Psychiatric Patient Overcrowding in Emergency Rooms

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INTRODUCTION

Psychiatric boarding reflects an output bottleneck in the emergency department. In many cases, psychiatric patients are medically stabilized in the emergency room, but there are too few appropriate places available for transfer, such as inpatient psychiatric beds, crisis units, or dual diagnosis treatment programs. As a result, patients remain in the emergency department much longer than it was designed to accommodate. Substance related crises make this problem even worse because they often require additional medical clearance, observation, and monitoring before a patient can be transferred. This project will examine whether longer boarding times are associated with slower hospital flow, lower quality of care, and greater strain on staff, safety, and physical space. It will also explore whether the main issue is not simply emergency room crowding itself, but the lack of available options for timely placement after stabilization.

RESEARCH METHODOLOGIES

- There were many methods in my research as I used mixed methods
  - Literature review
  - Public data
  - Physician interviews (open ended and 1-10 scale questions)
  - Shadowing Emergency Rooms in order to get first hand exposure towards
- Qualitative notes capture observed boarding, wait time pressure, and staff experiences
- The analysis compares emergency demand with inpatient and community receiving capacity
- I also called dozens of community based care facilities in lakewood to gather information about them

DATA AND FINDINGS

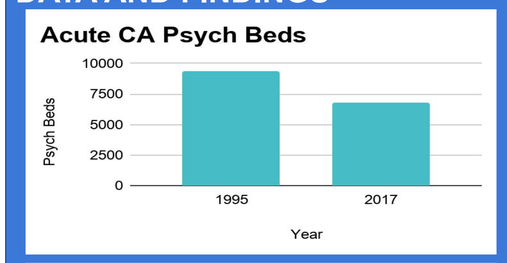

Figure 1 - comparison of total beds in CA over time

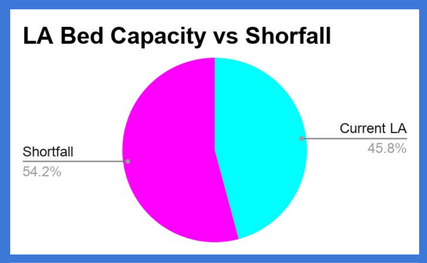

Figure 2 - amount of beds needed in LA

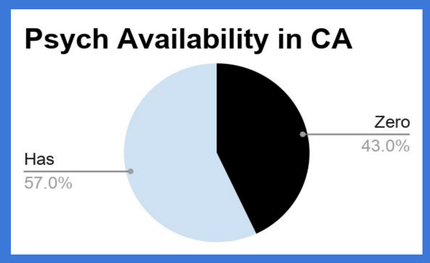

Figure 3 - community based care availability in CA

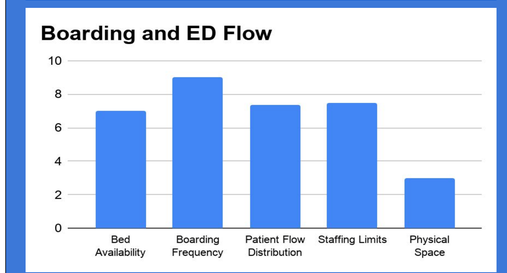

Figure 4 - doctor ratings of how boarding affects emergency department flow

Figure 5 - doctor ratings of how psychiatric boarding affects quality of care and safety

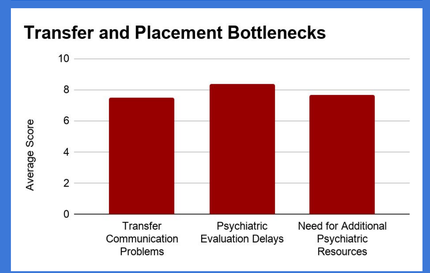

Figure 6 - comparison of physician ratings on transfer and placement bottlenecks

DISCUSSION, ANALYSIS, AND EVALUATION

Figures 1 through 3 show a clear capacity trend. Figure 1 shows that California had fewer acute psychiatric beds in 2017 than in 1995, which means inpatient psychiatric capacity declined over time. Figure 2 shows that Los Angeles County's psychiatric bed supply is well below the benchmark level, suggesting that local capacity is not meeting demand. Figure 3 shows that psychiatric services are uneven across California counties, which makes transfers harder and limits placement options. Figures 4 through 6 show how these shortages affect emergency department operations. Figure 4 shows that physicians gave high ratings to boarding frequency, bed availability problems, and patient flow disruption, suggesting that psychiatric boarding is a regular strain on the ED. Figure 5 shows that boarding also lowers quality of care and increases safety concerns for both patients and staff. Figure 6 shows that psychiatric evaluation delays, communication problems, and lack of resources are major transfer bottlenecks. Together, the figures show that limited psychiatric capacity and delayed placement are linked to longer boarding times, greater ED strain, and lower quality of care.

ACKNOWLEDGEMENTS / REFERENCES

Special thanks to Ms. Coutinho for guiding me through this project, and thank you to all of the emergency room doctors who were generous enough to let me interview them. I would also like to thank Mr. Shen for making this project possible and for his support and guidance throughout this past year.

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CONCLUSIONS, IMPLICATIONS, AND NEXT STEPS

Psychiatric boarding is mainly caused by an output bottleneck, not simply poor emergency department management. Since deinstitutionalization shifted mental health care away from long-term hospital treatment and toward community-based care, the system has relied more on outpatient programs, crisis services, and step-down placements. However, these supports have not kept pace with California's growing population or the demand for psychiatric and substance-use treatment, leaving too few inpatient beds and placement options for patients who need a higher level of care.

Patients are often medically stabilized in the ED, but limited psychiatric beds, slow transfer processes, and gaps in dual-diagnosis and crisis placement prevent timely movement to the proper setting. This slows patient flow, reduces bed availability, increases staff strain and safety concerns, and lowers the quality of care for both psychiatric and non-psychiatric patients. I also believe that limited public awareness of community-based care may contribute to ER overuse, since some patients and families may not know what services exist or how to access them. However, that part of my argument remains an informed interpretation rather than a proven conclusion because I do not have direct data measuring public awareness.