Public Focus
A Quarterly Governance Institute Newsletter
MAY 2021

The Growing Behavioral Health Crisis: A Perfect Storm for Public Hospitals

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Some years ago, like almost everyone else, I decided to retire the term "perfect storm." While the concept has existed for centuries, its popularization in a book of that title written to describe the "Great Halloween Nor'easter" of 1991[1] led to the term becoming an overused cliché. But cliché or not, it seems apt today to describe the impact of the COVID-19 pandemic on many areas of human endeavor—not least on behavioral health. Quite simply, in 2020 a number of elements that have been brewing for years merged with the pandemic to form a crisis of major proportions for public hospitals that provide behavioral health services.

It is essential that board members of such public hospitals understand (and be prepared to address) these elements and their implications for patients and providers alike. This article will identify and describe for board members each of the conditions and challenges that have merged to generate the current crisis. It will also provide public hospital governing boards with some action steps and opportunities to mitigate its impact on the viability of public hospitals that provide behavioral health services.

The Challenges

Deinstitutionalization

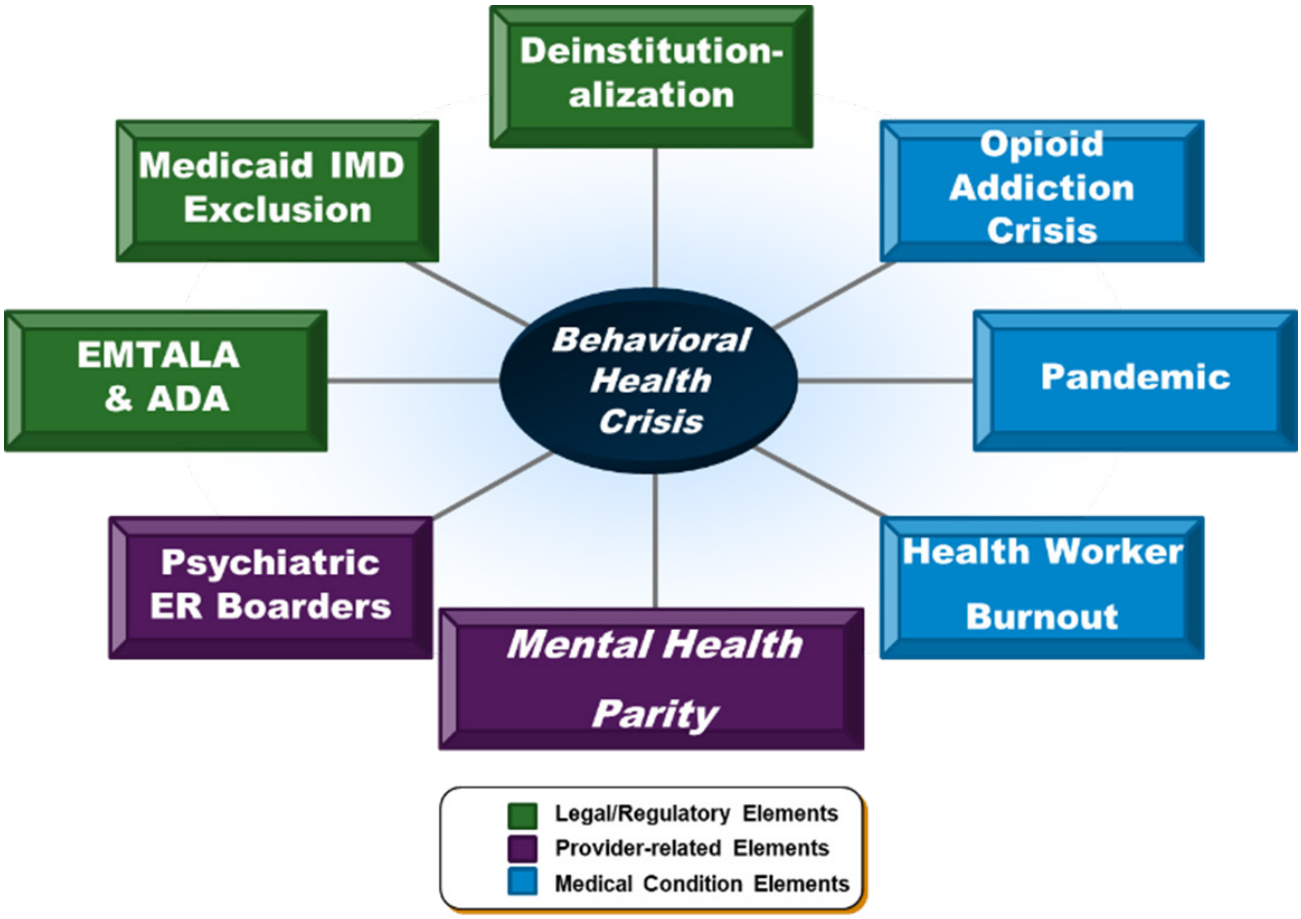
A search for the origins of the current behavioral health crisis takes us back to the middle of the last century. Starting in the mid-1950s, the per capita number of psychiatric beds in the United States decreased by 95 percent, from 680 beds per

1 Sebastian Junger, *The Perfect Storm*, W.W. Norton & Company: New York, 2009.

➜ Key Board Takeaways

- Develop a behavioral health "dashboard" to help the board track the various aspects of behavioral health.
- Advocate for the repeal of the Medicaid IMD exclusion, in order to make more treatment resources available for non-elderly adults, ease the pressure on your emergency departments, and reduce the likelihood that behavioral health patients will be "dumped" on your doorstep.
- Encourage hospital leadership to actively engage with the criminal justice system to develop treatment alternatives to criminalizing mentally ill patients and warehousing them in prisons and jails.
- If your hospital or health system has a behavioral health "boarder" problem in your emergency department, it may be helpful to convene an *ad hoc* board committee (including outside experts) to assist in addressing the problem, including consideration of alternative treatment sites like the "Alameda Model" described in the article.
- Such an *ad hoc* board committee could also address the extent to which your hospital has made effective use of other alternative treatments, such as telehealth services.
- Together with hospital leadership, be prepared to proactively advocate for more meaningful implementation of federal and state requirements for mental health parity.
- Board members should familiarize themselves and hospital leadership with additional funding opportunities for addressing the substance abuse aspects of the behavioral health crisis, including $3 billion in additional grants announced by DHHS Secretary Xavier Becerra on May 18, 2021.
- If your state has not enacted a version of "Laura's Law," the board should add this to your hospital's list of advocacy issues.
- Make sure that the board's ongoing attention to the impact of the COVID-19 pandemic on your hospital or health system includes an assessment of the impact on behavioral health services.
- Take steps to ensure that the board is kept informed of the impact of the pandemic—and other elements of the current crisis—on the behavioral health and well-being of your hospital's staff.

Exhibit 1: Behavioral Health Crisis Challenges

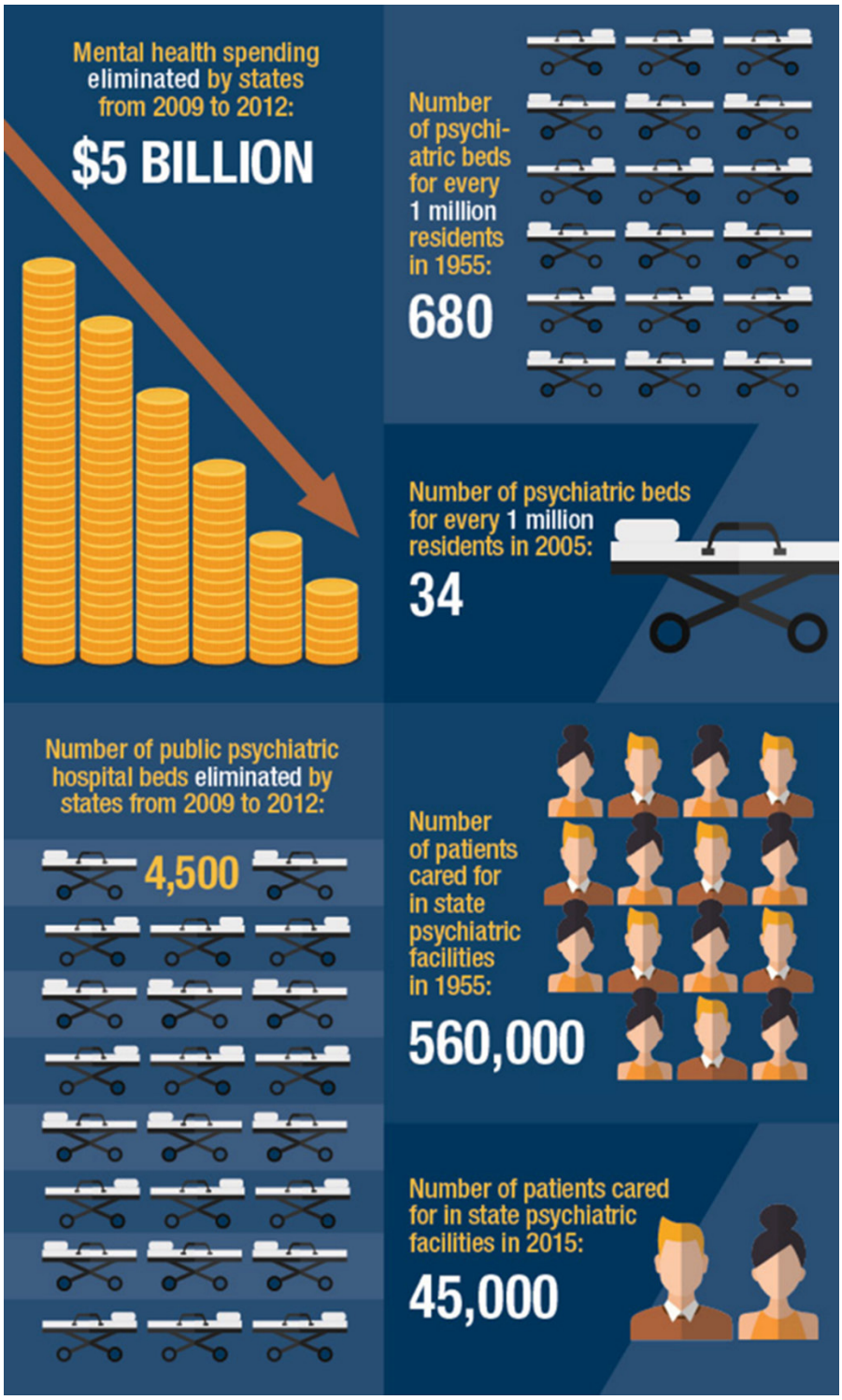


million residents in 1955 to 34 per million in 2005. Much of that decline is due to the closing of state asylums. In 1955, state psychiatric facilities cared for 560,000 patients. Today, they care for 45,000. (See **Exhibit 2**.) "Evidence all around us demonstrates the mental healthcare system is in crisis," said Dr. LaMarr Edgerson, Director-at-Large of the American Mental Health Counselors Association, at a U.S. House committee hearing in 2015. The broken system, Edgerson explained, "is generating increased demand for inpatient psychiatric beds while simultaneously decreasing their supply."[2]

A minimum of 50 beds per 100,000 people is considered necessary to provide minimally adequate treatment for individuals with severe mental illness. Every state fails to meet this minimum standard. A 2016 report on Washington State indicated that

2 J.B. Wogan, "After the Asylum: How America's Trying to Fix Its Broken Mental Health System," *Governing*, November 23, 2015.

Exhibit 2: Changes in Mental Health Spending and Facilities throughout the Years



Source: J.B. Wogan, "After the Asylum: How America's Trying to Fix Its Broken Mental Health System," *Governing*, November 23, 2015.

the state had lost 491 psychiatric beds between 2010 and 2016, for a rate of just 10.2 per 100,000 people.[3]

Criminalization As a "Substitute" for Inpatient Care

The results of this dramatic national reduction in available psychiatric beds can be found in the extent to which a majority of the nation's mentally ill end up homeless, incarcerated, or as chronic visitors to emergency rooms. An estimated 16 percent of the prisoners in jails and state prisons have a serious mental illness. Anyone who has such an illness is about three times more likely to be in a jail or in a state prison than in a psychiatric facility. That's why the Treatment Advocacy Center calls deinstitutionalization "the greatest social disaster of the 20th century."[4] The Treatment Advocacy Center estimated in 2010 that 35,711 inmates in Texas prisons suffered from serious mental illness, as compared with a total hospitalized population of just 4,579. In other words, seriously mentally ill individuals in Texas were almost eight times more likely to be incarcerated than hospitalized.[5]

Medicaid IMD Exclusion

The psychiatric bed shortage and the growth in homelessness and incarceration of the mentally ill are also the result of a provision in the 1965 Federal Medicaid law that excludes Medicaid reimbursement for non-elderly adult psychiatric inpatients in Institutions for Mental Diseases (IMDs). The Medicaid "IMD exclusion" is widely acknowledged to be an inequitable anachronism,[6] a concept dating back almost to 1950, or well before the creation of Medicaid. Its inclusion in the Medicaid statute was grounded in the effort to ensure that federal health programs would not substitute federal dollars for existing state dollars supporting state-operated long-stay mental institutions.[7]

3 Doris A. Fuller, et al., "Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds," Treatment Advocacy Center, June 2016.

4 E. Fuller Torrey, M.D., et al., "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States," Treatment Advocacy Center, May 2010

5 *Ibid.*

6 See, e.g., Government Accountability Office, *Medicaid: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, GAO-17-652, August 2017; Medicaid and CHIP Payment and Access Commission, *Report to Congress on Oversight of Institutions for Mental Diseases*, December 2019; and MaryBeth Musumeci, Priya Chidambaram, and Kendal Orgera, *State Options for Medicaid Coverage of Inpatient Behavioral Health Services*, *Kaiser Family Foundation*, November 2019.

7 S.Rep. No. 404, 89th Cong., 1st Sess., pt. 1, p. 144 (1965). See also H.R.Rep. No. 213, 89th Cong., 1st Sess., 126 (1965).

The 1965 Report of the U.S. Senate Committee on Finance on the IMD exclusion clearly stated that "the reason for this exclusion was that **long-term care** in such hospitals had traditionally been accepted as a responsibility of the states."[8] Congress' express intent, also evident in the Medicaid Act's legislative history, was to encourage "progress...in the provision of short-term therapy in the patient's own home, in special sections of general hospitals, in specialized mental hospitals, and in community mental health centers."[9]

Up until the Medicaid law took effect, states bore the responsibility of paying for psychiatric care, usually offered at large public mental hospitals. But those hospitals had earned a negative reputation as poorly maintained warehouses that made patients worse. So, the law excluded psychiatric hospitals with more than 16 beds. The expectation was that smaller community-based facilities would take over much of the job of mental health treatment, and that these would be able to tap into Medicaid funding.

The theory was that fewer patients would need the state hospitals because of advances in psychotropic drugs that could stabilize their conditions; any care they still required could be met by the smaller outpatient clinics and other community-based facilities. But very few of these smaller facilities were actually created. When states closed the older hospitals, they simply cut back mental health funding rather than switching to the new model. The IMD exclusion resulted in an acceleration of deinstitutionalization and imposed additional burdens on public acute-care hospitals.[10]

The history and original purpose of the IMD exclusion, and recent studies by governmental and private agencies, institutes, foundations, and other entities, indicates that there is a clear consensus that the IMD exclusion is outdated, inequitable, and discriminatory. It is the "only section of federal Medicaid law that prohibits federal payment to help states cover the cost of providing medically necessary care to Medicaid beneficiaries."[11]

8 *Ibid.* (emphasis added)
9 *Ibid.* See also Crystal Blyler, et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report*, Mathematica Policy Research, August 18, 2016; p. 3 ("The IMD exclusion policy is rooted in the national emphasis, beginning in the 1960s, on supporting community-based care as an alternative to long-term hospitalization.")
10 Lisa Gillespie, "The Big Change Coming to Mental Health," *Governing*, April 1, 2015.
11 "The Medicaid IMD Exclusion and Mental Illness Discrimination," Treatment Advocacy Center, August 2016.

Virtually every stakeholder in today's behavioral health industry has concluded that the IMD exclusion has greatly contributed to the nation's psychiatric hospital bed shortage, severely reduced access to care for the most vulnerable low-income patient populations, and contributed to bad outcomes and systemic problems for many underserved individuals. In a report released in February 2021, the Manhattan Institute concludes that "the IMD exclusion has outlived its usefulness and should be repealed. It discourages states from investing in inpatient care, hampering access to a necessary form of treatment for some seriously mentally ill individuals. As a result, these individuals end up repeatedly in the emergency departments of general hospitals, boarded for lack of access to available beds, and overrepresented among the homeless and incarcerated populations. More broadly, the exclusion discriminates, through fiscal policy, against the seriously mentally ill."[12]

Emergency Room Psychiatric "Boarders"

Another byproduct of deinstitutionalization, the Medicaid IMD exclusion, and other factors described in this article, has been the phenomenon of "boarding" mentally ill patients in emergency rooms—often in public hospitals and often for weeks at a time. This practice typically violates state laws, which require that such patients see a psychiatrist and then move to a mental health facility or psychiatric unit within a larger hospital. But in many cases, ER staff simply can't find a psychiatric hospital or unit that will take the patients, so they stay in the ER.

About half of all states admit to boarding psychiatric patients, according to a 2013 survey by the health data firm NRI. In King County, Washington, Harborview Medical Center saw a substantial growth in boarding prior to the State Supreme Court decision, with boarding growing fivefold between 2009 and 2012, from 425 patients to 2,160. *The Seattle Times* found in 2013 that the state cut 250 psychiatric beds and more than $100 million in funding for programs aimed at reducing detentions during that period. Nationally, states cut $1.6 billion from mental health budgets between 2009 and 2011.[13]

In a 2014 survey, the American College of Emergency Physicians found that 84 percent of emergency rooms said they board psychiatric patients. More than 50 percent said

12 Stephen Eide and Carolyn D. Gorman, *Medicaid's IMD Exclusion: The Case for Repeal*, Manhattan Institute, February 23, 2021.

13 Daniel Luzer, "Washington State Supreme Court Rules Leaving Mentally Ill in Emergency Rooms Is Illegal," *Seattle Times*, August 8, 2014.

they spend increasing time and energy trying to transfer those patients to appropriate psychiatric facilities.[14]

On August 7, 2014, the Washington State Supreme Court handed down a unanimous opinion that sought to end such practices in the state, albeit without providing a solution to the problem of what to do with these patients.[15] It is a decision that has resonated nationally over the last several years. The Washington Supreme Court ruled that patients who are in psychiatric crisis cannot be boarded in hospitals just because the appropriate evaluation and treatment facilities are overcrowded. According to the court, the state does have a legitimate interest in treating the mentally ill and protecting society from their actions, but the state cannot fail to provide that treatment because of a lack of funds, staff, or facilities. In a 2018 Advocacy Brief, the Washington State Hospital Association noted that the decision had resulted in the state adopting plans for additional funding between 2015 and 2017.[16] However, in many ways, the Court's decision amounted to another unfunded mandate on the part of public hospitals like Harborview.

Other Legal and Regulatory Barriers

There are a range of other legal and regulatory issues that have emerged since the enactment of the Medicaid statute that further contribute to the need to repeal or substantially amend the IMD exclusion. Those include federal laws like the Emergency Medical Treatment and Labor Act (EMTALA) and the mental health parity statutes, as well as the applicability to mental health services of the Americans with Disabilities Act, as interpreted by the U.S. Supreme Court decision in *Olmstead v. L.C.* Each of these issues will be addressed in this section.

EMTALA

The situation of IMDs is exacerbated by the requirements of EMTALA, which was passed in 1986, long after the enactment of the Medicaid statute. EMTALA regulations clearly require hospitals with specialized capabilities to accept a transfer of a patient with an emergency medical condition from a referring hospital without regard to the patient's age or source of coverage. The current EMTALA guidance set

14 American College of Emergency Physicians, "Psychiatric 'Boarding' in Emergency Departments Ruled Unconstitutional in Washington State" (press release), August 15, 2014.
15 Det. D.W. v. Dep't of Soc. & Health Servs., 332 P.3d 423 (Wash. 2014).
16 Washington State Hospital Association, "Mental Health Boarding: In Re Detention of DW and the Legislative Response."

forth in the State Operations Manual, Appendix V, clarifies the "Recipient Hospital Responsibilities" of EMTALA relating specifically to psychiatric hospitals, stating "if an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare and has capacity is obligated to accept an appropriate transfer of that individual. It does not matter if the psychiatric hospital does not have a dedicated emergency department." EMTALA therefore requires public hospitals with psychiatric units to accept behavioral health patients transferred from other hospitals but does not provide any funding for the stabilization of such patients who may be uninsured or underinsured.

The Supreme Court Olmstead Decision and the Americans with Disabilities Act

Another area of federal law that has impacted public hospitals that provide behavioral health services is the American's with Disabilities Act, first enacted in 1990. In 1999, as a recent Manhattan Institute report points out, the U.S. Supreme Court in the *Olmstead* decision held that unjustified segregation of disabled persons constitutes discrimination in violation of the Americans with Disabilities Act.[17] As such, the ruling requires mentally ill individuals to be provided services in the community when those services are appropriate, are not of objection to a patient, and can be reasonably accommodated. However, *Olmstead* did not outlaw institutional-based care. Rather, the *Olmstead* standard requires the placement of disabled people into "the most integrated setting appropriate to their needs." But while the *Olmstead* decision was intended to incentivize the development of fully integrated systems, which are capable of treating patients in the most integrated setting appropriate to their needs, in many public systems, this has proved to be yet another unfunded mandate for many patients in need of such services.

Failure to Achieve Mental Health Parity

The federal mental health parity law also appears to be in an area of concern. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), which requires health insurers to offer the same level of benefits for mental health and substance abuse that they do for physical health. But the federal government didn't issue regulations explaining the law until five years later, leaving states reluctant to enforce it. In the case of parity rules for Medicaid managed care plans, the federal government did not release enforcement rules to go into effect for almost 10 years.

17 Eide and Gorman, February 23, 2021.

The MHPAEA clearly articulated a policy of parity between mental health and physical health services. MHPAEA provides that covered individuals receive the same coverage for mental and behavioral health as for other medical and surgical benefits. However, the lack of federal guidance for many years made the law difficult to enforce, and it did not provide funding for the achievement of parity for patients who lacked coverage for mental health services. For example, such parity is impossible for non-elderly adult Medicaid patients in IMDs who not only lack coverage for IMD services, but stand to lose all of their Medicaid coverage (including for other medical care) while they are receiving inpatient services from an IMD.

Mental health parity is a straightforward concept: insurance coverage for mental health conditions, including substance use disorder (SUD) treatment, should be equal to coverage for any other medical conditions. In adopting final rules implementing the MHPAEA in 2016, however, CMS simply perpetuated the current inequitable distinction between IMDs and acute-care hospitals with psychiatric inpatient services. In response to commenters on the proposed mental health parity regulation who had expressed concern about the IMD exclusion, CMS responded that it would not extend the concept of mental health parity to IMDs because "[t]he full range of covered services, including MH/SUD services, could be provided to beneficiaries when they are in facilities that are not IMDs." However, this failure often simply served to increase the financial pressure on non-IMD public providers.

The Opioid Addiction Crisis

In 2017, opioid use disorder was formally declared to be a mental health condition. The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* describes opioid use disorder as a problematic pattern of opioid use leading to problems or distress, with at least two of a number of conditions occurring within a 12-month period.[18]

In 2017, more than 72,000 Americans died from drug overdoses, including illicit drugs and prescription opioids, a two-fold increase in a decade. From 2002 to 2017, there was a 22-fold increase in the total number of deaths involving fentanyl and other synthetic opioids (not including methadone) and more than a seven-fold increase in the number of deaths involving heroin. Emergency department visits for suspected opioid overdoses rose by 30 percent in the U.S. from July 2016 to September 2017.

18 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*, 2013.

The opioid crisis was declared a nationwide public health emergency on October 27, 2017, adding significantly to the already grave stresses on public hospitals and other providers of behavioral health services.

Impact of the Pandemic

Finally, board members of public hospitals that provide inpatient and outpatient behavioral health services should familiarize themselves with the impact on those services of the worldwide pandemic that has continued for over a year, and which (despite the increase in vaccinated Americans) promises to continue unabated for months if not years to come.

National crises are often correlated with a rise in mental health diagnoses in the population. On September 11, 2001, as the world looked on in horror, the New York Health and Hospital Corporation, and Bellevue Hospital Center in particular, were prepared to treat the physical casualties of the World Trade Center terrorist attack. For horrific reasons that played out on our television screens in real time, the expected wave of injured survivors never materialized. Some victims escaped unharmed, and others did show up in trauma centers with physical injuries, or later with respiratory ailments, but far fewer than expected. Instead, the real health crisis showed up gradually, over an extended period of time. According to a New York City 9/11 Health Research Report, those directly affected by 9/11 were more likely to report post-traumatic stress disorder (PTSD) symptoms six months after 9/11. However, a substantial number not directly affected also met the criteria for probable PTSD.[19]

In addition to the impact of the pandemic on a public hospital's patient population, board members should not ignore the behavioral health implications for the public hospital workforce. A new *Washington Post*-Kaiser Family Foundation poll released on April 23 found that three in 10 healthcare workers have weighed leaving their profession and "about six in 10 say stress from the pandemic has harmed their mental health."

Source: William Wan, "Burned Out and Disillusioned After a Year of Trauma," *Washington Post*, April 23, 2021.

19 NYC 9/11 Health, "Physical and Mental Health."

A study of low-income patients seven to 16 months after 9/11 found that those suffering a 9/11-related loss were twice as likely to be diagnosed with a mental health condition such as depression, anxiety, or PTSD. This group was also more likely to suffer functional impairment and work loss. Patients with loved ones in danger on 9/11 or who knew someone involved in the rescue and recovery effort were twice as likely to suffer from an anxiety disorder.[20]

Often during this past pandemic year, more Americans were dying of COVID-19 every day than died in the 9/11 terrorist attacks. The impact on the mental health of the American population is said to be substantial and profound. The COVID-19 pandemic and the resulting economic recession have negatively affected many people's mental health and created new barriers for people already suffering from mental illness and substance use disorders. As the Kaiser Family Foundation (KFF) recently reported, during the pandemic, about four in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in 10 adults who reported these symptoms from January to June 2019.[21] A KFF Health Tracking Poll from July 2020 also found that many adults are reporting specific negative impacts on their mental health and well-being, such as difficulty sleeping (36 percent) or eating (32 percent), increases in alcohol consumption or substance use (12 percent), and worsening chronic conditions (12 percent), due to worry and stress over the coronavirus. As the pandemic wears on, ongoing and necessary public health measures expose many people to experiencing situations linked to poor mental health outcomes, such as isolation and job loss.

In light of all the other adverse changes that have impacted our nation's behavioral health system, the result is likely to push public hospital providers of mental health services over a tipping point in the very near future unless substantial reforms are implemented and major funding sources are identified.

The Opportunities

While the factors that have generated the current crisis in behavioral health may appear daunting, there are also a number of potential opportunities that should be on the behavioral health "dashboard" of board members of public hospitals. Board

20 *Ibid.*

21 Nirmita Panchal, et al., "The Implications of COVID-19 for Mental Health and Substance Use," Kaiser Family Foundation Issue Brief, February 10, 2021.

members are often uniquely well placed to generate advocacy and take action to address the challenges identified above.

Expand Availability of Psychiatric Inpatient Services

Policy recommendations that have been proposed to address the behavioral health crisis include a moratorium on the elimination of public psychiatric beds and restoration of a sufficient number of beds to create access to inpatient care for qualifying individuals in crisis.[22]

Some healthcare advocates have even proposed returning to the traditional mental hospital, the very institution they fought to abolish in the 1960s. Last January, an article was published titled, "Bring Back the Asylum," where authors from the University of Pennsylvania called for the return of long-term psychiatric care. They wrote that "for persons with severe and treatment-resistant psychotic disorders, who are too unstable or unsafe for community-based treatment, the choice is between the prison-homelessness-acute hospitalization-prison cycle or long-term psychiatric institutionalization." They left no doubt that they considered institutionalization to be the best option.[23]

Innovations in Addressing Psychiatric Boarder Problem: The Alameda Model

As discussed above, despite laws and court decisions seeking to curtail the practice, "boarding" involuntary psychiatric patients in medical emergency rooms is still common in many parts of the United States. The practice can result in patients being held for days without treatment or a hospital room, often in busy corridors or treatment rooms.

One approach that has been proposed, called the "Alameda model," has been to create a regional emergency psychiatric facility. Rather than holding psychiatric patients in the public hospital's medical emergency department, emergency physicians send them to the regional facility, where specialized care can be provided. In addition to reducing boarding, the model has reduced the percentage of patients who require admission to an inpatient facility, because with appropriate treatment many of them can be stabilized and released within 24 hours. Those involved in the system note the importance of California's Medicaid program having a billing code

22 "Restoring Psychiatric Hospital Beds," Treatment Advocacy Center, 2018.
23 Dominic Sisti, Andrea Segal, and Ezekiel Emanuel, "Improving Long-Term Psychiatric Care: Bring Back the Asylum," *JAMA*, January 20, 2015.

for "crisis stabilization" that pays an hourly rate to the regional emergency psychiatric facility for up to 20 hours of care. The absence of such a payment option in other states may limit the applicability of the model.[24] However it is accomplished—and other models exist—creation of a systemic response to prolonged detention of psychiatric patients in medical emergency departments will be an important part of bringing state mental health systems into the 21st century.

Repeal the Medicaid IMD Exclusion

Legislation to repeal the IMD exclusion has been introduced in Congress in recent years, and public hospital board members should lobby for its enactment. It will expand the availability of behavioral health services and ease the pressure on public hospitals, which shoulder much of the burden of caring for Medicaid recipients who are denied reimbursement in IMDs. Early on in the history of the Medicaid program, legislators feared that the cost of repeal would be too great; one estimate from the 1990s was that it would cost more than $35 billion over a 10-year period. More recently, however, that estimate has dramatically declined, to $5 billion or less. Both state Medicaid officials and their federal counterparts have reason to believe that repeal might even save money. In Maryland, for example, the Department of Health and Mental Hygiene reported that the daily cost of care for a mental patient at an acute-care hospital is $2,965. At a private psychiatric facility that today is subject to the IMD exclusion, the daily cost would be just $864.[25]

Continue to Press for Expanded Coverage

Researchers from Harvard School of Public Health, Massachusetts Institute of Technology, the National Bureau of Economic Research, and Providence Health & Services have found that expanding low-income adults' access to Medicaid substantially increases healthcare use, reduces financial strain on covered individuals, and improves their self-reported health and well-being. According to a Harvard School of Public Health statement announcing a study released on the Web site of the National Bureau of Economic Research, "This study shows that Medicaid substantially expands access to and use of care for low-income adults relative to being uninsured," said Katherine Baicker, Professor of Health Economics at Harvard School of Public Health and co-principal investigator of the study. Medicaid, which is

24 Paul S. Appelbaum, M.D., "'Boarding' Psychiatric Patients in Emergency Rooms: One Court Says 'No More,'" *Psychiatric Services*, July 1, 2015.
25 Wogan, November 23, 2015.

jointly funded by the federal and state governments, covers the healthcare costs of eligible low-income individuals and families.[26]

Although many previous studies compare health or healthcare use between the insured and uninsured, inferring the impact of health insurance from such comparisons is difficult because differences between the insured and uninsured, such as in income, employment, or initial health, may affect the health and healthcare outcomes studied. This study is the first to avoid this problem by taking advantage of the random assignment created by the Oregon lottery. Based on the first year of this ongoing study, some of the key findings show that Medicaid coverage improved reported physical and mental health, in that it increases the probability that people report themselves in good to excellent health (compared with fair or poor health) by 25 percent and **increases the probability of not being depressed by 10 percent**.[27]

Expand Laura's Law to All States

"Laura's Law" is the name used for assisted outpatient treatment (AOT), which is sustained and intensive court-ordered treatment in the community for individuals with severe untreated mental illness and a history of violence or repeated hospitalization. Typically, AOT is only used until a person is well enough to maintain his or her own treatment regimen. In other states, it has been used as an alternative to court-ordered hospitalization and to maintain psychiatric stability after discharge from hospitalization.

Laura's Law is not necessarily for all people with mental illness. AOT is for those who are in a crisis or recovering from a crisis caused by mental illness and for whom voluntary services are not working. California's program is based on that of Kendra's Law, a statewide program created in New York in 1999 that has proven extraordinarily successful. In New York State, Kendra's Law is used to help approximately 1,000 of the estimated 230,000 people living in the state with untreated schizophrenia or severe bipolar disorder in any given year. But for the right patients, AOT appears to work well. Rigorous government and academic studies of AOT show that it drastically reduces rehospitalizations, length of hospital stays, arrests, incarceration, suicide attempts, victimization, and violent behavior.[28]

26 Harvard School of Public Health, "Medicaid Increases Use of Healthcare, Decreases Financial Strain, and Improves Health for Recipients" (press release), July 7, 2011.
27 *Ibid.*
28 For details, see Treatment Advocacy Center, "Assisted Outpatient Treatment—Backgrounder."

Expand Telehealth Services

The COVID-19 pandemic has resulted in a very substantial expansion of the use of telehealth services in a range of areas, including most prominently behavioral health. A report by FAIR Health's Monthly Telehealth Tracker indicated that telehealth claims had increased 2,817 percent nationally between December 2019 and December 2020, and that mental health conditions were the number one telehealth diagnosis during that period.[29] Federal reimbursement rules during the public health emergency have been waived or relaxed, and it is thought that many of those changes will become permanent, offering opportunities for public hospitals to offer alternative behavioral health services that could ease pressure on the ER.[30]

NIMH Research

The National Institute of Mental Health has unveiled a five-year strategic plan emphasizing research it hopes will ultimately give clinicians a better understanding of what mental illness looks like inside the brain—before a patient shows outward symptoms.[31] The plan signals investment to figure out the genes associated with mental illness, develop new treatments based on those findings, make sure research findings are eventually implemented into practice, and find brain patterns for a range of disorders.

Racism and Mental Health Equity

It is also important to examine the intricate ways that structural racism is embedded in psychiatry and investigate strategies to mitigate the impact of structural racism on mental health service delivery. Public hospitals with significant behavioral health services should consider how the intersections of race, ethnicity, class, gender, gender identities, and sexual orientation shape mental health experiences and access to psychiatric services, and attempt to develop innovative strategies and solutions to transform and dismantle structures of racism across different dimensions of mental health, including (but not limited to) clinical services, education, training, research, and advocacy.

29 FairHealth, "Telehealth Claim Lines Increase 2,817 Percent Nationally When Comparing December 2019 to December 2020" (press release), March 4, 2021.

30 In a December 1, 2020, final rule, CMS added over 60 services to the Medicare telehealth list that will continue to be covered beyond the end of the public health emergency. Fed. Register Vol. 85, No. 248, December 28, 2020, at 84472.

31 Lisa Gillespie, "A New National Institute of Mental Health Research Plan Could Change How Mental Illness Is Diagnosed and Treated," Kaiser Health News, April 1, 2015.

Social Determinants of Mental Health

Finally, as part of a behavioral health "dashboard," public hospital board members should also focus on clinical and policy issues as they relate to social justice in psychiatry and the social determinants of mental health, with a specific focus on mental health disparities and evidence-based strategies to improve mental health equity across population groups. Ways in which clinicians and mental health services can address social determinants of mental health should be highlighted, including discrimination, adverse early life experiences, poverty, social exclusion, low employment status, and low educational attainment, to name a few—and particularly how these determinants connect to mental health outcomes and can be addressed by mental health services. Some of the social determinants of mental health include inadequate housing, income inequality, nutritional deficiencies, and environmental causes, among others.

Conclusion

As increasing numbers of Americans continue to be vaccinated, and as other public health interventions prove to be effective, the COVID-19 pandemic should ultimately be brought under control in the U.S. However, the pandemic has helped to shed light on a crisis in behavioral health that will likely not diminish in the foreseeable future without very substantial efforts by all of the behavioral health stakeholders in our nation's health system. Public hospitals, and their governing boards, are going to continue to occupy an important and central role in those efforts.

The Governance Institute thanks Larry S. Gage, Senior Counsel, Alston & Bird LLP, and Senior Advisor, Alvarez & Marsal for contributing this article. He can be reached at larry.gage@alston.com.