Community-Based Treatment for Complex Psychiatric Problems:

Opportunities for Innovation in Intermediate Levels of Care

MindWork Group

Disclosures

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No financial disclosures

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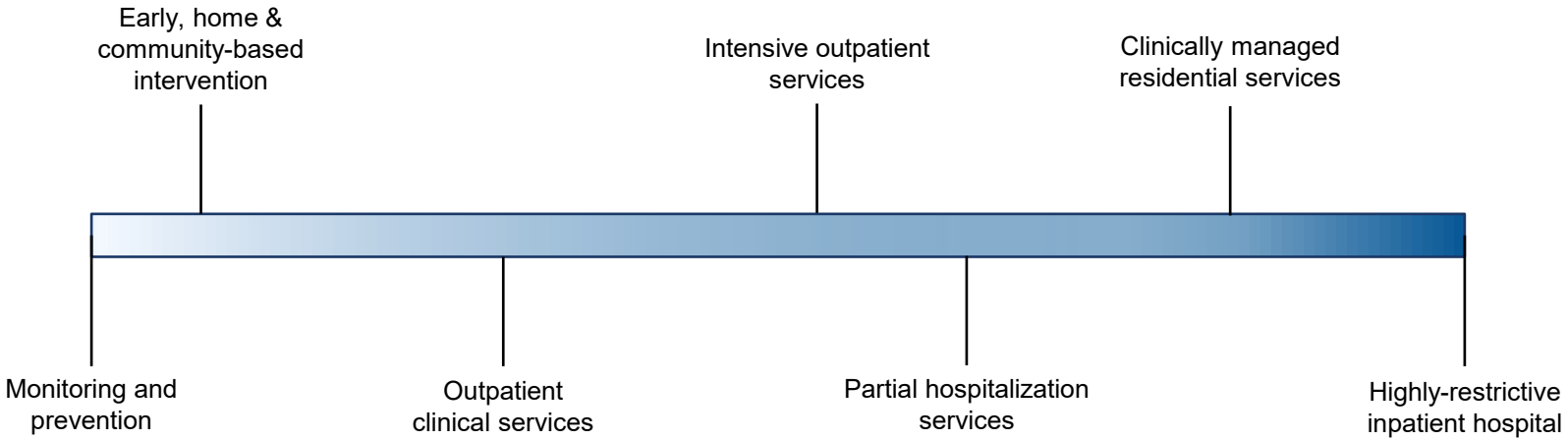
No financial disclosures

Continuum of Psychiatric Care



Premise

Observations:

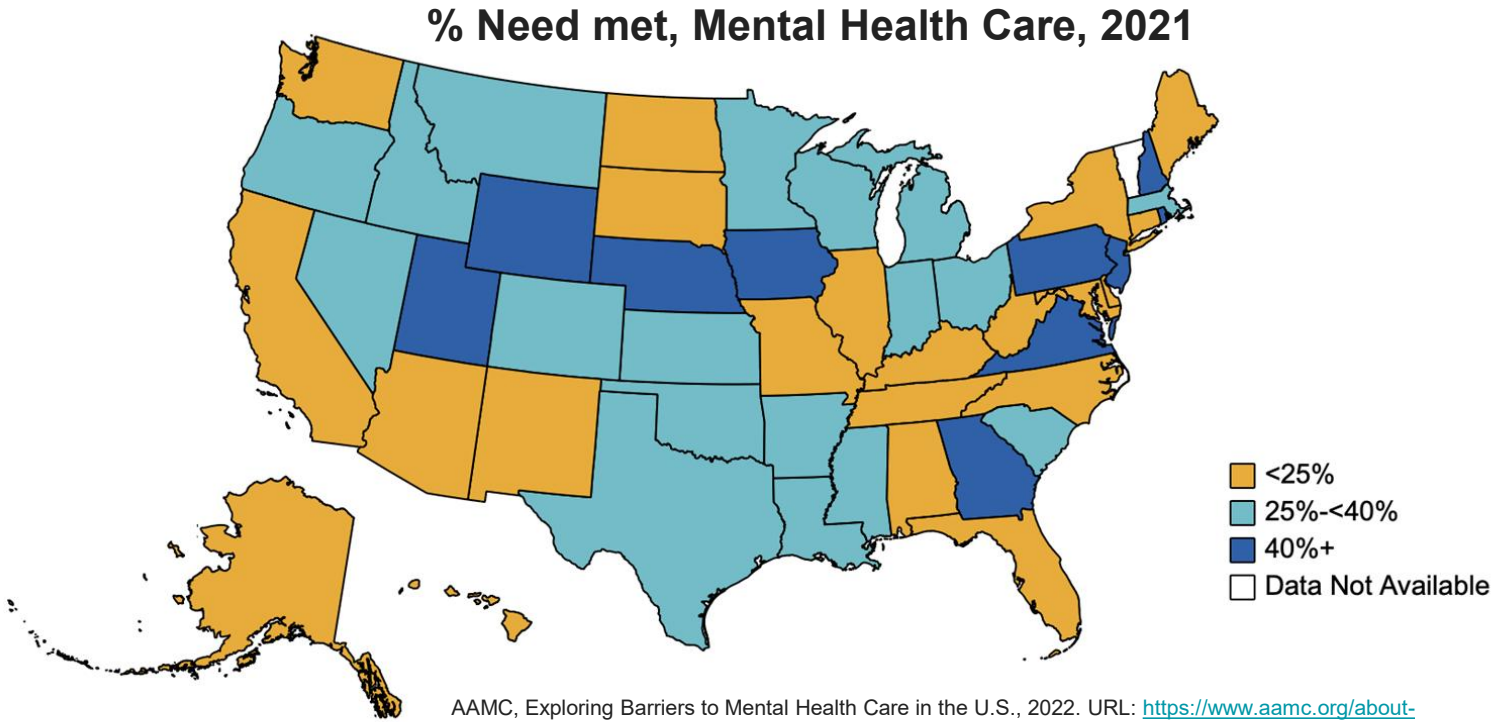
1. The ends of the psychiatric continuum of care are fraying.

1. Delivery of psychiatric services is often dis-integrated and removed from the community context.

Proposals:

1. Opportunities exist in the continuum's middle ground to deliver excellent, integrated psychiatric care in a community setting.
2. This can be a driver for nimble innovation.

Background



AAMC, Exploring Barriers to Mental Health Care in the U.S., 2022. URL: https://www.aamc.org/about-us/mission-areas/health-care/exploring-barriers-mental-health-care-us#:~:text=No%20Insurance%20Accepted,similar%20for%20Medicare%20and%20Medicaid.

Background

Recommended bed capacity per 100,000 residents

Optimal	Minimal
60	30

Mundt AP, Rozas Serri E, Irarrázaval M, O'Reilly R, Allison S, Bastiampillai T, Musisi S, Kagee A, Golenkov A, El-Khoury J, Park SC. Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process. Molecular Psychiatry. 2022 Apr;27(4):1873-9.

Maryland, inpatient psychiatric beds per 100,000 residents

2010	2018	2020
36	34.6	21.3

Maryland Health Care Commission, State Health Plan for Facilities and Services: Acute Psychiatric Services, 2021. URL: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_comar_10_24_21_20210809.pdf

Maryland Health Care Commission. URL: https://mhcc.maryland.gov/mhcc/pages/apcd/apcd/apcd.aspx

Background

Inpatient LOS at a single academic medical center

2005[1]	2017[2]	2019[3]
23.8	9	7.4

Short LOS-associated outcomes

-Lower global functioning, lower work functioning [1]
-Greater depressive symptoms [1]
-Increased readmission risk [2]
-LOS <7 days associated with increased suicide risk [2]
-LOS <14 days associated with increased suicide risk [2]

[1] Megna, J.L., Aneja, A., Sauro, M., Ahmad, N., Simionescu, M., Mustata, G., Rojas, M.H. and Wade, M., 2015. Awareness of treatment needs and length of stay amongst psychiatric inpatients. *Comprehensive psychiatry*, *63*, pp.65-70.

[2] Leontieva, L., Golovko, S., Adhlakha, A., Polinkovsky, L. and Harris, C., 2017. Attention, concentration and planning ability improvement in response to depression treatment during acute psychiatric hospitalization. *Clinical Depression*, *3*(02), pp.2572-0791.

[3] Shah, B., Leontieva, L. and Megna, J.L., 2020. Shifting trends in admission patterns of an acute inpatient psychiatric unit in the state of New York. *Cureus*, *12*(7).

[1] Lieberman, P.B., Wiitala, S.A., Elliott, B., McCormick, S. and Goyette, S.B., 1998. Decreasing length of stay: are there effects on outcomes of psychiatric hospitalization?. *American Journal of Psychiatry*, *155*(7), pp.905-909.

[2] Oh, H., Lee, J., Kim, S., Rufino, K.A., Fonagy, P., Oldham, J.M., Schanzer, B. and Patriquin, M.A., 2020. Time in treatment: Examining mental illness trajectories across inpatient psychiatric treatment. *Journal of psychiatric research*, *130*, pp.22-30.

Background

Abundant evidence has identified strain on outpatient psychiatric care, with evidence of increasing fragility.

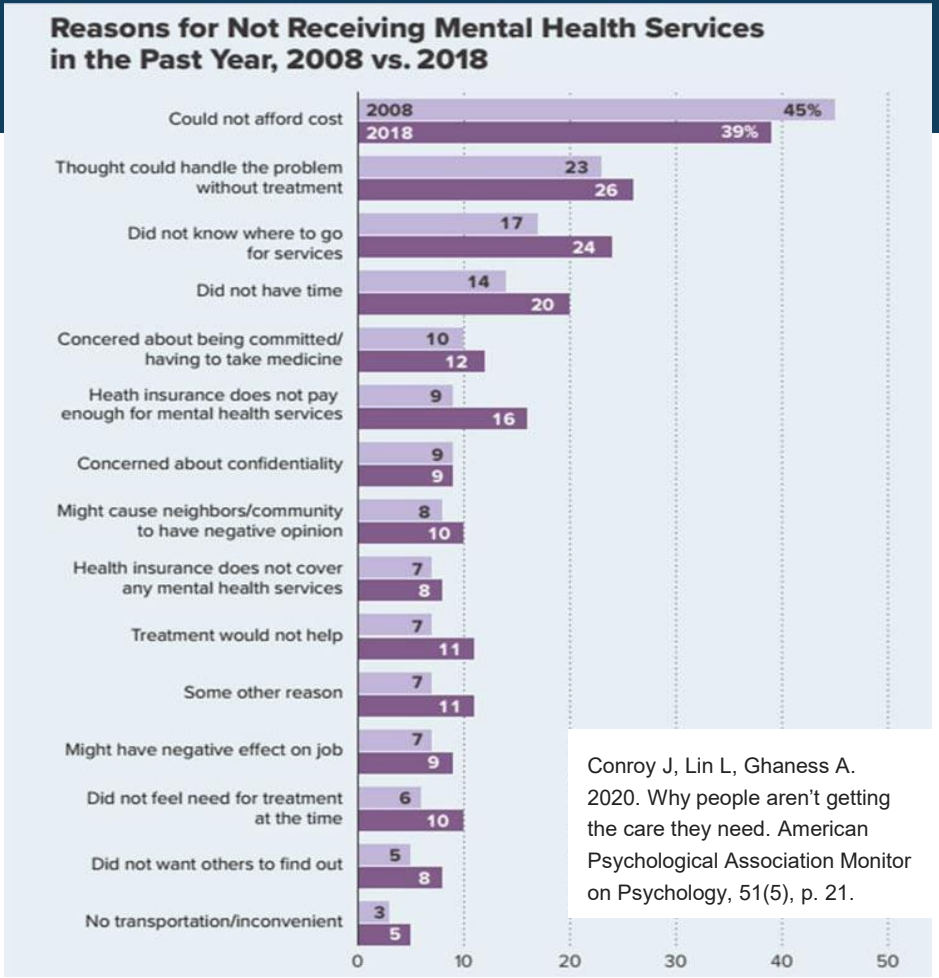
Flores, M.W., 2025. Financial strain on and systemic barriers in mental health treatment. *Psychiatric Services*, *76*(2), pp.109-109.

Gao, Y.N. and Olfson, M., 2025. High out-of-pocket cost burden of mental health care for adult outpatients in the United States. *Psychiatric Services*, *76*(2), pp.200-203.

Haizelden, J., Kim, N. and Payne, M., 2025. Factors Associated with Mental Health Service Utilization, Perceived Unmet Need, and Barriers to Treatment Among US Adults with Disabilities. *American Journal of Health Education*, pp.1-13.

Schneeberger, A.R. and Huber, C.G., 2022. Crisis within a crisis–the fragility of acute psychiatric care delivery. *World Psychiatry*, *21*(2), p.245.

Mongelli, F., Georgakopoulos, P. and Pato, M.T., 2020. Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus*, *18*(1), pp.16-24.



Conroy J, Lin L, Ghaness A. 2020. Why people aren't getting the care they need. American Psychological Association Monitor on Psychology, 51(5), p. 21.

A feasible model of community-based treatment

Aim 1: To develop a feasible, longitudinal intensive treatment program integrated into an outpatient multidisciplinary practice.

Aim 2: To create a learning system driving improvement of the model on a programmatic and individual patient basis.

Aim 3: To robustly study the model in collaboration with like-minded programs and establish best practices.



A feasible model of community-based treatment

9-10 patients maximum

- 4 week minimum commitment
- 5-6 month average length of stay
- Bespoke, personalized treatment experience

Supportive housing available

Other services available

- Transcranial Magnetic Stimulation (TMS)
- Neuropsychological testing
- Laboratory services

Multidisciplinary team of experts

- 4 psychiatrists
- family, art, occupational, and recreational therapies

Evidence based & measurement informed

~20 treatment hours/week

- 15 hours of group therapy
- 5-7 hours of individual sessions

Foundational Principles

- Education - developing a model of one's mind
- Community - community as a clinical tool to understand relationships
- Practice - gradual transition, re-entry, and (re)habilitation

OUTCOMES

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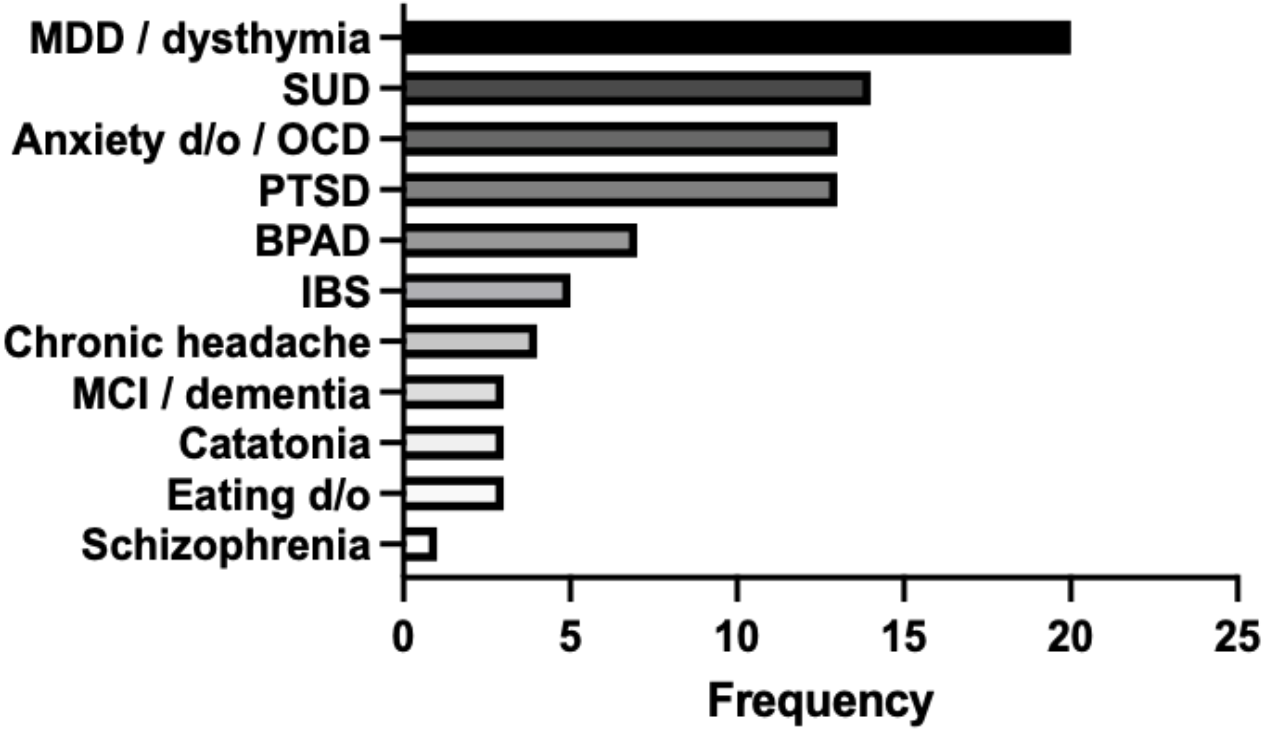
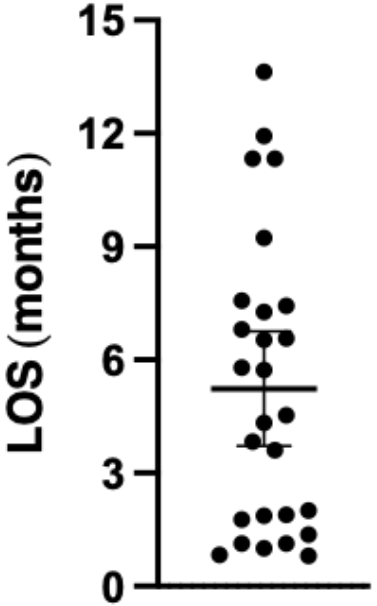
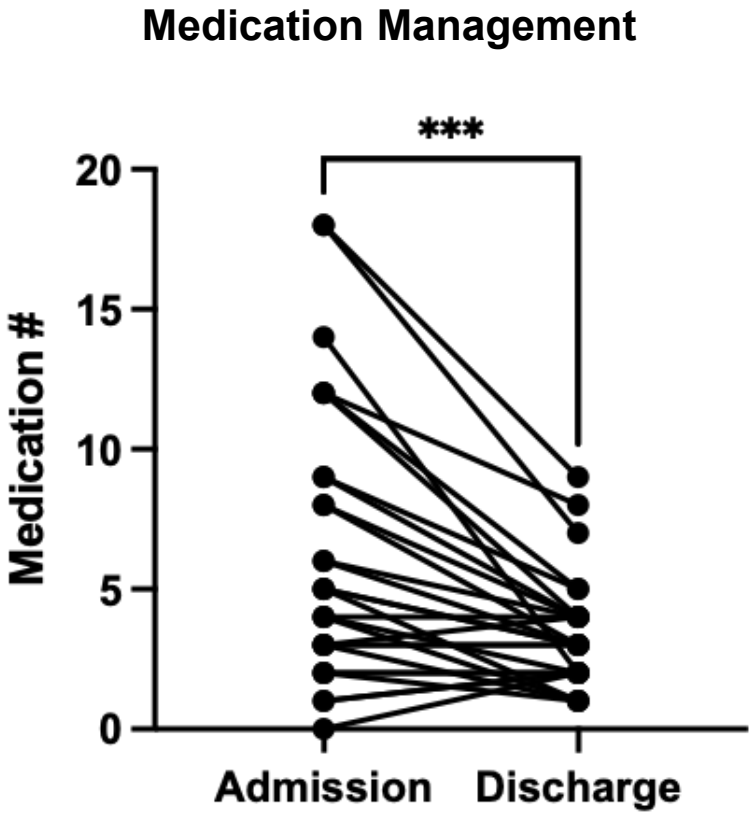
Reasons for referral & LOS



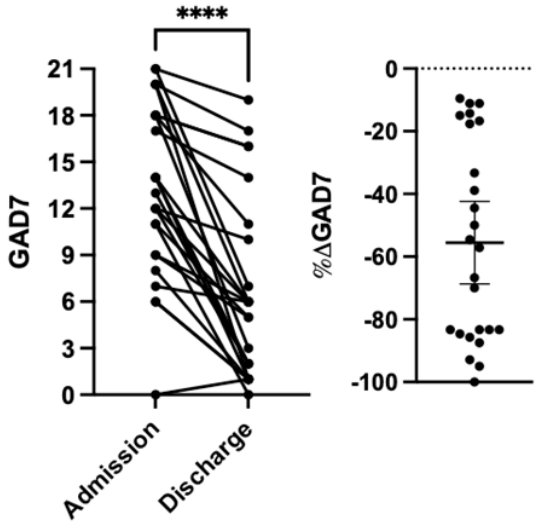


Outcomes at discharge

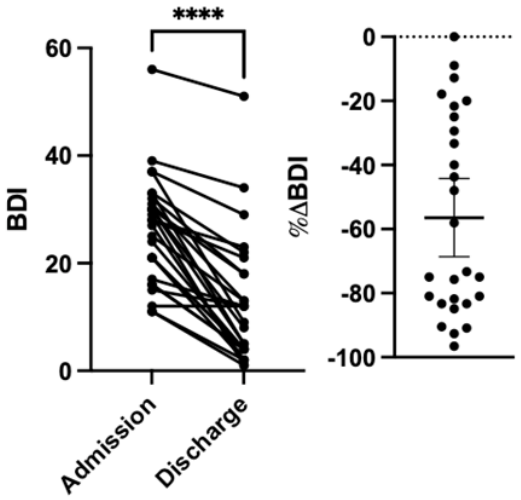


Outcomes at discharge

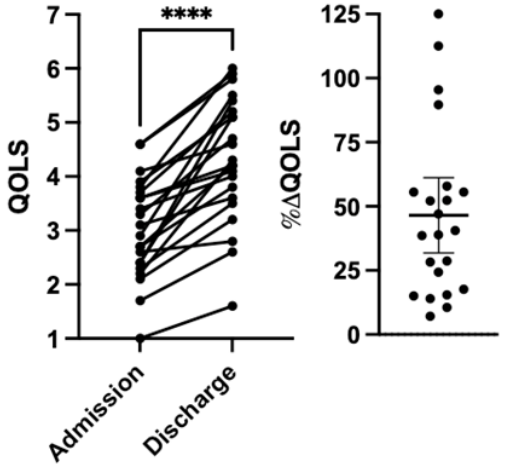
Anxiety



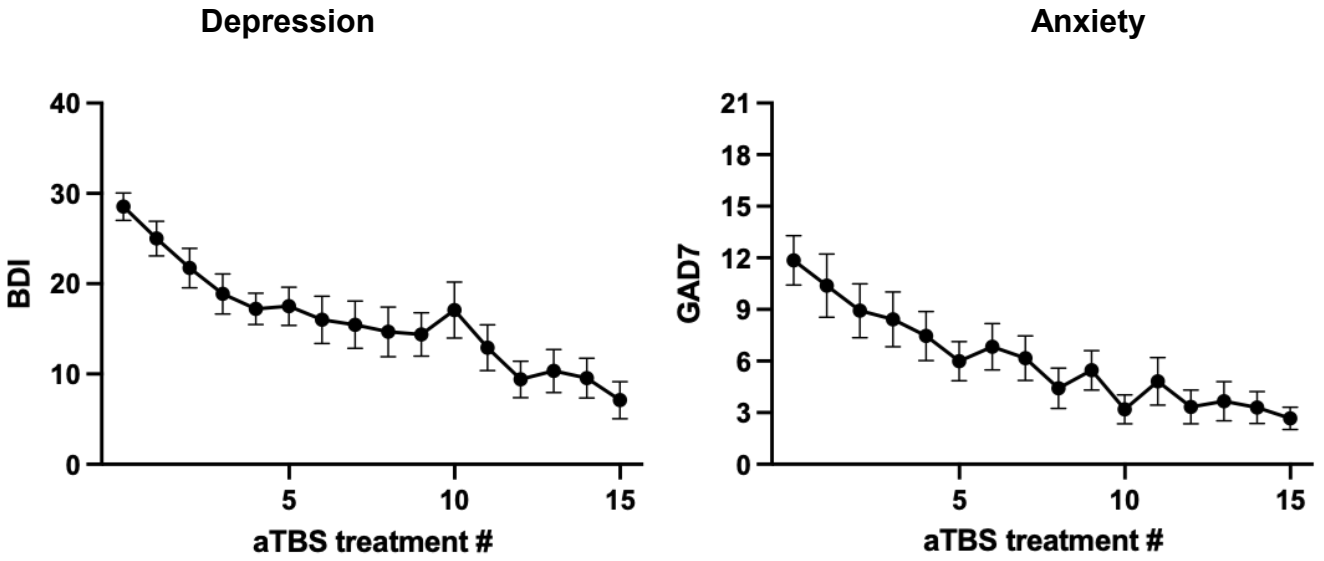
Depression



Quality of Life



Innovation - Transcranial Magnetic Stimulation (TMS)



aTBS protocol adapted from: Ramos MR et al. Accelerated theta-burst stimulation for treatment-resistant depression: A randomized clinical trial. JAMA psychiatry. 2025 May 1;82(5):442-50.

Measurement informed care - representative cases

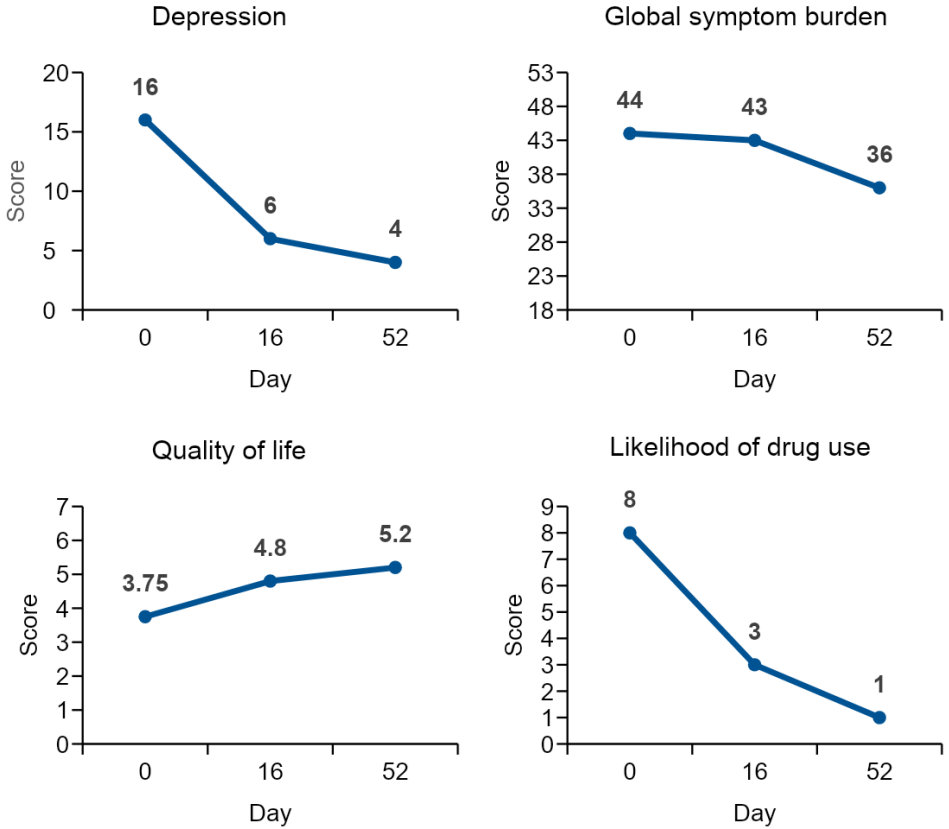
-Graduate student with a history of difficulties around individuation and establishing agency.

-High achieving in course work, but struggled tremendously beyond the first year in the absence of structure and concrete instruction.

-Diagnosed with ADHD and prescribed multiple stimulants. Also prescribed cannabis for anxiety.

-Stimulant and cannabis dependence followed, then polysubstance abuse.

-Became depressed and dropped out of school, ultimately resulting in referral for IOP-level treatment.



Measurement informed care - representative cases

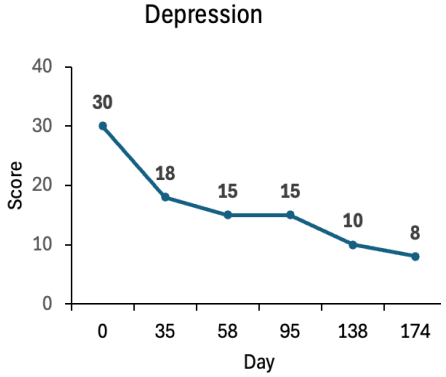
-Middle-aged pastor with a history of MDD.

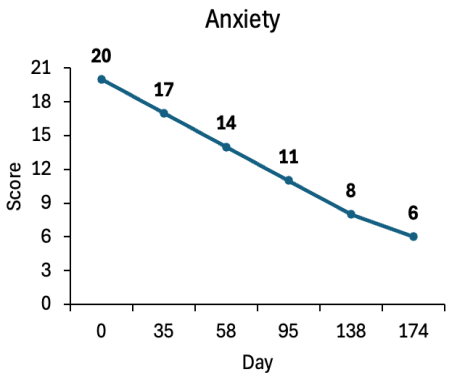
-Developed worsening anxiety and difficulty falling asleep in the context of work stressors.

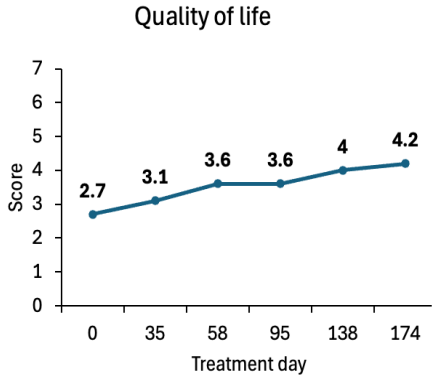
-Abandoned 1st line treatments after being prescribed cannabis, with rapidly escalating use.

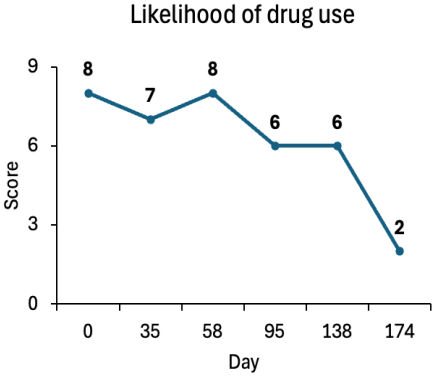
-Then prescribed steroids for an inflammatory skin condition, with worsening insomnia, anxiety, and recurrence of depression.

-Prescribed 3 additional cannabis products with onset of psychotic symptoms and cognitive impairment, ultimately resulting in referral for IOP-level treatment.









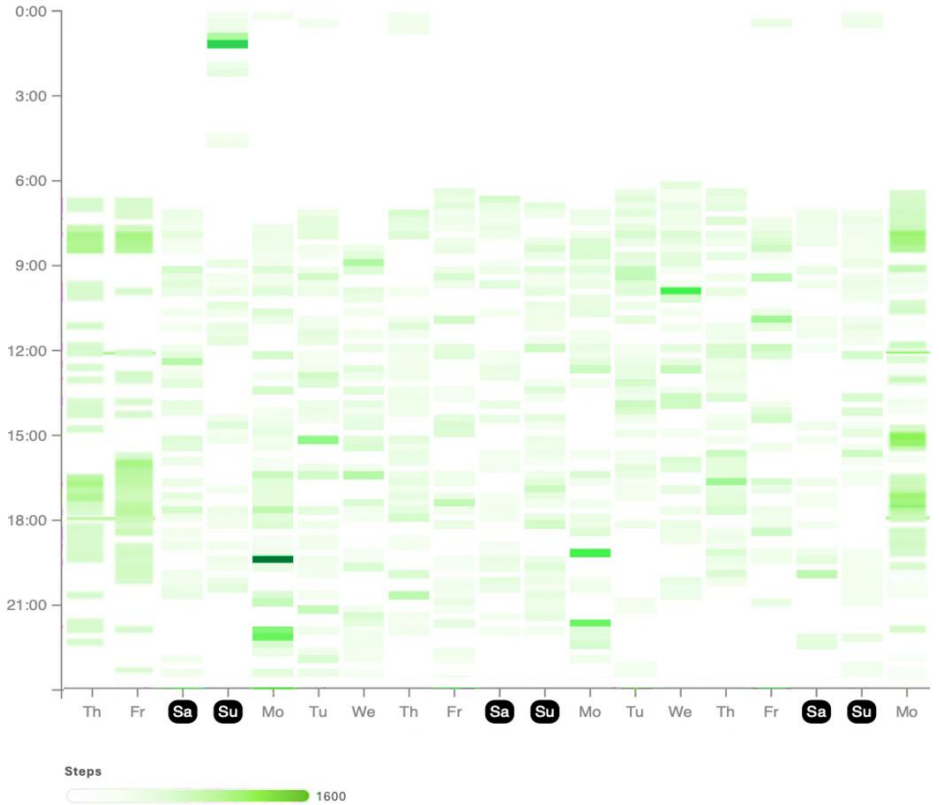
Measurement informed care - representative cases

-University instructor with a history of Bipolar Disorder and PTSD.

-Long history of mood episodes and worsening PTSD symptoms triggered or exacerbated by factors often largely out of awareness.

-Likewise, long history of sporadic medication non-adherence that the patient attributed to absentmindedness.

-At the same time, professionally capable of highly detailed work and complex analyses.



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Final Thoughts

- Intensive treatment for complex patients in a community-based private practice setting is feasible
- The model successfully integrates
  - Intimate, multidisciplinary treatment
  - Coordination of care for severe and complex cases
  - A measurement-informed approach
  - Nimble innovation within a learning health system
- Study, validation, and outcome-informed improvement of this model are areas of ongoing pursuits

