Treatment Advocacy Center

OFFICE OF RESEARCH AND PUBLIC AFFAIRS

Research Report

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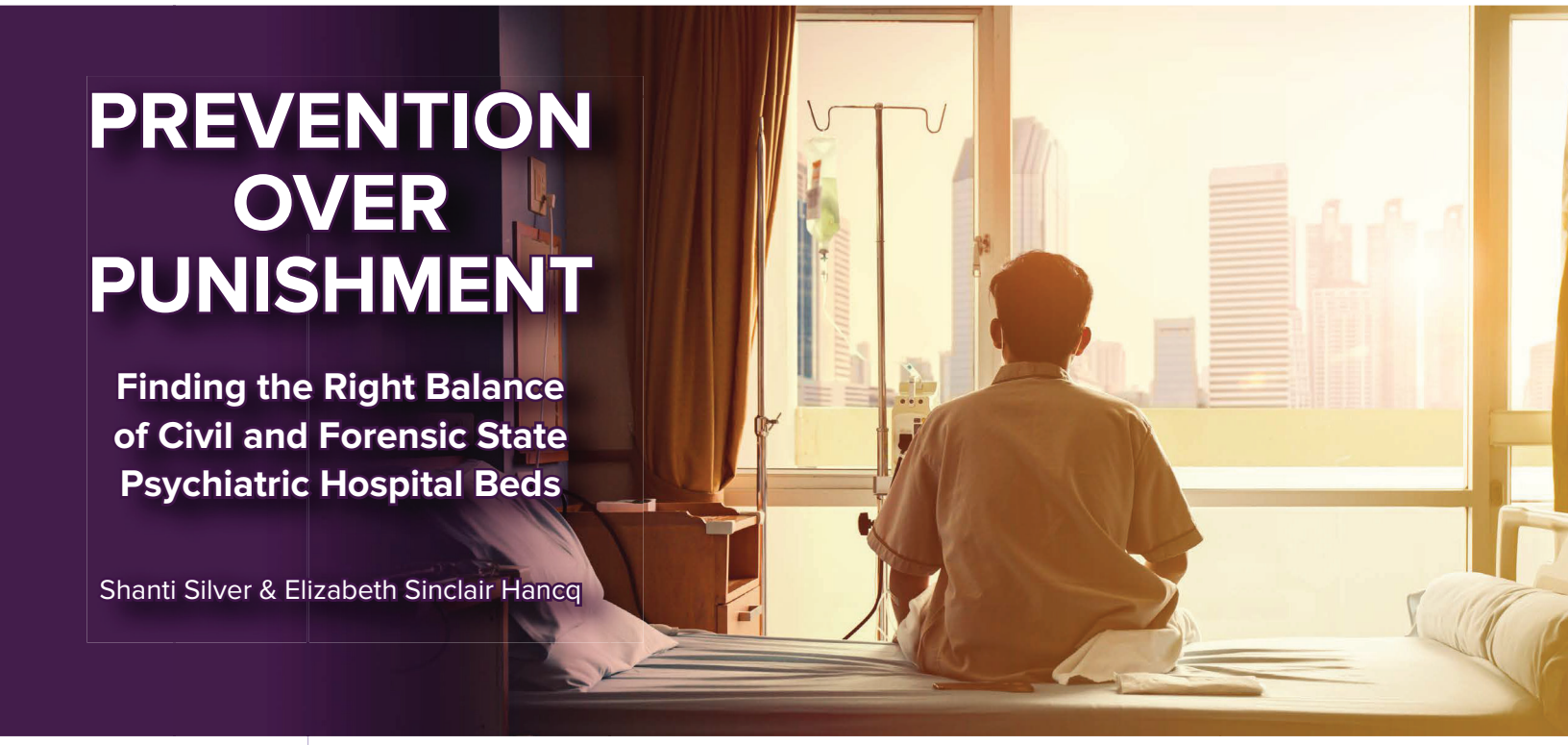
PREVENTION OVER PUNISHMENT

Finding the Right Balance of Civil and Forensic State Psychiatric Hospital Beds



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EXECUTIVE SUMMARY

State psychiatric hospitals provide a critical service for people with severe mental illness (SMI), especially those with a history of violent behavior, developmental disabilities, or complex medical needs. However, the number of state hospital beds for adults with SMI has been declining and reached a historic low of 36,150 (10.8 beds per 100,000 population) in 2023, with a majority of those beds (52 percent) occupied by people who have been committed to the hospital through the criminal legal system.

In 2016, Treatment Advocacy Center wrote, "The reality that an immeasurable number of people with treatable diseases only get treatment when they get sick enough to commit crimes that send them to jail and then to a forensic bed should be a source of national shame and outcry for reform." In the seven years since, the situation has gotten worse. The number of beds per 100,000 people occupied by civil patients has decreased by 17 percent since 2016.

Yet there are not enough beds for forensic patients either. Despite the increasing use of state hospitals for forensic patients, thousands of inmates with serious mental illness languish in jail for months, or even years, waiting for a state hospital bed to open. While incarcerated, such people often gain additional charges due to disruptive behaviors that are symptoms of their illness, get sicker as they spend extended periods of time without

treatment, and even die from preventable and tragic causes such as dehydration. As the number of state hospital beds continues to decline, finding the right balance of civil and forensic beds is critical. Without considering that balance, people with SMI who need long-term intensive care will continue to be pushed into the criminal legal system at alarming rates in states with too few civil beds, while states with too few forensic beds will be unable to provide those waiting in jail for a bed with timely access. However, regardless of how states balance their civil and forensic beds, one thing is clear: states must strive for prevention over punishment.

Prevention Over Punishment Fast Facts

By all measures of bed need, the United States is currently facing a shortage of state psychiatric hospital beds, ranging from moderate at a minimum to severe in many states. In 2023, the number of state hospital beds reached a historic low of

10.8 BEDS per **100,000 PEOPLE.**

By 2023, the proportion of beds occupied by forensic patients had increased

12% since 2016 **&** **58%** since 2010

In 2023

5,576 INMATES

were awaiting admission to a state hospital, with a median of 72 inmates waiting across 33 states.

In 2023, inmates spent a median of two months in jail waiting for a bed to open across

26 STATES

As of 2023

1 in **7**

state psychiatric hospital beds was closed due to staffing shortages across 33 states.

BACKGROUND

Where would you seek emergency mental health care if you were experiencing suicidal thoughts and were scared that you might hurt yourself? If a loved one began behaving erratically and was becoming increasingly frightened and paranoid, where would you take them to seek care? The answer to these questions for many is a hospital.

Hospital-level psychiatric care for mental health emergencies is a critical component of the continuum of care for people with severe mental illness (SMI). The term “continuum of care” refers to a range of services — such as outpatient treatment, inpatient hospitalization, and medication — working together to ensure that people with SMI receive an appropriate level of support at each stage of their journey toward stability.

While receiving treatment in the community is preferable to hospitalization in most cases, inpatient psychiatric care can help people experiencing very severe symptoms to stabilize through providing a level of support for a duration that cannot be provided in outpatient settings.

THE ROLE OF STATE HOSPITALS

A state hospital is a psychiatric hospital that is operated by the state. Most community hospitals in the United States are private (82 percent),[1] and unlike state psychiatric hospitals, private psychiatric hospitals generally do not accept patients who have been required to receive treatment through the criminal legal system or who may be dangerous to themselves or others.[2] State psychiatric hospitals are also often the only place that will accept patients with a history of violent behavior or both SMI and complex medical needs as many private hospitals refuse to admit patients whose comorbid conditions make them expensive to treat and difficult to discharge safely.[3]

As a result, state hospitals are an essential service for people with SMI, many of whom have co-occurring medical conditions and are at an elevated risk of being arrested or living in poverty due to the severity of their symptoms when untreated. Accordingly, in this report we discuss trends in the number and availability of state psychiatric hospital beds for adults in the U.S. who have SMI (see Appendix A for methodology).

THE CHANGING NATURE OF STATE HOSPITALS

State hospitals were the primary source of inpatient psychiatric treatment 70 years ago and primarily provided long-term care. Today, the landscape of inpatient psychiatric capacity looks very different. Inpatient psychiatric treatment is now provided most often in community hospital psychiatric units, private psychiatric hospitals, and crisis facilities, all with differing lengths of stay and treatment programs.

The role of state hospitals in the continuum of mental health care services also varies from state to state. Whereas some states like Missouri and Hawaii use their state hospitals almost exclusively to provide care to forensic patients (i.e., those whom the state has committed to a psychiatric hospital because of their involvement with the criminal legal system), others like Kentucky, Massachusetts, and North Dakota use less than 15 percent of their beds for forensic patients. The type of care provided in state hospitals also varies greatly across states. For example, some states use their state hospitals almost exclusively for acute care hospitalizations. In these states, such as Tennessee, Ohio, Kentucky, and Wisconsin, civil patients have relatively short average lengths of stay, approximately two weeks or less on average. Other states, such as Arizona, Delaware, Louisiana, North Carolina, and Utah, employ their state hospitals more like residential programs with civil patients staying on average well over a year in the hospital.

THE PSYCHIATRIC BED SHORTAGE IN THE U.S.

The psychiatric bed shortage in the U.S. The number of state hospital beds for the SMI population has been on the decline since the 1950s and has now reached a historic low of 10.8 beds per 100,000 people (see Figure 1 and Table 1).

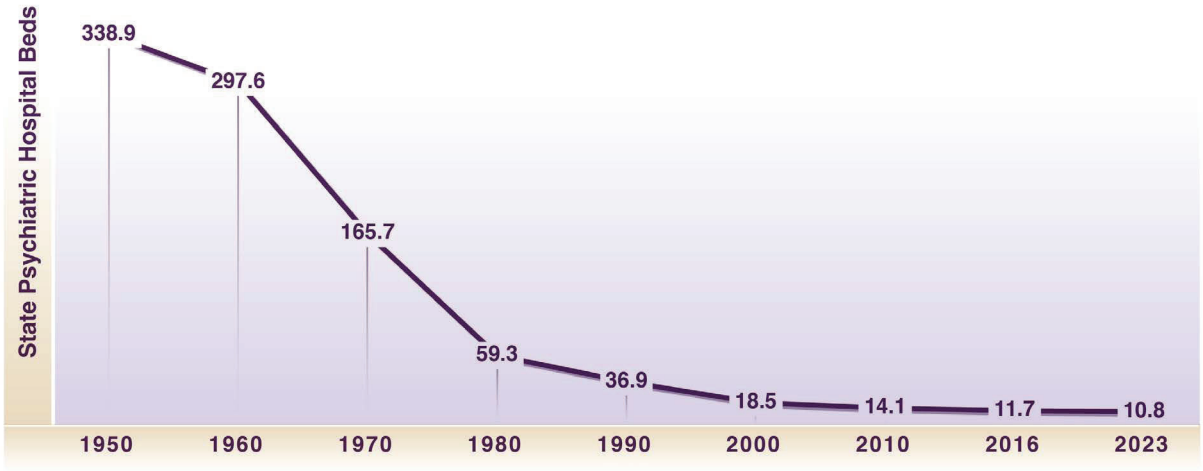

Figure 1. National number of state psychiatric hospital beds per 100,000 population

Since Treatment Advocacy Center released its latest state psychiatric hospital bed census report in 2016,[4] states have demonstrated a wide variety of trends in state hospital bed capacity (see Table 2 below):

- Six states — California, Hawaii, Illinois, Louisiana, Washington, and West Virginia — have increased the number of staffed beds per 100,000 population by at least 10 percent since 2016.
- In the following 19 states, the number of online beds has decreased by more than 20 percent: Alaska, Arizona, Arkansas, Colorado, Connecticut, Kansas, Kentucky, Michigan, Mississippi, Nebraska, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Texas, Vermont, Virginia, and Wyoming.

Table 2. Change in state psychiatric hospital beds, 2016 to 2023.

STATE	2023 TOTAL BEDS	2023 TOTAL BEDS PER 100,000 POPULATON	2016 TOTAL BEDS	2016 TOTAL BEDS PER 100,000 POPULATION	PERCENTAGE CHANGE IN BEDS PER 100,000
Alabama	408	8.0	383	7.9	1%
Alaska	60	8.2	80	10.8	-32%
Arizona	259	3.5	302	4.4	-26%
Arkansas	186	6.1	222	7.5	-23%
California	6,542	16.8	5,905	15.1	10%
Colorado	482	8.3	543	10.0	-20%
Connecticut	515	14.2	615	17.1	-20%
District of Columbia	240	12.2	282	12.9	-6%
Delaware	124	35.7	122	42.0	-18%
Florida	2,522	11.3	2,648	13.1	-16%
Georgia	1,055	9.7	954	9.3	4%
Hawaii	297	20.6	202	14.1	32%
Idaho	170	8.8	174	10.5	-19%
Illinois	1,359	10.8	1,351	9.3	14%

STATE	2023 TOTAL BEDS	2023 TOTAL BEDS PER 100,000 POPULATON	2016 TOTAL BEDS	2016 TOTAL BEDS PER 100,000 POPULATION	PERCENTAGE CHANGE IN BEDS PER 100,000
Indiana	815	11.9	818	12.4	-4%
Iowa	64	2.0	64	2.0	0%
Kansas	304	10.4	451	15.5	-49%
Kentucky	410	9.1	499	11.3	-24%
Louisiana	689	15.0	616	13.2	12%
Maine	159	11.5	144	10.8	6%
Maryland	946	15.3	950	15.8	-3%
Massachusetts	664	9.5	608	8.9	6%
Michigan	558	5.6	705	7.1	-21%
Minnesota	192	3.4	194	3.5	-3%
Mississippi	366	12.4	486	16.2	-31%
Missouri	890	14.4	874	14.4	0%
Montana	174	15.5	174	16.8	-8%
Nebraska	194	9.9	289	15.2	-54%
Nevada	287	9.0	296	10.2	-13%
New Hampshire	154	11.0	158	11.9	-8%
New Jersey	1,555	16.8	1,543	17.2	-2%
New Mexico	137	6.5	229	11.0	-69%
New York	3,300	16.8	3,217	16.3	3%
North Carolina	453	4.2	892	8.0	-90%
North Dakota	57	7.3	140	18.5	-153%
Ohio	1,126	9.6	1,121	9.7	-1%
Oklahoma	376	9.4	431	11.0	-17%
Oregon	704	16.6	653	16.2	2%
Pennsylvania	1,384	10.7	1,334	10.4	3%
Rhode Island	126	11.5	139	12.3	-7%
South Carolina	423	8.0	493	10.1	-26%
South Dakota	67	7.4	128	14.9	-101%
Tennessee	550	7.8	562	8.5	-9%
Texas	1,509	5.0	2,236	8.1	-62%
Utah	246	7.3	252	8.4	-15%
Vermont	16	2.5	25	4.0	-60%
Virginia	1,241	14.3	1,526	18.2	-27%
Washington	1,034	13.3	729	10.2	23%
West Virginia	300	16.9	260	14.1	17%
Wisconsin	450	7.6	458	7.9	-4%
Wyoming	72	12.4	201	34.3	-177%
United States	**36,150**	**10.8**	**37,698**	**11.7**	**-8%**

State Hospital Occupancy Rate Fast Facts

73%
of reporting states reported occupancy rates above the recommended 85% (n = 33).

90%
was the median occupancy rate (n = 33).

11 STATES
or approximately one-third of reporting states, reported occupancy rates operating at or above 95 percent: Alaska, Arkansas, Connecticut, Louisiana, Maryland, Massachusetts, Michigan, Oklahoma, Oregon, Texas, and West Virginia (n = 33).

Given that the availability of crisis, acute, and subacute beds and intensive outpatient services varies by community, it is difficult to determine the precise number of state hospital beds needed. This is further complicated by the fact that some patients with SMI are eligible for and able to afford treatment in private hospitals. However, sky-high occupancy rates suggest the current capacity of our state hospitals is not sufficient for meeting community needs.

Hospitals with occupancy rates in excess of 85 percent are considered to be experiencing a shortage of beds,[5] as hospitals with such high occupancy rates may be unable to admit patients in a timely manner and experience relatively higher nurse-to-patient ratios. Higher occupancy rates have also been associated with increased mortality in the 30 days after discharge,[6] including an increased risk of suicide.[7] Of the 33 states that provided occupancy rates for state psychiatric hospitals, 24 (73 percent) reported an average occupancy of greater than 85 percent, suggesting an insufficient number of beds to meet community need (see Table 3).

The shortage of psychiatric beds has real consequences for people with SMI — some will wait months in jail despite not yet being found guilty of a crime, others will be denied admission despite being critically ill, and others still will be discharged prematurely onto the streets to free up beds, where they may grow sicker and be at an elevated risk of mortality.

Context for understanding the psychiatric bed shortage

In 2021, the U.S. had somewhere between 18[8] and 20[9] psychiatric beds for every 100,000 people, including beds from public, private, community, and other hospitals, according to data from the Substance Abuse and Mental Health Services Administration and the American Hospital Association (see Table 4 in Appendix C). Experts have estimated that the optimal number of psychiatric beds per 100,000 people lies between 40 and 60[10] with 25 to 30 beds considered a mild shortage,[11] 15 to 25 a moderate shortage, and less than 15 a severe shortage. Mathematical models that attempt to estimate community need for psychiatric beds have found similar results, with one international study finding

an average need of 46 beds per 100,000 people[12] and a U.S. model finding a need of 35 beds per 100,000 people.[13]

California took measuring psychiatric bed need a step further, examining total bed need as well as need by type of bed. A RAND Corporation study found that California requires 50.5 inpatient psychiatric beds per 100,000 adults, 26 acute care beds per 100,000 adults, and 24.6 subacute care beds per 100,000 adults.[14]

While experts may disagree somewhat on the specific number of beds necessary to maintain healthy communities, it is clear that the U.S. faces a shortage of inpatient psychiatric beds. By all of these measures of bed need, the U.S. is currently facing a moderate shortage of psychiatric hospital beds.

The psychiatric bed shortage was initially created through good intentions. The process of eliminating psychiatric hospital beds and moving people with SMI out of hospitals and into communities, often called "deinstitutionalization," began after World War II. During World War II, the nation was confronted with three facts that would change the dialogue on SMI:[15]

1. SMI was much more common than previously believed. Mental illness was named the greatest cause of noneffectiveness or loss of manpower in the war effort.
2. Conditions in state hospitals were appalling. More than 3,000 conscientious objectors were assigned to alternative duty in state hospitals during the war and reported numerous violations of human rights.
3. Serious mental illness was treatable. In 1953, the antipsychotic drug chlorpromazine (marketed under the brand name Thorazine, among others) was introduced to American state psychiatric hospitals. Chlorpromazine decreased severe symptoms of SMI such as delusions, hallucinations, and manic symptoms.

These changes along with a series of landmark legal decisions in the 1960s and 1970s (Appendix B) that eliminated federal funding for state psychiatric hospitals and increased liability for hospitals that treated patients with SMI incentivized state and other community hospitals to close as many beds as possible to protect themselves from liability and save money. Whereas many patients, especially those with developmental disabilities, who formerly would have been confined to psychiatric hospitals have been able to live successfully in the community with the help of outpatient services,[16] many people with SMI who formerly would have been treated in psychiatric hospitals find themselves institutionalized in America's new largest mental health care system: prisons and jails.

TRENDS IN FORENSIC BEDS IN THE U.S.

State hospitals are vital for treating people with SMI who are involved with the criminal legal system because private hospitals generally do not accept patients for whom treatment has been mandated by the criminal system.[17] In 2023, forensic patients occupied the majority of state hospital beds (see Table 5). This reflects an alarming trend of waiting to treat patients with SMI in a state hospital until they have committed a crime, perpetuating the criminalization

of mental illness. The growth of forensic patients is largely driven by the explosion of individuals found not competent to stand trial who are in need of competency restoration.[18]

What is a forensic patient?

Forensic patients are those whom the state has committed to a psychiatric hospital because of their involvement with the criminal legal system. This population can include:

- People who have been charged with a crime but are not competent to stand trial.
- People who have committed a crime but are not guilty by reason of insanity.
- People who have been found guilty of a crime but are not mentally fit to be sentenced to a standard prison term.[19]

Patients who are not involved with the criminal legal system are typically referred to as *civil patients*.

The proportion of state hospital beds occupied by forensic patients has increased by 12 percent since 2016 and by 58 percent since 2010. In contrast, the proportion of beds occupied by civil patients has decreased by 11 percent since 2016 and by 29 percent since 2010 (see Figure 2 below).

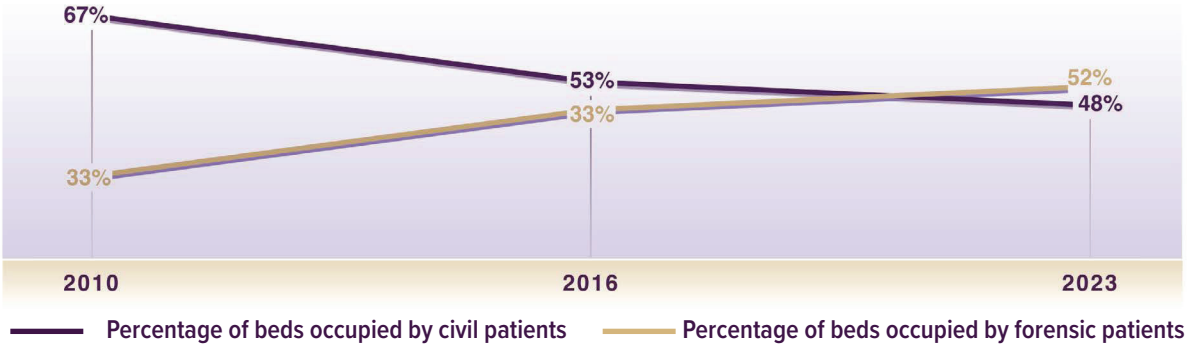

Figure 2. Change in proportion of beds occupied by civil and forensic patients from 2010 to 2023.

However, the actual number of beds per 100,000 people occupied by forensic patients has increased by only 3 percent since 2016 and 22 percent since 2010, while the number of beds occupied by civil patients per 100,000 people has decreased by 17 percent since 2016 and by 45 percent since 2010. Therefore, the majority of the 7,323 beds that have been lost since 2010 were beds used to treat civil patients (see Figure 3 below).

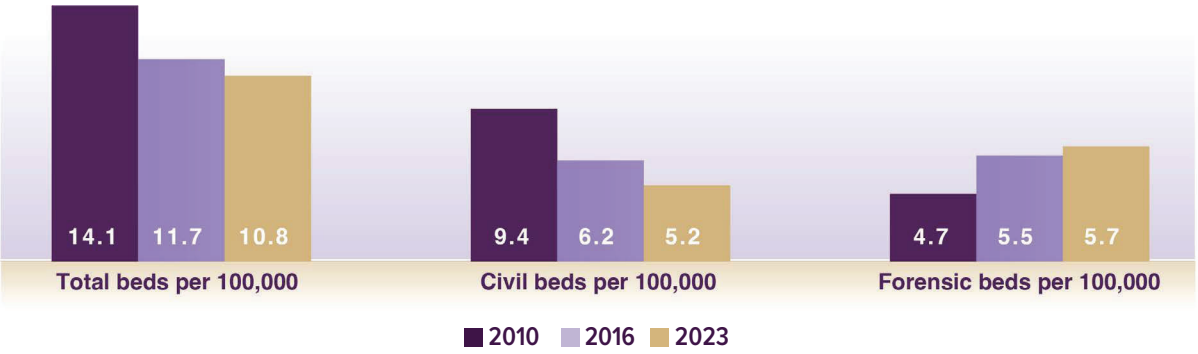

Figure 3. Change in beds per 100,000 population from 2010 to 2023 by legal status.

Note: Civil and forensic bed numbers may not sum to total bed numbers due to rounding.

Trends in patients determined to be not guilty by reason of insanity

Some individuals with SMI who have been charged with crimes will be determined to be not guilty by reason of insanity (NGRI). In some states, this is also called guilty except for insanity, or not guilty by reason of mental illness. In our survey of state officials, we found that a median of 15 percent of all state hospital beds and 31 percent of forensic beds were occupied by NGRI patients across 34 states. The percentage of total beds occupied by NGRI patients ranged from zero percent in states such as New Mexico, Alaska, and Idaho, which do not have NGRI laws, to approximately 50 percent in Hawaii and Wisconsin (see Table 6).

Overall, the number of beds occupied by NGRI patients appears to have stayed relatively consistent since 2005. According to research from the National Association of State Mental Health Program Directors, the number of NGRI patients in state hospitals decreased approximately 3 percent from 2005 to 2014.[20] We found that the percentage of all beds occupied by NGRI patients has continued to decrease slightly from a median of 17 percent in 2016 to 15 percent in 2023. Responses from state officials to our 2023 survey suggest that step-down programs for NGRI patients and conditional release programs may be slowing the growth of NGRI populations in state hospitals.

NGRI patients also often remain hospitalized for very long periods of time, and the low turnover caused by those long lengths of stay results in beds not becoming available for new patients.[21] However, further research is needed to determine whether long hospital stays for NGRI patients, which sometimes last decades or for life, are necessary for recovery. Research has shown that NGRI patients stay in state hospitals longer than people with comparable mental health conditions who have been civilly committed.[22] The increased length of stay may be due to concerns for public safety; however, NGRI patients also sometimes remain in the hospital years longer than they would have been held in prison for the same crime if they did not have a mental illness.[23] For example, in our survey, two states, Tennessee and Wisconsin, said explicitly that NGRI patients often stay in the state hospitals for life. Those two states also had some of the lowest lengths of stay for civil patients.

There is no federal oversight or nationwide system to track the length of stay of NGRI patients or reasons for extended hospital stays.[24] As Treatment Advocacy Center wrote in its 2017 report "Treat or Repeat," adequate community support and oversight of patients discharged to the community after being found NGRI are needed.[25] Accordingly, further research is needed to identify interventions that can help NGRI patients return safely to community living as soon as possible.

Recent research suggests that the increasing percentage of beds occupied by forensic patients is primarily being driven by an increase in the number of people who require competency evaluation and restoration before they can stand trial.[26] One 2020 survey of state officials who are responsible for patients who require competency evaluation and restoration found that referrals for competency evaluation had been increasing in 82 percent of states and referrals for competency restoration had been increasing in 78 percent of states. State officials identified a shortage of community mental health services, crisis services, and

psychiatric beds as the biggest contributors to the rising need for competency evaluations.[27] The majority of patients who are found not competent to stand trial have psychotic disorders.[28]

The national shortage of psychiatric beds and community treatment services is directly related to the increased criminalization of SMI. After arresting a person who is clearly in a mental illness–related crisis, an officer must decide whether to take them to jail or take them to a hospital or crisis center for treatment. Research suggests that officers may be less likely to take someone to a hospital when they believe that the person will likely not be admitted,[29] an all too frequent occurrence in mental health care systems with state hospitals that are operating at or over capacity due to bed shortages. Many such patients, once they have been charged with a crime, may be deemed not competent to stand trial and may spend weeks, months, or even years in jail waiting for a state hospital bed to open.

IMPACT OF THE FORENSIC BED SHORTAGE ON PEOPLE WHO REQUIRE COMPETENCY RESTORATION

When a person with SMI is determined to be too sick to stand trial (i.e., not competent to stand trial), they are typically criminally committed to a state hospital to receive treatment. However, if no beds are available, someone with SMI can wait in jail for months or even years for a bed to open (see Table 7). States reported how long, on average, inmates spent waiting for admission to a state psychiatric hospital after receiving a court order for treatment, and the results were alarming:

Competency Restoration Fast Facts

A total of
5,576 INMATES
were waiting for admission to a state hospital (n = 33).

Inmates spent a median of
2 MONTHS
(60 days) waiting for a bed to open (n = 26).

The amount of time inmates spent waiting for a bed to open varied substantially. Inmates in Texas spent the longest average time on the waiting list for a bed, an average of 1.2 years (444 days). That was followed by average wait times in Mississippi (9.6 months), Wyoming (6.8 months), and Louisiana (6 months). Other states had relatively short wait times for beds, such as North Dakota and Virginia, where inmates wait an average of one week to be admitted to a state hospital forensic bed. There was also a wide range in the number of inmates on the waiting list. States with the largest number of inmates per 100,000 population waiting for admission to a state hospital were Wyoming (12.4), Texas (8.1), and Colorado (7.7). Several states, such as Arizona, Hawaii, New Mexico, and Oklahoma, had no inmates waiting for a bed to open at the time of data collection.

"Rather than add beds, the state [of Missouri] is trying to cut costs by providing mental health services to people who don't belong in jail in the first place. It's a playbook other states have tried, with no data yet to show how it is working."

Tony Messenger, "Missouri Will Add Mental Health Workers in Jails. It Should Add Hospital Beds Too," *St. Louis Post-Dispatch* (September 25, 2023)

Our nation's jails are not equipped to care for people with SMI.[30] Yet because of the national shortage of state psychiatric hospital beds, jails have become a place where people with SMI who have not yet been convicted of any crime languish for months or even years. Although some states have attempted to address the issue by hiring mental health workers specifically for jails, that overlooks the fact that people with SMI who have been taken to jail due to their symptoms are being criminalized for their mental illness.[31] When people with SMI are detained in jail while in the middle of a mental health crisis, they may gain additional charges due to disruptive behaviors that are symptoms of their illness,[32] get sicker as they spend extended periods of time without treatment,[33] or even die from causes such as dehydration.[34]

Many states may be unaware of the extent of the problem. In speaking with state officials about their forensic waitlists, we discovered that some state officials could not tell us how many inmates were waiting for a bed to open because their state does not track it. According to Dr. Neil Gowensmith, a forensic psychology professor at the University of Denver, although some states have strong systems for tracking the amount of time it takes for people awaiting competency restoration to proceed to trial, that is sometimes because the state was previously sued for having inadequate competency restoration services and "even states with the strong systems rarely publish their data widely, making it difficult to spot promising practices or compare state systems … Without data, states cannot anticipate future demand for competency evaluation or restoration, understand what components of restoration are effective (or ineffective), or evaluate outcomes of restoration services."[35]

Our broken competency restoration system: The cost to states

In 1972, the U.S. Supreme Court determined that states are allowed to detain people who have been found not competent to stand trial for only a "reasonable period of time."[36] Although the Supreme Court has never defined a "reasonable" time frame, no court in the U.S. has ever found that detaining someone for a year or longer is "reasonable," according to reporting from WFAE. But the courts can do little to force states to uphold their citizens' rights other than by imposing monetary fines. Ultimately, only the state legislature or governor has the authority to provide funding for new state hospital beds.[37]

However, with the explosion in the number of people found not competent to stand trial, many states are struggling to admit forensic patients in need of competency restoration to state hospitals in a timely manner. This has resulted in massive settlements and fines levied against states.

At least 12 states have been sued for violating due process and failing to provide timely competency restoration services for people with SMI.[38] Most recently, in July 2023, the Washington Department of Social and Health Services was fined $100 million for its failure to provide timely treatment to people with serious mental illness who require competency

restoration services. That money, which could have been used to provide services, must now be paid as a fine because of the "DSHS's own lack of foresight, creativity, planning, and timely response to a crisis of its own making" as "the Court is unpersuaded that DSHS adequately planned for and took reasonable measures to address the bed shortage," according to the judge's statement on the ruling.[39]

Washington is not the only state to be fined a large amount of money for failing to provide timely competency restoration services to inmates with SMI. Other states include Colorado, whose Department of Human Services has been fined between $100 and $500 per day for every person with SMI waiting to receive competency restoration,[40] and Nevada, whose Division of Public and Behavioral Health has been fined $500 per day per person awaiting competency restoration in a jail, hefty financial penalties considering more than a hundred people are often on the waiting list, each of whom will wait three to four months for a bed to open.[41] Such fines do not include legal and monitoring costs that states expend in such cases, which also can amount to hundreds of thousands of dollars.[42]

IMPACT OF FORENSIC BED OVERFLOW ON CIVIL PATIENTS

When most or all of a state's psychiatric beds are used for patients who are involved with the criminal legal system, it leaves people with SMI who are in need of long-term hospital-level care and who have no criminal behavior with few options for treatment. When they are turned away from emergency departments or discharged before their symptoms have fully stabilized, they could go on to harm to themselves or engage in disruptive behavior that leads to arrest. According to Dr. Joe Bloom, for many years "civil commitment provided hospitalization for individuals suffering severe psychiatric decompensation, before their behaviors brought them into contact with the criminal justice system."[43] In fact, a 2023 study by Bloom and colleagues found a strong relationship between competency restoration orders and civil commitment orders in Oregon, suggesting that "neglecting civil commitment may well have contributed to the CST [competency to stand trial] crisis in Oregon."[44]

Thus, after being turned away from the hospital as voluntary civil patients, some people will deteriorate and experience increasingly severe symptoms. Although such patients may meet inpatient criteria and would have gained access to state hospital beds as civil patients in the past, even those who are experiencing very serious symptoms are increasingly deemed ineligible for commitment to state hospital beds until they have been charged with a crime and are committed as forensic patients.

In addition to neglecting to provide inpatient services to people with SMI until they have become involved with the criminal system, the shortage of civil beds in particular means civil patients who rely on state hospitals for care, such as those who have serious mental illness, complex medical needs, and/or cannot afford care in private hospitals, must often wait over a year for a bed to open to obtain the care they need.[45]

In 2016, Treatment Advocacy Center wrote, "The reality that an immeasurable number of people with treatable diseases only get treatment when they get sick enough to commit crimes that send them to jail and then to a forensic bed should be a source of national shame and outcry for reform."[46] In the seven years since, the situation has gotten even worse. The

number of beds occupied by civil patients per 100,000 population has shrunk by 17 percent, from 6.2 to 5.2 (see Table 8 below).

Table 8. State hospital bed population by legal status.

STATE	TOTAL BEDS PER 100,000	TOTAL BEDS — RANK AMONG THE STATES	CIVIL BEDS PER 100,000	% OF BEDS OCCUPIED BY CIVIL PATIENTS	% OF BEDS OCCUPIED BY CIVIL PATIENTS — RANK AMONG THE STATES
Alabama	8	36	5.3	66%	17
Alaska	8.2	35	6.8	83%	5
Arizona	3.5	48	1.6	45%	29
Arkansas	6.1	44	0	0%	48
California	16.8	6	5.2	31%	39
Colorado	8.3	34	3.3	40%	34
Connecticut	14.2	13	7.9	56%	24
Delaware	12.2	17	8.1	66%	15
District of Columbia	35.7	1	15.9	45%	30
Florida	11.3	21	6.4	56%	25
Georgia	9.7	27	3.6	37%	36
Hawaii	20.6	2	1.7	8%	44
Idaho	8.8	33	5.1	58%	21
Illinois	10.8	23	3.2	30%	41
Indiana	11.9	18	8	67%	14
Iowa	2	51	Unknown	Unknown	Unknown
Kansas	10.4	25	6.8	66%	16
Kentucky	9.1	31	8.2	90%	1
Louisiana	15	10	9.8	65%	18
Maine	11.5	20	NA	NA	NA
Maryland	15.3	9	0	0%	46
Massachusetts	9.5	29	8.4	88%	2
Michigan	5.6	45	2.7	60%	20
Minnesota	3.4	49	3.4	100%a	—
Mississippi	12.4	15	9.8	79%	7
Missouri	14.4	11	0	0%	48
Montana	15.5	8	10.7	69%	13
Nebraska	9.9	26	4.2	42%	31
Nevada	9	32	2.8	31%	40
New Hampshire	11	22	8.9	81%	6
New Jersey	16.8	4	11.9	71%	12
New Mexico	6.5	43	2.3	36%	37
New York	16.8	5	12.9	77%	8
North Carolina	4.2	47	2.4	58%	22
North Dakota	7.3	41	6.3	86%	3
Ohio	9.6	28	2	21%	43
Oklahoma	9.4	30	4.4	47%	28

STATE	TOTAL BEDS PER 100,000	TOTAL BEDS — RANK AMONG THE STATES	CIVIL BEDS PER 100,000	% OF BEDS OCCUPIED BY CIVIL PATIENTS	% OF BEDS OCCUPIED BY CIVIL PATIENTS — RANK AMONG THE STATES
Oregon	16.6	7	1.2	7%	45
Pennsylvania	10.7	24	7.9	74%	11
Rhode Island	11.5	19	6.6	57%	23
South Carolina	8	37	4	50%	26
South Dakota	7.4	40	4.5	61%	19
Tennessee	7.8	38	6.6	85%	4
Texas	5	46	1.9	38%	35
Utah	7.3	42	3.5	49%	27
Vermont	2.5	50	1.9	75%	9
Virginia	14.3	12	4.6	32%	38
Washington	13.3	14	5.5	42%	32
West Virginia	16.9	3	12.7	75%	10
Wisconsin	7.6	39	2.2	28%	42
Wyoming	12.4	16	5.2	42%	33
United States	**10.8**	**—**	**5.2**	**48%**	**—**

A human rights crisis: Booked into jail with no arrest

Civil commitment is a form of involuntary commitment in which a person with mental illness, who is not involved with the criminal legal system, is required to receive either inpatient or outpatient treatment. It is often used when people are at risk of harming themselves or someone else because of their illness, and cases include instances where a person's health is in danger because they are not capable of taking care of their essential needs or because they are likely to experience psychological deterioration if left untreated.[47] Investigative journalists have uncovered that in Mississippi people on civil commitment orders are routinely jailed despite not having been charged with a crime. According to ProPublica, people with mental illness who had not been charged with a crime were jailed in Mississippi at least 2,000 times from 2019 to 2022.[48]

Similar practices have been found in New Hampshire, where a shortage of state hospital beds means that people who have not been charged with crimes are held in jail where they are "dressed in prison jumpsuits, photographed and held in isolation up to 23 hours a day. They live side-by-side with convicted inmates who have significant mental health problems, people found not guilty by reason of insanity, and people undergoing evaluations to determine if they are competent to stand trial. They are guarded by state corrections officers and can be shocked or held in four-point restraint — strapped to a bed by their arms and legs — if they refuse medication."[49]

These practices were uncovered by journalists, not published by the state. There are no national estimates for the number of people with mental illness who are detained in jail because there is nowhere else to go during a mental health crisis.[50]

CONTRIBUTING FACTORS TO THE BED SHORTAGE

The national shortage of state psychiatric beds has dire consequences for some of our nation's most vulnerable. Many factors have contributed to the shortage the U.S. is experiencing today; however, in recent years some factors have accelerated this loss: healthcare workforce shortages, the lack of appropriate discharge facilities, and the COVID-19 pandemic.

Staffing shortages in state hospitals

Maintaining open and available beds to provide inpatient care to individuals with SMI requires more than just the physical bed itself. The Centers for Medicare & Medicaid Services requires certain staff-to-patient ratios for hospital certification, and each state has different regulations for appropriate staffing levels for licensing. The mental health care system is not spared from the significant healthcare workforce shortage in the U.S., and many states currently have a number of beds that cannot be used for patients because there are not enough professionals to staff them.

Thirty states provided information about staffing shortages in their state hospitals, and we were able to find information from public reports on four additional states. Out of these 34 states, 32 (94 percent) were experiencing staffing shortages.

State Psychiatric Hospital Staffing Shortages Fast Facts

94%
of reporting states said they were currently experiencing staffing shortages (n = 34).

15%
of beds were closed due to staffing shortages (n = 33).

The most common reason state officials gave for staffing shortages was
LOW WAGES

State officials report needing to hire contract staff, close units, and rely on overtime to keep an adequate staff-to-patient ratio.

Of the 12 states that provided reasons for their staffing shortage, the most common reason was a lack of competitive wages (75 percent). Because of different financial and budget limitations, state and other public hospitals often are forced to offer lower wages than private hospitals.

"Since the pandemic, some of our hospital employees have left for other jobs or retired; nursing has lost 30% of their pre-pandemic staffing. Replacing these employees is quite challenging due to the lower state salaries, nationwide healthcare workforce shortages (especially nursing), risk of being attacked by patients, and the facility mandating rules. Security and safety are two of the basic needs for human beings and these are often threatened in an environment such as a psychiatric hospital where trauma, stress, and insecurity are commonplace. This type of environment can also produce conditions in employees such as post-traumatic stress syndrome, depression and anxiety, clinical insomnia, and a profound long-term psychological impact."

Delaware Department of Health and Social Services

State officials cited several consequences of the staffing shortages, including being forced to use other, less desirable methods of keeping beds staffed such as hiring contract or traveling workers and relying on full-time staff to work overtime. Shortages of staff and expertise can also make it difficult to provide effective, quality treatment to patients, especially those with complex treatment needs or co-occurring conditions.

"Due to the pandemic's impact on our workforce, we have been forced to rely on more expensive traveler staff to maintain safe and effective facility operations. The cost of traveler staff alone, has resulted in a significant negative budget variance in the last fiscal year."

Montana Department of Public Health and Human Services in a report to the legislature

State officials also described how staffing shortages forced them to close beds and sometimes entire units, as well as pause or slow admissions. Those bed closures are reflected across the 33 states that reported quantitative information about both their total beds and active, online beds. Approximately one in seven state hospital beds were closed due to staffing shortages across the 33 states (see Figure 4). The bed closures and decreased admissions are directly related to growing waiting lists in some states.

Figure 4. Percentage of state hospital beds closed due to staffing shortages (n=33)

SOLUTIONS TO THE STATE HOSPITAL WORKFORCE SHORTAGE

States have turned to several strategies to bolster their state psychiatric hospital workforces. In addition to short-term solutions such as relying on contract staff, several states have undertaken initiatives to increase the strength of their healthcare workforce such as increasing salaries and subsidizing tuition for employees to gain further education and qualifications. However, it is worth noting that some states continue to have problems with staffing, even after implementing initiatives to boost workforce numbers.

"The challenges state hospitals were experiencing in recruitment and retention were largely salary based, as shown by the stabilization of filled positions after the implementation of the March 2022 salary increase, and the increase in filled positions after the implementation of the February 2023 salary increase."

Texas Department of Health and Human Services

Lack of appropriate discharge facilities

In addition to staffing challenges within state hospitals themselves, a shortage of appropriate facilities for people to receive care after being discharged contributes to overflowing state hospitals and long waiting lists for the remaining available beds. In the 26 states that provided data, 1,719 patients were ready but unable to be discharged because of a lack of appropriate facilities. This means that in those states, 1.2 beds per 100,000 population are occupied by patients who clinically no longer need hospital-level care. In fact, we lack the national figures with which to understand the true scope of this problem. Patients who can be difficult to discharge include people with violent tendencies, undocumented immigrants, people who require 24/7 nursing care, people with co-occurring disorders, people who are unhoused,

people with developmental disabilities, hearing-impaired people, Deaf people, and older adults.

"This is an issue the state has been grappling with for years. Many of our patients no longer need a hospital level of care, but other facilities will not accept them due to their criminal history or unique psychiatric/medical needs."

Colorado state official

The highest number of beds per 100,000 population occupied by patients who were ready to be discharged were in Wyoming and North Dakota, where 4.3 and 4.1 beds per 100,000 (including beds designated for pediatric and geriatric patients) were occupied by patients who could be discharged if appropriate discharge facilities were available (see Table 9).

"It is an ongoing challenge to find placement facilities for patients that require both mental health AND physical/activities of daily living care needs."

Wisconsin state official

Across the 26 reporting states, only four said they had no patients who were ready but unable to be discharged due to a lack of appropriate facilities: Kentucky, Mississippi, New Mexico, and Oklahoma. However, a state reporting that it has no or few patients who cannot be discharged safely is not always a sign of a robust care system. Some states, such as Montana, may have few patients who cannot be discharged because the state routinely discharges people to the street.

Treat and street: A case study from Montana

According to a 2023 report from Disability Rights Montana and journalism from *The Daily Montanan*,[51] Montana State Hospital regularly discharges its patients to homeless shelters, sometimes wearing T-shirts and flip-flops in the middle of winter or with wounds that require medical care, and often without informing shelter staff that they are coming. According to the report and subsequent news coverage, hospital staff "tell [patients] where they're going, leaving the impression that arrangements have been made on their behalf. But almost always, the residents are cold-dropped at those places and staff are left completely flat-footed." Shelter staff also said they were frustrated with Montana State Hospital for its practice of dropping off patients at discharge without contacting the shelters in advance, leaving them scrambling to find housing for these patients who sometimes require specialized care.

According to *The Daily Montanan*, in response to the report findings, representatives of the Montana Department of Public Health and Human Services noted that "when a patient no longer meets the legal and medical criteria required to remain hospitalized at the facility, the Department cannot keep them in its custody" and that "should a former patient be discharged to a shelter or mental health crisis center within the state, in lieu of other options, those shelters or mental health centers are tasked with providing a safe and appropriate environment for those former patients." However, *The Daily Montanan* also noted that "advocates and organizations across the state say that those shelters or centers, and the capacity to take patients, simply doesn't exist."[52] Notably, the Montana Department of Public Health and Human Services was one of only a few representative state agencies that refused to speak with us about their state hospitals for this report.

When appropriate community placements for discharge are unavailable for patients who no longer require hospital-level care, hospitals have few options: continue to use scarce beds for patients who no longer need them, discharge patients to facilities that are not able to meet their care needs, or simply send them out of a bed and onto the street.

Notably, 11 states said that they could not provide a specific tally of people in their state who were clinically ready for discharge because they did not track such information or records were not readily available (see Table 9). Several of those states, however, did note that they had patients who were ready for discharge but that they did not track the precise number of patients.

COVID-19

Whereas state hospital beds have been declining in numbers for decades, current bed shortages and workforce shortages should be considered in the context of the COVID-19 pandemic. Across the country, many psychiatric beds were closed during the pandemic due to staffing shortages or COVID-19 precautions. For example, in New York City, 21 percent of psychiatric beds were taken offline in favor of COVID-19 care with no date given for when those psychiatric beds would be restored.[53] Converting psychiatric beds to COVID-19 beds led to "virtually no local inpatient care" in some areas of the state, according to State Senator Michelle Hinchey, who represents New York's 46th Senate District.[54] In Washington State, capacity for behavioral health care was reduced to 65 percent, partially due to COVID-19 precautions, such as converting double-occupancy rooms to single occupancy.[55] In Virginia, some state hospitals saw staff shortages of up to 30 percent, primarily among frontline behavioral health workers, leading them to stop admissions altogether.[56]

"At one point during the pandemic the Department of Behavioral Health and Developmental Services closed 5 state facilities resulting in hospitals reducing census to safer patient to staff ratio. This impacted 354 beds across our system. We have restored 254 beds to the system [as of spring 2023]."

Virginia state official

Across 35 states that provided information about the impact of the COVID-19 pandemic on state psychiatric hospital bed availability, 29 (83 percent) reported experiencing negative impacts from the pandemic in their state hospital systems. The most common pandemic-related impacts were needing to convert beds to quarantine or isolation units (52 percent), needing to pause or slow admissions (38 percent), and challenges with staffing (45 percent).

"COVID-19 had a significant impact on staffing and has resulted in a nationwide clinical staffing shortage, which has impacted Maryland Department of Health facilities and community providers."

Maryland state official

Whereas many states were no longer affected by these pandemic consequences when this information was collected in the summer of 2023, the ongoing impacts of the COVID-19 pandemic remain a challenge for states whose workforce levels have not recovered to pre-pandemic levels and in which beds that were originally closed to create isolation units have still not been reopened.

CONCLUSION AND RECOMMENDATIONS

The number of state psychiatric hospital beds across the nation has declined to a historic low of 36,150, or 10.8 per 100,000 population, in 2023, with a majority of state hospital beds (52 percent) occupied by people who have been committed to a hospital through the criminal legal system. As the number of state hospital beds has continued to decline nationally, the percentage of beds occupied by forensic patients has been increasing. That increase is primarily being driven by patients who are being restored to competency after having been charged with a crime.

In addition to increasing the number and availability of state hospital beds, the system is in need of strategies to recruit and retain staff for state hospitals and to create and fund the infrastructure for step-down and other discharge facilities, as ensuring that those who do not require hospital-level care are able to access care in other settings is critical. To address the pressures on the state psychiatric hospital bed system and to ensure that the continuum of care for individuals with SMI includes accessible inpatient care when needed, Treatment Advocacy Center recommends the following:

- **State legislators and policymakers must ensure that state leaders are considering the balance of civil and forensic beds to prevent the further criminalization of mental illness.** Our survey found that the majority of state hospital beds are now occupied by forensic patients and that most state hospital beds taken offline in recent years have been civil beds. State policymakers must critically assess funding and bed allocation decisions to ensure that their state's mental health system does not require criminal legal system involvement before inpatient psychiatric treatment can be received.
- **Federal, state, and local governments must develop solutions to address staffing shortages to stop bed closures and bring unstaffed beds back online.** Our survey found that one in seven beds is closed because of staffing shortages. Strategies to recruit and retain staff can include tuition reimbursement programs, reducing the wage gap between state and private hospitals, and improving workplace safety.
- **State and local leaders should ensure that system mapping exercises take into account community inpatient capacity, including state hospital beds.** State hospitals have an important role in the continuum of care for people with SMI, especially those with complex medical comorbidities, developmental disabilities, or histories of violent behavior. State hospital leaders should be considered key stakeholders in state mental health system mapping processes. This may be especially pertinent as many states are currently undergoing redesigns of their mental health system with the implementation of 988, the new number for the suicide prevention lifeline.
- **Local leaders should consider using *dismiss and transfer* procedures for people with SMI who have committed low level, misdemeanor crimes to reduce the competency restoration backlog.** Our survey found that 5,576 people are waiting for a bed for competency restoration across 33 states. Dismiss and transfer is the practice by which criminal charges are dismissed prior to a competency determination or in lieu of competency restoration and held in abeyance while an application for civil commitment is filed in the probate (civil) court. Once a civil commitment order has been issued, the individual is released to an outpatient commitment program for

community treatment and monitoring usually after spending a short time in the hospital for stabilization.

- **The U.S. needs federal oversight or a nationwide system to track the length of stay of NGRI patients and the reasons for extended hospital stays.** NGRI patients often stay in the hospital longer than people with comparable mental health conditions who have been civilly committed and people who are imprisoned for comparable crimes. In addition to protecting the rights of NGRI patients, tracking the reasons for their long hospital stays can help to ensure that NGRI patients who no longer require hospital-level care do not continue to occupy scarce state hospital beds.
- **State government and state psychiatric hospital administrators should collect data on and monitor the number of patients ready for discharge.** Our survey found that 11 states could not report the number of patients ready for discharge because they did not collect that information. Systematic data collection and tracking of the number of patients who cannot be discharged due to a lack of appropriate discharge facilities would help states to have a better understanding of their community's need for step-down and other specialized discharge facilities.

APPENDIX A: Methodology

Treatment Advocacy Center conducted a survey of state officials from April to August 2023 to determine the number and availability of state hospital beds for people with SMI in each state. Official responses were received from representatives in 41 states and the District of Columbia, and information pertaining to the remaining states was gathered from state websites, media articles, preexisting reports, hospital admission staff, or personal contacts living in those states. When information provided by state officials contradicted information available on state websites, the information that was directly provided by state officials is presented.

Thirteen states and the District of Columbia provided official information through a right-to-know request or a Freedom of Information Act request. Only one state, Louisiana, required a $50 payment in order to view the information that we requested about psychiatric beds. For a complete list of sources, please see Table A.1.

When determining bed numbers available for the SMI population, the number of online beds (i.e., fully staffed, not under construction) in each state as of spring/summer 2023 is presented. This bed total represents beds available for adults with SMI and does not include pediatric beds (used for children and adolescents with developmental disabilities) or geriatric beds (used for older adults with dementia or Alzheimer's disease).

Because these bed numbers are meant to provide a representation of state hospital beds available to people with SMI in each state, beds that are exclusive to sex offenders, beds within prisons or those operated by a department of corrections (also called beds behind bars), beds provided through contracts with private organizations, beds in state-operated facilities that are not certified as hospitals, and beds within state-operated facilities that do not provide hospital-level care are not included. For further questions on methodology, please contact ORPA@treatmentadvocacycenter.org.

Table A.1. Data sources for each state

STATE	SOURCE
Alabama	Alabama Department of Mental Health website
Alaska	Alaska Psychiatric Institute
Arizona	Arizona State Hospital public report
Arkansas	Arkansas State Hospital, Arkansas Department of Human Services
California	California Department of State Hospitals public report, public records
Colorado	Colorado Office of Civil and Forensic Mental Health
Connecticut	Connecticut Department of Mental Health and Addiction Services website
Delaware	Delaware Department of Health and Social Services
District of Columbia	District of Columbia Department of Behavioral Health
Florida	Florida Department of Children and Families website
Georgia	Georgia Department of Behavioral Health and Developmental Disabilities open records
Hawaii	Hawaii State Hospital
Idaho	Idaho State Hospital North, Idaho State Hospital South

STATE	SOURCE
Illinois	Illinois Department of Human Services Freedom of Information Act request
Indiana	Indiana Family and Social Services Administration
Iowa	Iowa Department of Health and Human Services
Kansas	Kansas Department for Aging and Disability Services
Kentucky	Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities
Louisiana	Louisiana Department of Health, public records request, $50 paywall
Maine	Maine Department of Health and Human Services Freedom of Information Act request
Maryland	Maryland Department of Health Public Information Act request
Massachusetts	Massachusetts State website
Michigan	Michigan Department of Health and Human Services
Minnesota	Minnesota Department of Human Services
Mississippi	Mississippi Department of Mental Health
Missouri	Missouri Department of Mental Health
Montana	News articles, public report
Nebraska	Nebraska Department of Health and Human Services
Nevada	Nevada Department of Health and Human Services
New Hampshire	New Hampshire Hospital, Department of Health and Human Services right-to-know request
New Jersey	New Jersey Division of Behavioral Health Services, state hospitals
New Mexico	New Mexico Behavioral Health Services Division
New York	New York State Nurses Association public report, Gotham Gazette
North Carolina	North Carolina Department of Health and Human Services public records request
North Dakota	North Dakota State Hospital
Ohio	Ohio Department of Mental Health and Addiction Services
Oklahoma	Oklahoma Department of Mental Health and Substance Abuse Services
Oregon	Oregon State Hospital public records request, personal contact
Pennsylvania	Pennsylvania Office of Mental Health and Substance Abuse Services right-to-know law request
Rhode Island	Personal contact
South Carolina	South Carolina Department of Mental Health
South Dakota	South Dakota Human Services Center
Tennessee	Tennessee Department of Mental Health & Substance Abuse Services
Texas	Texas Health and Human Services open records request
Utah	Utah State Hospital
Vermont	Vermont Department of Mental Health
Virginia	Virginia Department of Behavioral Health and Developmental Services
Washington	Washington State Department of Social and Health Services public records request
West Virginia	West Virginia Department of Health and Human Resources
Wisconsin	Wisconsin Department of Health Services
Wyoming	Wyoming Department of Health

APPENDIX B: Legislation Affecting Deinstitutionalization — 1960s and 1970s

In addition to the creation of increased community programs, several influential legal decisions in the 1960s and 1970s encouraged states and hospitals to discharge as many patients as possible:[57]

- Community mental health clinics: In 1963, President John F. Kennedy signs into law legislation that would provide federal funds for building community mental health clinics, which would serve people previously confined to state hospitals in community settings. In 1965, Congress would pass additional legislation delegating federal funding to staff these community mental health clinics. However, many of the clinics would not go on to serve people with SMI, opting instead to treat patients with less severe symptoms.
- The institutions for mental disease (IMD) exclusion: In 1965, Medicaid passes the IMD exclusion, which prohibits use of Medicaid funds for people in mental institutions. This motivates hospitals to move patients from state hospitals to group homes or nursing homes where the federal government would cover the cost of their care.
- *Lake v. Cameron:* In 1966, the District of Columbia Court of Appeals rules that patients have the right to be released from state hospitals if a less restrictive treatment environment is available.
- *Rouse v. Cameron:* In 1966, the District of Columbia Court of Appeals rules that people who are committed to a mental institution have a right to receive treatment for their illness or be released.
- *Wyatt v. Stickney:* In this 1971 ruling, a federal court in Alabama establishes standards for adequate treatment in state hospitals, including a minimum staff-to-patient ratio. This is an important step toward better care for patients, but it also encourages hospitals to discharge more patients "because a better staff-patient ratio could be achieved less expensively by discharging patients than hiring more staff."[58]
- *Lessard v. Schmidt:* In 1972, a Wisconsin court rules that being a danger to oneself or others is the only justification for involuntary hospitalization.
- Supplementary Security Income (SSI) reform: The 1974 reform of the SSI program says people living in state mental hospitals who would otherwise be eligible for SSI payments are not eligible because they live in a public institution.
- *O'Connor v. Donaldson:* In 1975, a Florida court awards $20,000 to a patient who was kept in the hospital for nearly 15 years without proper treatment. Although this is an important ruling to protect the rights of people who are committed to hospitals, it provides an incentive for hospitals to discharge or refuse to accept patients who have complex and difficult treatment needs.

APPENDIX C:

Table 1. Number of state hospital beds in the U.S., 131-2023

YEAR	NUMBER OF PATIENTS IN PUBLIC PSYCHIATRIC HOSPITALS	RATE PER 100,000 POPULATION
1831	150	1
1840	471	3
1850	3,275	14.1
1860	7,696	24.4
1870	14,605	36.6
1881	36,780	71.4
1896	69,445	110.1
1903	144,653	179.4
1910	180,247	195.1
1923	255,245	228
1931	318,821	257
1940	423,445	320.9
1950	512,501	338.9
1960	535,540	297.6
1970	337,619	165.7
1980	135,134	59.3
1990	92,059	36.9
2000	54,836	18.5
2010	43,318	14.1
2016	37,643	11.7
2023	36,150	10.8

Table 3. Overall and forensic occupancy rates

STATE	STATE HOSPITAL OCCUPANCY RATE	FORENSIC BED OCCUPANCY RATE
Alaska	96%	100%
Arizona	83%	78%
Arkansas	99%	—
Colorado	93%	87%
Connecticut	100%	100%
Georgia	92%	89%
Hawaii	90%	90%
Illinois	89%	97%
Iowa	94%	—
Kentucky	89%	85%
Louisiana	96%	100%
Maryland	98%	—
Michigan	100%	—
Massachusetts	100%	—
Minnesota	85%–93%	—
Mississippi	94%	97%
Nebraska	82%	71%–97%
Nevada	85%	97%
New Mexico	83%	67%
North Carolina	67%	100%
North Dakota	89%	—
Ohio	90%	—
Oklahoma	100%	100%
Oregon	97%	—
Pennsylvania	—	100%
South Carolina	87%	85%
Tennessee	75%	—
Texas	95%	—
Utah	82%	95%
Virginia	86%	—
Washington	80%	78%
West Virginia	100%	100%
Wisconsin	90%	—
Wyoming	67%	82%
	Median occupancy = 90%	**Median occupancy = 96%**

Table 4. Number of psychiatric hospital beds in the U.S.

	NUMBER OF 24-HOUR PSYCHIATRIC INPATIENT BEDS IN 2021[a]	POPULATION IN 2021[b]	NUMBER OF BEDS PER 100,000 PEOPLE	NEED FOR BEDS[c]
Northeast	10,279	57,259,257	18.0	Moderate shortage
Midwest	13,853	68,836,505	20.1	Moderate shortage
South	21,983	127,346,029	17.3	Moderate shortage
West	13,537	78,589,763	17.2	Moderate shortage
National	**60,262**	**332,031,554**	**18.1**	**Moderate shortage**

[a] Data from Substance Abuse and Mental Health Services Administration. (2023). *National substance use and mental health services survey (N-SUMHSS), 2021.* https://www.samhsa.gov/data/sites/default/files/reports/rpt39450/2021%20N-SUMHSS%20Annual%20Detailed%20Tables_508_Compliant_2_8_2023.pdf

[b] Data from United States Census Bureau. (2022). *United states population growth by region.* https://www.census.gov/popclock/data_tables.php?component=growth

[c] Mundt, A. P., Rozas Serri, E., Irarrázaval, M., O'Reilly, R., Allison, S., Bastiampillai, T., Musisi, S., Kagee, A., Golenkov, A., El-Khoury, J., Park, S.-C., Chwastiak, L. & Priebe, S. (2022). Minimum and optimal numbers of psychiatric beds: Expert consensus using a Delphi process. *Molecular Psychiatry*, 27(4), 1873–1879.

Table 5. Forensic bed populations by state[a]

STATE	TOTAL BEDS	DESIGNATED FORENSIC BEDS	% OF ALL BEDS DESIGNATED FORENSIC	FORENSIC CENSUS	% OF ALL BEDS OCCUPIED FORENSIC[b]
Alabama	408	140	34%	140	34%
Alaska	60	10	17%	10	17%
Arizona	259	143	55%	143	55%
Arkansas	186	186	100%	186	100%
California	6,542	3,805	58%	4,522	69%
Colorado	482	22	5%	290	60%
Connecticut	515	229	44%	229	44%
Delaware	124	42	34%	42	34%
District of Columbia	240	133	55%	133	55%
Florida	2,522	1,108	44%	1,108	44%
Georgia	1055	641	61%	662	63%
Hawaii	297	297	100%	273c	92%
Idaho	170	0	0%	72	42%
Illinois	1,359	865	64%	952	70%
Indiana	815	192d	24%	266	33%
Iowa	64	0	0%	Unknowne	Unknown
Kansas	304	94	31%	104	34%
Kentucky	410	40	10%	40	10%
Louisiana	689	239	35%	239	35%
Maine	159	0	0%	NAf	NA
Maryland	946	0	0%	946g	100%
Massachusetts	664	0	0%	81	12%
Michigan	558	0	0%	223	40%
Minnesota	192	0h	0%	0i	0%

STATE	TOTAL BEDS	DESIGNATED FORENSIC BEDS	% OF ALL BEDS DESIGNATED FORENSIC	FORENSIC CENSUS	% OF ALL BEDS OCCUPIED FORENSIC[b]
Mississippi	366	62	17%	78	21%
Missouri	890	890	100%	890	100%
Montana	174	54	31%	54	31%
Nebraska	194	112	58%	112	58%
Nevada	287	199	69%	199	69%
New Hampshire	154	0	0%	30	19%
New Jersey	1,555	200	13%	450	29%
New Mexico	137	88	64%	88	64%
New York	3,300	757	23%	757	23%
North Carolina	453	82	18%	191	42%
North Dakota	57	0	0%	8	14%
Ohio	1,126	0	0%	890	79%
Oklahoma	376	200	53%	200	53%
Oregon	704	0	0%	654	93%
Pennsylvania	1,348	359	26%	359	26%
Rhode Island	126	54	43%	54	43%
South Carolina	423	213	50%	213	50%
South Dakota	67	15	22%	26	39%
Tennessee	550	0	0%	83	15%
Texas	1,509	0	0%	939	62%
Utah	246	124	50%	126	51%
Vermont	16	0	0%	4	25%
Virginia	1,241	111	9%	840	68%
Washington	1,034	603	58%	603	58%
West Virginia	300	0	0%	75	25%
Wisconsin	450	450	100%	322	72%
Wyoming	72	32	44%	42	58%
United States	36,150	12,599	35%	18,948	52%

[a] See methodology for details on data collection.

[b] Because not all states provided or tracked the number of forensic patients occupying state hospital beds, these estimates are likely an undercounting and can be interpreted as a conservative estimate of the number of forensic patients in state hospitals.

[c] Hawaii has several civil patients occupying forensic beds.

[d] As a network, Indiana does not designate beds for civil and forensic patients but has one hospital that typically only admits forensic patients.

[e] Iowa state hospitals do have forensic patients but do not track their forensic census.

[f] Maine state hospitals do have patients who are committed through the criminal system but patients are not classified as "forensic" and "civil" once admitted to the hospital.

[g] More than 99 percent of patients in Maryland state hospitals are committed through the criminal legal system, but it does have civil patients occasionally as well.

[h] Minnesota also operates a Forensic Mental Health Program, a supervised living facility that is not licensed as a hospital and thus not included in these counts. However, patients there receive substantially the same care as they do in licensed hospitals. This facility has 359 staffed beds.

[i] Minnesota does not distinguish between civil and forensic beds/patients as all commitments happen within the civil court system, regardless of the reason for commitment.

Table 6. Percentage of beds occupied by NGRI patients

STATE	PERCENTAGE OF ALL BEDS OCCUPIED BY NGRI PATIENTS	PERCENTAGE OF FORENSIC BEDS OCCUPIED BY NGRI PATIENTS
Alaska	0%	0%
Arizona	38%	69%
Arkansas	32%	32%
California	20%	29%
Colorado	27%	46%
Delaware	4%	12%
Georgia	10%	16%
Hawaii	53%	57%
Idaho	0%	0%
Illinois	25%	36%
Kansas	2%	5%
Kentucky	0%	0%
Louisiana	27%	77%
Michigan	37%	91%
Mississippi	4%	21%
Nebraska	18%	31%
Nevada	1%	2%
New Hampshire	3%	17%
New Mexico	0%	0%
North Carolina	13%	30%
North Dakota	9%	63%
Ohio	19%	24%
Oklahoma	27%	50%
Oregon	37%	40%
Pennsylvania	< 1%	< 1%
South Carolina	9%	19%
South Dakota	16%	42%
Tennessee	10%	67%
Texas	20%	33%
Utah	3%	6%
Vermont	0%	0%
Virginia	23%	35%
West Virginia	3%	12%
Wisconsin	47%	66%
Wyoming	21%	36%

Note: NGRI = not guilty by reason of insanity.

Table 7. Forensic waiting lists

STATE	NUMBER OF PEOPLE ON FORENSIC WAIT LIST	FORENSIC WAIT LIST PER 100,000 POPULATION	LENGTH OF TIME ON WAIT LIST (DAYS)
Alaska	35	4.8	135
Arizona	0	0.0	0
Arkansas	77	2.5	Not tracked
Colorado	448	7.7	96
Delaware	4	0.4	Not tracked
Georgia	409	3.7	156
Hawaii	0	0.0	0
Illinois	129	1.0	58
Kentucky	296	6.6	14 to 28 for outpatient evaluations, 120 to 180 for inpatient restoration, 300 to 360 for inpatient evaluations
Louisiana	153	3.3	180
Maine	6	0.4	17
Maryland	129	2.1	30
Michigan	200	2.0	92
Minnesota	49	0.9	—
Mississippi	70	2.4	287
Nebraska	57	2.9	60
Nevada	140	4.4	105
New Mexico	0	0.0	0
North Carolina	197	1.8	149
North Dakota	5	0.6	7
Ohio	78	0.7	30
Oklahoma	0	0.0	0
Oregon	52	1.2	32
Pennsylvania	110	0.8	30
South Carolina	107	2.0	75.5
South Dakota	12	1.3	—
Tennessee	150	2.1	60
Texas	2,422	8.1	444
Utah	2	0.1	13
Virginia	40	0.5	7
Washington	110	1.4	—
West Virginia	17	1.0	37.5
Wyoming	72	12.4	203

Table 8. State hospital bed population by legal status

STATE	TOTAL BEDS PER 100,000	TOTAL BEDS — RANK AMONG THE STATES	CIVIL BEDS PER 100,000	% OF BEDS OCCUPIED BY CIVIL PATIENTS	% OF BEDS OCCUPIED BY CIVIL PATIENTS — RANK AMONG THE STATES
Alabama	8	36	5.3	66%	17
Alaska	8.2	35	6.8	83%	5
Arizona	3.5	48	1.6	45%	29
Arkansas	6.1	44	0	0%	48
California	16.8	6	5.2	31%	39
Colorado	8.3	34	3.3	40%	34
Connecticut	14.2	13	7.9	56%	24
Delaware	12.2	17	8.1	66%	15
District of Columbia	35.7	1	15.9	45%	30
Florida	11.3	21	6.4	56%	25
Georgia	9.7	27	3.6	37%	36
Hawaii	20.6	2	1.7	8%	44
Idaho	8.8	33	5.1	58%	21
Illinois	10.8	23	3.2	30%	41
Indiana	11.9	18	8	67%	14
Iowa	2	51	Unknown	Unknown	Unknown
Kansas	10.4	25	6.8	66%	16
Kentucky	9.1	31	8.2	90%	1
Louisiana	15	10	9.8	65%	18
Maine	11.5	20	NA	NA	NA
Maryland	15.3	9	0	0%	46
Massachusetts	9.5	29	8.4	88%	2
Michigan	5.6	45	2.7	60%	20
Minnesota	3.4	49	3.4	100%a	—
Mississippi	12.4	15	9.8	79%	7
Missouri	14.4	11	0	0%	48
Montana	15.5	8	10.7	69%	13
Nebraska	9.9	26	4.2	42%	31
Nevada	9	32	2.8	31%	40
New Hampshire	11	22	8.9	81%	6
New Jersey	16.8	4	11.9	71%	12
New Mexico	6.5	43	2.3	36%	37
New York	16.8	5	12.9	77%	8
North Carolina	4.2	47	2.4	58%	22
North Dakota	7.3	41	6.3	86%	3
Ohio	9.6	28	2	21%	43
Oklahoma	9.4	30	4.4	47%	28
Oregon	16.6	7	1.2	7%	45
Pennsylvania	10.7	24	7.9	74%	11

STATE	TOTAL BEDS PER 100,000	TOTAL BEDS — RANK AMONG THE STATES	CIVIL BEDS PER 100,000	% OF BEDS OCCUPIED BY CIVIL PATIENTS	% OF BEDS OCCUPIED BY CIVIL PATIENTS — RANK AMONG THE STATES
Rhode Island	11.5	19	6.6	57%	23
South Carolina	8	37	4	50%	26
South Dakota	7.4	40	4.5	61%	19
Tennessee	7.8	38	6.6	85%	4
Texas	5	46	1.9	38%	35
Utah	7.3	42	3.5	49%	27
Vermont	2.5	50	1.9	75%	9
Virginia	14.3	12	4.6	32%	38
Washington	13.3	14	5.5	42%	32
West Virginia	16.9	3	12.7	75%	10
Wisconsin	7.6	39	2.2	28%	42
Wyoming	12.4	16	5.2	42%	33
United States	**10.8**	**—**	**5.2**	**48%**	**—**

Note: NA = Not applicable.

[a] All patients in Minnesota are deemed civil patients once they are committed to the state hospital.

Table 9. Number of patients ready for discharge

STATE	NUMBER READY FOR DISCHARGE	PERCENTAGE OF BEDS OCCUPIED BY PATIENTS READY FOR DISCHARGE	BEDS OCCUPIED BY PATIENTS READY FOR DISCHARGE PER 100,000 POPULATION
Alaska	20	33%	2.7
Arizona	5	2%	0.1
Arkansas	61	33%	2.0
Colorado	84	17%	1.4
Delaware	26	21%	2.6
Georgia	State has no records relating to this information	—	—
Hawaii	39	13%	2.7
Illinois	State does not track this information	—	—
Kentucky	0	0%	0.0
Louisiana	15	2%	0.3
Maine	State does not track this information	—	—
Maryland	161	17%	2.6
Massachusetts	81	12%	1.2
Michigan	100	18%	1.0
Minnesota	45	23%	0.8
Mississippi	0	0%	0.0
Nevada	State does not track this information	—	—
New Hampshire	State does not track this information but told us there are “several” patients ready for discharge	—	—
New Jersey	50	3%	0.5
New Mexico	0	0%	0.0
North Carolina	173	38%	1.6
North Dakota	32	56%	4.1
Ohio	State has no documentation relating to this information	—	—
Oklahoma	0	0%	0.0
Oregon	120	17%	2.8
Pennsylvania	State did not provide a specific number but described discharge process	—	—
South Carolina	37	9%	0.7
South Dakota	23	34%	2.5
Tennessee	State did not provide a specific number but described discharge process	—	—
Texas	377	25%	1.3
Utah	58	24%	1.7

STATE	NUMBER READY FOR DISCHARGE	PERCENTAGE OF BEDS OCCUPIED BY PATIENTS READY FOR DISCHARGE	BEDS OCCUPIED BY PATIENTS READY FOR DISCHARGE PER 100,000 POPULATION
Vermont	State has no records relating to this information	—	—
Virginia	152	14%	1.8
Wisconsin	35	8%	0.6
Wyoming	25	35%	4.3
Ohio	9.6	28	2
Oklahoma	9.4	30	4.4
Oregon	16.6	7	1.2
Pennsylvania	10.7	24	7.9

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