The Vital Role of State Psychiatric Hospitals

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Acknowledgments

This report recognizes some of the contributions that recipients and families have made to promote the concepts of recovery and the integration of individuals with mental health issues into broader society. Many of us who have received services from state institutions hold a variety of strong feelings about our experiences (some good, but many involving real and/or perceived injustices) in those institutions which still drive our advocacy efforts today. That said, most of us found in those experiences, real connections with the men and women who work in those institutions which provided the basis for hope and sustained our humanity at some of the lowest points of our lives. To those men and women, who worked in housekeeping, foodservice, maintenance, management, clinical and other roles, who engaged us as valuable human beings, who nurtured our sense of hope and possibility and who helped us endure and recover, we wish to recognize your work and to thank you for your efforts.

Sincerely,
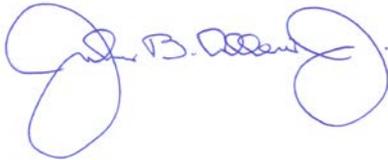
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Executive Summary

This technical report is advocacy for state psychiatric hospitals to be a vital part of the continuum of recovery services that should be integrated with a robust set of community services. Recommendations are provided for improving community integration, state psychiatric hospital services and operations, and policies on all system levels. This report is not advocacy for increasing state psychiatric hospitals or beds.

To support and justify the recommendations, the report includes background and discussion on the history and current context of state psychiatric hospitals; data and trends; how admission decisions to state psychiatric hospitals are made; the impact of the 1999 *Olmstead* Supreme Court decision; financing; the use of technology; and what the environment and culture of state psychiatric hospitals should be. The major findings and messages from the report and recommendations are the following:

- State psychiatric hospitals are a vital part of the continuum of care and should be recovery-oriented and integrated with a robust set of community services.
- All people served in state psychiatric hospitals should be considered to be in the process of recovery.
- Service recipients should be served in the most integrated and least restrictive environment possible.
- Changing the culture and environment of state psychiatric hospitals are keys to providing effective care. Cultures should be recovery-oriented; trauma-informed; culturally and linguistically competent; and address health and wellness.
- Peer support services are an integral part of assisting with people's recovery process and should be made available to all service recipients in state psychiatric hospitals. Peer support specialists should be made an equal member of the treatment team.
- A state psychiatric hospital is not a person's home. State psychiatric hospitals should be focused on service recipients returning to the community quickly when they no longer meet inpatient criteria.
- State psychiatric hospital staff, in partnership with the service recipient, should work directly with community providers on a discharge plan that includes what community services would be most helpful for the service recipient.
- For forensic service recipients, sex offenders, and in many states involuntarily committed service recipients, decisions for admission and discharge are made by courts and not by the state psychiatric hospital.
- State psychiatric hospitals include people with mental illness, people with criminal behavior driven by mental illness, and people with criminal and predatory behavior with no mental illness. These populations should be served in discrete locations.
- It is the duty of the state psychiatric hospital to make reasonable efforts to create environments in which service recipients and staff are as safe as possible. Addressing safety needs should be trauma-informed.
- Leadership and a well-trained, professional and paraprofessional workforce are paramount in ensuring quality care.

Introduction

The National Association of State Mental Health Program Directors (NASMHPD) represents state executives responsible for the $37.6 billion public mental health service delivery system serving 7.1 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

The Commissioners/Directors of State Mental Health Authorities (SMHAs) make up the membership of NASMHPD and are those individuals, many of whom are appointed by the Governors of their respective states, responsible for the provision of mental health services to citizens utilizing the public system of care. Currently, there are 207 state operated psychiatric hospitals nationwide and they serve approximately 40,600 people at any given point in time. NASMHPD includes the following 5 divisions made up of directors of special populations and services: Children, Youth and Families; Older Persons; Forensic; Legal; and Financing and Medicaid. In addition, NASMHPD has a Medical Directors Council and formal collaborative relationships with the National Association of Consumer/Survivor Mental Health Administrators and State Psychiatric Hospital Administrators. These entities provide technical assistance and expert consultation to the Commissioners and Directors related to issues specific to those populations and services.

The public mental health system is experiencing new challenges in a rapidly changing environment. Health care reform, economic restraint, complex civil commitment laws, and the need to ensure civil rights have placed pressures on the capacity and adequacy of state psychiatric hospitals. Today, most people with mental illness are served successfully in community settings. At times, those with the most serious mental illness need inpatient care provided at state psychiatric hospitals. As the public mental health system evolves in this new era of integrated, community-based care NASMHPD recognized the need to provide the nation's leaders with a technical report on the most appropriate role and approach to care for state psychiatric hospitals in the context of a larger system of care. Although there is not broad consensus on what the role of state psychiatric hospitals is and whether state psychiatric hospitals should even have a role, NASMHPD feels that there is currently a vital role for state psychiatric hospitals on the continuum of recovery services.

As a result, the NASMHPD Medical Directors Council developed this eighteenth technical report through extensive discussion, commentary, review of materials, and presentations made during an Expert Consensus Work Group meeting held September 12-13, 2013 in Morro Bay, California. Twenty-two (22) participants attended and included State Mental Health Commissioners, State Psychiatric Hospital CEOs, State Medical Directors, a service recipient representative, a former State Mental Health Commissioner, NASMHPD Research Institute, Inc. (NRI) staff, and NASMHPD staff. A complete list of participants is in Appendix A.

The information in this technical report is not intended as advocacy for increased inpatient services or more psychiatric hospital beds but instead is intended as advocacy for the state psychiatric hospital to be *integrated with* a continuum of a robust set of community services so that persons can be served in the community wherever possible and appropriate.

This technical report provides specific recommendations made by the expert panel that are the core of this report and relate to implementing culture change, state psychiatric hospitals being integrated with the community, and improvements on all system levels. To support and justify the recommendations, the technical report provides background that begins with the history and context of state psychiatric hospitals with the purpose of demonstrating the current context and culture of state facilities. In addition, the history addresses how states came to be primarily responsible for state psychiatric hospitals through President Pierce's 1854 veto of a national policy for financing mental health care. The history section conveys the ongoing undercurrent of shift in responsibility between the states and federal levels for people with mental illness based on the impact of that veto and the implications for treating mental illness. The history section concludes with positive developments in mental health treatment, policy, and philosophy.

The data and trends section that follows builds on the information from the history section. The report then moves into how admission decisions to state psychiatric hospital are made and the shift to increased forensic populations over the past two decades. This section includes some of the challenges state psychiatric hospitals face in treating these populations. It also underscores that the majority of people with mental illness are not violent and are often vulnerable. In light of this vulnerability, this section emphasizes the importance of providing discrete locations for people with mental illness and people with criminal and/or predatory behavior who have no mental illness or solely a personality disorder.

The report continues with information on how Title II of the Americans with Disabilities Act and the 1999 U.S. Supreme Court *Olmstead* decision impacts state psychiatric hospitals and community services followed by a section on financing that includes the anticipated impact of the Affordable Care Act (ACA) Disproportionate Share Hospital (DSH) reductions to be implemented in 2015. The latter sections include a position on the role of state psychiatric hospitals as a vital part of the continuum of recovery services. This position emphasizes that state psychiatric hospitals should be recovery-oriented and *integrated with* a robust set of community services and should not be a solution for an underfunded, fragmented system of care. Discussion follows on how providing a recovery-based and trauma-informed culture with the use of peer support services is essential to providing effective and healing treatment for mental illness. This discussion sets the context for workforce needs and training for state psychiatric hospital personnel.

The last and most critical section of this technical report provides the specific recommendations made by the expert panel members.

As a result of the growth of the consumer/family movements along with the advancement of the concepts of recovery, individuals served by state psychiatric hospital systems have evolved a number of terms that they prefer are utilized to identify their roles including service recipients, users of services, individuals receiving mental health treatment, inmates and others. Certain terms provide legal and statutory rights to individuals receiving treatment based on federal, state and local laws in combination with accreditation standards and a variety of court decisions. "Service recipients" is the term that we shall use in this report to represent the variety of ways that individuals may choose to be identified and to accommodate the variety of legal terms that may impart rights and responsibilities or protections for those served.

History and Current Context of State Psychiatric Hospitals

When looking at the current and future role of state psychiatric hospitals, it is important to have a brief understanding of the history and context of the mental health system in the U.S. to know how and why state hospitals function as they currently do and to identify lessons learned.

State psychiatric hospitals were originally established as a reform in the care of persons with mental illnesses. In colonial times, persons who were considered "demented" were placed in a local jail or almshouse if no relative or neighbor would care for them. With little oversight and funding, this way of care became environments of widespread abuse. In the 1840s, Dorothea Dix, a schoolteacher from Cambridge, Massachusetts, led a movement to establish a national policy for caring for persons with mental illness and for federal lands to be set aside across the country dedicated to asylums as outlined in the "12,225,000 Acre Bill." The movement emphasized the need for humane care based on compassion and "moral treatment," rather than ridding the person of demonic possession through corporal punishment. Care would be provided in asylums rather than housing people in jails, poorhouses, or having them live on the streets.[1][2]

Although this legislation passed Congress in 1854, President Franklin Pierce vetoed the bill stating that the responsibility for care of persons with mental illness should be placed on the states, not the federal government.[3] States were left to rely on state tax dollars to fund these facilities. Despite this veto, Dix's advocacy led to the establishment of 32 psychiatric hospitals in 18 states. The implications of this veto and placement of this responsibility on states have had lasting fiscal and philosophical effects to this day.

With significant increases in immigration in the second half of the 19th century and the ability of families and communities to obtain care for people with mental illness through these state supported asylums, these initially small therapeutically-based facilities became large public hospitals that housed a mix of individuals, some of whom had mental illness and others that needed long term care support but who did not necessarily have a mental illness.[4][5] Over the years, many state psychiatric hospital roles and missions changed to provide a variety of supports related to the most pressing issues and epidemics of the day, including serving as military hospitals during the Civil War; a place to quarantine and treat people with tuberculosis; and as hospitals for World War I and World War II veterans suffering from what is now known as Post Traumatic Stress Disorder (PTSD).

The quality of care, once conceived as reform, deteriorated over time. Concepts of "curability" began to be replaced by concepts of "incurability" leading to long and even lifetime lengths of stay.[6]

During the first half of the 20th century, state psychiatric hospitals became the primary mental health system in the U.S. with over 550,000 people residing in state psychiatric hospitals by

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[1] (Sharfstein, 2000)
[2] (Hunter, 1999)
[3] (Foley & Sharfstein, 1983)
[4] (Sharfstein, 2000)
[5] (Fisher, Geller, & Pandiani, 2009)
[6] (Sharfstein, 2000)

1955.[7] [8] Many state psychiatric hospitals existed in rural locations and were run as self-sustaining communities, including their own farms and factories. Service recipients in the hospital worked in the factories, laundry facilities, farms and other entities that contributed to the daily functions of the hospital.[9]

High numbers of World War II veterans suffering "battle fatigue" raised federal concerns for mental health policy which led to President Truman signing the National Mental Health Act in 1946 and the creation in 1949 of the National Institute for Mental Health. New treatments emerged midcentury, with antipsychotic medications being provided to state hospital service recipients. [10]

In 1954 Congress passed and President Eisenhower signed in 1956 Title II of the Social Security Disability Insurance Program (SSDI).[11] Over the next two decades, Title XVIII, Medicare; Title XIX, Medicaid; and Title XVI, the Supplemental Security Income Program (SSI) passed. These programs gave health insurance and funding support to people with disabilities, including people with a severe mental illness.

When the federal government established the Medicaid program in 1965, Congress underscored that the costs for state and local psychiatric hospitals should not be funded using the new Medicaid funding. As a result, Congress created the Institution for Mental Disease (IMD) Exclusion rule. This rule continues to exclude state psychiatric hospitals, and any hospital in which more than 50% of the beds are occupied by service recipients with a primary diagnosis of mental disorder, from reimbursement for care provided to Medicaid beneficiaries between the ages of 21 and 64. An "institution for mental disease" is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services."[12] Marginalized in federal reimbursement and regulatory structures, state psychiatric hospitals continued to depend predominantly on state funding.

During the mid-20th century, several reports and studies exposed poor conditions in the state psychiatric hospitals.[13] Conscientious objectors who served as attendants at state mental institutions in twenty states during World War II worked to expose the abusive conditions they discovered at these facilities. Their series of exposes initiated a reform movement that included the establishment of the National Mental Health Foundation, which soon found sponsors in Eleanor Roosevelt, Pearl Buck, and other prominent American leaders, and became the early impetus in the push for deinstitutionalization.

Calls for reforms combined with the initiation of chlorpromazine (Thorazine) in the U.S., enabled many people to be treated outside of the state psychiatric hospital. Policies began to support state and federal reforms towards community services outlined in the Community Mental

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[7] (Fisher, Geller, & Pandiani, 2009)
[8] (Scharfstein, 2000)
[9] (Winer, 2012)
[10] (Foley & Sharfstein, 1983)
[11] (Sharfstein, 2000)
[12] TITLE 42—THE PUBLIC HEALTH AND WELFARE
[13] (Hunter, 1999)

Health Centers (CMHC) Act of 1963.[14] [15] While several factors contributed to the downsizing of state psychiatric hospitals, this legislation championed by President John F. Kennedy, ushered in the era of community mental health services and the end of the state psychiatric hospital as the core of the mental health care system in the United States.

The CMHC Act included the first direct federal funding commitment in almost 100 years, and provided seed grants to local communities across the nation to develop community based services, many of which supported individuals previously confined to state hospitals as their only care option.[16] Over several years, the funding would decline; the federal government expected alternative funds, such as third party payments, to eventually replace the grant funding.

However, over the next decade, the funding for CMHCs competed with budget constraints created by the Vietnam War and urgent health related and non-health related domestic programs.[17] [18] Furthermore, Congress passed legislation in 1978 that broadened the scope of CMHCs to serve new groups, including people with substance use disorders, children, and older persons. With this broader scope, CMHCs often chose to use funding to serve a higher proportion of people with less severe impairment, leaving people with severe mental illness less opportunity for community options.

Need for further reform of mental health care gained political attention during the Jimmy Carter presidency in 1980, with the creation of the first President's Commission on Mental Health and the passage of the Mental Health Systems Act, which emphasized programs for people with serious mental illness through the CMHCs.[19] The Reagan presidency repealed the Act in 1981. Through separate legislation, Congress cut federal mental health funding significantly and converted the CMHC funding into a block grant for the states. Congress intended the block grant to provide each state with a flexible source of federal funding to design community mental health programs according to their local needs.[20]

States began to work around historical limitations in Medicaid financing for mental health care in earnest in the late 1970s and 1980s, developing small inpatient psychiatric units in general hospitals that were not IMDs and expanding coverage for outpatient, case management and day treatment services.[21] Development of general hospital units in many states was by design a replacement for acute care functions at state hospitals. Because of the application of the IMD exclusion to most free standing private psychiatric hospitals, the use of general hospitals grew as alternatives to state psychiatric hospitals, leaving state psychiatric hospitals, in most states, to provide intermediate and long term inpatient care. In addition, as a result of the IMD exclusion rule, many states shifted care for older persons with serious mental illness to nursing homes, which could utilize a larger amount of federal funding for people over 65.[22]

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[14] (Foley & Sharfstein, 1983)
[15] (Sharfstein, 2000)
[16] (Frank & Glied, 2006)
[17] (Sharfstein, 2000)
[18] (Frank & Glied, 2006)
[19] (Mechanic, 2007)
[20] (Frank & Glied, 2006)
[21] (Sharfstein & Dickerson, 2009)
[22] (Frank & Glied, 2006)

When originally enacted in 1965 the IMD exclusion applied to everyone except persons over 65 years old in any facility, which was more than half the people in state psychiatric hospitals that were there because of reasons other than mental illness. In 1971 the Intermediate Care Facilities for Mental Retardation (ICF-MR) program was created effectively exempting persons with mental retardation from the IMD exclusion leading to significant and continuing declines in the numbers of persons with mental retardation in state psychiatric hospitals.

In 1972 persons under age 21 were exempted from the IMD exclusion leading to an increase in free standing psychiatric hospitals operating child and adolescent units. In 1988, institutions with 16 or fewer beds also became exempted from the IMD exclusion leading to an increase in very small residential treatment programs and psychiatric hospitals.

In 2010 the Affordable Care Act authorized the Centers for Medicare and Medicaid (CMS) to fund a 3-year demonstration project under which selected non-government inpatient psychiatric hospitals could be exempted from the IMD exclusion for psychiatric emergencies provided to Medicaid enrollees aged 21 to 64 who have an acute need for treatment. This legislation further mandated an evaluation including a recommendation regarding whether the demonstration should be continued after December 31, 2013 and expanded on a national basis. The required evaluation submitted to Congress December 2013 concluded, "Due to the timing of the implementation of the demonstration and the time required to plan and conduct the evaluation, we do not have enough data to recommend expanding the demonstration at this time; given the limited data, however, we recommend that the demonstration continue through the end of the current authorization, December 31, 2015, to allow a fuller evaluation of its effects." Such an extension will require new legislation.

States began experimenting with Medicaid waivers to fund other home and community based services as a more cost efficient alternative to institutionally-based care. As reliance on Medicaid grew, states' interest in managed care led to implementation of carve-out contracts to manage Medicaid funded services, in some cases with explicit performance measures to decrease utilization of state psychiatric hospitals.[23] Further, to reduce costs, states recognized that other professionals could appropriately implement some interventions historically implemented only by psychiatrists.

The decline of psychiatric beds in state and county mental hospitals resulted from the promotion of deinstitutionalization and the ability for states to shift the economic challenges to federal sources.[24] Despite inconsistent and shifting federal policy, many states have worked to build community based treatment and recovery support systems. However, in many states, this growth has been insufficient to accommodate the level of community alternatives needed.

Increased use of emergency departments for acute psychiatric crises, shortfalls in funding for community-based services, and service fragmentation led to significant numbers of individuals with serious mental illnesses ending up chronically homeless or incarcerated.[25] [26] Homelessness among persons with serious mental illness has become increasingly prevalent since the 1980s

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[23] (Mechanic, 2007)
[24] (Sharfstein & Dickerson, 2009)
[25] (Sharfstein & Dickerson, 2009)
[26] (Kuno, Rothbard, Averyt, & Culhane, 2000)

and was cited as a significant consequence to the gaps in policy shift from institutional to community care. Studies indicate that persons with serious mental illness are ten to twenty times more likely than the general population to be at risk for homelessness.[27] In their 2009 study, Steadman et al. found rates of current serious mental illness for recently booked jail inmates were 14.5% for men and 31.0% for women across the jails and study phases. These percentages reinforce that the prevalence of inmates entering jails with serious mental illnesses is substantial.[28]

Important developments in mental health occurred during 1980's and 1990's, including the growth and impact of the self-advocacy service recipient movement.[29] This critical movement in social justice began with the establishment of self-help groups and expanded in the 1990's towards organized advocacy, peer-services, and roles and services within state and in federal initiatives.[30] The 1999 Surgeon General's Report on Mental Health and the 2003 President's New Freedom Commission Report on Mental Health sought service recipient input and found that, "nearly every consumer of mental health services...expressed the need to fully participate in his or her plan for recovery. Service recipients and families told the Commission that having hope and the opportunity to regain control of their lives were vital…"[31]

In most recent history, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) reflects reduced discrimination against people with mental illness with the understanding that financial and treatment requirements for mental illness and substance use disorders can be no more restrictive than those of medical/surgical benefits. In addition, the passage of the Affordable Care Act of 2010 may expand access to mental health services. However, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 does not include state psychiatric hospitals and community mental health centers as eligible for the Electronic Health Records (EHRs) stimulus payments general hospitals can receive.

Promising Developments in Mental Health Treatment, Policy, and Philosophy

Many promising developments have emerged in the 21st century. Psychiatric treatment has become highly specific by diagnostic or age groups, enabling treatment to be individualized with more emphasis on choice.[32] Service recipients and family members have become more informed and involved in decision making. The concept of recovery has become more infused philosophically into care and increases in peer support services have contributed to the recovery process of people with serious mental illness. Evidence-based practices have emerged and treatments continually improve. The U.S. Supreme Court *Olmstead* decision and the American Disabilities Act have also been important developments that underscore people living and being treated in the community wherever possible and at a fraction of state psychiatric hospital costs.

The recognition that mental health is integral to overall well-being has begun to drive the integration of mental health, addictions, and primary health care with an increased focus on

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[27] (Susser, Valencia, Conovor, Felix, Tsai, & Wyatt, 1997)
[28] (Steadman, C., Robbins, Case, & Samuels, 2009)
[29] (Mechanic, 2007)
[30] (Allen, Parks, & Radke, 2010)
[31] (Allen, Parks, & Radke, 2010)
[32] (Sharfstein & Dickerson, 2009)

overall health and wellness for people with mental illness. Further, harmful practices, including the use of seclusion and restraint, are being reduced and facilities are held accountable for these practices. In *Better But Not Well*, Frank and Glied attribute improvements in the care for mental illness to people with mental illness being able to receive disability income and housing supports, greater service recipient choice, newer medications that are easier to tolerate and prescribe appropriately, and more people with serious mental illness being treated by primary care physicians with medication.[33]

Data and Trends

State Mental Health Agency Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY'81 to FY'12
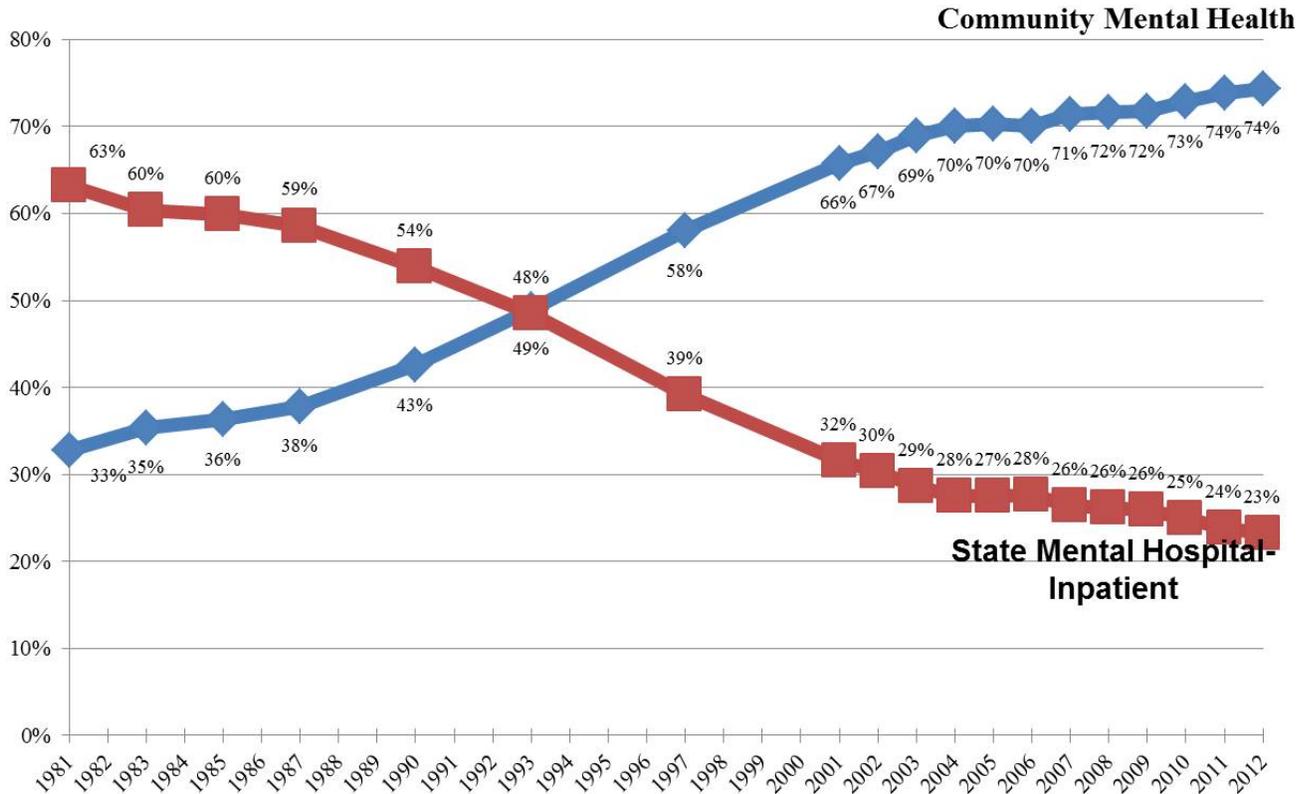
Source: NRI 2012 State MH Agency Revenues and Expenditures Study

NASMHPD and the NASMHPD Research Institute, Inc., (NRI) have documented a historic shift in the focus of state government expenditures for mental health services. In state fiscal year 1981, almost two thirds of State Mental Health Authority (SMHA) expenditures for mental

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[33] (Frank & Glied, 2006)

health were devoted to state psychiatric hospital inpatient services. As SMHAs built up their community mental health systems during the 1980s and beyond, the share of SMHA resources devoted to state psychiatric hospitals declined. In FY 2012, 23 percent of SMHA resources are now devoted to state psychiatric hospital inpatient services, while 74 percent are going towards community-based mental health services.

While state psychiatric hospital inpatient expenditures have declined as a percent of total SMHA expenditures, this decline is largely due to a major increase in SMHA expenditures for community mental health (an increase from $2.0 billion in FY 1981 to $29.4 billion in FY 2012 – 9 percent per year annual increase). Expenditures for state psychiatric hospitals have increased, just not nearly as fast as the increase in community mental health expenditures (state hospital expenditures increased from $3.9 billion in FY 1981 to $9.1 billion in FY 2012, an average annualized increase of 2.8 percent in expenditures per year).

Number of State Psychiatric Hospitals and Resident Patients at End of Year: 1950 to 2012
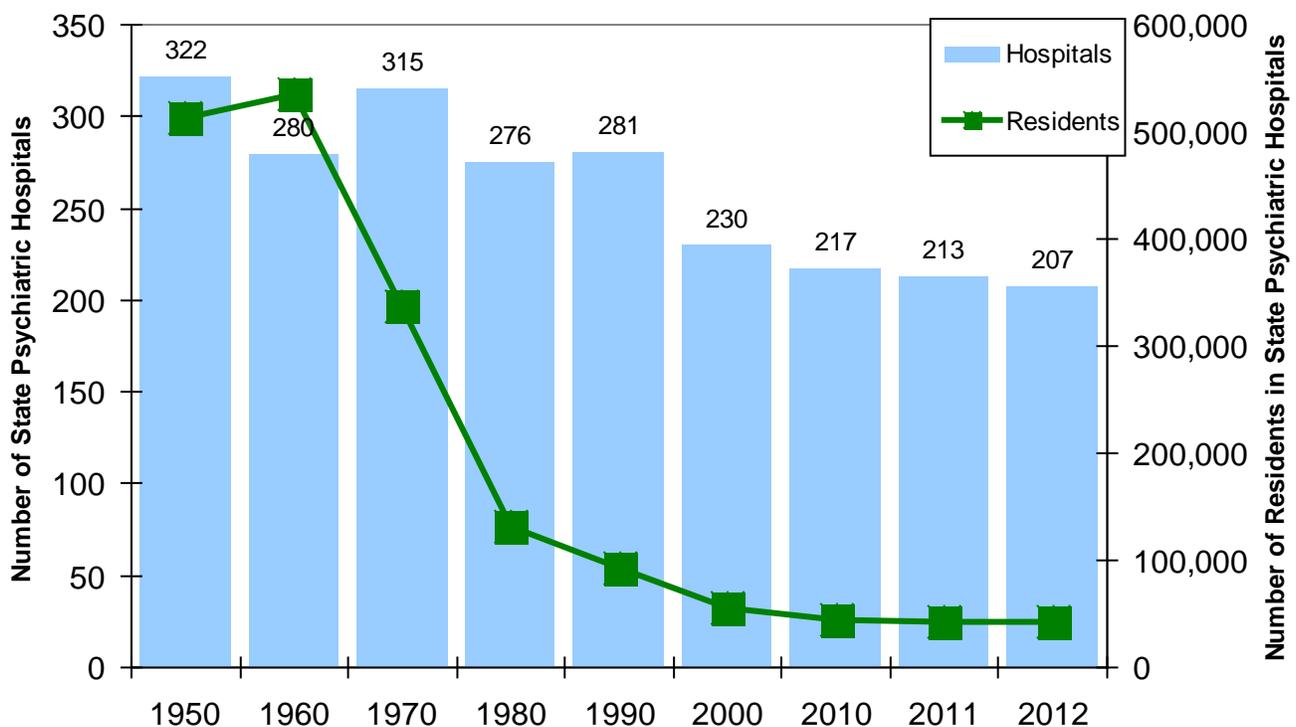
Sources: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States, 2002, and NRI 2013 State MH Agency Profiles System

In the 1950s, state psychiatric hospitals were the major source of public mental health services and on any day over 500,000 persons were residents in over 300 state psychiatric hospitals. Due to deinstitutionalization and the development of comprehensive community mental health

systems, the number of residents in state psychiatric hospitals has declined by 92 percent from 1950 to 2012. During this same 62 year period, the number of state psychiatric hospitals has declined by 36 percent.

None	(1)
1 SPH	(14)
2 SPHs	(9)
3 SPHs	(7)
4 to 5 SPHs	(9)
6 to 9	(7)
10 or More	(4)
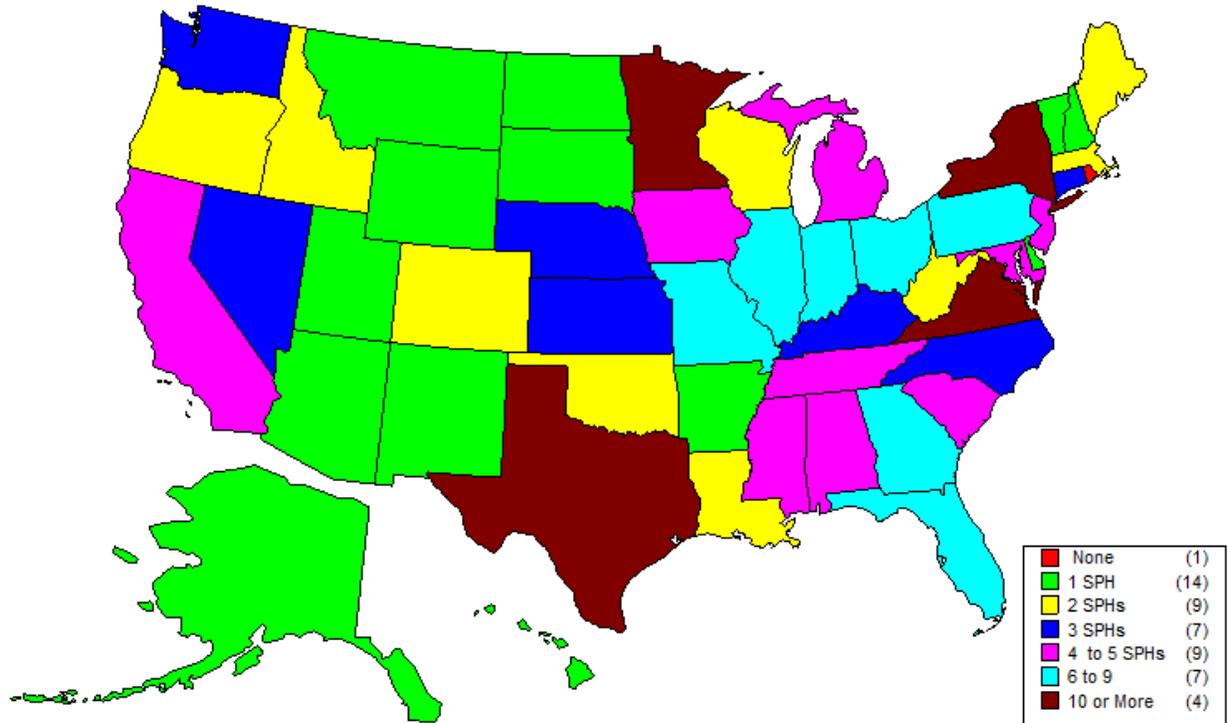
Source: NRI 2013 State Mental Health Agency Profiling System

The number of state psychiatric hospitals has not dropped nearly as much as the population in state hospitals, therefore the average size of state psychiatric hospitals has declined. In the 1950s, there were state psychiatric hospitals with thousands of service recipients (Central State Hospital in Milledgeville, Georgia may have been the largest with over 11,000 service recipients), while today the average state psychiatric hospital has about 200 service recipients on any given day. However, most of the closures of entire state psychiatric hospitals have occurred in states with multiple state hospitals. The map above shows that 14 states have only one state psychiatric hospital and 9 additional states have only 2 state hospitals, making it unlikely that those states will close a psychiatric hospital. (Note: Rhode Island does have state operated psychiatric inpatient beds; they are now located within a state operated general hospital and Vermont State Hospital was temporarily closed in 2011 and 2012 due to flooding from Tropical Storm Irene.)

**Closing State Psychiatric Hospitals
& Hospital Beds (2009-2012)**

	SMHA Has Closed	SMHA is Considering Closing	Total Closed or Considered for Closure
State Psychiatric Hospitals	8 States 9 State Hospitals	4 States 6 State Hospitals	12 States 15 State Hospitals
State Hospital Beds	29 States 3,222 Beds	10 States 1,249 Beds	4,471Beds*

* 4,471beds represents over 9% of State Psychiatric Hospital Bed Capacity

Source: 2012 NRI/NASMHPD Survey on the Impact of State Budget Shortages on SMHA Systems

The recession that started in 2008 resulted in the largest reduction in state government revenues since the Great Depression of the 1930s. As a result of the reduction in state government revenues, state mental health agencies in almost every state were forced to make multiple budget reductions that resulted in reduced mental health services. Collectively, SMHAs experienced budget reductions totaling over $4.4 billion between 2008 and 2013. Many states decided to focus their mental health budget reductions on their state psychiatric hospital services in order to protect community-based services. This decision making resulted in another wave of state psychiatric hospital bed closures in 29 states and the closure of entire state hospitals in 15 states. A total of over nine percent of state hospital beds were closed or scheduled for closure during this time of acute state budget shortages.

How States Use State Psychiatric Hospitals

States vary in the way they use their psychiatric hospitals by service population. As the following table shows, the most common service populations are the adult, elderly, and forensic populations. Some state psychiatric hospitals are dedicated to forensic service recipients while others include a mix of these service populations. Far fewer States use their hospitals to care for children and adolescents. There is a great deal less variability in the use of state hospitals for acute care (less than 30 days), intermediate care (30 to 90 days), and long-term care (more than 90 days); intermediate care is the most common, followed closely by long-term and then short-term care. Most individuals in need of shorter-term, acute care are now served in local general hospitals.

**Number of States with State Psychiatric Hospitals Providing Specific Inpatient Services
By Age and Targeted Length of Inpatient Service**

Target Population	Acute Care (less than 30 days)	Intermediate Care (30–90 days)	Long-Term Care (more than 90 days)
Children	15	13	11
Adolescents	20	20	16
Adults	42	44	42
Elderly	36	39	39
Forensic	34	41	41

Source: NRI 2013 State Mental Health Agency Profiling System

At the beginning of 2012, there were 40,305 service recipients residing in state psychiatric hospitals across the country. States varied in the number of total service recipients they had, ranging from a high of 6,016 in California to a low of 50 in Vermont. On average, states had 13.6 service recipients per 100,000 population ranging from a low of 3.7 service recipients per 100,000 population in Arizona to a high of 46 service recipients per 100,000 population in the District of Columbia.

Use of Public General and Local Hospitals

Seventeen states require that public general and local hospitals be used as an initial admission site for psychiatric inpatient treatment before an individual uses state psychiatric hospital facilities. For example, in the District of Columbia, acute involuntary admissions are authorized by the State Mental Health Authority and routed to one of four general hospitals. On the 15th day of hospitalization, if needed, the person is transferred to the state psychiatric hospital. In Oregon, individuals are admitted to acute care hospitals to rule out any physical health issues that may be causing their presenting symptoms. Once a physical health cause is ruled out, the individual receives a mental health assessment, and if deemed in need of long-term care, a mental health professional may request admission to Oregon State Hospital. In Washington, individuals must spend at least 14 days in a community hospital prior to admission to a state psychiatric hospital.

SMHA-Controlled Forensic and Sex Offender Mental Health Expenditures As a Percentage of State Psychiatric Hospital Expenditures, FY'83 to FY'12

Source: NRI 2012 State MH Agency Revenues and Expenditures Study
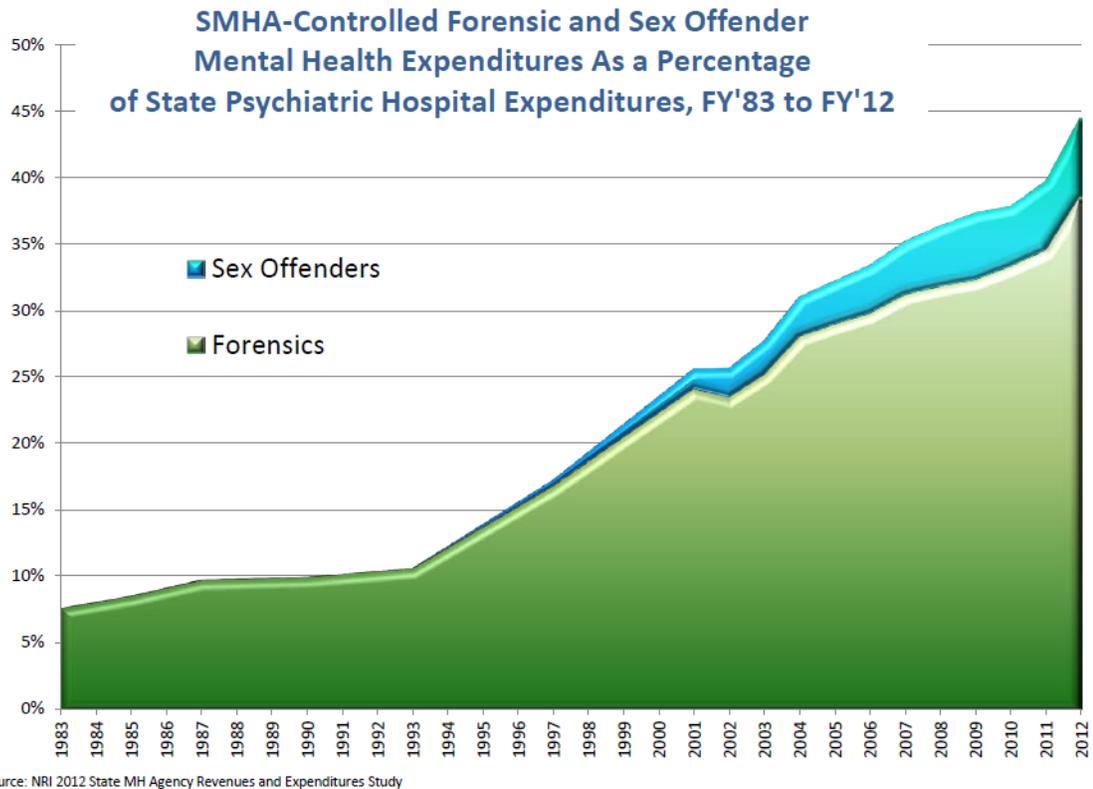
As states have downsized their state psychiatric hospitals, two types of involuntary treatment clients (forensic clients and sex offenders committed to the state hospital) have grown as a share of the clients served by state psychiatric hospitals. In FY 1983 state psychiatric hospitals expended 7.6 percent of their funds on forensic services. By FY 2012, the share of state psychiatric hospital expenditures for forensic clients has grown to 36 percent with an additional 4.7 percent for persons committed to state psychiatric hospitals under a sex offender commitment statute. In a few states, over 90 percent of the state psychiatric hospital expenditures are devoted to the treatment of persons with a forensic or sex offender commitment. [34]

How Admission Decisions to State Psychiatric Hospitals Are Made

The uninsured, the most ill, and people found not guilty by reason of insanity or incompetent to proceed are treated in state psychiatric hospitals. People admitted into state psychiatric hospitals can be there voluntarily or civilly committed, or committed by a criminal court. Civil commitment refers to state-sanctioned, involuntary hospitalization of individuals with mental illness who are believed to require treatment because of self-harming or dangerous behaviors. Every state has a civil commitment statute. These statutes all require that an individual be

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[34] (NASMHPD Research Institute, 2012)

judged dangerous to self or others as a result of a mental disorder, though the definitions of *dangerous* and *mental disorder* vary across states. In addition, almost all states permit commitment of individuals who are *gravely disabled* (i.e. unable to care for their basic needs, either explicitly or as part of the *danger-to-self* aspect). In most states, commitment to a hospital is not permitted if a less restrictive alternative exists. Involuntary outpatient commitment (IOC) refers to court-ordered, community based mental health treatment.[35]

People under forensic commitments for serious crimes committed as a result of mental illness generally come from jail or prisons after they have gone to court. They usually spend an inordinate amount of time incarcerated in jails without treatment before they go to court and often get much worse clinically.[36] Once they enter the state psychiatric hospitals, lengths of stay can vary from a few months to a lifetime. Unlike other psychiatric hospitals where a significant portion of their service recipients are voluntary, state psychiatric hospitals that serve people in forensic settings are not able to make admission or discharge decisions independently. For forensic service recipients, sex offenders, and in many states involuntarily committed service recipients, these decisions are made by courts and not by the hospital.

Further, some states have separate Boards that make formal recommendations to the Court regarding whether or not to discharge someone that has been forensically involved. In spite of this decision making by courts, a state psychiatric hospital must stay within its licensed and staffed bed capacity or risk losing CMS certification, Joint Commission accreditation, and federal funding. State courts do not always base their decisions regarding admission and discharge on the medical necessity of continuing psychiatric hospitalization for persons that have been committed to this level of care. In many states, courts refuse to discharge individuals who have been deemed clinically stable after months or years of treatment and also may admit individuals who could get treatment in the community.

Meeting experts reported that states have various approaches to addressing people who are forensically involved and may or may not have recovery principles infused into services provided. For example, California has a high number of people who are forensically involved whereas other states reported that they historically had served fewer people who were forensically involved but recognized a growing increase in this population. Some other states integrate recovery principles into the treatment of this population and prepare people for a return to the community when clinically appropriate. The meeting experts emphasized that all people served in state psychiatric hospitals should <u>be considered in the process of recovery</u>. Every individual who is committed to a state psychiatric hospital, forensic or otherwise, needs to be evaluated as an individual in terms of inpatient goals, risks, benefits, and to determine if this same treatment could be safely provided in community settings.

Meeting experts observed that the overall population in state psychiatric hospitals has become more mixed to include people with mental illness, people with criminal behavior driven by mental illness, and people with criminal and predatory behavior with no mental illness. While all service recipients and staff should have their safety needs met, meeting experts underscored that the majority of people with mental illness are not violent and are often vulnerable. As a

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[35] (Wells, NASMHPD, & CSG, 2010)
[36] Some states such as New York provide mental health services within jails and prisons, which is the exception.

result, this vulnerable population should not be served in the same locations as people with criminal or predatory behavior who have no mental illness or solely a personality disorder. State courts should be encouraged to use state psychiatric hospital forensic staff to conduct evaluations on people that present with histories of criminal involvement to determine whether the causal factors for their behavior is a mental illness and/or substance use disorder. If this evaluation is conducted, the state courts need to respect these decisions and act to discharge persons found to not have a mental illness or co-occurring substance use disorder and these individuals need to be removed and placed back into prison to enable state psychiatric hospitals to continue to provide services for people who have a condition to treat.

People with mental illness

People with criminal behavior
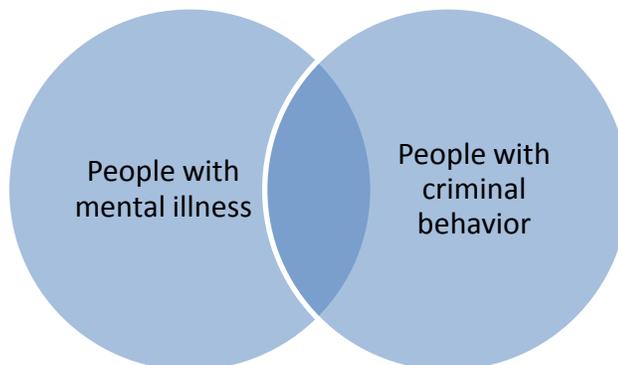
Service recipients should be provided treatment in the most integrated and least restrictive environment. However, if appropriate, service recipients who are at risk of harm to self or others should be provided a continuum of treatment security to address their safety needs. Once safety needs are met, a less restrictive environment should be explored when appropriate.

It is the duty of the state psychiatric hospital to make reasonable efforts to create environments in which service recipients and staff are as safe as possible. One way to address this safety is to create high security units for service recipients who are at high risk for aggression and violence, ensuring that building structures have clear sight lines, cameras, and adequate staffing. Addressing wellness in the treatment milieu and assisting service recipients in developing an internal locus of control related to decision making, symptoms, and behaviors has been also shown to be useful aspects in creating safety. It is important to note that a service recipient's perspective on safety may be very different from staff's and the courts. This perspective is critically important to the recovery process and addressing safety needs should be trauma-informed.

The Impact of *Olmstead*

The 1999 United States Supreme Court *Olmstead* decision reaffirmed the civil rights granted in the American Disabilities Act (ADA) of 1990 and the Civil Rights of Institutionalized Persons Act (CRIPA) of 1980 of people with disabilities to live in the least restrictive, most integrated settings possible. The *Olmstead* decision has prompted new efforts by states to end the unnecessary segregation of individuals with serious mental illness and other disabilities, and requires states to affirmatively plan and implement systems that prevent unnecessary institutionalization.

Olmstead is being applied across the country to individuals who may no longer need institutional settings (such as state psychiatric hospitals or nursing homes), those who may be at-risk of institutional placement (e.g. people who are homeless or those who have had their services significantly cut) as well as individuals in community settings that are considered segregated (e.g. large congregate residential settings, sheltered workshops).

Many states have developed and are implementing community-based services and supported housing options, stronger hospital diversion programs, and more effective inpatient treatment and discharge practices to service people with mental illness and other disabilities in integrated settings.

Several states have been investigated by the U.S. Department of Justice (DOJ) and various state Protection and Advocacy (P&A) groups for violating standards promulgated under *Olmstead* resulting in several settlement agreements designed to serve people in integrated settings. In some states, the investigations initially began as CRIPA investigations about the quality of care in state psychiatric hospitals, but progressed to broader system issues that were the causing the unnecessary institutionalization of individuals. The combination of states with established *Olmstead* Plans and those with settlement agreements have led to the expansion of community-based services and integrated supported housing options.

From the state psychiatric hospital perspective, *Olmstead* is aimed to help individuals to transition and live successfully in the community with the appropriate services and support systems. It emphasizes that if a person should need hospital care for disabilities, including people with mental illness, care should be provided in the *least restrictive*, most integrated setting possible within the hospital setting. Further, a person who is discharged from a state psychiatric hospital should be given the opportunity to move to the most integrated setting with community supports available. However, it should not be presumed that a "step down" to a 24-hour supervised residential program is the most appropriate; many individuals with serious mental illness discharged from state psychiatric hospital settings can succeed in more integrated living arrangements with support (e.g. Assertive Community Treatment or other flexible, intensive in-home support).

For continuity of care, state psychiatric hospitals, along with the service recipient and his or her family, have an important role in helping to define what services and community supports the service recipient needs. Such supports could include permanent supportive housing, which allow community support wrap around services.

Every State Mental Health Authority should have a strong *Olmstead* plan that also includes the role of state psychiatric hospitals. In systems where implementing standards promulgated under *Olmstead* results in less state psychiatric hospital usage, funding must be redirected to support the strengthening of the community system infrastructure.

Financing

As previously noted, from FY 2010 through FY 2013, states were forced to cut mental health care funding $4.4 billion. As a consequence, states eliminated nearly 4,500 inpatient psychiatric hospital beds and closed down many community mental health centers.[37]   The Agency for Healthcare Research and Quality (AHRQ) found that, during the same four-year period, emergency room use by individuals whose primary diagnosis was a mental illness or substance use disorder surged by 28 percent, with more than 6.4 million emergency room visits in 2010 alone.

Disproportionate Share Medicaid Revenues for Care Provided at State Psychiatric Hospitals: FY 2012
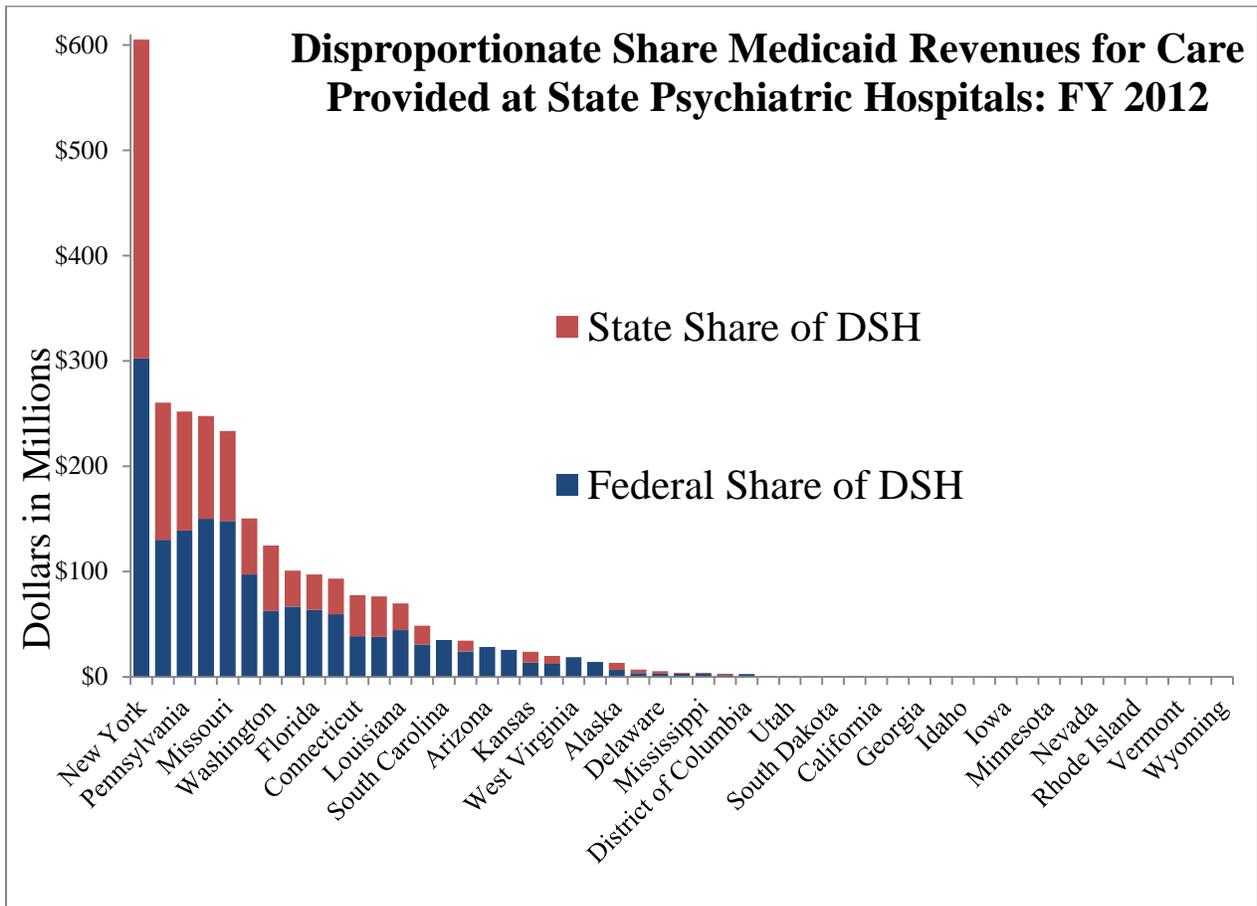
Source: NRI 2012 State MH Agency Revenues and Expenditures Study

Some states generate substantial amount of revenues for services provided by state psychiatric hospitals under the Medicaid Disproportionate Share Hospital (DSH) provisions. Under Medicaid law, State Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. However, while some states have chosen to use DSH funds for state psychiatric hospitals, many other states are not using DSH funds for this purpose. In state FY 2012, there were eight states that received over $100 million in DSH payments for care provided by state psychiatric hospitals.

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[37] (NRI, 2012)

Under the Affordable Care Act (ACA) as amended by the Bipartisan Budget Act of 2013, federal Medicaid DSH payments to hospitals to offset the hospital costs of the uninsured will be reduced beginning October 1, 2015 (Federal Fiscal Year 2016) and continue to be reduced through FFY2023. Those DSH reductions were originally included in the ACA due to the expectation that the enhanced federal funding for what was then a mandated Medicaid expansion would more than offset the loss of the DSH funding. However, in the states that have chosen, under the Supreme Court decision making Medicaid expansion optional, not to adopt Medicaid expansion, the states will be incurring the DSH funding loss without the benefit of the enhanced Medicaid funding.

While states that choose to expand Medicaid could not use those expansion dollars directly for state psychiatric hospitals because they are IMDs, they could use the expansion dollars for people in community services, including community hospitals that are not IMDs. Theoretically, state funds could then be utilized to go towards state psychiatric hospitals, potentially replacing the lost DSH dollars.

The states that choose not to expand Medicaid would not have this federal funding available and hence would have to use state funds to cover the lost DSH funding. If there were not enough state funds to cover the lost DSH dollars, states may need to close beds and/or reduce community service funding, including reducing the number of beds in psychiatric units located in community hospitals to offset for the loss of federal revenue.

States that do not expand Medicaid are also likely to experience a greater loss of psychiatric beds in general hospitals than non-psychiatric beds. General hospital psychiatric units have a significantly higher portion of uninsured persons in their payer mix than other units. When general hospitals get DSH reductions they are more likely to close units with a higher portion of uninsured persons (psychiatric units) to balance their reduced budgets. Loss of general hospital psychiatric beds will increase demands on state psychiatric hospitals.

State Psychiatric Hospitals Are a Vital Part of the Continuum of Recovery Services

State psychiatric hospitals are a vital part of the continuum of recovery services, providing a treatment component in the healthcare system to assess, evaluate, and treat people with the most complex psychiatric conditions who are at risk of harm to self or others and cannot be effectively treated by existing available services in the community. Only those persons who cannot be safely and effectively treated in another setting should be considered appropriate for state psychiatric hospital admission.

Treatment, stabilization, community re-integration, and public safety are the goals of state psychiatric hospitals. State psychiatric hospitals should be recovery-oriented, trauma-informed, and should be constantly seeking, developing, and implementing evidence-based practice and promising practice treatment approaches for service recipients with complex psychiatric conditions who are at risk of harm to self or others and cannot be effectively treated by existing available services in the community.

This technical report is not intended as advocacy for increased inpatient services or more psychiatric hospital beds but instead advocacy for the state psychiatric hospital to be *integrated with* a continuum of a robust set of community services. Debate continues on whether people with serious mental illness could and should be treated only through community services if a robust set of coordinated community services and support existed. While a robust set of community supports are essential to a strong public mental health system and many can avoid hospitalization with this level of community support, many people with serious mental illness will also need services that are provided only through the expertise of state psychiatric hospitals.

Throughout history, state psychiatric hospitals have been the places to care for people whose behavior has been so socially unacceptable and/or dangerous that their communities at the time could not tolerate their presence and no other treatment entity was willing and able to work with them. Various illnesses that we now know how to address, such as epilepsy and advanced symptoms of syphilis, populated state psychiatric hospitals in the past. Until there were solutions for these seemingly insurmountable challenges, the role of state psychiatric hospitals was to provide a place for health and safety. Once solutions were found, the people with these complex conditions lived successfully in their own communities.

Today, state psychiatric hospitals should continue this role of providing a place for health and safety in addition to serving clinical, fiscal, social, and legal roles. State psychiatric hospitals are a center of excellence for training of the public health care system in treatment of people with complex conditions that may be a risk of harm to self or others. Diagnostic assessment is a strength of state psychiatric hospitals and can be a resource and increase the skills of the whole system.

State psychiatric hospitals also evaluate court referrals. Further, state psychiatric hospitals often incur the fiscal responsibility of people with complex and expensive medical conditions when jails, prisons, the court system, and corrections transfer people to the state psychiatric hospital. In this manner, state psychiatric hospitals serve as a form of reinsurance for the rest of the healthcare system with respect to high cost and long stay service recipients.

Additionally, state psychiatric personnel have expertise that can be shared with community providers related to serving individuals with complex conditions. As such, state psychiatric hospitals should play a vital role on one end of the continuum in supporting the recovery process of people with serious mental illness by stabilizing individuals in crisis and assisting to connect them quickly to a strong community support system once they no longer meet inpatient criteria.

To ensure continuity of care, state psychiatric hospital services should be *integrated with* the continuum of community services so that persons can be served in the community wherever possible and appropriate. To accomplish this linkage and integration, state mental health authorities should create a shared safety net between state psychiatric hospitals and community providers as a tool to integrate the state hospital system into the public behavioral health system.

A shared safety net is when a state implements an accessible and comprehensive continuum of care between hospital-based care and community-based care to meet a service recipient's needs. Principles of a shared safety net include being recovery-oriented; addressing wellness, including medical and behavioral health needs; clear care coordination; and shared accountability and decision making. These goals are aligned with the *Olmstead* tenants; reinvesting in community

mental health services when state psychiatric hospital savings are achieved makes sense in this context, rather than returning any freed up funds to the state general funds.[38]

As part of the safety net, state psychiatric hospitals should not refuse admissions from acute care settings and emergency departments for service recipients who meet inpatient level of care criteria if a local acute care setting is unavailable. However, service recipients who no longer meet inpatient level of care criteria should be discharged to appropriate community-based settings as soon as possible.

Conversely, community treatment providers should not refuse to serve persons being discharged from state psychiatric hospitals who are determined to need a less restrictive setting and no longer meet inpatient criteria. Persons being discharged from state psychiatric hospitals should be a priority for community service placements.

The demand for the number of inpatient beds appears to be inversely correlated to the robustness of the community mental health system. State psychiatric hospitals should not be a solution or default system for an underfunded or fragmented community system of care. State psychiatric hospitals are not a solution to increases in homelessness and incarceration. Further, poor access, fewer community services, and insufficient related supports such as housing, employment, and income do not justify an increase in community and state psychiatric hospital beds.

A state psychiatric hospital is not a person's home. State psychiatric hospitals should be focused on service recipients returning to the community quickly when they no longer meet inpatient criteria. Treatment services provided by the state psychiatric hospital should help stabilize service recipients with a focus on why they were admitted. Treatment should also augment the care of a community provider that follows and is included on the service recipient's inpatient treatment team.

State psychiatric hospital staff, in partnership with the service recipient, should work directly with community providers on a discharge plan that includes what community services would be most helpful for the service recipient. Research supports that strategies to prevent homelessness and incarceration should be considered and addressed *prior* to discharge from a state psychiatric hospital.[39] At discharge, these strategies should be implemented to ensure that there are immediate community supports in place.

For service recipients who have experienced long state psychiatric hospital lengths of stay and no longer meet inpatient criteria, transition services to support the skills needed to manage their illness, health, daily activities, and living environment should be taught in the most integrated setting possible. Life skill development activities could include preparing meals, budgeting and paying bills, doing laundry, taking public transportation, and self-care.

State psychiatric hospitals have historically been considered the place of last resort to serve those with the most complex conditions. This place of "last resort" has often required state psychiatric hospitals to fill service gaps when community resources have been scarce and when providers are not willing or able to serve someone with a complex psychiatric condition. However, the role

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[38] (Goetz & Radke, 2013)
[39] (Kuno, Rothbard, Averyt, & Culhane, 2000)

of being "last resort" can reinforce separateness and discrimination against people with serious mental illness who have been served by state psychiatric hospitals. As stated previously, it is important to have state psychiatric hospitals *integrated with* a continuum of a robust set of community services. Admission and discharge planning should be a joint effort between the service recipient, state psychiatric hospital, and community providers.

Use of Technology

To be part of the whole health system, state psychiatric hospitals will need to incorporate the latest technologies in daily operations. In particular, state psychiatric hospitals should have a fully functioning Electronic Medical Record system to share health data and medication data with other health providers. In addition, state psychiatric hospitals should use telemedicine for specialty consultation, and consider using standardized computer based assessments of function, including cognitive, substance use, and other common co-occurring issues. These technologies allow for the level of integration necessary to participate as part of the larger healthcare system. They also allow the clinical expertise of state psychiatric hospital personnel to be accessed when dealing with extremely complex clinical presentations in the community, potentially avoiding hospitalization for the service recipient.

The Environment and Culture of State Psychiatric Hospitals

The conditions in state psychiatric hospitals and the need for humane treatment has been an underlying theme driving reform over history. Since the late 1990's, the National Association of State Mental Health Program Directors has focused national efforts on reducing coercive environments and practices to change the culture of violence that has existed in many state psychiatric hospitals. Through cultural changes, many state psychiatric hospitals have significantly changed their culture and reduced the use of seclusion and restraint.

Changing the culture and environment of state psychiatric hospitals are keys to providing effective care. The culture of state psychiatric hospitals should be recovery-oriented; trauma-informed; culturally and linguistically competent; transparent; hopeful; respectful; holistic; include peer support services; and be driven by meeting the needs of people served in state psychiatric hospitals while addressing the safety of service recipients, staff, and the community. Such cultures can create environments where service recipients heal and staff thrive.

Regardless of the reason for being admitted to the hospital or a person's behavior in the hospital, all people served in state psychiatric hospitals should be considered to be in the process of recovery. Furthermore, the focus should be to engage the person in their care and empower them to participate in making decisions about their care, with the ultimate goal of helping each person manage his or her own illness. This approach is similar to treating people with other chronic conditions, such as diabetes or congestive heart failure.

The following subsections describe the aspects of culture needed for state psychiatric hospitals to be healing environments providing effective care and treatment.

Recovery

State psychiatric hospitals and the services they provide should be recovery-based and oriented. All people in state psychiatric hospitals should be considered to be in the process of recovery. States and other stakeholders have varying definitions of recovery. In response to the need for defining this important and fundamental concept, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a working definition of "Recovery" that includes the following guiding principles:[40]

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

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[40] (del Vecchio, 2012)

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Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to

acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

Trauma-Informed Care

The majority of persons served in state psychiatric hospitals have experienced trauma and this trauma is often a major cause of their suffering. As such, state psychiatric hospitals should follow the following draft SAMHSA guidelines for Trauma-Informed Care.

Through the input of an expert panel that included trauma survivors, SAMHSA defines trauma as the following:

> *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being has propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma.

Evidence-based trauma interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, these clinical interventions did not fully address the issues. Building on lessons learned from the Women, Co-Occurring Disorders and Violence Study, the National Child Traumatic Stress Network, the National Center for Trauma-informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided play a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served.

Trauma-informed practices are policies, procedures, interventions, and interactions among clients and staff that recognize the likelihood that a person receiving services has experienced trauma or violence. Trauma-informed practices – sometimes called trauma-informed care – create healing environments that emphasize physical and emotional safety and promote the development of trusting, collaborative relationships. In a trauma-informed program, everyone, regardless of job level or specific role, is educated about trauma and its consequences. The role of peers – other people who have experienced trauma or violence – is very important in planning and implementing trauma-informed practices. The goal is to create an inviting environment of respect and safety that promotes healing and prevents the need for seclusion and restraint.[41]

SAMHSA is in the process of developing a guiding framework for implementing trauma-informed approach. The six key principles fundamental to a trauma-informed approach include:

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[41] (NCTIC, 2014)

1. *Safety*: Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. *Trustworthiness and Transparency*: Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, and among staff, and others involved in the organization.

3. *Peer Support Services:* Peer support services and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. *Collaboration and mutuality*: Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach.

5. *Empowerment, Voice, and Choice*: Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/ or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.

6. *Cultural, Historical, and Gender Issues:* The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, either directly or through referral, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Reducing Seclusion and Restraint: Six Core Strategies

Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint (6CS) is a clinical model and evidence-based practice designed for use by institutions providing mental health treatment to children and adults admitted to inpatient or residential settings.[42] The 6CS program works to change the way care is provided in these settings by focusing on the prevention of conflict and violence, the reduction in use of seclusion and restraint (S/R), the implementation of trauma-informed care principles, and the fullest possible inclusion of the client in his or her care.

These strategies were developed through extensive literature reviews and dialogues with experts who have successfully reduced the use of S/R in a variety of mental health settings for children and adults across the United States and internationally. The 6CS program is implemented at the institutional level, through the incorporation of the following six program strategies: [43]

1. ***Leadership toward Organizational Change:*** This first strategy is considered core to reducing the use of seclusion and restraint (S/R) through the consistent and continuous involvement of senior facility leadership (most specifically the State Psychiatric Hospital Administrator, Director of Nursing, and Medical Director).[44] Leadership strategies to be implemented include defining and articulating a vision, values and philosophy that expects S/R reduction; developing and implementing a targeted facility or unit based performance improvement action plan (similar to a facility "treatment plan"); and holding people accountable to that plan. This intervention includes the elevation of oversight of every S/R event by senior management that includes the daily involvement of the CEO or COO in all S/R events (24/7) in order to investigate causality (antecedents), review and revise facility policy and procedures that may instigate conflicts, monitor and improve workforce development issues and involve administration with direct care staff in this important work. The action plan developed needs to be based on a public health prevention approach and follow the principles of continuous quality improvement. The use of a multi-disciplinary performance improvement team or taskforce is recommended.

2. ***Use of Data to Inform Practice:*** This core strategy suggests that successfully reducing the use of S/R requires the collection and use of data by facilities at the individual unit level.[45] This strategy includes the collection of data to identify the facility/units' S/R use baseline; the continuous gathering of data on facility usage by unit, shift, day; individual staff member's involved in events; involved consumer demographic characteristics; the concurrent use of stat involuntary medications[46]; the tracking of injuries related to S/R events in both consumers and staff and other variables. The facility/unit is encouraged to set improvement goals and comparatively monitor use and changes over time.

3. ***Workforce Development:*** This strategy suggests the creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of

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[42] (NREPP, 2012)

[43] (Huckshorn, Kevin H., 2006)

[44] (Huckshorn, Kevin H., 2006)

[45] (Huckshorn, Kevin H., 2006)

[46] *Stat* is a medical abbreviation for urgent or rush

recovery and the characteristics of trauma-informed systems of care.[47] The purpose of this strategy is to create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense is a core primary prevention intervention.

Most events of seclusion and restraint stem from staff enforcing rules or ignoring requests that then escalate, especially if staff has not been fully trained in de-escalation strategies.[48] Conflict can often happen around issues of treatment and/or restrictions of client movement or communication with friends and family, being treated unfairly, humiliated or demeaned, not being listened to, made to wait in lines, long periods of time with nothing meaningful to do, feeling unsafe and scared with no one to talk to, and being hungry, angry, lonely, and/or tired.

Staff training, revision of rules, and empowering staff to make decisions in the moment is key.[49] This individualized approach could include allowing someone to use the phone in the middle of the night to call a friend; letting someone stay up and watch television if they cannot sleep; giving someone something to eat or drink regardless of the time of day; treating someone as an equal human being. These types of approaches need to be fully supported by leadership so that staff who truly individualize treatment responses for service recipients are not penalized for not enforcing "the rules".

It is important to attend to a person's distress and meet that distress to resolve it and be available to listen in a respectful manner.[50] Leaders and staff should take a person-centered approach and get to know the service recipients as well as possible. This relationship building assists with recovery and if someone's behavior shifts, staff can assist quickly.

4. *Use of S/R Prevention Tools:* This strategy reduces the use of S/R through the use of a variety of tools and assessments that are integrated into facility policy and procedures and each individual service recipient's recovery plan.[51] This strategy relies heavily on the concept of individualized treatment. It includes the use of assessment tools to identify risk for violence and S/R history; the use of an universal trauma assessment; tools to identify persons with high risk factors for death and injury; the use of de-escalation surveys or safety plans; the use of person-first, non-discriminatory language in speech and written documents; environmental changes to include comfort and sensory rooms; sensory modulation interventions; and other meaningful treatment activities designed to teach people emotional self-management skills.

It is important to emphasize that people who are deaf and hard of hearing have significantly higher levels of trauma than exists in hearing populations.[52] While the number of people who are deaf and hard of hearing in the public mental health system is small, these populations are especially vulnerable and have been historically underserved. Understanding and respecting the culture and unique needs of these populations in

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[47] (Huckshorn, Kevin H., 2006)
[48] (Huckshorn, 2013)
[49] (Huckshorn, 2013)
[50] (Huckshorn, 2013)
[51] (Huckshorn, Kevin H., 2006)
[52] (Tate & NASMHPD, 2012)

addition to people who are visually impaired and deaf-blind is critical to providing trauma-informed care and in reducing seclusion and restraint among these populations.[53]

5. ***Service Recipient Roles in Inpatient Settings:*** This strategy involves the full and formal inclusion of service recipients, families, and peers to assist in the reduction of seclusion and restraint.[54] It includes service recipients and advocates in event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees. It also involves the elevation of supervision of these staff members and volunteers to executive staff who recognize the difficulty inherent in these roles and who are poised to support, protect, mediate and advocate for the assimilation of these special staff members and volunteers. ADA issues are paramount here in terms of job descriptions, expectations, work hours, and an ability to communicate to staff the legitimacy of the purpose and function of these important roles.

6. ***Debriefing Techniques:*** This core strategy recognizes the usefulness of a thorough analysis of every S/R event.[55] If an adverse event occurs, there should be rigorous debriefing which is a thorough analysis of what happened and how the event can be avoided in the future.[56] Questions for debriefing can include the following: What happened? What was missed? What led up to this event? What could have been done differently? What practices precipated this event? What can be changed? This debriefing process should include peers and be used for quality improvement purposes. It is imperative that leaders and facilities identify the underlying root causes for the occurrence of conflict and violence and find ways to eliminate these issues.

To make this kind of organizational and cultural change can take several years and it requires an unremitting commitment to change an organization from one that is coercive, paternalistic, based on rules, and does not see each client as an individual human being to one that is trauma-informed, recovery-oriented, based on using evidence based practices, uses data driven decision-making, provides competency based training for staff, has stable leadership, uses peer support, provides ongoing supervision, and includes problem solving processes, including rigorous debriefing if an adverse event occurs.[57]

Safety

Courts are increasingly relying on state psychiatric hospitals to address individuals with a criminal nature who have mental health issues and also present as dangerous. A number of factors appear to be contributing to the increased number of these individuals and the severity of the violence risk they represent. However this population does not represent the population of all service recipients in state hospitals.

Recurrent violence is a major reason for court-ordered admissions to, and "refusal of proposed discharge" from, state psychiatric hospitals. While the presence of a mental illness in the absence

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[53] (NASMHPD, 2002)

[54] (Huckshorn, Kevin H., 2006)

[55] (Huckshorn, Kevin H., 2006)

[56] (Huckshorn, 2013)

[57] (Huckshorn, 2013)

of substance abuse does not increase the likelihood of violence across the population of all persons with mental illness neither does it reduce the likelihood that a person with mental illness will have a violent criminal nature independent, and not as a result of, their mental illness. It appears that the criminal justice system is increasingly relying upon state psychiatric hospitals to admit and treat persons of this nature. Courts often insist that state psychiatric hospitals continue to house/detain persons with a violent and criminal nature even after their mental illness has been successfully treated. State psychiatric hospitals are struggling to maintain safety for all persons that they serve and staff while maintaining the previously discussed principles of recovery-based care, trauma-informed care, and reduction/elimination of seclusion and restraint in a hospital environment (as opposed to jail or prison) when a portion of the persons they serve have a violent criminal nature in addition to and independent of their mental illness.

The Vital Role of Peer Support Services

The Centers for Medicare and Medicaid Services (CMS) recognizes peer support services as an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.[58] Currently, over 32 states and the District of Columbia receive Medicaid reimbursement for peer support services.[59] Research indicates that peer support specialists may have distinctive skills in communicating hope and acceptance to people receiving services in state psychiatric hospitals, leading to therapeutic connections with service recipients, including the most isolated and disengaged.[60] The research base also strongly suggests that the use of peer support services in state psychiatric hospitals and in the community shortens lengths of stays; decreases re-admissions; increases people's engagement into care; improves community linkages; reduces substance use among people with co-occurring disorders; increases overall wellness and quality of life; and can help reduce the use of emergency departments and the overall need for mental health services in the long term.[61] [62] [63] [64]

Peer support specialists have a unique role in that they establish trust with service recipients through their shared experiences. Persons served in the state psychiatric hospitals often view the information shared by peer support specialists as more credible than mental health professionals. From this understanding, a peer support specialist listens, educates, encourages and, in partnership with the service recipient, serves as a key voice in advocating for what is best for the service recipient's recovery process. Peer support specialists should be integrated as an equal member of the treatment team. It is important that a peer support specialist be given flexibility on how to navigate his or her unique role of being part of the hospital infrastructure and also a trusted advocate.

With their unique role, it is important that peer support specialists not work in isolation. State psychiatric hospitals should have a team of peer support specialists that work collectively to

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[58] (CMS, 2007)
[59] (NASMHPD, State Survey on Peer Support Services, 2014)
[60] (Sells, Davidson, Jewell, & Falzer, 2006)
[61] (Sledge, Lawless, Sells, Wiedland, O'Connell, & Davidson, 2011)
[62] (Davidson, Bellamy, Guy, & Miller, 2012)
[63] (Bouchard, Montreuil, & Gros, 2010)
[64] (Sells, Davidson, Jewell, & Falzer, 2006)

support service recipients. As referenced throughout this technical report, peer support services should be made available to all service recipients.

Health and Wellness

Research has demonstrated that people with mental illness have been dying approximately 25 years earlier than the general population because of preventable conditions, including cardiovascular disease, smoking related conditions, obesity, and health neglect.[65] Forty-four percent (44%) of all the cigarettes smoked in the United States are smoked by people with a mental illness and/or substance abuse condition.[66] Recent research suggests that half of deaths in people with a serious mental illness can be attributed to tobacco use.[67]

In 2006, NASMHPD developed a position statement and a technical report on smoking policy and treatment at state operated psychiatric facilities. In addition, NASMHPD developed a toolkit to assist states in implementing tobacco-free state operated facilities. As of 2011, almost 80% of state psychiatric hospitals have gone tobacco free. By nature, all state psychiatric hospitals should be places of health and wellness, including being tobacco free campus wide for service recipients and staff. As part of the planning process to go tobacco free, the need for nicotine replacement therapies and rules relating to self-medication such as nicotine gum need to be clearly addressed providing service recipients access to these supportive therapies.

**Percent of State Hospitals
by Smoking Policy: 2011**

79% non-smoking

Prohibit
Allow
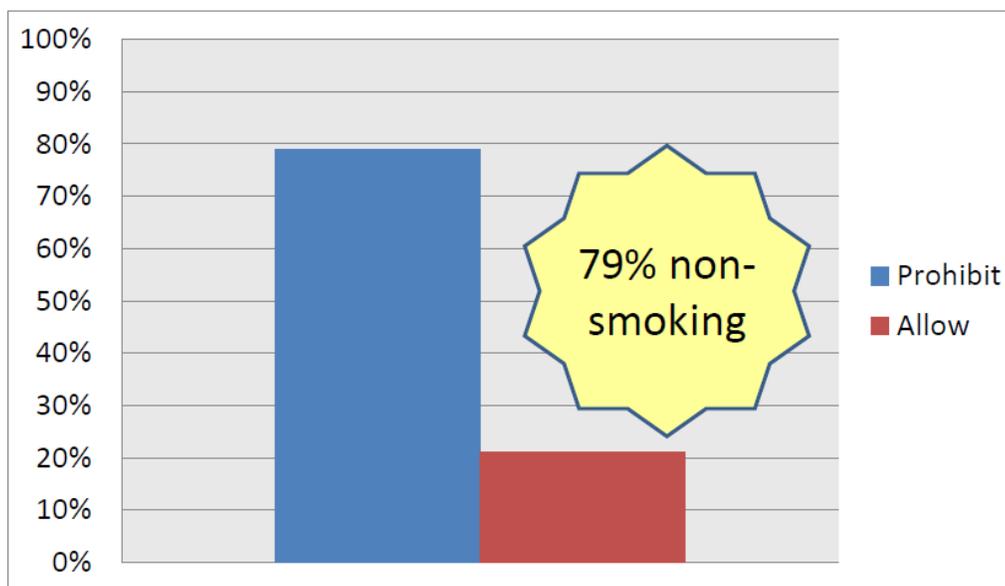
Source: NRI Smoking Study: 2011

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[65] (Parks, Svendsen, Singer, Foti, & Mauer, 2006)
[66] (Lasser, Boyd, Woolhandler, Himmelstein, McCormick, & Bor, 2000)
[67] (Callaghan, et al., 2014)

Workforce

A well trained, professional and paraprofessional workforce is paramount in ensuring quality care. The inappropriate use of psychiatric polypharmacy, seclusion and restraint, and involuntary medication can be indicators of inadequate professional staffing, training, and treatment programming. State psychiatric hospitals cannot maintain safe environments and provide effective treatments with perpetually high vacancy rates of professional staff and lack of staff training.

State psychiatric hospitals commonly report serving more medically compromised / medically fragile persons and persons with chronic health conditions who have for too long been unserved or underserved. In addition, as previously noted, courts are increasingly sending people with mental illness and criminal behavior who present a higher risk of violence than state psychiatric hospitals have previously seen. It is imperative to anticipate and provide effective responses to the greater resources needed to address these realities including providing higher security treatment settings where appropriate. Further, state psychiatric hospitals need to be adequately resourced in order to be compliant with CRIPA and the ADA. Staff vacancies are often an indicator of under-funding. State civil service employment system salary ranges must be competitive with the healthcare market salaries for mental health professionals and health care administrators.

State psychiatric hospitals should promote, enhance, support and strengthen the skill levels of all staff, including offering Continuing Education Credits. In addition, a recovery and trauma-informed environment can create a more positive and empowering working environment for staff. Staff should feel valued. Training should be in-person if possible and require demonstrated competency.

State psychiatric hospitals should strive to have teaching relationships with various professional fields including, but not limited to, psychiatry, psychology, nursing, direct care, social work, counseling and primary care. In addition, with the shortage of psychiatrists and professional staff, academic linkages and the funding of residency slots should become the norm for state psychiatric hospitals – though many state psychiatric hospitals across the country have academic linkages with colleges and universities, such affiliations should become a standard expectation. Done correctly such linkages provide a win-win for all. State psychiatric hospitals are more likely to have access to evidence-based treatment and research, which is a benefit to persons served. Students have training opportunities in a well supervised and professional clinical environment. The sponsoring state psychiatric hospitals have the opportunity to create synergies in services, education / training, financing and recruitment of professional staff.

Recommendations

Based on a review of the research literature on state psychiatric hospitals and discussion from the Expert Panel members at the meeting held on September 12-13, 2013 in Morro Bay, California, meeting participants drew the following Expert Consensus conclusions and recommendations.

These recommendations are the core of this report and represent the priorities determined at the meeting for state psychiatric hospitals focused specifically on the following four levels:

- State Psychiatric Hospital Facility Level
    - for the people they serve
    - for staff
    - for community integration
- State level – through the State Mental Health Authority;
- Federal level – through the work of NASMHPD; and
- NASMHPD at its own organizational level.

For the greatest success, coordination must occur between all of these levels. Service recipients and families are integral partners in moving these strategies forward and may wish to adapt many of the strategies and recommendations to promote the adoption of policies, practices, and procedures contained in this report. SMHAs, hospitals, and systems should consider convening service recipient and family stakeholder groups to identify recommendations specific to service recipients and families that would enhance the overall goals and objectives of this report.

Some State Mental Health Authorities and state psychiatric hospitals may be implementing some of these recommendations and should be commended and continue their efforts to improve.

STATE PSYCHIATRIC HOSPITAL LEVEL

The following are recommendations for State Psychiatric Hospitals to implement for *the people they serve:*

> **1.1: State psychiatric hospitals should continue to admit and care for service recipients with complex psychiatric conditions who are at risk of harm to self or others and cannot be effectively treated by existing available services in the community. State psychiatric hospitals should be constantly seeking, developing, and implementing evidence-based practice and promising practice treatment approaches.**
>
> State psychiatric hospitals are a vital treatment component in the healthcare system to assess, evaluate, and treat the most complex mental health and substance use conditions and should include the expectation of discharge to a continuum of a robust set of community supports.
>
> State psychiatric hospitals should continue the role of providing a place for health and safety as well as serve clinical, fiscal, social, and legal roles. Persons who cannot be safely and effectively treated in another treatment setting should be considered appropriate for state psychiatric hospital admission. State psychiatric hospitals should be constantly seeking, developing, and implementing evidence-based practice and promising practice treatment approaches for service recipients that have complex psychiatric conditions that are not effectively treated by existing available methods in the community.

1.2: State psychiatric hospitals should be responsive to service recipient needs. Service recipients should be significantly involved in planning, treatment, service, and discharge planning, program design, and hospital operations, wherever possible and appropriate.

State psychiatric hospital populations and structures vary throughout the country and often times the roles they play in their state systems are very different. All should evolve in a manner responsive to service recipient needs and involve service recipients and their families (biological and/or families of choice).

1.3: Trauma-informed practices improve mental health, can reduce violence, and are essential to providing a safe, respectful, and healing environment for service recipients and staff, and should be the standard of care in state psychiatric hospitals.

Trauma-informed practices are policies, procedures, interventions, and interactions among clients and staff that recognize the likelihood that a person receiving services has experienced trauma or violence. Trauma-informed practices – sometimes called trauma-informed care – create healing environments that emphasize physical and emotional safety and promote the development of trusting, collaborative relationships. In a trauma-informed program, everyone, regardless of job level or specific role, is educated about trauma and its consequences. The role of peers – other people who have experienced trauma or violence – is very important in planning and implementing trauma-informed practices. The goal is to create a healing environment of respect and safety that prevents the need for seclusion and restraint.[68]

1.4: State psychiatric hospitals should implement trauma-informed strategies to reduce seclusion and restraint, such as the Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint (6CS). The 6CS is a clinical model and evidence-based practice that is implemented at the institutional level, through the incorporation of the following six program strategies: (1) leadership through organizational change; (2) the use of data; (3) workforce development; (4) the use of seclusion and restraint prevention tools; (5) the fullest involvement and inclusion of service recipients, their families, and peer support services; and (6) rigorous analysis and debriefing of every S/R event.

1.5: State psychiatric hospitals should incorporate a person centered planning approach into all treatment, skill development, techniques, interventions, and interactions with service recipients.

A person-centered planning approach sets the stage for the person and the people who know the person best to work together, focusing on what is important to the person, how they wish to live and how they can change to reach their life goals.

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[68] (NCTIC, 2014)

1.6: **State psychiatric hospitals should ensure that services provided are culturally and linguistically competent and that the cultural and linguistic needs of the people they serve are addressed.**

Cultural and linguistic competency involves a number of elements including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that pertain to sexual orientation, ethnic, racial, religious, geographic, and/or social groups.

State hospitals should ensure that the cultural needs of the people they serve are addressed, including those who are deaf, hard of hearing, blind, visually impaired and deaf-blind. Understanding and respecting the culture and unique needs of these groups is critical to the effective delivery of mental health services and in reducing seclusion and restraint among these populations.[69]

1.7: **State psychiatric hospitals should take a leadership role in addressing mortality and morbidity among people with mental illness, including addressing tobacco use and obesity. All state psychiatric hospitals should be tobacco free campus wide for both service recipients and staff. In addition, state psychiatric hospitals should provide healthy foods for meals and snacks.**

Research has demonstrated that people with mental illness have been dying approximately 25 years earlier than the general population because of the increased risk of cardiovascular disease, smoking related conditions and health neglect which shorten life spans. State psychiatric hospitals are in an ideal and direct position to address health, including physical fitness and wellness among service recipients and staff. State hospitals should use a public health approach and utilize Whole Health Peer Support Services[70] to assist whenever possible. This approach should begin with education and should be directed by service recipients, not imposed upon them as a health treatment.

1.8: **<u>Treatment Planning</u> in state psychiatric hospitals should:**

- **Be individualized, person-centered, recovery-oriented, and humane;**

- **Address the whole person, including health and wellness;**

- **Include significant service recipient and family involvement throughout the process;**

- **Identify the person's strengths;**

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[69] (NASMHPD, 2002)

[70] Whole Health Peer Support focuses on managing both physical health and mental health conditions.

- **Identify needs related to self-management of symptoms through the development of internal locus of control;**

- **Engage and partner with natural supports, including peer support specialists, family, domestic partners, employers, friends, clergy, and others in a way that is sustainable outside of the state psychiatric hospital to ensure support for the treatment plan;**

- **Identify best, promising, and/or evidence-based practices to be used;**

- **Include collaboration with peer support specialists and direct care staff;**

- **Help the person identify his or her passions and goals in life and use those passions and goals as the basis to manage symptoms and engage the person in treatment; and**

- **Be community integration oriented which begins with a discharge focus at admission and includes community providers and peer support specialists within the state psychiatric hospital wherever possible.**

1.9: <u>Treatment</u> in state psychiatric hospitals should:

- **Use evidence-based, best, and/or promising practices;**

- **Instill hope through recovery-based approaches;**

- **Be person-centered;**

- **Utilize the person's strengths;**

- **Utilize self-management skills for symptom reduction through the development of internal locus of control;**

- **Engage natural supports, including family, domestic partners, employers, friends, clergy, and others in a way that is sustainable outside of the state psychiatric hospital.** State psychiatric hospitals should maximize the maintenance and expansion of natural supports through the use of technologies, including e-mail, Instant Messaging, video-conferencing, social media, and other electronic-assisted communication. These technologies and modes of communication have replaced pen and

paper for most individuals, and should be expanded to provide greater service recipient access to family supports.

- **Contain interventions that optimize the person's experiences each day. Time should be spent in a meaningful way according to the person;**

- **Address the whole person, including health and wellness. State psychiatric hospitals should work with the somatic health care community to ensure that the people they serve have access to state of the art somatic care;**

- **Acknowledge and support spirituality as an important part of the healing process for the service recipients who identify spirituality as a resource for them. These community based systems of spiritual practice can provide a host of support services to their members that can support service recipients living in the community;**

- **Include employment as an intervention widely used to reduce healthcare utilization. An increasing body of literature suggests that employment provides structure and support for psychiatric recovery while additionally positively impacting overall health expenditures, potentially reducing most costly interventions;**

- **Attempt psychosocial treatments and non-medication medical treatments before resorting to psychiatric medication polypharmacy. State psychiatric hospitals should not rely on medication treatment to the exclusion of other treatment approaches.**

1.10: **Service recipients should be provided treatment in the most integrated and least restrictive environment. However, if appropriate, service recipients who are at risk of being violent should be provided a continuum of treatment security to address their and staff's safety needs.**

It is the duty of the state psychiatric hospital to make reasonable efforts to create environments in which service recipients and staff are as safe as possible.

1.11: **State psychiatric hospitals often serve a percentage of service recipients who may become violent and should develop policies for the assessment of violence. If violence is present, an individualized treatment plan should be developed that addresses the violence.**

1.12: **State psychiatric hospitals should develop treatment standards, process measures, and clinical outcomes that are specific and individualized to the complex populations that they serve.**

1.13: **State psychiatric hospitals should be focused on service recipients returning to the community quickly when they no longer meet inpatient criteria. Treatment services provided by the state psychiatric hospital should be recovery-oriented and help stabilize service recipients with a focus on why they were admitted. State psychiatric hospital staff, in partnership with the service recipient, should work directly with community providers on a discharge plan that includes what community services would be most helpful for the service recipient.**

The following are recommendations for State Psychiatric Hospitals to implement for *staff*:

1.14: **State psychiatric hospitals should promote, enhance, support and strengthen the skill levels of all staff, including offering Continuing Education Credits. State psychiatric hospitals should strive to have teaching relationships with various professional fields including, but not limited to, psychiatry, psychology, nursing, direct care, social work, counseling, peer support specialists, and primary care. Training should be in-person if possible and require demonstrated competency.**

Developing professional affiliations that allow staff to become clinical faculty is beneficial and keeps the hospital informed on the most current best and promising practices available and in the development of a vibrant workforce.

1.15: **State psychiatric hospitals should have an adequate complement and balance of licensed professional staff, trained direct care staff, and paraprofessionals, including peer support specialists.**

Psychiatric polypharmacy, the use of seclusion and restraint, and the use of involuntary medication can be indicators of inadequate professional staffing, training, and treatment programming. State psychiatric hospitals cannot maintain safe environments and provide effective treatments with ongoing vacancies of professional staff and/or the over reliance on undertrained direct care staff and locum tenens.[71]

1.16: **State psychiatric hospitals should have strong peer support services program to assist with the recovery process of service recipients. Peer support services should be made available to all service recipients and peer support specialists employed by the state hospital should serve as equal members of the treatment team. Peer support specialists with forensic backgrounds could be included whenever possible and appropriate.**

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[71] *Locum tenens* (literally "place holder") is professional work done to fill in where help is needed. The term is used mostly in the context of medical professionals.

1.17: **State psychiatric hospitals are central hubs for workforce training and are encouraged to have strong linkages with medical schools and other academic institutions for education, training, and research to enhance recruitment and retention of workforce.**

With the shortage of psychiatrists and professional staff, academic linkages and the funding of residency slots should become the norm for state hospitals – though many state psychiatric hospitals across the country have academic linkages with colleges and universities, such affiliations should become a standard expectation. Done correctly such linkages provide a win-win for all. State psychiatric hospitals are more likely to have access to evidence-based treatment and research, which is a benefit to persons served. Students have training opportunities in a well supervised and professional clinical environment and the sponsoring state hospital has the opportunity to create synergies in services, education / training, financing and recruitment of professional staff.

The following are recommendations for State Psychiatric Hospitals to *integrate with the Community*:

1.18: **State psychiatric hospital care should be fully integrated with community treatment resources.**

State psychiatric hospitals should be recovery-oriented, provide a safe environment, and have a goal of community integration. State psychiatric hospitals are treatment facilities, not homes, and should augment the care of a community provider that follows and is included on the service recipient's inpatient treatment team. State psychiatric hospital staff in partnership with the service recipient, should work directly with community providers on a discharge plan that includes what community services would be most helpful for the service recipient.

Service recipients should be served in integrated community settings whenever possible, and states should have a robust continuum of community services that is linked with the services provided in state psychiatric hospitals in order to seamlessly reengage service recipients back into the community and the community to serve the service recipient. Admission and discharge planning should be a joint effort between the service recipient, the state psychiatric hospital, and the community providers.

In addition, staff should receive training on Title II of the Americans with Disabilities Act, *Olmstead*, and community-based best practices. Further, state hospital staff should be competent in integrated treatment for mental health and substance use disorders and community-based addiction services.

State psychiatric hospitals should not refuse admissions from acute care settings and emergency departments for service recipients who meet inpatient level of care criteria if a local acute care setting is unavailable. However, service recipients who no longer meet inpatient level of care criteria should be discharged to community-based settings as soon as possible.

Conversely, community treatment providers should not refuse to serve persons being discharged from state psychiatric hospitals that no longer meet inpatient criteria. Persons being discharged from state psychiatric hospitals should be a priority for community service placements.

1.19 State psychiatric hospitals should collaborate with community stakeholders to develop humane transportation mechanisms. Use of shackles, handcuffs, and soft restraints to transport service recipients, particularly within facilities, should be minimized to the fullest extent possible. Least restrictive approaches should be tailored for the individual service recipient through individualized assessments and not take a one size fits all approach.

1.20 State psychiatric hospitals should work in an environment of transparency by opening their doors to families and the community and develop metrics that hold them accountable to the public and to service recipients through reporting.

1.21: State psychiatric hospitals should incorporate the latest health information technologies in daily operations. In particular, state psychiatric hospitals should have a fully functioning Electronic Medical Record system, use telemedicine for specialty consultation, and use a standardized computer based assessment of functioning.

1.22: State psychiatric hospitals need to be clear regarding their role in recovery on one end of the continuum of mental health services and extend to the professional community their consultative expertise, access, and training related to the diagnosis and treatment of people with complex conditions who may be a risk of harm to self or others. This training and provision of consultative expertise is critical to having legislators, courts, community providers, families, and others understand the role of the state psychiatric hospitals in the context of recovery and the public health care system. Such experiences also provide opportunities to strengthen linkages with the community, develop staff skills, and recruit and retain high quality staff.

1.23: Policies related to state psychiatric hospitals should be managed in relationship with stakeholders (e.g. service recipient groups, state agency leaders, elected officials, other governmental entities, including criminal justice, universities, host communities, etc.).

Operating a state psychiatric hospital is a complex endeavor and is managed in relationship with many other stakeholders (e.g. service recipients, state agency leaders, elected officials, other governmental entities like criminal justice, universities, host communities, etc.) It is important to anticipate the corresponding evolution, future role and needs of other stakeholder groups. Such relationship building and involvement can

also provide the opportunity for clarifying the policies and reduce potential misunderstandings.

1.24: Addressing primary care and wellness should be a major part of all state psychiatric hospital functions. Given the limits of the ability of state psychiatric hospitals to address medical issues, state psychiatric hospitals should have strong relationships with general community hospitals, medical centers, and other primary care providers.

STATE LEVEL

Recommendations at the **State Level to be implemented through the State Mental Health Authority** include:

2.1: State psychiatric hospitals should continue to admit and care for persons whose conditions are considered untreatable by other healthcare providers in treatment settings or who the rest of the treatment system considers too dangerous. State psychiatric hospitals should be constantly seeking, developing, and implementing evidence-based practice and promising practice treatment approaches. State psychiatric hospitals should not be a solution for an underfunded, fragmented system of care.

2.2: State psychiatric hospitals should be integrated and aligned with the overall healthcare reform objectives in their respective states.

2.3: States should take appropriate steps to prevent the criminalization of people with mental illness. In particular, people who commit misdemeanors should not be subjected to a forensic commitment but rather treated in an appropriate community-based setting. States could include the following steps towards this recommendation:

- **Improve their relationship with the judiciary system and empower state hospitals to educate and collaborate with the courts to ensure the most appropriate clinical responses.**

- **Implement jail diversion programs and mental health courts to prevent the criminalization of people with mental illness.**

- **Provide legislative safeguards to ensure competency in court appointed evaluators.**

- **Work with local law enforcement to implement pre-booking diversion processes.**

2.4: **Individuals with mental illness who are forensically involved should be served in the most integrated setting possible within the hospital while still maintaining the safety of service recipients, staff, and community. When the clinical condition of individuals improves such that an inpatient level of care is no longer required, state psychiatric hospitals together with local providers, should recommend the most integrated and clinically appropriate community setting to the courts or other responsible authorities.**

At the system level, state psychiatric hospitals should continue to work with the court system to educate and build collaboration regarding the treatment of service recipients with forensic involvement, including the need to treat individuals in the most integrated settings.

2.5: **Every individual who is committed to a state psychiatric hospital, forensic or otherwise, needs to be evaluated as an individual in terms of inpatient goals, risks, benefits, and to determine if this same treatment could be safely provided in community settings. All people served in state psychiatric hospitals should <u>be considered in the process of recovery.</u>**

2.6: **State courts should be encouraged to use state psychiatric hospital forensic staff to conduct evaluations on people that present with a history of criminal involvement to determine whether the causal factors for his or her behavior is a mental illness and/or substance use disorder. If this evaluation is conducted, state courts need to respect these decisions and act to discharge persons found to not have a mental illness or co-occurring substance use disorder and these individuals need to be removed and placed back into prison to enable state psychiatric hospitals to continue to provide services for people who have a condition to treat.**

2.7: **State psychiatric hospitals should be adequately funded and staffed.**

State psychiatric hospitals commonly report serving more medically compromised / medically fragile persons and persons with chronic health conditions who have for too long been unserved or underserved. In addition, courts are increasingly sending people with mental health issues who have criminal behavioral and present with a higher risk of violence than state psychiatric hospitals have previously seen. It is imperative to anticipate and respond to the greater resources needed to address these realities including providing high security treatment settings where appropriate. Further, state psychiatric hospitals need to be adequately resourced in order to be compliant with CRIPA and the ADA. Staff vacancies are often an indicator of under-funding. State civil service employment system salary ranges should be competitive with the healthcare general market salaries for mental health professionals and health care administrators.

2.8: **States considering new or replacement hospitals should make choices that maximize community integration. Recovery is supported best when facilities are small and close to an individual's home and support system. To maximize community integration and recovery, states should consider smaller facilities and/or consider purchasing some of the needed inpatient care services from local community providers, or work with managed care to ensure adequate inpatient reimbursement. Long term capital investments can also be avoided by not replacing aging infrastructure.**

2.9: **State Mental Health Authorities should position state psychiatric hospitals as part of the shared safety net and work to establish clear roles and responsibilities assigned to state psychiatric hospitals, local inpatient units, and community providers. SMHAs should ensure that that there are strong linkages between state psychiatric hospitals and the community in order to seamlessly integrate individuals back into community settings.**

2.10 **Transition services to support community engagement and reintegration for service recipients who have experienced long state psychiatric hospital lengths of stay should be developed. These transition services would include skills to manage their illness, health, daily activities, living environment as well as care coordination, peer support services, and community consultation and liaison. Such services should be provided in the most integrated setting possible. Peer support services should be provided to role model and support the skills training while promoting the benefits of community integration.**

2.11: **State psychiatric hospitals should become or remain integrated with state and regional disaster planning initiatives.**

State psychiatric hospitals are often the places used to accommodate the overflow of medical response during a state and regional disaster. It is important that state mental health authorities proactively integrate the role of state psychiatric hospitals into state and regional disaster plans.

2.12: **Forensic mental health services should be proactively planned and guided in context of the larger public mental health system.**

It is important to recognize the need for public safety and address the safety needs of service recipients and staff. For forensic hospitals, the treatment of aggressive behavior and violence necessitate specialized training and competency. In the event that the state psychiatric hospital campus also houses sex offenders or correctional programs there should be a clear distinction in fiscal, administrative and clinical functions. State psychiatric hospitals should have multiple separate and distinct security levels sufficient to maintain the safety of different service recipient groups and the staff who treat them.

While all service recipients and staff should have their safety needs met, meeting experts underscored that the majority of people with mental illness are not violent and are often vulnerable. As a result, this vulnerable population should not be served in the same locations as people with criminal and/or predatory behavior who have no mental illness or solely a personality disorder.

2.13: **State Mental Health Authorities should require their state psychiatric hospitals to become tobacco free campus wide for service recipients and staff. SMHAs should provide the resources and empower the leadership of state psychiatric hospitals to implement this requirement. Staff and service recipients should be involved in every step of the planning and implementation process.**

2.14: **State Mental Health Authorities should address state psychiatric hospital critical incident events with quality improvement strategies.**

When an adverse event occurs at a state psychiatric hospital, it often is a symptom of the larger system, its processes, practices and policies, and/or cultural issues. State Mental Health Authorities should explore the causes of these events from a quality improvement perspective. That exploration should include a peer/family perspective as part of the review and evaluation process.

2.15: **State Mental Health Authorities should work with their legislators and judiciary system to assure that courts and guardians do not force service recipients to remain in state psychiatric hospitals after the hospital has advised them that the person is ready for discharge and an appropriate community setting and treatment is available.**

2.16: **State Mental Health Authorities should include their state psychiatric hospitals to help coordinate services, supports, and provide expertise and consultation across systems of state government (i.e. Veterans Administration, Criminal Justice System, Medicare, Medicaid, Employment, and other parts of state government).**

FEDERAL LEVEL THROUGH NASMHPD

Recommendations at the Federal Level through the National Association of State Mental Health Program Directors include:

3.1: NASMHPD should work with CMS on the following:

(1) Develop improved data about who state psychiatric hospitals serve, who ordered their admission if not voluntary, and who controls their disposition.

(2) Ensure that inpatient psychiatric care for short term inpatient stays is covered like any other Medicaid service. Further Medicaid should cover any general medical care people receive while in state psychiatric hospitals to the same extent as medical care is covered in non-psychiatric hospitals.

(3) Streamline the Social Security and State benefit approval process at the time of discharge from a state psychiatric hospital

(4) Develop mechanisms and strategies for people with mental illness discharged from IMDs who are eligible for Medicaid benefits but not yet enrolled to receive community-based supplemental support services that would facilitate community integration. Such programs could be similar to the supports provided by the Money Follows the Person program or the Community First Option Program under the ACA.

(5) Ameliorate the impact of Disproportionate Share (DSH) payments under the Affordable Care Act (ACA)

For policy and fiscal considerations, NASMHPD should work with SMHA fiscal officers to develop a report that clearly illustrates to policy makers the amount of lost DSH funding projected in each state for both state psychiatric hospitals and community hospital psychiatric units.

3.2: NASMHPD should work with NIMH on funding research that includes:

(1) Services and strategies designed to address complex clinical presentations not effectively served elsewhere including the percentage of individuals presenting violence and aggression.

(2) Best practices related to the safe treatment of forensic service recipients.

(3) Developing models of predicting the adequate number of state psychiatric hospital beds in a particular state that accounts for the full array and availability of clinical capacity of community based providers to provide appropriate care, community psychiatric beds, community behavioral health services, and state laws and practices related to the various modes of involuntary hospitalization. Any such research should be guided by a broad stakeholder consensus panel that

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includes people with lived experience and should include the most advanced predictive analysis methodologies.

3.3: **SAMHSA should continue to fund the NASMHPD Research Institute, Inc., to obtain state data, including state psychiatric hospital data and the effectiveness of services provided by state psychiatric hospitals.**

The data that NRI, Inc., collects is critical for state leaders, local legislators and other stakeholders to evaluate the effectiveness of their state psychiatric hospitals in comparison to trends nationally. NRI, Inc. is the only place currently providing this level of data metrics, comparison, and reports for State Mental Health Authorities.

3.4: **NASMHPD should work with the Health Resources and Services Administration (HRSA) on the following:**

(1) The National Health Service Corp Student Repayment Program to include work on inpatient psychiatric units.

The National Health Service Corps (NHSC) Students to Service Loan Repayment Program (S2S LRP) provides loan repayment assistance to medical students (MD and DO), nurse practitioners, physician assistants, psychologists, nurses, and social workers in their last year of school in return for a commitment to provide primary health care services in eligible Health Professional Shortage Areas (HPSAs) of greatest need. This arrangement should include work on inpatient psychiatric units and would provide training for students and opportunities for recruitment at state psychiatric hospitals.

(2) State psychiatric hospitals should have access to the 340B Drug Pricing Program. (<u>United States Code Annotated</u>, Title 42, Chapter 6a, Subchapter Ii, Part D--Primary Health Care, <u>Subpart VII--Drug Pricing Agreements</u>)

The 340B allows "covered entities" including safety net hospitals, federally qualified health centers, Indian health service and others to purchase pharmaceuticals at a substantially lower price than is otherwise available. State psychiatric hospitals are universally seen as a safety net for the public health system. As a result, federal statute should be amended to include them in the federal definition of covered entity for participation in the 340 B drug pricing program along with other safety net hospitals.

(3) Other workforce related activities.

3.5: **NASMHPD should promote to federal policy makers the appropriate role for state psychiatric hospitals and the continued critical need for state psychiatric hospitals as institutions of quality care. NASMHPD should be a resource to**

state and state legislatures on the role of state psychiatric hospitals and state hospital best practices.

NASMHPD AS AN ORGANIZATION

Recommendations for NASMHPD as an organization include the following:

4.1: NASMHPD should continue to promote and establish safe environments in state psychiatric hospitals through education to local, state, and federal entities about trauma-informed care and reducing seclusion and restraint.

4.2: NASMHPD should develop a "Brag and Steal" document that compiles promising and best practices in state psychiatric hospitals nationally.

4.3: NASMHPD should reinforce the goal of state psychiatric hospitals to treat and facilitate the discharge of service recipients to the most integrated settings possible. NASMHPD should develop a technical report on best practices for the expeditious return of people being served in state psychiatric hospitals to the most integrated community setting.

4.4: NASMHPD should develop a new technical report on polypharmacy and state psychiatric hospitals.

4.5: NASMHPD should look at the current functioning of the Interstate Compact on Mental Health and identify lessons learned.

An Interstate Compact is a contractual arrangement made between two or more states in which the assigned parties agree on a specific policy issue and either adopt a set of standards or cooperate with one another on a particular regional or national matter. The Interstate Compact on Mental Health is an interstate compact among 45 states and the District of Columbia. Only Arizona, California, Mississippi, Nevada and Virginia are not members.[72]

NASMHPD should explore lessons learned related to states that have Interstate Compacts on Mental Health and the impact on states that do not currently have an Interstate Compact on Mental Health.

4.6: NASMHPD should provide ongoing leadership training for state psychiatric hospital CEOs and medical directors. This training should include information on financial operations, including Medicare and Medicaid.

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[72] http://ballotpedia.org/wiki/index.php/Compact_on_Mental_Health

4.7: **NASMHPD should take a position that no valid or reliable methodology to project or estimate the number of state hospital beds needed by a state currently exists.**

It is not possible to build a model predicting the adequate number of state psychiatric hospital beds in a particular state without also taking into account the full array and availability of clinical capacity of community based providers to provide appropriate care, community psychiatric beds, community behavioral health services, and state laws and practices related to the various modes of involuntary hospitalization.

4.8: **NASMHPD should provide opportunities for discussions between State Mental Health Authorities and state psychiatric hospitals. NASMHPD should also provide opportunities for discussions between the state psychiatric hospitals and NASMHPD Divisions, including the state offices of consumer affairs (National Association of Consumer/Survivor Mental Health Administrators – NAC/SMHA), Forensic Division and the Legal Division.**

4.9: **NASMHPD should recommend standard staffing ratios that adequately reflect the acuity and complexity of service recipients served in state psychiatric hospitals taking into account public safety.**

4.10: **NASMHPD should support and encourage states to adopt Crisis Intervention Team (CIT) training for first responders on working with people with mental illness (fire fighters, police, etc.)**

4.11: **NASMHPD should collaborate with the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA), the National Alliance on Mental Illness, the Judge David L. Bazelon Center and other key stakeholders on modernizing Civil Commitment and Treatment laws.**

4.12: **NASMHPD should develop a technical report specific to forensic service recipients.**

Meeting experts reported that states have various approaches to effectively treat and maintain people who are forensically involved and how recovery principles may or may not be infused into services provided. There was unanimous agreement that there is a need for additional detailed guidance on how best to treat and manage persons in state psychiatric hospitals who continue to present a significant risk of violence due to a serious mental illness, substance use disorder, and/or criminal behavior in a manner that is consistent with recovery principles and practices.

4.13: **NASMHPD should collaborate with disability advocacy groups regarding the role of state hospitals in treating forensically involved service recipients and the issues that state psychiatric hospitals**

experience in moving service recipients to clinically appropriate, integrated settings.

4.14: NASMHPD should develop and Expert Consensus Report on Treatment Models and Standards for Persons Committed as Sex Offenders.

NASMHPD's policy stance that sex offenders should not be committed to State Mental Health Authorities should not prevent NASMHPD from supporting those SMHAs who are forced to accept commitments of sex offenders by developing an Expert Consensus on models and standards of handling committed sex offenders.

Conclusion

The recommendations in this report are driven by the understanding that creating a culture of hope, healing, respect, and social connectedness in an integrated system of care is essential to the recovery process of service recipients. While people should be served in the community wherever and whenever possible, some service recipients will need the services provided through state psychiatric hospitals. The recommendations in this report provide state psychiatric hospitals, State Mental Health Authorities, federal agencies, and NASMHPD ways to create safe, respectful, healing environments to meet the needs of service recipients and staff in state psychiatric hospitals. It is in creating this culture of healing and respect across the entire continuum of care that people with complex conditions can heal, recover, and live healthy and quality lives.

Appendix A: Expert Panel for Future Role of State Hospitals Meeting

September 12-13, 2013

Inn at Morro Bay, Morro Bay, California

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Regional Directors of State Hospital Associations

Western Psychiatric State Hospital Association (WPSHA)

Western Region: Alaska, American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming.

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Midwestern Association for State Mental Health Organizations (MASMHO)

Midwestern Region: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Oklahoma, Wisconsin.

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Southern State Psychiatric Hospital Association (SSPHA)

Southern Region: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, West Virginia.

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Northeast Regional State Psychiatric Hospital Association

Northeastern Region: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.

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