

[Music]

Ivette:

Hello, I'm Ivette Torres and welcome to another edition of the *Road to Recovery*. Today we'll be talking about assessing for behavioral health issues within primary care. Joining us in our panel today are Dr. Wilson Compton, Deputy Director of the National Institute on Drug Abuse, Washington, D.C.; Dr. John Kelly, Associate Professor of Psychiatry in Addiction Medicine at Harvard Medical School, Massachusetts General Hospital, Boston, Massachusetts; Frances M. Harding, Director of the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention, US Department of Health and Human Services, Rockville, Maryland; Paul Gionfriddo, President and CEO of Mental Health America, Washington, D.C. Dr. Compton, what is the prevalence of mental and substance use disorders in our nation?

Dr. Compton:

I think it's surprising how many people suffer from mental and substance use disorders in our country. When we try to tally the number of people, it's not an easy thing to do, so we use surveys that go from door to door in households. And from those surveys we find that there are millions of people with both substance use disorders and mental illness. For example, there's something like 6.5 to 7 million individuals with a disorder related to the illegal drugs and about 15 or 16 million or even higher 18 million with a disorder related to alcohol. So these are very common conditions.

Ivette:

And Paul, talk to us about mental health conditions. Are they pretty much do they, are they pretty much the same as for alcohol or drugs or are they a bit different?

Paul:

One of the things at Mental Health America we like to say is that mental health conditions are really no different from any other kinds of physical health conditions and that what we think needs to happen with all behavioral health conditions is that we need to start thinking about them as just simply physical health conditions like all others. We need to screen for them the way we screen for others, we need to act on them the way we act on others, and we need to stop having this separate system of care that really involves waiting till a crisis, waiting till what we call stage 4 of a disease process before intervening and then often only intervening through incarceration. We've got to act before stage 4. We've got to move upstream, talk about prevention, early identification and intervention and work from there.

Ivette:

And Dr. Kelly, obviously we have seen from both examples in terms of what the trend is that there is a great need. Are there a lot of unmet needs in the country for individuals who are living with these conditions?

Dr. Kelly:

Indeed there is. There's about 10% of people each year, for example, access or get care for a substance use disorder of the 100% of people who have those. So only about ten, about 2.3 million people actually access specialty care. Different reasons why that is true. Part of it is perceived stigma and discrimination. We know that these conditions, both mental health conditions and addiction substance use disorders are probably among the most if not the most stigmatized conditions in society. So it does prevent a lot of people from seeking out specialty care and that's, of course, why we're here talking about this topic today because primary care is where 90% of people actually with a substance use disorder or mental illness will access. They will access their primary care office. So there's a prime opportunity there to begin a conversation around alcohol, drugs and mental illness.

Ivette:

Fran, Paul just mentioned a little bit about prevention. As we look at the primary care system, does the ACA currently focus on prevention of these diseases?

Fran:

It focuses on prevention but not in the traditional way of just looking at insurance coverage although there are screenings for adults that are covered under the ACA for substance abuse, mental illnesses, tobacco-related illnesses, and such. For the young people we currently only have a couple of screenings; one for alcohol abuse and one for depression. But we look at ACA as embracing primary prevention across the continuum of services, not just insurance.

Ivette:

And tell us what those two screening mechanisms are so our audience will learn a little bit more.

Fran:

The difference between the adult and the youth, they are interventions, and the normal tests that could be performed in a professional—is performed in a professional's office, and young people also go to their doctor and they look for signs of high risk use or that the young person is in danger, or has the early signs and warnings of an alcohol disorder, a drug dependence, or a mental illness of sorts around mostly just depression with young kids.

Ivette:

Very good. Dr. Compton, in terms of really dealing with the assessment for mental health conditions and addiction issues within primary care, are we doing it in a way that's being effective within that system currently?

Dr. Compton:

Certainly there are examples of effective screening and effective ways of identifying people who have problems with alcohol and drug use disorders or mental illness, but the unfortunate answer is these are not being applied very widely. So part of our goal today is to increase attention to this issue so that more physicians will include in their practice, whether that's questions that they might ask or that might be asked with the online materials we all fill out when we go to the doctor or fill out before we see the nurse when we first get there. Those are the different creative ways to make this a seamless part of general medical care.

Ivette:

And Paul, have you noticed whether the ACA has in fact increased—obviously there was the Parity Legislation and the ACA does call for a larger plethora of services for the mentally ill as well. Has it been making a difference within the community?

Paul:

Well, I think we hope it will make a bigger difference in the future. In the course of the past year or so at Mental Health America we put up screening tools on our website that people can use anonymously. They just go to www.mhascreening.org to find them. We get about a thousand people a day who go and use those tools and what we have found is that the preponderance of people who are screening are young. Seventy-five percent are women. More than half are between the ages of 18 and 34, and about two-thirds of the people who use one of those screening tools screen out as either in the moderate to severe range or positive for one of the conditions, whatever condition for which they screen. And what they tell us also though is that two-thirds of those people have never been diagnosed with a mental health condition before. So what we think we need to do is to be able to use this kind of information and use these kinds of tools so people will be able to begin a discussion with their doctors in their primary care offices because I think personally that screening for children ought to be as ubiquitous as dental screening, vision screening and hearing screening. And I think for adults it ought to be as ubiquitous as blood pressure screening is and it has not become that yet. But I think that should be the goal we all should be aiming for.

Ivette:

Absolutely. Dr. Kelly, what are the services that people ought to be looking for within primary care to address mental and substance use disorders?

Dr. Kelly:

What are the services?

Ivette:

What services directly. Should they be receiving counseling, should they be looking for—if I walk into a service and I've got a child that is showing some

symptoms that are not within the norm and I take them into primary care, what should I, as a parent, be looking for?

Dr. Kelly:

Well, I think detection. So understanding the nature of the scope, the topography and the nature the symptoms. That should be elucidated in the encounter with a primary care physician or somebody within the primary care practice. It doesn't necessarily have to be the primary care physician themselves but somebody who is embedded within the primary care practice who can do that screening as part of the practice. And then beginning the conversation, doing a more—if they screen positive for a certain disorder, then to do an assessment and to identify the nature of the level of care that might be needed whether that's a brief intervention or something more in depth or a referral to some more specialty service that could benefit that individual.

Ivette:

Very good. Dr. Compton, is it similar with substance use disorder issues?

Dr. Compton:

Certainly, when we think about what can be done in a medical setting, in a primary care setting, the first goal will be the assessment. How severe is the problem, then a plan of treatment. Do we need to take care of it right there in the office of the primary care? That may work for a mild condition, but for anything of severity or complication it will almost always need to be referred out. But there's another key component. They physician can provide two other things. They can provide follow-up and long term assessment and determination whether there's complications over the long haul because that primary care doc will have a relationship with the patient for a very long time. They also might be able to provide medications and that's a key role for the medical system is to treat these with medications when those are indicated.

Ivette:

When we come back, I want to continue talking about behavioral healthcare within the primary care system. We'll be right back.

Male VO:

For those with mental or substance use disorders, what does recovery look like? It's a transformation. It's a supporting hand. It's new beginnings. When does recovery start? It starts when you ask for help and support. Join the Voices for Recovery. Speak up. Reach out.

Female VO:

For information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

[Music]

Pam:

It's really important that primary care be involved in the issue of identifying mental health issues, substance use issues the reason is because people who have these issues and have not been diagnosed or identified or I haven't risen all the way to an actual disorder but are having a problem that needs to be dealt with they don't walk into a program that is designed for substance abuse and mental health treatment. They walk into their primary care office and they walk into their doctor's office for things having nothing to do with addiction or mental illness. It's really important that primary care providers and practitioners be equipped to think about and to identify and ask questions about substance use, about alcohol use, about depression, about anxiety, about mental health issues in order to help identify those people who may need information or some brief intervention to prevent a more difficult problem or frankly to identify a person who may be suffering from an addiction or mental illness and needs treatment.

Ivette:

Fran, what is behavioral health? I know that a lot of people know what mental health and substance use disorder, but behavioral health, what is that concept?

Fran:

The concept for SAMHSA and our field is the emotional, mental and physical state of individuals. So specifically we're talking about services for promotion, prevention, treatment and recovery. It's a way for us to be able to focus on the whole person, the whole community and the whole family and all of the different needs that a person and the family and a community may need.

Ivette:

And Dr. Kelly, in terms of that impact of behavioral health, let's talk a little more about how it impacts physical health. If a person has a mental health problem or if they have a substance use disorder problem, how is that gonna impact the overall health?

Dr. Kelly:

It impacts health dramatically in many different ways. When you think about we talk about substance use disorders, for example, and related problems as a number one public health problem in the United States, right? So as a number one public health problem it affects physical health, mental health, productivity behavior in many different facets. But you can think of substances, for example, causing harm in three different ways. One is through addiction, so what we classify and talk about as substance use disorders. Another one is through intoxication. You don't necessarily have to be addicted to suffer the harm of intoxication. Accidents are the typical outcome of intoxication, for example. And toxicity is the other one. We know that through toxicity, long term exposure, for example, to

alcohol causes liver problems and also increases risk for certain types of cancer, cancer of the breast in women, esophageal cancer, cancer of the larynx and pharynx and colon. So it affects health particularly with substance use but also mental health because mental health issues apart from substance use also affects people's ability to cope with the demands of everyday living because it compromises their self care ability.

Ivette:

So it gets into productivity issues, Paul, and what they're giving back within their jobs and society?

Paul:

It does all of that, that's right. And that is one thing that a number of people are beginning to focus on increasingly is that in the workplace for adults, the affects of mental health problems, absenteeism, people being present in the workplace but not really able to give a full day have been dramatic and, of course, have now been quantified into the billions of dollars. But let's also talk children in this regard because the affects of major and significant mental health conditions on children is also dramatic. Those are the children who get suspended from school more frequently. Those are the children who get expelled from school more frequently. So those are the children who don't get their high school degrees, don't get their college degrees, and therefore get off with a very poor start in life when they hit adulthood. And we've really got to think about that. Think about changing this paradigm about moving upstream and trying to address and really more than address but deal with these issues much earlier on in a disease process so that we really can change trajectories of lives and really have good outcomes and not lead to these really bad and really devastating affects.

Compton:

One of the issues in general medicine and primary care is that these conditions are always related to one another so that a patient comes to their family doctor because of high blood pressure and they're not responding to medications. Well, one of the key things that doctor needs to ask about is how much alcohol they're drinking or whether they're using cocaine. So that when you have physical health conditions that are poorly responsive or not doing very well, a key risk factor and a key problem might be an underlying substance use issue. This is one simple way that they're related and showing us how important it is for doctors to use those clues from their clinical practice to then go after and start identifying mental illness and substance use problems in their patients.

Paul:

One of the things, by the way, that's so important about that point is that a lot of people think it only works one way. They think that, well, if somebody's got a chronic condition, say cancer, of course they're gonna become more depressed and that that's the natural outgrowth of these conditions. And what they don't understand is people who have first the mental health conditions are often more

likely to have other chronic conditions as well. So we have to ask the questions in both directions and we have to be treating the whole person at one time.

Fran:

I was gonna say, when we're not treating the whole person, we're also raising the cost of when we do treat the whole person. So if their behavioral health needs are ignored, it's two times the cost if you identify hypertension, for example, and you're not identifying the contributing factors of a mental health or a substance use disorder; three times for a coronary disease and then the biggest one is four times for diabetes which is one of the biggest areas of concern in our country right now.

Ivette:

So obviously this is a real issue in terms of dollars and cents for this country. So Dr. Compton, tell us why are we not getting more physicians to actually assess for these conditions, even now as we're trying to integrate it into primary care?

Dr. Compton:

I think there are multiple reasons for that. Some is this is many physicians have a sense that there's nothing they can do and there's no hope so why would you screen and identify cases when you can't do anything about it. So we need to address that what I would call therapeutic nihilism, a fear that you have nothing that you can do. And we can do that because there's a lot that the physicians can help with. A second very practical issue is there was no way to reimburse physicians for the extra effort they have to go to to identify and then intervene in these cases. So we need to make sure that there are financing mechanisms and that's where the Affordable Care Act, this new healthcare reform can play a role in providing the ways that we can reimburse physicians appropriately for the extra effort they put in for these sometimes very complicated patients.

Ivette:

And how are we going to do that?

Dr. Compton:

Well, some of it is by paying for substance use services so that up until now there have been many insurance programs that really provide almost no coverage for mental health and particularly the addiction services. And with healthcare reform with mental health and substance abuse parity laws there's at least the possibility of those being paid for. I have to say the possibility because so far we're still seeing gaps even in the insurance that's available just in the last year or two. So there's still some work to do.

Ivette:

Very good. Dr. Kelly, you're at Harvard and Harvard has a medical school. How are we now educating the new physicians that are coming in to actually screen for these conditions?

Dr. Kelly:

Well, I'm happy to report things are changing but when we make these shifts, it does take a while for them to really get into our blood and into our culture and the culture of medicine. I'm very happy to report that in fact Massachusetts General Hospital where I work, we have made the top priority of the hospital, of the general medical hospital, substance use disorder, we screen all patients at Massachusetts General Hospital. And that's a new initiative that's just started in the last year because of the recognition of the high volume, high disease burden on health and mental health that affects healthcare; healthcare service delivery, healthcare costs and healthcare efficiency. So it is changing but it's gonna take time for that to happen because really we're talking about a cultural shift in practice, a conceptual and practice shift where, you know, historically physicians have not—primary care physicians have thought addiction and mental health, that's not my business, I don't do that stuff, I do physical health, I do from the neck down, I do it from the neck up, and they're kind of separate issues. But now what we are seeing and observing in terms of efficiencies of care is treating the whole person. Treating the whole person as one entity, that mental health affects physical health, physical health affects mental health if you treat the whole person. I like what Paul is saying several times here which is if we're serious about addressing mental health and addiction issues in the country, if we're really serious about it, where do we start screening? Where in the population would you start to screen people just like we do with mammography and other kinds of—where should we start to do the screening? Because you look to see where the onset is and you start to screen early, detect it and offset trajectory as Paul is saying. And so in adolescents and young adults, that's really where we want to be putting our energy to try and identify cases early before, as Paul said, we don't wait until people get really sick and have a much poorer prognosis and cost more to treat by screening them early.

Ivette:

And Paul, yet we see if we take what Dr. Kelly is saying and we take it into real time, we know that schools can play a big role. We know that the family can play a big role. But can you expand on what they can do in order to identify those individuals early in the process so that it doesn't get to a crisis setting.

Paul:

I'm sure there are probably three or four things we all could identify but let me just talk about a couple of things. Centers for Medicare and Medicaid services back in December changed the Free Care role, or at least the interpretation of the Free Care role.

Ivette:

Which is?

Paul:

Well, in the past if you were to do ubiquitous screening in a school and you did it for free, then you couldn't bill Medicaid for that if you were providing it to kids who

were otherwise eligible for Medicaid. Now you can. So in nearly every public school in the country they could now generate hundreds of thousands of dollars, if not millions, just by screening ubiquitously for conditions like mental health conditions. So that removed a significant barrier to getting reasonable mental health screening and, by the way, de-stigmatizing because if you do mental health screening, not mental illness screening but mental health screening for every child, then we don't have to be concerned as much about our child being singled out if we're being told that there are behavior problems in school. So that's one thing that we could do. I think that parents also, as well as educators, need to be thinking of themselves as part of a clinical team along with their primary care providers and also their community clinicians. Right now if you do have a child who unfortunately shows signs of a serious mental illness, chances are they're going to need some support in school. They're going to have to be admitted to special education for that purpose and get that support. Well, in the most recent year, of every 28 children who had a serious mental illness, only one of them was actually identified for special education purposes as being a so-called SED kid, being a child who is eligible for Special Education because of that. The other 27 were being ignored. And it's parents and teachers who have to be willing to work with clinicians in the community, and schools that have to be willing to invite those community clinicians back in to help them that's gonna solve this.

Ivette:

And to know their rights as parents of the children that are in these schools systems and must provide those services. And when we come back, I want to continue to talk about these issues. We'll be right back.

[Music]

Daryl:

SAMHSA screening and brief intervention and referral to treatment programs better known as SBIRT has made a great contribution to the field by providing funds to train healthcare workers within primary care to assess clients for alcohol or drug problems. This effort is a key initiative in the drive to integrate behavioral health services into primary care. The center for substance abuse treatment supports addiction technology transfer centers where treatment providers in Academia can access training modules and other materials that address the SBIRT model.

[Music]

Carla Taylor:

At Affinity Healthcare Group, we provide services, such as individual and group counseling along with medical needs for the patient. We provide opiate addiction treatment.

Dr. John Scanlon:

Most of the folks that we see in this clinic have been addicted to heroin for greater than a year. How did they get addicted to heroin? Usually they were on pain pills first. The clinic is a practice that provides full service addiction services which extend from counseling services to the provision of medication-assisted treatment. The Methadone or the Buprenorphine, we do both in this clinic, is just a tool that's used to help the patient not get sick while we can use the other interventions.

Carla Taylor:

Our treatment modalities include cognitive behavioral therapy, motivational interviewing along with reality therapy.

Dr. John Scanlon:

Most of the patients that come to this particular practice walk in the front door or get referred to us by other people that are in the clinic, by word of mouth.

Carla Taylor:

Usually they have reached the point where they find that it's time for them to receive some type of assistance for the opiate addiction. I feel it is very important to have a holistic approach for each patient in order for them to receive the treatment they need which includes counseling at the clinic, receiving medical care they need, coordinating care with primary care physicians as well as possible psychiatrists, outpatient therapists.

Dr. John Scanlon:

We have become primary care in many of these cases. I would like to see the integration of substance abuse treatment in primary care. The goal is to catch the substance use before it becomes a conflagration, trying to catch occasional use before it becomes high risk use. We're approaching the 300 patient amount we've been open less than 2 years and there is still an unmet need out there. We are taking new patients all the time. That's the challenge not just here but in the health care system in general trying to take care of the health care needs and addiction care needs specifically of too many people in too short a period of time.

Male VO: Your path to recovery isn't like mine

Female VO: You have your own struggles with mental health issues

Male VO: Your own challenges with substance use disorders

Female VO: You also have your own abilities and strengths

Male VO: But when you need a hand

Female VO: Reach out until you find one.

Female VO:

For information on mental and substance use disorders including prevention and treatment referral call 1-800-662-HELP. Brought to you by the US department of health and human services.

Ivette:

Dr. Compton, you wanted to comment on some of the notations that Paul made.

Dr. Compton:

Absolutely. The idea of doing screening in an automated way whether that's online or in a nurse's office or in school is just a terrific idea. At the National Institute on Drug Abuse, for example, we have online screening as part of our universal prevention. So there's the family checkup that's a way for parents of teenagers to find out if they or their kids are at risk and get the services that they might need. We also have a program called NIDAMed that is an online screening tool that links people with the idea of screening and perhaps even a brief intervention for their alcohol, tobacco, or substance use issues. And that's a very promising model for either online, as we've implemented it, or particularly in primary care settings.

Ivette:

And Fran, SAMHSA has a prevention framework. Do you want to talk a little bit about that and tell us what that's all about.

Fran:

Everything that we've been talking about today I'm gonna back up because the best method of helping our country is to get the information out early, to get the medical profession informed, to get parents informed, to get communities informed and almost everyone else that we talked about. And we do this under our strategic prevention framework which basically is a community-based population model which is we help our communities and states to evaluate where their areas of high risk and need are. We help them build capacity and skills so that they can address these needs. They then go through a process of all the evidence-based programs and match the program specifically for the area of risk. We are that sophisticated in the prevention science. And last but not least, we then implement the program, evaluate it and start over because this is not a one shot. We continuously do that.

Ivette:

It is cyclical. I'm intrigued about the best practices. How are they identified?

Fran:

They go through a—we have a NREPP system which is basically a system built on rigor. It has to be tested in different communities, different settings, different demographics and tested again. So if it meets a level of rigor, then it's called an evidenced-based practice. We have to have a lot of data to show that this works because if we don't, then people are going to go back 20 years where we tried and experimented on communities and schools and did not get the results and the

outcome or the impact that we were looking for. Now we fit very nicely in the continuum of care which is promotion, prevention, treatment and recovery services.

Dr. Compton:

This is really a role where NIH can help. The mission of NIH is to bring science to improve health and well being and we've done a lot of work in testing, in developing and then testing in rigorous population-based settings. The exact kind of prevention interventions that Fran is talking about. So we see this as a way to work together with SAMHSA where we can help build the practices and then work with SAMHSA to see that they're implemented on a widespread basis that will have the most impact.

Ivette:

Very good. Dr. Kelly, let me go back to you and the assessment. When we talk about assessing for mental and substance use disorders, that's one thing. What other elements of someone's health—should we be looking at sexually transmitted diseases, should we be looking at also be screening for HIV of individuals that have a substance disorder and then have a mental health condition?

Kelly:

Absolutely and I think this is why primary care is so important in this regard is that primary care has the facility and ability to be able to address the whole person including these other kinds of infectious disease possibilities as comorbidities which are more common, obviously, among people who are using drugs, especially IV drugs as well as other kinds of liver diseases. So those are very important aspects to address as part of the screening process. We know in terms of the positive predictive value of screening among those individuals is much higher and that's why it should be done among those individuals in particular just because they affect health so dramatically if they're left undetected and untreated and then they're much more difficult to treat later on, and they compromise individuals' ability to then focus on their own recovery.

Ivette:

Indeed, and it should be done the other way around, too. I think that we're trying to get—particularly with the PEPFAR program internationally, they're trying to get those who serve individuals for HIV or screening for HIV to also look for issues related to alcohol, mental health issues as well.

Dr. Compton:

One of the ways to think about this is as a syndemic. We're all familiar with the word epidemic, you know, how you have a single disease that maybe increasing in how common it is. But a syndemic kind of reminds us that these things cluster and go together in important ways. So just like you said, if I'm treating a lot of patients with HIV, I better be paying attention to their alcohol and drug use or I'm not gonna have very good outcomes for my HIV treatment. I also better be thinking

about hepatitis C, I better be paying attention to tuberculosis, I better be paying attention to all sorts of other health conditions that cluster in these very high risk complicated patients.

Ivette:

And, Paul, you know, we haven't talked about in terms of there is a crisis in this country beginning to be or has existed with opioids. In terms of the mentally ill, have you seen a lot of mentally ill patients presenting with opioid use because of the prescription medications?

Paul:

Well, if the question is do people who have mental illnesses self medicate, I think everybody knows the answer is yes. But the fact of the matter is that one of the things we need to take into account is that the kind of system we built around people with mental health concerns and serious mental illnesses is one where we have frequently waited until they present a danger to themselves or others, and use that as a standard for a trigger to treatment. And then again, that standard means that often they go toward incarceration, and so if they are out and self medicating, especially with drugs that are illicit, then it feeds this stereotypical myth that we have that people with mental illnesses need to be incarcerated as opposed to needing to be treated. What I like about this show and what I like about this focus on health and bringing people back is, again, it brings us back to recognizing and understanding that this is not really about whether somebody with a serious mental illness self medicates. This is more about how do we identify people who are on that path early. How do we prevent it whenever we can. How do we identify it early. How do we intervene. How do we change trajectories of lives. How do we integrate our interventions to lead to recovery because that is our expectation for every other chronic disease or chronic condition that people have. Recovery is our expectation. We don't deny treatment at stage 4 of cancer because we feel like it's gonna be hopeless. We believe there's always hope and it's the same thing for people with diseases of the brain. There is always hope. There is always the opportunity and the possibility of recovery and we need to devise our system of services around that concept, not around the concept that, well, they're probably a danger to themselves or others and we need to through them in jail.

Ivette:

Very good. And, Fran, you had mentioned previously, or Dr. Compton had mentioned previously screening and brief interventions. Let's talk a little bit more about that as it relates to its value in terms of prevention.

Fran:

Yes. I always enjoy this question, you know that, because when we look at SBIRT as what it's called, screening brief intervention, people see it as a treatment tool only. It's to screen to get them into treatment. Actually, fewer people who are screened with the SBIRT tool need to go to have an assessment for treatment.

They actually need other services and that's what the prevention field will give them. Prevention is a variety of programs from primary prevention which is the education that Paul was talking about we so badly need out there, right straight through interventions which is where SBIRT comes in. And we have both trained people in the prevention world as well as the treatment world that will use this tool, and it's exactly what we've been talking about. If you show signs and symptoms of a problem, of being either a high risk user or having bouts of depression a little bit too often, it's good to do an SBIRT screening to be able to see. It can be done, as Dr. Compton had mentioned, in a doctor's office, it can be done in a community health center, it can be done in a school if they have a social worker that is trained in such. So it's a great tool. SAMHSA has had great success and our states and communities have reported that this has really been an effective tool, especially now they know you can have a screening for an assessment for treatment as well as a screening for helping people get to the right prevention and intervention service.

Ivette:

Excellent. And when we come back, we'll continue to talk about interventions and treatment within the primary care system. We'll be right back.

[Music]

Paul:

Hi, I'm Paul Gionfriddo. A lot of people think that serious mental illnesses begin to emerge during young adulthood. But as a parent, I learned that that wasn't the case. Now I know that half of all mental illnesses manifest by the age of 14 but when my son, Tim, first showed signs of serious mental illness when he was five, I didn't have any idea what it was that I was getting into or where that was going to lead us. Now, like a lot of young children who show signs of mental illness, Tim wasn't finally diagnosed with schizophrenia until he was 17 years old. By then, we had really lost ten years of opportunities to make a difference in Tim's life. Ten years of opportunities to change the trajectory of his life. What happened to Tim is pretty typical. Tim ended up being suspended from school, expelled from school and eventually didn't graduate from school. So when he turned 18 and wanted to live on his own, he really wasn't ready for that and couldn't keep housing. And when he first got himself a job, well, his symptoms of mental illness flared up and he wasn't able to keep that job. So Tim's story is a pretty typical story. Around the age of 20 Tim became homeless and for the last ten years of his life Tim's most frequent addresses have either been homelessness or the San Francisco County Jail or the Travis County Jail. Tim is now caught in that revolving door that has caught so many people, and at the age of 30 Tim lives primarily on the streets of San Francisco. While a lot of people might look at that and say, well, it's hopeless. But the fact of the matter is we never lose hope. We never lose hope for the people who are out on our streets that they might be able to recover and we should never lose hope for the people like Tim who are five years old today and not 30 years old today, because if we change what we do, if we screen them ubiquitously as we

should, if we get them integrated health, behavioral health and other services as they need, if we promote their recovery as we are ought to, then we will make a difference. We will change the trajectories of their lives and there will be hope for people like Tim.

Female VO:

At times, the path to recovery from a mental and substance use disorder may be unclear. At times, the path may be rocky. At times, the path may be wandering. But laying a strong foundation, with the support of others, makes all the difference.

For information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

[Music]

Carla Taylor:

Melvin came to our clinic about 2 years or so ago and he had a strong addiction to the opiates

Melvin:

When I first came to Affinity Healthcare Group I was a mess. It's great to have a support group but to have a counselor that you really can sit down and talk with and who will really really listen to you and not so quick to criticize you is wonderful it's wonderful because it helps. I've been trying to get clean on my own for 15 years. I'm very thankful for Affinity Healthcare Group. Very thankful.

Dr. John Scanlon:

The patients have come to me because they feel like they need some help. And they feel like they have come to a place in their life where they need assistance where they want me to do something or they want to do something to make their lives better

Melvin:

Once you clean up, really clean up, not just body but mind, it helped me get my life back together.

Carla Taylor: As of about a year or so ago, Melvin got on track.

Melvin:

I was able to find employment, I started being more attentive to my children, to my wife, I got me back.

Carla Taylor: Melvin is now 120 days clean.

Melvin:

I feel wonderful, today I am clean, I am happy I got my family, I have employment My experience with Affinity Healthcare Group has given me my life back.

Carla Taylor:

I've had several patients call back and let me know I'm still doing well, I'm still hanging in there I still haven't used and that just makes my day. Recovery is a profound experience.

Male VO:

For more information on national recovery month, to find out how to get involved or to locate an event near you visit the recovery month website at

recoverymonth.gov

Ivette:

Dr. Kelly, following up on what Fran has just mentioned, is the initial prevention screening within primary care enough and an initial referral or should the patients be followed?

Dr. Kelly:

I think it's critical that people are followed over time and checked in on regularly in terms of these symptoms and syndromes that they may suffer from. And this is where I think primary care is uniquely valuable because, as I mentioned earlier, what we know is that nine out of ten individuals with a mental health or substance use disorder will go see their primary care doctor. They may not go to specialty treatment but they will go see their primary care doctor so it's a very valuable opportunity for the primary care physician or team member in that setting to be able to check in on that individual over time. What we do know, and it can be frustrating for people because they may conduct a brief intervention and say, nothing's really changed that much. Maybe they don't see a whole lot of change, maybe they don't see complete abstinence and remission right away and so you think, well maybe this is not really working. Should I really bother with this? But when you follow people over time, what you see is that like other illnesses the earlier you intervene, the shorter the time to remission. That sometimes can take years to happen but when you look at prospective studies and retrospective studies, the people who began the conversation earlier about their mental health condition or substance use, those individuals got into remission and recovery earlier. So it's very important that we do this just the same as we treat other kinds of illnesses. The earlier you interview, begin the conversation, begin the treatment and keep the conversation going, I think that's key for families and for treaters, and primary care can do that.

Ivette:

Very good. And Dr. Compton, earlier we had mentioned issues of opioid misuse, and within primary care as we look at these issues, should we be talking about medication assisted therapies?

Dr. Compton:

Absolutely. Primary care is one of the main places where medication treatments will be started and continued so that we have patients that may benefit from Buprenorphine, as an example, is one of the main treatments for addiction to opioids. Or use of an opioid blocker like Naltrexone or Vivitrol, a long-acting injection that can be useful for helping prevent a relapse to opioids. But I also don't want to underestimate the importance of medications for alcohol and I think that's a tool that we haven't taken advantage of in this country very much, and primary care might be just the right place to encourage and consider medications whether that's Naltrexone like Vivitrol or the oral medications or Acamprosate is a new medication or even some others that are just coming down the line for the treatment of alcoholism and opioid disorders.

Ivette:

And, Paul, I'm gonna shift a little bit now and talk about our military families and the vets that are coming back in terms of PTSD. Within the primary care system, how should you think that the system should be handling those cases?

Paul:

Well, I think everybody realizes that notwithstanding the good work that the Veterans Administration does, they really can't handle the entirety of this problem and so a lot of people do show up in their primary care offices. You know, something like 80% of Vietnam Veterans will have said they've had PTSD symptoms at some point in their lives and we're gonna see numbers like that for all of our returning heroes from Iraq and Afghanistan as well. So unless we intervene in the primary care settings we're not really going to be addressing their needs moving forward.

Ivette:

Fran, no system is perfect as we continue to transition and attempt to get all services into primary healthcare. From a family perspective, particularly those that have signed up for the ACA, what should they be looking for, what should they be on the lookout for?

Fran:

They should be on the lookout for as much parent education as they can find. They should help join their coalitions and taskforces that are in their states and communities, around school issues, around childhood issues. They should be very vigilant when accompanying their child to their pediatrician or their primary doctor, depending upon the age. And there is no age limits here, right straight through higher education is also important to ask the right questions to ensure that the doctor is asking the right questions of a young person to look at the signs and the symptoms. SAMHSA, again, has a terrific education program for parents around alcohol use. Alcohol still remains the number one drug problem for young people in this country. We lose too many lives to senseless deaths because parents have not got the right education to talk to their kids. Why parents? Because our studies

show us time and time again young people listen to parents first. So they need to learn to gather all the information they can and be very active in the health of their child just as they are if their child has an earache, has a toothache, or has been having bouts of loneliness and depression. We need to get mental health and substance abuse all under the same umbrella.

Ivette:

And Dr. Compton, any other resources that NIDA may have that families ought to be aware of?

Dr. Compton:

I think it's very important to realize that the NIH is developing new tools that can be applied in general medical settings, so we're very interested to build on this vision that Fran just described of primary care as a place to get these needed services for families. But we haven't quite proven that these prevention interventions, how they can work in primary care so that's one of our goals right now is to retool some of the school-based interventions and test them and apply them in general medical settings. So that's a contribution that the NIH will be making over the next few years.

Ivette:

Very good. Dr. Kelly, in terms of physicians, what should they be on the lookout for in terms of the trainings they should have? Should we be encouraging the AMA and all of the medical schools to be training their physicians on issues of mental and substance use disorders?

Dr. Kelly:

You know what my answer is gonna be.

Ivette:

Of course, yes, but we want it to be underscored.

Dr. Kelly:

Absolutely, yeah, and we have been moving in that direction, we are moving in that direction. I think we're gonna be moving more strongly in that direction with the Affordable Care Act because health care systems now are incentivized to be smarter about healthcare delivery and that includes addressing substance use and mental health in those settings.

Dr. Compton:

It's very exciting to see Harvard as a medical system moving in that direction and that might be one of the peer leaders for our entire country. That's a really exciting move.

Ivette:

And, Dr. Compton, I'm gonna come to you for final thoughts.

Dr. Compton:

Well, certainly I think the most important message is one of hope, that by addressing these conditions in a forthright and direct manner we really can bring recovery and treatment to a much larger number of people than we do now, and that's why we're reaching out to primary care. That's where people are going so let's bring the services where the people are actually getting them.

Ivette:

And Dr. Kelly?

Dr. Kelly:

I would agree with that. I think that was nicely put, to continue to have programs like this where we can talk about it, address these issues, make our education for medical students. I think that's where a lot of it's been missing. But also other kinds of healthcare providers, too; social workers and psychologists. There's been an absence of substance use and mental health, particularly substance use in those settings. So I think changing our educational emphasis around these is gonna start to have an impact on healthcare delivery in primary care. But it does take time. I think all of these changes take time to happen so we have to start to be persistent and continue to push to make it happen.

Ivette:

I know, but how do we get these systems to understand that time is money. You know the old adage is time is money because as the clock ticks, so do the costs for these conditions. So if you had one recommendation beyond what we've already talked about, does anything come to mind in terms of what we really need to do as a country?

Dr. Kelly:

Whether we know it or not, one of the most major contributors to healthcare expenditure and poor inefficiencies is untreated substance use and mental health. The reason why Massachusetts General Hospital has made it the number one priority is for exactly that reason. Through their needs assessment, as Fran was talking about, they did a needs assessment looking at who's using healthcare services the most. It was individuals who were suffering from alcohol and other drug problems who were using a lot more—in other words, the care for those individuals was insufficient because those conditions were not being assessed and treated properly and it was compromising the rest of their care.

Ivette:

Very good. Thank you. Fran, final thoughts.

Fran:

I'd say we're all in this together. If we can get our country to understand their role, and that everyone has a role, in helping to reduce the incidence of substance

abuse and mental illness affects in the country and bring it to whatever level they're at, whether they're a young person in school just learning how to identify their own feelings, whether they're a parent, whether they're a member of the clergy. It doesn't matter where you stand. We've talked a lot about the physicians and their role and students and their role; we all need to begin to see that behavioral health issues are as, if not and more important than some of our physical health issues and we need to treat it together.

Ivette:

Very good. Paul, final thoughts.

Paul:

Well, some people think it's just professionals around the table when they see conversations like this and that we have just a professional interest in this; and we all do but like so many people in the field, I also have a personal interest in this because my son, Tim, developed signs of schizophrenia when he was five years old. That was 25 years ago. Tim is 30 years old now and he's homeless on the streets of San Francisco. We could have made a difference in the lives of so many people like Tim over the course of the last 25 years had we taken the approaches that we're talking about taking here. What we need to do is think forward over the next 25 years to how we're going to change the trajectories of the lives of so many Tim's in this country so that they don't end up homeless on the streets of San Francisco or worse.

Ivette:

This is very true. And, I want to remind our audience—first of all I want to thank you for being here and I want to remind our audience that September is **National Recovery Month**. We want to encourage you to go to recoverymonth.gov and get engaged in September and throughout the year in this observance supporting people in recovery for mental and substance use disorders. Thank you for being here. It's been a great show.

[Music]

Male VO:

To download and watch this program or other programs in the *Road to Recovery* series visit the website at recoverymonth.gov.

[Music]

Female VO:

Every September, **National Recovery Month** provides an opportunity for communities like yours to raise awareness of mental and substance use disorders, to highlight the effectiveness of prevention, treatment and recovery services, and

show that people can and do recover. In order to help you plan events and activities in commemoration of this year's **Recovery Month** observance, the free online **Recovery Month** kit offers ideas, materials, and tools for planning, organizing, and realizing an event or outreach campaign that matches your goals and resources. To obtain an electronic copy of this year's **Recovery Month** kit and access other free publications and materials on prevention, recovery, and treatment services, visit the **Recovery Month** website at recoverymonth.gov, or call 1-800-662-HELP.

[Music]

END.