



# Words of Wellness



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## FOCUS ON EMPLOYMENT AND EDUCATION TO IMPROVE WELLNESS

Adults living with a mental illness are more likely to experience either underemployment or unemployment, poverty, social isolation, and a shorter life span versus someone with no such diagnosis. Once a person is diagnosed with a mental illness, many well intentioned family members, professionals and others discourage the person from working or completing educational goals, stating that work (or school) is stressful and will have a bad impact on the course of the illness. There is no research to support that work has a negative impact on the course of the illness. Underemployment and unemployment are consistently associated with poor physical and mental health outcomes. Many individuals living with a diagnosis of mental illness who are not employed are intelligent, capable and talented individuals who too often resign themselves to live a life dependent on public benefits. These individuals, their families and loved ones, and society all incur a loss and burden since they do not have opportunities to contribute their innate talents and skills and engage in meaningful activity. Many are destined to live a life of poverty, and remain dependent on the social service system.

People who do wish to go back to work often find a wide array of barriers and disincentives. People on Supplemental Security Income (SSI) find their benefits cut by 50¢ for every dollar they earn after a trivial earned income exclusion. People receiving various kinds of housing vouchers, or various kinds of subsidized housing often have no earned income exclusion, so every dollar they earn can raise their rent by 25¢ to 40¢. People receiving Social Security Disability Insurance (SSDI) or SSI know that they will lose their cash benefits if they earn more than the Substantial Gainful Activity (SGA) level of income (for 2010, \$1000 for non-blind individuals). People waiting for the award of various disability benefits (public or private) often fear that even a dollar of earned income or demonstrating the capacity to do volunteer work may prevent or delay their award.

Similarly, people find that services ostensibly designed to help them become employed have disappointing outcomes. Pre-vocational programs, whether in the form of day treatment or workshops, are likely to have very limited success at getting people back to work. We have a research-tested Evidence Based Practice (EBP) in Supported Employment<sup>1</sup>, but many programs and practitioners are not set up or skilled to follow it.

There is no evidence that employment will lead to worsening of symptoms for the majority of people. Despite the availability of the Supported Employment EBP, there is limited focus on eliminating the cycle of dependency and helping people to move into full time competitive employment. There are multiple avenues and reasons we should create career development

<sup>1</sup> See the federal Supported Employment EBP toolkit online at <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/>

opportunities for people living with mental illness. The following are some potential areas of focus. We encourage our readers to think about these ideas and challenge ourselves, our organizations, and our Governments to change practice:

- Early intervention- Provide supported education and employment services prior to starting someone on any form of subsidies.
- Assess and develop employment readiness in every area of mental health service .
- Consider ways to "jumpstart" employment as a priority in both individuals and systems, and to increase the penetration rate of accessibility to employment services across the mental health population
- Look at ways to combine supported employment and supported education. This is a natural because education is a key means of career development.
- Think about the difference between getting people jobs and helping them build, pursue, and maintain careers.
- Think about skills teaching as a key component of supported employment, supported education, and other aspects of psychiatric rehabilitation. "Prepare a man's job application, it might get him a job; teach a man to prepare a job application, the skill could last him a lifetime."
- Look for myriad ways to partner to improve employment and education outcomes. Self-help groups can have informational sessions or whole recurring groups on employment and education<sup>2</sup>. Self-help groups and the business

<sup>2</sup> The prime example being the Peer Employment Support groups co-developed by CSPNJ and

community can provide practical sources to develop job banks. Interdisability services, such as the Centers for Independent Living/Independent Living Centers (CILs/ILCs) may be in a position to bring methods and insight into the mental health community.

- Become aware of the state of the art in supported employment and education. Read the EBP and the best practice documents on Supported Education.
- Consider the role of employment service navigation. People with various disabilities find the array of agencies and programs confusing. Program navigation can be a good role for peer providers and Peer Operated Services.
- Consider the vested position of various existing organizations when making systems changes. For instance, while "affirmative business"<sup>3</sup> is of limited value helping people transition to competitive

employment, it is closer to competitive employment than sheltered work. Krupa, Lagarde & Carmichael (2003)<sup>4</sup> wrote about a successful transformation of a sheltered workshop to an affirmative business.

UMDNJ, and running in many Self-Help Centers around New Jersey.

<sup>3</sup> Business enterprises managed and staffed by people with disabilities

<sup>4</sup> Krupa T, Lagarde M& Carmichael K (2003). Transforming sheltered workshops into affirmative businesses: an outcome evaluation. *Psychiatric Rehabilitation Journal*; Spring;26(4): 359-67.

### **ARE YOU, YOUR FAMILY, AND YOUR PROGRAM OR AGENCY WISE ABOUT SOCIAL SECURITY WORK INCENTIVES?**

One of the funny things about the Social Security Ticket to Work and Work Incentives program is that many people, including quite a few involved in mental health service provision and coordination, do not have a clear understanding of what the features of these programs are, and, specifically, how they can be used to help people take steps to get back to work. Because of that, the Social Security Administration sponsors a series of Work Incentive Seminar Events (WISE) to provide people program information. These are free online programs, but registration is required.

The next National WISE Webinar for Ticket Holders with Mental Health Disabilities is scheduled to take place on Wednesday, June 23, 2010, from 3-4:30pm Eastern Time. Registration is online at [www.cessi.net/wise](http://www.cessi.net/wise)

A few recommendations which are more directly aimed at Government (and by extension, at all systems advocates) include:

- Think about what we are paying for. It may be time to defund ineffective practices.
- Think about the impact of funding streams on employment delivery, specifically the relative impact of incentivized funding (how much is needed to make an impact) vs sanctions (defunding certain services that detract from employment).
- Think about how to hold provider agencies inside and outside of vocational service accountable for vocational outcomes. One way to increase that accountability and reduce agencies' disincentives for vocational outcomes is to pay for vocational goals attainment, rather than hours of service.
- Think about uniform ways to disclose fidelity scoring and outcome measures for employment and supported education programs. This helps empower service recipients to make informed choices.

### **SPIRITUAL RELATIONSHIPS**

*by Kathryn Bedard, MA, LCADC*

Our interactions with others are a reflection of our relationship with our self; if we don't have tolerance or respect for our self, we will have little for others. We live in a material society that focuses on what we don't have. We have bills, challenges, and stresses, and it becomes difficult to have gratitude when things are going wrong. When we have difficulties or become discouraged, it is natural to begin to think in negative terms. The problem with negative self talk is that at least some of that beating that we give ourself is rooted in reality; we have all had failure and misfortune. There are typically strong emotions in memories of past bad outcomes. Those memories emerge in language that relates to present day activity such as: "Oh no, you tried that before, it will never work out...". We *devalue* ourself each time we use negative self talk. Our relationships with spirit, self, and others suffer.

When we feel have a negative, stress filled outlook, we will attract energy that is negative. Our personal world is the reality that we shaped – no one else

gave us our opinions, interpretations responses or thoughts – no one else is living our life.

### **PEOPLE IN RECOVERY AS PROVIDERS OF PSYCHIATRIC REHABILITATION**

The US Psychiatric Rehabilitation Association (USPRA) has announced a new publication: *People in Recovery as Providers of Psychiatric Rehabilitation: Building on the Wisdom of Experience*. This book is a follow-on to the association's 1997 "Consumers as Providers in Psychiatric Rehabilitation." The new book contains topics such as

- Best Practices and Role Innovations in Peer-provided Services
- Successes from Self-help Groups
- Partnerships between Peer and Non-peer Providers
- Reviews of Training Programs for Peer Providers
- Models of Services: Vet to Vet
- To Disclose or not Disclose: Professionals Share Their Stories
- Certifications: The Ins and Outs of Professional Training
- Studies of the Effectiveness of Peers as Mental Health Practitioners

It is edited by our institute director, Peggy Swarbrick, OTR, PhD, CPRP, along with Lisa Schmidt, PhD, CPRP, and Kenneth J. Gill PhD, CPRP. It is available on the association's website, [www.uspra.org](http://www.uspra.org).

### **WELLNESS AND THE SMARTPHONE**

Recently, several members of our workforce who recently converted to iPhone use participated in some e-mail exchanges about our "favorite apps." It was amazing how many different kinds of apps these individuals had chosen to install and use, and how many of these apps were involved in people's various dimensions of wellness. While there are a variety of factors which we all weigh in deciding to use a cellphone, whether to use a SmartPhone versus a simpler device, and which kind of SmartPhone to use, we wanted to open this discussion of Wellness and the SmartPhone to our readers.

**Cross Dimensions** – Most SmartPhones have various kinds of features to make them usable by people with various challenges or disabilities around communications. Features like speech-to-text and talking icons may be useful for some people, and many phones have magnifying features. An app known as Wellness Wheel is specifically designed to help people consider daily actions across dimensions.

Life organizers can also be considered cross-dimensional, as they improve people's functioning in many spheres and help reduce emotional distress. SmartPhones are all designed to help people manage their calendars, address books, personal lists, etc. Cameras also seem to be cross dimensional, as we use them to capture pictures of everything from our family and friends (social) to images which bring us hope and inspiration (emotional, spiritual). The mapping and direction programs help us get places safely and with less anxiety, and engage in our work, school, and leisure pursuits more effectively. Music players and radio stream tuners help us maintain concentration at work and school (occupational, intellectual), appreciate arts, share common interests, and listen to the music of our faiths (spiritual).

**Physical Dimension** – Some SmartPhones have pedometer features to measure walking, and help people increase physical activity. Apps are available to help people manage various health conditions, coach themselves to stop smoking, improve their cooking skills, monitor their sleep habits, and maintain Personal Health Records. SmartPhone direct connections to devices such as blood glucose meters are starting to become available, and will likely be widely available in a few years.

**Emotional Dimension** – Recreational apps promote emotional well-being. Emerging apps support various kinds of psychotherapy, from general Cognitive-Behavioral Therapy (CBT) tools to coaching for Obsessive-Compulsive Disorder.

**Intellectual Dimension** – SmartPhone apps allow users to read books, follow newspapers, do complex web searches, and access research databases. Other things people can do with apps which are known to

exercise minds and are suspected of helping to maintain brain health include supporting their arts activities (music, graphic, dance), learning foreign languages, and playing games such as, Sudoku, Chess, and "Concentration-" type games [one of our colleagues uses the iPhone New York Times Crossword app].

**Social Dimension** – People use their SmartPhones to call and text family and friends, do social networking using sites such as Facebook and Twitter, set up parties, access dating sites, and more. Expanding the social dimension to pets, we see apps ranging from dog park finders to cat first aid.

**Occupational Dimension** – People not only use their SmartPhones to keep up with their jobs when away from the workplace, but also to search for jobs and maintain the business networks (e.g., by using LinkedIn) which help them in job searches.

**Environmental Dimension** – Just by using SmartPhones "where they are," rather than traveling to a fixed location to use a PC, people are likely benefiting the environment. Apps are available to help people shop greener, learn the basics of solar power, and even apply Feng Shui to improve their own living and working environments. Apps to improve safety and security, such as flashlights, alarms, and baby monitors are also part of the environmental dimension.

**Spiritual Dimension** – People use their SmartPhones to read the texts of their religions develop and apply meditations, see quotes on spirituality, and do other things which support their spiritual wellness.

**Financial Dimension** – Apps support personal budgeting, smart shopping, bank account management, stock trading, and more.

## CALLING FOR STRATEGIES TO CLOSE THE MORTALITY GAP

Michael Flaum, MD is a frequently published research psychiatrist. In an editorial published in the February, 2010 edition of *The American Journal of Psychiatry*<sup>5</sup>, Dr. Flaum pondered his own behavior as a psychiatrist. He indicated that he had transitioned from primarily treating symptoms to focusing more on whole people and their recovery outcomes, and asking patients and himself questions about people's stable housing, employment, and social relationships. At the same time, he took himself to task for not paying sufficient attention to the physical (including dental) needs of his patients, and noted that the oft-quoted mortality gap (people with serious mental illness (SMI) dying about 25 years sooner than the general population) may be getting wider, not narrower. To quote the editorial "If we want to pursue real recovery-oriented outcomes, then meaningful efforts to address this "mortality gap" must be added to our priorities, both clinically and on our research agenda."

The occasion of Dr. Flaum's editorial was an article in the same journal issue entitled "A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study"<sup>6</sup>. That article discussed a study of a medical care management intervention, and concluded that "medical care management was associated with significant improvements in the quality and outcomes of primary care." The lead author, Benjamin Druss, MD, MPH, has been a key mover and shaker in our movement to integrate physical and mental health care. Dr. Druss, who is a professor in the school of public health at Emory University, has written or co-authored over sixty articles in the peer-reviewed literature in the past

<sup>5</sup> Flaum M (2010). *Strategies to close the "mortality gap."* American Journal of Psychiatry; 167:120-121.

<sup>6</sup> Druss BG, von Esenwein SA, Compton MT, Rask KJ, Zhao L & Parker RM (2010). *A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study.* American Journal of Psychiatry; 167:151-9.

decade, and that about half of these related closely to medical care challenges and health disparities for people living with mental illness. Writing about the mortality of older patients after myocardial infarction (MI, heart attack), he concluded that "deficits in quality of medical care seemed to explain a substantial portion of the excess mortality experienced by patients with mental disorders after myocardial infarction"<sup>7</sup>. Another article concluded that "persons with psychiatric disorders, particularly with comorbid substance use, were at risk for lower rate of receipt of preventive services"<sup>8</sup>.

In 2005, Dr. Druss served on a subcommittee of the Presidents New Freedom Commission on Mental Health. This group, the *Subcommittee on Mental Health Interface with General Medicine*, published a report<sup>9</sup>, which started with five major findings:

- Mental Disorders Are Common in Primary Care
- Mental Disorders Commonly Co-occur With Other Medical Disorders
- Mental Disorders Often Go Undiagnosed and Untreated or Undertreated in Primary Care
- Patient, Provider, and System Factors Contribute to Poor Quality Care on the Primary Care-Mental Health Interface
- Medical Disorders Are Common but Often Poorly Treated in Specialty Mental Health Care Settings.

*It then went on to look at Innovative Mental Health Treatments and Services, and concluded with a discussion of policy options around Financing of Collaborative Care Services, Performance Standards, Technical Assistance, and Provider Training.*

<sup>7</sup> Druss BG, Bradford WD, Rosenheck RA, Radford MJ & Krumholz HM. (2001). Quality of medical care and excess mortality in older patients with mental disorders. *Archives of General Psychiatry*; Jun;58(6):565-72.

<sup>8</sup> Druss BG, Rosenheck RA, Desai MM & Perlin JB (2002). Quality of preventive medical care for patients with mental disorders. *Medical Care*; Feb;40(2):129-36.

<sup>9</sup> View online at [www.mentalhealthcommission.gov/subcommittee/MHIinterface\\_010803.doc](http://www.mentalhealthcommission.gov/subcommittee/MHIinterface_010803.doc)

In a 2008 editorial piece<sup>10</sup>, Dr. Druss commented that the physical health care needs of mental health peers, previously an orphan, has “come of age” in policy and research. Other publications in the past four years have included more on integrating mental health and primary care, and a look at medical care use by people who use Complementary and Alternative Medicine (CAM).

Dr. Druss serves on the 11-member steering committee for the SAMHSA 10x10 campaign to increase the longevity of the mental health peer community<sup>11</sup>. Dr. Druss’ most recent efforts have been around the adoption of the Chronic Disease Self-Management Program (CDSMP), an evidence-based program that uses peers to help peers change their whole health behavior, to serve mental health peers<sup>12</sup>. The first report in the peer-reviewed literature on this program<sup>13</sup>, known as The Health and Recovery Peer (HARP) Program, concluded that “This peer-led, medical self-management program was feasible and showed promise for improving a range of health outcomes among mental health consumers with chronic medical comorbidities.” CDSMP and HARP are direct precursors to the efforts of our own institute, in collaboration with UMDNJ-SHRP, to develop and implement a Peer Wellness Coaching model. Consistent with the recommendations of the subcommittee report referenced above, as well as other sources, we recommend the following “Strategies to Close the Mortality Gap.”

1. People served need to take full responsibility for their own overall health, including coordination

<sup>10</sup> Druss BG (2008). *An orphan comes of age*. *Psychiatric Services*; Aug;59(8):833.

<sup>11</sup> [www.promoteacceptance.samhsa.gov/10by10](http://www.promoteacceptance.samhsa.gov/10by10)

<sup>12</sup> First documented in Lorig KR, Sobel DS, Stewart AL, Brown BW Jr, Bandura A, Ritter P, Gonzalez VM, Laurent DD & Holman HR (1999). Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. *Medical Care*; Jan;37(1):5-14.

<sup>13</sup> Druss BG, Zhao L, von Esenwein SA, Bona JR, Fricks L, Jenkins-Tucker S, Sterling E, Diclemente R & Lorig K (2010). The Health and Recovery Peer (HARP) Program: a peer-led intervention to improve medical self-management for persons with serious mental illness. *Schizophrenia Research*; May;118(1-3):264-70.

of medical and mental health care and getting necessary medical **screenings**. This seems especially important when considering choices of medication

2. All stakeholders need to advocate for close attention to integrated physical-mental health at all levels, including public policy, agency practice, and the practices and policies of insurers. Insurers have been quick to adopt various “disease management programs” to help individuals manage conditions such as diabetes, high blood pressure, and asthma, but people covered by Medicaid or Medicare fee-for-service may have reduced access to such programs.
3. Provider programs and agencies should consider all of the following:
  - Offering and arranging routine screenings for people served
  - Maximizing the coordination between physical and mental health care
  - Offering access to health information, including information on disease prevention and management of chronic health conditions
  - Establish a pilot program to partner with medical and dental providers for integrated care
  - Making sure that all service staff understand the importance of health promotion for people served and how to use Motivational Interviewing/Motivational Enhancement to maximize people’s health behavior change.
  - Making sure that employees have resources to maximize their own physical health and health improvement, in order to model these to people served
  - Considering use of Peer Wellness Coaches (PWCs) and other emerging practices to supplement line staff roles around promotion. The following article page contains some questions and answers about PWCs, developed by our institute (CSPNJ) and UMDNJ-SHRP.
  - Developing and tracking metrics around health improvement interventions

We will continue to share aspects of many of these kinds of interventions in future issues.

## **SOME QUESTIONS AND ANSWERS ABOUT WELLNESS COACHING**

*Q: What is Wellness?*

A: Wellness is a conscious, deliberate process that requires a person to become aware of and make choices for a more satisfying lifestyle. Creating a lifestyle centered on wellness means continually seeking more information about how we can improve ourselves and realize our full potential in our wellness dimensions (physical, social, occupational, mental/emotional, intellectual, spiritual, environmental, and physical).

*Q: Why is wellness an issue to people with mental illness?*

A: Even though we have more treatments for psychiatric symptoms than people were able to use in the past, we have a problem where more members of the mental health community are experiencing shorter lives, mostly due to preventable lifestyle conditions.

*Q: What is a Peer Wellness Coach (PWC)?*

A: A PWC is a mental health peer provider (A person who lives with a mental illness and provides mental-health-related services) who has had special training in helping other people with mental illness make positive changes on health issues through the use of coaching principles.

*Q: Can the peer wellness coach work with others who are part of my treatment or support system in order to help me?*

A: Absolutely! The PWC will help you look at who is on your side around the kinds of changes you decide that you want to make. We know that having allies on your side plays an important part in making successful life changes of many kinds. Depending on what you decide, the PWC may work with your family, your mental health treatment team, your doctors, and other people.

*Q: How can a PWC help me?*

A: A PWC can help you assess your personal wellness and the areas that you might want to improve, set a plan, and support you to achieve the goals you set for yourself.

*Q: How long and how often will I work with the PWC?*

A: The amount of time you spend meeting with a PWC is generally less than an hour for each coaching session. Coaching is a short-term relationship and the number of sessions depends on your individual goals, objectives, and steps.

## **MY EXPERIENCES AT THE CSPNJ WELLNESS CONFERENCE**

*by Brenda Watson, VA Boston*

I want to tell you about the Wellness Conference that I attended in New Jersey. Six of us boarded a van last month from the Boston VA enroute to this conference. Each of us had different thoughts, actions and feelings but we all arrived at the same conclusion.

I am writing about what I can remember about the trip, because I felt good about the trip. I was given an opportunity to share some of my points and views about creativity and what it means to me. I am not an experienced writer, and I am nervous when I have to speak in front of people. The trip was long, yet rewarding and I was among others with similar problems.

Upon our arrival at the hotel in New Jersey we were checked into our rooms and given a free breakfast coupon, along with a set of instructions for the next day's presentation. Morning came fast, and then it was off to breakfast and we went our separate ways. I picked the Reiki class, which I thoroughly enjoyed, and I spent the most of the morning there.

When my turn came, I presented some opening remarks, and then asked all the session attendees to make some sort of creative conversation piece out of pipe cleaners which I furnished to everyone. The end result was quite a collection of varying items including eye glasses, carrots, boxes etc. Finally we did some warm up exercises and had a discussion about the exercise.

I am glad that I had the opportunity to participate with this group. The overall reaction from the class is what inspired me to become more active in various groups. I reacted to other individuals' points of view and gained clarity about the whole purpose of the Wellness group. Thank you, CSPNJ!

### **WEBSITE HELPS PSYCHIATRISTS REFER PATIENTS TO PRIMARY CARE**

WebMD, with sponsorship by a pharmaceutical manufacturer, has launched a "primary care referral" tool at [http://doctor.webmd.com/physician\\_finder\\_custom/home.aspx?sponsor=lillyz](http://doctor.webmd.com/physician_finder_custom/home.aspx?sponsor=lillyz). This site is designed for use by psychiatrists and their practices. It lists Primary Care Physicians" who have indicated a willingness and interest in accepting referrals "to evaluate and treat patients' non-psychiatric medical concerns." As of today, they have 480 PCPs in New Jersey, and nearly 1200 in California. This may be another useful tool in helping people pursuing psychiatric recoveries obtain the primary care we often do not get.

### **MAKE A "PLEDGE FOR WELLNESS"**

In 2007 the Center for Mental Health Services' (CMHS) launched the National Wellness Summit for People with Mental Illness. The heart of this summit is the "10 in 10" campaign, which strives to improve the life expectancy of individuals with serious mental illness (SMI) by 10 years and to achieve this goal within 10 years. Currently, individuals with SMI have a lifespan that averages 25 years less than the general population, due not only to SMI but also various comorbidities, such as diabetes and heart disease. At its summit, CMHS also introduced "The Pledge for Wellness," which includes the goal of the "10 in 10" campaign. All health and mental health provider organizations, individuals and government entities are strongly encouraged to make the pledge. To do so, visit [www.bu.edu/cpr/resources/wellness-summit/pledge.html](http://www.bu.edu/cpr/resources/wellness-summit/pledge.html).

### **WORDS OF WELLNESS**

As part of its broad array of services to foster wellness and recovery for individuals with disabilities, the Institute for Wellness and Recovery Initiatives at Collaborative Support Programs of New Jersey (CSPNJ) offers this monthly newsletter, Words of Wellness. This publication features valuable information and resources, including details about educational events, to help people to achieve and maintain wellness. The purpose of this newsletter is to bring useful information to all of our readers, whether pursuing recovery themselves, supporting recovery in clients or family members, helping to administer and change our mental health and related services system, or researching the field and educating future practitioners. Words of Wellness co-editors are Jay Yudof and Peggy Swarbrick. Free e-mail subscriptions are available from [nleditor@cspnj.org](mailto:nleditor@cspnj.org). We also welcome submissions and feedback at that address.