Going, Going, Gone

Trends and Consequences of Eliminating State Psychiatric Beds, 2016

updated for Q2 data

TREATMENT ADVOCACY CENTER

A REPORT FROM THE
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Going, Going, Gone

TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS, 2016

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EXECUTIVE SUMMARY

The number of state hospital beds that remain to serve the nation's most ill and potentially dangerous psychiatric patients has fallen to its lowest level on record, setting off a domino effect of unmet need coast to coast. Largely reserved for those individuals considered unsuccessfully treated and/or too dangerous for other health care settings, state hospitals today are the last resort of the mental health system. When there are no beds for them, people who can't be treated elsewhere instead cycle through other institutions or live on the streets. They crowd into emergency rooms and languish behind bars, waiting for beds to open. Some become violent or, more often, the victims of violence. They grow sicker and die. The personal and public costs are incalculable.

Ideally, people with serious mental illness never become psychiatry's equivalent of ICU patients; they receive timely and effective treatment long before they are critically ill. But a complete and reliable continuum of mental health care does not exist in the United States, and available mental health resources are oriented toward patients without serious mental illness. Because many individuals with the most severe psychiatric diseases are unable or unwilling to accept treatment, and some do not respond to treatment, there continue to be individuals—a growing number of people in a country with a growing population—who require the intensive, specialized services hospitals provide.

Those beds are going, going, gone.

The Treatment Advocacy Center in the first quarter of 2016 surveyed the 50 U.S. states and District of Columbia to determine how many state hospital beds remain and whom they serve. We found the following:

- 37,679 staffed beds remain in state hospitals. Adjusted for population growth, this represents a 17% reduction in the bed population since 2010, when 43,318 beds remained, and a 96.5% drop from peak hospital numbers in the 1950s.[1]
- 11.7 beds remain per 100,000 people. This means there are fewer state hospital beds per capita than at any time since before the nation stopped criminalizing mental illness in the 1850s.[2]

Key State Hospital Bed Trends, 1955-2016

YEAR	NATIONWIDE	PER 100,00 POPULATION+	AS A PERCENTAGE OF HISTORICAL PEAK*
2016			
37,679	Total state hospital beds	11.7	3.5%
20,078	Civil beds in state hospitals	6.2	*
17,601	Forensic patients in state hospitals	5.5	*
2010			
43,318	Total state hospital beds	14.1	4.2%
2005			
50,509	Total state hospital beds	16.8	5.0%
1955			
558,922	Total state hospital beds	337.0	

+ Adjusted for the growth in U.S. population
* 1955 data are not available.

- The United States ranks 29th of 34 Organization for Economic Cooperation and Development (OECD) countries. Even with all the psychiatric beds outside state hospitals included, the U.S. had only 37% of the OECD average psychiatric bed population of 68 beds per 100,000 people.[3]
- Nearly 50% of remaining beds—about 5.5 out of the 11.7—were occupied by forensic patients charged with or convicted of crimes.
- Forensic bed demand is exploding. Colorado alone saw a 500% increase in hospital referrals for pretrial competency evaluations for criminal offenders from 2004 to 2013.[4]
- State spending reflects the forensic shift. In the past 25 years, the percentage of state hospital budgets spent for forensic treatment has quadrupled.[5] It continues to rise.
- Despite this historic shift, a majority of states maintain wait lists for their forensic beds, and some lists are months long.[6]
- As more beds are diverted to the forensic population, fewer beds are left for people who haven't committed crimes. "Boarding" patients in mental health crisis to wait in loud, chaotic hospital emergency rooms has become virtually universal as the number of beds for non-offenders has shrunk.[7]
- A growing number of states are resorting to hospital beds behind bars for criminal offenders—psychiatric treatment facilities operated by corrections systems instead of mental health departments. New Hampshire even sends selected civil patients there.

"The mentally ill who have nowhere to go and find little sympathy from those around them often land hard in emergency rooms, county jails and city streets. The lucky ones find homes with family. The unlucky ones show up in the morgue."

Liz Szabo
"A Man-Made Disaster: A Mental Health System Drowning from Neglect"
USA Today (May 12, 2014)

The closing of state-operated psychiatric beds—a trend known as "deinstitutionalization"—has been ongoing in Western democracies since the mid-20th century. The United States is considered its leader, having started earlier and reduced beds more drastically than others. The trend was the result of financial incentives, new psychiatric medications and policies driven by the ideal that every patient would be better off in a small community setting than in a larger facility. The ideal, sound as it may have been, was incompletely realized. The hospitals closed, but community-based clinics did not replace them, or opened and later were defunded and closed. In many small communities, the clinics were often not viable to begin with. Meanwhile, the functions the hospitals once performed for people severely disabled by mental illness—treatment, structure, shelter—were lost, and the people who needed those functions were "transinstitutionalized" to other large settings, such as jails and prisons.[8]

Yet the march toward extinguishing state beds continues. *Going, Going, Gone* is the Treatment Advocacy Center's fourth survey of state hospital beds in eight years. Each reported double-digit bed losses, and there's no sign the next survey will be any different until no beds are left to count. Behind the scenes of the bed shortage, gravely ill and suffering people compete for the inpatient beds that remain. Typically the battle is between civil and forensic patients, but a state official in Connecticut told us children and adolescents in psychiatric crisis are backing up in ERs because juvenile psychiatric beds are being diverted to adults. The reality that an immeasurable number of people with treatable diseases only get treatment when they get sick enough to commit crimes that send them to jail and then to a forensic bed should be a source of national shame and outcry for reform.

Reducing emergency room boarding, jail bed waits and the steep price tags that come with these results of bed shortages requires reducing bed demand, increasing bed supply or both. As part of this survey, the Treatment Advocacy Center analyzed bed trends in 25 sample states to identify public policies and practices that hold some promise in altering the bed equation. The following recommendations are based on our findings and a review of research in the field.

RECOMMENDATIONS

1. **Determine how many psychiatric beds are necessary to meet inpatient need and set supply targets**

   In the mid-1950s, there were 337.0 state hospital beds per 100,000 population. This ratio has fallen continuously to reach the woefully inadequate level of 11.7 beds per 100,000 people found in this survey. Health policy experts converge around a minimum requirement of 40 to 60 inpatient beds per 100,000 people to meet demand. However, empirical research to relate any bed target to desired outcomes—much less to differentiate targets for the many categories of psychiatric need and facilities that meet them—has not been conducted. The data and technologies exist to develop these targets. In recognition of the national scope and consequences of the bed shortage and the need to discover a safe minimum number of psychiatric beds, the federal government should undertake an assessment of bed need and advance the use of tested tools to develop realistic hospital bed targets by type, facility and setting.

2. **Identify and reform public policies that incentivize bed shortages**

   Psychiatric bed access is exceptionally sensitive to economic incentives that, for half a century, have overwhelmingly been directed at reducing the number of mental health beds in America.[9] Averting the extinction of the nation's last-resort state hospital beds, slowing the elimination of other psychiatric beds, improving access to beds that already exist and motivating the creation of enough new beds to meet demand requires reversing those incentives. A new Medicaid reimbursement rule finalized in April 2016 partially repeals the discriminatory exclusion of institutions for mental diseases ("IMD Exclusion") and is an important step in that direction. But the rule applies only to certain Medicaid managed care enrollees and addresses only one of the federal policies that contribute to bed shortages. Others include Medicare reimbursement rates that are lower for psychiatric treatment than for most other medical and surgical conditions and hospital payment formulas weighted toward private hospitals. For the benefit of patients, their communities and taxpayers, Congress should direct and fund appropriate agencies to undertake a comprehensive review to identify all federal policies that create financial incentives to close psychiatric beds, assess their economic and other impacts and make evidence-driven reforms based on the findings.

3. **Improve data collection associated with bed shortages and build public policy on the evidence**

   Without outcome data, states blindly adopt and perpetuate costly practices that may contribute to bed shortages, possibly without any offsetting public or individual benefits. According to the OECD, "The lack of data on costs, quality and outcomes inhibits a complete assessment of mental health system performance. The result is poor policy and an inability to direct scarce resources to areas of need."[10] To this end, the National Institute of Mental Health (NIMH) should fund outcome research to study the impact of mental health policies on people with serious mental illness. States should identify and assess how their state policies increase or decrease access to treatment for serious mental illness, including beds, and the effectiveness of them. The public health departments of universities should incentivize doctoral and other research projects that contribute to the body of knowledge and the public good about psychiatric issues, including bed shortages.

THE DOMINO EFFECT: DYING FOR WANT OF A BED

Jamycheal Mitchell died of a heart attack after starving himself in a Virginia jail cell for three months while waiting for a state hospital bed. He was 24.

Mitchell was arrested in April 2015 for stealing $5.05 worth of snacks from a 7-Eleven. In his delusional state, he believed it was a relative's store. Mitchell stopped taking his medication for schizophrenia. After his arrest, he was evaluated, found incompetent to stand trial and court ordered into a Virginia state hospital for restoration of his competency. Because no bed was available, he remained in jail, waiting, until he died.

Inconceivably, even starving to death in a cell has ceased to be novel.

- *Keaton Farris, diagnosed with bipolar disorder and arrested for attempting to illegally cash a check, died of malnutrition and dehydration in a Washington state jail cell in April 2015.*[11]
- *Raleigh Priester, a U.S. Army veteran with schizophrenia and a long history of arrests and hospitalizations, died in a Broward County, Florida, jail after losing half his body weight over a five-month period.*[12]
- *In North Carolina, Michael Kerr died of dehydration in March of 2014 while in solitary confinement; the Associated Press reported he was not receiving treatment for his schizophrenia. North Carolina reached a settlement with his estate a year later.*[13]

The finger-pointing to fix blame for Mitchell's death in Virginia has been intense and isn't finished. While it rages, other inmates continue waiting. A month after Mitchell's death, Virginia state officials told the Washington Post *that 89 inmates, like Mitchell, had been found officially in need of a bed that wasn't available.*

Their average wait: 73 days.[14]

4. **Increase the use of diversion strategies that reduce hospitalization rates**
   Tools and strategies exist to intercept and treat people with serious mental illness before they need the last resort of a state hospital bed. None is implemented universally; some are barely used at all. The following three evidence-based practices are associated with reduced emergency room visits and psychiatric hospitalizations. Widely implementing even these three would help reduce the impact of bed shortages.

   a. Assisted outpatient treatment (AOT): A treatment option that utilizes a court order to require adherence to treatment for mentally ill individuals with a history of treatment nonadherence and rehospitalization or reincarceration, among other criteria

   b. Assertive community treatment (ACT, which may be included in AOT plans or independent): A multidisciplinary team approach to serving mentally ill patients where they live

   c. Sequential Intercept Model: A conceptual framework for preventing individuals with mental illness from entering or penetrating deeper into the criminal justice system. Among the intercepts are practices such as the use of mobile crisis teams and de-escalation training for law enforcement officers.

And, of course, states must stop closing the beds we still have before they are no longer "going" but entirely "gone."

Some states have built high- or medium-security forensic hospitals on prison grounds for mentally ill inmates. The numbers of such beds are not reported in this survey, nor do we recognize the strategy as a viable practice, even if it arguably could reduce demand for state hospital beds. Beds behind bars effectively bring the criminalization of mental illness full circle—back to

THE DOMINO EFFECT: FEWER BEDS, LONGER WAITS IN THE ER

In 2009, Sacramento County, California, eliminated 50 of the 100 beds in the county's inpatient facility and closed its outpatient crisis stabilization unit. The effect of these actions on the university hospital emergency room next door illustrates how reducing access to psychiatric treatment in one segment of the mental health system increases the demand and strain in others.*

In this case, access to both inpatient and outpatient resources was eliminated. Reduced treatment options in the county of 1.4 million people quickly produced more psychiatric emergencies involving sicker people who increasingly overwhelmed the local emergency room, where they waited longer for treatment and displaced more nonpsychiatric patients.[15]

To assess the impact of the bed and service reductions, Arica C. Nesper and colleagues compared emergency room use at the UC Davis Medical Center in the 8 months before the beds and outpatient services were closed and the 8 months following. They found the following:

- *The number of ER visits requiring psychiatric consultation tripled.*
- *The average time psychiatric patients spent waiting to be seen by a psychiatric clinician in the ER increased from an average of 14 hours to nearly 22 hours.*
- *The average number of psychiatric patients held in the ER longer than 24 hours skyrocketed from 28 patients in the 8 months before the county closures to 322 in the 8 months afterward.*
- *The number of psychiatric consultations when the most serious symptoms of psychiatric crisis—assaultive or suicidal behavior—were the chief complaint ballooned from 58 to 283. The number of patients presenting with hallucinations rocketed from 18 to 79.*
- *A smaller percentage of the patients—who now included more severely ill patients—were ultimately transferred to hospital beds; more were discharged home instead.*
- *The number of hours that psychiatric patients occupied bed space in the ER per stay rose from approximately 18 hours per patient to 97 hours, substantially affecting the flow of other patients through the ER. Care for as many as 13 to 20 nonpsychiatric patients may have been delayed or "displaced" as a result.*

"Ultimately, more than a 5-fold increase occurred in daily ED (emergency department) bed hours occupied by a patient receiving psychiatry consultation after this decrease in county mental health services," the authors concluded.[16] *In a functional mental health system, public hospitals—state and county facilities like Sacramento's—represent one point on a care continuum that also includes outpatient treatment for patients on the entire spectrum of illness: community services to support stability and prevent deterioration, hospital and residential beds to respond to acute illness, and medium- and long-term care to support recovery, among others.*

Sacramento's experience illustrates that if there is one thing more dysfunctional than reducing access to hospital treatment, it's reducing access to hospital and *community treatment at the same time.*

Arica C. Nesper et al.
"Effect of Decreasing County Mental Health Services on the Emergency Department"
Annals of Emergency Medicine (2015)

* In states as large as California, some counties operate public hospitals.

colonial times and the early 19th century, when the mentally ill were routinely jailed or kept in "poor houses." Beds behind bars are not counted in this survey because we regard this practice as an inhumane and unacceptable public policy for the treatment of disease. We would not call it just to incarcerate a man who crashed his car because he had a heart attack behind the wheel. Why would a just society incarcerate those with serious mental illness for the equivalent?

BACKGROUND

State mental hospitals—once called asylums because they were associated with protection—are remnants of a 19th-century reform movement to restore sanity with treatment and to provide shelter and humane care for individuals with serious mental illness. Since the mid-20th century, when state hospitals provided nearly 560,000 beds, a host of medical, social, political and economic factors have converged to shrink the bed population for adults in the U.S. by nearly 97%.

At the outset of the hospital construction era in 1850, there were 14 beds per 100,000 people in America. By 2010, public bed populations in state hospitals had sunk back to 14.1 beds per 100,000 people from their peak of 337.0 per 100,000 people in 1955.[17] By the first quarter of 2016, our survey of the states found the ratio had dropped an additional 17% to its lowest level on record: 11.7 beds per 100,000 people.

To put this in context, the Organization for Economic Cooperation and Development (OECD) ranks its 34 member nations—which include the United States—by their total psychiatric bed numbers. The OECD reported an average of 68 psychiatric beds per 100,000 people among its member states in 2011 or the nearest year available. Including state, county, general, community and private psychiatric beds, the United States ranked 29th, with a total combined public and private bed population of 25 beds per 100,000 people. Only New Zealand, Chile, Italy, Turkey and Mexico provided fewer beds.[18] Given the pace at which the U.S. continues closing both public and private beds, the ranking today is likely even lower.

State hospitals play a crucial role that is duplicated rarely or unevenly elsewhere in the U.S. health care system. They treat people in circumstances that are not, or cannot be, adequately addressed in a community setting. This population includes

- uninsured and indigent patients,
- pretrial defendants being "restored" to competency so they can stand trial,
- criminal defendants found "unrestorable" who remain hospitalized under civil commitment criteria,
- individuals who are violent or dangerous to self or others,
- jail inmates in need of psychiatric evaluation or treatment to restore their competency to stand trial,
- defendants being evaluated for criminal responsibility in conjunction with an "insanity" defense or for treatment in lieu of incarceration, and
- convicted prisoners in need of intensive psychiatric care.

The idea behind downsizing the state hospitals that treat these populations was fundamentally sound: Most psychiatric patients could live safely and be treated successfully in community facilities, provided such facilities existed. And many have. The rub came when and where the substitute facilities did not exist—when they were not widely constructed or were constructed and almost exclusively served more functional clients than state hospitals once did.[19] The further reality that approximately 25% of individuals with psychotic disorders do not respond to treatment and hence are unable to rejoin the community without substantial support was left completely unaddressed. In its report on 2010 bed populations, the Treatment Advocacy Center called the resulting treatment gap for individuals with the most serious psychiatric diseases "disastrous."[20]

Since then, the situation has become beyond disastrous.

- Approximately 6,000 state hospital beds were eliminated from 2010 to early 2016 (see Table 1). At the same time, the U.S. population grew by approximately 14 million people.
- Sixteen state hospitals in nine states closed or merged from 2010 to 2016. By July 2015, the number of state hospitals in the United States numbered 195, down from 254 in 1997, a 24% reduction in less than 20 years.[21]
- County, general and private hospital beds continued to decline in tandem with state hospitals. The Subcommittee on Acute Care of the New Freedom Commission appointed by President George W. Bush reported in 2004 that the number of inpatient beds per capita fell 43% from 1990 through 2000 and 32% in nonfederal general hospitals.[22] The shrinkage continues.
- Fewer beds resulted in people in crisis waiting longer for the ones that remained. Nearly 90% of surveyed emergency physicians reported in 2015 that mentally ill patients were being "held" in their ERs for lack of hospital beds to admit them to, a practice known as "boarding"[23] (see "The Domino Effect: Fewer Hospital Beds, Longer Waits in the ER for Everyone").
- 70% of ER physician survey respondents in 2015 said their ERs boarded patients in psychiatric crisis for more than 24 hours; 10% reported boarding them for a week or more.[24]

Table 1. *State Hospital Beds Remaining in 2016*

STATE	2016 TOTAL STATE HOSPITAL BEDS	2010 TOTAL STATE HOSPITAL BEDS	NUMBER OF BEDS LOST OR GAINED	2016 BEDS PER 100,000 POPULATION	RELATION TO TARGET BEDS PER CAPITA
Alabama	383	1,119	-736	7.9	15.8%
Alaska	80	52	28	10.8	21.7%
Arizona	302	260	42	4.4	8.8%
Arkansas	222	203	19	7.5	14.9%
California	5,905	5,283	622	15.1	30.2%
Colorado	543	520	23	10.0	19.9%
Connecticut	615	741	-126	17.1	34.3%
Delaware	122	209	-87	12.9	25.8%
District of Columbia	282	*	*	42.0	84.0%
Florida	2,648	3,321	-673	13.1	26.1%
Georgia	954	1,187	-233	9.3	18.7%
Hawaii	202	182	20	14.1	28.2%
Idaho	174	155	19	10.5	21.0%
Illinois	1,341	1,429	-88	9.3	18.7%
Indiana	818	908	-90	12.4	24.7%
Iowa	64	149	-85	2.0	4.1%
Kansas	451	705	-254	15.5	31.0%
Kentucky	499	446	53	11.3	22.6%
Louisiana	616	903	-287	13.2	26.4%
Maine	144	137	7	10.8	21.7%
Maryland	950	1,058	-108	15.8	31.6%

* District of Columbia bed numbers not collected in 2010

Table 1. ***State Hospital Beds Remaining in 2016, continued***

STATE	2016 TOTAL STATE HOSPITAL BEDS	2010 TOTAL STATE HOSPITAL BEDS	NUMBER OF BEDS LOST OR GAINED	2016 BEDS PER 100,000 POPULATION	RELATION TO TARGET BEDS PER CAPITA
Massachusetts	608	696	-88	8.9	17.9%
Michigan	725	530	195	7.3	14.6%
Minnesota	194	206	-12	3.5	7.0%
Mississippi	486	1,156	-670	16.2	32.5%
Missouri	874	1,332	-458	14.4	28.8%
Montana	174	194	-20	16.8	33.7%
Nebraska	289	337	-48	15.2	30.5%
Nevada	296	302	-6	10.2	20.5%
New Hampshire	158	189	-31	11.9	23.7%
New Jersey	1,543	1,922	-379	17.2	34.4%
New Mexico	229	171	58	11.0	22.0%
New York	3,217	4,958	-1,741	16.3	32.5%
North Carolina	892	761	131	8.9	17.8%
North Dakota	140	150	-10	18.5	37.0%
Ohio	1,121	1,058	63	9.7	19.3%
Oklahoma	431	401	30	11.0	22.0%
Oregon	653	700	-47	16.2	32.4%
Pennsylvania	1,334	1,850	-516	10.4	20.8%
Rhode Island	130	108	22	12.3	24.6%
South Carolina	493	426	+67	10.1	20.2%
South Dakota	128	238	-110	14.9	29.8%
Tennessee	562	616	-54	8.5	17.0%
Texas	2,236	2,129	107	8.1	16.3%
Utah	252	310	-58	8.4	16.8%
Vermont	25	52	-27	4.0	8.0%
Virginia	1,526	1,407	119	18.2	36.4%
Washington	729	1,220	-491	10.2	20.3%
West Virgina	260	259	1	14.1	28.2%
Wisconsin	458	558	-100	7.9	15.9%
Wyoming	201	115	86	34.3	68.6%
TOTALS	**37,679**	**43,318**	**-5,639**	**11.7**	**23.4%**

Behind bars, a parallel treatment gap grew, with equally devastating impact.

- In 44 states and the District of Columbia, a prison or jail holds more individuals with serious mental illness than the largest remaining state psychiatric hospital.[25]
- Suicide is the leading cause of death in jails, yet suicide and suicide attempts represent a small share of the acts of self-harm inmates inflict. Self-mutilation is commonplace, especially in solitary confinement, where mentally ill prisoners make up most of the population.[26]
- Jail and prison personnel untrained to be mental health workers are consigned to supervising psychotic and otherwise disordered inmates, leading to dangerous conditions and injuries in both groups.[27]
- Media reports of resulting tragedies—starvation deaths like Jamycheal Mitchell's, the alleged beating death of mentally ill inmate Michael Tyree by jail guards in California, the suicide of a man who swallowed razor blades in his cell—are uncommon enough to remain shocking but are no longer extraordinary.
- 75% of 39 state hospitals responding to a 2014 industry survey said demand for forensic services in their states had increased "a lot" or "moderately" in recent years. Only four states reported no change in forensic service demands; none reported that demand had decreased.[28]
- 78% of 40 state hospital officials responding to a survey in 2015 reported maintaining wait lists for forensic beds. The waits were "in the 30-day range" in most states, but three states reported forensic bed waits of six months to one year.[29]
- A growing number of states are being sued—some repeatedly—over forensic bed waits or other conditions involving mentally ill prisoners, and more lawsuits are threatened.

Between the two populations—mentally ill individuals inside and outside the criminal justice system—a bed shell game with life-and-death implications has ensued. Without enough beds to go around, states prioritize. Where bed access for patients who have committed crimes is given priority, bed waits behind bars tend to be shorter, and fewer civil patients are served. In states where bed access for noncriminal patients is preserved, forensic wait lists swell, and more civil patients are served. Although the tactic doesn't typically eliminate bed waits completely for either population, one population benefits somewhat, at the expense of the other (see "The Domino Effect: Treating More Forensic Patients Sooner by Treating Fewer Civil Patients").

The deplorable state of America's mental health care is hardly a function of state hospital bed shortages alone. Private and community bed shortages and a dearth of long-term residential care options have resulted from discriminatory Medicaid and Medicare reimbursement policies. State mental health budget cuts, which reached draconian proportions following the financial crisis, have reduced access to mental health treatment at every stop on the way to state hospitals. Mental health professionals are in dire shortage. Of the nation's 3,100 counties, 55% have no practicing psychiatrists, psychologists or social workers.[30] Promising early-intervention treatment models that could improve long-term outcomes of the most serious mental illnesses rely on community-based mental health services that can't be provided where providers don't exist. At the same time, an estimated 14,000 of America's 35,000 practicing psychiatrists are over the age of 55 and heading toward retirement, without new psychiatrists being graduated at anywhere near a replacement rate;[31,32] in states like South Dakota, state hospital bed waits are more a function of psychiatrist shortages than bed shortages.[33] Beyond the public system, a Mayo Clinic–affiliated psychiatric unit in Wisconsin closed in March 2016 because of psychiatric personnel shortages.[34]

Meanwhile, essential residential and supported housing for patients released from hospitals are at least as scarce as hospital beds. In November 2015, Virginia's mental health department

reported that 7% of the bed capacity at one of the commonwealth's state hospitals was occupied by "20 individuals who have been clinically ready for discharge for more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner." At the same time, 24 individuals were reported to be in jail waiting for one of those beds for evaluation or treatment to restore competency.[35]

Comprehensive mental health care reform and practices that address treatment gaps and deficiencies along the entire continuum of care are desperately needed. Until they are in place and operating, shutting down the last resort for treatment of gravely ill people who endanger themselves and their communities is premature, inefficient, expensive, inhumane and deadly.

THE DOMINO EFFECT:
TREATING MORE FORENSIC PATIENTS SOONER BY TREATING FEWER CIVIL PATIENTS

Colorado was sued in 2011 over its alleged failure to provide timely competency evaluations and treatment for pretrial inmates. In 2012, the state and Disability Law Colorado, which had filed the suit on behalf of affected inmates, reached a compromise meant to ensure that criminal defenders spent less time in jail waiting for a bed.

Under the settlement, the state Department of Health Services agreed to complete competency evaluations of pretrial inmates in the jails within 30 days of a court order or to admit them to the state hospital for evaluation within 28 days. Offenders found incompetent to stand trial were to be admitted to the state hospital or an in-jail program within 28 days of the finding. Monthly reports to Disability Law detailing when evaluation or treatment began for each inmate were required.

The settlement agreement had the desired effect of reducing how long forensic patients waited in jail for competency evaluations in one of the state's two state hospitals. "The average length of stay for defendants admitted for competency evaluations was greatly decreased, to 35 days at CMHIP (Colorado Mental Health Institute at Pueblo) and 38 days at the Colorado Mental Health Institute at Fort Logan (CMHIFL), as compared to 102 days prior to the lawsuit," according to an April 2015 analysis of existing services and future needs reported to the state's Department of Human Services.[36]

However, improved conditions for forensic patients came at the expense of civil patients. "A side effect of the settlement agreement has been fewer beds available for civil commitments," the report said. "The percentage of civil referrals being denied admission has increased substantially for both institutes, from 21 percent to 38 percent at CMHIP, largely due to referrals for competency evaluations."[37]

Intensifying the impact on civil patients was the length of stay for pretrial patients who require treatment to restore their competency to stand trial. "With nearly one-quarter of these individuals staying more than one year, CMHIP is forced to use a larger and larger portion of its civil beds to serve this population. The combination of increased admissions and longer lengths of stay is the driving force behind a projected shortage of beds over the next decade."[38]

The Western Interstate Commission for Higher Education, which conducted the assessment, concluded Colorado would need to increase its state hospital bed population by 90%—from 545 to 1,033 beds—by 2025 to "keep pace with increasing forensic admissions and to maintain the current civil bed rate,"[39] *which ranks 34th in the Treatment Advocacy Center's current state survey.*

Things haven't improved since then.

In October 2015, Disability Law Colorado filed a motion accusing the Department of Human Services of submitting "misleading and false data" in four of its required monthly reports and then covering up the falsifications.[40] *In early 2016, the legislature began deliberating a bill giving sheriffs specific authority to use jails for up to 48 hours—longer over weekends and holidays—to contain citizens who had not committed a crime but were in psychiatric crisis if no hospital bed was available.*

METHODOLOGY

State hospital bed numbers reported in *Going, Going, Gone* were collected in the first quarter of 2016 for patients 18 years or older. Data include voluntary and involuntary beds for patients who enter treatment either through the civil (non-criminal) or the forensic (criminal justice) systems.

Survey data for both bed classifications were collected in the 50 states and District of Columbia from three principal sources:

- Official state publications, including state websites, state reports and departmental reports to governors and legislative committees
- Email or telephone interviews with personnel in state mental health departments, state hospitals, public information offices and other state agencies with access to bed statistics
- Court filings associated with lawsuits against states for their treatment of mentally ill inmates

In states where beds exist but nobody is in them because they are not staffed (e.g., Kentucky, Minnesota, New York, Nebraska, Texas), the number of beds in operation is reported, not the beds that are approved but empty. Child and adolescent beds, which account for about 1% of state hospital budgets,[41] were excluded. Residential and geriatric state hospital beds that were characterized as primarily providing residential care to individuals with Alzheimer's, senile dementia and other age-related conditions—again, a small percentage of total beds—were excluded, as were beds for convicted sexual offenders, who are housed in state hospitals in some states even though not mentally ill.

States were surveyed for both their forensic hospital bed allocations and patient censuses. "Allocations" refers to the number of beds that states have been officially designated, budgeted and/or reserved for patients who are involved with the criminal justice system. "Census" refers to actual occupancy. In states where civil beds are being repurposed to meet forensic demand (e.g., Indiana, Massachusetts, Ohio), forensic bed occupancy typically exceeds forensic allocations. References to the ratio of forensic to other beds in all cases refer to occupancy, not allocation.

More detailed forensic bed wait information was solicited from a sample of 25 states in interviews conducted during March and April 2016. Sample states were asked for the following data:

- Number of inmates wait-listed for a state hospital bed
- Average (mean) time from being wait-listed for a bed to being admitted to one
- Average length of stay for forensic patients found not guilty by reason of insanity
- Forensic bed occupancy rates for 2015

When necessary and available, media reports were used to validate numbers from official sources. In each of the sample states, applicable statutes and regulations were reviewed to identify legal parameters that might govern or influence the classification, number and/or use of forensic beds.

Since the publication of the Treatment Advocacy Center's first survey of hospital beds in 2008, a per capita level of 50 psychiatric beds per 100,000 population has been widely accepted as a credible measure of bed supply adequacy. No better evidence-based benchmark having emerged since then, the 50/100,000 number continues to be used for comparative purposes in this survey.

One strength of this study is that it contains the most complete and current state hospital bed statistics available, including the numbers and ratios of forensic bed allocations and occupancy to total bed populations in each state. The 25-state sample goes beyond bed counts alone to examine bed trends in the context of applicable state laws and regulations affecting them, which illuminates how public policies can reduce or increase bed demand.

Limitations of the study include inconsistent data sets or timing resulting from variations in the laws that regulate state hospital beds and/or the techniques states use to collect data and report their statistics. For example, some states maintain real-time bed registries; others report bed counts weekly, monthly or annually. Forensic bed waits also are tracked and reported differently among the states; some report daily totals, while others average waits by the week or month. The average time inmates spend on a forensic wait list was subject to whether states prioritized patients and on what basis, such as clinical need or date of court order.

Hospital bed numbers are subject to circumstances that can change daily, even hourly. This affects the precision of numbers on any given date but does not materially affect the trends they reveal.

STATISTICS MAY NOT LIE BUT THAT DOESN'T MAKE THEM TOTALLY RELIABLE

States are not always reliable sources of their own data, undermining the precision of state bed surveys, regardless of who conducts them. The obstacles we encountered in surveying the states for Going, Going, Gone *typically fell into one of three categories.*

- ***State officials are not knowledgeable.***

  A 2014 National Association of State Mental Health Program Directors (NASMHPD) report on forensic mental health services noted that 41 or 42 respondents said their states recognize the insanity defense, "including respondents from 3 of the states in which the defense formally has been abolished."[42] *Our survey elicited similarly conflicting answers when identical questions were posed to different officials within the same state. We defaulted to the answer that was corroborated elsewhere (e.g., in a report or on the state website) or came from the official of the highest rank who had direct knowledge of the subject.*

- ***States report different numbers to different sources.***

  The state of Pennsylvania reported a total population of 2,495 state hospital beds to the NASMHPD Research Institute in late 2015, a population of 1,531 on its official website in early 2016 and, at the same time, a population of 1,334 to the Treatment Advocacy Center. Other states reported similarly inconsistent statistics. We defaulted to the data state officials personally conveyed to us.

- ***States choose to withhold or obfuscate the truth.***

  Our inquiries were not always answered with complete information. In New Hampshire, a state official hung up on the interviewer. In Illinois, state officials did not pick up the telephone or return calls or emails left during a two-month period; ultimately, a University of Chicago law professor was recruited to find a responsive state official for us. In Colorado, Disability Law Colorado filed a motion in federal court accusing the state of falsifying its court-ordered monthly reports on forensic bed waits.

FINDINGS

In 2015, there were an estimated 8.1 million individuals with schizophrenia or severe bipolar disorder in the United States, about half of them untreated at any given time.[43] Because of the severity of their symptoms when untreated and their heightened risk of being arrested and/or impoverished as a result, these are the citizens most likely to be admitted to a last-resort bed in a state hospital, as either civil or forensic patients.

Our 2016 survey of state psychiatric bed populations found the following:

- 37,679 staffed beds remained in state hospitals. This represented a 17% reduction in the bed population since 2010, when 43,318 beds remained.[44]
- 11.7 beds remained per 100,000 population. This compares with an average of about 68 beds per 100,000 people in the Organization for Economic Cooperation and Development (OECD) and marked the lowest per capita state bed availability since the nation began decriminalizing mental illness in the 1850s.[45]
- Of the 11.7 beds per 100,000 population, roughly half were available to civil psychiatric patients—people who had not committed crimes.
- "Boarding" psychiatric patients in emergency rooms while waiting for beds somewhere in the psychiatric inpatient system was virtually universal.[46]
- Of the 11.7 beds per 100,000 population, the other half were occupied by forensic patients admitted to the hospital via the criminal justice system. In two states, Hawaii and Missouri, all of them were.
- Because far more inmates are in need of or ordered by courts into hospitals than there are beds for them, they are placed on wait lists in most states, sometimes for months.[47]
- Those states without long forensic bed waits often have avoided them by diverting civil beds to forensic uses, leading to longer waits in the ERs where the civil patients accumulate.
- A growing number of states are resorting to hospital beds behind bars—psychiatric treatment facilities operated as part of the state's penal system.

Survey of the States

Our 2012 survey report, *No Room in the Inn* found that, in 2010, 11 states continued to provide at least 20 psychiatric beds per 100,000 population.[48] About 51 million people lived in those states. By the first quarter of 2016, only 2 states continued to provide at least 20 beds for each 100,000 people: Wyoming and the District of Columbia. They were home to roughly 1.2 million of America's 321 million residents (see Table 2).

In 16 states, fewer than 10 beds remained per 100,000 people by early 2016: Alabama, Arizona, Arkansas, Georgia, Illinois, Iowa, Massachusetts, Michigan, Minnesota, North Carolina, Ohio, Tennessee, Texas, Utah, Vermont and Wisconsin.

In 4 states, fewer than 5 beds remained per 100,000 population: Arizona, Iowa, Minnesota and Vermont. Arizona, Iowa and Minnesota were also at the bottom of the rankings in 2010; Vermont lost its state hospital to Hurricane Irene in 2012 and only recently restored some of those beds.

Table 2. *State Hospital Bed Populations by State and Rank*

STATE	2010 TOTAL STATE HOSPITAL BEDS	2010 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES	2016 TOTAL STATE HOSPITAL BEDS	2016 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES
Iowa	149	4.9	48	64	2.0	51
Minnesota	206	3.9	50	194	3.5	50
Vermont	52	8.3	42–43	25	4.0	49
Arizona	260	4.1	49	302	4.4	48
Michigan	530	5.4	47	725	7.3	47
Arkansas	203	7.0	46	222	7.5	46
Alabama	1,119	23.4	5	383	7.9	44–45
Wisconsin	558	9.8	37	458	7.9	44–45
Texas	2,129	8.5	41	2,236	8.1	43
Utah	310	11.2	27–28	252	8.4	42
Tennessee	616	9.7	38	562	8.5	41
North Carolina	761	8.0	44	892	8.9	39–40
Massachusetts	696	10.6	31	608	8.9	39–40
Illinois	1,429	11.1	29	1,341	9.3	37–38
Georgia	1,187	12.3	26	954	9.3	37–38
Ohio	1,058	9.2	39–40	1,121	9.7	36
Colorado	520	10.3	35	543	10.0	35
South Carolina	426	9.2	39	373	7.5	34
Washington	1,220	18.1	17	729	10.2	32–33
Nevada	302	11.2	27–28	296	10.2	32–33
Pennsylvania	1,850	14.6	20	1,334	10.4	31
Idaho	155	9.9	36	174	10.5	30
Maine	137	10.3	32–35	144	10.8	28–29
Alaska	52	7.3	45	80	10.8	28–29
New Mexico	171	8.3	42–43	229	11.0	26–27
Oklahoma	401	10.7	30	431	11.0	26–27
Kentucky	446	10.3	32–35	499	11.3	25
New Hampshire	189	14.4	21	158	11.9	24
Rhode Island	108	10.3	32–35	130	12.3	23
Indiana	908	14.0	24	818	12.4	22
Delaware	209	23.3	6	122	12.9	21
Florida	3,321	17.7	18	2,648	13.1	20
Louisiana	903	19.9	12	616	13.2	19
West Virgina	259	14.0	23–24	260	14.1	17–18
Hawaii	182	13.4	25	202	14.1	17–18
Missouri	1,332	22.2	8	874	14.4	16
South Dakota	238	29.2	2	128	14.9	15
California	5,283	14.2	22	5,905	15.1	14

Table 2. *State Hospital Bed Populations by State and Rank, continued*

STATE	2010 TOTAL STATE HOSPITAL BEDS	2010 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES	2016 TOTAL STATE HOSPITAL BEDS	2016 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES
Nebraska	337	18.5	14	289	15.2	13
Kansas	705	24.7	4	451	15.5	12
Maryland	1,058	18.3	15–16	950	15.8	11
Oregon	700	18.3	15–16	653	16.2	9–10
Mississippi	1,156	39.0	1	486	16.2	9–10
New York	4,958	25.6	3	3,217	16.3	8
Montana	194	19.6	13	174	16.8	7
Connecticut	741	20.7	10	615	17.1	6
New Jersey	1,922	21.9	9	1,543	17.2	5
Virginia	1,407	17.6	19	1,526	18.2	4
North Dakota	150	22.3	7	140	18.5	3
Wyoming	115	20.4	11	201	34.3	2
District of Columbia	*	*	*	282	42.0	1
TOTALS	**43,318**	**14.1**		**37,679**	**11.7**	

* District of Columbia bed numbers not collected in 2010

In 18 states, sufficient additional beds were added from 2010 to 2016 for the per capita rate to rise. In no state, however, did the increase boost a state's ratio to 20 beds per 100,000 popu-lation from the teens or below.* In most states, the increase simply made an abysmal ratio marginally less abysmal. For example, Arizona's beds per capita, which ranked 49th among the states in 2010 at 4.1 beds per 100,000 people, rose to 4.4. West Virginia rose from 14.0 beds per 100,000 to 14.1. Given how fluid jail census numbers are, "growth" this miniscule is as likely to be a statistical fluke as a sign of any real improvement.

Merely counting beds and reporting their ratio to state populations, however, does not fully reveal the trends and consequences of the bed shortage.

As the ER boarding data show, when beds are not available, people in psychiatric crisis back up in hospital emergency rooms or, worse, are discharged with no care at all, a practice known as "streeting."[49] When beds are not available for mentally ill inmates, their numbers grow in jail and prison cells, including solitary confinement.

Before deinstitutionalization, jails and prisons held relatively few mentally ill inmates. This made for few forensic patients for state hospitals to treat. By 2014, a prison or jail held more individuals with serious mental illness than the largest remaining state psychiatric hospital in 44 states and the District of Columbia. At least 20% of jail and prison inmates were estimated to suffer from a serious mental illness, though sheriffs around the country occasionally report populations running as high as 50% in their jails.[50]

* Wyoming, which reached 34.3 beds in 2016, already ranked 11th among the states in 2010, with 20.4 beds per 100,000 people. District of Columbia was not ranked in 2010.

Table 3. *Forensic Bed Populations by State*

STATE	TOTAL STATE HOSPITAL BEDS	DESIGNATED FORENSIC BEDS	% OF ALL BEDS DESIGNATED FORENSIC	CENSUS OF FORENSIC PATIENTS	% OF ALL BEDS OCCUPIED FORENSIC
Alabama	383	115	30.0	115	30.0
Alaska	80	10	12.5	10	12.5
Arizona	302	143	47.4	143	47.4
Arkansas	222	126	56.8	156	70.3
California	5,905	4,412	74.7	4,412	74.7
Colorado	543	184	33.9	184	33.9
Connecticut	615	232	37.7	232	37.7
Delaware	122	42	34.4	42	34.4
District of Columbia	282	0	0.0	158	56.0
Florida	2,648	1,124	42.4	1,559	58.9
Georgia	954	641	67.2	641	67.2
Hawaii	202	198	98.0	198	98.0
Idaho	174	55	31.6	55	31.6
Illinois	1,341	802	59.8	896	66.8
Indiana	818	88	10.8	267	32.6
Iowa	64	0	0.0	38	59.4
Kansas	451	200	44.3	200	44.3
Kentucky	499	0	0.0	0	0.0
Louisiana	616	70	11.4	70	11.4
Maine	144	44	30.6	47	32.6
Maryland	950	853	89.8	853	89.8
Massachusetts	608	0	0.0	70	11.5
Michigan	725	210	29.0	384	53.0
Minnesota	194	0	0.0	0	0.0
Mississippi	486	35	7.2	35	7.2
Missouri	874	874	100.0	874	100.0
Montana	174	59	33.9	59	33.9
Nebraska	289	67	23.2	67	23.2
Nevada	296	76	25.7	76	25.7
New Hampshire	158	0	0.0	0	0.0
New Jersey	1,543	200	13.0	471	30.5
New Mexico	229	44	19.2	44	19.2
New York	3,217	720	22.4	720	22.4
North Carolina	892	84	9.4	236	26.5
North Dakota	140	65	46.4	65	46.4
Ohio	1,121	0	0.0	714	63.7
Oklahoma	431	200	46.4	200	46.4
Oregon	653	416	63.7	439	67.2
Pennsylvania	1,334	236	17.7	236	17.7
Rhode Island	130	28	21.5	28	21.5
South Carolina	493	215	43.6	215	43.6

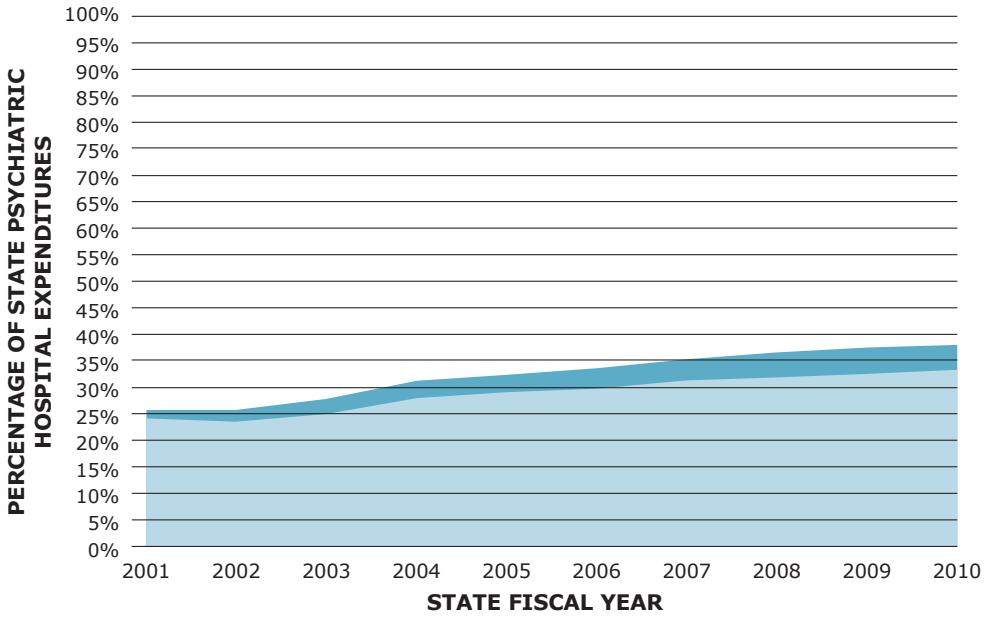
Table 3. *Forensic Bed Populations by State, continued*

STATE	TOTAL STATE HOSPITAL BEDS	DESIGNATED FORENSIC BEDS	% OF ALL BEDS DESIGNATED FORENSIC	CENSUS OF FORENSIC PATIENTS	% OF ALL BEDS OCCUPIED FORENSIC
South Dakota	128	0	0.0	0	0.0
Tennessee	562	0	0.0	100	17.8
Texas	2,236	1,047	46.8	1,216	54.4
Utah	252	100	39.7	100	39.7
Vermont	25	0	0.0	10	40.0
Virginia	1,526	356	23.3	356	23.3
Washington	729	138	18.9	138	18.9
West Virgina	260	0	0.0	95	36.5
Wisconsin	458	349	76.2	349	76.2
Wyoming	201	28	13.9	28	13.9
TOTALS	**37,679**	**14,886**		**17,601**	

When inmates require psychiatric evaluation or treatment, the state hospital is the most common—in many circumstances, the only—facility where they can be admitted. Our survey of the states found the following with regard to forensic patients (see Table 3):

- In 15 states, more than 50% of the remaining state hospital beds were occupied by foren-sic patients: Arkansas, California, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Maryland, Michigan, Missouri, Ohio, Oregon, Texas and Wisconsin.
- In an additional 19 states, forensic patients occupied 25% to 49% of the state hospi-tal beds: Alabama, Arizona, Colorado, Connecticut, Delaware, Idaho, Indiana, Kansas, Maine, Montana, Nevada, New Jersey, North Carolina, North Dakota, Oklahoma, South Carolina, Utah, Vermont and West Virginia.
- In two states—Hawaii and Missouri—officials reported the state hospitals were essentially 100% dedicated to forensic use.
- In only one state—Mississippi—did forensic patients occupy fewer than 10% of the state hospital beds.
- Of the roughly 6 forensic beds per 100,000 population, 50.5% of those in our sample of 25 states were occupied by patients found not guilty by reason of insanity, who may spend decades or their entire remaining lifetimes in the hospital. This effectively left 3 beds per 100,000 people for mentally ill inmates in need of pretrial services or other in-patient treatment.
- Three states reported no forensic beds because they provide psychiatric treatment to inmates entirely in forensic units at state prisons: Kentucky, New Hampshire and South Dakota. The move to beds behind bars does not guarantee a sufficient supply of beds for demand: In Kentucky, an average of 37 inmates waited an average of three weeks each for a bed in the first quarter of 2016.[51]
- State hospital budgets reflect the shift from civil to forensic treatment. In 1990, 10% of state psychiatric hospital expenditures were for forensic services; by 2010, the figure had risen to 40%[52] and was still going up (see Figure 1).

Figure 1. ***Forensic and Sex Offender Expenditures as a Percentage of State Psychiatric Hospital Expenditures Fiscal Years 2001 to 2010***



Source: National Association of State Mental Health Program Directors Research Institute. (2012). FY 2010 State Mental Health Revenues and Expenditures. Retrieved from http://media.wix.com/ugd/186708_c6beb833346b45429322cc4421d83aa1.pdf

In a bizarre display of how thoroughly mental illness is returning to its status as a criminal condition, New Hampshire authorizes civil patients who have committed no crime to be treated inside the state's Secure Psychiatric Unit—a prison. Figure 2 is a photograph of the cages where group therapy sessions are conducted for civilly committed patients.

A bill to prohibit the practice was introduced this year but referred for study, which means it passed no committee or legislative chamber and received no hearing. Meanwhile, over the state line, a Maine bill to authorize transferring selected patients from the state hospital in Augusta to a prison psychiatric unit like New Hampshire's fell short of passage by one vote in April. The candidate patients also were people who had not been charged with or convicted of crimes.

Figure 2. ***Group Therapy Booths for Civil Patients in the New Hampshire Secure Psychiatric Unit***

Source: Nancy West, New Hampshire Center for Public Interest Journalism

Families and friends of the mentally ill routinely report that police officers, mental health workers and other families advise that the most reliable way for their loved one to get treatment is to be arrested. The dwindling number of beds for patients who haven't committed crimes is one explanation (see Table 4).

- In only 13 states do at least 10 nonforensic beds remain per 100,000 people: Connecticut, District of Columbia, Kentucky, Louisiana, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New York, South Dakota, Virginia and Wyoming.
- In 22 states, only 5 to 9 civil beds are available per 100,000 people.
- In 16 states—including the 2 where no civil beds remain—fewer than 5 civil beds remain for each 100,000 people.

Table 4. *State Hospital Bed Population by Legal Status*

STATE	CIVIL BEDS PER 100,000 POPULATION	FORENSIC BEDS PER 100,000 POPULATION	TOTAL BEDS PER 100,000 POPULATION*
Alabama	5.5	2.4	7.9
Alaska	9.5	1.4	10.8
Arizona	2.3	2.1	4.4
Arkansas	2.2	5.2	7.5
California	3.8	11.3	15.1
Colorado	6.6	3.4	10.0
Connecticut	10.7	6.5	17.1
Delaware	8.5	4.4	12.9
District of Columbia	18.4	23.5	42.0
Florida	5.4	7.7	13.1
Georgia	3.1	6.3	9.3
Hawaii	0.3	13.8	14.1
Idaho	7.2	3.3	10.5
Illinois	3.9	5.4	9.3
Indiana	8.3	4.0	12.4
Iowa	0.8	1.2	2.0
Kansas	8.6	6.9	15.5
Kentucky	11.3	0.0	11.3
Louisiana	11.7	1.5	13.2
Maine	7.3	3.5	10.8
Maryland	1.6	14.2	15.8
Massachusetts	7.9	1.0	8.9
Michigan	3.4	3.9	7.3
Minnesota	3.5	0.0	3.5
Mississippi	15.1	1.2	16.2
Missouri	0.0	14.4	14.4
Montana	11.1	5.7	16.8

* Inconsistencies in totals are due to rounding.

Table 4. ***State Hospital Bed Population by Legal Status, continued***

STATE	CIVIL BEDS PER 100,000 POPULATION	FORENSIC BEDS PER 100,000 POPULATION	TOTAL BEDS PER 100,000 POPULATION*
Nebraska	11.7	3.5	15.2
Nevada	7.6	2.6	10.2
New Hampshire	11.9	0.0	11.9
New Jersey	12.0	5.3	17.2
New Mexico	8.9	2.1	11.0
New York	12.6	3.6	16.3
North Carolina	6.5	2.3	8.9
North Dakota	9.9	8.6	18.5
Ohio	3.5	6.1	9.7
Oklahoma	5.9	5.1	11.0
Oregon	5.3	10.9	16.2
Pennsylvania	8.6	1.8	10.4
Rhode Island	9.7	2.7	12.3
South Carolina	5.7	4.4	10.1
South Dakota	14.9	0.0	14.9
Tennessee	7.0	1.5	8.5
Texas	3.7	4.4	8.1
Utah	5.1	3.3	8.4
Vermont	2.4	1.6	4.0
Virginia	14.0	4.2	18.2
Washington	8.2	1.9	10.2
West Virgina	8.9	5.2	14.1
Wisconsin	1.9	6.0	7.9
Wyoming	29.5	4.8	34.3
TOTALS	**6.2**	**5.5**	**11.7**

* Inconsistencies in totals are due to rounding.

Another reason why the public views law enforcement and jails as the most accessible routes for mental health crisis intervention are well-publicized developments like these:

- In California, the Tehama County sheriff and Health Services Agency asked the Board of Supervisors to declare the jail a mental health treatment facility so mentally ill inmates can be medicated over objection there.[53] State law prohibits involuntary medication outside a state hospital or designated facility.
- In Colorado, legislation was under consideration to authorize jails to be used in lieu of hospitals when no bed is available for individuals in psychiatric crisis who have not committed crimes, for up to 48 hours or longer over weekends and holidays.[54]

- In Florida, a mental health court judge told an interviewer from the NASMHPD, "Competency is rarely his primary concern when he orders an evaluation. If there were another means of obtaining quick treatment, he said, he would use it instead." The interviewer concluded, "There is reason to believe that in some states with large numbers of evaluations, referrals serve not only to help determine triability but also as an avenue to treatment for mentally ill persons in jail."[55] It is likely no coincidence that Florida reports the highest number of competency restorations in the country: about 1,550 per year.[56]

There's even jargon for when law enforcement resorts to arrest because treatment isn't available: "mercy bookings."

Sample of the States

As a nation that combines the highest incarceration rate in the world with an incomplete and selective mental health system oriented toward the healthiest patients, the United States perhaps inevitably holds an enormous number of mentally ill individuals behind bars: more than 350,000 on any given day.[57] In 2014, an estimated 1.8 million U.S. jail bookings involved people with serious mental illness.[58] These pretrial offenders made up the majority of inmates in line for forensic beds, and their numbers are exploding. Colorado reported a 500% increase in referrals for pretrial competency evaluations for criminal offenders from 2004 to 2013.[59] Oregon reports that forensic bed demand nearly doubled from 2010 to 2013.[60] In Virginia, forensic admissions to state hospitals rose 13.5% from fiscal year 2014 to 2015.[61] If demand for pretrial forensic services is surging, the logical explanation is that arrests of people with psychiatric symptoms are surging, too. Examining whether and why such a trend might be emerging is beyond the scope of this study but merits investigation, given the significant toll incarcerating individuals with mental illness exacts from them, the criminal justice system and taxpayers.

To sample the impact of bed shortages on forensic patients, the Treatment Advocacy Center collected detailed data from 25 states that are highly populated, being sued or threatened with legal action for nontreatment of mentally ill inmates, and/or actively considering mental health system reforms to increase treatment access (see Table 5). Statutes and regulations were reviewed in the same states to identify public policies that may be associated with their bed trends (see Appendix).

Table 5. *Forensic Bed Trends in 25 Sample States*

STATE	2016 FORENSIC BED CENSUS	# OF INMATES WAITING FOR FORENSIC BED	AVERAGE # OF DAYS FROM WAIT LIST TO ADMISSION	# OF INMATES WAITING PER 100,000 POPULATION	FORENSIC BED OCCUPANCY RATE IN 2015	% OF FORENSIC BEDS OCCUPIED BY NGRI◆	AVERAGE LENGTH OF STAY FOR NGRI (DAYS)	OPENING (++) OR CLOSING (--) BEDS IN THE NEXT 12 MONTHS
California	4,412	418	75	1.4	*	*	*	*
Colorado	184	100	*	2.4	*	68%	3,175.5	n/c
Florida	1,559	44	13	0.3	100%	31%	921.0	++
Georgia	641	72	*	0.9	96%	53%	*	++
Illinois	896	62	38	0.6	112%	60%	2,007.5	n/c
Indiana	267	26	*	0.5	*	8%	1,950.0	

◆ NGRI = People found "not guilty by reason of insanity"
* Information unavailable
^ All of Kentucky's forensic beds are behind bars and not included in census count
\+ Patients waiting for beds behind bars
º NGRI patients converted to civil commitment after 180 days

Table 5. ***Forensic Bed Trends in 25 Sample States, continued***

STATE	2016 FORENSIC BED CENSUS	# OF INMATES WAITING FOR FORENSIC BED	AVERAGE # OF DAYS FROM WAIT LIST TO ADMISSION	# OF INMATES WAITING PER 100,000 POPULATION	FORENSIC BED OCCUPANCY RATE IN 2015	% OF FORENSIC BEDS OCCUPIED BY NGRI◆	AVERAGE LENGTH OF STAY FOR NGRI (DAYS)	OPENING (++) OR CLOSING (--) BEDS IN THE NEXT 12 MONTHS
Kentucky	0^	56+	18+	1.6+	86%+			++
Maine	47	5	7	0.5	94%	20%	925.0	n/c
Maryland	853	75	*	1.6	*	*		*
Massachusetts	70	0	0	0	*	*	180°	*
Michigan	384	120	190	1.6	100%	100%	*	++
Minnesota	0	0	0	0	93%	85%	2,555.0	n/c
New Jersey	471	38	270	0.6	125%	35%	1,787.0	--
New York	720	0	0	0	94%	39%	*	n/c
North Carolina	236	0	0	0	92%	65%	2,956.5	n/c
Ohio	714	9	*	0.1	95%	49%	733.0	n/c
Oklahoma	200	0	0	0	100%	43%	*	--
Oregon	439	0	0	0	91%	55%	945.0	++
Pennsylvania	236	220	180	2.2	*	*	*	--
Tennessee	100	0	0	0	100%	50%	640.0	n/c
Texas	1,216	397	61	2.0	113%	20%	1,001.0	++
Virginia	356	70	73	1.1	90%	64%	*	*
Washington	138	176	43	3.2	*	*	*	++
Wisconsin	349	57	70	1.3	97%	82%	1,095.0	++
Wyoming	28	11	*	2.5	100%	25%	*	n/c
TOTALS	**14,516**	**1,956**			**AVERAGE**	**50.1%**	**1,591.7**	

◆ NGRI = People found "not guilty by reason of insanity"
* Information unavailable
^ All of Kentucky's forensic beds are behind bars and not included in census count
\+ Patients waiting for beds behind bars
° NGRI patients converted to civil commitment after 180 days

As overwhelming as the volume of referrals is to state hospitals with bed shortages, remarkably few pretrial inmates become candidates for a psychiatric bed stay. Out of the 1.8 million jail bookings in which a mental health condition is identified, the National Judicial Council in 2011–12 reported that 60,000 legal competency evaluations are court ordered annually.[62] Of the evaluated inmates, an estimated 12,000 defendants were found incompetent to stand trial and entitled to treatment to restore their competency.[63] Because most states authorize competency evaluations to be conducted in jails or community settings,[64] these evaluations do not necessarily require hospital stays. Restoration in the community or in jail is also authorized by many states, though it is less widely practiced than outpatient evaluation; the majority of inmates under treatement to restore competency are treated in state hospitals.[65]

However, pretrial inmates are just the tip of the criminal justice iceberg in state hospitals. Also vying for forensic beds:

- Defendants being treated in lieu of conviction ("not guilty by reason of insanity," or NGRI)
- Offenders found guilty but mentally ill, an alternative to acquittal by reason of insanity

- Convicted offenders undergoing presentencing evaluations
- Sentenced offenders in need of treatment, presumably including many of the estimated 30,000 state prisoners with mental illness in solitary confinement
- In some states, sexual offenders

Bed waits for the swelling ranks of pretrial inmates in need of psychiatric services are in part a function of how many state hospital beds are already occupied by subsets of the forensic population who are long-term patients. In the 19 states of our sample that supplied census numbers, NGRI patients occupied 3,882 beds—an average of 50% of all forensic beds in the state hospitals. The impact of NGRI hospitalization on bed access for other patients was intensified by the duration of their NGRI state hospital stays: an average of 1,592 days, or 4 years and 4 months. At the extremes, the shortest stay was 640 days, or a little over 21 months, in Tennessee. The longest was 3,175 days, almost 9 years, in Colorado.

When there are no beds available for forensic services, inmates wait, typically behind bars and without treatment. In 2014, 31 of 40 state hospitals responding to an industry survey reported maintaining forensic waiting lists; 19 of 38 respondent states reported being threatened with or held in contempt of court for failing to admit court-ordered patients in a timely manner.[66] Lawsuits have since been filed in several of them.

Consider these figures from the 25 states the Treatment Advocacy Center sampled:

- Forensic bed occupancy rates in 2015 were at least 90% in every state.
- Approximately 1,950 pretrial inmates were reported in 17 states to be on waiting lists for state hospital beds: California, Colorado, Florida, Georgia, Illinois, Indiana, Maine, Maryland, Michigan, New Jersey, Ohio, Pennsylvania, Texas, Virginia, Washington, Wisconsin and Wyoming. Due to the exigencies of how and where bed waits are tracked, this count is far from comprehensive.
- The number of inmates waiting for pretrial services—competency evaluation or restoration—ranged from 5 inmates in Maine on March 11, 2016, to 397 inmates reported waiting in Texas on April 8, 2016.

"The (Department of Human Services) commissioner is telling us they no longer can comply with the law, and that leaves us with an interesting dilemma. Do we hold inmates illegally in jail, or is the commissioner failing in her public duty and violating a judge's order? The victim in all this is the person with mental illness sitting in jail."

Jim Franklin, executive director of the Minnesota Sheriffs' Association
"County Jails Struggling with Mentally Ill Inmates Left to Languish"
Minneapolis *Star Tribune* (July 21, 2015)

- Average bed waits ranged from a low of 7 days in Maine to a high of 270 days (approximately 9 months) in New Jersey.
- Eight of the 25 states sampled were operating under court orders or the threat of a court order related to their mentally ill inmates: California, Colorado, Oklahoma, Pennsylvania, Texas, Utah, Washington and Wisconsin. A ninth state, Minnesota, is under threat of litigation by county sheriffs, who want state mental health officials to stop violating a state law requiring that mentally ill inmates be transferred to the state hospital within 48 hours of being committed by a judge.[67]
- After adjusting for the role of state population on the number of inmates waiting for beds, Washington had the biggest logjam of mentally ill inmates waiting for a bed: 3.4 inmates per 100,000 adult population waiting for a forensic bed. Ohio had the smallest: 0.1.

- Six states reported no bed waits because civil beds are diverted as needed for forensic purposes: Massachusetts, North Carolina, New York, Oklahoma, Oregon and Tennessee. Minnesota mandates treatment of mentally ill inmates within 48 hours of a court order's being issued and reported no wait list for beds. The fact that Minnesota sheriffs are threatening to sue the state mental health department for failing to admit inmates within the legal time limit suggests that, while official wait lists may not be maintained, inmates in the state are, in fact, waiting for beds.

Grim as this picture is, it should not be mistaken as complete. At best, our survey provides a snapshot of the impact of bed shortages on inmates in America's jails and prisons. Vast additional populations of mentally ill offenders are behind bars but don't "count" as waiting for a bed. At a minimum, these populations include the following:

- An undetermined number of mentally disordered pretrial inmates who haven't yet been targeted for a competency evaluation
- An undetermined number of pretrial inmates who are mentally disordered but are not found to be in need of a psychiatric evaluation or restoration of competency
- An undetermined number of inmates who meet the legal standard for competence but are not clinically stable
- An undetermined number of inmates who are segregated in "mental health pods" reserved for mentally ill prisoners behind bars, where "treatment" may consist of daily medications and a monthly check-in through the bars by a psychiatrist
- Several thousand inmates in high-security psychiatric units on prison grounds
- An undetermined number of the estimated 30,000 mentally ill inmates housed in solitary confinement because their symptoms render them unable to live in the general prison population
- An undetermined number of other prisoners with mental illness who fit none of the categories above

It is far easier to count the number of beds available for forensic patients than the number of people who would benefit from them. What is undeniable is that demand vastly outstrips supply, with devastating consequences to the inmates, the jail and prison personnel who manage them, and taxpayers.

"Detention in a prison is not treatment. It is custodial management. It also is inconsistent with the concept of 'milieu' referring to a therapeutic environment. Department of Corrections leaders are not subject matter experts on the treatment of the mentally ill. We must be vigilant to protect vulnerable individuals from a corrections paradigm being substituted for a behavioral health treatment one."

Beatrice Coulter, registered nurse
"The Trouble with New Hampshire's Secure Psychiatric Unit"
Concord Monitor (February 28, 2016)

DISCUSSION

The Treatment Advocacy Center issued state bed surveys in 2008, 2010 and 2012. In each, we reported double-digit declines in state hospital bed censuses. We called for repealing or reforming the discriminatory exclusion of institutions for mental disease from Medicaid payments (the IMD Exclusion), promoting wider use of hospital-diversion strategies such as assisted outpatient treatment (AOT) and assertive community treatment (ACT), and raising awareness and accountability for the association between hospital bed shortages and social problems such as the criminalization of mental illness. We additionally called for a moratorium on further public hospital bed closures until a sufficient number of beds are created to meet inpatient needs.

Noteworthy progress has been made since 2012 toward the first three recommendations.

- In April 2016, the Centers for Medicare and Medicaid Services issued a final rule partially repealing the IMD Exclusion's restrictions on managed care organizations. They are now authorized to provide up to 15 days of acute psychiatric care in a month to Medicaid enrollees. While not extending to state or county hospitals or other IMDs, the rule is expected to improve access for impoverished psychiatric patients by making it economically viable for additional psychiatric facilities to admit them. At the same time, final evaluation and a report to Congress on a demonstration of waiving the IMD Exclusion is forthcoming under provisions of the Affordable Care Act. Preliminary findings already reported were positive.
- Two additional states—Nevada in 2013 and New Mexico in 2016—authorized the use of AOT for qualifying patients, New Jersey funded AOT implementation in every county statewide, and Congress in 2015 appropriated $15 million to jump-start up to 50 new AOT programs nationwide. ACT teams in 2012 were reported to be available in at least 42 states[68] and continue to be activated in additional communities.
- Emergency room boarding, forensic bed waits and tragedies resulting from bed shortages are now routinely reported in the media and reflected in public opinion and pressure on lawmakers. Ninety-five percent of the state mental hospital directors responding to a 2014 survey about forensic services said the public in their states had "very strong" or "somewhat strong" concerns about the "very large presence of people with mental disorders in the nation's jails and prisons."[69] Provisions to improve treatment access and reduce the criminalization of mental illness have been included in all the major mental health reform and criminal justice reform bills introduced in Congress and proposed legislation in almost every state.

"While many academic researchers and even governmental regulatory agencies such as the Department of Health and Human Services (DHHS) have looked at the issue of boarding, all have identified a relatively common culprit—a mismatch between supply and demand. This simple, yet doomed equation of shrinking psychiatric patient resources with an ever-expanding psychiatric patient population represents the main cause for reduced psychiatric patient capacity in the emergency deparment."

American College of Emergency Physicians
Care of the Psychiatric Patient in the Emergency Department: A Review of the Literature
(October 2014)

These are all to the good, but the United States has dug itself a mental illness treatment hole that will take more than a few shovelfuls of additional beds and an occasional enlightened policy or court order to fill. Given the numbers of mentally ill prisoners and boarded ER patients—not to mention the homeless, the victims of violence and all the other people suffering consequences of nontreatment—more beds are urgently needed, and a moratorium to save the scant number that remain is critical before these, too, are gone.

Strategies for Reducing Demand

Our sample identified a number of states attempting to alleviate shortages with policies aimed at reducing demand for state hospital beds. Although evaluation of their effectiveness is beyond the scope of this study, and no endorsement is implied, the following strategies merit examination for their effectiveness in meeting patient need while relieving shortages and containing costs. By serving patients in outpatient settings, the first three would have the added value of providing treatment in less restrictive settings.

- **Conducting psychiatric evaluations of legal competency in the community**
  Outpatient competency evaluations are authorized by law and conducted in most states, but courts may still order offenders to be evaluated in a hospital.[71] In our survey, 14 of the 25 states legally authorized evaluations in the community without restriction, 3 authorized them with conditions (e.g., if the defendant is entitled to community release), 6 did not address the issue or left it unclear, and 2 prohibited evaluation in the community.

- **Conducting competency evaluations in the jail**
  Most authorities say the "vast majority" of competency evaluations can be completed in one or two interviews with the defendant.[72] Perhaps with this in view, more states in our sample—19 of the 25—authorized evaluations in jail than authorized them in the community, with state law silent or unclear in 5 more states. Only Georgia prohibited the practice.

- **Conducting restoration of competency in the community**
  Historically, all offenders were hospitalized for treatment to restore their competency to stand trial, and the vast majority today continue to be restored in state hospitals.[73] Many states report the largest group of defendants they serve in state hospitals are those found incompetent to stand trial, with stays that usually exceed 2 months and can last a year or more.[74] In our sample, 19 states authorize community restoration. The laws in 6 states are unclear; only 2 states—Kentucky and Wyoming—prohibit it.

- **Contracting with community hospitals with psychiatric units to serve the state hospital population**
  North Carolina has increased access to psychiatric beds for uninsured patients in crisis by contracting and funding short-term psychiatric crisis services and detoxification in community hospitals.[75] Rhode Island supplies 130 "state hospital" beds in a general hospital. A Rhode Island official told our interviewer that one of the benefits of this strategy was qualifying state beds for Medicaid reimbursement by maintaining them in a facility that can collect insurance rather than in a state hospital that can't.

- **Maintaining bed registries**
  Some of the most widely publicized tragedies associated with bed shortages—including the death of Jamycheal Mitchell—occurred when public psychiatric beds were, in fact, available but not identified because of systemic disorganization or human error. Matching people who are waiting with beds that are open improves bed access and treatment. Bills to create bed registries have been passed or are before legislatures in multiple states. Early results have shown decreased bed waits where they are operated efficiently.

The uneven use of such strategies suggests many states have unrealized opportunities to address their bed shortages with public policy reform. Like the ideal of deinstitutionalization itself, these policies would be best implemented after careful examination of the evidence and local conditions for implementing them. For example, competency restoration in the community is an alternative only where appropriate clinical services to provide it are available.

Obstacles to Balancing Bed Supply with Demand

Our review also identified public policies that appear to create obstacles to balancing bed supply and demand and thus represent additional opportunities for reform. Among them are the following five.

- **Bail requirements**
  Often unemployed and impoverished, mentally ill offenders are overrepresented among low-level defendants accused of petty crimes. At the same time, they are less likely to be released on bail than other inmates and spend more time behind bars before posting bail. An analysis of mental illness in New York City jails in 2012 found mentally ill inmates took five times longer than other inmates to make bail.[76] Half of the states in our sample explicitly or likely required inmates to post bail before they could be released for restoration in the community (see Appendix). For many mentally disordered offenders, this creates an insurmountable obstacle to outpatient restoration and guarantees they will require a state hospital bed. Reducing barriers to community mental health services for nonviolent offenders accused of low-level crimes would reduce demand for state hospital beds.

- **Public assistance practices**
  In most states, access to public assistance such as Medicaid is automatically terminated when an individual is detained or incarcerated, and the inmate must re-enroll after discharge. This causes delays in receiving medication and other mental health services and can pose an insurmountable bureaucratic hurdle for people arrested because of untreated psychiatric symptoms, which often worsen while they remain untreated in the stressful jail environment. Termination of coverage also is believed to contribute to the two to three times greater risk of rearrest for mentally ill inmates.[77] Some states are taking steps to suspend rather than terminate Medicaid benefits during incarceration and reinstate coverage upon jail discharge to close this gap to reduce this consequence.

- **Length–of–stay practices**
  Psychiatric hospital stays have shrunk to 7.2 days in the United States on average,[78] but the length of forensic hospital stays is typically far longer, and the conditions of discharge may be dictated by state law or the courts rather than clinical need (see Appendix). In the NASMHPD forensic survey of 2014, 43% of the responding state hospitals said they may release a defendant as soon as a competency evaluation is completed; 57% said they could not. The resulting average length of stay for an evaluation ranged from 0 to 1 month in 12 states and more than 6 months in 1 state.[79] Our sample of states found a limit of 60 days for competency restoration of accused felons in Pennsylvania, 120 days in Texas and 3 years in California. Converted into bed demand, this means 18 times as many forensic patients could be hospitalized for the maximum restoration stay in Pennsylvania as in California over a three-year period. In some states, pretrial offenders spend longer waiting for or receiving competency services than they would be sentenced if convicted of their crimes.

- **Discharge and release practices**
  The longer existing patients remain in the hospital, the fewer new patients can be admitted. In Virginia, for example, an estimated 150 people had been on the commonwealth's "extraordinary barriers to discharge list" of state hospital patients considered "clinically ready for discharge" for more than 30 days in November 2015, and another 60 to 70 had been in the category for up to one month. In other words, about 20% of the state's psychiatric bed population was occupied by patients considered clinically stable who had nowhere to go if they were discharged.[80] It is another sad irony of America's dysfunctional mental health system that acutely ill patients who would benefit from short-term intervention are left to become sicker because of long-stay patients deemed ready to leave the hospital if they had access to an appropriate step-down level of care.

- **Sexual predator confinement**
  Twenty states and the District of Columbia have laws providing for the civil commitment of certain sexual offenders (often called "sexually violent offenders") after they complete their sentences, whether they are in need of treatment or not.[81] They are held in a variety of settings, including state hospitals, which spent an estimated 5% of their budgets on sex offenders in 2010.[82] NASMHPD, the American Bar Association and other organizations have criticized and called for reform of these policies on civil liberty and other grounds. Where they continue, they reduce hospital bed access for civil and other forensic patients who do need treatment.

RECOMMENDATIONS

More meaningful treatment legislation has been introduced in the last two congressional sessions than in the previous half-century, an encouraging sign. Less encouraging: Not one has passed. In addition to enacting the reforms in these bills, we recommend the following actions to stem the devastating trends and consequences of America's dire psychiatric hospital bed shortage.

1. **Determine how many psychiatric beds are needed to meet inpatient need and set supply targets**

   With lawsuits and court orders proliferating over illegal boarding of psychiatric patients in hospital ERs and bed waits in jails, there is little doubt the United States needs more psychiatric beds to meet inpatient demand. Psychiatric literature converges around an optimal estimated supply of 40 to 60 psychiatric beds per 100,000 population, and 50 beds per 100,000 population is widely used as a rule of thumb. Researchers at Duke University have created a simulation model to analyze how many nonforensic beds would be needed to reduce the amount of time people in psychiatric crisis currently spend waiting for a hospital bed.[83] Denmark operates a psychiatric case registry that enables the nation to monitor the association of deinstitutionalization with higher rates of incarceration. It is time to build on existing data-mining technologies to develop evidence-based bed targets that recognize the role of subpopulations (e.g., juvenile, adult, geriatric, civil, forensic, acute, long–term) and facility types (e.g., public, private, crisis/respite, residential). In recognition of the national scope and impact of the bed shortage and the need for baseline data nationwide and tools for setting targets, the federal government should undertake an assessment of hospital bed need by type, facility and location, and advance the use of tools such as Duke University's computer modeling to develop realistic hospital bed targets.

2. **Identify and reform public policies that exacerbate bed shortages**

   The 50-year-old exclusion of IMDs from Medicaid reimbursement outside of 16-bed facilities created a discriminatory economic incentive for denying care to impoverished mentally ill citizens between the ages of 21 and 64. The new rule that partially repeals the IMD Exclusion by expanding Medicaid reimbursement to managed care organizations is an important first step. But Congress needs to end this discriminatory treatment of mental illness by repealing the IMD Exclusion altogether and enforcing parity so that hospital treatment of psychiatric disease is funded the same way as inpatient care for other medical and surgical disorders. Expanding the IMD rule to cover all Medicaid enrollees, without artificial restriction on length of stay, would help states create new beds, open existing beds that are approved but unstaffed and incentivize other IMDs to accept Medicaid patients. For the benefit of patients, their communities and taxpayers, Congress should direct and fund appropriate agencies to undertake a comprehensive review to identify all federal policies that create financial incentives to close psychiatric beds and assess their economic and other impacts in light of costs to law enforcement, corrections, courts, homelessness services and other public domains affected when mentally ill citizens do not receive needed inpatient services. To address the critical and worsening shortage of psychiatric professionals, the federal government also needs to adopt incentives for medical students to study and practice psychiatry, especially in less populated regions, just as it has incentivized medicine to address other public health shortages in the past. At the state level, legislatures need to undertake economic studies of the net cost taxpayers incur from bed shortages and use these findings to create dedicated funding sources for public investments in new beds—the same mechanisms used to fund other necessary infrastructure projects such as bonds, specifically directed taxes and focused trust funds.

3. **Improve data collection associated with bed shortages and build public policy on the evidence**

   States have experimented with and implemented many strategies in their efforts to reduce demand for state psychiatric beds and treat more patients in less restrictive settings. A few, like New Hampshire's incarceration of civil patients, are giant steps in the wrong direction, raising constitutional and civil rights concerns. Others are more enlightened approaches that remain widely authorized but not widely used. Conducting more competency evaluations in jails or in the community, providing competency restoration in the community, and reexamining length–of–stay requirements and practices are among them. States should gather and assess evidence for strategies that reduce bed demand, identify statutory and regulatory obstacles to implementing such policies, and reform their practices in such a way that demand and supply are better balanced. At the same time, the National Institute of Mental Health (NIMH) should fund outcome research to study the impact of mental health policies on people with serious mental illness. The public health departments of universities should incentivize doctoral and other research projects that contribute to the body of knowledge and the public good about psychiatric issues, including bed shortages.

4. **Increase the use of diversion strategies that reduce hospitalization rates**

   Tools and strategies have been developed that reduce the likelihood that people with serious mental illness will become hospital patients or jail inmates waiting for a bed. None is implemented universally; some are barely used at all. The following three evidence-based practices are associated with reducing emergency room visits and psychiatric hospitalizations. Widely implementing them would help reduce the impact of bed shortages.

   a. Assisted outpatient treatment (AOT): A treatment option that utilizes a court order to require adherence to treatment for individuals with a history of nonadherence and rehospitalization or reincarceration, among other criteria. Authorized in 46 states and the District of Columbia, AOT has been deemed an evidence-based treatment effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization and violent episodes.[84]

   b. Assertive community treatment (ACT, which may be included in AOT or independent): A multidisciplinary team approach to serving mentally ill patients where they live. One of the oldest and most widely researched practices in behavioral health care for serious mental illness, ACT decreases client use of intensive, high-cost services such as emergency department visits, psychiatric crisis services and psychiatric hospitalization. Clients of ACT are also more likely to be living independently and have higher rates of treatment retention.[85]

   c. Sequential Intercept Model: A conceptual framework for preventing individuals with mental illness from entering or penetrating deeper into the criminal justice system. Among the intercepts are practices such as mobile crisis teams, which integrate law enforcement and mental health workers to respond to psychiatric calls, and crisis intervention training (CIT), which gives law enforcement specialized training in spotting and responding to individuals in psychiatric crisis.[86] CIT has been shown to significantly increase the likelihood a law enforcement contact with a person with serious mental illness will result in transport to a treatment facility rather than arrest and booking.[87]

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Going, Going, Gone is the latest reflection of Dr. E. Fuller Torrey's determined effort to assure that the dire trends and consequences of closing of America's last-resort hospitals are not overlooked, ignored or understated.

Since 2008, the state surveys Dr. Torrey has conducted for the Treatment Advocacy Center have served as the most accessible and reliable state hospital bed resource available and often the only source of complete state-specific bed data about the dwindling state hospital population. With Dr. Torrey's continued technical and editorial guidance, *Going, Going, Gone* continues this legacy of keeping a spotlight on an issue of critical importance to public health and safety and the well-being of countless men and women living with the most severe psychiatric diseases.

Ted Lutterman and the National Association of State Mental Hospital Program Directors Research Institute, where he is senior director of research, continue to be incomparable sources of state hospital data. Julie Plyler, J.D., M.P.H., made a significant contribution with her detailed and careful identification of the laws and regulations that contribute to or mitigate state hospital bed shortages. The photographs contributed by Nancy West, New Hampshire Center for Public Interest Journalism, are worth many thousands of words.

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APPENDIX

Public Policies Impacting Bed Trends in 25 Sample States

STATE	COMMUNITY PSYCHIATRIC EVALUATION?	JAIL PSYCHIATRIC EVALUATION?	COMMUNITY RESTORATION?	JAIL RESTORATION?	UNDER LITIGATION?	CONSENT DECREE OR SETTLEMENT AGREEMENT?
California	N/A	Yes	Yes*	Yes*	Yes	Yes
Colorado	Yes	Yes	Yes°	Yes	Yes	No
Florida	Yes	N/A	Yes°	Yes	No	Yes
Georgia	Yes*	No	Yes*°	No	No	Yes
Illinois	Yes	Yes	Yes°	No	No	Yes
Indiana	N/A	N/A	Yes	Yes	No	Yes
Kentucky	Yes	Yes	No	No	Yes	No
Maine	Yes	Yes	Yes	No	No	Yes*
Maryland	Yes	Yes	Yes*°	No	No	No
Massachusetts	Yes*	Yes	Yes	Yes	Yes	No
Michigan	Yes*	Yes	Yes	Yes	No	No
Minnesota	Yes*	N/A	Yes*	No	No	No
New Jersey	No	Yes*	Yes*	No	No	Yes
New York	Yes	Yes	Yes	N/A	No	Yes
North Carolina	N/A	N/A	Yes°	Yes	No	Yes
Ohio	Yes	Yes	Yes°	N/A	No	No
Oklahoma	Yes	Yes	Yes	Yes	No	Yes
Oregon	N/A	N/A	Yes	N/A	No	No
Pennsylvania	Yes	Yes	Yes	Yes	No	Yes
Tennessee	Yes	N/A	Yes*	Yes	No	No
Texas	Yes*	Yes	Yes°	Yes*	No	Yes
Virginia	Yes	Yes	Yes°	Yes	Yes	No
Washington	Yes	Yes	Yes°	Yes	Yes	Yes
Wisconsin	No	Yes	Yes	Yes	Yes	No*
Wyoming	Yes	Yes	No	No	No	Yes

* Conditional
° Bail required

REFERENCES

1. Torrey, E. F., Fuller, D. A., Geller, J., Jacobs, C., & Ragosta, K. (2012). *No room at the inn: Trends and consequences of closing public psychiatric hospitals.* Arlington, VA: Treatment Advocacy Center. Retrieved from http://tacreports.org/storage/documents/no_room_at_the_inn-2012.pdf
2. Ibid.
3. Organization for Economic Cooperation and Development. (2014). *Making mental health count: The social and economic costs of neglecting mental health care*. Retrieved from http://www.oecd.org/publications/making-mental-health-count-9789264208445-en.htm
4. Colorado Department of Human Services. (2015). *Needs analysis: Current status, strategic positioning, and future planning.* Retrieved from https://drive.google.com/file/d/0B6eUVZvBBTHjSGhSYUJjVE95ck0/view
5. 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
6. 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. Available from http://www.nasmhpd.org/sites/default/files/Assessment%203%20-%20Updated%20Forensic%20Mental%20Health%20Services.pdf
7. American College of Emergency Physicians. (n.d.). *Psychiatric emergencies* [Fact sheet]. Retrieved from http://newsroom.acep.org/fact_sheets?item=30093
8. Lamb, H. R., and L. E. Weinberger. (2016). Rediscovering the concept of asylum for persons with serious mental illness. *Journal of the American Academy of Psychiatry and the Law, 44*(1):106–10.
9. Salinsky, E., & Loftis, C. (2007). *Shrinking inpatient psychiatric capacity: Cause for celebration or concern*. Washington, D.C.: National Health Policy Forum.
10. Organization for Economic Cooperation and Development. *Making mental health count*.
11. King 5 News. (2015, June 18). Death by dehydration prompts changes at Island Co. Jail. Retrieved from http://legacy.king5.com/story/news/local/investigations/2015/06/18/island-county-jail-death-keaton-farris/28899369/
12. Alanez, T. (2014, July 13). Mentally ill inmate dies at half his body weight in Broward jail; lawsuit alleges neglect. *Sun Sentinel*. Retrieved from http://articles.sun-sentinel.com/2014-07-13/news/fl-jail-starvation-20140713_1_ill-inmate-broward-jail-jail-medical-records
13. Ball, B. (2014, April 1). Mentally ill inmate dead on arrival at Central Prison in Raleigh. *Indy Week*. Retrieved from http://www.indyweek.com/indyweek/dead-on-arrival-at-central-prison-in-raleigh/Content?oid=4009765
14. Jouvenal, J. (2015, September 29). Man accused of stealing $5 in snacks died in jail as he waited for space at mental hospital. *Washington Post.* Retrieved from https://www.washingtonpost.com/local/crime/man-accused-of-stealing-5-in-snacks-died-in-jail-as-he-waited-for-space-at-mental-hospital/2015/09/29/7ceac8a2-5aff-11e5-9757-e49273f05f65_story.html
15. Nesper, A. C., Morris, B. A., Scher, L. M., & Holmes, J. F. (2015). Effect of decreasing county mental health services on the emergency department. *Annals of Emergency Medicine, 67*(4), 525–530.
16. Ibid.
17. Torrey et al. *No room at the inn.*
18. Organization for Economic Cooperation and Development. (2013). *Health at a glance 2013: Hospital beds by function of health care, 2011 (or nearest year).* Paris: OECD Publishing. Retrieved from http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-2013/hospital-beds-by-function-of-health-care-2011-or-nearest-year_health_glance-2013-graph72-en#page2
19. Torrey, E. F. (2014). *American psychosis: How the federal government destroyed the mental illness treatment system*. New York, NY: Oxford University Press.
20. Torrey et al. *No room at the inn*.
21. National Association of State Mental Health Program Directors Research Institute. (2015). *Tracking the history of state psychiatric hospital closures from 1997 to 2015*. Retrieved from http://media.wix.com/ugd/186708_afa348ce61184f4d902ae55c29fcb7b7.pdf
22. New Freedom Commission on Mental Health. (2004). *Subcommittee on acute care: Background paper*. DHHS Publication No. SMA-04-3876. Washington, DC: U.S. Government Printing Office.
23. American College of Emergency Physicians. (2015, December 15). *Survey: 8 in 10 ER docs say mental health system is not working for patients* [Press release]. Retrieved from http://www.prnewswire.com/news-releases/survey-8-in-10-er-docs-say-mental-health-system-is-not-working-for-patients-300193187.html
24. American College of Emergency Physicians. (2014). *Care of the psychiatric patient in the emergency department: A review of the literature*. Retrieved from https://www.acep.org/uploadedFiles/ACEP/Clinical_and_Practice_Management/Resources/Mental_Health_and_Substance_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf
25. Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). *The treatment of persons with mental illness in prisons and jails: A state survey.* Arlington, VA: Treatment Advocacy Center.

26. Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., . . . & Venters, H. (2014). Solitary confinement and risk of self-harm among jail inmates. *American Journal of Public Health, 104*(3), 442–447.
27. Parks & Radke. *The vital role of state psychiatric hospitals*.
28. Fitch. *Assessment #3*.
29. Ibid.
30. DeVita, C. (2015). *The hiring war for mental health physicians: How to compete and win*. St. Louis, MO: Cejka Search.
31. Staff Care. (n.d.). *Behavioral health: "The silent shortage."* Retrieved from https://www.staffcare.com/uploadedFiles/StaffCare/Content/Resources/Blogs/white-paper-behavioral-health-silent-shortage.pdf
32. Bureau of Labor Statistics. (2015*). Occupational employment and wages, May 2015: 29-1066 psychiatrists*. Retrieved from http://www.bls.gov/oes/current/oes291066.htm
33. Walker, M. (2015, November 15). Psychiatrist shortage worsens court bottleneck. *Argus Leader*. Retrieved from http://www.argusleader.com/story/news/2015/11/15/psychiatrist-shortage-worsens-court-bottleneck/75493648/
34. Tighe, M. (2016, March 31). Mayo-Franciscan to suspend inpatient mental care, amid shift to head off crisis level. *La Crosse Tribune*. Retrieved from http://lacrossetribune.com/news/local/mayo-franciscan-to-suspend-inpatient-mental-care-amid-shift-to/article_b7c7dd66-968f-5cf2-a90e-099f59a5472d.html
35. Virginia Department of Behavioral Health and Developmental Services. (2015). *Study of Piedmont Geriatric and Catawba Hospitals*. Retrieved from http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3762015/$file/RD376.pdf
36. Colorado Department of Human Services. *Needs assessment.*
37. Ibid.
38. Ibid.
39. Ibid.
40. Steffen, J. (2015, October 28). Federal motion alleges cover-up on competency evaluations, seeks to reopen case against Colorado. *Denver Post*. Retrieved from http://www.denverpost.com/news/ci_29038231/federal-motion-alleges-cover-up-seeks-reopen-case
41. National Association of State Mental Health Program Directors. (2014). *Assessment #10: Expenditures*. Retrieved from http://www.nasmhpd.org/sites/default/files/Assessment%2010%20-%20Expenditures.pdf
42. Parks & Radke. *The vital role of state psychiatric hospitals*.
43. Treatment Advocacy Center. (2016). *Prevalence of untreated serious mental illness by state*. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/Research/sz%20and%20bp%20numbers%20by%20state.pdf
44. Torrey et al. *No room at the inn*.
45. Ibid.
46. American College of Emergency Physicians. *Care of the psychiatric patient in the emergency department*.
47. Fitch. *Assessment #3*.
48. Torrey et al. *No room at the inn*.
49. Bevelacqua, G. D. (2011). *OIG semiannual report: October 1, 2010 to March 31, 2011*. Richmond, VA: Office of the Inspector General, Behavioral Health and Development Services. Retrieved from http://leg2.state.va.us/dls/h&sdocs.nsf/fc86c2b17a1cf388852570f9006f1299/5c52997caf397a4b8525772d00621b5f/$FILE/RD118.pdf
50. Torrey et al. *No room at the inn*.
51. Mooney, P. (2016). Personal correspondence. Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities. Frankfurt, Kentucky.
52. National Association of State Mental Health Program Directors Research Institute. (2012). *FY 2010 state mental health revenues and expenditures*. Retrieved from http://media.wix.com/ugd/186708_c6beb833346b45429322cc4421d83aa1.pdf.
53. Szdlowski, J. (2016, May 2). Tehama sheriff seeks authority to medicate incompetent inmates. *Record Searchlight*. Retrieved from http://www.redding.com/news/local/tehama-sheriff-seeks-authority-to-medicate-incompetent-inmates-31dfe65f-4b60-0825-e053-0100007f3058-377889991.html
54. Rittiman, B. (2016, May 2). Debate rages over holding mentally ill patients. *9News*. Retrieved from http://www.9news.com/news/local/politics/debate-rages-over-holding-mentally-ill-patients/167367683.
55. Fitch. *Assessment #3*.
56. Ibid.
57. Torrey et al. *The treatment of persons with mental illness in prisons and jails.*
58. Steadman, H., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*(6), 761–765. Steadman's prevalence methods were applied to U.S. jail admissions for June 30, 2013, to June 30, 2014, as reported by the Bureau of Justice Statistics.
59. Colorado Department of Human Services. *Needs analysis.*

60. Fitch. *Assessment #3*.
61. Virginia Department of Behavioral Health and Developmental Services. *Study of Piedmont Geriatric and Catawba Hospitals.*
62. National Judicial College. (2011–12). *Mental competency: Best practices model.* Available from www.mentalcompetency.org.
63. Ibid.
64. Fitch. *Assessment #3*.
65. Ibid.
66. Ibid.
67. Chanen, D. (2015, July 21). County jails struggling with mentally ill inmates left to languish. *Star Tribune*. Retrieved from http://www.startribune.com/county-jails-struggling-with-mentally-ill-inmates-left-to-languish/315137451/
68. Mahadevan, T., Moser, L., Vanderzwaag, C., & Cowan, E. (2012, October 20). *A road to recovery through assertive community treatment* [PowerPoint slides]. Presented at National Alliance on Mental Illness (NAMI) North Carolina's 28th Annual Conference. Retrieved from http://www.naminc.org/nn/Conferences/2012presentations/recoverythruact.pdf
69. Fitch. *Assessment #3*.
70. Torrey, E. F. (2016, February 25). The dearth of psychiatric beds. *Psychiatric Times.* Retrieved from http://www.psychiatrictimes.com/psychiatric-emergencies/dearth-psychiatric-beds.
71. Fitch. *Assessment #3*.
72. Ibid.
73. Ibid.
74. Ibid.
75. Quinterno, J., & Rash, M. (2012). Serving mental health patients in crisis: A review of the state's program to buy beds and build capacity. *North Carolina Insight, 23,* 54–113.
76. Council of State Governments. (2012*). Improving outcomes for people with mental illnesses involved with New York City's criminal court and correction systems.* Retrieved from https://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf
77. Sisti, D. A., Segal, A. G., & Emanuel, E. J. (2015, January 20). Improving long-term psychiatric care: Bring back the asylum. *Journal of the American Medical Association, 313*(3)*,* 243–244.
78. Centers for Disease Control. Mental health. Retrieved from http://www.cdc.gov/nchs/fastats/mental-health.htm
79. Fitch. *Assessment #3*.
80. Virginia Department of Behavioral Health and Developmental Services. *Study of Piedmont Geriatric and Catawba Hospitals.*
81. Parks & Radke. *The vital role of state psychiatric hospitals*.
82. National Association of State Mental Health Program Directors Research Institute. *Assessment #10*.
83. La, E. M., Lich, K. H., Wells, R., Ellis, A. R., Swartz, M. S., Zhu, R., & Morrissey, J. P. (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
84. Treatment Advocacy Center. (2012). *Assisted outpatient treatment backgrounder*. Retrieved from http://www.treatmentadvocacycenter.org/about-us/our-reports-and-studies/471
85. Center for Evidence-Based Practices. *Assertive community treatment*. Retrieved from https://www.centerforebp.case.edu/practices/act
86. 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), 544–549. Retrieved from http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.4.544
87. Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., … & Watson, A. C. (2014). The police-based crisis intervention team (CIT) model: II. Effects of level of force and resolution, referral, and arrest. *Psychiatric Services, 65*(4), 523–529. Retrieved from http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300108

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.

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