The Majority of Inpatient Psychiatric Beds Should Not Be Appropriated by the Forensic System

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In 2006, the National Association of State Mental Health Program Directors (NASMHPD) published a report entitled "The Crisis in Acute Psychiatric Care."[1] The report noted reduced inpatient bed capacity in state, private, and general hospital psychiatric units. Citing estimates from the National Association of Psychiatric Health Systems, NASMHPD reported a long-term shift in the locus of hospitalization from state hospitals to community hospitals and to nonhospital residential units. NASMHPD also noted the collateral effects of reduced hospital level psychiatric beds on hospital emergency departments and on the increased number of mentally ill individuals in the nation's jails and prisons.

The May 2007 meeting of the American Medical Association's House of Delegates passed Resolution 714, which stated:

> . . .that our American Medical Association work with relevant stakeholders, such as the American College of Emergency Physicians, the American Psychiatric Association, the National Association of EMS Physicians, and the American Ambulance Association, to study and develop recommendations regarding the national scope of the problem of psychiatric bed availability and its impact on the nation's emergency and general medicine resources including emergency department overcrowding [Ref. 2, p 63].

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This resolution, originated by the American College of Emergency Physicians, focuses on the problem in the nation's emergency departments, which were described as being near collapse.

In October 2007, the *American Journal of Psychiatry* published a commentary entitled the "The Future of Psychiatric Services in General Hospitals."[3] The authors documented a significant increase in these beds from 1960 to 1998 and then a decline from 1998 to 2002 and presumably to the present time. They attributed this decline to several factors, including poor reimbursement from all payment sources and conversion to medical-surgical beds, which were needed and contribute much more to hospital margins. The authors concluded with a plea for policy makers to address these problems, emphasizing the importance of general hospital psychiatric beds as a significant component of the health care delivered by the nation's general hospitals.

We present a brief review of the substantial evidence demonstrating that the number of psychiatric inpatient beds nationally has declined dramatically in both state and community hospitals. Next, we review the psychiatric inpatient bed situation in Oregon where the dramatic decline in beds mirrors the national trend. Finally, we examine the legal status of patients hospitalized in these facilities. We make the assumption that a patient's legal status partially determines his or her hospital course, including the treatment received.

The Nationwide Decline in Psychiatric Hospital Beds

State Hospital Beds

The substantial decline in the number of state hospital psychiatric beds has been well documented. Lamb and Weinberger[4] reported that between 1955 and 2000, the number of state hospital beds declined from 339/100,000 to 22/100,000. Salzer *et al.*[5] examined national public hospital census data during five-year time periods from 1984 to 2003 with special attention to the effects of the 1999 U.S. Supreme Court decision in *Olmstead v. L. C. by Zimring*.[6] During the study period, the number of state hospital beds decreased by 55 percent. From 1984 through 1987, the average state hospital census was 110,000 while in 2000–2003 the average census was 49,437. The authors also found that the rate of decline in state hospital populations following the 1999 *Olmstead* decision slowed rather than accelerated, as they had expected.

In a recent non-peer-reviewed article published on its website, the Treatment Advocacy Center (TAC) reviewed the loss of psychiatric beds in each state, comparing data from 1955 and 2005.[7] This comparison revealed a 95 percent decrease in the number of available beds in the nation's public mental hospitals. In addition, the TAC used an expert panel to determine the number of public hospital beds needed for a "minimum level of care" for each state. The panel recommended that 50 public hospital beds per 100,000 population was needed for a minimum level of care. (Specifically regarding Oregon, the TAC noted that in 2005, Oregon had 19.2 beds/100,000 population, placing the state in the TAC category of currently having a "severe bed shortage.")

Community Hospital Psychiatric Beds

In 2004, the Subcommittee on Acute Care of the New Freedom Commission[8] appointed by President Bush went beyond state hospitals and examined summary data regarding total inpatient bed capacity nationwide. They reported that from 1990 through 2000 the number of inpatient beds per capita declined 44 percent in state and county mental hospitals, 43 percent in private psychiatric hospitals, and 32 percent in nonfederal general hospitals.

Within the overall picture of loss of inpatient beds, Mechanic *et al.*[9] in 1998 noted that the locus of hospitalization for persons with serious mental disorder shifted from state hospitals to community hospitals, with the largest increase in these patients found in private nonprofit hospitals.

Watanabe-Galloway and Zhang[10] examined trends in discharges from general hospitals in 1995 to 2002 for individuals with serious mental disorders (primarily schizophrenia, bipolar disorder, and major depression). They found a substantial increase in hospital discharges of patients with these disorders (from 29/10,000 in the U.S. population in 1995 to 39/10,000 in 2002). This increase occurred in the latter three years of the study period (2000–2002). In addition, they found that most of the discharges occurred in nonprofit hospitals but that the proportion of such discharges dropped from 78 to 64 percent, while the proportion in for-profit hospitals rose from 13 to 28 percent. Partially explaining this trend, the authors noted that the number of nonfederal general hospitals with separate psychiatric units increased from 1,674 in 1990, to 1,700 in 1998, but dropped to 1,373 in 2000.

Psychiatric Beds in Oregon

In 1988, Bloom *et al.*[11] reported on the legal status and place of hospitalization of 621 individuals with schizophrenia or bipolar disorder during two time periods, 1981 to 1984 and 1991 to 1994. Until the middle 1990s, there had been a division of labor between the state hospitals and the general hospitals in Oregon that was determined by the patient's legal status. During the first period, the general hospitals were used primarily for voluntary patients and for those on civil emergency holds,[12] while the state hospitals served voluntary and civilly committed patients and those with criminal court commitments. In the second period, the state hospitals were used primarily for those who were civilly committed and those entering the hospital from criminal courts, while the general hospitals continued to serve patients hospitalized on emergency civil holds and were also treating some civilly committed patients. Voluntary patients had declined in both settings and were primarily seen in nonhospital facilities. It is important to note that 76 percent of all of the voluntary admissions in this particular sample were seen in the 1981 to 1984 time period. As time went on, voluntary patients were less likely to be admitted to the state hospital. If they were admitted, it was to the general hospitals or to several types of nonhospital facilities.

Oregon's Psychiatric Bed Situation on July 13, 2007

Oregon's Alcohol and Mental Health Division (AMH) publishes data twice weekly on the population of patients in its remaining two state hospitals,[13] and the published data also track the number of beds that it is using in Oregon's community hospitals. On July 13, 2007, there were approximately 1,032 psychiatric beds in the state of Oregon. As depicted in Table 1, on this day 940 (91%) of the total psychiatric beds in the state were used by the Oregon public mental health system: 752 patients in the state's two hospitals and 188 in the community hospitals. (State and county mental health programs in Oregon receive mental health service data for those patients who are enrolled in the Oregon Health Plan, who are Medicaid eligible, or who are indigent, including all patients who are entered into the civil commitment system, including those who may have private health insurance.) So, when we speak of public patients or say that the public system is using 188 beds, these are for patients who fit one of these categories, most admitted as emergency holds in the civil commitment process. On this particular day, only approximately 90 beds were available for all Oregonians who were covered by private insurance and may have needed voluntary admission.

Oregon's State Hospitals

Referring to Table 1, on July 13, 2007, of the 752 patients in Oregon's two state hospitals, 466 were hospitalized on criminal court commitments, 177 were civilly committed, and 109 were on a specialized geriatric inpatient service and were either civil or criminal court commitments. Subtracting the geriatric group of long-term patients who were very difficult to place, it means that approximately 28 percent of the state hospital patients were civilly committed, and 72 percent were committed by Oregon's criminal courts. Of the 466 patients committed by the criminal courts, 111 (24%) were committed for competency to stand trial evaluation or for competency restoration. The remaining 355 (76%) were insanity acquittees committed to the Oregon State Hospital's forensic units following their commitment to the jurisdiction of Oregon's Psychiatric Security Review Board (PSRB).[14] If there were voluntary patients in the hospital on July 13, 2007, the number of such patients was negligible.

Table 1 Oregon's Public Psychiatric Bed Use on July 13, 2007

	Number	Percent
State hospital		
Civil commitment	177	28
Criminal court	466	72
Geriatric	109	—
Total	752	
Community hospitals	188/280	67
Total public bed use on July 13, 2007	940	

Oregon's Community Hospitals

In 2007, there were approximately 280 community psychiatric beds in the state. (In January 2008, the state lost another 20+ beds when another general hospital closed its psychiatric unit.) The 280 beds were divided among 11 different inpatient units. On July 13, 2007, Oregon's public mental health program was using 188 (67%) of the 280 beds.

How does the state program use these beds? In 2005 (the most recent year when complete data were available), there were 7,453 public admissions to community inpatient units. Seventy percent of these admissions were patients involved in the civil commitment system (67% on civil emergency holds and 3% civilly committed) and 30 percent were voluntary. The average length of stay was 10.7 days for emergency holds, 7.3 days for voluntary patients, and 35.5 days for civilly committed patients.

Discussion

There is little dispute that the number of psychiatric inpatient beds has declined significantly in the nation's state-run mental hospitals. In addition, both the national data and the Oregon data demonstrate that general hospital psychiatric units may be very vulnerable at this time. The NASMHPD report and the APA commentary[3] mentioned earlier, speculated that general hospitals were increasingly converting psychiatric beds into more lucrative medical-surgical beds, mainly because psychiatric bed reimbursements have either remained static or have decreased. The NASMHPD report also noted that the Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency departments and hospitals to accept, evaluate, and hospitalize (should a bed be available) all psychiatric patients who present to their hospital in an emergency situation. Because of this law, hospitals may have limited their potential losses by reducing the number of available inpatient psychiatric beds. A decision of this nature

would in turn cause a back-up of psychiatric patients in emergency departments as they wait for a bed to become available somewhere in the state. In Oregon, waiting for long periods in emergency rooms for a psychiatric bed is a common situation, and if an inpatient bed is finally located, it may be in a hospital many miles away. This situation represents a complete antithesis of a rational community mental health system.[15]

In addition to the loss of psychiatric beds in state and community hospitals, another important trend to note is the increasing use of the available beds for involuntary patients. As mentioned, Salzer *et al.*[5] found that the decline in state mental hospital beds slowed, rather than increased, in the period following the *Olmstead* decision. In this case, the Supreme Court determined that mental health authorities must provide necessary community-based care when an individual can safely be placed in the community. It is possible that, before *Olmstead,* state hospital populations were reduced to a group of very difficult to place civil patients and an overrepresentation of patients committed by criminal courts. In this latter situation, *Olmstead* might not apply in the same manner as it does to civil patients. A similar situation was described in 1991 in two Massachusetts[16] state hospitals, as civil patients were released into the community with a concomitant increase in the forensic population of the hospitals.

The Oregon data allow for examination of the legal status of patients in the system. On July 13, 2007, virtually all patients in the remaining two state hospitals were forensic. As noted, of the 643 nongeriatric patients in the state hospitals, 28 percent came from civil commitment court, and 72 percent came from criminal court. Although unorthodox in concept, we view those patients who come from either civil commitment court or from criminal court as forensic admissions. Both groups are committed to the hospital by a judge, following a court hearing in which physicians have less say about the wisdom of the commitment than do statutory definitions of mental illness. With this approach, at the present time Oregon's state hospitals are, in essence, forensic hospitals governed by the rules of three statutes: civil commitment, competency to stand trial, and the post-insanity defense commitments to the jurisdiction of the Oregon Psychiatric Security Review Board. After more than a century of struggling to achieve a balanced mental health inpatient system that is integrated with community care, the voluntary admissions have virtually disappeared from Oregon's state hospitals.[17]

Community psychiatric inpatient units in Oregon show the same trend. As presented earlier, in 2005, 70 percent of the public admissions were related to the civil commitment process (67% were on civil emergency holds and 3% were committed) while only 30 percent were voluntary patients. We know from prior studies and from anecdotal experience that most of the emergency hold patients leave the hospital without having received any significant hospital-level care.[18] Further, we also know anecdotally that many individuals who are discharged from an emergency hold do not receive an effective referral to community treatment.

The conclusion is that the Oregon public inpatient psychiatric system is moving ever closer to a total forensic system governed by the rules of the civil commitment statute on the one hand and the criminal courts on the other. It is important to emphasize the role of the criminal courts in assigning patients to Oregon's state hospitals. Of the statewide total of 1,032 psychiatric beds, 466 (45%) were used by the state's criminal courts for competency evaluation and restoration or for the management and treatment of insanity acquittees, leaving only 55 percent of the beds in the state for other public purposes, such as voluntary and civil commitment, and for the use of the whole of the private sector.

Are there any solutions on the horizon? In regard to the portion of inpatient beds dedicated to civil commitment and voluntary patients, the *American Journal of Psychiatry* commentary[3] referenced earlier advocated for a renewed focus on general hospital psychiatric units with the goal of rebuilding the lost capacity and solving the problems that led to a decline in the number of these units in the first place.

The NASMHPD report[1] lists several strategies to "respond to the acute care problem," including "aggressive management of care" and improved collaboration between hospital service providers, to manage most effectively those beds that remain in the system. The report also summarizes steps taken by some states to increase inpatient capacity, including modestly increasing state hospital bed capacity, expanding contracts with private and community hospitals, and developing residential and nonhospital crisis services for pre- and post-hospital services.

In addition to advocating for an increase in state hospital beds to meet the experts' estimate of 50 beds per 100,000 in the population, TAC advocated[7] for the widespread use of assertive community treatment programs that can help offset the negative consequences resulting from the drastic reduction of state hospital beds.

Oregon will soon build two new state hospitals with a modest increase in capacity. The state has also focused on a recovery-oriented treatment philosophy in minimizing hospitalization and on post-hospital services, such as the development of secure residential treatment beds that serve as step-down units from acute hospitalization. However, Oregon has yet to develop a statewide strategy for acute inpatient care, even as the state hospitals are over census and facing difficult legal challenges, most recently from the U.S. Department of Justice.

There now seems to be national resignation to the fact that there will continue to be a large number of mentally ill persons in the criminal justice system and that state hospitals will have to designate a significant number of beds for the use of the criminal courts. In addition, the criminal justice system has come to rely more on itself and on building its own capacity[19] to care for mentally ill offenders. This self-reliance is demonstrated by the increased number of inpatient mental health facilities within prisons and by mental health courts[20] for offenders who are kept in the community. The drift toward criminalization will continue without a well-reasoned and determined national mental health plan that attempts to re-establish a viable and well-funded mental health system that includes, but is not limited to, adequate state and community inpatient care facilities.

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