Alaska's Lack of Psychiatric Beds and Consequences

Pamela Cravez

Dr. Anne Zink, Medical Director at Mat-Su Regional Medical Center (MSRMC) and head of Mat-Su's Emergency Department (ED), is seeing more and more psychiatric emergencies. The first quarter of last year the ED saw 68 psychiatric emergencies; this year it was 283, according to Zink. The problem is that MSRMC, like most hospitals in the state, does not have a psychiatric emergency department or behavioral health unit. This means that psychiatric patients may wait days until one of the state's few psychiatric treatment beds becomes available.

This updates the article that appears in the Summer 2017 print edition.

MSRMC's ED has 22 beds total, including two lockdown rooms next to the cardiac unit. Dr. Zink has sewn up the lip of a child while a patient suffering a psychotic break pounded on a nearby locked door. She's treated a person suffering a heart attack while a severely depressed patient lay in the next bed.

Among those with psychiatric emergencies, according to Dr. Zink, are people abusing alcohol and drugs, little kids with awful home situations who are threatening to hurt themselves, people who've cycled through over and over when they've gone off their medication, the acutely psychotic and severely depressed.

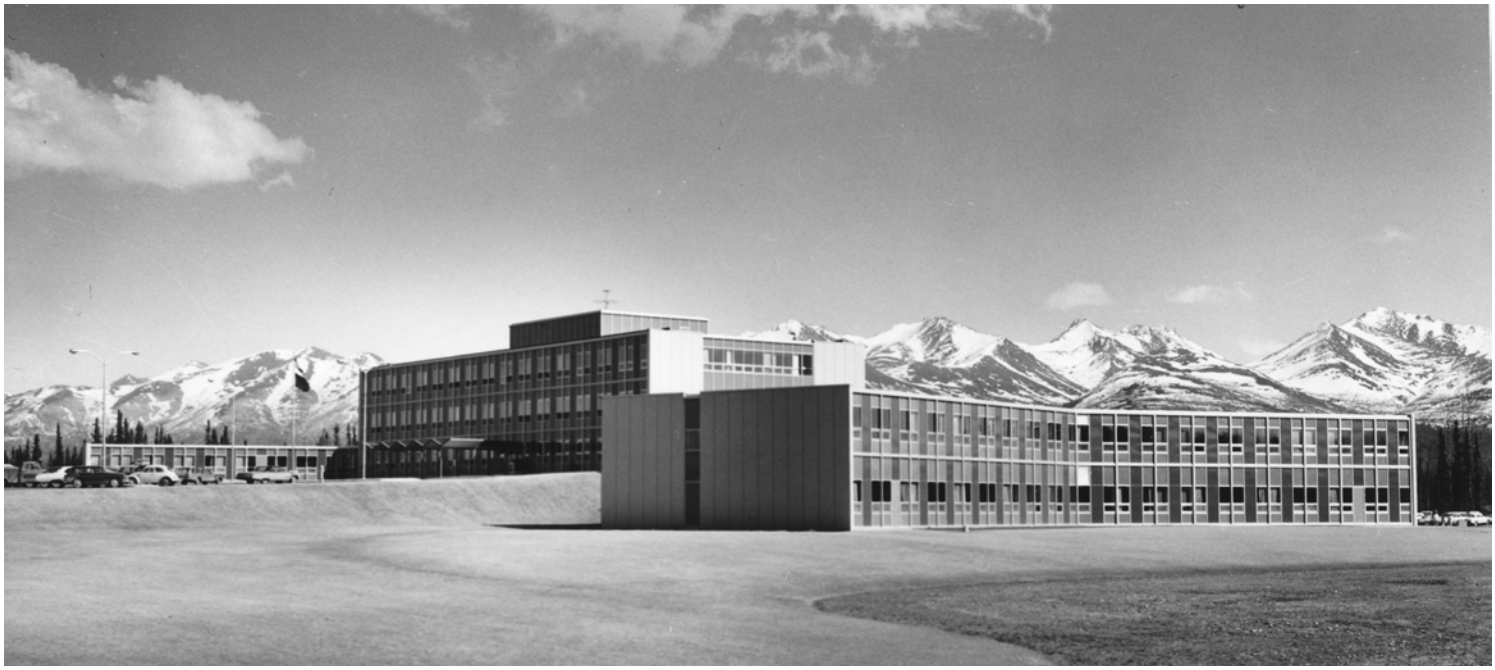
API's current capacity is 80 beds.

Zink refers patients to Alaska Psychiatric Institute (API) in Anchorage, but they frequently must wait four to six days before being admitted. API, the state's sole psychiatric hospital and provider of inpatient services has 80 beds. There are two additional state Designated Evaluation and Treatment (DET) hospitals: Fairbanks Memorial Hospital (20 beds) and Juneau's Bartlett Regional Hospital (12 beds) provide care for acute psychiatric emergencies.

"We are calling (API) every day, asking what place they are on the list." Zink said. "Our system is set up for acute care, not boarding patients. People are ill. We know we're not doing the right thing just holding them."

▸ API is Full

May 31, 2017, API Chief Executive Officer Gavin Carmichael held a list with the names of 18 people waiting to get into API that day. Nine are at MSRMC's ED. Others on Carmichael's list include four patients at Providence Alaska Medical Center Psychiatric Emergency Room (PPER) — the psychiatric emergency department in Southcentral Alaska. Two at Central Peninsula Hospital, one at Yukon Kuskokwim Health Center and one more in Barrow. Another two patients are forensic cases — one is in jail and another is waiting to be evaluated for competency to stand trial.



In May 1968, at the time of this photo, API had 225 beds. Christine M. McClain papers, Archives and Special Collections, Consortium Library, University of Alaska Anchorage. Jim Balog, photographer.

API is full all the time, Carmichael said. API will discharge five people and five people from the list will be admitted on the same day. The first to be admitted will be those coming from rural Alaska. If patients are in a relatively safe place, they are farther down the list. MSRMC's ED is a safe place according to Carmichael.

Before a patient can be transferred to API an assessment must be done to show they are gravely disabled and/or a danger to themselves or others and a magistrate must make that finding in accordance with the civil commitment statutes. A.S 47.30.700.

Last year, the Alaska State Legislature passed SB 74, requiring a study of the feasibility of privatizing API with the goal of determining whether privatization could improve service delivery at a potentially lower cost without sacrificing quality of care. Released in January 2017, the Feasibility Study of the Privatization of the Alaska Psychiatric Institute by Public Consulting Group (PCG/Health) found state management to be the best option. The report offered insight into how API operates given the high demand for beds.

▸API: High Admission Rates, Short Stays

Although API has 80 beds, only 50 of them are available for adult acute psychiatric care. The other 30 beds are reserved for adolescents 13–17 years old (10 beds), medium security forensic cases (10 beds) and people who need extended care that is unavailable elsewhere in the state including individuals suffering from Alzheimer's Disease (10 beds). The low number of beds and high demand create high admission rates and low average length of stays (ALOS).

According to the privatization report API does not operate like most state hospitals around the country:

- Utilization per 1,000 people in Alaska is more than triple the national average for state hospitals (1.66 compared to .44 in FY 2015).
- Admission rates are significantly higher than the national average and continue to grow. In FY15, of the 1,683 admissions at API, the hospital served 1,219 unduplicated individual patients at a rate of 1.38 per 1,000, compared to the .83 national average.
- ALOS at API was 13 days in FY15, far below the national average of 244.
- Readmission rates within 30- to 180-days are 160 percent to 180 percent higher than the national average.

API's admission rates and ALOS are more similar to hospitals that provide short-stay acute treatment and stabilization. Acute-care hospitals — often privately run — act as gatekeepers to state hospitals which serve more complex cases requiring longer term care.

According to the privatization report there is no infrastructure in Alaska to support longer, more complex intervention as a routine form of inpatient treatment.

This has not always been the case.

▸Full-Service Hospital

When API opened in 1963, it was a 50-bed state-of-the-art hospital that provided complete medical care, including surgical, obstetrics, dental and ex-ray departments for individuals with acute mental illness. By 1965 it reached its capacity of 225 beds, including 38 for children and adolescents. In 1967, it added public school classrooms and two-full-time teaching positions.

By 1971, API coordinated services with 96 community agencies. During the mid-1970s and early 1980s, as Alaska's economy and population grew, API continually operated at or above capacity. Throughout the rest of the country, though, the deinstitutionalization movement was in full swing. The drive to rely less on state institutions and more heavily on community-based services began to gain support in Alaska. By 1993, there were 31 Community Mental Health Centers (CMHC). In 1993, Bartlett Memorial Hospital added six DET beds, and in 1999 Fairbanks Memorial opened six DET beds.

▸Downsizing

In Alaska, the deinstitutionalization movement coincided with a downturn in the economy and the need to address API's deteriorating physical condition. In 1990, after five assessments, the state decided to replace

Table 1. A Twenty-Five Year Snapshot of Alaska Psychiatric Institute Uitilization

Calendar year	Official bed capacity	Total number of admissions	Total number of actual bed days used as a percentage of maximum days possible		Average number of admissions per month	Number of days in the year with 5 or more admissions in a single day	Number of discharges
			Number	%			
1990	160	831	33,147	57%	69	32	831
2000	74	1,448	23,954	88%	121	140	1,448
2011	80	1,489	25,225	85%	124	143	1,506
2015	80	1,547	23,276	88%	129	166	1,555

Source of data: *API Dashboard, Alaska Division of Behavioral Health (http://dhss.alaska.gov/dbh/Documents/api/API_Dashboard.pdf)*

the building. API 2000, a community planning process, defined API as a "tertiary" care facility that provided acute short-term care and/or longer term care for those with highly complex or high security needs.

In 1993, Governor Walter Hickel authorized a 114-bed facility at a cost of $64.9M. The Alaska State Legislature appropriated only $28.9M — reducing the number of beds to 79, relying upon assertions that fewer beds would be needed if non-hospital/community types of treatment were established.

▸New Admissions Policy

Simultaneously, budget cuts shut down existing beds at API. Between 1992 and 1994, capacity dropped from 160 to 79 beds. To accommodate its smaller capacity, a new admissions policy gave priority to consumers who were acutely suicidal, homicidal, or gravely disabled. A new discharge policy expedited the release of individuals from the facility once their behavior stabilized. Hospitalization would not be prolonged for the sole reason that the consumer, family, referring agency, or community did not concur with API staff diagnoses or treatment recommendations.

In 2003, Providence Alaska Medical Center Psychiatric Emergency Room (PPER) opened, with money from the state, to provide Anchorage residents psychiatric emergency services. PPER supported the goals to reduce the need for beds in API. In July 2005, API's new building opened with 80 beds, virtually the same number as in 1994 and today. In 1994, Alaska's population was 608,308; latest U.S. Census figures for 2015 are 739,828, an increase of more than 140,000 people (21.62%).

A 25-year snapshot of API from 1990 to 2015 shows that the number of yearly admissions and discharges have nearly doubled, while the number of beds have been cut in half. In 1990, API had 160 beds, 831 admissions and 831 discharges. In 2015, API had 80 beds, 1,547 admissions and 1,555 discharges (Table 1).

Every week API experiences nearly a complete turnover in patients.

Since the mid-1990s CMHC's have limited their services in Alaska, currently only providing service to those with severe mental illness.

According to API CEO Carmichael, API no longer operates as a "tertiary" hospital. It is an acute care facility where the high volume of consumers needing treatment means that every week API experiences nearly a complete turnover in patients. There is no routine capacity for long-term care.

▸Fewer Hospital Beds, More Prison Beds

In-Step, Alaska' 5-year mental health plan for 2001–2006, produced by the Department of Health and Social Services (2001), traced the path between lack of capacity to treat those with mental illness in the community to growing numbers entering the corrections system. When there was no place to commit a person who was a danger to themselves or others under Title 47, they were placed in jail for their own safety. Those who would have been sent to state hospitals because they'd committed a minor crime due to mental illness, substance use disorder or developmental disability were now being sent to jail.

In 1997, Alaska Department of Corrections determined that 37 percent of inmates were either mentally ill, chronic alcoholics and/or developmentally disabled (In-Step). By 2007, that number was 42 percent, and in 2012, a one-day snapshot found 65 percent of inmates to fit the description. (Hornby Zeller 2014).

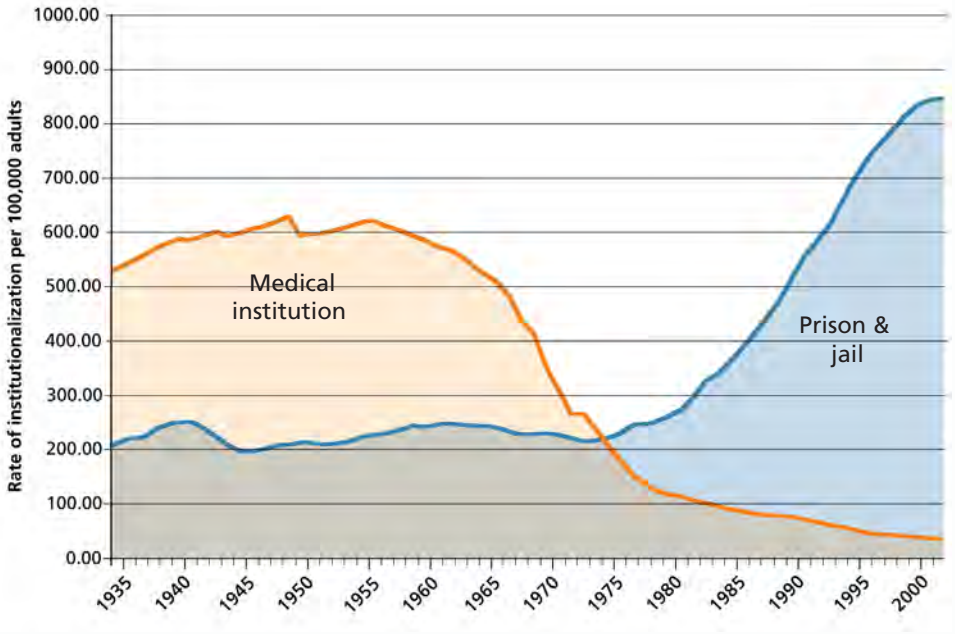
In 2005, the Bureau of Justice Statistics found that more than half of all inmates of correctional facilities in the United States had a mental illness.

Mat-Su Regional's Dr. Zink sees another impact of too few inpatient beds and the lack of outpatient community options.

One man suffering from anxiety kept coming back into the Emergency Department. His primary care physician didn't have the time and he had two stays at API, she said.

ED physicians can only see and treat immediate and life threatening situations, according to Zink. She saw him in the grocery store and could tell he wasn't doing well. "You guys just send me through, I'm struggling," he told her. She told him to come back and that she would help him with a safety plan. Zink learned later that he died by suicide. "It just breaks my heart," she said.

Figure 1. Location of Adults with Mental Illness: Medical Institution vs. Prison and Jail in the U.S., 1934–2001



Adapted from "An Institutional Effect" (Harcourt, 2011).

Mental Health Problems High Among Inmates, Especially Females

In June 2017, the Bureau of Justice Statistics (BJS) released a study showing that female inmates both experienced serious psychological distress (SPD) while incarcerated and had been told in the past by a mental health professional that they had a mental health disorder at higher rates than male inmates.

The BJS study found that incarcerated people experienced serious psychological distress (SPD) at three to five times the rate of the general population. Fourteen percent of state and federal prisoners and 26 percent of jail inmates reported experiences that met the threshold for SPD. In comparison, the BJS study found that one in 20 persons (5%) in the U.S. general population with similar sex, age, race and Hispanic origin characteristics met the threshold for SPD.

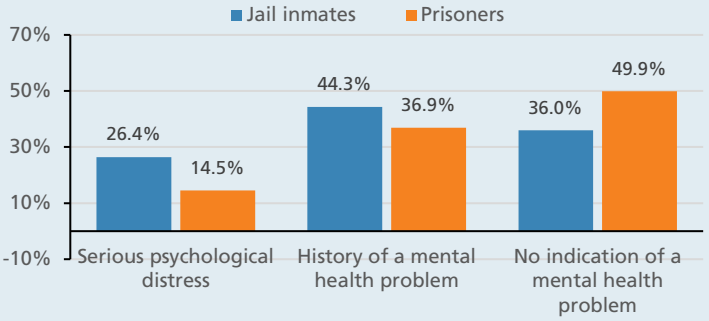
The report examined the prevalence of mental health problems among inmates based on two indicators: self-reported experiences that met the threshold for SPD in the 30 days prior to the survey and having been told at any time in the past by a mental health professional that they had a mental health disorder.

The report found that 37 percent of state and federal prisoners had been told by a mental health professional in the past that they had a mental health disorder. Among jail inmates, 44 percent had been told they had a mental health disorder. Female inmates experienced both at higher levels than male inmates.

In state and federal prisons 20 percent of females met the threshold for SPD, compared to 14 percent for males. In jails, 32 percent of females and 26 percent of males met the threshold.

Two-thirds of female inmates in both prisons (66 percent) and jails (68%) had been told they had a mental health disorder compared to around one-third (33%) male prisoners and 41 percent of male jail inmates.

Mental Health Status of Prisoners and Jail Inmates, 2011–2012



Source of data: *Bureau of Justice Statistics*

▸More Beds and Fewer on Horizon

In June 2017, Mat-Su Regional applied for a certificate of need to add 36 psychiatric and substance abuse inpatient beds, the first acute inpatient behavioral health services to be provided in Mat-Su Borough. The project is in response to a dramatic increase in the need for behavioral health services at MSRMC. Since 2014, behavioral health assessments for patients in acute psychiatric crisis have nearly tripled, from 349 to 1,100. The number of times the Emergency Department has had to divert psychiatric emergencies because the hospital was at capacity has jumped even more, from five time in 2012 to 234 times in 2016.

New inpatient beds will serve both voluntary admissions and involuntary admissions under Title 47 of the Alaska Statues, according to Alan Craft, Director of Marketing and Public Relations for MSRMC. Once approved, new construction will take place on the Palmer campus and is projected to be completed by December 2020.

This fall, though, API is undergoing a remodel that is projected to last four to six months and close 18 beds for a portion of the time. API CEO Carmichael told behavioral health care providers in the Anchorage area to expect "bottlenecks in the community."

Pamela Cravez is editor of the Alaska Justice Forum and author of the recently published "The Biggest Damned Hat: Tales from Alaska's Territorial Lawyers and Judges."

▸References

Alaska Comprehensive & Specialized Evaluation Services. (2003). *History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project*. ACSES Technical Report #85. Anchorage, AK: University of Alaska Anchorage.

Alaska Department of Health and Social Services. (2001). *In-Step: Comprehensive Integrated Mental Health Plan*. Juneau, AK: Alaska Department of Health and Social Services, Office of the Commissioner.

Alaska State Legislature. (2015). Senate Bill 74. (http://www.akleg.gov/basis/Bill/Detail/29?Root=sb74#tab1_4).

Bronson, Jennifer & Berzofsky, Marcus. (2017). *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12*. BJS Special Report. Bureau of Justice Statistics, U (https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946).

Center for Behavioral Health Research & Services. (2012). *Emergency Mental Health Services Utilization Project: Current and Historical Admission Patterns at Alaska Psychiatric Institute*. CBHRS EMHS Technical Report #1. Anchorage, AK: University of Alaska Anchorage. (http://www.ashnha.com/wp-content/uploads/2012/08/EMHU_Report1_07272012.pdf).

Harcourt, Bernard E. (2011). "An Institutionalization Effect: The Impact of Mental Hospitalization and Imprisonment on Homicide in the United States, 1934–2001." *The Journal of Legal Studies* 40(1): 39-83 (Jan 2011). (https://doi.org/10.1086/658404).

Hornby Zeller Associates. (2014). *Trust Beneficiaries in Alaska's Department of Corrections*. South Portland, ME. http://www.ajc.state.ak.us/acjc/doc/hornbyz.pdf).

Interview with Dr. Anne Zink, May 2017.

Interview with Gavin Carmichael May 2017.

PCG/Health. (2017). *Feasibility Study of the Privatization of the Alaska Psychiatric Institute: Final Report*. Public Consulting Group. (http://dhss.alaska.gov/HealthyAlaska/Documents/Initiatives/API%20Privatization%20Feasibility%20Report_Jan%2026%202017.pdf).