



CRISIS STABILIZATION IN ALASKA: UNDERSTANDING HB 172

FREQUENTLY ASKED QUESTIONS
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Psychiatric Response System Overview

History

Prior to 1981, the Alaska Psychiatric Institute (API) was the only designated psychiatric facility in the state, meaning it was the only facility in the state that could involuntarily hospitalize people for behavioral health evaluation and treatment.

It is possible for other hospitals to provide these services. However, hospitals must voluntarily apply for designation to evaluate respondents to determine if they meet criteria for involuntary civil commitment. “Designated Evaluation and Stabilization” (DES) facilities provide evaluation and stabilization for up to seven days. “Designated Evaluation and Treatment” (DET) hospitals provide both evaluation and treatment. Individuals can only be committed to a DET. From 1981 until very recently, only Fairbanks Memorial Hospital and Bartlett Regional Hospital were DETs.

In 1981, Alaska adopted a decentralized system of behavioral health care in a major revision of the civil commitment statutes. The rationale behind this approach was that in-community services would be developed which would reduce the need for institutional care. In practice, however, Alaska’s system of behavioral health community services has never been robust enough to meet the needs of Alaskans – and unfortunately, the number of Alaskans needing mental health services has risen, while recruiting and retaining mental health providers and substance abuse providers has only become more difficult. These problems have resulted in increasing pressure on API, the court system, the Department of Corrections, public safety, and hospitals, including emergency departments. Too frequently, emergency departments and correctional facilities have been the only available 24/7 option for someone in a behavioral health crisis.

Current State of Psychiatric Crisis Services

Since their inception, the designated evaluation and stabilization (DES) and designated evaluation and treatment (DET) beds have been the primary means of treatment for those with acute psychiatric needs. Both Fairbanks Memorial Hospital and Bartlett Regional Hospital in Juneau have been DET facilities for years, with both accepting voluntary and involuntary patients. Mat-Su Regional Hospital became a DET facility in early 2020. Fairbanks Memorial Hospital operates 20 beds, Bartlett Regional Hospital operates 12 beds, and Mat-Su Regional Hospital operates 16 beds. Non-DES/DET hospitals are supported by community-based Psychiatric Emergency Services (PES) grantees, who can evaluate whether an individual meets criteria to be held pending transport for further evaluation or treatment.

Nationally, over the last several years, there has been a large rise in patients presenting with behavioral health challenges. This rise in patients presenting in crisis has only been exacerbated by a shortage of behavioral health providers. There simply are not enough community-based providers to meet these needs, including medication prescription and management and all types of talk-based therapy. Given the increase in cases and the lack of a full continuum of care for behavioral health emergencies in the state, many components of this system are continually stretched beyond capacity, especially in Anchorage.

Psychiatric care cannot solely rest upon acute crisis management within DET facilities under the involuntary commitment process.

In partnership with the Alaska Mental Health Trust and other partners, the state has for the past several years been establishing crisis stabilization services. These services have precedent in other states (for example, Georgia

and Arizona), and have been successfully implemented through the development of crisis stabilization services as discussed below.

“Crisis Now”

Crisis Now is a model of behavioral health/psychiatric care designed to provide an intermediary, diversionary level of care in the least restrictive setting and earliest moment possible to support individuals in crisis. With this in place, individuals do not have to escalate to the highest level of care to have their needs addressed. “Crisis Now” is a specific model comprised of three components:

1. A regional or statewide crisis call center that coordinates in real time with the other components to connect patients, providers, and families to services;
2. Centrally deployed, 24/7 mobile crisis teams (ideally, a clinician and a peer) to respond in-person to individuals in crisis;
3. 23-hour and short-term stabilization, which may be operated separately or jointly, offering a safe, supportive and appropriate behavioral health crisis placement for those who cannot be stabilized by call center clinicians or mobile crisis team response.

The Department of Health (formerly the Department of Health and Social Services) is successfully partnering with community stakeholders on implementation of the first two components.

The Division of Behavioral Health is leading a coalition focused on organizing a statewide crisis call center which would “988”¹ direct calls to Alaska’s existing [Careline](#) suicide prevention call line to the simpler number “988.” Just as 911 works all across the country to connect to emergency services, 988 will work all across the country to connect to emergency mental health services, including suicide prevention. Alaska’s Careline has long been in place as a number to call for suicide prevention and mental health support. Incorporating crisis call center duties into Careline’s efforts will streamline resources and make it easier to connect individuals with the local supports they need, such as counselors in their area. Having a number other than “911” to use will also encourage non-police responses when appropriate by having mobile crisis teams visit people in need of behavioral health support.

There are mobile crisis response teams already working in Anchorage and Fairbanks.

However, until now Alaska could not implement the third component to stand up 23-hour and short-term crisis stabilization centers due to the limitations of our state law. Our historical model was singularly focused on the designated hospital system and did not have specific provisions for psychiatric response centers outside of the historical structure. Crisis response centers are designed to provide immediate stabilization and support, which in other states has decreased the need for inpatient admissions, medications, and restraints. That is why we proposed changes to the system as outlined in HB 172.

What is HB 172?

Why is HB 172 needed?

Alaska needs facilities that can provide behavioral health care in less restrictive environments. This has been a gap in our continuum of care that results in higher cost of health care and treatment at the highest level of acuity.

¹ Recent federal legislation designated 988 as the new dialing code to connect individuals to crisis counselors through the National Suicide Prevention Lifeline network of local call centers.

Along with the Alaska Mental Health Trust and other stakeholders, the Disability Law Center (DLC) and the Public Defender Agency (PDA) were highly engaged in the formulation of HB 172.²

The main goal of the bill is to create a strong system of care that is easy to access for Alaskans with behavioral health needs. It does this through enabling immediate response mechanisms such as crisis response teams, and through licensing and creating a legal structure for new facilities such as crisis stabilization and crisis residential centers to assist individuals suffering from an acute mental health crisis. This would help provide a less restrictive option and reduce the number of individuals who are held at emergency rooms, jails, or psychiatric hospitals.

Under the statutory changes in HB 172, individuals in mental health crisis can easily access crisis stabilization centers (23 hour stay) or crisis residential centers (up to 7 day stay). The crisis centers will also provide law enforcement, EMS, and families with a place to take individuals in crisis, other than local emergency departments. The crisis stabilization centers can triage, treat, or refer to the appropriate level of care, rather than individuals waiting in an emergency department that is not structurally equipped to provide therapeutic behavioral health care, or being escalated immediately to the highest level of care (such as being committed to one of the four psychiatric hospitals that are Designated Evaluation & Treatment Facilities). The vast majority of Alaskans who seek behavioral health care do so voluntarily, but when a person is in crisis and unable to ask for help, HB 172 allows for a more nimble and responsive psychiatric crisis response system that does not require hospitalization.

HB 172 is critical for the implementation of Alaska's Behavioral Health crisis care continuum. It is a result of collaborative and intentional efforts by the Department of Health and Social Services (which will continue with both the new Department of Health and Department of Family and Community Services), the Alaska Mental Health Trust Authority, public safety, community providers, and patient advocates to transform Alaska's behavioral health system to better serve the most vulnerable Alaskans and their families.

What does HB 172 change?

This bill made several key changes to the law:

1. Previously, only hospitals could provide evaluations to determine if a person should be civilly committed. Now, licensed non-hospital entities (crisis residential centers) can conduct these evaluations.
 - a. This can alleviate the backlog/waitlist for evaluation and avoid unnecessary hospitalizations.
2. Clarified and created subacute facility types including crisis stabilization centers and crisis residential centers.
 - a. This approach supports parity for behavioral health, to allow for different levels of care just as physical medical concerns are treated in different settings, such as urgent care.
 - b. The no wrong door/low barrier access means that someone in mental health or drug related crisis will have additional access to trained medical and mental health professionals as well as trained and certified peers (those with lived experience and who have accessed care from the current system) that will immediately assess, triage, and connect individuals to appropriate interventions.
 - c. Crisis stabilization centers will provide access to pertinent interventions that do not necessitate an emergency room department response. A crisis stabilization center can serve someone for 23 hours and 59 minutes. They have recliners instead of beds since it is a quick intervention and stabilization and not an inpatient setting.

² This is in part due to a settlement agreement between the Department of Health and Social Services (DHSS), the DLC, and the PDA in September 2020 in which the parties agreed that the state would pursue legislation to increase system capacity and reduce wait times for individuals requiring evaluation.

3. Allows Mobile Crisis Teams to respond more effectively to individuals in crisis.
 - a. This will reduce the need for law enforcement to respond to all behavioral health emergencies, more appropriately allocating public safety resources to emergencies and criminal response. Behavioral health crises are less likely to escalate when the first contact is with mental health response instead of a uniformed and armed officer.
4. Created an alternative to involuntary hospitalization for individuals who are likely to be stabilized within 7 days.
5. Clarifies language and amends definition of “health officer” to include firefighters and EMS.
 - a. This will fully maximize the effectiveness of mobile crisis teams already operating in the Anchorage Municipality and Fairbanks area.
6. Protects patient rights and requires the submission of a report that has stakeholder input and public comment considerations with recommendations to the legislature regarding patient rights, including:
 - a. Patient grievance and appeal policies.
 - b. Data collection on patient grievances, appeals and the resolution.
 - c. Patient reports of harm, restraint and the resolution.
 - d. Requirements that could improve patient outcomes and enhance patient rights.
 - e. identifying methods for collecting and making statistics available to the legislature and the public regarding patient injuries, patient complaints, and traumatic events.
7. Codifies Supreme Court rulings to align with statutory language.
 - a. Incorporates rulings finding statutes to be unconstitutional.
 - b. Clarifies standards for court ordered non-crisis medication.
 - c. Amends definition of “gravely disabled”.

What is the difference between a crisis stabilization and a crisis residential center?

Crisis stabilization centers can serve someone for 23 hours and 59 minutes. They are staffed 24/7 with a multi-disciplinary team and provide a safe and secure environment to immediately assess and stabilize individuals to avoid unnecessarily higher levels of care. They coordinate with community-based services and refer out to proper supports, using a high engagement and recovery-oriented peer-support approach. They have recliners instead of beds since it is a quick intervention and stabilization and not inpatient.

Crisis residential centers (aka short-term crisis centers) can serve someone for up to seven days and can accept an involuntary admission. They utilize multi-disciplinary treatment teams to stabilize and restore, avoiding unnecessary inpatient hospitalization. In order to be designated by the department, a crisis residential center must be able to perform the 72-hour evaluations described in AS 47.30.660-47.30.915.

Are these facilities only for involuntary commitments?

No, they can provide critical stabilization and evaluation services on both a voluntary and involuntary basis. In a comparison to physical care, these new lower-level facilities can be analogized to an urgent care center. Many, if not most, subacute facilities will provide mostly (or only) voluntary treatment. Those that are properly licensed and designated will be able to hold a person long enough to get them to a residential center or hospital and/or hold a person to evaluate whether the person needs to be civilly committed to a hospital for longer-term care.

The bulk of individuals who need mental health or behavioral health treatment in Alaska are served through voluntary treatment. However, we still need a robust and improved Crisis Psychiatric response system for those individuals who are experiencing a mental health crisis and are unable to seek the care they need voluntarily.

Currently the only options for care for evaluation or treatment, whether that be on a voluntary or involuntary basis is at hospitals that serve as Designated Evaluation and Treatment Centers (DETs) or the Alaska Psychiatric Institute. Those facilities are only in the communities of Anchorage, Fairbanks, Mat-Su, Juneau, and Ketchikan (evaluation only).

In terms of how a civil involuntary commitment works, there is a constitutional process by which persons who are suffering from mental illness and who are a threat to themselves or others or are gravely disabled are held for evaluation upon application to the court. Treatment is then offered either on a voluntary basis or after the hospital files a petition signed by a mental health professional and full evidentiary hearings are conducted where the respondent/patient is represented by legal counsel.

Similar to the hospitals that are currently designated by the department (now DFCS after the split of DHSS), only crisis stabilization centers and crisis residential centers that apply to be designated and can meet all of the requirements under AS 47.30.660-47.30.915 will be allowed to accept an involuntary patient.

Does this change who can initiate involuntary commitment proceedings?

HB 172 adds physician assistants and health officers to the list of persons qualified to take action to initiate involuntary commitment proceedings by ordering a hold for evaluation. Peace officers and health officers also have the authority to bring a person to a hospital, crisis stabilization center, or crisis residential center if they are in immediate danger to themselves or others. In some communities the health officers will be the same individuals operating the mobile crisis teams and responding much like they do in a physical health emergency. Once the individual arrives at a crisis stabilization center, crisis residential center, or hospital designated as an evaluation or treatment facility, a mental health professional will perform the actual 72 hour evaluation. It is critical to note that if at any time the individual does not meet criteria for an emergency hold, they must be released.

The term “health officer” means a federally certified health care provider, public health nurse, emergency medical technician, paramedic, firefighter, or a person authorized by the court to carry out AS 47.30.660-47.30.915. This definition removed some provider types from the current definition of “peace officer” found in AS 47.30.917(7) and creates a new term for them. This new term was needed because the bill updated the definition of “peace officer” to reference what it commonly means in our state statutes. The new additions of EMT, paramedic, or firefighter are an important addition since they are the trained first responders operating mobile crisis teams in communities such as Anchorage. These trained first responders will free up our Troopers and police officers to respond to criminal activity. The Department of Public Safety and local police officers all testified extensively regarding how long they find themselves driving around an individual in crisis before they can get them into care. This often results in them having to wait in the ER for many hours with an individual.

A “federally certified health care provider” in this context means a behavioral health aide or community health aide that operates in our tribal health system. They are provider types only in our tribal system and often the only providers in a small village who are responding to a person in crisis.

All of the provider types listed in the language that was deleted in section 14 of the bill are captured by the definition of a “mental health professional.” The amendments simplified the language to conform to the existing definition of mental health professional and to add physician assistant to the list of persons qualified to take action.

The definition of mental health professional is found at AS 47.30.915(13). It reads in full:

(13) “mental health professional” means a psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; an advanced practice registered nurse or a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; and a person who

(A) has a master's degree in the field of mental health;

(B) has at least 12 months of post-masters working experience in the field of mental illness; and

(C) is working under the supervision of a type of licensee listed in this paragraph;

How will this be paid for?

HB 172 does not address the capital needs of a provider to build a crisis stabilization center or crisis residential center. However, there are existing mechanisms for payment of building and/or operating costs.

The Alaska Mental Health Trust Authority has given grants to providers for preparation work and will likely contemplate other capital needs. Additionally, there was an appropriation of \$8 million by the legislature for Providence Alaska Medical Center to stand up a crisis stabilization center and crisis residential center (slated to open in calendar year 2023).

Like other medical care, a combination of private insurance, private pay, and Medicaid (through the 1115 waiver) will pay for specific services provided. When an individual receives care under the Title 47 involuntary commitment statutes, the State of Alaska through AS 47.31, the Mental Health Treatment Assistance Program, is the payer of last resort to designated facilities performing evaluations and treatment on behalf of the state.

For Medicaid, the 1115 Waiver allows for referral-based care determined by need. The 1115 Waiver supports efforts to immediately stabilize an individual a crisis stabilization center, which is a less restrictive alternative to traditional voluntarily commitment holds.

This bill also provides a referral pathway for individuals who need additional behavioral health services through admission to a crisis residential center.

The 1115 Waiver drives down health care costs by enabling payment for service providers of critical behavioral health supports – including mobile crisis teams, crisis stabilization and crisis residential services. This occurs through the diversion of appropriate individuals from costly hospital and emergency room care to Medicaid reimbursable crisis response services approved by the Centers for Medicare and Medicaid Services (CMS). These services are delivered by qualified mental health professionals. They connect individuals in behavioral health crisis to the appropriate level of care and they prevent the behavioral health crisis from escalating.

By leveraging the Medicaid 1115 behavioral health waiver, the goal is to have more treatment options including crisis stabilization centers and crisis residential centers in all 9 regions of the state served by the waiver. This will allow individuals to seek crisis psychiatric care much closer to their home communities.

Police power, arrest, and involuntary medications

Do the HB 172 changes affect criminal law?

HB 172 did not make substantive changes to criminal law. The bill only makes conforming language updates so that the crisis facility types and names are consistent throughout civil and criminal statutes.³

HB 172 allows a civil emergency hold of an individual in crisis, if they meet the legal criteria for an emergency hold, to ensure the individual stays at the Crisis Stabilization Center for treatment. The emergency hold is not based on whether someone was involved in the commission of a crime. HB 172 does not add to the existing authority of a peace officer to detain or arrest any individual; it allows a peace officer to deliver an individual experiencing a mental health or behavioral health crisis to a Crisis Stabilization Center or Crisis Residential Center. These facilities are better equipped to deal with mental health emergencies and will provide a less restrictive level of care. This will also avoid individuals suffering from a mental health crisis from experiencing holds in emergency rooms or jails. This is a win-win-win for the patient, our partner hospitals, and public safety.

Does HB 172 interfere with a police officer's ability to arrest someone for criminal activity?

No. It provides a framework for individuals in crisis to access resources at an appropriate level of care and avoid unnecessary involuntary commitments. It does not limit or interfere with an officer's authority or ability to effectuate an arrest and provides police officers with an additional tool to protect public safety for all Alaskans. Police officers frequently encounter individuals who are experiencing a behavioral health crisis but are not committing a crime. The officers have limited options for resolving the situation. This bill will provide more options for public safety officers when dealing with individuals who are suffering from mental health issues. Right now, they have limited options.

Police officers are limited by state law A.S.12.25.030 on when they are permitted to effectuate an arrest. Officers can only effectuate an arrest when there is a warrant for the individual's arrest, probable cause exists that a felony or a misdemeanor in their presence have been committed, or the alleged offense requires an arrest such as with domestic violence. Outside of the few specific mandatory arrest categories, officers use their discretion and rely on department policies and procedures to determine how best to resolve calls for service and officer-initiated activity. HB 172 recognizes this discretionary authority of an officer related to arresting someone who has committed a crime and does not change it – rather, it provides a community resource for officers who have determined that, in their discretion, arrest is not appropriate in a given situation. It provides another option when a person has not committed a crime, but the officer is responding to a situation where a person is simply suffering from a mental health crisis.

Does HB 172 give arrest authority to EMS, fire, and police over those suffering from a mental health crisis? Can they now show up at someone's door and make an arrest?

Put simply, no – HB 172 did not expand arrest power for any law enforcement or first responder agencies.

It is important to understand that an emergency hold is not an arrest. An emergency hold is the authority to issue a time limited hold for someone who is suffering from a mental health crisis– an authority that was currently in

³ [SB 120](#) was passed in 2020, and was designed to support police officers' ability to exercise discretion and divert individuals to immediate mental health treatment when appropriate. SB 120 also added "crisis stabilization center" as a licensed facility type. HB 172 updates the language defining crisis stabilization facilities.

statute and which happens daily in Alaska. There are no criminal consequences for these holds, and there are no arrests under civil commitment proceedings. This emergency and temporary hold lasts only until the person gets to the proper facility (such as a crisis center) to be evaluated by a clinician. Once the hold is initiated, the person cannot be held at the facility without the Mental Health Professional at the facility seeking permission from the Court to hold the person any longer than the minimum time necessary.

HB 172 did expand the definition of “health officer” to include firefighters, paramedics, and EMTs. Under the civil commitment statutes, “health officers” who have probable cause to believe a person is gravely disabled or likely to cause harm to self or others can place an emergency hold on that person to have them delivered to the nearest appropriate facility (AS 47.30.705). Before HB 172, only law enforcement or physicians could place a person into an emergency hold. By expanding the definition of “health officer,” trained first responders other than police will have the correct tools to ensure individuals in crisis can receive needed services faster and without unnecessary police involvement.

Even though police could place a person under an emergency hold prior to HB 172, they never could simply “show up at someone’s door and make an arrest.” To show up at your door and pick you up, there would either be an existing ex-parte order, or police are there for another legitimate reason (such as an investigation or welfare check) and find that you are having a mental health crisis. HB 172 certainly does not grant additional authority to police or other first responders to enter your home, or to make any arrest.

Again, it is important to note that an emergency hold is NOT an arrest.

What is the difference between custody and arrest, or hold and involuntary commitment?

There are numerous ways to define custody in both case law and statute. For example, one kind of custody is the kind of custody that parents have with their children. Parents who are separated or divorced might share physical custody, or legal custody, or both. It could be that one parent has physical custody – control over where the child lives – but the parents share legal custody – the right to make legal decisions.

Protective custody is a kind of custody. For example, police officers can take people who are incapacitated by alcohol or drugs into protective custody for the purpose of taking the incapacitated person to a treatment facility. (AS 47.17.170(b)).

The hold at a crisis stabilization center is like protective custody, but for a person experiencing a mental health crisis.

An “involuntary commitment” is when a court orders a person who is gravely disabled (definition found in AS 47.30.915(9)) or an immediate threat to themselves or others to be detained at a hospital for an initial 72-hour mental health evaluation to determine if an individual requires longer stabilization and treatment up to 30 days. Under our current statutes, involuntary medication for treatment can only be ordered if someone is involuntarily committed first.

Arrest is a kind of custody. Arrest is the taking of a person into custody in order that the person may be held to answer for the commission of a crime (AS 12.25.160).

Medication

Does HB 172 empower police, EMS, and/or firefighters to administer medications? Can police officers involuntarily medicate people?

No. HB 172 does not give authority for a peace officer or other individual to administer psychotropic medications (crisis or otherwise). It does not change that crisis medication can only be prescribed by a physician, Advanced Nurse Practitioner or a physician's assistant. To be clear: at no time does HB 172 authorize a police officer to administer medications to a person in their care or custody.

Can a subacute mental health or DET facility administer psychotropic medication without informed consent?

Only if there is a crisis. **A crisis is when there is a situation that requires immediate use of medication to preserve the life of, or prevent significant physical harm to, the patient or another person.** Please note that it is "significant" physical harm, not just "any" physical harm. This is the current law at designated evaluation and treatment facilities (DETs) which are Alaska Psychiatric Institute and 3 hospitals (Fairbanks Memorial Hospital, Mat-Su Regional Medical Center, and Bartlett Regional Hospital).

HB 172 gives crisis stabilization centers and crisis residential centers the ability to use crisis medication according to the same limitations.

Important takeaways:

- Crisis medication can be given when there is a "crisis situation" or an impending crisis situation as defined in the law.
- A crisis situation happens when medication must be used immediately to preserve life or prevent significant physical harm.
- Only a physician, Advanced Nurse Practitioner, or physician's assistant can determine that a crisis situation exists (that is, a regular nurse cannot).
- Absent crisis medication, the only option to protect the patient and providers would be a physical restraint. Providers will universally say physical restraint is much worse for patients than medication.
- A facility can administer crisis medication for no more than three crisis periods without court approval.
- This type of crisis medication response would be similar to an emergency room doctor providing life saving medication to someone experiencing a heart attack or a stroke.

Does HB 172 make it easier to administer involuntary psychotropic medication?

No. HB 172 does not make any changes to the current legal requirements for crisis psychotropic medication.⁴

⁴ These requirements are found in [AS 47.30.838](#): Psychotropic medication in crisis situations. "(a) Except as provided in (c) and (d) of this section, an evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, **only** if (1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to preserve the life of, or prevent significant physical harm to, the patient or another person, as determined by a physician, physician assistant, or advanced practice registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition must be documented in the patient's medical record; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient; and (2) the medication is ordered by a physician, physician assistant, or advanced practice registered nurse."

In fact, HB 172 *adds* additional protections for minors when administering psychotropic medications:

AS 47.30.838 is amended by adding a new subsection to read: (e) Before determining whether a minor patient should be given psychotropic medication under this section, a mental health professional shall, to the extent time and the nature of the crisis permit, consult with a parent or guardian of the minor, evaluate the minor for drug withdrawal and medical psychosis caused by currently prescribed drugs or self-medication, and review all available information regarding the minor's family history, diet, medications, and other possibly relevant factors.

Does HB 172 allow arrest or detention of a person for speaking, believing, or living differently than others?

No. HB 172 does not reduce or change any constitutionally protected rights.

HB 172 does not create a way to penalize a person for engaging in first amendment protected free speech and association.

HB 172 does not permit the arrest, detention, or hold of an individual because of their medical choices (such as not being vaccinated).

Patient Rights

Does HB 172 expand access to a person's sensitive health information?

The crisis center facilities are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and must comply with HIPAA requirements. These are confidential treatment services and nothing can be disclosed unless by consent or otherwise authorized by state or federal law. HB 172 does not create disclosure authorization or requirements that would supersede HIPAA.

In short, HB 172 does not change privacy and protection requirements for individual health information.

Does HB 172 create a "workaround" of the commitment process?

No. The existing protections and processes of the commitment laws remain in place.

HB 172 *does* create more opportunities for an individual to avoid unnecessary hospitalizations, and supports a system where *fewer* individuals have to go through the commitment process. It also enacted additional patient rights provisions applicable to these new settings.

How are due process rights protected?

It is well settled in case law that the constitution requires the state to provide due process when its actions impact a person's liberty. The government cannot impair a person's right to liberty without due process of law. This concept applies to all civil commitment proceedings and is embedded in the constitution. Procedural rules are outlined in state law (AS 47.30.725) and court rules surrounding probate proceedings, including civil commitment. Nothing in this bill impacts these constitutionally protected rights. A few examples of the rights patients have in these situations include the right to communicate immediately with your guardian /and or attorney of your choice, the right to be represented by an attorney, and the right to be notified of your rights.

Due process is also protected in the following ways:

- A crisis stabilization center is intended only for people who are gravely disabled or likely to cause harm to themselves or others. Those terms are strictly defined by statute and now codify Supreme Court rulings.
- A person held at a crisis stabilization center must be examined within 3 hours.
- A person can only be held at a crisis stabilization center for 23 hours and 59 minutes.
- The person must be released from the crisis stabilization center if the person no longer meets criteria at any time during their stay.
- A crisis residential center is intended only for people who are gravely disabled or likely to cause harm to themselves or others. Those terms are strictly defined by statute.
- In order for a person to be held at a crisis residential center, it must first be approved by a neutral judge.
- A person held at a crisis residential center must be examined within 3 hours.
- A person can only be held at a crisis residential center for up to 120 hours.
- The person being held must be released from the crisis residential center if the person no longer meets criteria at any time during their stay.
- If an ex-parte application is granted by the Court, the Public Defender Agency will be appointed as counsel.
- Neither a crisis stabilization center nor a crisis residential center can give involuntary medication outside of crisis medication to treat a person's condition. Crisis medication can only be given to prevent significant physical harm to other patients or staff who are in immediate danger (or self-harm).

Does HB 172 take away rights from minors or parents?

Minors have the exact same rights as adults do in the civil commitment statutes, and even have more rights for court appointed Guardian Ad Litem and parents' rights.

Parents receive all the notices the minors get; minors will and parents can each get their own attorneys appointed. This ensures the parent can have representation if they disagree with the recommendation the minor's attorney is making.

Does HB 172 take away patient rights?

No, this bill protects civil liberties and explicitly ensures protection and monitoring of patient rights.

This bill was thoroughly vetted and debated by a diverse array of stakeholders, including state and local law enforcement, the Disability Law Center, mental health advocates, Public Defender Agency, and the Alaska Mental Health Trust Authority. Protecting patient civil liberties was a priority, and in fact numerous sections of HB 172 *expand* patients' rights (compared to the current civil involuntary commitment statutes).

As a reminder, the state committed to this legislation as part of an agreement with the Disability Law Center and the Public Defender Agency, after an October 2018 lawsuit that was filed alleging individuals in psychiatric crisis were being held indefinitely in jails or emergency departments due to a lack of available beds at the state psychiatric hospital.

The greatest "patient right" HB 172 creates is the ability to provide a less restrictive alternative than hospitalization and reduce the need for individuals to wait in emergency rooms for days or Alaska Correctional Institutions without access to proper behavioral health treatment while they wait for a bed to become available at one of the limited DET facilities. Crisis stabilization centers and crisis residential centers can now operate in a "no wrong door" fashion, much like your local emergency room when you have a physical health emergency.

Section 36 of the bill requires that within one year, a report is submitted to the legislature that contains recommendations for future improvements to the law, potential changes to grievance procedures, how to improve patient outcomes and enhance patient rights, and data reporting. This report is to be created with the participation of a diverse group of stakeholders, including those with lived experience. This requirement helps ensure that Alaskans continue to receive the utmost consideration and protection of their civil liberties.

Below you will find details on numerous sections of HB 172 that expands patients' rights compared to the current law around civil involuntary commitment.

- Sec. 12 – Notice of parent or guardian (pg. 4; lines 19 -23)
 - Amends AS 47.30.693, Notification to a parent or guardian, to make the statute applicable to notifying guardians of adult patients who are admitted to a treatment facility and the facility is aware of the appointment of a guardian.
- Sec. 13 – New subsection related to notification of guardian (pg. 4; lines 25 – 31 and pg. 5; line 1)
 - Adds a new subsection (or brand-new requirement in the law) to AS 47.30.700, Initial involuntary commitment procedures, to require a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility to notify the minor patient's parent or guardian of the location of the minor as soon as possible after the arrival of the minor at the facility. Also requires the center or facility to notify a guardian of the adult patient's location as soon as possible after the arrival of the patient if the center or facility is aware of an adult patient having an appointment of a guardian. This will apply to new facilities as well as current facilities such as API or our hospitals with secure mental health wings like Fairbanks Memorial Hospital, MSRMC and Bartlett Regional Hospital.
- Sec. 15 – notification of parent or guardian (pg. 5; lines 29 – 31 and pg. 5 lines 1 – 5)
 - This adds a new subsection (d) (or brand-new requirement in the law) which adds a new subsection to AS 47.30.705, Emergency detention for evaluation, to require a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility to notify the patient's parent or guardian as soon as possible after the arrival of the minor. Also requires the center or facility to notify a guardian of the adult patient's location as soon as possible after the arrival of the patient if the center or facility is aware of an adult patient having an appointment of a guardian. This will apply to new facilities as well as current facilities such as API or our hospitals with secure mental health wings like Fairbanks Memorial Hospital, MSRMC and Bartlett Regional Hospital.
- Sec. 16 – Admittance to Crisis Stabilization Center & Appointment of an attorney immediately (pg. 6; lines 21 – 30)
 - This overall section lays out the structure of care at these new facilities. This specific subsection in AS 47.30.707 is for 23-hour crisis stabilization centers. Lines 21-30 highlight that an individual is appointed an attorney to represent the patient. It also protects the patients' rights by requiring the court to order the patient released if there is no probable cause to hold the patient due to the patient having a mental illness and is suffering an acute behavioral health crisis, and as a result, is likely to cause serious harm to self or others or is gravely disabled. All of those findings must be in place for the patient to be held for involuntary treatment.
- Sec. 16 – Computation of time (pg. 7; lines 22-31 and pg. 8; lines 1 – 9)
 - This subsection sets out the computation of time at a crisis residential center (or the up to 7 day facility). It provides for the computation of time of the 72-hour period, which does not include

Saturdays, Sundays, and legal holidays, except that if the exclusion of Saturdays, Sundays, and legal holidays from the computation of the 72-hour period would result in the respondent being held for longer than 72 hours, the 72-hour period would result in the respondent being held for longer than 72 hours, the 72-hour period ends at 5:00 p.m. on the next day that is not a Saturday, Sunday, or legal holiday. This was a change made on the House Floor that further protects patient rights. Under current law, Saturdays, Sundays and Legal holidays never count in the computation of time when someone is being held for a 72 hour evaluation

- This subsection also requires hearings to be held at the crisis residential center in person by contemporaneous two-way video conference or by teleconference. This is actually an improvement for less trauma for patients. At other Designated and Evaluation Treatment Hospitals (DETs), each judicial district sets the rules for hearings. In Fairbanks, patients are required to attend in person at the courthouse unless the court orders otherwise. That means a patient is transported in handcuffs and in the back of a police car to court.
- Sec. 16 – Computation of time (pg. 10; lines 8 – 13)
 - This subsection (e) sets out that an individual can be held at a crisis stabilization center for 23 hours and 59 minutes and at a crisis residential center for seven days. Both of these time periods include Saturdays, Sundays and legal holidays.
- Sec. 18 – AS 47.30.710 – Examination; hospitalization.
 - Amends the current statute (current law) to add a new subsection (c) to require the mental health professional to apply for an ex parte order if a judicial order is not in place, which further ensures that patients are not held without judicial process.
- Sec. 19 – Procedure after order – AS 47.30.715
 - Amends the current law to require the Court to notify a patient’s legal guardian of any hearing arrangements. Currently, the Court does not notify legal guardians. It also amends the law to specifically require the court to notify everyone of the exact time and place of the hearing, which now includes the legal guardian as well as the patient’s attorney.
- Sec. 20 – Computation of time (pg. 12; lines 2 – 12)
 - Amends current law AS 47.30.805(a), a computation of time statute. It adds a new computation for a seven-day detention at a crisis residential center, which says the time starts at the arrival of a patient at a crisis stabilization center or crisis residential center, whichever is earlier. This ensures a patient is held only for 7 days total, even if they started in the 23 hour crisis stabilization center.
 - A House floor amendment also changed the current computation of time to require a period to end at 5:00 p.m. on the next day that is not a Saturday, Sunday, or legal holiday if exclusion of those days would result in the patient being held for longer than 72 hours or 48 hours as applicable. Under current law, Saturdays, Sundays and Legal holidays never count in the computation of time when someone is being held for a 72-hour evaluation
- Sec. 21 – New subsection related to administration of psychotropic meds (pg. 12; lines 30 -31 and pg. 13; lines 1-3)
 - Adds a new subsection (or brand-new requirement in the law) to AS 47.30.836, Psychotropic medication in non-crisis situations, to require a mental health profession to consult with a parent or guardian of the minor, evaluate the minor for drug withdrawal and medical psychosis caused by currently prescribed drugs or self-medication, and review all available information regarding

the minor's family history, diet, medication, and other contributing factors before administering psychotropic medication to a minor. This adds further protections to parents and patients' rights.

- Sec. 23 – New subsection related to administration of psychotropic meds (pg. 13; lines 11 – 16)
 - Adds a new subsection (or brand- new requirement in the law) to AS 47.30.838, Psychotropic medication in crisis situations, to require a mental health professional, to the extent time and the nature of the crisis permit, to consult with a parent or guardian of a minor, evaluate the minor for drug withdrawal and medical psychosis caused by currently prescribed drugs or self-medication, and review all available information regarding the minor's family history, diet, medication, and other possibly relevant factors before administering psychotropic medication in a crisis situation to a minor. This is brand new addition to the law and adds further protections to parents and patients' rights.
- Sec. 24 & 25 – Involuntary medications (pg. 13; lines 17 – 31)
 - Both sections were added to address a statute declared unconstitutional by the Alaska Supreme Court and align the language with the court decision. In particular, amends AS 47.30.839(g) regarding court-ordered administration of medication to require the court determine by clear and convincing evidence that any 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.
 - Both of these sections were identified by the Jim Gottstein of Law Project for Psychiatric Rights and the language was vetted by him before it was added to the bill.
- Sec. 26 – Notification of guardian (pg. 15.; lines 7 – 12)
 - Amends AS 47.30.840(a), Right to privacy and personal possessions, to add a requirement that a minor or adult patient with a guardian may not be transferred from a crisis stabilization center, evaluation facility, or treatment facility to a different evaluation facility or treatment facility before the facility makes a good faith attempt to notify the parent or guardian of the person, as applicable, of the proposed transfer. This is brand new addition to the law and adds further protections to parents and patients' rights.