SB

100

COMMITTEE REPORT

SENATE

FURTHER: None

3/31/81

Date: MAY 13, 1981

Mr. President:

The Committee on JUDICIARY 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)

[X] replace with CS for SB100 (JUD) [X] same title [ ] new title

and ~~recommends~~ WITH INDIVIDUAL RECOMMENDATIONS

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

Richards

MEMBERS HAVING
OTHER RECOMMENDATIONS:

Bill Kay NO REC

CHAIRMAN

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
POUCH K — 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 (Masa 1968); Wyatt v. Stickney, 325 F.Supp. 781 (M.D. Ala. 1971), 344 F.Supp. 373, 344 F.Supp. 387 (M.D. Ala. 1972), affirmed sub. nom.; Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Welsch v. Likins, 373 F.Supp. 487 (D. Minn. 1974) dealing with mentally retarded persons; Davis v. Watkins, 384 F.Supp. 1196 (N.D. Ohio 1974); Stachulak v. Coughlin, 364 F.Supp. 686 (N.D. Ill. 1973).

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMITMENTS UNDER AS 47.30

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

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

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

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

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

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

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

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

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

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

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

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

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

9/ continued:

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

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

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

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

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

9/ continued:

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

(i) The superior court shall terminate the proceedings and dismiss the application upon completion of the hearing and consideration of the record, except that the court shall order the hospitalization of the proposed patient for an indeterminate period if the court or the jury find the proposed patient is mentally ill and (1) because of his illness is likely to injure himself or others if allowed to remain at liberty; or (2) is in need of immediate care or treatment in a hospital, and because of his illness, lacks sufficient insight or capacity to make responsible decisions concerning hospitalization.

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

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

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

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

DUE PROCESS CONSIDERATIONS

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

A. Standards for Commitment

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

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

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

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10/ See footnote 7.

11/ See footnote 8.

12/ AS 47.30.040. NEWLY ADMITTED PATIENTS.

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

13/ See footnote 9.

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

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

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

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

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

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

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

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

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

B. Time Before Hearing

(1) Analysis: While a prior hearing is normally a prerequisite to the state's interference with a person's liberty, it may be delayed until some time after the deprivation has taken place where there is a compelling state interest to warrant post-ponement. 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 386 (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 520 F.2d 931, 935-37 (7th Cir. 1975); Suzuki v. Quisenberry, 411 F.Supp. at 1132. Cf. In re Winship, 397 U.S. 358 (1970), where the

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

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

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

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

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

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24/ See footnote 9.

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

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

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

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

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

(6). Other Rights at Hearing.

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

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

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

D. Recommitment After Release on Convalescent Statute.

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

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

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

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

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

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

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

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

E. Indeterminate Commitment and Provisions for Periodic Judicial Review.

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

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

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

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

F. Minors.

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

25/ See 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.

G. Substantive Rights of Committed Persons.

(1). Consent to Treatment.

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

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27/ AS 47.30.130(b) provides:

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

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

. . . . . .

27/ continued:

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

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

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

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

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

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

(2). Consideration of less restrictive alternatives.

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

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

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

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

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

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

In Dixon v. Weinberger, 405 F.Supp. 974 (D. D.C. 19[illegible], 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 tha Division of the safest

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

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

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

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

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

(a) adequate prior notice;

(b) a neutral judicial officer;

(c) right to effective assistance of counsel;

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

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

(f) adherence to the rules of evidence;

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

(h) consideration of less restrictive alternatives to commitment;

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

(j) appellate review;

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

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

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

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

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

Very truly yours,

AVRUM M. GROSS
ATTORNEY GENERAL

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

ERA:md

Alaska State Legislature

Senate

Judiciary Committee

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

M E M O R A N D U M

TO: Senator Bennett
Senator Hohman
Senator Parr
Senator Ray

FROM: Senator Rodey PMR

DATE: May 11, 1981

SUBJECT: CS for Senate Bill 100 "An Act relating to mentally ill persons; and providing for an effective date."

Attached please find a draft of a proposed substitute for the above-referenced legislation.

The Judiciary Committee will be conducting hearings on this bill on Wednesday, May 13. I would appreciate your review and comments on this draft.

PMR/ods
Attachment

Alaska State Legislature

Senate

Judiciary Committee

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

May 4, 1981

Ms. Natalie Gottstein
Executive Director
Alaska Mental Health Association
1030 West 26th Avenue, #1
Anchorage, Alaska 99503

Dear Natalie:

Thank you for your extensive comments on SB 100.

I have incorporated most of your suggestions into a committee substitute that is now being drafted.

One particular suggestion which I have modified is the length of the second period of commitment. The committee substitute will provide for a 21-day commitment rather than the 30 days allowed in the current bill.

I will forward a committee substitute draft to you as soon as it is ready.

Again, I appreciate your concerns and your valuable assistance in this legislation.

Sincerely,

Pat

Senator Patrick M. Rodey
Chairman

PMR/ods

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

RECEIVED
APR 29 1981

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

Dear Pat:

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

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

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

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

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

relating to mentally ill

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

NORTHWEST ACADEMY OF PREVENTIVE MEDICINE

VOL. VII NO. 10 NEWSLETTER OCTOBER, 1980

LAST CALL ON MAUI SEMINAR NOVEMBER 9-16

The Fall NAPM Seminar is now into its final registration planning; airline reservations and booking will now have to be made on a first-come, first-serve basis. Similarly the hotel accomodations at the Royal Lahaina at Kaanapali will have to be made now on a first-come, first-serve basis. Please call the business office today to make arrangements as expediently as possible.

To highlight this Fall seminar Dr. Jeffrey Bland, Ph.D., biochemistry professor at the University of Puget Sound and director of the Bellevue Redmond Laboratories will be speaking on several areas in clincal nutrition: Recent advances in interpretation of hair mineral anlysis; application of clinical laboratory and nutritional evaluation to a standard medical practice; the integration of diet survey information, biochemical data and a patient history in nutritional assesment; and new advances in cardiovascular disease prevention and therapy by nutritional and lifestyle intervention. Dr. Scott Rigdin, M.D. will talk on the implementation of a holistic practice. Dr. Philip Stonebrook, M.D. will consider the interface of a general practice between crisis care and prevention. Dr. Arthur Davis, M.D. will explore the future of noninvasive therapies of cancer.

Attendance at the meeting will provide education requirements for most boards, 15 credits of category 2 A.M.A. approved. /=

LEGAL SURVEY UNDERWAY, PLEASE PARTICIPATE

We are collecting and correlating information nationwide regarding two common problems for preventive doctors. These are (a) the mechanisms of county medical societies for repressing "unscientific" or "unfounded" diagnostic and treatment modes and (b) the use, by insurance companies, of the mechanism of peer review committee to justify denying treatment and diagnostic coverage.

If you have been affected by these problems we would like to hear from you as to your experience.

Contact George Wm. Cody, Box 1056, Lynwood, WA 98036. (206) 775-4626. Counsel for the Northwest Academy of Preventive Medicine. /=

THIS MONTH'S NEWSLETTER

LETTERS TO THE EDITOR

FEBRUARY CARDIAC FITNESS MEETING IN HAWAII

I have enjoyed looking through the August NEWSLETTER of the NAPM. I am interested to see your seminar in Maui from Nov. 9 to 14. It turns out I will be speaking at a conference for Emergency Physicians from Nov. 5 to 9 at the Hotel Inter-Continental at Wailea Beach, Maui.

Also, I am enclosing a brochure on a conference on cardiac rehabilitation and fitness which will be held at the Kona Surf Hotel on the big island of Hawaii, Feb. 14-21, 1981. I will be happy to give information to any reader.

Stephen R. Yarnall, M.D., F.A.C.P.,FACC
21700 76th Ave., West #100
Edmonds, WA 98020

It's called "Nature's Organic Toasties." There's no artifical color or chemicals. It's made from sugar and wood bark.

OTT TO PUBLISH NEW BOOK ON LIGHT

Thank you for sending me the copies of the NEWSLETTER with the first part of my article and I look forward to receiving copies including the balance of it. I am in the process of writing another book which I hope will be available shortly after the first of the year. There have been quite a few new developments regarding the electric dimension of living cells that I am discussing in the book.

John Nash Ott, (Hon.) Sc. D.
8324 Sanderling Road
Sarasota, Florida 33581

WANTS TO KNOW ABOUT POSTGRADUATE EDUCATION

In the September NEWSLETTER you refer to extensive postgraduate medical education being available from the academy. Please advise. I have Dr. Bland's ND's tapes.

Roy Kupsinel, M.D.
Lost Horizon Health Awareness Center
Artesia St. Rt. 2 Box 1246
Oviedo, Florida 32765

Ed. Note: Because of Washington State Post-Graduate Educational Requirements physicians are required each three years to accumulate 150 hours of education. One category which many physicians do not take advantage of is the Category 5 training, which is independent study by the physician. In the range of this category one can independently study taped materials from this academy presented at previously authorized (Category 2) seminars. Roughly 100 hours of such taped material is available and at some point shortly we will catalogue the available lecture material. This would be an excellent way to catch up with nutritional medical education at your convenience in the home or while driving to work.

ANNOUNCEMENT ANNOUNCEMENT ANNOUNCEMENT

The John Bastyr College of Naturopathic Medicine is opening a low-cost natural health care clinic in the University District of Seattle on September 22, 1980. The Naturopathic Medical Center will offer family-oriented health care provided by student interns of the College under the supervision of licensed naturopathic doctors. Care available includes pediatrics, gynecology, preventive health care, homeopathy, herbal medicine, geriatrics, stress management, physical therapy, and psychological counselling. According to Dr. Joseph Pizzorno, President of the College, "We are striving to aid our students in developing a wellness orientation while treating the common problems of health care."

Appointments will be accepted by phone (632-0354) beginning Sept. 15. (See p. 8)

CLINICAL EDUCATION NOTES

The John Bastyr College of
Naturopathic Medicine
Seattle, WA

THE IDEAL TEACHING OF NUTRITION

Clinical nutrition as such is not a regular teaching course in the curriculum of the medical colleges of the U.S. Courses in nutrition are presented electively to students and taught with very narrow bases. The Albany Medical College of Albany, N.Y. presented in 1975 one course in dietetics for medical students as an elective, taught at the lunch hour, and titled appropriated "Taste What You Treat". The purpose of the course was to give the medical doctor some flavor of what he was prescribing dietarily to his patients. Not a modicum of material was presented to establish the clinical biochemistry of nutrition or diet. And in the five years since 1975 clinical nutrition education in the U.S. has not appreciably changed. Some schools such as the Albert Einstein Medical College of the Bronx, New York are beginning to conceptualize and teach clinical nutrition, but on a very rudimental level and still elective like in nature. Thus, for the most widely accepted health practitioner, nutrition remains untaught. Other health professions including dentistry, chiropractic, and to some extent osteopathy, and especially naturopathic are beginning to seriously study clinical nutrition. A critical question to ask now at the start of the eighties is: what is an ideal clinical nutrition course?

The following curricula established by the John Bastyr College of Naturopathic Medicine provides an ideal teaching of clinical nutrition. Perhaps the American Medical Association and the Association of American Medical Colleges might consider such a curricula for the purpose of instituting nutritional education of a required basis in primary medical student education.

What follows is the course outline for Nutrition I and Nutrition II:

A. Absorbtion and Utilization
  1. Nutrient digestion
  2. Nutrient transport

B. Biochemistry
  1. Protein
  2. Carbohydrate
  3. Lipids
  4. Vitamins
    a. Vitamin A & Carotene
    b. Vitamin D
    c. Vitamin K
    d. Vitamin E
    e. Essential fatty acids
    f. Thiamine
    g. Niacin
    h. Pantothenic Acid
    i. Pyridoxine
    j. Folic Acid
    k. Vitamin B12
    l. Choline
    m. Inositol
    n. Carnitine
    o. Pangamic Acid
    p. Amydalin
    q. Ascorbic Acid
    r. Bioflavinoids, rutin, hesperidine
  5. Minerals
    a. Calcium and Phosphorous
    b. Magnesium
    c. Iron
    d. Electrolytes
    e. Iodine
    f. Zinc
    g. Copper
    h. Chromium
    i. Selenium
    j. Nickel, vanadium, lithium, molybdenum

C. Food supply
  1. Farming techniques
  2. Naturally occuring food-borne Intoxicant
  3. Food processing and transport
  4. Food additives and fortilization
  5. Nutritional content of foods
  6. Special formulas

D. Nutrition and Metabolism
  1. Hormone control of nutrient metabolism.

(Continued on page 7)

CLINICAL REVIEW

Originally Published in
Der informierte Arzt
October, 1974
by W. Bartsch

PROTEOLYTIC ENZYMES IN THE TREATMENT OF HERPES ZOSTER

Weber and Roth (1967) discussed therapy for herpes zoster and indicated no causal therapy was then available. Research review indicated similar progress lack until 1974. Gradual discussion had been made of the use of enzymes in treatment of zoster. Gotz (1967) used proteolytic enzymes in ointment form for topical treatment; while Shields(1962) administered chymotrypsin by the oral route. Wolf (1970) suggested enzyme injections. Such investigators have agreed that the administration of enzymes hastens the recovery and promotes reduction in the pain quickly. Post-herpes neuritis is virtually eliminated.

Bartsch (1968) has found significant results clinically in treating herpes zoster with enzymes particularly in the form of Wobe-Mugos*. Patients receiving high doses of the Wobe-Mugos responded readily.

To verify these findings Bartsch tested herpes zoster treatment-wise. With one group convention symptomatic treatment for the herpes zoster was instituted. Such therapies included shaking therapies, antibiotic ointments; if necessary I.M. injections of antibiotics. To the other group receiving enzyme therapy treatment began with i.m. wobe-mugos enzyme and wobe-mugos tablets. Dose related responses were studied by giving initially higher doses for the zoster. Results did reveal the zoster clearing on higher doses of enzymes.

Standard treatment included administration of 3 0.1 ampoules of wobe-mugos to be injected i.m.; 6-8 tablets of the wobe-mugos to be taken orally. After the third day enzymes were administered in enema form.

RESULTS

With the patients receiving symptomatic and conventional methods the duration and the course of herpes zoster remained unchanged. With 43 herpes patients treatment with enzymes has reduced treatment length and some pain. Skin lesions and eruptions are under control in the enzyme treated group. The author felt that enzymes were the most convincing answer, particularly in reducing side effects.

The role the enzyme plays in treatment may reflect the antiviral property of Wobe-Mugos enzyme. As an example foot and mouth disease caused by a virus, (Wild,1967) when treated by the enzyme, brings remission or cure to that disease. Thus enzyme therapy for viral disorders appears very valuable.

Weber G. and Roth W.G., Z. Haut-Gerschl, -Kr., 43, 79, 1968.
Gotz H. Munch. med Wschr., 109, 1240, 1967
Shields Th. L., Current News in Dermatol, Aug. 1962
Wolf M. and Ransberger K., Enzyme Therapy, Maudrich, Vienna 1970
Bartsch W. and Gosemarker H. Med. Mschr. 22, 267, 1968
Wild,T.F. and Brown F.J., J. gen Virol, 1, 247, 1967

* Wobe--Mugos is manufactured by Mucos Emulsionsges, mbh, 8022 Grunwald, Nordl. Munchner Str. 20.

W. Bartsch, Waldsanatorium Urbachtal, 3579 Neukirchen.

"Calmatives, *Mrs. Kennedy, not* downers!"

EDITORIAL

CLINICAL NUTRITION, ITS ROLE IN MEDICAL EDUCATION

Nearly four decades have passed since Weston Price, D.D.S. published Nutrition and Physical Degeneration (Price-Pottinger Foundation) and established clinical nutrition as a primary etiologic agent in the development of dental malformations, caries, degenerate arch (dental) development, infectious disease, and emotional disorders. One of the original nutritional studies issued by the U.S. Federal Government through a forebear of H.E.W. in the 1930's noted a decided change in the U.S. population's eating habits and predicted in the years to follow progressive increases in degenerative disease, including higher numbers of cardiovascular disorders, arthritides, and cancer. The U.S. Department of Agriculture through the late 50's and early 60's has continuously reported on a steady decline in the optimal mineral and vitamin nutriture found in the American diet. Specifically in study of food substances on a one to one basis it found less content of minerals such as calcium, zinc, copper, magnesium, and potassium when comparing the food produce of the late 1960's as compared to the early 1950's. Agriculture has failed to implement a direct solution to this crop deficiency and has persisted in continuing a heavy chemical fertilization program involving nitrogen phosphorus supplementation. The advent of mineral analysis with the clinical tool of the cellular hair analysis has permitted widespread clinical analysis of the population. A staggering percentage of the population demonstrates widespread mineral deficiency substantially below optimal recommendations. Clinical nutritional reviews by nutritionists including Cheraskin, Frederick, Williams, Davis, Passwater, Hoffer, Pauling, Airola, Bland, etc. have documented sub-clinical disease affecting plant, animal, and human physiology and biochemistry. Clinical nutrition implemented into practice in medicine has demonstrated major remission of symptomatology, avoidance of degenerative progression, and inklings of true prevention of degeneration (see Williams, Pauling, Cheraskin, Bland, etc.) With the reports of these individuals becoming well known it is astounding to see the "grand indifference" of the medical education committees of the U.S. Medical Colleges to recommended nutrition education. Individual schools continue to ignore this obligatory education and turn out thousands of practitioners with sub-standard nutritional education expected to confront a public population wanting nutritional guidance. Instead academic hit-men are put on the lecture circuit in 1979 and 1980 teaching at "academic" seminars about the faddism and "cultism" of nutritionally oriented physicians. Local medical societies are gearing up increasing harassment actions against physicians acceptance of nutrition; in Canada an internist in Toronto was subject to reeducation because of his routine use of nutrition in his practice. Here in Washington State one physician is in court with Health Education and Welfare battling medicare's argument that"excessive and unnecessary medicine" is unjustifiable and will not be reimbursable under medicare statutes.

Yet, nutritional education, nutritional study, and nutritional practice is taking shape and form here and across the U.S. and Canada through extramural medical education (outside the medical school). Chiropractic has long demanded nutrition to be a key part of the patient life-style changing. When will the medical college begin to accept clinical nutrition as a requirement for routine medical education? Last year we took a soft approach to this. This year, 1980, is time for a change. Medical doctors must demand nutrition education at the post-graduate level and insist that clinical nutrition be implemented as a regular part of the medical student's curriculum. It is the responsibility of this Northwest Academy of Preventive Medicine to ensure that clinical nutrition become primary in the medical student's education. We will provide information monthly in this NEWSLETTER, annually through our clinical seminars, and post-graduate wise through taped lectures on clinical nutrition and support education throughout the U.S. on this. We recommend your participation and welcome original articles and reviews on clinical nutrition.

Jonathan Collin, M.D.

SMALL BUSINESS VERSUS BIG GOVERNMENT

This news brief was excerpted from the NFIB (National Federation of Independent Business). Excessive government regulation is a severe problem for small business, and although members of Congress concede that the bureaucracy is indeed out of control, they have been slow to deal with the problem.

NFIB lobbyists have constructed a regulatory reform package. The Equal Access to Justice Act would reimburse small businesses for lawyers' fees when they win in civil cases against the federal government. This bill passed the Senate with overwhelming approval. The second bill--the Smaller Enterprise Regulatory Improvement Act--would allow federal authorities to tailor regulations to the size and resources of those businesses affected by them. The third bill--the Legislative Review and Veto Act--would require agencies to submit new regulations for congressional review.

For further information write NFIB, 150 West 20th Ave, San Mateo, CA 94403; or 490 L'Enfant Plaza East, S.W., Washington, D.C. 20024. /=

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LEO J. BOLLES, M.D. LEGAL DEFENSE FUND ESTABLISHED

A substantive and significant legal proceeding is currently ongoing between Dr. Leo J. Bolles of Bellevue, WA and the Health Bureaucracy of H.E.W., Medicare. The case has reached the appeals section (formal hearing) of H.E.W. Administrative Court (within the agency proper, not in federal court). Original notice regarding the case was given in the summer of 1978 when the Medicare notice was made that because of excessive and unnecessary laboratory services and medical treatment, Dr. Bolles would no longer be coverable by Medicare carriers. Such notice was appealed immediately but Medicare proceeded to publish and execute their notice in October, 1978. A suit for unfair notice and slander was served on H.E.W. and its administrators. Using the Freedom of Information Act in 1979 a vast collection of data from H.E.W. was received. Most of the information under Dr. Bolles' name was irrelevant material; nevertheless, the agency kept such information anyway. In the summer of 1978 an informal hearing was held with H.E.W. Top witnesses called in to provide data regarding laboratory and clinical methodology in preventive medicine were received but their testimony was for all practical purposes ignored. H.E.W. decided its aforementioned notice was totally correct. The case is now at the first level of appeals in formal hearing of H.E.W. Such suit has exceeded $19G; the government employs the famous "keep the case going longer" technique so that incredible time and money is forced to be maintained. This case is based on nothing illegal nor malpractice like. It is based on orthodox medicine forcing government beauracracy to attempt to dislodge a preventive medical practice extent and surviving. Hearing materials have identified specific medical officials (see p. 8)

Reprinted by permission of Richard Wright, editorial cartoonist, *Providence (R.I.) Journal-Bulletin.*

THE IDEAL TEACHING OF NUTRITION (Cont. from p. 3)

2. Physiology of hunger and satiety

E. Epidemiology of Nutrient Intake
1. Criteria of an adequate diet
2. Food fads and faddism
3. Community nutrition surveys
4. Social determinants of food choice

F. Malnutrition
1. Classic deficiency diseases
2. Malnutrition in hospitalized patients
3. Protein-calorie malnutrition
4. Drug induced nutritional deficiencies

G. Nutrition during Physiologic Stress
1. Nutrition and cell growth
2. Nutrition in pregnancy and lactation
3. Nutrition in infancy and adolescence
4. Nutrition for the aging and the aged
5. Nutrition and work, exercise and environmental stress
6. Nutrition during infection
7. Nutritional support during surgery
8. Nutrition and stress

H. Therapeutic and Preventive Nutrition
1. Nutrition and behavior
   a. Mental retardation
   b. Hyperactivity
   c. Schizophrenia
   d. Criminal behavior
2. Nutrition and the nervous system
3. Nutrition and arthritis
4. Carbohydrate metabolic abnormalities
   a. Diabetes
   b. Hypoglycemia
5. Nutrition and the Cardiovascular system.
   a. Atherosclerosis
   b. Hyperlipidemia
   c. Hypertension
   d. Kidney disease
   e. Intravascular clotting and platelet adhesion

   Nutrition and diseases of the gastrointestinal tract
   a. Diseases of the stomach
   b. Diseases of the intestines
   c. Diseases of the pancreas
   d. Diseases of the liver
   e. Colitis and constipation

7. Nutrition and the skin
   a. Eczema, dermatitis and psoriasis
   b. Acne
   c. Acrodermatitis enteropathica
8. Nutrition and dental medicine
9. Nutrition and neoplasia
10. Nutrition and infection
11. Nutrition and the endocrine system

I. Special Topics in Nutrition
1. Obesity
2. Alcoholism
3. Fasting
4. Parental nutrition
5. Genetic aspects of nutrition
6. Food allergy
7. Food component intolerance
8. Maldigestion
9. Megavitamin therapy
10. Nutrient excess
11. Pancreatic insufficiency and achlorhydria
12. Vegetarianism
13. Amino acid therapy

J. Nutritional Assessment
1. Diet analysis
2. Clinical methods
3. Anthropometric assessment
4. Hematological assessment
5. Hair analysis
6. Biochemical techniques

K. Patient Management
1. Patient motivation
2. Diet modification techniques

The John Bastyr College of Naturopathic Medicine in Seattle, WA is looking for qualified individuals to teach sections or individual lectures of this course. Prospective candidates should contact the President of the JBCNM, Joe Pizzorno N.D., telephone (206) 632-0165. If so qualified your participation would and is very much appreciated. /=

"What is the pain reliever we recommend most often according to that ad on TV?"

ANNOUNCEMENT ANNOUNCEMENT ANNOUNCEMENT

(Cont. from page 2)

The Clinic is located at 1408 N.E. 45th St., and will be open Monday through Friday, 1-7 P.M. Visitors are welcome, and the public is invited to an Open House at the Clinic on Saturday, October 12th, 1-5 P.M. For more information, contact Dr. Joseph Pizzorno or Sheila Quinn at 632-0165/0166. Write JBCNM, 1408 N.E. 45th St., Seattle, WA 98105.

/=

LEO J. BOLLES, M.D. LEGAL DEFENSE FUND

(Cont. from page 6)

in the King County area providing the U.S. government through H.E.W. questionable reports regarding Dr. Bolles. Other preventive physicians are being similarly reported. It is the feeling of many individuals involved with the case that this suit can be precedent standing for preventive medicine. With a victory many practitioners may be eligible to come out publicly and practice exactly as they wish. With a defeat harassment in the King County area may take a serious and endangering turn, particularly for physicians who have already received warnings from HMO's or similar groups.

We are strongly encouraging financial support for this fund, and recommend your speaking to Dr. Bolles personally regarding this case. Please submit supports to Dr. Leo Bolles, c/o the NAPM, 15611 Bellevue Redmond Road, Bellevue, WA 98008 (206) 881-9660.

/=

LAETRILE LEGISLATION (in WASHINGTON STATE)

Public Health and Safety 70.54.150

70.54.130 Laetrile-Legislative declaration
It is the intent of the legislature that passage of this act shall not constitute any endorsement whatever of the efficacy of amygdalin in the treatment of cancer, but represents only the legislature's endorsement of a patient's freedom of choice, so long as the patient has been given sufficient information in writing to make an informed decision regarding his/her treatment and the substance is not proven to be directly detrimental to health.

70.54.140 Laetrile-Inteference with physician/patient relationship by health facility--Board of Pharmacy, duties.
No hospital or health facility may intefere with the physician/patient relationship by restricting or forbidding the use of amydalin when prescibed or administered by a physician; and requested by a patient under his/her care who has requested the substance after having been sufficient information in writing to make an informed decision.

70.54.150 Physicians not subject to disciplinary action for prescribing or administering laetrile--Conditions.
No physician may be subject to disciplinary action by any entity of either the State of Washington or a professional association for prescribing or administering amygdalin to a patient under his care who has requested the substance after having been given sufficient information in writing to make an informed decision.

/=

THE NORTHWEST ACADEMY OF PREVENTIVE MEDICINE
15611 BELLEVUE REDMOND ROAD
BELLEVUE, WA 98008 (206) 881-9660

Alaska State Legislature

Senate

Judiciary Committee

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

May 5, 1981

Jonathan Collin, M.D. F.A.A.M.P.
Physician & Surgeon
15611 BEllevue-Redmond Road
Building A
Bellevue, Washington 98008

Dear Dr. Collin:

Thank you for your letter regarding SB 100. I expect the committee to pass out this bill shortly, and to gain Senate approval this session.

Since nutritional approaches to psychiatric problems are essentially a health issue, I have taken the liberty of forwarding a copy of your correspondence to Senator Parr, Chairman of the Senate Health, Education, and Social Services Committee for his information.

Again, I appreciate your comments on this legislation.

Sincerely,

Pat

Senator Patrick M. Rodey
Chairman

PMR/ods

cc: Senator Parr

LEO J. BOLLES, M.D., INC., P.S.
15611 Bellevue-Redmond Road
Building A 206-881-2224
Bellevue, Washington 98008

Leo J. Bolles, M.D. F.A.A.M.P.
Physician & Surgeon

Jonathan Collin, M.D. F.A.A.M.P.
Physician & Surgeon

April 30, 1981

Senator Rodey
Chairman Judiciary Committee
Pouch V
Juneau, AK 99811

Dear Senator Rodey:

Re: S-100 Commitment Bill

It is a pleasure to see that the Northwestern States are taking a greater interest in seeing that mental health is handled with appropriateness and conviction. I support your state's venture into bringing a more effective approach to dealing with the crisis situation where commitment questions are sometimes difficult to march through the beauracratic machinery.

May I suggest that after this bill is considered and hopefully passed that the Senate consider the value of Orthomolecular Psychiatric approaches which are used by Abram Hoffer of Victoria, B.C. in dealing with the committed patient.

I am the editor of the Northwest Academy of Preventive Medicine Newsletter and have access to physicians throughout the Northwest who actively support a nutritional approach to psychiatric problems.

Sincerely,

Jonathan Collin

Jonathan Collin, M.D.

TESTIMONY BEFORE THE SENATE JUDICIARY COMMITTEE

APRIL 22, 1981

PRESENTED BY

STEPHAN C. KOZACHIK
REGIONAL DIRECTOR
CITIZENS COMMISSION ON HUMAN RIGHTS
701 VANCE BUILDING
SEATTLE, WA 98101
(206) 622-4563

Mr. Chairman, members of the Committee, my name is Steve Kozachik. I am the Rgional Director of the Citizens Commission on Human Rights, a psychiatric patients rights group in Seattle. My organization is one chapter of the 20 or so in the United States and is sponsored by the Association of Scientologists for Reform. The Association is a private, non-profit organization made up of members of the Church of Scientology That sponsors the Commission and other social reform groups.

From my position with the Commission I have dealt with involuntary commitment and other mental health issues for nearly 6 years. During that time we have investigated dozens of complaints regarding various failings in Washington state's commitment law and worked on a number of proposed legislative solutions. I have studied and discussed Senate Bill 100 with an eye on these individual problems encountered in Washington.

Essentially what we determined was that the bill in its present form represents a dramatic, major improvement over the current involuntary commitment statute in Alaska. Some of the major positive aspects of the bill are the following:

* The progressive lengthening of periods of commitment from 3 days to 30 days to 90 days and finally to 120 days serve all citizens best interests. They ensure that the rights of the individual patient are protected to the maximum level possible while at the same time ensuring that society is protected from those whose mental condition makes them dangerous to their fellow citizens.

* The definitions section, easily one of the most important sections of any new law, is at once innovative where needed and conservative where past experience has shown the value of

language, standards and concepts. Most prominent among these are the definitions of "likelihood of serious harm" and "gravely disabled".

* Throughout the legislation the balance of patients versus societal rights has been most carefully maintained. The incorporation of philosophical concepts into judicial and bureaucratic processes has resulted in a streamlined procedure that should leave no possibility of unfortunate surprises once the bill reaches the stage of implementation.

* The actual language of the bill is clear enough that judges, mental health professionals, and attorneys for both sides should have no difficulty in understanding the intent of the legislature. This is not to say that there will never be arguments as these are inevitable whenever human beings are involved in such complex issues.

In our study of the bill we found several areas where the bill is not entirely adequate in dealing with possible future problems. I have provided copies of the Commission's proposals to the Committee and would ask that you consider adopting these amendments into the current version of the bill. In the interest of brevity I would like to address the major proposals in this set of amendments. If you have questions regarding these or other amendments, please feel free to ask.

Our first major proposal, and the one that is numbered (1) in the pack, is a suggestion that the second period of commitment be returned to its original length of 14 days. The bill was recently amended to extend this period to 30 days at the suggestion of the Department of Health and Social Services, as

I understand it. The rationale behind this amendment was that 21 to 22 days may be required for some psychotropic medications to take full effect, therefore 30 days should be allowed.

In dealing with a similar proposal in Washington state 2 years ago it was brought to light that only an estimated 2½ to 5% of the total patient population would be taking this type of drug. Essentially you end up with a forced solution to a problem encountered in a small percentage of cases that affects all involuntarily committed patients. If the period were restored to its original 14 day limit, the mental health professionals in charge of a patient's care would still be able to file for the commitment of a patient for a 90-day period at any time during the 14 day period. This would give them the opportunity to keep the person in the hospital long enough to obtain the maximum benefits from the medication. It would eliminate the tendency inherent in all organizations to take all of the time available to accomplish something, in this case leading to a trend of taking more and more of the 30 days in all cases.

The second problem we would like to see addressed, encompassed in proposal number (7), is the right of patient access to medical records. Currently the bill allows for the right of a patient to allow a third party to have access to the records, but not for the person himself to obtain a copy of his own records. This would appear to be an oversight that could easily be corrected.

It has been said that the mental health of a person could

be damaged by reading his own chart but in all my years of struggling to assist patients in obtaining copies of their records I have never seen any of them get anything but mad at some of the comments made by staff. Access to the records has assisted our agency to resolve a number of complaints without having to resort to the trauma of malpractice suits and oftentimes a problem was solved simply by seeing, in writing, just what was said and done.

The third proposal I would like to address, number (5), is the 2 sections that deal with returning patients to the hospital. The bill currently states that the professional person in charge of a facility may cause persons to be "taken into custody and returned to the facility". On its face this would give the head doctor the right of arrest. Our proposal would require that law enforcement agency personnel be involved in cases of involuntary return to the hospital. This would protect mental health personnel from having to face the potential use of deadly force by an unwilling patient when they are not trained to deal with it. It would also tend to protect the innocent bystander by minimizing the "fallout" from such situations.

Our fourth proposal, amendment number (8), is that the definition of the term "gravely disabled" be amended to include the word "imminent" modifying "danger". The reasoning for this proposal is basically philosophical. Our position is that the state has no inherent right to interfere with the life of any citizen unless there is a clear and present danger to either

the individual in question or to society. The fact is that life is basically a learning experience in which each of us tries to deal with both the ups and downs of life. The inclusion of the word "imminent", which would raise the threshold of commitment, would clearly state that the intent of this legislature is to leave people to their own lives to the greatextent possible and to intervene only when there is vital necessity. Intervention prior to this point leads to increased reliance on state systems rather than one's own capabilities. The decision is one of thresholds, at what point do you want to take over the control of someone's life.

Finally, in amendment number (9), we would propose that the "screening investigation", that earliest contact with the mental health system that puts the person in jeopardy of loosing his liberty, include a requirement that the reliability and credibility of persons providing information be considered prior to making a decision. Since attempting to commit someone with false information would be a felony under this legislation, I would assume that a very dim view is to be taken of wrongful commitments. This early evaluation of the quality of information would serve to prevent wrongful commitment rather than relying on felony convictions after the fact to exact retribution.

In conclusion, I would urge the adoption of the amendments we have proposed; but even more important, I would urge quick passage of this valuable legislation. As it stands, it is easily a model other states would do well to emulate. I, naturally, feel that the amendments would make a good thing even better.

(1)

30-DAY PERIOD REVERTED TO 14-DAY PERIOD
Page 4, Line 20

Sec. 47.30.690. VOLUNTARY ADMISSION OF MINORS UNDER 14 YEARS OF AGE. (a) A minor under the age of 14 may be admitted for ((30)) 14 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: ...

Would amend this and all other mentions of 30 days to read 14 days.

Throughout its lengthy legislative history, this re-write of the involuntary commitment statute has specified 14 days as the length of time allowed for the 2nd period of commitment and treatment. This was amended only this session.

As I understand it, the Department of Health and Social Services suggested changing the original 14-day period to a 30-day period primarily because certain medications were in use in Alaska facilities that required 21 or 22 days to take effect or to stabilize the patient. In Washington state the legislature dealt with the same issue except that the proposed change was from 14-days to 21-days. The same argument was raised.

There are several different reasons for returning to the original period of 14-days. Among these are the following:

1) The number of patients receiving drugs that take more than 2 weeks to take substantial effect was found to be very small in Washington state. Estimates on the order of 2½ to 5% were cited in testimony. A question that needs to be asked is whether a 30-day commitment period is justified by the number of persons that require this long solely because of the medi a-tion they are taking. The length of time will have a defini effect on all persons committed under the proposed statute.

2) Unfortunately, there is such a thing as bureaucratic inertia. If the facility has 14 days to either get the person into a releasable condition or file for a 90-day commitment, there will be a tendency to take the entire 2 weeks. If the facility has 30 days to fulfill the same obligation, there will be the same tendency to take the entire month, regardless of a statement that they should release the person as soon as possible.

3) The 90-day commitment period is available to mental health professionals at any point during the 2nd commitment period, whether it is 14 days or 30 days. If the facility finds that medication with drug that takes longer than 14 days to take effect is advisable, they do have the option to file for the 90-day period. Since the minimum effective period

of any drug is variable on a case by case basis, they would then have the length of time necessary to stabilize the patient prior to release.

3) While the patient has the right to be as free as possible from the effects of medication at a hearing on involuntary commitment, it can take months to be totally free from the effects of some psychotropic medications. The brief interruption necessary to hold a hearing after 14 days (or at some other point earlier in the 14-day commitment) should have little effect on the final stabilization point of the patient. In the few cases where the nature of the medication requires it, the balance of 90 days is available for the medication to take full effect.

4) A period of 14 days was found to be sufficient in Washington state which has a much bulkier mental health system, more prone to bureaucratic snarls and fumblings. There should be no problem in implementing a similar period in Alaska where the problems of the individual patient should not be significantly different, and the quality of mental health care should be at least as good.

5) Commitment statutes must be a balance of 3 factors. The need of society to protect itself from the acts of troubled persons, the responsibility of society to help those in need, and the constitutional requirement that those in danger of loss of liberty be accorded the maximum right to be free from undue intervention. A period of 30 days of involuntary treatment overbalances the second at the expense of the third. The same ends can be met through a transition from 3 days to 14 days to 90 days.

(5)

RELEASE OF MINORS
Page 5, Line 10

Sec. 47.30.695. NOTICE OF REQUEST FOR RELEASE OF MINORS UNDER 14 YEARS OF AGE FROM VOLUNTARY DETENTION AND COMMITMENT. The parent or guardian of any 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. The minor may request his own release and shall be immediately released unless the professional person in charge of the facility feels that the minor is gravely disabled or is suffering from mental illness and as a result he is likely to cause serious harm to himself or others and there is reason to believe that the patient's mental condition could be improved by the further course of treatment sought. If such be the case the professional person in charge of the facility must initiate involuntary commitment proceedings to further hospitalize the patient.

Without the above amendment there is no specific provision for a minor to request his or her release. While the sections dealing with a request for release by an adult may cover such a situation, it would be appropriate to accord minors the same rights specifically.

This amendment would retain the right of parents to file for involuntary commitment of minors, the right of the person in charge of a facility to file for commitment, and the right of a minor to request his or her own release.

ORAL ORDERS FOR COMMITMENT
Page 5, Line 25

... 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. In cases of oral orders a written order shall be issued by the court no later than 24 hours following the issuance of the oral order.

Without this amendment there is a question as to when an oral order for commitment must be put in writing. In a state as large as Alaska, there is no doubt that provisions for an oral order must be made; however, specific time limits for the production of a written order must be made.

(4)

DELETING BASIS FOR 90-DAY COMMITMENT
Page 12, Line 3

(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~~));

This phrase is extremely vague when the question of proof in the courtroom is raised. What would constitute "demonstrates" in an objective framework? How can current intent be shown in court? Essentially, the phrase lends itself to a strict prediction of future violent behavior.

The American Psychiatric Association has, in writing at their last convention, stated that they have no special expertise in predicting future behavior of a violent nature and that they, as a profession, would prefer not to have the burdensome responsibility of making such predictions.

Actual acts of violence are covered in earlier portions of the same section and the possibility of future violence is dealt with in AS 47.30.730(a), Paragraph (1). (See Page 9, Line 19 of CSSB 100)

The inclusion of the phrase vastly expands the basis for involuntary detention and forcible treatment and the reliance on what would be predictions of possible future actions. Since potential harm to self or others is adequately covered in other sections of the bill it would seem to be redundant to repeat such provisions and inappropriate to throw the door open wide when the intention of the legislation is clearly to close the door to unnecessary involuntary commitment.

(5)

RETURNING UNWILLING PATIENTS TO THE HOSPITAL
Page 17, Line 13 and Page 18, Line 10

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 of the facility or his professional designee may contact the appropriate law enforcement agency which shall cause the respondent to be taken into custody and returned to the treatment facility. When considered by the professional person in charge to be appropriate, hospital staff may accompany the peace officer or officers in their effort to return the patient to the facility.

AND

... If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge ((~~shall cause him to be taken into custody~~)) may contact the appropriate law enforcement agency which shall cause the respondent to be taken into custody and transported to the facility. ((~~If requested, a peace officer shall assist the provider of outpatient care or the facility.~~)) When considered by the professional person in charge to be appropriate, facility staff may accompany the peace officer or officers in their effort to return the patient to the facility.

Those two proposed amendments should be considered together as they deal with the same possible problem in the implementation of the law.

Without these changes the bill would give hospital or other treatment facility staff the power of arrest with all the attendant responsibilities and problems. It would expose them to potentially deadly risk in cases where patients were extremely unwilling to return to the facility. It would unnecessarily increase the risk to bystanders as facility staff would not normally be trained or experienced in dealing with an armed and dangerous person. In addition, the possibility of misidentification must be taken into account in which case the state could face massive civil suit for wrongful arrest.

Dammasch State Hospital, outside Portland, Oregon had a system for the return of patients to the hospital which was markedly similar to this one. Called a "Code 44", it involved dispatching hospital staff in an unmarked hospital car to take alleged patients back to the hospital. While involved in such operations hospital staff were attacked by persons with axes, lengths of 2 X 4, bottles, and a variety of other impromptu

weapons. Things progressed to the point where any suspicious person was reported to the hospital and staff sent to investigate. There were incidents where citizens of surrounding towns were accosted by hospital staff and forced to produce identification or be faced with a trip to the state hospital.

The provision for facility staff to accompany peace officers would help to lessen the trauma of being "arrested" by the police and assist the officers in persuading the person to return peacefully.

The combination of the two provisions would enhance the effectiveness of both facility staff and peace officers while minimizing the potential of harm to staff, police, and bystanders.

(6)

RELEASE OF PHOTOGRAPHS
Page 24, Line 14

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 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 not be released by the facility to anyone other than the patient or a person he designated in writing except under court order.

Photographs which would become part of a patient's medical record should be as available as the record itself to the patient or to the person(s) of his choice. Without this amendment, a patient would have to resort to the courts to obtain a picture of himself made by a facility. This would seem to be an unnecessary precaution.

AVAILABILITY OF RECORDS
Page 25, Line 11

Sec. 47.30.845. CONFIDENTIAL RECORDS. Information and records obtained in the course of a screening investigation, evaluation, examination or treatment are confidential and are not public records, except as the requirements of a hearing under AS 47.30.655 - 47.30.915 may necessitate a different procedure. Information and records may be copied and disclosed under regulations established by the department only to

(1) the person who is the subject of the information or records or to individuals to whom the ((~~patient~~)) person has given written consent to have information disclosed;

(2) physicians and providers of health, mental health or social and welfare services involved in caring for, treating or rehabilitating the patient;

As it is written, the bill would allow a patient to authorize a third party to obtain copies of his records without having access himself! It would seem appropriate to give the person at least the same degree of access. It would also be appropriate, philosophically, to list the person or his designee first in line as persons with access; hence the juxtaposition of paragraphs (1) and (2) in the above amendment.

The fruits of a "screening investigation" should be added to the classes of records available for a number of reasons. First, since the records would become non-public records by their exclusion in this paragraph, even the passage of Senate Bill 90 (a state-level Freedom of Information Act) would not guarantee access for the person investigated whether he was committed or not. Second, since information of an extremely derogatory nature may be collected, proven false, and then maintained in a file on the person, the subject should be able to discover the nature of the material in the records and respond accordingly.

In Seattle, which already has the equivalent of SB 90 in effect, we were forced to sue King County to force the disclosure of information maintained on a woman investigated for possible involuntary commitment. After nearly a year of effort we were finally able to force the disclosure of the file which included charges of no less than 3 criminal assaults allegedly committed by the woman. The charges were found to be unsubstantiated by the investigation and the woman was not committed. However, the only mention of the result of the investigation was a check mark in a square on one of the forms and a brief sentence handwritten on the back of one of the forms.

(8)

"GRAVELY DISABLED" AMENDED
Page 33, Line 11

(7) "gravely disabled" means a condition in which a person, as a result of mental illness, is in imminent 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;

The concept of parens patrie, or the necessity for the state to intervene in the life of a person to protect himself from himself, is still in a state of growth, development, and change. This concept is the basis of the definition of gravely disabled. The addition of the word "imminent" would more clearly define the point at which the state's parens patrie would trigger in the form of involuntary commitment.

The reasons for this are many and varied. First, the word imminent appears as the trigger level in the definition of likelihood of serious harm provisions in other sections of the bill. It would be appropriate to require the same degree of seriousness in the much less clear area of indirect danger to self through failures to provide. Second, the imposition of state protection of the individual should occur only at the point where a clear and present danger can be shown.

On a philosophical level, the state should keep in mind that life is basically a long learning experience and everyone goes through periods when their life is not seemingly under their control. In the vast majority of cases people regain control of their lives and pick up where they left off. It is in the state's and the person's best interests to intervene only when the regaining of this control is not in sight and the person is clearly in danger. Intervention prior to this point places the person at risk of loosing the chance to do it himself as well as making him dependent on the state whenever problems arise. We should all have the chance to learn to take care of ourselves, and the assurance that if we fail we have the option of outside help.

(9)

EXPANSION OF "SCREENING INVESTIGATION"
Page 35, Line 6

(15) "screening investigation" means the investigation and review of facts which have been alleged to warrant emergency examination or treatment, including interviews with the persons making such allegations, any other significant witnesses who can readily be contacted for interviews, ((~~and, if possible,~~)) the respondent, if possible, and an investigation and evaluation of the reliability and credibility of the person or persons providing information or making allegations;

Since the bill makes attmpting to commit someone with false information a felony, one would assume that wrongful commitments are considered to be very undesireable. It would be appropriate to attempt to head off such commitments as early in the process as possible since a felony conviction after the fact is not nearly as desireable as the absence of the wrongful commitment in the first place.

This amendment would specify a pre-detention consideration of the quality of information used as a basis for commitment. It would ensure that the information on credibility would be easily available to both "prosecution" and "defense" at the first judicial opportunity.

A clear and explicit statement of state policy on heading off wrongful and/or malicious involuntary commitment would go a long way in assuring fair application of the statute.

alaska
state
hospital
association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Ketchikan

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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

May 12, 1981

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

Dear Senator Parr:

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

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

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

Sincerely,

Dennis L. DeWitt
Executive Director

DLD/b

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

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF PUBLIC SAFETY
OFFICE OF THE COMMISSIONER

POUCH N
JUNEAU, ALASKA 99811
PHONE: 465-4335

May 12, 1981

Kevin Bruce
Administrative Assistant
Senate Judiciary Committee
Room 207, Capitol Building
Juneau, Alaska 99801

Dear Mr. Bruce:

Re: SB100

I did not get an opportunity to testify on this bill before the Judiciary Committee and would therefore like to reiterate the concerns of the Division of Motor Vehicles as reflected in the Bill Analysis.

First, on Page 26, Section 47.30.865(a)(4) reflects the fact a person is or has been evaluated or treated for mental illness may not be a basis for discrimination in obtaining or retaining a motor vehicle operator's license. The Division of Motor Vehicles has some concern as to what the intent or actual meaning of this part is. If it means just the fact that a person is or has been treated cannot be used as a basis to deny a driver's license, then we have no problem with it. However, if it means irregardless of the mental condition of the person being treated for mental illness we cannot deny issuance of a license, then we have some basic conerns, which I think you can understand when you read the definition of mental illness on Page 34. This section was discussed with an attorney with the Department of Law, and due to the wording he was unsure of its meaning, thus impact on traffic safety.

Also on Page 27, lines 1, 2, and 3, this bill would prevent us from asking an applicant for a driver's license whether or not he or she had been institutionalized as a mental patient. That question is asked for the same reason we ask if the applicant suffers from epilepsy, heart trouble, dizzy spells, etc. If the answer is yes we ask for a doctor's statement as to whether or not the condition will affect the applicant's ability to operate a motor vehicle safely. The decision made by the department is based on the doctor's statement. The present authority used for the question is AS 28.15.061(b)(4), which states the application shall contain other information which the department may reasonably require to determine the applicant's competence and eligibility.

AS 28.15.031(b)(5) reflects the department shall not issue a driver's license to a person when, based upon medical evidence, it was determined that because of mental disability the person is not able to drive a motor vehicle safely.

It appears SB100 may be in conflict with the above sections of AS 28.15. The Division of Motor Vehicles would like to see the bill amended wherein it would be in harmony with AS 28.15. It is a known fact that a person's mental condition can affect the safe operation of a motor vehicle.

If I can be of any assistance in this matter please let me know.

Sincerely,

Bill Brown
Chief of Driver Services

cc: Robert J. Rowan, Director
Division of Motor Vehicles

Alaska State Legislature

Senate

Judiciary Committee

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

M E M O R A N D U M

TO: Senator Bennett
Senator Hohman
Senator Parr
Senator Ray

FROM: Senator Rodey PMR

DATE: May 11, 1981

SUBJECT: CS for Senate Bill 100 "An Act relating to mentally ill persons; and providing for an effective date."

Attached please find a draft of a proposed substitute for the above-referenced legislation.

The Judiciary Committee will be conducting hearings on this bill on Wednesday, May 13. I would appreciate your review and comments on this draft.

PMR/ods
Attachment

INVOLUNTARY CIVIL COMMITMENT UNDER SB 100

Initiation of Petition by any adult

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

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

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

Designated facility 30 day instead of 14 day

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

Discharge

Outpatient commitment less restrictive alternative

90 Day Commitment

Discharge

Outpatient commitment less restrictive alternative

120 Day Commitment

Discharge

Outpatient commitment less restrictive alternative

120 Day Commitment

Discharge

Outpatient commitment less restrictive alternative

= Suggested Amendments

ROBERT BOWERS — DEPT TO TRANSITION LIKES BILL

JERRY SCHNEIDER — 47-30.700

ORIGINATE TRANSPORTATION TO API WITHOUT 1ST EXAMINED BY DOCTORS.

DIANA FABE — FISCAL NOTE

DR. STIHNER — ?

OFFICE OF PATIENT ADVOCATE — ?

BETTY HARSEY — 1.) 30 DAY TO 14 DAY COMMITMENT,

2.) ACCESS TO RECORDS

3.) RIGHT TO REFUSE MEDICATION

4.) PATIENT ADVOCATE —

5.) 47.30.705 — DOESN'T LIKE JAIL ALLOWANCE — PLEASE REWORD

NATALIE GOLDSTEIN

1.) EXTENTION TO 30 DAY COMMITMENTS (DOESN'T LIKE)

~~JESSICA~~ CECILIA KLEMENCIC — 1.) 47-30.690 WANTS CHANGE

WANTS TO PROTECT RIGHTS OF MINORS (SAME AS THE PROTECTION AS ADULTS)

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 100)
Title An Act Relating to Mentally Ill Persons.
Requested by _____ Date February 17, 1981

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

EXPENDITURES (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

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

POSITIONS

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

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

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

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

IV. DATE February 17, 1981 PREPARED BY: [signature]
AGENCY Department of Health and Social Services
Original: Legislative Finance PHONE 465-3370
cc: Budget and Management
Prime Sponsor (First Legislator Named) Head Approval [signature] Date 2/17/81

33-001 (Rev. 12/80

Committee Substitute for SB 100
D. Thompkins
2/24/81

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 physician 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 reimbursable 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

Anchorage Daily News Saturday, April 18, 1981 C-4

Court bans committing retarded boy

The Associated Press

A mentally retarded individual who is not dangerous to himself or others may not be committed involuntarily to a state mental institution, the Alaska Supreme Court said Friday.

The court ruled that state law "clearly indicates the Legislature's intent that the mentally retarded be regarded as handicapped individuals, who through habilitative efforts, can be taught to live complete and normal lives."

In an opinion by Justice Edmond W. Burke, the court urged the state "to fulfill its obligation ... to render the necessary assistance to individuals such as K.M.L."

The initials were the only identity given for the 18-year-old slightly retarded youth whose parents sought to have him committed because of what they called "difficult behavior."

Medical witnesses drew a distinction between mental illness — which is treatable — and mental retardation — which is not.

THE SUPREME COURT OF THE STATE OF ALASKA

IN THE MATTER OF THE NECESSITY OF THE HOSPITALIZATION OF K.M.L.	)	File No. 4708
	)	O P I N I O N

(No. 2325 - April 17, 1981)

Appeal from the Superior Court of the State of Alaska, Third Judicial District, Anchorage, Victor D. Carlson, Judge.

Appearances: Sue Ellen Tatter, Assistant Public Defender, Brian Shortell, Public Defender, Anchorage, for Appellant. Larri Irene Spengler, Assistant Attorney General, Anchorage, Avrum M. Gross, Attorney General, Juneau, for the State of Alaska. Jeffrey M. Feldman, Gilmore & Feldman, Anchorage, Amicus Curiae.

Before: Rabinowitz, Chief Justice, Connor, Burke and Matthews, Justices, and Dimond, Senior Justice. (Compton, Justice, not participating.)

BURKE, Justice.

This appeal challenges the superior court's authority to order the involuntary commitment of a moderately retarded individual.

In 1978, the parents of K.M.L. requested the State of Alaska to initiate commitment proceedings against their eighteen year old son, K.M.L. Their request was prompted, at least in part, by what they viewed as difficult behavior

on the part of K.M.L.,[1] who is moderately

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1. K.M.L.'s parents identified four separate incidents of troubling aggressive behavior on his part:

First, his mother related an incident in December 1977 (nine months prior to the filing of the petition) in which K.M.L., while riding in a car with his mother, became upset at several individuals who failed to move out of the path of her car in a parking lot. K.M.L.'s mother stated, "well, as I started past them, this one kid--kid, I always--he was a young adult--stepped back toward into [sic] the car like, like he was daring me to hit him or whatever." K.M.L. got out of the car, "call[ed] the guy names" and "put up his fists" in an apparently challenging gesture. The other individual backed off and no further contact resulted.

The second incident occurred some time within the twelve months prior to the filing of the petition and involved K.M.L.'s handling of an unloaded rifle. K.M.L.'s mother returned to the home one day and observed that K.M.L. "had one of the rifles that was in the house and [was] pretending to shoot at the wall or the posters on the wall or whatever but he was using it like you would a machine gun." No other persons were present and no contact, harm, or violence resulted.

The third incident occurred in April 1978 and involved K.M.L.'s falling on the kitchen floor with his father. Apparently the incident was prompted by his father's complaining that the T.V. was too loud. K.M.L.'s father testified that he had grabbed his son by the neck to turn him around. He then testified K.M.L. "slipped underneath my arm and I fell on the floor. And about that time she [K.M.L.'s mother] came into the business." Regarding the severity of this incident, K.M.L.'s mother testified "they were just altogether laying on the floor. Nobody was punching anyone per se." No injuries or physical harm resulted.

The fourth incident occurred during the summer of 1977 (approximately a year prior to the filing of the petition) and involved K.M.L.'s contact with Anchorage police officers. K.M.L.'s father testified that he observed his son spit at and kick a police officer while being detained on the street.

retarded.[2]

The state refused to initiate such proceedings, after concluding that there was no basis upon which K.M.L. could be involuntarily committed.[3] The parents then hired their own attorney and petitioned privately for K.M.L.'s commitment.[4] The petition seeking civil commitment was filed on August 23, 1978.

Probate Master Marjorie D. Bell held a hearing on the parents' petition on September 12, 1978. A psychiatrist

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2. K.M.L. has an I.Q. of approximately 70 to 80. The American Association on Mental Deficiency states that mental retardation "refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior" and appearing in the "developmental period." Quoted in Herr, The New Clients: Legal Services for Mentally Retarded Persons, 31 Stan. L. Rev. 553, 555 (1979). The World Health Organization formerly classified all individuals with I.Q. scores of 68-85 as "borderline mentally retarded." This category was later amended to exclude such persons from the definition of mentally retarded. Id. & n.6. Based upon available classifications, it would thus seem that K.M.L. does not suffer severely from mental retardation.

3. K.M.L. has opposed his commitment from the outset. Following the filing of the petition for his involuntary commitment, the Public Defender Agency was appointed to represent his interests.

4. In their petition, K.M.L.'s parents alleged that K.M.L. suffered from "slight mental retardation, severe emotional illness, and certain physical problems which lead him to engage in explosive and violent behavior." (Emphasis added.) As noted below, Dr. Nyman confirmed that K.M.L. suffered from "borderline" mental retardation, but contradicted the assertion that he suffered from any mental illness.

who was familiar with K.M.L., Leslie Joel Nyman, M.D.,[5] testified that K.M.L. was "borderline" retarded with an I.Q. of "somewhere around 80, 70."[6] This placed K.M.L at the highest range of the spectrum of individuals classified as mentally retarded on the basis of I.Q. test scores, and he did not, in Dr. Nyman's own words, suffer from "severe or profound retardation." Stated otherwise, K.M.L. was just barely retarded. Dr. Nyman testified further that K.M.L. suffered from an "aggressive reaction of adolescence,"[7] a behavior problem common to many teenagers. While an aggressive reaction of adolescence is not a psychosis or mental disease, it apparently had resulted, on two occasions, in instances of "scuffling" between K.M.L. and his father and police officers.[8]

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5. Dr. Nyman's testimony was the only medical evidence presented by the petitioners in support of the petition for involuntary commitment.

6. See note 2, supra.

7. Dr. Nyman described K.M.L.'s condition, testifying:

> Well, the primary diagnosis that applies is the unsocialized aggressive reaction of adolescence which is sort of a catch-all for behavior problems, people who have problems controling [sic] their feelings or their emotions.

8. See note 1, supra.

K.M.L.'s parents also testified at the hearing before Probate Master Bell. Although they expressed concern about his "lifestyle"[9] and about his having threatened individuals and having "scuffled" with his father and a police officer, no testimony was presented indicating that K.M.L. had ever, on any past occasion, actually physically injured himself or anyone else.

Based on the testimony of Dr. Nyman that K.M.L. did not suffer from any psychosis or severe mental illness and was not severely retarded, the Probate Master granted K.M.L.'s motion to dismiss the petition.

K.M.L.'s parents filed objections to the Master's report and findings. A hearing on the objections was held on October 27, 1978, before the Honorable Victor D. Carlson, Superior Court Judge.[10] Following brief arguments of counsel, now including counsel for the State of Alaska who

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9. The primary focus of the petition for involuntary commitment and Dr. Nyman's testimony concerned K.M.L.'s street contacts and observations of his frequenting the Fourth Avenue area in Anchorage.

10. The objections to the Master's findings did not dispute the conclusions, by the Master, that K.M.L. was not psychotic and was only slightly retarded. The petitioners attempted to draw a distinction between the medical and the statutory or "legal" definition of severe retardation. The petitioners advanced the proposition that the term "severe mental retardation," within the meaning of the statute, "connotes someone who is functioning well below normal levels."

argued against K.M.L.'s commitment,[11] Judge Carlson reversed the Master's findings holding that the Master had applied "the wrong legal test" to the determination of whether K.M.L. was "severely mentally retarded" and, hence, properly committable.

One month later, in November 1978, the matter again came on for hearing, once more before Judge Carlson. Dr. Nyman testified that Alaska Psychiatric Institute (API), where K.M.L. was being detained, would be an improper place for K.M.L. on a long-term basis. Dr. Nyman stated that the therapy, medication, and care offered by API were more conducive and effective for individuals suffering from mental illnesses, not mental retardation. Unlike mental illness, which may be treated and sometimes cured, retardation reflects limitations in intellectual capacity. As such, retardation may be rendered less disabling with training and education, but not with drugs, therapy, or other psychiatric treatment.

Although API constituted an inappropriate placement for K.M.L. on a long-term basis, the court was advised

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11. Prior to this hearing before Judge Carlson, the state had not appeared in the proceedings. The only parties previously present were the petitioners (K.M.L.'s parents), represented by their private attorney, and K.M.L., represented by his court-appointed public defender.

that API was the only licensed facility under the authority of the Commissioner of Health and Social Services and, thus, the only institution to which K.M.L. could have been involuntarily committed.

Following the taking of testimony at the November 1978 hearing, Judge Carlson affirmed his earlier commitment order, implying that profound retardation was not required to support an involuntary commitment. Judge Carlson concluded that under the former version of AS 47.30.340(10) the medical standard for severe retardation was not the same as the "legal standard" for severe retardation. Under Judge Carlson's view, then, K.M.L. was properly committed as suffering from "severe retardation," at least in a legal sense. Following Judge Carlson's order of November 1, 1978, K.M.L. appealed to this court.[12]

Subsequent to the filing of the notice of appeal, K.M.L.'s counsel became aware of a recent change in the definition of a mentally ill person provided in an amendment to AS 47.30.340(10). Prior to July 1, 1978, a person who was "severely mentally retarded" could be involuntarily committed pursuant to AS 47.30.340(10). After that date, however, an amendment to the statute became effective and a

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12. In re K.M.L. v. State of Alaska, Supreme Court File No. 4412.

"mentally ill individual," capable of being committed involuntarily pursuant to AS 47.30.070(i), was defined as only:

> [A]n individual having a psychosis or senile changes which substantially impair his mental health to the degree that he is a danger to himself or others.

Because Dr. Nyman clearly testified that K.M.L. did not suffer from either a psychosis or senile changes, K.M.L.'s counsel moved to vacate Judge Carlson's November 1, 1978, commitment order based on a mistake of law, as the parties had been using the wrong (outdated) definition of "mentally ill" in determining whether or not K.M.L. could be involuntarily committed.

A hearing on K.M.L.'s motion to vacate the commitment order was held on April 5, 1979. Although counsel for the state declined to oppose K.M.L.'s motion to vacate, and although counsel for K.M.L.'s parents conceded that the new statute did not expressly authorize K.M.L.'s involuntary commitment, the court nevertheless ordered K.M.L. committed pursuant to the authority contained in another newly amended chapter of the Welfare, Social Services and Institutions Title. Judge Carlson stated:

> The order of commitment . . . is reaffirmed pursuant to the authority contained in AS 47.80, based upon the fact that my findings support that . . . [K.M.L.] is a person with a handicap and also has a developmental disability, and that it's necessary to provide for him

> exactly what 47.80 sets forth to do; that it provides for him the opportunity to achieve his highest level of achievement.

K.M.L.'s counsel objected to the entry of the order on the grounds that he had received no notice concerning the possibility of K.M.L.'s commitment under the new chapter, the hearing having been scheduled for the sole purpose of resolving K.M.L.'s motion to vacate the earlier commitment order. The court ruled that the hearing six months earlier, in November 1978, had afforded K.M.L. all of the process which he was due and an amended order of commitment was entered. K.M.L. now appeals the legality of Judge Carlson's second order, involuntarily committing him under the amended statute.

The parties all recognize that AS 47.80.010-.900 does not specifically provide for involuntary commitment.[13] The state and the amicus curiae support K.M.L. in his contention that his order of commitment should be reversed. We agree and hold that AS 47.80.010-.900 contains no implicit authority for the involuntary commitment of those handicapped individuals who fall within its scope.

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13. On appeal, petitioners waived their right to respond to appellant's contentions in the case at bar. It is their decision to willingly follow the decision resulting from the appellant's arguments.

The purpose of AS 47.80 is to provide affirmative services to the handicapped. Mentally retarded individuals have been specifically included within the scope of this chapter. AS 47.80.900(6), (7)(A)(i). The drafters of the act made clear its affirmative nature, stating:

> INTENT. This Act is intended to assure the provision of quality services to those children and adults who have handicaps by reason of mental or physical disabilities, including persons qualifying for special education services . . . other persons with the same or similar handicaps, and persons handicapped by mental retardation, cerebral palsy, epilepsy, autism or by other developmental disabilities defined in this Act. The primary objective of the Act is to bring together and make optimal use of all available resources--federal, state, local, and private--so that persons with handicaps may be served in the most effective and efficient way. A second goal of the Act is to assure the dignity of persons with handicaps, by reaffirming, and providing for the protection and advocacy of, their rights, which are the same rights as other people of the state of the same age and include the right to live as complete and normal lives as possible and develop their ability and potential to the fullest extent possible.

Ch. 165, § 1, SLA 1978.

In certain situations AS 47.80.010 provides for the modification of a handicapped person's civil rights, stating:

> Some persons with handicaps may be unable, due to the severity of their handicap, to exercise for themselves all of their rights in a meaningful way; for

> others modification of some or all of their rights is appropriate. The procedure used for modification of rights shall contain proper legal safeguards against every form of abuse, shall be based on an evaluation of the social capability of the person by qualified experts, and shall be subject to periodic reviews and to the right of appeal to higher authorities.

The statutory scheme requires the Department of Health and Social Services to establish a system to "protect and advocate rights of persons with handicaps." AS 47.80.020. We do not believe that this section should be read so broadly so as to create the implied authority to involuntarily commit the handicapped.[14]

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14. AS 47.80.020 was enacted in response to a federal statute providing for joint federal and state protection and advocacy of the rights of developmentally disabled individuals. The statute provides in relevant part:

> (a) In order for a State to receive an allotment . . . (1) the State must have in effect a system to protect and advocate the rights of persons with developmental disabilities, (2) such system must (A) have the authority to pursue legal, administrative, and other appropriate remedies to insure the protection of the rights of such persons who are receiving treatment, services, or habilitation within the State, (B) not be administered by the State Planning Council, and (C) be independent of any agency which provides treatment, services, or habilitation to persons with developmental disabilities . . . .

42 U.S.C. § 6012(a); see also 42 U.S.C. § 6010.

(Cont'd)

Furthermore, such an interpretation would be inconsistent with the principles of the act. AS 47.80.110 provides:

> Program Principles. The system of services and facilities required . . . shall accord with the principle that treatment, services, and habilitation shall be designed to maximize individual potential, minimize institutionalization, and shall be provided in the least restrictive setting, enabling a person to live as normally as possible within the limitations of the handicap.

Thus, it would seem clear that a fundamental goal of AS 47.80 is to minimize institutionalization in the habilitation of handicapped individuals. "Habilitation" is defined as "education or training for the handicapped to enable them to function better in society." AS 47.80.900(4).

Based upon this reading of AS 47.80 and its available legislative history, we do not believe that this

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14. (Cont'd)

While a non-profit corporation has been organized to serve as a vehicle for this joint federal and state support of the protection and advocacy of rights, state and federal regulations more fully delineating the implementation of the acts are still in the process of being promulgated.

statutory scheme gives the courts authority to involuntarily commit the handicapped.[15]

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15. We believe that a holding to the contrary would suffer from vagueness permitting excessive subjectivity on the part of the courts. Papachristou v. City of Jacksonville, 405 U.S. 156, 31 L. Ed. 2d 110 (1972). Potential abuse would be great if the courts possessed the authority to place handicapped persons in mental institutions without strictly defined standards. One court could commit a deaf person whom he believed is incapable of caring for himself. Another may permit deaf individuals to remain at large but believe that limbless veterans are in need of commitment. Furthermore, chapter 80 does not provide adequate procedural safeguards found in chapter 30 of title 47 which specifically provides for the involuntary commitment of the mentally ill.

We also note that the United States Supreme Court has held that "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." O'Connor v. Donaldson, 422 U.S. 563, 576, 45 L.Ed.2d 396, 407 (1975). In other words, an individual cannot constitutionally be confined involuntarily simply because he has a handicap and "treatment" may be beneficial.

In addition, the Court has held that, as a constitutional minimum, the criteria justifying an individual's involuntary civil commitment must be proved by "clear and convincing" evidence. Addington v. Texas, 441 U.S. 418, 431-33, 60 L.Ed.2d 323, 334-35 (1979).

The statutory scheme granting courts the power to involuntarily commit the mentally ill is found in AS 47.30.010-.340. We agree with Judge Carlson's conclusion that the legislature, by amending AS 47.30.340(10), effectively withdrew the court's authority to involuntarily commit the mentally retarded. This amendment became effective on July 1, 1978. This was the same date that AS 47.80.010-.900 was implemented establishing new safeguards for the protection of the rights of the handicapped. The fact that the legislature withdrew the mentally retarded from the scope of chapter 30 and included these individuals within the purview of chapter 80 of title 47, clearly indicates the legislature's intent that the mentally retarded be regarded as handicapped individuals, who, through habilitative efforts, can be taught to live complete and normal lives to the fullest extent possible.

In reversing the lower court's commitment order, we are not unmindful of the plight of K.M.L. and his parents. By holding that the courts have no authority to involuntarily commit K.M.L., we in no way suggest that K.M.L. should not avail himself of existing educational programs. We urge the state to fulfill its obligations under AS 47.80.010-.900 to render the necessary assistance to individuals such as K.M.L. We also call to the attention of the parties the protections available under AS 13.26.

The lower court's order of commitment is hereby REVERSED.

TO TESTIFY IN ANCHORAGE ON SB 100

JIM PARSONS,

ALASKA MENTAL HEALTH

(TIME CONSTRAINT 11:45 AST)

DANA FABE,

ALASKA PUBLIC DEFENDER

(TIME CONSTRAINT 12:00 AST)

1:30 PST

4/22

FROM TERMINAL LJ28 ON PRINTER LJH8; DATE=81112, TIME=134550

MSG 84=0004352A PRTY 4 04/22/81 13:32:09 ORIG: LA00 IN: 0005 OUT= 0004
FROM: MICKI IN ANCHORAGE TO: JELLO/JUNEAU TELECONFERENCE
TARGET: LJ28 SUBJ: SEN. JUD. T/C ON SB 100 PAGE 0001

FOLLOWING IS A LIST OF PARTICIPANTS IN THE ORDER THEY WISH TO TESTIFY

1. JIM PARSONS, AK. MENTAL HEALTH ASSN. 421 W. FIREWEED LN. #225, ANCH.

2. DANA FABE, AK. PUBLIC DEFENDERS AGENCY, 716 W. 4TH #500, ANCH.

3. JAY VERKOZEN PH.D., CLINICAL PSYCHOLOGIST, 308 G STREET, #309, ANCH.

4. BETTY HELSEY, REACH, 2146 BELAIR DR, ANCH. 99503

5. NATALIE GOTTSTEIN, AK. MENTAL HEALTH ASSN., 1030 W. 26TH AVE. #1 ANCH.

6. GERI HARRINGTON, SELF, 1820 CHEROKEE WAY, ANCH. 99504

7. CHARLIE [illegible], SELF, NASW,

PLEASE NOTE WITNESS'S 1,2, AND 4 HAVE TIME CONSTRAINTS

NXT MSG U/R/S PREV MSG U/R/S RESEND CANCEL

FROM TERMINAL LJ2= ON PRINTER LJH8; DATE=81112, TIME=133603

MSG 81-09013513 PRTY 1 04/22/81 13:04:45 ORIG: LA02 IN= 0004 OUT= 0003
FROM: KATHI, ANCH TO: JELLO, JUNEAU T/C
TAKE-1 -- LJ2= SUBJ: PARTICIPANTS, SEN. JUD 4/22 PAGE 0001

PLEASE ARE THOSE PEOPLE WHOM WE EXPECT. IT DOES NOT INCLUDE THOSE PEOPLE WHO HAVE NOT ANNOUNCED THEIR INTENT TO ATTEND.

JOAN FABE, ACTING DIRECTOR, PUBLIC DEFENDER'S OFFICE
*** HAS SCHEDULE CONFLICT - MUST LEAVE BY 12:00 P.M. AST ***

NATALIE GOTTSTEIN, DIRECTOR, ALASKA MENTAL HEALTH ASSOCIATION
JAMES FAHRENKOPF, PSYCHOLOGIST
PUDGE KLEINKAUF, SOCIAL WORKER
GRANT CALLOW, ALASKA COURT SYSTEM
JERRY SCHROEDER (SP?)
BETTY HOLLIS (SP?)

Bob Bower Govt.
Dr. Jerry Schrader

AS THEY ARRIVE, WE WILL JELLO THE NAMES.

NXT MSG U/R/S _ PREV MSG U/R/S _ RESEND _ CANCEL _

Alaska State Legislature

Senate

JUNEAU, ALASKA

Persons to notify for SB 100 hearings:

Natalie Gottstein, Director of the Alaska Mental Health Association 276-1705

Verner Stillner, M.D., Director of the State Division of Mental Health and Developmental Disabilities, 465-3370

Elizabeth Shaw, Assistant Attorney General, 465-3603

Barry Stern, Criminal Division of the Dept. Law, 465-3460

James Parsons, psychologist, 276-2230

Pudge Kleinkauf, 279-4824 or 253-1714

Grant Callow, Alaska Court System, 264-0550

Dana Fabe, Acting Direct, Public Defender, 279-7541

Dennis DeWitt, Alaska Hospital Association, 586-1790

✓ calls made Mon, 4/20/81

✓ will testify

Alaska State Legislature

Senate

JUNEAU, ALASKA

Teleconference 4/22, Wed. 1:30

Persons to notify for SB 100 hearings:

✓ Natalie Gottstein, Director of the Alaska Mental Health Association 276-1705

✓ Verner Stillner, M.D., Director of the State Division of Mental Health and Developmental Disabilities, 465-3370

W/BE THERE Elizabeth Shaw, Assistant Attorney General, 465-3603

NOT THIS TIME Barry Stern, Criminal Division of the Dept. Law, 465-3460

✓ James Parsons, psychologist, 276-2230

CALLED — MAYBE MESSAGE REPI Pudge Kleinkauf, 279-4824 or 263-1714

MESSAGE LEFT Grant Callow, Alaska Court System, 264-0550

Dana Fabe, Acting Direct, Pubiic Defender, 279-7541

WILL NOT BE THERE Dennis DeWitt, Alaska Hospital Association, 586-1790

✓ will testify

✓ JERRY SCHNAER

✓ NANCY HALSEY

✓ BOB BOWERS - GOV MENTAL HEALTH ADVISORY COMM

243-5411

✓ WON'T BE THERE A.P.I. - 277-6551 ~~DIRECTOR~~ ADMINISTRATOR MRS. ~~PAT~~ POWERS

S 10

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LAW

CRIMINAL DIVISION

POUCH KC – STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3428

April 22, 1981

The Honorable Patrick M. Rodey
Chairman
Senate Judiciary Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Re: Proposed Amendment to CSSB 100

Dear Senator Rodey:

The criminal division of the Department of Law has proposed the enclosed amendment to CSSB 100 that has the effect of placing the burden of proof on the defendant in a criminal proceeding to establish his insanity by a preponderance of the evidence if he raises the defense of not guilty by reason of insanity. While the existing statute, AS 12.45.083, refers to insanity as an "affirmative defense", it defines that term in a manner which requires the state to disprove the defense of insanity beyond a reasonable doubt once the issue is raised. This definition differs from the definition of affirmative defense appearing in the revised criminal code which requires the defendant to establish an affirmative defense by a preponderance of the evidence.

The proposed amendment places the insanity defense statute in Title 11, thereby applying the revised criminal code's definition of the term affirmative defense to that statute. AS 11.81.900(b)(1) defines affirmative defense in the following manner:

(1) "affirmative defense" means that

(A) some evidence must be admitted which places in issue the defense; and

(B) the defendant has the burden of establishing the defense by a preponderance of the evidence.

The constitutionality of requiring a criminal defendant to establish his insanity by a preponderance of

the evidence was specifically recognized by the Alaska Supreme Court in State v. Alto, 589 P.2d 402 (Alaska, 1979). Approximately 25 states place this burden on the defendant.

Requiring a criminal defendant to establish his insanity in a criminal trial by a preponderance of the evidence is good public policy. Under existing law, as illustrated in the following example, a defendant who has committed a violent crime but is found not guilty by reason of insanity may completely escape confinement.

1. A defendant charged with murder is found not guilty by reason of insanity. The verdict does not mean that the jury has found him to be insane, but rather that a reasonable doubt exists as to his sanity.

2. At the subsequent commitment proceeding the defendant, who had previously contended that he was insane in order to be found not guilty by reason of insanity, now argues that he is sane in order to gain immediate release.

3. The state, which had previously argued that the defendant was sane beyond a reasonable doubt in order to obtain a guilty verdict must now argue that he is insane in order to insure the protection of the public.

4. The defendant goes free even though the trier of fact finds that there is a reasonable doubt that the defendant is sane.

The proposed amendment attempts to minimize such an unacceptable result. Because the defendant would be required to establish his insanity by a preponderance of the evidence at the criminal trial, the court at the commitment proceeding could rely on the prior determination of insanity in deciding whether commitment was appropriate.

In 1978 a similar amendment was considered by the legislature during its hearings on the revised criminal code. Though recognizing the need for revision of AS 12.25.083, the legislature decided not to address the issue since it was viewed as primarily a procedural question requiring

further consideration which could delay passage of the criminal code. Now that the legislature is considering a comprehensive revision of Alaska's mental health laws, it appears appropriate to address this important issue which affects entry into the mental health system by criminal defendants who are found not guilty by reason of insanity.

Very truly yours,

WILSON L. CONDON
ATTORNEY GENERAL

DANIEL W. HICKEY
CHIEF PROSECUTOR

By: Barry Jeffrey Stern
Assistant Attorney General

BJS:dm

cc: Art Peterson
Assistant Attorney General

Keith Specking
Legislative Assistant
Office of the Governor

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 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.

Recommended by: Verner Stillner, MD

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

Date: 4/8/81

Approved by: Helen D. Beirne

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

Date: 4/15/81

TWELFTH LEGISLATURE

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)

GENERAL FUND		58.5	64.4	70.7	77.8	85.7
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

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

83-001 (Rev. 12/80
Keith Specking

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 effecti
Requested by _____ Date 2/18/81
date"

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	65.9	71.2
200	TRAVEL		3.0	3.2	3.5	3.8	4.1
300	CONTRACTUAL		3.0	3.2	3.5	3.8	4.1
400	COMMODITIES		2.5	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)

GENERAL FUND		61.8	64.0	69.2	74.8	80.8
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

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 additionel 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.

IV. DATE February 18, 1981 PREPARED BY Richard I. Pegues, Mgr., Admin. Svcs.
AGENCY Department of Law
PHONE 465-3695

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

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)

GENERAL FUND	58.5	84.3	91.0	98.3	106.2	
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

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)

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)

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

POSITIONS

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

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

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

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

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

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

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

SUMMARY FOR SENATE BILL 100

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. Six principles of modern mental health care are specified on pages 1 and 2 of the bill.

The Department of Health and Social Services' powers and duties are explained 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, notification of patient rights, and voluntary 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 30-day, 90-day, and 120-day commitment period. A court hearing is mandatory for each commitment period.

Article 9, which begins on page 20, lists specific patient rights. They include: patient participation in a treatment plan, the right to examine records, the right to know the name of medication, the use of the quiet room, the right to refuse unnecessary medication, the right to accept or refuse shock therapy, the use of psychosurgery or lobotomy, the right to have surgery, and the right to a discharge plan.

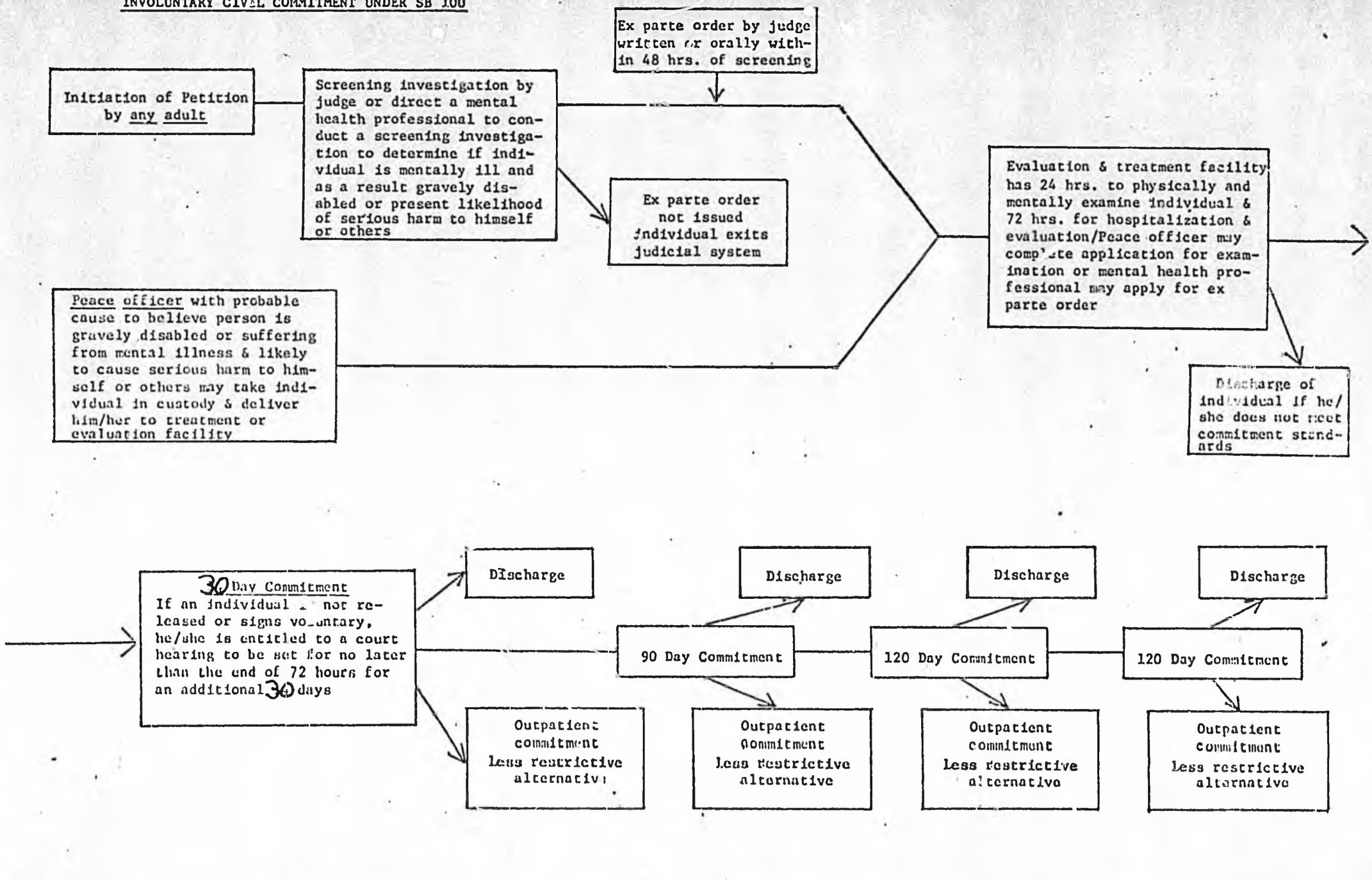
Additionally, Article 9 prohibits experimental treatments, establishes patient rights to privacy and personal possessions, and states that patient records remain confidential.

All patient rights must be accessible to patients in a language understood by the patient.

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

SB 100 would repeal AS 47.30.010 through 47.30.170, and AS 47.30.190 through 47.30.340. These are the current mental health statutes and their constitutionality has been questioned.

INVOLUNTARY CIVIL COMMITMENT UNDER SB 100



30-DAY PERIOD REVERTED TO 14-DAY PERIOD
Psge 4, Line 20

Sec. 47.30.690. VOLUNTARY ADMISSION OF MINORS UNDER 14 YEARS OF AGE. (a) A minor under the age of 14 may be admitted for ((30)) 14 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: ...

Would amend this and all other mentions of 30 days to read 14 days.

Throughout its lengthy legislative history, this re-write of the involuntary commitment statute has specified 14 days as the length of time allowed for the 2nd period of commitment and treatment. This was amended only this session.

As I understand it, the Department of Health and Social Services suggested changing the original 14-day period to a 30-day period primarily because certain medications were in use in Alaska facilities that required 21 or 22 days to take effect or to stabilize the patient. In Washington state the legislature dealt with the same issue except that the proposed change was from 14-days to 21-days. The same argument was raised.

There are several different reasons for returning to the original period of 14-days. Among these are the following:

1) The number of patients receiving drugs that take more than 2 weeks to take substantial effect was found to be very small in Washington state. Estimates on the order of 2½ to 5% were cited in testimony. A question that needs to be asked is whether a 30-day commitment period is justified by the number of persons that require this long solely because of the medication they are taking. The length of time will have a definite effect on all persons committed under the proposed statute.

2) Unfortunately, there is such a thing as bureaucratic inertia. If the facility has 14 days to either get the person into a releasable condition or file for a 90-day commitment, there will be a tendency to take the entire 2 weeks. If the facility has 30 days to fulfill the same obligation, there will be the same tendency to take the entire month, regardless of a statement that they should release the person as soon as possible.

3) The 90-day commitment period is available to mental health professionals at any point during the 2nd commitment period, whether it is 14 days or 30 days. If the facility finds that medication with drug that takes longer than 14 days to take effect is advisable, they do have the option to file for the 90-day period. Since the minimum effective period

of any drug is variable on a case by case basis, they would then have the length of time necessary to stabilize the patient prior to release.

3) While the patient has the right to be as free as possible from the effects of medication at a hearing on involuntary commitment, it can take months to be totally free from the effects of some psychotropic medications. The brief interruption necessary to hold a hearing after 14 days (or at some other point earlier in the 14-day commitment) should have little effect on the final stabilization point of the patient. In the few cases where the nature of the medication requires it, the balance of 90 days is available for the medication to take full effect.

4) A period of 14 days was found to be sufficient in Washington state which has a much bulkier mental health system, more prone to bureaucratic snarls and fumblings. There should be no problem in implementing a similar period in Alaska where the problems of the individual patient should not be significantly different, and the quality of mental health care should be at least as good.

5) Commitment statutes must be a balance of 3 factors. The need of society to protect itself from the acts of troubled persons, the responsibility of society to help those in need, and the constitutional requirement that those in danger of loss of liberty be accorded the maximum right to be free from undue intervention. A period of 30 days of involuntary treatment overbalances the second at the expense of the third. The same ends can be met through a transition from 3 days to 14 days to 90 days.

RELEASE OF MINORS
Page 5, Line 10

Sec. 47.30.695. NOTICE OF REQUEST FOR RELEASE OF MINORS UNDER 14 YEARS OF AGE FROM VOLUNTARY DETENTION AND COMMITMENT. The parent or guardian of any 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, ıe minor is likely to cause serious harm to himself or othe~. The minor may request his own release and shall be immediately released unless the professional person in charge of the facility feels that the minor is gravely disabled or is suffering from mental illness and as a result he is likely to cause serious harm to himself or others and there is reason to believe that the patient's mental condition could be improved by the further course of treatment sought. If such be the case the professional person in charge of the facility must initiate involuntary commitment proceedings to further hospitalize the pat~.

Without the above amendment there is no specific provision for a minor to request his or her release. While the sections dealing with a request for release by an adult may cover such a situation, it would be appropriate to accord minors the same rights specifically.

This amendment would retain the right of parents to file for involuntary commitment of minors, the right of the person in charge of a facility to file for commitment, and the right of a minor to request his or her own release.

ORAL ORDERS FOR COMMITMENT
Page 5, Line 25

... 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. In cases of oral orders a written order shall be issued by the court no later than 24 hours following the issuance of the oral order.

Without this amendment there is a question as to when an oral order for commitment must be put in writing. In a state as large as Alaska, there is no doubt that provisions for an oral order must be made; however, specific time limits for the production of a written order must be made.

DELETING BASIS FOR 90-DAY COMMITMENT
Page 12, Line 3

(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~~));

This phrase is extremely vague when the question of proof in the courtroom is raised. What would constitute "demonstrates" in an objective framework? How can current intent be shown in court? Essentially, the phrase lends itself to a strict prediction of future violent behavior.

The American Psychiatric Association has, in writing at their last convention, stated that they have no special expertise in predicting future behavior of a violent nature and that they, as a profession, would prefer not to have the burdensome responsibility of making such predictions.

Actual acts of violence are covered in earlier portions of the same section and the possibility of future violence is dealt with in AS 47.30.730(a), Paragraph (1). (See Page 9, Line 19 of CSSB 100)

The inclusion of the phrase vastly expands the basis for involuntary detention and forcible treatment and the reliance on what would be predictions of possible future actions. Since potential harm to self or others is adequately covered in other sections of the bill it would seem to be redundant to repeat such provisions and inappropriate to throw the door open wide when the intention of the legislation is clearly to close the door to unnecessary involuntary commitment.

RETURNING UNWILLING PATIENTS TO THE HOSPITAL
Page 17, Line 13 and Page 18, Line 10

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 of the facility or his professional designee may contact the appropriate law enforcement agency which shall cause the respondent to be taken into custody and returned to the treatment facility. When considered by the professional person in charge to be appropriate, hospital staff may accompany the peace officer or officers in their effort to return the patient to the facility.

AND

... If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge ((~~shall cause him to be taken into custody~~)) may contact the appropriate law enforcement agency which shall cause the respondent to be taken into custody and transported to the facility. ((~~If requested, a peace officer shall assist the provider of outpatient care or the facility.~~)) When considered by the professional person in charge to be appropriate, facility staff may accompany the peace officer or officers in their effort to return the patient to the facility.

These two proposed amendments should be considered together as they deal with the same possible problem in the implementation of the law.

Without these changes the bill would give hospital or other treatment facility staff the power of arrest with all the attendant responsibilities and problems. It would expose them to potentially deadly risk in cases where patients were extremely unwilling to return to the facility. It would unnecessarily increase the risk to bystanders as facility staff would not normally be trained or experienced in dealing with an armed and dangerous person. In addition, the possibility of misidentification must be taken into account in which case the state could face massive civil suit for wrongful arrest.

Dammasch State Hospital, outside Portland, Oregon had a system for the return of patients to the hospital which was markedly similar to this one. Called a "Code 44", it involved dispatching hospital staff in an unmarked hospital car to take alleged patients back to the hospital. While involved in such operations hospital staff were attacked by persons with axes, lengths of 2 X 4, bottles, and a variety of other impromptu

weapons. Things progressed to the point where any suspicious person was reported to the hospital and staff sent to investigate. There were incidents where citizens of surrounding towns were accosted by hospital staff and forced to produce identification or be faced with a trip to the state hospital.

The provision for facility staff to accompany peace officers would help to lessen the trauma of being "arrested" by the police and assist the officers in persuading the person to return peacefully.

The combination of the two provisions would enhance the effectiveness of both facility staff and peace officers while minimizing the potential of harm to staff, police, and bystanders.

RELEASE OF PHOTOGRAPHS
Page 24, Line 14

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 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 not be released by the facility to anyone other than the patient or a person he has designated in writing except under court order.

Photographs which would become part of a patient's medical record should be as available as the record itself to the patient or to the person(s) of his choice. Without this amendment, a patient would have to resort to the courts to obtain a picture of himself made by a facility. This would seem to be an unnecessary precaution.

AVAILABILITY OF RECORDS
Page 25, Line 11

Sec. 47.30.845. CONFIDENTIAL RECORDS. Information and records obtained in the course of a screening investigation, evaluation, examination or treatment are confidential and are not public records, except as the requirements of a hearing under AS 47.30.655 - 47.30.915 may necessitate a different procedure. Information and records may be copied and disclosed under regulations established by the department only to

(1) the person who is the subject of the information or records or to individuals to whom the ((~~patient~~)) person has given written consent to have information disclosed;

(2) physicians and providers of health, mental health or social and welfare services involved in caring for, treating or rehabilitating the patient;

As it is written, the bill would allow a patient to authorize a third party to obtain copies of his records without having access himself! It would seem appropriate to give the person at least the same degree of access. It would also be appropriate, philosophically, to list the person or his designee first in line as persons with access; hence the juxtaposition of paragraphs (1) and (2) in the above amendment.

The fruits of a "screening investigation" should be added to the classes of records available for a number of reasons. First, since the records would become non-public records by their exclusion in this paragraph, even the passage of Senate Bill 90 (a state-level Freedom of Information Act) would not guarantee access for the person investigated whether he was committed or not. Second, since information of an extremely derogatory nature may be collected, proven false, and then maintained in a file on the person, the subject should be able to discover the nature of the material in the records and respond accordingly.

In Seattle, which already has the equivalent of SB 90 in effect, we were forced to sue King County to force the disclosure of information maintained on a woman investigated for possible involuntary commitment. After nearly a year of effort we were finally able to force the disclosure of the file which included charges of no less than 3 criminal assaults allegedly committed by the woman. The charges were found to be unsubstantiated by the investigation and the woman was not committed. However, the only mention of the result of the investigation was a check mark in a square on one of the forms and a brief sentence handwritten on the back of one of the forms.

"GRAVELY DISABLED" AMENDED
Page 33, Line 11

(7) "gravely disabled" means a condition in which a person, as a result of mental illness, is in imminent 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;

The concept of parens patrie, or the necessity for the state to intervene in the life of a person to protect himself from himself, is still in a state of growth, development, and change. This concept is the basis of the definition of gravely disabled. The addition of the word "imminent" would more clearly define the point at which the state's parens patrie would trigger in the form of involuntary commitment.

The reasons for this are many and varied. First, the word imminent appears as the trigger level in the definition of likelihood of serious harm provisions in other sections of the bill. It would be appropriate to require the same degree of seriousness in the much less clear area of indirect danger to self through failures to provide. Second, the imposition of state protection of the individual should occur only at the point where a clear and present danger can be shown.

On a philosophical level, the state should keep in mind that life is basically a long learning experience and everyone goes through periods when their life is not seemingly under their control. In the vast majority of cases people regain control of their lives and pick up where they left off. It is in the state's and the person's best interests to intervene only when the regaining of this control is not in sight and the person is clearly in danger. Intervention prior to this point places the person at risk of loosing the chance to do it himself as well as making him dependent on the state whenever problems arise. We should all have the chance to learn to take care of ourselves, and the assurance that if we fail we have the option of outside help.

EXPANSION OF "SCREENING INVESTIGATION"
Page 35, Line 6

(15) "screening investigation" means the investigation and review of facts which have been alleged to warrant emergency examination or treatment, including interviews with the persons making such allegations, any other significant witnesses who can readily be contacted for interviews, ((~~and, if possible,~~)) the respondent, if possible, and an investigation and evaluation of the reliability and credibility of the person or persons providing information or making allegations;

Since the bill makes attmpting to commit someone with false information a felony, one would assume that wrongful commitments are considered to be very undesireable. It would be appropriate to attempt to head off such commitments as early in the process as possible since a felony conviction after the fact is not nearly as desireable as the absence of the wrongful commitment in the first place.

This amendment would specify a pre-detention consideration of the quality of information used as a basis for commitment. It would ensure that the information on credibility would be easily available to both "prosecution" and "defense" at the first judicial opportunity.

A clear and explicit statement of state policy on heading off wrongful and/or malicious involuntary commitment would go a long way in assuring fair application of the statute.

HB 472 Tp 12

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December 3, 1975

To Interested Persons:

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

Background Information

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

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

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

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

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

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

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

Commentary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The definitional section (beginning on page 55), on the other hand, received considerable attention and contains the heart of many of the provisions of the proposed legislation. Reference has previously been made to the critical terms of "individualized treatment plan", "least restrictive alternatives" and "likelihood of serious harm". The definition of "mental illness" was also discussed at some length. There was great concern that certain conditions such as mental retardation not be mistaken for mental illness, and yet the Task Force wanted to insure that a retarded person, for example, could receive mental health services if he happened to be afflicted with mental illness in addition to his state of retardation. The definition was designed to meet these ends.

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

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

Conclusion.

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

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

Sincerely,

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

JMK/am

Enclosure

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MEMORANDUM

TO: The Alaska Mental Health Association

FROM: Joan M. Katz

RE: Comparison of HB 733 and HB 472

DATE: July 11, 1977

HB 733 and HB 472 contain numerous differences. Perhaps the most obvious is the absence of any provision for a mental health advocate in 472. Other areas of major impact are more subtle; sections on involuntary admissions; treatment of minors; and patients rights will be discussed in some detail. Less significant differences will be noted in the order in which they appear (or are omitted) in HB 472.

Involuntary admissions. One of the most glaring deficiencies of HB 472 is the provision authorizing a judge to issue an ex parte order directing peace officers to take an individual into custody for evaluation and treatment simply on the basis of a petition of "any adult person" stating that the respondent is mentally ill and gravely disabled or presenting a likelihood of serious harm to himself or others. The ex parte procedure is one in which the opposing side -- in this case the would-be patient and/or his representative -- is not present to state his version of the case to the judge; in fact, he is not even notified of theproceedings until they have been concluded. Such a procedure for commitment initiation would be worse than the present requirements which at least insist on a physician's certificate as contrasted with the word of "any adult person". Judges have little choice but to issue the orders requested when faced with allegations from one side only. HB 733, in contrast, would allow mental health professionals to make the initial determination of mental illness and potential forharm, and would provide the individual involved with an opportunity to speak for himself in most instances. Except in emergencies, moreover, a summons procedure, rather than police custody, would be utilized.

Some other facets of commitment: under hb 472, a patient may have to wait a whole day to be examined by a doctor (24 hours); HB 733 allowed only 12 hours. Again, under 472, the petition for a 14-day commitment need not allege that the respondent's condition could be improved by treatment unless he is labeled "gravely disabled". HB 733 requires such an allegation and finding before anyone can be committed. HB 472 allows exclusion of the respondent from his own probable cause hearing on the grounds that his presence would be

"seriously disruptive to the hearing"; HB 733 contains no such provision. It would seem that unless counsel for the respondent were willing to stipulate to such an exclusion, it should be granted if at all only after an attempt has been made to have the respondant at the hearing.

The standard of proof required for commitment is higher in HB 472 than in 733; the former requires "clear and convincing evidence" while the latter asks only for a "preponderance of the evidence". In this connection, thus, HB 472 affords the respondent greater protection. The provisions for 90-day commitments do not differ substantially between the two bills. What does differ, however, is the fact that after the first 90-day commitment, HB 472 would allow additional 180-day commitments ad infinitum, while HB 733 would only allow a total of three 90-day commitments. It was the medical members of the task force which authored HB 733 who argued for the finite limit on commitment periods, contending that if substantial progress could not be made in 9 and 1/2 months, the psychiatric establishment had no right to impose further "treatment" upon the unwilling patient.

Treatment of Minors. The provisions of HB 472 for inpatient treatment of minors are contradictory. Section 47.30.041 states clearly that a minor may be admitted "voluntarily" if his parent or guardian signs the admission papers and the facility agrees that he is suffering from a mental illness. The next section, however, (AS 47.30.116) says that any minor may request release with the result that involuntary commitment proceedings must be initiated to keep the minor institutionalized. And several pages later, Section 47.30.116 indicates for the first time that the minor has the right to refuse voluntary admission and be treated as an adult for commitment purposes. Under HB 733, by contrast, it is clear that the only way a minor can be "voluntarily" admitted is if he or she voluntarily agrees to such admission. In addition, HB 733 allows the minor to be admitted voluntarily and receive treatment against his or her parents' wishes pursuant to evaluation and court order. It should be noted that HB 472 does not define the term "minor" although distinctions are made between minors over and under the age of 14.

Patients' Rights. The patients' rights provided in HB 472 are generally far weaker than in 733. Notably missing in 472 are the protections against non-essential and undesired medication and the requirement that individual treatment plans be formulated. In HB 733, for example, there are statements regarding patients' rights to refuse medication; a philosophical statement that "all persons have the right to be free from unnecessary or excessive medication" (Section 47.30.221(6)); requirements for detailed explanation for the use of any medication ; consultation with the treatment team, etc. These protections were seen as vital by most members of the 733 task force.

Similarly, HB 733 contains a requirement that patients receive adequate physical and mental care (AS 47.30.221(1)) and further specifies that an individualized treatment plan must be

developed to insure that each patient receives personalized attention and treatment appropriate to his or her particular condition. In the same vein, the requirement of a discharge plan, included in HB 733, is not present in HB 472.

Outside of the strictly medical realm, HB 472 also eliminates any reference to physical exercise for patients; does not delineate the circumstances under which work may be appropriate for a patient; does not require the establishment of grievance procedures within each facility; and does not mention the use of Native language notices where practicable and necessary. Further, HB 472 requires the committed patient to pay his/her way the same as the voluntary admission; HB 733 required payment only from the voluntarily admitted individual.

Beyond the areas of patients' rights, minors' rights and involuntary admission, there are numerous other, usually less far-reaching, differences between the two pieces of proposed legislation. These differences are noted in the order in which the appear in the bills:

Transportation. Transportation is not excplicitly included as a Departmental power and responsibility. Since transportation is so essential in this State, it should be mentioned at the outset.

Prayer Treatment. HB 472 contains a section (AS 47.30.016) providing that an individual is entitled to treatment by spiritual means through prayer "in accordance with the tenets and practices of a recognized church or denomination" and further suggests that such treatment may be imposed on a minor if his parent so desires. This smacks of infringing on liberties, rather than protecting them; provisions for visits by clergy whether "recognized" or not should adequately protect freedom of religion; this section should be deleted.

Standards for Voluntary Admission. HB 472 has a much simpler standard for voluntary admission than does 733; under 472, a person need only be mentally ill and voluntarily sign the admission papers. Under 733, it is required that the person actually need inpatient care and treatment or be likely to cause harm to himself or others, and the bill further requires, in effect, that the individual understand what it is that he or she is signing. The intention in HB 733 was to protect the person who might not comprehend the full implications (E.G. on his future search for jobs, quest for adoption, etc.) of institutionalization from agreeing too readily to this voluntary procedure if it were not, in fact, necessary to his or her well-being. It is debatable how significant this difference really is.

Notice of Rights/Description of Facility. The notice of rights required in HB 472 Section 47.30.026 does not include

a description of the particular facility in which a patient finds himself, as required in HB 733. While a nice touch, this provision is not essential.

Notice of Intent to Leave Facility. HB 472 allows 48 hours to "initiate" commitment proceedings against a voluntary patient who desires to leave. It is unclear whether this means that the facility has 48 hours to decide whether a 72-hour period shall begin to run, or whether some other meaning is intended. HB 733 makes it clear that commitment proceedings must be commenced immediately, with the 72-hour period starting from the time notice was given. In addition, HB 733 addresses the question of whether the initial commitment shall be for 14 or 90 days when a decision is made to commit a previously voluntary patient. HB 472 does not make this distinction, leaving an ambiguity as to the length of the commitment; the presumption would be for the 14-day duration.

Gravely Disabled. HB 472 contains a distinct category of mentally ill termed "gravely disabled". This person would also be covered under HB 733's definition of "likely to cause serious harm". The terminology is not, therefore, material.

Appointment of independent mental health professional. At the 14-day commitment hearing, there is no provision in HB 472 for appointment of an independent mental health professional as there is in HB 733.

Right to waive 72-hour period for hearing. The waiver of the 72-hour limit, contained in HB 733, was eliminated in HB 472. While not of great importance, this provision could conceivably allow the patient to save face by obtaining treatment during an extended evaluation period without ever actually being admitted to a facility. Similarly, it could insure that the mental health professionals were certain that commitment was essential in close cases. Whether in practice a patient would be pressured to consent to the extension to give the facility more time is open to speculation.

Location of probable cause hearing. HB 733 provides that the hearing need not necessarily be at the courthouse, but can also take place at the evaluation facility or some other setting "least likely to have a harmful effect on the mental or physical health of the respondent". AS 47.30.116. HB 472 has no such provision. While the present practice of holding such hearings at API, etc., might continue in any event, it seems appropriate to include this section in the legislation.

90-day commitment. The provisions contained in HB 472 are streamlined somewhat from those in HB 733, but no major substantive changes (other than those previously noted) have been wrought.

Placement Close to Home. The provisions of HB 733, Section 47.30.151 regarding placement close to home are not included in HB 472. Given the impact of transfer to API for someone in the Bush, this section should be included in the legislation.

Outpatient Treatment. HB 733 requires that a patient released early from inpatient treatment on condition that he or she receive specified outpatient treatment should be given a copy of the conditions for his or her early release. No such document is required by HB 472. Similarly, HB 472 ignores the possibility that the outpatient care might be in a different community than the inpatient treatment, and makes no provision for time and transportation from one to the other.

Visitors. Vistors are handled in one general provision in HB 472; HB 733 makes specific reference to clergy and attorneys and recognizes that there may be times when other visitors may be inappropriate. HB 472 is thus both more "liberal" in not specifically allowing for the cut-off of visitors and more "conservative" in not insuring access to attorneys and clergy.

Discrimination Against Mental Patients. This section in HB 733 (AS 47.30.246) is of great significance since Alaska's human rights laws contain no reference to mental illness; mental patients -- present and former -- are still subject to substantial discrimination. HB 472 has eliminated this vital section.

In conclusion, it should be noted that no attempt was made to touch on every difference between the two bills in this memorandum. It is hoped, simply, that this highlighting of the more significant ways in which the two bills diverge will be useful to the Mental Health Association.

HOUSE BILL 2
INTRODUCTORY STATEMENT
By Verner Stillner, M.D., M.P.H.

From 1904 to 1962 Alaska's mentally ill residents requiring hospital treatment were sent to Morningside Hospital in Portland, Oregon. Thus, they had to leave their spouses, families, and home communities in Alaska. In 1962 the Alaska Psychiatric Institute (API) was constructed and opened its doors thereby enabling mentally ill Alaskans to obtain hospital treatment in-state. The Community Mental Health Services Act of 1975 laid the groundwork for community operated mental health centers to become available in every district which would make mental health care available to many in their home communities. In 1975 only five such outpatient mental health centers existed; today 21 centers exist. 20 of these 21 centers are operated by communities via G.F. grants and local matching monies. These local community centers currently allow for outpatient services to be delivered close to the family and community of many patients.

A major concern today in the case of the mentally ill is deinstitutionalization. This concern and policy should be considered not only at the time of discharge of patients, but also before their admission. House Bill 2 provides an excellent means for providing regional services of outpatient evaluation to all children and adults prior to hospitalization. In the provision of evaluations and treatment nearest to families and communities of origin, a greater local involvement is fostered. This enables better community planning for pre and post hospitalization services.

House Bill 2 correctly addresses our present unconstitutional mental health statute and provides for treatment to be in the least restrictive environment, close to family and community. In addition, the bill safeguards the individual's legal rights while protecting society from persons who are mentally ill and dangerous to self or others.

House Bill 2 does not allow discrimination against the mentally ill in issues of housing and work. This act relating to mentally ill persons is a humane progression from the pre statehood treatment in Portland, Oregon to Anchorage to local communities close to the homes of the mentally ill.

Rule 35. Physical and Mental Examination of Persons.

(a) **Order for Examination.** When the mental or physical condition (including the blood group) of a party, or of a person in the custody or under the legal control of a party, is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control. The order may be made only on motion for good cause shown and upon notice to the person to be examined and to all parties and shall specify the time, place, manner, conditions, and scope of the examination and the person or persons by whom it is to be made.

(b) **Report of Examining Physician.**

(1) If requested by the party against whom an order is made under Rule 35(a) or the person examined, the party causing the examination to be made shall deliver to him a copy of a detailed written report of the examining physician setting out his findings, including results of all tests made, diagnoses and conclusions, together with like reports of all earlier examinations of the same condition. After delivery the party causing the examination shall be entitled upon request to receive from the party against whom the order is made a like report of any examination, previously or thereafter made, of the same condition, unless, in the case of a report of examination of a person not a party, the party shows that he is unable to obtain it. The court on motion may make an order against a party requiring delivery of a report on such terms as are just, and if a physician fails or refuses to make a report the court may exclude his testimony if offered at the trial.

(2) By requesting and obtaining a report of the examination so ordered or by taking the deposition of the examiner, the party examined waives any privilege he may have in that action or any other involving the same controversy, regarding the testimony of every other person who has examined or may thereafter examine him in respect of the same mental or physical condition.

(3) This subdivision applies to examinations made by

agreement of the parties, unless the agreement expressly provides otherwise. This subdivision does not preclude discovery of a report of an examining physician or the taking of a deposition of the physician in accordance with the provisions of any other rule. (Amended by Supreme Court Order 158 effective February 15, 1973)

(a) CROSS REFERENCES: Civ. Forms 64, 65

4600 Shelikof St.
Anchorage, Alaska 99507
April 28, 1981

Senator William Ray
Pouch V
Juneau, Alaska 99811

Dear Senator Ray,

I appreciate your questions regarding my testimony by teleconference on CS for SB 100. As I indicated in my testimony, there are physical medical conditions that manifest their symptoms through mental disturbances. Some of them are serious infections such as encephalitis. I have attached a list for your information of some of the diseases that concern me.

I wanted to let you know that I support the passage of the bill but I believe Section 47.30.700 needs to require the involvement of a physician and the examination of the patient. Otherwise, I believe physically ill people will be transported hundreds of miles needlessly. These persons will be at risk of dieing themselves and of exposing other people to serious illnesses. As you know, emergency commitment in Alaska currently requires a physician involvement before a patient is tranported. I know of no state where this action is taken without a physicians being involved.

The reason I believe this will be a problem is that the Alaska Psychiatric Institute is the only facility capable of providing involuntary evaluation and treatment in the entire state. No other hospital in the state is willing or able to accept this type of responsibility. Although the law permits hospitals in cities such as Juneau or Bethel to be designated as evaluation and treatment facilities, it does not require them to accept the designation. In the past these hospitals have refused to accept this responsibility. No other facilities (except jails) exist in these communities capable of providing 24 hour residential care and treatment. As a consequence patients will have to travel to Anchorage without being evaluated locally by a physician.

In my opinion, this section is simply too permissive to provide the public with the protection it deserves. If it is not amended then I beleive you should not vote for SB 100 unless you are satisfied that this defect has been overcome by some other mechanism.

Sincerely,

Jerry L. Schrader, MD

cc: Sen. Charles Parr
Sen. Pat Rodey

Psychiatric Presentations in Medical Illness

1. Metabolic - toxic disorders

   A. Endocrinopathies

      hypoparathyroidism
      hyperparathyroidism
      hypoadrenalism
      hyperadrenalism
      hypothyroidism
      hyperthyroidism
      acromegaly
      hypopituitarism
      insulinoma - hypoglycemia
      inappropriate ADH

   B. Encephalopathies

      uremic
      dialysis dementia
      dysequilibrium syndrome
      hepatic - Reye's
      CO_2 intoxication
      hypomagnesemia

   C. Nutritional disorders

      pellagra
      Wernicke's
      pernicious anemia
      hypervitaminosis A

   D. Miscellaneous

      sarcoidosis
      acute intermittent porphyria

2. Infectious Disorders - intracranial and systemic

      encephalitis
      syphilis - general paresis
      malaria
      pancreatitis
      acute chorea

3. Hereditary - Degenerative Disorders

multiple sclerosis
Freidreich's ataxia
Wilson's disease
tuberous sclerosis

4. Collagen - Vascular

systemic lupus erythematosus
polyarteritis nodosa
(cerebral ischemia, ASCVD, TIA)

5. Neoplastic Disorders

intracranial tumors
extra-cranial malignancies
specific tumors:
  pancreatic carcinoma
  carcinoid
  pheochromocytoma

6. Miscellaneous

Munchausen's syndrome
psychiatric side effects of non-psychiatric drugs
pseudotumor cerebri