SB
346

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

POUCH H 04
JUNEAU, ALASKA 99811
PHONE:

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

March 6, 1984

The Honorable Bill Sheffield
Governor
State of Alaska
Pouch A
Juneau, AK 99811

Dear Governor Sheffield:

Your Mental Health Advisory Council has been following the developments of Senate Bill Number 346 amending an Act entitled: "An act relating to the treatment of mentally ill persons." We are aware that many public hearings have occurred prior to its introduction January 11, 1984 by Senators Josephson and Halford. Additionally, individual professionals, the Alaska Psychiatric Association and the Alaska Psychological Association have had consultation and input into these revisions with strong support for these amendments. These amendments are thought to represent improvements in the treatment of adolescents and adults from the standpoint of both providers and consumers.

Your advisory Council heard today that this bill is being held "hostage" pending untold bargaining possibilities. Since these amendments would improve the quality of care and likely result in more efficiently and less cost for both the Mental Health and Judicial Divisions, it seems unfortunate to delay its enactment.

Your Mental Health Advisory Council recommends your support for the quick passage of this act. On behalf of all Council Members thank you for your consideration.

Sincerely,

Herbert G.W. Bischoff, Ph.D.
Chairperson

Council Members
David R. Samson, M.D.
Anchorage, Vice Chairperson
Ann Egrass, McGrath
Mabel Rosvold, Petersburg
Alice Wardlow, Bethel
Barbara T. Wihloborg, Fairbanks
Robert Hunter, M.D., Mt. Edgecumbe
Kevin C. Ritchie, Juneau

cc: Bill Ray, Chairman, Judiciary Committee
All Judiciary Committee Members
HGWB/dmb

05-F100LH

MSG 84-00023727 PRTY 1 03/13/84 12:14:18 ORIG: LA01 IN= 0001 OUT= 0011
FROM: FLORENCE, ANCHORAGE TO: POM - JUNEAU INFO
TARGET: LJHK SUBJ: POM 10

POM 3/13/84 FLORENCE, ANC LIO MSG 23737

TO: SENATORS ELIASON, F. FISCHER, V. FISCHER, HALFORD, JOSEPHSON, MOSS, PETTYJOHN, RAY AND ZIEGLER

FROM: SUSAN HOUSE-DARDEN
4534 E 9TH
ANCHORAGE, AK 99508
(H) 337-1182 (W) 786-1256

I AM STRONGLY OPPOSED TO SB 346. THE CHANGES PROPOSED IN THIS BILL WOULD ADVERSELY EFFECT THE QUALITY OF MENTAL HEALTH CARE PROVIDED IN ALASKA. MINIMAL EDUCATIONAL PREPARATION FOR PSYCHIATRIC NURSES SHOULD BE THE MASTERS DEGREE. THIS IS A NATIONAL PROFESSIONAL STANDARD. TO REQUIRE LESS WOULD BE A DETRIMENTAL STEP.

***8
EOM

MSG 84-00023984 PRTY 1 03/13/84 15:54:56 ORIG: LA17 IN= 0012 OUT= 0090
FROM: KIM / ANCH LIO TO: POM / JNU INFO
TARGET: LJHK SUBJ: P O M

TO: SENATORS JOSEPHSON, V FISCHER, HALFORD, P FISCHER, MOSS

SENATORS RAY, ELIASON, ZIEGLER, PETTYJOHN

FROM: GWEN OTTE, 3330 WINDLASS CIRCLE, ANCHORAGE 99516
H 345-7148 W 786-1249

RE: SB346 TREATMENT OF MENTALLY ILL PERSONS

NATIONAL PROFESSIONAL STANDARDS FOR PSYCHIATRIC NURSES HAVE FOR MANY YEARS REQUIRED A MASTER'S DEGREE. EXPERIENCE IN AND OUT OF ITSELF IS NOT A SUBSTITUTE FOR PREPARATION IN THE KNOWLEDGE BASE REQUIRED FOR THIS ADVANCED AREA OF PRACTICE.

Senator Bill Ray
Chairman
Senate Floor Leader

Alaska State Legislature
State Senate

Judiciary
3/14/84

Committee on Judiciary

SENATE JUDICIARY COMMITTEE
MEETING ANNOUNCEMENTS
(3/9/84)

811

MONDAY, MARCH 12, 1984

CSHB 345 (Jud)	Relating to victim's rights.
SB 513	Relating to renunciation of rights in decedents' estates.

WEDNESDAY, MARCH 14, 1984

SB 346	Relating to the treatment of mentally ill persons.
HB 48	Repealing certain insurance laws.

(The Senate Judiciary Committee meets every Monday, Wednesday and Friday at 1:30 p.m. in the Butrovich Committee Room, #205 Capitol Bldg., unless announced otherwise)

Senator Bill Ray, Chairman
Senate Judiciary Committee
State Capitol, Pouch V
Juneau, Alaska 99811

March 7, 1984

Re: Senate Bill 346

I am writing to share my concern regarding several aspects of Senate Bill 346 "An Act Relating to the Treatment of Mentally Ill Persons." I am a registered nurse with a Master's in psychiatric nursing and ten years of experience in the mental health area. As a general comment, it is unclear as to what the proposed changes are intended to provide other then an enhancement of the treatment facility's ability to manage its clientele.

I am very concerned about the incarceration and loss of civil liberties of the mentally ill. The current retrenchment in the attitude about the treatment of the mentally ill in this bill is alarming given the many advancements that have been made in providing safe and humane approaches to their care. It would seem that there needs to be a distinction made in the legal language between those who are mentally ill and the appropriate treatment and those who are criminal and mentally ill and the associated loss of civil rights that accompanies criminal status. Most mentally ill persons are not criminals.

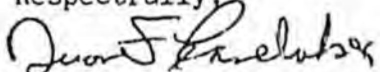
Specifically, Section 20 AS 47.30.840 (b) makes provisions for the professional in charge to suspend patients' rights under (a) (4) - (7). If rights can be suspended by such a professional person without the patient having access to counsel, then there were no rights in the first place. It is unclear as to what is meant by "in the best interests of the patient" and how these interest are determined specifically and by whom. I have not much faith in such a decison being made by a professional, given that the treatments that can be provided to the mentally ill are primarily supportive. There are no cures. In fact, there is now occuring an increase in the iatrogenic effects of treatments provided to the mentally ill. I do not mean to belabor the point, but treatment of the mentally ill consists of more than just prescribing and dispensing medications.

I am also concerned with the loss of rights taken from adolescents between the ages of 14 and 18. While treatment of this age group may be difficult, it is not a reason to remove their right to participate in self-determination. These changes are in Section AS 47.30.690. The implication is that this age group would not have the right to refuse treatment, even treatment that will have permanent effects upon them, such as psychosurgery and electroconvulsive therapy. These treatments are very serious in their consequence; and while they may be beneficial in the short term, they may be quite deleterious in the long term. In fact, I would propose a review board consisting of lay persons and professionals to approve such treatment prior to being administered.

In summary, I hope that serious review and consideration will be given to the possible effects of Senate Bill 346 upon the mentally ill and to the need for protecting their rights as citizens.

If you have any questions, feel free to contact me. Thank you for your serious consideration of my concerns.

Respectfully,



Duane F. Pennebaker, R.N., M.N., Ph.D.
324 Pribilof
Eagle River, Alaska 99577

SECTIONAL ANALYSIS - DRAFT "AN ACT RELATING TO THE TREATMENT OF MENTALLY ILL PERSONS." by Senators Josephson and Halford

NOTE: Throughout the bill draft, the age of majority has been changed from 14 to 18, commitment time periods for computation purposes have been changed from 21, 90 and 120 days to 30, 90, and 180 days, and neutral words have been substituted for gender pronouns.

Section 1	Provides a word change to limit the endless paperwork from patients transfering in and out of voluntary status in order to leave against medical advice.
Section 2-5	Changes the age of majority under the title from 14 to 18, changes the commitment period for minors from 21 to 30 days, and eliminates sex gender pronouns. Section 4 also changes the term "immediate" to "timely" in order to avoid inoperable situations (eg. if a patient wants to leave in the middle of the night, the facility must call in a psychiatrist). Pg. 3, line 8 changes "notice of intent" to "request". Section 5 (3) adds language to admission procedures to allow treatment of those minors whose condition would worsen without treatment.
Section 6	Provides options for the release of a minor, and options for the facility to keep a minor who is in danger of causing serious harm to self and others.
Section 7	Adds "mental health professional" to current law allowing a peace officer to take someone into custody for emergency detention. Also limits the use of correctional facilities for the mentally ill to situations requiring protective custody while awaiting transportation to a treatment facility.
Section 8	Changes the commitment time period from 21 to 30 days.
Section 9	The purpose of this section was to move the term "gravely disabled" after "mentally ill" (pg. 6, line 21). Other changes relate only to neutral pronouns and changing commitment time periods.
Section 10	Changes the 21 day commitment period to 30 days, and substitutes neutral pronouns in the section.
Section 11	Changes the commitment time period from 21 to 30 days. Subsection (4) relaxes the rules of evidence and allows for informal court preceedings. Subsection (9) allows respondent to call experts and witnesses to testify.

Section 12	Changes 21 day commitment to 30 day, and substitutes sex neutral pronouns.
Section 13-14	Changes commitment time periods from 21 to 30 days; and from 120 days to 180 days. Pg. 12, line 9 corrects typo.
Section 15	Adds a new section to the statute allowing a designated facility to administer medication or treatment that is consistent with Article 9 - Patients Rights.
Section 16	Adds new language to the section relating to unauthorized absences to provide that the facility must notify the parent or guardian or a person threatened by the patient immediately upon discovery.
Section 17	Adds a new section relating to the change of admission status from involuntary to voluntary if the responsible physician agrees that it is appropriate and that the change is made in good faith.
Section 18	Adds to provisions for computation of time, specific references to AS 47.30.715 (Acceptance of order), and AS 47.30.685. Current interpretation of the law requires that a judge must be brought to the facility at these times, and many are unwilling to do so on a holiday or weekend. Also changes commitment time periods to be consistent with other sections.
Section 19	Amends section relating to liability to include a mental health professional and transportation, to be consistent with Section 7.
Section 20	Amends the section of law relating to informed consent for unusual procedures, to include informed consent of the parent or guardian in case the patient is unable to give informed consent.
Section 21	New language specifies that the discharge plan shall be shared with the parent or guardian.
Section 22	Adds a new section to patients' rights to include the right to a proper diet.
Section 23	Limits the rights of the patient in areas of visitors, mail and access to a phone if the professional person in charge determines that it is not in the best interest of the patient or will cause harm to the patient or others.
Section 24	Allows access to records to a law enforcement agency under special circumstances.
Section 25	Adds federal facilities to the definition of "evaluation facility."

Section 26 Expands the definition of "gravely disabled" to include persons who are not in imminent danger but whose lack of treatment would cause deterioration of their condition.

Section 27 Expands definition of "likely to cause bodily harm" beyond recent attempts, to include threats and likelihood of injury in the near future.

Section 28 Changes the requirements for a nurse to be classified as a mental health professional, as there are only two in the state with a Master's Degree in Psychiatric nursing. Changes the language for the qualifications of a Psychologist and Psychological Associate to conform with their licensing statutes.

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

SECTIONAL ANALYSIS OF CSSB 346 (JUD) - AN ACT RELATING TO THE TREATMENT OF MENTALLY ILL PERSONS by Josephson, Halford and Faiks.

NOTE: Throughout the bill, the age of majority has been changed from 14 to 18, commitment time periods have been changed from 21, 90 and 120 days to 30, 90 and 180 days, and neutral words have been substituted for gender pronouns.

Section 1	Provides a word change("every" to "reasonable") to limit the endless paperwork from patients transfering in and out of voluntary status.
Sections 2-5	Changes the age of majority under the title from 14 to 18 to make this statute consistent with others dealing with juveniles. Section 4 also changes the term "immediate" to "timely" in order to avoid inoperable situations caused by literal interpretation of the language Section 5(3) adds language to admission procedures to allow treatment of those minors whose condition could worsen if untreated.
Section 6	Provides options for the release of a minor, and options to keep a minor in danger of harming self or others. (Statutory basis for procedure currently used at A.P.I.)
Section 7	Adds "mental health professional" to current law allowing peace officers to take someone into custody for emergency evaluation. It also limits the use of a correctional facility for the mentally ill, providing only emergency protective custody while awaiting transportation to an evaluation facility.
Sections 8-9 and 10	Technical amendments concerning time computations and neutral language to comply with other sections of the bill.
Section 11	Adds to respondents rights in a 30 day commitment hearing; that the rules of evidence and civil procedure be applied in an informal way; that experts and other witnesses may testify on the respondent's behalf.
Sections 12, 13 and 14	Time computation changes.
Section 15	Adds a new section providing that medication and treatment may be administered to an involuntarily commited patient in compliance with patient's rights.
Section 16	Provides new language to the statute dealing with unauthorized absences providing that a parent, guardian or a person known to have been threatened by the patient will be immediately notified.
Section 17	Adds a new section to the statute relating to the change of status from involuntary to voluntary,

providing that the physician must agree that the transfer is appropriate and must be made in good faith.

Section 18 — Provides that acceptance of order, and 48 hour detention period time computations will not include weekends and holidays.

Section 19 — Amends liability section to include a mental health professional who detains and transports a patient.

Section 20 — Provides that an adult designated as a guardian shall be provided with a copy of a patient's discharge plan.

Section 21 — Adds a new section to the law providing that a patient has the right to a nutritionally sound and medically appropriate diet.

Section 22 — Adds to the patient's rights section of law, additional rights to:
be free of corporal punishment;
exercise and recreation;
at any time have a visit or phone conversation with an attorney;
not be retaliated against for assertion of rights.

Section 23 — Allows for temporary suspension of certain patient rights (wearing personal clothing, phone calls, visitors and recreation) only after the initial evaluation period, if there is a threat to the patient or others.

Section 24 — Allows access to confidential records by a law enforcement agency if there is substantial concern over imminent danger from a presumed mentally ill person.

Section 25 — Includes federal facilities in the definition of "evaluation facility"

Section 26 — Expands the definition of "gravely disabled" to include persons who are not in immiment danger, but whose lack of treatment would cause deterioration of their condition.

Section 27 — Expands the definition of "likely to cause serious harm" beyond recent attempts to include threats and likelihood of injury in the near future.

Section 28 — Changes language relating to psychologists and psychological associates, to be consistent with their licensing statute, which indicates that they do not have a "specialty designation" but have training in clinical psychology.

RECEIVED

POSITION PAPER

Senate Bill No. 346

"An Act relating to the treatment of mentally ill persons."

In October, 1981, Chapter 84, SLA 1981 became effective. This act completely revised Alaska's involuntary commitment laws for mentally ill persons that required involuntary hospitalization or treatment. Upon its effective date, there was considerable concern that the Act was procedurally cumbersome which would require that an excessive amount of professional treatment staff time be consumed in filling out forms, testifying in court, and other non-treatment related activities. While the Act has proven workable and involuntary commitment of the mentally ill have continued to occur, there are a number of areas in the Act that have proven repeatedly troublesome since its effective date. Senate Bill 346 is an attempt to amend some of those troublesome provisions that have tended to inhibit or hamper the treatment of the involuntarily committed mentally ill patient.

The majority of the amendments that are proposed in Senate Bill 346 are technical rather than substantive in nature, a number of the amendments are intended to change the Act in a way that is seen by many as improving its effectiveness. Those amendments that are considered to require clarification are discussed below:

Page 1, Section 1, Line 20

During the period of time the Act has been in effect, many areas have applied literal interpretation to the requirement that "every" opportunity be afforded to respondents to accept voluntary treatment. The result has been instances in which a prospective involuntary patient has repeatedly refused to accept voluntary treatment until the court hearing is actually in progress or about to begin and then suddenly decides he will accept voluntary treatment. The court proceedings cease and the petition for commitment is dismissed. If, prior to arrival to API for involuntary admission, the patient changes his mind and again refuses voluntary treatment (as has been the case), the entire involuntary commitment process must be started anew.

This has been cause for considerable concern and confusion. The amendment offered would change "every" opportunity to "reasonable" opportunity to accept voluntary treatment. This would allow for some discretion in its interpretation. Thus, if a patient repeatedly refused voluntary treatment, the commitment process would proceed even if the patient requested voluntary treatment at a later time. This would insure that treatment would be possible and the expensive commitment process would not have to be repeated unnecessarily.

Page 2, Section 2, Line 7

Under the Act, the age of majority for purposes of accepting or rejecting voluntary treatment without the consent of a parent or guardian was set at 14 years old. This has created a number of difficulties especially for those children between the ages of 14 and 18 years of age.

For example, a 14 year old child could present himself at API and request admission without the knowledge or approval of the parent or guardian. As A.S. 47.30.845 (Confidential Records) does not give the hospital the authority to release any information to the parents or guardians of a person 14 years of age or older without the permission of the patient, it may not be legal for us to tell parents or guardians the whereabouts or condition of their child.

Also, a 14 year old child that would benefit from evaluation or treatment at API but does not meet involuntary civil commitment standards may not be admitted at the request of the parents or guardian unless the child voluntarily agrees to accept treatment. Thus, some mentally ill children may not receive necessary mental health care and treatment even though their parents or guardian attempt to provide these services for them. In cases such as this, it becomes even more ludicrous if the Division of Family and Youth Services attempts to file a petition to have the court find the youth as a child in need of aid by alleging that the child's medical needs are being neglected. If the parents or guardian sought voluntary hospitalization of the child that is 14 years old but the child refused treatment, then parental neglect, which would support a finding of a child in need of aid status, is not possible.

The amendment proposed would change the age of majority under this section from 14 to 18 years of age. This would be consistent with other statutes that govern the care of treatment of these children and adolescents as well as correct these legal anomalies.

Page 3, Section 5, Line 12

This would increase the period of time for voluntary hospitalization of a minor by 9 days (from 21 to 30 days). This additional time will increase the ability of the hospital to provide a more thorough and comprehensive evaluation and treatment program for mentally ill children.

Page 3, Section 5, Line 22-23

This language would broaden the circumstances under which a minor may be accepted for admission at the hospital if the professional person in charge believes that hospitalization is necessary on a voluntary basis. This added provision could prove very helpful in addressing the treatment needs of mentally ill children and adolescents who are at risk of further deterioration and need hospitalization. Under the existing statutes, unless improvement in their condition can be reasonably expected, admission may not be possible. We believe this added provision will prove helpful in providing necessary care and treatment for this group of patients.

Page 4, Section 6, Lines 6-26

The addition of this language provides needed clarification regarding the circumstances and procedures for releasing or retaining mentally ill minors with or without the consent of the parent or guardian. It is especially pertinent as there have been occasions when the safety of the child or others was questionable and the child was not committable but the parents or guardian have demanded immediate release of the child. This amendment will make it possible to insure the safety of all concerned prior to release of the minor.

Page 5, Section 7, Line 3

By granting mental health professionals the authority to take mentally ill persons into custody under an emergency situation and deliver them to an evaluation facility, a number of problems will be alleviated. Under the existing statutes, if a physician in an emergency room examines an individual that is brought to the hospital by relatives or friends, and the patient is clearly mentally ill and is in need of immediate hospitalization, the physician may have to call the police in order to have a peace officer take the patient into custody and sign an application for the patient's examination. This situation may occur in any hospital in Alaska including API.

Under the proposed amendment, the physician or any other health care professional that is included in the definition of a mental health professional under A.S. 47.30.915(11), can sign the application for examination under A.S. 47.30.705 and have the patient held in custody pending completion of the exam and receipt of an ex part order.

Page 5, Section 7, Lines 9-12

As written, this proposed amendment, if strictly interpreted, could tend to prohibit the completion of examination or evaluations of patients that were detained in jails or correctional centers even if qualified evaluation personal were available. We certainly agree in principle that jails and correctional centers should not be used to hold the non-criminal, mentally ill; however, in practice, we have found that under certain exceptional circumstances, a jail or correctional center may be the only facility available to detain the patient at the local level for purposes of evaluation and insure the safety of the patient and the community.

It has been our experience that the utilization of there types of facilities is neither widespread nor indiscriminate and is used only on a very short-term basis. Nevertheless, when it is necessary to house patients in jails or correctional centers, we proceed with the examination, evaluation, and involuntary commitment process when the necessary resources are locally available. The time spent by these

POSITION PAPER/Department of Health & Social Services

patients under these circumstances is then counted for purposes of the 24 hour and 72 hour time limit that is required for examinations and evaluations to occur by mental health professionals. This tends to insure that patients are not detained longer than necessary and treatment, if indicated, can commence immediately.

Consequently, we recommend that this amendment be deleted and that the existing language in A.S. 47.30.705 on lines 12-15 (in brackets) should be retained.

Page 5, Section 7, Line 24

This amendment would change the period of time for the first involuntary commitment from 21 to 30 days and is repeated throughout Senate Bill 346. The additional 9 days would tend to reduce the administrative workload of our treatment staff while having little or no effect on the period of time patients are actually involuntarily hospitalized.

Rather than interrupt treatment on the 21st day in order to undergo the 90-day commitment process, treatment could continue for an additional 9 days if necessary. This would allow medications and other forms of therapy an additional period of time to stabilize the patient, possibly resulting in a discharge of the patient between the 21st and 30th day.

Page 9, Section 10, Lines 17-19

This amendment is designed to insure that a less formal courtroom atmosphere is possible during the involuntary civil commitment process. This should make the commitment proceedings less painful and frightening to the mentally ill respondent.

Page 9, Section 10, Lines 27-28

The addition of this provision to allow a respondent to call his own experts or other witnesses to testify on his behalf is not seen as necessarily having an impact on the Division of Mental Health and Developmental Disabilities unless the respondent decides to call experts from API to testify on his behalf. It may, however, have a financial impact on the Alaska Court System if the respondent is indigent and the court has to pay the expenses of the experts and other witnesses called by the respondent on his behalf.

Page 12, Section 13, Line 7

This amendment would change the 120-day commitment to 180 days and is repeated throughout the bill. This change will reduce the administrative and procedural requirements necessary for the long-term, chronic mentally ill patients that require extended periods of involuntary hospitalization.

POSITION PAPER/Department of Health & Social Services

Page 13, Section 16, Lines 23-26

This additional requirement for notification of a patients family or guardian as well as any person known to been threatened by the patient of his unauthorized absence from the treatment facility is supported by the Division of Mental Health and Developmental Disabilities. We feel that this is an appropriate and necessary measure in cases such as this.

Page 14, Section 18, Lines 8-9

The addition of this language is seen as necessary and will correct what appears to have been an oversight when the he Act was drafted. It simply makes specific that computations of time for a patient being evaluated or a patient being detained for evaluation do not include Saturdays, Sundays, legal holidays, or transportation time and are not to be included in the 72 or 48 hour time limitation prescribed by the Act.

Page 15, Section 19, Lines 6-7

This adds mental health professionals among those that may not be held civilly or criminally liable for detaining and transporting a person under the Act. This amendment is consistent with this section of the Act.

Page 15, Section 20, Lines 15-17

This amendment will require that an adult designated by the respondent must give informed consent in cases in which the patient is unable to give informed consent prior to certain treatments being authorized. We feel this is an appropriate addition to the Act.

Page 15, Section 21, Lines 28-29

This simply requires that an adult designated by the patient must be provided a copy of the patient's discharge plan. This is consistent with A.S. 47.30.845 under the existing statutes regarding confidential information.

Page 17, Section 24, Lines 6-8

This proposed amendment would clarify the circumstances under which the hospital may release confidential information and records to law enforcement agencies when they are concerned that a patient or ex-patient may present as an imminent danger to the community. Under certain circumstances, we feel it is in the best interests of the community and the patient to take such action.

Page 17, Section 24, Line 13

The addition of this language will include hospitals operated by the federal government, such as the PHS facilities, for use as evaluation facilities for purposes of the Act. Under the existing statutes, these facilities are not included in the definition of an evaluation facility and some of these federal facilities have not been able or willing to be utilized in this capacity.

Page 17, Section 24, Lines 21-25

This addition to the definition of a gravely disabled person will significantly clarify and improve our position with respect to the involuntary care and treatment of these patients. An additional period of hospitalization may help prevent further deterioration of gravely disabled persons in order to avoid or reduce the risk of further tragedy and/or agony.

Page 18, Section 27, Line 1

This amendment offered in the bill will reduce the standard upon which a potentially suicidal person may be taken into custody and involuntarily committed. It is our belief that this is both necessary and appropriate given our current rate of death by suicide in Alaska.

Page 18, Section 27, Lines 5-8

As in the previous section, this language will alter the standard for involuntary hospitalization of a person that may present as a danger to others or to the property of others. This may allow some seriously mentally ill persons to be involuntarily committed before they actually harm another person or another person's property.

Page 18, Section 28, Lines 17-20

This simply requires that a psychologist or a psychological associate must be trained specifically in clinical psychology in order to be considered a mental health professional for purposes of screening, examination, and evaluation under the Act.

Page 18, Section 28, Lines 22-24

This amendment is intended to include in the definition of mental health professionals those registered nurses that have experience in psychiatric nursing in a JCAH accredited psychiatric hospital for purposes of screening, examination, and evaluation under the Act. This is considered an appropriate addition to this definition.

The Department of Health and Social Services generally supports the amendments contained in Senate Bill 346 and endorses its passage with the exceptions noted above.

Recommended by: [signature]
Philip Shapiro, M.D.,
Director, Division of Mental Health and Developmental Disabilities

Date: 1/30/84

Approved by: [signature]
Robert London Smith, Ph.D.
Commissioner

Date: 1/30/84

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 346
Title: An Act relating to the treatment of mentally ill persons
Sponsor: Josephson and Halford
Requestor:
Date of Request: 1-11-84

FISCAL DETAIL
Agency Affected: Division of Mental Health and Developmental Disabilities
Program Category Affected: API
BRU, Program or Subprogram(s) Affected:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING		0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis * See Attached

Prepared By: James L. Scoles PS
Phone: 465-3370
Division: Mental Health & Developmental Disabilities
Date: 1-20-84

Approved by Commissioner: Robert London Smith
Date: 1/30/84
Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83

The Division of Mental Health and Developmental Disabilities does not foresee any increase or decrease in expenditures as a result of the passage of SB 346 at this time. The primary purpose of this bill is mainly directed at reducing the procedural requirements of A.S. 47.30.655 - 47.30.915, changing the age of majority from 14 to 18 years of age, changing the period of time for the initial commitment from 21 to 30 days and the third period of commitment from 120 to 180 days, expanding the definition of peace officers to include mental health professionals, and slightly relaxing the standards for commitment.

We do not believe that any of these proposed amendments will increase or decrease the number of mentally ill persons that will require hospitalization. The amendments should, however, make it easier to commit the mentally ill which should result in more professional staff time available to provide direct patient care and treatment rather than excessive time being expended in the commitment process.

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 346
Title: An Act relating to the treatment of mentally ill persons
Sponsor: Josephson and Halford
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Agency Affected: Division of Mental Health and Developmental Disabilities
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BRU, Program or Subprogram(s) Affected:

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING		0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis * See Attached

Prepared By: James L. Scoles PS Phone: 465-3370
Division: Mental Health & Developmental Disabilities Date: 1-20-84

Approved by Commissioner: Robert London Smith Date: 1/30/84
Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):
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- Impacted Agency(ies)

12/1/83

The Division of Mental Health and Developmental Disabilities does not foresee any increase or decrease in expenditures as a result of the passage of SB 346 at this time. The primary purpose of this bill is mainly directed at reducing the procedural requirements of A.S. 47.30.655 - 47.30.915, changing the age of majority from 14 to 18 years of age, changing the period of time for the initial commitment from 21 to 30 days and the third period of commitment from 120 to 180 days, expanding the definition of peace officers to include mental health professionals, and slightly relaxing the standards for commitment.

We do not believe that any of these proposed amendments will increase or decrease the number of mentally ill persons that will require hospitalization. The amendments should, however, make it easier to commit the mentally ill which should result in more professional staff time available to provide direct patient care and treatment rather than excessive time being expended in the commitment process.

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER Mental Health Commitment Law DATE Oct. 14, 1983 (Anchorage)

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
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Josef J. [illegible]	MOA/DSS	Pouch 6-650	264 6534
[illegible] MD	API	2900 Providence	561-1633
L. Nackerud	"	"	"
David R Sanson MD	ACMHC / APA	1020 E 4th 99501	276 5400
Natalie Gottstein	AMHA	2[illegible] [illegible] ST	276-1705
Jay Vonkozen	self	309 G Street, Anch. [illegible]	272-0200
[illegible]	Anch. Com. Mental Health	1577 C St. anch	278-4558
Steve Harrison	Division Mental Health	3601 'C' Street Anc	561-4247
Frances Purdy	Behavioral Health Division Municipality of Anch.	Pouch 6-650 99502	264-4876
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[illegible]	Alaska Ch. Natl Ass. Social Workers		

MENTAL HEALTH COMMITMENT LAW

Senate HESS 9/23/83

Attendance: Josephson, P. Moss. Sens. V. Fischer, P. Fischer, and Halford excused.

018 Josephson convened meeting regarding mental health commitment law testimony.

093 Josephson: Our purpose today is to receive testimony on the question of mental health commitment I think our purpose would be better served if those wishing to testify could talk to how you evaluate the existing law, what changes you would like to see, rather than to address any specific work draft as a mark-up vehicle.

120 Sonya Benson, representing Representative Niilo Koponen: I don't have any specific testimony at this time.

129 Mrs. Ann Denardo, Family of Chronically Ill Victims, Fairbanks: Our son is schizophrenic and housed at A.P.I. We've had a lot of experience of with this commitment act and we find it to be burdensome, vague, and emotional. We feel families should have a great role in commitment procedures. A broader criteria for commitment should be studied based on ability to function with thought processes.

198 Denardo: Under paragraph 7, 'gravely disabled' means a condition in which a person is a result of mental illness. We would like to add 'or is not receiving such care in mental medical treatment as is necessary for health and safety' or 'a person who thought processes, perception of reality or judgment is substantially impaired'.

230 Josephson: Has this language been used anywhere else?

273 Denardo: I've studied other acts from other states, and this language comes from a combination of law in two or three other states. We also suggest that a study be done of other commitment acts.

299 Denardo: Commitment procedures should be redefined, with a view to creating a less adversarial situation and family. Court procedures are either civil or criminal. Commitment comes under civil procedure. In civil procedure, there has to be cross-examination and rules of evidence presented. This puts family members in the position of testifying against their child. I would like to suggest that the legislature study the possibility of another procedure, not civil and not criminal, but a procedure just for mental commitments.

335 Denardo: Mentally ill patients should receive better continuity of care as they move from hospital to community. Commitment procedures should reflect this need. We feel that the courts should be better apprised to the mental health system and the whole problem of severe mental illness.

374 Josephson: What do families experience in Fairbanks, being far from API? What happens as the family member enters the system?

389 Denardo: First of all, there aren't very many involuntary commitments from Fairbanks because we do all we can to convince the patient that they should go in on a voluntary admission. It's emotionally easier because the court procedures are skipped. We then have to pay for transportation to A.P.I. I think this is a legislative oversight. When there is an involuntary commitment, the patients airfare is paid to Anchorage. We have asked for designated beds. We desperately need a psychiatric unit here in Fairbanks. There are approximately 200 chronically mental ill people in this area. We have no half-way houses or programs. The Community Mental Health Center struggles along on a few dollars. They have a small day treatment program, but it's insufficient for the needs of the community.

421 Denardo: Because of the high cost of travel, meals, hotel accommodations, rent-a-cars, etc., I am only able to visit my son once a month. We feel that the most important part of treatment for the patient is proximity to family and friends.

477 Denardo: Twenty years down the line, we will look at the neuroleptic medications as pharmaceutical labotomies. With this medication, the patients are not cured. They are put into a medicated miasthma. They can't move. Patients say that the medication makes them feel unpleasant, sick, and tired. My own son was taken off the medication because he couldn't get out of bed. This is the condition in which he returns home.

510 Josephson: For the schizophrenic, is it the only thing we have?

559 Denardo: There are no other therapies that professionals are using at this point. At this time, more than 20% of the patients don't respond to this medication. Some patients do come out of their psychotic state, but many others fall into the pharmaceutical labotomies. Eventually, all patients develop a nervous disorder, which is totally irreversable. In many cases, the liver of the patient is ruined.

601 Josephson: Do you have any anxiety that the language, 'a person whose thought processes, perception of reality or judgment is substantially impaired', could be abused by commiting people who are eccentric, etc.?

610 Denardo: No. The screening process is cumbersome and is so comprehensive that I can't see an eccentric person being committed.

621 Josephson: Is your organization part of a national group?

629 Denardo: We are part of The National Alliance for the Mentally Ill.

683 Denardo: There is inappropriate jailing of mental ill patients. People having psychotic crisis are treated as criminals. Once they get into the criminal system, it is quite hard for them to get out of it. They get on probation, they get put into A.P.I. and know that when they are released, they have to return to jail for breaking probation. They, in turn, have no incentive to be released for A.P.I.

740 End of Side A. Turned to Side B

001 Cathleen Nixer, Nurse Manager, Psychiatric Inpatient Unit, Fairbanks Memorial Hospital: Many of the problems we face with the mental health system, is based on a premise that the mental health service delivery system in Alaska is decentralized, when in fact, it is not. When the Mental Health Law was passed in 1981, there was only one in-patient treatment facility in the state, A.P.I. Today, there still remains only one designated in-patient treatment facility in the state.

103 Nixer: The easiest way for a mentally ill person to receive treatment would be through the commitment process. They at least receive care why the legal process is taking place. It's sort of a Catch-22 situation, since we encourage people to accept voluntary treatment, yet we provide no funding for this treatment.

210 Moss: What is the average number of patients in the Fairbanks facility?

216 Nixer: Our average daily count runs around 7 to 8 patients. We have an 11 bed in-patient unit, with a proposal for 1985 for 17 beds.

270 Josephson: What is the longest patient stay you've experienced?

274 Nixer: Approximately 30 days.

305 Moss: Will the 17 beds be additional beds?

308 Nixer: Yes.

318 Moss: Are you receiving any federal funding?

326 Nixer: Sometimes patients are eligible for the standard medicaid programs. We would like to see patients who may voluntarily elect to seek their treatment after a commitment process in Fairbanks, which is close to their home.

458 Maureen Phillips, Board of NARA: The designated bed problem has come up in a recent meeting with the NARA Board. The University of Alaska health coverage for mental illness does not allow for patients to be admitted to anything other than a "designated mental facility", not designated medical floor a hospital. I feel it is important that something be done about the designated bed situation here in Fairbanks.

491 Josephson: That appears to conclude the testimony this afternoon. We will make minutes of this meeting available to our colleagues who are absent today. Thank you very much for coming.

538 Meeting adjourned.

Senate Health, Education & Social Services Committee
October 14, 1983
Anchorage

TOPIC: Mental Health Commitment Bill (Work draft of "An Act relating to the treatment of mentally ill persons.")

ATTENDANCE: Senators J. Josephson (Chairman), R. Halford
Excused - P. Fischer; Absent - V. Fischer, H. Moss

The hearing was commenced at 9:15 by Chairman Josephson.

Introductory remarks by Chairman Josephson:

Previously we've heard testimony in Anchorage and recently in Fairbanks on this issue.

This new draft incorporates ideas from Department of Health and Social Services, family groups and others, particularly those who work with troubled children.

New draft incorporates these changes: involvement of correction system is reduced in terms of dealing with the mentally ill; age change from 14 to 18; time computations changed from 21-90-120 days to 30-90-180 days for commitment periods; commitment period for minors changed from 21 to 30 days; records can be made available to law enforcement agency if substantial concern over any danger to community; qualifier added to right to privacy and personal possessions - if professional in charge determines not in the best interest of patient or will pose a threat to safety, visitors and telephone calls can be denied; approval of psychologist would be added requirement for patient wanting to change from involuntary to voluntary; court proceeding would be as informal as possible; family and guardians would be notified if patient is absent without leave; form consent required of parent or guardian of patient's right relating to alternative treatments; and notification of parent or guardian of discharge plan.

Other areas you may wish to consider today; hearings for minors; equal protection of the law relating to minors; time period commitment for minors; designated facilities; involuntary outpatient commitment; use of correctional system for mentally ill; and transportation costs for voluntary committed people where costs are paid for as required by statutes.

40 Jerry L. Schraider, M.D., Alaska Psychiatric Association

Appreciate the hearing being held, general reaction to working draft is supportive.

Have often been frustrated and confused over commitment law, mental health professionals are not all legalistically minded, don't have available legal counsel when working in these situations (often crisis situation) and must proceed best we can in interest of patient. Because of confusion, believes there's been some people that should've been committed who were not.

Will study draft further and hopes it will be submitted as legislation.

170 Ed Essa, Staff, Rep. Mae Tischer

Submitted letter addressed to Senator Josephson by Rep. Tischer stating that extensive research has suggested that nutritional deficiencies have a correlation with mental illness and that when deficiencies are identified and treated, improvements in the mental health of clients are made. Propose that the draft bill require extensive and mandatory nutritional analysis of each client be made upon admittance. This way the client is treated both mentally and physically.

190 Deborah B. Geeseman, M.D., private psychiatrist (formerly did work with children at API)

Supports most of what's in the bill. Suggested minor changes - 1) Pg 5, ln 19; instead of "21 days" should be 30 days. 2) Pg 4, ln 7; "the person" should be self.

Need a better working relationship with police force and understanding of what goes on with commitment laws.

Admission of minors - child under 14 cannot remain in hospital for evualation or treatment for no more than 21 days (under current law) without having a commitment hearing. An adult who wants to be voluntary committed may stay in hospital as long as they want or treatment facility deems necessary. Then if they want to leave hospital, it becomes a legal issue.

For children, often a good evualation cannot be made until after 3-4 weeks. Limited resources are available for treatment of children in Alaska. Only have one facility for extensive psychiatric treatment. Have some facilities for conduct and behavorial management of children (but full and have a waiting list).

260 Supports change in age from 14-18.

Pg 2, lns 23-29; not sure you need any of these three criteria, one just needs to make sure the person is mentally ill or gravely disabled. Or if it remains in #3 (pg 3, ln 1) should be "deteriorate further if" not "treated" (add not to sentance).

290 Sen. Josephson - While at API you noted that severe psychosis does not appear that often below the age of 14, correct?

Yes.

Sen. Josephson - What additional facilities do you feel Alaska needs for young children?

Difficult in state with our small population and distance from other states (where we could jointly share use of facilities). Presently we don't have a sizeable population of psychiatric young children. When we do, they will need a place, the only facility we have now is API. Would like to see other facilities that would address more extensively psychiatric needs of children.

PART II

As draft now stands, court has to get involved in 30 days, recommends 30 days be taken out, child could be a voluntary patient.

Many times children need evualation when they encounter s me trauma (ex: divorce of parents). If that evualation goes beyo d the time limit set, they could end up with commitment as legal statement on their record. If it remains on their record, can hamper their future.

Pg 3, Section 47.30.695; support it but has trouble with the wording. #2, lns 18-21, part (a)(b) (lns 22-29) - believes it to imply if child is dangerous, can still discharge them against medical advice. Dosen't feel its consistant. #2, ln 18; should read "treating physician," release of (should be added) "the minor" would be seriously detrimental to child's health that (should be added) "the treating physician may". (b) lns 26-29 the minor is likely to cause serious harm to self or others, or there's reason to believe the release could place the minor in immediate danger (should be added) "refuse to discharge".

60 Joseph Reum, Handicapped Services Coordinator, Municipality of Anchorage

Pg 4, ln 26 - "commitment hearing, to be held if needed", Who determines need?

Sen. Josephson - Depends whether patient is voluntary or involuntary.

80 Dr. Conrad, Superintendent, API

Submitted memorandum on admission statistics for FY'83.

Out of 1013 admissions, 500 were voluntary, 36% came involuntary under Title 47. Out of 100 involuntary patients, 73% have dropped out of involuntary channel before 72 hour limit.

Agree with Dr. Geeseman's comment on page 3 that paragraph 2a is inappropriate, not allowed that option with an adult.

Under present statute, cannot release information on history of violence to law enforcement agencies. In our judgement, release of this information (when there's concern about safety) might be helpful.

140 Patient would be better served by expeditious entry into treatment using physician's certificate. Most times used is after a suicide attempt.

150 Sen. Halford - In analysis of American Psychiatric Association guidelines, we don't allow certain types of evidence, we protect communication between patient and doctor. What kind of a problem does this bring up in involuntary commitment?

Has caused a problem by not allowing hearsay evidence at commitment hearing. Often it's highly relevant and meaningful evidence but due to rules of evidence not allowed because it's hearsay.

180 Often relatives and other people are frightened to testify for fear the person being committed will hold a grudge or seek revenge later. Also consider some people (to testify) live far away (would be expensive for transportation cost).

200 Sen. Josephson - What happens during, example a domestic conflict and people exaggerate testimony or state it falsely?

When it does occur, then don't rely on element of danger but fall back on object of evidence of mental illness. Do not proceed to commitment hearing if lacking evidence of mental illness.

210 In vast majority of cases, most do not go forward to hearing, and where there is mental illness, majority of patients accepts need for treatment. When cases do go to court, public defenders and probate masters become very involved.

240 Sen. Josephson - What is treated as confidential?

Commitment hearing itself is confidential.

260 David D. Samson, M.D., Psychiatric Supervisor, Anchorage Community Mental Health Center.

Mentally ill are more prone to be brought in for disturbing peace, public nuisance kinds of things, where their liberties are not essentially protected.

Concept of outpatient commitment should be addressed. What do you do when outpatients don't show up for their scheduled appointments?

Generally supportive of draft and comments that have also been made.

PART III

Voluntary medication on outpatient is a problem. Sometimes people are crafty enough to manipulate the system and be released (these are the dangerous ones).

30 Natelie Gottstein, Executive Director, Alaska Mental Health Association

Commends Committee for making changes, particularly inclusion of physician to be able to institute commitment procedures and redifinition of gravely disabled.

Pg 2, ln 10; concerned about definition of "timely", what's considered timely?

Dr. Conrad - Would interpret to be 8-12 hours.

70 N. Gottstein - Pg 16, ln 5; definition of mental health professional - important people working in the bush (social workers, etc) be included in this definition. A further clarification of social worker might be in order due to so many areas of social work.

90 Sen. Josephson - There's another bill on licensing of social worker and we may run into some difficulty with that.

100 Sen. Josephson - Is there an official position by Mental Health Association on this?

Not on this, but we will make recommendations before January.

110 Sen. Halford - What does Association think in terms of communication between doctor and patient, should be available in commitment hearings or not?

Don't have an official position. My opinion - if hearings are closed, then in very specific and well defined instances, that privilege should be opened. In individuals right to receive treatment, the doctor's opinion certainly is an important matter.

150 Sen. Josephson - Question of changing or relaxing rule of confidentiality, would it have the effect of causing people not to tell doctors what they would otherwise say? Or would it have a useful affect in bringing these matters out into the commitment hearing? The real danger would be if patients refused to give information to their doctors for fear it would be used against them (in court). That people shouldn't be afraid to see a psychiatrist when they have problems.

These relaxations in confidentiality need to be carefully worded, possibly be limited to psychiatric people for involuntary commitment.

200 Dr. Jay Verkozen, clinical psychologist (private practice)

Pg 13, lns 27-28; issue of psychosurgery, lobotomy, or other comparable forms of treatment. Not specific with other comparable forms. Consider these types of barbarisms and should be done away with. Psychosurgery has been abused.

PART IV

80 Sen. Josephson - (to Dr. Conrad) Has there been any record keeping in Alaska of psychosurgery or lobotomy given?

Dr. Conrad - No, the only way would be to ask all the neurosurgeons. Electroshock - no one to my knowldege at API has been administered with it.

J. Verkozen - But it does go on regularly at Providence.
Pg 14 lns 19-23; suspension of people's rights; if you're going to do something to someone, need to be clear about it with the person and if it's not in their interest to know about it, then it shouldn't be done.

150 You can't treat people psychologically unless you get them involved in it. If somebody might be better off with something, it dosen't mean you can force it on them.

170 Pg 8, ln 20 (#4) "efficient" - efficient for what? For commitment? For civil liberty?

250 Pg 8, ln 15 (#2); Right to view and copy all petitions - they should be given copies and helped to understand it.
Pg 12, lns 25-27; good point that family or guardian be notified on patient's absence.
Pg 11, ln 14; Disagree with 180 days for commitment, more advantageous for longer length of time.
Pg 5, ln 22; "gravely disabled" - too broad.
Pg 6, lns 4-5; replace "maximum extent possible" with absent of violence.

PART V

Dr. Conrad - Two cases of patients at API treated involuntary: 1. if violent to themself or to others; 2. severly catonic people (who don't eat or drink)

J. Verkozen - Pg 6; objects to (e)(2) and (3) lns 14-18; aren't necessary.

Pg 13, ln 9; objects to 72 hours, procedure should be speeded up rather than be long.

Pg 4; notion of deputizing all physicians in state so they can commit someone. This authority should stay with the police. All physicians shouldn't have this type of power. You're just making a cosmetic change, you're still locking someone up.

80 Dr. Glade Birch, Acting Director, Anchorage Community Mental Health Center

It's a good document.

Balance of right of people to receive treatment and their civil liberties. That's the balance we're maintaining.

Regarding who has the authority to commit someone, remember we're talking about all Alaska (including the bush). Physician does have degree of training in recognizing mental illness, where police officer dosen't. To protect civil liberties of people, it's better for at least someone qualified in mental health to make determination of commitment.

As a neuropsychologist, be very careful before you write into statute prohibitation against treatments.

150 Individuals released as outpatients from API, isn't a comfortable solution to it. You may consider transitional living (intermediate type of commitment). (A transitional facility where they could receive supervision.)

Has reservations about having licensed social workers being able to commit someone (pg 4). You may get a social worker who has no actural diagnostic abilities.

180 Topic of confidentiality. Two solutions: 1) treatment (must maintain confidentiality in this); 2) examination with notice for commitment (person knows it is commitment, does not have to disclose information, takes away effectiveness of examination).

190 Sen. Josephson - What a person discloses when he wants treatment is going to be in stream of what is revealed in commitment process, no way to unlearn that material.

That's why I tried to make the distinction. The disclosure of patient's statement when presenting himself for treatment needs to be protected. If someone is going to testify at commitment proceeding, may have to be a separate examination by another person.

200 Steve Harrison, Regional Administrator for South Central Region, Division of Mental Health

Agrees with Dr. Birch in including mental health professional in emergency detention. If we use a mental health professional, we should use those with national accreditation for social workers.

Law is workable, changes are good.

240 Frances Purdy, Mental Health Program Coordinator, Behavorial Health Division, Municipality of Anchorage

Thanks for nonsexist law.

Pg 3, Part a; lns 22-25 should be deleted, they should not be able to release someone who is dangerous.

Pg 12, lns 25-27; good idea to notify parents or guardians of patient's absence. May also want to add anyone that has been threatened by patient, also may add immediate notification instead of 3 hours.

Pg 14, lns 24-27; good idea.

Consider what other states have done with mental health professional being the office of involuntary commitment. Probably more important for Anchorage than for the bush. Impractical to have officer in bush for involuntary commitment. In Anchorage, specifically we're beginning to need an area of expertise in just emergency cases. Check into Washington state statutes. They have designated person who is trained to do reading of rights, is impartial, not hired by institution or other agency.

PART VI

Jim Parsons, Manager, Behavorial Health Division, Municipality of Anchorage (former member of licensing board of psychologists)

Concurs with Purdy's opinion of release of minors when we don't do that with adults.

Most of my concerns have been covered.

Pg 16; licensing law for psychiatrist is generic rather than speciality. There are some psychologist trained in areas other than clinical who may not have expertise in mental illness at all. May be a good idea to say licensed by state with adequate clinical training or something similar rather than clinical psychologist since we don't license in that sense.

Mention of social workers appears to be too broad. Perhaps should use national accreditation with it. Too broad to say experienced in field of mental illness rather than having some type of specific training in that area.

30 Cecilia Kleinkauf, Alaska Chapter, National Association of Social Workers

Pg 16; issue of professional social work, as included in definition of "mental health professional" - just received the draft copy and will have to be reviewed by board before Assoc. takes a position on it and makes recommendations.

Admission of minors at API - the bill, as it is, would constitute age discrimination on state in regards to minors. Minor has a constitutional right to liberty equal to adults. Unconstitutional to deprive minor of right to liberty for a greater amount of time than an adult (in institutionalizing). We have repeated this point at every hearing.

One item not covered in bill is protection of court for child's right regardless of his/her parent's right. Does not provide the child the right to a court hearing which court then hears evidence as to institutionalize the child. The bill leaves the right to child's parents and to mental health professional. Sometimes parents don't act in best interest of their children.

120 There are a number of children institutionalized at API whom mental health professionals say these children are not probably mentally ill but "there's no place else to put them".

The previous director of State Division of Mental Health testified at Senator Parr's Committee stating it is frequently difficult, if not impossible, to make definitive diagnosis with respect to mental illness in children.

130 Sen. Josephson - Which is an explanation as to why we have a longer period to evualate. I don't think the Constitution requires that you cannot make classification if there is a rational basis for it.

250 Why is it ok to institutionalize a child without court's protection in mental illness, and in statutes of state, it's not ok to institutionalize without court's protection when it comes to delinquincy?

PART VII

50 Grandfathering clause on social worker - the language and amendments proposed by National Association Social Work Chapter. Only spoke to baccalaureate level of social work. Individuals will not be grandfathered at master's level of social work with training in any other field. Anyone who is grandfathered, who wishes to be called a social worker and be licensed under social work law, could at maximum, only be licenses as a baccalaureate level. Only level grandfather amendments refer to.

60 Meeting was adjourned by Chairman Josephson at 12:50 pm.

BARANOF MENTAL HEALTH CLINIC

POST OFFICE BOX 1180
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(907) 747-8994

STANLEY T. LAUGHRIDGE, PH.D.
CLINICAL PSYCHOLOGIST

12-16-83

Honorable Joe Josephson
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Senator Josephson:

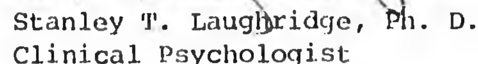
I have read the proposed draft bill that you are submitting to the legislature in the forth coming session. It contains precisely those very important amendments and stipulations that I have been trying to encourage for a number of years regarding mental health commitments.

If you will check the admission record of Sitka over the past six and a half years, that our clinic has been here; you will see that we have an extremely low admission rate. This is because we have treated people in our local hospitals rather than sending them to API. Often in doing so we have had great difficulty getting under the 72 hour limit before having to go into the court room. Usually within 72 hours, I am able to obtain the person's voluntary commitment but on those few cases where I am not able to do so we end up sending some to API that we could very c[illegible]ly have treated in our local hopitals.

Your bill will very nicely resolve that problem and should, if we in the mental health field do our part, reduce the admission rate to API dramatically.

Congratulations on your good work.

Cordial regards,



Stanley T. Laughridge, Ph. D.
Clinical Psychologist

cc: Joe Adelmeyer, ACSW Supervisor
Susan Will, R.N., M.S.

CORDOVA COMMUNITY HOSPITAL
MENTAL HEALTH AND ALCOHOL CLINIC

P.O. Box 160 Phone: (907) 424-7131
CORDOVA, ALASKA 99574

Oct. 27, 1983

Senator Joe Josephson
Alaska State Legislature
Senate
Pouch V.
State Capitol
Juneau, AK 99811

RE: THE MENTAL HEALTH COMMITMENT LAW

Dear Senator Josephson:

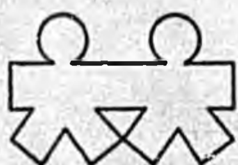
We urge you to incorporate the changes proposed by the Department of Health and Social Services and the Alaska Psychiatric Association and in particular the amendment to add licensed psychologists in changing procedures for emergency detention for evaluation in Sec.47.30.705.

In our experience the present state of things in which a peace officer must be convinced that there is probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to himself or others and should be taken into custody for evaluation is highly precarious. Just recently we had a case of a possible suicide and homocide situation in which help was delayed past a critical point because the peace officier did not believe the physician and licensed psychologist who were urging intervention. When it's a matter of arranging a flight before dark every minute is crucial. It is perhaps unfair to expect a peace officer to understand the dynamics of depression or paranoia without any particular training when years of post-graduate training and supervised experience are needed for a psychologist to do so. It is time Alaska made better use of the unique qualifications that psychologists do provide for intervention in and prevention of tricky situations.

Sincerely,

Judy Ringenson-Knutsson, Ph.D.
Clinical Psychologist

The Cordova Community Hospital



Central Peninsula Mental Health Center

P.O. BOX 4683 • KENAI, ALASKA 99611 • (907) 282-7501

February 1, 1984

RECEIVED

Senator Joe Josephson
Alaska Senate
Pouch V (MS 3100)
Juneau, Alaska 99811

Josephson

Dear Senator Josephson,

I am writing relative to Senate Bill No.346 related to certain revisions of Title 47 of the Civil Commitment Statutes.

I am strongly in favor of the revisions relative to admission of minors, changing the age from 14 to 18 years of age.

The procedure for emergency detention for evaluation is improved by allowing the mental health professional in addition to a police office to have an individual taken into custody. The procedure relative to placement or utilization of the jail for protective custody and holding prior to transportation is appropriate and is an accurate description of the need for rural areas such as Kenai.

I am also in favor of the use of a 30 day as opposed to a 21 day commitment procedure.

I sincerely appreciate the opportunity to comment on the revisions in this Statute.

Respectfully Submitted,

Paul E. Turner, Ph.D.
Clinical Psychologist
Program Director

PET/jvh

Ann DeNardo
Families of Chronically Mentally Ill
Victims
SR Box 30754
Fairbanks, Alaska 99701

Senator Joe Josephson, Chariman
Health, Education and Social Services Committee
Pouch V
Juneau, Alaska 99811

RE: Chronic Mental Ilness

Dear Senator Josephoson:

The enclosed article tells you who I am and what I am about.

During last week's teleconference with our Fairbanks legislators, I addressed short comings in Chapter 84, Laws of Alaska, relating to mentally ill persons.

1. Families should have a greater role in and be consulted with regard to commitment procedures.

2. A broader criteria for commitment should be studied, based on ability to function rather than just being a danger to self or others.

3. Commitment and guardianship procedures should be redefined with a view to creating a less adversarial situation between patient and family.

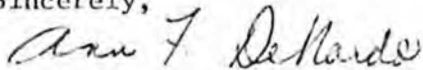
4. Mentally ill patients should receive better continuity of care as they move from hospital to community and commitment procedures should reflect this need.

In this week's teleconference we will address the glaring lack of hospital space for our chronically mentally ill relatives. While other states are grappling with problems of closed wards and community acceptance, Alaska struggles to get patients out of the corridors and into the wards! The only State facility, Alaska Psychiatric Institute, is perpetually overcrowded.

The Fairbanks Memorial Hospital is willing and able to become a designated treatment facility for psychiatric patients. I don't understand the mechanisms involved in such a designation and would appreciate your telling me. I do understand the urgent need for such a facility in the Interior.

I urge you to work toward this goal as a positive step toward a better mental health delivery system for the entire State of Alaska.

Sincerely,



Ann F. DeNardo
Families of Chronically Mentally Ill Victims

Enclosure

AD:aw

Families of CMI Victims
SR Box 30757
Fairbanks, Alaska 99701

RECOMMENDATIONS FOR AMENDMENTS TO ALASKA'S COMMITMENT ACT

The Commitment Act, Chapter No. 84, Laws of Alaska, has caused a great deal of pain to families already engulfed in an ultimate tragedy--the loss of a loved-one; loss through the ravages of a disease as old as mankind, and for which we know no cause or cure.

We are familiar with the Commitment Act on a experiential level and on paper and make the following recommendations for amendments:

1. Families should have a greater role in and be consulted with regard to commitment procedures.

2. A broader criteria for commitment should be studied, based ability to function when thought processes, perception of reality or judgement is substantially impaired.

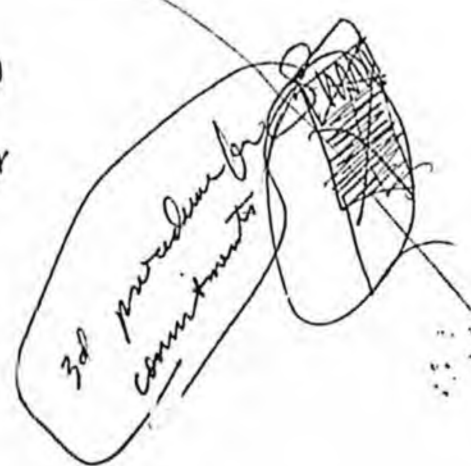
3. Commitment procedures should be redefined with a view to creating a less adversarial situation between patient and family.

4. Mentally ill patients should receive better continuity of care as they move from hospital to community and commitment procedures should reflect this need.

5. The courts, the judiciary, should be better apprised of the mental health system.

The above five points are overall conclusions. Some specific changes by page, section, and line were given in testimony before Senators Josephson and Fisher of the Hess Committee in Anchorage on March 19, 1983.

The above five points are still pertinent and present a good summary of the attached material presented in testimony before the HESS committee on September 23, 1983, in Fairbanks, Alaska.



TESTIMONY BEFORE THE SENATE HESS COMMITTEE
Re: Mental Health Commitment Law
September 23, 1983 - Fairbanks, Alaska

The families of severely mentally ill victims have worked with the Mental Health Commitment Law for two years. We wish to convey our position regarding the bill.

Section 47.30.660. This section sets out the powers and duties of the Department of Health and Social Services. Paragraph (4) of this section calls for the Department to designate, operate and maintain treatment facilities...to provide...care and treatment for the mentally ill. A treatment facility is defined in 47.30.915(15). In spite of the directive to designate treatment facilities, the API remains Alaska's only such facility.

Section 47.30.670. This section sets out standards for voluntary admission. A patient who accepts voluntary admission can leave the hospital anytime "against medical advice," or AMA. This is why there are so many voluntary admissions as opposed to involuntary. A psychiatrist might do a screening at this point to determine a patient's ability to function and make these decisions.

Section 47.30.705. This section addresses emergency detention for evaluation. It states that a police officer"...may cause the person to be taken into custody and delivered to the nearest evaluation facility. A correctional facility may be used as an emergency evaluation facility if an evaluation facility is not available... (and) the peace officer shall...be interviewed by a mental health professional at the facility." There are no mental health professionals at the correctional facilities.

Section 47.30.710. Examination. This section states that a person so placed in a correctional facility shall be examined and evaluated within 24 hours. This puts a person in jail for 24 hours because of an illness he cannot control. There is no other illness where, due to the illness itself, a person is incarcerated!

Section 47.30.715. Acceptance of Order. In this section the court is ordered to set a date for hearing and notify the respondent's attorney. There is no directive for the attorney to make an effort to see the respondent. Often the first contact the respondent has with his attorney is in the courtroom itself, immediately preceeding the hearing.

Section 47.30.735. This section sets out the civil procedure for a 21 day commitment. These procedures should be redefined in order to create a less adversarial situation between patient and family. Families become the caretakers following hospitalization in 50-55% of the cases. It is important to understand that hospitals do not cure patients. They are only stabilized with neuroleptic medications and returned to the family with their illness in tact, and the added belief that the family has turned against them.

Judicial procedures are either civil or criminal. Commitment procedures are civil. Families feel it might be possible to create a new area within which commitments could be handled. We request the Judiciary Committee to study this concept with a view toward lessening the adversarial approach.

Section 47.30.790. This section deals with absence without leave. If a patient is absent from a treatment facility without authorization a peace officer is instructed to take the patient into custody and return him to the treatment facility. This section should include a provision that the family or guardian be notified of such absence with a specified time, say 3 hours.

Section 47.30.795. This section addresses involuntary outpatient care. Paragraph (c). It states that if it is determined that respondent needs inpatient care due to a critical condition, oral and written notice that he must return to a treatment facility within 24 hours must be given him. If the patient is experiencing thought disorder this gives him 24 hours to get out of town. This section further states a police officer shall pick up the patient if he has not complied with the notice. The respondent is not a criminal, to be served and treated as a criminal. We object to the constant posture of addressing mental disease as criminal.

Section 47.30.825. This section deals with patient rights. Paragraph (6) of this section prevents psychosurgery, lobotomy, or other form of treatment without specific, informed consent of the patient and a court order. We would like to see a provision included that would also require specific informed consent given by "an adult designated in accordance with 47.30.725". (This is an adult designated by the respondent.)

Again, paragraph (8) of this section should insure a copy of the discharge plan is given to "an adult designated in accordance with 47.30.725". Families rarely know of any discharge plan and it is the nature of the disease that patients will not follow through without help.

Section 47.30.845. This section deals with confidential records. Paragraph (2) of this section makes it possible for an individual to whom the patient has given written consent to receive records and information on the patient. This release of records should be dated within a specified time period,-say-one year. This release of records to a designated individual should not be open-ended, but lapse within a restricted time frame.

Section 47.30.870. This section deals with transportation of patient and escort to the designated facility following involuntary commitment. (In this State, of course, this means a trip to Anchorage.) There is provision authorizing the Department to pay for transportation of patient and escort the API for INVOLUNTARY commitments only. Provision should be made to authorize payment of transportation costs for VOLUNTARY commitments as well. At present the family, or the patient, must bear this cost. This creates a continuing financial burden for families trying to remain "case manager" over the years. The continuing financial burdens encourage families to give up attempts to maintain relationships beneficial to the patient.

Section 47.30.875. This section addresses nonresident patients and the return of a mentally ill resident of this state who has been placed in a facility outside of this state. Paragraph (c) of this section is the only section of this Act which mentions the importance of maintaining family relationships and encouraging visits beneficial to the patient. It is ironic that this important approach to treatment is mentioned only under such subtitle as "nonresident patients". We would like to see the encouragement of more family involvement.

Section 47.30.915. Definitions. Paragraph (7) defines "gravely disabled" and paragraph (10) defines "likely to cause serious harm". It is the contention of everyone involved with this Act that these definitions must be broadened. This is such a complicated and emotional issue that agreement is difficult. As a consequence many people who need mental health treatment desparately are not being served. Instead of waiting for a person to commit a crime, or attempt to commit a crime, we recommend the following criteria to enlarge the definition of a mentally ill person for purposes of providing treatment:

> (7) "gravely disabled" means a condition in which a person, as a result of mental illness,...
> (b) or is not receiving such care and mental medical treatment as is necessary for health and safety, or (c) a person whose thought processes, perception of reality or judgement is substantially impaired.

2 or 3 other states

We would like to see a study of other states' commitment laws in reference to their criteria for commitment.

ALASKA PSYCHIATRIC ASSOCIATION

ALASKA DISTRICT BRANCH
of
AMERICAN PSYCHIATRIC ASSOCIATION

February 4, 1983

Senator Joseph Josephson
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

The Alaska District Branch of the American Psychiatric Association is a professional organization which represents the majority of the physicians in Alaska who are specialist in the field of psychiatry. The membership is composed of psychiatrists who work in both the private and public sector. The members of our organization have an ongoing interest in any subject which affects the treatment of mentally ill individuals. As a result of this interest we were actively involved in the development and passage of the Alaska Statute for the Civil Commitment of the Mentally Ill (AS 47.30). Our national organization has also been very active in monitoring the subject of civil commitment and has recently developed guidelines on this subject which we recently provided you.

The Alaska District Branch supports fully the objectives of the current Alaska Statute on Civil Commitment of the Mentally Ill which became law in October of 1981. After the first year of experience with this new law and after discussion with judicial and civic leaders, we wish to recommend certain amendments to the law which we believe will assure that its worthwhile goals are more effectively achieved. These amendments are provided in the enclosed material.

The experience during the past year has indicated to us that the following refinements are needed:

1. The Definition of "Gravely Disabled" needs to be expanded to recognize that some patients, if left untreated, will needlessly lose their capacity to be self-reliant.

2. There are many instances when physicians have clearly psychotic or suicidal persons under care in an emergency setting, and need to arrange for their hospitalization at the Alaska Psychiatric Institute. The current requirement that a peace officer be called to form an independent judgement and duplicate work already accomplished is unnecessarily cumbersome. Allowing the physician the authority to arrange for emergency detention would simplify this procedure. When family and friends are willing and able to transport the patient, the peace officer would be free for more serious business.

3. The patient and society could be better served if the rules governing evidentiary and procedural matters at commitment hearings under this law were promulgated so as to facilitate a more informal and efficient presentation of all the relevant facts.

4. The definition of "likely to cause harm to self and others" has set such a rigid standard that some of the most dangerous clients have not been committed. The issue of dangerousness is a complex one and the judge must be given the opportunity to weigh both the magnitude of the risk and the magnitude of the harm. Also, the law needs to recognize that harm to others may include property.

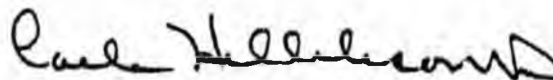
5. An unanticipated consequence of the current law, has created an undue hardship in the care and treatment of children under the age of 14. The right to be voluntarily hospitalized and treated, which is available to everyone over the age of 14, is curtailed for children and limited to 21 days. After 21 days, even if the parents, the child, and the treating physician agree that continued treatment is needed, the law forces them to obtain an involuntary commitment.

6. Since very few persons actually require involuntary commitment, it would facilitate their care and treatment if the law recognized that patients in this group lack the necessary understanding to accept treatment voluntarily, and authorize the use of medications and other treatments under the direction of a licensed physician subject to the medical rights already guaranteed the patients in Article 9 of Section 47.30.

7. In some instances the law requires the staff of the hospital to respond "immediately" when, in practice, a "timely" response is all that is practical or needed.

As we gain experience with the new commitment statute, I am sure we will have other suggested changes. However, for the present time, we feel these changes are urgently needed to iron out some of the procedural problems and to improve the care and treatment of the mentally ill. We would be happy to provide any additional documentation you may need. We hope you will consider putting the attached amendments in bill form and submitting them to the Legislature.

Sincerely,



Carla Hellekson, M.D.
President
Alaska Psychiatric Association

CH:mm

Alaska State Legislature

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House of Representatives
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

POUCH V
STATE CAPITAL
JUNEAU, ALASKA 99811
(907) 465-3777

October 12, 1983

The Honorable Joe Josephson
Member of the Alaska State Senate
Anchorage, Alaska 99501

Dear Senator Josephson:

Thank you for your kind offer to submit a suggestion to your committee during deliberations on the "Mental Health Commitment Law," scheduled for Thursday, October 13.

I am sorry that House HESS hearings in Fairbanks prevent my discussing this matter with your committee personally; however, I have asked Ed Essa to present this letter to you for your consideration.

In recent years, medical science has come a long way in better understanding mental illness. Research has uncovered some very interesting facts. Perhaps the most intriguing discoveries relate to the effects vitamin and other nutritional deficiencies have on our mental well-being. Extensive research has suggested that nutritional deficiencies have a correlation with mental illness, and that when deficiencies are identified and treated with vitamin therapy, some startling improvements in the mental health of clients are made.

Given this information and with the knowledge that our mental health is tied intricately to our physical health, I am proposing that the draft bill you are considering be adapted to require an extensive and mandatory nutritional analysis of each client upon admittance; and that these findings be used as the basis for appropriate intensive theraputic treatment, along with other applied therapy. In this way, the whole client is treated -- both mentally and physically.

Your favorable consideration of this suggestion may well serve to improve the methods of treating many Alaskans who want to be healthy, while helping to induce a marked decrease in the recurrence of mental illness.

Senator Josephson, thank you for extending me the courtesy to be heard today. I join with many others in seeking a continued dialogue on this encouraging new approach to a long-standing and seemingly worsening

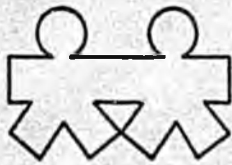
problem that faces our state and our nation.

Respectfully,

Mae Tischer
State Representative

MMT:wtl

Send to Nancy ✓



Central Peninsula Mental Health Center

P.O. BOX 4683 • KENAI, ALASKA 99611 • (907) 282-7501

October 25, 1983

Senator Joe P. Josephson
1526 "F" Street
Anchorage, Alaska 99501

Dear Senator Josephson,

I am writing to you relative to recent Senate HESS Committee Hearings on the Title 47 Commitment Statute.

I am writing to request that licensed psychologists be given the same prerogatives as physicians within the Statute. For example in 47.30.705, the recommended change is that emergency detention for evaluation can be made by a police office or a physician. Generally, however, licensed psychologists are much more able in terms of training, expertise, education and practice to be able to make determinations of need for emergency detention. It would seem wise to include this independent profession in this activity. There are also other sections that are being amended in Title 47 adding the medical profession as the identified entity, for example 47.30.815(b)(4). In those instances I think that clinical psychologists should also be included.

Thank you very much for this opportunity to correspond with you relative to this issue.

Respectfully,

Paul E. Turner, PhD

Paul E. Turner, Ph.D.
Clinical Psychologist
Program Director

RECEIVED
1983
Josephson

PET/jvh

Send to Nancy ✓

RECEIVED
1983
Josephson

Oliver Osborn, M.D.
Cordova Medical Clinic
Box 310
Cordova, Alaska 99574

Nov. 5, 1983

Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson,

I am writing in regard to the proposed changes to the Mental Health Commitment Law. My concern is that the proposed law will not allow a licensed psychologist in Alaska to initiate emergency detention for evaluation (under sec. 47.30.705).

Here in Cordova, our health team includes a licensed psychologist working in a mental health clinic which is a department of the hospital. The psychologist is often the person most immediately involved with patients who might be a danger to themselves or to others. It is imperative that this professional be allowed to initiate emergency detention for evaluation in cases with serious potential. It has been our experience that the psychologist often works closely with the local police department to defuse crisis situations in Cordova.

Thank you for your attention.

Sincerely,

Oliver S. Osborn MD

Oliver s. Osborn, M.D.
Member, Cordova City Council

COMMUNITY MENTAL HEALTH CENTER

Box 2274
Homer, Alaska 99603-2274
(907) 235- 7701

October 25, 1983

Senator Joe Josephson
1526 "F" Street
Anchorage AK 99501

Dear Senator Josephson:

It has come to my attention that the Senate Health Education and Social Services Committee is reviewing Alaska's Mental Health Commitment Law of 1981 (SP100). I am essentially in support of the changes which have been proposed.

Under Section 47.30.705 regarding emergency detention for evaluation, I would recommend the following addition to the revised statute:

> "A peace officer or a physician licensed in this state or a psychologist licensed in this state who has probable cause to believe that a person is suffering from a mental illness and is likely to cause serious harm to the person or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken in to custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while needing transportation to a treament facility. The peace officer or physician or psychologist shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility."

In addition, I would recommend that AS 47.30.815(b) (4) be further ammended to read:

> "A peace officer or physician or psychologist responsible for detaining or transporting a person under AS 47.30.700-47.30.915."

Alaska has a pool of well qualified psychologists whose competency and training have been carefully scrutinized by the Board of Psychologists and Psychological Associate Examiners as well as the Division of Occupational Licensing. Insofar as many rural mental health practitioners in the state are licensed psychologists, it would seem appropriate and expedient to include this professional group in the emergency detention clause. With regard to

familiarity with psychiatric disorders, conducting mental status evaluations, and determining the appropriateness of civil commitment, licensed psychologists are well prepared to handle the responsibilities involved in civil commitment in a professional manner.

Thank you for considering this input to the legislative process. I appreciate your consideration.

Paul L. Craig, Ph.D.
Psychologist, Director

PLC: cjs

ALASKA PSYCHIATRIC ASSOCIATION

ALASKA DISTRICT BRANCH
of
AMERICAN PSYCHIATRIC ASSOCIATION

February 15, 1984

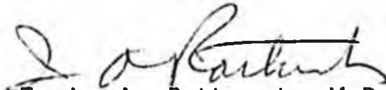
The Honorable Joseph Josephson
Alaska State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

At a recent meeting of the Executive Committee of the Alaska District Branch of the American Psychiatric Association this group voted to support your bills regarding changes in the involuntary hospitalization statutes and also the bill which you have submitted requiring parity coverage for psychiatric services by insurance companies doing business in the State of Alaska. It was the wish of the Executive Committee that I write you and notify you that we strongly support you on both these issues.

Thank you very much for introducing this much needed legislation.

Sincerely yours,



Irvin A. Rothrock, M.D.
President, Alaska District Branch
American Psychiatric Association

IAR:bw

ALASKA MENTAL HEALTH ASSOCIATION

2611 Fairbanks Street, Suite A
Telephone 276-1705

Anchorage, Alaska 99503

A Division of the National Mental Health Association

March 6, 1984

RECEIVED

MAR 19 1984

Josephson,

Senator Joe Josephson
Pouch "V"
Juneau, Alaska 99811

Dear Senator Josephson:

The Alaska Mental Health Association commends the Senate HESS committee for undertaking the review of the Mental Health Commitment Statute. As you know, implementation of the current Statute which was enacted in 1981 has revealed some major problems which the current bill addresses. We wholeheartedly support this effort.

Our concern is that the mentally ill of Alaska receive the best available treatment in a timely manner, in their home community or as close as possible. We believe the procedures established by this Statute must protect individual civil/human rights AND provide for the protection of society. These goals must be accomplished in a manner that recognizes that the primary purpose of this statute is to enable individuals who are mentally ill to receive appropriate treatrent. On the whole we believe the Bill does this quite well.

When we consider that mental disease is today's most common disabling condition, one of its least understood, one of its most difficult to treat and yet, the major disease group we spend the least amount of research dollars to study, we can see why the central purpose of the Statute must be to provide care and treatment.

We believe that the current Statute needed to be reviewed and improved. Before commenting specifically on the proposed changes in the Statute, we would offer the following proposal:

> Since one of the original purposes of the Statute was to provide for evaluation and treatment as close to the individual's home as possible, we suggest the Legislature conduct a study of the commitments during the past year to determine whether or not this purpose is being met. Another important purpose the Statute attempted to include was to provide for a timely judicial review and supervision of the commitment process. The study should also focus on the actual length of time required for judicial involvement.

With respect to some of the specific proposed changes, in AS 47.30.655-915 we have the following comments and suggestions:

#1 AS 47.30.690 Admissions of minors, line 12:

The limitation on the involuntary admission of a minor should be increased to 60 days. It is generally recognized that therapy with minors, when hospitalization is necessary, requires a longer average length of stay than do adults. Even this requirement will place a needless burden on the facility and the parents if they live in remote portions of Alaska.

#2 Sec. 47.30.705 Emergency detention for evaluations - Line 3:

The extension of the emergency detention's powers to all "mental health professionals" has both advantages and disadvantages. It greatly expands the numbers of people who will have the power in the bush areas. This will create the kind of flexibility that is needed to provide timely and local action. The disadvantage is that many, if not most, non-medical mental health professionals have not received training or experience in the legal and clinical issues involved in the commitment process. As a consequence, we recommend that these powers be somewhat more limited. The law should limit this power to (i) peace officers and (ii) physicians and mental health professionals who have had sufficient training to properly perform this function. In conjunction with this, we would like to see the establishment of a system to train and designate "mental health professionals" who will have the expertise to exercise this function. Although this will require an additional state expenditure, it should not be prohibitive.

#3 AS 47.30.730(b) - 30 day commitment, line 26:

The extension of the commitment to provide 30 days of treatment is recommended because it is a reasonable length of time considering the seriousness of these disorders.

#4 AS 47.30.735(b)(4):

The attorney member of our Board of Directors informs us this section does not make sense because the rules of civil procedure and evidence would not be "informal but efficient presentation of evidence" in that they are formal rules. It appears the intent is for the respondent to be given a choice between (i) the formal rules of evidence and the rules of Civil Procedure and (ii) an informal set of rules. The draft we have reviewed does not make this at all clear.

#5 AS 47.30.845(7) - Confidential Records, Line 7:

We feel that the "presumed mentally ill person" standard is (i) not defined and (ii) too broad. "Presumed" by whom? What does "presumed mentally ill" mean anyway? If the intent is to release records of former mental patients, that is what should be stated. If the intent is something else, that should be stated. In any event, the standard should be in language that is susceptible to clear interpretation and implementation.

#6 AS 47.30915 (7) - Definition of "gravely disabled":

We strongly support the passage of this amended language as many psychotic patients' symptoms prevent them from seeking the treatment which may restore them to a nearly normal state of mind.

#7 AS.47.30.915 (10) - Definition of likely to cause serious harm:

We strongly recommend the amendments to this section since, in our opinion, the former language created a "standard" which was too restrictive and led to persons being released who were actually dangerous.

Sincerely

Dr. Jerry Schrader
President

ALASKA MENTAL HEALTH ASSOCIATION

2611 Fairbanks Street, Suite A
Telephone 276-1705
Anchorage, Alaska 99503
A Division of the National Mental Health Association

February 29, 1984

Senator Joe Josephson
Pouch V
State Capitol
Juneau, Alaska 99811

Dear Senator Josephson:

On February 15, 1984, I was involved in an emergency commitment situation which occurred at approximately 4:30 p.m., and which I think exemplifies one of the basic problems with the current commitment law. A patient came to the Fairbanks Community Mental Health Center for treatment and expressed an intent to kill herself. After evaluating her, the mental health professional called Carol Davis, the Probate Clerk who ordinarily handles these cases for the Magistrate. Ms. Davis stated she could not order an involuntary emergency commitment after hours because she could not do the paperwork. She would give the order if a physician at the hospital requested it. She advised the Center to call the police and have them exercise their authority to Emergency Commit the patient.

When the municipal police arrived, they said they knew they could commit, but refused to exercise their power because it is their agency's policy to avoid this responsibility except when they "encounter" a person in the usual course of their duties. They appeared to feel that the court system was "dumping" the responsibility on their shoulders after hours.

As you know, under current law, neither the mental health professional or a physician can act in this type of situation alone. In fact, the policemen involved were aware of this and also aware that they were the only ones empowered to act alone. Needless to say, this stalemate tied up the mental health professional - who was forced to cancel other patients - the court representative, and the police. It was finally resolved by an extra-legal (in my opinion) act. The police officer said that he would transport the patient to the Fairbanks hospital emergency room if the emergency room doctor would agree to see her and, in effect, authorize the involuntary transport. This freed the Center to resume its activities and seemed to shift the responsibility to the hospital.

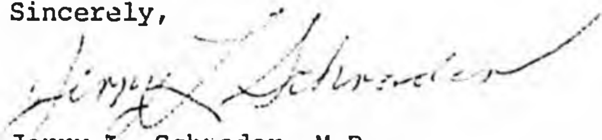
I think you can see that the Mental Health Center and the patients are caught in a kind of territorial dispute between the municipal police and the court

system. Since both of these systems feel free to operate independently, the "system" of care breaks down. It results in one emergency commitment system for 9:00 a.m. to 5:00 p.m., and another for 5:01 p.m. to 8:59 a.m. A similar stand-off has occurred in Anchorage, although the situation in Fairbanks is more complicated because the system must depend upon a private hospital.

The provision in the revised commitment bill which reinstates the physician certificate (or mental health professional certificate) would alleviate this this problem.

It would also be alleviated if the courts and the police would work cooperatively.

Sincerely,



Jerry L. Schrader, M.D.
President, Alaska Mental Health Association

cc: Chief Mathew Kiernan
Charles M. Mac Gibson
Phyllis Vanairsdale

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

POUCH H 04
JUNEAU, ALASKA 99811
PHONE:

DIVISION OF MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES

March 6, 1984

The Honorable Bill Sheffield
Governor
State of Alaska
Pouch A
Juneau, AK 99811

Dear Governor Sheffield:

Your Mental Health Advisory Council has been following the developments of Senate Bill Number 346 amending an Act entitled: "An act relating to the treatment of mentally ill persons." We are aware that many public hearings have occurred prior to its introduction January 11, 1984 by Senators Josephson and Halford. Additionally, individual professionals, the Alaska Psychiatric Association and the Alaska Psychological Association have had consultation and input into these revisions with strong support for these amendments. These amendments are thought to represent improvements in the treatment of adolescents and adults from the standpoint of both providers and consumers.

Your advisory Council heard today that this bill is being held "hostage" pending untold bargaining possibilities. Since these amendments would improve the quality of care and likely result in more efficiently and less cost for both the Mental Health and Judicial Divisions, it seems unfortunate to delay its enactment.

Your Mental Health Advisory Council recommends your support for the quick passage of this act. On behalf of all Council Members thank you for your consideration.

Sincerely,

Herbert G.W. Bischoff, Ph.D.
Chairperson

Council Members
David R. Samson, M.D.
Anchorage, Vice Chairperson
Ann Egrass, McGrath
Mabel Rosvold, Petersburg
Alice Wardlow, Bethel
Barbara T. Wihloborg, Fairbanks
Robert Hunter, M.D., Mt. Edgecumbe
Kevin C. Ritchie, Juneau

cc: Bill Ray, Chairman, Judiciary Committee
All Judiciary Committee Members
HGWB/dmb

06-F100LH

American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900
Melvin Sabshin, M.D., Medical Director

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Ex-Officio
Robert O. Pasnau, M.D.
Past Speaker
Melvin M. Lipsett, M.D.
Past Speaker
Robert J. Campbell, M.D.
Parliamentarian
Henry H. Work, M.D.
Deputy Medical Director

Alaska Psychiatric Association
4001 Dale Street, Suite 101
Anchorage, Alaska 99508

February 28, 1984

Senator Josephson
Pouch V
Juneau, Alaska 99801

Dear Senator Josephson:

The Legislative Committee of the Alaska Psychiatric Association has reviewed Senate Bill 346 -"An Act relating to the treatment of the mentally ill." We support the proposed amendments. We have one additional suggestion pertaining to page 18, line 24. We believe the inclusion of a period of experience for psychiatric nurses is a good idea, but we do not believe this should serve to eliminate a Masters Degree in Psychiatric Nursing from the list of mental heatlh professionals. A simple "or" in line 24, page 18 would suffice to change this.

Thank you once again for your efforts on the behalf of the mentally ill.

Sincerely,

Jerry L. Schrader

Jerry L. Schrader, M.D.
Legislative Representative
Alaska Psychiatric Association

JLS/saw
Enc.

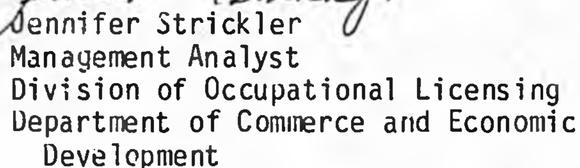
MEMORANDUM State of Alaska

TO: Nancy Deitrick
Aide to Senator Josephson
Alaska State Senate

DATE: April 4, 1984

FILE NO:

TELEPHONE NO:



FROM: Jennifer Strickler
Management Analyst
Division of Occupational Licensing
Department of Commerce and Economic
Development

SUBJECT: SB 303 and SB 346

This is to inform you that at a meeting held on March 13, 1984, the Board of Psychologist and Psychological Associates reviewed SB 303, "An Act relating to the practices of social work and establishing the Board of Social Worker Examiners; and providing for an effective date"; and, also, SB 346, "An Act relating to the treatment of mentally ill persons."

Determinations were made by the Board to support both SB 303 and SB 346.

JS/shA/20-3
4484a

1650 Cowles Street, Fairbanks, Alaska 99701

April 6, 1983

Dennis DeWitt
Alaska Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Dennis,

I have reviewed the work draft that would amend the current act relating to the treatment of the mentally ill persons and have the following comments.

Much of this work draft simply cleans up the language of the current legislation. (Apparently the law is going to allow for those rare instances when a female is mentally ill!)

Several areas in the work draft propose significant content changes. In all cases these content changes would significantly improve the current legislation.

1. AS 47.30.915 (7) and AS 47.30.915 (10) change the definition of 'gravely disabled' and 'likely to cause serious harm.' The proposed changes in these definitions, if enacted, would greatly improve the ability of the legal system and providers of mental health care to intervene appropriately in situations where emergency detention is in the best interest of the patient.
2. Section 47.30.705 This proposed change allows a physician to initiate the involuntary commitment procedures. This is an essential addition to the current legislation and entirely appropriate.
3. The other content changes (dealing with the detention and commitment of minors, etc.) also upgrade the current legislation and make it more workable.

Overall there are no objections in the changes proposed by this work draft. The content changes deserve support and would markedly improve the current legislation governing the treatment of the mentally ill.

I would recommend that the Alaska Hospital Association support a bill that reflects the content and intent of the work draft.

Sincerely,

M. J. Emmert, R.N.
Director of Nursing Service

MJE:mc

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

April 14, 1983

Document No. 83-15?

The Honorable Joe Josephson
Senator
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Senator Josephson:

RE: AS 47.30.655 - 47.30.915
(Involuntary Commitment Act for Mentally Ill Persons)

We appreciate the work you are undertaking and would like to add our comments to those you have already received regarding possible amendments to Alaska's recently enacted civil commitment statutes for mentally ill persons. As you know, the Division of Mental Health and Developmental Disabilities supports the general intent of the Act but feels it is procedurally too cumbersome. This seems to have resulted in treatment staff wasting their time in complying with procedures and filling out numerous forms rather than providing treatment for mentally ill persons.

I have enclosed a copy of our earlier suggested amendments that were prepared during the previous administration. The status of these suggested amendments is unknown to us. Upon review, however, I believe that you will agree that they are primarily designed to facilitate treatment. In addition, I am confident that the Attorney General's Office will be able to assist your staff in determining which forms, notices and procedures that are presently required can be deleted while still protecting the rights of the mentally ill.

Another area of extreme importance in the successful implementation of this Act has been the availability, or lack thereof, of detoxification facilities and other alcohol and substance abuse programs and services. Experience has shown that the emergency involuntary hospitalization at API of persons with a primary diagnosis of alcoholism has increased dramatically since the new Act became effective. This is cause for considerable concern to us as our bed space for legitimate psychiatric emergency cases is in extremely short supply. We believe that if additional alcoholism and substance abuse programs offering emergency

inpatient care were available, especially in Anchorage, that the number of referrals of intoxicated persons to API would be substantially reduced. You may be interested to know that the provisions of the Uniform Alcoholism and Intoxification Treatment Act (AS 47.37.010 - 47.37.270) have never been fully implemented, partially as a result of a lack of inpatient facilities that offer various types of alcoholism services and treatment.

The most utilized provision of the Uniform Alcoholism and Intoxification Treatment Act seems to have been what is called the "12-hour drunk law." This provision allows persons that are seriously incapacitated as a result of alcohol to be placed in a local jail or state correctional center for up to 12 hours with no criminal charges being filed. In the past, this has permitted law enforcement agencies the opportunity to take intoxicated persons into custody and house them in a jail or correctional center until the person has regained sobriety and is no longer in danger of harm as a result of his inebriated condition.

Unfortunately, as a consequence of the extreme shortage of bed space in all of Alaska's correctional centers, law enforcement agencies are no longer able to deliver these incapacitated persons to correctional facilities and have them held in custody until they are no longer incapacitated by alcohol. More simply put, as a result of serious overcrowding in our correctional systems, drunks are being taken to API and kept there until they sober up sufficiently to make a diagnosis. More often than not, the diagnosis reveals that they are suffering primarily from alcoholism and not a major mental illness. At that point they are discharged and referred elsewhere. This results in a serious misuse of the few psychiatric resources we have. It is our position that these limited resources should be exclusively available to the seriously mentally ill person that presents himself, or is presented, to Alaska's only designated psychiatric hospital.

In addition to the recommended amendments contained in the enclosure, as well as the previously mentioned concerns, we have listed below a number of other changes to the Act that we would like to support:

1) We recommend that the period of commitment be changed from 21 days, 90 days, and 120 days to 30 days, 90 days, and 180 days. It is our opinion that this would reduce the administrative workload of our treatment staff while having little or no effect on the period of time patient's are actually involuntarily committed.

   Rather than interrupt treatment after 21 days in order to undergo the 90-day commitment process, treatment could continue for an additional 9 days if necessary. This would allow medications and other forms of therapy some additional time to stabilize the patient, possibly resulting in a discharge between the 21st and 30th day. The change from 120

days to 180 days is simply to reduce the administrative and procedural requirements necessary for the long-term, chronic metally ill patients that require extended periods of hospitalization.

2) We propose that all references to a minor child be changed from age 14 to age 18 throughout the Act. Numerous situations have arisen as a consequence of this provision that indicate it has fostered confusion as well as placing young people and API in an awkward position with regard to their status. It is also not in concert with other provisions of Title 47 that address the care and treatment of minors in Alaska.

3) Under AS 47.30.730(a)(3), we recommend that the following language be added with regards to gravely disabled: "... or that painful or dangerous regression could be prevented and the respondent could maintain the capacity for self-reliance;...". It has been our experience that some gravely disabled individuals may not be expected to actually improve during hospitalization, buc if left untreated can be expected to suffer substantially, even to the point of requiring permanent institutionalization as a result.

4) Under AS 47.30.840(4), (5), (6), and (7), we suggest that provision be made to restrict these rights in unusual circumstances in which harm to the patient or others may result if these rights are exercised. We propose adding "... unless the professional person in charge determines it is not in the best interests of the patient and will pose a threat to the safety or well being of the patient or others;..." to these sections.

5) We recommend that AS 47.30.845 be amended to add a provision that would allow confidential information or records to be disclosed to law enforcement agencies in emergency situations involving a current or former patient. In order to restrict this disclosure we suggest the following section be added: "(7) a law enforcement agency when there is substantiated concern over imminent danger to the community by a presumed mentally ill person."

This would allow the disclosure of information to law enforcement agencies that may be helpful in preventing needless injury or death occurring as a result of the actions of a mentally ill persons during an emergency situation.

6) An additional area that, in our opinion, should be revised is the area of involuntary outpatient commitment. Thusfar, there have only been a limited number of these types of commitments. It seems, however, that none have proven successful for various reasons. While the idea of involuntary outpatient

commitment appears sound, the provisions of the Act appear to militate against the successful utilization of this less restrictive alternative. Perhaps your proposed revision to the definition of "likely to cause serious harm" will have a positive influence on the successful use of outpatient commitment.

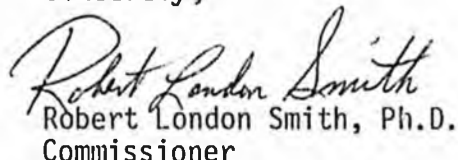
It should be noted, with regards to outpatient treatment, that AS 47.30.800(a) requires persons seeking conversion from involuntary outpatient commitment to inpatient commitment must have direct knowledge that the respondent is mentally ill or gravely disabled. If the respondent fails to report to the provider of service, than the provider will be unable to substantiate the allegations necessary to convert the commitment to inpatient treatment.

7) In AS 47.30.745(b), the last sentence should read "... not later than 90 days..." rather than "... not earlier ...." as it currently reads.

8) The final area in which we would recommend revision is the requirement that all patients be given the opportunity to be voluntarily admitted. We do not dispute the value of this option in the vast majority of cases that require psychiatric hospitalization; there are, however, instances in which it may not be wise or prudent to be required to offer or allow the voluntary admission of some patients to the hospital. Certainly, the substitution of "reasonable" for "every" in Section 1 of your draft is a step in the right direction. We would hope that it would be interpreted to mean in cases in which it was deemed unreasonable, that involuntary commitment proceedings would commence.

While I am confident that these recommendations for amendments do not represent a panacea for all that is wrong with such a complicated set of laws, I am certain that these, along with many other suggestions that you have received, represent a substantial improvement in providing for the care and treatment of Alaska's mentally ill. Again, I would like to thank you and your staff for giving this information your review and consideration. My staff and I look forward to working with you and other members of the Legislature in revising our civil commitment laws.

Sincerely,



Robert London Smith, Ph.D.
Commissioner

Enclosure

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

February 3, 1984

DOCUMENT #84-32

The Honorable Joe Josephson
Alaska State Senator
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Senator Josephson:

RE: Senate Bill 346
(Suggested Amendment)

The language listed below is suggested as an amendment to Senate Bill 346 to allow persons under the age of 18 to be voluntarily hospitalized by their parents or guardians for additional 30 day periods. Under the existing statute, children and adolescents may not be voluntarily hospitalized by their parents or guardians for a period longer than 21 days even if they meet the criteria for hospitalization under A.S. 47.30.690. The amendment would rectify this oversight.

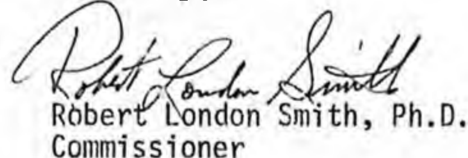
On page 4, line 3, Section 5 of Senate Bill 346, we recommend that the following subsection be included:

"(c) Additional 30-day voluntary admissions of a minor under the age of 18 may be sought by parents or guardians if, in the opinion of the professional person in charge, the conditions under subsections (1), (2), and (3) continue to exist."

This amendment is considered especially important, even critical, in providing the necessary and appropriate level of care for this oftentimes fragile group of patients.

We will be happy to provide you or other members of the Senate Health, Education, and Social Services Committee with any additional information you may require concerning this proposed amendment as well as any questions you may have regarding our Position Paper which was submitted earlier.

Sincerely,



Robert London Smith, Ph.D.
Commissioner

06-F38LH

MSG 84-00028880 PRTY 1 03/27/84 16:24:35 ORIG: LA01 IN= 0007 OUT= 0115
FROM: KAREN, ANC LIO TO: POM - JUNEAU INFO
TARGET: LJHK SUBJ: POM

TO: ALL SENATORS

FROM: G. KENT EDWARDS
2113 DUKE DRIVE
ANCHORAGE, AK, 99508
H. 276-2664; W. 274-3576

MARGARET BROWN, 2957 EMORY, ANCHORAGE, AK. 99508
H. 272-6039' W. 272-3454

RECEIVED
MAR 28 1984
Josephson

I URGE YOUR SUPPORT OF SB 346,, THE MENTAL HEALTH BILL.
SECTIONS 26 AND 27 ARE ESPECIALLY IMPORTANT SINCE CURRENT
DEFINITIONS ARE INADEQUATETO DEAL WITH MANY
MENTALLY ILL PATIENTS WHO MAY CAUSE BODILY HARM.

3/28/84, SHIRLEE ANC LIO, 29182

RECEIVED
MAR 28 1984
Josephson.

TO: ALL MEMBERS
ALASKA SENATE

FROM: PAT EDWARDS
2113 DUKE DRIVE
ANCHORAGE, AK 99508
(H) 276-2264 (W) 271-3735

SUBJ: SENATE BILL 346 (TREATMENT OF MENTALLY ILL PERSONS)

I URGE YOUR SUPPORT OF SENATE BILL 346, ESPECIALLY SECTION 27. PSYCHOTIC HISTORIES AND ACTS OF VIOLENCE TOWARDS PROPERTY MUST BE CONSIDERED WHEN EVALUATING MENTAL PATIENTS.

****

RECEIVED
MAR 3 0 1984
Josephson.

MSG 84-00029328 PRTY 1 03/28/84 14:47:49 ORIG: LA09 IN= 0005 OUT= 0105
FROM: KIM / ANCH LIO TO: POM / JNU INFO
TARGET: LJHK SUBJ: P O M

TO: ALL SENATORS

FROM: JOHN BROWN, 1936 BEAVER PLACE, ANCHORAGE 99504
H 337-2755 W 272-3454

SB 346, TREATMENT OF MENTALLY ILL PERSONS

URGING YOUR SUPPORT, SPECIFICALLY SECTIONS 26 AND 27. MY FAMILY HAS BEEN PLAGUED BY A PARANOID SCHIZOPHRENIC. HE'S BEEN IN AND OUT OF API FOR THE PAST 8-10 YEARS. HE'S 6'4, 300 POUNDS PLUS AND I AM AN EX-STATE HEAVYWEIGHT WRESTLING CHAMP WHOM HE TOSSED AROUND LIKE A RAGDOLL LAST CHRISTMAS EVE.

FROM: LINDA THAGGARD
4701 CANTERBURY WAY
ANCHORAGE, AK. 99503Q
561-8085

I URGE YOU TO SUPPORT SB 443 BRINGING POWER LINES TO THE CASWELL LAKE AREA.

MSG 84-00030841 PRTY 1 04/03/84 09:14:09 ORIG: LF01 IN= 0003 OUT= 0027
FROM: PAULA/FKS TO: JNU INFO
TARGET: LJHK SUBJ: POM

TO: ALL MEMBERS OF THE SENATE

FROM: JEANETTE GRAFTO
SR 20683
FAIRBANKS, AK, 9970[illegible]
455-6212-H

RE: SB 346, MENTALLY ILL

MSG: I SUPPORT SB 346. I HAVE A MENTALLY ILL BROTHER AND I BELIEVE HIS RIGHT TO TREATMENT IS VERY IMPORTANT. CIVIL RIGHTS ARE NOT EVEN RELATIVE WHEN YOU CANNOT TAKE CARE OF YOURSELF AND PEOPLE IN THE STREET ARE TAKING ADVANTAGE OF YOU.

------------EOM

TO: ALL MEMBERS OF THE SENATE

FROM: DOROTHY STELLA
235 IDITAROD
FAIRBANKS, AK, 99701
456-1454-H 372-4265-W

RE: SB 346, TREATMENT OF MENTALLY ILL

MSG: TO CONTINUE TO DENY TREATMENT OF THE CHRONICALLY MENTALLY ILL MIGHT HAVE SERIOUS LEGAL RAMIFICATIONS. SUPPORTING BILL 346 AS PROPOSED WOULD ELIMINATE DEPRIVATION OF MEDICAL CARE TO THESE INDIVIDUALS.

--------------EOM

MSG 84-00030806 PRTY 1 04/03/84 08:45:59 ORIG: LF01 IN= 0002 OUT= 0019
FROM: PAULA/FKS TO: JNU INFO
TARGET: LJHK SUBJ: POM

TO: ALL MEMBERS OF THE SENATE

FROM: MR. & MRS. AARON, MEMBERS OF FKS ALLIANCE FOR THE MENTALLY ILL
P.O. BOX 74132
FAIRBANKS, AK, 99707-4132
456-4407-H

RE: SB 346

MSG: FOR THOSE HELPLESSLY SUFFERING THE UNCONTROLLED DEPRIVATIONS OF SEVERE PSYCHOTIC DELUSIONS AND DEPRESSIONS, THE MOST URGENT CIVIL RIGHT IS THE RIGHT TO HAVE PROPER CARE AND TREATMENT, ESPECIALLY WHEN THE VICTIM IS TOO DISTURBED TO REALIZE THE NEED FOR HELP AND MAY BE STARVING FOR EXAMPLE. YES TO SB 346.

----------------------EOM

MSG 84-00030851 PRTY 1 04/03/84 09:32:01 ORIG: LF01 IN= 0004 OUT= 0031
FROM: ANNIE IN FAIRBANKS TO: JUNEAU INFO.
TARGET: LJHK SUBJ: POM

TO: ALL SENATORS

FROM: PHYLLIS VAN ARISDALE
141 STEEL HEAD ROAD
FAIRBANKS 99701
HOME 479-3271

RE: SB346, MENTAL ILLNESS

IT IS VITAL THAT YOU DO PASS SB346, THE MOST DIFFICULT PROBLEM IN THE MENTAL ILLNESS PROCESS IS GETTING TREATMENT WHEN A PSYCHOTIC BREAK OCCURS. THE MOST IMPORTANT CIVIL RIGHT OF MENTALLY ILL PEOPLE TODAY IS THE RIGHT TO TREATMENT. DENIAL OF TREATMENT WAS A CAUSE OF OUR SON'S DEATH.
****

-------------------EOM   6

TO: SENS RAY, ELIASON, PETTYJOHN, ZEIGLER, JOSEPHSON

FR: RICHARD H. RUSSELL
MEMBER OF FBX ALLIANCE FOR THE MENTALLY ILL
304 12TH AVE. #3
FBX, 99701
452-5662

RE: SB 346 TREATMENT OF THE MENTALLY ILL

MSG: THIS IS NECESSARY AND LONG OVERDUE LEGISLATION. WHILE OUR SON WAS AT API, I BECAME QUITE FAMILIAR WITH ALASKA'S COMMITMENT ACT. IT IS UNNECESSARILY VAGUE AND OFTEN MISLEADING. SB346 IS AN IMPORTANT ADJUSTMENT.

-------------------EOM

FR: TOM MINGEN
FBX MEMORIAL HOSPITAL
1650 COWLES
FBX, 99701
452-8181 EXT 505

RE: SB346 TREATMENT OF MENTALLY ILL

MSG: URGE YOUR SUPPORT OF SB 346.

-------------------EOM

FROM: GERALDINE HARRINGTON
1820 CHEROKEE WAY
ANCHORAGE, AK. 99504
333-9252

SUPPORT SB 346, THE MENTAL HEALTH BILL. I'M A DIAGNOSED MANIC DEPRESSIVE, HOSPITALIZED SEVERAL TIMES DURING THE PAST 16 YEARS.

FROM A PATIENT'S VIEWPOINT, IT IS CRUCIAL THAT A TRAINED PROFESSIONAL BE IN THE POSITION TO TREAT THE INDIVIDUAL WHOSE JUDGEMENT CANNOT BE RELIED UPON AT THE MOMENT TREATMENT IS NEEDED MOST.

MSG 84-00023748 PRTY 1 03/13/84 12:28:17 ORIG: LS01 IN= 0004 OUT= 0019
FROM: SITKA TJ: JUNEAU
TARGET: LJHK SUBJ: POM

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZIEGLER

FROM: STAN LAUGHRIDGE, BARANOF MENTAL HEALTH CLINIC
BOX 1180
SITKA, AK 99835

RE. SB 346, TREATMENT OF MENTALLY ILL PERSONS

I AM A PROFESSIONAL MENTAL HEALTH WORKER AND I STRONGLY SUPPORT THE PROVISIONS OF SB 346.

###SITKA LIO, 3/13, 23748##

MSG 84-00023914 PRTY 1 03/13/84 15:05:07 ORIG: L-v0 IN= 0009 OUT= 0070
FROM: TRACIE/FBX 15 TO: JUN INFO
TARGET: LJHK SUBJ: POM

TO: SENS RAY, JOSEPHSON, ELIASON, ZIEGLER, PETTYJOHN, RAY, BENNETT, FAHRENKAMP, MOSS
REPS DAVIS, BETTISWORTH, KOPONEN, RINGSTAD, M.W. MILLER

FR: JANET WHITE, IMMACULATE CONCEPTION COMMUNITY SERVICES DIRECTOR
PO BOX 81652
FBX, 99708
488-0646-H
456-4918-W

RE: SB 346TREATMENT OF THE MENTALLY ILL

MSG: FAMILIES OF THE MENTALLY ILL SUPPORT SB346. THIS BILL IS A TESTIMONY FOR THE IMPROVEMENT OF THE CONDITIONS FOR SUFFERING FAMILIES AND THEIR LOVED ONES, IE THE PATIENT.

-------------------EOM

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZEIGLER

FROM: RANDY HURST
BOX 4310
MT. EDGECUMBE, AK. 99835 966-2438 (W)

RE: SB 346

I'M WRITING IN SUPPORT OF SB 346. THE LONGER TIME FRAMES, THE FOCUS ON LEAST RESTRICTIVE ENVIRONMENTS, AND ABILITY TO INITIATE PETITIONS BY MENTAL HEALTH PROFESSIONALS ARE VERY IMPORTAN INCLUSIONS. I WISH THE INITIAL TIME FRAME OF 30 DAYS COULD BE MADE LONGER, ESPECIALLY SINCE MEDICATION STABILIZATION TAKES AT LEAST THAT LONG IN MANY CASES.

----------------------SITKA LIO, 3-12-84------------------------------

MSG 84-00023818 PRTY 1 03/13/84 13:39:52 ORIG: LS01 IN= 0006 OUT= 0041
FROM: ELAINE, SITKA TO: JUNEAU
TARGET: LJHK SUBJ: POMS

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZIEGLER

FROM: DR. SUSAN CARLSEN
BOX 4575
MT. EDGECUMBE, AK. 99835 747-6474

RE: SB 346 - MENTAL HEALTH ILLNESS

I URGE SUPPORT OF THE MENTAL HEALTH BILL, SB 346, WHICH WOULD FACILITATE MENTAL HEALTH TREATMENT LOCALLY AND ALLOW MENTAL HEALTH WORKERS IN SITKA TO WORK WITH THOSE WHO ARE IN INVOLUNTARY COMMITMENT.

-------------------SITKA LIO, 3-13-84 23818-------------------------

file SB 354 - Mental Health

ATTACHMENT 1
Speaker/Speaker-Elect
Report to Reference Commit
and Board

American Psychiatric Association

GUIDELINES FOR LEGISLATION ON THE PSYCHIATRIC HOSPITALIZATION OF ADULTS[1]

These Guidelines Deal With:

- Emergency Psychiatric Evaluation
- Voluntary Admission
- Involuntary Hospitalization
- Right to Treatment
- Right to Refuse Treatment
- Patients' Rights
- Legal Immunity for Mental Health Personnel

---

[1] These Guidelines for Legislation on the Psychiatric Hospitalization of Adults have been prepared and approved by the American Psychiatric Association in order to assist psychiatrists, legislators and the public in considering possible revisions of civil commitment laws. The American Psychiatric Association believes that these Guidelines constitute a responsible set of proposals which would improve the process of psychiatric hospitalization in many states. However, because local laws, community conditions, and medical practices vary, state and local psychiatric associations and individual psychiatrists may properly support provisions which differ in many respects from these general Guidelines.

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ADDENDUM A-1

Section 1. SHORT TITLE

These provisions governing the psychiatric hospitalization of adults may be cited as Title I of the Mental Health Code.[1]

Section 2. LEGISLATIVE PURPOSES

This Act is intended to achieve and shall be construed so as to promote these legislative purposes:

-- To make available psychiatric evaluation, care and treatment to all persons who suffer from severe mental disorders and can benefit from treatment, and to encourage voluntary rather than involuntary admission whenever hospitalization is necessary;

-- To safeguard the legal rights of patients in a manner which will advance and not impede the therapeutic and protective purposes of psychiatric hospitalization;

-- To provide workable procedures for obtaining consent to and administering medications and other treatments;

-- To provide legal immunity for reasonable, good-faith efforts to implement this Act, and legal penalties for knowing, willful efforts to subvert the processes in this Act; and

-- To provide a statutory framework for the promulgation of regulations by the Department of Mental Health.

Section 3. DEFINITIONS

As used in this Act, the terms below shall have the meanings indicated:

"aversive therapy" means any treatment or procedure which, because it is believed to be painful or physically uncomfortable to the patient, is administered in order

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[1] These Guidelines deal only with persons who may be hospitalized for psychiatric care and treatment under the civil commitment process; they do not deal with persons who may be confined for forensic evaluation or other purposes under the criminal justice process.

to reduce the frequency or intensity of a behavior; except that aversive therapy does not refer to verbal therapies, seclusion or physical restraints used in conformity with Section 10.F., or psychotropic medications which are not used for purposes of aversive conditioning.

"consistent with the least restrictive alternative principle" means that (1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, where treatment provides the patient with a realistic opportunity to improve, and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient; and (2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.

"court" means the court or judicial officer designated under the laws of this State for the discharge of the functions described in this Act.

"emergency situation" means a situation in which the patient exhibits substantial behavior which is self-destructive, assaultive, or threatens significant damage to the property of others, or which indicates that the patient is suffering extreme anxiety amounting to panic, or sudden exacerbation of his severe mental disorder.

"experimental treatment" means any treatment other than one which is commonly accepted for treatment of the mental disorder involved or is supported by widely accepted scientific studies, and is provided by a qualified health professional; if such treatment poses a significant risk of harm to the patient.

"informed consent to treatment" means a knowing and voluntary decision to undergo treatment, evidenced in writing, and made by a person who has the capacity to make an informed decision, after the treatment facility has explained to the person the nature and effects of the proposed treatment.

"lacks capacity to make an informed decision concerning treatment" means that the person, by reason of his mental disorder or condition, is unable despite

conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment, or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment as evidenced by inability to weigh the possible risks and benefits.

"likely to cause harm to himself or to suffer substantial mental or physical deterioration" means that as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.

"likely to cause harm to others" means that as evidenced by recent behavior causing, attempting or threatening such harm, a person is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person.

"patient" means any person receiving evaluation, care or treatment under this Act, except that "patient" for purposes of the rights provided in Section 10 shall refer only to persons in residential treatment programs.

"person" means for purposes of any provision of this Act authorizing the commitment or treatment of a "person," an individual aged eighteen years or more.[2]

"psychosurgery" means any procedure which by direct access to the brain, removes, destroys, or interrupts the continuity of brain tissue which is histologically normal (as distinguished from normal in its physiological or psychological functioning) for the primary purpose of altering behavior or treating a mental disease or disorder. Psychosurgery includes the implantation of electrodes with such an effect and

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[2] For provisions concerning persons under the age of eighteen, refer to the American Psychiatric Association's "Guidelines for Psychiatric Hospitalization of Minors" (1981).

for such a purpose, with or without subsequent electrocoagulation. Psychosurgery does not include neurosurgical procedures designed to treat reliably diagnosed intractable physical pain or epilepsy.

"severe mental disorder" means an illness, disease, organic brain disorder, or other condition which (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or (2) substantially impairs behavior as manifested by recent disturbed behavior.[3]

"treatment facility" means a community mental health facility, a general medical facility providing psychiatric services, or other psychiatric facility or program meeting applicable licensing standards, which has been approved for the provision of services under this Act by the Department of Mental Health; provided that no jail or other correctional facility shall be approved as a treatment facility for any persons other than those who could otherwise lawfully be detained there.

Section 4. EMERGENCY PSYCHIATRIC EVALUATION

4.A. Detention by a Police Officer

1. A police officer may take a person into custody, and transport the person to a treatment facility for emergency psychiatric evaluation if and only if:

a. the person would otherwise be subject to lawful arrest and the police officer believes that the person is in need of emergency psychiatric treatment; or

b. the police officer has probable cause to believe that the person has attempted suicide within the last 48 hours; or

c. the police officer has probable cause to believe, based on his personal observation and investigation, or based on the petition of any interested adult under subsection

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[3] Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder. States may wish to provide by other provisions of law for persons whose use of or addiction to intoxicating substances warrants hospitalization.

4.C. and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs, and that immediate hospitalization is necessary to prevent harm to the person or to others; or

d. he is acting upon the certification of a licensed physician under subsection 4.B.

2. Any person taken into custody pursuant to this subsection shall be presented promptly to a treatment facility. Correctional facilities shall not be used as temporary shelter for such persons except for the protective custody of the person pending transportation to a treatment facility.

3. Upon or shortly after taking a person into custody, the police officer shall take reasonable precautions to safeguard and preserve the personal property of the person unless a guardian or responsible relative is able to do so. Upon presenting a person to a treatment facility the police officer shall inform the staff in writing of the facts which caused him to take the person into custody, and specifically state whether the person is otherwise subject to arrest.

4.B. Certification by a Licensed Physician

A person may be taken into custody by a police officer, or accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation, when a licensed physician certifies in writing that he has examined the patient in the last 72 hours, or that he has ongoing medical responsibility for the person and has knowledge of his current condition, and on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as a result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

4.C. Petition by Any Interested Adult

Any interested adult may petition for, or present a person for, emergency psychiatric evaluation by alleging based on personal observation that he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs; and immediate hospitalization is necessary to prevent harm to the person or to others.

4.D. Treatment Facility Determination

1. Upon the presentation of a person to a treatment facility pursuant to this Section 4, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth in subparagraph 2.

2. The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

3. If the examining psychiatrist determines that there is not probable cause to believe that the person meets the criteria for emergency evaluation and treatment, the person shall be released. If a person was presented to the treatment facility by a police officer and was otherwise subject to lawful arrest, he shall continue under the custody of police officers.

4.E. Advice of Rights

The treatment facility shall advise any person admitted for emergency evaluation and treatment of the purposes and possible duration of emergency evaluation, and of his rights under this Act, as soon after admission as his medical condition permits.

4.F. Hearing on Emergency Evaluation

1. Each person who is admitted to a treatment facility shall receive a preliminary hearing before the court within five business days of admission or be discharged, unless he has, after consultation with counsel, executed a written waiver of such hearing. The hearing shall be informal and subject to such rules as the court sets consistent with fundamental fairness.

2. The court shall determine at the close of the hearing, or within five business days of the patient's admission, whether he should be discharged. A patient shall then be discharged, unless the court determines that there is probable cause to believe that he satisfies the criteria for thirty-day commitment provided in Section 6, and unless within two business days of the court's decision a petition for such commitment is filed with the court.

4.G. Duration of Emergency Evaluation and Treatment

The period of emergency evaluation and treatment shall in no case exceed fourteen days.

Section 5. VOLUNTARY ADMISSION

5.A. Admission

1. A treatment facility may admit a person if after examining the patient a psychiatrist [or: "a physician"]* on the staff or with privileges at the treatment facility believes the person is mentally ill and in need of hospitalization, and if the person gives written consent to admission. Prior to such admission, the person shall be advised orally and given a written statement of his rights under this Act; provided that if his condition upon admission makes such advice infeasible and the medical reasons are entered in the record, such advice may be deferred until the patient's medical condition permits, for not more than 48 hours. Each patient shall be asked to sign an acknowledgement that he has been so advised and has consented to voluntary admission for treatment.

2. Initial consent to voluntary admission for treatment shall be valid for sixty days. Thereafter,

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* Optional provision.

a patient may remain at the treatment facility for periods of up to one hundred eighty days each upon a signed consent executed after the patient has had an opportunity to consider with such persons as he wishes his need for continued hospitalization and treatment.

3. If the responsible psychiatrist [or: "the responsible physician"][5] has substantial reason to believe that a person seeking to admit himself or to consent to further hospitalization lacks capacity to make an informed decision concerning treatment, he shall obtain in addition to the consent of the patient, the informed consent of the patient's next of kin or guardian. The responsible psychiatrist [or: "the responsible physician"][6] shall renew his effort to obtain the informed consent of the patient if the patient regains the capacity to make an informed decision concerning treatment.

5.B. Discharge or Petition for Thirty-Day Commitment

Any patient who is voluntarily admitted to a treatment facility shall be discharged within five business days of his written request for discharge (and any patient who indicates his desire to be discharged but is unable to write shall be assisted to put his request in writing), unless a petition for thirty-day commitment is filed within that period by the treatment facility or the patient's next of kin or guardian.

5.C. Conversion from Involuntary to Voluntary Status

A patient who is subject to involuntary hospitalization pursuant to Sections 4, 6, or 11 of this Act may at any time convert to voluntary status if the responsible psychiatrist [or: "the responsible physician"][7] agrees that such conversion is made in good faith and that the patient is an appropriate patient for voluntary hospitalization.

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[5] Optional provision.

[6] Optional provision.

[7] Optional provision.

Section 6. THIRTY-DAY COMMITMENT

6.A. Petition

1. Persons who are present at a treatment facility under voluntary admission but have requested discharge, and persons present at a treatment facility for emergency psychiatric evaluation, may be committed involuntarily for a period of up to thirty days upon a petition filed by the treatment facility or by the next of kin or guardian; and other persons may be so committed upon a petition filed by any interested adult. The petition shall allege that such person meets the criteria set forth in subsection 6.C. The petition shall set forth the facts supporting the allegations, and, in the case of petitions filed by a treatment facility, describe why the patient requires treatment. The petition shall be filed with the court, which shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

2. The copies of the petition served by the court shall be accompanied by a notice advising of the person's rights concerning the proceeding.

6.B. Summons for Evaluation; Psychiatric Report

1. Upon the filing of a petition for thirty-day commitment of a person who is not currently under emergency evaluation or voluntary admission, the court shall issue a summons to the person to submit to an examination (on an outpatient basis) conducted by a psychiatrist at a treatment facility or a private psychiatrist. The examining psychiatrist shall promptly prepare a report on his examination and file it with the court. The court shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

2. A person served with a summons to submit to a psychiatric examination may in lieu of such examination submit a report of a psychiatrist stating that he has recently examined the person, or has ongoing medical responsibility for the person and knowledge of his current condition, and that in his opinion the person does not meet the criteria for involuntary commitment. The petition for commitment may then be dismissed by the court, or continued.

6.C. Criteria for Thirty-Day Commitment*

A person may be involuntarily committed for a period of up to thirty days if, after the hearing provided in Section 6.D., the court determines, based upon clear and convincing evidence, that:

1. the person is suffering from a severe mental disorder; and

2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and

3. the person either refuses or is unable to consent to voluntary admission for treatment; and

4. the person lacks capacity to make an informed decision concerning treatment; and

5. as the result of the severe mental disorder, the person is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others.

6.D. Hearing on Thirty-Day Commitment

1. Every person as to whom a petition for thirty-day commitment has been filed shall be notified by the court sufficiently in advance to be able to prepare for the hearing, and shall receive a prompt hearing. For persons confined for emergency psychiatric evaluation, or currently under voluntary admission, this hearing shall take place within three business days of the filing of the petition.

2. The respondent shall be present at the hearing unless the court finds (1) that he has knowingly and voluntarily waived such right after consulting with counsel, or (2) that because his behavior at the hearing

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* Refer to the Commentary for a discussion of the disposition of various types of persons who do not meet the criteria in Section 6.C.

is so disruptive, it cannot reasonably continue in his presence. Hearings shall be held in the treatment facility wherever feasible given the other functions of the court.

3. Any respondent who is unable to pay for counsel shall have the right to be provided with counsel to prepare for and represent him at the hearing. [Any respondent who is unable to pay for an examination for purposes of the hearing shall have the right to be provided with one examination by a licensed psychiatrist, at the expense of the (state or local government).][9]

4. The District Attorney or County Counsel shall represent the interests of the State at the hearing. [If the District Attorney or County Counsel fails to proceed with the commitment, the next of kin or a petitioning party may retain counsel to do so in his stead, and the reasonable costs of such counsel shall be paid by the (state or local government).][10]

5. The rules governing evidentiary and procedural matters at hearings under this Act shall be promulgated so as to facilitate informal, efficient presentation of all relevant, probative evidence and resolution of issues with due regard to the interests of all parties. Hearsay evidence may be received, and experts and other witnesses may, consistent with law, testify to any relevant and probative facts at the discretion of the court.

6. Patients shall not have a "right to remain silent" at a psychiatric examination or hearing conducted pursuant to this Act; provided that no patient shall be held civilly or criminally liable for not speaking or testifying. Any information obtained from or disclosed by the patient during the course of evaluation or treatment is admissible in any hearing provided in this Act without regard to whether it would otherwise be privileged; provided that no disclosure made by the patient during the course of evaluation or treatment or in any proceeding conducted under this Act, and no opinion testimony based on such disclosures, may be admitted against the patient on the issue of guilt in a criminal proceeding unless he places his mental condition in issue in such proceeding, and the disclosure or opinion is relevant to such an issue raised by him.

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[9] Optional provision.

[10] Optional provision.

7. The hearing shall be closed to the public, unless the respondent requests that it be open, or the court determines for other good cause that the hearing should be open. The court shall keep a complete record, written or recorded, of every hearing.

8. At the conclusion of the hearing, or within one business day thereafter, the court shall make its findings, including specific findings as to whether the commitment is warranted because the person is (a) likely to cause harm to others, or (b) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (c) both (a) and (b). As to any person found likely to cause harm to himself or to suffer substantial mental or physical deterioration, the court shall further make findings as to whether commitment is warranted because the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will, if not treated, suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own.

9. The court shall enter an order discharging the person unless it finds by clear and convincing evidence that the person satisfies all of the criteria for commitment in Section 6.C., in which event it shall enter an order committing the person for evaluation and treatment for a period of "up to thirty days." If at any time during thirty-day (or any subsequent) commitment a patient is absent without permission, the order of commitment constitutes a continuing authorization to the treatment facility and to any police officer to procure his return.

Section 7. INFORMED CONSENT TO MEDICATION OR OTHER TREATMENT -- VOLUNTARY PATIENTS

7.A. Informed Consent

Except in an emergency situation, a treatment facility shall, prior to beginning any course of medication or other treatment for a patient who is subject to voluntary admission under Section 5, obtain informed consent to treatment. If the patient does not lack

capacity to make an informed decision concerning treatment, the consent shall be his own. If he does lack such capacity, the consent shall be that of his next of kin or guardian, provided that such a patient may receive appropriate medications or other treatments, except as limited by Section 8.C., until such time as the consent or refusal to consent of such next of kin or guardian can be obtained.

7.B. Revocation of Consent

A voluntary patient (or the next of kin or guardian who consented to treatment on his behalf) may revoke consent to treatment at any time by a reasonably clear statement in writing (and patients who indicate a desire to revoke consent but are unable to write shall be assisted to put their statement in writing). If such consent is revoked, the treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.

7.C. Refusal to Consent

Except in an emergency situation, any voluntary patient (himself or through his next of kin or guardian) shall have the right to refuse any and all medications or other treatments. If appropriate medications or treatments are refused, the facility may then discharge the patient, and shall not be liable in any respect for such action.

Section 8. INFORMED CONSENT TO MEDICATION OR OTHER TREATMENT -- INVOLUNTARY PATIENTS

8.A. Consent During Emergency Evaluation

Following admission and during the period of emergency evaluation provided in Section 4, the treatment facility may administer medications or other treatments, except as limited by Section 8.C., to a patient consistent with good medical practice and without the informed consent of the patient or his next of kin or guardian. However, prior to administering any such medication or other treatment, the staff shall explain the purposes, nature, and effects of the treatment and shall request the patient's consent to it, unless the responsible

psychiatrist [or: "the responsible physician"][11] determines that the patient's condition makes doing so infeasible or harmful to him, and enters the reasons for not doing so in the record.

8.B. Consent During Thirty-Day or Subsequent Commitments

It being a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments, except as limited by Section 8.C., to such persons consistent with good medical practice without their consent. Although consent to treatment is not required, during the course of treatment the responsible psychiatrist [or: "the responsible physician"][12] shall consult with the patient and his next of kin or guardian, and give consideration to the views they express concerning treatment and any alternatives.

8.C. Special Therapies

Notwithstanding subsections A. and B. above, a treatment facility shall not administer aversive therapy, experimental treatment, psychosurgery, or any other special therapy designated by the Department of Mental Health except as provided by law or in regulations promulgated by the Department of Mental Health.

8.D. Other Medical/Surgical Treatments

Consent for other medical/surgical treatments not intended primarily to treat a patient's mental disorder shall be obtained in accordance with applicable law.

Section 9. PROVISION OF TREATMENT

9.A. General Duty To Provide Treatment

Every patient shall be provided with prompt, competent and appropriate treatment, which offers him a realistic prospect of improvement. Patients shall be afforded treatment by sufficient numbers of duly qualified personnel, in facilities which meet applicable

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[11] Optional provision.

[12] Optional provision.

licensing and accreditation standards, which conform to applicable regulations of the Department of Mental Health, and which are able adequately to care for and treat the patients they serve.

9.B. Individual Treatment Plan

1. A written individual treatment plan shall be prepared, with the participation of the patient to the extent he is able, during voluntary admission or emergency psychiatric evaluation, or if a person has been subject to neither, then within seven days of a patient's thirty-day commitment. The individual treatment plan shall be approved by the responsible psychiatrist [or: "the responsible physician"],[13] and the course of treatment actually administered shall conform to the plan.

2. The patient's progress in attaining the objectives in the treatment plan shall be noted in his records and revisions in the plan shall be made as appropriate. The patient, and if the patient desires, the next of kin or guardian, shall be afforded an opportunity to participate in considering any substantial change in the treatment plan.

3. The individual treatment plan shall be available upon request to the patient, and to any other person designated by him, provided that the responsible psychiatrist [or: "the responsible physician"][14] may preclude disclosure of the individual treatment plan to the patient or others for a period not to exceed seven days from the request, if he states in writing why disclosure would be harmful to the patient.

9.C. Administration of Medications and Other Treatments

1. Medications and other treatments shall only be prescribed, ordered and administered in conformity with accepted clinical practice. Medication shall be administered only in accordance with the written order of a physician or upon a verbal order, noted in the patient's medical record and subsequently signed by the physician. Medication shall be administered only by a qualified physician, or qualified nurse, or by

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[13] Optional provision.

[14] Optional provision.

qualified other persons pursuant to procedures approved by the Department of Mental Health. The attending physician shall review regularly the drug regimen of each resident patient under his care and shall monitor any symptoms of harmful side effects. Prescriptions for psychotropic medications shall be written with a termination date not exceeding thirty days thereafter, but may be renewed.

2. Medications and other treatments shall be administered in accordance with all applicable law.

3. If a patient is given any psychotropic or other medication which has an effective duration of action including the day of a court hearing, the facts concerning its administration and effects, and the patient's mental status and behavior in the absence of medication, shall be brought to the attention of the court.

9.D. Other Medical/Surgical Care

All patients shall be provided with prompt, regular and competent medical care for physical ailments under the supervision of a licensed physician. Every patient shall have a reasonably complete physical examination at appropriate intervals.

Section 10. RIGHTS OF PATIENTS

10.A. Preservation of Rights

No right of any person (including but not limited to the right to register and vote at elections; rights to acquire, use and dispose of property including contractual rights; rights to sue and be sued; rights relating to licenses, permits, privileges and benefits under law; and rights concerning domestic relations) shall be denied or reduced solely by reason of his having been evaluated, committed or treated under this Act, except as otherwise specifically provided herein or in other applicable law. A finding of lack of capacity to make an informed decision concerning treatment under Section 6 shall not alone establish lack of competence for any other purpose. A treatment facility may for clinical reasons preclude a patient who is believed to lack competence from making substantial dispositions of his property until his competence can be decided by a court.

10.B. Right to Treatment

Patients shall have a right to treatment to the extent provided in Sections 9, 10.C., and 10.D.

10.C. Healthful and Humane Environment

Every patient shall have the right to a healthful and humane environment. Every treatment facility shall provide a clean, sanitary, safe and comfortable environment in a structure which complies with applicable licensing requirements governing physical facilities, nutrition, health and safety, and medical services, and for aspects of care for which there are not mandatory requirements, with generally accepted professional standards. In addition, every patient shall have a right to a humane psychological environment which protects him from harm or abuse, provides reasonable privacy, promotes personal dignity and provides opportunity for improved functioning.

10.D. Least Restrictive Alternative and Leaves of Absence

1. Every patient shall have the right to treatment consistent with the least restrictive alternative principle.

2. Leaves of absence may be granted in appropriate cases at the discretion of the treating facility. Police officers shall be authorized to and shall, at the request of a treatment facility, take into custody and return to the treatment facility any person who has been committed there and leaves without proper authorization or does not return at the end of an authorized leave of absence.

10.E. Institutional Labor

1. Patients have a right to perform labor as part of a therapeutic program.

2. Patients may not be required to perform labor, except that to the extent they are able, they may be required to perform (1) tasks necessary to care for their personal possessions, (2) routine, nondegrading housekeeping tasks necessary to maintain their living quarters, or (3) other tasks which the responsible

psychiatrist [or: "the responsible physician"][15] approves and which are monitored as part of a therapeutic program for the patient. No patient shall be subjected to any loss of any right under this Act (as distinguished from a privilege which is conferred as part of a therapeutic program) because of his refusal to perform such tasks.

3. Any patient labor which confers an economic benefit upon the institution beyond merely supplementing employee performance of housekeeping tasks shall be compensated on a reasonable basis in accordance with applicable law, and the proceeds of such labor shall be paid to the patient or his designee.

10.F. Restraints and Seclusion[16]

1. Restraints and seclusion may be of therapeutic benefit to some patients and therefore may be administered in conformity with good medical practice.

2. Every patient shall have the right to be free from unwarranted or inappropriate restraints or seclusion.

3. A patient shall be physically restrained or placed in seclusion only at the written order of a physician or upon a verbal order noted in the patient's record and subsequently signed by the physician.

4. During any period in which a patient is restrained or secluded, he shall be periodically checked and cared for properly to assure his well-being.

10.G. Corporal Punishment

Every patient shall have the right to be free from corporal punishment.

10.H. Nutrition

Every patient shall have the right to a nutritionally sound and medically appropriate diet.

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[15] Optional provision.

[16] These provisions establish only a basic framework for the use of restraints and seclusion. More detailed guidelines are being prepared by the American Psychiatric Association to deal with the many subtle problems which arise.

10.I. Exercise and Recreation

Every patient shall have reasonable opportunities for physical and outdoor exercise and access to recreational areas and equipment. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.J. Visitors

Every patient has the right to receive visitors of his choosing with reasonable privacy. Reasonable limitations on access of visitors may be set by general rules or, for clinical reasons, in particular cases.

10.K. Communications

1. Every patient shall have the right to send and receive mail. Reasonable rules governing inspection (but not reading) of incoming mail may be enforced, provided that they are necessary to substantial health care purposes and that they preserve the patient's privacy rights to the extent compatible with his clinical status.

2. Every patient shall have the right to reasonably private access to telephones, including the right to make long-distance calls to the extent he can arrange for payment for such calls.

3. A treatment facility shall provide reasonable assistance to patients in exercising their communication rights. Reasonable limitations on use of the mails and telephones may be set by general rules or, for clinical reasons, in particular cases.

10.L. Practice of Religion

Every patient shall have the right to practice or refrain from practicing religion, and pressure shall in no event be placed on those who do not wish to practice religion. The treatment facility shall provide appropriate assistance so that patients wishing to practice a religion have a reasonable opportunity to do so.

10.M. Personal Possessions

Every patient shall have the right to keep, use and store personal possessions and to maintain and use

bank accounts or other sources of personal funds, unless precluded from doing so by order of a court. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.N. Notice of Rights

As soon after admission as his medical condition permits, a patient shall be advised orally and given a written statement of his rights under this Act, and such a statement of rights shall be posted so that it is available to patients.

10.O Non-Retaliation

No patient shall be retaliated against or subjected to any adverse change of conditions or treatment solely because of his having asserted his rights.

10.P. Access to Counsel

A patient may at any time have a telephone conversation with or be visited by his lawyer.

Section 11. SUCCESSIVE PERIODS OF COMMITMENT

11.A. Sixty-Day Re-Commitment

1. Any person who has been subject to a thirty-day commitment pursuant to Section 6, may be re-committed for up to sixty days upon a petition by the treatment facility or by the next of kin or guardian. The petition may be filed with the court at any time prior to the expiration of the thirty-day commitment. The petition shall include a statement of the treatment facility as to why the person still meets the criteria for involuntary commitment; what treatment has been provided and what progress has been made; why a further period of commitment is warranted; and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.

2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following the expiration of the thirty-day commitment, and shall have all other rights to which he was entitled at the hearing on thirty-day commitment.

3. The court shall order that the person be discharged unless it determines (a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and (b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.

11.B. One Hundred Eighty-Day Re-Commitments

1. Any person who has been subject to sixty-day re-commitment pursuant to Section 11.A. may be re-committed for up to one hundred eighty days upon a petition filed with the court by the treatment facility or by the next of kin or guardian. The petition shall include a statement of the treatment facility as to why the person still meets the criteria for involuntary commitment; what treatment has been provided and what progress has been made; why a further period of commitment is warranted; and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.

2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following expiration of the operative period of commitment and shall have all other rights to which he was entitled at the hearing on thirty-day commitment.

3. The court shall order that the person be discharged unless it determines (a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and (b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.

4. Additional re-commitments for periods of up to one hundred eighty days each may be ordered in accordance with Section 11.B.1-3 when warranted.

11.C. Waiver of Hearings

A patient may waive any hearing to which he is entitled under this Section 11 upon a written waiver which the court finds is knowingly and voluntarily executed by the patient.

Section 12. DISCHARGE

12.A. The responsible psychiatrist [or: "the responsible physician"][17] shall review periodically whether a patient still meets the criteria for lawful commitment, and if he concludes that the patient does not, he shall undertake discharge procedures as provided herein.

12.B. As to a patient committed because he was likely to cause harm to himself or to suffer substantial mental or physical deterioration, if the responsible psychiatrist [or: "the responsible physician"][18] concludes that the patient no longer meets the criteria for lawful commitment, he may discharge the patient directly.

12.C. As to a patient committed solely because, or partly because, he was likely to cause harm to others, if the responsible psychiatrist [or: "the responsible physician"][19] concludes that the patient no longer meets the criteria for lawful commitment, or that the patient's treatment program has been completed or is unlikely to provide further benefits, he shall apply to the court for an order discharging or transferring the patient, as may be appropriate. The application shall set forth the relevant facts. The court may conduct an informal hearing, subject to such procedures as the court sets. Nothing in this subsection shall reduce any rights to hearings which patients have pursuant to other provisions of this Act.

12.D. Discharge of any patient may be delayed for a reasonable period of time in order to arrange transportation or lodging for the patient, or for other good cause.

12.E. A person who has been discharged from emergency evaluation, thirty-day commitment or a subsequent period of commitment may be re-committed only pursuant to the same procedures provided in this Act and upon a showing of some new circumstances warranting such commitment which were not known at the time of discharge.

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[17] Optional provision.

[18] Optional provision.

[19] Optional provision.

12.F. The responsible psychiatrist [or: "the responsible physician"][20] may, as part of an individual treatment plan for a patient who is involuntarily committed, release such patient to outpatient treatment upon the condition that if the patient fails to follow through with or respond acceptably to such outpatient treatment, he may be returned to inpatient treatment for the remainder of the operative period of commitment.

12.G. Nothing in this Act shall limit any other legal rights or remedies concerning discharge which a patient may have or acquire pursuant to law, regulation or policy, including the right to petition for a writ of habeas corpus.

Section 13. CONFIDENTIALITY AND DISCLOSURE OF INFORMATION

[This Section adopts the American Psychiatric Association's "Model Law on Confidentiality of Health and Social Service Records."]

Section 14. REPRESENTATION OF PATIENTS

14.A. Right to Counsel at Hearings

Every patient shall have a right to counsel to represent him at court hearings under this Act, except that a patient need not be provided with counsel for the preliminary hearing on emergency evaluation provided in Section 4.F.

14.B. Resolution of Grievances in Treatment Facilities

Every treatment facility shall establish a fundamentally fair procedure for the assertion, resolution, and redress of patients' grievances, and shall have a patients' representative or similar person who shall hear patients' grievances, attempt to resolve problems, and protect patients' interests.

14.C. Representation by Next of Kin or Guardian

Any right of patients provided in this Act may be exercised on behalf of a patient who is unable to exercise such right by a next of kin or guardian, in accordance with State law.

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[20] Optional provision.

Section 15. TRANSPORTATION

Whenever a patient is to be brought to or from a treatment facility, or is to be transferred to another facility or to a home, the court may direct the sheriff, state police or other appropriate authorities to furnish suitable transportation.

Section 16. NON-DEROGATION OF PATIENTS' RIGHTS

Rights conferred upon patients by this Act shall be in addition to, and nothing in this Act shall revoke or reduce, any rights, privileges or immunities which a patient may have or acquire by law, regulation or policy.

Section 17. COSTS OF CARE

In accordance with law, indigent public patients shall receive care and treatment under this Act without charge to them. Patients committed under this Act who are able to pay may be required to pay some reasonable costs of care and treatment, and to that end treatment facilities and the State shall be authorized to recover such costs from them or their estate, their family, custodians of their property, or third parties liable for the costs of their care or treatment, in conformity with law. The liability of patients, their families, and others for the long term care of patients committed as likely to cause harm to others shall be specially limited by regulations of the Department of Mental Health.

Section 18. IMMUNITIES AND PENALTIES

18.A. Immunities

1. In the absence of willful misconduct or gross negligence, no officer, director, staff member or employee of a treatment facility shall be liable for acts or omissions within the scope of his employment related to admission, evaluation, care, treatment, nonadmission, transfer, removal of restrictions upon, or discharge of a person, pursuant to this Act.

2. No other person who, acting in good faith and with a reasonable basis, participates in any of the processes provided in this Act shall be liable for such actions.

3. Notwithstanding any other provision of this Act, no police officer, no officer, director, staff member or employee of a treatment facility, and no other person or entity performing actions pursuant to this Act, shall be liable for any action of a patient who is discharged from or is absent from a treatment facility pursuant to this Act.

4. Under no circumstances shall any person performing actions pursuant to this Act have a duty to, or be liable for failing to, notify, advise or warn anyone concerning the non-admission, transfer, removal of restrictions on, or discharge of any person.

18.B. Penalties

1. Any person who knowingly and willfully gives substantial, false information or takes other wrongful action for the purpose of distorting, corrupting or interfering with the processes provided in this Act shall be subject to a civil fine, and shall be liable for injunctive relief and money damages, in addition to any other liability under law.

2. Any person who takes into custody, admits for evaluation or commitment, detains for a further period of time, discharges, or administers medication or treatment to a patient, or takes other action affecting the substantial rights of a patient, doing so knowingly and willfully in substantial violation of this Act, shall be subject to a civil fine, and shall be liable for injunctive relief and money damages, in addition to any other liability under law. This subsection shall not be invoked in cases of minor, merely technical, or otherwise justifiable breaches of the provisions of this Act.

Section 19. REGULATIONS

The Commissioner of Mental Health is empowered to promulgate regulations to implement this Act which are consistent with its provisions.

Section 20. CONSTRUCTION

20.A. Gender and Number

As used in this Act, pronouns shall refer to both male and female persons equally, and articles shall refer to singular and plural references equally.

20.B. Severability

If any provision of this Act or its application to any person or circumstance is held invalid, it is the legislative intent that such invalidity not affect other provisions or applications which can be given effect apart from that which is invalidated, and to this end the provisions of this Act shall be deemed severable.

20.C. Construction Against Implied Repeal

This Act is intended as a unified, general Act covering its subject matter, and accordingly none of its provisions shall be deemed impliedly repealed by subsequent legislation if such a construction reasonably can be avoided.

ADDENDUM

This addendum contains Guidelines for states which do not wish to undertake a comprehensive revision of their civil commitment laws, but do wish to add provisions for the commitment of persons who are likely to "suffer substantial mental or physical deterioration."

* * *

DEFINITIONS

As used in this Act, the terms below shall have the meanings indicated:

* * *

"consistent with the least restrictive alternative principle" means that (1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, where treatment provides the patient with a realistic opportunity to improve, and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient; and (2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.

* * *

"lacks capacity to make an informed decision concerning treatment" means that the person, by reason of his mental disorder or condition, is unable despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment, or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment as evidenced by inability to weigh the possible risks and benefits.

"likely to cause harm to himself or to suffer substantial mental or physical deterioration" means that as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.

* * *

"severe mental disorder" means an illness, disease, organic brain disorder, or other condition which (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment or (2) substantially impairs behavior as manifested by recent disturbed behavior.[1]

* * *

EMERGENCY PSYCHIATRIC EVALUATION

Detention by a Police Officer

A police officer may take a person into custody, and transport the person to a treatment facility for emergency psychiatric evaluation if:

* * *

-- the police officer has probable cause to believe, based on his personal observation and investigation, or based on the petition of any interested adult and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or others or is manifestly unable to care for some of his basic needs, and that immediate hospitalization is necessary to prevent harm to the person or to others;

* * *

Certification by a Licensed Physician

A person may be taken into custody by a police officer, or accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation when a licensed physician certifies in writing that he has examined the patient

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[1] Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder. States may wish to provide by other provisions of law for persons whose use of or addiction to intoxicating substances warrants hospitalization.

in the last 72 hours or that he has ongoing medical responsibility for the person and has knowledge of his current condition, and on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioriation, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

* * *

Treatment Facility Determination

Upon the presentation of a person to a treatment facility, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth below.

The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

* * *

CRITERIA FOR COMMITMENT

A person may be involuntarily committed for a period of up to ( )[1] days if after the hearing the court determines, based upon clear and convincing evidence, that:

1. the person is suffering from a severe mental disorder; and

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[1] Insert the time period under existing law.

2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and

3. the person either refuses or is unable to consent to voluntary admission for treatment; and

4. the person lacks capacity to make an informed decision concerning treatment; and

5. as the result of the severe disorder, the person is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others.

* * *

INFORMED CONSENT TO MEDICATION OR
OTHER TREATMENT -- INVOLUNTARY PATIENTS

* * *

It being a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments, except special therapies which are subject to particular laws or regulations, to such persons consistent with good medical practice without their consent. Although consent to treatment is not required, during the course of treatment the responsible psychiatrist shall consult with the patient and his next of kin or guardian, and give consideration to the views they express concerning treatment and any alternatives.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465-3800

M E M O R A N D U M — September 9, 1983

SUBJECT: Mental health commitment laws
(Work Order No. 13-1516)

TO: Senator Joe Josephson
Chairman, Senate Health, Education and Social Services Committee

FROM: Edward H. Hein
Legislative Counsel

You have asked for a comparison of the American Psychiatric Association's draft guidelines for psychiatric hospitalization of adults with Alaska's mental health commitment laws (AS 47.30.655 - 47.30.915). I have enclosed a section-by-section comparison, with the APA guidelines on the left-hand pages and the corresponding Alaska statutes on the right-hand pages. My comments follow.

In general, there are many similarities between the APA guidelines and Alaska law. Both provide for emergency or involuntary commitments, voluntary commitments, initial periods of detention followed by longer periods of extension, standards, hearings, patient rights, immunities for mental health professionals, and penalties for bad faith commitments. In most cases Alaska law appears to provide equal or better patient protections than those recommended by the APA.

The major specific differences between the guidelines and the statutes are as follows:

1. Emergency detention. Under APA section 4.A.2. a person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility, except for protective custody purposes and only while awaiting transportation to a treatment facility. Under AS 47.30.705. a correctional facility may be used as an emergency evaluation facility if a regular evaluation facility is unavailable.

2. Petition for involuntary commitment. Under APA section 4.C. any "interested adult" may petition for an emergency psychiatric evaluation of another person. The APA does not define what "interested" means. Under AS 47.30.700 "any adult" may petition for involuntary commitment of another person.

3. Deadline for emergency examination. Under APA section 4.D.1. a treatment facility must examine a person under emergency detention "promptly" after arrival at the facility. Under AS 47.30.710 the examination and evaluation must be completed within 24 hours of arrival.

4. Advisement of rights. Under APA section 4.E. a treatment facility must notify a person admitted for emergency evaluation of the purposes and possible duration of the evaluation, as well as the person's legal rights relating to commitment. Under AS 47.30.725 there is no specific requirement of notice relating to the purposes and duration of evaluation. But the Alaska statute requires that notice be both oral and written and in a language the person understands.

5. Hearing after emergency detention. Under APA section 4.F. a person under emergency detention must receive a hearing before a court within five business days after being admitted to a facility. This right to a hearing may be waived in writing upon advice of counsel. The hearing is informal and is conducted under rules set by the court consistent with "fundamental fairness". After the hearing a person may be discharged by the court or committed for 30 days. Under AS 47.30.725 a person under emergency or involuntary detention has a right to a hearing within 72 hours of arrival at the facility. The person may not waive the right to a hearing, but may waive the 72-hour limit if the person is represented by counsel. However, the hearing must be held within seven calendar days of the person's arrival at the facility. The person has a right to communicate, immediately after arrival at the facility, with a guardian or other adult and with an attorney. At the hearing the person has a right to be represented by an attorney, to present evidence and to cross-examine witnesses. Subject to specified exceptions, the person has a right to be free of the effects of medicine or treatment before the hearing. After the hearing the person may be discharged or committed for a period of 21 days. Additional hearing rights are

specified elsewhere in the APA guidelines and the Alaska statutes.

6. Voluntary admission. Under APA section 5.A. a person believed to be mentally ill and in need of hospitalization may be admitted voluntarily if the person consents in writing after being advised of rights. The consent is effective for 60 days, but may be renewed for an unlimited number of periods of up to 180 days each. Under AS 47.30.670 the only requirements are that the person (1) in fact be suffering from mental illness, (2) be 14 years old or older, and (3) "voluntarily" signs the admission papers. A person under 14 years of age may be "voluntarily" admitted for a period of 21 days if (1) the minor's guardian or parent signs the admission papers and (2) the senior mental health professional at the facility concludes that specified criteria are met. Presumably the minor is automatically released after 21 days unless the minor is admitted again under the same requirements as for initial admittance.

7. Discharge from voluntary admission. Under APA section 5.B. any person voluntarily admitted must be discharged within five business days after submitting a written request for discharge, unless the treatment facility or the person's guardian files a petition for 30-day commitment. Under AS 47.30.685 - 47.30.695 a person who was voluntarily admitted to a treatment facility shall be discharged immediately upon submitting a written notice of intent to leave the facility. However, the treatment facility may hold the person for 48 hours after receiving an intent to leave notice in order to initiate involuntary commitment proceedings. In that case, the facility must give the person written notice of its intent to initiate the proceedings by the time the person would otherwise be released. A person who is under 14 years of age must be discharged immediately upon the request of the parent or guardian, unless the minor, if released, is likely to cause serious harm to himself or another as a result of a mental illness.

8. Conversion of status. Under APA section 5.C. a person who was committed involuntarily may change to a voluntary admitee with a psychiatrist's approval. No comparable provision exists in Alaska law.

9. Further periods of commitment. The APA guidelines provide for 30-day, 60-day, 90-day, and 180-day commitments. Alaska law provides for 21-day, 90-day, and 120-day

commitments. Each period of commitment is to be preceded by a hearing under both the APA guidelines and the Alaska statutes. The patient's rights at the hearing vary considerably, however, under the two different schemes. The most noticeable differences are that (1) the APA guidelines allows the use of hearsay evidence so long as it is relevant, while Alaska requires the use of civil rules of evidence; (2) the APA denies a patient's Fifth Amendment right to remain silent, while Alaska law specifically recognizes it; and (3) the APA does not allow the exclusion from evidence of privileged communications between the patient and psychiatrist or physician made during the course of evaluation or treatment, whereas Alaska law recognizes such an evidentiary privilege.

10. Petitions for further periods of commitment. Under both the APA guidelines and Alaska law, all commitments are initiated by the filing of a petition. Under APA section 6.A. a petition for a 30-day commitment of a person already at a treatment facility may be filed by the facility or by the person's "next of kin" or guardian. If the person is not currently committed, any "interested adult" may file a petition for a 30-day commitment of the person. The language of the guidelines does not make clear whether additional petitions may be filed for successive commitments of 30-days each. Under APA section 11.A. a person who "has been subject to" a 30-day commitment may be recommitted for an additional 60-day period upon a petition filed by the treatment facility or the person's "next of kin" or guardian. (The drafting here is imprecise and ambiguous. The phrase "has been subject to" could mean "has ever been subject to" or it could mean "is currently under" or it could mean "has met the criteria for".) Under APA section 11.B., a person committed for any period of time and who is dangerous to himself or herself may be committed for one additional period of "up to 90 days" upon a petition filed by the treatment facility or by the person's next of kin or guardian at any time before the current period of commitment expires. Under APA section 11.C., a person who "was committed for up to 30 days and is subject to 60-day recommitment" and who is likely to harm others may be committed for successive additional periods of 180 days each upon a petition filed by the person's next of kin or guardian, or by the state "upon advice of the treatment facility". Under AS 47.30.730, a petition for a 21-day commitment must be signed by two mental health professionals who have examined the person. It is not clear who may file

the petition. Under AS 47.30.740, a petition for a 90-day commitment may be filed by "the professional person in charge" while the person is under a 21-day commitment. Under AS 47.30.770 the "professional person in charge" may file a petition for a 120-day commitment of a person who is under a 90-day commitment. Successive commitments of 120 days each are authorized.

11. Informed consent. Under APA section 7, a treatment facility must obtain a patient's informed consent before administering medicine or treatment to a voluntary admitee in a non-emergency situation, unless the person lacks capacity to consent. A voluntary admitee may revoke consent in writing at any time except in an emergency. Under APA section 8, an involuntary admitee, or a voluntary admitee in an emergency, may be treated or given medicine without informed consent. Under AS 47.30.825, every mental patient has the right to know the name, purpose and side effects of medicine to be administered. In a "true medical emergency", surgery to save the "life, physical health, eyesight, hearing or member of the patient" may be performed without the consent of the patient, guardian or court. The law specifically recognizes an adult patient's right to not be operated on if the patient knowingly withholds consent on religious grounds.

12. Special therapies. Under APA section 8.C. experimental treatments, psychosurgery, aversive therapy or other special therapy designated by the appropriate state department may not be administered, except as provided by law or regulation. AS 47.30.825 provides that a lobotomy or psychosurgery may not be performed without specific informed consent, a full due process hearing, and a court order. Electro-convulsive therapy or aversive conditioning requires informed consent or, if the patient lacks substantial capacity to give informed consent, a court order. Under AS 47.30.830 experimental treatments involving any significant risk of physical or psychological harm are prohibited.

13. Patient rights. This is one area where the APA guidelines are more thorough than Alaska law. Under both schemes patients have rights to privacy, property, civil rights such as voting, mail, access to attorneys and visitors, and treatment consistent with the "least restrictive alternative" principle. APA section 10, however, also provides a right to "nutritionally sound and medically appropriate diet", a right to exercise and recreation, a

right to perform labor, and a right to be free from corporal punishment.

14. Discharge. Under APA section 12.F. a person may, as part of an individual treatment plan, be released from commitment at a facility to outpatient treatment. The person may, however, be returned to inpatient treatment for failure to comply with the outpatient treatment program requirements. APA section 15 provides that law enforcement or other appropriate authorities shall provide transportation of patients to and from a treatment facility. Under AS 47.30.825, a person upon discharge from a facility must be given a discharge plan suggesting, but not requiring, the kinds and amounts of treatment the person should have to maintain mental health. The person has a right to participate in formulating the discharge plan. Also, under AS 47.30.890 a person is entitled to "suitable clothing" upon discharge, and if indigent, to transportation to the person's permanent residence in the state and "a reasonable amount of money to meet immediate needs". See also AS 47.30.795.

15. Confidentiality. The APA guidelines adopt by reference the "Model Law on Confidentiality of Health and Social Service Records". AS 47.30.845 provides that patient records are confidential and not public records, and specifies the persons or agencies to whom records and information may be disclosed.

16. Grievance procedures. APA section 14.B. requires that treatment facilities establish "fundamentally fair" procedures for patients' grievances. Alaska statutes have no similar provision.

17. Immunities. Under APA section 18.A. employees of a treatment facility are not liable for acts or omissions within the scope of employment, absent willful misconduct or gross negligence. Other persons who act in good faith and with a reasonable basis are not liable for actions provided for under the guidelines. The guidelines disclaim any liability for actions by a patient who is absent from a treatment facility or who has been discharged. Finally, the guidelines disclaim any liability for failure to warn or notify anyone of a patient's discharge. Immunity under Alaska law is much more limited. Under AS 47.30.815 a person is not subject to criminal or civil liability for petitioning for evaluation or treatment of another person in

good faith and upon actual knowledge or reliable information. Also, four classes of officials may not be held civilly or criminally liable for detaining or releasing a person "at or before the end of" the period for which the person was committed, so long as the official acted in good faith and without gross negligence.

18. Penalties. APA section 18.B. provides that a civil fine, injunctive relief and money damages may be imposed or granted if a person (1) "knowingly and willfully gives substantial, false information or takes other wrongful action for the purpose of distorting, corrupting or interfering with the processes provided in this Act" or (2) commits, detains, discharges, or treats a patient, or otherwise affects a patient's "substantial rights" knowingly and willfully in substantial violation of the guidelines. AS 47.-30.815 makes it a class C felony to willfully initiate an involuntary commitment procedure without good cause.

19. Miscellaneous provisions. The last four pages of the comparison booklet (enclosed) consist of provisions of Alaska law for which there are no corresponding provisions in the APA guidelines. Note especially AS 47.30.760, providing for placement at the closest facility; AS 47.-30.765, providing for appeal of involuntary commitment orders; AS 47.30.875, providing for handling of nonresident patients; AS 47.30.880, adopting the Interstate Compact on Mental Health; and AS 47.30.895 - 47.30.900, disposition of personal property and money of patients who die while in custody or who leave a facility without authority. Note one error: AS 47.30.795, relating to outpatient care and appearing among the miscellaneous provisions, actually corresponds with APA section 12.F. and should have appeared opposite that section.

If you have any questions or comments, feel free to contact me at your convenience.

EHH:ljb

Enclosure
29/002

Given to Patients at API
(ALSO IN A LANGUAGE UNDERSTOOD BY PATIENT)

PATIENT RIGHTS

Your legislators have tried to protect your rights to freedom and at the same time protect everyone from dangerous people and protect people who are harmful to themselves because of mental illness.

The following are your rights according to law:

1. You may join in developing your treatment plan, and you are entitled to be informed of your medical and psychological condition and prognosis.

2. You will be told the name, purpose, and side effects of any medication you are asked to take.

3. No unnecessary or excessive medication will be given to you. All medication will be given only on the order of a licensed physician.

4. Physical restraint will not be used on you unless you behave in a manner harmful to yourself or others

5. You will not receive electroconvulsive therapy, aversive conditioning, experimental treatment or psychosurgery.

6. You will be given a discharge plan outlining the kind and amount of care and treatment you should have after discharge.

7. Your civil rights will not be impaired.

8. Your hospital record and I.D. photograph will be confidential.

9. Unless you sign a release of responsibility, your personal property will be inventoried and safe-guarded and returned to you at discharge.

10. You will have private storage space, and will be allowed to wear your own clothing, and keep certain personal possessions and a reasonable amount of your own spending money.

11. You may have visitors during visiting hours.

12. You will have access to letter writing materials and stamps, and may send and receive unopened mail.

13. You will have reasonable access to a phone and may make and receive confidential calls.

14. After discharge you may move to have all court records pertaining to your care expunged.

Under the law certain rights may be restricted by your doctor when it is necessary for the protection of yourself or others.

The following additional information will help you better understand your care here. If you still have questions, ask your nurse or social worker:

1. No matter what your legal status is, the more you want to help yourself and work with the staff in an honest, open manner, the quicker and more effective will be your recovery.

2. You do not have the right to do the following:

   - Injure or threaten others.

   - Damage property

   - Intrude on the rights of others, such as rudeness, shouting, or excessive noise that you can control.

   - Make messes for others to clean up.

   - Bring or use drugs, alcohol or weapons.

   - Do illegal acts (break the law). This includes writing threatening letters or making threatening or obscene phone calls.

If you feel you are being treated unfairly or improperly, please follow these steps:

1) Bring it up in the community meeting.

2) If you are not satisifed with the results of that action, bring it up with your nursing advisor, doctor, or any member of the treatment team.

3) If not satisfied, write down your problem and complaint and forward it to the Superintendent.

4) You always have the right to write to your attorney, the State Ombudsman, the Commissioner of the Department of Health and Social Services, or the Superior Court which may have been involved in your hospitalization.

If you feel you've been discriminated against in any way because of race, color, sex, religion, age, or national origin, you may file a complaint with the Civil Rights Commission. You can get the forms from the Administrator's Office. If you need help in filling them out, see your nurse advisor or the Hospital Administrator's Office.

/ojb/vnc

HALOPERIDOL (Systemic)

Haloperidol (ha-loe-PER-i-dole) is used to treat nervous, mental, and emotional conditions. It is used also to control nausea and vomiting and the effects of Gilles de la Tourette's disease. Haloperidol is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have any of the following medical problems:

Alcoholism	Lung disease
Blood disease	Overactive thyroid
Epilepsy	Parkinson's disease
Glaucoma	Prostate enlargement
Heart or circulation disease	Severe mental depression
Kidney disease	Stomach ulcers
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Asthma medicine
Anticonvulsants (seizure medicine)	Epinephrine
Antihypertensives (high blood pressure medicine)	Ulcer medicine

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Prescription pain medicine
Barbiturates	Sedatives, tranquilizers, or sleeping medicine
Narcotics	Tricyclic antidepressants (medicine for depression)

Proper Use of This Medicine

Use this medicine only as directed by your doctor. Do not use more of it, do not use it more often, and do not use it for a longer period of time than your doctor ordered.

If this medicine upsets your stomach, it may be taken with food or milk to lessen stomach irritation.

If you miss a dose of this medicine, take it as soon as possible unless it is within 6 hours of your next scheduled dose. Do not double doses. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

Sometimes haloperidol must be taken for several days to several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.

Do not suddenly stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally, especially as the amount of medicine is increased. Even if you take this medicine at bedtime, you may feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Although not a problem for many patients, dizziness, light-headedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. However, if the problem continues or gets worse, check with your doctor.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

Shuffling walk	Tic-like, jerky movements of head, face, mouth, and neck
Stiffness of arms and legs	Trembling and shaking of hands and fingers

Less common

Difficulty in urination	Fine, worm-like movements of tongue
Dizziness, light-headedness, or fainting	Skin rash

Rare

Sore throat and fever	Yellowing of eyes and skin

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

More common

Blurred vision	Dry mouth
Constipation	

Less common

- Decreased sexual ability
- Drowsiness
- Nausea or vomitting

Other side effects not listed above may also occur in some patients. If you notice any other effects, check with your doctor.

ADDITIONAL INFORMATION

For patients taking the liquid form of this medicine

This medicine is to be taken by mouth even though it may come in a dropper bottle. Each dose is to be measured with the included, specially marked dropper. This medicine may be taken straight or mixed with food or beverages.

When using the liquid form of this medicine, try to avoid getting it on your skin or clothing because it may cause a skin rash or other irritation.

TRICYCLIC ANTIDEPRESSANTS (Systemic)

Applies to:
Amitriptyline (a-mee-TRIP-ti-leen)
Desipramine (dess-IP-ra-meen)
Doxepin (DOX-e-pin)
Nortriptyline (nor-TRIP-ti-leen)
Imipramine (im-IP-ra-meen)

Does *not* apply to:
Protriptyline

This medicine belongs to the group of medicines known as tricyclic antidepressants or "mood elevators." It is used to relieve mental depression and depression that sometimes occurs with anxiety. One form of this medicine (imipramine) may be used to treat enuresis (bedwetting). Tricyclic antidepressants are available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have experienced an allergic reaction to other tricyclic antidepressants.

—if you have any of the following medical problems:

Alcoholism	Heart disease
Asthma (history of)	High blood pressure
Difficult urination	Liver disease
Enlarged prostate	Overactive thyroid
Glaucoma	Stomach or intestinal problems

—if you are now taking any other medicines, including over-the-counter (OTC) or nonprescription medicine, especially the following:

Allergy medicine	Other medicine for depression
Antihistamines	Pain medicine
Barbiturates	Sedatives
Blood pressure medicine	Seizure medicine
Cold remedies	Sleeping medicine
Hay fever medicine	Tranquilizers
Narcotics	

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of This Medicine

Take this medicine only as directed by your doctor.

To lessen stomach upset, take this medicine with food, unless your doctor has told you to take it on an empty stomach.

Sometimes this medicine must be taken for several weeks before you begin to feel better.

Keep this medicine out of the reach of children since overdose is especially dangerous in young children.

If you miss a dose of this medicine, take it as soon as possible and then go back to your regular dosing schedule. However, if a once-a-day bedtime dose is missed, do not take that dose in the morning. Instead, check with your doctor.

Precautions While Using This Medicine

It is very important that your doctor check your progress at regular visits.

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are using before stopping completely.

Before having any kind of surgery (including dental surgery) or emergency treatment, tell the doctor or dentist in charge that you are using this medicine.

This medicine will add to the sedative effects of alcohol and other medicines that slow down the nervous system such as antihistamines or medicines for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; other medicine for depression; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine. *Check with your doctor before taking any of the above while you are taking this medicine and also for several days after you stop taking it.*

This medicine may cause some people to become drowsy or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If this problem continues or gets worse, check with your doctor.

Side effects of this Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

Blurred vision	Irregular heartbeat (pounding, racing, skipping)
Constipation	Problems in urinating

Less common

Eye pain	Hallucinations (seeing, hearing, or feeling things that are not there)
Fainting	Shakiness
	Unusually slow pulse

Rare

Seizures	Sore throat and fever
Skin rash and itching	Yellowing of eyes and skin

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

More common
- Dizziness
- Drowsiness
- Increased appetite for sweets
- Dry mouth
- Headache
- Nausea
- Tiredness or weakness

Less common
- Diarrhea
- Excessive Sweating
- Heartburn
- Increased sensitivity to sunlight
- Sleeping difficulty
- Vomiting

LITHIUM (Systemic)

Lithium (LI-thee-um) is a medicine used in the treatment of certain mental and emotional conditions. Lithium is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you are pregnant or if you intend to become pregnant while using this medicine.

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

Heart disease	Severe infection
Kidney disease	Thyroid disease
Parkinson's disease	

—if you drink large amounts of coffee or tea.

—if you are on a low-salt diet.

—if you are now taking any of the following medicines or types of medicine:

Asthma medicine	Haloperidol
Caffeine	Potassium iodide
Chlorpromazine	Sodium bicarbonate (baking soda)
Diuretics (water pills, especially thiazide-type)	

Proper Use of This Medicine

Take this medicine exactly as directed. Do not take more of it, do not take it more often, and do not take it for a longer period of time than your doctor ordered.

Sometimes this medicine must be taken for 1 to several weeks before you begin to feel better.

While taking this medicine, *drink 2 or 3 quarts of water or other fluids each day,* and use a normal amount of table salt in your food, unless otherwise directed by your doctor.

Take this medicine immediately after meals or with food or milk to lessen stomach upset, unless otherwise directed by your doctor.

If you miss a dose of this medicine, take it as soon as possible unless it is 2 hours or less until your next scheduled dose. Do not double doses. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits to make sure that the medicine is working properly and that possible side effects are avoided.

This medicine may cause some people to become drowsy or less alert than they are normally. ***Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.***

Use extra care in hot weather and during activities that cause you to sweat heavily, such as hot baths, saunas, or exercising. The loss of too much water and salt from your body may lead to serious side effects from this medicine.

Do not drink large amounts of caffeine-containing beverages, such as coffee, tea, or colas, while taking this medicine. Since lithium is lost from the body through the urine, the increased urine flow caused by caffeine may lessen the medicine's effect.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

Nausea and vomiting
Shakiness and tremor

Less common

Drowsiness	Swelling of feet and lower legs
Mental confusion	Weakness
Pains in lower stomach	Slurred speech

Rare

Blurred vision	Jerking of arms and legs

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

More common

Decreased sexual ability	Dry mouth
Diarrhea	Increased thirst
Dizziness	Increased urination

Less common

Skin eruption or rash

Signs of low thyroid function

Coldness of fingers and toes	Menstrual changes
Constipation	Muscle aches
Dry, puffy skin	Sleepiness
Headache	Tiredness
	Unusual weight gain

BENZTROPINE (Systemic)

Benztropine (BENZ-troe-peen) is a medicine used to treat Parkinson's disease, sometimes referred to as "shaking palsy." By improving muscle control, benztropine allows more normal movements of the body as the disease symptoms are reduced. Benztropine is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have any of the following medical problems:

Asthma	High blood pressure
Bronchitis	Intestinal blockage
Difficult urination	Kidney disease
Emphysema	Liver disease
Enlarged prostate	Myasthenia gravis
Glaucoma	Overactive thyroid
Hiatal hernia	Severe ulcerative colitis

—if you are taking any of the following medicines or types of medicine:

Amantadine	Medicine for diarrhea
Antacids	Medicine for Parkinson's disease
Antihistamines or medicine for hay fever, other allergies, or colds	Medicine for sleep
	Nerve medicine
	Sedatives or tranquilizers
Haloperidol	
Heart medicine	Ulcer medicine

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of This Medicine

Take this medicine only as directed by your doctor To lessen stomach upset, take this medicine immediately after meals or with food, unless your doctor has told you to take it on an empty stomach.

If you miss a dose of this medicine, take it as soon as possible. If it is within 8 hours of your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for depression; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine. *Check with your doctor before taking any of the above while you are taking this medicine.*

Do not take this medicine within 1 hour of taking antacids or medicine for diarrhea. Taking them too close together will make benztropine less effective.

This medicine may cause your eyes to become more sensitive to light than they are normally. Wearing sunglasses may help lessen the discomfort from bright light.

This medicine may cause some people to become drowsy, dizzy, or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Benztropine will often reduce your tolerance of heat, since it makes you sweat less, causing your body temperature to increase. *Use extra care not to become overheated during exercise or hot weather while you are taking this medicine, as this could possibly result in heat stroke.*

Your mouth, nose, and throat may feel very dry while you are taking this medicine. *To help relieve mouth dryness, chew sugarless gum or dissolve bits of ice in your mouth.*

Check with your doctor if you develop intestinal problems such as constipation. This is especially important if you are taking other medicine while taking benztropine, because if the problems are not corrected serious complications may result.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common
Constipation

Less common
Difficult urination

Rare
Eye pain
Skin rash

THIOXANTHENES *(Systemic)*

Applies to:
Chlorprothixene (klor-proe-THIX-een)
Thiothixene (thye-oh-THIX-een)

This medicine belongs to the general family of medicines known as thioxanthenes. It is used in the treatment of nervous, mental, and emotional conditions. This medicine is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have ever had any unusual reaction to other thioxanthene or phenothiazine medicines.

—if you have any of the following medical problems:

Alcoholism	Lung disease
Blood disease	Parkinson's disease
Glaucoma	Stomach ulcers
Heart or circulation disease	Prostate enlargement
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Guanethidine (high blood pressure medicine)
Anticonvulsants (seizure medicine)	Levodopa
Epinephrine	Ulcer medicine

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Sedatives, tranquilizers, or sleeping medicine
Barbiturates	Tricyclic antidepressants (medicine for depression)
Narcotics	
Prescription pain medicine	

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of this Medicine

Do not take more of this medicine or take it more often than your doctor ordered. This is particularly important when it is given to children, since they may react very strongly to the effects of the medicine.

This medicine may be taken with food or a full glass (8 ounces) of water or milk to reduce stomach irritation.

Sometimes this medicine must be taken for several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.

If you miss a dose of this medicine, take it as soon as possible. If it is two hours or less until your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally, especially during the first few weeks the medicine is being taken. Even if you take this medicine only at bedtime, you may feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If the problem continues or gets worse, check with your doctor.

Sometimes, patients may show signs of restlessness and excitement after taking this medicine. If this occurs, stop taking the medicine and check with your doctor.

This medicine will often make you sweat less, causing your body temperature to increase. Use extra care not to become overheated during exercise or hot weather while you are taking this medicine, since overheating could possibly result in heat stroke. Also, hot baths or saunas may make you feel dizzy or faint while you are taking this medicine.

A few people who take this medicine may become more sensitive to sunlight than they are normally. When you first begin taking this medicine, avoid too much sun or too much use of a sunlamp until you see how you react. If you have a severe reaction, check with your doctor.

Do not take this medicine within an hour of taking antacids or medicine for diarrhea. Taking them too close together may make this medicine less effective.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur

they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

- Fainting
- Muscle spasms, especially of neck and back
- Restlessness
- Shuffling walk
- Tic-like (jerky)movements of head, face, mouth, and neck
- Trembling and shaking of hands and fingers

Less common

- Fine, worm-like movements of tongue
- Skin rashes

Rare

- Eye problems
- Sore throat and fever
- Yellowing of eyes and skin

ANTIHISTAMINES (Systemic)

Applies to:
Azatadine (a-ZA-ta-deen)
Bromodiphenhydramine (broe-moe-dye-fen-HYE-dra-meen)
Brompheniramine (brome-fen-EER-a-meen)
Carbinoxamine (kar-bi-NOX-a-ameen)
Chlorpheniramine (klor-fen-EER-a-meen)
Dexchlorpheniramine (dex-klor-fen-EER-a-meen)
Dimethindene (dye-meth-IN-deen)
Diphenylpyraline (dye-fen-il-PEER-a-leen)
Doxylamine (doxe-ILL-a-meen)
Pyrilamine (peer-ILL-a-meen)
Tripelennamine (tri-pel-ENN-a-meen)
Triprolidine (trye-PROE-li-deen)

Does not apply to:
Cyproheptadine
Dimenhydrinate
Diphenhydramine
Hydroxyzine
Promethazine
Trimeprazine

Antihistamines are used to relieve or prevent the symptoms of hay fever and other types of allergy. Certain antihistamine preparations are available only with your doctor's prescription. Others are available without a prescription; however, your doctor may have special instructions on the proper dose of the medicine for your medical condition.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

Enlarged prostate	Overactive thyroid
Heart disease	Stomach ulcer
High blood pressure	Urinary tract blockage
Increased eye pressure	

—if you are now taking any central nervous system (CNS) depressants such as:

Barbiturates	Prescription pain medicine
Medicine for seizures	Sedatives, tranquilizers, or sleeping medicine
Narcotics	Tricyclic antidepressants (medicine for depression)
Other antihistamines or medicine for hay or colds	

—if you are now taking or have taken within the past two weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of This Medicine

Antihistamines are used to relieve or prevent the symptoms of your medical problem. Take them only as directed. Do not take more of them or take them more often than your doctor ordered.

Take this medicine with food or a glass of water or milk to lessen stomach irritation.

If you are taking the long-acting tablet form of this medicine, the tablets are to be swallowed whole. Do not break, crush, or chew before swallowing.

Do not give this medicine to premature or newborn infants, unless otherwise directed by your doctor.

Precautions While Using This Medicine

Antihistamines will add to the effects of alcohol and other medicines that slow down the nervous system, such as anesthetics, including dental anesthetics; tranquilizers; medicine for depression; narcotics; prescription pain medicine; medicine for seizures; sleeping medicine; sedatives; or medicine for hay fever, other allergies, or colds. ***Check with your doctor before taking any of the above while you are taking this medicine.***

This medicine may cause some people to become drowsy or less alert than they are normally. Even if taken at bedtime, it may cause some people to feel drowsy or less alert on arising. ***Make sure you know how you react to this medicine before you drive or do other jobs that require you to be alert.***

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. The following side effects may go away during treatment as your body adjusts to the medicine; however, check with your doctor if they continue or are bothersome:

More common

Dizziness	Upset stomach or stomach pain
Drowsiness	
Thickening of the bronchial secretions	

Less common or rare

Blurred vision	Nervousness, restlessness, or trouble in sleeping(especially in children)
Difficult or painful urination	Skin rash
Dryness of mouth, nose, and throat	Unusual increase in sweating
Headache	Unusually fast heartbeat
Loss of appetite	

Other side effects not listed above may also occur in some patients. If you notice any other effects, check with your doctor.

Applies to:
Acetophenazine (a-set-oh-FEN-a-zeen)
Butaperazine (byoo-ta-PAIR-a-zeen)
Carphenazine (kar-FEN-a-zeen)
Chlorpromazine (klor-PROE-ma-zeen)
Fluphenazine (floo-FEN-a-zeen)
Perphenazine (per-FEN-a-zeen)
Piperacetazine (pi-per-a-SET-a-zeen)
Prochlorperazine (proe-klor-PAIR-a-zeen)
Promazine (PROE-ma-zeen)
Thioridazine (thye-oh-RID-a-zeen)
Trifluoperazine (trye-floo-oh-PAIR-a-zeen)
Triflupromazine (trye-floo-PROE-ma-zeen)

Does *not* apply to:
Ethopropazine
Methdilazine
Methotrimeprazine
Promethazine
Propiomazine
Thiethylperazine
Thiopropazate
Trimeprazine

Phenothiazines (fee-noe-THYE-a-zeens) are a family of medicines used to treat nervous, mental, and emotional conditions; some are used also to control anxiety, nausea and vomiting, and severe hiccups. Phenothiazines are available only with your doctor's prescription.

Before Using this Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have ever had any unusual reaction to any of the phenothiazine medicines.

—if you are pregnant or if you intend to become pregnant while using this medicine.

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

Alcoholism	Lung Disease
Blood disease	Parkinson's disease
Glaucoma	Prostate enlargement
Heart or circulation disease	Stomach ulcers
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Guanethidine (high blood pressure medicine)
Anticonvulsants (seizure medicine)	Levodopa
Asthma medicine	Ulcer medicine
Epinephrine	

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Prescription pain medicine
Barbiturates	Sedatives, tranquilizers, or sleeping medicine
Narcotics	Tricyclic antidepressants (medicine for depression)

—if you are now taking or have taken within the past two weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of This Medicine

Do not take more of this medicine or take it more often than your doctor ordered. This is particularly important when it is given to children, since they may react very strongly to the effects of the medicine.

Sometimes this medicine must be taken for several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

If you miss a dose of this medicine and your dosing schedule is one dose to be taken:

Once a day—	Take the missed dose as soon as possible. Then go back to your regular dosing schedule. But if you do not remember the missed dose until the next day, do not take it at all and do not double the next one. Instead, go back to your regular dosing schedule
Two times a day—	Take the missed dose as soon as possible. Then go back to your regular dosing schedule. However, if it is almost time for your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule.
More than two times a day—	If you remember within an hour or so of the missed dose, take it right away. Then go back to your regular dosing schedule. But if you do not remember until later, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule.

If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system

such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally, especially during the first few weeks the medicine is being taken. Even if you take this medicine only at bedtime, you may feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If the problem continues or gets worse, check with your doctor.

Sometimes, patients may show signs of restlessness and excitement after taking this medicine. If this occurs, stop taking the medicine and check with your doctor.

This medicine will often make you sweat less, causing your body temperature to increase. *Use extra care not to become overheated during exercise or hot weather while you are taking this medicine,* since overheating could possibly result in heat stroke. Also, hot baths or saunas may make you feel dizzy or faint while you are taking this medicine.

A few people who take this medicine may become more sensitive to sunlight than they are normally. When you first begin taking this medicine, avoid too much sun or too much use of a sunlamp until you see how you react. If you have a severe reaction, check with your doctor.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common (occurring with increase of dosage)

Muscle spasms, especially of neck and back	Tic-like (jerky) movements of head, face, mouth, and neck
Restlessness	Trembling and shaking of hands and fingers
Shuffling walk	

Less common

Fainting	Skin rashes
Fine, worm-like movements of tongue	

Rare

Eye problems	Yellowing of eyes and skin
Sore throat and fever	

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

More common

Blurred vision	Dry mouth
Constipation	Increased sensitivity of skin to sun
Decreased sweating	Nasal congestion
Dizziness	Unusually fast heartbeat
Drowsiness	

Less common

Changes in menstrual period	Difficult urination
Decreased sexual ability	Swelling of breasts

This medicine may cause the urine to turn pinkish red to red or reddish brown; this is harmless and may be expected. If you have questions about this, ask your doctor or pharmacist.

Other side effects not listed above may also occur in some patients. If you notice any other effects, check with your doctor.

ADDITIONAL INFORMATION

For patients taking this medicine by mouth

This medicine may be taken with food or a full glass (8 ounces) of water or milk to reduce stomach irritation.

Do not take this medicine within an hour of taking antacids or medicine for diarrhea. Taking them too close together may make this medicine less effective.

If you are taking a liquid form of this medicine, try to avoid getting it on your skin or clothing because it may cause a skin rash or other irritation.

If your medicine comes in a dropper bottle, it must be diluted before you take it. Just before taking, measure each dose with the specially marked dropper and dilute it in ½ glass (4 ounces) of tomato or fruit juice, water, soup, coffee, tea, milk, or carbonated beverage.

For patients taking the extended-release tablet form of this medicine

The extended-release tablets or capsules are to be swallowed whole. Do not break, crush, or chew before swallowing.

For patients using the suppository form of this medicine

How to insert suppository: First remove the foil wrapper and moisten the suppository with water. Lie down on side and push the suppository well up into the rectum with finger.

If the suppository is too soft to insert because of storage in a warm place, before removing the foil wrapper chill the suppository in the refrigerator for 30 minutes or run cold water over it.

For patients receiving this medicine by injection

The effects of the long-acting injection form of this medicine may last for up to 6 weeks. The precautions and side effects information for this medicine applies during this period of time.

Detaining the Insane

Detention Hospitals, Mental Health, and Frontier Politics in Alaska, 1910-1915

Thomas G. Smith

The strong interest in social history during the last decade has produced several studies on the care and treatment of disadvantaged, dependent, and deviant persons. Significant general works have been undertaken, but local, state, and institutional studies, especially ones set in the 20th century, are lacking. This essay explores the efforts of Alaskans to establish detention hospitals for the mentally ill between 1910 and 1915. Although students of Alaskan history point to poor treatment of the insane as evidence of the federal government's neglect of and indifference toward Alaska, the study reveals that Alaskans themselves must share the blame. In addition, the essay provides insights into mental health policy, Alaskan politics, and federal-territorial relations during the period.[1]

By the turn of the century, the prevalence of mental illness was a growing concern among many Alaskans. As the population surged due to the gold rushes of the 1890s, so did the number of insane. The arduous journey, excruciating work, harsh climate, loneliness, and dashed hopes sometimes proved more than pioneers could endure. In 1900 nine Alaskans were adjudged insane. By 1910 the number had climbed to 130, and a decade later the figure reached 217. Responding to pleas for assistance from Alaskans, the federal government provided for the care of the mentally ill in the civil government bill of 1900. That measure made insanity a criminal offense. The person accused in a written complaint was arrested by the marshal, brought before a district commissioner, and tried by a six-man jury. If found guilty, he was committed to an asylum. Since Alaska had no mental hospital, the governor was empowered to contract with the lowest-bidding institution west of the Rocky Mountains for the care of the insane. From 1904 to 1956 the Morningside Sanitarium (formerly Mount Tabor), near Portland, Oregon, held the contract.[2]

The contract system came under severe attack by residents of Alaska. They complained that it was an archaic and inhumane practice not followed by any other American state or territory. Noncontiguous dependencies such as Hawaii, Puerto Rico, and the Philippines all had asylums that were built and maintained at local or territorial expense. Not until 1912, however, did Alaska win territorial status and its own government; in the meantime, it had to rely on the federal government to care for the insane.[3]

Alaskans also decried the practice of incarcerating the afflicted in jails until they could be transported to Oregon. In interior Alaska the mentally ill often had to spend as long as six months in jail until weather conditions permitted transportation to the "outside." An Alaska asylum was the solution, but Congress rejected the proposal for such an institution because of cost ($75,000 for the building alone). Alaskans next implored the government to establish small hospitals in which the mentally afflicted could be temporarily detained pending removal to Morningside.[4]

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1. See, for example, Gerald Grob, *Mental Institutions in America* (New York, 1973); Blake McKelvey, *American Prisons* (Montclair, N.J., 1977); David Rothman, *The Discovery of the Asylum* (Boston, 1971), and *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston, 1980). For criticisms of the way the federal government dealt with Alaska's insane, see *Alaska Daily Empire* (Juneau), Nov. 6, Dec. 6, 30, 1912; Ernest Gruening, *The State of Alaska* (New York, 1968), 280.

2. For the early treatment of Alaska's insane, see Thomas G. Smith, "The Treatment of the Mentally Ill in Alaska, 1884-1912: A Territorial Study," *PNQ*, Vol. 65 (1974), 17-28. Also see Claus-M. Naske, "Bob Bartlett and the Alaska Mental Health Act," *ibid.*, Vol. 71 (1980), 31-39.

3. Apparently Alaskans were not troubled by assigning criminal status to the insane, indigent sick, elderly, etc., lacking asylums, almshouses, old folks homes, and local charities, they classified social dependents as criminals in order to assure them of government care. The federal government also maintained Indians who were mentally ill (a government asylum was established in 1898 at Canton, S.D.). Canada, like Alaska, transported its insane from remote and sparsely populated areas to provincial hospitals rather than build mental institutions in the Yukon and Northwest Territories. See Henry Hurd, ed., *The Institutional Care of the Insane in the United States and Canada*, 4 vols. (Baltimore, 1916-17), III, 630-32, 871-80; IV, 2-25, 228-36.

4. For introduction of these two measures, see *Congressional Record*, 61st Cong., 2d Sess., 1910, pp. 1452 (H.R. 20111), 5243 (H.R. 24833); for the texts of these bills, *ibid.*, 6853 and 61st Cong., 2d Sess., House Document 637, p. 2 (Serial 5836).

The need for some type of "holding tank" or detention center seemed obvious to the residents of interior Alaska. Detailed descriptions of mental breakdowns appeared frequently in the press. "DANGEROUS LUNATIC NOW AT LARGE" ran a Nome *Nugget* headline in October 1908. The escaped "lunatic" threatened to kill the district judge, marshal, and commissioner. In Fairbanks, a "crazed" woman shot to death the police chief in 1908. A year later in the same city a "madman" tried to kill the proprietor of the Pioneer Hotel by hurling a boulder through the window, and a knife-wielding, "blood-seeking headhunter" went berserk in Dempsey Lewis's saloon before being felled by a pool cue. In Fairbanks, the roster of persons taken into custody included the president of the Washington-Alaska Bank, an Indian woman, a prospector who repeatedly tried to commit suicide, a sourdough who imagined he was being run over by automobiles, and a woodchopper from Fox City who broke down when fire destroyed 12 cords of firewood. The Fairbanks *Daily News-Miner* pointed out that the number of insane in that community in 1909 had doubled over the previous year.[5]

Alarmed by the increasing frequency of insanity, Fairbanksans called for proper detention facilities for the afflicted. The federal jail lacked sufficient space to accommodate both prisoners and mental patients. Attempts to integrate criminals and the insane resulted in "pandemonium." On one occasion an insane man "kept everyone awake . . . by praying loudly and the noise was well calculated to make the rest of the prisoners nervous." The *News-Miner* noted that the number of insane was increasing at such a rapid rate that "separate quarters must necessarily be provided for them." The grand jury of the fourth judicial division at Fairbanks concurred.[6]

James Wickersham, Alaska's delegate to Congress, also advocated proper facilities for the care of the insane. Wickersham was a fiery progressive from Fairbanks who had served as a federal district judge at Eagle, Nome, and Fairbanks before being elected delegate in 1908. In February 1910, he tried to convince Congress to appropriate money for a permanent insane asylum in southeastern Alaska (HR 20111). When that effort failed, he introduced new legislation in April calling for an appropriation of $50,000 to build detention hospitals at Fairbanks and Nome for the temporary care of the insane (HR 24833). The House Committee on Territories recommended passage of the measure, declaring that the mentally afflicted "are entitled to the most scrupulous care, and should not be subjected to commitment in an ordinary jail." With an eye for economy, however, the committee recommended $25,000 instead of $50,000 for the project. The Senate Committee on Territories also approved the measure. Despite still opposition from some economy-minded congressmen, the bill was passed into law "in the interest of humanity."[7]

James Wickersham, who wrote the defective hospitals bill, blamed others for the delay in construction. (Whalen Collection, University of Alaska Archives, Fairbanks)

Specifically, the measure called for the establishment of a detention hospital in the second judicial division at Nome and in the fourth judicial division at Fairbanks. Insane persons would receive temporary care in a detention center until trails and waterways thawed sufficiently to permit the U.S. marshal to transport them to the Morningside Sanitarium in Oregon. Each hospital was to cost no more than $12,500. The marshal, the governor of Alaska, and the U.S. district judge, acting as a board of governors, would call for bids and award a contract for construction. Once completed, the detention houses would be administered and maintained by the Department of Justice.[8]

From the beginning, the detention hospitals project encountered difficulties. Although the bill became law on June 25, 1910, the summer expired without any attempt to implement it. Pressed for an explanation by the *Alaska Citizen*, Governor Walter E. Clark stated that, after reading the measure carefully, he had discovered a shortcoming which made it "practically inoperative." According to the governor, the law was defective because it failed to provide for the acquisition of sites on which to build the hospitals. John Rustgard, U.S. district attorney at Juneau, supported the governor's interpretation of the bill and advised him not to proceed without instructions from the Justice Department. Judicial officers from Nome expressed similar views.[9]

But U.S. District Judge Peter D. Overfield of Fairbanks voiced a different opinion. He favored prompt implementation of

5. Nome *Nugget*, July 17, Oct. 21, Nov. 2, 1908; Fairbanks *Daily News-Miner*, April 12 (headhunter), 14, May 4, Oct. 29, 1909 (hereafter cited as *News-Miner* with appropriate date).

6. *News-Miner*, Aug. 6, 1909.

7. 61st Cong., 2d Sess., 1910, House Report 1238, p. 2 (first quotation) (Serial 5593); *Congressional Record*, 61st Cong., 2d Sess., 1910, pp. 6853-58 (6856, last quotation); *Care of the Insane in Alaska: Statements of Hon. James Wickersham, Delegate from Alaska, Hon. W. R. Ellis, M.C., Mr. George Coe, Stanfield, Oregon, March 4 and April 1, 6, and 20, 1910*, House Committee on the Territories (Washington, D.C., 1910), 19, 26-28, 31-32.

8. 36 Stat. 852 (1910). In 1910 Alaska was divided into four judicial divisions; in the second and fourth, waterways froze and land routes were virtually impassable for seven or eight months of the year.

9. *Alaska Citizen* (Fairbanks), July 10, 1910; John Rustgard to Walter E. Clark, Oct. 3, 1910, Clark to Peter D. Overfield, Oct. 8, 1910, Overfield to Clark, Oct. 8, 1910, Box 564, File 4-7-2-1, Record Group 129, Department of Justice (DJ), National Archives.

the law and accused Clark and Rustgard of pettiness and needless delay. Although Wickersham had failed to provide for hospital sites when he drafted the bill, the oversight could be remedied, Overfield held, by securing donated land. Residents of Fairbanks were eager to have a detention hospital and would furnish land to the government free of charge. Nome residents would probably follow suit. Clark rejected Overfield's suggestion because he doubted the legality of accepting land as a gift on behalf of the federal government.[10]

Pointing out that on several occasions in the past the federal government had accepted "gratuitous deeds of lands for public purposes," Overfield urged the governor to seek the advice of the U.S. attorney general; if land donation proved unacceptable, Congress might be asked to remedy the problem by authorizing the acquisition of land or by permitting the hospitals to be built as additions to the Fairbanks and Nome jails.[11]

Although the governor agreed to consult the attorney general, he did not agree to present the case objectively. Indeed, besides underscoring the law's legal defects, Clark assured the attorney general that the detention hospitals were "entirely unnecessary" because adequate provisions had been made "for the temporary care of the insane in the modern jails erected at Nome and Fairbanks two years ago." He denounced Overfield's dogged support for the detention houses as political loyalty to Wickersham, who was responsible for the judge's appointment, and he also censured Overfield for showing disrespect for the governor's office by "his conspicuous absence without excuse from a public dinner in my honor at Fairbanks."[12]

In October 1910 the Justice Department declared the hospitals act defective because it lacked provision for the acquisition of land; hence, it found that Governor Clark had properly delayed construction of the hospitals. Since the federal government did not own land in Fairbanks and Nome appropriate for hospital sites, the attorney general recommended referring "the matter back to Congress for a further expression of its wishes." Inexplicably, he failed to rule on whether the federal government could accept hospital sites as a gift from the residents of Fairbanks and Nome.[13]

Governor Clark's objections to the detention hospital law were guided by political as well as legal considerations. Clark and Wickersham were bitter political enemies despite being members of the Republican party. Republicans in Alaska and around the nation were divided into regular and progressive factions. Clark and Lewis W. Shackleford, Alaska's Republican national committeeman, headed the regulars; Wickersham, the progressives.

Disturbed by his independence, GOP regulars referred to Wickersham as a "political harlot" and in the delegate race of 1910 nominated Edward S. Orr, a businessman from Fairbanks, to oppose him. The Socialists also entered a candidate, William O'Connor, a newspaper editor from Tanana. The Democrats, a minority party in Alaska, refused to run a candidate. When the votes were counted, the incumbent, Wickersham, easily retained his seat.[14]

Although the detention hospitals were not an issue in that election, residents of interior Alaska were growing increasingly irritated by the lack of action on the project. In March 1911 the grand jury of the fourth judicial division reported that the federal jail at Fairbanks was "inadequate for the proper care and detention of insane persons, of whom there are several now in custody." Due to overcrowding, it was necessary to confine the sane and insane in the same room. The grand jury found that practice unacceptable from a humanitarian standpoint and urged immediate construction of a detention center.[15]

In May the town council of Fairbanks passed a resolution offering the federal government free of charge a parcel of land on which to erect a detention hospital. Noting that the residents of Fairbanks "are pressing me pretty hard," Governor Clark forwarded the resolution to Attorney General George Wickersham (no relation to the delegate) for an opinion. At the same time, Clark recommended that the detention center be erected as an addition to the Fairbanks jail instead of as a separate facility.[16]

Even as he obstructed implementation of the hospitals act, Governor Walter Clark blamed Wickersham for the delay. (Bunnell Coll., University of Alaska Archives)

10. Overfield to Clark, Oct. 14, 15, 1910, Clark to Overfield, Oct. 17, 1910, Box 564, File 4-7-2-1, RG 129, DJ; Rustgard to Clark, Oct. 17, 1910, Box 768, Alaska Governors Papers (AGP), Alaska State Archives, Juneau.

11. Overfield to Clark, Oct. 18, 1910, Box 564, File 4-7-2-1, RG 129, DJ; Overfield and Henry K. Love to Clark, Oct. 19, 1910, Box 244, File 9-1-10, Office of the Territories (OT), National Archives; Overfield to Clark, Oct. 20 (quotation), Nov. 14, 1910, Box 768, AGP.

12. Clark to George Wickersham, Oct. 4, 19 (quotations), 1910, Box 564, File 4-7-2-1, RG 129, DJ.

13. Acting attorney general to Clark, Oct. 18, 1910 (quotation), Box 768, AGP; attorney in charge of titles to attorney general, Nov. 1, 1910, Box 564, File 4-7-2-1, RG 129, DJ.

14. Nome *Nugget*, June 17 (harlot), July 13, Aug. 4, 1910; Fairbanks *Sunday Times*, Oct. 22, 1911; Evangeline Atwood, *Frontier Politics: Alaska's James Wickersham* (Portland, 1979), 225-34, 300.

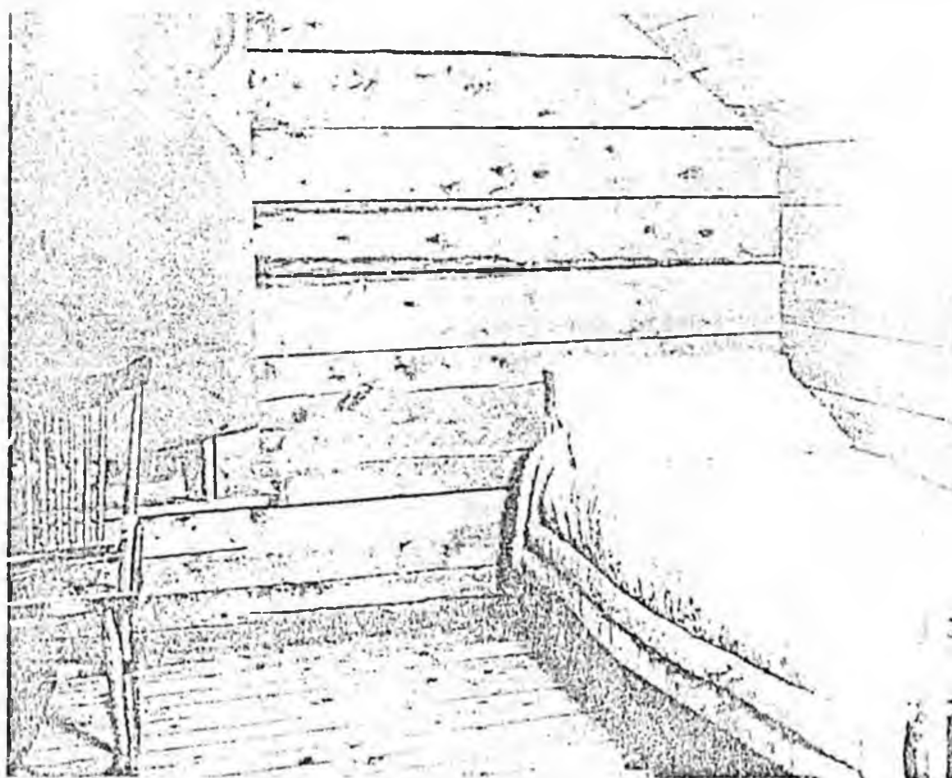
15. Overfield to Clark, Jan. 7, 1911, Box 768, AGP; grand jury of the fourth division to Overfield, March 23, 1911, Box 244, File 9-1-10, OT; *News-Miner*, Jan. 6, 1911.

16. Fairbanks town council to Clark, May 5, 1911, F. S. Gordon to Clark, June 3, 1911, Clark to attorney general, June 21, 1911, Box 768, AGP.

Nearly two months elapsed without a decision. Numerous Fairbanksans seethed over the delay and sought scapegoats. Some considered the lack of progress another example of federal indifference toward Alaska. Others, particularly the Republican press in Fairbanks, faulted Wickersham for having drafted a defective bill. In an editorial entitled "Our Detained Hospital," the Fairbanks *Daily Times* criticized the delegate for failing to follow the "businesslike course" of admitting his mistake and introducing legislation to rectify it. Had he introduced corrective legislation, the community "would have a detention hospital built and running today." Wickersham had rejected that course of action, the editor opined, because as a politician he was concerned mainly with retaining office. "He is making political capital out of the fact that the hospital is not built," the newspaper charged. "Such political capital is worth more to him than the hospital would be, so he has deliberately failed to remedy the matter."[17]

Wickersham himself blamed the delay on Governor Clark and District Attorney Rustgard. The delegate claimed that he had purposely omitted provision for the purchase of land sites in the bill because he planned to build the centers on public land. The public domain, he stated, had been utilized in the past for jails, courthouses, and telegraph offices. It could also be used for detention centers. "It would have been considered silly," he explained to the Fairbanks Commercial Club, "for the United States to appropriate money out of its own treasury to buy its own land in Alaska for a United States hospital. Nobody but Governor Clark and Mr. John Rustgard would have ever thought of such a foolish proposition, and they would not have thought of it except for the fact that they wished to make the law a failure."[18]

Pro-Wickersham newspapers such as the *Alaska Citizen* echoed the delegate's charges. The *Citizen* held that there was "no one to blame for the delay" but Clark, who had advanced "the ridiculous proposition that the government could not accept a donated site." That view, the paper continued, was based on Clark's "bitter opposition to the delegate, and his determination that Wickersham shall get nothing for the territory that could in any way enhance his prestige."[19]



The federal jail at Fairbanks housed both prisoners and the insane; the women slept in this 12-by-14-foot room with a sloping ceiling and one window. (National Archives)

Nonetheless, the argument in defense of the law was weak. If the hospitals were to be erected on public land, the act should have so specified. Moreover, its author should have realized that public land was unavailable in Fairbanks and Nome: once a patent is granted for a townsite, the land is no longer public. Instead of introducing corrective legislation, Wickersham stubbornly defended a defective law and blamed his political enemies for sabotaging the hospitals. As the Fairbanks *Daily Times* remarked, "the delegate overlooked an important detail in his bill, and in trying to cover it up is attempting to unload upon the governor whatever blame exists."[20]

In August 1911 the attorney general instructed Governor Clark to proceed with the construction of the Fairbanks hospital. Instead of being constructed on a donated site, the facility would be erected on top of the federal jail. Such a plan would minimize delay and save expense by using the same personnel to operate both institutions.[21]

But the instructions sparked a heated protest from Wickersham. Addressing the Fairbanks Commercial Club on September 28, he ridiculed the idea of housing "poor crazy people" above the "dirty old rotten jail." His plan, he reminded the town's businessmen, was to build the hospitals on public land. Appealing to their booster spirit, he informed his listeners that the Fairbanks detention facility was part of a larger plan to secure a permanent insane asylum in the town. That larger effort would be stymied, he warned, unless Alaskans insisted upon

17. Fairbanks *Daily Times*, Oct. 28, 1911 (hereafter cited as *Times* with appropriate date).

18. *Ibid.*, July 15, 1911.

19. *Alaska Citizen*, July 10 (quotations), 17, 1911.

20. *Times*, July 15, 1911.

21. C. H. McGlasson to attorney general, June 28, Aug. 7, 1911, Box 564, File 4-7-2-1, RG 129, DJ; attorney general to Clark, Aug. 8, 1911, Box 768, AGP.

construction of detention centers separate from the jails at Fairbanks and Nome.[22]

Urged on by Wickersham, the commercial club branded the Justice Department's plan to build the hospital as an addition to the jail "unsafe, unsanitary, and undesirable generally." It forwarded to Washington a petition signed by more than 900 residents protesting the proposal as "an act of injustice." The petitioners demanded a separate facility for the temporary care of the mentally ill.[23]

Other Fairbanks civic groups joined the protest. The Tanana Valley Democratic Club unanimously adopted a resolution condemning the governor for concocting a scheme whereby the "prisoners will be a nuisance to the sick, and the insane a nuisance to the prisoners." Moreover, the town council of Fairbanks announced its displeasure with the proposal by passing an ordinance forbidding the detention of the insane "upon the upper, second or higher story" of any wooden building. The Fairbanks press also lambasted the plan, calling it a "sorry makeshift." To accept a portion of the appropriation and build the hospital above the jail, said the *Daily Times*, would qualify Fairbanksans "to become the first inmates of such a hospital." The editor of the *Daily Times* urged the governor to build a hospital on a donated site and worry later about the legal consequences. Such a move, he declared, "would be worthy [of] the red blood of the pioneer."[24]

The strong protest from Fairbanks brought results. In October 1911, the Justice Department decided to "suspend action" on the construction of the hospital as an upper story to the jail. More than a year passed without further developments.[25]

Meanwhile, the issue continued to provoke controversy between Clark and Wickersham. The delegate repeatedly blamed the absence of a detention center on "one petty man, with a wooden nutmeg heart." Appealing to the emotions of a Fairbanks audience, Wickersham pointed out that if one's mother or wife were arrested because she was mentally ill, she would be confined in a "dirty jail" because the governor was so "spiteful" he refused to spend the money Congress had appropriated for a modern detention facility.[26]

Predictably, Clark denied Wickersham's charges. He reiterated the fact that his position was based not on politics but on his interpretation of the law, an interpretation supported by the Justice Department. It would be foolish, he stated, to proceed with the construction of the hospital on a donated site without prior approval from the federal government. What contractor, he asked, would build a hospital without official authorization? Neither Clark nor Wickersham explained why he did not push for an official decision on the legality of building on a donated site.[27]

Wickersham's opponents used the defective hospitals act against him in the delegate election of 1912 but without effect. Indeed, his successful efforts to obtain for Alaska an elective territorial government more than offset any loss of votes caused by his mishandling of the detention hospitals affair. Running as an independent "Bull Mooser," he was reelected, defeating a regular Republican, a Socialist, and two Democrats.[28]

On the national level, the Republican party, split between regulars and progressives, lost the White House to Woodrow Wilson. Although he was disappointed that Theodore Roosevelt, his idol, had lost, Wickersham was confident that he would be able to cooperate with the new president. And he was encouraged when Wilson's secretary of the interior, Franklin K. Lane, invited his opinions on Alaskan issues, including the appointment of a new governor.[29]

Created in August 1912, Alaska's first territorial legislature took the lead in securing construction of the detention centers, though prohibited by law from dealing with the insane. The territorial government act had left to the federal government responsibility for the care of the mentally ill, which meant that vic-

This cartoon depicts the Fairbanks view of Governor Strong's arrival in Alaska — a long-awaited hospital under each arm. (Alaska Citizen, Aug. 4, 1913)

22. *Alaska Citizen*, Oct. 2, 1911.

23. Fairbanks Commercial Club to attorney general, Oct. 4, 1911 (injustice), Box 564, File 4-7-2-1, RG 129, DJ; *Times*, Sept. 29 (first quotation), Oct. 5, 1911.

24. *Times*, Sept. 30 (last three quotations), Oct. 1 (nuisance), 8 (second quotation), 1911.

25. *News-Miner*, Oct. 5, 1911.

26. *Fairbanks Sunday Times*, Oct. 22, 1911.

27. *Times*, Jan. 24, 1912; *Alaska Citizen*, Feb. 5, 1912; Clark to secretary of the interior, Dec. 22, 1911, Box 564, File 4-7-2-1, RG 129, DJ.

28. *News-Miner*, Oct. 8, 1912; *Alaska Citizen*, Aug. 12, 1912.

29. Atwood, 247-65, 271.

tims would continue to be farmed out to Morningside Sanitarium and that patients in interior Alaska would be held in jails until detention facilities were constructed. But in April 1913, Alaskan legislators forwarded to Congress a joint memorial protesting the practice of detaining the insane in jails and requesting an appropriation of $4,000 to buy land on which to build two detention houses. The memorial went unheeded.[30]

Despite the lack of congressional action, supporters of the detention hospitals were encouraged when President Wilson named John F. A. Strong to succeed Walter Clark as governor of Alaska. Born in New Brunswick in 1859, Strong had been in Alaska since 1897. He had engaged briefly in mining, then entered the newspaper business, and was editor of the Democratic Juneau *Daily Empire* at the time of his appointment.[31]

In June 1913, the new governor and Wickersham met with Secretary of the Interior Lane to discuss the detention hospitals. Sympathetic, Lane agreed to build the hospitals promptly if Strong could secure donated land. Within three months, the governor had obtained the sites, and Lane had authorized him to advertise for construction bids. Strong's success convinced some Alaskans that the previous delay had been "for political and personal reasons only." It also showed that Washington could be moved to action when Alaskans put aside politics and united behind a project.[32]

Construction of both hospitals began in September and concluded in December 1913. After a delay of more than three years, then, the communities of Fairbanks and Nome possessed detention hospitals. The Fairbanks facility was a 2-story wooden building, 42 feet square, located on 1.25 acres of land at the corner of Turner Street and Tenth Avenue. It had a porch that ran along the full front of the first floor and a large second-story balcony. The first story contained a kitchen, oak-paneled dining room, seven rooms, a bath, and a padded cell. On the second floor were four rooms, one ward, a shower-bath, and two padded cells. The facility had electric lights and steam heat and could accommodate 15 male and 5 female patients. Local residents described the building as "a thing of beauty" that was "equipped with all modern conveniences." The Nome hospital was similarly appointed, though lacking the large front porch and balcony. The Nome *Nugget* described it as a "monument" to the builder. In Juneau, the *Alaska Daily Empire* editorialized that the "construction of these institutions marks a step forward in caring for unfortunate men and women of the Territory."[33]

Within six months of assuming office, J. F. A. Strong had delivered the Nome and Fairbanks hospitals; opening them was the next step. (Bunnell Coll., Univ. of Alaska Archives)

Financial considerations, however, prompted Washington to reevaluate its decision to open the hospitals. The money to maintain the centers was to come from an appropriation of $500,000 for support of prisoners in all the states and territories. Marshal Emmet R. Jordan of Nome informed the Justice Department in early 1914 that it would cost $17,500 a year to maintain each of the detention hospitals. The attorney general balked at spending $35,000 yearly to provide temporary care for a handful of patients. It cost only twice that amount, including transportation, to maintain 150 Alaska patients at the Morningside Sanitarium in Oregon.[34]

Marshal Lewis T. Erwin of Fairbanks, who had replaced Henry Love in 1913, took issue with Jordan's figures. Erwin estimated that operation of the Fairbanks hospital would cost only $7,500 per year. Because the two estimates differed so significantly, the Justice Department refused to open the facilities until accurate figures had been secured. On the recommendation of the U.S. superintendent of prisons, the attorney general sent an inspector to Alaska to determine the cost of running the hospitals and the necessity of opening them.[35]

Proud of their new facilities, residents of Fairbanks and Nome were distressed to learn that neither structure might be utilized. "Loss of the detention hospital" would "be a serious blow" to the community, declared the Fairbanks *Daily Times*; "It means that we will be right back where we were before the building of the hospital was authorized, except that we have the structure to remind us of the long fight made to secure the hospital." There was a pressing need for the centers, according to that paper, and townspeople "have every reason to expect the terms of the bill to be carried out, for, after all, the cost of maintenance is a question which should have been investigated before the money for the building was appropriated."[36]

30. (Alaska) Senate Joint Memorial Number 17 to Congress, April 11, 1913, Box 244, File 9-1-10, OT; *Times*, May 2, 1913.

31. Juneau *Daily Empire*, July 29, 1929 (obituary); Gruening, 166.

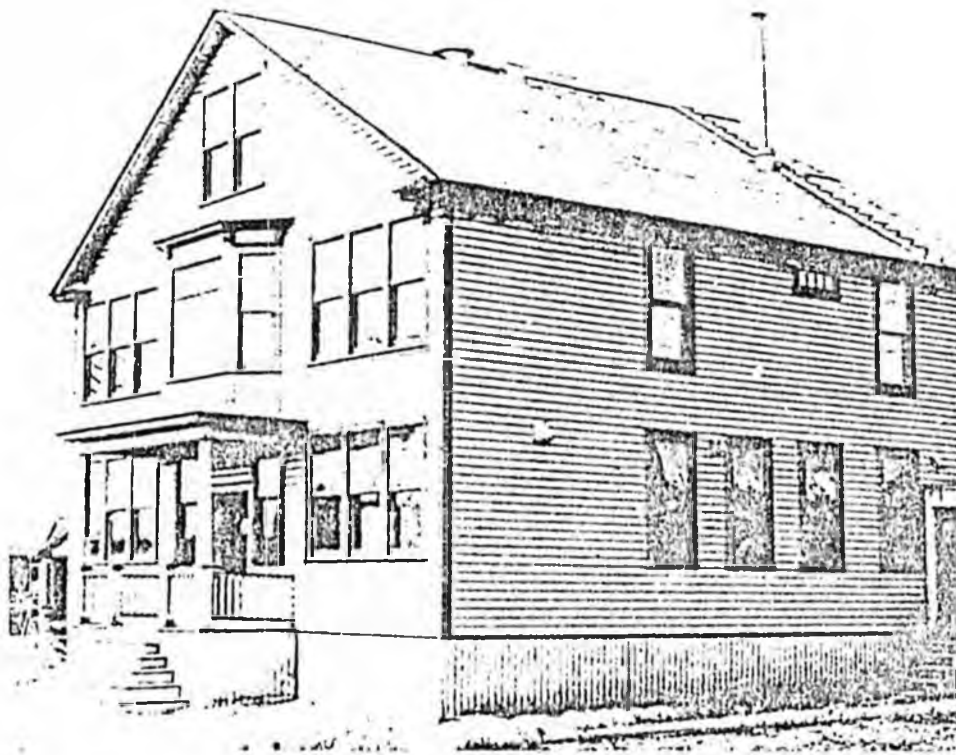
32. J. F. A. Strong to secretary of the interior, June 11, 12, 16, Aug. 5, 1913, secretary of the interior to Strong, June 12, 1913, Box 244, File 9-1-10, OT; *Alaska Citizen*, July 28, 1913 (quotation).

33. *News-Miner*, June 17, Sept. 3, Nov. 17, 1913; *Times*, Aug. 7, Sept. 3, Dec. 27 (quotations), 1913; *Alaska Daily Empire*, Nov. 21, 1913; Nome *Nugget*, Sept. 12, 15, Nov. 5 (quotation), 25, 26, 1913.

34. Superintendent of prisons to attorney general, April 1, 1914, Box 565, File 4-7-2-1, RG 129, DJ.

35. *Ibid.*; L. T. Erwin to assistant attorney general, Feb. 20, 1914, Box 564, File 4-7-2-1, RG 129, DJ.

36. *Times*, Dec. 13, 1913; *Alaska Citizen*, Dec. 15, 1913.



Equipped with electric lights, steam heat, and other conveniences, the Nome facility was hailed as a step forward in the care of the insane. (National Archives)

Meanwhile, Governor Strong, Delegate Wickersham, and Marshal Erwin of Fairbanks pushed Attorney General T. W. Gregory to open the detention hospitals. Erwin was especially insistent. On March 5, he had wired the Justice Department: "Have now three insane, jail not proper place." Four days later he had telegraphed: "Have just taken into custody insane woman in addition to three insane men reported. Hospital much needed." On June 2 he sent yet another message informing the attorney general that he had 14 prisoners in the jail, including two women. One of the women was insane. "No place to keep women except jail attic. Roof covered with tin. Fear women cannot live in such quarters during warmest summer weather. No toilet except men's department. Women taken ladies toilet courthouse. Makes it bad handling raving maniac. Condition insane woman requires three matrons eight-hour shifts." The marshal asked permission to transfer both women to the detention hospital where they could receive proper care. The attorney general refused the request and advised the marshal to install toilet facilities in the jail, fix the roof, and transport the insane woman to Morningside.[37]

That same month, R. J. W. Brewster, the Justice Department's investigator, arrived to inspect the hospitals. After examining the facilities, he recommended against opening them. His reason: expense. He estimated that the yearly operating costs of each institution, including heat, light, food, guards, a cook, repairs, and sundry expenses, would exceed $7,000.

The number of insane in interior Alaska was not large enough to justify the expense of operating two detention centers, Brewster advised. At Nome only three people were adjudged insane during fiscal year 1913-14, and these victims were housed in the jail for a total of 45 days; since the hospital would stand empty most of each year, Brewster recommended that the building be transferred to another government department and put to better use. At Fairbanks he found that 21 individuals had been adjudged insane in fiscal year 1913. "This hospital," he declared, "should never have been built, and although there is more reason for its opening than there is for the opening of the Nome institution, I do not see the *real* necessity which would warrant the expense of operation." To those who argued that modern mental health care practice called for separate facilities for the sane and insane, he replied that the "theory may be beautiful but would be expensive to carry out."[38]

The delay over opening the detention hospitals became a campaign issue in the delegate election of 1914. Running as a "Woodrow Wilson Progressive," Wickersham sought his fourth term as delegate. He was opposed by John M. Brooks, a Socialist from Jack Wade Creek, and Charles E. Bunnell, a Democrat from Valdez who had the support of the Wilson administration. Alaska Republicans did not nominate a candidate.[39]

Throughout the campaign Wickersham reminded his constituents of his past accomplishments, including passage of the territorial government act, the Alaska railway bill, and the detention hospitals measure. That the hospitals remained closed, he asserted, was the fault of Marshal Erwin, a Democrat and political enemy. Wickersham accused Erwin of obstructing efforts to open the hospitals, and he asked Alaskans to consider the "inhumanity of an officer who keeps a sick prisoner in the attic of that dirty, filthy jail when you have a fine detention hospital where she should be kept."[40]

Wickersham's charges against Erwin were unwarranted. The Justice Department advised the marshal to issue a statement "disclaiming all responsibility for the failure to open and occupy the de-

37. Quoted in *Times*, Feb. 11, 1915.

38. Superintendent of prisons to attorney general, July 11, 31, Oct. 14, 1914, and R. J. W. Brewster to attorney general, Sept. 19, 1914 (quotations), Boxes 564, 565, File 4-7-2-1, RG 129, DJ; *News-Miner*, July 27, Aug. 1, 1914. The Justice Department was also reluctant to go to the expense of opening the Nome hospital because the population of that town had declined steadily since the boom days of the early 1900s.

39. Atwood, 277-87.

40. Quoted in Erwin to attorney general, Nov. 14, 1914, Box 564, File 4-7-2-1, RG 129, DJ.

tention hospital." Opponents of Wickersham were probably correct when they declared that his attack on the marshal was a smokescreen to cover up his own ineptness. The Democratic Fairbanks *Daily Times* reminded readers that the law "was so clumsily drawn that the hospital never would have been built but for the efforts of Governor Strong and the Democrats of Fairbanks." Despite Wickersham's irresponsible charges, he was reelected with votes to spare.[41]

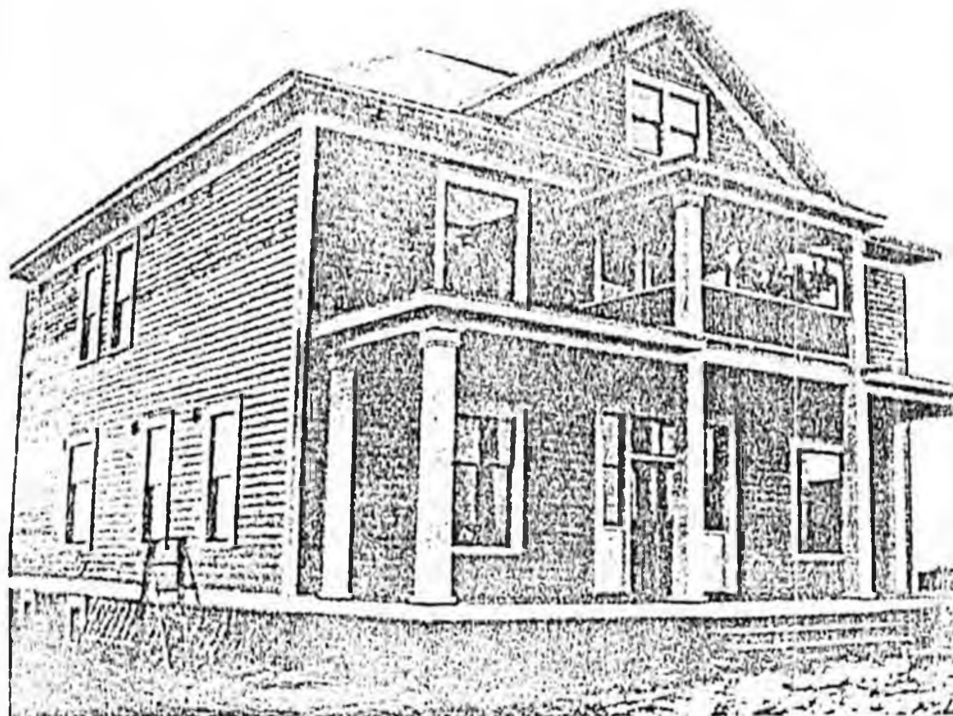
After his reelection, Wickersham continued to lash out against Erwin for failing to utilize the hospitals. In mid-November 1914, he informed the press that the marshal permitted the caretaker to use the Fairbanks institution as a "chicken coop." Producing a photograph that showed chickens hanging lifeless by their feet from a rope stretched across the hospital's balcony, Wickersham urged Fairbanksans to petition the Justice Department to use the hospital for needy mental patients not dead chickens.[42]

The delegate also censured the Justice Department for its indifference. He informed the Fairbanks Commercial Club on November 9 that "there is no reason in the world why the Department of Justice should not make the necessary appropriation to maintain the institution." Instead of utilizing a modern facility, he noted, the federal government is confining the insane in a "hellhole." He implored club members "to get busy, to do something to force the proper parties to open the hospital and I pledge myself to do all I can to help."[43]

Wickersham made good his promise. On January 6, 1915, he sent a long letter to the attorney general lamenting the policy of holding Alaska's insane in "dirty foul-smelling old jails." He enclosed three photographs taken by the Fairbanks health officer, Dr. J. A. Sutherland, showing the "exact condition of the room in the attic" of the Fairbanks jail where insane women were housed. "In this stinking hole the United States of America keeps the insane women who fall into their clutches," the delegate wrote. "It is a disgrace to the Department of Justice that such a condition may continue to exist." He reminded the attorney general that the detention hospitals act was intended to prevent the "vile arrangement" of housing the mentally ill in jails. Failure to open the institutions for financial reasons, he believed, was unjustified. According to section 2 of the act, the hospital expenses were to be paid "from the same fund as the expenses of the United States jails under the same marshal." Enclosing the "chicken coop" photograph, Wickersham informed the attorney general that the hospital at Fairbanks was being used to accommodate slaughtered chickens instead of mentally afflicted human beings. He exhorted the Justice Department to make proper use of the Nome and Fairbanks structures at once.[44]

Wickersham's hard-hitting letter to Washington was not entirely accurate. He had written on the photograph that the jail was a "dirty hole," a description that was exaggerated, as Erwin, Dr. Sutherland, and several newspapers pointed out. Yet the delegate's main point was on the mark—namely, that the detention hospitals and not jails should be used for the temporary confinement of the mentally afflicted and that the government, in delaying the opening of the facilities, had failed to execute the law. Responding to Wickersham's letter, the attorney general stated that the issue was "under consideration" and would be resolved soon.[45]

Actually, the Justice Department was working diligently to rid itself of both buildings, to "turn them loose" on other government departments. The Bureau of Education in the Interior Department wanted the Nome building as a medical facility for Indians. The deal fell through though when the Justice Department insisted that the Interior Department take



This photograph of the Fairbanks hospital, its balcony festooned with dead chickens, no doubt furthered the campaign to open the facility. (National Archives)

41. Assistant attorney general to Erwin, Dec. 14, 1914, Box 565, File 4-7-2-1, RG 129, DJ; *Times*, Nov. 1, 1914.

42. *Times*, Nov. 10, 1914.

43. *Ibid.*; George C. Brace to Wickersham, Nov. 16, 1914, Box 565, File 4-7-2-1, RG 129, DJ.

44. Wickersham to attorney general, Jan. 6, 1915, Box 564, File 4-7-2-1, RG 129, DJ.

45. *Times*, Feb. 10, 11, 12, 1915; Fairbanks *Weekly Times*, Feb. 15, 1915; assistant attorney general to Wickersham, Jan. 12, 1915, Box 565, File 4-7-2-1, RG 129, DJ.

both "white elephants"; having no use for the Fairbanks facility, the secretary of the interior refused the offer.[46]

Residents of Fairbanks were enraged when they learned of the Justice Department's attempts to unload their hospital. The mayor, marshal, district judge, and district attorney sent wires to the attorney general reminding him that the Fairbanks City Council had donated land for a "detention hospital only" and would oppose using the building and grounds for any other purpose. One Fairbanks citizen scored the federal government for being parsimonious toward a laud "which has returned so much more than it cost to the government which owns it." The three local newspapers pushed hard for the cause by running editorials that supported the opening of the detention hospital.[47]

The strong protest brought results. In March 1915, nearly five years after Congress passed Wickersham's bill, the attorney general instructed Erwin to open the Fairbanks hospital immediately. That message elicited "great joy" among Alaska's territorial officials. Nomites, on the other hand, had little to cheer about: their facility remained closed. Inspired by the Fairbanks success, however, Nome residents, including the mayor, city council, Western Federation of Miners, and several fraternal organizations, petitioned Washington in June and repeatedly during the next year, but without results. In 1921 the Justice Department transferred the building to the Bureau of Education for use as a residence for teachers.[48]

In Fairbanks the triumph was short lived. Within five months of the hospital's opening, high operating costs caused the Justice Department to contemplate closing it again. Governor Strong admitted that the building required around-the-clock caretakers and that it would "always be a source of continued expense to the Government, whether occupied or not." Yet he advised against shutting down the institution because a "considerable percentage of the patients would recover, and the expense of their transportation to Morningside Sanitarium and their maintenance there would be avoided." Wickersham sided with Strong and blamed the high maintenance costs on the extravagance of Erwin, whom he accused of using the hospital as a place of residence.[49]

Wickersham's charges prompted an investigation by the Department of Justice. Asked for a response, Erwin maintained that he was making every effort to keep expenses at a minimum. He reported that from the opening of the hospital in March 1915 through August, a total of seven patients had been detained for 114 days at a cost of $2,000. Admitting that he lived at the hospital, he claimed that his presence saved the government money by obviating the need for a guard and custodian to watch the patients. He paid his own board and maintained a garden on the grounds that brought the government $625 worth of produce. He also economized by feeding the inmates fish, moose, and mountain sheep, which he provided free of charge. "I have attempted to economize and save the Government all I could at the same time rendering a good service but not a wasteful one," Erwin declared.[50]

Erwin's report convinced the Justice Department that the operation of the facility "has been economical and careful under the circumstances." Yet the paucity of inmates and high cost of their care (approximately $15 per day for each) did not seem to warrant keeping the hospital open on a permanent basis. Nonetheless, the attorney general decided to "continue its operation during the closed period of this winter in order to get a complete list of the cost of its maintenance."[51]

The Justice Department's position proved "disquieting" to Wickersham. Moreover, he continued to attack the marshal for extravagance. In December 1915, he wrote a scathing letter to the attorney general accusing Erwin of reckless spending and graft. He pointed out that for much of the year the hospital contained no patients, yet the cost of a building caretaker and electricity totaled $1,260. This money could have been saved, the delegate contended, had the facility been closed when it was unoccupied. The only reason for a caretaker, he declared, was that the marshal "wants the use of this nice, warm, new, handsome, well lighted building as a private residence: he needs the caretaker and his wife as servants, and he is annoyed that insane persons are intruded upon his privacy."[52]

Once again Wickersham's charges were groundless and probably sparked by political animosity. As most federal officials in Fairbanks realized, the hospital required the services of a permanent caretaker to protect the building and grounds from vandalism. It was necessary to heat the structure to prevent burst pipes and frost damage. Moreover, the institution might be needed at any time to detain an individual who suddenly became insane. To shut down the facility when it was unoccupied seemed senseless. Judge Charles Bunnell and District Attorney R. J. Roth both believed that the marshal's residence in the hospital re-

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46. Memorandum (from "W.C.F.") to attorney general, Nov. 12, 1914, attorney general to secretary of the interior, Nov. 12, 1914, and assistant secretary of the interior to attorney general, Dec. 9, 1914, Box 565, File 4-7-2-1, RG 129, DJ; assistant secretary of the interior to attorney general, Sept. 17, 1914, File 6—51, Bureau of Education, Hospital Service, Nome, Alaska, part 1, RG 48, National Archives (hereafter cited BE-Nome, RG 48).

47. Charles Bunnell et al to attorney general, March 10, 12, 1915, Box 565, File 4-7-2-1, RG 129, DJ; *News-Miner*, March 11 (first quotation), 12, 13 (last quotation), 1915; *Times*, March 13, 1915; *Alaska Citizen*, March 15, 1915.

48. Attorney general to Erwin, March 12, 1915, and to Wickersham, March 16, 1915, Box 565, File 4-7-2-1, RG 129, DJ; *Times*, March 16, 1915 (great joy); Nome Residents Petition for Attorney General, June 8, 1915, Box 769, AGP; Nome *Nugget*, Aug. 20, 1915, April 10, Sept. 19, 1916; assistant secretary of the interior to attorney general, Oct. 11, 1922, attorney general to secretary of the interior, Oct. 16, 1922, File 6—51, BE-Nome, RG 48.

49. Wickersham to attorney general, July 9, 1915, and Strong to attorney general, Aug. 27, 1915, Box 564, File 4-7-2-1, RG 129, DJ.

50. Attorney general to Erwin, Aug. 14, 1915, Erwin to attorney general, Sept. 22, 1915, *ibid.*

51. Assistant attorney general to attorney general (memorandum), Oct. 30, 1915 (first quotation), attorney general to Erwin, Nov. 1, 1915, and to Wickersham, Nov. 1 (last quotation), Dec. 11, 1915, *ibid.*

52. Wickersham to attorney general, Dec. 27, 1915, *ibid.*

sulted in an efficient and economical operation. To avoid the appearance of impropriety and to silence Wickersham, however, they recommended that the marshal cease living there. The attorney general agreed.[53]

To secure the permanent operation of the detention hospital, Wickersham stressed the need for humane care of the mentally ill and for following the dictates of Congress. He emphasized that in 1910 Congress passed legislation establishing detention hospitals for patients in interior Alaska who could not be promptly shipped stateside. "Now what authority has an Attorney General, the Marshal, or any one else," he asked, "to disregard and violate that law?" Will the Justice Department return to the archaic practice of keeping the mentally ill in jails? he queried. He advised the attorney general to continue the operation of the institution and to adhere to "humane methods for the care and protection of the insane sick entrusted to your care, as you are instructed to do by Congress."[54]

Wickersham's appeal proved persuasive. The detention hospital was not shut down, and it remained in operation for two decades. In the 1930s the facility served as both a detention hospital and jail until a new federal building was erected in 1933.

Although Alaskans in 1910 sought to provide humane care for the insane by maintaining them in detention centers rather than jails, they achieved modest success only after five years of delay caused by indifference and parsimony at the federal level and political factionalism within Alaska itself. When territorial officials at last united behind Governor Strong in 1913 and 1915, they got two hospitals built and one operating; the second—for lack of patients and excessive maintenance costs—never opened. The detention center episode was one of the early fights in the long crusade for mental health care in Alaska; it would take another 40 years for Alaskans to obtain a permanent asylum. □

Thomas G. Smith is associate professor of history at Nichols College, Dudley, Massachusetts. His research interests include 20th-century America, Alaska, and U.S. foreign policy. He is currently at work on a biography of the New Deal budget director and cold war ambassador Lewis W. Douglas.

53. R. J. Roth to attorney general, Jan. 7, 1916, Bunnell to attorney general, Feb. 18, 1916, and attorney general to Erwin, March 17, 1916, Box 565, File 4-7-2-1, RG 129, DJ.

54. Wickersham to attorney general, Dec. 27, 1915, *ibid.*

E. T. Barnette

E. T. Barnette: The Strange Story of the Man Who Founded Fairbanks. By TERRENCE COLE. (Anchorage: Alaska Northwest, 1981. ix, 163 pp. Illustrations, notes, selected bibliography, index. $7.95)

Terrence Cole has put flesh on a phantom. The year of Barnette's birth is uncertain. When, or where, or from what cause he died is unknown. There are, apparently, only two probable Barnette photographs. In one his face is obscured, and in the other a fur hat and a bushy moustache hide his hairline and mouth. Paradoxically, Barnette was as substantial as he was phantasmal.

Cole's study of the real Barnette is a fine historical narrative and investigation. Barnette established a trading post on the Chena River in 1901. The trading post became Fairbanks, while Barnette became a prosperous merchant, miner, and banker. He was a large man, ambitious, gregarious, and plausible. He invested much of his money in a Kentucky farm and a Mexican plantation. Affable though he was, court suits and controversy swirled around him. He throve until his bank collapsed in 1911, a few months after he had resigned its presidency and left town. The bank failure was the beginning of the end of Barnette's fortune. His Mexican property suffered from the turmoil of revolution, his wife divorced him and won a large property settlement, and his comeback attempts were ineffectual.

Such schemes and adventures call for placement in the context of western and Alaska history, yet Cole's interpretations rarely venture beyond the judgments of contemporaries. Those judgments were possibly too particularistic and severe, delivered as they were from a provincial "sourdough" perspective. For instance, Barnette's manufactured rush to Fairbanks certainly duped some gullible miners. Nevertheless, it was in the tradition of western boom-town promotionalism. Interpretive lacunae aside, Cole writes with verve. He skillfully relates Barnette to the development of Fairbanks and the Alaska-Yukon interior. His book is nicely composed, with many pertinent maps and photographs. Best of all, Cole, a widely published Alaska historian, is not yet out of his twenties. Therefore we may look forward to many more worthwhile studies from the author of *E. T. Barnette.* □

WILLIAM H. WILSON
North Texas State University

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

Ann DeNardo
Families of Chronically Mentally Ill
Victims
SR Box 30754
Fairbanks, Alaska 99701

Senator Joe Josephson, Chariman
Health, Education and Social Services Committee
Pouch V
Juneau, Alaska 99811

RE: Chronic Mental Ilness

Dear Senator Josephoson:

The enclosed article tells you who I am and what I am about.

During last week's teleconference with our Fairbanks legislators, I addressed short comings in Chapter 84, Laws of Alaska, relating to mentally ill persons.

1. Families should have a greater role in and be consulted with regard to commitment procedures.

2. A broader criteria for commitment should be studied, based on ability to function rather than just being a danger to self or others.

3. Commitment and guardianship procedures should be redefined with a view to creating a less adversarial situation between patient and family.

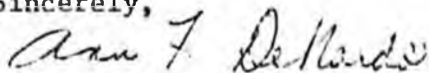
4. Mentally ill patients should receive better continuity of care as they move from hospital to community and <u>commitment procedures</u> should reflect this need.

In this week's teleconference we will address the glaring lack of hospital space for our chronically mentally ill relatives. While other states are grappling with problems of closed wards and community acceptance, Alaska struggles to get patients out of the corridors and into the wards! The only State facility, Alaska Psychiatric Institute, is perpetually overcrowded.

The Fairbanks Memorial Hospital is willing and able to become a designated treatment facility for psychiatric patients. I don't understand the mechanisms involved in such a designation and would appreciate your telling me. I <u>do</u> understand the urgent need for such a facility in the Interior.

I urge you to work toward this goal as a positive step toward a better mental health delivery system for the entire State of Alaska.

Sincerely,



Ann F. DeNardo
Families of Chronically Mentally Ill Victims

Enclosure

AD:aw

CHAIRMAN
SENATE TRANSPORTATION COMMITTEE
SENATE SPECIAL AGRICULTURE COMMITTEE

MEMBER
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
LEGISLATIVE COUNCIL
REAA BUDGET OVERSIGHT COMMITTEE

Alaska State Legislature

State Senate

SENATOR
H. PAPPY MOSS
P.O. BOX 182
DELTA JUNCTION, ALASKA 99737
(907) 095-4384

JUNEAU OFFICE:
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4921

February 20, 1984

Philip Shapiro, M.D. Director
Division of Mental Health & D.D.
Department of Health & Social Services
Pouch H-01
Juneau, Alaska 99811

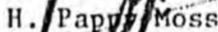
Dear Dr. Shapiro:

Enclosed is a copy of a letter I received from Ann DeNardo, Chair of the Fairbanks Alliance for the Mentally Ill.

She notes the $600,000 appropriated by the legislature is apparently only being utilized for caucasian populations.

If this is true I would also appreciate an explaination. I am looking forward to your reply.

Sincerely,



H. Pappy Moss

cc: Ann F. DeNardo
Senator Joe Josephson

SR Box 30754, Fairbanks, Alaska 99701 (907) 452-3733

FEB 13 1984

January 31, 1984

Philip Shapiro, M.D. Director
Divisior of Mental Health & D.D.
Dept. of Health & Social Services
Pouch H-01
Juneau, Alaska 99811

Dear Dr. Shapiro:

The Fairbanks Alliance for the Mentally Ill, FAMI, would like to know the rationale behind the refusal to fund the programs set out in the recent RFP from the Tanana Chiefs Mental Health Program in Fairbanks.

There was $600,000.00 appropriated by the Alaska Legislature to aide in setting up community systems to serve the chronically mentally ill population. It's been our experience, through our membership, that the burden of insanity is not confined to caucasian populations. The appropriated $600,000.00 should have been sufficient to address programs designed to aide the total target group.

We look forward to your reply.

Sincerely,

Ann F. DeNardo
Chairperson, FAMI
Ann F. DeNardo

c: Fairbanks Area Legislators
Governor Bill Sheffield
Commissioner Robert London Smith

Families of Chronically Mentally Ill Victims
SR Box 30754
Fairbanks, Alaska 99701
452-3733

FOR Nancy

September 24, 1983

Senator Joe P. Josephson
District C, Anchorage
1526 F Street
Anchorage, Alaska 99501

Dear Senator Josephson:

-Re: Severe Mental Illness

Our family group appreciates the work you do in your attempt to understand the needs of Alaska's severely mentally ill population and to translate these needs into law.

You have heard from the professional community, the social agencies and from family support groups. In order to round out your perception of the world of the insane, it would be beneficial to hear from the consumers. I wonder what direction would come out of a closed hearing with patients at the A.P.I. In our family support group, we have an articulate, intelligent young man who successfully returned to his career following an extreme psychotic break. I have also enclosed a Newsletter with a report on the life of a restored mental patient named Marsha Lovejoy. We learn a great deal from these sources. Since patients' civil rights include the right to participate in planning for their future, you might consider speaking with them!

If you're not "up" for such a closed hearing, the following books are informative.

<u>A Mind that Found Itself</u>, by Clifford W. Beers
<u>The Eden Express</u>, by Kurt Vonnegut, Jr.

Thank you for coming to Fairbanks. I hope we were able to transmit our needs to you - successfully.

Sincerely,

Ann F. DeNardo

Enc. 1

ALASKA STATE SENATE

JOE P. JOSEPHSON

COMMITTEES
HEALTH EDUCATION & SOCIAL SERVICES (CHAIR)
JUDICIARY (VICE CHAIR)
FINANCE
MAJORITY CAUCUS (CHAIR)

October 14

Ann F. DeNardo
Families of Chronically Mentally Ill Victims
SR Box 30754
Fairbanks, Alaska 99701

Dear Ann:

Thank you for the letter following our hearing in Fairbanks, I want to thank you for coming and presenting such compelling testimony to the committee. We are having another hearing in Anchorage today, and I am enclosing a copy of the new draft bill the committee will be considering. I tried to incorporate many of your group's comments into the new draft, and would appreciate your comments on it.

The idea of having a hearing with some patients from API is very fascinating, and I will suggest this to the Committee members for their response.

We have received many remarks concerning the lack of equal protection under the law for children, and would like to hear any comments from your group concerning proceedings for minors, and if you feel that the lack of hearings for this group leaves the children at a disadvantage.

Please feel free to contact me at any time, I work in Joe's Juneau office.

Sincerely yours,

Nancy

Nancy Deitrick, aide
Senate HESS Committee

Feb. 20, 1984,
P.O. Box 1269,
Palmer, Alaska 99645

Hon. Joe. P. Josephson,
Alaska State Senator
Chairman, H. E. S. S.,
Rm #508, Capitol,
(Meets in Rm. #504),
Juneau, Alaska 99811,

RECEIVED

Dear Mr. Josephson,

Please impress upon Messrs. Vic Fischer, Rick Halford, Paul Fischer & Pappy Moss, imperative necessity of passage & implementation into law, at earliest possible moment, S. B. 346.

Present law renders hospitalization virtually impossible, no matter how badly needed.

(Don't let Vic Fischer talk you out of it, or screw it up.)

Women's Resource Centers should be monitored & scrutinized more thoroughly (See John Hellenthal).

Blue-ribbon panel, from South 48, should be brought in to go over Mental Health from top to bottom.

Meanwhile, immediate implementation of plan to regionally shift out-patient psychiatric personnel, & deprive them, completely, of previous jurisdiction. This would remedy some ongoing abuses, & be a cheap, simple & direct remedy.

Sincerely yours, M. S. Baker

The following print letter, from page 7 of the Feb. 20th issue of U.S. News & World Report, expresses the problem so well, in synthesis, that I felt I could do no better than Xerox a copy & send it along.

Twenty years have not dealt kindly with the collaborative efforts of politicians and social reformers that spawned the release of the chronically mentally ill—chemically restrained, though not often cured—into communities that were emotionally and financially ill-equipped to cope with them. In the past decade, the legal system has made it increasingly difficult for those in need of psychiatric care, but not designated as being dangerous to themselves or to others, to receive medical treatment. The number of homeless and hungry is going to keep increasing—perhaps to a level that even Ed Meese can detect.

NOEL JOHNSON
Urbana, Ill.

The simple facts of the matter are that, since the advent of tranquilizers, the vaster percentage of cases, such as schizophrenia, respond quite well to treatment.

It is equivalent to a form of cruelty, to be unable to hospitalize a family member who badly needs treatment.

Fictitious "concerns" over "patients-rights" (under existing legislation) fail to recognize that the mentally-ill person should be privileged to an alleviation of their condition which is not possible under the present law on the books.

Alaska State Legislature

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

November 17, 1983

Oliver Osborn, M.D.
Cordova Medical Clinic
Box 310
Cordova, Alaska 99574

Dear Dr. Osborn:

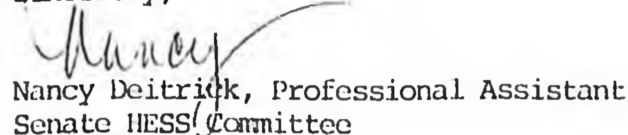
Senator Josephson sent your letter to me, as I am the one who has been working on the drafting of the Mental Health Commitment Bill, and I wanted to respond to your concerns over commitment procedures.

At the last hearing on the draft bill in Anchorage, the Committee decided to expand those permitted to initiate emergency detention to include "Mental Health Professional". As defined in the title, this includes physicians, psychologists, psychological associates (both with training in clinical psychology) and social workers.

I expect to receive the latest copy of the draft from our legal services within the next few days, and would be happy to send you a copy of the bill for your perusal and comments. I think we have come up with a good bill that deals with the concerns of professionals and family groups as well, and should make the system work better and provide better care for those in need.

Thank you for taking the time to write, and feel free to contact me at any time at the above address or at 465-4907.

Sincerely,



Nancy Deitrick, Professional Assistant
Senate HESS Committee

ALASKA PSYCHIATRIC ASSOCIATION

ALASKA DISTRICT BRANCH
of
AMERICAN PSYCHIATRIC ASSOCIATION

February 15, 1984

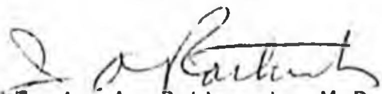
The Honorable Joseph Josephson
Alaska State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

At a recent meeting of the Executive Committee of the Alaska District Branch of the American Psychiatric Association this group voted to support your bills regarding changes in the involuntary hospitalization statutes and also the bill which you have submitted requiring parity coverage for psychiatric services by insurance companies doing business in the State of Alaska. It was the wish of the Executive Committee that I write you and notify you that we strongly support you on both these issues.

Thank you very much for introducing this much needed legislation.

Sincerely yours,



Irvin A. Rothrock, M.D.
President, Alaska District Branch
American Psychiatric Association

IAR:bw

FAMI
Fairbanks Alliance for the
Mentally Ill
SR Box 30754
Fairbanks, Alaska 99701

October 17, 1983

Ms. Nancy Deitrick, Aide
Senate HESS Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Nancy:

Thank you for the copy of the new draft bill. Our group will study it and comment in detail in the near future. A quick reading shows me the committee is making an attempt to include families in the overall approach to the continuing treatment of chronic mental illness and we deeply appreciate it.

Two concerns jump immediately to attention:

1. Section 47.30.870. Transportation of patient and escort to the designated facility. Once more this section authorizes payment for transportation to the API only for involuntary patients. No where does the act provide payment for transportation of voluntary patients, thus presenting a great hardship to patients willing to accept treatment. By the time folks are ready for the API, they have also bottomed out financially. See page 3, paragraph 1 of our written testimony dated September 23, 1983.

2. Section 27. AS 47.30.915(a) of the draft bill changes the description of registered nurse...and we agree with these changes. However, we are concerned with the description of social worker. A Master's level with no experience does not preclude an understanding of severe mental illness. Thus, "experience in the field of mental illness" should be changed to three years experience in the field of mental illness." I will enlarge upon this in our detailed comment.

On behalf of FAMI, I thank you for your sensitivity and understanding. Please convey this to Senator Josephson and other members of the HESS Committee.

Sincerely,

Ann F. DeNardo
Chairperson

ALASKA STATE SENATE

JOE P. JOSEPHSON
DISTRICT G - ANCHORAGE
1526 F STREET
ANCHORAGE, ALASKA 99501
(907) 277-4419

COMMITTEES
HEALTH, EDUCATION & SOCIAL SERVICES (CHAIR)
JUDICIARY (VICE CHAIR)
FINANCE
MAJORITY CAUCUS (CHAIR)

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4907
(907) 465-4525

October 21, 1983

Ann F. DeNardo, Chairperson
Fairbanks Alliance for the Mentally Ill
SR Box 30754
Fairbanks, Alaska 99701

Dear Ann:

Thank you for responding to promptly to my letter, because I really am quite anxious to get this bill in final form to be introduced this session. We had a hearing in Anchorage on the 14th with a very good turnout, and some further suggestions for changing the bill although the overwhelming response was good.

I want to address your concerns specifically:

1. Transportation - When I have questioned the department about the way they handle transportation costs, I have been informed that costs are paid for anyone who needs it regardless of the type of commitment. If you know of instances when people have requested transportation expenses and been denied, I would like to hear about it.

2. Social Workers - The issue was raised and completely discussed at the Anchorage hearing, with pretty much the same conclusion you reached - three years experience. We have a bill to license social workers in our committee, but the governor has expressed himself against the bill - nothing against the profession, but he feels we have too many boards and wants no more.

Suggestions made in Anchorage:

1. That all "mental health professionals" listed in the bill be allowed to commit people, not just physicians and police officers.

2. The constant battle over the rights of juveniles continues. If any of the families in your group have experience with minors, I would greatly appreciate hearing their feelings about

the 72 hour hearing not being provided for children following admittance for evaluation. Those who [illegible] would like to see children admitted indefinitely for evaluation (not 21 or 30 days), and feel the court proceedings are too frightening for children. Those advocating equal protection feel that the children should have the same procedures as adults. A law similar to ours was overturned by a California court.

3. That the concept of <u>outpatient</u> commitment is not feasible and should be dispensed with.

4. That anyone threatened by the individual before they were committed should also be notified when the person is absent without leave, and that notification should be immediate and not within three hours.

If you have any comments on these suggestions or any others relating to the draft bill, I will be happy to consider them. Thank you for your time and interest.

Sincerely yours,

Nancy Deitrick, aide
Senate HESS Committee

SECTIONAL ANALYSIS - DRAFT "AN ACT RELATING TO THE TREATMENT OF MENTALLY ILL PERSONS." by Senator Joe Josephson

Section 1	Provides a word change to limit the endless paperwork from patients transfering in and out of voluntary status in order to leave against medical advice.
Section 2-5	Changes the age of majority under the title from 14 to 18, changes the commitment period for minors from 21 to 30 days, and eliminates sex gender pronouns. Section 4 also changes the term "immediate" to "timely" in order to avoid inoperable situations (eg. if a patient wants to leave in the middle of the night, the facility must call in a psychiatrist). Pg. 2, line 9 changes "notice of intent" to "request".
Section 6	Provides options for the release of a minor, and options for the facility to keep a minor who is in danger of causing serious harm to self and others.
Section 7	Adds "physician licensed in the state" to current law allowing a peace officer to take someone into custody for emergency detention. NOTE: we should also add a clause for Federally employed physicians exempt from licensure (drafting error). Also limits the use of correctional facilities for the mentally ill to situations requiring protective custody while awaiting transportation to a treatment facility.
Section 8	Changes the commitment time period from 21 to 30 days.
Section 9	The purpose of this section was to move the term "gravely disabled" after "mentally ill" (pg. 5, lines 20-22). Other changes relate only to neutral pronouns and changing commitment time periods.
Section 10	Changes the 21 day commitment period to 30 days, and substitutes neutral pronouns in the section.
Section 11	Changes the commitment time period from 21 to 30 days. Subsection (4) relaxes the rules of evidence and allows for informal court preceedings. Subsection (9) allows respondent to call experts and witnesses to testify.
Section 12	Changes 21 day commitment to 30 day, and substitutes sex neutral pronon
Section 13-14	Change [illegible] commitment time periods from 21 to 30 days; and from 120 days to 180 days.
Section 15	Adds a new section to the statute allowing the designated facility to administer medication or treatment that is

consistent with Article 9 - Patients Rights.

Section 16 Adds new language to the section relating to unauthorized absences to provide that the facility must notify the parent or guardian of the situation within three hours.

Section 17 Adds a new section relating to the change of admission status from involuntary to voluntary if the responsible physician agrees that it is appropriate and that the change is made in good faith.

Section 18 Adds to provisions for computation of time, specific references to AS 47.30.715 (Acceptance of order), and AS 47.30.685. Current interpretation of the law requires that a judge must be brought to the facility at these times, and many are unwilling to do so on a holiday or weekend. Also changes commitment time periods to be consistent with other sections.

Section 19 Amends section relating to liability to include physician and transportation, to be consistent with Section 7.

Section 20 Amends the section of law relating to informed consent for unusual procedures, to include informed consent of the parent or guardian in case the patient is unable to give informed consent.

Section 21 New language specifies that the discharge plan shall be shared with the parent or guardian.

Section 22 Limits the rights of the patient in areas of visitors, mail and access to a phone if the professional person in charge determines that it is not in the best interest of the patient or will cause harm to the patient or others.

Section 23 Allows access to records to a law enforcement agency under special circumstances.

Section 24 Adds federal facilities to the definition of "evaluation facility."

Section 25 Expands the definition of "gravely disabled" to include persons who are not in imminent danger but whose lack of treatment would cause deterioration of their condition.

Section 26 Expands definition of "likely to cause bodily harm" beyond recent attempts, to include threats and likelihood of injury in the near future.

Section 27 Changes the requirements for a nurse to be classified as a mental health professional, as there are only two in the state with a Master's Degree in Psychiatric nursing.

TESTIMONY BEFORE THE SENATE HESS COMMITTEE
Re: Mental Health Commitment Law
September 23, 1983 - Fairbanks, Alaska

The families of severely mentally ill victims have worked with the Mental Health Commitment Law for two years. We wish to convey our position regarding the bill.

Section 47.30.660. This section sets out the powers and duties of the Department of Health and Social Services. Paragraph (4) of this section calls for the Department to designate, operate and maintain treatment facilities...to provide...care and treatment for the mentally ill. A treatment facility is defined in 47.30.915(15). In spite of the directive to designate treatment facilities, the API remains Alaska's only such facility.

Section 47.30.670. This section sets out standards for voluntary admission. A patient who accepts voluntary admission can leave the hospital anytime "against medical advice," or AMA. This is why there are so many voluntary admissions as opposed to involuntary. A psychiatrist might do a screening at this point to determine a patient's ability to function and make these decisions.

Section 47.30.705. This section addresses emergency detention for evaluation. It states that a police officer"...may cause the person to be taken into custody and delivered to the nearest evaluation facility. A correctional facility may be used as an emergency evaluation facility if an evaluation facility is not available... (and) the peace officer shall...be interviewed by a mental health professional at the facility." There are no mental health professionals at the correctional facilities.

Section 47.30.710. Examination. This section states that a person so placed in a correctional facility shall be examined and evaluated within 24 hours. This puts a person in jail for 24 hours because of an illness he cannot control. There is no other illness where, due to the illness itself, a person is incarcerated!

Section 47.30.715. Acceptance of Order. In this section the court is ordered to set a date for hearing and notify the respondent's attorney. There is no directive for the attorney to make an effort to see the respondent. Often the first contact the respondent has with his attorney is in the courtroom itself, immediately preceeding the hearing.

Section 47.30.735. This section sets out the civil procedure for a 21 day commitment. These procedures should be redefined in order to create a less adversarial situation between patient and family. Families become the caretakers following hospitalization in 50-55% of the cases. It is important to understand that hospitals do not cure patients. They are only stabilized with neuroleptic medications and returned to the family with their illness in tact, and the added belief that the family has turned against them.

Judicial procedures are either civil or criminal. Commitment procedures are civil. Families feel it might be possible to create a new area within which commitments could be handled. We request the Judiciary Committee to study this concept with a view toward lessening the adversarial approach.

Section 47.30.790. This section deals with absence without leave. If a patient is absent from a treatment facility without authorization a peace officer is instructed to take the patient into custody and return him to the treatment facility. This section should include a provision that the family or guardian be notified of such absence with a specified time, say 3 hours.

Section 47.30.795. This section addresses involuntary outpatient care. Paragraph (c). It states that if it is determined that respondent needs inpatient care due to a critical condition, oral and written notice that he must return to a treatment facility within 24 hours must be given him. If the patient is experiencing thought disorder this gives him 24 hours to get out of town. This section further states a police officer shall pick up the patient if he has not complied with the notice. The respondent is not a criminal, to be served and treated as a criminal. We object to the constant posture of addressing mental disease as criminal.

Section 47.30.825. This section deals with patient rights. Paragraph (6) of this section prevents psychosurgery, lobotomy, or other form of treatment without specific, informed consent of the patient and a court order. We would like to see a provision included that would also require specific informed consent given by "an adult designated in accordance with 47.30.725". (This is an adult designated by the respondent.)

Again, paragraph (8) of this section should insure a copy of the discharge plan is given to "an adult designated in accordance with 47.30.725". Families rarely know of any discharge plan and it is the nature of the disease that patients will not follow through without help.

Section 47.30.845. This section deals with confidential records. Paragraph (2) of this section makes it possible for an individual to whom the patient has given written consent to receive records and information on the patient. This release of records should be dated within a specified time period,-say-one year. This release of records to a designated individual should not be open-ended, but lapse within a restricted time frame.

Section 47.30.870. This section deals with transportation of patient and escort to the designated facility following involuntary commitment. (In this State, of course, this means a trip to Anchorage.) There is provision authorizing the Department to pay for transportation of patient and escort the API for INVOLUNTARY commitments only. Provision should be made to authorize payment of transportation costs for VOLUNTARY commitments as well. At present the family, or the patient, must bear this cost. This creates a continuing financial burden for families trying to remain "case manager" over the years. The continuing financial burdens encourage families to give up attempts to maintain relationships beneficial to the patient.

Section 47.30.875. This section addresses nonresident patients and the return of a mentally ill resident of this state who has been placed in a facility outside of this state. Paragraph (c) of this section is the only section of this Act which mentions the importance of maintaining family relationships and encouraging visits beneficial to the patient. It is ironic that this important approach to treatment is mentioned only under such subtitle as "nonresident patients". We would like to see the encouragement of more family involvement.

Section 47.30.915. Definitions. Paragraph (7) defines "gravely disabled" and paragraph (10) defines "likely to cause serious harm". It is the contention of everyone involved with this Act that these definitions must be broadened. This is such a complicated and emotional issue that agreement is difficult. As a consequence many people who need mental health treatment desparately are not being served. Instead of waiting for a person to commit a crime, or attempt to commit a crime, we recommend the following criteria to enlarge the definition of a mentally ill person for purposes of providing treatment:

> (7) "gravely disabled" means a condition in which a person, as a result of mental illness,...
> (b) or is not receiving such care and mental medical treatment as is necessary for health and safety, or (c) a person whose thought processes, perception of reality or judgement is substantially impaired.

We would like to see a study of other states' commitment laws in reference to their criteria for commitment.

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB 346 - RE: mentally ill persons DATE FEB 1, 1984

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
Dr. Philip Shapiro	Dept of H&SS / Mental Health And Dev Disabilities	Pouch H04	465 3370
Tim Parsons	Behav. Health MHA		

SENATE AMENDMENT

BY [illegible]

To: ______ SENATE BILL No. 346

To: ______ HOUSE BILL No. ______

PAGE: 4 LINE: [illegible]

Add a new subsection to read:

(e) an additional 30 day commitment of a minor under the age of 18 may be sought by parents or guardians if, in the opinion of the professional person in charge of the treatment facility, the conditions under subsection (a) (1), (2) and (3) continue to exist.

COMMITTEE REPORT

SENATE

FURTHER:

Date: ____________________

Mr. President:

The Committee on ______________________________ has had ______________________

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

[ ] do pass [ ] do not pass

[✓] do pass with attached amendments(s)

[ ] replace with CS for ______________________________ [ ] same title [ ] new title

and recommends ______________________________

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

[ ] reports it back without recommendation

[ ] referred to the ______________________________ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

____
CHAIRMAN

S 60 (Rev. 12/78)

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB 346 - Mental ill persons DATE February 3, 1984

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
Dr. Phillip Shapiro	Health & Social Services	Juneau	465-3370

ALASKA STATE SENATE

JOE P. JOSEPHSON
DISTRICT G · ANCHORAGE
1526 F STREET
ANCHORAGE, ALASKA 99501
(907) 277-4419

COMMITTEES
HEALTH, EDUCATION & SOCIAL SERVICES (CHAIR)
JUDICIARY (VICE-CHAIR)
FINANCE
MAJORITY CAUCUS (CHAIR)

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4907
(907) 465-4525

February 2, 1984

Ms. Ann F. DeNardo
Chairperson
Fairbanks Alliance for the
Mentally Ill
SR Box 30754
Fairbanks, Alaska 99701

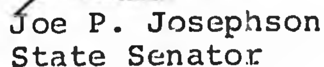
Dear Ann:

Thank you for sending me copy of your letter to Governor Sheffield dated January 11.

We have been working with community mental health groups, especially within Anchorage, and will try to remain mindful, as our session proceeds, of your concerns for adequate community-based living facilities for the chronically mentally ill.

With best wishes, I am

Sincerely,



Joe P. Josephson
State Senator

JPJ:rak

FAMI -- Fairbanks Alliance for the Mentally Ill
SR Box 30754
Fairbanks, Alaska 99701

January 11, 1984

Governor "Bill" Sheffield
Pouch A
Juneau, Alaska 99801

RE: State of the State Message, January 10, 1984

Dear Governor Sheffield:

How disappointing that the plight of the chronically mentally ill did not appear as one of your priorities in the State of the State message.

During our meeting and exchange of correspondence this past summer, we pointed out that discharge from the API without adequate living arrangements will cause the patient to suffer more crises and to soon return to the hospital. The State walks a dangerous path by ignoring the lack of adequate community-based living facilities for its chronically mentally ill population.

We look forward to your public recognition of the needs of this vulnerable and suffering population.

Sincerely,

Ann F. DeNardo

Ann F. DeNardo, Chairperson
FAMI - Fairbanks Alliance for the Mentally Ill

c: Commissioner Robert L. Smith
Alaska Legislators (60)

Thank you for sending me copy —

SB 346 - Mentally Ill.

Dr Phil Shapiro - DHSS

revisions consistent w/ secure, safe & therapeutic treatment of the individual & the community.

Jim Parsons - MOA - Beh. Health.

In 30 yrs know of no misuse of MH law.

"a state licensed or certified" mental health professional

MEMORANDUM

TO: JOE
FROM: NANCY
RE: MENTAL HEALTH HEARING - OCTOBER 14, 1983

There is a new draft version of the bill which incorporates suggestions made by the Department, family groups and others who work with troubled children at the two previous hearings in Anchorage and Fairbanks.

These amendments include:

1. Reducing the involvement of the correction system in dealing with the mentally ill, by allowing a mentally ill person to be held in a prison facility before transfer only for protective custody purposes, and allowing physicians to admit patients for emergency care rather than only policemen.

2. Changing the age of majority in the Title from 14 to 18.

3. Changing time computations from 21, 90 and 120 days to 30, 90 and 180 days for the commitment periods. Also changes the commitment period for minors from 21 to 30 days to allow sufficient evaluation and placement time.

4. Allowing records to be available to a law enforcement agency if there is substantiated concern over imminent danger to the community.

5. Adding a qualifier to the Right to Privacy and Personal Possessions that mail, visitors and access to a phone can be denied if the professional person in charge determines it is not in the best interest of the person and will pose a threat to the safety or well being of the patient or others.

6. Adding approval of psychiatrist as a requirement for Conversion of status if a patient wants to change from involuntary to voluntary.

7. Changing court proceedings by relaxing the rules of evidence and recommending that the hearing be as informal as possible.

8. Requiring that families or guardian be notified if a patient is absent without leave.

9. Requiring informed consent of parent or guardian under subsection (6) of patient rights relating to alternative treatments, and notification of a parent or guardian of the discharge plan.

OTHER AREAS THAT NEED CONSIDERATION:

HEARINGS FOR MINORS - Under current law, a minor may be admitted by a parent or guardian for a 21 day period, but does not receive the 72 hour hearing which is required for an adult. Questions over equal protection have been raised by Pudge Kleinkof and others.

TIME PERIOD OF COMMITMENT FOR MINORS - The Department recommended deletion of the 21 day limit for minors (which was in the first draft), I have extended that period to 30 days in the second draft because it seems unfair to commit someone for an indefinite time period. The committee needs to decide if this 30 days is adequate.

DESIGNATED FACILITIES - The regulations have been in the drafting process since 1981, and have currently been returned to the Department by the Attorney General's office in order to be adapted to recent changes in Medicaid standards. There has been a great deal of concern at hearings over the designation of regional facilities, and I have asked the Department to have someone available to answer questions.

INVOLUNTARY OUTPATIENT COMMITMENT - This is not addressed in the draft bill, but is an area that is apparently not working well according to the Commissioner's letter (Page 3, (6)). He states that the change in the definition of "gravely disabled" may assist the success of the concept, but there are still problems with the conversion from involuntary outpatient commitment to inpatient commitment.

USE OF THE CORRECTIONAL SYSTEM FOR THE MENTALLY ILL - I have changed emergency detention (AS 47.30.705) to match the Model APA Law, but that still allows a person to be taken into a correctional facility for protective custody prior to transfer within 24 hours. Realistically, many areas of the state have no alternative facility and may continue to use prisons, but this change should eliminate the conflict over evaluations in prisons.

TRANSPORTATION - Costs are paid for a person involuntarily commited, ordered by statute, but there is no requirement for those who voluntarily admit themselves. The Department says that it pays costs for anyone in need, but the parent groups talk about this creating a financial hardship for families. You may want to discuss this issue and solve it within the bill.

13-0936
Josephson
10/11/83

IN THE SENATE BY JOSEPHSON

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the treatment of mentally ill persons."

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

* Section 1. AS 47.30.655(1) is amended to read:

(1) that persons be given a reasonable [EVERY] opportunity to accept voluntary treatment before involvement with the judicial system;

* Sec. 2. AS 47.30.670 is amended to read:

Sec. 47.30.670. STANDARDS FOR VOLUNTARY ADMISSION. A person 18 [14] years of age or older may be voluntarily admitted to a treatment facility if the person [HE] is suffering from mental illness and [HE] voluntarily signs the admission papers.

* Sec. 3. AS 47.30.675 is amended to read:

Sec. 47.30.675. NOTICE OF RIGHTS. (a) Upon the application of a person for voluntary admission, or at the time a person admitted under AS 47.30.690 reaches the age of 18, the person [14, HE] shall be given a copy of the following documents which shall be explained [TO HIM] as necessary:

(1) notice of rights as set out in AS 47.30.825 - 47.30.865 and an explanation of any document served upon the person [HIM]; and

(2) notice that should the person [HE] desire to leave at a time when the treatment facility determines that the person [HE] is mentally ill and as a result is likely to cause serious harm to self [HIMSELF] or others or is gravely disabled, the facility could

initiate commitment proceedings against the person [HIM].

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

* Sec. 4. AS 47.30.685 is amended to read:

Sec. 47.30.685. NOTICE OF INTENT TO LEAVE FACILITY; COMMITMENT. A voluntary patient who is 18 [14] years of age or older and who desires to leave a treatment facility must submit to the facility a request [WRITTEN NOTICE OF INTENT] to leave on a form provided [TO HIM] by the facility. Upon timely [IMMEDIATE] investigation, the patient shall be evaluated in writing and discharged immediately or given written notice that involuntary commitment proceedings will be initiated against the patient [HIM]. The treatment facility may detain the patient for no more than 48 hours after receipt of the patient's request [NOTICE OF INTENT] to leave in order to initiate involuntary commitment proceedings.

* Sec. 5. AS 47.30.690 is amended to read:

Sec. 47.30.690. ADMISSION OF MINORS UNDER 18 [14] YEARS OF AGE. (a) A minor under the age of 18 [14] may be admitted for 30 [21] days of evaluation, diagnosis, and treatment at a designated treatment facility if the minor's [HIS] parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,

(1) the minor [HE] is gravely disabled or is suffering from mental illness and as a result [HE] is likely to cause serious harm to the minor [HIMSELF] or others;

(2) there is no less restrictive alternative available for the minor's [HIS] treatment; and

(3) there is reason to believe that the patient's mental condition could be improved by the course of treatment or would ~~not~~

1 deterioriate further if treated.

2 (b) The minor may be released by the treatment facility at any
3 time [DURING THE 21-DAY PERIOD] if the professional person in charge
4 or the minor's [HIS] designated mental health professional determines
5 the minor would no longer benefit from continued treatment [HOSPITAL-
6 IZATION] and the minor is not dangerous. The minor's parents or [HIS]
7 guardian must be notified by the facility of the contemplated release
8 [AND THAT, UNLESS THEY INITIATE INVOLUNTARY COMMITMENT PROCEEDINGS,
9 THE MINOR WILL BE RELEASED].

10 * Sec. 6. AS 47.30.695 is amended to read:

11 Sec. 47.30.695. NOTICE OF REQUEST FOR RELEASE OF MINORS UNDER 18
12 [14] YEARS OF AGE FROM DETENTION AND COMMITMENT. The parent or
13 guardian of a minor who is less than 18 [14] years of age may file a
14 notice to withdraw the minor from the facility. On receipt of the
15 notice, the facility may

16 (1) discharge the minor to the custody of the parent or
17 guardian; or

18 (2) if, in the opinion of the treating physician, the minor
19 is likely to cause serious harm to self or others or there is reason
20 to believe the release could place the minor in imminent danger, the
21 treating physician may

22 (A) discharge the minor to the custody of the parent
23 or guardian after advising the parent or guardian that this
24 action is against medical advice and after receiving a written
25 acknowledgement of the advice; or

26 (B) refuse to discharge the minor, initiate involun-
27 tary commitment proceedings, and continue to hold the minor until
28 a court order under AS 47.30.700 has been issued [REQUEST AND
29 OBTAIN IMMEDIATE RELEASE OF THE MINOR AT ANY TIME, UNLESS AS THE

Does this apply to minors?

1 RESULT OF MENTAL ILLNESS, THE MINOR IS LIKELY TO CAUSE SERIOUS
2 HARM TO HIMSELF OR OTHERS].
3 * Sec. 7. AS 47.30.705 is amended to read:
4 Sec. 47.30.705. EMERGENCY DETENTION FOR EVALUATION. A peace
5 officer or a physician licensed in this state who has probable cause
6 to believe that a person is gravely disabled or is suffering from
7 mental illness and is likely to cause serious harm to the ~~person~~ self [HIM-
8 SELF] or others of such immediate nature that considerations of safety
9 do not allow initiation of involuntary commitment procedures set out
10 in AS 47.30.700, may cause the person to be taken into custody and de-
11 livered to the nearest evaluation facility. A person taken into
12 custody for emergency evaluation may not be placed in a jail or other
13 correctional facility except for protective custody purposes and only
14 while awaiting transportation to a treatment facility. The [A COR-
15 RECTIONAL FACILITY MAY BE USED AS AN EMERGENCY EVALUATION FACILITY IF
16 AN EVALUATION FACILITY IS NOT AVAILABLE. UPON ARRIVAL AT THE EVALU-
17 ATION FACILITY, THE] peace officer or physician shall complete an
18 application for examination of the person in custody and be inter-
19 viewed by a mental health professional at the facility.
20 * Sec. 8. AS 47.30.715 is amended to read:
21 Sec. 47.30.715. ACCEPTANCE OF ORDER. When a facility receives
22 a proper order for evaluation, it must accept the order and the
23 respondent for an evaluation period not to exceed 72 hours. The
24 facility shall promptly notify the court of the date and time of the
25 respondent's arrival. The court shall set a date, time and place for
26 a 30-day [21-DAY] commitment hearing, to be held if needed within 72
27 hours after the respondent's arrival, and the court shall notify the
28 facility, the respondent, the respondent's [HIS] attorney, and the
29 prosecuting attorney of the hearing arrangements. Evaluation

ISER then police do this well →

1 personnel, when used, shall similarly notify the court of the date and
2 time when they first met with the respondent.
3 * Sec. 9. AS 47.30.725 is amended to read:
4 Sec. 47.30.725. COMMITMENT PROCEEDING RIGHTS; NOTIFICATION. (a)
5 When a respondent is detained for evaluation under AS 47.30.660 -
6 47.30.915, the respondent [HE] shall be immediately notified orally
7 and in writing of the [HIS] rights under this section. Notification
8 shall be in a language understood by the respondent. The respondent's
9 [HIS] guardian, if any, and if the respondent requests, an adult
10 designated by the respondent, shall also be notified of the respon-
11 dent's rights under this section.
12 (b) Unless a respondent is released or voluntarily admitted
13 [ADMITS HIMSELF] for treatment within 72 hours of [HIS] arrival at the
14 facility or, if the respondent [HE] is evaluated by evaluation person-
15 nel, within 72 hours from the beginning of the respondent's [HIS]
16 meeting with evaluation personnel, the respondent [HE] is entitled to
17 a court hearing to be set for not later than the end of that 72-hour
18 period to determine whether there is cause for detention [TO DETAIN
19 HIM] after the 72 hours have expired for up to an additional ~~21~~ 30 days
20 on the grounds that the respondent [HE] is [GRAVELY DISABLED OR]
21 mentally ill, and as a result presents a likelihood of serious harm to
22 the respondent [HIMSELF] or others, or is gravely disabled. The
23 facility or evaluation personnel shall give notice to the court of the
24 releases and voluntary admissions under AS 47.30.700 - 47.30.820.
25 (c) The respondent has a right to communicate immediately, at
26 the department's expense, with the respondent's [HIS] guardian, if
27 any, or an adult designated by the respondent and the attorney desig-
28 nated in the ex parte order, or an attorney of the respondent's
29 choice.

1 (d) The respondent has the right to be represented by an attor-
2 ney, to present evidence, and to cross-examine witnesses who testify
3 against the respondent [HIM] at the hearing.
4 (e) The respondent has the right to be free of the effects of
5 medication and other forms of treatment to the maximum extent possible
6 before the 30-day [21-DAY] commitment hearing; however, the facility
7 or evaluation personnel may treat the respondent [HIM] with medication
8 under prescription by a licensed physician or by a less restrictive
9 alternative of the respondent's [HIS] preference if, in the opinion of
10 a licensed physician in the case of medication, or of a mental health
11 professional in the case of alternative treatment, the treatment is
12 necessary to
13 (1) prevent bodily harm to the respondent or others;
14 (2) prevent such deterioration of the respondent's mental
15 condition that subsequent treatment might not enable the respondent
16 [HIM] to recover; or
17 (3) allow the respondent to prepare for and participate in
18 the proceedings.
19 (f) A respondent, if [HE IS] represented by counsel, may waive,
20 orally or in writing, the 72-hour time limit on the 30-day [21-DAY]
21 commitment hearing and have the hearing set for a date no more than
22 seven calendar days after [HIS] arrival at the facility. The
23 respondent's counsel shall immediately notify the court of the waiver.
24 * Sec. 10. AS 47.30.730 is amended to read:
25 Sec. 47.30.730. PROCEDURE FOR 30-DAY [21-DAY] COMMITMENT; PETI-
26 TION FOR COMMITMENT. (a) In the course of the 72-hour evaluation
27 period, a petition for commitment to a treatment facility may be filed
28 in court. The petition must be signed by two mental health profes-
29 sionals who have examined the respondent, one of whom is a physician.

1 The petition must

2 (1) allege that the respondent is mentally ill and as a
3 result is likely to cause harm to the respondent [HIMSELF] or others
4 or is gravely disabled;

5 (2) allege that the evaluation staff has considered but has
6 not found that there are any less restrictive alternatives available
7 that would adequately protect the respondent or others; or, if a less
8 restrictive involuntary form of treatment is sought, specify the
9 treatment and the basis for supporting it;

10 (3) allege with respect to a gravely disabled respondent
11 that there is reason to believe that the respondent's mental condition
12 could be improved by the course of treatment sought;

13 (4) allege that a specified treatment facility or less
14 restrictive alternative that is appropriate to the respondent's
15 condition has agreed to accept the respondent;

16 (5) allege that the respondent has been advised of the need
17 for, but has not accepted, voluntary treatment, and request that the
18 court commit the respondent to the specified treatment facility or
19 less restrictive alternative for a period not to exceed 30 [21] days;

20 (6) list the prospective witnesses who will testify in
21 support of commitment or involuntary treatment;

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

24 (b) A copy of the petition shall be served on the respondent,
25 the respondent's [HIS] attorney, and the respondent's [HIS] guardian,
26 if any, before the 30-day [21-DAY] commitment hearing.

27 * Sec. 11. AS 47.30.735 is amended to read:

28 Sec. 47.30.735. 30-DAY [21-DAY] COMMITMENT. (a) Upon receipt
29 of a proper petition for commitment, the court shall hold a hearing at

1 the date and time previously specified according to procedures set out
2 in AS 47.30.715.

3 (b) The hearing shall be conducted in a physical setting least
4 likely to have a harmful effect on the mental or physical health of
5 the respondent, within practical limits. At the hearing, in addition
6 to other rights specified in AS 47.30.660 - 47.30.915, the respondent
7 has the right

8 (1) to be present at the hearing; this right may be waived
9 only with the respondent's informed consent; if the respondent is
10 incapable of giving informed consent, the respondent may be excluded
11 from the hearing only if the court, after hearing, finds that the
12 incapacity exists and that there is a substantial likelihood that the
13 respondent's presence at the hearing would be severely injurious to
14 the respondent's [HIS] mental or physical health;

15 (2) to view and copy all petitions and reports in the court
16 file of the respondent's [HIS] case;

17 (3) to have the hearing open or closed to the public as the
18 respondent [HE] elects;

19 (4) to have the rules of evidence and civil procedure
20 applied so as to provide for the informal but efficient presentation
21 of evidence [TO BE PROCEEDED AGAINST ACCORDING TO THE RULES OF
22 EVIDENCE APPLICABLE TO CIVIL PROCEEDINGS];

23 (5) to have an interpreter if the respondent [HE] does not
24 understand English;

25 (6) to present evidence on the respondent's [HIS] behalf;

26 (7) to cross-examine witnesses who testify against the
27 respondent [HIM];

28 (8) to remain silent;

29 (9) to call experts and other witnesses to testify on the

1 respondent's behalf.

2 (c) At the conclusion of the hearing the court may commit the
3 respondent to a treatment facility for not more than 30 [21] days if
4 it finds, by clear and convincing evidence, that the respondent is
5 mentally ill and as a result is likely to cause harm to the respondent
6 [HIMSELF] or others or is gravely disabled.

7 (d) If the court finds that there is a viable less restrictive
8 alternative available and that the respondent has been advised of and
9 refused voluntary treatment through the alternative, the court may
10 order the less restrictive alternative treatment for not more than 30
11 [21] days if the program accepts the respondent.

12 (e) The court shall specifically state to the respondent, and
13 give the respondent [HIM] written notice, that if commitment or other
14 involuntary treatment beyond the 30 [21] days is to be sought, the
15 respondent shall have the right to a full hearing or jury trial.

16 * Sec. 12. AS 47.30.740 is amended to read:

17 Sec. 47.30.740. PROCEDURE FOR 90-DAY COMMITMENT FOLLOWING 30-DAY
18 [21-DAY] COMMITMENT. (a) At any time during the respondent's 30-day
19 [21-day] commitment, the professional person in charge, or that
20 person's [HIS] professional designee, may file with the court a
21 petition for a 90-day commitment of that respondent. The petition must
22 include all material required under AS 47.30.730(a) except that
23 references to "30 days" ["21 DAYS"] shall be read as "90 days"; and

24 (1) allege that the respondent has attempted to inflict or
25 has inflicted serious bodily harm upon the respondent [HIMSELF] or
26 another since the respondent's [HIS] acceptance for evaluation, or
27 that the respondent [HE] was committed initially as a result of
28 conduct in which the respondent [HE] attempted or inflicted serious
29 bodily harm upon the respondent [HIMSELF] or another, or that the

1 respondent [HE] continues to be gravely disabled, or that the
2 respondent [HE] demonstrates a current intent to carry out plans of
3 serious harm to the respondent [HIMSELF] or another;
4 (2) allege that the respondent has received appropriate and
5 adequate care and treatment during the respondent's 30-day [HIS
6 21-DAY] commitment;
7 (3) be verified by the professional person in charge, or
8 that person's [HIS] professional designee, during the 30-day [21-DAY]
9 commitment.
10 (b) The court shall have copies of the petition for 90-day
11 commitment served upon the respondent, the respondent's [HIS]
12 attorney, and the respondent's [HIS] guardian, if any. The petition
13 for 90-day commitment and proofs of service shall be filed with the
14 clerk of the court, and a date for hearing shall be set, by the end of
15 the next judicial day, for not later than five judicial days from the
16 date of filing of the petition. The clerk shall notify the
17 respondent, the respondent's [HIS] attorney, and the petitioner of the
18 hearing date at least three judicial days in advance of the hearing.
19 (c) Findings of fact relating to the respondent's behavior made
20 at a 30-day [21-DAY] commitment hearing under AS 47.30.735 shall be
21 admitted as evidence and may not be rebutted except that newly
22 discovered evidence may be used for the purpose of rebutting the
23 findings.
24 * Sec. 13. AS 47.30.745(b) is amended to read:
25 (b) Unless the respondent is released or is admitted voluntarily
26 [ADMITS HIMSELF] following the filing of a petition and before the
27 hearing, the respondent [HE] is entitled to a judicial hearing within
28 five judicial days of the filing of the petition as set out in AS 47.-
29 30.740(b) to determine if the respondent [HE] is mentally ill and as a

result is likely to cause harm to self [HIMSELF] or others, or if the respondent [HE] is gravely disabled. If the respondent is admitted voluntarily [ADMITS HIMSELF] following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS 47.30.740 or under AS 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request [NOTICE OF INTENT] to leave, the professional person in charge may file with the court a petition for a 180-day [120-DAY] commitment of the respondent under AS 47.30.-770. The 180-day [120-DAY] commitment hearing shall be scheduled for a date not later [EARLIER] than 90 days after the respondent's voluntary admission.

* Sec. 14. AS 47.30.770 is amended to read:

Sec. 47.30.770. ADDITIONAL 180-DAY [120-DAY] COMMITMENT. (a) The respondent shall be released from involuntary treatment at the expiration of 90 days unless the professional person in charge files a petition for a 180-day [120-DAY] commitment conforming to the requirements of AS 47.30.740(a) except that all references to "30-day commitment" ["21-DAY COMMITMENT"] shall be read as "the previous 90-day commitment" and all references to "90-day commitment" shall be read as "180-day commitment" ["120-DAY COMMITMENT"].

(b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS 47.30.740 - 47.30.750. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 180 [120] days from the date on which the first 90-day treatment period would have expired.

(c) Successive 180-day [120-DAY] commitments are permissible on

the same ground and under the same procedures as the original 180-day [120-DAY] commitment. An order of commitment may not exceed 180 [120] days.

(d) Findings of fact relating to the respondent's behavior made at a 30-day [21-DAY] commitment hearing under AS 47.30.735, a 90-day commitment hearing under AS 47.30.750, or a previous 180-day [120-DAY] commitment hearing under this section shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.

* Sec. 15. AS 47.30 is amended by adding a new section to read:

Sec. 47.30.772. MEDICATION AND TREATMENT. A designated treatment facility may administer medication or other treatment to an involuntarily committed patient consistent with the provisions of AS 47.30.825 - 47.30.865.

* Sec. 16. AS 47.30.790 is amended to read:

Sec. 47.30.790. RETURN FROM UNAUTHORIZED ABSENCE. When a respondent undergoing involuntary treatment on an inpatient basis is absent from the treatment facility without, or in excess of, authorization under AS 47.30.785, the professional person in charge, or that person's [HIS] professional designee, may contact the appropriate peace officers who shall take the respondent into custody and return the respondent [HIM] to the treatment facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody. In addition, the family or guardian of the patient shall be notified of the patient's unauthorized absence within three hours of its discovery.

* Sec. 17. AS 47.30 is amended by adding a new section to read:

Sec. 47.30.803. CONVERSION FROM INVOLUNTARY TO VOLUNTARY STATUS.

A patient subject to involuntary hospitalization under AS 47.30.705, 47.30.735, or AS 47.30.755 may at any time convert to voluntary status if the responsible physician agrees that

(1) the patient is an appropriate patient for voluntary hospitalization; and

(2) the conversion is made in good faith.

* Sec. 18. AS 47.30.805(a) is amended to read:

(a) Except as provided in (b) of this section,

(1) computations of a 72-hour evaluation period under AS 47.30.715 or a 48-hour detention period under AS 47.30.685 do not include Saturdays, Sundays, legal holidays, or any period of time necessary to transport the respondent to the treatment facility;

(2) a 30-day [21-DAY] commitment period expires at the end of the 30th [21ST] day after the 72 hours following initial acceptance;

(3) a 90-day commitment period expires at the end of the 90th day after the expiration of a 30-day [21-DAY] period of treatment;

(4) a 180-day [120-DAY] commitment period expires at the end of the 180th [120TH] day, after the expiration of a 90-day period of treatment or previous 180-day [120-DAY] period, whichever is applicable.

* Sec. 19. AS 47.30.815(b)(4) is amended to read:

(4) a peace officer or physician responsible for detaining or transporting a person under AS 47.30.700 - 47.30.915.

* Sec. 20. AS 47.30.825(6) is amended to read:

(6) In no event may treatment include psychosurgery, lobotomy, or other comparable form of treatment without specific informed consent of the patient, including a minor unless the minor

1 [HE] is clearly too young or disabled to give an informed consent in
2 which case the consent of the minor's [HIS] legal guardian is
3 required. In the case of an adult patient who is unable to give
4 informed consent, informed consent must be obtained from an adult
5 designated in accordance with AS 47.30.725. In addition, that [SUCH]
6 treatment may not be given without a court order after hearing
7 compatible with full due process.
8 * Sec. 21. AS 47.30.825(8) is amended to read:
9 (8) A patient upon discharge shall be given a discharge
10 plan specifying the kinds and amount of care and treatment the patient
11 [HE] should have after discharge and such other steps as the patient
12 [HE] might take to benefit the patient's [HIS] mental health after
13 leaving the facility. The patient shall have the right to
14 participate, as far as practicable, in formulating the patient's [HIS]
15 discharge plan. A copy of the plan shall be given to the patient, the
16 patient's [HIS] guardian, an adult designated in accordance with
17 AS 47.30.725, the court if appropriate, and any follow-up agencies.
18 * Sec. 22. AS 47.30.840 is amended by adding a new subsection to read:
19 (b) The patient's rights under (a)(4) - (7) of this section may
20 be suspended temporarily if the professional person in charge of the
21 patient determines it is not in the best interests of the patient and
22 will pose a threat to the safety or well-being of the patient or
23 others to grant the patient those rights.
24 * Sec. 23. AS 47.30.845 is amended by adding a new paragraph to read:
25 (7) a law enforcement agency when there is substantiated
26 concern over imminent danger to the community by a presumed mentally
27 ill person.
28 * Sec. 24. AS 47.30.915(5) is amended to read:
29 (5) "evaluation facility" means a health care facility that

1 has been designated or is operated by the department to perform the
2 evaluations described in AS 47.30.660 - 47.30.915; or a medical facil-
3 ity licensed under AS 18.20.020 or operated by the federal government;
4 * Sec. 25. AS 47.30.915(7) is amended to read:
5 (7) "gravely disabled" means a condition in which a person
6 as a result of mental illness [,]
7 (A) is in danger of physical harm arising from such
8 complete neglect of basic needs for food, clothing, shelter, or
9 personal safety as to render serious accident, illness or death
10 highly probable if care by another is not taken; or
11 (B) will, if not treated, suffer or continue to suffer
12 severe and abnormal mental, emotional or physical distress, and
13 this distress is associated with significant impairment of judg-
14 ment, reason or behavior causing a substantial deterioration of
15 the person's previous ability to function independently;
16 * Sec. 26. AS 47.30.915(10) is amended to read:
17 (10) "likely to cause serious harm" means a person who
18 (A) poses a substantial risk of [IMMINENT AND SUBSTAN-
19 TIAL] bodily harm to that person's self [HIMSELF], as manifested
20 by recent behavior causing, attempting or threatening that
21 [ATTEMPTS AT SUICIDE OR BODILY] harm;
22 (B) poses a substantial risk of [IMMINENT AND SUBSTAN-
23 TIAL BODILY] harm to others [ONE OR MORE OTHER PERSONS] as mani-
24 fested by recent behavior causing, [OR] attempting, or threaten-
25 ing harm, and is likely in the near future to cause physical
26 injury, physical abuse or substantial property damage to another
27 person [INCLUDING, IN REGARD TO EVALUATIONS, AT LEAST ONE INCI-
28 DENT WITHIN 30 DAYS BEFORE THE FILING OF A PETITION FOR EMERGENCY
29 HOSPITALIZATION]; or

(C) manifests [DEMONSTRATES] a current intent to carry out plans of serious harm to that person's self [HIMSELF] or another;

* Sec. 27. AS 47.30.915(11) is amended to read:

(11) "mental health professional" means a psychiatrist or physician who is licensed to practice in this state or employed by the federal government; a clinical psychologist licensed by the state Board of Psychologists and Psychological Associate Examiners; a psychological associate with a clinical psychology or counseling specialty licensed by the Board of Psychologists and Psychological Associate Examiners; a registered nurse with three years of experience in clinical psychiatric nursing in a psychiatric facility accredited by the Joint Commission on the Accreditation of Hospitals [A MASTER'S DEGREE IN PSYCHIATRIC NURSING], licensed by the State Board of Nursing; and a social worker with a master's degree in social work and experience in the field of mental illness;

FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 346
Title: "An Act relating to the treatment of mentally ill persons."
Sponsor: Sen. Josephsen
Requestor: Senate HESS
Date of Request: 1/17/84

FISCAL DETAIL
Agency Affected: Department of Law
Program Category Affected: General Government
BRU, Program or Subprogram(s) Affected: Legal Services Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
GENERAL FUND	0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

N/A

ANALYSIS: Attach a separate page for analysis

Richard I. Pegues
Prepared By: Richard I. Pegues, Director Phone: 465-3672
Division: Administrative Services Date: 1-18-84

Richard I. Pegues / FOR
Approved by Commissioner: Norman C. Gorsuch Date: 1-18-84
Agency: Department of Law

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83

Fiscal Note
Analysis
SB 346

January 18, 1984

This act amends the state's statutes covering the treatment of mentally ill persons. The amendment clarify existing law and provide additional safeguards for the general public and the relatives of mentally ill persons, while seeking to protect the legal rights of persons suffering from mental illness. The amendments will not require any additional legal services, over those currently being provided, and their enactment will not have a fiscal impact on the department's operations.

RECEIVED

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 346
Title: "An act relating to the treatment of mentally ill persons."
Sponsor: Sen. Josephson & Halford
Requestor: Senate HESS
Date of Request: 1-20-84

FISCAL DETAIL
Agency Affected: Public Safety
Program Category Affected: Administration of Justice
BRU, Program or Subprogram(s) Affected: Alaska State Troopers

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: Francis C. Allan G.C.A. mck Phone: 269-5691
Division: Alaska State Troopers Date: 01/19/84

Approved by Commissioner: Robert J. Sundberg Date: 1-26-84
Agency: Public Safety

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

12/1/83

DEPARTMENT OF PUBLIC SAFETY

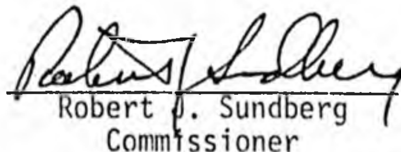
POSITION PAPER - SB 346

Support

January 19, 1984

SB 346 - "An act relating to the treatment of mentally ill persons."

This Bill provides law enforcement officers with the latitude to protect both the mentally ill person and the public from the actions of the mentally ill.



Robert J. Sundberg
Commissioner

DEPARTMENT OF PUBLIC SAFETY

RECEIVED

POSITION PAPER - SB 346

<u>Support</u>

January 19, 1984

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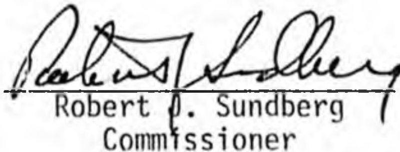

Robert J. Sundberg
Commissioner

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 346
Title: "An act relating to the treatment of mentally ill persons."
Sponsor: Sen. Josephson & Halford
Requestor: Senate HESS
Date of Request: 1-20-84

FISCAL DETAIL
Agency Affected: Public Safety
Program Category Affected: Administration of Justice
BRU, Program or Subprogram(s) Affected: Alaska State Troopers

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
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600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: Francis C. Allan G.C.A. mck
Phone: 269-5691
Division: Alaska State Troopers
Date: 01/19/84
Approved by Commissioner: Robert J. Sundberg
Date: 1-26-84
Agency: Public Safety

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83