



How Many Psychiatric Beds Does America Need? (created March 2016)

The current shortage of psychiatric beds in the US is a major problem. Emergency departments (EDs) are crowded with acutely psychotic patients—some who wait for beds for up to a month. The pressure on existing beds is so intense that patients are discharged prematurely and often have to be readmitted or end up homeless or incarcerated. Nevertheless, many states continue to decrease the number of state hospital beds. One reason for such decisions by state officials is that there is no accepted standard regarding how many psychiatric beds are needed.

The recently published study of psychiatric bed needs by La and colleagues¹ provides such a standard. The authors studied a 25-county region of North Carolina with a population of 3.4 million. The regions' total psychiatric bed capacity consisted of 398 beds in a state hospital; 494 adult psychiatric beds in 14 general or private psychiatric hospitals; and 66 nonhospital crisis beds in five facilities. Combined, this totaled 958 psychiatric beds, or approximately 28 adult beds per 100,000 population. The average emergency room preadmission wait time for psychiatric beds in this region at the time of the study (2010 to 2012) was 3.3 days.

The authors used a computer simulation program to model different scenarios to ascertain how many additional psychiatric beds would be needed to achieve an average preadmission wait time of less than a day. The answer was 356 additional beds, bringing the total bed capacity to 1314 or about 39 adult beds per 100,000 population. This calculation included only adult patients (ages 18 to 64) and assumed a median duration of stay in the state hospital of 20 days, which existed in the hospital under study at that time. This calculation did not include psychiatric beds for children or for forensic patients, who usually stay for extended periods.

In 2008, a study was published by the Treatment Advocacy Center that estimated the minimum number of public beds necessary for adequate psychiatric services for a population of 100,000.² Estimates were solicited "from 15 experts on psychiatric care in the US, [including] individuals who have run private and state psychiatric hospitals, county mental health programs, and experts on serious psychiatric disorders."

In contrast to the study by La and colleagues, the 2008 estimates included beds for children and forensic patients. The consensus estimate of bed need by the 15 experts was 50 (range 40 to 60) public psychiatric beds per 100,000 population. Given these findings, it seems reasonable to establish a range of 40 to 60 psychiatric beds per 100,000 population as a minimum standard currently needed for reasonable psychiatric care in the US in light of the realities of the present funding system.

Such caveats are necessary because we actually do not know how many psychiatric beds would be needed if we were not constrained by Medicaid and other federal regulations. Before these regulations, several studies demonstrated effective and less expensive alternatives to psychiatric hospitalizations. For example, in 1961 to 1964 the Louisville Homecare Project demonstrated that approximately 75% of persons with schizophrenia could be successfully treated at home rather than the hospital with daily visits by public health nurses and guaranteed medication compliance.^{3,4} Similarly, the Southwest Denver Mental Health Services contracted with private homes to take acutely ill individuals with care coordinated from the mental health center.⁵ Without federal regulations, many alternatives to hospitalization might be found.

Given the present system, however, it is clear that a small number of individuals will continue to need a hospital that is staffed for very difficult patients and/or those whose stay should be measured in weeks, not days. As La and colleagues note, state psychiatric hospitals have traditionally played this role, since they “are designed and staffed to care for people with severe mental illness, including those who may become violent.” Thus, “state psychiatric hospitals are the ultimate safety net for people with mental illness.”

Psychiatric units in general hospitals and private psychiatric hospitals occasionally admit individuals who have the most severe forms of mental illness, but most are not staffed to do so. In addition, most individuals with the most severe forms of mental illness do not have health insurance and are considered less desirable by private psychiatric hospitals and psychiatric units in general hospitals, 81% of which are privately owned.

It would thus be useful to establish a standard for what percentage of the 40 to 60 beds per 100,000 population should be in state psychiatric hospitals, but there is no such standard at this time. In 1955 there were 558,239 state and county psychiatric beds available, or about 340 beds per 100,000 population. Currently, there are about 35,000 state psychiatric beds available, or about 11 beds per 100,000 population. However, even this figure is misleading because in most states the existing state psychiatric hospital beds are largely occupied by court-ordered long-stay patients and therefore not available for the admission of acutely psychotic patients.

For example, a 2014 study reported that Larned State Hospital in Kansas had 457 beds.⁶ However, 190 of the beds were occupied by court-ordered forensic patients who had criminal charges, and another 177 beds were occupied by court-ordered sexual predators; this left only 90 beds for possible admissions. And in many state hospitals such beds are used only for brief hospitalizations, leaving no alternatives for patients who need longer periods for stabilization.

As La and colleagues point out, other measures can be taken to decrease the need for psychiatric beds. Such measures include assertive community treatment and the use of assisted outpatient treatment (AOT) to ensure medication adherence. Studies of AOT have shown that it results in a dramatic decrease in psychiatric rehospitalization.⁷

It is very clear that the more effective the outpatient services, the less need for psychiatric hospitalization. But despite the best outpatient efforts, some severely ill patients will continue to need the ultimate safety net of the state psychiatric hospital. It is important that we recognize that fact and establish a minimum standard for how many psychiatric beds are needed.

References

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