REPORT TO THE LEGISLATURE

HB 172 –Psychiatric Patient Rights in Alaska

September 15, 2023

Trust
Alaska Mental Health Trust Authority

STATE OF ALASKA DEPARTMENT OF HEALTH

AK | DFCS
ALASKA DEPARTMENT OF FAMILY AND COMMUNITY SERVICES

Contents

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Many individuals contributed their time and expertise to the development of this report. Those listed below participated in at least one meeting and are listed alphabetically; some participated in multiple ways and are listed more than once. We are deeply grateful to many other Alaskans who graciously shared their time, stories, and expertise and who are not specifically named here.

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Executive Summary

Purpose

House Bill (HB) 172, signed into law July 18, 2022, increased access to behavioral health crisis services in less restrictive settings by adding an intermediate, sub-acute level of care, which allows individuals in behavioral health crisis to divert from institutional settings. It also allows examinations under a notice of emergency detention and evaluations for civil commitment to occur in sub-acute mental health facilities, when appropriate.[1]

To ensure protection of psychiatric patient rights, the passage of HB 172 required the Department of Health (DOH), the Department of Family and Community Services (DFCS), and the Alaska Mental Health Trust Authority (the Trust) to submit a joint report to the Alaska Legislature by October 16, 2023.

Process

DOH, DFCS, and the Trust formed the Project Management Team for this report and directed the contract team led by Agnew::Beck. The contract team completed a scope of work that included:[2]

- Site visits to Designated Evaluation and Stabilization/Designated Evaluation and Treatment (DES/DET) facilities and emergency departments;
- Virtual and in-person interviews with providers, individuals with lived experience, law enforcement, and other State division and department stakeholders;
- Comprehensive review of regulatory, judicial, and accrediting requirements related to psychiatric care in acute and inpatient settings; and,

The consultant team also reviewed relevant reports, research articles, and publications recommended by stakeholders. These are listed in the Supplementary Report – Appendix A.

The contract team facilitated four subcommittees: Legal, Data, Providers, and Lived Experience. The team assessed information gathered during stakeholder engagement and prioritized the assessment and recommendation findings presented to the Advisory Team. In accordance with Section 36 of House Bill 172, the Advisory Team included a diverse stakeholder group including individuals with lived experience, patient advocates, the Disability Law Center of Alaska, psychiatric service providers, the Alaska Ombudsman, the Alaska Mental Health Board, the Public Defender Agency, the Alaska Native Health Board, the Department of Health, the Department of Family and Community Services, the Alaska Mental Health Trust Authority, and others.

Assessment Findings

The assessment of current state, federal and accrediting body requirements for psychiatric patient rights identified a complex and highly regulated system for protecting psychiatric patient rights. Facilities that care for psychiatric patients adhere to processes that monitor compliance with these requirements, including internal processes for addressing patient grievances and complaints and providing access to external resources. While there are robust processes in place, stakeholders with lived experience indicated that the reported processes did not describe their experiences of care.

The assessment found systemic challenges to consistently applying patient protections because of a lack of understanding of Title 47 commitment laws and variations between statutory process and the experience of patients and providers on the ground.

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[1] For more information on HB 172, see "Crisis Stabilization in Alaska: Understanding HB 172," available at: https://health.alaska.gov/Commissioner/Documents/PDF/Crisis-Stabilization-in-Alaska-HB-172.pdf.

[2] Trust RFP 23-114M HB172 Report to Legislature
https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=209122

The assessment of data collection and reporting of patient grievances and appeals, patient and staff injuries, and use of seclusion, restraint, and involuntary medication, identified robust processes for documenting these events. Data is reported externally to oversight agencies and other government entities as mandated (such as the Office of Children's Services and Adult Protective Services) but is not publicly released in most situations due to HIPAA and state documentation protection laws. Some stakeholders expressed concern with this and believed such information is withheld to the detriment of psychiatric patients. Other stakeholders expressed concerns with increasing data collection and reporting requirements that could increase administrative burden on health care providers and increase stigma and lack of parity between requirements associated with psychiatric care compared with other health care services.

Recommendations

The proposed recommendations seek to increase alignment and consistency between statutory requirements, provider processes, and patient experience by increasing access to less restrictive services closer to a patient's home; improving training for health care providers, court and legal staff, law enforcement, and others; and improving the use of data to inform system improvements. The recommendations are summarized as follows:

- **Provide additional guidance to hospital emergency departments and inpatient units to ensure access to care during emergency detention and while awaiting transportation to an evaluation facility**. Ensuring alignment between state statute, regulation, and funding streams to support the best possible care for psychiatric patients in hospital settings is critical to ensure patient experience does not vary as widely as it does today. This could include guidance for hospitals to more clearly define the process and requirements to become a DES facility, increase statewide capacity, and decrease transportation and wait times for 72-hour evaluations.
- **Align statutory language, court forms, and provider practices related to emergency detention.** Establish a process to align policy and practice related to emergency detention. This may include the development of a guidance document for emergency departments, hospital inpatient units, crisis stabilization and residential centers, and designated facilities that clearly defines their roles in the process and patient rights that apply in these settings, identifies statutory and regulatory changes to increase clarity and alignment between statute and practice, and identifies necessary revisions to ensure court forms and statute are aligned.
- **Develop and require training in the involuntary commitment processes, patient rights law, and clinical best practices across disciplines.** To protect patient rights during involuntary commitment, stakeholders identified specific groups and training needs including:
    - Law enforcement entities need to receive training in emergency detention processes and rights notification;
    - Judges and magistrates need training in involuntary commitment statutes and processes;
    - Providers across disciplines need training in patient rights laws, mental health patient advocacy; and,
    - Providers also require training to assist patients to expand the use and appropriate sharing of psychiatric advanced directives before a crisis occurs. Health care facilities will require training in how to access and use psychiatric advanced directives during a crisis.
- **Conduct a comprehensive analysis of current data and reporting processes and develop a plan to improve collection and use of data.** As highlighted in the data section of the report, data relevant to psychiatric patient rights are already reported externally. Before creating new systems or adding requirements for providers, the State, including the judicial branch, should assess current data and reporting processes to inform which additional information is needed, who is responsible for collection and reporting, and how this will improve outcomes.

A comprehensive list of issues, recommendations, category of patient rights addressed, and source is included in the Supplementary Report – Appendix F and organized by three categories: Systems, Legal and Data. The tables in Appendix F contain over 90 recommendations identified by this project.

Introduction

Sec.36 Report to the Legislature

House Bill (HB) 172 increased access to behavioral health crisis services in less restrictive settings by adding an intermediate, sub-acute level of care, which allows individuals in behavioral health crisis to divert from institutional settings. It also allows examinations under a notice of emergency detention and evaluations for civil commitment to occur in sub-acute mental health facilities, when appropriate.

To ensure protection of psychiatric patient rights, the passage of HB 172 required the Department of Health (DOH), the Department of Family and Community Services (DFCS), and the Alaska Mental Health Trust Authority (the Trust) to submit a joint report to the Alaska Legislature within one year from the effective dates of sections 1-37 and 39. Section 36 of HB 172 detailed report requirements, including:

- An assessment of current state, federal and accrediting body requirements for psychiatric patient rights, including the adequacy of these policies and procedures and the practical challenges patients face in availing themselves of these rights;
- Recommendations to change state requirements to improve patient outcomes and enhance patient rights, particularly involving involuntary admissions, involuntary medications and the practical ability of patients to avail themselves of their rights;
- An assessment of current processes for data collection and reporting of patient grievances and appeals, patient reports of harm and restraint and the resolution of these matters;
- Recommendations to change current processes related to data collection and making specified data available to the legislature and the public;
- The formation of a diverse stakeholder group inclusive of individuals with lived experience, patient advocates, the Disability Law Center of Alaska, providers of psychiatric services, the Alaska Ombudsman, the Alaska Mental Health Board, the Department of Health, the Department of Family and Community Services and the Alaska Mental Health Trust Authority to inform the draft assessment and recommendations; and,
- A public comment and review period prior to production and transmittal of the final report.

Project Approach

DOH, DFCS, and the Trust formed the Project Management Team for this report and directed the contract team led by Agnew::Beck. The contract team completed a scope of work that included:

- Site visits to Designated Evaluation and Stabilization/Designated Evaluation and Treatment (DES/DET) facilities and emergency departments;
- Virtual and in-person interviews with providers, individuals with lived experience, law enforcement, and other State division and department stakeholders; and,
- Comprehensive review of regulatory, judicial, and accrediting requirements related to psychiatric care in acute and inpatient settings.

The team also reviewed relevant reports, research articles, and publications, recommended by stakeholders.

Figure 1: Overview of Stakeholder Engagement

The contract team facilitated four subcommittees: Legal, Data, Providers, and Lived Experience.[3] The team assessed information gathered during stakeholder engagement and prioritized the assessment and recommendation findings presented to the Advisory Team. In accordance with Section 36 of House Bill 172, the Advisory Team included a diverse stakeholder group including individuals with lived experience, patient advocates, the Disability Law Center of Alaska, psychiatric service providers, the Alaska Ombudsman, the Alaska Mental Health Board, the Public Defender Agency, the Alaska Native Health Board, the Department of Health, the Department of Family and Community Services, the Alaska Mental Health Trust Authority, and others.

The Advisory Team further prioritized stakeholder and legal findings to provide final guidance on the report and accompanying recommendations. The draft report was submitted to the Project Management Team on June 30, 2023, and posted for public comment in September 2023. Comments during this period were considered for additions, revisions, and edits to the report before final submission to the State legislature in October 2023. A detailed overview of the stakeholder engagement process is found in the Supplemental Report – Appendix B.

Definitions

There are several terms used in this report that are important to define to clearly understand the legal meaning of these terms and the context in which they are used.

Facility Definitions

Critical Access Hospital, 7 AAC 12.104(a): The department will consider a facility as a critical access hospital if the department finds that the facility:

(1) provides inpatient short-term hospitalization for medical care of acute illness or injury;

(2) has no more than 25 inpatient beds;

(3) is located in a rural area of no more than 15,000 residents, based on the most recent calculations of the United States Bureau of Census; and

(4) meets the applicable requirements of 7 AAC 12.100 - 7 AAC 12.190 and 7 AAC 12.600 - 7 AAC 12.990.

Designated Evaluation and Stabilization (DES): means a hospital or crisis residential center that has been designated or is operated by the department to perform the evaluations described in AS 47.30.660 — 47.30.915, or a medical facility operated under 25 U.S.C. 5301 — 5423 (Indian Self-Determination and Education Assistance Act), as amended, that performs evaluations. **(AS 47.30.915(9))**

Designated Evaluation and Treatment (DET): means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670 — 47.30.915 but does not include correctional institutions. **(AS 47.30.915(7))**

General Acute Care Hospital, 7 AAC 26.999(1): "acute care hospital" means a state licensed hospital or federal hospital that provides medical and surgical outpatient and inpatient services to persons with injuries or illnesses

Subacute mental health facility, AS 47.32.900(20): Means a facility, or a part or unit of a facility, that has been designed to evaluate, stabilize, and treat, on a short-term, intensive, and recovery-oriented basis, and without the use of hospitalization, individuals experiencing an acute behavioral health crisis, including a crisis stabilization center and a crisis residential center; in this paragraph,

(A) "crisis residential center" means a subacute mental health facility that has a maximum stay of seven days for an involuntary admission.

[3] The contract team conducted interviews and listening sessions with 14 individuals with lived experience of seeking and accessing emergency and inpatient psychiatric care. These includes adults with lived experience with singular and repeated voluntary and involuntary commitment in the last 6 months to 20 years; parents of adolescent and adult children who experienced involuntary commitment within the last 6 months to 20 years, and those with a mix of singular and repeated admissions both voluntary and involuntary; and an Elder from an Alaska Native community who described the need for psychiatric care in her community and the adverse impacts of having to use the involuntary commitment process to address psychiatric care needs.

(B) "crisis stabilization center" means a subacute mental health facility that has a maximum stay of 23 hours and 59 minutes.

Psychiatric hospital: A hospital which is primarily engaged in providing inpatient psychiatric services for the diagnosis and treatment of mental illness is a psychiatric hospital. (7 AAC 12.215(a))

Process Definitions

Ex parte: Refers to granted orders at the request of one party, and without challenge or notification of other involved parties. Common shorthand used in the state to refer to the beginning of the involuntary commitment process, including both the initial petition for evaluation and the resulting court order.

Involuntary commitment: Refers to the process of commitment that can follow an initial order for evaluation. Often this term is used informally to refer to proceedings involving involuntary medication, although they are two separate legal concepts.

Notice of Emergency Detention (NED): The authorization given to individuals/professionals as identified under AS 47.30.705 to detain an individual for emergency evaluation when there are concerns for safety.

Respondent: The individual named in an emergency hold, involuntary commitment petition or order.

Title 47: Alaska statues pertaining to Welfare, Social Services, and Institutions. This is a common moniker used throughout Alaska to refer to the process of involuntary commitment and individuals held under this process.

Voluntary admission: when a person suffering from mental illness is voluntarily signs admission papers and is admitted to a treatment facility.[4]

Voluntary-in-lieu: A patient who agrees to go from an involuntary status to a voluntary status but continues to meet criteria for an involuntary commitment. To be eligible for financial assistance via the Mental Health Treatment Assistance Program (MHTAP) a patient must meet the involuntary commitment criteria even if the patient is under a voluntary commitment.[5]

State Context

Although the report required by HB 172 is specific to psychiatric patient rights, many stakeholders provided information and recommendations related to other aspects of the behavioral health system of care in Alaska. These are included in Supplementary Report – Appendix B.

Emergency and Inpatient Care

When a person's psychiatric crisis cannot be stabilized in a community setting, the person requires a higher level of care. Alaska communities and regions vary in the level of psychiatric care available at hospital emergency departments and inpatient units. Hospital emergency departments are often the front door to higher levels of behavioral health care. While HB 172, along with other statewide efforts such as the 1115 Behavioral Health Medicaid Waiver, seek to add more levels of care, there are currently no crisis centers operating that accept individuals under emergency detention or involuntary holds. Individuals are frequently held in hospital emergency departments and inpatient units awaiting an appropriate behavioral health placement. Most hospitals have rooms that are or can be made ligature safe, but few have dedicated space for behavioral health patients; hospitals in Anchorage and Bethel do have dedicated units. Providence Alaska Medical Center in Anchorage has a dedicated 7-bed psychiatric emergency department where patients are detained awaiting a bed at an evaluation facility; however, the "Psych ED" is frequently at capacity, meaning behavioral health patients are seen at other hospitals or in the hospital's medical emergency department. The Yukon-Kuskokwim Delta Regional Hospital in Bethel has a similar 6-bed unit adjacent to the emergency department designed for behavioral health patients.

To involuntarily hospitalize individuals for behavioral health evaluation and treatment, hospitals must voluntarily apply for state designation. These designated hospitals can evaluate respondents to determine if they meet

[4] AS 47.30.670

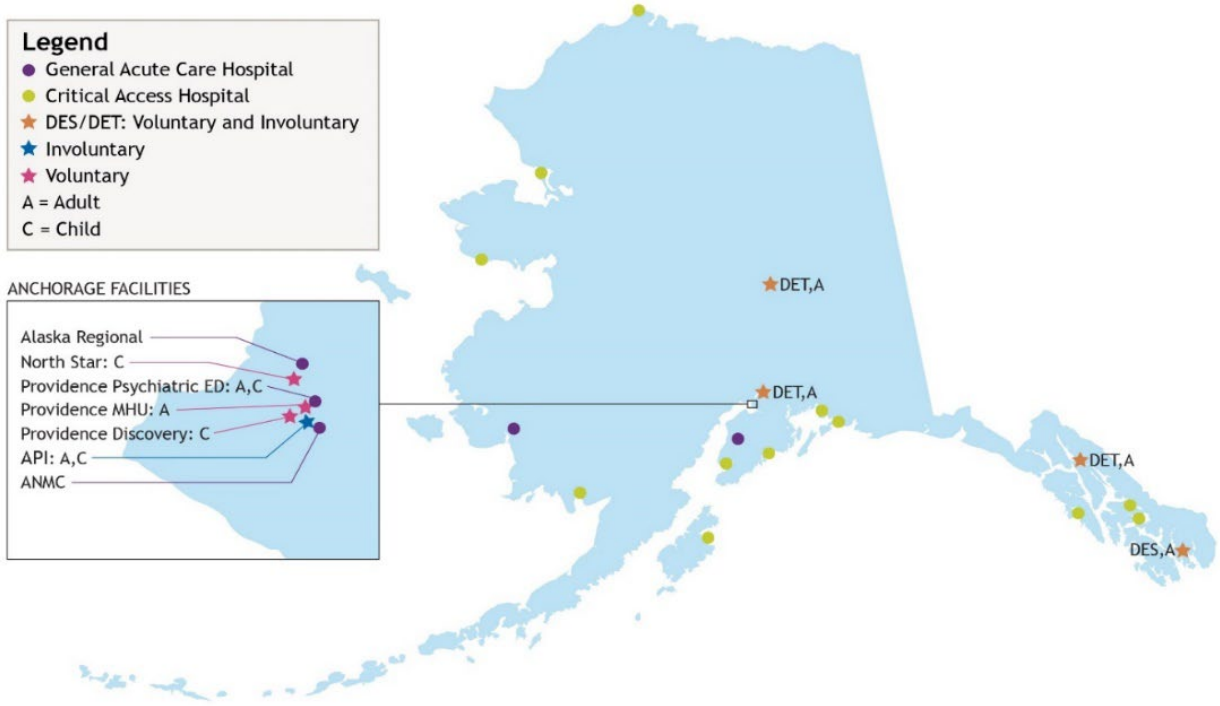
[5] State of Alaska Department of Health and Social Services. Division of Behavioral Health. (2020). Designated Evaluation and Treatment Program Manual.

criteria for involuntary civil commitment. “Designated Evaluation and Stabilization” (DES) facilities provide evaluation and stabilization for up to seven days. “Designated Evaluation and Treatment” (DET) hospitals provide both evaluation and treatment. Individuals can only be committed to a DET.

Mat-Su, Fairbanks, and Juneau have hospital inpatient mental health units that are designated by the Alaska Department of Health (DOH) to accept voluntary and involuntary adult patients, perform evaluations for civil commitments, and provide treatment. Ketchikan’s hospital is designated by the DOH to accept voluntary and involuntary adult patients, perform civil commitment evaluations, and provide stabilization services.

The Alaska Psychiatric Institute (API) serves adults and adolescents (13 and older) and only accepts patients under involuntary orders, although many patients admitted involuntarily convert to voluntary status during their stay. North Star Behavioral Health serves adolescents admitted with patient or guardian consent. Children and adolescents who are in the custody of the Office of Children’s Services and are placed at North Star Behavioral Health have a judicial review of their continued stay after 30 days. Providence Alaska’s Anchorage Medical Center has an adult mental health inpatient unit that accepts voluntary admissions and a unit for voluntary adolescents. The map below (Figure 2) shows the location of different facility types across the state.

Figure 2: Map of Alaska Facilities



Assessment: Psychiatric Patient Rights in Alaska

Guiding Principles: Alaska's State Mental Health Policy

In 1981, the Alaska Legislature undertook a major revision of Alaska civil commitment statutes (AS 47.30.660 and 47.30.670 – 47.30.915) "to more adequately protect the legal rights of persons suffering from mental illness". It attempted to "balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings." The following principles of modern mental health care are included in this 1981 revision:

1) that persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system;
2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;
3) that treatment occur as promptly as possible and as close to the individual's home as possible;
4) that a system of mental health community facilities and supports be available;
5) that patients be informed of their rights and be informed of and allowed to participate in their treatment program as much as possible; and,
6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.[6]

Input from stakeholders during this process in 2023 confirmed that these guiding principles are as urgent and relevant today as they were in 1981. The final section of the report titled "Stakeholder Input: Vision and Access to Appropriate and Timely Treatment, Stabilization, and Discharge" addresses principles one through four and six, exploring the systemic challenges that psychiatric patients in Alaska experience. The section titled "Psychiatric Patient Rights: Access and Implementation" addresses principle five, including how individuals are informed of their rights, have access to support during treatment, and the extent to which they can participate in their treatment.

State, Federal and Accrediting Body Requirements: Overview

The assessment of psychiatric patient rights in Alaska begins with defining the legal frameworks that guide policies, practices, and operations at all facilities providing psychiatric assessment, stabilization, and treatment.

Medical and behavioral health services are delivered through a complex system with legal and procedural requirements and protections. The focus of this project is on the adequacy of Alaska statutes and regulations and the ability of patients to avail themselves of their rights.

Laws come from federal or state government and are sometimes written as part of comprehensive packages designed to implement and regulate a system, such as a state's Medicaid regulations, or to target specific concerns. Some legal requirements come from court decisions that establish judicial precedents by ruling on constitutional issues, clarifying ambiguities, or resolving conflicts in the law.

In addition to federal and state legal requirements, behavioral health care providers have three additional layers of guidance: accreditation standards, requirements to qualify for Medicare or Medicaid payments, and their own policies. Accrediting bodies are national (Joint Commission) or international (Council on Accreditation and

[6] AS 47.30.655

Commission Accreditation of Rehabilitation Facilities (CARF)), and their role is to guide and ensure quality. Accrediting bodies and state governments have separate roles, but a state may choose to write an accreditation standard into regulation to ensure clearer and more immediate recourse or to avoid potential inconsistencies between the different accrediting bodies.

Legal requirements and other guidance are constantly evolving in response to deeper awareness of patient vulnerabilities, improved understanding of best practice, and efficient delivery of care nationwide. Complying with ever-evolving requirements requires significant effort from providers tasked with putting legal, regulatory and accreditation requirements into practice. While larger providers and governmental divisions can employ staff to interpret and monitor these changes, smaller providers, law enforcement, and others may rely on more direct communication from accrediting bodies and state entities to maintain compliance. Individuals seeking and receiving care rely on advocates, peers, targeted training, and documents or forms to receive notification of their rights and resources.

Center for Medicare and Medicaid Services (CMS) Conditions of Participation & Conditions for Coverage

The United States Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS) has developed criteria that health care organizations must meet to receive reimbursements from the insurance programs. The criteria are often referred to as the Conditions of Participation (CoP) and Conditions for Coverage (CfC). The CoP/CfC set the standard for health and safety, as well as the quality of care in a range of health care settings. The CoP/CfC standards are specified in Federal Regulations, specifically in Title 42 of the Code of Federal Regulations (CFR; see above). Therefore, for organizations to be reimbursed for services via Medicare or Medicaid, they must meet a core set of Federal Laws and Regulations that are specified via the CoP/CfC.

For example, one of the Conditions of Participation (CoP) is that hospitals meet 42 CRF 482.13a - which states that hospitals must provide patients with a notice of their rights as a patient and have a grievance and resolution process.

The CoP/CfC are also the foundation for accreditation standards for health care organizations. For organizations that are accredited (see below), CMS also recognizes that the organization meets the CoP/CfC, through a process called 'deeming' or 'deemed status' for Medicare reimbursement. Health care settings that are most applicable to this report include, but not limited to, Hospital, Critical Access Hospitals, Psychiatric Hospitals, and Community Mental Health Centers (CMHC).[7]

Alaska Law and Judicial Precedent

As stated above, each state may enact its own statutes and regulations regarding patient rights so long as they offer at least the same level of protections as federal law. Alaska often provides a higher level of protection than federal law requires. For example, the Alaska Supreme Court has interpreted the state's constitutional right to privacy to include protections for patients subject to involuntary commitment proceedings.

Accreditation for Health Care Organizations

In Alaska, many types of Health Care Organizations are required to be 'Accredited' by a third-party organization to seek reimbursement for services from Medicaid. Hospitals and Community Behavioral Health Providers are required to be accredited. If a Community Behavioral Health Provider is not accredited, it can apply for provisional approval from the Division of Behavioral Health as it seeks accreditation. The Provisional status also meets standards outlined in the Conditions of Participation (see above) and is often analogous to third-party Accreditation.

Common Accreditations include The Joint Commission (TJC), Council of Accreditation (CoA), and Commission on Accreditation of Rehabilitation Facilities (CARF). Often, Hospitals hold Accreditation from the Joint Commission, whereas many outpatient community behavior health programs hold accreditation from either TJC, CoA, or CARF.

[7] https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs

Accreditation is an indication of an organization meeting or exceeding established patient safety and quality metrics.

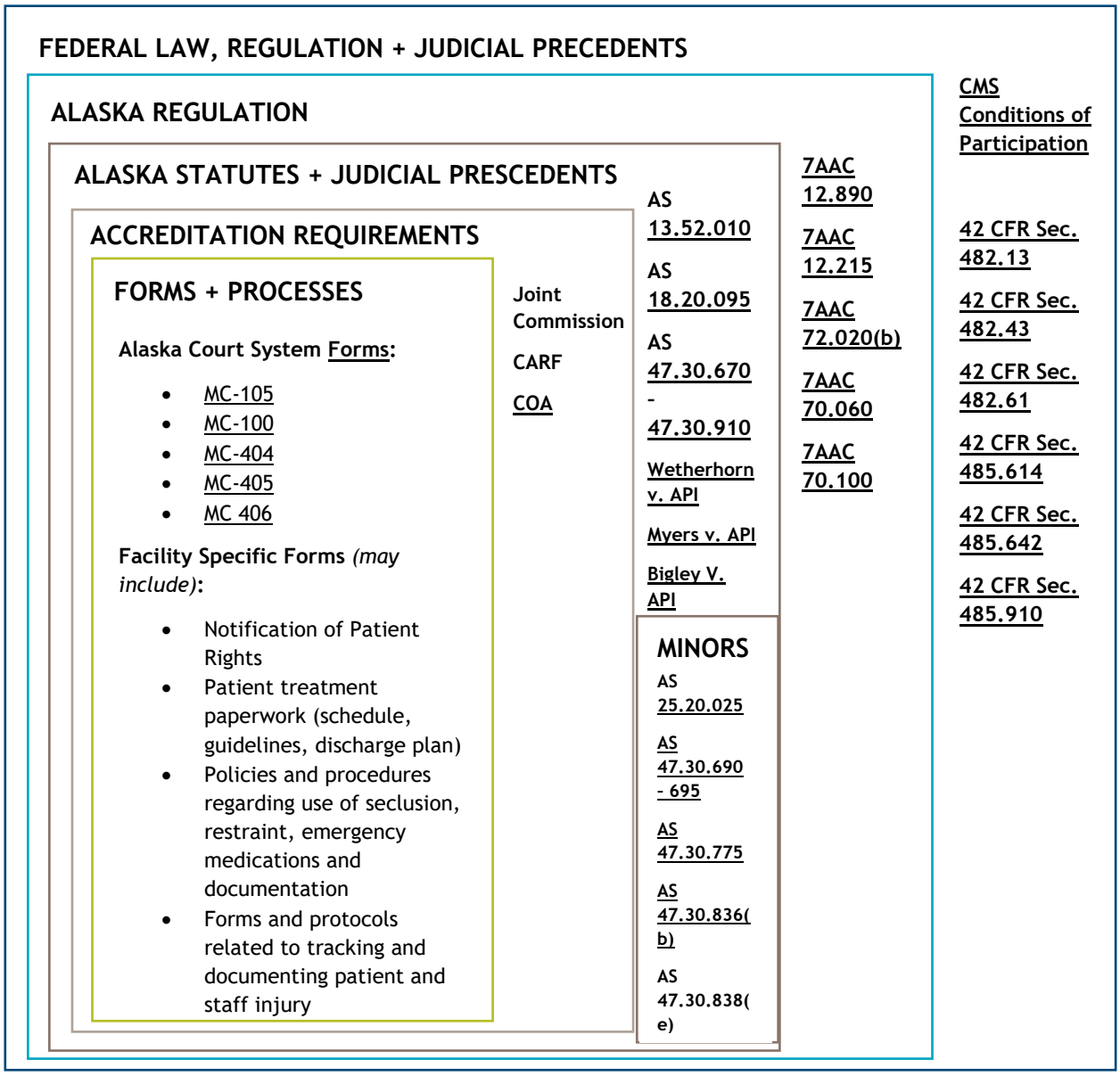
Regardless of the Accrediting organization, they are all rooted in the Conditions of Participation (CoP) and hold additional standards for the delivery of health care services. Organizations that have achieved accreditation are required to submit to a Surveyor who examines in detail how an organization maintains the health and safety of patients. During a survey, a Surveyor (sometimes a team of surveyors) travels on-site to an organization. Once on-site, the Surveyor reviews the organization's Policies and Procedures, inspects medical records, and conducts physical safety inspections of the physical facilities. Often the surveyors will interview staff and patients who have received care from the organization. Surveyors also require organizations to provide all copies of grievances submitted by patients, the resolution of the grievances, as well as any documentation related to patient injuries.

Following a Survey, the Surveyor provides the organization with a list of areas that the organization is meeting criteria, as well as any variances that require remediation. Depending on the type of variance, sometimes a surveyor will conduct another on-site visit to ensure the organization is meeting standards. If an organization fails to take corrective action, they can lose their accreditation, which also triggers their disbarment from participating in Medicaid or Medicare reimbursements.

Figure 3 illustrates the multiple layers of guidance that involved parties need to be familiar with to understand their constraints and obligations related to psychiatric patient rights in Alaska. For each layer, the listed guidance may or may not apply to a specific situation. For example, if someone experiencing a mental health crisis were served in a mental health facility, the additional privacy protections beyond HIPPA which are included in 42 CFR Part 2 would not apply, as those additional protections apply only to substance use treatment facilities. The rights of minors and their guardians are protected under Alaska statutes, while the requirements for a license to operate in the state of Alaska is a regulatory matter. Finally, the smallest box refers to documents that are most likely to end up in the hands of the person served, and therefore, in the absence of an advocate, are often the primary means by which a patient is informed about their rights.[8]

[8] For a complete list of court forms applicable to mental commitment, see Alaska Court System Forms Catalog, pages 41-42: https://public.courts.alaska.gov/web/forms/docs/adm-510.pdf

Figure 3: Facility, State, Federal Requirements Associated with Psychiatric Patient Rights



Psychiatric Patient Rights Legal Framework

Federal and state laws and regulations and accrediting bodies also require the collection and reporting of specific data elements. The requirements included in the supplemental section of this report do not represent a comprehensive list of all data elements providers are required to report or may choose to collect for internal quality improvement purposes but reflect the three categories of data required for the purposes of the HB 172 analysis: Patient and staff injuries, patient and staff complaints and traumatic events as defined in the legislation (involuntary medication, seclusion, and physical restraint). These requirements are summarized in the tables below.

Patient Rights Legal Framework & Accreditation Summary Matrix

The following matrix, while not a comprehensive compilation, attempts to highlight those patient rights provisions that are most relevant to the HB 172 report process. It is important to note that not every item listed will apply to every facility type, which adds further complexity to an analysis of patient rights across settings. The matrix is organized by key topics related to patient rights:

- Patient Rights, Informed Consent and Collaborative Decision-Making
- Notice and Provision of Due Process Rights
- Minors and Adults with Guardians
- Grievance Requirements
- Seclusion and Restraint
- Patient Safety
- Medications
- Outpatient Commitment
- Treatment and Discharge Planning
- Data

Patient Rights, Informed Consent and Collaborative Decision-Making

Text Summary	Issuing Authority	Citation Reference
Patient (or representative) has the right to make informed decisions regarding care including being informed of health status, being involved in care planning and treatment, and being able to request or refuse treatment.	Federal Regulations	42 CFR section 482.13 (b) (2)
A patient who is capable of giving informed consent has the right to give and withhold consent to medication and treatment in all situations that do not involve a crisis or impending crisis as described in AS 47.30.838 (a) (1)	Alaska Statute	AS 47.30.825 (c)
Patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives	Federal Regulations	42 CFR section 482.13 (b) (3)
	Alaska Statute	AS 13.52.10
Individuals may create an advance health care directive either in writing or orally and may be limited to take effect only if a specified condition arises.	Alaska Statute	AS 13.52.010

Patient Rights, Informed Consent and Collaborative Decision-Making

Text Summary	Issuing Authority	Citation Reference
A health care provider or a health care institution may not require or prohibit the execution or revocation of an advance health care directive as a condition for admission, discharge, or providing health care.	Alaska Statute	AS 47.30.817
A person 18 years of age or older may be voluntarily admitted to a treatment facility if the person is suffering from a mental illness and voluntarily signs the admission papers	Alaska Statute	AS 47.30.670
The administrator of a designated facility shall develop written policies and procedures that cover patient rights, consistent with 7 AAC 12.890 and AS 47.30.825-47.30.865.	Alaska Regulation	7 AAC 72.020(b)(4)
Patient Rights (General) • The organization respects the rights of the individual served and informs the individual (or surrogate) of their rights • The organization has written policies on rights of individual served • If an individual served is disoriented or lacks capacity to understand rights at the time of entry, they are informed again when they are able to understand. • The organization respects the cultural and personal values, beliefs, and preferences of the individual served. • The organization respects the right of the individual served to privacy. • In accordance with law and regulation, the organization allows the individual served to access and request amendment to the individual's clinical/case information and to obtain information on disclosures of this information • The organization prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. • The organization informs the individual served of the program rules. • The organization considers the privacy of individuals served and complies with law and regulation when making and using recordings, films, or other images of individuals served	Accreditation Standards	TJC RI.0.01.01 TJC RI.01.01.03 CoA CR 1.01 / CoA CR 1.02 / CoA CR 2.01 / CoA CR 2.03 / CoA CR 2.04 CARF 1.K(a)-(l) / CARF 1.L(a1) / CARF 1.L(b6) CARF 2.A.1(a)-(d) / CARF 2.A.3-7, 8(b), 8(c), 9,18,19, 23(a)- (c), 24 (b), 24(l)

Patient Rights, Informed Consent and Collaborative Decision-Making

Text Summary	Issuing Authority	Citation Reference
Informed Consent • The organization follows a written policy on informed consent that describes the following: the specific care, treatment, or services that require informed consent. Circumstances that would allow for exceptions to obtaining informed consent, such as situations involving threat of harm to self or others, child abuse, or elder abuse • The licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation • When a surrogate decision-maker may give informed consent	Accreditation Standards	TJC RI.01.03.01 CoA CR 1.06 / CR 2.01/ CoA CR 2.04/ CoA PRG 1.02 CARF 1.K(a)-(l) / CARF 1.L(a1) / CARF 1.L(b6) / CARF 2.A.1(a)-(d) / CARF 2.A.3-7, 8(b), 8(c), 9,18,19, 23(a)- (c), 24 (b), 24(l)
The informed consent process includes a discussion about the following: • The proposed care, treatment, or services for the individual served. • The goals and potential benefits and risks of the proposed care, treatment, or services. • Reasonable alternatives to the individual's proposed care, treatment, or services. • The discussion encompasses risks and benefits related to the alternatives and the risks related to not receiving the proposed care, treatment, or services. • **For child welfare:** The agency obtains the appropriate consents from all parties as required by law and regulation. • **For Youth:** The organization states in writing circumstances under which it will serve minors without consent from a parent or legal guardian and provides this information upon request.	Accreditation Standards	TJC RI.01.03.01 CoA CR 2.01/ CoA CR 2.04/ CoA PRG 1.02/ CR 1.06 CARF 1.K(a)-(l) / CARF 1.L(a1) / CARF 1.L(b6) / CARF 2.A.1(a)-(d) / CARF 2.A.3-7, 8(b), 8(c), 9,18,19, 23(a)- (c), 24 (b), 24(l)

Patient Rights, Informed Consent and Collaborative Decision-Making

Text Summary	Issuing Authority	Citation Reference

Patients' Right to Collaborative Decision-Making Regarding Treatment
• The organization respects the right of the individual served to collaborate in decisions about their care, treatment, or services.
• The organization involves the individual served in making decisions about their care, treatment, or services.
• When an individual served is unable to make decisions about their care, treatment, or services, or chooses to delegate decision making to another, the organization involves the surrogate decision-maker in making these decisions.
• The organization respects the right of the individual served or surrogate decision-maker to refuse care, treatment, or services in accordance with law and regulation.
• When an individual refuses care, treatment, or services, the organization fully informs the individual about its responsibility, in accordance with professional standards, to terminate the relationship with the individual upon reasonable notice, or to seek orders for involuntary treatment or other legal alternatives.
• The individual served has the right to involve their family in decisions about care, treatment, or services. When there is a surrogate decision-maker, the surrogate can exercise the right to involve the family on behalf of the individual served, in accordance with law and regulation.
• The organization accommodates the right of the individual served to request the opinion of a consultant.
• The organization accommodates the right of the individual served to request an internal review of the individual's plan of care, treatment, or services.
• The organization has a process for resolving disagreements about therapeutic issues.
• The organization provides the individual served or surrogate decision-maker with the information about the following:
  ○ Outcomes of care, treatment, or services that the individual needs to participate in current and future decisions about their care, treatment, or services
  ○ Unanticipated events related to the individual's care, treatment, or services
	Accreditation Standards	TJC RI.01.02.01
		
		CoA CR 1.01/ CoA CR 1.02 ? CoA CR 1.04 / CoA CR 1.05
		
		CARF 1.K (d)-(h) / CARF 1.L(a1) / CARF 1.L(b6) / CARF 2.A.1(a)-(d) / CARF 2.A.3-7, 8(b), 8(c), 9, 10 18,19, 23(a)- (c), 24 (b), 24(I) / CARF 3F.15(f)

Patient Rights, Informed Consent and Collaborative Decision-Making

Text Summary	Issuing Authority	Citation Reference
Patients' Rights to Materials in Language & Ability to Understand • The organization respects the right of the individual served to receive information in a manner the individual understands. • The organization provides interpreting and translation services, as necessary. • The organization communicates with the individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets the needs of that individual.	Accreditation Standards	TJC RI.01.01.03 CoA CR1.01 CARF 1.K 2 (a)-(b) / CARF 1.L (a)-(b) CARF 2.A.1(a)-(d) / CARF 2.A.3-7, 8(b), 8(c), 9, 10 18,19, 23(a)-(c), 24 (b), 24(l)
Psychiatric Advance Directives • Organizations document if a patient has a psychiatric advanced directive and follows patient's advanced directive • Organizations shares resources to create psychiatric advance directives with patient and/or guardian	Accreditation Standards	TJC RI.01.05.01 TJC CTS.01.04.01 CARF 2C.4(d6) / 3F.2(b15)

Notice and Provision of Due Process Rights

Text Summary	Issuing Authority	Citation Reference
A hospital must inform each patient, or when appropriate, the patient's representative, of the patient's rights in advance of furnishing or discontinuing patient care whenever possible.	Federal Regulation	42 CFR section 482.13 (a) (1) 42 CFR section 485.614 (a) (1)
When a respondent is detained for evaluation under AS 47.30.660-AS 47.30.915, the respondent shall be immediately notified orally and in writing of the rights under this section. The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section	Alaska Statute	AS 47.30.725 (a)
When detained for an evaluation, unless the respondent is released or voluntarily admitted for treatment within 72 hours of arrival at the facility or, if the respondent is evaluated by evaluation personnel, within 72 hours from the beginning of the respondent's meeting with evaluation personnel, the respondent is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause for detention after the 72 hours have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result presents a likelihood of serious harm to the respondent or others, or is gravely disabled.	Alaska Statute	AS 47.30.725 (b)
A person cannot be involuntarily committed as "gravely disabled" unless the person is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or if the person's level of incapacity is so substantial that the respondent is incapable of surviving safely in freedom.	Alaska Statute	AS 47.30.915(9)(A), (B),
The respondent has the right to communicate immediately, at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice	Alaska Statute	AS 47.30.725 (c)
At a 30-day commitment hearing, the respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing	Alaska Statute	AS 47.30.725 (d)

Notice and Provision of Due Process Rights

Text Summary	Issuing Authority	Citation Reference
The respondent in a commitment hearing has the right to be free of the effects of medication to the maximum extent possible before the hearing; however the facility or evaluation personnel may treat the respondent with medication or by a less restrictive alternative of the respondent's preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to: (1) prevent bodily harm to the respondent or others; (2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable the respondent to recover; or (3) allow the respondent to prepare for and participate in the proceedings.	Alaska Statute	AS 47.30.725 (e)
Commitment hearings shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits.	Alaska Statute	47.30.735 (b)
The respondent has the right to be present at commitment hearings and can be excluded only if they are incapable of giving informed consent and the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to the respondent's mental or physical health.	Alaska Statute	47.30.735 (b) (1)
At commitment hearings, the respondent has the right to; view and copy all petitions and reports in the court file, have the hearing open or closed to the public, have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence, to have an interpreter if the respondent does not understand English, to present evidence, to cross-examine witnesses, to remain silent, and to call experts and other witnesses to testify on the respondent's behalf.	Alaska Statute	AS 47.30.735 (b) (2)-(9)
A court may commit the respondent to a treatment facility if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled	Alaska Statute	AS 47.30.735 (c)
If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment if the program accepts the respondent	Alaska Statute	AS 47.30.735 (d)
The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond 30 days is to be sought, the respondent has the right to a full hearing or jury trial	Alaska Statute	AS 47.30.735 (e)

Notice and Provision of Due Process Rights

Text Summary	Issuing Authority	Citation Reference
For commitment hearings for commitments beyond 30 days, the respondent has the right to retain an independent licensed physician or other mental health professional to examine the respondent and to testify on the respondent's behalf. Upon request by an indigent respondent, the court shall appoint an independent licensed physician or other mental health professional to examine the respondent and testify on the respondent's behalf. The court shall consider an indigent respondent's request for a specific physician or mental health professional.	Alaska Statute	AS 47.30.745 (e)
A written notice that sets out the rights listed in 7 AAC 12.890 (a) must be posted in a conspicuous location, and a copy must be given to a patient, a client, a resident, a family member, or the legal representative of the patient, client, or resident and, at cost, to a member of the public	Alaska Regulation	7 AAC 12.890 (b)
Organizations must provide policies and procedures that describe the responsibilities of the program when a person served is admitted to the program under an involuntary commitment order; how communication and informed consent is obtained with the person, or their legal representative/guardian occurs, and how the expiration of the order is managed; and, how staff are trained.	Accreditation Standards	TJC RC.01.02.01 TJC RC.02.01.01 CARF 3E.7(f) / 3E.11 / 3E.13 (c) / 3F.2(b) / 3.F.15.f 3.F.16(a)-(b) / 3.F.17(a)-(c) / 3F.18(a)-(b) / 3J.19(a)-(b)
If patient has been committed to inpatient treatment through legal processes, a physician or similar medical practitioner must determine medical necessity on a daily occurrence.	Accreditation Standards	TJC PC.01.03.01 CARF 3J.12
Patient has the right to access protective and advocacy services and be informed on how to access the assistance. Note – Advocate or advocacy services is NOT required to be employed by outside organization.	Accreditation Standards	TJC RI.01.07.03 CARF 1E.1(i) / 1K.3(a)/ 2A.17

Minors and Adults with Guardians

Text Summary	Issuing Authority	Citation Reference
When a minor or adult with a guardian is detained at or admitted or committed to a treatment facility, the facility shall inform the parent or guardian of the location of the minor as soon as possible.	Alaska Statute	AS 47.30.693
When a minor or adult with a guardian (if the center or facility is aware of the guardianship) is involuntarily admitted to a crisis stabilization center, crisis residential center, evaluation or treatment facility, the facility shall inform the parent or guardian of the location of the minor as soon as possible.	Alaska Statute	AS 47.30.700 (c)
AS 47.30.700-815 apply to minors however, all notices required to be served on the respondent shall also be served on the parent or guardian and they shall be notified that they may appear as parties in any commitment proceeding and that as parties they are entitled to retain their own attorney or have the office of public guardian appointed for them. A minor respondent has the same rights to waiver and informed consent as an adult however, the minor shall be represented by counsel in waiver and consent proceedings.	Alaska Statute	AS 47.30.775
A minor's parent or guardian may admit the minor to a designated treatment facility for 30 days if the professional person in charge believes that the minor is gravely disabled or is suffering from mental illness and as a result is likely to cause serious harm to the minor or others, there is no less restrictive alternative for the minor's treatment, and there is reason to believe that the minor's mental condition could be improved by the course of treatment or would deteriorate if untreated.	Alaska Statute	AS 47.30.690
A guardian ad litem (GAL) shall be appointed as soon as possible for a minor admitted under AS 47.30.690 to monitor the best interests of the minor. If the GAL finds that the placement is not appropriate, they may request that an attorney be appointed to represent the minor. The attorney may request a hearing on behalf of the minor during the 30-day admittance	Alaska Statute	AS 47.30.690 (b)
A parent or guardian of a minor may file a notice to withdraw the minor from a facility where they have been detained or committed.	Alaska Statute	AS 47.30. 695
Upon receipt of a notice to withdraw a minor from a facility, the facility may discharge the minor to the custody of the parent or guardian. If in the opinion of the treating physician, release of the minor would be seriously detrimental to the minor's health, the treating physician may discharge the minor to the custody of the parent or guardian after advising the parent or guardian that this action is against medical advice or refuse to discharge the minor and initiate involuntary commitment proceedings. If, in the opinion of the treating physician, the minor is likely to cause serious harm to self or others and there is reason to believe the release could place the minor in imminent danger, the treating physician shall refuse to discharge the minor and initiate involuntary commitment proceedings.	Alaska Statute	AS 47.30.695 (1) AS 47.30.695 (2) AS 47.30.695 (3)

Minors and Adults with Guardians

Text Summary	Issuing Authority	Citation Reference
Before administering psychotropic medication to a minor patient in a non-crisis situation under AS 47.30.836, the mental health professional shall consult with the parent of guardian of the minor, evaluate the minor for drug withdrawal and medical psychosis caused by currently prescribed drugs or self-medication, and review all available information regarding the minor's family history, diet, medications, and other contributing factors.	Alaska Statute	AS 47.30.836 (b)
Before determining whether a minor patient should be given psychotropic medication in a crisis situation under AS 47.30.838, a mental health professional shall, to the extent time and the nature of the crisis permit, consult with a parent or guardian of the minor, evaluate the minor for drug withdrawal and medical psychosis caused by currently prescribed drugs or self-medication, and review all available information regarding the minor's family history, diet, medications, and other possibly relevant factors.	Alaska Statute	AS 47.30.838 (e)
Accreditation standards indicate that Healthcare Providers must seek consent from parents/guardians for treatment, except when legal exempt per State and/or Federal law (e.g., emergency situations).	Accreditation Standards	See Patient Rights, Informed Consent, and Collaboration above

Grievance Requirements

Text Summary	Issuing Authority	Citation Reference
A hospital must establish a process for prompt resolution of patient grievances	Federal Regulation	42 CFR section 482.13 (a) (2)
The grievance process must specify time frames for review of the grievance and the provision of a response. The hospital must review, investigate, and resolve each patient's grievance within a reasonable time frame. For example, grievances about situations that endanger the patient, such as neglect or abuse, should be reviewed immediately, given the seriousness of the allegations and the potential for harm to the patient(s). On average, a time frame of 7 days for the provision of the response would be considered appropriate. If the grievance will not be resolved, or if the investigation is not or will not be completed within 7 days, the hospital should inform the patient or the patient's representative that the hospital is still working to resolve the grievance and that the hospital will follow-up with a written response within a stated number of days in accordance with the hospital's grievance policy. The hospital must attempt to resolve all grievances as soon as possible.	CMS Conditions of Participation	State Operations Manual, Appendix A
A patient has a right to bring grievances regarding treatment, care, or rights through a formal process to an impartial body within an evaluation or designated treatment facility	Alaska Statute	AS 47.30.847 (a) – (c)
An evaluation or designated treatment facility shall have a designated staff member who is trained in mental health consumer advocacy who will serve as an advocate, upon a patient's request, to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights	Alaska Statute	AS 47.30.847 (c)
A patient, client, or a nursing facility resident has the right to be informed of the facilities' grievance procedure for handling complaints relating to patient, client, or resident care.	Alaska Regulation	7 AAC 12.890 (a) (4)
Organizations must have a compliant/grievance process and notify patients and/or guardians of the process. Patient and/or their guardians and family members have the right to have their grievances and complaints reviewed by the organization/facility. The facility must acknowledge receipt of complaint/grievance, review the complaint/grievance, and inform patient of course of action and/or resolution.	Accreditation Standards	TJC LD.04.01.07 TJC MS.09.01.01 TJC RI.01.07.01 CoA CR1.05 CARF 1K.3-1K.4

Seclusion and Restraint

Text Summary	Issuing Authority	Citation Reference
All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff member, or others and must be discontinued at the earliest possible time.	Federal Regulations	42 CFR section 482.13 (e) 42 CFR section 482.614 (e) 42 CFR section 485.910 (e) (1-5)
Restraint includes a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition	Federal Regulations	42 CFR section 482.13 (e) (1) (B) 42 CFR section 482.614 (e) (1) (B) 42 CFR section 485.902
Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm	Federal Regulations	42 CFR section 482.13 (e) (2) 42 CFR section 482.614 (e) (2)
The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm	Federal Regulations	42 CFR section 482.13 (e) (3) 42 CFR section 482.614 (e) (3)
The use of seclusion or restraint is subject to numerous limitations and conditions including monitoring time frames, training for staff and the reporting of deaths that occur.	Federal Regulations	42 CFR sections 482.13 (e)-(g) 42 CFR section 482.614 (e)-(g) 42 CFR section 485.910 (f) (1-4)
A locked quiet room, or other form of physical restraint, may not be used, except as provided in this subsection, unless a patient is likely to physically harm self or others unless restrained. The form of restraint used shall be that which is in the patient's best interest and which constitutes the least restrictive alternative available. When practicable, the patient shall be consulted as to the patient's preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored.	Alaska Statute	AS 47.30.825 (d)

Seclusion and Restraint

Text Summary	Issuing Authority	Citation Reference
For a specialized hospital, guidelines for the use of seclusion and restraint must include: (A) the location of a seclusion room which allows for direct supervision and observation by staff; (B) construction of a seclusion room which minimizes opportunity for concealment, escape, injury, or suicide, including locks and doors which open outwards; (C) recording in a patient's medical record the time the patient spent in seclusion or restraints; (D) visiting a patient who is in restraints or seclusion at least hourly, and providing the patient with adequate opportunity for exercise, access to bathroom facilities, and time out of restraints or seclusion; (E) limiting the use of restraints or seclusion to situations in which alternative means will not protect the patient or others from injury; and (F) when practicable, consultation with the patient regarding the patient's preference among available forms of adequate, medically advisable restraints, including medication.	Alaska Regulation	7 AAC 12.215(d)(7)
Organizations must have policy and procedures outlining its position on its use of seclusion and restraint, including physical, mechanical, or chemical restraint. Organizations must demonstrate how they train their staff regarding de-escalation, seclusion, and restraint. The use of seclusion or restraint is subject to numerous limitations and conditions including monitoring time frames, training for staff and the reporting of deaths that occur during any seclusion or restraint.	Accreditation Standards	TJC RI.01.06.01 TJC PC.01.03.03 TJC PC.01.03.05 TJC PC.03.05.15 TJC PC.03.05.19 TJC CBH CTS 05.06.33 COA BSM 1-5 CARF 2A.15 (a)-(b) / 2A.16 (a)-(c) / 2B.8 (f) / 2F.1 – 2F.11

Patient Safety

Text Summary	Issuing Authority	Citation Reference
A patient has the right to receive care in a safe setting free from all forms of abuse or harassment	Federal Regulation	42 CFR 482.13 (c) (2)-(3) 42 CFR section 482.614 (c) (2)-(3)
A patient has the right to have intimate care provided by a staff member who is the gender that the patient requests.	Alaska Statute	18.20.095 (a)
Commitment hearings shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits.	Alaska Statute	47.30.735 (b)
When a person is to be involuntarily committed to a facility, the department shall arrange, and is authorized to pay for, the person's necessary transportation to the designated facility accompanied by appropriate persons and, if necessary, by a peace officer. The department shall pay return transportation of a person, the person's escorts, and, if necessary, a peace officer, after a determination that the person is not committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility following an evaluation conducted in accordance with AS 47.30.715. When advisable, one or more relatives or friends shall be permitted to accompany the person. The department may pay necessary travel, housing, and meal expenses incurred by one relative or friend in accompanying the person if the department determines that the person's best interests require that the person be accompanied by the relative or friend and the relative or friend is indigent.	Alaska Statute	47.30.870
Patients have the right to be free from neglect, exploitation, & abuse. Organizations must protect patients served from neglect, exploitation, and abuse that could occur while the individual is receiving care, treatment, or services. Organizations must investigate and report all allegations and observations of abuse, neglect and exploitation to the appropriate authorities.	Accreditation Standards	TJC RI.01.06.03 CoA CR 1.02/ CoA CR 1.03/ CoA CR 1.04/ CoA CR 1.05 CARF 1K.1 (a)-(c);(h)

Medications

Text Summary	Issuing Authority	Citation Reference
An evaluation facility or designated treatment facility may administer medication or other treatment to an involuntarily committed patient only in a manner that is consistent with the provisions of AS 47.30.818-865	Alaska Statute	AS 47.30.772
Absent informed consent, a patient may only be administered psychotropic medication in a non-crisis situation if it is proven by clear and convincing evidence that it is in the patient's best interests and no less intrusive alternative is available.	Alaska Supreme Court Alaska Statute	Myers v. Alaska Psychiatric Institute 138 P.3d 238 (2006) AS 47.30.839(g)
A patient who is capable of giving informed consent has the right to give or withhold consent to medication and treatment in all situations that do not involve a crisis or impending crisis as described in AS 47.30.838 (a) (1)	Alaska Statute	AS 47.30.825 (c)
A facility shall follow the procedures required under AS 47.30.836-839 before administering psychotropic medication	Alaska Statute	AS 47.30.825 (c)
When practicable, the patient shall be consulted as to the patient's preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored	Alaska Statute	AS 47.30.825 (d)
An evaluation or designated treatment facility may only administer psychotropic medication in a non-crisis situation if the patient (1) has the capacity to give informed consent to the medication and gives that consent, (2) has authorized the use of psychotropic medication in an advance health care directive or authorized an agent or surrogate to consent, or (3) is determined by a court to lack the capacity to give informed consent to the medication and the court approves use of the medication	Alaska Statute	AS 47.30.836
A patient has the capacity to give informed consent if the patient is competent to make mental health or medical treatment decisions and the consent is voluntary and informed.	Alaska Statute	AS 47.30.837 (a)
"competent", "informed' and "voluntary" are defined in AS 47.30.837 (d)	Alaska Statute	AS 47.30.837 (d)
When seeking a patient's informed consent, the evaluation or designated treatment facility shall give the patient information that is necessary for informed consent in a manner that ensures maximum possible comprehension by the patient.	Alaska Statute	AS 47.30.837 (b)

Medications

Text Summary	Issuing Authority	Citation Reference
An evaluation or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if there is a crisis situation, or an impending crisis situation, that requires the immediate use of the medication to preserve the life of, or prevent significant physical harm to, the patient or another person. The behavior or condition of the patient giving rise to a crisis and the staff's response to the behavior or condition must be documented in the patient's medical record and include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient.	Alaska Statute	AS 47.30.838 (a)
If crisis situations occur repeatedly, or it appears that they may occur repeatedly, the evaluation or designated treatment facility, crisis stabilization center or crisis residential center may administer psychotropic medication during no more than three crisis periods without the patient's informed consent or court approval	Alaska Statute	AS 47.30.838 (c)
An evaluation or designated treatment facility may seek court approval to administer psychotropic medication to a patient in a noncrisis situation when it has reason to believe that the patient is incapable of giving informed consent.	Alaska Statute	AS 47.30.839 (a) (2)
The process for court approval of administering psychotropic medication in a noncrisis situation for a patient incapable of giving informed consent includes the patient's right to an attorney who may request that a guardian ad litem be appointed, the appointment of a visitor who shall prepare a report including an assessment of the patient's capacity and any expressed wishes of the patient regarding medications and a hearing within 72 hours of the filing of the petition	Alaska Statute	AS 47.30.839 (c) – (e)
If the court determines that the patient is not competent to provide consent and, by clear and convincing evidence, was not competent to provide consent at the time of previously expressed wishes, that the proposed medication is in the best interests of the patient, and that there is no feasible less restrictive alternative, the court shall approve the facility's proposed use of psychotropic medication.	Alaska Statute	AS 47.30.839 (g)
Healthcare providers follow accreditation standards applicable to seclusion and restraint regarding 'chemical restraint'. See applicable standards above.	Accreditation Standards	See Seclusion & Restraint Standards above

Outpatient Commitment

Text Summary	Issuing Authority	Citation Reference
A respondent who was originally committed to involuntary inpatient care may be released before the expiration of the commitment period if a provider of outpatient care accepts the respondent for specified outpatient treatment for a period of time not to exceed the duration of the commitment, and if the professional in charge finds that (1) It is not necessary to treat the respondent as an inpatient to prevent the respondent from harming self or others; and (2) there is reason to believe that the respondent's mental condition would improve as a result of the outpatient treatment.	Alaska Statute	AS 47.30.795 (a)
A copy of the conditions for early release shall be given to the respondent and the respondent's attorney and guardian, if any, the provider of outpatient care, and the court.	Alaska Statute	AS 47.30.795 (b)
If during the commitment period the provider of outpatient care determines that the respondent can no longer be treated on an outpatient basis because the respondent is likely to cause harm to self or others or is gravely disabled, the provider shall give the respondent oral and written notice that the respondent must return to the treatment facility within 24 hours. If the respondent fails to arrive at the treatment facility within the 24 hours, the professional person in charge may contact the appropriate peace officers who shall take the respondent into custody and transport them to the facility. If necessary, a member of the treatment facility staff shall accompany the peace officers.	Alaska Statute	AS 47.30.795 (c)
If the provider of outpatient care determines that the respondent will require continued outpatient care after the expiration of the commitment period, the provider may initiate further commitment proceedings.	Alaska Statute	AS 47.30.795 (d)
A respondent ordered by the court to receive involuntary outpatient treatment may be required to undergo inpatient treatment when the provider of outpatient care finds that; (1) the respondent is mentally ill and is likely to cause serious harm to self or others or is still gravely disabled; (2) the respondent's behavior since the hearing resulting in court-ordered treatment indicates the respondent now needs inpatient treatment to protect self or others; (3) there is reason to believe that the respondent's mental condition will improve as a result of inpatient treatment; and (4) there is an inpatient facility appropriate the respondent's need that will accept the respondent as a patient.	Alaska Statute	AS 47.30.800 (a)
Accreditation standards require that care settings incorporate a patient's legal status (e.g., inpatient/outpatient commitment) in determining their care and implications in care.	Accreditation Standards	See Patient's Rights, Informed Consent, and Collaboration above

Treatment and Discharge Planning

Text Summary	Issuing Authority	Citation Reference
Psychiatric hospitals must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning	Federal Regulation	42 CFR 482.62(a)-(g)
Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm	Federal Regulation	42 CFR section 482.13 (e) (2) 42 CFR section 482.614 (e) (2)
A locked quiet room or other form of physical restraint shall be that which is in the patient's best interests and which constitutes the least restrictive alternative available.	Alaska Statute	AS 47.30.825 (d)
When delivering a person to a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility under AS 47.30.705 (a), a peace officer or health officer shall give priority to a crisis stabilization center or crisis residential center if one exists in the service area served by the peace officer or health officer.	Alaska Statute	AS 47.30.705 (c)
Involuntarily committed individuals shall be placed in the designated treatment facility closest to their home unless another treatment facility in the state has a program more suited to the respondent's condition or another treatment facility is closer to respondent's friends or relatives who could benefit the respondent through their visits, or the respondent wants to be further removed from home and the mental health professional seeking the commitment concurs in the desirability of removed placement.	Alaska Statute	AS 47.30.760
The patient and the following persons, at the request of the patient, are entitled to participate in formulating the patient's individualized treatment plan and to participate in the evaluation process as much as possible, at a minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in the treatment program, and being informed as to the patient's present medical and psychological condition and prognosis; (1) the patient's counsel, (2) the patient's guardian, (3) a mental health professional previously engaged in the patient's care outside of the facility, (4) a representative of the patient's choice, (5) a person designated as the patient's agent or surrogate with regard to mental health treatment decisions under AS 13.52, (6) the adult designated under AS 47.30.725.	Alaska Statute	AS 47.30.825 (b)
A hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support persons as active partners in the discharge planning for post-discharge care.	Federal Regulation	42 CFR 482.43

Treatment and Discharge Planning

Text Summary	Issuing Authority	Citation Reference
The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.	Federal Regulation	42 CFR 482.61 (e)
A patient upon discharge shall be given a discharge plan specifying the kinds and amount of care and treatment the patient should have after discharge and such other steps as the patient might take to benefit the patient's mental health after leaving the facility. The patient shall have the right to participate, as far as practicable, in formulating the patient's discharge plan.	Alaska Statute	AS 47.30.825 (i)
Patients receiving care in crisis or inpatient settings will have their patient rights protected and the patient (or legal representative/guardian) will be engaged in collaboration in determining their treatment.	Accreditation Standards	See Accreditation Standards in Patient Rights, Informed Consent, & Collaborative Decision-Making
A patient is discharged or transferred from care based on patient's assessed needs and ability of organization to meet that need, and in collaboration with the patient and/or guardian.	Accreditation Standards	TJC PC.04.01.01 TJC PC.04.01.03 CARF 3F.4(b) / 3J.10(a)-(b)
At time of discharge from crisis stabilization or inpatient treatment setting, the patient has an established appointment for on-going services and sufficient medication (if applicable). The discharge facility will provide information about the care and treatment of patient (with consent) to receiving care provider.	Accreditation Standards	TJC PC.04.01.03 TJC PC.04.02.01 TJC PC.04.01.05 CARF 3F.4(b) / 3J.10(a)-(b)

The table below provides a summary of required requirements and affiliated data elements that psychiatric hospitals and distinct psychiatric treatment units are required to maintain and document to be made available upon request of an oversight authority (e.g., Joint Commission, State of Alaska, Federal). While organizations are required to document and maintain such information, the information is typically used for internal quality assurance and improvements programs and may be made available upon request of an oversight authority.

Summary of Required Data Elements related to Psychiatric Care and Patient Rights for Facilities

Data Category		Joint Commission	State of Alaska	US Federal Government
Patient Rights	Documentation	Documentation of informed consent for treatment	Records of patient rights education and acknowledgment	Compliance with the CMS Conditions of Participation for patient rights
	Complaint Logs	Grievance and complaint logs, including resolution and follow-up actions	Complaint investigation reports and outcomes	Records of patient complaints and resolutions
Patient Safety	Reporting	Adverse event reporting, including medication errors, falls, and patient injuries	Incident reports related to patient fatalities or serious patient safety, including investigations and corrective actions	Compliance with CMS quality measures and reporting requirements*
	Training	Staff training records on patient safety practices	Training records for staff on patient safety protocols	Staff training records on patient safety protocols
Seclusion and Restraint	Documentation	Documentation of the use of seclusion and restraint, including reasons, duration, and monitoring	Documentation of seclusion and restraint incidents, including justification and monitoring	Documentation of seclusion and restraint incidents, monitoring, and compliance with CMS regulations
	Review	Periodic review of seclusion and restraint practices	Review of seclusion and restraint practices	
Emergency Crisis Medications & Involuntary Medications	Logs	Usage logs for emergency crisis medications & involuntary medications, including dosage, administration, and monitoring	Logs of emergency crisis medication & involuntary medications usage, including administration, dosages, and monitoring	Logs of emergency crisis medication & involuntary medications administration and monitoring

*Not all facilities opt-in to the voluntary CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

The table below provides a list of Clinical Quality Measures required by CMS for facilities participating in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. Only three Alaska facilities current participate in the program and report the data annually to CMS.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Measures ***(FY24 and subsequent years)***

Measure ID	Measure Description
HBIPS-2	Hours of Physical Restraint Use
HBIPS-3	Hours of Seclusion Use
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
SMD	Screening for Metabolic Disorders
SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention
SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset, Alcohol and Other Drug Use Disorder Treatment at Discharge
TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay)
TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge
TR-1	Transition Record with Specified Elements Received by Discharged Patients
COVID HCP	COVID-19 Healthcare Personnel (HCP) Vaccination
IMM-2	Influenza Immunization
FAPH	Follow-Up After Psychiatric Hospitalization
N/A	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)
N/A	Medication Continuation Following Inpatient Psychiatric Discharge

Psychiatric Patient Rights: Access and Implementation

The assessment of psychiatric patient rights in Alaska looked at key elements of psychiatric patient rights including notification of rights, access to courts, legal guardians and advocates, use of seclusion, restraint and involuntary medication, patient and staff safety and patient grievance and appeals processes. The assessment examined provision of and access to these rights depending on location of care. Information compiled in this assessment drew from site visits and stakeholder interviews including providers, law enforcement, individuals with lived experience, and review of relevant regulatory, statutory, and accrediting body requirements.

Notification of Due Process Rights

Rights notification is guided by requirements in Alaska statute and regulation and by accrediting body requirements.

Prior to Evaluation/Treatment Facility Arrival

The number of individuals who must wait in hospital emergency departments (EDs), inpatient units, or protective custody pending admission to a DET is a common source of concern. This report focuses particularly on patient rights within these settings.

Hospitals are highly regulated and have robust systems in place to ensure that legally required processes are followed. Patients who are experiencing a mental health crisis, might not understand or recall provided information, yet the onus is often on the patient to utilize provided information or contacts, including contacting local legal representation.

The MC-105 form, *Notice of Emergency Detention and Application for Examination*[9] is used when a mental health professional has taken the respondent into custody for emergency evaluation. Individuals detained under an MC-105 receive the MC-404 *Notice of Rights During Emergency Detention*.[10] All hospitals interviewed were familiar with this form and report regular provision of this form to patients. Law enforcement knowledge of this form varied, and no entities reported routinely providing this form. Law enforcement expressed concerns about providing notice of rights in the community, identifying that it could escalate the situation. There is a general reliance on the custody facility to provide the notification of patient rights to an individual under emergency detention. Signed forms are scanned into the patient medical record. Individuals detained for evaluation are given the MC-405 form, *Notice of Rights During Court-Ordered Evaluation*.[11]

When this form is compared to Alaska Statute it is unclear to which settings this form applies and if the form language is consistent with statute. Hospital emergency departments commonly provide this form to patients, but these locations serve as a point of custody and not as the location of emergency detention for evaluation. It is unclear if hospitals should be providing this notification or if it should be provided only at delivery facilities. Regardless of setting, the notification of rights form appears to contain language that is not clearly aligned with statute and should be thoroughly reviewed.

For example, AS 47.30.710(a) states:

> A respondent who is delivered…to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

The MC-404, *Notice of Rights during Emergency Detention*, states:

> The facility where you are being held must ask for a court order if they want to keep you in emergency custody for longer than 24 hours. During this period, you must be examined by a mental health professional.

One provider noted that it would be beneficial to have a state-issued list of psychiatric patient medical rights that would be posted in all EDs and provided to patients. The provider opined that statute is so convoluted, a plain language document is needed for facilities to reference and is accessible to patients.

During Evaluation and Treatment

Designated Evaluation and Stabilization/Designated Evaluation and Treatment (DES/DET) facilities report patients are notified verbally and in writing of their rights at admission and at subsequent points if the patient is unable to understand their rights upon admission. Interpretation services are available and written forms are available in select languages depending on the facility. All facilities reported that patient rights are posted in the facility or unit. Groups on patient rights are provided at some facilities, but this is not a standard or required service. While providers report robust processes related to rights notification, most individuals with lived experience interviewed for this report could not recall if or when they were ever provided notification of their rights.

Access to Courts, Legal Counsel, Guardians and Advocates

Provision of due process rights via access to courts and legal counsel is predominately guided by Alaska statute and regulation. For CARF and Joint Commission accredited facilities, access to protective and advocacy services is predominately guided by accreditation standards, although Alaska statutes and regulations still apply.

Prior to Evaluation/Treatment Facility Arrival

During the period when a person is being detained in a hospital ED or a community facility while awaiting transport to a hospital, there is variable access to the Court System. According to the Alaska Court System, magistrates are available 24/7 for involuntary commitment proceedings; however, in some communities there is a perception that the Court System is not available after hours or over the weekend unless there is a criminal complaint. This report

[9] https://public.courts.alaska.gov/web/forms/docs/mc-105.pdf

[10] https://public.courts.alaska.gov/web/forms/docs/mc-404.pdf

[11] https://public.courts.alaska.gov/web/forms/docs/mc-405.pdf

does not attempt to resolve inconsistency in these perspectives. In these locations, individuals may be detained for a longer period waiting for court approval of the ex parte order. Additional procedural delays include completed ex parte orders not being distributed to all DES/DET facilities, even when all facilities are selected on the order.

Because the emergency hold statute does not provide for the appointment of counsel, the Public Defender Agency is not notified when an individual is detained under an MC-105 and it is the detainee's responsibility to reach out. If an individual is a minor or is an adult with a guardian, the facility will contact the legal guardian.

Regardless of commitment status, facility processes guide how and when individuals are informed of the facility's grievance processes, patient advocate availability, and access to visitors or telephones.

During Evaluation and Treatment

State Agency Support

A public defender is assigned immediately once an ex parte order is approved by the court system. The State of Alaska DES/DET Coordinator provides daily respondent status reports to the Public Defender Agency and the agency reaches out to any new individuals. There are specific public defenders assigned to civil commitment cases and these public defenders typically have lighter caseloads than other public defenders. They receive national training related to mental health law and internally developed training specific to Alaska laws and issues. The Public Defender Agency reports engaging an expert witness for 90 and 180-day hearings but that timing is a barrier to getting expert testimony for 30-day commitment hearings. In Anchorage, it is typically unknown if a 30-day petition will be filed until 11AM, with a hearing scheduled for 1:30PM leaving little time to engage a witness and for the witness to review the case. In Fairbanks, the petition is sometimes filed contemporaneously with the hearing itself.

It is important to note that under statute, the public defender is entitled to continue the hearing until 7 days after arrival. Additionally, the right to counsel includes the right to *effective* counsel, which may include additional time for the attorney to obtain an expert witness.

Some providers asserted that magistrates or judges and public defenders in their judicial districts are not well-versed in case law pertinent to mental health proceedings, increasing delays for the patient and the time psychiatrists spent in court. Other stakeholders disagreed with these perspectives. Some providers identified variability in district court approval of petitions, noting that their district court is less likely to approve petitions based on gravely disabled criteria compared to another district. Providers report they are very selective about filing 30-day petitions due to the high level of scrutiny and review of these cases.

The Office of Public Advocacy (OPA) noted that if a Guardian ad Litem (GAL) is assigned to a youth, the GAL is typically very involved in the youth's care. If an adult has a Public Guardian, there is typically less involvement due to high caseloads. Providers noted limited involvement by both family and public guardians.

Patient Advocacy

While facility-based stakeholders all identified processes and staff in place to support patient advocacy, there was no mention of any specific training to fulfill the training requirement as identified in statute. Only one facility had a designated, full-time advocate position; others described advocate roles as shared with other responsibilities, such as an executive assistant, included in clinical staff job descriptions, or Patient Experience/Quality Improvement staff serving the entire facility and engaging with behavioral health patients only when complaints, concerns, or grievances are initiated. There are no current examples of DES/DET facilities routinely engaging a third-party patient advocate to support patient care needs.

Crisis centers and designated facilities have additional requirements for patient advocacy, beyond what is specified by an entity's accrediting body. The additional requirements are specified in AS 47.30.847 (c): "An evaluation or designated treatment facility shall have a designated staff member who is trained in mental health consumer advocacy who will serve as an advocate, upon a patient's request, to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights."

Psychiatric Advanced Directives

Psychiatric advanced directives were identified during this process as a practical tool to increase an individual's ability to advocate for themselves during a psychiatric crisis. Like medical advanced directives, these documents can identify individual preferences for psychiatric care. Alaska Statute contains provisions for the use of advanced directives and "Part 4" of the advanced healthcare directive form available online via the Alaska Court System is specific to mental health treatment.[12] All facilities interviewed noted that they ask about advanced directives but could only think of one or two examples where a patient had an advanced directive for mental health in place. Many stakeholders were interested in increased use of this self-advocacy tool throughout the state. One suggestion has been to store advanced directives on Alaska's health information exchange to make them available to facilities during crisis periods to provide information on patient preferences regarding medication, coping strategies, and other preferences. More detail on psychiatric advanced directives can be found in the Supplemental Report – Appendix C.

Use of Seclusion, Restraint, and Involuntary Medication

The definition and documentation of seclusion, restraint, and involuntary medications is guided by requirements in Federal and Alaska statute and regulation and accrediting body requirements. Facilities report minimal use of these interventions; however, individuals with lived experience highlighted the traumatic impact these interventions had on them when used. Medication can be issued in crisis and non-crisis situations and both types of medication can be administered voluntarily or involuntarily.

Seclusion and Restraint

Facility and State stakeholders described the process of utilizing any of these practices as intensely regulated and involving significant documentation. Facilities described their use as minimal and a "last resort" after all other efforts at de-escalation in a crisis have failed. Facilities reported reduced rates or perceived need for seclusion or restraint when they have sufficient staffing ratios and their staff have been adequately trained in de-escalation techniques. Seclusion and restraint are used across facility types.

Involuntary Crisis Medication[13]

Evaluation or designated treatment facilities may only administer psychotropic crisis medications in specific situations and for no more than three crisis periods without court approval.[14] In interviews with providers at hospital facilities, some providers expressed concern that Alaska Statute places limits on the use of crisis medication but not the use of seclusion and restraint. These providers considered seclusion and restraint to be more harmful and traumatic interventions compared with the use of crisis medications.

Court-Ordered Medication

Specific facility types may petition the court for the use of court-ordered medication in non-crisis situations if the facility has reason to believe the patient is incapable of giving informed consent. In these situations, the Public Defender reviews petitions for court-ordered medications with clients, including the medications, potential side effects and alternatives. In interviews with legal representatives for patients, some reported that the judge presiding over the petition typically defers to the opinion of the physician representing the State's case and that there is limited capacity to provide physician testimony on the defense side. Representatives from the Department of Law and DFCS disagreed with this characterization. This report does not attempt to resolve this discrepancy.

Stakeholders shared differing viewpoints on the use of involuntary medication as an intervention and about how current statute is implemented. Some Advisory Team members expressed strong disagreement regarding the use of involuntary psychotropic medications in any situation, while others advocated for the necessity of medication to help an individual stabilize. Both groups agreed that using psychotropic medication is the medical standard of care; the disagreement was about whether that should be the medical standard of care. Regarding implementation

[12] https://courts.alaska.gov/shc/family/docs/aahc-directive.doc

[13] This report does not address the legal authority for emergency room or general acute care hospitals to administer chemical restraint.

[14] AS 47.30.838(c)

of statute, one stakeholder who is a legal representative for patients reported regularly seeing petitions for a broad list of psychotropic medications and administration methods, while another reports that this is not the case. Statute specifies that if a facility seeks to use psychotropic medication but believes "the patient is incapable of giving informed consent" a facility may seek court approval for administration of psychotropic medication. Some stakeholders who are clinical providers noted that there are no petitions for administering medication for individuals who are incapable of giving informed consent but are willing to take medication. Several Advisory Committee members believe that statute indicates that refusal of treatment or medication does not necessarily indicate lack of capacity, but in practice they report that when a patient refuses medications it can be used as grounds for court-ordered medications. Representatives from the Department of Law and DFCS disagreed with this characterization. This report does not attempt to resolve this discrepancy.

Providers noted that the statutes are written to protect individuals from being medicated against their will, but they do not address a right to *access* appropriate treatment for the person's condition, which may include medication. Providers also noted that providing access to treatment, including medication, can decrease the use of seclusion and restraint and the administration of crisis medications, which are used to address the symptoms of acute psychiatric distress but do not treat the condition that is causing the distress.

Patient and Staff Safety

Patient and staff safety standards are guided by requirements in Federal and Alaska statute and regulation and accrediting body requirements. Facilities of all types noted a heavy emphasis on de-escalation training and noted that the documentation of patient injuries is highly regulated and involves significant documentation. One facility shared that a change in the de-escalation training provided to staff significantly improved safety and reduced injuries for staff and patients. Certain types of injuries must be reported to Adult Protective Services or the Office of Children's Services.

AS 18.20.095 provides an additional right to intimate care by a staff member who is the gender that the patient requests. This additional right is limited to patients 18 and older who are receiving mental health treatment and are being provided intimate care at a hospital. All facilities interviewed reported making efforts to ensure patients are matched with staff of the gender of their choice but emphasized this was not always an option based on available staffing. Only one facility identified they had a documented policy aligned with the requirements under this statute. Stakeholders also noted the current statute only references intimate care at a hospital.

Patient Grievances and Appeals Processes

Per federal regulation and accrediting body requirements all facilities must have a grievance and appeals process in place, and patients have the right to a review of grievances by the facility. Subacute mental health and designated facilities have additional requirements, specified in AS 47.30.847 (a) – (b) including the right to "bring grievances regarding treatment, care, or rights through a formal process to an impartial body" and specifies the facility "shall inform each patient of the existence and contents of the grievance procedure."

Facilities interviewed as part of this assessment shared similar processes for addressing complaints and grievances, which typically started with a staff member discussing the issue with the patient to see if it could be resolved immediately. Grievances that could not be resolved immediately or require a more complete process are typically discussed at team meetings and escalated according to internal processes. Patients typically can file a grievance by phone call, email, or a card/form on the unit. Patients in all facilities can contact the Alaska Disability Law Center, Health Facilities Licensing at the Department of Health, or the facility's accrediting body. Facilities provide patients with phone numbers for these entities. Patients at API have an additional avenue to file complaints and grievances with the Alaska Ombudsman. The Alaska Ombudsman's jurisdiction extends to "administrative acts of state agencies."[15] As the only hospital that is a state agency, API is the only psychiatric facility in Alaska under this jurisdiction. One individual with lived experience shared that licensing and accrediting bodies are not responsive to complaints from patients. Other individuals with lived experience shared feelings of being minimized, ignored, or 'punished' in some way for using the grievance process. Facilities report responding

[15] AS 24.55.100

to most grievances within seven days, with one facility identifying they respond within 24-hours to most grievances.

While facilities report robust processes for addressing grievances, some stakeholders expressed concern with the lack of a standardized statewide grievance process. Grievances are typically tracked and reported through internal processes or by external oversight agencies and are not shared with the public. For some stakeholders, the lack of public reporting contributes to concerns that patient grievances are not taken seriously or even addressed. Instituting a standard grievance process has long been discussed in Alaska, with three bills proposed between the 2009 and 2013 legislative sessions (see Supplemental Report – Appendix D). These bills attempted to standardize the grievance process, create specific timelines for responses to grievances, require departmental review of grievances, and reporting of grievances and outcomes to the State. Additional elements in some bills included a 24/7 call line for grievances, creation of grievance processes that included levels for appeals, among others. A proposal was reviewed by the Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse in 2018. The Boards did not recommend action at that time, citing the need for additional information. Four states with statewide grievance processes were reviewed (see Supplemental Report – Appendix E).

Stakeholders raised the concern that there is no standard timeframe for response to grievances and a facility's processes may not coincide with the timeframe of an individual's detention. Accrediting bodies and CMS Conditions of Participation do not require a timeframe for responses to grievances, but the Conditions of Participation State Operations Manual provides guidance regarding timeframe: that the organization's grievance process must specify timeframes and that seven days is considered appropriate. The CMS State Operations Manual identifies that a timeframe is not specified because some grievances, for example those related to patient harm and safety issues, should be addressed immediately, while others may take significant time to investigate. Being too prescriptive may impede a facility's ability to respond to grievances in a timeframe appropriate to the grievance.

AS 47.30.847(a) ensures psychiatric patients have the right to bring grievance to an impartial body but there is debate about the definition of "impartial body." Some Advisory Committee members expressed concern that statute allows the "impartial body" tasked to investigate or resolve grievances to include facility management or leadership, and these stakeholders expressed a belief that a facility's management or leadership would place priority on protecting the facility rather than enhancing patient rights. Interviews with facility staff and leadership did not agree with this characterization. This report does not attempt to resolve the discrepancy.

Recommendations: Changes to Improve Patient Outcomes and Enhance Patient Rights

The following recommendations provide a starting point for significant and complex work. Implementing the recommendations will require effort from multiple parties including State of Alaska Departments and Divisions, providers, patient advocates, policymakers, and funders. Very few, if any, of the recommendations can be successfully implemented without sufficient funding and organizational commitment. Implementation could avoid future lawsuits, improve outcomes, and contribute to a comprehensive system of care for individuals with behavioral health needs that is aligned with the principles for care enacted by the Alaska Legislature in 1981.

A comprehensive list of the issues, proposed recommendations, category of patient rights addressed, and source of discussion are identified in a series of tables located in the Supplemental Report – Appendix F. The tables included in Appendix F include over 90 recommendations explored during the project. It is important to consider the entire system when exploring implementation of any specific recommendation. The recommendations in Appendix G are organized by three categories: Systems, Legal, and Data within each category; individual recommendations are associated with a topic area.

Priority recommendations related to the topic areas specified in HB 172 and others raised during stakeholder engagement are listed below and grouped by topic area.

Access to Appropriate Processes and Protections

Recommendations to improve patient outcomes and enhance patient rights included in this section focus on system and process change. The prioritized recommendations strive to clarify existing policies and processes, encourage the development of training and support to better implement existing requirements, support collaboration between providers, state divisions and departments, and patient advocates to ultimately improve the protection of the rights and experiences of individuals receiving care.

Notification and Provision of Due Process Rights

- Align statutory language, court forms, and provider practices related to emergency detention. A working group is needed to address conflict between statute, court forms and practice. Possible outcomes of the working group may include:
    - Development of a guidance document for emergency departments, hospital inpatient units, crisis stabilization and residential centers and designated facilities that clearly defines their role in the process;
    - Development of a guidance document for these settings that clearly defines the patient rights that apply in these settings;
    - Identification of statutory and regulatory changes to increase clarity and alignment between statute and practice; and,
    - Identification of specific revisions to court forms to ensure forms and statute are in alignment.
- Enact a psychiatric patient care Ombudsman's office in statute.
- Increase and standardize opportunities for patient rights education. Specifically:
    - Develop curriculum for providers to use for patient rights groups;
    - Develop a state-approved list of psychiatric patient rights and require posting and provision to patients in facilities where these rights apply; and,
    - Explore use of third-party entity to provide patient rights groups at specified facility types.
- Develop standardized training for providers regarding statutory requirements for patient rights.
- Include in statute a requirement for law enforcement officers to receive training on their statutory responsibility related to detention, transportation, and rights notification for psychiatric patients.

Access to Courts, Legal Counsel, Guardians, and Advocates

- Increase use of psychiatric advanced directives;
- Increase access to Family Advocates to help address concerns regarding treatment and discharge; and

- Develop standardized training in mental health consumer advocacy for all patient advocate/patient experience staff and ensure provision of training to staff at all facilities to which AS 47.30.847c applies.

Patient and Staff Safety

- Provide education to hospitals providing mental health treatment related to AS 18.20.095 to inform patients being provided intimate care at a hospital of their right to have care provided by a staff member who is the gender that the patient requests. This should include sample language to post on units and in patient rights documents/handbooks.

Patient Grievances and Appeals Processes

- Define “impartial body” as it is used in Sec. 47.30.847. Patients' grievance procedures and ensure compliance at all evaluation and designated treatment facilities.

Assessment: Data Collection and Reporting

The statistics requested in the HB 172 legislation are tracked and reported internally to the provider agency and to external entities such as licensing and accrediting bodies upon request. Providers interviewed for this report and those who served on the Data committee noted that if additional external reporting requirements are imposed, a central data repository that minimizes provider burden is essential. Providers noted significant time already spent documenting and reporting and that additional requirements would further reduce time for patient care. Current reporting is provided in aggregate, which providers prefer rather than patient or encounter-level data. Providers would also like to understand the purpose of external reporting and how data will be used to improve patient outcomes.

Any new data collection and reporting requirements must specify which facility types are subject to each requirement. As previously described, current statutes apply to specific facility types (e.g., DET facilities), not patient types (e.g., individuals who experience psychoses or suicidal ideation). Because psychiatric patients are detained in various hospital settings along with many other types of patients, the target population for data collection and reporting must be carefully defined. For example, it may be easier for a Designated Evaluation and Stabilization/Designated Evaluation and Treatment (DES/DET) facility to isolate data related to seclusion and restraint of psychiatric patients because these facilities only treat psychiatric patients, compared to a hospital ED that treats many kinds of patients, a subset of whom may experience seclusion or restraint.

Providers shared concerns about increasing reporting requirements on behavioral health providers, particularly if such mandates are unfunded. Stakeholders expressed concern that singling out psychiatric patient data could have the unintended consequence of increasing stigma associated with psychiatric patients and care. For example, public reporting on patient-on-staff assaults by psychiatric patients might further perpetuate the view that psychiatric patients are dangerous, especially if assaults by other types of patients are not required to be reported as a comparison. Other stakeholders strongly advocate for the need to have transparent and accessible data on psychiatric patients specifically, due to the nature of involuntary commitment and a need to have more oversight when individuals have their rights restricted, and the vulnerability of individuals with psychiatric conditions. This report does not attempt to reconcile these disparate views.

These concerns demonstrate the need to define a clear purpose for external data reporting. System-level questions remain about who is responsible for gathering, analyzing, and sharing data to inform systems change. Data collection should improve patient rights and outcomes and requires clear goals and processes.

Court Forms, Petitions and Processes

While not explicitly identified as a data element in HB 172, it became clear throughout stakeholder engagement that a lack of data on involuntary commitment processes impedes a robust understanding of system functioning.

The involuntary psychiatric commitment process begins with a community ex parte order or an MC-105 *Notice of Emergency Detention*. Hospitals scan the MC-105 form into the patient's electronic health record and use other internal systems to alert the healthcare team that an individual is under an involuntary hold. However, there is no statewide tracking of MC-105 forms or the individuals detained. Only one law enforcement agency out of the eleven agencies interviewed for this report indicated it would be able to run a report on the number of MC-105s initiated by their agency.

When the Courts grant a MC-100 petition, the DES/DET Coordinator provides data entry and administrative coordination for transportation and admission to a DET facility. There is currently no system for this position to provide any robust analysis or reporting. The Alaska Court System provides data in their annual report on the number of civil commitment petitions filed by judicial district, but it does not specify the total number of unique petitions and the number of unique individuals involved in the process. The lack of infrastructure and responsible entity for robust data tracking, analysis, and reporting of the involuntary commitment process makes identifying system needs and making improvements very challenging.

Patient and Staff Injuries

Facilities report documenting all known patient injuries into the electronic health record, and then to internal event/unusual occurrence software systems used by each facility. Reporting and analyzing trends from this data is internal to each facility except in specific circumstances. Any patient injury or death during or resulting from seclusion and restraint is immediately reported to Health Facilities Licensing. Facilities must also notify either Adult Protective Services or the Office of Children's Services of any patient-on-patient assaults or any disclosure of abuse, neglect, or harm occurring within or external to the facility. API reports on the rates of self-harm and patient falls during Governing Body meetings, which are open to the public.

Reporting and tracking of staff injuries often relies on staff to make initial report(s). Injuries are required reporting under the Occupational Safety and Health Administration (OSHA) and are reported to the U.S. Bureau of Labor Statistics. Some facilities noted that it is also the individual right and choice for staff to report workplace injuries to law enforcement.

Stakeholders expressed concerns regarding specific reporting on injury data for psychiatric patients. "Patient and staff injuries" represents a broad range of possible data points, spanning accidental falls to patient-on-patient assaults. To recommend changes in current reporting related to patient and staff injuries will require a clear definition of the goals, parameters, responsible entity, and process, for data collection and reporting.

Patient and Staff Grievances and Complaints

The number, type, and outcomes of grievances are tracked in internal quality improvement or risk management software and addressed by staff within those departments at health facilities. Grievances may be reported internally to track trends or progress toward internal facility goals for patient safety or satisfaction outcomes. Some facilities that are part of a larger healthcare systems report data through internal systems. Some patient grievances may be reported to the Alaska Ombudsman, Health Facilities Licensing, CMS or Accreditation bodies, depending on the grievance or level of escalation initiated by the patient. API reports the number of patient compliments and grievances at Governing Body meetings, which are open to the public. Patient grievances are typically well documented, but facilities report less rigorous tracking of staff complaints.

Stakeholders report concerns that looking at the number of grievances attributed to a specific facility or even across facilities might not be beneficial. For example, a high number of grievances may mean an accessible process, rather than poor care; conversely, few grievances may indicate a process that is inaccessible to patients. Again, the question of purpose and use of this data by an external entity was repeatedly raised as well as concerns about singling out psychiatric patients and providers for this information.

Seclusion, Restraint, and Crisis and Involuntary Medication Orders

Licensed and accredited healthcare facilities have robust documentation standards on traumatic experiences, however, documentation, tracking and analysis currently is kept internal to each facility or healthcare organization with limited exceptions. Data that is reported to State entities is not analyzed or reported publicly. Some stakeholders believe this hinders system-level accountability or advocacy to improve patient outcomes.

Documentation and reporting of the rate of seclusion and restraint is kept internal to the facility or healthcare system, except for three facilities in the state that report the hours of seclusion and restraint into the Centers for Medicare & Medicaid Services (CMS) Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. API also reports their rates of seclusion and restraint at Governing Body meetings, which are open to the public. Review of accrediting body definitions of seclusion and restraint identified some slight differences between accrediting organizations. As there is no definition of seclusion and restraint in Alaska Statute or regulation, different definitions could be a challenge to statewide data collection and reporting efforts.

It is unclear how frequently crisis medications are administered during a behavioral health crisis in any facility setting. The Alaska Court system tracks petitions for additional episodes of crisis medication and whether petitions are granted petitions but does not provide public reporting of these data. Facilities follow rigorous authorization and documentation standards, but do not have a method to track or monitor the rate of involuntary crisis medication administration. Facilities do not externally report any data on crisis medication administration.

The Alaska Court system tracks the number of petitions for involuntary medications and whether petitions are granted but does not provide public reporting of these data. Facilities document court-ordered medications in the patient's electronic health record, but do not externally report these occurrences.

Patient Outcomes and the Continuum of Care

There is no single entity with oversight responsibility or authority to gather various data elements to provide a timely, cohesive understanding of system needs. Individual facilities track readmission rates, but readmission rates are not tracked across facilities. Even analysis of data collected in other avenues, such as the Health Facility Data Reporting (HFDR), is challenged by a lack of uniform definitions for behavioral health or psychiatric patients.

Recommendations: Data Collection and Reporting

HB 172 requires identification of changes to current data collection and reporting processes for patient grievances and appeals, patient reports of harm and restraint, the resolution of these matters, and recommendations to make this information available to the public. The legislation further requests an identification of methods for collecting and making available to the Legislature and the public statistics identifying: the number, type and cause of patient and staff injuries; the number type and resolution of patient and staff complaints and the number, type and cause of traumatic events experienced by a patient (including administration of involuntary medication, use of seclusion and physical restraint).

Recommendations related to the topics specified in HB 172 and others raised during stakeholder engagement are detailed below and in the Supplemental Report – Appendix G.

Data Availability

- Create a coordinating entity to collect and review existing data and analyze and use data to inform systems change. Duties of the coordinating entity may include:
    - Collection and review of existing data;
    - Definition of parameters for future data collection (facility type, patient type, responsible entity, purpose);
    - Identification of new data points needed to track outcomes at the system and individual level; and,
    - Determining information that can/should be made publicly available and an appropriate method for publishing.

Court Forms, Petitions and Processes

- Create a system managed by the State of Alaska for receiving and tracking all MC-105s. Make data publicly available.
- Create a standing committee to create, review, and revise court forms.
- Track, by region, the wait times between when an MC-100 is approved, an MC-305 is granted, and when a bed becomes available or when a respondent's Order is dismissed. Regularly report data on wait times.
- Provide more detailed data and analysis of available Court System data:
    - Total number of MC-100 petitions:
        - Number approved, number denied
        - Number rescinded
        - Number of community ex partes filed and outcomes
        - Petitioner credentials for community ex partes
    - Track cases across the life of the case and by location:
        - Number of 72-hour holds by judicial court
        - Number of 72-hour holds that go on to 30- 90- and 180-day commitments
        - Total number of 30-, 90-, 180-day commitment
            - Number approved, number denied, number rescinded
            - Number by judicial court

Patient and Staff Injuries

- Work with State agencies to compile reports using existing data for a defined list of facility types:
    - Adult Protective Services and Office of Children's Services:
        - Patient-on-patient assault while at an inpatient psychiatric facility, designated facility or crisis center.

        - Disclosure of abuse, neglect or harm occurring within an inpatient psychiatric facility, designated facility, or crisis center.
    - Health Facilities Licensing (HFL):
        - Injury or death in seclusion and restraint at all facilities under HFL oversight.
- Explore use of OSHA establishment-specific and inspection data and U.S. Bureau of Labor and Statistics data to understand possible data pulls related to staff injuries.

Patient and Staff Grievances and Complaints

- Work with State agencies to compile reports using existing data for a defined list of facility types:
    - Alaska Ombudsman: Provide more detailed data on number, type, and resolution of patient complaints/grievances in annual report or more frequently upon request.
    - Health Facilities Licensing: Number, type and resolution of patient complaints/grievances originating within an inpatient psychiatric facility, designated facility, or crisis center.
- Develop and administer a standard survey of psychiatric patients who have been detained in a facility and/or received care at an evaluation or designated treatment facility to understand patient experience and identify issues related to patient rights. This survey should be administered by an external entity and not by the facilities providing care. The external entity would be responsible for data collection, analysis, and sharing back findings with facilities and the public.

Seclusion, Restraint, and Involuntary Medication

- Provide more detailed data and analysis of available Court System data by judicial district. Including:
    - Number of court orders for additional episodes of crisis medication and outcomes;
    - Number of involuntary medication petitions and outcomes; and,
    - Proportion of involuntary medication petitions compared to number of involuntarily committed individuals (by petitioning facility).
- Explore use of Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Measures as an existing data source for seclusion and restraint data reporting. Explore why only certain facilities report into the program. Identify and address barriers to standardization of use by all inpatient facilities.

Patient Outcomes and the Continuum of Care

- Track readmission rates to inpatient psychiatric hospitals, designated facilities, crisis stabilization and residential centers across facility types.
- Institute a suicide death notification and review system to identify and track deaths following care.

Conclusion

This report was informed by significant stakeholder engagement which provided a wide range of observations, experiences, and beliefs about the factors that influence psychiatric patient rights in Alaska. The recommendations included in this report provide appropriate next steps to align legal requirements, data, and practice to ensure protection of psychiatric patient rights.