

Brief History of Community Mental Health Centers in Indiana

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Historical Context

Confinement of persons suffering from mental illness prior to 1800 in the United States was a rare exception rather than the rule. Care of these persons was viewed as a family responsibility. After 1800, however, new circumstances led to reliance on some form of institutional care for the mentally ill. In 1820, only one State Hospital for the mentally ill existed in the United States. By the Civil War, virtually every State had established one or more public institutions for that purpose. This change was the result of complex demographic, social, religious and philosophical factors and reflected, paradoxically, an extraordinarily optimistic view of the nature and prognosis of mental illness. At the time, mental hospitals were viewed as environments where medical, moral and occupational treatment could break the link with the defective environment that had given rise to the disease. In general, patients stayed in mental hospitals from three to nine months.

The prevailing view at the time was that a hospital of 200 beds could serve a total of 600 patients throughout the course of a year. Until the last decade of the 19th century, the proportion of long-term chronic mentally ill patients in State Hospitals was relatively low. This was due in part to the method of financing institutional care. Although the States were responsible for providing capital to build and equip State Hospitals, local government was responsible for paying a per diem to cover the cost of custodial and treatment services.

For much of the 19th century, a significant proportion of persons considered to be insane were maintained in municipal almshouses. During the latter half of the 19th century, there was much public debate about the divided system of responsibility wherein individuals with chronic mental illness were consigned to local almshouses while patients considered “curable” were treated in State Hospitals.

During the first half of the 20th century, the character of State Hospitals underwent a dramatic transformation. Short-term cases fell and long-term cases increased. What occurred was not a deinstitutionalization movement, but rather a lateral transfer of patients from local institutions to State institutions. States adopted legislation that relieved local communities of responsibility for the mentally ill. Although the intent of State care acts was to ensure that the mentally ill would receive a higher quality of care and treatment, the consequences turned out to be quite different as local officials saw a golden opportunity to shift some of their financial obligations onto the State.

State hospital populations peaked in the 1950's. As State hospital populations grew and the characteristics of the population tended toward greater chronicity, the challenge of providing therapeutic environments became extremely difficult. In the immediate post-war years, journalists and mental health professionals published numerous critical accounts of mental hospitals. A decade and a half of financial neglect due to the combined impact of the Great Depression of the 1930s and the global conflict of the 1940's exacerbated already existing severe problems. Mental hospitals that had been the cornerstone of public policy began to lose their social and medical legitimacy.

“After World War II, the prevailing consensus on mental health policy began to dissolve. A number of developments converged to reshape public policy during those years. First, psychiatric thinking shifted toward a psychodynamic and psychoanalytic model emphasizing life experiences and socio-environmental factors. Second, the experiences of WW II appeared to demonstrate the efficacy of community and outpatient treatment of disturbed persons. Third, the belief that early intervention in the community would be effective in preventing subsequent hospitalization became popular. Fourth, a faith developed that psychiatry could promote prevention by ameliorating social problems that allegedly fostered mental diseases. Fifth, the introduction of psychological and somatic therapies (including, but not limited to, psychotropic drugs) held out the promise of a more normal existence for patients outside of mental institutions. Finally, an enhanced social welfare role of the federal government not only began to diminish the authority of state governments, but also hastened the transition from an institutionally-based to a community-oriented policy.” (Gerald N Grob, Ph.D.)

In 1955, President Eisenhower appointed the Joint Commission on Mental Illness and Health. The publication of its influential ***Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health*** in 1961 set the stage for passage of the Community Mental Health Centers Act of 1963 during the administration of John F. Kennedy.

Community Mental Health Center Development in Indiana

As a result of the Community Mental Health Centers Act of 1963, the States were provided the opportunity to develop a State plan for community mental health and to obtain federal grants to establish a system of community mental health centers. There were some strings attached to the offer of financial assistance. It was the intention of the federal government that there would be a community mental health center to serve each catchment area having a population of at least 75,000 and not more than 250,000 citizens. Also, in order to receive a grant to establish a community mental health center, the grant application had to describe a system of services consisting of “five essential services”: inpatient hospitalization, partial hospitalization, outpatient, 24/7 emergency services and Consultation/Education services.

Early on, Indiana chose to follow the federal model for development of community mental health centers. The Indiana Department of Mental Health in collaboration with local communities and the Mental Health Association set up a statewide planning process

to develop a state plan for community mental health services. Local communities were empowered to establish locally governed not-for-profit corporations. These corporations would initially start mental health outpatient clinics. Later, they would submit grant applications to the U.S. Department of Health, Education and Welfare in order to be designated as full-fledged community mental health centers offering the five essential services to a designated catchment area. The geographic size of the cmhc's catchment area depended on population density. Thus, in urban areas a typical CMHC would serve a part of a county (e.g. Lake County), a whole county (e.g. St. Joseph County), a whole county and part of another county (e.g. Marion and surrounding counties) while in rural areas, a CMHC would serve multiple counties.

In order to provide coverage of the entire state population and meet federal requirements, a minimum of 30 CMHCs were required. The first, Midtown Community Mental Health Center opened its doors in 1969 at Marion County General Hospital, later named Wishard Memorial Hospital. Midtown provided services to largely urban and inner city neighborhoods. Twenty-nine additional community mental health centers would be developed around the State of Indiana during the next decade and a half.

The development of CMHCs in Indiana was facilitated by the passage in 1971 by the Indiana General Assembly of the statute governing community mental health centers (originally IC 16-16-1) that established the so-called deficit financing methodology by which CMHCs would be financed throughout the 1970s and 1980s until the introduction of the Hoosier Assurance Plan by the Bayh administration in the 1990s. IC 16-16-1 required that each county provide financial support to the CMHC designated to serve that county's population in an amount equivalent to four cents for each \$100 of assessed property valuation. The statute provided that the Department of Mental Health would review and approve the operating budget of each CMHC and, after accounting for the required county funding, federal grants and service revenue, would contract with the CMHC for the amount of the operating deficit utilizing funds appropriated by the Indiana General Assembly for that purpose.

Although the deficit financing methodology had its shortcomings, it was providential for the time because it allowed start-up funds to be moved from one CMHC to another, thereby facilitating the fairly rapid development of the statewide system without gigantic increases in funding from the General Assembly that might have been resisted.

Throughout the decades of the 1970s and 1980s, Indiana relied on the federal government to set policy for the governance of CMHCs. The Department of Mental Health focused its energies on the operation of State Hospitals. One might say that the CMHCs suffered from benign neglect.

Jimmy Carter became President of the United States in January 1977. He appointed a blue ribbon commission to review progress that had been made in development of community based mental health services. Rosalyn Carter was a strong mental health advocate and served on the commission. Among the issues taken up by the commission was the problem of homelessness that had developed and was manifested by large

numbers of street people in urban centers throughout the country. Research into the causes of homelessness revealed that significant numbers of the homeless were individuals who had a history of mental illness, many of whom had been previously institutionalized.

Many critics blamed the community mental health centers for not serving the deinstitutionalized population. Deinstitutionalization had resulted from a host of factors, not the least of which was the effort of State policy makers to control the cost of institutional care. It was less costly to the State to enrich the staffing ratio of the institutions by reducing the population than by increasing funding to hire additional staff. Compounding the problems was the failure of planners to design a new mental health system that would encompass the needs of the institutionalized population as well as the needs of individuals in the community needing mental health services.

The Carter Commission recommended a substantial expansion of services provided by CMHCs. In addition to the original five essential services, the Mental Health Systems Act that resulted from the Commission's recommendations would require an additional seven services. These were: Child and Adolescent Services, Services to the Elderly, Alcoholism Services, Drug Abuse Services, Rape Crisis Services, Screening Services and Residential Services. The last two were particularly directed toward the seriously mentally ill who were historically institutionalized. Screening services meant that individuals should be evaluated at the local CMHC before being sent to a State Hospital. Residential Services were aimed at seriously mentally ill clients who need support in the form of affordable housing in order to avoid homelessness.

The Tipping Point: From Institutional System to Community System

In 1981 a major cultural shift occurred in mental health services in Indiana when newly elected Governor Orr appointed the first non-physician to serve as Commissioner of Mental Health. Dennis Jones, MSW, MBA was also the first Commissioner to have come up through the community mental health center system. He had previously served on the staff of Midtown Community Mental Health Center and had served as the first Executive Director of the Indiana Council of Community Mental Health Centers, Inc.

Another milestone was passed during the Orr administration when funds were appropriated by the Indiana General Assembly for community residential services to serve seriously mentally ill clients in the community. A portion of the funding for community residential services was actually transferred from the budgets of the State Hospitals' family care programs.

Also in 1981, Ronald Reagan became President of the United States. His administration had a very different view of the role of the federal government in the maintenance of mental health services than that of the Carter administration. During the Reagan years, the role of the National Institute of Mental Health was redefined to be primarily research and evaluation. Funding systems were radically changed. Grants that had heretofore been provided by the federal government directly to local community

mental health centers were rolled up into the Alcohol, Drug Abuse and Mental Health Block Grant and given to the States to administer.

Although the federal government maintained strings on the block grants to ensure that changes made during the Carter administration would not be totally lost and to ensure that the States would report data to the federal government, the policy-making role played by the federal government since the 1960s was largely turned over to the various States. This was another major change for Indiana, a State that had relied almost totally on the federal government to lay out the ground rules for the operation of community mental health centers and had also relied on the federal government funding of community mental health initiatives.

The policy changes initiated by the Carter administration combined with the creation of the community residential program in Indiana and the ongoing negative publicity regarding homeless mentally ill persons on the streets of large cities shifted the focus of community mental health center program development irrevocably away from what many policy makers referred to as the “worried well” toward community support services for the seriously mentally ill.

Major Policy Development in the 1990s

Major changes in the mental health delivery system occurred during the Bayh administration. Mental Health was incorporated into the Family and Social Services Agency and re-named the Division of Mental Health and Addictions (DMHA). Responsibility for the Developmental Disabilities Services was separated from mental health and incorporated into the Division of Aging and Rehabilitation Services. A process was started that ultimately resulted in the closure of several State institutions. Major policy development was initiated by DMHA that spawned legislation to repeal the Deficit Financing statute and replace it with the Hoosier Assurance Plan.

Also during the Bayh administration, an effort by CMHCs to obtain increased funding for community support services for the seriously mentally ill resulted in agreement by the administration to seek a change to the State Medicaid Plan that would allow funding of Mental Health Rehabilitation services (MRO). This agreement was reached with the condition that implementation of MRO services would be budget neutral for the State of Indiana. In other words, funds previously appropriated by the Indiana General Assembly for the provision of community mental health services (originally deficit financing dollars and later Hoosier Assurance plan dollars) would be used to leverage federal financial participation (FFP) without any additional appropriation of matching funds by the Indiana General Assembly.

It is impossible to overstate the importance of this agreement on the future delivery of mental health services in Indiana. It set the course whereby mental health appropriations would be gradually but relentlessly absorbed into the Medicaid match eventually making mental health services primarily dependent upon Medicaid revenues and subordinating mental health policy to Medicaid policy.

HAP

The Hoosier Assurance Plan states that a citizen of the State of Indiana whose total family income is at or below 200% of federal poverty level, who has a diagnosable mental illness or addiction disorder of significant duration that impairs his/her ability to function in major life areas is eligible to receive subsidized services from a certified Hoosier Assurance Plan provider. In addition to being required to be certified, DMHA says to providers that they must provide a 10 point continuum of care based upon the needs of the client (individualized treatment plan, acute stabilization, day treatment, outpatient, 24/7 emergency services, case management, medication management, residential, family support and services to prevent unnecessary hospitalization), conduct a standardized assessment of the client, and agree to care for the client for the duration of the fiscal year of enrollment. In return, DMHA provides a differential case rate payment to the provider.

The major impact of the Hoosier Assurance Plan on CMHCs has been to focus providers on enrolling clients who are seriously disabled and whose annual family income is at or below the 200% FPL threshold. Under the prior deficit financing methodology, the State was able to exercise little or no control over to whom services were provided.

MRO

The major impacts of the Medicaid Rehabilitation Option funding have been threefold. First, it has further focused the provider system on that subset of the population that is Medicaid eligible. Second, because MRO is flexible with respect to the credentials of staff persons who provide services (on condition that the services are certified as medically necessary, provided in accordance with an approved comprehensive treatment plan and supervised by a Qualified Mental Health Professional), it is possible to deliver a diversity of wrap-around services that assist clients to live independently in the community with a minimum amount of inpatient services and to improve clients' compliance with psychiatrists' orders. Third, as the focus of CMHC services has shifted incrementally toward seriously disabled clients, a preponderance of CMHC services is funded by MRO, thus subordinating DMHA policy and financial support to the Medicaid program.

This, in turn, has created a precarious situation for CMHCs. Since the MRO program is substantially financed by federal Medicaid dollars, policy changes at the federal level, in an increasingly restrictive fiscal environment, may be incompatible with the program development that has occurred in Indiana during the last decade. If MRO were to be significantly cutback or withdrawn, the impact on CMHC services would be extensive and possibly catastrophic.