

Lack of Access to Behavioral Health Care Forcing Unnecessary Emergency Department Gridlock

The Issue: New Jersey emergency departments are facing a critical breaking point. Providers are attempting to address overcrowding and excessive holds of the increased number of psychiatric patients who are being left to wait for days to access services.

- Recommendations from the Governor’s Task Force on Mental Health in March 2005 focus on shifting care for patients to a least restrictive, community-based model, however those services are not yet available, nor is there a reasonable expectation that they will be on line in the near future. The recommendations date back almost four years, and plans addressing the system of acute care have just begun, absent any significant background information to help drive decision making. There has been no systematic approach to statewide planning based on data.
- There is no resolution on any of the assurances made over the past three years by the state’s leadership to implement systems that will support patients who are being warehoused in emergency departments for excessive periods of time. An NJHA survey conducted in 2007 showed that both children and adults, on average, wait in the emergency departments for 24 to 48 hours awaiting transfer to an appropriate level of care, while some patients can wait as much as 8 to 10 days for transfer to another facility. More recently, NJHA conducted a 24/7 Fast Fax study to capture information relative to excessive emergency department holding of patients in need of behavioral health services. Key demographic information was gathered for psychiatric patients who remain in the emergency department at 12 hour intervals. In one four week period, participating hospitals reported that there were more than 1,300 episodes where a patient was made to wait more than 12 hours. Of those episodes, more than 93% waited at least 48 hours, with others waiting even longer.
- There is a lack of communication between state agencies responsible for coordinating services to the mentally ill, and the spillover effect impacts the acute care system. Providers are consistently receiving conflicting messages regarding policy, and patients suffer as a result. For example, while the Division of Mental Health Services has assured NJHA that there is no cap on admissions to the state psychiatric facilities, those responsible for admissions at Ancora Psychiatric Hospital have advised that there is a daily cap on admissions, and a “no admission” policy on the weekends. There continues to be inconsistent practices in medical clearance, and providers are deflected from one state facility to another during evening hours and on the weekends. Providers, although well intended, cannot provide quiet, stabilizing care for the mentally ill when they are forced to hold at times dozens of patients seeking care for their psychiatric or substance abuse issues.
- A very high percentage of those entering emergency departments in need of mental health services have a co-occurring need for substance abuse treatment. When a patient presents at the emergency room to detox and the patient does not meet the medical criteria for an inpatient bed, the patient has three options: (1) Go into a sub-acute care bed

and pay out of pocket, (2) go into a sub-acute care bed that is subsidized by a county contract, or (3) detox in the emergency room. Because there are a limited number of subsidized sub-acute detox units in the state, many patients are presenting and remaining in the emergency departments for this care.

- The bifurcated system of care for the mentally ill does not provide for consistent policy and practices when addressing the needs of children, adolescents and adults. There is little training for screening professionals in the area of the needs of children, adolescents or the developmentally disabled, and the requirement to work with these populations is viewed as another unsupported, unfunded mandate.
- Hospitals have an ethical obligation to treat patients with dignity. Providers are unable to meet that responsibility when they are forced to hold patients in an emergency department for days at a time, when an individual should be cared for in a different setting.

New Jersey's behavioral health patients and the state's hospitals seek legislative support for the following priorities:

1. Require DMHS to develop standardized admission processes and medical clearance criteria for admissions to state psychiatric facilities, county facilities, and those specifically earmarked for the forensic population, which is part of a centralized admissions function that operates 24/7, including weekends.
2. Establish a time frame in which DMHS is responsible for implementing a mechanism to map behavioral health needs throughout the state, taking into consideration projected patient care level needs and availability of services. This mapping will facilitate the development of systems that will help move patients through the system of care to address their needs most appropriately. This mechanism should have measurable goals, timeframes for implementation and defined outcomes based on clinically recognized best practice.
3. Require DHSS, in conjunction with DMHS, to release calls for psychiatric beds, based on a nationally benchmarked methodology, according to a standing calendar, no less than every six months.
4. Commission a panel of mental health leaders, led by experts outside of state government, that will identify the issues that consistently plague the acute care system for mental health and, based on clinical best practices, provide oversight to assure that the priorities identified are tied to realistic plans of action with measurable goals, outcomes and timeframes for implementation.
5. Establish child screening legislation that sets forth requirements for consistent, appropriate screening and assessment supported by meaningful education and training for specialists in this field.