2353 SHESS SB 343 - SB 346

2353

ALASKA STATE MEDICAL ASSOCIATION
4107 Laurel Street • Suite 1 • Anchorage, Alaska 99504 • (907) 562-2662

ADOPTED BY THE ALASKA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES AT ITS ANNUAL MEETING IN CORDOVA, ALASKA MAY 28, 1982

RESOLUTION NO. 83 - 3

SUBJECT: Repeal of Mandated Premarital Tests for Syphilis

WHEREAS, the control of diseases affecting the public's health in a cost-effective manner is of the highest priority, and

WHEREAS, a thorough review of the effectiveness of current statutes requiring premarital syphilis serological testing has revealed this requirement to be ineffective in controlling syphilis, and

WHEREAS, the elimination of mandatory premarital syphilis blood testing will allow available public health personnel to increase their efforts to insure that all women receive prenatal syphilis blood tests so that the elimination of congenital syphilis will become a reality, and

WHEREAS, a substantial savings can be realized through the suspension of premarital blood testing without decreasing the effectiveness of venereal disease control efforts, and

WHEREAS, the Venereal Disease Branch of the Centers for Disease Control, Atlanta, Georgia, the Alaska State Medical Association; the Alaska State Hospital Association, the Alaska Native Health Board; and the Southcentral Health Planning and Development Agency are all on record supporting the repeal of Alaska's premarital syphilis blood test requirement, therefore

BE IT RESOLVED, that the Alaska State Medical Association urge the legislature to act decisively and rapidly to repeal the premarital syphilis blood test requirement currently mandated by AS 25.05.102 and AS 25.05.105.

****

1. Felmau, Yehudi M. - Repeal of mandated premarital tests for syphilis: a survey of state health offices. AJPH 1981, 71:155-149.

2. Weisner, P.J. and Kingon, R.J. - Premarital syphilis screening: weighing the benefits. AJPH 1981, 71:160-162.

3. Felmau, Yehudi M. - Should premarital syphilis serologies continue to be mandated by law? JAMA 1978, 240:459-60.

4. Polonof, D.E. and Garland, M.J. - Oregon's premarital blood test: an unsuccessful attempt at repeal. VD News 1979, 4:1-5.

DISTRIBUTION:

Governor	Legislature
Dept. of Health & Soc. Svc.	Pres. Local Societies
Local Legislative Chairmen	Rick Urion
AK State Hospital Assoc.	AK Medicine
Dept. of Education	

RESOLUTION:

REPEAL OF MANDATED PREMARITAL TESTS FOR SYPHILIS

The Alaska Public Health Association,

Recognizing that the control of diseases affecting the public's health in a cost-effective manner is of the highest priority, and

Realizing that a thorough review of the effectiveness of current statutes requiring premarital syphilis serological testing has revealed this requirement to be ineffective in controlling syphilis, and

Realizing that the elimination of mandatory premarital syphilis blood testing will allow available public health personnel to increase their efforts to insure that all women receive prenatal syphilis blood tests so that the elimination of congenital syphilis will become a reality, and

Recognizing that a substantial savings can be realized through the suspension of premarital blood testing without decreasing the effectiveness of venereal disease control efforts, and

Knowing that the Venereal Disease Branch of the Centers for Disease Control, Atlanta, Georgia, the Alaska State Medical Association; the Alaska State Hospital Association, the Alaska Native Health Board; and the Southcentral Health Planning and Development Agency are all on record supporting the repeal of Alaska's premarital syphilis blood test requirement, therefore

Urges the legislature to act decisively and rapidly to repeal the premarital syphilis blood test requirement currently mandated by AS 25.05.102 and AS 25.05.105.

Submitted by: John Middaugh, M.D.
3010 Glacier Street
Anchorage, Alaska 99504

Resolution Representative: John Middaugh, M.D.

Adopted: April 29, 1983

Alaska Native Health Board

1689 C STREET, SUITE 230, ANCHORAGE, ALASKA 99501 PHONE (907) 276-8989

Reference #A80-0960

September 24, 1980

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

Dear Governor Hammond:

The Alaska Native Health Board endorses the repeal of the statute requiring premarital syphilis serological blood testing.

By doing so, the Board recognizes the continuing need to actively seek to discover and treat all cases of syphilis but it is believed that premarital testing is not the most effective means. The nearly $81,000 required for the 9,000 tests given in 1979 could better be used in a more promising, productive manner. This change should not impair the effectiveness of the Venereal Disease Control efforts of the State.

As always, the Board is concerned with the well-being of all Alaskans. It seeks the epitome of service delivery and to eliminate waste. It believes to continue the "routine testing" to be such a waste.

Sincerely,

for David E. Cates, Ph.D.
Executive Director

DEC:blg

cc: John Middaugh, M.D.

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

Municipality of Anchorage

MEMORANDUM

DATE: January 22, 1984

TO: Tyler Jones, Legislative Affairs
Municipality of Anchorage

FROM: Rodman Wilson, M.D., Director
Department of Health and Environmental Protection

SUBJECT: Requests to the Thirteenth Alaska State Legislature

The Municipality of Anchorage, Department of Health and Environmental Protection, asks the Alaska Legislature to act on the following matters on behalf of the MOA:

1. Categorical Grants:

   A. Community Health Services Grant FY 85 - $971,830

   Comment: This grant is for public health nursing. It has been awarded perennially to MOA in lieu of the State's having to field its own public health nurses (PHN's) in Anchorage as it does in all other parts of Alaska. Anchorage uses the grant funds to employ PHN's and to operate clinics at DHEP at 825 L Street and at the satellite clinic in Eagle River. Activities of the PHN's in the field are investigation, mitigation and follow-up of outbreaks of diesase, home visits to new mothers, particularly when there is special risk to the newbord child, visits to the handicapped and elderly, visits to child-care centers and other institutions, and health education, which will be substantially augmented this year. Clinics are principally for immunizations, eradication of tuberculosis, sexually transmitted disease control, and advice about nutrition. MOA employs 14 nurses with its own funds. With the grant 13 additional nurses are hired, without whom much of the above work could not be done.

   In FY 83 the Community Health Services Grant was $939,100. Last year a legislator at a House committee hearing on the DHSS budget apparently remarked that the grant funded the Anchorage Open Door Clinic in an amount of $100,000. This was not true. The Open Door Clinic was funded only from MOA funds, not from the grant, and is not funded at all by MOA at present. DHSS personnel at the hearing did not gainsay the legislator's remark. MOA people were not present at the hearing to correct the misstatement either. Thereupon, $100,000 was subtracted from the committee's recommendation for the Community Health Services Grant to MOA, reducing it to $839,100. Then $85,000 pass-through money for a dental program at Anchorage Neighborhood Health Clinic was added (later deleted by the Governor). At Conference Committee the lower amount, $839,100 ($924,100 counting the dental money) stood. The Senate HESS Committee had recommended approximately $1,035,000. The upshot was that our grant was reduced by $100,000 in part because of misinformation (for which we are to blame perhaps for not being at the hearing). This is why we seek $971,830 this year to restore last year's cut and allow modestly for inflation.

DHEP does not oppose funding the dental clinic at Anchorage Neighborhood Health Clinic. It is a good program as long as it stresses preventive rather than restorative dentistry, but it is not a priority of DHEP when compared with epidemiology (disease outbreak control), immunizations, visits to babies at risk of poor mothering and abuse, and visits to the handicapped and the elderly.

B. Health Aide Services Grant FY 85 - $286,300

Comment: This grant provides health aide services to approximately 75 chronically ill, handicapped or frail elderly individuals. These are not skilled nursing services but are services designed to assit patients in staying in their homes longer than they would be able to otherwise, thus sparing costs of institutionalization.

C. Alcoholism Grant FY 85 - $3,675,000

Comment: This grant is to fund the prevention and treatment of alcoholism. It is done by DHEP through contracts to local non-profit organizations like the Alaska Council on Prevention of Alcohol and Drug Abuse, Salvation Army, Akeela House, Adolescent Residential Center for Help (in Eagle River), Cook Inlet Native Association, and the Alaska Women's Resource Center. It funds, among many other programs, treatment of DWI's at a time when intervention is often quite effective.

Anchorage traditionally has been underfunded compared to other areas of the State. In FY 84 Anchorage received only about 29% of State alcoholism money even though we treat innumerable alcoholics who come into the city either voluntarily or as outcasts from bush communities. The obverse of the argument is, of course, that even though Anchorage has half the State's population, all of its people - perhaps, not even half - do not need publically funded alcoholism service. In contrast in rural communities there frequently are no private resources for treatment of alcoholism. Nonetheless MOA hopes that the Legislature will fund alcoholism programs more equitably and more generously this year, for we do have sophisticated and fairly effective programs particularly in prevention education, treatment of DWI's, detoxification, and residential care of dried-out alcoholics who are not yet ready to return to their families and jobs.

D. Drug Abuse Grant FY 85 - $889,000

Comment: Drug abuse treatment is almost exclusively in the public domain in Anchorage, although the Charter Hospital, now abuilding, will have private treatment for paying addicts. MOA funds a methadone clinic, Akeela House, and ARCH in Eagle River for treatment of drug addiction in both youths and adults. Without this grant the methadone clinic would surely close. The methadone clinic is an effective way to keep a number of addicts from abusing the community through robbery

and violence, and it helps many of these unfortunates to restore their lives to genteel ways. Through counseling services they are able, once away from the awful need for a daily illicit fix, to get back to work and to family life. Residential treatment is given both at ARCH and Akeela House. In addition outpatient and early intervention programs are available at Akeela.

E. Treatment Alternatives to Street Crime (TASC) Grant FY 85 - $650,000

Comment: In FY 84 Treatment Alternatives to Street Crime (TASC), an in-house program operated at DHEP at 825 L Street, received $385,000 from the Division of Corrections. We ask for substantially more for FY 85 because of steadily rising, essentially open-ended case loads:

FY	Staff	Clients
78	5	144
79	8	246
80	8	260
81	10	366
82	11	628
83	14	868
84	14	980 (est)

MOA is contributing more than ever to this useful program in CY 1984, $150,000 (cf 1983, $80,500) despite Proposition 24 stringencies. The Anchorage Assembly also recently appropriated $100,000 to TASC as a one-time catch-up for program deficits.

TASC is an out-patient program which accept from the courts arraigned or convicted adult or juvenile drug, or occasionally alcohol, addicted felons or misdeameanants for testing urine and for counseling. As long as urine tests, done several times weekly, remain free of drugs including alcohol, the subject remains out-of-jail. Counseling is given to all clients either at the clinic or by referral. It is an excellent program in that it keeps hundreds of persons out of jail, thereby enormously reducing custodial costs to the State. The problem DHEP has is that TASC is essentially open-ended. The courts, or occasionally attorneys directly, feel entirely free to refer persons to TASC and, in our enthusiasm to be helpful, we do not know how to say no. TASC has the best laboratory in the state for testing urine for a variety of narcotic and other drugs. It accepts specimens from all over the State including specimens from military installations. TASC bills for these tests at cost.

DHEP understands that the governor's budget for Corrections has $400,000 for TASC in it. This is not nearly enough if we are to continue accepting more and more persons from the courts.

F. Mental Health Grant FY 85 - $1,445,100

Comment: MOA decided on December 19, 1983 not to apply for a mental health grant for FY 85 and so imformed Commissioner Smith. The main reason was simply that we were not certain that we could supply the required 25% match. At the request of Senator Fisher this position was reversed on January 16, 1984, and MOA did submit a letter of intent to apply for a grant. It is still far from clear whether we will have sufficient match money to apply by the March 15 deadline for the full amount listed in the letter of intent.

The dominant non-profit mental health organization in Southcentral Alaska is ithe Anchorage Community Mental Health Center. The State already deals directly with ACMHC through a contract to provide a transitional living center for chronically mentally ill individuals that have been discharged from Alaska Psychiatric Institute. In many ways it would be preferable for the State also to contract directly with ACMHC for provision of the statutorily prescribed mental health priorities of the State (emergency care, treatment of schizophrenics, treatment of the elderly, etc.), thus allowing MOA with its monies to fill gaps and fund new or experimental programs. In particular DHEP would like to do more in the area of rape, family strife, and prevention of mental illness but these are not Division of Mental Health priorities.

The countervailing argument is that MOA should not relinquish "local control" by eschewing the state grant. In fact there is little local control because the priorities are so rigidly prescribed. This means preeminently treating API discharges, 40% of whom are from out-of-town. About half of these then settle in Anchorage. ACMHC, though having many other programs, besides treating API discharges, should perhaps be an arm of API, or at least have so close a relationship with the Division that it does not need MOA to intrude as its agent. MOA has much more flexibility with respect to the alcoholism, drug abuse, and TASC grants in terms of tailoring programs to local taste.

At this juncture DHEP is still pondering what it should do. If we follow through on the grant to apply, say, for approximately $812,000, we could meet the first half of the FY 85 25% match with our slim CY 84 budget and hope that an equal amount would be forthcoming in our CY 85 budget. Proposition 24 may work even greater hardships in 1985 than in 1984.

We also await written word from the Commissioner or the Division whether DHSS will consider making grants to both ACMHC and to MOA, for differing programs. If it did, then MOA would choose to fund organizations like Family Connection, CINA Amouak, and Suicide Prevention and Crisis Center, if their proposals won RFP competition. Other programs such as those having to do with sexual abuse and domestic strife do not qualify for state mental health funds in any event. These are, however,

priorities of the State Department of Public Safety. MOA would like to support organizations such as S.T.A.R. one way or another. Also Anchorage wants to fund programs in the prevention of mental illness. Primary prevention is not a state priority.

2. Capital Grants:

Animal Control Shelter $3.8 million

Comment: The Anchorage animal control shelter is in a state of shabby, out-of-code delapidation. Each month it receives approximately 1,000 animals and 1,500 complaints about animals. We intend to build a state-of-the-art animal shelter which will be pleasing to the eye, ear, and nose. The final A & E contract is scheduled to be awarded by the Assembly January 24. Construction will begin in August or September at a 2½ acre Tudor Road site on the edge of Bicentennial Park.

A completely overhauled program will strive to inculcate responsible pet ownership so that the risks of bites, parasitic diseases, rabies and annoying barking are minimized, so that as few injuries to animals as possible occur in town, and so that as few stray animals as possible are destroyed.

3. Special Requests:

There are 3 special DHEP environmental projects which need funding:

A. Ground Water Testholes $58,000

Comment: Most cities of substantial size test ground water at quarterly or other suitable intervals for contamination of ground water (i.e., water in the ground to a depth of 25-30 feet) for coliform bacteria, nitrates, phosphates (from detergents), and heavy metals. This is to see if on-site septic system effluents are having an adverse effect on ground water, which is naturally pure. If they are, then the contamination will soon seep down well casings to pollute deep aquifers. It is virtually impossible to sterilize an aquifer once contaminated. This project, mandated by the Hillside 208 study but never done, would simply drill approximately 50 20' holes around Anchorage, place piping and caps, and then use them indefinitely for regular testing. Eventually as many as 200-250 holes should be placed, but it is best to stage this over several year's time.

B. Telemetry of Air Monitoring Devices; Addition of two monitoring stations $140,000

Comment: The amount of carbon monoxide in air above Anchorage is continuously monitored at 4 sites (downtown, Spenard, City View, and Sand Lake) to see if it stays within safe boundaries set by EPA. We

need 2 more stations (Glenn Highway and Airport Heights Road; Eagle River). Addition of 2 new monitoring devices would cost $20,000.

All 6 devices should be telemetered to the Air Laboratory at 825 L Street. This would, among other advantages, allow the department to watch build-ups and decay of CO levels hour-by-hour so that the director would be able to alert the mayor if an air alert was at hand or imminent. This winter so far, Anchorage has experienced 4 air episodes in which CO exceeded 15 ppm over an 8-hour average. Air alerts should have been called but due to delay in collecting data, they were not called. By that time, air had cleared. But it is likely that before the winter passes, high levels for much longer intervals than 8 hours will occur, making it highly desirable to have on-line information at the department. Cost for telemetring 6 stations is estimated at $120,000.

C. Temperature Inversion Monitor (Telemetered) $30,000

Comments: Anchorage suffers many temperature inversions which traps cold air and pollutants near the ground. We need a temperature towers or poles to 100-200 fee to measure air temperatures at successive levels continuously and to telemeter readings to the Air Lab at 825 L Street. Differential temperatures thus obtained will help us predict periods when pollutants such as CO are likely to be dangerously elevated.

4. Possible source of more money for items 3 A, B, C.

Last year the Legislature appropriated $88,000 to Anchorage as a part of the Capital Budget to contribute to construction of the extended care residential unit for alcoholics at the city owned Clitheroe Center at Point Woronzof. Because of a sharp reduction in the alcoholism grant for FY 84 operating monies to the Salvation Army which runs Clitheroe were reduced. Other arrangements were made for extended care. The Center does need $18,000 to reconstruct their large kitchen which is badly in need of rebuilding and re-equiping. We seek permission to use $18,000 of the $88,000 for this purpose. This leaves $70,000 which could apply with the Legislature's permission to Projects 3 A, B, or C.

5. Legislation Sought (non-budgetary):

A. Making Vital Statistics Documents Available to Municipal Health Officers

Comment: MOA seeks amendment of AS 18.50.310 to allow municipal health officers to inspect vital statistics documents including birth and death certificates. It is not clear in Alaska Statutes that a municipal health officer is entitled to see vital statistics documents. These are sorely needed, virtually day-by-day, in order to know what is occurring in a community from the standpoint of the health of the citizenry.

See attached suggested wording which has been sent to HESS Committee chairpersons.

B. Support of SB 343 Repealing Requirement for Pre-Marital Blood Test for Syphilis

Comment: Repeal of the requirement for a blood test for syphilis prior to marriage is in order. It costs over $100,000 to discover one case of infectious syphilis this way. The proper time to test is not at marriage but at pregnancy. This is routinely done by physicians. More than 30 states have repealed this anachronistic requirement. It is high time Alaska did too. We support SB 343.

Rodman Wilson

Rodman Wilson, M.D.
Director, Department of Health
and Environmental Protection

Approved by:

Tony Knowles

Tony Knowles
Mayor

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

LETTER OF INTENT

FOR STATE USE ONLY - DO NOT FILL IN

3a Clearinghouse Identification No.	6a Program number	6b Program Title

1. Name of Applicant: Municipality of Anchorage, Dept. of Health & Env. Prot.
2. Organizational Unit: Physical Health Division
3. Address of Applicant (c) Street or P.O. Box: Pouch 6-650, (d) City: Anchorage (e) Borough: (f) State: Alaska
4. Title of Applicant's Project: Community Health Services
5. Contact Person (Name and Phone): Rita Schmidt, 264-4607
6. Type of Applicant/Recipient
   - ☐ D - Borough
   - ☐ I - Higher Education Institution
   - ☒ E - City
   - ☐ J - Indian Tribe
   - ☐ F - School District
   - ☐ K - Other (Specify)
   - ☐ H - Community Action Agency
   - ☐ L - Private nonprofit including Native Corporations
7. Area of Project Impact (City, Borough, Native Corporation, Statewide): Anchorage
8. Estimated number of persons benefiting: 230,000
9. Type of Application: ☐ A - New ☒ D - Continuation
10. Project Start Date: 7/1/84
11. Project Duration (Months): 24 months
12. State Agency to Receive Request: Dept. of Public Health

PROJECT COORDINATION

Is this proposed project contained within an adopted local and/or state plan or program? ☒ Yes ☐ No

If so, list plan/program and year of adoption (i.e. comprehensive plan, health plan, water/sewer plan): 1982 Anchorage Health Plan

List other related plans of applicant agency or other agency used to prepare the application, including year of adoption.	List other agencies you feel may be interested in reviewing this project.

Indicate agencies project already coordinating with. (Attach letters as appropriate.)

Will any requested funds be subcontract? ☐ Yes ☒ No If yes, show amount

13. BUDGET

Multi-Year Projections	Current Year	Year 1 of Application	Year 2 of Application
a. Federal (direct)	$	$	$
b. Federal (through state)	$	$	$
c. State (amount requested from)	$ 839,100	$ 971,830	$ 1,020,421
d. Local Government Contribution	$	$	$
h. Applicant (cash)	$	$	$
e. Applicant (in-kind)	$	$	$
f. TOTAL	$ 839,100	$ 971,830	$ 1,020,421

ATTACH ADDITIONAL INFORMATION REQUESTED ON REVERSE SIDE

The applicant certifies that: To the best of my knowledge and belief, data in this Letter of Intent are true and correct and the document has been duly authorized by the governing body of the applicant.

Date Signed: 1-12-84

Certifying Representative (Name and Title): Barbara Stecker, Municipal Manager

Signature of Representative:

06-2060 (REV 11-83)

PLEASE COMPLETE REVERSE SIDE

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

LETTER OF INTENT

FOR STATE USE ONLY - DO NOT FILL IN

3a Clearinghouse Identification No.	6a Program number	6b Program Title

1. Name of Applicant: Municipality of Anchorage, Dept. of Health & Env. Protection
2. Organizational Unit: Physical Health Division
3. Address of Applicant (c) Street or P.O. Box: Pouch 6-650 (d) City: Anchorage (e) Borough (f) State: Ala
4. Title of Applicant's Project: Health Aide Services
5. Contact Person (Name and Phone): Rita Schmidt 264-4607
6. Type of Applicant/Recipient
   - ☐ D - Borough
   - ☐ I - Higher Education Institution
   - ☒ E - City
   - ☐ J - Indian Tribe
   - ☐ F - School District
   - ☐ K - Other (Specify)
   - ☐ H - Community Action Agency
   - ☐ L - Private nonprofit including Native Corporations
7. Area of Project Impact (City, Borough, Native Corporation, Statewide): Anchorage
8. Estimated number of persons benefiting: 230,000
9. Type of Application: ☐ A - New ☒ D - Continuation
10. Project Start Date: 7/1/84
11. Project Duration (Months): 24 months
12. State Agency to Receive Request: Dept. of Public Health

PROJECT COORDINATION

Is this proposed project contained within an adopted local and/or state plan or program? ☒ Yes ☐ No

If so, list plan/program and year of adoption (i.e. comprehensive plan, health plan, water/sewer plan): 1982 Anchorage Health Plan

List other related plans of applicant agency or other agency used to prepare the application, including year of adoption.	List other agencies you feel may be interested in reviewing this project.

Indicate agencies project already coordinating with. (Attach letters as appropriate.)

Will any requested funds be subcontract? ☒ Yes ☐ No If yes, show amount: $239,000

13. BUDGET

Multi-Year Projections	Current Year	Year 1 of Application	Year 2 of Application
a. Federal (direct)	$	$	$
b. Federal (through state)	$	$	$
c. State (amount requested from)	$ 270,000	$ 286,300	$ 303,480
d. Local Government Contribution	$	$	$
e. Applicant (cash)	$	$	$
e. Applicant (in-kind)	$	$	$
f. TOTAL	$ 270,000	$ 286,300	$ 303,480

ATTACH ADDITIONAL INFORMATION REQUESTED ON REVERSE SIDE

The applicant certifies that: To the best of my knowledge and belief, data in this Letter of Intent are true and correct and the document has been duly authorized by the governing body of the applicant.

Date Signed: 1-12-84

Certifying Representative (Name and Title): Barbara Steckel Municipal Manager

Signature of Representative:

PLEASE COMPLETE REVERSE SIDE

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

FY 85 Letter of Intent

LETTER OF INTENT

FOR STATE USE ONLY - DO NOT FILL IN

3a Clearinghouse Identification No.	4a Program number	4b Program Title

1. Name of Applicant	2. Organizational Unit
Municipality of Anchorage	Behavioral Health Division

3. Address of Applicant (c) Street or P.O. Box	(d) City	(e) Borough	(f)
Pouch 6-650		Anchorage	

4. Title of Applicant's Project
Behavioral Health Treatment System - Alcoholism Components

5. Contact Person (Name and Phone)
James C. Parsons, Manager (264-4775)

7. Area of Project Impact (City, Borough, Native Corporation, Statewide)
Municipality of Anchorage

8. Estimated number of persons benefiting 230,876 residents of Municipality of Anchorage & additional residents of surrounding areas # unknown

9. Type of Application
☐ A - New ☒ O - Continuation

10. Project Start Date
July 1, 1984

6. Type of Applicant/Recipient
☐ D - Borough ☐ I - Higher Educatic Institution
☐ E - City ☐ J - Indian Tribe
☐ F - School District ☒ K - Other (Specify Municipality
☐ H - Community Action Agency ☐ L - Private nonprof including Nativ Corporations

11. Project Duration (Months)
Twelve (12) Months

12. State Agency to Receive Request
Office of Alcoholism and Drug Abuse

PROJECT COORDINATION

Is this proposed project contained within an adopted local and/or state plan or program? ☒ Yes ☐ No If so, list plan/program and year of adoption (i.e. comprehensive plan, health plan, water/sewer plan) State Plan - HSA - Municipal Plan

List other related plans of applicant agency or other agency used to prepare the application, including year of adoption.	List other agencies you feel may be interested in reviewing this project.

Indicate agencies project already coordinating with. (Attach letters as appropriate.)

Will any requested funds be subcontract? ☒ Yes ☐ No If yes, show amount $4,088,000

13. BUDGET

Multi Year Projections	Current Year	Year 1 of Application	Year 2 of Application
a. Federal (direct)	$	$	$
b. Federal (through state)	$	$	$
c. State (amount requested from)	$ 2,900,000	$ 3,675,000	$ 3,859,000
d. Local Government Contribution	$ 1,648,220	$ 925,000	$ 971,000
e. Applicant (cash)	$	$	$
f. Applicant (in-kind)	$	$	$
g. TOTAL	$ 4,548,220	$ 4,600,000	$ 4,830,000

ATTACH ADDITIONAL INFORMATION REQUESTED ON REVERSE SIDE

The applicant certifies that: To the best of my knowledge and belief, data in this Letter of Intent are true and correct and the document has been duly authorized by the governing body of the applicant.

Date Signed 11-10-84

Certifying Representative (Name and Title)
Barbara Streckel, Municipal Manager

Signature of Rep tive
Barbara Streckel

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES

LETTER OF INTENT

FOR STATE USE ONLY - DO NOT FILL IN

3a Clearinghouse Identification No.	5a Program number	6b Program Title

1. Name of Applicant	2. Organizational Unit
Municipality of Anchorage	Behavioral Health Division

3. Address of Applicant (c) Street or P.O. Box	(d) City	(e) Borough	(f)
Pouch 6-650	Anchorage		

4. Title of Applicant's Project
Behavioral Health Treatment System - Drug Abuse Components

5. Contact Person (Name and Phone)
James C. Parsons, Manager (264-4775)

6. Type of Applicant/Recipient
- ☐ D - Borough
- ☐ I - Higher Educ Institution
- ☐ E - City
- ☐ J - Indian Tribe
- ☐ F - School District
- ☒ K - Other (Spec Municipal
- ☐ H - Community Action Agency
- ☐ L - Private nonp including Na Corporations

7. Area of Project Impact (City, Borough, Native Corporation, Statewide)
Municipality of Anchorage

8. Estimated number of persons benefiting 230,876 residents of Municipality of Anchorage & additional residents of surrounding areas # unknown

9. Type of Application
☐ A - New ☒ O - Continuation

10. Project Start Date
July 1, 1984

11. Project Duration (Months)	12. State Agency to Receive Request
Twelve (12) Months	Office of Alcoholism and Drug Abuse

PROJECT COORDINATION

Is this proposed project contained within an adopted local and/or state plan or program? ☒ Yes ☐ No If so, list plan/program and year of adoption (i.e. comprehensive plan, health plan, water/sewer plan) State Plan - HSA - Municipal Plan

List other related plans of applicant agency or other agency used to prepare the application, including year of adoption.	List other agencies you feel may be interested in reviewing this project.

Indicate agencies project already coordinating with. (Attach letters as appropriate.)

Will any requested funds be subcontract? ☒ Yes ☐ No If yes, show amount $1,129,000

13. BUDGET

Multi-Year Projections	Current Year	Year 1 of Application	Year 2 of Application
a. Federal (direct)	$	$	$
b. Federal (through state)	$	$	$
c. State (amount requested from)	$ 647,500	$ 889,000	$ 934,000
d. Local Government Contribution	$ 506,300	$ 341,000	$ 358,000
h. Applicant (cash)	$	$	$
e. Applicant (in-kind)	$	$	$
f. TOTAL	$ 1,153,800	$ 1,230,000	$ 1,292,000

ATTACH ADDITIONAL INFORMATION REQUESTED ON REVERSE SIDE

The applicant certifies that: To the best of my knowledge and belief, data in this Letter of Intent are true and correct and the document has been duly authorized by the governing body of the applicant

Date Signed 1-10-84

Certifying Representative (Name and Title)	Signature of Representative
Barbara Steckel, Municipal Manager	Barbara Steckel

DEPARTMENT OF HEALTH & SOCIAL SERVICES

LETTER OF INTENT

FOR STATE USE ONLY - DO NOT FILL IN

3a Clearinghouse Identification No.	6a Program number	6b Program Title

1. Name of Applicant: Municipality of Anchorage
2. Organizational Unit: Behavioral Health Division
3. Address of Applicant (c) Street or P.O. Box: Pouch 6-650 (d) City: Anchorage (e) Borough (f)
4. Title of Applicant's Project: Behavioral Health Treatment System - Mental Health Components
5. Contact Person (Name and Phone): James C. Parsons, Manager (264-4775)
6. Type of Applicant/Recipient
   - ☐ D - Borough
   - ☐ I - Higher Education Institution
   - ☐ E - City
   - ☐ J - Indian Tribe
   - ☐ F - School District
   - ☒ K - Other (Specify) Municipality
   - ☐ H - Community Action Agency
   - ☐ L - Private nonprofit including Native Corporations
7. Area of Project Impact (City, Borough, Native Corporation, Statewide): Municipality of Anchorage
8. Estimated number of persons benefiting: 230,876 residents of Municipality of Anchorage & additional residents of surrounding areas # unknown
9. Type of Application: ☐ A - New ☒ O - Continuation
10. Project Start Date: July 1, 1984
11. Project Duration (Months): Twelve (12) Months
12. State Agency to Receive Request: Dept. of Health and Social Services, Div. of M.H. and D.D.

PROJECT COORDINATION

Is this proposed project contained within an adopted local and/or state plan or program? ☒ Yes ☐ No

If so, list plan/program and year of adoption (i.e. comprehensive plan, health plan, water/sewer plan): State Plan - ilSA - Municipal Plan

List other related plans of applicant agency or other agency used to prepare the application, including year of adoption.	List other agencies you feel may be interested in reviewing this project.

Indicate agencies project already coordinating with. (Attach letters as appropriate.)

Will any requested funds be subcontract? ☒ Yes ☐ No

If yes, show amount: $1,791,400

13. BUDGET

Multi-Year Projections	Current Year	Year 1 of Application	Year 2 of Application
a. Federal (direct)	$	$	$
b. Federal (through state)	$	$	$
c. State (amount requested from)	$ 806,300	$ 1,445,100	$ 1,517,360
d. Local Government Contribution	$ 522,740	$ 481,700	$ 505,790
b. Applicant (cash)	$	$	$
e. Applicant (in-kind)	$	$	$
f. TOTAL	$ 1,329,040	$ 1,926,800	$ 2,023,150

ATTACH ADDITIONAL INFORMATION REQUESTED ON REVERSE SIDE

The applicant certifies that: To the best of my knowledge and belief, data in this Letter of Intent are true and correct and the document has been duly authorized by the governing body of the applicant.

Date Signed: 11/16/84

Certifying Representative (Name and Title): Barbara Steckel, Municipal Manager

Signature of Representative:

06-2060 (REV 11-83)

PLEASE COMPLETE REVERSE SIDE

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

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB343 "PREMARITAL BLOOD TESTS; EFF DATE DATE January 25, 1984

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
C. S. Rakeau	DHvSS	AOB	465-3030

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)

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 1, 1984

Senator Frank Ferguson
Senator Don Bennett
Senator Bill Ray
Senator Tim Kelly

Subject: SB 354 (PreMarital Blood Tests)

Gentlemen:

For years, the Alaska State Medical Association has recommended the repeal of the Alaska law requiring the premarital blood test for syphilis.

Rodman Wilson, M.D., the Municipality of Anchorage Health Director, and for many years an outstanding medical practitioner, has recently communicated with me on this subject. (See enclosure).

The test has nothing to do with AIDS or other diseases which I think came up in the Rules Committee. The administration supports the bill vigorously. Current practice is a waste of money and just as important, a waste of health care resources which are limited in the State.

As Dr. Wilson observes, over 30 states have eliminated this test. I know that in Hawaii, where I was married in December, the bride is required to present evidence of rubella screening but neither party needs the premarital blood test for syphilis.

As. Dr. Wilson notes, the syphilis test is administered prenatally, in any event.

I request that the Rules Committee place this matter on the calendar for floor debate and action at the earliest opportunity.

Sincerely,

Joe

Joe P. Josephson

- The bill has NOTHING to do with Herpes, gonnorhea, rubella, etc. I know of no medical opinion opposing this bill. Rep. Fritz (M.D.) has sponsored the same measure in the House and would be happy to talk with you about it as a medical expert.

- JPJ

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

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

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, P. 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.

Rex

Alaska State Legislature
State Senate

Judiciary
3/14/84

Committee on Judiciary

Senator Bill Ray
Chairman
Senate Floor Leader

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

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.

POSITION PAPER/Department of Health & Social Services

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 ever 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

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.

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: Philip Shapiro

Philip Shapiro, M.D.,
Director, Division of Mental Health and Developmental Disabilities

Date: 11/30/84

Approved by: Robert London Smith

Robert London Smith, Ph.D.
Commissioner

Date: 11/30/84

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: AP1

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) (PR) 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
Requestor:
Date of Request: 1-11-84

FISCAL DETAIL
Agency Affected: Division of Mental Health and Developmental Disabilities
Program Category Affected: A01

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						
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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) (PR) Phone: 465-3370
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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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Liz Lamm	Rep Mac Justice		
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L. Nankervis	"	"	"
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Jan Vorhoven	self	304 G Street, Juneau AK	272-0200
Vlad Bierko	Anch. Com. Mental Health	1577 C St apt	278-4558
Steve Harrison	Division Mental Health	3601 'C' Street ANC	561-1247
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Jim Parsons	Behavioral Health Div Municipality of Juneau	625 C St 99501	264-4775
Ruby Kleinkauf	Alaska Ch. Nat'l Ass. Soc'l 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 could 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.

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.

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).

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).

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 some trauma (ex: divorce of parents). If that evualation goes beyond 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.

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.

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.

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).

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

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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 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,

S. T. Laughridge

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

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

Oct. 27, 1983

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.

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

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

Ann F. DeNardo
Families of Chronically Mentally Ill Victims

Enclosure

AD:aw

Families of CMI Victims
SR Box 30737
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 a person whose thought processes, perception of reality or judgement is substantially impaired.

2 in 30 days

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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CO-CHAIRMAN

REP. MILO FRITZ
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POUCH V
STATE CAPITAL
JUNEAU, ALASKA 99811
(907) 465-3777

House of Representatives
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

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

Mae Tischer
State Representative

MMT:wtl

Sent 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, Ph.D.
Clinical Psychologist
Program Director

PET/jvh

Send to Nancy ✓

RECEIVED
NOV 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.

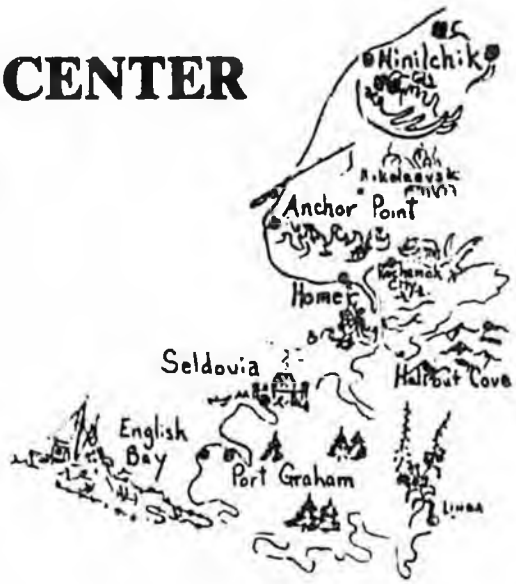
Sincerely,

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 Anchorage, Alaska 99503
Telephone 276-1705

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 involunatry 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

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 health 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

Fairbanks Memorial Hospital
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. 83-157

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

Robert London Smith, Ph.D.
Commissioner

Enclosure