

How behavioral health crises strain Alaska's emergency rooms

*Emergency medical personnel say that they can, will and do help patients in crisis
- but that a new approach would benefit everyone involved.*

**Part 3 of 6 - Presented by Alaska Mental Health Trust Authority
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A broken arm. A heart attack. A manic episode. Thoughts of suicide.

All of these are emergencies, and any one of them might land you in the nearest emergency room. But the clinicians who work in those emergency rooms say the same high-energy, high-intensity environment that is life-saving for medical emergencies can also be high-risk for patients who are experiencing a behavioral health crisis.

Over the years, some Alaska hospitals have found ways to relieve pressure in their emergency rooms while providing more appropriate care to their behavioral health patients. Emergency department staff say that they've seen firsthand the positive results for everyone involved -- and that there is still more room to improve in ways that can benefit all emergency patients, their families, and the providers standing by to care for them.

The wrong environment

Dr. Rick Ellsasser is the medical director for the behavioral care urgent response team at Alaska Native Medical Center. His team works with patients in the emergency department as well as on the hospital's medical floors.

"A typical medical ER is set up to handle medical emergencies," Ellsasser said. "Behavioral health emergencies may have a medical component to them, but the patients have different and unique needs."

That includes more "verbal intervention," he added -- they want to talk, or they want and need to be heard in a crisis situation. Medical ERs often cannot provide the level of privacy needed for sensitive conversations, he added. A person who is brought to an ER for a behavioral health crisis may be more guarded and difficult to connect with, or even negotiate with, in this environment.

"Emergency rooms are also very busy and loud, so someone who's coming in who's psychotic or manic, that can further exacerbate a situation, and controlling that environment is difficult," Ellsasser said.

Behavioral health patients -- those experiencing a mental health or substance abuse emergency, or, as is often the case, both -- are kept under one-to-one supervision to ensure their safety and the safety of those around them, but there's only so much that can be done about the sometimes-chaotic setting they're in.

"We can segregate them as much as possible to give them a calm, soothing environment, but when a code comes in or it's a bad day in the community ... the noise and the stimulus that that provides them is something that can't be controlled in the ER," said Tiffany Kirby, director of emergency services at Alaska Regional Hospital in Anchorage.

Emergency department staff are trained in de-escalation and trauma response, but they're not behavioral health experts.

"With the medical patients, everything is 'Go, go, go, quick, quick, quick,'" Kirby said. "For a psychiatric patient, you can't approach it that way. You have to approach it slow and calm and positive."

It can be emotionally and mentally challenging to switch between those modes in the fast-moving emergency department, she said. On a busy day, doctors and nurses don't always have the capacity to slow down and be intentional in their interactions with behavioral health patients, and that can contribute to a patient's agitation. Sometimes patients need to be re-stabilized multiple times. Sometimes employees are injured. Sometimes the best that anyone can do is to simply make sure the patient doesn't harm themselves or anyone else.

"We do what we can for them," Kirby said. "We make sure they're stabilized, we make sure they're screened, and we make sure they're safe."

Maybe not the best place, but the right place for now

There are a few simple reasons that people in behavioral health crisis go to the emergency room: It's there, it's open, and it's safe. Absent community-based crisis stabilization services, emergency rooms are also often considered the only place for law enforcement and first responders to bring individuals in a behavioral health crisis that they know to be safe.

"Really the only place that someone can access the health care system anytime they want, regardless of their ability to pay, is the emergency department," said Dr. Mark Simon, an emergency medical physician at Fairbanks Memorial Hospital.

Emergency rooms are expensive to operate and utilize, but often they're the only option.

"At the end of the day, people have distress and they don't know where else to turn," Simon said. "The person who is in crisis needs a resource, and it is the only resource. The reason why people are there is because there's no place else to go."

That's not necessarily wrong, Simon said -- if you need help, you should go to where you know you can get it, and seeking help in the ER is better than not seeking it at all.

"Balancing both behavioral health priorities with more classic medical priorities can be challenging," Simon said. "You have to remember that people are both participants and observers in an emergency department setting. They're an actor, but also acted upon by the environment."

An extended stay in the ER can be traumatizing for someone in mental health crisis, he added, but they may also behave in ways that are traumatizing to other patients, and emergency department personnel have to balance the rights of all of their patients.

"At the end of the day, our specialty was founded on being there for everyone at every time," Simon said.

Ellsasser said some emergency departments are better equipped than others to care for behavioral health crises -- ANMC, for example, has clinicians and physicians who can respond on demand, while other hospitals have no in-house behavioral health services. But that's not

what people are thinking about when they or a loved one are having a psychiatric emergency.

"People are going to go to the place where they feel the most comfortable and safe," Ellsasser said.

For better or for worse, often, that's the nearest emergency room -- and, these clinicians said, even if it's not always ideal, it's also not wrong.

"We're open 24/7," Kirby said. "We're known to be a safe spot. You can always go to an ER and you will always have a safe haven there."

Specialized units for specialized care

Until about a year ago, it wasn't unusual to find half of the 20 emergency beds in Mat-Su Regional Medical Center's emergency department occupied at any given time by behavioral health patients who might stay as long as two weeks until they could be placed in the appropriate treatment program.

"It was awful for patients, and it was really difficult for our routine emergency department operations, too," said Emergency Department Director Dr. Tom Quimby. "We didn't have any capacity for finding therapy during their stay in the department. We're emergency physicians -- we're not psychiatrists."

In January 2020, the hospital opened a 16-bed behavioral health unit that brought psychiatrists into the facility and provided a safe, appropriate place for patients to stabilize and get care.

"Just being able to get rid of that huge amount of stress -- it's way better for the patients and has significantly increased our capacity to respond to emergency care," Quimby said. "It's been completely transformative. It's way better for the care of patients with mental crises."

Providence Alaska Medical Center went through a similar transition in 2002, when it established a dedicated psychiatric emergency department located within its medical emergency department. The seven-bed unit has been designed to remove many of the distractions, aggravations and risk factors that a standard ER can present to behavioral health patients.

"We're able to provide care so that they might be able to go down to a lower level of care within 24 hours," said Behavioral Health Manager Kimberly Pettit, one of the co-founders of the "psych ER."

Along with a quieter environment and rooms designed with behavioral health patients in mind, the psych ED and its nurses' station are secure, meaning patients can walk around freely within the unit.

"Being able to care for them in a secure environment is very important," Pettit said. "That enables us to care for very acute involuntary patients -- patients who, if left to their own will, would walk away from the emergency department."

After being triaged in the main emergency department, psych ED patients are placed in a room in the secure unit. Their belongings are secured in a locker. They can remain in their own clothing if it's safe, or they may be offered scrubs to wear while their wet or soiled clothing is laundered. The rooms themselves are equipped only with a gurney, chair and bedside table, removing many of the risk factors present in a typical emergency department.

Most days, Pettit said, the psych ED sees about 15 patients experiencing any of a range of crises -- suicidal ideation, mania, psychosis related to mental illness or substance abuse. Some need to stay overnight; others are discharged after a few hours. About 70 patients a month are adolescents.

"About 75 percent of our patients go home from here," Pettit said. "Most patients are able to be assessed and discharged."

About 100 patients per month need to remain for a longer period of stabilization and observation, and that's where things get tough.

After the emergency

Providence's psych ED was intended to be the first phase of a plan that included additional designated evaluation and treatment beds as well as community-based assisted living facilities for longer-term care, according to Pettit. But the other facilities never materialized, helping lead to today's reality: There are a lot of Alaskans who need help, and there aren't a lot of places where they can get it.

"We believe that there are not enough long-term treatment beds for the severely mentally ill patient in Alaska," Pettit said. "We're doing a disservice to our most vulnerable population by not having long-term care for them."

State law strictly dictates how long patients can be held involuntarily. If they don't meet the high bar for a 72-hour hold for assessment at Alaska Psychiatric Institute -- and most don't -- it can be hard to get them into treatment. The level of difficulty increases for patients with substance use disorders, which often co-occur with mental health issues. Alaska law allows involuntary commitment for substance abuse, Pettit said, but the facilities that treat substance abuse aren't set up to manage involuntary patients. Even for patients who want to go into treatment, intake processes for substance abuse programs tend to be lengthy -- the application packet alone for the Salvation Army's Clitheroe Center, for example, is 19 pages long -- and beds can be hard to come by. A short delay can be enough to deter a patient from getting treatment.

"With substance abuse, if somebody's ready to go, they're ready to go now," Pettit said. "There's very, very little access to treatment right now."

And the challenges are even greater for patients in medical emergency rooms, which are built to triage and stabilize patients before discharging them or sending them on to the next level of care. With a behavioral health patient, that's easier said than done.

"The ability to find resources, the ability to get an appointment, the ability to get the right appointment with the right person -- the nexus of challenges -- is not easily addressed with a pill or a surgery or a procedure," Simon said. "It's addressed with more complicated and nuanced and difficult work."

Even the Tribal health care system, which has increased its investment in behavioral health and has the benefit of being able to provide a high level of continuity between providers, runs into the same problem. It comes down to the availability of services, said Melissa Merrick, one of the behavioral health clinical directors at Southcentral Foundation, which jointly operates ANMC with the Alaska Native Tribal Health Consortium.

"If a patient does not meet that involuntary criteria ... and they are not comfortable going to a voluntary option -- or even if they were, the voluntary options are very limited -- we end up discharging customer-owners (in a way that) they don't feel very good about it, and we don't feel very good about it," Merrick said. "It is a safe discharge plan, but not one that the customer-owner, their family or the clinician would prefer."

Impacts beyond the treatment room

While ER visits can be hard on behavioral health patients, there are two more groups that are also negatively impacted: their family members and the emergency room doctors, nurses and support staff who want to help but often end up feeling helpless.

"It's hard to see somebody that is in a crisis -- not in a medical crisis, but in a crisis, they're suffering, they're either acting out aggressively, they're crying or they're silent, and we can't get them to the level of care that they truly need, where they have the experts that are experts in that kind of care," said Tammy Bailey, the reimbursement director at Alaska Regional Hospital.

Like other first responders, emergency room professionals tend to be problem-solvers, and when they can't get the right kind of help for their patients, it takes a toll.

"I don't think you can really overestimate ... the amount of moral distress that can be caused in those people who are working in those environments," Simon said. "Everyone who goes into health care is looking to help people, and to see people over and over on a recurring basis with problems that are significant and important, and yet not have the tools to be able to contribute to that person's wellbeing -- it's just a terrible thing that gets inflicted on health care workers across our community, across our country, on a regular basis."

For family members, it can be a shock to discover that there may not be a treatment option readily available for their loved one.

"Families get so angry," Pettit said. "I spend some time every week talking with a family member because we didn't meet their expectation of -- and I quote -- 'Please put them somewhere safe.' They are desperate for help, and it's heartbreaking because we don't have the ability to always help them."

A new level of crisis care

In 2019, the Alaska Mental Health Trust Authority, in partnership with the state Department of Health and Social Services, began assembling a coalition of health care organizations, government agencies, social services providers and community members to bring **Crisis Now, a framework for expanding behavioral health crisis response**, to Anchorage, Fairbanks and the Mat-Su. Three significant components of the *Crisis Now* model are a mobile crisis team and 23-hour and short-term crisis stabilization centers where people experiencing a mental health or substance use emergency can go for safe, compassionate care in a setting that is specifically designed to be calming and comforting. Once stabilized, organizers emphasize, it is important that individuals are connected or reconnected to ongoing support services in the community.

Crisis Now is expected to be funded in part through a 1115 waiver from Medicaid, which means its services will be available to all Alaskans, not just those with private insurance. That has to be part of the equation, according to Simon.

"The thing that the emergency department does do is provide universal access regardless of ability to pay," Simon said. "For (behavioral health crisis care) to be effective, you need that same level of access. You're dealing with a population that sometimes has difficulty navigating some of the normal social processes. You need nearly universal access, and you need the resources -- a human resource -- to be able to engage with the person in a way that allows them to feel heard and allows them to figure out what the next step is going to be for them."

Mat-Su Regional's Quimby said he was initially skeptical of the *Crisis Now* framework and questioned whether the system would really result in better outcomes. After learning more about it and the effects it has had in Arizona, he said, he's convinced -- especially after seeing firsthand what happens when you release the pressure on an emergency room.

"(It is) better resource utilization for sure," Quimby said. "Patients that need the emergency department will now have a better experience there because we're not split trying to provide that kind of care. I think it'll also help us better utilize our other psychiatric health resources. This crisis model would make it more likely that a patient would get the care they needed."

Along with better care for crisis and medical emergency patients, Pettit said the new services will benefit those patients who come to the psychiatric ED, which is currently full to capacity about 80 percent of the time.

"*Crisis Now* is going to improve our situation," Pettit said. "From my perspective, we will be able to fulfill the role that I believe we were initially asked to fill, which is to care for the most acute psychiatric crisis. We're happy to care for those patients. We're built for that."

The new framework is "one piece of the puzzle," according to Merrick.

"It's a really important piece, because we do need a behavioral health safety net to catch our community members that are in crisis," Merrick said. "But we also need a solid continuum of care that provides for smooth transitions between services."

Advocates like Bailey and Merrick say they are optimistic about the *Crisis Now* model, which has the support of dozens of organizations around the state -- and, they caution, it is the next step in better care for Alaskans, not the final answer.

"It's like we're moving forward instead of backwards," Bailey said. "We are bringing those silos together, and I think that's a good step forward. I think the *Crisis Now* model will be the starting point of even more discussions on what we need."

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The Alaska Mental Health Trust Authority is a state corporation that administers the Alaska Mental Health Trust to improve the lives of beneficiaries. Beneficiaries of the Trust include Alaskans who experience mental illness, developmental disabilities, chronic alcohol or drug addiction, Alzheimer's disease and related dementia, or traumatic brain injuries. Learn more at AlaskaMentalHealthTrust.org.