HB 172 Public Comments and Response

Name	Date	Comment	Response
Faith Myers	9/18/23	House Bill 172 was signed into law July 15, 2022. State law CH 41 SLA 2022 came about because of a successful lawsuit by the Disability Law Center and others. State agencies unsuccessfully argued in court that the state had a right to hold psychiatric patients in jail while waiting for a bed to open in a psychiatric facility. House Bill 172 had a requirement that a report must be sent to the Legislature in October outlining ways to improve psychiatric patient rights, care and outcomes. The Department of Health and the Department of Family and Community Services are the first two organizations listed as authors of the report along with the Mental Health Trust Authority. The 47-page draft report is now available on the state website http://notice.alaska.gov/212567 for public review and comment. In my opinion, the report that will be sent to the Legislature in October by the Department of Health and others will be incomplete because there was no larger conversation with psychiatric patients or an attempt to gain necessary statistics—number of people that rotate in and out of locked psychiatric facilities or units each year; number and type of patient complaints and injuries; and are the patients and advocates satisfied with the current grievance and appeal process. Without that information being added to the report, it will be difficult for the Legislature to reach any conclusion on needed improvements in psychiatric patient rights. The report to the Legislature leaves the reader to believe that any person locked in a psychiatric facility or unit is protected by the psychiatric patient grievance law AS47.30.847. According to state agencies, the law only applies to five facilities. Less than half of the people locked in psychiatric facilities or units are protected by a state grievance law. Federal laws and hospital certification regulations do little or nothing to protect psychiatric patients in the grievance or appeal process. Alaska is one of the few states that has not written a state grievance law to protect all psychiatric patients in locked facilities or units. Many of the worst examples of psychiatric patient rights and care in the 1880's was adopted by the Alaska Legislature starting in the 1980's. The psychiatric patient grievance law AS47.30.847 states that managers of psychiatric facilities write the patient grievance and appeal process. The Department of Family and Community Services has stated that the managers of psychiatric facilities will act as the impartial body to rule on a patient's complaint. At the Alaska Psychiatric Institute, the CEO is designated the impartial body! And, as of now, psychiatric patients have never explicitly been given the right by state law or regulation to file a grievance at the time of their choosing. Between 1981 and 1984, eleven rights were given to people locked in psychiatric facilities, state law AS47.30.840. There is no enforcement mechanism in the law. And there is no independent oversight that advises managers of facilities if they are correctly following the law and if patients are well-treated. As of now, locked psychiatric facilities or units that detain people for evaluation or treatment operate with many of the powers and duties of the state, with insufficient state oversight and standards of patient care.	*Thank you for your comments and participation in the process.* *The Legislature required that the process used to develop this report include patients with lived experience. The team conducted interviews with people with lived experience, participated in site visits to provide opportunities for individual interviews and listening sessions, created a survey for statewide distribution, and held in-person and virtual listening sessions and one-on-one interviews in Bethel, Fairbanks, Ketchikan, Juneau, Mat-Su, Anchorage, and Chevak, to capture the voices of individuals who wished to share their experiences.* *While not specifically otherwise identified, multiple stakeholders during other interviews, subcommittees and the Advisory Team also identified dual experience as individuals or family members of loved ones with psychiatric care experiences. The final report has been updated to feature more detailed information about this stakeholder engagement process.* *Alaska Statute 47.30.847 provides for patient grievance protections to crisis centers as well as those who are at the Alaska Psychiatric Institute or at those specially designated hospitals that may receive involuntarily civilly committed patients.* *The Grievance Requirement matrix included in the Psychiatric Patient Rights Legal Framework section of the report, starting on page 27, has been updated in the final report to include AS 47.30.709, which applies the grievance rights of AS 47.30.847 to respondents held at crisis stabilization centers or detained at crisis residential centers.* *The Recommendations section [starting page 43] of this report suggests changes to grievance related laws, including a recommendation to enact a psychiatric patient care Ombudsman's office in statute and a recommendation that the legislature define the term "impartial body"(AS 47.30.847). The final version of the report has also been updated to include a recommendation to amend AS 47.30.709 to clarify that the grievance protections apply to patients regardless of voluntary/involuntary status.* *Other authorities, primarily federal, require hospitals to have patient grievance procedures for all types of patients, and this includes behavioral health patients. A Summary of Required Data Elements table*

		Managers of psychiatric facilities have always wanted to keep secret what happens to patients within the walls of the institutions. Over a hundred years ago, Dr. Dent testified to a New York grand jury that he had no means by which to tell if the psychiatric nurses were cruel to the patients. Today, every psychiatric facility or unit is required by regulations to keep statistics of the number and type of psychiatric patient complaints, injuries and what could be classified as traumatic events. In the report to the Legislature, providers of psychiatric patient care bristle at the idea of sharing statistics with the Legislature and the general public. To me it is vital to producing good psychiatric patient policies for the Legislature and the general public to have those statistics. It has been my experience that psychiatric patients locked in facilities or units are mistreated in the grievance and appeal process because of the antiquated state patient grievance law AS47.30.847. Over the last 15 years there has been two attempts in the Legislature to improve the grievance rights for psychiatric patients. To my knowledge, every provider of psychiatric patient care testified against legislatively improving the grievance and appeal rights for people locked in facilities. And that included the Department of Health and Social Services. I estimate there are 10,000 people that rotate in and out of locked psychiatric facilities or units every year. The level of disability of acute care psychiatric patients is underestimated by the Legislature and the general public. Some patients have a developmental or intellectual disability along with a mental illness. In 2024, the Legislature must provide more independent assistance and protections for people locked in psychiatric facilities or units. Faith J. Myers has spent over 7 months locked in psychiatric facilities in Alaska. She is a co-author of a White paper that addresses the requirements of the HB172 report, including what has succeeded in mental health care worldwide. The document can be viewed at https://psychrights.org/whitepaper.pdf	*[page 16 of report] summarizes federal and state data requirements related to grievance tracking. Current laws require confidentiality of certain patient information; none require aggregate reporting of patient data.* *In the Recommendations: Data Collection and Reporting section [page 48] the report points out these areas for legislative consideration and suggests possible improvements.*
Dave Branding, JAMHI Health & Wellness	9/19/23	Thanks for the report! We especially appreciate Figure 4 that shows the envisioned system of supports that will enable individuals with psychiatric conditions to live full lives in their communities of choice. JAMHI Health & Wellness reviewed and discussed the figure at a supervisor team meeting and would like to suggest that in addition to 'Food' as a basic need, the figure further specify 'Nutritious Food' as well as add 'Physical Movement and Activity' as these are critical elements of preventative basic needs. Thanks for the opportunity to provide input and thanks for all you do. -DB	*Thank you for your suggestions. We have incorporated these additions into the final report.*
Smkubitz	9/21/23	Hi, what data supports needing more Psychiatric Facilities in Alaska? How will this be funded? Why are we using COVID money to fund this project? Why isn't all Psychiatric facility participating in Appendix B, Stakeholder Engagement? ex? Chris Kyle Patriots Hospital - Alaska Department of Health and …	*Thank you for your comments. This report was not funded through any Covid-related funds or grants. The Alaska Mental Health Trust Authority provided funding and contract support for the development of the report.*

		WEB Facility Details. Level of Care: Acute Inpatient Psychiatric Hospital. Age Range: 18+. Gender: Male & Female. Beds: 18. Length of Stay: Average 30 Days. Address: 1650 Bragaw St, … Emergency rooms are open for all types of patients, maybe advocate and look more at staffing and resources at this entry point. I was told at our Staff meeting we were using COVID money to support this and I did not understand then why we were. Thank you for this opportunity to Voice my opinion.	*The report required visits to all DES/DET facilities and at least one facility visit to each of the following regions: Southcentral, Southeast, Far North, Interior and Southwest. Facilities were asked to participate based on their region and general population served. Chris Kyle Patriots Hospital currently does not admit involuntary patient, but the consultant team did meet with North Star Behavioral Health, which owns Chris Kyle Patriots Hospital, as part of the stakeholder interview process.* *We recognize that emergency rooms often encounter people with behavioral health crises; however, staffing levels at emergency rooms are governed by federal and state laws and regulations, and are beyond the scope of this report.* *However, there is widespread community support for expanding the behavioral health continuum – this includes inpatient facilities as well as other kinds of behavioral health services. It is expected that increased availability of lower-intensity behavioral health services would decrease the pressure experienced by emergency rooms.* *We encourage all Alaskans, including behavioral health providers, to stay involved as the Legislature considers this report.*
Fairbanks, AK, US Anonymous User	9/28/23	Thank you for the opportunity to provide comments. I cannot stress enough how badly this is needed. There are so few mental health services available in Alaska, especially those that are emergency related. Oftentimes family members and caregivers only have the police departments to rely on for support, which can and does end in criminal charges and jail time. What the Alaska community needs is assistance in caring for our loved ones experiencing mental illness – not arresting them and setting them up for a lifetime of being in and out of the prison system and/or a lifetime of living on the streets because they are unable to find a place that will rent to them. The past and current system was not created to care for people experiencing mental illness. People experiencing mental illness are scared and need help. I petitioned for my adult daughter to receive a psychiatric evaluation and it was denied because of her drug abuse. But the drug abuse is a symptom of her illness. The screener at the court even recommended giving my daughter an eviction notice. This was the only option that was communicated to us. As an Alaska Native person, this is not how we care for our loved ones. There must be so many families across our state that are experiencing these same problems. The system must be fixed. Quyanaa.	*Thank you for providing comment. We hope to improve behavioral health care in Alaska and have included additional discussion of the continuum of care in the Supplement to the report.*
Senator Löki Gale Tobin	10/5/23	I appreciate the opportunity to provide this public comment regarding the report on psychiatric patient rights as required by HB 172 to be submitted to the Alaska State Legislature later this month. I appreciate the work of the stakeholder group assembled to meet the requirements of the HB 172 report, which is in response to numerous concerns raised on the record in the House Judiciary Committee regarding the grievance resolution process for psychiatric	*Thank you for your comments.* *The final report has been amended to include the exact legislative text in the Introduction section for clarity. Additionally, each of the four sections responsive to HB 172 now include the relevant legislative text at the beginning of each section.*

		patients in Alaska. The complexity of issues, including an overlapping system of state and federal laws and institution rules regarding psychiatric care, combined with a burdened system of care in Alaska makes the time-frame for this report challenging. In passing the report requirement in HB 172, the Legislature sought to identify deficiencies in the current system that can be rectified through future statutory changes. Unfortunately, the report fails to provide a thorough assessment of existing guidance and how the guidance impacts patient outcomes. Instead, the report largely functions to summarize laws, regulations, and rules. Before the report is submitted to the Legislature, I respectfully request the report be restructured to highlight, in detail, all of the working group assessments and recommendations and the rationale for them at the beginning of the report. The bulk of the report - pages 10 through 34 - serves the important function of summarizing existing guidance and practice. It does not meet the requirements set forth by the Legislature to provide "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." To provide greater guidance to the Legislature, I request the working group revisit this section and comment on the "adequacy" of the system. This will require input from a much larger group of individuals who have been through the system and have lived experience. A significant amount of attention in the Legislature has been paid to the subject of the grievance process. As noted in the HB 172 report supplemental material, three separate bills have been introduced since 2009 to create a uniform statewide grievance process. A uniform grievance proposal was reviewed by the Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse in 2018. Early debate on HB 172 focused on a uniform statewide grievance process, and the report requirement was adopted as a way to clarify issues around a potential statewide grievance process. Specifically the report requires "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." The fact that this issue continues to arise before the Legislature warrants much greater attention in the report. Pages 38 and 39 of the report begin to explore and discuss the differences in opinion among working group members on the adequacy of the grievance process, but concludes that that the report "does not attempt to resolve the discrepancy." Attempting to resolve the discrepancy is exactly what HB 172 requires. Please provide greater detail in the report and a suite of policy options considered by the working group. This information will help inform future legislation over this ongoing issue and provide the needed and necessary guidance for Legislators. There is discrepancy between the report and the "Legal Recommendations" section on page 43 of the supplemental material. A super majority of the group members surveyed answered in the affirmative to the question of whether there "should be a standardized,	*The Recommendations section of the Executive Summary has also been revised to more clearly itemize recommendations for change to statute, policy, and systems. There is also now a specific recommendation for a comprehensive update of the civil commitment structure.* *In structuring this report, the drafters prioritized fulfilling the specific legislative requests enumerated in Section 36 of the report. During the process of stakeholder engagement, including the subcommittees and working groups, significant input was received regarding the larger system of behavioral health care in Alaska. Although much of this discussion expands upon the scope of the HB 172 report requirements, it represents important considerations for the state.* *The drafters chose to take an inclusive approach to reporting this information by recording and reporting all recommendations, even those that were potentially out of scope or did not reach a consensus.* *Recommendations contained in Appendix F of the supplement to the report reflect this stakeholder input. Some of these recommendations are also included in the main body of the report (for example, the recommendation to define "impartial body" under AS 47.30.847 is included in multiple places: it is the first recommendation in Appendix F, System Recommendations; it is the second recommendation in Appendix F, Legal Recommendations; and it is included as a specific recommendation on page 44 of the main report.* *In response to public comment, the Executive Summary Recommendations section has been updated to specifically highlight recommendations related to the grievance process.*

		state-wide grievance and appeal process applicable to all evaluation and designation facilities, Crisis Respite, Crisis Stabilization and Crisis Residential Centers that provide individuals an effective and meaningful grievance and appeal process." It would be useful to move all of Appendix F of the supplemental material into the main body of the report, and to highlight those recommendations identified to have majority support among respondents, and to dig deeper into those areas. It is important that this report lay out clear guidelines for how the Legislature can improve psychiatric patient outcomes in Alaska, and this can only be fully accomplished with greater input from those who have been in the system. There are currently pieces of legislation in the 33rd legislature that seek to expand the involuntary commitment law. If enacted this will have the impact of increasing the population at psychiatric facilities in Alaska. We must ensure that our psychiatric care in Alaska is accountable, humane, and effective. Please consider modifying the HB 172 report for greater clarity, guidance and lived experience input as the Legislature continues to wrestle with how to create a better system for those in need.	
Stephanie Rhoades	10/5/23	This report reviewed many highly technical legal and other mechanisms that affect Alaskans committed for mental health evaluation and treatment. It well outlined the process but not the horrific personal experience for people with mental illness who experience these commitments. The report was clearly not informed by sufficient patient stakeholder engagement. I can attest that I personally identified an individual who cycles regularly for commitment for evaluation and treatment, as she is a highly suicidal. She was in fact stood up for her interview and not rescheduled for interview for his report. The system assessment and recommendations the report relates do not do justice to the perspective of the mental committee, their family, and friends. There are outrageous and shocking deprivations of due process accorded to a personal with mental illness committed for evaluation and treatment. The report does not adequately call out the obvious problems that contribute to this: the systematic underfunding of Alaska's behavioral health system, from API down. The report also never identifies or considers the deprivation of rights and disrespect of those committees who languish in the Emergency Room hospital 'holding' system, awaiting a room at the API Inn. For those who have not personally experienced this, at least in Anchorage, it usually amounts to this: First, the person with mental illness who is a danger to self or others will be detained either by police or they may be hospitalized. Next, a mental health clinician will petition the Alaska Court System. It will in turn hold a hearing with no one present, conducted by a single judicial officer who is generally in a hurry. If a parent, family member or close associate of the person with mental illness wants to learn when this hearing will be held and, God-forbid, give testimony – they are unable to do so. There is no place on the Alaska Court System website that offers a contact	*Thank you for sharing your perspective on the individual impacts of psychiatric emergency care. As you recognized, this report is inherently technical and legal in nature, but the impact of these structures are very real to the individuals in need of psychiatric services.* *The Legislature required that the process used to develop this report include patients with lived experience. The team conducted interviews with people with lived experience, participated in site visits to provide opportunities for individual interviews and listening sessions, created a survey for statewide distribution, and held in-person and virtual listening sessions and one-on-one interviews in Bethel, Fairbanks, Ketchikan, Juneau, Mat-Su, Anchorage, and Chevak, to capture the voices of individuals who wished to share their experiences.* *While not specifically otherwise identified, multiple stakeholders during other interviews, subcommittees and the Advisory Team also identified dual experience as individuals or family members of loved ones with psychiatric care experiences. The final report has been updated to feature more detailed information about this stakeholder engagement process.* *We are sorry someone who volunteered to participate in an interview did not get to participate; we are unsure how this error happened.* ----

		for mental commitment petitions. This is because they are 'confidential' to protect the person with mental illness. It should be noted that these 'confidentiality' rights tend to concertedly work against the individual by excluding them and their family or those close to them from participation in a hearing that fully deprives them of their liberty. The individual, their family and friends often know far more about the individual's situation than the clinician who brings the petition and has used a 'checklist' to gather the evidence of imminent harm to self or others. The individual, their family and friends have no opportunity to be heard by the court about the issues involving commitment, or the least restrictive setting for obtaining evaluation and treatment in their own community. These voices are never heard at the detainment stage. Once an ex parte commitment for evaluation and treatment is issued, the law allows a 72 hour in duration order for evaluation and treatment which should be conducted at API or a DET. Regardless of that, the mental health committee will sit in an Emergency Room for many days where they become the pariah of that hospital because they can't be evaluated or treated there and they are demonstrably either an imminent danger to themselves or others. The mental health committee becomes an immediate burden on the core functions of an ER. They are confined to their beds in small, curtained areas or secure rooms. After the 72-hour period expires, it will not matter. The mental health committee will remain in the hospital holding pen until a bed at API opens. The Alaska Court System has no process for holding API to account for its Order. There are no community legal advocates who have maintained any pressure on the state or the court to enforce these orders either. As for the mental health committees, different rules of detainment will apply to them, depending on what hospital they are in. They will wait there for many days without their phone, in a paper gown, without access to anything of their own. There are few means offered for them to keep their mind off what is essentially incarceration without treatment. Friends and family members who try to contact a mental health committee in the hospital are put to an inquisition concerning their relationship and why they want to talk to the committee. Only those who can identify themselves as family or a person 'authorized' by say, the mental health committee's Guardian, will be allowed telephone contact. Telephone contact is not allowed if the staff is too busy to either answer the phone or to physically retrieve the mental health committee to take the call. When calls are put through, all telephone calls for the mental health committee are conducted in the hospital hallway, without privacy and with pressure to make the call short. Mental health commitees are treated better at ANMC. They are provided hospital food and a 'watcher' who assures their safety and tries to interact and be a support person.	*The Alaska State Constitution, and other laws and regulations, protect the privacy and confidentiality rights of individuals subject to involuntary commitment proceedings.* *There is a screening investigation for community ex partes, and a requirement for courts to interview respondents when reasonably possible (Matter of Paige M, 433 P.3d 1182 Alaska 2019).* *---* *The report focuses on patient rights within hospital, inpatient, and protective custody settings pending admission to a DET. Emergency detention is one of the areas identified as a patient rights concern in the Recommendations section of the main report.* *The time period between an initial hold and arrival at an evaluation facility is highlighted in multiple sections, with various recommendations for resolution. Stakeholders did not agree on a clear solution, leading to the main report recommendation to "align statutory language, court forms, and provider practices related to emergency detention."* *The final version of the report specifically recommends a comprehensive review and potential revision of the civil commitment structure in Alaska Statute.*

		Those detained at Regional are detained in a single room without a bathroom, with blaring fluorescent lighting that is never turned off. They are watched by contracted security staff who sit outside the room. They order food in from local restaurants. During my visits to commitees at Regional, I overhead the contracted security staff loudly talking about many of the commitees they were charged with and making fun of their behaviors, all well within earshot of the person I was visiting. I have seen situations also, more in the past that currently, where Anchorage-based comittees were shipped to Juneau to receive evaluation and treatment rather than waiting in Anchorage for a bed at API. Both places are hectic emergency settings, they are loud, bright, and not private. They are entirely anti-therapeutic and traumatic to those experiencing a mental health crisis. The recommendations in this report purport to provide next steps to align legal requirements, data, and practice to ensure protection of psychiatric patient rights. The sad truth is that regardless of how much legal alignment might occur in the future, how much data is collected – much of which is already damning, the process is fundamentally broken. This report failed to really convey in painful detail, from the perspective of patients, their family and friends, the sheer horror of hospital Emergency Room detainment of indefinite periods for human beings that a court of law has ordered to be evaluated and treated within 72 hours. That is the fact that should militate the immediate interest of the courts, the legislature and involved policy makers in bringing change to this system. Let us hope that House Bill (HB) 172 will increase access to behavioral health crisis services in less restrictive settings. The current settings are nearly as restrictive as jail, which I might add is still a reality for some mental health commitees located in very rural locations without immediate travel access to a hospital or behavioral health venue authorized to hold them.	
James B. (Jim) Gottstein, Esq	10/6/23	With very few exceptions, primarily related to grievances, The Draft HB172 Report fails utterly to comply with the requirements of Section 36, CH 41 SLA 2022. The Draft Report does not comply with the requirement contained in Section 36 that "the Report must . . . (2) identify and recommend any additional changes to state statutes, regulations, or other requirements that could improve patient outcomes and enhance patient rights, including items that could be added to AS 47.30.825, particularly involving involuntary admissions, involuntary medications, and the practical ability of patients to avail themselves of their rights". In contrast, the White Paper on Improving Patient Outcomes, Addressing Treatment Caused Trauma & Injuries, Enhancing Patient Rights, and Grievance Procedures for the Report Required by § 36 of CH 41 SLA 2022 (HB172), hereinafter referred to as the "White Paper,"	*Thank you for your participation in the stakeholder process and as a subcommittee member, and for your comments.* *The White Paper and associated recommendations were shared and extensively discussed in the stakeholder and subcommittee engagement period. Although the White Paper was not adopted in its entirety, over 25 of the recommendations were included in the report and supplement to the report.* *The final version of the report specifically recommends a comprehensive review and potential revision of the civil commitment structure in Alaska Statute.*

		does all of the things required in §36(2). It documents that Alaska's current coercive mental health system is massively harmful and counterproductive and identifies statutory and programmatic changes that should be adopted. The White Paper was provided to the Project Management Team, the Contract Team, the Advisory Team, and the Legal Subcommittee Team in April. In spite of my repeated urging--even pleading--none of the Teams addressed these issues. Except for the adequacy of representation disputed by the attorney for the State, the information presented in the White Paper was never even disputed and let alone rebutted. The Draft Report is a white wash. The Draft Report should be withdrawn and re-written to identify and recommend any changes to state statutes, regulations, or other requirements that could improve patient outcomes and enhance patient rights, including items that could be added to AS 47.30.825, particularly involving involuntary admissions, involuntary medications, and the practical ability of patients to avail themselves of their rights, with the White Paper serving as the guide to the re-writing.	
Mark Regan, Disability Law Center	10/6/23	Disability Law Center was among the organizations named in HB 172 to be part of the diverse stakeholder group the State and the Trust were to convene. Thank you very much for the opportunity to comment on the draft report. Because the focus of the HB 172 report is on patient rights within psychiatric facilities, it may not be necessary for the report to include anything about patients' involuntary moves from the community into short-term evaluation and treatment; but if the report is going to discuss those issues, Disability Law Center respectfully suggests that it analyze them along the following lines. We append some observations on problems with the HB 172 report-production process. * * * Alaska law provides a slightly indirect process for evaluating whether people should be deprived of their liberties through civil commitment, and until passage of HB 172 itself the law itself has not been explicit about requiring people to receive involuntary short-term treatment, even though much involuntary short-term treatment has been required for many years under the label of ex parte holds for civil commitment evaluation. First, a short statutory history; second, observations about how civil commitment evaluations have actually been done; third, some thoughts about improvements that might be made both in the evaluation system and in the Crisis Now statutes. Statutory history Alaska enacted a major revision of its civil commitment statutes in 1981. [ch 84 SLA 1981.] Commitment criteria were (and are): is it likely that someone will cause serious harm to himself or herself or to others, or is the person gravely disabled, basically being unable to care for himself or herself? [E.g., AS 47.30.700(a).] Any adult could provide concerns to a magistrate, who would set up a screening investigation and then, if the investigation indicated that the person should be evaluated, issue a pickup order. [AS 47.30.700(a).]	*Thank you for your participation in the stakeholder and subcommittee process and for your comments. These comments will be published and included in Public Comment appendix to the final report.* *In HB 172, the legislature directed that a report be written addressing "psychiatric patient rights," a highly technical and complex topic. While it was challenging to accomplish in a short time frame, participants strived to answer the direct questions in Section 36 while still providing an overview of the larger discussions and concerns relating to behavioral health in Alaska.* *Evaluation and treatment settings were included in the analysis and recommendations relating to psychiatric patient rights. The final report has been amended to explicitly include the statutes enacted under HB 172 which relate to patient rights in crisis stabilization and crisis residential centers.* *In order to ensure that a responsive report was produced timely, the scope of this effort focused on the current landscape of patient rights and was not enlarged to provide a full history of psychiatric care in Alaska. Your comments with historical context are appreciated.* --- *HB 172 defines the process for holds at crisis residential centers, including who may file for further proceedings.* *When a respondent is admitted to a crisis stabilization center, the respondent must be examined by a mental health professional within 3*

		Under that order, a peace officer was to take the person to an evaluation facility, or, if no evaluation facility was available, evaluation personnel were to conduct the evaluation where the person was. [AS 47.30.700(a), see, e.g., AS 47.30.720.] In an emergency where the person's welfare or public safety would be imperiled if there was a delay, a peace officer or medical professional could order the person to be taken directly to an evaluation facility, without prior judicial involvement [AS 47.30.705.] At the evaluation facility, or under the supervision of evaluation personnel, there would be a quick examination, and after the person arrived at the facility, a 72-hour clock would start running for a more detailed civil commitment evaluation to be conducted. [AS 47.30.715. For the clock not starting to run on the person's being taken into custody, see Matter of Gabriel C., 324 P.3d 825 (Alaska 2014).] A report would go to the court, which would appoint counsel, and the person would get a notice of rights. [E.g., AS 47.30.700(a).] The person would get some immediate treatment. If in the judgment of the facility, the person did not meet or no longer met civil commitment criteria, the facility would release the person [AS 47.30.720]; if the system concluded that the person met criteria and needed further treatment, someone would file a 30-day civil commitment petition and the court would hold a hearing. [AS 47.30.725, .730.] There was no such thing as a petition for short-term treatment. The system anticipated that delays before someone received an evaluation would be caused by delays in transporting the person to an evaluation facility, and imposed some limits on where a minor respondent could be held awaiting transportation: no jails. [AS 47.30.705(a).] Otherwise, the law assumed the person would immediately be evaluated. [E.g., Matter of Gabriel C., 324 P.3d 825 (Alaska 2014); Matter of Mabel B., 485 P.3d 1018 (Alaska 2021); Matter of Abigail B., 520 P.3d 440 (Alaska 2023).] "Evaluation facilities" were fairly broadly defined, [former AS 47.30.915(5)], and included most hospitals. However, in practice, civil commitment evaluations only happened at facilities which DHSS had designated as evaluation and treatment facilities, starting with API, and including Fairbanks Memorial and Bartlett Regional, and maybe a very small number of other hospitals, such as Ketchikan PeaceHealth. Recent statutory modifications have redefined evaluation facilities to restrict them to essentially the facilities that have been designated to do evaluations, now including Mat-Su, but not including the rural hub hospitals that had qualified as evaluation facilities under the 1981 law. [AS 47.30.915(9).] Recent statutory changes have put the "Crisis Now" model into state law. Realizing that some people need treatment that includes involuntary short-term treatment, the Legislature passed SB 120 (2020) and then HB 172 (2022), which allow people to be taken into custody and placed at 24-hour crisis stabilization centers and up-to-7-days crisis residential centers. [AS 47.30.700-.709.] The same statutory civil commitment criteria apply. The person gets the same notice of rights and appointment of counsel. Within 72 hours of the person's arrival, there should be a hearing on 30-day civil commitment or on continued involuntary treatment at the crisis residential center for the rest of the 7-day	*hours and may not be held for longer than 23 hours and 59 minutes. If the professional person in charge finds probable cause, a mental health professional* may *submit an ex parte application. If court ordered, the respondent will be delivered to a crisis residential center. Section 16, AS 47.30.707.* *Once the respondent arrives at the crisis residential center, the respondent must be examined and evaluated by a mental health professional within 3 hours. If filed, both a petition for a seven-day detention at a crisis residential center or a petition for a 30-day commitment must be signed by two mental health professionals, one of whom is a physician. AS 47.30.708.* *This process is represented in Figure 6 in the Supplement along with an extensive discussion of the ex part and civil commitment process.* *----* *The Grievance Requirement matrix included in the Psychiatric Patient Rights Legal Framework section of the report [on page 27] has been updated in the final report to include AS 47.30.709, which applies the grievance rights of AS 47.30.847 to respondents held at crisis stabilization centers or detained at crisis residential centers.* *The final version of the report has also been updated to include a recommendation that AS 47.30.847 be amended to apply to all patients regardless of voluntary/involuntary status.* *---* *The final version of the report specifically recommends a comprehensive review and potential revision of the civil commitment structure in Alaska Statute.*

		period. How commitment to a Crisis Now facility overlaps with commitment for evaluation is, as a statutory question, not completely clear. It's conceivable that a person could spend up to a week in a Crisis Now facility and then be transferred over to a designated evaluation facility for 72-hour civil commitment evaluation; the statute also provides for a 30-day commitment to be initiated within 72 hours of the person's arrival at the crisis center. Also, the statutory definitions of subacute mental health facilities, including crisis stabilization centers and crisis residential centers, do not provide much detail on what a subacute mental health facility is meant to do: treat, on a short-term, intensive, and recovery-oriented basis, and without the use of hospitalization, individuals experiencing an acute behavioral health crisis. [AS 47.32.900(20).] How measurable any of this is, and how officials are to regulate it, is not clear. Involuntary medication of respondents at evaluation facilities and Crisis Now centers is governed by ordinary treatment facility standards. [See AS 47.30.838 (applying to evaluation facilities); for Crisis Now facilities, AS 47.30.709(d) cross references .838. There is a special authorization/prohibition for evaluation facilities in AS 47.30.725(e) when a 30-day commitment petition is being filed.] From the standpoint of patient rights, another unclear question is whether the patient grievance procedure statute applies to crisis stabilization centers and crisis residential centers. It does not do this by its terms – which apply only to evaluation facilities and designated treatment facilities, [AS 47.30.847], -- but it may do this by a cross-reference in the patient rights at crisis centers statute. [AS 47.30.709(b).] The burden of proof for taking someone into custody is probable cause. [AS 47.30.700 and .705.] The burden of proof for a 30-day civil commitment is clear and convincing evidence. [AS 47.30.735(c).] Minors may be held at evaluation facilities, crisis stabilization centers, and crisis residential centers, with notice to parents or guardians. [AS 47.30.705(c) and (d); cross reference, AS 47.30.709(b)(2).] Stresses on the system When the 1981 Legislature passed its civil commitment statute, it anticipated that there might eventually be more than 20 facilities in the State that could conduct 72-hour civil commitment evaluations, but that hasn't happened. There has not been a significant practice of using traveling evaluation personnel, either. The place which has conducted by far the most civil commitment evaluations over the years has been API, followed by the hospitals in Fairbanks and Juneau, and now in the Mat-Su. Those are the four places now designated to provide medium- and longer-term treatment. In practice, the system appears to prefer that when someone is to be evaluated somewhere, there be a bed at	

		that hospital that might be able to provide medium and longer-term treatment if someone does file a 30-day petition. In practice, most pickup orders are on the initiative of peace officers and health facilities; few follow from magistrate-conducted screening investigations. All of which has become somewhat more complicated over time. API was larger in 1982 than it is now. It now has an 80-bed capacity, with 10 beds earmarked for competency restoration – which has serious problems of its own, but can't be discussed here. (Other API capacity issues, also not to be discussed here, have to do with patients who are subject to recurring civil commitments because they are dangerous to self or others but have been found incompetent to stand trial but who are no longer in competency restoration proceedings; patients under long-term civil commitment whose primary diagnosis is a developmental disability and whose conditions remain roughly the same over time; and patients who are minor children, where API's Chilkat Unit has closed and then reopened.) In the early 2010s, there were times when API turned people away when they had been taken into custody and held at a hospital awaiting transportation, which was available as transportation but did not take place because API did not have an evaluation bed. When a man held at Central Peninsula Hospital sued for invalidation of the orders against him, the Alaska Supreme Court held in the Gabriel C. case that the 72-hour clock did not start running until the man finally arrived at API for evaluation, but that the statutes did not anticipate a prolonged hold outside an evaluation facility because evaluation facilities were at capacity, and DHSS and the Court System had responsibilities to get a person into evaluation and monitor his or her condition. [Matter of Gabriel C., 324 P.3d 835 (Alaska 2014).] API's struggles to remain at its 70 civil bed capacity became more difficult in the late 2010s, leading to litigation, a settlement, and a slow and not entirely steady return at API to its prior capacity. The best explanation is probably in the recitals to which the State agreed during the settlement: In the fall of 2018, the civil commitment system in Alaska was approaching a crisis. The Alaska Psychiatric Institute ("API") had a capacity of close to seventy patients (sixty civil, ten forensic). Seventy-two-hour evaluations (see AS 47.30.725(b)), were being done at API, as well as at three Designated Evaluation and Stabilization ("DES") facilities: Fairbanks Memorial Hospital in Fairbanks, Alaska, Bartlett Regional Hospital in Juneau, Alaska, and Ketchikan PeaceHealth in Ketchikan, Alaska. Treatment for 30-day commitment periods was being provided at API as well as at two Designated Evaluation and Treatment ("DET") facilities: Fairbanks Memorial Hospital and Bartlett Regional Hospital. Respondents were being transported and admitted to API and other DES/DET facilities promptly. API had, however, come under significant regulatory scrutiny due to high rates of patient seclusion and restraint, high rates of patient and staff	

		injury, and it was in serious jeopardy of being forced to close. In response, API implemented a capacity policy of only accepting as many patients as it could safely care for. This new policy affected respondents who had been picked up in the community pursuant to ex parte evaluation orders, as well as respondents who were due for release from correctional facilities but who had been held there pursuant to emergency detention (see AS 47.30.705) and a petition for evaluation (see AS 47.30.700). Both groups of respondents experienced longer wait times for admission to API, and some respondents who had been picked up in the community were brought to correctional facilities because they could not be admitted directly to API, and no hospital would admit them. In addition, respondents at health care facilities who were being held pursuant to emergency detention also began waiting longer before admission to API. For the reasons noted above, in the fall of 2018 the Alaska Department of Health and Social Services ("DHSS") reduced API's bed capacity causing respondents who normally would have been admitted to API for evaluation and treatment to wait in hospital emergency rooms, Department of Corrections ("DOC") facilities, and other correctional facilities for space to become available at API. That change prompted DLC to file this lawsuit. DLC and the Does petitioners raised constitutional and statutory claims, asserting (i) that failing to provide timely evaluation and treatment violates the civil commitment statutes as interpreted by the Alaska Supreme Court in Gabriel C.; and (ii) that holding people in the punitive setting of jails and correctional facilities awaiting evaluation is unconstitutional. DLC's complaint also alleged violation of AS 47.30.660; AS 47.30.760, which provides that "[t]reatment shall always be available at a state-operated hospital"; 42 C.F.R. 489.24(f); the Americans with Disabilities Act; the Rehabilitation Act; and the Alaska Human Rights Act. In Matter of Gabriel C., the Alaska Supreme Court anticipated situations when API might be at capacity and closed to people needing 72-hour evaluations. The Court observed that two civil commitment statutes evidence a legislative intent that respondents who are subject to an emergency ex parte order be "transported immediately to the nearest evaluation facility so that the 72-hour evaluation period can begin without delay." It concluded that "it is clear to us that the legislature did not intend to authorize these evaluations to be delayed simply because the nearest designated evaluation facility is filled to capacity." The Court then authorized judicial officers "to expedite an evaluation if the respondent cannot be transported to the initially designated facility without delay." In an Order dated October 21, 2019, the Court found that defendant DHSS had failed to fulfill its obligations to provide timely evaluations and treatment to respondents subject to civil commitment orders as required by AS 47.30.700-.725, and to fulfill its obligation to transport respondents "immediately to the nearest evaluation facility so that the 72-hour evaluation period can begin without delay," as required by Gabriel C. The Court also found that the result of this failure—respondents waiting in emergency rooms and correctional	

		facilities—caused ongoing irreparable harm to respondents in need of statutorily required evaluations and treatment. Further, the Court found that DHSS' actions and inactions violated the due process rights of respondents held in the punitive conditions of correctional facilities. The parties recognize and agree that the Court's factual findings and legal analysis contained in its October 21, 2019 order form the basis for this final judgment. They further agree that the Court should now enter final judgement resolving the claims raised by the plaintiffs. The parties further agree that Plaintiffs will not be barred by res judicata or other legal doctrine from bringing future litigation against DHSS based on the same legal theories as in this case, but based upon future conduct or omissions. The parties agree that under Title 47 of the Alaska Statutes, DHSS is the government agency principally responsible for administering the civil commitment process. They recognize that the solutions to the problems identified by the Court in its October 21, 2019 order require both greater capacity for inpatient evaluation and treatment as well as the creation of diversionary and less restrictive services, as outlined in a document entitled "Crisis Now Consultation Report." The Crisis Now report was released by the Mental Health Trust Authority in December, 2019 and provides the model for a significant portion of DHSS's ongoing and future efforts to address the infirmities identified by the Court in its October 21st order. Because these systemic solutions will take time to implement, the parties agree, and the Court orders, DHSS to take the following additional actions, subject to the stipulations and agreements set forth in this Final Judgment. Under the settlement, DHSS agreed to do a number of things to manage the ex parte holds pre-evaluation process, including coordinating where people would go for evaluation, producing and filing with the court daily status reports, managing wait lists, providing training for community providers, working out arrangements with mental health providers to examine and provide updates on people being held pre-72-hour-evaluation, sending mental health professionals to conduct evaluations, training peace officers, and ensuring that people starting outside Corrections custody should be held at Corrections facilities only under the rarest circumstances. Those DHSS commitments remain in effect today. Gabriel C. is not the only court case where people have challenged the practice of holding them at non-therapeutic places, such as hospital emergency rooms, awaiting evaluation. In October 2018, the month in which API's capacity collapsed, a respondent was held for two weeks at Central Peninsula awaiting an evaluation bed at API. In December 2018, some time before Mat-Su became a designated evaluation and treatment facility, a respondent was held there for more than two weeks awaiting an evaluation bed at API. As a matter of substantive due process, the Alaska Supreme Court vacated both superior court decisions to hold the respondents outside an evaluation facility for 16- and 15-day periods. [Matter of Mabel B., 485 P.3d 1018 (Alaska 2021).] Similarly, in January 2019, a respondent was	

		held at Providence Kodiak for 13 days awaiting transportation for evaluation, and eventually was evaluated, and released, at Bartlett Regional Hospital in Juneau. In May 2019, a respondent was held at Central Peninsula for 17 days awaiting transportation to API for evaluation. The Alaska Supreme Court held that both holds violated the respondent's substantive due process rights. The Alaska Supreme Court declined to adopt any presumptions about how long a delay violated substantive due process, and declined to impose fines against State officials. It noted that the respondents had not requested contempt sanctions in the trial courts. [Matter of Abigail B., 520 P.3d 440 (Alaska 2023).] All of these holds took place before the Disability Law Center v. State case was settled, and before the Crisis Now bills became law. They also took place before API returned to close to its maximum capacity. Because the problems with API waiting lists continue, however, a continuing practice has developed of respondents challenging lengthy holds outside evaluation facilities in superior court review hearings. The Crisis Now system is starting slowly, as might have been expected. The 2020 statute prioritizes going to a Crisis Now facility over going to other types of places. [AS 47.30.705(b).] We do not yet have enough Crisis Now facilities to take the burden off evaluation facilities to conduct evaluations and provide short-term treatment, and, on information and belief, evaluation personnel are not routinely going to places where people are being held to do 72-hour evaluations. API is returning to its role as a 70-civil-bed facility open for evaluations, and Mat-Su has become a designated evaluation facility. API's competency restoration waiting list has typically been much longer than its civil commitment evaluation waiting list, and that competency restoration problem probably has gotten worse over the past few years. Recently, there have been two widely-publicized problems with ex parte holds, both involving Mat-Su. In one, peace officers chemically restrained an 11-year-old experiencing autism and transported him to Mat-Su. In the other, peace officers served what they believed to be a pickup order, but wasn't, on a school principal and transported her to Mat-Su. Possible improvements to the statutes Pending in the Legislature are two bills that in their current form would alter the ex parte holds system. One, CSSB 53 (FIN) am S, by Sen. Claman, with this provision at the prompting of the AG's office, might validate lengthy holds outside evaluation facilities by providing for a review hearing after seven days. The other, SB 142, by Sen. Shower, would clarify the circumstances under which peace officers and others ought to verify what looks like a pickup order to make sure due process has been provided, change probable cause standards to clear-and-convincing standards, and restrict involuntary medication. Here are several other changes that might be made to the statutes. When someone's being held at a crisis residential center, the statutes should clarify who	

		decides whether the person will go through a 30-day civil commitment proceeding or instead stay at the crisis residential center for the full 7-day period, and clarify what happens if the person's stay at the crisis residential center comes to an end but the person still, in the view of the petitioner, needs involuntary treatment. More generally, the statutes ought to spell out what treatment is provided at Crisis Now centers and how that treatment is to be regulated and measured. It may be that the probable cause standard for ordering someone in for evaluation, or for Crisis Now treatment, should be changed to clear and convincing evidence. Statutes ought to clarify whether the patient grievance procedures apply at Crisis Now centers. This may depend on whether there is an external grievance process. If there isn't, a patient's stay at a Crisis Now center is likely to be over long before an internal grievance is processed, raising complications for how patients and facilities will track grievances. The proposal to provide review hearings after 7 days to people being held outside designated evaluation facilities or Crisis Now centers would likely validate lengthy holds of this sort, and also interfere with the settlement in the Disability Law Center v. State case. We're against that proposal. The statutes' mandate that a person be transported to an evaluation facility without delay is worth preserving. If necessary, the substantive provisions of the Disability Law Center v. State case might be converted into statutory language and incorporated into the statutes; but the present settlement ought to remain in effect. When and if the process takes too long, the person caught and held at a place which can neither provide adequate treatment nor evaluate the person for civil commitment ought to be able to challenge the hold as a matter of substantive due process, when the State's limitations on evaluation facilities, or inability to provide evaluations, is responsible for the delay, as it was in the court cases mentioned above. Rural hospitals and police departments are generally not responsible for the delays and generally are not the entities being sued, so it is not necessary to alter present practice for their benefit. Thoughts about the HB 172 report production process Many meetings took place, and much information was presented and exchanged. Then, however, this past summer, when the contractor began to write its report, the drafting went out of public view. There was no prior agreement that the report would address ex parte holds issues, or on what line it should take if it did. What actually has happened is that the draft report itself briefly addresses ex parte holds issues (at pages 5 and 8-9) and the main, lengthy discussion is in draft supplemental materials (at pages 7-16). The discussion does not substantively mention the Gabriel C. case, or the crisis at API, or the Disability Law Center v. State order or settlement. The discussion of court case law and	

		agency procedure on page 14 of the supplemental materials needs significantly to be rethought and reworked, if indeed the ex parte holds discussion remains in the document. The draft report and supplemental materials need revision. Either they should delete their ex parte holds discussions or replace them with a discussion based on the narrative presented here. If substantial improvements are not made, we will submit these comments as a dissent or minority report. Thank you very much for the opportunity to comment.	
John Solomon, LPC Chief Executive Officer Alaska Behavioral Health Association	10/6/23	Dear Department of Health and Division of Behavioral Health Colleagues, Thank you for your tremendous commitment to assessing the strengths and challenges of Alaska's psychiatric crisis system. We applaud your efforts to meet the Legislature's directive in assessing the current state of psychiatric crisis services and putting forward recommendations for improvement. ABHA would also like to acknowledge the care and expertise of Agnew::Beck, Inc. (A::B), in their facilitation of the assessment. A::B's processes in developing the advisory groups and workgroups, coupled with DET/DES site visits were truly comprehensive. Presented below are key areas that ABHA would like to express support for the recommendations put forward within the report, as well as concerns. Some concerns are in regard to potentially further increasing administrative burdens on psychiatric services providers (including possible requirements not found with other provider types, thus violating parity standards). Other concerns focus on the notable discrepancies between workgroup recommendations and lack of inclusion within the report for parity for psychiatric emergency transport, when compared to any other medical emergency. **Recommendations ABHA Supports** In general, ABHA supports the broad recommendations of: • 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. • Align statutory language, court forms, and provider practices related to emergency detention. • Develop and require training in the involuntary commitment processes, patient rights law, and clinical best practices across disciplines. More Specifically, ABHA supports the recommendation for the Alaska Court system (or other State entity) to begin tracking MC105s (24-hour Emergency Holds), as there appears to be a dearth of awareness on how many individuals are being legally (or possibly illegally) detained under a 24-hour hold. Not to mention that lack of information available on how many individuals necessitate multiple 24-hour holds due to challenges in accessing evaluation and treatment services.	*ABHA's commitment to participating in the process of the report development is appreciated, as are the comments on the draft.* *Transportation is an important aspect of access to care, and is discussed in detail in multiple sections of the supplemental report. In recognition of the impact that timely transportation can have on subsequent exercises of patient rights, a specific recommendation to conduct further analysis of transportation access has been added to recommendations and to the Executive Summary.* --- *The need to minimize additional provider burden and avoid increasing stigma was noted in the Assessment portion of the data discussion.* *To underscore the importance of these considerations, the Executive Summary Recommendations section has been reorganized, and the data section specifically states "Before creating new systems or adding requirements for providers, the State should assess current data and reporting processes to avoid adding undue provider burden or inadvertently increasing stigma for those receiving care."*

		Similarly, ABHA supports the recommendation for improvements in Court processes and standardization. As noted in the report and supplemental materials, providers are often faced with a changing landscape of legal professionals and magistrates, resulting in inconsistencies of legal interpretation and processes. The changing landscape creates highly variable experiences related to the submission and approval/denial for petitions of 72-hour evaluation and Treatment and even more so for 30-day Commitment periods. Further, ABHA supports the recommendation for additional training and education of Psychiatric Advanced Directives (PAD). PADs appear to be a very useful mechanism to support patients' rights, as well as help inform providers how to best meet a patient's need in delivering care. As noted in the report, there is a significant lack of awareness and understanding of the value of PADs, and ABHA welcomes the opportunity for broader education and awareness. **Recommendations ABHA has Concerns** ABHA has concerns about the recommendation, *Conduct a comprehensive analysis of current data and reporting processes and develop a plan to improve collection and use of data*. While ABHA acknowledges the need for improvements in data collection and/or reporting and appreciates the notation that "*data relevant to psychiatric patient rights are already reported externally."* We at ABHA feel compelled to further emphasis and reiterate caution in creating new systems of data reporting, especially given the on-going duplicity behavioral health providers face in current data reporting, resulting in a resource drain away from clinical services. Again, we appreciate the language noted in the report AND want to emphasize providers cannot be further burden with additional data reporting. Further, if there are additional reporting/monitoring burdens placed on providers related to psychiatric patient and staff injury, we are concerned about the further stigmatization of individuals who experience psychiatric disorders. We recognize that patients and staff have the right to be free of injury and the need for oversight of patient and staff safety. ABHA wants to ensure that ALL providers (e.g., non-psychiatric hospital services, non-psychiatric outpatient services, etc.) face the same level of data reporting and scrutiny for those domains and that psychiatric patients or psychiatric provides are not singled-out and further stigmatized. **Lack of Parity for Psychiatric Emergency Transport** ABHA appreciate the detailed analysis and description of transportation experiences related to psychiatric crisis, both in the final report and especially the supplemental material. ABHA also appreciates the description of the variability across Alaska on how emergency psychiatric transport is provided (e.g., State Troopers in some places, zero law enforcement transport in others, commercial flights vs medevacs, etc.). One area that concerns ABHA, is the notable lack of inclusion of **Providers' request (pleading) for parity in medical transport for psychiatric emergencies**. As you are likely aware, ABHA was a member of the provider workgroups, as well as many ABHA members	

		participated in other workgroups. Those members have noted the clear need (and have voiced the need for YEARS) to have a transport system for psychiatric emergencies equitable to any other medical emergency. **If someone is deemed to be at risk to their self or others, or gravely disabled, thus necessitating either a 24-hold or a 72-hour evaluation, there should NEVER be a reason NOT to get a medevac service.** However, as alluded to in the report, medevac services are rare for psychiatric emergencies. Additionally, the narrative among medevac provider companies, is "oh that's a behavioral health issue, we can't come get the patient, we won't get paid." Lack of payment for medevacs for psychiatric emergencies needs to stop. Psychiatric Emergency transport should be on par with any other medical emergency – not relegated to a wholly separate process that can take multiple days to complete. Furthermore, the brief narrative in the supplemental report, highlights an interesting dynamic between urban and rural communities related to psychiatric emergency transport: *In some regions of the state when a person is being transported under an emergency detention because of psychiatric distress they will always be transported by law enforcement; in other parts of the state, they will very rarely be transported by law enforcement. Only one region visited for this project regularly uses Medevac services for behavioral health emergencies. Some providers described situations where the individual in distress consented to a commercial flight with supervision provided by a family member or facility staff.* *In urban Alaska communities, this same process would most likely occur in person and over a shorter period. In some cases, a clinician is sent by the court to assess the person in their home; or a person may be transported by law enforcement or emergency medical services (EMS) to a hospital emergency department for further assessment. If the person was determined to need a higher level of care and to meet criteria for involuntary commitment, and the person was not willing to receive care, the attending physician would detain the person and initiate the ex parte process.* What really stands out to ABHA, is that in rural communities, if there is a psychiatric emergency necessitating transport to an emergency care, the patient (and often escorts) are often r**equired to travel on commercial flights** (with rare exceptions of Trooper transport). To map that onto an urban experience, that would mean the patient (and their escort) **would be required to take the public bus** to the emergency medical care. Of course, we don't require our urban residents to ride the bus for psychiatric crisis transport, we send ambulances, fire trucks, or police cars for transport. We should ensure our rural residents have the same level transport for psychiatric emergencies as our urban residents. Additionally, individuals experiencing psychiatric crisis should get the consideration and respect for emergency transport as any other medical emergency.	

		In closing, ABHA again is appreciative of the comprehensive analysis of the Alaska Psychiatric System of Care, and offers both support and concerns regarding elements of the report.	
Val Van Brocklin	10/6/23	At a cost of over $250,000 and over a year since it was legislated, the HB172 Report offers nothing that wasn't already known and overlooks or seriously understates much relevant information that is known. The report is heavy on existing regulations, statutes, and certification requirements. These could have been assembled by a state employee for the legislature's ease much less expensively. The recommendations have been urged by advocates for years. It's very simple. There must be public transparency and accountability for patient treatment outcomes, patient commitments and drugging, patient injuries and trauma, and a viable patient grievance process. Repeated ombudsman reports from 2018, 2020, and 2022, as well as mainstream media reporting, and academic research show that such accountability and transparency have been lacking in the current mental health system for years. There is no reason to believe more regulations, court rules, statutes, or facility policies and procedures will remedy the situation with respect to crisis care centers. What is needed is independent oversight- independent of the service providers, the state agencies, and the court system — all of which have resisted public accountability and transparency and are disincentivized from providing it. Such transparency and accountability can be provided without violating patient privacy. The players in the current system need to stop delaying and accept real public accountability and transparency—not more studies, more reports (ombudsman or legislated), or more words and requirements that aren't enforced.	*Thank you for your comment. This report includes an overview of regulations, statutes, and accreditation pursuant to the requirements of HB 172.* *The report recommends several actions to increase accountability and transparency, including the recommendations to create a psychiatric ombudsman, to conduct a comprehensive data and reporting analysis, and to provide comprehensive guidance and training to all entities involved in the civil commitment process.*
April Kyle, President and CEO Southcentral Foundation	10/6/2023	Thank you for the opportunity to provide public comments related to the psychiatric patient rights report mandated by the passage of House Bill 172, which established the Crisis Now model in state law. Southcentral Foundation (SCF) clinicians and leaders take patient rights seriously and are keenly aware of the intricacies of caring for those in a behavioral health crisis. SCF staff work to partner with customer-owners to meet them where they are, including in a behavioral health crisis, and journey with them toward health and wellness. Overall, the report is well done and the comments and critiques SCF offers are in service to a better publication for policymakers' use. We agree with the four recommendations identified that seek to increase alignment and consistency between statutory requirements, provider processes and patient experience. However, it is important to note that on a few occasions the report claims that the mere passage of HB 172 increased access to crisis care. That is not the case. The passage of that law laid the foundation for increased access, but that access will not be realized until facilities open and programs begin operation. SCF clinical and operational leaders offer the following specific comments:	*Thank you for your support and recommendations for improvement.* --- *The language in the final report has been revised to reflect that HB 172 was designed to increase access and laid that structural foundation for a better continuum of behavioral health care.* --- *The need to minimize additional provider burden was noted in the Assessment portion of the data discussion.* *To underscore the importance of these considerations, the Executive Summary Recommendations section has been reorganized, and the data section specifically states "Before creating new systems or adding*

		• There is strong support for the recommendation on training related to the MC 105 form. Currently, across many providing organizations, there is confusion related to medical holds versus psychiatric holds. There may be some providers inappropriately using the process due to a lack of training. • On page five, the recommendation is to conduct a comprehensive analysis of current data and reporting processes and develop a plan to improve data collection. We are supportive of aggregate data being collected and minimizing any administrative burden and cost that additional data collection efforts would place on organizations. It would be appropriate for the state to consider tasking the DES/DET coordinator with tracking and reporting aggregate information. Any additional data elements that would be required for providers and organizations need to be carefully considered to • 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. We strongly agree with this recommendation. There has been inconsistency in practice across emergency departments within the state about how to approach treatment and care for those individuals awaiting transfer to a DES/DET facility. This recommendation would improve the care being delivered to individuals across the state while waiting for transportation to an evaluation facility. • It is important to keep in mind that many individuals in a mental health crisis have co-occurring substance use challenges. We recommend adding the need to expand access to outpatient and residential substance use treatment in the section titled "Enhancing community-based service continuum." Further, state policies need to reflect this reality, and the state should help fund capital and start-up costs for treatment facilities for these often hard to treat individuals. • On page 12 of the supplemental report, the report language may need to change from "return to home" to "return to community." Many individuals experiencing a psychiatric crisis may be unhoused or otherwise housing insecure. • Page 37 covers court-ordered medication and use of seclusion, restraint, and involuntary medication. As a provider, we are concerned about limiting professional clinical judgement and clinical decision making by law. If the ability to administer crisis medication is artificially limited due to statute, the result would be an increase in the instances of restraint and seclusion, which leads to greater trauma for the individual. Finally, SCF leaders appreciate the emphasis on enhancing the community-based services continuum of care, as well as the state's desire to stand up crisis services across Alaska. However, both of these aspects of the behavioral health system of care need capital and start-up funding to realize the goals outlined in House Bill 172. The state and the legislature, along with many community partners, have laid the foundation of a better, more robust, care continuum for Alaskans in crisis. Now, policymakers need to take the next step and financially commit to building out these facilities and services. Thank you for your consideration of these comments.	*requirements for providers, the State should assess current data and reporting processes to avoid adding undue provider burden or inadvertently increasing stigma for those receiving care."* --- *These suggestions for the "enhancing community-based service continuum" section and to change the language to "return to community" have been incorporated into the final report.* --- *The draft report includes the concerns that limiting crisis medication can result in more traumatic experiences to the patient through necessitating physical interventions.* *Additionally, the final report adds a recommendation for a comprehensive review and revision of the civil commitment structure, to include analysis of court-ordered and crisis medication laws. The discussion underscores the need for any changes to the civil commitment structure to occur as a result of extensive and meaningful engagement with stakeholders representing all components of the commitment system.*