MENTAL HEALTH SERVICES

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Expanding Access to Mental Health Services — *from Prevention to Crisis*

Dignified care for Americans with serious mental and substance use disorders requires access to inpatient and community-based resources.

In 1955, Congress ordered an investigation into how mentally ill Americans were treated once institutionalized.[1] The investigation followed the availability of chlorpromazine, the first medicine to treat serious psychosis. The 1961 report found that mental hospitals were holding thousands of mentally ill and intellectually disabled patients in inhumane conditions.[2] In 1963, Congress took action to end the abuse of mentally ill Americans in substandard inpatient hospitals.[3]

The intent was noble: Congress created funds for new, community-based mental health centers. Signing the legislation, President John F. Kennedy declared, "Under this legislation, custodial mental institutions will be replaced by therapeutic centers."[4]

By 1965, with the creation of Medicaid, state institutions shuttered at a fast pace as states turned to federal funding matches to care for patients outside of institutional settings.[5,6] This movement and these reforms were intended to end permanent institutionalism and create community-based care for the mentally ill.

Unfortunately, comprehensive and effective mental health care is not the present reality for the one in five — or 59 million — Americans who experience mental illness.[7]

The U.S. mental health system remains broken, condemning those with the most severe illnesses to suffer without effective care. Too often, these vulnerable Americans experience a steady downward spiral, often leading to incarceration and death.

Mentally ill or substance addicted Americans most often find crisis care in hospital emergency departments and are relegated to prisons and homeless encampments in lieu of effective treatment and safe, productive lives in the community.

- More than **1.9 million** emergency department (ED) visits yearly are psychiatric visits. Of these, **21.5%** require ED boarding at a cost of over **$968 million** yearly.[8]
- Over **270,000** of the **1,829,000** adults incarcerated in America have serious mental and substance use disorders with an annual cost of more than **$13 billion**.[9]
- **67%**[10] of more than **275,000** unsheltered homeless people in the US have serious mental illness and/or chronic substance use disorders. Treatment costs to taxpayers are approximately **$35,578** per person — more than **$6 billion** annually.[11,12,13,14]

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KEY TAKEAWAYS

- To reform care for Americans with serious mental illness in the 1950-60s, institutional state hospitals were shuttered as Congress turned away from supporting inpatient care.
- Despite good intentions, this move has resulted in Americans suffering from serious mental illness and substance abuse lingering in prisons, homeless encampments, and hospital emergency departments.
- Congress and the Administration should structure spending to fund crisis-based inpatient beds, reform commitment standards, create a real continuum of community-based outpatient care, and track outcomes for Americans with serious mental health and substance use disorders.

IN THIS REPORT

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FAST FACTS

The average number of psychiatric beds per 100,000 people

Among the 34 Organization for Economic Co-operation and Development (OECD) countries, the average number of psychiatric beds per 100,000 people is **68**. In the United States, the average number of beds is **25** — near last in OECD countries.

The populations of mentally ill individuals in jails and prisons

A 2016 report by the Treatment Advocacy Center found that **44** states and the District of Columbia have higher populations of mentally ill individuals in their jails and prisons than they do in their public psychiatric facilities.

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This is especially true for Americans suffering from substance abuse. Unfortunately, substance use disorders, which often co-occur with psychiatric illnesses, are still subject to the same lack of effective long-term care options that other psychiatric illnesses face. Drug overdoses have skyrocketed in the past decade as more dangerous drugs are used. In 2023, 105,007 Americans died from drug overdoses.

Congress has taken specific action to open inpatient beds for substance use disorders, but more can be done. The 2016 21st Century Cures Act opened opportunities for Medicaid coverage of short stays for serious mental illness, including state use of 1115 waivers.[15,16] The 2018 SUPPORT Act created another state waiver option for Institutions of Mental Diseases (IMD) stays for substance abuse treatment (in addition to serious mental illness).[17,18]

Congress also funded the former Substance Abuse and Mental Health Services Administration (SAMHSA), now the Administration for a Healthy America (AHA), which provides block grant funding for addressing mental and substance use disorders in states at $7.5 billion in FY2023.[19]

There have also been positive steps to address these longstanding issues administratively. President Trump issued an Executive Order in July 2025 that begins to address some of these issues by encouraging "the identification, adoption, and implementation of maximally flexible civil commitment, institutional treatment, and step-down treatment standards that allow for the appropriate commitment and treatment of individuals with mental illness who pose a danger to others or are living on the streets and cannot care for themselves."

Financial Impact of the America's Mismanaged Mental Health Industry

$968 million
Emergency Department boarding

+ $13 billion
Incarceration of Americans with serious mental and substance abuse disorders

+ $6 billion
Treatment for homeless people with serious mental and substance abuse disorders

Estimated cost to society:
$20 BILLION DOLLARS
— per year

Americans with serious mental illnesses and substance abuse deserve dignified care, both within their communities and from inpatient facilities when necessary. Unfortunately, there remain four severe impediments to that reality.

1) Inpatient Bed Shortages

There are times when inpatient facilities are appropriate to care for individuals who experience serious psychiatric or substance abuse episodes. Unfortunately, the deinstitutionalization movement has led to a dramatic shortage of inpatient beds for mentally ill individuals in crisis. Part of this is due to the incentives created through Medicaid.

Good intentions lead to bad consequences:

The idea behind the IMD Exclusion was for states to assume the cost and create community-focused psychiatric care.

The federal Medicaid program matches, on average, 57% of state funding for indigent care. However, in the Medicaid authorization in 1965, Congress also created the Institutions of Mental Disease exclusion.[20] The idea behind the IMD Exclusion was for states to assume the cost and create community-focused psychiatric care. However, the result was that hospitals stopped providing these services at the newly created limit of 16 beds. Consequently, it prevents federal Medicaid payments to facilities with more than 16 inpatient beds dedicated to serving adults (defined as individuals aged 21 – 65) with mental and/or substance use disorders.[21] Many institutions find it financially unviable to operate facilities with fewer than 17 beds. This further accelerated the number of states closing state-funded public psychiatric hospitals.

With federal funding only available for smaller mental health facilities, the U.S. experienced a dramatic decrease in the number of inpatient psychiatric beds. In 1955, there were 558,922 inpatient beds in state mental hospitals. By 2023, that dropped to only 36,150 inpatient psychiatric beds in state facilities.[22] The National Institutes of Health estimates that only half of individuals with mental illness find appropriate care.[23]

2) Lack of a True Continuum of Care

While crisis-based inpatient care is a vital component of the mental health treatment system, individuals with serious mental illnesses or substance addiction require a continuum of care after inpatient care to fully return to health and their communities. Further, there are some with serious mental illness who do not respond to currently available treatments and will need longer term care in a residential setting to obtain a level of symptom relief that will support a safe return to the community.

Following inpatient hospitalization and stabilization of those with serious mental illness, outpatient care with robust psychosocial supports is needed.

While the individual lives at home or in a residential setting that includes behavioral health supports in the community, outpatient treatment provides continued psychiatric, substance-use disorder and medical care. This usually takes the form of psychotropic medications that serve to address psychosis, hallucinations and delusions as well as depression and anxiety.

Additional therapies include cognitive behavioral therapy and supportive therapies to assist the person in developing adaptive coping mechanisms that can help them to live successfully in the community.

Assertive community treatment (ACT) and, for those with justice system involvement, Assisted Outpatient Treatment (AOT), offer wrap-around services to the most severely affected by mental illness and substance-use disorders. These approaches involve team-based community care in which behavioral health services are delivered directly in the community rather than requiring a person to get to a bricks-and-mortar facility to obtain behavioral healthcare. Services include case management, medication administration, nursing care, and peer support.

A key goal of ongoing outpatient services for this population is assistance with integration back into community living. To meet this aim, enriched services are necessary. Those served may live independently in the community or sometimes in supervised, residential care facilities in their communities. Enriched

psychosocial supports occur along a continuum as well and may take the form of community group homes with supervision as well as mental health and substance use services.

One model, the clubhouse model, has demonstrated the value of enriched community services, including social supports, supportive group activities, vocational assistance, and health services as a positive force in assisting those with serious mental health conditions to be integrated into the community and to enhance their community living experience. These types of resources are, in many ways, as important as ongoing medical care for those with serious mental illness and severe substance-use disorders who are in recovery.

Currently Medicaid reimbursement is variable across the nation because clinical services are funded through the state's Medicaid 1915(c) waiver for community-based services. Medicaid 1915(c) waivers are optional for states and allow states to provide home and community-based services (HCBS) to those who might otherwise need institutional care.

The optional state waiver supports personalized care options, promoting independence and integration into the community. However, these services are an essential part of the continuum of care. A national-level public discourse is long overdue on expanding community supports across the continuum of care.

States should also integrate resources across programs to help vulnerable populations as they transition from inpatient settings back to the community. For example, specific vocational rehabilitation and transportation services can support a pathway back into dignified work and are essential to successfully addressing the epidemic of homelessness.

All these strands of community care — from continuing psychiatric, substance abuse, and medical treatment to integration into community living — will require a multi-agency, integrated, and collaborative effort within the federal government including the Centers for Medicare and Medicaid Services, the Substance Abuse and Mental Health Services Administration, Department of Justice, and Department of Housing and Urban Development. Innovation from a federal level must then be implemented at the state level, requiring close working relationships between federal and state agencies.

3) Insufficient Commitment Standards

To ensure the successful implementation of the services mentioned above, it is necessary to review state laws related to involuntary treatment. Civil commitment is the legal process by which a judge can order someone with a serious mental illness to either be confined against their will or compelled to receive outpatient treatment. These normally are predicated on an imminent "dangerousness to self or others" standard. Without an intermediary standard, individuals with mental illness or serious substance abuse only receive care when their condition is at a severe crisis point.

It's important to preserve individual autonomy wherever possible. One aspect of achieving this goal would be broader use of the Psychiatric Advance Directive (PAD), which has been permitted, indeed encouraged, by CMS since 2006.[24]

The PAD allows mentally ill or substance-addicted individuals to draft a document specifying how they would prefer to receive care before a crisis occurs. These can detail the conditions they face, triggering actions or events for inpatient care, and even the level of care or medication they consent to in advance.

Funding of inpatient or community care that includes Medicaid and Medicare reimbursements should require PADs wherever possible.

Increasing the use of PADs in hospitals, outpatient care, and across the entire continuum of care could help reduce the number of emergency mental health care admissions.

4) Lack of Data, Particularly Outcome Data

It's vital that any policy reforms should include clear outcome measurements for mental health and SUD providers. Policymakers need more data to assess current funding efforts.

Unfortunately, even when funding is made available for those with serious mental health conditions or substance-use disorders to find inpatient and community-based care, there isn't sufficient evidence that the programs are effective. This is primarily because policymakers may only collect input data, for instance whether the individual was enrolled in the program, and possibly end of service data, but not outcome data — for instance whether the individual relapsed to substance abuse or whether the individual maintained their mental health treatment services over time and after completion of a treatment program.

Further, few hospitals collect and report data on admissions and readmissions due to these conditions.[25] Federal and state governments should collaborate to develop standardized outcomes for the treatment of substance abuse or mental illness.

Collection and reporting of behavioral health admissions and course of treatment for EDs, inpatient care facilities, state prisons, and homeless shelters should be required. Analysis of this data should be the basis of determining which services would continue to be available and compensated.

SOLUTIONS

Congressional Reform and Offsets

Lift the IMD Exclusion

The Congressional Budget Office has said that lifting the IMD exclusion completely for substance-use disorders and mental-health disorders would cost $38.4 billion over 2024-2033.[26] Congress should modify the number of beds above 16 for acute care, psychiatric facilities (IMDs), which would allow for increasing the number of beds while maintaining the 30-day limit on length of stay. Congress should specifically authorize removal of the 16-bed limit for state hospitals to assure that those most ill and unresponsive to currently available mental health treatments and/or in need of competency restoration services can access safe and compassionate care.

Define Conditions for Federal Funding

- **Co-occurrence of mental and substance-use disorders present in a single patient are the rule and not the exception** The artificial separation of care for these conditions helps to assure that relapse to either exacerbation of mental illness or to the use of substances will occur. Facilities that receive federal and/or state funding should be required to show evidence that staff are competent to assess and treat co-occurring conditions using evidence-based practices. Systems of care using team-based approaches for the treatment of mental health conditions and teams that address substance-use disorders should be able to share medical information on the course of clinical care provided to a patient with co-occurring conditions. Prohibitions on sharing medical information concerning a shared patient imposed by outdated language in 42 CFR Part 2, the substance abuse confidentiality statutes, assure less than optimal care and can be medically dangerous when medication treatments are provided in the absence of understanding the full picture of clinical and pharmacological interventions.
- **Any IMD exclusion modification should incorporate Psychiatric Advance Directives (PAD)**

Federal Funding Offsets for Increased Spending to Lift the IMD Exclusion:

- ✔ **Equalize the Federal match that was put in place for expansion of Medicaid to able-bodied enrollees.** The Affordable Care Act (ACA) added nearly 17 million new, work-capable, non-disabled adult enrollees under Medicaid expansion.[27] In some states, expansion increased enrollment by more than 30%. States receive a higher federal dollar amount, called the enhanced federal matching rate which reimburses 9 out of every 10 state dollars spent on these able-bodied adults while only reimbursing 5.7 out of 10 state dollars spent on the traditional population. Winding down the 90 percent match produces savings that can be reallocated towards lifting the IMD exclusion.
- ✔ **Move resources for prison-based boarding of the mentally ill to fund inpatient and community-based care where appropriate.** There are more than 2.3 million Americans in federal or state prisons. Studies have estimated that nearly half of inmates have a mental health condition, with 29% having serious mental illness.[28]
- ✔ **End Housing First funding and move funding to Treatment First with housing and community-based care.** Housing First, also called Permanent Supportive Housing (PSH), requires immediate and unconditional housing for homeless individuals. This, unfortunately, characterizes homelessness as merely a lack of resources, instead of addressing the underlying behavioral health conditions so prevalent in this population. A 2019 UCLA survey of homeless individuals found that 78% reported mental illness and 75% reported substance abuse.[29] Indeed, the National Academy of Sciences found "no substantial evidence that PSH contributes to improved health outcomes."[30] When the majority of homeless individuals are mentally ill or suffering from substance abuse, Housing First resources should be redirected to treatment first that includes housing resources.

Administrative Solutions

1115 Waivers

In 1997, the Clinton Administration granted several states waivers from the IMD exclusion waiver, but these were generally phased out by 2007.[31] Since 2018, states have been using a demonstration authority in Medicaid, the 1115 waiver, to use federal funds to cover the cost of inpatient services.

These 1115 waivers are subject to Secretary of Health and Human Services discretion and to budget neutrality rules. Currently, 37 states have approved 1115 Substance Use-Disorders (SUD) waivers.[32] Thirteen states have approved 1115 waivers for hospital services associated with serious mental disorders.[33]

- States should evaluate their 1115 waivers to ensure that they provide sufficient inpatient care options for Medicaid enrollees in need of crisis-based inpatient care.
- Because 1115 waivers require budget neutrality, these waivers should specifically establish systems to move Medicaid enrollees from ED boarding to fund state beds.
- Any IMD exclusion modification should incorporate Psychiatric Advance Directives.
- CMS should require states with waivers to collect and report data on treatment outcomes, as well as readmissions within 30 and 90 days due to exacerbation of substance abuse or mental illness.

1915 Waivers

Medicaid statute also allows states to obtain waivers to provide specific services to target populations that may otherwise need institutional care, for instance people with disabilities or the mentally ill. This can include different eligibility rules, for instance how income or assets are counted, and services particular to the target population's needs, such as long-term support services.

- States should evaluate their waivers to ensure they include continuum of care support services for individuals with mental health needs and substance use disorder.
- CMS should require states with waivers to collect and report outcomes data at 30 days, 1 year, and 5 years after receipt of services. While Congress has authorized and CMS has increased approval for 30-day inpatient SUD programs, outcomes data on their effectiveness is lacking. This can be undertaken as part of the Medicaid Enterprise System or through other state reporting requirements that address the need to assure efficient and effective use of Medicaid funds.

Additional Outcome Tracking

The current "Government Performance and Results Act" (GPRA) data primarily collects metrics while individuals are in programs, but once they exit inpatient or residential facilities, recovery data is less reliable, particularly after 30 days.

The National Academy of Sciences, Engineering and Medicine found, "the Center for Substance Abuse Treatment Government Performance Results and Modernization Act tool does not elicit adequate data on the process of recovery."[34] AHA should add additional timepoints at which outcome data is required to better assess the efficacy of treatment programs receiving federal funding.

Action, Common Sense, and Compassion is NEEDED NOW

Americans are a generous people and deeply care about the vulnerable, including those suffering from serious mental illness and substance-use disorder. This requires major reform to our systems so that Americans with these conditions who are currently suffering in prisons, homeless encampments, and hospital emergency departments have access to long-term, effective care.

Today, it is imperative policymakers in Congress and Administration officials take action to:

- ✔ **Restructure current spending to open inpatient beds for patients in crisis,**
- ✔ **Reform commitment standards,**
- ✔ **Further define the continuum for outpatient care, and**
- ✔ **Track outcomes.**

By implementing these person-focused reforms, Americans with serious mental illness or substance use disorders will have the opportunity to live healthy and productive lives in our communities.

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She obtained her Ph.D. from Yale University with a specialty in Infectious Disease Epidemiology and is a graduate of the University of Connecticut School of Medicine. She is board certified in General Psychiatry and in Addiction Psychiatry and she is a Distinguished Fellow of the American Academy of Addiction Psychiatry with more than 30 years as a clinician, teacher, clinical researcher, and government official. Dr. McCance-Katz has had a longstanding interest in improving health and mental health care for people with substance use disorders and serious medical and mental illness.

Over the years, she has worked to establish best practices for the treatment of behavioral health conditions and has been able to successfully advocate for and implement policy changes that better serve this population. She teaches at the Warren Alpert Medical School of Brown University where she has the opportunity to interact with the next generation of psychiatrists and mental health professionals.

Her clinical work is now at the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals Forensic Division Outpatient Clinic providing care to those with serious mental and substance use disorders and involvement with the justice system.

Dr. McCance-Katz continues her advocacy work through serving on the Board of One Chance to Grow Up and is a Senior Fellow at Able Americans and at the Cicero Institute.

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Ford previously served in the Trump Administration in the White House as a Domestic Policy Advisor and Special Assistant to the President from 2018 to 2020. In that role, Ford had broad responsibility for the development of the Administration's welfare and anti-poverty strategic agenda and oversaw the execution of policy at the Assistant Secretary level throughout the Administration as well as the interagency policy coordination process. She also worked with leading anti-poverty practitioners and Congressional policy leaders. She focused on advancing reforms to the U.S. social safety net programs so that all Americans can access meaningful work that enables them to move toward self-sufficiency and greater control of their futures.

Before her work in the White House, Ford was a Legislative Advisor to Sen. Mike Lee (R-Utah) on Capitol Hill. She oversaw the development of 22 pieces of legislation and more than 50 amendments on significant bills to advance health and welfare reforms. Ford started her career at the Heritage Foundation in 2011 as a Research Assistant focusing on religious liberty, civil society and poverty studies. Her work has been featured in the Wall Street Journal and National Review. Ford received a bachelor's degree from Franciscan University of Steubenville. She has four children and lives with her husband in Virginia.

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