Part 1: History and Context for Mental Health Services and the Mental Health Block Grant in US

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Division of State and Community Systems Development
Disclaimer Slide

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The purpose is to bring together the threads of psychiatric treatment over time, the development of the federal structure for mental health services, and the legislative and legal milestones in public mental health services in a way that makes it clear how the 1982 block grant requirements were embedded in the prior history and context.

This is Part 1 of a two part presentation. Part 2 will be similarly structured and will address events preceding the passage of the 2016 Cures Act.
The primary focus is to acquaint new planners with the history and context for the Mental Health Block Grant (MHBG) so that the requirements are better understood.

A bonus would be to give more experienced planners an “Ah, Ha” moment or at least an “oh, yeah, I remember that” moment.
Who am I?

• My name is Molly Brooms.

• 36 Years with the Alabama Department of Mental Health – have lived a lot of the history

• Director of Mental Illness Community Programs

• State Planner for Mental Health Services Block Grant

• Block Grant Reviewer

• National Association for State Mental Health Program Directors consultant
• For both Parts 1 and 2, the following major sub-headings will be addressed:
  – History of Psychiatric Treatment in the US
  – Research, Legislative, and Legal Milestones
  – Connection to the Block Grant requirements
  – Roles and Responsibilities
This section will cover the following:
Beginnings of Psychiatric Treatment
Advent of Psychotropic Medications
Deinstitutionalization
Family and Consumer Advocacy
Diversity
Beginnings of Psychiatric Treatment

- **1773** – The first psychiatric hospital was opened in Virginia.

- **1775** – Dr. Benjamin Rush, known as the “Father of American Psychiatry”, applied scientific principles to the study of mental illness. His efforts improved treatment and the cleanliness of living quarters.

- **1840** – first census to include the category of “insane and idiotic”
Precursors to the 1982 Block Grant

**History of Psychiatric Treatment in the US**

**Beginnings of Psychiatric Treatment**

- Mid 1800’s – Dorothea Dix’s lobbying led to the creation or expansion of 32 state hospitals – moved people with mental illness from jails and poorhouses – humane treatment
- An article on Dorothea Dix in Medical News Today is part of a series of articles on women’s contribution to medicine. Her contributions continue to inform and inspire those who advocate for better mental health care.
- 1900’s – mental hygiene movement begun based on Clifford Beers experience as a mental patient in New England – founder of first outpatient clinic in 1913 and Mental Health America
Precursors to the 1982 Block Grant

History of Psychiatric Treatment in the US

Advent of Psychotropic Medication

- 1930’s – Electro-convulsive Therapy introduced as a treatment and Dr. Abraham Low created Recovery, Inc., a consumer self-help organization.

- 1950’s – introduction of thorazine, tricyclic anti-depressants, and monoamine oxidase inhibitors - first successful medications for psychiatric disorders

- 1960’s – Librium and Valium introduced – Benzodiazepines were safer than barbiturates for insomnia and anxiety
• As medical treatments improved, so did the possibility that persons with mental illness could live in the community.
• Media exposes overcrowding and poor conditions in psychiatric hospitals.
• State hospitals in 1955 had a census of approximately 550,000. In 2014, an average of 40,600 persons resided in 207 state hospitals.
• In 1981, 67% of state mental health funding went to state hospitals. In FY2012, state hospitals received about 24% of state mental health funds.
• Scientific principles were applied to the study of psychiatric disorders leading to increased knowledge and skills in community treatment.
• Major lawsuits (discussed under Research, Legislative, and Legal Milestones) provided additional impetus to focus on community alternatives to psychiatric hospitalization.

• Federal policy, research, funding, and leadership have focused on improving psychiatric services, particularly in the community, since the mid-1950’s.

• The focus in the Mental Health Block Grant is on creating a system of mental health services that is embedded in the larger community of other service organizations and that reduces reliance on state hospitals. This focus is reflected in Criterion 1 and Criterion 3.
The genesis of Mental Health America (MHA) began in 1909.

The organization set forth the following goals:
- to improve attitudes toward mental illness and the mentally ill;
- to improve services for people with mental illness; and
- to work for the prevention of mental illnesses and the promotion of mental health.

Current guiding principle is Before Stage 4 (B4Stage4) – that mental health conditions should be treated long before they reach a crisis stage in the disease process.
• The National Alliance for the Mentally Ill (NAMI) started with a few families in 1979.
• Today there are hundreds of local affiliates, state organizations, and volunteers providing education, advocacy, information, referral, and support.
• NAMI provides advocacy to build better lives in the community for those with mental illness.
• NAMI gave identity and voice to the concerns of families who have someone with mental illness.
The earliest consumer self-help initiative is attributed to Dr. Abraham Low who started Recovery, Inc. in 1937.

In 1969, Howard Geld, Howie the Harp, initiated what would become a national movement for consumer advocacy and peer support.

In the 1970’s, consumer organizations were created in the context of women, gay, and disability rights advocacy.

These early efforts focused on creating consumer-run alternatives to traditional treatment based on self-help and mutual support.

By the 1980’s, consumer efforts focused on partnering with providers, improving the treatment system, and continuing to develop peer services.
The importance of having vigorous and sustained family and consumer input is reflected in the Block Grant requirement that at least 50% of the State’s Planning Council members be families or consumers of mental health services.
The 1978 President’s Commission on Mental Health (discussed in more detail under Research, Legislative, and Legal Milestones) noted that the needs of racial and cultural minorities, people in rural areas, children, adolescents, and older Americans were not being met.

With the advent of individualization in treatment and disability advocacy, the idea of addressing the unique needs of diverse populations emerged.
Precursors to the 1982 Block Grant

Research, Legislative, and Legal Milestones

- 1854 veto of bill to provide national land for asylums
- World War II – National Mental Health Act – National Institute of Mental Health (NIMH)
- 1955 Joint Commission on Mental Illness and Health
- 1961 Report “Action for Mental Health”
- 1963 Mental Retardation Facilities and Community Mental Health Center Act
- 1965 Medicaid, Staffing Grants, and Joint Commission on MH of Children
- 1970 Wyatt v Stickney
- 1973 NIMH report on rural mental health
- 1974 Lynch v Baxley
- 1978 President’s Commission on Mental Health Report
- 1980 Toward a National Plan for the Chronically Mentally Ill
- 1980 Williams, et al article on deinstitutionalization and homelessness
- 1980 ECA study
• In 1854, a bill passed Congress that would set aside federal land for asylums and create a national policy on treatment of mental illness.
• President Pierce vetoed the bill on the basis that States should be responsible for treatment of mental illness.
• This veto had a lasting impact on the fiscal and philosophical underpinnings of mental illness treatment.
• MHBG represents the only on-going direct federal funding to states to generally support community mental health services – roughly 2% of national expenditures.
Precursors to the 1982 Block Grant

Research, Legislative, and Legal Milestones

World War II, National Institute for Mental Health, Action for Mental Health

- World War II – the most frequent reason for discharge was neuropsychiatric disorders.
- Many conscientious objectors worked in state hospitals and exposed conditions.
- 1946 National Mental Health Act led to the creation of the National Institute for Mental Health in 1949.
The Action for Mental Health document was sent to Congress on December 31, 1961.

- Recognized the special needs of children and people with chronic mental illness
- CMHC for every 50,000 population
- No more state hospitals >100 beds
- Federal government primary funder

In 1963 President Kennedy made the first address to Congress dealing with mental health issues which lead to passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act the same year.
• In 1965, Congress authorized funding for staffing grants directly to community mental health centers. Staffing grants were later replaced with Operational Grants.
• The Joint Commission on the Mental Health of Children was created in 1965 to recommend national action on child mental health.
• Medicaid was created in 1965. The IMD exclusion continued the idea that States were responsible for psychiatric hospitals and reflected the increasing reliance on community alternatives. Medicaid is now the single largest payer of covered mental health services.
In the fall of 1969, the Final Report of the Joint Commission on Mental Health of Children, Inc. was published. The report was titled *Crisis in Child Mental Health: Challenge for the 1970’s*. Among the many findings of the Commission, the following were noted:

- Recognized the right of children to receive care and treatment through facilities which are appropriate to their needs and which keep them as closely as possible within their normal social setting
- Put the welfare of children in the context of a full array of services in the community
- Identified the full array of mental health services needed in the community for children with mental illness and the need for coordination with the educational system
The 1970 Federal Court decision in Wyatt v Stickney established the principle that a person involuntarily committed to a state hospital has a constitutional right to treatment.

As a result, minimum standards were established for individualized treatment, safety, education, training, medication, nutrition, physical accommodations, staff/patient ratios, and aftercare.

The Wyatt case was dismissed on December 5, 2003, almost 32 years after initiation.
In 1973 the National Institute of Mental Health published a report on rural mental health titled *The Mental Health of Rural America, The Rural Programs of the National Institutes of Mental Health.*

This report identified the rates of mental illness in rural areas, the unique challenges of providing mental health services in rural areas, and the role of community mental health centers in providing services.
In 1974, Judge Johnson wrote on behalf of a 3 judge panel that the involuntary commitment procedures in Alabama violated the Due Process Clause of the 14th Amendment because they:

- provided inadequate notice,
- allowed detention without a probable cause hearing within a reasonable period of time,
- did not require the presence at the hearing of the person being committed,
- did not require counsel, and
- contained ill-defined standards for commitment.
Precursors to the 1982 Block Grant
Research, Legislative, and Legal Milestones
Impact of Federal Court

• Taken together, the Wyatt v Stickney and Lynch v Baxley lawsuits firmly established a constitutional right to treatment under minimum standards when involuntarily committed and the right to due process in the commitment proceedings.

• The far-reaching impact of these decisions on all states and on those confined to Alabama institutions cannot be overstated.
• In the late 1970’s, the concept of a Community Support Program emerged.

• The concept was to provide coordinated and comprehensive mental health services to individuals with serious mental illness (at the time styled serious and persistent mental illness).

• Case Management was a foundation of the Community Support Program.
1978 President’s Commission on Mental Health Report made the following recommendations:

- Create a network of high quality comprehensive mental health services, including in rural areas
- Address the needs of diverse racial and cultural minorities
- Address the needs of special populations including children, adolescents, and the elderly
- Create a national priority for those with chronic mental illness and develop a national plan
- Provide adequate financing and staff training
- Coordinate with health and human services
- Increase knowledge about the nature and treatment of mental illness
- Develop a national prevention effort
- Protect human rights and freedom of choice

Many of the recommendations from this report are directly reflected in the 1981 Block Grant legislation.
• *Toward a National Plan for the Chronically Mentally Ill* was published in 1980 but not adopted as official policy by the Reagan administration.

• This plan recognized the unique needs of this population in the shift from hospital to community care, estimated the number of people with chronic mental illness, recommended national goals, a federal priority for this population, and a number of financing strategies.
Williams, Bettis, and Wellington published an article in 1980 titled, “Deinstitutionalization and Social Policy: Historical Perspectives and Present Dilemmas”.

They proposed that deinstitutionalization had overwhelmed community mental health centers which “…left thousands of former patients homeless or living in substandard housing, often without treatment, supervision, or social support”.
The 1980 Epidemiological Catchment Area study provided incidence and prevalence rates of mental illness and substance use disorders.

Results found that an estimated 20% of the population has a mental disorder during any 6 month period and that 1 in 3 have a mental illness over their lifetime.

Also found that less than 20% seek treatment and that there are high rates of co-occurring disorders.
1982 Block Grant

- The Omnibus Budget Reconciliation Act of 1981 replaced the construction and staffing grants begun in the early and mid-1960s. This legislation was implemented in 1982.
- The Block Grant shifted funding from community providers to the State, which:
  - decreased funding
  - increased flexibility in how States could use funds
  - prohibited use of funds for hospitalization, capital projects, and payments to individuals
  - required submission of an annual application to receive funds.
1982 Block Grant Requirements

• The Mental Health Services Block Grant legislation established 5 statutory criteria for the application and requirements for Maintenance of Effort, Child Set-Aside, Planning Council, and Public Comment.

• The following slides will list the 5 criteria along with the related context from historical events.
Criterion 1: Comprehensive Community-Based Mental Health Service Systems – organized community-based system of care for individuals with mental illness or co-occurring disorders. Coordinated system of care to enable individuals to live outside of inpatient or residential institutions to the maximum extent possible

Related context:
Advent of Psychotropic Medications
Deinstitutionalization
Community Support Programs (CSP)
Federal Court Decisions
1961 Action for Mental Health
1978 President’s Commission on Mental Health Report
Toward a National Plan for the Chronically Mentally Ill
Precursors Relationship to BG Requirements

**Criterion 2**: Mental Health Systems Epidemiology – Contains an estimate of incidence and prevalence of serious mental illness and severe emotional disturbance. Requires quantitative targets to be achieved in implementing the system of care described in Criterion 1 and 3.

**Related context:**

1980 ECA study of incidence and prevalence

*Toward a National Plan for the Chronically Mentally Ill*
Precursors Relationship to BG Requirements

**Criterion 3**: Provides for a system of integrated services for children to receive care for their multiple needs.

**Children’s Set-Aside**

Related context:

*Crisis in Child Mental Health: Challenge for the 1970’s*

*1978 President’s Commission on Mental Health Report*
Precursors Relationship to BG Requirements

**Criterion 4:** Targeted Services to Rural and Homeless Populations and to Older Americans – provides for outreach to and community-based services for individuals who are homeless, in rural areas, and who are older.

**Related Context:**

*The Mental Health of Rural America, The Rural Programs of the National Institutes of Mental Health.*

*1978 President’s Commission on Mental Health Report*

*1980 Williams, et al, article citing deinstitutionalization as one cause of homelessness*
Criterion 5: States describe their financial resources, staffing, and training for MH services; provides for training of emergency health services regarding SMI and SED; how the State intends to expend the grant for the relevant fiscal years.

Related Context:
- Medicaid
- 1978 President’s Commission on Mental Health Report
- Veto of 1854 act reflected in prohibited payment for hospitalization
- Maintenance of Effort – supplement not supplant
Summary of Major Trends

• Major federal reports focusing on mental health issues beginning in the 1950’s – all recommended increased community services with attention to special populations (age, rural, homeless, diversity) and coordination with other community resources
• Psychotropic medications and civil rights led the way to deinstitutionalization.
• Recognition of federal role in mental health services – NIMH, SAMHSA
• Identification of serious mental illness and severe emotional disturbance as priority populations
• Lawsuits assured due process during commitment and right to treatment for those who were committed.
• Importance of consumer and family input recognized
Summary for 1982 Block Grant

Precursor Highlights:
Asylum----1854 veto----Clifford Beers----WWII----National Agenda----NIMH----
Psychotropic meds----Deinstitutionalization----CMHC Act----Medicaid----Joint
Commission on MH of Children----Wyatt----President’s Commission on MH Report (key
recommendations)----1980 ECA study----family and consumer advocacy

1982 Block Grant Requirements:
Focus on integrated community services for people with SMI/SED to reduce
hospitalization----attention to rural and homeless----specific attention to children----
requires incidence and prevalence data with quantifiable targets----financing and
training----expenditure of block grant funds-----Planning Council membership
# Crosswalk from Criteria to Web BGAS

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<thead>
<tr>
<th>Mental Health Statutory Criteria/Requirements</th>
<th>WebBGAS</th>
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<tbody>
<tr>
<td>1. Comprehensive Community-based Mental Health Service Systems</td>
<td>Planning Step 1 Including FEP, Environmental Factors and Plan – 4 and 19</td>
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<tr>
<td>2. Mental Health System Data Epidemiology</td>
<td>Planning Steps 2, 3, and 4; Table 1</td>
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<tr>
<td>3. Children’s Services</td>
<td>Planning Step 1, Environmental Factors and Plan 10 and 19</td>
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<td>4. Targeted Services to Rural and Homeless Populations</td>
<td>Planning Step 1</td>
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<td>5. Management Systems</td>
<td>Planning Step 1, Tables 2–6, Environmental Factors and Plan - 7 and 10</td>
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<tr>
<td>6. Public Comment</td>
<td>Environmental Factors and Plan – 23</td>
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The Substance Abuse and Mental Health Services Administration was created in 1992 as a result of reorganizing the previous Alcohol, Drug Abuse, and Mental Health Administration.

There are currently four centers:
- Center for Mental Health Services (administers the MHBG)
- Center for Substance Abuse Prevention (administers the SABG along with the Center for Substance Abuse Treatment)
- Center for Substance Abuse Treatment
- Center of Behavioral Health Statistics and Quality
History and Role of SAMHSA/CMHS (cont’d)

• SAMHSA leads efforts to advance mental health and to decrease the impact of substance abuse and mental illness on communities. Note how many references there have been to SAMHSA studies, resources, and policies.

• In this leadership role, SAMHSA established Strategic Initiatives as areas of highest priority to provide a platform for directing its resources and to shape national policy.
History and Role of SAMHSA/CMHS (cont’d)

• SAMHSA provides leadership in other areas:
  ➢ Collection and dissemination of research and program evaluation findings
  ➢ Publication of resource materials for states, communities, families, consumers, and providers
  ➢ Hosting national conferences to acquire and disseminate information
  ➢ Management of the block grant programs including creation of the block grant application guidance, review and approval of applications, and monitoring use of the block grants
  ➢ Provide technical assistance to improve care delivery
  ➢ Improve public awareness of mental illness
Role of State Project Officer (SPO)

• The State MHBG Project Officers are located in the Center for Mental Health Services and are responsible for the following:
  ➢ knowing the statutory and WebBGAS requirements and providing technical assistance and additional application guidance to state planners
  ➢ Linking state planners to resources for program development and evaluation
  ➢ Providing oversight and monitoring for the block grant
  ➢ Reviewing and approving the application and implementation report
  ➢ Managing fulfillment of technical assistance requests
Role of Block Grant Monitor

• Block grant monitors conduct site visits to states to determine compliance with the block grant requirements.
• The block grant monitors collaborate with the State Project Officers (SPO) before and after the site visit.
• The monitors develop written reports of the monitoring visits which highlight any statutory issues or need for technical assistance.
• The report also highlights innovative practices.
• The report is shared with the SPO and the State.
• As a result of their review, they make recommendations to the state for technical assistance, i.e., know resources that might help the state.
Role of State Planner

• Central to the block grant application and report process

• Manage the preparation process to submit approvable documents:
  - Know your SPO and ask for their advice
  - Know those responsible for financial, programmatic, and service data – who do you depend on to provide what and by when – create a timeline and politely ask for input by x
  - Know who signs the assurances and certifications and what time frame is needed to get them signed
  - Know deadlines for submission of the application and report
Role of State Planner (cont’d)

- Work with the Planning Council to establish priorities, goals, and measures – meet with them in time to incorporate their input – provide information from the Implementation Report to guide the discussion
- Coordinate with the Olmstead Plan and the PATH grant as well as any internal planning processes
- Request technical assistance through the Technical Assistance Tracker in coordination with SPO
- Get the application and report in on time and looking pretty – concise but comprehensive, tell your story
Role of Planning Council

• The Mental Health Planning Council is a statutory requirement. SAMHSA encourages a Behavioral Health Planning Council.
• They will be as valuable as you let them be – coffee and chatting versus engagement and respect
• Consider frequency of meetings and agenda – quarterly is about right
• Possible use of funds to support special projects selected by the Planning Council
• Provide input on block grant priorities, goals, and measures
• Required to review and comment on the plan – provide access to WebBGAS to view sections as completed
The End

Questions?

Thank you for your attention.

Please send questions and suggestions for improvement to david.miller@nasmhpd.org