

Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?

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OVERVIEW — *This issue brief examines reported capacity constraints in inpatient psychiatric services and describes how these services fit within the continuum of care for mental health treatment. The paper summarizes the type and range of acute care services used to intervene in mental health crises, including both traditional hospital-based services and alternative crisis interventions, such as mobile response teams. It reviews historical trends in the supply of inpatient psychiatric beds and explores the anticipated influence of prospective payment for inpatient psychiatric services under Medicare. The paper also considers other forces that may affect the need for and supply of acute mental health services, including key factors that could improve the quality and efficiency of inpatient psychiatric care.*

Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?

The April 2007 tragedy at Virginia Tech, while unprecedented in terms of the number of lives lost in a mass shooting, is also sadly evocative of disturbing headlines from the past. Although it is very rare for people with mental disorders to be violent towards others, mental health crises do occur every day and too often result in harm to self or suicide. In 2004, over 32,000 people committed suicide in the United States, making it the 11th leading cause of death.¹ Tragedies that result from a failure to intervene effectively in an individual's mental health crisis are particularly appalling, as they are often preventable.

Multiple cultural, legal, and medical obstacles hinder crisis intervention, but gaps in mental health treatment capabilities are significant. The mental health system that exists today is widely perceived to be ineffective in both preventing mental health crises from developing and intervening in crises when they occur. As discussed in the report issued by the President's New Freedom Commission on Mental Health,² disjointed policies and reforms of the past have converged to create the "patchwork relic" that is the current mental health system. Understandably, the commission focused the bulk of its work "upstream"—identifying the changes that are needed to ensure that as few people as possible ever experience a mental health crisis. The commission concluded that the "nation must replace unnecessary institutional care with effective, efficient community services that people can count on" and articulated a vision for what a consumer- and family-centered system of care would look like.

Institution-based treatment resources are, in fact, contracting, but this reduction in inpatient psychiatric services is not being balanced by the development of strong, comprehensive community-based systems of care. The number of dedicated psychiatric hospital beds has dropped precipitously over the last decade, and many communities report serious constraints in inpatient psychiatric capacity. New outpatient models are being developed, but they have not been implemented at the scale necessary to compensate for the decrease in inpatient beds.

The commission recognized that acute care services are an essential part of the mental health care continuum and noted the inadequacy of these services in terms of both scope and availability. The commission's Subcommittee on Acute Care documented the shortage of acute care capacity as a growing problem nationally.³ Given the historical reliance on inpatient

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services, some consumer advocates have been rather reluctant to emphasize acknowledged deficiencies in hospital-based psychiatric capacity. Many advocates fear that policy attention to inpatient psychiatric services will only detract from the challenging task of developing a system of care that is directed at prevention, early intervention, and community-based services. However, even if such a system were in place today, people with mental disorders would continue to experience crises that warrant intervention.

This paper presents information on the decreasing supply of acute mental health services, describes the forces that have led to this trend, and identifies proposals that have been made to address perceived inadequacies. This narrow emphasis is not intended to imply that expansion of acute mental health services merits priority over the development of a more robust system of community-based care. In addition, the paper does not address how training and models of professional practice influence provision of acute care services. A comprehensive analysis of existing mental health system service capacity, while worthwhile, is beyond the scope of this issue brief. The following focuses on important changes in acute mental health capacity and discusses the influence of federal policy, particularly Medicaid and Medicare reimbursement, on these services.

WHAT IS ACUTE MENTAL HEALTH CARE?

Acute mental health care can be broadly defined as a short-term response to the urgent needs of an individual experiencing a mental health crisis. The specific behaviors and conditions constituting a mental health crisis are open to interpretation, by individuals and mental health professionals alike. Generally speaking, a danger of suicide, harm to self due to intentional acts or impaired self-care, or harm to others is commonly used to identify a person's need for acute care services. These services ideally include assessment and short-term interventions to defuse the immediate crisis, along with treatment planning to provide referrals for follow-on monitoring and, possibly, additional treatment. It is important to note that many people with mental disorders never experience a mental health crisis necessitating acute services.

Acute mental health services have traditionally been provided in inpatient hospital settings, hospital emergency departments (EDs), and other urgent care facilities. Recently, alternative forms of effective crisis intervention (such as mobile crisis units and crisis intervention in residential programs) have been developed that do not require 24-hour medical supervision in an institutional setting. Some consumer-driven services do not rely primarily on mental health care providers but rather support consumers and their families in managing their own psychiatric symptoms.

However, these nontraditional forms of acute care are not widely available, and most communities continue to rely heavily on hospital-based psychiatric services to intervene in mental health crises. For the purposes of

this paper, “acute care” refers broadly to crisis intervention services that can be provided in either an inpatient or an outpatient setting. Nonetheless, given that hospitals continue to be the dominant and most widely studied setting for acute mental health care, much of the discussion focuses on inpatient psychiatric services.

Acute mental health treatment differs from acute care for general medical/surgical cases in a number of ways. Over 85 percent of the costs of inpatient psychiatric care are captured by the routine costs of staffing the unit in which psychiatric patients are placed. In general, inpatient psychiatric patients do not use a large amount of ancillary services, such as laboratory, imaging services, telemetry, and operating room suites.⁴

The critical danger facing patients in mental health crisis is typically the risk that their behavior will result in harm (rather than organ or metabolic failure). Therefore, providing the appropriate level of supervision and behavioral management to minimize this risk is an important component of acute psychiatric care. Diagnostic workups of psychiatric cases generally do not rely on capital-intensive technologies; rather, they involve expert interpretation of symptoms, patient interviews, and medical records. Care may also include treatment for medical comorbidities, such as wound care, orthopedic services, or cardiac care. These comorbidities may be linked to injuries sustained during the crisis episode or may reflect preexisting conditions.

Acute care services are often the first and, in some cases, the only type of care people with mental disorders access. However, individuals with persistent serious mental illness (SMI)—about 5 percent of the population⁵—often experience mental health crises recurrently and are particularly likely to use inpatient psychiatric services. Persons with SMI are particularly vulnerable to experiencing a mental health crisis when their chronic mental disorders are exacerbated by co-occurring health issues or other personal problems, such as insufficient financial resources, interpersonal conflict, social isolation, or housing instability.

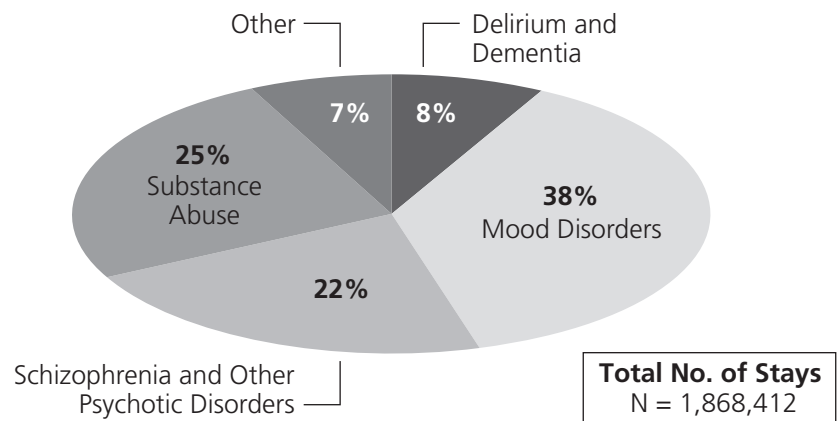
Sometimes referred to as “frequent flyers,” these more vulnerable patients are heavy users of inpatient psychiatric and ED services, but the clinical and social circumstances of persons experiencing a mental health crisis can

Involuntary Treatment

While many patients may accept acute psychiatric services voluntarily, some refuse care and may be compelled to remain in the custody of health care providers against their will. Legal standards for involuntary commitment to inpatient facilities for acute mental health care typically rest on demonstrating an immediate danger of serious harm to self or others. Once committed to an inpatient facility, patients may still refuse treatment, such as medication. Legal standards for compulsory treatment, which vary across states, usually hinge on determining a patient’s competency to make treatment decisions in his or her own self-interest. States have applied varying standards for compulsory treatment and have allowed “outpatient commitment” when a patient is assessed to be gravely disabled by mental illness or there is potential for a patient’s condition to deteriorate absent treatment. The legal framework for outpatient commitment, in terms of relevant state statutes and case law, is not as well developed as the law used to guide judicial decisions regarding inpatient commitment. These differences may contribute, in part, to the continued reliance on inpatient psychiatric services to deliver acute mental health care.

vary widely; these differences can influence whether, how, where, and what type of acute mental health services are used. Examples of cases requiring acute mental health care include a mother who is suicidal after the recent death of a child, a depressed senior citizen who has stopped all self-care activities after the loss of a spouse, a returning veteran failing to recognize heart palpitations as a symptom of post-traumatic stress disorder, a teen who has overdosed on illegal drugs, and a homeless man who is psychotic, hearing voices, and threatening to kill himself. Such cases can present quite differently, with the need for acute treatment varying significantly.

FIGURE 1
Distribution of Mental Health and Substance Abuse Admissions in General Hospitals



Source: Agency for Healthcare Research and Quality, "Care of Adults with Mental Health and Substance Abuse Disorders in U.S. Community Hospitals, 2004," HCUP Fact Book #10, 2007; available at www.ahrq.gov/data/hcup/factbk10/factbk10.pdf.

Most psychiatric hospital stays are for depression or some other form of mood disorder, schizophrenia or other psychoses, and/or substance abuse. Although approximately one-quarter of psychiatric hospitalizations identify substance abuse as the principal diagnosis, many people hospitalized for other types of mental disorders also have co-occurring substance abuse problems. Over one-half of patients hospitalized for psychiatric care in general hospitals have a substance abuse problem (Figure 1).

The acute service needs of psychiatric patients depend on a wide variety of factors that, while influenced by diagnosis, may be affected to a greater extent by the severity and duration of the disorder, the patient's receptivity to treatment, existing comorbidities, and the extent to which patients have necessary social supports to promote treatment compliance. In reality, the actual acute care services individuals receive may be dictated less by their needs and more by the availability of those services within the community in which they live and their ability to pay for those services, either directly or through public or private health insurance.

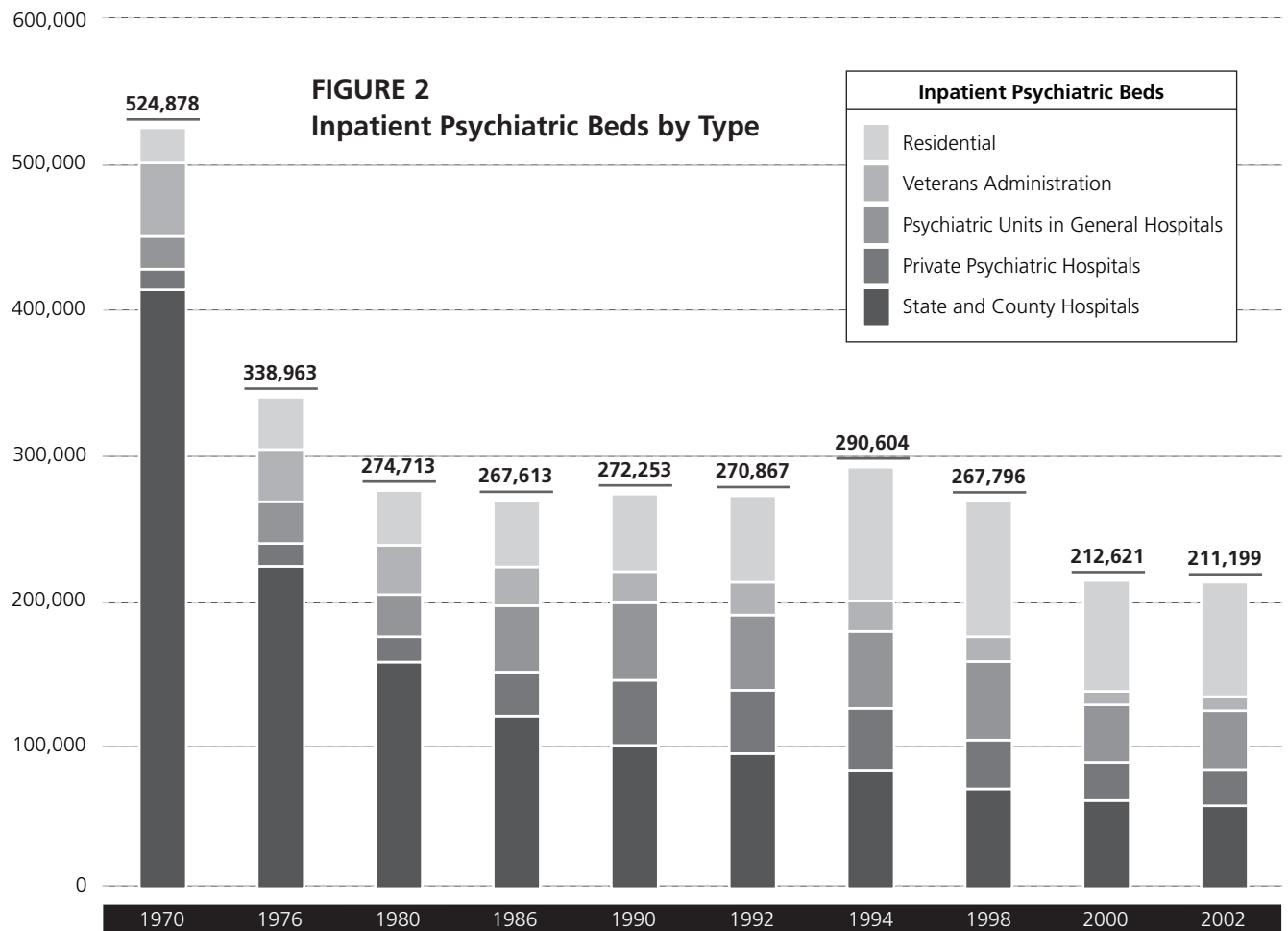
TRENDS IN INPATIENT PSYCHIATRIC CAPACITY

Capacity for inpatient psychiatric services, the most widely available form of acute mental health care, has declined dramatically over the last four decades and bed supply has shifted across service providers. Inpatient psychiatric services can be delivered in a variety of settings, including public mental hospitals, private freestanding psychiatric hospitals, and psychiatric units within general hospitals. Increasingly, inpatient psychiatric

services are also being delivered in nonspecialized medical/surgical beds located in general hospitals, commonly referred to as “scatter beds.”⁶ Over time, the availability and interchangeability of different types of inpatient psychiatric beds have varied considerably (Figure 2).

Downsizing by state- and county-run mental hospitals is the primary reason for the large decrease observed in the total number of dedicated inpatient psychiatric beds. In 1970, there were approximately 524,878 psychiatric beds in the United States, with about 80 percent of these beds provided by state or county mental hospitals. By 2002, the total number of psychiatric beds had declined to 211,199, with over 68 percent of inpatient capacity provided by the private sector. Private-sector capacity grew

No. of Beds



Source: Daniel J. Foley et al., “Highlights of Organized Mental Health Services in 2002 and Major National and State Trends,” in Center for Mental Health Services, Mental Health, United States 2004, Ronald W. Manderscheid and Joyce T. Berry, Eds., DHHS pub. no. (SMA)-06-4195 (Rockville, MD.: Substance Abuse and Mental Health Services Administration, 2006), table 19.2, chap. 19, p. 203; available at http://download.ncadi.samhsa.gov/ken/pdf/SMA06-4195/CMHS_MHUS_2004.pdf.

considerably between 1970 and the 1990s, partially offsetting contractions in the public sector. However, since the mid-1990s, private-sector closures have added to the continuing decline in public inpatient psychiatric beds. These trends have led to capacity levels for inpatient psychiatric services that are now significantly lower than they had been throughout the 1980s and much of the 1990s.⁷

Public Mental Hospitals

Much of the decrease in state- and county-run psychiatric beds was precipitated by a shift away from institutional, long-term, custodial care for persons with severe and persistent mental illness. A variety of forces drove the “deinstitutionalization” movement that began in the 1960s, accelerated during the 1970s, and continues today. Scandals over the inhumane conditions within many facilities, patient advocacy efforts, evolving treatment techniques (including new psychotropic pharmaceutical agents), and budgetary pressures converged to prompt the discharge of psychiatric patients residing in institutions into community settings. When Medicaid was enacted in 1965, the program excluded “institutions for mental diseases” (IMDs) from reimbursement, which intensified states’ financial incentives to move patients out of public psychiatric hospitals. Between 1965 and 1990, the resident population of public mental hospitals dropped from approximately 500,000 to less than 100,000.⁸ On any given day, this resident population included a mix of long-stay and short-stay acute patients.

It is difficult to characterize precisely how the significant decline in public psychiatric beds affected acute psychiatric capacity. States were initially slow to close public mental hospitals entirely, preferring instead to reduce beds and census levels. Arguably, acute-care capacity initially increased in these facilities as more long-term patients were discharged to live in the community, nursing homes, and other types of facilities—freeing beds for short-term stays. At the same time, the demand for acute services increased, since the discharged high-risk patients, particularly vulnerable to mental health crises, often found themselves in settings where they lacked adequate access to the outpatient services they needed.

More recent developments have likely served to reduce the acute care capacity available from public mental hospitals. Following the rapid deinstitutionalization of resident patients in the 1960s and 1970s, some

The IMD Exclusion

When Medicaid was enacted in 1965, Congress barred federal contributions for any care delivered in certain institutions that fall within the definition of an “institution for mental diseases” (IMD). The ban was intended to prevent states from supplanting resources that had historically been dedicated to supporting persons with mental illness in state and local mental hospitals. An institution for mental disease is defined as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in the provision of diagnostic services, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” The exclusion applies only to persons between the ages of 22 and 64. IMD residents 65 and older have been exempted from the exclusion since Medicaid was enacted, and state Medicaid plans have had the option of exempting those under the age of 22 since 1972.

long-term care services continued to be provided by public psychiatric hospitals (particularly for forensic purposes). However, by the early 1980s, these facilities became primarily acute care sites in many states. In other states, public hospitals were closed to all but long-stay patients. Closures of public psychiatric facilities became more common in the 1990s, and bed closures within facilities continued at a steady but slower rate as a result of tightening state budgets and increasing reliance on Medicaid to fund mental health services. These more recent closures likely represent a decrease in acute, not long-term, capacity. However, state and local mental hospitals rarely designate beds for short-term or long-term use, making it difficult to accurately determine acute capacity levels in public institutions.

Private Psychiatric Hospitals and General Hospitals

The dramatic decline of psychiatric (primarily long-term care) beds in public mental hospitals over the last 40 years tends to obscure more subtle changes in private inpatient psychiatric capacity during this period. Given the historic focus of private psychiatric hospitals and general hospitals on short-term, acute treatment rather than custodial care, capacity in these institutions was less directly affected by the movement to deinstitutionalize psychiatric residents from long-term care mental hospitals. In fact, the demand for acute services stimulated by the needs of these former residents of government psychiatric hospitals, combined with increasingly generous inpatient psychiatric coverage through Medicare, Medicaid, and private insurers, likely precipitated an initial increase in the supply of private psychiatric beds.

Over time, policy changes have significantly influenced private-sector decisions to both expand and (more recently) contract inpatient psychiatric capacity. While acute care capacity levels in private, freestanding psychiatric hospitals and psychiatric units of general hospitals rose steadily between 1970 and 1980, expansion accelerated significantly between 1980 and 1990. This spike in private-sector capacity can be attributed to a confluence of factors, including the following:

■ **Relaxation of certificate of need (CON) requirements** — As states began to loosen or eliminate CON laws that had required hospitals to obtain regulatory approval prior to adding or expanding services, hospitals were able to increase psychiatric bed capacity without facing significant administrative and legal hurdles.

■ **Changes to Medicaid's IMD rule** — After rule changes in the early 1970s allowed Medicaid funds to be used for the care of children in psychiatric hospitals, many states decided to include this option in their state plans. This change created a new revenue stream for psychiatric hospitals that had generally been barred from receiving Medicaid dollars. Combined with expanding coverage for inpatient psychiatric services through commercial insurers, this change in Medicaid policy helped to

fuel a significant expansion in the number of freestanding psychiatric hospitals. Between 1976 and 1992, approximately 300 new private (mostly for-profit) psychiatric hospitals were opened.⁹ As the for-profit psychiatric hospital industry grew, marketing to parents struggling to control “troublesome” children became more prevalent.¹⁰ During this period, the increase in the use of inpatient psychiatric hospitalization for children was particularly striking. Among children hospitalized in short-stay institutions for psychiatric disorders, nearly one-quarter were hospitalized in for-profit psychiatric hospitals.

■ Implementation of prospective payment under Medicare in 1983

— When Medicare replaced cost-based reimbursement for hospital services with a prospective payment system (PPS), psychiatric services (in both freestanding psychiatric hospitals and dedicated units of general hospitals) were exempted. As hospital-wide length-of-stay averages and occupancy levels dropped, many general hospitals opened psychiatric units to boost census and revenue. The cost-based reimbursement mechanism established for PPS-exempt services tended to favor new units and facilities and likely contributed to the expansion in the number of private psychiatric hospitals and dedicated units. Lengths of stay for psychiatric admissions declined, but numbers of admissions increased.¹¹

Private inpatient psychiatric capacity held relatively stable during the early 1990s but began to decline sharply as financial incentives shifted. Increased managed care penetration in Medicaid and among commercial insurers; reductions in third-party payment rates, followed by increases in utilization management; and declining growth in Medicare reimbursement rates led many inpatient psychiatric service providers to close or reduce capacity levels.

Evolution of Cost-Based Payment for Inpatient Psychiatric Services under Medicare

TEFRA — When Medicare established inpatient prospective payment for most types of hospital care in 1983, inpatient psychiatric services were exempted and continued to be reimbursed under

rules established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Psychiatric facilities were exempted from PPS because diagnosis (the basis for PPS payment methodology) did not provide an accurate prediction of resource use by psychiatric patients and failed to capture variations observed in costs and lengths of stay.

TEFRA established both facility-specific baseline payment rates (based on an individual facility’s actual average cost per discharge) and target rates for cost increases based on update factors set in legislation. Exempt providers were paid their actual costs per discharge, provided these costs did not exceed their target rate, and were given bonus payments if costs fell below target and some relief payments if costs exceeded target.

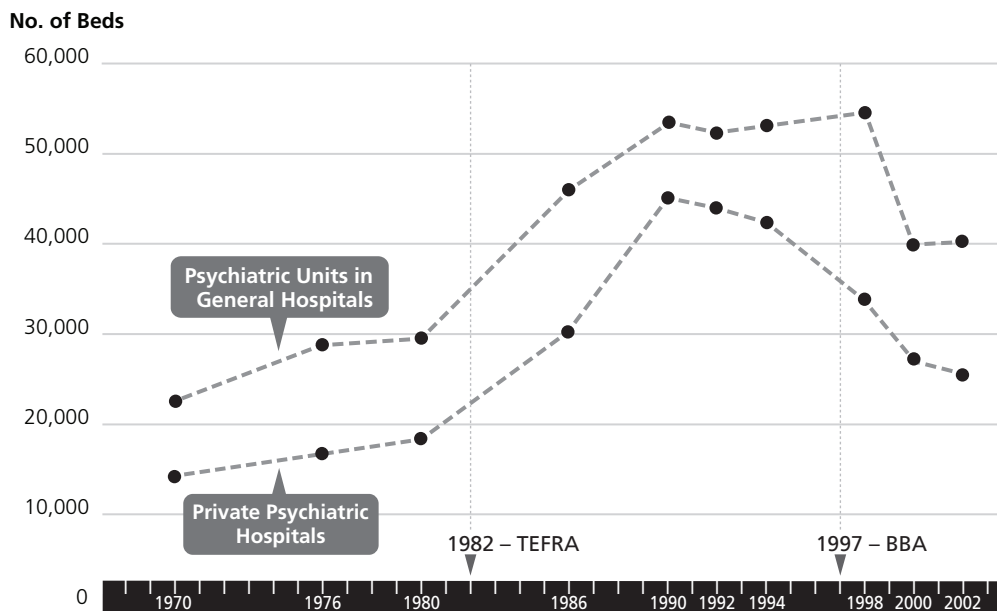
BBA — The Balanced Budget Act of 1997 (BBA) modified TEFRA rules in a number of important ways. A national payment cap was established (set at the 75th percentile of the distribution of target amounts for all psychiatric facilities in fiscal year 1996) and inflated to the current year using an annual update factor. Each facility’s payment was limited to the lesser of its target or the national cap amount. New providers’ baseline costs were limited to 110 percent of the median target amount of all established providers, with geographic wage and annual inflation adjustments. A variable, provider-specific formula to update target amounts was also established, giving smaller update increases to providers whose costs were less than their targets.

This downsizing trend was initially evident among private psychiatric hospitals in the mid-1990s. General hospitals also began to close or reduce the size of psychiatric units in the late 1990s, partly as a result of these changing financial incentives. (Figure 3)

Complex factors beyond the direct profitability of psychiatric services have reportedly played important roles in general hospitals' decisions to eliminate dedicated psychiatric units. Although some would argue that psychiatric services are still profitable for hospitals, they may be less profitable than other inpatient services and represent an opportunity cost for hospital administrators. A variety of other issues, such as the purported unwillingness of psychiatrists to serve inpatients or provide on-call services in EDs and the impact of psychiatric cases on ED overcrowding, may also play a role in general hospitals' decisions to eliminate dedicated psychiatric units. The rationale behind hospital decisions to close psychiatric units is not well documented nor is the impact of such closures on hospital finances and utilization.

The burden of treating people with mental disorders in EDs is well established. Psychiatric patients remain in hospital EDs more than twice as long as other patients, with 42 percent spending nine or more hours in the emergency room, and staff have to spend twice as much time looking for beds for psychiatric patients as they do to find beds for nonpsychiatric patients.¹² Figure 4 (next page) presents results from a cross-sectional study of EDs indicating that mental health-related visits increased 75 percent between 1992 and 2003.¹³ Survey data reveal that 60 percent of emergency

FIGURE 3
Private Inpatient Psychiatric Beds



Note: Values are imputed for years in which data were not collected.

Source: SAMHSA, Mental Health, United States, 2004.

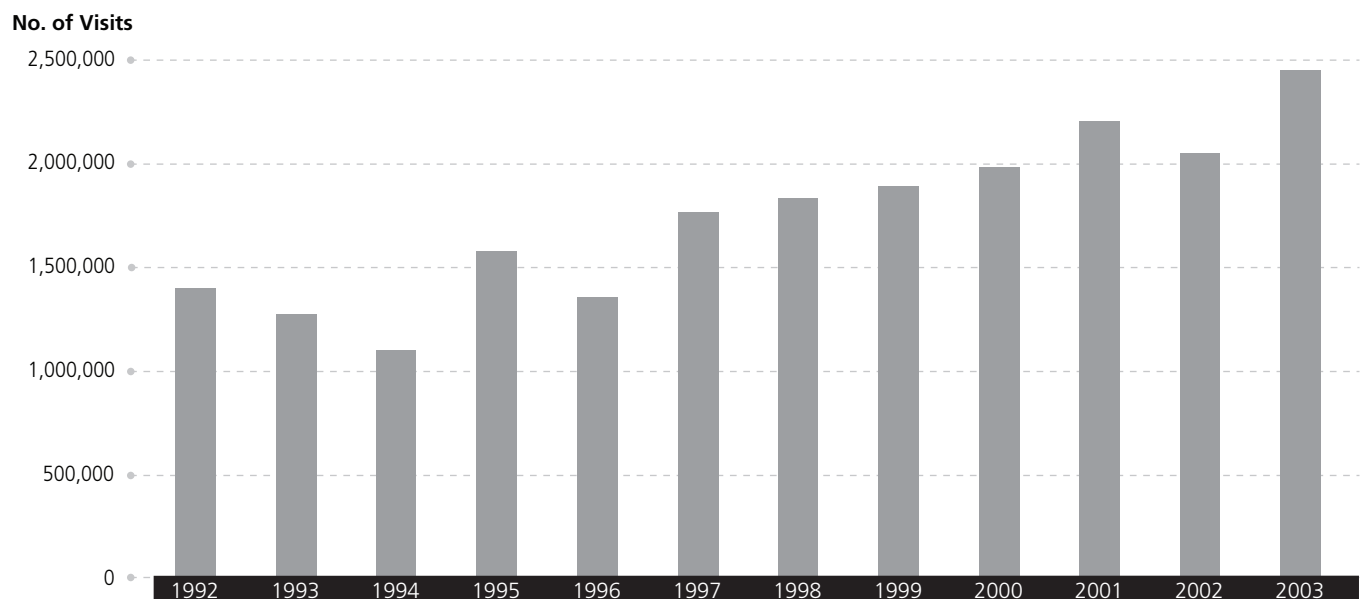
physicians believe the upsurge in ED visits from individuals with mental illness is negatively affecting access to emergency medical care for all patients, causing longer wait times, fueling patient frustration, limiting the availability of hospital staff and decreasing the number of available ED beds.¹⁴

Available data suggest that psychiatric bed closures by private hospitals have continued, but the relationship between these closures and increasing ED use is uncertain. The American Hospital Association reports that the combined number of psychiatric beds in freestanding psychiatric hospitals and dedicated units of general hospitals has declined by an additional 3 percent since 2002 (the most recent year for which comparable, national data are available across all types of inpatient psychiatric beds). Most of this decline was due to a reduction of beds in general hospitals. Bed capacity in freestanding psychiatric hospitals, though down from the level reported in 2002, rebounded slightly in 2005.¹⁵

“Other” Kinds of Psychiatric Beds

While general hospitals have reduced psychiatric beds, they have reportedly increased the use of nonspecialized scatter beds to treat psychiatric patients. Although this trend is not well documented, some observers

FIGURE 4
Emergency Department Visits for Mental Health Disorders



Source: Centers for Disease Control and Prevention, Advance Data from Vital and Health Statistics, nos. 245, 271, 275, 285, 293, 304, 313, 320, 326, 335, 340, 358, published 1993 through 2004; available at www.cdc.gov/nchs/products/pubs/pubd/ad/ad.htm.

have raised concerns about the growing use of scatter beds. Because these beds are not located in contained, locked units with high levels of security to regulate the access and egress of patients and visitors, these beds cannot be used for patients who are committed to an inpatient facility on an involuntary basis. Therefore, hospitals may be able to avoid serving difficult (and costly) patients by relying solely on scatter beds for the provision of psychiatric services. Because the nursing staff in general medical/surgical units do not have specialized expertise in the unique treatment needs of psychiatric patients, some question whether the care delivered in scatter beds is comparable in quality to the care delivered in dedicated psychiatric units.

Other alternative forms of around-the-clock psychiatric services include residential treatment centers (RTCs) for children and partial hospitalization programs or day treatment for adults that incorporate a residential option. These facilities are sometimes viewed as hybrids between institutional and community settings and are not reimbursed in the same way as hospitals. It is unclear whether all of these programs provide the level of patient supervision required to truly meet acute care needs. However, these bed types are often included in efforts to monitor psychiatric bed capacity.

Capacity in these newer forms of 24-hour psychiatric care beds has more than tripled, rising from only 24,435 beds in 1970 to 78,967 beds in 2002.¹⁶ Although the number of RTC beds has risen steadily over this period, bed supply associated with partial hospitalization programs has fluctuated, in large part due to Medicare payment policy. After reimbursement for partial hospitalization programs under Medicare was explicitly authorized in 1987, capacity in these programs rose sharply, with bed supply more than doubling between 1992 and 1994. Fraud and abuse investigations revealed financial irregularities and quality of care concerns in a number of partial hospitalization programs.¹⁷ Subsequent improvements in regulatory oversight were followed by a decrease in the number of residential beds available through these programs.¹⁸

Newer forms of acute treatment “beds” have helped to offset the declines in inpatient hospital beds, but this increase has not been large enough to counterbalance the magnitude of reductions in inpatient psychiatric capacity. Between 1990 and 2002, the number of beds reportedly available through “other” facilities rose by 25,565, while bed supply from traditional inpatient psychiatric providers fell by 86,619.¹⁹

A CRISIS IN CRISIS INTERVENTION SERVICES?

Anecdotal reports suggest that inpatient psychiatric capacity is becoming severely constrained in many communities and that more locales are beginning to experience this problem, although the magnitude of the shortage is not well documented. A 2006 survey of state mental health authorities revealed that over 80 percent of the states are reporting a shortage in psychiatric beds; 34 states report a shortage of acute care beds, 16 states

report a shortage of long-term care beds, and 24 states report a shortage of forensic beds.²⁰ As a result, 27 states report longer waiting lists for inpatient psychiatric services and 14 states are struggling with overcrowding in public psychiatric facilities. The American Psychiatric Association has called the inpatient psychiatric delivery system “fragile and beset by problems.”²¹

Reports of long wait times to find inpatient placements for psychiatric patients and of increased reliance on jails to address persons in mental health crisis are becoming increasingly common. Police are often dispatched to respond to 911 calls regarding persons in mental health crisis and traditionally have taken people into custody if harm to self or others appears imminent. Depending on the circumstances, officers may place these individuals under criminal arrest or escort them

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to the hospital emergency room until admission to a secure bed can be made. Across the country, police officers are reporting longer times spent in hospital emergency rooms while waiting for a bed to be found for persons in custody, as well as increased incarceration rates as officers seek to avoid the time delays associated with hospital-based services.

Although there appears to be widespread consensus that current capacity levels for acute psychiatric services are inadequate, the need for additional inpatient psychiatric beds is unclear. The President’s New Freedom Commission on Mental Health Subcommittee on Acute Care²² notes that “in some communities, the shortage of acute care beds has risen to crisis proportions. Too often, budget shortfalls have reduced funding for other essential community mental health services, consequently increasing the demand for already limited inpatient care as an alternative.” This statement reflects the tensions inherent in responding to the prevailing shortage of inpatient psychiatric beds. Advocates for persons with mental illness argue that perceptions of inpatient psychiatric bed shortages are distorted by inadequate funding for high-quality outpatient treatment and community-based forms of crisis intervention, resulting in unnecessarily high, or inflated, demand for inpatient psychiatric care. Evidence supports the belief that comprehensive and appropriately intensive outpatient services provide better health outcomes than inpatient treatment and reduce the demand for psychiatric hospitalization.²³ Many advocates believe that if ambulatory services were adequately funded and more easily accessible, demand for inpatient psychiatric hospitalization would decrease and obviate the need for additional inpatient bed capacity.

Community-based forms of crisis intervention, such as assertive community treatment and mobile crisis response teams, have been found to be highly effective and cost-efficient relative to inpatient-based acute treatment. Mobile crisis response services are often provided through collaborative arrangements between local mental health authorities and

police departments. Mobile crisis teams include trained mental health professionals who can relieve first responders at the call site, evaluate and frequently stabilize the person in crisis, and triage to community-based services for follow-up treatment. Where implemented, mobile crisis response has been found to produce lower hospitalization rates than those resulting from ED-based interventions²⁴ and to minimize the amount of time police officers must spend intervening in mental crises.²⁵ Small-scale studies have also found acute care services delivered through residential programs to be both less costly than and as effective as psychiatric hospitalization.²⁶ However, since it is likely that such programs vary considerably in terms of quality and intensity of services, it is difficult to generalize from available research.

Alternative forms of crisis intervention and intensive outpatient treatment do not appear to be widely accessible, largely as a result of funding limitations. Reimbursement constraints appear to have hampered the growth of community-based mental health services capacity. Often, public mental health agencies are the only providers of such services, and capacity levels are subject to budgetary limitations at the state and local level.

Despite these perceptions, capacity levels for alternative forms of crisis intervention have not been well documented. Unlike hospital beds, the capacities of community-based crisis intervention modalities are somewhat hard to gauge, very little information on the magnitude or quality of these service offerings is collected nationally, and regulatory oversight is very limited. The scope, staffing, and protocols of these programs vary substantially, further complicating efforts to develop national data.

ACUTE MENTAL HEALTH SERVICES IN THE 21ST CENTURY: CRYSTAL BALL

Financing and regulatory policies are likely to play a pivotal role in influencing the capacity of both outpatient and inpatient psychiatric services. Growth (or downsizing) in one sector will likely influence the utilization, financial viability, and capacity of the other. But the nature of this dynamic is hard to predict. Ideally, policies regarding inpatient and outpatient services would be considered in tandem to recognize this interplay and achieve a strategic balance of resource investment.

Impact of Inpatient Psychiatric Facility PPS

It is unclear whether recent changes to Medicare payment policy for inpatient psychiatric services will compound or mitigate psychiatric bed shortages. In January 2005, Medicare began paying for inpatient psychiatric services on a prospective basis, ending the 22-year PPS exemption that had applied to psychiatric facilities. Efforts to develop a diagnosis-based PPS for psychiatric facilities have been fraught with difficulty, leading to a three-year delay to the October 2002 implementation deadline set in the

Balanced Budget Refinement Act of 1999. For many of the same reasons that psychiatric services were exempted from inpatient PPS in 1983, a psychiatric patient classification system based solely on diagnosis poorly predicts the influence of case mix differences on variation in costs.

The PPS methodology ultimately developed for inpatient psychiatric facilities (IPF-PPS) set a prospective per diem base payment rate with payment amounts for each case adjusted for (i) patient characteristics—age, principal diagnosis (coded by diagnosis-related group, or DRG), select comorbidities, length of stay (recognizing the higher costs incurred in the early days of a psychiatric stay and the higher first-day costs associated with the operation of a full-service emergency room), and use of electroconvulsive therapy—and (ii) facility characteristics—rural location, teaching status, geographic wage index, and cost of living adjustments for Alaska and Hawaii. Outlier payments were made available for high-cost cases. A three-year blended transition period was established, with a stop-loss provision during the transition guaranteeing an average payment per case no less than 70 percent of the payment amount under TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982). Full transition to the IPF-PPS payment methodology and elimination of stop-loss protections is slated for 2008.

Some researchers believe that the IPF-PPS methodology does not adequately reflect patient differences that account for substantial variations in the resources needed to provide effective treatment. The cost of treating psychiatric patients is largely a function of the staff time spent assessing, directing, guiding, and monitoring them. Some of the patient characteristics found to affect staff time, such as severity of diagnosis and degree of suicidal or assaultive tendencies, are not reflected in DRG-based classifications.²⁷ For example, patients at extreme risk for harming themselves or others may be subject to seclusion or restraint procedures that require one-on-one observation from medical staff. Providers that draw more resource-intensive patients may be disadvantaged by this deficiency in the payment methodology.

Psychiatric providers are cautiously monitoring the effect of IPF-PPS on an industry that has experienced significant fluctuation in inpatient psychiatric capacity over the past two decades. Payment analysts predict that the IPF-PPS methodology implemented will likely serve to increase the reimbursement levels available to public mental hospitals, but the impact on other provider types is less certain. Some worry that the IPF-PPS may encourage general hospitals (which tend to have higher average cost structures than freestanding facilities) to further reduce inpatient psychiatric capacity in favor of more reliably profitable medical

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services or to shift beds from specialized units to scatter beds, which will not be reimbursed under IPF-PPS.

Others believe that IPF-PPS will not reduce bed supply and could create incentives for capacity expansions. While less efficient providers might eliminate psychiatric services, organizations that have developed the expertise and economies of scale to deliver psychiatric services in the most efficient manner could expand their operations, further enhancing their financial viability. Concerns have been raised that such expansions might be concentrated within for-profit, freestanding hospitals because they have lower cost structures and greater ability to target desirable patients. Such a shift has the potential to increase the overall supply of psychiatric beds but reduce access for the neediest patients. Both Medicaid's IMD exclusion and alleged attempts by freestanding facilities to limit utilization by the uninsured (for example, by avoiding the requirements of the Emergency Medical Treatment and Active Labor Act, or EMTALA, by not offering ED services) restrict the degree to which low-income patients can use the services of private, freestanding psychiatric hospitals.

The generosity of Medicare payments relative to those of other insurers could influence access for non-Medicare patients in unpredictable ways. The extent to which IPF-PPS effects will be augmented or counterbalanced by the coverage and reimbursement policies of other insurers is unclear. Shifts in providers' relative competitive positions and available capacity will affect their ability to negotiate with private payers and influence Medicaid payment rates.

The impact of IPF-PPS merits on-going attention from policymakers. Medicare represents a fairly modest share of revenue for both psychiatric units of general hospitals and freestanding psychiatric hospitals (about 30 percent).²⁸ However, historically changes in Medicare payment have had a significant influence on psychiatric capacity levels. It is too early to know if the move to prospective payment will have a positive or negative effect on psychiatric bed supply, but some impact is likely.

Changes in Medicare psychiatric payment policy may ultimately lead to changes to Medicaid policy as well. Some have called for private psychiatric hospitals to be exempted from the IMD exclusion to ensure that this type of inpatient psychiatric facility is available to meet the needs of Medicaid beneficiaries in the event that alternative placements are unavailable. Proposals to exempt some providers from (or entirely eliminate) the IMD exclusion are controversial, given the desire to move away from institution-based services. Ideally, policy efforts to assess and respond to IPF-PPS would also consider changes in the availability of outpatient mental health services and the extent to which access to these services is shaping demand for inpatient psychiatric care.

The generosity of Medicare payments relative to those of other insurers could influence access for non-Medicare patients in unpredictable ways.

FORECAST FOR OUTPATIENT SERVICES

Many consumer advocates believe that the best way to address shortages of psychiatric beds is to increase the availability of comprehensive, community-based services that include crisis intervention capabilities. However, such expansions are unlikely if funding streams for these activities remain unchanged. Some advocates believe that public and private health insurers should be more generous in their coverage and reimbursement for mental health services. Policy efforts to achieve parity in health insurance coverage for mental health services would likely increase the funding available for some types of outpatient mental health services. However, even broadly constructed parity requirements will have limited impact on the financing available for the many types of mental health services that fall outside the traditional medical model.

Health insurers do not typically cover the broad range of evidence-based services found to support mental health recovery. Many of the therapies demonstrated to be effective in treating mental illness, such as assertive community treatment and multisystemic therapy, include a range of interventions that are more closely associated with social support services than with medical services. Examples of these services include monitoring health status and treatment compliance through home visits and assisting patients to secure housing and employment. Hopes that managed care plans might create innovative, patient-focused interventions to better address mental disorders (and other types of chronic diseases) generally have not been met, and insurers find that prevailing financial incentives are not aligned to encourage such innovation. The feasibility of managing utilization of such services in a fee-for-service context is challenging; administrators of health plans may be wary of the adverse risk selection potential inherent in providing mental health benefits that are far more generous than standard offerings.

Federal officials have begun to question the inclusion of some of these comprehensive services within state Medicaid programs and are calling for increased delineation of such bundled services to clarify the appropriateness of Medicaid coverage. Reducing the federal matching funds available to finance outpatient mental health would likely lead to a decrease in the availability of these services. In light of prevailing outpatient financing policies, inpatient psychiatric shortages are not likely to be alleviated by expanded outpatient mental health capacity in the near future.

WILD CARD: BETTER INFORMATION

Research suggests that psychiatric services are particularly responsive to financial incentives.²⁹ Multiple theories have been posited to explain these observations, including (i) that psychiatric services are highly inefficient and have more opportunities to improve when faced with constrained resources; (ii) that appropriate treatment approaches are not well defined,

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giving providers latitude to change practices to maximize prevailing incentives; and (iii) that undertreatment of psychiatric cases is less visible because quality of care is difficult to measure.³⁰ All of these explanations suggest that better information is needed to guide mental health practice and policy.

The success of future attempts to monitor acute mental health capacity levels holistically will require more accurate data on both inpatient- and outpatient-based acute mental health services. Information on outpatient acute services is particularly difficult to track, as the nature of these services can vary widely and conventional capacity metrics have yet to be developed. Mental health treatment experts believe that untapped opportunities to provide more acute care in outpatient settings abound, but the circumstances under which outpatient treatment could be substituted for inpatient care are not well defined.

Experts have called for additional research to develop better methods for classifying levels of acute care and defining the clinical standards and protocols appropriate to each level. Such standards would help to guide the monitoring and assessment of acute capacity levels, regardless of the setting in which these services are offered. Improved standards for defining acute mental health care needs and services would be useful for a much wider variety of purposes, however. Well-defined acute care standards could be used to develop regulatory requirements at the state and local level, to construct analytic models to forecast the impact of proposed closures or expansions of psychiatric facilities, to guide utilization review techniques, and to evaluate whether IPF-PPS payment incentives are appropriately aligned.

A number of strategies have also been proposed to improve the efficiency and quality of both hospital- and community-based acute care services. Some of these needed improvements in clinical practice (such as expanded use of electronic medical records to facilitate continuity of care and better coordination among inpatient and outpatient providers to allow for seamless transitions across care sites) are certainly not unique to mental health services. But realizing these improvements within the mental health context does pose special challenges. The profound degree of fragmentation found in these services, as well as heightened sensitivity regarding patient confidentiality and autonomy of decision making, add a level of complexity that may be difficult to overcome in the absence of more formal integration across provider organizations.

The extent to which the delivery of acute services is complicated by the cognitive and behavioral effects of mental disorders can not be underestimated. Some have called for the expanded use of advance psychiatric directives to facilitate the delivery of acute services. Advance directives allow patients to both establish treatment preferences and authorize designated persons to make treatment decisions on their behalf in advance of crises during which their mental competency may be compromised.

These treatment planning efforts could address some of the legal and logistical hurdles that undermine the efficiency and effectiveness of acute mental health services.

Better information on both preferred and prevailing acute mental health practices, combined with well-calibrated financial incentives, has the potential to shape provider practices and encourage strategic decisions regarding service offerings and capacity levels that are advantageous for both treatment facilities and the communities they serve. But the interplay of these various incentives and best-practice recommendations—and the relative power of each—continue to evolve, making predictions regarding future capacity levels very speculative.

CONCLUSION

Ideally, mental health crises would be averted entirely. But they do occur and require effective interventions to mitigate their consequences. The word “crisis” is almost synonymous with terrible outcomes characterized by a devastating loss of control and an unanticipated disruption to the natural order of things. Yet, “crisis” is actually derived from the Greek word meaning “decision.” Mental health crises have the potential to be turning points that lead to recovery if appropriate decisions are made and response plans are in place.

The probability of positive outcomes is greatly enhanced by supportive acute mental health services. Policymakers face a number of difficult decisions in attempting to redirect the mental health system away from crisis-oriented care toward a system that optimizes consumer health and functionality. Efforts to build a more robust community-based system will be challenging. Some believe that the “old” system serves as a crutch, delaying investments in new approaches. Others believe that stabilizing inpatient psychiatric bed capacity in the short-term is crucial, given that a community-based infrastructure may take time to develop. The degree of fragmentation in mental health services exacerbates these tensions and suggests that the transition to a community-based model will not be seamless.

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