Beyond Beds

The Vital Role of a Full Continuum of Psychiatric Care



October 2017

NASMHPD

TREATMENT ADVOCACY CENTER

Beyond Beds:

The Vital Role of a Full Continuum of Psychiatric Care

Debra A. Pinals, MD
Medical Director, Behavioral Health and Forensic Programs
Michigan Department of Health and Human Services
Clinical Professor of Psychiatry
Director, Program in Psychiatry, Law and Ethics
University of Michigan

Doris A. Fuller, MFA
Chief of Research and Public Affairs
Treatment Advocacy Center

This work was supported by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services.

This National Association of State Mental Health Program Directors report is joint-released by the Treatment Advocacy Center

NASMHPD

TREATMENT ADVOCACY CENTER

NASMHPD.org/content/tac-assessment-papers
TreatmentAdvocacyCenter.org/beyond-beds

EXECUTIVE SUMMARY

Nearly 10 million individuals in the United States are estimated to live with a diagnosable psychiatric condition sufficiently serious to impair their personal, social, and economic functioning. Hardly a day goes by without a study, headline, court case, or legislative action calling for reforming the mental health system to better serve this population. Often, these calls to action end in two words: "More beds."

Largely missing from the outcry are answers to broader questions such as these:

- *What do we mean by "beds"? More precisely, what types of beds are needed: acute, transitional, rehabilitative, long-term or other?*
- *Are there differences in the needs of different age groups – youth, adults, older persons – and diagnoses that need to be reflected in the bed composition?*
- *What are the evidence-based outpatient practices that would reduce bed demand by reducing the likelihood that a crisis will develop or by diverting individuals in crisis to appropriate settings outside of hospitals?*

Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care addresses these questions and offers 10 public policy recommendations for reducing the human and economic costs associated with severe mental illness by building and invigorating a robust, interconnected, evidence-based system of care that goes beyond beds. Each recommendation is drawn from data and observation and is illustrated by the story of the ficitional Taylor, a representative young adult whose journey toward mental health recovery illustrates both the failings and the potential of the current continuum of psychiatric care.

Beyond Beds also launches a year of National Association of State Mental Health Program Directors (NASMHPD) publications reporting on aspects of psychiatric care that together can enhance the capabilities of a robust continuum. These include a review of comprehensive U.S. inpatient capacity, forensic bed capacity and number of beds; health integration and co-occurring substance use disorders; populations with intellectual and developmental disorders and other special needs; crisis intervention; homelessness; trauma-informed care; peer services; and health disparities and cultural competence. Each assessment is grounded in the premise that people with serious mental illness need and deserve access to the same levels of care that individuals with other medical conditions already commonly experience and that obstacles to such treatment need to be removed.

To lay the foundation for the detailed stakeholder recommendations that conclude each of these papers, policymakers at every level should take the following steps:

Recommendations

Recommendation #1: The Vital Continuum

Prioritize and fund the development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services known to improve outcomes for individuals of all ages with serious mental illness.

Recommendation #2: Terminology

Direct relevant agencies to conduct a national initiative to standardize terminology for all levels of clinical care for mental illness, including inpatient and outpatient treatment in acute, transitional, rehabilitative, and long-term settings operated by both the public and private sectors.

Recommendation #3: Criminal and Juvenile Justice Diversion
Fund and foster evidence-based programs to divert adults with serious mental illness and youth with serious mental illness or emotional disorders from justice settings to the treatment system. These programs should operate at all intercept points across the sequential intercept framework and be required to function in collaboration with correctional and other systems.

Recommendation #4: Emergency Treatment Practices
Monitor hospitals for adherence to the Emergency Medical Treatment and Labor Act in their emergency departments and levy sanctions for its violation, including the withholding of public funding. Hospitals with licensed psychiatric beds that refuse referred patients should similarly be sanctioned if monitoring shows they have a record of refusing referred patients without legitimate cause.

Recommendation #5: Psychiatric Beds
Identify those policies and practices that operate as disincentives to providing acute inpatient and other beds or that act as obstacles to psychiatric patients' accessing existing beds (e.g., the institutions of mental disease exclusion) and require hospitals benefiting from taxpayer dollar investments to directly provide or ensure timely access to inpatient psychiatric beds.

Recommendation #6: Data-Driven Solutions
Prioritize and fully fund the collection and timely publication of all relevant data on the role and intersystem impacts of severe mental illness and best practices.

Recommendation #7: Linkages
Recognize that the mental health, community, justice, and public service systems are interconnected, and adopt and refine policies to identify and close gaps between them. Practices should include providing "warm hand-offs" and other necessary supports to help individuals navigate between the systems in which they are engaged.

Recommendation #8: Technology
Create and expand programs that incentivize and reward the use of technology to advance care delivery, promote appropriate information sharing, and maximize continuity of care. Policymakers should require as a condition of such incentives that outcome data be utilized to help identify the most effective technologies, and they should actively incorporate proven technologies and computer modeling in public policy and practice.

Recommendation #9: Workforce
Initiate assessments to identify, establish, and implement public policies and public-private partnerships that will reduce structural obstacles to people's entering or staying in the mental health workforce, including peer support for adults and parent partners for youth and their families. These assessments should include but not be limited to educational and training opportunities, pay disparities, and workplace safety issues. The assessments should be conducted for the workforce across all positions.

Recommendation #10: Partnerships
Recognize the vital role families and non-traditional partners outside the mental health system can play in improving mental health outcomes and encourage and support the inclusion of a broader range of invited stakeholders around mental illness policy and practice.

BACKGROUND

That access to psychiatric beds is a topic of national urgency is an understatement.

Emergency physicians regularly issue grim reports on the boarding of psychiatric patients in emergency departments (EDs), and states are being sued—sometimes repeatedly—over bed waits. In the academic literature and mass media, psychiatric bed shortages are often blamed for homelessness, mass incarceration, mass violence, and a host of other individual and societal consequences. At times, it can appear there is no poor outcome or social system failure that cannot be attributed to the number of psychiatric beds in general, the number of state hospital beds in particular, and the trend known as deinstitutionalization.

The National Association of State Mental Health Program Directors (NASMHPD) is a membership organization of the state executives responsible for the nation's public mental health delivery system, including state hospitals. In the current environment, NASMHPD is frequently asked questions like these:

- How many psychiatric beds exist in the United States, where are they, who operates them, and who do they serve?
- How many psychiatric beds does the nation need, of what kind and where?
- What is the quality of care in these inpatient settings, and what are the outcomes they produce for patients, staff, and the public?
- Why do states continue eliminating psychiatric beds (or why are they not creating more) if these beds are in short supply?
- To what degree can homelessness; mass incarceration; violence—including suicide and homicide—substance use disorder prevalence; and a host of other clinical, social, and public health issues be attributed to the number of psychiatric beds available?

Authoritative answers have been hard to come by. No government agency publishes a comprehensive national census that includes all categories of available mental health beds—child/adolescent, adult and geriatric, forensic, public and private, crisis and rehabilitation, mental health and substance use, and all the others that serve patients with behavioral health conditions (see Figure 1). No evidence-based target number exists for how many psychiatric beds are needed at each level of care, either in the United States or elsewhere. Causality between deinstitutionalization and social trends that developed in the same time frame (e.g., increased incarceration and homelessness) is complicated by so many confounding factors that it is never beyond debate. At the same time, a consensus definition of "psychiatric bed" that would make answering any of these questions easier does not exist.

WHY *BEYOND BEDS*?
The Vital Continuum

Timely and appropriate supports are the first line of mental health care. When fully realized, they reduce the demand for the inpatient beds which provide essential backup when psychiatric needs cannot be met in the community.

RECOMMENDATION: *Policymakers should prioritize and fund development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services known to improve outcomes for individuals of all ages with serious mental illness.*

As crucial as these questions and their answers are, what is too often lost in the clamor surrounding them is the reality that 24/7 inpatient care represents only a single component of a well-functioning continuum of care for any life-threatening health condition. We readily acknowledge that patients with cancer, stroke, congestive heart failure, and an endless number of

other medical conditions may require hospitalization at some point, but we do not expect hospitals to provide all the care required for those patients to survive and recover.

Indeed, the U.S. health care system generally has moved to a model that prioritizes the swiftest possible return to the medical patient's natural environment. From 2005 to 2014, the total number of hospital stays for all causes fell by 6.6%; for mental health/substance use conditions, hospital admissions rose by 12.2% in the United States—the only category of hospitalization that increased in the time period.[1]

Figure 1: Estimated U.S. Psychiatric Bed Availability

U.S. Psychiatric Beds by the Numbers

1955	558,922 – inpatient psychiatric beds in state hospitals (peak year; 337 beds per 100,000 population)
2014	37,209 – inpatient psychiatric beds in state and county hospitals (11.7 beds per 100,000 population, of which 17,046 or 5.4 beds per 100,000 population are occupied by forensic patients)
	30,864 – inpatient psychiatric beds in general hospitals with separate psychiatric units (9.7 beds per 100,000 population)
	24,804 – inpatient psychiatric beds in private psychiatric hospitals (7.8 beds per 100,000 population)
	8,006 – inpatient psychiatric patients in medical/surgical "scatter" beds (2.5 beds per 100,000 population)
	3,124 – inpatient psychiatric beds in Veterans Affairs hospitals (1.0 beds per 100,000 population)
	3,499 – inpatient beds in other specialty mental health centers (1.1 beds per 100,000 population)
TOTAL	101,351 – inpatient psychiatric beds (29.7 beds per 100,000 population)

U.S. Residential Care Beds by the Numbers

2014	41,079 – residential treatment beds in residential treatment centers (12.9 beds per 100,000 population)
	183,534 – inpatients in nursing homes with diagnosis of schizophrenia or bipolar disorder (57.8 beds per 100,000 population)
2017	**Bed numbers not reported by public agencies**
	Child/adolescent beds, total public and private
	Geriatric beds, total public and private
	Acute-care mental health beds, total public and private
	Residential treatment beds specialized in transitional services, public and/or private
	Residential treatment beds specialized in rehabilitation services, public and/or private
	Residential treatment beds specialized in long-term services, excluding nursing homes
	Group-living beds, total public and private
	Supported housing beds, total public and private
	Psychiatric emergency room beds

Source: Substance Abuse and Mental Health Services Administration. (2014). *2014 national mental health services survey*, Tables 2.3 and 2.3.
Retrieved from https://wwwdasis.samhsa.gov/dasis2/nmhss/2014_nmhss_q.pdf

Prior to the late 20th century, the psychiatric hospitals operated by the individual states essentially were the U.S. mental health system. In 2014, NASMHPD issued *The Vital Role of State Psychiatric Hospitals* to examine and affirm the continuing place of state psychiatric hospitals in the continuum of recovery services for this population.

However, the era of state mental health authorities' holding the keys to the system is over. Today, private providers, public agencies serving specific subpopulations, managed care organizations and other insurers, courts and other justice stakeholders, corrections systems, community partners such as faith-based organizations, policymakers and budgeters at every government level, special interest advocacy groups, and of course, the individuals living with serious mental illness themselves influence, fund, oversee, provide, or participate in mental health service delivery and recovery.

The opportunities and options for improving mental health care have perhaps never been greater. The Mental Health Parity and Addiction Equity Act, the Comprehensive Addiction and Recovery Act, the 21st Century Cures Act, and other federal and state initiatives have been enacted largely in response to growing recognition by the public and policymakers that inefficient and ineffective care delivery is costly, and that discriminatory practices produce poor outcomes for a large and vulnerable population. Nonetheless, consensus on priorities, strategies, and steps to achieve this end has proven elusive. In this debate, few subjects have been as fraught as the issue of psychiatric beds.

In Search of a Definition

Despite cries for more of them, the term "psychiatric bed" has no commonly recognized definition.

In the most basic sense, a bed is a place where an individual can sleep at night, but that definition relates more to housing than to treatment. After all, jails report bed numbers, too.

TERMINOLOGY

Shared terminology for core components of mental health care is essential to discussing, defining, and establishing an evidence-based continuum. Standardized definitions in American Society of Addiction Medicine (ASAM) level of care guidelines for substance use and the Level of Care Utilization System (LOCUS) for psychiatric and addiction services are examples that model the benefits to clinicians, patients, and researchers of using a common language.

RECOMMENDATION: *Policymakers should direct relevant agencies to conduct a national initiative to standardize terminology for all levels of clinical care for mental illness, including inpatient and outpatient treatment in acute, transitional, rehabilitative, and long-term settings operated by both the public and private sectors.*

In the behavioral health world, beds were once defined principally by their location inside state hospitals. The term "psychiatric bed" continues to be used interchangeably with "state hospital bed," and also generically, as if all beds serve the same purpose. Yet, most mental health beds in the United States today are located outside state hospitals, and they serve a variety of purposes for distinct subpopulations, critical distinctions that are often lost in the larger beds narrative. Beds that provide the around-the-clock psychiatric nursing and psychiatric care once found only in state hospitals now also exist in university and community hospitals, charity and for-profit hospitals, private facilities dedicated entirely to mental health care, and other configurations. Patients such as older persons with dementia who once were housed almost exclusively in state hospitals now are accommodated in a variety of community settings. Persons with substance use challenges are often treated in

facilities to address their specific needs. To further complicate matters, treatment services and a place to sleep are often delivered in the same setting, such as nursing homes and supported housing, a dual purpose that is often missed in the beds conversation. Similar overlaps are seen in the child/adolescent behavioral health and welfare systems.

Beds where psychiatric care is delivered also exist outside hospital psychiatric units altogether:

- Crisis stabilization beds for a level of care short of hospitalization, generally for very brief lengths of stay (several hours to a few days)
- Transitional or respite beds in residential or other settings for 24-hour non-medical monitoring and significant supports, typically for a fixed or limited period following hospitalization
- Long-term beds in group living environments or adult foster care settings, board-and-care facilities, nursing homes and a variety of other placements for individuals with chronic mental illness who are not ready or able to reenter the community
- Jail or prison hospital beds operated by correctional systems for incarcerated individuals with mental illness, along with placements for youth in the delinquency system
- "Scatter beds" where psychiatric patients are treated in hospital medical-surgical and pediatric units[2]

These bed descriptions recognize functional differences and durations of stay, but funding also differentiates and complicates the examination of psychiatric beds. When virtually all psychiatric beds were in state hospitals, they were often called "public" beds because they were funded by state budgets. In today's world of managed care contracts and expanded Medicaid coverage, where psychiatric care in private settings may be provided through public insurance, the phrase "public bed" is antiquated, and even the notion of "publicly funded" can be problematic.

When a child/adolescent or adult bed in the psychiatric unit of a for-profit private, hospital is occupied by a patient whose treatment is publicly insured by Medicaid or Medicare, is that a private or public bed? The lack of a shared language for discussing psychiatric beds and the historical scarcity of comprehensive data about them has immeasurably complicated and obscured our understanding of the beds, their numbers, and their role in the continuum of psychiatric care.

Beyond terminology, philosophical differences also bedevil the beds conversation. More than 50 years after deinstitutionalization began, bed critics continue to fear that bed expansion on any scale could precipitate a return to the 19th-century model of institutional care that peaked in 1955. At the same time, after 50 years of watching state hospital bed numbers inexorably shrink, bed proponents fear that beds will continue to be closed until none are left. It is time to retire the extremes of both viewpoints. Three generations of pharmacological treatment development[3] and federal laws and programs such as the Social Security Disability Insurance program, the Americans with Disabilities Act, the Children's Health Insurance Program (CHIP) and its 2009 reauthorization, the Individuals with Disabilities Education Act (IDEA), and others now ensure that individuals with chronic conditions and disabilities, regardless of income, will be integrated into society and entitled to lives of inclusion.

At the same time, a recognition that hospital beds continue to play a vital role in providing acute and chronic care for a segment of the population with serious mental illness at times of need is widespread. This recognition has prompted some states and providers to reexamine bed numbers, and generated unprecedented support for repealing federal limits on Medicaid reimbursement to adult psychiatric facilities of more than 16 beds. Halting bed closures has been another approach.[4] With the extremes laid to rest, we will be better prepared to discuss the full continuum of psychiatric care in all its aspects.

STATE HOSPITAL BEDS AT THEIR PEAK…

It is 1955. There are nearly 560,000 state hospital beds in the United States 337 for every 100,000 men, women, and children.

The beds are occupied by patients with a wide variety of medical, neurological, and psychiatric conditions, including epilepsy, neurosyphilis, developmental and intellectual disabilities, schizophrenia, depression, and geriatric dementia, among others. Monuments to a 19th century period of social reform and a century of construction, many are sprawling clusters of buildings – the urban ones set in vast manicured lawns, the rural ones operated as self sustaining communities with their own farms and factories. In heavily populated areas like Southern California, it is nearly impossible to cross a county line without coming across a state hospital complex. Some patients stay briefly, while stabilizing from a mental health crisis; others enter in their youth and grow old on the state hospital grounds.

While the pendulum has continually swung between permissive and restrictive admission criteria, access has generally tilted toward allowing families to admit their young and adult children, spouses, and elderly parents to state institutions with little legal scrutiny, process, or question. Individuals may self admit as well. Patients are also committed by the courts because they meet civil commitment criteria that are typically broad and focused on a need for treatment, or because of simultaneous criminal justice involvement, a circumstance that ultimately becomes known as forensic or criminal justice involvement.

The quality and condition of the facilities and the treatment they provide is as varied as the patient population itself, some infamously decrepit and abusive, others therapeutic. Outside the hospitals, relatively few community centers have emerged to replicate, supplement or sustain the functions of the state hospitals.

All of this is about to change.

HOW WE GOT HERE

The period of state hospital downsizing and closure that has come to be known as deinstitutionalization began in the United States in the 1950s and, with a few exceptions, eventually became a worldwide phenomenon.[5,6] Although federal legislation in the 1960s vastly accelerated the trend, deinstitutionalization grew from a confluence of political, social, legal, ideological, clinical, economic, and other forces that began to emerge two decades earlier.[7]

By the 1940s, physical deterioration of many state hospitals nearing the century mark and deplorable conditions inside them were prompting media exposés and congressional hearings. Returning World War II veterans with psychiatric injuries expected to receive care in their home communities, not in institutions.[8] In 1953, the discovery of the antipsychotic effects of chlorpromazine (trade name Thorazine) made it possible to sufficiently resolve symptoms that individuals with psychotic disorders could, for the first time, live safely and stably in the community. On their own, a few states had begun recognizing the benefits of moving toward a decentralized, community-based model of care and opened community mental health centers. Already by 1955, state hospital bed numbers had peaked.

Fuel for the nascent shift came in the 1960s from the federal government. The Community Mental Health Centers Construction Act (CMHCA) of 1963 established community-based treatment as the national standard of care for people with mental illness and intellectual disabilities by authorizing construction of a national system of community mental health centers. Two years later, in 1965, the Social Security Disability Insurance program established Medicaid insurance for low-income individuals and those with mental health disabilities. By the early 1970s, lawsuits were restricting civil commitment. The ethos of society at the same time was shifting toward recognition of individual empowerment and autonomy. Due to these and the earlier developments, the pendulum swung away from the state hospital model and toward community-based care.

Had the community mental health centers envisioned by the CMHCA been developed to meet the needs of the full spectrum of psychiatric patients, including those with special needs, the system would likely have evolved differently. Instead, a succession of U.S. presidents and Congresses reduced and eventually eliminated federal funding for community-based mental health centers.

Meanwhile, Medicaid reimbursement was and has since been prohibited for treatment of individuals aged 22 to 64 hospitalized in psychiatric facilities of more than 16 beds, a provision known as "the institutions of mental disease (IMD) exclusion." This economic disincentive efficiently motivated states to downsize or close existing state hospitals and discouraged private enterprise from developing alternatives of more than 16 beds. In 2014, NASMHPD's *The Vital Role of State Psychiatric Hospitals* described this evolution of state hospitals. The report found that although some states had succeeded in building community-based systems or aspects of them, and peer-provided recovery services had begun to emerge, demand for mental health services had often outstripped community resources.[9]

For some populations, more tailored systems developed. Mental health services for children, for example, shifted to emphasize retention in family settings and brief placements rather than longer institutional care. For some conditions (e.g., neurosyphilis and epilepsy), medical discoveries produced cures or effective treatments for disorders that previously had been treated in state hospitals. For older adults, other long-term support services and models were crafted, and nursing homes took over the role that state mental health institutions had

held in the prior century. For individuals with intellectual disabilities, policies and institutions began to be separated organizationally and financially from mental health services to better serve the population.

For many individuals with serious mental illness, community settings and systems produced the positive results envisioned in the beginning with many people with mental illness living successfully in the community. However, other subgroups of state hospital patients became underserved or unserved and began to cycle in and out of acute care settings or migrate to jails, prisons, homeless shelters, and similar settings, a trend that has come to be known as "trans-institutionalization" or "cross-institutionalization."

Other trends contributed to this effect. Policies that criminalized drug use significantly impacted people with co-occurring disorders, routing them to jails rather than treatment. Housing market forces, restrictions on funding for housing, and "not-in-my-backyard" attitudes toward neighborhood housing contributed, too. Legislation to restrict criteria for commitment made it harder to intervene with individuals who declined or did not seek treatment until they became a risk of harm to themselves or others, at which point they increasingly attracted law enforcement response.

The net effect is problems like the following, which are widely recognized as symptoms of these and other system failures, including the lack of a full continuum of accessible psychiatric care:

- Psychiatric boarding, in which children and adults presenting in EDs are held for days and even weeks awaiting an open community hospital bed
- ED "streeting," in which ED patients are discharged without supports
- Forensic wait-listing, in which defendants spend weeks or even months in jails awaiting a state hospital bed

INTRODUCING "TAYLOR"

Taylor is 20 and diagnosed with schizoaffective disorder. He lives with his divorced mother in a tidy home not far from the suburban high school where he graduated two years ago. His story will be used throughout *Beyond Beds* to illustrate both the gaps and the opportunities in the continuum of psychiatric care.

> *It is midnight, and Taylor has just returned to his mother's home after several hours of drinking in a local park with his "friends," the personalities that his mother and other people claim do not exist but he knows are real. He knows he shouldn't drink a bottle of vodka like this, but once he starts, it's hard to stop. The house is quiet, his mother asleep or pretending to be, but he feels nervous and harassed. Sometimes his friends whisper commands him to do things in exchange for their friendship that get him in trouble with his mother, even the police, and they get mad when he does not obey. Tonight, they want to hear glass breaking, and the compulsion to satisfy them is haunting and troubling but feels too powerful to overcome.*
>
> *Taylor paces the living room and tentatively runs his fingers over a pane of glass at the front window before backing away and going to the kitchen. Beside the sink, he opens the cabinet where his mother keeps the dishes. So many dishes! Plates, bowls, glasses of all sizes. He chooses a small glass, the kind they use for orange juice, looks around for a target, and then hurls it against the farthest wall. The shards have not finished scooting across the floor before he hurls the next one and then another.*

Taylor benefited from an individualized education program (IEP) in high school and consistently received treatment, psychotherapy and educational support after his hospitalization for a suicide attempt while hearing voices. But his safety network fractured when he turned 18. The adult mental health system required a re-review of his eligibility for the community mental health services he received and the public benefits that helped pay for them, which produced a lapse in his support.

BEDS BEFORE ADULTHOOD

The child/adolescent mental health system is as complicated as the adult system but in different ways. A continuum of care is as important for youth as it is for adults, but the roles and influences of families, schools, child welfare systems and the juvenile justice system add different nuances and contexts.

In the child/adolescent service system, program goals relate to maximizing the tenure of youth at home and in school. To fulfill these goals, an array of interventions have been implemented, albeit inconsistently across and within the states. Interventions include mobile crisis intervention with in-home follow up supports, parent-peer support and coordinator/system supports, therapies and navigators to help the family. In the more robust continuums, pediatricians may have access to child psychiatrists, and clinical, residential and transitional systems work together through family centered, youth guided planning in a system that is sensitive to cultural differences.

We show Taylor receiving a full spectrum of child/adolescent benefits as a way of illustrating how a full continuum of care can work, not because it always does work better than the adult system.

Eventually, Taylor was assigned to a new clinic, but psychiatrists were in short supply, and it took three months for him to get an appointment there. In the interim, he stopped taking medication for the first time and had his first encounter with law enforcement when police were called because he refused to stop an aggressive rant at a neighbor he believed was plotting to kidnap him. He eventually returned to the mental health clinic, but it was not particularly specialized in working with emerging adults. Taylor's adherence to medication and his engagement with treatment never returned to the consistency he achieved while in the children's behavioral health system.

Taylor's story is fictional but contains many common elements of serious mental illness and its treatment in the service delivery system: onset of symptoms in adolescence, disruptive hand-offs between service providers and at specific age cutoffs, irregular adherence to medication and other treatment in adulthood, worsened symptoms when not treated, behaviors that frighten others even when not intended to be dangerous, and suicidal thinking and behavior. From here through the conclusion of this assessment, he will be the human face illustrating where gaps in the psychiatric care continuum persist and where strategies for addressing them exist beyond merely building more beds.

> *In her bedroom, where she rarely sleeps when her son is out at night, Taylor's mother is jolted upright by the sound of shattering glass. For one merciful moment, she hopes the sound merely signals an accident in the kitchen; with the next crash, she feels sick with fear and dread. Taylor has never hurt her, and his mother firmly believes he never will, but as one glass after another hits the wall on the other side of her wall, she takes comfort in the dead bolt she has reluctantly installed on her door.*
>
> *Groping for her cell phone in the dark, she wishes, not for the first time, that these episodes occurred only during business hours on weekdays. Then, she could have tried to reach Taylor's caseworker. Instead, finding the phone, she presses 9-1-1, desperately hoping tonight is one of the nights when an officer with mental health crisis training is on duty.*

Early in the course of his illness, Taylor probably would have benefited from a specialized first-episode psychosis (FEP) program[10] where evidence-based practices are provided as a comprehensive clinical strategy, but FEP programs did not exist when he first became symptomatic. In 2017, after nearly a decade of federal initiatives to expand such programs, they are growing in number, but most adolescents and young adults still live without access to one.

> *"Where is your son now, Mrs. Wilson? Can you still hear him?"*
>
> *The police dispatcher does not hang up until officers have taken control on the scene. To Taylor's mother, the voice is a lifeline.*
>
> *"I think he's throwing something bigger now, maybe cups. The sound is louder when they hit the wall."*
>
> *"Officers should be there within two minutes. Do you have a safe path to a door to let them in?"*
>
> *"I am locked in my bedroom. He probably left the front door open when he came in. The officers should be able to walk right in."*

MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

Mental illness is global, but mental illness response is local, and whether a 911 call is made during a first psychotic break or a relapse, it triggers one of several response types reflective of the circumstances and local conditions. These circumstances include:

- the individual's behavior at the time;
- the state where the person lives and its laws, policies, and practices related to who can be held for psychiatric evaluation and where they may go for one;
- the robustness of the community's mental health services and their accessibility;
- the existence of emergency, crisis stabilization, inpatient, and recovery beds and personnel;
- the training of local law enforcement in de-escalation tactics;
- access to crisis stabilization centers and police drop-off sites;
- the availability of jail diversion programs for individuals with mental illness;
- insurance status;
- —and many others.

A crisis like Taylor's will usually mobilize one of the types of responses described in Figure 2.

The sequential intercept model is a framework based on the premise that criminal justice involvement of individuals with mental illness can be reduced by identifying and redirecting them into treatment at various intercept points along the criminal justice continuum (e.g., during police encounters and court proceedings, upon jail or prison entry or reentry, while on community probation or parole supervision).[13] This framework, which was incorporated in the 21st Century Cures Act, has led to the development of many innovative diversion strategies as a means of reducing the likelihood that individuals with conditions like Taylor's will end up charged with a crime or in law enforcement custody.[14] That many individuals at risk of criminal involvement also have substance use challenges is widely recognized.

CRIMINAL AND JUVENILE JUSTICE DIVERSION

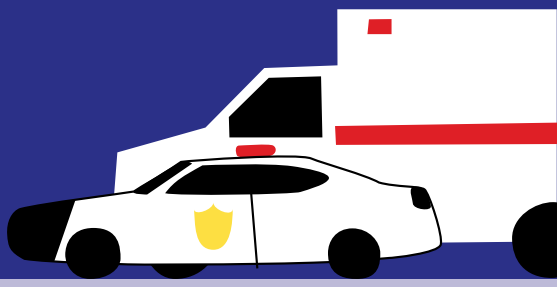
Though individuals with serious mental illness make up an estimated 4% of the population, "severe psychological distress" is reported to affect 26% of jail inmates and 14% of prison inmates overall and 20 33% of women inmates. Similar overrepresentation is seen in the juvenile justice system.

Evidence-based practices have been developed to prevent or diminish the prevalence of serious mental illness in the criminal and juvenile justice systems, but they are not universally available and remain underused.

RECOMMENDATION: *Policymakers should fund and foster evidence-based programs to divert adults and youth with serious mental illness or emotional disorders from justice settings to the treatment system. These programs should operate at all intercept points across the sequential intercept framework and be required to function in collaboration with correctional and other systems.*

Because his mother did not have the option of calling for a mobile mental health crisis response, Taylor's crisis has become a police incident, delivering him to this new "intercept" crossroads. Acting on the basis of their training and experience, the laws of their state, and practical realities such as the availability of acute-care options within their jurisdiction and how Taylor behaves on the scene, responding officers will decide whether Taylor's actions warrant his arrest on criminal charges, his transport to an emergency medical facility or their departure without further action. During the encounter, Taylor's risk of injury or death will be 16 times greater than that of members of the public without serious mental illness[15] and his risk of arrest six times greater.[16]

EXAMPLES OF PSYCHIATRIC CRISIS RESPONSE





Default Law Enforcement Crisis Response



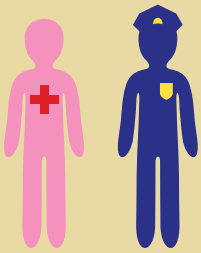
- **Most commonly practiced**
- Response by law enforcement officer
- Little training in mental health crisis or response
- With or without emergency medical backup

Specialized Police Response



- **Available in approximately half of US counties**
- Response by specially trained officers
- Immediate or near-immediate response time
- 24/7/365 response capability`

Collaborative Police-based / Mental Health Response



- **Emerging model;** usage data not available
- Joint response by police and mental health professionals
- Crisis response with mental health follow-up and guidance for police department

Mental Health-based Response



- **Promising model** if goal is to directly link to mental health system; usage data not available
- Part of mental health system; partnership with police
- Mental health responder(s) only
- **Families have the option to call mental health team rather than law enforcement**

Taylor's episode occurs on a Friday night. If he is arrested and his mother is too fearful to post bail for his release, Taylor will be kept in jail custody over the weekend, without access to prescribed medication or other mental health supports, waiting to go to court. He will be at risk of victimization,[17] suicide[18] and other violence.[19] If symptoms of the psychiatric state that led him to the dish-smashing episode are still evident when he reaches the courtroom (e.g., Taylor appears confused/disorganized/aggressive, makes statements that seem out of touch with reality, does not understand why he is before a judge or cannot communicate with his counsel), the judge may order an evaluation of Taylor's competence to stand trial before the matter can move forward in the criminal justice system.

Although practices vary by state, criminal competency evaluations typically take place in the jail, in the community or, less commonly, at the courthouse or state hospital. Once an individual is adjudicated incompetent to stand trial, laws in almost all states require restoration to legal competence before trial. Most states provide such restoration services in their state hospitals[20] even when the services are legally authorized for other settings, such as the community.[21] These services include medications and individual and classroom therapies but also explicitly teach information about courts and criminal processes.

When the number of pretrial jail detainees court-ordered into the state hospital for competency services exceeds available beds, forensic waits develop. These waits average from weeks in some states to more than a year in others,[22] and their numbers have been growing.[23] State mental health directors report that court-ordered restoration services are the single greatest source of pressure on state hospital bed supplies. States are attempting to reduce or eliminate their bed waits, but waitlists remain common, and many states have been sued—sometimes repeatedly—or threatened with lawsuits over the situation.[24] Some innovations hold promise for reducing forensic bed waits. Miami-Dade County in Florida has implemented a successful strategy for reducing bed waits by diverting individuals with psychiatric symptoms who commit minor criminal offenses directly to crisis stabilization units in the community instead of booking them into the county jail,[25] for example, and computer modeling is being explored as a tool for identifying small changes in common practices that would reduce forensic bed waits without adding beds.[26]

Family caregivers of individuals in crisis often call police under the assumption that law enforcement involvement will ensure their loved ones' safety and get them into treatment. Police say they arrest individuals in crisis for the same reasons and for public safety, and judges say they order competency restoration because there are no other accessible treatment options.[27] However, restoring criminal competence to stand trial is fundamentally a process to ensure that criminal defendants can participate in their own defense. Confinement and security, not treatment, are the priorities in correctional systems, and recent government data indicate that only one in five jails provides any form of psychiatric treatment to inmates.[28] Some pretrial defendants spend far more time waiting for competency services or undergoing them than they would have spent if convicted of their alleged offenses. Others are restored and returned to jail, where they relapse, return to the hospital, and cycle through the process anew, trapped in a revolving door of personal suffering and public cost.

A continuum of care that promotes mental health stability before law enforcement encounters occur and diverts individuals with mental illness from jail if they do occur (e.g., through mental health training for law enforcement, mental health specialty courts, or forensic assertive community treatment [ACT] teams) reduces the risk of arrest. However, such interventions and strategies are not sufficiently widespread and accessible, and thus the demand for competency restoration in state hospitals continues to grow.

MENTAL ILLNESS IN THE EMERGENCY DEPARTMENT

Despite the circumstances, Taylor is lucky. The officers who respond to his mother's 911 call are experienced in crisis intervention. They even know Taylor, having been called to the family home in previous emergencies. Though they are aware that calls involving psychiatric symptoms can be volatile, the officers act relaxed and friendly, asking him, "What's happening, man?" and giving him ample time and space to respond. They suggest that getting some sleep and a checkup at the local hospital might help him feel better.

Taylor stands, silent, arms slack at his sides, staring at his mother's door for several minutes. "Mom!" he finally shouts. "These guys want me to go to Community General with them."

The lock clicks open and his mother steps into the room. Taking in the broken glass and ceramics on the kitchen floor, she says, "Oh, Taylor. It's such a mess here, and it's already so late. Why don't you go with the officers? I'll come along and keep you company until they get you into bed."

Taylor squeezes his eyes shut, gives an exaggerated shoulder roll. Finally, with a sigh, he mutters, "Okay. Just for one night."

When there is an incomplete continuum of care, law enforcement and families rely on the Emergency Departments (EDs) of their local hospitals for psychiatric crisis intervention. The demand this creates contributes to ED crowding and often results in psychiatric "boarding," a practice in which psychiatric patients whose condition merits hospital admission are held in the ED because no inpatient bed is available to admit them.

The American College of Emergency Physicians (ACEP) reports that 90% of hospital EDs board psychiatric patients,[29] with bed wait times averaging three times what non-psychiatric patients experience.[30] Bed waits in EDs can last days or even weeks, and lawsuits, court orders, and costly settlements have resulted, just as they have with jail waits.[31] Studies of boarding patterns indicate that psychiatric patients who have the most extreme symptoms or are the most suicidal often wait the longest for admission or are discharged without care because of the difficulty of matching them to beds.[32] Virginia State Senator Creigh Deeds tragically became the face of this phenomenon when his son, Gus, stabbed and slashed him in the head and then killed himself hours after being released from an ED because personnel said they could not find a bed for him within Virginia's statutory time limit for admission.[33]

ACEP for two decades has been proposing strategies to reduce ED crowding, but reports only "minor gains" from the efforts.[34] The intractability of the problem despite efforts by this and other organizations and agencies reflects its complexity. Boarding is a symptom of need and resources that are not balanced. These needs include

- patient access to preventative and access to supports in the community that reduce the likelihood of crisis (e.g., ACT teams);[35]
- hospital access to real-time information about where and what kinds of beds are available (e.g., state bed registries);
- availability of intensive-care treatment alternatives outside of hospitals (e.g., crisis stabilization units in the community);

- law enforcement training and practices that influence whether law enforcement encounters like Taylor's are de-escalated at the scene (e.g., crisis intervention training)
- governing state laws and criteria that influence the volume of involuntary mental health evaluations and hospital admissions initiated through EDs;
- the absolute number of beds available within the hospital or within transport distance;
- the licensing and distribution of those beds (e.g., by gender, age, purpose); and
- staffing resources, including sufficient numbers of qualified mental health professionals willing to treat the population whether patients are in the public or private sector.

Changes in practice at any point on the continuum of care connected to the ED can impact boarding dramatically. One 2017 study, based on computer modeling, found that adding a single half-time clinician during the 8 a.m. to 4 p.m. shift could cut average wait time to discharge by 35% and average wait time to admission by 13%.[36] Conversely, when Sacramento, California, closed an outpatient crisis stabilization unit and eliminated 50 of 100 inpatient beds in 2009, the number of ED visits requiring psychiatric consultation at the city's university hospital tripled, and the average time psychiatric patients spent waiting to be seen by a psychiatric clinician in the ED increased from an average of 14 hours to nearly 22 hours.[37]

Relevant to treatment systems across the continuum, studies and surveys consistently find that patients in psychiatric crisis do not receive the same quality of health care in the ED that patients presenting with other medical conditions receive. Provider biases and prejudices that result in inferior intervention are reported.[38, 39] Misinterpretations and over-interpretations of confidentiality provisions of the Health Insurance Portability and Accountability Act (HIPAA) in psychiatric cases often leave caregivers out of treatment discussions that family members of other medical patients are afforded.[40]

EDs under-equipped to handle mental health emergencies may be even less prepared to expeditiously evaluate and place patients with co-morbid conditions such as substance use, intellectual/developmental disabilities including autism, sensory issues including deafness, and others.[41] "Emergency in the emergency room" is how more than a few observers have described the situation.

> *As he would in most EDs in the United States, Taylor finds himself waiting in the general ED population to be evaluated. Next to the broken-leg patient in the wheelchair and not far from the stabbing victim with a blood-soaked T-shirt wrapped around his wounds, Taylor grows increasingly anxious. The lights, bustle, and sounds add to the sensory overload he is already experiencing from his psychotic symptoms. He begins rocking in his chair, his lips moving as he talks softly to the voices in his head, his fingers repeatedly rising to the shirt pocket where his cigarettes usually rest, then dropping as he finds it empty. When he jumps to his feet and begins gesticulating in his inner conversation, surrounding patients begin to look alarmed. The stabbing victim's girlfriend sidles away to find a nurse.*
>
> *Taylor's mother wavers between staying next to her son and leaving to plead the case for finding a cubicle for him or at least a calmer corner. She feels guilty for promising him the hospital would be quieter than home. It never is.*

EMERGENCY TREATMENT PRACTICES

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires stabilization and treatment of all persons coming to an ED prior to transfer, regardless of their insurance status or ability to pay. Nonetheless, psychiatric patients wait longer in EDs than other medical patients for admission and experience other disparities, including discharge without treatment or even arrest. Potential receiving hospitals are not obligated to accept patients from EDs.

RECOMMENDATION: *Federal, state and local agencies should monitor hospitals for adherence to EMTALA in their EDs and levy sanctions for its violation, including the withholding of public funding. Hospitals with licensed psychiatric beds that refuse referred patients should similarly be sanctioned if monitoring shows they have a record of refusing referred patients without legitimate cause.*

Each year, there are an estimated 800,000 ED visits in the United States where the cause is symptoms of schizophrenia and 1.5 million visits where the presenting problem is associated with a mood disorder.[42] Optimally, psychiatric patients are seen in an area of the ED where they can be evaluated and cleared medically, then examined by a mental health specialist in no more time than a stroke or sepsis patient would wait for comparable services. At a minimum, a private space to distance them from the tumult of the ED, which can intensify symptoms is available, an accommodation that is especially critical for individuals who might find the sounds and activity of the typical ED overwhelming. In practice, most psychiatric patients are seen in the general ED, where, like Taylor, they are given a seat or a gurney and may spend hours or days in a public hallway.

An ED visit is another crossroads. What transpires there determines the patient's next step along the continuum of care, or off it. Figure 3 displays the most common ED outcomes for psychiatric patients.

The outcome that any individual patient experiences, like arrival at the ED itself, is a function of multiple factors, including the gravity of the symptoms; the patient's behavior; the availability of appropriate beds; the clinical assessment of the evaluator; the tenacity of the patient's advocates, who may include family members, outpatient providers and caretakers; and transient factors such as whether the hospital has a psychiatrist on staff.

All other factors being equal, however, if the supply of appropriate beds does not match the demand for them at this juncture, hospital admission likely will be delayed or denied altogether.

EMERGENCY DEPARTMENT OUTCOMES



Discharge by Arrest

- **Departure from the ED in police custody**
- Perceived as relatively uncommon
- Used when patient's behavior escalates beyond ED's capacity



Discharge Without Support

- **Also known as "streeting"**
- Perceived as relatively uncommon
- Discharged to the community without outpatient support



Discharge With Support

- **Symptoms have abated; return to community is reasonable and safe**
- Appropriate follow-up and outpatient support have been secured

1 in 5 ED patients with schizophrenia or mood disorders were discharged with support in 2015



Boarding

- **Bed waits of days, weeks or months in the ED**
- No appropriate placement is available

29 of 46 Responding states reported ED boarding in 2015

90% of ED physicians report boarding psychiatric patients



Hospital Admission

- **Admission to same hospital or elsewhere in the community**

38% of psychiatric ED patients admitted to the same hospital in 2015

Patients admitted to short-term-beds in another community hospital **8%**

5.8% Patients admitted to non-psychiatric "scatter" beds

PSYCHIATRIC HOSPITALIZATION

It is nearly 7 a.m. Taylor has been evaluated and determined to need hospitalization for monitoring and stabilization. Once she was assured he would have a bed, his mother went home to get some sleep. Taylor has been moved to a gurney pushed into a quieter corner of the ED, where he waits. He rejected the food his nurse brought him and is drowsy after accepting medication to relieve his anxiety.

There are no beds open in Community General's psychiatric unit. Under a contract with the county, the private hospital accepts patients held involuntarily as a danger to themselves or others, which makes voluntary patients like Taylor a lower priority for admission. There is no real-time bed registry for acute hospitals in his state. This leaves the crisis triage worker to hunch over a telephone in a cubicle off the nursing station, making call after call, hunting for a placement, a routine she follows several times in a single shift.

Most hospitals report that they are full or their units are currently too active, and maybe it will be better in the morning. A hospital two hours distant from Community General confirms it can admit Taylor. It takes another hour for the ambulance to arrive to transport him and two hours for the drive. It will be hours more before his mother finds him because Taylor left home without his cell phone and, observing confidentiality protections, Community General will not tell her where her son is or even confirm that he has been discharged to a hospital and not to the streets.

Even so, Taylor is again fortunate: His wait to admission lasted less than half a day. The nurse in the psychiatric unit when he arrives is welcoming and tells him it is fine to sleep through the morning group therapy session because he has earned some peace and quiet.

Inpatient treatment remains a vital component of the continuum of care.[49,50,51,52] At a minimum, emergency hospitalization allows time for stabilization of acute psychiatric symptoms, much as intensive care in a cardiac bed promotes stabilization of acute cardiac symptoms. When state hospitals functioned as virtually the entire mental health system, they were the

PSYCHIATRIC BEDS

A full continuum of care includes a sufficient number of beds to meet the acute, intermediate and long-term needs of those individuals with mental illness who require more intense or specialized services than are available in the community. Currently, statutory, licensing, funding and other policies are combining to limit bed supply and access in most states. Hospitals receiving public funding are not required to have psychiatric beds to serve their communities, and patients are often then hospitalized at sites far away from home.

RECOMMENDATION: *Identify those policies and practices that operate as disincentives to providing acute inpatient and other beds or that act as obstacles to psychiatric patients accessing existing beds (e.g., the IMD exclusion) and require hospitals benefiting from taxpayer dollar investments to directly provide or ensure timely access to inpatient psychiatric beds.*

main disposition point for patients transferred from community hospital EDs, whether voluntarily or involuntarily. It is largely a result of this model that state hospitals continue to be viewed as synonymous with psychiatric hospitalization.

Today, however, inpatient care extends far beyond state hospitals and far beyond hospitalization in other settings as well. Psychiatric hospitalization itself has been transformed. In 2014, approximately 75% of residential psychiatric beds were located outside of state and county hospitals,[53] and fewer than 2% of all public mental health care clients were treated in state hospitals.[54] Individuals 65 years of age or older, who made up 29% of the state and county hospital population in 1970, were being largely cared for in the community.[55] Although some state hospitals continue to accept voluntary patients, the majority of state and county beds are reserved for civil patients deemed by a court to meet criteria established by each state for involuntary commitment or, increasingly, by forensic patients involuntarily committed through the criminal justice system.[56,57]

> *In the hospital, Taylor is seen every day by a psychiatrist on rounds and goes to group therapy sessions led by an occupational therapist. The groups are mixed, some interesting and some not. He spends time in the day room, which is better than some he has seen, with a foosball game and a game table. In therapy with his social worker, he fills out familiar lists about "triggers" that upset him, his goals, and where he sees himself in a year. Already, she is talking to him about discharge.*
>
> *Taylor's social worker asks him about the medications he has been on over the years and what he likes and does not like about them. He says he noticed that he mostly stays out of trouble when taking medication and makes plans for getting a job, saving up money for his own car, and having a girlfriend. What he does not like is that the medications make him gain weight, but do not make the voices stop ordering him to do things he probably should avoid, like breaking his mom's dishes.*
>
> *Various members of his team describe a drug the doctor discussed with him at a treatment team meeting called clozapine. The nurses tell him people who have a history of drugs that do not eliminate symptoms often find this one works for them. They call that one of the pros. There are cons, too: regular blood testing, drooling at night and, probably, continued struggles to keep his weight down. His social worker asks him to consider going on clozapine despite the cons because it could control his symptoms better and make it easier to follow through on his plans and dreams. He says he will consider it.*

As with other medical conditions, insurers require clinical evidence that a continued hospital level of care is necessary at this point. With psychiatric hospitalization, justification requires describing impairments resulting from continued symptoms that cannot safely be managed without around-the-clock medical monitoring. Taylor's hospital experience illustrates how this strategy works in practice. On his third day of intensive hospital treatment, Taylor agrees to give clozapine a try. By then, he has accepted anti-anxiety medications and a few doses of antipsychotic medications when he complained the voices were overwhelming him. He is noticeably calmer and more focused in groups and is interacting socially with other patients. This all goes into his medical chart. He is still distracted by voices others cannot hear, but he opens up to his social worker, has no behavior issues, and reports and demonstrates no intention to harm himself or others. On the fifth day, his psychiatrist documents in Taylor's

DATA DRIVEN SOLUTIONS

Evidence-based public policy and practice require reliable, comparable, scalable data from which to identify, quantify, and analyze individual and community outcomes and thus implement best practices. Under new federal direction, more such data are becoming available, but their value to policymakers and the public continues to be limited by the lack of common definitions and methodologies, by delays in publication, and by barriers to public access.

RECOMMENDATION: *Policymakers should prioritize and fully fund the collection and timely publication of all relevant data on the role and intersystem impacts of severe mental illness and best practices.*

clinical notes that he is ready for a step-down placement. The insurer lowers payment to the hospital based on this finding, and the hospital's actual costs are no longer fully covered. Discharge becomes imminent.

In 2014, the federal government reported 800,000 hospital discharges of patients with schizophrenia and 1.5 million discharges of those with mood disorders, including bipolar disorder and major depression. Discharge practices vary by state and by county within states and are influenced by state laws, public policy priorities, state and local budgets and a host of other factors. While two to three weeks are necessary for antipsychotic medications such as clozapine to reach a therapeutic level at which they significantly reduce symptoms, few patients outside of state hospitals remain inpatients long enough for that to happen. In 1980, the median length of stay (LOS) for an acute episode was 42 days.[58] By 2014, it was about seven days.[59] At 77 days, the average LOS is much longer in state hospitals,[60] one of the reasons that some researchers, advocacy groups, family members and others continue to call for more state hospital beds.

One analysis compared state data and found shorter state hospital LOS to be associated with higher rates of readmission,[61] but the link between LOS and outcomes is largely unexplored at the patient level. Those data that do exist about LOS typically are not diagnosis-specific, making it difficult to determine whether LOS is more critical for some diagnoses or symptoms than others. This dearth of information deprives all the stakeholders of an essential ingredient for evidence-based LOS guidelines and practices. Also lost are the findings necessary to make an outcome- or cost-based rationale for expanding transitional residential beds as a means of reducing the demand for hospital beds and improving mental health outcomes overall.

In a more complete continuum of care, Taylor's episode likely would have been avoided entirely, or he would have gained immediate access to the level of care needed, avoiding the encounter with police, visit to the ED, and hospitalization. The next stage of his journey illustrates how an integrated approach with a full spectrum of appropriate services works to achieve better outcomes.

TRANSITIONAL BEDS

Taylor's social worker is the one who tells him about Stepping Stones House. He will eat and sleep there temporarily, but it is not a hospital, she promises. It is small – only six beds in a real house, in his home county. He will see some of the same kinds of people he does in the hospital – a social worker, a psychiatrist, a caseworker – but he will meet new ones. Stepping Stones' staff will introduce him to an entire team that will be "his" once he moves back to his mother's home or to another setting. They will link him to the clozapine clinic that operates at an academic medical center he will be able to reach by public transit. While his medications are still being adjusted and his psychiatric symptoms continue to subside, Stepping Stones will work with Taylor to map his next steps and provide the linkages to services that will support his further recovery.

Taylor also will be connected with a young adult peer with a serious mental illness diagnosis who has been trained to support others with similar disorders and help them navigate their own recovery journeys. As long as Taylor attends group sessions and stays on the plan his treatment team has developed with him, he will be able to go on unsupervised outings with his mother or the trained peer. And after two weeks, maybe less, he will move to an even less restrictive setting that his team inside and outside Stepping Stones will work with him to select. His mother says he is welcome to come back home, but the Stepping Stones House staff also can introduce him to group living options near his home if he wants to try something different until he is ready to live more independently.

LINKAGES

Outpatient supports could effectively increase bed capacity by reducing the number of patients in need of inpatient care. However, because these often are unevenly distributed and operate in silos rather than in collaboration, system inefficiencies occur that create barriers to recovery as individuals are left to themselves to navigate a complex array of interventions despite their significant mental health and other challenges.

RECOMMENDATION: *Policymakers should recognize that mental health, community, justice and public service systems are interconnected and adopt and refine policies to identify and close gaps between them. Practices should include providing "warm hand-offs" and other necessary supports to help individuals navigate between the systems in which they are engaged.*

Residential treatment beds are the fastest-growing category of capacity in the United States. Since 1970, the number of such beds has doubled, from 6.8 beds per 100,000 people to 13.5 per 100,000 in 2014.[62] Terminology differs by locale. They may be described as "respite," "transition" or "step-down" services, or by another name, but their essential characteristic is providing a place to stay that is monitored by non-medical staff who are trained in medication administration and who provide transportation and other support and structure. They generally do not have a psychiatrist or a nurse on-site but may have medical personnel on call in the case of an emergency. The stays are short-term, typically four weeks or less.

Functionally, transitional beds may operate either as a hospital diversion or a hospital step-down strategy. Residents typically are referred by the public mental health system, hospitals

or other public agencies; individuals and private providers cannot access them. Had Taylor still been engaged with the mental health system when symptoms that led to his latest psychotic episode began, he could have been referred to Stepping Stones to head off the emergency. Respite, structure, abstention from alcohol and other substances, refocusing on his goals, medication adjustments, and other supports might have stabilized him sufficiently to return home and carry on with no further intervention. The police call, ED visit, and hospital stay would have been averted, along with the resulting stress on Taylor and his mother and the costs to the systems involved. Had he continued to destabilize, he could have been transferred from Stepping Stones to the inpatient unit, and perhaps back again before returning home.

TECHNOLOGY

Mental health applications for computer and other technologies are proliferating and hold promise for promoting more precise, timely and effective treatment for individuals with serious mental illness. At the same time, computer models are emerging that equip decision makers to analyze large data sets and project the impact of small changes to systems of care to better tailor interventions toward positive outcomes. Technology assisted medical record keeping has increasingly been constructed to preserve and draw down clinical information, while maximizing allowable sharing of such information between clinicians through health information exchanges.

RECOMMENDATION: *Policymakers should create and expand programs that incentivize and reward the use of technology to advance care delivery, promote appropriate information sharing and maximize continuity of care. Policymakers should require as a condition of such incentives that outcome data be utilized to help identify the most effective technologies, and they should actively incorporate proven technologies and computer modeling in public policy and practice.*

There have been few studies to assess the effectiveness of transitional residential programs in producing measurably improved outcomes, but their role in linking people with mental illness to evidence-based programs and other promising supports strongly suggests an indirect association. For example, Stepping Stones staff makes sure every qualifying resident moves on with an active application for services such as mobile ACT teams, and members of the ACT team for his area will come to Stepping Stones to meet Taylor. Sometimes called "hospitals without walls," the ACT model has repeatedly been found to reduce re-hospitalization and improve other outcomes.

Because of the nation's psychiatrist shortage, Taylor may have to wait a month or two for an appointment with a supervising psychiatrist, as he did when he transitioned from youth to adult services. To bridge that gap, the staff at Stepping Stones introduces Taylor to a tele-psychiatrist from a different region who is on contract to provide interim services. Taylor also is introduced to some of the newest mobile apps for mental health. Although still to be fully studied, apps show promise in monitoring symptoms and keeping patients connected to their community providers.[63] He is allowed to use his mobile phone for an extra hour each day if he downloads at least two apps and works at becoming familiar with them. Interestingly, Stepping Stones staff also are encouraged to use apps to manage their own stress and mitigate compassion fatigue.

Stepping Stones is able to bill Medicaid for Taylor's medication supervision and some of its services, but the rest of its services are funded by Taylor's county. By tracking and analyzing intersystem costs, the county was able to determine that funding Stepping Stones 24/7, 365 days a year costs less than maintaining the status quo without hospital diversion and hospital step-down.

WORKFORCE

The capacity of any system to deliver services effectively and efficiently is impaired by workforce shortages. Both outpatient and inpatient mental health services and supports are being limited in many locations because there are not sufficient numbers of trained workers and certified peers to provide them. These neglected services include psychiatric beds that cannot be used because they are unstaffed. Limiting services in turn limits opportunities for recovery and the benefits of recovery to individuals and their communities.

RECOMMENDATION: *Policymakers at every level should initiate assessments to identify, establish and implement public policies and public-private partnerships that will reduce structural obstacles to people entering or staying in the mental health workforce. This workforce includes peer support for adults and parent partners for youth and their families. These assessments should include, but not be limited to, educational and training opportunities, pay disparities, and workplace safety issues, and the assessments should be conducted for the workforce across all positions.*

For example, county officials found that law enforcement officers had spent more than 60,000 hours during the previous year driving people in psychiatric crisis to EDs, between EDs and admitting hospitals, and more rarely, to the state hospital, four hours away. The county's costs for psychiatric emergencies also included paramedic hours, ED, and local hospital charges for patients held for emergency evaluation, the costs of medication for inmates in the county jail, and medical costs for citizens and law enforcement injured during encounters.

A majority of the county commissioners eventually decided that every county resident with a serious mental illness who did not have a crisis in any given year represented a dollar–or many dollars–saved. By the time Taylor entered Stepping Stone House, the county mental health department had already been directed to find another small residential house where a second Stepping Stone House could be opened.

LIVING IN THE COMMUNITY

Taylor leaves Stepping Stones after three weeks. He goes back to his mother's home for the time being, but he is on a waiting list for a room in a staff-supported group living environment not far from where she lives. He has mixed feelings about leaving his boyhood home because there he knows what to expect, and his mom's food is good. But most of the friends with whom he went to high school went away to college after graduating. For now, this is a step in a similar and hopeful direction.

PARTNERSHIPS

A growing number of advocacy organizations, faith based communities and others outside the mental health field are emerging as able and willing to support and supplement public resources. In some circumstances, such as with children, families are being included in treatment and policy development in new and more vigorous ways.

RECOMMENDATION: *Policymakers should recognize the vital role that families and non-traditional partners outside the mental health system can play in improving mental health outcomes and should encourage and support the inclusion of a broader range of invited stakeholders around mental illness policy and practice.*

Taylor's trajectory is unlikely to be without further setbacks. He lives with a serious mental illness that can be unpredictable, with symptoms that come and go and can be more or less impairing at different times. He will be more stable and successful while consistent with medications, but there can be breakthrough symptoms or incomplete remission and, like most people with chronic conditions, it is likely he will periodically go off his prescribed medicine.

Depending on the symptoms he develops when he rejects treatment, civil or criminal courts may become involved in his care. He will have a range of side effects from annoying to, in very rare cases with clozapine, life-threatening. The weight gain associated with his medications places him at risk for developing comorbid health conditions, such as diabetes. His cigarette smoking compounds his risks.

Taylor's trajectory will, to some extent, depend on how thoroughly and successfully his local mental health agency is funded and how it is equipped to invest in programs that promote his well-being and success. He will benefit from access to integrated health care in which his medical and mental health providers collaborate on his treatment and care. His mother will remain a critical foundation of his stability, as family members can be, but she will need support and encouragement, too. Ultimately, Taylor's recovery will be a product of how completely the continuum of care serves him, along with his own courage and determination.

When he leaves Stepping Stones House after a stay of nearly three weeks, Taylor feels more hopeful than he has in a long time. His team has expanded well beyond his mom and a caseworker. He moves into a house with a half-dozen other young men and women with disabilities and enters a Clubhouse International day program nearby. There, he meets and socializes with others in mental health recovery and receives employment coaching. Through the Clubhouse's introductions, he gets hired as a bagger by a local grocery store committed to employing people with special challenges. Clubhouse emphasizes and encourages sobriety to participate, which motivates Taylor to follow through with a vow to stay away from substances that have undermined his recovery in the past. After one of his new friends introduces him to a local church program that provides scholarships to attend

the local community college, he enrolls in a psychology class. On his first night back in school, he meets a young woman who eventually becomes his girlfriend.

Taylor has one short relapse after he decides he has recovered beyond any need for medication and stops taking his clozapine, but he stabilizes quickly during a brief stay at Stepping Stones and returns to his group living environment, job, and girlfriend. Occasionally, the old voices break through and speak up again, but he has learned tactics for ignoring them, and he no longer gets into trouble when they do. As he works his way to the top of the list for a supported housing apartment, he and his case manager agree he is ready for less frequent appointments, and his meetings with the peer support worker from Stepping Stones shift from weekly to twice-monthly.

Taylor is on his way.

CONCLUSION

Taylor's story, although fictional, represents the challenges of a young adult with a chronic and serious mental illness. His role in this paper is to illustrate both the gaps and the opportunities in the continuum of mental health care. We depict him as having received excellent supports as a young adolescent with youth-guided and family-driven care, and then, when our story begins, experiencing symptoms and personal setbacks after the transition to adult services.

Comparatively, his narrative illustrates more positive than negative outcomes: He was not arrested during his crisis, spent less than a day in the ED, was admitted to a psychiatric bed for treatment of his acute symptoms, accepted new medication, and was discharged to transitional care, which became a turning point. "More positive than negative," however, should not be considered acceptable for someone like Taylor, but more psychiatric beds alone would not have improved the outcome.

A robust system of care for individuals with serious mental illness must look beyond beds and offer comprehensive and quality treatment and services before, during, and after acute illness episodes. Without a broader view of what is needed, individuals with mental illness will remain at risk of negative outcomes, including hospitalization and rehospitalization, arrest and re-arrest, homelessness, and even early death. Efforts across the country are underway to build successful alternatives to these outcomes–a good start–but validation, replication, and proliferation of effective treatment practices for individuals of all ages are urgently needed in communities of every size nationwide.

The era of mental health care that is centralized and provided primarily through government-operated inpatient facilities is over. For more people with serious mental illness to survive and thrive, we need better early detection and prevention practices, more precise diagnostic methods, more targeted and effective medications with fewer side effects, more parity with care for other medical conditions, and less isolation for individuals with psychiatric illness. We need to know more about why devastating co-occurring substance use is so common in mental illness and develop effective approaches to reducing it.

On every level, the rush to "more beds" needs to be tempered with illumination and clarity about patient need, the kinds of beds best suited to meet those needs, and the recognition that bed capacity is a function of more than sheets on a mattress. Only a complete continuum of psychiatric care can reduce the human and economic costs associated with mental illness.

REFERENCES

[1] McDermott, K. W., Elixhauser, A., & Sun, R. (2017). *Trends in hospital inpatient stays in the United States, 2005–2014.* Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.pdf

[2] Slade, E. P., & Goldman H. H. (2015). The dynamics of psychiatric bed use in general hospitals. *Administrative Policy in Mental Health, 42(2)*, 139–146.

[3] Carpenter, W. T., & Davis J. M. (2002). Another view of the history of antipsychotic drug discovery and development. *Molecular Psychiatry, 17(12)*, 1168–1173.

[4] Lutterman, T. (2015). *Tracking the history of state psychiatric hospital closures from 1997 to 2015*. Falls Church, VA: National Association of State Mental Health Program Directors Research Institute, Inc.

[5] Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry, 15*, 276–286.

[6] Geller, J. L. (2000). The last half-century of psychiatric services as reflected in *Psychiatric Services*. *Psychiatric Services, 51(1)*, 41–67.

[7] Torrey, E. F. (2014). *American psychosis: How the federal government destroyed the mental illness treatment system*. New York, NY: Oxford University Press.

[8] Brown, P. (1979). The transfer of care: U.S. mental health policy since World War II. *International Journal of Health Services, 9(4)*, 645–662.

[9] Parks, J., & Radke, A. (eds.). (2014). *The vital role of state psychiatric hospitals*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved from http://www.nasmhpd.org/sites/default/files/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

[10] Substance Abuse and Mental Health Services Administration. (n.d.). *Understanding first-episode of psychosis*. Retrieved from https://store.samhsa.gov/shin/content/SMA16-5006/SMA16-5006.pdf

[11] Borum, R., Deane, M. W., Steadman, H. J. & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness. *Behavioral Sciences and the Law, 16*, 393–405.

[12] Reuland, M., Schwarzfeld, M. & Draper, L. (2009). *Law enforcement responses to persons with mental illness: A guide to research-informed policy and practice*. New York, NY: Council of State Governments Justice Center. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2012/12/le-research.pdf

[13] Munetz, M. R. & Griffin P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57(4)*, 544–559.

[14] Pinals, D. A. (2014). Forensic services, public mental health policy, and financing: Charting the course ahead. *Journal of the American Academy of Psychiatry & Law, 42(1)*, 7–19.

[15] Fuller, D. A., Lamb, H. R., Biasotti, M., & Snook, J. (2015). *Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters*. Arlington, VA: Treatment Advocacy Center. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf

[16] Livingston, J. D. (2016). Contact between police and people with mental disorders: A review of rates. *Psychiatric Services, 67*, 850–857.

[17] Harral, E. (2017, July). *Crime against persons with disabilities, 2009–2015 statistical tables*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from https://www.bjs.gov/content/pub/pdf/capd0915st.pdf

[18] Noonan, M. E. (2014, October). *Mortality in local jails and state prisons, 2000–2012 statistical tables*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from https://www.bjs.gov/content/pub/pdf/mljsp0012st.pdf

[19] Human Rights Watch. (2015, May 12). *Callous and cruel: Use of force against inmates with mental disabilities in U.S. jails and prisons*. Retrieved from https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and

[20] Wik, A., Hollen, V. & Fisher, W. H. (2017). *Forensic patients in state psychiatric hospitals: 1999–2016*. Falls Church, VA: National Association of State Mental Health Directors Research Institute, Inc. Retrieved from https://nasmhpd.org/sites/default/files/TACPaper.10.Forensic-Patients-in-State-Hospitals_508C.pdf

[21] Fuller, D. A, Sinclair, E., Lamb H. R., Cayce, J. D., & Snook, J. (2017). *Emptying the "new asylums": A beds capacity model to reduce mental illness behind bars*. Arlington, VA: Treatment Advocacy Center. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf

[22] Ibid.

[23] Wik et al. *Forensic patients in state psychiatric hospitals*.

[24] Fuller et al. *Emptying the "new asylums"*.

[25] South Florida Mental Health Association. (2016). *Miami-Dade Forensic Alternative Center pilot program status report*. Retrieved from https://www.neomed.edu/wp-content/uploads/CJCCOE_11_FACStatus.pdf

[26] Fuller et al. *Emptying the "new asylums."*

[27] Fitch, W. L. (2014). *Assessment #3: Forensic mental health services in the United States: 2014*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved from https://nasmhpd.org/sites/default/files/Assessment%203%20-%20Updated%20Forensic%20Mental%20Health%20Services.pdf

[28] Bronson, J. & Berzofsky, M. (2017, June). *Indicators of mental health problems reported by prisoners and jail inmates, 2011–2012*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

[29] American College of Emergency Physicians. (2016, October). *Physician poll on psychiatric emergencies.* Irving, TX.

[30] Zeller, S. (2015). *Psychiatric boarding problems in the emergency department*. Oakland, CA: Alameda Health System.

[31] In July 2017, AnMed Health in South Carolina was ordered to pay nearly $1.3 million to settle 36 cases in which patients in psychiatric crisis were boarded from six to 38 weeks each during 2012–2013, per Meyer, H. (2017, July 6). S.C. hospital to pay $1.3 million for not properly treating psych patients. *Modern Healthcare*. Retrieved from http://www.modernhealthcare.com/article/20170705/NEWS/170709977

[32] Bender, D., Pande, N., & Ludwig, M. (2008, October). *A literature review: Psychiatric boarding*. Washington, DC: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

[33] Portnoy, J. (2016, January 5). Va. Sen. Creigh Deeds sues the state, others for $6 million in son's suicide. *Washington Post*.

[34] American College of Emergency Physicians. (2016). *Emergency department crowding: high impact solutions*. Irving, TX.

[35] The Joint Commission (2015, December). Alleviating ED boarding of psychiatric patients, *Quick Safety 19*. Retrieved from https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_19_Dec_20151.pdf

[36] Chepenik, L., & Pinker, E. (2017). The impact of increasing staff resources on patient flow in a psychiatric emergency service. *Psychiatric Services, 68(5)*, 470–475.

[37] Nesper, A. C., Morris, B. A., Scher, L. M., & Holmes, J. F. (2016). Effect of decreasing county mental health services on the emergency department. *Annals of Emergency Medicine, 67(4)*, 525–530. Retrieved from http://www.annemergmed.com/article/S0196-0644(15)01270-6/fulltext

[38] Dovidio, J. F., & Fiske S. T. (2012). Under the radar: How unexamined biases in decision-making processes in clinical interactions can contribute to health care disparities. *American Journal of Public Health, 102(5)*, 945–952

[39] Lawrence, D., & Kisely S. (2010). Inequalities in healthcare provision for people with severe mental illness. *Journal of Psychopharmacology, 24*, 61–68.

[40] Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce. (2013, April 26). *Does HIPAA help or hinder patient care and public safety?* U.S. House of Representatives, 113th Congress. Retrieved from https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82190/html/CHRG-113hhrg82190.htm

[41] The Joint Commission. Alleviating ED boarding of psychiatric patients.

[42] Agency for Healthcare Quality and Research. (n.d.). Emergency department national statistics, 2014. Rockville, MD: Healthcare Cost and Utilization Project. Retrieved from https://hcupnet.ahrq.gov/

[43] Ibid.

[44] Ibid.

[45] National Association of State Mental Health Directors Research Institute, Inc. (2015). State Mental Health Authority Profiling System: 2013 Retrieved from http://www.nri-incdata.org/ProfilesDataReport.cfm?Field=P_11&Database=Profiles13&ReportSelect=P_11,%20P_11a,%20P_11b,%20P_11c,%20P_11c1,%20P_12,%20P_12a&Ptable=P13Policy1&Year=13

[46] American College of Emergency Physicians. *Physician poll on psychiatric emergencies*.

[47] Ibid.

[48] Ibid.

[49] National Association of State Mental Health Program Directors. (2014). *Assessment #10: Expenditures*. Retrieved from https://www.nasmhpd.org/sites/default/files/Assessment%2010%20-%20Expenditures.pdf

[50] La E. M., Lich, K. H., Wells, R., Ellis, A. R., Swartz, M. S., Zhu, M., & Morrissey, J. R. (2015). Increasing access to state psychiatric hospital beds: Exploring supply-side solutions. *Psychiatric Services, 67*, 523–528. Retrieved from http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201400570

[51] Allison, S., Bastiampillai, T., Fuller D. A., Gupta, A., & Chan, S. K. (2016). The Royal Australian and New Zealand College of Psychiatrists guidelines: Acute inpatient care for schizophrenia. *Australian & New Zealand Journal of Psychiatry, 51(2)*, 191-192.

[52] Page, A. C., Hooke, G. R., & Rampono J. (2005). A methodology for timing reviews of inpatient hospital stay. *Australian and New Zealand Journal of Psychiatry, 39*, 198–201.

[53] Lutterman, T., Shaw, R., Fisher, W. H., & Manderscheid, R. (2017). *Trend in psychiatric inpatient capacity, United States and each state, 1970 to 2014*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved from https://www.nasmhpd.org/sites/default/files/TAC.Paper_.10.Psychiatric%20Inpatient%20Capacity_Final.pdf

[54] Substance Abuse and Mental Health Services Administration. (2016). State Mental Health Authority Uniform Reporting System. Retrieved from https://wwwdasis.samhsa.gov/dasis2/urs.htm

[55] Lutterman et al. *Trend in psychiatric inpatient capacity*.

[56] Wik et al. *Forensic patients in state psychiatric hospitals*.

[57] Substance Abuse and Mental Health Services Administration. State Mental Health Authority Uniform Reporting System.

[58] Taube, C. A. & Barrett, S. A. (1985). *Mental Health, United States 1985*. Rockville, MD: National Institute of Mental Health.

[59] Health Cost and Utilization Project. (2014). *National inpatient statistics Outcomes by 659 schizophrenia and other psychotic disorders*. Rockville, MD: Agency for Healthcare Research and Quality.

[60] Substance Abuse and Mental Health Services Administration. (2016). State Hospital median length of stay for discharged clients, State Mental Health Authority Uniform Reporting System. Retrieved from https://wwwdasis.samhsa.gov/dasis2/urs.htm

[61] Fuller, D. A., Sinclair, E., & Snook, J. (2016). *Released, relapsed, rehospitalized: Length of stay and readmission rates in state hospitals: A comparative state survey*. Arlington, VA: Treatment Advocacy Center. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/released-relapsed-rehospitalized.pdf

[62] Lutterman et al. *Trend in psychiatric inpatient capacity*.

[63] Hepburn, S. (2017). *Crisis services' role in reducing avoidable hospitalization*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved from https://www.nasmhpd.org/sites/default/files/TAC.Paper_.3.Crisis_Services%E2%80%99_Role_in_Reducing_Avoidable_Hospitalization_Final.pdf

ACKNOWLEDGEMENTS

The authors acknowledge the daily work of the public mental health system staff and leadership and the hard work of the persons they serve. Their many successes and their determination provide for hope for the future.

The authors also are indebted to the individuals who contributed their expertise to this project: Elizabeth Sinclair, research associate for the Treatment Advocacy Center, and our executive committee under the inspired leadership of Brian Hepburn: John Allen, Jeremy Christiansen, Meighan Haupt, Ted Lutterman, David Miller, Joe Parks, Leon Ravin, Kathy Sanders, Doug Thomas, A.J. Walker, Amanda Wik, and Lynda Zeller.

200 North Glebe Road
Suite 801
Arlington, Virginia 22203

The Treatment Advocacy Center is a national nonprofit organization dedicated exclusively to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

66 Canal Center Plaza
Suite 302
Alexandria, Virginia 22314

The National Association of State Mental Health Program Directors (NASMHPD) represents the state executives responsible for the $41 billion public mental health service delivery system serving 7.5 million people annually in all 50 states, 4 territories, and the District of Columbia.