FAIRBANKS EMERGENCY SERVICES INVESTIGATION

Division of Mental health and Developmental Disabilities
Alaska Mental Health Board

Background:

The Alaska Mental Health Board, at its meeting on January 9, 1999, passed a resolution requesting that the Division of Mental Health and Developmental Disabilities conduct a "special investigation of emergency (mental health care) services in Fairbanks". On January 19, 1999, a letter was written by the Board to the Division formally requesting the review. The letter of request contained several specific questions the Board wanted answered by the investigation:

- Is there a 24-hour on-call emergency coverage in Fairbanks from the community mental health center (CMHC)?
- What is the number of crisis respite beds available in Fairbanks, who has access to them, and under what circumstances?
- What is the status of the use of jails to house or hold those in crisis?
- What is the access to emergency services by those who are not clients of the CMHC?

In addition to the questions above, the Board had additional concerns they wished the investigation to address:

- If CMHC crisis workers go to the hospital emergency room to see clients, and if not, why not;
- Whether or not there is psychiatric backup for the emergency services team;
- The existence of phone versus in-person services by the CMHC for after-hours crises, and the appropriateness of after-hours crisis services;
- The involvement of the CMHC in mental health evaluations as part of ex parte orders for civil commitment; and
- The lack of a single point of entry for mental health crises in Fairbanks.

Procedure:

In response to the Board request, a special investigation was conducted of the mental health emergency system in Fairbanks. The investigation was conducted on February 22 through February 24, 1999. The review team included Leonard Abel, DMHDD, Co-leader; Pat Murphy, Alaska Mental Health Board, Co-leader; Steve Emerson, DMHDD; Kris Jenkins, Consumer and

past Alaska Mental Health Board member; Pam Miller, DMHDD Quality Assurance; and Michelle Arnold, DMHDD (assisted with part of the review).

Fairbanks Community Mental Health Center (FCMHC) is the agency with the primary state-funded responsibility for emergency mental health services for the Fairbanks community. The investigation team met with the director and senior clinical staff of FCMHC for an entrance interview. The team discussed the background for the investigation and the questions and concerns from the Board that the review was to address.

Following the entrance interview, the team interviewed staff from over 30 community agencies involved with mental health emergency services. The agencies included police, the court system, jails, the hospital, private mental health providers, homeless and emergency shelters, advocacy groups, and health and social services agencies.

In addition, a community meeting was held for consumers and family members only, to allow them to discuss their experiences with the Fairbanks mental health emergency system. More than 35 consumers and family members attended, and most spoke.

Also, Pam Miller conducted a review of emergency services clinical records and contact forms at FCMHC. The report of that review is included in this report in its entirety.

Following the interviews, the team consolidated its findings and conducted an exit interview with the director and senior clinical staff of FCMHC. The gist of the findings, described in the following sections, was discussed at this interview.

Findings:

A. Fairbanks Emergency Services Structure:

FCMHC is the agency with the primary state-funded responsibility for emergency mental health services for the Fairbanks community. FCMHC operates a 24-hour on-call emergency system, which is described in more detail in the next section. After hours, an answering service takes the initial call, and connects the caller with the on-call worker. The on-call worker will provide telephone screening, crisis counseling, or consultation. No face-to-face outreach is provided. If the person in crisis is in need of more intensive care, he or she is referred to the emergency room of Fairbanks Memorial Hospital. Police may be called if serious suicidal or homicidal ideation is present. If the police are involved, they may transport the person to the emergency room.

After the person in crisis arrives at the emergency room, he or she is screened by the emergency room physician, or an emergency room nurse. If the person is a FCMHC client, there may be telephone consultation regarding medications or other treatment issues. No one from FCMHC comes to the emergency room. None of the FCMHC psychiatrists or clinicians has admitting or treating privileges at the hospital. If the person is a client of the Fairbanks Psychiatric and Neurological Clinic (FPNC), their on-call psychiatrist is available for consultation. No psychiatrist comes to the emergency room, either during normal work hours or after hours, to assess or treat persons in crisis. There are rare exceptions, when a FPNC psychiatrist is already

in the hospital on other business. The hospital operates a nine-bed psychiatric unit. Sometimes a nurse from that unit is called to the emergency room to assess a difficult case. When that happens, the unit is usually left dangerously short-staffed.

If the person is considered appropriate for admission to the psychiatric unit, the FPNC is contacted. The on-call psychiatrist approves the admission to the psychiatric unit, then FPNC provides inpatient services while the client is in the hospital. If the person is a FPNC client, that clinic will provide follow-up after discharge. If the person is a FCMHC client, an FPNC psychiatrist may admit the person, with FCMHC providing follow-up after discharge. If the person is "unattached" (not a client of either FPNC or FCMHC, they may be admitted by the FPNC psychiatrist, by any one of 44 physicians who have hospital admitting privileges, or not admitted at all. Those not admitted are usually transferred to the Alaska Psychiatric Institute on an ex parte or POA.

A person may be kept in jail awaiting transport to API. The community perception was that the use of jails had declined since a community meeting to address the use of jail last July. Jail use date did not confirm the decline. This issue is discussed below.

There appears to be a parallel system in operation for beneficiaries of the Tanana Chiefs Conference (TCC). The Chief Andrew Isaac Clinic (CAIC) provides outpatient mental health care on behalf of TCC. Four family practice clinicians employed by the clinic have hospital admitting privileges. One of these physicians will admit a beneficiary who is in crisis, then refer them to FPNC, who provides inpatient care under a contract with TCC. Psychiatrists under contract with TCC provide only outpatient services through CAIC.

The Probate Master handles ex parte orders during the workday. After hours ex parte's are not available in Fairbanks. All persons are held, evaluated and/or transported on a POA after normal work hours and on the weekend. This structure is reported by the court to be due to the absence of clinical outreach by FCMHC. An ex parte order requires a screening by a mental health professional, which is not available after hours or on the weekend. FCMHC reports that they do not do the necessary screenings because the court offices are closed after hours.

There is a crisis line in Fairbanks that responds to a number of the people in crisis after hours and on weekends. They do not answer the phone for FCMHC, or any other Fairbanks mental health agency, and tend to operate fairly independently. They sometimes call FCMHC or refer clients to the hospital, but stated a reluctance to do either, because they are not satisfied with the services received. The clinical situations they handle often extend beyond their level of training, but they are frequently the only option available outside the hospital.

The Fairbanks Rescue Mission (FRM) and Family Focus (FC) each operate shelters in Fairbanks for persons who are homeless. FRM serves adults, and FC serves youth. Neither is trained to serve mentally ill persons, but each has found that service becoming a large part of its operation. These two agencies provide a significant amount of the non-hospital support services in the evening.

The Fairbanks Alliance for the Mentally Ill (FAMI) also provides a significant amount of direct support services to consumers and their families when they have nowhere else to turn. FAMI offers two support groups to help defuse crises. One is a family and consumer group to allow whole families to discuss problems together, and a family group to help families cope with the stress of helping their loved ones with mental illnesses. In addition, members call each other at times of crisis, and arrange special group meetings. FAMI also provides advocacy to push the system when it is not working.

The operation of the Fairbanks emergency mental health system, and the quality of the services provided under this system, are discussed in the following sections.

B. <u>Alaska Mental Health Board Questions</u>:

Each of the questions from the Board is addressed in this section. There is overlap with the discussion of the structure of the emergency system, and between the questions themselves. An effort has been made to acknowledge and explain that overlap as it occurs.

1. Is there a 24-hour on-call emergency coverage in Fairbanks from the community mental health center (CMHC)?

There is an on-call system operated by the CMHC, Fairbanks Community Mental Health Center (FCMHC). Seven of the 16 - 18 center clinicians volunteer to be on-call on a rotating basis. Additional staff provide community outreach during the day to do case management and crisis intervention. These efforts are aimed toward preventing persons going into a more severe crisis after hours. One or two agencies reported after-hours outreach, usually by case management staff, and to help active center clients that are shared with that agency. There were a number of positive comments about the services provided *during the day*. There appears to have been an increase in outreach to a variety of community locations. Several agencies reported a "good working relationship with FCMHC".

The on-call clinicians carry a packet of emergency information, which includes notes from center staff about clients who appear to be heading toward problems, and an intervention plan. If those clients need assistance after hours, there may be some telephone consulting with the case management staff or other center staff regarding intervention. If the client is referred to Fairbanks Memorial Hospital, there may also be phone consultation with the hospital regarding medications or other clinical information. The on-call clinician will often come into the center after hours to look up medication or other information in the client's clinical record and report that information to the hospital by phone. The on-call clinician does not go to the hospital. If the client is suicidal or otherwise in danger, police are sent to investigate and transport to the Fairbanks Memorial Hospital emergency room. If the client is in less danger, the client is instructed to go to the emergency room.

If the person in crisis in not a FCMHC client, they are referred to the emergency room, with or without police involvement, depending upon the severity of the situation. There is little, or no involvement of the on-call worker beyond the referral. There is no outreach of any kind after hours for a non-client. The use of the on-call system by non-clients is apparently infrequent. By

FCMHC staff report, they only get two or three actual crisis calls a month from non-clients. Community agencies and consumers were uniformly negative about the after-hours emergency services provided by FCMHC. Most stated that they have simply stopped calling, because the services are of no use to them.

2. What is the number of crisis respite beds available in Fairbanks, who has access to them, and under what circumstances?

There are five crisis respite beds in Fairbanks, operated by FCMHC. Three of the beds are at the Intensive Rehabilitation Services facility and two are at the DeNardo Center. The beds tend to be full a good deal of the time. The lack of long-term bed capacity keeps clients in crisis respite beds longer than usual, and prevents access to others in crisis. When there is a vacancy, a center client may access a bed.

Of particular concern, the beds are only available to someone who has had "at least a limited intake". A "limited intake" is apparently a mental status examination and sufficient social and medical history to ensure safety and protect the agency from liability concerns. The emergency services practices noted above preclude these assessments being done at night or on the weekend, because no clinician is available. FCMHC indicated that a call requesting a crisis respite bed at 11:00 pm on a Friday night could not be responded to until Monday, at the earliest. If no clinician is available on Monday to do an intake, or limited intake, the client would not be able to access a bed until later in the week.

The five crisis respite beds serve FCMHC clients fairly well. The use helps prevent client decompensation, and keeps the hospitalization rate of active FCMHC clients relatively low. However, the beds are of no real use to the community at large. Several agencies stated that they do not try to refer clients to the crisis respite beds because they are never available, either because they are full, or because they are available only to FCMHC clients. The same statements were made by some of the consumers in the consumer/family meeting.

3. What is the status of the use of jails to house or hold those in crisis?

Jails are continuing to be used to hold mental health clients on ex parte or POA holds awaiting transport to API. 80 individuals were held in jail between 8/1/97 and 3/10/99. The community perception is that the number has decreased since the big community meeting last July. The data do not support the community perception. 36 persons have been held in jail between 8/1/98 and 3/10/99. A comparable period one year earlier (8/10/97 to 3/9/98) had 37 holds. There have been efforts made to solve the problem, and there were anecdotal accounts of jail holds being prevented through good case management. It is possible that the efforts have prevented growth in the number of jail holds that would have occurred if the extra effort had not been expended, and the perceived decrease was the observed case management successes.

4. What is the access to emergency services by those who are not clients of the CMHC?

This question is addressed in other sections. Access to services other than phone contact after hours and on the weekend is minimal for everyone, and there is little difference whether one is or is not a client. A non-client cannot access crisis respite beds, at least not until they have had a "limited intake".

C. <u>Additional Alaska Mental Health Board Concerns</u>:

1. If CMHC crisis workers go to the hospital emergency room to see clients, and if not, why not;

FCMHC staff do not go to the hospital to either assess or treat clients. The issue is hospital privileges. For a master's level FCMHC clinician to be officially recognized at the hospital, at least one FCMHC psychiatrist would have to have hospital privileges. The clinician would then have to have some level of associate privileges. The associate privileges are contingent upon the psychiatrist's privileges. In addition, that psychiatrist would have to be available as a backup, within 30 minutes, any time the clinician is in the hospital.

2. Whether or not there is psychiatric backup for the emergency services team;

FCMHC is currently recruiting for two psychiatrists. In the interim, they are using locum tenens psychiatrists. These psychiatrists rotate through, so there is little consistency. They are available as backup, but apparently not all the time.

3. The existence of phone versus in-person services by the CMHC for after-hours crises, and the appropriateness of after-hours crisis services;

This issue was discussed above. There is phone services after hours, limited to brief crisis counseling and referral to the hospital emergency room or to the police, and no face-to-face. Any "face-to-face" is provided by police or emergency room staff.

4. The involvement of the CMHC in mental health evaluations as part of ex parte orders for civil commitment; and

FCMHC is actively involved in ex parte orders during the normal workday. There is no involvement after hours or on the weekends, and Fairbanks does not do ex parte's during those hours, as noted above. The reason is in dispute, as is also noted above.

5. The lack of a single point of entry for mental health crises in Fairbanks.

The "single point of entry" for Fairbanks is the emergency room at Fairbanks Memorial Hospital. That status is by default. The answer to the current emergency service deficits in Fairbanks is not the establishment of a "single point of entry". The answer to the current emergency service deficits in Fairbanks is not additional money. The problem lies in nobody wanting to do anything after hours, long-standing animosity and distrust among the key agencies providing

services, and not using existing resources in the most effective way. If the system can recognize the responsibility to develop an emergency services system that meets the needs of the entire community, to work together, and to utilize existing resources in the most effective manner, a responsive system can be built. Then a "single point of entry" can be added to further improve the system.

D. <u>Additional Findings</u>:

1. There are several apparent barriers to crisis services not listed above that were reported by consumers or community agencies:
   a. A new FCMHC client, being referred from Fairbanks Memorial Hospital after hospitalization for an acute crisis, must go through a number of hoops to get to a psychiatrist. They must first attend an "orientation group", then be scheduled to have a "paperwork session", then be scheduled again for an intake with a clinician. After all of these have been done, an appointment with a psychiatrist is finally made. Total time is 2 - 4 weeks, for a person partially stabilized after an acute psychiatric crisis.
   b. There is an "initiation fee" of $10.00 at FCMHC to see a clinician, and a $15.00 "initiation fee" to see a psychiatrist. There is apparently no access to services unless these fees are paid. At least one local agency that purchases food, clothing, and other personal items for indigent persons has been asked by FCMHC to pay this fee on behalf of indigent clients so they can get services.
   c. If a client misses or cancels an appointment without a 24-hour notice, a $25.00 fee is charged. Services are discontinued until the fee is paid. After 3 missed appointments the client is terminated. A scenario alleged to be common is as follows: a client misses an appointment and is charged a $25.00 fee; he then has no access to services and stops medications; he then becomes psychotic and ends up in the emergency room; he then starts through the system again, only to repeat.

   The agency states that these fees are not a barrier to emergency services, and that the "initiation fee" does not exist, but the prevailing community perception among agencies and consumers is that they are barriers. If they exist, and are barriers, they are inappropriate and should be removed. If they do not exist, or are not barriers, effort should be made to educate consumers, families and service agencies to clarify a very strong and common perception.

2. Some consumers and community providers reported that FCMHC does not permit their clients to receive part of their services from other providers. Reportedly, the client must receive all mental health services from FCMHC. The agency denies that these reports are true, and indicated a number of clients who do receive part of there services from other providers. The number is small. The most efficient use of available resources is to allow all of them that are needed to be utilized by a single client.

3. Record review. The Quality Assurance review is attached here in its entirety.

File Review, FCMHC, Feb. 22-24, 1999

Documentation examined for this review included 5 Medicaid, and 3 non-Medicaid charts, in addition to forty four non-client (of FCMHC) contact logs. Non-clients were recipients of FCMHC's emergency services only. Notes that documented crisis/on –call services are referred to as "contact log notes." The notes reviewed were dated from Jan.1, 1998 to Feb.24, 1999. Findings indicate that the majority of habitual callers appeared to be clients of the agency. There was documentation of one repeat user (3 times) who was not a client of the center. Every note recorded that the service provided by the on-call worker was via telephone. FCMHC's on-call workers are Mental Health Professional Clinicians (MHPC's), although they do not consistently document their credentials on contact log notes. FCMHC does not bill Medicaid for their crisis/on-call services provided after working hours. For the purpose of this review, Medicaid's and the Division's definition of crisis intervention will be utilized. This definition states that "crisis intervention means mental health services provided to an individual during an acute episode of psychiatric distress that is intended to prevent harm to the individual or others, prevent further deterioration of the individual's condition, provide hospitalization, resolve the crisis, or acquire needed additional services." The following report will address review results for the three types of consumers stated (Medicaid, non-Medicaid, non-clients of FCMHC other than recipients of emergency services.).

The first Medicaid chart reviewed contained a total of 9 contact log notes. The client reported in the majority of the notes that he was suicidal, hearing voices, experiencing sleeping problems (nightmares) and in one case was experiencing chest pains and a tingling sensation in his arms. Out of the nine contact notes, four were considered crisis oriented. The documentation reports that three of these four notes indicated the client was suicidal, and the fourth note indicated the client was either experiencing anxiety or possible physical ailments. The on-call workers' written dispositions to these matters included having the client promise not to overdose; to call back if he continued to feel suicidal; contracting; asking the client if he needed to go to the hospital; and referring him to his psychiatrist. The staff psychiatrist at FCMHC met with this client three out of the four crisis episodes the following day. Progress notes document that the suicide issues were addressed during these sessions. The fourth crisis oriented episode that described possible physical/ anxiety problems had no documented follow through. Two of the three psychiatric progress notes documented following the crises stated that "this patient has not gone through any crisis lately." Of the additional 5 contact log notes, in which sleeping problems or hearing voices was the issue, the on-call worker documented appropriate dispositions. The chart contained documentation that face-to-face service episode were provided to the client by staff other than psychiatrists, and occurred anywhere in a period of time from 2 days to 21 days. The contact in 4 of those cases was with the client's caseworker, and one note indicated it was a group contact.

The second Medicaid case contained 6 contact log notes. One records a question about medication, one was from a doctor making a referral, and 4 were to report that the client was missing. All were handled in a seemingly appropriate manners by the on-call clinicians. Scheduled appointments occurring after these calls took place in about 4-6 days after the date of

the contact note. The appointment in all but one of the cases was with a MHPC; the other was with the caseworker. Out of the four appointments with the MHPC, the content of the progress note did not document that the problem described in the contact log note had been addressed, one note documented that issues were partially addressed, and one note documented that issues were fully addressed. It should be noted that there were two Medicaid billings for Crisis Intervention on the dates of 10-9-98 and 10-21-98. The note dated 10-9-98 did not describe that crisis intervention was conducted. The note was not clearly labeled as to which type of service was provided. It appeared to be either a case management or individual therapy note. The note stated "case management adult crisis service for case management." The Crisis Intervention note dated 10-21-98 was conducted via telephone and signed by a casemanager, not a MHPC. The service provided was not clearly labeled.

Of the third and fourth Medicaid files reviewed, one contained no contact logs. The one file that contained the one contact log note appropriately addressed a question regarding medication. Both of these clients received emergency IRS services. All notes billed for were present in the files. However, they did not describe active interventions.

The final Medicaid chart had one billing for Crisis Intervention. For the most part, the content of the note was appropriate. One comment of concern documented in the note stated that the client "could call back and set up an appointment after she was feeling more stable." There was also a billing for emergency IRS. Two notes for this service were missing (8-15 and 8-19-98). The remainder did not describe that active interventions occurred.

There were a total of 7 contact log notes for non-Medicaid clients. One of these documented a call from a client that reported she (the client) wanted to "hurt her friend for using drugs." The on-call clinician reported that the client was defused and redirected (by the clinician). It is stated that the client was told "to call back or go to the emergency room if her feelings worsen." The other six notes did not appear to be crisis oriented, and were handled appropriate to the problems reported.

Forty-four non-client contact logs were reviewed. This was the total number of recipients receiving emergency services documented from the aforementioned dates of review. Out of the 44, it is felt that approximately 9 of these appeared to be crisis contacts (using the definition in the Medicaid Regulations). Sixteen appeared to be for information and referral, 3 questions about medications, 14 seemed to need someone to talk to, and 2 fell into an "other" category (these notes were unclear as to what the problem or disposition was). All the crisis-oriented notes appear to have made at least one of three recommendations; go to the emergency room (Fairbanks Memorial Hospital), call the police, and/or make an appointment at FCMHC. The arrangements for these recommendations do not appear to be made by the on-call worker. It appears as if the client in crisis is informed to make the necessary arrangements themselves.

Summary and Recommendations:

The Fairbanks emergency services system operates with no one clearly taking responsibility for emergency services for the city. Everyone involved provides a small part of the services, in isolation from the other service providers. The pieces do not fit together well, and consumers fall through the cracks. No agency seems to want to work after hours or on the weekend. Each of the key agencies blames the others for the problems, and old animosities and suspicions prevent any meaningful communication.

The people who provide the actual after hours contact with consumers in the community are frequently the least trained to do the job. Most of the crisis calls are handled by a volunteer crisis line. The outreach workers are police officers. Homeless shelter staff provide on-site support to mentally ill adults and severely emotionally disturbed youth. The Fairbanks Alliance for the Mentally Ill also provides support to families and consumers through family-to-family contact.

The system is not responsive to broad community mental health needs of the community. Consumers who are not clients of a mental health agency are the least likely to get the services they need.

Recommendations:

There must be someone clearly identified in the community as the agency responsible for leading the mental health emergency services system. The community mental health emergency services grants should be awarded on that basis. The FY2000 Community Mental Health RFP does that.

There must be after hours outreach by mental health professionals to locations that are safe for the consumer and the outreach staff. The lead agency should provide those services, directly or through some type of contractual arrangement, to jails, homeless shelters, hospitals, or any other similar location. The RFP also demands that.

The psychiatrist(s) in the lead agency must have hospital privileges, and subsequently the clinicians must have some kind of affiliate or associate privileges. This action will enable outreach to the hospital for emergencies and for better continuity of care. The RFP also demands that the lead agency seek these privileges.

If it becomes clear that local agreements can't be reached, there should be assistance offered to mediate differences and facilitate discussion to bring the key organizations to the point they can work together. The key organizations would include, at a minimum, Fairbanks Community Mental Health Center, Fairbanks Memorial Hospital, Fairbanks Psychiatric and Neurological Clinic, police and the court system.

The Board and Division should jointly monitor the Fairbanks mental health emergency services system for the next year or two to assure continued progress toward a responsive and integrated mental health emergency services system in Fairbanks.