inSocialWork Podcast Series

Episode 19 - Dr. Michael Hogan: The "President's New Freedom Commission on Mental Health": Promise, Progress, and Challenge

[00:00:08] Welcome to living proof. A podcast series of the University of Buffalo School of Social Work at www.socialwork.buffalo.edu. Celebrating 75 years of excellence in social work education. We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. This is your host Adjoa Robinson and I'd like to take a moment to tell you about a new feature after living proof. In addition to listening subscribing to and sharing podcasts you can now rate and write a review of each episode of living proof to rate or write a review of the pod cast. Just go to our Web site at www.socialwork.buffalo.edu/podcast and click on that create your own review button. Thanks. And we look forward to hearing from you. Today's podcast features a conversation between Dr. Catherine Dulmus Associate Dean for Research and Director of the Buffalo Center for Social Research at the University at Buffalo School of Social Work and Dr. Michael Hogan commissioner of the New York Office of Mental Health. Prior to accepting the position of Commissioner Dr Hogan served as director of the Ohio Department of Mental Health. He was previously director of the Connecticut Department of Mental Health from 1987 to 1991. Dr Hogan chaired the president's new Freedom Commission on Mental Health from 2002 to 2003. He also served from 1994 to 98 on the national advisory Mental Health Council and as president of the National Association of State Mental Health Program Directors from 2003 to 2005.

[00:02:05] He also coauthored a book and several national reports and written over 50 journal articles or book chapters. In this episode Dr's Hogan and Dulmus discuss the impact of policy decisions on individuals with severe mental illness. Examining the need for evidence based practices and what recovery means for individuals with mental illness. Commissioner Hogan thank you for joining us today. We appreciate your time and look forward to this interview one of the major milestones from a from an educators perspective but I've seen that you have achieved in your career as chairing the President's Commission on Mental Health and that report that came out I think it was in 2003 as a seminal piece of work. Our students read it all the time it's cited everywhere in our own literature and research and often in a speech I hear about mental health that is cited as well. I wondered if youa could to speak to us around the context of that and the significance of that report. In order to provide us with a context of how you got involved with that and what happened and what your charge was when you were asked to chair that mission. Well let me actually take a step back before doing that and say how much I appreciate both the leadership that you and your colleagues have exercised at the University of Buffalo but also social work professors around the state who are partnered with us to try to help people entering the profession look at a focus on what we call the publics mental health system where people with Sursum persistent mental illness.

[00:03:39] It's a group of people though I'm not sure it's fair to describe them as a group but it's a population that has often been neglected. I have my own family connections to it and I would make the argument that a focus on people with serious mental illness is a very important focus in social work. This is really the only discipline that has as a longitudinal part time perspective coupled with a focus on people in the environments that they're in and with a particular focus also to community care. But unless people have the opportunity to develop some specific skills and an awareness and get to know people that are living with these with these disorders it can be sort of a daunting task as well. And we believe that your project has brought people into this field who have turned out to like it and be good at it who might not have come in otherwise. And it probably made really significant differences in the lives of many people who previously might not have had anybody who was a comfortable enough to establish a relationship with them and b could bring some skills some

specific skills to the to the work of recovery. So I wanted to say that at the outset chairing the commission was a roller coaster experience. These things don't come along very often. It had been really a quarter of a century since there had been a President's Commission on Mental Illness. Shared by the rest of the honorary chair was Rosalynn Carter. She would have been the real chair except that there were regulations and she couldn't be the real chair but she was clearly the spirit and the force behind it.

[00:05:11] And so one interesting question is why this president President Bush has not thought of as as a guy who was interested in social services where did this come from. And the best that I can figure out. He made a commitment to have this commission actually during the campaign. His first campaign to be president. And some people had impressed on him the idea that this was that mental health was an area where some presidential attention and really the opportunity for the field to with presidential support take a look at itself could be a good thing a little bit of in a sense the compassionate conservative side that we didn't see that much of later. But it was a generous thing for the president to do it. Most presidents go through their term without ever focusing on mental health. And so the fact that he committed to do it was the first most important thing a lot of the framework for what the commission would do was established by the former administrative Samso Charlie Currie a social worker himself who worked with the staff in the White House to frame the commission to consider who would participate in it and to draft an executive order that the president signed. And that's how these commission work. There's an executive order that describes what should be focused on and also indicates some assignments for the commission. And in this case what I'll never forget is the one line that is in the executive order that describes the commission's mission which the president said was to focus on approaches that would allow adults with serious mental illness and children with severe emotional disturbance to live work learn and participate fully in their communities which I think is both very practical and grounded. And at the same time a really uplifting challenge.

[00:07:04] It did not say the focus on that commission was to pay attention to financing and organization and program this and program that but it set a very high bar of in fact working on those things that tend to be the same kind of concerns that people living with and trying to recover from mental illness or their families are are interested in. So I guess the first thing to note that is that it was really an opportunity for the field to have this this effort and the second that the focus that sort of practical uplifting focus was a really good thing and then I guess there was a diverse group of people that that participated in it with Charlie curry and people in the White House. We developed a little bit of a game plan for it. We were only given a year to do it which was a very short period of time and so we started on several tracks of work simultaneously on the very first meeting of the commission. There was a very strong sense of purpose from all the members to not just sit and listen to presentations and we had some terrific initial presentations for example one of them that was very important was to hear from Howard Goldman who was the senior scientific editor of The Surgeon General's Report on Mental Health about the surgeon general's report which led the members of the commission right away to say that's the essentially the foundation that we want to stand on to do our work which was which was very logical but at that first meeting the members of the commission all said we want to roll up our hands and get to work.

[00:08:45] And so we formed a number of subcommittees and each member of the commission was on several of the subcommittees the subcommittees all had an outside expert or sometimes two as their sort of consultant and advisor and each of the subcommittees ended up studying a particular issue and producing a set of recommendations that then came back before the commission as a whole. So we got started on that right away. And we also got started right away on trying to figure out how to hold a set of hearings in a sense so we could listen to people how to plan a couple of trips outside of Washington. We went we went to Chicago and went to Los Angeles and had a sort of wonderful experience and both of those places. So again the the mission the opportunity from the

president the mission from the president and from Charlie and a game plan that allowed us to start doing lots of things simultaneously and then it went from there. And it was a year to get all this accomplished. Yes right. So what were some of the major recommendations that came out of there. Well one of the things before I get the recommendations was a sense of what the what the work really was I was really fortunate to have tremendous amount of supportive advice and guidance from people that knew more about Washington than than I I did in particular to have the advice and support of Tom Bryant who had been the staff director of the Carter Commission on Mental Health. And indeed later we we invited Mrs. Carter to come to one of our meetings which was probably for most members of the commission.

[00:10:30] One of the real high points of the whole the whole experience and we figured out or I figured out in the context of getting started with this that this was not going to be a president's commission. Like some of them like for example a commission on Social Security that would produce a big report. And then people would actually go out and make major changes in social policy that we were certainly charged with making recommendations practical recommendations but in a different way. The focus of the commission was in a sense an opportunity for the field to think about its own priorities and direction. So there were many formal recommendations that were that were made. I think there were 19 formal recommendations that were made. There were more than 70 recommendations that were in the text of the of the report about things that ought to have been have been done. But in a sense the biggest message of the report was not a recommendation at all but it was two concepts that emerged to reinforce each other. One of them was the notion of recovery and resiliency. These ideas were not original with us. I mean people have been writing about both of them and researching them for many many years starting with a few researchers and then particularly in the case of recovery. I think a lot of the leadership work was done by people who have been through the process of living with serious mental illness and then talked about their own learnings and began to create a sense that this was possible.

[00:12:11] But I am proud that we represented the first official body or document that essentially said this is real and this is actually how we came to focus on on recovery as a headline was an interesting process steeped in the mental health system as we were. People were aware that this was emerging as an organizing concept. I also remember a conversation with one of the leading advocates in Washington about halfway through the commission. When I was getting beginning to get frustrated that it was ever going to get done and that we were going to produce anything that had any lasting value. And this guy said to me Mike if the if the commission can just have a headline and a message that recovery is real we the advocates can do the rest of the work which sort of put things into perspective for me and that the thing that probably clinched the deal with respect to recovery as a headline was in fact the the conversation that we had with Rosalynn Carter who met with us about two thirds of the way through the through the process. And she actually insisted on meeting with the members of the commission not in a public meeting but privately which was very disappointing to me because I figured if she was there then we could get C-SPAN to come out. And it would help get the message out around the country. But she said very graciously that that basically she wanted to meet in private precisely for that reason that if she was there it was going to be sort of a mental health celebrity moment and she didn't want the focus to be on her celebrity. She wanted to be on the work that had to be done right now.

[00:13:52] And so she talked with us a little bit about the experience the Carter Commission and what worked and what didn't work and she gave us some tips and pointers but then she also said that she had been thinking a lot about what had changed in mental health from the 1977 78 period to the 2002 2003 period and she said there have been lots of changes. There are these new treatments where we're starting to understand that there's an evidence base to certain kinds of interventions. So lots of changes. But she said the one change that's more important than any other in the field of mental health is that today we know that it's possible for any individuals to recover which is not to

say that every person will but the fact that we know that it's possible is such a radical difference and it's true if you go back to the psychiatric textbooks for example you'll read that some diagnoses of serious mental illness essentially were thought to consign somebody to an inevitable downward course. And we don't talk about that anymore. It does happen for some people who we don't get too early or we don't. We're never able to connect to or find the right approach to their life. But we know that it's possible. And so to be able to articulate that recovery is possible. Was was probably the first big headline in a sense and a second was this notion of transformation as an approach to change. The commission had big debates about what the approach that change would be. We knew we were going to make recommendations and so on. But that was a question about in a sense what would that be the tag line.

[00:15:28] So people talked about the term reform and decided that that was really old and you know reorganize and that sounds really boring. Then at some point in that conversation the idea of transformation emerged and it spoke to people I think because it has a sense and it like a recovery that the work doesn't have to be all top down. That is one of the things that we know about recovery is that while we staff have to help people understand their circumstances and make suggestions for them how to change their life. Until people really decide to make that change and try to improve their life. Recovery is not going to exist it's not like just pop a pill. And all the problems go away. A transformational change is a somewhat similar idea. That is that there are mental health programs around the country that have become exemplary because the people who are in them decided to make them special and they were no different in terms of funding and they were no different in terms of regulations and they were really no different terms of policy but the commitment of the people to do something different made a made a real difference. So at some level although there were lots of recommendations these underlying ideas of recovery resiliency transformation even though they made sense may sound fuzzy. Well I think the real the real contribution that we are make and I would agree related to that because my working in the community educating students and going into field agencies are inspiring the field placements.

[00:16:54] There's a buzz about recovery resiliency and transformation and I wonder how that has occurred it feels to me as if it's occurred across New York State. And as I think about having worked several years ago in a field that wasn't the case and wonder how how has that transformation started to take hold here in New York State. That's a good question and I'm not sure that I really know the answers because that to some extent I'm relatively new to this I would say that the biggest reason is ironically the belief that it's possible and if if you believe that things are possible then they they tend to you know there's a much better chance that they're going to happen than if you have a pessimistic outlook about about things we know from all the research in medical science. That when people are testing some kind of a treatment whether it's a surgery or medication whatever that we have to do that in a controlled trial where people get some kind of placebo intervention instead. And one of the reasons we do this is that we understand that placebo is very powerful. It turns out across all of medical research that placebo has about a 35 percent improvement in people's circumstance. So and there's something I think about that of just knowing first of all that somebody is paying attention to you and the second that you're doing something that might make a difference is is a is a powerful thing. And so focusing on the positives I believe is the single biggest single biggest reason I think belief is the first thing and not everybody believes that it's possibly. And in truth you know there are there are people for whom a full recovery is just not realistic.

[00:18:45] Which leads me to my favorite way of thinking about recovery when when the commission did its work we said there were really three meanings of recovery in mental health and the first was that some people would in fact get all better now people with schizophrenia and other disorders some of them are going to progress to a stage where it's as if they didn't have the illness. It really is a remission that may happen more than most mental health professionals are aware because

we spend most of our time working with people who don't recover but it doesn't happen for a majority of people certainly to a level of being symptom free. But the second meaning of recovery is what I in some ways think of as the Oprah definition of recovery which is to say that it's possible to live your best life it's possible to live a good life despite the fact that you've got an illness. We've all got challenges and warts and wrinkles and aspects of our personalities that hold us all this back. But if we can somehow come to grips with that and try to try to move forward we can still do we can still do very well. And the third meeting of recovery that we talked about in the report which is what I've alluded to is just that idea that it conveys hope and hope slash recovery slash placebo whatever you want to call it. It turns out is the single most powerful intervention that we have in the human services.

[00:20:05] So we know that on from there for example the so-called Pygmalion in the classroom studies where teachers were told some teachers were told at the beginning of the year that the kids might look average but they were really below average in some ways and the other teacher was told that the kids might look at risk but they were really you know much more intelligent than they looked in at the end of the year. These kids had done much better. And there was nothing else that was that was changed. So I think the reason that hope is infectious is the first reason why this is improving probably a second. That's also self reinforcing is that we have more evidence now that comes from people who are living with these disorders who are willing to be open about it into discuss with other with other people. And a lot of them are turn out to be you know are smart good nice people who are making progress in their lives and that communicates that as well. We do know at the same time and this is another challenge in the field that the outcomes we bet that we get are the outcomes that people experience are sometimes better than the treatments we have and in some other cases the treatments we have are just not good enough to help people achieve good outcomes. So this is another dimension of change that's really important and that is to have better interventions that are available and then to get those interventions into the hands of therapists and clinicians and social workers. What we found out is those who are dying are dying on average 25 plus years younger than a standard mortality table would seem to suggest that is if you know you're 45 years old the standard mortality table would tend to suggest you have a good chance of living a 50 50 chance to live until you're 80 or something like that.

[00:21:52] But people with a serious with serious mental illnesses are dying in their 40s and 50s. And also that we now understand that we know that suicide is a big risk. A lot of the studies suggested that the lifetime risk of suicide for people with schizophrenia or bipolar disorder or clinical depression might be in the range of 10 percent. So that's a huge risk but it's not the big thing it's killing people. The big thing that's killing people is cardiovascular disease. When we start to think about it what we realize is that we have people who tend to be poor which is not good for your health in general. So whose diet may not be good. Who may have a relatively sedentary lifestyle. But then on top of that tend to disproportionately smoke you know that 70 or 80 percent of people with serious mental illness smoke. And when they smoke we understand that this is partly related to what nicotine does in the brain of somebody with a serious mental illness. And there also are these interactive effects between nicotine and the other the other drugs. So a drug that might have some of the treatments we provide to people with might have been in a way a kind of a depressing impact on thinking nicotine makes you feel a little sharper. So we know that people who are having a mental illness in United States smoke 44 percent of all the cigarettes consumed in the United States of America they smoke. So they smoke a lot of cigarettes. They change smoke. They inhale more deeply. They smoke all the way down to the end.

[00:23:22] So first of all we've got sedentary lifestyle bad diet. And then we've got smoking which is a killer in and of itself. And then we've got lousy medical care. And this this is an area where I think the social work profession has a tremendous amount to contribute. Not as necessarily the provider of health care per se but to educate people and get them to a place of thinking about

changes in their health behaviors and then also to try to make connections to medical care when it's when it's provided. We know that people with serious mental illness are in effect discriminated against and have bad access to regular health care services and there are several reasons for that. One is that we tend to not provide regular health care services in our mental health settings which I think makes no sense at some level and some people think well I'm going to the clinic but that our clinic is just like from the head up and we also need a clinic for the rest of the rest of the body. And then when we make a referral to another clinic setting it's another bus ride on another you know to the other other part of town. So it's very inconvenient. And then you get to the waiting room and you don't feel comfortable and people with mental illness are to some extent because they're used to being discriminated against become hypersensitive to this. So sedentary lifestyle. Way too much smoking bad engagement with regular health care and then the killer is. And we're starting to use or have always used to some extent treatments that make all this work.

[00:24:58] And so particularly I'm thinking about some of the most used and psychotic medications that we understand have a direct relationship for many people with weight gain and other metabolic problems. So this is a huge problem and we are in the mental health field we have been indifferent to it. And I'll give an example of that. And I think if our work for example just as in community mental health and like the single biggest thing you're supposed to do and commitment is keep people out of the hospital. Sometimes I think we work too hard to keep people out of the hospital sometimes going to a hospital briefly is not such a bad thing. But we will do anything to keep people out of a hospital and we may even medicate them a little too much or we may medicate them with medications that we know have got these other side effects but we don't think about a medication change to another medicine that might have less risk of weight gain because we don't want to raise the chance that somebody will decompensate and go in the hospital is the worst thing at all. So we we I think we've actually been sort of in denial about the reality of this of this problem. So what should we be doing about it.

[00:26:08] Well one of the things that we want to do in the Office of Mental Health is to say pretty clearly that the standard of clinical care includes attention to a person's overall health doesn't mean that we necessarily have to treat it although I personally am of the belief that in 10 or 15 years the standard practice is going to be to have an internal medicine clinic or to have a nurse practitioner in every organized mental health treatment setting just as I think we ought to have therapists in every organized Primary Care pediatric setting and I think that's where we're going to we're going to be in the in the future. So to say that it is our expectation of any licensed clinic that it pays attention to the physical health and wellness of its people. So first just establish that second to try to provide people with who done clinical work or minimal health work with some practical tools to assist in this and probably the best of those that you pointed out is wellness management and recovery as an overall an integrated approach to helping people not just with their mental wellbeing but there to understand that recovery in a sense is a part of a larger approach to wellness. A third challenge for us is to try to figure out how to really be much more aggressive and helpful with respect to smoking cessation. If there was one single thing that we could do that would have the most impact in terms of our consumers lives it would be to help them quit smoking. But we can't just say you can't do that here because in fact we understand that smoking is one of the toughest addictions to beat. And it's it's an even tougher addiction to beat if you're if you have and are being treated for a serious mental illness. So we have to work with people on getting them ready to that step. We have to figure out how to provide them with peer support.

[00:28:07] We have to make sure they have access to the medications the package the gum the patches and all those things. So to talk about it and to establish standards of care to promote wellness oriented approaches and then to help people with the task of smoking cessation I think those are the things that are on our radar screen right now. You've been listening to a conversation between Dr. Catherine Dulmus Associate Dean for Research and Director of the Buffalo Center for

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