

**ALASKA STATE LEGISLATURE  
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

April 10, 2018

3:03 p.m.

**MEMBERS PRESENT**

Representative Ivy Spohnholz, Chair  
Representative Tiffany Zulkosky, Vice Chair  
Representative Sam Kito  
Representative Geran Tarr  
Representative Jennifer Johnston  
Representative Colleen Sullivan-Leonard

**MEMBERS ABSENT**

Representative David Eastman  
Representative Matt Claman (alternate)  
Representative Dan Saddler (alternate)

**COMMITTEE CALENDAR**

PRESENTATION: ALASKA PSYCHIATRIC INSTITUTE

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

RANDALL BURNS, Director  
Division of Behavioral Health  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Presented the PowerPoint "The Alaska Psychiatric Institute.

FAITH MYERS  
Mental Health Advocate  
Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of Alaska Psychiatric Institute (API).

DORRANCE COLLINS  
Mental Health Advocate

Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

JAMELIA SAIED

Counselor

Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

ANGELIKA FEY MERRIT

Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

RICH RADUEGE, Psychiatric Nursing Assistant (PNA)

Alaska Psychiatric Institute (API)

Shop Steward, Alaska State Employees Association Local 52

Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

SHEILA LITTLE, Registered Nurse (RN)

Alaska Psychiatric Institute

Shop Steward, Alaska State Employees Association Local 52

Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

MUSA KANTEH, Psychiatric Nursing Assistant (PNA)

Alaska Psychiatric Institute

Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

JASON LESSARD

NAMI (National Alliance for Mental Illness) Anchorage

Anchorage, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

ALISON KULAS, Executive Director

Alaska Mental Health Board

Division of Behavioral Health

Department of Health and Social Services

Juneau, Alaska

**POSITION STATEMENT:** Testified during discussion of API.

STEVE WILLIAMS, COO

Alaska Mental Health Trust Authority

Anchorage, Alaska

**POSITION STATEMENT:** Testified during the discussion on API.

#### **ACTION NARRATIVE**

[3:03:23 PM](#)

**CHAIR IVY SPOHNHOLZ** called the House Health and Social Services Standing Committee meeting to order at 3:03 p.m. Representatives Spohnholz, Johnston, Sullivan-Leonard, and Zulkosky were present at the call to order. Representatives Tarr and Kito arrived as the meeting was in progress.

**Presentation: Alaska Psychiatric Institute**

[3:04:03 PM](#)

CHAIR SPOHNHOLZ announced that the only order of business would be a presentation by the Alaska Psychiatric Institute which will include: an in-depth discussion surrounding the Alaska Psychiatric Institute (API); the Department of Health and Social Services, Division of Behavioral Health; a variety of stakeholders; patient and employee advocates; and organizations that may be able to offer insight and background as to API's issues and how to chart a course forward to ensure that patients and employees are safe and well.

[3:05:24 PM](#)

RANDALL BURNS, Director of the Division of Behavioral Health, Department of Health and Social Services, paraphrased slide 2, "Alaska Psychiatric Institute: the Basics," as follows [original punctuation provided]:

API's proposed SFY19 budget is \$33,360.0

Only 22% of API's funding is UGF: \$7.2 Million

More than half of the remainder of API's budget is funded by DSH (Disproportionate Share Hospital) Medicaid Funds: \$18.7 Million

The remainder of API's budget comes from Statutory Designated Program Receipts (SDPR - \$7.4 Million), including Medicare, Medicaid, third party/private payers, grants, etc.

API is the largest user of the State's DSH funds

DHSS currently uses its other available DSH funds to pay for the Division's support for Alaska's 3

important designated hospitals providing psychiatric evaluation and treatment services [Fairbanks Memorial Hospital (FMH); Providence Alaska Medical Center for the Providence Psychiatric Emergency Department (PPED); and Bartlett Regional Hospital (BRH)]

FMH has a 20 bed mental health unit, with 4 acute beds; BRH has 12 mental health beds; and the Providence Psychiatric Emergency Department, which acts as a behavioral health triage center for the Anchorage area, has 7 beds. All three have psychiatrists at the head of their units.

[3:07:39 PM](#)

MR. BURNS, paraphrased slide 3, "An 80 Bed Hospital" as follows [original punctuation provided]:

API is an 80 bed hospital with 5 distinct units:

Two adult acute units: Katmai (24 beds) and Susitna (26 beds) for a total of 50 adult acute patient beds

One 10 bed unit for adolescent patients (Chilkat) - ages 13 through 17

One 10 bed unit for longer term adult patients (Denali) with a real mix of diagnoses, from TBI, autism, dementia, IDD, and all with very difficult and complex behavioral issues

One 10 bed unit for "forensic" patients (Taku) - for defendants' whose criminal trials are on hold because of concerns for their mental status (competency to stand trial)

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MR. BURNS advised that slide 4, "Average Length of Stay by Unit by Year, 2014-2017" is an example of the length of stay over the last four years of each unit and they have been relatively stable across these years.

MR. BURNS, paraphrased slide 5, "History: A Range of Bed Options: From 162 Beds to Just 45 Beds" as follows [original punctuation provided]:

Beginning in 1986, and over the next 14 years, there were a variety of scenarios proposed to replace the aging API

Most of the scenarios ended up being primarily based on the funding available and did not significantly rely on the approximately \$6 Million in programming work DHSS had contracted for as it prepared its CON for the replacement hospital

DHSS issued its preliminary study in February of 1992, summarizing the work of many of its consultants; this study targeted the new API as requiring 162 beds: 72 Adult, 18 adolescent, 36 forensic, and 36 elderly (although a year later, in 1993, a final DHSS study suggested Alaska would need between 198 and 237 beds)

DHSS' early 1992 report was highly criticized by advocates and community behavioral health providers who supported a focus on more community-based services

[3:09:38 PM](#)

MR. BURNS, paraphrased slide 6, " History: The 'Alyeska Accord': Finding Stakeholder Agreement on the Bed Capacity of the New API," as follows [original punctuation provided]:

The Alaska Mental Health Board held a meeting at Alyeska of 42 community mental health advocates and mental health service providers in June 1992 (over 25 years ago)

The results from this weekend meeting became known as the "Alyeska Accord" and was a set of principles which were to guide the AMHB's response to DHSS' Certificate of Need (CON) application for a new API

Agreements reached included the decision that the central purpose of API was to provide "tertiary" care and agreement that the new API should be built at 114-beds, as follows: - Adolescents: 18 beds - Elderly: 18 beds - Adults: 36 beds - Swing (complex adults): 18 beds - Forensic: 24 beds (not a part of the original accord, but adopted by the AMHB a month later, in July of 1992

3:11:00 PM

MR. BURNS, paraphrased slide 7, " History: From 114 beds to 57 to 72 to 80!" as follows [original punctuation provided]:

Based on the Alyeska Accord result, a CON for the 114 beds was submitted in August of 1993 by DHSS

However, this CON and its cost (\$64.9 Million) was DOA. Four years later, in 1997, the DHSS Commissioner reviewed a report with different five scenarios, based primarily on funding availability: a 72-bed option, a 63-bed option, two different 54-bed options, and even a 45-bed option.

Based on this report, the DHSS Commissioner selected one of the 54-bed options (which included adolescent beds).

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CHAIR SPOHNHOLZ referred to the Certificate of Need for 114 beds for the roughly \$65 million API facility, and asked Mr. Burns to explain why it was "dead on arrival."

MR. BURNS responded that it was due to the cost. He explained that there was no support from the legislature for a capitol budget of which would have been essentially \$40 million above the funding that the department had available at that point in time.

3:12:50 PM

MR. BURNS continued paraphrasing slide 7, as follows [original punctuation provided]:

After four more years, in 2001, with over \$16 Million in legislative-approved COP bonds, the re-appropriation of \$19 Million in existing committed capital funds, and a Trust Authority contribution of \$3 Million, DHSS finally had the funds to procure a 72-bed facility. Another controversy: the construction proposal was issued as design-build.

Because of concerns for the ability of the 72 beds to handle API's capacity issues in 2001, DHSS issued API

a CON for 72 beds but did allow for an expansion to 80 beds with proof of a history of needing additional beds. API opened with 80 beds in 2005.

As a part of this effort to fund a new hospital, DHSS also applied for and was awarded a SAMHSA grant for \$5 Million a year for three years to help fund expanded community-based treatment to support the downsized-hospital. These funds primarily were used to support the development of additional DET capacity, and training in role recovery, dual diagnosis, cultural competence, and crisis intervention.

[3:15:05 PM](#)

CHAIR SPOHNHOLZ requested the definition of DET.

MR. BURNS answered that it is Designated Evaluation and Treatment (DET). During the downsizing of API, it was decided that more regional-based mental health options were necessary. The Fairbanks Memorial Hospital and the Bartlett Regional Hospital mental unit are both considered designated evaluation and treatment facilities, he explained. Those facilities are also designated to receive a portion of the DSH each year, he said.

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MR. BURNS paraphrased slide 8, "Calendar Year Snap Shot of API Utilization," and noted that in 1990, API had 160 beds and in 2017, it had 80 beds. He referred to the column titled, "No. of Unduplicated Admits With Just a Single Stay during the Year" and pointed out that in 2017 there were 839 unduplicated admits and of those, 486 were admitted and had never been admitted to API previously. He described it as one-third of the admissions for that year, which is typical.

[3:17:11 PM](#)

MR. BURNS paraphrased slide 9, "The Current Bed "Capacity" Issue" as follows [original punctuation provided]:

As members of this Committee are aware, API needs - and has been going through - an expensive but very necessary face-lift, retrofitting every bathroom and portions of every bedroom to meet revised Joint Commission safety requirements

Since mid-November of last year, this six-month long, temporary closure of each of API's five hospital units for repairs has had a major impact on community hospital EDs and Alaskans experiencing psychiatric emergencies: patients with court orders for hospitalization for evaluation at API have been held for days - not hours - sometimes up to a week or more - awaiting transfer to API for evaluation and treatment [or transfer to one of the two other hospitals with Designated Evaluation and Treatment (DET) mental health units]

The API contractor has been working on the last unit for about a month now (the Susitna Unit); unfortunately, it is the hospital's largest unit, with 26 adult acute beds, so API's census capacity has been set at just 54 patients, not 80 (or even 70)

MR. BURNS paraphrased slide 10, "API's Current Estimated Bed Capacity " as follows [original punctuation provided]:

The construction on the Susitna unit was completed last week; other off-patient-unit bathrooms were also being repaired last week (e.g., restrooms off the gym and dining room); the Susitna Unit is being thoroughly cleaned and should be ready to open back-up this very week

However, because of a shortage of nursing staff - on April 11th - when API will have completed the renovation project on time and the contractor is out of the building -at this time, and for at least the next several months, we believe API will only be able to run a census of 58 beds, down a total of 22 beds for the foreseeable future.

We are not going to be able to open up the Denali Unit (10 beds) and we will be forced to run the Katmai unit at half of its normal census, or just 12 beds instead of the normal 24 beds.

Until we are able to hire more RNs (travelers or full-time positions), or the staff currently out on various types of leave (whether it be workers' comp or FMLA) are able to return to work, we are not going to

be able to fully staff the Katmai unit, nor open the Denali Unit

3:19:30 PM

REPRESENTATIVE SULLIVAN-LEONARD offered concern regarding the shortage of nurses at API, and asked how Mr. Burns plans to overcome this challenge. She further asked whether he is working through the University of Alaska nursing program or recruiting from out-of-state or out-of-country.

MR. BURNS responded that API's recruitment problems are due mainly to its salaries, and later in the presentation he will address that issue.

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REPRESENTATIVE TARR referred to slide 7, and its different scenarios and offered that in addition to the funding issue there were some challenges in the location. She asked whether any challenges to the location had influence over the size of the facility.

MR. BURNS answered that the community in that area has always been highly supportive of API, and it was not a community objection to the size. He explained that the acreage API sat on was considered to be highly valuable and there were many competing (indisc.), the university, Providence Hospital, and the Alaska Mental Health Trust and its ability to use part of that land for profit or for the beneficiaries. The real debate related to what the footprint of API would look like, and how to get it onto that property, which is how it ended up back in the corner of that much larger lot (indisc.), he explained.

3:22:16 PM

REPRESENTATIVE TARR referred to the first paragraph on slide 9, which read as follows [original punctuation provided]:

As members of this Committee are aware, API needs - and has been going through - an expensive but very necessary face-lift, retrofitting every bathroom and portions of every bedroom to meet revised Joint Commission safety requirements

REPRESENTATIVE TARR requested a description of the Joint Commission, and whether there is a report the legislature would have received.

MR. BURNS described that the Joint Commission is the entity that credits all (indisc.) seeking new accreditation so it can bill for Medicaid clients. The Centers for Medicare & Medicaid (CMS) has given its authority to the Joint Commission, and the Joint Commission regularly visits hospitals around the country and accredits them to make sure they meet the standards jointly produced by the Joint Commission and CMS.

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MR. BURNS paraphrased slide 11, "API's Current Estimated Bed Capacity " as follows [original punctuation provided]:

We have hired four (4) traveling RNs, but we continue to run at an RN deficit. The salaries that API is able to pay for starting RNs is not competitive with private sector hospitals

DHSS is presently exploring hiring bonuses and other types of incentive pay in an attempt to make the positions more attractive to prospective RNs (incentives used by other departments, like DOC)

We have been meeting with Southcentral Alaska hospitals and are going to be implementing some admissions changes that should somewhat help mitigate the stress on hospital ED's during this perfect storm of problems affecting API

While we have been pleased with the Certificate of Need (CON) applications from both Alaska Regional Hospital and MatSu Regional Medical Center, CONs that Commissioner Davidson has approved, we are anxious about the actual dates that these facilities will be able to open and actually begin accepting behavioral health patients

Finally, in Governor Walker's capital budget for FY19, there is a request to remodel the Anchorage Pioneer Home to add at least six beds for psychiatric patients needing dementia care.

MR. BURNS, in response to Representative Sullivan-Leonard's previous question, advised that recently API spent a great deal of time looking into what the department would need to bring API fully online. Subsequent to API's research, it determined that API had approximately 10 RNs out on a variety of leave, with 10 vacancies. Therefore, in order to keep the unit open, API is seeking 10 new positions to cover those out on leave and five positions to cover those vacancies. Clearly, he stressed, the state's nursing salaries are simply not competitive, and 18 years ago in order to solve a similar problem the department raised all of the nursing salaries by two ranges and it worked. He said that API is suggesting the state try that same solution at this time, and fund the 15 new positions as well as increase the salaries of the existing RNs at API. The total funding, he explained, would be approximately \$2.5 million to have competitive salaries. For example, he advised, API learned that a current API nurse also works on the Psychiatric Unit at Providence Hospital and earns \$8.00 more an hour at Providence Hospital than she does at API. However, he said, API also needs funding for programing for staff; it is particularly concerned about the need to increase salaries for physician assistants, Adult Nurse Practitioners (ANPs), forensic psychologists, and pharmacists. These issues have been closely reviewed and he would be happy to provide more details in going forward as to what API believes its true needs are for its staff.

[3:27:36 PM](#)

REPRESENTATIVE ZULKOSKY surmised that over 25 years ago there was an acknowledgement that the capacity needs of API were well over what was actually constructed, and asked whether that is, in part, due to the costs of construction.

MR. BURNS responded that it was a combination of construction costs but mostly it was (indisc.) around the hospital with the amount of capitol funds and eventually some bonding that allowed API to cobble together the funding.

REPRESENTATIVE ZULKOSKY advised that in coming from travel health recently she understands the challenges around recruiting needs, the need to operate at capacity, and to provide some market adjustments to make sure the salaries are competitive. She asked whether API has found that there is a shortage of medical professionals nationwide as she knows the shortages exist for hospitals. She further asked whether the facility is HIPPA compliant.

MR. BURNS responded that API is compliant with all patient privacy requirements, and he agrees that there is a national shortage of RNs and medical staff, so Alaska is not alone in that regard. Given the shortages, it is an employee market in the healthcare industry and medical providers can probably choose where they want to work given their skills set if given competitive salaries.

[3:30:42 PM](#)

REPRESENTATIVE JOHNSTON asked that Mr. Burns repeat the number of nursing vacancies.

MR. BURNS replied that API has 10 vacant positions and 10 positions that are essentially vacant because the staff is on some type of leave.

REPRESENTATIVE JOHNSTON surmised that API must have a "pretty high" vacancy factor.

MR. BURNS answered that it has the normal budget vacancy factor of 8 percent.

REPRESENTATIVE JOHNSTON related that she is trying to understand how API can operate as well as it is currently, and asked whether there are duties an LPN can perform for an RN to relieve some of the pressure on the RN.

MR. BURNS answered that there are some jobs an LPN can perform rather than an RN, the API physician descriptions (indisc.) for them, and these are site nursing positions. As long as API is meeting the Joint Commission standards for its nursing staff, it can use LPNs for RNs if they have had the appropriate medical training, he said.

REPRESENTATIVE JOHNSTON explained that she is trying to understand how API can transform when it has an RN shortage and a need, and how some of those duties are transformed in order to make it all work. She related that with the vacant positions, API could possibly revise some of its salary structure to be competitive and review its job descriptions to put "more feet in the building." She asked whether Mr. Burns had been looking at those possibilities in API's organizational management to determine how to work with what it has currently in order to meet some of these chronic needs.

MR. BURN responded that in using API's existing salary schedules, it was suggested that it simply take the existing salary schedule and boost the ranges of those positions in order to make them more competitive. He reiterated that that approach was made some time ago and it was successful.

REPRESENTATIVE JOHNSTON asked whether API would be looking at what its needs are on the floor to determine whether it could shift some of those needs to an LPN, or another medical provider, to make it all work.

MR. BURNS replied that API has been looking at a variety of options to get those positions filled and it will continue to review options.

REPRESENTATIVE JOHNSTON said that she did not mean a licensed practical nurse, but other healthcare providers who are not an RN but have the capability to be effective on the floor.

MR. BURNS advised that those are where the limitations come in in terms of the Joint Commission standards, there are very strict standards about the nature of the positions that can work in a hospital and the duties of those positions. Therefore, API must make sure it is recruiting and staffing at the appropriate level of clinical expertise.

[3:35:30 PM](#)

CHAIR SPOHNHOLZ noted that Mr. Burns testified that he had a requested \$2.5 million to assist in addressing the staffing shortage, and asked where that request was located.

MR. BURNS answered that that is not a request API has in any budget. In the event API could get its staff up and running again as quickly as possible and assuming it could fund those positions at a higher level, the cost would be \$2.5 million to fully staff API and empty out the emergency departments across the state.

CHAIR SPOHNHOLZ surmised that that is both an adjustment of salaries in order to be more competitive and also an increase in the number of personnel.

MR. BURNS stated that Chair Spohnholz was exactly correct.

CHAIR SPOHNHOLZ, for context, noted that psychiatric nurses in API are working in the absolute most complex working environment

in the State of Alaska in terms of the acuity and the complexity of the patients admitted into API. She stressed that she could not state strongly enough how important it is to make sure these salaries are at the correct range to attract and retain the most qualified personnel possible. The State of Alaska must employ the best of the best in these positions because the patients cannot go anywhere else, and they are the most challenging simply because API is the state's only psychiatric institution. She stated that she will follow up with Mr. Burns and department representatives to try to figure out some of the fiscal elements of these problems. These issues about patient safety and worker safety cannot continue to be neglected when it is a known problem and there are clear straight-forward solutions to resolving these problems. She pointed out that API has been neglected for "a very, very long time." Chair Spohnholz noted that she had read API's PowerPoint presentation earlier and read some of the reports and history, and she was struck that the legislature has refused to address the known problems directly and as forthrightly as necessary.

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REPRESENTATIVE ZULKOSKY noted that according to the presentation, currently API is only running 58 beds, and is down 22 beds. She asked Mr. Burns to speak to the total count of staff necessary for the current number of beds in operation, and the necessary staff if API operated at full capacity.

MR. BURNS replied that 22 of the 58 beds is based on the staffing it currently has available, particularly RNs. The API does have a total of 56 RN positions, but it is down 20 of those positions due to the vacancies and/or personnel out on a variety of leave, it is down to 36 beds. He explained that that is the reason API is currently staffing the hospital at 58 beds rather than 80 beds.

REPRESENTATIVE ZULKOSKY restated her question and asked the number of full-time exempt position (travel health), and the total number of employees necessary to run however many beds are currently in operation versus how many full-time employees would be required to run a full-capacity facility.

MR. BURNS answered that API would need 56 nursing positions filled in order to fully staff the facility, obviously other staff is needed for every shift. The RNs are particularly important because if there is not an RN on shift, the unit must be closed. He related that that is why API looks to the RN in

order to set the capacity of the hospital because it is staffing 24/7 and those units would need all 56 RN positions filled in order to keep the units open on a 24/7 basis.

REPRESENTATIVE ZULKOSKY surmised that 20 full-time positions.

MR. BURNS responded that API would need an additional 20 full-time positions, currently 10 positions are vacant because API cannot fill the positions. The facility is not counting on all of the staff that are on leave will return, which is why it set 15 as the number "we really are looking to" in order to have the hospital up and running.

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REPRESENTATIVE TARR referred to the \$2.5 million figure and said that when she spreads it out among 20 positions it is approximately \$125,000 per position. She asked how the \$2.5 million translates into those positions relative to the private sector and whether it is necessary to add \$125,000 to the overall compensation package to be competitive with the positions of the private sector. Previously, Mr. Burns had said that the \$8.00 per hour for a full-time employee is approximately \$16,000 more per year, and she asked Mr. Burns to explain the numbers.

MR. BURNS apologized for not providing the information in a format that would be useful. He explained that API took the existing RN position range of 19, and the \$62,000 per year with benefits equals \$108,000, if that range is bumped up two full ranges to make it more competitive with the private sector, it becomes \$70,800 per year and with benefits it is \$120,591. Thereby, API would be increasing the cost of that position of \$108,000 to \$120,000, he explained.

REPRESENTATIVE TARR surmised that the \$2.5 million roughly is 10 of those range 21 positions.

MR. BURNS clarified that it is 15 positions plus the addition of the funding necessary to also bring, not just the 10 vacant unfilled positions, but bring up the salaries of the other positions, which is another \$500,000.

[3:45:57 PM](#)

MR. BURNS paraphrased slide 13, "API and its Forensic Population," as follows [original punctuation provided]:

There is another population besides adolescents that pose a particular problem for API.

The Alaska Court System's demand for DHSS's forensic services has simply outstripped API's ability to manage the caseload assigned to its staff utilizing API's 10-bed, medium security unit - the Taku Unit - to serve the defendants court-ordered to API for treatment

API did seek consultation on this issue and Dr. Patrick K. Fox, a psychiatrist with significant forensic experience, was hired by the Western Interstate Commission for Higher Education (WICHE) to provide API with a report. His report was issued in November 2016.

The report offered a number of recommendations, including additional education to API staff, consideration of a jail-based competency restoration program, an evidenced-based jail- diversion program, involvement of more experienced outside forensic examiners, and training for judges and the legal community on forensic issues (including the Sell involuntary medication standard)

The API Forensic Evaluation Team was served with a notice last month that an Anchorage Mental Health Court Judge had set April 16th for an "Order to Show Cause Hearing" as to why API should not be held in contempt of court for not evaluating a defendant within the judge's requested time frame. This was recently resolved, but it shows the level of frustration.

In partial response to this crisis, and with the original support of this Committee and the eventual support of the House Finance Committee, the House of Representative is seeking Legislative and Alaska Mental Health Trust Authority support for a feasibility study to explore the value of establishing a forensic hospital in Alaska, given the various demands on API and the general needs of Alaska's mentally ill correctional population.

MR. BURNS advised that prior to the late 1980s, API's forensic patients were sent out of state to (indisc.) a hospital in California. At some point, California decided it was finished with taking care of another state's patients and returned the patients to Alaska and then to API. Since that time, API has worked with this population and the court system has been unhappy with the delays in API's ability to perform competency examinations of those people accused of crimes who may not be competent to stand trial. While API is behind in that issue, it has only three staff members to handle those numbers and API feels fortunate in their abilities. In the event the patient is reviewed and determined to be incompetent but could be restored, they are admitted to the API 10-bed unit for treatment and restoration, he offered. Due to the fact that API has so few beds, a number of those defendants found to be non-restorable are waiting in the Department of Corrections (DOC) for API to admit them into the hospital. In order to show the committee the court system's level of frustration, last month an Anchorage judge in the mental health court sent API an Order to Show Cause as to why it shouldn't be held in contempt for not accepting this particular client within a certain period of time. That order has since been resolved, he said, and API appreciates the House Health and Social Services Standing Committee, the House Finance Committee, and the Mental Health Trust Authority's support in funding a forensic feasibility study for a forensic hospital.

[3:48:52 PM](#)

MR. BURNS paraphrased slide 14, "Studying Alaska's Need for a Forensic Hospital," as follows [original punctuation provided]:

The study would look at Alaska's needs for forensic beds in order to admit, evaluate, and treat criminal defendant with issues around the insanity defense and their competency to stand trial (see AS 12.47). The list of issues is long and complex and would involve defendants: - needing competency evaluations; - found incompetent to stand trial who need treatment to determine if they can be restored to competency in order stand trial; - found non-restorable and who are then civilly committed to API (including dangerous persons who often have committed serious felonies); - found Guilty but Mentally Ill (GMI) and held in prisons; - found Not Guilty by Reason of Insanity (NGRI) and committed to API's forensic unit; or - found guilty of a variety of crimes where competency

was not raised and who have been incarcerated but who are experiencing a mental illness and need ongoing treatment because of the severity of their symptoms - and just as often - the severity of their crimes.

MR. BURNS described this as an incredibly complex area with a long list of needs for this population.

3:49:43 PM

CHAIR SPOHNHOLZ asked how many people have been admitted to API who were found to be non-restorable and are essentially committed for an indeterminate amount of time.

MR. BURNS answered that there are 10 patients in the forensic unit that API is trying to restore, there are currently four patients on the civil side who were determined non-restorable and committed to API. He advised that three of those patients committed very serious crimes.

CHAIR SPOHNHOLZ asked how many are in the Department of Corrections (DOC) when they should rightly be in API.

MR. BURNS apologized and said he does not have that number off the top of his head.

CHAIR SPOHNHOLZ asked that Mr. Burns follow up with that number.

MR. BURNS agreed.

3:51:24 PM

MR. BURNS paraphrased slide 15, "So: the Short List of API Current Challenges:" as follows [original punctuation provided]:

Admissions pressures: - Continuing demand for treatment beds at API from all regions of the state - Long waits for patients (boarding) in hospital EDs for an evaluation and/or a treatment bed at API because of API's general lack of an adequate number of treatment beds

Staffing related budget concerns, including recruitment, retention, appropriate unit staffing coverage, quality of care (i.e., need for unit programming / therapeutic activities for patients in

treatment), and the reliance on overtime to keep the hospital minimally staffed (Premium Pay)

Concerns for the safety of staff and patients and staff training to ensure their safety and the safety of patients when staff are appropriately redirecting or intervening with challenging patients; ongoing concerns for the use of seclusion and restraint

Current inadequate local community behavioral health programming to support patients who are discharged from API or either Fairbanks Memorial or Bartlett Regional, including inadequate community-based medication management services, and an ongoing need for community mental health (MH) treatment, for substance use/misuse disorder (SUD) treatment, for a combination of both MH and SUD (Co-occurring) treatment, and / or because of a lack of housing or appropriate living arrangements

In partial response to the clear need for more community based services, and to address the substance use / opioid crisis in this state, the Governor has introduced an FY18 supplemental request for \$18 Million to assist in providing greatly needed SUD treatment programs in local communities, especially withdrawal management and residential treatment programs

[3:53:02 PM](#)

MR. BURNS paraphrased slide 16, "A Summary of Potential Projects that Could Significantly Improve API," as follows [original punctuation provided]:

There are a number of projects presently being considered by the Legislature that would have a direct - and highly beneficial - impact on API's current crisis:

Support for an expansion of Alaska's DSH Program, allowing DHSS to explore ways to financially assist those hospitals highly impacted by the reduction in treatment bed capacity at API

Support for the \$18 Million in additional substance use/misuse disorder treatment, providing funding for

inpatient and ambulatory withdrawal management services, residential and intensive outpatient residential treatment services, sobering center or 72-hour SUD crisis evaluation services, and housing assistance and support services

Support for the \$318.0 feasibility study to explore the need for a forensic hospital in Alaska

Support for API's budget and recognition that present funding is inadequate to meet the dramatic admission, discharge, and patient and staff safety pressures facing the hospital

[3:54:09 PM](#)

CHAIR SPOHNHOLZ acknowledged Mr. Burn's long service time with the department, and asked whether he feels the legislature made the right decision in terms of building API with an 80 bed capacity, or does he feel the legislature should have built API out larger in the 1990s proposals.

MR. BURNS answered that part of the appeal in building a smaller API was that there would be 16 beds of designated evaluation and treatment directly in Anchorage with the understanding that 80 beds would have been adequate. He related that that particular portion of the commitment was never followed up on, there was an attempt but it failed which meant the facility was down 16 beds. In addition, he opined, there was a real expectation, particularly by advocates in the communities, that there would be substantial ongoing support to make sure the communities had adequate local support for those individuals with mental health/substances abuse issues. Unfortunately, he said, that commitment would have required a continuing additional commitment to those communities which has been hard to maintain. In a perfect world, if everyone had done what the plans said they would do, API would probably be okay but that didn't really take place.

[3:57:29 PM](#)

FAITH MYERS, Mental Health Advocate, advised that she volunteers as a mental health advocate, she has served on numerous API committees, and is a board member (indisc.). Psychiatric hospitals and (indisc.) operate in self-interest, "we are not going to voluntarily improve rights of care for psychiatric patients." Thereby, leaving the legislature and the court

system to protect psychiatric patients wherein thousands of individuals are brought into forced psychiatric evaluation or treatment each year in Alaska at over \$1,500 per day. In the process, 47 percent will experience sexual trauma or harm which may cause exacerbate post-traumatic stress disorder (PTSD). Evidence indicates that PTSD is associated with the highest rates of medical and mental health services, making it one of the costliest mental disorders. There is a real correlation between the lack of rights for acute care of psychiatric patients and the poor system of care, as at API. Among those rights, psychiatric patients should have the right to have (indisc.) trauma recognized by the Alaska hospitals and units and treatment provided. Providing care rights for psychiatric patients will force the various state departments to develop proper systems of care that reach best practices in psychiatric hospitals and units. Best practices for the state, she offered, would be for the legislature to pass a bill similar to the 2008 Georgia House Bill 535, a summary of which read as follows [original punctuation provided]:

This legislation repeals current law providing for a State and a Community Ombudsman for Mental Health, Mental Retardation, and Substance Abuse, and instead provides for the Office of Disability Services Ombudsman (Office). The Ombudsman will serve as chief officer of the office. The Ombudsman will promote the safety, well-being, and rights of mental health consumers; will establish procedures for investigating and resolving complaints; investigate actions of service providers; establish a uniform statewide complaint process; enter and inspect facilities; access clinical and agency records; promote the interests of consumers to government agencies; and report to law enforcement when appropriate. The bill also includes a separate clause to cover persons with developmental disabilities and addictions.

[4:00:20 PM](#)

REPRESENTATIVE TARR shared that Legislative Legal and Research Services is drafting legislation based on Georgia House Bill 535 for the committee's review and study.

[4:00:51 PM](#)

DORRANCE COLLINS, Mental Health Advocate, advised that he volunteers as a mental health advocate. In 2010, he said he served as a board member on the Alaska Psychiatric Institute Advisory Board, made a tour of three of the hospital units, and wrote a four-page report with 16 constructive criticisms. He described that a patient was lying in a urine soaked bed at 3:00 p.m., and he was informed that the hospital had no policy for when to change the sheets of the patients. The API and other hospitals have never voluntarily developed psychiatric patient policies that properly protect disabled patients and help with recovery. He referred to the 2008 Georgia House Bill 535, and advised that 10 years ago, the Georgia legislature determined that its equivalent of the Department of Health and Services and the providers of services of psychiatric patients operated in self-interests. So much so, he said, it was proven that Georgia's Department of Health and Social Services was incapable of writing or enforcing fair rules to protect their clients. (Indisc.) cost of investigating their client's basic rights. A number of years ago, he said he went to the Ombudsman's Office and it was determined that Behavior Health had not investigated patients' complaints in five years as it was not their priority list to investigate complaints. He noted that as to the testimony today, his group is totally against practice of the transfer of criminals into non-criminal units in API and if a larger hospital was built the rights of the patients would be improved. Patrons of API and the people who make decisions believe that the patients have no clear right to fair treatment, or fair rights, he said.

[4:04:13 PM](#)

JAMELIA SAIED, Counselor, advised that she grew up in Fairbanks, is a professional mental health counselor, has had interactions with API over 25 years, and has served on the boards for several mental health organizations. For several years, she said she offered weekly presentations at API on particular treatment programs, and worked with her own patients at API. She applauded the committee for performing this long overdue investigation and she considers most the employee concerns to be valid because they often are not adequately trained in best practices and often work in conditions without supervision or support. She asked the committee to strongly consider the impact that the inadequate employee conditions have on patients. During the time she conducted the presentations at API, numerous patients were always asking her for help with some kind of problem, sometimes the issues were easily resolved by a staff members, and other issues were fundamental problems with their

treatment. For example, there were constant problems with their medications due to a revolving door of providers, and being told they were about to be discharged with no plan in place. Working as a clinician for patients at API, she said she would generally have difficulty reaching the attending doctor to discuss ongoing outpatient care, and oftentimes they could not remember the patient to whom she was inquiring. She described that she had advocated for a larger institution, API is too small for its community especially when considering that API not only serves Anchorage, it serves rural communities statewide. Due to the constant shortage of beds, many individuals who need help end up in jail, thereby resulting in the DOC being the largest mental health provider in the state. Also, she remarked, many API patients have co-existing substance abuse disorders and opined that there are only eight de-tox beds available in Anchorage. The API has serious problems for both employees and patients, and the other states that have examined these issues have successfully corrected the problems. It will cost money, she offered, because nurses and the other medical staff need competitive wages when the committee considers the additional stress in working with API patients. She expressed that the salaries should actually be higher at psychiatric institutions. The inadequate care the patients are receiving ends up costing the state more dollars in terms of increased crime, homelessness, and the substance abuse epidemic Alaska is experiencing.

[4:09:09 PM](#)

CHAIR SPOHNHOLZ commented that she appreciates Ms. Saied drawing the link between appropriate staffing levels, appropriate training, and how that translates to appropriate care for patients.

[4:09:30 PM](#)

ANGELIKA FEY MERRIT shared anecdotes about her daughter's experiences at API. After sharing her daughter's experiences, she stated that API is not a safe place for the patients or the staff, it is not a stable environment for her daughter, and no treatment is provided for the patients other than medications. She urged the legislature to provide treatment programs for long term patients, like her daughter, rather than re-traumatizing the patients.

[4:18:54 PM](#)

RICH RADUEGE, Psychiatric Nursing Assistant (PNA), Alaska Psychiatric Institute, Shop Steward for the Alaska State Employees Association Local 52, said that API is a dangerous place to work and he shared his experiences working at API since 1987. In 2018, the Occupational Safety and Health Administration (OSHA) found API to be a generally unsafe workplace, and in 2015, Dr. Joshua Dvorkin, forensic psychologist, law professor at the University of Arizona, was hired by then CEO Melissa Ring at API to make recommendations regarding the unsafe workplace issues. He related that Dr. Dvorkin wrote as follows:

In my opinion, API is significantly and at times dangerously understaffed. When staff is inadequately staffed, staff members become fearful of patients and as a result they may spend too much time in the nursing station and not enough time interacting with their patients. Understaffing also reduces the ability of staff to intervene early in non-confrontational ways which would allow them to avoid many of the circumstances which lead to ... end up use of force."

Dr. Dvorkin also recommended that 24 permanent floor staff be added and noting that CEO Dr. Ring had previously made that same recommendation as well. The staffing of permanent experienced PNAs is inadequate and API recently started a program of filling the lack of those permanent staff positions with on-call non-permanent staff. He described that these staff members are inexperienced, can only work a certain number of hours, and are supposed to be used as substitutes for the permanent staff on leave or workmen's compensation. Staff are reluctant to take the lead in controlling a disruptive patient because every restraint is likely to result in blame by the lead staff person, he stressed, the PNA performing the restraint should not be subject to blame because this prevents open debriefing when blame occurs and it prevents interventions that would benefit the other patients, and no standardize policy exists allowing for the restraint type of intervention. Staff are reluctant to open up in debriefing for fear of blame and punishment, which prevents adequate recordkeeping for the benefit of the patient involved as well as the staff who must deal with the patient on the next shift. Code Grey, he explained, is called when more staff are needed for a behavioral emergency, oftentimes the code is for a show of support and moving more PNA staff onto the floor, which has the calming effect of safety in numbers. The theory behind the 101 and the 201 is that it prevents harm to

the patient as well as the staff and often this is enough to prevent what otherwise might be a restraint. The staff receives only a couple of days of training per year by the PNA-4; however, many PNA-4s are themselves investigated for performing restraints incorrectly. He said, API was found to have four times the number of assaults as other residential mental health facilities.

[4:25:28 PM](#)

REPRESENTATIVE ZULKOSKY requested the definition of PNA, and the ratio of staff to patient. She said she thought that Mr. Raduege had said there was an additional 12, and he had stated another number.

MR. RADUEGE answered that a psychiatric nursing assistant is a PNA. Previously, staffing was based on acuity wherein a high acuity patient would be a four, a low acuity patients would be a one, and the unit would be staffed for the day or the next shift by that acuity. Currently, he explained, it is a core of three staff members no matter the height of the acuity, and there is extra staff if a patient is on a one-to-one which means they are observed by one person 24 hours per day sometimes.

[4:26:40 PM](#)

REPRESENTATIVE ZULKOSKY asked Mr. Raduege to repeat his testimony wherein he had mentioned additional recommendations for additional positions.

MR. RADUEGE reiterated that the way staffing was previously followed was by an acuity on the severity of the milieu, and now it is a flat three number, if that is the number, of staff that come in every day.

REPRESENTATIVE ZULKOSKY commented that she thought Mr. Raduege had mentioned an additional 12 staff per shift.

MR. RADUEGE clarified that he meant 12 staff for the whole 24-hour period.

[4:27:30 PM](#)

REPRESENTATIVE JOHNSTON said she thought Mr. Raduege had mentioned an additional 8 staff for the weekend.

MR. RADUEGE answered that on the weekends, staff works 12-hour shifts. There are three shifts on the weekdays and then 12-hour shifts which would decrease the number needed on the weekend because they work 12-hour shifts on the weekends.

REPRESENTATIVE JOHNSTON requested the current number of vacant PNA positions.

MR. RADUEGE responded that he does not know the number of vacant positions.

REPRESENTATIVE JOHNSTON surmised that Mr. Raduege suggested that even with API's current positions, staff is basically put on the floor according to a flat number versus the level of acuity and there is room for a management change here.

MR. RADUEGE answered that Representative Johnston was correct.

REPRESENTATIVE JOHNSTON surmised that the plan for acuity has changed as far as management's approach.

MR. RADUEGE answered that Representative Johnston was correct.

[4:28:32 PM](#)

CHAIR SPOHNHOLZ commented that Mr. Raduege has been performing this work for 30 years, which is a longtime for a public servant in any line of work but particularly in this line of work.

[4:29:04 PM](#)

SHEILA LITTLE, Registered Nurse (RN), Alaska Psychiatric Institute (API), Shop Steward for the Alaska State Employees Association Local 52, advised that she is a level 2 registered nurse (RN) at API and she usually works a 12-hour shift on a 10 bed unit and supervises anywhere from two to five PNAs during her shift. First of all, she pointed out, some of API's members had a peaceful demonstration in front of API, which was posted on social media. After reading some of the comments on the post, it occurred to her that there is a rather negative image of the people who work at API, and state workers in general, but especially people who work with the mentally ill. She advised that she has been in the workforce for 42 years and without reservation she could say that the staff at API are some of the finest people she has ever worked with, these people bring integrity, experience, and knowledge to this job. The staff is from all over the world and they are the most diverse workforce

she has ever seen. She described the mental health field as the least desirable of all healthcare fields to work in due to its very nature, it is a complex series of illnesses and disorders, it is hard to interpret, hard to understand, and hard to treat. There is not a great deal of job satisfaction and feeling like "you are really accomplishing something" because the patients suffer with these illnesses for the rest of their lives. Sometimes, she offered, the best that the staff can do is patch them up and send them back out again, and that becomes very disheartening. In addition, when patients are admitted to an acute care facility, they are ill to begin with, they have often been off of their medications, and are frustrated and fed up with their illness and the changes it brings to their lives. Consider that these patients usually do not have a good support system or housing, they are not working, they do not have insurance, and on top of that they are now committed to this facility by family members or someone in the community, she remarked. By the time these patients are admitted to API they are quite upset and spoiling for a fight, unfortunately, the PNAs are the closest staff upon which to vent their frustrations, she advised.

[4:32:03 PM](#)

MS. LITTLE stressed that the first 24-hours, the first three days, the patients admitted to API are incredibly dangerous for the PNAs. The PNAs have suffered injuries, such as: injury to their backs; legs; knees when patients kick their legs out from under them; bones have been broken including their fingers and faces; staff have endured the patients spitting blood on them; and throwing urine into their eyes and mouths to cause as much damage as they possibly can because the patients are extremely angry people. Ms. Little stressed that these wounds are carried by the staff for the rest of their lives. She advised that her rotator cuff had to be repaired because she happened to be walking down the hallway when a patient grabbed her arm, threw it behind her, ripped it, and in just a matter of seconds, she could not lift her arm.

[4:33:02 PM](#)

MS. LITTLE explained that as difficult as these physical injuries are, the worst parts are the constant verbal assaults with vile and vicious attacks regarding the staff's race, gender, the shape of staff's bodies, and so forth. These attacks are meant to disarm the staff and make them lose confidence in themselves, and even though the staff expects this

type of treatment, it is not always easy to put things, such as those verbal attacks, away. She advised that the staff shared with her that the greatest current issue facing them is this culture of fear that began approximately seven years ago. Seven years ago, the safety department was staffed with nursing staff who understood the interactions on the floor, when the cameras were installed, the safety department was then staffed with social workers who had no experience with the interactions on the floor or with patients. Currently, everything the staff does is judged and judged quite harshly, and there is no nursing staff input when it comes to reviewing the tapes when an incident takes place, she expressed. A Code Grey is not called as it should be called, when a Code Grey is called everyone knows it is serious and everyone needs to respond. Currently, the staff is hearing things like the staff needs a show of support because the difference there is that there is no paperwork for a show of support, the paperwork generates the reviews, and once the reviews take place, people start getting suspended, she advised. She reiterated that this is a culture of fear wherein people no longer want to respond. She described a "bystander effect" wherein when the staff does show up for codes, the staff stand around waiting for someone else to take the first move. The common attitude is, she remarked, if staff does not touch anyone and does not say anything, the staff cannot get in trouble.

[4:35:25 PM](#)

MS. LITTLE explained that together with the culture of fear, the staff shortage definitely contributes to a cycle of ill will between the patients and staff, and it interferes with the staff's ability to give the patients the help they need. Due to the shortage of staff, they are not available to talk to the patients, calm their fears, and give them what they need. Therefore, she explained, the patients become even more disgruntled with the staff, become more aggressive and more demeaning toward the staff, thereby causing the staff to "kind of drift into the nurses' station and stay away from them, it is a cycle."

MS. LITTLE pointed out that this entire situation from poor staffing to poor management and a hostile safety environment makes it almost impossible to work at API, and during the two years she has returned to API, it lost a good majority of its experienced staff. She advised that PNAs are not formally trained, they learn everything they know about mental illness on the job. The on-call staff currently working at API know

absolutely nothing about mental health so they cannot bring their concerns to the nurses because they do not necessarily know how to read a situation, they do not know what it looks like when a patient is escalating, or when a patient is decompensating and looking for a quiet place to slip away and do danger to themselves. Documentation from the on call staff is proof of this situation because time and time over again what they have written in the documentation is very generic with no useful information whatsoever, and from what she has been told, on any given day, 35 percent of the staff are the on-call people coming in. She stressed that API is no longer a safe environment.

[4:37:24 PM](#)

REPRESENTATIVE SULLIVAN-LEONARD requested information regarding her interactions with the nursing supervisors and the administration in order to seek problem solving solutions for the issues she discussed.

MS. LITTLE shared that previously, she worked on the forensic unit but was recently moved to another unit because an incident took place on the floor of the forensic unit. She stated, "I'm going to be very careful here because I don't want to be retaliated against." Ms. Little explained that the ball was dropped for a particular patient by the psychiatric staff, the psychologist, wherein the PNA staff was put in the position where someone was injured and then someone was fired. She stressed that none of this would have taken place if the psychology staff had handled this issue in the manner it would normally have been handled for this particular patient. Wherein, she and all of the PNAs involved complained and advised that "this is where everything went wrong, if this would have been fixed, none of this would have happened." As a result, within three weeks of the incident, each person who complained received a letter to be interviewed and they all received some sort of instruction. There was an interview with one of the PNAs because he was looking at a newspaper between performing his locator rounds. She explained that every 15 minutes the PNA has a slip of paper with everyone's name on it, and they walk around and make eye contact with each patient and write down the time, and this takes place four times in one hour. On the very back of the slip of paper, it actually read, "While you are doing the locator, you are not to do anything else, you cannot be distracted." The PNA had performed his rounds as required, then stood at the desk flipping through a newspaper while still looking out and keeping an eye on what was happening on the

unit, with eight patients in bed asleep at the time. The PNA was called upstairs for reading that newspaper in between performing his rounds, and she was called upstairs for failing to supervise him and allowing him to read that newspaper between rounds. Now, she said, they both have a letter of instruction and she believes this was simply retaliation because the administration was so insistent in not holding the psychology staff responsible for what had taken place with this very volatile patient.

4:40:03 PM

REPRESENTATIVE SULLIVAN-LEONARD asked whether she could explain whether there were pro-active meetings and not reactive meetings. She further asked whether the nursing staff supervisors hold weekly meetings to discuss what had taken place with the patients on the floor, whether they discuss continuing education unit (CEU) for educational purposes for the staff, and whether there are meetings with the administration where it is looking at pro-active solutions.

MS. LITTLE responded that each of the five units are supposed to have a nurse manager, and for almost a year, three of the units have not had a nurse manager with the Taku Unit being one of the units. The Taku Unit did not have a supervisor or a liaison, and occasionally the Director of Nursing would hold a meeting in the Taku Unit once a week, usually at 6:00 a.m. She advised that the meeting was on her day off and she rarely made the meeting because she lives 45 miles away. The nursing shift supervisors usually have their meeting amongst themselves upstairs and the floor staff has its meetings daily at shift change. She related that when concerns are shared with the shift supervisors, it is on a very casual basis as they make their rounds.

4:41:25 PM

REPRESENTATIVE JOHNSTON referred to Ms. Little statement that outsourced nurses come in, and in looking back at the earlier presentation, there are four traveling nurses. She asked whether these are two different approaches, one group are traveling nurses and the other group are outsourced nurses.

MS. LITTLE answered that the traveling nurses are different from the on-call staff, the on-call staff are PNAs and they are all the unschooled PNA staff, psychiatric nursing assistants. The traveling nurses are a recent new approach in filling those 11

nursing vacancies, and she has not yet encountered any of the traveling nurses.

[4:42:35 PM](#)

REPRESENTATIVE JOHNSTON referred to the 11 nursing [leave] vacancies due to various reasons, and asked whether any of those leave vacancies were due to suspensions, fear, knowledge, or are they all related to illnesses, birth of babies, and so forth.

MS. LITTLE replied that she was unsure, although, a couple of months ago there was an exodus of approximately three nurses who had been employed at API for some time. She opined that the exodus had something to do with discontent over the nurse-3 positions, the nurse manager positions. These are nurses who wanted these positions and yet the positions were not being made available, at least one nurse moved on because she was unable to apply for a position that she was well qualified for even though the need was there.

[4:43:46 PM](#)

REPRESENTATIVE JOHNSTON asked whether it was seven years ago that API installed the cameras, or seven years ago it changed from nurses reviewing the cameras to social workers.

MS. LITTLE responded that both of those actions occurred approximately seven years ago and at the same time. She explained that she first went to work at API in 2009, and when the new prison in valley, that was close to her home, opened she moved to the prison and worked for two years. She then returned to API in 2016 and has been there for two years wherein she has noticed a big change. She related that the cameras were installed and the safety department switched over to social services type individuals rather than the nursing staff around the time she left API.

REPRESENTATIVE JOHNSTON asked whether the social services individuals have Master of Social Work Degrees (MSW) or are just people with a social services backgrounds and risk assessment backgrounds.

MS. LITTLE opined that that is the case, but there is not a lot of personal interaction from the people downstairs with the people upstairs. She related that about the only time they see the people upstairs is when staff has been called upstairs.

[4:45:54 PM](#)

MUSA KANTEH, Psychiatric Nursing Assistant (PNA), Alaska Psychiatric Institute (API), advised that he has been employed at API since 2011, he is graduate of (indisc.). He explained that he had been on-call staff for four years, and the last five years he has been full-time staff. He described that API has been sliding downhill since 2011 with staffing being the number one issue, and he has observed that the training is currently quite different from 2011, such that, "When we got cited last time by OSHA, we used to (indisc.). With man some of the patients are violent toward themselves or the patient peers or staff so you can hold them down, we decide what we need to do, call the doctor, and the doctor will write the order." Previously, the training department staff had been there for 25-30 years and they all left. Currently, the staff must find a place to hide when the patients are violent toward the staff, and there are people training the staff that he has never seen on the floor, and if he sees them, after 5-10 minutes they have left the floor. He commented that a person cannot train when they have no idea of the job duties, and requested that the staff receive professional training, which would help the staff train themselves. For example, two years ago, a supervisor trained the staff, which resulted in four out of seven staff members cited for mishandling the patients, and he questioned how someone could teach him who was cited based on doing the job right. He stated that has received verbal assault and has been beat up while performing his job duties, and now, most of the experienced staff are all leaving by retiring or moving on. Most of the staff have five years invested, and he said, "you take a hike, you don't want to go into be on medical care for the rest of your life." For example, a couple of his co-workers were beat up in front of him and now they can no longer walk. He related that he is scared going to work and prays to God that he completes the day in one piece and continues to enjoy his life with his family. Another example, a supervisor was beat up a couple of times, suffered broken ribs, and due to the violence stepped down and is now going to school and leaving. There is no communication between the upstairs and the downstairs, and working as a team is not happening because everyone is scared. The staff is afraid that if they do something, they might lose their job making it very stressful to work at API. He stressed that he loves his work, but he is scared as to whether he will lose his job or be injured.

[4:51:21 PM](#)

REPRESENTATIVE SULLIVAN-LEONARD referred to the situations the staff has been experiencing and said that she knows the staff is working closely with their union. She asked whether the staff is unable to all band together and have the types of interactions with the administrators at API as he is having with the committee. Obviously, she said, the administrators must know and hear about these situations.

MR. KANTEH explained that he has a good relationship with most of the supervisors he works with, but there is no contact with the administrators because "they pass by, they're gone." The staff is supposed to have a monthly meeting with the management but that is not taking place, he noted that the staff has a safety committee but if the staff's comments are unlikeable, they will be dropped from the safety committee.

REPRESENTATIVE JOHNSTON related that part of her challenge is that he has no authority with the operations of API itself, but the staff collectively at least has its union. She suggested that the staff "very strongly" have those meetings with the administrators and have a "come to Jesus meeting." It is clearly unacceptable for people to be hurt consecutively and continually at the API, and it is a real challenge to see the dollars, the low numbers of staff, and so forth. She offered her appreciation for Mr. KanteH to travel to Juneau to offer his testimony.

MR. KANTEH added that a couple of on-calls have been hired, but the on-calls have no job guarantee or benefits, so when you want to train those people they are not interested and they make clear that their jobs are not guaranteed and they will not get into anything. He noted that when patients bang their head against the wall, the staff now walk away and cry because the patients cannot be touched until someone gives the order to hold the patient down. Previously, when a patient started banging their head, the staff would put a pillow under their head, but now the staff cannot do that. For example, he advised, a patient said a bad word to him and he said, "yeah, I like it," and he was pulled off the floor for six weeks, plus there was an incident where six staff members were pulled off the floor for six weeks.

[4:55:16 PM](#)

CHAIR SPOHNHOLZ offered appreciation for his testimony and noted that one of the reasons he was asked to testify was to share some his concerns.

4:55:40 PM

JASON LESSARD, National Alliance on Mental Illness Anchorage (NAMI), pointed out that API is the only organization of its kind in the state and it is a critical component to the safety and recovery of many Alaskan. He said that when the National Alliance on Mental Illness (NAMI) hears reports of concerned safety issues and workplace violence, it worries about the safety of Alaskans in the acute phase of serious mental illness who may have symptoms causing them to be violent or have severe cognitive impairments and/or a danger to themselves or others. The NAMI also greatly worries about the safety of those who have chosen to work in this field in any capacity that supports those suffering from serious mental illness and their path to recovery. He pointed out that if the API environment is unsafe, there are really no other options for those patients in API who are in a state that puts them among the most vulnerable. All too often, [DOC] becomes the de facto provider of mental health services, which is not only inadequate with regard to the services and support of patient needs but it is also not the job of the (indisc.). The staff are not trained as mental health professionals and it is unfair to all involved when it becomes the only other option. The fact that such a vital component in the continuum of care does not have an alternative and that the environment is unsafe is extremely disconcerting, he stressed. For these reasons, those at NAMI believe it is imperative that the safety concerns and staff shortages be addressed, not just quickly, but thoughtfully, collaboratively, and with a holistic approach in relation to the larger mental health community in the state. He related that NAMI is confident that in working together a solution will be found.

4:58:10 PM

ALISON KULAS, Executive Director, Alaska Mental Health Board, advised that she is the Executive Director of the Advisory Board of Alcoholism and Drug Abuse, and the board is statutorily charged with advising the governor, the related departments, and the legislature in planning and coordinating mental health services funded by State of Alaska. This board advocates for programs and services that serve people with behavioral health disorders, their families, care providers, and communities, it has long partnered with Department of Health and Social Services (DHSS) and EPI. This board has a standing seat on the API board to better understand the service needs and identify resources for Alaskans experiencing a mental health disorder episode. The

Alaska Mental Health Board believes it has long been demonstrated that there is a need for additional acute behavioral health care services in Alaska and she noted the lack of residential facilities for adults with acute mental health needs. The inpatient psychiatric emergency services and inpatient psychiatric hospitals, emergency departments, and inpatient general hospitals, are the primary location for these services. This board is working with partners across the spectrum to truly understand the current needs of API patients and staff, and she advised that it is gathering information as to other state's promising best practices, such as the Georgia legislation, and some promising work out of the Unity Program in Portland, Oregon. She stated that this board is committed to continuing this conversation with providers, patient advocates, and the department to identify short-term and long-term solutions. This board will then pull all of this information together with some proposed solutions wherein the legislature and all stakeholders involved can share back their comments. Additionally, this board is advocating for allowing other hospitals and community health programs across the state to increase capacity through the enhanced DSH funding that Director Burns mentioned. This additional funding, together with the federal funds, will alleviate the immediate needs in order to provide the appropriate level of care to Alaskans experiencing a mental health crisis. Long-term solutions are underway, she advised, to increase behavioral health treatment with the additional Certificates of Need that addresses Title 11.15, Division of Behavioral Health Demonstration Waiver. This board wants to look at the big picture of the structure of all of the above services in Alaska and identify where those situations are occurring and how to meet the needs of Alaskans, she explained.

[5:01:43 PM](#)

REPRESENTATIVE SULLIVAN-LEONARD asked whether Ms. Kulas said she is on the API board.

MS. KULAS responded that the Alaska Mental Health Board does have a seat on API's board (indisc.) current board member working with API.

[5:02:07 PM](#)

REPRESENTATIVE SULLIVAN-LEONARD referred to the testimony of the psychiatric nursing assistant and the nurse working at API, and requested her comments as to these great concerns.

MS. KULAS answered that she had been taking a lot of notes during this entire hearing, and this is something the Alaska Mental Health Board has heard about and has discussed. This board will have this quarter's full board meeting next week and this discussion will be continued. She said that one of the questions the board has asked, particularly when it pertains to the violence piece, is where the violence is occurring, on which unit, and whether it is patient to patient, patient to staff, staff to patient, in order to understand the issues and incorporate that information into its proposed solution. The board members are definitely asking those questions in order to support the staff and patients at API.

[5:03:01 PM](#)

REPRESENTATIVE JOHNSTON referred to slide 22, "Patient Injury Rate - Number of Client Injury Events for all Causes that Occurred for Every 1000 Inpatient Days" from 2014 to the second half of 2017; and slide 23, "Staff Injury Rate - Number of Staff Injury Events of any Severity that Occurred for Every 1000 Inpatient Days" from 2014 to the second quarter of 2017. Representative Johnston commented that both slides are interesting graphs because the incidents are from zero to 3.5, and they look fairly dramatic. She asked whether Ms. Kulas had reviewed these slides and studied why there are peaks and sometimes drops in injuries. She further asked whether this has been part of the board's discussions, whether the board is aware of these graphs because it appears things have changed on the floor since 2013, and she would like to see the stats beginning in 2011.

MS. KULAS answered that she is not entirely sure about those graphs in particular, but she knows this board does have some of that information and she would follow up with Director Burns to be sure she has a copy. This board is also interested in the peaks of injury, and what changes were taking place to really understand what that data means. One of the testifiers mentioned that during the last seven years the staff has noticed the change, and it is important for the board to ask additional questions, she commented.

[5:06:15 PM](#)

CHAIR SPOHNHOLZ noted that Ms. Kulas mentioned other assets in the community, and a couple of Certificate of Needs were recently approved for Alaska Regional Hospital and Matanuska-Susitna Regional Hospital to add a significant number of

additional behavioral health beds. She asked whether Ms. Kulas believes that is an important remedy, whether it is just a piece of the puzzle, and whether that remedy will be a significant contributor from her perspective.

MS. KULAS replied that definitely it is critical that the members of the communities follow this issue so it does not all fall directly onto API, and asked what other support can be given to the communities. The additional Certificates of Need is one piece and it is a little bit more of an intermediate solution, and just to make sure that those facilities are getting up and running and able to serve the needs. That is where this board also sees the Disproportionate Share Hospital (DSH) funding that is currently in the House of Representative's budget in giving (indisc.) in addition to getting that other (indisc.) match to increase the services across the state. She related that originally, when they put this proposal together as Director Burns mentioned, they were anticipating a lot more of that community support piece but that really has not happened. She opined that with the Certificates of Need and potential DSH funding, there can be more community based support to relieve some of that pressure.

[5:08:04 PM](#)

CHAIR SPOHNHOLZ requested information regarding the forensic bed capacity challenges, and pointed out that the committee is aware that the Department of Corrections (DOC) has turned into the de facto provider of mental health care when there is not enough capacity at API. She asked whether the Alaska Mental Health Board has been looking into that issue.

MS. KULAS responded that this board is especially interested in the forensic bed study as this is something that some of the board members have taken a particular interest in as to what other states are doing, how does Alaska differ, what can be pulled from other state's models, and definitely supporting the Alaska Mental Health Trust Authority in the forensic bed study.

[5:09:19 PM](#)

STEVE WILLIAMS, Chief Operating Officer, Alaska Mental Health Trust Authority, offered that due to time constraints and the wealth of information offered today, he will defer to any outstanding questions or verifications the committee may have wherein the trust could provide additional information.

5:09:48 PM

REPRESENTATIVE TARR referred to the testimony that PNA positions are not formally trained, and noted her surprise in terms of making sure people have the background and resources to be successful in their positions, even absent staffing challenges and behavioral challenges. It appears, she said, that the Alaska Mental Health Trust Authority, because it funds the initial phase of work, or start up projects, could be a place to fill that gap and provide some additional support. She asked whether that is something the Trust has considered or how could the legislature look to the Trust to help address that issue.

MR. WILLIAMS asked whether Representative Tarr was talking specifically about the Trust providing some additional support as it relates to workforce training, and in particular API.

REPRESENTATIVE TARR answered in the affirmative, and specifically for these individuals who are doing the best they can but given the staffing and safety challenges, are put in harm's way just to go to work every day. She explained that she was talking about training in de-escalation or other behavioral modification training.

MR. WILLIAMS answered that for several years, the Trust has been heavily focused on workforce training and development, and it is largely focused in community behavioral health and other systems of care that serve Trust beneficiaries. In order to make sure there is a well trained field workforce that can provide that quality of care, and in listening to the discussion today, certainly this is an area in which the Trust could work with the department and Director Burns in looking at the opportunities here where the Trust might be able to partner to help provide additional training to staff on an ongoing basis.

5:12:29 PM

REPRESENTATIVE TARR asked whether the Trust has the authority to, within its own budget, have funding available because the legislature is not quite finished with the budget for the Alaska Mental Health Trust Authority, and if there is something that needs to be included, now would be time. The state is in a crisis situation, she described, and she is thinking of something more immediate and "very near term kind of activity." Even if it was just more in a therapeutic sense, it almost sounds like the trauma associated with the positions must be taking its toll. She asked whether that is something the Trust

could independently do given the authority and the dollars it has, or is it something the legislature must specifically outline as a priority.

MR. WILLIAMS answered that it would be something the Trust would want to discuss with API as to its staffing and training needs. The Trust certainly has the ability to help in a short-term and quick manner if there is a need, and it has the ability to pull in the additional training these folks need. He stressed that it would require sitting down to really understand the training needs and what is missing in getting the staff that training.

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REPRESENTATIVE TARR commented that that suggestion sounds like a good idea, and she truly hopes that that is an issue that receive attention in the very near future for everyone's safety, the safety of vulnerable Alaskans who need tremendous support, and also the safety of the staff. She expressed that she is thankful there are people who are willing to take those positions, especially given the challenges, and she hopes the Trust and API can talk soon so the legislature will learn the results of that discussion soon.

MR. WILLIAMS replied that the Trust will be happy to share the results of those conversations with the legislature.

[5:14:36 PM](#)

REPRESENTATIVE JOHNSTON referred to slide 28, "What is DBH Doing to Work these Problems? Staff Injuries (continued)" and noted that it appears API is working with the Western Interstate Commission for Higher Education (WICHE) to access the value of the API training programs. It appears that with Mr. Williams having a discussion with [API], and hopefully outside resources are being pulled in which can be of great benefit, that this is something the Trust could be doing no matter what the legislature ends up doing.

MR. WILLIAMS answered that that is exactly what the Trust does with these and other types of situations, and the WICHE report is one, there have been several others in talking with API that pointed out areas for improvement or for services and the Trust can sit down with the department and look at how to get to those ends and "get this recommendation."

[5:15:51 PM](#)

REPRESENTATIVE ZULKOSKY commented that in trying to wrap her mind about this discussion, it is clear that not enough resources have been put forward for API in understanding what the facility staffing needs are, married with the actual facility needs, infrastructure needs, as well as the needs of ongoing continuing education. Having had this conversation, it is important to know the numbers of staffing needs versus what has actively been budgeted, so the legislature can understand from a high level of perspective what the funding needs are overall and how the legislature can help API get positioned to a place where the staff are safe and the patients are actually receiving the resources and care they need at such an important facility she said.

MR. WILLIAMS asked whether hers was an overarching statement and that when the information is provided back to the committee members, having some of this detailed information better illustrated would be helpful.

REPRESENTATIVE ZULKOSKY answered in the affirmative and that it was an overall request that was not so much focused solely on the Alaska Mental Health Trust Authority.

[5:17:47 PM](#)

CHAIR SPOHNHOLZ referred to the capacity level, and asked whether there is the capacity to meet the needs for acute psychiatric care in the state. She related that she continues to be concerned when speaking with patient advocates, about the state's tendency "for lack of a better word, sort of get people stabilized or tuned up and then send them back out into the community" without a lot care, and the fact that the state has many folks with severe mental illness in prisons. She asked Mr. Williams to describe the discussions around looking at the forensic bed capacity within API.

MR. WILLIAMS answered that Director Burns talked about it in his presentation when walking through the beds and services API provides to Alaskans with mental health issues. Director Burns mentioned that API carved out 10 beds dedicated to the forensic unit and those beds are generally used for individuals with a pending criminal charge wherein their legal competency has been raised. He explained that the person's criminal case is stayed until a staff psychologist has performed a forensic competency evaluation for the court. He further explained that the results of a competency evaluation are as follows: in the event the

evaluation determines the person competent to stand trial, the trial will commence; if the person is not competent but there is a potential for competency and restoration, the criminal case is stayed until the person is restored to legal competency and they are aware of the court's surroundings, the charges against them, and are able to assist their attorney in their own defense, wherein the criminal case proceeds; and there are situations where a person is found not competent and not capable of restoration, in which case the determination is reported back to the court and the charges are generally dismissed.

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MR. WILLIAMS advised that the impact of the competency evaluations are significant because currently there are 10 beds for this service and the courts have a steady referral rate for these types of evaluations. The evaluations are timely, and when a person cannot access the restoration piece and also the initial evaluation, the person ends up staying in DOC until the evaluation or restoration can take place. He pointed out that that poses problems for the DOC and it certainly poses issues for the due process of the person in terms of the pending charges. The Trust is looking at where that type of service is delivered and how it is delivered in an effort to potentially free up some space at API and the people not involved in the criminal justice system can access additional beds or treatment in a more expedited manner. Also, he said, to expedite the process itself so people are not languishing in the DOC waiting for this process to take place and their criminal case to come to resolution in some fashion.

[5:22:39 PM](#)

CHAIR SPOHNHOLZ referred to slide 13, "API and its Forensic Population" and noted that Director Burns described that the Alaska Court System's demand for forensic services exceeds API's capacity to manage the caseload, and he used the word "crisis." Director Burns is seeking support for a feasibility study to explore the value of establishing a forensic hospital in Alaska.

MR. WILLIAMS responded that part of that study is to: try to find another location; what is that location; is it feasible; and then start looking at: accreditation; staffing needs; the operations; transportation needs because individuals are often transported back and forth to the court for their hearing; wherein all of these issues will be taken into consideration

together with looking at how other states manage their forensic population and competency issues.

[5:23:57 PM](#)

CHAIR SPOHNHOLZ asked whether he has a sense of the numbers in terms of people sitting in the Department of Corrections (DOC) awaiting entry into API for psychiatric stabilization.

MR. WILLIAMS answered that he does not have the exact number, but roughly 160 Alaskans received competency evaluation orders in FY 2017. As to the delay and someone is sitting in DOC awaiting those types of evaluations, there are variables in play as to how long someone sits in DOC. For example, he offered, there is a difference when someone has a pending serious felony level charge and the defendant's competency is in question, and there is someone else with a lower level charge where their legal exposure in terms of the amount of time they may be sentenced to a crime if convicted is much less. He explained that API does what it can to try to triage and prioritize, but the judicial system is set up with different court locations statewide ordering these evaluations which includes transportation. For example, because all of these evaluations take place through API, and defendants are flown in statewide, clearly "things can get stacked up pretty quickly." Also, due to staffing and the amount of time required for these types of evaluations, defendants can end up sitting DOC for periods of time that one would hope would be shortened, he offered.

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CHAIR SPOHNHOLZ noted that stakeholders and the legislature are looking for ways to strategize and free up space for folks who really need serious mental health services, and that the forensic patients tend to be at API for twice as long as other patients. She referred to Slide 4, which lists the length of stay, and noted that it depicted an average of 44 days for a forensic patient in API versus a much lower number ranging between 10 and 24 days for the non-forensic patients. It appears, she pointed out, that addressing that forensic patient needs would be a useful strategy.

MR. WILLIAMS explained that part of that differential can be the amount of time required for someone to be re-stabilized on medications in order to understand the upcoming legal process with their pending criminal charge, and assist in the defense of their own processing of the case. In fact, he pointed out,

there are longer periods of time because the requirement is that a person is at the legal competency threshold. He described that it is not "apples to apples."

5:27:49 PM

CHAIR SPOHNHOLZ noted that she had heard the Alaska Mental Health Trust Authority may be exploring preparing a feasibility study for the needs gap or the capacity gap currently existing at API, and she requested an update.

MR. WILLIAMS responded that that is something the Alaska Mental Health Trust Authority and the department are preparing separate from this forensic look. He explained that the feasibility study is working with the department all the way back to when the current API facility was designed and built, and he has been discussing the design and building with Director Burns and reviewing documents from history, noting that it was built with the potential to possibly expand or add an additional wing in the future. Therefore, he said, the Trust, in partnership with the department and API, will go back and look at how API was originally designed and built to determine whether the current facility has the capacity to literally add a wing to the existing facility. In the event that is the case, then taking a step further and looking at the planning and zoning issues that might be attached within the municipality. In the event all of those issues play out and it is possible not only from a campus and facility perspective and but a planning and zoning perspective, they will start looking at what the additional wing would look like, its capacity, how many beds, conceptual designs, ultimate construction costs, contingencies, and so forth. He advised that the Trust would not be looking at the operating costs associated with that expansion, it would literally look at the capital costs for an additional wing.

5:30:30 PM

REPRESENTATIVE SULLIVAN-LEONARD referred to slide 13, third bullet and noted that Dr. Patrick Fox provided a November 2016 report regarding the forensic needs for API. Considering the that report of November 2016 is available, she asked whether Mr. Williams believes there is a need for a new forensic study.

MR. WILLIAMS answered that that study looked at API and its forensic service process and the way API managed its cases, it was not necessarily looking at the possibility of having that service in a different location and serving that population in a

separate manner. Certainly, he said, the Trust has access to that report and it will be reviewing that report, there is no interest in re-inventing the wheel, especially given that the report is only two years old.

[5:32:14 PM](#)

REPRESENTATIVE SULLIVAN-LEONARD offered that her interest was peaked when Mr. Williams talked about expanding a wing at API, which is why she believes this study may correlate with those efforts.

[5:32:38 PM](#)

MR. WILLIAMS thanked the committee for taking the time to look into this issue, obviously it is a complex situation with many people interested in providing quality care. Many Alaskans are looking for that quality of care from the Alaska Psychiatric Institute (API), and the Trust is certainly interested in making sure that goal is reached. He also thanked those who testified previously, including the department, patient advocates, and the staff members. These are very complex needs for Alaskans and the community behavioral health system cannot meet their psychiatric needs, thereby for whatever reasons, these needs have moved into a psychiatric crisis. This is a safety net, he described, and there must be a safety net to meet those needs and get people back into the community in positive manner as quickly as possible.

CHAIR SPOHNHOLZ remarked that the people who count on the state to care for them at API are the most vulnerable and are at API because they have no other place to go, and it is incumbent upon the legislature to make sure it is thoughtful about their care. She noted that many topics had been discussed today, but the committee did not cover in great detail the access issues of the lack of community health supports for people who inevitably leave API and go back out into the community for whom there are not many supports. She opined that Ms. Merrit referenced that issue when she described the challenges her daughter suffers in finding appropriate community supports for her serious mental health issues. There are serious acute psychiatric services needs with gaps in terms of community supports, in which "we'll see more of being offered in the private sector" at MatSu Regional Hospital and Alaska Regional Hospital soon. There was a small discussion regarding the forensic needs for the State of Alaska, and she commented that its criminal justice system only works when the people tried for crimes actually understand the

crimes for which they've been accused, and are competent to stand trial. She stressed that that is definitely a "big need gap." Also, a topic not discussed today, she advised, is the shortage for adolescent acute care behavioral needs. She described long stays for children in emergency departments, sometimes as long as 14 days in Anchorage, Fairbanks, and MatSu, and the community providers of these services are not able to keep up with those needs, thereby leaving children sitting in emergency departments. She noted that the commissioner has been in attendance since the beginning of this meeting for those who are listening in and watching, as have her deputy commissioner and assistant commissioners.

[5:37:20 PM](#)

#### **ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:37 p.m.