the Comprehensive Employment and Training Act (CETA) to hire workers on a part or full time basis to provide services to the elderly. Many of these workers are themselves senior citizens. For example, 130 older Arkansans are employed as aides under the Senior Community Employment Services Program. Another 150 aides are employed through the CETA Program. Over 350 senior citizens work part time in a variety of jobs, such as nutritional centers, through the Older Workers Program. Services are also available through Medicaid, Title XX, and the Older Americans Act. Such services include day care, transportation, information and referral, nutrition, chore, and home health services.

Any individual applying for admission to a nursing home is referred to the program. The first step in an assessment process is determining the client's own perception of his or her needs; this is frequently done by telephone prior to any in-home visit. Subsequently, a case worker (i.e., a social worker from the local area agency on aging) performs a needs assessment for each client. Upon completion of the assessment, an individual who is eligible for the in-home services program will receive services under one of two sub-programs.

If it appears that personal care services will be needed, a registered nurse then performs a medical assessment of the client's underlying health problems and needs, and develops a plan of care. The plan of care, outlining the type, duration, and schedule of care, as well as other social or economic needs, must be approved by the client's physician prior to its implementation. A licensed practical nurse is responsible for the direct care aide asigned to the client. Generally, services provided under the Personal Care Program are Medicaid reimbursable.

Should the plan of care be rejected by the physician, or if personal care services are not required, the caseworker will attempt to match the client's needs with existing services. These services may include home delivered meals, chore services, legal counseling, home repairs, shopping assistance, and assistance with obtaining such benefits as food stamps and SSI. To the extent possible, services are funded under Title XX; if Title XX funding is not available, the services may be funded from state appropriations.

A preliminary survey of some 1300 clients found that the average monthly cost of the In-Home Services Program was $122.20.

B. Connecticut: TRIAGE

The TRIAGE Program is unique in that it is the only Medicare funded program which is an alternative community based long term care system. TRIAGE began in 1974 in seven towns in Central Connecticut, an area with an elderly population of approximately 20,000 people. The program grew out of a study conducted by the Connecticut Commission on Aging which showed that it is easier to institutionalize a person than to negotiate him through the maze of services which he would need in order to remain at home. In particular, the study cited barriers to financing home services and confusion regarding their availability, location and eligibility criteria.

The state of Connecticut has been heavily involved financially in the program, which is now in its second stage of funding. During the first stage, developmental funds were obtained from the Administration on Aging; an annual state appropriation of approximately $430,000 covered operating expenses; the National Center for Health Services Research contributed funding for a research component; and a waiver from Medicare permitted direct reimbursement for services not traditionally funded under that program. TRIAGE's second funding era began in 1979; under this arrangement, Medicare has agreed to fund operating costs as well as direct service delivery, and the state provides an annual appropriation of approximately $100,000.

The program can serve up to 1500 clients. Although there is no income restriction, clients must be over 60, Medicare eligible and local residents.

In addition to a separate research component at the University of Connecticut, the TRIAGE staff consists of 46 members. Three teams of five members each are responsible for assessment and monitoring clients. The teams are jointly headed by a nurse clinician and two geriatric social workers.

After receiving a referral for a client, a complete physical and social history is obtained. Additional information on nutrition, hygiene, housing, transportation and financial needs is also gathered. TRIAGE staff develop a plan of care, detailing the number, type and frequency of services required. The plan is then discussed with the client and family to assure that it has their approval. TRIAGE staff monitor the client at least every six months, or more often if needed.

TRIAGE contracts with providers for service. Forty-nine different services are available from 191 different providers. In another unique arrangement each provider does not bill Medicare separately. Instead, all bills are submitted to TRIAGE where fiscal and claims staff review them against the approved plan of care. TRIAGE then submits the bills to Medicare, which reimburses the providers directly.

Over the first four years of the project, 2128 clients were served. Average 1978 costs for each client totalled $312.33 per month, of which $28.00 went for program administration. Of the remaining amount, $158.08 (55%) went for institutional care — usually either acute hospital care (34.1%) or stays in skilled nursing facilities (14.8%). $126.25 (44.4%) was expended on non-institutional care. While this ratio may appear high for a program aimed at

keeping people out of nursing homes, it represents a substantial shift in publically funded programs. In Fiscal Year 1977, 89.4% of Connecticut's budget was directed at institutions; under the TRIAGE Program that year, only 52.5% was directed at institutions. Extrapolating from this data, the Health Care Financing Administration has estimated that this program saved $1.7 million in 1977 alone.

C. Connecticut: Project SAIL

The objectives of Project SAIL (Strengthened Assistance in Independent Living) are similar to those of TRIAGE. Where TRIAGE relies on funding from Medicare, however, SAIL utilizes Title XX funds ($675,000), state appropriations ($1.8 million) and Title III monies ($185,000). SAIL covers a broader geographic area than does TRIAGE, and the program is administered differently.

A case management program is available without regard to income; client eligibility for actual services, however, is somewhat more strict under Project SAIL than under TRIAGE. As with TRIAGE, clients must live within a program area and be over 60 years of age. In addition, the client must be a resident of an institution or within 90 days of inappropriate institutionalization. Priority is given to persons eligible for SSI and Medicaid.

Five area aging agencies perform case management and assessment functions. After a potential client is referred to the program, Project SAIL staff perform a prescreening test, frequently by telephone. This prescreening assesses the client's general eligibility for the program by obtaining information on such items as his age, income, and risk of institutionalization. Should the client pass this screen, a formal assessment is performed. A client with health problems is generally assessed by a registered nurse, while one with predominantly social problems is seen by a social worker. The assessment included a review of the client's health, social needs, and support systems.

At this point, SAIL staff develop a plan of care for the client and review it with him. Staff then facilitate contact between the various service providers and the client. Unlike TRIAGE, project SAIL does not directly contract for services on behalf of the client. An additional activity includes assistance with determining client eligibility for programs such as Medicaid or Supplemental Security Income. Staff monitor the client's progress and perform a reassessment at least every six months.

While project staff assist with eligibility determinations, facilitate client/provider contact, and perform monitoring and reassessment functions, the client is responsible for actually obtaining the services. Some 20 community based services are purchased under the State's Title XX plan, while other funds are used to provide counseling, meals on wheels, home health and other services. The provider bills the appropriate funding sources directly for services provided.

An evaluation of the program found that it served 1350 clients in 82 towns. Funding limitations have led to a waiting list for the project's services. During the fourth quarter of Fiscal Year 1979, the average monthly cost per client was $242. Sixty-five percent of this - $157 — came from state and Title XX funds. The balance was funded through other programs. Staff estimate that 75 percent of the funding is for direct services, excluding case management and administrative functions.

D. New York: Nursing Home without Walls

The State Legislature enacted the Nursing Home without Walls program in 1977. It operates as part of New York's Medicaid program, and is an effort to provide nursing home level care to persons in their own homes. New York has received waivers from the Health Care Financing Administration which permit reimbursement for services not traditionally funded under Medicaid. This program, rather than drawing only on existing home services, establishes an entirely new category of providers who are responsible for delivering care.

The program has three major components: provider selection, client selection, and funding mechanism. The program is coordinated through county social services departments, under guidance from the state Department of Social Services. The state Department of Health maintains responsibility for selecting providers and for determining reimbursement rates.

Providers may be hospitals, nursing homes, or home health agencies. (Under New York law, only public or voluntary non-profit home health agencies may be certified to receive direct Medicaid/Medicare reimbursement, and this restriction carries over to the Nursing Home without Walls program.) In addition to demonstrating a public need for the program, providers must also be capable of providing, directly or through contract, a wide range of services such as home health nursing; home health aide services; physical, occupational, respiratory and speech therapy; audiology; medical social work; nutritional services; personal care, homemaker and housekeeper services; and

medical supplies and equipment. Nursing, aide and homemaker services must be available on a seven-day-per-week, 24-hour-per-day basis. The Nursing Home without Walls program is a distinct part of the "parent" agency or facility. Ten providers have been selected throughout the state; four are in the New York City area, while six are located Upstate. They include three county health departments, two visiting nurse services, two hospitals, and three nursing homes.

Clients are Medicaid eligible individuals who are considering or are being considered for nursing home placement. If a nursing home without walls program is available locally, potential nursing home patients must be given written notification of its availability. In its initial stages, primary consideration has been given to patients who are in acute care hospitals awaiting nursing home placement due to a shortage of nursing home beds. New York uses a uniform assessment tool to determine the level of nursing home care which patients require. A potential patient must meet the minimum criteria for either the skilled nursing or intermediate care level in order to join the program. An assessment considers the client's medical, social and environmental needs. The assessment team, which includes a registered nurse from the provider agency and a social worker from the county social services department, also considers such issues as the desire of the patient to stay at home; the wishes of family or friends with whom he would be staying; the safety of the home; and the ability of the client to remain alone when an aide or another adult is not present. If all parties agree that the client is able to remain at home, a plan of care is developed.

The program's funding mechanism limits the cost of care under the nursing home without walls program to 75 percent of the average nursing home rate in the county. This figure, however, is flexible, so that a patient may overspend the budget during the early months if it appears likely that the budget will fall within that level over the short term.

As of August 31, 1980, 325 patients were enrolled in the program. Six hundred and thirty patients have been served under the program since it formally began in April, 1978. The average monthly budget for each patient has been $785, compared to $1351 for residential care and $6600 for acute hospital care.

E. Oregon: Project Independence

Oregon established Project Independence in response to recognition that alternative services were frequently unavailable for the elderly who had difficulty managing at home. The program is funded almost entirely through state money. A measure of its support is reflected in the annual increases granted since the program's inception in 1975. The appropriation for the first biennium (1975-77) was $929,000; for the 1977-79 biennium, the appropriation was increased to $2.7 million; and for the current biennium, the appropriation was raised to $4.6 million. In addition to state money, some county money is used to fund area aging agencies, visiting nurse associations, etc. Services are provided free to individuals who meet low income standards, and a sliding scale fee is imposed on those above these levels. The program is designed to service persons who are not receiving welfare, or other state grants and services.

Area aging agency staff perform an assessment on clients to determine their level of risk. Criteria include such items as difficulty with shopping, working, housekeeping, and transportation; disabling health problems; loss of a spouse; and housing or financial problems. The aging agency does not provide services directly, but contracts with local providers. Volunteer services are also sought and are frequently used for friendly visiting, transportation, and telephone reassurance. A major effort is now underway to expand the availability of adult day care services.

During its first years, Project Independence provided no additional money for administrative costs. Agencies were required to absorb the increased administrative duties with existing staff. Now, however, the agencies are permitted to spend up to five percent of their allotment for administration. The Legislature also recognized that in many areas of the state, sufficient in-home services were simply not available to meet the need. Accordingly, one-third of the initial appropriation was set aside for start-up services in rural areas.

A formal evaluation of the program has not been performed. Oregon estimates, however, that in 1979 the average annual cost per client was $215.

F. Texas: Community Care Program

The Texas Community Care Program is operated by the Texas Department of Human Resources. The program is intended to provide services to people without major medical disabilities in order to enable them to remain in the

community. The main funding source is Title XX, although Medicaid and Medicare funds are utilized for services which are reimburseable under those programs. Title XX, for example, is used to pay for chore and homemaker services, family care, day activities, home delivered meals and adult protective services, while Title XIX monies are used to pay for visiting nurse services.

Funds are limited under the Community Care Program so priorities must be set regarding who may receive the services. The aged, blind and disabled receiving supplemental security income and who are released from nursing homes are the highest priority. SSI recipients over 65 years of age are the second priority; SSI recipients between 18 and 64 are at the third level of priority; and the fourth level is comprised of those aged, blind and disabled with incomes below 80 percent of the state median.

The Department of Human Resources administers the program through twelve regional offices. At present, service provision under and entry into the Community Care Program is fragmented. In 1977 the Texas Joint Committee on Long Term Care Alternatives was established to examine the program. The Committee made a number of recommendations, many of which have been adopted. These include authorization for the development of adult day care and respite care programs, nursing home outreach, expansion of volunteer programs, and crisis counseling for the elderly and disabled. In addition, the Department of Human Resources, has combined formerly separate medical and social divisions. It is anticipated that this union will result in more effective coordination of services to the elderly.

Further recommendations, which are the subject of ongoing cooperation between the legislature and the executive branch, include the development of a standardized preadmission assessment form, increased coordination of services for the elderly, and the implementation of a comprehensive continuum of community and institutional care.

The program now consists of two major components. The "Primary Home Care Program" is intended primarily for those with medical needs; home services are available on a physician's order if they are needed to maintain an individual in the community. This program is funded primarily through Medicaid; a waiver has permitted reimbursement for additional services. For those without major medical needs, a "Family Care Program" provides services under Title XX.

The Community Care Program serves approximately 37,000 elderly or disabled Texans, who average 78 years of age. Fiscal Year 1978 expenditures were $57.6 million; for Fiscal Year 1981, the appropriation level is $82 million. This funding, however, will also have to cover services to persons who had resided in Intermediate Care Level II facilities, a level of care which has been discontinued.

G. Utah: The Alternative Program

Utah has developed a program which is intended to supplement other available community services in order to enable persons to remain in the community. The initial goals of the program, which commenced in 1978, were modest: to reduce inappropriate or premature admissions to nursing homes by twelve per month, and to maintain these persons in the community at lower state costs.

The program is administered by the State Division of Aging, through the area agencies on aging. It is funded exclusively through state monies (plus donations and fees) and acts as a supplement to informal and formal funding sources and providers. There are no strings attached to the money; the funds may be used to purchase virtually any service required to keep a needy person at home.

Any Utah resident who will enter a nursing home within 90 days is eligible for the program, regardless of income. At the same time, any person applying for nursing home admission under Medicaid must undergo an assessment, or reimbursement to the nursing home is withheld.

The assessment is performed by a registered nurse and a case manager from the area aging agency. These personnel develop a plan of care for the client, including services needed, providers who can deliver the services, and funding sources. An important aspect of the Utah program is that the plan of care must retain any formal or informal support system which the client is utilizing. For example, if a local church group is now providing home delivered meals to the client, additional funding from the Alternative Program would not be available for this service. Likewise, the client's family would be expected to continue to provide services which it was already undertaking. The Alternative Program would, however, pay for new services which the patient required. A sliding fee scale is used for individuals with an income in excess of 61 percent of the state's median. Fees are assessed for the entire package of services rather than for each individual service.

Following the assessment, the client's physician and the State Division on Aging must approve the plan of care. Provision of services may begin immediately after the assessment. The local aging agency monitors the client after 10 days, and then every 30 days, in an effort to assure service coordination, appropriateness, and quality, and to determine any changes in the client's condition.

An evaluation of the program's first nine months indicated that the clients and their families were very pleased with the operation of the program. For example, 96 percent of the clients thought that the services were adequate, 88 percent reported they felt more independent, 94 percent felt happier, and 67 percent reported that their physical condition had improved. All the clients interviewed agreed that the program should continue. Ninety-one percent of the clients' families thought the services met the client's needs; 70 percent said that the client was more independent; 88 percent thought his mental coordination had improved; 90 percent believed that family stress had decreased; and 96 percent believed that the program provided better care for the client.

The evaluation also determined that the total average daily cost of the program was $7.68, compared with $33 per day in skilled nursing facilities, $28 per day in ICF Level I facilities, and $24 per day in ICF Level II facilities. The per diem cost of the Alternative Program is broken down as follows:

Federal Contribution	$2.07
Client Contribution (Fees)	.61
State Share of Federal Programs (e.g., Title XIX)	.69
Alternative Program Funding	4.31
Total Cost	$7.68

The initial annual appropriation for the program was $200,000. In 1979 this was increased to $250,000, and by 1980 this rose to $600,000. With this appropriation, the Division on Aging hopes to place 550 patients in 350 different "slots" during the year.

H. Virginia: Preadmission Screening Program

The Virginia Preadmission Screening Program does not actually deliver services to the elderly. Instead, its purpose is to apprise potential nursing home patients of alternative services. The Preadmission Screening Program has also proven successful in identifying gaps in community services. The program was established on a pilot basis in four counties in 1976, and

Persons applying for nursing home admission are screened under the program. Any individual who is Medicaid eligible or who will become Medicaid eligible within 90 days of admission to a nursing home must be screened or Medicaid reimbursement is withheld. The assessment committee consists of a social worker, registered nurse, and physician. In addition, other local community agencies (such as a community mental health center) are encouraged to participate in the review. The panel performs a complete social and medical assessment of the individual. The panel determines whether an existing services or combination of services can meet the client's needs. It also assesses which services are needed, whether they can be delivered at the time and in the quantity needed, and the financial eligibility of the client.

The assessment panel informs the referring agency or individual of its determination. The panel also makes a referral to provider agencies and informs the client or family of how to proceed in arranging for services. The panel continues to monitor the client to assess changes in his condition.

The Assessment Program is funded under Medicaid. During its first year of operation, 2062 individuals were screened. Of these, 444 (21.5 percent) were able to be maintained in the community.

In cases where services are unavailable, the client often has little choice but to enter a nursing home. A long term benefit of the program is assistance with planning for additional services by identifying gaps in current areas. In its initial evaluation, the Department of Health found that companion services were not available in 29 percent of cases. Chore services (22 percent), homemaker services (21 percent), home delivered meals (20 percent) and adult day care (18 percent) were also unavailable in many cases. Reasons cited for the lack of services included: the individual was not eligible on the basis of income, particularly where his resources exceeded Title XX criteria; services simply did not exist in the community; and insufficient units of service were available to meet the need.

IV. FEDERAL LEGISLATION

Congressional activity in the long term care field has focused on two bills introduced during the 96th Congress. Although action is anticipated on neither piece of legislation this year, each has generated a great deal of interest among groups concerned with the provision of long term care, and it appears likely that the bills will be reintroduced in Congress next year.

A. H.R. 6194: The Medicaid Community Care Act

This legislation was introduced by the Chairman of the House Subcommittee on Health and the Environment (Congressman Waxman from California) and the Chairman of the House Committee on the Aging (Congressman Pepper from Florida). The approach contained in this bill is particularly appealing to states for a number of reasons. First, the bill increases the federal matching share under Medicaid by 25 percentage points (up to a maximum of 90 percent) for community based long term care services. Second, the bill does not mandate this program upon the states, but seeks to encourage their adoption of alternative programs through positive fiscal incentives. Third, the legislation itself is based upon state programs, such as those described above.

In order to qualify for the increased Medicaid match, states need to meet four requirements.

1. States must provide for a comprehensive medical and social assessment of persons who are seeking entry into a nursing home. This assessment must encompass all factors — medical, social, environmental, and financial, — which relate to the individual's ability to live in the community.

2. An expanded range of in-home/community services must be available to persons at risk who can and choose to remain in the community. The services include nursing; home health aides; medical supplies and equipment; physical, occupational, and speech therapy; and audiological services. While these services are currently reimburseable under Medicaid, a number of new services are added, including adult day health services, respite care, short-term full time nursing care, homemaker services and nutritional counseling.

3. Financial limits, at a rate not in excess of those set for nursing home care must be established.

4. The state must provide a plan for coordinating this program with other community based programs under Medicare, Title XX, the Older Americans Act, etc.

Hearings on this legislation were held in June of this year. For your information, I have included as an Appendix a copy of testimony which Senator Chet Brooks, Chairman of the Texas Senate Human Resources Committee, presented on behalf of the National Conference of State Legislatures.

B. S. 2809: The Noninstitutional Long-Term Care Services for the Elderly and Disabled Act

This legislation, introduced by Senator Packwood (Oregon) pulls together all non-institutional long term care services into a new Title XXI of the Social Security Act. In addition to coordinating existing services, this legislation provides reimbursement for additional services, such as adult day care and respite care. The proposal also provides a tax credit of up to $100 for families caring for dependent elderly relatives.

Eventually, states must establish Preadmission Screening and Assessment Teams which will have the responsibility for performing health status and functional assessment of individuals seeking Title XXI services or applying to nursing homes; developing a plan of care for each person; conducting periodic reassessment; assisting the client in obtaining services; and keeping the client's physician aware of his progress. Ten statewide demonstrations (one in each Federal region) will be conducted for a three year period. Following an evaluation of these demonstrations and after any necessary adjustments are made, the program would be implemented nationwide.

Concerning the provision of service, 50 free visits are permitted for home health care, homemaker-home health aides, and adult day care. Following these initial visits, a ten percent copayment is imposed. No individual, however, is required to pay more than a specified portion of his annual income, ranging up to a maximum of five percent for persons with an income of $10,000 per year or more.

To finance the program a trust fund similar to that used for Medicare is established. Fees for services are set by the Secretary of Health and Human Services in consultation with the Governor of each state.

V. CONCLUSION

The case for making community based alternatives to nursing homes more readily available can be easily made by looking at the costs -- in both fiscal and social terms -- of doing nothing.

There appear to be six key issues which must be resolved prior to establishing a new program or expanding an existing one:

1. Funding. Issues which need to be addressed here include both the level and source of funding. Federal programs, such as Medicaid and Title XX, can stretch available state dollars; yet each such program contains some limits on client eligibility and reimburseable services. State dollars along, however, may not have the impact which a federal-state combination may generate.

2. Eligibility. While it might be desireable to cover all senior citizens or disabled, such a policy might make the program prohibitively expensive. Decisions must be made on whether to limit services to those who are eligible under existing categorical programs, or to expand eligibility to reach populations which may not now be receiving services.

3. Administration. Where in the state government should the program be operated? How will local units of government be involved in the program's operation?

4. Assessment. Most existing programs utilize a uniform assessment mechanism to determine needed services. Which assessment tool best suits your purposes? Should an assessment be required for all individuals who want services? Only for those under public programs? Or for all those considering entry into a nursing home?

5. Case Management. The case manager is the key individual who monitors the client's condition and arranges for the provision of needed services. The number of case managers needed, their educational and licensing requirements, and funding sources and levels are among the issues which must be addressed.

6. Coordination with existing services. Some effort must be made to determine the current availability of in-home services. What services are needed? What services are now unavailable? To what extent should services be expanded?

While the foregoing questions are not exhaustive, they should provide a general direction in which you can proceed. As I mentioned before, we at the National Conference of State Legislatures will be available to assist you as you examine these issues and others which you may identify.

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Policy Resolution of the National Conference of State Legislatures

Adopted July 27, 1979

HEALTH AND SUPPORTIVE SERVICES FOR OLDER AMERICANS

NCSL is concerned -- for both humane and economic reasons -- that many older Americans unnecessarily reside in nursing homes. NCSL is pleased to note that many states have taken the initiative to develop alternative types of health and supportive services. NCSL is concerned about the difficulty states have had in obtaining federal reimbursement for these services.

NCSL urges Congress to enact legislation modifying Title XVIII (Medicare) and Title XIX (Medicaid) of the Federal Social Security Act to promote the development of innovative health and supportive services for older persons. These modifications should include adjustments in the reimbursement and waiver provisions of the law to encourage alternatives to the traditional institutional models.

In addition, NCSL recommends that Congress and the U.S. Department of Health, Education and Welfare increase federal support for model projects undertaken to promote the happiness, self-sufficiency and health of older persons and to prevent inappropriate placement of these persons in nursing homes.

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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MEMORANDUM October 16, 1980

TO: Representative Hugh Malone

FROM: Betty Barton and Susan Brody
Research Staff

RE: Alternatives to Institutional Care for the Elderly
Research Request No. 165 (additional material)

The purpose of this memorandum is to provide you with supplementary information concerning alternatives to institutional care for the elderly. A review of the current treatment of elderly housing issues at the national level has furnished us with some additional information which we felt could be useful to your steering committees. Our findings are based on conversations with several authorities in the field of elderly housing and various readings in gerontological reviews. An interview list, bibliography and several excerpts from our reading are attached for your review.

To determine current or proposed innovations in the field of elderly housing, we approached staff members from the Gray Panthers, the Philadelphia Geriatric Center, and the American Baptist Convention's Cooperative Living for Older Americans Program. From our conversations we learned of several models for alternative living, most of which are "intermediate" housing programs.[1] The following is a brief summary of the alternative models which were presented to us.

<u>Small Group Living in Converted Family Residences</u>

This concept has gained appeal nationally in recent years both because of the non-institutional atmosphere it provides for elderly residents and the comparatively low costs of its implementation and operation. Under programs of this nature, single-family houses are converted into intermediate housing units for the elderly. Depending upon the housing design, homes

1. Intermediate housing refers to semi-independent living environments and is generally regarded to be the middle [illegible] ween home residency and institutional care. Congregate faciliti[illegible] [illegible]r citizen housing, and retirement communities are all examples of [illegible] diate housing.

have tended to range in size from 5 to 25 occupants. Converted houses may either be purchased or leased; several housing organizations choose to reduce front-end and, in some cases, overhead costs by leasing, rather than purchasing, houses. Some programs are designed to enable occupants to purchase their housing space but most appear to employ monthly rental-service fees. The costs of most programs are offset totally by the monthly tenant fees. Some programs are eligible for HUD Section 8 subsidies.

Houses under some programs are converted into several private apartments or townhouses. Other programs employ a communal living concept with shared bathrooms, kitchens, living and dining areas. Many programs offer a private bedroom and kitchenette with shared living areas. Service options are equally diverse among the various programs. To better illustrate variations among the programs, we have summarized two of the larger, more established programs. (Additional information is attached to this memorandum):

Share-A-Home Association - Located in Winter Park, Florida, Share-A-Home Association leases, rather than purchases, its homes in order to maintain low operating costs. Eleven homes were recently added to the program with less than $2,000 in initial operating capital required for each home. Share-A-Home Association functions solely on tenants' monthly fees, which range from $275 minimum for semi-private rooms to $475 and above for private units. Services include three daily meals, laundry, maid, and transportation. A live-in manager, employed by the occupants, is located in each house.

Community Housing - Operated through the Philadelphia Geriatric Center in Pennsylvania, Community Housing consists of 3 efficiency apartments located in each of 9 remodeled houses. Units provide private kitchens, baths, and bed-sitting areas. The facilities are operated by tenants' fees; however, 40 per cent of the tenants pay less than the full fee (full charges are $95 per month for a second floor apartment and $98 for a first floor location), with the balance provided by HUD subsidies. The program includes no live-in or daily staff although building maintenance and cleaning of communal areas is provided. Meal and cleaning services are available under

optional purchase plans. Administrators of the program maintain that this service system affords occupants an opportunity to individualize their service needs. The program relies heavily on its proximity to the Philadelphia Geriatric Center for other group service offerings, e.g. recreation and social programs.

Multi-Generational Housing

Research indicates that elderly persons occasionally encounter an element of stress when placed in an environment populated solely by other senior citizens. For example, studies have identified some negative effects on senior citizens residing in urban neighborhoods which younger populations have vacated. Similarly, some researchers have speculated that retirement community settings may be less satisfying for the occupants than situations where elderly persons share living units with several generations of relatives. Consequently, some gerontological theorists maintain that multi-generational housing, in which varied age groups share a living environment, offers more opportunities for social interaction and support and therefore can better promote the social well being of residents. An example of a simple application of this concept might be a townhouse project that sets no age limit for occupants; while a more complex demonstration might be an intermediate housing unit with communal facilities and varied age groups.

Although there has been support for multi-generational housing for a number of years, the concept has not been applied extensively. Nonetheless, several highly successful programs are currently operating -- including the home of Ms. Margaret Kuhn, National Convenor of the Gray Panthers.

Multi-Level Accommodation for the Elderly

Multi-level accommodation refers to a concept where two or more kinds of lodging and/or care are furnished within one building or complex. An example of comprehensive multi-level accommodation might be a housing complex which would offer occupants a variety of options ranging from self-contained suites to room and board, while also including a full range of personal, intermediate, and extended care services. The underlying purpose of this concept is to reduce relocation trauma of the elderly which can result from multiple moves necessitated by economic, health, or social circumstances.

In a 1976 research paper concerning multi-level accommodation for the elderly, Dr. Gloria M. Gutman of the Psychology Department, University of British Columbia, lists the following additional perceived advantages of multi-level housing:

1) Couples (or friends) can remain in close proximity should the health of one deteriorate;

2) Where there is day-to-day or week-to-week fluctuation in health status, as so often is the case among the frail elderly, appropriate nursing care is readily available;

3) Where an individual is rehabilitated to a higher functioning level he can remain in proximity to staff and residents with whom he has established rapport; and

4) In rural locations where it could be uneconomical to build separate facilities offering self-contained suites, board-residence, personal, intermediate and extended care, these services could economically be provided if combined in the same building or on the same site.

Whether or not a program of this type is regarded as an alternative to institutional housing may rest with the nature of the architectural design and the extent of the program services. For example, Seton Villa, a multi-level accommodation project in Burnaby, British Columbia, is a complex which includes seven floors of self-contained suites and six floors of board-residence. It also offers two floors each for minimal and comprehensive personal care. The complex, which is geared for occupants of low and moderate income levels, offers an extensive range of services including an infirmary (staffed with 3 registered nurses), auditorium, health spa (including exercise pools), arts and crafts room, workshop, dining room, and beauty parlor/barber shop.

Conclusion

Generally speaking, at the national level we found the current emphasis regarding housing for the elderly to be non-institutional in nature. Advocacy groups, such as the Gray Panthers, are presently stressing the need for increased incentives to enable senior citizens to better maintain comfortable

self-sufficient lifestyles. Although institutional care is still considered to be a valid approach, professionals are citing the need for expanded development of alternatives for the elderly, the majority of whom do not require the level of treatment offered in a nursing home setting. M. Powell Lawton, Director of Behavioral Research for the Philadelphia Geriatric Center, notes that 90 percent of the nation's elderly reside in their own homes. The implications of this, according to Dr. Lawton, should be a correspondingly high level of service located within the home or within the community. Instead, Dr. Lawton maintains, home maintenance and repair services are in short supply, as they receive substantially less federal funding than other Title III services of the Older Americans Act. Similarly, funding for health care services remains, for the most part, institutionally oriented with many home care services under funded or deemed ineligible for subsidy.

In the course of our research we learned of the recent convening of the White House Mini-Conference on Older Women. During the two day session, housing issues were addressed. We have contacted representatives of the San Francisco-based Western Gerontological Society, who will be forwarding us materials from the conference. (The final report on the conference findings is scheduled for release on January 10, 1981.) We will transmit copies of any pertinent materials to you when we receive them.

If we can assist you further with any of the subject areas presented in this memorandum, or in any future research concerning housing for the elderly, please do not hesitate to contact us.

BB:SB:bf
Attachments

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