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Key stakeholder perceptions regarding acute care psychiatry in distressed publicly funded mental health care markets

Dr. B. Christopher Frueh, PhD,

Department of Psychology, University of Hawaii, Hilo, Hawaii, and The Menninger Clinic and Baylor College of Medicine, Houston, Texas

Dr. Anouk L. Grubaugh, PhD,

Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, and Veterans Affairs Medical Center, Charleston, South Carolina

Dr. Anthony T. Lo Sasso, PhD,

School of Public Health, University of Illinois at Chicago, Chicago, Illinois

Dr. Walter J. Jones, PhD,

Center for Health Economic and Policy Studies, Medical University of South Carolina, Charleston, South Carolina

Dr. John M. Oldham, MD, and

Menninger Clinic and Baylor College of Medicine, Houston, Texas

Dr. Richard C. Lindrooth, PhD

School of Public Health, University of Colorado, Denver, Colorado

Abstract

The role of acute care inpatient psychiatry, public and private, has changed dramatically since the 1960s, especially as recent market forces affecting the private sector have had ripple effects on publicly funded mental health care. Key stakeholders' experiences, perceptions, and opinions regarding the role of acute care psychiatry in distressed markets of publicly funded mental health care were examined. A qualitative research study was conducted using semi-structured thematic interviews with 52 senior mental health system administrators, clinical directors and managers, and nonclinical policy specialists. Participants were selected from markets in six regions of the United States that experienced recent significant closures of acute care psychiatric beds.

Qualitative data analyses yielded findings that clustered around three sets of higher order themes: structure of care, service delivery barriers, and outcomes. Structure of care suggests that acute care psychiatry is seen as part of a continuum of services; service delivery barriers inhibit effective delivery of services and are perceived to include economic, regulatory, and political factors; outcomes include fragmentation of mental health care services across the continuum, the shift of mental health care to the criminal justice system, and market-specific issues affecting mental health care. Findings delineate key stakeholders' perceptions regarding the role acute care psychiatry plays in the continuum of care for publicly funded mental health and suggest that

public mental health care is inefficacious. Results carry implications for policy makers regarding strategies/policies to improve optimal utilization of scarce resources for mental health care, including greater focus on psychotherapy.

The role of acute care inpatient psychiatry in mental health care, both public and private, has changed dramatically since the 1960s, with changes over the past decade as private sector market forces have had profound ripple effects on publicly funded mental health care. Care has shifted from state-owned psychiatric hospitals to privately owned facilities that are driven largely by market forces (Foley et al., 2006; Frank & Glied, 2006; Frank & McGuire, 2001; Geller, 2006). Reasons for this shift are multifaceted, including changing attitudes toward mental illness, deinstitutionalization of the severely mentally ill, growth in the number and types of mental health providers, and expanded insurance coverage options. Between 1971 and 2001, there was more than a two-thirds reduction in spending for state psychiatric services by payer type relative to other provider types (Frank & Glied, 2006). Approximately 80% of inpatient psychiatric beds were public in 1970, whereas by 2002 only 27% were public (Foley et al., 2006). Patients who would have historically been treated in public psychiatric hospitals are increasingly treated in private facilities (Mechanic, McAlpine, & Olfson, 1998).

Now, recent closure of privately owned psychiatric hospitals reflects the general shift toward outpatient care that has occurred over the past few decades (Foley et al., 2006; Mechanic et al., 1998), as well as factors related to the financial viability of providing services (e.g., low reimbursement rates) and declining state budgets to support mental health services. For example, expenditures in private psychiatric hospitals decreased by 56%, while use decreased by only 32% between 1994 and 2000 (Geller, 2006). The viability of a psychiatric facility cannot be viewed in isolation, however, because viability is complex and related to the type, quantity, and quality of community services that are available across the continuum of care, including outpatient psychotherapy. If there are sufficient community alternatives, the demand for acute care psychiatric beds should be lower. At least one study showed that the closure of a state psychiatric hospital and the subsequent reallocation of funds resulted in the growth of community services that better met the needs of the community (Kamis-Gould, Snyder, & Casey, 1999).

Despite available data, a clear picture of the current—or desired—role of acute care psychiatry is not evident. Relatively little is known about current acute care bed capacity and need, the integration of acute care services with community mental health services, or how the shift from public to private psychiatry has affected general public mental health services along the continuum of care. To address this gap, qualitative research methods were used to learn about the perspectives of key informants in distressed markets nationwide. Key informants included senior mental health system or agency administrators, clinical directors and managers, and nonclinical managers and policy specialists. These professionals are in a unique position to provide information about the reasons for and effects of acute care psychiatric bed reductions or closures, the general role of acute care psychiatric beds, and the effects of relevant policies on mental health services and access to care at the community

level. This work is timely because communities throughout the U.S. have seen draconian reductions in state mental health budgets.

Method

Participants

Fifty-two mental health administrators were recruited from six U.S. markets (Asheville, North Carolina [$n = 12$]; Columbia, South Carolina [$n = 2$]; Janesville, Wisconsin [$n = 5$]; Portland/Salem, Oregon [$n = 11$]; Seattle/Tacoma, Washington [$n = 10$]; and Tampa/St. Petersburg, Florida [$n = 12$]). Markets were selected, a priori, as part of a larger mixed-method study if the metropolitan area had experienced a large reduction in private beds over the past 10 years. With regard to state beds, markets were selected that had experienced large reductions in state beds, such as the Tampa Bay area and Columbia, South Carolina, and markets where the state beds were relatively stable or increasing, such as Portland, Oregon and Janesville, Wisconsin (see Table 1 for description of market characteristics). Reductions in private beds in Asheville, Portland, and the Tampa Bay area were due to the closure of specialty hospital(s), downsizing, and/or closure of general hospital units. Both Janesville and Seattle-Tacoma experienced closure of county-owned psychiatric hospitals in addition to downsizing of general hospital units.

There was variability across markets in timing of hospital closures, although bed closures occurred throughout the period. Hospital closures were most recent in the Seattle-Tacoma (2006) and Portland (2004) markets. In other markets, hospitals closures mostly occurred prior to 2003. Two of the sampled states, Washington and Wisconsin, allocate state money and responsibility to counties or groups of counties. The Asheville market is unique in that the state mental health system had gone through a substantial restructuring within 1 year of our visit. As part of this restructuring, state funding and responsibility were shifted to counties or groups of counties similar to the Washington and Wisconsin systems. The mental health systems in other markets were relatively stable in the years prior to our visit. Other systems were administered either at the state or through large regional areas.

Participants were identified through direct contact with mental health administrators who were working or had worked at a facility that reduced or closed psychiatric acute care beds, or mental health administrators from nearby facilities that may have been affected by reductions; media articles and Internet postings on access to psychiatric care or specific reductions in targeted markets; and referrals from participants. The recruitment strategy was purposive in that individuals who had direct knowledge of and experience with the inpatient and outpatient mental health system treatment infrastructure and its utilization in relevant markets were sought.

One hundred fourteen potentially eligible participant names were obtained. Of these, 13 could not be reached, 27 did not respond to e-mail and telephone invitations, 14 declined to participate but referred other potential participants, 2 declined due to lack of interest or time constraints, 1 declined because the topic was “too political,” 4 agreed to participate but were unable to schedule, and 1 individual agreed but did not show. Participants were senior mental health system or agency administrators (chief executive officer, president, vice

president, executive director [$n = 15$]; clinical directors and managers (medical director, director, program manager [$n = 26$]); and nonclinical managers and policy specialists (director of financial policy, director of development, state senator, manager of program analyses and evaluation unit, assistant director of department of mental health, director of human services [$n = 11$]). Of the sample, 33% (17/52) were female; approximately 50% had clinical degrees (MD, RN, MSW, PhD) and 50% had business or public health training backgrounds (MBA, MPH). Data were collected from May 2007 to January 2008 under the approval of the Institutional Review Board of the Medical University of South Carolina.

Thematic interview procedures

Two authors (doctoral-level economists or clinical psychologists) conducted on-site thematic interviews at each identified market. Interviews were conducted in an individual format unless participants were unable to meet individually due to time or scheduling constraints. In four instances, interviews were conducted with two or three respondents at a time. Six interviews were conducted by telephone to accommodate respondent schedules. Interviews lasted between 30 and 60 minutes.

After verbal reconfirmation of informed consent and an introduction to the project, participants were asked to discuss the role of acute inpatient psychiatric care, bed capacity and access to mental health care services, changes over time, precursors and effects of acute care bed reductions and/or hospital closures, effects of relevant policies on mental health services and access to care, and suggestions for improving the public mental health care system. Our semistructured interview guide was flexible, including optional follow-up questions. Interviewers could explore, probe, and ask relevant follow-up questions as needed or to clarify participants' responses (Greenbaum, 1987). They were allowed to adapt wording and question sequence according to context. This approach was chosen because it is more systematic than conversational interview approaches, but allows for more flexibility to elicit individual perspectives than a fully standardized interview approach.

Data management

Interviews were recorded on an MP3-compatible recording device and professionally transcribed. Transcriptions were compared to the audiotapes to correct errors or omissions.

Qualitative analyses and interpretation approach

To appropriately focus analyses, study personnel convened on a regular basis during the course of the study to review and reevaluate initial research questions. While there is no exact rule for sample size estimates for qualitative interviews, interview experiences and subsequent data analyses support that the point of theoretical saturation was reached (Greenbaum, 1987). A series of narrative analyses were performed to identify salient thematic categories regarding the role of acute care psychiatry in the public mental health system (Patton, 1987). Each author identified a list of thematic categories and subcategories. These themes were then further developed and ordered by the first author and edited by the others. The authors then met in a consensus conference to discuss the categories, resolve questions, and refine the thematic categories. After additional discussion to review and refine categories and resolve questions raised by manuscript reviewers, the final thematic

categories were completed and higher order categories were developed. The lead author (B.C.F.) has previously used similar analytic approaches to qualitative research with a range of public sector health care patient and provider populations (Affonso et al., 2010; Frueh, Cusack, Grubaugh, Sauvageot, & Wells, 2006; Frueh, Sauvageot, & Grubaugh, 2006; Noël, Frueh, Larme, & Pugh, 2005; Robins, Sauvageot, Cusack, Suffoletta-Maierle, S., & Frueh, B. C., 2005).

Results and discussion

Results from thematic interviews provide important information about perceptions of key stakeholders regarding the role of acute care psychiatry in public mental health. Although there were site variations, stakeholder participants spoke with passionate conviction about their purpose and many expressed concern with the “crisis” state of public mental health care in their distressed markets. Many spoke of the “moral dilemmas” faced in making treatment, discharge, and referral decisions in the face of limited resources and service options. Qualitative data analyses yielded findings that clustered around three sets of higher order themes, in descending order of importance (see Table 2 for representative quotations).

1. Structure of care

Continuum of care—Acute care psychiatric beds are viewed as only one component of a large and dynamic system of mental health care that includes outpatient services (e.g., psychotherapy, case management), assertive community treatment, residential care, stabilization beds, partial hospitalization, and homeless outreach. Acute care psychiatric bed capacity needs are difficult to assess independent of other local mental health care components within this continuum. Many respondents were unsure whether there were sufficient beds in their market or whether adding more beds would be an appropriate response to larger systemic concerns. Acute care options are often inappropriately used to make up for deficiencies in the system elsewhere (“a safety valve”) or to take advantage of financial opportunities proffered by the market or reimbursement contingencies. Respondents in most markets noted that the frequency and duration of emergency department admissions for psychiatric reasons has increased in recent years, in parallel to local psychiatric bed closures. Additionally, they noted that lengths of hospitalizations are often longer than necessary due to a lack of suitable discharge options, and population-specific (e.g., geriatric, child/adolescent) services are often viewed as lacking. Thus there is a need for other community mental health services to help mitigate the need for acute care admissions and shorten lengths of stay.

Quote: “Continuum of care could obviate need for acute beds if better transitions, step-downs, PACT teams, residential care, even case management.”

2. Barriers

Economic barriers—Stakeholders perceive that rapid changes to reimbursement and financial models have dramatically altered market incentives and viability of components across the continuum of care, especially acute psychiatric hospitalizations. They believe that state systems have not planned successfully for these changes, and unclear or perverse financial incentives have affected service provision. Thus bed reductions are typically driven

by market economics and local politics. For example, many general hospitals were not under contract for care given to clients in the state system. Either the terms of the contracts were not favorable or investments required to upgrade facilities to treat severe mental illness were prohibitive. Low reimbursement rates for acute psychiatric beds and related services have affected hospital administrators' decision making and resource allocations. Such decisions combine with a general lack of resources for community outpatient services to create major gaps in public mental health care. Mental health systems cannot offer wages commensurate with the skills and training required to provide adequate services, creating staffing problems ("we're competing with the local car wash for employees"). Across the board, most respondents viewed their state public mental health systems as grossly underfunded, as funds to support deinstitutionalization have not kept pace with the increase in costs of treating people in the community. Many respondents believed that the promises to support community care were never delivered to begin with.

Quote: "We lost our shirt doing psychiatric services at the hospital. It was the worst financial service that we had by a long shot."

Regulatory barriers—State and federal regulations regarding psychiatric services and hospital units are experienced as extraordinarily complex moving targets that frequently interfere with effective service provision across the continuum of mental health care. Regulations are often viewed as barriers to entry or survival. For example, Balanced Budget Act changes in seclusion and restraint, although well intentioned, have had unintentional consequences by creating perceived financial and legal disincentives for general medical hospitals to operate psychiatric units, leading to reductions in bed capacity. Also, eligibility regulations for individual patients vary widely by setting (e.g., inpatient, outpatient), service (e.g., psychotherapy, rehabilitation, case management), diagnosis, and clinical population (e.g., child, adult, elderly), reinforcing fragmentation and major gaps in the continuum of mental health care. Confusing regulations and the paperwork they require also cause frustration among mental health workers, contributing to high levels of "burnout" and turnover and the subsequent difficulties these create for patient care. Similarly, respondents reported that well-intentioned regulations on staffing and credentialing have made recruiting clinical staff difficult given low wages that must be offered to maintain financial viability.

Quote: "Insurance eligibility and regulations act as barriers to access."

Political barriers—In poorly funded markets, there is a perceived lack of political will among some legislators and community leaders to advocate change. Legislators often do not appear to understand the high cost burden of severe mental illnesses to society, including costs related to criminal justice, medical services, and homeless shelters. The required funding to address these issues is perceived as too expensive by many taxpayers, and reforming regulatory barriers is seen as too complicated and time consuming. Furthermore, people with severe mental illnesses rarely have a powerful advocate in the room when important political decisions are made regarding services. The problem is compounded by the fact that budgets of mental health agencies fall into the discretionary spending category and are often reduced when states have to make adjustments in order to balance budgets, as has happened recently in many states throughout the U.S..

Quote: “Mental health care is not something politicians lose any sleep over providing.”

3. Outcomes

Fragmentation of care—Consistent with findings of the New Freedom Commission (U.S. Department of Health and Human Services, 2003), mental health services are perceived to be fragmented among many different funding and service delivery systems. Given that acute care psychiatry does not occur in isolation, careful coordination with other services (e.g., psychotherapy, case management) is necessary for optimizing outcomes. Unfortunately, these services are generally not well coordinated. There is frequently a lack of systems and case managers to track patients as they transition through this continuum of services. Fragmented services for substance abuse, mental health, and comorbid medical conditions result in less efficient care and reduced outcomes, with many vulnerable people falling out of the system altogether (“slipping through the cracks”). Competing priorities and different incentives across sectors, systems, agencies, and governance structures (e.g., county vs. state vs. federal) worsen this problem. Thus acute care psychiatry typically is seen to function in an isolated, haphazard, and reactive mode (“plugging fingers in the dike”). Of the markets sampled, Janesville, Wisconsin, seemed to be the best organized, while the large urban sites appeared the least coordinated.

Quote: “It’s very hard from a provider’s perspective to be able to coordinate clinical care and treatment with other providers.”

Shift to criminal justice system—Respondents believe people with severe mental illnesses frequently end up in the criminal justice system, where mental health care needs are likely to go unrecognized or be inadequately treated (Crisanti & Frueh, 2011; Lutterman, Mayberg, & Emmet, 2006; Wolff et al., 2011). As acute psychiatric beds and other services across the continuum of mental health care become scarcer, fragmented, and increasingly difficult to access, a prominent shift toward the criminal justice system was reported in all of the markets studied. Thus jails and prisons, constitutionally mandated to provide psychiatric care for inmates in need, have gradually taken on more of the public mental health care burden. Respondents in most markets (excepting Janesville, Wisconsin) remarked that local police are regular visitors to hospital emergency departments, either delivering patients or receiving patients for transport to criminal justice facilities. Some respondents noted that many severely mentally ill patients perceive that the only way to obtain needed psychiatric care is to “hit a cop.”

Quote: “We’ve criminalized the severely mentally ill. It’s not right.”

Market-specific issues—There were issues specific to the various local markets included in this study. Some hospitals had closed for good reasons. Some were known for providing poor care, others were not financially viable with low censuses (at only 25%–50% capacity), and others were adversely affected by prominent sentinel events, lawsuits, and/or public scandals related to substandard practices. Because many of these hospitals were not at capacity prior to their closure, the “shock to the system” within their respective markets was not as dramatic as the reduction in beds might imply. Respondents also noted market-

specific patterns of service shortages due to lack of alternative services (e.g., lack of partial hospitalization, geriatric psychiatry services, child/adolescent services). In several markets, competing hospitals were able to pick up the slack and treat patients displaced by closures. This was universally true for the less severely ill, private patients. “Bottlenecks” and access problems were most severe for the state, uninsured, and Social Security Income (SSI)–disabled populations. Among the six markets sampled, Janesville, Wisconsin, stood out as an exception, with less perceived fragmentation of care and higher functioning mental health care networks. This market is also a small community, with providers and administrators who know each other and work collaboratively, highlighting the importance of continuity of care.

Conclusions

In distressed markets of publicly funded mental health care, defined as those with a large proportion of psychiatric hospital bed closures, there is a sense of despair and concern among mental health administrators regarding the current state of public mental health care in the U.S. There was consensus that efficacy of the public mental health care system could be vastly improved. Many respondents in five of the six distressed markets surveyed described the state of public mental health care as in “crisis,” that “the system we’ve got is truly broken.” As part of a large and dynamic continuum of mental health care, acute inpatient psychiatric care represents a point that is not functioning efficiently in distressed markets. Current findings have implications for strategies and policies that could improve public mental health care for severely mentally ill children and adults. These findings complement quantitative data from multipayer administrative databases related to the precursors and effects of acute care psychiatric bed closures on access to mental health care, which indicate that access to residential facilities, partial hospitalizations, and psychiatry emergency services significantly reduces admissions through general hospital emergency departments in the context of psychiatric bed closures (Lindrooth, Grubaugh, Jones, Lo Sasso, & Frueh, 2010).

The importance of access to community care to enable persons with severe mental illness to live in the community is well documented (Lutterman et al., 2004; Manderscheid & Berry, 2006). Community care is an important prerequisite for successful deinstitutionalization. Administrators across a broad spectrum of markets believe this. However, over time, funding for community care has not kept pace with demand. As a result, persons who could live ably in the community with proper access to mental health care shift unnecessarily to the criminal justice system and/ or general hospital emergency departments. Both criminal justice and emergency departments have become “safety valves” of a fragmented system of care in distressed markets (Epperson et al., 2011). Community mental health systems should be planned with an understanding of how acute care psychiatry fits within the full continuum of mental health services. Moreover, very recent empirical data support the efficacy of a range of psychotherapeutic interventions (e.g., cognitive-behavioral therapy) for adults with severe mental illnesses (Frueh et al., 2009; Turkington, Kingdom, & Weiden, 2006), yet these interventions have not been widely implemented in public mental health systems. System administrators and legislators should work together with awareness of the threats posed by a

fragmented system of care and the powerful economic and regulatory barriers that have adversely affected the availability of community services.

This study has several limitations, including all those inherent to qualitative research and our inability to locate and recruit all of those initially targeted (46% participation rate), which likely introduces some form of bias into the results. Nevertheless, according to these stakeholders, the current status quo does not represent an optimal utilization of resources, either for individuals with severe mental illness or society. In that mental health care is not a state entitlement, it is not clear where ultimate responsibility lies. Given the link between privately and publicly funded mental health, there is hope that the recently passed mental health care parity act will lead to improved access to care for some (Barry, Frank, & McGuire, 2006; Glied & Frank, 2008; Goldman et al., 2006), although to the extent that most mental health care use is controlled by managed care, it may be less than fully successful in filling all gaps (Lu, Frank, & McGuire, 2008). It remains to be seen how the recent health care reform will influence this. Apart from humanitarian reasons for caring for people with severe mental illnesses, we should also be informed by the economic costs of failing to provide care—including increased costs related to crime (value of stolen and damaged property, physical violence and injuries, security and prevention, effects of illegal drugs), law enforcement (police investigations, patrols), criminal justice (courts, prisons), and reduced economic growth (lost wages and productivity, unemployment).

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Table 1

Characteristics of Study Markets

City	% Change in State Beds 1998–2005	% Change in Private Beds 1998–2005	Bed Closures after 2005
Asheville, NC	–21.6%	–68.6%	Downsized state beds
Columbia, SC	–29.9%	–14.9%	Downsized state beds
Janesville, WI	–7.8%	–79.3%	Stable
Portland, OR	22.3%	–31.9%	Stable
Seattle-Tacoma, WA	–15.9%	–21.2%	Specialty hospital closure
Tampa Bay Area, FL	–31.4%	–51.6%	Stable
U.S. overall	–11.5%	–18.0%	

Table 2**Representative Quotations for Thematic Categories**

<p>1. Structure of care</p> <p>Continuum of care</p> <p>“What the old system did was the continuity of care. I’m not saying it was a good system, but it was a public health–minded system that dealt with continuity of care for folks who needed that track.”</p> <p>“The system funds acute care beds, but not outpatient services or discharge services to keep them stable or out of the hospital.”</p> <p>“Quality of care has gone down. People are not getting needed care.”</p> <p>“Part of the problem is the locality’s overreliance on acute care services. If you get too close to a hospital you get sucked in ... but those people would be better served if we had a really intact, competent community mental health system. That’s where the money needs to be spent, not on creating more psychiatric beds.”</p> <p>“There’s inappropriate use of hospital beds.”</p> <p>“Seventy-five percent of older adult hospitalizations could have been avoided with better community services.”</p> <p>“Continuum of care could obviate need for acute beds if better transitions, step-downs, PACT teams, residential care, even case management.”</p> <p>“Bed closures forced SMI (severely mentally ill) patients back into community.”</p> <p>“We’re trying to integrate, fighting silo mentality.”</p> <p>“Money should follow the patient along the continuum of care, align the incentives that way.”</p> <p>“Resources haven’t followed people into the community.”</p> <p>“...the emergency room, which is kind of default provider, if you will, for certain mentally ill and substance abuse individuals in crisis...”</p>	<p>2. Barriers</p> <p>Economic barriers</p> <p>“It’s a sad state of affairs—there’s not enough funding.”</p> <p>“Lack of slots makes it hard for people to get into the mental health care system, lack of capacity.”</p> <p>“...increasing pressures on the state institutes ... they’re typically double-bedded, they’re over census.”</p> <p>“New for-profits pop up, picking of the paying patients, leaving uninsured for the rest to care for.”</p> <p>“We need funding for the entire continuum of services.”</p> <p>“Capacity has not grown but population has.”</p> <p>“Low reimbursement rates led to hospital closures of psych beds.”</p> <p>“Punitive accounting systems scare (potential) providers.”</p> <p>“No incentives for skilled nursing facilities.”</p> <p>“Workforce shortages and employee turnover—we’re competing with the local car wash for employees.”</p> <p>“Poor reimbursement since Medicaid carve-out.”</p> <p>“Insurance really dictates everything here.”</p> <p>“It’s very hard from a provider’s perspective to be able to coordinate clinical care and treatment with other providers ... and the reason is nobody values the financials. It is not reimbursed by the state system.”</p> <p>“It’s just underfunded.”</p> <p>“We lost our shirt doing psychiatric services at the hospital. It was the worst financial service that we had by a long shot.”</p> <p>“It’s just not very profitable for general hospitals to open psych beds, and there have really been problems getting the Medicaid rate to be competitive.”</p> <p>“There are perverse (financial) incentives in the system ... reimbursement for psychiatry is inadequate.”</p>
<p>Regulatory barriers</p> <p>“The system is enormously complicated. Accessing Medicaid deductible services ... virtually none of our (patients) in our program have been able to navigate that system without our help...”</p> <p>“Insurance eligibility and regulations act as barriers to access.”</p> <p>“Liability decisions, risk management, affect bed capacity.”</p> <p>“Seclusion and restraint regs (Joint Commission) drove up costs—the last straw.”</p> <p>“...not enough incentive for the responsibility that’s involved.”</p> <p>“...administrative paperwork requirements that far exceeded administrative requirements prior to ... the old system...”</p> <p>“...over twenty potential ways that you could get a fatal error (on service authorization requests), and you had folks in the service authorization department that were really very subjective.”</p> <p>“There are so many concerns over legal liability.”</p> <p>“...the single greatest barrier to managing older adults in the community is Medicare’s discrimination against mental health care, clearly.”</p> <p>“That’s been an ongoing concern for our emergency departments, and our hospitals are very heavily regulated and licensed...”</p>	<p>Political barriers</p> <p>“State legislators have cut back on funding for severely mentally ill and community mental health care.”</p> <p>“...from county government to state legislators there is little political will to put money into community mental health.”</p> <p>“The promised mental health funding was never delivered.”</p> <p>“We need more advocacy for the mentally ill. Who will do it?”</p> <p>“State promised to close hospitals and replace with PACT. But it was never delivered. It was a classic bait-and-switch.”</p> <p>“The politics are very bitter.”</p> <p>“Mental health care is not something politicians lose any sleep over providing.”</p>
<p>3. Outcomes</p> <p>Fragmentation of care</p> <p>“Substance use disorders treatment is not integrated with mental health care.”</p> <p>“...makes discharge planning difficult. (There are) not many options out there.”</p> <p>“...two month wait-lists for outpatient services.”</p> <p>“With no electronic record, information exchange for patients is poor.”</p> <p>“...gaps in med coverage between discharge and reuptake.”</p> <p>“...you can’t live in state institute anymore because nobody can pay for it ... so that means you’re probably gonna end up homeless...”</p>	

“...there appears to be a substantial population in our eyes who have fallen through the cracks.”

“It’s very hard from a provider’s perspective to be able to coordinate clinical care and treatment with other providers ... and the reason is nobody values the financials. It is not reimbursed by the state system.”

“I think the issue is the full continuum needs to be fully funded, including capabilities for psychiatric beds and including some capability for long term for people who do need it, as well as step-down, you know, short-term residential treatment ... the consumers and family members have actually really come to the recognition that it’s not one specific service, we need a fully funded continuum of care, a system of services that includes that capability.”

Shift to criminal justice system

“We’ve criminalized the severely mentally ill. It’s not right.”

“As psych beds went down, jail beds have gone way up—16% to 33%.”

“...so many people needing service there’s sort of a de facto screening process ... if you’re referred by the police, those are the priority cases, those are the ones that get screened.”

“...it’s broken ... it’s battered by the criminalization and forensicization of the mentally ill.”

“...look at the population of schizophrenics in the prisons now—it’s 16%! What’s going on? Where are these people being treated?”

“Judge Latham’s report said if you don’t do anything different in Florida, they are going to have to build a new jail for the next however many years to hold all of the people.”

Market-specific issues

“No provision locally for long-term care.” (Wisconsin)

“We as a group of behavioral health providers sort of catastrophized what the future would be when (local psychiatric hospitals) closed and those catastrophes did not come true in my opinion.” (Wisconsin)

“We lost all free-standing psychiatric hospitals.” (Florida)

“It’s very tight, all adult facilities, virtually nothing for kids—only 16 beds.” (Florida)

“No involuntary beds for organic disorders—TBI, dementia.” (Washington)

“In the state of Washington, if you want to get mental health services, you have to be on Medicaid if you want public mental health services.” (Washington)

“Geropsychiatrists are hard to find ... child psychiatrists are very hard to find ... there’s a general nursing shortage...” (Washington)

“There is a distinct difference between bed availability in Eastern Washington than in Western Washington, and the only thing that we can figure out is the population density is lower but also that their state hospital is much more responsive to their acute care...” (Washington)

“It went from a publicly delivered system to a publicly managed system.” (North Carolina)

“One of the consequences we’ve seen with the closure is much of the resources have left the area completely ... clinical folks, supervisory level.... A lot of those folks relocated to other communities.” (North Carolina)

“They have a very high rate of hospital utilization compared to (other counties).... a higher prevalence of mental illness associated with more metropolitan area and they need more capacity.” (Oregon)

“The closures were not without good reason.... They were used, but they were last resort hospitals because the system didn’t trust the quality of care provided.” (Oregon)