Southern States Psychiatric Hospital Association
Joint Conference with
The NASMHPD Forensic Division

“The Lay of the Land”

October 3, 2016
Nashville, Tennessee

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For Discussion

• NASMHPD Strategic Plan
• NASMHPD Papers 2016
• First Episode Psychosis Program
• Trends in State Public Mental Health Systems
• Trends in Psychiatric Hospitalization
• Points for Consideration Regarding Psychiatric Hospitalization
• Discussion
Represents the $41 Billion Public Mental Health System serving 7.5 million people annually in all 50 states, 4 territories, and the District of Columbia.

Affiliated with the approximately 195 State Psychiatric Hospitals: Serving 147,000 people per year and 41,800 people at any one point in time.
MISSION

NASMHPD will work with states, federal partners, and stakeholders to promote wellness, recovery, and resiliency for individuals with mental health conditions or co-occurring mental health and substance related disorders across all ages and cultural groups, including: youth, older persons, veterans and their families, and people under the jurisdiction of the court across the full continuum of services including inpatient.
NASMHPD Strategic Plan - Values

- Least Restrictive and Most Integrated Setting
- Human Rights and Health Equity
- Health and Wellness
- Recovery and Person-Centered Services and Planning
- Unique Role of Safety Net Services in the Public Mental Health System
- Empowerment
- Community Education
- Zero Suicide
- Working Collaboratively
- Effective and Efficient Management and Accountability
- Culturally and Linguistically Responsive
- High Quality Workforce Capacity
NASMHPD Goals

• Health, wellness, and resiliency
• Integrated care
• Prevention and Early Intervention
• Zero suicide
• The use of trauma-informed approaches
• Interventions that minimize individuals’ contact with police, jails, prisons, juvenile correctional facilities, and courts
• Workforce
• Employment, housing and reducing homelessness
• The use of data and Health Information Technology (HIT) to improve quality
NASMHPD Papers 2016

• Clozapine Underutilization: Addressing the Barriers

• Innovative Uses of Technology to Address the Needs of Justice-Involved Persons with Behavioral Health Issues

• Technology and Human Trafficking

• State Behavioral Health Authorities' Use of Performance Measurement Systems
Papers (cont.)

• Promoting Young Adult Mental Health Through Electronic and Mobile Health Technologies

• Promising and Emerging Approaches and Innovations for Crisis Intervention for People Who Are Deaf, Hard of Hearing and DeafBlind

• Improving Community Options for Older Adults
• Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels
The Vital Role of State Psychiatric Hospitals

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Key Messages

• 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.

• 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.
Key Messages (cont.)

- Service recipients should be served in the **most integrated and least restrictive** environment possible.

- 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.
Key Messages (cont.)

- 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.
First Episode Psychosis Program
Background Overview of the MHBG Set-Aside

For the **2014 fiscal year** appropriation, SAMHSA was directed to require that states set aside **5 percent** of their MHBG allocation to support “evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.”
Good News in FY 2016…
MHBG Set-Aside Funding Increase

• In the appropriations bill passed by Congress in December of 2015, funding was added to increase the set-aside from 5% to 10% in FY 2016.

• National MHBG Set-Aside funding was initially $22.87 M. In just two years, it has increased to $50.47 M
State Allocations of the MHBG 10% Set Aside for FY 2016/2017

- Over $500,000 (30 states, inc. PR)
- $250,000 to $500,000 (9 states)
- $100,000 to $250,000 (9 states, inc. D.C.)
- Less than $100,000 (4 states, & all territories except PR)
Critical Importance of Reducing the Duration of Untreated Psychosis

• Reducing the Duration of Untreated Psychosis (DUP): FEP programs focus on the Early Identification and Engagement of individuals who have just experienced their first episode of psychosis. Shorter DUP is associated with¹,²:

  – Improved response to treatment
  – Reduction in symptom severity
  – Improved functioning
  – Improved quality of life


²See: www.nimh.nih.gov/health/topics/schizophrenia/raise
Looking Ahead...

• The outlook for on-going funding of the set-aside is very positive at this time

• Continuing strong bi-partisan support in Congress for this type of programming
Trends in State Public Mental Health Systems
NASMHPD Research Institute works with the states and territories. Thank you to NRI for allowing NASMHPD to use the following slides.

- NRI collects and analyzes data related to federal reporting requirements for the Mental Health Block Grant Program, as well as collection and reporting activities related to state psychiatric hospitals.
- NRI maintains a data base on financing, quality management and information systems.
- NRI conducts specialty state study analyses.
For Additional Information

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Organization of M/SUD
Service Responsibilities: 2015

- Combined MH/SA: 35
- Separate Department: 4
- Separate, In Same Umbrella Dept.: 11
- No Response: 1
State Mental Health Authority persons Served Per 1,000 State Population.
Individuals Served by State Mental Health Authority

- SMHAs provided mental health services to over 7.5 million individuals during FY 2015
  - 2.3% of the US Population
  - 68% of Adults served had a Serious Mental Illness (SMI)
  - 70% of Children served had a Serious Emotional Disturbance
• Percent of Clients Served, by Service Setting: 2014 Uniform Reporting System

❖ 98% of clients received community-based mental health services
  ○ 22.3 per 1,000 population (range from 0.8 to 51.2 per 1,000)

❖ 2% of clients received services in state psychiatric hospitals
  ○ Range from less than 1% of clients (in 11 states) to 12% in (2 states) of total clients served

❖ 4.6% of clients received services in other psychiatric inpatient settings (37 states reporting on OPI)
Trends in Financing State Public Mental Health Services
SMHA-Controlled Revenues for Mental Health Services: FY 1981 to FY 2014

- State General Funds
- Other Federal
- MH Block Grant
- Federal Medicaid
- State Medicaid Match
- Other Funds

Mental Health Block Grant

State General Funds
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'14

State Mental Hospital Inpatient

Community Mental Health
Psychiatric Hospitals
Residents in State Psychiatric Hospitals, Jails, and Prisons, 1950 to 2014

- State Psychiatric Hospital Residents
- Jail
- Prison
Intended Use of State Psychiatric Hospitals: 2015

- **Forensic**: 41 states use Long-Term Care (more than 90 days), 39 states use Intermediate Care (30-90 days), 35 states use Acute Care (less than 30 days).
- **Elderly**: 42 states use Long-Term Care (more than 90 days), 42 states use Intermediate Care (30-90 days), 39 states use Acute Care (less than 30 days).
- **Adults**: 43 states use Long-Term Care (more than 90 days), 44 states use Intermediate Care (30-90 days), 41 states use Acute Care (less than 30 days).
- **Adolescents**: 15 states use Long-Term Care (more than 90 days), 18 states use Intermediate Care (30-90 days), 21 states use Acute Care (less than 30 days).
- **Children**: 10 states use Long-Term Care (more than 90 days), 14 states use Intermediate Care (30-90 days), 13 states use Acute Care (less than 30 days).
Trend in All Psychiatric Beds: By Type of Hospital, 1970 to 2015

- State Hospitals
- Private Psychiatric Hospitals
- VA Psychiatric Services
- General Hospitals
- Total Psych Beds

Slide 34

Prepared by Ted Lutterman, National Association of State Mental Health Program Directors Research Institute using public-domain data from Foley et al., 2002.
Estimating the Total Psychiatric Inpatient Capacity

SAMHSA periodically surveys private psychiatric hospitals and general hospitals with separate psychiatric units. Currently 2010 is the most recent data available, but 2014 information should be available soon.

NRI combined 2012 URS data on State Psychiatric Hospitals with data on private psychiatric hospitals and non-Federal general hospitals with separate psychiatric units (from SAMHSA’s 2010 National Mental Health Services Survey (N-MHSS))

<table>
<thead>
<tr>
<th>Type of Psychiatric Facility</th>
<th>Number of Facilities</th>
<th>Number of Beds/Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Psychiatric Hospitals (2012)</td>
<td>195</td>
<td>41,821</td>
</tr>
<tr>
<td>Non-Federal General Hospitals with Separate Psychiatric Units (2010)</td>
<td>1,157</td>
<td>35,351</td>
</tr>
<tr>
<td>Private Psychiatric Hospitals (2010)</td>
<td>374</td>
<td>24,919</td>
</tr>
<tr>
<td>Total Psychiatric Inpatient Capacity</td>
<td>1,726</td>
<td>102,091</td>
</tr>
</tbody>
</table>
State Psychiatric Hospital data are residents in state hospitals on the first day of 2012. Private psychiatric bed counts represent separate psychiatric units in general hospitals and private psychiatric hospitals from SAMHSA's 2010 Survey.
Points for Consideration Regarding Psychiatric Hospitalization
• Beds: state hospital beds, private IMD beds, acute general hospital psychiatric unit beds and veterans administration beds.

• Legal status: civil involuntary admissions, civil voluntary admissions, and court-ordered admissions.
• Insurance status, and managed care,

• EMTALA

• Even within states, there are acute general hospitals that would only admit an individual to a psychiatric unit while others would admit to a medical bed and treat the individual if a psychiatric unit bed was not available.
Almost all involuntary admissions in some states go to the private sector.

Some states have well-developed crisis programs which decreases pressure on Emergency rooms and inpatient services.

Clozapine underutilization contributes to the length of hospital stay.

Lack of housing contributes to the delay in discharge.
Additional Thoughts for Consideration

• State hospitals should be part of the continuum of care. Primarily for forensics?
• Civil voluntary and involuntary admissions should be admitted only to the private sector?
• EMTALA should be enforced strongly?
• Acute General Hospital's should admit to an open medical bed when a psychiatric bed is not available?
Thank you!

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