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Psychiatry

Friday Feedback: Solutions for the Psych Bed Shortage?

Published: Jan 31, 2014 | Updated: Feb 5, 2014

By Elbert Chu, Associate Producer, MedPage Today

This week, Friday Feedback takes a second look at the link between the shift to deinstitutionalized mental healthcare and public safety.

We reached out to a diverse group of healthcare providers by email and asked them to respond to the following question:

De-institutionalization of the mentally ill sounded like a great idea, but decades later the hoped for benefit has not materialized. What lessons can be drawn from this failed fix?

The participants this week:

Janet R. Cummings, PhD, assistant professor, department of health policy and management, Center for Behavioral Health Policy Studies, Emory University

Steven L. Dubovsky, MD, professor and chair, department of psychiatry, University at Buffalo

Daniel C. Ehlke, PhD, MA, assistant professor of health policy and management, SUNY-Downstate Medical Center School of Public Health

Michael B. Friedman, LMSW, adjunct associate professor, Columbia University School of Social Work, and former deputy commissioner of the New York State Office of Mental Health *

Russell T. Joffe, MD, chairman, psychiatry and behavioral science, Staten Island University Hospital

Carol Koontz, RN, retired psychiatric staff nurse of 20 years, both on acute and long-term care units, and a member for 2 years of the national Veteran's Affairs Office of Nursing Services Mental Health Field Advisory Committee

Patrick Runnels, MD, assistant professor and director, Community Psychiatry Fellowship, University Hospitals Case Medical Center in Cleveland

Sally Satel, MD, is a psychiatrist and resident scholar at the American Enterprise Institute and lecturer at Yale University School of Medicine

Mitch Shuwall, PhD, licensed clinical psychologist and acting executive director, Zucker Hillside Hospital, Glen Oaks, N.Y.

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* Michael Friedman's Original Statement is attached.

Flawed Question?

Michael B. Friedman, LMSW: "Your position regarding serving people with mental illness (please stop using the offensive expression 'the mentally ill') in the community is incorrect for a number of reasons. Most importantly, the shift in policy from institution-based to community-based mental health services has enabled hundreds of thousands of people who would have been held in hospitals unnecessarily to lead far better lives in the community. We need to continue to improve the service system for those who have not fared well in the community."

What Went Wrong?

Patrick Runnels, MD: "The original plans were greatly underfunded with far too little nuance and direction."

Sally Satel, MD: "Some patients did well upon discharge, but the sickest were caught in a revolving door, neither institutionalized nor embedded in a community. The number of psychotic patients in the federally funded community centers would never rise above 5%. Many others ended up living in flophouses, on the streets, or in jails. When Medicare and Medicaid came on the scene in the mid-1960s, states simply shifted the financial burden to the feds, who would pay for housing patients in poorly equipped nursing homes. Finally, legal decisions issued in the 1960s and 1970s made it hard for judges to order needed treatment for debilitated patients who were refusing care."

Carol Koontz, RN: "I realize that there are mandated mental health units, but from all credible reports, these are not being utilized effectively. I also see a problem with inadequately trained or overworked clinicians who are not able to realistically assess whether a patient is malingering or is a danger to self and others."

Steven L. Dubovsky, MD: "Those who have flimsy boundaries between their inner demons and the world outside do not thrive outside of an institutional setting and end up seeking another setting in which they can be contained. In some instances, that setting is in the legal system."

Mitch Shuwall, PhD: "While reductions in bed capacity were substantial, the establishment of needed transitional/community resources was never fully met. As a result, the potential benefits of deinstitutionalization -- integration into society and the workforce, empowerment of the individual, recovery, and cost savings -- have been overshadowed by increased homelessness and incarceration, clogged emergency rooms, revolving-door hospitalizations, and shortages in psychiatric beds for those with acute behavioral needs."

Russell T Joffe, MD: "Deinstitutionalization has not worked because no alternative has been funded and provided for since this began more than 50 years ago."

Janet R. Cummings, PhD: "Individuals with severe mental illness are more likely to be uninsured, to have public insurance (e.g., Medicaid), and/or to be living in poverty than the general population, and many private hospitals and private-practice psychiatrists do not offer services to those with public insurance and/or limited economic resources. Therefore, while shortages of psychiatric beds and mental health providers have been documented in many communities, these shortages are exacerbated for some of the most vulnerable individuals in need of mental health treatment."

Friedman: "There is a terrible problem of transinstitutionalization -- the movement of people who might in the past have been in mental hospitals/asylums to prisons, nursing homes, and adult homes. There also continues to be a problem of homelessness for some people with serious

and persistent mental illness. To address these problems we may (or may not -- no one really knows) need more hospital beds. We may or may not need increased use of coercive interventions (forced hospitalization or outpatient treatment); this is highly controversial."

Daniel C. Ehlke, PhD, MA: "An impulse runs through American politics to bring the business of governing and regulating as close to the people as possible -- decentralization as panacea. The deinstitutionalization debacle points up the occasional perils of this approach, as well as perhaps one of the best examples of unintended consequences to be found in the policy realm."

Solution: More Funding

Shuwall: "Addressing these problems will mean fulfilling the other half of the deinstitutionalization promise, i.e., the establishment of wrap-around services such as clinical/psycho-social services, crisis stabilization beds, and enhanced crisis-oriented outpatient services; supported housing [also] must be enhanced. Navigating complex healthcare and social service systems is difficult [even] for those without mental illness. For the seriously mentally ill, however, the importance of providing care coordination support will be essential. New constructs such as Health Homes are being developed to help these individuals connect with and remain engaged with needed support services."

Joffe: "Mental health funding and reimbursement has severely limited inpatient treatment to the extent that it is available. With pressure to reduce length of stay, most patients are discharged after the immediate therapeutic crisis has resolved but before they are adequately stabilized."

Koontz: "In my ideal society, we could actually expand the role of prisons to provide a more therapeutic, mental health oriented environment and still maintain safety, and, of course, this will take money to provide expanded resources to train and lure quality mental health providers."

Dubovsky: "A shortage of psychiatrists and poor reimbursement for their work results in brief visits every few months in which it becomes impossible to follow the patient closely enough to determine how things are really going and what needs to be done next."

Runnels: "We need both the federal and state government to dedicate more money to fund services across an array of settings -- principally the justice system, housing, substance abuse, and physical healthcare."

Solution: Better Policy

Ehlke: "It is often best to rely on the community for services, rather than resorting to a heavy-handed federal presence. More important, however, than the quantity of centralized control, however, is the nature -- the quality -- of governance. Government works best when its different levels -- local, state, and federal -- work together, and each receive the resource support they need."

Friedman: "Your statement totally neglects the policy shifts that have taken place since 'deinstitutionalization.' For example, New York State had no units of specialized housing for people with serious and persistent mental illness in 1978. Today, it has about 35,000 units of housing run by the mental health system, and thousands more in various supportive housing programs. Services in the community have also expanded considerably, and state hospitals -- now much smaller -- are far better places than they used to be."

Cummings: "To provide adequate community-based care for those with severe mental illnesses, the healthcare system needs to provide access to inpatient treatment for those in crisis as well as outpatient treatment for those in recovery. Any effort to increase the availability of psychiatric

beds and/or outpatient resources for those with serious mental illness must attend to the accessibility of these resources for the uninsured, the publicly insured, and those living in poverty. The 'Excellence in Mental Health Act' (S.264), introduced in the U.S. Senate in February 2013, is an example of legislation that could bolster federal resources for community-based mental health safety-net providers."

Dubovsky: "The shift to community mental health centers has been accompanied by a shift toward a broader 'team' of providers, in which the psychiatrist often plays a subordinate or even peripheral role. One irony is that most patients don't see a psychiatrist until a therapist determines that the physician is needed and until the patient 'proves' a commitment in the form of keeping several appointments first. Patients who want a psychiatrist may fail this test when they don't understand why they have to wait to see a doctor, or when they accept directions that may or may not be scientifically sound about psychiatric treatments from clinicians who are not psychiatrists."

Runnels: "Rather than narrowly addressing the consequences of poor health, we should work to integrate healthcare and amp up preventative interventions. And rather than allowing individuals to be incarcerated for violations related to their mental health and substance abuse issues, we should invest in diversion programs, more enduring substance abuse treatment, and housing."

Satel: "Mental-health policy was a bipartisan failure. The care of the most severely ill patients remained financed through an uncoordinated patchwork of local, state, and federal agencies with no single accountable overseer. In 1992, a federal law was passed establishing the Substance Abuse and Mental Health Services Administration, which was tasked with overseeing block grants to the states. In his recent book, *American Psychosis*, psychiatrist E. Fuller Torrey estimates that $140 billion is annually spent on 'grossly inadequate and disjointed services,' a sum that 'should be more than sufficient to support excellent services if the money were used wisely.' Finally, after decades of tinkering on the Hill, there is important proposed legislation that could make a significant improvement in the well-being of severely mentally ill individuals. It was introduced last fall by Rep. Tim Murphy (R-Pa.) and deserves to be passed."

What's Working

Joffe: "Assertive Community Treatment (ACT) teams are an excellent option for the severely mentally ill; however, there are extremely limited ACT services available in New York State and presumably the rest of the country."

Satel: "There is 'assisted outpatient treatment,' a court-ordered treatment (including medication) for individuals with severe mental illness who have a history of doing poorly if untreated. We must make greater use of teams (social worker, nurse, psychiatrist, occupational therapist) and endorse a 'need for treatment' standard for civil commitment."

Koontz: "In Pittsburgh, we have a Veteran's Mental Health Court and advocacy system for nonviolent Veteran offenders, which from all reports is doing well. We also have Operation Safety Net, which originates from a local hospital but has volunteers from many places, and is being studied internationally as a model for treating those seriously mentally ill living on the streets."

Friedman: "We need what are called 'assertive' community services, which go to people where they are rather than waiting for them -- or forcing them -- to come to the mental health system on their own. We definitely need more housing (preferably using a highly effective model known as 'housing first')."

Runnels: "The great news is that a multitude of evidence-based programs have demonstrated that these up-front expenditures would not only be so much better for individuals with severe mental illness than the current system provides, but would pay for themselves over the long run in reduced healthcare costs, less jail and prison time, and less need for shelters."

Misplaced Focus

Shuwall: "Support for these developments needs to be sustained beyond the media cycle associated with the latest adverse event."

Dubovsky: "A lot of these problems are based on the notion of 'person-centered therapy.' When the system is geared toward moving large numbers of patients through psychiatrist's offices quickly while following a rote 'recovery model' that assumes that everyone is capable of achieving great things and that devalues not getting worse -- and when the role of the psychiatrist is to follow an unchanging diagnosis with prescriptions that are divorced from the overall care of the patient, the person around whom therapy is centered is not the patient."

Joffe: "The prison system has become the de facto alternative mental health system in this country where many people with chronic mental illness are sent -- usually -- for relatively minor, nonviolent crimes .... Violence amongst psychiatric patients is rare. The few times it occurs causes a media sensation but needs to be viewed in the context of the rates of violent crime that occurs in this country where no mental illness is involved. The true victims of deinstitutionalization are the patient and their families."

Friedman: "Recent attacks on the mental health system have been stimulated by several awful and highly publicized mass murders, some of which have been committed by people with serious mental illness. (Emphasize 'some.' Most are not). Sadly, the 'fixes' being proposed for the mental health system are highly unlikely to have any significant impact on the rate of mass murders in America."

Friday Feedback is a feature that presents a sampling of opinions solicited by MedPage Today *in response to a healthcare issue, clinical controversy, or new finding reported that week. We always welcome new, thoughtful voices. If you'd like to participate in a Friday Feedback issue, reach out to e.chu@medpagetoday.com or @elbertchu.*

Attachment: Michael Friedman's Original Statement

Dear Mr. Chu--

The communications office at Columbia University asked me to respond to your statement and request for comment regarding deinstitutionalization. Here's a few thoughts.

You said, "*Deinstitutionalization-shifting the treatment of the mentally ill from a "warehoused approach" (large hospitals, many state-run) to community mental health centers was a broad stroke, simple fix that sounded like a great improvement in care. In reality, it has filled prisons with the mentally ill and overwhelmed both patients and providers. Deinstitutionalization of the mentally ill sounded like a great idea, but decades later the hoped for benefit has not materialized. What lessons can be drawn from this failed fix?*"

Your position regarding serving people with mental illness (please stop using the offensive expression "the mentally ill") in the community is incorrect for a number of reasons.

First, and most important, the shift in policy from institution-based to community-based mental health services has enabled hundreds of thousands of people who would have been held in hospitals unnecessarily to lead far better lives in the community. Yes, a significant portion of people who might have been held in hospitals in the past have not fared well in the community, and we need to continue to improve the service system for them. But most are far better off than in state hospitals, which at that time were often squalid and dangerous places. The "warehouse" metaphor doesn't come close to capturing how awful some of them were.

Second, your statement totally neglects the policy shifts that have taken place since "deinstitutionalization", which was the first phase of community-based mental health policy. This policy was instituted (arguably) with the passage of the Community Mental Health Centers Act in 1963. Within ten years it was clear that it was not working as hoped for many people. By 1977 NIMH had begun recommending to the states that they institute "Community Support Programs", which they began to do. These programs included housing, rehabilitation programs, expanded outpatient treatment programs, use of local general hospitals for inpatient care, shortened lengths of stay--but sometimes increased admissions--to state hospitals, and widespread case management to follow people into the community and to coordinate their care. For example, NYS had no units of specialized housing for people with serious and persistent mental illness in 1978. Today it has about 35,000 units of housing run by the mental health system and thousands more in various supportive housing programs. Services in the community have also expanded considerably, and state hospitals--now much smaller--are far better places than they used to be. More is definitely needed, but it's not as if the system has been sitting on its hands all these years.

Third, you are right that there is a terrible problem of transinstitutionalization--the movement of people who might in the past have been in mental hospitals/asylums to prisons, nursing homes, and adult homes. There also continues to be a problem of homelessness for some people with serious and persistent mental illness. To address these problems we may (or may not--no one really knows) need more hospital beds. We may or may not need increased use of coercive interventions (forced hospitalization or outpatient treatment); this is highly controversial. We definitely need more housing (preferably using a highly effective model known as "housing first") and we definitely need a system that reaches out more to people who reject or are unable to use the services currently available. In this regard, we have known for years--and have acted on this knowledge--that more of the same old kinds of mental health services is not the answer for people who do not benefit from these services whether in the hospital or in the community. We need what are called "assertive' community services, which go to people where they are rather than waiting for them--or forcing them--to come to the mental health system on their own.

There's so much more I could say, but I'll stop there for now. Except to say that recent attacks on the mental health system have been stimulated by several awful and highly publicized mass murders, some of which have been committed by people with serious mental illness. (Emphasize "some". Most are not). Sadly, the "fixes" being proposed for the mental health system are highly unlikely to have any significant impact on the rate of mass murders in America.

I would be happy to talk with you at some time if you wish.

Michael B. Friedman
Adjunct Associate Professor
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