Congressional staff briefing addresses crisis in older adult mental health

If the current prevalence of mental illness among older adults — one in five have one or more mental health and substance use conditions — remains unchanged, over the next two decades, the number with mental and/or substance use disorders will nearly double from 8 million to 14 million older adults, according to hosts of a congressional briefing to address the crisis in the older adult mental health population.

The briefing, “Addressing the Crisis in Older Adult Mental Health,” marked Mental Health Awareness Month. The May 17 event was hosted by the National Coalition on Mental Health and Aging, the National Association of County Behavioral Health and Developmental Disability Directors, the National Association for Rural Mental Health and the National Association of Counties, in coordination with Reps. Grace Napolitano (D-California) and John Katko (R-New York), co-chairs of the House Mental Health Caucus.

Remote locations, the shortage of mental health providers, the opioid epidemic and social isolation were among the topics addressed and discussed by a panel of experts. Panelists included Stephen Bartels, M.D., and the Association for Rural Mental Health.

Bottom Line…
Mental health groups and congressional staff discuss policy and program approaches, including evidence-based practices, to address mental health issues affecting older adults.

CDC: More treatment-cessation efforts needed for smokers with MH, SUDs

Persons with mental health or substance use disorders or both are more than twice as likely to smoke cigarettes as persons without such disorders and are more likely to die from smoking-related illness than from their behavioral health conditions, according to the Centers for Disease Control and Prevention’s (CDC’s) Morbidity and Mortality Weekly Report. Many persons with mental health or substance use disorders who smoke want to and can quit smoking, although they may require more intensive treatment, the May 11 report stated.

About half of mental health (49 percent) and a third of substance abuse treatment facilities (35 percent) reported having smoke-free campuses in the 50 states; Washington, D.C.; and Puerto Rico, according to the report, “Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities — United States, 2016.”

Tobacco-free campus policies and integration of tobacco-cessation interventions in behavioral health facilities’ workflows is one way of removing barriers to delivery of cessation interventions, the Centers for Disease Control and Prevention suggests.

Bottom Line…
Integrating screening and treatment protocols into behavioral health facilities’ workflows is one way of removing barriers to delivery of cessation interventions, the Centers for Disease Control and Prevention suggests.
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professor of psychiatry, community and family medicine, and of health policy at the Dartmouth Institute; Brian Kaskie, Ph.D., associate professor in the M.S. in Health Policy Program and director of health management and policy at the University of Iowa; and Jacque Gray, Ph.D., research professor and associate director for the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences.

The elderly and disabled in the Medicare program are often at the highest risk for mental health problems such as depression and suicide, Joel Miller, executive director and CEO of the American Mental Health Counselors Association (AMHCA), told MHW in an interview prior to the event.

“The aging of our population is going to have a major impact on the financing and delivery in mental health care services and health care services, along with Social Security programs over the coming decade,” said Miller. The impact is due to the influx of baby boomers coming into the Medicare program, he said.

The elderly population over 65 will double in the next 20 years, he said. “We’re going to see an increase from 40 million in 2011 to 80 million in 2030,” said Miller, who also serves as chair of the National Coalition on Mental Health & Aging. Up to 14 to 15 million people will be enrolled in Medicare by 2028, he said.

Miller added, “Based on public systems and the private-sector systems, there is no way those systems will be able to handle or address the increase in the number of people coming into the Medicare program.”

The older population with mental illness have high mortality rates due to such chronic conditions as heart disease, diabetes and cancer, he said. Older white males have the highest suicide rates, Miller added.

Solutions “We believe there is a crisis in older adult mental health care,” said Miller. “We know things we can do about it, [such as the provision of] well-established evidence-based practices to address the needs of older adults with mental health conditions.”

Integrated physical and mental health care and self-management programs for this population are effective, he noted. Home- and community-based service delivery and community health interventions also represent critical solutions in addressing the needs of older adults with mental health conditions. In the future, these programs that now only reach a few need to be “scaled up,” he said.

The problem, however, is that few older adults receive these kinds of evidence-based services treatment and support, said Miller. “Only about 25 percent of older adults with mental health or substance use disorders receive any behavioral health services,” he said.

The issues include workforce shortages and public policy issues, he said. “Over the last several years, more funding and resources have gone to address the needs of children and young adults,” Miller said. “The older adult mental health population has been neglected.” They also need to be viewed as a priority population, he said.

Speaking from AMHCA’s standpoint, Miller said that legislation,
Manderscheid noted that there is a lot of depression and alcohol use among the elderly. “We have very few services for the elderly,” he said. In general, it’s important to determine how best to care for the elderly, said Manderscheid. “It’s not just about treatment,” he noted. “It’s about how to prevent depression in the first place and how to prevent alcoholism in the first place. We want to hear what the congressional caucus is going to do.”

The panel aims to discuss the nature of the problem and what should be done about it, he said, and look at how the Community Mental Health Services block grant and the Substance Abuse Prevention and Treatment block grant and the Projects for Assistance in Transition from Homelessness, for example, can help the senior population.

Both the U.S. Senate Special Committee on Aging and the House Mental Health Caucus recognize that aging is an issue in America, said Manderscheid. “But we also want them to recognize the growing crisis of behavioral health care,” he said. “We want that to be a part of the agenda.”

### Rural support for older population with mental health issues

Jacque Gray, Ph.D., research professor and associate director for the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences, and one of the panelists at the congressional briefing, also spoke with MHW before the event.

Gray noted that rural communities have the least access to mental health care. “With cutbacks happening, it’s getting worse,” said Gray, who works with Native Americans and the Indigenous population. “Many rural hospitals and clinics are closing, meaning people have to travel very far to receive services.” Her remarks will focus on technology and strategies to address the needs of rural and culturally diverse older adults, she said.

Gray, who works with Native American populations, noted that on the reservations there may be limited internet access and no way to receive a wireless signal to allow for phone calls and texts. “It’s not adequate enough for bandwidth to carry telemedicine” or video, she noted. It ends up with providers making phone calls to patients as opposed to being able to pick up mental health cues from them, such as facial expressions, she noted. “We don’t have the infrastructure in place to allow that to happen,” she said.

The crisis in the older adult mental health population includes the opioid epidemic. Family members or caregivers of the elderly may use medications “to control elderly persons by overmedicating them so that they aren’t making demands,” she said. In a lot of families, they could also be undermedicated, Gray said. Caregivers of older adults themselves may be using opioids, “adding an additional layer of risk,” she said.

Gray added, “If a caregiver or family member is using opioids, that impacts the care the elderly person receives. They could be stealing from or exploiting their family member or doing other things that might jeopardize the elders’ health.”

### Long-term care shortages

Gray noted the difficulty of elderly patients with mental health needs maintaining their lives in rural areas. “The shortage of long-term care facilities really impacts where tribes go. They’re leaving their community, their family, to go more than 100 miles away where no one understand their background or culture or about the things that are important to them,” she said.

Additionally, staff at the long-term facilities might not be culturally competent enough to know what the patients’ needs are, she said. “That’s added stress for them,” said Gray. They can become more depressed and feel like they’re being sent away to die. There’s no connection, no family, and they can feel very isolated. That can be detrimental to their mental health as well as their physical health.”

Gray added, “The more we can help the elderly age in place, the better the quality of their life will be.”
Potential treatment found for patients at risk of suicide

Observing that major depressive disorder is the most prevalent mental health condition, affecting one in five adults in the United States, and the psychiatric diagnosis most commonly associated with suicide, researchers of a new study looked at medication that might be effective for the treatment of patients with major depression assessed to be at imminent risk for suicide.

The authors compared the efficacy of standard-of-care treatment plus intranasal esketamine or placebo for rapid reduction of symptoms of major depression, including suicidality, for this population.

The study, “Efficacy and Safety of Intranasal Esketamine for Rapid Reduction of Symptoms of Depression and Suicidality in Patients at Imminent Risk for Suicide: Results of a Double-Blind, Randomized Placebo-Controlled Study,” appears online in the American Journal of Psychiatry (AJP). The Janssen-funded study will appear in the July issue of AJP.

Normally, antidepressant medications could take weeks to work, said Carla M. Canuso, M.D., senior director of clinical development at Janssen Research & Development, and lead author of the study. “The goal of the study design was to aim at rapidly reducing symptoms of depression, including suicide ideation,” Canuso told MHW. Researchers defined rapidly as four hours, she stated. “This is the first study of esketamine in this patient population,” said Canuso.

Currently, there is no approved treatment for this medication, she said. Janssen has not filed the drug yet for approval. Esketamine is part of the ketamine molecule, she noted. A rapidly active treatment could be beneficial for the patient population at high risk for suicide, Canuso added.

Bottom Line…
Preliminary findings from a study regarding clinical use of intranasal esketamine for suicidal patients with major depression have prompted researchers to prepare for a phase 3 trial.

Method
Researchers of the double-blind, multicenter, proof-of-concept study provided 66 participants (ages 19 to 64 who had a diagnosis of major depressive disorder without psychotic features) esketamine or placebo twice weekly for four weeks, in addition to comprehensive standard-of-care treatment.

‘This is the first study of esketamine in this patient population.’
Carla M. Canuso, M.D.

The primary efficacy endpoint was change in score from baseline to four hours after initial dose on the Montgomery-Asberg Depression Rating Scale (MADRS). Researchers also assessed clinician global judgment of suicide risk (from the Suicide Ideation and Behavior Assessment Tool). Secondary endpoints included these measures at 24 hours and a double-blind endpoint at day 25.

Canuso indicated she and fellow researchers wanted to explore whether esketamine can rapidly reduce depressive symptoms and help to bridge the gap of several weeks between when a patient begins a standard antidepressant and when that treatment begins to work.

Findings
Researchers found that esketamine treatment added to the standard of care resulted in a statistically significant, clinically meaningful improvement in depressive symptoms at four hours, including a measure of suicidal ideation, in patients with major depressive disorder who were at imminent risk for suicide, compared to a placebo added to the standard of care.

Suicidal ideation, as measured by the MADRS suicidal thoughts item, was also significantly reduced at this four-hour time point, researchers noted.

Participants in the esketamine group had significantly greater improvement in score on the MADRS suicidal thoughts item compared with those in the placebo group four hours after first dose, but not 24 hours after the first dose or at the double-blind endpoint day.

Researchers noted that intranasal esketamine was generally well-tolerated. During the double-blind phase, none of the participants in the placebo group and four participants in the esketamine group experienced a serious adverse event (two had suicidal ideation, considered by investigators as doubtfully related or unrelated to the study drug; one had agitation, considered unrelated to the study drug; and one had exacerbation of depressive symptoms, considered possibly related to the study drug).

While the results are preliminary, “it gives us the confidence to go into a phase 3 study,” said Canuso. The study will involve two trials, each with 224 patients, she said. Researchers are still gathering study participants. “If the results are confirmed from the findings of our preliminary study, this could become the first treatment for this patient population,” Canuso said.

Suicide is on the rise in this country, she said. “Over 44,000 people die from suicide annually,” she said. “We feel it’s important to provide medication for [this unmet] need right now. There are no available treatments.”

Currently, when patients are in an acute crisis state, they are kept...
Many providers eager to learn more about diabetes care

Interest has been brisk in a training curriculum designed to help mental health professionals work more effectively with patients who are also managing diabetes. Organized under a partnership (see MHW, June 19, 2017) between the American Psychological Association (APA) and the American Diabetes Association (ADA), the training attracted larger-than-expected enrollment at last year’s APA annual conference and could do so again this summer in San Francisco.

The two organizations’ joint registry of mental health professionals who have diabetes-specific education or experience now numbers around 100 providers, APA Director of Integrated Health Care W. Douglas Tynan, Ph.D., confirmed in an interview with MHW. In order to be listed in the public directory, professionals must maintain an annual membership with the ADA, an organization Tynan says traditionally includes a substantial number of mental health providers (along with general health professionals and patients).

Tynan says he consistently emphasizes the importance of integrated care for patients with diabetes when he speaks with fellow mental health professionals. “In my talks to clinical psychology groups, I tell them that 20 percent of the people they see are probably pre-diabetic or diabetic,” he said.

Identifying and understanding the illness carries a great deal of importance for the mental health provider because the manifestations of diabetes and depression can appear nearly identical, Tynan said. Feelings of lethargy, for example, could be attributable to either underlying depression or a lack of blood sugar control, he explained.

‘I would like to see joint workshops of medical societies and psychologists.’

W. Douglas Tynan, Ph.D.

Details of training

The full-day course for mental health professionals consists of both didactic and experiential elements. As part of the experiential component, participants conduct blood tests and carbohydrate counts in an effort to understand what diabetes patients go through on a daily basis to manage their illness.

These daily pressures, Tynan says, often lead to feelings of hopelessness in the patient with diabetes. “They may lose the motivation to take better care of themselves,” he said.

Tynan explained that the ADA initiated the partnership with the APA at a time when it was receiving many requests from general health professionals who wanted to refer patients to mental health providers who had a better working knowledge of diabetes and the complex regimens patients fulfill to manage it. It also has been important for mental health professionals to learn more about potential interactions between psychotropic drugs and diabetes medications.

Sixty of the psychologists attending last year’s ADA conference received the training at the meeting. Subsequently, the course attracted an overflow attendance of 88 at the APA annual conference last August, said Tynan, who added that he has been pleasantly surprised by the level of interest in the psychology community.

This year, the course again will be offered at both the ADA Scientific Sessions, scheduled for June 22–26 in Orlando, Florida, and the APA annual meeting, to be held Aug. 9–12 in San Francisco.

Tynan said the next phase of the organizations’ work could involve enhanced mental health training for primary care providers working in diabetes care. In addition, “I would like to see joint workshops of medical societies and psychologists,” he said.
treatment facilities could decrease tobacco-related disease and death and could improve behavioral health outcomes among persons with mental and substance use disorders, the report indicated. "We know that people with mental health and substance use disorders are two times more likely to smoke as the general population," Kristy Marynak, MPP, lead public health analyst in the CDC’s Office on Smoking and Health and corresponding author of the report, told MHW. Forty percent of all cigarettes smoked in the United States are by people with mental health and substance use disorders, she said.

Any person who smokes, regardless of behavioral health conditions, is at risk for 13 different types of cancer, and heart disease and stroke, Marynak said. "Smoking harms virtually every area of the body," she said. Additionally, people with behavioral health conditions are more likely to die from a smoking-related illness than from a behavioral health condition, she noted.

To assess tobacco-related policies and practices in the United States (including Puerto Rico), the CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) analyzed data from the 2016 National Mental Health Services Study and the 2016 National Survey of Substance Abuse Treatment Services.

The indicators that the CDC looked at with SAMHSA included screening efforts, tobacco counseling, nicotine medications and whether facilities had smoking policies for indoors or outdoors, said Marynak.

The report found that cessation counseling was the most commonly offered tobacco-dependence treatment in mental health (37.6 percent) and substance abuse (47.4 percent) treatment facilities. Approximately one-fourth of all mental health (25.2 percent) and substance abuse (26.2 percent) treatment facilities offered nicotine-replacement therapy, and approximately one-fifth of mental health (21.5 percent) and substance abuse (20.5 percent) treatment facilities offered non-nicotine medications.

State variabilities By state, the percentage of facilities offering tobacco-cessation counseling ranged from 20.5 percent (Idaho) to 68.2 percent (Oklahoma) among mental health facilities and from 26.9 percent (Kentucky) to 85 percent (New York) among substance abuse treatment facilities.

Marynak credited New York and Oklahoma with leading the way in providing cessation services and offering tobacco-free campuses to consumers with mental health and substance use disorders. 

CDC, SAMHSA data To assess tobacco-related policies and practices in the United States (including Puerto Rico), the CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) analyzed data from the 2016 National Mental Health Services Study and the 2016 National Survey of Substance Abuse Treatment Services.

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One lack of provider incentives for delivering tobacco-cessation treatment, including reimbursement challenges, however, might pose additional barriers, the report stated. In the past, the tobacco industry has opposed smoke-free psychiatric hospital policies, donated cigarettes to mental health facilities and funded research suggesting that patients...
with psychiatric illnesses need tobacco for self-medication.

The report notes that several actions could help address actual and perceived barriers to integrating tobacco-dependence treatment into behavioral health treatment. These actions could include removing administrative and financial barriers to delivery of cessation interventions and integrating tobacco screening and treatment protocols into facilities’ workflows and electronic health record systems.

Additionally, outreach to behavioral health providers could emphasize that their patients can benefit from evidence-based cessation treatments, although longer-duration or more intensive cessation treatments might be indicated, the report stated.

“Tobacco cessation is a key part of our mission at the CDC,” added Marynak. “We not only track cessation trends in research [and education], we have a tobacco-cessation campaign.” The campaign is currently on the air nationwide on cable and network television and online, she noted.

The CDC launched its first tobacco education campaign in March 2012. The Tips From Former Smokers campaign profiles real people — not actors — who are living with serious long-term health effects due to smoking and secondhand smoke exposure. Ads have featured people living with stomas, lung cancer, amputations, and serious health conditions as a result of their smoking.

### NASMHPD tobacco policy statement embraces community

Following much success in ensuring that nearly 80 percent of all state psychiatric hospitals are tobacco-free, the National Association of State Mental Health Program Directors (NASMHPD) last summer revised its policy statement on tobacco cessation to include all behavioral health settings, particularly in the community.

The NASMHPD had announced its success rates with tobacco-free hospital settings in 2012 following the organization’s commitment to working with national organizations and decision-makers, public and private service providers, and other support systems to ensure continued access to smoking-cessation treatment and support in the community (see *MHW*, Aug. 13, 2012).

The NASMHPD’s new Policy Statement on Tobacco Cessation in all Behavioral Health Settings notes, “Smoking, and tobacco use of any kind, continues to be an issue of focus due to its detriment on health and the well-being of any community.” The NASMHPD in the summer of 2017 implemented a new smoking-cessation policy to emphasize tobacco cessation in community programs, said Brian Hepburn, M.D., NASMHPD executive director. “This is a very important issue for us trying to help individuals and employees in our hospitals to stop smoking,” Hepburn told *MHW*. “Around the country, we’ve had quite a bit of success in trying to get public and private hospitals to move to a no-smoking [environment] for employees and patients.”

Hepburn added that over the last couple of years, consistent with the Centers for Disease Control and Prevention (CDC) report, the NASMHPD has been concerned about the high smoking rates among consumers with mental illness or addictive disorders. The prevention emphasis has been on hospitals over the last few years, Hepburn noted. “Changes in the hospital have been very successful,” he said. “Now we’re working with members to [take that success] into the community.”

Hepburn added, “Like the CDC says, we can move nonsmokers in the right environment with the right support.”

### Hospitals versus community settings

Hepburn explained that the difference between hospitals and the community is that the former represents more controlled and smaller environments. “Trying the same effort in the community is much more challenging because people [participate] in community programs and then go back home,” he said. It may be harder for them to quit, he noted, especially if people are smoking in the environment they’re in.

Hepburn attributes much of the success of tobacco-free psychiatric hospitals to former NASMHPD Executive Director Robert Glover, Ph.D. Glover, along with state medical directors and mental health commissioners working together, had a direct impact on the hospitals’ smoking-cessation efforts, he said. “That’s what counted for the success,” he said. “We’re hoping for similar efforts in the community.”

The policy statement points to the NASMHPD’s commitment to assisting local, state and national efforts to engage consumers in going smoke-free. “This will include consumer voice on how best to initiate efforts and begin the dialogue as it also coincides with meeting mental health and physical health needs. Peer and advocacy organizations will be at the forefront of this work...” according to the statement.
African-American clergy can influence parishioners’ pursuit of treatment

A survey of African-American Protestant clergy indicates an overall positive attitude toward their parishioners’ pursuit of professional mental health services, suggesting that these religious leaders can help increase their communities’ access to mental health care. These data were presented this month at the annual meeting of the American Psychiatric Association (APA). The survey, which involved 98 clergy in Georgia and South Carolina, looked at theological beliefs, education and personal experience and how each correlated with clergy’s attitudes toward individuals who are seeking treatment for mental health issues. The survey found that theological beliefs were the factor that influenced African-American clergy’s attitudes about parishioners seeking help. Neither education nor personal experience were correlated with clergy’s attitudes around help-seeking. These findings are important in light of the fact that only one in three African-Americans who need mental health treatment receive it, with stigma playing a prominent role. Many individuals with mental health concerns often will meet with a religious leader before they seek services from a health professional. The study was led by Ebony Gaffney, M.D., Ph.D., an APA fellow and a psychiatrist with Horizon Behavioral Health in Savannah, Georgia.

Names in the News

Altha Stewart, M.D., began her one-year term as president of the American Psychiatric Association (APA) at the conclusion of the APA annual meeting in New York on May 9, APA officials announced. At the same time, Bruce Schwartz, M.D., began his term as APA president-elect. Stewart is the first African-American to lead the APA and the fourth consecutive woman chosen to lead the association. She is an associate professor of psychiatry and director of the Center for Health in Justice Involved Youth at the University of Tennessee Health Science Center in Memphis. Her career includes serving as president of the Association of Women Psychiatrists and president of the Black Psychiatrists of America. In her address at the APA annual meeting, she announced one of her areas of focus during her yearlong tenure as president will be on leadership opportunities for early-career psychiatrists and residents and better reflecting their needs and the voices in APA strategies and actions.

Coming up…


In case you haven’t heard…

Could the introduction of trees, hedges and green roofs reduce air pollution and improve mental and physical well-being? According to a May 14 University of Surrey press release, this is the question a new task force at the university is looking to answer. The Green Infrastructure and Health Mapping Alliance of Surrey Academics (GREENMASS) will see academics from a range of disciplines use their combined knowledge and expertise to explore whether initiatives, such as planting trees and investing in green roofs, actually make a difference to well-being. Guildford, a town in the United Kingdom, will be used as the initial pilot study area, but it is hoped that GREENMASS will grow to surrounding towns and cities. The team at Surrey is hoping that the new supergroup will lead to a long-term collaborative platform for academics to develop a new approach to linking green infrastructures to health outcomes. Professor Simon de Lusignan, a founding member of GREENMASS and the head of the Department of Clinical & Experimental Medicine, said, “As a clinician and researcher, I have seen the impact of pollution on physical and mental health…. GREENMASS connects clinical knowledge and data with those with environmental expertise, and is a very welcome initiative.”