TRENDS IN PSYCHIATRIC INPATIENT CAPACITY

United States and Each State, 1970 to 2018

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Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2018

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Abstract:

Although inpatient beds are only one part of a complete psychiatric care continuum, the availability of psychiatric beds for individuals in crisis is a continuing national issue. Individuals experiencing mental health crises who need intensive supervised treatment frequently are stuck (boarded) in emergency departments for hours or days awaiting an appropriate bed or do not receive timely, appropriate services, with many even being routed to the criminal system. Discussions about shortages of psychiatric beds often start with dialogue of the major decrease in state psychiatric hospital beds over time—a reduction of over 84% since the 1970s. However, these conversations often do not address the growth of psychiatric beds in settings outside of state psychiatric hospitals or the tremendous increase in a broad array of community-based mental health services and supports during that time. This report updates a 2017 NRI/NASMHPD paper[1] on trends in psychiatric bed capacity from 1970 to 2014 by adding information between 2014 through 2020[*]. This report also addresses the very different use of state psychiatric hospitals in 2018 and 2020 compared with their use 50 years ago and discusses where some of the individuals who previously would have been served in state psychiatric hospitals are now receiving care today.

Highlights:

- From 1970 to 2018, there has been an 84% reduction in state hospital beds, but most of those bed closures occurred decades ago during the 1970s and 1980s, with 65% of all state hospital beds that closed between 1970 and 2020[2] having closed during the first decade (1970 to 1980).
- In the most recent decade (2010 to 2018), despite many discussions about bed shortages and assumptions about the downsizing of beds, overall inpatient psychiatric beds in all types of organizations increased 17% between 2010 to 2018. State hospital beds decreased 18.5%, but private psychiatric hospital patients more than doubled, and general hospital psychiatric unit beds increased more than 25%.
- There was a major shift in use of psychiatric beds by age. Children in mental health inpatient or residential treatment beds decreased by 20% from 2010 to 2018. The number of adults in inpatient or residential treatment beds increased by 24% from 2010 to 2018.
- Historical comparisons of the number of mental health patients often focus only on state psychiatric hospital data and do not adequately account for how state hospitals have changed the populations they serve over time, serving for example, fewer older adults with dementias and intellectual disabilities and more people with criminal justice legal statuses.
- An increasing majority of State Mental Health Authorities (SMHAs) are reporting shortages of psychiatric beds, but the major policies to address these shortages are not focused on reopening state hospital beds but are instead focusing on community-based services and crisis services to divert clients from inpatient care.
- Medicaid's role in paying for mental health services, especially community-based services, has grown over time helping to support alternatives to inpatient and residential care, and Medicaid's Institution for Mental Disease (IMD) policy continues to restrict Medicaid's role in financing inpatient mental health services.

[*] Although this paper includes data through 2020, the 2020 data are excluded from many analyses due to the unreliability of bed data reporting during the start of the COVID-19 pandemic.

Recommendations:

1. Although this report uses the latest complete information available about mental health patients in 24-hour settings, it identifies several major areas where data are not available for 2018 or 2020, and where trend data are not available. Major gaps include the provision of mental health services to persons in jails and prisons, and mental health services in general hospital scatter beds. Future analyses of available mental health beds could benefit if estimates of beds in these additional settings become available.
2. The COVID-19 pandemic affected 2020 reporting and has led to the closure of some facilities amid persistent workforce shortages. Updating information now as systems emerge from the COVID-19 pandemic will be important.
3. One area of focus is a shortage of beds for children with complex health needs. Little information is available about the number and capacity of Medicaid Psychiatric Residential Treatment Facilities (PRTFs) and other settings being used for children, including information about the number of children being sent to out-of-state placements. SAMHSA and CMS data systems do not currently detail the number of PRTF beds available, or characteristics of children being served in them. Developing information about the availability of PRTF beds and the characteristics of the children served could provide useful, additional data for future reports.
4. Care for older adults (ages 65 and over) with complex needs, such as co-occurring mental health disorders and neurocognitive disorders is a challenge states are starting to address as the older adult population in the United States grows. Collecting information about where older adults with these complex needs are being served, and the necessary appropriate services can be helpful to states and others working to assure appropriate treatments and supports are available.
5. The July 2022 launch of the national three-digit 988 crisis call center system and the growing adoption of the Crisis Now model of crisis services has great potential to help many individuals experiencing psychiatric crises be diverted to less-intensive service settings. The impact of more states providing comprehensive crisis service systems on the future need for psychiatric inpatient and 24-hour residential treatment services should be studied.
6. NASMHPD's 2017 "Beyond Beds" report and framework argues for a robust continuum of care as opposed to inpatient beds as a single policy solution to current access challenges. In August 2022, the American Psychiatric Association's Presidential Task Force on Assessment of Psychiatric Bed Needs in the United States issued the report: "*The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions* 2022.[2]" Supporting states and communities to test and refine the bed-need models proposed in the APA report (models that factor in crisis and community resources) could greatly enhance understanding of the appropriate number and types of mental health treatment beds needed in different communities or regions.

Limitations: *This report focuses on the number of individuals in mental health treatment beds in 2018 and trends until 2018. Some 2020 data on individuals in mental health beds are available, however, due to the COVID-19 pandemic, 2020 data likely reflect substantial underreporting by facilities. COVID resulted in many mental health providers experiencing major staffing shortages that resulted in them focusing their attention on serving clients rather than responding to surveys, and also reflect temporary closures of mental health beds due to staff shortages and requirements for social distancing measure (e.g., limiting occupancy to one bed per room). As a result, SAMHSA's 2020 N-MHSS data show an overall reduction of 35.4% of beds between 2018 and 2020 (a decrease of over 66,500 beds). Before the 2020 data collected during COVID, there had been a substantial increase of psychiatric beds every time-period from 2010 to 2018, with a net increase of 16.8% (27,620 residents).*

Psychiatric inpatient and residential treatment beds are the most expensive and typically considered the most restrictive form of mental health treatment, but are a critical safety net service for individuals who are experiencing psychiatric crises that require high levels of clinical support and 24-hour treatment. Every state government operates some psychiatric inpatient beds, and provides a variety of psychiatric inpatient and other 24-hour residential treatment beds. However, state operated mental health beds are only a small portion of the overall behavioral health system and the role of state operated inpatient beds within the larger behavioral health system (including private provider beds and community mental health services) are important to understanding whether a system or region has sufficient inpatient bed capacity compared to other complimentary services across a psychiatric continuum of care.[3] To that end, in 2017, NASMHPD produced its seminal "Beyond Beds" framework,[4] arguing for more clarity on what is meant by "Beds" and noting that a robust continuum of psychiatric care should be the primary focus, rather than rely upon one intensive service-state hospital or inpatient psychiatric care-as the single solution to address the needs of all individuals with mental illness. This has spawned further discourse and this paper articulates further information about data on psychiatric bed availability across time.

APA Task Force Report

"Mental health systems optimally include a care continuum to meet people's needs in the most accessible, least restrictive environment. In a broad perspective, this continuum includes a range of services such as crisis services, accessible outpatient services, rehabilitation and recovery support services and inpatient psychiatric care. Access to inpatient psychiatric beds undergirds local mental health systems, providing essential services to help treat adults or young people who are experiencing mental illness, just like inpatient medical hospitalization serves the most acutely ill."[5]

Since the 1970s, 24-hour inpatient and residential treatment has dramatically shifted away from being provided in state government-operated psychiatric hospitals. As this paper shows, in 1970, 78.5% of mental health inpatients were served in a state psychiatric hospital, compared with 19% in 2018 (and 16.2% in 2020). For older adults and children who require inpatient and residential-level care, treatment has shifted away from state psychiatric hospitals at an even greater rate.

Shortages of psychiatric beds are often highlighted in media headlines and a Google search for the term "mental health bed shortage" conducted on July 22, 2022, returned over 10.9 million hits.

Sample Newspaper Headlines within the last 2 month of google search:

"Shortage of beds in state mental hospitals delays treatment in North Texas"

WFAA news (Dallas, Tx) June 30, 2022 https://tinyurl.com/bdefm9sw

"New facilities won't solve Southwest Michigan's shortage of inpatient psychiatric beds"

Mlive.com (Kalamazoo, MI) June 3, 2022 https://tinyurl.com/yj28x3z8

"'Clearly our children are in crisis': Mental health resources scarce, legislation looks to improve access"

Buck County Courier Times, (PA) July 6, 2022 https://tinyurl.com/5ewnhd3s

"Waiting on Treatment: Bed shortage leaves mentally ill Nebraskans in jail for months"

KOLN (Lincoln, NE) May 26, 2022 https://tinyurl.com/238kemks

"Hundreds of Suicidal Teens Sleep in Emergency Rooms Every Night."

New York Times (NY, NY) May 9, 2022 https://tinyurl.com/yzwcab9v

The initiation of 988, the new three-digit national mental health suicide and behavioral health crisis line in July 2022 is projected to greatly increase the demand for mental health services. Although the 988 crisis lines are expected to immediately address the urgent needs of callers, a few callers will require higher levels of care, including crisis stabilization, crisis residential, as well as inpatient treatment for clients needing the most intensive levels of care. Early intensive crisis services may help resolve behavioral health crises and reduce the need for psychiatric hospitalizations, but the projected doubling of 988 calls over the next several years may result in increased demand for more intensive level services.[6] As such, as articulated in *From Crisis to Care,*[7] it will be important for policymakers to continue to build out community-based services and understand their system need for different aspects of the care continuum. This paper's review of the historical trends in inpatient beds provides a record for posterity while offering insights into current trends and future directions.

Methodology

This report relies on data collected by multiple data sources over time:

2018 Data Sources

1. SAMHSA's National Mental Health Services Survey (2018[8], also N-MHSS data from 2010,[9] 2014,[10] 2016,[11] and 2020[12] are used in this report). N-MHSS is an annual survey to collect information on the location, organization, structure, services, and utilization of mental health treatment facilities. It is designed to collect statistical information on all known mental health treatment facilities in the United States. This includes the 50 states, the District of Columbia, and all U.S. territories. Every other year, starting in 2014, N-MHSS also collects information on the numbers and demographics of persons served in these treatment centers.
2. SAMHSA Uniform Reporting System (URS).[13] The URS provides annual information about the number of patients being served in state psychiatric hospitals on the first day of the reporting

year. States submit URS data every December as part of their Annual Mental Health Block Grant Implementation Report.

3. NRI State Profiles System 2020. The State Profiles System information is compiled by NRI every 2 years and focuses on state level policy, services, and financing information about public mental health services. State Mental Health Agency leaders guide the development of questions to collect and NRI maintains this data. The State Profiles builds on existing data and collects information that adds context to more quantitative data systems, by compiling information about state policies, regulations, and organization that allows better use of quantitative data.
4. CMS Nursing Home Minimum Data Set: Reported annually by nursing facilities includes information about the number and percent of residents in nursing homes with a diagnosis of schizophrenia and/or bi-polar disorders for which they received active treatment.

Historical Data Sources

1. NIMH/SAMHSA Inventory of Mental Health Organizations (IMHO): the IMHO was a mental health treatment facility survey similar to the current N-MHSS that was conducted every two years by NIMH and then SAMHSA (after it was created). The historical IMHO reports include information about the number of residential patients on a single day who were in either psychiatric inpatient or other 24-hour residential treatment beds. Unlike the N-MHSS datasets, historical IMHO data sets only contain a combined count of individuals in inpatient or other 24-hour residential treatment beds (e.g., separate numbers are not available for inpatient or other-24-hour residential treatment beds)
2. NIMH-SAMHSA Annual Survey of Patient Characteristics—annual report--State and County Mental Hospital Inpatient Services (data available from 1971 through 2005).[14]
3. NIMH/SAMHSA Statistical Notes: these are brief summaries of research studies written by NIMH or SAMHSA staff that often include historical data on inpatient and residential treatment services.

Data Sources for Information about Mental Health Treatment Beds

Mental Health Bed Settings	Current Data Sources	Historical Data Sources
Psychiatric Inpatient Residents Settings: State Hospitals, Private Psych Hospitals, General Hospitals with Separate Psych Units, VA Medical Centers, RTCs, Other Psych Beds	**N-MHSS: (2010 to present)** N-NMHSS provides separate counts for Psych Inpatient and Other 24-Hour Residential Treatment	**IMHO (1970 to 2008)** IMHO data combines Psychiatric Inpatient and Other 24-Hour Residential Treatment
State Psychiatric Hospitals: Several data sources include more details on patients in state psychiatric hospitals	**Uniform Reporting System (2002 to present)** Number of residents in state hospitals on the first day of years (by Children and Adults)	**Annual Survey of Patient Characteristics (1971 to 2005)** Number of Residents in state hospitals on a single day: Information by age and major diagnoses.

Mental Health Bed Settings	Current Data Sources	Historical Data Sources
NRI State Mental Health Agency Profiles The State Profiles information is collected by NRI approximately every two years and includes information about the organization, policies, services, and funding of state mental health agencies. Information about the number of state hospitals, policies regarding the use of state hospitals, and financing of state hospitals are collected each cycle**.**	**SAMHSA Sponsored State Profiles: (1990 to 2015)** With financial support from SAMHSA, NRI conducted State Profile reports regularly from 1990 to 2015. State expenditures for state hospitals was collected from FY 1981 to FY 2015.	**State Sponsored State Profiles: (2020 to present)** In 2020, NRI re-launched State Profiles with financial support directly from state mental health agencies. Information about the use of state hospitals, their financing, and patient legal characteristics are included in the data set.

Use of Psychiatric Beds and the Policies Focusing on Transition to Community-based Services

The decline in psychiatric inpatient capacity over the past 65 years has been part of a historic transformation of how and where services to individuals with serious mental illness are provided. Until the 1960s, the Federal collection of information about mental health services focused exclusively on psychiatric hospitals, as they were the primary settings where individuals with serious mental illnesses received services.

Today, psychiatric beds are used as one piece of a continuum of mental health care for individuals in acute crises and those with complex needs that may not be met by community services, often with multiple diagnoses—and individuals with criminal justice involvement who are sent to psychiatric institutions by the judicial system for evaluations and treatment. In 2020, state mental health systems provided mental health services to over 8 million individuals, but only 1.6% received mental health services in state psychiatric hospitals.[15] Although fewer than 2% of clients received services in state psychiatric hospitals, states expended $11.5 billion providing those intensive services (24% of total SMHA expenditures).[16]

The shift of state mental health services from state psychiatric hospitals to community mental health services and supports reflects an over 50-year evolution in mental health treatment philosophy and treatment objectives. Several authors have investigated how the development of first-generation antipsychotic and antidepressant medications in the 1950s permitted the movement of patients out of state psychiatric hospitals that had grown into large institutions—some of which were essentially "warehousing" over 10,000 patients with little successful treatment prior to the new medications.[17,18,19,20] In 1963, President Kennedy pushed the adoption of the Community Mental Health Act (CMHA),[21] funding the establishment of comprehensive community mental health centers (CMHCs) across the country. One of the explicit goals of the CMHA was to reduce the use of psychiatric hospitals by adopting a philosophy of making community mental health centers the central location for mental health services, including inpatient care as a key service. The Act also considered individuals with intellectual and developmental disabilities (I/DD) in its formulation as the organization of services were generally combined at the time for individuals with I/DD and those with serious mental illness.

Implementation of the CMHA never met the goals originally envisioned, and failed to end the need for specialized psychiatric hospitals.[22,23,24] In 1982, the CMHA was transitioned into the MHBG.[25] The MHBG directs community mental health funds through each state's SMHA, with the requirement that states use the MHBG funds to plan and implement comprehensive community-based mental health service system that minimizes the use of restrictive inpatient care. The MHBG statute requires SMHAs enable individuals receiving comprehensive community mental health services to function outside of inpatient or residential institutions to the maximum extent of their capabilities.[26] In implementing the MHBG, SAMHSA also developed and worked with states to implement Community Support Program (CSP) model services that uses trained mental health case managers to help individuals with serious mental illnesses access the services and supports necessary to live in their own communities. While appropriations for the MHBG have failed to keep up with inflation and population growth, the MHBG remains a critical source supporting state development of comprehensive community mental health systems designed to minimize the use of hospital level of care.

During the 1980s and 1990s, the National Institute of Mental Health (NIMH), SAMHSA, and others developed evidence-based model community-based mental health treatment options with the goal of helping individuals with serious mental illness to receive services in their own communities and avoid hospitalizations—services such as ACT, supportive housing, supported employment, Cognitive Behavioral Therapy (CBT), and recovery-focused psychosocial rehabilitation services.

The development of community-based services over the past 50 years was further supported by the passage of state and Federal laws that drastically increased financial support for community mental health services.[27] In particular, Medicaid and Medicare have expanded as major sources of reimbursement for community mental health services. Also, in recent years the passage state and Federal mental health parity laws mandate that private insurance plans eliminate restrictions on payment for mental health services that are not on parity with restrictions on payment for analogous medical/surgical services, creating more access to mental health services and healthcare coverage and reimbursement for them. In the 1990s, the use of managed care for both private insurance and Medicaid increased the potential funding of community mental health services, but also added new levels of oversight/utilization review that limited payments for psychiatric inpatient care.[28,29]

Finally, since the 1970s, the Federal Government, through a series of laws and court cases has been actively pursuing policies that reduce the use of psychiatric hospitals unless absolutely necessary. Federal policy has challenged inappropriate hospitalizations, incentivized community-based treatments, and supported the development of evidence-based community-based alternatives to hospitalization such as Assertive Community Treatment (ACT) services and Coordinated Specialty Care for individuals experiencing a first episode of psychosis.

Federal policies that explicitly limit funding or use of psychiatric inpatient services include:

1. **Federal Medicaid Institutions of Mental Disease (IMD) Coverage Limitations (1965)** — When the Social Security Act Amendments of 1965[30] creating the Medicaid program were enacted, they set limits on Medicaid payment for services in IMDs. Over the years, exceptions to the limits were carved out for inpatient services provided to older adults and children. The current Medicaid regulations prohibit Federal Medicaid matching payments for adults' ages 22 to 64 in inpatient and other 24-hour residential treatment settings in institutions with more than 16 beds where more than half the patients have a mental illness.[31] The IMD rule has incentivized states to shift acute psychiatric treatment for adults from state psychiatric hospitals (which are IMDs and thus unable to

bill Medicaid) to general hospital psychiatric beds (which are able to bill Medicaid). For example, if a state closes an acute unit in a state hospital that relied on $10 million in state general revenue funds, the state could use those $10 million as match for Medicaid billing of acute psychiatric inpatient services in a general hospital to leverage an additional $10 to $20 million of federal Medicaid funds (the Federal Medical Assistance Percentage (FMAP) match rates range from 50% state-50% federal contribution to 18% state-82% federal depending on a state's per capita income level).

A recent change to Medicaid managed care regulations[32] also allows coverage of 15 days or less in a month for residential substance use disorder services and psychiatric inpatient services in a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services through the capitated payments made to Medicaid managed care organizations.[33]

Medicaid Disproportionate Share (DSH) Payments have allowed some states to receive reimbursements from Medicaid for providing services to individuals without insurance. However, while Medicaid DSH has been an important source of funding for some state and private psychiatric hospitals, the use of DSH to cover IMD services varies considerably from state to state.[34] The Affordable Care Act (ACA) has increased the number of individuals with insurance coverage and as a result, the ACA is scheduled to phase out DSH funding over the next few years. If DSH funds are eliminated, an additional federal source of support for psychiatric inpatient care will disappear.

2. **Mental Health Block Grant (MHBG) Law** —The MHBG law requires SMHAs to use block grant monies to "enable individuals receiving comprehensive community mental health services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities." The MHBG statute prohibits any expenditure of MHBG funds for inpatient services.[35]

3. **Civil Rights of Institutionalized Persons (CRIPA) —** The Federal law intended to protect the rights of individuals in state and local psychiatric hospitals, nursing homes, institutions for individuals with intellectual/developmental disabilities, or in correctional facilities has been the basis of a number of lawsuits and settlements focusing on overuse and inappropriate care in state psychiatric hospitals. The goal of that litigation is frequently the reduction in use of inpatient care and an expansion of community-based alternatives.

4. **Americans with Disability Act of 1990 (ADA)** – The ADA is a Federal statute that requires several accommodations for individuals with disabilities, prohibits unjustified segregation of them. [36] In 1990, the Supreme Court determined in the *Olmstead* decision[37] that the ADA applies to patients in state psychiatric hospitals and that states must make reasonable accommodations to support the community integration of individuals with mental illnesses who are clinically appropriate for discharge and community-based settings. The *Olmstead* decision has been the focus of much litigation, and many settlements have focused on inappropriate or overuse of institutional care.

5. **Fair Labor Standards Act and the 1973 *Souder v Brennan* Federal Court Decision** – Although not often cited as a reason for deinstitutionalization, the Federal District Court for the District of Columbia held in a 1973 decision that hospital patients who perform work within state institutions are entitled to payment for their labor, even where such employment is considered to be therapeutically advisable for the patient. [38] The result of this decision was that volunteer patient laborers working in state hospitals to maintain the hospital (working in the laundry, kitchen, maintenance or to grow food in rural areas on hospital farms) or in workshops contained within the hospital that produce products for the hospital and outside sale now needed to receive minimum wage for hours worked.[39] An example of the impact of this decision is found in a 1974 Michigan budget document that appropriated

$800,000 for wages for patients in state hospitals, citing the *Souder* decision.[40] After the *Souder* decision, the increased costs of having to pay for kitchen, laundry, workshops, farms and other state hospital operations led some states to close their workshops and farms and downsize the hospitals.

6. **New Behavioral Health Crisis Services** In 2020, SAMHSA issued the "National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit."[41] The Crisis Toolkit identifies three core service elements for crisis systems:

    - Regional or statewide crisis call centers coordinating in real time. In July 2022, the National Suicide Lifeline transitioned to a three-digit (988) number that connects individuals in crisis with over 200 regional crisis centers for phone, text, and chat services.
    - Centrally deployed, 24/7 mobile crisis teams.
    - 23-hours crisis receiving and stabilization programs.

The new national initiative to expand behavioral health crisis services has great potential to reduce the need for psychiatric bed use by helping individuals experiencing a behavioral health crisis to receive immediate care and avoid using emergency rooms or hospitalization. The Crisis Now model in Arizona has documented that by offering these three sets of coordinated behavioral health services, that they have greatly reduced the number of individuals receiving psychiatric hospitalization services while providing immediate services to meet needs in the community.

Availability of Psychiatric Inpatient Services in 2018

Beds available to provide 24-hour mental health treatment to individuals requiring a high level of intensive and expensive treatment are available in a variety of settings, including as noted above specialized psychiatric hospitals (run by state government, city/county governments or private corporations), specialty psychiatric inpatient and licensed residential treatment units in general hospitals and other organizations, RTCs for children and adults (organizations that provide intensive 24-hour treatment services but are not licensed as "inpatient" services), DOD and VA facilities, nursing homes, and psychiatric inpatient units within jails and prisons. Unfortunately, there is no single source of information that documents all psychiatric inpatient capacity across the various types of organizations that provide these services. This paper combines available information from multiple data sources to estimate the overall inpatient and other 24-hour inpatient capacity in the U.S. in 2018.

The most recent year for which information on psychiatric inpatient capacity is available across multiple settings is 2020, but that information is confounded by data being collected during the start of the COVID-19 pandemic. Information on resident patients (inpatient and other 24-hour treatment) in 2020 reflects a 35.4% decrease in the number of residents over the 2018 data (a 40% reduction in inpatients and 26% reduction in patients in other 24-hour residential treatment beds). The number of organizations reporting inpatient data also decreased by 6% from 2020 to 2018. While some of the decrease may be due to temporary closing of beds during the early stages of COVID, analysis of some state data shows some facilities may have not reported any data during the COVID epidemic. For example, one state reports that they did not close any of their state psychiatric hospitals during COVID, but the 2020 N-MHSS shows a decline of six public psychiatric hospitals from 2018 to 2020. Because of the uncertainty of the 2020 data, this report includes some tables that show the 2020 data, but predominately relies on 2018 in discussing trends and current inpatient capacity.

The SAMHSA National Mental Health Service Survey (N-MHSS) is collected every two years and documents inpatient and other 24-hour mental health treatment beds in organizations that provide

specialized mental health units. Organizations covered by SAMHSA surveys include (1) state and county psychiatric hospitals, (2) private psychiatric hospitals, (3) general hospitals with psychiatric units, (4) VA Medical Centers with psychiatric units, (4) Residential Treatment Centers (RTCs) for Children and Adults, and (5) other mental health treatment organizations that provide inpatient or other 24-hour treatment beds (organizations such as community mental health centers). RTCs are a type of mental health treatment provider that provides specialized mental health residential treatment (usually licensed separately from inpatient beds) that has grown rapidly in their capacity over the past decades.

Psychiatric Inpatient Capacity in Mental Health Specialty Organizations

SAMHSA and its predecessor agency, the Alcohol, Drug Abuse, and Mental Health Administration, have been routinely conducting surveys of all specialty mental health providers since the 1970s. These surveys, called the Inventory of Mental Health Organizations (IMHO) in the 1980s and 1990s and recently revised into the National-Mental Health Services Survey (N-MHSS) compile information on the number of specialty mental health providers that provide psychiatric inpatient and residential services and information on the number of residents in these facilities on the last day of the year.

The 2018 N-MHSS documents that 187,877 individuals were patients in specialty psychiatric beds at the end of the year (Table 1). Sixty-nine percent of those individuals were residents in licensed inpatient beds at the end of the year, and 31% were residents in other types of 24-hour residential beds at the end of the year.

Table 1: Number and Rate per 100,000 population of psychiatric inpatients and other 24-hour residential treatment patients at end of year 2018

Type of Organization	Patients in Inpatient Settings at End of Year			Patients in Other 24-Hour Residential Treatment at End of Year			Patients in Inpatient and Other 24-Hour Residential Treatment at End of Year		
	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate per 100,000 Population
State & County Psychiatric Hospitals	33,225	26%	10.2	2,500	4%	0.8	35,725	19%	10.9
Private Psychiatric Hospitals	50,200	39%	15.3	4,196	7%	1.3	54,396	29%	16.6
General Hospital with Separate Psychiatric Units	40,052	31%	12.2	478	1%	0.1	40,530	22%	12.4
VA Medical Centers	2,662	2%	0.8	4,330	7%	1.3	6,992	4%	2.1
Residential Treatment Centers (RTCs)	454	0%	0.1	36,391	62%	11.1	36,845	20%	11.3
Other Specialty Mental Health Providers with Inpatient/Residential Beds	2,522	2%	0.8	10,867	18%	3.3	13,389	7%	4.1
Total in specialty MH Provider Organizations	129,115	100%	39.5	58,762	100%	18.0	187,877	100%	57.4

Source: Table compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a

Among specialty inpatient providers, private psychiatric hospitals were the largest single source of inpatient residents (50,200) in 2018, followed by general hospitals with separate psychiatric units (40,052 residents), and state and county psychiatric hospitals (33,325, as counted on patients in a bed on April 30th). Note that 2018 is the first time that more individuals were residents in private psychiatric hospitals and general hospitals than in state psychiatric hospitals.

Among specialty mental health providers with 24-hour residential treatment beds, RTCs, with 36,391 patients on the last day of the year) and other specialty mental health providers (such as community mental health centers), were the second largest setting for other 24-hour psychiatric treatment patients. Combining inpatient residents with other 24-hour treatment units, private psychiatric hospitals (with 54,396 residents) were the largest provider of psychiatric beds in 2018.

Rates of Psychiatric Inpatient Capacity and 24-Hour Treatment Capacity per 100,000 Population

In analyzing the use of psychiatric inpatient capacity between states and over time, it is important to factor in the differences in the size of individual state populations and population changes over time. A standard method used to adjust for variation in population size and growth over time is to calculate a ratio per 100,000 population (dividing the number of patients by the relevant population number and then multiplying by 100,000).

Using this approach, in 2018, there were 39.5 psychiatric inpatient residents per 100,000 in specialty mental health providers and an additional 18.0 patients per 100,000 in 24-hour residential treatment beds. A total of 57.4 residents per 100,000 were in various specialty psychiatric treatment beds on the last day of 2018.

Children in 24-hour mental health beds in Specialty Programs, 2018

The types of organizations where children (under age 18) receive 24-hour inpatient and residential treatment differ greatly from the types of organizations and settings where adults receive treatment (Table 2). Among children treated in psychiatric inpatient settings, 65%were served in private psychiatric hospitals, followed by general hospitals with separate psychiatric units (26%). Only 6% of children receiving inpatient services received those services at a state psychiatric hospital. A 2021 NRI report found that by policy 31 states do not treat any children in their state psychiatric hospitals.[42]

Children were more likely to receive 24-hour treatment in residential treatment programs (60% of children) than in psychiatric inpatient programs (40%). Most children received 24-hour residential treatment services in RTCs (79%), followed by private psychiatric hospitals (10%) and other specialty settings (including community mental health centers).

Table 2: Number and Rate of Children (under age 18) per 100,000 population of psychiatric inpatients and other 24-hour residential treatment patients at end of year 2018

Year/Setting	Children in Psychiatric Inpatient Settings at End of Year			Children in Other 24 Hour Residential Treatment at End of Year			Total Numbers of Children in either Inpatient or Other 24 Hour Residential Treatment at End of Year		
	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate per 100,000 Population
State & County Psychiatric Hospitals	1,000	6%	1.4	41	0%	0.1	1,041	2%	1.4
Private Psychiatric Hospitals	10,827	65%	14.8	2,564	10%	3.5	13,391	32%	18.2
General Hospital with Separate Psychiatric Units	4,298	26%	5.9	110	0%	0.1	4,408	11%	6.0
VA Medical Centers	14	0%	0.0	15	0%	0.0	29	0%	0.0
Residential Treatment Centers (RTCs)	182	1%	0.2	20,069	79%	27.3	20,251	48%	27.6
Other Specialty Mental Health Providers with Inpatient/ Residential Beds	336	2%	0.5	2,470	10%	3.4	2,806	7%	3.8
Total Specialty MH Providers	**16,657**	**100%**	22.7	**25,269**	**100%**	34.4	**41,926**	**100%**	57.1

Source: Table compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

Legal Status of Inpatients in Specialty Programs, 2018

Psychiatric patients may enter inpatient and other 24-hour residential treatment facilities either on a voluntary basis or involuntarily basis. There are two types of involuntary admissions that are tracked in the SAMHSA datasets: “involuntary, non-forensic” (persons civilly committed) and “involuntary, forensic” (individuals ordered by a criminal court to evaluation or treatment). Under their state’s civil commitment statute, individuals may be held on involuntarily commitment orders if they are determined by a court to be at risk to harming themselves or others as a result of the symptoms of their mental illness. Classes of forensic patients include individuals sent to hospitals for:

1. assessment of competency to stand trial (CST),
2. competency restoration before trial for individuals found incompetent to stand trial (IST)
3. evaluation or treatment of individuals found Not Guilty by Reason of Insanity (NGRI)
4. treatment of individuals found Guilty but Mentally Ill (GBMI),
5. evaluation and/or treatment of patients transferred from jail or prisons for psychiatric treatment not available in those settings
6. in some states, convicted sexual offenders requiring psychiatric treatment.

In 2018, under half (43%) of psychiatric inpatients in specialty settings were voluntary patients, while 41% were “involuntary, non-forensic” and 16% were involuntary-forensic status.

Table 3: Patients in 24-hour psychiatric inpatient settings in specialty mental health organizations, by legal status, 2018

	Voluntary Patients		Involuntary, non-Forensic		Involuntary, Forensic	
	Number	Percent	Number	Percent	Number	Percent
State And County Psychiatric Hospitals	3,099	11%	10,429	36%	15,734	54%
Private Psychiatric Hospitals	22,877	50%	21,173	47%	1,438	3%
General Hospitals With Separate Psychiatric Units	20,548	56%	14,608	40%	1,407	4%
VA Medical Centers	1,535	74%	453	22%	79	4%
RTC For Children	116	79%	29	20%	1	1%
RTC For Adults	130	45%	138	47%	24	8%
Other facilities providing specialized psychiatric inpatient care	1,229	53%	961	42%	119	5%
Total	49,534	43%	47,791	41%	18,802	16%

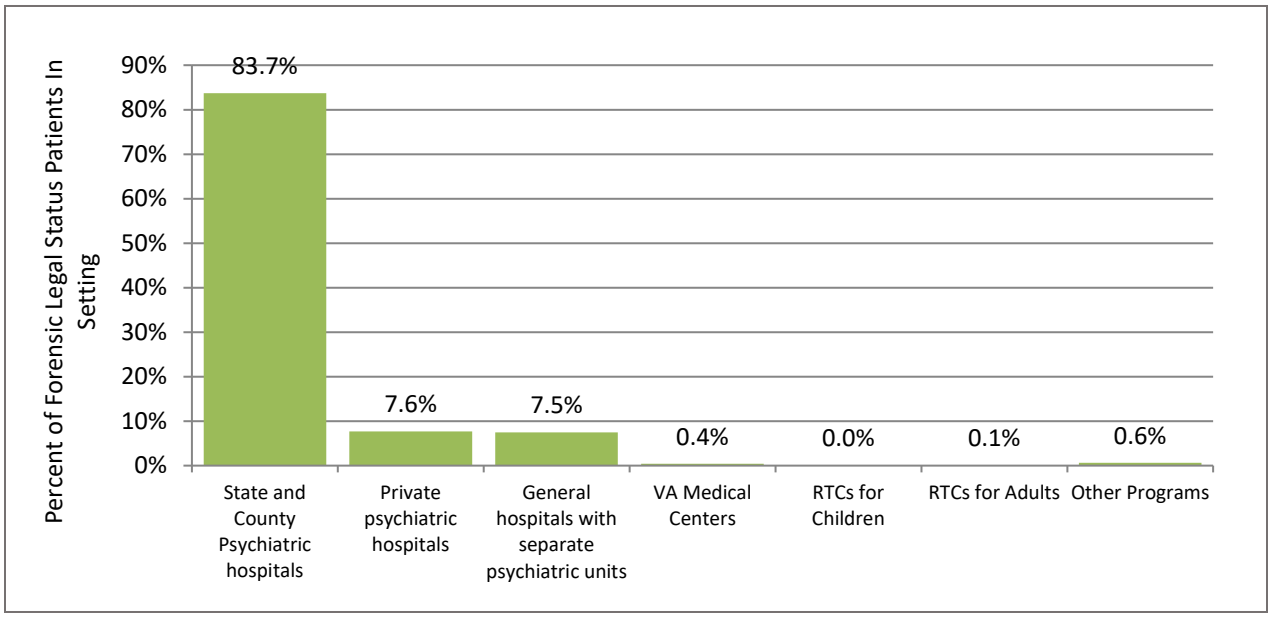
Source: Table compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

Table 3 shows that the legal status of patients differs significantly by type of treatment setting. Forensic status patients were the largest patient group (54%) in state and county psychiatric hospitals but were 5% or less of patients in every other psychiatric inpatient setting.

Patients voluntarily admitted comprised the largest groups in all settings other than state and county psychiatric hospitals. Only 16% of patients in state and county psychiatric hospitals had a voluntary legal status. The low percentage of voluntary patients in state and county psychiatric hospitals may reflect policies developed in some states that reserve state psychiatric hospital beds for involuntary civil and forensic admissions and direct persons seeking voluntary admission into other settings.

The majority of involuntary, forensic legal status patients (84%) were patients in state and county psychiatric hospitals. Only 6% were residents in private psychiatric hospitals and four percent were in general hospital special psychiatric inpatient units (Figure 1).

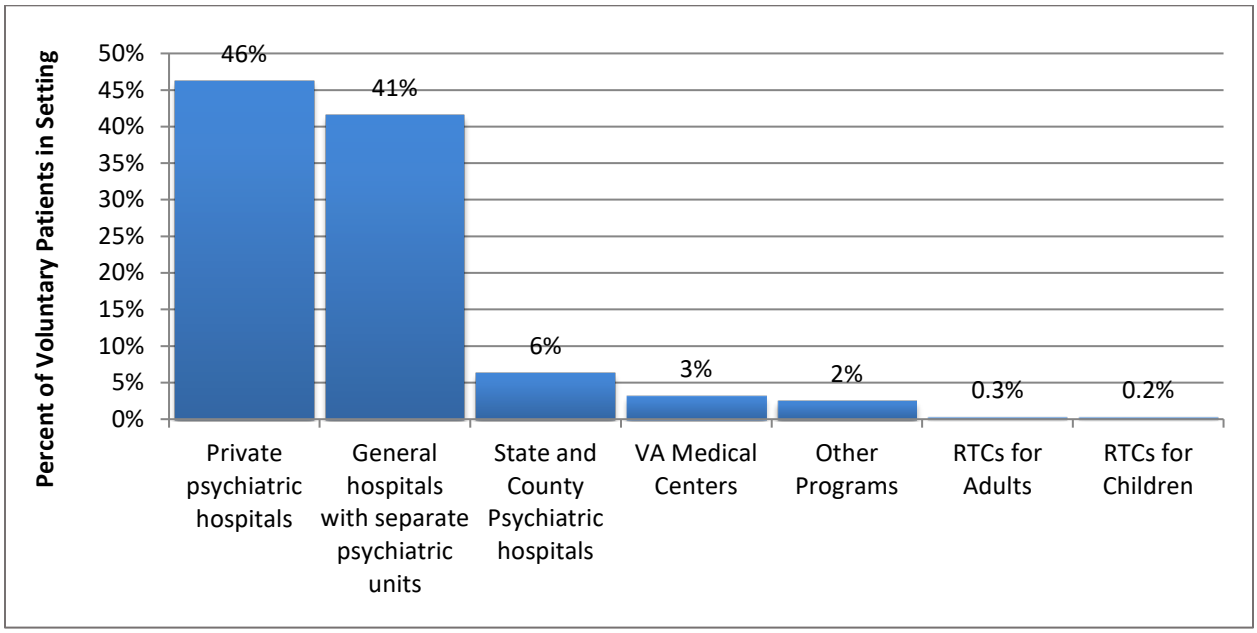
Figure 1: Inpatient Settings where Involuntary-Forensic Patients were served, 2018



Source: Figure compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

In another way of examining the data, inpatients with a voluntarily legal status in psychiatric inpatient beds were most frequently served in private psychiatric hospitals (46%) and general hospitals with separate psychiatric units (41%). Only 6% of patients voluntarily admitted to inpatient units were in state and county psychiatric hospitals (Figure 2).

Figure 2: Inpatient Settings where Voluntary patients were served 2018



Source: Figure compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

Number of Organizations with Specialized Inpatient and Other 24-Hour Residential Mental Health Treatment Programs

In 2018, there were 1,920 different mental health organizations nationally providing psychiatric inpatient services and, 1,932 mental health organizations providing 24-hour residential (i.e., non-hospital) mental health treatment (note many mental health treatment organizations provide both inpatient and 24-hour residential treatment). General hospitals were the most frequent setting providing psychiatric inpatient care, representing 55% of organizations providing inpatient treatment and 31% of psychiatric inpatients. Private psychiatric hospitals were the second largest group of providers of inpatient care, with 25% of psychiatric inpatient organizations serving 39% of psychiatric inpatients. State and county psychiatric hospitals represented only 11% of the organizations providing psychiatric inpatient care, but since they were the largest organization in terms of beds, they served 26% of psychiatric inpatients in 2018.

Residential Treatment Centers (RTCs) were the most common type of organization providing other non-inpatient 24-hour treatment services in 2018—76% of all organizations providing other 24-hour treatment serving 62% of residents—followed by other specialty mental health organizations (12% of organizations serving 18% of residents) and private psychiatric hospitals (5% of organizations, representing 7% of patients receiving 24-hours residential treatment).

Table 4: Number of Organizations Providing Psychiatric Inpatient Services or Other 24-hour Residential Treatment and Number of Individuals in Beds in these Settings on April 30, 2018

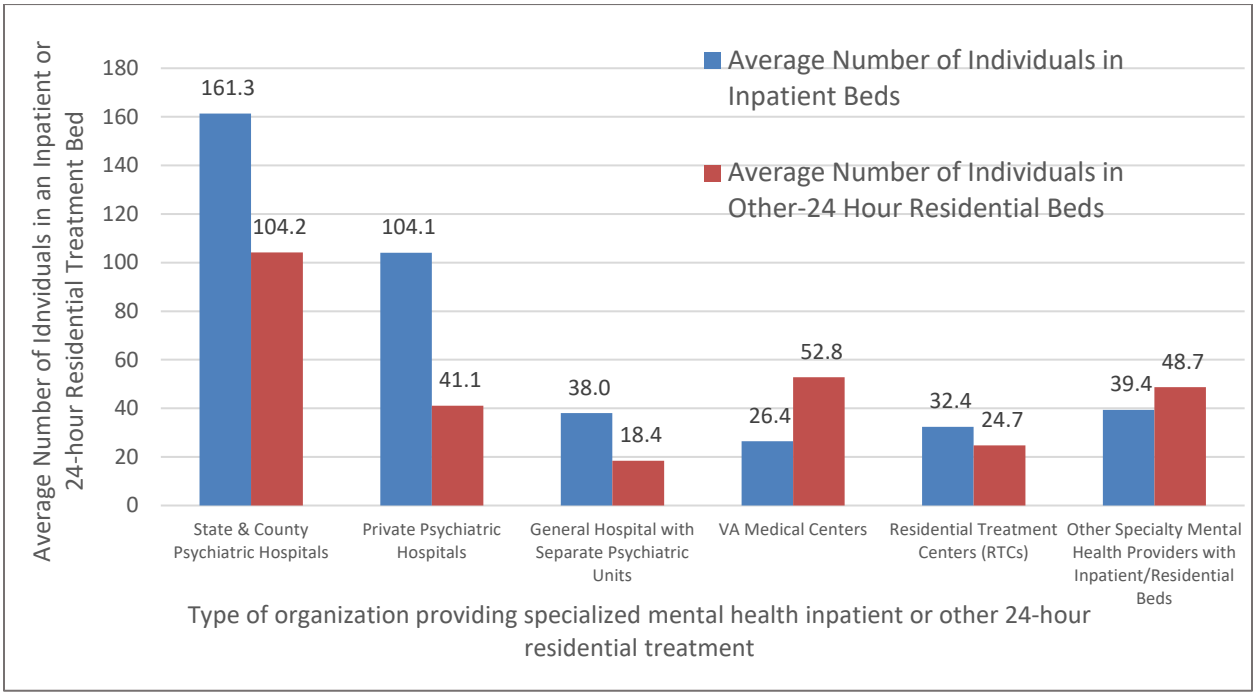
Year/Setting	Psychiatric Inpatient Settings			Other 24-Hour Residential Treatment Settings		
	Number of Organizations	Number Individuals in Inpatient Beds	Average Inpatient Bed Per Organization	Number of Organizations	Number Individuals in Residential Treatment Beds	Average Individuals in a Residential Treatment Bed Per Organization
State & County Psychiatric Hospitals	206	33,225	161.3	24	2,500	104.2
Private Psychiatric Hospitals	482	50,200	104.1	102	4,196	41.1
General Hospital with Separate Psychiatric Units	1,053	40,052	38.2	26	478	18.4
VA Medical Centers	101	2,662	26.4	82	4,330	52.8
Residential Treatment Centers (RTCs)	14	454	32.4	1,475	36,391	24.7
Other Specialty Mental Health Providers with Inpatient/Residential Beds	64	2,522	39.4	223	10,867	48.7
Total Specialty MH Providers	**1,920**	**129,115**	**401.7**	**1,932**	**58,762**	**289.9**

Note, many organizations provide both inpatient and other 24-hour residential treatment services
Source: N-MHSS 2018: Tables 2.3, 2.5, 3.1a, and 3.2a

Table 4 and **Figure 3** show that, on average in 2018, state and county psychiatric hospitals have the largest capacity for psychiatric inpatient services, averaging 161 patients per hospital, followed by private psychiatric hospitals with an average of 104 patients per hospital, General hospitals with separate psychiatric units averaged 38.2 inpatients per hospital, and VA Medical Centers averaged 26.4 patients per hospital.

Among other 24-hour mental health residential treatment providers, state and county psychiatric hospitals had the largest patient populations—with an average of 104 patients per state and county hospital providing this service—followed by VA Medical Centers with 52.8 patients per hospital, and other specialty mental health providers (48.7 patients per organization). RTCs, although the most frequent provider of 24-hour residential treatment had a smaller average size of 24.7 patients per RTC.

Figure 3: Average Number of individuals in Inpatient Beds and Other 24-Hour Residential Treatment Beds, by type of Mental Health Organization, 2018



Other Settings with Psychiatric Inpatient and 24-hour Residential Treatment in 2014

Use of Nursing Homes to Serve Individuals with Mental Illnesses and Systems Considerations in Serving Older Adults with Dementias

With support from Medicaid, Medicare, and private health insurance, nursing homes have become one of the major sites for long-term health care, not only for older adult individuals, but also for patients with complex health conditions who do not need intensive inpatient psychiatric level care but are unable to live independently and need active nursing and other services. Nursing home residents may have a variety of mental health-related diagnoses, including major mental illnesses such as schizophrenia, depression, and bipolar disorders, as well as other brain diseases related to aging such as Alzheimer's disease and other neurocognitive disorders (commonly referred to as dementias).

The Centers for Medicare and Medicaid (CMS) maintain a Minimum Data Set (MDS) that includes information about major diagnoses of patients in nursing homes. Since most state psychiatric hospitals currently focus on serving persons with major psychiatric illnesses, they have ceased to focus on Alzheimer's and dementia disorders for older adult individuals, though will still have patient populations with these conditions for a variety of reasons, and often these patients have co-occurring mental illness with their neurocognitive challenges. For example, many are sent in via criminal justice or forensic processes. In 2021, 34 SMHAs reported responsibility for Alzheimer's services are no longer a primary target population of the SMHA and are instead the responsibility of a different state government agency. Some have noted that more work needs to be done to understand the older adult population with dementia that are caught between systems especially the criminal and forensic systems.[43] Because states no longer view the state hospitals as the placement for these populations, data on their prevalence in state and other psychiatric settings is difficult to get.

For purposes of this estimate of psychiatric bed utilization now found in nursing homes, we have limited the review to the count of nursing home capacity for residents with schizophrenia or bipolar disorders. In 2018, 13% of residents in nursing facilities had a diagnosis of schizophrenia or bipolar disorders residing in nursing homes (about 152,149 residents).[44] The MDS system identifies much higher numbers of residents with other mental disorders (616,804 residents or 48.74% had an active diagnosis (last 7 days) of depression and 372,055 residents or 29.36% had an active diagnosis (last 7 days) of anxiety disorders.[45]

But we advise caution: while this report identifies more than 180,000 patients with serious mental illnesses in nursing facilities, it is not possible to determine from the MDS database if a patient is residing in a nursing facility due to a mental health diagnosis or due to other health conditions that require nursing facility level of care.

Gaps in information about inpatient psychiatric beds

There are several settings where individuals are known to receive 24-hour inpatient or residential mental health treatment, but for which estimates of the number of beds or residents were not available for 2018 (or 2020). Two potentially major areas that are missing from these bed estimates are inpatient psychiatric units or the equivalent available in jails and prisons, and general hospitals providing mental health services in non-specialty units (sometimes referred to as 'scatter beds').

Inpatient Psychiatric Units in Jails and Prisons

The level of mental illness among inmates in prisons and jails is enormous, with estimates ranging from 15% to 20% of inmates in prison and up to 44% of individuals in jails having some kind of mental distress.[46] Just like in society generally, many of the inmates within jails and prisons do not require the intensive level of mental health treatment of an inpatient psychiatric unit. Only a portion of the population of inmates with mental illness would require intensive inpatient psychiatric treatment and, for most of these patients, the need for inpatient psychiatric treatment is likely short-term acute care to stabilize their illnesses. In a few states, inmates with mental illness who need an inpatient level care may be transferred to a state psychiatric hospital to receive intensive inpatient services. (The companion Forensic Trends White Paper details some of the number of patients transferred from jails and prisons to state psychiatric hospitals.)

To meet the acute psychiatric inpatient needs of inmates with mental illnesses, some jails and prisons have opened and staffed inpatient mental health units within their correctional facilities. Unfortunately, these units are not subject to the routine SAMHSA data collection efforts and no comprehensive and historical data on the treatment capacity of these units has been identified, nor have their standards as inpatient settings been consistently applied, making it difficult to know what level of care is needed or received. The Federal Bureau of Justice Statistics (BJS) indicates it is planning to include identification of such resources in future surveys of jails and prisons.

General Hospitals Providing Mental Health Services in Non-Specialty Units

In 2019, there were 5,262 community (general) hospitals in the United States,[47] of which 1,053 had specialty psychiatric units that reported to SAMHSA in the 2018 NMHSS.[48] In some areas of the country—particularly rural and frontier areas—there may be no specialized psychiatric beds available, and in other areas the limited number of available psychiatric beds may all be filled when a person needs admission for intensive psychiatric services. General hospitals often provide acute inpatient

services to patients with mental health disorder. As noted above, when these services are provided in general hospitals on medical or pediatric beds, these are often labeled psychiatric "scatter beds".[49]

No routine data collection exists that identifies "scatter beds" in general hospitals. The SAMHSA NMHSS survey focuses on general hospitals that have specialized mental health treatment units and does not estimate scatter beds being used to provide mental health treatment in general hospitals without specialty units. The Federal Agency for Health Care Research and Quality (AHRQ) produces annual reports through its Healthcare Cost and Utilization Project (HCUP) that identifies patients discharged from all general hospitals in various diagnostic groupings, including a set of mental health and substance abuse diagnostic groupings, but this data set does not allow for identifying if the discharges are from specialized or non-specialized general hospital units. The HCUP database has been used by other researchers to estimate the use of general hospital scatter beds to provide mental health inpatient care. A 2010 study by Mark, et.al, found that approximately 6% of mental health care discharges came from scatter beds.[50]

Summary: All Psychiatric Inpatient and Other 24-Hour Capacity

The 2018 SAMHSA N-MHSS survey identified a total of 187,877 person in a mental health bed (both inpatient and 24-hour residential treatment beds). This equates to a ratio of 56.8 residents in a mental health bed occupied per 100,000 population in 2018.

In addition to the residents in inpatient psychiatric beds and other 24-hour residential treatment beds, estimates of the number of individuals with serious mental illnesses (schizophrenia and bipolar disorders) served in nursing homes add an additional 152,149 residential treatment patients to the 58,762 mental health patients identified by the SAMHSA N-MHSS study. Therefore, an estimated 210,911 patients with mental illness were in a 24-hour residential treatment bed in 2018 (a ratio of 63.8 per 100,000 population).

Table 5, below, shows the combined estimate that 411,794 individuals with mental illness were in either an inpatient or other 24-hour residential treatment bed during a day in 2018. The 411,794 mental health patients in a mental health inpatient or other 24-hour residential treatment bed when adjusted for the U.S. population means there were at least 124.5 patients per 100,000 population in an overnight bed on a single day in 2018.

Table 5: Psychiatric Inpatients and Other 24-hour Patients in Specialty and Non-Specialty Psychiatric Organizations, 2018

Year/Setting	Patients in Inpatient Settings at End of Year		Patients in Other 24-hour Residential Treatment at End of Year		Patients in Inpatient and Other 24- hour Residential Treatment at End of Year	
	Residents	Rate Per 100,000 Population	Residents	Rate Per 100,000 Population	Residents	Rate per 100,000 Population
NMHSS Identified Specialty Mental Health Organizations	129,115	39.0	58,762	17.8	187,877	56.8
Nursing Homes - patients with diagnosis of schizophrenia or bipolar disorders (2019)			223,917	67.7	223,917	67.70
Scatter Beds in General Hospitals	Estimate <6% of discharges		Estimate Not Available		Estimate Not Available	
Psychiatric Treatment Units in Jails	Estimate Not Available		Estimate Not Available		Estimate Not Available	
Psychiatric Treatment Units in Prisons	Estimate Not Available		Estimate Not Available		Estimate Not Available	
Total Known Psychiatric Inpatient/Residential	**129,115**	**39.0**	**282,697**	**85.5**	**411,794**	**124.5**

Trends in Total Psychiatric Inpatient and Other 24-Hour Treatment 1970 to 2018

Since 1970, the number of individuals in a psychiatric inpatient or other 24-hour residential treatment bed on any given day has decreased by over 283,000 (a decrease of 60.1%). Most of this decline has been observed in state and county psychiatric hospitals, where patient census decreased by 90.3%, and VA Medical Center psychiatric units, with decreases of 86.5%. However, some of the other types of specialty mental health providers increased the number of inpatient and other 24-hour residential treatment patients they served in that time. Private psychiatric hospital inpatient census increased by 43,433 or 396.2%. Patients in general hospitals with separate psychiatric units increased by 22,722 (127.6%). RTCs increased by 23,356 (173.1.%). And other specialty mental health providers increased by 5,863, or 77.9% (Table 6).

***Table 6: Trends over time in combined psychiatric inpatients and other 24-hour treatment residents in specialty mental health organizations, 1970 to 2018* (resident patients in the facility on a given day)**

Year/ Setting	State & County Psychiatric Hospitals	Private Psychiatric Hosp	General Hospital with Separate Psychiatric Units	VA Medical Centers	RTCs	Other (Inpatient & Residential Treatment beds)	Total Psychiatric Inpatient & Residential Care
1970	369,969	10,963	17,808	51,696	13,489	7,526	471,451
1975	193,436	11,576	18,851	31,850	16,307	12,138	284,158
1979	140,355	12,921	18,753	28,693	18,276	11,188	230,186
1983	117,084	16,079	32,127	20,187	15,791	23,079	224,347
1986	111,135	24,591	34,474	24,322	23,171	20,152	237,845
1988	100,615	29,404	34,858	19,499	23,301	20,186	227,863
1990	90,572	32,268	38,327	17,233	27,785	20,768	226,953
1994	72,096	26,519	35,841	18,019	29,493	54,142	236,110
1998	63,765	20,804	37,053	14,329	29,049	56,216	221,216
2000	56,716	16,113	27,385	8,228	30,272	38,746	177,460
2002	52,612	17,858	28,460	8,386	35,709	37,518	180,543
2010	43,854	24,025	32,395	5,602	41,536	12,845	160,257
2014	39,907	28,461	31,453	7,010	42,930	20,439	170,200
2016	37,478	35,706	36,716	6,948	43,604	13,594	174,046
2018	35,725	54,396	40,530	6,992	36,845	13,389	187,877
2020*	31,817	25,386	21,522	3,799	29,607	9,235	121,366
Percent Change Over Time							
1970 to 1979	-62.1%	17.9%	5.3%	-44.5%	35.5%	48.7%	-51.2%
1979 to 1990	-35.5%	149.7%	104.4%	-39.9%	52.0%	85.6%	-1.4%
1990 to 2000	-37.4%	-50.1%	-28.5%	-52.3%	9.0%	86.6%	-21.8%
2000 to 2010	-22.7%	49.1%	18.3%	-31.9%	37.2%	-66.8%	-9.7%
2010 to 2018	-18.5%	126.4%	25.1%	24.8%	-11.3%	4.2%	17.2%
1970 to 2018	-90.3%	396.2%	127.6%	-86.5%	173.1%	77.9%	-60.1%
1970 to 2020*	-91.4%	131.6%	20.9%	-92.7%	119.5%	22.7%	-74.3%
Annualized Percent Change							
1970 to 1979	-10.2%	1.8%	0.6%	-6.3%	3.4%	4.5%	-7.7%
1979 to 1990	-3.9%	8.7%	6.7%	-4.5%	3.9%	5.8%	-0.1%
1990 to 2000	-4.6%	-6.7%	-3.3%	-7.1%	0.9%	6.4%	-2.4%
2000 to 2010	-2.5%	4.1%	1.7%	-3.8%	3.2%	-10.5%	-1.0%
2010 to 2018	-2.5%	10.8%	2.8%	2.8%	-1.5%	0.5%	2.0%
1970 to 2018	**-4.8%**	**3.4%**	**1.7%**	**-4.1%**	**2.1%**	**1.2%**	**-1.9%**

1970 to1979 data from NIMH Surveys
1983 to 2002 data from NIMH and SAMHSA Inventory of Mental Health Organization Surveys
2010 to 2020 from SAMHSA N-MHSS Surveys, Note, the 2012 N-MHSS did not collect client counts
** 2020 N-MHSS data shown, but likely reflects temporary closures and reduced reporting due to COVID.*

During the last decade (2010 to 2018) the number of patients in mental health inpatient and residential treatment beds increased by 17.2%. However, not all types of providers grew. State and county psychiatric hospitals decreased by 18.5% and residential treatment providers decreased their patients by 11.3%. During the same period, however, private psychiatric hospitals more than doubled their capacity (up 126.4% and general hospital specialty units (up 24.1%) and Veterans Department Medical Centers (up 24.8%) also increased.

"During the last decade (2010 to 2018) the number of patients in mental health inpatient and residential treatment beds increased by 17.2%.

At the same time, given population growth, psychiatric bed capacity per 100,000 population increased by 9.2%"

If one examines psychiatric bed capacity in relation to the total population, numbers are declining. The population of the United States has grown by 65.7% since 1970. As a result, the psychiatric bed capacity per 100,000 population as a ratio of patients per population (Table 7) shows an even greater total capacity decline than the decline in the total number of patients in **Table 6**. From 1970 to 2018, the number of patients in psychiatric beds in specialty providers declined from 236.8 patients per 100,000 population to 56.8 patients in beds per 100,000 population (a total reduction of 76%—an average annual drop of 2.9% per year from 1970 to 2018 [note 2020 numbers are also listed in **Table 7**, due to issues with the collection of 2020 data during the COVID-19 pandemic, discussion of changes over time utilize the 2018 data]). This may not be as dire as it seems, as with that decreased reliance upon inpatient psychiatric level of care has come an array of other community-based services that have continued to grow.

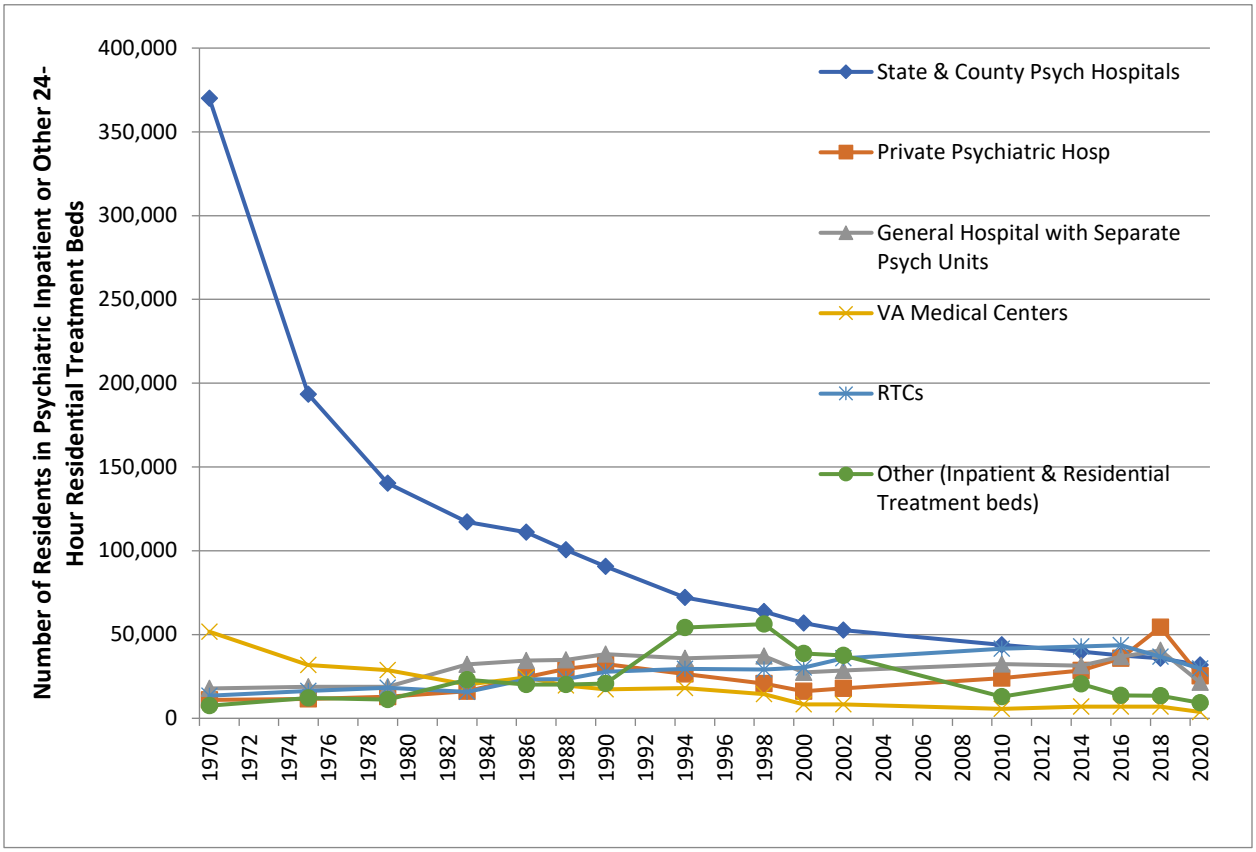
Table 7: Trends over Time in Residents per 100,000 population Residents in Psychiatric inpatients and other 24-hour treatment beds in specialty mental health organizations, 1970 to 2018

Year/ Setting	State & County Psychiatric Hospitals	Private Psychiatric Hospitals	General Hospital with Separate Psychiatric Units	VA Medical Centers	RTCs	Other (Inpatient & Residential Treatment beds)	Total psychiatric Inpatient & Residential Care
Rate per 100,000 population							
1970	185.80	5.50	8.90	26.00	6.80	3.80	236.80
1975	91.50	5.50	8.90	15.10	7.70	5.70	134.40
1979	63.00	5.80	8.60	13.30	8.20	5.00	103.90
1983	50.40	6.90	13.80	8.70	6.80	9.90	96.50
1986	46.50	10.30	14.40	10.20	9.70	8.50	99.60
1988	41.20	12.00	14.30	8.00	9.50	8.30	93.30
1990	37.10	13.20	15.70	7.10	11.40	8.50	93.00
1994	27.80	10.20	13.80	7.00	11.40	20.90	91.10
1998	23.70	7.70	13.80	5.30	10.80	20.90	82.20
2000	20.10	5.70	9.70	2.90	10.70	13.70	62.80
2002	18.30	6.20	9.90	2.90	12.40	13.00	62.70
2010	14.23	7.80	10.51	1.82	13.48	4.17	52.01
2014	12.56	8.96	9.90	2.21	13.52	6.43	53.58
2016	11.47	10.92	11.23	2.13	13.34	4.16	53.25
2018	10.80	16.45	12.26	2.11	11.14	4.05	56.81
2020	9.58	7.65	6.48	1.14	8.92	2.78	36.56

Percent Change Over Time							
1970 to 1979	-616.1%	5.5%	-3.4%	-48.8%	20.6%	31.6%	-56.1%
1979 to 1990	-41.1%	127.6%	82.6%	-46.6%	39.0%	70.0%	-10.5%
1990 to 2000	-45.8%	-56.8%	-38.2%	-59.2%	-6.1%	61.2%	-32.5%
2000 to 2010	-29.2%	36.8%	8.4%	-37.3%	26.0%	-69.6%	-17.2%
2010 to 2018	-24.1%	111.0%	16.6%	16.3%	-17.4%	-2.9%	9.2%
1970 to 2018	-94.2%	199.1%	37.7%	-91.9%	63.9%	6.5%	-76.0%
1970 to 2020	-94.8%	39.0%	-27.2%	-95.6%	31.1%	-26.8%	-84.6%
Annualized Percent Change							
1970 to 1979	-11.3%	0.6%	-0.4%	-7.2%	2.1%	3.1%	-8.7%
1979 to 1990	-4.7%	7.8%	5.6%	-5.5%	3.0%	4.9%	-1.0%
1990 to 2000	-5.9%	-8.1%	-4.7%	-8.6%	-0.6%	4.9%	-3.9%
2000 to 2010	-3.4%	3.2%	0.8%	-4.6%	2.3%	-11.2%	-1.9%
2010 to 2018	-3.4%	9.8%	1.9%	1.9%	-2.4%	-0.4%	1.1%
1970 to 2018	**-5.8%**	**2.3%**	**0.7%**	**-5.1%**	**1.0%**	**0.1%**	**-2.9%**

Source: Table created by NRI using historical data from NIMH, SAMHSA, and SAMHSA N-MHSS

Figure 4: Number of Residents in Psychiatric Inpatient and Other 24-Hour Residential Treatment Beds at End of Year, 1970 to 2018



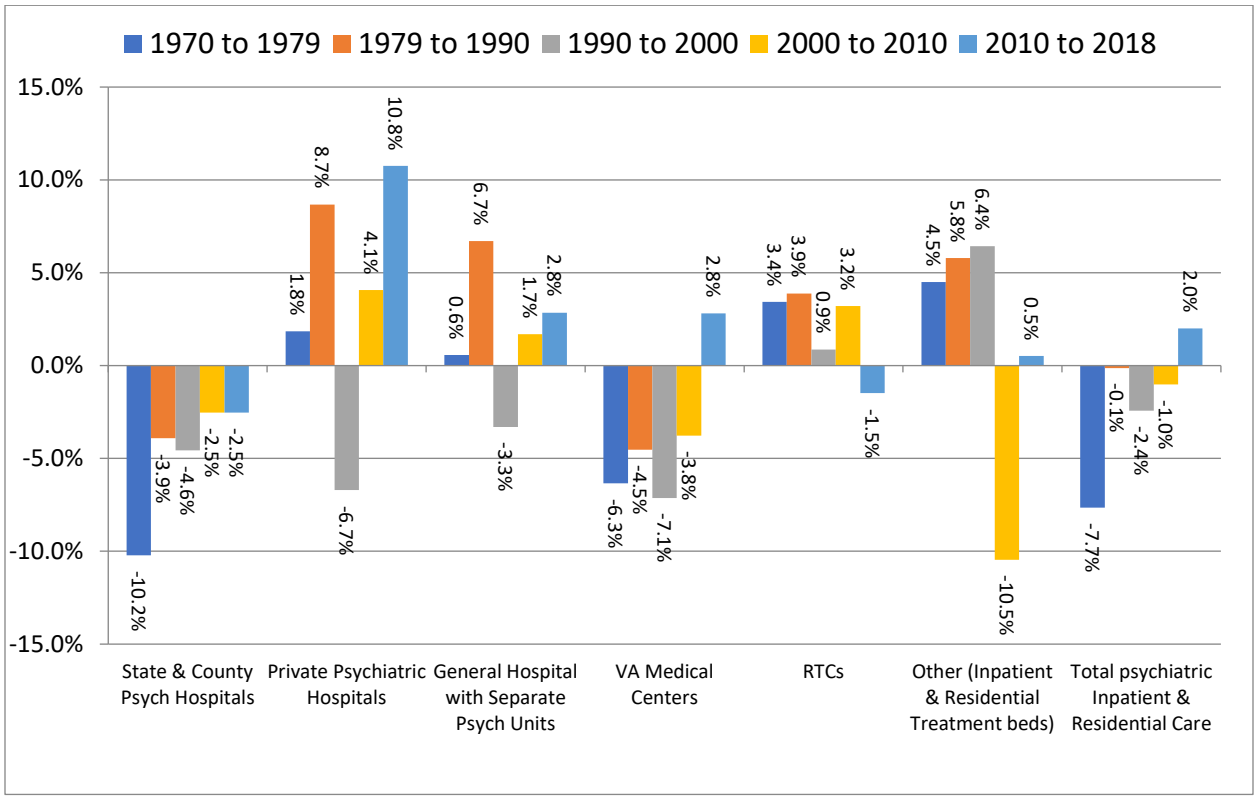
Tables 6 and 7 and **Figure 4** show that not all types of organizations experienced changes in psychiatric bed inventory at the same rates or in the same direction. While state and county psychiatric hospitals and VA Medical Centers both display long-term reductions in inpatient census, other types of organizations providing specialized mental health beds experienced much more complicated bed

inventory patterns over time. From 1970 to 2018, the number of individuals in beds in private psychiatric hospitals almost doubled (up 199%). Private psychiatric hospital utilization has varied greatly by decade, increasing by 150% during the 1980s and then dropping 50% during the 1990s, before growing again in the last 18 years (up 49% during the period from 2000 to 2010 and then up by 126% from 2010 to 2018, until the decrease during the COVID-19 pandemic).

Residential Treatment Centers and general hospitals with separate psychiatric units also both more than doubled their patients from 1970 to 2018 (RTCs increased by 173% and general hospitals increased by 127.6%). In the last decade, 2010 to 2018, general hospitals increased their caseload by 25%, while RTCs decreased by 11.3%.

Figure 5 shows that for state psychiatric hospitals, most of their decease in the number of mental health patients occurred in the 1970s' when they had a reduction of over 10% every year. In the past two decades (since 2000), state hospital residents have decreased only 2.5% per year. The number of residents being served in private psychiatric hospitals increased every decade, except the 1990s when they decreased by 5.7% per year. In the 2010s, private psychiatric hospitals experienced the largest growth in mental health patients (increasing 10.8% per year).

Figure 5: Annualized Percent Change in Psychiatric population, by Setting and Decade: 1970 to 2018



Trend in Child and Adult Psychiatric Inpatient Populations, 2010 to 2018

SAMHSA's N-MHSS datasets allow separate analysis of trends of psychiatric inpatient units, whereas the earlier IMHO SAMHSA reports combined inpatient and other 24-hour residential treatment data. The 2010 to 2018 N-MHSS data provide a better understanding of the changing use of types of organizations and settings serving for children and adults needing 24-hour treatment over the last decade.

Table 8 shows that from 2010 to 2018, the number of children who were in a mental health bed decreased by 20% (a decrease of 10,579 individuals). The majority (60%) of children in a mental health bed in 2018 were in receiving care in a 24-hour residential bed (mostly in Residential Treatment Centers (48%) followed by private psychiatric hospitals (32%) and general hospital psychiatric units (10.5%). Only 2.5% of children in a mental health bed were in a state psychiatric hospital in 2018 (a decrease of 71% from 2010). As described above, 31 states reported in 2020 that by policy they do not serve children in their state psychiatric hospital.[51]

1. Over time the child and adolescent population has moved from inpatient settings to residential treatment settings (60% of children in a mental health treatment bed in 2018 were in a 24-hour residential treatment bed and 40% were in an inpatient bed). Residential Treatment Centers (RTCs) are where 48% of children who were in a mental health bed were served, and Private Psychiatric hospitals were the next most frequently used setting for children (32% of children in a mental health bed were in an RTC). The number of children who were being served in state psychiatric hospitals decreased by 71% from 2010 to 2018.
2. Adults who were in a mental health bed are still more likely to be in inpatient beds than in 24-hour residential treatment beds, and their treatment in private psych hospitals and general hospital inpatient has grown in the last 8 years (separate from the numbers related to the COVID-19 most intense years), while adult patients in state psychiatric hospitals had a slight decrease.

Trend in Children in Inpatient and Other 24-Hour Residential Treatment Beds, 2010 to 2018

During the last decade, the number of children in a mental health bed has dropped by 20% (with children in psychiatric inpatient beds decreasing 19% and children in residential treatment beds decreasing by 21%). Forty percent of children receiving 24-hour mental health treatment were patients in an inpatient bed and 60% received care in a 24-hour residential treatment bed.

Children served in state psychiatric hospitals had the largest decrease (71%). The only inpatient or residential organizational setting that had an increase in the number of children in mental health treatment beds were private psychiatric hospitals (up 33% overall with a 36% increase in child inpatients and a 19% increase in children in residential treatment beds).

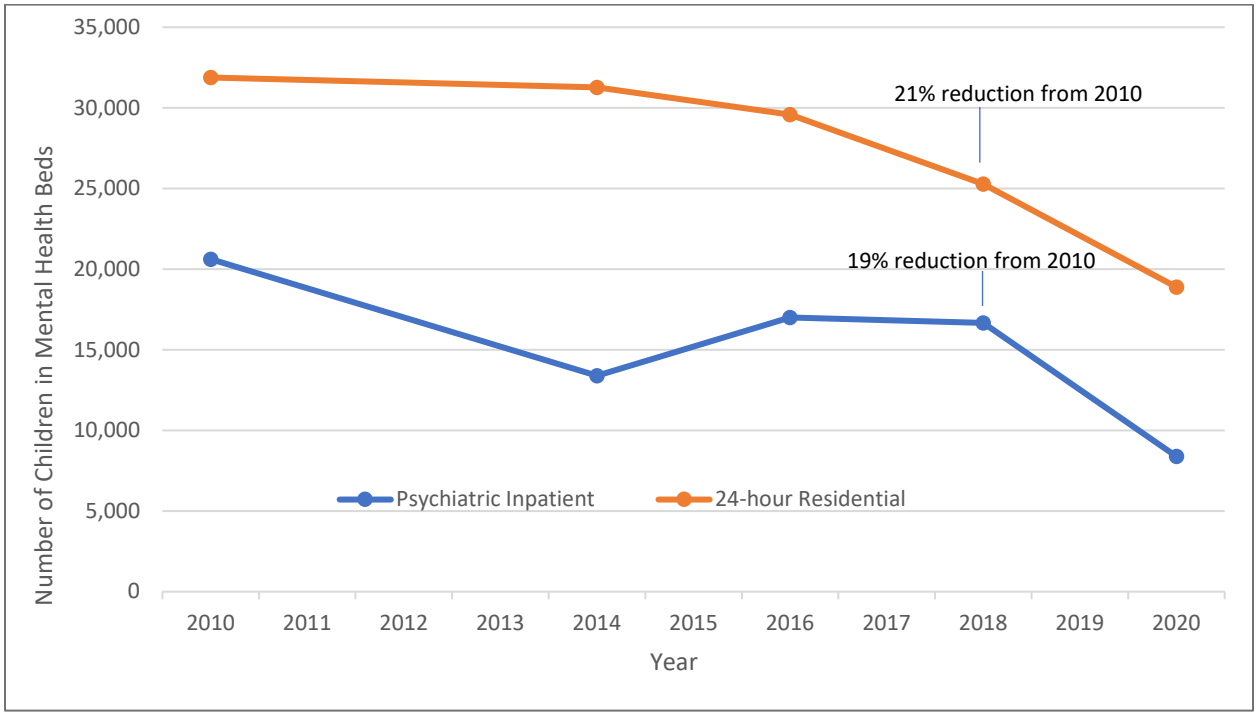
Table 8: Children (under age 18) in psychiatric inpatient and other 24-hour residential treatment beds, end of year, 2010 to 2020

Organization	Bed Type	Year					Change 2010 to 2018
		2010	2014	2016	2018	2020	
State & County Psych Hospitals	Inpatient	3,447	2,468	1,382	1,000	1,098	-71%
	24-hour Residential	177	203	169	41	33	-77%
	Total	3,624	2,671	1,551	1,041	1,131	-71%
Private Psychiatric Hospitals	Inpatient	7,941	7,141	7,570	10,827	5,149	36%
	24-hour Residential	2,146	2,432	2,376	2,564	1,836	19%
	Total	10,087	9,573	9,946	13,391	6,985	33%
General Hospital with Separate Psych Units	Inpatient	7,826	2,743	2,914	4,298	1,589	-45%
	24-hour Residential	512	236	395	110	102	-79%
	Total	8,338	2,979	3,309	4,408	1,691	-47%
VA Medical Centers	Inpatient	414	139	95	14	0	-97%
	24-hour Residential	1	241	110	15	0	*
	Total	415	380	205	29	0	-93%
RTCs	Inpatient	428	491	2,804	182	440	-57%
	24-hour Residential	25,653	23,918	23,368	20,069	14,324	-22%
	Total	26,081	24,409	26,172	20,251	14,764	-22%
Other (Inpatient & Residential Treatment beds)	Inpatient	565	408	2,247	336	112	-41%
	24-hour Residential	3,395	4,233	3,159	2,470	2,595	-27%
	Total	3,960	4,641	5,406	2,806	2,707	-29%
Total psychiatric Inpatient & Residential Care	**Inpatient**	**20,621**	**13,390**	**17,012**	**16,657**	**8,388**	**-19%**
	24-hour Residential	**31,884**	**31,263**	**29,577**	**25,269**	**18,890**	**-21%**
	Total	**52,505**	**44,653**	**46,589**	**41,926**	**27,278**	**-20%**

Table created by NRI using N-MHSS data from 2010, 2014, 2016, 2018, and 2020.

The number of children in both psychiatric inpatient beds and 24-hour residential treatment beds has declined this decade (Figure 6).

Figure 6: Children (under age 18) in Mental Health Inpatient and Residential Treatment Beds, 2010 to 2018



Trend in Adults in Inpatient and Other 24-Hour Residential Treatment Beds, 2010 to 2018

The number of adults who were in a mental health treatment bed (inpatient or residential treatment) increased by 24% from 2010 to 2018 (Table 9). Adults were also most likely to be in an inpatient bed (77%) with only 23% in a 24-hour residential treatment bed (again very different from children where only 40% were in an inpatient bed and 60% were in a residential treatment bed.

Adults in psychiatric inpatient beds alone grew by 31% from 2010 to 2018, while adults in residential treatment beds increased by only six% over that time period. Private psychiatric hospital inpatient beds (up 187%) and general hospital psychiatric unit inpatient beds (up 40%) were the psychiatric inpatient setting that grew the most from 2010 to 2018. Adults in State psychiatric hospital inpatient beds decreased by 23% during this time period.

As a result of the downsizing of state psychiatric hospital inpatient beds and the increase in private psychiatric hospital adult patients, in 2018 private psychiatric hospitals were the largest location of adult inpatient beds (39 in 2018, up from 16% of adult patients in 2010) and state hospitals decreased from 48% of inpatients in 2010 to 26% of inpatients in 2018.

Table 9: Adults (age 18 and over) in psychiatric inpatient and other 24-hour residential treatment beds, end of year, 2010 to 2020

Organization	Bed Type	Year					Change 2010 to 2018
		2010	2014	2016	2018	2020	
State & County Psych Hospitals	Inpatient	38,238	34,741	29,003	29,618	28,245	-23%
	24-hour Residential	1,992	2,495	3,613	2,103	1,943	6%
	Total	40,230	37,236	32,616	31,721	30,188	-21%
Private Psychiatric Hospitals	Inpatient	12,876	17,663	22,161	36,962	16,623	187%
	24-hour Residential	1,062	1,225	1,831	1,485	1,431	40%
	Total	13,938	18,888	23,992	38,447	18,054	176%
General Hospital with Separate Psych Units	Inpatient	23,355	28,121	30,593	34,012	18,919	46%
	24-hour Residential	702	353	622	283	323	-60%
	Total	24,057	28,474	31,215	34,295	19,242	43%
VA Medical Centers	Inpatient	1,787	2,985	2,946	1,667	1,709	-7%
	24-hour Residential	3,400	3,645	3,624	3,645	1,879	7%
	Total	5,187	6,630	6,570	5,312	3,588	2%
RTCs	Inpatient	394	1,360	1,231	262	271	-34%
	24-hour Residential	15,061	23,031	19,130	14,889	10,998	-1%
	Total	15,455	24,391	20,361	15,151	11,269	-2%
Other (Inpatient & Residential Treatment beds)	Inpatient	2,222	3,091	2,914	920	905	-59%
	24-hour Residential	6,663	6,837	6,927	8,248	6,424	24%
	Total	8,885	9,928	9,841	9,168	7,329	3%
Total psychiatric Inpatient & Residential Care	**Inpatient**	**78,872**	**87,961**	**88,848**	**103,441**	**66,672**	**31%**
	24-hour Residential	**28,880**	**37,586**	**35,747**	**30,653**	**22,998**	**6%**
	Total	**107,752**	**125,547**	**124,595**	**134,094**	**89,670**	**24%**

Table created by NRI using N-MHSS data from 2010, 2014, 2016, 2018, and 2020.

Figure 7 shows that the growth in mental health beds for adults has been primarily in psychiatric inpatient beds, which increased by 31% from 2010 to 2018. Residential treatment beds used by adults increased by 6% from 2010 to 2018, with the number of adults in residential treatment beds peaking in 2014 and then decreasing in 2016 and 2018.

Figure 7: Number of Adults in Mental Health Inpatient and 24-Hour Residential Treatment Beds, 2010 to 2018

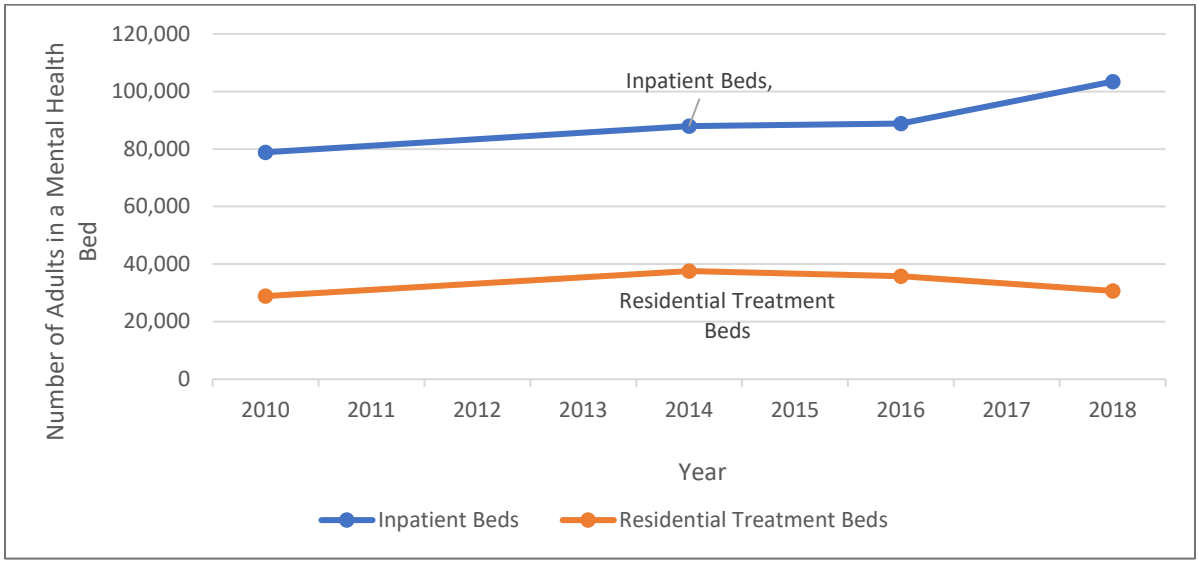
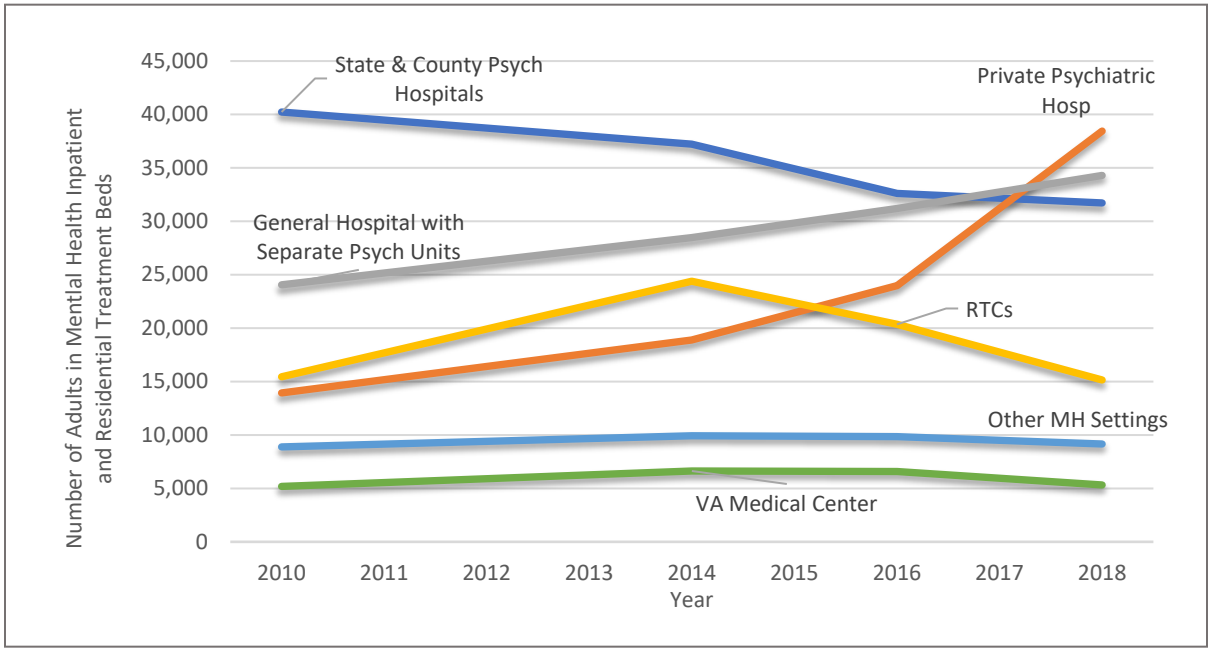


Figure 8 highlights that private psychiatric hospitals have experienced the largest increase in use by adults, followed by general hospitals with separate psychiatric units. The number of adults in state psychiatric hospitals dropped 21% and are now only the third most frequent location where adults are receiving mental health treatment in a bed.

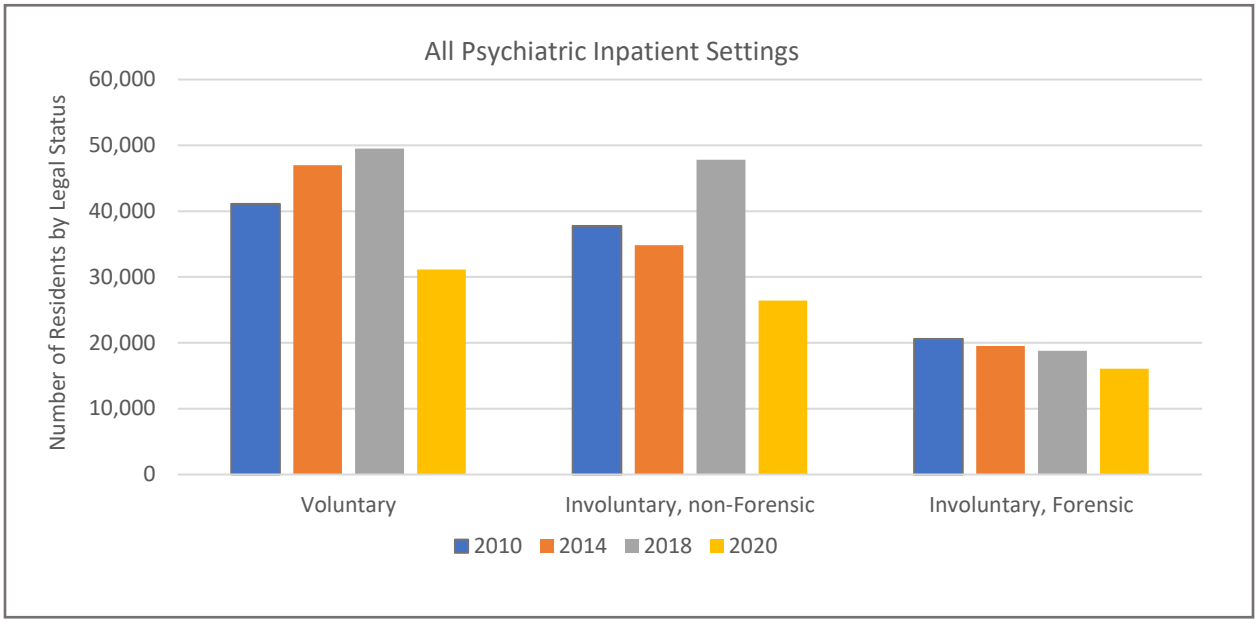
Figure 8: Number of Adults (age 18 and over) in Mental Health Inpatient and Residential Treatment Beds, by type of Organization, 2010 to 2018



Trend in Legal Status of Patients: 2010 to 2018

Over the last decade, the number of voluntary patients in psychiatric inpatient settings increased by 20% and the number of involuntary-civil status patients increased by 27%, while the number of forensic patients (legal status involuntary-criminal) decreased by 9% (a decrease of 1,795 patients) (Figure 9). Note, SAMHSA has specialty providers report on the admission legal status of individuals in inpatient and other 24-hour residential treatment beds. Legal status of individuals may change during their course of treatment (e.g., forensic clients may have their legal status change to involuntary-civil status or vis-a-versa while receiving treatment).

Figure 9: Legal Status of Patients in a mental health Inpatient bed, 2010 to 2020



State psychiatric hospitals mostly decreased their use of beds for voluntary patients (down 52% from 2010 to 2018) and involuntary civil status patients (down 42% from 2010 to 2018) (Table 10). Forensic patients served in state and county psychiatric hospitals decreased by only 8% from 2010 to 2018.

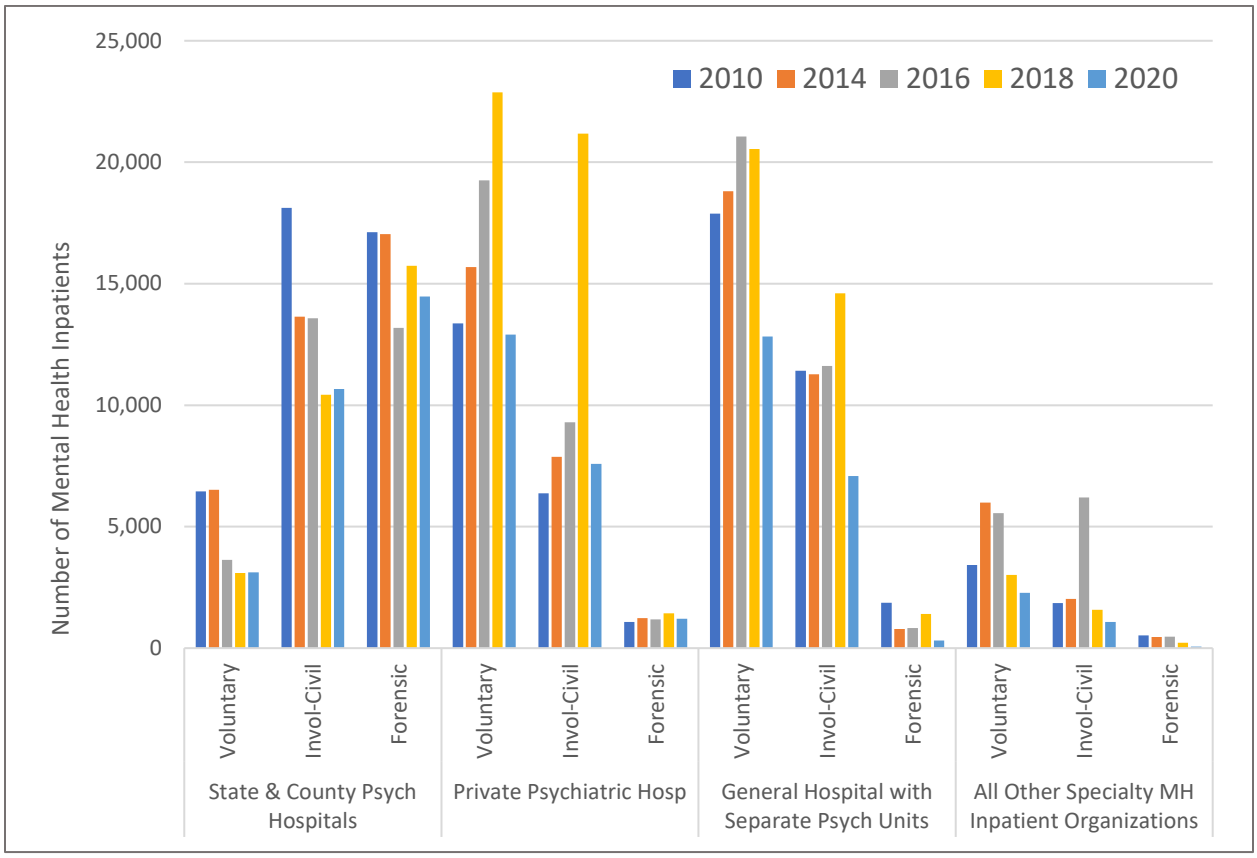
The number of involuntary-civil status clients served by private psychiatric hospitals had the largest percentage increase (up 232%% from 2010 to 2018) of any client legal status or setting, followed by voluntary clients in private psychiatric hospitals (up 71% from 2010 to 2018).

Table 10: Number of Mental Health Inpatients by Legal Status and Organization Type, 2010 to 2020

Year		2010	2014	2016	2018	2020	2010 to 2018
State & County Psych Hospitals	Voluntary	6,448	6,523	3,636	3,099	3,117	-52%
	Involuntary-Civil	18,118	13,640	13,572	10,429	10,661	-42%
	Forensic	17,119	17,046	13,178	15,734	14,472	-8%
	Total	41,685	37,209	30,386	29,262	28,250	-30%
Private Psychiatric Hosp	Voluntary	13,365	15,691	19,248	22,877	12,901	71%
	Involuntary-Civil	6,377	7,876	9,299	21,173	7,582	232%
	Forensic	1,075	1,237	1,184	1,438	1,204	34%
	Total	20,817	24,804	29,731	45,488	21,687	119%
General Hospital with Separate Psych Units	Voluntary	17,885	18,801	21,062	20,548	12,827	15%
	Involuntary-Civil	11,423	11,278	11,616	14,608	7,086	28%
	Forensic	1,873	785	829	1,407	311	-25%
	Total	31,181	30,864	33,507	36,563	20,224	17%
VA Medical Centers	Voluntary	1,887	2,501	2,420	1,535	1,254	-19%
	Involuntary-Civil	277	476	522	453	451	64%
	Forensic	37	147	99	79	6	114%
	Total	2,201	3,124	3,041	2,067	1,711	-6%
RTCs	Voluntary	406	1,100	1,135	246	492	-39%
	Involuntary-Civil	350	525	2,789	167	211	-52%
	Forensic	66	226	111	25	9	-62%
	Total	822	1,851	4,035	438	712	-47%
Other (Inpatient beds)	Voluntary	1,131	2,393	2,004	1,229	531	9%
	Involuntary-Civil	1,229	1,021	2,890	961	414	-22%
	Forensic	427	85	267	119	49	-72%
	Total	2,787	3,499	5,161	2,309	994	-17%
Total psychiatric Inpatient	Voluntary	41,122	47,009	49,505	49,534	31,122	20%
	Involuntary-Civil	37,774	34,816	40,688	47,791	26,405	27%
	Forensic	20,597	19,526	15,668	18,802	16,051	-9%
	Total	99,493	101,351	105,861	116,127	73,578	17%

Table created by NRI using SAMHSA N-MHSS data from 2010, 2014, 2016, 2018, and 2020

Figure 10: Number of Mental Health Inpatients by Legal Status and Organizational Setting, 2010 to 2020



Trend in State and County Psychiatric Hospital Capacity

The historical decrease in patients being served in state psychiatric hospitals is often attributed to increases in persons with mental illness residing in jails, increases of homelessness and other societal ills. Articles often cite the decline from over 500,000 individuals residing in state hospitals in the 1950s, or for slightly more recent analysis from 1970 when there were still over 300,000 individuals in state hospitals every day to pivot toward the argument that there has been a complete "transinstitutionalization" of this population to jails and prisons.[52]

However, these analyses often fail to address other factors about the historical use of state psychiatric hospitals, and the current population in carceral settings and among the homeless. In the 1950s and even the 1970s many of the clients who were in state hospitals in those eras when state hospitals had hundreds of thousands of residents were individuals with serious health or behavioral issues, but not mental illnesses, and who would not be treated in any psychiatric hospital today. Using historical NIMH data from their "Annual Survey of State and County Psychiatric Hospitals, data from (1971 is the earliest year that this series is available) can be used to better understand the characteristics of patients in state hospitals back in an era when there were 309,852 residents in state hospital beds on a single day. In the 1971 data, only 49% of patients in state psychiatric hospitals had a diagnosis of schizophrenia or other psychosis and 5.9% had a diagnosis of depression. However, state hospitals in 1971 contained significant numbers of residents with diagnoses of neurocognitive disorders (reported in the SAMHSA series as "Organic Brain Syndrome"), this was the second largest diagnostic group in state psychiatric hospitals in 1971), intellectual disability/developmental disorders, and alcohol and substance abuse. Patients with these diagnoses that are no longer a focus of treatment in state hospitals represented over one-third

(36.1% or 111,839 of the patients in 1971. Moreover, there are broad assumptions that the incarcerated population with mental illness is currently so symptomatic at any moment that they would be meet hospital level of care criteria. Thus, the data and experience with these populations points to a much more complicated picture.

Change in State psychiatric hospital patients, by Patient Age Group 1970 to 2020

In 1970, state and county psychiatric hospitals provided 78% of the psychiatric inpatient and other 24-hour mental health residential treatment capacity. Since 1970, state and county psychiatric hospital case load on a single day has decreased by over 330,000 patients. However, most of the decrease in state and county psychiatric hospitals beds occurred over 30 years ago—during the 1970s, with a decrease of 229,600 patients between 1970 and 1979, a reduction of 62%. The rate of downsizing of state and county psychiatric hospitals has drastically slowed in the last 15 years. From 2001 to 2010, state and county hospital census declined by 2.5% per year. From 2010 to 2018, state and county hospital census declined by 2.5% per year.

Table 11 shows that that older adult patients are the age group that has had the largest decrease in receiving services in state psychiatric hospitals, with a decrease of 96% from 1970 to 2005 (after 2005, that SAMHSA report series no longer collected data on older adults as a separate service population).

Table 11: Change in State Psychiatric Hospital Patients Served, by Age, 1970 to 2020

Decade	Children (under Age 18)	Adults (ages 18-64)	Older adult (age 65+)	Total
1970 to 1980	-49%	-57%	-57%	-57%
1980 to 1990	-18%	-20%	-61%	-31%
1990 to 2000	-39%	-35%	-68%	-40%
2000 to 2005	-23%	-6%	-30%	-9%
2005 to 2010	-37%	-7%	included w/ Adults*	-15%
2010 to 2020	-10%	-6%	included w/ Adults*	-6%
1970 to 2005	-80%	-79%	-96%	-84%
1970 to 2020	-89%	-82%	included w/ Adults*	-87%

** Data systems shifted and separate counts for age 65 and over are not available after 2005 and "adult" numbers for 2005 to 2020 include all individuals in a state psychiatric hospital bed ages 18 and over.*

Changing Patient Diagnostic Groups Served in State Psychiatric Hospitals, 1971 to 2020

Changing Service Populations Being Served by State Psychiatric hospitals: The Annual Census of State and County Psychiatric Hospitals shows how the age and diagnostic groups being served in state psychiatric hospitals in 1971 are different from clients being served today.

In 1971

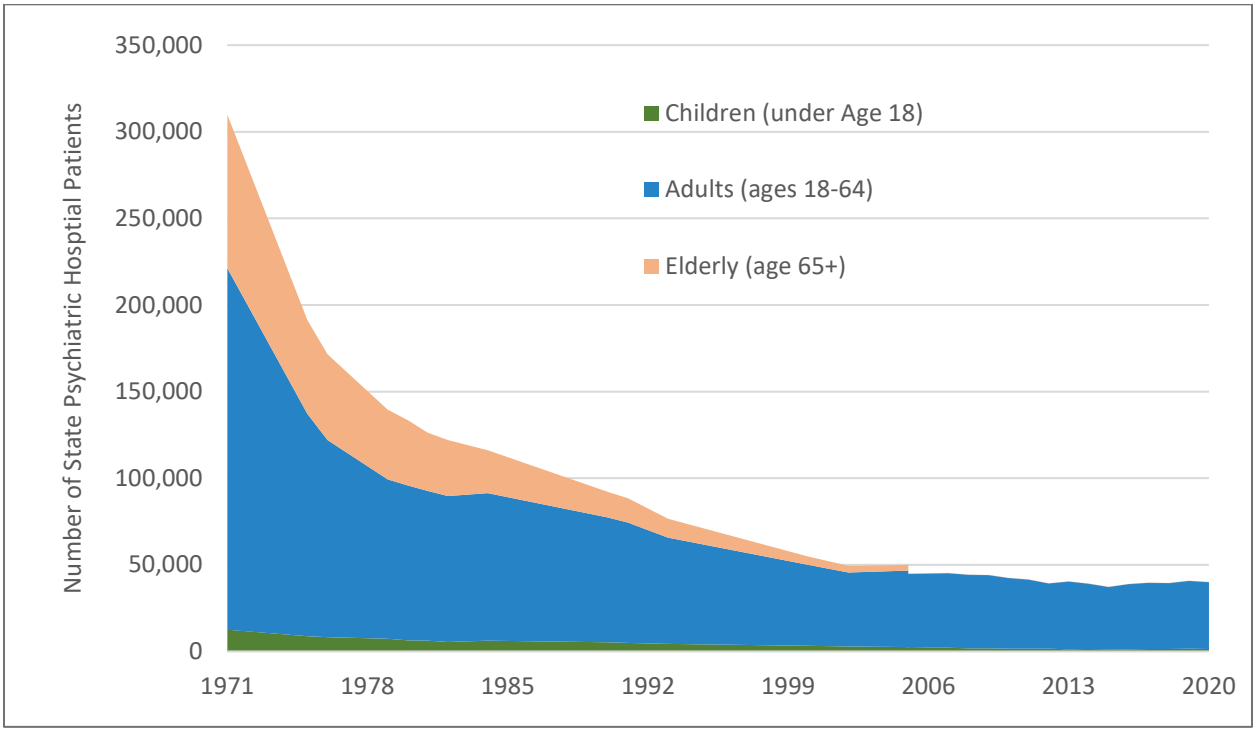
- 29.3% (99,087) Patients were age 65 and Over
- 24% (81,621) had an Organic Brain Syndrome
  - (45,811 of whom were Older Adults)
- 9% (31,884) had a Diagnosis of Intellectual Disability (reported then as "Mental Retardation."
- 7% (18,098) had an Alcohol or Drug Disorder (1973 data)

In 2005: (*After 2005, state hospital patients by diagnosis was no longer collected and reported by SAMHSA)*

- 3.8% of patients had an Intellectual Disability diagnosis,
- 3.6% had an Organic Brain disorder and
- 5.1% had an Alcohol or Drug Disorder

Figure 11 below shows how the number of patients by three age groups, served in state hospitals on a single day, has decreased over the past 50 years. Older adult patients (age 65 and over) decreased by 96% from 1970 to 2005, while children (under age 18) decreased by 79% (to 2020) and adults (ages 18 to 64) decreased by 80%. Note again that for populations age 65 and older, data available ends in 2005.

Figure 11: State Psychiatric Hospital Patients Served, by Age, 1970 to 2020

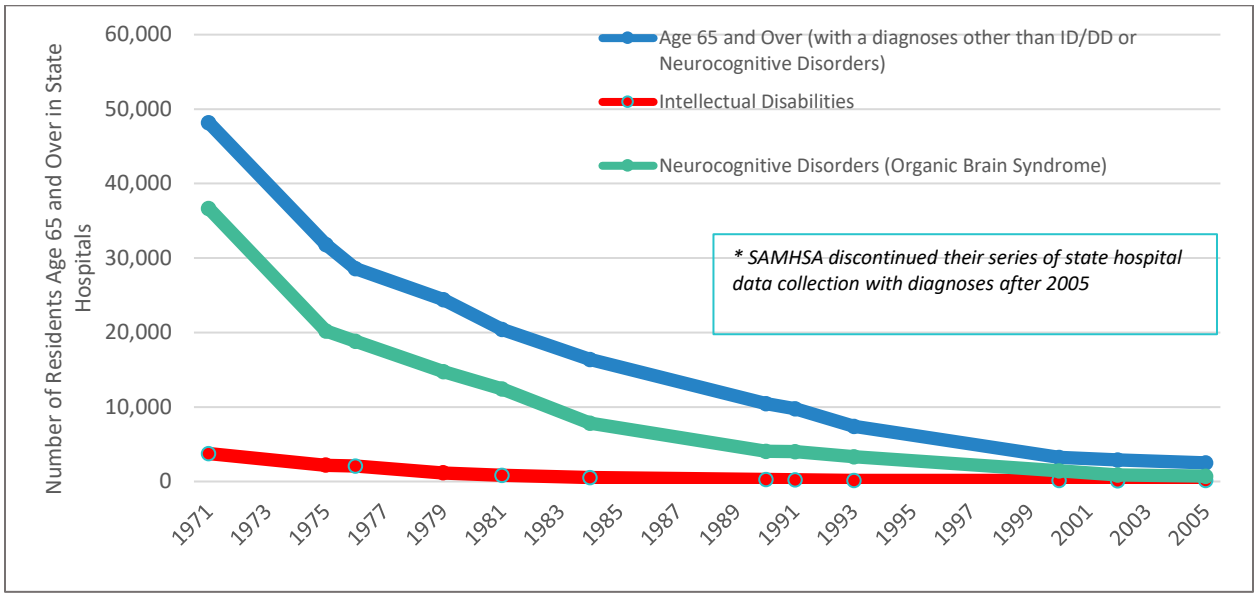


Sources: State Psychiatric Hospitals from: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States, 2002, and SAMHSA Uniform Reporting System: 2004 to 2020

State hospital patients with a diagnosis of neurocognitive disorders (at the time labeled as "Organic Brain Syndrome or OBS"), ID/DD or SUD have decreased from almost 112,000 patients in 1971 (36% of all state hospital patients) to just over 6,000 patients in 2005 (12.5% of patients).

Figure 12 shows the reduction in older adult patients in state psychiatric hospitals from 1971 to 2005 for clients with a diagnosis of neurocognitive disorders (green line), Intellectual/ Developmental Disability (red line) and all other diagnoses (blue line). In 1971, there were over 36,000 older adult patients with a diagnosis of neurocognitive disorders in state hospitals. By 2005, that number had decreased to 750 patients. Many of the older adult patients with primary neurocognitive disorders who were historically treated in state hospitals are likely now receiving care in nursing homes and or receiving Medicaid and Medicare supported home and community-based services (services not widely available in the 1970s) with diagnoses of Alzheimer's disease, though a subset of the current psychiatric hospital patients may have co-occurring mental illness and neurocognitive challenges.

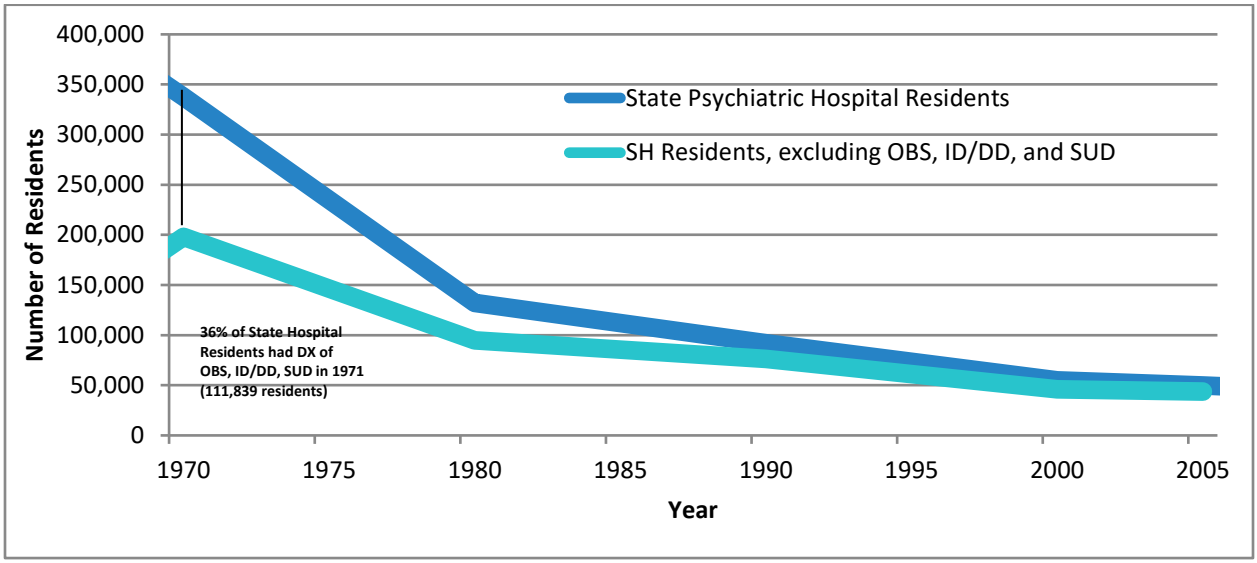
Figure 12: Resident Patients Ages 65 and Over in State Psychiatric Hospitals, by Diagnostic Group: 1971 to 2005



Sources: State Psychiatric Hospitals from: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States series, 1971 to 2005 annual reports.

Figure 13 shows a how the trend in state psychiatric hospital patients is very different if patients with diagnoses of Organic Brain Syndrome, Intellectual Disabilities, and substance use disorders (111,839 residents served in 1971) are backed out of state hospital patient data from 1971 to 2005. The lower line of patients with diagnoses likely to still be treated in state hospitals in 2020 shows a reduction of 157,430 patients from 1971 to 2020 (an 80% reduction), but a much lower reduction than the 297,036 decrease that is frequently used (counting all clients in state hospitals in the 1970s).

Figure 13: Residents in State Psychiatric Hospitals, with and without Diagnoses not Currently Focus of Treatment in State Hospitals, 1970 to 2005

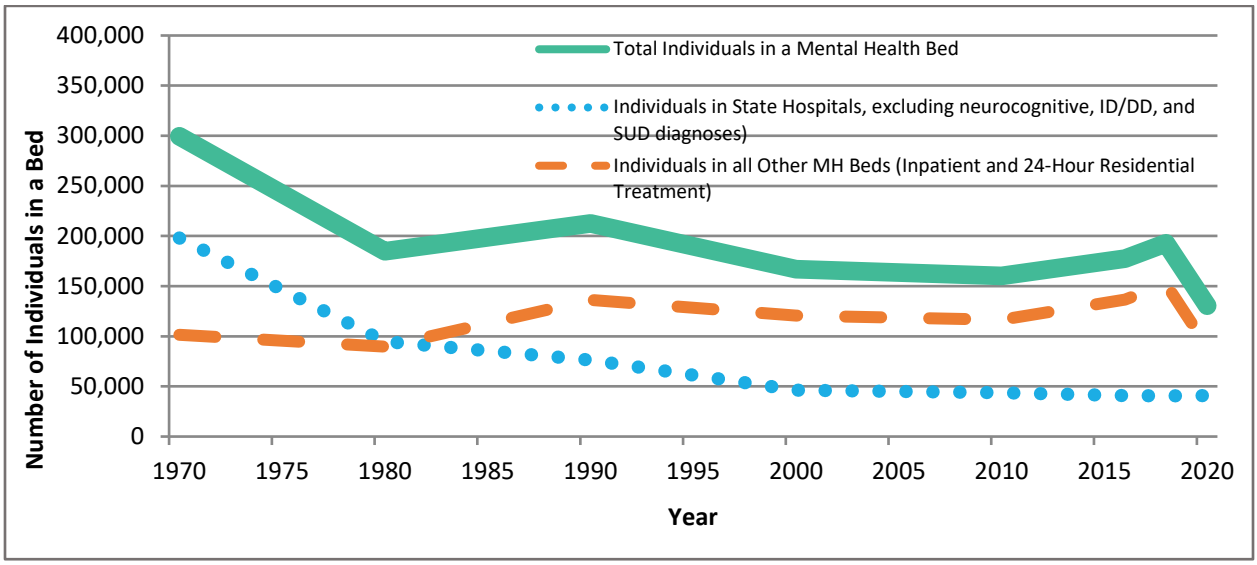


Change in individuals in any inpatient and 24-hour residential treatment beds excluding historical rates of neurocognitive and ID/DD clients in state hospitals:

In addition to references seen in the literature using total clients served in state hospitals over time, not adjusting for clients whose diagnoses would likely exclude them from care in a state psychiatric hospital today, a focus on only state psychiatric hospital patients and beds also leaves out the major growth (an increase of over 50% from 1970 to 2020) in other inpatient and 24-hour residential treatment beds over the past 50 years.

Figure 14 shows what the number of clients served in any psychiatric bed would be from 1970 to 2020 if the subpopulation of state hospital clients with diagnoses no longer treatment focuses in state hospitals are excluded and private psychiatric hospital, general hospital specialty beds, residential treatment center, and other behavioral health provider beds are included. The net result of this adjusted number of mental health patients, is not a decrease of 297,036 patients, but rather a decrease of 36% over the 48 years (from 1970 to 2018) that is a decrease of 106,760 patients being served on a given day.

Figure 14: Number of Individuals in a Mental Health Beds (State hospital and other inpatient and 24-hour treatment beds) excluding historical SH Patients with Diagnoses not Currently Focus of Treatment in State Hospitals, 1970 to 2020



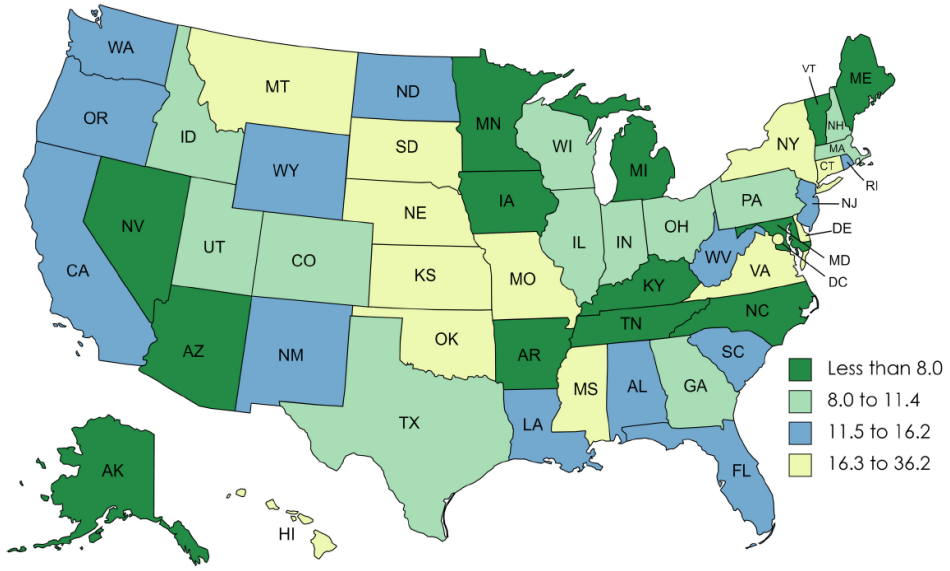
State Psychiatric Hospital Use in 2020

NRI's State Profiles data includes information about policies for the intended use of state psychiatric hospitals to serve children and adults in acute (30 day or less length of stay) or long units and also their use to provide forensic and sex offender client services. SAMHSA Uniform Reporting System data allows analysis of the number of clients admitted to and served in state hospitals.

Patients Served in State Psychiatric Hospitals, 2020

In 2020, 39,963 patients were in a bed in a state psychiatric hospital at the start of the year and state hospitals served 124,519 unique patients throughout the year—each bed was used by an average of 3.1 patients during the year (2020 Uniform Reporting System, SAMHSA). States varied from having 6,104 resident patients in California to 21 patients in Vermont. Adjusting for state population, states averaged 12.1 patients per 100,000 population, but varied from a high of 36.2 per 100,000 in Virginia to a low of 2.9 per 100,000 in Arizona (Figure 15). Although some advocates have called for 50 beds per 100,000 population, NASMHPD in its *Beyond Beds* analysis by Pinals and Fuller urged caution about this metric, given that no set formula has been adopted and that bed need also depends on the level of the psychiatric care continuum that is available to a population.[53] This was further supported in the recently released report of the American Psychiatric Association.[54]

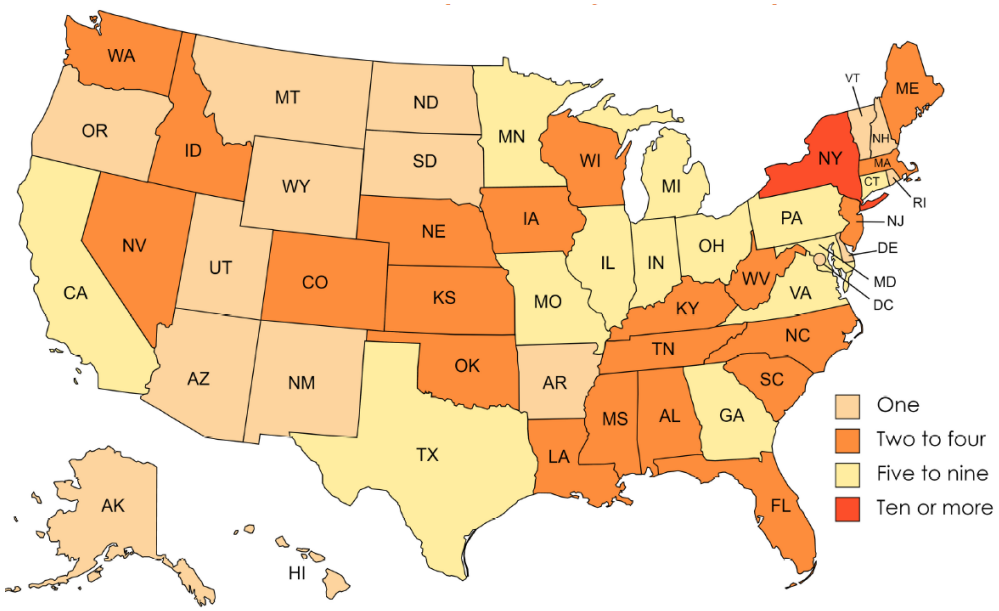
Figure 15: Resident Patients in State Psychiatric Hospitals per 100,000 State Population, 2020 (URS data)



Number of State Operated Psychiatric Hospitals 2020

In 2020 there were 177 state-operated psychiatric hospitals, with the median state operating two separate hospitals. The number of state psychiatric hospitals in each state ranges from a high of 23 hospitals in New York, to a low of one hospital in 16 states (Figure 16). Of note, Rhode Island and Massachusetts, for example, run specific state-operated psychiatric inpatient beds within state-operated general hospital. In 42 states, there were 150 state psychiatric hospitals accredited by the Joint Commission or other independent accrediting organization (80% of state hospitals were accredited). This was very different from the 1960s, when only 33% (97 out of 292 state psychiatric hospitals in 1966) were accredited.[55]

Figure 16: Number of State Operated Psychiatric Hospitals, 2020



The majority of SMHAs are responsible for both the oversight and management of state psychiatric hospitals and community mental health services. However, in 16 states, responsibility for state psychiatric hospitals is located in a different state agency than the SMHA agency responsible for community mental health services. Those states that have their hospital system managed by a separate state agency from the SMHA are Arizona, California, Maine, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Washington, and West Virginia. With Medicaid having become a predominant funder of community-based services, and only contributing a small portion of payment for state hospitals (see below), some of these shifts show community service SMHAs more closely aligning with the state's Medicaid office, leaving the state hospital organizational structure as its own entity or built within other aspects of state agencies.

How States Prioritize their Use of State Psychiatric Hospitals, 2020

NRI's State Profiles datasets include information about policies for how they use their state psychiatric hospitals. Thirty-one states reported their state psychiatric hospitals do not treat children (Table 12). Three states use their state hospitals to only provide acute (short-term 30 day or less) services for adults and six states focus their state hospital services for adults on longer term services (more than 30 days), but most states use their state hospitals to provide both short and long-term care services.

Table 12: Number of States using State Hospitals by Length of Stay and Age/Forensic Status, 2020

State Psychiatric Hospital Use	Children	Adults	Forensic Patients
Acute (30 day LOS) Only	7 states	3 states	0 states
Long Term Only	3 states	6 states	6 states
Both Acute and Long Term	7 states	37 states	41 states

Legal Status of Patients Served in State Psychiatric Hospitals, 2020

NRI's state Profiles system collects information about the legal status of patients served in state hospitals in two ways. It collects the legal status of patients at admission to a state hospital through the year (status at any admission over 365 days and one individual may have multiple admissions during the year with different legal statuses for each admission. Second, NRI collects the current legal status of all individuals who were patients in a state hospital on the first day of the reporting year (July 1 for most states).

Legal Status of Admissions throughout the Year: Forensic legal status patients were 30% of all admissions during the year, but patients in the hospital for a short-term involuntary hold, and civil status involuntary clients constituted a much larger share of admissions throughout the year than the number of patients in a hospital bed on the first day of the reporting year (Table 13). States varied considerably in how they use their state hospitals for forensic patients or civil status patients. In six states, over 70% of patients on the first day of the year had a forensic or sex offender legal status (California, Illinois, Maryland, and Wisconsin) and in six states over 70% of admissions had a forensic or sex offender legal status (California, Colorado, Florida, Louisiana, Maryland, and Rhode Island).

Legal Status of Patients in state hospitals on the first day of the reporting year: Over 56% of patients in state psychiatric hospitals at the start of the year had a forensic (criminal justice or sex offender) legal status. Only 5.1% of patients on the first day of the year were in the hospital as a voluntary patient. In four states, over 70% of patients on the first day of the year had a forensic or sex offender legal status (California, Illinois, Maryland, and Wisconsin).

Table 13: Legal Status of Patients in State Psychiatric Hospitals (Admissions during the Year and Patient at Start of Year, 2020)

Patient Legal Status	Admissions		Patients In Hospital on First Day of Year	
	N	%	N	%
Voluntary	4,443	6.9%	1,729	5.1%
Involuntary Holds	20,166	31.4%	2,217	6.5%
Involuntary Civil	17,478	27.2%	9,526	28.1%
Involuntary Forensic	18,965	29.5%	16,868	49.8%
Sex Offender	379	0.6%	2,055	6.1%
Dual Legal Status	70	0.1%	15	0.0%
Other	2,653	4.1%	1,470	4.3%
Total	64,211	100.0%	33,880	100.0%
Number of States Reporting	37		32	

Source: NRI 2020-2021 State Profiles

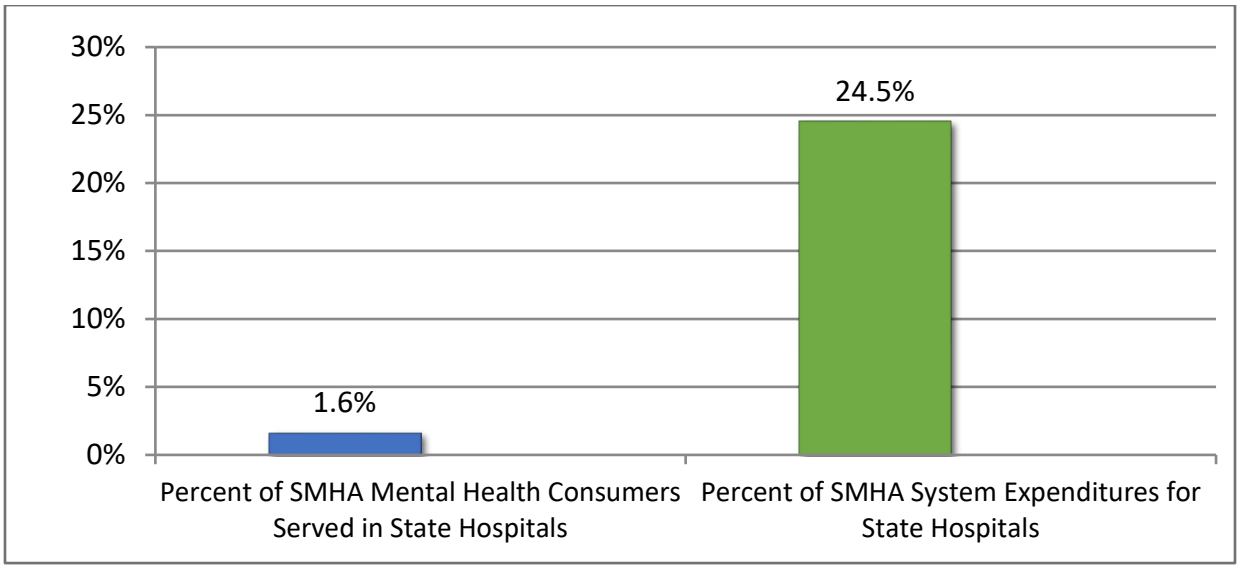
Expenditures for State Psychiatric Hospitals in FY 2019

SAMHSA does not collect information about expenditures for all psychiatric bed settings in the N-MHSS or other routine surveys, but NRI has a State Mental Health Agency Revenues and Expenditures data base that routinely compiles expenditures for state psychiatric hospitals and state community-based services from Fiscal Year 1981 up through 2019 (collection of FY 2021 data is currently underway).

In FY 2019, State Mental Health Agencies (SMHAs) controlled the expenditure of over $47.9 billion for mental health services that paid for services to over 8 million persons. (Note, these expenditure and service counts are for mental health services only—they exclude substance use disorder (SUD) expenditures except for co-occurring mental health and SUD services. State psychiatric hospital expenditures were 24.5% ($11.5 billion) of total state mental health expenditures for mental health. Note, while state psychiatric hospitals in several states are the organizational responsibility of a separate state agency than community mental health services, both SAMHSA reporting and NRI data systems collect and combine client counts and expenditures for both community mental health programs and state psychiatric hospitals to permit better comparisons of total state specialty agency mental health services and expenditures.

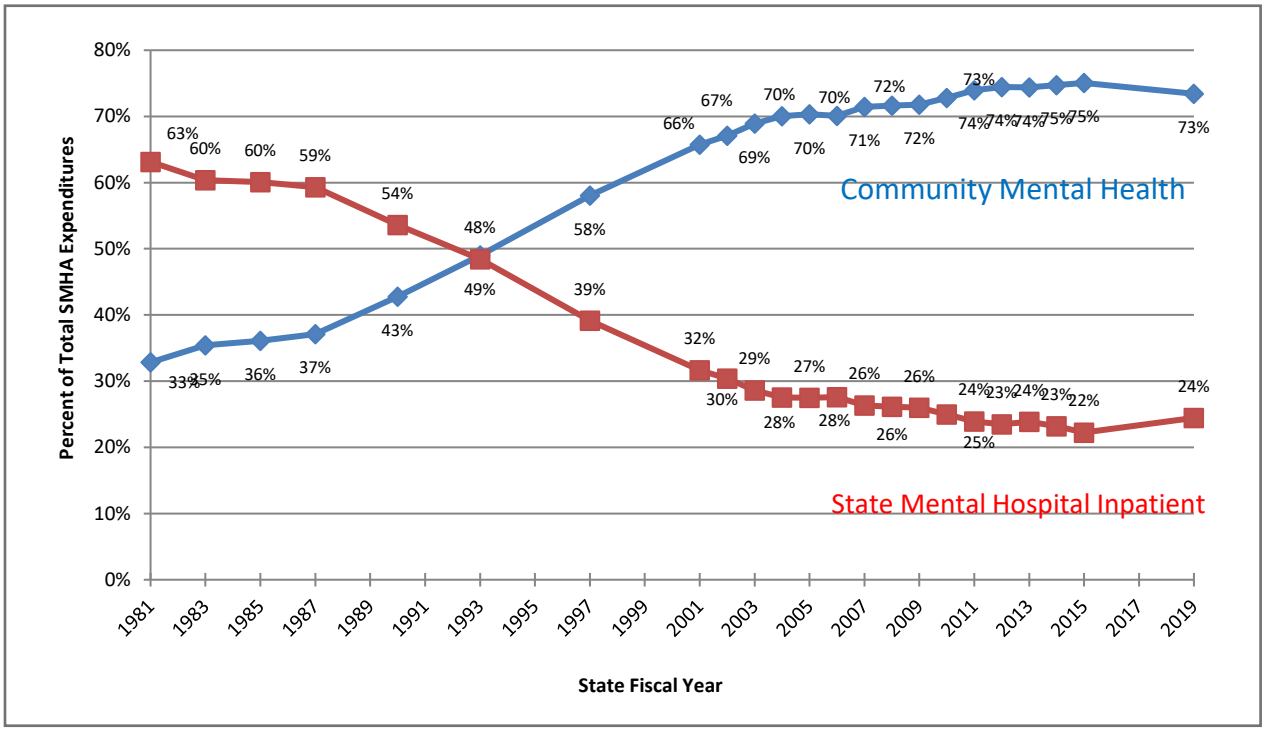
Although almost one quarter of state mental health expenditures were spent on state psychiatric hospitals, state hospitals only served 125,305 or 1.6% of the 8 million individuals served by SMHA systems in 2019. **Figure 17** shows how state hospitals are an expensive set of services used to serve the small percentage of mental health clients.

Figure 17: Patients in State Psychiatric Hospitals as a Share of SMHA Mental Health Clients Served and State Hospital Expenditures as a Share of Total SMHA Expenditures: FY 2019



The 24.5% of state mental health expenditures devoted to state psychiatric hospitals in FY 2019 represents a major shift in where states devoted their mental health resources historically. **Figure 18** shows how the percentage of state mental health expenditures devoted to state hospitals has decreased from 63% of state mental health expenditures in FY 1981 to 24.5% FY 2019. During that same time period, expenditures for community mental health services have increased from 33% in FY 1981 to 73% in FY 2019.

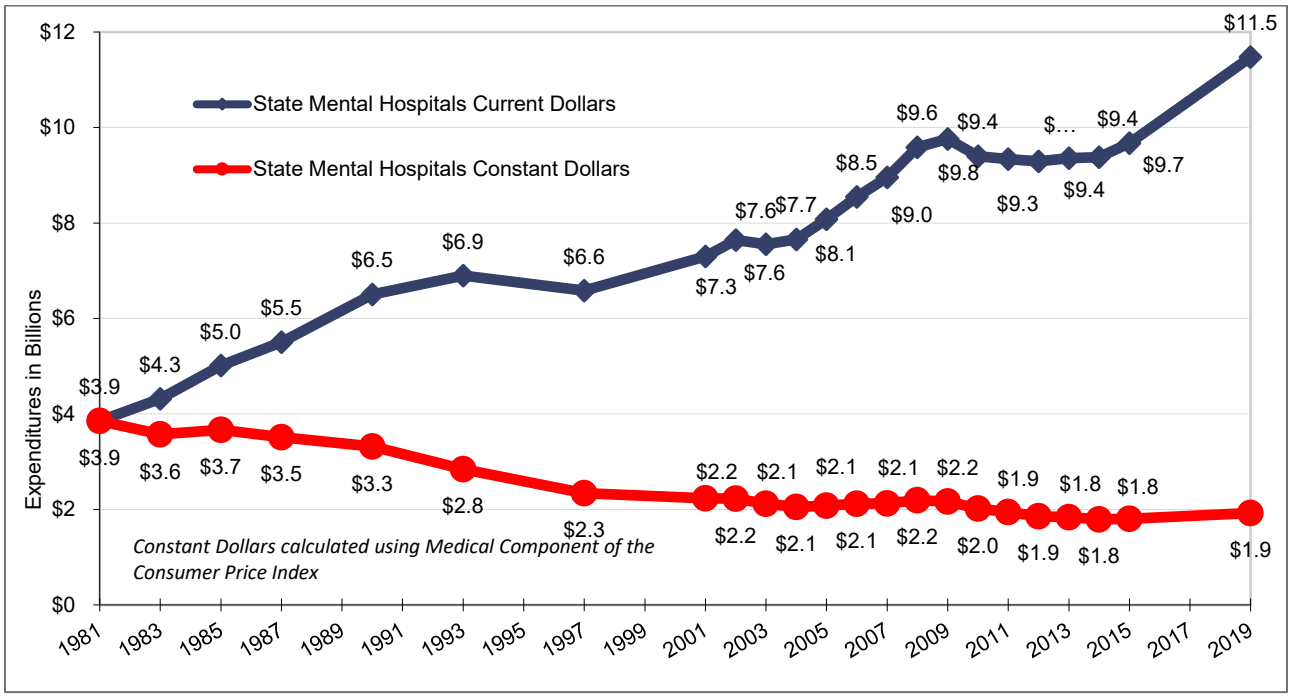
Figure 18: State Mental Health Agency-Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY 1981 to FY 2019



Total SMHA Expenditures for Mental Health Over Time: from FY 1981 to FY 2019, SMHA expenditures for mental health services grew over six-fold, from $6.1 billion in FY 1981 to $47.5 billion in FY 2019. During the last decade, from FY 2010 to FY 2019, SMHA expenditures for mental health grew by 24.8%. However, when SMHA expenditures are adjusted to account for medical inflation, SMHA spending for mental health services deceased by 2.8% (from FY 2010 to 2019).

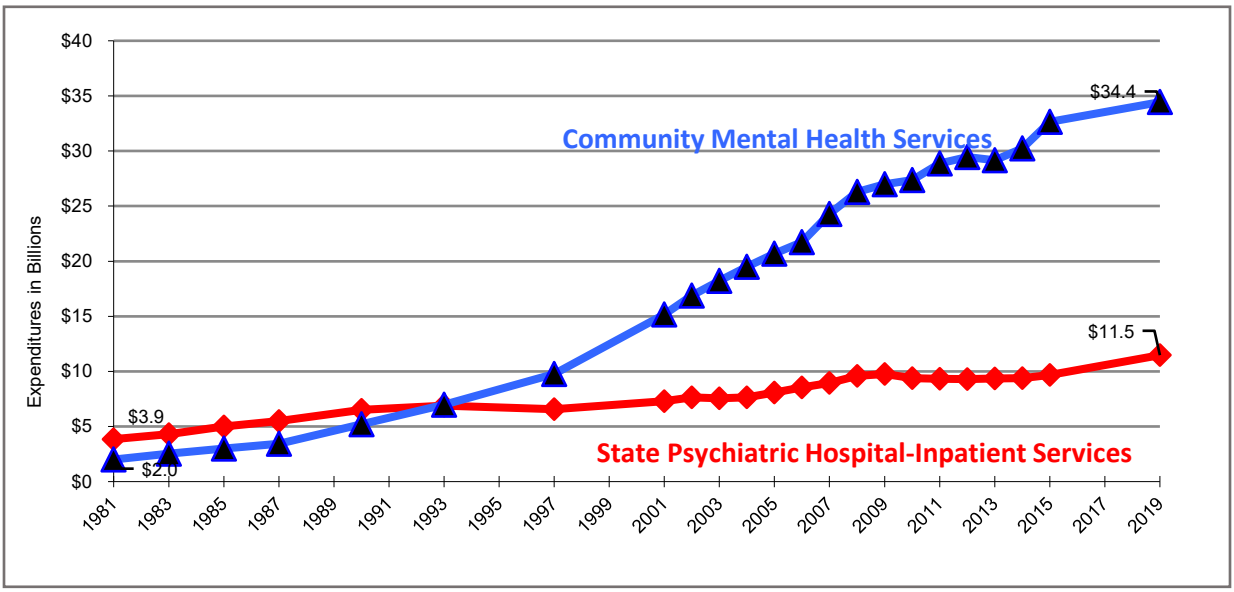
SMHA Expenditures for State Hospitals Over Time: from FY 1981 to FY 2019, state psychiatric hospital expenditures increased from $3.9 billion to over $11.5 billion in FY 2019 (an increase of 197% or an annual average increase of 2.9% per year). However, if state psychiatric hospital expenditures are adjusted to account for medical inflation, state psychiatric hospital expenditures do show a decrease from $3.9 billion in FY 1981 to $1.9 billion in FY 2019 (Figure 19).

Figure 19: SMHA Controlled Expenditures for State Psychiatric Hospital Inpatient Services, FY 1981 to FY 2019



SMHA Expenditures for Community Mental Health Over Time: Community mental health expenditures controlled by SMHA systems grew much faster than state hospital expenditures. Community mental health expenditures grew from $2 billion in FY 1981 to over $34.4 billion in FY 2019, an annual increase of 7.8% per year (Figure 20).

Figure 20: SMHA-Controlled Expenditures for Inpatient Mental Health Services in State Hospitals and Community-Based Mental Health Services, FY 1981 to FY 2019

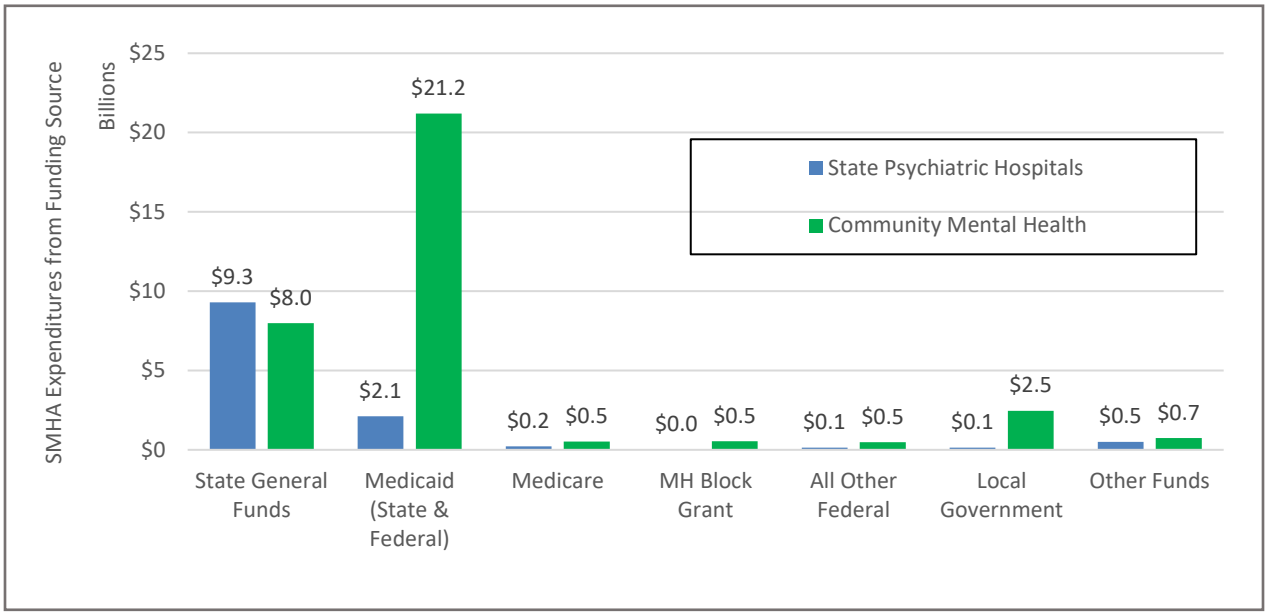


Funding Sources Paying for State Hospital Services, FY 2019

State General Revenues were the largest single payment source for state psychiatric hospitals, representing $9.3 billion of state hospital funding in FY 2019. Medicaid was the next largest funding source (at $2.1 billion) and Medicare paid over $200 million for state hospital services (note, the SAMSHA Mental Health Block Grant is prohibited by statute from paying for care in psychiatric hospitals).

Figure 21 shows the funding sources for both state psychiatric hospitals and community mental health services in FY 2019. Medicaid has become the major funding source for public mental health services, but the majority ($21.2 billion) of Medicaid is used to pay for community mental health services and only $2.1 billion supports care in state hospitals. The reliance on state general funds instead of Medicaid to pay for state hospital services is mostly due to Medicaid's Institution for Mental Disease (IMD) restriction that prohibits Medicaid payment for services to individuals between the ages of 21 and 64 in an IMD (any institution with over 16 beds where the majority of are mental health patients).

Figure 21: SMHA Funding Sources for State Psychiatric Hospitals and Community-Based Programs: FY 2019

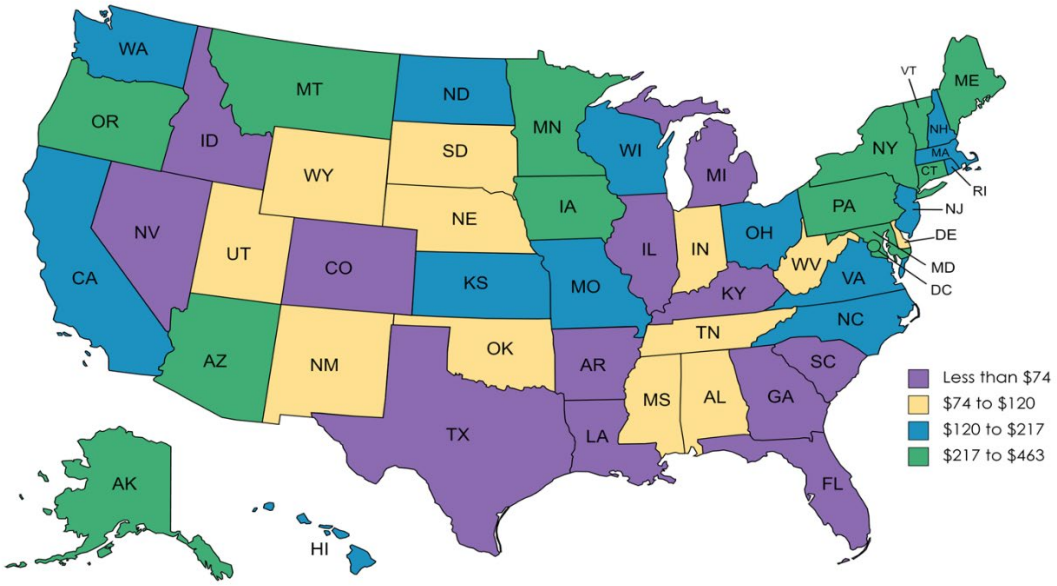


Medicaid payments supporting community mental health have grown by 245% from FY 2001 ($6.1 billion) to FY 2019 ($21.2 billion), while Medicaid support for state psychiatric hospitals decreased by 9.3% over this time period (from $2.2 billion in FY 2010 to $2.1 billion in FY 2019).

State per capita expenditures for state psychiatric hospitals

States varied considerably regarding how much they expended on state psychiatric hospitals in FY 2019, with states on average expending $34.87 per resident (Figure 22). States in the South tended to expend the lowest amounts per capita and states in the Northeast and West expended the most per capita.

Figure 22: Total FY 2019 SMHA-Controlled Per-Capita Expenditures for Mental Health Services



Conclusion

Historical comparisons of the number of mental health patients often focus only on state psychiatric hospital data and do not account for the growth of mental health treatment beds in non-state hospital providers, nor adequately account for how state hospitals have changed the populations they serve over time.

In the most recent decade (2010 to 2018), despite many discussions about bed shortages, overall inpatient psychiatric beds in all types of organizations increased 17% between 2010 to 2018. The increase in overall psychiatric beds occurred even while state psychiatric hospital beds decreased 18.5%. During this decade private psychiatric hospital patients more than doubled, and general hospital psychiatric unit beds increased more than 25%.

While the total number of individuals in a mental health bed increased from 2010 to 2018, there was a major shift in the age of patients in these beds, with the increase in beds focusing on adults while the number of children in a mental health treatment bed decreased.

- Children in mental health inpatient or residential treatment beds decreased by 20% from 2010 to 2018.
- The number of adults in inpatient or residential treatment beds increased by 24% from 2010 to 2018.

Over the past 50 years, State psychiatric hospitals have closed many of their beds and have greatly transitioned their focus on the types of individuals they serve. From 1970 to 2018, there was an 84% reduction in state hospital beds, but most of those bed closures occurred decades ago during the 1970s and 1980s (65% of all state hospital beds that closed between 1970 and 2020 were closed during the first decade (1970 to 1980).

- 70% of state hospital beds for adults (ages 18-64) that closed between 1970 and 2020 closed during the 1970s.
- 60% of state hospital beds for older adults (ages 65+) that closed between 1970 and 2020 closed during the 1970s, and 27% closed during the 1980s.
- Children in state hospital beds closed at a slightly slower rate than those for adults & older adults. Of the beds closed from 1970 to 2018, 50% were closed during the 1970s, 10% during the 1980s, 18% during the 1990s, 15% during the 2000s, and only 1% during the 2010s

Historical data from the 1970s and 1980s show that major populations then being served in state hospitals included older adults (often with neurocognitive disorders) and individuals with intellectual or developmental disabilities. Individuals with these diagnoses are no longer the focus of state psychiatric hospital treatment (unless they have a co-occurring mental health disorder) and are now largely treated in community settings or nursing facilities. Older adult patients (and especially those with diagnoses of dementia) historically occupied a large share of state psychiatric hospital beds (24% in 1970). Only 6% of patients served in state hospitals in 2020 were aged 65 and over.

State hospitals in many states no longer serve children and are increasingly focusing on providing services treating clients with criminal justice (forensic) legal statuses. As states refocus their state hospitals to serve forensic adults, individuals who need intensive inpatient or 24-hour residential treatment without criminal justice involvement are increasingly being served by private psychiatric

hospitals, general hospital specialty psychiatric units, residential treatment centers (RTCs) and other mental health providers.

An increasing majority of SMHAs are reporting shortages of psychiatric beds, but the state policies to address these shortages are not focused on reopening state hospital beds and are instead focusing on community-based services and Crisis Now-model services, including the new three-digit 988 behavioral health crisis and suicide number, mobile crisis teams, and crisis stabilization centers to divert many individuals away from inpatient care.

SMHA expenditures for state psychiatric hospitals increased over the last decade, but states have increased expenditures for community mental health services even more. State Mental Health Agency support for community mental health services increased from $2 billion in FY 1981 to over $34.4 billion in FY 2019, an annual increase of 7.8% per year. In 2019, over 8 million individuals received community mental health services from SMHA systems.

Medicaid's role in paying for mental health services, especially community-based services, has grown over time helping to support alternatives to inpatient and residential care, and Medicaid's Institution for Mental Disease (IMD) policy continues to restrict Medicaid's role in financing inpatient mental health services.

Appendix Information with State-by-state data about psychiatric beds

Appendix A: shows state-by-state information about the number of state psychiatric hospitals in each state, the number of residents in the hospital at the start of the year, the number of additions to the hospital during the year, the percent of clients who had a forensic or civil legal status, and information about the intended use of state hospitals by patient age group. This Appendix uses information from NRI's 2020-2021 State Profiles system combined with public information from SAMHSA's 2020 Uniform Reporting System (Table 6).

Appendix B: Shows state-by-state the number of organizations with mental health treatment beds in 2018, the number of inpatient residents and the number of 24-hour residential treatment patients in a bed and the utilization rates per 100,000 state population. This table was created by NRI using information from SAMHSA's 2018 N-MHSS report.

Appendix C: Shows state-by-state the number of inpatient residents, other 24-hour residential treatment patients, and total mental health treatment patients for the years 2010 to 2020. These tables were created by NRI using information from SAMHSA's 2010, 2014, 2018, and 2020 N-MHSS reports.

Appendix A: 2020 State Psychiatric Hospital Data, by State

Table 14: Patients in State Psychiatric Hospitals, by Sate, 2020

State	Number of State Hospitals (2020)	Number of Patients (Start of 2020)	Patients per 100,000 population (2020)	State Population: 2020	State Hospital Admissions (2020)	Admissions per 100,000 Pop (2020)	Forensic Percent of Admissions (2020)	Forensic Percent of Patients (2020)
Alabama	3	567	11.5	4,921,532	238	4.8	30.3%	30.3%
Alaska	1	31	4.2	731,158	538	73.6	NR	NR
Arizona	1	216	2.9	7,421,401	65	0.9		
Arkansas	1	215	7.1	3,030,522	318	10.5		
California	5	6,104	15.5	39,368,078	4,602	11.7	98.7%	92.7%
Colorado	2	528	9.1	5,807,719	757	13.0	73.6%	67.0%
Connecticut	6	581	16.3	3,557,006	715	20.1	35.4%	35.4%
Delaware	1	174	17.6	986,809	98	9.9	46.7%	46.7%
District of Columbia	1	237	33.2	712,816	233	32.7	77.0%	58.8%
Florida	3	2,631	12.1	21,733,312	2,173	10.0	72.7%	65.2%
Georgia	5	947	8.8	10,710,017	2,740	25.6	23.2%	57.6%
Hawaii	1	258	18.3	1,407,006	331	23.5	NR	NR
Idaho	2	152	8.3	1,826,913	1,044	57.1	22.0%	
Illinois	7	1,155	9.2	12,587,530	3,190	25.3	18.8%	77.3%
Indiana	6	606	9.0	6,754,953	499	7.4		
Iowa	3	NA	NA	3,163,561	0	0.0	6.6%	6.6%
Kansas	2	649	22.3	2,913,805	2,371	81.4		
Kentucky	3	349	7.8	4,477,251	6,225	139.0	3.2%	
Louisiana	2	687	14.8	4,645,318	369	7.9	82.0%	42.3%
Maine	2	102	7.6	1,350,141	2,231	165.2		
Maryland	5	NA	NA	6,055,802	0	0.0	84.7%	83.2%
Massachusetts	2	597	8.7	6,893,574	846	12.3	13.7%	
Michigan	5	623	6.3	9,966,555	1,381	13.9	46.9%	
Minnesota	8	174	3.1	5,657,342	889	15.7		
Mississippi†	4	654	22.0	2,966,786	2,131	71.8	4.3%	6.5%
Missouri	6	1,184	19.2	6,151,548	450	7.3	73.1%	66.4%
Montana	1	228	21.1	1,080,577	759	70.2	14.5%	21.8%
Nebraska	2	595	30.7	1,937,552	198	10.2	66.7%	66.5%
Nevada	2	125	4.0	3,138,259	2,331	74.3	3.6%	98.7%
New Hampshire	1	118	8.6	1,366,275	1,227	89.8	2.5%	2.5%
New Jersey	4	1,321	14.9	8,882,371	1,007	11.3	16.0%	16.0%
New Mexico	1	344	16.3	2,106,319	420	19.9		
New York	23	3,779	19.5	19,336,776	4,900	25.3		
North Carolina	3	757	7.1	10,600,823	1,469	13.9	6.3%	6.3%
North Dakota	1	115	15.0	765,309	732	95.6	11.4%	

State	Number of State Hospitals (2020)	Number of Patients (Start of 2020)	Patients per 100,000 population (2020)	State Population: 2020	State Hospital Admissions (2020)	Admissions per 100,000 Pop (2020)	Forensic Percent of Admissions (2020)	Forensic Percent of Patients (2020)
Ohio	6	1,059	9.1	11,693,217	4,734	40.5		
Oklahoma	2	667	16.8	3,980,783	1,547	38.9		
Oregon	1	605	14.3	4,241,507	1,051	24.8		6.7%
Pennsylvania	6	1,458	11.4	12,783,254	943	7.4	32.1%	
Rhode Island‡	1	135	12.8	1,057,125	54	5.1	100.0%	
South Carolina	3	763	14.6	5,218,040	932	17.9	51.5%	51.5%
South Dakota	1	184	20.6	892,717	1,323	148.2	11.4%	11.4%
Tennessee	4	433	6.3	6,886,834	8,278	120.2	8.2%	41.8%
Texas	9	2,407	8.2	29,360,759	16,395	55.8		
Utah	1	306	9.4	3,249,879	262	8.1		
Vermont	1	21	3.4	623,347	92	14.8		
Virginia	9	3,113	36.2	8,590,563	7,526	87.6	22.9%	41.2%
Washington	3	1,180	15.3	7,693,612	1,172	15.2		
West Virginia	2	240	13.4	1,784,787	2,362	132.3	6.6%	6.6%
Wisconsin	2	505	8.7	5,832,655	7,043	120.8	72.9%	72.9%
Wyoming	1	84	14.4	582,328	191	32.8	26.5%	26.5%
Total	**177**	**39,963**	**12.1**	**329,484,123**	**101,382**	**30.8**	**30.0%**	**56.0%**
Median	**2**	**567**	**12.1**	**4,477,251**	**943**	**20.1**	**25.0%**	**42.0%**
Maximum	**23**	**6,104**	**36.2**	**39,368,078**	**16,395**	**165.2**	**100.0%**	**99.0%**
Minimum	**1**	**21**	**2.9**	**582,328**	**0.0**	**0.0**	**2.0%**	**2.0%**

Notes on Table:

Number of Admissions and Residents from 2020 URS Table 6

Number of State Psychiatric Hospitals, Percent Forensic, and Use of State Hospitals from 2020 State Mental Health Profiles

† State submitted updated information different from their URS submission

‡ Rhode Island has state-operated psychiatric inpatient beds that are part of a general hospital

State Hospital Admissions and Discharges can be duplicated (e.g., one client can have multiple admissions/discharges during the year)

Table 15: Use of State Psychiatric Hospitals, by State, 2020

State	Hospitals are used for Short or Long-Term Care (2020 Profiles)		
	Children & Adolescents	Adults/Older adult	Forensic Patients
Alabama		Acute & Long	Acute & Long
Alaska	No Data Available	No Data Available	No Data Available
Arizona		Acute & Long	Acute & Long
Arkansas		Acute & Long	Acute & Long
California		Acute & Long	Acute & Long
Colorado	Acute & Long	Acute & Long	Acute & Long
Connecticut		Acute & Long	Acute & Long
Delaware		Acute & Long	Acute & Long
District of Columbia		Acute & Long	Acute & Long
Florida		Long Term	Long Term
Georgia		Acute & Long	Long Term
Hawaii			
Idaho		Acute & Long	Acute & Long
Illinois		Acute & Long	Acute & Long
Indiana	Long Term	Long Term	Long Term
Iowa	Acute & Long	Acute & Long	Acute & Long
Kansas			
Kentucky		Acute & Long	Acute & Long
Louisiana		Acute & Long	Acute & Long
Maine		Acute & Long	Acute & Long
Maryland		Acute & Long	Acute & Long
Massachusetts		Acute & Long	Acute & Long
Michigan	Long Term	Long Term	Long Term
Minnesota	Acute & Long	Acute & Long	Acute & Long
Mississippi	Acute	Acute & Long	Acute & Long
Missouri	Acute		Acute & Long
Montana		Acute & Long	Acute & Long
Nebraska		Acute & Long	Acute & Long
Nevada			Acute & Long
New Hampshire	Acute	Acute & Long	Acute & Long
New Jersey		Acute & Long	Acute & Long
New Mexico		Acute & Long	Long Term
New York	Acute & Long	Acute & Long	Acute & Long
North Carolina	Acute & Long	Acute & Long	Acute & Long
North Dakota		Acute	Acute & Long
Ohio		Acute	Acute & Long
Oklahoma	Acute	Acute & Long	Acute & Long
Oregon		Long Term	Acute & Long
Pennsylvania		Long Term	Long Term
Rhode Island§		Acute & Long	Acute & Long
South Carolina	Acute & Long	Acute & Long	Acute & Long
South Dakota		Acute & Long	Acute & Long
Tennessee		Acute & Long	Acute & Long
Texas	Acute & Long	Acute & Long	Acute & Long
Utah	Acute	Acute	
Vermont		Acute & Long	Acute & Long
Virginia	Acute	Acute & Long	Acute & Long
Washington	Long Term	Long Term	Acute & Long
West Virginia		Acute & Long	Acute & Long
Wisconsin	Acute	Acute & Long	Acute & Long
Wyoming		Acute & Long	Acute & Long

§ Rhode Island had state-operated psychiatric inpatient beds that are part of a general hospital

Appendix B: Patients in Psychiatric Beds (All Types of Organizations), 2018

Table 16: Patients in Mental Health Inpatient and 24-Hour Residential Treatment Beds on April 1, 2018, by State

State	Organizations with Inpatient Beds	Inpatient Clients	Inpatients per 100,000 State Population	Organizations with Residential Treatment Beds	Residential Clients	24-Hour Residential TX Clients per 100,000 State Population	Total MH Patients in Bed (April 30, 2018)	Total Inpatient and 24-Hour Residential TX Clients per 100,000 State Population
Alabama	40	1,650	33.8	47	1,070	21.9	2,801	57.3
Alaska	9	286	38.8	27	487	66.0	839	113.7
Arizona	36	8,041	112.1	97	1,468	20.5	9,718	135.5
Arkansas	39	1,456	48.3	29	1,307	43.4	2,840	94.2
California	128	13,157	33.3	169	5,462	13.8	18,821	47.6
Colorado	22	6,582	115.6	42	987	17.3	7,727	135.7
Connecticut	28	2,107	59.0	34	2,898	81.1	5,098	142.7
Delaware	5	377	39.0	4	71	7.3	491	50.8
District of Columbia	5	350	49.8	1	12	1.7	413	58.8
Florida	110	14,992	70.4	94	2,914	13.7	18,070	84.8
Georgia	37	2,006	19.1	21	1,187	11.3	3,233	30.7
Hawaii	8	344	24.2	3	92	6.5	463	32.6
Idaho	9	352	20.1	5	107	6.1	484	27.6
Illinois	78	3,962	31.1	70	1,769	13.9	5,832	45.8
Indiana	64	2,080	31.1	55	1,801	26.9	3,967	59.3
Iowa	27	763	24.2	18	587	18.6	1,392	44.1
Kansas	23	1,122	38.5	19	825	28.3	2,005	68.8
Kentucky	32	1,323	29.6	40	1,371	30.7	2,764	61.8
Louisiana	67	5,889	126.4	6	265	5.7	6,286	134.9
Maine	12	422	31.5	52	396	29.6	902	67.4
Maryland	32	1,608	26.6	34	953	15.8	2,622	43.4
Massachusetts	55	2,248	32.6	63	1,888	27.4	4,232	61.3
Michigan	56	2,979	29.8	24	1,295	13.0	4,328	43.3
Minnesota	33	1,310	23.3	51	1,637	29.2	3,021	53.8
Mississippi	37	1,152	38.6	22	1,093	36.6	2,306	77.2
Missouri	53	5,063	82.6	37	1,477	24.1	6,660	108.7
Montana	8	576	54.2	21	444	41.8	1,095	103.1
Nebraska	15	599	31.0	22	534	27.7	1,186	61.5
Nevada	12	559	18.4	6	191	6.3	774	25.5
New Hampshire	9	277	20.4	16	324	23.9	637	47.0
New Jersey	44	3,751	42.1	45	1,172	13.2	5,010	56.2
New Mexico	15	670	32.0	9	286	13.6	997	47.6
New York	129	8,306	42.5	100	4,032	20.6	12,481	63.9
North Carolina	53	2,627	25.3	96	987	9.5	3,735	36.0
North Dakota	7	293	38.5	10	169	22.2	511	67.2
Ohio	72	3,370	28.8	62	2,123	18.2	5,584	47.8
Oklahoma	33	844	21.4	15	334	8.5	1,214	30.8
Oregon	16	1,066	25.4	55	937	22.4	2,083	49.7
Pennsylvania	100	4,578	35.7	79	2,517	19.7	7,210	56.3
Rhode Island*	8	438	41.4	21	304	28.8	804	76.1
South Carolina	24	1,351	26.6	12	510	10.0	1,900	37.4
South Dakota	5	169	19.2	7	372	42.2	567	64.3
Tennessee	44	1,893	28.0	40	1,585	23.4	3,546	52.4
Texas	101	7,151	24.9	47	2,281	7.9	9,504	33.1

State	Organizations with Inpatient Beds	Inpatient Clients	Inpatients per 100,000 State Population	Organizations with Residential Treatment Beds	Residential Clients	24-Hour Residential TX Clients per 100,000 State Population	Total MH Patients in Bed (April 30, 2018)	Total Inpatient and 24-Hour Residential TX Clients per 100,000 State Population
Utah	17	912	28.9	30	984	31.1	1,955	61.8
Vermont	6	193	30.8	29	306	48.9	559	89.2
Virginia	47	2,781	32.6	38	1,792	21.0	4,644	54.5
Washington	30	1,883	25.0	41	1,120	14.9	3,069	40.7
West Virginia	17	822	45.5	17	633	35.1	1,518	84.0
Wisconsin	38	1,418	24.4	25	825	14.2	2,292	39.4
Wyoming	8	212	36.7	9	254	44.0	512	88.6
Puerto Rico	14	730	22.8	16	327	10.2	1,096	34.3
Other Jurisdictions	3	25					25	
US Total	1,920	129,115	39.1	1,932	58,762	17.8	191,821	58.1

Table created by NRI using NMHSS 2018 Tables 4.6 and 4.8 and US Census Data.

Appendix C: Trend in Psychiatric Patients, 2010 to 2020

Table 17: Mental Health Inpatients in Beds on April 30 each year, 2010 to 2020

State/Year	Inpatient Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
Alabama	1,785	1,116	1,650	1,144	-135	-8%
Alaska	190	243	286	63	96	51%
Arizona	1,274	1,398	8,041	1,569	6,767	531%
Arkansas	1,021	1,166	1,456	1,091	435	43%
California	8,220	13,318	13,157	8,941	4,937	60%
Colorado	693	1,222	6,582	1,815	5,889	850%
Connecticut	2,167	1,693	2,107	645	-60	-3%
Delaware	431	393	377	427	-54	-13%
District of Columbia	528	450	350	275	-178	-34%
Florida	5,261	5,950	14,992	6,373	9,731	185%
Georgia	2,592	1,407	2,006	1,568	-586	-23%
Hawaii	324	321	344	353	20	6%
Idaho	380	462	352	316	-28	-7%
Illinois	3,725	3,965	3,962	3,568	237	6%
Indiana	1,948	3,385	2,080	1,587	132	7%
Iowa	805	671	763	868	-42	-5%
Kansas	1,187	993	1,122	708	-65	-5%
Kentucky	1,715	1,116	1,323	993	-392	-23%
Louisiana	2,073	1,971	5,889	1,936	3,816	184%
Maine	422	411	422	323	0	0%
Maryland	1,857	2,060	1,608	1,269	-249	-13%
Massachusetts	2,373	2,405	2,248	2,499	-125	-5%
Michigan	2,302	2,441	2,979	1,421	677	29%
Minnesota	1,003	1,445	1,310	803	307	31%
Mississippi	1,893	1,352	1,152	783	-741	-39%
Missouri	2,772	3,062	5,063	2,024	2,291	83%
Montana	256	886	576	562	320	125%
Nebraska	648	632	599	1,685	-49	-8%
Nevada	498	726	559	533	61	12%
New Hampshire	386	308	277	230	-109	-28%
New Jersey	4,322	3,497	3,751	2,538	-571	-13%
New Mexico	342	591	670	217	328	96%
New York	9,526	9,544	8,306	4,077	-1,220	-13%
North Carolina	1,945	2,402	2,627	1,770	682	35%
North Dakota	518	116	293	416	-225	-43%
Ohio	2,894	2,447	3,370	2,275	476	16%
Oklahoma	1,496	1,454	844	790	-652	-44%
Oregon	1,166	888	1,066	772	-100	-9%
Pennsylvania	5,965	4,976	4,578	3,780	-1,387	-23%
Rhode Island	373	485	438	313	65	17%

State/Year	Inpatient Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
South Carolina	1,061	1,274	1,351	756	290	27%
South Dakota	314	105	169	84	-145	-46%
Tennessee	1,404	1,773	1,893	1,771	489	35%
Texas	6,301	5,691	7,151	4,792	850	13%
Utah	629	580	912	823	283	45%
Vermont	246	154	193	112	-53	-22%
Virginia	2,618	2,081	2,781	2,662	163	6%
Washington	3,436	1,843	1,883	1,483	-1,553	-45%
West Virginia	1,014	818	822	530	-192	-19%
Wisconsin	1,049	1,513	1,418	972	369	35%
Wyoming	184	187	212	152	28	15%
Puerto Rico	1,938	1,964	730	141	-1,208	-62%
Jurisdictions	23	NA	25	24	2	9%
US Total	**99,493**	**101,351**	**129,115**	**77,622**	**29,622**	**30%**
Median	**1,187**	**1,313**	**1,323**	**868**	2	6%
Minimum	**23**	**105**	**25**	**24**	-1,553	-62%
Maximum	**9,526**	**13,318**	**14,992**	**8,941**	9,731	850%
States	**53**	**52**	**53**	**53**	53	53

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.
**2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.*

Table 18: Inpatient Patients per 100,000 State Population on April 30 Each Year, 2010 through 2020

State/Year	Inpatients Patients per 100,000 State Population				2010 to 2018*
	2010	2014	2018	2020	% Change
Alabama	37.30	23.08	33.76	23.24	-10%
Alaska	26.61	34.00	38.78	8.62	46%
Arizona	19.87	20.83	112.12	21.14	464%
Arkansas	34.95	39.40	48.31	36.00	38%
California	22.01	34.46	33.26	22.71	51%
Colorado	13.73	22.97	115.56	31.25	742%
Connecticut	60.61	47.17	58.98	18.13	-3%
Delaware	47.90	42.18	38.98	43.27	-19%
District of Columbia	87.29	68.65	49.83	38.58	-43%
Florida	27.93	30.01	70.39	29.32	152%
Georgia	26.69	14.03	19.07	14.64	-29%
Hawaii	23.76	23.39	24.22	25.09	2%
Idaho	24.19	28.34	20.07	17.30	-17%
Illinois	29.01	30.85	31.10	28.35	7%
Indiana	30.01	51.34	31.08	23.49	4%
Iowa	26.39	21.61	24.18	27.44	-8%
Kansas	41.52	34.46	38.54	24.30	-7%
Kentucky	39.45	25.40	29.61	22.18	-25%
Louisiana	45.61	42.56	126.37	41.68	177%
Maine	31.79	30.93	31.53	23.92	-1%
Maryland	32.10	34.64	26.61	20.96	-17%
Massachusetts	36.20	35.68	32.57	36.25	-10%
Michigan	23.31	24.64	29.80	14.26	28%
Minnesota	18.89	26.49	23.35	14.19	24%
Mississippi	63.74	45.38	38.57	26.39	-39%
Missouri	46.23	50.65	82.64	32.90	79%
Montana	25.83	86.88	54.22	52.01	110%
Nebraska	35.41	33.71	31.05	86.97	-12%
Nevada	18.42	25.68	18.42	16.98	0%
New Hampshire	29.31	23.24	20.42	16.83	-30%
New Jersey	49.12	39.17	42.11	28.57	-14%
New Mexico	16.55	28.51	31.97	10.30	93%
New York	49.12	48.40	42.50	21.08	-13%
North Carolina	20.34	24.42	25.30	16.70	24%
North Dakota	76.78	15.84	38.55	54.36	-50%
Ohio	25.08	21.12	28.83	19.46	15%
Oklahoma	39.79	37.69	21.40	19.85	-46%
Oregon	30.38	22.38	25.44	18.20	-16%
Pennsylvania	46.90	38.94	35.75	29.57	-24%
Rhode Island	35.44	46.14	41.43	29.61	17%
South Carolina	22.88	26.60	26.57	14.49	16%

State/Year	Inpatients Patients per 100,000 State Population				2010 to 2018*
	2010	2014	2018	2020	% Change
South Dakota	38.45	12.36	19.16	9.41	-50%
Tennessee	22.08	27.16	27.96	25.72	27%
Texas	24.95	21.21	24.91	16.32	0%
Utah	22.66	19.74	28.85	25.32	27%
Vermont	39.30	24.60	30.82	17.97	-22%
Virginia	32.63	25.34	32.65	30.99	0%
Washington	50.96	26.30	24.99	19.28	-51%
West Virginia	54.68	44.24	45.52	29.70	-17%
Wisconsin	18.43	26.29	24.39	16.66	32%
Wyoming	32.59	32.18	36.69	26.10	13%
Puerto Rico	48.58	54.62	22.89	4.42	-53%
Jurisdictions					
US Total	**32.16**	**31.91**	**39.46**	**23.56**	23%
Median	**31.94**	**29.26**	**31.31**	**23.37**	**0%**
Minimum	**13.73**	**12.36**	**18.42**	**4.42**	**-53%**
Maximum	**87.29**	**86.88**	**126.37**	**86.97**	**742%**
States	**52**	**52**	**52**	**52**	**52**

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020

**2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.*

Table 19: Number of Patients in 24-Hour Residential Treatment Beds on April 30 Each Year, by State, 2010 through 2020

State/Year	24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
Alabama	1,763	1,613	1,070	985	-693	-39%
Alaska	286	534	487	179	201	70%
Arizona	781	1,478	1,468	1,274	687	88%
Arkansas	561	1,249	1,307	963	746	133%
California	3,508	4,824	5,462	4,762	1,954	56%
Colorado	898	1,008	987	338	89	10%
Connecticut	919	1,099	2,898	677	1,979	215%
Delaware	189	124	71	21	-118	-62%
District of Columbia	15	300	12	0	-3	-20%
Florida	4,174	3,988	2,914	1,874	-1,260	-30%
Georgia	1,707	1,197	1,187	806	-520	-30%
Hawaii	123	386	92	111	-31	-25%
Idaho	207	251	107	119	-100	-48%
Illinois	3,275	2,538	1,769	1,188	-1,506	-46%
Indiana	2,026	1,933	1,801	1,375	-225	-11%
Iowa	1,186	1,023	587	626	-599	-51%
Kansas	296	1,635	825	584	529	179%
Kentucky	1,440	1,127	1,371	661	-69	-5%
Louisiana	61	125	265	258	204	334%
Maine	478	564	396	590	-82	-17%
Maryland	1,593	1,831	953	902	-640	-40%
Massachusetts	2,636	2,257	1,888	1,175	-748	-28%
Michigan	1,716	1,444	1,295	598	-421	-25%
Minnesota	1,391	1,201	1,637	1,351	246	18%
Mississippi	925	1,139	1,093	663	168	18%
Missouri	1,722	1,663	1,477	2,365	-245	-14%
Montana	483	787	444	576	-39	-8%
Nebraska	603	570	534	309	-69	-11%
Nevada	116	64	191	42	75	65%
New Hampshire	542	493	324	372	-218	-40%
New Jersey	1,138	1,585	1,172	1,057	34	3%
New Mexico	547	472	286	208	-261	-48%
New York	4,993	6,517	4,032	2,341	-961	-19%
North Carolina	521	1,312	987	595	466	89%
North Dakota	257	187	169	188	-88	-34%
Ohio	2,159	2,384	2,123	1,080	-36	-2%
Oklahoma	530	694	334	300	-196	-37%
Oregon	1,021	1,613	937	734	-84	-8%
Pennsylvania	3,120	2,852	2,517	1,656	-603	-19%

State/Year	24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
Rhode Island	445	368	304	386	-141	-32%
South Carolina	534	722	510	298	-24	-4%
South Dakota	718	533	372	334	-346	-48%
Tennessee	897	1,649	1,585	242	688	77%
Texas	1,762	2,750	2,281	1,091	519	29%
Utah	1,326	1,112	984	1,587	-342	-26%
Vermont	541	545	306	1,230	-235	-43%
Virginia	1,659	1,327	1,792	376	133	8%
Washington	978	1,272	1,120	1,407	142	15%
West Virginia	406	360	633	647	227	56%
Wisconsin	1,049	1,071	825	1,351	-224	-21%
Wyoming	443	276	254	641	-189	-43%
Puerto Rico	82	803	327	251	245	299%
Jurisdictions	18	NA	NA	NA		
US Total	**60,764**	**68,849**	**58,762**	**43,744**	**-2,002**	**-3%**
Median	**897**	**1,120**	**969**	**644**	-76	-13%
Minimum	**15**	**64**	**12**	**0**	-1,506	-62%
Maximum	**4,993**	**6,517**	**5,462**	**4,762**	1,979	334%
States	**53**	**52**	**52**	**51**	52	52

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.
**2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.*

Table 20: 24-Hour Residential Treatment Patients per 100,000 of State Population on April 30 Each Year, by State, 2010 through 2020

State/Year	24-Hour Residential Treatment Patients per 100,000 State Population (on April 30th)				2010 to 2018*
	2010	2014	2018	2020	% Change
Alabama	36.84	33.36	21.89	20.01	-41%
Alaska	40.05	74.73	66.04	24.48	65%
Arizona	12.18	22.02	20.47	17.17	68%
Arkansas	19.20	42.20	43.37	31.78	126%
California	9.40	12.48	13.81	12.10	47%
Colorado	17.79	18.95	17.33	5.82	-3%
Connecticut	25.70	30.62	81.12	19.03	216%
Delaware	21.00	13.31	7.34	2.13	-65%
District of Columbia	2.48	45.77	1.71	NA	-31%
Florida	22.16	20.12	13.68	8.62	-38%
Georgia	17.58	11.93	11.28	7.53	-36%
Hawaii	9.02	28.13	6.48	7.89	-28%
Idaho	13.18	15.40	6.10	6.51	-54%
Illinois	25.50	19.75	13.88	9.44	-46%
Indiana	31.21	29.32	26.91	20.36	-14%
Iowa	38.88	32.94	18.60	19.79	-52%
Kansas	10.35	56.75	28.34	20.04	174%
Kentucky	33.12	25.65	30.68	14.76	-7%
Louisiana	1.34	2.70	5.69	5.55	324%
Maine	36.01	42.45	29.59	43.70	-18%
Maryland	27.53	30.79	15.77	14.89	-43%
Massachusetts	40.21	33.49	27.35	17.04	-32%
Michigan	17.37	14.58	12.96	6.00	-25%
Minnesota	26.19	22.02	29.17	23.88	11%
Mississippi	31.14	38.23	36.60	22.35	18%
Missouri	28.72	27.51	24.11	38.45	-16%
Montana	48.74	77.18	41.80	53.30	-14%
Nebraska	32.95	30.40	27.68	15.95	-16%
Nevada	4.29	2.26	6.29	1.34	47%
New Hampshire	41.16	37.20	23.89	27.23	-42%
New Jersey	12.93	17.75	13.16	11.90	2%
New Mexico	26.48	22.77	13.65	9.88	-48%
New York	25.74	33.05	20.63	12.11	-20%
North Carolina	5.45	13.34	9.51	5.61	74%
North Dakota	38.10	25.53	22.23	24.57	-42%
Ohio	18.71	20.58	18.16	9.24	-3%
Oklahoma	14.10	17.99	8.47	7.54	-40%
Oregon	26.60	40.66	22.36	17.31	-16%
Pennsylvania	24.53	22.32	19.65	12.95	-20%

State/Year	24-Hour Residential Treatment Patients per 100,000 State Population (on April 30th)				2010 to 2018*
	2010	2014	2018	2020	% Change
Rhode Island	42.28	35.01	28.75	36.51	-32%
South Carolina	11.52	15.07	10.03	5.71	-13%
South Dakota	87.93	62.73	42.17	37.41	-52%
Tennessee	14.11	25.26	23.41	3.51	66%
Texas	6.98	10.25	7.95	3.72	14%
Utah	47.78	37.85	31.13	48.83	-35%
Vermont	86.43	87.06	48.86	197.32	-43%
Virginia	20.68	16.16	21.04	4.38	2%
Washington	14.50	18.15	14.86	18.29	2%
West Virginia	21.89	19.47	35.05	36.25	60%
Wisconsin	18.43	18.61	14.19	23.16	-23%
Wyoming	78.47	47.50	43.96	110.08	-44%
Puerto Rico	2.06	22.33	10.25	7.87	399%
Jurisdictions					
US Total	**19.64**	**21.68**	**17.96**	**13.28**	**-9%**
Median	**23.34**	**25.40**	**20.55**	**16**	**-16%**
Minimum	**1.34**	**2.26**	**1.71**	**1**	**-65%**
Maximum	**87.93**	**87.06**	**81.12**	**197**	**399%**
States	**52**	**52**	**52**	**51**	**52**

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.
**2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.*

Table 21: Inpatient and 24-Hour Residential Treatment Patients on April 30 Each Year, by State, 2010 through 2020

State/Year	Inpatient and 24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018	
	2010	2014	2018	2020	N	% Change
Alabama	3,548	2,729	2,720	2,129	-828	-23%
Alaska	476	777	773	242	297	62%
Arizona	2,055	2,876	9,509	2,843	7,454	363%
Arkansas	1,582	2,415	2,763	2,054	1,181	75%
California	11,728	18,142	18,619	13,703	6,891	59%
Colorado	1,591	2,230	7,569	2,153	5,978	376%
Connecticut	3,086	2,792	5,005	1,322	1,919	62%
Delaware	620	517	448	448	-172	-28%
District of Columbia	543	750	362	275	-181	-33%
Florida	9,435	9,938	17,906	8,247	8,471	90%
Georgia	4,299	2,604	3,193	2,374	-1,106	-26%
Hawaii	447	707	436	464	-11	-2%
Idaho	587	713	459	435	-128	-22%
Illinois	7,000	6,503	5,731	4,756	-1,269	-18%
Indiana	3,974	5,318	3,881	2,962	-93	-2%
Iowa	1,991	1,694	1,350	1,494	-641	-32%
Kansas	1,483	2,628	1,947	1,292	464	31%
Kentucky	3,155	2,243	2,694	1,654	-461	-15%
Louisiana	2,134	2,096	6,154	2,194	4,020	188%
Maine	900	975	818	913	-82	-9%
Maryland	3,450	3,891	2,561	2,171	-889	-26%
Massachusetts	5,009	4,662	4,136	3,674	-873	-17%
Michigan	4,018	3,885	4,274	2,019	256	6%
Minnesota	2,394	2,646	2,947	2,154	553	23%
Mississippi	2,818	2,491	2,245	1,446	-573	-20%
Missouri	4,494	4,725	6,540	4,389	2,046	46%
Montana	739	1,673	1,020	1,138	281	38%
Nebraska	1,251	1,202	1,133	1,994	-118	-9%
Nevada	614	790	750	575	136	22%
New Hampshire	928	801	601	602	-327	-35%
New Jersey	5,460	5,082	4,923	3,595	-537	-10%
New Mexico	889	1,063	956	425	67	8%
New York	14,519	16,061	12,338	6,418	-2,181	-15%
North Carolina	2,466	3,714	3,614	2,365	1,148	47%
North Dakota	775	303	462	604	-313	-40%
Ohio	5,053	4,831	5,493	3,355	440	9%
Oklahoma	2,026	2,148	1,178	1,090	-848	-42%
Oregon	2,187	2,501	2,003	1,506	-184	-8%
Pennsylvania	9,085	7,828	7,095	5,436	-1,990	-22%
Rhode Island	818	853	742	699	-76	-9%

State/Year	Inpatient and 24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018	
	2010	2014	2018	2020	N	% Change
South Carolina	1,595	1,996	1,861	1,054	266	17%
South Dakota	1,032	638	541	418	-491	-48%
Tennessee	2,301	3,422	3,478	2,013	1,177	51%
Texas	8,063	8,441	9,432	5,883	1,369	17%
Utah	1,955	1,692	1,896	2,410	-59	-3%
Vermont	787	699	499	1,342	-288	-37%
Virginia	4,277	3,408	4,573	3,038	296	7%
Washington	4,414	3,115	3,003	2,890	-1,411	-32%
West Virginia	1,420	1,178	1,455	1,177	35	2%
Wisconsin	2,098	2,584	2,243	2,323	145	7%
Wyoming	627	463	466	793	-161	-26%
Puerto Rico	2,020	2,767	1,057	392	-963	-48%
Jurisdictions	41	NA	25	24	-16	
US Total	**160,257**	**170,200**	**187,877**	**121,366**	27,620	17%
Median	**2,055**	**2,496**	**2,245**	**1,994**	-76	-6%
Minimum	**41**	**303**	**25**	**24**	-2,181	-48%
Maximum	**14,519**	**18,142**	**18,619**	**13,703**	8,471	376%
States	**53**	**52**	**53**	**53**	53	53

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.
**2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.*

Table 22: Inpatient and 24-Hour Residential Treatment Patients per 100,000 State Population on April 30 Each Year, by State, 2010 through 2020

State/Year	Inpatient and 24-Hour Residential Treatment Patients per 100,000 State Population (on April 30th)				2010 to 2018
	2010	2014	2018	2020	% Change
Alabama	74.14	56.45	55.65	43.26	-25%
Alaska	66.65	108.73	104.82	33.10	57%
Arizona	32.04	42.85	132.59	38.31	314%
Arkansas	54.15	81.60	91.68	67.78	69%
California	31.41	46.94	47.07	34.81	50%
Colorado	31.52	41.92	132.89	37.07	322%
Connecticut	86.31	77.79	140.09	37.17	62%
Delaware	68.90	55.49	46.32	45.40	-33%
District of Columbia	89.77	114.41	51.53	38.58	-43%
Florida	50.08	50.13	84.07	37.95	68%
Georgia	44.26	25.96	30.35	22.17	-31%
Hawaii	32.79	51.52	30.69	32.98	-6%
Idaho	37.36	43.74	26.17	23.81	-30%
Illinois	54.51	50.59	44.98	37.78	-17%
Indiana	61.23	80.65	58.00	43.85	-5%
Iowa	65.27	54.55	42.77	47.23	-34%
Kansas	51.87	91.21	66.87	44.34	29%
Kentucky	72.58	51.05	60.29	36.94	-17%
Louisiana	46.95	45.26	132.06	47.23	181%
Maine	67.80	73.38	61.12	67.62	-10%
Maryland	59.63	65.42	42.38	35.85	-29%
Massachusetts	76.41	69.17	59.92	53.30	-22%
Michigan	40.68	39.22	42.76	20.26	5%
Minnesota	45.08	48.51	52.52	38.07	17%
Mississippi	94.88	83.62	75.17	48.74	-21%
Missouri	74.95	78.15	106.75	71.35	42%
Montana	74.57	164.06	96.02	105.31	29%
Nebraska	68.36	64.11	58.73	102.91	-14%
Nevada	22.70	27.94	24.72	18.32	9%
New Hampshire	70.47	60.43	44.31	44.06	-37%
New Jersey	62.05	56.92	55.26	40.47	-11%
New Mexico	43.03	51.28	45.62	20.18	6%
New York	74.86	81.44	63.14	33.19	-16%
North Carolina	25.79	37.75	34.80	22.31	35%
North Dakota	114.88	41.37	60.78	78.92	-47%
Ohio	43.79	41.70	46.99	28.69	7%
Oklahoma	53.88	55.68	29.88	27.38	-45%
Oregon	56.98	63.04	47.80	35.51	-16%
Pennsylvania	71.44	61.25	55.40	42.52	-22%

State/Year	Inpatient and 24-Hour Residential Treatment Patients per 100,000 State Population (on April 30th)				2010 to 2018
	2010	2014	2018	2020	% Change
Rhode Island	77.72	81.15	70.18	66.12	-10%
South Carolina	34.40	41.67	36.60	20.20	6%
South Dakota	126.38	75.09	61.32	46.82	-51%
Tennessee	36.19	52.42	51.37	29.23	42%
Texas	31.93	31.46	32.86	20.04	3%
Utah	70.44	57.60	59.98	74.16	-15%
Vermont	125.74	111.66	79.67	215.29	-37%
Virginia	53.30	41.50	53.69	35.36	1%
Washington	65.46	44.45	39.85	37.56	-39%
West Virginia	76.58	63.71	80.57	65.95	5%
Wisconsin	36.86	44.90	38.58	39.83	5%
Wyoming	111.06	79.69	80.66	136.18	-27%
Puerto Rico	50.64	76.95	33.14	12.29	-35%
Jurisdictions					
US Total	**51.81**	**53.58**	**57.43**	**36.84**	**11%**
Median	**60.43**	**56.06**	**55.33**	**38**	**-10%**
Minimum	**22.70**	**25.96**	**24.72**	**12**	**-51%**
Maximum	**126.38**	**164.06**	**140.09**	**215**	**322%**
States	**52**	**52**	**52**	**52**	**52**

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.
**2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.*

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