Organization & Funding of Community Mental Health Services

NRI's 2020-2021 State Profiles

September 2021

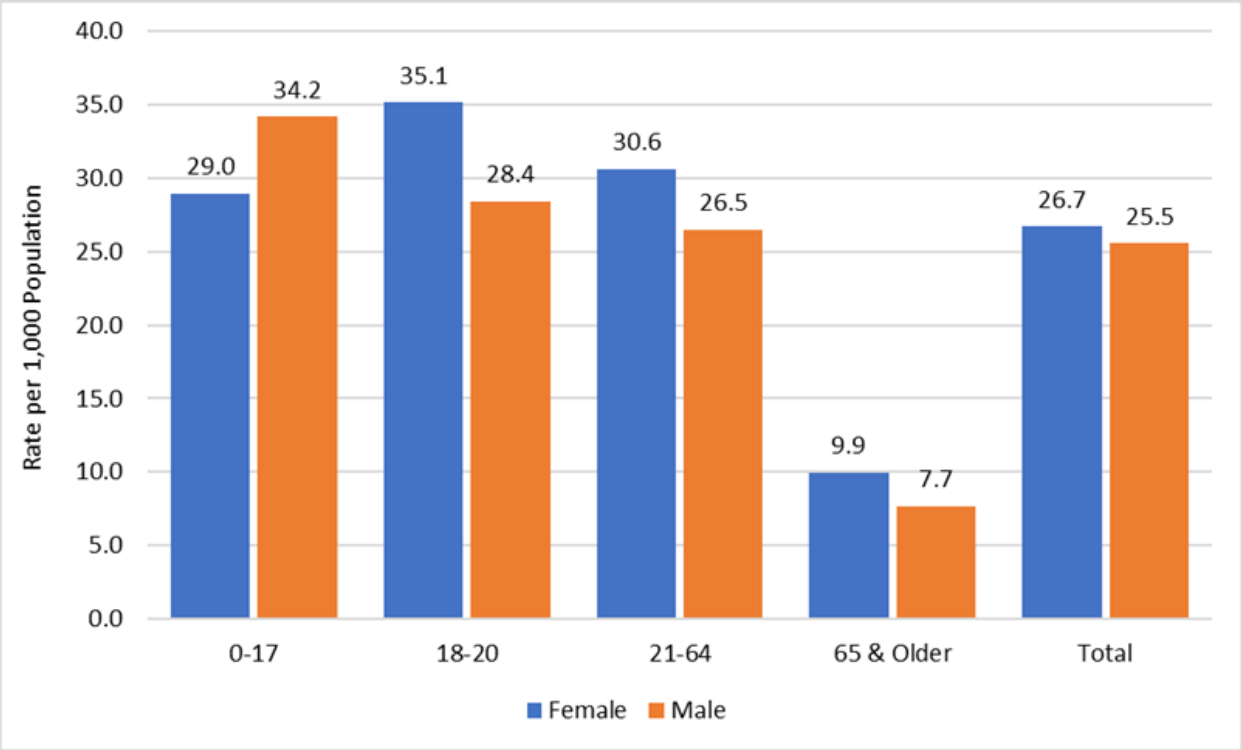
HIGHLIGHTS BASED ON 49 STATES RESPONDING TO THE ORGANIZATION AND STRUCTURE COMPONENT AND 46 RESPONDING TO THE FINANCE COMPONENT OF NRI'S 2020 STATE PROFILES AS WELL AS SUPPLEMENTAL INFORMATION FROM THE 2020 SAMHSA UNIFORM REPORTING SYSTEM

Community mental health systems provide a comprehensive array of mental health services and supports run by state and local governments as well as nonprofit and for-profit organizations. Community-based mental health service providers include community mental health centers (CMHCs), psychosocial rehabilitation programs, outpatient clinics, residential treatment programs, crisis programs, consumer-operated programs such as clubhouses or drop-in centers, and a variety of other specialty mental health service providers.

Clients Served in Community Settings

in 2020, 97% (7.8 million) of the over 8 million clients served by State Mental Health Agencies (SMHAs) in 49 states and the District of Columbia (2020 Uniform Reporting System, SAMHSA). Females represented over half (53%) of all clients served, whereas males represented 47%. Total utilization rate—clients served per 1,000 population—for community services was 24.2, ranging from a low of 3.2 in Illinois to a high of 85.4 in New Mexico. Males in all age groups except those aged 0 to 17 years had lower utilization rates than females.

Utilization Rates of Clients Served in Community Settings, by Age and Gender (rate per 1,000 population)



36

SMHAs primarily fund, but do not operate community-based agencies

12

SMHAs primarily fund local, county, or city mental health authorities

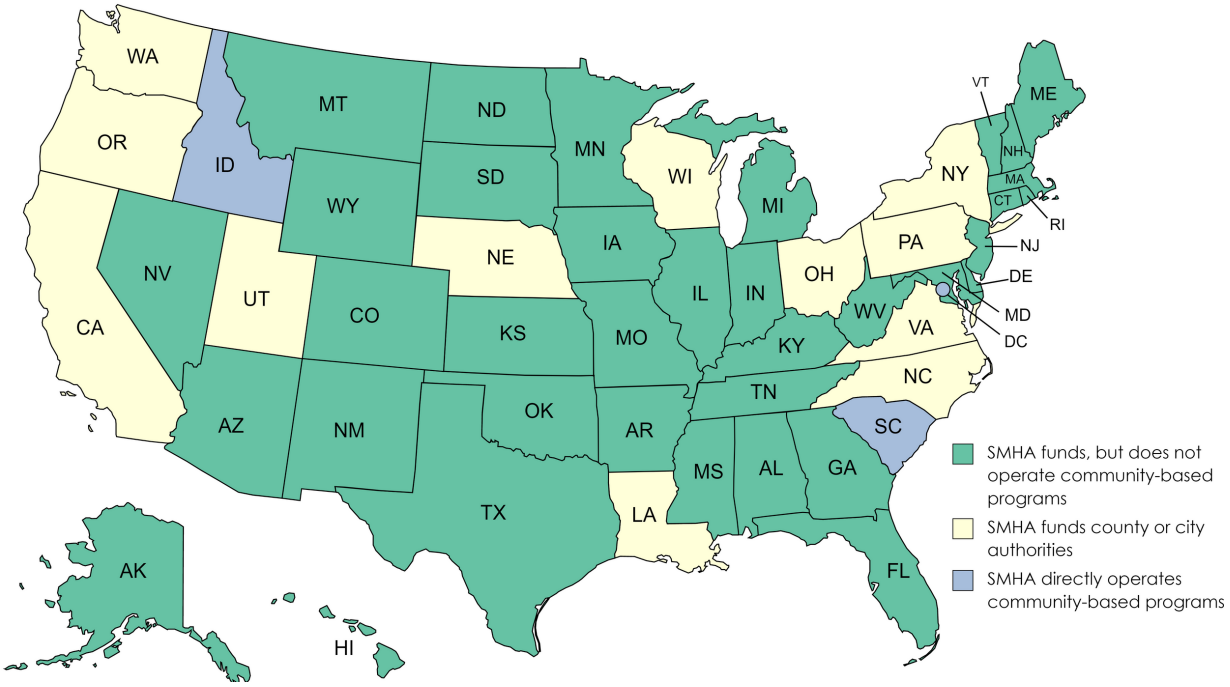
3

SMHAs primarily directly provide community-based mental health services

Mechanisms SMHAs Use to Administer Fund & Fund Community-Based Mental Health Services

SMHAs use a combination of mechanisms to administer and fund community-based mental health services. Majority of SMHAs (36) directly fund, but do not operate local community-based agencies. Twelve (12) SMHAs fund local, county, or city mental health authorities—in parts of the state or statewide—which in turn fund local provider agencies or directly provide community mental health services. Only three SMHAs directly provide community-based mental health services.

Primary Mechanism the SMHA Uses to Fund Community Mental Health Services



Initiatives to Restructure Community-Based Mental Health Services

In 14 states, the SMHAs have restructured the way community-based mental health services are delivered. For example:

- In Iowa, the state transitioned from a 99-county mental health and disability system to a regional system requiring counties to form into regions of three or more counties. The mental health and disability service regions are mandated to provide a set of core mental health and disability services which include crisis and intensive mental health service to eligible adults and children with serious emotional disturbance who meet financial and clinical eligibility.
- In Massachusetts, the Department of Mental Health (DMH) completed restructuring of adult community services to provide evidence-based interventions within the context of standardized, clinically focused model. The Adult Community Clinical Services (ACCS) is the cornerstone of the DMH adult community-based system and services approximately three-quarter of all adults receiving a DMH community-based service. ACCS enhanced and transformed service components by combining into one service type—the delivery of residential and community rehabilitative services—that were previously provided through a separate funding and through a more fragmented system. The goal is to offer assertive engagement to improve health and behavioral health outcomes. ACCS offers clinical rehabilitation services integrated with the healthcare system through care coordination functions delivered by the Behavioral Health Community Partners (BHCPs), DMH care management, and One Care (Medicare-MassHealth eligible) Health Homes. The delivery system design of ACCS includes continuity of clinical teams across living arrangements thus allowing clients to move into a subsidized apartment and keep the clinical team which supported them during their stay in group living. In addition, integration of addiction treatment specialists within the clinical teams provide assertive care for those living with co-occurring M/SUD.

Controlling Entry to State Psychiatric Hospitals

In 16 states, community mental health programs control admissions into state psychiatric hospitals. For example:

- In Indiana, by state statue, a CMHC must review and approve all civil commitments to state psychiatric hospitals.
- In Kentucky, while CMHCs are not legally mandated gatekeepers, CMHCs actively work to divert individuals from hospitalization when a lower level of care can meet the needs of the client. These activities are preventative as well as crisis intervention oriented. In cases where hospitalization may be necessary, law enforcement and others may call CMHCs 24/7 through their crisis line to request an evaluation by a credentialed Qualified Mental Health Provider (QMHP). QMHPs assess the individual for harm to self or others and determine if the individual may wish to voluntarily admit to a hospital or proceed with an involuntary commitment.
- In Missouri, a pre-admission screening must be conducted by a certified community mental health provider before a commitment exam can be conducted for a Chancery Court Judge to determine if a person needs a state psychiatric hospital placement.
- In Tennessee, mobile crisis teams operated by community mental health centers commonly issue the first Certificate of Need for possible admissions to state psychiatric hospitals.
- In Texas, local mental/behavioral health authorities (LMHAs/LBHAs) are responsible for recommending the most appropriate and available treatment alternative for an individual in need of mental health services. Before LMHAs/LBHAs refer an individual for inpatient services, they must screen and assess the individual to determine if the individual requires inpatient services. If the screening and assessment indicate the individual requires inpatient services, inpatient services are the least restrictive setting available, and if the LMHA/LBHA determines that the individual meets the criteria for admission, the LMHA or LBHA refers the individual to the state mental health facility or contracted psychiatric bed.

Types of Community-Based Mental Health Services Provided

SMHAs offer a variety of community-based mental health services, including crisis services, including mobile crisis (43 SMHAs); extensive/intensive outpatient treatment (42 SMHAs); outpatient testing and treatment (42 SMHAs); case management (41 SMHAs); assertive community treatment (41 SMHAs); wraparound (41 SMHAs); residential support services (41 SMHAs); in-home services (40 SMHAs); peer/consumer operated services (40 SMHAs); supported employment (39 SMHAs); cooccurring MH/SUD treatment (38 SMHAs); residential room and board (38 SMHAs); school-based services (38 SMHAs); and collateral treatment (31 SMHAs).

Financing of Community Mental Health Services

In 2020, SMHAs expended over $45.9 billion (2020 Uniform Reporting System, SAMHSA) to provide mental health services in community and state hospital inpatient settings. Of this, nearly 70% ($32 billion) were expended on community-based mental health services and supports, with Medicaid—both state and federal share—accounting for 62% of all funds. State general funds were the second largest funding source for community-based mental health services accounting for 23% ($7.6 billion) of all funds.

SMHAs are funded through a variety of funding sources to finance community-based mental health services. State general funds were most often used to fund residential support services (40 SMHAs), crisis services (39 SMHAs), and outpatient testing and treatment (37 SMHAs). SMHAs most frequently used federal Medicaid funds for case management (34 SMHAs), crisis services (34 SMHAs), extensive/intensive outpatient services (32 SMHAs), and outpatient testing and treatment (32 SMHAs).

Number of States Using Funding Sources for Community Mental Health Services, by Type of Service

Funding Sources	Inpatient Hospital	Residential: Room & Board	Residential: Support Services	Outpatient: Testing and Treatment	Extensive/Intensive Outpatient	Collateral Treatment	Case Management	Crisis Services	Assertive Community Treatment	Supported Employment	School-Based Services	Wraparound	In-Home Services	Peer/Consumer Run Services	Co-Occurring MH/SUD Services
State general fund	31	32	40	37	34	21	31	39	31	31	23	29	25	33	31
State special funds	4	4	4	4	4	1	3	6	5	3	5	4	4	4	2
State Medicaid match	22	4	23	28	27	13	26	27	24	13	23	16	20	18	11
Medicaid (federal)	22	6	24	32	32	18	34	34	27	19	26	28	27	25	25
Clinic option	6	1	1	9	5	4	5	6	2	0	4	0	2	1	12
Rehabilitation option	5	0	12	19	18	9	13	18	15	7	14	9	16	13	5
Targeted case management	1	0	1	2	1	1	20	3	2	1	0	2	2	1	15
1915(i) option	0	0	3	0	1	0	5	1	0	4	1	3	3	2	2
1115 waiver	10	2	8	8	8	5	5	7	3	7	3	5	5	5	0
1915(b) waiver	8	0	8	10	10	4	9	10	9	4	9	9	10	7	7
1915(c) waiver (HCB)	0	0	5	2	0	0	5	3	2	2	1	4	7	3	10
EPSDT	8	3	7	12	11	7	10	10	5	5	11	7	11	7	0
Other Medicaid	2	1	0	0	0	0	0	0	0	0	0	0	0	0	9
Medicare	16	3	2	14	10	3	3	4	1	0	1	1	3	0	0
Veteran's Affairs	5	5	4	5	4	4	3	3	2	0	1	0	3	0	3
Mental Health Block Grant	4	11	15	25	22	13	21	19	12	20	12	18	18	25	4
Social Services Block Grant	1	3	3	5	4	3	6	5	4	3	3	3	3	3	17
Housing and Urban Development	1	6	2	0	0	0	0	0	0	0	0	0	1	0	4
Other federal	0	3	6	3	3	1	7	4	1	3	3	4	1	2	0
Local government	0	10	12	14	12	6	12	12	11	9	10	9	8	10	0
First party	10	13	12	17	16	8	13	13	10	4	7	7	9	5	11
Third party	17	6	6	18	16	7	10	13	8	3	8	5	8	4	12
Charity	19	3	3	5	4	3	4	3	3	3	3	3	3	5	12
Other funds	4	0	0	1	1	0	0	0	0	1	1	0	0	0	4

For additional information about this Report, or the State Profiles Project,
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National Association of State Mental Health Program Directors Research Institute (NRI)