

ACMHA ARM CHAIR REFLECTIONS

Preparing the Public Mental Health and Substance Use Systems for H1N1

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I wanted to share some thinking with you what is probably paranoia, but, perhaps not. I've been thinking about the impending flu epidemic predicted to hit across the country in late fall and winter. These ideas are ringing alarm bells for me about pandemic flu and the vulnerability of people with addictions and mental illnesses and the staff of the programs that treat them. Perhaps HHS, SAMHSA, and state emergency preparedness agencies have already seen these issues and put plans into place. I hope so.

My understanding from the press is that the H1N1 pandemic flu will likely affect young people who have a very strong antihistamine reaction to the flu virus. It will severely affect people whose immune systems are compromised. It will be dangerous for people with chronic medical problems, especially those who smoke or who have diabetes. It will spread through people who congregate in close quarters with others who are infected. It will impact people who do not have access to primary care, early intervention, and ongoing access to medical services. And it will affect those care givers who work with affected, ill populations.

Doesn't this sound to you like many people who are addicted to alcohol or other drugs, people with severe mental illnesses, and the staff of the public specialty substance use and mental illness treatment and recovery organizations? We have seen the devastation of the waves of HIV/AIDS and Hepatitis C, when they came roaring through the public substance use and mental health treatment systems. Lots of consumers/clients died. Lots of counselors got sick and died, too. H1N1 could have that effect this fall and winter.

There are additional reasons to be concerned about the impact of a H1N1 pandemic. There's every reason to expect that emergency services will be overwhelmed, particularly in those areas of the country where there have been cutbacks in emergency departments and economic recession has further sapped hospitals' emergency capacities. This pretty well defines the Mexico border regions and coastal Florida, and large metropolitan communities such as Washington DC, Philadelphia, and New York. When emergency departments become overwhelmed by flu emergencies from the general population, we will likely see crowd-out of psychiatric and substance use emergencies. I imagine that people with both addictions or mental illnesses and flu are likely to be crowded out the furthest. Already there are very severe problems across the country in the availability of crisis mental health and substance use services. Throw in the huge bottleneck that will occur in communities hit by the flu that have no surge capacity in their emergency systems and you've got a psychiatric/addiction emergency. Add to that the fact that crisis services staff is likely to become ill themselves, cutting service capacity when it is most needed.

My final concern is that our public treatment programs that handle the most addicted and ill people will be hit by the flu. Staff in these programs will be at very high risk of becoming ill themselves through proximity with infected patients and, for some, their own compromised immune systems from HIV/AIDS, Hepatitis C, and past substance use. The public substance use and mental health treatment programs will be short staffed precisely at the time that they will need to deliver medical services for people who are ill. The public substance use treatment programs are already extremely understaffed with medical personnel. The public mental health systems are overstressed by the economic downturn; reducing public funding while demand has increased. Further stress these systems with staff absences from the flu and physically ill clients/consumers (with their chronic medical problems, their addictions and mental illness, and their flu) and we will likely see confusion and capacity problems should a pandemic flu hit. What happens when patients in psychosocial rehabilitation, day treatment, intensive outpatient programs, residential programs, halfway houses, psychiatric/substance abuse inpatient, etc. become ill from the flu and its complications, and they need medical treatment precisely at the time that the overwhelmingly non-medical staff of these programs are sick themselves?

There are solutions. Start planning and preparing with an awareness of the impending disproportionate impact that pandemic flu could have on people with mental illnesses and addictions, especially those who are poor. Make sure that people with addictions and serious mental illnesses are among the populations prioritized for vaccinations this fall. Especially prioritize those who have severe mental illnesses, addictions and co-occurring chronic medical problems. Make sure that public mental health and substance use treatment program staff and behavioral health crisis services staff are among the priority health care providers who receive flu vaccinations. Publicize flu prevention in public mental health and substance use treatment programs. The Federal agencies leading national preparedness and the Federal agencies responsible for mental health and addictions services should immediately convene meetings with their counterparts at the state and local level and with behavioral health care provider organizations that will be at the front lines of the epidemic to create and implement emergency plans.

Three specific steps that can be taken this week:

1. Identify the 500 largest substance use treatment programs and 1,000 largest mental health service programs serving high risk, high volume patients. Target messages from HHS and respective State Substance Abuse and Mental Health Agencies to each of these programs for H1N1 preparedness and prevention, stressing that these programs are the front line and that their disaster preparation is necessary to prevent serious health problems for their patients and staff and to prevent contagion to vulnerable populations that their patients and staff could infect. Improve state planning and disaster preparedness through the SAMHSA block grant programs, including giving states permission to spend block grant funds for disaster preparedness. Among substance use programs, the high risk, high volume programs would primarily be methadone/buprenorphine and intensive outpatient programs, with a total patient volume of about 400,000 annually. For mental health, these programs would include inpatient psychiatric treatment programs (especially VA and state mental hospitals), partial hospitalization and psychosocial rehabilitation programs, club house programs, and day treatment programs, with a total patient volume of about two million per year.

2. For each high volume, high risk program, implement an H1N1 vaccination program for all patients and staff. These groups constitute high risk vectors for infection and for high morbidity/mortality.

3. For each high volume, high risk program, recommend specific plans be developed and implemented to use and to stockpile depot antipsychotics, take-home doses of oral psychotropics and oral and depot anti-craving drugs. Consider opening HRSA's 340b drug discount purchasing to these high volume, high risk behavioral health programs.

I hope that I'm just coming late to a well developed planning and preparation process. But if not, then it may not be too late to act to effect a better outcome.