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The Status of Community Mental Health Centers Ten Years into Block Grant Financing

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ABSTRACT: This study tracks the 761 community mental health centers which received federal grants as of 1981 and assesses their status 10 years after the shift to Block Grant financing. Contrary to what had been predicted (Biegel, 1982), the vast majority of centers remained open (88.3%), a small proportion were involved in mergers (8.5%) and an even smaller percentage closed (3.3%). No pattern was evident as to which centers closed or merged by type of initial funding, although some states showed a concentration of mergers and closures. Data from the 1988 Inventory of Mental Health Organizations are used to characterize the centers still in operation by facility type, ownership, service mix and revenue mix. In 1988, federally funded CMHCs accounted for 34% of the total patient episodes treated and 22.7% of the total revenues reported by specialty mental health providers in the United States.

The Community Mental Health Centers Act of 1963 (*PL 88–164*) was intended to create a national system of community-based care for the mentally ill and to promote general mental health and well-being in the nation (Jerrell & Larsen, 1986). This "bold, new approach" established the role of the federal government in supporting and directing community efforts to care for the mentally ill for the next two decades. That mission went largely unchallenged until the Nixon and Ford administrations attempted to transfer (unsuccessfully) federal responsibility for

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this "successful demonstration" to other sources, primarily state and local governments (Sharfstein, 1978). Instead of being curtailed, Congress voted to continue federal support for community mental health centers [CMHCs] in 1975 (*PL 94–63*), and to expand the range of mandated services provided in them. By 1978, the original 5 mandated services were increased to 12, and special services were required for the elderly, children and for substance abuse treatment. The CMHC system thus appeared to be expanding in its mission, though constrained by Congressional unwillingness to fully fund the grant mechanisms designed to accomplish the task (Sharfstein, 1978).

With the passage of the Reagan administration's Omnibus Budget Reconciliation Act of 1981 [OBRA '81] (*PL 97–35*), a substantive challenge came to this system of federal financing for CMHCs. The initiation of a "Block Grant" for mental health services transferred authority to the states for the dispersement of federal funds to CMHCs, with the requirement that a minimum of five essential services be provided (outpatient, partial hospitalization, emergency services, screening of patients at risk of state hospitalization, and consultation and education). Along with a reduction in mandated services, states were given broad discretion in the use of federal funds, with the hope of minimizing federal involvement in state affairs and increasing the accountability of states to their citizens (ADAMHA, 1981). This shift to Block Grant funding led to a 21% decrease in overall federal financing for community mental health services by 1983 (Estes & Wood, 1984).

Some observers saw these changes as a threat to the very existence of the community-based mental health center that offered a comprehensive array of services to a broad spectrum of citizens (Woy, Wasserman & Weiner-Pomerantz, 1981). Concerns have been expressed about potential cutbacks in the services provided in CMHCs and about a reduced commitment to serving those most in need or who lack insurance (Beigel, 1982; Jerrell & Larsen, 1986). Beigel (1982) furthermore predicted professional staffing reductions, expanded catchment areas, and a wave of consolidations and mergers caused, in part, by increased competition from the private sector. Others predicted that there would be a reorganization of services, but no disruption in the care of clients (Pardes & Stockdill, 1984). Because states simultaneously began to refocus their resources on the chronically mentally ill [CMI] and on rehabilitation and residential services, Okin (1984) saw a potential opportunity for greater attention to the needs of the CMI and for greater coordination of their care within state mental health systems.

Unfortunately, few evaluations of the impact of OBRA '81 on the overall CMHC system have been conducted because in 1981 the Na-

tional Institute of Mental Health [NIMH] eliminated both a separate survey of CMHCs, and a specific designation for CMHCs in the Inventory of Mental Health Organizations [IMHO]. However, a few studies have been conducted using samples of CMHCs. For example, Jerrell and Larsen (1986) surveyed 71 centers in 15 states, examining changes in the service mix, case mix, staffing profile and financing of CMHCs. Estes and Wood (1984) surveyed the directors of 36 centers in 8 states, and Drolen (1990) surveyed 69 centers in 27 states, regarding the same set of issues. In general, these studies have found that professional staffing has been reduced, caseloads increased, services reorganized to target both the CMI and insured clients, fewer services being made available to children, adolescents, the elderly and the uninsured, and a decline in federal revenues partially offset by state funds and private-paying clients.

Because of the difficulty of identifying CMHCs in NIMH datasets, none of the above studies looked at the "universe" of CMHCs–the 761 centers that had been federally supported by the time of OBRA '81. The present study was therefore designed to identify that universe in 1991 and to examine whether Beigel (1982) was correct in predicting a wave of mergers and closures of federally funded CMHCs. This study was also designed to investigate whether there are any differences in the closed, merged and unmerged operating centers by type of initial grant or by state. Finally, this study looks at the distribution of services, organization type, ownership, and funding for CMHCs in the 1988 IMHO, and the relative size and revenue mix of CMHCs compared to the overall system of mental health service providers.

METHOD

Case Identification

The *1981 Directory of Federally Funded Community Mental Health Centers* (NIMH, 1981) lists 761 agencies (excluding one in Guam) which received federal grants prior to the initiation of the Block Grant in 1981. These 761 centers were tracked through the *National Registry of Community Mental Health Services* [*Registry*] (National Council of Community Mental Health Centers, 1991)[1] to identify those agencies which were still

[1]*The National Registry of Community Mental Health Services* is a directory of the member agencies in the National Council of Community Mental Health Centers and lists the mailing address, telephone number and executive director of its members. This registry includes agencies that were never the recipients of federal funds as CMHCs but that nevertheless describe themselves as community mental health centers. The earlier directory from 1981 published by NIMH lists only those centers funded by the federal government as CMHCs, includes similar information as the 1991 edition, and indicates the initial type of federal grant received by the agency.

in existence and operating either under the same name or under a different name but at the same address. Agencies which were not identified by those criteria were tracked in the 1985 edition of the *Registry,* where all mergers, name changes and address changes as of 1985 were listed. The remaining pool of agencies which could not be identified in either the 1985 or 1991 *Registry* were either called directly or the local or state mental health authority in their area was contacted to ascertain whether the agency still existed, had merged with another facility or had closed. The status of all 761 centers as of November 1, 1991 was thus identified as either "still in operation (unmerged)," "merged" or "closed."

We then attempted to identify all of the CMHCs which were still in operation (merged and unmerged) in the 1988 Inventory of Mental Health Organizations (IMHO). Some agencies which were involved in mergers after 1988 were also identified by their former names. Sixty-three cases were missing, or 8.3% of the population (IMHO has a 3% nonreporting rate; RW Manderscheid, personal communication).

Analyses

Frequencies for the three categories of operating status were calculated: still in operation (unmerged), merged and closed. Potential differences by state and by initial type of grant were assessed among the three groups.

For those CMHCs still in operation (merged and unmerged), frequencies were calculated for type of organization, service mix, revenue mix, total clients served and total episodes. The total episodes and revenue mix of CMHCs were compared with those of the total pool of mental health providers reporting in IMHO, excluding state hospitals and private psychiatric hospitals.

RESULTS

Table 1 shows a tabulation of the results from the tracking of CMHCs through the 1981, 1985 and 1991 directories. As of November 1, 1991, 672 of the original 761 CMHCs, or 88.3%, were still in operation and had not been involved in a merger. Approximately 24% of this group had undergone a change in name. Another 8.5% of the total, or 65 CMHCs had been involved in a merger, creating 29 newly constituted

TABLE 1
The Status of Federally-Funded CMHC's
Existing in 1981, as of 1991

	N	%
Still in Operation ("unmerged")	672	88.3
Merged	65	8.5
Closed	24	3.2
Total	761	100.0

centers and producing a net decline of 36 facilities. An additional 24 facilities closed, representing 3.2% of the original 761 federally funded CMHCs.

A chi-square test of the distribution of facilities by operating status (still open [unmerged], merged and closed) by type of initial grant (i.e. construction, support, staffing) revealed that the type of initial funding had no observable relationship to later operating status. A similar tabulation crossing operating status by state did suggest some concentrations of change, with 20% of the mergers occurring in Texas, 17% in California, and 15% in Kentucky. The closures were disproportionately concentrated in Puerto Rico (29%) and Florida (13%).

Table 2 shows the distribution of CMHCs by organization type as listed in the IMHO. The vast majority (77.1%) were listed as multiservice mental health facilities, the category which replaced CMHCs in the IMHO. Multiservice mental health facilities must provide 2 or more core services (i.e. inpatient, outpatient, partial, emergency, residential), and include many facilities that are not and never have been community mental health centers. However, given their mandate, it is logical that most CMHCs are now among this provider category. The next largest subgrouping of CMHCs was under the category of general hospitals (10.3%). Again, IMHO definitions require that CMHCs based in general hospitals report as part of the general hospital. The remaining CMHCs have either re-defined themselves or reduced their range of services such that they are categorized as outpatient clinics (5.8%), freestanding psychiatric hospitals (5.3%), or residential treatment centers (1.4%).

Regarding service mix (see Table 3), as would be expected from their service mandate, the overwhelming majority of CMHCs provide outpatient, partial and emergency services. Given that residential and inpa-

TABLE 2
Operating CMHC's in 1988, by Facility Type (Source: IMHO, 1988)

	N	%
Multiservice M.H. Facilities	492	77.1
General Hospitals	66	10.3
Outpatient Clinics	37	5.8
Freestanding Psychiatric Hosps.	34	5.3
Residential Treatment Facilities	9	1.4
Total	638	100.0

TABLE 3
Percentages of Operating CMHC's in 1988, by Services Offered (Source: IMHO, 1988

	N	%
Inpatient	212	33.2
Residential Care	395	61.9
Emergency	561	87.9
Partial Care	573	89.9
Outpatient	621	97.3

tient services are no longer required of CMHCs, only a third are direct providers of inpatient services, and two-thirds are providers of residential services. The centers which do not report to be direct providers of these services may deliver them through contractual arrangement with another provider.

Regarding ownership status, 67.2% of the identified facilities were classified as non-profit corporations, 18.6% were owned by a local government or authority, and 12.4% were state-owned. The vast majority, 77.4%, received funds directly from the state mental health authority, and only 5% received no state funds at all.

The average annual expenditures of CMHCs in 1988 were $4.65 million. Nearly 50% had budgets of under $3 million, another 40% had budgets between $3 and $8 million, and 5% had budgets in excess of $14 million. The total annual revenues reported by the CMHCs (excluding psychiatric hospitals) were $2.7 billion. As shown in Table 4, approximately half (48%) of those revenues were from state government (excluding Medicaid), and government sources accounted for fully 85% of the total revenues.

Relative to the overall specialty mental health provider system, the CMHCs accounted for 34% of the total patient episodes reported in the IMHO, and 22.7% of the total revenues. The CMHCs were much more dependent on state funds (exclusive of Medicaid) than the total provider pool (48% versus 26%), whereas the total provider pool was more dependent on client fees, Medicare and "other federal" support (39% versus 19%) (see Table 4).

DISCUSSION

If the original intention of the CMHC Act of 1963 was to create a national system of community services for the mentally ill, that system appears to have largely survived the federal cutbacks and funding changes of the 1980's. A very small number of centers closed as a result

TABLE 4
Distribution of Revenue Sources for Operating CMHC's and All Specialty Mental Health Providers in 1988 (Excluding Psychiatric Hospitals) Source: IMHO, 1988

	CMHC's	*All Specialty MH Providers*
	%	%
State (exclusive of medicaid)	46.9	26.9
Client Fees	10.8	17.3
Medicaid	15.1	14.6
Medicare	3.7	9.1
Other Federal	4.6	12.3
Local Government	12.9	12.9
All Other	6.1	7.0
Total	100.1	100.1

of funding shifts, and a relatively small group (8.5%) was involved in mergers. Whether specific services, client groups, or staffing patterns have also shifted as a result of these changes will require further study, though research on smaller samples of CMHCs seems to suggest that significant changes have occurred in each of these areas (Jerrell & Larsen, 1986; Estes & Wood, 1984; Drolen, 1990a).

Nonetheless, CMHCs remain a very significant part of the overall mental health treatment system, accounting for fully one-third of the patient episodes, though receiving less than one-quarter of the total revenues. More research is needed to determine any shifts in these patterns over the last ten years.

While the CMHCs seem to have survived a decade of harsh fiscal conditions, more information is needed on both the changes occurring within those centers and the needs of catchment areas which still lack centers (and never had them). Given the shift in policy to stop federal "seed" money for new centers, and the change in service priorities occurring at the state level, more research is needed to determine what role CMHCs should play in the future, and how the existing configuration of services and funding could be modified toward that goal.

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