Change Is Constant

Community Mental Health Past, Present and Future

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The great Jewish mathematician, Benoit Mandelbrot is known as the father of fractal geometry for his discovery of the natural phenomenon in which nature often displays the same pattern at different levels of magnitude. Although he and others typically applied his principle to economics and physics, it might equally be applied to the formation of community mental health. F·E·G·S has emerged as a significant provider of community mental health in synchrony with the pattern of "reforms" that marks the changes in the broader field. One factor enabling it to be such a major provider has been its willingness to embrace change and anticipate new models of care and undertakings on behalf of its client constituency. Another factor has been the infrastructure of core supports that mitigate risk and support calculated changes in response to community needs and emerging opportunities.

CHANGES KEEP ON COMING

Historians of community mental health often refer to four periods of reform that shaped the array of services that we are familiar with today (Goldman et al., 1983; Grob, 1987): moral treatment (1800–1850), mental hygiene (1890–1920), community mental health (1955–1970), and community support (1975–present). On a positive note, each generation of reformers introduced new sensitivity to the treatment and care of the mentally ill, along with the newly promoted service model. At the same time, each generation of reform brought new means of government funding that shaped the institutions and the providers who delivered care.

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Most argue that we are now, one decade into the 21st century, on the cusp of a fifth reform, rooted in integrated health and mental health and pressured by shrinking support for health care expenditures. The goals for this generation of reformers are to engage clients in their pursuit of more effective recovery, to promote greater self-sufficiency, to prove that there are measurable outcomes in community mental health, and to accomplish all this with a more efficient and less costly system of customized services.

These goals have marked F·E·G·S for its entire history. As a "fractal" F·E·G·S has reflected the need for new approaches and has been a willing agent of change in adjusting to changing consumer and community demands, always within the parameters of our Jewish traditions and values. The Rambam (Moses Maimonides, 1135–1204), the great Jewish rabbi, physician, and philosopher, is often quoted

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for his statement that there are eight levels of charity, each greater than the next. The greatest level is to endow others with a gift or loan, or enter into a partnership or find employment for them to strengthen their hand until they need no longer be dependent on others.

With its roots in the Jewish tradition of *tzedakah*, F·E·G·S has implemented new opportunities offered by government funders that help people achieve greater self-sufficiency. On many occasions, these services were new demonstrations or untried service models. Other services were housed in agencies that were in financial difficulty and needed to reorganize under an umbrella agency.

The past is the foundation for future changes. Building on its values for helping others and on its strong central infrastructure of finance and technology, F·E·G·S was positioned to take calculated risks in organizing new programs and considering mergers. Moreover, its willingness to be shaped by the forces of change at the national and state levels gave F·E·G·S the incentive to apply for new RFPs and develop innovative program models. By tracking the history of the national and state changes, we gain perspective on the agency's growth in mental health service. We also obtain a strategic view of the changes that mark the future of community mental health both nationally and for F·E·G·S.

Historically, each wave of mental health reformers was inspired to reorganize and add services for persons with mental illness. The 19th century introduced more humane, restorative, "moral treatment" by establishing state-run asylums to protect and serve the mentally ill who were homeless and abused. The second reform saw the introduction of mental hospitals and outpatient clinics that marked the period of "mental hygiene" reform from the 1880s to the 1920s; during this time a medical and scientific orientation in working with the mentally ill was also introduced. The "community mental health" reform of the third period was driven by the introduction of psychotropic medications, rehabilitation, and community-based programs from 1955–1970. During this period, F·E·G·S became active in helping psychiatric centers and institutions for the developmentally disabled treat people in community-based day programs. As state hospitals were further deinstitutionalized in the 1980s, the fourth period of reform introduced advances in psychiatric rehabilitation that are still in progress. F·E·G·S became one of the first community providers to win licenses to operate psychiatric rehabilitation programs in the community and return individuals to school, jobs, and independent housing. During the last three decades mainstream community supports were introduced in the forms of employment and housing services targeted for persons recovering from mental illness, and F·E·G·S expanded its programs for housing and employment in accordance with these new funding streams from both state and local governments (see Table 1 for a history of community mental health care).

The words of Maimonides are apparent in these reform efforts, which have been built on partnering with consumers to reduce their reliance on services and public charity by increasing their self-sufficiency.

F·E·G·S: A FOUNDATION OF HEALTH AND MENTAL HEALTH SERVICES

In its 25 years of providing community mental health, F·E·G·S has established a broad array of related services to support persons with mental illness and help

them achieve their individual goals while providing them with the highest standards of treatment and care.

Each year the agency's extensive network of behavioral health outpatient services reaches more than 19,000 individuals at locations across New York City and Nassau and Suffolk counties on Long Island. This array of services is supported through a broad base of government licenses for insurance-based treatment and state and local government contracts. F·E·G·S operates 15 New York State Office of Mental Health (NYSOMH) licensed outpatient clinics or counseling centers. Until 2008, it had also operated 10 day and rehabilitation programs, but in the past two years, F·E·G·S was among the first community providers to work with the NYSOMH in converting almost all these day and rehabilitation programs into five Personalized Recovery Oriented Services (PROS) programs for people with long-term mental illnesses. This new licensed program is geared to achieving more ambitious outcomes like jobs, school, less restrictive housing, and self-sufficiency. Medicaid funds six case management services programs that are designed to help the most difficult mentally ill clients manage their clinical prescriptions and remain stable in the community. Most recently, these case management programs have adopted an integrated approach to promote health education, wellness training, and improved holistic care as well.

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F·E·G·S also provides specialized family services to help people deal with a broad array of needs, especially in the Jewish community but also in the general community; these services are designed for victims of domestic violence, survivors of breast cancer and their families, individuals with HIV/AIDS, and end-of-life hospice care. Professional staff members provide screening, evaluation, and counseling and medication therapies, individually tailoring the treatment to meet the needs of the individual where medical necessity exists. F·E·G·S uses evidence-based best practices and adheres to the values of strength-based treatment in which the client and family members are partners with the staff.

Table 1.

A Brief history of Community Mental Health Care

1773 - Williamsburg, VA opened the first asylum.

1840 - US Census begin first count of persons with MI & MR.
Dorothea Dix convinced governments to build asylums.

1900 - Mental Hygiene was moved by shocking first-person book, *The Mind that Found Itself,* by Clifford Bears.

1946 - President Harry Truman signed the National MH Act.

1952 - Thorazine, one of the first psychotropic drugs, revolutionized medical care and triggered deinstitutionalizations. Around this time, NY State had over 105,000 patients in State Psychiatric Centers (now there are around 4,000).

1965 - President John F. Kennedy signed legislation for Community MH Centers.

1977 - NIMH funded community support services with a rehabilitative orientation.

1978 - Medicaid began to cover community mental health outpatient services.

1980 - President Jimmy Carter funded Specialized Community Services for the severely mentally ill.

1986/7 Case management was established as a benefit under Medicaid.

1988 - States funded community residences for the mentally ill.

1996 - HIPAA promoted privacy and computerization via national standards.

1997 - Balanced Budget Act redefined allowable services with expanding coverage.

2003 - President George W. Bush's New Freedom Commission of Mental Health criticized institutional and community services as "fragmented."

In addition, since 1988 F·E·G·S has provided recovery-oriented housing services to more than 4,000 consumers recovering from serious and persistent mental illness, as well as individuals with a history of homelessness and/or substance abuse, who are deaf or deaf-blind, who are HIV-positive, and who have a criminal history. During this 22-year history, community housing for people with mental illness has evolved from the initial notion of living in community residences with 24-hour staffing as the "last stop" after lengthy institutionalization to living in independent apartments with support services such as case management, socialization, and job training. Principles such as self-determination, choice, and health and wellness are at the core of housing programs. For fiscal year 2009, F·E·G·S provided housing and rehabilitation services to more than 980 individuals in a range of community residences, single-room occupancies, specialized apartment treatment beds, and mainstream apartments.

F·E·G·S also provides services in a New York City homeless shelter, transitioning homeless men with serious mental illness to supportive housing.

PREPARING FOR THE FUTURE: A FIFTH REFORM OF TRANSFORMATION

Today's mental health system is often criticized as fragmented, with insufficient coordination between hospitals, residences, and outpatient programs. The system's complex and multiple layers are the result of successive stages of health care reforms, disjointed financial incentives by government, disorganized funding structures, idiosyncratic state ideologies. and a history of competing agendas among providers, hospitals, community members, and advocates.

Many people today believe that too much tax money is being spent on Medicaid to care for the mentally ill in institutional settings such as hospitals, emergency rooms, adult homes, jails, and even community residences. Moreover, the mentally ill are still not achieving standards of "health" despite all this funding; recent findings indicate that despite today's complex services this population tends to have a shortened lifespan by 25 years. These problems were underscored in the 1999 Report by the President's New Freedom Commission on Mental Health chaired by Dr. Michael Hogan, the present Commissioner for the New York State Office of Mental Health (NYSOMH). This report also introduced some of the contemporary principles for the transformation of the community mental health system.

Recent changes in government regulation reflect a new emphasis on less expensive and more effective community care and the goal of reduced rehospitalizations. There is also a strong pressure toward integrating behavioral and health services to promote a more holistic and medically based approach. We also see demands to develop improved systems of care that are rooted in research and proven best practices with an emphasis on clear outcomes of employment, or at least greater self-sufficiency accompanied by reduced use of government resources. It is of interest that these new directions are consistent with Maimonides' description of the highest level of charity.

Certainly, national health care reform is serving to accelerate changes already underway in community mental health. As a major provider of community services, F·E·G·S has often anticipated and tried to shape the new agenda and

even to get ahead of the changes in the field. This section summarizes national and state initiatives in community mental health.

Integrated Health and Mental Health Service

An emerging policy issue is whether community providers can spearhead specialty services for the chronically mentally ill. This approach requires partnerships among a range of providers, a theme that has been central to F·E·G·S' work for decades. We already are providers of choice when we coordinate the care for the chronic mentally ill through Medicaid-reimbursed case management services. For example, in 2009, F·E·G·S partnered with the Nassau University Medical Center and a managed care organization on a three-year state grant to establish Specialized Medical Homes for 250 "heavy-use" patients; the goal is to determine whether expert care coordination can reduce the overall cost of service and improve health outcomes.

Along the same vein, F·E·G·S has long partnered with community health agencies to co-locate behavioral and health programs to serve long-term populations and achieve better health outcomes.

Best Practices

Much of the research on serving the mentally ill has been based on middle-class populations in hospital-centered settings, usually not in the inner cities of America. For 20 years, F·E·G·S has cosponsored professional conferences to share expertise across providers, most recently in the areas of cognitive remediation, the dual diagnoses of developmental disabilities and mental illness, the comorbidity of substance abuse and mental illness, specialized housing models, dialectic behavioral therapy, forensic service strategies, and peer specialists as an emerging workforce. In partnerships with universities and medical schools, F·E·G·S has promoted research on advances in treating the mentally ill, such as cognitive remediation. Most recently, F·E·G·S has forged a partnership with the Columbia University School of Social Work to promote applied research around practice issues. F·E·G·S also joined forces with other providers in founding the Urban Institute for Behavioral Health (UIBH) to develop a learning collaboration and to adapt best practices for the types of setting encountered by New Yorkers. Numerous foundation grants have sustained the efforts at applied research. One practical outcome has been training residential staff and case managers to take more responsibility for both the health and behavioral needs of their challenging clients.

Technology in Mental Health Networks

The Obama administration is promoting the use of technology to reduce the cost of health care, and through state financial incentives to promote the computerization of electronic medical records, local health care networks are creating Regional Health Information Organizations (RHIOs). Their objective is to coordinate service, reduce unnecessary laboratory tests, promote medication adherence and wellness, and lower health care costs. These networks exchange patient information (always with their consents) to improve health coordination. The networks are usually centered on local hospitals and the community programs that both refer to and receive referrals from inpatient care.

In a pioneering project, F·E·G·S is partnering with Maimonides Medical Center and other providers in Brooklyn and Queens to become part of a Regional Health Information Organization (RHIO). It is moving toward the use of shared information by establishing protocols for better coordination of care across regional providers. As of this writing, F·E·G·S has joined two other RHIOs in the Bronx and Long Island.

Supporting Change: Central Infrastructure as a Paradigm

A strong central infrastructure permits management to concentrate on adapting to changing expectations while staff focuses on their work with the consumer and on service outcomes. In his article in this issue Ira Machowsky writes about the vital role that infrastructure plays in supporting an agency's growth. The growth and change in community mental health provide a concrete example of the leverage made possible via strong central infrastructure services.

AllSector Technology and Specialized Applications Software

F·E·G·S' growth has been fueled by 14 mergers or acquisitions, which have been made possible by adopting a uniform set of billing algorithms for the complex and demanding insurance rules dominating Medicare, Medicaid, and health insurance. Moreover, adapting to changes in billing rules requires the constant efforts of a project management team to assure that reimbursement continues to flow in a steady stream. Finally, joining a RHIO means a willingness to exchange information with other providers. All these adaptations require a degree of technological savvy and problem solving that would challenge the most sophisticated agency. There is an obvious economy in scale in working with a specialized company that serves multiple agencies in addressing information exchanges.

Human Resources Dynamics

Each year sees new rules promulgated by government agencies about the types of staff who can deliver each type of service, the plethora of fingerprinting and credential checks needed, and the extensive reporting required for public transparency and accountability. As we see a shift in the locus of care for the chronically ill to community providers, the next step is to emulate the types of credentialing functions previously only seen in hospitals. Selecting and managing the credentialing and employee tracking software are daunting tasks, and central infrastructure reduces the load and cost for each program.

Corporate Compliance, Quality Assurance, and Utilization Review

In this era of the Fifth Reform, government is increasingly stringent that every service is efficient and necessary, as a means not only of preventing fraud but also of wringing out efficiencies. The new premise is that the provider must prove the integrity of its service; that is, a presumption of guilt unless efforts are made to establish innocence. Various arms of government pursue the recoupment funds for any slip in billing, for every oversight or departure from accounting protocols. Consequently, providers are encouraged to prepare sophisticated corporate compliance procedures to reduce any staff irregularities. Agencies need to develop an aggressive program of integrity training and self-examination through internal audits to self-police the services provided by their staff. Furthermore, central quality assurance and utilization review are conducted for all billing procedures not only to satisfy government requirements but also to improve on the

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clarity of every aspect of billing. Once again centralized quality control proves that "the best defense is a strong offense."

One avenue to address the growing need for corporate compliance is the local trade association or professional organization. As both a learning community and a coalition of providers, there are advantages to that association to adopt standards as a group and to present a common front on best practices. To this end, F·E·G·S has often encouraged its executives to take leadership roles in coalitions and trade associations. It provides information that allows agencies to stay up-to-date on emerging policy and program issues, but also offers the opportunity to shape government policy through an active dialogue.

CONCLUSION

There is a confluence of values and economic priorities facing community mental health today. Unfortunately, in some states, the harsh economic climates are such that budget reductions threaten the capacity to deliver basic services, much less to improve services. However, in most other states like New York, there are more moderate pressures that are likely to contribute to the new economy and that can be shaped to focus on better outcomes for the persons we serve. In partnership with government, it is incumbent on social service leaders to help prove the advantages of desirable changes both for the consumers and the fiscal viability of the local services that form the community safety net. A clear mandate that is shared by social service providers and government social engineers is to help persons with disabilities lead more economically productive and self-sufficient lives. We are appreciative of the value of *tzedakah* that represents the generosity and philanthropic backbone of our community. At the same time, we should underscore that aspect of *tzedakah* that cherishes a partnership with the needy leading to self-sufficiency. Working with government, we might better influence the next generation of community mental health services that emerge from this challenging period in history.

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