In 2012, CHA collected anecdotal statements, issues and concerns from members across the state. What follows are summaries of the examples given.

1. According to our local County Department of Mental Health (DMH) that back-to-back holds will no longer be granted. This obviously will increase ED bottlenecks and really leave non-designated hospitals in a bind. DMH doesn’t think this is a major issue; it also wants to clarify that the 72-hour hold starts when a physician order to admit as an inpatient is made.

2. Need opinion or guidance for hospitals that are discharging clients brought to non-designated ERs on 5150s by police. Client is then screened and discharged to the police.

3. Who can end a hold when things change midway through the process? What happens to a hold when a superseding medical emergency requires admission to acute care, etc.?

4. Do you recommend that a county with no locked psychiatric facility beds, and no crisis stabilization unit (CSU), still "designate" out-of-county facilities so that they can quasi-comply with W&I Code 5150? Or do you truly not need to know about arrangements they make with facilities that have already been designated by a host county?

5. What does a county need to do in order to legally transfer an involuntary 5150 client to a locked psychiatric facility in Nevada? Our county has no designated beds inside county lines and is having trouble finding available beds for their clients in California; they have been offered bed space by locked Nevada psychiatric facilities.

6. Our county psychiatric hospitals/PHFs are insisting that out-of-county hold writers be approved by the receiving county’s Mental Health Department (these out-of-county professionals have already been designated by their own counties to write 5150 holds).

7. The patient goes to or is sent to a non-LPS medical facility. After medical treatment, if they need psychiatric treatment, the Psychiatric Mobile Response Team (PMRT) is called. PMRT places the patient on 5150. The medical facility is then required to find a psychiatric bed because they cannot treat the patient. The medical facility calls around and tries to find a psych bed for the patient. The limited psych bed availability causes the patient to be held in the non-designated facility without any psych treatment until a bed is found. Depending on the length of time to find a bed, PMRT has been known to write a second 5150, which is not legal according to current LPS regulations. This puts the receiving psychiatric facility at-risk with Patient’s Rights because the 72-hour evaluation period has passed without any psychiatric evaluation.
8. We get calls from ERs for patients placed on 5150 by the County. The holds are expired or soon to expire. Our physicians, without the 72-hour evaluation, are put in the position of having to either discharge the patient or place the patient on 5250. We receive holds written to other hospitals and, if the patient comes medicated, how do we evaluate them for our hospital?

9. We receive a hold with errors that make the hold invalid. No matter how minor the error (i.e., name of facility, date of birth, or spelling of name is incorrect), there’s no mechanism in place for anyone other than the person who wrote the hold to make corrections to it. The patient is being held illegally on an invalid hold. The only way to correct it is to completely re-write the hold. The patient may not be currently presenting with the same behaviors and no longer meets criteria based solely on what is being seen at that moment. We don’t have the current crisis or psycho-social history to assist in doing a proper initial evaluation for 5150. This puts the patient at risk of not getting proper treatment. Having a place for amendments would alleviate this issue of unnecessarily re-writing holds.

10. Our county views police-written holds as applications for assessment. When they transport to a non-designated county, the County then sends the PET team to assess. If the patient meets criteria, he/she is then transported to the County Crisis Unit or transported directly from the ED to a designated facility.

11. In our county, the psych ER is limited to 23 hours and 59 minutes detention, not 8 hours. Only a psychiatrist can release a patient from a 5150, but he/she may do so at any location where the evaluation takes place. A 5152 begins at the time of admission to an inpatient hospital from the psychiatric emergency room. However, the 72-hour time clock begins at the time the 5150 application is written, even if the patient is in a medical facility for 2.5 days before transfer to a psychiatric hospital.

12. A distant county PHF asked them to write a "new" 5150 and insisted that they needed to send someone down to that county (100 miles away) to write that new hold. Background: the PHF waited until the last minute and was too late to apply for a 5250 and the patient wasn't safe to discharge after 72 hours. They convinced the patient to stay voluntarily. Then he decided to leave but was still unsafe, and for some reason they didn't want to be the ones to have their attending staff write a new 5150 for fear it would look like a "parking lot serial hold" which they had been cautioned against doing.

13. A person is brought in to the Emergency Department intoxicated and on a hold. These patients are typically treated as a medical detox and when they are sober and medically clear, they no longer meet criteria for a hold. LPS Law clearly states that a 5150 hold is only authorized when the patient is a danger to self or others or gravely disabled due to a mental condition. Being intoxicated is not a mental condition. Therefore, if our designated Emergency Department physicians medically clear a previously intoxicated patient and they no longer believe the patient meets criteria for a hold, they should have the authority to release the patient from a hold.
14. Another instance of an unnecessary hold is one written to remove someone from a threatening situation in the community. This could be anything from a threat of violence or an expression of suicidal thinking not due to a mental disorder, but a reaction to a bad situation, such as a domestic quarrel. However, domestic violence does not necessarily meet the criteria for a hold.

15. Emergency Department physicians may have reason to discontinue a hold when the behavioral or emotional symptoms are found to actually be due to a medical condition or more frequently due to substance abuse. If the behavior is a result of a medical or substance abuse problem the Emergency Department physician should be authorized to release the hold.

16. If, after examination by the attending Emergency Department physician, the doctor reasonably believes the patient can safely be released or handed off to a member of the family or a friend with an adequate discharge plan, the Emergency Department physician should have the authority to release the hold.

17. If a patient on a hold is found to have a medical condition that requires transfer to a medical unit, the Emergency Department physician should have the authority to release the hold and use his or her discretion for recommending a psychiatric consultation for the patient on the medical unit.

18. Had to "house" an adolescent in a local hotel while looking for an inpatient bed, which took days.

19. Wanted to cross state lines to take patients to Nevada and stated they were not clear on how to "designate" a non-California facility (and whether this facility falls under the state's ability to approve the designation).

20. Had an Alzheimer’s patient who was a definite danger to his wife due to confusion, etc., but no place to take him. More recently, had an elderly mental health client with chronic serious medical issues and no one would accept him on a 5150. It took over a week to find a bed.

21. Neighboring county PHFs won't take clients who have been waiting more than 72 hours on a hold for a bed unless a 5250 is written. They explained that the client had never had 72 hours of evaluation and treatment, but the PHF still refused the patient unless he/she was on a 5250. They start the clock at the writing of the hold.

22. Patients kept in a jail cell while waiting to find a bed because the small Critical Access Hospital has no safe place to keep these folks.

23. Local hospital "admits" patients to Medical/Surgical unit while waiting for transport/bed and insists that hold is still in effect.
24. Local hospital emergency department (ED) doctors don't "trust" crisis team and arrange their own transfers without a hold being written, based on taking patient to other hospital, where a hold will be written on arrival.

25. Confusion on whether a Crisis Stabilization Unit (CSU) can be a "designated facility. In talking with the state, it sounds like they permit that designation. State says it has to be "close" to being a 72-hour facility (though vague on how close). CSU's should be designated as a place for a first stop to attempt to stabilize and avoid hospitalization, but I would feel better if there was more definition of what criteria should exist for designation.

26. Our local hospital is not a "designated facility." If a Sheriff takes someone there who was on a 5150 hold and Mental Health is called, who is responsible to watch the client? EMTALA seems to indicate the hospital has that responsibility.

27. Who is responsible to find the bed at a psychiatric facility?

28. Now PHFs and Acute Psych Hospitals (APH) in neighboring county insist on contracts wherein our county will send staff (full day travel round-trip) to pick up client at end of hospital stay and will guarantee ($) discharge plan and transport costs, etc.

29. All counties continue to struggle with payment issues, especially with Medi-Cal patients who enter the system outside their county of residence. Wouldn't it work better to just pay for hospitalization regardless of where it happens to be needed geographically?

30. What if a Sheriff arrests someone and also writes a 5150 but does not do the "inform" step? Can the Sheriff’s Office keep that hold in case charges are dropped? If so, does the 72-hour clock start when the Sheriff signs and dates/times the form or when the Sheriff informs?

31. Judge "ordered" the designated LPS facility to accept an inmate on a Penal Code 4011.6 transfer from the jail. There has been no mental health assessment by the "access team" and there is a question as to whether the inmate is being "released" from jail (which means Medi-Cal could pay for his hospitalization) or how/who will pay. Also, there is a question about medical necessity. This happens so infrequently that there is no "protocol" and the judges throughout California don't seem to be aware of the bed shortage.

32. A judge "ordered" the admission of an inmate to the local Psychiatric Health Facility. The inmate arrived unannounced in shackles with two correctional officers at 5:00 p.m. on a Friday with no empty beds available on the unit.

33. County patient on an LPS conservatorship due to grave disability due to serious chronic mental illness (schizophrenia) for four years and living at a Residential Care facility. Patient has now started showing signs of dementia on top of mental illness; patient hits staff member at the facility and is "5150'd" to an acute psych hospital in another county.
This hospital tries to send him back to the original hospital after a few days of inpatient evaluation and treatment and they refuse to take him back (too aggressive towards staff, "no thanks"). So this hospital calls our county and says, "we've got your conservatee, and are planning to send him back to you". The County calls the original hospital and tries to get them to accept him back (where he has been for 4 years and where it feels like home to him), "NO" they say, so County Mental Health starts calling around the state looking for long term placement for this conserved patient...with no luck. A few days pass, and there is a knock at the door of their crisis stabilization outpatient unit, and there are two of the out-of-county hospital’s staff members with the conservatee, who has been driven by them, and DROPPED OFF without so much as a howdy do. They leave. The patient has been sitting in a chair at the crisis unit since last week while they try "everything they can think of to find someone to accept this man."

34. We have a man brought in to ER who made some clear threats about suicide and did a suicide attempt through pills. We dismissed the Sheriff’s 5150 to transport and worker started the 5150 evaluation, partly as it appeared he would be medically cleared and would clearly meet criteria. However, Poison Control recommended a 12-hour wait at the ER/hospital. He is on medical/surgical floor, but “formally” still in ER – basically NOT medically cleared. Per our protocol, we had to stop our evaluation process and will restart at 8PM or so w/evening worker. We are following our protocol w/the issue being no good security at hospital if the person wants to leave. We don’t believe we can hold him on a 5150 when he is a patient of the ER, though we have had the hospital keep persons on a 5150 as we await for a psychiatric hospital bed to open (but in all cases, they were medically cleared). MD had concern about how hospital could hold the patient if not on a 5150 and on what grounds they can restrain him. They will have a sitter. The elephant in the room is that ER has no good security, so they will call Sheriff’s for help if the patient goes AWOL, but Sheriff’s Dept. will not want to sit w/client for very long.

35. Our local hospital is not a "designated facility". If Sheriff takes someone there who was 5150’d and MH is called, who is responsible to watch the client? EMTALA seems to indicate the hospital has that responsibility. Who is responsible to find the bed at a psych facility? What if Sheriff arrests someone but also writes a 5150 - but does not do the "inform" step - can the SO keep that hold in case charges are dropped? If so - does the 72-hour clock start when the Sheriff signs and dates/times the form or when the Sheriff informs?

36. Most counties consider the 5150 automatically terminated (don't throw away the paperwork though) and you will need to re-assess and write a new one if needed when he is feeling well enough to be discharged from the hospital.