# EVOLUTION AND DEVOLUTION OF INPATIENT PSYCHIATRIC SERVICES: FROM ASYLUMS TO MARKETING MADNESS AND THEIR IMPACT ON ADULTS AND OLDER ADULTS WITH SEVERE MENTAL ILLNESS

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I examined the factors that led to the rise and fall of psychiatric hospitals and its impact on two select groups of individuals: adults and older adults with severe mental illness. To explore the reasons behind these fluctuations, the State of Texas was used as a case study. Additionally, the fluctuations occurred for different reasons in public vs. for-profit investor-owned psychiatric hospitals. Using an investor-owned psychiatric hospital organization as a case study, I investigated the differences in factors that influenced the growth and/or demise in public vs. investor-owned psychiatric hospitals. Evolution and devolution of psychiatric hospitals was assessed during select time periods: 1700 to1930, 1940 to1970, 1980 to 2000, and 2000 to present. Time period selections were relevant to the important drivers of the span of time that influenced the psychiatric hospitals. Historical review and trend analysis was used to identify the total number of psychiatric hospitals and/or total number of psychiatric hospital beds and psychiatric hospitals by type. Analysis showed there was a cyclical pattern of evolution and devolution of psychiatric hospitals and each cycle altered the form, function, and role of the psychiatric hospital along with altering the location of care for adults and older adults with severe mental illness. The research results suggest a long-stay residential facility, specializing in evidence-based treatment for adults and older adults with severe mental illness, to counter the dire shortage of psychiatric hospital beds.

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# LIST OF ABBREVIATIONS

CON – Certification of need

CMC – Charter Medical Corporation

CMS – Center for Medicare and Medicaid

DRG – Diagnostic related grouping

ER – Emergency room

HBIPS – Hospital based inpatient psychiatric services

IMD – Institutions of mental disease

MedPAC – Medicare Payment Advisory Committee

NAMI – National Alliance for Mental Illness

NIMH – National Institute of Mental Health

NME – National Medical Enterprise

OBRA – Omnibus Budget Reconciliation Act

PSI – Psychiatric Solutions, Inc.

SAMHSA – Substance Abuse and Mental Health Services Administration

TDSHS – Texas Department of State Health Services

UHS – Universal Health Services

# CHAPTER 1

# INTRODUCTION

*I must be crazy to be in a looney bin like this*.
(McMurphy, *One Flew Over the Cuckoo's Nest*)

Inpatient psychiatric hospitals have played a central role within the U.S. healthcare system as providers of hospital based treatment for mental illness for more than 250 years. Over the course of history, psychiatric hospitals underwent radical changes. These changes altered their purpose, function, and form. Public psychiatric hospitals were once the central health service organizations that served the needs of individuals with mental illness, around which the first U.S. mental health policy was developed (Dowdall, 1996; Grob, 1994; Mechanic, 1989). However, by the 1950s, the function of psychiatric hospitals as institutions of care for mental illness came into question and the institutional treatment lost its legitimacy (Geller, 2000; Grob, 1994; Mechanic, 1989). The collective thinking that individuals with mental illness are better served in the community, led to the change in location of treatment for mental illness from formal organizations of institutional care to more informal community care settings (Dowdall, 1996). Private psychiatric hospitals born after the closure of a large number of public psychiatric hospitals in the 1970s came to fill the gap in the community. Unlike the private psychiatric hospitals before the 1970s, the new breed of psychiatric hospitals is largely for-profit, multi-hospital, and investor-owned organizations. But by 1990, the number of investor-owned psychiatric hospitals dropped by more than half and public psychiatric hospitals and general hospitals with psychiatric units also reduced in size (Mark, Stranges, Vandivort-Warren, Stocks, & Owen, 2009). By 2010, the investor

owned psychiatric hospitals are on the growth cycle again (Geller, 2009; Hutchins, Frank, & Glied, 2011).

In order to understand whether the current inpatient psychiatric hospitals meet the needs of individuals with mental illness, it is first important to understand how and why they developed and evolved over time. The aim of this research was to explore the dramatic rise and fall of psychiatric hospitals and to assess its impact on two select groups of individuals: adults with severe mental illness and older adults over the age of 65 with mental illness. Through a historical review, the first goal of this paper was to: a) understand the precipitating factors that led to the growth of psychiatric hospitals and the factors that led to the reduction of psychiatric hospitals. b) Increase and or decrease in the inpatient psychiatric hospitals did not occur at an even rate across the United States and there was great variation among states. Using the state of Texas as an example, I aim to understand the reasons behind the fluctuations in the inpatient psychiatric hospitals in Texas. c) The fluctuations of increase or decrease occurred for different reasons in public psychiatric hospitals compared to the for-profit investor-owned psychiatric hospitals. Using an investor-owned psychiatric hospital organization as a case study, I aim to gain knowledge of the differences in factors that influence the growth or demise in public psychiatric hospitals vs. investor-owned psychiatric hospitals.

In the 1960s, when the Community Mental Health Act of 1963 was formulated, it shifted and altered the focus from providing mental health services to individuals with severe mental illness to providing mental health service for everyone (Mechanic, 1989; Torrey, 2014). This resulted in creating a homogenous blanketed array of mental health services with the primary focus of prevention of mental health problems and treatment

in the community settings (Mechanic, 1989; Torrey, 2014). However, only a small percentage of those with mental illness have severe mental illness such as schizophrenia, schizoaffective disorders, or major depression with psychosis. These types of mental illness are chronic and persistent conditions and frequently resistant to treatment. Currently, there is no real cure for severe mental illness except for management of the condition. Individuals with severe mental illness are the most frequent users of inpatient psychiatric hospitals (National Alliance for Mental Illness, 2016).

Additionally, with demographic shifts in the U.S population, the number of adults over the age of 65 is growing at an alarming rate. The prevalence rate of mental illness is not only higher in older adults, but the prevalence rate of organic and neuro-degenerative mental illness such as Alzheimer's and dementia is higher in older adults (Segal, Qualls, & Smyer, 2011). The second goal of this research was to gain knowledge of how the various fluctuations in the inpatient psychiatric hospital as related to the availability of inpatient psychiatric hospital beds affects adults and older adults with serious mental health needs.

Previous historical, critical, and sociological studies on psychiatric hospitals attributed the growth of psychiatric hospitals to the varied socio-cultural and political trends and ideologies of the time (Foucault, 1965; Goffman, 1961; Laing, 1960; Szasz, 1974). However, they viewed the psychiatric hospital as a static and mechanistic institution that is impermeable to change. Through a comprehensive review of evolution and devolution of inpatient psychiatric hospitals, my third goal of this research was to

illuminate the psychiatric hospital as a health service organization that is not only amenable to change but that is a strategic organization capable of adaptation.

This research is based on the assumption that inpatient psychiatric hospitals provide a unique type of health services not provided in other type of health service organizations. So, the other questions this research explores are: What role do psychiatric hospitals still play in the overall health service system in providing mental health service to adults and older adults with serious mental illness? What is the future of this type of health service organization?

## Theoretical Background

Though this research does not fully embrace a theoretical stance and is primarily an explorative and historical analysis of a health service organization, it was influenced and guided by Estes' (2001) theory of political economy. As part of the critical gerontological theories, theory of political economy provides a framework to understand the role of economic and political forces and ideologies in shaping the experience of aging and the aged in a market economy. The theory of political economy states the way societies structure social policies often perpetuate rather than eliminate social inequalities in later years (Street, 2007). Estes (2001) discusses four social process that shape old age, aging, and policy formation: medicalization, commodification, privatization, and rationalization. The social construction of aging resulted in commodification of goods and services which in turn shifted the mode of production of medical goods and services from mode of service to a mode of medical production oriented toward monetary exchange for creation of private profit and increasing

enormous private wealth. This resulted in the formation of the medical-industrial complex and the aging enterprise. Attempts to rationalize this shift has led to the restructuring of health care in pursuit of efficiency and cost reduction (Estes, 2001).

## Scope of the Study

Hospital based psychiatric services are provided in a wide range of settings: public hospitals, private hospitals, residential facilities, and units in general hospitals. Psychiatric services are provided in private clinics, community settings, and rehabilitation settings. The scope of the current research was limited primarily to public and private psychiatric hospitals and a review of psychiatric units in general hospitals where data was available. As residential and rehabilitation services do not provide services for individuals with acute levels of psychiatric needs, they were not reviewed in this research.

The review of the history of madness or mental illness is limited in scope and only to the extent of how the social construction of madness and mental illness affected the creation, invention, and evolution of the psychiatric hospital as a specialized provider for mental health services. The effect of inpatient psychiatric hospitals is limited to two select groups: a) adults with serious mental illnesses and b) adults over the age of 65 with both mental illness and organic illness.

## Methodology

I explored and assessed the evolution and devolution of inpatient psychiatric services to its current model of delivery of health/mental health services listed in

significant years of U.S health service history: From 1700-1930; from 1940-1970; from 1980-2000, and from 2000-Present. Selection of the time periods is relevant to the significant important drivers of the time period that influenced the inpatient psychiatric services. To study the growth or decrease in the inpatient psychiatric hospitals, trend analysis was used to calculate the total number of psychiatric hospitals and or total number of psychiatric hospital beds and psychiatric hospitals by type. Primary data for psychiatric hospital beds was collected from the U.S Department of Health and Human Services (2014), Substance Abuse and Mental Health Services Administration (2004, 2008, 2010, 2011, 2012), Agency for Healthcare Quality and Research (2017), American Hospital Association (2006-2017), Center for Medicare & Medicaid Services (n.d., 2010, 2015), National Institute of Mental Health (1977), and Texas Department of State Health Services (2010, 2011, 2012, 2013a, 2013b, 2014, 2015a, 2015b, 2016, 2017) among other governmental data. Primary data was also collected from hospitals' annual reports. When data was unavailable, especially for years prior to 1950, secondary data was collected from peer review journal articles. Other sources used were books, peer review journal articles, company websites, and news and media publications. Data for Chapter 3 on Texas psychiatric hospitals was collected from Texas Department of State Health Services (2010, 2011, 2012, 2013a, 2013b, 2014, 2015a, 2015b, 2016, 2017), Texas Department of Aging and Disability Services (2008, 2009, 2011a, 2011b, 2011c) Texas Historical Society, and Texas Medical Association (2016) among other state and local government organizations. Secondary data for Texas was collected from local news articles and mental health organization briefings and annual reports. Data for Chapter 4 investor-owned psychiatric hospitals was

collected from company websites, company annual reports, company 10k-filings, and from peer reviewed journal articles, publications, and books.

## National Demographical Trends

The U.S. population aged 65 and over increased to 40 million in 2010 (Colello, 2011). The rate of growth of the older adult population began to increase dramatically in 2011 and is expected to grow to 55 million by 2020 and 72 million by 2030. Along with the increase in the number of older adults, the life span of older adults is expected to increase by an additional 18.5 years. Though the population age 85 and older is currently a smaller segment of the older adult population, this segment is the fastest growing population. By 2020, population age 85 and older is expected to increase to 7.3 million. The rate and total growth of the older adult population varies across the states with California leading the demographic shift in population (Colello, 2011). Prevalence rates of serious mental illness and organic illness is greater in older adults. Fifteen to 25% of older adults reported serious mental illness, and individuals over the age of 65 commit 25% of all reported suicides in U.S. Despite the increase in mental illness, research shows elderly seek and receive far less care than younger adults for mental illness (G. D. Cohen, 1977). Parks and Josef (1997) investigated the factors that influence the length of stay for geriatric patients in a state hospital and found the median length of stay for a geriatric patient in the inpatient psychiatric setting is 72.0 days. In addition, older adults with mental illness also suffer from co-existing medical conditions.

According to National Alliance on Mental Illness (2016), 1 in 5 adults in the U.S. experience mental illness or 43.8 million adults experience mental illness in a given year

and 1 in 25 (10 million) adults live with serious mental illness. Of those with serious mental illness, 2.4 million report schizophrenia, 6.1 million report bipolar disorder, 16 million adults report major depression, and 42 million report anxiety disorders. Approximately 10.2 million adults have co-occurring mental and addiction disorders. Twenty-six percent of adults staying in homeless shelters have serious mental illnesses and 24% of state prisoners have a recent history of mental illness. Serious mental illness costs $193 billion in lost earnings each year and nearly 60% of adults with mental illness do not receive treatment each year (National Alliance for Mental Illness, 2016). In 2003, the national expenditures for the treatment of mental disorders costs $100 billion. Expenditures on mental health continue to increase from $33 billion in 1986 to $203 billion in 2014. As healthcare spending increased in all conditions, the total mental health spending amounted to 7.5% of the total healthcare spending in 1986 and the proportion dropped to 5.9% of total healthcare spending in 2014.

Individuals with serious mental illness such as schizophrenia and bipolar disorder and alcohol and substance use related disorders tend to rely on healthcare and mental healthcare services at a greater degree. Often individuals with serious mental illness also report additional physical and medical problems. According to the Medicare Payment Advisory Commission (MedPAC, 2010), in 2008 Medicare spent $3.9 billion on inpatient psychiatric services. Medicare beneficiaries accounted for one-quarter of all inpatient psychiatric hospital discharges; 295,000 had almost 443,000 stays.

Severe mental illnesses, such as schizophrenia or organic neuro-degenerative illness such as dementias, are associated with a number of sub-acute and acute symptoms which lead to an inpatient psychiatric admission. Patients are referred to the

inpatient psychiatric setting from nursing homes, emergency rooms, community settings such as board and care homes, group homes, referred by other physicians, or by family members who are no longer able to take care for the individual or manage the individual's condition or behavior. Patients may be highly psychotic, aggressive, agitated, delirious, confused, assaultive towards family or staff, or sexually inappropriate towards others. Patients may be paranoid, wandering into the streets, or if living in another community setting, wandering into other patient rooms. Patient might be cognitively impaired or experiencing delusions or experiencing visual/auditory/tactile hallucinations, exhibiting bizarre behaviors such as talking to self, stripping themselves naked, or accusing others. Patients may also exhibit depressive symptoms, engaging in self-harming behaviors, highly suicidal, or attempt suicide. Frequently, patients experiencing acute and sub-acute symptoms also lack insight or are unaware of their illness or mental health condition. Along with psychiatric symptoms, patients might also have chronic medical conditions or have an existing substance use disorder. Many times, family or relatives involve the police because the patient is violent and a danger to others. Family may obtain legal guardianship rights to allow them to hospitalize the patient or the police might initiate emergency detention to admit the patient to the psychiatric hospitals (Boronow, 2009; Hirschbein, 2010; Klimstra, Latoussaki, Kiosses, & Alexopoulous, 2009).

## Summary

The purpose of this explorative study was to examine the dramatic rise and fall of psychiatric hospitals and to assess its impact on two select groups of individuals: Adults

with severe mental illness and older adults over the age of 65 with mental illness. This chapter introduced and provided the background information on the problem. Psychiatric hospitals have played a central role within the U.S. healthcare system as providers of hospital based treatment for mental illness for more than 250 years. Individuals with severe mental illness are the largest users of this type of health care setting, especially during states of acute mental health crisis. To understand whether the current inpatient psychiatric hospitals meet the needs of individuals, it is first important to understand how and why they developed and evolved overtime and which factors influence their growth or demise. Psychiatric hospitals were originally built with a noble goal of providing humane care and treatment for individuals with serious and chronic mental illness. In this research, I hope to examine the plight of the individuals who most depend on this type of health service. I conclude with implication of the findings on the two select group of individuals as well as suggestions for future research.

# CHAPTER 2

# LITERATURE REVIEW

## National and Historical Trends in Inpatient Psychiatric Hospitals

As of the 21st century, inpatient psychiatric hospitals' function is to meet the urgent needs of individuals experiencing an acute mental health crisis. The individual must be in imminent danger to self or others, either intentionally or because of a psychological impairment. The goal of the psychiatric hospitalization is to stabilize and restore the individual's ability to live independently and to discharge to the next level of care provider safely. This type of health service provides 24-hour supervision, observation, and behavioral management to reduce risk of harm to self or others. Services provided in the inpatient psychiatric setting include nursing services, medication management, psychosocial rehabilitation, psychoeducation, family therapy, and group therapy (individual therapy is provided as ordered or deemed necessary). Patients are required to be seen by both a medical and a psychiatric physician and the emphasis is on interdisciplinary treatment.

Inpatient psychiatric services are provided in various types of health care organizations such as public hospitals, for-profit, non-profit, general hospitals with psychiatric units, or Veterans Administration hospitals. Units within the psychiatric hospital are separated by either age specific populations, e.g., pediatric/adolescence/ adult/ geriatric and or by treatment specialization such as adult/chemical dependency/military/women etc. (MedPAC, 2010). Most psychiatric hospitals now admit patients to specialized units based on clinical need. For example, older adults over the age of 65 with mental or organic illness are admitted to specialized geriatric units and

individuals with serious/acute mental illness, especially if the individual is experiencing psychosis or is aggressive, are admitted to the acute/intensive psychiatric unit (Glick & Tandon, 2008). However, this was not always the case. The current model and delivery of inpatient psychiatric services evolved over a course of more than 200 years.

Like the rest of the U.S. health services (Williams & Torrens, 2008), the years before 1930 was the development of the first hospitals or in this case, the first asylums as formal organizations of psychiatric hospital services; followed by the era of development of psychiatric treatments and research of mental illness in scientific medicine. The years from 1940-1980 were marked by a shift in location of care of psychiatric services from asylums or institutional settings which were formal organizations of delivery of services to more informal and community based settings. From the 1980s onwards to the present, inpatient psychiatric services have evolved into a commercialized business organization which is driven by economics rather than clinical need (Grob, 1994, Geller, 2000, Mechanic, 1989, Morrissey, 1989; Williams & Torrens, 2008).

In this chapter, I explore and assess the evolution and devolution of inpatient psychiatric services to its current model of delivery of health/mental health services listed in significant years of U.S health service history: From 1700-1930, 1940-1970, 1980-2000, and 2000-Present. Selection of the years to investigate is relevant to the significant important drivers of the time period that influenced inpatient psychiatric services. The goal of this exploratory chapter was to review the historical trends, understand the precipitating factors that led to the growth of psychiatric hospitals, the factors that led to the reduction of psychiatric hospitals, and to assess how the various

phases of transformation in the inpatient psychiatric hospitals impacted adults with severe mental illness and older adults over the age of 65 with mental illness.

## History

### *1700–1930*

Before the 20th century, the rural and public policies that defined the role of the local, state, and federal government in the treatment and care of individuals with mental illness did not exist. Individual with mental illness was a family problem first, and when the family was unable to take care of the individual, the responsibility of the individual shifted to the local government (Bell, 1989; Dowdall, 1996; Pietikainen, 2015). Insanity and mental illness were not seen as a medical problem, and social policies related to mental illness and the care of the individual with mental illness were influenced by two social problems—poverty and insanity—with two sets of institutions namely the almshouse and the asylums (Grob, 1994). Michel Foucault called the 17th and 18th centuries care of mental illness as the *era of great confinement*. He viewed this time as the dark period filled with brutality and distress of mental patients largely driven by the elites to subjugate the poor and downtrodden (Foucault, 1965). Other authors point to reformers such as Phillipe Pinel in France (Bell, 1989; Pietikainen, 2015). Pinel championed moral treatment and for the provision of humane treatment for individuals with mental illness. He was known as one of the first reformers of care for the individual in the institutional setting. Pinel's work played a vital role in the *medicalization of insanity* and established asylums legitimacy as institutions of therapeutic care for mental illness (Bell, 1989; Pietikainen, 2015).

By the 18th century, the social and cultural belief system shifted to one of collective moral obligation toward the individuals with mental illness (Grob, 1994). Increases in population and urban/industrial development, influenced by the European ideologies brought new ways of thinking. The era of enlightenment followed by Phillippe Pinel's *moral treatment* in Europe and the humanitarian movement that emerged from the Quakers ways of thinking in the U.S. emphasized stewardship and philanthropy. This led to a growing consensus that government, particularly the local government, had a moral obligation to foster the welfare of its citizens and thus the care of individuals with mental illness. Soon local governments began to build general hospitals (Geller, 2000, 2006a; Grob, 1994; Pietikainen, 2015).

In 1752, the first psychiatric hospital in the colonies, The Institute of Pennsylvania Hospital developed as part of the general hospital (Penn Medicine, 2017; Pietikainen, 2015). But the first hospital exclusively built as an insane asylum was Eastern Lunatic Asylum of Virginia, in 1773. Individuals with mental illness during this time period were called *distracted* or *lunatics* and administrators of the early asylums were called *alienists* (Pietikainen, 2015). New York Hospital began to accept *lunatic* patients in 1791 and Maryland Hospital in 1798. Asylum for the Relief of Friends Deprived of their Reason was established in 1817 and helped introduce moral treatment to America. By 1818, Mclean Asylum for the Insane opened in Boston (Geller, 2006a; Pietikainen, 2015).

Between 1752 and 1754, 18 out of 117 individuals admitted to the institutional setting were classified insane and by 1787, the number had grown to 40 (Grob, 1994). The three new private institutions built between 1811 and 1822—The Mclean Asylum, Friends' Asylum, and the Hartford Retreat Asylums—were mostly private and semi-

private hospitals opened initially with the intent of providing care for the whole community, but quickly ran out of operational funding. When the states opened public institutions in 1839 and 1843, the private institutions readjusted their role and began to cater to the rich and affluent individuals. The development of the State Asylum in Massachusetts in 1830 was the beginning of setting the public/state owned psychiatric hospitals at the center of U.S. mental health policy and increased states responsibility of the care of the individual with mental illness. In its essence the first U.S. mental health policy was a policy of institutional settings and the asylum treatment played a center role in the larger mental health system (Geller, 1998, 2000, 2006a; Grob, 1994; Pietikainen, 2015).

Largely due to the efforts of asylum reformers like Dorothea Dix, one of the most prominent and persuasive figures in asylum development, dozens of new institutions across the United States developed and helped change public perceptions of individuals with mental illness (Geller, 1998, 2000, 2006a; Pietikainen, 2015). By the middle of the 19th century, most states had at least one or more asylums. By the end of 1844, there were more than 20 asylums in the U.S. (Geller, 1998, 2000, 2006a; Pietikainen, 2015). Until the 1930s, local and state governments held the primary social and financial responsibility of the care of the mentally ill individual (Grob, 1994).

In their origins, the asylums were similar to their predecessor–the almshouses. Before asylums came into existence, almshouses provided care to the sick and aged individual, along with providing shelter and food (Grob, 1994). Almshouses were supported by public funds and the initial asylums were supported by private philanthropy (Grob, 1994).

As almshouses decreased their population and began to shut down, populations in asylums grew and increasingly housed patients who were elderly (Grob, 1994; J. R. Sutton, 1991). In his theory of political economy of madness, J. R. Sutton (1991) analyzed the reasons for the growth in the number of asylums and the increase in patient population in the asylums between the years of 1880 and 1920s. J. R. Sutton attributed the growth of asylums to:

1. The shift in the social definition of madness or the lack thereof and the inability of asylums to identity a target population; in 20th century terms, this is defined as lack of admission criteria
2. Lack of psychiatric knowledge which led to the loose categorization or identification of mental illness
3. Power struggle between new and emerging disciplines of neurology and psychiatry
4. Growth of insane asylum advocates and activists such as the National Association for the Protection of the Insane and the Prevention of Insanity in 1880 and the National Committee for Mental Hygiene in 1909
5. Closure of almshouses as custodial warehouses of the poor and the increase in elderly population which in turn increased the demand and growth of asylums

Though most social historians of early asylum development attribute the growth in asylums to the increased urbanization, industrialization, and increase in population, J. R. Sutton saw the growth of asylums as driven by the self-serving need to garner greater social and political power by the bureaucratic actors and administrators of asylums. His theory of political economy of madness attributes the growth of asylums to

the incapacity of the U.S. local, state, and federal government to formulate systematic solutions to the problem of poverty and blames the progressive era political parties for controlling the distribution of wealth and resources via a range of programs that differentiated population by social status. Asylum building was also favored over almshouses as it funneled jobs to state and local agencies which helped the bureaucratic actors and administrators gain even more power (J. R. Sutton, 1991). J. R. Sutton explained the growth of asylums before 1930s and the demise of the asylums in 1950 to the political and institutional structure of the U.S. government. J. R. Sutton states in his conclusion ". . . and the link between social control and social welfare continues to provide a fruitful line of inquiry into the production of deviance" (p: 676). On the other hand, Grob (1994) attributed the explosive growth before 1930s as motivated by fiscal incentives for local officials which shifted the burden of care for the mentally ill individual from local to state responsibility. Figure 1 shows the reduction of almshouses and reformatories and growth of asylums from 1880-1930 (J. R. Sutton, 1991).

Grob (1992) analyzed the patient population from 1890 to 1930 and found the characteristics of the asylums had changed in those decades due to a greater number of chronic and long stay populations. The percentage of short-stay population (12 months or less) rose from 27.8% of total patient population in 1904 to 12.7% in 1910 and rose again to 17.4% in 1923. The percentage of long stay populations (five years or more) increased from 39.2% of the total patient population in the asylums to 52.0% in 1910 and 54.0% in 1923 (Grob, 1992).

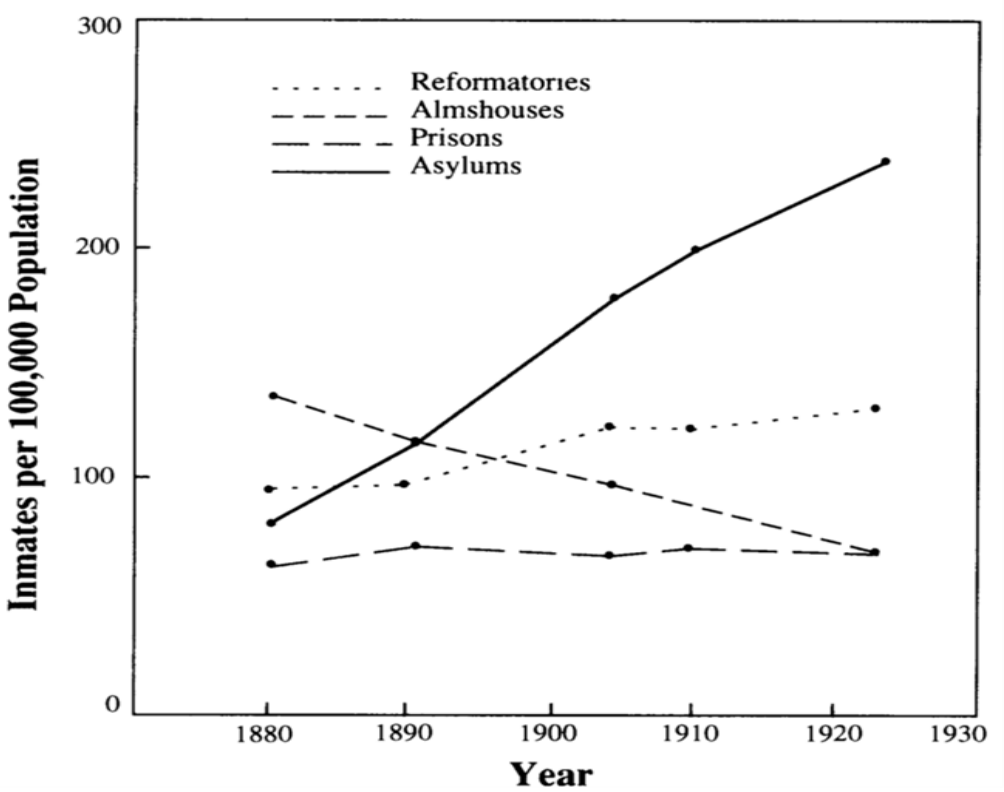



*Figure 1.* Reduction of almshouses and reformatories and growth of asylums from 1880-1930 (J. R. Sutton, 1991, p. 666).

Using New York State Hospital as an example, there were 16,006 patients in New York State hospitals in 1890. By 1910, the number had increased to 31,658, an increase of 104% in merely two decades. During the same period of time, New York's population increased by only 51.8% (State Hospital Commission, 1914). New York State overall had the largest asylum system in the nation and accounted for about a fifth of all institutionalized patients (Grob, 1994). The annual report of the New York State Hospital Commission in 1914 attributed this growth in population to the natural increase of State population and inadequate federal legislation for preventing the entry of insane from other countries or improper enforcement of these laws. Nine thousand patients in New York State institutions were neither citizens of New York nor of the United States (State Hospital Commission, 1914). In 1912, there were 31,624 patients in civil hospitals

and 1,272 in institutions for the criminally insane. There were a total of 8,368 admissions in 1912–7,664 of them to civil hospitals, 272 to hospitals for the criminally insane, and 432 to private institutions. After accounting for readmissions and transfers – the total number of patients under treatment in 1913 in New York was 43,042 of which 39,893 were in civil hospitals, 1,549 in criminal institutions, and 1,600 in private institutions. The average daily census in the 14 civil institutions was 32,319 which was an increase of 739 patients from 1912. In 1913, 29,797 patients or 91.4% were supported by the State, 2,582 or 7.9% inpatient residents were supported by the partial cost of maintenance, and 220 or .7% were admitted under special agreement in accordance with the provision of Section 89 of the insanity law (State Hospital Commission, 1914).

By the 1930s, patient demographics had changed in the asylums. In 1913, of the total admissions to New York State Hospitals, 9.8% were cases of senile psychoses, 16.8% were suffering from dementia praecox, and 12.7% with dementia paralytica. By 1930, 18% of all first time admissions to New York State mental hospitals were diagnosed psychotic because of senility or arteriosclerosis, by 1940 this number grew to 31%, and by 1950 it further increased to 40%. By 1950, nearly 40% of the inpatient psychiatric patients in public/state hospitals was over the age of 65 (Grob, 1992; State Hospital Commission, 1914). The proportion of chronic and long-stay patients between the 1830s and 1870s was low, but by 1900 the number of chronic and long-stay patients began to increase greatly. The number of chronic and long-stay patients increased substantially between 1890 and 1950. Patients over the age of 65 accounted for only 5-10% of the total population between 1830 and 1875. But between 1880 and 1940 more

than a third of the total inpatient was over the age of 65 (Grob, 1992). In 1920, there were a total of 232,680 patients in mental hospitals in the U.S.–200,109 were in state hospitals, 21,584 in county and city facilities, 1,040 in institutions for temporary care, 809 in public health service hospitals, and 9,238 in private hospitals. In 1920, only 4% of the total inpatient psychiatric population was in private psychiatric facilities (Geller, 2006b).

In 1922, of the 49,116 admissions, 16,407 were identified as somatic conditions such as senility, cerebral arteriosclerosis, paresis, Huntington's chorea, brain tumors, etc. From 1922-1940, the percentage of patients with the same diagnosis increased from 33.4% to 42.4%. A large number of the public psychiatric population was elderly over the age of 65. As late as 1958, a third of all public inpatient psychiatric population was over the age of 65. In 1946, senility and paresis were half of the total admissions (Grob, 1992, 1994).

### *1940–1970*

By the 1940s, the number of patients in mental health institutions increased and the public psychiatric hospital played a center role in the treatment of mental illness and the role of private psychiatric institutions rescinded. The location of care had shifted from the community (almshouses) to institutional settings (asylums) and a greater percentage of the state hospital patients were older adults, the seriously mentally ill, or the incurable. As a result, the percentage of long stay population in asylums increased. This shifted the function and role of the mental health institution from a therapeutic institution to a custodial institution. The responsibility of the mentally ill individual shifted

from the local government to the state government (Bell, 1989, Grob, 1992, 1994, 2005; Mechanic, 1989; Morrissey, 1989; Torrey, 2014).

In 1946, the Hill Burton Act was passed (Health Resources & Services Administration (n.d.). The Hill Burton Act subsidized construction of general hospitals and provided substantial federal funds for general hospital expansions and facilitated admission of psychiatric patients. Also in 1946, The National Mental Health Act passed which provided grants to states to support existing and new outpatient facilities (Grob, 1992, 1994, 2005; Torrey, 2014).

Articles exposing the internal life and conditions of public psychiatric hospitals in various journals such as Life magazine and Reader's Digest, newspapers, books, and movies in the 1940s brought national attention to the desperate conditions of psychiatric hospitals. Mary Jane Ward published *The Snake Pit* in 1946: in 1948 Reader's Digest made the book into a movie. The book was based on the authors own fictionalized experience of staying at the Rockland Psychiatric Center in New York for eight months (Ward, 1946). Maisel (1946) published an article titled "Bedlam 1946: Most Mental Hospitals in the U.S. are a Shame and a Disgrace" in *Life* magazine which brought national attention to life inside Byberry, a Philadelphia psychiatric hospital, and Ohio's Cleveland State Hospital. Journalist Mike Gorman (1946) published "Misery Rules in State Shadowland" in the *Daily Oklahoman*, as part of a series of six articles, which were turned into a book titled *Oklahoma Attacks its Snake Pits* in 1948. Albert Deutsch (1948) published a book titled *Shame of the States*. Written by journalists and activists, the common and prevailing theme of all these publications was state/public psychiatric hospitals were overcrowded, under staffed, and provided their services in inhumane and

dehumanizing conditions. A close reading of these depictions show the fictionalized and sensationalistic account of inner life in asylums of the 1940s, the intent, I assume, was to reform and improve the conditions of institutional treatment for individuals with mental illness.

In 1955, the antipsychotic drug chlorpromazine (Thorazine) became available in the U.S. (Mechanic, 1989; Torrey, 2014). Thorazine was reported to reduce delusions, hallucinations, and manic symptoms of patients with severe mental illness. Also, between 1920 and the 1970s, there was tremendous progress and advancements in psychiatry and psychological treatments and cures. In 1920 psychoanalysis was introduced in the inpatient settings. In 1930 insulin coma, Metrazol shock, electroconvulsive therapy along with occupational therapy and psychosocial rehabilitation were used in the inpatient settings. In the 1940s milieu therapy was introduced and in 1955 the introduction of the first antipsychotic medication as shown in Figure 2, Thorazine, would result in fundamentally altering the locus of the treatment and inpatient treatment setting (Mechanic, 1989; Torrey, 2014).

The 1950s also saw the growth of the civil rights movement and growth of civil libertarian lawyers who argued for the rights of patients in psychiatric hospitals. The libertarian lawyers initiated a series of highly successful lawsuits which forced states to discharge patients and also made it difficult for the psychiatric hospitals to admit patients (Torrey, 2014). As a result of the lawsuits, a series of laws were passed that gave patients the right to refuse treatment. The 1964, a District of Columbia ruling changed the standards for the involuntary commitment of psychiatric patients. This

ruling changed the *need-for-treatment* standard to *danger-to-self-or-others* standard (Glass, 1976; Mechanic, 1989; Morrissey, 1989; Torrey, 2014).

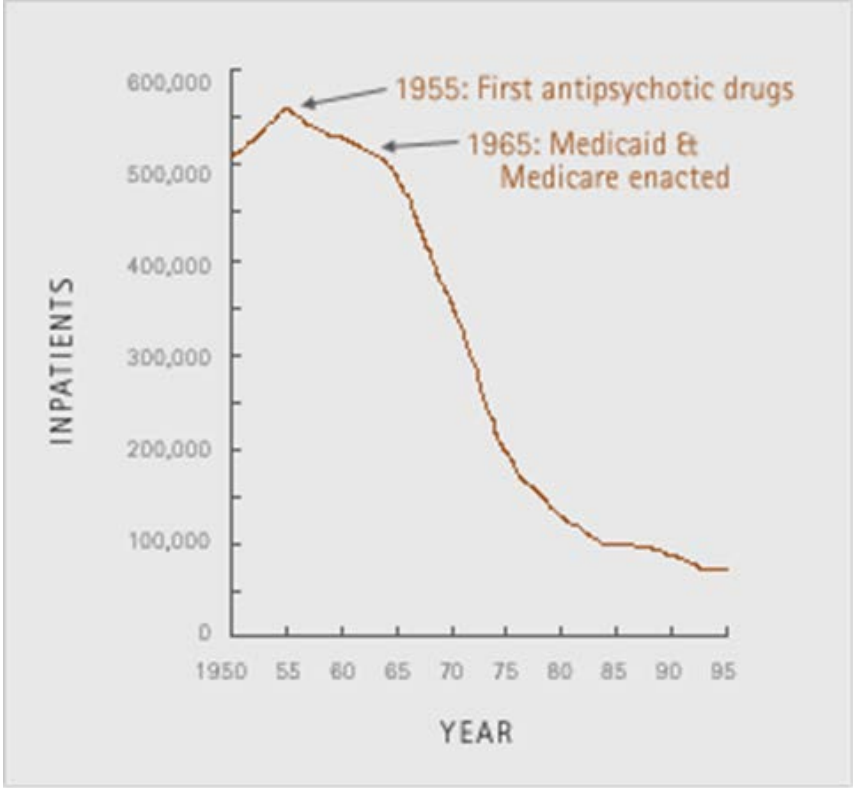



*Figure 2.* First antipsychotic drug and reduction of inpatient psychiatric discharges (Torrey, 1997, para. 1).

As a result of all the developments, public hospitals began to discharge patients into the community. Discharge of patients from the public and private institutions occurred gradually by late 1940s, but picked up momentum in the 1950s. In the initial phase of the deinstitutionalization movement, between 1945 and 1955, 17 states decreased their state mental hospital census, while 48 states continued to increase their census. There were 417,315 patients in all state mental hospitals in 1941, and 520,683 in 1953. In 1955, there were 558,922 patients in state mental hospitals across United States (Bell, 1989; Gronfein, 1985).

By the early 1960s the social, political, and cultural climate shifted to one of anti-institutions, anti-establishment, and anti-psychiatry. Laing published *The Divided Self: An Existential Study in Sanity and Madness* in 1960, Szasz's book *The Myth of Mental Illness: Foundations of Theory of Personal Conduct* was first published in 1961, and Goffman's *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* was also published in 1961. In 1962, Kesey's *One Flew Over the Cuckoo's Nest* was published as a book and in 1965 Foucault published *Madness and Civilization: A History of Insanity in the Age of Reason*. Taken together, the prevailing theme that emerged from these historians, psychiatrists, and critical social scientists was the root cause of mental illness or mental distress was attributed to environmental factors and situated within the institutional setting. They disagreed with the medicalization of mental illness.

Szasz (1961/1974) argued mental illness does not exist and it was a social construct. Goffman (1961) compared asylums to prisons and coined the term *total institutions*. Goffman defines total institutions as an isolated and enclosed system with the primary purpose of control on all aspects of the participants' lives. These authors questioned and forcefully criticized the patriarchal psychiatrist relationships with patients and perceived the confinement in public hospitals as a means of control (Goffman, 1961; Szasz, 1961/1974). They argued mental illness is socially constructed and exacerbated by environmental factors and hence, cannot be understood in isolation or studied in isolation from the institutional treatment settings (Goffman, 1961; Szasz, 1961). R. D. Laing (1960) worked extensively with patients residing in asylums with schizophrenia and argued the treatment and medicalization of mental illness was the

root cause of the distress and the continued stay in the psychiatric setting institutionalized the individual. Though these authors themselves were not directly involved nor did they champion the removal of patients from public psychiatric settings, their thinking and writings influenced the larger prevailing social and cultural ideas of public psychiatric hospitals as institutions that caused mental illness rather than providing therapeutic treatment (Dowdall, 1996; Foucault, 1965; Geller, 2009; Goffman, 1961; Laing, 1960; Pietikainen, 2015; Szasz, 1961/1974; Torrey, 2014).

In 1963, President Kennedy signed the the Community Mental Health Center Act (Grob, 1994; Torrey, 2014). This act officially shifted the U.S. mental health policy based on institutional settings to community settings. In 1965, under President Johnson, modifications of the Social Security Act, Medicare and Medicaid were created. Medicare is the federally funded health insurance program for individuals over the age of 65, while Medicaid is jointly funded by state and federal dollars that provides medical care for the indigent and poor. Both programs initially excluded coverage for mental illness. For Medicaid, an exclusionary criteria called the IMD (Institutions of mental disease) was established. An IMD is

> defined as an institution of mental disease as a hospital, nursing facility or other institutions of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental disease including medical attention, nursing care, and related services. (Department of Health and Human Services, 1988, para. 6)

In lay terms, this law prohibited federal financial participation (FFP) for inpatient psychiatric care provide in an IMD with more than 16 beds. The original IMD was enacted in 1905 for individuals 65 and older in hospitals and nursing homes that were IMDs. In 1972, Medicaid amended the IMD exclusionary criteria and allowed states to

use federal funds when paying for individuals under the age of 21 or in certain circumstances for under age 22 in the inpatient psychiatric settings. The reason for this exclusion was to ensure states, rather than federal government, continued to take primary responsibility for funding inpatient psychiatric services and to encourage community-based services. Essentially, this law excludes inpatient psychiatric services for adult patients but covers services for children, adolescents, and seniors (Rosenbaum, Teitelbaum, & Mauery, 2002).

In the 1960s private health insurance increased mental health coverage via the Federal Employees Health Benefit Plan (Geller, 2006a; Grob, 1994; Hutchins et al., 2011; Torrey, 2014). Also, the United Auto Workers and Health Insurance Plan of Greater New York provided mental health services. Private health insurance covered inpatient psychiatric care. The enactment of Medicaid in 1965 expanded healthcare coverage to low-income individuals (Geller, 2006a; Grob, 1994; Hutchins et al., 2011; Torrey, 2014).

Federal programs such as Medicare, Medicaid, SSI, and SSDI were allocated for seriously mentally ill in the community and shifted costs of care for mentally ill individuals from state to federal government (Geller, 2006a; Grob, 1994; Hutchins et al., 2011; Torrey, 2014). After the 1940s, psychiatry and psychopharmacology as fields of study evolved and provided a better generation and class of drugs. Following the National Mental Health Act of 1946 to the 1970s, the intensity of activity in the field of mental health grew. Clinical research on mental illness from various disciplines also grew. Increased emphasis of prevention of mental illness in the community and greater focus of promoting mental health came to be the norm. Training of psychiatrists,

psychologists, psychiatric social workers, nurses, and other types of mental health personnel also increased. The period between 1950 and 1970 was marked by an increased number of outpatient clinics and the establishment of general hospital inpatient units for psychiatric patients (Grob, 1992; National Institute of Mental Health, 1977; Walkup, 1997). As a result of all these developments, between the years of 1956 and 1970, the number of state hospital beds decreased by 400,000 (Torrey, 2014). By the early 1960s, the median stay for adults with schizophrenia in 23 select states was 12.8 years (Grob, 1994). After the 1960s, both the number of beds and the length of stay in the public psychiatric hospital decreased.

Also between the years of 1955 and 1965, the number of residents in the public psychiatric hospitals were discharged slowly at first and then dramatically thereafter. In 1955, there were 178,002 admissions to state and county mental hospitals, and in 1965, there were 316,664 admissions and 384,511 admissions in 1970. This indicates an important shift in the function of the state and county hospitals. Before the 1950s, state and county hospitals treated a large number of chronic and long stay patients. After the 1950s and forward, due to the discharge of a large number of the inpatient population whom nearly a third of the population was over 65 years of age, the state and public hospitals began to provide more short term care and treatment for severely mentally ill patients (Grob, 1992; National Institute of Mental Health, 1977; Torrey, 2014).

During the 1970s, more than a dozen states enacted laws requiring health insurance within the state to offer a specific minimum set of mental health benefits−30 inpatient hospital days and 20 outpatient days (Frank, Koyanagi, & McGuire, 1997). At the beginning of 1970, there were 150 private for-profit psychiatric hospitals which

accounted for less than 4% of the total inpatient psychiatric capacity. By the end of the decade, the number increased to 184 (Hutchins et al., 2011).

Between 1975 and 1980,

> the President's Commission on Mental Health, the Secretary's Committee on Mental Health and Illness of the Elderly, and the National Conference on Mental Health and Aging, coordinated by the U.S. House of Representatives Select Committee on Aging emphasized the need for improved responsiveness of community mental health service programs to the mental health programs of older adults. (Knee & Krueger, 1981, p. 6)

The Community Mental Health Centers Act of 1975, Public Law 94-63, Section 201 (b) (1) increased the required number of services and increased the range of services including specialized programs and services for the mental health of the elderly including diagnosis, treatment, outreach and follow-up services (Dowell & Ciarlo, 1989; Knee & Krueger, 1981).

In 1978, a report titled: *Mental Health and the Elderly: Recommendation for Action* was submitted to the President's Commission on Mental Health (Federal Council on Aging, 1979). The task panel on mental health was chaired by the first lady Rosalind Carter. The summary of this report clearly outlines the aging demographic challenges facing the U.S. by 2030 and the need for mental health services for the elderly. This report stated the older population and their mental health problems remained outside mainstream understanding as older adults during the process of deinstitutionalization were merely transferred out of the public mental hospitals into communities which were ill-prepared to care for them. The report is also a critique of the trend of transferring older patients out of state mental hospitals into less expensive boarding homes (Federal Council on the Aging, 1979).

During the middle of the 1970s when National Institute for Mental Health (1977)

initiated the nation-wide program of closing down the state mental hospitals, President Jimmy Carter's Commission on Mental Health focused on the development of specialized programs for the discharged patients. The Federal Council on the Aging (1979) put forward seven options and suggestions in developing community mental health resources and services for the elderly:

1. Outreach: the problem of accessibility can be ameliorated using an outreach approach, with coordinator integrating the various services available within the community;

2. Home care: Home care must become an essential component of the continuum of mental and physical health care of elderly

3. Medicare: The discriminatory treatment of mental health services under the provisions of Medicare must be reformed to reduce expensive institutionalization which results from the way current legislation is written;

4. Geriatric medicine: Geriatric training must become part of the mainstream of knowledge in preparing doctors, nurses, social workers, and psychologists;

5. Research: There must be major national effort to promote and support accelerated research on the single most terrifying mental health problem of the elderly-organic brain disease;

6. Allocation of resources: Resources within the Department of Health, Education, and Welfare (HEW) especially in NIMH and NIA must be allocated in a realistic way as they bear on different age groups;

7. Revitalization of AOA: The executive of all these options will be heavily dependent upon the effective, revitalized leadership of the specific office created by congress to be a visible and strong advocate for older Americans. (p. 8)

By the time President Reagan took office the mental health policy was not a federal priority and the above suggestions were ignored. During this period Medicaid, Supplemental Security Income, and Section 8 housing covered the needs of the chronically mentally ill (Dowell & Ciarlo, 1989; Madianos, 2010).

In 1950, 39% of the total psychiatric patients were in mental institutions, 19%

were in homes for the aged and dependent, and 17% were in correctional institutions (Grob, 1992; National Institute of Mental Health, 1977). By 1970s there was a dramatic shift in the location of care due to the development of community based programs for the diagnosis, treatment, and rehabilitation of persons with mental disorders. By 1970, 44% were in homes for the aged and dependent, 20% in mental institutions, and 15% in correctional institutions (Grob, 1992; National Institute of Mental Health, 1977).

By the end of the 1970s, the social, cultural, and economic trends in mental health treatment and the location of care shifted from institutional settings back to community settings. Private hospitals and general hospital psychiatric units began to play a greater role in the treatment of individuals with mental illness (see Figure 3).

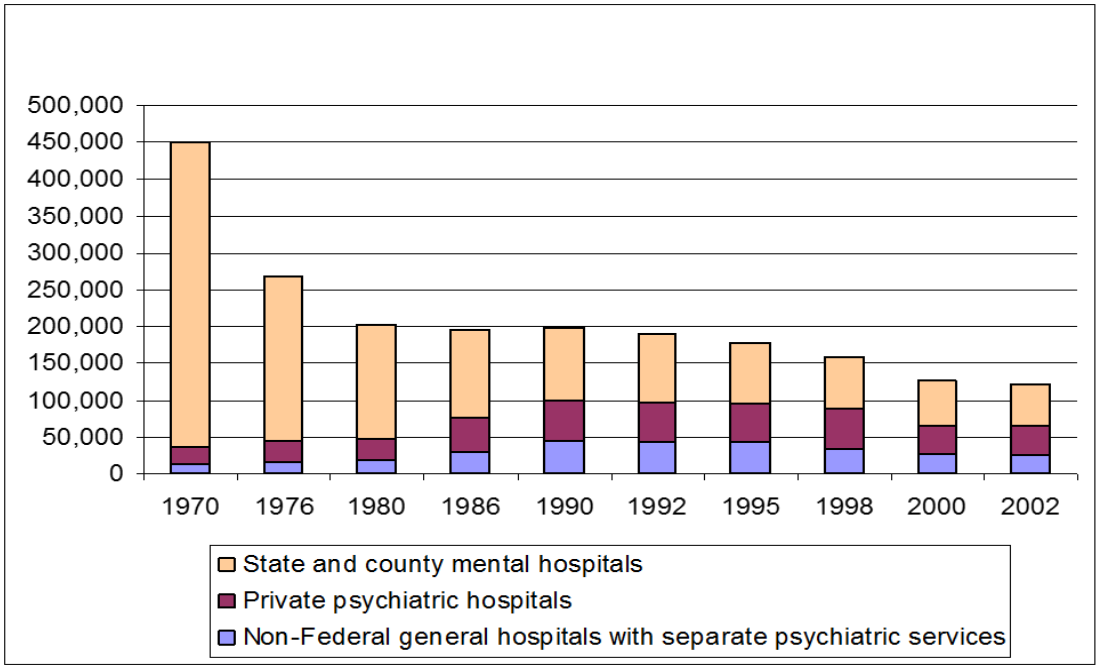



*Figure 3.* Changes in state, private, and general hospital psychiatric hospitals beds from 1970 to 2002 **(**Mark et al., 2009)

Public hospitals lost their legitimacy as psychiatric and therapeutic institutions of care (Grob, 1992). Their function shifted from providing custodial care to providing care to

serious/acute mental illness. Private and employer insurance increased coverage for mental illness. Other types of settings such as nursing homes and outpatient centers grew.

### *1980–2000*

In 1980, President Jimmy Carter signed the Mental Health Systems Act (Knee & Krueger, 1981). This act sought greater integration of mental health services to individuals with serious mental illness, elderly and other underserved population. In 1981, the Mental Health System Act (PL-96-398) was enacted and used as a resource guide for Mental Health and Support Services for Elderly was realized in conjunction with the National Mental Health Institute and Department of Health and Human Services. The purpose of the resource guide was:

> to bridge the gap between the geriatric mental health service program and those programs offering support of complementary social and health services to the elderly. It provides a context of developing a range of approaches to comprehensive geriatric mental health services . . . The goal of the users is to offer alternative approaches to the development of comprehensive programs for elderly individuals in need of mental health services. It is hoped that it will assist in increasing the quantity and quality of mental health services to the elderly. (Knee & Krueger, 1981; p. 5)

However, in 1981 when President Ronald Regan took office, the Mental Health Act was repealed and the role of federal government in mental policy rescinded and gradually diminished (Grob, 2005; Mechanic, 2007). Soon after taking office, President Regan passed the Omnibus Budget Reconciliation Act (OBRA) of 1981. Federal funding was cut for many social programs and policies designed to boost privatization and competition were implemented. These changes dramatically shifted the landscape of

the public for-profit and non-profit healthcare service industry and the federal and state funding of community services. Estes (2001) stated

> . . . funders were encouraging a new level of competition between . . . community-based nonprofits and for-profits providers of healthcare, behavioral health care, services to elderly, long-term care, children's services, services to the disabled, education, and job training. Most nonprofits found it difficult to compete with larger institutions that had extensive infrastructure, information systems, and financing capabilities. (p. 64)

Budget cuts for community services increased, but it also created a rich and fertile environment for the for-profit healthcare industry. Many types of for-profit health care services such as acute care, nursing homes, and inpatient psychiatric services grew exponentially in the 1980s. Surveys of nursing homes from 1977-1999 found that in 1977 there were 1.28 million residents in nursing homes, and by 1999 this number grew to 1.63 million, a 27% increase. During the same time period, the number of nursing home facilities and the number of beds in the nursing facilities also increased from 16,200 nursing homes with average of 79 beds per nursing home to 18,000 nursing homes with average of 105 beds per nursing home (Decker, 2005). Much of the nursing home industry expansion occurred in the for-profit and multi-chain/investor owned nursing homes.

In 1983, the Social Security Amendment- Medicare Inpatient Prospective Payment System (IPPS) shifted the reimbursement of health care services from retrospective cost-based reimbursement to set care-based reimbursement. This new system exempted inpatient psychiatric hospitals and certified psychiatric units of general hospitals because the diagnostic related group classification system (DRGs) was shown to have greater variation in psychiatric diagnosis (Center for Medicare & Medicaid Services, 2015; Cotterill & Thomas, 2004; Hutchins et al., 2011). Prior to the passage of

this Amendment, hospitals were paid whatever they spent hence there was very little incentive for cost control. To encourage healthcare cost control, Congress legislated several changes to the Medicare reimbursement system as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). To control cost but to continue reimbursement, the system was designed to pay a single flat rate per type of discharge. Each discharge was classified into a diagnosis-related group (DRGs). However, this new system exempted inpatient psychiatric hospitals because the diagnosis related group based classification system was shown to have greater variation in the psychiatric diagnosis than the medical diagnosis. Hospitals and service settings exempt from the new IPPS system were paid under a modified cost-based reimbursement system in TEFRA (Center for Medicare & Medicaid Services, 2015). TEFRA provided generous benefits to private psychiatric hospitals. The Inpatient Psychiatric Facility Prospective Payment System was not implemented until 2005.

Pottash, Gold, Bloodworth, and Extein (1982) predicted the ownership of inpatient psychiatric services will become more centralized and the greater number will be owned by hospital chains. The authors recommended private hospitals increase contracts with health maintenance organizations and develop relationships with other healthcare organizations. The authors conclude abrupt changes in reimbursements and the regulatory environment are major risk factors to the future growth of private psychiatric hospitals (Pottash et al., 1982). Gibson (1978) commended and even lauded private psychiatric hospitals on how they responded to the changing environment by modifying their role, diversifying their services to target select population, and developing alternatives to inpatient settings. The author encouraged private hospitals to

expand and explore relationships with other healthcare systems and provide services to the underserved (Gibson, 1978).

Between 1972 and 1982, investor-owned for-profit psychiatric hospitals increased dramatically and accounted for more than half of the psychiatric hospitals. The growth was seen particularly in the for-profit investor-owned multihospital chains. In 1984, Hospital Corporation of America (HCA), National Medical Enterprise (NME), Charter Medical Corporation (CMC) and Community Psychiatric Centers (CPC) together owned 85% of the total private inpatient psychiatric market (Hutchins et al., 2011). Charter Medical increased its growth by 50% in three years from 1984-1987. HCA increased its ownership from 0 to 43 facilities in the first five years of its operation. By 1986, Charter Medical and HCA owned 5,000 psychiatric beds (Hutchins et al., 2011).

In 1986, 207,000 individuals were admitted to private psychiatric hospitals with a "mood disorder" as the most frequent diagnosis (Koslowe, Rosenstein, Milazzo-Sayre, & Manderscheid, 1991). Between 1983 and 1986, the number of for-profit private psychiatric hospitals increased from 220 to 314. During the same time period the number of for-profit psychiatric beds increased from 21,474 in 1983 to 30,201 in 1986, an increase of 41%. The number of admission increased from 164,732 to 234,663 and by the end of 1986, admissions increased from 16,079 to 24,591. Of the total inpatient admissions, two-fifths were under the age of 18, almost 50% were between the age of 18-44, and 8% were over the age of 65. The total number of staff (full-time employees) increased from 42,202 in 1984 to 58,912 in November 1986 (Redick, Stroup, Witkin, Atay, & Manderscheid, 1989). Along with the exponential growth, the demographics of

for-profit hospitals also changed from admitting patients with acute/severe mental illness to admitting patients with moderate distress or mood disorders.

Also, there were greater number of patients in the inpatient psychiatric hospitals below the age of 18 than in the prior years. Gralnick and Caton (1992) conducted a retrospective study of 2,041 patients admitted to a long-term private psychiatric hospital using admission files on all patients from January 1, 1962 to December 31, 1986. They found by the1980s, much younger than the cohort in 1962 (mean age dropped from 38 to 25), the number of youth increased from one-quarter to almost half of the patients. Miller's (1985) testimony to the U.S. Congressional panel lamented from 1980 to 1984 nationally there was a 450% growth in the number of admissions for youth below 18 years of age in the private psychiatric industry. In 1962, more than half of the patients admitted had a diagnosis of schizophrenia, usually paranoid or un-differentiated. By 1985, this number dropped to a quarter of the patients admitted and there was a substantial increase in the admitting diagnosis of depression. While substance abuse was not a major diagnosis in 1962, there was a marked increase in the substance abuse diagnosis along with marked increase of personality disorder, particularly borderline and antisocial subtypes by the 1980s (Gralnick & Caton, 1992).

Dorwart and Schlesigner (1988) analyzed the causes for the dramatic growth of the for-profit inpatient psychiatric industry in the 1980s. The authors attributed the growth to five social and political changes:

1. Increase in the number of mental health care professionals. Psychiatry as a profession grew resulting in number of psychiatrists growing from 10,600 in the 1950s to 33,000 in the1980s, along with increases in professionals in social work and clinical psychology
2. Growth in mandated insurance coverage for mental illness by various states which covered inpatient care over outpatient care

3. Demographic shift in the inpatient population, especially in the age group between 24-44 to 5 million between 1980-1985

4. Greater awareness of mental illness and the indirect costs of mental illness related to productivity. Employers increased healthcare benefits for mental illness, along with Medicare Part A coverage for inpatient psychiatric hospitals. Older adults living in nursing homes are reimbursed by Medicare Part B coverage which has minimal coverage for mental illness

5. Reduced stigma of mental illness, increased research in psychiatry, and discovery and categorization of new mental illnesses and the "*medicalization*" of psychiatric illness (Dorwart & Schlesigner., 1988, 545-546)

Other causal factors for growth of for-profit psychiatric hospitals included: the increased acceptance of *marketability of services*. For-profit and investor-owned psychiatric companies aggressively marketed their services as a healthcare commodity, along with the aggressive marketing of drugs from the psychopharmaceutical companies. As psychiatry and psychiatric cure became more commercialized and medicalized, the demand for inpatient psychiatric services increased (Dorwart & Schlesigner., 1988; Hutchins et al., 2011; Patzer & Rawwas, 1994).

1990s

By 1990, spending on inpatient psychiatric services had grown from $750 million in 1979 to $6 billion in 1990 (Hutchins et al., 2011). The aggressive growth of for-profit psychiatric hospitals in the 1980s was followed by a steep decline in the number of public psychiatric hospitals and for-profit psychiatric beds in the 1990s. The decline for-profit psychiatric hospitals are attributed to:

Growth of managed behavioral organizations. Managed behavioral organizations rose to contain the growing costs of inpatient psychiatric and substance abuse services. The growth of unprecedented costs of care in the for-profit industry garnered much national attention. Managed care companies often rely on *utilization management* as a

tool to curtail increasing costs of inpatient psychiatric care in the private psychiatric hospitals. Utilization management determines *medical necessity* of the inpatient stay, requires prior authorization certificate for all admissions as medically necessary prior to or within 24 hours of admission, and authorizes a certain number of days per admission. They require concurrent review of the inpatient stay admissions specific to treatment and discharge plan. Reimbursement for the inpatient is then linked to the review. The process of utilization review began to impact the length of stay in the inpatient psychiatric hospital. The length of stay in the inpatient psychiatric setting dropped from months (20-30days) in 1980s to length of stay of 8-10 days in the 1990 (Geller, 2009; Hutchins et al., 2011; Sandell, 1993; Sharkey, 1994).

The scandalous exposure of unethical practices by the investor-owned/for-profit inpatient psychiatric organizations. Exposure of *guerrilla marketing* and aggressive advertising by these companies to garner patients with insurance, including paying clergy, police, and physicians for referrals brought national attention (Hutchins et al., 2011). In 1992, the federal government investigated National Medical Enterprise, Inc. (NME). It was one of the large owners of inpatient psychiatric hospitals in the 1980s. NME hospitals in Texas were investigated for false billing claims, and NME pled guilty. In addition, criminal charges were filed against NME. Multiple civil lawsuits filed by insurers, shareholders, and former patients soon followed. NME agreed to pay $2 million in government settlement charges, filed for bankruptcy, and closed its hospitals. This impacted the public image of for-profit companies and quickly spread to HCA and Charter Medical Corporation (Hutchins et al., 2011).

Other factors that impacted and escalated the decrease of inpatient psychiatric beds were: Development of other types treatment setting for psychiatric services such as outpatient or partial programs, residential programs, and continued developments in psychopharmacology and continued emphasis of civil rights of individuals with mental illness. By the 1980s growing mental health consumer movement sand organizations increased the emphasis on treatment of the individual in a least restrictive environment. The legal requirements for involuntary commitments and focus on least restrictive environments would continue to impact the private psychiatry hospital industry (Geller, 2009; Hutchins et al., 2011; Sandell, 1993; Sharkey, 1994).

By 1995, the four major for-profit private organizations either filed for bankruptcy and shut down their facilities, renamed themselves and made another attempt at regaining their market share, shifted their focus to other types of health services, or merged and/or were acquired by other companies. By 1995, Community Psychiatric Centers and National Medical Enterprise were shut down; Hospital Corporation of America, once the largest owner of inpatient psychiatric hospitals, diversified and shifted its focus to other types of healthcare services such as acute care. Charter Medical Corporation changed its name and made another attempt to regain its market share, but eventually it closed or sold all its facilities (Hutchins et al., 2011).

Apart from the inpatient psychiatric services, other types of health care services also underwent a period of great scrutiny. Nursing homes gained national attention for poor quality of services, fraudulent claims and billing for services, violation of patient rights, and abuse and neglect issues. The results of a study by the Institute of Medicine in 1986 on nursing homes found nursing home residents were often neglected, abused,

and inadequately cared for (Gray, 1986). To address and reform these concerns, the Nursing Home Reform Act of 1987 was passed. The Act was part of the Omnibus Budget Reconciliation Act of 1987. It mandated nursing homes to provide mental health services for its residents which included comprehensive initial and periodic mental health screenings and assessments both for new applications and current residents that establish the need for psychiatric services. Additionally, these services include individual psychotherapy, pharmacological management, and group therapy (Gray, 1986). Grabowski, Aschbrenner, Rome, and Bartels (2010) applied the Donabedian's framework to assess the quality of mental health care in nursing homes. Donbedian's framework is based on the structure, process, and outcome-based measures of assessing quality healthcare. Based on their research, the authors concluded individuals with mental illness admitted to nursing homes received poor quality of care. Research on mental illness in nursing homes also found residents under 65 were more than three times more likely to be admitted to inpatient psychiatric hospitals from nursing homes and the diagnosis of dementia increased the risk of admission to inpatient psychiatric hospital by three fold (Becker, Andel, Boaz, & Howell, 2009). Further, a study of Medicare beneficiaries of adults 65 and over found 46% of Medicare beneficiaries in this age group with a diagnosis of severe mental illness were hospitalized in 2010 compared to only 17% without serious mental illness (Scan Foundation, 2013). The 30-day readmission rate is also higher for this population compared to beneficiaries without serious mental illness and older adults dually eligible for Medicare and Medicaid with serious mental illness (Scan Foundation, 2013).

A study by the Office of the Inspector General (2003) on Medicare claims paid by Medicaid Part B in nursing homes found Medicare payments in 1999 totaled $194 million s (Department of Health and Human Services, 2001). Findings from this report concluded over 27% or $22.6 million of psychiatric services in nursing homes were medically unnecessary and deemed inappropriate as the services provided to individuals whose cognitive limitations made them unable to benefit from the psychiatric intervention, nor did the services help stabilize or improve the individuals' conditions (Department of Health and Human Services, 2001). Burns et al. (1993) analyzed the utilization of mental health services by elderly in nursing homes and found the most frequent diagnosis of nearly 75% of the elderly with mental illness was schizophrenia, followed by dementia, and other mental disorders. This study also found of those with mental disorders only 4.5% received mental health treatment.

Hoover et al. (2008) analyzed the Medicare utilization and payment data for inpatient psychiatric services for non-dementia psychiatric conditions among elderly between 1992 and 2002. Patients with the diagnosis of dementia are coded and billed in a separate category than mental illness. Between the decade of 1992 and 2002, the Medicare expenditures for inpatient psychiatric hospital and length of stay declined. The cost per patient dropped from $8,461 in 1992 to $6,207 in 2002 and the average length of stay reduced by 2.8 days from 14.9 days to 12.1 days. Expenditures increased dramatically for elderly Medicare beneficiaries in skilled nursing facilities during the same time period. Though Medicare dollars per stay was less in the skilled nursing home compared to the inpatient psychiatric setting, the number of elderly with non-dementia related mental illness in the skilled nursing home setting grew from 8,542 in

1992 to 17,312 in 2002. In 1999 only 50% of nursing homes were Medicare certified, but by 2002, 90% of the nursing homes were Medicare certified (Harrington et al., 2006; Hoover et al., 2008; Rhoades & Krauss, 1999).

By 1992, two thirds of all psychiatric hospitals and 50% of inpatient psychiatric beds were in the for-profit sector. By 2002, both the number of psychiatric hospitals and the number of beds decreased by half (Hutchins et al., 2011). Inpatient psychiatric hospital expenditures decreased from 47.8% in 1986 to 29.1% in 2005 (Substance Abuse and Mental Health Services Administration, 2010).

### *2000–Present*

#### Medicare and Medicaid Payment for Inpatient Psychiatric Services

Inpatient psychiatric hospitalization is covered by Medicare Part A. In 2010, the deductible amount was $1,100 for the first admission during a spell of illness and a copayment of $275 per day between 61st through 90th days. Copayment increases to $550 per day for each lifetime reserve day. Beneficiaries are limited to 190 days of treatment in a freestanding psychiatric hospital over their lifetime (Liptzin & Summergrad, 2010). Beneficiaries are covered for 90 days of care per spell of illness with a 60-day lifetime reserve (MedPAC 2010).

A study by MedPAC (2015) on Medicare cost showed in 2012, there were 434 freestanding inpatient psychiatric facilities in the U.S. and 1,097 hospital based psychiatric units. The Medicare reimbursements for free standing inpatient psychiatric facilities increased by 2.7% per year between 2004 and 2012 while it reduced for psychiatric units. Further, Medicare beneficiaries receiving care in for-profit inpatient

psychiatric facilities increased by 3.2% and decreased by 2.9% in nonprofit inpatient psychiatric settings between 2004 and 2012. Between 2006 and 2012, the total number of Medicare cases in inpatient psychiatric stayed steadily above 450,000 each year, however the length of stay in days decreased from 13.0 days to 12.8 days and the cost per case went up from $677 per day to $819 per day and payment per case went up from $7,989 to $9,718. The most frequent diagnosis for Medicare patients in the inpatient settings accounting to 73% of inpatient discharges was psychosis, followed by degenerative nervous system disorder. Of the total Medicare beneficiaries' utilizers of inpatient psychiatric settings, 34.6% were in the age group of 45-64, 24.5% between the group of 65-79, and 17.1% were over the age of 80. The age group of 45-64 were also reported to have more than one inpatient psychiatric hospital stay (MedPAC 2015). Medicare Part D prescription drug coverage totaled $89.8 billion in 2012, with central nervous system agents such as antipsychotics amounting to $6.3 billion, antidepressants spending totaling $3.4 billion, and anti-dementia drugs amounting to $2.2 billion dollars (MedPAC 2015). On the prescriber-level, the highest number of prescriptions filled by beneficiaries of Part D was from psychiatrists (MedPac 2015).

Mark et al. (2003) reviewed studies on Medicaid expenditures and found "Medicaid is the largest single public payer, accounting for 35% of all public spending on mental health and substance abuse services" (p. 1). Title XIX of Social Security Act established Medicaid as a jointly-funded, Federal-State health insurance program (Office of the Inspector General, 2003). Like Medicare, Medicaid pays for a broad range of services such as counseling, assessment, group therapy and prescription of psychopharmacological drugs. But unlike Medicare, the reimbursements rates are much

lower in Medicaid. The estimated spending by Medicaid in 2001 on drugs was $20 billion, out of which $4 billion was spend on psychiatric drugs (Office of the Inspector General, 2003).

The Balanced Budget Act of 1999 mandated a CMS amendment for the Prospective Payment System in 2002 to include the Prospective Payment System for Inpatient Psychiatric Facilities (PPF IPF) (Center for Medicare & Medicaid Services, 2015). The federal per diem rate scheduled went into effect in 2002 but was delayed and went into effect in 2005. The PPF IPF provided patient-level and facility-level adjustments which include wage index, teaching adjustments, and an add-on for rural facilities. The payment for individual patient care was further adjusted for factors such the Diagnosis Related Group Classification, age, length of stay, and the presence of specific comorbidities (Center for Medicare & Medicaid Services, 2015). Medicare PPF IPF payments initially give some incentive to providers to increase the length of stay and Medicare offsets this by reducing per diem payments for later days. The base payment rate of Medicare to inpatient psychiatric hospitals is $652 per day in 2010 (MedPAC, 2010). By 2010, the reduction of supply in inpatient psychiatric beds by elimination of excess beds lowered competition and had a favorable impact on the PPF IPF reimbursement rate.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 passed as part of the amended Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. This is a federal law that prevents group health plans and health insurance companies that provide mental health or substance abuse disorder benefits from

imposing less favorable benefits on those benefits than medical/surgical benefits. On April 26, 2016, Medicaid IMD exclusionary criteria was amended again. This new amendment allows for states to make a capitation payment for enrollees with short term stays in IMDs. The final rule indicates states can make a capitation payment for enrollees with a short-term stay of no more than 15 days. This rule was amended to increase access of inpatient psychiatric and substance use disorder services. Passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Law of 2008 equalized the reimbursement rate for mental illness and the passage of the Affordable Care Act of 2010 increased the number of individuals covered by insurance.

Since the 1950s, the inpatient psychiatric hospitals are required to comply with federal rules and codes as a condition of participation in federal financial programs and also to meet the Joint Commission (2016a) accreditation requirements. Over the last few decades, the federal rules have changed from fee-for-service to fee-for-performance models. Psychiatric hospitals are required to measure their performance and quality of services to stay in compliance with the rules, codes, and standards of care to receive a higher reimbursement rate. For example, Hospital-Based Inpatient Psychiatric Services (HBIPS) measures admission screening for violence risk, history of trauma, history of substance abuses and tobacco use, hours of physical restraint, hours of seclusion, patients discharged on multiple antipsychotic medication, post discharge continuing care plan, and post discharged continuing care plan transmitted to the next level of care provider within five days of discharge (MedPAC, 2010). These performance measures are reported monthly, quarterly, and annually to the Center for Medicare and Medicaid Services.

Population with Serious Mental Illness in Prison and Jails in 2005

In 1880, there were 75 public psychiatric hospitals for a total of 50 million residents in the U.S. There were 91,959 *insane persons* on the first census data collected in 1880. Of this number, 41,083 were living at home, 40,942 were living in hospitals or insane asylums, 9,302 were housed in almshouses, and 397 were in jail. The total prison population in 1880 was 58,609 and 0.7% of them were severely mentally ill (Torrey, 2008). In 2005, 56% of state prisoners (705,600), 45% of federal prisoners (78,800), and 65% of local jail inmates (479,900) had mental health problems. Twenty-three percent of state prisoners met criteria for mania and 54% jail prisoners met criteria for mania; 23% of state prisoners and 30% of jail prisoners reported major depression, and 15% of state prisoners and 24% of jail prisoners reported symptoms of psychotic disorder. State and jail inmates that reported mental health problems were also twice as likely as prisoners and inmates who did not report mental health problems to be homeless, had higher rates of substance dependence or abuse disorders, likely to have lived in a foster home or agency or institutional setting while growing up, reported higher rates of unemployment, higher rates of illegal income, report past history of physical and/or sexual abuse, and had a family history of mental illness and/or higher rates of family history of substance abuse (U.S. Department of Justice, 2006). Currently, the largest provider of mental health services for individuals with serious mental illness is the federal, state, and local prisons and jails.

In the 1970s, there were 14,295 private psychiatric hospital beds in the U.S., by 1990, private psychiatric hospital beds grew exponentially to 44,871. In fact, between 1970 and 1986, in less than 16 years, the number of private psychiatric hospital beds

more than doubled to 30,201. Starting in 1990 to 1992, the number decreased from 44,871 to 43,684. From 1992 to 2002, there was a steep decline from 43,684 to 25,096. During the same time periods, general hospitals with separate psychiatric unit beds also saw a similar trend. In 1970 there were 22,394 general hospitals with separate psychiatric unit beds and they grew to 53,479 by 1990. Unlike private psychiatric hospitals, general hospitals with separate psychiatric unit beds decreased at a much slower rate in the following two decades from 53,479 in 1990 to 40,202 in 2002. The greatest reduction in psychiatric hospitals and psychiatric hospital beds occurred in state and county mental hospitals. In 1970, there were 413,066 public and county mental hospital beds in the U.S. Only six years later, in 1976, they decreased by nearly half to 222,202. They continued to decrease and by 2002 there was a total 57,263 public and county psychiatric hospital beds in the community. Comparatively between the three groups, even at their highest, private psychiatric hospital beds were almost less than half the number of total state and county hospital beds.

In 1990 there were 44,871 private psychiatric hospitals beds and 98,789 public and state psychiatric hospital beds. By 2002, though the number of public and state hospital beds decreased from 413,066 in 1970 to 57,263, they still accounted for more than the total number of private psychiatric hospital beds (25,095) and general hospitals with separate psychiatric beds (40,202). This indicated that even though the total number of public and county hospital beds in the community reduced, they are still the largest provider of mental health services in the U.S. (Mark et al., 2009). Table 1 shows the changes in psychiatric hospitals by type 1970-2002.

Another comparison was beds per 100,000 civilian population. In 1986, there

were 49.7 state and county beds for 100,000 civilian population and the number continued to decrease to 19.1 by 2004. Private psychiatric hospital beds saw an initial surge between 1986 to 1990 when they went up from 12.6 beds per 100,000 population to 18.4. From 1992, there was a steep decline and beds reduced to 9.5 beds per 100,000 in 2004. Like the private psychiatric hospitals, general hospitals with private psychiatric unit beds also saw an initial surge when they grew from 19.1 in 1986, to 21.9 in 1990. Though the decrease in the number of beds was at a slower pace than the private psychiatric hospital beds, the number of beds for 100,000 civilian populations in general hospital psychiatric beds did decreased to 13.9 by 2004 (Kiesler, 1991; Substance Abuse and Mental Health Services Administration, 2010). Table 2 shows the number of psychiatric hospital and the beds per 100,000 population for 1986-2004.

By 2010, the public and state psychiatric beds continued to decrease along with the beds in private psychiatric and general hospitals with psychiatric unit beds. Public/state psychiatric beds decreased from 50,509 in 2005 to 43,318 in 2010. When comparing this data with the number of available public/state psychiatric beds in 1850 for the number of beds available for 100,000, the number of public/state beds was identical. There were 14 public/state psychiatric beds for 100,000 in 1850 and there were 14 public/state psychiatric beds for 100,000 in 2010.

Various states in the U.S. continued to reduce public/state psychiatric beds at a varied rate, and as of 2016, the number of public/state psychiatric beds had decreased to 37,679, which is 11.7 psychiatric beds for 100,000. This means in 2016 there are fewer public/state psychiatric beds in the community than in 1850 (Treatment Advocacy Center, 2010 and 2016).

## Summary

In this chapter, the precipitating factors which led to the growth of psychiatric hospitals and factors that led to the reduction of psychiatric hospitals in the selected time periods were reviewed. The selection of the time periods was relevant to the significant important drivers of the time period that influenced inpatient psychiatric services.

Each phrase of transformation in the inpatient psychiatric hospital affected the location of care for adults and older adults with serious mental illness. Currently, though mental health care is provided in community settings, for those individuals with serious/acute mental health needs, the national jails (another type of institutional setting) are the largest providers of mental health services. The trends and various shifts in location of care for individuals with serious mental illness and older adults show a cyclical pattern; with each cycle, the primary responsibility of the care of the individual with mental illness shifted from family and local government to state and federal government. Psychiatric hospitals were originally built with a noble goal of providing humane care and treatment for the mentally ill around which the first U.S. mental health policy was developed. Currently, they function as the last resort, acute crisis stabilization centers. Their growth or demise is largely driven by social, economic, and political ideologies rather than the clinical need of the individual they are meant to serve.

Next, I explore the reasons behind the fluctuations in the inpatient psychiatric hospitals in Texas and how it impacted the adults and older adults with severe mental illness.

Table 1

*Changes in Psychiatric Hospitals by Type 1970-2002*

| | 1970 | 1976 | 1980 | 1986 | 1990 | 1992 | 1995 | 1998 | 2000 | 2002 |
|---|---|---|---|---|---|---|---|---|---|---|
| Non-Federal general hospitals with separate psychiatric services | 22,394 | 28,706 | 29,384 | 45,808 | 53,479 | 52,059 | 52,984 | 54,434 | 39,690 | 40,202 |
| Private psychiatric hospitals | 14,295 | 16,091 | 17,157 | 30,201 | 44,871 | 43,684 | 42,399 | 33,408 | 26,484 | 25,095 |
| State and county mental hospitals | 413,066 | 222,202 | 156,482 | 119,033 | 98,789 | 93,058 | 81,911 | 68,872 | 60,675 | 57,263 |

*Note*. Mark et al., 2009

Table 2

*Number of Mental Health Organizations with 24-hour Hospital/Residential Treatment Settings and Number of Beds, by Type of Organization, U.S., Selected Years 1986-2004*

| | Type of organization | 1986 | 1990 | 1992 | 1994 | 1998 | 2000 | 2002 | 2004 |
|---|---|---|---|---|---|---|---|---|---|
| Total mental health organizations | All organizations[1] | 3,039 | 3,430 | 3,415 | 3,827 | 3,729 | 3,199 | 3,032 | 2,891 |
| | Department of Veterans Affairs Medical Centers[2] | 124 | 130 | 133 | 135 | 123 | 133 | 131 | — |
| | State and county mental hospitals | 285 | 273 | 273 | 256 | 229 | 223 | 222 | 237 |
| | Private psychiatric hospitals | 314 | 462 | 475 | 430 | 348 | 269 | 253 | 264 |
| | Non-Federal general hospitals with separate psychiatric services | 1,287 | 1,571 | 1,517 | 1,531 | 1,593 | 1,325 | 1,232 | 1,230 |
| | All other mental health organizations[3] | 592 | 493 | 520 | 1,016 | 975 | 774 | 686 | 702 |
| Beds per 100,000 civilian population[3] | All organizations[1] | 111.7 | 111.6 | 107.5 | 112.1 | 99.5 | 75.4 | 73.3 | 71.2 |
| | Department of Veterans Affairs Medical Centers[2] | 11.2 | 8.9 | 8.9 | 8.2 | 6.3 | 3.3 | 3.4 | — |
| | State and county mental hospitals | 49.7 | 40.5 | 36.9 | 31.6 | 25.6 | 21.5 | 19.9 | 19.1 |
| | Private psychiatric hospitals | 12.6 | 18.4 | 17.3 | 16.4 | 12.4 | 9.4 | 8.7 | 9.5 |
| | Non-Federal general hospitals with separate psychiatric services | 19.1 | 21.9 | 20.7 | 20.4 | 20.2 | 14.1 | 14 | 13.9 |
| | All other mental health organizations[3] | 8.8 | 9.7 | 11.7 | 23.2 | 23.1 | 15.3 | 13.9 | 17.3 |

*Note*. Data are based on reporting by a sample of mental health organizations and general hospitals with separate psychiatric services. (Substance Abuse and Mental Health Services Administration, 2010, p. 160).

# CHAPTER 3

## PSYCHIATRIC HOSPITALS IN TEXAS

In this chapter, I explore the precipitating factors for the rise of or demise of inpatient psychiatric hospitals in the state of Texas and its impact on adults and older adults with severe mental illness.

Texas is both the second largest state in the U.S. and the second most populated state in the U.S. with a population of 26.6 million in 2013 which grew to 33 million in 2014 (Texas Demographic Center, 2016). In terms of demographic shift, the older adult population in Texas grew at a faster pace from 2000 to 2014 compared to rest of the nation, however, the aging population is still a smaller percentage of the total Texas population. Texas is reported to have the third largest older adult population in the nation after California and Florida and the older adult population in Texas grew from 2.1 million in the year 2000 to 3.1 million in 2014 an increase of 1.0 million older adults over the age of 65. This trend is expected to continue into the next decade when the aging Texas population is expected to grow to 19.4% or 5.9 million of the Texas total population in 2030 (Texas Demographic Center, 2016).

The Texas Department of State Health Services (TDSHS) analyzed the consumers served though the TDSHS mental health system by primary diagnosis (Sunset Advisory Commission, 2014). In 2011, of all the adults diagnosed with mental illness in Texas, 20.84% or 35,573 adults had a primary diagnosis of schizophrenia, 33.34% (56,929 adults) had a primary diagnosis of bipolar disorder, 31.37% (53,560 adults) had a primary diagnosis of major depression, and 6% or 24,674 adults had a primary diagnosis of *other* category. In 2014, TDSHS provided inpatient psychiatric

services to more than 22,000 individuals with serious mental illness in nine state psychiatric hospitals and other settings receiving state funding (Sunset Advisory Committee, 2014).

In 2010, 25% of the total Texas population which amounts to over 6 million people, were uninsured compared to the U.S. average of 16% and 47% of Texas' rural population is uninsured. Of the 75% insured, 44% were insured via employer sponsored insurance, 9% of the Texas population is insured under Medicare, 16% has Medicaid, 4% has individual insurance and 1% other public coverage (Henry J. Kaiser Family Foundation, 2010). According to Center for Public Policy Priorities [CPPP] (2005), there were 862,452 adults on Texas Medicaid in 2005. Of those, 667,561 (77%) were elderly or disabled and 316,677 aged and disabled were dual eligible for Medicaid-Medicare. Seventy percent of Texas nursing home residents are covered by Medicaid and more than 50% of the nursing home population report either a history of or current mental health concern such as severe depression, anxiety, or age related neurocognitive and degenerative illness. The aged and disabled group consisted of 60% of the individuals living on SSI, which was $579 per month in 2005; "$579 per month is less than 75% of the poverty line" (CPPP, 2005, p.1).

According to the Henry J. Kaiser Family Foundation, Texas per capita mental health service expenditures in 2004 was $36.70 compared to the national U.S. average spending of $93.04. Almost a decade later, in 2012 the national U.S. average spending increased to $124.99 while Texas mental health service expenditures increased to $38.05. The mental health spending per capita in the state of Texas by the Department of State Health Services has continued to be the lowest in the nation for more than a

decade. Texas ranks 47th in the nation for mental health per capita spending (Henry J. Kaiser Family Foundation, 2011).

There is a large variation in terms of population, demographics, and mental health needs among Texas counties. Harris County's population is expected to reach 5 million by 2020 and the poverty level in Harris County is expected to increase to 19%. It has the second highest uninsured citizens in Texas counties and it is ranked 30th out of 34 local mental health authorities in per capita mental health funding. In the year 2012012, of the census of 3.1 million adults in Harris County, 516,362 were estimated to have a mental illness; 137,219 of those reported a severe and persistent mental illness (major depressive disorder, bipolar disorder, or schizophrenia). Over 89,000 with serious mental illnesses had no insurance and fully rely on the public mental health system (Mental Health Needs Council, Inc., 2015). Twenty percent of the jail population reported a current or past diagnosis of mental illness, 15% of the individuals with severe mental illness reported to be homeless within the year, and 28% with severe mental illness reported co-occurring substance abuse disorder. According to the Dallas County Sheriff's Department (2012), Lew Sterrett Justice Center houses the 2nd largest mental health facility in Texas with 1,700 inmates in the Dallas County Jail with reported severe mental illness.

## Texas Public Psychiatric Hospitals–Past and Present

The first state owned asylum–Austin State Hospital–opened its doors in 1861. The North Texas Lunatic Asylum opened in 1883, Southwestern Lunatic Asylum in 1892, and Abilene State Hospital in 1904. By the 1940s, problems of overcrowding,

staffing shortages, and increasingly aged population resulted in development of the San Antonio State Hospital in 1951, which later became Kerrville State Hospital. In the same year, Wichita Falls State Hospital opened a new branch–Vernon State Home. Both San Antonio State Hospital and Vernon State Home were opened with the primary purpose of providing care for the geriatric patients. By the end of 19th century there were four Texas state hospitals and by the end of 20th century the number grew to nine (Texas Department of State Health Services [TDSHS], 2017). As of 2016, these 9 state hospitals, along with 1 state run inpatient residential care facility for youth and state owned infectious disease facility are operated in Texas (TDSHS, 2017).

Privately owned psychiatric hospitals also grew between the 19th and 20th century, the most prominent being the Hogg Institute which opened in Austin in 1893. In 1917 three physicians, James J. Terrill, Guy F. Witt, and George Moody, opened the Timberlawn Psychiatric Hospital in Dallas with 15 beds (Creson, 2010; Hogg Foundation for Mental Health, 2016; TDSHS, 2017). Similar to the rest of the nation, psychiatry as a profession grew in Texas in the 1930s and psychoanalytic therapy grew after World War II along with the mental health hygiene movement in the 1940s. In 1957, the state's first mental health code passed. In 1965, the Texas Department of Mental Health and Mental Retardation was established and the same year Action for Mental Health passed Texas legislature which set in motion the establishment of the Comprehensive Community Mental Health Centers Act (Creson, 2010; Hogg Foundation for Mental Health, 2016).

According to TDSHS (2017), in 1930 the Wichita Falls State Hospital which later came to be known as the North Texas State Hospital (NTSH) had a census of over

1,500 patients and a staff of 235. A decade later, during World War II, 234 staff members served approximately 2,400 patients. By the end of the war, the staff grew to 503. Also during the decade of the 1960s, Texas public psychiatric hospitals sought accreditations from outside agencies such as the Center for Medicare and Medicaid Services and the Joint Commission. These accreditations required hospitals to complete major renovations to meet life safety codes and standards requirements (TDSHS, 2015a).

By 1970s, the census in Wichita Falls Hospitals alone dropped below 900. Also by the 1970s, the nine public hospitals re-invented their models of delivery and began to provide more specialized services for select population such as the child and adolescent units, adult units, substance abuse treatment, forensic units, and geriatric units. The first state psychiatric hospital, Vernon State Hospital, an extension of Wichita Falls State Hospital, opened in 1951 specifically to serve geriatric patients. Vernon's census in its early years was 400 geriatric patients. By 1969, Vernon offered services to general psychiatric patients from 30 counties in North Texas. In 1998, Wichita Falls and Vernon State hospitals were combined and renamed to North Texas State Hospital. The average daily census in NTSH in 2010 as seen in the Table 3 was 589.

Texas state hospital population reduced from 14,921 in 1964 to 9,477 by 1972 and to 8,000 by 1975 (Creson, 2010). In the fiscal year 2010, the average daily census in all nine state psychiatric hospitals combined was 2,321 as shown in Table 3. Which is less total population served by Wichita Falls Hospital alone in the 1940s.

Texas provides each local mental health authority and NorthSTAR an allocation of state hospital resources to coordinate inpatient psychiatric services for individuals

residing in service area of state hospital. NorthSTAR is a publicly funded managed care program that delivers mental health and substance abuse services to low-income individuals in Dallas, Ellis, Collin, Hunt, Navarro, Rockwall, and Kaufman counties. In 2011, TDSHS provided funding to Montgomery County for a forensic facility that provides competency restoration for up to 94 adults and in 2012 new funding was provide to Harris County for 20 additional competency restoration beds in the Houston area (Hogg Foundation for Mental Health, 2016; Legislative Budget Board, 2011). To meet the demands of severally mentally ill individuals, Texas also contracts additional psychiatric beds (372 beds) with local community hospitals.

Nearly all of the Texas state psychiatric hospitals suffer from aged infrastructures as nearly all the hospitals were built before the 1960s. Hospitals also reported staffing crisis, increase in turnover, and difficulties in recruitment and retention. More severely mental ill and forensic population require additional staffing. Staffing shortages increased from 4.8% in 2006 to 7.1% in 2010 (Legislative Budget Board, 2011).

In 2013, Texas was one of 29 states that increased state funding for mental health services. The state funding remained stagnant between the years of 2003-2013 for all mental health services including services for substance abuse disorders. In 2013, Texas released $2.6 billion in all funds for which $1.7 billion was for state general revenue, $665 million for new investment in community mental health services for adults; $200 million for community mental health services for children and adolescents; $221 million for community mental health crisis services; $315 million for substance abuse services; $153 million for community mental health hospitals, and $835 million in

funding for nine state-owned psychiatric hospitals (Hogg Foundation for Mental Health, 2016; NAMI, 2016; TDSHS,2013b).

The 2013 budget increase was to renew the state's commitment for providing services to seriously mentally ill individuals in the state, improve infrastructure and services, and renew commitment in recovery (Ligon, 2013). Though the budget itself would not be available for a few years, the budget increase marked a significant commitment to improve state psychiatric hospitals in more than five decades.

In recent years, the population within the Texas state hospitals shifted to a more forensic population than civil population, increasing the demand for forensic beds over civil beds, and further reducing the beds capacity for civil population. Civil commitments for individuals with mental illness that are a danger to self or others can be for 24-hour emergency detention, 30 day orders of protective custody, or 90-day court ordered mental health commitment which at times can extend up to 12 months by the court. Individuals on forensic commitment have been admitted to the state hospital by judicial order because they could not stand trial or were found guilty by reason of insanity. An order by the judge is required to be discharged from the hospital (Hogg Foundation for Mental Health, 2016; Legislative Budget Board, 2011).

Table 3 shows the average length of stay and cost per patient for each hospital. The average length of stay and also the average cost per patient for forensic population is much higher than the population on civil commitments. Additionally, the average length of stay between 2006 and 2010 increased from 44.5 days to 51.5 days−an increase of 16% (Legislative Budget Board, 2011). This indicates individuals admitted to the state psychiatric hospitals are entering much sicker and staying longer. Figure 4

shows the average cost per patient served in state hospitals in Texas from 2006 to 2010.

Table 3

*Texas State-Owned Psychiatric Hospitals in 2016*

| Name | Year Opened | Area of Texas Served | # of Beds | Avg. Daily Census 2010 | Avg. Stay Fiscal Year 2010 in Days | Avg. Cost per Patient |
|---|---|---|---|---|---|---|
| Austin State Hospital | 1861 | South Central | 299 | 275 | 25 | $10,321 |
| Big Spring State Hospital | 1938 | West and Plains | 200 | 196 | 51 | $16,424 |
| El Paso Psychiatric Center | 1996 | West | 74 | 70 | 28 | $12,974 |
| Kerrville State Hospital | 1951 Converted to Forensic Facility in 1999 | Statewide for adults on Forensic Commitment | 202 | 199 | 777 | $30,000 |
| North Texas State Hospital | Wichita Falls State Hospital and Vernon State Center became NTSH in 1998 | North | Wichita Falls: 257 Vernon: 343 | 589 | 97 | $18,100 |
| Rusk State | 1919 | East | 335 | 305 | 113 | $19,805 |
| Terrell State | 1885 | North and North East | 316 | 309 | 37 | $10,760 |
| San Antonio State | 1892 | South | 302 | 274 | 44 | $15,825 |
| Rio Grande State | 1962 | South | 55 | 52 | 18 | $7,425 |

*Note*. Legislative Budget Board, 2011.

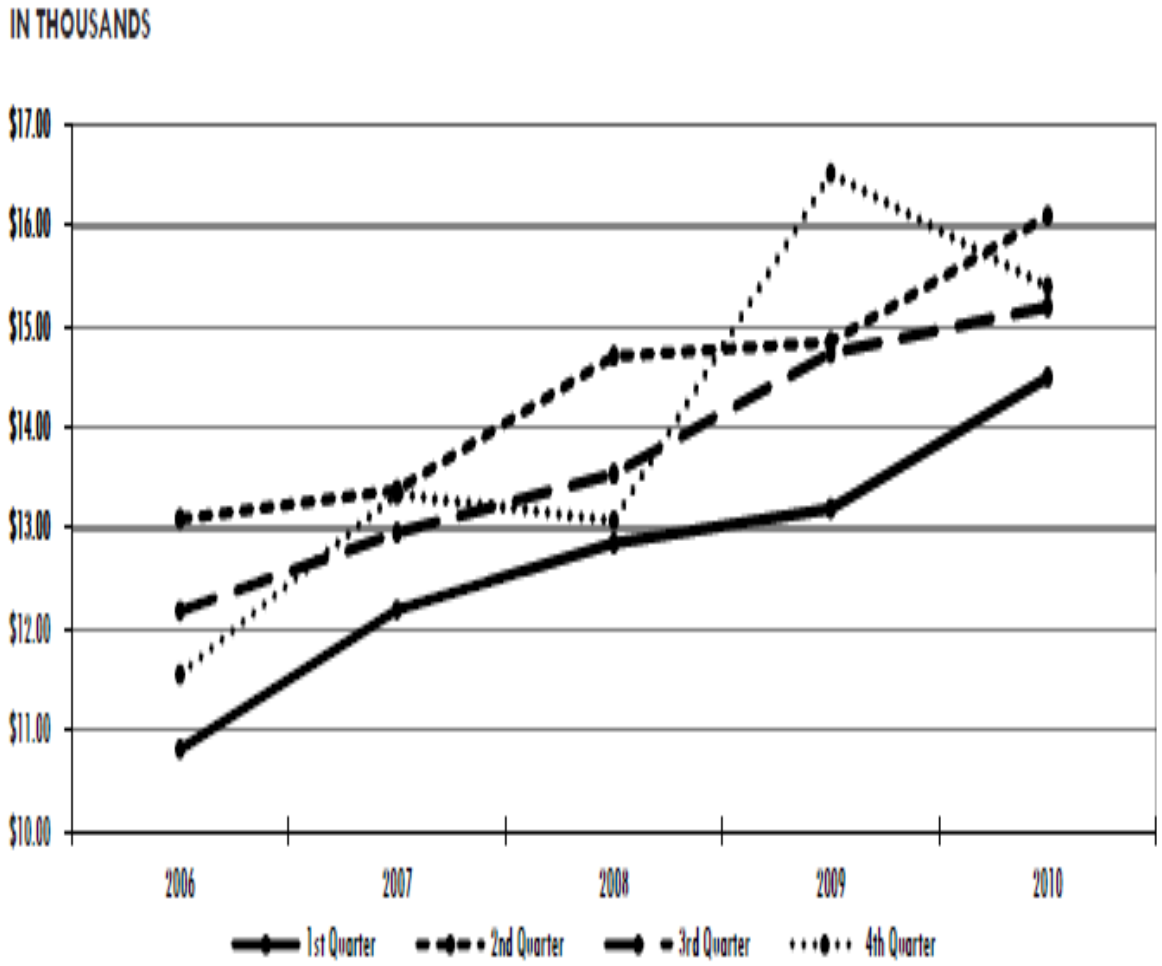



*Figure 4.* Average cost per patient served in state hospitals in Texas from 2006 to 2010 (Legislative Budget Board, 2011).

In 2015, the TDSHS formulated a State Hospital System Long-Term Plan to address the crisis in public psychiatric beds. Key strategies and recommendations from the plan include:

- Transition the primary role of the state mental health hospital into tertiary referral centers providing recovery care for the most complicated mental health patients and those individuals on forensic (criminal code) commitments
- Transition local hospitals to providers of initial assessment, crisis management and short-term inpatient recovery care of voluntary and involuntary mental health patients; expand access to inpatient care by contracting with local public, community not-for-profit, private and university hospitals

- Ensure that any new inpatient resources are targeted to areas with unmet need and allocated through a state-wide needs-based system that is informed by a collaborative local planning process

- Replace five state mental health hospitals with new facilities that more easily support contemporary mental health care (Austin State Hospital, North Texas State Hospital- Wichita Falls, Rusk State Hospital, San Antonio State Hospital, and Terrell State Hospital (procurement in process with private entity) (TDSHS, 2015b, p. 1)

Among other recommendations were to repair and improve six state hospitals that are currently in fair to good condition; demolish those no longer safe, and reduce the overall size of the hospital campus to one acre per 8-12 beds (TDSHS, 2015b). The report further assessed the future need of psychiatric bed capacity in Texas and estimated the total needed bed capacity for both public and private beds in 2014 is 5,425 and it is expected to grow to “6,032 by 2024” (TDSHS, 2015b, p. 4).

### *Other Issues that Impact Texas Psychiatric Hospitals*

Directly or indirectly-merger of Texas state departments*.* According to the Texas Department of Aging and Disability Services [DADS] (2011), the Texas Department on Aging (TDOA), the Texas Department of Mental Health and Mental Retardation (TDMHMR), and the Texas Department of Human Services (TDHS) were abolished in 2004. The powers, functions, programs, and activities of TDOA, TDMHMR (relating to the provision of mental retardation services), and TDHS (relating to the provision of long-term care services and community based support and services, licensing and enforcing regulations applicable to long-term care facilities, and licensing enforcing regulations applicable to home and community support service agencies) were transferred to the Texas Department of Aging and Disability Services (DADS). Also on that date, the powers, duties, functions, programs, and activities of TDMHMR relating to

provision of mental health services were transferred to the Texas Department of State Health Services (DADS, 2011). In Texas, currently TDADS and TDSHS are the main bodies that govern aging and mental health issues from various levels.

### *Certification of Need (CON Regulations)*

Certification of need (CON) laws were nationally passed in 1974 as part of the National Health Planning Resource Development Act (1975) in order to receive funding via certain federal programs. Though the state of New York passed its own CON laws in 1964. Hospitals are required to file for permission before proposing acquisitions, expansions to their existing facilities, or building new facilities. The assumption behind CON laws was it would restricted entry of the facilities into the state which would keep health care costs lower (Yee, Stark, Bond, & Carrier, 2011). Its goal was to increase coordinated and planned development of health facilities. CON laws make entry into a new market i.e., either entry of hospital into a new state or service line difficult. Proponents that are currently already in the market of their choosing favor CON laws, i.e., hospital owners who want to protect their existing market share and block competition favor the CON laws. However, the ones attempting to enter a new geographic location or service line find it cumbersome (Mitchell & Koopman, 2016).

Also, in 1986, the federal government repealed the CON mandate and by 1990, 11 states dropped CON programs. Soon other states followed and by 2016, 35 states and the District of Columbia retain these restrictions (Mitchell &Koopman, 2016). According to Sharkey (1994), by the end of the 1980s states without CON laws had 33% more for-profit psychiatric beds than states with CON laws.

In Texas, the Texas Health Planning and Development Act of 1975, created the Texas Health Facilities Commission (THFC). THFC was responsible for administering the state certification of need. In 1985, THFC was abolished and the state certification of need program was eliminated (National Conference of State Legislatures, 2016; Texas State Library and Archives Commission, 1999). In 2016, 36 states retained some type of CON program, law, or agency. Texas is one of the 15 states without a certification of need law (Becker's ASC Review, 2010).

### *Texas Oversight of Its Public and Private Psychiatric Hospitals*

Texas public and private psychiatric hospitals are subject to multiple state and federal regulations, rules, laws, and guidelines. And the survival of the psychiatric hospital depends on compliance with the standards of practice and care. State regulations are set by the Texas Department of State Health Services, Texas Department of Aging and Disability Services, Center for Medicare and Medicaid, and the Joint Commission. Regulations include rules for patient care and patient safety standards such as the regulations for medication management, restraint and seclusions, protection of patient rights, and rules against patient neglect and abuse; rules related to admission such as the EMTALA, involuntary commitment and admission screening among others; discharge planning and aftercare; health information and patient protection of privacy; leadership and governance; medical and clinical staff credentialing/licensures/staff training/staffing ratios for nursing services; regulations related to facility licensure and accreditation requirements; regulations related to participation of federal government funding requirements; rules and regulations related

to reimbursement of services from Medicare, Medicaid, private, and third payers; performance measures, quality monitoring, and reporting; federal statutes that prohibit illegal inducements to potential referral sources, false claims, among other restrictions. Hospitals that are found in violation of state and federal laws, rules, and regulations related to inpatient psychiatric care are subjected to surveys, audits, and investigations. If found guilty of neglect either in terms of patient care or financial integrity, psychiatric hospitals are fined or the state/federal/private payer will recoup previously billed services or will result in closure of the facility by the state (Dickson, 2015; TDSHS, 2016).

Between 2012 and 2015, at least three Dallas–Fort Worth psychiatric hospitals received immediate jeopardy (Joint Commission, 2016b). Immediate jeopardy denotes the patients in the hospital are in immediate jeopardy of serious harm. This finding by the federal and state regulators carries the potential forfeiture of critical federal funds. Timberlawn Psychiatric Hospital in Dallas, TX, owned by Universal Health Services (UHS) since 1996, a for profit health care corporation (Case study – Chapter 4 for details), came very close to losing CMS funding over patient safety concerns. Timberlawn was opened in 1917 by three physicians and is one of the oldest for-profit psychiatric hospital in Dallas with 144 beds. It also operates a 72 bed facility in Garland, TX. Medicare and Medicaid funding accounts for a third of the hospital's revenue. The near closure of the hospital was as a result of an incident in December 2014 at Timberlawn Hospital. A 37-year-old female patient with dissociate disorder died at the hospital after hanging herself with a bedsheet and closet doorknob. A preventable death if the hospital had followed standards of care by removing ligature risks. According to

the Joint Commission (2016b), and CMS, inpatient hospital suicides and serious unsuccessful attempts that lead to disability are deemed *near events* or *sentinel events*. Joint Commission and CMS require psychiatric hospitals to comply with stringent standards of care to eliminate preventable incidents such as inpatient suicides or deaths as a result of restraints and seclusions. Joint Commission (2016b) reports that the second-most common sentinel event reported to the agency is inpatient suicides next only to wrong site surgeries. During the investigation of the December 2014 incident, CMS and State regulators found other safety concerns such as plastic liners in trash cans and electrical and phone cords accessible to the patients among others (R Dunkin, 2015; Hethcock, 2015; Moffeit, 2015, 2016a, 2016b). CMS found Timberlawn deficient and in violation of safety standards and gave Timberlawn time to submit a corrective action plan. However, Timberlawn failed to further adequately meet the standards set by CMS and the hospital failed the second inspection due to staffing ratios and a lack of adequate monitoring of patients (Brino, 2015). CMS nearly shut down hospital, and in last quarter of 2015, Timberlawn reached an agreement with CMS regulators to remain open while it re-enrolls in CMS funding. As of October 2016, Timberlawn shut down and closed most of its bed capacity and currently has 10 operating beds while it re-enrolls for CMS funding and re-applies for licensure (Joint Commission, 2016b).

Another major event that is shifting the Texas psychiatric hospital landscape is Parkland Hospital. Parkland (2017) health and hospital system opened in 1894 and is located in Dallas, TX. It is one of the largest public hospital systems in the U.S. Parkland serves 1 million patient visits annually. In 2013, Parkland treated 8,539 patients needing acute psychiatric care in the Psychiatric Emergency Room and

provided psychiatric services to 1,409 inmates per day in the Dallas County Jail (Parkland, 2014). Parkland Psychiatric Hospital has been riddled with regulatory problems since 2012. CMS threatened to cut off funding twice to the psychiatric units in a span of three years due to numerous patient safety and quality of care issues in both its Psychiatric ER and Psychiatric units. Parkland psychiatric hospital implemented the necessary changes and was able to retain its CMS funding. In 2015, Parkland shut down its current facilities built in 1950s and 1960s and opened a new hospital with more than twice the size with an $747 million bond (Jacobson, 2015). As of 2014, Parkland Psychiatric unit is participating in two behavioral health care funded programs by the Medicaid Transformation 1115 waiver to improve psychiatric services to local residents (Parkland, 2014). The Medicaid Transformation 1115 waiver provides federal and local funds for health care providers to improve access and quality of care for low-income patients.

## Texas Psychiatric Hospital Trends

Both public and private combined, the total number of psychiatric hospitals decreased by 34.5% between 1998 and 2003 and increased by 16.7% between 2003 and 2008 (TDSHS, 2014). Texas had 36 psychiatric hospitals in 2003. This number increased to 47 psychiatric hospitals in 2013. In the first decade of 21st century, Texas opened 11 new psychiatric hospitals, resulting in an increase of 30.56%. In 2008 there were 5,196 psychiatric beds in the state and in 2012, the number of beds grew to 5,619 psychiatric beds in the state, and in 2013 the number of beds grew to 5,769 increasing the number of beds by 573 between 2003 and 2013. (TDSHS, 2013b, 2014).

As of 2014, there are 2,963 total inpatient psychiatric beds in state psychiatric hospitals, community psychiatric hospitals, and private hospitals for general psychiatric, forensic, and maximum security commitments funded by the State as shown in Figures 5 and 6 (Hogg Foundation for Mental Health, 2016; TDSHS, 2011). Seven hundred seventy-three beds or 13% of total Texas psychiatric beds were non-profit and 38% of the total beds (2,216) were for-profit beds (TDSHS, 2014).

According to Center for Health Statistics, 87% of Texas psychiatric hospitals are located in the metropolitan areas and operate 76% of the 4,390 beds in the state (TDSHS, 2013). Harris County has the largest number of psychiatric hospitals followed by Travis, Bexar, and Dallas counties. As of 2013, 228 Texas counties do not have a psychiatric hospital.

### *Texas Geriatric–Psychiatric Hospitals*

Haven Behavioral Healthcare, formed in 2008, is a specialty behavioral health company that specializes in private geriatric inpatient psychiatric units (PR Newswire, 2008). From zero in 2008, it grew to six hospitals with one location in Frisco, Texas. Oceans Behavioral Hospital (2017) is another privately owned geriatric psychiatric hospital formed in 2004. In 2016 it has 20 geriatric psychiatric inpatient units in various locations of Texas and Louisiana. Its market share grew from 0 to 241 geriatric psychiatric beds in 2015 and it has 120 beds in the greater Dallas-Fort Worth area (General Catalyst Partners, 2013; TDSHS, 2015a).

Springstone Inc., founded in 2010, celebrated opening its 10th hospital in 2015 and it had projected to open six new hospitals in new markets by 2016. (PR Newswire,

2015). It also received a $100 million private-equity investment in 2010 (Evans, 2010). In 2016, it has two hospitals in the Dallas-Fort Worth Market. Mesa Springs opened in Fort Worth, TX in 2013 with 72 inpatient psychiatric beds and the hospital also runs outpatient programs. Mesa expanded its outpatient services in 2015. Carrollton Springs opened in Carrollton, TX in 2012 with 45 beds in the inpatient setting and operates an outpatient program (City of Carrollton Planning and Zoning Commission, TDSHS, 2015a). In 2014, it expanded its outpatient location to Plano, TX. In 2016, Carrollton Springs is scheduled to nearly double its inpatient psychiatric beds to 72. Mayhill Hospital and Millwood Hospital owned by UHS have specialized geriatric inpatient units; Carrollton Springs owned by Springstone has a specialized geriatric unit. Green Oaks which opened in 1983 also has an inpatient geriatric psychiatric unit. Baylor Hospital in Irving and Garland, TX, also opened specialized geriatric psychiatric units. It is safe to say that the inpatient geriatric psychiatric private for-profit, geriatric psychiatric unit within the general hospital settings has seen a dramatic and significant raise at the beginning of the 21st century. Specialized inpatient services for this sub-population is projected to grow exponentially.

### *Texas Private For-Profit Hospitals*

Mirroring the rest of the nation, private for-profit psychiatric hospitals beds dramatically increased in the greater Texas region in the 1980s. However, the advent of managed care which resulted in the reduction of length of stay; lax state and federal regulations, questionable practices such as overbilling, patient right violations, fraudulent reimbursement, and reporting of false claims profoundly re-shaped the for-profit psychiatric hospital market.

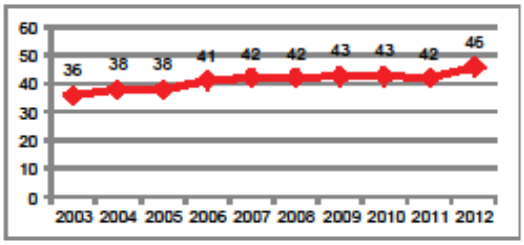
# TEXAS Fact Sheet -2012

## Psychiatric Hospitals

### Number of Psychiatric Care Hospitals, January 2012*

- There were 46 psychiatric care hospitals in Texas as of January 2012.
- In 2003, there were 36 psychiatric care hospitals in the state and 46 in 2012. During this period, 2003-2012, there was a 27.8% increase in the number of psychiatric care hospitals.

Psychiatric Care Hospitals, Texas, 2003-2012*



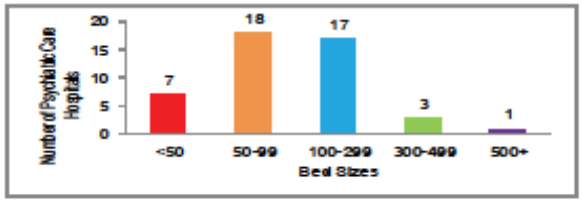

### Psychiatric Care Hospital Beds, January 2012*

- There were 5,619 psychiatric beds in the state.
  - 15% of the hospitals (7) had fewer than 50 hospital beds.
  - Average number of beds per hospital was 122.
  - 49%(2,758) were public beds, 14%(778) were nonprofit beds, and 37% (2,083) were for-profit beds.

Average number of beds according to hospital type and location:

| | | | |
|---|---|---|---|
| *Metropolitan* | *106* | *For-Profit* | *60* |
| *Non-Metropolitan* | *227* | *Public* | *251* |
| | | *Nonprofit* | *86* |

Texas Psychiatric Care Hospitals By Bed Size, January 2012*

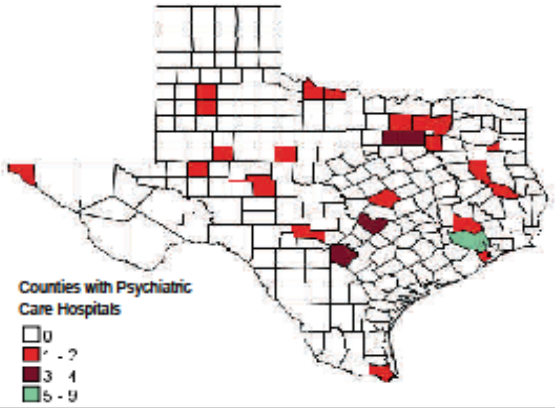



### Psychiatric Care Hospitals by Location, January 2012*

- 87% of the 40 psychiatric hospitals were in metropolitan areas.
- Of the 40 metropolitan area hospitals, 60% (24) were for-profit, 23% (9) were nonprofit, and 18% (7) were public hospitals.
- Of the 6 non-metropolitan area hospitals, 67% (n=4) were public, 33% (n=2) were for-profit, and there were no nonprofit hospitals.
- Metropolitan hospitals operated 76% of the 5,619 beds in the state; non-metropolitan area facilities operated the remaining 24%.


- Two hundred and twenty-eight (228) counties did not have a psychiatric hospital.
- Harris County had the largest number of psychiatric hospitals (n=9) followed by Travis County (n=4), Bexar (n=3), and Dallas (n=3).

2012 Psychiatric Care Hospitals By County, Texas




Sources: "2012 Directory of Active Hospitals, Health Facility Licensing and Compliance Division, Texas Department of State Health Services; Hospital Tracking Database, Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services.
Prepared By: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services
1100 W. 49th Street, Austin, Texas 78756-3199 Phone: 512-776-7261 Fax: 512-776-7344 www.dshs.state.tx.us/chs/hosp/
March 4, 2013 - E Publication No: E25-14055

*Figure 5.* Texas psychiatric hospitals – 2012.

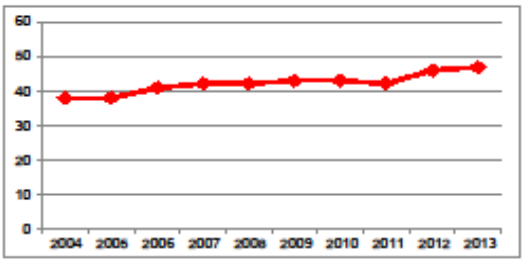
# TEXAS Fact Sheet -2013

## Psychiatric Hospitals

### Number of Psychiatric Care Hospitals, January 2013*

- There were 47 psychiatric care hospitals in Texas as of January 2013.
- In 2004, there were 38 psychiatric care hospitals in the state and 47 in 2013. During this period, 2004-2013, there was a 23.7% increase in the number of psychiatric care hospitals.

Psychiatric Care Hospitals, Texas, 2004-2013*



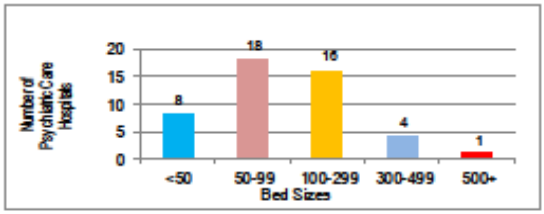

### Psychiatric Care Hospital Beds, January 2013*

- There were 5,769 psychiatric beds in the state.
  - 17% of the hospitals (8) had fewer than 50 hospital beds.
  - Average number of beds per hospital was 123.
  - 48%(2,780) were public beds, 13%(773) were nonprofit beds, and 38% (2,216) were for-profit beds.

Average number of beds according to hospital type and location:

| | | | |
|---|---|---|---|
| *Metropolitan* | *107* | *For-Profit* | *82* |
| *Non-Metropolitan* | *230* | *Public* | *253* |
| | | *Nonprofit* | *86* |

Texas Psychiatric Care Hospitals By Bed Size, January 2013*

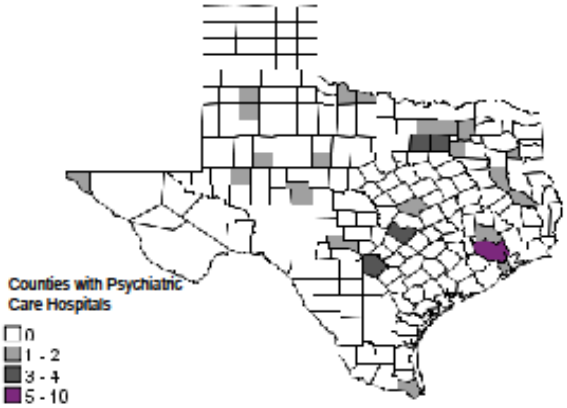



### Psychiatric Care Hospitals by Location, January 2013*

- 87% of the 41 psychiatric hospitals were in metropolitan areas.
- Of the 41 metropolitan area hospitals, 61% (25) were for-profit, 22% (9) were nonprofit, and 17% (7) were public hospitals.
- Of the 6 non-metropolitan area hospitals, 67% (n=4) were public, 33% (n=2) were for-profit, and there were no nonprofit hospitals.
- Metropolitan hospitals operated 76% of the 4,390 beds in the state; non-metropolitan area facilities operated the remaining 24%.


- Two hundred and twenty-eight (228) counties did not have a psychiatric hospital.
- Harris County had the largest number of psychiatric hospitals (n=10) followed by Travis County (n=4), Bexar (n=3), and Dallas (n=3).

2013 Psychiatric Care Hospitals By County, Texas




Sources: "2013 Directory of Active Hospitals, Health Facility Licensing and Compliance Division, Texas Department of State Health Services; Hospital Tracking Database, Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services.
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January 10, 2014 - E Publication No: E2S-14153

*Figure 6.* Texas psychiatric hospitals – 2013**.**

By the year 2000, many of the main players in the Texas for-profit inpatient psychiatric industry such as the National Medical Enterprises, Inc, Charter Medical hospitals and Community Psychiatric Centers hospitals in Texas shut down and/or filed for bankruptcy. The number of inpatient beds in Fort Worth alone reduced from 900 beds in 1993 to fewer than 200 beds by the year 2000 (Fuquay, 2013. However, by 2010 the private psychiatric hospitals have seen a dramatic resurgence (Kutscher, 2013). Tarrant County alone doubled the number of private psychiatric beds from 200 in 2010 to 400 by 2014 (Francis, 2014; TDSHS, 2017).

Between 2010 and 2016, acquisitions and merger activity among private psychiatric hospital corporations also increased. Universal Health Services acquired Ascend Health Corporation for $517 million and acquired 187 psychiatric hospitals including hospitals in the DFW area of Texas−Millwood in Arlington, Hickory Trails in Desoto, Timberlawn in Dallas, and Mayhill and UBH in Denton. New psychiatric hospital companies such as Sundance Hospital opened in 2012 and expanded its services by opening a second hospital in Garland, TX. Also since 2010, various public psychiatric hospitals expanded their psychiatric inpatient bed capacity such as the John Peter Smith Hospital, Baylor Hospitals, and Texas Health Resources (Braff Group, 2017).

### *Texas Psychiatric Hospital Staffing*

Texas ranks below the national average in the number of mental health professionals per capita. Texas ratio of psychiatrists per capita is 58% of the U.S total per capita ratio. In the last two decades, the Veteran's Administration added or increased positions. The growing state population, along with the increasing number of

skilled practitioners nearing retirement age and uneven distribution of the state's inadequate workforce is further exuberating the problem. Department of State Health Services reports 31.1% of Texans live in a federally designated Health Professional Shortage Area for mental health. A total of 173 out of 254 Texas counties are designated by the federal government as having a shortage of mental health professionals such as psychiatrists, psychologists, counselors, and social workers (TDSHS, 2014). Additionally, Texas Medical Association reported that only fewer than half of all the Texas psychiatrists accept private health insurance and fewer than 21% of the psychiatrists accept patients with Medicaid due to the lower reimbursement rate (Moy, 2015).

The Texas Department of State Health Services (2014) outlines numerous initiatives to address mental health workforce shortages such as expansion of the use of certified peer specialists, creation and expansion of telemedicine and telehealth programs, expansion of workforce training and education programs, and adoption of strategies to attract and retain more providers as shown in Table 4. The Affordable Care Act also provides a number of incentives to address the insufficient supply of professionals providing behavioral health services. These include increasing the number of primary care physicians who provide behavioral health care, and educating the existing primary care staff about behavioral health care. Other provisions seek to increase the supply of behavioral health professionals through loan repayment, expanded residency training programs, and increased use of certified peer specialists (Hogg Foundation for Mental Health, 2016; Moy, 2015; TDSHS, 2014).

Table 4

*Mental Health Workforce Shortages in Texas*

| | Year | |
|---|---|---|
| | 2009 | 2000 |
| Texas Population | 24,782,302 | 20,945,963 |
| Psychiatrists | 1,634 | 1,422 |
| # of Psychiatrist per 100,000 Residents | 6.59 | 6.79 |
| Psychologists | 6,547 | 5,044 |
| # of Psychologists per 100,000 Residents | 25.8 | 24.8 |
| Social Workers | 16,674 | 14,549 |
| # of Social Workers per 100,000 Residents | 66.88 | 69.46 |
| Marriage and Family Therapists | 2,789 | 3,417 |
| # of Marriage and Family Therapists per 100,000 Residents | 11.26 | 16.31 |
| Licensed Professional Counselors | 13,352 | 52.6 |
| # of Licensed Professional Counselors per 100,000 Residents | 10,036 | 48.5 |

*Note*. (TDSHS, 2014)

## Summary

In this chapter, I reviewed the precipitating factors that influenced the growth or demise of inpatient psychiatric hospitals and psychiatric hospital beds in the State of Texas and its impact on adults and older adults with mental illnesses. Texas is both the second largest and second most populated state in the U.S. and 25% of the total Texas population is uninsured. Texas' mental health spending is one of the lowest in the nation. In comparison to the rest of the nation, the reduction of population in public psychiatric hospitals in Texas occurred at a slower pace and was immediately followed by the development of community mental health services and growth of private investor

owned/operated psychiatric hospitals. Despite the dramatic fluctuations in growth/demise of private psychiatric hospitals in Texas, public psychiatric hospitals continue to be largest providers of institutional care for chronic/acute/serious mental illness for adults and older adults.

Texas has seen dramatic fluctuations in private psychiatric hospitals which increased in size and numbers in the 1980s and dramatically reduced in size and numbers in the 1990s. Currently, they are on the growth cycle again. Specialty psychiatric hospitals such as geriatric psychiatric hospitals in the for-profit sector have grown exponentially since 2010 due to an increase in reimbursement. However, according to the Treatment Advocacy Center (2016), Texas is one of the states with fewer than 10 state hospital beds per 100,000 people leading to insufficient availability of services and difficulty in access to services. The resulting consequence of the shortage in psychiatric beds is increased homelessness and increased criminalization of individuals with mental illness as is evident from the Lew Sterrett Justice Center in Dallas, TX which is the second largest mental health facility in Texas.

In the next chapter, I explore the growth and or demise and resurgence of investor owned psychiatric hospitals and their impact on the needs of adults and older adults with serious mental illness.

# CHAPTER 4

# PRIVATE, FOR-PROFIT, AND INVESTOR-OWNED PSYCHIATRIC HOSPITALS

In this chapter, I explore to understand the delivery of inpatient psychiatric services by investor-owned organization and illuminate the issues involved. The aim was to understand what, if anything, is new and significant about the provision of investor psychiatric hospitals and how they impact the needs of adults and older adults with serious mental illnesses.

## Background

In 2015, there were 14,000 for-profit behavioral health and substance abuse facilities in the U.S with revenues of $1 million per facility. Between 2003 and 2013, the number of for-profit organizations increased from 25% of the facility operators to 32%. During the same time period, the number of patients treated by for-profit facilities increased by 53% (Duff & Phelps Corp., 2015). The for-profit psychiatric industry provides services for mental illness and substance abuse disorders in a wide range of treatment settings–free standing inpatient acute care facilities, residential care services−population specific such as youth alcohol or substance abuse disorder, partial day programs, and outpatient services. According to the Substance Abuse and Mental Health Service Administration (2004), treatment for substance abuse services in the for-profit facilities alone cost $35 billion annually. In 2007 alone, 2.1 million adults received inpatient psychiatric services and roughly 13.4% of all total mental health expenditures are spent on private psychiatric hospitals (SAMHSA, 2008). Mental health expenditures in the U.S. increased from $3.3 billion in 1969 to $38.5 billion in 1998. However,

between 1998 and 2002, the total expenditures declined slightly to $34 billion. Of the total mental health expenditures, expenditure on private psychiatric hospitals increased until 1990, but in the years when SAMSHA (2004) collected data—1992, 1998, and 2000—private psychiatric hospital expenditures declined. Comparing private psychiatric hospitals to public psychiatric hospitals, public psychiatric hospitals receive 72% of their total funding from state mental health agencies and other state government sources, while 44% of private psychiatric hospital funding comes from Medicare and Medicaid (SAMSHA, 2004).

Ceccherini-Nelli and Priebe (2007) explored the association between economic factors such as consumer price index, real gross domestic product per capita, base discount rate, rate of unemployment, and the number of hospital psychiatric beds. The researchers analyzed two sets of data from the 19th century and three sets of data from the 20th century to explore the role economic factors play in the process of psychiatric hospital institutionalization and deinstitutionalization. Results from their study suggests when consumer price increased, there was a decrease in psychiatric bed numbers and vice versa. The authors concluded that economic factors are a very important driver in the supply of psychiatric hospital beds (Ceccherini-Nelli & Priebe, 2007).

Geller (2006a) documented the origins, function, and role of private psychiatric hospital from its beginnings in the 18th century to 2003. The author states in the 19th century, public and private psychiatric hospital partnerships grew with public psychiatric hospitals purchasing private psychiatric hospital beds, a practice that continues to the present day. In their origins, private psychiatric hospitals were built for the affluent and wealthy. From the early 1900-1970, various factors, namely, introduction of

antipsychotic medications, shift in location of care from institutional settings to community based settings, newer model of services in psychiatric services such as partial or outpatient services, shift in payment/reimbursement sources, and psychiatrist and nurse staffing shortages directly impacted the private psychiatric hospital. By the 1960s, the future of private psychiatric hospital was uncertain. Historically, by 1920 only 4% of the patient population received treatment in the private psychiatric hospital. But by the 1970s, as state hospitals discharged patients and reduced their spending on public psychiatric hospitals, there was a renewed growth in private psychiatric hospitals.

Since the 1970s, the organizational and structural changes in the private psychiatric hospitals sector have had a profound effect on the delivery and landscape of mental health services in the U.S. Investor-owned psychiatric hospital structures are like other corporate organizations. The horizontal and vertical integration of services, diversification of services, and affiliation of hospitals with each other and other sectors of the health care system have profoundly altered the governance, operational management, and accountability of the psychiatric hospitals. The corporate environment of the investor owned psychiatric organization has changed the roles of administrators, physicians, nursing personnel and other key players along with facilitating and increasing industry closures, consolidations, mergers and acquisitions (Gaumer, 1998; Williams & Torrens, 2008).

### *Trends in Investor-Owned Psychiatric Hospitals from 1970-2016*

The dramatic growth of private psychiatric hospitals between 1970 and 1990 is attributed to several factors: a) the increase in demand for services, b) public hospitals

began to discharge rapid numbers of patients into the community, c) increases in insurance coverage from private insurance under the cost-based system in 1970, d) advances in psychiatry, e) increased numbers of professionals, and f) the reduced stigma associated with inpatient psychiatric settings. On the supply side, the profitability margins between 20%-30% for inpatient psychiatric services; higher occupancy rates, looser treatment protocols, less costly operations, and the ability to transfer patients to other settings. Investor-owned companies that were already in the health care market providing other types of health care services, either had access to capital or could quickly arrange financing. Private corporations saw a window of opportunity to reap huge profits easily (Geller, 2006b; Gray, 1986; Hutchins et al., 2011; Levenson, 1982, 1983). For-profit psychiatric hospitals tended to market and advertise their services aggressively, along with the previous fee-for-service models of reimbursement and lax regulations, the overall expenditures for inpatient psychiatric services grew. In 1983, 50% of all psychiatric hospitals were in the public psychiatric hospitals. However, by 1985, for-profit, investor owned psychiatric hospitals grew (American Hospital Association, 1984). According to the National Association of Private Psychiatric Hospitals (NAPPH) (National Association of Psychiatric Health Systems, 2008), by mid-1985, 52% of the 224 NAPPH member affiliated with the organization were investor-owned psychiatric hospitals. By 1985, private psychiatric hospitals earnings amounted to $3.8 billion. Cost containment efforts from managed care companies such as prospective, concurrent, and retrospective review were quickly set in place which reduced the length of stay in the hospital from months to 9-10 days. Along with the implementation of treatment in the least restrictive environment, privatization of public

services, illegal practices by the private owners resulted in a rapid decline of the private psychiatric industry.

But by 2000, as excess capacity of beds in the community was eliminated, and occupancy rates grew and as public psychiatric hospitals continued to reduce public beds, demand for services grew and reimbursement rates improved (Dorwart & Schlesinger, 1988; Hutchins et al., 2011; SAMHSA, 2010). By 2010, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008) passed and required insurers to equalize coverage for behavioral health and medical health benefits, in terms of copays, deductibles, and lifetime caps.

The Medicare Improvements for Patients and Providers Act of 2008 increased access to mental health federal programs. The Patient Protection and Affordable Care Act (2010) increased the number of lives covered. By 2000, there were fewer public psychiatric beds, fewer psychiatric units in general hospitals and fewer privately owned psychiatric beds, thus the window of opportunity for reinvestment into private psychiatric hospitals opened again. Other drivers for the renewed growth by 2000 were psychiatric hospitals streamlined billing structures typically billing for only 15 to 17 diagnoses related groups compared to medical settings and the issues of fraudulent billing dramatically reduced. Also, psychopharmacology advanced to the next generation of drugs but serious mental illnesses and geriatric mental illnesses are difficult to treat and require treatment over long periods of time.

The advent of cognitive behavioral therapy which replaced prior generations of psychotherapy showed to be more suitable to inpatient settings. Technological advances such as telepsychiatry and software based clinical interventions also

consolidated resulting in more efficiency and profitability (Bithoney, 2015; Geller, 2006a; Hutchins et al., 2011). Between 1976 to 1992, the number of private psychiatric hospitals more than doubled, but from 1992 to 2002, the number of private psychiatric facilities dropped by half. By 2010, the number of for-profit, especially investor-owned psychiatric hospitals was growing again dramatically (Hutchins et al, 2011; SAMHSA, 2010).

### *Characteristics of Investor-Owned Psychiatric Hospitals*

Until the 1960s, individuals or groups of psychiatrists independently owned nearly all the private psychiatric hospitals (Geller, 2006a). There are both similarities and differences in the growth of investor-owned hospital systems and investor owned psychiatric hospital systems. The similarities are rapid growth and expansion, a high degree of ownership in fewer companies, acquisition of multihospital systems by other multihospital systems, and the decrease in independently owned for-profit hospitals. Differences included: there were much fewer psychiatric hospitals in the not-for-profit sector and investor owned psychiatric hospitals have a much greater market penetration (Gaumer, 1986). As of 2016, investor owned or multi-chain systems are the dominant owners and operators of private psychiatric hospitals. In 1985, Hospital Corporation of America, National Medical Enterprises, Charter Medical Corporation, and Community Psychiatric Centers owned or operated 66% of the investor-owned psychiatric hospitals. The growth in their size is a result of acquisitions of other multi-chain hospitals. For example, National Enterprises acquired almost all the psychiatric hospitals when it brought Psychiatric Institutes of America in 1982 (Levenson, 1983). By 2000, they either

filed for bankruptcy and shut down, or sold off their hospitals or renamed themselves or merged with other investor-owned psychiatric hospital organizations. By 2011, Universal Health Services and Psychiatric Health Solutions were the largest owners or operators of psychiatric hospitals. But by 2012, Universal Health Solutions acquired Psychiatric Health Solutions and as of 2016, UHS is one of the largest owner and operator of private psychiatric hospitals in the market (Universal Health Services, Inc., 2017). Additionally, new investor-owned psychiatric hospital corporations already in the health service market entered the psychiatric hospital market such as Acadia or new organizations that did not exist before were formed. With reduced competition, mergers and acquisition, public equity financing and private equity investments in the psychiatric industry grew exponentially and investor-owned psychiatric hospitals once again pursued aggressive growth strategy (Hill, 2012).

### *Structure of Investor-Owned Psychiatric Hospitals: Horizontal Integration, Vertical Integration, and Diversification*

Horizontal/vertical integration and diversification as structural strategies overlap between financing and service delivery (Gaumer, 1986). Horizontal integration is designed to provide increased levels of efficiency of scale across multiple institutions; its aim is to reduce duplication of services; competition in the marketplace; facilitate operational efficiency such as purchasing, information systems, quality assurance and management capacity; to establish contractual arrangement with other types of health care providers; and participate in the larger health care delivery systems. Whereas, vertical integration is when an organization incorporates a diverse set of health care *products* into a comprehensive health delivery system. In vertical integration, other

levels of care which precede or follow the inpatient psychiatric stay, such as acute care services, nursing home, outpatient, or partial hospitalization, are incorporated as part of the psychiatric hospital line of health services. Vertical integration allows the organization to negotiate with insurers and managed-care providers so the full range of services are provide in a contractual arrangement. Vertical integration increases patient flow into the hospital inpatient services by capturing more patients and dollars and additional revenues of income into the hospital and ensures patient are not lost to the competition and ensures financial viability of the organizations. It allows the delivery chain for a range of health services rather than specializing in only one product (Gray, 1986; Williams & Torrens, 2008). Diversification refers to selling of other services or broadening its services. As a business strategy, it is used to control a hospital's market position and its long-term economic viability. As prospective payment systems reduce the length of stay in the inpatient setting, expanding into outpatient services/providing next step services allows the investor-owned psychiatric hospital to receive revenues that might otherwise be lost to competition (Gray, 1986; Williams & Torrens, 2008).

## Case Study: Universal Health Services, Inc.

Universal Health Services, Inc. (UHS) is a registered trademark of UHS of Delaware, Inc. Found by Chairman and CEO Alan B. Miller with seed capital of $3.95 million in 1979, its corporate office is in King of Prussia, Pennsylvania. Its healthcare and management operations are conducted by subsidiaries of Universal Health Services, Inc. (UHS, 2015a, 2015b). UHS owns and operates, through its subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery

centers, and radiation oncology centers. UHS' various hospitals provide general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services, and behavioral health services. UHS on a corporate level provides capital resources, a variety of management services such as central purchasing, information services, finance and control systems, facilities planning, physician recruitment services, administrative personnel management, marketing, and public relations to its various facilities (UHS, 2015a). In 2016, Universal Health Services was one of the largest for-private investor owned psychiatric hospital providers in the U.S. (Universal Health Services, Inc., 2017). Although the company owns and operates other types of health services, the focus of this case study is limited to the behavioral health division of UHS.

UHS entered psychiatric care in 1983 and steadily expanded its psychiatric division. UHS is one of the few investor-owned chains that successfully crossed the psychiatric hospital downturn in the 1990s and increased its growth since 2000. UHS relies primarily on three business strategies: a) acquisition of additional hospitals by selectively seeking opportunities to expand its operations by acquiring, constructing, or leasing additional hospital facilities around its behavioral health businesses. This expansion provides access to new markets and new healthcare delivery capabilities. UHS also relies on divestiture of facilities that do not have potential to contribute to its growth or operation strategy. b) Improvement of operations of its existing hospitals and services–UHS increases the operating revenues and profitability of owned hospitals by the introduction of new services, improvement of existing services, physician recruitment, and the application of financial and operational controls by filing

applications with the state health planning agencies to add new services in existing hospitals in states which require a certification of need. c). HSC improves the quality and efficiency of services to deal with the pressures of cost containment and technological developments which push for more outpatient care wherever possible. UHS behavioral health division emphasizes the expansion of outpatient services. In response to cost containment pressures, UHS implements programs in its facilities designed to improve financial performance and efficiency while continuing to provide quality care, including more efficient use of profession and paraprofessional staff, monitoring and adjusting staffing levels and equipment usage, improving patient management and reporting procedures, and implementing more efficient billing and collection procedures. UHS also emphasizes innovation in response to the rapid changes in regulatory trends and market conditions while trying to meet the demands of patients, physicians, employees, communities, and its stakeholders (UHS, 2015a).

UHS strategically acquires other psychiatric facilities in geographically select market. In 1983, UHS acquired four psychiatric hospitals. It continued to acquire psychiatric facilities and in 2010, it acquired Psychiatric Solutions (PSI) for $3.1 billion which added 94 psychiatric hospitals spread across 32 states. At the time of its acquisition, PSI was the largest provider and operator of for-profit psychiatric hospitals. This expansion increased UHS revenues from $2.3 billion in 1996 to $7 billion in 2010. In 2012, UHS acquired Ascent Health Corporation, another large private psychiatric hospital company for $517 million. In 2015, it expanded its operation in the UK by acquiring a 46-bed psychiatric hospital and four additional psychiatric hospitals with 305 beds. Also in 2015, US acquired Foundation Recovery Network. By the end of the year

in 2015, UHS owned or operated more than 220 facilities in 37 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the United Kingdom. Foundations Recovery Network was a provider of addiction treatment, with four residential treatment facilities and eight outpatient centers that treat co-occurring mental health disorders. The acquisition via foundation recovery increased the UHS strategy for direct to consumer marketing, national sales team, web-based marketing, and call center to support the growth of its eating disorders, trauma, autism, and neuropsychiatric programs. In 2015, net revenues from its behavioral health care operations accounted for 40% of its consolidated net revenues (UHS, 2015a, 2015b).

UHS also grew by organic growth which added 344 new beds in select states and specialty fields. UHS selected specialty programs and services to take advantage of market opportunities by expanding beds in existing facilities: 52 beds to include eating disorder and women's trauma care program in California, adolescent and adults beds in Michigan and Arizona hospitals, conversion of acute inpatient psychiatric beds to serve children and adolescents in Virginia, increased geriatric units in Arkansas, converted 18 acute beds into an *extended acute care unit* in Pennsylvania, and 16 residential beds in North Carolina into acute care services (UHS, 2015a).

UHS opened UHS Behavioral Health Integration Solutions in 2015 with the goal of leveraging its expertise and resources to develop mutually beneficial strategic partnerships with the healthcare system. UHS entered a decade long agreement to establish a unique 34-bed older adult unit in Washington. UHS also implemented new technologies such as telehealth to improve access to mental health professions to more than 115 projects. The technological implementation includes HIPAA-compliant

technology allowing UHS to conduct evaluations and assessments, another facility uses the telehealth program to conduct remote outpatient evaluations and medication management for students in 42 schools throughout the U.S., and their facility in Nevada uses telehealth for conduct family therapy sessions to minimize geographic challenges and increase family involvement. UHS also acquired HealthLinkNow, a network of psychiatrists and other providers, to serve as the platform to integrate telemedicine into its mental health delivery model and expand its telemedicine capability nationwide. By the end of 2015, UHS increased its financial operations with $4.4 billion in net revenues. Despite increases in completion and reimbursement cuts, its occupancy rate averaged at 75.4% and admission grew 3.2% (UHS, 2015a).

A significant portion of its revenue is produced by facilities located in Texas, Nevada, and California. In Texas, it owns seven inpatient acute care hospitals and 24 inpatient psychiatric hospitals. UHS has 25% of the private psychiatric hospital market share in South Texas. The South Texas health care market is reported to be rated as the 24th fastest growing healthcare market in the U.S. Texas contributed 18% of the total consolidated net revenues in 2014 and 17% of the total consolidated net revenues in 2015. In 2015, UHS served 446,000 patients. Since the inception of the Joint Commission Top Performer program, nearly half of UHS hospitals achieved Top Performer status. It also monitors quality of care and outcome of care. Of the total patients served in the behavioral health division, 318,000 patients participated in the Patient Satisfaction Survey and it received a score of 4.5 out of 5 on each question of the patient satisfaction surveys and 92% of the patients indicated they felt better after care (UHS, 2015a). Between 2011 and 2015, the average licensed beds increased from

19,280 to 21,202 and the average available beds increased from 19,262 to 21,116 Average available beds is the number of beds which are in service at any given time for immediate patient use with the necessary equipment and staff available for patient care. A hospital may have appropriate licenses for more beds than are in service for several reasons, including lack of demand, incomplete construction, or anticipation of future needs. Its admissions increased from 352, 208 to 447,007 and the average length of stay decreased from 14.6 to 13.1 days. Occupancy rate increased steadily year after year from 73% in 2011 to 76% in 2015 (UHS, 2015a, 2015b).

In its behavioral health division, UHS employed approximately 435 psychiatrists directly or through contracts with affiliated group practices. The day-to-day operations of each of its psychiatric hospitals is managed by a CEO employed by a subsidiary of UHS. In addition, a Board of Governors, including members of the hospital's medical staff governs the medical, professional, and ethical practices of each hospital (UHS, 2015a).

UHS behavioral health services are frequently under investigation from the Office of Inspector General (OIG), the Department of Justice (DOJ), or CMS for the False Claim Act, potential Stark law violations among other investigations (UHS, 2015a). In 2015, funding from CMS was terminated for Timberlawn Mental Health System, one of the 24 hospitals owned/operated by UHS in Texas (Dallas Morning News, 2015). UHS reached an agreement with CMS relative to its reapplication to the Medicare/Medicaid program. Also, in 2015, another UHS operated facility in Texas–Texoma Medical Center entered a Systems Improvement Agreement (SIA) with CMS. CMS found failure of Texoma Medical behavioral health operations to comply with conditions of participation.

Also in 2015, seven of UHS's psychiatric hospitals received letters from Pennsylvania Department of Public Welfare demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital Payments (DSH). Other issues include, claims and lawsuits related to damages for personal injuries, medical malpractice, commercial/contractual disputes, and employee related claims (Dallas Morning News, 2015; UHS, 2011a, 2012a, 2015a). Additionally, between 2013 and 2015 a series of news articles were published in local newspapers such as the Dallas Morning News either about one of the UHS owned facilities or UHS as a company at large, which were quickly picked up by other media outlets. Moffeit (2016) published an article titled "Danger in the Psych Ward: Safety Issues Plague a Chain of Mental Health Hospitals in Texas and Across the United States," the exposed allegations about the corporation are eerily similar to those written about in the 1940s or 1960s, except overcrowding is no longer an issue in the 21st century psychiatric hospitals. But the other problems such as an unsafe environment and staffing issues prevail.

Staff roles in investor-owned psychiatric hospitals. The 21st century inpatient psychiatric practice is both market driven and consumer driven. Consumer advocacy began around the same time the investor ownership of psychiatric hospitals had shifted the medical model of inpatient psychiatric to a patient-centered model (Schwartz & Sharfstein, 2009). Though the physicians continue to assume a largely paternalistic approach to treatment, the movement in the inpatient psychiatric setting has shifted to emphasize *wellness and recovery*. Also, the dynamics, role, practice, and environment of the inpatient psychiatric settings differs significantly from the medical hospital settings. The current model of inpatient psychiatric services are oriented towards an

interdisciplinary approach, led under the guidance of the attending physician who must be a board certified psychiatrist. A psychiatrist makes the initial overall assessment, provides an initial diagnosis, and prescribes and monitors medication; while the nursing services provide 24-hour observation, supervision, monitoring, and medication management (Roca & Magid, 2009). The social services team provides psychotherapy, psycho-education, rehabilitation, family planning, and discharge planning. Though physicians continue to be gatekeepers of inpatient psychiatric settings with the sole authority to admit patients, most private psychiatric hospitals do not employee physicians; physician services are contracted. The medical staff, under the guidance of hospital bylaws, rules, and regulations, serves as decision makers and plays an important role in aligning physicians with institutional needs (Zajac, D'Aunno, & Burns, 2006). The governing body of the hospitals holds the highest authority and delegates responsibilities to key players. The Administrator, financial officer, elected medical staff, and senior leaders of each facility within the investor owned organization run the day-to-day operations of the hospital. The sources of authority and power lie among the governing body, the medical staff and the administrator. Typically, the individuals with the most power are the least involved in patient/clinical care. Each facility is control by the overall corporation. The parent organization has additional legal responsibility to securities, regulation, and corporate governance.

The administrator delegates the responsibility and duties to an array of other managers' department heads and who in turn delegate it to the front-line staff (Schwartz & Sharfstein, 2009; Williams & Torrens, 2008). The management team includes the medical records/information systems, environment of care, financial, legal, quality

assurance, clinical, human resources, marketing, and contracting. In the investor owned and for-profit psychiatric hospitals, the administrator of the hospital is similar to other types of corporate businesses. They receive valuable benefit packages and pay for performance and other types of bonuses. They usually have a management/business related educational background or individuals with clinical trainings who worked their way up to a management position. Even though the traditional highest authority role in the psychiatric hospital is the administrator, many of the clinical staff such as the physicians and nurses have management and administrative roles, otherwise known as clinical leaders (Schwartz & Sharfstein, 2009). Within the leadership structure, one physician acts as the Medical Director of the facility and the nurse as the Director of Nursing. The clinical leaders apart from providing routine clinical care, are also given tasks of hiring/firing personnel, organizational decision making, supervision of clinical staff (both clinical supervision and management), marketing, public relations, among other duties.

The role of psychiatric hospital administrator has changed dramatically since the 1960s (Schwartz & Sharfstein, 2009). In the 1960s, when there were lax regulations and accountability, the hospital administrator essentially focused on motivating groups of people or agencies to finance or sponsor new facility development. Charismatic abilities to inspire and the ability to build/sustain teams/groups to meet the organization goals and mission was sufficient. As the financing and regulatory environment become more complex and the need for efficiency grew, the function of the administrator also changed. Changes in consumer preferences, the growing quality of care expectations, staffing shortages, and increased competition from alternative models of health services

make the role of an administrator complex, complicated, and at most times highly stressful. The administrator and the leadership team of the facility also must maintain the delicate balance with the organization's external relationships (Zajac et al., 2006). Multiple third party payers; staffing companies; independent physician organizations; local, state and federal regulators; other hospitals; referral sources; community service organizations; allied health service organizations; pharmaceutical companies; and facility maintenance companies are among the many external organizations that exist in an interdependence relationship with the psychiatric hospital. The leadership also has to consider ways in which to utilize the internal and external resources and inter organizational relationships effectively. The multiple stakeholders, vendors, and consumers demand effective management (Schwartz & Sharfstein, 2009; Zajac et al., 2006). Also, the leadership is required to continuously look for ways to maintain and bolster organizational creativity and innovation while at the same time making sure the basic clinical care and other essential practices are met.

In an environment of person-centered care and an expanding range of psychiatric options, proficiency in both management and leadership is crucial for the organization to survive (Schwartz & Sharfstein, 2009). Additional challenges to leadership include the demand to avoid or prevent errors in delivery of care. A psychiatric hospital is an organization in which human factors, such as human strengths and limitations, result in the development of an interactive system that involves people, tools, technology, and environments that ensure staff and resident safety, effectiveness, and ease of use. The relationship between psychiatric hospital staff (clinical, administrative, and allied health professionals) and residents in conjunction with

provider knowledge, caregiving skills, and willingness/availability, combined with patients' characteristics such as physical/cognitive/behavioral/sensory capabilities, motivation, and attitude collectively influence the environment of care.

Challenges of investor-owned psychiatric hospitals. Investor-owned psychiatric hospitals are highly volatile as economic conditions influence and drive them. They are affected by the availability of reimbursement programs such as Medicare and Medicaid, changes in reimbursement policies, and the pricing and outcome of contract negotiations with third party payers. The market position of the hospital, variations in the market, competition, demographic changes, and staffing shortages especially in the nursing and physician services affect the hospital. It is also affected by improvements in clinical practice, medical technology, and pharmacology. The for-profit psychiatric industry is highly competitive and the competition has intensified in the last few decades in the U.S. due to regulatory and technological changes, increasing use of managed care payment systems, cost containment pressures, and a shift toward outpatient treatment. Psychiatric hospitals are subjected to numerous laws, regulations, and rules including those related to government healthcare participation, licensure and accreditations requirements, health information privacy and security rules, CMS fraud, and abuse statutes among others. In this sense, the 21st century psychiatric hospital exists in a highly regulated and litigious environment. Hospitals found guilty or in violation of any federal, state, or local regulation must pay significant fines or penalties to the government, repay amounts received from the government for previously billed services, or they may be excluded from participation in government healthcare programs. Psychiatric hospitals are required to comply with standards of care and

conditions of participation, as well as the requirements of municipal building codes, health codes, and fire department codes. They are also required to acquire licenses and permits for dispensing narcotics, handling radioactive materials, and operating certain equipment (UHS, 2015a, 2015b; Williams & Torrens, 2008).

## Summary

In this chapter, I reviewed the factors that led to the growth and or demise and resurgence of investor-owned and operated psychiatric hospitals using Universal Health Services as a case study. The characteristic of investor-owned psychiatric hospitals, hospital structures, and changing staff roles was explored. For-profit psychiatric hospitals grew or reduced in size for different reasons when compared to public psychiatric hospitals. Private/Investor owned psychiatric hospitals are set up and established explicitly as business ventures and in response to a favorable economic climate. They are also highly strategic in their business and operational decisions. Strategies taken to capture more market share and capture more patient dollars to stay financially viable play a key role in shaping their health service delivery and overall organization at large (Gray, 1986; UHS, 2005a; Williams & Torrens, 2008).

Nearly 7.5 million adults with serious mental illness do not have health insurance or are underinsured (McAlpine & Mechanic, 2000; Mental Health America, 2017). Based on its business model, investor owned psychiatric hospitals target patients with mild to moderate mental illness, provide less treatment to uninsured patients or transfer them out to other settings as quickly as possible, or they *skim and dump* if the patient is not financially profitable to the hospital as they select patients on their ability to pay. In

comparison to public psychiatric hospitals, less than 1% of the private hospitals provide care without charge (Dorwart & Schlesinger, 1988; Long, Fleming, & Chesney, 1993). Additionally, care in private psychiatric hospitals is largely dictated by the managed care industry that dictates the need for stay and length of stay of the patient in the psychiatric hospitals. Individuals with serious/chronic mental illness that require longer term stays are ill-served in the private psychiatric hospitals and public psychiatric hospitals continue to be the largest providers of care for patients with serious mental illnesses.

# CHAPTER 5

## ANALYSIS

Goldman and Morrissey (1985) characterized the cyclical pattern of psychiatric hospital reform in the U.S public mental health policy as each transformation resulted in a new approach to treatment for mental illness and a shift in the location of care for mental illness. The first cycle in the early 19th century was the introduction of moral treatment. The second cycle in the early 20th century was the mental hygiene movement and the psychopathic hospital. The third cycle in the mid-20th century was the community mental health movement and the fourth cycle as defined by the authors was “homelessness” (Goldman & Morrissey, 1985, p.727). I add to these cycles and believe we had a fifth cycle of reform in the 1980s–growth of for-profit/investor owned psychiatric hospitals and nursing homes, sixth cycle–care dictated by managed care organizations and an increase in population with mental illness in prisons and jails, and currently, the seventh cycle– the resurgence of for-profit psychiatric hospitals. This historical and trend analysis shows that each cycle of evolution in the psychiatric hospital setting was preceded by noble and idealistic goals from the social, political, and activist groups of what is best understood as improving the delivery of services for individuals with mental illnesses. Though the need for inpatient psychiatric hospital services has remained unchanged and in fact has grown due to increases in the population and variations in population demographics, such as minorities, women, and the aged, the socio-political and activist ideologies has shifted from one end of the pendulum to the other over the course of the last century. Each cycle ended with

unfulfilled promises and a new set of challenges for both the psychiatric hospitals and the population they were intended to serve.

In Part A of this study, using a historical review and trend analysis, the first goal of this exploratory research was to examine the precipitating factors that led to the growth of the psychiatric hospitals and the factors that led to the reduction of psychiatric hospitals. The second goal of this research was to gain knowledge of how the various fluctuations in inpatient psychiatric hospital, as related to the availability of inpatient psychiatric hospitals and psychiatric hospital beds, affected adults and older adults with serious mental health needs.

## Part A

From 1700-1930, the number of initial psychiatric hospitals grew largely due to the changes in the social and cultural beliefs systems which shifted the responsibility and care of individual from primarily family and local government responsibility to one of collective, social, and moral obligation. As the decrepit conditions of care in almshouses and jails came to public attention, states began to build asylums. Some of the causes identified in the literature review in Chapter 2 that led to the increase in demand for inpatient psychiatric services were increases in urbanization, industrialization, and populations; inadequate federal legislation for preventing the entry of the insane from other countries; improper enforcement of the laws; insufficient psychiatric knowledge; shift in the social definition of madness; and lack of admission criteria. Increased efforts from social activists and reformers to build large institutions to care for individuals with mental illness aligned with political interests. Local officials motivated by the fiscal

incentives preferred asylum development as it funneled job to the states. Slowly, the responsibility of the care of individual with mental illness shifted from local government to state government along with increasing the state ownership of the public/state psychiatric hospitals. As almshouses closed and moved residents to asylums, the resident population in the asylums increased and increasingly housed older adults and a chronic/long stay population. The number of chronic/long stay patients increased substantially from 1890 to 1950. Between 1880 and 1940 more than a third of the total inpatient population was over the age of 65. By 1946, senility and paresis were half of the total admissions. This shift in resident population of the asylums altered its original function from a therapeutic institution to a custodial institution. By the end of 1930, the location of care shifted from the community almshouses which were funded largely by charity to the state run institutional settings–asylums.

By 1940, the pendulum of social, political, and cultural climate swung from one of social, collective, and moral obligation of the care of the individual with mental illness to one of anti-institutions and anti-psychiatry. Thus, institutional treatment in public psychiatric hospitals garnered tremendous public scrutiny and institutional treatment lost its legitimacy. Invention and use of antipsychotic drugs helped to reduce or manage the severe symptoms of serious mental illness such as delusions, hallucinations, and manic symptoms of patients. The decade of the 1950s also saw the growth of the civil rights movement and the growth of civil libertarian lawyers who argued for the rights of patients in psychiatric hospitals. In the 1960s, the Community Mental Health Act and enactment of federal programs such as Medicare, Medicaid, SSI, and SSDI allocated for seriously mentally ill shifted costs of care for mentally ill individuals from state to

federal government and encouraged a shift in location of care from state run institutional settings back to the community settings. Starting slowing in 1940s and increasing at a rapid speed in the 1950s and 1960s, large numbers of patients from public psychiatric settings were discharge into the community and public psychiatric hospitals reduced in size and in numbers. As a result, the function of the psychiatric hospital shifted from providing custodial care to providing short term care for serious/acute mental illness. The number of elderly patients in the inpatient psychiatric settings reduced as they were discharged to various community settings such as board and care homes, residential homes, or nursing homes. Nursing homes, residential homes, and board and care homes grew dramatically in numbers and in size, especially in the for-profit sector. In addition to the growth of nursing homes, as more and more of the asylum population was discharged into the community, homeless among individuals with serious mental illness increased. This shift in the U.S. mental health policy from treatment in an institutional setting to a community setting moved the psychiatric hospital from its central role in the treatment of mental illness to a last resort treatment setting. However, increases and or decreases in inpatient psychiatric hospitals did not occur at an even rate across the U.S. and there were variations among the states.

In Part B of this research, I analyzed the growth and or demise of inpatient psychiatric hospitals in Texas. The fluctuations of increase or decrease occurred for different reasons in public psychiatric hospitals compared to the for-profit investor owned psychiatric hospitals.

## Part B

Texas is the second largest state in the U.S. and the second most populated state in the U.S. and nearly a quarter of its population is uninsured. Texas per capita mental health service expenditures are one of the lowest in the nation for more than a decade. Texas has nine state owned/operated public psychiatric hospitals which suffer from aged infrastructures, staffing crises, increases in turnover, and difficulties in recruitment and retention of mental health care staff. Compared to the rest of the nation the reduction of population in public psychiatric hospitals in Texas occurred at a slower pace and was followed immediately by the development of community mental health services and private psychiatric hospitals. Texas eliminated the Certification of Need program in 1985, which created a fertile economic environment for growth of private psychiatric hospitals.

In Part C of this research, I analyzed the factors that influenced the growth or demise in public psychiatric hospitals vs. investor owned psychiatric hospitals.

## Part C

By the 1980s, federal cuts to community mental health services and an increased focus on privatization encouraged the development of private psychiatric hospitals which until then played a smaller role in the treatment of mental illness. Policies such as the Omnibus Budget Reconciliation Act in 1981 were designed to boost privatization and competition. Also, private and employer insurance increased coverage for mental illness. The for-profit and investor-owned psychiatric companies aggressively marketed their services as a healthcare commodity which aligned with aggressive marketing of

drugs from the pharmaceutical companies. As psychiatry and psychiatric cures became more commercialized and medicalized, the focus of psychiatric illness shifted from environmental factors to biological/physical factors. Development of other types of treatment settings for psychiatric services such as outpatient programs, residential programs, and continued developments in psychopharmacology encouraged rapid discharge of patients from institutional settings to community settings. The growing mental health consumer movement and consumer organizations increased the emphasis on treatment of the individual in the *least restrictive environment* and made it further difficult to admit patients to psychiatric hospitals.

Additionally, private psychiatric hospitals targeted patients with mild to moderate mental illness, provided less treatment to uninsured patients or transferred them out to other settings as quickly as possible, or they *skimmed and dumped* if the patient was not financially profitable to the hospital as they selected patients on their ability to pay (Gallagher, 2012). In comparison to public psychiatric hospitals, less than 1% of the private hospitals provide care without charge (Dorwart & Schlesinger, 1988; Long et al., 1993). Shifts in reimbursement of health care services from retrospective cost-based reimbursement to prospective set care based reimbursement benefited the private psychiatric industry. As public psychiatric hospitals continued to discharge patients due to funding cuts and reduced in size, the demand for inpatient psychiatric services continued to increase. By the 1980s, the role of state government in the care of individual with mental illness reduced and shifted to the federal government and to the private sector. However, the growth of managed care organizations, lax state and federal regulations, questionable practices such as overbilling, patient rights violations,

fraudulent reimbursement, and reporting of false claims resulted in dramatic decreases in the for-profit psychiatric hospitals and hospital beds across Texas and the nation.

But by the first decade of the 21st century, private psychiatric hospitals quickly rebounded as the demand for services continued to grow and public psychiatric hospitals continued to decrease their beds. Continued advances in psychiatry and psychopharmacology increased the number of professionals especially physicians who had the sole authority to admit patients to psychiatric hospitals, reduced stigma associated with inpatient psychiatric settings, greater profit margins, lower operational costs compared to other medical settings, the ability to transfer chronic and severely mental ill individuals to other types of settings, and looser treatment protocols are some of the contributing factors for the growth of private psychiatric hospitals. In addition, the unique characteristics of investor-owned psychiatric hospitals, such as the acquisition of multihospital systems by other multihospital systems, decreased competition, higher degree of ownership in fewer companies, greater market penetration, private equity investments, and easier capital acquisition are additional contributing factors for growth of private psychiatric hospitals.

Further economic benefits for private psychiatric hospitals were increases in private insurance coverage under the cost-based system; increases in overall reimbursement which equalized coverage of behavioral health and medical health benefits in terms of copays, deductibles, and lifetime caps; the Medicare Improvements for Patients and Providers Act of 2008 which increased access to mental health in federal programs; and the Patient and Affordable Care Act of 2010 also increased the number of lives covered. By 2000, private psychiatric companies adapted to the cost

containment efforts from managed care companies such as prospective, concurrent, and retrospective reviews set in place reduced the length of stay in the private psychiatric hospitals. The for-profit business models and internal strategic plans to counter cost-containment pressures such as emphasis on diversification of services; monitoring and adjusting staffing levels and equipment usage; and implementing more efficient billing and collection procedures further encouraged the growth of investor operated psychiatric hospitals as they are established explicitly as business ventures and in response to a favorable economic climate.

## Psychiatric Hospitals as an Adaptive Health Service Organization

The third goal of this research was to illuminate the psychiatric hospital as a health service organization that is not only amenable to change but is a strategic organization capable of adaptation. Psychiatric hospitals have adapted and evolved over the course of 250 years and continue to retain some of the original function of providing intensive treatment in structured and institutional settings for individuals with chronic and severe mental illnesses. This evolution has transformed treatment models to include more effective forms of therapeutic and pharmaceutical interventions. However, in other ways it has returned to its beginnings; in 2017, the demand for inpatient psychiatric services exceeds the number of psychiatric hospitals and psychiatric hospital beds, especially in public psychiatric hospitals. Currently, many states in the U.S. have fewer public and private psychiatric hospitals beds than in 1850. (Treatment Advocacy Center, 2016). As noted in Chapter 2, there were 14 public/state psychiatric beds for 100,000 in 1850 and there were 14 public/state psychiatric beds for

100,000 in 2010. Various states in the U.S. continued to reduce public/state psychiatric beds at varied rates, and as of 2016, the number of public/state psychiatric beds had decreased to 37,679, which is 11.7 psychiatric beds per 100,000. This means in 2016 there are fewer public/state psychiatric beds in the community than in 1850 (The Treatment Advocacy Center, 2012, 2016).

Apart from the location of treatment, the role and function of the inpatient psychiatric hospitals also changed and a new form of psychiatric hospital has emerged in the 21st century. The current model of psychiatric hospitals are no longer monolithic and static institutions whose function is to provide therapeutic care nor are they custodial institutions of earlier decades. In the 21st century, this type of hospital merely functions as crisis stabilization centers for acute psychiatric crisis and as a last resort choice. This shows psychiatric hospitals have adapted to both internal and external forces of change and evolved along with retaining some of their core functions such as providing structured treatment in the institutional settings for chronic and severe mental illness (Morrissey, 1989).

Additionally, psychiatric hospitals have also retained some of their challenges and continued to struggle with some of their chronic and persistent problems such as financial uncertainties, budgetary constraints, staffing issues, patient safety, and quality of care concerns. In the for-profit sector, managed behavioral and investor-owned corporations control the provision of inpatient psychiatric services and financing them. Apart from the few psychiatric beds, the length of treatment days has reduced dramatically. Though medicine, psychiatry, psychotherapy, and psychopharmacology have evolved and provide more effective treatments, they have played a minimal role in

the growth or demise of psychiatric hospitals and play a minimal role in the treatment decisions.

## Implications

From the 1700s to now, the location of care—inpatient psychiatric hospital—has gone thru various transformations as the care of and responsibility of individuals with mental illness and proposed solutions changed and evolved from personal to local to state/public and federal government responsibility. This exploratory study and review of the history of psychiatric hospitals and the populations it is intended to serve shows there is an underlying important and crucial question that remains without a decisive answer – whose responsibility is it to take care of the severely and chronically mental ill individual? And as the answer to this crucial questions changed over the course of the last century, the location of care for the severely mentally ill individual changed. The inability of the society to come up with a decisive answer and formulate practical solutions has led to the various shifts in location of treatment (from almshouses to asylums then back to community settings and back again to institutional settings which by the 1990s include prisons and jails). In addition, as the definition and categorization of what is considered as *mental illness* changed, the focal treatment setting for mental illness also changed resulting in expansion of the overall U.S. mental health policy and services.

Currently, public psychiatric hospitals continue to face serious challenges. A rapidly growing population, increasing number of forensic patients, workforce shortages, increased turnover and aging facilities, uneven/delayed/insufficient funding have made it

increasingly difficult for state hospitals to meet the demand for inpatient psychiatric care. State budget cuts for community mental health services have made it difficult for community services to meet the mental health needs of its residents adequately. According to the Treatment Advocacy Center (2016), currently Texas is one of the 16 states with fewer than 10 state hospital beds per 100,000 people. As noted in Chapter 3, in Texas the forensic commitments to state psychiatric hospitals have increased exponentially, reducing the availability of civil beds. Subsequently, the average wait time for inmates in jail needing a state hospital bed rose from 20 days in 2014 to 122 days in 2016 (Legislative Budget Board, 2011; Martinez & Bush, 2016)). The forensic population has longer lengths of stays than civil/voluntary patients further challenging the state hospital system to care for patients involved in criminal proceedings. Like the rest of the nation, patients with co-occurring mental illness and substance abuse disorders and patients with mental illness with medical complexities are increasing. Patients served in the state psychiatric hospitals are more acutely psychiatrically and medically ill. Treatment for this population requires additional staffing and specialized services. Also, the older adult population is expected to consume higher health care resources given the rise in age related acute/chronic or organic mental illness (TDSHS, 2015a).

### Shortages in Psychiatric Beds and Increase in Suicide Rates

Research on the impact of deinstitutionalization and the resulting shortage of psychiatric hospital beds, especially in public psychiatric hospitals, showed an increase in suicide rates. The supply of for-profit psychiatric hospital beds did not compensate for

the public psychiatric beds (Yoon & Bruckner, 2009). According to the American Association of Suicidology (2017), there were 5,404 suicides among aged 65 and over in 2005, which translates to 15 elder suicides per day or one suicide every hour and 37 minutes. In 2005, the suicide rate among the older adult population represented 16.6% of all suicides (American Association of Suicidology, 2017). Along with the increase in suicide rates among elderly, the rate of homicide-suicide has increased by 10% in the elderly from 2005 to 2014 (Violence Policy Center, 2015).

I am uncertain as to whether we needed to abandon the public psychiatric institution in the process of change and transformation as they were not fully replaced by any other type of treatment setting and they continue to maintain a critical function for the care of individuals with mental illness. As of 2016, the demand for inpatient psychiatric services continues to grow due to a greater awareness of psychiatric illnesses and reduced stigma associated to mental illness treatments, regional population growth and aging population along with increased number of insured, and increased diversion of patients from the criminal justice system to the mental health system.

The increased need for inpatient psychiatric services, especially elderly due to biomedicalization or psychiatrization and commodification of mental illness services along with favorable economic conditions, is creating a resurgence in growth in the for-profit inpatient psychiatric facilities. Advances in psychiatric treatments especially psychopharmacology, telemedicine, and telepsychiatry; increased funding from the federal governments and federal legislation affecting insurance benefits such as the passage of The Mental Health Parity and Addiction Equity Act of 2008 which requires

large group plans to provide mental health and substance-abuse benefits at the equal rates applied to medical and surgical treatments; the Patient Protection and Affordable Care Act of 2010 which extends benefits to the uninsured including the expansion of Medicaid and the mandate for individuals to buy health insurance or face penalties; low overhead capital requirements and an increase in capital resources in the for-profit inpatient psychiatric facilities is creating a conducive social, political, and economic environment for psychiatric hospital resurgence. Presently the social, cultural, economic, and political trends, especially in Texas, favor inpatient admission as it has become clear that past decisions of community care did not work out as well as one had hoped for. Adults and older adults with severe and chronic mental illnesses require higher levels of care to meet their needs and nursing homes are ill-equipped to provide services for acutely mentally ill patients. Also, currently, there are no other alternative types of health services apart from hospital emergency rooms that provide emergency care and hold the patient until a bed in a psychiatric hospital becomes available.

## Limitations of the Study

The focus of this study was on the location of care of treatment for severe and chronic mental illness in the institutional settings and the causal factors of the growth or demise of this type of settings. Part of the data collection relied on second sources as no data was available during those years. The causal factors identified in this study were limited to factors identified via the literature review. This research failed to assess the quality of services provided in the inpatient psychiatric settings such as patient outcomes, patient preference, or patient satisfaction of inpatient psychiatric hospitals.

There is a need for greater research in this area to identify other factors that affect this type of health service and patient outcomes and patient preference for this type of health service.

# CHAPTER 6

# FUTURE OF PSYCHIATRIC HOSPITALS

In the 21st century, the psychiatric hospital operates in a complex and often confusing matrix of not only the U.S. mental health system, but also within the larger U.S. healthcare system. Considering the U.S. healthcare system is dominated and driven largely by the economic factors both in terms of provision of services and financing of services (Olsen, 2002), the private psychiatric hospitals will continue to function and operate as business ventures and continue to adapt the entrepreneurial model of service delivery. Within this context, the psychiatric hospital is part of the multihospital systems, alternative mental health services, insurance companies, and other governmental institutions such as courts, jails, and police departments. Each system of health service affects the other in a complex, unpredictable, and constantly changing environment. Additionally, the roles, interest, and expectations of providers, third party payers, regulatory agencies, physicians, and patients are constantly changing and many times contradictory to each other (Sharfstein, 2009; Williams & Torrens, 2008).

## Challenges Ahead for Inpatient Psychiatric Hospitals

Inpatient psychiatric hospitals continue to face serious challenges. For example, in Texas, the recent report by the Sunset Advisory Commission on the Texas Department of State Health Services (TDSHS) evaluated and enumerated the many problems that exist in effectively serving Texas' mental health consumers. Sunset described TDSHS as being spread too thin and set up to be a *jack of all trades and a*

*master of none*. Sunset strongly recommended that HHSC and TDSHS "immediately review and streamline human resources policies to ensure state mental health hospitals are appropriately staffed" (Sunset Advisory Commission, 2014-2015). As noted in Chapter 3, the growth trends for psychiatric hospitals in Texas are highly uneven. Public psychiatric hospitals are still the largest providers of inpatient psychiatric care in Texas. Currently 86% of all Texas psychiatric hospitals are in metropolitan areas. Texas does not have CON laws. Research shows that states without CON laws have 33% more for-profit psychiatric hospitals than states that have CON laws (Geller, 2006a). This shows an uneven distribution of psychiatric hospitals resulting in difficulties of access to care for services. Texas is also one of the most highly regulated states for inpatient psychiatric hospitals. Texas inpatient psychiatric hospitals continue to struggle with meeting and staying in compliance with laws, rules, and regulations from multiple regulatory bodies. Patient safety and quality of care must continue to be a high priority for psychiatric hospitals to regain lost trust for institutional settings.

In the last few decades, there have been dramatic changes in the investor-owned psychiatric hospitals. Today's for-profit psychiatric hospitals are new types of health service organizations and very different from private psychiatric hospitals that existed a century ago. Today's investor-owned psychiatric hospitals are explicitly established as business ventures and in response to a favorable economic climate. As such it is a highly volatile industry. Increased competition and accountability along with increasingly litigious environment are shaping the business strategy (Bloche & Studdert, 2004). Within this framework of operations, there is intense involvement in *strategy*. Strategies taken to capture more market share and capture more patient dollars to stay financially

viable play a key role in shaping their health service delivery and the overall organization at large. Investor-owned psychiatric hospitals also exist in a highly competitive healthcare environment, 60% of all for-profit psychiatric hospitals are owned and operated by a handful of investor-owned corporations (Hutchins et al., 2011). Additionally, the care of the patient is not dictated by the clinical need but is driven by cost-containment strategies from the managed care entities. Psychiatric hospitals are expected to provide effective treatment intervention at more efficient and competitive pricing, while they attempt to continuously achieve their budgetary goals (Shortell & Kaluzny, 2006).

The availability of investor-owned psychiatric beds and the psychiatric services is directly tied to the fluctuations in the reimbursement rates. Currently, Medicare and private insurance are the largest and highest payers (over $800 per day in the psychiatric hospital) for geriatric psychiatric services. The number of geriatric psychiatric hospitals are growing due to the favorable reimbursement rate and the extended length of stay due to the acuity/severity of the illness of this population. But, if this trend were to change and reimbursement rates reduced, then I expect private psychiatric hospital beds, especially the specialty geriatric beds will reduce in size and numbers. Many adults with a serious mental illness are poor, under-insured, or uninsured and require higher length of stay due to the acuity of the illness. For-profit psychiatric hospitals do, at times, provide uncompensated care—via charity care and bad debt write off—however, compared to other types of psychiatric hospitals (public, not-for-profit hospitals), for-profits provide a much lower portion of uncompensated care and when the uncompensated care is provided, the goal is to get the patient out of the hospital as

quickly as possible. There are both positive and negative attributes of the investor-owned psychiatric hospitals. The positive attribute is, as public psychiatric hospitals continue to reduce the number of beds available in the hospitals, private for-profit hospitals can fill the gap in need for inpatient services. They also funnel jobs into the community and provide a wide range of specialized psychiatric hospital services (Hutchins et al., 2011). The negative attribute is that they do not necessarily provide higher quality of care, the availability of their services is unpredictable, and there is no guarantee that they will accept patients without insurance.

Comparing private psychiatric hospitals to public psychiatric hospitals, public psychiatric hospitals receive 72% of their total funding from state mental health agencies and other state government sources, while 44% of private psychiatric hospital funding comes from Medicare and Medicaid (Substance Abuse and Mental Health Services Administration, 2004). As care follows money, few for-profit psychiatric hospitals and behavioral health providers accept Medicaid due to low reimbursement rates. However, at the time of writing this paper, the U.S. National elections were less than a month away and the fate of the Patient Protection and Affordable Care Act (2010) and reimbursement for mental health is undecided and uncertain. It is safe to expect that the psychiatric hospitals will undergo another transformative cycle before 2020. For now, the need for inpatient psychiatric hospital beds exceeds the supply of inpatient psychiatric beds and the stipulated average length of stay in the inpatient psychiatric setting does not adequately and effectively meet the needs of severe mentally ill consumers.

Since the 1980s, community mental health services such as the board and care homes, residential homes, and nursing homes have expanded to contain institutional costs. However, the community settings are ill-equipped both clinically and operationally to attend to the acute crisis needs of the adults and older adults with severe mental illnesses. In addition, the commitment laws passed 40 years ago and emphasis on treatment in-least restrictive settings were originally set in place with the goal of reforming the desperate structural and operational conditions of the public psychiatric hospitals (Mechanic, 2007). However, they failed to consider the acute symptoms of severe mental illness such as schizophrenia, psychosis, and neuro-degenerative conditions such as Alzheimer's which are amenable, if not 100% of the time, but 80% of the time to medication management and require a team of professionals (psychiatrists, physicians, and social workers).

Furthermore, according to the U.S. Department of Health and Human Services, as of June 19, 2014, there is a shortage of approximately 4,000 mental health professionals in the U.S. The Health Professional Shortage Area (HPSA) for mental health is based on a psychiatrist to population ratio. If there are more than 30,000 people per psychiatrist, then it is designated as a mental health HPSA. According to HPSA there are nearly 4,000 such areas in the U.S. (U.S. Department of Health and Human Services, 2014). In addition, nearly 60% of the psychiatrists are over the age of 55, which makes it the fourth profession of the medical specialties in terms of practitioners age (Treatment Advocacy Center, 2016). Addressing nursing and physician shortages will continue to plague the psychiatric hospitals. I expect the challenge of providing additional staffing levels for the severely mentally ill (adults and

elders) will continue to be an issue. Additionally, staff willingness to care for individuals with severe mental illness needs further investigation. Psychopharmacology will continue to advance and hopefully provide the third and fourth generation of psychopharmaceutical medications and reliance on technologies such as telepsychiatry and telemedicine will increase. Although the advancements in psychiatric medicine and technology will prove highly beneficial to individuals with mental illness, they might even help in delaying an acute episode. However, the acutely and severely ill individual will need inpatient admission to stabilize the crisis. Hence, shortage of inpatient psychiatric beds will need to be addressed at a pragmatic level.

## Proposed Model

Just like the current form of psychiatric hospital has evolved, transformed itself, and adapted to its present model of service delivery over the course of 250 years, it is safe to expect the current model of psychiatric hospital will continue this course and will undergo other forms of transformations which will replace the current form. The question is not whether the current form of inpatient psychiatric hospital will change, but if the next evolution will adequately, efficiently, and effectively provide services and meet the needs of the individuals that it was always intended to serve.

It would be difficult to provide care for acute psychiatric crises in the community or home settings. Patients with an acute psychiatric crisis, also have medical needs and require 24-hour care in a safe and structured environment until the crisis is stabilized. Currently, for those individuals that require an acute level of psychiatric care and psychiatric crisis stabilization, there is no other alternative to inpatient psychiatric

hospitals. Other types of social or health services such as ERs, nursing homes, or jails do not provide intensive psychiatric services but merely act as holding places until a public or private psychiatric hospital bed becomes available. As seen in the previous chapters, the need for inpatient psychiatric services has always existed for chronically and severely mentally ill individuals. However, based upon the analysis in this dissertation, the growth or demise of psychiatric hospitals seems largely to be driven by social, political, ideological, and economic factors rather than the clinical need of the individuals they are meant to serve.

It is evident in the 21st century, there is a need for a health service setting that provides better care for individuals with severe mental illness that does not involve rapid discharges. It is difficult to treat acute episodes of psychiatric crisis within a week or an institutional setting that does not criminalize the patient in a state of psychiatric crisis. I believe there is a need for a treatment setting specializing in acute and chronic psychiatric services that combine the original spirit and therapeutic function of the asylums and the current custodial function of the nursing homes. The meaning of asylum is a place of "refuge, protection, and safety" (Sacks, 2009, p. 50). It is evident that in the 21st century, it is impractical to expect an institution like the large asylums of the 20th century. However, prisons, emergency rooms, and nursing homes are not the safest alternatives either for treatment of severe mental illnesses or acute psychiatric crises. What is missing in the nursing home care is structure and support for treatment of acute psychiatric illness. What is missing in current psychiatric hospitals is lack of availability of financial and staff resources. What is needed is a structured long stay residential facility that specializes in evidence- based treatment for severe mental illness

for adults and older adults. A setting that maintains higher staffing ratios and relies on a combination of medication management, therapy, case management, and rehabilitation services within a multidisciplinary team of specialists in a structured environment. This type of treatment setting must collaborate with intensive outpatient and community settings such as the Assertive Community Treatment (Center for Evidence-Based Practices, 2011), local prisons, and police departments to provide intermediate and long term treatment. The focus of this type of setting is to maintain patient safety without providing the prison like atmosphere of the old age asylums. I believe a specialized residential care setting whose focus is on treatment and care of individuals with severe mental illness will reduce mental health systems reliance on prisons as custodians and caretakers of individuals with serious mental illness. It will also help eliminate the cyclical loop that many patients with serious mental illness get caught in–from community to ER to jail to short-stay psychiatric hospitals then to public psychiatric hospitals or prison and back to community for a short period before the cycle starts over again. Currently, U.S. spends $28 billion on hospitalization costs per year for those with severe mental illness (SAMSHA, 2012). An intermediate/long term residential setting for severe mental illness can help reduce the pressures on the public psychiatric hospitals for civil beds and help offset hospitalization costs. For more than 200 years, we have debated the meaning and definition of severe mental illness, the need for treatment, the appropriate location of such treatment, and the type/modality of treatment for severe mental illness; along the way we have formulated policies that are myopic and short-lived.

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