

EDITORIAL

Physical Wellness: An Integral Feature of Recovery



Judith A. Cook
University of Illinois at Chicago

Five years have passed since the publication of a landmark report by the National Association of State Mental Health Program Directors, calling attention to the high morbidity and mortality associated with psychiatric disabilities (Parks, Svendsen, Singer, & Foti, 2006). On average, people with serious mental illnesses die 25 years earlier than the general population, and 60% of these deaths are due to preventable, treatable medical conditions such as cardiovascular disease, diabetes, and high blood pressure. Access to medical treatment and coordination of care is also poor due to inadequate insurance coverage and a dearth of effective models for care integration. Another issue is lack of affordable care, with “safety net” health care clinics at full capacity, and many disadvantaged communities having few or no health care providers. People in recovery report stigma and discrimination from health care providers, while providers themselves express discomfort and lower expectations that these patients can be partners in their own care. Inadequate health care coverage is made even worse by antiquated Medicaid reimbursement policies with restrictions such as prohibitions against billing for both medical and mental health services on the same day. Perhaps not surprisingly, the

health care people do receive is of demonstrably poor quality, with little attention to prevention, health monitoring, and adherence to evidence-based treatment guidelines.

The field of psychiatric rehabilitation (PSR) has responded by developing wellness and health promotion approaches. These range from modest efforts such as walking groups (McDevitt & Wilbur, 2006) and weight loss classes (Brown, Goetz, Van Sciver, Sullivan & Hamera, 2006) to large-scale programs such as integrated health and mental “health care homes” located within PSR programs (McDevitt, Braun, Noyes, Snyder, & Marion, 2005). The peer community has responded with models such as Peer Support Whole Health (Daniels, Grant, Filson, Powell, Fricks, & Goodale, 2010), Wellness Coaching (Swarbrick, Hutchinson, & Gill 2008) and Wellness City (Ashcraft, 2009), to name just a few. Yet many in the field feel that more can and must be done to enhance the health and wellness of people in recovery. The question is how to pay for these services, train and mobilize the PSR workforce to provide them, motivate people to use them, and ensure that they are effective and have high levels of user satisfaction.

Newly enacted health care legislation presents opportunities but also uncertainty as debates rage about how to implement new policies and regulations. An already-overburdened health care and behavioral health system struggles to adapt to new imperatives in an ever-shifting landscape. It is well known that effecting systems change on even a moderate scale has been difficult to achieve in mental health systems nationally. While numerous behavioral health research interventions have proven successful, practices often are not sustained beyond the research trials nor adopted by programs and communities that stand to benefit from them.

At the same time, participatory community approaches have been developed in the field of public health to promote better health outcomes. One of these models, “collaborative partnership” (Roussos & Fawcett, 2000) involves alliances among people and organizations across sectors (treatment, business, philanthropy, education) that partner to improve health outcomes and environmental conditions at either the systems or population levels. These partnerships use a host of strategies to effect systems change including social planning, community engagement, community organizing, and political advocacy. This approach aims to create change in multiple venues by engaging diverse constituencies such as local political organizations, neighborhood clinics, pharmacies, religious institutions, and civic organizations. The key principles of collaborative partnerships dovetail nicely with the empowerment principles embraced by mental health advocates: 1) public health goals cannot be reached by any one person or organization; 2) participants must include a wide diversity of stakeholders who represent the concern or population being addressed;

and 3) shared interests make consensus more achievable.

Using the collaborative partnership model and approaches like it, we can promote demand-side change by giving people with psychiatric disabilities and their supporters the knowledge and tools they need to lobby for better and better coordinated care. We must also create supply-side systems change by mobilizing primary care and behavioral health providers to understand and address the negative impact of untreated health conditions on recovery and community integration. This and similar public health approaches (Leung, Yen, & Minkler, 2004; Wallerstein & Duran, 2006) are called for to increase the political will to address health risks and needs, if we truly believe that physical health is integral to mental well-being.

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JUDITH A. COOK, PHD, IS A PROFESSOR IN THE DEPARTMENT OF PSYCHIATRY AND DIRECTOR OF THE CENTER ON MENTAL HEALTH SERVICES RESEARCH AND POLICY, UNIVERSITY OF ILLINOIS AT CHICAGO.