Improving Lives Conference
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Improving acute care psychiatric patient outcomes

Through improving psychiatric patient rights

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There are at least 3 critical reasons why approximately 10,000 people in Alaska undergoing a forced psychiatric evaluation or treatment each year need improved rights:

1. **Quality of patient care will improve**

2. **Opportunity for patient recovery will improve**

3. **Trauma experienced by patients during treatment will be reduced.**

Bottomline—Improving psychiatric patient rights to best practice will improve patient outcomes.

I am the author of the book, "Going Crazy in Alaska: A History of Alaska's Treatment of Psychiatric Patients." The book is about my experience of being locked in acute care psychiatric facilities or units for over 7 months and my effort to improve the care of psychiatric patients through advocacy. I have also written or contributed to over 40 commentaries on needed improvements in psychiatric patient care.

In 1999, as a 48-year-old grandmother, with an associate degree in Early Childhood Education, everything seemed fine. I did not smoke cigarettes, rarely drank alcohol, and I did not do illegal drugs. It was the luck of the draw I developed a severe mental illness.

For approximately 5 years, from 1999 to 2003, I was in and out of acute care psychiatric facilities or units and at times, homeless. On seven occasions I ended up in a psychiatric facility, four times in a psychiatric evaluation unit, six times I was escorted to those facilities by the police in handcuffs and I was in crisis treatment centers three times. It was the indifference of my treatment and mistreatment that led me to become a mental health advocate.

Almost every state has created a statewide standardized grievance and appeal process for individuals the state considers having a disability. Alaska has not. Psychiatric patients may receive a level of state protection after being injured or after they are mistreated in a facility. But the Alaska legislature has passed very few laws to prevent psychiatric patients from being mistreated, injured, or traumatized.

One hundred thirty-four-years-ago, Dr. E.C. Dent, the Superintendent of Blackwell's Island Women's Insane Asylum in New York, testified to a Grand Jury that he had no means by which to tell positively if nurses were cruel to their patients. Alaska state agencies tragically still have not developed a reasonable method to determine if hospital staff are mistreating psychiatric patients.

From mid-2005 to mid-2006, there were about 1200 patients at the Alaska Psychiatric Institute and 256 patient complaints, including sexual abuse allegations and not feeling safe. The largest number of patient complaints were from patients stating they were "not receiving respect and dignity" and "treatment team issues." All were considered by management to be informal complaints that went nowhere and did not change any policies or procedures at API.

In 2011, the Disability Law Center of Alaska produced a 9-page report stating that patients at API could not file a grievance in a fair way. It was pointed out that any complaint by a patient against a staff member was considered an internal investigation, and that patients were left with insufficient protection.

In 2017, there were approximately 1400 patients at API and 544 patient complaints that were all considered by management to be informal, 116 patients were injured, 90 needing medical care or hospitalization. There were 50 patient-on-patient assaults. Even when patients were injured, complaints were considered informal.

As reported by the State Ombudsman's Office, in 2018, a woman was sexually assaulted at API. At some point the staff intervened. She was left to sit half-naked by API staff in the tv room and later wandered back to her room. The male perpetrator was released from API with no charges.

From 2019 on, the State Ombudsman's Office released reports stating that it appeared that staff at API displayed a permissive attitude towards patient-on-patient assaults and that management was not handling staff on patient assaults correctly. The latest Ombudsman's report Feb. 8, 2022, charged that API was not providing federally required individual treatment plans for about ½ of the patients. As of now, API management is not required to adopt suggestions on needed improvements in psychiatric patient care from the State Ombudsman's Office.

In 2021, the number of patients at API was 862, the number of complaints or grievances 235. Over 25% of the patients were so unsatisfied they filed a complaint. We have no idea what the complaints were about because API management no longer notifies the state or the general public of the type of patient complaints because they do not have to. Without knowing the type of patient complaints, the state and the Legislature cannot make improvements in patient care.

As a patient in the Alaska Psychiatric Institute in 2003, I was repeatedly traumatized when male staff would walk into my bedroom, bathroom or shower when I was undressed. I was sexually assaulted as a young woman and when men walked into my private areas, I was forced to relive traumatic events. No amount of explaining my trauma to staff and management at API made any difference.

A gender choice of staff by patients for intimate care law was initiated by patient advocacy organizations, including myself and was passed in 2008. (AS18.20.095) The law was necessary because management at the Alaska Psychiatric Institute refused to make even reasonable accommodations in writing policies to reduce unnecessary patient trauma. The failing of the gender choice law—there is no state enforcement mechanism.

The stories of patient mistreatment in locked psychiatric facilities gained national attention when celebrity Paris Hilton testified Feb. 8, 2021, to a Utah Senate Committee concerning her traumatic experience in a psychiatric facility of being required to shower with male staff watching. Adolescents in Alaska are not protected by the gender choice for intimate care law which was a big mistake by the Legislature.

Traumatic events that happen to patients in psychiatric facilities often never leave a person, as it was in my case. A 7-page, 2003, South Carolina report by Karen J. Cusack, Ph.D., and others (Trauma within the Psychiatric Setting) concluded that up to 47% of the patients locked in an acute care psychiatric facility will experience trauma that may cause or exacerbate post-traumatic stress disorder. And those patients express feeling "fear, helplessness and horror."

Alaska has not done adequate research on institutional trauma and has not taken the necessary steps at a state level to reduce trauma. As of now, there are no state requirements for psychiatric facilities or units financially supported by the state to recognize and treat institutional trauma.

Maine, in 1995, was the first state in the nation to begin systematically addressing the interpersonal violence that has affected many of the people served through their Department of Behavioral and Developmental Services. The Maine Office of Trauma Services in 1997 produced a 95-page book titled "In their own words." Patients spoke about what traumatized them during treatment and providers of psychiatric services spoke of what helped patients. As an example, one patient wrote, "I would rather die than go back to the (psychiatric) hospital. They put male staff on female one-on-one. Male staff observes female patient taking a shower." A trusted professional stated: "One set of staff are helpful; another set are sadistic and re-traumatizing. Yes, sadistic and intentionally."

Over 90% of the acute care psychiatric patients in Alaska that spend at least one night in a facility for a forced evaluation or treatment do so outside of state-run API. And by any measurement are not well protected by the state. The standard of psychiatric patient care receives less scrutiny by the state outside of API.

Just like 60-years-ago, private/non-profit psychiatric facilities, even the ones financially supported by the state are allowed to keep secret the number and type of patient complaints, injuries and traumatic events. And keep secret whether patients are treated respectfully because the state does not require independent patient exit polls.

In 2015, the Legislative Legal Services put forth the following opinion: State law AS47.30.660 (b) (13) authorizes state agencies to delegate the powers and duties of the state to private entities. "A delegation may result in the authority of a mental health treatment facility to essentially regulate itself, for departmental purposes, in the care and treatment of mental health patients." Alaska has a 122-year history of letting private psychiatric facilities set the standard of psychiatric patient care and rights, including the patient grievance procedure. (AS47.30.847)

Following are my recommendations to the Legislature on how to improve psychiatric patient rights to best practice to improve patient outcomes.

The state should be required to determine if psychiatric patients are being mistreated during treatment or transportation; the best way to do it is to start asking the patients. In Alaska there must be regular, independent patient exit polls of psychiatric patients that have spent at least overnight in a psychiatric facility or unit.

Every acute care psychiatric patient should be asked the following questions in an independent survey: "Were you injured during treatment or transportation?" "Were you told you had a right by state law to bring your grievance to an impartial body?" "Were you treated fairly in the grievance and appeal process?" "Did you experience any trauma?" "Did the hospital patient advocate help you?" "Were you treated with respect and dignity?" Pretty basic and necessary questions the state should have to ask every acute care psychiatric patient.

Acute care psychiatric patients being treated in a facility often feel they cannot give honest answers to hospital staff in a patient survey. For the best results of a survey, patients must be able to trust who is asking questions. All surveys should be done by someone outside the Department of Health or hospital staff.

To improve psychiatric patients' care and outcomes, Alaska must establish a standardized, state-wide grievance and appeal process for psychiatric patients.

Psychiatric patients must be informed up front that they have a right by state law to bring their grievance to an impartial body and patients must be given reasonable access to a trained patient advocate (AS47.30.847) Reasonable is between the hours of 8 am and 5 pm every day.

Acute care psychiatric facilities or units must be required to recognize and treat institutional trauma.

All psychiatric patient complaints must be reviewed by an independent agency.

Alaska must start collecting and make available to the Legislature and the general public statistics recording the number, type and cause of patient and staff injuries; the number, type and resolution of patient and staff complaints; and the number, type and cause of traumatic events experienced by a patient. "Traumatic event" means being administered medication involuntarily or being placed in isolation or physical restraint of any kind or being injured during treatment or transportation.

There must be a new state law or regulations giving psychiatric patients and individuals with a developmental disability or their guardians a right to file a grievance at the time of their choosing. As of now, there is no state law that prevents psychiatric facilities from putting patients through a long, informal complaint process.

There must be an agency with the authority to help set a standard of care and oversight for psychiatric patients locked in facilities. For example, ensuring that patients have fair rights for going outdoors, using the phone, having visitors, etc. As of now, there is no agency to advocate for fair patient rights.

There must be a statewide standard for how disabled psychiatric patients, or their guardians are informed of their rights. As an example, an individual detained for a forced evaluation or treatment and their guardian must be given both written material and verbal explanations of their rights and options to protect themselves.

Any person locked in a psychiatric facility must be given a right to call a designated representative between the hours of 7am and 7pm at the time of their choosing. Some states are doing something similar now.

To promote patient recovery and to help individuals to re-adjust back into society, Alaska psychiatric patients must be given rights that meet or exceed best practice. Much of what I have outlined as being needed to help patients is best practice in a number of other states.

Reference Information:
Alaska provided mental health care 122-years-ago that fit with the times and could best be described as inhumane. Some of the worst treatment in mental health care and transportation from the past is still being used by the Department of Health in 2022.

Psychiatric hospitalization in the United States dates to the late 1700's. Early hospitals were called "Asylums." The conditions in many of these institutions were inhumane. There were a few that attempted to provide humane treatment and the directors of 12 of the asylums banded together to establish what is now the American Psychiatric Association.

In 1887, Nellie Bly, a 23-year-old investigative journalist for the New York World was given the assignment of getting inside of Blackwell's Island Women's Insane Asylum as a patient and report the experience.

Nellie Bly's newspaper articles were published as a book, "Ten Days in a Mad-House" in which she described the deplorable conditions for patients first-hand. A grand jury was convened to determine the level of patient mistreatment. Dr. E.C. Dent, the superintendent at Blackwell's Island, testified to the grand jury that he had no means by which to tell positively if nurses were cruel to their patients.

Alaska today has developed no method by which to accurately measure the extent of patient mistreatment in locked psychiatric facilities.

Bly wrote of corporal punishment in 1887. Patients would be choked, slapped in the face, pinched, their fingers twisted and locked in a closet. In 1984, psychiatric patients in Alaska were finally given the right by state law AS47.30.840 to be free from corporal punishment. But there is no definition in the law or regulations of what the state considers to be corporal punishment. *In my experience as a former psychiatric patient, "unnecessary physical takedowns," "strapping patients to gurneys longer than necessary," "removal of rights for a minor infraction of hospital rules to punish patients," etc. are some of the forms of corporal punishment used today in Alaska psychiatric facilities.*

Thirteen years after Nellie Bly published "Ten Days in a Mad-House," on June 6th, 1900, Congress passed a law that allowed the US Department of the Interior Office of the Territories to contract for the care of Alaska's psychiatric patients. Between 1900 and 1904, Alaskans who needed care were sent to the Oregon Insane Asylum (later called the Oregon State Hospital) and Alaska forgot about them.

By the early 20th Century, almost every state had large mental hospitals with 3 to 5000 residents at any given time. Many of the inmates in these institutions who were labeled insane would live out their entire lives within these institutions. There were almost no successful treatments for patients. Many were subjected to cold wet sheet packs, insulin coma therapy and electro-shock therapy.

In 1904, the US Department of the Interior awarded Morningside Hospital in Portland, Oregon, a federal contract for providing care for Alaskans with a disability. The price that was settled on in the contract was $1 a day per patient. With one dollar, the hospital was expected to provide medical care, clothes, therapy, food and a bed. Around 1959 the state of Alaska took over the contract.

From 1900 to 1968, many Alaska Natives and others were shipped from Alaska to psychiatric facilities in Oregon and forgotten. In total, approximately 3,500 Alaskans made the journey. Of the people that died during treatment, very few were returned to Alaska for burial by their family and most were buried in Oregon.

In 1959, Alaska became a state. The cost of caring for Alaska's disabled did not remain a dollar a day per patient. But the cost remained low because the private hospitals providing care did not expect or receive many concerns or questions from the state of Alaska about patient rights, quality of care or patient outcomes. Alaska today is still not setting a sufficient standard of psychiatric patient care and protection.

The state-run Alaska Psychiatric Institute opened its doors in 1962 with 225 beds and a footnote in American history. The warehousing of the disabled was coming to an end and API was one of the first state psychiatric hospitals that was built with a mission statement of preparing patients for release and community care.

Preparing psychiatric patients for release and integrating them into the community was a brand-new job for mental health providers in Alaska. The staff at API from 1962 to 72 wrote a 9-page outline of what helped in preparing patients for successful release. First was the recognition that "the traditional hospital routine perpetuated the return to hospitalization" and that keeping patients connected with the community was an important part of successful release, along with providing coping skills.

The positive lessons learned by API staff in the 1960's was forgotten by the 1990's. Management at API was encouraged by state agencies to downsize and go in a new direction. Instead of improving a patient's rights and choices and preparing an individual to go back to society and community care, patients at API were cloistered into a system of care that was very similar to a jail. Patients were then released, often back to the streets, with insufficient preparation and support.

There are concerning similarities between the hospital policies that allowed for the mistreatment of psychiatric patients in 1887 and the hospital policies today in 2022. As an example, state agencies and the general public do not know the number of psychiatric patients undergoing a forced evaluation or treatment state-wide each year, number and type of patient complaints, injuries and traumatic events. Allowing psychiatric facilities to keep patient mistreatment secret always leads to more mistreatment.

The Mental Health Trust Authority provided a $56,439 grant to Access Alaska to try to locate people that were lost when they were sent to Oregon's insane asylums and Morningside. ("Lost Alaskans: The Morningside Hospital History Project")

Many negative reports have been published—by the Disability Law Center, Medicaid/Medicare, the State Ombudsman's Office and the Joint Commission—concerning the Alaska Psychiatric Institute's mistreatment of patients, poor treatment, and lack of rights. *I am not aware of any negative reports of private, non-profit psychiatric facilities—It is concerning because they operate in the same manner as API and under the same state laws. It's just that they are permitted to do so in secret.*

Ann F. Jennings, Ph.D., in 1994, published "On Being Invisible in the Mental Health System." The report goes into detail of the unnecessary trauma psychiatric patients face in psychiatric facilities and the cost to the patient and society.

My Estimates of patient statistics are based in part on the API 2015, 2017 dashboards.

Number of acute care psychiatric patients annually in Alaska—10,000.
Number of complaints/grievances—1,000. Medicaid/Medicare see a grievance and a complaint as interchangeable.
Type of complaints/grievances—Highest number of complaints is not receiving respect and dignity, not being treated fairly by the treatment team.
Number of patients injured during treatment or transportation annually—600.
Number of patients traumatized based on a South Carolina study—4000.
My estimations are based in part on what happened to patients in API 2015 and 2017—the state could dispute my estimations; except they do not keep any statistics or try to determine what happens to acute care psychiatric patients outside of API.

Psychiatric patients in Alaska have a right by state law AS47.30.847 to bring their grievance to an impartial body. When I was in API in 2003, none of the patients were told they had that right. According to the same law, there must be a trained patient advocate to assist patients in bringing a grievance or other redress. Patients were not told there must be an advocate who must assist them. Although the words "patient advocate" are used in the patient grievance law, psychiatric facilities shied away from mentioning they had a patient advocate and used words like "family specialist" instead. As a note: Patient advocates should be available on the units 7 days a week.

In 2018, author and reporter Charles Wohlforth, wrote several newspaper articles about psychiatric patient care in North Star Behavioral Health System. They are considered by many to be Alaska's largest provider of psychiatric services. Patients claimed they were being mistreated. Private psychiatric facilities can operate in secret and that makes it difficult for any reporter to gain facts to write a story.

A Personal Observation: When I was a patient in API there was a young man on my unit. I will call him Bob. He was about 19, intelligent but suggestible. The time I remember most fondly, Bob came over to me and showed me a dixie cup full of leaves and said, with green spittle coming down his chin, "Nightshade!" I added the word "deadly." Bob strung the words together murmuring "deadly nightshade," and wandered off happily. I knew the Ficus plant was going to have a difficult time that day.

The point I want to make; when Bob's family came to visit on the unit, he seemed much more calm, more lucid. He could hold a conversation. Being connected with family and friends is important to recovery.

Starting in 2005, management at API started separating families from patients. They were no longer able to eat meals together, etc. Under these conditions, when patients are released, it is a shock for patients to go back to society. Separating families from patients is a mistake by API management.

It should be incumbent upon the state of Alaska to set a standard of psychiatric patient care and protection that meet or exceed best practice in law or regulations-- As of now, the state of Alaska is not doing it.

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Author of the soon to be released e book, "Mental Health Care in Alaska 2022: A report card by a former psychiatric patient."
And the book, "Going Crazy in Alaska: A History of Alaska's Treatment of Psychiatric Patients."