Ken Duckworth

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Margaret Flinter: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds, who are shaping the health care of the future. This week Mark and Margaret speak with Dr. Ken Duckworth, Medical Director for NAMI, the National Alliance for Mental Illness, the nation's largest grassroots organization seeking to improve the lives of the millions of Americans dealing with mental illness. He talks about the anxiety and depression epidemic, especially among teens, the need to democratize depression screening, diagnostic tools, and the need to expand the use Telehealth to fill the clinician gap.

Lori Robertson also checks in, Managing Editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea, that's improving health and well-being in everyday lives. If you have comments, e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, iTunes, or wherever you listen to podcasts, and you can also hear us by asking Alexa to play the program Conversations on Health Care.

Now, stay tuned for our interview with Dr. Ken Duckworth of NAMI on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Ken Duckworth, Medical Director for NAMI, the National Alliance on Mental Illness, nation's largest grassroots mental health organization dedicated to improving lives for the millions of Americans affected by mental illness. Dr. Duckworth was the Medical Director and Acting Commissioner of Mental Health in Massachusetts. He's an assistant professor at Harvard Medical School and an adjunct clinical assistant professor at Boston University School of Public Health. Dr. Duckworth, welcome to Conversations on Health Care.

Dr. Ken Duckworth: Thank you for having me.

Mark Masselli: Ken, obviously, I think all of our listeners know that we have a mental health crisis in the country and anxiety, depression, suicide are on the rise among our nation's youth. All of this is further complicated by the devastated opiate crisis, and I wonder if you could talk with our listeners about this growing health crisis and what do you believe is behind the rise in mental health issues in our nation, especially among our nation's youth?

Dr. Ken Duckworth: If you look at the CDC's work on the rise in adolescent suicide from 2007 to 2017, that corresponds pretty well with the development of social media, which is a potential bullying effect. It also corresponds

with the rise in school shootings and the resultant school shooting drills that are now omnipresent. Also the black box warning on antidepressants came out in 2003. Fewer antidepressants are being written for teenagers. Modern life is complicated, and I think if you've ever had a kid go through the college admissions crisis, you can see kids feel the pressure in a way that, I went to my local state school at the University of Michigan, I just showed up at school. A completely different mindset in every way. Young adults do report more anxiety and more depression and it may also be because this generation is more open to discussing these vulnerabilities. It's the willingness to talk about it, which is a great advantage that this generations bring into the equation.

Margaret Flinter: We often think, well, if people have health insurance, that's something that gets them access to care, but it kind of turns out that; one, there may not be a clinician available; and two, we've seen a trend towards behavioral health providers not taking insurance, and then, we still haven't gotten to parity. Speak to that and how these things make it challenging for patients to get the help they need?

Dr. Ken Duckworth: Yeah, NAMI advocated very intensely to get mental health parity and it has shown an increase in accessibility and availability, and attitudes have improved towards help seeking. There has been no corresponding public health response to create more practitioners, more psychiatrists. There are millions of people right now, who didn't get the Medicaid expansion in their State. The people who have the Medicaid expansion are doing better per person than the States that don't have the Medicaid expansion. Many psychiatrists are choosing not to take insurance. My experience here in Massachusetts is that masters level clinicians are very happy to take insurances, and so, we have more people getting assessments and evaluations and being seen by licensed mental health counselors. What I would encourage people to do is, work with their health plan. The health plan has an obligation to give you the help you've paid for. I think that's a secret that people don't really know.

Mark Masselli: Well, that's great. Let me just share another secret that the Community Health Center Movement is a place where there is a fully integrated medical, dental and behavioral health team waiting for you, whether you're coming in the door for dental or coming in for medical, that PHQ-9 is being done, understanding your mental health status. We've got to educate people to make sure they understand it just like they understand their blood pressure score. NAMI is partnering with Google to attempt to do a much broader access for the population. I wonder if you could talk about this online screening to really democratize mental health and depression screening?

Dr. Ken Duckworth: Yeah, the PHQ-9 is the Patient Health Questionnaire-9. It is universally

accepted as a great metric for the potential for depression. There are nine areas each of those is rated zero to three. 27 is an extremely high score. Walking around with five is probably, not something that needs intervention, but you might want to look at how's your self care, how's your sleep, how's your exercise. A score of 15 is an indication that you should see your primary care doctor or find a clinician to get an assessment. These tools need to be democratized, because there simply aren't enough practitioners who will sit with you as you go through your PHQ-9. If you can find a good clinician, it's the best case scenario. We have half the counties in America have no psychiatry at all. The idea that you could structure your own self understanding around your depression. Before I go on my vacation, honey, my PHQ-9 score is 20. We have to stop at CVS, get my meds and set an appointment for the day I come back to see my therapist. Just people do this to blood pressure every day. PHQ-9 is a kind of outcome metric in the depression field. I think if people have this vulnerability, it's useful for them to have self knowledge.

Margaret Flinter: Ken, I wonder if we could talk a little bit about stigma in mental health. I think traditionally people had a lot of concerns about potential reprisals in the workplace or in school. You were just recently in an hour-long special segment on the CBS morning show, you were talking about stigma and how to address it. You said that young people may be way less afraid of stigma, but we're concerned about everybody. How are you addressing stigma, which is a real barrier to people getting the help that they need?

Dr. Ken Duckworth: Couple of programs that I think are pretty cool. One is, Ending The Silence, which was invented by one NAMI chapter, and this is given middle school students and high school students across America. This is people in recovery discussing their journey. It’s a big barrier breaker to have somebody who looks like you or talks like you or thinks like you that you can identify with. Literature is pretty strong that when you meet people who have a mental health vulnerability, your attitudes tend to improve. The program, Ending The Silence, is getting people with real life experience in the junior and high schools. In our own voice as a program, any business, any community health center, which are a jewel in our American health system, community mental health and community health centers are really valuable resources. You could have a person or two with lived experience come and help the staff think about their attitudes. I think these are good examples that we have put together that's rooted in the science. I mean, 0.5 million people have seen these -- each of these programs. I gave a talk in Midland, New Jersey, and because they've had a problem with adolescent suicide, which is a common problem, the local NAMI chapter was asked to involve themselves in the school district and do Ending The Silence workshops. That's a great example of responding to a real time problem.

Mark Masselli: We're speaking today with Dr. Ken Duckworth, Medical Director for NAMI, the National Alliance for Mental Illness, the nation's largest grassroots mental health organization, dedicated to improving the lives of millions of Americans affected by mental illness. Ken, I was struck when you said that half the counties in the United States don't have access to psychiatry. Perhaps that's one of the reasons that we're seeing this incredible proliferation of Telehealth interventions in the space. It seems that the evidence supports the Telehealth visit is effective as an in-person visit. Yet we're still such a long way from the widespread adoption of Telehealth protocol. I'm wondering what NAMI is considered in terms of its strategy on trying to cultivate more of those Telehealth partnerships?

Dr. Ken Duckworth: Telehealth is the same quality as in-person treatment. The American Psychiatric Association has really reviewed this entire literature. The question is, how do you incent practitioners and individuals to receive care through this vehicle? This doesn't create more mental health practitioners, but it might use them more efficiently. You can see people during snowstorms, I happen to live in Boston, there's efficiency there. Another idea to deal with the supply-demand mismatch is the idea of bringing peers into the equation, someone who has well managed their fill in the blank bipolar disorder, schizophrenia, opiate use disorder. They can offer something to the treatment equation, it is a powerful piece of the future, I think. Practitioners weren't trained on this for the most part. Well, we'd have to think of ways to incent them with loan repayment or some other ideas, and we have to make sure that people are getting trained in this model. NAMI is connected to a major medical school in Iowa that is working with primary care clinicians. Telehealth is one of the many things that we're trying to do, so that when there are patients present with mental health vulnerabilities, which is about a third to a half of primary care work that they're aware of a free resource that they can utilize.

Margaret Flinter: I want to get back to something Mark referenced and you seconded it around the community health center model and there's a lot of wonderful things in our opinion about that, but it's also true in the VA, it's true in Kaiser, that where you have fully integrated primary care and behavioral health, you eliminate a whole set of barriers right off the bat. We have felt the need to take that to the next level of recognizing that unless we train the next generation to this model and in this model, we can't expect that the next generation is going to be prepared to practice and lead an integrated model of care and you're teaching at some of the finest institutions in the country. What are you seeing about the uptake of training in an integrated model as a fundamental strategy? Then, what the leaders in psychiatry and behavioral health are thinking about this as a critical element of training the next generation?

Dr. Ken Duckworth: Yes, this is an important challenge. I was the Medical Director of the Massachusetts Mental Health center for eight years, and the Brigham and Women's Hospital was 250 yards away, but that was a big 250 yards.

Margaret Flinter: Absolutely.

Dr. Ken Duckworth: Different record system, different culture. I think there's cultural and historical challenges here. What you're doing is great, hosting people for warm handoffs is probably your gold standard. I think the hope is with global payment models on the commercial side that people will recognize that the people who consume a lot of resources require integrated care. What I had been disappointed by is the new collaborative care codes, which have a very strong evidence base that you don't have to co-locate, because people will frequently say it's expensive to co-locate social workers, psychologists, psychiatrists. Collaborative care codes has a very strong evidence base and the idea with that, let's take the PHQ-9, which we already talked about, the idea as a practitioner in the field in a different office than a primary care doctor is following the same patient with the same metric, with a Case Manager connecting the two. You can imagine in some rural areas, it's going to be difficult to get co-location, so the collaborative care model, I think, like Telehealth, represents a future state, but we haven't created the culture or the momentum to make that happen. What you're doing by posting practitioners in primary care, I think would be the optimal outcome.

Mark Masselli: Now, let's just take a moment to talk about the policy landscape. Lots of activity going on in Iowa in terms of the primaries about what might be the best health care coverage model. As we look in our rearview mirror, we see good news, which was the Affordable Care Act passed and 20 million Americans got coverage to be able to seek mental health and substance abuse treatment in a way that hadn't happened before. We're hearing a lot in terms of Medicare for all and other elements of a modified Affordable Care Act. We have the Mental Health Parity Act, which passed in 2008. I'd be interested in your thoughts about the larger policy conversations going on, but I also want you to talk about anything at the state level that might be happening best practices at businesses. Is there any exemplar out there that people could look to?

Dr. Ken Duckworth: A couple things. NAMI is part of a challenge with other mental health associations, where the so called junk health plan. There's a plan to undermine the Affordable Care Act implementation by selling plans that don't cover mental health and substance use disorder. These plans also don't have to exclude pre existing conditions, and they can be quite expensive for people who have these vulnerabilities. These are not comprehensive. They are not mental health parity friendly.

That's a great example of a real time struggle that's happening right now. We agree that mental health parity was good, hasn't been fully implemented, is not been realized, but it represents a floor. These new health plans that are being proposed by the administration undermine that basic floor. Medicaid expansion is a crucial thing. 27% of people with serious mental illness have Medicaid and there are several million people who aren't getting access to care, because of the expansion of Medicaid challenges in many states. I do want to mention, are you familiar with the 988 crisis line legislation?

Mark Masselli: No.

Margaret Flinter: I'm not.

Dr. Ken Duckworth: Okay. This is the idea that you call 911 if your house is on fire, but you have to call a long number for the national suicide crisis hotline. NAMI is supporting legislation that you should be able to pick up any phone and call 988 and be connected directly to the national suicide hotline. We're facing a crisis here in our country and every barrier you can remove, whether it's Telehealth legislation or a simple phone call. The national suicide hotline is a long number right now. There is legislation in the Senate, your Senator in Connecticut has proposed the standard parity enforcement legislation, which would really subject more institutions to a more rigorous examination. Medicare for all -- the details in that haven't been clear to me, how that would impact access to care. I do know that other countries seem to be able to ensure people across the board in western countries without much problems, in terms of having the population insured. That's our first threshold problem is people without insurance then have to rely on free care and seeing if they can qualify for Medicaid. Of course, mental health is part of health. If you don't have the mental health benefit, you can even begin to hope to get the care. I think there's millions of people who could get Medicaid if Medicaid were to expand.

I am impressed that the opiate crisis is actively part of the presidential conversation. I was at a talk by our Governor, here in Massachusetts, Governor Charlie Baker who said that when he traveled across Massachusetts, he couldn't get away from the opiate crisis. I think that Massachusetts has seen the leveling and overdose deaths. There's probably many, many reasons for that, so we may be prescribing fewer opiates, making Narcan more available. Medicaid just added Telehealth. There is some hope that the presidential campaign will continue to shine a light on that national emergency, which of course, is at the same time, a mental health crisis.

Margaret Flinter: That’s right.

Dr. Ken Duckworth: Right? I think that's a long answer there.

Mark Masselli: That's great. Perfect.

Dr. Ken Duckworth: Let's talk about employers. I want to shout out a couple groups that I'm aware of in Massachusetts that are impressive. Some of the construction industries have really taken the opiate crisis to heart. Construction workers and people in the fishing industry are the two highest risk groups. In the commercial fishing industry, they now have Narcan on every boat. I feel like that is a progressive, thoughtful, game changing way to approach opiate overdoses. Now, obviously, prevention is a big challenge. Physician prescribing of opiates is down substantially. I think with the emergence of fentanyl, which is a leading compound found in overdose deaths, that's more of a criminal justice problem, is figuring out how to keep fentanyl out of the supply chain. I think the presidential conversation is going to be very interesting, because mental health is a core American crisis now. Suicide rates are up for virtually every demographic imaginable. The American life span is actually shortening, because of the opiate crisis and because of suicide. This is not happening in other first world countries.

Margaret Flinter: We've been speaking today with Dr. Ken Duckworth. He's the Medical Director of NAMI, the National Association of Mental Illness, the largest grassroots organization, seeking to improve the lives of those who are dealing with mental illness. You can learn more about his important work by going to nami.org or follow them on Twitter @NAMICommunicate. Ken, we want to thank you for your vital work in this important area of health for highlighting so many issues for our listeners, and for joining us today on Conversations on Health Care.

Dr. Ken Duckworth: It's a pleasure. Thank you for taking this topic up.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: The Census Bureau in September released its report on health insurance coverage in the United States in 2018. Finding that the rate and number of the uninsured increased from 2017 to 2018, the first time it has found a yearly increase since the Affordable Care Act was enacted in 2010. In 2018, 8.5% of people were uninsured for the entire year. That's up from 7.9% in 2017 and it's an increase of about 1.9 million people. 67.3% of people have private coverage with most getting that coverage through their employment. Those with Medicaid coverage dropped 0.7 percentage points from 2017 to 2018

to 17.9% of the population. Medicare coverage went up by 0.4 percentage points, covering 17.8% of the population. The percentage of children without insurance went up by 0.6 percentage points. The Census Bureau uses data from the current population survey and the American community survey making this measurement dependent on a large amount of responses and that's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. If music soothes the savage beast, the question they want to answer at the sync project is, how exactly? There are lots of anecdotal studies supporting music's ability to trigger memory or boost endurance or focus. Virtually nothing is known about how music truly impacts our physiological and neurological state. This is the question that intrigued scientist Ketki Karanam, a Systems Biology PhD from Harvard, who wondered, how could music be scientifically harnessed as a powerful precision medicine tool? They formed the Sync Project with a cross-section of neuroscientists, biologists, audio engineers, and even some rock stars like Peter Gabriel, and started by using artificial intelligence systems to analyze existing play lists that purports or promote relaxation induced sleep, enhanced focus, or athletic performance.

Female: Once we have this set of songs that our machine learning algorithms predict to be effective for a specific activity, we can then draw on studying using these devices like your heart rate monitors, your smart watches, the activity trackers and actually look at how effective indeed is that song for that purpose.

Margaret Flinter: Karanam and her colleagues note that most of us self-medicate with music already. Why not harness this ubiquitous tool that's available to all of us and develop strategies and systems that might replace pharmacological interventions with musical ones?

Female: We are literally walking around with 14 million songs in our pocket every single day. We saw a great opportunity and really being able to understand how music was affecting us to measure how different types of music to affect both our psychological health as well as a physiology.

Margaret Flinter: Karanam and her team see vast potential for reducing reliance on drugs by crafting personalized music interventions in the management of a variety of complex conditions such as pain management, PTSD, even Parkinson's disease.

Female: In Parkinson's disease, patients have trouble coordinating movements, so by playing them the right kind of music, it can be an external auditory support they have that's going to help them walk more smoothly.

Margaret Flinter: The Sync Project, combining computer technology and neuroscience, physiology and musicology to harness the healing powers inherent in music, now that is a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace and health.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.