

NATIONAL TRENDS

CHALLENGES FACING BEHAVIORAL HEALTH CARE

The Pressures on Essential Behavioral Healthcare Services

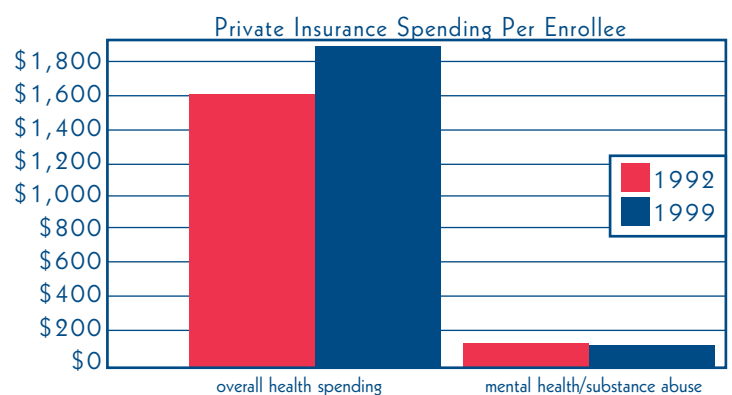
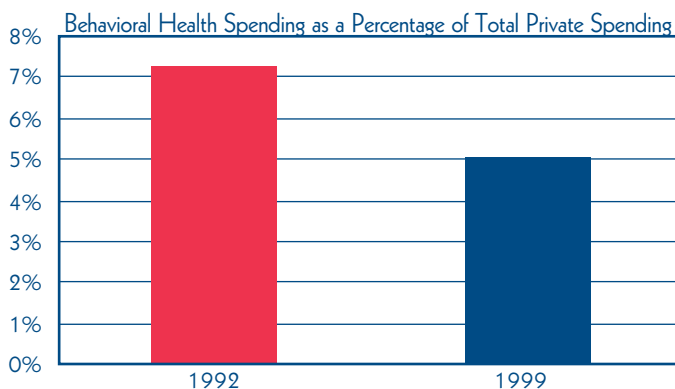
Millions of Americans of all ages experience psychiatric and substance use disorders every year, according to the National Institute of Mental Health (NIMH)¹. But access to necessary services is becoming an increasing challenge for many.

- Funding for behavioral health has been reduced dramatically.
- Psychiatric beds have disappeared from the system due to hospital closures and bed reductions.
- Psychiatric patients are facing emergency room backlogs.
- Children and adolescents have been hard-hit by access challenges.
- The costs of care are rising.

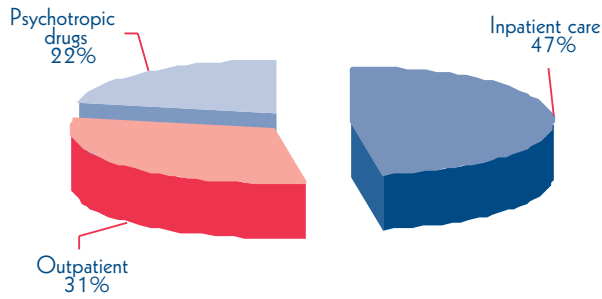
This white paper discusses national trends and changes in behavioral healthcare delivery that are contributing to unprecedented pressures on essential behavioral healthcare services. It also includes recommended solutions.

■ OVERALL FUNDING FOR BEHAVIORAL HEALTH HAS DIMINISHED.

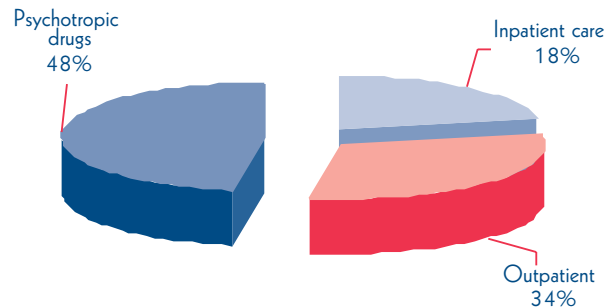
In reviewing claims from large employers responsible for 1.7 million covered lives, researchers² have found that behavioral health spending dropped from 7.2% of total private health insurance spending in 1992 to 5.1% of total spending in 1999 (primarily because of a dramatic decrease in hospital treatment due to shorter lengths of stay and reduced probability of admission). As overall health spending **increased** by 15.7%, mental health and substance abuse spending **decreased** by 17.4% during this period.



1992, Distribution of Behavioral Health Spending in Private Insurance



1999, Distribution of Behavioral Health Spending in Private Insurance



SOURCE: *Health Affairs*, January/February 2003

The distribution of spending also shifted. Where inpatient spending was 48% of total behavioral health spending in 1992, in 1999 it was only 18%, according to the *Health Affairs* study. At the same time outpatient care grew somewhat, but visits remained static. However, outpatient use only grew just over 0.1% each year (from 5.8% of enrollees using outpatient services to 6.8% over eight years).

THE IMPACT OF DIMINISHED FUNDING ON ACCESS IS SIGNIFICANT.

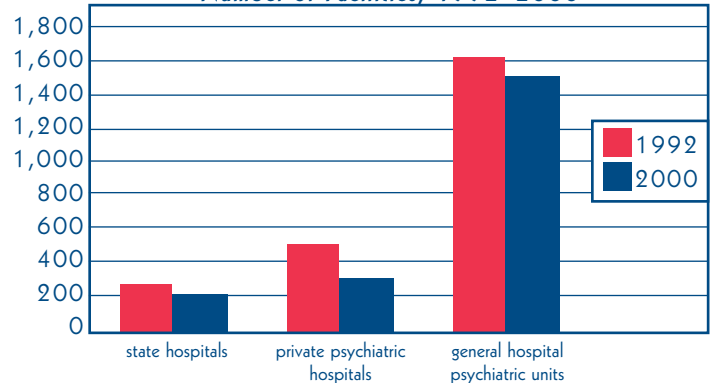
Acute Care Access Has Been Strained by Hospital Closures and Bed Reductions.

Acute psychiatric care is an integral component of community-based care. Inpatient psychiatric care delivered in general hospitals and freestanding specialty psychiatric hospitals today provides acute, short-term stabilization for those persons who are acutely ill and are generally dangerous to themselves and others. These individuals require 24-hour care and intensive treatment to get them back to their community where they can take advantage of the range of outpatient and community support services.

Hospital Closures

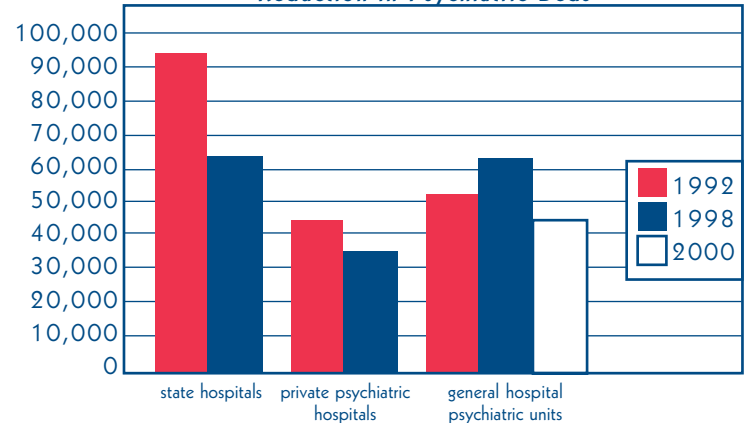
In 1992 there were 273 state mental hospitals, 475 private psychiatric hospitals, and 1,616 general hospital psychiatric units. In 1998, there were 229 state mental hospitals, 348 private psychiatric hospitals, and 1,707 general hospital units.³

Number of Facilities, 1992–2000



SOURCE: CMS and CMHS.

Reduction in Psychiatric Beds



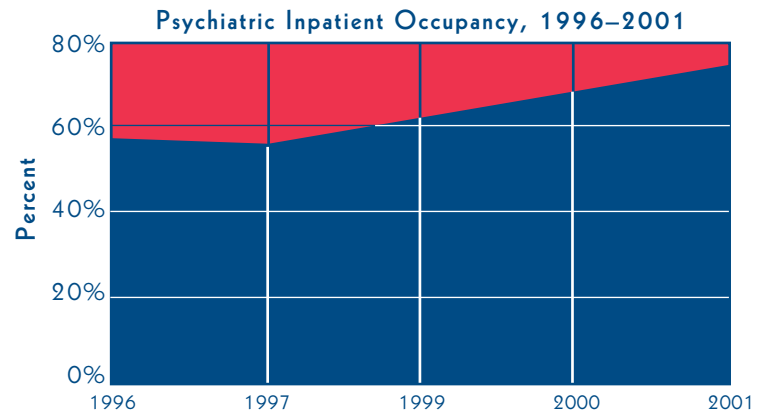
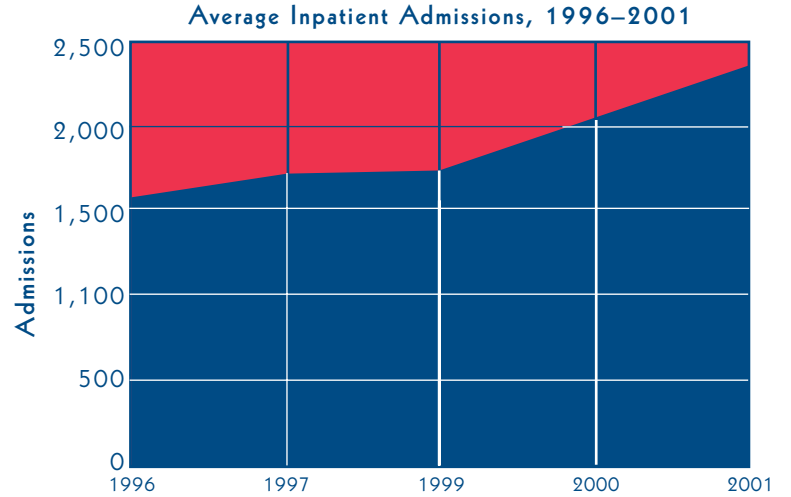
SOURCE: CMHS and MedPAC.

In 2000, there were 195 state mental hospitals, 293 private psychiatric hospitals, and 1,464 general hospital units.⁴ This means that from 1992 to 2000, the number of state mental hospitals declined by 29%, private psychiatric hospitals declined by 38%, and general hospital units declined by 14%.

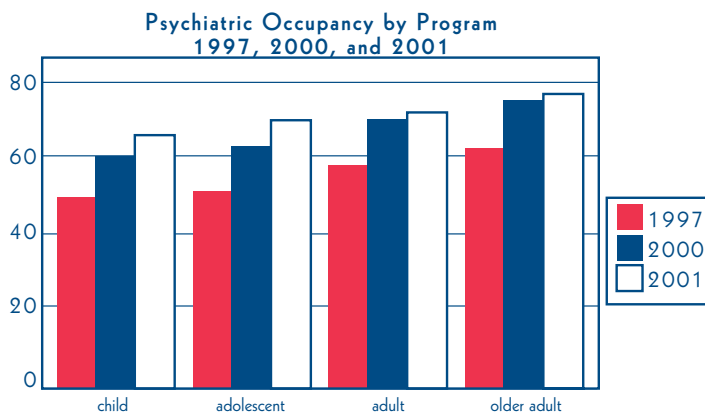
Bed Reductions

The number of inpatient psychiatric beds also substantially declined. During the period of 1992-98, state mental hospital beds declined 32% (from 93,058 beds to 63,525). Private psychiatric hospital beds declined 23% (from 43,684 beds to 33,635). And general hospital unit beds slightly increased (up 4%) during this period (from 52,059 to 54,266).

NOTE: General hospital units and beds began to decline after 1998. The June 2001 Medicare Payment Advisory Commission (MedPAC) report to Congress stated “that after years of increases, the number of general hospital units declined by 14% from 1999-2000.” Based on this data, it can be estimated that there were approximately 43,920 psychiatric unit beds in 2000 — or a 19% decline between 1998 and 2000 (estimating the average unit bed size to be 30 beds based on MedPAC data).



SOURCE: NAPHS 2002 Annual Survey Report.



SOURCE: NAPHS 2002 Annual Survey Report.

The Impact on Access

The reductions in facilities and beds have resulted in substantial increases in admissions to the remaining hospitals. According to a survey of members of the National Association of Psychiatric Health Systems (NAPHS),⁵ admissions per facility on average have increased 11% (from 2,113 in 2000 to 2,354 in 2001).

Occupancy rates have also substantially increased over the past few years. Based on the NAPHS survey, occupancy rose from 69.2% in 2000 to 74.1% in 2001 — a 7% increase in occupancy rates in one year. In 1996 occupancy rates were 55.6%, compared to 74.1% in 2001. In addition, 25% of the respondents to the survey had occupancy rates greater than 88% in 2001.

Rising Demand and Constrained Capacity Have Overburdened Emergency Departments.

These trends have led many individuals in need of acute inpatient psychiatric care to seek care in emergency rooms across the country as well as to travel far distances to get an open inpatient psychiatric bed.

An American Hospital Association report⁶ indicates that 62% of all hospitals — and 79% of urban hospitals — are “at” or “over” emergency department capacity. In addition, the study found that more than half of urban hospitals reported time on “emergency department diversion” when the hospital is unable to accept patients by ambulance. Also, one in eight hospitals are on diversion more than 20% of the time, according to the report. Two critical factors driving emergency department diversions are the nursing shortage and the lack of available beds. The report also shows that the number of emergency room visits continues to climb (from just over 80 million visits in 1990 to more than 100 million visits in 2001).

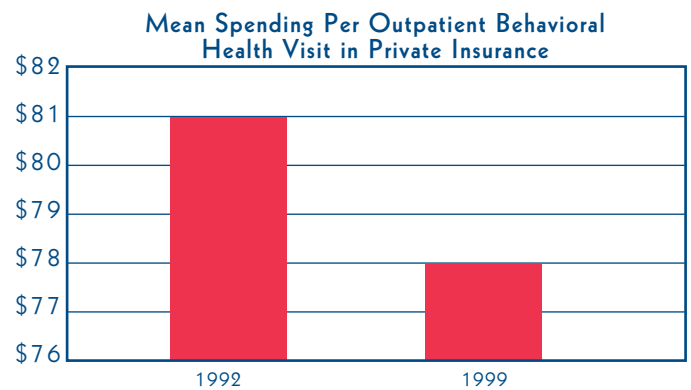
The Overall Infrastructure Is Under Stress, and Access to All Levels of Behavioral Health Care Is Affected.

A Dwindling Supply of Partial Hospitalization Services Increases Pressure on Remaining Programs.

Many partial hospital programs have closed or limited the number of patients they can accept. While 82.5% of respondents to the National Association of Psychiatric Health Systems’ *Annual Survey* offered partial hospitalization services in 2000, in 2001 only 66.7% of respondents offered this level of care. Fewer partial hospital slots now exist as facilities have struggled with administrative costs due to Medicare regulations, fewer payors for partial hospital services, and managed care organizations’ pressure to look to lower-cost alternatives. While the number of facilities offering partial hospitalization programs has shrunk, those that remain have seen substantial increases in their admissions and visits. For example, in 2000 partial hospital admissions increased 9.4% (from 487 in 2000 to 533 in 2001), and partial hospital visits were up 2.9% in the same time period.

The Availability and Payment for Outpatient and Other Community-Based Services Are Not Keeping Pace with Demand.

While outpatient services grew somewhat for privately-insured patients in a recent Medstat study,⁷ outpatient visits remained static and the amount paid per visit declined. In 1992, some 5.8% of enrollees in 22 large businesses covering approximately 1.7 million employees, dependents, and early retirees used an outpatient behavioral health service (vs. 6.8% in 1999)—a 17.5% increase. Over the same period, the number of outpatient visits per enrollee increased 4.5% (going from 5.9 per enrollee in 1992 to 6.2 in 1999). However, the mean spending per visit dropped 3.6% (going from \$81 in 1992 to \$78 in 1999).



SOURCE: *Health Affairs*, January/February 2003

Further evidence that the availability of outpatient services has not kept pace with growing demand can be seen in a recent NAPHS survey.⁸ While 64.2% of respondents to the National Association of Psychiatric Health Systems' *Annual Survey* offered outpatient services in 2000, only 49.2% offered this level of care in 2001.

CHILDREN AND ADOLESCENTS WITH BEHAVIORAL HEALTHCARE DISORDERS HAVE BEEN PARTICULARLY HARD-HIT.

“Stuck children” with psychiatric disorders, who are backlogged in emergency rooms because there are no specialty psychiatric beds available for them, have been documented throughout the country.^{9,10,11,12} Young people who are ready to move to a less restrictive level of care often remain in a residential program or acute inpatient bed because no appropriate alternative is available. As occupancy rates in existing programs continue historic upward trends, children and adolescents are often hard-pressed to access necessary services.

Child/Adolescent Inpatient Occupancy Rates Are Up.

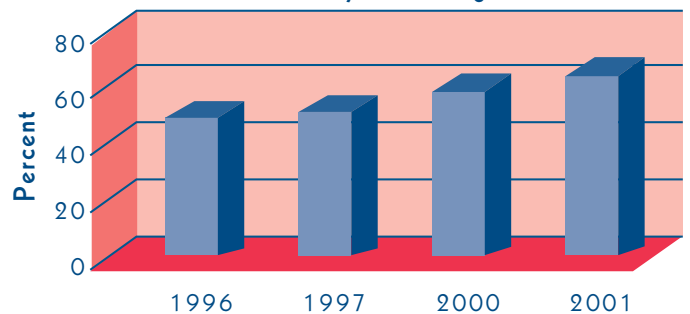
In the five-year period between 1997 and 2001, occupancy rates have increased 30.8% for inpatient child programs and 33% for inpatient adolescent programs, according to the *2002 Annual Survey* of the National Association of Psychiatric Health Systems.

These trends are occurring at a time when admissions are up and lengths of stay are down dramatically. For example, the average length of stay in an inpatient child program in 2001 was 11.7 days (vs. 33.4 days in 1991), or a 65% decline. The average length of stay in an inpatient adolescent program in 2001 was 9.8 days (vs. 23.6 days in 1991), or a 58.5% decline, according to the *2002 Annual Survey* of the National Association of Psychiatric Health Systems.

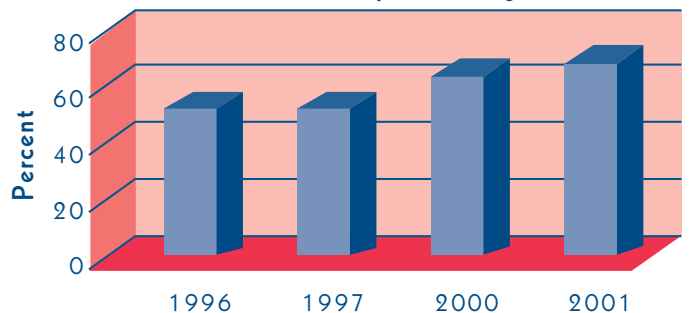
Occupancy Rates in Child/Adolescent Residential Treatment Programs Are at Historic Highs.

According to the *2002 Annual Survey* of the National Association of Psychiatric Health Systems, the median occupancy in child/adolescent programs within freestanding residential treatment centers was 93.5% and 83.9% in hospital-based residential treatment centers. These exceptionally high occupancy rates — coupled with strong admissions rates — demonstrate the critical need for this level of care — and the limited availability of resources.

Inpatient Occupancy Rates for Child Psychiatric Programs



Inpatient Occupancy Rates for Adolescent Psychiatric Programs



SOURCE: NAPHS 2002 Annual Survey Report.

■ THE OVERALL COSTS OF CARE ARE RISING.

Not only are the caregivers, hospitals, and behavioral healthcare programs working at maximum capacity and productivity, but the cost of the care continues to grow while payments from all sources fail to keep pace. The major factors driving cost are:

- **workforce shortages** (including shortages of nurses, inpatient psychiatrists, child psychiatrists, mental health paraprofessionals, and other workers). According to the American Academy of Child and Adolescent Psychiatry (AACAP), shortages today are severe. They cite a 2001 Surgeon General's report¹³ on mental health, which states that there is a "dearth of child psychiatrists, appropriately trained clinical child psychologists, or social workers."¹⁴ Nationwide, 3,543 urban, suburban, and rural localities have been designated Mental Health Professional Shortage Areas by the federal government due to their severe lack of psychiatrists, psychologists, social workers, and other professionals to serve children and adults.
- **skyrocketing professional liability** insurance. A PriceWaterhouseCoopers study for the American Hospital Association and Federation of American Hospitals found that medical liability premiums increased between 30% and more than 100% in 2002.¹⁵ Members of the National Association of Psychiatric Health Systems have reported increases of 100% to 200%.
- growing **pharmaceutical costs**. A study¹⁶ of 22 large businesses covering 1.7 million covered lives found that **expenditures per psychotropic prescription increased 49%** from 1992 to 1999 (from \$35 to \$52), and **expenditures per user increased 101%** (from \$156 in 1992 to \$314 in 1999).
- ever-growing **regulatory requirements** affecting all aspects of behavioral healthcare delivery. Behavioral healthcare providers have expressed concern about a variety of issues, including EMTALA requirements that force providers to accept patients for whom they are statutorily prevented from being paid to treat, Medicare partial hospitalization documentation demands that bankrupt programs, and the one-hour restraint/seclusion rule that requires actions that do not add to improved patient care.

■ OPTIONS TO ADDRESS BEHAVIORAL HEALTHCARE CHALLENGES

- 1) Pass mental health parity legislation to ensure non-discrimination in mental health care.
- 2) Allow non-governmental psychiatric hospitals to be paid under Medicaid for persons between the ages of 21 to 64 if the patient requires immediate hospitalization mandated under the Emergency Medical Treatment and Labor Act (EMTALA) to stabilize his or her condition.
- 3) Provide adequate payment to cover the cost of services for Medicare/Medicaid beneficiaries.
- 4) Build a behavioral healthcare workforce that meets the rising demand for behavioral healthcare services.
- 5) Address the growing crisis in the medical liability insurance market.
- 6) Within the Substance Abuse and Mental Health Services Administration (SAMHSA), create programs to assist communities in developing innovative models to address the growing acute care crisis.
- 7) Create effective models that can be implemented in emergency room settings to improve assessment, treatment, and triaging.
- 8) Improve training of emergency physicians so that they are better equipped to appropriately assess and treat psychiatric emergencies.
- 9) Establish emergency diversion programs to avoid hospitalization.
- 10) Review regulatory requirements to determine the cost-benefit of these regulations and whether they add to patient safety and quality of care.
- 11) Assure adequate resources for special education and provide an option for children with disabilities who are unable to succeed in public schools.

END NOTES

- ¹ National Institute of Mental Health. *The Numbers Count: Mental Disorders in America*. See <http://www.nimh.nih.gov/publicat/numbers.cfm>.
- ² “TRENDS: What Drove Private Health Insurance Spending on Mental and Substance Abuse Care, 1992–1999?” by Tami L. Mark and Rosanna M. Coffey. A federally-funded Medstat study. January/February 2003 *Health Affairs* [22(1):165–172].
- ³ *Mental Health, United States, 2000, 2001*. Center for Mental Health Services. Page 137.
- ⁴ *Report to Congress on Inpatient Psychiatric PPS*, Centers for Medicare and Medicaid Services. August 2002.
- ⁵ National Association of Psychiatric Health Systems. *2002 Annual Survey Report*. 2003. Washington, DC.
- ⁶ *Cracks in the Foundation: Averting a Crisis in America’s Hospitals*. American Hospital Association. 2002.
- ⁷ “TRENDS: What Drove Private Health Insurance Spending on Mental and Substance Abuse Care, 1992–1999?” by Tami L. Mark and Rosanna M. Coffey. A federally-funded Medstat study. January/February 2003 *Health Affairs* [22(1):165–172].
- ⁸ National Association of Psychiatric Health Systems. *2002 Annual Survey Report*. 2003. Washington, DC.
- ⁹ December 2001. “Little Hoover Report released on children’s mental health,” Center for Behavioral Health News, California Healthcare Association. For copies of the report, contact the commission at 916/445-2125 or www.lhc.ca.gov.
- ¹⁰ November 22, 2002. “Report: Children don’t get enough mental health care” by Michael Lasalandra, Boston Herald. NOTE: Report available at <http://www.ppal.net/speakout/>.
- ¹¹ *Assessing Child Mental Health Services in the Oregon Health Plan: A Report on Three Focus Groups*. Bazelon Center for Mental Health Law. Fall 2002.
- ¹² June 19, 2002. “Cuts in mental care leave more youths waiting for help” by Martha Irvine, The Associated Press, Worcester Telegram & Gazette Corp.
- ¹³ *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. 1999.
- ¹⁴ Thomas, CR, & Holzer, CE III. “National Distribution of Child and Adolescent Psychiatrists,” *Journal of the American Academy of Child and Adolescent Psychiatry* [38:9–15]. 1999.
- ¹⁵ “Cost of Caring: Key Drivers of Growth in Spending on Hospital Care” by PriceWaterhouseCoopers for the American Hospital Association and Federation of American Hospitals. February 19, 2003. Page 18.
- ¹⁶ “TRENDS: What Drove Private Health Insurance Spending on Mental and Substance Abuse Care, 1992–1999?” by Tami L. Mark and Rosanna M. Coffey. A federally-funded Medstat study. January/February 2003 *Health Affairs* [22(1):165–172].



NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS

325 Seventh Street, NW, Suite 625, Washington, DC 20004-2802

Phone: 202/393-6700 ■ Fax: 202/783-6041 ■ E-mail: naphs@naphs.org ■ Web: www.naphs.org