



# State Profile Highlights

New Information from the National Association of State Mental Health Program Directors Research Institute, Inc (NRI)

No. 4  
August 2000

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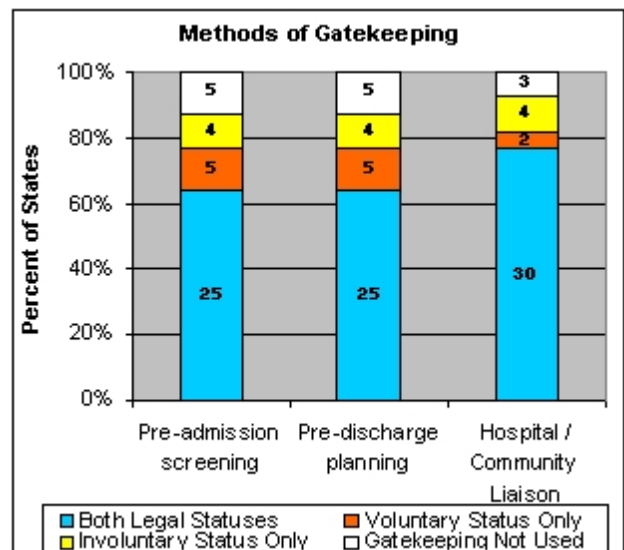
## *Controlling Entry Into State Psychiatric Hospitals: 1999*

### Highlights:

- 85% of states use community-based programs to act as gatekeepers to control entry into state psychiatric facilities (39 states reporting)
- 67% of states do not require that potential admission to the state psychiatric hospital be screened by general and local hospitals (39 states reporting)
- In 95% of states, community-based programs provide crisis programs to reduce admissions to the state psychiatric facilities (39 states reporting)

An important aspect of state hospital downsizing is control of entry into these facilities. As a policy and a practice, most states (35 of 41 responding) use community-based programs to perform a gatekeeping function over entry into the state psychiatric hospital. The states vary in the type of authority they use to require gatekeeping activity by the community-based programs. The levels of authority include statutes, SMHA regulations, and SMHA policy. Of the 35 states using formal modes of authority, 11 reported using more than one method. Nineteen states use statutes and six of these states supplement statutes with SMHA regulations or policy. Twenty-one states use SMHA policy and 11 states supplement the policy with SMHA regulations. One state reported using no formal means of authority, but rather used contracts with hospital and community providers.

Gatekeeping activities can occur for both admissions to and discharges from state psychiatric hospitals. In addition to the 35 states that reported using formal authority, four other states also reported using gatekeeping activities to control entry to and discharge from the state hospitals. Three forms of gatekeeping activities were reported: pre-admission screening, pre-discharge planning, and hospital/community liaison activities. The accompanying figure shows the number and percent of states using each of these mechanisms. The majority of states that used specific activities applied those activities to both voluntary and involuntary clients. Most states reported using pre-discharge planning, while almost as many states reported using pre-admission screening and hospital/community liaison activities. Most community-based programs engage in all



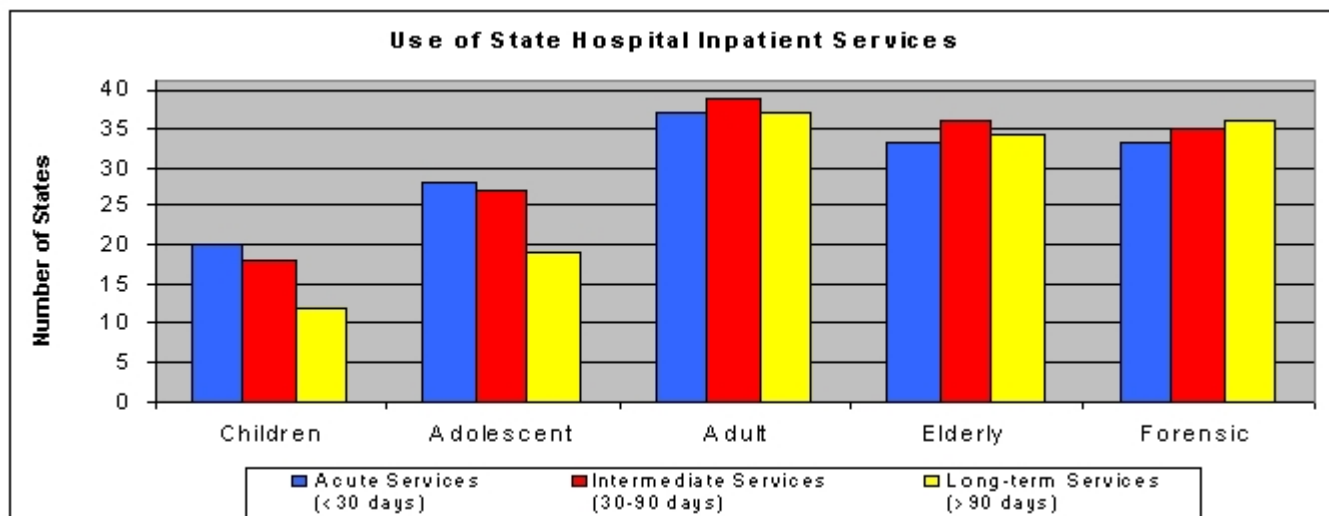
The SMHA Profiles System was developed by the NASMHPD Research Institute, Inc., under contract No. 280-96-0003 from the Substance Abuse and Mental Health Services Administration/Center for Mental Health Services (CMHS)/Division of State and Community Systems Development/Survey and Analysis Branch. Cited reproductions, comments and suggestions are encouraged.

three activities. In only two states did the community-based programs provide pre-admission screening but not pre-discharge planning. In four other states, the community-based programs provided pre-discharge planning but not pre-admission screening. In addition to community-based mechanisms for gatekeeping, several states also reported the use of specific hospital policies to control admissions.

A different facet of gatekeeping is requiring that admissions be screened at general and local hospitals before clients can be admitted to the state psychiatric hospital. Thirty-six states provided information on the required use of other hospitals before the state facility. Twenty-four states (67%) report that they do not require the use of public general and local hospitals before using the state hospital. Seven states require the use of public general and local hospitals for children, adolescents, and adults (AZ, HI, MA, NJ, OR, TN, WA). One other state (WV) requires the use of public general and local hospitals for children and adolescents only. Four additional states (KY, MN, NH, PA) require the use of public general and local hospitals for adults only.

In addition to gatekeeping activities, 95% of states (38 of 40) report that the community-based programs provide crisis programs to reduce admissions to state psychiatric hospitals. Most of these programs share key features. The crisis programs generally provide 24 hour emergency phone lines, mobile crisis, psychiatric emergency beds, and general emergency and crisis stabilization services.

Across the country, there is some diversity in the populations served and levels of care provided in the state psychiatric hospitals. The figure below depicts the population served and level of care provided for the 41 states reporting this information. The least common service is long-term care (more than 90 days) for children. Only 12 states report providing long-term care (29% of states), while 20 states report providing acute care services (less than 30 days) for children (49% of states). All state hospitals that provided services to children also provide services to adolescents, although 8 other states provide acute care services and 7 states provide long-term care services to adolescents but not children. The most common service is intermediate care for adults, reported by 39 states (95%). Most of these states also provide acute care and long-term care services for adults. A majority of states also provide intermediate care to elderly clients, with most also providing acute and long-term care services. Acute services are provided for forensic clients in 33 states and long-term care for forensic clients is provided in 36 states.



The SMHA Profile Highlights are based on preliminary information from 41 States. The SMHA Profiles data are available via the internet at [www.nasmhpd.org/nri](http://www.nasmhpd.org/nri). For further information, please contact Ted Lutterman at [ted.lutterman@nasmhpd.org](mailto:ted.lutterman@nasmhpd.org) or Robert Shaw at [robert.shaw@nasmhpd.org](mailto:robert.shaw@nasmhpd.org) with any comments or questions.

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