

Detailed History of Mental Health

1773: The first hospital for the mentally ill in the US opened in Williamsburg, Virginia.

1840: There were only eight “asylums for the insane” in the United States. Dorothea Dix crusaded for the establishment or enlargement of 32 mental hospitals, and transfer of those with mental illness from almshouses and jails. First attempt to measure the extent of mental illness and mental retardation in the United States occurred with the U.S. Census of 1840, which included the category “insane and idiotic.”

1900: The “mental hygiene” movement began; Clifford Beers, a mental health consumer, who shocked readers with a graphic account of hospital conditions in his famous book, *The Mind that Found Itself*

Inspection of immigrants at Ellis Island included screening to detect the “mentally disturbed and retarded”. The high incidence of mental disorders among immigrants prompted public recognition of mental illness as a national health problem.

1930: The US Public Health Service (PHS) established the Narcotics Division, later named the Division of Mental Hygiene, bringing together research and treatment programs to combat drug addiction and study of the causes, prevalence, and means of preventing and treating nervous and mental disease.

1944: During World War II, severe shortages of professional mental health personnel and the understanding of the causes, treatment, and prevention of mental illness lagged behind other fields of medical science and public health. Dr. William Menninger, chief of Army neuropsychiatry, called for federal action. A national mental health program was proposed, forming the foundation of the National Mental Health Act of 1946.

1946: On July 3, President Truman signed the National Mental Health Act, creating for the first time in US history a significant amount of funding for psychiatric education and research and leading to the creation in 1949 of the National Institute of Mental Health (NIMH).

1947-51: Governor Luther Youngdahl started development of community-based mental health services and humane treatment for people in state institutions.

1949: Lithium was discovered to treat and reduce symptoms for people diagnosed with a bipolar disorder (Ann Palmer’s *20th Century History of the Treatment of Mental Illness*.) The FDA approved the drug in 1970.

1952: Chlorpromazine (Thorazine), one of the first psychotropic drugs, was discovered, greatly improving the condition of consumers with psychosis and delusion. In many cases, Thorazine alleviated symptoms of hallucinations, delusions, agitation and thought disorders.

1955: Congress authorized the Mental Health Study Act of 1955 and called for “an objective, thorough, nationwide analysis and reevaluation of the human and economic problems of mental

health.” The act provided the basis for the historic study conducted by the Joint Commission on Mental Illness and Health, *Action for Mental Health*.

1958: Governor Luther Youngdall (Minnesota legislation-humane treatment of MI)

1956: Congress appropriated \$12 million for research in the clinical and basic aspects of psychopharmacology and the Psychopharmacology Service Center was established. The number of consumers in mental hospitals began to decline reflecting the introduction of psychopharmacology in the treatment of mental illness. The Health Amendments Act authorized the support of community services for the mentally ill, such as halfway houses, daycare, and aftercare under Title V.

1961: *Action for Mental Health* was transmitted to Congress. It assessed mental health conditions and resources throughout the United States “to arrive at a national program that would approach adequacy in meeting the individual needs of the mentally ill people of America.”

1963: President Kennedy proposed and signed legislation that started community mental health center movement to substitute comprehensive community care for custodial institutional care.

1965: The CMHC (Community Mental Health Center) Act Amendments of 1965, (P.L. 91-211), were enacted and included the following major provisions: Construction and staffing grants to centers were extended and facilities that served those with alcohol and substance abuse disorders were made eligible to receive these grants. Grants were provided to support the initiation and development of mental health services in poverty-stricken areas. A new program of grants was established to support further development of children’s services.

1969: Minnesota Association of Community Mental Health Centers forms. Around that same time the MN legislation on CMCH's (245.62-245.69) was passed.

1975: Coverage of Ambulatory mental health services (outpatient) by private health plans – The CMCH Act Amendments of 1975 (P.L. 94-63) mandated a more detailed community mental health center definition emphasizing comprehensiveness and accessibility to all persons regardless of ability to pay, through the creation of a community governing board and quality assurance. Required core services expanded from the 1963 levels from 5 to 12, which included the following: Children Services Elderly Services Screening Services Follow-up Care Transitional Services Alcohol abuse Services Drug abuse Services.

1978: Medical Assistance (MA) added for community MH services (outpatient and day treatment).

1980: The Mental Health Systems Act, (P.L. 96-398), restructured the federal community mental health center program by strengthening the linkages between the federal, state, and local governments. The Act was the final result of a series of recommendations made by President Jimmy Carter’s Mental Health Commission. Per the Mental Health Systems Act, a litany of grant programs were mandated for the CMHCs to assist in expanding services to meet an array of priority populations. They included the following:

- An expansion grant for a wide range of services for the severely mentally ill (SMI) population;
- Grants for the severely emotionally disturbed (SED) population;
- Non-revenue producing services were also funded via a grant aimed at expanding education and consulting needs;
- Additionally, the commission sought to include consumer input and involvement in service and treatment.

1981-2: Federal Mental Health Systems Act repealed and replaced by the Alcohol, Drug Abuse and Mental Health (ADMS) Block Grant, and in 1982, ADMS block grant decreased by 30% resulting in dramatic service reductions. Despite passage of block grants, the federal share of funding decreased to 11% of the total while state and local funding share increased.

1985: By 1985, federal funds through the ADM block grant dropped to 11 percent of agency budgets. State funding grew substantially to 42 percent and local government sources increased to 13 percent Medicaid decreased slightly to 8 percent, Medicare remained at 2 percent, and patient fees had grown to 8 percent — double the amount from a decade earlier. (NCCMHCPprofile Data)

1986: Mental Health Planning Act of 1986 (Federal law requiring state plans) passed; Case management established as a distinct benefit under Medicaid; Medicaid amendments improve MH coverage of community MH services, add rehabilitative services, and expand clinical services to homeless.

1987: Medicare adds to outpatient mental health benefit but retains large patient copayments and cost sharing.

1987: Minnesota's Comprehensive Mental Health Act for adults passed, describing array of mandated services, authorizing MN Department of Human Services (DHS) as the state mental health (MH) authority and counties as local MH authority.

1988: The concept of behavioral health managed care evolved from theory to practice. Massachusetts was the first state that utilized a managed care platform regarding service of its behavioral healthcare needs. The state “carved out” mental health from physical healthcare and awarded the contract for management of the mental health benefits to a private company whose responsibilities included service authorization, utilization, quality management, a provider network, claims processing and interagency coordination. The managed care platform was based on efficiency and effectiveness, and sought to take advantage of emerging technologies. However, capturing the cost savings proved to be a difficult task as managed care programs spread throughout different states. Population disparities in the rural and urban areas, unfulfilled technological promises, decreasing social service budgets in the states, and erosion in the areas of access and quality had a lasting effect on managed care systems

1988: Prepaid Medical Assistance Demonstration projects started in Minnesota in Hennepin, Dakota and Itasca Counties. Mental health included in comprehensive benefits.

1988: State grants provided for Community Residential Treatment Facilities (Rule 36).

1989: Minnesota Comprehensive MH Act for Children passes (paralleled adult act); MH Coverage for outpatient mandated in private health plans if plan also covered inpatient care.

1990: MA coverage for services of independent psychologists and clinical social workers in Minnesota.

1990: Minnesota's Children's Health Plan includes limited MH benefits (limits were removed in 1992).

1991: Community Mental Health Centers authorized to provide partial hospitalization services under Medicare.

1993: MinnesotaCare legislation covers MH services.

1993: State closes Moose Lake Regional Treatment Center and makes region service changes.

1993 : The National Council for Community Mental Healthcare Centers changed its name to the National Community Mental Healthcare Council. The change was viewed as necessary since it excised the term "centers" and put more emphasis on the word "community" as the primary focus for providing a continuum of care.

1994: Minnesota statewide expansion of Prepaid Medical Assistance (PMAP) program authorized for all counties.

1994: Minnesota Child MH Collaboratives authorized.

1995: Minnesota one of first states to pass a comprehensive mental health and chemical dependency parity bill regulating private health plans.

1996: The Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) was enacted. HIPAA's intent was to protect health insurance coverage for workers and their families when they change or lose their jobs. It was recognized that this new protection would impose additional administrative burdens on both public and private healthcare providers, payers, and clearinghouses.

An additional purpose of HIPAA was to devise a strategy that would regulate administrative functions including claim forms, privacy, and security. To achieve these goals, the law includes a section called Administrative Simplification. This section of HIPAA is specifically designed to reduce the administrative burden associated with the transfer of health information between organizations, and more generally to increase the efficiency and cost-effectiveness of the United States healthcare system. An additional purpose of HIPAA was to accelerate the move from certain paper-based administrative and financial transactions to electronic transactions through the establishment of nationwide standards.

The Temporary Assistance for Needy Families (TANF) Act was created as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104 –193). The law contains strong work requirements, a performance bonus to reward states for moving welfare recipients into jobs, state maintenance of effort requirements, comprehensive child support, and supports for families moving from welfare to work, which includes increased funding for child care and guaranteed medical coverage.

The Social Security Administration terminated payments for Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) for persons listed as having a substance abuse disorder that is primary to their finding of disability.

Additionally, functional assessment procedures were created that provided for stricter medical listings imposed on children receiving SSI benefits.

1996 also saw the passage of the first parity law. The law prohibited insurers or plans serving 50 or more employees from setting lower annual or lifetime dollar caps on mental health benefits than for other health benefits. However, the legislation did not address many of the limits insurance plans frequently apply to the coverage of behavioral healthcare services. These restrictions include limits on the number of treatment visits, days of treatment, co-pays, and deductibles.

Temporary housing rental vouchers for people with SPMI funded, called Bridges.

1997: Congress passed the Balanced Budget Act of 1997 which achieved substantial reductions in federal spending by decreasing funds allotted to both Medicaid and Medicare through a five year restructuring that saved \$130 billion over five years.

The federal government expanded health coverage through the State Children’s Health Insurance Program (SCHIP), which seeks to provide healthcare for uninsured minors. SCHIP marked the first time that mental health services were *mandated* by a federal entity and administered by the states.

However, severe cuts were made in programs that affected our members. The federal Social Services Block Grant (SSBG) was created in 1975 and provides assistance to states that enables them to furnish services directed at self-sufficiency, abuse prevention, abuse remediation, delivery of community based care, and securing institutional based care when it is deemed appropriate.

The SSBG was cut under the Balanced Budget Act (BBA), from over \$2 billion to \$1.7 billion in FY 2002.

Medicaid also encountered decreases in funding given the BBA.

Ten billion dollars were slashed from the program as a result of the cutbacks. In addition, the Medicaid Disproportionate Share (DSH) payments were also affected. DSH payments were created in 1982 and used as a vehicle to adjust payments to hospitals for the higher operating

costs they incur in treating a large share of low-income patients. The BBA reduced DSH payments by 5 percent, with the reduction to be implemented in one percentage point increments between fiscal years 1998 and 2002. The BBA cut DSH payments by \$10 billion (a figure which is included in the overall \$13 billion decrease in the Medicaid program) and set a large restriction on the amount of DSH dollars that states could transfer to their inpatient facilities.

Furthermore, the BBA mandated that states enroll beneficiaries into managed care programs through HCFA's 1915(b) waiver program. 1915(b) waivers seek to utilize cost savings to provide additional services within the Medicaid program. If the state saves money using the managed care option under the 1915(b) waiver, then it can provide an enhanced package of additional services for Medicaid beneficiaries

Also in 1997, the National Community Mental Healthcare Council changed its name once again to reflect our evolving membership base. The National Council for Community Behavioral Healthcare was chosen to recognize the efforts of many of our members who provide services aimed at treating addictive disorders

Medical Necessity for mental health defined in Minnesota statute.

Prescription privileges for mental health clinical nurse specialists, with special training

1998: First Prepaid MA program in Hennepin, Dakota and Itaska Counties

1999: The Supreme Court issues its opinion on *Olmstead v. L.C* which held that it is a violation of the Americans with Disabilities Act to keep individuals in restrictive inpatient settings when more appropriate community services are available.

The National Council for Community Behavioral Healthcare helped to secure passage of the Ticket to Work and Work Incentives Improvement Act (TWWIIA, P.L. 106-170). TWWIIA removed many of the disincentives that faced people with disabilities receiving SSI or SSDI benefits but wished to return to full-time employment. In the event of a reoccurrence of an acute episode, the law includes presumed eligibility for immediate continuation of SSI or SSDI cash payments.

The Clinton White House held a conference on mental health issues in June 1999 that focused on dispelling the myths about mental illness and decrying prejudices against behavioral health consumers, one of which was insurance coverage that excludes behavioral health services. The conference also brought together the mental health community in anticipation of the Surgeon General's Report

Mental Health: A Report of the Surgeon General was published in late 1999 and sought to eradicate the stigma surrounding mental health and simultaneously encourage the use of innovative pharmaceutical and psychotherapy treatments

2000: By the dawn of the 21st Century, behavioral health providers' revenue streams were of a much different nature than when they began nearly 40 years before. A key example of this has

been the funding provided under the Medicaid program, which currently accounts for 80 percent of the average revenue stream. This is in sharp contrast to the levels seen in the late 1980s, where Medicaid funding accounted for only 16 percent of the average revenue stream

In October 2000, President Clinton signed the Children's Health Act (P. L.106-310) into law. The law establishes national standards that restrict the use of seclusion and restraint in all psychiatric facilities that receive federal funds and in "non-medical community-based facilities for children and youth." The act also mandated that a report be submitted to Congress on co-occurring disorders

Minnesota Attorney General sues BlueCross/BlueShield Minnesota; parties agree to settlement aiming to improve/reform MH system.

2001: Minnesota advocates proposed Mental Health Act of 2001. Due to that effort, additional MH services and funding were added or expanded for adults and children.

In August 2001, the Department of Health and Human Services provided guidance to states on Medicaid 1115 demonstration waivers that allowed them to expand the program to include uninsured individuals by incorporating unspent SCHIP block grant funds through a new demonstration initiative: The Health Insurance Flexibility and Accountability (HIFA) Waiver. Chief among the National Council's concerns, is the role that behavioral health consumers play as the waivers are comprised in each state. There is concern that these stakeholders are being removed from the process, and as a result, optional benefits and the populations receiving them could be eliminated. Furthermore, HIFA waivers could facilitate an increase in cost sharing among beneficiaries

2002: An in-depth study on co-occurring disorders, mandated under the Children's Health Act of 2000, was delivered to Congress.

The National Council for Community Behavioral Healthcare, along with several coalition partners, played a prominent role in the writing of this report.

President Bush increased funding for Community Health Centers that provided appropriations for the construction of additional centers and offered more services, including behavioral healthcare benefits

President Bush forms the New Freedom Commission on Mental Health, which will seek "to conduct a comprehensive study of the United States mental health service delivery system, including both private and public sector providers." The Commission is charged with a set of objectives that includes reviewing the current quality and effectiveness of private and public providers, identifying innovative services, treatments, technologies, and issuing a report on its subsequent recommendations.

Minnesota State Legislature approves copays and adjusts GAMC eligibility, decreasing eligible populations.

2003: President Bush's New Freedom Commission on Mental Health issued final report, "to conduct a comprehensive study of the United States mental health service delivery system, including both private and public sector providers." Objectives include reviewing the quality and effectiveness of private and public providers, identifying innovative services, treatments, technologies, and report on its subsequent recommendations.

Facing 4.5 billion dollar deficit, MN State Legislature approves copays, adjusts GAMC eligibility, and decreases eligible populations, creating a direct impact on the MH system.

The MH Action Group is created to recommend strategies to improve and reform the Minnesota MH system across both private and public sectors.