

Transforming New Jersey's Mental  
Health System:  
"New wine in old skins" or "Being the  
change you wish to see"

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Recovery is cited in *Transforming Mental Health Care in America, Federal Action Agenda* as:

The **single most important goal** for the mental health service delivery system.

# Recovery

- "A deeply personal, unique process of changing one's attitudes, values, feelings, and goals, skills, or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by mental illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (Anthony, 1993)

## Components of Recovery



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# Wellness

- A wellness lifestyle can lead to positive outcomes that can be measured in terms of improved health status, greater productivity, enhanced social relationships, and participation in purposeful activity- all which provide meaningful opportunities for healing, personal growth and improved quality of life. (Swarbrick, 1997, 2006)

# Wellness includes 7 Dimensions

 Spiritual

 Physical

 Emotional-Mental

 Occupation

 Social

 Environment

 Intellectual

# Transformation Statement

- Based upon the growing body of research and knowledge in the recovery field, as well as first hand accounts from people recovering from mental illness, ...people with mental illness can achieve wellness and recovery. ...consumers of mental health services are able to identify and articulate their individual service and support needs. A strong, responsive system can recognize and meet the varying needs of people as they experience the recovery process...it is the Division's policy to ensure that consumers and families receive a system of recovery-oriented services and resources that promote wellness, an improved quality of life and true community inclusion.
- - Kevin Martone, Assistant Commissioner February 10, 2006

# What will keep our system from transforming?

- Inadequate system for managing people in acute stages of their illness, actively psychotic, systems resources are devoted to trying to manage a very flawed approach.
- Emphasis on involuntary treatment approaches: screening, inpatient commitment and calls for expanding to outpatient commitment without adequate resources added
- The extent of the needs:
  - The economic dependence, poverty of persons with mental illness.
  - The poor overall health of persons with mental illness

# What will keep our system from transforming?

- Poorly trained and poorly paid community mental health staff
- Competing priorities for government resources
- Inertia of individuals, organizations, and systems
  - Keeps things the way they are
  - Makes it hard to collaborate across units of government and organizations

# Hopelessness and The Clinician's Illusion

(Cohen & Cohen, 1984)

- Most of our staff see individual's when they are in crisis and in the acute stages of their illness.
- They rarely see successes but usually see decompensation and what they might call 'failure.'
- This pattern often builds a sense of frustration and discouragement rather than hope and optimism.

# Vermont Studies

- 269 “back ward” patients
- 32 years later
- At 10 years 70% were still out of the hospital
- At 30 years 50 to 66% were recovered or improved

# Results from Strauss-Carpenter Level of Functioning Scale for 168

Vermont study subjects who were alive and interviewed.

<b>AREA OF FUNCTIONING</b>	<b>N</b>	<b>%</b>
■ Not in hospital in past year	140	83%
■ Met friends every week or two	111	66%
■ Had one or more close friends	128	76%
■ Employed in the past year	79	47%
■ Displayed slight or no symptoms	121	72%
■ Able to meet basic needs	133	79%
■ Led moderate to very full life	128	76%
■ Slight or no impairment in overall functioning	92	55%

# A Big Challenge

- If many people's recovery takes 20 to 30 years, how can we help staff see that their work is effective and important?
- How do we help the staff keep the sense of hope and optimism so necessary to their work?

# The Role of Hospitals

- Optimal length of stay needed to resolve acute episodes (Pratt et al., 2006)
  - Stays which are too brief are associated with relapse
  - Stays that are too long are associated with institutionalized syndrome & poor community integration
- Ideal setting for Illness Management to begin (Mueser & Gingerich, 2005), fostering long-term medication adherence
- Continuity of care, close partnership with community more important than specific setting (Geller, 2000)

# Using more diverse techniques than hospitalization to manage acute phases of the illness

- Early intervention teams
  - Assertive outreach
  - Multi-disciplinary teams
  - Intervene early as people are getting sick or relapsing
  - Getting people to enter the mental health system, early, often, and as volunteers
- Crisis residences
- Acute partial hospitals

# Mental Illness is really bad for your health

- Circulatory disease; metabolic conditions including diabetes, obesity, hyperlipidemia and osteoporosis; chronic pulmonary disease; HIV-related illnesses; polydispsia and epilepsy elevated (Lambert, et al., 2003; Green et al, 2003; Jeste et al, 1996).
- Life expectancy is 20%-30 shorter for persons with serious mental illnesses than that of the general population (Bailey, 2002; Kaplan & Sadock, 2002). People with psychiatric disabilities die 15-20 years earlier than the general population from illnesses such as cardiovascular disease, hypertension, respiratory illnesses and diabetes (Berren, Hill, and Merikle, 1994; NASMHPD, 2006).

# Poverty and unemployment are also bad for one's health

- Social and environmental factors contribute to medical co-morbidity among the population of people with psychiatric illnesses
- Worsening “medical” problems exacerbate psychiatric conditions (Dixon et al., 1999)
- Increased psychiatric symptoms lead to increased social withdrawal & further avoidance of medical treatment feeding a vicious cycle

# Promoting Economic Self-Sufficiency

- Promoting employment outcomes
  - Both education and work are tough areas
  - Arena associated with previous failures, familial tensions
- Nevertheless, work is good for you and unemployment, inactivity, poverty and isolation are not good for you
- Supported employment is best approach
- Now also our partial care, PACT, and new supported housing programs also must offer some vocational service
- Financial planning, trusts and other mechanisms should be used.

# Benefits of Employment to Symptoms, Quality of Life, Well-being

- “If you think work is stressful, try unemployment, poverty, and isolation”
  - Marrone et al 1999
- Employment among with persons with severe and persistent mental illness is:
  - Not associated with relapse
  - Associated with decreasing symptomatology, reductions in hospitalization, improved subjective and objective quality of life  
(Bond et al., 2004; Bond et al., 2001; Drake et al., 1999)

# Integrating primary health care and mental health care

- Type II diabetes, hypertension, and related conditions are common among persons with mental illness and are “no joke” for anyone
- Working with individual physicians/practices
- System-wide changes

# Strengthening the mental health workforce

- All professionals and direct care staff trained in the relevant knowledge and skills
- Better remuneration for community-based mental health staff
- Less turnover
- Higher quality of service and continuity of care

# Another challenge

- Much of what contributes to wellness and recovery is outside the *traditional* scope of mental health services
- Employment, housing, overall health & well-being always acknowledged as important
- Services and systems for these recovery-promoting factors are traditionally outside mental health system

## Vermont versus Maine (DeSisto, Harding et al., 1995)

“The Vermont legacy is not to be found, as Bacharach (1989) has suggested, in the details of the programme or the methods used. Instead, its legacy is the values and principles which guided it. Perhaps the most important value was that the programme had a pervasive attitude of hope and optimism about human potential, through the vision that, if given the opportunity, persons with mental illness could become self-sufficient.” (p. 340)

# What can you do to assist transformation?

## ■ Individually

- Become as informed a “consumer” as possible, educated as possible
  - NAMI has “Family to Family
  - Family Psychoeducation
- Approach mental health and other helping professionals as partners in the recovery process
  - Likely the less sophisticated providers will rebuff you, but persist and expect them to come around
  - Becoming the norm in other areas of exemplary medicine, that the family is a partner
  - People will do the right thing, after all other possibilities are exhausted

# What can you do to assist transformation

- Collectively
  - Continue your advocacy efforts
  - You have the moral high ground
    - PACT/ACT in every state, not just because it is an EBP
    - Parity example
  - Insist on resources being committed to any reform or change:
    - Employment/education;
    - Integrating primary care;
    - Early intervention teams;
    - Workforce development

# Department of Psychiatric Rehabilitation

- Academic programs to prepare direct service staff (all levels), supervisory, and research
  - Ken Gill, Ph.D. [kgill@umdnj.edu](mailto:kgill@umdnj.edu) 908 889-2438
- Integrated Employment Institute
  - Melissa Roberts, Ph.D. [robertmm@umdnj.edu](mailto:robertmm@umdnj.edu) 908 889-2470
- Anti-stigma community education presentations
  - Amy Spagnolo [spagnoam@umdnj.edu](mailto:spagnoam@umdnj.edu) 908 889-2544

# Selective Review of State Transformation Efforts

## ■ Connecticut

- One of the first, began in 2000 or so
- Done in collaboration with Yale Recovery Center
- Recovery Self Assessment effort
  - Do programs and services have characteristics or features that promote recovery?
- “No wrong door” policy on dual diagnosis
- Workforce development/ training emphasis

# Other States

## ■ Washington

- Anti-stigma focus
- Integration with primary care/other health
- Emphasis on social/leisure activities
- Clubhouse model

## ■ Wisconsin

- Older effort, 1999-2003
- Broad stakeholder input
- Parallel collaborative process of recovery
- Involvement of U. of Wisconsin
- Narrative Recording (*In Recovery*, Nora Jacobson)
- No formal evaluation

# More Examples

## ■ Maryland & Ohio

- Capitalized on all sorts of diverse federal opportunities
- Evidence-Based Focus (both states)
- Supported employment and other employment opportunities (Maryland)
- Involvement with Dartmouth Psychiatric Research Center, and U. Maryland-Baltimore
- Heavy evaluation emphasis (especially in Ohio), state and community evaluation effort