INADEQUATE ACCESS TO ACUTE PSYCHIATRIC BEDS IN BRITISH COLUMBIA

Is Anybody Listening?

Joint Report, October 2019
BC Schizophrenia Society and BC Psychiatric Association

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EXECUTIVE SUMMARY

Timely access to psychiatric beds in acute care hospitals is an essential and critical service for people suffering from serious mental illness—sometimes with a concurrent substance use disorder—who cannot safely or appropriately be treated as outpatients. The British Columbia Schizophrenia Society (BCSS)[1] and the British Columbia Psychiatric Association (BCPA)[2] often hear serious complaints about these bed shortages, hence this report.

The purpose of this project was to examine and bring to light some of the most familiar and troubling elements of the health care system for British Columbians dealing with chronic and severe psychiatric illness.

Methodology included a questionnaire for families and others, input from emergency room physicians, coroners' reports, literature, input from a Canadian authority, and discussion within the joint BCSS-BCPA group.

Good community services and resources for people with mental illness are essential. But while these may reduce the overall need for hospitalization, they *cannot* replace acute inpatient care for persons who must be involuntary admitted to hospital under the Mental Health Act, or for voluntary patients who need hospital care to address risk of danger to self or others, illness relapse, crisis situations, complex concurrent (substance) disorders, physically caused psychiatric symptoms or medication changes. Without access to hospital beds in psychiatry, serious harms can occur to the ill person and to those who care for them and about them.

In an 11 year period there was a 29% increase in psychiatric admissions and an increase in the population but no increase in beds. A shortage of access to psychiatric beds can result in long and disruptive stays in the Emergency Room, premature discharge and other problems.

Indicators of inadequate access include emergency room "boarding", increased patient numbers in a set number of beds, high rates of involuntary admission crowding out voluntary admissions, very high occupancy rates, use of non-psychiatric beds, high levels of acuity, discharge to homelessness, and relapse after a short hospitalization.

The number of acute beds can be assessed using the indicators above but authorities recommend approximately 50 publically funded beds per 100,000. Acute geriatric, child and youth, and beds for those with psychiatric symptoms associated with brain injury and other conditions also need to be addressed.

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[1] bcss.org

[2] psychiatrybc.ca

We recommend that Ministry of Health ensure that the current *Needs Based* approach address this report. Health Authorities in conjunction with the Ministry should apply the indicators of bed inadequacy identified in this report, with an urgent concomitant focus on supported housing to improve hospital discharge planning and maintain patient recovery and wellness.

INTRODUCTION

Timely access to psychiatric beds in acute care hospitals is an essential and critical service for people suffering from serious mental illness—sometimes with a concurrent substance use disorder—who cannot safely or appropriately be treated as outpatients.

> *"The day after police took him to the hospital under the Mental Health Act, he fled the hospital, but police apprehended him again and took him to a different hospital with a more specialized level of care. After three days waiting for a bed in the psychiatric unit, he was found dead in a staff bathroom. He had died by suicide."* [3]

The British Columbia Schizophrenia Society (BCSS) and the British Columbia Psychiatric Association (BCPA) often hear complaints from patients, their families, the police and others that there must be a shortage of acute care psychiatric beds in BC because of unacceptable practices including:

- Patients with psychotic illnesses wait in the emergency room for an inordinate amount of time
- Patients are kept in an unlocked "Quiet Room" or seclusion room, not because they require it, but because it is the only space available
- Patients are sometimes kept on gurneys waiting for a bed
- Patients are not admitted to a psychiatry bed but to some other, less-than-ideal available bed in the hospital
- Patients are not admitted because there are no available beds even though their physicians believe admission is necessary
- Patients are being discharged very soon after admission—prematurely in the opinion of some—because of a shortage of beds in psychiatry.

The BCSS and BCPA formed a joint Acute Care Bed Group to examine the issues and prepare a report with analyses and recommendations for government, health authorities and concerned others. Emergency room physicians who experience the consequences first hand were also consulted.

[3] Andrea Woo, *Globe and Mail*. Published August 23, 2015 Updated May 15, 2018. Numerous researchers, academics and journalists. E.g., https://vancouversun.com/news/local-news/mental-health-gap-in-b-c-psych-beds-dwindle-as-community-supports-struggle-to-keep-up
https://med-fom-ubcmj.sites.olt.ubc.ca/files/2015/11/ubcmj_1_1_2009_25-26.pdf

A Co-President of the Emergency Medicine Section wrote:

> *"I applaud your efforts to raise this issue that is too often not addressed…. and unfortunately seems to get worse every year, to the detriment of our mentally ill patients."* [4]

Research for this report examined the following questions:

- Who needs hospital acute psychiatric care?
- What are the effects of the lack of timely availability of these beds?
- What are the key indicators of acute psychiatric bed shortages?
- Where do acute beds fit into the mental health care system?
- Could other resources facilitate a more appropriate use of acute beds?
- How many acute beds are needed?
- What recommendations flow from this analysis?

[4] Letter to Alan Bates from Steve Fedder, 11/13/2018

METHODOLOGY

In examining this issue, we:

- developed, distributed and analysed a questionnaire for families, patients and friends who have direct experience with hospital admission to psychiatry, often through the emergency department (over 100 responses received);
- interacted with emergency room physicians who are on the front line, and who often must restrain and retain patients in the emergency while waiting for a bed in psychiatry;
- examined available relevant statistics;
- utilized the experience of psychiatrists and others in the BCSS/BCPA group on this issue;
- examined BC Coroners' reports of deaths possibly associated with bed shortages;
- discussed possibilities for acute beds to be used more efficiently (e.g., provide alternatives for people needing some hospital-level care and support that might be provided in a residential care setting); and
- examined the literature and spoke with a Canadian authority on bed numbers to set recommendations regarding acute psychiatric care bed numbers in British Columbia in the context of the broader system.

WHO NEEDS ACUTE PSYCHIATRIC CARE IN HOSPITAL?

Psychiatric acute hospital admissions comprise a significant portion of overall hospital care. For example, in 2016/2017, there were 38,139 discharges from psychiatric units involving 26,663 individuals. Of the total number of discharges, 17,656 were "voluntary" patients, and 20,483 were patients admitted under an "involuntary" status. (Ombudsperson's report)[5]

Some people think that if there were adequate community and residential services for psychiatric patients, there would be no need for psychiatric beds in hospitals. However, this is not the case. There are many instances requiring the use of inpatient psychiatric beds in general hospitals— cases that cannot be managed on an outpatient basis. These include the following:

Voluntary Admissions

Voluntary admissions occur when a patient capable of making a decision to be admitted needs to be hospitalized for psychiatric treatment and the physician agrees that admission is required. The person admitted is free to leave hospital at will, unless two physicians change their status to involuntary.

Voluntary admissions address the following situations:

- Danger to self (e.g., suicidal) or others but able to consent to admission and treatment
- Relapse that cannot be remediated without a hospital stay—sometimes caused by failure to take medication as prescribed or by medications that may have become ineffective or intolerable
- Crises, especially involving dangerous or bizarre public behaviours and/or family concerns
- Concurrent (i.e. substance-induced) or other complex cases that need diagnosis and treatment because they involve two or more disorders.
- Physical medical illnesses or injuries that relate to psychiatric symptoms and require urgent medical and psychiatric specialists for diagnosis and treatment.
- Medication changes are often required, especially during the first 10 years following schizophrenia onset. The delayed therapeutic effect of many psychotropic medications means that a longer acute care stay may be necessary to find the medicine that works

[5] Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act

best and produces the least side effect profile for an individual patient. There is no "one size fits all" medication. As well, trials of new medications for treatment-resistant conditions often require hospital admission. In fact, about 25% of people with schizophrenia do not respond to common antipsychotic regimens, and more creative treatment options must be trialed. Tapering medications that aren't working and starting a new medication can be fraught with complications for some particularly fragile patients, or for patients who don't have adequate community support to undertake these changes at home. Unfortunately, these patients are rarely admitted to hospitals now because they don't meet acuity level for admission. This means that the treatment of outpatients is also compromised by the lack of access to inpatient beds, as they are forced to either stay on the same problematic medication, or to try and change medications in a manner that is slower, riskier, and less successful than admitting the patient to hospital.

Concurrent (Substance Use) Disorders

People with mental illness presenting to the hospital in an intoxicated state have become much more prevalent in recent years. In the past, most people with substance induced psychosis would clear within a day in an emergency room, similar to those with alcohol intoxication. They would not be admitted to psychiatric wards but would be discharged from the emergency room. However, with the advent of crystal meth, the severity of the psychoses are such that patients require extended stays on psychiatric wards or in emergency rooms. They are not suitable for detox facilities.

These patients can be admitted voluntarily, but usually are not capable and must be admitted involuntarily. Irrespective of the mode of admission, they present unique problems requiring access to acute care beds, including:

- Evaluating the nature and extent of primary psychiatric condition once the patient is detoxified on the psychiatric unit. Traditional detox units are ill-equipped to manage patients with severe and persistent mental illness plus an addiction, and so tend to transfer patients out to emergency rooms for psychiatric assessment instead.

- Engaging patients in treatment when their insight is impaired by a substance addiction in addition to the mental illness. If there is less pressure to discharge patients, a longer period of abstinence in hospital helps with engagement in

treatment for both mental illness and addiction disorders. Longer stays in these situations may assist in breaking the addiction/detox cycle.

- Assisting patients with concurrent disorders to find housing. These patients are often homeless. Until their behaviour is more appropriate, they are unable to access appropriate housing. With extremely short stays in hospital, such patients are unlikely to be eligible for housing that can help them cope with their addictions and mental illnesses, leading to a constantly "revolving door" of admission and readmission.

Involuntary Admissions under the Mental Health Act

Involuntary admission occurs when it is established that a psychiatric patient requires hospitalization and is not able to leave hospital of their own free will. Patients must have been examined by two physicians and found to have a serious mental illness that requires psychiatric treatment in a hospital, and that they are *not* suitable as voluntary patients. A patient may require hospital admission to protect themselves and/or others from danger or other harms, including substantial mental or physical deterioration. Such cases currently constitute the majority of admissions.

HARMS ASSOCIATED WITH BED SHORTAGES

Lack of access to acute care psychiatric beds can lead to very negative effects for the patient, and significant stress for family members and professional staff who must try to manage difficult behaviours in the community because beds are not available. If a person who needs inpatient psychiatric care does not receive it because of delays, or denial of entry, or premature discharge—the resulting harms can include the following:

- Worsening of symptoms (depression, delusions, hallucinations)
- Suicide (under-treated depression, schizophrenia, bipolar, etc.)
- Poorer prognosis (more likely to relapse)
- Premature death related to medical comorbidities
- Violence to others, most often close family members
- Non-violent crimes (public nuisance charges, petty theft, dine-and-dash)
- Incarceration and burden on the courts and the criminal justice system
- Family disruption and burden on family caregivers
- Increased burden on community health professionals, police, paramedics, and other first responders.

INDICATORS OF INADEQUATE ACCESS TO ACUTE PSYCHIATRIC BEDS[6]

Indicators of inadequate access can be derived from the negative effects for patients, for the care system, and for the community. These key indicators can be used by managers to assess actual bed needs.

1. Misuse of Emergency Departments

Without access to psychiatric beds, it is inappropriate and unpleasant for psychiatric patients to be held in the emergency room, sometimes strapped to a gurney. They are not receiving the treatment they need in a timely manner. If they are agitated, it can upset the other patients in the emergency room who are subject to shouting or other disturbing behaviours. Relatives and others supporting the patient are likewise distressed. Co-Chairs of the Doctors of BC Section of Emergency Medicine concur:

> *"It is not uncommon for multiple psychiatric patients to be in our [Emergency] department for up to 72 hours while awaiting a ward bed".*[7]
>
> *"As expected this ["emergency boarding"] very likely prolongs their stay in hospital for a multitude of reasons, including poor sleep, lack of privacy, inadequate care spaces and spaces for activities of daily living (eating, washing and walking)".*
>
> *"As a full time Emergency Physician in Kelowna I completely agree with Dr Fedder's impression as being typical throughout the province."*[8]

Indicator: "Emergency room boarding" as measured by, for example, stays of more than 8 hours in the ER waiting for a bed could be used as an indicator of bed shortages.

[6] Adapted from O'Reilly, R., Allison, S., and Bastiampiallai, T. Observed Outcomes: an approach to calculate the optimum number of psychiatric beds. Vol.:(0123456789)1 3Administration and Policy in Mental Health and Mental Health Services Research https://doi.org/10.1007/s10488-018-00917-8

[7] Steven Fedder, Co-President, Doctors of BC, Section of Emergency Medicine, Nov 13, 2018.

[8] Gordon McInnes, Co-President, Doctors of BC, Section of Emergency Medicine, September 8, 2019

2. Access to Psychiatric Units: Same number of beds but increased number of patients

Pressure on acute psychiatric beds is illustrated in the Ombudsperson's report. Table 1 below shows that in 2005/6 the total (voluntary and involuntary) discharges were 29,500. Eleven years later in 2016/17 the total discharges were 38,139. This is *a 29% increase*—with no increase in beds. In fact with the closure of Riverview it could be argued that there was a decrease of acute beds.

Serving 29% more patients could have only been achieved with significantly shorter stays, possibly suboptimal.

Table 1. Discharges from Psychiatric Units: 2005 and 2016

YEAR	Voluntary Discharges	Involuntary Discharges	Total	Changes
2005/6	17,656 (estimate)	12,000	29,656	5,656 **fewer** involuntary (32% **fewe**r involuntary)
2016/17	17,656	20,483	38,139	3000 **more** involuntary (16% **more** involuntary)
Difference Over 11 years	No increase	8,483 increase (71% increase in involuntary discharges.)	8,483 increase (29% increase in total discharges)	Total increase 8,483 (29% increase in 11 years)

(From B.C. Ombudsperson's Report. Some figures are approximated from graphs.)

Indicator: Significant increases in the numbers of patients served in a set number of beds, especially in view of population increases, achieved through reducing length of stay can be an indicator of insufficient access to acute beds.

3. Increases in Involuntary Admissions vs. Voluntary Admissions

The desired status for patient admission is *voluntary.* Ideally, there should be a higher number of voluntary patients compared to involuntary patients. However, with insufficient beds, involuntary patients who *must be admitted by law* take precedence over patients actively seeking help. This appears to be happening in BC.

With numbers of involuntary patients increasing but numbers of beds staying constant, voluntary patients have a lower priority. The condition of some patients who are not

voluntarily admitted due to bed shortages almost certainly worsens, and they eventually have to be admitted involuntarily. They will then likely stay longer because they have become more ill. Some physicians indeed may prioritize them for admission by certifying them as involuntary patients— a less than desirable solution. Other ill patients are simply turned away and not admitted, being told by staff, "Sorry. We have no beds."

Indicator: A high ratio of involuntary to voluntary patients indicates that there may be insufficient beds for voluntary patients.

4. Occupancy Rates in Psychiatric Units

According to the Royal College of Psychiatrists in the UK, occupancy rates on psychiatric units should be 85% or less in order to have optimal functioning of the unit. .

Occupancy rates of more than 100% indicate that all beds in the psychiatric unit are full and psychiatric patients have to be admitted to non-specialized wards.

For example, the hospital in Prince George almost always has psychiatric occupancy rates over 100%, indicating a lack of access to acute psychiatric beds. Overcapacity protocols are often in place on psychiatric units around the province of BC.

When occupancy rates in psychiatry are very high, patients may be "boarded" in the emergency room, producing the negative effects noted earlier. If there are beds available that can be utilized on other wards, psychiatric patients may also be admitted there, but they do not receive the treatment and care of a specialized psychiatric ward. Such patients will receive less than adequate care due to a lack of appropriate services. This can result in a longer than necessary stay or—ironically— a premature discharge due to full beds on non-psychiatric wards.

Indicator: Occupancy rates on psychiatric units should be monitored. Rates higher than 85% indicate that there may be insufficient access to acute psychiatric beds.

5. Level of Acuity on Inpatient Wards

With fewer acute care beds available, studies have shown increased acuity as indicated by more violence to nurses and others, and more need for restraints and seclusion. Everyone wants to minimize the use of seclusion and restraint, so this is distressing for patients and staff, and not conducive to providing a therapeutic atmosphere. There have been many concerns expressed in recent years about violence in the emergency room and on psychiatric wards.

As the level of acuity increases, it raises the question as to whether or not more specialized services need to be developed for patients who are chronically violent or who have extreme violence. Anecdotally, many psychiatrists are aware of patients who stay in general hospital for extended periods (up to years!) because their behaviour is not suitable for any other lower level of care.

Indicator: Level of Acuity on inpatient wards indicates insufficient access for people who have significant needs but are not "difficult" enough to warrant admission.

6. Discharges to Homelessness

When there is pressure to discharge because of high priority patients waiting for a bed, and there are too few feds, some patients are being discharged to homeless shelters. Discharging patients with chronic psychiatric illness to homeless shelters is an unacceptable level of care that has become standard practice—due to lack of access to acute inpatient psychiatric beds *and* the serious lack of residential and supported housing options in the community. As Dr Kane has noted:

> *"Despite the fact that physicians know that discharging patients to shelters is a very poor option for patient, these discharges occur because of the intense pressure on the acute inpatient psychiatric system."*

Homeless shelters can have many negative effects on the discharged patient and family. Such stressors are likely to induce psychotic relapses, leading to more distress for patients and more hospitalizations.

The chronically homeless *are* primarily people with serious and persistent mental illness. Not only do they have a higher likelihood of relapse and hospital readmission, their life expectancy is 20 years less than average.[9]

None of the recommended aftercare services for people with mental illnesses are available in shelters, aside from basic food and somewhere to sleep. Medication management is not provided as a routine. Although shelter staff do their best to help people with psychiatric illness, such facilities were not developed as mental health housing resources. But this is what they are expected to be these days—because "the system" has not developed the appropriate after-care residential and community resources for psychiatric patients.

Another issue not often mentioned is the demoralizing effect that discharging patients to homelessness or shelters has on hospital staff. When patients have been stabilized in hospital, and doctors, nurses and others know that their patients are being discharged to homelessness or shelters, it seems to be almost a wasted effort. Caring professionals realize they are discharging patients to a system that is almost certainly likely to make them worse and result only in readmission. One health authority psychiatrist described this issue as causing "a high level of moral distress" among professionals in his region, and that has resonated with many professional staff members across the province.

Indicator: *Discharge to homelessness* is more an indicator of inadequate residential and recovery resources for people with mental illness in the community—but it is an important statistic to follow.

[9] William Honer et al. The Hotel Study: Multimorbidity in a Community Sample Living in Marginal Housing. *American Journal of Psychiatry*. August 8, 2013. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2013.12111439

7. Readmission Rates

Insufficient hospital length of stay can result in early readmission—another likely indicator of too few beds. Hospital admissions and readmissions are not pleasant for most patients. People do not want to re-experience the pain and disruption to their lives and that of their families.

The current BC relapse and rehospitalisation rate is very high, suggesting inadequate bed availability. The BC Ombudsperson found that the average length of stay was 14 days for patients with the highest need (involuntary patients), so many other patients must have very short stays. The same report notes 38,139 discharges for 26,663 individuals in a one-year period—which indicates that in total there were *43% readmissions* within a year, including some people with more than one readmission. For involuntary patients the rehospitalisation rate was 37% and for voluntary patients 51%!

Indicator: Relapse and rehospitalization within a short period (3 months) indicate insufficient access to acute psychiatric beds.

8. Effects on Overall Hospital Functioning

One of the issues that emerged during our review was the fact that having psychiatric patients stay in hospital for much longer than average lengths of stay—i.e., months to years—means that the overall function of the hospital is being compromised. We have already mentioned the effect on emergency room overcrowding. However, when psychiatric patients have to be housed and treated on other wards, including medical wards, surgical wards, even maternity and paediatric wards at times, this means that patients with medical, surgical and other issues needing inpatient hospital care are compromised as it is more difficult to access beds for them.

While this issue has not been comprehensively studied, our review suggested that inadequate psychiatric care resources (both inpatient and outpatient) may be a factor in the current problems of overall hospital functioning.

Indicator: The numbers of psychiatric patients cared for in other nursing units (e.g. medical, surgical etc,) and measures of the disruption to the treatment of non-psychiatric inpatients.

9. Other Potential Indicators

The following have also been used as indicators of acute hospital bed shortages: Rates of suicide; rates of all-cause mortality; rates of crime and incarceration of people with serious mental illness; and burden on caregivers because patients could not be admitted or were discharged prematurely.

WHERE DO ACUTE BEDS FIT INTO THE SYSTEM? CAN OTHER SERVICES FACILITATE THE APPROPRIATE USE OF ACUTE BEDS?

Acute hospital psychiatric beds are part of a care system to help people with serious mental illnesses recover. The system includes:

Pre-hospitalization Services and Resources

Services and resources that keep people from needing hospital care in the first place—community mental health clinics, rehabilitation and recovery services, private psychiatrists and family doctors, supported housing facilities, cognitive assessment and remediation services, assertive community treatment, use of the BC Mental Health Act provisions for extended leave from hospital, etc. Use of pre-hospitalization services and resources should be at optimum levels to minimize the need for acute hospital beds.

However, as discussed above, even with the best outpatient services in the world there will continue to be a need for inpatient beds. People with serious psychiatric illness may relapse because they do not take their prophylactic medication. Many patients have serious cognitive deficits—a core feature of schizophrenia—which means they are unable to organize and perform ordinary tasks of daily living. Also, due to the very nature of brain illness, many patients suffer from *anosognosia*[10], which occurs frequently in both schizophrenia and bipolar disorder and prevents the ill person from recognizing or understanding that they are ill. In such instances, clinicians and family members, while persuasive, often cannot convince the person to take their medication.

Post-hospitalization Services and Resources

In order to have an appropriate place for hospitals to discharge a person *to* — there must be adequate residential options with evidence-based clinical and rehabilitation supports. These help to reduce readmissions and maximize the use of hospital beds.

- **Residential**. Without appropriate residential options for proper discharge planning, hospitals have the dilemma of having to keep someone in acute care who does not

[10] Anosognosia, also called "lack of insight," is a symptom of severe mental illness that impairs a person's ability to understand and perceive his or her illness. It is the single largest reason why people with schizophrenia or bipolar disorder refuse medications or do not seek treatment.

really need to be there. This in turn may prevent others from being admitted. But discharging a very vulnerable patient to a homeless shelter is something that many physicians who have a duty of care will not do. A range of residential resources and services is needed, from tertiary care to supported residential living.[11]

- **Supporting services.** Once an appropriate length of acute hospital stay has occurred and the patient is ready for discharge Services, the services needed to sustain improvement *are essentially the same* as those mentioned above in the Pre-Hospitalization section—all of which may prevent the need for hospitalization in the first place. Pre- or post-hospital, these are the supports that can help people with psychiatric illness live safely and with dignity in the community.

[11] BC Auditor General, May 2016. *Access to Adult Tertiary Mental Health and Substance Use Services.* www.bcauditor.com/sites/default/files/publications/reports/OAGBC_Mental_Health_Substance_Use_FINAL.pdf

HOW MANY ACUTE PSYCHIATRIC BEDS ARE NEEDED?

There has been a significant loss of psychiatric hospital beds in BC. Riverview Hospital, now closed, provided over 1,000 acute and tertiary care beds. Although a number of non-hospital beds were created with some of the Riverview funds, based on our review and first-hand experience, that number was far from adequate.

From an international perspective, which includes 35 advanced countries, Canada has the *29th lowest* number of beds per 100,000 population with approximately 30 beds per 100,000. By contrast, Belgium has the second *highest*, at 165 beds per 100,000 population.[12]

Alison et al, after reviewing a number of countries including results from jurisdictions that have increased acute bed numbers, conclude:

> *"These adverse effects [ED boarding, out of area admissions, and increased suicide risk in the community] may worsen as total bed numbers fall (below a range of 50-60 beds per 100,000 population for people with SMI)."*[13]

An important study published in the *American Journal of Psychiatry*[14] in 2013 on the tragic and dangerous situation of the mentally ill on Vancouver's Downtown Eastside prompted Vancouver's Mayor and Chief of Police to hold an emergency citizens' roundtable, and to call for 300 new hospital beds in the city of Vancouver. The Vancouver Police cited a substantial number of incidents where they escort people with mental illness to hospital, only to find them back on the street hours later.

BC Auditor General's Report

In May 2016, BC's Auditor General presented the important report on tertiary care previously referenced. The report concluded that the Ministry of Health and the Regional Health Authorities collectively *had not adequately managed access to adult tertiary care.*[15]

Although work was apparently underway, the Ministry had failed to establish clear, province-wide direction for access to adult tertiary care. And while there were some pockets of good

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[12] O'Reilly, R., Allison, S., and Bastiampiallai, T. Observed Outcomes: an approach to calculate the optimum number of psychiatric beds. Vol.:(0123456789)13 Administration and Policy in Mental Health and Mental Health Services Research https://doi.org/10.1007/s10488-018-00917-8

[13] Allison, S., Bastiampillai, T. Licinio J., et al. When should governments increase the supply of psychiatric beds? Molecular Psychiatry (2017) 00, 1-5. See also Canadian Psychiatric Association, Psychiatric Bed Levels, 1997

[14] William Honer et al. The Hotel Study: Multimorbidity in a Community Sample Living in Marginal Housing. *American Journal of Psychiatry*. August 8, 2013 https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2013.12111439

[15] BC Auditor General, May 2016. *Access to Adult Tertiary Mental Health and Substance Use Services,* page 6.

practice, it was suggested that the Ministry and the health authorities must be more proactive to meet the needs of British Columbians with serious and persistent mental illness.

Special Populations

In addition to identifying gaps in services for patients with significant needs, the Auditor General also described specific barriers to the 'flow' of chronic patients in and out of hospital and adult tertiary care as required. Many of the concerns noted in 2016 were similar to those of our current joint committee, as described earlier in this paper. So far as we are aware, the Ministry and health authorities have not yet publicly reported on adult tertiary care.

This report has mainly been concerned about general adult psychiatry. However, there are a number of special populations and issues regarding the numbers and types of acute psychiatric care beds that need to be addressed. These include:

- Geriatric and child/youth need for inpatient care
- Involuntary admissions
- The prevalence of serious mental illness in an area affects the number of acute care beds needed. e.g., Vancouver's Downtown Eastside

In addition, there are several other conditions with a high rate psychiatric disturbance where patients stay in acute care for a long time because residential facilities are not available. For example, the Auditor General's report indicated "there was no provincial strategy for ensuring that patients with acquired brain injury (ABI), developmental disabilities (DD) or those with a history of extreme violence or current high levels of aggressive behaviours, as well as serious mental illness and/or substance use, will be able to receive the services they need."[6] The Auditor General also noted that planning services for these individuals is challenging as "no single program area is responsible for developing resources to meet the needs" and "the exact number of these patients is unknown".[7]

One of the issues repeatedly found in our review was the significant lack of appropriate residential resources for mental health housing in the community. When patients must stay longer than their actual need for acute hospital care because there are no residential beds to discharge them to, it reduces access for others. In theory, if patients could be appropriately discharged to facilities with suitable levels of care and support, fewer acute beds would be needed. This raises the issue of the adequacy (or more correctly, the inadequacy) of the post-discharge system.

WILL INCREASING ACUTE PSYCHIATRIC BEDS ADDRESS THE PROBLEMS?

Results from a somewhat comparable jurisdiction to BC show that an increase in beds can address significant problems.

In South Australia a crisis in access to beds led the Government to increase acute beds.

> *"It is notable however that a 12% increase in publically funded hospital beds (above the threshold of 30 beds per 100,000 population) reduced average Emergency Department wait times to their lowest for over a decade, despite a continuing increase in mental health presentations to the EDs. …the state suicide rate reduced from 14.2 to 13.4 per 100,000 population in 2015. South Australia was the only Australian state to record a decline in their suicide rate during 2015"*[16]

Community residential beds use was decreased during this period.

[16] Allison, S., Bastiampillai, T., Licinio J., et al. When should governments increase the supply of psychiatric beds? Molecular Psychiatry (2017) 00, 1-5.

CONCLUSION

There is a serious lack of access to hospital acute psychiatric beds in BC. This manifests in long stays in emergency, too-high occupancy rates in psychiatry, patients being shunted to non-psychiatric beds, and inadequate lengths of stay. This results in high numbers of readmissions, poor outcomes, high levels of coercion, and dissatisfaction among patients, families, hospital and community care staff and referring agencies (e.g., police, housing authorities.)

Issues may differ between hospitals, but common contributing factors include a lack of targeted community mental health care for people with severe mental illness likely to need hospital admission, and, more urgently, a lack of suitable residential facilities and support services for discharged patients, especially those with complex or high needs.

There have now been multiple reports on calls for action on this issue but in our view, the problem is worsening and there is no obvious plan to address it.

RECOMMENDATIONS

Recommendation 1

The Ministry ensures that the current development of a "Needs Based Approach," addresses the issues raised in this BCPA/BCSS joint report. This should include recommendations regarding the number of acute psychiatric care beds required in BC. The need for essential support services to reduce admissions to acute care and to facilitate discharge to appropriate levels of residential, rehabilitation and ongoing clinical care should also be addressed. Planning numbers should cover the province and provide guidance on distribution, considering an area's prevalence of serious mental illness, and the special needs of people in the geriatric, child and youth, and involuntary admissions categories.

Recommendation 2

Health Authorities in coordination with the Ministries should collect statistics and develop solutions that relate to access to acute psychiatric beds using the following variables:

a) **After medical clearance, the number of hours patients spend in the emergency room waiting for a bed in psychiatry should be monitored**
b) **Numbers of patients sent to non-psychiatric wards**
c) **Occupancy rates for psychiatry**
d) **Long stay patients (over 30 days) who no longer need hospital care but have no other safe place to go.**
e) **Ratio of involuntary to voluntary patients**
f) **Discharges to homeless shelters or other unsatisfactory residential placements**
g) **Indicators regarding out-of-hospital community services access.**
h) **Patient readmission rate within 3 months.**

Recommendation 3

There should be an urgent focus on the development of supported housing in the community in all health authorities, so that people can be discharged to safe, appropriate mental health housing that includes life skills support and medication administration.

Recommendation 4

The Ministry of Health should respond to the Auditor General's report with concrete recommendations regarding patients with acquired brain injury (ABI), developmental disabilities (DD) and those with a history of extreme violence or current high levels of aggressive behaviours, as well as serious mental illness and/or substance use. This should include the creation of a specific group with responsibility for overseeing the development of services for these patients. This may include development of a psychiatric hospital in the province to deal with the most severely affected patients, as recommended by the Vancouver Police Department. Currently, many of those patients are inappropriately incarcerated, admitted to general hospitals, or on the street.

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APPENDIX

Comments from Respondents to British Columbia Schizophrenia Society *Access to Acute Psychiatric Bed Survey**[17]

1. From experience over the past ten years, it has seriously deteriorated. Doctors are way too busy. Too many patients now that the psych ward is in XXXX. The patients from other towns have NO support. I think it is a major problem. I have been told by the patients that it is a major drawback from feeling better. I think it is a major injustice when an ill person has to wait so long to be able to get help. It has to be a crisis at the time of seeing an ER doctor. My son would have usually calmed down by then only to return home and have another episode later or in a day or two. We found the staff were doing the best job they could for being so under-staffed.
2. For myself I needed to be hospitalized for severe bi-polar depression and every time I needed to be in hospital the doctor could never get me in because it is a small psych ward in XXXX and there are never enough beds. Finally I got in through emergency but I'm terrified of hospitals so it caused me extra anxiety having to sit in emergency.
3. Once you get help, it's hard to get your loved one back from the psych unit. Being certified not easy to get back in the care of your family.
4. Went well.
5. It is very difficult to get into an acute psychiatric bed even when the family knows that it is the best place for the individual. The family's wishes are not always taken into consideration. Try to be awake all day and then have an ear open at night to make sure that the child is not attempting suicide again shortly after leaving the hospital. The system is broken and it needs to be fixed. Although I personally do not have an answer there has to be one.
6. There are never enough beds. There is seldom room in a long-term facility for them to be sent to. It particularly disturbs me that my son has been discharged to homelessness several times. How is he supposed to recover if that happens? Staying with me is no longer an option as he has developed severe addiction problems and I do not feel safe living with someone half my age and twice my size who becomes aggressive on meth.
7. Sad, but staff were kind and doing their best.
8. The access is good for those admitted. But, there does need to be contact with family member before person is discharged. I believe that there does need to be contact with family member/or counsellor to consult on client's care or diagnosis while in Psychiatric ward especially when person is from First Nations community. And type of medication client has been prescribed.
9. When it comes to drugs it is just not there.
10. It leaves the patient worried and fearful and the caregiver a feeling of hopelessness. It is heartbreaking when there is a loved one that is in medical distress and there is no immediate help available and at times it can be frightening because as a caregiver you are left to deal with a situation that needs the help of a good medical team of doctors and professionals that are educated and experienced in mental health and addiction. Family and friends can provide love

[17] *Identifiers have been redacted.

and kindness but cannot provide the expertise needed to meet the health issue itself, leaving the patient and caregiver in a vulnerable and unpredictable situation until a bed is available.

11. See details in my previous answers. After 8 months of trying very hard to get my son care, I became exhausted, moved 15 min away from him. I limit my access to my so I can keep my own mental health. Sad but true.
12. I feel there is a huge shortage I found a lot of people that are homeless with no place to stay took up space for mental health there is always a waiting g list which tells me there is a huge problem. When it comes to beds there is a shortage as well as a shortage on mental health help lack of professionals
13. XXXX is in need of psychiatric beds and the XXXX XXXX is in need of more. I have been admitted multiple times this year and there is almost always a wait list.
14. There are definitely not enough beds available when you can finally convince someone along with the persuasion of the doctor. There need to be beds avail now & counselling also available immediately. Also being placed in a TV room is not good enough. They obviously did not build the new hospitals big enough to hold more beds. Every week I hear of patients displaced out of rooms.
15. Brand new hospital, but no psych beds is wrong!!
16. We need more services for the person I cared about.
17. There are not enough beds. If they can discharge despite family concerns they discharge them too early before they are stable.
18. Definitely not enough beds.
19. As explained earlier, there was no intervention plan, intervention and actions should have happened sooner, and for youth, the psych-bed system seems completely broken.
20. I was pleasantly surprised at the care and treatment she received
21. I was very lucky and received excellent care. This has not always been the case. I have had many hospitalizations over the years at XXXX. My hospitalizations were always too short and I never really got the help I needed.
22. The biggest problem is the inability to get the unwell person into care. So many roadblocks, barriers, etc. It took a serious incident involving a knife, police/ambulance involvement to get help. There has to be a better way.
23. Access is very difficult when there is so little community support in place. I would like to see mental health professionals make home visits to assess and help treat patients. Currently people suffering a serious mental crisis are treated like criminals.
24. Ambulance transportation requires sedation. This interferes with the next doctor's assessment.
25. Very limited access
26. It was hard to get support, took lots of waiting and confusion. No follow up with team, I had to fight for it. And when I did, the team then tried to push the responsibility onto me. I didn't know what to do. I was only 22.
27. Medical staff is over worked & shortage of beds
28. I believe that if we had been helped early when the first symptoms of illness had appeared, we would not be in the mess we are in now. I call the system a labyrinth nightmare, with every door we needed to get through whether we knew it or not at the time firmly guarded by a clipboard bitch. The lack of knowledge and understanding in our schools and social services (first contacts) is shocking. It has been a do it yourself project for us.
29. I needed to remind staff there are many reasons why a patient becomes ill.
30. Totally insufficient!
31. It's been always great— psychiatrist great—1995.
32. (no text comment)

33. Frustrating.
34. Over the years sometimes quick other times it was many weeks.
35. Looked after well and not a care about money spent as should be
36. Sitting in a chair in the emergency department for 18 hours was very distressing. I couldn't escape the sights and sounds of the ER and I was already in a terrible headspace. I had to sit still in cold, oversized hospital pyjamas with no sense of what was going to happen to me next. I was adjacent to two patients who were also being involuntarily held and seemed deep in their psychosis. One kept removing her hospital pyjamas and trying to make a break for it only to be dragged back into the ER by security guards. The other was restrained and alternating between singing and swearing/spitting. I felt like a burden on an over-taxed system. I've never felt so exposed, ashamed and alone. Eventually I was informed that there was space for me in the Brief Interventions Unit, but it turned out that I could only be given a bed in a conference room on the ward that had been repurposed to accommodate three hospital beds. I felt so embarrassed to be sleeping in the kind of room that I typically would have worked in. It really made me feel like a restrained nut-job rather than a person in need of hospital care.
37. I felt the stay in the hallway was more detrimental to my mental health than helping me.
38. Tons of people have psychiatric conditions, some are easy to treat. But there's a huge majority who get absolutely no support for their mental health. E.g., I can't' get a psychiatrist so can't get a badly needed medication adjustment. Twice in the last couple months, I've gone into a hypomanic state. I have been to emergency once and since I said I would not kill myself, they sent me on my way. No medication adjustment, no plan, no help. If I had a doctor. It wouldn't get so bad at the ER; problems would be taken care of.
39. I never had a time that I was unable to assess a bed due to lack of beds at least within the same day but I've heard of many people that it was the case for them.
40. We have had a family member discharged too early, still exhibiting serious psychiatric instability, and a real lack of care! Food consists of the same type of sandwiches day in and day out. Young people's dietary needs are not considered as they are all left hungry as the servings are for weak or elderly people! They fight over anyone meals that anyone is not consuming! The situation is ridiculous. The mental health system needs a total overhaul! There is no communication between acute and tertiary psychiatric units. No information is passed on. People are discharged from tertiary and their workers in their community are not even notified!
41. (no text comment)
42. Completely sucks. Makes it so I won't go when needed.
43. The patient was held in emerg for three days before they were given a bed on the ward. The patient was put in a dark hallway out of sight from the main emerg area. During that time other patients with mental health issues were located with him. The patient was not actively supervised, so I and my husband took turns living with the patient in emerg. I spent the nights in a chair in the dark hallway. It was a terrible time made worse by the experiences we had in emerg during our stay. Acute beds are only part of the puzzle, effective treatment was not available on a continuing basis and it wasn't available on discharge. The patient was discharged too soon.
44. Delays. Have to use police rather than specialized mental health team. Poor discharges.
45. My son wasn't violent or aggressive enough towards himself or others to get a bed at XXXX so he did not get the services he desperately needed not once but 3 times!
46. Psychiatric patients wait over four hours on average. I have taken my husband to XXXX emerg.four times in the past 20 years. Every time we feel shunted to the bottom of barrel. His

psychiatric care only started once he got admitted to XXXX. Emergency is heartbreaking for those in mental distress.

47. I feel that our experience was a good one and I feel that we were very fortunate as I've heard stories of other people who have not got beds but I attributed that to the fact that my daughter was very young.
48. In 2017 we tried to admit a sibling who has been admitted before. He was threatening suicide and manic. We were told that they don't do intakes on weekends and to come back Monday if he was still acting the same. He has also been kept in an ER bed for a week approx when he needed mental health help desperately. Once in psych they kept him until he was no longer a risk but did not take his situation as seriously as we would have hoped.
49. Need more beds, especially at the XXXX help, and better view in the emergency room.
50. Complete nonsense.
51. Done in a disgraceful manner with no compassion, no empathy or respect shown to my spouse. As a result my spouse's behaviour escalated. The Nurse and Doctor did not equate my spouse's sudden behaviour change to being restrained as they thought my spouse's behaviour was due to psychiatric reasons. So the Nurse and Doctor injected my spouse with a very strong anti-psychotic medication. My spouse had never been on any anti-psychotic medications.
52. I have begged for years , but it falls on deaf ears.
53. I was treated well on XXXX but do to ecttx have had lost my memory for 6 months
54. It is a waste of time to get admitted, treated like they don't really want you there and discharged without getting help.
55. XXXX was in gridlock as individuals were not being discharged in a timely manner and the XXXX kept having an increasing amount of admissions with individuals being forced to use recliners as beds and stretchers lined up and down hallways and seclusion rooms being used as beds.
56. Terrible.
57. When taken to the hospital by paramedics or police in psychosis he has usually been admitted to emergency and then to a ward within 24 hrs. When his condition is deteriorating and monitoring or stabilization might be helpful to prevent full blown psychosis, I have been told that getting him admitted is next to impossible. This has led to much worry, daily concern, phone calls and hyper-vigilance with a feeling of very little control and helplessness.
58. The system is broken! If that discharged patient needs to go back to Kamloops they must go through the whole scenario again! Back to police escort to emergency, sedation, seclusion for many days until a bed becomes available in Kamloops! Patients should be able to go direct to Kamloops without a useless stay in their area emergency and psychiatric hospital.
59. No difficulty.
60. The access was overzealous and has caused me lifelong emotional scarring and brain damage from a over-prescription of psychiatric drugs
61. Just wanted to clarify above, although admitted to ER voluntarily, was admitted under the MHA but agreed to it. I'm concerned about supportive networks AFTER discharge. Thank you!
62. I have been involved with a number of families whose children or other family members have had psychiatric emergencies. In most cases, the outcome was less than satisfactory. The biggest problem is that people who really need some help don't get it, they are just told to go home and then maybe go to the XXXX or elsewhere, which often can't or won't help either. I had thought that the XXXX would solve way more of the problems than it does. Very disappointing.
63. I do not believe he received enough professional care (i.e., with psychiatrists and counsellors). Instead he was left (as were other patients) too much on his own. It appeared he was being "housed" there and given medicine instead of receiving full care.

64. When my family member is in crisis, safety is the number one priority. We have had times where he was sent home without being admitted, only for us to all fear that he would suicide. When he has had access to beds, the durations of stays have often felt short or cut off abruptly with no release plan. Bed shortages are a problem and so are appropriate resources for release (XXXX has been a good option on a few occasions, but there need to be more beds in facilities such as this.)
65. XXXX has less per capita mental health beds than most cities in the country. It is unconscionable.
66. It has been very difficult and the last admissions were not long enough to adequately bring him back to anywhere near his usual self.
67. Involvement with the mental health professionals is counter-productive; antipsychotics increase her vulnerability and do nothing to dispel her delusions and fearfulness. The system has no skills nor time to treat anosognosia and increases paranoid behaviour.
68. Sometimes beds are not available.
69. At first I couldn't believe how early he was released! He lost his housing due to psychosis and drug use. He flipped out and was sent to the hospital by police. I felt relieved, thinking that now he'd be given proper treatment. But he was out on the street the next day. When I called the hospital demanding to know who had authorized his release, the nurse snickered, as if this was all so amusing, and told me the psychiatrist would call me back. He never did. This was about seven years ago. Since then I've learned to accept that that's usually all they do.
70. Personally I see if the patient has the supports from other agencies they are better supported with recommendation in the unit. In the XXXX we do not have anything for the youth and the closest place is XXX that is not always accessible.
71. (no text comment)
72. It is extremely obvious the protocols and system to deal with acute mental health disorders is over capacity and inadequate to meet the needs of our society.
73. A new Hospital was built in our growing community, there are fewer psychiatric beds available...this is madness.
74. It went smoothly because there were beds available and my family member was not violent or anything and cooperated with emergency doctors. Probably would have been a different experience though if no beds were available.
75. The protocol for dealing with psychiatric patients is totally extreme. I think it makes people WORSE in health as they are dealt with in a sub-human way.
76. Our daughter-in-law lives in XXXX....she has had to stay in their regional hospital for up to a month before there was a psych bed in XXXX where she usually comes. Now she has been placed in XXXX where there is no family. It is a heart-break to the family for a loved one to b placed that far away.
77. My partner was refused services at Mental Health 4 times last year & then when suicidal was refused admission (by XXXX) to XXXX Hospital!!!
78. We were fortunate. This was a suicidal crisis which was managed. However, since then, effective long term treatment has not been available. Daughter is still disabled by mood disorder and unable to function well outside our home. Age 23.
79. My son, who is turning 30 soon, was very traumatized at his first admission to XXXX at age 13. He often speaks bitterly of the experience, including being ‘tackled’, staff forcing him into the hospital gown. I have heard of many other patients as well having similar awful experiences.
80. Sometimes they aren’t available.
81. (no text comment)

82. Armed guard escorted my husband to the psych ward. It was very embarrassing for him. He was depressed, not violent.
83. The psychiatric ward offers safety for them. To be anywhere else in the hospital isn't the greatest.
84. It was non-existent. No beds for 17 year olds with acute psychosis in the XXXX Region. Totally unacceptable and a failure to meet the BC mental health care act which states 5 days MAX till a bed is found. Most stressful time in my life and no help in our region. This will be addressed at the highest level, starting with my MP/MLA and then XXXX and XXXX in Victoria, I want answers why this situation exists!!
85. (no text comment)
86. Accessing the beds were OK, getting ongoing treatment in a residential setting is almost impossible. What we need are more residential treatment beds.
87. More beds are desperately needed and people are dying waiting.
(2018)
88. I have a son who has schizophrenia and a daughter with serious bipolar type 1 illness. We have had numerous problems with getting admitted over the last twenty odd years. In 2014 it was a nightmare when both my offspring had psychotic breaks at the same time. The story is too long for this venue. It took from February to May and a lot of trauma in order to finally get admissions that year. Thank goodness it has been better since.
89. Whole system with acute and tertiary care is broken.
90. My son was once sent to XXXX. This was the worst hospital experience ever. We live in XXXX. It took 2.5 hours to drive each way. They said he had to go there because there were no other acute locked units. I complained to the head of psychiatry that XXXX patients should not be shipped out of the health region for acute care. He said there was a financial arrangement for sharing between XXXX and XXXX . XXXX was like One Flew Over the Cuckoo's Nest. Our son was overmedicated. There was no communication with family. We were very disappointed. VCH needs its own psych ICU.
91. It's extremely frustrating that our public health system is not prioritizing mental health like it does physical health; individuals who are sick in their brain are just as ill as those who have liver or heart diseases and tend to fill more hospital beds! Yet when an individual is sick, scared, psychotic, and traumatized we do not have the appropriate care to make sure that episodes do not worsen, do not affect their family beyond what they can handle and does not cause strain on untrained medical staff.
92. It is hard to get anyone admitted. People are further traumatized waiting for a bed. Sometimes people are shuffled from floor to floor before getting to psychiatry.
93. "roller coaster" feelings, especially rural area here.
94. Through my work I mainly hear family members I work with feeling like their loved ones are not admitted or are discharged early because their illness is not severe enough or they need the bed for another person deemed more severe. Their loved ones often fall through the cracks after discharge and do not receive the outpatient support they require. This appears to happen a lot and I think the system needs to do a better job.
95. My son has been diagnosed with schizophrenia and really suffers from anxiety and depression. The last time we went to the hospital because his anxiety was uncontrollable and he wanted to die. 36 hours later we were driving home, defeated once again by the clipboards.
96. It seemed to our family that the entry process was too long and painful. It would have helped if a worker was accessible to calm her down and help our family understand the process. It seemed there were judgements towards the family. It wasn't until she was admitted to the unit that we all felt a sense of relief and cared for.

97. Abysmal. I believe he was discharged many times, inappropriately. The system is broken, there is a lack of beds, staff, training in ER regarding mental health patients, a lack of care and compassion for those with the dual diagnosis of mental health and substance use, and innumerable other problems.
98. He was discharged far too early without discussing it with the person who admitted him.
99. The system is broken we would never treat people with any other serious illness the way our loved ones are treated. The most vulnerable people in our society are treated so unfairly!