array

2026 REPORT

The Behavioral Health Reality Gap

This report examines why health systems struggle to deploy capacity to patients and how that impacts care.

Executive Summary

A critical disconnect threatens the stability of behavioral health care.

Eighty-three percent of hospital and health system leaders believe their behavioral health models are financially and operationally sustainable. At the same time, 40% reported turning new patients away or implementing extended waitlists in the past year. The disconnect points to a deeper challenge: health systems struggle to deploy existing capacity across a fragmented care continuum, leaving patients, clinicians, and ultimately emergency departments (EDs) to absorb the consequences.

The Behavioral Health Reality Gap: 2026 Report surveyed 253 hospital and health system leaders and 261 clinicians to examine how fragmentation, step-down gaps, and disconnected care pathways affect patients and clinicians, and how virtual care and AI can help when integrated into existing care teams and workflows.

253
hospital and health system leaders surveyed

261
clinicians surveyed

83% of hospital and health system leaders believe their behavioral health models are sustainable

40% of hospital and health system leaders turned new patients away or implemented waitlists

Array Behavioral Care's research uncovered several key findings, all with a common throughline: Health systems appear sustainable and sufficiently resourced on the surface, but that capacity is not consistently reaching the patients who need it. Highlights from surveyed hospital and health system leaders and clinicians include:

System constraints are driving suboptimal clinical decisions.

Ninety-five percent of clinicians say system constraints, such as capacity pressures, staffing shortages, or a lack of step-down options, led them to make a clinical decision they weren't fully comfortable with in the past year.

Behavioral health care remains fragmented across the continuum.

Thirty-nine percent of clinicians say patients with behavioral health needs frequently experience gaps or delays during care transitions, and 30% warn poor coordination between care settings negatively affects patient safety or clinical outcomes.

The ED is now the de facto behavioral health safety net.

Seventy-one percent of hospital leaders say the ED has become their community's mental health safety net, and half say more than 20% of ED beds are occupied by behavioral health patients who could be treated in a less intensive setting.

Clinicians are feeling the pressure.

Ninety-five percent of clinicians are considering reducing their hours, or leaving their current role, due to burnout related to behavioral health patient volume or complexity.

Virtual care and AI are poised to ease system strain, when integrated into existing care teams and workflows.

Eighty-four percent of clinicians say virtual behavioral health produces better patient outcomes than in-person care for similar acuity levels, and 98% expect AI to meaningfully reduce their workload within three years. The opportunity now is integration: only 26% of clinicians say virtual behavioral health is fully embedded in their clinical workflows today, and just 28% of hospital and health system leaders have fully operationalized and embedded AI into core clinical workflows as well.

The Sustainability of Today's Behavioral Health Care Model is at Risk

Eighty-three percent of hospital and health system leaders say their behavioral health care model is financially and operationally sustainable over the next three years, and 100% believe their capacity meets or exceeds current demand. However, over the past 12 months, 40% of hospital and health system leaders admit to clinicians absorbing higher caseloads or working beyond sustainable capacity. Another 40% had to completely turn new patients away or implement extended waitlists. This confidence mismatch points to a key blind spot: traditional capacity metrics, like beds, staffing levels, and budgets, don't capture whether that capacity is usable, deployable, or reaching the right patients at the right time.

Behavioral health demand is only rising. Ninety-one percent of clinicians report that behavioral health patient volume has increased over the past two years, including 30% who say the increase has been significant. And as demand grows, clinicians report increasing strain on both the workforce and patient care. Many report job burnout, and 95% say capacity pressures, staffing shortages, or a lack of step-down options have led them to make a clinical decision they weren't fully comfortable with in the past year.

The Reality

The Majority of Frontline Clinicians are Burnt Out and Scaling Back

of clinicians are considering reducing their hours or leaving their role due to burnout related to behavioral health patient volume or complexity.

Over the next 24 months, clinicians' greatest concerns include:

Resource decisions add to the strain. When health system budgets are tight, 27% of hospital and health system leaders admit that high-revenue service lines — like surgery, cardiology, and oncology — are prioritized ahead of behavioral health. Only 25% report that behavioral health is treated as a strategic priority and protected from reductions.

"Behavioral health leaders have spent years measuring capacity in terms of beds, budgets, and staffing levels. Those metrics still matter, but they miss whether that capacity reaches the patients who need it. A system isn't truly sustainable if clinicians are burning out, or if capacity pressures, staffing shortages, and a lack of step-down options are pushing them into clinical decisions they aren't fully comfortable making. When behavioral health systems can't deploy the capacity they have to meet patients' needs, those needs don't disappear. Too often, they surface in the ED."

Shannon Werb
Chief Executive Officer
Array Behavioral Care

The ED as the Default Community Safety Net

Surging demand and gaps in outpatient infrastructure have turned the ED into the default entry point for behavioral health care — not by clinical design, but by systemic default. Seventy-one percent of hospital and health system leaders say the ED is effectively the community's mental health safety net, while the remaining 29% report their ED absorbs overflow that should be going elsewhere, such as outpatient or community clinics.

The resulting pressure is acute and constant: at any given time 50% of hospital and health system leaders say more than 20% of ED beds are occupied by behavioral health patients who could be treated in a less intensive setting.

The Clinical Outlook

Many Behavioral Health Patients Don't Need to Be in the ED

ED clinicians estimate that on average, nearly 1 in 4 (24%) of the behavioral health cases they manage could have been avoided if patients had earlier access to appropriate outpatient or community-based care.

41%

41% of **outpatient clinicians** say patients in their practice *always* deteriorate to a crisis requiring ED or inpatient support that could've been prevented with better system support. Forty-eight percent report this clinical deterioration happens often.

This pattern is the result of a breakdown in early intervention or preventative care. The challenge is not simply access to care, but ensuring patients can find and connect to the right care before a crisis occurs. ED clinicians report that an average of 31% of the behavioral health patients they treat have had zero prior contact with a mental health provider for their current condition. This means these individuals often arrive at their highest point of acuity without a documented treatment history or an established care team.

The top reasons patients default to the ED reflect systemic challenges, according to ED clinicians:

1. **20%** **Social instability (housing, transportation, and lack of support)**
2. **20%** **Having nowhere to go for behavioral health care outside of business hours**
3. **20%** **Inability to get a timely outpatient appointment**

The downstream operational impact is a highly inefficient revolving door inside the health system's highest-acuity and most costly setting: hospital and health system leaders say, on average, 22% of behavioral health patients return to the ED within 30 days of discharge.

22% of behavioral health patients return to the ED within 30 days of discharge, according to hospital and health system leaders

Systemic Bottlenecks Leave Acute Patients in Flux for Hours

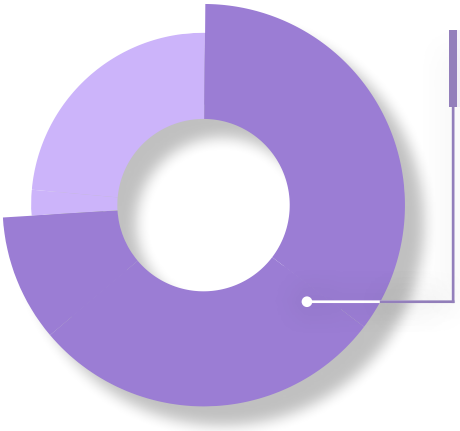
The ED does not provide an immediate fix. Once behavioral health patients enter the ED, operational bottlenecks leave them in flux for hours, or even more than a day, before receiving specialized attention.

Seventy-four percent of hospital and health system leaders say patients wait, on average, 7 hours or more before being evaluated by a behavioral health professional in the ED. A mere 2% say patients are evaluated within three hours of arrival.

The delay continues after a doctor decides to admit or transfer them. After evaluation or disposition, many say patients continue boarding for an average of 13 hours or more (43%) while awaiting placement or next-level care. Eight percent say patients wait more than a day.

Average Time to Behavioral Health Evaluation

Wait Time Duration	
Less than 3 Hours	**2.4%**
3-6 Hours	**23.7%**
7-12 Hours	**35.2%**
13-24 Hours	**28.5%**
More than 24 Hours	**10.2%**

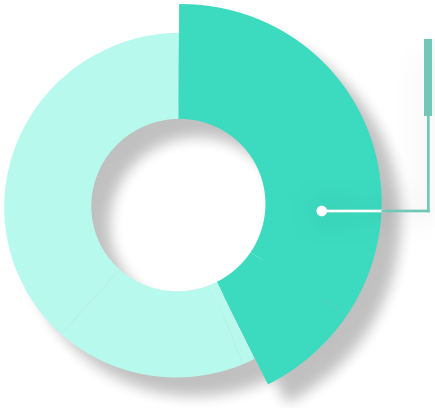


74%

of hospital and health system leaders say patients wait, on average, 7 hours or more before being evaluated by a behavioral health professional in the ED

Average Length of ED Stay *(i.e. Boarding Time)*

Wait Time Duration	
Less than 3 Hours	**1.2%**
3-6 Hours	**17.8%**
7-12 Hours	**38.3%**
13-24 Hours	**34.4%**
More than 24 Hours	**8.3%**



43%

say patients board for an average of 13+ hours while awaiting placement or next-level care

Top Two Barriers to Moving Patients out of the ED for Hospital and Health System Leaders

43%

No accessible step-down options

including partial hospitalization, intensive outpatient, or residential treatment.

38%

Lack of inpatient availability

inability to place patients in appropriate inpatient psychiatric beds after admission decisions.

Out of **253** hospital and health system leaders surveyed, only **1** said their organization faces no significant barriers to moving behavioral health patients out of the ED.

Workforce shortages are also contributing to longer waits in the ED.

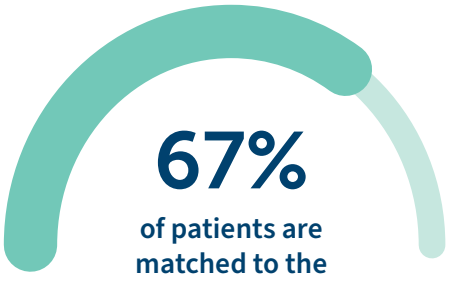
39% of hospital and health system leaders say behavioral health patients waited longer in the ED in the past year due to insufficient staff.

Further, **42%** had to temporarily divert patients or close inpatient psychiatric beds.

The Clinical Outlook

Beyond Delays, Care is Misallocated Through Under- and Over-Treatment

ED Clinicians report over two-thirds (67%) of patients are frequently matched to levels of care that aren't right for their needs, with 35% receiving less intensive care than clinically necessary and 32% receiving more intensive care than clinically necessary. These findings suggest behavioral health programs are not only constrained by capacity but are also struggling to consistently match patients to the right level of care. The result is both clinical risk and inefficient use of scarce resources.



Care Follow-Through Breaks Down Across Care Settings

Behavioral health care often breaks down not because a patient lacks a next step, but because the system lacks visibility into whether that next step happens. Across the continuum, patients enter care without complete histories, move between settings without information consistently following them, and leave care without reliable confirmation that follow-up occurred.

At Entry

Clinicians often lack the information needed to understand the patient's full behavioral health history, making it harder to determine the right level of care from the start.

39% of clinicians and **38%** of hospital and health system leaders report having no visibility into their patient's prior medications or dosages.

37% of clinicians have no knowledge of prior crisis events or hospitalizations.

35% of hospital and health system leaders report a lack of access to prior psychiatric history or treatment records.

During Transitions

Communication between ED, inpatient, outpatient, and community-based care teams is inconsistent, causing continuity to break down further.

3 in 10 outpatient clinicians consistently receive complete, timely clinical information after a patient returns to their care following an ED visit or inpatient stay.

35% of clinicians also report having no information on what follow up care the patient has or hasn't engaged with.

37% of hospital and health system leaders say they lack a reliable way to communicate clinical updates to the next provider.

After Discharge

Many organizations conduct some form of outreach, but fewer actively verify that the patient connected to the next level of care.

39% of hospital and health system leaders actively verify that discharged behavioral health patients successfully connect to their next level of care.

45% of hospital and health system leaders conduct outreach, but do not confirm attendance at the patient's next appointment.

13% of hospital and health system leaders provide referral or discharge instructions with no follow-up.

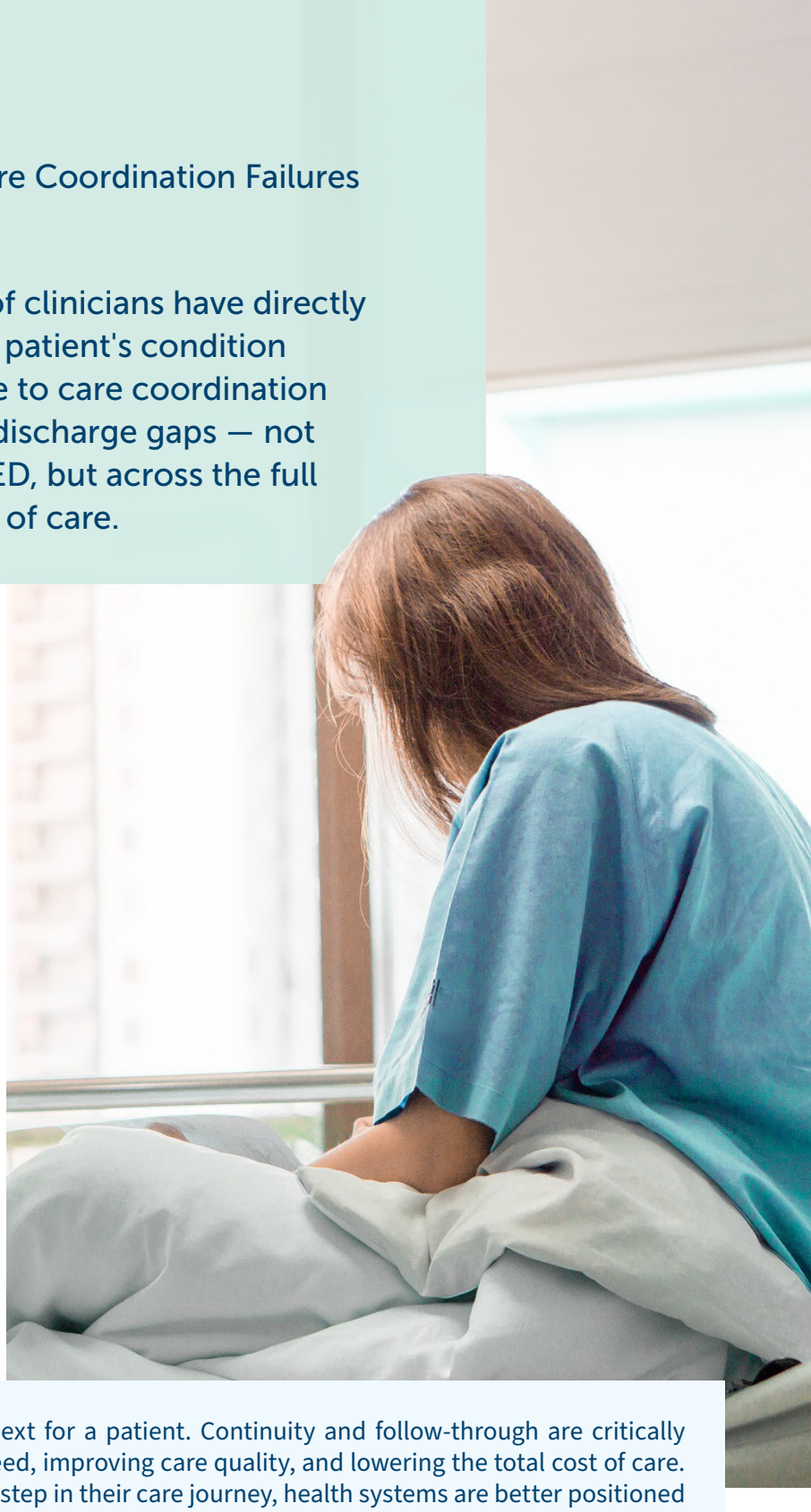
38% of clinicians know the intended treatment plan when a patient leaves their care but cannot confirm it actually happens.

The result is a cycle of fragmented treatment, missed handoffs, and avoidable clinical deterioration. Thirty-nine percent of clinicians say patients with behavioral health needs frequently experience gaps or delays during care transitions. Another 30% warn poor coordination between care settings negatively affects patient safety or clinical outcomes.

The Clinical Outlook

Patients are Getting Worse due to Care Coordination Failures

98% of clinicians have directly observed a patient's condition worsen due to care coordination failures or discharge gaps — not just in the ED, but across the full continuum of care.



These care transition breakdowns appear in several ways, including a lack of communication between care teams, insufficient information sharing, tech inoperability, and more. In fact, EHR and technology incompatibility (33%) outranks behavioral health staffing shortages (28%) as a top obstacle to seamless care transitions.

Measurement on patient outcomes often exists, but a unified view and interoperability across the system tends to be missing. In many cases, outcomes are being tracked at the point of care, but not consistently connected or visible across the broader continuum. Just 45% of hospital and health system leaders use standardized outcome measures consistently across all care settings. Another 51% say they track outcomes in some settings but not across the continuum. Clinicians echo similar challenges: 58% use standardized measures and tracking systems, while 38% admit they track them informally, not systematically.

"Every care transition shapes what happens next for a patient. Continuity and follow-through are critically important for matching treatment to clinical need, improving care quality, and lowering the total cost of care. When patients successfully connect to the next step in their care journey, health systems are better positioned to improve outcomes, support clinicians, and reduce avoidable utilization."

Sara Gotheridge, MD
Chief Medical Officer
Array Behavioral Care

Virtual Behavioral Health Can Close the Gaps Once Fully Integrated

Many hospital and health system leaders are turning to virtual behavioral health to alleviate capacity and broader system constraints. Seventy-one percent of hospital and health system leaders surveyed report virtual behavioral care is already in use across ED, inpatient, and outpatient settings, and the majority of clinicians report results that outperform in-person care.

The Clinical Outlook

Virtual Outcomes Outperform In-Person for Similar Acuity Levels

84%
of clinicians surveyed say virtual behavioral health produces better patient outcomes than in-person care for similar acuity levels.

1 in 3
say outcomes are significantly better.

Clinicians see the greatest value from virtual care in:

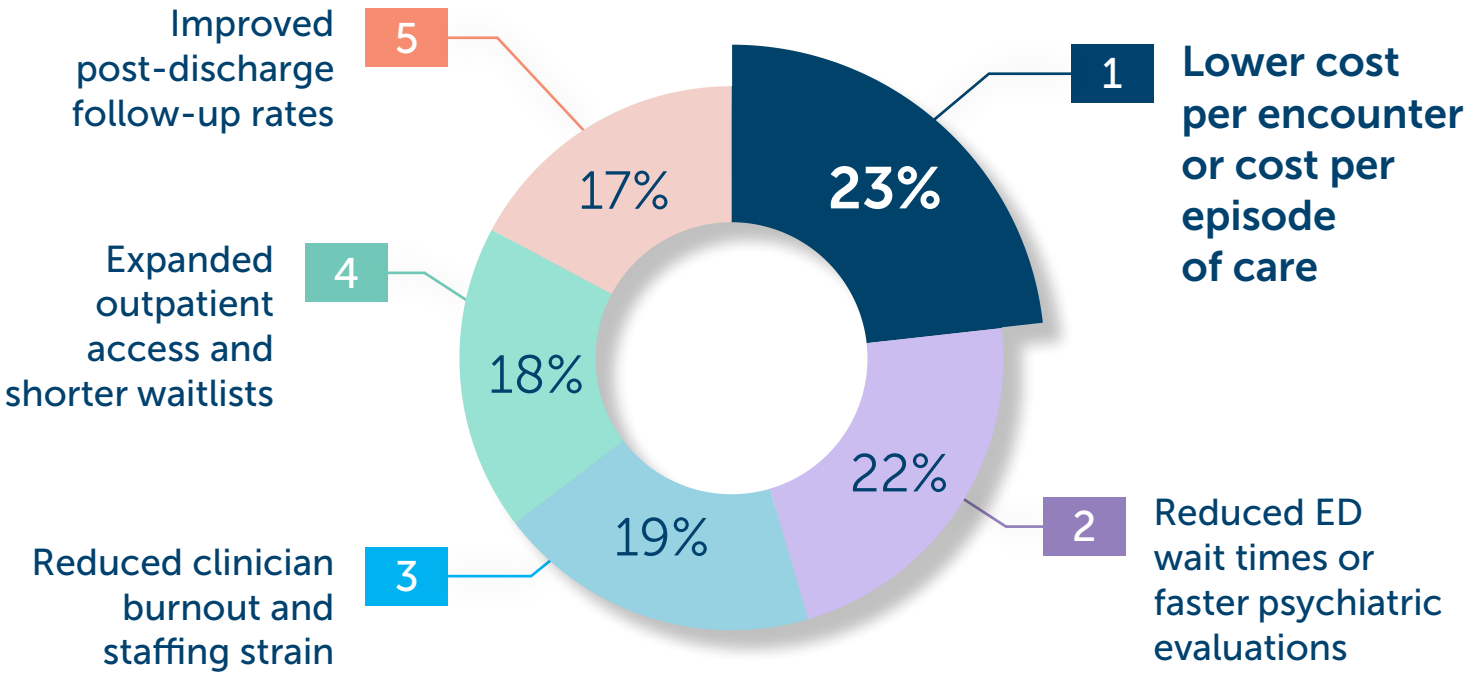
19% Intervening with high-risk patients early enough to prevent crisis escalation

18% Embedding behavioral support directly into primary care workflows

17% Catching patients after discharge before they return to the ED

Hospital and health system leaders report clear, measurable system-level impacts from their virtual behavioral health investments as well.

Five System-Level Impacts from Virtual Behavioral Health Investments



Every hospital and health system leader whose organization uses virtual behavioral health pointed to a measurable system-level impact.

Not one reported none.

With the technology already widely adopted, the opportunity now is full integration: ensuring virtual behavioral health functions as a seamless extension of the care team, not just an available resource.

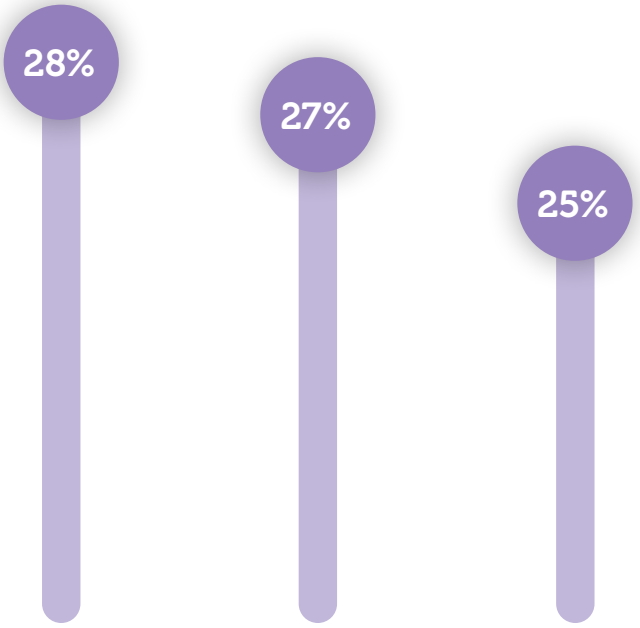
26% of clinicians say virtual behavioral health is fully embedded in their clinical workflows.

54% of clinicians report it's available and used regularly but not fully integrated.

That integration challenge is in part tied to how virtual behavioral health is being delivered. Seventy-one percent of systems rely primarily on an internal or employed model, while 28% rely primarily on an external partner. Yet the barriers leaders cite to scaling virtual care are less about adoption itself and more about whether virtual capacity is reliable, clinically aligned, and integrated with the broader care team.

Barriers to Scaling Virtual Care

According to hospital and health system leaders, common barriers to scaling virtual offerings include:



Behavioral health partners not meeting expectations for response time or clinical quality

Patients lacking reliable technology or connectivity

External partners not integrating clinically or operationally with the broader care team

"If a virtual behavioral health partner isn't wired into your electronic health record (EHR), your order sets, and your existing workflows, you haven't reduced fragmentation. You've just added another system for someone to check, and it's usually a clinician who's already stretched thin. Real integration means the technology disappears into the workflow instead of becoming one more thing to log into. That's the difference between a partner that reduces burnout and one that quietly adds to it."

Patrick Williamson
Chief Information Officer
Array Behavioral Care

As hospitals weigh new technology investments, they should be asking: does it work the way our clinicians need it to, or does it become one more thing to manage? AI is now facing that same test, though it's still in the early stages.

AI Shows Promise, but the Evidence and Trust Haven't Caught Up

Every hospital and health system leader surveyed said their organization plans to deploy AI, but only **28%** have fully operationalized and embedded AI into core clinical workflows. Current deployments include:

23%
Measurement-based care tracking and outcomes reporting

22%
Crisis intervention and de-escalation support

21%
Scheduling and staffing optimization

20%
Care coordination and discharge planning

As with virtual care, AI's success depends not just on access, but on how effectively it is integrated into care delivery. Hospital and health system leaders report the following barriers to wider rollouts: cost and unclear return on investment (41%), no clear evidence that AI improves patient outcomes in behavioral health (37%), and liability and regulatory uncertainty (28%).

The Clinical Outlook

AI Will Reduce Workload, but it Will Also Influence Patient Interactions

98% of clinicians say AI will meaningfully reduce their workload within three years, through improved efficiency in clinical workflows (60%), reduced administrative burden (25%), or both (14%).

Regardless of internal AI adoption, clinicians say the technology is already impacting care:

+

26%
Patients arrive more engaged and self-aware after using AI

21%
AI gives patients a useful starting point for discussions

−

18%
AI-generated information erodes patients' trust in clinical judgment

18%
AI makes patients more anxious or fixated on symptoms

Where the Behavioral Health Industry Goes from Here

More behavioral health capacity won't fix a system that can't deploy the capacity it already has. The organizations that improve outcomes over the next decade will be those that can connect patients to the right care, at the right time, and ensure they successfully reach the next step in their journey.

This research points to four priorities for health systems and hospitals looking to build a more sustainable behavioral health model. Together, they shift the conversation beyond expanding access to improving care quality, clinician sustainability, patient outcomes, and the total cost of care.

1

Expand how you define system performance

Traditional operational metrics, such as response times, discharge rates and session counts remain important, but they only capture part of the picture. Health systems should also measure clinician workload, workforce sustainability, care transitions, and patient outcomes to better understand whether the behavioral health system is truly meeting demand. A model that appears sustainable on paper may still be placing unsustainable pressure on clinicians and compromising patient care.

2

Lean into team-based models

Behavioral health demand continues to grow, making it increasingly difficult for psychiatrist-only models to keep pace. Team-based care allows psychiatrists, therapists, social workers, nurses, and other licensed behavioral health professionals to contribute at the top of their license while ensuring patients receive care aligned with their clinical needs. Matching treatment intensity to patient acuity helps improve outcomes, strengthens clinician sustainability, and allows scarce psychiatric resources to be focused where they have the greatest impact.

3

Make continuity of care a strategic capability

Every care transition influences what happens next for a patient. Improving continuity requires connected clinical workflows, timely information sharing, standardized outcomes tracking, and visibility across care settings so clinicians can make informed decisions with confidence. Health systems that strengthen continuity across the patient journey will be better positioned to improve outcomes while reducing avoidable utilization and the total cost of care.

4

Scale virtual behavioral health as an integrated extension of the care team

Virtual behavioral health delivers the greatest value when it functions as part of the clinical care team rather than as a standalone access solution. Health systems should prioritize partners that integrate into existing clinical workflows, support acuity-aligned care across emergency, inpatient, and outpatient settings, and share accountability for both clinical and operational outcomes. The right partnership expands access while strengthening care quality, reducing clinician burden, and improving patient outcomes across the continuum of care.

Health systems and behavioral health providers need help to ensure patients are always receiving the right care, at the right time, with the right dose.

Contact Array Behavioral Care to see where we can help you ease current capacity constraints, overcome care fragmentation, and improve patient outcomes.

Demographics

A total of **253 hospital and health system leaders** and **261 clinicians** responded to the survey.

Hospital and Health System Leaders

Role	
ED Medical Director	57%
ED Director	26%
Director or VP of Behavioral Health	7%
Chief Medical Information Officer/ Chief Health Information Officer/ Chief Digital Officer/ Chief Information Officer	4%
Chief Nursing Officer	3%
Director or VP of Population Health	2%
Director or VP of Ambulatory/ Outpatient Care	1%

Type of Organization	
Academic Medical Center	46%
Community Hospital (Single-Site or Small System with Less than 5 Hospitals)	46%
Regional Health System	4%
Large National Health System	2%
Rural Hospital	2%

Clinicians

Role	
Emergency Medicine Physician (MD/DO)	21%
Hospitalist/Inpatient Medical Physician	18%
Emergency Department Nurse (RN)	12%
Primary Care Physician or Advanced Practice Provider (NP/PA) Managing Behavioral Health Patients	12%
Emergency Department NP or PA	10%
Inpatient Nurse (Medical, Surgical, Step-Down, ICU)	8%
Crisis Stabilization or Mobile Crisis Clinician	8%
Behavioral Health Clinician Embedded in ED or Inpatient Units	6%
Social Worker, Case Manager, Referral Coordinator Involved in Behavioral Health Discharge Planning or Care Transitions	4%
Other Clinical Role Treating Behavioral Health Patients	1%

Clinical Practice Setting	
Multiple Hospital-Based Settings (e.g. ED and Inpatient)	27%
Emergency Department in a Hospital or Health System	25%
Hospital-Affiliated Outpatient or Ambulatory Clinic	24%
Inpatient Medical or Psychiatric Unit in a Hospital	23%

About Array Behavioral Care

Array Behavioral Care is the nation's leading virtual psychiatry and therapy practice, delivering high-quality behavioral health services through a fully integrated continuum of care from hospital to home. Array partners with hospitals, health systems, community organizations, and payors to provide timely, expert treatment that meets the needs of patients where they are with the Right Care, Right Time, Right Dose℠. As an established leader with more than 25 years of experience in telepsychiatry, Array sets the standard for excellence by offering innovative solutions that improve access, enhance outcomes, and support seamless care delivery. Its Epic-based EHR platform is eliminating system-wide gaps in mental health treatment. Learn more about how Array is transforming behavioral health at arraybc.com.

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