
**Abuse and Neglect Investigation:
Bartlett Regional Hospital, Juneau
Alliance for Mental Health, Inc.,
Securitas USA, and Alaska
Psychiatric Institute**

**Inaccurate Assessment of Mental
Health Crisis Results in Inappropriate
Use of Emergency Detention Statute
and Physical Restraints**

August 2009

**The Disability Law Center of Alaska
Community Integration Unit - Abuse/Neglect Investigation**

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I. General Information & Terms

The Disability Law Center of Alaska (DLC) is a private, independent, not-for-profit agency, and is Alaska's federally mandated Protection and Advocacy (P&A) system. Under its federal mandates, two of which are the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act),¹ and the Developmental Disabilities Assistance and Bill of Rights Act (DD Act),² DLC has the duty and authority to investigate allegations of abuse and/or neglect involving individuals who experience a disability if the incident is reported to DLC, or if DLC determines there is probable cause that an incident of abuse and/or neglect occurred. Both the PAIMI and DD Acts give DLC the authority to access facilities, records, patients, staff and administration in order to complete its investigation.

Alaska Psychiatric Institute (API) is licensed as a Specialized Hospital, located in Anchorage, Alaska. API is licensed for 80-beds, is the State's only state-operated psychiatric hospital, and provides evaluation and treatment to individuals experiencing or suspected of experiencing a mental illness, regardless of their home-community within the state. The hospital is certified to receive Medicare and Medicaid funding, and is also accredited under the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). API is a Designated Evaluation and Treatment (DET) facility as identified by the State's Department of Health and Social Services.³ API's adolescent unit has 10 beds.

Bartlett Regional Hospital (BRH) is licensed as a General Acute Care Hospital, is located in Juneau, Alaska, and serves individuals throughout Southeast Alaska. The hospital is licensed for 71-beds, and is certified to receive Medicare and Medicaid funding. It is also accredited under the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). BRH is a Designated Evaluation and Treatment (DET) facility as identified by the State's Department of Health and Social Services. BRH's Mental Health Unit has 12 adult beds.

Catholic Community Service (CCS) is a social service agency located in Juneau, Alaska, offering services to seniors and adults with disabilities; child care and family resource services; and hospice and home health services.

Cornerstone Residential Facility and Emergency Services is a component program under Juneau Youth Services, and provides short-term crisis intervention, shelter and support services to 10-18 year olds.

Juneau Alliance for Mental Health, Inc. is the Community Mental Health Center for Juneau, Gustavus, Elfin Cove and Tenakee Springs, and provides emergency services; case management and rehabilitation services; psychiatric and nursing services; general mental health services; enhanced residential services; and a drop-in center.

¹ Under the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. § 10801 *et seq.*, DLC is mandated to protect and advocate for the rights of people with mental illness.

² Under the Developmental Disabilities Assistance and Bill of Rights Act (PADD or the DD Act), 42 U.S.C. § 6000 *et seq.*, DLC is mandated to protect and advocate for the rights of individuals with developmental disabilities.

³ See A.S. § 47.30.915.

Juneau Youth Services (JYS) is a comprehensive behavioral health provider for children, youth, and their families, providing emergency, residential, and community-based programs, including both mental health and chemical dependency services.

Securitas USA provides a wide variety of security and security-related services throughout the United States. Among the services provided in Alaska, Securitas is contracted by the State to provide security and escort services.

Abuse under PAIMI regulations “...means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes but is not limited to acts such as: rape or sexual assault; striking; the use of excessive force when placing an individual with mental illness in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment; and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.” 42 C.F.R. § 51.2.

Abuse under the DD Act regulations “...means any act or failure to act which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with developmental disabilities, and includes such acts as: Verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.” 45 C.F.R. § 1386.19.

Complaint under PAIMI and DD Act regulations “...includes, but is not limited to any report or communication, whether formal or informal, written or oral, received by [DLC], including media accounts, newspaper articles, telephone calls (including anonymous calls) from any source alleging abuse or neglect of an individual with mental illness.” 42 C.F.R. § 51.2 and 45 C.F.R. § 1386.19.

Ex parte involuntary commitment refers to when a judge orders an emergency examination or treatment of an individual when “...there is probable cause to believe the [individual] is mentally ill and that condition causes the [individual] to be gravely disabled or to present a likelihood of serious harm to self or others.” A.S. § 47.30.700.

Neglect under PAIMI and DD Act regulations “...means a negligent act or omission by an individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes, but is not limited to, acts or omissions such as failure to: establish or carry out an appropriate individual program or

treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate numbers of appropriately trained staff.” 42 C.F.R. § 51.2 and 45 C.F.R. § 1386.19.

Physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. 42 C.F.R. § 482.13(e)(1)(i).

POA is an acronym sometimes used for “Peace Officer Authorization.” Use of the acronym in this way is related to the statutory provisions for emergency detention for evaluation.⁴ Specifically, a peace officer, psychiatrist, physician or clinical psychologist who has probable cause to believe a person is gravely disabled or suffering from a mental illness and is likely to cause serious harm to self or others, may cause the person to be taken into custody and delivered to the nearest evaluation facility. POA is commonly used to describe such an evaluation, whether or not it’s actually initiated by a peace officer versus the additional professionals also authorized by law to initiate such an action. An important element of this statutory provision is that a POA is only to be used when the concerns of actual or potential harm are of such an immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in A.S. § 47.30.700.

⁴ See A.S. § 47.30.705

I. Introduction & Executive Summary

In August 2009, DLC received a report alleging a 17 year old adolescent (the adolescent), whose diagnoses include Autistic Disorder, had been transferred from Bartlett Regional Hospital (BRH) to the Alaska Psychiatric Institute (API), handcuffed and under the supervision of two guards. It was alleged the experience of the transfer between the two facilities constituted abuse to the adolescent and a violation of his rights. It was further reported to DLC that the adolescent's mother was not allowed to participate in development of the transfer plan or accompany her son to API. Following receipt of the reports, DLC initiated an abuse and neglect investigation into the allegations.

As a result of the complaint received, DLC sought to determine if:

- 1) the allegation of abuse and/or neglect could be substantiated;
- 2) BRH had adequate and appropriate policies and procedures for the transfer of children or adolescents from their hospital to API;
- 3) the understanding and communication between the agencies involved (including BRH) in the transfer of the adolescent to API, were sufficient to ensure an appropriate, safe and orderly transfer; and
- 4) the use of handcuffs and two escorts was necessary, appropriate and consistent with applicable laws, regulations or policies.

Based on DLC's investigation it was determined:

- 1) sufficient information was available to make a determination that abuse and neglect had occurred;
- 2) policies and procedures utilized by BRH for the transfer of children or adolescents from their hospital to API were not adequate or appropriate to ensure an orderly transfer of children or adolescents from their hospital to API;
- 3) understanding and communication between the agencies (including BRH) involved in the transfer of the adolescent to API were not sufficient to ensure an appropriate safe and orderly transfer; and
- 4) the use of handcuffs and two escorts was not necessary, appropriate or consistent with applicable regulations or policies.⁵

⁵ DLC could not find statutes that governed the use of handcuffs or escorts in this situation so instead relied on the regulations applicable to acute care facilities. *See* 42 C.F.R. § 482.13(e).

III. DLC's Investigation, Findings & Analysis

In August 2009, DLC received a report that the adolescent, whose diagnoses include Autistic Disorder, Intermittent Explosive Disorder, Learning Disorder NOS (not otherwise specified), and Bipolar Disorder NOS, had been abused as a result of his experience during the process of being transferred from BRH to API.

It was reported that the adolescent was receiving services under the State's Medicaid Waiver for Home and Community Based Services for individuals who experience developmental disabilities. It was further reported that the adolescent's mother had been working with the adolescent's care coordinator and multiple social service agencies in Juneau. Based on the adolescent's escalating behaviors as well as a mental health evaluation, a plan was developed to have the adolescent admitted to API for further evaluation and treatment. This was to include evaluation for the possible use and benefits of using medications as well as evaluating the possible benefits of sending the adolescent to a treatment facility in the Lower 48.

Reportedly, with the assistance of one or more of the social service agencies, an arrangement had been made for API to accept the adolescent for admission. It was further reported the adolescent's mother had received authorization by the State to have the adolescent flown from Juneau to Anchorage, with her accompanying him.

According to the report received by DLC, the last thing the mother was directed to do before she and the adolescent were to fly to Anchorage, was to go to BRH and obtain a medical clearance for travel and admittance to API. It was reported that upon her arrival, she was informed by BRH staff that the process she had been utilizing was not the appropriate process used for getting the adolescent admitted to API, and that the travel plans were not valid. While the adolescent had already received a mental health evaluation from one social service agency (JYS), he was evaluated again by a different mental health professional (JAMHI), this time at BRH, then kept overnight at the hospital under continual staff observation. The adolescent was transported to API under a POA order the next day, in handcuffs by two security guards.

Specific Activities and Findings:

1. Interview with the Adolescent's Mother

DLC staff met with and interviewed the adolescent's mother in September 2009. Accompanying the mother was the adolescent and the mother's family support specialist from Catholic Community Services (CCS).

The mother reported that for the two or more months leading up to the adolescent's February 20, 2009 visit to BRH, he had been displaying more and more unwanted behaviors. Those behaviors included: increasing aggression and destruction of property at home; use of a chair and knife at home in a threatening way; defiance and name calling directed at her; public masturbation in school; and spreading feces on the bathroom wall at home.

The mother reported that at various times in response to those behaviors, the adolescent would spend a few days away from home, staying at Cornerstone.⁶ The mother went on to report that, given the continued escalation of the adolescent's behaviors, she, staff at Cornerstone, and her son's care coordinator believed her son's issues and needs exceeded the abilities of the local mental health and other service providers to meet them. As a consequence, it was decided admission to API was the best possible alternative.

The adolescent's mother went on to report that the desired outcome of her son's admission to API included: providing a structured environment to diminish or eliminate the adolescent's unwanted behaviors; additional evaluation to include possible re-evaluation of the use of medications; development of a comprehensive discharge plan that would either develop additional supports in Juneau or look into possible out-of-state placements.

The mother reported that staff at Juneau Youth Services (JYS), Cornerstone and CCS had been working to find out what was needed to get her son admitted to API. The mother reported she had been told by staff at those agencies that: contact had been made with API, and API agreed to admit the adolescent; transportation was in the process of being arranged so that she could take her son to API; and that what she needed to do next was to go to the BRH emergency room to get her son a medical clearance for travel and API admission. Someone from Cornerstone was to call ahead to BRH to let BRH know they were on their way, and the purpose of their coming. The mother reported that obtaining the required medical clearance from BRH was the only reason she took her son there, and the timing of taking him on that particular day was because that was the day everything came together (i.e., an adolescent bed at API was available; API agreed to admit him). The mother reported her son was not in crisis the day she took him to BRH (February 20, 2009).

The mother reported she, the adolescent, and the family support specialist from CCS arrived at the hospital together on February 20, 2009. When she arrived at the BRH emergency department, she met with hospital staff and communicated what had been going on for her son, the plan to have him admitted to API, and her instructions to get him cleared medically so that he could travel either that day or the next. Hospital staff reported they had not received a telephone call from anyone at Cornerstone. Hospital staff began collecting medical and mental health information about her son. Sometime thereafter, hospital staff informed the mother that BRH needed to contact the Juneau Alliance for Mental Health, Inc. (JAMHI).

Shortly thereafter, someone from JAMHI arrived at the hospital. The mother reported informing the JAMHI staff person what had been going on and why they were at the hospital (i.e., to obtain medical clearance). According to the mother, the JAMHI staff person soon requested hospital security to monitor her son; she didn't understand why, but kept silent. The JAMHI staff person then continued to collect information about the

⁶Cornerstone Residential Facility and Emergency Services is a component program under Juneau Youth Services (JYS), and provides short-term crisis intervention, shelter and support services to youth, 10-18 years of age.

recent behaviors of her son. The mother reported when she tried once again to explain plans were already in place for her son to be admitted to API, the JAMHI staff person told her the hospital had its own policies and procedures for how such transfers were to take place. The JAMHI staff person then excused herself saying she needed to make several phone calls and complete some paperwork to effect the admission.

The mother reported shortly after that the family support specialist from CCS received a telephone call from someone at Cornerstone stating they had secured a Prior Authorization (PA)⁷ number and approval for the mother and adolescent to travel together to Anchorage the following day. The mother reported the CCS family support specialist asked the hospital security guard to let the JAMHI staff person know she needed to speak with her about travel, but that the security guard returned saying the JAMHI staff person would be available after she had completed her paperwork.

The mother reported shortly thereafter that a hospital physician showed up, saying he was there to meet the adolescent in relation to the possible transfer to API. The doctor then had to leave for a family emergency. The mother reported feeling extremely frustrated and upset and believed that her and her son's rights were being violated.

The mother reported about an hour and a half passed, and both the doctor and the JAMHI staff person returned. They informed her that her son would be staying overnight in the hospital, and would be escorted by two women to API the following day. The mother reported both she and the CCS family support specialist informed the physician and JAMHI worker that a plan was already in place, but they were told that plan was not going to happen.

The mother reported the JAMHI staff person informed her that her son would be staying on the hospital's mental health unit for the night, that she could not stay, and that someone would be in the room with him at all times. The mother spoke further with the physician. Among other concerns about how things had gone, the mother told the physician that it felt as though her rights and the rights of her son had been taken away. Then, the physician informed her her son's rights superseded her own. The mother asked if that meant that she couldn't take her son out of BRH even if she wanted to, to which the physician said she could not. The physician reportedly stated this was the way it was going to go, and offered a telephone number where she could "rant and rave" if she wanted to. The mother then left BRH and returned to Cornerstone. Her son remained at the hospital.

The mother reported that she returned the following day, and a meeting had been called to address her concerns. The on-call psychiatrist was there, someone was there from JAMHI, other hospital staff came and went, and there were some individuals on the phone, among them someone from API.

⁷ For Medicaid recipients, prior authorization for travel must be obtained through the State's contractor before travel can be approved. Once approved, a Prior Authorization (PA) number is issued. That number is given to the State Travel Office to book the approved travel.

Shortly thereafter two escorts came and her son was taken away in handcuffs. The mother was informed by the escorts that she was not allowed to accompany her son to the airport.

2. Interview with CCS Family Support Specialist

DLC staff met with and interviewed the CCS family support specialist in September 2009. The information obtained through that interview was substantially consistent with information provided by the adolescent's mother.

3. Interview with BRH Triage Nurse

DLC staff met with and interviewed the BRH registered nurse who first had contact with the adolescent at the hospital. According to the nurse, she was acting as a triage nurse in the emergency room (ER) when the adolescent, his mother and the CCS family support specialist first arrived. The nurse reported the adolescent's mother said someone from Cornerstone was supposed to have called ahead to let the hospital know she and her son were coming, but the nurse had not received advance notice of their arrival.

The nurse reported that her understanding of why the adolescent and his mother were at the ER was due to a "behavioral crisis." When asked if an adolescent coming to the ER like this was fairly common, the nurse responded that she knew of other times when minors had come to the ER for a mental health evaluation connected to transfers, but not just for clearance to travel such as the adolescent's mother reported.

The nurse described the adolescent's affect and behavior during the evaluation as withdrawn but cooperative. The nurse stated that there was no involvement by security initially, but went on to say that generally when disclosures are made of potential for self-harm, or harm to others, security is called to observe outside the examination room.

Following her examination (e.g., taking of vitals), the triage nurse reported to the primary nurse.

4. Interview with JAMHI Mental Health Clinician

DLC staff conducted a telephonic interview with the JAMHI mental health clinician who evaluated the adolescent after he had been seen by the BRH triage nurse. The clinician stated her first awareness of the adolescent presenting at BRH was when she received a call from the BRH emergency room reporting the adolescent needed to be transferred to API.

After she arrived and during her evaluation of the adolescent, she described his behavior as "pacing," "raising his fists," "posturing," and displaying "psychomotor agitation." She

reported at one point the adolescent tried leaving the room, and shortly thereafter she requested a security guard be present for observation and assistance if needed.⁸

The clinician stated the family support specialist from CCS informed her API had agreed to accept the adolescent for admission. She later confirmed this through contact with API. The clinician reported the adolescent's mother told her about the adolescent's escalating, out-of-control behaviors (e.g., throwing things; picking up a knife; difficulty with authority; problems at home and at school; masturbating in public; smearing feces).

The clinician observed that the adolescent's mother was visibly upset, as were the family support specialist from CCS and the adolescent himself. She reported the ER was also getting quite busy shortly after her arrival. In response to the mother's assertion that travel arrangements had already been made and approved, the clinician stated she had received training by the State regarding how things were to occur in the event a transfer to API became necessary. Because of that training and her experience, she knew the travel would not go through as described, because the State person who had to authorize the travel had not been involved.

The JAMHI clinician reported that she discussed the adolescent's situation with someone from the State's Division of Behavioral Health (DBH). She was informed the State would not pay for travel if the adolescent's admission to API was voluntary.⁹ She reported it was after receiving that information that a POA admission was first discussed or considered. Based on a discussion the clinician had with the BRH on-call physician, he agreed with her assessment that a transfer to API was needed, and agreed to sign a POA order.

The clinician saw that because the adolescent's mother was very upset, and the adolescent became more upset around her, she decided someone other than the mother should escort the adolescent to Anchorage. The clinician reported she requested two escorts because she was unable to secure a same-sex escort. The clinician told the mother that parental rights would be temporarily terminated during the flight, and the State accepted temporary guardianship during the transfer due to liability.

5. Interview with BRH, ER Attending Physician and Review of Peace Officer/Mental Health Professional Application for Examination (POA)

DLC staff reviewed the Peace Officer/Mental Health Professional Application for Examination (aka POA),¹⁰ signed by the physician at BRH who was the attending physician for the ER on the day the adolescent presented. The application was dated

⁸ The description of the adolescent's behaviors provided by the JAMHI clinician during her interview with DLC were not the same as those found in her documentation within the adolescent's BRH medical record. In the BRH record, she described the adolescent as "...slightly agitated during the interview, rocking back and forth and averting eye contact, client did not want to describe events leading up to coming to the ER, and became upset when mom responded, tics all present during speech, labile mood with flat affect, clients posture was depressed, slouching picking at shoes, did not want to talk about upsetting events..."

⁹ See A.S. § 47.30.870.

¹⁰ This is the application used for Emergency Detention for Evaluation. See A.S. § 47.30.705.

February 20, 2008, probably in error.¹¹ The physician checked the box for “gravely disabled,” but did not check boxes for “likely to cause serious harm to self or others.”

The physician, or someone on the physician’s behalf, wrote:

Client has escalating aggression, easily agitated, and unable to maintain safety when upset. Client has used furniture as weapons with mom at home and been recipient of violence of peers as result of functioning level as result of oppositional disorder, autism, Tourettes [disorder], poor internal coping skills.

DLC staff met with and interviewed the BRH physician who signed the POA order. When asked what he could remember about the adolescent and the way he presented on February 20, 2009, the physician stated he did not remember anything specific about the adolescent’s behavior. Later in the interview the physician disclosed he had not met with the adolescent, but had spoken with the nurse practitioner.¹²

6. Interview with Juneau Youth Services (JYS) Clinician, Review of Comprehensive Behavioral Health Assessment and Review of E-Mail

DLC staff conducted a telephonic interview with the clinician at JYS who had worked with the adolescent and conducted the Comprehensive Behavioral Health Assessment. In the “Reason for Assessment/Current Status” section of the assessment, the clinician wrote “[Adolescent] reportedly deteriorating rapidly at home, community and school and an assessment was requested and needed in order to determine the need for more services for [adolescent].”

In the “Presenting Problems/Concerns” section of the assessment, the clinician wrote that the adolescent’s mother reported the escalation of her son’s behaviors had become more pronounced during the prior 6-7 months. The mother further reported that her son had become more aggressive and destructive in the home.

The assessment concluded with a recommendation that the adolescent receive evaluation and treatment at API. Specifically, the “Clinical Impressions” section of the assessment stated “...explosive behavior appears to be increasing and may place him at risk to harm himself and others without a period of observation and stabilization. There is a clinical team at API that specializes in the treatment and stabilization of Autistic children. This appears to be the most suitable placement for [adolescent] at this time.” The assessment was dated February 10, 2009.

¹¹ Although the application is dated February 20, 2008, all other documentation and an interview with the physician confirms it should have been dated 2009.

¹² This statement is confirmed in a progress note dated February 20, 2009 and electronically signed February 21, 2009 by the physician. The note stated “I supervised care provided by the NP [Nurse Practitioner]. We have discussed the case. I agree with the plan of treatment. (Reviewed and agree with need for transfer to API).”

The clinician described his involvement in trying to facilitate the adolescent's admission to API. According to the JYS clinician, he had been in contact with a social worker at API and other API admitting staff. Based on those communications, a physician at API had agreed to admit the adolescent for observation and treatment, but the adolescent had to first go to BRH for a medical clearance before a transfer and admission could take place.

DLC was provided an e-mail sent from the JYS clinician to the JYS Clinical Director; the e-mail was dated February 20, 2009. The e-mail stated:

Ok... I talked with API and these are the instructions per [name of API social worker].

There is a doctor at API willing to accept him [adolescent] for observation and treatment: [doctor's name]. He must be able to use medication or [adolescent's name] will be sent back.

1. [Adolescent] needs to be taken to Bartlett to have an overall medical clearance. They must be told that API is ready to accept him and given the name of the physician there [physician's name]. 2. POA or other travel needs to be done. Bartlett has social workers that can do that I am assuming. They used to anyway. I'm not familiar with how transportation is done. He is SSI/Medicaid. 3. Bartlett is to contact API's ASO (assessment screening officer...if before 4 it's [name of API social worker]) to arrange transport.

API will accept him. Mom and [name of CCS family support specialist] will need to accompany [adolescent] to Bartlett. Someone may need to accompany [adolescent] on the plane. Not sure how that is to work. Perhaps all 3 can go.

7. Interview with Adolescent's Care Coordinator

DLC staff conducted a telephonic interview with the adolescent's care coordinator. During that conversation the coordinator affirmed descriptions of the escalation of the adolescent's behaviors for several weeks prior to his transfer to API. When asked what the care coordinator was hoping would be accomplished from the adolescent's API admission, she responded she had hoped the adolescent's behaviors would be stabilized, possibly with the assistance of medications, and that he would then be discharged to an out-of-state placement for long-term treatment.

8. Interview with JAMHI Emergency Services Supervisor

DLC staff conducted a telephonic interview with the JAMHI emergency services supervisor that was on duty the day the adolescent presented at BRH. The emergency services supervisor reported he was asked to come to BRH in response to how upset the adolescent's mother was.

The emergency services supervisor stated the adolescent and his mother were actively engaged in an argument of some sort when he arrived. He tried speaking with the adolescent, however the adolescent refused to speak. The emergency services supervisor stated the adolescent soon began watching a video, and calmed down.

The emergency services supervisor reported JAMHI typically did not get involved in the transfer of adolescents who had been receiving services through JYS and were being transported to API. The reason, he explained, was that such transfers were normally made physician-to-physician. He stated the reason it did not occur that way this time was because the psychiatrist who had treated the adolescent in the past would not make the referral as he had not treated or seen the adolescent for several months.¹³

9. Review of Adolescent's BRH Records

DLC reviewed the adolescent's records from BRH. The adolescent first presented at BRH on February 20, 2009, and was transferred to API on February 21st. The sections of those records that DLC determined to be the most salient to this investigation and report are provided below:

9.1. Triage Nurse's Initial Assessment

The "Chief Complaint" noted by the BRH triage nurse documented:

AGITATED AND AGGRESSIVE BEHAVIOR
(Escalating violent behavior at home. Defiant toward mother.). Onset (10 days). The patient describes feelings of depression, has had situational stress and has had anxiety. Describes feelings of sadness and anger.

Under "Social History" the nurse wrote:

...The family reported the patient's behavior as aggressive and combative. In the ED [Emergency Department] the patient has been agitated. A further in-depth assessment is planned. The patient has been placed under 1-on-1 supervision with family at bedside...

¹³The psychiatrist referred to by the JAMHI Emergency Services Supervisor was the on-call psychiatrist the day the adolescent presented at BRH. The psychiatrist conducted the psychiatric evaluation and admitted the adolescent to the BRH Mental Health Unit.

9.2. Primary Nurse's Assessment

Under the "History of Present Illness" section of her assessment, the primary nurse summarized the adolescent's behaviors which she wrote had started to escalate three weeks prior to the current encounter. Under "Physical Exam" and "Appearance," the nurse wrote "Alert. Patient in apparent distress (agitation). Patient is in mild distress. Anxious."

Under "Suicide Risk Assessment," the nurse wrote "The patient's suicide risk factors are as follows: male. The patient has a diagnosis of borderline personality disorder. History of frightened friends and/or relatives."

9.3. BRH Mental Health Consultation/Crisis Intervention

The initial portion of the JAMHI clinician's assessment described the historical behaviors that led up to the decision and plan to transfer the adolescent to API, and a statement that the adolescent sometimes became aggressive toward others. As to how the adolescent presented during her evaluation, the clinician wrote in the Mental Status Examination section that the adolescent was "...slightly agitated during the interview, rocking back and forth and averting eye contact, client did not want to describe events leading up to coming to the ER, and became upset when mom responded, tics all present during speech, labile mood with flat affect, clients posture was depressed, slouching picking at shoes, did not want to talk about upsetting events..."

The clinician's "assessment of risk" was "high risk of grave disability." Her recommendations were "Client will benefit from inpatient setting to stabilize on medications and treatment solutions to ensure better fit in his home environment."

9.4. BRH Mental Health Unit Psychiatric Admission Orders

The on-call psychiatrist signed orders for the adolescent to be admitted to the BRH's Mental Health Unit on February 20, 2009, at 6:40 p.m.

9.5. BRH Mental Health Unit Application for Voluntary Admission

At approximately 7:03 p.m., the adolescent's mother signed the adolescent into the Mental Health Unit under a voluntary admission.

9.6. BRH Nursing Progress Notes Just Prior to Admittance to Mental Health Unit, and Mental Health Assistant and Nursing Progress Notes Following Admission to the Unit

Nursing progress notes document that the JAMHI clinician had requested one-on-one security due to her concern that the adolescent might try and leave the hospital. The adolescent, with security staff at his bedside, was reported as

laughing while watching videos. Following admission to the mental health unit, hospital staff notes indicate the adolescent was calm and cooperative. The notes went on to document the adolescent's behavior as being appropriate, and that he watched movies and ate sandwiches.

The progress notes for the next morning indicate the adolescent had been cooperative and compliant with staff. An addendum note stated "A POA (Peace Officers Assist 48 hour hold for eval)" was needed for admission to API.

The next note stated the adolescent was being discharged in stable condition with two private security (Securitas) staff to accompany him to API.

9.7. Progress Note Written by BRH On-Call Psychiatrist¹⁴

For the most part the progress note written by the on-call psychiatrist re-stated the historical behaviors that led up to the adolescent presenting to BRH. From his meeting with the adolescent, however, the adolescent was described as alert and calm, with no evidence of psychosis, visual or auditory hallucinations. The psychiatrist wrote toward the end of his note that "[Patient] has exhausted family & community resources, needs hospitalization for stabilization & treatment."

9.8. Psychiatric Evaluation Written by BRH On-Call Psychiatrist

Under "Mental Status Exam," the psychiatrist described the adolescent during the interview as "alert and calm." He wrote "...does not display evidence of psychosis...denies auditory and visual hallucinations...denied all allegations of violent behavior...denied suicidal and homicidal ideation." Under "Assessment" the psychiatrist wrote:

This patient with autistic disorder has a history of escalating oppositional and violent behavior, such that he has exhausted family and community resources. He needs hospitalization for stabilization and medication treatment.

The psychiatrist went on to include in his assessment:

Need for intensive supervision and special education. Failed outpatient treatment. High intensity needs adolescent. Limited family resources.

Under "Plan" the psychiatrist wrote "...have the patient transported by security escort to API immediately under a POA order, due to danger to himself and others."

¹⁴Based on interviews with the adolescent's mother and review of the mental health evaluation conducted by Cornerstone staff, it was learned the on-call psychiatrist had treated the adolescent for approximately 2 years, but had not had contact with him for 9 or more months prior to this encounter.

The psychiatric evaluation was electronically dated February 21, 2009, with a time of 11:06 a.m.

10. Review of “Guard Escort Authorization to API, DET Hospital or Other Hospital Approved by API/DBH” Form

DLC reviewed the two-page document referenced above. Under a section entitled “Additional Information Required as Applicable” were two questions asking about the adolescent’s propensity for violence: “Does consumer have history of violence?” and “Is consumer violent at this time?”

The JAMHI clinician who completed the document indicated the adolescent did have a history of violence, but was not violent at the time.

Another section of the same document was entitled “Additional Guard.” The box for requesting an additional guard was checked. Under a sub-section for justification of the request was written: “Client is unable to monitor self and has been increasingly aggressive at home and in the community.”

The “escort gender requirement” was waived and “appropriate to have opposite gender guard” was written.

11. Review of “Policy & Procedures for the Secure Escort of Mental Health Consumers Who are Involuntarily Committed to API or Other Hospitals”

DLC reviewed the above document, written by the State’s Department of Health & Social Services and providing direction to Community Behavioral Health Centers (CBHCs). The last revision date was July 10, 2008.

Under a section entitled “Approved Guard Service” were the following points DLC found most pertinent to this investigation:

- When moderate risk is present or when there is no practical way for a CBHC staff member or a family member to escort the consumer, the local CBHC will authorize transport with an approved Guard Service.
- The MHP [mental health professional] must provide written authorization for a second guard specifying the specific clinical, safety, and or control concerns.
- The Guard Service will attempt to transport consumers without using restraints.
- When the consumer is presently at a hospital and is to be transferred to API or another hospital, federal law (EMTALA)¹⁵ requires that the transferring doctor

¹⁵ “EMTALA” is the acronym for Emergency Medical Treatment and Active Labor Act, also known as the patient anti-dumping law. In brief, the law governs what a Medicare participating hospital must do when a patient presents at their emergency department, and when and how an individual may be refused treatment or transferred from one hospital to another. See 42 U.S.C. § 1395dd *et seq.*

approve the transfer in a direct conversation with the receiving doctor. (footnote added)

12. Review of “Secure Transport and Escort Services Duty Log”

DLC reviewed various documents completed by staff of Securitas, the private company contracted to provide the escort services for the adolescent to API. One section of the document referenced above was entitled “Restraint Use.” That section stated:

Please document all use of restraints and provide a justification that includes the circumstances under which they are used, the type of restraint, the duration of the restraint, and the patient’s response. (NOTE: If a patient refuses to be restrained and is determined to be a danger to self/others, transport by a Peace Officer will be utilized to ensure the patient’s safety.)

For that section, Securitas staff wrote “cuffs & belt,” and nothing more. Under “Comments,” staff wrote “patient was cooperative.”

Another page with the same title (Secure Transport and Escort Services Duty Log) also had a section entitled “Restraint Use.” It had the same opening paragraph as found above. On this page Securitas staff wrote “cuffs, waist belt, patient was cooperative.”

13. Contact with Securitas¹⁶

DLC sent a letter to Securitas in September 2009, requesting their assistance and an opportunity to interview the escorts involved in this matter. Although DLC did not receive a written response to that correspondence, DLC staff were able to contact the local Securitas manager telephonically. The manager indicated his desire to cooperate with DLC's investigation, but stated he first needed to run it by his corporate office.

There was no subsequent communication from the local manager or any other Securitas employees, and phone messages left by DLC staff thereafter were not returned.

14. Review of Memorandum of Agreement (MOA) Between BRH and JAMHI

DLC staff reviewed a MOA between JAMHI and BRH. The MOA documented that its purpose was to delineate specific responsibilities and services for psychiatric hospitalization to be supplied by BRH and JAMHI.

According to the MOA,¹⁷ BRH was to:

- Notify JAMHI any time an Ex Parte' order is contemplated.
- Provide emergency medical management of patients, ensuring their physical well-being and that of others.

¹⁶ Following an initial release of this report, DLC was contacted by a representative of Securitas. In that correspondence, the Securitas representative informed DLC that the escorts were justified in the use of restraints (handcuffs) when transporting the adolescent, based upon his behavioral history. The representative went on to say that Securitas escorts use handcuffs with each transport so that they cannot be accused of "...handcuffing based on race, religion, gender, etc." The representative further reported Securitas escorts do not carry such things as pepper spray, do not have body armor and are not trained in defensive tactics.

In contrast to that statement, the Division of Behavioral Health's provider agreement for secured transport and escort services (Form 06-5896, Rev. 7/7/06) requires "Escorts must satisfactorily complete MANDT or similar training and documentation of that training must be submitted to the DBH Secured Transport & Escort Servicers Manager before their initial patient transport." According to its website, "The Mandt System® is a person-centered values-based process that was developed to encourage positive interaction with others. The concepts offered in The Mandt System® clearly promote respect and dignity for all people. There is emphasis on the team approach to ensure well-being and safety in both non-physical and physical interactions."

"The Mandt System® builds on skill development through a system of gradual and graded alternatives for de-escalating and assisting people, using a combination of interpersonal communication skills, conflict resolution strategies and physical interaction techniques. The goal is to assist others in managing themselves and the safety of all involved through skillful non-physical means. Physical strategies are also taught to provide additional 'least restrictive' options in the event the person poses a clear threat of substantial harm to self or others if physically unassisted." (<http://www.mandtsystem.com/mandtnew/articles/AgencyBrochure.pdf>)

¹⁷ Although the bulk of the MOA was copied into this report verbatim, sections believed not to apply to this investigation were omitted.

- Notify JAMHI of any mental health Ex Parte’ evaluations that may be required regardless of impairment by alcohol or other drugs.
- Provide psychiatric hospitalization for patients who are admitted on a voluntary basis, or who are admitted under Title 47.¹⁸ (footnote added)
- Provide an examination and evaluation of the mental and physical condition by a physician within 24 hours of admission.
- Provide stabilization, establishment of a psychiatric or medical diagnosis and the initiation of pharmaco-therapy with the goal of permitting the individual’s early return to the community for follow up.
- For admissions that are to be followed by JAMHI:
 - The Mental Health Unit social worker or designee will contact JAMHI within 72 hours of admission to coordinate treatment planning and define discharge criteria, involve the patient’s family or other providers as appropriate and consistent with goals set in the individual treatment plan (for voluntary admissions only).
 - The Mental Health Unit will provide the JAMHI with a copy of the Physician’s discharge orders or the Patient Discharge Instructions at the time of discharge. A discharge summary will be mailed upon completion, provided that a current release of information is on file.
- The Mental Health Unit will notify JAMHI of any proposed changes in BRH Mental Health Unit civil commitment policies and procedures prior to implementation.

The MOA documents that JAMHI agrees to:

- Provide either through contract or direct hire, a psychiatrist who will apply for admitting and treatment privileges at BRH and who will chare community-wide on-call.
- Provide qualified Master’s level or doctoral level mental health clinicians who will apply for Allied Health Professional credentialing at BRH in order to provide evaluation and consultation for emergency mental health response.
- Respond to calls for assistance within 15 minutes by telephone and within 30 minutes in person unless otherwise agreed to by the hospital staff member requesting response.
- Perform mental health evaluations on any patient for whom it is requested and complete hospital and court required documents.
- Provide consultation with Emergency Room physicians of if admission is indicated, the on-call psychiatrist.
- Follow all BRH policies and procedures, BRH Bylaws and Rules and Regulations of the Medical Staff, and the Civil Commitment Handbook (Dept. of Law; current edition).
- Coordinate with Mental Health Unit social worker and/or other staff for transportation of patients committed to Alaska Psychiatric Institute or other

¹⁸ Certain sections within “Title 47” of the Alaska Statutes delineate the requirements for both voluntary and involuntary admissions for mental health evaluation and treatment.

facilities outside of Juneau, through the JAMHI Policy for Mental Health Client Transport.

- Coordinate with Mental Health Unit social worker and/or other staff for secure escort of patients as needed to Title 47 court hearings and transportation of patients committed to Alaska Psychiatric Institute or other facilities outside of Juneau, through the JAMHI Policy for Mental Health Client Transport.

Summary and Analysis

The MOA between BRH and JAMHI outlines their respective responsibilities and what is to occur when someone arrives at BRH with a mental health emergency or is otherwise there seeking evaluation and/or treatment.

In brief, the MOA documents that if someone shows up at the hospital with mental health concerns, at the point in the hospital's evaluation that it is determined that a mental health emergency exists and/or involuntary admission for mental health services is contemplated, JAMHI is to be contacted. BRH is responsible to provide initial evaluation, both mental and physical health; services to stabilize; and hospitalization as needed. JAMHI, when notified, provides a mental health evaluation, and if the need for involuntary admission for mental health evaluation and/or treatment is identified, JAMHI staff provide and coordinate the services necessary to achieve such admission. This includes admission to facilities other than BRH.

15. Review of Draft BRH “Mental Health Unit Youth Admission Information” Notice

During the course of its investigation, DLC staff requested various BRH policies and procedures as they related to admissions, transfers and discharges of adolescents for mental health evaluation or treatment. One of the documents provided was entitled “Bartlett Regional Hospital Mental Health Unit Youth Admission Information.” Although “draft” was handwritten on the document, interviews with BRH staff supported the draft document was what occurred in practice.

The document read:¹⁹

If your child has been brought to Bartlett Regional Hospital due to a mental health emergency, he or she will first be medically evaluated by an Emergency Department physician to determine whether or not there is a medical problem that may be the source of, or a contributing factor to any mental health symptoms or complaints.

Emergency Department staff will then contact an Emergency Services on-call clinician for further mental health evaluation who will determine need for hospitalization.

¹⁹ Although the bulk of the notice was copied into this report verbatim, sections believed not to apply to this investigation were omitted.

Because Bartlett Regional Hospital's Mental Health Unit is a psychiatric unit for adults, and because there is no psychiatric unit in Juneau for patients aged 17 or under, if your child requires hospitalization the Emergency Services clinician will coordinate referral to Anchorage, or a facility in the lower 48 if necessary.

Due to the referral and travel process, if your child is unable to leave Juneau in an appropriate window of time, the Mental Health Unit at Bartlett will provide interim stabilization, pending transportation to an approved adolescent or youth facility.

If your child is admitted to the Mental Health unit, he or she will be placed in a patient room separated from the adult patient population, and will have a 1-1 hospital staff chaperone at all times.

The custodial parent or custodial agency representative will sign the necessary admission documents, and will also be able to specify approved visitors and phone contacts for the child. They will also work with the treatment team towards safe, therapeutic and time sensitive discharge.

Summary and Analysis

The information contained in this single-page document notifies a minor's parent or guardian that, if the minor presents at the hospital with a mental health emergency:

- The minor will be evaluated/screened medically.
- The minor will be evaluated for mental health concerns.
- If it's determined the minor requires inpatient mental health services, a referral will be made to a facility elsewhere in the State or the Lower 48 as there are no inpatient mental health services available to minors in Juneau.
- If transfer to an appropriate location cannot be accomplished immediately, the minor will be placed on BRH's Mental Health Unit, separate from any adult patients.
- Because that unit is for adults only, BRH staff will stay with the minor throughout the time the minor remains on the unit.

16. Interview with API Social Worker

DLC staff met with and interviewed an API social worker who had been contacted by staff at Cornerstone and/or JYS prior to the adolescent going to BRH. The social worker stated he had first been contacted on February 13, 2009, by staff at Cornerstone about the prospect of the adolescent being admitted to API. Cornerstone staff provided some basic information about the adolescent. The social worker reported he had requested a mental health evaluation occur prior to the adolescent seeking a medical clearance.

The social worker received another call from Cornerstone staff on February 17, 2009, providing some additional information about the adolescent. Upon hearing that the

adolescent was at home and attending school, the social worker remembered questioning whether or not the adolescent was truly in crisis for the purposes of an admission to API.

The social worker spoke to a different individual from Cornerstone on February 20, 2009. At that time the social worker, after having spoken to an API psychiatrist, directed the Cornerstone staff to have the adolescent go to BRH for a medical clearance, necessary for the adolescent's admission to API.

The social worker stated individuals who are admitted to API, especially those coming from another facility, are generally under some form of "legal status" such as "Ex Parte or POA." He stated that while it was not unheard of that an adolescent could be admitted to API as a voluntary admission, it was rare and only occurred on a space-available basis. The social worker went on to state this was because, given limited beds and other resources, API's primary mission was to provide services to those individuals who were in crisis and/or most in need of their services.

The social worker explained that API's admission criteria was that an individual either had to be determined to be "gravely disabled"²⁰ and/or pose a "serious risk of harm to themselves or others."²¹ The social worker went on to explain that another reason why most individuals entered API under some form of legal status was because, in order to meet admission criteria, it typically meant the individual was in crisis and/or severely decompensated. If the individual was able to come in voluntarily, it brought into question whether or not the individual truly met admission criteria.

The social worker explained that another reason for the individual to be under Ex Parte or POA status when traveling from another facility was, if they were coming voluntarily with the State paying for the travel, once the individual arrived they could just decide not to come to API. This, he explained, brought up some potential concerns about the State ending up paying for travel used for purposes other than those authorized, and issues concerning potential liability.

When asked if the required medical clearance could have been done somewhere other than BRH, and been accepted, the API social worker indicated going to the local hospital's ER was "the way it was generally done." He went on to say that, in most cases, this is occurring during a crisis and it's therefore difficult to get the medical evaluation done anywhere other than the local hospital's ER on such short notice.

²⁰ "Gravely disabled means a condition in which a person, as a result of mental illness, (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairments of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently." A.S. 47 § 30.915(7).

²¹ "Likely to cause serious harm means a person who (A) poses a substantial risk of bodily harm to that person's self, as manifested by recent behavior causing, attempting, or threatening that harm; (B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or (C) manifests a current intent to carry out plans of serious harm to that person's self or another." A.S. § 47.30.915(10).

17. Interview with API Nurses

DLC staff met with and interviewed two nurses, one who had met with the adolescent shortly after he was admitted to API, and one who met with the adolescent the following day. Both nurses remember the adolescent as not being aggressive or threatening, but calm and cooperative.

18. Review of Adolescent's API Records

DLC staff reviewed the adolescent's API records for this admission, and selected certain sections to include in this report. The adolescent was admitted to API on February 21, 2009.

18.1. Progress Note Day of Admission

7:15 pm – “[Patient] has been calm, and compliant with staff requests thus far...”

18.2. Legal Status Record

2/21/2009 – “Appin [Application] for Vol [Voluntary] Adm [Admission] form signed by Mother on behalf of minor.”

18.3. Multidisciplinary Assessment

The “Multidisciplinary Assessment,” dated February 22, 2009, indicated the adolescent's attitude was “cooperative” and “relaxed.” His mood was described as “calm/relaxed” and “indifferent.” And his affect was described as “flat/blunted.”

18.4. Certificate of Need for Hospitalization

API's “Certificate of Need for Hospitalization” was signed on behalf of the Licensed Independent Practitioner (LIP) and dated February 22, 2009. The reasons given for the adolescent's need to be hospitalized were:

- Local outpatient resources could not manage the crisis.
- The patient is dangerous to self and others without inpatient care. He needs medications with inpatient monitoring of medication administration and effectiveness.

Listed for the expected outcome were:

- Improve the patient's ability to self-manage impulsive and dangerous actions.

- Stabilize significant affective instability that is debilitating to the patient and determine recommendations for outpatient providers for maintaining safety and stability in the outpatient setting.

The certificate went on to state:

...Though the patient's initial assessed behaviors at API may differ from referral and collateral sources, continued inpatient observation and evaluation and further collateral information collection is necessary to ensure safety management for discharge, given that capable referral sources deemed the patient needed to be hospitalized at the peak of the perceived crisis and outpatient sources could not adequately manage this patient...

18.5. Admission Psychiatric Evaluation

Under the "Mental Status Examination" of the "Admission Psychiatric Evaluation," dated February 22, 2009, the adolescent was described as:

He is alert and oriented x4 [oriented to person, place, time and situation]. His speech was somewhat rapid and difficult to understand. He had a vocal tic which he reports that he is aware of and that it "bothers me a lot." His eye contact was very poor. His mood was anxious, somewhat irritable, but he engaged appropriately. His affect was congruent with his mood. His concentration was distracted. His thoughts were appropriate and intact and organized. He denies any auditory or visual hallucinations. No delusions or psychosis noted during the assessment. His memory is intact...

18.4 Summary of Guardian Ad Litem Contact With Minor

A guardian ad litem reviewed the adolescent's records and met with him on February 23, 2009, and determined the adolescent's placement at API was appropriate.

19. Review of API Admissions Policy & Procedures (P&P)

DLC reviewed a copy of an API P&P entitled "Admission of Patient," No. ASSESS-030-06, with an effective date of February 5, 2009.

The P&P stated that in order to be admitted the individual had to meet the definition of mental illness,²² as well as the “gravely disabled” or the “likely to cause serious harm” conditions discussed earlier in this report. In addition, there must be a determination that no less restrictive treatment alternative is available in the community.

The P&P goes on to state that individuals who meet the definition of having a mental illness as cited above, may be admitted on a voluntary basis without being gravely disabled or likely to cause serious harm whenever possible and as there is available space.

20. Review of Alaska Statute for Voluntary Admission of Minors to a DET

DLC reviewed the Alaska statute for the voluntary admission of minors to a designated treatment facility, of which API is one. The statute provides for the following:

- (a) A minor under the age of 18 may be admitted for 30 days of evaluation, diagnosis, and treatment at a designated treatment facility if the minor's parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,
 - (1) the minor is gravely disabled or is suffering from mental illness and as a result is likely to cause serious harm to the minor or others;
 - (2) there is no less restrictive alternative available for the minor's treatment; and
 - (3) there is reason to believe that the minor's mental condition could be improved by the course of treatment or would deteriorate further if untreated.
- (b) A guardian ad litem for a minor admitted under this section shall be appointed under AS 25.24.310 to monitor the best interests of the minor as soon as possible after the minor's admission. If the guardian ad litem finds that placement is not appropriate, the guardian ad litem may request that an attorney be appointed under AS 25.24.310 to represent the minor. The attorney may request a hearing on behalf of the minor during the 30-day admittance.
- (c) The minor may be released by the treatment facility at any time if the professional person in charge or the minor's designated mental health professional determines the minor would no longer benefit from

²² "Mental illness means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand..." A.S. § 47.30.915(12).

continued treatment and the minor is not dangerous. The minor's parents or guardian must be notified by the facility of the contemplated release.

21. Interview with Staff of Division of Behavioral Health (DBH) and Review of Statute Pertaining to Travel

DLC staff interviewed a staff member of DBH to determine whether or not the State might have paid for travel for the adolescent to API, had he been admitted as a voluntary admission. The staff member indicated the State would not pay for travel as a voluntary admission, and provided the following authority:

When a person is to be involuntarily committed to a facility, the department shall arrange, and is authorized to pay for, the person's necessary transportation to the designated facility accompanied by appropriate persons and, if necessary, by a peace officer. The department shall pay return transportation of a person, the person's escorts, and, if necessary, a peace officer, after a determination that the person is not committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility following an evaluation conducted in accordance with AS 47.30.715. When advisable, one or more relatives or friends shall be permitted to accompany the person. The department may pay necessary travel, housing, and meal expenses incurred by one relative or friend in accompanying the person if the department determines that the person's best interests require that the person be accompanied by the relative or friend and the relative or friend is indigent. A.S. 47 § 30.870

IV. Overview and Summary

Based on the information available to DLC through interviews and records, it was clear the adolescent was involved with multiple agencies and providers (i.e., Catholic Community Services; Cornerstone; JYS; his care coordinator). From at least early January 2009 (if not before) until February 21, 2009 when the adolescent was transferred to API from BRH, staff working with the adolescent noted the following:

- acting out and getting into fights at school;
- becoming increasingly defiant with authority at home, sometimes throwing things including furniture;
- brandishing a knife as a weapon at home;
- masturbating in public places;
- having to spend time more frequently at Cornerstone shelter due to the problems at home;
- smearing feces.

From records and interviews it was also clear that the adolescent's mother was getting frustrated and discouraged with her son's behaviors, and that the various providers did not believe community services were either working or proving adequate given the adolescent's behaviors and needs. The decision to send the adolescent to API was developed by consensus, and with the belief that API could provide the specialized treatment needed to effect positive change in the adolescent's behaviors, and hopefully his quality of life.

With this in mind, the providers noted elsewhere in this report began working together to develop a plan on how to get the adolescent transferred and admitted to API. On February 20, 2009, it appeared to those involved that the transfer and admission to API was coming together. All that seemingly needed to be done was to solidify the travel arrangements (i.e., mom and son to travel together to Anchorage) and to get the adolescent medically cleared at BRH. That understanding and those plans, however, changed dramatically when the mother, adolescent and advocate from CCS arrived at BRH's Emergency Department.

Unfortunately, the call from Cornerstone to the ER to inform them of the mother's pending arrival with her son never made it to the ER triage nurse. Whether or not this would have ultimately changed what followed is unknown, but still it was unfortunate the ER hadn't received the advance notice. As a consequence, and based on the information the adolescent's mother was providing to the triage nurse, the nurse assessed the adolescent as presenting with a mental health crisis. This triggered the provisions of the MOA between BRH and JAMHI.

The JAMHI clinician determined the adolescent met the criteria for admission to API, and confirmed API had agreed to admit him. Security was asked to observe the adolescent for fear of possible elopement and concern that his behavior might escalate. In anticipation of the transfer to API, the ER staff and JAMHI clinician sought to obtain a POA order. This appears to be based upon the belief that: a) the adolescent met the criteria for a POA; b) the belief that API would not admit the adolescent without either a POA or Ex Parte; and c) information that the State would not authorize (pay for) travel without either a POA or Ex Parte.

The JAMHI clinician made a determination that, due to the volatility between the adolescent and his mother, having her as an escort was not a sound idea. Further, a determination was made that JAMHI staff would not escort the adolescent. This left a State approved security company – Securitas.

Because Securitas could not provide a same-sex escort, the JAMHI clinician asked for two escorts. She believed this added extra protection to the adolescent and mitigated any appearance of impropriety in having a minor escorted by a member of the opposite gender. The adolescent was kept overnight at BRH on the Mental Health Unit (on a voluntary status), because the escorts could not arrive until the following day. Because BRH does not provide inpatient mental health services to adolescents, the adolescent was kept under one-on-one, bedside staff observation during the time he was in the hospital.

When the Securitas guards/escorts arrived the following day, they informed the adolescent's mother she would not be able to accompany them to the airport, placed the adolescent in a waistbelt and handcuffs, and left for the airport. When the JAMHI clinician asked about the handcuffs, she was told it was standard procedure.

The adolescent was flown to Anchorage, escorted by Securitas staff while remaining in the waistbelt and handcuffs. He was admitted to API on February 21, 2009, and his admission was changed to "voluntary" on February 23rd. The adolescent was discharged from API back to his home on March 27, 2009.

V. Discussion, Conclusion and Recommendations

It is noteworthy that so many providers worked together to coordinate services for this young man and his mother, and to develop a plan they collectively thought best to help alleviate his symptoms. It is unfortunate that there was a disconnect between BRH, JAMHI and the other providers, both in terms of communication and their respective understanding of the process for transferring an adolescent to API, and that this disconnect resulted in additional stress to the adolescent. Below are questions raised by the circumstances of this situation:

1. Did the adolescent need to have a medical clearance to begin with?

DLC could find nothing in either the State's or APIs policies and procedures, or in the Alaska Statutes, that requires some sort of medical clearance before an individual can be admitted to a DET, or API.

While DLC can appreciate the merits of obtaining such a medical clearance, and understands that there are certain requirements under EMTALA when an individual presents at the hospital with a mental health emergency, we could find no standalone requirement for a medical clearance in order to be admitted to API. Lack of requirement notwithstanding, this was clearly the expectation of API staff in order to admit the adolescent. Based on the e-mail from the JYS clinician, it also appears the directions were for the adolescent to be taken to BRH for the medical clearance.

Once the adolescent was taken to BRH, two things appear to have guided much of what happened next: the MOA between BRH and JAMHI and potentially the hospital's understanding of its requirements under EMTALA. The MOA dictated how the transfer to API was going to occur.

2. Did BRH have an obligation to conduct a medical and/or mental health evaluation of the adolescent under EMTALA?

According to Interpretive Guidelines established by the Centers for Medicare & Medicaid Services (CMS), when an individual presents at a Medicare participating hospital's (such as BRH) emergency department, the hospital must:

- provide an appropriate medical screening examination (MSE);
- provide necessary stabilizing treatment to an individual with an emergency medical condition (EMC) or an individual in labor; and
- provide for an appropriate transfer of the individual if either the individual requests the transfer or the hospital does not have the capability or capacity to provide the treatment necessary to stabilize the EMC (or the capability or capacity to admit the individual).²³

²³ See CMS Manual System, Pub. 100-07 State Operations Provider Certification, Transmittal 46, dated May 29, 2009.

As may be seen above, once the adolescent presented at BRH's emergency department, the hospital had an obligation under EMTALA to conduct a medical screening examination to determine whether or not an emergency medical condition existed. An emergency medical condition is defined as:

- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part.²⁴

Based on information obtained by DLC through interviews and record review, the adolescent did not present to BRH with either acute medical symptoms or acute mental illness symptoms. Therefore, DLC determined the hospital had no obligation under EMTALA to stabilize or transfer the adolescent following their screening.

3. Did the adolescent meet API's admission criteria (i.e., likely to cause serious harm; gravely disabled; no less restrictive treatment alternative available in the community)?

Based on the information available, DLC accepts that all parties believed the adolescent met API's admission criteria.

4. Did the adolescent have to be admitted to API under either a POA or Ex Parte if he was willing to go voluntarily?

Based on the interview with the API social worker, the e-mail from the JYS clinician, and the State's policies and procedures for authorizing (paying for) travel, it appears admission to API under a POA or Ex Parte was clearly the expectation of API. And even if a voluntary admission would have been acceptable (it does not appear it was ever discussed or considered), it does not appear the State would have authorized travel.²⁵

API's expectations or requirements and authorization for travel notwithstanding, it appears as the adolescent met the statutory criteria that would allow for a voluntary admission to API, and thus could have been a voluntary admission. That criterion again is:

- the minor's parent or guardian must sign the admission papers;

²⁴42 U.S.C. § 1395dd(e)(1)(A).

²⁵ DLC was unable to determine how or why a Prior Authorization (PA) was issued at the time when it was believed the adolescent was to be a voluntary admission to API.

- in the opinion of the professional person in charge, the minor is determined to be:
 - gravely disabled or is suffering from mental illness;
 - and as a result is likely to cause serious harm to the minor or others;
- there is no less restrictive alternative available for the minor's treatment; and
- there is reason to believe that the minor's mental condition could be improved by the course of treatment or would deteriorate further if untreated.²⁶

5. Did the adolescent meet the criteria for a POA?

To answer that question we must first remember that a POA is to be sought over an Ex Parte only when the individual initiating the POA "...has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700..."²⁷

Based on all of the interviews as well as records from BRH and JYS/Cornerstone, DLC does not find sufficient evidence to indicate the criteria set forth in statute for a POA had been met (i.e., "...of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700..."). For example, records showed a progression of the adolescent's behaviors over the course of 1-2 months prior to him presenting at BRH. Contemplation of admitting the adolescent to API for additional evaluation and treatment had occurred at least one week prior to him presenting to BRH, if not much earlier than that. Nothing from the records nor the interviews indicated the decision to have the adolescent go to API on that particular day (February 20, 2009) was brought about by a precipitating crisis or exacerbation of his behaviors.

Neither the records nor interviews with the mother or professional staff showed the adolescent was in acute crisis when he presented to BRH. Furthermore, based on the interview with the physician who signed the POA, he had neither seen the adolescent nor could he remember anything about the adolescent that resulted in his ordering the POA. The absence of a crisis is further evidenced by the fact that the adolescent was admitted to BRH's Mental Health Unit as a voluntary admission.

²⁶ A.S. § 47.30.690.

²⁷ A.S. § 47.30.705.

6. Was it necessary for BRH to have security assigned to observe the adolescent when he first arrived, and staff assigned for one-on-one observation once he was admitted?

Based on the information available, DLC understands the basis for BRH's decision to have the adolescent observed by security shortly after his arrival. Specifically, BRH staff were being told that the adolescent had been exhibiting increasingly aggressive behaviors in the days prior to him presenting at BRH.

DLC accepts the explanation offered by BRH as to why there was one-on-one staff providing direct supervision while the adolescent was on the Mental Health Unit (i.e., it was an adult unit and staff wanted to ensure no adult had access to the adolescent).

7. Did the adolescent require two escorts?

The use of two escorts appears to have been solely because an escort of the same-sex was not available. While it doesn't appear that use of two escorts caused any harm to the adolescent, it does not appear that the State's criteria for the use of two escorts had been met.

8. Did the adolescent's behavior meet criteria for the use of restraints, specifically a waistbelt and handcuffs?

There is nothing in the BRH records or the documentation of the Securitas guards themselves that indicate handcuffs were necessary for the protection of either the adolescent or others.

Discussion

Based on the information available, it appears that prior to and leading up to his admission to API, the adolescent was exhibiting behaviors that were becoming more aggressive (i.e., throwing objects; brandishing a table knife); socially inappropriate (i.e., masturbating in public); and bizarre (i.e., smearing feces). Those behaviors were causing problems at school, at home, and were resulting in numerous temporary stays for the adolescent at Cornerstone. The mother had attempted to obtain services to mitigate or resolve those behaviors, but nothing she had tried was working. The service providers from multiple agencies, the adolescent's care coordinator and mother believed API had staff specially trained that could meet the adolescent's treatment needs, or at the least, stabilize him until he could be transferred to a treatment facility in the Lower 48.

For those reasons, the service providers sought to determine what was required in order for the adolescent to be admitted to API, to take the necessary steps and accomplish the necessary tasks. To that end, JYS staff initiated communication with API staff and conducted a mental health evaluation. API staff ultimately agreed to accept the adolescent for admission, and agencies were working together to arrange for and have the State authorize travel to Anchorage for both the adolescent and his mother. Throughout this process, the adolescent's mother, staff from CCS, Cornerstone and JYS, as well as the adolescent's care coordinator were working under the premise this would be a voluntary admission.

On the day the adolescent, his mother and the CCS family support specialist went to BRH, a bed on the adolescent unit became available at API, API staff had indicated their willingness to accept the adolescent for admission, and all that was outstanding as far as anyone knew was to take the adolescent to BRH's ER and obtain a medical clearance for travel. It was for that reason and that reason alone that the adolescent and his mother presented at BRH; it was not due to a mental health crisis.

On arrival to BRH, however, it appears as though during the initial screening BRH staff perceived the reason the adolescent had been brought to the ER was because there was a "behavioral crisis," and that as a result of the crisis, admission to API was being sought. This belief seemingly kicked in the process established by BRH and JAMHI for psychiatric hospitalizations. From that point forward, the case was handled as it would be were it a mental health crisis. Not only did this dramatically change the way the process was being handled, but it also resulted in a POA order being signed by the BRH on-call physician. The plan of a voluntary admission was immediately set aside and a POA admission was put in its place. Not surprisingly, this sudden change in plans and the process itself further heightened stress levels already being experienced by both the adolescent and his mother as a result of the anticipated travel to Anchorage and API voluntary admission.

From the mother's perspective as well as some of the staff from other involved agencies, it appeared as though all of their efforts to arrange for a smooth, orderly and as much as possible, stress-free admission to API had been dashed by BRH and JAMHI staff. In addition to going immediately from a voluntary admission to an emergency commitment without explanation, security staff were soon brought on the scene and all other aspects of the process were seemingly dictated rather than discussed with the adolescent or his mother. Not only was the mother told she could not travel with her son, but she was told by the on-call physician that she couldn't take her son home at that point even if she wanted to. Soon thereafter her son was admitted to the BRH mental health unit under constant one-on-one supervision (it is important to note this was a voluntary admission and not a POA), only to leave the next day for API in a waistbelt and handcuffs and under the supervision of two security guards.

Based on interviews and other information obtained by DLC, it appears as though it was API staff's requirement that the adolescent be admitted under a POA or Ex Parte order. DLC also determined that the State would not have authorized and paid for travel absent a POA or Ex Parte order. DLC was unable to determine how or why a prior authorization (PA) for travel, which would have paid for the adolescent and his mother to travel to API, was issued when at the time it was issued the API admission was to be voluntary.

Based on interviews, it's clear that this young man needed some form of assistance, treatment or intervention to assist with the amelioration or elimination of his symptoms. Without such help, it appears likely that his behaviors would have, over time, continued to escalate thus raising the potential for self-harm or harm to others. It's also clear that those working with the adolescent, as well as his mother, believed the services available in the community had been exhausted and were not sufficient.

When DLC asked some of the individuals involved in the development of the plan as to why a transfer to another facility in Alaska besides API had not been explored, the response was because past experience in sending other adolescents with similar problems to other Alaska facilities had not resulted in positive outcomes. Further, other individuals who had been seen by some of the clinicians and who had gone to API for treatment had returned improved. Thus, API had a positive reputation and was therefore the desired treatment option.

Given API's limited resources, DLC concurs with API's self-identified need to focus its attention on people who meet the "dangerous to self or others, or gravely disabled" standards, and notes that those standards apply to adolescents whose parents are attempting to have them admitted. Although the mother's efforts to get treatment for her son at API are understandable, and her wishes were shared by many of the people involved in the process at the Juneau end, it is clear that the adolescent's symptoms or condition at the time he presented at the hospital were not of such an emergent or immediate threat to his or others' safety that a POA was appropriate. Accordingly, if after the initial evaluation it was still determined that admission to API was desired and appropriate, involuntary commitment proceedings should have been initiated or a voluntary admission should have been sought.

While DLC does not offer specific recommendations on how to alleviate this situation, this case does represent an example of the State's limited resources for both inpatient as well as outpatient treatment for youth whose needs are such that community mental health treatment options are insufficient to adequately resolve or mitigate their symptoms. This is an ongoing problem that especially frustrates the State's goal of "bringing the kids home" and keeping them in state to begin with.

Conclusion

Based on the information available, it appears the adolescent's mother and multiple service providers in the community came to believe the adolescent required and would benefit from an admission to API. Along with that process, a decision had also been reached that local services had been exhausted and that a less restrictive setting for treatment was not available.

Unfortunately, no one who had been working on the plan to have the adolescent admitted to API up to that point was aware of what his presenting at BRH would trigger. This clearly demonstrates a disconnect in communication between BRH, JAMHI and other community providers. Not only was this unfortunate for the adolescent and his mother, but it holds the potential of being repeated for other mental health consumers in similar circumstances.

While API staff effectively required either a POA or Ex Parte for admission in this instance, it appears a voluntary admission could have occurred.²⁸ Regardless, based on the information available DLC determined the statutory criteria for when a POA should be used was not present. Therefore, DLC determined the physician who signed the POA did so inappropriately and not in compliance with the law. Specifically, DLC determined the adolescent's mental state and potential to harm himself and/or others was not "...of such immediate nature that considerations

²⁸ Indeed the adolescent's admission to API was converted to a voluntary admission on the day of his arrival.

of safety [did] not allow initiation of involuntary commitment procedures set out in AS 47.30.700...”²⁹

Based on its investigation DLC determined:

- the experience of the adolescent during his evaluation at and admittance to BRH constituted neglect in its potential for injury.³⁰ For example, when the adolescent arrived at BRH with his mother, it was his understanding he was soon to be headed for Anchorage and API, accompanied by his mother. Instead, shortly after his arrival, he was asked a variety of personal questions by various strangers (e.g., about whether or not he was suicidal or homicidal; issues surrounding incidents of public masturbation and spreading feces); had to sit and listen to his mother telling these same strangers personal information (e.g., such as the subjects noted above); and was soon placed under the watchful eye of a security guard. The adolescent was then informed that he would not be traveling to Anchorage with his mother as was originally planned, but instead would be staying overnight on the hospital’s locked, adult mental health unit, and due to the risk of harm this posed to the adolescent, he was to be under the constant surveillance of hospital staff. The following day, the adolescent was sent to a place he had never been before (API), with strangers (two Securitas escorts), in handcuffs. It is DLC’s determination that this experience, which DLC believes could have been avoided, placed the adolescent at risk for emotional injury and/or trauma and as such constituted neglect. Securitas staffs’ use of restraints, namely handcuffs, was:
 - done knowingly, recklessly and intentionally, without justification;
 - contrary to the State’s policies and procedures;
 - in non-compliance with Federal and State regulations;³¹
 - and that such practice constituted abuse as a result of having placed the adolescent at risk for injury, mental and emotional harassment and physical or emotional harm.³²
- the on-call physician inappropriately signed a POA for the purpose of an involuntary admission to API, and while DLC did not have sufficient evidence to support a finding of abuse or neglect, it did determine the practice denied the adolescent the full measure of his due process rights prior to involuntary commitment for mental health evaluation and treatment.

²⁹ A.S. § 47.30.705(a)

³⁰ See 42 C.F.R. § 51.2 and 45 C.F.R. § 1386.19, pages 4-5 of this report.

³¹ Federal regulations for hospitals require that “All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. 42 C.F.R. § 482.13(e) Alaska’s regulations for hospitals state that patients have the right “...to be free from physical or chemical restraints except as specified in AS 47.30.825 or 7 AAC 12.258.” 7 A.A.C. § 12.890(a)(5)

³² See 42 C.F.R. § 51.2 and 45 C.F.R. § 1386.19, pages 4-5 of this report.

Recommendations

1. That the providers involved in this case meet to discuss the particulars of what occurred, analyze what occurred, and develop procedures for making a more coordinated process for the transfer of adolescents to API in the future. Ideally this would include identifying and inviting other providers who may be involved in such transfers, but were not with this particular transfer.
2. That as a result of such meeting(s), materials and training be developed and provided to the appropriate community members.
3. That special training be provided by the State, BRH, JAMHI or some combination thereof to educate or remind those who can issue a POA what the law requires.
4. That API reexamine its informal policy and/or practice of requiring minors come to its facility through a POA or Ex Parte only.
5. That the State take whatever action is necessary to ensure its authorized contractors for escort services are educated about and comply with the requirements for the use of restraints, as well as the contractual requirement for escorts to be trained in alternative methods of de-escalation and behavior management.
6. That the legislature re-examine A.S. 47.30.870, the statute that restricts payment for travel to a designated treatment facility to only when the individual is being involuntarily committed.