
The National Reporting Program for Mental Health Statistics: History and Findings

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A videotape, "Making the Numbers Work for You," has been produced by the Survey and Reports Branch to accompany this paper. Single copies of the 25-minute tape are available from the senior author.

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Synopsis.....

The National Reporting Program for Mental Health Statistics had its origins in the decennial U.S. census, with enumeration of the "insane and idiotic" in 1840. A series of special censuses of the insane and feeble-minded in public and private hospitals and other institutions began in 1904, and

annual censuses of patients in mental institutions were conducted from 1926 to 1946.

The National Institute of Mental Health of the Public Health Service took over responsibility for the annual census of patients in mental institutions in 1947. Coverage and content remained the same until the mid-1960s, when only State and county mental hospitals were included in the census. Because the annual census could not provide the data needed, separate programs were begun for inpatient and outpatient service. These were integrated into the National Reporting Program in 1966.

Trend data for the last 40 years describe how the specialty mental health sector has developed. Non-Federal general hospitals with separate psychiatric services increased dramatically, from 81 in 1940 to 1,531 in 1982, as did community mental health centers, from 125 in 1965 to 691 in 1980. There was generally less emphasis on inpatient care and more on outpatient care. Full-time equivalent staff in specialty mental health facilities increased from about 325,000 in 1970 to about 432,000 in 1982. Expenditures by facilities also increased dramatically.

THE NATIONAL REPORTING PROGRAM for Mental Health Statistics is an extension of research undertaken in 1840 under the direction of the Superintendent of the Census (the U.S. Bureau of the Census after 1902). The National Institute of Mental Health (NIMH) has operated the program since 1947.

Two keystones of the program are noteworthy. First, it is based on collaboration between NIMH and the States; ad hoc committees ensure regular and continued consultation. Second, the program is based on voluntary reporting of data, without Federal funding to States or local programs to support data collection. The National Reporting Program is the only major human services data collection program that has functioned in a voluntary, collaborative manner over a long period.

History of National Reporting Program

U.S. census. The first attempt to measure the extent of mental illness and mental retardation in

the United States was in the U.S. census of 1840 (see chronology) (1). This attempt came 10 years after the first enumeration of persons with physical disabilities, deafness, and blindness in a U.S. census. In 1840, the category "insane and idiotic" was added, and persons so enumerated were divided into those under "private care" (at home) or "public charge" (in hospitals or almshouses). Although these early counts undoubtedly suffered from unreliability, 1840 is a significant historical beginning for mental health statistics in the United States. In the censuses conducted in 1850, 1860, and 1870, the insane and the idiotic continued to be treated as a distinct category and tabulated separately.

By 1880, the mental health professional community realized that the census procedures had not produced adequate enumerations of the insane and idiotic. In the 1880 census, an attempt was made to begin to limit the concept of insanity by defining it more precisely. A review of existing diagnostic classifications used by physicians found

that no single classification seemed entirely acceptable. As a result, the Superintendent of the Census, in consultation with members of the New England Psychological Association and other experts, developed for the 1880 census a diagnostic classification encompassing seven distinct forms of insanity (mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy).

Similarly, for the 1890 census, a special census of the "insane, feeble-minded, deaf and dumb, and blind" was carried out in virtually the same way as in the 1880 census. No enumeration of special classes was conducted in conjunction with the census of 1900.

In 1902, an act of Congress established the U.S. Bureau of the Census and prohibited any further general census of special classes, limiting future surveys to patients in institutions. The special census in 1904 limited data collection to the insane and feeble-minded in public and private hospitals and other institutions, and it dropped diagnostic categories. However, data were collected on the geographic distribution and demographic characteristics of patients (age, sex, race, nationality), as well as patient movement in and out of hospitals and maintenance expenditures for institutions.

The 1910 special census of the insane and feeble-minded in institutions was modeled on the 1904 census, and similar data on patients in institutions were collected. Unlike the 1904 census, which collected no data on diagnosis, an attempt was made in 1910 to secure separate data on alcoholism, psychoses, and general paralysis. The next census of patients in mental institutions, taken in 1923, was similar to that of 1910.

Annual collection of data from mental institutions began in 1926. In these annual censuses of patients in mental institutions, which were conducted by the U.S. Bureau of the Census from 1926 to 1946, data similar to those in the 1910 census were collected. In the 1923 census, as well as in those conducted in 1933 and 1939-46, diagnosis was again included to describe the patients in mental institutions. This step resulted from the joint efforts of the National Committee for Mental Hygiene and the American Psychiatric Association to bring about the adoption and introduction of a standard classification of mental diseases to most State mental hospitals in the country. This new classification was also adopted by the Surgeon General of the Army and used in all Army camps and hospitals. Eventually it was adopted by the Public Health Service and the U.S. Bureau of the Census and almost all private and

1840 U.S. decennial census measures extent of mental illness and mental retardation by enumerating the "insane and idiotic." Later censuses will attempt to define mental illness more precisely.

1902 Congress establishes U.S. Bureau of the Census and prohibits further general censuses of special classes. Special censuses of patients in mental institutions are conducted in 1904, 1910, and 1923.

1926-46 Annual censuses of patients in State mental institutions are conducted, and other mental hospitals are included beginning in 1931. Diagnosis is used as a variable to describe patients because of efforts to standardize classification of mental illness.

1946 The National Mental Health Act mandates creation of the National Institute of Mental Health and make it responsible for conducting institutional censuses.

1947 NIMH conducts its first annual census of patients in public and private mental hospitals and in psychiatric wards. Consolidated data are reported by age, sex, and diagnosis. After 1966, only State and county mental hospitals are included in the census.

1951 The Model Reporting Area Program for Mental Hospital Statistics (MRAP) is organized to provide the data needed to analyze inpatient services of State and county mental hospitals and to develop standards for statistical reporting and analysis. MRAP membership grows as more States meet statistical criteria.

1954 Nationwide reporting program for outpatient psychiatric clinics begins. Data are collected on geographic distribution of clinics, staffing, patients, and services.

1961 An outpatient advisory committee is formed to advise NIMH on the reporting program for psychiatric clinics.

(Continued on next page)

1966 MRAP and the outpatient advisory committee merge, becoming the National Reporting Program for Mental Health Statistics. Comprehensive approach collects inpatient data from mental hospitals and outpatient data from clinics, community mental health centers, and other community mental health facilities.

1969 NIMH begins sample surveys of admissions and discharges from State and county mental hospitals and outpatient psychiatric services. Coverage of other facilities expands in ensuing surveys.

public mental hospitals.

From 1926 to 1930, the annual census was taken only of patients in State mental hospitals; beginning in 1931, the census also covered county, city, Veterans Administration (VA), and private mental hospitals. Psychiatric wards of general hospitals were included in the 1933 census and again in 1939, after which time they were included annually.

National Mental Health Act. The year 1946 was the last in which the annual census of patients in mental institutions was conducted by the U.S. Bureau of the Census. The Public Health Service of the Federal Security Agency was given responsibility for administration of the National Mental Health Act, which went into effect in 1946, and for creation of the NIMH. Formally established in 1949, the NIMH was an expansion of the Mental Hygiene Division of the Public Health Service, which had been delegated responsibility for institutional censuses in the 1946 act.

The 1947 census of patients in mental institutions was the first to be conducted by what became the Biometry Branch of NIMH in 1949. The census covered patients in State, county, city, and private hospitals for mental disease and mentally ill patients in psychiatric wards of general hospitals, VA hospitals, and other Federal hospitals. Beginning in 1947, participating hospitals and institutions reported data in the form of consolidated reports rather than individual records for each patient. For example, all admissions during the year were cross-classified by age, sex, and diagnosis and reported by facilities in consolidated tables.

Between 1947 and 1966, the coverage and content of the census remained essentially the same.

However, the data were analyzed extensively by Dr. Morton Kramer and Dr. Earl Pollack of NIMH, who contributed significantly to the epidemiology of psychiatric disorders through their reports. Subsequently, Dr. Kramer used this knowledge in the NIMH-supported Epidemiological Catchment Area Project in Baltimore, and Dr. Pollack helped develop the field of cancer epidemiology at the National Cancer Institute.

After the mid-1960s, only State and county mental hospitals were included in the annual census, which has been continued to the present. Trend data from this census on the number of resident patients in State and county mental hospitals are frequently used as a barometer of deinstitutionalization of patients.

Model Reporting Area Program. Soon after NIMH assumed responsibility for the annual census of patients in mental institutions, it was recognized that the annual census alone could not provide the range of basic data required to analyze the facilities providing inpatient mental health services. To address these shortcomings, NIMH proceeded to develop the Model Reporting Area Program (MRAP) for Mental Hospital Statistics under the direction of Dr. Kramer. In February 1951, NIMH invited the mental health administrators and statisticians of 11 States and the VA to a conference that organized the model program.

The goals of MRAP were to develop a strong statistical bureau in each State's mental hospital system, to develop and use standardized data categories for mental hospital patient movement, and to produce a standard set of basic tabulations useful to every State mental hospital system. Membership in MRAP was accorded to States able to meet these criteria. In the ensuing years, MRAP continued to grow, and by the mid-1960s there were 34 member States. In the annual conferences on mental hospital statistics sponsored by NIMH, beginning in 1954, the problems directly connected with the preparation and interpretation of model reporting area statistics continued to receive primary consideration. From 1954 to the present, these conferences have been the primary means for sharing statistical information among States and between NIMH and the States. Conceptually, the MRAP had historical antecedents in the vital records registration areas for births, deaths, marriages, and divorces initiated before World War I.

Outpatient reporting. A nationwide reporting program for statistics on outpatient psychiatric clinics

was begun by NIMH, under direction of Dr. Kramer, in cooperation with State mental health agencies in July 1954. The goals were to obtain basic information on the geographic distribution of outpatient psychiatric clinics, the number and kinds of professional staff, the number and characteristics of persons served, the amount and type of service received by patients, and the community-oriented services provided.

In 1961, an outpatient advisory committee was formed to review and advise NIMH on the nationwide reporting program for outpatient psychiatric clinics. Membership was drawn from different geographic areas, professions, and levels of clinic operation. A regular exchange of observers occurred at MRAP and outpatient advisory committee meetings to bring about better integration of the separate statistical reporting programs for inpatient and outpatient psychiatric services.

National Reporting Program. Better integration was realized in 1966 when NIMH developed an integrated, comprehensive approach to statistics that included data not only from mental hospitals, but also from outpatient clinics, community mental health centers (CMHCs), and other community-based mental health facilities. In that year, the separate activities of MRAP and the outpatient advisory committee were merged into the National Reporting Program. The annual conference, identified subsequently as the National Conference on Mental Health Statistics, included representatives dealing with both hospital and community mental health statistics from all 50 States. The goals and objectives of the National Reporting Program continued those developed through MRAP: to foster the achievement of standards for statistical reporting and analysis and to continue to work with State agencies in developing uniform definitions, comparable tabulations, and special studies of interest to both NIMH and the States. Between 1967 and 1980, the program's development was primarily the result of the work of Dr. Carl Taube of NIMH, who extensively revised data collection procedures.

Inventory of Mental Health Facilities. In view of the consolidation and expansion of the mental health facility reporting system, a survey form was designed by NIMH and the States to cover a broad range of facilities. These included federally funded CMHCs; State, county, and private mental hospitals; general hospital psychiatric services; residential treatment centers for emotionally disturbed chil-

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dren; outpatient psychiatric clinics; mental health day-night facilities; and other multiservice mental health organizations.

The initial survey using this new form, the Inventory of Mental Health Facilities, was conducted in January 1968 under Dr. Taube's direction. On the basis of the results, NIMH determined that the form's design did not produce data that adequately described the operation of general hospital psychiatric services and federally funded CMHCs. This led to the development and use of separate inventory forms for these two types of facilities by Dr. Taube in the January 1969 inventory.

NIMH originally intended to conduct these inventories annually. However, except for the inventories of the CMHCs and State and county mental hospitals, which continued on an annual basis, the inventories of all other types of mental health facilities were conducted every 2 years, beginning in January 1970.

Sample patient surveys. With the broad implementation of sample survey methodology in the late 1960s, NIMH and State mental health agencies initiated sample surveys under the direction of Dr. Taube of admissions to State and county mental hospitals and outpatient psychiatric services in October 1969. For these surveys, data on such variables as age, sex, race, marital status, education, prior psychiatric care, type of services received, and referral on discharge were requested on a sample of admissions from a national sample of facilities for 1 month in the year. Sample figures were inflated to represent all admissions to State and county mental hospitals and outpatient psychiatric services during 1 year.

In ensuing years, the sample survey program was expanded to include private psychiatric hospitals, general hospital psychiatric services, and VA medi-

Distribution of mental health organizations, United States, selected years, 1970-82¹

Type of organization	1970		1976		1980		1982	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All organizations	3,005	100.0	3,480	100.0	3,727	100.0	4,302	100.0
State and county mental hospitals	310	10.3	303	8.7	280	7.5	277	6.4
Private psychiatric hospitals	150	5.0	182	5.2	184	4.9	211	4.9
Non-Federal general hospitals with separate psychiatric services	797	26.5	870	25.0	923	24.8	1,531	35.7
VA psychiatric services ²	115	3.8	126	3.6	136	3.6	129	3.0
Federally funded community mental health centers	196	6.5	517	14.9	691	18.5
Residential treatment centers for emotionally disturbed children	261	8.7	331	9.5	368	9.9	339	7.9
Freestanding psychiatric outpatient clinics	1,109	36.9	1,076	30.9	1,053	28.3	1,473	34.2
Other organizations ³	67	2.3	75	2.2	92	2.5	342	7.9

¹ For the most recent years shown (1981-82), some organizations were reclassified as a result of changes in reporting procedures, and data for some types of organizations and programs were not available. For 1979-80, comparable data were not available for certain organization types, and data for either an earlier or later period were substituted. These factors influence the comparability of 1979-80 and 1981-82 data and those from earlier years.

² Includes VA neuropsychiatric hospitals, VA general hospital psychiatric

services, and VA psychiatric outpatient clinics.

³ Includes freestanding psychiatric day-night organizations and multiservice mental health organizations with inpatient services that are not elsewhere classified.

SOURCE: Adapted from "Mental Health, United States, 1985" (2), for facility data collected by the Survey and Reports Branch, Division of Biometry and Applied Sciences, National Institute of Mental Health.

cal centers. Generally, for any specific type of facility, the sample surveys were conducted approximately every 5 years. Six such surveys have been conducted in State and county mental hospitals; three in private psychiatric hospitals; three in outpatient psychiatric services; three in general hospital psychiatric services, and one in VA medical centers.

Findings

Data collected by the National Reporting Program over the years can be used to describe the development, growth, and evolution of mental health services in the United States.

Facilities. Some noteworthy changes have taken place in the mix of facilities constituting the nation's specialty mental health service delivery system. In 1940, there were 223 State and county mental hospitals in operation in the United States. By 1970, this number had increased to 310. As a result of the recent deinstitutionalization movement and the closure of facilities, the number of State and county mental hospitals in operation during 1982 had decreased to 277 facilities.

Since 1940, a dramatic rise has also occurred in the number of general hospitals with separate psychiatric services. In 1940, there were 81 non-Federal general hospitals with psychiatric units; in the ensuing years this number increased steadily. By 1982, there were 1,531 non-Federal general hospitals with separate psychiatric services, as well

as 129 VA medical centers with separate psychiatric services. The dramatic increase in general hospital psychiatric units was stimulated by the 1965 passage of Titles 18 and 19 (Medicare and Medicaid) of the Social Security Act, as well as by increased coverage of mental health care by private insurance. Inpatient care in a local general hospital is now an alternative place for treatment for many patients who could not previously have afforded community-based treatment.

Subsequent to passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act (Public Law 88-164) by Congress in 1963, the number of federally funded CMHCs grew steadily through 1980. The act authorized NIMH to make long-term construction grants, as well as short-term services development grants, to initiate local CMHCs. In 1965, 125 federally funded CMHCs were in operation. By 1970, this number had increased to 196, and, by 1980, to 691. These centers offer community-based services through an integrated program of inpatient and outpatient care, and frequently they serve the less advantaged and minority members of the community.

Between 1970 and 1982, the total number of facilities offering mental health services rose from 3,005 to 4,302, an increase of 43 percent (see table) (2), while State and county mental hospitals decreased from 310 to 277 facilities. Freestanding psychiatric outpatient clinics increased from 1,109 to 1,473 facilities, partially as a result of reclassification of CMHCs in 1981. Between 1970 and

1980, CMHCs increased more than any other type of mental health organization, with a net gain of 495 organizations. They accounted for 19 percent of all specialty mental health facilities in January 1980, compared with 7 percent in January 1970. Other types of facilities that increased during this period included non-Federal general hospitals with psychiatric services, residential treatment centers for emotionally disturbed children, private psychiatric hospitals, and VA psychiatric services.

Patients. Another important indicator of the development of mental health services is how they are used. A considerable increase occurred in the number of admissions to mental health facilities between 1940 and 1980, mostly during the past 20 years of that period. These data also underscore a changing orientation of the nation's specialty mental health service delivery system from inpatient to outpatient services. Freestanding psychiatric outpatient clinics and outpatient units of federally funded CMHCs were the major recipients of the increased number of new patients.

The changes described previously are reflected in the patient rolls of State and county mental hospitals. In 1940, there were approximately 420,000 resident inpatients in State and county mental hospitals; by 1955, this number increased to approximately 559,000 resident inpatients. Since then, the number of resident inpatients in State and county mental hospitals has decreased steadily to a low of approximately 114,000 in 1984.

Between 1969 and 1981, the number of inpatient additions (first admissions, readmissions, and returns from long-term leave) to all types of mental health facilities increased from about 1.3 million to 1.5 million (approximately 15 percent). In the early part of the decade, a consistent increase was observed, but then the number of inpatient additions leveled off. The pattern for State and county mental hospitals, which ran counter to the overall trends, appears to explain the leveling off of inpatient additions in the latter part of the decade. An indication of how the number of inpatient care episodes (that is, the sum of patients on rolls plus additions) decreased in State and county mental hospitals, relative to other mental health facilities, is illustrated by the fact that 45 percent of all inpatient episodes were in State and county mental hospitals in 1969, compared with only 30 percent in 1979.

Although the number of inpatient additions increased between 1969 and 1981, the number of inpatient days decreased from about 168.9 million

to approximately 77.1 million. This decline suggests that the average length of stay for inpatients decreased during this period.

In contrast, the number of outpatient additions more than doubled for all facilities between 1969 and 1981; the total number of outpatient additions increased from approximately 1.1 million to about 2.5 million. The major impetus behind this change was the substantial increase of outpatient additions to federally funded CMHCs, which rose from approximately 177,000 to more than 1.2 million between 1969 and 1979—approximately 592 percent. At the end of the decade, federally funded CMHCs accounted for 47 percent of all outpatient additions, compared with 15 percent at the beginning of the decade. Sharp increases were also evident for VA psychiatric services. In contrast, outpatient additions to State and county mental hospitals decreased sharply between 1969 and 1981.

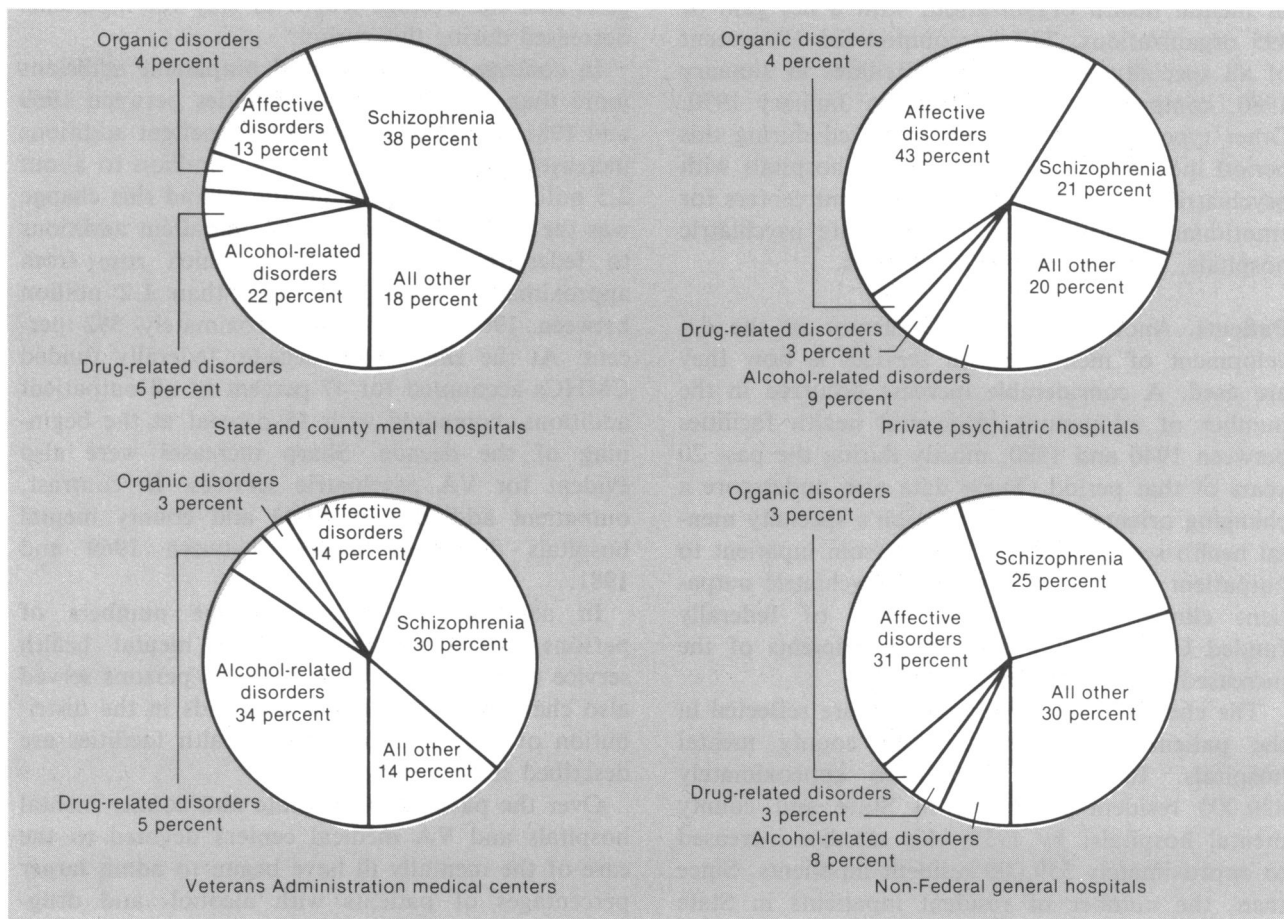
In addition to changes in the numbers of persons served by the specialty mental health service delivery system, the types of persons served also changed. Some long-term trends in the distribution of diagnoses in mental health facilities are described subsequently.

Over the past 40 years, State and county mental hospitals and VA medical centers devoted to the care of the mentally ill have begun to admit larger percentages of patients with alcohol- and drug-related mental illnesses, while private psychiatric hospitals and non-Federal and VA general hospitals with psychiatric units are admitting smaller percentages. These changes appear to be due to the development of special alcohol and drug facilities that absorb patients from general and private hospitals, but not from State and county mental hospitals and VA medical centers for the mentally ill.

Other trends between 1940 and 1980 also show shifts in the patterns of care. All hospital types admitted smaller percentages of patients with organic brain syndromes, apparently as a result of the increased use of nursing homes by such clients. Patients with affective disorders, primarily depressive disorders, were admitted in larger percentages to general hospital psychiatric units and private psychiatric hospitals. These trends appear to have been due to the improved ability to treat such disorders on a short-term basis.

All hospital types also admitted larger percentages of persons with a diagnosis of schizophrenia. This trend was apparently due to the movement of clients with organic brain syndromes out of the

Percent distribution of admissions, by selected primary diagnosis and type of inpatient psychiatric service, United States, 1980



SOURCE: Adapted from Mental Health, United States, 1985 (2), for patient survey data collected by the Survey and Reports Branch, Division of Biometry and Applied Sciences, National Institute of Mental Health.

specialty mental health service delivery system.

Although long-term trends are not available for outpatient psychiatric clinics and federally funded CMHCs, analyses of the distribution of recent admissions to these facilities are informative. About one-quarter of all admissions to outpatient psychiatric services and federally funded CMHCs were children and youth in contrast to inpatient psychiatric services where they represented less than 10 percent of admissions. This pattern is probably due to the many former child guidance clinics that were transformed into CMHCs between 1965 and 1980.

In 1975, schizophrenia and depressive disorders accounted for more than half of all inpatient admissions, compared with only one-quarter of all admissions to outpatient clinics and federally funded CMHCs. For inpatient psychiatric services, this pattern did not change appreciably by 1980 (see chart). About one-quarter of all admissions for outpatient psychiatric services and to federally

funded CMHCs were persons who had transient reactions or social maladjustments, compared with less than 5 percent of admissions for inpatient psychiatric services.

Staffing. Staffing patterns also changed within specialty mental health facilities. The total full-time equivalent staff in specialty mental health facilities increased from about 325,000 to about 432,000 persons between 1970 and 1982. Of this number, patient care staff increased from about 218,000 to about 299,000.

Between 1970 and 1982, the four core-service disciplines grew dramatically. The number of psychiatrists increased from approximately 10,100 to 15,300, psychologists from 6,700 to 18,000, social workers from 13,700 to 30,900, and psychiatric nurses from 25,800 to approximately 49,300. It should be noted that these numbers only include staff within organized specialty mental health facilities.

Expenditures. Aggregate facility expenditures also showed considerable change. In 1940, State and county mental hospitals expended approximately \$127 million. By 1960, this sum had increased to approximately \$1 billion and, by 1979, to approximately \$3.8 billion. When these figures are adjusted for inflation, the increase is less striking. If 1967 is used as the base year, expenditures for State and county mental hospitals in 1940 were equivalent to approximately \$345 million and in 1979 were equivalent to approximately \$1.6 billion. The year 1967 was used for adjustment because it is the current baseline for the Consumer Price Index.

Between 1969 and 1981, a period of historically high inflation, expenditures made by mental health organizations to provide services and administer programs increased substantially. Total expenditures in current dollars for all facilities rose from approximately \$3.3 billion to approximately \$11.5 billion, an increase of about 250 percent. Between 1969 and 1979, the per capita expenditures in current dollars increased from \$16.53 to \$39.61 (approximately 140 percent). Much of the increase in expenditures was due to inflation. As measured in constant dollars with 1969 as the base year, adjusted expenditures in all mental health facilities rose from \$3.3 billion in 1969 to approximately \$4.7 billion in 1981, an increase of about 42 percent. Per capita expenditures in constant dollars rose from \$16.53 to \$19.37 between 1969 and 1979, or about 17 percent. Because revised facility inventories were first conducted in 1969, that year was used for adjustment.

For the different types of facilities measured, the increase in expenditures, expressed in constant dollars, tended to be larger in the first half of the decade and to level off in the second half. Two exceptions were noted. For private psychiatric hospitals and federally funded CMHCs, overall expenditures and per capita expenditures, expressed in constant dollars, were consistently higher through the 1970s. Because of the growth in the number of federally funded CMHCs during this period, expenditures by these programs rose from about \$143 million in 1969 to about \$700 million in 1979, an increase of 388 percent when corrected for inflation. By contrast, for State and county mental hospitals, expenditures in constant dollars, with 1969 as the base year, decreased from about \$1.81 billion to \$1.76 billion between 1969 and 1981. In all likelihood, this pattern is due to the decrease in the size of the resident population in State and county mental hospitals, as well as to

the closing of hospitals. At the end of the period, in 1981, State and county mental hospitals still accounted for approximately 39 percent of all expenditures for organized specialty mental health services, although this figure is considerably smaller than the 55 percent in 1969.

Conclusions

All of the data we present point to continued growth, development, and evolution of mental health services. Such data are useful for examining and understanding national trends. The National Reporting Program's data are also useful to States, local facilities, and university researchers. The data permit comparison of services delivery patterns among different States and among different facility providers. They also allow construction of relevant norms against which providers may compare themselves; patient-staff ratios are a case in point.

Results from the facility inventories and patient surveys carried out in conjunction with the National Reporting Program are made available through a series of publications. A complete list of publications is available from the senior author.

The first type of publication, *Mental Health Statistical Notes*, gives brief presentations of data dealing with specific topics (for example, resident patient trends in State and county mental hospitals), as well as data tabulations and brief summaries of data highlights. The second type of publication, *Mental Health Service System Reports*, presents descriptive data in greater detail for specific types of psychiatric facilities, for a particular group of patients, or for comparisons among different types of psychiatric facilities. Another publication, "Mental Health, United States," begun in 1983, provides summary national and State data on an annual basis.

These publications are prepared by the staff of NIMH's Survey and Reports Branch, and single copies are available from the Public Inquiries Branch, NIMH, Rm. 15C-03, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857.

References.....

1. Redick, R., Manderscheid, R. W., Witkin, M. J., and Rosenstein, M. J.: A history of the National Reporting Program for Mental Health Statistics. *Mental Health Service Systems Reports*, Series HN, No. 3. DHHS Publication No. (ADM) 83-1296. National Institute of Mental Health, Rockville, MD, 1983.
2. Taube, C. A., and Barrett, S.: *Mental health, United States, 1985*. DHHS Publication No. (ADM) 85-1378. National Institute of Mental Health, Rockville, MD, 1985.