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Marianne O'Hare: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter. In observance of National Mental Health Month this week we welcome Dr. Thomas Insel, former Director of the National Institute on Mental Health and author of the new book calling for an overhaul of America's mental health system.

Dr. Thomas Insel: People with these disorders, more than with most medical disorders, can recover, and they do recover if they're given appropriate care.

Marianne O'Hare: We'll hear from FactCheck.org Managing Editor Lori Robertson and we end with a bright idea, improving health and well being in everyday lives. Now, here are your hosts Mark Masselli and Margaret Flinter.

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Mark Masselli: One in 20 US adults experienced serious mental illness each year. That's what the government's statistics tell us. Our guest wants to understand how we can do a better job helping some of our most vulnerable.

Margaret Flinter: Dr. Thomas Insel led the National Institute of Mental Health for 13 years and his new book Healing: Our Path from Mental Illness to Mental Health is now available.

Mark Masselli: Well, thank you for joining us, Dr. Insel. Just to set the stage, here's what we know about mental health in our country during the pandemic, anxiety increased 50% depression was up 44% and those rates were about 20 points higher for those ages 18 to 29. Do you think greater incidence of mental health issues will or can result in more understanding and support? Is there any such thing as a silver lining in all of these pandemic related issues that we've been facing?

Dr. Thomas Insel: Well first Mark, thanks for having me. I do think as you say that there is a potential silver lining here, it's the case that this pandemic has been particularly difficult for mental health for young people. If you just look at the numbers, people under 30, we've lost about 7000 people to COVID in the last two years in a few months. We've lost about 70,000 to deaths of despair from mental illness in the same age group. It is without question been a rough go for those particularly young people who have been more affected by the psychological consequences of COVID than by the infectious disease itself.

That said, I think it has brought a lot of attention to a problem that was there before the pandemic, and it's also helped us to understand that we're going to have to approach it with different approaches. It's not going to be the old brick and mortar 50 minute hour, but it's the opportunity to innovate. Using telehealth and using a lot of new

programs that have been developed by entrepreneurs a chance to actually improve access and increased quality for people with mental illness.

Margaret Flinter: Dr. Insel during your time leading the National Institute for Mental Health, you oversaw $20 billion in federal funds, we'd like to say here in Connecticut $20 billion is about the size of the entire annual budget for the state of Connecticut. But in this federal role, you made a critical decision to shift institute funding towards the neuroscience and genetics of area more and away from the behavioral research. Share with us a little bit about the strategy of this move. What was compelling that directional shift for you?

Dr. Thomas Insel: Yeah, so it's important to remember that NIMH is the science agency. We have other agencies in the federal government that respond to services and are really accountable for service delivery. But the NIMH and broadly the NIH role is to chase after the very best science and to support the best science to answer those questions, giving us kind of new understanding of the biology and the psychology of these illnesses. I had a fantastic opportunity, observed a great time. I think it's still a great time, but the science was really developing in those areas you mentioned, in the areas of neuroscience, genomics. Also I would say in behavioral science and cognitive science, we had just entirely new frontiers, new tools, and a whole new generation of people who are asking very compelling questions about schizophrenia and bipolar illness and depression and PTSD.

It's an extraordinary period of time for research to really begin to reframe the problem, help us to understand that these were really problems of brain circuitry, brain connectivity, and would potentially open up new ways of trying to treat and ultimately even cure some of the problems at hand. It's clearly far more complicated than any of us would have bargained for in 2002. I think when I left in 2015 it was with the pride that we made a lot of progress. Problems always ended up being more complicated than you expect at the beginning often, and it will take more time more investment.

I left not because I was disappointed in the science or anything but I was still really fire up by the science. But it's clear that there was a need for services for implementing the science that we had already developed that whole industry that had said we know how to help people recover. Yet, those insights weren't being used by the service sector, so it wasn't any sort of regret or disappointment with what NIMH had done. It was really the need to say, how are we going to be able to help people recover? That's not an NIMH problem, it's not a scientific problem. We have the science to help us there. It's a problem of implementation. It's a problem of service delivery, it's a problem of actually providing the incentives and paying people for the

things that work.

Mark Masselli: Yeah, let me just pull the thread on that. You say that mental illness is a medical problem, yet the solutions seem to be social, environmental, and political, or at least elements of them. It seems that's going to be a tough sell to get buy-in from many sectors, because we have a bias that if you're sick you take a pill and that should solve the problem. Fixing society is much harder.

Dr. Thomas Insel: Well, that's really why I wrote the book, because I agree with you. I mean, if we need to resolve racism before we begin to reduce suicide, it's going to be a tough climb. We're working on this for decades, and so we have to think much more I think strategically about what can we do. I lay out what I call the recovery model of three P's, People Place and Purpose, and it turns out that we actually have solutions hiding in plain sight for each of those. We have clubhouses which are not expensive, which are able to give people the social support the job training, actually the sense of purpose as well, so they can actually begin to recover. We have what we call assertive community treatment teams or ACT teams that proactively engage people to make sure they get the kinds of access they need.

We have what we need in that realm of rehabilitative or recovery services, and in fact we do pay for those on the medical side. You break your leg, you get to go into a six months of rehab, physical therapy, all that will be paid for by insurance, but you have a psychotic break, and you're going to need 6 to 9 to 12 months of rehabilitative support that's going to be paid for by some charity that's holding a bake sale to make sure you have access to some social support. Maybe you'll even get some job training if you happen to be really, really lucky. But healthcare doesn't pay for that.

The point of the book was to say, just as with a broken leg you've got a broken brain, you need the same kinds of services it needs. It's not enough to just provide medication in an emergency room and send somebody home. You need to make a commitment. This is a long process if you want someone to heal, which is why the book is called Healing. It's about this whole process of People, Place and Purpose, and building that in for someone over a long enough time to let them really get back to a state of private.

Margaret Flinter: Well, I think that there's been a good response to the fact that President Biden has put forward a number of mental health initiatives focused on expanding access and services. We've certainly seen a big focus on reaching kids in schools, for instance, for behavioral health, and the National Alliance on Mental Illness has called it an unprecedented focus on mental health when he gave the State of the Union address, and yet I think seared in the eyes of people around the country are the sights of homeless people with mental illness on the

streets in so many of our major cities, and still so much work to be done. If President Biden were here with us, what advice would you give him on what still needs to happen from a national perspective?

Dr. Thomas Insel: That's a great question. The first thing I would say is bravo. I think we haven't had leadership on this problem in 41 years. President Carter was the last one to really focus at all on the national crisis around mental health. It's only gotten worse since, much worse. Now I look at that unity agenda that the White House put out on the day of the State of the Union, I was pretty excited because it conforms almost exactly to what I wrote in the book. It's almost all the same points and I was delighted to see that. I was also a little worried. I was worried that we maybe haven't learned all of the lessons from the 1960s and 70s. What happened with the Community Mental Health Act that President Kennedy launched in 1963 was we built these community mental health centers around the country with federal dollars. They didn't integrate with state and local programs, and so when they were defunded, there's no backup. There was no safety net beyond the community mental health centers. We need to make sure we don't do that again.

As we think about the -- in some ways, a good way to think about this is it's a balance of federal support, state and local support. What we need is to weave those together seamlessly. But I'm concerned about this now that federal support, federal leadership is coming back in literally for the first time in four decades, we need to make sure that it's not supplanting the work, but it's synergizing with the work that's already being done and also being proposed in states like California, so that we've got federal local state partnerships to provide the care that people need. That's the mistake that I think we made in the 1970s.

Mark Masselli: I want to sort of get back to that sort of concept of a local social movement being needed and you write about this, right, in terms of mental health. I wonder if we don't have that already. We certainly have elements of it, we have celebrities and politicians who share their struggle. We've had former Congressman Patrick Kennedy on our show. We've also recently had Jane Pauley on talking about the issues and advocacies. But what do you think is missing from this larger public dialogue? Can that top end leadership be sustained without a real strong grassroots effort, and what's your assessment of where we stand in terms of that level of social engagement?

Dr. Thomas Insel: I think the message that we've had so far from my perspective are not quite the right message. I think the message that we hear a lot about is kind of, it's okay to talk about it, it's kind of an anti-stigma message. I don’t actually think that's useful. In fact, I don't like the term stigma. It's a victim term, it doesn't lead to change and I personally have been

involved with anti-stigma campaigns for decades, and stigma has only gotten worse. Let's bring this as discrimination. It's not stigma. It's actually something that's in some ways more insidious and more difficult. The piece of that, that I think needs to really be honed as a message needs to be conveyed very clearly to the public, and somehow has been so overlooked is that these treatments really work, not just medication, but psychological interventions, these rehabilitative treatments, they really work. People with these disorders more than with cancer, more than with heart disease, more than with most medical disorders can recover, and they do recover if they're given appropriate care. The real tragedy here isn't that we're stigmatizing them, it's that we have great stuff to offer that we're not giving them even though it's hiding in plain sight, and so I think that message that people can recover is really lost.

There was a wonderful headline in the New York Times, it said, “Dementia is where my mother lives it’s not who she is.” That's actually exactly the right message here. Schizophrenia is where some people live, but it's not who they are, and so we need to treat that illness so those people can actually thrive. We know how to do that and we're not doing it and that's the tragedy. I think that's a piece of it. But I would agree with you that we do need more of a social movement that comes from below as well, and that means empowering families to demand the kind of care that works. It’s outrageous that families take their adolescent to an emergency room, and they're told that they have to wait 9 days or 12 days for a bed, and so their 17 year old is chained to a gurney day and night for 12 days in the back of an emergency room. That is happening every day across America. That is not acceptable.

It’s time for families to begin to say to people who represent them, we're not going to put up with this. I say in the book that we're sort of in Jim Crow era of mental health care. I mean, this is just outrageously unjust. It's unethical. It's a painful immorality in this country, and yet people are not yet talking about it. There's no reckoning with this kind of an injustice. Until people are faced with it themselves and then they're so overwhelmed they can't tell they can do to manage that, let alone become advocates for social change. It’s going to take an effort. I've used the proceeds of the book to launch MindSite News, which is a platform it's a new digital publication to sort of lift up this issue and help people to understand just (a) how unjust it is and (b) how fixable it is. Unlike climate change, we can do this immediately. We know what to do. We're just not doing it, and that's the piece that really needs to be made -- where people need to be more clearly aware of that in the public dialogue.

Margaret Flinter: Well, Dr. Insel, that is a very powerful story how many teens spend their nights in the emergency room just waiting for a bed to open up. I

have to wonder Governor Gavin Newsom appointed you as the mental health leader for California. Whether you think that this is a moment in the country's history when these issues around mental health and public policy, government and services, transcends partisanship, there isn't a family in America that probably hasn't been touched by behavioral health issues. Do you think this is a time when you can really make great strides in a bipartisan way?

Dr. Thomas Insel: When I look what the governor's done in California, it's pretty extraordinary, I mean, some really big programs and big commitments and it is inspiring. I think you're onto something. I think this is an area that is more personal than political, and I do think that it is absolutely bipartisan in the sense that leadership of both parties in the Federal Congress have decided that this is an important area for them to try to effect some kind of change. I'm pretty hopeful. I think that the pandemic that one of the, maybe unexpected silver linings here was that it's made this an issue that we can all now begin to talk about, because we have to.

To your point, I say in the book, there are really only two kinds of families in America, they're the families who are struggling with a mental health issue and the families who are not yet but they will, and so we all become involuntary experts here. We all end up whether it's spouse, or parent or child, all of us, every family, eventually is faced with having to figure out how to help a loved one. Our job is to make that easier, not harder.

Mark Masselli: I want to go back to earlier part of the conversation you started talking about the sort of force multiplier of technology. You're also just mentioning your evidence based in terms of how you look at this and even though its evidence based, it's not necessarily fully yet embraced in the public's mind. But walk through some of the technology that you see out there, you're excited about you had spent some time at Google working with startups, obviously, we're seeing a lot coming out of Silicon Valley to make more accessible mental health services.

Right now we're in a community health center. Our population is cost conscious, this old model that somehow I have to leave my 7-Eleven job, take two buses, waiting your waiting room for an hour to be seen for 15 minutes just seems to be antiquated. But walk through not only that the value of telehealth but what are you seeing in some of these very interesting, very exciting, yet I'm not sure researched enough startups that are going on in the behavioral health space?

Dr. Thomas Insel: Yeah, thanks for asking Mark. I mean, I think the conversation about technology and mental health often centers on apps, is there going to be a chatbot for depression? Is there maybe some virtual reality software and hardware that can fix phobias? There are some

interesting things there. But I think what we've seen in this last couple of years, is the enormous value of being able to access care online so people moving from the brick and mortar to being able to use Zoom or some interface that allows you to find therapists or find care and even find medication at your convenience, not at the convenience of when the clinics open, or meaning that you have to leave your job and drive for an hour, or take two buses to get there. That's great. I think you've already seen this. We've got companies like Mira [PH] and Cerebro [PH] and Modern [PH] and Big Health [PH] that are all very valuable and they're providing care to literally tens of thousands and actually hundreds of thousands of people who might not have been getting care before. Yeah, this is a pretty interesting way of improving access through increased convenience, kind of like what Amazon does, right.

It's not clear that it's improving quality or improving outcomes. I think the next stage of this innovative revolution that we're on is going to be how do we ensure that people are not only getting access, but getting access to what works and getting better as a result and that means measuring. We have to start to bake in measurement. I call that telehealth 2.0 so that becomes part of every interaction. The same way with your diabetes or your hypertension you manage it through getting actually outcomes that you work to work towards. We're not fully doing that in the mental health space, but we could and we will. I think if act, one was getting some of the major players so we could see who they were going to be getting access improved, act two is going to be improving quality through measurement.

Margaret Flinter: Well, I'd like to maybe following up on that give you just a moment to talk about 988 the three digit dialing code that will route callers to the National Suicide Prevention Lifeline beginning in July. What do you want people to know and share with their friends and neighbors about 988?

Dr. Thomas Insel: Well so we have a new line, it's not going to be a 10 digit number, but a three digit number. Three things I would say. One is that 988 is not 911, right. 911 is just a dispatch service. 988, if it's done right can be a telehealth service. It's a place where you can go in real time like within minutes, either through phone, chat or text, to be able to connect with somebody who has the skills to either direct you to care or to provide care. If it's done really well, unlike 911 they'll call you back the next day to make sure that's working, so that's the first thing that 988 is something quite different than what we've been thinking about for emergency services in the past, particularly in the 911 space.

Second thing to remember is it's just a phone number, right. For a lot of people it's going to require more than just to call. Some people are

going to require someone to come, so you need mobile vans to go with that. Some of those people are going to need some place to go, so you need to have psych emergency rooms or crisis stabilization units, all of that. We don't want people going to jail. We don't want them go into a medical surgical emergency room unless they absolutely have to. We have to build out that whole continuum, and that's not going to happen right away, which is my third point.

The third point is it took about a decade to get 911, right. It's going to take us some time to get 988 to actually solve the problems that it was set up for. The problem we have now is tragic interactions with police, people ending up in jail or incarcerated instead of in health care, and the crowding in of our emergency rooms. Those three things are not going to get solved on July 16th when the new number goes in place, but it's the beginning of solving those problems. Give us some time, it's going to take a while to build out that continuum. But we know if we put in the continuum of care we can actually see some pretty good results in terms of fewer interactions, tragic interactions with the police department, fewer use of jails as the kind of default mental health system, and not so much crowding in the emergency rooms.

Mark Masselli: Thank you so much Dr. Insel. The New York Time calls you one of the most influential neuroscientist of our time, and it certainly easy to understand why. Thank you also to our audience for joining us. You can learn more about Conversations on Health Care and can sign up for our email updates at www.chcradio.com.

Dr. Thomas Insel: Thanks for having me.

Margaret Flinter: Thank you so much.

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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 healthcare 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 US politics. Lori, what have you got for us this week?

Lori Robertson: A leaked draft opinion indicated that the Supreme Court is ready to abolish the 1973 Roe v. Wade decision establishing a constitutional right to abortion. The draft written by Justice Samuel Alito is authentic. The High Court said in a statement noting that circulating draft opinions was a routine part of the court's work and that this one didn't represent the final position of any justice. But what happened if the court does overrule Roe. Jurisdiction would go back to the states likely setting up a patchwork of abortion restrictions and rights across

the country. Roe v. Wade established that states couldn't limit abortion before a fetus is viable or able to survive outside the womb, which is generally considered to be at about 24 weeks of gestation. But state laws have sought to challenge the point of viability.

The Center for Reproductive Rights and Advocacy and legal groups supporting abortion rights brands 25 states as hostile to abortion rights, saying they would be likely to prohibit or severely restrict abortion. The Guttmacher Institute a reproductive health research group counts 26 states as certain or likely to ban abortion under all or most circumstances or early in the gestation period, such as abortions after six weeks of pregnancy. Among those states are nine that have pre Roe abortion bans on the books that could take effect if Roe is overturned, and 13 states have passed so called trigger laws after Roe to ban abortion if Roe was abolished.

On the other side of the debate 16 states in the District of Columbia have laws protecting the right to an abortion. A decade ago only seven states had such laws on the books, but more state legislatures have been taking up the issue in anticipation of a possible reversal of Roe v. Wade. New Jersey Governor Phil Murphy, for example, signed a law In January that permits abortions throughout pregnancy. In some states, including Alaska and Minnesota, the right to an abortion is protected not by law, but by their state constitutions. In a few others, there are not legal protections for abortion rights, but the states also aren't likely to restrict or ban abortion. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

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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 www.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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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Anxiety disorders are on the rise among the nation's youth and experts in the field of child psychology feel the condition starts much earlier in childhood, and it's far more common than previously thought with an estimated one in five children being affected. But too often these so called internalizing disorders go undiagnosed. Unlike children with more expressive conditions such as ADHD, young kids struggling with anxiety or depression may just seem like an introvert to the casual

observer.

University of Vermont Child Psychologist Ellen McGinnis says the process of diagnosis for younger children is often painstaking and can take months to confirm. Dr. McGinnis says the traditional method of diagnosis involves creating scenarios that induce anxiety, followed by behavioral observation by clinicians, and the results can be inexact. She teamed up with her husband and fellow researcher biomedical engineer Ryan McGinnis to create a wearable sensor that can pick up on physical cues that suggest the presence of anxiety, using accelerometers and simple algorithms to compare normal stress responses.

Dr. Ellen McGinnis: The device is called Inertial Measurement Unit, and it's about the size of a business card and so we strap that to belts on each child. When they did the mood induction task it has an accelerometer in it and so we were able to pick up angular velocity, speed, how much the child is bending forward and backward, and turning side to side, and it actually picks up 100 samples per second, so much more than the eye can see. We were able to see if kids with anxiety and depression move differently in response to potential threatening information, and they do. Kids with disorder turn further away from the potential threat than kids without a disorder.

Mark Masselli: Their research paper shows the device was nearly 85% accurate in making a correct diagnosis. She says early diagnosis is the key to avoiding more damaging manifestations of anxiety disorder later on. A simple wearable tool that can assist in determining if a child is suffering from anxiety disorder, leading to more rapid diagnosis and treatment, now that's a bright idea.

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health

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Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at www.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.

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