



State Profile Highlights

New Information from the National Association of State Mental Health Program Directors Research Institute, Inc (NRI)

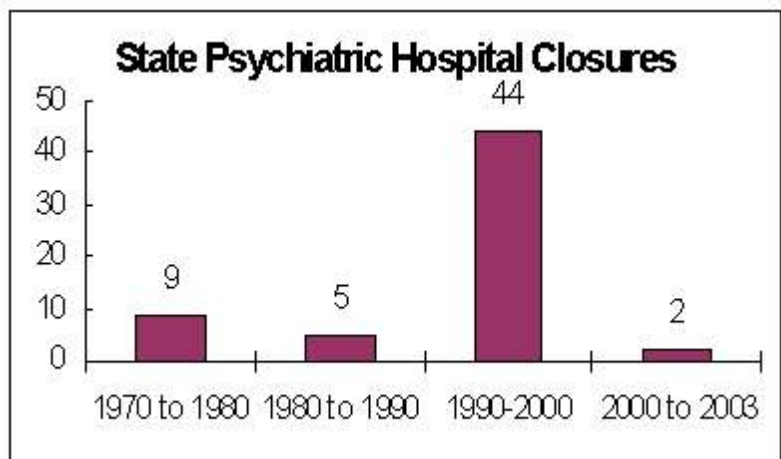
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Closing and Reorganizing State Psychiatric Hospitals: 2003

MAJOR FINDINGS

- ◆ Hospital closings continue, but at a slower pace than in 1990s.
- ◆ Half the states (28) are planning to close hospital beds in the next two years.
- ◆ Half the states (27) are reorganizing their state psychiatric hospitals.
- ◆ Half the states (24) have shortages in psychiatric beds as a result of hospital downsizing.
- ◆ The shift in spending away from hospitals to community programs continues.

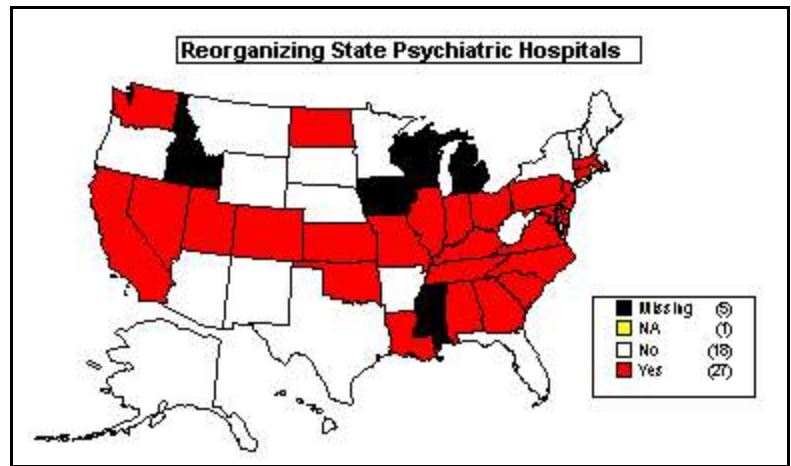
State Psychiatric Hospital Closings: The closure of state psychiatric hospitals and hospital beds continues. From 1972 to 1990, according to data from the Center for Mental Health Services (CMHS), state and county psychiatric beds decreased over 70 percent (from 361,765 to 98,647). During this time, 14 of 277 state psychiatric hospitals closed. In the 1990s, 44 hospitals were closed as the number of hospital residents decreased to about 54,000 (a further decline of over 40%). Since 2000, only two states have closed hospitals (one each in Florida and Illinois). Five states (IL, MA, MD, NC, SC) plan on closing hospitals over the next two years. States continue to close psychiatric hospital beds. In the last five years, 28 states reported closing beds. There are 13 States planning to close from 1000 to 1300 beds over the next two years (AL, CO, CT, DC, DE, IN, MA, MN, NE, PA, TN, VA). Only Indiana plans to increase the size of one or more of its hospitals. State budgets are tighter now than at any time since the 1940s, yet few hospitals have been closed and few closings are planned, though the number of beds continues to shrink. A great realignment in state mental health care occurred in the 1990s, from hospital to community-based care.



Privatization of State Mental Health Agency Operated Services: In the last two years, the privatization in state mental health agencies occurred in only a few states. Illinois and Oklahoma privatized state psychiatric hospitals. South Carolina partially privatized a state psychiatric hospital. Connecticut and Georgia have privatized some state operated community mental health programs.

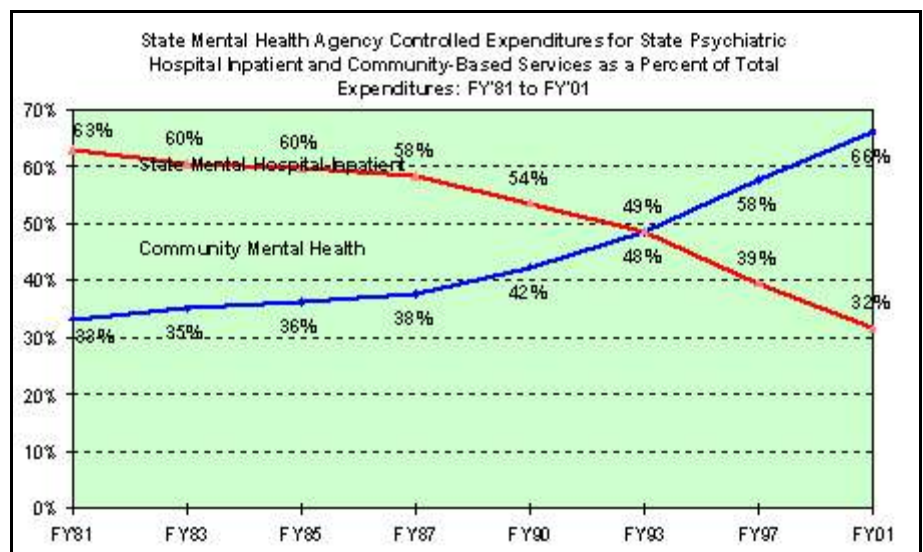
Hospital - Community Linkage: In Most states (41) community-based programs perform a gate keeping function over entry to state psychiatric hospitals via a single portal of entry, screening, or other procedure or mechanism. Six states (AZ, IL, KY, PA, RI, WY) have portable benefits that follow a client from a state hospital (Rhode Island does not have a state psychiatric hospital) to the community.

Reorganization of state hospitals: Half the states (AL, CA, CO, CT, DC, DE, GA, IL, IN, KS, KY, LA, MA, MD, MO, NC, ND, NJ, NV, OH, OK, PA, SC, TN, UT, VA, WA) are reorganizing their state hospitals, including downsizing, reconfiguring, closing and/or consolidation. These reorganizations affect 84 hospitals, including 58 affected by downsizing or closures. Six states (AL, GA, KS, MA, MD, NC) are consolidating two or more hospitals into one facility. Six states (IL, LA, MD, MO, SC, UT) are significantly reorganizing within hospitals. A third of states (CO, DC, DE, IL, IN, LA, MA, MD, NC, NJ, NV, OK, PA, SC, TN, UT, VA, WA) are downsizing hospitals. Four states (ND, NJ, SC, VA) are reconfiguring their state hospital system.



Psychiatric Inpatient Bed Shortages: SMHAs have not been alone in closing psychiatric beds. Over the last five years, 23 (of 38) states have experienced declines in the number of general hospital specialty unit psychiatric beds and 26 states have experienced a decline in the number of private psychiatric hospital beds. The impact of all these closings, is that over half (22 of 41) of the states are experiencing a shortage in psychiatric beds as a result of the reduction of inpatient beds. The impact of these bed shortages, is increased waiting lists for state hospital beds in 14 states, increased waits for other psychiatric beds in 12 states, overcrowding in state hospitals in 11 states, and increased resistance to closing additional state hospital beds in seven states.

Finance: The major shift of state mental health agency (SMHA) controlled expenditures from hospital to community-based services continues. In 1981, 63% of SMHA funding was for hospitals, or \$4.1 billion, and 33% for community-based programs or \$2 billion. In 2001, 32% of funding was for hospitals, or \$7.4 billion and 68% was for community-based programs, or \$15.4 billion. This shift has occurred despite relatively flat growth in inflation adjusted SMHA expenditures. Adjusted for inflation, hospital spending decreased 3.9% from FY'97 to FY'01.



The SMHA Profile Highlights are based on information from 46 SMHAs. The SMHA Profiles data are available via the Internet at www.nri-inc.org. For further information, please contact Robert Shaw (ext.124) or Ted Luterman (ext. 121) on (703) 739-9333 or via e-mail at robert.shaw@nri-inc.org or ted.luterman@nri-inc.org

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