Published in final edited form as:
JAMA Psychiatry. 2013 November ; 70(11): 1127–1128. doi:10.1001/jamapsychiatry.2013.2824.

Bus Therapy:

A Problematic Practice in Psychiatry

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Crossing state lines, a man arrives alone in San Francisco, having traveled by bus on a 1-way ticket provided by a psychiatric hospital in his home state. He is disoriented,with few possessions,lacks medications and medical records, and calls 911 as he was instructed. He is brought to the county psychiatric emergency service, which,hectic and often over capacity,treats nearly 6000 patients annually (of which 39% are not San Francisco residents).The patient needs housing,a psychiatrist,case manager, primary care provider, and transfer of Medicaid or general assistance—a package known colloquially asthe*San Francisco Special*.Placements are challenging— the county hospital reduced its acute inpatient psychiatrycapacity50% in thelast 5years owing to budget short-falls—yet out-of-state visitors are not turned away.

Shipping patients across state lines on 1-way bus fares without a treatment plan or identified residence is referred to as *bus therapy*, a form of patient dumping. In April 2013, the *Sacramento Bee* reported that more than 1500 mentally ill and questionably discharged patients from Nevada were transported by Greyhound bus to states across the country in the past 5 years.[1] One-third were sent to California—San Francisco and Los Angeles counties initiated formal investigations.

Patient dumping is not new. In the 1970s, with US mental health deinstitutionalization, psychiatric beds were reduced, uninsured patients were often turned away, and more patients sought emergency care. The 1986 Emergency Medical Treatment and Active Labor Act was intended to reduce patient dumping, by requiring emergency departments to screen and stabilize presenting patients (a subjective process). With continued reductions in inpatient capacity (4000 acute beds reduced nationally between 2010-2012), the impact on emergency services is expected to grow.[2]

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Conflict of Interest Disclosures:
None reported.

People with mental illness have the right to relocate willingly and preferably when in stable condition and with facilitated continuity of care.On the other hand,patient dumping has many implications for psychiatric patients, especially the severely mentally ill. Obvious ones are potential harms owing to decompensation,poor self-care, loss of support networks, vulnerability to victimization, and/or failure to access care. In 2009, 40% of adults with serious mental illness went untreated.[3]

Lack of Resources and Burnout

Although mental health funding has increased with gross domestic product increases, funding has fallen as a share of overall health expenditures[4]: 11% in 1970 to 5% in 2006. Between 2009-2012, 29 states and Washington, DC, were affected by cuts to non-Medicaid state mental health spending (Table), totaling nearly $1.6 billionincommunity/hospital-basedpsychiatriccare,housing, and pharmacotherapy. With one of the highest suicide rates and greatest proportions of residents with poor mental health, Nevada already was in the lowest quartile of per capita mental health funding and ranked 5th for largest percentage cut[2] (28%) from 2009-2012. Another stressor to states, federal stimulus funds that temporarily increased the federal match for Medicaid expired in 2011, resulting in a projected $14 billion loss for state Medicaid programs.

The Affordable Care Act(ACA)includes coverage for 32 million individuals currently without mental health or addiction treatment benefits. However, states may opt outof ACA's Medicaid expansions,which would leave individuals below the poverty line uninsured.[5] In 2009, 25% of people with mental illness were uninsured and 30% were living in poverty.[3]

For those with insurance under ACA, there is the risk that in an already understaffed field, there will be more demand for mental health providers,causing crowd out.[5] Patient dumping across state lines is anticipated to compound the issue and deplete recipient states' resources, leading to worse care for native patients. Increasing demand for providers can contribute to staff burn out, especially with readmissions, which are common in psychiatry: 13% at 90 days and 44% at 1 year.[6]

Opening a Dialogue

As the country undergoes changes to health care guidelines and spending,the timing is pivotal for reducing practices such as patient dumping. An initial step toward solutions is increasing awareness and opening a dialogue among providers,funding agencies, and Congress. Areas to address include resource allocation, transitional interventions, and innovative proven methods of health care delivery. Punitive threats to resources would emphasize consequences, yet largely fail to address the root causes of patient dumping and may exacerbate the problem. A recent example is notification by the Centers for Medicare and Medicaid Services to Nevada health officials that, owing to "serious deficiencies," the state's primary psychiatric hospital "may be subject to termination of its Medicare provider agreement."[1] Instead, a key solution would be increasing mental health budgets (or at least reducing cuts described). Special attention also is needed for mental health as a parity diagnosis. Next, transitional interventions shown to reduce read missions include predischarge and postdischarge education, structured needs assessment, medication

reconciliation/education, transition managers, and provider communication.[6] The Joint Commission's psychiatric measurement set now includes"postdischargecontinuing care plan transmitted to next level of care provider upon discharge."[7] Use of transitional interventions with this measure, if tied to accreditation/resource allocation, could motivate providers toward better discharge planning. Furthermore, innovative treatment delivery is a targetable area. Allocating funds to intensive case management programs, telehealth for underserved areas, and group-oriented programs could serve larger populations efficiently. These types of interventions may reduce provider burnout,increase patient support and community connections, and address the shortage of providers. These options are only a few known to providers that would be useful in initiating discussions to address mental health needs in the changing landscape.

The Nevada example highlights a problem that has reached sizeable proportions. Providers and organizations engage in other smaller forms of dumping regularly: examples include incomplete care, inadequate screening/stabilization,and poor discharge planning.Frustrations arise in an overworked and burnt-out field facing major cuts infunding. Dumping is not justifiable,and the determinants of dumping are evident.During this time of change in health care overall,special attention to mental health may mitigate the causes of practices such as bus therapy. A greater dialogue could help address the core issues to be a stimulus for change and not just a headline.

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Table

State Mental Health Budget Cuts FY2009-FY2012[a,b]

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State	Per Capita Spending 2010	FY2009 (Millions)	FY2012 (Millions)	Absolute Change (Millions)	Change, %
South Carolina	60.24	187.30	113.70	–73.60	–39.30
Alabama	77.89	100.30	64.20	–36.10	–36.00
Alaska	289.71	125.60	84.70	–40.90	–32.60
Illinois	85.30	590.70	403.70	–187.00	–31.70
Nevada	64.00	175.50	126.20	–49.30	–28.10
District of Columbia	388.83	212.40	161.60	–50.80	–23.90
California	157.62	3612.80	2848.00	–764.80	–21.20
Idaho	44.00	57.10	46.90	–10.20	–17.90
Kansas	130.24	115.40	101.10	–14.30	–12.40
Mississippi	108.96	262.50	235.30	–27.20	–10.40
Virginia	93.81	424.30	386.60	–37.70	–8.90
Massachusetts	114.57	685.40	629.80	–55.60	–8.10
Colorado	86.83	124.70	115.00	–9.70	–7.80
Missouri	86.15	310.70	289.50	–21.20	–6.80
Utah	64.01	91.40	85.30	–6.10	–6.70
Oklahoma	56.56	194.50	183.10	–11.40	–5.90
Montana	159.35	65.00	61.20	–3.80	–5.80
New York	241.59	3775.40	3570.50	–204.90	–5.40
Ohio	74.26	511.90	485.90	–26.00	–5.10
Hawaii	212.15	181.40	172.70	–8.70	–4.80
Delaware	109.13	78.60	76.00	–2.60	–3.30
Indiana	87.65	249.90	245.60	–4.30	–1.70
New Hampshire	138.17	104.00	102.70	–1.30	–1.30
North Carolina	174.66	615.30	608.00	–7.30	–1.20
Pennsylvania	270.67	723.20	717.20	–6.00	–0.80
Nebraska	73.61	108.70	108.20	–0.50	–0.50
Louisiana	71.80	415.60	414.10	–1.50	–0.40
Washington	115.23	444.40	443.10	–1.30	–0.30
Kentucky	55.06	177.20	177.10	–0.10	–0.10

Abbreviation: FY, fiscal year.

[a] Percentage change, high to low.[2]

[b] Twenty-eight states and the District of Columbia had mental health budget cuts from FY2009 to FY2012. Nevada had the 5th largest percentage cut from its budget. Nevada is also in the lowest quartile of per capita mental health budgets. California ranked 7th for percentage cuts and 2nd for absolute change. In the states with the largest reductions, about one-third of their mental health budgets decreased during a 3-year period.