Testimony
Senate Bill 2098 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
January 14, 2009

Chairman Lee, members of the Senate Human Services Committee, I am Dr. Andrew McLean, the Medical Director of the One Center (North Dakota State Hospital [NDSH] and North Dakota Developmental Center) and Southeast Human Service Center. I am here today to provide you testimony in support of Senate Bill 2098.

I will go through the proposed changes individually, but there are three general areas of interest in the Chapter 25 civil commitment rules.

First, there are minor definition changes.

Second, there are changes in reference to screening of individuals to the North Dakota State Hospital. Also, we will be requesting an amendment to a sentence in our proposal.

The third has to do with including licensed addiction counselors as experts in their ability to support petitions for commitment in the area of addiction issues. Currently they are seen as experts, but they are not included with psychologists, physicians, and psychiatrists in being able to utilize their treatment or evaluation of an individual to support a petition. We believe this was simply an oversight in the rule.

Fourth is the overall language of mandates to the state hospital. We are requesting a review of this to continue to ensure ongoing standard of care for the patients served.

To begin:

Page 1, Section 1, Line 10. The original rules states: "Person requiring treatment" means a person who is mentally ill or chemically dependent, and there is a reasonable expectation that if the person is not treated, there exists a serious risk of harm to that person, others, or property.

We are asking for the proposed change to include "<u>for the mental illness or chemical dependency"</u> due to the fact that many people we see may actually still be at risk of harming others quite separate from any treatment of their illness. For instance, a person who has a chemical dependency, but their primary risk of harm is due to their sociopathic tendencies, should not be a "person requiring treatment". The spirit of the definition is to identify those individuals who should be civilly committed due to their illness(es).

Page 2, Section 2, Line 4. We are asking to strike "and admission" as there are some individuals who are appropriately screened, but not admitted to the state hospital. The screener serves as the gatekeeper, not the admitter. For instance, someone may be screened for admission "when medically stable", etc…

Line 6. We recognize that the spirit of the screening by human service centers should be face to face when feasible. However, this cannot always happen. While we originally added "in person whenever possible", we respectfully ask for this to be amended to "<u>in person whenever reasonably practicable</u>".

Page 3, Section 3, Lines 5,6 and 27 refer to the above recommended changes pertaining to Licensed Addiction Counselors.

Page 5, Section 5, Lines 21 and 22 (as well as Page 8, Section 7 Line 6), refer to mandated acceptance of patients. We are requesting this change, as mentioned, to ensure continued appropriate care. We have been able to dialogue with various stakeholders and negotiate adequate transfer. NDSH is a free standing psychiatric facility, and the current rules leave open the potential for individuals to be unsafely placed. For instance, "pick-up orders" could allow the transfer of medically unstable patients, or patients who require a higher level of services, to NDSH. An example: An 8 month pregnant methamphetamine using patient could be transferred from an area with appropriate facilities for high risk pregnancies to NDSH which is not equipped for such. Or a patient in DTs (a potentially life threatening type of alcohol withdrawal) or severe diabetic reaction could potentially be mandated to NDSH.

We are not attempting to be a barrier to admission in requesting these changes; we will continue to negotiate with our stakeholders. We are simply asking for a change in rules to reflect standard of care.

Page 6, Section 6, Lines 17 and 18, simply reiterates the screening process and requirements, for consistency throughout the commitment rules.

Page 8, Section 7, Line 6 mentioned above.

Page 9, Section 8, Lines 4 and 5. We are committed to fostering patients' rights and have embraced the recovery model, which places the client/patient first. It also puts an emphasis on including patient advocates, family, etc., in the decision-making process.

The current rule reads as follows:
"Whenever any treatment facility licensed by any state for the care and treatment of mentally ill or chemically dependent persons agrees with a parent, a spouse, a brother, a sister, a child of legal age, or guardian of any patient to accept the patient for treatment, the superintendent or director of the treatment facility shall release the patient to the other facility."

We do engage in appropriate facility to facility transfers whenever possible, and will continue to work with families and others to accomplish this. However, the language above appears to mandate transfer despite the potential objections of a patient, and despite potential conflicts of interest by family. While these instances are rare, we believe clinicians should be able to weigh those issues and have time to gather collateral information for the safety of the patient before being mandated to transfer care.

Hence, the changes cited.

I would be happy to answer any questions.