Research Data Brief

Changes in the availability of community-based mental health care for various population groups from 2014 to 2020

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Key findings

From 2014 to 2020:

- For every 100,000 people in the United States, there were about three facilities offering community-based mental health care with little variation across years. States and regions varied considerably, however, in the number of these facilities per capita, which decreased in more than half of states.
- Facilities reported a 10 percent increase in White clients and a 3 percent increase in Black clients who received community-based mental health care. Hispanic or Latino clients increased slightly for partial hospitalization/day treatment only and were the only group to decrease slightly in 2020 for outpatient treatment.
- Facilities with community-based mental health care available in languages other than English increased by 21 percent, with greater use of on-call interpreters. Facilities with staff who offered services in languages other than English decreased by about one-fifth for Spanish and about one-third for American Indian and Alaska Native languages.
- More than 90 percent of facilities accepted Medicaid for outpatient treatment, and less than 75 percent accepted Medicare. Facilities accepting private commercial insurance, cash, or self-payment increased somewhat, and facilities accepting Medicaid or Medicare for partial hospitalization or day treatment decreased somewhat.

Despite policy efforts to increase access to mental health care, people with mental health needs continue to face barriers to accessing care.[1] Community-based services, the front line for access to mental health care, are a critical resource for early intervention, ongoing management of mental health conditions, and alternatives to residential or inpatient services. Although studies have examined decreased availability of inpatient mental health services in recent years, not as much is known about trends in community-based mental health services, which are affected by conditions including provider shortages, reimbursement barriers, time-consuming administrative requirements, and limited support for designing new services in rural areas.[2,3,4,5]

Population data from the National Survey on Drug Use and Health (NSDUH) show rising mental health needs, particularly among young adult and adolescent populations, as well as Hispanic or Latino populations.[6,7] Better understanding is needed about how trends in the availability of community-based mental health services align with the changing needs of the population, especially for key subgroups that could be at high risk of mental health conditions or likely to face barriers to accessing mental health care. Furthermore, the COVID-19 public health emergency in 2020 affected the availability and need for mental health services. Anxiety and depression increased in 2020 along with increased mental health service use and unmet mental health need.[8,9]

This brief uses data from the National Mental Health Services Survey (N-MHSS), a census of specialty mental health treatment facilities in the United States. The N-MHSS collects data about facilities annually and gathers additional information from the facilities in even-numbered years about the number of clients served and certain client characteristics. In 2020, the N-MHSS collected data from March to November, the first eight months of the public health emergency, providing a window into mental health services during this period.[10] This brief reports on trends in (1) the number and geographic distribution of facilities that offered outpatient treatment (OT) or partial hospitalization/day treatment (PH/DT) from 2014 to 2020, (2) changes over time in the number and characteristics of clients served by these facilities, (3) support for services in languages other than English, and (4) accepted forms of payment.

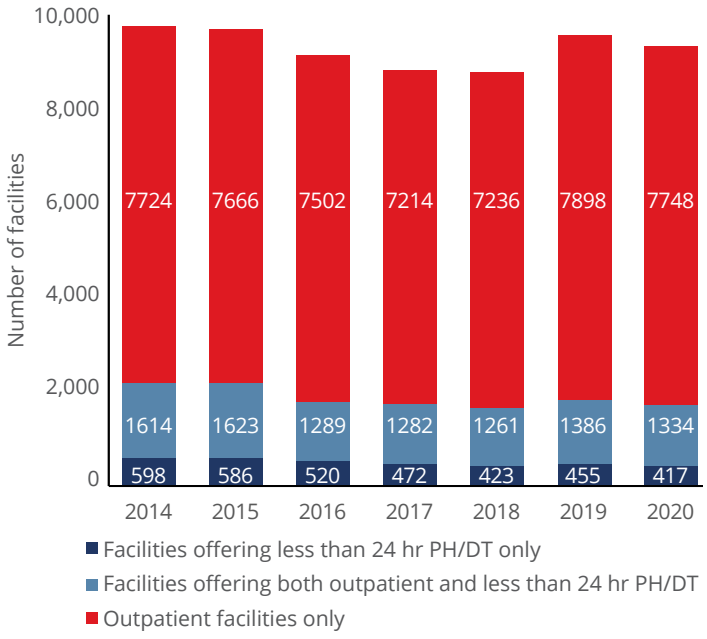
Facilities offering OT and PH/DT

Less-than-24-hour community-based mental health services (hereafter, community-based mental health care) do not involve an overnight stay and include OT and PH/DT. As defined in the N-MHSS, clients generally receive OT for less than three hours a day for a single visit, whereas clients receive PH/DT for more than three hours per day on a regular schedule.[11] OT includes services such as counseling, psychotherapy, and psychiatrist visits and PH/DT addresses higher levels of need, providing less intensive community-based alternatives to residential or inpatient services.

Availability of these services varied from 2014 to 2020. From 2014 to 2018, the number of facilities offering OT or PH/DT declined by 10 percent but increased again by 9 percent in 2019, falling off by 2 percent with the public health emergency in 2020 (Figure 1). Among facilities that offered either OT or PH/DT, nearly all facilities (from 94 percent in 2014 to 96 percent in 2020) offered OT, and about one-fifth offered PH/DT, with PH/

DT decreasing from 22 percent in 2014 to 18 percent in 2020. About 5 percent of facilities only offered PH/DT and did not offer OT. Across the survey years, per 100,000 people nationally, about three facilities offered OT or PH/DT, slightly more than two facilities offered only OT, and less than one facility offered PH/DT or both services with little change over time (Figure 2).[12,13]

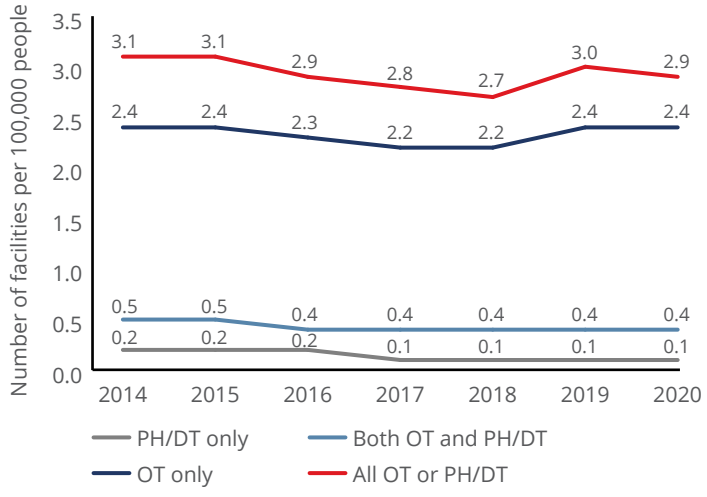
Figure 1. Number of facilities offering OT or PH/DT, 2014 to 2020



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS) (2014 to 2020).

OT = outpatient treatment; PH/DT = partial hospitalization/day treatment.

Figure 2. Number of facilities offering OT or PH/DT per 100,000 people, 2014 to 2020



Sources: Center for Behavioral Health Statistics and Quality, Substance Abuse and MentalHealth Services Administration, National Mental Health Services Survey (N-MHSS) (2014 to 2020); Population Division, U.S. Census Bureau, Annual Estimates of the Resident Population for the United States, Regions, States, and the District of Columbia: April 1, 2010 to July 1, 2020.

Note: The number of facilities per 100,000 people was calculated using the U.S. Census Bureau's annual population estimates for the United States.

OT = outpatient treatment; PH/DT = partial hospitalization/day treatment.

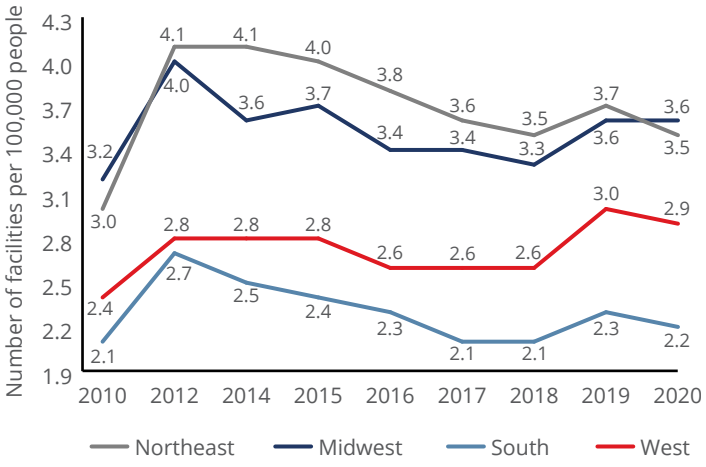
Geographic variations in availability of community-based mental health care

Changes in the number of facilities offering community-based mental health care occurred at regional and state levels from 2014 to 2020.

Regional variation

The availability of community-based mental health care varied by region (Figure 3), with the Northeast and Midwest having the most facilities offering these services and the South having the fewest facilities. Trends in the number of facilities per 100,000 people by region were similar across regions, with the West having the highest increase in facilities per capita from 2018 to 2019.[14] There was a slight decrease in facilities from 2019 to 2020 in all regions.

Figure 3. Number of facilities offering community-based mental health care per 100,000 people by geographic region, 2014 to 2020



Sources: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS) (2014 to 2020); Population Division, U.S. Census Bureau, Annual Estimates of the Resident Population for the United States, Regions, States, and the District of Columbia: April 1, 2010 to July 1, 2020.

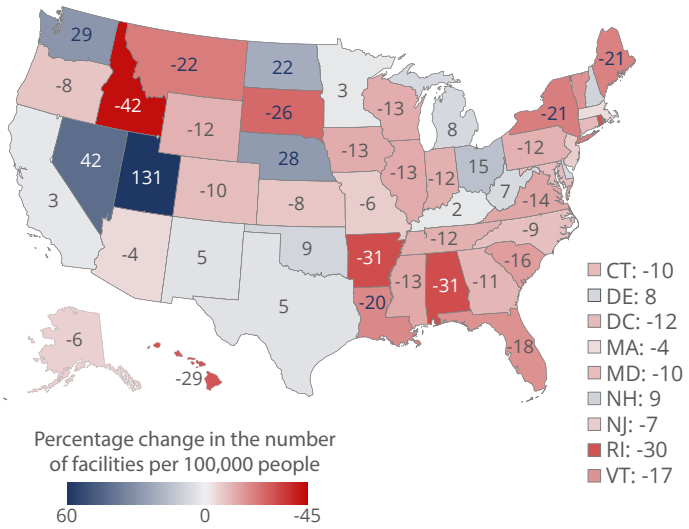
Note: Community-based mental health care includes outpatient treatment or partial hospitalization/day treatment. The number of facilities per 100,000 people for geographic regions was calculated using the U.S. Census Bureau's annual population estimates for geographic regions.

State variation

The map in Figure 4 shows the percentage changes in the number of facilities offering community-based mental health care per 100,000 people from 2014 to 2020.[15] The number of states with fewer facilities offering OT or PH/DT was more than the number of states with more facilities offering these services. Only five states showed increases of more than 20 percent: Utah (131 percent), Nevada (42 percent), Washington (29 percent), Nebraska (28 percent), and North Dakota

(22 percent). Conversely, Idaho (-42 percent), Arkansas (-31 percent), Alabama (-31 percent), and Rhode Island (-30 percent) had the greatest decreases in facilities offering these services.[16]

Figure 4. Percentage change in the number of facilities offering community-based mental health care per 100,000 people by state, 2014 to 2020



Sources: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS) (2014 to 2020); Population Division, U.S. Census Bureau, Annual Estimates of the Resident Population for the United States, Regions, States, and the District of Columbia: April 1, 2010 to July 1, 2020.

Notes: Community-based mental health care includes outpatient treatment or partial hospitalization/day treatment. Blue indicates increase, red indicates a decrease, and gray indicates no change in the number of facilities per 100,000 from 2014 to 2020. The number of facilities per 100,000 people for each state was calculated using the U.S. Census Bureau's annual population estimates for states and Washington, D.C.

Characteristics of facilities offering community-based mental health care

Types of facilities offering community-based mental health care

More than 75 percent of facilities that offered OT or PH/DT identified as being either outpatient mental health facilities or community mental health centers. The proportions represented by outpatient mental health facilities and community mental health centers, however, changed over time. In 2014, 33 percent of facilities that offered these services were community mental health centers, which decreased to 28 percent in 2020. The proportion of facilities offering community-based services that identified as outpatient mental health facilities increased from 48 percent in 2014 to 56 percent in 2019, falling by 2 percent in 2020 during the public health emergency.

In 2015, the N-MHSS introduced the option for facilities to identify themselves as PH/DT facilities. The proportion of facilities offering PH/DT that identified as PH/DT facilities increased from 17 percent in 2015 to 23 percent in 2020. The number of community mental health centers that offered PH/DT decreased from 25 percent in 2014 to 17 percent in 2020, and the number of outpatient mental health facilities that offered PH/DT fell from 20 percent in 2014 to 14 percent in 2020, with the largest decreases for these facilities occurring from 2014 to 2015 (5 percent and 3 percent, respectively).[17] Other facility types accounting for more than 10 percent of those offering PH/DT were separate inpatient psychiatric units, psychiatric hospitals, and multi-setting mental health facilities.

Age groups served by facilities offering community-based mental health care

Most facilities offered community-based mental health care to all age categories, and changes in the proportion of facilities serving different age groups from 2014 to 2020 were slight. Almost all facilities offered services to young adults (18 to 25 years), increasing by 2 percent from 2014 to 93 percent in 2020. Facilities serving adults (24 to 64 years) and seniors (65 and older) each increased by only one percent to 87 percent and 83 percent, respectively, in 2020, and those serving adolescents (13 to 17 years) increased by 4 percent to 77 percent. Facilities serving children (12 years and younger) increased from 68 percent in 2014 to 71 percent in 2019. This was the only age group for which there was a slight drop (to 70 percent) in 2020 during the public health emergency.

Characteristics of clients receiving community-based mental health care

Every other year, the N-MHSS collects information from facilities on the number of clients who received less-than-24-hour care (OT or PH/DT) in April and those clients' sex, age, race, ethnicity, and voluntariness of services. The number of clients who received care in facilities offering OT changed little from 2014 to 2018 but fell by 7 percent from 2018 to 2020. The number of clients receiving care from facilities offering PH/DT declined by 36 percent overall from 2014 to 2020 and fell by 19 percent from 2018 to 2020 (Table 1).

Table 1. Number of clients receiving community-based care by facilities offering OT or PH/DT in one month (April), 2014 to 2020

	Number of clients			
	2014	*2016*	*2018*	*2020*
OT	3,471,589	3,465,529	3,510,259	3,244,760
PH/DT	646,241	537,963	507,221	411,920

Clients receiving community-based mental health care by age group

By age groups, the proportion of clients who received community-based mental health care did not differ across facilities offering OT or PH/DT and did not change across years. In each survey year, about 29 percent of clients who received OT or PH/DT were ages 17 or younger, 62 percent were ages 18 to 65, and 9 percent were older than age 65. Facilities offering PH/DT served about 3 percent more adults ages 18 to 65 from 2014 to 2018 than those offering OT; in 2020, the percentage of PH/DT clients fell to the same level as OT clients.

Compared with 2019 census estimates, the proportion of clients age 17 or younger who received OT or PH/DT was about 6 percent higher, and the proportion of clients age 65 and older was about 7 percent lower than the proportion of the U.S. population for these age groups, suggesting the possibility of a greater-than-expected need for services among children and youth and a lower-than-expected level of need or care provided for seniors.

Clients receiving community-based mental health care by sex

The proportion of male and female clients served by facilities providing community-based mental health care changed by less than 2 percent for OT and PH/DT from 2014 to 2020. Male clients decreased to 47 percent for OT and 48 percent for PH/DT, and female clients increased comparably. The slight decrease in male clients contrasts with the increase in prevalence of mental illness among men from 14 percent in 2014 to 16 percent in 2019. The increase in female clients served could reflect the higher prevalence estimates for mental illness for females than for males, which increased from 22 percent in 2014 to 25 percent in 2019.[18]

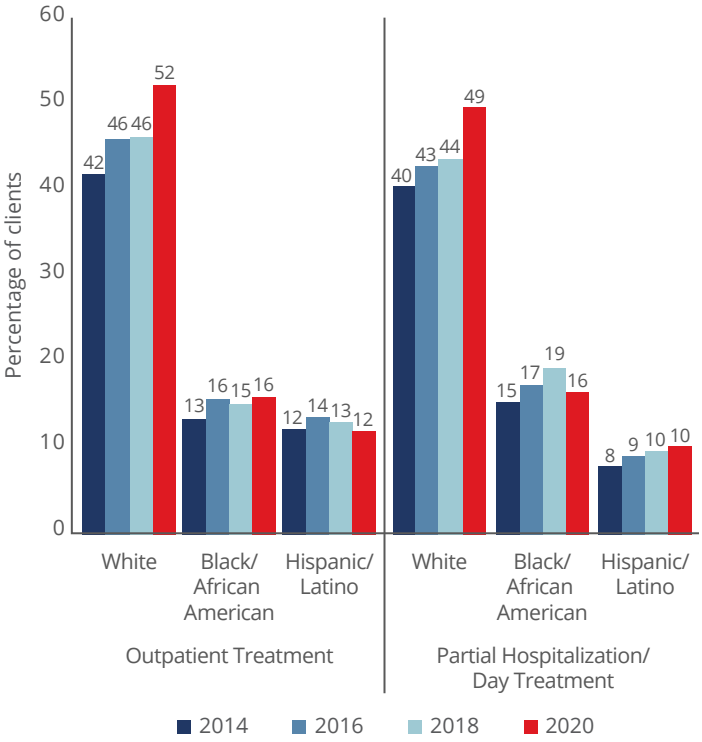
Clients receiving community-based mental health care by race and ethnicity

The proportion of White clients receiving community-based care in facilities offering OT rose from 42 percent in 2014 to 52 percent in 2020, and rose from 40 percent to 49 percent in those offering PH/DT (Figure 5). In contrast, the proportion of Black or African American clients receiving community-based care changed little over this period: Those receiving care in facilities offering OT increased from 13 percent in 2014 to 15 percent in 2016 and did not change in 2018 or 2020, and in facilities offering PH/DT increased from 15 percent in 2014 to 19 percent in 2018 but fell to 16 percent in 2020. Less than 2 percent of clients receiving community-based care were Asian, about 1 percent were American Indian or Alaska Native, and less than 1 percent were Native Hawaiian or Pacific Islander. The proportion of clients identified as other race varied from 3 to 6 percent, and clients identified as having an unknown race, which was nearly 40 percent in 2014, decreased by 14 percent for OT settings and 12 percent for PH/DT settings by 2020.

The proportion of Hispanic or Latino clients served by facilities with OT settings increased by 2 percent from 2014 to 2016 and decreased by 1 percent from 2018 to 2020. Hispanic or Latino clients were 8 percent of those receiving PH/DT services in 2014 and 10 percent of those receiving these services in 2020, a slight increase from 2018.

The NSDUH reports increases in prevalence of mental illness for adults ages 18 and older who are White, Hispanic or Latino, and two or more races; no change for Black or African American adults; and no change or a decrease for other racial groups from 2014 to 2019. The percentage of youth ages 12 to 17 with depression, however, increased by 4 percent to more than 8 percent across all racial and ethnic groups except Black or African American youth, who had an increase in depression of 2 percent.[19]

Figure 5. Percentage of facility clients receiving OT or PH/DT in one month (April) by race and ethnicity, 2014 to 2020



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS) (2014 to 2020).

OT = outpatient treatment; PH/DT = partial hospitalization/day treatment.

Voluntariness of services

Almost all clients voluntarily received community-based mental health care. The proportion of those voluntarily receiving either OT or PH/DT increased by about 5 percent from 2014 to 2020 to 96 percent for OT and 98 percent for PH/DT. Decreases in clients receiving either type of services involuntarily were slightly greater for those referred by the judicial system than those involuntarily receiving services for non-legal reasons.

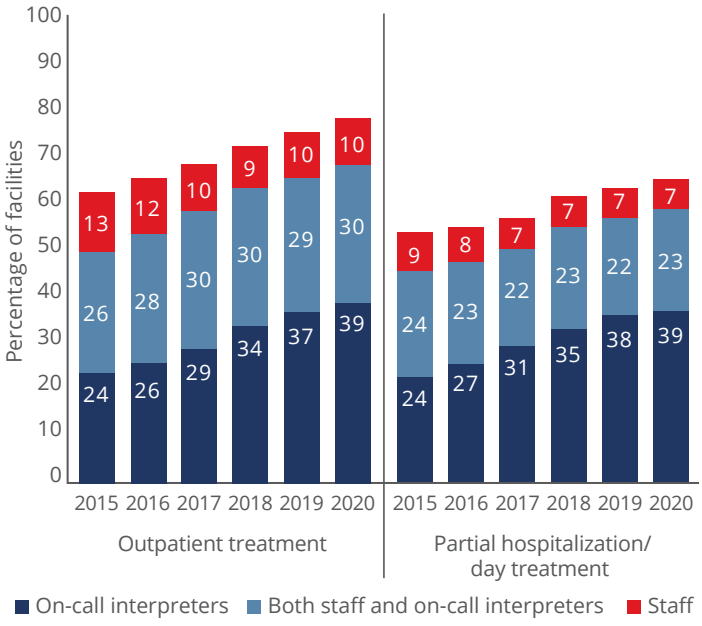
Accessibility of community-based mental health services

The N-MHSS asks facilities about factors that might affect access to services, including whether services are provided in languages other than English, in which languages staff provide services, acceptable forms of payment, and services offered for tribal populations.

Access to services in languages other than English

The number of facilities offering community-based mental health care in languages other than English increased from 5,696 to 7,387 from 2014 to 2020, an increase from 57 percent to 78 percent of facilities. This increase primarily reflects facilities' greater use of on-call interpreters, which increased from 49 percent in 2015 to 69 percent in 2020 for facilities offering OT and from 47 percent to 61 percent for those providing PH/DT (Figure 6). Facilities that only use staff with foreign language skills as interpreters declined slightly. The proportion of facilities offering OT or PH/DT services in sign language fell slightly from 57 percent in 2014 to 52 percent in 2016 and then increased to 60 percent in 2020.

Figure 6. Percentage of facilities offering OT or PH/DT using on-call interpreters and staff as interpreters, 2015 to 2020.



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS) (2014 to 2020).

Note: Data are not available for this survey question prior to 2015.

OT = outpatient treatment; PH/DT = partial hospitalization/day treatment.

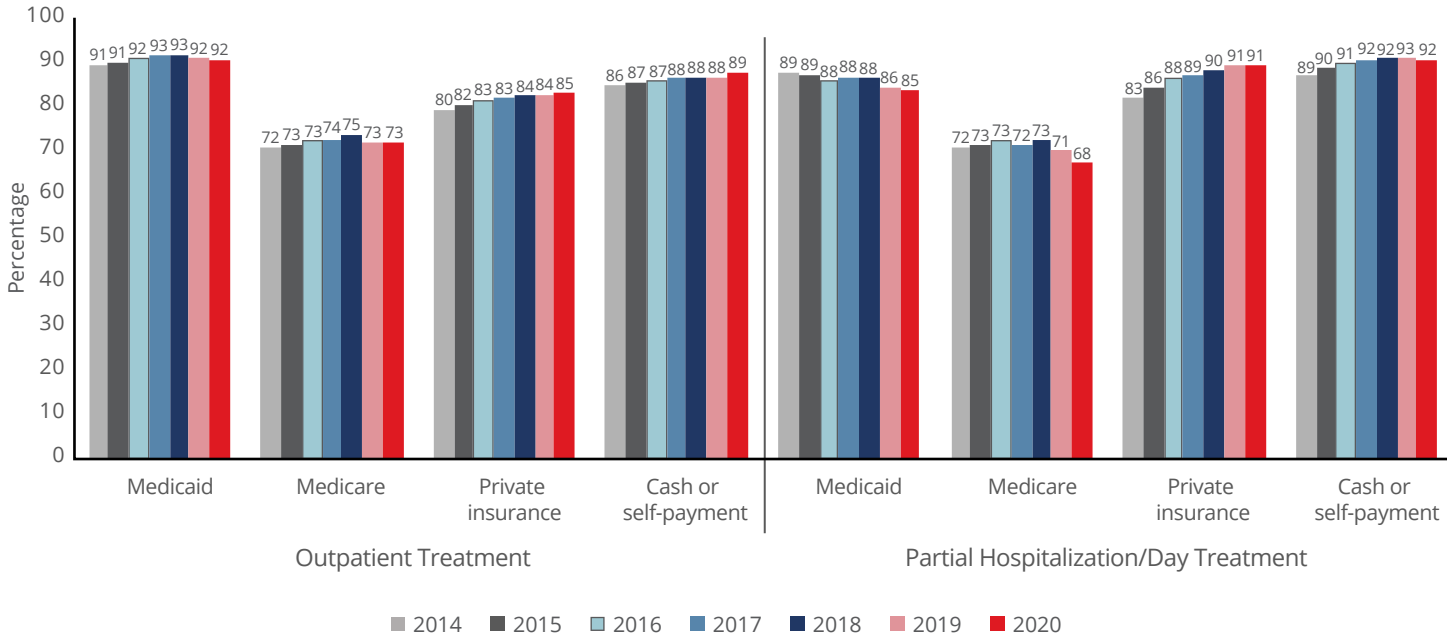
In contrast with the increased use of on-call interpreters, facilities with staff providing services in other languages decreased. The proportion of facilities offering OT that have staff who provide services in Spanish fell from 46 percent to 38 percent and fell from 40 percent to 28 percent for those that offer PH/DT from 2014 to 2020. Across survey years, between 0.2 and 0.6 percent of facilities that offered OT and between 0.2 and 0.4 percent of facilities that offered PH/DT had staff who provided services in American Indian or Alaska Native languages. In terms of the number of facilities, these small numbers represent a 26 percent decrease (from 57 facilities in 2014 to 42 facilities in 2020) in facilities with staff providing OT or PH/DT services in American Indian or Alaska Native languages. Almost all these facilities offered OT, but only a small number offered PH/DT, which decreased by 50 percent from 8 in 2014 to 4 in 2016 and 2017 and then increased to 7 in 2019 and 2020. Facilities with staff providing these services in any other languages varied from 13 to 14 percent for facilities offering OT and from 9 to 11 percent for facilities offering PH/DT.

Accepted forms of payments

From 2014 to 2020, private insurance grew as a payment option for community-based mental health care (Figure 7). The percentage of facilities accepting private insurance increased by 5 percent from 2014 to 2020 for those with OT settings, and by 7 percent for those with PH/DT settings. The proportion of community-based facilities accepting cash or self-payment grew by 3 percent over this six-year period to a total of 89 percent of facilities with OT settings and 92 percent with PH/DT settings. In contrast with private health insurance, Medicaid and Medicare changed little as an accepted method of payment among facilities with OT settings and decreased by 4 percent for Medicaid (to 85 percent) and 6 percent for Medicare (to 68 percent) for facilities with PH/DT settings from 2014 to 2020.

The percentage of facilities with OT settings offering either a sliding-scale fee, no charge for services, or minimum payment remained roughly the same from 2014 to 2020, increasing by only 1 percent each (to 68 percent and 57 percent in 2020, respectively). Among facilities with PH/DT settings, however, the proportion accepting sliding-scale fees, no charge, or minimum payment decreased for each. Sliding-scale fees decreased from 54 to 49 percent as an option among facilities with PH/DT settings, and the proportion of these facilities offering no charge or minimum payment decreased from 52 to 45 percent. From 2014 to 2020, the percentage of OT facilities receiving "other state/local funds" stayed roughly the same (increasing from 85 to 86 percent), and the percentage of PH/DT facilities receiving "other state/local funds" decreased from 81 to 77 percent.

Figure 7. Percentage of facilities offering OT or PH/DT accepting selected forms of payment, 2014 to 2020



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS) (2014 to 2020).

OT = outpatient treatment; PH/DT = partial hospitalization/day treatment.

Facilities operated by tribal governments and Indian Health Service

Tribal governments or the Indian Health Service (IHS) operate about 0.5 percent of facilities that provide community-based mental health care in the N-MHSS. The number of these facilities increased from 20 in 2014 to 34 in 2020. The number of clients served in these facilities was 7,674 in 2014, 4,098 in 2016, 3,239 in 2018, and 4,867 in 2020. Clients were equally distributed across facilities operated by tribal governments or the IHS, except in 2018, when about two-thirds of clients were served in facilities operated by a tribal government and one-third by the IHS. All of these facilities provided OT across the years, but fewer facilities provided PH/DT services: three in 2014, one from 2015 to 2018, and none in 2020.

A larger number of facilities than those operated by tribal governments or the IHS accepted payment from the Indian Health System, which is made up of the IHS, Tribal health programs, and urban Indian organizations (commonly called the ITU system). The number of facilities offering community-based mental health care that accepted this type of payment increased from 470 in 2014 to 874 in 2020, with a similar trend from 448 in 2014 to 832 in 2020 for those offering OT. A smaller number of facilities that offer PH/DT accepted ITU payment, but this number also nearly doubled from 115 in 2014 to 196 in 2020.

Discussion

The number of facilities offering community-based mental health care from 2014 to 2020 at a national level did not change appreciably, however much greater differences exist between geographic regions and states. Only the West saw increases over 2014 levels in facilities providing these services, and the South had the fewest facilities per capita. More than 50 percent of states showed some level of decrease in the number of facilities per capita providing these services from 2014 to 2020. Fewer facilities offered more intensive PH/DT services over this period, and the number of clients receiving these services fell by more than one-third, with the largest decrease from 2018 to 2020 during the public health emergency. Fewer adult and Black or African American clients were served by facilities offering PH/DT in 2020, whereas more White clients were served by facilities offering OT or PH/DT, and there was a slight increase in Hispanic or Latino clients served by facilities offering OT.

The variability in service availability across states and regions raises questions about the extent to which populations in need of mental health care can access this care within their communities. Data from the NSDUH show increases in mental illness from 2014 to 2019, particularly for youth and young adults, with smaller increases for adults in their middle years. Young adults are the least likely among adults to receive mental health services and report the greatest need for these services. Youth ages 12 to 17 had the second highest increase in mental illness with a more than 30 percent increase in depression (the measure of youth mental illness in the NSDUH) during this

period. Although the N-MHSS shows that more than 70 percent of facilities offer community-based mental health care for youth, and more than 90 percent offer this care for young adults, these facilities might not meet the needs of these age groups. NSDUH data show that less than 50 percent of young adults with any mental illness receive any mental health services, and less than half of youth with depression received services.[20]

Reasons why facilities might not be meeting the needs of certain population groups could be affected by practitioner shortages and changes in the payment environment. According to the Health Resources and Services Administration, there are 5,807 Health Professional Shortage Areas for mental health care in the United States that require an additional 6,471 practitioners to bridge the gap in available providers for a population totaling 124 million. The N-MHSS data show that facilities that provide community-based mental health care have considerably improved access to services in languages other than English by using on-call interpreters, but have fewer staff providing services in other languages. The increases in interpreters could contribute to the slight increases in Hispanic or Latino clients who received OT and continued to receive these services in 2020 when these services were largely provided remotely. Changes in the forms of payment seen in the N-MHSS data suggest that there could be payment barriers to more intensive PH/DT services through public options or with reduced costs, and at the same time payment options are shifting to private insurance and cash or self-payment. Additional investigation is necessary to explore the relationships between such changes and access to community-based mental health care.

Suggested Citation:

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Endnotes

1. Alegría, M., R. Frank, H. Hansen, J. Sharfstein, R. Shim, M. Tierney. "Commentary: Transforming Mental Health and Addiction Services." Health Affairs, vol. 40, no. 2, 2021, pp. 226–234. https://doi.org/10.1377/hlthaff.2020.01472.
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10. Because N-MHSS data populate information about facilities in the Substance Abuse and Mental Health Services Administration treatment locator, in 2020, facilities were guided to describe available services according to how these should appear in the locator.
11. Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS): 2019. "Data on Mental Health Treatment Facilities." Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
12. Facilities per 100,000 people for geographic regions and states were calculated using the U.S. Census Bureau's Annual Estimates of the Resident Population for the United States, Regions, States, and the District of Columbia.
13. U.S. Census Bureau, Population Division. "Annual Estimates of the Resident Population for the United States, Regions, States, and the District of Columbia: April 1, 2010 to July 1, 2020 (NST-EST2020)." Washington, DC: U.S. Census Bureau, Population Division, December 2020.
14. The U.S. Census Bureau's population estimates for geographic regions were used to calculate facilities per 100,000 people for geographic regions.
15. The U.S. Census Bureau's population estimates for U.S. states and the District of Columbia were used to calculate facilities per 100,000 people in each state.
16. For almost all states, changes from 2014 to 2019 showed a similar trend to changes from 2014 to 2020. From 2014 to 2019, the percentage change in the number of facilities per 100,000 people increased in 15 states and decreased in 36 states; from 2014 to 2020, this percentage increased in 16 states and decreased in 35 states.
17. Other facility types that showed a decrease from 2014 to 2015 were "other type of RTC" (from 7.1 percent to 0.5 percent) and "multi-setting mental health facility" (from 15 to 12 percent). These decreases may reflect a change in identification of facility type with the addition of the PH/DT facility type response category.
18. See endnote 6.
19. See endnote 7.
20. See endnote 6.