State Hospitals as "the Most Integrated Setting According to Their Needs"

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In its 1999 *Olmstead v. L.C.* decision, the U.S. Supreme Court ruled that states have an obligation to provide services to individuals with disabilities in "the most integrated setting appropriate to their needs," as the unjustified institutionalization of people with disabilities is discriminatory under the Americans With Disabilities Act.[1] Increasing the quantity and improving the quality of outpatient mental health services makes a difference in the lives of persons with mental illness, and federal leverage helps states achieve this aim. For example, in July 2013, New York State agreed to settle a long-running lawsuit under *Olmstead*, which will allow about 4,000 persons with serious mental illness to move out of adult group homes into their own apartments "in the most integrated setting according to their needs."[2] This consent decree will increase access to housing and to cultural and social activities for persons with mental illness, consistent with recovery principles. Quality and quantity of care both matter on the outpatient continuum, to provide persons with mental illness the most integrated setting appropriate to their needs.

In contrast, many states struggle with an imbalance between the quantity and quality paradigms within state mental hospitals, to the detriment of persons with mental illness. Funding increases to improve the quality and continuum of community-based treatment, while the number of state mental hospital beds continues to decline, in the belief that psychiatric treatment should take place in the community and not in hospitals. On the inpatient side, increasing quality remains important, but largely in an effort to discharge and cut the number of beds. However, increasing the number of state mental hospital beds should be as important as improving quality, to provide persons with mental illness the most integrated setting appropriate to their needs when that need is the hospital.

I present a brief review of the continued decline in the number of state mental hospital beds. I then review the commonly acknowledged consequences of this decline. In addition to asserting that increased funding should continue to focus not only on quality but also on increasing the number of state hospital beds, I assert that the ability of hospitals and rehabilitation and recovery facilities at times to be the most integrated setting capable of meeting the needs of persons with mental illness is another justification to increase the number of state mental hospital beds. Many individuals whose needs would best be met in the integrated setting of the institution are ineligible for admission in the current era because census limits, funding cuts, and the legal classification of persons currently residing in state mental hospital beds preclude admission on the basis of need. A needs-based approach to state mental hospital bed usage should be part of a well-funded mental health system.

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By improving quality and number of state mental hospital beds, hospitals and outpatient facilities can better serve as the most integrated settings based on patient need, not legal classification.

The Continued Decline in State Hospital Beds

The number of state mental hospital beds continues to decline significantly. Lamb and Weinberger[3] reported that between 1955 and 2000, the number of state mental hospital beds decreased from 339 to 22 per 100,000 population. In a 2008 non-peer-reviewed article published by the Treatment Advocacy Center (TAC), an expert panel determined that 50 public psychiatric hospital beds per 100,000 population are needed to sustain a minimum level of care.[4] From 1955 to 2005, there was a 95 percent decrease in the number of state mental hospital beds. A more recent TAC publication reported that *per capita* state mental hospital bed populations fell further between 2005 and 2010. By 2010, the nation's state mental hospital beds had declined to 1850 levels, which is about 14 per 100,000 population.[5] In addition, 13 states closed 25 percent or more of their total state hospital beds from 2005 to 2010. Although 10 states increased their total hospital beds, they continued to provide less than half the beds TAC considers minimally adequate. That being said, current state mental hospital bed counts do not reflect capacity in the acute/private system that absorbs some of the patient need, so what may appear as diminished resources for public beds may mean resources shifted to both private and public beds.

Consequences of the Decline

Despite the shifting of resources to private beds and community-based care, the overall loss of state hospital beds affects the entire health care system. Individuals in acute or chronic disabling psychiatric crises increasingly end up in hospital emergency departments, jails, and prisons. Service calls, transportation, and security utilization for people in psychiatric crisis strain public safety resources. The number of persons with mental illness who are homeless has increased.[5–7] The courts, having taken away discretionary authority from psychiatrists, require more, not less, psychiatric input, and generating the resultant forensic reports and providing testimony strains mental health resources.[8] Many systems have moved to a completely involuntary civil system governed by the rules of the civil commitment statute or the criminal courts.[9] The impact of forensic hospitalization takes away beds for civil use, and the remaining civil beds are generally used for involuntary admission of persons with chronic, severe, persistent psychosis or mania, many of whom are unaware of their illnesses and are dangerous to themselves or others, such that they cannot function outside of a hospital.

The 2012 TAC report characterizes the current status of state mental hospital bed usage as follows:

> In the United States, many states are in the process of dismantling the system whereby they provided treatment for individuals with acute or chronic severe mental illness. This system, operational for almost 200 years, has provided protection (asylum) for those who are mentally ill as well as protection of the public from the consequences of untreated mental illness. Its abolition, leaving virtually no public psychiatric beds for the subgroup of severely mentally ill individuals who cannot be successfully treated in the community, no matter how comprehensive the services, is therefore a profound change. It is taking place with little forethought and even less regard for consequences [Ref. 5, first paragraph of Discussion section].

Another unintended consequence is restriction in the ability to admit persons to state mental hospitals who do not meet strict legal criteria under involuntary civil commitment or criminal statutes or even some who meet the commitment criteria. Because there are not enough state mental hospital beds, the few remaining beds are reserved only for those most dangerous to self or others or for those in criminal courts.

Quality Remains Important

Similar to the New York outpatient treatment consent decree, states are invested in using federal leverage to improve mental hospital bed quality, even as they cut, eliminate, or otherwise limit admission to such beds. This year, Geller and Lee[10] reviewed the benefits and drawbacks states experience in negotiating Department of Justice investigations of alleged civil violations in institutions. States can face difficult legal challenges from the Department of Justice under the Civil Rights of Institutionalized Persons Act, but making deals with federal agencies helps procure more inpatient resources to improve quality. The problem is that quality improvement occurs without a concomitant increase in number of beds, in large part because of efforts to depopulate state hospitals

for cost-shifting reasons. States want to improve care and treatment in their mental hospitals to effect shorter and fewer inpatient lengths of stay and longer outpatient lengths of community-based care. This is a desirable goal, but having too few beds, even of the highest quality, causes the loss of an important function of the institution.

Discussion

States endeavor to expand outpatient mental health treatment modalities, emphasizing quality and recovery ideals. In contrast, as many states work to improve the quality of mental hospital services, the number of state mental hospital beds continues to decline. Increasing the quality of inpatient state hospital services while cutting the number of beds is paradoxical and problematic. Strict admission criteria and forensic encumbrances can hinder or prevent inpatient access for difficult populations who may benefit from short- or long-term state hospital treatment. Long-term care is a dynamic process in which persons may need state mental hospital admission for a time, as there are limitations to even the best outpatient treatment modalities.

A needs-based approach to state mental hospital admission, combined with an increased number of beds, would allow for flexibility in hospitalizing patients who sometimes cannot be admitted in the current era. This population includes those who meet commitment criteria but cannot be admitted because of the census factor. Others are those who are nonpsychotic, such as sex offenders with mental health problems; severely personality disordered individuals with problematic behavior in community settings that results in repeated conflict; prisoners needing more intensive treatment in lieu of correctional placement; persons with substance abuse problems who continue to fail intensive residential placement; and persons with mental illness in immigration detention. For example, Ochoa and Pleasants[11] reviewed how the growth in mental health care disparities in the U.S. immigration detention has Immigration and Customs Enforcement conceding that many immigrants should be in facilities less restrictive than jails and prisons.

A more flexible use of state mental hospitals so that psychiatrists could freely admit certain types of patients is presently lacking. A need-for-treatment standard could help certain patient populations regain access to the integrated setting of the institution. Use of this standard would allow for a continual flow of admissions and discharges based on patient need. The criteria for admission should be broader and based on clinical need, not on narrow interpretations of dangerousness. Hospital stays should be of sufficient length to stabilize persons with mental illness to allow an avoidance of future admissions. Funding should look to the continuum of who could benefit from longer stays and the additional multidisciplinary supports and assessments that hospitals can provide. Inpatient psychiatric hospitalization with targeted objectives should parallel how the medical system looks at the hospital level of care.

It is appropriate for states to focus on a treatment philosophy to decrease hospitalization, even if for financial reasons. However, there remains a role for the institution in the treatment continuum. Quality care in state mental hospitals, as well as treatment planning for admission and discharge, is appropriate and desirable.[12] Gauging inpatient satisfaction can increase treatment adherence and patient functioning and increase the likelihood that patients will seek out mental health services following discharge.[13]

In short, there is a role for the institution. Expanding state mental hospital beds in conjunction with increasing quality is compatible with increasing outpatient services. Systems that have more capacity to provide inpatient care with targeted goals and less emphasis on legal classification should play greater, not lesser, roles in legal, policy, and clinical deliberations.

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