Psychiatric Beds: Getting from Not Enough to Safe Minimum

The information deficit around mental illness treatment and policy is especially deep on the subject of psychiatric beds, both public or private.

Neither the federal government nor any of the states has identified or established population-based "safe minimum" bed target numbers. No member of the Organization for Economic Cooperation and Development has either, even though nearly all the 34 member nations have reduced their psychiatric beds over recent decades and continue to do so, with accompanying reports of negative impacts on patients and their communities.

We do know that, by early 2016, more than 96% of our population-adjusted state mental health beds had been eliminated over a 60-year period. Mental health advocates and providers, law enforcement and corrections officials, homelessness service providers and emergency room personnel, families and policymakers all were reporting significant and sometimes dire consequences from resulting bed shortages and increasingly calling for more psychiatric beds.

Yet we all operate without empirical evidence of just how many more beds are needed. How many beds per capita do we need to reduce the number of people who deteriorate to the point of committing crimes, hurting themselves or others, becoming homeless or suffering any of the innumerable other consequences that are relatively common when serious mental illness is left untreated?

Nobody knows for sure.

Bed Supply Calculation

In "Psychiatric Bed Supply Need Per Capita," our September 2016 background paper on the topic, we suggest that two conditions associated with bed shortages provide the most promising starting point for developing evidence-based, safe-minimum targets: psychiatric "boarding" times in hospital emergency rooms (ER) and inmate waitlisting in jails and prisons.

The American College of Emergency Physicians reports that ER boarding of psychiatric patients is now virtually universal in the United States, with some patients waiting weeks for hospital admission. "The severe shortage of all types of psychiatric beds across the United States affects not only whether people are admitted for inpatient treatment but also how long they wait for a bed," Elizabeth La and colleagues wrote in a May 2016 Psychiatric Services study. At the same time, a majority of states report maintaining wait lists for forensic beds, with some inmates waiting months for admission to a bed.

Two recent efforts demonstrate the potential for using bed waits as a basis for developing bed targets.
In the study published in *Psychiatric Services*, La and colleagues report on a novel approach to developing bed targets developed by researchers at the University of North Carolina (UNC) and Duke University. The research team used a discrete-event simulation model to project how many additional non-forensic beds would be needed in one region of North Carolina to reduce average ER bed waits by patients age 18-64 years to less than one day. Their model found that capacity would need to be increased by 165% (356 beds) to reduce average wait time to below 24 hours.

At approximately the same time, in the state of South Australia (SA), public officials were conducting essentially a real-time test of how bed supplies could be used to reduce ER boarding times.

In October 2014, 284 psychiatric patients in the Australian state were reported held in SA emergency rooms for 24 hours or more before admission to a mental health bed. Bucking the nation's bed-reduction trend, the state added 30 new acute care beds (typically used for patients with psychotic symptoms) and six new forensic beds. By December 2015, the number of patients waiting 24 hours or more for a bed had dropped nearly 75%, to 76 patients. The average wait time for psychiatric hospitalization was cut in half.

**Not a Simple Equation**

Bed waits do not result from bed numbers alone. If fewer mentally ill people arrived in ERs or jails because they received treatment earlier and averted crisis, as just one example, fewer beds would be needed to treat them. The UNC/Duke team note that expanding intensive services in the community - programs such as assertive community treatment - also could alter bed need by reducing bed demand.

However, in a functional mental health system, hospital care is one of the essential points on the continuum of care. "While community and hospital-at-home teams can be effective for many (but not all) patients, inpatient care is essential when an acute episode is accompanied by potentially high risks of suicide or violence," Stephen Allison and a team of international colleagues write in the September issue of *Australian & New Zealand Journal of Psychiatry*.

In our June 2016 beds survey, *Going, Going, Gone*, the Treatment Advocacy Center called on the federal government to assess hospital bed need by type, facility and location. Computer modeling such as UNC/Duke's "quickly provide 'what if' results without requiring actual implementation of costly and possibly ineffective interventions" - is a good place to start.