Rachel Breidster: Hello and welcome to public health live the third Thursday breakfast broadcast cast. I’m Rachel Breidster and I’ll be your moderator for today. Before we get started I would like to ask that you please fill out are you online evaluations at the close of today’s program. Continuing education credits are available after you complete our short post-test and your feedback is helpful in the planning of future programs. We encourage you to list what topics interest you and how we can best meet your needs. As per today’s program, we will be taking your questions throughout the hour by phone. Our toll free number is 800-452-0662 or e-mail us at any time throughout the hour at phlive.ny@gmail.com. Our program today is Mental Abuse and Substance Abuse, Connecting the Dots. Our guests are Dr. Gerald Fishman, a licensed psychologist and University professor with a background in public health and Raymond Bizzaro, who’s been an active public health practitioner and serves currently as Cayuga County’s Director of Community Services and the Interim Director of Cayuga County Health and Human Services. Thank you both very much for being here. Now before we begin I would just like to point out to our audience on slide 9 we have a list of acronyms and terms that our viewers will see throughout the show so you can follow along with the discussion please reference that slide. Thank you both for being here. We’re excited to have this conversation. Doctor Fishman, in addition to the acronyms and terms that are on that slide, there are some other terms that we want our audience to be familiar with. Can you start by talking about some of those terms for our audience today?

Dr. Fishman: We talk about co-occurring disorders and this term generally refers to the presence of more than one mental health disorder. Substance abuse disorders are included here. So for COD we’re really referring to co-occurring mental health and substance abuse disorders. Other terms that are often used: mica, some people may be familiar with, mentally ill, chemically addicted folks, misa, mentally addictive, substance abuse folks and then there’s a term that they refer to as comorbidity. That refers to the presence of more than one disease in an individual that has to be addressed. Comorbid conditions, with respect to today’s program, really have to do with the presence of mental health and substance abuse issues that make treatment complicated.

Rachel Breidster: Is there data that can help us understand the prevalence of and incidence of co-occurring disorders or comorbidity in the United States?

Dr. Fishman: There’s the National Co-morbidity Survey. Essentially it was done in 2012 our most recent data and they say approximately half of our US inhabitants will meet criteria for diagnostic and statistical mental disorder. Anecdotally, in the field we say that 60% to 80% of clients coming into substance abuse treatment have co-occurring mental health disorders. We find 50% to 60% of folks entering mental health treatment they have co-occurring substance use disorders. So as a result there is critical need to address both. Substance abuse disorders generally occur in mental health population much more prevalently than they do in the general population.

Rachel Breidster: Are there estimations as to how many people in the United States may be living, I mean certainly we see that there are high percentages, but that do the actual raw numbers look like?

Dr. Fishman: If you look at SAMHSA data, the Substance Abuse and Mental Health Services Administration, they talk about 8.9 million people having both mental health and substance abuse...
disorder. What we find as well is that over 80% of folks that are diagnosed with mental illness generally have some form of substance abuse or dependence issues that are contributing to the mental health symptoms that are emerging.

Rachel Breidster: That’s a pretty significant number. So certainly the statistics that you’ve just shared with us demonstrate we have a high percentage of folks with substance abuse are often co-occurring with mental health. Can you tell us about the general statistics of what that population looks like?

Dr. Fishman: What we find in the research as well as field base practice is there a genetic component that increases vulnerability to both mental health and substance abuse disorders in most of our clients. That really reflects how the brain is going to work with stress. And it’s going to influence predisposition to acquire drug use and progress more rapidly to addiction. Similarly we do find that co-occurring disorders occur across the life span for all individuals that we see; mental health and substance abuse. And as a result we’re seeing evidence consequences across functional areas, housing, and employment, more often involvement with the law and the legal system in general and then, unfortunately, we have high periods of relapse or repeat cycles of treatment. It’s a very difficult condition to address in terms of sustainability of outcomes.

Rachel Breidster: What are the behavioral characteristics of the population?

Dr. Fishman: Both are for mental health and substance abuse co-occurring clients. Cognitive impairments are demonstrated, difficulties with encoding, comprehension, processing and storage. It affects executive functions so they have difficulty in planning, decision-making, control of emotions, impulses, disorganized approach networking with stress and general life situations. Can result in, unfortunately, making poor decisions, and often using alcohol and drugs as a way to cope.

Rachel Breidster: Thank you. So, the data clearly shows we’ve got a problem on our hands. There’s a very high percentage of people affected by this. You work in Cayuga County, can you tell us what specific events started occurring in your county that indicated to you we have a situation we really need to address?

Raymond Bizzari: We have drug and alcohol subcommittee which is a subcommittee of the community services board and chaired by the undersheriff, Jim Stall. We started getting reports, so a lot of people were presenting in the emergency room with alcohol poisoning, it started this way. So we started hearing about those caffeinated alcohol drinks and got people talking and thinking more about the increased risk people were impacting their lives and then the synthetic marijuana thing, it really did blow up in our community just like it did in communities all across the state. We started hearing from emergency medical technicians and cops on the road responding to calls and people were very violent and behaving strangely and they didn’t know what to make of that. So we just started having conversations around the things that people were seeing and there was an awful lot of concern and worry from people. They didn’t know what to do. They were looking for help, guidance and advice. So those conversations ended taking us to a bunch of places. We got very concerned, you know. We had a lot of folks in treatment and then you make sure people have fidelity to their treatment. People
behaving so erratically—doctors didn’t know what was in people’s blood streams or urines. We stayed out of that with testing. That didn’t work very well. Out of those conversations came some pretty good ideas about stuff that we could do. I think it was a little overwhelming at the beginning but started to put one foot in front of the other and we got some stuff done.

Rachel Breidster: Great. I look forward to hearing about some of those things as we move through today’s show. So all of the evidence points to the fact that we need to implement some sort of intervention, but with this population there’s going to be certain barriers to doing an effective intervention. Can you talk about what some of those barriers to individuals might be?

Dr. Fishman: Unfortunately, there’s still a substantial amount of stigma attached with entering treatment for mental health or substance abuse disorders.

Rachel Breidster: Absolutely.

Dr. Fishman: As a result people who are suffering are more likely to use services when in crisis, more likely to go into emergency departments versus accessing more traditional services. And they tend to be less engaged in treatment. C.O.D. clients also have a decreased likelihood of complying with treatment recommendations and follow through, and what is particularly critical for us in the field is that with C.O.D. there’s a rapid progression what starts out with recreational use becomes abuse to dependence. There’s that vulnerability to more rapidly progress to addiction and reliance on the drug than in folks in the general population.

Rachel Breidster: Interesting. So, Raymond in your work at the county level what are some of the individual circumstances that you see and that people say it makes it hard for them to access treatment?

Raymond Bizzari: There are a number of things that make it difficult for people. Insurance coverage is a big one. You know, they are not going to pay for treatment. They have really interesting rules around denying people and providers who have experience and determining people’s level of care are arguing with insurance company. And while that’s happening people are continuing to use and experience the symptoms that get them jammed up a lot of social and family issues. The stigma that Jerry talks about is huge for individuals. We say these things are diseases but we don’t behave that way nor do we treat people that way. We marginalize them and blame them. A lot of homelessness people who are homeless are not able to keep their appointments or take care of themselves. This makes things worse. Unemployment, interrupted treatment they get bounced back and forth between the systems because they can’t manage their symptoms or their life well enough to be able to get to places and things like that. Those are some of the thing that keep people from being able to connect and follow through and get on a course towards recovery.

Rachel Breidster: And what about the systemic barriers? Certainly as an individual facing homelessness I imagine is a huge barrier but what about the system barriers. Any others you want to discuss?

Raymond Bizzari: There’s a long wait list. You have a bias in the system around how we’re going to take care of these people. A lot of the practitioners have rules that people aren’t able—it gets them kicked
out of treatment, you know. And people who do refer—you present in different places, they send you to places where they think you’ll get help and you don’t. There’s no organization in the system always good enough to get folks to where they need to be. They end up losing their benefits when they don’t stay in treatment. It becomes a cycle for people. I think the system really doesn’t do a good job and it makes it difficult for people to get help.

**Rachel Breidster:** So one of the things that we would agree on is we need some sort of integrated care but certainly we’re seeing substance abuse and mental illness occur together. Are there specific combinations that tend to occur and can you start talking about some of the specific mental illness we see such as anxiety disorder and the combinations that tend to occur?

**Dr. Fishman:** What we’re finding is reliably there are certain drugs of choice that are used by folks with particular differential diagnoses. So, for example with anxiety disorders, the Epidemiological Catchment Area and National Comorbidity Studies indicate that there’s two times to four times risk of alcohol disorder in individuals with anxiety. Interestingly we also find stimulant use is much greater in individuals who have anxiety as well as post-traumatic stress disorder and that includes the veteran population which about 75% with vets are going to meet criteria for substance abuse disorder. Anxiety folks tend to find that alcohol can be a sedating agent but at times leave them vulnerable and out of fear of being hurt, they often will select stimulants as a way to remain on hyper alert to be capable of a quick startle and response if there is any jeopardy. We do find that more than 70%, actually, of clients coming into treatment have trauma background. It’s becoming very important for us to inquire about trauma as well.

**Rachel Breidster:** What about drug preferences or co-occurring with schizophrenia.

**Dr. Fishman:** Over a third of them have alcohol abuse disorders, 75% to 80% are nicotine dependent. It’s interesting, nicotine serves as both a sedative and a stimulant in terms of its pharmacological activity; and it actually works with a neurotransmitter in the brain called dopamine, which is responsible for hallucinatory activity and delusional activity. We’re finding nicotine will reduce some of the psychotic phenomenon in clients’. We also find that alcohol, cocaine and cannabis are frequently used, in many cases it’s due to price.

**Rachel Breidster:** Interesting. What about bipolar disorders?

**Dr. Fishman:** Bipolar disorder tends to be the principle mental health disorder that's associated with substance abuse. 56% of any bipolar diagnostic client tends to have a life time prevalence of substance abuse disorders. Odds ratios for say 12 month alcohol use disorders and drug use disorders quite high compared to the general population, as high as 8.3 times respectively. We do find that the most common substances that are selected by bipolar patients tend to be alcohol, cocaine and cannabis. Folks with bipolar who swing between moods do not generally select opiates as a drug of choice because it as a CNS depressant effect.

**Rachel Breidster:** And can you finally tell us about depression.
Dr. Fishman: Depression tends to be associated with alcohol and opiates. They tend to allow an individual to disassociate from the negative affect and depressed mood. We do find a lifetime prevalence of co-occurring alcohol use and drug use disorders among patients with Major Depressive Disorder tends to be approximately 18%. So they’re vulnerable as a population and we find the use of alcohol and opiates paradoxically, will worsen the depression.

Rachel Breidster: And what about lifetime prevalence for those with depression and certain substances they might be engaged with.

Dr. Fishman: When we talk about alcohol prevalence we’re really looking at 40% to 70% of the clients with a diagnosis of major depressive disorder are likely across studies to show vulnerability to substance abuse disorder. Cocaine dependence about 30% to 40% of clients may get involved with that. Opiate dependence is becoming increasingly popular as high as 64%, about two-thirds of those people with a diagnosis of depression are likely to be utilizing that substance.

Rachel Breidster: Thank you very much for those statistics. Certainly throughout New York State various counties have seen increases in substance abuse as a result of these co-morbidities. Let’s look at a dynamic public health intervention in Erie, New York that is working to reduce the comorbidity of substance use disorders and overdoses.

Cheryll Moore: My name is Cheryll Moore, a Medical Care Administrator in the Erie County Department of Health. In Erie County we’ve seen an overdose increase in the past three years, especially with opiates. The prescription drug problem led this to us to this and now with the “I Stop” Law in place, it’s less access to prescription drugs, and our heroin overdose are increasing dramatically. In the past year, we’ve seen an 85% increase in heroin overdoses alone. Historically we thought of like you saw in the movies a person in the dark alley behind the dumpster and shooting up drugs. That’s not what we’re seeing today. The opiate overdose comes from pharmaceutical venues as well as heroin utilization. We had a huge, huge opiate pharmaceutical problem, which we worked through the law, through the “I Stop” Law, to address. What we’re seeing are the repercussions. People that enter the system through legal means it was a disease of means, a disease of affluence, a disease of people with health insurance. They don’t have access any more. It’s these folks, they are sick. They are seeking to feel like you and I do every day and this is what they are doing. Our population is now very much suburban. It’s young, it's generally white. It’s not what we saw in the past. In the past it was older, it was folks who had been in the system for many years. Low socio-economic. Generally one of the ethnicities that had a small minority population. Now it’s your next door neighbor. NARCAN, is an opiate antagonist. How it works, is that it gets in there and it kicks out where an opiate would be and blocks it for 20 minutes to about an hour and a half and doesn’t allow the opiate to work at all. Narcan is administered to somebody experiencing an opiate overdose. By administering to them they go into complete withdrawal. Initially when we started this program, working with law enforcement was a new way of administering this program. This has historically been first responders being EMS and there were some lines there that we had to look at that were being crossed. We had to look at the piece that EMS as medical providers, law enforcement are law enforcement. But under the Good Samaritan law people respond with EDDs, with CPR, it’s do no harm, just try to help someone. This falls under the same law. We had to address this and
teach people that whoever is there first gives someone the option to live and touch the system. We tried being as open as possible to keep lines of communication open. We hosted a heroin summit a few months back. We brought all different venues of law enforcement, prevention providers, treatment providers, and public health, everybody together in the same room to learn about the problem in our community and how we should respond to it. Workgroups were created there. Work groups came with us and said Narcan needs to happen. We work closely with our local syringe exchange programs. Our clients are offered, Narcan training, a consumer kit because they are ones closest to the scene. The point is they are the ones closest to the scene. If you're using or your family member or your friend you’re the first one that's going to be there. The other agency in our community is horizon health services focused on educating consumers and getting the kits in their hands and loved ones, and their acquaintances. Our program is geared much differently, geared as a law enforcement community and first responder community to give broader access. One of the things we reiterate in our training over and over when we train our officers and first responders is this is the only touch many of these people will have with the system to get them linked to services this is the chance. Addiction is a disease. It's not a choice. They lost the choice. The only choice is the first time they use drugs. Now it's become a disease. So to link people with help when they don’t think they need help, this is a chance.

Rachel Breidster: So Erie county is doing innovate work around harm reduction. And I understand that Cayuga County has been doing some as well. So I’m wondering if you can tell us some of the specific elements of your county’s plans to address this issue.

Raymond Bizzari: So, you know, I talked earlier about how we started having this community discussion about what we were seeing and it led us to sort of think about the sort of things we can do. Initially people were overwhelmed, what will we do. This is a big problem. We started breaking it down and we do have some resources so we were figuring out what we were going to do. We talked about Narcam, housing first, those kinds of things. We started having a lot of public discussions, forums where we would have different people coming in and having a conversation about what they are seeing and talking about much like this. This engaged other people in the community. We started talking about prevention because that's a fairly easy low-hanging fruit to do. We got information out to school districts. They were great. They sent stuff home with their students. We talked to pharmacists and physicians, talked about best practice prescribing, CMEs that you could enroll in that could help you figure this out. A lot of public health elements to this which is different for us typically to look at a problem like this. And we did a bunch of other things. The district attorney passed local law because the legislatures are struggling with synthetic drugs. We strangled the supply of that. When we did that, then, you know, started pushing people towards heroin and we started seeing different things. But the same plan works anyways. It was just a different focus. Those are the kinds of things we did initially around, what are some of the moves we can do rather than just sit still and watch this happen in our community.

Rachel Breidster: There are a lot of elements contained in your plan. Can you talk about where did you specifically focus your resources to try to achieve some of those goals?

Raymond Bizzari: So, you know, on the prevention side we were able to divert some funding and divert some energy to do that. We wanted to do some things around integration. When we looked at our
system we saw the holes in it when you start carrying about what happens to individuals. So then we made some state aid available to fund some evidence-based king of training for police. We did mental health for state; training for community; training 30 trainers that went out over the course of time train hundreds of people. So we can be smarter about how we respond to stuff. Critical incident training for the police agencies and the EMTs because when they are out there in the community and handling this, they don’t know what they are up against. Peel some state aid in for a mobile crisis team. We had police bringing people into our clinic from an ER diversion. After hours there wasn’t a lot of help for them. So we give them some sort of resources; do screenings in the field. Figure out what we’re up against and connect those folks to treatment, resource that a little bit. You know, then just delivery system reform initiative (DSRIP). Kelly was on the show and she talked about this. We have this coming out of our ears. What’s nice is you can do some good planning and get some resources. In our community they are going to build something next to the emergency room in the HPT. You come in the one door and get diverted to where you need to go. Primary care half of it they will be launching behavioral health services, both mental and substance abuse will be integrated; and also, you know, physical health is integrated there and hopefully have some detox. Some ability to sort of figure out what people need and sort of make that connection. Those is the kinds of things we did with the resources we had at our disposal.

Rachel Breidster: Excellent. Thank you. One of the ways, Jerry, to identify clients who may need treatment is using the cage or cage aid. Can you talk what that is and how it is used?

Dr. Fishman: Screeners can be helpful because they are short instruments that have items that would red flag someone who may be in need of a higher level of care or treatment. So screeners such as the cage or cage adapted for use with individuals with drugs are essentially questionnaires that can give us a very quick look at whether or not an individual has a potential problem with alcohol or drugs. So, they tend to include four items the cage and cage aid and essentially we’re talking the acronym cage refers to feel the need to cut down as a concern, have you ever been annoyed by what others consider to be problematic for you? Have you had guilt or any type of shame or feelings about your drinking and drug use that get you to question your use? And then finally looking at amount and frequency of consumption and saying, how does your day begin? You know, are you using this essentially as a way to open your eyes and begin the day?

Rachel Breidster: Sure. What about there’s another assessment modified mini. Can you talk about who can administer that and once a person is screened how they should be directed?

Dr. Fishman: The modified mini screen was developed by Oasis. Essentially is a mental health screener that looks at three primary areas.it looks at mood disorders. It looks at anxiety and that include PTSD and it also looks at psychotic process disorders. Para professionals as well as professionals can administer the modified mini. Agencies tend to set cutoffs which would then lead to referring for more comprehensive evaluation. What the modified mini does is give you a sense of an individual’s mental health could be influencing their substance abuse patterns or made worse by substance abuse.

Rachel Breidster: Can you talk about some of the theoretical or theoriess professionals would consider when thinking about treatment for an individual.
Dr. Fishman: We talk about integrated treatment as Ray is mentioning. When we talk about integration we have to look at models that would explain the co-occurrence of mental health and substance abuse disorders. One model called the Common Factor Model, argues there is a genetic vulnerability that’s present that trigger one or both disorders. It also talks about commonality of environments that may elicit symptoms of both disorders. Secondary substance abuse disorders model are those self-medicating to help cope with stress. These are individuals that got into alcohol and drug use to control and stabilize their mother-in-law health and led to adverse outcomes. The super sensitivity model is important for folks to be aware of because what it found in the research is that individuals with mental health disorders tend to have a heightened effect of alcohol and drugs. So that it’s a quicker effect. It’s a more intensified effect which leads to more addictive potential. And can actually worsen the mental health symptoms being presented. The secondary psychopathology model is the substance abuse that trigged the mental health symptoms. So another reason to be asking critical questions about both disorders, that leads to what we consider by directionality which is at some point etiology isn’t the issue. It’s more about the fact that both are affecting the individual.

Rachel Breidster: Sure. Can you talk about some of the challenges or successes regarding these different treatment models?

Dr. Fishman: The treatment models used in the field there’s been an evolution of thought which started out as a sequential model which said if you come in for a mental health problem and you have substance abuse issues we’ll stabilize your mental health first before we address the substance abuse. If you came into a substance abuse treatment facility we would need to stabilize you in recovery in order for us to then begin working with mental health and they found that was leading to very poor outcomes, high degree of relapse. They then began to look at parallel models which argued we’ll treat both simultaneously but in different settings. So that disconnect between treatment approaches and modalities and different setting was again leading to poor outcomes which led many of the federal agencies working in the integrative model. Under the same roof, individuals are getting services that include coping skills and relapse prevention and within each group talk being about what can we do to essentially soothe ourselves and cope in ways that’s more effective to avoid worsening our mental health or to return to active alcohol and drug use. It’s those integrated models that are getting a lot of research support.

Rachel Breidster: So that seems to be one of the themes. Integration, integration, integration. Raymond, in Cayuga County, can you talk about the different elements that were adopted to coordinate and integrate the identification, the treatment for individuals with co-occurring disorders?

Raymond Bizzari: We’re a long away from integrated treatment. But that doesn’t mean we can’t start at certain places. We have—our role is to plan and allocate resources and create a system that meets people’s needs. Some things we started to do early on with the planning was, so we universally adopted a Columbia suicide severity rating. We have a lot of kids and adults brought to the emergency room presenting—getting all sorts of crazy things happening in the community, not knowing who is at risk. We contract with a lot of providers and do a lot of things for people and we use that leverage. This is an evidence base recommended tool that you can use to gauge where people are. Then you can create a
system of what to do with them afterward. Do they need safety planning? Do you need to contact parents? You can wrap yourself around taking care of people. We made sure all the agencies and a lot of school districts were using this as empirically fixing out where the individual was at rather than responding to some sort of feeling about risk. We do cross training with mental health and substance abuse providers and law enforcement. The silos you're in it don't work. We're trying to get people the idea that there's a different way and a better way and we can go down this road together. There's some excitement about that. Although there's a lot of regulatory, a lot of issues prevent that. We have a lot of clinics in schools and open door access at our clinics so people are moving through them. We sort of, you know, ask people and they were agreeable to do the screenings. Again evidence-based. We're screening kids in schools before they present with some sort of issues. Do some early identification before they get more ill. Then we're screening in primary care doctor's offices because a lot of people who are struggling with substance abuse or mental health issues are getting their care from primary care doctors. We’re putting practitioners in those practices. Doing the screening. There’s that stigma thing we mentioned. People go to the primary care doctor and don't want to sit in a clinic. Those are some of the things we think we can do. The oasis screening, the mental health screening for substance abuse and doing a little bit of work with that. So we want to get to the next step.

Rachel Breidster: Great. Now once individuals are screened and get into treatment oftentimes medication is used to manage co-occurring disorders. Can you talk about the different medications that might be used and how they are incorporated into treatment plans?

Dr. Fishman: There's increased use of pharmacotherapy as an adjunct to clinical treatment to assist folks with mental health and substance use recovery. With anxiety for example, they found a medication called Buspar; it has had good effect in addressing the anxiety symptomology but reducing alcohol consumption rates. They use SSRIS, selective serotonin reuptake inhibitors, to look at addressing anxiety and depressed mood. They found it reduces cocaine and opiate consumption patterns and rates. Benzods, such as zenex, valium, are discouraged because that will generally trigger relapse with alcohol and other sedative agents.

Rachel Breidster: Are there specific drugs that are often used with depression?

Dr. Fishman: Again the anti-depressants like the SSRIS have been found to reduce cocaine and opiates use. They don't reduce alcohol consumption. With bipolar disorders we find category of meds anti-convulsants that have reduced substance use rates, including alcohol use.

Rachel Breidster: What about with schizophrenia?

Dr. Fishman: With schizophrenia, a drug that is first generation, but continues to get used is clozapine. It decreases psychotic symptomatology, it's been found to increase abstinence rates from substance use which includes increasing reduction in nicotine and cocaine. Risperdal has become more recently prescribed. It tends to stabilize dopamine levels, which will also stabilize psychotic process. It has been found interestingly to reduce alcohol cravings and beginning to be used as an alcohol specific med as well.
Rachel Breidster: There are specific medicines that folks might hear about. Can you talk about those?

Dr. Fishman: Cyboxon is used primarily with opiate dependent individuals and used as a maintenance medication to reduce harm reduction, getting involved in drug use but other risky behaviors. Cyboxon tends to be a reduced term of maintenance compared to what methadone has and intent is two to five years on cyboxon and hopefully someone will be weaned off. They have meds that address alcohol, for example Campro has been very helpful in reducing alcohol cravings. There's now a string of research that uses Provigil. That refers to working with wakefulness and sleep disorders and finding that Provogel is useful in reducing cocaine cravings as well. For nicotine dependent individuals, there's a mixed review on the continued use of Chantex for essentially occupying those nicotine receptors in the brain. It is prescribed. It has to be monitored closely.

Rachel Breidster: Sure.

Dr. Fishman: Due to the fact it can cause significant anxieties and other mood based issues.

Rachel Breidster: Now moving beyond the medication aspect of things what are some strategies that are important in maintaining a successful therapeutic relationship?

Dr. Fishman: Well, you want to keep in mind when you have co-occurring disorders you want to match clients with the appropriate type and level of care. We use ASHAM criteria to determine level of care and which is appropriate, and we really want to, with these clients because there's stigma attached, because they are very unfamiliar with integrated treatment we will use a supportive and empathic approach to work with them. When people relapse we welcome them back. We said what did you learn from that? We’re really trying to be much more receptive, to maintaining a recovery perspective, and that recovery is for both mental health and substance abuse and really we’re talking about helping an individual return to a higher level of functioning and fuller quality of life in the community. We have to be careful as professionals whether it's public health or practitioners in the field of what we call counter transference which is our own feelings and perceptions and thoughts that are projected on to a client who continues to return to treatment. Because co-occurring disorders tend to have, unfortunately, high remission rates for treatment. We have to monitor psychiatric symptoms closely because they will often trigger a return to active use.

Rachel Breidster: As we saw before, Erie County has developed interventions to address it in their area. You’ll see a clip on their school based mental health program and how that’s meeting clients right where they are.

Deborah Goldman: The Erie county school base mental health program is a set of clinic satellite services located in the schools. When we started expanding into the schools we used the satellite status for those clinics so they could be where these kids and families are, and be able to provide treatment services in a natural environment. The circumstances that led us to integrate treatment services into a school setting were the arrival of say yes into the buffalo public schools. Say yes is a collaboration in the buffalo public schools to bring support into the schools to help kids number one, help kids graduate and number, two if they graduate, to be able to support their college education. Say Yes came to the County
Department and asked us to partner with them. We partnered with say yes, buffalo public schools, Erie county department of, health, mental health, and social services. The community foundation for buffalo entered that collaboration. This collaboration allowed us to join with schools in cooperation with the school system with a standard set of outcomes, a standard set of responsibilities, a standard set of accountability. It’s been really great. The clinic treatment programs in the schools is part of what they do. They provide treatment for individuals who have a dual diagnosis in their families. So as part of the assessment process, they will identify when a child has behavioral health issues, when a child has both behavioral and substance abuse issues. If they identify the child who needs more help than that they will work to address those needs and get the child to the best program. Some of the benefits of being in the school are being where the kids and families are. Being in a natural environment. Often there's a stigma going to a mental health clinic. People don't want to be identified as having a mental health issue. This works better with the schools, to better coordinate services with the schools, to better be where kids and families are so they don't have to go somewhere else to get the services that they need.

Rachel Breidster: So Raymond, there are a number of resources and places where people can find more information. We only have a limited amount of time to talk during the show. Can you direct our viewers to where they can find more information on the work you're doing?

Raymond Bizzari: They can go to the OASAS mental health websites. You know, there's a lot of research out there. There’s a lot of success happening in a lot of different places. We just have to look for it. Stuff can be replicated. A lot of is research base. There’s some track record of following outcomes. I would just have people direct them to those websites and there’s an awful lot of advice and consultation available and that's what they should do.

Rachel Breidster: Great. Thank you. Dr. Fishman another great resources is the SAMHSA kit for co-occurring disorders. Can you talk a little bit about that?

Dr. Fishman: Yes they have been involved in developing training manuals and kits that would assist in developing programs, developing programs and then actually doing some outcome assessment. The kit itself goes through four stages of programming. So you’re talking about exploration needs, adoption of a program, implementation and outcome assessment. It talks about how to build the program, talks about how to train staff working directly with clients; it talks about how you evaluate your program. The beauty of evidence-based kits they are promoting research and standardized protocols.

Rachel Breidster: Excellent. Raymond, we're coming to the end of the show. Can you share with us a review of some of the interventions in your county that you feel have been most successful and that others might want to emulate?

Raymond Bizzari: I think it's difficult to move providers. Like people that, you know, they have a way of doing business. They have a way of behaving. It gets institutionalized. They train their workforce when they come out. You have to put pressure on them and do it in a way that they don't know its pressure. I think for us it worked really well the way it happened and it was accidental the way it happened. The observation is if you can start talking about this, as a public health problem, you know, sort of try to change that dialogue. You take a look at your population. Take a look at things you can do, early
screenings, which is stuff that people accept and don't feel very threatened by. You bring more people involved in that conversation. Then it gets—when you have the providers in the room and you start talking about things, these people you're kicking out of treatment is homeless and this is how it's impacting the community. I don't think people necessarily know what happens with the consequences of their treatment decisions sometimes. It happens and then that person walks out the door and that's it. I don't think we understand what really is going on with the populations that we're trying to treat. So I would suggest that you start that way and you bring sort of different kind of players to the table, public health people who normally aren't at the table but have a seat. We're being asked to include them in our planning. There's such a wealth of information that they do around community outreach and education and it moves systems. so OMH and OASAS should sale some of those ideas. That's what's worked for us. Continue meeting and continuing, you know, gaining momentum and putting pressure on people. Then they sort of come to the realization on their own. People don't like to be shoved. So I think that's where I would start.

**Rachel Breidster:** Excellent. Thank you so much. So we've got a few questions that have come in so far from our audience. We'll start, for those of us who don't know can you explain harm reduction.

**Raymond Bizzari:** I would start right here. You're in a community, harm reduction is, get clean needles. A lot of people won't do that. A lot of communities have an issue with that. Kicking people out of treatment. That's not harm reduction that's increasing the risk of harm. Narcam is a tool because you're preventing somebody from dying but not forcing them to engaging treatment. Housing is a thing that's important. There's an awful lot of research how people do better when they are housed. Can't make housing contingent on treatment compliance; not fair to the consumer. Sort of perpetuates that stuff. Some of the medications that Jerry was discussing. That was harm reduction. Very important.

**Dr. Fishman:** As ray is saying, it's like a three leg stool. You really need to be talking about treatment, housing and employment as a way to stabilize someone in recovery. And harm reduction really can be assistive with medications that allow an individual to maintain functionality and be engaged in the community while they are continuing to work on changing lifestyle which is critical in order not to return to patterns of use or to be vulnerable to risk factors. Harm reduction becomes particularly helpful in that respect too.

**Rachel Breidster:** So not necessarily looking at it as we're going to solve all these problems right now, right here but let's look at the situation and minimize the harm to the individual and support them.

**Dr. Fishman:** The goal of abstinence is unrealistic. That may be contrary to what many people in the field argue and many people in recovery argue. We find harm reduction can move an individual on the pathway to recovery.

**Raymond Bizzari:** I would like to give you an example how this plays out in the world. We have a guy who goes through detox and inpatient for opiate abuse and goes to a halfway house and gets caught with cough syrup and gets kicked out. Doesn't make sense.
Rachel Breidster: Absolutely. Are there current plans working towards an integrated mental health and substance abuse treatment program on a systems or policy level?

Raymond Bizzari: Office of mental health and OASAS, they have been talking about and had issued some guidance around, you know, integrated licensing models. The thing that gets in the way on the ground for doing integrated care is the regulations and the payment methodology and staffing patterns of the people that working those particular facilities, whatever the licensing is, doesn't allow four to do that. They've been talking about this for a while and there's a couple of—there's a few sort of demonstration sites. Most of the work has really been around massaging the regulations. SO you are also talking DOH licensing too because you know primary care, qualified clinics, are doors people walk through. So I think there's some movement there. There's not as much as we need and there needs to be some sort of efforts on training the workforce. We have a workforce that doesn’t know how to behave this way necessarily.

Rachel Breidster: Sure. We have another question, could you please speak to how the screening brief intervention and referral to treatment may assist with AOD and mental health integration

Dr. Fishman: Yes. The expert can be very helpful in that it has a range of items that will cover both mental health and alcohol and all other drug use. It’s a useful tool because it's quite clear in terms of interpreting scores and moving towards what ASAMH criteria need to look at what proper level of care would be most effective for this client as well as their term of readiness for that level of treatment.

Rachel Breidster: Thank you. We have a number of comments coming in. Folks were unable to read the resource kits. The handouts are available on our website, [www.phlive.org](http://www.phlive.org) download the slides there and they contain the written information for where you can find any of the resources that’s being discussed today. We have another question—all right. You offer screenings for schools and for young people who are not diagnosed with a disorder but still may have levels of anxiety or depression or not yet showing symptoms. What do you do?

Raymond Bizzari: So, that's what the screenings do. I think when it started out we were screening in like third and fifth grade. We were in elementary schools and middle schools. You would screen kids and then you would get—you would evaluate the screening tools and then you would get some information about whether or not the kid was experiencing that sort of stuff and then you would sit with the parents and you would have a conversation and say this is what we did. There was signed consent. You would sit with the family and talk about that sort of stuff so the goal was to raise their awareness and get the kid sort of connected to early treatment because the earlier the better. So that's kind of how it works, you work closely with your clinics and school districts and parents to pull that together. It’s easier now than then because it's normalized to do those screenings. Same thing in primary care physicians’ offices.

Dr. Fishman: These screenings can be very useful from a behavioral health perspective in primary care settings because it alerts the physician or physician assistant or nurse to be inquiring further and actually doing some education along the way with the patient.
Rachel Breidster: Great. Another question, how did New York state or your community balance approaches to mental health promotion and disorder prevention with treatment and recovery approaches?

Raymond Bizzari: That's a pretty good question. I'm not sure that we approached it in that organized manner which is part of the challenge for us. We spent a lot of time putting fires out. Don’t spend enough time on the early identification, the prevention and all the sort of thing you do to work the circle. So yeah, we have a long way to go there.

Dr. Fishman: There's a disconnect. You know, we focus our efforts on screening and prevention, early intervention but it doesn’t necessarily correlate with the evidence-based approaches for recovery. We have a ways to go for fully integration in how we identify the approach we'll utilize in treatment.

Rachel Breidster: Another question is it truly an opiate epidemic in New York State and if so why is it such a problem now?

Raymond Bizzari: It's a plague upon us. This is what this is. The entire thing you talked about. What the woman talked about from Erie County. You had a prescription drug explosion. People were getting opiates, adults, kids, sports injuries, all that sort of stuff; some prescribers were a little loose. Folks were able to get these refills for a long time. A lot of attention got focused on this. “I Stop” came out, when I talked to my psychiatrist, the things they would see freak them out. People getting 90-day supplies of OxyContin. That disease didn't disappear so you buy them on the street. So can’t afford that. So you can go, heroin is very cheap, very potent, and very inexpensive. You can snort it now. You don't have to shoot it. If anybody who thinks there's not an opiate problem in New York State should rethink that.

Dr. Fishman: There’s a similar epidemic in Massachusetts and Vermont. They had state summits on this issue. There’s a lot of diversion of medications. They end up on the streets. Eventually folks switch to heroin because it's less expensive. The reason for so many overdoses is you can't be sure about the purity of the heroin that you’re consuming. So heroin that had been cut in one way can differ from another batch that you got to consume and that can lead to overdose and more folks buying heroin are not sure what actually is the purity of that heroin.

Rachel Breidster: Absolutely. You’re getting the prescription, it’s regulated, and you know what it is. Once you can't access that any more now you're taking a much bigger gamble with what you're injecting to meet that addictive need.

Raymond Bizzari: The thing that hurts people from an overdose perspective. You get folks who stop. However they do it. They stop and they have a period of sobriety and then they use again and they use at the same level they had when they had a tolerance and that gets risky for people as well.

Rachel Breidster: We have time for one more question. We know how much stigma hurts our campaign. Is there anything going on to change people's beliefs about mental health and substance abuse. That’s a great point and a good question.
Raymond Bizzari: That's public health. That's approaching it that way through education, through awareness, through conversations. Normalizing it and changing the discussion and moving away from, you know, the blaming business that we're doing. They are diseases, are very powerful diseases, profound effects on people's lives. Public health has shown it's able to sort of turn the way society thinks about things around.

Dr. Fishman: Public health really uses what we call an ecological model. It says there is to be integration between levels. You work at the individual level. You work at the interpersonal level. You work at the organizational level, school and occupations. You work in communities. And then it's got to, at some point move policymakers and it can work in one direction or the other. So for education, for awareness, for shifting of beliefs that might lead to policy and funding you have to work at all these levels. Unfortunately, a lot of our efforts may get isolated to one level versus another and our efforts and energy don't travel. And public health, you need to work at this in a more generalized fashion so that there's commitment from all the different levels that might influence ultimately helping that individual.

Rachel Breidster: That's all the time we have for today. Thank you very much for your presentations and answering all the questions. And thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain nurse continuing education hours, CME and CHES credits visit www.phy.org and complete an evaluation and the post-test for today's offering. Additional information on upcoming webcasts on relevant public health topics can be found on our Facebook page. Like us on Facebook to stay up to date. This webcast will be available on demand within two weeks of our show. Please join us for our next webcast Breast Feeding Grand Rounds on August 7th. I'm Rachel Breidster, thank you for joining us on Public Health Live.