NEW FREEDOM COMMISSION ON MENTAL HEALTH

Subcommittee on Acute Care:

BACKGROUND PAPER

June 2004

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The content of this publication reflects the views and opinions of the Subcommittee on Acute Care. Therefore, this paper is a product of the process that advised the full Commission and as such does not reflect the position of the President's New Freedom Commission on Mental Health or any agency of the United States Government.

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Preface

The President's New Freedom Commission on Mental Health appointed 15 subcommittees to assist in its review of the Nation's mental health service delivery system. The full Commission appointed a Chair for each subcommittee. Several other Commissioners served on each subcommittee, and selected national experts provided advice and support. The experts prepared initial discussion papers that outlined key issues and presented preliminary policy options for consideration by the full subcommittee. The subcommittee reported to the full Commission only in summary form. On the basis of this summary, the full Commission reached consensus on the policy options that were ultimately accepted for inclusion in the Final Report, *Achieving the Promise: Transforming Mental Health Care in America*. Therefore, this paper is a product of the subcommittee only and does not necessarily reflect the position of the full Commission or any agency of the United States Government.

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The Need for Acute Care

Acute care is an essential component of a comprehensive system of mental health services in a community (Schreter, 2000). The term *acute care* has traditionally referred to:

- Short-term (with a median length of stay of approximately 30 days or fewer), 24-hour, inpatient care and emergency services provided in hospitals;
- Short-term, 24-hour care provided in residential treatment facilities for children; and
- Treatment in other crisis and urgent care service settings.

In recent years, non-traditional approaches to 24-hour acute care have emerged. These approaches, which may be more normalized and less costly alternatives to inpatient care, include:

- Crisis residential programs for adults (Fenton et al., 1998; Hawthorne et al., 1999; Community Research Foundation, 2001), and
- Crisis family care and treatment foster care for children (Boothroyd et al., 1998; Evans et al., 1997).

An important role for acute care is to provide a safe setting to address crises and to evaluate and assess the adult or child who is in crisis.

In addition, a number of non-traditional services, while they are not 24-hour acute services, do provide alternative forms of care for many who would otherwise require 24-hour acute care. These non-traditional services include:

- Multi-systemic therapy for children and families (Cunningham & Henggeler, 1999; Schoenwald et al., 2000),
- Mobile crisis teams (Guo et al., 2001),
- Assertive community treatment (Quinlivan, 2000),
- Peer-based services (Burns-Lynch et al., 2001), and
- Integrated systems of community mental health care (Curlee et al., 2001; Huff, 2000).

An important role for acute care is to provide a safe setting to address crises and to evaluate and assess the adult or child who is in crisis. It is generally thought that, in an ideal, fully developed mental health service system, inpatient settings are most appropriate for those situations in which personal safety is a significant consideration.

While the Subcommittee on Acute Care is committed to the principle of full community integration for people with mental illnesses across the lifespan, it believes that access to available and effective acute inpatient and other short-term, 24-hour services are essential components of a balanced system of mental health care—especially for those in crisis who need the safety and intensive treatment in such settings.

The problem that the Subcommittee addressed is the lack of availability of needed short-term acute care of all types:

- Acute 24-hour, inpatient care and treatment in some communities,

- Non-traditional forms of acute care and alternative services in others, and
- Both forms in many communities.

Another concern of the Subcommittee is the excessive use of hospital emergency rooms (Schafermeyer & Asplin, 2003) sometimes associated with the unavailability of more appropriate inpatient and other acute care settings (Hirdes et al., 2002; Lesage et al., 2002).

In some communities, the shortage of acute care beds has risen to crisis proportions.

The Subcommittee heard accounts of communities where patients reportedly spent up to a week in an emergency room while waiting for scarce hospital beds. Some testimony described communities where emergency departments were overwhelmed with patients in extreme psychiatric distress who had no place to go.

Appropriately managing acute care needs requires a comprehensive community mental health system with a full range of effectively coordinated components (Catalano et al., 2003) and a wide range of other services in a community appropriate for people with mental illnesses across the life span.

Solutions to the problem of acute care are complicated by the lack of consensus on the role of short-term, 24-hour care and on the standards for determining the appropriate number of beds and the most appropriate types of acute care settings. The problem is also compounded by the limited availability of relevant data (Bartlett et al., 2001; Hirdes et al., 2002; Lesage et al., 2002; Lund et al., 2002).

Outstanding models exist for every type of acute care. However, fully developed and integrated model community systems seem to be lacking (Kiser et al., 1999; Schreter, 2000).

Numerous news stories, public comments, and testimony before the Subcommittee described communities that experienced severe problems with access to short-term, inpatient care and other forms of acute care (Azrin et al., 2003; Irby, 2002; Reiger, 2002).

In some communities, the shortage of acute care beds has risen to crisis proportions. Too often budget shortfalls have reduced funding for other essential community mental health services, consequently increasing the demand for already limited inpatient care as an alternative (Allen, 2000).

Background

The President's New Freedom Commission on Mental Health focused on the full range of community mental health services needed to support people across the life span. Experts universally agree that care in the least restrictive setting possible is desirable and strongly support alternatives to long-term institutional care as called for in the *Olmstead* decision.

The goal of the President's Executive Order that established the New Freedom Commission on Mental Health is to move toward fully integrating adults with serious mental illnesses and children with serious emotional disturbances into their communities. Unfortunately, during crises, people with mental illnesses sometimes must be evaluated in emergency settings, while others must be admitted to short-term, inpatient or other acute care settings. Still others must receive crisis intervention services in their home or in community settings.

Young people with severe emotional disturbances may need crisis family care, treatment foster care, or short-term hospital or residential treatment. Adults in mid-life may need emergency services, acute crisis residential or hospital treatment, or alternative forms of crisis care. In later life, some adults with mental illnesses may also require acute care in a hospital or other setting to help manage a mental illness.

In particular, the short-term hospital or residential treatment facility may be a place of safety where a variety of observations and treatments occur. For those willing to voluntarily

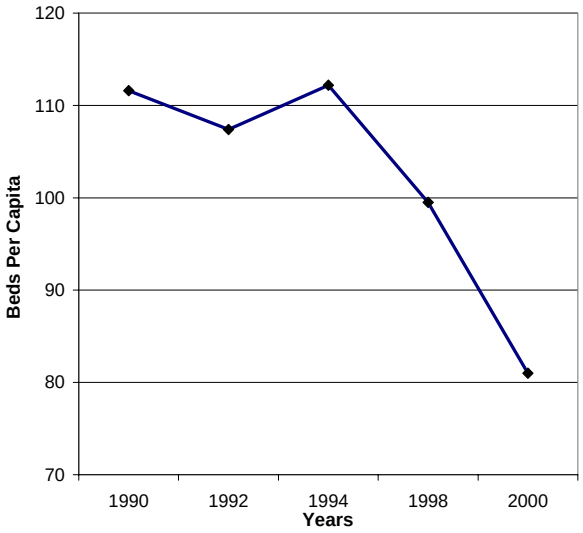
accept services, crisis residential services may serve a similar function (Fenton et al., 1998; Hawthorne et al., 1999).

These settings are considered by many to be essential places for care when an individual who is experiencing a mental disorder needs emergency protection because of the serious danger of suicide, harm to others, or neglect from impaired self-care.

Inpatient Beds Per Capita Have Declined

The total number of inpatient psychiatric beds per capita has declined substantially (27%) since 1990, as illustrated in *Figure 1*.

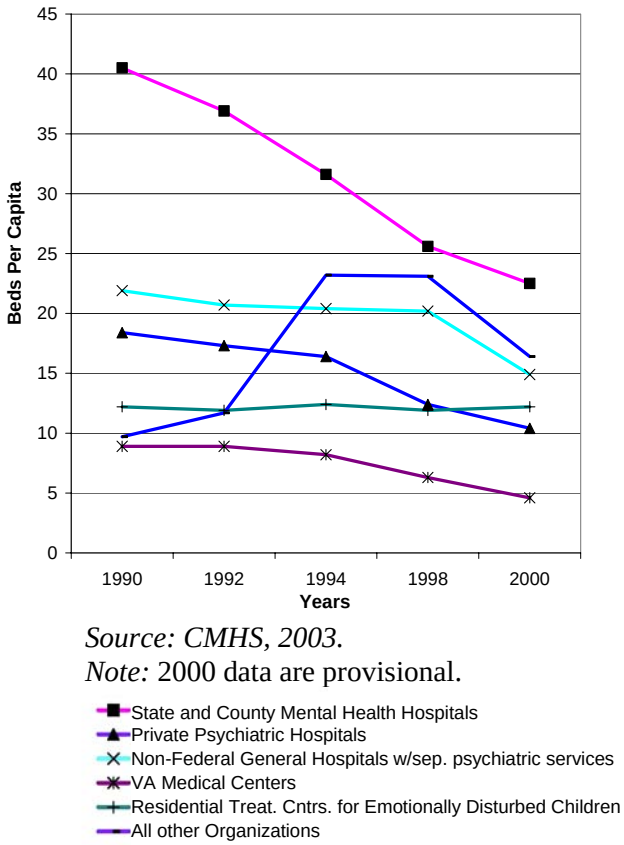
FIGURE 1. 24-HOUR HOSPITAL AND RESIDENTIAL MENTAL HEALTH TREATMENT BEDS PER 100,000 CIVILIAN POPULATION, 1990-2000



Source: CMHS, 2003.
Note: 2000 data are provisional.

Figure 2 shows the changes by type of facility. It is important to note that these figures reflect only traditional, 24-hour acute care settings because no national data are yet available on non-traditional acute care settings, such as crisis residential programs for adults or crisis family care or treatment foster care for children.

FIGURE 2. 24-HOUR HOSPITAL AND RESIDENTIAL MENTAL HEALTH TREATMENT BEDS PER 100,000 POPULATION, BY FACILITY TYPE, 1990-2000



Source: CMHS, 2003.
Note: 2000 data are provisional.

Over this same 10-year period[1], State and county psychiatric hospital beds per capita have decreased even more sharply (44%). Private psychiatric hospital beds per capita decreased by 43%, while per capita beds in psychiatric units of non-federal general hospitals showed a more modest 32% decline.

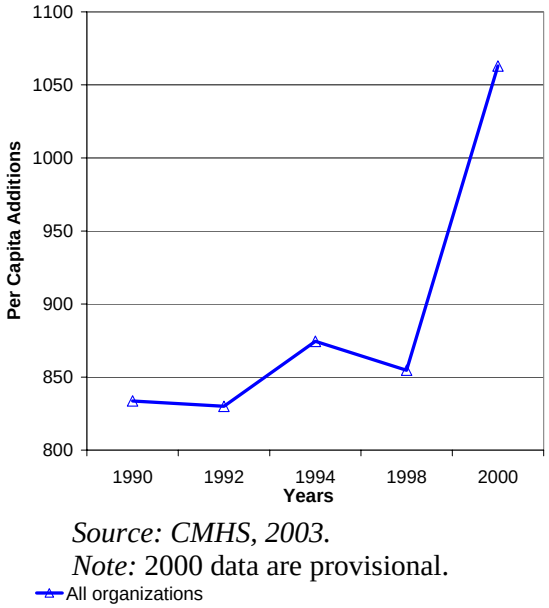
Only in residential treatment centers for children have per capita bed counts remained unchanged between 1990 and 2000. Provisional national data for 2000 suggest that the supply of psychiatric beds per capita in every category except residential treatment centers for children may have declined between 1998 and 2000.

[1]Note that the 2000 data are provisional.

Additions to 24-hour Acute Care Settings Have Increased

As *Figure 3* illustrates, total additions per capita have increased dramatically over the last decade (27%). Relatively moderate changes between 1990 and 1998 were dwarfed by the steep rise in 2000.

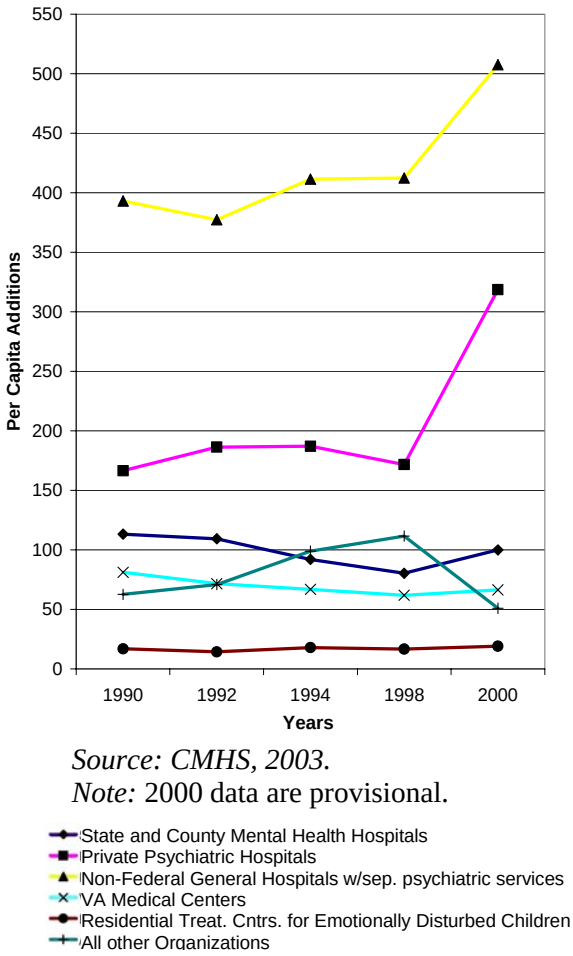
FIGURE 3. HOSPITAL AND RESIDENTIAL MENTAL HEALTH TREATMENT ADDITIONS PER 100,000 CIVILIAN POPULATION, 1990-2000



Source: CMHS, 2003.
Note: 2000 data are provisional.

Figure 4 displays the same data, disaggregated by facility type. It makes clear the dramatic shift in utilization patterns. Additions per capita actually decreased in publicly operated facilities (State and county hospitals [12%] and Veterans Health Administration facilities [18%]) and in the "all other facilities" category (19%).

FIGURE 4. HOSPITAL AND RESIDENTIAL MENTAL HEALTH TREATMENT ADDITIONS PER 100,000 CIVILIAN POPULATION, BY FACILITY TYPE, 1990-2000



Source: CMHS, 2003.
Note: 2000 data are provisional.

However, these decreases were more than offset by the sharp rise in additions to private psychiatric hospitals (91%) and less striking but still notable increases in the remaining facility types.

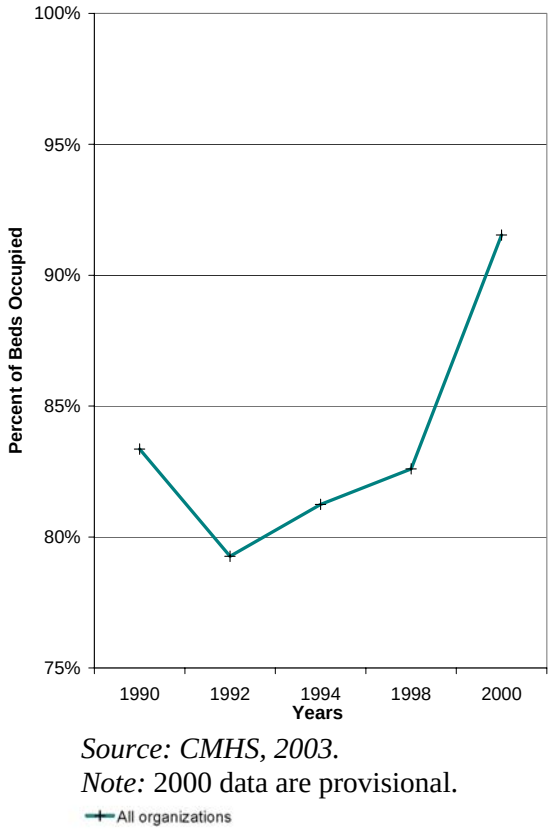
While not graphically displayed, the growth in outpatient (less than 24-hour care) additions per capita over this time period has been very similar, but even slightly more dramatic (28%).

The decline in beds seems to be concurrent with continued reductions in length of stay to a week or less as a median for most facility types (CMHS, 1998).

Occupancy Rates in 24-hour Acute Care Settings Have Risen

The change in occupancy rates[2] between 1990 and 2000 follows an interesting pattern, as shown in *Figure 5*. Occupancy rates across facility types actually decreased between 1990 and 1992 and did not rise back to the 1990 level until 2000, when they were significantly higher than at any other time in the decade.

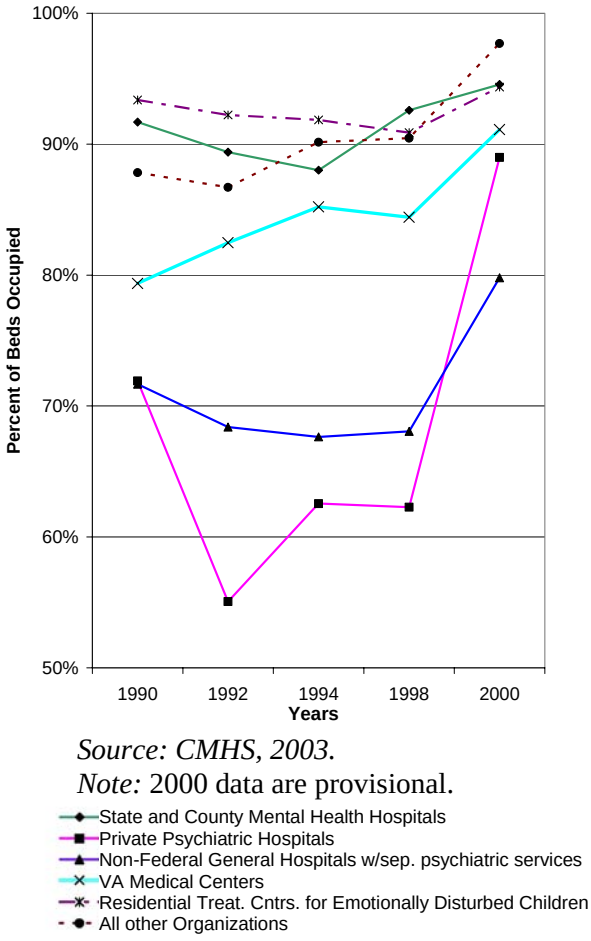
FIGURE 5. PERCENT OF HOSPITAL AND RESIDENTIAL MENTAL HEALTH TREATMENT BEDS OCCUPIED, 1990-2000



Source: CMHS, 2003.
Note: 2000 data are provisional.

The disaggregation by facility type in *Figure 6* makes clear that the private psychiatric hospitals account for the shape of the overall distribution. Private psychiatric hospital occupancy dipped to 55% in 1992, but rose to 89% in 2000.

FIGURE 6. PERCENT OF HOSPITAL AND RESIDENTIAL MENTAL HEALTH TREATMENT BEDS OCCUPIED, BY FACILITY TYPE, 1990-2000



Source: CMHS, 2003.
Note: 2000 data are provisional.

Even at its peak, the occupancy rate for private psychiatric hospitals was slightly lower than for any other type of facility except non-federal general hospitals with separate psychiatric services.

[2] *Occupancy rates* were defined simply as number of residents divided by number of beds (CMHS, 2003). Note that the bed count and the resident count may have been taken on different days of the year.

Summary of National Data on Beds and Utilization

What seems clear from the national data is that the supply of most types of beds for short-term inpatient psychiatric care has declined with the most severe drop occurring in publicly operated services. This decrease most affects those individuals who have the greatest level of impairment—adults with serious mental illnesses and children with serious emotional disturbances.

Data on many forms of non-traditional acute care and alternative crisis intervention services are not readily available.

The decline in the supply of services has accompanied an increasing demand for admission into short-term inpatient care as shown by continued growth in additions to some of these facility types. Increasing admissions can co-exist with a shrinking bed supply because of the continued drop in the length of stay nationally and an increase in average occupancy rates. In some communities, these conditions have led to the inability to admit people into short-term inpatient care.

In considering these conclusions, it is critical to recall that data on many forms of non-traditional acute care and alternative crisis intervention services are not readily available. These data illustrate the changes on one portion of the overall service delivery system, but provide no information on the availability of alternative services that could lessen the demand for acute inpatient care.

Clear guidelines are also lacking for what level of acute care or alternative services is appropriate for individual mental health consumers in crisis. Some researchers have attempted to develop rough schema of the characteristics of services along the continuum of care (see for example, Kiser et al., 1999; Schreter, 2000). Other researchers have attempted to apply standardized assessment instruments and clinical judgment to assess what level of acute care is required for individual clients in crisis (see for example, Hirdes et al., 2002; Lesage et al., 2002).

However, few models exist in which structured assessment and clinical guidelines are linked to comprehensive continuum of care, so that people receive the most appropriate and normalizing care for their needs with attention to cost effectiveness.

Expenditures for Acute Care and Other Behavioral Health Services Dropped

It is widely known that the share of health care expenditures allocated to mental health and substance abuse treatment declined from 1987 to 1997 (Coffey et al., 2000). Recent analysis by Mark and Coffey (2003) has examined that trend in a sample of the employer-based, private insurance market. These authors found that the share of expenditures for mental health and substance abuse (MH/SA) treatment decreased from 7.2% to 5.1% between 1992 and 1999.

Spending on MH/SA grew at a lower rate than other health care spending. Compounding the problem, MH/SA spending also grew at a lower rate than general price inflation.

These authors conclude that the reasons for this decrease in spending are a lower probability of admission to inpatient care and shorter lengths of inpatient stay. Mean expenditure per day or per visit declined for both inpatient and outpatient care, but the number of outpatient visits increased while inpatient stays decreased. It is noteworthy that the cost for psychotropic drug prescriptions more than doubled during this time period.

Some Communities Face Acute Care Shortages

The trends in the national data suggest an emerging widespread problem. Press accounts and testimony to the Subcommittee clarified that

the problem has seriously disrupted the service delivery system in a substantial number of communities where crises exist in the availability of acute care, including short-term inpatient care.

For the person or the family in crisis with no place to turn, national data and the availability of care in another community provide little comfort. In the most troubled communities, the lack of acute inpatient care is sometimes compounded by a simultaneous shortage of other effective alternative community services.

This dual problem underscores the functional connection among community services, emergency departments, and acute care services in inpatient or other settings. Again, a fully functional community-based mental health system requires robust, effective, and well-coordinated acute and longer term care, inpatient and outpatient treatment, other appropriate supports, and strong consumer involvement.

Each community has a different experience, however, with the various forces that account for the dramatic changes in the patterns of care that have occurred over the last 20 years. Starting in the 1980s, the payment mechanisms (such as prospective payment) that created an incentive to reduce the length of hospital stay did not affect each community in the same way.

Similarly, managed care in the 1990s also created incentives to reduce use of hospitals while trying to increase use of outpatient services. In some communities, this confluence of forces means that adults and children in clinical crises often resort to repeatedly using emergency room services because short-term, 24-hour services are unavailable.

Existing payment systems are not fully aligned with our goals for the system of care.

The utilization guidelines that so dramatically limited length of inpatient stays and tightened reimbursement methods that have challenged the viability of acute inpatient services did not appear everywhere at the same time or in the same way. Some communities have also successfully built and maintained robust outpatient treatment systems and community-based acute and longer term services that may reduce the need for short-term inpatient care and the misuse of emergency rooms.

Defining the Policy Issues

The solution to this complex problem must balance integration in the community with the need for safety and acute care during crises. It must also reflect a consensus on the role of acute inpatient care and emergency services in an array of community mental health services. Finally, the solution must take into account the regional and local forces that lead to the differences across communities.

Quality care, effective coordination with other community programs, and appropriate discharge policies are essential in every acute care setting.

Many policy issues relevant to acute care are being considered in other subcommittees, including those devoted to financing (Medicaid policy in particular), children's services, evidence-based practices, rights and engagement, and the criminal justice system. Those specific concerns are not addressed by this paper. Instead, this paper focuses on the lack of a clear policy path to solve the problem of local deficiencies in access, availability, and coordination of acute care.

The policy path is unclear because we do not know enough about the problems associated with acute and crisis care. Problems exist with:

- Access and availability of acute care services,
- Coordinating the care between short-term 24-hour and community-based services, and
- Outcomes and quality of care throughout the service system.

It is difficult to solve these problems when we lack consensus standards for assessing the number of beds needed for acute and crisis care or the balance and mix of settings and services that constitute an ideal community-based system of care.

Also no agreement exists on the best approach to paying for acute inpatient care. The method of payment and the payment rates are a matter of current study and much controversy. Clearly, payment methodologies have a powerful determining role in structuring the array of community services.

It is equally clear that existing payment systems are not fully aligned with our goals for the system of care — another indicator of the pervasive fragmentation of our national mental health system.

Current utilization guidelines also vary and are subject to controversy about their appropriateness. Without agreement on basic functions, it is very difficult to agree on the content of such care.

For instance,

- What is the appropriate mix of short-term hospital care and other forms of acute care for adults?
- How should we balance short-term hospital care, residential care, and other forms of 24-hour acute care for children?
- What complements to acute care should exist in what proportions in a well-developed comprehensive system of community mental health care?

Most of the mental health community would agree that we lack clear standards and evidence to help answer these questions. All would agree that quality care, effective coordination with other community programs, and appropriate discharge policies are essential in every acute care setting.

Meanwhile, many are frustrated that essential acute care services are not available in their communities.

Policy Option

POLICY OPTION	**Form a National Working Group on Acute and Crisis Care**

RATIONALE

The Subcommittee on Acute Care urges that a National Working Group on Acute and Crisis Care be formed to analyze the current circumstances of regional variation, lack of a consistent vision and set of standards, and limited availability of critical data.

IMPLEMENTATION STRATEGY

The Subcommittee envisions a work group started and initially funded by the Federal Government with full participation by all stakeholder groups. The mission of the work group would be to:

- Synthesize existing knowledge,
- Review the many outstanding existing model programs,
- Develop new knowledge as necessary, and
- Attempt to develop a consensus on and policy options relevant to the following issues:
  - The role of acute care in an array of community mental health services, including the proper connections among services.
  - The range and types of longer-term care and supportive services needed to effectively complement acute care in a comprehensive community system, with particular attention to evidence-based services and the need for consumer involvement.
  - The forces that shape the role of acute care and the relationships in the service system.
  - Methods for assessing and quantifying the need for short-term 24-hour care. Such methods could include more widespread use of comprehensive, multi-disciplinary mental health assessment systems to indicate the appropriate level of acute care in the continuum of care. Also valuable would be the development and widespread use of psychiatric beds needs analysis. The methods should recognize that these assessments must be tailored to local conditions and regional variations.
  - Methods for paying for acute and crisis care that support a vision for a comprehensive system of care.
  - Standards for coordinating care between short-term 24-hour services and non 24-hour community services. These standards must consider the "functional interface" between these settings that takes different forms in different communities on the basis of existing resources and policies in other human services, such as in housing, homelessness services, and criminal justice for adult populations; and in child welfare, school, and juvenile justice for child populations.
  - Standards for determining the appropriate content of care and what constitutes effective short-term, 24-hour care and treatment.

Conclusion

The Subcommittee on Acute Care fully appreciates the New Freedom Commission on Mental Health's focus on full community integration for people with mental illnesses across the life span.

Available and effective acute inpatient and other short-term, 24-hour services are essential components of an integrated system of mental health care, especially for those in crisis who may need the safety and intensive treatment possible in such settings.

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