

## The changing face of community-based mental health care: Changes in the types of community-based mental health services available from 2014 to 2020

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### Key findings

- The percentage of community-based mental health facilities offering standard treatment services, rehabilitation and support services, and many evidence-based practices has changed little since 2016. Even so, the need for mental health care has increased during the same time period, suggesting that these mental health services have become less available relative to need over the past five years.
- The most commonly offered services, offered by more than two-thirds of facilities in 2020, were standard treatment services (behavior modification, case management, couples or family therapy, individual and group therapy, and psychotropic medication), cognitive behavioral therapy, and family psychoeducation. In addition, more than half of facilities offered dialectical behavioral therapy, integrated treatment for co-occurring disorders, and screening for tobacco use.
- Fewer than a third of facilities offered education, housing, and vocational rehabilitation services; evidence-based practices including assertive community treatment, illness management and recovery, intensive case management, supported employment, and supported housing; psychiatric emergency walk-in services; diet and exercise counseling; mental health treatment programs or groups dedicated to eating disorders; and therapeutic foster care.

In recent years, stakeholders have perceived, and research has suggested, that community-based specialty mental health care has become less available over time.<sup>1,2,3,4</sup> Little is known, however, about how changes over time in the availability of community-based care might vary by the type of services offered. In this brief, we use data from National Mental Health Services Survey (N-MHSS) to document changes from 2014 to 2020 in the availability of various community-based mental health services.

For these analyses, we define community-based mental health services as those offered by specialty mental health facilities that provide treatment in less-than-24-hour outpatient, partial hospitalization, or day treatment settings. N-MHSS excludes jails, prisons, and detention centers that provide treatment exclusively for people who are incarcerated or juvenile detainees. Because we aimed to assess the availability of services for the general

public, we also excluded Veterans Administration medical centers and health care facilities. Our analysis period begins with 2014 because the procedures for identifying facilities for N-MHSS, which began in 2010, did not stabilize until 2014. In all cases, changes over time in the number of facilities offering each type of service (data not shown) mirror the patterns shown for percentages of facilities offering these services.

### Background context: Changes in need for mental health care over time

To provide context for interpreting the results, we examined estimates from the National Survey on Drug Use and Health (NSDUH) of the population with mental health problems from 2014 to 2019, the last years for which NSDUH data are available.<sup>5</sup> We examined changes in the number of adults with any mental illness and serious mental illness in the past year stratified by three age groups: 18 to 25, 26 to 49, and 50 and older. We also examined changes in the number of youth ages 12 to 17 with a major depressive episode in the past year and those with a major depressive episode with severe impairment in the past year, which are the only estimates NSDUH provides regarding mental illness among children.<sup>6</sup>

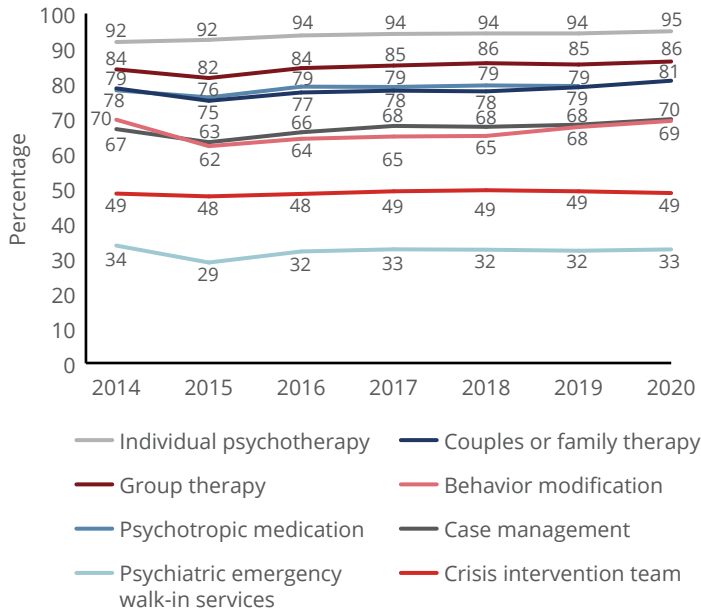
The NSDUH estimates indicate that the need for mental health care increased from 2014 to 2019 among people ages 12 to 49. The changes were most substantial for young adults ages 18 to 25 (increasing by 42 percent for any mental illness and 72 percent for serious mental illness). Changes were also substantial for adults ages 26 to 49 (increasing by 26 percent for any mental illness and 42 percent for serious mental illness) and for youth ages 12 to 17 (increasing by 38 percent for major depressive disorder and 34 percent for major depressive disorder with severe impairment). The number of people age 50 and older with any mental illness or serious mental illness changed little (by 1 percent) during this period.

### Changes in availability of particular types of services over time

To help interpret the results, we grouped the mental health treatment modalities and services N-MHSS asks about into six categories. First, we examined a group of core or standard services for community-based treatment (Figure 1). The percentage of facilities offering each of these types of services has changed little since 2014, which, in combination with the increased need for mental health care over the same time period, suggests a decrease in availability.

The most commonly offered standard services are individual and group therapy, couples or family therapy, and psychotropic medication, each of which was offered by more than 80 percent of facilities. More than two-thirds of facilities offered case management and behavior modification in 2020, and about

**Figure 1. Percentage of facilities offering standard mental health treatment services, by year**



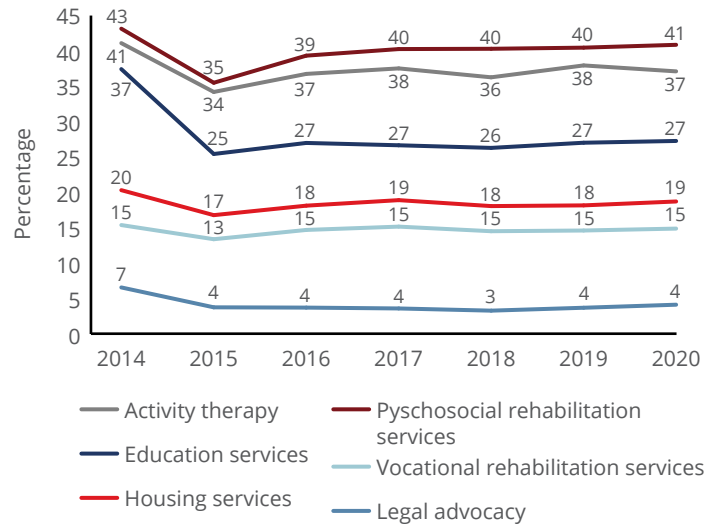
Note: The 2020 National Mental Health Services Survey did not ask whether the facility provides psychotropic medication.

half of facilities offered crisis intervention teams. Fewer facilities (about a third) offered psychiatric emergency walk-in services.

In addition to standard services, mental health facilities serving adults with serious mental illness and children or youth with serious emotional disturbance often offered rehabilitation and support services to help clients develop, recover, or further advance life skills and address a range of life circumstances that might have been affected by their mental health challenges. The percentage of facilities offering rehabilitation and support services decreased from 2014 to 2015, tended to increase from 2015 to 2016, and has changed little since then (Figure 2). Despite the increases from 2015 to 2016, the percentage of facilities offering such services in 2020 remains slightly lower than the percentage of facilities offering such services in 2014. Moreover, the relatively flat level since 2016 suggests a decrease in availability because of the increase in need for mental health care during the same time period.

The most commonly offered rehabilitation and support services were psychosocial rehabilitation services (defined in N-MHSS as addressing skills such as daily and community living skills, self-care, social skills, and basic language skills) and activity therapy (defined as including art, dance, music, recreational and occupational therapies, and psychodrama). In 2020, less than 30 percent of facilities offered education services (through which the facility helped clients find or directly provided services related to basic literacy, general equivalency

**Figure 2. Percentage of facilities offering rehabilitation and support services, by year**



diplomas, college courses, or special education). Less than one in five facilities offered housing or vocational rehabilitation services, and very few offered legal advocacy services.

In addition to general categories of services, facilities might offer specific evidence-based practices that are based on standardized models that have been proven effective for achieving particular outcomes. From 2008 to 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) published the Evidence-Based Practices Knowledge Informing Transformation (EBP KIT) series to provide information and tools to help states and communities implement a number of evidence-based community mental health practices.<sup>7</sup> N-MHSS asks facilities whether they offer seven of these practices.

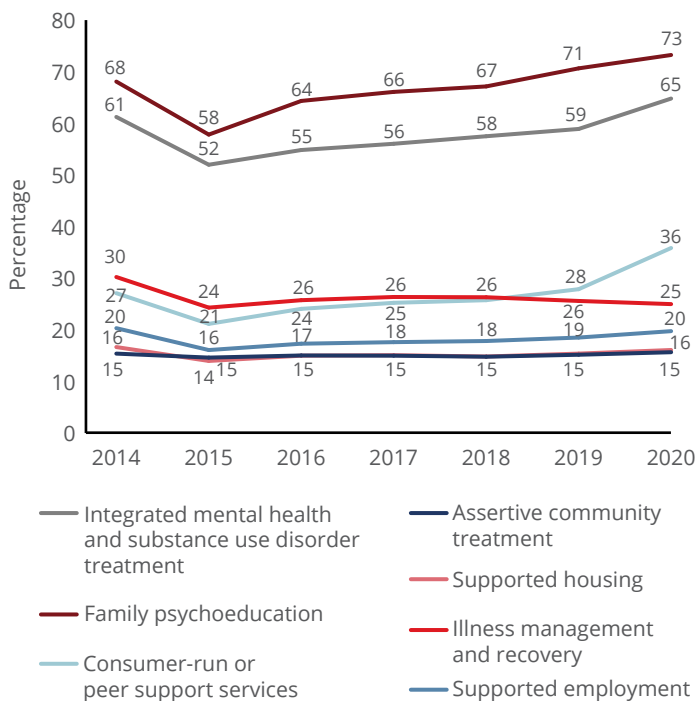
The percentage of facilities offering assertive community treatment and supported housing was consistently low from 2014 to 2020 (Figure 3). The low percentage of facilities offering assertive community treatment is particularly surprising because it was the first evidence-based practice developed during the deinstitutionalization era; it is widely studied and supported by considerable evidence; and SAMHSA has continued to promote and support it in numerous ways since the agency's inception, including in recent years.<sup>8,9,10</sup> The low percentage of facilities offering supported housing is concerning because, in 2019, 6 percent of adults served by state mental health authorities with known living situations were homeless, and an additional 13.1 percent were living in foster homes, residential care or treatment centers, correctional facilities, or other institutional settings.<sup>11</sup> There is no U.S. housing market in which a person living solely on Supplemental Security Income can afford a safe, decent apartment without rental assistance, relegating many people with disabilities, including psychiatric disabilities, into costly congregate or institutional settings or homelessness.<sup>12</sup> Substantial literature, including seven randomized controlled trials, has demonstrated that permanent supportive housing reduces homelessness,

increases housing tenure, and decreases emergency room visits and hospitalization, and consumers consistently rate this model more positively than other housing models.<sup>13</sup> The lack of change in the percentage of facilities offering supported employment from 2014 to 2020 is also surprising given considerable evidence for its effectiveness over the past 25 years and federal promotion and support for it, including in recent years.<sup>14,15,16</sup> The percentage of facilities offering illness management and recovery has also remained low from 2014 to 2020.

The percentage of facilities offering the three most commonly offered SAMHSA-promoted evidence-based practices in 2020 (family psychoeducation, integrated treatment for co-occurring mental health and substance use disorders, and consumer-run or peer support services) increased over time from 2015 to 2020 (Figure 3). The increase in the percentage of facilities providing peer support services likely continues the trend among mental health programs since 2007 when the Center for Medicaid and State Operations released guidance to states on funding peer support services under the Medicaid program.<sup>17</sup>

We do not know the extent to which facilities that reported providing SAMHSA-promoted evidence-based practices implemented them with fidelity to the evidence-based models described in the EBP KITs. The N-MHSS definitions do not reference the EBP KITs or other implementation manuals, literature on the effectiveness of the models, or the need

**Figure 3. Percentage of facilities offering SAMHSA-promoted evidence-based practices, by year**

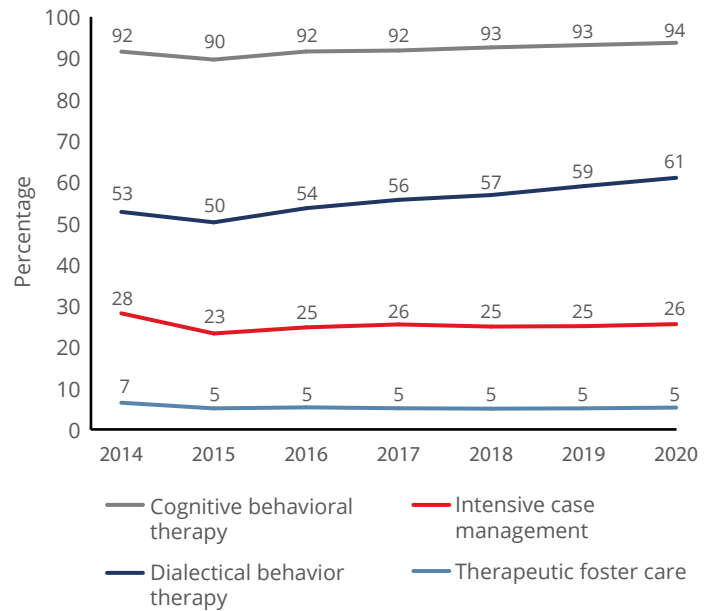


SAMHSA = Substance Abuse and Mental Health Services Administration.

for documentation of fidelity to the evidence-based models. More generic descriptions provided in the N-MHSS definitions packet could influence facilities to say they offer such practices without reference to the evidence-based models.

In addition to the evidence-based practices SAMHSA promotes through the EBP KIT series, N-MHSS asks about four other evidence-based practices. The percentage of facilities offering dialectical behavior therapy increased from 2014 to 2020, and

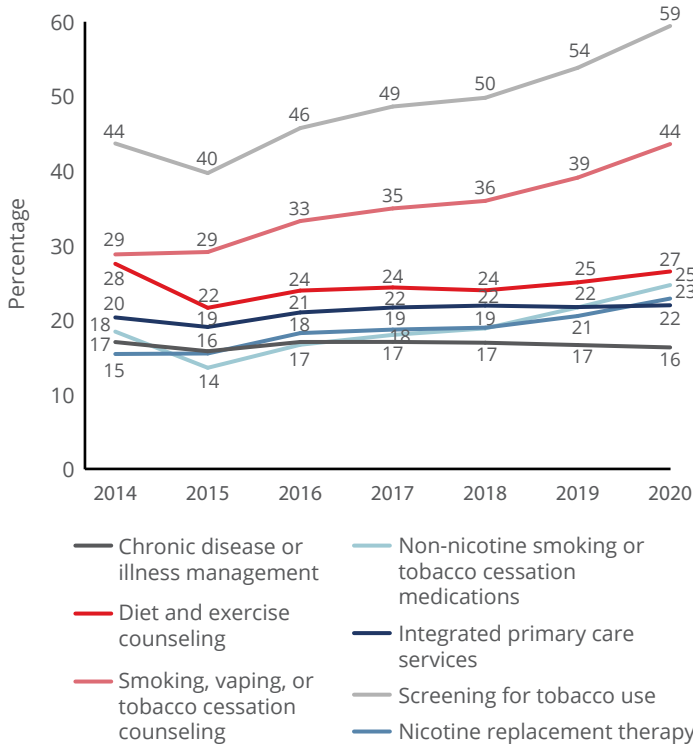
**Figure 4. Percentage of facilities offering other evidence-based practices, by year**



the percentage offering the others changed little (Figure 4). More than 90 percent of facilities reported providing cognitive behavioral therapy, and more than half offered dialectical behavior therapy. Less than a third provided intensive case management, and very few offered therapeutic foster care.

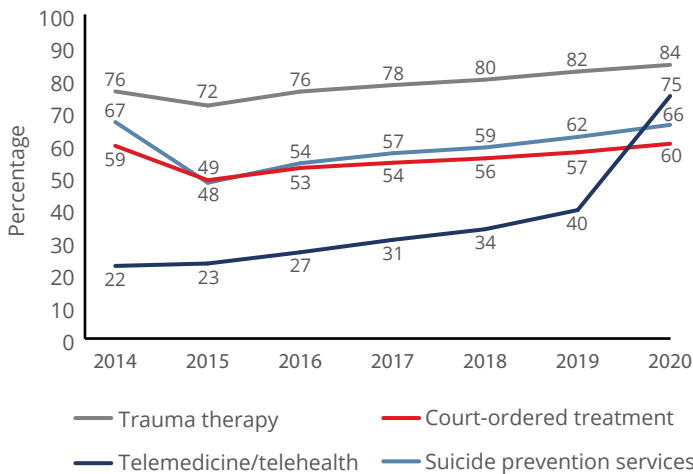
Despite the efforts of SAMHSA and other stakeholders to promote the integration of primary and behavioral health care over the past 10 years, the percentage of mental health treatment facilities offering integrated primary care services has not increased substantially since 2014 (Figure 5).<sup>18,19,20,21</sup> In 2020, less than a quarter of facilities offered such services. Similarly, the percentage of facilities providing chronic disease or illness management and diet and exercise counseling has remained consistently low since 2014. In contrast, the percentage of facilities providing screening for tobacco use; smoking, vaping, or tobacco cessation counseling; non-nicotine smoking or tobacco cessation medications; and nicotine replacement therapy have increased substantially since 2015.

**Figure 5. Percentage of facilities offering integrated physical health and wellness services, by year**



SAMHSA has emphasized smoking cessation in its integrated care grants programs since 2015, reflecting changing cultural norms regarding the acceptability of smoking where others gather, increasing liability risks related to secondhand smoke, and research on the high incidence and negative consequences of smoking.<sup>22</sup>

**Figure 6. Percentage of facilities offering other services SAMHSA promotes, by year**



SAMHSA = Substance Abuse and Mental Health Services Administration.

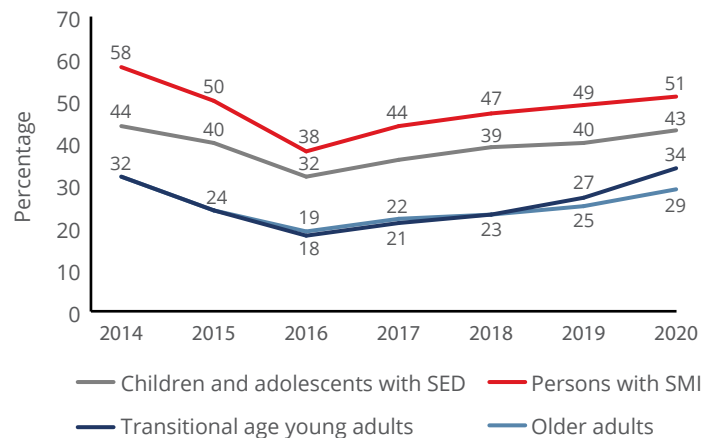
The percentage of facilities providing several other types of services that SAMHSA has promoted has also increased since 2015, including trauma therapy, suicide prevention, court-ordered treatment, and telemedicine (Figure 6).<sup>23</sup> The particularly large increase in the percentage of facilities providing telemedicine or telehealth services from 2019 to 2020 might have resulted from necessity, because the COVID-19 pandemic made providing in-person services physically risky starting in spring 2020, and emergency orders encouraged expansion of telehealth options.<sup>24</sup>

**Changes in the availability of specialized programs dedicated to specific populations**

The pattern of availability over time was similar for all mental health treatment programs or groups dedicated or designed exclusively for specific subpopulations (Figures 7 to 9): the percentage of facilities offering specialized programs steadily increased from 2016 to 2020 after steadily decreasing from 2014 to 2016. As a result, the percentage of facilities offering each program type in 2020 was generally comparable with the percentage offering the program type in 2014 or 2015. Although the reason for the inflection point in 2016 is not clear, a change in N-MHSS data collection procedures in 2017 to prefill responses to these items with the previous year's responses might contribute to the steady increase after 2016.

The age group most commonly targeted for specialized mental health treatment programs or groups is persons with serious mental illness, defined from 2016 to 2020 as age 18 and older (Figure 7). This is not surprising because adults age 18 and older comprise the largest percentage of the population. NSDUH estimates that in 2019, more than 13 million adults

**Figure 7. Percentage of facilities offering a mental health treatment program or group dedicated to or designed exclusively for specific age groups, by year**



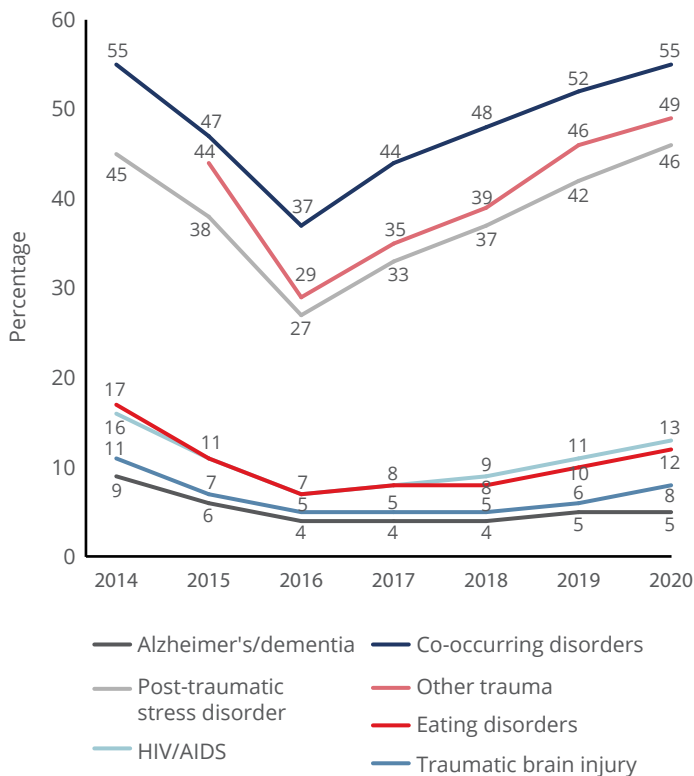
Notes: From 2014 to 2015, the N-MHSS did not define the ages included in any of the groups. From 2016 to 2020, N-MHSS defined "Persons with SMI" as age 18 and older. In 2020, N-MHSS changed the category "Transitional age young adults" to "Young adults."

N-MHSS = National Mental Health Services Survey; SED = serious emotional disturbance, SMI = serious mental illness.

had serious mental illness. The age group for which the second greatest percentage of facilities dedicates a program or group is children and adolescents (assumed to be younger than age 18) with serious emotional disturbance. NSDUH estimates that almost 4 million youth ages 12 to 17 experienced major depressive episodes in 2019, almost 3 million of whom experienced accompanying severe impairment. Although NSDUH estimates that almost 3 million young adults ages 18 to 25 and almost 3.4 million adults age 50 or older experienced serious mental illness in 2019, programs dedicated to or designed for transitional age young adults and older adults are less common.

The change over time in the percentage of facilities offering programs dedicated to or designed for specific diagnostic groups has been most extreme for the three diagnostic groups for which the greatest percentages of facilities have dedicated programs: co-occurring mental health and substance use disorders, post-traumatic stress disorder, and other trauma (Figure 8). Despite increases since 2016, the percentages of facilities offering programs dedicated to or designed for people with HIV/AIDS, eating disorders, traumatic brain injury, and Alzheimer's/dementia in 2020 remain lower than in 2014. Mental health facilities might consider HIV/AIDS, traumatic brain injury, and Alzheimer's/dementia outside their primary responsibilities or the responsibility of other types of health care providers or organizations. The low number of facilities

**Figure 8. Percentage of facilities offering a mental health treatment program or group dedicated to or designed exclusively for specific diagnostic groups, by year**

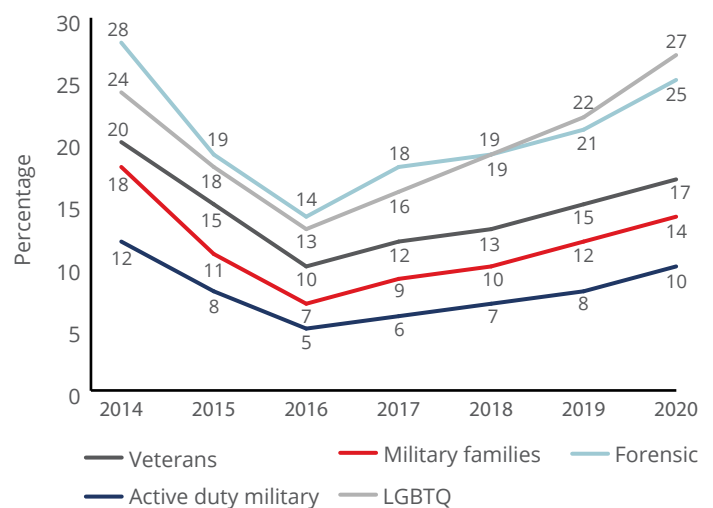


Note: Co-occurring means co-occurring mental illness and substance use disorder.

offering programs dedicated to or designed for people with eating disorders could be attributable to the relatively low lifetime prevalence of these disorders (0.5, 1.0, and 2.8 percent for anorexia nervosa, bulimia nervosa, and binge eating disorder, respectively),<sup>25</sup> which might not support treatment in a group format for many facilities. Future research on the extent to which facilities meet the treatment needs of people with eating disorders is warranted because of the high mortality rates for these disorders.<sup>26</sup>

The highest percentages and most extreme changes over time in percentages of facilities offering programs dedicated to or designed for other specific populations are for LGBTQ clients and for forensic clients (Figure 9). Because N-MHSS excludes jails, prisons, and detention centers that provide treatment exclusively for people who are incarcerated or juvenile detainees, it is notable that up to 25 percent of community-based mental health facilities have enough of a forensic population to warrant programs dedicated to or designed for them. Lower percentages of mental health facilities have programs dedicated to or designed for veterans, active duty military, and military families. Because we excluded Veterans Affairs medical centers and health care facilities from the analysis, general mental health facilities might consider veteran and military populations outside their primary responsibilities or the responsibility of the U.S. Departments of Veterans Affairs or Defense.

**Figure 9. Percentage of facilities offering a mental health treatment program or group dedicated to or designed exclusively for specific subpopulations, by year**



Note: The National Mental Health Services Survey defines forensic as referred from the court or judicial system.

## Discussion

Most facilities offered the expected types of mental health treatment services, including psychotherapy, medication, and case management. The lack of change over time in the percentage of facilities offering these services, paired with the increased need for mental health care over the same time period, indicates decreasing availability. Fewer facilities offered crisis intervention teams and psychiatric emergency walk-in services. In recent years, SAMHSA and other stakeholders have made significant efforts to promote increased availability of crisis services and alternatives to psychiatric hospitalization.<sup>27,28</sup> The two categories included within N-MHSS, crisis intervention teams and psychiatric emergency walk-in services, however, do not reflect the full range of crisis intervention models, so our results could underestimate recent changes in availability of community-based crisis services.

The percentage of facilities offering rehabilitation and support services and many evidence-based practices has not kept pace with the increasing numbers of adults with serious mental illness and children and adolescents with serious emotional disturbance over the past five years. This suggests that people with more severe or persistent mental health challenges might have less access to services that could help them gain or regain lost skills, address life circumstances affected by and affecting their mental health, and achieve their recovery goals. Particularly notable are the low percentages of facilities providing assertive community treatment, supported employment, and supported housing.

The most commonly available mental health treatment programs or groups dedicated to or designed for particular categories of people are those for persons with serious mental illness, children and adolescents with serious emotional disturbance, people with co-occurring mental illness and substance use disorder, and people with a diagnosis of post-traumatic stress disorder or other trauma. Adults with serious mental illness and children with serious emotional disturbance are the core groups targeted by the SAMHSA-administered community mental health services block grants, and the past few decades have brought increasing recognition of the prevalence of and special needs for interventions regarding trauma and co-occurring substance use disorders among these populations.<sup>29,30,31</sup>

Increases over time in the percentage of facilities providing consumer-run or peer support services, court-ordered treatment, integrated treatment for co-occurring mental health and substance use disorders, suicide prevention, telemedicine, tobacco cessation services, and trauma therapy reflect SAMHSA and other federal initiatives in these areas.

## Endnotes

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