DMH 5150 Evaluations – Lack of Beds / Emerging and Escalating Crisis

At our last Department of Mental Health / Regional Center MOU meeting on 1/22/07 at East Los Angeles Regional Center, Irma Castenada (Chief of the Emergency Outreach Bureau for DMH) revealed that DMH had received 400 phone calls in the month of December, resulting in 222 holds (roughly 50%) for the general population, including regional center.

It was also revealed that 25 calls did not have any response for a hold due to a lack of available psychiatric beds. San Gabriel Pomona Regional Center and South Central Los Angles Regional Center each had a client that was part of the 25 calls that were not assessed by Department of Mental Health.

Due to the closing of psychiatric beds at Martin Luther King Hospital (although 30 beds were obtained in the private sector) there were no available beds to place clients who called in crisis. DMH has four county hospitals and in the past would rotate between hospitals, however when there are no vacancies, there is no assessment since there will be no destination to transport the client. DMH is not sending teams to assess clients when it does not have a destination for the client. DMH will provide crisis stabilization and may recommend calling Law enforcement since they can transport to a medical hospital emergency room. Regional center is treated equally in denials for assessment, along with the rest of the mental health population when there are no psychiatric beds available.

Law enforcement has an average of 800 holds per month (four times the amount of DMH), but can transport to any Medical Center, whereas DMH will only transport to a psychiatric hospital. Medical centers cannot write the hold, but can temporarily house a client for 23 hours and 59 minutes, while waiting for DMH to transport to an available psychiatric bed. If there are no psychiatric beds, the patient is not admitted, but remains waiting at the emergency room for assistance. Some police "drop offs" and "walk ins" at medical hospitals are remaining in hallways when medical beds for medical emergencies take precedence over a psychiatric crisis. Regional center is getting calls from hospital emergency rooms about picking up "their clients" who are left at medical hospitals when there is no psychiatric bed available. Some vendors are dropping off clients at medical hospital emergency rooms when they have a behavioral or psychiatric crisis.

The limited number of IMD beds (locked long-term placements for mentally ill) are remaining occupied longer and stabilized patients are having longer stays in psychiatric hospitals while awaiting an appropriate discharge placement. The back up of clients waiting for placement has decreased the number of active available psychiatric beds.

When all four of the county hospital's psychiatric beds are occupied, DMH must call private psychiatric hospitals with contracted beds to determine if there are any vacancies. Private hospitals do not have the same obligation as county hospitals and discussions before and after the MOU meeting determined the following information about why there is a crisis with regional center clients being placed on a hold and obtaining psychiatric beds.

Group discussions with liaisons before and after the meeting determined the following factors affect the availability of psychiatric beds:

1) **Time of day** (after 3 pm, the beds begin filling up (children return home from school, parents and adults begin returning from their jobs, regional center clients begin returning from their day program.) and crises across the county result in beds quickly becoming unavailable. By 5 p.m. and on weekends, it may be extremely difficult to find an available psychiatric bed and/or obtain an assessment for a 5150, except by law enforcement.

2) **Acuity**: If a private psychiatric hospital is near full or has many clients with significant and difficult behaviors (as opposed to passive behaviors such as being depressed) a private psychiatric hospital may choose not to admit additional clients to its unit if the new admissions are perceived as requiring significant care beyond their staffing capabilities for the acuity of their unit.

3) **Financial Impact** 1:1 requirements for patients are extremely expensive and a financial drain on hospitals. If the hospital census is low, a $20/hr ($480/day) in-house staff person may be used, but when the census is high and no in-house staff person is available, the nurse registry can charge up to $60/hr ($1440/day) in addition to the fixed and variable costs of serving a patient in the hospital. Medi-cal has a low flat rate of $570/day, which for psychiatric hospitals only covers basic costs and is used as "filler beds" to supplement private insurance and government contracts.. Medi-cal doesn't reimburse for the cost of the additional 1:1s. When an incoming patient is perceived as needing a 1:1, hospitals will be less inclined to accept the patient. Additionally, 1:1 clients tend to be harder to place and after medical necessity has been met, the $374.75/day administrative rate, ($380 effective August) guarantees the hospital loses money on the patient stuck in the unit and loss of future income from full-paying patients (private insurance and government contracts.)

4) **Placement**: Private psychiatric hospitals are increasingly having extended stays (weeks / months) by clients who are stabilized, but without placement. Some clients may be declined for admission when it is perceived there is no placement for them after they are stabilized. Private hospitals do not want to lose money on clients who take up active treatment beds and are forced to accept only paid "administrative days" while active treatment clients are turned away due to a lack of beds.

5) **Reputation**: Some clients are declined psychiatric beds due to poor agency response in treatment, placement coordination and payment. Unfortunately, this "bad reputation" includes some regional centers who have clients without placement, in private hospitals for weeks and months after their stabilization.