The Psychiatric Bed Crisis in the US:

Understanding the Problem and Moving Toward Solutions

Section 1

Historic and Contemporary Uses of Psychiatric Beds

AMERICAN PSYCHIATRIC ASSOCIATION

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A. Early U.S. History

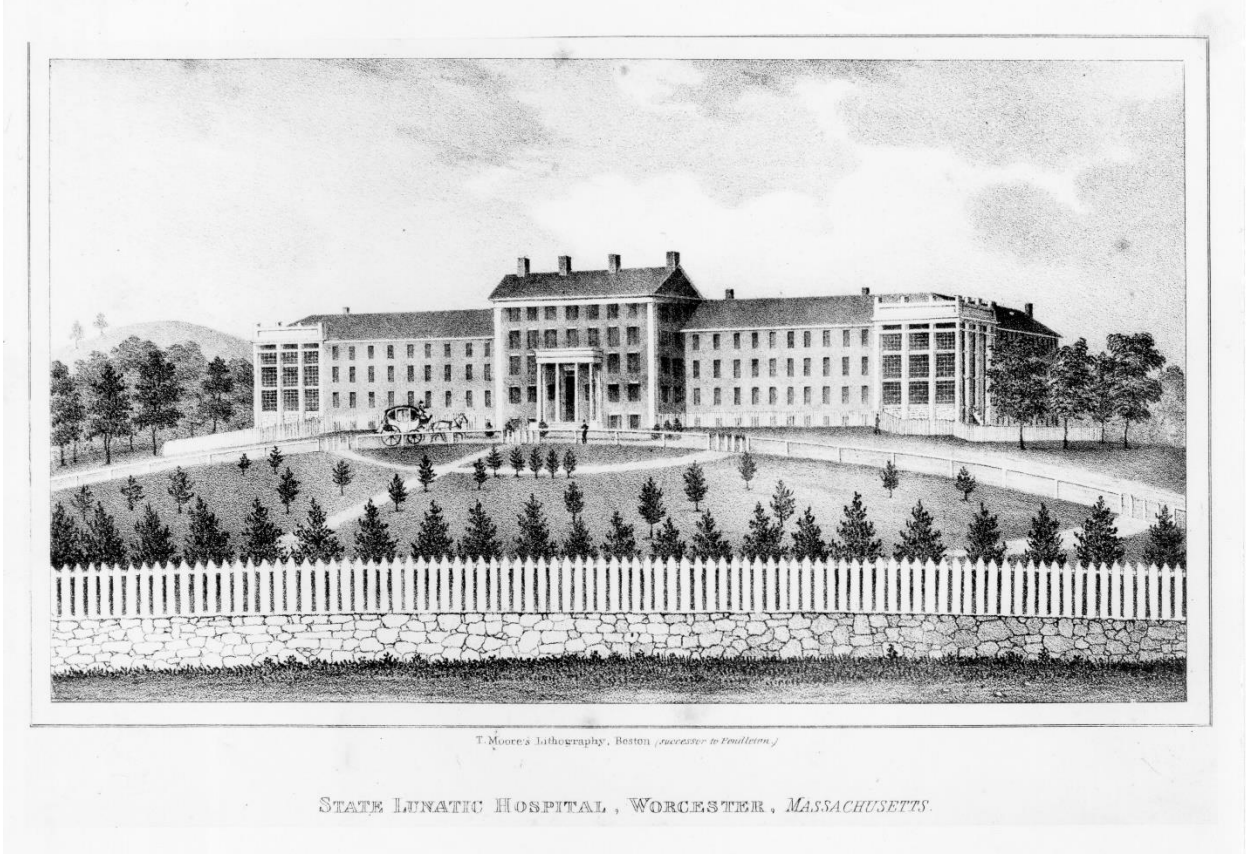
Early in U.S. history, responsibility for the care of people with severe mental disorders fell to families and local communities who did whatever they could to provide assistance and sustenance (Grob 1994). People whose needs exceeded the capacity of their families or neighbors to care for them were often housed in poorhouses or jails that were typically financed and managed by local governments. Little or no distinction was made in the confinement and custodial care of people with different types of dependence whether related to severe mental illness, poverty, dementia, disability or old age. The term *social dependent* was commonly used to describe the array of residents in these settings.

During the nineteenth century, Dorothea Dix (1802-1887) was the nation's leading advocate and reformer working to improve care for people with severe mental illnesses. She visited jails and poorhouses where she documented the prevailing abject conditions. By midcentury, she had generated significant public support. She is credited with establishing 32 state asylums throughout the country.

By 1890, every state had established one or more public institutions for the care of people with severe mental illnesses (Ozarin, 2006).

In the early decades of the nineteenth century, when hospitals were small, "moral treatment"—care that was kind and compassionate—prevailed. Patients were treated with respect in environments that emphasized social interactions and the cultivation of their skills and interests (Mechanic, 2014). However, moral treatment required intensive clinician involvement with extensive staffing and proved difficult to maintain as service demands increased. To accommodate rising numbers of older patients with dementia, general paresis, and other neurodegenerative conditions, smaller facilities gave way to larger, crowded custodial institutions leading to a marked deterioration in the quality of care.

From the 1860s through the 1930s, the census of inpatient facilities dramatically increased, and many facilities expanded or formed new regional hospital systems. Southern states addressed overcrowding in part by establishing segregated state hospitals for Black patients and moved Black patients from the state's other institutions into them, transforming hospitals into white-only facilities. In Louisiana and Texas, the white-only facilities became overcrowded, and whites were admitted to the Black facilities, thereby "integrating" Black state hospitals.



State Lunatic Hospital. Worcester, Mass. (National Library of Medicine)

In the nineteenth century, children and adolescents who could not be managed by their families were also sent to poorhouses. Contemporary distinctions between developmental disabilities, juvenile delinquency, and early onset adult psychiatric disorders did not yet exist. By midcentury, rising fears over the safety of these youth, who were housed alongside adults in deplorable conditions, motivated efforts to transfer the young people to orphanages, asylums, or foster homes. In New York, this trend was accelerated by the Children's Act, which passed the State Legislature in 1875, and ordered all children aged 2-16 years to be removed from poorhouses (Katz, 1986). Although other states followed, enacting similar legislation, removal of children from poorhouses was slow. In 1880 there were 7,770 US children aged 2-16 years in poorhouses and in 1890 there were 4,987 (Thomas, 1972).

B. 1900 to Present

It was not until 1937 that the first public psychiatric hospital unit for adolescents opened in the U.S. at Bellevue Hospital in New York City. This was followed in 1955 by the opening of the first private unit for adolescents at Hillside Hospital, also in New York City.

The history of the uses of psychiatric inpatient treatment is as much a story of accommodating urgent societal needs, economic pressures, and shifting ideologies as it is a tale of the development and delivery of new and more effective treatments. In the first half of the twentieth century, the population

in state mental hospitals rose rapidly, peaking at 558,922 in 1955 (Bockoven, 1972). Support for this model of care was fueled by economic forces and efficiencies of economies of scale. Following the U.S. Food and Drug Administration's approval of chlorpromazine in 1954, the new medication was hailed as a "miracle drug" for its calming effects on agitated patients. During the late 1950s through the middle 1960s, evidence accumulated that chlorpromazine and the other "major tranquilizers" had specific effects on psychotic symptoms in people with schizophrenia and related disorders (Moncrieff, 2013). Expanded use of these medications was credited with greatly facilitating the ensuing large reductions in state mental hospital population (Cancro, 2000). Yet careful analysis reveals that between 1955 and 1965, the number of patients in public mental hospitals declined by only 15%, while a substantially greater decline of 65% occurred between 1965 and 1985 (Mechanic 2014). In addition to the advent of antipsychotics, the decline in the inpatient census was related to federal policies including passage of two important laws. The first was the Mental Retardation and Community Mental Health Centers Construction Act (1963), envisioned by President John F. Kennedy as "a wholly new emphasis and approach to care for the mentally ill" and the second was passage of Medicaid and Medicare (1965) (Sharfstein, 2000). This era was also associated with attention to civil rights and legal reforms including revising civil commitment codes and ensuring due process for the rights of individuals who were involuntarily hospitalized (Fisher et al., 2009).

Medicare and Medicaid programs provided strong financial incentives for states to transform their financing of mental health care. Under Medicaid, the "institutions for mental diseases" (IMD) exclusion provision prohibited Medicaid billing for treatment in psychiatric units of more than 16 beds for Medicaid beneficiaries aged 21-64 years. Because states received matching federal funds through Medicaid, the Medicaid program created incentives for states to develop small units in local hospitals that could bill Medicaid and discouraged state investments in state psychiatric hospitals. An additional critical policy lever that encouraged shorter stays was the Medicare lifetime cap on the total number of days of inpatient psychiatric treatment.

Between 1970 and 2014, the resident population in state psychiatric hospitals declined from approximately 370,000 to 40,000. This massive shift from public hospital-based to community-based services was only slightly offset by an increase over the same period in general hospital psychiatric short-term inpatients from approximately 18,000 to 31,000 and growth in longer-term private psychiatric hospital patients from approximately 11,000 to 28,000 (Lutterman et al., 2017). Without adequate publicly financed community-based mental health services, some patients discharged from state mental hospitals were relocated to other institutional settings (Geller, 2000). With the expansion in nursing home capacity accompanying Medicaid and Medicare legislation, roughly one-half of older patients discharged from mental hospitals went directly into nursing homes (Kiesler and Sibulkin, 1987). See Figure 1.

A vigorous debate developed over the extent to which closing public mental hospitals coupled with under-resourced community mental health centers pushed people with serious psychiatric disorders into the criminal justice system or homeless shelters. Ecological studies and personal observations supported the view that patients discharged from state hospitals commonly entered prisons or became homeless (Raphael and Stoll, 2013; Bassuk and Lab, 1986; Whitmer, 1980; Torrey, 2014). Cohort studies,

however, suggest that homelessness and incarceration occurred only sporadically among long-term psychiatric inpatients following discharge to the community (Winkler et al., 2016). Nevertheless, adults with major psychiatric and substance use disorders remain disproportionately common in jails (Fazel and Seewald, 2012; Fazel et al., 2017) and homeless shelters (Toro et al., 2014), underscoring serious challenges in meeting basic social and housing needs of adults with major mental illnesses.

Beginning in the late 1970s, there was an increase in proprietary psychiatric hospitals that faced few constraints on service delivery. Growth in managed care during the late 1980s and early 1990s achieved health care cost savings by reducing the number of hospital admissions, shortening lengths of inpatient stay, and requiring participating physicians and other health care providers to offer their services at discounted rates. Between 1990 and 2000, the median stay of child and adolescent mental health inpatients in community hospitals declined from 12.2 to 4.4 days (Case et al., 2007).

Unfortunately, research on the effectiveness of adult or child psychiatric inpatient care has been nearly absent. A dearth of prospective clinical trials establishing the benefits of inpatient psychiatric treatment proved fertile ground for the rise of behavioral managed care and health utilization review that have narrowed the scope of inpatient psychiatric treatment. The average length of inpatient psychiatric stay for adults in private nonprofit hospitals steadily declined during the period of rising managed care (Mechanic et al., 2013) and has remained stable ever since. Between 1998 and 2017, the national average length of stay for mental health and substance use disorders in short-term facilities has hovered around seven days (AHRQ, n.d.).

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The scope of inpatient psychiatry has progressively narrowed. Treatment has become focused on acute stabilization and integration of treatment into a continuum of care even as the range of types of beds has broadened to include a variety of subspecialty beds such as geriatric beds, medical psychiatric beds, and substance use beds. To the present day, inpatient psychiatric settings concentrate on stabilizing patients in crises related to suicidal symptoms, psychosis, mania, anorexia nervosa, and other potentially life-threatening conditions that require care in safe settings and continuous observation. Within psychiatric hospitals, patients can receive more aggressive pharmacotherapy, psychotherapy, and other procedures such as complex diagnostic assessments and electroconvulsive therapy that are difficult to provide and often unavailable in other settings. An additional value in inpatient treatment includes being out of the environment the person came from for several days within a clean, orderly, caring hospital environment with regular meals. The hope for relief from an undesirable environment adds to the demand for inpatient settings.

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In the era of short inpatient treatment, inpatient clinicians have little time to facilitate engagement with outpatient mental health services for continuing care. Between 2008 and 2018, the percentage of patients hospitalized for mental illnesses who actually attended follow-up mental health care within seven days of discharge declined from 57.2% to 45.2% for commercially insured HMO patients and from 42.6% to 35.8% for Medicaid HMO patients (NCQA, 2021). Although attention to discharge planning can reduce the risk of psychiatric hospital readmission (Stefen et al., 2009), early hospital readmission remains common. Approximately one in seven Medicare patients discharged from a psychiatric inpatient facility is readmitted to the hospital within the first 30 days (NAPHS, 2013).

The prevailing psychiatric hospital paradigm, which relies on short hospital treatment episodes, provides little opportunity to establish interpersonal connections between patients, family and inpatient clinicians or develop an effective treatment plan that is integrated with longer-term outpatient treatment. A narrow emphasis on immediate patient safety also risks dehumanizing inpatient care processes and curtailing opportunities to individualize clinical care to meet the patient's specific needs under the financial pressures for arranging an early discharge.

The modern history of psychiatric inpatient care reflects a struggle to provide compassionate care with diminishing resources and within time frames that are often too short to evaluate treatment response or initiate meaningful recovery. Within the broader context of social welfare, and medical, political, and legal systems, the future success of inpatient psychiatric care will be shaped by the extent to which effective inpatient psychiatric treatment models are developed. This will involve providing compassionate care in an efficient manner for people who cannot be safely treated in other settings and then improving their lives by integrating their recovery within a continuum of community treatment.

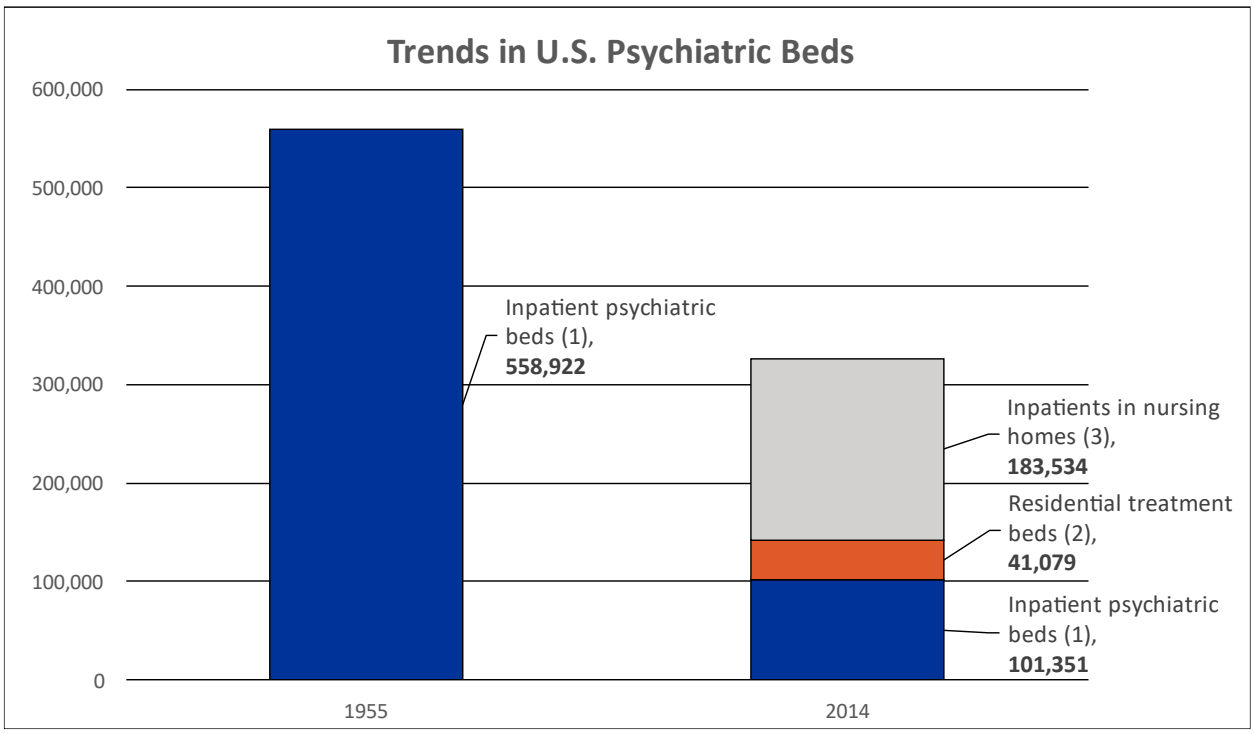

Figure 1: Trends in Psychiatric Beds

Notes:

(1) **1955** - Inpatient psychiatric beds in state hospitals (peak year; 337 beds per 100,000 population)

2014 – Total 101,351 – inpatient psychiatric beds (29.7 beds per 100,000 population), includes:

37,209 – inpatient psychiatric beds in state and county hospitals

30,864 – inpatient psychiatric beds in general hospitals with separate psychiatric units

24,804 – inpatient psychiatric beds in private psychiatric hospitals

8,006 – inpatient psychiatric patients in medical/surgical "scatter"

3,124 – inpatient psychiatric beds in Veterans Affairs hospitals

3,499 – inpatient beds in other specialty mental health centers

(2) Residential treatment beds in residential treatment centers (12.9 beds per 100,000 population)

(3) Inpatients in nursing homes with a diagnosis of schizophrenia or bipolar disorder (57.8 beds per 100,000 population)

Note: Bed numbers not reported by public agencies (2017):

- 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

Sources: NASMPHD and Treatment Advocacy Center, 2017; SAMHSA, 2014.

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