REPORT TO THE LEGISLATURE

HB 172 –Psychiatric Patient Rights in Alaska

Supplemental Material

October 16, 2023

Trust
Alaska Mental Health Trust Authority

STATE OF ALASKA DEPARTMENT OF HEALTH

AK | DFCS
ALASKA DEPARTMENT OF FAMILY AND COMMUNITY SERVICES

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Advocacy Reports

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- Alaska Department of Family and Community Services and Alaska Department of Health - Overview of Alaska's behavioral health system of care for children, 2023.
- Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse – Patient rights research findings, 2018.
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    - Myers and Collins – Legislative wish list, 2015.
    - Testimony to the AMTHA Board, 2021.
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Appendix B: Stakeholder Vision and Access to Appropriate and Timely Treatment, Stabilization, and Discharge

Introduction

One of the objectives of this report was to assess the adequacy of the requirements, policies, and procedures related to psychiatric patient rights and the "practical challenges patients face in availing themselves of these rights."[1] Stakeholders described challenges a person experiences in their journey to and from inpatient psychiatric care in Alaska and many emphasized the practical challenge of accessing appropriate care in community settings before or after receiving inpatient psychiatric care. Many felt that the ability to access voluntary care at all levels is optimal to protect individual choice and patient rights.

Advisory Team and subcommittee discussions identified a wide range of beliefs related to treatment access, with some members advocating for the right to receive treatment, while others advocated for the right to refrain from receiving treatment. This report strives to strike a balance between perspectives by sharing feedback about access across the full continuum of care.

Provider stakeholders identified different types of mental health treatment and which facility types and settings can feasibly deliver them:

- **Crisis intervention services** are provided in many settings. Mental health clinicians provide assessment and interventions to help address the immediate crisis, such as coping skills and safety planning. Non-assessment services can also be provided by peer support specialists or other paraprofessionals.
- All facility types attempt to offer **support and connection services** during admission and in anticipation of discharge. While sometimes limited based on community availability, case management services seek to connect individuals with community resources including housing/food assistance, outpatient behavioral health, peer support services, and more.
- **Pharmacological interventions** are available in all facility types but are monitored differently depending on the type of facility. Medications can be provided voluntarily or involuntarily, in crisis situations or as a longer-term intervention. Selecting medications and dosages requires education and training beyond the scope of most ED physicians. While selecting crisis medications and supporting continuation of already prescribed medications is common practice in ED and inpatient settings, initiating new medications or changing doses typically requires a provider with specialized training in psychiatry.
- **Clinical interventions** such as individual and group therapies are generally only available to individuals admitted to API, a DET facility, or other voluntary inpatient units. This treatment modality will be available in crisis stabilization and crisis residential settings.
- **Milieu-based treatment**, or use of a structured group environment, is currently only available to individuals admitted to API or a DET facility or voluntarily in other inpatient units or facilities. This treatment modality will be available in crisis stabilization and crisis residential settings.

While outside the scope of this report to assess treatment provided at individual facilities, it is important to note conditions at API have improved considerably since the Alaska Ombudsman's investigations and findings reports in 2018 and 2020.[2] Over the last two to three years, API instituted new staff training models, which contributed to a

[1] Alaska Mental Health Trust Authority. (2022, December 8). Request for Proposals: HB 172 Report to Legislature. RFP 23-114M. Preparing a report for submission to the Legislature as identified in House Bill 172: Mental Health Facilities and Medications.

[2] https://ombud.alaska.gov/case-summaries/

significant reduction in patient and staff injuries. API has a robust patient advocate program with patient advocates present and available on the units in person and through a formal grievance process. The units at API have been reorganized to ensure that individuals with complex conditions such as a psychiatric diagnosis and an intellectual or developmental disability, traumatic brain injury (TBI) or dementia can be cared for on units with staff that has additional training to help them care for those patients. The adolescent unit at API reopened in spring 2021 following a lengthy closure.

The State, the Trust, providers, and others have made significant efforts to implement a behavioral health crisis continuum through efforts that include adapting the Crisis Now framework for Alaska communities. Stakeholders shared great hopes that implementing mobile crisis teams and crisis centers around the state will dramatically decrease wait times and improve care for individuals in behavioral health crisis. Many emphasized the need to support programs through opening, monitor system impacts in the initial years of operation, and to expand statewide. Investing in expanding services through the 1115 Behavioral Health Medicaid Waiver can also bolster the behavioral health continuum of care. Provider groups recommended addressing their concerns about reimbursement rates and regulations to expand services. Multiple stakeholder groups indicated that a quick and reliable system for transportation for individuals experiencing psychiatric crisis, akin to a medevac response, is essential.

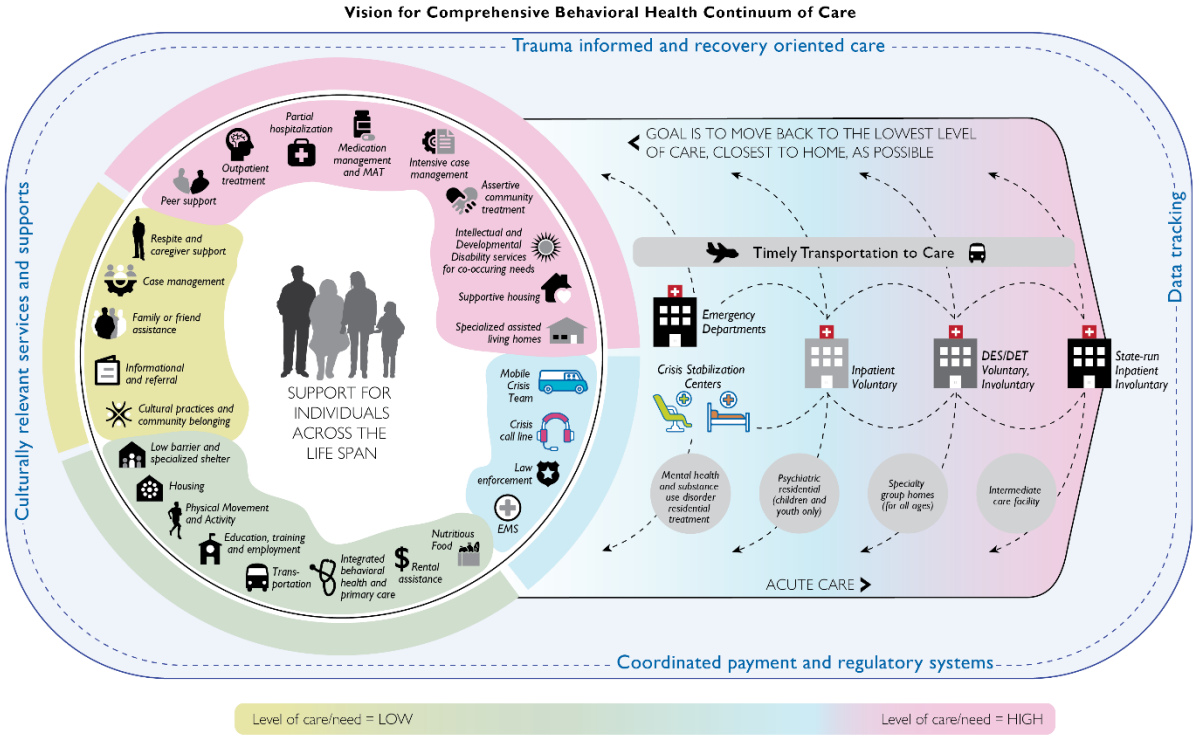
Various stakeholders proposed recommendations that included:

- Enhance the community-based service continuum:
    - Make available a full array of home and community-based supports. Identify service gaps and needs at the community, regional, and state levels and strategically invest to meet regional demand.
    - Increase access to outpatient behavioral health and substance use disorder care, primary care, and community-based supports including Assertive Community Treatment (ACT), Intensive Case Management (ICM), and medication management.
    - Create access to very-low barrier shelter, low-barrier housing with appropriate behavioral health supports (Housing First and other models), and outreach and support to successfully maintain housing.
    - Increase opportunities for education, training, and supportive employment for individuals with behavioral health needs.
- Enhance the crisis continuum:
    - Ensure all Public Safety Answering Points (PSAPs) have call transfer protocols in place with a crisis call center.
    - Make mobile crisis teams available to all communities either through behavioral health-led teams of a clinician and a peer support specialist or through a co-response model which includes a behavioral health specialist and local emergency medical services or law enforcement. Payment rates must support transportation costs and time regardless of location and team composition.
    - Develop crisis stabilization and crisis residential centers in regional hubs around the state and prioritize rural regions by population size, age range, and rate of suicide and crisis incidents.
    - Where available, use crisis residential centers as a step-up from crisis stabilization and a step-down from higher levels of care to support transitions back to community.
    - Explore development of a peer-run warmline.
    - Add crisis respite care for adolescents and adults as a Medicaid billable service, allow peers to provide this service.
- Enhance the out-of-home care continuum:

    - Increase access to behavioral health treatment in hospitals around the state by addressing barriers to providing and billing for behavioral health services provided on hospital inpatient units and increasing awareness of hospitals about the DES/DET program, including what the requirements are, how to become designated and the payment mechanism for services.
    - Develop secure and structured group homes for children and youth with conditions/behaviors that screen them out of residential settings and make family placement difficult or not appropriate. Ensure payment rates support necessary staffing and supports.
    - Develop payment mechanism to support transitions in care for children and youth particularly for those moving from inpatient to residential, and then from residential to community.
    - Expand access to residential behavioral health and substance use disorder settings.
    - Explore the development of an intermediate care facility and specialty group homes for adults with conditions/behaviors that often exclude them from other placements.
- Address barriers to transportation for psychiatric treatment:
    - Address barriers to payment for transportation for voluntary hospitalization.
    - Ensure timely transportation for psychiatric emergencies comparable to “medical” emergencies for both voluntary and involuntary care.
- Enhance supports across the continuum:
    - Support integration of peer support specialists across services and settings.
    - Provide technical assistance, start-up funding, and operating support to Community Behavioral Health Services providers to develop or expand identified services.
    - Develop specific strategies to address transitions in care for all individuals, and individuals that are challenging to discharge including children, adolescents and adults with complex needs such as dementia, intellectual and developmental disabilities, autism, and those who are unhoused.
    - Research and provide funding to support non-clinical approaches to training and support for individuals with psychiatric conditions.

To help visualize these components of a larger system, the contract team shared a draft vision graphic developed by Agnew::Beck. The Advisory Committee reviewed an initial draft of the vision graphic at the April 27, 2023 meeting and provided input. This was incorporated into the current draft of the graphic and the set of recommendations that was reviewed at the June 15, 2023 meeting, where no further input was provided and no disagreement was shared. Figure 4 depicts the envisioned system of supports that will enable individuals with psychiatric conditions to live full lives in their communities of choice.

Figure 1: Vision for Improved Patient and Community Outcomes



Practical Challenges: Access to Appropriate and Timely Stabilization and Treatment

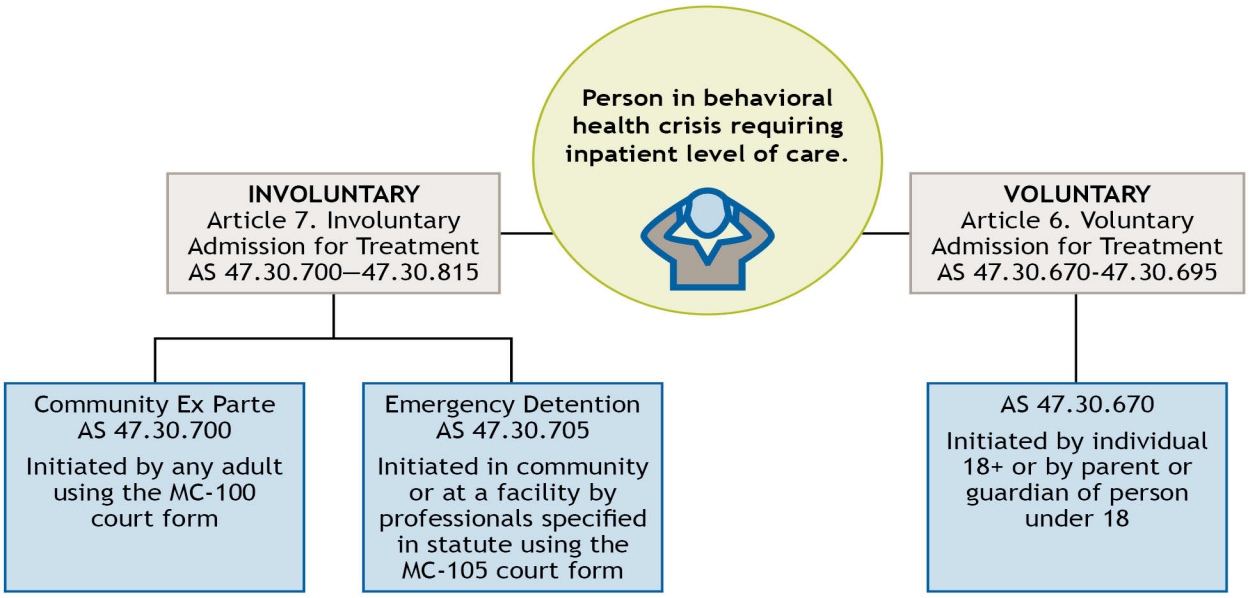
Stakeholders expressed that the rights of individuals with psychiatric care needs are not confined to the processes and resources they have access to while receiving care but include when and how individuals access care during acute crisis, treatment and upon discharge. Many of the practical challenges individuals experience in availing themselves of their rights relate to whether they can access needed services at all.

The statutory framework assumes individuals have immediate access and rapid flow through the involuntary examination and evaluation process. In fact, there are numerous barriers that slow and impede the process.

Figure 5 depicts three pathways an individual may take to access inpatient psychiatric care in Alaska: they may present voluntarily for care, typically at their local healthcare facility, or involuntarily. Individuals who enter the system involuntarily may do so through the community ex parte process, which can be initiated by any adult, or by the emergency detention process, which can be initiated by a statutorily defined list of professionals.

As an individual moves through the system, stakeholders identified significant barriers to accessing care and described a system that uses involuntary commitment to access the highest levels of care. The following sections provide an overview of current processes to access emergency examination and court-ordered evaluations, access to appropriate treatment close to home, special considerations for children and adolescents, and access to appropriate resources upon discharge.

Figure 2: An Alaskan's Pathway to Inpatient Psychiatric Care



Access to Examination

As depicted in Figure 5, an individual may take one of three pathways to access inpatient psychiatric care: voluntarily or involuntarily, and involuntary care may be initiated using the Notice of Emergency Detention (NED) process or by the community ex parte process.

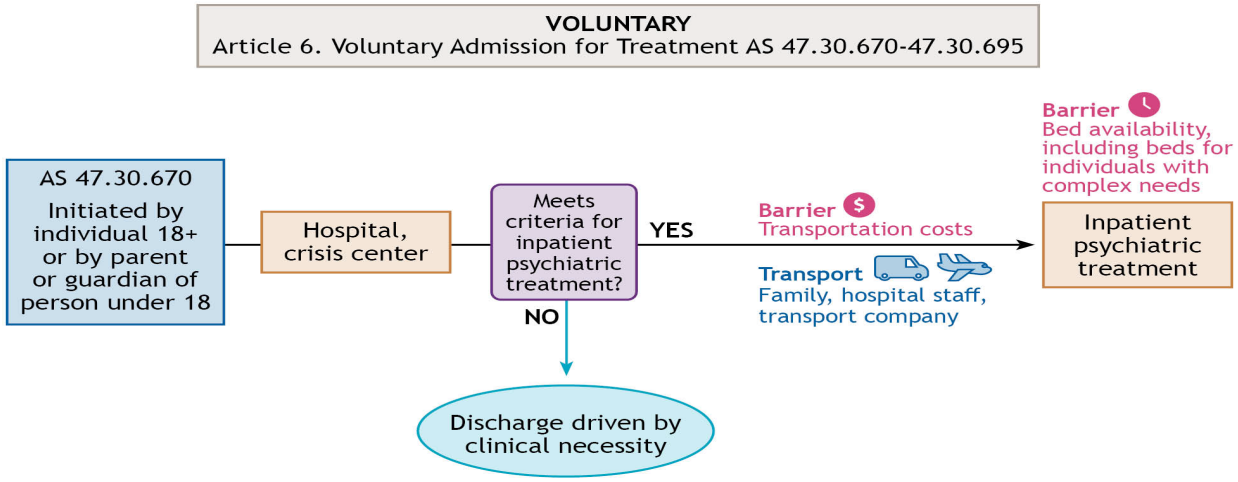
Voluntary Care

A person in crisis often presents to the hospital emergency department (ED) or local health clinic. In other cases, the person in crisis, a family member, or friend of the person might call 9-1-1 or contact law enforcement such as a Village Public Safety Officer or Tribal Police Officer for assistance. The medical provider and/or behavioral health staff assess the level of care needed by the individual. Treatment planning is based on this clinical assessment and reporting from the person in crisis. When necessary, the provider initiates the process to arrange

transport to inpatient level of care if local resources are not sufficient to keep the person safely in the community. If available, the ED may transfer the person to an inpatient unit while waiting for admission at another facility.

Individuals who require a higher level of care but are voluntary have fewer options for inpatient care than those who are involuntary. Alaska Psychiatric Institute (API) does not accept voluntary admissions.[3] Two of the three Designated Evaluation and Treatment (DET) facilities are regularly unable to accept patients from outside of their regions, and the voluntary-only facility in Anchorage has restrictive intake criteria. Sometimes during the wait periods to transition to another facility the person stabilizes and returns to their community, ideally resuming or initiating behavioral health services in the community. However, stakeholders in all Alaska communities engaged for this report noted long waitlists and very limited access to a comprehensive array of outpatient care options.

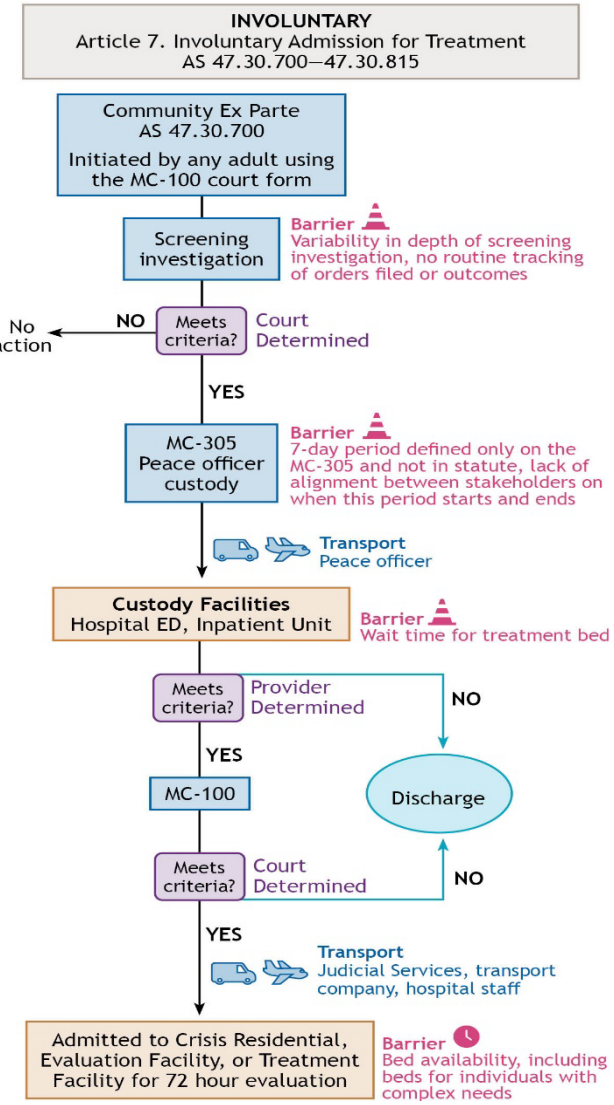
Figure 3: Pathway to Voluntary Inpatient Psychiatric Care



[3] Many patients at API convert to voluntary status at some point during their stay although typically only involuntary patients are admitted.

Community Ex Parte

Figure 4: Pathway to Involuntary Inpatient Psychiatric Care – Community Ex Parte



The community ex parte process is initiated using the MC-100 *Petition for Order Authorizing Hospitalization for Evaluation*. According to AS 47.30.700 any adult may petition, including concerned family members. The Court System receives the community ex parte and a judge immediately conducts a screening investigation or directs a mental health professional to conduct such investigation to determine whether the individual is gravely disabled or presents a likelihood of serious harm to self or others. Within 48 hours of completing the screening investigation, a judge may issue a *MC 305 Order Authorizing Hospitalization for Evaluation*. The Court may then direct a peace officer to take the individual into custody and deliver the person to the nearest appropriate facility for examination or treatment. The least restrictive method of transport is used, which may involve a family escort or a secure transport contractor, rather than a law enforcement officer. A granted MC-305 *Order Authorizing Hospitalization for Evaluation* expires within seven days unless the respondent is at a medical facility waiting for transportation or is already at an evaluation facility.

Community ex parte orders are reported to be a small proportion of total ex parte orders. Stakeholder engagement did not include individual court systems, but providers report variability in the depth of the screening investigation conducted by the court system which results in more detentions under this process that a facility-based provider then finds to be inappropriate. As one provider shared "Only one out of ten is warranted. Family members are not professionals". When individuals under a community ex parte are held in an emergency department bed awaiting an evaluation bed, hospital staff must rescind the ex parte order if their assessment finds the individual no longer meets criteria for an involuntary admission even if the professional believes that the person still requires some level of mental health care. Law enforcement stakeholders reported challenges related to knowing the start and end point of the seven-day pick up period for those with a granted community ex parte. The seven-day period is defined only on the MC-305 and not in statute. Law enforcement noted that providers and the court system have differing views on when the period starts and ends which means that sometimes after they have located an individual and bring them to a facility, they are told the order is no longer valid.

Emergency Detention

This process is commonly used by law enforcement and hospitals to detain individuals for an emergency examination. The MC-105 *Notice of Emergency Detention and Application for Examination* can be completed by a peace officer, health officer, mental health professional or licensed physician assistant. If detained in the community and brought to a hospital for examination, the MC-105 is typically filled out either by the law enforcement officer who initiated the detention or an ED physician upon arrival at a hospital ED. In rural areas, this may mean the form authorizing the detention is not completed until hours or days after the individual was originally detained. Interviews with law enforcement agencies revealed inconsistent knowledge of what the MC-105 is, with several agencies referring to this court form as a hospital form.

Discussion with stakeholders identified significant gaps in understanding of the emergency detention pathway, the responsibilities of different entities defined in statute, and how the emergency detention process occurs in practice. The forms developed by the Court System are not aligned with statutory language which creates confusion for providers attempting to implement compliant procedures. There are three primary ways these processes are misaligned, to the detriment of individuals with psychiatric care needs:

- In AS 47.30.700-AS 47.30.710 and in court forms, the terms examination and evaluation are used interchangeably, inconsistently, and are not defined.
- No statute addresses the period from when a person is detained to when they are delivered to a crisis stabilization center, a crisis residential center, or an evaluation facility. In practice, all individuals are detained for some period before delivery. Although no statute addresses procedures to be applied during the detention period, the Alaska Supreme Court has held that the sole purpose of the statute is transportation, and that therefore 11 days of detention violates due process.[4] The Alaska Supreme Court has also held that 4 days of detention, on the other hand, even in jail, does not violate due process.[5] It is unquestioned that a detainee is entitled to a review hearing during detention.[6] The Alaska Court System has informally stated that if a detainee is not transported within 7 days, it will set a hearing.[7] The Alaska Supreme Court has stated that at a review hearing, it must be shown that probable cause exists to detain a person for evaluation.[8] If a detainee is in jail, it must be shown by clear and convincing evidence that there is no less restrictive alternative.[9] The Alaska Supreme Court has also held, however, that a detainee's grave disability or risk of harm to others is not a relevant consideration during detention, nor is the quality of treatment (if any) received during detention.[10]
- Facilities that hold individuals in custody have different responsibilities from those where a person is delivered for evaluation and treatment, however, many facilities that hold individuals in custody believe they must comply with the same requirements as the facilities where the person is delivered.

The subsections below describe the processes and challenges specific to facilities that hold individuals in custody, which can be any number of locations, and those where a person is delivered for evaluation and treatment, which are defined in statute as crisis stabilization centers, crisis residential centers, evaluation facilities, and treatment facilities.

Facilities that may hold Individuals in Custody

Most individuals placed under a Notice of Emergency Detention to be delivered to a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility will experience some time in custody at an emergency department, hospital inpatient unit, or, infrequently, jail. For adults, the length of time in custody can be hours or days depending on multiple factors including physical distance, transportation time, and bed availability. While the promise of a redesigned behavioral health crisis system is to divert as many individuals as possible from institutional care, not all communities or even regions of the state will have local access to crisis centers and evaluation and treatment facilities, necessitating some level of behavioral health support at other entry points for care such as hospital emergency departments.

[4] *Matter of Abigail B.*, 528 P.3d 440, 449 (Alaska 2023).

[5] *Matter of Vern H.*, 486 P.3d 1123, 1132 (Alaska 2021).

[6] *See, e.g., Abigail B. and Vern H., supra.*

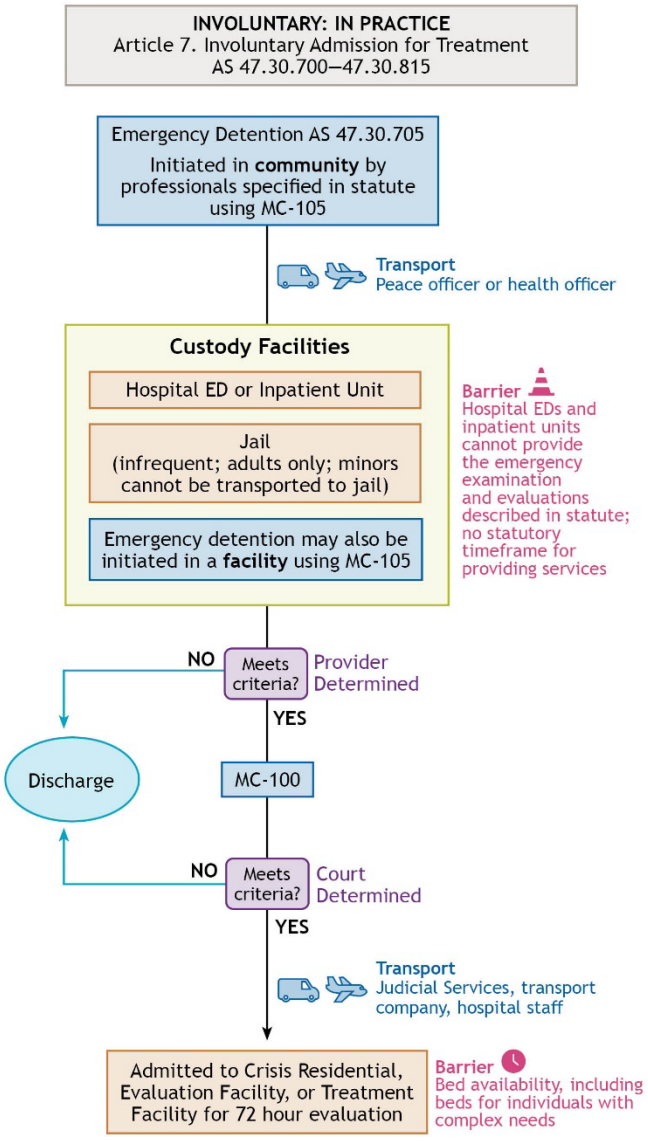
[7] Discussion with Aesha Pallensen.

[8] *Vern H.*, 486 P.3d at 1130.

[9] *Vern H.*, 486 P.3d at 1130.

[10] *Abigail B.*, 528 P.3d at 450.

Figure 5: Pathway to Involuntary Inpatient Psychiatric Care – Emergency Detention, Process in Practice



The availability of behavioral health services during the custody period varies greatly by geography and facility, however, all hospital emergency departments have a mechanism for assessing behavioral health needs and determining whether to file a MC-100. Once the assessment is complete, if an ex parte order is filed, the waiting period between when an order is granted and when an evaluation facility can receive them can last hours or days. In some hospitals, individuals are transferred to inpatient beds to wait, while others remain in the ED for the duration of the wait. For children and adolescents, the wait can last days and weeks for those seeking voluntary or involuntary care.[11]

During this waiting period the person is typically assessed every 24 hours to determine if they still meet criteria for an involuntary hold. This reassessment is not statutorily defined but appears to be best practice in hospitals. During this period, stabilization and treatment services are not typically provided, unless an individual is so agitated that they receive crisis medications to maintain safety to self and others.

During the waiting period before the person is delivered to an evaluation facility, the ex parte order may be rescinded because the person's condition stabilizes to the point where they no longer meet criteria to be held. In these cases, unless the person agrees to receive treatment voluntarily, the person would be discharged without receiving treatment, although their detention could have lasted multiple days. This also can happen when a person has been transported to a regional hub community under emergency detention; if the person does not meet criteria to initiate an involuntary commitment, the person must be released from the facility even if they do not receive treatment for behavioral health concerns. In most cases, individuals are not connected to ongoing community-based care.

[11] Alaska Hospital and Healthcare Association. (2022). Child and Adolescent Behavioral Healthcare Improvement Project: Report and recommendations for positive change across the continuum. https://www.alaskahha.org/_files/ugd/ab2522_ac2ea6eb4e074397b9f5c7499a003f6f.pdf

Crisis Stabilization Centers, Crisis Residential Centers, Evaluation and Treatment Facilities

Figure 6: Pathway to Involuntary Inpatient Psychiatric Care – Emergency Detention, Statutory Process

If an individual is delivered directly to a designated evaluation or treatment facility, the facility has 24 hours to conduct the examination. In practice, an individual is seldom delivered directly to a designated facility from the community. As these facilities are located on hospital inpatient units, all require screening through a hospital emergency department first. If an individual is delivered directly to a crisis stabilization or crisis residential center, these facilities have three hours to conduct the examination. These centers are not yet available for immediate delivery of an individual under a notice of emergency detention. If the mental health professional who performs the emergency examination has reason to believe the respondent is mentally ill and meets the criteria for an ex parte order the professional applies for an ex parte order authorizing hospitalization for evaluation. There are no provisions in statute for individuals who cannot be examined within the 3 and 24-hour timeframes specified, which sometimes occurs when an individual is under the influence of substances or otherwise unable to participate in an examination.

Challenges

Regardless of which path an individual takes to access psychiatric care, stakeholders described that process occur differently in different regions and that transportation to appropriate care is a significant challenge across Alaska.

Variability by Geography

When a person experiences psychiatric distress, the care they receive varies greatly depending on where in Alaska they live. It varies not only between urban and rural communities, but even between two equally remote communities in different regions of the state.

Variability includes the level of care they receive, the way in which care is delivered and by whom, the method of and the time it takes to be transported to care, the likelihood of the person receiving care voluntarily or involuntarily, and the degree to which law enforcement is involved. This variability in the process means that the degree to which a person's rights are protected during psychiatric care depends a lot on where they live.

Transportation

The distance a person must travel to access the level of care they need varies greatly in Alaska. A person living in a small remote community may have access to a local health clinic with a community health aide, possibly a behavioral health aide, and a telehealth connection to a primary care physician. If their needs exceed what can be met by local resources, and the person's symptoms are acute, a mental health provider at a regional hub

community will talk with the person and their family to assess the situation. If the clinician believes the person requires a higher level of care, and if the person is not willing to travel to access care, the next step is to determine if the person is gravely disabled or at serious risk of harm to themselves or another person. Clinicians talk by phone with the person and others present to determine this. In some regions, law enforcement may be called upon to determine if the person meets criteria for an emergency detention, but it could be hours or days before they arrive on scene.

If this process determines that the person needs to be detained while transport is arranged and there is no adequate location that will ensure safety (such as a hospital), individuals can be kept in protective custody by law enforcement. [12] In some communities, the person may be detained in a health clinic or other facility. In some communities where no jail facilities exist, law enforcement may have to hold the person outside of a jail setting, such as an office or home. In some regions, transport is done by law enforcement. According to interviews with law enforcement officers, this can sometimes escalate the situation, although experienced officers learn how to communicate effectively and help deescalate situations. Involuntary transport can include medication administered by medical personnel against a person's will, and usually involves the person being put in physical restraints during a plane flight to a regional hub community, for the safety of all occupants of the plane.

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.

Access to Evaluation and Treatment

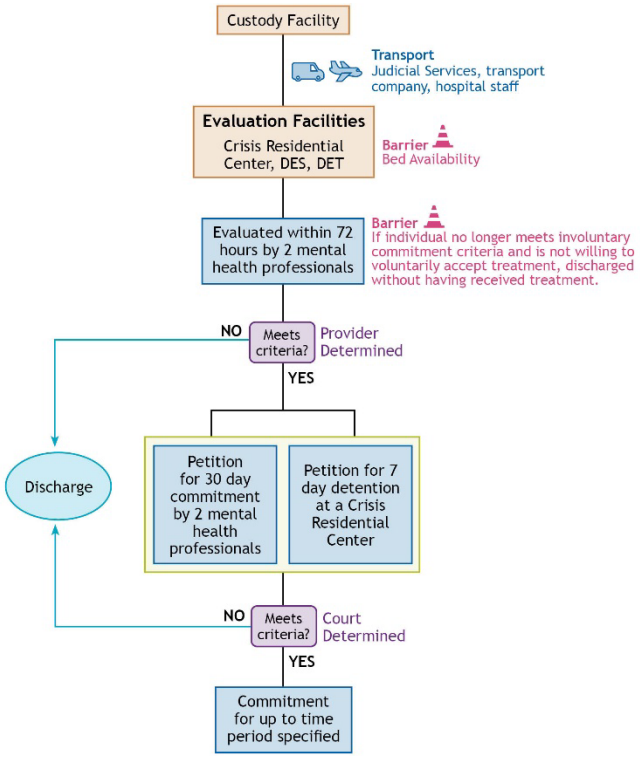
Stakeholders emphasized that lack of access to care and delaying care increases the risk of crisis situations, which increases the risk for more restrictive interventions. Stakeholders without access to Designated Evaluation and Stabilization/Designated Evaluation and Treatment (DES/DET) beds within their region report unpredictable wait times. Local admissions typically fill beds at two of the three DET facilities, increasing delays for patients from other regions. DES/DET facilities also have varied criteria for labs and paperwork needed prior to admission and different screen-in/out criteria. The DES/DET Coordinator position has helped to track individuals once an ex parte order is granted to the next available bed that will meet their needs.

Once a bed becomes available, transportation to the facility poses yet another challenge. For individuals who are voluntary, some receiving facilities require transportation via a transport company which requires additional time and coordination. A patient may be required to pay for this service. Payment for transport through Alaska Medicaid is challenging to arrange and once approved can take additional time for the contracted services to travel to and from the community. This can add two to five days to the person's wait period. For individuals who are involuntary, transportation is easier to arrange because the State of Alaska is responsible for paying for the transportation fees and transportation company services and the DES/DET Coordinator is available to assist with transportation challenges. [13]

[12] Sec. 47.30.705. Emergency detention for evaluation.

[13] See page 16 of the Designated Evaluation & Treatment (DET) Program Manual for information on Secure Transport and Escort Services

Figure 7: Pathway to Evaluation and Treatment



There are currently more inpatient psychiatric beds available in Alaska for involuntary admissions than there are for voluntary admission. Additionally, payment options for voluntary transportation are limited. If an individual is involuntarily committed, the cost of their transportation is covered by the State of Alaska.[14] This is not the case for individuals who seek voluntary care.

Once a person is admitted to a DES/DET facility,[15] or Alaska Psychiatric Institute (API), the 72-hour period begins during which the evaluation must be completed to determine if they require treatment, and if they meet criteria for involuntary treatment.[16] DET units admit patients on a voluntary and involuntary basis; API only admits patients who are involuntary. Stakeholders report that many patients convert from involuntary to voluntary during inpatient stays. Once a person is admitted to either a DET unit or to API the person is evaluated by a mental health clinician and a physician to determine the course of treatment and whether an additional period of involuntary commitment for treatment is warranted.

Individuals who access an emergency department in a community that has a DET unit, and who meet the level of care requirements for inpatient psychiatric care, will often be admitted quite rapidly to the unit whether the person is voluntary or involuntary. People who live in communities distant from these units often experience lengthy waiting periods to access inpatient level of care.

Considerations for Minors

Stakeholder interviews identified accessing inpatient psychiatric care is especially difficult for children and adolescents, with young patients remaining in emergency departments and inpatient beds for days and weeks waiting for appropriate care. Parents are often seeking, and therefore consenting to, care for their child in severe psychiatric crisis. Voluntary inpatient treatment is available at North Star Behavioral Health and the Providence Discovery Unit, but these facilities do not always have beds available and can decline referrals for care, commonly due to staffing challenges or the complexity of a youth's care needs.

When a youth is admitted to a treatment bed, there are sometimes additional challenges when the family and the treatment provider disagree. Some parents seeking inpatient psychiatric care for their children interviewed for

[14] AS 47.30.870

[15] Designated facilities provide psychiatric inpatient services for individuals experiencing a psychiatric crisis who are on a voluntary or involuntary court order. DETs provide psychiatric evaluation and treatment, and DES provide evaluation services only. Both also provide crisis stabilization and transitional services to community-based services. DETs require psychiatric, occupational, and psychiatric inpatient hospital services, while DES facilities do not (7 AAC 72.012). DET and DES facilities are collectively referred to as designated facilities. Page 2. Designated Evaluation & Treatment (DET) Program Manual.

[16] AS 47.30.710

this report expressed concern of OCS action if a family wanted to have their child discharged against medical advice, or if they wanted their child to stay longer than the facility agrees is appropriate.

Schools play a significant role in both initiating requests for further evaluation for a youth and in supporting youth upon return from inpatient or residential treatment. A family member with lived experience recounted how the school's response to her child's behavioral health crisis furthered the stigmatization and humiliation her child felt during their time of crisis and that when it came time to return to school, staff were fearful and uncertain of how to provide support.

The situations described by families with lived experience and providers highlight the need for family advocates before, during, and after treatment.

Discharge Planning and Return to Community

When a person is discharged from API or a DET unit the facility is required to and does engage in discharge planning.[17] In some cases this planning can be very involved, including meeting with assisted living home operators, orienting the patient to the home, providing training for staff there and in some cases even paying for the aftercare so the patient can succeed in the new setting. In many cases, however, because Alaska communities do not have the robust array of offerings to care for individuals with severe needs in our communities, discharge is often to inadequate supports. Behavioral health providers in rural communities interviewed for this report described a lack of collaboration and connectivity upon discharge. One rural provider shared, "sometimes we don't know someone has been discharged until we run into them at the grocery store." In urban areas, patients can be discharged into low-barrier shelters for individuals experiencing homelessness with only temporary supplies of medication and an outpatient appointment that could be weeks away. Across stakeholder groups, including individuals with lived experience, providers of inpatient psychiatric services and State stakeholders, there was universal agreement about the challenges providers and individuals face at discharge.

API has 80 total beds with 70 beds available for civil patients. An involuntarily committed person must be discharged as soon as they no longer meet criteria, unless they agree to stay on a voluntary basis, even if their underlying condition is not significantly improved. This, along with the lack of adequate discharge supports, leads to frequent cycling through emergency departments, DET units, API and jail, frequent interactions with law enforcement, and poor health and functioning for the individual experiencing psychiatric distress.

Stakeholders expressed that housing is one of the main deficits in our communities. For individuals experiencing mental illness, this includes supportive housing that will ensure access to medication, outpatient behavioral health treatment, supported employment, supports to maintain hygiene and adequate nutrition, and to ensure a person can manage their symptoms to not harm themselves or others, or damage the property where they live which can lead to them losing their housing.

Specialty Populations

All stakeholders identified specific populations that are particularly difficult to treat and to find appropriate treatment options to meet their needs. These include individuals with substance use disorders, unmet basic needs such as housing, food, transportation and access to healthcare, intellectual and developmental disabilities, neurocognitive disorders (e.g., dementia), complex medical needs, severe and complex trauma, children, and adolescents.

[17] AS 47.30.825(i)

Appendix C: Psychiatric Advanced Directives

Overview

A Psychiatric Advanced Directive (PAD) is a subset of medical Advanced Directives that allows an individual to make decisions about their care, or to designate an appointee, if they are unable to make or communicate those decisions in the future. The Alaska Court System has a link on its webpage to a form for Advanced Health Care Directive drafted by Alaska Legal Services that is consistent with the statute and includes an optional section for mental health treatment that explicitly identifies psychotropic medications, electroconvulsive treatment and admission to and retention in a facility. There is room in the form for additional instructions and the form is customizable.

PADs are widely endorsed. The Department of Health requires educating the person served about PADs as part of the certification criteria for a provider to becomes a Certified Community Behavioral Health Clinic.[18] SAMHSA has included PADs in the "Essential Principals for Modern Crisis Care Systems."[19] That toolkit is cited in the most recent Alaska Behavioral Health Provider Service Standards and Administrative Procedures for Behavioral Health Provider Services.

Challenges

The primary challenge limiting the use of PADs is consumer awareness. Many people simply don't know that PADs exist or how they can be useful. But even if someone is interested in creating a PAD, they may not have sufficient understanding of treatment options or legal implications to be able to complete the process. Facilitation is not only essential to guiding the individual through the steps required to make a legally valid PAD, but it also assures that the content of the PAD will provide clear guidance, avoiding contradictions and increasing the likelihood that future providers who honor the PAD have sufficient effective treatment options to provide support. A study by the NRC-PAD found that peer-facilitated PADs were rated more feasible and consistent than those facilitated by non-peer clinicians.[20] Like person-directed treatment planning, reviewing and updating the PAD can serve as important tool for empowering the person served. Once a person has a PAD, it should be reviewed as part of discharge planning after any crisis episode. PADs should also be reviewed as new treatment options become available. While the state of Alaska does not include advanced care planning as a Medicaid-reimbursable behavioral health service, the Centers for Medicaid and Medicare Services have recently updated Medicare billing guidance for Federally Qualified Health Center and Rural Health Clinics.[21]

Once a PAD is valid, it must be communicated. In an ideal scenario, a PAD would be shared with that person's primary physician and mental health care provider. The PAD would then be added to the person's medical record. A dozen states currently have state-wide registries, with three states contracting to a private registry company.[22] Many registries also encourage wallet cards to alert providers or emergency responders of the existence of an advanced directive. Because each state has their own laws on advanced directives, portability across state lines is a concern, although most states will honor an advanced directive so long as it is valid in the state in which it was written.[23]

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[18] HSS - requires PAD education be provided as part of CCBHC criteria: 2.c.3, 3.a.4, 4.e.7, 4.k.4.

[19] SAMHSA. (2019). Practical Guide to Psychiatric Advanced Directives.

[20] Belden, C.M., Gilbert. A., Easter, M., & Swartz, M., & Swanson, J. (2021). Appropriateness of psychiatric advanced directives facilitated by peer support specialists and clinicians on Assertive Community Treatment Teams. Journal of Mental Health, 31(2), 239-245.

[21] Centers for Medicaid and Medicare Services. (Feb 2023). Medicare Learning Network Factsheet.

[22] Holmes, Preston. (2016). A Tour of State Advance Directive Registries. *Bifocal* 37(6): 122-127.

[23] Sabatino, C. (2016). Can my Advance Directives travel across state lines? An essay on portability. *Bifocal* 38(1): 3-6.

If a provider is unfamiliar with PADs, they may have concerns about liability or may even be skeptical about the ethics and effectiveness of shared decision making.[24] Provider education, clear policies on the state and organizational level, and robust training for PAD facilitators are all important components of successful PAD implementation.

[24] SAMHSA. (2019). Practical Guide to Psychiatric Advanced Directives.

Appendix D: Previously Proposed Alaska Legislation Regarding a Statewide Grievance Process

	HB 214 – 2013-2014 Session
Proposed Changes	Section 1. AS 44.64.030(a) is amended by adding a new paragraph to read: **AS 47.30.847(a)(3) (mental health patient grievance appeals).**
Proposed Changes	Sec. 2. AS 47.30.840(a) is amended to read: (a) A person undergoing evaluation or treatment under AS 47.30.660 -47.30.915 (11) may not be retaliated against or subjected to any adverse change of conditions or treatment solely because of assertion of rights under this section; **(12) has the right to file a grievance under AS 47.30.847;** **(13) has the right to a designated representative employed and clearly identified by an evaluation facility or unit or a designated treatment facility or unit to act as a patient advocate and to assist in the filing of a grievance under AS 47.30.847;** **(14) who has been evaluated or treated in a locked evaluation facility or unit or a designated treatment facility or unit for more than three days has the right to a reasonable opportunity to maintain natural support systems, including family, friends, and help networks.**
Proposed Changes	Sec. 3. AS 47.30.847 is repealed and reenacted to read: **3 Sec. 47.30.847. Patient grievance procedure. (a) The department shall establish a standardized statewide mental health patient grievance procedure for the benefit of any person who is undergoing evaluation or treatment at an evaluation facility or unit or designated treatment facility or unit under AS 47.30.660 - 47.30.915.** **The grievance procedure must include** **(1) a 24-hour crisis telephone line operated by the department for filing and reviewing a grievance;** **(2) a standardized form for filing a grievance;** **(3) an appeal procedure that includes an administrative appeal to an impartial body designated by the department;** **(4) a standardized notice of the grievance and appeal procedure;** **(5) regular monitoring of compliance with the procedure; and** **(6) timely records review and maintenance.** **(b) An evaluation facility or unit and a designated treatment facility or unit shall comply with the grievance procedure established in (a) of this section, regardless of the availability of a less formal procedure for comments and suggestions. Once filed, all grievances shall be processed on a single form and completed to resolution.** **The facility or unit shall** **(1) provide a form approved by the department for submission of a grievance and a secure box for deposit of grievances; the contents of the box must be reviewed each day a patient is being treated or evaluated; the form must be readily accessible to the patient and easily understood by the patient or easily explained by a staff member in a language and method understandable to the patient; the original and a copy of a completed form submitted to the facility or unit must be kept in the patient's record;** **(2) maintain a complete record of all documents, including the grievance and appeals and responses to the grievance and appeals;** **(3) deliver to the department within 24 hours an electronic copy of the initial grievance and all documents received under (2) of this subsection; and** **(4) conduct an urgent level of review and provide to the grievant a decision within 24 hours after receipt of a grievance that alleges** **(A) sexual abuse; B) physical abuse; or (C) denial of** **(i) lifesaving treatment or procedures; (ii) lifesaving medications; or (iii) basic care or human rights, as defined by the commissioner.**

	(c) Unless an extension of time of not more than five business days is agreed to by a patient or the patient's representative, an evaluation facility or unit or a designated treatment facility or unit shall mail or hand deliver a written response to the patient and an electronic copy of the response to the department within five days after receipt of a grievance or request for additional review. The response must include the reasons for the decision and a description of the appeal process. The grievant may request review by the commissioner within five business days if a written response is not consistent with this section or AS 47.30.840. **(d) An evaluation facility or unit and a designated treatment facility or unit shall have a designated staff member who is trained in mental health consumer advocacy who shall, on a patient's request, serve as an advocate to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights.** **(e) A grievant may not file a grievance or an appeal later than one year after being discharged from an evaluation facility or unit or a designated treatment facility or unit. The facility or unit shall make a good faith effort to mail a response to a grievant who has been discharged from the facility.** **(f) The department shall review all grievances and responses to grievances for compliance with this section and intervene when necessary to protect rights under AS 47.30.840.** **(g) An evaluation facility or unit and a designated treatment facility or unit shall prepare and file a quarterly report with the department that describes the** **(1) number of grievances submitted; (2) general issue raised in each grievance; and 3) resolution, including litigation, of all grievances submitted.** **(h) The department shall provide to the governor and to the legislature a biennial report of the number, locations, and types of grievances filed under this section and recommendations of the department to improve mental health evaluation, treatment, and procedures in the state. The report must preserve the confidentiality of a person who is the subject of a grievance. The department shall make the report available to the public.** **(i) In this section,** **(1) "grievance" means a complaint or concern filed by a grievant on a form provided by an evaluation facility or unit or a designated treatment facility or unit;** **(2) "grievant" means a patient of an evaluation facility or unit or a designated treatment facility or unit, or the patient's representative;** **(3) "unit" means a portion of a health care facility dedicated to the evaluation or treatment of mental health patients.** * Sec. 4. AS 47.30.855 is amended by adding new subsections to read: **(b) The department shall provide to an evaluation facility or unit or designated treatment facility or unit for posting and distribution a standardized notice that is designed to be easily understood and that separately describes patient rights, available assistance, and the grievance procedure described in AS 47.30.847.** **(c) A person in charge of an evaluation facility or unit or designated treatment facility or unit shall ensure that each patient or patient's representative receives a written copy of the standardized notice provided by the department under (b) of this section and of the grievance procedure described in AS 47.30.847.** **(d) In this section, "unit" has the meaning given in AS 47.30.847.**
Sponsor Statement	None available as of 6/5/23.
Opposing Statement	None available as of 6/5/23.

	SB 55 – 2011-2012 session
Proposed Changes	* Section 1. AS 47.30.840(a) is amended to read: **(12) has the right to be treated with dignity and respect;** **(13) has the right to confidentiality of and access to the person's evaluation and treatment records maintained by the facility;** **(14) has the right to an individualized treatment plan, and the right to be involved in developing the treatment plan, while residing at the facility;** **(15) has the right to informed consent by the person or the person's legal representative;** **(16) has the right to freedom from seclusion and restraint;**

	(17) has the right to file a grievance any time during operating hours under AS 47.30.847; **(18) has the right to a designated staff member clearly identified by a treatment facility to act as a patient advocate and to assist in the filing of a grievance under AS 47.30.847;** **(19) has the right to consult with a patient advocate or representative of the patient's choosing on any day during reasonable hours.**
Proposed Changes	*** Sec. 2.** AS 47.30.847 is repealed and reenacted to read: a) A person undergoing evaluation or treatment at a public or private evaluation facility or unit or designated treatment facility or unit under AS 47.30.660 - 47.30.915 has the right to bring a grievance concerning the patient's treatment, care, or rights. (b) The department shall establish one or more impartial call centers for the purpose of receiving, referring, and tracking grievances filed under this section. The call center shall maintain an electronic database and hard copies of all grievances filed under this section. The call center shall be made available to a grievant at no charge and at all times and shall process a grievance immediately as provided in this section. The call center shall assist a grievant in filing a grievance and shall provide procedural information but may not advise a grievant. (c) A facility or unit shall provide a formal grievance procedure, which must include referral to a call center established under (b) of this section, for all patient grievances on any subject brought under (a) of this section, regardless of the availability of a less formal procedure for comments and suggestions. Once filed to the best of the grievant's knowledge and ability, all grievances shall be processed on a single form. The grievance procedure must include (1) written notice on admission to the facility of the availability of the formal grievance procedure and facility rules pertaining to the grievance procedure; (2) a form for submission of a grievance, access to a call center, and a secure box for deposit of grievance reporting forms; the contents of the box must be reviewed each day patients are being treated or evaluated; the form must be readily accessible to the patient and understood by the patient or easily explained by a staff member in a language and method understandable to the patient; the original of a completed form submitted to the facility must be kept in the patient's record; the form must contain the heading "Alaska Department of Health and Social Services, Mental Health Grievance Reporting Form," and include (A) the name of the grievant and the grievant's contact information, including the grievant's address and telephone number; (B) the date and time of the completion of the grievance form; (C) the name and physical location of the service provider; (D) the date on which the event giving rise to the grievance took place; (E) the names of persons involved in the event giving rise to the grievance, if known; (F) a narrative description of the event giving rise to the grievance; (G) the specific issue to be addressed; (H) the grievant's suggested resolution of the grievance; (I) the investigative steps taken to formulate the facility's or unit's response; (J) the response and date of response by the facility or unit; (K) the signature of the grievant at each level, including the initial grievance; (L) the signature of the reviewer and date of review for each level of review; and (M) options for the grievant to check following each response by the facility or unit, as follows: (i) I agree; (ii) I do not agree; (iii) submit to level two review; (iv) submit to level three review; (3) a written list showing contact information for available advocacy agencies, including the department, facility accrediting bodies, the ombudsman, and the Disability Law Center of Alaska; (4) three levels of review, as follows: (A) level one, an initial review and written decision by a supervisory staff member to determine whether a grievant's treatment, care, or rights have been adversely affected, a written record of that determination, and, if the grievant's rights have been aversely affected, implementation of a mutually agreed upon resolution of the grievance; (B) level two, if a resolution is not agreed upon or implemented under a level one review, a grievant may initiate a review within 20 calendar days after the determination is made under level one; a chief executive officer or the commissioner's designee for a facility shall make written findings and issue a decision within five business days after initiation of a level two review; if the level two review results in a finding of no adverse effect, no additional review is necessary, but the decision may be appealed under (C) of this paragraph by a grievant, and the written decision must include notice of the availability of a level three appeal;

	C) level three, a grievant may appeal the final written decision made under level two to the commissioner within 30 calendar days after receipt of the findings of the level two review; the commissioner shall make a final written decision on or before the 14th calendar day after the appeal is filed; if the commissioner fails to enter a timely decision, the appeal shall be considered denied; the commissioner may deny an appeal for substantial failure to follow the procedures set out in this section; a denial or decision by the commissioner may be appealed to the superior court within 30 calendar days; (5) maintenance of a complete and confidential record, available on request by the grievant or the grievant's designated representative, of all documents, including the grievance and appeals and responses to the grievance and appeals; (6) delivery, within 24 hours, of a copy of the initial grievance and of all documents maintained under (5) of this subsection to the call center established under (b) of this section, which shall promptly provide all necessary information to (A) the grievant or the grievant's representative; (B) the department; the department shall maintain confidentiality over the grievant's health and personal information; (C) the person responsible for the next level of review; and (D) the person in charge of the facility or unit; and (7) in addition to the three levels of review and parallel procedures available under criminal and other laws provided under (4) of this subsection, an urgent level of review and expedited administrative decision, available at all times to a current patient of a facility or unit, to be conducted immediately by the chief executive officer at the facility and referred to a call center and reviewed by the department not later than 24 hours after receipt of a grievance that alleges an immediate threat to the health or welfare of a grievant. (d) Except as provided in (c)(7) of this section, unless an extension of time of not more than five business days is agreed upon by a patient or the patient's representative, an evaluation facility or unit or a designated treatment facility or unit shall mail or hand deliver a written response to a call center within five business days after receipt of a grievance or request for additional review. The response must include the reasons for the decision and a description of the appeal process. The grievant may request review at the next level if a written response is not timely. (e) An evaluation facility or unit and a designated treatment facility or unit shall have a designated staff member who is trained in mental health consumer advocacy who shall, on a patient's request, serve as an advocate to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights. (f) A grievant may not file a grievance later than one year after the incident giving rise to the grievance. The facility or unit shall make a good faith effort to mail a response to a grievant who has been discharged from the facility. (g) The department shall review all grievances and responses to grievances for compliance with this section. (h) A facility or unit shall prepare and file a quarterly report with the department that describes the (1) number of grievances submitted; (2) general issue raised in each grievance; and (3) resolution, including litigation, of all grievances submitted. (i) The department shall compile the information provided under (h) of this section and provide a quarterly report to be posted for public review that describes the number and types of grievances filed against each facility in the previous quarter. (j) Nothing in this section shall be interpreted to prohibit informal dispute resolution or mediation by the written agreement of the grievant, the facility or unit, and the department at any time during the grievance process but before a lawsuit concerning the subject of the grievance is filed by a grievant. (k) A facility may not discourage or delay a patient's access to an advocate or representative of the patient's choosing. (*l*) If a grievance decision made under this section is appealed to a court, the court shall presume that the imposition of attorney fees on a grievant would inflict a substantial and undue hardship on the grievant under AS 09.60.010(e). (m) In this section, (1) "facility" has the meaning given to "designated treatment facility" or "evaluation facility" in AS 47.30.915; and means a unit of a hospital in which patients receive mental health evaluation or treatment and for which public funds are provided; (2) "grievance" means a complaint made by a grievant concerning a patient's treatment, care, or rights at a facility;

	(3) "grievant" means a patient of a public or private mental health treatment or evaluation facility or unit or the patient's representative; (4) "unit" means a discrete portion of a facility dedicated to the treatment or evaluation of mental health patients. *** Sec. 3.** AS 47.30.855 is amended by adding new subsections to read: (b) The department shall provide to a facility for posting and distribution a standardized notice that is designed to be easily understood and that separately describes patient rights, available assistance, and the grievance procedure provided under AS 47.30.847. *New Text Underlined [DELETED TEXT BRACKETED]* (c) A person in charge 1 of a facility shall ensure that each patient or patient's representative receives a written copy of the standardized notice provided by the department under (b) of this section and of the formal grievance procedure described in AS 47.30.847(c). (d) In this section, "facility" has the meaning given in AS 47.30.847. *** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read: INDIRECT COURT RULE AMENDMENT. AS 47.30.847(*l*), added by sec. 2 of this Act, has the effect of changing Rule 82, Alaska Rules of Civil Procedure, and Rule 508, Alaska Rules of Appellate Procedure, by limiting the court's discretion in awarding attorney fees in certain cases. *** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read: CONDITIONAL EFFECT. AS 47.30.847(*l*), added by sec. 2 of this Act, takes effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.
Sponsor Statement	• Bill applies to all state and private mental health hospitals, clinics and units which receive public funds • 8,00-10,000 admissions/year, yet few formal grievances for a particularly vulnerable population • Criminals in corrections systems ironically afforded more comprehensive grievance procedures, due rights and protections under law. • "Because of the exceptional circumstances under which mental health patients are admitted and treated, due process requires special safeguards in transparent, readily available grievance procedures and more state oversight."
Opposing Statement	North Star Behavioral Health • Already have many avenues to protect patient rights. • On floor staff help resolve many grievances, and leadership review all grievances monthly. • Bill impetus "not related to children and adolescents" who have "numerous adults" to ensure care and safety. • "This population, by its nature, often exhibits poor judgment and boundaries" and would use the system to distract from care and tie up staffing time. • Please limit bill to patients over 18 years old. ABADA + AMHB • Gaps must be addressed without adding complexity- bill should be reviewed in context of other requirements • No support of a "call center" • Commissioner of HSS cannot designate an officer within private facilities. Also note concerns for fiscal notes and processes to involve an assistant attorney general. • Burden of proof shifted to the treatment provider, which "contradicts the usual course of these sorts of proceedings" and denies treatment providers due process.

	SB 66 – 2009-2010 session
Proposed Changes	Section 1. AS 44.64.030(a) is amended by adding a new paragraph to read: (41) AS 47.30.847(b)(4)(C) (mental health patient grievance appeals).
Proposed Changes	* Sec. 2. AS 47.30.847 is repealed and reenacted to read: Sec. 47.30.847. Patient grievance procedure. (a) A person undergoing evaluation or treatment at a public or private evaluation facility or unit or designated treatment facility or unit under AS 47.30.660 - 47.30.915 has the right to bring to an impartial body as a formal grievance suggestions about, complaints about, and appeals related to the person's treatment, care, or rights at the evaluation facility or unit or designated treatment facility or unit. The person may designate a representative to bring and appeal a grievance on the person's behalf.

	(b) An evaluation facility or unit and a designated treatment facility or unit shall provide a formal grievance procedure that includes due process for all patient grievances on any subject brought under (a) of this section, regardless of the availability of a less formal procedure for comments and suggestions and regardless of the outcome of the less formal procedure. Once filed, all formal grievances shall be processed on a single form and completed to resolution. The grievance procedure must include (1) a form for submission of a grievance and a secure box for deposit of grievances; the contents of the box must be reviewed each day patients are being treated or evaluated; the form must be readily accessible to the patient and easily understood by the patient or easily explained by a staff member in a language and method understandable to the patient; the original and a copy of a completed form submitted to the facility must be kept in the patient's record; the form must contain the heading "Alaska Department of Health and Social Services, Division of Mental Health, Grievance Reporting Form," and include (A) the name of the grievant and the grievant's contact information, including the grievant's address and telephone number; (B) the date and time of the completion of the grievance form; (C) the name and physical location of the service provider; (D) the date on which the event giving rise to the grievance took place; (E) the names of persons involved in the event giving rise to the grievance; (F) a narrative description of the event giving rise to the grievance; (G) the specific issue to be addressed; (H) the grievant's suggested resolution of the grievance; (I) the investigative steps taken to formulate the facility's or unit's response; (J) the response and date of response by the facility or unit; (K) the signature of the grievant at each level, including the initial grievance; (L) the signature of the reviewer and date of review for each level of review; and (M) options for the grievant to check following each response by the facility or unit, as follows: (i) I agree; (ii) I do not agree; (iii) submit to level two review; (iv) submit to level three review, a formal hearing before the office of administrative hearings; (2) notice of the availability and content of the grievance procedure and the associated policies provided to each patient or the patient's representative in writing; (3) signed verification of the information provided under (1) and (2) of this subsection; (4) three levels of review, as follows: A) level one, an initial review by a supervisory staff member to determine whether a grievant's treatment, care, or rights have been adversely affected and, if implementation of a mutually agreed upon resolution of the grievance; (B) if a resolution is not agreed upon or implemented under a level-one review, level two, review by a chief executive officer of a private facility or by the commissioner's designee for a public facility initiated by a grievant within 20 days after the determination made under level one; if the level-two review results in a finding of no adverse effect, no additional review is necessary, but the decision may be appealed under (C) of this paragraph by a grievant; (C) level three, a grievant may appeal the final written decision made under level two of this section to the office of administrative hearings (AS 44.64.010) under AS 44.62.330 - 44.62.630 within 20 days after receipt of the findings of the level-two review; (5) maintenance of a complete record of all documents, including the grievance and responses to the grievance; (6) immediate delivery of a copy of all documents maintained under (5) of this subsection to (A) the division of the department that is responsible for behavioral health; (B) the person responsible for the next level of review; and (C) the person in charge of the facility or unit; (7) in addition to the three levels of review provided under (4) of this subsection, an urgent level of review to be conducted by the chief executive officer or a designee of a private facility or unit or by the commissioner for a public facility within 24 hours after receipt of a grievance that alleges (A) sexual abuse;

	(B) physical abuse; or (C) denial of (i) lifesaving treatment or procedures; (ii) lifesaving medications; or (iii) basic care or human rights, as defined by the commissioner; and (8) a written response to the grievant on the form required by (1) of this subsection within five days after receipt of the grievance. c) Unless an extension of time of not more than five days is agreed upon by a patient or the patient's representative, an evaluation facility or unit or a designated treatment facility or unit shall mail or hand deliver a written response to the patient within five days after receipt of a grievance or request for additional review. The response must include the reasons for the decision and a description of the appeal process. The grievant may request review at the next level if a written response is not timely. (d) An evaluation facility or unit and a designated treatment facility or unit shall have a designated staff member who is trained in mental health consumer advocacy who shall, on a patient's request, serve as an advocate to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights. (e) A grievant may file a grievance at any time, except that a grievant may not file a grievance or an appeal later than one year after being discharged from the facility or unit. (f) The burden of proof required for all grievance reviews shall be on the facility or unit against which a grievance is filed to prove compliance or remedial action sufficient to comply with applicable laws and procedures. (g) The department shall review all grievances and responses to grievances for compliance with this section. (h) A public or private mental health treatment facility or unit shall prepare and file a quarterly report with the department that describes the (1) number of grievances submitted; (2) general issue raised in each grievance; and (3) resolution, including litigation, of all grievances submitted. (i) Nothing in this section shall be interpreted to prohibit informal dispute resolution or mediation by the written agreement of the grievant, the facility or unit, and the department at any time during the grievance process but before a lawsuit concerning the subject of the grievance is filed by a grievant. (j) In this section, (1) "grievance" means a complaint, concern, or suggestion made by a grievant on a form provided by a public or private mental health treatment or evaluation facility or unit; (2) "grievant" means a patient of a public or private mental health treatment or evaluation facility or unit or the patient's representative.
Sponsor Statement	None available as of 6/5/23.
Opposing Statement	None available as of 6/5/23.

Appendix E: Comparison of Statewide Grievance Processes in Other States

State	MA	ME	MD	VA
Statute/Code	104 CMR 32.00	34-B M.R.S.A section 3003	COMAR 10.21.14.02	12VAC35-115-10; 12VAC35-115-175
Applied To	104 CMR 32.00 applies to the Department and to **all programs, and facilities licensed or contracted for** by the Department.	any facility that provides inpatient psychiatric services and any agency or facility providing in-patient, residential or outpatient mental health services that is licensed by, funded by or has a contract with either the Department of Mental Health and Mental Retardation or the Department of Human Services.	Inpatient or residential institutions owned or directly operated by the Behavioral Health Administration	All facilities owned, operated or licensed by the Department of Behavioral Heath and Developmental Services
Grievance Process	*Availability + Process* 1) Facility management ensures "conspicuous" placement of complaint and appeals process education and copies of relevant paperwork 2) Patients or employees may file 3) Human Rights Officer (facility/program designated) may 1) assist with filing complaint or 2) refer complainant to an attorney or advocate. 4) The Human Rights Committee (facility/program based) may file a complaint on behalf of a client or group of clients and may intervene as a party to a complaint by submitting a notice	*Availability + Process* 1) During admission or intake, or as soon afterwards as is feasible, recipients should be informed of their rights and given a summary of these rights in plain language. 2) At each level of the formal grievance procedure, the recipient or other grievance have rights to the following a) Assistance by a representative of their own choosing b) Representation by the Office of Advocacy or the rights protection	*Availability + Process* Facilities shall provide direct and effective communication means between residents and the rights advisor (works for the Dept of Health, and based in the facility) *Grievance Receipt* **Stage 1** 1) After receipt of the grievance, the Rights Advisor will meet with all parties involved.	*Availability + Process* 1) Individuals may file a complaint about the violation of any rights or under other applicable laws. 2) Providers/facilities must have established processes and detail the complaint review process. 3) Complaint resolution policies and procedures must be written and approved by the department before implementation.

	of intervention to management/leadership *Complaint Receipt* 1) Facility management/leadership will determine if it meets one of seven criteria. (Medicolegal Death; Sexual assault or abuse; Physical assault or abuse resulting in serious physical harm; Attempted suicide attempt resulting in serious physical harm; Commission of a felony; Serious physical injury resulting from restraint/seclusion practices; Incident management believes, at their discretion, is serious or complicated enough to require investigation 2) If YES. Management will forward the complaint to one of 5 identified State Agencies/Depts, based on the location/nature of the complaint: a) Area Director b) Director of the Office of Inpatient Management c) Director of Statewide Program Management d) Senior Manager of a Dept e) The applicable Director of Licensing 3) Once the responsible State entity receives the complaint a) Immediate assignment of public log number b) Referral to the Office of Investigations c) Notify parties and appropriate Human Rights Officer	and advocacy agency of the Main mental health system c) Review of any information pertained to the processing of the grievance, except that which would violate the confidentiality of another person. d) Presentation of evidence or witnesses pertinent to the grievance. e) Receipt of complete findings and recommendations except those what would violate confidentiality. 3) Electronic or written record will be made of all proceedings associated with formal grievances. 4) Burden of proof shall be on the agency, facility or program to show compliance or remedial actions. 5) Findings will include: facts, determination regarding facility, agency, or program adherence or failure to specific policies and procedures, and any specific remedial steps to assure compliance. *Grievance Receipt*	2) The Rights Advisor will determine if the grievance is valid or invalid. 3) The Rights Advisor will make every effort to "negotiate, mediate and resolve" grievances fairly. If the grievant is satisfied, the case is closed. 4) Decisions must be made within 10 working days of receipt. 5) If resolved to the grievant's satisfaction, a copy of the decision shall be forwarded to the unit director, the grievant, the CEO, and legal representative, if applicable. 6) If there is concern for immediate harm, facility leadership and appropriate State leadership will be notified. If substantiated, development and implementation of a solution must occur within 24 hours. *Grievance Resolution* If a "grievance with merit" is not resolved to the grievant's satisfaction and they wish to appeal, the Rights Advisor will forward a copy of the grievance and recommendations to the unit director.	*Complaint Receipt* 1) The individual will be contacted by the program/facility within 24 hours of the complaint 2) Providers will a) notify the department no later than the next business day. b) Initiate an impartial investigation no later than the next business day. c) Ensure protection from retaliation or harm for all involved. d) Communicate to the individual in the manner, format and language most easily understood by that individual. e) Report the decision and action plan within 10 working days to the individual or other authorize representative. 3) Additional provisions noted for complaints involving abuse, neglect or exploitation.

	4) There is a separate process if the complaint is about violations of privacy rights 5) If the complaint doesn't meet one of the seven criteria, facility/program management is responsible for addressing a) State-operated programs or facilities must enter the complaint into the Department complaint recording system b) State-licensed: internal logging system *Complaint Resolution* 1) Responsible Person may resolve **administratively** if complaint meets one of six criteria. 2) Responsible Person must meet with client/complainant within 3 business days of determining administrative resolution, unless complainant declines to meet or cannot be located. 3) Meeting content: review, determine if there are disagreements, discuss and possibly agree upon actions that may address concerns raised by the complaint **4)** If criteria for administrative resolution aren't met, the Responsible Person shall refer the complaint for **fact-finding or investigation.** 5) Written decision provided within 5 business days of filing the complaint or 2 business of the meeting, whichever is later.	**Level One** 1) Formal grievances should be filed first with the supervisor of that service delivery unit. 2) Copies of the grievance are forwarded by the supervisor to the administrative head of that agency/facility, and to the office of advocacy upon request of the grievant. 3) In state operated facilities, all grievances are immediately forwarded to the office of advocacy. 4) Formal written response shall be made within 5 days, excepting weekends and holidays. 5) A 5-day extension may be granted if more investigation time is necessary, with the grievant notified. 6) If the grievant is dissatisfied with the findings, they may appeal the decision to the Chief Admin Officer of the facility or the Director of the Division of Mental Health for grievances arising in the community. 7) Appeals must be made within 10 days, excluding weekends or holidays. **Level Two**	**Stage 2** 1) Upon receipt of the grievance, the unit director will decide within 5 working days whether to accept the Rights' Advisor completely or modify/reject recommendations. 2) A written decision will be forwarded to the Right's Advisor, who shall forward copies to the grievant, CEO, and grievant's legal representative, if involved. 3) The grievance may end at this stage. 4) If dissatisfied with the action taken, the Right's Advisor may request a review by the resident's rights committee with subsequent review by the CEO at the request of the grievant. Or skip committee review and go straight to the CEO. **Stage 3** 1) Resident's rights committees is composed of at least 9 members representative of: facility staffs, residents (former, current, or family members), and advocacy groups. 2) The resident's rights committee shall meet within 15 working days of receipt of grievance.	

	Referral to the Office of Investigation 1) Confirm complaint logging and whether another entity has jurisdiction within two business days of receipt 2) If Office of Investigation doesn't believe their role necessary/appropriate, they will consult with the applicable Responsible Person who will determine the appropriate resolution process. 3) Investigator has specifically described duties, which must be done within 30 days of assignment. a) Within 10 days of receiving Investigator's report, the Responsible Person shall: b) Accept decision and identify corrective actions, if any c) Refer the matter for further fact-finding d) Issue a decision-making of their own conclusion, including explanation of rationale 4) Decision provided to all parties with notice of the right to request reconsideration 5) Investigation may be deferred if another authorized entity is conducting investigations 6) Deferrals >60 days shall be reviewed by the Office	1) A level two grievance is responded to within 5 days, excluding weekends and holidays, of appeal receipt. 2) The Chief Admin Officer or the Director of the DMH, or designee, may hold a hearing before an impartial officer who shall be free from bias, personal/financial interest, with all involved parties. 3) Grievants may appeal within 10 days, excluding weekends or holidays, to the Commissioner of the Dept of Mental Health and Mental Retardation. 4) Grievances determined to be without merit may not be appealed. 5) Justification of the decision of lack of merit will be provided in writing to the grievant and will include notice of other avenues of redress. *Exceptions* 1) Any allegations of abuse, mistreatment or exploitation shall be immediately reported to the Office of Advocacy and the Chief Admin Officer of the facility/agency. 2) Any grievance the grievant considers urgent will be forwarded by staff within 1 working day to the Chief	3) The committee will review all relevant information, data and recommendations pertaining to the grievance and forward written recommendations to the CEO. 4) The grievant may choose to waive review by the committee. 5) While the Rights' Advisor is responsible for notification of all parties and presenting information, they are not allowed to be present during deliberations. 6) The CEO shall determine what, if any, action is to be taken and notify the committee in writing of any action taken after receipt of committee recommendations. 7) The CEO has 15 working days to respond to recommendations if legal representation is involved, or 5 working days if not. 8) Grievance decision by the CEO is forwarded to the Rights' Advisor, who will forward copies of this decision to the appropriate parties. 9) If the grievant is not satisfied with the CEO's decision, they have the right to file an appeal within 5 working days after receipt of that decision.	

		Admin Officer of the facility, or the Director of the Divisions of Mental health, or designees at Level 2 and the Office of Advocacy notified. 3) All grievances concerning the development, substantive terms or implementation of discharge plans, hospital treatment or Individual Support Plans shall be considered urgent.		
Appeal Process	*Request for Reconsideration* 1) Must be submitted in writing within 10 days of the complainant party receipt of the decision. 2) Time period may be waived by the Responsible Person, upon request and "for good cause shown" 3) Responsible Person has 10 days from receipt of request to issue a **final** decision affirming, modifying ore reversing initial decision. 4) Final decision will be in writing and inform the client of the right to appeal. *Appeals* 1) Must be in writing and filed within 10 days of receipt of applicable decision. 2) Appeal must be based on at least one of the following factors	*Commissioner* **Level 3** 1) The Commissioner or designee will make a formal written reply within 5 days, excluding weekends or holidays. 2) If no hearing was held at the Level 2 grievance a hearing shall be held at Level Three. 3) A 5-day continuance may occur if a hearing is to be held, or if parties to the grievance concur. 4) The Commissioner's or designee's findings will constitute the final action by the Department regarding grievances. *Further Appeal*	*Central Review Committee* The Central Review Committee is comprised of MD Dept of Health staff or their designees from the following positions: Director of BH Administration, clinical director of BH Administration and Director of the Resident Grievance System **Stage 4** 1) This committee must meet within 10 days of receipt of an appeal. 2) May perform an investigation within an additional 10 working days. 3) The committee will write and forward a decision to the appropriate parties. 4) The committee shall request the CEO to provide	*Appeals* 1) Individuals or their representative disagreeing with the final decision or action plan may request a hearing with the Local Human Rights Committee (LHRC). 2) Petitions for a hearing must be filed in writing within 10 working days from receipt of final decision. 3) The LHRC Chair will forward a copy of the petition to the facility/program director and human rights advocate as soon as it's received. 4) The director must submit an entire written record of the complaint and a written response to everything contained in

	3) Failure to interview an essential witness or consider an important fact or factor. 4) Decision wasn't reasonably supported by the facts 5) Decision was based on erroneous interpretation of applicable law/policy. 6) The responsible party for deciding the appeal may direct additional fact-finding within 10 days of receipt of appeal. 7) Decisions on appeal shall be issued within 30 days of receipt of appeal, unless further fact-finding is required. 8) Specific State entities identified for appeal based on the program/facility involved in the original complaint. *Appeal Resolution* 1) Appeal decision may affirm, modify or reverse the decision. Corrective actions, if any, shall be included. 2) Sent in writing to all parties. 3) Notify the client of their right to further appeal within 10 days to the Commissioner, whose decision is final.	Grievants may appeal the decision to the Superior Court	a written report on the status of implementation of recommendations within 20 working days. 5) Until the decision is fully implemented, the CEO shall make periodic reports to the committee every 30 days. 6) If the grievant is satisfied, the case is closed. If dissatisfied, the Right's Advisor shall inform them on additional relevant legal services they may contact.	the petition within 5 working days. 5) The LHRC will hold a hearing within 20 working days of receipt of the petition. 6) All parties will have at least 5 working days' notice of the hearing. 7) Hearings are informal and rules of evidence are not applicable. Hearings are also conducted in a non-adversarial manner. 8) Within 10 working days of the hearing, the LHRC's written findings and recommendations are provided to all parties. 9) Within 5 working days of receiving the findings, the director shall give a written action plan for intended implementation in response to findings. Included will be a written notice to the individual about the timeframe for their response; failure to respond within that timeframe will close the complaint. 10) Other parties may object to the written action plan within 5 working days by stating the objection and what the director should do to resolve the objection(s).

				Appeal to the State Human Rights Committee 1) Individuals may appeal to the SHRC if they disagree with the LHRC's findings, final decisions or a director's final action plan.
State	*MA*	*ME*	*MD*	*VA*

Appendix F: Recommendations

System Recommendations

The project team engaged with a diverse array of stakeholders with varied experiences and philosophies. Recommendations were shared in many settings, including community engagement, subcommittee meetings, and other stakeholder interactions. It is important to note that unanimity was reached only for a minority of recommendations, and a substantial number of recommendations were determined to fall outside of the legislative directive in HB 172. The systems recommendations below are organized alphabetically by topic area and are not in order of priority.

Identified Issue	Recommendation	Topic Area	Source/Notes
Under AS 47.30.847(a) psychiatric patients have a right to bring their grievance to an impartial body, but there is debate about what constitutes an impartial body.	Define impartial body in statute and explore implementation across facility types.	Grievances and Appeals	Gottstein et. al., While Paper. April 2023; Subcommittee and project team discussions
Advanced directives for mental health are an underutilized resource.	Increase use of advanced directives for mental health. • Develop and provide training for providers about advanced directives for mental health, including best practices for development and processes for implementation. (Short-Term). • Explore development of a training for MH advanced directive facilitators (Medium-Term). • Explore methods for communicating MH advanced directives (ex. Statewide registry) (Medium-Term). • Conduct further research to understand if statutory changes are needed to support MH advanced directive use (Long-Term).	Informed Consent	HB 172 Stakeholder Engagement

Identified Issue	Recommendation	Topic Area	Source/Notes
If an MC-305 is granted for a community ex parte, it expires after 7 days unless the respondent is at a medical facility awaiting transportation to an evaluation facility or is already at an evaluation facility. Law enforcement express concern about a lack of clarity between courts, providers and law enforcement regarding when the 7-day period starts and ends.	Develop and distribute written guidance to all parties clarifying the start and end of the 7-day period for community ex parte pick up.	Initial Detention – Community Ex Parte	HB 172 Stakeholder Engagement
Significant gaps in understanding of the emergency detention pathway, the responsibilities of different entities under statute and how the emergency detention process plays out in practice.	Align statutory language, court forms and provider practices related to emergency detention. A working group led by an external facilitator and comprised of the Department of Law, providers, the Alaska Court System, and other relevant stakeholders 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. • Identification of revisions to court forms to ensure forms and statute are in alignment.	Initial Detention – Emergency Detention	HB 172 Stakeholder Engagement
Access to after hours/weekend magistrate varies by region, which delays an individual's admission or position on the waitlist for a bed.	Ensure consistent after-hours/weekend access to magistrates across the state. Provide region-specific education on access.	MC-100	HB 172 Stakeholder Engagement
Reports of inconsistencies in granting of MC-100 petitions depending on court location.	Develop and provide standardized training for magistrates and judges related to MC-100 processes and requirements.	MC-100	HB 172 Stakeholder Engagement

Identified Issue	Recommendation	Topic Area	Source/Notes
Courts do not distribute all Orders to all DET/DES facilities, even if all DET/DES facilities are selected.	Provide training to district courts to ensure consistent distribution of orders to all DES/DET facilities selected on the MC-100.	MC-100	HB 172 Stakeholder Engagement
An evaluation facility or treatment facility must petition for additional periods of crisis medications, additional periods for seclusion and restraint do not have the same required court review From a clinical perspective physical intervention is more harmful to the patient. Statute appears to favor seclusion and restraint over crisis medication by making it easier to administer these interventions in some settings, even though it may not be the best intervention clinically.	Review requirements in other states regarding court authorization for additional periods of crisis medications, seclusions and restraints. Research clinical best practice regarding use of seclusion, restraint and crisis medication. Consider statutory revisions based on findings and clinical best practice.	Medication, Seclusion and Restraint	HB 172 Stakeholder Engagement; Legal Subcommittee
Differing viewpoints on implementation of involuntary medication and application of existing statute related to capacity to consent for medication.	Develop a workgroup comprised of providers, Public Defender, DOL, Court Visitors and other necessary stakeholders to further explore and reconcile differing views on implementation of involuntary medication statutes.	Medications	HB 172 Stakeholder Engagement
OPA Public Guardians have extremely high caseloads. A “constant default” to full guardianship is noted, despite a statutory requirement for use of least restrictive option.	Increase use of least restrictive guardianship options.	Minors and Adults with Guardians	HB 172 Stakeholder Engagement
Variability in school response to behavioral health crisis. School response can be stigmatizing/humiliating for the child.	Develop working group to assess and address variations in district policy and implementation of policies related to behavioral health crisis.	Minors and Adults with Guardians	HB 172 Stakeholder Engagement
Group sessions that explain patient rights are inconsistently provided in facilities. No standardized notification of rights throughout the process.	Increase and standardize opportunities for patient rights education. Specifically: • Develop curriculum for providers to use for patient rights groups (Short-Term). • Develop a state-approved list of psychiatric patient rights and require posting in facilities where these rights apply and provision to patients (Short-Term). • Explore use of third-party entity to provide patient rights groups at specified facility types (Long-Term).	Notice and Provision of Rights	HB 172 Stakeholder Engagement

Identified Issue	Recommendation	Topic Area	Source/Notes
No standardized training for providers related to psychiatric patient rights in different settings.	Develop standardized training for providers regarding statutory requirements for patient rights (Short-Term).	Notice and Provision of Rights	HB 172 Stakeholder Engagement
Access to expert witness testimony for the defense typically limited to 90 and 180-day commitment hearings due to short turnaround between time petition is filed and time of hearing. Access to expert witness testimony in involuntary medication hearings.	Fund and secure a state employee position for a qualified professional to regularly confer with and testify related to commitment and involuntary medication hearings for the Public Defender Agency.	Notice and Provision of Rights, Medications	HB 172 Stakeholder Engagement.
Concerns if patient advocate staff are trained as required by AS 47.30.847(c).	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 47.30.847(c) applies (Short-term). • Contact Patient Advocate Certification Board to identify available trainings and Alaska-based trainers.	Patient Advocacy	HB 172 Stakeholder Engagement
Concern about effectiveness of patient advocacy when it is internal rather than external.	Explore use of third-party patient advocates (via State contract or other means), (Long-Term).	Patient Advocacy	Advisory Team
Parents lack support in navigating treatment decisions.	Increase access to Family Advocates to work with families when concerns arise regarding treatment and discharge.	Patient Advocacy	HB 172 Stakeholder Engagement
Current system can incentivize involuntary treatment over voluntary treatment since only involuntary status guarantees access to and payment for the highest levels of care.	Align policies, procedures and payment mechanisms to facilitate ease of access to voluntary psychiatric treatment. Specifically, address barriers to payment for transportation for voluntary hospitalization.	Patient Consent, Transportation	HB 172 Stakeholder Engagement, Legal Subcommittee discussion
Psychiatric patient rights statutes and regulations are currently tied to facility type, not patient type which means that certain rights only apply in certain settings, even if individuals are being held for the same presenting issues. Existing psychiatric patient rights statutes may not be applied uniformly.	Develop a matrix that identifies all currently enacted rights for psychiatric patients and the facility types to which the rights apply. Use the matrix to identify gaps and as a tool to consider how to apply psychiatric patient rights more broadly.	Patient Rights	Legal Review, Advisory Team

Identified Issue	Recommendation	Topic Area	Source/Notes
Concerns about training requirements for private entities that transport patients.	Ensure training requirements for transportation services provided by contracted entities for behavioral health patients are met and make training opportunities more available.	Patient Safety	Advisory Team
Staff mental health needs due to trauma experienced at work.	Support development of a platform for a daily staff safety survey that all facilities can opt in to participating in.	Patient Safety	Advisory Team
Need for more staffing and training for staff.	Develop a pool of funding to support shift coverage for staff to attend training and to support staff in participating in training.	Patient Safety	Advisory Team
All facilities reported making efforts to ensure patients are matched with staff of the gender of their choice for intimate care, but only one facility shared this is a documented policy as part of patient rights and patient handbook.	Provide education to hospitals providing mental health treatment related to AS 18.20.095, including sample language to post on units and in patient rights documents/handbooks.	Patient Safety	HB 172 Stakeholder Engagement
Medevac less likely to be initiated for behavioral health emergencies when compared with physical health emergencies. Transportation for behavioral health emergencies frequently relies on commercial flights or law enforcement transport.	Ensure timely transportation for psychiatric emergencies comparable to “medical” emergencies for both voluntary and involuntary care.	Transportation	HB 172 Stakeholder Engagement

Identified Issue	Recommendation	Topic Area	Source/Notes
Revolving door of individuals being detained, examined, waiting for an evaluation bed, transported to evaluation facility, determined not to meet criteria, and sent back to community without ever having received treatment. Individuals in rural communities lack treatment options close to home.	Increase access to behavioral health treatment in hospitals around the state. Suggestions include: • Support partnerships between hospitals and community behavioral health providers to explore development of 1115 waiver Crisis Residential and Stabilization programs within hospital campuses (but carved out from hospital cost reporting). Identify barriers and strengths of this approach. • Identify pathways for tribally-operated hospitals, critical access hospitals, and general acute care hospitals to bill for behavioral health services provided on inpatient units. • Continue to provide education to hospitals about the DES/DET program: What the requirements are, how to become designated and the payment mechanism for services. • Advocate for changes to address barriers to providing and billing for behavioral health services in hospital inpatient units. • Support hospitals with funding and technical assistance needed to provide behavioral health services on their inpatient units and/or in partnership with Community Behavioral Health via the 1115 Waiver.	Treatment and Discharge Planning	HB 172 Stakeholder Engagement; Recommendations from AHHA Child and Adolescent Behavioral Health Improvement Project workplan
Facilities providing psychiatric treatment do not all use exit surveys for patients.	Develop a standardized engagement survey for facility use and a state entity responsible for collection and analysis. Track CMS updates to reporting requirements for providers participating in the IPFQR program which includes potential adoption of a patient experience of care measure.	Treatment and Discharge Planning	Gottstein et. al., White Paper. April 2023; Advisory Team; HB 172 Stakeholder Engagement

Identified Issue	Recommendation	Topic Area	Source/Notes
Transitions back to school following inpatient or residential stays are identified as a challenge point for some families.	Develop working group comprised of school districts, providers, and parents or youth with lived experience to identify changes to improve process for back-to-school transitions following inpatient or residential care.	Treatment and Discharge Planning, Minors and Adults with Guardians	HB 172 Stakeholder Engagement

Legal Recommendations

To prioritize and sort the many recommendations proposed by members of the Legal Subcommittee, the contract team distributed a survey to committee members to identify their level of support for the recommendations involving statutory change. The recommendations below are organized by level of subcommittee support. The Advisory Team provided additional feedback on recommendations with "mixed support" from the legal subcommittee. A summary of this feedback was added to the table. The Legal Subcommittee included a mix of individuals, some of whom were State employees; some of these employees abstained from voting on the recommendations.

Within the Legal Subcommittee, as in the other subcommittees, fundamental differences in philosophy between participants resulted in varied levels of support for each recommendation. Some team members approached recommendations from the perspective of ensuring protection of psychiatric patient rights within a system of mental health care. Other team members believed that the civil commitment laws should be fully repealed and that in no case should any person be subject to involuntary care or medical treatment.

The "identified issues" are listed as they were described by the participant. Using the participant's description is not necessarily an endorsement of that framing of the issue. The table below details the presenting issue, the proposed recommendation, level of support for further exploration by legal subcommittee participants, topic area and when available, reports or additional resources for more information. Level of support for recommendations are shown via color coding, using the following key:

Majority support	5+ "yes" votes	
Majority no support	5+ "no" votes	
No support	7 "no" votes	

Full support	7 "yes" votes	
Majority no opinion	5+ "no opinion" votes	
Mixed Support	No majority vote for any option	

Identified Issue	Recommendation	Subcommittee Support	Topic Area	Source
Inconsistent understanding/usage of Title 47 by law enforcement.	Include in statute a requirement for officers to receive training on their statutory responsibility related to detention, transport and rights notification for psychiatric patients.	7 Yes	Notice and Provision of Due Rights	Legal Subcommittee meeting discussion, 4.17.23
Under AS 47.30.847(a) psychiatric patients have a right to bring their grievance to an impartial body, but that term is not defined.	Amend AS 47.30.847 to identify that the impartial body needs to be identified in the notice of rights that are provided to patients.	6 Yes 1 No	Patient Grievances	Gottstein et. al., White Paper. April 2023

A legitimate, standardized grievance process is needed.	There should be a standardized, 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.	6 Yes 1 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023 (page 37)
Lack of clarity around when an emergency detention begins and when various forms should be filled out/provided to detainee: •Many law enforcement agencies identify they do not fill out the MC 105 until an individual arrives at a facility (which could be days after the individual has been detained). •Hospitals are providing the MC-404, but this may not coincide with the time of detention. •Concern from LE about providing MC-404 in the field: Provision of forms and rights when you're handcuffing someone/they are escalated might not be the best approach – could lead to further escalation, person not able to understand what is being read to them. •Unclear when someone is detained under AS 47.30.705 when they must be notified of their rights. MC-105 appears to indicate two options: You must provide a Notice of Rights upon Emergency Detention (form MC-404) to the person being detained, immediately upon detention or arrival at the facility.	Amend AS 47.30.705 to specify when the MC-105 must be filled out, how it is filed and a timeframe for notification of rights.	5 Yes 1 No 1 No Opinion	Notice and Provision of Due Rights	HB 172 Stakeholder Engagement
Evaluation and examination used interchangeably throughout AS 47.30.	Provide definitions for examination and evaluation and distinguish usage throughout AS 47.30.	5 Yes 1 No 1 No Opinion	Notice and Provision of Due Rights	HB 172 Stakeholder Engagement

Availability of patient advocate.	The trained mental health advocate required in AS 47.30.847(c) must be clearly identified as the patient advocate in literature and postings and readily available in person to psychiatric patients.	5 Yes 1 No 1 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023 (page 37)
AS 47.30.660(b)(12) requires the Department of Family and Community Services and the Department of Health, to investigate complaints made by a patient or an interested party on behalf of a patient, but AS 47.30.660(b)(13) allows them to delegate their responsibility. There should be independent oversight beyond CMS and accrediting bodies to ensure the grievance procedure requirements are being followed, including the grievance and appeal process being fully and accurately explained to patients and available in both written form and verbal.	Direct Health Facilities Licensing to ensure grievance procedure requirements are being followed, including the process being fully and accurately explained to patients and available in both written and verbal form.	5 Yes 1 No 1 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023 (page 37)
There is no standardized and public reporting related to traumatic events experienced by a patient. The state should be required to keep and share statistics of traumatic events experienced by patients (inclusive of seclusion and restraint).	Create an equivalent to the Alaska Criminal Justice Data Commission to develop mechanism for tracking and reporting specified events and using the data to inform systems improvement initiatives.	5 Yes 1 No 1 No Opinion	Seclusion and Restraint	Gottstein et. al., White Paper. April 2023 (page 21)
Current statute related to gender choice references only hospitals who provide mental health treatment (AS 18.20.095(a)).	Include additional facility types under those required to provide a right to request intimate care by a staff member of a specific gender. Current statute references only hospitals who provide mental health treatment.	5 Yes 2 No Opinion	Patient Safety	Lived experience engagement
The word "serious" is omitted in some of the statutes allowing people to be confined for being mentally ill and dangerous to themselves or others.	Insert "serious" before "harm" in AS 47.30.730(a)(1), .735(c), & .745(b).	5 Yes 1 No	Detention + Commitment	Gottstein et. al., White Paper. April 2023

The gap period between when someone is detained under an ex parte order and when they arrive at an evaluation facility has long been identified as an issue, but likely difficult to resolve. The Alaska Supreme Court has identified that, at some point, detention while waiting for evaluation becomes a due process issue that requires the legal case to be dismissed. The court has not provided explicit guidelines.	Add to statute the explicit right to a review hearing upon request for an individual held under an ex parte order awaiting a bed, while leaving scheduling of a review hearing up to the court.	5 Yes 1 No 1 No Opinion	Detention + Commitment	Legal Subcommittee meeting discussion, 4.17.23 Alaska Supreme Court Opinion No. 7650, April 28,2023 Department of Law, email communication 4.28.23
Data tracking - Tracking should include number of involuntary commitment and involuntary medication proceeds, the results of such proceedings and patient outcomes.	Issue statutory direction to DFCS to develop a system to track individuals from the moment an MC-105 is completed, with further alerts when the MC-100 is filed, outcome of MC-100, etc.	5 Yes 1 No 1 No Opinion	Detention + Commitment	Gottstein et. al., White Paper. April 2023 (page 17) Legal Subcommittee meeting discussion, 4.17.23
AS 47.30.837(d)(1)(b), identifies that a patient's denial of their mental disorder is evidence of their lack of competence.	Repeal AS 47.30.837(d)(1)(b). *Advisory Team feedback:* Refinement rather than repeal would allow for more nuance on decisions of competency and safety. More support for refinement than for full repeal.	4 Yes 3 No	Patient Consent	Gottstein et. al., White Paper. April 2023
Rights of minors who are placed by their parents in treatment. When minors and parents have different opinions, there are issues with parents assenting to things. Add rights of minors to refuse medication.	Further exploration needed related to the rights of minors to consent for or refuse psychotropic medication without parent/guardian consent. *Advisory team feedback:* Agreement on further exploration language. Consider if the exploration should include consent for behavioral health interventions beyond psychotropic medications.	4 Yes 1 No 2 No Opinion	Minors and Adults with Guardians	Legal Subcommittee meeting discussion, 4.17.23

Some individuals are committed in a psychiatric facility for 72 hours or less. A lengthy grievance/appeal process is not meaningful.	Require a timeframe for answering a grievance or appeal that is meaningful to the time of an individual's stay (i.e. within 72-hours for those under a 72-hour evaluation order). *Advisory team feedback:* Mixed support.	4 Yes 1 No 2 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023 (page 37)
AS 47.30.660(b)(12) requires the Department of Family and Community Services and the Department of Health, to investigate complaints made by a patient or an interested party on behalf of a patient, but AS 47.30.660(b)(13) allows them to delegate their responsibility. There should be independent oversight beyond CMS and accrediting bodies to ensure the grievance procedure requirements are being followed, including the grievance and appeal process being fully and accurately explained to patients and available in both written form and verbal.	Facilities subject to AS 47.30.847 must report grievances and outcomes to DOH, and DOH will report in aggregate to the legislature. Consideration should be given to expanding this requirement to all healthcare facilities regardless of subjection to AS 47.30.847. *Advisory team feedback:* Support, but need to understand logistical and financial implications.	4 Yes 1 No 1 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023 (page 37)
Seclusion and restraint are defined differently depending on the accrediting body.	Adopt a definition of seclusion and restraint to support consistent data reporting. See 42 CFR 482.13(e) for proposed definition.	4 Yes 3 No Opinion	Seclusion and Restraint	HB 172 Contract team
The state should be required to keep and share statistics related to patient injuries for facilities subject to AS 47.30.847.	Facilities subject to AS 47.30.847 must report patient injuries to DOH and DOH will report in aggregate to the legislature. Consideration should be given to expanding this requirement to all healthcare facilities regardless of subjection to AS 47.30.847. *Advisory Team feedback:* Support. Consider inclusion of staff injuries.	4 Yes 3 No	Patient Safety	Gottstein et. al., White Paper. April 2023 (page 21)

If someone is voluntary and wants to agree to future crisis medication, they should be able to do that. The patient should be able to consent for this in advance, but the statute doesn't say that.	Amend AS 47.30.838 to allow for patients to consent in advance for crisis medications. *Advisory Team feedback:* Concern about ability to revoke previously given consent. If the ability to revoke consent is allowed for, there would be more support.	4 Yes 1 No 2 No Opinion	Medication	Legal Subcommittee meeting discussion, 4.17.23
A person taken into emergency custody should not be placed in a jail or correctional setting.	Amend AS 47.30.705 to remove "jail or other correctional facility" as locations where an individual may be delivered for protective custody/while awaiting a bed. *Advisory Team feedback:* Extensive discussion where some members expressed support and others expressed concern about where else people would be held, particularly in rural communities.	4 Yes 3 No	Detention + Commitment	Advisory Team Meeting, 5.11.23

Pre HB-172, the definition read, " 'evaluation facility' means a health care facility 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 licensed under AS 47.32 or operated by the federal government." The current language reads, " 'evaluation facility' 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." The proposal keeps the changes regarding designated facilities (changing from "health care facility" to "hospital or crisis residential center") and with respect to federal facilities (from "medical facility . . . operated by the federal government"), and it adds back to the definition other licensed hospitals as provided under the old statute. The idea with this change is to increase the number of facilities that are authorized to conduct 72-hour evaluations, which would have the effect of reducing waitlists for bed space at a designated evaluation facility and increase the likelihood individuals could be evaluated closer to their homes, which furthers the original intent of the legislature with the early 1980s rewrite of Title 47.	Amend the definition of evaluation facility in AS 47.30.915 to read (new text underlined): "Evaluation facility" 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; <u>or a hospital licensed under AS 47.32</u>; or a medical facility operated under 25 U.S.C. 5301-5423 (Indian Self-Determination and Education Assistance Act), as amended, that performs evaluations. *Advisory Team feedback:* Mixed support. Some identified that hospitals that want to can go through the existing designation process. Others advocated for evaluation personnel to be sent to hospitals that won't do the evaluations themselves, something authorized in current statute.	4 Yes 1 No 2 No Opinion	Detention + Commitment	Public Defender Agency, email communication 4.11.23 Stakeholder engagement

Two sentences in AS 47.30.705 might need to be changed. The wording, after passage of HB 172, is: "A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility. However, protective custody under this section may not include placement of a minor in a jail or secure facility." What was and is missing from this language is something that limits how long someone remains in jail "awaiting transportation," or at least prompts the authorities to get the examination done.	Add language to AS 47.30.705 to require clinical review within a certain time period of all individuals held in a jail or other correctional facility awaiting transportation.	4 Yes 2 No 1 No Opinion	Detention + Commitment	Disability Law Center, email communication 4.3.2023
HB 172 changed facility definitions and appears to have accidentally excluded emergency departments as a place where an individual can be held and examined under an MC-105.	Amend AS 47.30.705 to include health facilities as locations where an individual can be held and examined under an MC-105.	4 Yes 2 No 1 No Opinion	Detention + Commitment	Stakeholder engagement
47.30.825(h) specifically authorizes surgery in an emergency, but only surgery, not other things an individual might need in an emergency, like antibiotics.	47.30.825(h) should be amended to read: When, in the written opinion of a patient's attending physician, a true medical emergency exists and emergency medical care ~~a surgical operation~~ is necessary to save the life, physical health, eyesight, hearing, or member of the patient, the professional person in charge, or that person's professional designee, may give consent	3 Yes 2 No 2 No Opinion	Patient Consent	Legal subcommittee discussion
Further exploration needed related to the rights of minors to consent for or refuse psychotropic medication without parent/guardian consent.	Amend 47.30.660(b)(13) to continue to allow authority to be delegated, but to have that delegated authority be required to inform DFCS/DOH of all patient complaints/grievances and resolution.	3 Yes 1 No 3 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023

Availability of patient advocate.	Licensing or regulation should provide guidance to facilities related to the hours of patient advocate availability, at least between the hours of 8 am and 5 pm, 7 days a week.	3 Yes 4 No	Patient Grievances	Gottstein et. al., White Paper. April 2023 (page 37)
Individuals may be responsible for attorney's fees if they appeal a grievance to the Superior Court and lose.	People appealing a grievance to the Superior Court should be exempted from Civil Rule 82 if they are unsuccessful and awarded full, reasonable, attorney's fees if they are successful. *Advisory Team feedback:* One member expressed desire for priority consideration for this recommendation.	3 Yes 3 No 1 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023 (page 37)
Section 25 of the Legislation amended AS 47.30.839(g) to read as follows: If the court determines by clear and convincing evidence that the patient is not competent to provide informed consent and was not competent to provide informed consent at the time of previously expressed wishes documented under (d)(2) of this section, <u>that the proposed use of medication is in the best interests of the patient considering at a minimum the factors listed in AS 47.30.837(d)(2)(A) - (E), and that there is no feasible less intrusive alternative</u>, the court shall approve the facility's proposed use of psychotropic medication...	Add a definition of feasible to AS 47.30.915. It is suggested the Alaska Supreme Court's definition of feasible in *State v. Alaska Laser Wash, Inc.* be used that "feasible" means "capable of being accomplished or brought about; possible	3 Yes 2 No 2 No Opinion	Medication	Gottstein et. al., White Paper. April 2023
Does recent Supreme Court Case No. S-18326, Sergio F. related to least restrictive alternatives call for any changes in statute?	AS 47.30.735 (c) should be amended to require a finding by clear and convincing evidence that there are no feasible less restrictive alternatives to the commitment. AS 47.30.755 (a) should be amended to also require a finding by clear and convincing evidence that there are no feasible less restrictive alternatives to the commitment.	3 Yes 4 No	Treatment and Discharge Planning	

In Section 29 of the Legislation, in order to conform the statute to the Alaska and United States constitution as held in *Wetherhorn v. Alaska Psychiatric Institute*,68 the definition of "gravely disabled," in subsection (b) of AS 47.20.9915(9) was amended to read: (9) "gravely disabled" means a condition in which a person as a result of mental illness . . . (b) is so incapacitated that the person is incapable of surviving safely in freedom. However, this only partially conformed AS 37.40.915(9) to the requirements of the United States and Alaska constitutions as held by the Supreme Court in *Wetherhorn*.	"through their own efforts or with the aid of willing family members or friends" should be inserted at the end of AS 37.40.915(9)(b) so it reads, "is so incapacitated that the person is incapable of surviving safely in freedom through their own efforts or with the aid of willing family members or friends." *Advisory Team feedback:* One member expressed desire for priority consideration for this recommendation.	3 Yes 3 No 1 No Opinion	Detention + Commitment	Gottstein et. al., White Paper. April 2023
Under AS 47.30.745(c) and AS 47.30.770(b), people accused of being mentally ill and as a result dangerous to self or others have the right to a jury trial in 90-day and 180 commitment hearings, respectively. However, they don't for 30-day commitment trials.	Amend AS 47.30.735 to include the right to request a jury trial for 30-day commitment hearings.	2 Yes 4 No 2 No Opinion	Notice and Provision of Due Rights	Gottstein et. al., White Paper. April 2023
Respondent perception they have not had “their day in court”.	AS 47.30.735(b) should be amended to read as follows: (b) The respondent may elect to have the hearing ~~shall be conducted~~ in a real courtroom at a courthouse ~~in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits~~. At the hearing, in addition to other rights specified in AS 47.30.660 – 47.30.915, the respondent has the right….	2 Yes 5 No	Notice and Provision of Due Rights	Gottstein et. al., White Paper. April 2023 (page 33)

AS 47.30.700 states: (a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional... to conduct a screening investigation… Current language does not appear to require a screening investigation by a mental health professional and providers report community ex partes are less likely to be warranted than those initiated under AS 47.30.705.	For community ex partes, require completion of a screening investigation by a mental health professional who can directly contact the individual. If direct contact is not made, a reason should be documented.	2 Yes 5 No	Notice and Provision of Due Rights	Stakeholder engagement
Opinion that when someone agrees to treatment, but they do not want to agree to all possible medications, they are involuntarily committed. Need to allow for some choice around what medications are used and method of administration.	AS 47.30.836 Psychotropic medication in non-crisis situation (a)(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 under AS 47.30.839" should be repealed.	2 Yes 5 No	Medication	Gottstein et. al., White Paper. April 2023
The outpatient commitment statute has practical difficulties.	Further exploration of existing outpatient commitment statute needed to determine possible amendments.	2 Yes 3 No 2 No Opinion	Outpatient Commitment	Legal Subcommittee meeting discussion, 4.17.23
Masters only have authority to make recommendations for the Superior Court to consider, but under Probate Rule 2(b)(3)(C) &(D) the Master's decisions are effective prior to such approval. Opinion expressed that this makes the Masters' decision a *fait accompli*, eviscerating the requirement that the Superior Court Judge makes the decision, which the Alaska Supreme Court has held is critical.	Referrals to Masters for involuntary commitment cases should be eliminated.	2 Yes 4 No 1 No Opinion	Detention + Commitment	Gottstein et. al., White Paper. April 2023 (page 43)
Further exploration needed related to the rights of minors to consent for or refuse psychotropic medication without parent/guardian consent.	AS 47.30.660(b)(13) should be repealed.	1 Yes 5 No 1 No Opinion	Patient Grievances	Gottstein et. al., White Paper. April 2023

There is no statutory definition of psychotropic medication, which can lead to odd results. Example: Treating a chronic UTI with the intent to improve mental presentation, but that medication wouldn't traditionally be considered psychotropic.	Add a definition of psychotropic medication to statute.	1 Yes 4 No 2 No Opinion	Medication	Advisory Team meeting discussion, 3.30.23
Predictions of violence are not accurate and no one else besides someone who receives a psychiatric diagnosis is incarcerated for something they might do in the future.	Court proceedings to involuntarily detain individuals on the grounds it is necessary to protect other people from harm should be eliminated.	1 Yes 5 No 1 No Opinion	Detention + Commitment	Gottstein et. al., White Paper. April 2023 (page iii)
Predictions of violence are not accurate and no one else besides someone who receives a psychiatric diagnosis is incarcerated for something they might do in the future.	Children and youth should not be committed or medicated without youth and parent consent.	1 Yes 3 No 3 No Opinion	Detention + Commitment	Gottstein et. al., White Paper. April 2023 (page 38)

Data Recommendations

The data recommendations below are organized by topic area and are not in order of priority. The Data Subcommittee reviewed these recommendations that are based on subcommittee discussions and approved by consensus to include these in the report.

Identified Issue	Recommendation	Topic Area	Source
MC-105s are not tracked. No capacity in current systems for collecting and analyzing this data.	Develop statutory direction to the department to create a system to track individuals starting from the moment an MC-105 is initiated, with further alerts when an MC-100 is filed, the outcome of the petition and time and location of facility arrival. Make data publicly available. Implementation: Necessitates development of centralized location for MC-105s to be sent. Create DES/DET Coordinator-like position responsible for receiving and tracking all MC-105s.	Data Collection Pre-facility Arrival	HB 172 stakeholder engagement
Individuals without DES/DET beds in their communities may experience longer wait times for a bed.	Track, by region, the wait times between when an MC-100 is granted and when a bed becomes available. Regularly report out on wait times. Implementation: Could be done by DES/DET coordinator	Data Collection Pre-facility Arrival	HB 172 stakeholder engagement

Concern from providers regarding differing approvals of ex parte petitions depending on the court system and concern regarding the appropriateness of community ex partes approved by the court. Concern from some individuals with lived experience and advocates about overuse of Title 47 processes.	Provide more detailed data and analysis of available Court System data. Including:
	
	• Total # of MC-100 petitions
	  • Number approved, number denied, number rescinded
	  • Number of community ex partes filed and outcomes
	  • Petitioner credentials for community ex partes
		Data Collection Pre-facility Arrival	HB 172 stakeholder engagement

Existing reporting obscures count of unique cases and individuals moving through the process. If the case has multiple petitions in multiple courts (Ex. 72-hour petition filed in one district, but then the person moved to a different district for treatment and had a subsequent petition filed) the "case" would be counted twice. The initial case in the district of origin would be closed and a new case would be opened in the current district.	Support tracking of cases across the life of the case by providing more detailed analysis of available Court System data. Including:
	
	• # of 72-hour holds by judicial court
	• # of 72-hour holds that go on to 30-, 90-, 180-day commitments
	• Total # of 30-, 90-, 180-day commitments
	  • Number approved, number denied, number rescinded
	  • Number by judicial court
		Data Collection Post-facility Arrival	HB 172 stakeholder engagement

Detailed analysis of Court documents will require additional staffing capacity.	Add staff capacity for data analysis to Alaska Court System.	Data Collection Post-facility Arrival	
The complexity of facility and State of Alaska systems requires greater time and in-depth discussion to guide data collection changes.	Create a coordinating council to collect data from involved parties, analyze and use data to inform systems change. Ex. Utah Forensic Mental Health Coordinating Council, Alaska Criminal Justice Commission, Alaska Bring the Kids Home Initiative	Data Collection Post-facility Arrival	HB 172 stakeholder engagement
Children, youth and individuals with complex care needs experience longer waits and typically require more support from DES/DET Coordinator to navigate to appropriate bed.	Create a working group comprised of DES/DET Coordinator, Complex Care Systems Coordinator and DES/DET leadership to identify additional data to collect, review data on wait times and barriers to care for complex cases.	Data Collection Post-facility Arrival	HB 172 stakeholder engagement
Reported and perceived lack of transparency about the experiences of patients during treatment in facilities.	Create publicly available dashboard comprised of identified data points. Ex. Idaho Department of Health and Welfare, Mental Health Public Dashboard	Data Collection Post-facility Arrival	HB 172 stakeholder engagement

The complexity of facility and State of Alaska systems required greater time and in-depth discussion to guide data collection changes.	Create coordinating council (as previously described/recommended) and use as vehicle for further discussion related to scope of data request and body responsible for ongoing analysis and monitoring of data once collected.	Reporting Categories	HB 172 stakeholder engagement

Facilities already report some patient injury data to state entities.	In the near-term, 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:
	  ○ Injury or death in seclusion and restraint at all facilities in HFL purview.
		Patient & Staff Injuries	HB 172 stakeholder engagement

Some data on staff injuries, when reported, already exists and could be shared more transparently.	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 & Staff Injuries	HB 172 stakeholder engagement

Some data on patient grievances is already reported externally by the facility or collected by licensing.	In the near-term, 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.
		Patient & Staff Complaints and Grievances	HB 172 stakeholder engagement

An external process for grievances has long been identified as a desire by some patient advocates.	Long-term, and as part of exploration of an external process for grievances, explore the role of the coordinating council in compiling and reporting out on complaints/grievances across a broad range of facility types.	Patient & Staff Complaints and Grievances	HB 172 stakeholder engagement
There is a gap in system-wide analysis and transparency regarding patient experiences with crisis and involuntary medications.	Provide more detailed data and analysis of available Court System data by district court. Including: • Number of court orders for additional periods of crisis medications and outcomes • Number of involuntary medication petitions and outcomes • Proportion of involuntary medication petitions compared to number of involuntarily committed individuals (by petitioning facility)	Medication, Seclusion & Restraint	HB 172 stakeholder engagement
Only three facilities in Alaska participate in the IPFQR; it is unclear what the benefits or barriers are to other facilities participating as well.	In the near term, explore use of IPFQR 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 across all inpatient facilities	Medication, Seclusion & Restraint	HB 172 stakeholder engagement

Definition of seclusion and restraint varies between facilities depending on their accrediting body.	In the long term, explore other avenues for standardized, external reporting of seclusion and restraint across facility types.	Medication, Seclusion & Restraint	HB 172 stakeholder engagement
The State of Alaska does not gather aggregate data to understand system trends or the needs of patients.	Track readmission rates to inpatient psychiatric hospitals, designated facilities, crisis stabilization and residential centers across facility types.	Patient Outcomes	HB 172 stakeholder engagement
The State of Alaska does not gather aggregate data to understand system trends or the needs of patients.	Institute a suicide death notification and review system to identify and track deaths following care.	Patient Outcomes	HB 172 stakeholder engagement
The State of Alaska does not gather aggregate data to understand system trends or the needs of patients.	Support existing discussions related to development of data dashboards at the state level.	Patient Outcomes	HB 172 stakeholder engagement

Appendix G: 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	*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*

		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. 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	*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 [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.	*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 … 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.	*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.* *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	*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.*

		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.	
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 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	*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.* *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.*

		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, 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.	*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.*
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	*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.*

		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 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.	*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.* --- *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*

		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. 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.	*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.*

		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," 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	*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.*

		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).] 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	*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 hours and may not be held for longer than 23 hours and 59 minutes. If the professional person*

		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 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.	*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.*

		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:	*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,*

		• 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. 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-	*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."*

		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.	*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.*

		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.	
April Kyle, President and CEO Southcentral Foundation	10/6/23	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: • 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	*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 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.*

		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.	*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.*