Health Policy Considerations in Treating Mental and Behavioral Health Emergencies in the United States

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KEYWORDS

• Mental health access • ED crowding • Mental health parity • Boarding
• Mental health reform • Substance abuse • Homelessness • Incarceration

KEY POINTS

- The US mental health system, based largely on outpatient services, has failed to meet the growing need for acute psychiatric care in the United States.
- Limited mental health access, especially for acute behavioral emergencies, has led to increased visits in emergency departments (EDs) nationwide.
- The boarding of psychiatric patients in overburdened EDs with inadequately trained staff creates a suboptimal acute care setting that negatively impacts patient care.
- Deficiencies in acute/chronic mental health care have contributed to growing rates of substance abuse, homelessness, and incarceration among the mentally ill in the United States.

HISTORY OF MENTAL HEALTH SERVICES IN THE UNITED STATES

The mental health system in the United States has dramatically evolved in the past 2 centuries. Economic factors, advances in medicine, and changes in government policies have all contributed to a paradigm shift in psychiatric care. During the nineteenth century, the focus in the US mental health policy was to treat those patients who had the most severe and chronic mental health problems. This focus led to the construction of the asylum, a state institution offering shelter and care for those with mental health impairments. Asylums benefited communities, families, and patients alike by

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offering comprehensive therapies and humane custodial care for the chronically ill. By the midnineteenth century, the asylum became widely regarded as a symbol of an "enlightened and progressive nation that no longer ignored or mistreated its insane citizens."[1] By the 1950s, however, positive perceptions of the state mental hospital began to erode as financial neglect, due largely to the Great Depression and World War II, deteriorated the quality of care at these facilities. This deterioration along with several other major developments, including a shift toward psychoanalytic and pharmacologic therapies, an emphasis on preventative approaches, and greater federal government support for community programs, propelled the evolution of the US mental health delivery system virtually overnight. These advances unlocked the doors of state asylums allowing patients to transition into communities for outpatient treatment and management of their psychiatric conditions.

Ultimately, deinstitutionalization of the US mental health system resulted in a decentralized, heterogeneous, community-based array of outpatient services. A mass exodus of psychiatrists from mental hospitals ensued during the late 1950s; by the following decade 80% of the 10,000 members of the American Psychiatric Association were employed outside of mental hospitals.[1] This revolution toward outpatient psychiatry gained momentum with the passage of the National Mental Health Act in 1946 (PL 79-487), which provided federal funding to states to support expanding outpatient care facilities. Beginning in the 1960s, deinstitutionalization resulted in a decrease of beds in state and county psychiatric hospitals. This trend has continued as the number of beds nationwide dropped from approximately 400,000 in 1970 to 50,000 in 2006, with 80% of states reporting a shortage of acute care psychiatric beds.[2,3] Since then, the number of psychiatric hospitals and acute care psychiatric units has maintained a steady decline (**Fig. 1**).

This systemic shift toward prevention and maintenance in outpatient clinics left few options beyond EDs for patients experiencing acute psychiatric exacerbations. Whether due to the long-term effects of deinstitutionalization, inadequate community resources, the large numbers of uninsured patients, or other causes, it is inarguable that the number of patients in psychiatric crises presenting to EDs is on the rise.[4] Between 1992 and 2001, there were 53 million mental-health-related ED contacts in the United States, an increase from 4.9% to 6.3% of all ED visits and an upswing from 17.1 to 23.6 visits per 1000 of the US population during this period.[5] By 2007, psychiatric visits accounted for 12.5% of the 95 million visits to the ED, almost doubling from the proportion (6.3%) in 2001.[4,6]

EMERGENCY MENTAL HEALTH DELIVERY IN THE UNITED STATES TODAY

There are 3 common models of emergency psychiatry delivery in the United States currently differing by where patients are placed.[4] Although each of these models carry their own advantages and disadvantages, the general treatment goals of emergency psychiatry are the same: first exclude medical causes for symptoms, rapidly stabilize the acute crisis, and develop an appropriate disposition and aftercare plan.

Emergency Department Boarding with Psychiatric Consultation

In this traditional model, the patient is evaluated and treated in the ED by both an emergency medicine (EM) physician and a psychiatry consultant. First, the EM physician performs an appropriate medical screening evaluation looking for any organic causes explaining the psychiatric symptoms. Once organic causes are ruled out and/or stabilized, the patient is evaluated by the psychiatry consultant. One major advantage of this model is that it possesses the lowest cost and is the easiest to