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State of New Jersey
DEPARTMENT OF HUMAN SERVICES
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CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

April 24, 2012

Honorable Paul A. Sarlo, Co-Chair
Joint Budget Oversight Committee
PO Box 099
Trenton, NJ 08625-0099

Honorable Vincent Prieto, Co-Chair
Joint Budget Oversight Committee
PO Box 098
Trenton, NJ 08625-0098

Dear Senator Sarlo and Assemblyman Prieto:

I am submitting the Department of Human Services' report on the Senator Garrett W. Hagedorn Psychiatric Hospital Closing, in accordance with N.J.S.A. 30:1-7i.4(d).

Please feel free to contact me with any questions.

Sincerely,

Jennifer Velez
Commissioner

JV:3:jc
Enclosure
c: George LeBlanc
Mary Alice Messenger
David J. Rosen, OLS
Ernest T. Hagans, OLS
Lori O'Mara-Van Driesen, OLS

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SENATOR GARRETT W. HAGEDORN STATE PSYCHIATRIC HOSPITAL FINAL CLOSURE REPORT

April, 2012

INTRODUCTION

The following summary report is submitted to the Joint Budget Oversight Committee in accordance with P.L. 1996, c.150 (NJSA § 30:1-7.4). This report sets forth the background, policy rationale, fiscal impact analysis and summary of the testimony received at the statutorily required public hearing.

BRIEF SUMMARY

In FY 2010, the New Jersey Department of Human Services (DHS) recommended the closure[1] of the Senator Garrett W. Hagedorn Psychiatric Hospital (Hagedorn or HPH). The proposal was developed based on several factors:

1. The Mental Health Olmstead settlement
2. Census reduction
3. Regional accessibility
4. Campus interconnectivity
5. A need to rebalance resources from institutions towards community services

Specifically, the closure will:

1. advance goals outlined in the Division of Mental Health and Addiction Services' (DMHAS) settlement agreement with Disability Rights New Jersey (DRNJ), which mandated that individuals with mental illness receive treatment in the least restrictive and most integrated setting as clinically appropriate;
2. manage system wide vacant capacity due to a 26% reduction of inpatient census;
3. continue to provide regional accessibility to state offered inpatient care;
4. maintain the existing connectivity of shared campuses; and
5. reduce reliance on institutional services and expand the community based mental health system.

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In 2006, DMHAS initiated its recovery-oriented, community service model. As embodied in the recommendations of the Mental Health Task Force (2005), the DMHAS' Wellness and Recovery Transformation Plan (2008), "Home to Recovery" (2008), and the Olmstead Settlement Agreement (2009), an additional $80 million in state funding was allocated and a dramatic expansion of community services and placements began in FY 2007, which continues today.

These funds were responsible for 1,424 new community placements between FY 2006 and FY 2009. An additional 251 placements were developed in FY 2010, considerably expanding housing options for consumers of mental health services in all 21 counties. The development continued into FY 2011, when DMHAS developed 253 housing options for consumers of mental health services. Currently, DMHAS is finalizing 145 housing options for FY 2012. Also this fiscal year, the DMHAS implemented an array of evidence-based practices to: support individuals in the community, divert unnecessary and inappropriate hospital admissions, and advance innovative pilot treatment programs.

Since 2008, DMHAS has restructured its state psychiatric hospital policies and procedures to operationalize best practice strategies that support stabilization, treatment, recovery and discharge in a responsible and timely manner. All consumers receive active therapies and treatment during their in-patient stay as well as coordinated community based support services, upon discharge.

The above factors have resulted in a significant decrease, system-wide, inpatient census. In July 2006, the census was 2,173. At the time the Hagedorn Closure Report was published, the census was 1,601. Additionally, while there has been some increase in census (1,752 in March 2012), the rate of discharge is steady and the remaining hospitals are under capacity.

Hagedorn's closure is scheduled for June 30, 2012.

POLICY RATIONALE

The closure of a state psychiatric hospital and the reconfiguration of New Jersey's public mental health system represent a significant achievement that has substantially reduced reliance on institutional systems of care and expanded opportunities and supports for community living. These efforts are consistent with the Department of Human Services policy of moving mental health and addiction service delivery toward a recovery-oriented system that enables and empowers individuals to live in the least restrictive and most integrated setting appropriate to their clinical needs.

Promoting wellness and recovery through policy, regulation, and funding is central to the DMHAS' short and long term planning. DMHAS' anticipated transition toward the implementation of an Administrative Services Organization will allow the State to manage the care delivered in the public mental health and addiction service system, in which more individuals will be served in their communities. This move builds upon initiatives represented in the Wellness and Recovery Transformation Action Plan (2008),[2] "Home to Recovery" Plan (2008),[3] and the Substance Abuse Prevention and Treatment Block Grant and the Mental Health Block Grants (both expiring 8/31/12).[4] It also is reflected in the *Olmstead* Settlement Agreement

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reached in 2009 with Disability Rights New Jersey, which seeks to ensure that individuals in psychiatric hospitals deemed discharge eligible receive appropriate services and timely discharges into the most integrated community setting based on their clinical status and personal preferences.[5]

DMHAS continues to invest in the expansion of community services and residential options, evidenced by the Governor's proposed budget for FY 2013. Funding has been allocated to develop affordable, permanent housing and support services for consumers of mental health services. The additional funding also enables DMHAS to expand the acute care system, develop local treatment options for serious mental illness and provide consumer-driven treatment options and evidence-based practices in the community as well as in the psychiatric hospitals. The additional funding has created services in the community that have advanced the mission of enabling individuals to live in the least restrictive and most integrated setting appropriate to their need.

It was in accordance with this agreement and the resultant decline in census that the proposal to close Hagedorn and reconfigure the three remaining state adult psychiatric hospitals was announced in March, 2010. Final determinations were made with particular focus on several factors including, overall feasibility of closure within a reasonable timeframe, census at each of the hospitals, statewide geographic inpatient accessibility, each facility's capacity to serve a significant legally-involved population, financial considerations, and campus interconnectivity.

DMHAS closure process began in July 2011, after the adoption of the Governor's FY 2012 budget. Admissions to the hospital were frozen, effective October 3, 2011, and the catchment areas for the remaining hospitals were revised. An initial assessment was made with each patient to determine appropriateness for discharge or transfer to another hospital. The census on April 4, 2012 was 82. There currently are four units open at the hospital; one unit will close in April. The remaining units will be closed as patients are discharged or transferred. On June 30, 2012 the hospital will close.

FISCAL IMPACT

Hagedorn is located in the town of Glen Gardner, Hunterdon County. Hunterdon is a relatively rural and affluent area of New Jersey. According to the U.S. Census bureau, New Jersey has 1,195.5 persons per square mile while Hunterdon has 300 persons per square mile. In 2010, the state wide median income was $69,811 and the median income in Hunterdon was $100,980. That same year, 9.1% of the New Jersey population had incomes below the federal poverty level, while Hunterdon had only 4% of its population living with incomes below the poverty level.

When the closure of Hagedorn was announced in April 2010, Hagedorn employed 777 staff. Almost three fourths (74.5% or 579) of staff were full-time employees. Of the remainder, 8.9% (69) were employed part-time and 16.6% (129) were Temporary Employment Services (TES) staff.

In order to ascertain economic impact to the region, DHS analyzed Hagedorn employees' addresses using GIS (Geographic Information Systems) to identify their county and state of

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residence.[6] Data was available for 730 employees. Results indicated that 462 or 63.3% lived in New Jersey while 268 (36.7%) resided in Pennsylvania. The Hagedorn staff with New Jersey addresses, show the highest concentration in the two counties closest to the hospital. Specifically, Warren County is home to 226 employees and Hunterdon County is home to 93. There are employees residing in 16 of the State's 21 counties, including Essex (36), Middlesex (17), Union (17) and Mercer (14) counties.

In 2010, 2011, and 2012, DMHAS expanded outpatient services in both Hunterdon and Warren Counties starting with the creation of a new program known as Intensive Outpatient Treatment and Support Services, in each county. Additionally, DMHAS expanded two programs: the Program for Assertive Community Treatment (PACT), and Residential Intensive Support Teams (RIST), in each county. All of these program expansions brought resources to the communities and developed job opportunities in private, not for profit agencies.

DMHAS also has been working actively with hospital staff. To minimize the impact of closure on employees, the hospital developed a Placement Policy to offer lateral positions at other state run facilities exclusively to Hagedorn staff. In addition, the Employee Resource and Information Center (ERIC) was established to provide Hagedorn staff assistance in finding alternate employment opportunities within and outside state government. Further, DMHAS is working with the Department of Labor and Workforce Development (DLWD) to host job fairs with private companies and community agencies interested in recruiting Hagedorn employees. The first is scheduled for late April. On several occasions, DLWD has been on-site at Hagedorn to offer staff assistance in areas such as resume writing, interview skills, and job search tools.

During Governor Chris Christie's Fiscal Year 2013 Budget Address, the Governor announced that the Department of Military and Veterans Affairs (DMAVA) will be re-purposing portions of the Hagedorn hospital campus to expand Veterans Haven, which serves Veterans who are homeless. The proposed number of Veterans to be served is 100 and this will create potential opportunities for employment of Hagedorn staff and provide consistent patronage for businesses in the community.

PUBLIC HEARING/SUMMARY OF TESTIMONY

Pursuant to P.L. 1996, c.150 (NJSA § 30:1-7.4), DHS convened a public hearing on March 19, 2012 regarding the closure of the Hagedorn at the Hunterdon County Complex Conference Center from 1:30 pm to 4:00 pm. All members of the general public were permitted to attend and present testimony related to the closure of the facility.

DHS Commissioner, Jennifer Velez, provided introductory remarks and acknowledged the attendance of certain Department staff. Public comment immediately followed. Joseph Young, Executive Director of DRNJ, was the sole registrant and presenter.

Mr. Young testified in support of Hagedorn's closure because it reflects the progress being made in reducing the census in the state psychiatric hospitals and increasing community based resources. Mr. Young stated, "[t]he progress that the Division (of Mental Health and Addiction Services) has been making can result in lasting change only if there is a rebalancing of resources, bringing more services and a more robust continuum of services to the community. As the need

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for long term inpatient services decreases, those redundant resources need to be brought closer to the individuals' homes in the community."

When speaking specifically to the needs of the older adult population Mr. Young stated, "DRNJ recognizes that the needs of older citizens with mental illness is a specialized need that requires careful attention," adding that these specialized services should be developed in the community enabling consumers to be served, "as close as possible to their homes and communities."

No other testimony was heard at the hearing. The Commissioner and other state representatives remained at the Hunterdon County Complex Center until 4:00 pm, at which point the Commissioner closed the meeting.

DMHAS subsequently received written testimony from Kristina Ragosta, Esq. Ms. Ragosta represents the Treatment Advocacy Center. Her correspondence opposed the closure of Hagedorn. Citing statistics, Ms. Ragosta indicated that currently there is a shortage of psychiatric beds in the state and that closure will only exacerbate this problem. Ms. Ragosta stated that while the closure may be well intentioned by shifting treatment to community settings, individuals in need of mental health treatment may not receive adequate services. She went on to state that, ultimately, people will require more expensive placements such as jails, emergency rooms and the streets (suggesting homelessness) and that there also will be a negative impact to the families (of individuals with mental health disorders). Ms. Ragosta suggested that closure will cost the state more money and put some of the state's most fragile citizens at risk.

The statements of Mr. Young and Ms. Ragosta are included as attachments to this report.

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[1] See http://www.state.nj.us/humanservices/dmhs/home/HPH%20-%20Plan%20for%20Closure.pdf
[2] See http://www.state.nj.us/humanservices/dmhs/recovery/Welln_Recov_action_plan_jan2008_Dec2010.pdf
[3] See http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf
[4] See http://www.state.nj.us/humanservices/dmhs/news/publications/Block%20Grant_State_Plan_2010.pdf
[5] See http://www.state.nj.us/humanservices/dmhs/olmstead/olmstead_settlement_agreement.pdfT
[6] Some addresses could not be located, while post office boxes were excluded because they may not be located where employees reside. Of the 579 full-time staff, 542 were located using GIS. Of the 69 part-time employees, 64 could be located, and of 129 TES staff, 123 could be located.

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DISABILITYRIGHTS NEWJERSEY

TESTIMONY SUBMITTED
ON BEHALF OF
DISABILITY RIGHTS NEW JERSEY
TO THE
DEPARTMENT OF HUMAN SERVICES

Disability Rights New Jersey (DRNJ) supports the Department's decision to close Hagedorn Psychiatric Hospital.

DRNJ is the designated protection and advocacy system for people with disabilities in New Jersey, which includes the Protection and Advocacy for Individuals with Mental Illness (PAIMI), 42 U.S.C. §§ 10801 to 10851.[1]

In February 2008, I was among a number of persons who spoke before a legislative committee in response to the numerous disturbing reports coming out of Ancora Psychiatric Hospital. At those hearings, I observed that the state psychiatric hospitals had become the treatment option of last resort for individuals in need of extended acute psychiatric treatment and care, while also serving as a warehouse of last resort for a significant number of others who did not require acute psychiatric care, including those with developmental disabilities, acquired and traumatic brain injury, substance abuse, and dementia. In addition, at that time, between 45% and 55% of the daily hospital census included persons who could return to the community but for whom there were no available supports and services. Since then the overall hospital census has been reduced by close to 19%, and there is a settlement agreement in place to continue to reduce the

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length of time individuals remain in the hospital after they no longer require acute care.

We need to continue to focus less on the redistribution of persons among the hospitals, but the redistribution of resources out of the hospitals. The United States Supreme Court in its *Olmstead v. L.C.* decision indicated that a state's desire to keep its institutions fully populated was not an acceptable reason to avoid the requirements of that decision. 527 U.S. 581, 606 (1999). The progress that the Division has been making can result in lasting change only if there is a rebalancing of resources, bringing more services and a more robust continuum of services to the community. As the need for long term inpatient services decreases, those redundant resources need to be brought closer the individuals' homes in the community.

DRNJ recognizes that the needs of older citizens with mental illness is a specialized need that requires careful attention. DRNJ is also concerned, however, that too often the state psychiatric hospitals are used as the warehouse of last resort for individuals who are too inconvenient to serve in less restrictive placements. In order to avoid filling our state hospitals in the future with increasing numbers of Alzheimer's and dementia patients, New Jersey needs to plan for, and the resources to establish, a comprehensive continuum of care for an exploding population of older citizens that keeps them as close as possible to their homes and community.

Joe Young
Executive Director
Disability Rights New Jersey
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Trenton, New Jersey 08608
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[1]Other programs incorporated within the protection and advocacy system include:

- Protection and Advocacy for Individuals with Developmental Disabilities (PADD), 42 U.S.C. §§ 15041 to 15045,
- Protection and Advocacy of Individual Rights (PAIR); 29 U.S.C. § 794e
- Client Assistance Program (CAP); 29 U.S.C. § 732
- Protection and Advocacy for Assistive Technology (PAAT); 29 U.S.C. § 3004
- Protection and Advocacy for Beneficiaries of Social Security (PABSS); 42 U.S.C. § 1320b-21
- Protection and Advocacy for Individuals with Traumatic Brain Injury program (PATBI), 42 U.S.C. § 300d-53
- Protection and Advocacy for Voter Access (PAVA); 42 U.S.C. §§ 15461 and 15462.

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New Jersey Department of Human Services

March 19, 2012

Testimony by Kristina Ragosta, Esq.
Treatment Advocacy Center

Commissioner Velez:

The Treatment Advocacy Center is a national non-profit organization whose focus and expertise is civil commitment laws. Our mission is to eliminate barriers to treatment for people with severe mental illnesses such as schizophrenia and bipolar disorder. We oppose the closure of the Senator Garrett W. Hagedorn Psychiatric Hospital.

It is estimated that roughly 50 public psychiatric beds are needed per 100,000 population. In 2005, New Jersey had roughly 32 beds per 100,000 population. This state is already suffering from a serious bed shortage, and this closure will exacerbate an already dangerous situation.

For more information, please refer to the attached study published in March 2008, "The Shortage of Public Hospital Beds for Mentally Ill Persons" <http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf> .

Hagedorn Psychiatric Hospital in New Jersey is just one of the latest state facilities to be closed in the name of cost savings. Although well intentioned, reform efforts meant to shift treatment to the community and to protect civil liberties have resulted instead in many of the most severely ill going without needed treatment. The cost of closing this unique facility will ultimately far exceed the $9 million in savings that closure is supposed to produce as the people who are displaced deteriorate and end up in more expensive alternative settings - jails, emergency rooms or the streets. According to a joint study we conducted with the National Sheriffs' Association, a person is already almost twice as likely to end up incarcerated rather than in a psychiatric hospital in New Jersey. In addition to the individual and family suffering it causes, closing Hagedorn will only make the situation worse.

The closure of Hagedorn threatens the well-being of some of New Jersey's most fragile citizens and will ultimately cost the state more in money and lives than it saves.

Sincerely,

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The Shortage of Public Hospital Beds for Mentally Ill Persons

A Report of the Treatment Advocacy Center

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The Treatment Advocacy Center is a nonprofit 501(c)(3) organization. TAC does not accept funding from pharmaceutical companies or entities involved in the sale, marketing or distribution of such products.

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The Shortage of Public Hospital Beds for Mentally Ill Persons

A Report of the Treatment Advocacy Center

Summary

Since the 1960s there has been a mass exodus of patients from public psychiatric hospitals. Data are available on the number of patients in such hospitals in 1955 and in 2004–2005. The data show that:

- In 2005 there were 17 public psychiatric beds available per 100,000 population compared to 340 per 100,000 in 1955. Thus, 95 percent of the beds available in 1955 were no longer available in 2005.
- The states with the fewest beds were Nevada (5.1 per 100,000), Arizona (5.9), Arkansas (6.7), Iowa (8.1), Vermont (8.9), and Michigan (9.9). The states with the most beds were South Dakota (40.3) and Mississippi (49.7).
- A consensus of experts polled for this report suggests that 50 public psychiatric beds per 100,000 population is a minimum number. Thus, 42 of the 50 states had less than half the minimum number needed, and Mississippi was the only state to achieve this goal.
- The total estimated shortfall of public psychiatric beds needed to achieve a minimum level of psychiatric care is 95,820 beds.
- The consequences of the severe shortage of public psychiatric beds include increased homelessness; the incarceration of mentally ill individuals in jails and prisons; emergency rooms being overrun with patients waiting for a psychiatric bed; and an increase in violent behavior, including homicides, in communities across the nation.
- The consequences of the severe shortage in public psychiatric beds could be improved with the widespread utilization of PACT (Program of Assertive Community Treatment) programs and assisted outpatient treatment (AOT), both of which have been proven to

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decrease hospitalization. It could also be improved with greater flexibility in federal and state regulations allowing for the development of alternatives to hospitalization.

I. Introduction

The mass exodus of patients from public mental hospitals, known as deinstitutionalization, began in the 1960s. It was driven by a variety of factors:

1. Public revelations following World War II that most state mental hospitals were grossly overcrowded and that patients were living in squalid conditions, e.g., Albert Deutsch's 1948 exposé *The Shame of the States*.
2. The introduction in 1954 of chlorpromazine (Thorazine), the first effective antipsychotic, which made it possible, for the first time, to control the symptoms of schizophrenia and thus discharge some patients.
3. The creation in the 1960s of federal programs such as SSI, SSDI, Medicaid, and Medicare, which provided fiscal support with federal funds for mentally ill individuals who were living in the community. Patients in state hospitals, however, were not eligible (with a few exceptions) for Medicaid and SSI. Since state mental hospitals continued to be almost completely funded with state funds, these federal programs created a huge incentive for states to discharge patients to the community and thus effectively shifted the cost of their care from the state to the federal government. Fiscal conservatives in the state legislatures therefore strongly encouraged deinstitutionalization.
4. The emergence of a group of young, civil libertarian lawyers in the 1960s who decided that mental patients needed to be "liberated." They implemented a series of successful lawsuits, forcing states to discharge mental patients and making rehospitalization exceedingly difficult.

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It is important to realize that very little was known about the causes of severe psychiatric disorders when deinstitutionalization was getting underway in the 1960s. Influential figures such as Dr. Thomas Szasz argued that mental illness was a myth (*The Myth of Mental Illness*, 1961). Others, such as sociologist Erving Goffman (*Asylums*, 1961) and novelist Ken Kesey (*One Flew Over the Cuckoo's Nest,* 1962), argued that being hospitalized was itself causing the patients' mental problems and that patients would be much better off if simply discharged. The history of deinstitutionalization, with its odd coalition of fiscal conservatives and civil rights liberals, has been thoroughly documented elsewhere.[1]

II. Study of the Availability of Public Psychiatric Beds, 1955 and 2005

Surveys of public psychiatric beds, were carried out in 2004 and 2005 by the Center for Mental Health Services, part of the U.S. Department of Health and Human Services, and by the NASMHPD Research Institute, an affiliate of the National Association of State Mental Health Program Directors (NASMHPD). Since similar data are also available from a survey done in 1955, it is possible to compare the availability of public psychiatric beds over a fifty-year period, prior to and after deinstitutionalization.

In 1955 there were 558,239 public (state and county) psychiatric beds available for mentally ill individuals. The population of the United States was 164.3 million. The availability of public psychiatric beds was thus 340 beds per 100,000 population.[2] In 2005 there were 52,539 public (state and county) psychiatric beds available for mentally ill individuals. The population of the United States was 269.4 million. The availability of public psychiatric beds was thus 17 beds per 100,000 population.[3]

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Table 1 presents the 1955 and 2005 data by state.* In 2005 the states with the most public psychiatric beds per 100,000 population were Mississippi (49.7), South Dakota (40.3), Delaware (33.8), and New Jersey (32.4). The states with the fewest beds were Nevada (5.1),‡ Arizona (5.9), Arkansas (6.7), and Iowa (8.1). The difference in bed availability per population between the states with the most beds compared to states with the least beds was approximately sixfold.

Table 1 also presents public psychiatric bed availability in 2005 as a percentage of bed availability in 1955. On average, only 6.5 percent of the 1955 beds were still available in 2005. Mississippi (19.8%), New Mexico (18.7%), and South Dakota (17.0%) had the highest percentage of beds still available, while Arkansas (2.4%), Nevada (2.6%), and Vermont (2.6%) had the lowest percentage. This number is a measure of how completely the state has emptied its state and county psychiatric hospitals, the degree of deinstitutionalization.

In defending the emptying of public psychiatric hospitals, some officials have claimed that the decrease in public beds has at least been partially offset by increases in private psychiatric hospital beds and psychiatric beds in general hospitals. According to federal data, however, there were very modest increases in both types of facilities in the 1980s and 1990s, but both have subsequently decreased almost to their previous levels.[4] Furthermore, 81 percent of psychiatric beds in general hospitals are in private, not public, general hospitals. Private hospitals are often reluctant to admit individuals who do not have health insurance or are deemed to be "disruptive" or "too violent" to be managed. Since most individuals with serious psychiatric disorders do not have insurance and many are thought to be inappropriate for care in these small settings, private psychiatric hospitals and private general hospitals have been of limited

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* The District of Columbia was not included, since its public psychiatric hospital was used for many years for admissions of non-District residents and its data are not comparable with the states. Data are not available for Alaska and Hawaii in 1955, since they were not states at that time.

‡ In 2007, Nevada opened a new state mental hospital. Thus, their ranking on availability of beds would now be higher than is reflected by these 2005 and 2006 data.

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usefulness in compensating for the massive loss of psychiatric beds in public hospitals; even if they do admit such patients, private hospitals tend to discharge them prematurely or transfer them to public hospitals. To make matters worse, there has also been a significant loss of psychiatric beds in Veterans Administration Hospitals since 1970.

III. How Many Public Psychiatric Beds Are Needed?

There were 340 public psychiatric beds per 100,000 population in 1955 but only 17 such public psychiatric beds per 100,000 population in 2005. This marked contrast raises the question of how many beds are actually needed. What is the correct number?

Surprisingly, almost nothing has been written on this question, and there are no federal guidelines. It is a difficult question to answer because it depends on several factors. These include:

1. The number of seriously mentally ill individuals who are potential candidates for hospital admission. Depending on how one defines "seriously mentally ill," estimates of their number at any given time have ranged from 3 percent to 10 percent of the population. Furthermore, those needing hospitalization tend to be more concentrated in urban areas, so the need for psychiatric beds in cities is greater than in rural areas.
2. The number of seriously mentally ill individuals who actually need hospital admission. This depends heavily on the quality of outpatient treatment in the community. If a state has good community services, such as widespread PACT (Program of Assertive Community Treatment) programs and clubhouses, fewer admission will be needed. If the state uses laws allowing outpatient commitment (assisted outpatient treatment, or AOT), fewer admissions will also be needed, as has been demonstrated in multiple studies.[5]

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3. How long the person remains in the hospital. If the average hospital stay of a person with mental illness is 20 days in one state and 10 days in another state, the first state will need twice as many hospital beds to accommodate the same number of admissions. The average length of hospitalizations depends on many factors, including the skill of the hospital's treatment team, the ability of social workers to make realistic discharge plans, and the availability of appropriate housing and treatment in the community.
4. Short stay beds and long stay beds. Most individuals with serious psychiatric disorders are able to live in the community, either independently or in supervised housing, most of the time. When hospitalization is needed, it is usually for a few days to a few weeks. Public psychiatric beds are used chiefly for individuals needing such short stays; those staying for long periods in these beds are mostly forensic patients who have been court-ordered to the hospital.

   Most seriously mentally ill individuals who require long-term supervised treatment, other than forensic patients, are no longer in public psychiatric beds. Instead they have been transferred to long-term residential facilities including nursing homes. Residential facilities vary widely from state to state; a 2003 survey by the Center for Mental Health Services reported 63 different types of residential facilities in 34 states.[6] Furthermore, this survey was unable to obtain information on the other 16 states. Thus, there are no reliable data on the number of seriously mentally ill individuals in long-term residential facilities in the United States.
5. How the beds are financed. The final factor determining the number of public psychiatric beds needed is how the beds are financed. The more flexible the financing is, the fewer beds will be needed. Currently in the United States, most such beds are financed

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primarily with state funds with smaller amounts of federal funds. These programs have relatively inflexible regulations regarding what constitutes hospitalization, thereby restricting the utilization of alternative forms of care. It was demonstrated more than 30 years ago that alternatives to hospitalization such as the use of public health nurses[7] and crisis homes[8] can be effectively used as alternatives to hospitalization in many cases, but federal and state regulations have impeded their widespread development.

Taking into consideration all these factors, an estimate of the minimum number of public psychiatric beds needed was derived for children and adults with serious psychiatric disorders, including forensic patients. We solicited opinions from 15 experts on psychiatric care in the United States. They included individuals who have run private and state psychiatric hospitals, county mental health programs, and experts on serious psychiatric disorders. We asked them to assume the existence of good outpatient programs and the availability of outpatient commitment and told them that they would not be publicly identified.

The replies received were surprisingly consistent. Almost all 15 experts estimated a need for 50 (range 40 to 60) public psychiatric beds per 100,000 population for hospitalization for individuals with serious psychiatric disorders. Since it assumes the availability of good outpatient programs and outpatient commitment, this is a minimum number.

IV. The Magnitude of Psychiatric Bed Shortage

Using 50 public psychiatric beds per 100,000 population as a minimum, it is possible to compare the present bed capacity in each state with the minimum needed. The results are shown on Figure 1. The states can be divided as follows:

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1. Critical bed storage (less than 12 beds per 100,000 population)

Nevada‡	5.1	Ohio	10.6
Arizona	5.9	South Carolina	10.6
Arkansas	6.7	Oklahoma	11.0
Iowa	8.1	Idaho	11.3
Vermont	8.9	Alaska	11.3
Michigan	9.9		

2. Severe bed shortage (12–19 beds per 100,000 population)

Florida	12.1	Colorado	16.9
Texas	12.1	North Carolina	17.1
Rhode Island	12.5	New Hampshire	17.2
Maine	12.6	California	17.5
Wisconsin	13.0	Tennessee	18.1
Hawaii	13.5	Georgia	18.5
Utah	13.8	Pennsylvania	18.9
West Virginia	14.2	Washington	18.9
Illinois	14.3	Oregon	19.2
Kentucky	15.6	Indiana	19.3
Massachusetts	15.8		

‡ In 2007, Nevada opened a new state mental hospital. Thus, their ranking on availability of beds would now be higher than is reflected by these 2005 and 2006 data.

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3. Serious bed shortage (20-34 beds per 100,000 population)

Louisiana	20.2	New Mexico	22.3
Nebraska	20.7	Wyoming	24.1
Montana	20.9	Connecticut	25.4
Missouri	21.5	North Dakota	25.9
Maryland	21.6	Minnesota	26.8
Kansas	21.7	New York	27.4
Alabama	22.1	New Jersey	32.4
Virginia	22.2	Delaware	33.8

4. Marginal bed shortage (35–49 beds per 100,000 population)

South Dakota 40.3

5. Meets minimal standard (50 or more beds per 100,000 population)

Mississippi 49.7

This assessment is a measure of the chances for a person with a serious mental illness to be admitted to a public psychiatric facility in that state; it does not assess the quality of psychiatric care the person, once admitted, is likely to receive.

Table 2 presents data on the actual number of public psychiatric beds available in 2004–2005 by state; the minimum number of beds that should be available (assuming 50 beds per 100,000 population) to meet minimum standards of treatment; and the number of beds that need to be added. In all 50 states, there are presently a total of 51,413 public psychiatric beds, whereas

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147,233 are needed to meet minimum standards of treatment. The United States is thus 95,820 psychiatric beds short of what is needed for minimum standards of treatment. The number of beds to be added in each state is a target against which public officials can be measured and held accountable.

V. Discussion

The present study of public psychiatric beds in the United States suggests that 42 of the 50 states have less than half the minimum number of beds considered to be reasonable by knowledgeable experts. In 32 of the states, the shortage is critical or severe. Only one state, Mississippi, achieves the minimum standard, and one other state, South Dakota, has only a marginal shortage. At the other extreme, Nevada,‡ Arizona, Arkansas, Iowa, Vermont, and Michigan have less than 20 percent of the minimum number of beds needed.

The consequences of this radical reduction in psychiatric hospital beds have been manifold. One has been a marked increase of severely mentally ill individuals who are homeless. A 2005 federal survey estimated that approximately 500,000 single men and women are homeless in the United States at any given time;[9] multiple studies have reported that one-third of them are seriously mentally ill. These individuals are homeless because of deinstitutionalization and the failure of the state to provide aftercare for them once they are discharged from the hospital. A study in Massachusetts, for example, found that 27 percent of patients discharged from a state psychiatric hospital became homeless within six months of discharge; in a similar study in Ohio, the figure was 36 percent.[10] A recent study of 81 American cities demonstrated a direct relationship between having fewer psychiatric beds and more homeless individuals.[11]

‡ In 2007, Nevada opened a new state mental hospital. Thus, their ranking on availability of beds would now be higher than is reflected by these 2005 and 2006 data.

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The effect of mentally ill homeless persons on the quality of life on nation's sidewalks and in parks and public libraries are known by all who live in cities. According to one observer: "A simple visit to the local elementary school, post office or grocery store . . . can be a Dantean journey through the dark underside of our society. Violence, harassment and an astonishing list of antisocial behavior are commonplace."[12] These social costs are matched by fiscal costs. In Los Angeles it was estimated that the cost of "arrests, incarcerations, emergency medical care and other crisis interventions" runs between $35,000 and $150,000 per person per year for individuals who are chronically homeless.[13] In Reno "a chronically homeless mentally ill man . . . cost the county at least $1 million during his 10 years on the streets before he died in 2005."[14] Fiscal conservatives thought that they would save money by emptying state mental hospitals, but they in fact only shifted the fiscal burden from the department of mental health to departments of corrections and social services and to the courts.

A second consequence of the radical reduction in public psychiatric hospital beds has been a massive increase in severely mentally persons in jails and prisons. Conservative estimates have placed the number at 7 to 10 percent of all inmates, but some studies have put the figure at 20 percent or higher. In Alabama in 2007, for example, Corrections Commissioner Richard Allen told the state legislature that 20 percent of inmates in state prisons were "in need of mental health treatment."[15] In many jails, such as Miami's Dade County Jail, 10 percent of the inmates are being treated with antipsychotic drugs.[16] The three largest *de facto* psychiatric institutions in the United States are the Los Angeles County Jail, Chicago's Cook County Jail, and New York's Riker Island Jail. We have been unable to identify a single county in the nation where the county psychiatric inpatient facility is holding as many mentally ill individuals as the county jail. And once a person is in jail, it is almost impossible to find them a bed in a psychiatric hospital. In

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Virginia, for example, Sheriff Paul Lanteigne of Virginia Beach "estimates that it typically takes at least six months to find an available bed for a deranged inmate."[17]

A third consequence of the reduction in psychiatric hospital beds is a concentration of mentally ill persons in emergency rooms (ERs), waiting for psychiatric beds to be found. In North Carolina, for example, Doug Trantham at the Smoky Mountain Mental Health Center described "an inpatient crisis so bad that what it does is backup the entire system."[18] Officers there have sometimes had to drive patients across the entire state—a seven- to eight-hour drive one way—to a hospital with a bed. Emergency rooms are said to have mentally ill people waiting "four or five days in our ICU just waiting for a place to go. . . . You may have somebody in there all weekend, screaming for 12 or 18 hours," said a nurse. It is the same in every state; in Arlington, Virginia, county officials had to call 31 hospitals before finding one that would accept a patient.[19] The impact of overburdening the ERs with patients needing hospital beds goes far beyond psychiatric patients; rather, it interferes with all medical and surgical care in the ER.

A fourth consequence of the reduction in psychiatric hospital beds is violent crime. Because there are so few beds available, individuals with severe psychiatric disorders who need to be hospitalized are often unable to get admitted, and those who are admitted are often discharged prematurely. Fred Markowitz, in his 2006 study of 81 American cities, reported a statistically significant correlation between the number of public psychiatric beds available in that city and the prevalence of violent crimes, defined as murder, robbery, assault, and rape.[11] This is not surprising, since studies have shown that between 5 to 10 percent of seriously mentally ill persons living in the community will commit a violent act each year, almost all because they are not receiving treatment. Such individual are responsible for at least 5 percent of all homicides.[20]

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The correlation between fewer psychiatric beds and more violent crime, which was statistically demonstrated by the Markowitz study, is anecdotally illustrated by daily news reports. The following tragedies, for example, all occurred in California in recent years:

- San Diego, April 2001: Benjamin Flores, diagnosed with schizophrenia, was killed by the police after he attacked them with scissors. He had been released from a psychiatric hospital two days earlier.[21]
- Fresno, March 2002: Bobby Mallory, diagnosed with bipolar disorder, killed his wife "within hours" of being released from a psychiatric hospital.[22]
- Los Angeles County, February 2004: Edward Hernandez, diagnosed with schizophrenia, killed his brother within a day of being released from a psychiatric hospital.[23]
- Tiburon, September 2004: Ramdeen Solomon, diagnosed with schizoaffective disorder, stabbed his mother the day after having been psychiatrically evaluated for possible admission but then refused for admission.[24]

VI. Solutions

The present severe shortage of public psychiatric beds should not be tolerated. It is imperative that individuals with severe psychiatric disorders have access to hospitalization when needed. The present shortage can be ameliorated by the following:

1. Holding state governors and mental health officials responsible for the shortage and demanding that they create the number of public psychiatric beds needed to meet the minimum standards of treatment.
2. Implementing and using PACT programs and assisted outpatient treatment (AOT) in every state; both programs have been proven to decrease the need for hospitalization.

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3. Modifying federal and state regulations to allow more flexibility in the utilization of alternatives to psychiatric hospitalization.
4. Changing the federal prohibition on the use of Medicaid in state hospitals, thus moving decisions regarding treatment from being based primarily on fiscal considerations to being based on clinical needs.
5. Implementing a moratorium on the closure of any more beds in state psychiatric hospitals.
6. Making the public aware that the current severe shortage in public psychiatric beds is in part responsible for the increase in homelessness, the increase in the number of mentally ill persons in jails and prisons, the increase in mentally ill persons in emergency rooms, and the increase in violence, including homicides.

A civilized nation has a responsibility to protect those who cannot protect themselves. If people need care they should be able to access it and then to not be discharged until they are ready. As Dr. Robert Reich eloquently expressed it:

> No one who is chronically mentally ill should be summarily discharged to the community unless the community can provide an appropriate and safe place for him or her to live. Those patients unable to physically protect themselves must be protected from the predators in our society; those unable to feed and clothe themselves must be placed in a surrounding where they will be fed and clothed. . . . [The] freedom to be sick, helpless and isolated is not freedom. . . . Our present policy of discharging helpless human beings to a hostile community is immoral and inhumane. It is a

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return to the Middle Ages, when the mentally ill roamed the streets and little boys threw rocks at them.[25]

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[1] See E. Fuller Torrey, *Nowhere To Go: The Tragic Odyssey of the Homeless Mentally Ill* (Harper and Row, 1988); *Out of the Shadows: Confronting America's Mental Illness Crisis* (John Wiley and Sons, 1997); and *The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens* (W. W. Norton, 2008). See also Rael Jean Isaac and Virginia C. Armat, *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (Free Press, 1990).

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[3] (a) 2006 State Mental Health Agency Profiles (Alexandria, Va.: NASMHPD Research Institute, October 2007); this includes state hospital data only. (b) Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004 State Tables, Table 10b (Rockville, Md.: Department of Health and Human Services); this includes state and county hospitals.

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