Center for Mental Health Services
Division of State and
Community Systems Development
Survey and Analysis Branch

Mental Health Statistical Note 210. May 1994

Data Highlights on:

The Evolution and Expansion of Mental Health Care in the United States Between 1955 and 1990

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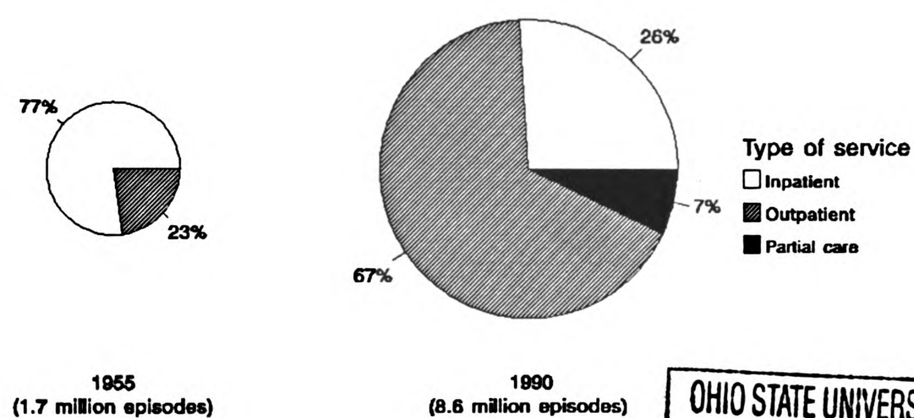
Major Findings

The locus of organized mental health care has shifted from inpatient to ambulatory care.

Over the past 35 years, the locus of mental health care in the United States has shifted from inpatient to ambulatory services, as measured by the number of patient care episodes. Of the 1.7 million episodes in 1955, 77 percent were in inpatient services and 23 percent in outpatient; by 1990, the percents were nearly reversed, with 67 percent of the 8.6 million episodes in outpatient, 26 percent in inpatient and 7 percent in partial care services (figure 1). (Detailed tables are in appendix 1. Sources and qualifications of the data are in appendix 2.)

Figure 1. Patient care episodes in mental health organizations in 1955 and 1990



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES/Public Health Service/Substance Abuse and Mental Health Services Administration
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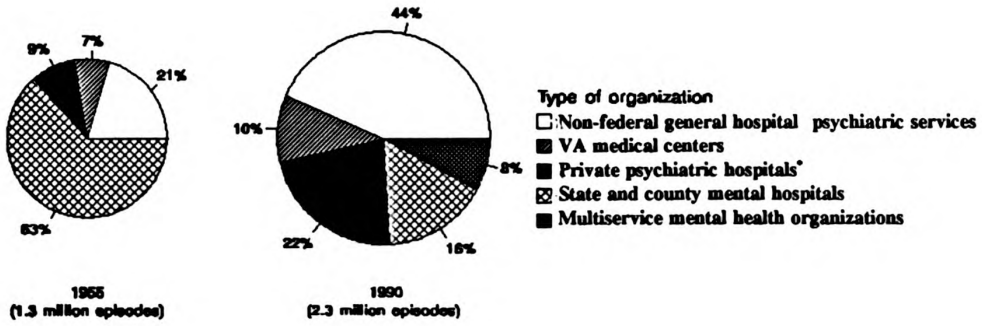
The organizations providing inpatient and outpatient care have changed.

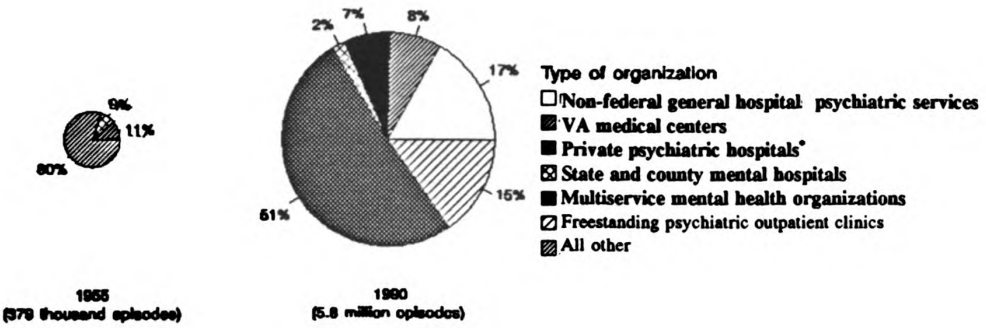
Concomitant with the shift of patient care episodes from inpatient to outpatient services, a shift has also occurred across organization types, both within inpatient and outpatient services. State and county mental hospitals (State mental hospitals) accounted for 63 percent of the inpatient episodes in 1955, compared with only 16 percent in 1990. By contrast, the psychiatric inpatient services of nonfederal general hospitals and private psychiatric hospitals, community-based organizations which comprised 21 and 9 percent, respectively, of total inpatient episodes in 1955, accounted for 44 and 22 percent, respectively, in 1990 (figure 2). The proportion of total outpatient care episodes provided by State mental hospitals and VA medical centers was considerably higher in 1955 than in 1990, while those of all other organizational types were substantially lower in 1955, than in 1990 (figure 3).

Figure 2. Inpatient and residential treatment care episodes in mental health organizations in 1955 and 1990



*Includes residential treatment centers for emotionally disturbed children.

Figure 3. Outpatient care episodes in mental health organizations 1955 and 1990



*Includes residential treatment centers for emotionally disturbed children.

Policy Observations

Policy implications evident from these findings involve such issues as (1) the future role of the State mental hospital, (2) the balance between community-based and State mental hospital services, (3) the balance between inpatient and ambulatory services, and (4) the contracting by State mental health agencies for the provision of services through the private sector.

Should State mental hospitals be closed or expanded?

As the number of inpatient episodes in State mental hospitals has continued to decline, policy makers are confronted with momentous decisions regarding these organizations. At the one extreme, some argue that these hospitals have contracted in size to such an extent that persons with severe mental illness are being denied admission, and, therefore, further downsizing is unwise. By contrast, others argue that all persons, regardless of the severity of their mental illness, can be cared for in the community and that the State mental hospitals should be phased out entirely. Confounding the options of the policy makers are economic pressures brought by communities and labor unions to keep the State mental hospitals open and to increase their size.

What should be the balance between community-based and State mental hospital services?

Most State mental health agencies favor the expansion of community-based services at the expense of State mental hospital services. In addition, Federal legislation promotes community-based services over State mental hospital services in the distribution of block grant funds to the States. Furthermore, aftercare services have shifted from the State mental hospitals to community-based services between 1955 and 1990. Despite these facts, State mental hospitals still consumed nearly 58 percent of total expenditures by State mental health agencies in 1990.

What should be the role of inpatient and ambulatory services?

The proper balance of inpatient and ambulatory services needs to be examined for treatment efficacy as well as cost-benefit. Although the proportion of outpatient episodes increased greatly between 1955 and 1990, the proportion has remained almost the same since 1975. Decisions will have to be made whether or not ambulatory services should be increased at the expense of inpatient services.

Should inpatient services be contracted out?

As an alternative to the provision of inpatient services in the State mental hospitals, many States have contracted with private psychiatric hospitals and nonfederal general hospitals to provide these services. It could be argued, however, that if the State mental hospitals were restructured to provide more short-term care and rehabilitative services, they could potentially provide comparable services more cheaply than private psychiatric or general hospitals. Additional work is needed to examine the effects of civil service regulations and cost benefit on contracting out.

Once the decisions are made regarding these issues, policies will have to be developed to shape the desired outcomes. In this regard, conjecture is no substitute for reliable data.

Appendix I

Table 1. Number of mental health organizations and number and percent distribution of inpatient, outpatient, and partial care patient care episodes within these organizations, by type of organization: United States (excluding territories), 1990.

Type of organization	Number of mental health organizations	Patient care episodes							
		Total	Inpatient	Outpatient	Partial care	Total	Inpatient	Outpatient	Partial care
		Number				Percent distribution by organization			
All organizations	5,284	8,617,080	2,262,474	5,810,405	544,201	100.0	100.0	100.0	100.0
State and county mental hospitals	273	513,223	371,325	121,543	20,355	6.0	16.4	2.1	3.7
Private psychiatric hospitals	462	683,806	435,539	198,262	50,005	7.9	19.3	3.4	9.2
VA psychiatric organizations	141	704,183	215,583	455,450	33,150	8.2	9.5	7.8	6.1
Nonfederal general hospitals with separate psychiatric services	1,674	2,044,880	997,602	978,159	69,119	23.7	44.1	16.8	12.7
Residential treatment centers for emotionally disturbed children (RTCs)	501	291,815	68,729	195,826	27,260	3.4	3.0	3.4	5.0
Freestanding psychiatric outpatient clinics	743	891,982	-	891,982	-	10.4	-	15.4	-
Freestanding psychiatric partial care organizations	93	24,097	-	-	24,097	0.3	-	-	4.4
Multiservice mental health organizations	1,397	3,463,094	173,696	2,969,183	320,215	40.1	7.7	51.1	58.9

Table 2. Number and rate per 100,000 civilian population of inpatient, outpatient, and partial care episodes in mental health organizations: United States (excluding territories), selected years 1955 through 1990

Year	Total episodes	Inpatient care episodes	Outpatient care episodes	Partial care episodes
		Number		
1990	8,617,080	2,262,474	5,810,405	544,201
1988	8,344,904	2,229,217	5,627,792	487,895
1986	7,885,618	2,055,571	5,451,538	378,509
1983	7,194,038	1,860,613	5,007,928	325,497
1975	6,857,597	1,817,108	4,810,923	229,566
1971	4,190,913	1,755,816	2,316,754	118,343
1965	2,636,525	1,565,525	1,071,000	-
1955	1,675,352	1,296,352	379,000	-
		Number per 100,000 population		
1990	3,491	917	2,354	220
1988	3,419	914	2,305	200
1986	3,295	859	2,278	158
1983	3,084	799	2,146	139
1975	3,245	860	2,276	109
1971	2,052	860	1,134	58
1965	1,376	817	559	-
1955	1,028	795	233	-

APPENDIX II. SOURCES AND QUALIFICATIONS OF THE DATA AND DEFINITIONS

Sources and Qualifications of the Data

The most recent data on patient care episodes was obtained from the 1990 Inventory of Mental Health Organizations and General Hospital Mental Health Services, a biennial complete enumeration of all mental health organizations in the United States, conducted by the Survey and Analysis Branch, Division of State and Community Systems Development, Center for Mental Health Services [formerly part of the National Institute of Mental Health (NIMH)], with the cooperation of the State mental health agencies, the National Association of State Mental Health Program Directors, the National Association of Psychiatric Health Systems, and the American Hospital Association. Trend information shown in this report is based on data collected in similar Inventories conducted by NIMH for the previous years shown.

The mental health organizations covered in this Data Highlight include those organizations listed and defined below. Omitted from this report are patient care episodes in all psychiatric services maintained by Federal agencies other than the VA, such as the Indian Health Service, Department of Defense, Bureau of Prisons, etc. Also excluded are episodes of psychiatric care in private office-based practices of mental health professionals, general medical practice and clinics, and other health settings, such as neighborhood health centers, general hospital medical services, and nursing homes.

Other CMHS publications on patient care episodes in mental health organizations are as follows:

Statistical Note 23, *Changes in the Distribution of Patient Care Episodes--1955-1968, by Facility Type.* April 1970.
Statistical Note 58, *Distribution of Patient Care Episodes in Mental Health Facilities, 1969.* January 1972
Statistical Note 92, *Patient Care Episodes in Psychiatric Services, United States, 1971.* August 1973.
Statistical Note 127, *Provisional Data on Patient Care Episodes in Mental Health Facilities, 1973.* February 1976.
Statistical Note 139, *Provisional Data on Patient Care Episodes in Mental Health Facilities, 1975.* August 1977.
Statistical Note 154, *Trends in Patient Care Episodes in Mental Health Facilities, 1955-77.* September 1980.
Statistical Note 171, *Trends in Patient Care Episodes in Mental Health Organizations, United States, 1970-81.* August 1985.
Statistical Note 192, *Patient Care Episodes in Mental Health Organizations, United States: Selected Years Between 1955 and 1986.* August 1990.
Statistical Note 204, *Patient Care Episodes in Mental Health Organizations, United States: Selected Years from 1955 to 1988.* May 1992.

Definitions

Patient Care Episodes

Patient care episodes are defined as the number of residents in inpatient programs at the beginning of the year (or the number of persons on the rolls of ambulatory programs), plus the total additions to these programs during the year. The total additions count during the year includes new admissions and readmissions; it is, therefore, a duplicated count of persons. In counting additions rather than persons, two types of duplication are introduced. First, the same person may be admitted more than once to a particular program during the year. In this case, the same person is counted as many times as admitted. Second, the same person may be admitted to two or more different services during the year. Again, this person is counted as an addition for each service to which admitted. Duplication also occurs because episodes are counted independently by type of service (inpatient, outpatient, partial care). A person who is an inpatient in a hospital, released to a partial care service, and then followed as an outpatient, for example, would be counted as having three episodes.

Types of Mental Health Organizations

State and county mental hospital. A psychiatric hospital that is under the auspices of a State or a county government, or operated jointly by both a State and county government.

Private psychiatric hospital. A hospital operated by a sole proprietor, partnership, limited partnership, corporation, or not-for-profit organization, primarily for the inpatient care of persons with mental disorders.

Department of Veterans Affairs psychiatric organization. An organization that is operated and controlled by the Department of Veterans Affairs (formerly the Veterans Administration) (e.g., VA multiservice mental health organization) and provides mental health services.

General hospital with separate psychiatric service(s). A nonfederal general hospital that routinely admits patients to a separate psychiatric service (e.g. inpatient care, outpatient care, or partial hospitalization), for the express purpose of diagnosing and treating psychiatric illness. A separate psychiatric unit is an organizational or administrative entity with a general hospital that provides one or more treatments or other clinical services for patients with a known or suspected psychiatric diagnosis and is specifically established and staffed for use by patient served in this unit. If this is an inpatient unit, beds are set up and staffed specifically for psychiatric patients in a separate ward or unit. These beds may be located in a specific building, wing, or floor, or they may be a specific group of beds physically separated from regular or surgical beds.

Residential treatment center for emotionally disturbed children (RTC). An organization that must meet all of the following criteria:

- It is an organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for its patient/clients.
- It has a clinical program within the organization that is directed by either a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master's and/or a doctorate degree.
- It serves children and youth primarily under age 18.
- The primary reason for the admission of 50 percent or more of the children and youth is mental illness, which can be classified by DSM-III/DSM-IIIR/ICD-9-CM codes, other than those codes for mental retardation, substance (drug) related disorders, and alcoholism.

Freestanding psychiatric outpatient clinic. An administratively distinct organization that is not part of another psychiatric organization (e.g., a hospital). It is composed of programs for ambulatory patients who generally require more time (3 or more hours) than that provided through an outpatient visit, but who require less than 24-hour care.

Multiservice mental health organization. An administratively distinct organization that provides any combination of two or more services (inpatient, residential, outpatient or partial care) in services that are under the organization's direct administrative control.

Types of Services

Inpatient care. Provision of 24-hour care in a hospital setting.

Outpatient care. Mental health services to ambulatory clients/patients on an individual, group or family basis, generally provided in less than 3 hours at a single visit in a clinic or similar organization. Includes ambulatory emergency care in a planned program to provide psychiatric care in crisis situations by staff specifically designated for this purpose.

Partial care. A planned program of mental health treatment services generally provided to groups of clients/patients in sessions lasting 3 or more hours. Included are the following:

Day/evening treatment. Treatment programs that place heavy emphasis on intensive short-term therapy and rehabilitation.

Day/evening care. Treatment programs that focus on sustainment, maximization, or socialization through recreation, and/or occupational activities, etc., including sheltered workshops.

Education and training. Treatment programs that focus on change through an integration of education, habilitation and training, including special education classes, therapeutic nursery schools, and vocational training.

Residential treatment care. Overnight care in conjunction with an intensive program in a service other than a hospital. Examples of residential services those for emotionally disturbed children.

The authors: Richard W. Redick, Ph.D., private consultant, developed this report under contract number 92-MF-3354554-01D, from the Center for Mental Health Statistics. The DSCSDE staff members, Michael J. Witkin, M.A., C.P.A., Joanne E. Atay, M.A., and Ronald W. Manderscheid, Ph.D., conceptualized the survey upon which the report is based, provided and edited data for the tables, and prepared sections of the text. The CMHS Statistical Notes are edited by Mary Anne Sonnenschein, M.A., DSCSD.

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