Serious and Persistent Mental Illness (SPMI):

The Impact of Clubhouse Participation on the Utilization of Mental Health Services

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Abstract

Persons with serious and persistent mental illness (SPMI) are frequent users of mental health services. Such services may be delivered by mental health and/or other medical professionals in a hospital, emergency room or outpatient clinic setting. In addition, individuals with SPMI may participate in community-based mental health care programs known as Clubhouses. Here they are considered members, and participate in the day-to-day business of running the Clubhouse. This business includes placement of members in supported employment opportunities, housing, educational assistance, and a variety of other activities that promote recovery and integration into the community. However, there is no direct delivery of mental health services, such as counseling or medication management. The current study seeks to measure the impact of Clubhouse participation on the use of other mental health services. Billing records for 37 individuals with SPMIs were analyzed to determine use of inpatient, outpatient, and emergency services for a three-year period before joining a local Clubhouse, as well as the three-year period following initial contact with the Clubhouse. It was hypothesized that usage of other mental health services would decrease after participation in Clubhouse. Statistical analysis indicated no significant difference in utilization of outpatient and emergency or crisis care before, as compared to after, Clubhouse participation. However, there was a trend towards significance particular to the decrease in hospital readmission after Clubhouse participation.

Keywords: serious and persistent mental illness (SPMI), mental health services, Clubhouse Model, psychosocial rehabilitation, community-based mental health care

Serious and Persistent Mental Illness (SPMI):

The Impact of Clubhouse Participation on the Utilization of Mental Health Services

Five million-seven hundred thousand persons in the United States suffer from serious and persistent mental illness (SPMI): chronic, debilitating conditions such as schizophrenia, bipolar disorder, and major depressive disorder. This accounts for over 15% of all burden of disease in the United States, which is more than all cancers combined. The U.S. Surgeon General specifies: "Brain-based mental health disorders *are a* public hearth concern" (1999. p. 16).

Recovery is the primary goal for many individuals with SPMI (Anthony, 1993) as well as for local, state, and national policy makers. A portion of every municipal budget in this country is spent dealing with these issues (U.S.D.H.H.S., 1999). Corrigan et al. (2008) report that there are currently 1334 models of community-based mental health programs in the United States. Community-based mental health programs are the principal delivery systems for recovery (Anthony, 2003). These programs were created in the 1970s as a response to the trans-institutionalization of persons with mental illness in the United States (Corrigan, Mueser, Bond, Drake, Solomon, 2008). However, there is a need for empirically supported evaluations of community-based mental health programs.

A critical and pressing question remains: Which of these programs significantly promotes sustainable and measureable recovery for persons with SPMIs? Further, how can recovery be measured in a way that programs can be compared? The ability to measure treatment and rehabilitation to determine recovery has critical implications for all stakeholders. However, definitions of recovery vary.

Individuals with SPMIs define recovery as a process—not an outcome—and explain that recovery for them occurs in intervals, as symptom relapse often occurs, interrupting the recovery

process (Anthony, 1993). Local and state policy makers, meanwhile, define recovery in terms of client self-reports of satisfaction and empowerment (UT.D.H.H.S, 2008). National policy makers define recovery in terms of being able to live as independently as possible in an integrated community environment (U.S.D.H.H.S., 1999). Such diverse definitions of recovery complicate the analyses of the efficacy of treatment and rehabilitation programs.

Defining recovery in terms that are measureable is critical to its evaluation. A significant issue affecting many persons with SPMI is frequent use of mental health services, such as emergency crisis care, and outpatient care, and inpatient psychiatric hospitalization. One example of recovery may be evaluating inpatient hospitalization. Inpatient hospitalization and re-admissions generally occur when the individual with SPMI is experiencing high symptoms requiring stabilization (Segal, Watson & Akutsu, 2002). Further, the mental health system views the role of psychiatric hospitalization as a means of stabilization (Mueser et al., 2002). Inpatient hospitalization is not recovery. Therefore, reduction of mental health service usage, such as a reduction in inpatient hospitalization, may indicate recovery, and may be a valid, objective definition, thus measurement of recovery.

Background

Prior to the mid-twentieth century, the majority of persons with SPMIs lived in institutions. The deintuitionalization movement, often termed transintuitionaliztion, sought to integrate individuals with SPMIs into a community setting, as opposed to the isolation of State run hospitals and mental asylums (Anthony, 1993; Bond, Salyers, Rollins, Rapp, Zipple, 2004; Drake, Green, Magaw, 2003; Mueser, Goldman, 2003). The advent of new medications contributed to this shift in treatment. For example, lithium was believed to be an effective treatment with which recovery was seen as possible for persons with SMPIs. However, early on,

little was known about the side-effects of psychopharmaceutical treatment. Further, many persons with SPMIs that were released from institutions had nowhere to go. Moreover, families, medical health care workers and mental health care workers knew very little about providing services to these individuals (Drake, et al., 2003; Mayo Clinic, 2009; U.S.D.H.H.S., 1999; WHO, 2004).

From the 1970s to the present, community-based mental health programs have focused on mental illness as a social welfare problem while providing both community integration and access to necessary services (Anthony, 1993; Drake, et al., 2003; U.S.D.H.H.S., 1999). Community integration and inclusion is foundational to recovery for persons with SPMIs, as well as for health and mental health professionals, and policy makers. Of additional importance are opportunities for persons with SPMIs to direct their treatment and recovery (Magaw, 2003; Mowbray et al., 2006).

A person-centered approach (referred to as the Recovery Model) focuses on the rights of an individual with SPMI, and in promoting choice (Anthony, 1993). Current direction has moved toward a Recovery Model (Anthony, 1993; Cougnard et al., 2006; Hutchinson et al., 2006). Specifically, this shift seeks to enhance the overall well-being of individuals with SPMIs, rather than just simply treat their diagnosis or attend to their symptoms (Bryant et al., 2005; McKay & Pelletier, 2007). Individuals with SPMIs play an integral role in the direction and type of treatment they receive (Hutchinson et al., 2006; Mowbray et al, 2006). One example of a community-based mental health program emphasizing the recovery approach is the Clubhouse Model (Drake, et al., 2003; Glickman, 1992: McKay, 2005).

History of the Clubhouse

In the 1940s a self-help group of individuals with SPMIs were discharged from the Rockland State Hospital in New York. With the help of their families, they purchased an old brownstone in Hell's kitchen that had a fountain in front. They called it their Clubhouse, and aptly named it Fountain House (Di Masso, Avi-Itzhak, Obler, 2001; McKay, 2005). In 1948 Fountain House members hired John Beard as their director. Beard developed what is now known as the Clubhouse Model (Glickman, 1992; McKay, 2005). Central to the Clubhouse Model's ideology is the premise that relationships, meaningful activities, and supported employment promote recovery for persons with SPMIs (Corrigan et al., 2008; Di Masso, Avi-Itzhak, Obler, 2001; ICCD, 2001; McKay, 2005, Pernice-Duca, 2008).

At Clubhouse, persons with SPMIs are referred to as members. Clubhouse membership is not time limited and members can come and go as at will. Social support and the power of choice in a community setting are the bases of the Clubhouse Model (Corrigan.et at., 2008; Glickman, 1992; McKay, 2005). Moreover, it is difficult to distinguish staff from members, as no direct treatment is provided. For example, Clubhouses are not centered in traditional talk therapy, nor do they dispense and monitor medications. Further, there is no direct delivery of mental health services, such as counseling or medication management (Barbato et al., 2007; Hutchinson et al., 2006; McKay, 2005; McKay & Pelletier, 2007). However, access to information about services is always available. Staff and members work side-by-side in the day-to-day business of running the Clubhouse. This is termed the "work-ordered day" (Glickman, 1992; McKay, 2005).To best understand the "work-ordered day," (McKay, 2005) the following is a description of a typical day at a Clubhouse in Salt Lake City, Utah, Alliance House.

Upon arrival, club members decide for themselves what level of engagement they feel is best for them. Sign-up boards flank the rooms and halls, listing duties such as gardening, sweeping, greeting people, answering the telephone, cleaning up or making lunch. Each job is regarded as important and necessary to the existence of the Clubhouse (Mowbray et al., 2005; Magaw, 2003; Masso et al., 2001).

The day starts with a general meeting, which is facilitated by a volunteer member of the Clubhouse. The meeting opens with an overview of ongoing Clubhouse business. Members who are working in various projects share their progress, as well as ideas, questions, concerns, or make requests of the group. Members and staff then break into the self-selected unit groups (Alliance House, 2009; McKay, 2005). There is a culinary unit, responsible for planning, shopping for, and preparing Clubhouse meals, as well as tending the Clubhouse garden; a business development unit, responsible for such activities as member housing, producing a newsletter and so on; and a career development unit which seeks supported employment and educational opportunities for members in the community (Alliance House, 2009; McKay, 2005).

Philosophy of the Clubhouse Model

The philosophy of the Clubhouse Model is to facilitate the needs and issues of persons with SPMIs (McKay & Pelletier, 2007). Clubhouse members are encouraged to actively participate in the creation of their treatment plan. This client-centered, client-directed approach is implemented in an environment focused on social support (Hutchinson et al., 2006; McKay & Pelletier, 2007; Mowbray et al., 2006). Clubhouses are situated in neighborhoods, and club members are active members in their community.

Treatment for individuals with SPMIs can be difficult. Persons with SPMIs generally have a dual diagnosis (McKay & Pelletier, 2007). Specifically, persons with SPMIs, in most

cases, have a physical impairment or diagnosis, and/or substance abuse issues (Nguyen et al., 2005). One diagnosis, or the symptoms of that diagnosis, can trigger or impair treatment of the other diagnosis (Nguyen et al., 2005; Jones et al., 2004; Berren et al., 1994). Foundationally, the Clubhouse Model facilitates treating the whole person (Anthony, 1993; McKay & Pelletier, 2007), not just focus on symptoms (Nguyen et al., 2005). This model also addresses the consequences of all of the conditions that may impair an individual with SPMI from achieving complete well-being, while assisting and promoting recovery through these difficult intervals (Anthony, 1993; Barbato et al., 2007; Hutchinson et al., 2006; Mowbray et al., 2006).

One condition that severely impacts persons with SPMIs is employment (McKay & Pelletier, 2007). Surviving life: keeping food, clothing, and shelter intact are overwhelming. Individuals' with SMPIs struggles don't stop here. Not having access to necessary medication and services or service providers that see the whole person compounds these struggles. This, in turn, most often leads to crisis care, emergency room visits and/or hospital stays (Berren et al., 1994). Therefore, holding and keeping a job becomes problematic for this population; creating a vicious cycle that one afflicted with SPMI has difficulty escaping (Hutchinson et al., 2006). Employment becomes a central and significant issue. Recent studies suggest that providing a bridge back to employment, on an individual's terms, with appropriate levels of community and social support, promotes well-being (Bryant et al., 2005; Magaw, 2003; McKay & Pelletier, 2007; Mowbray, et al., 2006).

When the club member decides he/she is ready, the Clubhouse Model provides access to outside, community employment. Mentors (often previous clubhouse members who are in recovery) lead sessions such as building resumes, dressing for interviews, and interview preparation. Business and community partnerships are integral elements of the Clubhouse

Model. (Mowbray et al, 2005; Masso et al., 2001; Mckay & Johnsen, 2005). It is through these partnerships that a staff member of the Clubhouse will train for a specific community-based job or position, as well as insure the employer that someone will be there, on time, and trained to do the job (Mckay & Johnsen, 2005). The Clubhouse staff member then trains a club member or members (Masso et al., 2001; Mckay & Johnsen, 2005). With the added social support, more often than not, it is reported that the experience is positive and beneficial for all involved. Clubhouse members then reap the benefits of job security, and are often asked by the employer to become a permanent part of the staff (Bryant et al., 2005; Masso et al., 2001; Magaw, 2003; McKay & Pelletier, 2007; Mckay & Johnsen, 2005; Mowbray, et al., 2006). Further, unique to the Clubhouse Model, club members experience little or no interruption in employment. This is because of supported employment services provided by the Clubhouse Model Program (McKay, 2003).

Methods

The purpose of the current study was to measure the impact of participation in Alliance House on subsequent usage of other mental health services. The hypotheses of this study it that mental health service usage would decrease after participation in one Clubhouse, Alliance House. This study builds on the findings of three previous studies specific to the Clubhouse House Model and hospitalization recidivism (Di Masso et al., 2001; Propst, 1997; Wilkson, 1992). However, robust research particular to other types of community-based mental health programs have focused on outcomes specific to hospitalization recidivism (for example see Bond et. al., 2004). This study is unique in that no other Clubhouse research is known to have evaluated the effectiveness of the program specific to outpatient service usage and crisis care

service usage. Rather, research conducted on the Clubhouse Model has primarily focused on employment (for example see McKay, 2005).

Participants

This current study was a secondary statistical data analysis utilizing Medicare, Medicaid and insurance billing records provided by Valley Mental Health, specific to all persons (N = 378) who have had contact with Alliance House from 1988 to July 2009. Valley Mental Health is a not-for-profit organization in Salt Lake City serving 3 counties (Salt Lake – Tooele – Summit). Valley Mental Health makes available "comprehensive treatment and services for people of all ages who are experiencing serious mental illness, substance abuse, and/or behavioral problems" (Valley Mental Health, 2006, p.6). No personally identifying characteristics were provided.

Data for 378 persons from 1988-2008 were provided in the format of three files; 1988-1990, 1991-2000, 2001-2008. The sub-set for this study was created utilizing data in the two most current files (1991-2000 and 2001-2008). These two files were split in half, identifying the years 1996 and 2005. Data was then sorted specific to all persons who made initial contact with Alliance House in 1996 or 2005. Data for 41 persons emerged and were analyzed for this study.

Analysis

This analysis was an evaluation of a seven-year time frame, including the year of initial contact with Alliance House: Three-year period pre-initial contact with Alliance House, and a three-year period post-initial contact. All persons analyzed in the current study had mental health service usage through Valley Mental Health in each of the seven years, as well as a minimum of 20 hours of participation at Alliance House. Upon analysis 4 of the 41 individuals were excluded as outliers because their mental health service usage minutes had data that exceeded three standard deviations from the mean. Therefore, for this study, n = 37.

To determine possible significant differences in utilization of services pre- verses post-initial contact with Alliance House, the total number of minutes was calculated for each of the following categories:

- Outpatient care: A planned program for the alleviation of specific mental health problems, outside of an inpatient or emergency treatment program.
- Emergency care: Immediate UNSCHEDULED care required to deal with an acute need or psychological crisis.
- Hospitalization (inpatient) care: any licensed hospital that provides twenty-four hour psychiatric supervision (excluding the Utah State Hospital). (Valley Mental Health, 2006, p.16.)

The totals of pre-contact service usage were compared to totals of post-contact service usage in each of the three categories of service. Due to restrictions in data, analysis did not include the year of initial contact with Alliance House.

Results

The purpose of the current study was to evaluate the impact of participation at one Clubhouse, Alliance House, on mental health service usage. Statistical analysis netted mixed results. The hypothesis that mental health service usage would decrease after initial contact with Alliance House was only partially supported. This analysis suggests no significant change in the utilization of outpatient services or emergency and crisis care services. However, there was a decrease in minutes of re-hospitalization post-initial contact Alliance House, as illustrated in Figure 1. The pre-inpatient usage mean was 236.08 minutes (n = 37, std. = 507.664, $\pm$ 83.46). The post- inpatient usage mean was 57.56 minutes (n = 37, std. = 156.78, standard error of $\pm$ 26.27). Comparing pre-inpatient usage minutes mean to the post-inpatient mean, utilizing a

paired-samples, two-tailed t-test (t = 1.98; d/f = 36) a trend approaching statistical significance (p = .055) emerged.

Limitations

The sample (n = 37), where valid, is small. Analysis included a sub-set of data for one Clubhouse, Alliance House. Future research should include evaluation of entire Alliance House data set (N = 378), which would provide a more complete look at this particular program.

Discussion

This study supports findings of previous research specific to participation in the Clubhouse Model and a significant reduction in hospitalization (Di Masso et al., 2001; Propst, 1997; Wilkson, 1992). Specifically, this analysis indicates that Alliance House members experienced a reduction in hospitalization—by more than four-times—after initial contct.. It is evident that secondary data analysis of existing billing records may be an efficient and effective way to conduct an evaluation of recovery for persons with SPMIs, allowing for a comparison of mental health service usage before and after participation in a community-based mental health programs over time. Further, this type of analysis allows for cross- and inter-program comparisons, as well as illustrating trends of recovery experienced by persons with SPMIs attending such programs.

One challenge to this solution may be that policy makers value client narratives (Farkas & Anthony, 2007) and employ self-reports surveys (UT.D.H.H.S., 2008) to guide policy, rather than objective measures of recovery validated by significance rates and coefficients (Farkas & Anthony, 2007). Utilizing both types of analysis–client self-report evaluations combined with empirical analysis of inpatient psychiatric hospitalization readmissions–may provide a substantive view of the effectiveness of community-based programs for persons with SPMIs.

Studies such as this have strong implications towards advising both policy and practice. One example is in the ability to critically evaluate the cost associated with hospital readmissions contrasted with the cost of a community-based mental health program, such as a Clubhouse. Evidence that is suggestive of a program's economic value is critical to policy makers, and important to the fiscal wellness of the consumer. Specifically, Jeremy Christensen, the Executive Director for Alliance House reports (personal communication, September 28, 2009), "on average, [one three-day stay of] psychiatric hospitalization for an individual with SPMI generally costs $1200-$3000. The median cost of one-year at Alliance House is approximately $750, with the mean annual cost of $3000. Further, Wilkson (1992) reports that [in North Carolina] "the average length of stay [in an inpatient psychiatric hospital] is 11.4 days for a person in acute care psychiatric unit ….the average stay at an acute care facility is 15.9 days…. State Hospital [the average stay] is 4005 days." The reported cost of this type of hospitalization varies, ranging from $4,550 to $75,000 per stay, concluding that the average cost, per year, for Clubhouse membership is $4,750 (p. 7). Further, Probst (1997) reports that in New York the average cost of Clubhouse participation is $21,000 at Fountain House. The annual cost of inpatient psychiatric hospitalization in New York is estimated to be $120,000.

Recovery is possible for many persons with SMPIs. Current community-based mental health programs, when evaluated with the criteria of evidence-based analyses, may conclude the programs significance, effectiveness, and economic and fiscal value, in promoting recovery for persons with SPMIs.

Future Research

This analysis compared total pre- and post-minutes of mental health service utilization aggregated across three year periods. However, it appears that there may be some interesting

patterns of usage from year to year that warrant further investigation (see Figures 2-5). As a next step, analyzing patterns and changes in mental health service usage from year to year is merited. These additional analyses may provide a better understanding of the role this Clubhouse Model plays in recovery for persons with SMPIs. For example, as shown in Figure 2, it seems that minutes of participation at Alliance House actually decrease from year to year after initial contact. However, this trend has not been tested for statistical significance. In addition, Figure 3 illustrates an increase in utilization of outpatient minutes in the three years post-contact with Alliance House, followed by a gradual decrease. Emergency and crisis care, as seen in Figure 4, appear to have peaked in this sample during the year of initial contact, and the years immediately following, and then shows a decrease. Hospitalization, as seen in Figure 5, on the other hand, peaked in the year before initial contact, while the years after remained relatively low. Again, these patterns have not been tested for significance.

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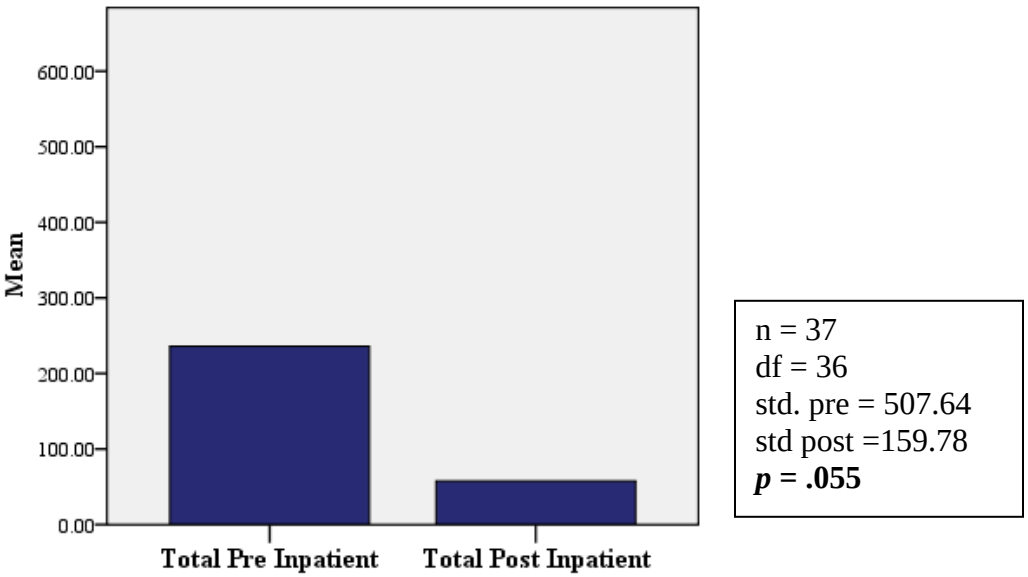
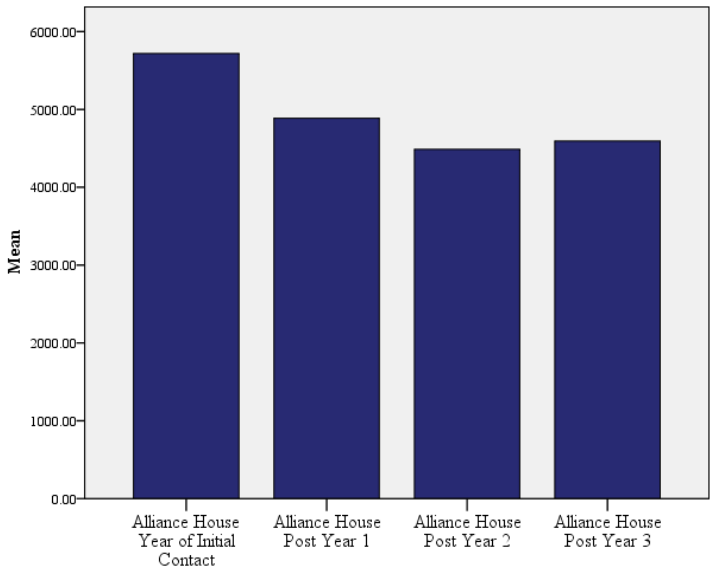


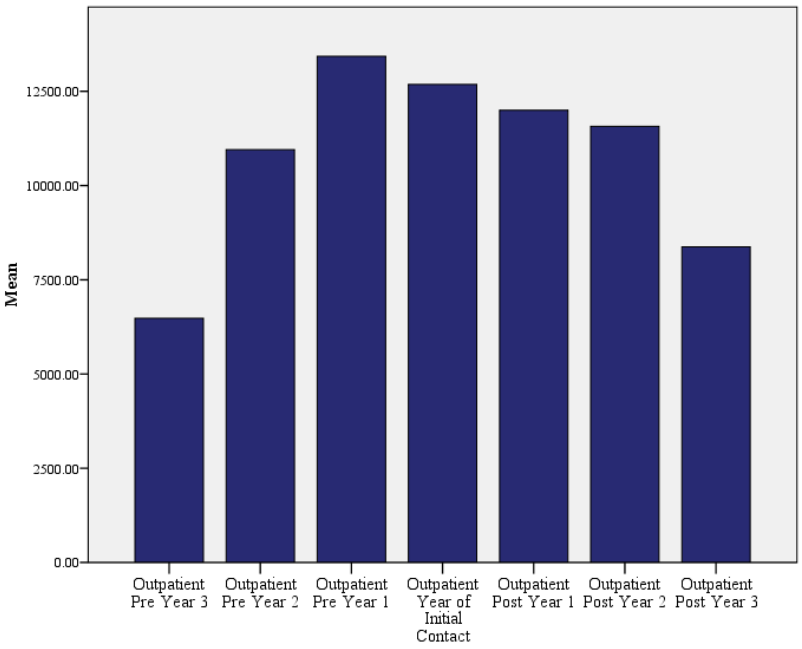
Results: Hospitalization (Inpatient) Care

Figure 1: There was a decrease in minutes of inpatient hospitalization post-initial contact Alliance House. This decrease approached statistical significance.



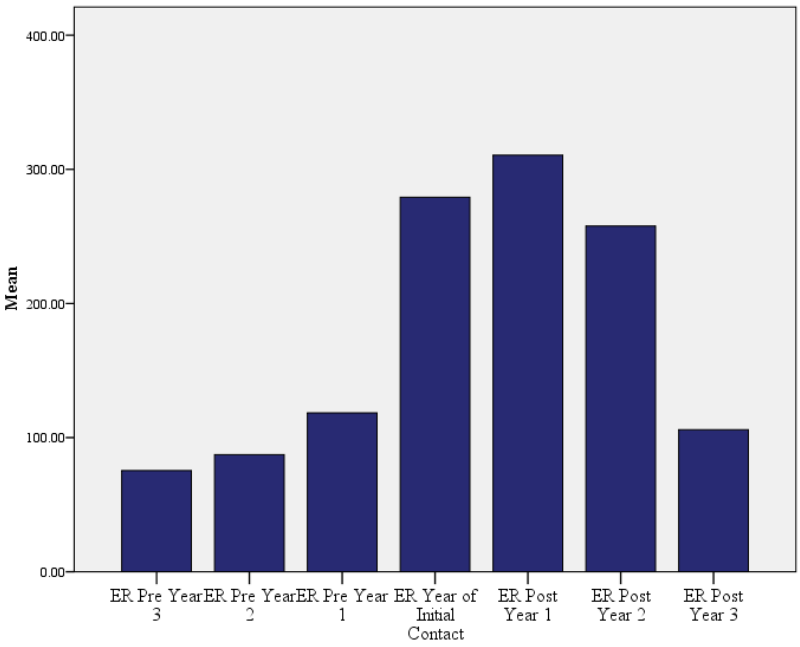
Future Research: Alliance House

Figure 2: Minutes of participation at Alliance House seem to actually decreases from year to year after initial contact. However, this trend has not been tested for statistical significance.



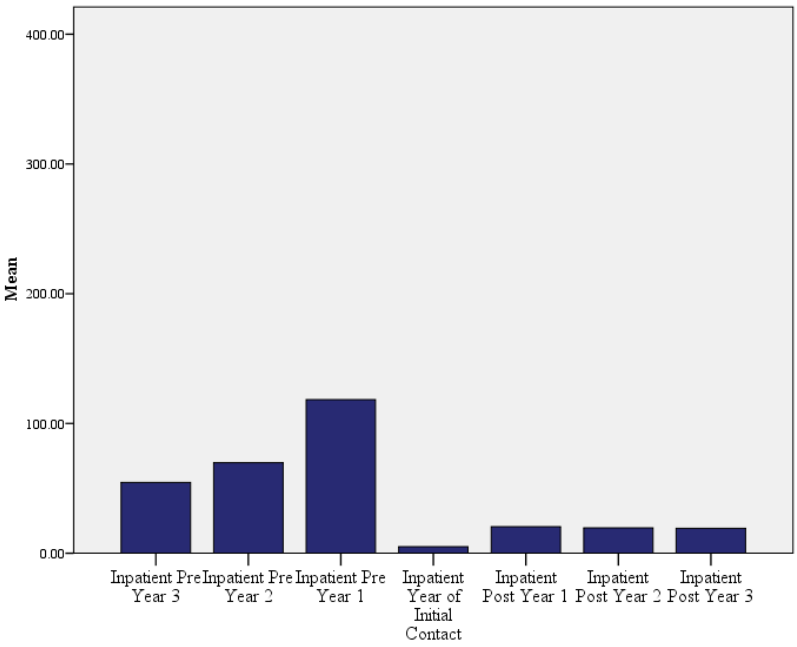
Future Research: Outpatient Care

Figure 3: An increase emerges in the utilization of outpatient minutes in the three-years post-contact with Alliance House, followed by a gradual decrease. This trend has not been tested for statistical significance.



Future Research: Emergency and Crisis Care

Figure 4: Emergency and crisis care, however, appear to have peaked in this sample during the year of initial contact, and the years immediately following, and then shows a decrease. This trend has not been tested for statistical significance.



Future Research: Hospitalization (Inpatient) Care

Figure 5: Hospitalization peaked in the year before initial contact, while the years after remained relatively low. This trend has not been tested for statistical significance.

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